University Hospitals Sussex NHS Foundation Trust

# Meeting of the Board of Directors

**10:00 to 13:15** on Thursday 17 September 2026

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

## AGENDA – MEETING IN PUBLIC

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| Item:1 | 10:00 | **Welcome and Apologies for Absence**<br>*Apologies: Helen Brown* | *To note* | Verbal | Presenter: Philippa Slinger |
| | | **Confirmation of Quoracy**<br>*A meeting of the Board shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that at least half of the Board must be present this being nine Board members. With a minimum of two Executives and two Non-Executive Directors.* | *To agree* | Verbal | Presenter: Philippa Slinger |
| Item:2 | 10:00 | **Declarations of Interests** | *To determine if any action is required* | Verbal | Presenter: All |
| Item:3 | 10:00 | **Minutes of UHSussex Board Meeting held on 11 June 2026** | *To approve* | Enclosure | Presenter: Philippa Slinger |
| Item:4 | 10:05 | **Matters Arising from the Minutes** | *None* | Verbal | Presenter: Philippa Slinger |
| Item:5 | 10:05 | **Questions from the public**<br>To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting. | *To respond* | Verbal | Presenter: Philippa Slinger |
| Item:6 | 10:15 | **Patient Story** | | Verbal | Presenter: Patient *(Tori Cooper)* |
| Item:7 | 10:45 | **Report from Chief Executive** | *To receive and note overview of the Trust's activities* | Enclosure | Presenter: Dr. Andy Heeps |
| Item:8 | 11:00 | **CQC Maternity Service Inspections St Richards Hospital and Princess Royal Hospital** | *To receive and discuss* | Enclosure | Presenter: Emma Chambers |
| Item:9 | 11:10 | **Progress on NHSE Sprint** | *To receive and note assurance* | Enclosure | Presenter: Emma Chambers |
| Item:10 | 11.30 | **Independent Maternity Review update** | *To share* | Verbal | Presenter: Gail Byrne |

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| Item:11 | 11:40 | **One UHSussex update *including***<br>- *Well Led Developmental review action stocktake* | *To consider* | Enclosure | Presenter: Dr.Andy Heeps |
| | *11:50* | ***5 Minute Break*** | | | |
| | | **REPORTS FROM COMMITTEES** | | | |
| Item:12 | 11:55 | **Report from Audit Committee from the meeting held on the 28 July 2026** | *To note assurance from Committee and action recommendations from the Committee* | Enclosure | Presenter: Mike Driver |
| Item:13 | 12:00 | **Report from the Research Innovation & Digital Strategy Assurance Committee from the meeting held on the 6 August 2026** | *To note assurance from Committee and action recommendations from the Committee* | Enclosure | Presenter: Prof. Jackie Cassell |
| Item:14 | 12:05 | **Report from Strategy & Major Projects Assurance Committee from the meetings held on the 3 September 2026** | *To note assurance from Committee and action recommendations from the Committee* | Enclosure | Presenter: Prof. Paul Layzell |
| Item:15 | 12:10 | **Report from Patient & Quality Assurance Committee from the meetings held on the 7 July, 4 August, 13 August 2026** | *To note assurance from Committee and approve the annual reports* | Enclosure | Presenter: Lucy Bloem |
| Item:16 | 12:20 | **Report from People & Culture Assurance Committee from the meetings held on the 8 September 2026** | *To note assurance from Committee and approve the annual reports* | Enclosure | Presenter: Prof. Paul Layzell |
| Item:17 | 12:30 | **Report from Finance & Performance Assurance Committee from the meetings held on the 2 July 2026, 6 August 2026** | *To note assurance from Committee and action recommendations from the Committee* | Enclosure | Presenter: Philip Hogan |
| | | **PERFORMANCE AND RISK** | | | |
| Item:18 | 12:35 | **Maternity Performance Assurance Report** | *To receive papers and triangulate with P&Q Committee chair's report* | Enclosure | Presenter: Emma Chambers |
| Item:19 | 12.45 | **Integrated Performance Report** | *To triangulate with Committee reports and agree actions* | Enclosure | Presenter: Dr. Andy Heeps |

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| Item:20 | 12:55 | **Board Assurance Framework** | *To approve* | Enclosure | Presenter: Glen Palethorpe |
| | | **WIDER COMPLIANCE** | | | |
| Item:21 | 13:05 | **Company Secretary Report** *including review of UHSussex Constitution* | *To note and to approve the UHSussex Constitution* | Enclosure | Presenter: Glen Palethorpe |
| | | **OTHER** | | | |
| Item:22 | 13:15 | **Any Other Business**<br>To receive any notified urgent business and action | *To receive any notified urgent business and action* | Verbal | Presenter: Philippa Slinger |
| Item:23 | 13:15 | **Date and time of next meeting:**<br>The next meeting in public of the Board of Directors is scheduled to take place at **10:00 on Thursday 12 November 2026.** | | Verbal | Presenter: Philippa Slinger |

**Supporting Appendices:**

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| Item: 7 | Chief Executive Report | *Surrey & Sussex Cancer Alliance Annual Review 2025-26* | *To receive and note* | Enclosure |
| Item: 8 | CQC Reporting | *CQC Maternity Report St Richards Hospital*<br>*CQC Maternity Report Princess Royal Hospital* | *To receive and discuss* | Enclosures |
| Item:12 | Audit Committee | *Annual Audit Committee Report 2025-26* | *To receive and note* | Enclosure |
| Item:15 | Patient & Quality | *Mortality & Learning from Deaths Report Quarter 4 2025-26*<br>*Organ Donation 2025-26*<br>*Infection Prevention & Control Annual Report 2025-26*<br>*Safeguarding Children & Adults Annual Report 2025-26* | *To receive and approve the Annual Reports 2025-26* | Enclosures |
| Item:16 | People & Culture | *Annual Equalities Report 2025-26*<br>*Annual Medical Appraisal and Revalidation Statement of Compliance 2025-26* | *To receive and approve the Annual Reports 2025-26* | Enclosures |
| Item:18 | Maternity | *Perinatal Quality Oversight Model Report (May data)* | *To receive and note* | Enclosure |
| Item:21 | Company Secretary | *UHSussex Constitution* | *To approve* | Enclosure |

# Minutes

University Hospitals Sussex NHS Foundation Trust

**Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 11 June 2026, held in the Washington Suite Boardroom, Worthing Hospital, Lyndhurst Road, Worthing and via Microsoft Townhall Live Broadcast.**

**Present:**

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| Philippa Slinger | Chair |
| Professor Paul Layzell CBE | Non-Executive Director |
| Bindesh Shah | Non-Executive Director |
| Professor Gordon Ferns | Non-Executive Director |
| Professor Jackie Cassell | Non-Executive Director |
| Jin Sahota | Non-Executive Director |
| Lucy Bloem | Non-Executive Director |
| Mike Driver | Non-Executive Director |
| Philip Hogan | Non-Executive Director |
| Dr Andy Heeps | Interim Chief Executive |
| Helen Brown | Interim Chief Corporate Affairs Officer |
| Jonathan Reid | Chief Financial Officer |
| Professor Catherine “Katie” Urch | Chief Medical Officer |
| Nigel Kee | Chief Operating Officer |
| Sarah-Jane Taylor | Interim Chief People Officer |

**In Attendance:**

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| David Coyle | Interim Managing Director Medicine |
| Maria Emmanuel | Managing Director Cancer & Specialist |
| Oliver White | Managing Director Women, Children & Clinical Support |
| Wilson Dodzo | Interim Managing Director Medicine |
| Joe Mills | Director of Strategy |
| Annette Gericke | Deputy Chief Nurse |
| Helen Weatherill | Director of HR Services (Item 6 only) |
| Valaar Ravi | Specialty Medicine Practice Nurse Educator (Item 6 only) |
| Julie Allen | Lead Radiographer Non-Obstetric Ultrasound RSCH/PRH (Item 6 only) |
| Jackie Groves | Associate Director – Major Projects (Item 9 only) |
| Jenny Preece | Deputy Director – Strategy (Item 9 only) |
| Martin Llewelyn | Clinical Director, Research and Innovation (Item 9 only) |
| Jonathan Keeble | Director of Communications & Engagement (Item 9 only) |
| Glen Palethorpe | Company Secretary |
| Tamsin James | Board and Committees Manager (minutes) |
| Catherine Bridger | Board and Committees Manager (production support) |

**TB/06/26/1 WELCOME AND APOLOGIES FOR ABSENCE** **ACTION**

1.1 The Chair welcomed all those present to the meeting including Joe Mills and Annette Gericke who were attending the meeting on behalf of Rox Smith and Maggie Davies respectively, along with the new Managing Director for Medicine Wilson Dodzo, and the new Non-Executive Director Jin Sahota.

1.2 The Chair noted apologies for absence were received from Rox Smith, Maggie Davies and Andy Hobart.

**TB/06/26/2 DECLARATIONS OF INTERESTS**

2.1 There were no interests declared.

**TB/06/26/3 MINUTES OF THE MEETING HELD ON 14 MAY 2026**

3.1 The Board received the minutes of the meeting held on 14 May 2026.

3.2 The Board **APPROVED** the minutes of the meeting held on 14 May 2026.

**TB/06/26/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING**

4.1 There were no matters for discussion.

**TB/06/26/5 QUESTIONS FROM THE PUBLIC**

5.1 The Chair noted that seven questions had been received from a member of the public. The individual had been advised that, although all questions had been carefully considered and responses prepared, only one question would be read out and addressed during the meeting. It was also confirmed that full responses to all of the submitted questions had been provided directly to the individual and were available on the UHSussex Trust website here: https://www.uhsussex.nhs.uk/about/board/board-meetings/

**TB/06/26/6 STAFF PRESENTATION**

6.1 The Board welcomed Helen Weatherill, Valaar Ravi, and Julie Allen to the meeting and the Chair advised that this item was valued today as it enabled the board to receive updates from staff members given the importance of considering staff experiences alongside those of patients.

6.2 Val Raavi presented to the Board on the Specialty Medicine Staff Well-Being Programme, and in doing so she described that the programme is aimed at enhancing nurses' knowledge and confidence in caring for patients with specialty or mental health needs, whilst improving safeguarding awareness, and promoting staff well-being in specialty medicine ward areas.,.

6.3 Val shared the levels of incidents of violence against her staff reported via the Trust's Datix system and reported an increase in incidents of violence and aggression towards staff within the specialty wards, highlighting workforce challenges such as staff burnout, absenteeism, and estate issues and insufficient security presence. Val emphasised the need for improved referral processes to mental health teams and better support from security and mental health services. The Board thanked Val for the presentation and agreed to take questions at the end of both presentations.

6.4 Julie Allen then provided a presentation on the supportive clinical supervision programme for ultrasound staff, which offers monthly one-to-one sessions to address stress, burnout, and professional development. Julie advised that the programme had led to reduced sickness absence, increased staff engagement, and participation in leadership and service improvement activities, with evaluation being undertaken through questionnaires and independent staff interviews.

6.5 The Board thanked both Val and Julie for their presentations and firstly discussed the need for ongoing support and cross-system collaboration when supporting patients with a mental health need, and resource allocation to sustain and expand staff well-being initiatives. In response to a question from the Board as what may make a difference, Val requested more timely mental health team support and raised concerns about increased demands on the site ward teams when caring for patients with such needs.

6.6 The Board discussed the sustainability of the programme, the use of simulation training, integration with enhanced care support worker roles, and the impact of the physical environment. Val confirmed ongoing evaluation and simulation use and plans to expand training and support. The board agreed to revisit progress in six months and to consider further actions to address staff well-being and mental health challenges.

6.7 The Board also noted its appreciation for the presentation and work of Helen Weatherill, Val and Julie and suggested they return later in the year so the Board can hear of the progress and wider learning opportunities these projects could bring to the Trust.

**TB/06/26/7 CHIEF EXECUTIVE REPORT**

7.1 Dr Andy Heeps reflected on his first six months in his role as Chief Executive, marking the milestone with a sense of pride and perspective on both the challenges and achievements across the organisation. He highlighted a significant recent event with the laying of the Sussex Cancer Centre foundation stone and the official opening of the new helipad at RSCH, attended by partners and stakeholders. Andy shared that the £250m investment in the Cancer Centre as transformational for cancer care in Sussex, underlining its future impact on patients and staff, and the opportunity to further improve care across the region.

7.2 Andy shared the sad news of the passing of Jim Sewell, Honorary Vice-President of the Friends of Chichester Hospitals and recognised his longstanding contribution, particularly his support for maintaining high standards of environment and catering at St Richard's Hospital. The Board offered its condolences to Jim's family.

7.3 Andy offered congratulations to the six UHSussex colleagues who had received prestigious national Chief Nursing Officer Awards, recognising their exceptional contribution and excellence across clinical practice, education, leadership and patient care. The Board also offered congratulations to consultant urological surgeon and UHSussex Deputy Chief Medical Officer Suzie Venn on her appointment as Joint Clinical Lead of NHS England's Getting It Right First Time (GIRFT) urology programme. The new Managing Directors were also welcomed, and the announcement of Alex Shaw as the new Chief Delivery Officer was shared.

7.4 Andy gave an update on the recent mental health summit supported by the Sussex Partnership Foundation Trust (SPFT) which created a greater shared recognition of system challenges and updated the Board on the key issues being progressed. A recent site visit with the Chair of NHS Surrey and Sussex highlighted similar pressures across organisations and opportunities for closer joint working.

7.5 Bindesh Shah asked given the earlier presentation, how the organisation was measuring the success of its Violence and Aggression initiatives beyond reducing incident numbers. Andy shared an update on improving reporting culture, so staff feel confident using systems like Datix, whilst also highlighting the need to move away from top-down approaches towards consistent, meaningful standards that feel authentic to staff. Jonathan Reid outlined the restart of a mandated quarterly Executive Security Group, jointly chaired by himself and the Chief Nurse. The group reviews areas such as security staff training, organisational policies and incident trends, with the aim of strengthening the overall security presence for staff. The Chair added that a recent meeting with the Head of Security, Mark Rosser, helped provide a clearer understanding of the scope and capability of security services.

7.6 Lucy Bloem raised concerns about reference in the presentation to long waiting times for its workforce accessing Trust occupational health support services and asked what assurance could be given on managing demand and prioritisation. Sarah Jane-Taylor explained that the workforce provision of occupational health support services were being actively reviewed, with plans to scale up capacity in response to a wider national issue affecting occupational health, along with additional measures that included targeted local initiatives and staff support programmes to help reduce waiting times. Andy Heeps acknowledged the concern in relation to Occupational Health and confirmed that this would require further review whilst noting that improvements and additional support measures were being developed.

7.7 The Board focused on the concerns raised in the earlier staff presentations regarding about increased exposure to challenging behaviours on Trust's wards. It was acknowledged that there is a need to strengthen support for ward staff in managing these situations and to ensure that actions taken were aligned with, and reflective of, frontline concerns. It was also highlighted that clear, open conversations with patients and families, alongside empowering and supporting staff to manage issues confidently, were key to addressing the problem.

7.8 The Board further discussed that leadership visibility was not just about being physically present, but about meaningful engagement and action whereby staff value leaders who actively listen to their issues, build strong relationships, and model positive behaviours. There was collective agreement on strengthening local leadership impact, empowering mid-level leaders from bands 4–7 through developmental leadership training, supporting and developing consistent, effective leadership at all levels was seen as key to improving staff experience and outcomes.

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

**TB/06/26/8 ONE UHSUSSEX**

8.1 Helen Brown informed the Board that the programme originally established in response to the developmental Well Led (NICHE) review was now moving towards conclusion. Any residual elements would move into the Integrated Improvement plan that the Trust was now working with NPIP and regional colleagues to develop. A 12-month on closure report for the 2025 NICHE review, alongside a refreshed set of improvement priorities will be brought to the September Board. The Chair commented that it was important to acknowledge progress within the organisation since the previous CQC well led review in 2022 and recent finding of the CQC that moved the Well Led rating from Inadequate to Requires Improvement.

8.2 The Board **NOTED** the update.

**TB/06/26/9 STRATEGY & MAJOR PROJECTS UPDATE**

9.1 The Board welcomed Jackie Groves, Jenny Preece, Martin Llewelyn and Jonathan Keeble, who presented an update on five major projects within the Trust's 'Excellent Care Everywhere' strategy by outlining progress against each of these projects and next steps, recognising that project governance has been supported by strengthened oversight through the Strategy and Major Projects Committee.

9.2 On RSCH Acute Floor Reconfiguration, Jackie Groves shared that good progress was reported within Surgical Assessment Units (SAU) and Acute

Assessment Unit (AAU) phases completed and being well utilised; enabling works were also underway ahead of further development, including a significantly expanded resuscitation area aligned with the helipad. Jackie also outlined the strong stakeholder engagement and delivery was on track for completion by 2030.

9.3 On Ventilation Remediation, Jackie advised that a complex, multi-year programme affecting 64 theatres was progressing with secured national funding, and there were mobile theatres in place to maintain capacity through phased refurbishment improving safety, efficiency and long-term maintenance capability.

9.4 Jackie also provided an update on the Sussex Cancer Centre (3Ts Stage 2) programme which was advancing following a £250m business case approval, with construction continuing well. There remained strong staff engagement, and plans for improved radiotherapy capacity, consolidated services, enhanced patient experience and operational readiness were being informed by previous 3Ts phase-1 learning. The RSCH Helipad was already operational with measurable improvements in transfer times and patient outcomes, and ongoing optimisation of usage and integration with clinical pathways. Jonathan also reflected positively on recent ITV coverage, noting pride in the outcome and the collaborative opportunities it had created with partners.

9.5 In respect of the Clinical Research Facility programme, Martin Llewelyn advised this remained on track to expand and modernise research infrastructure across UHSussex, he added that funding was in place through a combination of Trust capital and additional funding, with approximately £5m invested over the past five years which reflected strong organisational commitment, as well as recognition of the Trust as an important research partner.

9.6 Jenny Preece highlighted the wider transformation governance framework, which included the Strategic Delivery Plan and strengthened assurance processes being implemented to better demonstrate clearer impact measures, alongside improved tracking of benefits from completed projects. She also noted the need for a more strategic approach to communicating the Trust's strategy and delivery, with a focus on reshaping the narrative around UHSussex and building confidence in its future.

9.7 Jonathan Keeble provided an update on culture and the Behavioural Compass, outlining progress in delivering the strategy to support colleagues and drive cultural improvement representing a significant step forward, with current efforts focused on raising awareness, equipping managers with toolkits, and embedding its principles across wider communications. The next phase would prioritise strengthening the behavioural compass conversations alongside expanding into forums to gather feedback and reinforce organisational values.

9.8 The Chair stressed the importance of focusing on delivery, risks, cost control, and assurance on timelines, alongside ensuring strong staff engagement, clear prioritisation, and improved project reporting, with committees continuing to strengthen oversight and learning.

9.9 The Board **NOTED** the update.

**TB/06/26/10 REPORT FROM PEOPLE & CULTURE ASSURANCE COMMITTEE FROM THE MEETINGS HELD ON THE 2 JUNE 2026**

10.1 Paul Layzell, Chair of the People & Culture Assurance Committee updated the Board on their recent meeting 2 June 2026.

10.2 Paul shared that the Committee had received its 6 monthly update on safer staffing, which provided assurance that ward staffing levels remained safe providing assurance that SafeCare as a real-time acuity and dependency tool was continually being used to match staff to patient need, thus confirming that staffing was monitored on a day-to-day basis and adjusted using bank and temporary resources where required. While the Board acknowledged that wards may at times feel understaffed, it was recognised that this reflected increasing patient complexity and rising acuity levels. Ongoing audits, peer reviews and data validation processes were noted as strengthening confidence in the approach, alongside a commitment to further strategic work on capacity.

10.3 Paul also shared the Committee had received the annual Freedom to Speak Up report, noting that most cases fell within green and amber categories, often relating to management behaviours or process challenges and not patient safety matters. This was seen as indicative of a developing speaking-up culture, whilst also highlighting ongoing issues linked to siloed working and psychological safety. The Board noted a reduction in overall cases and welcomed progress in encouraging earlier escalation of concerns, supported by alignment with employee relations processes. However, it was recognised that further improvement was required, particularly in the speed and resolution of issues raised.

10.4 In relation to workforce development, the Board welcomed the Committee Chairs reporting of positive progress in apprenticeship programmes, noting their growing importance in supporting workforce sustainability and delivering value for money. The Board encouraged continued expansion of apprenticeship opportunities as part of the overall workforce strategy.

10.5 The Board **APPROVED** the safer staffing report and **NOTED** the FTSU annual report.

**TB/06/26/11 ANY OTHER BUSINESS**

11.1 The Board noted the planning underway in advance of the scheduled resident doctor industrial action week commencing 15 June, with enhanced planning meetings in place, contingency rotas established whilst aiming to maintain delivery of the elective programme. *[It was subsequently reported that the planned Resident Doctor Industrial Action had been stood down for the time being while further negotiations continued.]*

**TB/06/26/12 DATE OF NEXT MEETING**

12.1 It was noted that the next meeting of the Board of Directors in Public was scheduled to take place at **10.00** on **Thursday 17 September 2026 in Worthing**

**Tamsin James**
**Board & Committees Manager**
**June 2026**

Signed as a correct record of the meeting.

…….. Chair

..…… Date

NHS
University Hospitals Sussex
NHS Foundation Trust

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| **Agenda Item:** | 7. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 17 September 2026 |
| **Report Title:** | Chief Executive's Report | | | | |
| **Sponsoring Executive Director:** | Dr Andy Heeps, Chief Executive | | | | |
| **Author(s):** | Dr Andy Heeps, Chief Executive | | | | |
| **Purpose of the report:** *(indicate as appropriate)* | **For Decision** | **For Assurance** | **For discussion** | **For Information only** | |
| | *N/A* | *Yes* | *Yes* | *N/A* | |
| **Reason for not being taken in public** *(indicate as appropriate)* | **Commercial confidentiality** | **Staff confidentiality** | **Patient confidentiality** | **Other exceptional circumstances (please detail)** | |
| | *N/A* | *N/A* | *N/A* | *N/A* | |
| **Regulatory Reporting Requirement** | | | | | |

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| **Summary of the report describing**<br><br>**What** *(summary of current position / issue & why it matters and evidence to support that position etc)*<br><br>**So What** *(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*<br><br>**What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)* | The Trust is balancing immediate operational and financial recovery with significant quality, regulatory and strategic commitments. The principal areas of executive focus are urgent and emergency care, planned care and cancer performance, financial recovery, workforce controls, maternity and neonatal improvement, readiness for external review, and delivery of major digital, education and research programmes. The Board is asked to consider whether the pace of improvement, governance arrangements and management of quality and delivery risks provide sufficient assurance. |
| **Recommendation** *(linked to What Next section)* | The Board is asked to:<br>1. **Note** the updates set out in the Chief Executive's Report.<br>2. **Consider** the implications of national, regional and system developments for UHSussex.<br>3. **Seek assurance** that the principal operational, financial, quality, workforce and regulatory risks are being managed through clear executive and divisional accountabilities, with material gaps, slippage or decisions escalated through the appropriate Board committee or to the Board. |

<table>
<tr><td>Assurance / Scrutiny route already undertaken (please explain where matter previously considered, and assurance provided)</td><td colspan="6">This is the Chief Executive's standing report and is presented directly to the Board. Where specific issues require deeper assurance, these are considered through the relevant Board Committees (e.g. People & Culture Assurance Committee for workforce and culture; Patient & Quality Assurance Committee for safety and maternity).</td></tr>
<tr><td rowspan="2">Link to Trust Strategy (note which theme)</td><td>Care</td><td>People</td><td>Future</td><td>Communities</td><td>One UHSussex</td><td>Culture</td></tr>
<tr><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td>Link to annual delivery plan</td><td colspan="6">The report supports delivery of the Annual Delivery Plan through its focus on maternity and neonatal improvement, urgent and emergency care, planned care and cancer performance, financial recovery, workforce development, digital transformation, research and system collaboration. Delivery depends on clear priorities, disciplined execution and effective governance across these areas.</td></tr>
<tr><td>Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc</td><td colspan="6">The report has implications across the Board Assurance Framework, particularly for risks relating to quality and safety, operational performance, financial sustainability, workforce, digital transformation and system partnership working. No change to risk scores is proposed through this report. Any material change in risk or assurance will be considered through the relevant committee and Board Assurance Framework review process.</td></tr>
<tr><td rowspan="2">Link to CQC domain</td><td>Safe</td><td>Caring</td><td>Effective</td><td>Responsive</td><td>Well-led</td><td>Use of Resources</td></tr>
<tr><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
<tr><td rowspan="2">Other impacts</td><td colspan="2">Equality and Diversity (if yes has HEIA completed)</td><td>Environmental</td><td>Legal</td><td colspan="2">External Registrations (if yes please indicate which)</td></tr>
<tr><td colspan="2">N/A</td><td>N/A</td><td>N/A</td><td colspan="2">N/A</td></tr>
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University Hospitals Sussex NHS Foundation Trust

# Chief Executive's Report – September 2026

Since the July Board meeting, my time and that of the executive team has been focused on four connected priorities: improving urgent and emergency care; recovering planned care and cancer performance; reducing the Trust's underlying cost base; and strengthening quality, governance and organisational capability. These priorities are being pursued alongside preparations for the independent maternity review and delivery of our major strategic programmes of change. This report sets the national, regional and local developments in that context and highlights where the Board should seek assurance.

## National Policy and Regulation

### Investigation into NHS maternity and neonatal care

Since the Board last met, the government has published the report and recommendations of the Independent Investigation into Maternity and Neonatal Services in England chaired by Baroness Valerie Amos, in which UHSussex took part. The investigation found that the NHS does not have a maternity and neonatal system that consistently delivers safe, equitable and compassionate care, and recommends a fundamental redesign of the service to provide stronger accountability, place a greater focus on safety and put the voices of women and families at the centre of decision-making.

Many of the experiences detailed in the report were difficult to hear, but are deeply important because of that. This is particularly true for us at UHSussex, where we know there are families whose care fell below the standards they had every right to expect. I am deeply sorry for that, and for the harm and distress they have suffered as a result.

The report is clear that all NHS maternity and neonatal services must improve. UHSussex is committed to doing so, and our teams have made important progress despite sustained operational pressure. Telephone triage has been transformed in response to experiences heard by Baroness Amos; we have recruited more midwives and strengthened how we listen and learn when care falls short. These changes have contributed to improved performance against national safety and quality standards over the past three years. We must now sustain that progress and support our teams to deliver further improvement.

### Independent Maternity Review

The independent review of maternity services in Sussex is finalising its terms of reference following an initial meeting with affected families. Together with the Chair, I recently met Donna Ockenden, the senior midwife leading the review, and officials from NHS England as part of our preparations to engage effectively and support families and staff throughout the process. We have established a comprehensive readiness programme covering information requests, records retrieval, case tracking and stakeholder engagement, with dedicated capacity agreed to support the Review Team and coordinate Trust responses.

Our engagement approach commits us to openness, transparency and learning, and will be family-centred and trauma-informed to recognise the experiences of those participating in the review and ensure their voices remain central to the process. We are also highly conscious of the potential impact of the review on maternity colleagues and are increasing the wellbeing and psychological and professional support available to them. All preparations are being undertaken alongside the wider UHSussex maternity and neonatal improvement programme to ensure that review readiness is aligned with broader efforts to achieve sustained improvements in safety, quality and patient experience.

**New Health Secretary**

A new Prime Minister has meant a new Secretary of State for Health and Social Care too, with Yvette Cooper replacing James Murray. Her immediate priorities in the role are improvements in NHS performance, finances and maternity care, devolving control and responsibility away from the centre, and providing more career opportunities for young people in the service.

That improvement agenda is already the primary focus of all NHS organisations and the Health Secretary's two wider ambitions are embedded in the Communities and People elements of our Excellent Care Everywhere strategy. These commit us to working closely with the local government and health service partners the new administration aims to empower, and to developing local talent to provide good jobs for our communities and reduce our reliance on temporary staffing.

Our education and apprenticeship teams are already doing great work on the latter, partnering with schools, colleges, training providers and the Department for Work and Pensions to offer T-Level placements, work experience, pre-employment programmes, skills bootcamps and apprenticeships. This year, we welcome 30 T-Level students onto our adult nursing pathway, continue to recruit apprentices into roles including finance and business administration, and are expanding supported internships and our work with young people not in education, employment or training.

**New NHS England guidance**

NHS England has issued significant new guidance strengthening expectations for quality, governance, patient experience, leadership, information governance and operational resilience. Several requirements involve formal Board oversight, organisational self-assessment or Board Assurance Statements. Relevant executive leads and committees will oversee the Trust's response, with material gaps, risks and required Board approvals reported through established governance routes.

*Patient experience standards for elective care*

NHS England has introduced minimum standards for patient experience and communication across elective care pathways in response to concerns about poor communication with patients waiting for treatment. The standards cover referral confirmation, waiting-list updates and appointment information. Trusts are expected to assess themselves against eight national standards and provide a Board statement during 2026/27. UHSussex will undertake a gap analysis of current arrangements, review elective communication processes and develop a prioritised improvement plan for any areas of non-compliance.

*Mortuary oversight and care after death*

Following findings from the Nottingham maternity review, concerns raised by the Human Tissue Authority and recommendations from the David Fuller Inquiry, NHSE has strengthened requirements relating to mortuary services and post-death care. Trusts are required to assess compliance against the NHS-relevant Fuller recommendations and submit a Board Assurance Statement. UHSussex will review its current arrangements against the national recommendations, including governance, safeguarding, physical security and assurance processes.

*Preventing unlawful access to patient records*

Patients must be able to trust that their personal information is protected. Staff may access a patient record only where there is a legitimate work-related need to do so. Access for personal reasons, curiosity, or because the patient is known to the member of staff is unacceptable, harmful to patients and unlawful. It may result in disciplinary action, dismissal, referral to a professional regulator or criminal investigation. UHSussex will reinforce these responsibilities through staff communications

and training, strengthen monitoring and audit arrangements, and take appropriate action where concerns are identified.

*NHS College of Leadership and Management*

In support of the NHS 10 Year Health Plan, NHSE has established the NHS College of Leadership and Management and introduced a national Leadership and Management Framework. The objective is to create a more consistent and professional approach to leadership development across the NHS. UHSussex will assess the alignment of our own leadership development arrangements with the new framework and incorporate relevant requirements into recruitment, appraisal, talent management and people processes.

*Winter planning*

NHS England has outlined expectations for winter preparedness, building on improvements achieved during the last winter period. Organisations are expected to develop robust, clinically led plans that protect urgent and emergency care performance while maintaining elective activity. UHSussex is finalising its organisational winter plan, supported by readiness assessments and stress testing. The plan and accompanying Board Assurance Statement will be presented to the Board in October, with delivery monitored through established operational governance arrangements.

*National Maternity Triage Specification*

A new National Maternity Triage Specification has been issued following independent reviews of maternity and neonatal services. The guidance establishes national standards for maternity triage and seeks to improve the consistency, safety and timeliness of urgent maternity care. Trust Boards are required to undertake a board-level audit within three months of implementation and complete any necessary improvements within twelve months. UHSussex will undertake the required assessment and implement actions identified through the national diagnostic process.

*National Quality Strategy for NHS-funded Care*

NHSE has published a new Quality Strategy, together with a national Call to Action on Quality and associated modern service frameworks. The intention is to strengthen improvement capability and align organisations around a shared quality agenda. UHSussex will review alignment between the national strategy and the Trust's existing quality priorities, governance arrangements and improvement programmes, ensuring we remain well positioned to respond to national expectations. The emerging guidance is consistent with national priorities around quality, patient experience, transparency, leadership and assurance; several communications set out additional requirements for self-assessment submissions, assurance returns and Board-level sign-offs throughout 2026/27.

## Regional and ICB update

### Local government reorganisation

The Government announced on 7 September that it is pausing and reviewing local government reorganisation in several areas, including East Sussex, Brighton and Hove and West Sussex. Local elections in May 2027 will proceed on existing council boundaries while the review is completed. There are no immediate changes to council services, but the pause creates further uncertainty about future structures and timescales. We will continue to work closely with local authority partners and monitor any implications for health and care planning, neighbourhood working and joint service delivery.

**NHS Surrey and Sussex**

I was pleased to welcome Karen McDowell, Chief Executive of NHS Surrey and Sussex, to our Brighton campus at the end of August. The visit provided an opportunity to discuss shared priorities and strengthen partnership working across the system. UHSussex also participated in NHS Surrey and Sussex's commissioning intentions and winter planning event on 8 September, helping to align organisational plans and dependencies ahead of the pressures expected this winter.

**Major incidents**

NHS and emergency service partners came together to respond to two major incidents in the space of a week last month: the train derailment outside Lewes and the tragic deaths of four members of the same family in the sea at Shoreham. Collaboration with our partners is key to achieving the improvement ambitions of our Excellent Care Everywhere strategy, but these events are a reminder of its more immediate importance in managing emergency situations too. On behalf of the Board and the communities we serve, I would like to commend everyone involved in these incidents for their rapid and professional response.

**Sussex Provider Collaborative**

The Sussex Provider Collaborative is moving several system-wide programmes from design into implementation across integrated care, elective recovery, digital services and productivity. A draft Neighbourhood Alliance Operating Model and Core Offer Specification is nearing completion, and a Sussex-wide Single Point of Access model is being implemented across several specialties. Work on procurement and occupational health is also being developed to improve resilience, reduce duplication and release value. UHSussex will remain focused on ensuring that these programmes produce measurable benefits for patients and support the Trust's operational and financial priorities.

**Surrey and Sussex Cancer Alliance annual report**

The Surrey and Sussex Cancer Alliance has published its Annual Report for 2025/26, highlighting recent progress made in diagnosis and treatment across the region, including in gynaecology and breast cancer at UHSussex. Clinical and operational colleagues have worked with the Alliance to review, streamline and improve pathways in these services, giving patients faster access to diagnostics and treatment, and better information about their care. The full document is attached as an appendix to this report.

**Queen Victoria Hospital**

The Queen Victoria Hospital NHS Foundation Trust (QVH), which specialises in services such as reconstructive surgery, treatment of burns and maxillofacial care, is to join the Ashford and St Peter's Hospitals NHS Foundation Trust (ASPH) and Royal Surrey NHS Foundation Trust (RSFT) provider group following the approval of all three organisations' Boards. The partnership aims to protect QVH's specialist services and improve their long-term sustainability. Access to these services is a great benefit to UHSussex and our patients so I welcome all moves to strengthen them and look forward to continuing to work closely with QVH.

**Mental health support**

Rising levels of need for mental health support remain a significant source of pressure on our hospitals so I welcome the launch of a new wellbeing service for Brighton, Hove and East Sussex. UOK is funded by NHS Surrey and Sussex, the City Council and East Sussex County Council to make support easier to access for people experiencing mental health and wellbeing challenges. The service reflects the NHS neighbourhood health approach, bringing together community organisations and local

partners to provide more coordinated, person-centred support closer to home. This more connected approach will help people get support earlier, build resilience and stay well.

## University Hospitals Sussex

### Q1 NHS Oversight Framework position

NHS England has confirmed that UHSussex has moved from Segment 4 to Segment 3 for Quarter 1 of 2026/27 and ranked 100th of 134 acute trusts. This is an improvement on our previous position and reflects progress in several areas. It does not, however, change the need for sustained improvement in urgent and emergency care, planned care, productivity and financial performance. Our focus remains on delivering better services and outcomes, with improvement in the oversight position treated as a consequence rather than the objective.

Operational and financial recovery remains the executive team's immediate priority. Performance in urgent and emergency care, planned care and cancer services is not yet consistently where it needs to be, while the Trust must reduce its underlying cost base and improve productivity. We have established a weekly Recovery Board, strengthened controls over recruitment, temporary staffing, overtime and discretionary expenditure, and are developing an integrated view of operational, workforce, financial and quality delivery. Recovery actions are expected to have a named owner, a clear timescale, a measurable outcome and an assessment of quality and equality impacts.

### Visits and engagement since the last Board

Since the last Board meeting, I have continued a programme of frontline and stakeholder engagement to strengthen my understanding of operational challenges, test the assurance available to the executive team and develop key partnerships. The Executive Management Committee now meets at a different Trust site each week, giving senior leaders regular opportunities to spend time with services, hear directly from colleagues and understand the operational and clinical challenges they face. Visits to all four mortuaries and, with Chief Medical Officer Professor Katie Urch, the perinatal bereavement pathway provided important insight into care after death, the experience of bereaved families and our responsibilities in relation to the Human Tissue Authority. Engagement with obstetrics and gynaecology consultants, including welcoming Professor Alison Wright, President of the Royal College of Obstetricians and Gynaecologists, to Worthing, supported our continued focus on clinical leadership and maternity improvement. I also visited Worthing theatres and attended Brighton Pride on 1 August. Discussions with Dr Adam Fazakerley of the Brighton and Hove Primary Care Federation focused on demand management and reducing avoidable pressure on hospital services. Meetings with the Chair and Chief Executive of Healthwatch Brighton and Hove and Alison Bennett MP strengthened our understanding of community priorities and patient experience. Together, these engagements are informing executive oversight of quality, operational delivery, partnership working and improvement priorities.

### Trust Operating Model Phase Two

Consultation has begun on the second phase of our Trust Operating Model, covering the proposed alignment of directorates, services and leadership arrangements within the four divisions. The aim is to create clearer accountability, stronger clinical and operational leadership, more consistent ways of working across our hospitals and better opportunities for staff development. We have appointed 20 new cross-Trust clinical directors from a field of more than 40 applicants. This level of interest is an encouraging indication of clinical engagement and colleagues' willingness to take on leadership roles across UHSussex. Organisational change can nevertheless create significant uncertainty, particularly for colleagues whose roles may be affected. We must ensure that feedback is heard, staff are properly supported and concerns about the process or communication are addressed as the proposals develop.

**Integrated Education Plan**

As a leading NHS teaching provider, we are committed to developing the workforce and capability the Trust will need for the future. The five-year Integrated Education Plan published last month supports our strategy commitment to be always learning. It is also directly relevant to our current challenges by helping us develop local talent, improve retention, strengthen leadership and improvement capability, and reduce reliance on temporary staffing.

The plan's ambitions are that by 2030 everyone at UHSussex will have easier access to high-quality learning, training and development that supports their career ambitions, and have structured progression opportunities through which to realise them. We will offer expert support and guidance from skilled educators, supervisors, mentors and coaches; provide modern ways of learning; bring colleagues from different professions together to share skills and experience; connect learning with research, quality improvement and innovation; and do so in an inclusive environment in which learning, development and career progression are open to everyone, and where differences are recognised, valued and celebrated.

**New radiotherapy service**

The opportunity to provide specialist care closer to patients' homes was one of the main drivers of UHSussex's formation and remains an important focus of our Excellent Care Everywhere strategy. So the opening of our new head and neck radiotherapy service in Eastbourne over the summer is great news for patients living in and around the town. This is a highly specialised treatment that needs a multidisciplinary team of clinicians, nurses and allied health professionals to maintain patients' wellbeing; being able to offer that locally will help improve outcomes and experiences for them.

**Professor Lucy Chappell visit**

I was pleased to welcome Professor Lucy Chappell, Chief Executive of the National Institute for Health and Care Research and Chief Scientific Adviser to the Department of Health and Social Care, to UHSussex on Friday 4 September. The visit, jointly hosted with Brighton and Sussex Medical School, demonstrated the breadth of our research across critical care, perioperative medicine, hepatology, infection and microbiology, HIV and sexual health, clinical academic careers and public involvement, as well as our ambitions for translational research. This growing portfolio is an important strategic asset: it improves access to innovation for patients, supports recruitment and retention, develops clinical academic careers and strengthens our ability to attract external investment. Our partnership with Brighton and Sussex Medical School, the universities and other research partners is central to realising those benefits.

**Clinical research**

Colleagues across our hospitals continue to act on our strategy commitment of ensuring patients have access to research and its benefits by developing innovative trials that improve outcomes and experiences for them. Since the Board last met, a UHSussex gynaecology study has identified an innovative technique that could help prevent serious complications in endometriosis surgery, and a multidisciplinary trial has begun evaluating whether a specialised liquid nutrition programme could help patients with inflammatory bowel diseases recover better from surgery.

UHSussex research has also been shared at one of the world's largest conferences dedicated to infectious diseases and microbiology, where colleagues presented their work on preventing hospital infections, tackling antimicrobial resistance, and exploring the potential of artificial intelligence.

**Electronic patient record**

The electronic patient record programme has progressed with the appointment of Alcidion as UHSussex's system provider. The EPR will bring together information currently held across multiple systems, enabling staff to access and share patient information more quickly when and where it is needed. The next phase will build on readiness work already under way across the Trust, with phased implementation scheduled to begin in 2027. Effective delivery will require sustained clinical engagement, disciplined programme governance and careful management of operational and financial dependencies.

**Healthcare awards**

Recent national recognition reflects the quality, innovation and partnership working of colleagues across UHSussex. Max Thomas was named the Rising Star of the Advancing Healthcare Awards for improving respiratory and sleep pathways, championing innovation and strengthening collaboration across services. The Sussex Pathology Network won the Institute of Biomedical Science Annual Award for Partnership Working for creating one of England's largest and most advanced digital histopathology programmes, supporting 1.2 million patients. The Trust's Faster Diagnosis Service for lung cancer was shortlisted in the Nursing Times Awards for transforming the diagnostic pathway, and the Practice Development Education team for children's services was shortlisted in the HSJ Patient Safety Awards for its work to improve education in the care of children and young people experiencing a mental health crisis.

**Appointments**

I would also like to congratulate Sarah-Jane Taylor on her appointment as Chief People Officer on a permanent basis, and to welcome Alex Shaw, who has now started as our new Chief Delivery Officer, and Gail Byrne as interim Chief Nurse while Dr Maggie Davies is on planned leave. I would also like to thank Nigel Kee for his leadership and commitment as Interim Chief Operating Officer before he left UHSussex at the end of August, and wish him well for the future.

**Canon Rachel Bennett**

Colleagues across the Trust were saddened to learn of the death of Canon Rachel Bennett last month. Rachel gave many years of compassionate service to Worthing and St Richard's hospitals and, most recently, our One UHSussex chaplaincy team. Our thoughts are with her family, friends, church community and all those who knew and loved her.

Finally, I want to recognise the extraordinary commitment of colleagues across UHSussex. They have continued to provide compassionate care in an exceptionally difficult operational climate, including sustained urgent and emergency care pressures, high demand across services, financial constraints and repeated heatwaves. Many are also managing the uncertainty associated with the Trust Operating Model consultation and wider organisational change. I am deeply grateful for their professionalism, resilience and continued focus on patients and one another. We must match that commitment by listening carefully, communicating honestly and supporting colleagues through the demanding period ahead.

In conclusion, the Trust has identified the principal operational, financial, quality and regulatory challenges and has strengthened the arrangements for managing them. Assurance remains developing rather than complete: recovery plans must translate into sustained improvement, quality impacts must be monitored closely, and several national requirements and external review preparations are still in progress. These matters will continue to be reported through the relevant committees and escalated to the Board where required.

**Dr Andy Heeps**
**Chief Executive**
**September 2026**

University Hospitals Sussex NHS Foundation Trust

## Appendix: Executive Management Committee update

### Purpose

The Executive Management Committee is the Trust's senior executive forum for collective leadership, decision-making and oversight of strategic, operational, quality, workforce and financial delivery. Since the July Board meeting, it has met weekly, with discussions focused increasingly on operational and financial recovery, while continuing scrutiny of quality, governance, workforce and major programmes.

### Summary of meetings

| Meeting | Principal matters considered | Decisions and agreed actions |
|---|---|---|
| **29 July 2026** | Current performance in urgent and emergency care, planned care, cancer and diagnostics; NHS Oversight Framework position; financial run-rate and efficiency delivery; workforce controls; Divisional Accountability Meetings; quality and equality impact assessment arrangements; investment proposals. | Agreed that stronger quality and equality impact assessment arrangements were required for efficiency, investment and disinvestment decisions. Requested further analysis of organisational change capacity and benefits realisation arrangements. Referred the relevant investment proposal to the Finance and Performance Assurance Committee. |
| **5 August 2026** | Financial recovery and the need to reduce the underlying monthly run-rate; urgent and emergency care improvement; delivery against national standards; workforce grip and control; implementation of the Mutual Agreed Resignation Scheme; quality impact assessment processes. | Confirmed that the quality impact assessment policy and supporting process needed to be simplified and consistently applied to all material changes. Agreed that managing directors should identify where additional support was required. Maintained the action to map change resources and expected outcomes. |
| **12 August 2026** | Month 4 financial position; urgent and emergency care and planned care performance; the Target Operating Model and Mutual Agreed Resignation Scheme; theatre ventilation; major project delivery; decision-making on investment and disinvestment. | Reinforced that no business case should proceed without an identified funding source and that invest-to-save proposals must deliver benefit within the year. Agreed that external delivery support should be secured promptly and aligned with divisional need, reporting capability and financial recovery. Confirmed that quality impacts must remain under regular review as recovery actions are implemented. |
| **19 August 2026** | Operational and financial recovery; independent maternity review readiness; risk management; integrated governance; | Agreed that formal recovery arrangements should strengthen, rather than replace, existing divisional and |

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| | provider capability assessment; internal audit recommendations; medico-legal themes and external visits. | programme governance. Confirmed that future recovery reporting should concentrate on a small number of material measures, clear accountabilities and measurable outcomes. Reaffirmed the use of quality and equality impact assessment in decisions affecting run-rate, productivity and service delivery. |
| **26 August 2026** | Urgent and emergency care, planned care and cancer performance; financial recovery; workforce and change capacity; Strategy Delivery and Improvement Framework; Integrated Performance Report and NHS Oversight Framework position; divisional updates; quality, finance and people assurance. | Agreed that improvement and recovery activity should be brought together through clearer divisional and enterprise accountabilities. Continued the action to complete the mapping of change capacity and benefits. Confirmed that business cases could not be considered without an identified source of funding. |
| **2 September 2026** | Establishment of the Recovery Board; delivery support; financial and operational recovery; recovery dashboard; urgent and emergency care improvement; estates assurance. | Agreed that recovery actions must have a named owner, timescale and expected outcome. Confirmed executive sponsorship for the enterprise recovery workstreams. Agreed that recovery reporting must include a quality dimension and link activity, workforce and finance. Requested proposals on Recovery Board membership and terms of reference, a communications approach for the recovery programme, and decisions on external support for urgent and emergency care. |
| **9 September 2026** | Recovery governance and outstanding controls; workforce vacancy and candidate pipeline; financial and operational recovery; urgent and emergency care support; Strategy Delivery and Improvement Framework; provider capability assessment; premises assurance; clinical transformation and research, innovation and digital updates. | Considered the decision route and conditions for external urgent and emergency care support. Reviewed implementation dates for tighter bank and overtime controls and the approach to recruitment during recovery. Tested the deliverability of strategic improvement trajectories and reviewed the evidence supporting the provider capability assessment and premises assurance model before submission to the Board. |

**Main themes and conclusions**

Across the period, EMC has maintained a consistent focus on four connected priorities: urgent and emergency care, elective and cancer performance, financial recovery, and organisational capability. The principal shift has been from describing the challenges towards establishing tighter delivery arrangements, including:

- a weekly Recovery Board with clearer executive and divisional accountability;
- an integrated recovery dataset linking operational, workforce, financial and quality measures;
- stronger control of recruitment, temporary staffing, overtime and other discretionary expenditure;
- greater discipline over business cases, requiring an identified funding source and credible benefits;
- more consistent assessment and monitoring of quality, equality and patient impacts;
- clearer use of internal capability and targeted external support to accelerate delivery; and
- continued oversight of maternity review readiness, risk, governance, estates and major programmes.

EMC has been clear that recovery must improve patient care and access while reducing the underlying cost base. Actions are expected to identify a named owner, deadline, intended outcome and evidence of delivery, with material risks or decisions escalated through the appropriate Board committee or to the Board.

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| **Agenda Item:** | 8. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 17 September 2026 |
| **Report Title:** | CQC Maternity Inspection Report, 2026 | | | | |
| **Sponsoring Executive Director:** | Gail Byrne, Interim Chief Nursing Officer | | | | |
| **Author(s):** | Nicole Chavaudra, Director of Patient Experience, Engagement and Involvement | | | | |
| **Purpose of the report:** *(indicate as appropriate)* | **For Decision** | **For Assurance** | **For discussion** | **For Information only** | |
| | *N/A* | *Yes* | *Yes* | *N/A* | |
| **Reason for not being taken in public** *(indicate as appropriate)* | **Commercial confidentiality** | **Staff confidentiality** | **Patient confidentiality** | **Other exceptional circumstances (please detail)** | |
| | *N/A* | *N/A* | *N/A* | *N/A* | |

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|---|---|
| **Regulatory Reporting Requirement** | The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. This includes the regulation of all maternity services. Inspections cover antenatal services, pregnancy units, maternity assessment centres, labour wards, postnatal services, and neonatal services.<br><br>NHS trusts are responsible for reviewing draft Care Quality Commission reports for factual accuracy, publishing final reports, and implementing any required improvements arising from the findings.<br><br>Trust boards and chief executives are required to discuss the findings of CQC reports transparently at public board meetings and ensure that any regulatory breaches or enforcement actions are appropriately addressed. |
| **Summary of the report describing**<br><br>**What** *(summary of current position / issue & why it matters and evidence to support that position etc)*<br><br>**So What** *(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)* | When inspecting maternity services, the CQC ask the following five key questions:<br>• Is this service safe?<br>• Is this service effective?<br>• Is this service caring?<br>• Is this service responsive to people's needs?<br>• Is this service well-led?<br><br>The reports, enclosed within appendix 8a and 8b, set out the CQC's findings from their inspections at St Richards Hospital and Princess Royal in 2025 which were published in 2026 following a factual accuracy process. Both services were rated as 'requires improvement'. |

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| **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)* | In the reports, a number of regulatory breaches were noted in relation to safe care and treatment (Regulation 12), governance (Regulation 17) and staffing (Regulation 18) as follows: -<br><br>• **Reg 12.** The maternity unit did not meet the needs of women due to lack of space (SRH only)<br>• **Reg 12** Women did not receive a midwifery and medical review within 15 mins of arrival (both sites)<br>• **Reg 12.** Gaps in medicines record keeping by anaesthetic team (PRH only)<br>• **Reg 17** Lack of audit schedule and completion (both sites)<br>• **Reg 17** Lack of up-to-date policies and guidance (both sites)<br>• **Reg 17** Lack of compliance with intercollegiate safeguarding document (PRH only)<br>• **Reg 17** Medications and risk management (PRH only)<br>• **Reg 18** Not enough staff to keep women safe (PRH only)<br>• **Reg 18** Staff feeling burnt out and tired due to workforce pressures – high sickness rates due to staff stress (PRH only).<br><br>Further to the above breaches, inspectors also identified positive findings for each site. It was noted that, for example: -<br><br>• Policies reflected NICE guidance (both sites)<br>• Staff worked well as a team and there was a good culture between midwives and obstetricians (both sites)<br>• There was a positive working relationship with the Maternity and Neonatal Voices Partnership staff (MNVP) (both sites)<br>• Patients were positive about the service (both sites)<br>• Staff were professional, understanding and kind (PRH)<br>• Patients were treated with dignity and respect (PRH)<br>• Person centred care was evident (PRH)<br>• The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care. Leaders had set a clear vision and values, and fostered a culture of openness, learning and continuous improvement (SRH)<br><br>The previous inadequate rating for well-led at PRH improved to requires improvement.<br><br>Consistent with all CQC inspection reports, an action plan is being developed to ensure that all required improvements are delivered. These action plans, together with supporting evidence, are reviewed through the CQC Improvement Steering Group.<br><br>Assurance that improvements have been implemented effectively and that the supporting evidence meets the required standard is provided through bespoke |

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| | evidence review sessions between the relevant service lead and the Chief Nursing Officer.<br><br>Progress against the improvement plan is reported through the Quality Governance Steering Group, the Maternity and Neonatal Improvement Group, the Patient and Quality Committee and ultimately to Trust Board. |
| **Recommendation** *(linked to What Next section)* | It is recommended that members of the Board note and discuss the content of the CQC maternity reports (appendices 8a and 8b) and the findings arising from the inspections. The Board is also asked to consider the actions being taken in response to the reports and the arrangements in place to provide assurance that the required improvements are being implemented, monitored, and sustained. |
| **Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*** | These reports have previously been considered by Maternity and Neonatal Improvement Group. |

| **Link to Trust Strategy (note which theme)** | **Patients** | **People** | **Future** | **Communities** | **One UHSussex** | **Culture** |
|---|---|---|---|---|---|---|
| | Yes | Yes | Yes | Yes | Yes | *Yes* |
| **Link to annual delivery plan** | | | | | | |
| **Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc** | This report links to the following BAF strategic risk:<br><br>SR3. If we fail to have robust quality governance systems and processes then we will not know how safe or high quality our care is resulting in potential avoidable harm, adverse outcomes and poor patient experience. | | | | | |

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

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

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| **Agenda Item:** | 9. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 17 September 2026 |
| **Report Title:** | Progress of NHSE Sprint | | | | |
| **Sponsoring Executive Director:** | Gail Byrne – Interim Chief Nursing Officer | | | | |
| **Author(s):** | Stephanie White – Divisional Head of Quality & Safety for Women & Children, WC&CS | | | | |
| **Purpose of the report:** *(indicate as appropriate)* | **For Decision** | **For Assurance** | **For discussion** | **For Information only** | |
| | *N/A* | *Yes* | *Yes* | *N/A* | |
| **Reason for not being taken in public** *(indicate as appropriate)* | **Commercial confidentiality** | **Staff confidentiality** | **Patient confidentiality** | **Other exceptional circumstances (please detail)** | |
| | *Yes / N/A* | *Yes / N/A* | *Yes / N/A* | *Yes / N/A* | |
| **Regulatory Reporting Requirement** | | | | | |

**Summary of the report describing**

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

**Initial Gap analysis / progress update for Amos report recommendations, Ockenden report recommendations and NHS England Sprint actions including Triage – August 2026**

**What:**

Initial gap analysis and progress update against recommendations arising from the Amos report, Ockenden reviews and NHS England's 10 Point Sprint, including maternity triage requirements.

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

**So What:**

Assurance can be taken that all actions arising from the 2022 Ockenden review have been completed, while gap analyses for the Nottingham Ockenden review, Amos report and NHS England 10 Point Sprint published in June 2026 have been completed and implementation is underway. Progress against the NHS England Sprint remains on track, with a Board-approved assurance return required for submission to NHS England by 25 September 2026. Continued oversight is required in relation to workforce, maternity triage and estate challenges.

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

**What Next:**

- Complete and submit the NHS England assurance return.
- Develop and deliver action plans arising from the Amos and Nottingham Ockenden gap analyses.
- Maintain focus on workforce sustainability, maternity triage compliance and estate improvements.

**Recommendation** *(linked to What Next section)*

For the Trust Board to **NOTE** the contents of the NHSE Sprint report.

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

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|---|---|---|---|---|---|---|
| **Link to Trust Strategy (note which theme)** | **Patients** | **People** | **Future** | **Communities** | **One UHSussex** | **Culture** |
| | Yes / N/A | Yes / N/A | Yes / N/A | Yes / N/A | Yes / N/A | *Yes / N/A* |
| **Link to annual delivery plan** | | | | | | |
| **Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc** | | | | | | |

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

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

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# *Initial Gap analysis / progress update on:*
# Amos report recommendations
# Ockenden report recommendations
# NHS England Sprint actions (including Triage)

Dr Jenny Davidson DDoM

Excellent
Care
Everywhere

We are compassionate
We are inclusive
We are respectful

# Overall summary

- NHSE 10 Point Sprint (July 2026) - detailed gap analysis completed with all but one action in progress and on schedule. NHSE Assurance reporting tool received 12th August and is in process of being completed. We are required to provide Board signed off assurance progress report to regional NHSE by 25th September 2026 (see slide 5)

- Ockenden Shrewsbury report (2022) all Trust actions complete
- Ockenden Nottingham report (2026) High level gap analysis completed
- Amos National review and local actions (2026) High level gap analysis completed

- Workforce and Perinatal services estates remain a consistent challenge and area of focus

# NHSE 10 point sprint gap analysis

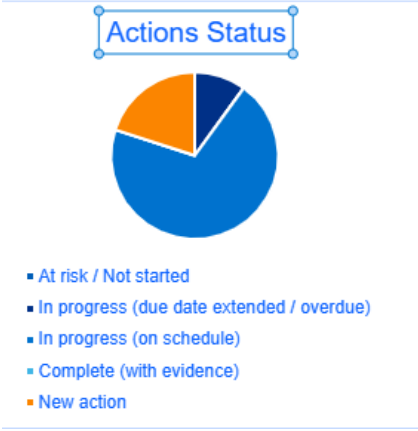
NHS England » Maternity and Neonatal 10 Point Plan assurance process

**Initial Gap analysis completed.**

**NHSE assurance reporting tool** received 12th August 2026, will be completed by 20th August 2026

**Current status based on own gap analysis** (completed July 2026):

- 7 points in progress and on schedule
- 1 point in progress but extended (Homebirth consultation delayed but due to launch 1st Sept)
- 2 dependent on national task force actions which are pending




Maternity Triage is one of the sprint points and has ten associated actions

- National Standard published in July 2026
- National assessment tool published 14th Aug and will be completed by 10th Sept
- All actions in progress with strong MDT working party
- Key risks relate to a) estate challenges (not fit for purpose) and b) staffing configurations which current data suggests impedes meeting national initial triage targets (15mins)

See detail on actions within NHSE 10 Point Plan Sprint tab within MNIP: MASTER MNIP action plan January 2024 V3.xlsx

# 10 Point plan Assurance request baseline due 25th September 2026 (board sign off)

- The reporting template is a tool designed to support a baseline assessment against the 10 point plan and support reporting to region and national teams. It is ordered as per the 10 point plan and allows for evidence of compliance, gaps in compliance, mitigations and comments to be recorded in text format. This template is intended to be built around existing governance structures.  The use of the reporting tool is compulsory and should be used by Trust Boards to assure against the actions.
- Trust boards should complete tab 1. Submission A-Baseline once only and returned to regional teams by Friday 25 September 2026. Tab 2. Submission B-Progress Report, should be completed by Thursday 31 December 2026. Each return should be completed once and returned regionally for assurance.
- Both submissions must be approved by the trust board. Boards should provide visible ownership and scrutiny of delivery, ensuring actions are progressing at pace, risks are managed appropriately and any significant concerns are escalated through ICB and regional routes.
- Regional teams will review returns, provide constructive challenge where needed, identify where additional support is required, and escalate significant concerns nationally to enable timely action.

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# Recommendation

- The Board is asked to review the assurance template (Tab 1) and the accompanying evidence (in Tab 3) and provide feedback before regional submission on the 25th September
- The Board is asked to provide approval for submission.

- Assurance template and evidence log: PRN02631iii-maternity-and-neonatal-services-reporting-template.xlsx
- Evidence: Evidence

# Ockenden update

- Ockenden Shrewsbury report (2022)
  - 15 Immediate And Essential Actions (= 82 actions)
  - Our position: all Trust actions complete; reviewed and signed off by ICB July 2026

- Nottingham Maternity report (2026)
  - 18 Recommendations (Essential Actions) =65 actions, 55 relate to NHS Trusts
  - High level gap analysis completed: 6 not yet commenced (planning stage), 27 in progress (or already part of an existing workstream), 9 completed/in place already (but evidence needs collating), 12 not compliant and need substantial work.
  - Key areas of focus: workforce planning and safe staffing, service configuration, multidisciplinary learning, anaesthetic record keeping, appointment of maternity subject matter specialist
  - Many actions link to NHSE 10 Point Sprint or can be adopted across within existing working groups

# Baroness Amos Report

Final Reports - National Maternity and Neonatal Investigation

NHS
University Hospitals Sussex
NHS Foundation Trust

## Nationally 8 overall recommendations

- 5 apply to DHSC/NHSE
- 3 apply to DHSC, NHSE, ICB (GMC / NMC) and NHS Trusts relating to
  - Listening to the voices of women, birthing people and families within 12 months (Initial gap analysis Trusts have 8 targeted actions, 1 complete, 7 in review)
  - Tackling racism, discrimination and inequality as a critical maternity safety issue (Initial gap analysis Trusts have 2 targeted actions and both are in review)
  - Improving culture and teamworking and strengthen leadership (Initial gap analysis Trusts have 7 targeted actions, 1 is complete and 6 under review)

**The 19 local issues identified in UHS report** are mostly covered within the NHSE 10 Point Sprint actions, however specific review required for the following:

- 4 site working challenges (practical and emotional pressures and hard to maintain consistency)
- Ensuring learning from incidents and embedding PSIRF
- Skill mix (junior staff managing complex cases, senior review)
- Reports of bullying, fear of raising concerns, weak trust in whistleblowing or escalation

These are being added to existing workstreams MNIP

Excellent Care Everywhere

University Hospitals Sussex
NHS Foundation Trust

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|---|---|---|---|---|---|
| ***Agenda Item:*** | 11. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 17 September 2026 |
| ***Report Title:*** | Progress update – Implementation of the Niche developmental well-led review recommendations (July 2025) | | | | |
| ***Sponsoring Executive Director:*** | Andy Heeps, Chief Executive | | | | |
| ***Author(s):*** | Fleur Blakeman, Improvement Director NHSE, Jabir Alam, Project Lead NHSE | | | | |
| ***Purpose of the report:*** *(indicate as appropriate)* | ***For Decision*** | ***For Assurance*** | ***For discussion*** | ***For Information only*** | |
| | *N/A* | *Yes* | *Yes* | *N/A* | |
| ***Reason for not being taken in public*** *(indicate as appropriate)* | ***Commercial confidentiality*** | ***Staff confidentiality*** | ***Patient confidentiality*** | ***Other exceptional circumstances (please detail)*** | |
| | *N/A* | *N/A* | *N/A* | *N/A* | |
| ***Regulatory Reporting Requirement*** | | | | | |

***Summary of the report describing***

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

This paper summarises progress made to date, as assessed by colleagues from NHSE National Provider Improvement Team, in addressing the recommendations for improvement identified by the well-led developmental review conducted by Niche Health and Social Care Consulting in 2025.

The report concludes that good progress is being made in addressing the recommendations made (see Appendix 1). A further 6 recommendations have been implemented since a six-month progress update was presented to the Board in March 2026.

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

Whilst good progress has been made in all areas, further work is needed to implement the 9 recommendations which remain 'in progress'. All outstanding actions will be incorporated into the Strategy Delivery Improvement Framework and will be time bound. Future reporting will track progress through Strategy Delivery Improvement Framework and Integrated Improvement Plan updates to the Board.

This report acknowledges some of the key achievements to date as well as outlining proposed next steps.

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

It is recognised that since the Niche well led developmental review was completed, the Trust has also had a CQC well led inspection. The CQC inspection report, published in May 2026, acknowledges the improvements made by the Trust, and upgrades the Trusts' rating for well led from Inadequate to Requires Improvement. However, it should be noted that a review of the CQC recommendations for improvement was out of scope of the stocktake completed by NHSE.

Going forward, the Trust should complete the work that is planned/already underway and develop reporting to incorporate updates on the outstanding Niche recommendations for improvement within the Strategy Delivery Improvement Framework and Integrated Improvement Plan updates to the Board.

The Trust may benefit from commissioning a repeat well-led developmental review next financial year to assess the overall progress made following the latest CQC well led inspection.

University Hospitals Sussex
NHS Foundation Trust

| | |
|---|---|
| ***Recommendation*** *(linked to What Next section)* | The Board is asked to consider and confirm whether this assessment is a fair and accurate reflection of the progress made to date. The Board is asked to note those recommendations that have yet to be implemented in full and proposed next steps.<br><br>The Board is asked to note that going forward progress updates will be incorporated into the Strategy Delivery Improvement Framework and Integrated Improvement Plan progress updates to the Board.<br><br>The Board is asked to consider commissioning a further developmental well led review next financial year. |
| **Assurance / Scrutiny route already undertaken** (***please explain where matter previously considered, and assurance provided)*** | Executive Management Committee. |

| **Link to Trust Strategy (note which theme)** | **Patients** | **People** | **Future** | **Communities** | **One UHSussex** | **Culture** |
|---|---|---|---|---|---|---|
| | N/A | Yes | Yes | N/A | Yes | *Yes* |
| **Link to annual delivery plan** | *Yes – supporting good governance and oversight.* | | | | | |
| **Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc** | **SR11 - Living our values in everything we do.**<br><br>Implementing the recommendations of the Niche well-led developmental review will help improve organisational culture and behaviours. It may be some time before there is any related positive impact on the score for this risk but the work that has already been completed and is underway helps to mitigate this risk. | | | | | |

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

| **Other impacts** | **Equality and Diversity (*if yes has HEIA completed)*** | **Environmental** | **Legal** | **External Registrations *(if yes please indicate which)*** |
|---|---|---|---|---|
| | *N/A* | *N/A* | *Yes* | *Yes - CQC well led* |

University Hospitals Sussex
NHS Foundation Trust

# Progress Update – Implementation of the Niche developmental well-led review recommendations (July 2025)

## 1. INTRODUCTION

1.1. Niche Health and Social Care Consulting were commissioned by University Hospitals Sussex NHS Foundation Trust to undertake a developmental well-led review. The review findings and recommendations for improvement based on field work undertaken between January and June 2025, were published in July 2025 and presented to the Trust Board, in public, in September 2025.

1.2. The review made 22 recommendations for improvement; these were accepted by the Board, and the Board has subsequently received regular updates on progress. A six-month progress update was presented to the Board in March 2026.

1.3. The NHSE National Provider Improvement Team, who are currently providing support to the Trust, were asked to undertake a stocktake of the progress the Trust has made to date with implementing the recommendations for improvement. This report provides a 12-month, arm's length review of progress.

1.4. This report includes an assessment of the status of the recommendations for improvement and indicates the proposed next steps to enable all outstanding recommendations to be implemented in full.

1.5. Whilst the Trust subsequently had a CQC well led inspection in July 2025 (report published May 2026), a review of the CQC recommendations for improvement was out of scope of this review. It is however pleasing to note that the CQC acknowledges the improvements made, upgrading the Trusts' rating for well led from Inadequate to Requires Improvement. Subsequent progress updates will include progress updates on the outstanding Niche recommendations as well as the CQC recommendations for improvement. This will be accomplished through the Strategy Delivery Improvement Framework and Integrated Improvement Plan progress updates to the Board.

## 2. CONTEXT

2.1. Aligned with best practice, University Hospitals Sussex NHS Foundation Trust commissioned Niche Health and Social Care Consulting to undertake a developmental well-led review in 2025.

2.2. The findings of the review and recommendations for improvement were published in July 2025 and presented to the Board in September 2025.

2.3. The Trust considered the recommendations for improvement and developed an action plan. Progress against the action plan, has been routinely monitored through regular progress updates to the Board via the Strategy and Major Projects Committee.

2.4. NHSE colleagues from the National Provider Improvement Team were asked to complete a 12-month stocktake review of progress on implementation of the Niche 22 recommendations for improvement.

## 3. MAIN REPORT

3.1 The findings of this stocktake indicate that the Trust is making good progress overall in implementing the 22 recommendations for improvement identified through the developmental well-led review conducted by Niche in 2025.

3.2 From the information provided 13 of the 22 recommendations are now considered as complete with the 9 remaining recommendations in progress (see **Appendix 1** for further information). Since the six-month progress report presented to the Board in March 2026, the Trust has met a further 6 recommendations and it is anticipated that the majority, if not all, of the remaining recommendations will be addressed in full by the end of this financial year (whilst recognising that good governance and culture are never completely finished and take time to become embedded).

3.3 Going forward the outstanding Niche recommendations will be incorporated into progress updates to the Board on delivery of the Strategy Delivery Improvement Framework and the Integrated Improvement Plan.

3.4 As already stated, good progress has been made in all areas. Some of the key achievements to date include:

- Development of the Trust Strategy 'Excellent Care Everywhere, approved by the Board in November 2025, underpinned by a strategy delivery plan.
- Refreshed the Board Assurance Framework, aligned to the Excellent Care Everywhere Strategy
- Development of a new Target Operating Model, first phase delivered in May 2026, creating 4 new pan Trust divisions and strengthened senior leadership across both corporate and divisional teams.
- Targeted culture and organisational training and development and rollout of the values and behaviours framework is well underway,
- Leadership development,
- Strengthened arrangements for sharing the learning from when things don't go well and sharing best practice,
- Strengthened the effectiveness of Board and Board Committees,
- Greater emphasis on quality improvement,
- Phase one of the new Target Operating Model has been implemented,
- Patient and staff engagement have been strengthened,
- The creation of a new role, a Director of Voice, Improvement and Partnerships, to champion equality, diversity and inclusion, staff and patient engagement, co-production and partnership working,
- Alignment of key strategic enablers with delivery of the Trust strategy.

3.5 Areas for further work include:

- Agreeing how the Board will gain assurance regarding the safety culture of the organisation, through the development of a safety culture dashboard,
- Agreeing how the Board will further develop its relationship with the top 70 leaders within the organisation,
- Embedding the new Divisional structures and associated revised governance arrangements,
- Considering how best to support staff in upholding the Trust values, behaviours, and fundamental standards of care,
- Completing an evaluation of the revised governance and accountability arrangements 6 months post implementation,

- Implementing the improvement actions developed in response to the Dearden review,
- Fully implementing and evaluating a Board training programme and evaluating the effectiveness and impact of the new Alert, Advise, Assure reporting arrangements,
- Maturation of the approach to risk identification and proactive management of key risks and material issues.

## 4. NEXT STEPS

4.1 Next steps are to completing the work that is already underway to progress implementation of the outstanding Niche recommendations for improvement and developing reporting to track progress through Strategy Delivery Improvement Framework and Integrated Improvement Plan updates to the Board.

4.2 The Trust may wish to consider commissioning a repeat developmental well led review in the next financial year.

## 5. RECOMMENDATIONS

5.1 The Board is asked to consider and confirm whether this assessment is a fair and accurate reflection of the progress made to date. The Board is asked to note those recommendations that have yet to be implemented in full and proposed next steps.

5.2 The Board is asked to note that going forward progress updates will be incorporated into the Strategy Delivery Improvement Framework and Integrated Improvement Plan progress updates to the Board.

5.3 The Board is asked to consider commissioning a further developmental well led review next financial year.

**Fleur Blakeman**
Improvement Director, NHSE

**Jabir Alam**
Project Lead, NHSE

University Hospitals Sussex
NHS Foundation Trust

**Appendix 1 – Assessment of progress July 2026**

| NICHE Well Led recommendations - UPDATED AUGUST 2026 | | | | |
|---|---|---|---|---|
| | | | | |
| **Recommendation** | **Description** | **NHSE Assessment July'26** | **March '26 Status (Trust)** | **NHSE RAG July '26** |
| 1 | Prioritise and expedite the work to embed the Trust values and build these into all people processes (such as recruitment, development, appraisal, job planning and raising concerns processes). Make explicit how behaviours not in line with the Trust values will be dealt with, regardless of seniority or role. | The Trust has defined values and is actively embedding them through strategy, induction, and a structured Behavioural Compass, supported by leadership toolkits and team-based interventions to reinforce expected behaviours in daily practice. Evidence of integration into recruitment and development approaches and consistent messaging across culture initiatives and strategy has been provided.<br>However, evidence of consistent integration across formal people processes remains limited given that it was only launched in May 2026. While the materials promote addressing poor behaviours, they do not clearly set out the formal consequences of behaviours not in line with the Trust values or demonstrate that these are applied consistently regardless of seniority or role.<br><br>Next steps are to:<br>- Progress work to ensure consistent integration of new values and behaviours across formal people processes.<br>- Ensure consistent application at all levels of seniority and ensure behaviours not in line with the new Behaviour Compass are addressed. | In progress | In progress |

| Recommendation | Description | NHSE Assessment July'26 | March '26 Status (Trust) | NHSE RAG July '26 |
|---|---|---|---|---|
| 2 | Clarify the timescale and process for updating supporting plans to align these to the new strategy. This includes: the Delivery Plan, all underpinning strategic plans (including clinical, estates, workforce), and the process for ensuring that these will be coherent and mutually supportive of each other | The Trust has now provided timelines and process for updating supporting plans. The documents set out a clear overall timetable (e.g. Integrated Improvement Plan by September 2026) and establish programme management and governance arrangements to oversee delivery and ensure accountability.<br><br>They also articulate a clear strategic intent for alignment through "one strategy, one delivery plan, one source of truth" as part of ECE (Excellent Care Everywhere).<br><br>However, they do not define a specific process or integrated timeline for updating all supporting plans (e.g. clinical, estates, workforce) or describe how coherence between these plans will be achieved in practice. We conclude this recommendation has been implemented. | Complete | Complete |
| 3 | Review the draft Strategy in light of the findings of this report and its recommendations, to identify any areas where remedial work may be required and how the strategy can support this. | The Trust reviewed the draft strategy against the NICHE recommendations and made targeted amendments. The five strategic ambitions were retained, but content was strengthened on values, behaviours, safety culture, speaking up, Board assurance, leadership, discrimination, patient voice, co-production and health inequalities.<br>NICHE actions were mapped into specific strategy sections, year 1–2 delivery priorities and the later Strategy Delivery and Improvement Framework.<br><br>The evidence shows a structured response: the strategy was reviewed, adjusted and linked to delivery and assurance arrangements. We conclude this recommendation has been implemented. | Complete | Complete |

| Recommendation | Description | NHSE Assessment July'26 | March '26 Status (Trust) | NHSE RAG July '26 |
|---|---|---|---|---|
| 4 | Agree as a Board how assurance will be sought about the organisation's culture, and particularly in light of thew findings within this report. Consider:<br>• Introducing staff stories at Board meetings.<br>• How existing intelligence (such as the culture heat maps) can be used to better affect to improve Board insight.<br>• How to drive a 'problem-sensing' approach to culture within the Board environment.<br>• How the Board will continuously review its role in setting the tone at the top of the organisation. | The papers provide evidence that the Board is hearing directly from staff through presentations and is considering a range of cultural indicators, including staff survey feedback, Freedom to Speak Up reporting, Datix data and workforce wellbeing evaluations. The Board has also received an update on the Behavioural Compass programme and discussed leadership visibility and staff engagement. The Board has recently heard a staff story which was well received and these are planned to be presented bi-annually. Evidence has been provided confirming that the Board recruitment process is aligned with the behaviours framework. However, it is less clear whether Board members have participated in Behavioural Compass organisational development activity, and it appears the Board has yet to develop and introduce a culture measurement framework. Next steps are:- To ensure staff stories are presented at Board on a bi-annual basis.- Board members to participate in Behavioural Compass organisational development activity. - The Board to develop and adopt an agreed culture measurement framework. | In progress | In progress |
| 5 | Introduce 360 feedback into Board member appraisal processes. Where relevant, this should include feedback external to the Board, including from stakeholders and senior leaders. The process should align to the refreshed vision and values. | The Trust has introduced 360 degree feedback within the Board member appraisal processes.<br><br>For Non-Executive Directors, the Chair considers feedback from peer NEDs, Executive Directors and Governors as part of annual appraisals. Individual appraisals reference the use of 360 feedback to inform performance and development discussions. Executive Director appraisals also incorporate externally facilitated 360 feedback, delivered by Third Space. We conclude this recommendation has been implemented. | In progress. | Complete |

| Recommendation | Description | NHSE Assessment July'26 | March '26 Status (Trust) | NHSE RAG July '26 |
|---|---|---|---|---|
| 6 | Agree how relationships will be developed between the executive (and wider board) and the Top 70 Trust leaders, with a focus on building mutual trust, and balancing challenge and support in performance conversations. As part of this, discuss explicitly the perceptions around paternalism in the Trust's culture. | The TOM demonstrates a clear focus on leadership relationships, trust building, constructive challenge, collaboration and coaching support. However, it does not explicitly describe how relationships between the Executive/Board and the Top 70 leaders will be developed, how challenge and support will be balanced in performance conversations, or how perceptions of paternalism in the Trust's culture will be explored and addressed.<br><br>The Trust has developed learning and development programmes such as Fearless Leadership, Take the Lead, Civility Saves Lives and management development programmes (e.g. Managing Difficult Conversations) that promote inclusive leadership, staff empowerment and collaboration which may challenge paternalistic behaviours.<br><br>Next steps are:<br>- To implement the next phase of the target operating model.<br>- Develop a leadership engagement strategy.<br>- Review the effectiveness of the Divisional Assurance Meetings in circa 6 months time.<br>- Consider options to 'check back in' with leaders on the Trust's leadership culture, explicitly exploring the issue of 'paternalism' and whether this is improving with the changes to the operating model and related governance improvement work. | In progress. | In progress |

| Recommendation | Description | NHSE Assessment July'26 | March '26 Status (Trust) | NHSE RAG July '26 |
|---|---|---|---|---|
| 7 | Agree how learning from good practice and excellence in the Trust can be adopted. For example, appreciative enquiry into how changes in maternity were able to be made, and how this can be adapted into challenged parts of the organisation. | The Trust evidences that good practice is shared through its Improvement Community Forum, which is designed as a structured platform for "sharing ideas, showcasing work and learning from one another."<br>Regular agenda items such as improvement success stories, spotlight sessions, and sharing/celebration ensure consistent dissemination of improvement work, supported by guest speakers and team presentations, with further sharing enabled via a dedicated Teams channel. We conclude this recommendation has been implemented. | In progress. | Complete |
| 8 | The risks of clinical leadership accountability models are potentially high and all aspects of this must be considered through a proper evaluative process. Ensuring the right people with the right training are fulfilling the most appropriate roles is key. | Whilst the Trust has worked with Tricordant to do a structured operating model review with clear governance, stakeholder engagement and diagnostic activity, the evidence provided does not set out a formal evaluative methodology, assessment criteria to how effectiveness will be assessed. For the purposes of this review however, we conclude this recommendation has been implemented. | Complete | Complete |
| 9 | Benchmark the Trust's People directorate (to include HR and OD) to understand how its resourcing compares to trusts of a similar scale and complexity. The recent merger during the pandemic needs to be factored into decision-making arising from this process. | The Trust commissioned an independent HR review by Dearden. This was informed by interviews, focus groups, stakeholder and team discussions, and benchmarking against Model Hospital and professional comparators. Evidence showed HR costs and WTE below national median for comparable trusts, with OD capacity underdeveloped. The review factored in the 2021 merger during Covid-19, recognising legacy integration, cultural and workforce pressures. Agreed actions include phased improvements to capacity, structure, OD, EDI, workforce information and automation.<br><br>In response to the report findings, a plan has been developed and this has been considered and approved by the People and Culture Committee. We | In progress. | Complete |

| Recommendation | Description | NHSE Assessment July'26 | March '26 Status (Trust) | NHSE RAG July '26 |
|---|---|---|---|---|
| | | believe this recommendation has now been met and confident the Trust will go on to implement the plan in full. | | |
| 10 | Use a forthcoming Board development session to reflect on the findings within this report in relation to discrimination, and initiate discussions about the Board's role in leading a more visible campaign to tackle this across the Trust. | The Trust has embedded equality, diversity and inclusion (EDI) within its governance, workforce and culture programmes. It has established Board and executive equality objectives, a Workforce Inclusion Plan, mandatory EDI training, staff voice and engagement initiatives, and leadership development focused on inclusive behaviours and creating psychological safety. Following the Lord Mann Review, the Trust is reviewing alignment with national expectations and integrating any additional actions through existing governance, workforce inclusion and culture improvement arrangements. A Director of Voice, Engagement and Inclusivity role has been created as part of the TOM to ensure a senior dedicated focus on inclusivity. We understand an offer has been made and the individual is expected to be in post before the end of this calendar year (2026).<br><br>Board oversight is evident, we are aware a Board session is planned for October 2026 and anticipate that this recommendation will be implemented in full by the end of this calendar year. | In progress. | In progress |

| Recommendation | Description | NHSE Assessment July'26 | March '26 Status (Trust) | NHSE RAG July '26 |
|---|---|---|---|---|
| 11 | As part of the annual reviews of committee effectiveness and terms of reference, consider the feedback relating to each Board committee in Chapter 7 of this report. All committees need to ensure that reports submitted clearly identify the material issues, areas of key risk, and action requested from the committee. | The Board Committees have completed an effectiveness review and the terms of reference have been refreshed and there are plans to repeat this on an annual basis. A Board development programme is now in place. The evidence provided included a copy of the slides used in one of the Board development sessions confirmed the intent to strengthen governance, assurance and board effectiveness, with evidence of improved focus on strategic oversight, constructive challenge and psychological safety. They reflect learning from past performance, including CQC findings.<br><br>Committee and Board paper front sheets have been revised to ensure that material issues and risks are highlighted. The Trust has also developed and is in the process of delivering an effective Board writing course to improve the standard of papers being presented.<br><br>Whilst there is evidence that the Committees and Board are now actively considering the material issues and key risks we consider this to remain as work in progress until such time that the Board is satisfied that the required standards of reporting and Board and Committee effectiveness have been reached. This is to ensure that the new style of reporting and working is being consistently adopted, particularly with reference to evidence of the Board and Committees requesting and following up on actions to mitigate material issues and risks. | In progress | In progress |

| Recommendation | Description | NHSE Assessment July'26 | March '26 Status (Trust) | NHSE RAG July '26 |
|---|---|---|---|---|
| 12 | Any redesign of the COM needs to be coproduced with those involved in implementing it successfully. The review underway needs to have a key focus on the behaviours, attitudes and operating principles required to make the new model work week. See also Recommendation 6. | The Trust has provided evidence of engagement work undertaken in the development of the Clinical Operating Model and the Target Operating Model and has now implemented the first phase of the TOM. Organisational development and learning support has been commissioned to support the new Divisional teams in transitioning to the new model. The wider work on culture / values and behaviours compliments this, as does the work on risk and governance and the development of the new divisional assurance meeting model. Work is now progressing on the next Phase of the TOM (Phases 2a and 2b). We conclude this recommendation has been implemented. | Complete | Complete |
| 13 | As part of the review of the COM, evaluate the efforts to standardised approaches to divisional governance meetings after six months. | Not yet due.<br><br>Next steps are to:<br>- Develop Directorate level governance and set out clear 'minimum viable' directorate level governance expectations.<br>- Review effectiveness of divisional governance arrangements (Q1 2027/2028). | In progress | In progress |
| 14 | Further develop the emerging quality impact assessment process to include training and support for divisions, as well as how the Trust will undertake post- implementation reviews of efficiency schemes for any adverse quality/equality impacts. | The Trust has purchased an online database (Monday.com) to support the launch of the new EQIA process for sustainable assessment and management of higher EQIA score projects, with the aim of providing regular updates to the Committee.<br><br>Next steps are to:<br>- To continue to develop the EQIA approach and review the effectiveness of this approach in 2027/28.<br>- To provide training and support to the new divisions as required. | In progress. | In progress |

| Recommendation | Description | NHSE Assessment July'26 | March '26 Status (Trust) | NHSE RAG July '26 |
|---|---|---|---|---|
| 15 | Refresh the Board Assurance Framework's strategic risks. Ensure that the Board's subcommittees have routine and robust oversight of these, seeking assurance around risk management and reduction where possible. | The Board Assurance Framework (BAF) maps each strategic risk to a lead Committee, ensuring clear ownership, oversight, confirm and challenge for the purposes of gaining adequate assurance that the strategic risks are being actively managed. Examples include Finance and Performance, Patient and Quality, People and Culture, RIDC, and Strategy and Major Projects Committees, which are each responsible for specific BAF risks.<br><br>The Risk Sprint currently in progress aims to improve Trust-wide risk management through engagement, clearer escalation, consistent language, and stronger executive oversight with an alignment workshop Trust-wide targeted for September 2026.<br><br>The Trust has refreshed its BAF for 2026/27 and this is fully aligned with the Trust strategy. Each Committee receives the reports and the documentation is clearly showing sources of and levels of assurance and is actively reviewing risks and mitigations.<br><br>Next steps are to:<br>- Continue to develop and embed the new BAF, including integrating the Trust level and operational risk profile into future reports. | In progress | In progress |
| 16 | Consider whether the Trust has appropriately calibrated its response to how technology will underpin the success of its new strategy. This should include a review of leadership structures, capacity and the Board's line of sight to the management of associated risks. | The Trust has developed a Digital and Data Strategy with a supporting roadmap for 2025/26–2027/28, covering core programmes, governance and investment. Further assurance should test whether leadership capacity, delivery resources and Board oversight are sufficient, including clear line of sight to roadmap delivery, dependencies, risks and benefits realisation. We conclude this recommendation has been implemented. | Complete | Complete |

| Recommendation | Description | NHSE Assessment July'26 | March '26 Status (Trust) | NHSE RAG July '26 |
|---|---|---|---|---|
| 17 | Simplify the strategic deployment reviews to focus on:<br>• The mutual review and discussion of key priorities for each division (this should also encompass corporate support functions).<br>• The agreement of next steps and any support required.<br>• The identification of any cross-trust issues requiring executive intervention. See also recommendations relating to shared ways of working | The Divisional Assurance Meetings are now part of the business as usual governance cycle. The Performance Management and Accountability Framework has been provided that outlines how divisional performance will be managed.The Executive Management Committee now includes divisional representation, providing the opportunity for cross cutting themes and interdependencies to be explored and discussed. For the purposes of this review we conclude this recommendation has been implemented. However, given the new divisional structures have only been recently implemented, the new approach is likely to take some time to become fully embedded and the Trust should consider regular effectiveness reviews of the new divisional ways of working. | In progress | Complete |
| 18 | Service changes implemented as part of the Strategy Delivery Plan must be co-produced with patients, and specific attention given to potential health inequalities. | Co-production is considered to be best practice and likely to be more successful at implementation.<br><br>Strong examples of patient engagement provided for example evidence of patient involvement is strongest within the colorectal cancer surgery reconfiguration, where a two stage engagement process gathered feedback from people with lived experience to inform service proposals. Evidence from ophthalmology programmes demonstrates extensive patient feedback and Healthwatch involvement, highlighting accessibility and experience concerns. The catheter lab documentation show that staff and a large cohort of patients were involved in the survey, including presentation to the local Health Overview Scrutiny Committee which was well received, securing their endorsement for the proposed service reconfiguration. Evidence of engagement with the local HealthWatch regarding service changes was also provided.<br>Copies of the 'Engaging to support change: Strategic Engagement Framework' presented to the Clinical Transformation Board in January | Complete | Complete |

| Recommendation | Description | NHSE Assessment July'26 | March '26 Status (Trust) | NHSE RAG July '26 |
|---|---|---|---|---|
| | | 2026 setting out the proposed approach to strategic engagement, and an update on implementation of the Welcome Standards have also been provided demonstrative of the Trust's commitment to engagement and co-production with staff and patients. The Trust is currently developing a Playbook for Clinical Transformation, which will establish best practice expectations of early and ongoing engagement of patients (and staff) and consideration of potential health inequalities in clinical and strategic transformation. The first design group will meet in August 2026. The Trust is appointing a Director of Voice, Improvement and Partnerships to secure senior and sustained focus on ensuring effective patient and staff engagement and inclusivity. Whilst for the purposes of this review we conclude this recommendation has been implemented, the Trust should ensure a continued focus on assessing health inequalities as part of any service change. | | |
| 19 | Work with partners to plan (together) a series of cross-system strategy sessions in 2025/26 in order to develop longer-term and sustainable care models. These will need:<br><br>• Executive and clinical contribution,<br>• Learning from established and mature systems, and may benefit from external facilitation. | The Trust is engaged in cross system strategy through the Provider Collaborative and Acute Alliance, with executive and clinical contribution to ICB strategic commissioning discussions. The ICB board paper (April 2026) sets out shared priorities including neighbourhood health, provider alliances, pathway redesign and the hospital to community "left shift". Examples include HALO learning, INT engagement, UEC and rehabilitation/intermediate care work, and shared measures for outcomes, prevention and cost efficiency. Whilst for the purposes of this review we conclude this recommendation has been implemented, we would encourage the Trust to continue to prioritise system and partnership working as they seek to develop solutions to some of their key operational challenges associated with meeting patient demand and need. | Complete | Complete |

| Recommendation | Description | NHSE Assessment July'26 | March '26 Status (Trust) | NHSE RAG July '26 |
|---|---|---|---|---|
| 20 | Agree a corporate approach to improvement, which reflects the feedback in this report. The approach taken should be supportive of the culture the Trust is seeking to drive, and build on existing strengths. We would suggest that a model which enables local, grassroots engagement, and feels intuitive to the widest group of staff would be helpful. | The Trust has taken a corporate approach to improvement through Try, Learn, Share. It uses Trust's Behavioural Compass. The model promotes staff led change through, reflection and shared learning. Experimenteers, toolkits and leadership engagement help make it accessible across teams, while EMC follow up demonstrates senior commitment to modelling the culture and spreading learning. We conclude this recommendation has been implemented. | In progress | Complete |
| 21 | Review the safety culture of the Trust in full in light of the findings in this report in relation to psychological safety and wider organisational culture | The Trust has undertaken significant work to strengthen safety culture, with early signs of improvement reflected in NHS Staff Survey results. The Excellent Care Everywhere Strategy identifies safety culture as a key priority, supported by work on harmful behaviours, psychological safety, incident learning, violence prevention, Human Factors, PSIRF and Freedom to Speak Up.The Behavioural Compass promotes clear behavioural expectations and a Speak Up, Listen Up, Follow Up culture, supported by Civility Saves Lives, targeted Active Bystander and Human Factors training. Freedom to Speak Up arrangements are being strengthened through a refreshing of the policy (currently out for comment August 2026), supporting guidance and essential e-learning. Trust communication has increasingly focused on "You said, you/we did", so that staff can see that something is actively being done when they speak up and speak out. The Trust has introduced dedicated Violence Prevention and Reduction (VPR) and Sexual Safety programmes. Next steps are to:- Finalise the Freedom to Speak Up Policy.- Explore opportunities for rolling out active bystander training to other areas of the Trust.- Agree forward actions and align with the Strategic Delivery Improvement Framework.- Review actions in the context of the next set of NHS Staff Survey safety culture related survey results. | In progress | In progress |

| Recommendation | Description | NHSE Assessment July'26 | March '26 Status (Trust) | NHSE RAG July '26 |
|---|---|---|---|---|
| 22 | Agree and re-confirm, as a Board, the level of organisational commitment to the Green Plan (and wider Green agenda), the realistic goals aligned to this, and how they will be monitored. Re-confirm this to staff and clarify how they can contribute to these goals. | Green plan slides dated May 2026 clearly outlining the organisations' commitment to going green have been provided. However, it is not clear which forum these were presented at.<br><br>The Strategy and Major Projects Assurance Committee assessed the Green Plan's deliverability, metrics, engagement and governance at the meeting on the 7th May 2026. Challenges centred on affordability, competing priorities, measurable impact, and sustaining staff/community engagement.<br><br>The Board approved the Green Plan on 14th May 2026 based on the presentation provided from the Strategic and Major Projects Committee update. We conclude this recommendation has been implemented. | In progress | Complete |

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| **Agenda Item:** | 12. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 17 September 2026 |
| **Report Title:** | Audit Committee Chair's Report | | | | |
| **Author(s):** | Mike Driver – NED & Committee Chair | | | | |
| **Purpose of the report:** *(indicate as appropriate)* | **For Decision** | **For Assurance** | **For Discussion** | **For Information only** | |
| | *N/A* | *Yes* | *Yes* | *N/A* | |
| **Reason for not being taken in public** *(indicate as appropriate)* | **Commercial confidentiality** | **Staff confidentiality** | **Patient confidentiality** | **Other exceptional circumstances (please detail)** | |
| | *N/A* | *N/A* | *N/A* | *N/A* | |
| **Regulatory Reporting Requirement** | | | | | |

| | |
|---|---|
| **Summary of the report describing**<br><br>**What** *(summary of current position / issue & why it matters and evidence to support that position etc)* | *The report provides information over the business undertaken at the Audit Committee on 28 July 2026.*<br><br>*The Committee meeting was quorate and received its scheduled business covering internal audit, counter fraud and external audit along with reports on the Trust's BAF and risk management processes.*<br><br>*The Committee also received reports detailing the Trust's management oversight for the use of single tender waivers and the mitigations for any losses or special payments.* |
| **So What** *(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)* | *The Board can take assurance from the oversight provided by this Committee over the systems and processes supporting the Trust's Board Assurance Framework, the Trust's compliance with the Data Protection Regulations, the processes for oversight of fraud risks were effective and that the Trust has effective systems of control over the use of tender waivers.*<br><br>*The Committee Chair provided an annual report, summarising the activity of the Committee for the period 2026 / 2026 and through this the Board can take assurance over the Committee's fulfilment of its terms of reference. (appendix 2)*<br><br>*The Committee has agreed that in order to better support the work of the Auditors they would engage more directly with the accountable directors were agreed actions were becoming aged.* |
| **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)* | *The Board can take assurance through the work of the Audit Committee on the underlying processes in support of the Trust's BAF and that it referred items linked to the activity of other Committees where of value.* |
| **Recommendation** *(linked to What Next section)* | ***The Board is asked to NOTE that:***<br>- ***The Committee was quorate and considered all the expected reports in line with its schedule of business.***<br>- ***The Committee's assurance over the continuation of the underlying BAF processes.*** |

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| | - ***The Committee's annual report which provides assurance that the Committee has discharged its terms of reference***<br>- ***The Committee's action to provide more direct support to accountable directors where agreed actions are becoming aged.*** |
| **Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*** | *The BAF processes were reviewed by the Trust Executive Management Committee prior to the report to the Committee*<br><br>*The audit recommendation thematic review was considered by the Trust Executive Management Committee prior to its presentation to the Committee.* |

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

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

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

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

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# Audit Committee Chair's Report

The Audit Committee met on the 28 July and was quorate. It received all its planned business. In attendance were the Interim Chief Corporate Affairs Officer, the Chief People Officer, the Trust's Operational Finance Director, Deputy Director of Finance – Operational Finance, Chief Procurement Officer and Company Secretary along with the Trust's Internal and External Auditors and Local Counter Fraud team members. The Chief Information Officer also attended to present the reports on the Data Security and Protection Toolkit report and Data Protection Officer's annual report. The Director of Infrastructure attended the meeting to support the discussion on the Internal Audit report in respect of the premises assurance model assessment process and the internal audit recommendation traker.

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

## Risk Management and BAF reports

The Committee considered, reviewed and discussed the underlying processes for the maintenance of the Trust's BAF and as a result were assured over these processes. The Committee noted the work undertaken that revised the format of the BAF document had achieved the ambition of bringing into sharper focus the levels of assurance being provided and greater visibility on the tracking of the mitigating action delivery.

The Committee reconfirmed its desire to undertake a complementary thematic review of the people related strategic risks at its meeting in October

The Committee considered the risk management compliance report and noted the continued progress being made to improve the divisional risk literacy whilst the risk improvement work commences. The Committee discussed the focus of the risk improvement work and endorsed the plan to tailor the engagement to change the culture from risk capture to risk management and this would itself support teams understanding the value of having complete risk entries through the completion of smart mitigations and focused assurances.

## Thematic review of Audit Recommendations

The Committee received the requested thematic analysis of the audit recommendation made by both Internal and External Audit. The Committee discussed this analysis and noted the strong links with the cultural improvement work being undertaken and asked that in Internal Audit reviews they consider explicitly the cultural drivers as to the how the systems of internal control are working. The Committee also reflected that whilst the revised Trust Operating Model is bringing clearer accountability there remains a role for the Audit Committee to consider within its receipt of the respective reports it could offer support in respect of reinforcing the importance of appropriate engagement with the shaping of the control systems and then the delivery of all agreed improvements.

## Internal Audit activity

The Committee received a report on the Internal Audit work undertaken in the quarter and noted the negative assurance opinion on the design of the Trust's system of internal control in respect of the oversight of the Premises Assurance Model return for 2024/25 and the depth of available evidence to support the self-assessment judgements. The Audit Committee were informed by the Director of Infrastructure that the recommendations made were being actions and that the significant weaknesses were being addressed in time for the latest 2025/26 return to be submitted in September 2026.

The Audit Committee also sought an update from the Director of Infrastructure on the engagement with Internal Audit to provide evidence of the delivery of the actions agreed. The Committee was informed of the revised processes put in place within the division to ensure there is a single point of contact who will ensure all such evidence is provided to Internal Audit as it is reported through the Trust's internal management and governance groups.

The Audit Committee welcomed the Director of Operational Finance's personal commitment to take a more active role in the follow up of overdue recommendations and support conversations between the action owner and internal audit were due to changes in the control environment the initial action needed to be changed.

The Committee **agreed** that for actions that were very aged that they would require the appropriate named accountable director to attend the Committee to discuss the delay, understand the impact of the delay and offer a further opportunity for engagement with the auditors where a change in action is needed.

**Data Security Protection Toolkit Submission and Data Protection Officers Annual Report**

The Committee **received** the report confirming that the Trust had been judged as **standards met** based on its 2025/26 submission. The Committee noted that it had received a position report from Internal Audit earlier in the year on the Trust's processes for making its assessment.

The Committee **received** the annual report of the Trust's Data Protection Officer which provided **assurance** over the Trust's compliance with the data protection legislation and that the Trust's Data Protection Officer has met their statuary requirements.

The Committee **discussed** the challenges facing the Trust in this area and the work undertaken by the Data Protection Officer and their team.

**Local Counter Fraud activity**

The Committee considered the Local Counter Fraud progress report for Quarter 1 2026/27 in relation to their work undertaken in respect of reported concerns. The Committee was also updated in response to the actions taken in respect of any reported concerns. Through this report and the update provided by the Trust's Local Counter Fraud Specialists the Committee noted there were no significant fraud risks which Trust needed to be actioned urgently.

The Committee in receiving the LCFS benchmarking report in respect of the level of reactive work at the Trust in comparison to their other clients noted that the Trust's referral patterns and sources of referrals were relatively comparable and took confidence over the quality of referrals at the Trust.

**Annual Review of the Trust's External Auditors**

The Committee received an update on the performance of the Trust's external auditors and agreed that this was a correct reflection of their work for the 2025/26 year and therefore agreed for it to be presented to the Council of Governors.

**Annual Audit Committee Report for 2025/26**

The Committee noted the report from the Audit Committee chair for the period to June 2026 and agreed this reflected the work of the Committee and provided assurance that the Committee had met its terms of reference. The Committee agreed that this report should be provided to the Board to provide assurance that the Committee had met its terms of reference.

**Referrals to other Committees**

The Committee agreed there were no specific matters that it needed to refer to other Committees.

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**Appendix 1**

## COMMITTEE HIGHLIGHTS REPORT TO BOARD

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

**Items received at the Committee meeting**

| Item | Presenter | Purpose of the paper | Action Taken |
|---|---|---|---|
| Board Assurance Framework | Company Secretary | For assurance over the application of the Trust's process | The Committee considered the underlying processes for the maintenance of the Trust's BAF and as a result were **assured** over their continuation.<br><br>The Committee **agreed** that at its future meetings it would continue to undertake a complementary and additive thematic review of the people risks at its October meeting. |
| Risk Management Policy Compliance report | Interim Chief Corporate Affairs Officer | For assurance over the application of the Trust's process | The Committee **received** the risk management policy compliance report provided.<br><br>The Committee **received** an update on the work being undertaken to strengthen the risk management processes within the divisions and discussed how this work would support a change in culture from risk recording to risk management. |
| Thematic Analysis | | | The Committee **received** a Thematic analysis of Audit recommendations and noted the strong links with the cultural improvement work being undertaken and asked that in Internal Audit reviews they consider explicitly the cultural drivers as to the how the systems of internal control are working.<br><br>The Committee **welcomed** the commitment of the operational director of finance to become more involved in securing action for aged actions. |

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|---|---|---|---|
| Internal Audit Reports<br>- Activity Progress Report<br>- Recommendation Follow Up Report | BDO (Internal Auditors) | For assurance over respective areas of internal control | The Committee **noted** the work undertaken in the quarter and that internal audit had concluded work in areas where management anticipated they could add value through focused improvement recommendations.<br><br>The Committee **noted** the negative assurance opinions in respect of the application of the systems of internal control within the areas of premises assurance model assessment. The Committee **received** assurance from the Director of Infrastructure that the recommendations to agrees the key identified weaknesses with the Trust PAM self-assessment submission would be addressed by the 2025/6 submission in September<br><br>The Committee also **received** assurance from the Director of Infrastructure on the aged actions and that a revised process has been established to engage with Internal Audit. |
| Counter Fraud<br>- Q1 progress report<br>- Benchmarking report | RSM (LCFS) | For assurance over respective areas of internal control and for information on the Trust's fraud profile | The Committee **noted** the work undertaken by the counter fraud team, that there were no elevated fraud concerns from the work in the first quarter of the year.<br><br>The Committee **noted** that the benchmarking undertaken provided confidence that the Trust's referral rate was not atypical and that the quality of the referrals made was good. |
| External Audit Update<br>- Progress report | GT (External Audit) | To note status of the External Audit work | The Committee **noted** that the 2025/26 external audit had been concluded with the opinion issued. |
| Annual Review of the Trust's External Auditors | Deputy Director of Finance - Operational Finance | To review and recommend to the Council of Governors | The Committee **received** an update on the performance of the Trust's external auditors and **agreed** that this was an accurate reflection of their work for the 2025/26 year and therefore **agreed** for it to be presented to the Council of Governors. |

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|---|---|---|---|
| Losses, Special Payments | Assistant Deputy Director of Finance - Operational Finance | To note the report and the assurance it provides over the application of the Trust's processes. | The Committee **noted** that the quarter one update noting the analysis provided and discussed the work undertaken to recover outstanding amounts.<br><br>The Committee **discussed** the actions being taken to minimise losses and the risk of wastage through better cross site working in the use of stock.<br><br>The Committee took **assurance** from the continued comparably low value of losses and special payments. |
| Tender Waiver Report | Chief Procurement Officer | To note the report and the assurance it provides over the application of the Trust's processes. | The Committee **noted** the continuing relatively low level of these across the year and in the quarter and through discussion with the Chief Procurement Officer the Committee was **assured** over the processes being applied to support the review of Waivers. |
| Data Security and Protection Toolkit 2025/26 | Chief Information Officer | To note the progress made and receive an update on the Trusts processes | The Committee **noted** the Trust's self assessment of standards met had been agreed by NHS E.<br><br>The Committee **discussed** the progress being made to amalgamate the cyber security local training into the nationally set IG training perhaps through a discrete module within that course. |
| Data Protection Officer Annual Report for 2025/26 | Chief Information Officer | To note the IG activity undertaken over the previous year | The Committee **noted** the assurance this report provided over the Trust's compliance with the data protection legislation and that the Trust's Data Protection Officer has met their statuary requirements. |
| Health and Safety Committee Chairs Report | Company Secretary | Provision of information on the activity of this Committee and that Committee's view of the Trust's Health and Safety risks. | The Committee **noted** the assurance provided by the report and that the alerts raised were all being supported appropriately. |
| Annual Audit Committee Report for 2025/26 | Committee meeting Chair | For assurance to the Board on the operation of the Committee for 2025/26 | The Committee **noted** the report from the Audit Committee chair for the period to June 2026 and **agreed** this reflected the work of the Committee |

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| | | | and provided assurance that the Committee had met its terms of reference. |

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| **Agenda Item:** | 13. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 17 September 2026 |
| **Report Title:** | Research, Innovation and Digital Assurance Committee Chair's Report | | | | |
| **Author(s):** | Jackie Cassell – NED & Committee Chair | | | | |

| **Purpose of the report:** *(indicate as appropriate)* | **For Decision** | **For Assurance** | **For Discussion** | **For Information only** |
|---|---|---|---|---|
| | *N/A* | *Yes* | *Yes* | *N/A* |

| **Reason for not being taken in public** *(indicate as appropriate)* | **Commercial confidentiality** | **Staff confidentiality** | **Patient confidentiality** | **Other exceptional circumstances (please detail)** |
|---|---|---|---|---|
| | *N/A* | *N/A* | *N/A* | *N/A* |

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|---|---|
| **Regulatory Reporting Requirement** | |
| **Summary of the report describing**<br><br>**What** *(summary of current position / issue & why it matters and evidence to support that position etc)*<br><br>**So What** *(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)*<br><br>**What Next** *(summary of intended action and benefits supporting the choices and recommendations made)* | This report provides information over the business undertaken at the Research, Innovation and Digital Assurance Committee on 5 August 2026. The Committee meeting was quorate and received its scheduled business.<br><br>The Board can take assurance from the oversight provided by this Committee over the domains of Research, Innovation and Digital with particular focus on digital transformation, cyber security, the Electronic Patient Record (EPR) programme, research delivery performance and the Board Assurance Framework (BAF).<br><br>The Committee is able to provide assurance to the Board that appropriate governance, risk management and oversight arrangements are in place across these domains, and that areas of risk are clearly identified, monitored, mitigated and escalated where required. The Board can also take confidence that through the work to develop the research delivery workstreams the Committee will through their regular reporting be able to provide assurance on the delivery against the Trust research strategic ambitions.<br><br>The Board can receive the BAF with confidence knowing that the content and scores for the new strategic risks 7 and 9 have been scrutinised by the Research, Innovation and Digital Assurance Committee. |
| **Recommendation** *(linked to What Next section)* | **The Board is asked to NOTE:**<br>- **The Committee was quorate and considered all the expected reports in line with its schedule of business**<br>- **The Committee's assurance over the digital and research & innovation domains.**<br>- **The Committee's approval of the UHSussex Institutional PCIE in Research Strategic Plan for submission to the NIHR.**<br>- **The Committee's recommendation that strategic risk 7 should remain at 20 and risk 9 should remain at 16 for Q2 2026/27.** |
| **Assurance route already undertaken** | |

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

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|---|---|
| **Link to annual delivery plan** | The Committee provides oversight of the delivery of the Trust's research, innovation and digital domains that are aligned to the Trust's Strategy which supports the delivery of the Trust's annual plan. |
| **Link to BAF** | The Committee has oversight of the key assurances referred to within the BAF for new strategic risks 7 and 9 and through their scrutiny of these recorded assurances consider and recommend to the Board their relevant current scores. |

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

| **Other impacts** | **Equality and Diversity** | **Environmental** | **Legal** | **External Registrations** |
|---|---|---|---|---|
| | N/A | N/A | Yes | Trusts are required to maintain effective systems of governance, risk management and internal control- FT Code of Governance) |

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# Research, Innovation and Digital Assurance Committee Chair's Report

The Research, Innovation and Digital Assurance Committee met on 05 August 2026 and was quorate, with the required Non-Executive and Executive Director/s present. The Committee received all scheduled business in line with its agreed programme of work. The meeting provided the Committee with assurance across the Trust's research, innovation and digital portfolios, with particular focus on digital transformation, cyber security, the Electronic Patient Record (EPR) programme, research delivery performance and the Board Assurance Framework (BAF). The Committee is able to provide assurance to the Trust Board that appropriate governance, risk management and oversight arrangements are in place across these domains, and that areas of risk are clearly identified, monitored, mitigated and escalated where required.

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

## Research and Innovation

The Committee received its scheduled items to enable it to have oversight of research performance and assurance over the quality and governance of the research undertaken. The Committee noted that the research agenda at the next meeting would give particular focus to the Innovation Delivery Plan.

### Research Delivery Plan for research and innovation

The Committee received the Quarter 1 Research Delivery Plan and performance reports and was assured by continued progress across the research portfolio. Performance remains strong, with continued growth in active studies, participant recruitment, commercial research activity and principal investigator numbers. The Committee noted that UHSussex remains among the top-performing acute trusts nationally for research recruitment and study activity.

The Committee also reviewed progress of the Commercial Research Delivery Centre (CRDC) and noted continued improvement in commercial trial set-up performance, growth in commercial research opportunities and positive progress against key performance indicators. The Committee was assured that growth in commercial research continues alongside strong performance in non-commercial and academic research activity.

### Deep Dive into Patient & Community Involvement & Engagement and Inclusion inc Draft UHSussex Institutional PCIE in Research Strategic Plan

The Committee was joined by partner representatives from the Sussex Health and Care Research Partnership and from the NIHR Commercial Research Delivery Centre that launched in April.

The Committee received a deep dive on Patient and Community Involvement and Engagement (PCIE) and research inclusion, including the draft UHSussex Institutional PCIE in Research Strategic Plan for submission to the NIHR. The Committee heard how this work supports the Trust's ambition to widen participation in research, reduce inequalities in access and strengthen engagement with underserved communities across Sussex.

The Committee was encouraged by the focus on gaining evidence of increasing research participation from more deprived communities and the development of the Surrey and Sussex Research Engagement Network, which is helping build research capability through trusted community partnerships. The Committee **endorsed** the draft Strategic Plan and requested a future update on outcomes and impact.

Embedding Research within the Trust Operating Model

The Committee reviewed the approach to embedding research within the new Trust Operating Model and received assurance that plans are progressing to strengthen research leadership, research participation and research capability across all divisions and professional groups. This includes strengthened clinical research leadership structures and continued development of multiprofessional research careers.

Clinical Research Facilities

The Committee noted continued progress on delivery of the Clinical Research Facility programme. Assurance was received that both the Princess Royal Hospital and Louisa Martindale Building developments remain on track and continue to mitigate one of the Trust's key research infrastructure risks.

Research Quality and Safety

The Committee received the annual Research Quality and Safety Report and was assured that robust governance, quality assurance and oversight processes remain in place. No significant governance concerns or regulatory issues were reported during the year. The Committee noted ongoing work to strengthen governance arrangements and further align research oversight structures.

**Digital**

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

Digital Data Delivery Plan

The Committee reviewed progress against the Digital and Data Delivery Plan and was assured that the digital portfolio continues to be actively managed through clear governance, prioritisation and risk management arrangements. Progress was noted across a number of digital transformation programmes including infrastructure resilience, digital clinical systems, digital communications and patient-facing services including for prescribers with the introduction of EMPA.

The Committee also reviewed the Trust's approach to Artificial Intelligence governance and the management of Ambient Voice Technology. The Committee heard that appropriate governance arrangements are being established and that implementation is proceeding through controlled and approved routes. The Committee requested further discussion on organisational risk appetite and adoption of AI technologies at a future meeting

Cyber Security and Information Governance

The Committee received reports on the Data Security and Protection Toolkit (DSPT) and cyber resilience. Assurance was provided that the Trust successfully achieved a "Standards Met" submission for 2025/26 and continues to strengthen cyber resilience, information governance and business continuity arrangements.

The Committee welcomed evidence of strengthened disaster recovery planning, identification of critical services and cyber exercise activity. Attention was drawn to increasing national cyber requirements and the need to continue investment in cyber resilience, monitoring and recovery arrangements.

Electronic Patient Record (EPR)

The Committee received assurance on progress of the EPR programme. It noted successful completion of the Electronic Document Management System (EDMS) programme, which represents an important milestone in EPR readiness. The Committee was assured that detailed planning, design validation and programme mobilisation activity is progressing following approval of the business case.

The Committee discussed programme risks, particularly organisational capacity and workforce readiness, and was assured that these are being actively managed through programme governance arrangements.

Patient Facing Digital Services

The Committee reviewed the Trust's patient-facing digital architecture and heard about ongoing progress in digital communications, patient portals and digital engagement. The Committee supported the strategic direction and recognised the opportunity to improve patient experience and operational efficiency while ensuring inclusive access and support for those unable to use digital channels.

**Risk and Board Assurance Framework**

The Committee reviewed both the Research & Innovation and Digital risk registers and was assured that risks are being actively managed through established governance arrangements. The Committee noted continuing progress against key mitigation plans.

The Committee specifically reviewed the Board Assurance Framework risks within its remit:

- **SR7: Analogue to digital - harnessing technology and data to transform healthcare**
- **SR9: Widening access to research and innovation**

Following consideration of the reports received throughout the meeting, the Committee concluded that the current scores remain appropriate and reflect both the progress being made and the residual risks associated with delivery

**Referrals to other Committees**

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

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**Appendix 1**

## COMMITTEE HIGHLIGHTS REPORT TO BOARD

| **Meeting Details** | | | | | |
|---|---|---|---|---|---|
| **Meeting Date** | 5 August 2026 | **Chair** | Jackie Cassell | **Quorate** | Yes |
| **Declarations of Interest** | No declarations were raised | | | | |

**Items received at the Committee meeting**

| Item | Presenter | Purpose of the paper | Action Taken |
|---|---|---|---|
| Research, Innovation and Digital Steering Group Chair's report | Chief Medical Officer Chief Strategy Officer | To provide context for the papers being considered at the meeting | The Committee **noted** this report and how the work of the steering committee supported the flow of performance and assurance reports to the Committee. |
| Item | Presenter | Purpose of the paper | Action Taken |
| Research & Innovation | | | |
| Research Delivery plan Q1 Highlight Report | Director of Research & Innovation | To provide information on the workstream activity since the last meeting | The Committee received the report giving an update on performance measures via the workstreams that have been established to meet the Trust's research ambitions. The Committee was **assured** by continued progress across the research portfolio |
| Research Performance Report 2026-27 Q1 | Director of Research & Innovation | To note a summary of research performance against agreed key indicators. | The Committee noted the KPI performance with positive growth in new commercial trials. |
| Commercial Research Delivery Centre milestone report | Director of Research & Innovation | To provide information on this initiative | The Committee **noted** the delivery against the established KPIs for the Commercial Research Delivery Centre in quarter 1 with further improvement in commercial study set-up efficiency and improved time to recruit first patients to studies while also increasing the number of Trials running in the Trust and more widely across Sussex. |
| Clinical Research Facility Major Project update. | Director of Research & Innovation | To Note | The Committee **noted** progress on the Clinical Research Facility major project. |

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| Research & Innovation Annual Review 2025/26 | Director of Research & Innovation. | To note the summary of achievements and impact during 2025/26. | The committee **noted** the report and recognised the broad range of positive stories emerging from research activity. |
| DEEP DIVE Patient & Community Involvement & Engagement and Inclusion including Draft UHSussex Institutional PCIE in Research Strategic Plan | Director of Research & Innovation | To discuss and approve the strategic plan. | The Committee **noted** the deep dive report and updates. A future update on PCIE, community engagement activity and research inclusion outcomes is to be **brought back** to the Committee.<br><br>Members considered Strategic Plan and supported its direction, particularly focus on community engagement, prevention, primary care and reducing inequalities in research participation.<br>The Committee **approved** the Draft UHSussex Institutional PCIE in Research Strategic Plan for submission to the NIHR. |
| Delivery of Embedded Research within the New Trust Operating Model | Director of Research & Innovation | To Note | The Committee **noted** the report which described progress embedding research within the Trust Operating Model (TOM) and divisional leadership structures to ensure research became part of routine clinical and operational practice per the strategic intent. |
| Digital | | | |
| Digital & Data Delivery Work Plan - Programmes and Project Update 2026/27 Q1 | Chief Information Officer | To Note: progress made to manage the demand and strategic alignment for digital transformation activity; major digital transformation programmes; and the range of digital transformation activity last quarter that contribute towards improving the digital maturity of the Trust. | The Committee received an update on the digital programme work across the breadth of projects being supported. And **noted** the programme is actively managed, with clear governance, prioritisation and risk mitigation.<br>Updates on the Sussex Pathology Network to be **brought back** to future meetings. |
| Electronic Patient Record Update | Chief Information Officer | To note | The Committee recognised the successful completion of the EDMS programme and noted progress with the EPR implementation planning and design activity. |

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| Patient-Facing Infrastructure update | Chief Information Officer | To note and consider as a contribution to a strategic debate on the ways in which the Trust interacts with patients | **Noted** the contents of this report and opportunities to streamline communications.<br><br>Action for an update on Outpatient Transformation and its relationship with patient-facing digital architecture to be brought to a future Committee meeting |
| Cyber Exercise Reporting | Chief Information Officer | For assurance and noting | [Actions redacted at Public Board] The Committee noted the reports, **noted** the successful DSPT-CAF submission and **noted** the Trust's response to the NHS England cyber security assurance requirements. |
| Item | Presenter | Purpose of the paper | Action Taken |
| Risk | | | |
| Research, Innovation and Digital key risk registers | Director of Research & Innovation and Chief Strategy Officer | To enable the Committee to consider their allocated elements of the BAF | The Committee **noted** the R&I risk register continued to develop with risks being added to reflect risks to delivery of the 5 year delivery plan. The Committee **noted** the Digital Risk Register and that all risks are managed actively and reported through governance. Cyber security risks remained high reflecting the geopolitical shifts observed by the technical industry and some challenges faced.<br><br>The Committee utilised this report when considering their allocated element of the Trust's BAF. The Committee **noted** the contributing elements of most risks were generally on a downward trend. |
| Board Assurance Framework | Company Secretary | To review and recommend to the Board the scores for the new strategic risks 7 and 9 | The Committee considered the relevant segments of the BAF and alongside the reports received at the meeting agreed with the executives view of the risk scores.<br><br>The Committee agreed with the recommended scores for risk 7 and 9 for Quarter 1 2026/27. |

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| **Agenda Item:** | 14. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 17 September 2026 |
| **Report Title:** | Strategy and Major Projects Assurance Committee Chair's Report | | | | |
| **Author(s):** | Paul Layzell – NED & Committee Chair | | | | |
| **Purpose of the report:** *(indicate as appropriate)* | **For Decision** | **For Assurance** | **For Discussion** | **For Information only** | |
| | *N/A* | *Yes* | *Yes* | *N/A* | |
| **Reason for not being taken in public** *(indicate as appropriate)* | **Commercial confidentiality** | **Staff confidentiality** | **Patient confidentiality** | **Other exceptional circumstances (please detail)** | |
| | *N/A* | *N/A* | *N/A* | *N/A* | |
| **Regulatory Reporting Requirement** | | | | | |

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| **Summary of the report describing**<br><br>**What** *(summary of current position / issue & why it matters and evidence to support that position etc)* | *The report provides information over the business undertaken at the Strategy and Major Projects Assurance Committee in September 2026.*<br><br>*The Committee meeting was quorate and received its scheduled business, including the routine reporting on the strategy delivery plan report, the major project portfolio delivery report along with its cyclical review of a sample of major projects, these being Theatre Ventilation and the Electronic Patient Record. The Committee also maintained its oversight of its allocated element of the BAF. At this meeting the Committee received the Trust's developed Strategy Delivery & Improvement Framework and the Clinical Sustainability Tool.* |
| **So What** *(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)* | *The Board can take assurance from the oversight provided by this Committee over the progress and delivery of the Major Project portfolio.*<br><br>*The Board can take assurance through the more detailed review of the Theatre Ventilation Project and EPR programme that both projects have robust delivery plans and that the risks within each project were understood and being managed.*<br><br>*The Board should note that the developing clinical sustainability tool will aid the Trust to better prioritise the deployment of its change resource.* |
| **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)* | *The Board as it receives the Strategy Delivery & Improvement Framework having confidence that its structure and content align to the Trust's overarching strategy and its delivery will support the Trust's delivery of its agreed undertakings*<br><br>*The Board in receiving the BAF should note that Committee was generally content with the current score at quarter one for Strategic Risk 6 at 16 but reflected that the BAF narrative did not represent the current system financial challenge and thus the implications of this on the Trust's risk may be understated. Also, the Committee asked that the Executive Team consider if the allocation of BAF risks is appropriate or if a different risk is needed in respect of transformation delivery.* |
| **Recommendation** *(linked to What Next section)* | ***The Board is asked to NOTE*** |

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| | - ***The Committee was quorate and considered all the expected reports in line with its schedule of business***<br>- ***The Committee's review of the Strategy Delivery & Improvement Framework***<br>- ***The Committee review and endorsement of the developing Clinical Sustainability Tool***<br>- ***The Committee's review of the Major Project Portfolio Delivery report alongside the review of the specific Theatre ventilation project and the EPR programme***<br>- ***The Committee's referral of the BAF to the Executive Team to consider if the allocation of BAF risks is appropriate or if a different risk is needed in respect of transformation delivery*** |

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| **Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*** | *The Strategy and Major Project Board had reviewed the items prior to there reporting to the Committee.* | | | | | |
| **Link to Trust Strategy (note which theme)** | **Patient** | **People** | **Future** | **Communities** | **One UHSussex** | **Culture** |
| | Yes | Yes | Yes | Yes | Yes | *Yes* |
| **Link to annual delivery plan** | *The Committee provides oversight of the delivery of the Trust's major projects aligned to the Trust's Strategy which support the delivery of the Trust's annual plan.* | | | | | |
| **Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)** | *The Committee has oversight of the key assurances referred to within the BAF for strategic risk 6 and through their scrutiny of these recorded assurances consider and recommend to the Board their relevant current score.* | | | | | |
| **Link to CQC domain** | **Safe** | **Caring** | **Effective** | **Responsive** | **Well-led** | **Use of Resources** |
| | *N/A* | *N/A* | *N/A* | *N/A* | *Yes* | *N/A* |

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

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# Strategy and Major Projects Assurance Committee Chair's Report

The Strategy and Major Projects Assurance Committee met on the 3 September 2026 and was quorate with at five NEDs and two Executives being present including the Chief Strategy Officer as the lead executive for the Committee, along with the Chief Executive who attended for the strategy delivery and improvement framework and clinical sustainability tool items. In attendance were also the Director of Strategy, Deputy Director of Strategy, Director of Infrastructure, Head of Financial Management and Company Secretary and for the item on the EPR programme the Chief Information Officer and EPR programme lead both joined the meeting.

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

## Trust Strategy Delivery & Improvement Framework

The Committee **received** the report on the developing Strategy Delivery & Improvement Framework which has evolved the initial strategy delivery plan to include the Trust's improvement plan. The developed framework ensures that there are clear and measurable delivery milestones aligned to the Trust's strategy which incorporate the Trust's undertakings with NHS E and the agreed well-led recommendations.

The Committee noted that this framework and the construction of the tracking tool will allow oversight and reporting at a project level and portfolio level which will facilitate better decisions to be taken at the board on the deployment of effort and resources.

The Committee took confidence from the collaborative approach to the development of the specific plans and their milestone with both NHS E and internally between respective teams that the plan will meet the needs of NHS E and the Trust when finalised at the end of September,

The Committee discussed the capacity challenges to deliver what is a wide range of improvement and transformational ambitions and noted the interlinkage with the developing clinical sustainability tool to aid the deployment of Trust resources. The Committee through these discussions recognised that within the current year the focus must be on recovery to place the Trust on a sustainable footing to progress with the more transformational elements of the Strategy and that the improvement actions are focused on developing a sound foundational platform.

The Committee **agreed** that the developing plan should be shared with the Board and form the basis of future routine board reporting once finalised at the end of September.

## Clinical Sustainability Tool

The Committee **received** an update in the developing Clinical Sustainability Tool. The Committee was taken through the tool which looks at access, quality and cost data to determine where the greatest opportunity for improvement exists.

The Committee noted the level of clinical and operational staff engagement secured in the tool and that each of the four divisions have identified opportunities they wish to explore through this tool. The meeting also discussed the alignment of the Trust's change team resource to support the delivery of the identified opportunities. The meeting noted that the

application of the tool is seeking to move the services to the benchmarked median performance ahead of further discussions to move to upper quartiles. The Committee whilst recognising this approach encouraged that conversations be held about what it may take to become best in class so that opportunities for greater transformation are not lost.

The meeting noted that in the immediate term this tool will be used in pursuit of the Trust recovery programme.

The meeting discussed how the quality gain will be measured and noted that the intention was to utilise the GiRFT opportunities as a measure of quality gain. The meeting asked that in delivery reporting this dimension is included within the dashboards in development.

Through the discussions the Committee **endorsed** this tool recognsing that the tool brings the ability to determine project prioritisation and alignment of change resource in the service of delivering the Trust's strategy of Excellent Care for our patients.

**Major Projects – Theatre Ventilation Project update**

The Committee **noted** the Theatre Ventilation Project report and **received** information on the complexity within the project, which has three elements, large scale refurbishments, moderate refurbishments and a latter addition to the programme of updating procedure rooms.

The meeting discussed the benefit of a shift in short term focus of the programme to procedure room upgrading to create operational capacity to enable theatre refurbishments to take place.

The meeting noted that the programme was taking the learning from the recent heat waves in terms of the refurbishment scope.

The Committee through feedback by the Trust's Patient and Quality Committee Chair that the overall programme was aligned to those areas which will bring quality gains. The Committee also discussed the performance gains this work will bring and that the prioritisation of the work needed to align to those areas that will give the best performance and thus quality gain.

The Committee noted the risks associated with this project including that capital funding must be bid for on an annual basis.

Through the discussions the Committee was **assured** over the project oversight whilst noting the complexity of the project. The Committee **noted** the flexing in the overall project to include and focus on procedure room refurbishment to create operational capacity to enable the wider refurbishment to take place.

**Major Projects – Electronic Patient Records (EPR) Programme update**

The Committee **received** the report on the Electronic Patient Records (EPR) programme and **discussed** the project oversight, revised governance process developed as the project moves towards the implementation phase for the first module.

The meeting noted the workstreams through which the programme will be delivered and discussed the developed benefits realisation tracking process and their established reporting. The meeting also received information on the level clinical engagement within phase 1 and the level of confidence this gives for a successful delivery.

The meeting received assurance over the change management process established through both a technical and clinical design authority groups and there focus on improving standardisation and digital efficiency.

The meeting discussed the key risks to the successful implementation of the programme and noted that whilst there were risks to resourcing the implementation phase there was also a key risk brought about by the phasing of the LIMS replacement being so close to the implementation of module 1. In respect of this key risk the Committee heard of the mitigations put in place including highly engaged project manager siting on each other's programme steering groups.

Through the discussions the Committee was **assured** over the project oversight whilst noting the key risks to effective delivery but received confidence that the developed mitigations will be effective.

**Board Assurance Framework**

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

Following the review of the BAF the Committee generally **agreed** with the executives view that the quarter 1 score for this risk at 16 but reflected that the BAF narrative did not represent the current system financial challenge and thus the implications of this on the Trust's risk may be understated.

The Committee reflected on its business transacted at the meeting and the discussions held were reflective of the change prioritisation and resource availability to deliver the transformational projects whilst working within the Trust's financial plan. The Committee **asked** that the Executive Team consider if the allocation of BAF risks is appropriate or if a different risk is needed in respect of transformation delivery.

**Referrals to other Committees**

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

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**Appendix 1**

## COMMITTEE HIGHLIGHTS REPORT TO BOARD

| **Meeting Details** | | | | | |
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| **Meeting Date** | 3 September 2026 | **Chair** | Paul Layzell | **Quorate** | Yes |
| **Declarations of Interest** | No declarations were raised | | | | |

**Items received at the Committee meeting**

| Item | Presenter | Purpose of the paper | Action Taken |
|---|---|---|---|
| Strategy Delivery & Improvement Framework | Chief Strategy Officer and Director of Strategy | To discuss and provide feedback prior to submission to NHS E | The Committee **received** the developed strategy delivery and improvement framework document.<br><br>Through the report and discussion the Committee took assurance that the plan will meet the needs to NHS E and the Trust itself.<br><br>The Committee **agreed** that the developing plan should be shared with the Board and form the basis of future routine board reporting once finalised at the end of September. |
| Clinical Transformation Programme – Clinical Sustainability Tool | Chief Strategy Officer and Director of Strategy | For discuss | The Committee **received** the report on the developing tool.<br><br>The Committee discussed the tool and **endorsed** this brings to the ability to determine project prioritisation and alignment of change resource in the service of delivering the Trust's strategy of Excellent Care for our patients. |
| Major Project Portfolio Overview report | Director of Strategy | To note and be agree new major projects admitted to the portfolio and agreement to the closure of completed projects | The Committee **received** and **discussed** the report noting the project progress and that the overall portfolio was on track.<br><br>The Committee discussed the two projects with the most challenges and **received** assurance that the established mitigations will secure their delivery.<br><br>The meeting **requested** that where milestones change that these are |

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| | | | reported more explicitly within the report. |
| Theatre Ventilation Major Project update | Director of Infrastructure | To note the project governance and oversight | The Committee **discussed** the report on the Theatre Major Project presented by the project SRO.<br><br>The committee **noted** the challenges and complexity of the project and the actions being taken to mitigate the risks within this project. |
| Electronic Patient Records Programme update | Chief Information Officer | To note the project governance and oversight | The Committee **discussed** the report on the Electronic Patient Records (EPR) programme and was **assured** over the project oversight whilst noting the key risks to effective delivery but received confidence that the developed mitigations will be effective. |
| Board Assurance Framework | Company Secretary | To review and recommend to the Board the score relating to strategic risk 6 | The Committee **considered** their allocated segment of the BAF whilst generally agreeing with the executives view that the quarter 1 score for this risk was 16 it reflected on the business transacted at the meeting and the discussions held noting these were reflective of change prioritisation and resource availability to deliver the transformational projects whilst working within the Trust's financial plan. Therefore, the Committee **asked** that the Executive Team consider if the allocation of BAF risks is appropriate or if a different risk is needed in respect of transformation delivery |
| Strategy and Major Projects Programme Board Chair's report | Chief Strategy Officer | For information only | The Committee **noted** the update but asked if future reports could contain more detail on the key elements and challenges raised with the respective project SROs with then information on the outcome of these discussions thus providing a depth to the assurance the report provides over oversight and management of the major projects. |

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| **Agenda Item:** | 15. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 17 September 2026 |
| **Report Title:** | Patient & Quality Assurance Committee Chair's Report | | | | |
| **Author(s):** | Lucy Bloem, Non-Executive Director, Chair of Patient & Quality Assurance Committee | | | | |

| **Purpose of the report:** *(indicate as appropriate)* | **For Decision** | **For Assurance** | **For discussion** | **For Information only** |
|---|---|---|---|---|
| | *Yes* | *Yes* | *Yes* | *N/A* |

| **Reason for not being taken in public** *(indicate as appropriate)* | **Commercial confidentiality** | **Staff confidentiality** | **Patient confidentiality** | **Other exceptional circumstances** |
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| | *N/A* | *N/A* | *N/A* | *N/A* |

| **Regulatory Reporting Requirement** | |
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**Summary of the report describing**

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

The Committee considered various annual reports including the 2025/26 Annual Safeguarding Report, Infection prevention and Control Report and Organ Donation Reports and recommend to the Board these for approval for their publication.

The Patient & Quality Assurance Committee (PQAC) met on 4th August for the main quarterly assurance meeting covering Q1 2026/27and was quorate. The Committee's overall assessment remains one of **partial but strengthening assurance**. Quality governance is broadly functioning effectively and with expectation that the ongoing implementation of the the Target Operating Model will strengthen both the focus and capacity. Where there is limited or partial assurance these areas are understood.

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

In summary, there are a number of areas that require sustained focus, some of which warrant ongoing executive oversight to ensure risks are effectively managed and improvement actions are delivered at pace. Triangulation across the quality domains highlights gaps in assurance relating to the management of deteriorating patient, incident backlog, embedding of learning across the Trust, infrastructure-related risks, the impact of delays on patient care, maternity and neonatal service challenges, and the pace of improvement against several long-standing quality indicators such as clinical documents. These areas require continued scrutiny

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

The Board should note that, following deep dives into Oral and Maxillofacial Surgery in August and previously Ophthalmology, the Committee has requested a review of the follow-up waitlist (non-RTT waitlist) across all services. This is to provide assurance that appropriate governance and oversight are in place, and that key constraints, harms and patient safety risks are understood and managed. The Committee is also seeking assurance that learnings, including risk stratification and escalation processes, has been adopted, and that any gaps are identified.

Incident reporting remains strong, with consistently good levels of reporting. however, there is an increasing incident backlog (except for most serious incidents) which alongside recent changes arising from the Target Operating Model and has prompted the Committee to request the Chief Nurse to review Trust incident governance. The aim is to provide assurance that robust oversight is in place, early learnings are identified, captured and acted upon, and that appropriate scrutiny is maintained. It will also support the development of a clear plan to address the incident backlog.

Complaints continue to rise and are at their highest recorded level reflecting increasing concerns regarding delays, appointments, communication and aspects of clinical care. A persistent theme across complaints, incidents, medico-legal cases, maternity reviews and Martha's Rule feedback continues to be communication, including communication between teams, communication with patients and families, and clarity around escalation. Learnings are identified across

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| | the quality domain but there remains variability in how these are embedded across the Trust. The Committee will continue to scrutinise improvement work in these areas.<br><br>Committee remains concerned regarding the Trust's performance in recognising and responding to patient deterioration. Compliance with timely sepsis bundle delivery remains below target and deterioration management continues to feature in incidents, inquests and Prevention of Future Deaths reports. The committee heard how a planned technology solution will improve this and will continue to scrutinise.<br><br>The Committee sought assurance on the pace of improvement in clinical documentation compliance and also GIRFT recommendations, national audit participation, health inequalities programme. Members considered overall progress is too slow and highlighted the patient safety, governance and regulatory risks arising from this position and requested clearer trajectories to enable on considered view on the BAF risk score.<br><br>The Committee acknowledged improved reporting regarding estates compliance and risks. However, assurance remains limited due to the scale of known infrastructure issues and continued uncertainty regarding the extent of estate-related risk. The discussion led to an escalation to the Executive to clarify the overarching process for prioritisation of infrastructure risks for investment across the Trusr and for areas that do not receive investment the mitigation of these risks.<br><br>The Committee received the full suite of maternity assurance reports and remains assured regarding the maternity and neonatal based perinatal morality and hypoxic ischaemic encephalopathy rates remaining below national benchmarks, maintenance of 100% one-to-one care in labour and that no Maternity Oversight Safety Signals raised. The Committee devoted attention to risks associated with the volume of national, regional and local improvement requirements and the gaps identified from these reviews and sought assurance regarding the oversight, workforce capacity, infrastructure constraints and organisational capability to deliver these actions simultaneously. This will be reviewed at the next meeting.<br><br>The committee asked for an update on the plan the challenges with BAPM (British Association of Perinatal medicine) neonatal medical staffing standards and how current risks are being mitigated which has been previously escalated to the Executive. Board should note this is a requirement of Year 8 Maternity Indemnity Scheme. Assurance given this is being worked on and will come back to the next quarterly meeting. Concern remains regarding previously escalated obstetric theatre capacity particularly in the context of increasing number C-Sections, neonatal workforce capacity and maternity triage requirements. The Committee welcomed ongoing work focused on listening to women, families and staff, consent, communication and implementation of Martha's Rule principles, recognising that these themes are strongly reflected within both local and national maternity reviews. Alongside this committee sought assurance that staff have appropriate support in place at this challenging time.<br><br>The committee received the Quality Impact Assessment Report in relation to Cost Improvement Programme and agreed the importance of considering the risks created by financial savings initiatives and extending the use of EQIAs/QIAs to assess the wider impact of significant organisational changes and new initiatives. Committee asked for timeline for work that is underway to redesign the process to ensure it more effectively supports decision-making by assessing the impact of both proposed savings and investments on patients, staff, equality, the environment and research. |

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| | **Board Assurance Framework**<br>The Committee reviewed Strategic Risks 3 and 4 and considered Strategic Risk 8 through its quality and patient safety lens. Members concluded that the current scores remain appropriate:<br>• **SR3 Improving Safety and Experience: 20**<br>• **SR4 Improving Equality of Access and Outcomes: 16**<br>• **SR8 Better, More Sustainable Buildings and Equipment: ongoing concern with limited assurance**: **20**<br><br>The Committee's view is that while governance arrangements and improvement programmes are increasingly established, there remain gaps and there is not yet sufficient evidence of impact to support reduction of these risk scores. The themes outlined above supported this judgement. |
| **Recommendation**<br>*(linked to What Next section)* | **Recommendation**<br>The Board is asked to:<br>- **NOTE** the business undertaken by the Patient & Quality Assurance Committee since the last report.<br>- **TAKE ASSURANCE** from the Committee's scrutiny of patient safety, quality, safeguarding, maternity, infection prevention and clinical effectiveness.<br>- **NOTE** the Committee's continuing concerns outlined in this report<br>- **NOTE** the Committee's recommendation that the current BAF scores for SR3 and SR4 and SR8 remain unchanged pending clearer evidence of sustained improvement and risk reduction.<br>- **APPROVE** for publication the 2025/26 annual reports relating to Safeguarding Report, Infection prevention and Control Report and Organ Donation Reports and recommend to the Board these for approval for their publication. |
| **Assurance / Scrutiny route already undertaken** | |

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| **Link to Trust Strategy (note which theme)** | **Patients** | **People** | **Future** | **Communities** | **One UHSussex** | **Culture** |
| | Yes | Yes | N/A | Yes | Yes | *Yes* |
| **Link to annual delivery plan** | *No specific link* | | | | | |
| **Link to BAF** | *No specific link* | | | | | |
| **Link to CQC domain** | **Safe** | **Caring** | **Effective** | **Responsive** | **Well-led** | **Use of Resources** |
| | *Yes* | *Yes* | *Yes* | *Yes* | *Yes* | *Yes* |

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

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**Patient and Quality Assurance Committee Chair's Report**

The Patient & Quality Assurance Committee (PQAC) met on 4 August 2026. For its quarterly assurance meeting. The key areas of focus for the Committee over the Quarter are listed below, noting the full breadth of the meeting's activity since the last report to Board is included in a table at the end of this paper.

In addition, the committee met in focussed meetings in July and August to review the Quality Account and 2025/26 annual Patient Safety, Patient Experience and Medico-Legal Annual Report Safeguarding Report, Infection prevention and Control Report and Organ Donation Reports.

All meetings were quorate and received the business scheduled. Quarterly reports for the main quality and patient safety domain areas were received at this meeting. The Board can take assurance through the work of the Committee that focus is being provided to the areas of patient safety, quality of services and patient experience including the processes supporting the reporting of patient, quality, safety KPIs and associated strategic risks.

The Committee received assurance that quality governance arrangements continue to mature under the Trust Operating Model and that improvement activity is progressing across a range of quality domains. However, the Committee concluded that assurance remains partial or limited in a number of areas where governance structures and action plans are increasingly established but evidence of measurable risk reduction is not yet consistently apparent.

**Follow-up Waiting Lists and Oral & Maxillofacial Surgery (OMFS)**
The Committee undertook a deep dive into Oral and Maxillofacial Surgery following concerns regarding a substantial follow-up backlog and associated patient safety incidents. Members received assurance regarding the extensive work undertaken to validate patient lists, review cases clinically and strengthen governance arrangements. The Committee noted that approximately 5,800 patients were originally identified within the backlog and welcomed progress made in reducing risk and validating patients affected.

Discussion extended beyond OMFS and raised broader concerns regarding follow-up waiting lists across the Trust. The Committee noted that OMFS is not an isolated service and reflected on previous concerns seen within Ophthalmology and other specialties. Members requested further assurance regarding organisational grip over follow-up pathways, the identification of patients at risk of harm and the pace of standardisation across services following merger. The Committee requested a broader review of follow-up backlog management and associated governance arrangements.

**Maternity Services**
The Committee received the quarterly maternity reports and was assured that key safety indicators remain stable, Perinatal mortality, neonatal mortality and hypoxic ischaemic encephalopathy rates remain below national benchmarks, 100% one-to-one care in labour was maintained and no Maternity Oversight Safety Signals were activated during the period. The Committee nevertheless devoted considerable attention to the scale of operational and regulatory requirements facing maternity services. Members reflected on the cumulative impact of CNST requirements, maternity improvement programmes, national reviews, local action plans and other regulatory expectations. Whilst recognising substantial progress, members sought further work to improve visibility of the totality of requirements, associated resource implications and areas where delivery remains challenging.

The Committee also noted continuing workforce challenges, particularly within neonatal services, ongoing risks regarding obstetric theatre capacity and infrastructure limitations, and variation in training compliance. Progress against Birthrate Plus recommendations and associated capacity planning will continue to be monitored.

**Patient Safety, Experience and Learning**
The Committee reviewed the quarterly Patient Safety and Patient Experience report. The Committee reviewed Quarter 1 patient safety, patient experience, medico-legal and CQC performance. Incident reporting remains strong, with good levels of reporting and the majority of incidents graded as no or low harm. The Patient Safety Incident Response Framework is embedded and there are no overdue Patient Safety Incident Investigations (most serious incidents) however there is an increasing backlog of other incidents.

Duty of Candour compliance remains strong for initial contact measures; however, the Committee noted with concern the timeliness of sharing investigation findings with patients and families, which had reduced to 68% and work is being done to address this. The Committee sought assurance that learning from incidents is being translated into improvement activity at pace.

Members noted increasing incident reporting activity but took assurance that no emerging pattern of serious harm was evident. Delays in care continue to feature prominently within patient safety investigations. The Committee focussed particular attention on the effectiveness of organisational learning. Whilst substantial work has been undertaken to improve governance arrangements, members sought stronger assurance that learning from incidents and complaints is consistently translated into both local and Trust-wide improvements. This remains an area for continued scrutiny. The committee requested improved visibility of key CQC actions to enable assurance that all regulatory requirements were being effectively managed with clearer, separate reporting of CQC and other regulatory actions in future.

**Fundamental Standards of Care**
The Committee received the Quarter 1 Fundamental Standards of Care report and noted continued strengthening assurance through governance arrangements and harm-reduction programmes. Improvements in falls, pressure damage prevention and ward-level quality systems and positive engagement with initiatives such as Martha's Rule. Mixed-sex accommodation and corridor care also featured within discussion, recognising the links between patient experience, dignity and operational pressures. The Committee remains concerned regarding the pace of improving Trust's performance in identifying and responding to patient deterioration. Compliance with timely sepsis bundle delivery remains below target and deterioration management continues to feature in incidents, inquests and Prevention of Future Deaths reports. Committee were updated on the roll-out of new technology which is expected to improve this area. The Committee expects continued focus and clearer evidence of impact from improvement actions.

**Infection Prevention and Control**
The Committee received the Quarter 1 IPC report and noted generally favourable benchmarking compared with peers. However, assurance remains partially limited by recurring cardiac surgical site infection concerns, decontamination challenges, antimicrobial stewardship requirements and infrastructure-related issues, particularly ventilation. Members noted concern that repeated infection-control themes may have an estates-related component and requested continued scrutiny of the relationship between environmental conditions and infection risks.

**Clinical Outcomes and Effectiveness**
The Committee remains concerned regarding the pace of improvement in clinical documentation compliance, which remains below 50% against a target of 95% compliance by the end of 2026. Members acknowledged improvements in governance arrangements, the establishment of a single document library and strengthened document control processes and a common approach to clinical documentation remains under development. members highlighted the patient safety, governance and regulatory risks arising from this position. The Committee also reviewed progress against GIRFT recommendations, NICE

compliance, national audits and health inequalities actions. While structures are developing, members considered some programmes to be progressing too slowly and requested clearer trajectories demonstrating that actions will result in measurable improvements in strategic risk scores.

**Safeguarding and Mental Health**
The Committee was assured regarding statutory safeguarding governance arrangements, while noting continuing increases in complexity, demand and referral activity. Areas of focus include delayed discharges, the impact of the Supreme Court acid test on Deprivation of Liberty Safeguards (DOLs) activity, safeguarding training compliance, and risks associated with mental health pathways. The Committee welcomed continued rollout of Oliver McGowan training and enhanced support arrangements for vulnerable patients, whilst recognising the significant organisational challenge associated with achieving full compliance at scale. The Committee noted the Mental Health update following an ICB Summit around an improvement programme led by the ICB Sussex Partnership NHS Foundation Trust (SPFT) across the ICB and the committee had sought assurance that this has the resourcing and oversight required to achieve impact. Actions to date had not meaningfully impacted the pressure in the Emergency Department.

**Infection Prevention and Control**
The Committee considered the quarterly Infection Prevention and Control report and received assurance that performance remains broadly in line with expected standards. The Committee discussed ongoing work relating to vascular access, antimicrobial stewardship and surveillance systems. Scrutiny was given to cardiac surgical site infections and the relationship between environmental issues, ventilation, estate condition and infection risk. Members recognised significant IPC involvement in balancing these risks and requested continued oversight of infrastructure-related infection control concerns.

**Estates, Infrastructure and Strategic Risk**
The Committee welcomed materially improved reporting and visibility regarding estates and infrastructure risks. Members acknowledged that the organisation now has a considerably stronger understanding of the scale and nature of infrastructure-related risks than previously. The principal concern raised by the Committee was no longer identification of risk, but rather prioritisation. Members sought clearer assurance regarding how decisions are made across competing infrastructure demands, how those decisions are reflected through governance structures and how they support a reduction in Strategic Risk 8. The Committee supported **escalation** of this issue for further executive consideration and requested greater visibility of the prioritisation process for future assurance discussions.

**Quality Governance and Assurance Group**
Chief Medical Officer briefed the committee on areas covered by QGSG by exception which included Medicines Management, including assurance national drug shortages, controlled drugs management and medicines storage and Human Tissue Authority Inspection.

**Board Assurance Framework**
The Committee reviewed Strategic Risks 3, 4 and 8. Whilst recognising progress in governance arrangements and improvement activity, the Committee concluded that there remains insufficient evidence of sustained impact to support reductions in the current ratings. Accordingly, the Committee supports retention of the current risk scores pending further evidence of measurable improvement.

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**Appendix 1**

## COMMITTEE HIGHLIGHTS REPORT TO BOARD

| **Meeting Details** | | | | | |
|---|---|---|---|---|---|
| **Meeting Date** | **7 July 2026** | **Chair** | Lucy Bloem | **Quorate** | Yes |
| **Declarations of Interest** | No declarations were raised | | | | |

**Items received at the Committee meeting**

| ***Focus, Operation and Priorities of the Committee*** | | | |
|---|---|---|---|
| Patient Safety, Patient Experience & Medico-legal Annual Report 2025/26 | **Presenter** Interim Director of Quality Governance / Director of Patient Experience | **Purpose**<br>For Assurance | **Outcome /Action taken**<br>The Committee **noted** the report.<br>The Committee requested adjustments were made to the report as discussed in the meeting, including:<br>- detail on PFD reports issued to other organisations that related to a UHSussex patient<br>- benchmarking or comparison with 2024/25 data<br>- narrative setting out the reasons and any persisting themes for re-opened complaints<br>- narrative relating to waits for specified services<br>- ensure inclusion of patient voice was fully and accurately captured throughout the report |
| Quality Account 2025/26 | **Presenter** Chief Medical Officer | **Purpose**<br>To Note review prior to submission to Trust Board<br>To note 2026/27 quality priorities | **Outcome /Action taken**<br>The Committee **received** the Quality Account 2025/26 that included a review of the Trust's quality performance and achievements during 2025/26, the statutory statements of assurance, and the quality improvement priorities for 2026/27.<br>The Committee **noted** the 2026/27 quality priorities, and that these would be fully reported to the Committee within the Clinical Outcomes & Effectiveness report at the next quarterly meeting on 4 August 2026.<br>The Committee **noted** the PQAC Chair review of the Quality Account 2025/26 prior to submission to the Board and subsequent Board approval. |

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| Meeting Details | | | | | |
|---|---|---|---|---|---|
| **Meeting Date** | **4 August 2026** | **Chair** | Lucy Bloem | **Quorate** | Yes |
| **Declarations of Interest** | No declarations were raised | | | | |

**Items received at the Committee meeting**

| ***Focus, Operation and Priorities of the Committee*** | | | |
|---|---|---|---|
| Deep Dive: Oral and Maxillo-facial Surgery | **Presenter** Chief Medical Officer / General Manager Surgery / Division Director of Nursing | **Purpose** To discuss and agree actions | **Outcome /Action taken:** Discussed service challenges & agreed action to bring assurance paper on the follow-up backlog waiting list (non-RTT Wait list) across services, so to provide assurance that appropriate governance and oversight is in place for each speciality or identify where there are gaps, that appropriate processes are in place such as risk stratification, standardised pathways and escalation routes and key constraints for the speciality and any known safety impacts. |
| ***Patient Safety & Experience*** | | | |
| Patient Safety and Engagement Q1 2026/26 Medico-legal and CQC Report Q1 2026/27 and Complaints Review | **Presenter** Director of Patient Experience | **Purpose** For Assurance | **Outcome /Action taken** Noted the report discussed the triangulation of themes from complaints and inquests identifying Communication issues as an area for future deep-dive |
| Fundamental Standards of Care Q1 2026/27 | **Presenter** Deputy Chief Nurse (Quality) | **Purpose** For information | **Outcome /Action taken** Noted update and data. Discussed how mixed sex accommodation are captured and action to include in report |
| Infection Prevention and Control Q1 2026/27 | **Presenter** Chief Nurse | **Purpose** For assurance | **Outcome /Action taken** Noted. Seeking further clarification to come back after sternum surgical site infections investigation to determine if these were due to patient comorbidities or issues the Trust had sought to learn from. |

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|---|---|---|---|
| Facilities & Estates- Q1 2026/27) | **Presenter** Director of Estates and Facilities / Chief Finance Officer | **Purpose** For information | **Outcome/Action taken** Noted the update on work taking place and apparent progress. Informed the discussion toward the infrastructure Board Assurance Framework risk oversight. |
| Safeguarding (Adults, Children and Maternity) Q4 2025/26 | **Presenter** Director of Safeguarding | **Purpose** For assurance | **Outcome/Action taken** Noted the update on work taking place and apparent progress. |
| Clinical Outcomes & Effectiveness & Health Inequalities Q1 2026/27 Report<br><br>Mortality & Learning from Deaths Q1 2026/27 | **Presenter** Director of Clinical Outcomes and Effectiveness | **Purpose** For Assurance | **Outcome /Action taken** Noted the compliance processes. Actions to provide confirmation of the governance process for the review, approval and sign-off of clinical documents, including associated clinical accountability arrangements and the communication process, and to re-circulate the relevant SOP and to include clinical document internal review report in next quarterly paper. |
| Efficiency Programme (QIA) update | **Presenter** Chief Medical Officer | **Purpose** For Assurance | **Outcome /Action taken** Noted the report that confirmed all risks assigned to QIAs for the projects in the efficiency plans are rated low (1-8) with one at moderate (9) |
| ***Maternity*** | | | |
| Perinatal Quality Surveillance Report and Dashboards to May 2026 | **Presenter** Director of Midwifery | **Purpose** For information | **Outcome /Action taken** Noted the Perinatal Quality Oversight Model Report. Action: To provide assurance that risks of BAPM non-compliance are being mitigated. |
| Maternity Claims Scorecard Q4 2025/26 | **Presenter** Director of Midwifery | **Purpose** For information | **Outcome /Action taken** Noted the data and actions in response included ongoing education and audit activity on communication, strengthened learning processes, improvements in obstetric documentation and the use of emergency proformas, together with targeted training and guideline updates. |

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|---|---|---|---|
| Perinatal Mortality Review Tool (PMRT) Q3 2025/26 | **Presenter**<br>Director of Midwifery | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted and assured over the performance |
| Maternity PSIRF Q1 2026/27 | **Presenter**<br>Director of Midwifery | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted and assured over the process for review, investigation and learning |
| Saving Babies Lives Q4 2025/26 | **Presenter**<br>Director of Midwifery | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted and assured over the performance including areas that require action. |
| National Maternity and Neo-natal Investigation & Nottingham (Ockenden) Report Executive Briefing | **Presenter** Interim Chief Nurse /<br>Director of Midwifery | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted the eight National priorities and summary of the key local themes from the Baroness Amos visit to UHSussex.<br>Noted review of Maternity & Neonatal services against 10 point plan and extent to which already progressed through the comprehensive Maternity and Neonatal Improvement Plan. |
| **Reporting Group** | | | |
| QGSG Chair's Report Q1 2026/27 including:<br>a) Quality Scorecard & SPC Charts<br>b) QGSG Divisional Reports<br>c) Pharmacy and Medicines Governance Q1 2026/27 | **Presenter**<br>Chief Medical Officer | **Purpose**<br>For assurance | **Outcome /Action taken**<br>Noted |
| **CQC action tracking** | | | |
| CQC Update / Action Plans | **Presenter**<br>Chief Medical Officer | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted and assured over the process for tracking actions |
| **Risk** | | | |
| Patient and Quality Risk Report | **Presenter**<br>Chief Nurse/ Chief Medical Officer | **Purpose**<br>For information | **Outcome /Action taken**<br>The Committee noted the report and the work taking place through the Risk Improvement Sprint |
| Board Assurance Framework | **Presenter**<br>Chief Nurse/ Chief Medical Officer | **Purpose**<br>For information | **Outcome /Action taken**<br>The Committee reviewed its allocated segments and agreed with and recommended the proposed score for BAF SR3 and SR4 to the Board and BAF SR8 |

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| Meeting Details | | | | | |
|---|---|---|---|---|---|
| **Meeting Date** | **13 August 2026** | **Chair** | Lucy Bloem | **Quorate** | Yes |
| **Declarations of Interest** | No declarations were raised | | | | |

**Items received at the Committee meeting**

| ***Focus, Operation and Priorities of the Committee*** | | | |
|---|---|---|---|
| Safeguarding (Adults, Children and Maternity) Annual Report 2025/26 | **Presenter**<br>Interim Chief Nurse<br><br>Associate Director of Nursing for Safeguarding | **Purpose**<br>To approve | **Outcome /Action taken**<br>The Committee **approved** the report subject to final tracked amendments being agreed by correspondence. The Committee noted the increasing complexity of safeguarding responsibilities and commended the quality of the report.<br>The Committee sought clarification that maternity safeguarding training requirements included neonatal services, which was confirmed. |
| Infection Prevention and Control Annual Report 2025/26 | **Presenter**<br>Interim Chief Nurse<br>Interim Corporate Director of Infection Prevention & Control | **Purpose**<br>To Approve | **Outcome /Action taken**<br>The Committee **approved** the Infection Prevention and Control Annual Report 2025/26, subject to final tracked amendments being agreed by correspondence. |
| Organ Donation Annual Account 2025/26 | **Presenter** Clinical lead in Organ Donation | **Purpose**<br>To Approve | **Outcome /Action taken**<br>The Committee **received and approved** the Organ Donation Annual Report 2025/26.<br>The Committee **noted** the Trust had continued to achieve one of the highest consent rates nationally, particularly for donation after circulatory death, despite a reduction in consent rates nationally.<br>The Committee welcomed continued improvement in specialist nurse involvement, noting the benefits this provided to patients and families during difficult circumstances. |

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|---|---|---|---|---|---|
| **Agenda Item:** | 16. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 17 September 2026 |
| **Report Title:** | People & Culture Committee Chair's Report | | | | |
| **Author(s):** | Paul Layzell – NED & Committee Chair | | | | |
| **Purpose of the report:** *(indicate as appropriate)* | **For Decision** | **For Assurance** | **For Discussion** | **For Information only** | |
| | *Yes* | *Yes* | *N/A* | *N/A* | |
| **Reason for not being taken in public** *(indicate as appropriate)* | **Commercial confidentiality** | **Staff confidentiality** | **Patient confidentiality** | **Other exceptional circumstances (please detail)** | |
| | *N/A* | *N/A* | *N/A* | *N/A* | |
| **Regulatory Reporting Requirement** | | | | | |

**Summary of the report describing**

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

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

*The Committee meeting was quorate at each of these meetings and received its scheduled business and had a positive discussion on the Trust's cultural improvement programme.*

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

*The Board can take assurance through the work of the Committee that focus is being provided to the areas of culture and workforce including the processes supporting the reporting of workforce KPIs, the quality of medical training, the progress of the 10 point plan for resident doctors, the guardian of safe working hours oversight and violence prevention.*

*The Committee took the following actions:-*

- *Considered the Annual Equality report and recommend this be presented to the Board for information*
- *Considered the Trust's Annual Medical Appraisal and Revalidation Statement of Compliance for 2025-26*
- *Reviewed the allocated segments of the Board Assurance Statements allowing it to make a recommendation to the Board.*

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

*The Board can receive the BAF with confidence that the content and opening score for the three strategic risks SR5, SR11 and SR 12 having been scrutinised by the Committee.*

*The Board can approve the publication of the Trust's Annual Equality Report and the approval of the Annual Medical Appraisal and Revalidation Statement of Compliance based on the assurance provided to and through this Committee.*

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|---|---|
| **Recommendation** *(linked to What Next section)* | *The Board is asked to **NOTE***<br>- *the Committee met and received the expected assurance reports*<br>- *the Committee's recommendation of the scores for their allocated elements of the BAF, strategic risks 5, 11 and 12.*<br>*The Board is asked to **APPROVE** the Trust's*<br>- *Annual Equality Report and*<br>- *Annual Medical Appraisal and Revalidation Statement of Compliance 2025-26* |
| **Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*** | *A number of items presented to the Committee had been considered by the People and Culture Steering Group and its reporting groups.*<br>*The BAF had been considered by the Executive Management Committee and the underlying process at the Audit Committee.* |

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

| | |
|---|---|
| **Link to annual delivery plan** | *The People and Culture Committee provide oversight of the Trust's delivery of many aspects that link to the delivery of the Trust's annual plan, not least those covered by the people promises, workforce wellbeing actions and those linked to staff training and development* |
| **Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)** | *The Committee has oversight for the allocated people related strategic risks, risks 5, 11 and 12* |

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

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

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# People and Culture Committee Chair's Report

The People and Culture Committee met on 8 September 2026. The Committee was quorate at its meeting as was attended by at least two Non-Executive Directors and two Executives Directors. In attendance at these meetings were the respective report presenters including the Director of Human Resources, the Director of Integrated Education and the Associate Director of Leadership, Culture and Development, and Head of Equalities and Inclusion who attended to support the presentation of the Annual Equalities Report

At its meeting the Committee received its planned items including a report on the delivery of the Excellent Care Everywhere people ambition delivery plan for quarter 1 of 2026/27, a report on embedding values and behaviours, the annual equality report, and the medical appraisals and revalidation report along with reports on violence prevent and reduction; NHS staff survey; clinical education; job planning; resident doctors 10 point plan; and the Guardian of Safe Working quarter 1 report. The meeting also considered the 2026/27 quarter 1 BAF to provide the oversight of those risks the Committee has allocated lead oversight.

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

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

The Committee **received** a report from the Chief People Officer. Through this report the Committee **noted** the current status of delivery of the recommendations flowing from the external review of the People function. The Committee **noted** also the work being undertaken in support of enhancing the Trust's workforce grip and control mechanisms to support the Trust's recovery plans and the development of IT systems including manager self-service to improve timely reporting of staff circumstances.

The Committee **considered** the People scorecard. It discussed the increase in freedom to speak up reporting and noted work to understand the drivers for this increase, including a change in the Trust's assigned team. The Committee **noted** that in a number of cases staff were simply seeking advice on process rather than safety matters. Such an increase strengthens the business case for a more robust internal route to ask for such advice.

<u>Culture Programme</u>

The Committee **received** an update on the work undertaken to embed the Trust's Value and Behaviours framework. The Committee was **assured** through the discussion and update provided by the programme SRO, the Director of Integrated Education. The meeting noted the positive launch and continued development of the manager toolkit and the engagement of staff with the Trust's experimenteers programme.

The Committee **noted** that the programme is at a critical point in balancing the resourcing challenges within the Trust against the need to continue to develop the programme to the next phase resulting in increased risk to the pace of the cultural change possible. The Committee however was **assured** over the actions being taken to progress the work and extend the use of the tools developed as part of the overall programme.

Excellent Care Everywhere strategic delivery plan quarter 1 update

The Committee **received** its scheduled report providing an update on the improvement projects aligned to the Trust's Strategic People Ambition. The Committee **noted** that this work has been incorporated into the Strategy Delivery & Improvement Framework Plan.

The Committee **noted** the update given that those areas at quarter 1 which at that time were behind their trajectory have broadly moved back to on track in the later months.

The Committee **discussed** the ambitions and the respective commitments and the Trust's capacity to deliver these within the wider improvement framework offers an ability to align and prioritise work in support of the Trust recovery priority for this year. The meeting received confidence that there is clarity over the workstreams and how these align with the wider recovery programme work including workforce grip and control.

Annual Equality Report

The Committee **received** and discussed the Trust's Annual Equality Report recognsing that much of the core data had been reported to the Committee at its previous meeting.

The Committee **discussed** the areas of improved performance within the report including a more diverse workforce (30%), an increase in staff confidence in sharing their information on disabilities, a much improved experience of reasonable adjustments, strengthening of the staff voice through increased engagement with staff networks and positive feedback on the positioning of workforce support within the Trust's strategy.

The Committee **discussed** improvements actions being taken to address the need for increased diversity in senior leadership positions, removing areas of disparity within some of the Trust's processes and differences in the levels of harassment committed against staff of global majority by patients, public or visitors.

The Committee was **assured** over the actions to secure current improvements and address remaining challenges.

The Committee **noted** the improved reporting being provided to the respective divisions to enable them to engage with the actions to address areas of inequality. The Committee noted action being taken to encourage staff participation in sharing their experiences to enable stronger information on which to base improvement actions.

Based on the discussion and assurance received in respect of its content the Committee **agreed** to recommend to the report for final approval of its publication.

Education and Learning reporting including clinical education quality report

The Committee **received** a report on the outcomes of trainee surveys covering pre-registration nursing, undergraduate medicine, postgraduate medicine and AHPs, noting that the formal outcomes of the post graduate medicine trainee survey are due shortly. The Committee **noted** that the outcome of these surveys provide **assurance** on the quality of the training provision provided within the Trust.

The meeting **discussed** the areas where further improvement can be made and secured **confidence** that the developing actions will secure that improvement within the areas of culture and trainee wellbeing.

The Committee **discussed** the level of engagement with the surveys from the medical staffing group and noted that the timing of these can be challenging for people to engage as they are undertaken at the same time as other surveys are undertaken by respective universities.

The Committee **discussed** the Trust's processes to prepare staff to support trainees and were updated on the actions being taken including the review of the trainer providers, the update of training case studies. The Committee **asked for** further information to be provided to a future committee meeting given the changing expectations of trainees

10 – point plan improving resident doctors working lives

The Committee **noted** the continued progress in respect of the mandated 10 point plan to improve resident doctors working lives and remained **assured** over the oversight of the action plan delivery.

The Committee **noted** the appointment of the new resident doctor representative who would be welcomed at the next committee meeting.

Annual Medical Appraisal and Revalidation Statement of Compliance 2025-26

The Committee **received** and considered the medical appraisal and revalidation annual statement of compliance and was assured over its completeness. Based on the presentation of this report by the Chief Medical Officer the Committee **agreed** to recommend this statement to the Board for approval and submission.

Guardian of Safe Working Hours Annual report

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

The Committee thanked the retiring Guardian for the work they have undertaken to support resident doctors and the Guardian's work to enhance the clarity of the reporting on action taken.

The Committee **noted** the recruitment of deputy guardians support the Guardian workload – a challenge that had bene previously raised.

Risk report and Board Assurance Framework

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

The Committee scrutinised its allocated element of the Board Assurance Framework relating to strategic risks 5, 11 and 12 aligned to the objectives of ensuring our workforce is happy, healthy and supported, we are living our values in everything we do, and we have the right people, right skills working towards a common goal.

Following the review of the BAF itself the reports received at the Committee in its meeting the Committee **agreed** with the executive recommendation in respect of their quarter 1 scores for these risks are 16, 16 and 20 respectively. The Committee **noted** the actions planned for the management of these three risks and secured confidence that the delivery of those actions will move the respective risk to their target scores.

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

Referrals to other Committees

The Committee having considered the reports it received at its meeting **agreed** there were no matters it needed to refer to any other Committees.

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**Appendix 1**

## COMMITTEE HIGHLIGHTS REPORT TO BOARD

| **Meeting Details** | | | | | |
|---|---|---|---|---|---|
| **Meeting Date** | 8 September 2026 | **Chair** | Paul Layzell | **Quorate** | Yes |
| **Declarations of Interest** | No declarations were raised | | | | |

| **Items received at the Committee meeting** | | | |
|---|---|---|---|
| People Performance Overview including People Scorecard; Lord Mann review; resident doctor guidance and NHS staff standards. | **Presenter**<br>Chief People Officer | **Purpose** For discussion and assurance | **Outcome /Action taken**<br>The Committee **utilised** the overview to bring a focus on to the meeting. |
| Culture Programme Update – embedding values and behaviours | **Presenter**<br>Chief Strategy Officer and Director of Integrated Education as SRO for cultural improvement workstreams | **Purpose** For information | **Outcome /Action taken**<br>The Committee **received** an update on the work undertaken to embed the Trust's Value and Behaviours framework. The Committee was **assured** through the discussion and update provided by the programme SRO, the Director of Integrated Education.<br><br>The Committee **noted** the risks the Trust's current resourcing challenges pose but was **assured** over the actions being taken to progress the work and extend the use of the developed tools. |
| Annual Equality Report | **Presenter**<br>Associate Director, Leadership, OD & Engagement<br><br>Head of Equalities and Inclusion | **Purpose** For recommending to the Board | **Outcome /Action taken**<br>The Committee **received** and discussed the Trust's Annual Equality Report recognsing that much of the core data had been reported to the Committee at its previous meeting.<br><br>The Committee **discussed** the areas where the report reflects improvement and those where actions are being taken. |

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| | | | The Committee through these discussions was **assured** over the actions taken which delivered the reported improvements and secured confidence that the actions being taken will support improvement in those areas where attention is needed.<br><br>The Committee **agreed** to recommend the report to the Board |
| Violence Prevention & Reduction and Sexual Safety | **Presenter**<br>Associate Director, Leadership, OD & Engagement | **Purpose** For information | **Outcome /Action taken**<br>The Committee **received** the update and noted the strengthen governance processes developed.<br><br>The Committee **noted** how the impact of societal challenges are being felt within the Trust<br><br>The meeting **discussed** the processes in place to support staff subjected to violence. |
| NHS Staff Survey | **Presenter**<br>Associate Director, Leadership, OD & Engagement | **Purpose** For information | **Outcome /Action taken**<br>The Committee **received** the update and reflected on the improvement actions being delivered.<br><br>The Committee discussed the plans being developed to encourage greater staff engagement with the 2026 survey. |
| Trust Staff Conference 2026/27 | **Presenter**<br>Chief Strategy Officer | **Purpose** For information | **Outcome /Action taken**<br>The Committee **received** an update on the Trust's plans for the 2026/27 staff conference.<br><br>The Committee **endorsed** the work being undertaken to increase accessibility of any conference and agreed to receive an update later this year. |

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|---|---|---|---|
| Education and Learning reporting including clinical education quality report | **Presenter**<br>Director of Integrated Education | **Purpose** For information | **Outcome /Action taken**<br>The Committee **received** the paper providing assurance on the quality of the training undertaken.<br><br>The Committee **noted** the areas of improvement the surveys show along with the planned actions aligned to where improvements can be made.<br><br>The Committee **discussed** the work being undertaken to engage and prepare Trust staff to support learners and asked for further information to be reported on this at a later committee meeting.<br><br>The Committee also **noted** the Trust's arrangement for making NHSE role payments. |
| Excellent Care Everywhere – Patient Promise strategic delivery plan for quarter 1 | **Presenter**<br>Director of workforce | **Purpose** For discussion and assurance | **Outcome**<br>The Committee **received** its scheduled report providing an update on the improvement delivery across quarter one. The Committee **noted** that this work has been incorporated into the Strategy Delivery & Improvement Framework Plan.<br><br>The Committee **noted** that for those areas at quarter 1 which were behind their trajectory have broadly moved back to on track in the later months. |
| Management and support for contingent bank workforce | **Presenter**<br>Associate Director, Leadership, OD & Engagement | **Purpose** For information | **Outcome /Action taken**<br>The meeting **received** a report on the support being provided to bank only staff and feedback noting that this support was aligned to feedback from the last staff survey.<br><br>The meeting also **discussed** the entry and continuation |

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|---|---|---|---|
| | | | requirements for bank only staff. |
| Consultant and SAS job planning | **Presenter**<br>Chief Medical Officer | **Purpose** For information | **Outcome /Action taken**<br>The Committee **received** the report and **noted** the progress made, and the reinstatement of the oversight meetings with clinical directors. The Committee **noted** the focus of this work remains on the quality of the job plans.<br><br>The Committee was informed that there are no matters to escalate from the work undertaken. |
| Medical Appraisal and Revalidation annual statement of compliance | **Presenter**<br>Chief Medical Officer | **Purpose** to recommend to the Board | **Outcome /Action taken**<br>The Committee **received** the report and was **assured** of its completeness and **agreed** to recommend the report to the Board. |
| 10-point plan improving resident doctors | **Presenter**<br>Director of Medical HR | **Purpose** For assurance | **Outcome**<br>The Committee **noted** the continued progress from the last Committee report through the delivery of the action plan and was **assured** over the oversight of the action plan delivery. |
| Guardian of safe working hours quarter 1 report | **Presenter**<br>Chief People Officer | **Purpose** For assurance | **Outcome /Action taken**<br>The Committee **received** the report and noted the Guardian's assurance over the established processes for exception reporting. The Committee **noted** that the report provided **assurance** over the action being taken in respect of issues raised. |
| People and Culture Steering Group update | **Presenter**<br>Chief People Officer | **Purpose** For information | **Outcome /Action taken**<br>The Committee **received** the report from this newly established group established to support the Committee undertake its business. |

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| People Risks update | **Presenter**<br>Chief People Officer | **Purpose**<br>To note | **Outcome /Action taken**<br>The Committee **noted** the report and recognised that work is to be undertaken to review the recording and management of risks within the organisation. |
| Board Assurance Framework | **Presenter**<br>Company Secretary | **Purpose**<br>To review and recommend to the Board | **Outcome /Action taken**<br>The Committee reviewed its allocated segments and agreed with the scores of the three allocated strategic risks, SR5, scoring 16, SR11, scoring 16 and SR 12 scoring 20.<br><br>The Committee **noted** the actions planned as recorded in the document and had confidence that they will as delivered move the risk to their respective target scores. |

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| **Agenda Item:** | 17. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 17 September 2026 |
| **Report Title:** | Finance & Performance Assurance Committee Chair's Report | | | | |
| **Author(s):** | Philip Hogan, NED and Committee Chair | | | | |

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

| **Reason for not being taken in public** *(indicate as appropriate)* | **Commercial confidentiality** | **Staff confidentiality** | **Patient confidentiality** | **Other exceptional circumstances** |
|---|---|---|---|---|
| | *N/A* | *N/A* | *N/A* | *N/A* |

| **Regulatory Reporting Requirement** | |
|---|---|

**Summary of the report describing**

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

This report presents the business of the Finance and Performance Assurance Committee (FPAC) meetings in June, July and August 2026.

FPAC received, reviewed and noted the Financial and Performance reports for months 1, 2 and 3 of 2026/27 including forecasts for the full year. The Committee received its scheduled business and maintained oversight of the Trust's financial recovery arrangements, operational performance trajectory, capital programme, efficiency delivery and associated strategic risks. The principal focus of the Committee during Quarter 1 was the Trust's financial and operational performance against the 2026/27 plan, the deliverability of the efficiency programme, cash sustainability, and the actions required to improve constitutional performance standards.

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

Whilst Quarter 1 performance remained broadly in line with plan, the Committee recognises that considerable risks remain. The delivery of recurrent efficiencies, improvement in operational performance, management of cash constraints and successful implementation of recovery actions will be critical determinants of success during the remainder of the financial year. The Committee will continue to provide close oversight and assurance to the Board in these areas.

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

- A replacement MRI Scanner for RSCH agreed in principle subject to additional clarification on benefits and funding prioritisation
- Midwifery Workforce Investment Business Case.

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

The Board can take assurance from the oversight being provided by FPAC on the Trust's:

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

The Board can receive the BAF with confidence that the content and score for strategic risks assigned to the Committee. The new strategic risks for have been scrutinised and the current and target assessment scores are presented for Q2 2026/27.

**Recommendation**
*(linked to What Next section)*

The Board is asked to note that the Trust:

- Is managing within very tight cash limits and applied for cash support in July;

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| | • Capital expenditure remained ahead of plan at Quarter 1, reflecting accelerated delivery of several major schemes. The Committee continues to scrutinise prioritisation of spend to ensure best use of funds within its Capital Budget.<br><br>The Board is asked to approve:<br><br>• The recommended risk scores for BAF strategic risks 1, 2, 8 and 10 whilst noting the risk to achievement of their target scores. |
| **Assurance / Scrutiny route already undertaken** | |

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

| | |
|---|---|
| **Link to annual delivery plan** | *The Committee provides oversight of the delivery of the Trust's annual financial and operational plan delivery.* |
| **Link to BAF** | *The Committee has oversight of the key assurances referred to within the BAF for strategic risks 1,2, 8 and 10 and through their scrutiny of these recorded assurances consider and recommend to the Board their relevant current scores.* |

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

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

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# Finance and Performance Assurance Committee Chair's Report

The Finance and Performance Assurance Committee met in June, July and August 2026 and was quorate at each meeting with Executive and Non-Executive attendance in accordance with the Committee's Terms of Reference. The Committee received its scheduled business and maintained oversight of the Trust's financial recovery arrangements, operational performance trajectory, capital programme, efficiency delivery and associated strategic risks.

The principal focus of the Committee during Quarter 1 was the Trust's financial and operational performance against the 2026/27 plan, the deliverability of the efficiency programme, cash sustainability, and the actions required to improve constitutional performance standards. The Committee also reviewed the emerging Financial Recovery Plan, the findings of external review work undertaken by PwC, and significant investment and business case decisions.

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

## Quarter 1 2026/27 Financial Performance Report

At each meeting the Committee received detailed reports on the Trust's financial position against plan.

The Committee noted that the Trust reported planned deficits throughout Quarter 1 and remained on its planned in-year financial trajectory. At Month 3 the Trust reported a deficit of £5.9m for the month and a year-to-date deficit of £20m, in line with the approved financial plan. Whilst this demonstrates delivery against the agreed trajectory, the Committee recognised that the underlying financial position remains challenging and that delivery of the Financial Recovery Plan will be critical if the Trust is to improve financial sustainability during the remainder of the year.

The Committee noted that clinical divisions remained adverse to plan, reflecting workforce pressures, unidentified efficiencies and underlying cost pressures. Efficiency delivery at Quarter 1 was £3.4m, £2.8m behind plan, and the estimated underlying deficit remained substantially higher than the reported position. The Committee received assurance that strengthened financial controls, divisional accountability arrangements and enhanced governance had been introduced through the Trust Operating Model and Financial Recovery Programme. However, members continued to seek assurance regarding the pace of delivery, confidence levels attached to individual schemes, and the degree to which proposed savings could be achieved without adversely impacting quality, workforce sustainability or operational performance.

The Committee considered the findings of the independent PwC review which identified a significant underlying financial challenge, limited maturity in parts of the efficiency programme and the need for a longer-term recovery trajectory. The Committee welcomed management's acceptance of the review findings and the incorporation of recommendations into the Financial Recovery Plan, but emphasised the need for future reports to provide clearer evidence of delivery, risk-adjusted confidence assessments and measurable outcomes.

The Committee continued to receive regular reports on liquidity and cash management. Whilst the Trust maintained a cash balance broadly in line with plan during Quarter 1, the Committee discussed extensively the continuing risks associated with cash flow, supplier payment performance and overall financial sustainability. At Month 3 cash was reported at £3.2m against a £3.0m plan and the Committee noted a deterioration in Better Payment Practice Code performance together with increasing supplier concerns. An application for

£20m of cash support was submitted to NHS England following previous Committee endorsement.

The Committee recognised the robust multidisciplinary arrangements in place to manage supplier payments and prioritise operationally critical expenditure. Nevertheless, members expressed concern about the extent to which continuing cash constraints could impact service delivery and requested greater assurance regarding forecast assumptions, supplier risks and dependency upon delivery of cash-releasing efficiencies. Cash sustainability remained a considerable risk discussed by the Committee during the quarter.

**Efficiency and Productivity**

The Committee **received** the scheduled efficiency and productivity reports at each of its meetings in the quarter.
The Committee received regular updates on the Trust's £140m Efficiency and Productivity Programme and the subsequently developed Financial Recovery Plan.

Throughout the quarter the Committee noted that efficiency delivery remained behind plan and that a substantial proportion of the recovery programme remained immature or in development. Whilst acknowledging improvements in governance, programme management and executive oversight, the Committee sought assurance that divisional leaders fully understood, owned and were accountable for delivery of required savings.

The Committee welcomed strengthened controls on workforce growth, expenditure and temporary staffing, together with evidence that substantive workforce growth had begun to stabilise. The Committee has been clear that assurance would come not simply from the implementation of controls, but from demonstrable evidence that those controls were delivering recurrent improvements in financial performance. The Committee will continue to closely monitor delivery of the Financial Recovery Plan as one of its principal areas of focus during the remainder of 2026/27.

**Capital**

The Committee maintained oversight of the capital programme throughout Quarter 1.
The Committee noted that capital expenditure remained ahead of plan at Quarter 1, reflecting accelerated delivery of several major schemes. Members continued to scrutinise prioritisation arrangements in the context of both capital affordability and cash constraints and sought assurance that investment decisions remained aligned with organisational risk and strategic priorities.
Under its delegated authority the Committee approved investment in the replacement MRI scanner at the Royal Sussex County Hospital, recognising the operational risks associated with ageing diagnostic equipment and the importance of maintaining capacity for emergency, elective and cancer services. The Committee also supported progression of the marketing of the Southpoint Brighton site as part of the wider estate rationalisation programme, subject to further Board consideration of the strategic case and operational implications.

The Committee continues to acknowledge there are lessons for capital plan profiling and associated contracting and looks forward to the action plan addressing these issues **to be brought back** in future capital updates.

**Investment decisions**

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

• A contract award for the supply of Security Services (March 2026); and

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

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

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

## Quarter 4 2025/26 Operational Performance

Each meeting the Committee **received** a detailed report on the Operational performance of the Trust including the constitutional standards set by NHSE. The Committee discussed the Trust operational performance report in detail and **noted**:
The Committee received operational performance reports at each meeting and continued to monitor delivery against NHS constitutional standards.

The Committee noted that Urgent and Emergency Care performance remains significantly challenged and below both national and local trajectories. While improvements in ambulance handovers and some site-based metrics have been sustained, overall four-hour performance continues to fall below required levels. The Committee discussed the refresh of the UEC Improvement Plan, the ongoing procurement process for external improvement support, and the role of the new Target Operating Model in driving more consistent operational delivery across sites. Members requested future reports provide stronger evidence of the impact of improvement interventions and clearer articulation of lessons learned.

Elective recovery performance remained a central focus. The Committee noted that RTT performance improved relative to the preceding year but remained below national performance levels and behind the trajectories required to achieve longer-term improvement ambitions. By August the Patient Tracking List remained approximately 116,000 patients and members heard that recovery performance had been adversely affected by exceptionally high demand and the impact of summer heatwaves on productivity, theatres and diagnostics. The Committee sought assurance that these impacts had been incorporated into revised forecasts and specialty recovery plans.

Cancer performance continued to present challenges, particularly within dermatology and skin cancer pathways. The Committee heard that skin cancer represented approximately half of the cancer backlog and agreed that a more detailed review of the pathway and associated recovery actions should be undertaken. Members also maintained oversight of non-RTT follow-up backlogs and requested continued reporting on improvement plans, recognising the potential patient safety implications associated with prolonged waits.

## Risk and the Board Assurance Framework

The Committee **reflected** on the reports received and the key operational and financial risks and scrutinised their allocated elements of the Board Assurance Framework relating to the strategic risks assigned to the Committee by the Board.

Strategic Risks 1, 2, 8 and 10, relate to the following strategic objectives:

- SR1 Delivering timely care for planned treatment and cancer care
- SR2 Urgent and Emergency Care - improving access, quality, safety and environments
- SR8 Better, more sustainable buildings and equipment
- SR10 Improving value and financial sustainability

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

During Quarter 1 the Committee challenged the extent to which reported actions were demonstrably reducing risk exposure rather than simply evidencing activity. Members requested future reporting provide stronger links between mitigating actions, evidence of effectiveness and proposed reductions in risk scores. Particular attention was given to increasing elective demand, financial sustainability and the delivery confidence associated with the Financial Recovery Plan.

**Referrals to other Committees**

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

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NHS Foundation Trust

**Appendix 1**

## COMMITTEE HIGHLIGHTS REPORT TO BOARD

| **Meeting Details** | | | | | |
|---|---|---|---|---|---|
| **Meeting Date** | **4 June 2026** | **Chair** | Philip Hogan | **Quorate** | Yes |
| **Meeting Date** | **7 July 2026** | **Chair** | Philip Hogan | **Quorate** | Yes |
| **Meeting Date** | **6 August 2026** | **Chair** | Philip Hogan | **Quorate** | Yes |
| **Declarations of Interest** | No declarations were raised | | | | |

| **Items received at the Committee meeting** | | | | | | |
|---|---|---|---|---|---|---|
| **2026/27 Quarter 1 Financial Performance Report**<br>- monthly position<br>- cash reporting (including cash support application in June and July)<br>- grip and control reports<br><br>(Financial Recovery Update Report in July) | **Jun** | **Jul** | **Aug** | **Presenter**<br>Chief Finance Officer / Director of Operational Finance | **Purpose**<br>For assurance | **Outcome /Action taken**<br>**Noted** M3 position and delivery against the 2026/27 financial plan. Committee focused on underlying deficit position, cash constraints and early efficiency delivery risks. Cash Support Application proposed and endorsed in June and approved in July. Actions for reporting to support Continued monitoring of efficiency delivery, cash and Division performance |
| **2025/26 Quarter 4 Efficiency & Productivity Reporting**<br>- monthly position and assurance process | **Jun** | **Jul** | **Aug** | **Presenter**<br>Chief Finance Officer / Efficiency Director | **Purpose**<br>To inform the committee on the update on the 2026/27 plan delivery | **Outcome /Action taken:**<br>**Noted** progress against CIP programme and discussed deliverability risks. Asked for enhanced tracking of scheme delivery and assurance arrangements. |
| **Capital Investment Progress Report**<br><br>Update on Capital Plan for 2026/27 delivery at Months 1 (Apr), 2 (May) and Quarter 1 (August) | **Jun** | **Jul** | **Aug** | **Presenter**<br>Director of Strategic Finance | **Purpose**<br>To update on implementation of the 2026/27 capital plan & set out actual position at Q1 | **Outcome /Action taken**<br>**Noted** the delivery of the capital programme and prioritisation arrangements. Considered reprioritisation of 2026/27 capital expenditure and links to estates and medical equipment risks. Updated capital paper to be presented in October following reprofiling exercise. |

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| **Commercial Progress Report Q1 2026/27 including Procurement Update** | | | **Aug** | **Presenter**<br>Chief Procurement Officer | **Purpose**<br>To Note | **Outcome /Action taken**<br>Noted activity undertaken by the commercial directorate |
| **Minimum Standards of Patient Experience (Sir Jim Mackey Letter)** | | | **Aug** | **Presenter**<br>Chief Operating Officer | **Purpose**<br>To Note | **Outcome /Action taken**<br>Noted update and alignment with outpatient transformation work. Baseline assessment to come to Committee. |
| **Operational Performance Reporting**<br>▪ Performance Scorecard<br>▪ Constitutional Standards Performance Report | **Jun** | **Jul** | **Aug** | **Presenters**<br>Chief Operating Officer;<br>Director of Performance/BI<br>Managing Director Planned Care | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted performance against constitutional standards and emerging risks to delivery of elective and UEC trajectories. Focus on reporting on performance recovery actions. Non-RTT waiting list and recovery plan to return in October. Heatwave after-action review and Skin cancer pathway deep dive to be presented by next meeting. |
| **Property Disposal per SFIs**<br><br>- Southpoint Brighton Disposal | | | **Aug** | **Presenter**<br>Chief Finance Officer | **Purpose**<br>To Agree and recommend for Board approval | **Outcome /Action taken**<br>The Committee supported commencement of marketing of the property. Full disposal case to be presented to Board, including strategic rationale and staff relocation arrangements |
| **Workforce Reconciliation Update** | | | **Aug** | **Presenter**<br>Chief Operating Officer | **Purpose**<br>To approve | **Outcome /Action taken**<br>Noted progress on workforce establishment review. reconciliation update to return to October meeting. |
| **Investment Decisions & Contract Recommendations**<br>- MRI scanner replacement | | | **Aug** | **Presenter**<br>Chief Operating Officer) | **Purpose**<br>To approve | **Outcome /Action taken**<br>The Committee **approved** replacement of the RSCH MRI scanner, subject to additional clarification on benefits and funding prioritisation. |
| **Investment Decisions & Contract Recommendations**<br>- St Richard's Hospital RAAC Remediation Strategic Outline Case (SOC) | | **Jul** | | **Presenter**<br>Chief Finance Officer | **Purpose**<br>To consider ahead of Board approval | **Outcome /Action taken**<br>The Committee commended the strategic outline case to the Board for approval. |

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| **Investment Decisions & Contract Recommendations**<br><br>- Radiology Workforce Business Case<br>- Pathology Workforce Business Case | | | **Aug** | **Presenter**<br>Chief Medical Officer | **Purpose**<br>To approve | **Outcome /Action taken**<br>Approval decision deferred. Revised business cases to return with clearer activity, workforce and affordability information |
| **Investment Decisions & Contract Recommendations**<br><br>Urgent & Emergency Care Business Case Update | | | **Aug** | **Presenter**<br>Chief Corporate Affairs Officer | **Purpose**<br>To note update | **Outcome /Action taken**<br>Received verbal progress update. Further development and return through governance process; possible extraordinary meeting if required. |
| **Investment Decisions & Contract Recommendations**<br><br>Wholly Owned Subsidiary Development update | | | **Aug** | **Presenter**<br>Chief Corporate Affairs Officer | **Purpose**<br>To note update | **Outcome /Action taken**<br>Noted progress towards Full Business Case and NHSE engagement. |
| **Investment Decisions & Contract Recommendations**<br><br>Midwifery Workforce Investment Business Case. | | | **Aug** | **Presenter**<br>Chief Medical Officer | **Purpose**<br>To approve | **Outcome /Action taken**<br>**Approved** recurring investment to meet maternity safety requirements and CNST standards. Implementation through established workforce governance |
| **Joint Capital Resource Use Plan 2026/27** | | **Jul** | | **Presenter**<br>Chief Finance Officer / Company Secretary | **Purpose**<br>To recommend to the Trust Board for approval | **Outcome /Action taken**<br>**Recommended** to the Trust Board the approval of the Joint Capital Resource Use Plan 2026/27 and publishing on the Trust website |
| **Risk and Board Assurance Framework** | | | **Aug** | **Presenter**<br>Chief Finance Officer / Company Secretary | **Purpose**<br>To agree whether risks for Q2 are fairly stated. | **Outcome /Action taken**<br>Committee **reviewed** their allocated risks and **agreed** recommended risk scoring for Q2 2026/27. Future BAF report to strengthen links between controls, actions, evidence and target risk scores. |

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| **Agenda Item:** | 18. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 17 September 2026 |
| **Report Title:** | Maternity Assurance Reports – Public Board | | | | |
| **Sponsoring Executive Director:** | Gail Byrne – Interim Chief Nursing Officer | | | | |
| **Author(s):** | Stephanie White – Divisional Head of Quality & Safety for Women & Children, WC&CS | | | | |
| **Purpose of the report:** *(indicate as appropriate)* | **For Decision** | **For Assurance** | **For discussion** | **For Information only** | |
| | *N/A* | *Yes* | *Yes* | *N/A* | |
| **Reason for not being taken in public** *(indicate as appropriate)* | **Commercial confidentiality** | **Staff confidentiality** | **Patient confidentiality** | **Other exceptional circumstances (please detail)** | |
| | *Yes / N/A* | *Yes / N/A* | *Yes / N/A* | *Yes / N/A* | |
| **Regulatory Reporting Requirement** | | | | | |

**Summary of the report describing**

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

**Perinatal Quality Oversight Model (PQOM) Report (May 2026 data)**

**What:**

May 2026 PQOM dashboard providing Board oversight of maternity and neonatal quality, safety, workforce and outcomes.

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

**So What:**

Board Assurance

Maternity and neonatal services remain safe and operationally stable, with no MOSS safety signals, sustained 100% 1:1 care in labour and perinatal outcomes remaining below national benchmarks.

Board Attention Required

- Maternal death remains subject to MNSI and PSII investigation.
- Variation in fetal monitoring training compliance requires continued oversight.
- Communication, consent and listening to women remain recurring themes in patient feedback and complaints.

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

**What Next:**

- Complete investigations and implement learning.
- Sustain improvements in training compliance and workforce resilience.
- Continue monitoring outcomes and safety indicators for emerging risks.

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| **Recommendation** *(linked to What Next section)* | For the Trust Board to **NOTE** the contents of the assurance report. |
| **Assurance / Scrutiny route already undertaken** | Quality Governance Steering Group – July 2026<br>Patient & Quality Assurance Committee – August 2026 |

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| (*please explain where matter previously considered, and assurance provided)* | | | | | | |
| **Link to Trust Strategy (note which theme)** | **Patients** | **People** | **Future** | **Communities** | **One UHSussex** | **Culture** |
| | Yes | Yes | Yes | Yes | Yes | *Yes* |
| **Link to annual delivery plan** | | | | | | |
| **Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc** | | | | | | |
| **Link to CQC domain** | **Safe** | **Caring** | **Effective** | **Responsive** | **Well-led** | **Use of Resources** |
| | *Yes* | *Yes* | *Yes* | *Yes* | *Yes* | *Yes* |
| **Other impacts** | **Equality and Diversity (*if yes has HEIA completed)*** | | **Environmental** | **Legal** | **External Registrations *(if yes please indicate which)*** | |
| | *Yes / N/A (Yes / No)* | | *Yes / N/A* | *Yes / N/A* | *Yes / N/A* | |

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|---|---|---|---|---|---|
| **Agenda Item:** | 19. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 17 September 2026 |
| **Report Title:** | Integrated Performance Report | | | | |
| **Sponsoring Executive Director:** | Dr. Andy Heeps, Chief Executive | | | | |
| **Author(s):** | Various Executives | | | | |

| **Purpose of the report:** *(indicate as appropriate)* | **For Decision** | **For Assurance** | **For discussion** | **For Information only** |
|---|---|---|---|---|
| | *N/A* | *N/A* | *Yes* | *N/A* |

| **Reason for not being taken in public** *(indicate as appropriate)* | **Commercial confidentiality** | **Staff confidentiality** | **Patient confidentiality** | **Other exceptional circumstances (please detail)** |
|---|---|---|---|---|
| | *N/A* | *N/A* | *N/A* | *N/A* |

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|---|---|
| **Regulatory Reporting Requirement** | The Board is expected to receive routine reporting on the Trust's performance. |
| **Summary** | Please see enclosed the integrated performance report for University Hospitals Sussex. It shows our performance to June 2026 and sets out the progress we are making to deliver the Trust's priorities, the NHS National Oversight Framework (and associated league tables updated to Quarter 4 of 2025/6 in Jun-26) and the NHS Operating Plan, framed against the new Trust Strategy which will develop further over the next few months with its associated delivery plan. Where possible and meaningful we will use Statistical Process Control to illustrate special cause variation beyond normal variation to help focus on key changes to performance. We have also included some of the key corporate projects underway to support our future success.<br><br>As categorised in the body of the report the new trust strategy has five key ambitions: our patients, our people, our communities, our future, and One UHSussex. The metrics shown fit under these ambitions and follow that structure. This supports our ten-year goal and overall aim of excellent care, everywhere, which aligns with NHS national objectives and our local aims.<br><br>We will illustrate our performance against the metrics within these ambition areas, describe what has happened, whether it is significant, whether it is in keeping with our key plans, and strategy objectives, and where we are behind target or planned recovery, the key actions we are taking next to improve the position. |
| **Recommendation** *(linked to What Next section)* | The Board is asked to **NOTE** and **DISCUSS** this report. |
| **Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*** | This is the standing report and is presented directly to the Board, however specific elements of performance have been scrutinised via the relevant Board Committees. |

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

| | |
|---|---|
| **Link to annual delivery plan** | This report provides a summary overview of the delivery of the Trust's annual plan |
| **Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/** | This report relates to several BAF strategic risks, covering people, quality, performance and finance. |

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|---|---|---|---|---|---|---|
| **change in assurance profile etc** | | | | | | |
| **Link to CQC domain** | **Safe** | **Caring** | **Effective** | **Responsive** | **Well-led** | **Use of Resources** |
| | *Yes* | *Yes* | *Yes* | *Yes* | *Yes* | *Yes* |

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

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# Integrated Performance Report

June 2026 *(reporting period)*

Excellent
Care
Everywhere

We are compassionate
We are inclusive
We are respectful

# Chief Executive summary

Excellent
Care
Everywhere

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

# Chief Executive Summary

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Please see enclosed the integrated performance report for University Hospitals Sussex. It shows our performance to June 2026 and sets out the progress we are making to deliver the Trust's priorities, the NHS National Oversight Framework (and associated league tables updated to Quarter 4 of 2025/6 in Jun-26) and the NHS Operating Plan, framed against the new Trust Strategy which will develop further over the next few months with its associated delivery plan. Where possible and meaningful we will use Statistical Process Control to illustrate special cause variation beyond normal variation to help focus on key changes to performance. We have also included some of the key corporate projects underway to support our future success.

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

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

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

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

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# Chief Executive Summary page 2

Overall Trust performance during June was challenging, exacerbated by the early summer heatwave, but performance for planned care recovery longest waits were better than plan for 52 weeks. Cancer performance has been hampered by material growth in skin cancer demand. Workforce, finance, and quality indicators remain broadly in line with trajectory, although several areas require ongoing focus to ensure delivery of year-end targets. The Trust continues to progress its range of ongoing major projects which will enhance patient care across various services as part of our strategic plans.

## Our Patients

Performance against the Standard Hospital Mortality Index (SHMI), has improved comparatively relative to 2024/5, and has remained within an expected range throughout this year. This information runs in arrears to March so as to capture other trusts relative performance against our own.

Incident rates per 1000 bed days are tracked each month and by their severity. The Trust strives for improved levels of incident reporting to encourage continuous learning as part of an open and transparent culture and met the Trust aim for >60 incidents per 1000 beddays in May-26. Key themes from incidents, include falls and pressure ulcers as key contributors. The Falls Rate per 1,000 bed days June 2026, was 4.47, with an average rolling year 4.46 against a target of 4.2. Overall, Trust data is tracking along the mean average and within the upper control limit, for both the number of falls and the number of falls per 1,000 bed days. Work continues with harm free care alongside divisions to undertake risk assessments relating to bed rails, and blood pressure levels, to reduce risk. The pressure ulcer damage rate, was below the mean average June-26. The mattress audit and replacement programme are actions to reduce pressure ulcers further. Pressure ulcers and falls both impact patient experience, outcomes and length of stay and recovery in hospital.

Whilst elective waits remain a material issue for the Trust, reflected in the Trust being in Tier 1 for elective support from NHSE, the Trust remained below plan for its longest 52 week waits. The waiting list is higher than planned due to increases in demand, and some constraints in certain specialties. Long waits impact patient experience, and have a strong relationship with financial performance , including the ambition to improve productivity for outpatient and theatre utilisation within budget where possible. This remains a key focus area for the Trust into 2026/7.

Trust constitutional access standard performance for diagnostics saw a marginal deterioration in Q1 of 2.2% to 13.8% but remained significantly better than National position (23.3%), and is focussing on mitigating endoscopic modality , audiology, and neurophysiology backlogs.

Cancer performance for 62 day performance was below Trust planned recovery target in June but did improve by 4.4% relative to the same time the previous year. Faster diagnosis performance was below target Jun-26. Skin and colorectal anatomical sites are most challenging and have largest backlogs. Focus is being dedicated to these anatomical sites.

# Chief Exec Summary page 3

ED performance at the Trust has remained challenging in quarter 1. In June, the Trust saw 68.6% of patients within four hours. 12 hour performance and corridor care saw a worsened position in Q1 in the context of a 4% increase in attendances via ambulance in Q1 2026/7 compared to Q1 2026/7 . 45 minute handovers were higher in Q1 2026/7 compared to 2025/6 . Work to improve UTC and emergency care environment forms a key part of the Trust strategy. The Trust also has renewed its UEC improvement programme with the intention to help facilitate flow of patients from A&E, to inpatient wards and early supported discharge with help from our community, social care and mental health partners. The trust is targeting improved streaming of patients to urgent treatment centres, same day emergency care (SDEC), to decongest the front door, with quick and enhanced therapy support, improve performance against the safer care bundle and target shorter length of stay, pre and post the point at which a patient no longer requires acute care. This all impacts positively on flow and performance indicators, and influences financial costs, staff morale and nursing cover requirements, patient experience indicators, and health outcomes.

## Our People

Sickness levels at the trust fell in quarter 1 (and below q1 2025/6 levels), was below the mean average at the Trust over the past 20 months and track peers (broadly in line with Regional averages and better than other Sussex providers). Work to target areas with most sickness continues including F&E and nursing hotspots. High levels of sickness can impact staff morale, patient care, and cost to fill in clinical areas.

Vacancy rates were 7.0% Jun-26, compared to 10.4% a year ago. A range of recruitment initiatives are being undertaken to further reduce substantive vacancies, although some are held as part of cost control. It is critical that the Trust has a sufficient core workforce to deliver patient care and minimise the use of agency or bank deployment unless necessary.

Statutory and Mandatory Training and Appraisal rates continued to perform well over the past quarter, with sustained compliance (above 90%) for STAM and a marginal deterioration in appraisal rates to 86.2% June compared to May, but 5% higher than June-25.

## Our Communities

Patient experience increased marginally to 91.7% in June, from 91.2% May and remained above the 90% target, but was 0.6% below June-26. A&E FFT remains most challenged for the Trust (and nationally) with 82.4% June-26, compared to 77% Nationally (June) with links to A&E waiting times and 4hr performance. Work to improve this environment through UTC and other emergency department strategic developments should therefore aid further improvement to patient experience scores.

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# Chief Exec Summary page 4

## Our Future

The Trust submitted a breakeven financial plan for 2026/27, with a deficit in Q1 offset by a surplus in Q4. The Trust delivered a deficit in Q1 of £20.0m, in line with plan. There were £9.3m of non-recurrent mitigations supporting the Q1 position. Efficiency programme delivery is £5.0m adverse against the internal plan YTD. The planned and underlying deficit position is contributing to an increasingly challenging cash position. Capital programme expenditure is £2.7m greater than plan. The primary driver is expenditure on deferred/multi-year schemes taking place ahead of plan (£6.7m adverse YTD) with partly offsetting delayed expenditure on PDC funded schemes. It is anticipated that timing differences will unwind and programme expenditure will be on plan at year-end.

Plans to reduce bank and agency spend were behind the challenging 31% temporary staffing spend reduction plan this financial year. As of June, the Trust was £2.37 M behind plan of £28M expenditure

R&D recruitment to interventional studies continues to improve in relative rank terms, and is 13th , ahead of our ambition to be in the top 20% for research studies. There are various actions noted in the body of the report which describe plans to further develop our R&D strategy.

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

## One UHSussex

Staff engagement scores are tracking below national average staff survey results (6.6 versus 6.68 National Survey results 2025) but has improved since June 2025. Other indicators, such as declining turnover, sickness absence and vacancies suggest a stable or improving position, reflected too in early staff survey results.

## National performance assessment framework

UHSx remains Segment 4 overall rating with a provider capability assessment of red, and the Trust Overall ranking remained static at 121 of 134 in comparison to Q3. The most notable drivers are performance against access constitutional standards (both planned care and UEC) and two key metrics from NHS national staff survey (raising concerns and engagement sub-scores). Relative UEC performance deteriorated in Q4, resulting in a lower score and ranking. People and workforce improved segmentation from segment 3 to segment 2. A new oversight framework is being rolled forward for 2026/7, with 13 new metrics, and the Trust anticipate an improved ranking as a result for Q1 (expected publication September)

# Summaries

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# Metric Summary

| Strategic Ambition | Performance Measure | Latest | Month | Previous | Direction | 25/26 Month | Target | Plan | National |
|---|---|---|---|---|---|---|---|---|---|
| Patients | A&E and Emergency flow - % treated and admitted/discharged within 4 hours | Jun-26 | 68.6% | 69.1% | Decrease | 72.80% | 82% (March-27) | 73.40% | 75.0% |
| | A&E and Emergency flow - Ambulance Handovers > 60 minutes | Jun-26 | 10.30% | 6.9% | Increase | 5.0% | < 2025/6 | 3.79% | n/a |
| | A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments | Jun-26 | 8.10% | 6.96% | Increase | 5.61% | < 2025/6 | 7.48% | 11.70% |
| | Cancer - 28 day faster diagnosis standard | Jun-26 | 75.8% | 78.0% | Decrease | 78.0% | 80.0% | 80.6% | 79.0% |
| | Cancer - 31 day treatment standard | Jun-26 | 79.6% | 77.4% | Increase | 77.0% | 94% (March-27) | 86.6% | 92.2% |
| | Cancer - To achieve the 62 day standard | Jun-26 | 64.5% | 64.1% | Increase | 60.1% | 80% (March-27) | 76.0% | 69.9% |
| | Diagnostics - % Breaching 6 week target (DM01 modalities) | Jun-26 | 13.8% | 12.3% | Increase | 13.60% | <5% | 13% | 24.0% |
| | RTT 52 Weeks | Jun-26 | 4638 (4.0%) | 4297 (3.7%) | Increase | 5860 | 3782 / 3.7% (March-27) | 4.20% | 1.70% |
| | RTT Elective care - >=65 Weeks | Jun-26 | 394 (0.3%) | 354 (0.3%) | Increase | 580 | 0 | 0 | 0.10% |
| | RTT Elective care - 18 Week Performance | Jun-26 | 53.2% | 54.1% | Decrease | 51.3% | 60% (March-27) | 53.9% | 65.6% |
| | Safer Staffing - Average fill rate - registered nurses/ midwives (day shifts) | Jun-26 | 92.7% | 93.4% | Decrease | 89.6% | 95% | | |
| | Safer Staffing - Average fill rate - registered nurses/ midwives (night shifts) | Jun-26 | 93.4% | 96.4% | Decrease | 93.4% | 95% | | |
| | Safer Staffing - Average fill rate - care staff (day shifts) | Jun-26 | 87.0% | 86.6% | Increase | 81.0% | 95% | | |
| | Safer Staffing - Average fill rate - care staff (night shifts) | Jun-26 | 93.2% | 95.4% | Decrease | 91.1% | 95% | | |
| | Care Hours Per Patient Day | Jun-26 | 9.3 | 7.8 | Increase | 7.8 | | | |
| | Incidents/1000 beddays | Jun-26 | 66.17 | 62.20 | Increase | 54.69 | | | |
| | Falls | Jun-26 | 4.47 | 4.68 | Decrease | 4.64 | | | |
| | Pressure Ulcers | Jun-26 | 2.3 | 2.19 | Increase | 3.01 | | | |
| | Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M) | Mar-26 | 101.55 | 100.8 | Increase | 104.8 | 100 (as expected range) | | 100 |
| People | Training & development - Appraisals completed | Jun-26 | 86.2% | 87.1% | Decrease | 82.70% | >90% | | |
| | Training & development - STAM Weighted Average | Jun-26 | 93.2% | 93.6% | Decrease | 91.67% | >90% | | |
| | Workforce capacity - Vacancy Factor (Substantive contracted FTE) - monthly | Jun-26 | 7.0% | 6.7% | Increase | 7.40% | 10% | | |
| | Workforce efficiency - Absence Sickness in month | Jun-26 | 4.2% | 3.9% | Increase | 4.3% | <4.5% | | |
| Communities | Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good | Jun-26 | 91.7% | 91.20% | Increase | 92.30% | >=90% | | 91.9% |
| Future | Financial Stability - Variance from breakeven plan YTD | Jun-26 | £0 | £0 | Same | | £0 | | |
| | Bank and Agency Spend against planned trajectory | Jun-26 | -£2.37M | £-1.27M | Increase | | £0 | | |
| | Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies | Jun-26 | 13th | 13th | Same | | <27th | | |
| One UHSX | Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score | Jun-26 | 6.59 | 6.74 | Decrease | 6.23 | >6.9 | | |

# Statistical Process Control

**Statistical process control**

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

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

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

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

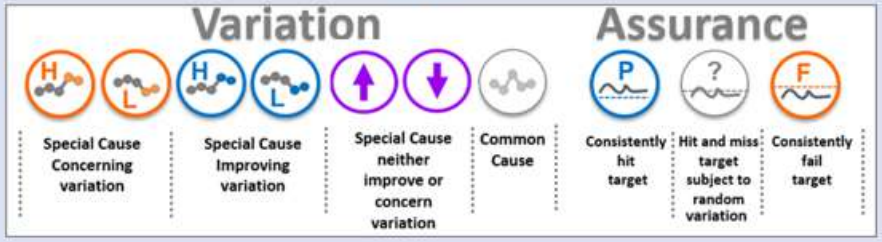
**The rules (please note the rules are ordered to priortised in the order trend, shift, 2 out of 3, single point)**

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

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

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

**Icon key**



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## IPR SPC Summaries

| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| RTT < 18 Week Performance | Jun 26 | 53.2% | 60.0% | | | 50.2% | 47.9% | 52.6% |
| A&E < 4 hr Performance | Jun 26 | 68.6% | 82.0% | | | 70.1% | 67.0% | 73.1% |
| A&E 12 hr breaches | Jun 26 | 3174 | 2498 | | | 2780 | 1878 | 3682 |
| Ambulance Handovers > 45 mins | Jun 26 | 10.3% | 0.0% | | | 9.3% | 4.4% | 14.3% |
| Cancer - 28 day faster diagnosis standard | May 26 | 78.0% | 83.2% | | | 74.5% | 66.2% | 82.9% |
| Cancer <62 Day performance | May 26 | 64.1% | 80.1% | | | 62.7% | 52.6% | 72.9% |
| RTT >52 Weeks | Jun 26 | 4638 | 3782 | | | 6600 | 5122 | 8077 |
| Diagnostics - % <6 weeks | Jun 26 | 13.8% | 11.0% | | | 16.2% | 11.5% | 20.9% |
| RTT >65 weeks patients | Jun 26 | 394 | 0 | | | 1061 | 238 | 1884 |
| L&D - Appraisals completed | Jun 26 | 86.2% | 90.0% | | | 86.2% | 84.0% | 88.3% |
| L&D - STAM Weighted Average | Jun 26 | 93.2% | 90.0% | | | 92.2% | 91.3% | 93.1% |
| Workforce - Vacancy Factor | Jun 26 | 7.0% | 10.0% | | | 8.4% | 7.2% | 9.6% |
| Workforce - In Month Sickness | Jun 26 | 4.2% | 4.5% | | | 4.7% | 4.0% | 5.4% |
| National staff engagement score | Jun 26 | 6.59 | 6.90 | | | 6.43 | 6.08 | 6.77 |
| Summary Hospital-level Mortality Indicator (12M) | Mar 26 | 101.55 | 100.00 | | | 102.74 | 101.29 | 104.18 |
| Patient experience - FFT | Jun 26 | 91.7% | 90.0% | | | 90.9% | 89.1% | 92.7% |
| Incident Rate /1000 Beddays | May 26 | 66.17 | - | | | 58.17 | 51.57 | 64.78 |
| Patient Experience FFT A&E | Jun 26 | 81.9% | 90.0% | | | 82.6% | 77.9% | 87.2% |
| Safer Staffing: CHPPD | Jun 26 | 9.30 | - | | | 8.15 | 7.36 | 8.94 |
| Falls | Jun 26 | 266 | - | | | 260 | 210 | 310 |
| Pressure Ulcers | Jun 26 | 137 | - | | | 155 | 103 | 207 |
| Falls per 1000 beddays | Jun 26 | 4.47 | 4.20 | | | 4.40 | 3.54 | 5.26 |
| Pressure Ulcers per 1000 beddays | Jun 26 | 2.30 | 2.00 | | | 2.62 | 1.78 | 3.46 |
| 31 Day Cancer | Jun 26 | 79.60% | 94.40% | | | 79.20% | 70.99% | 87.40% |
| | | | - | | | | | |

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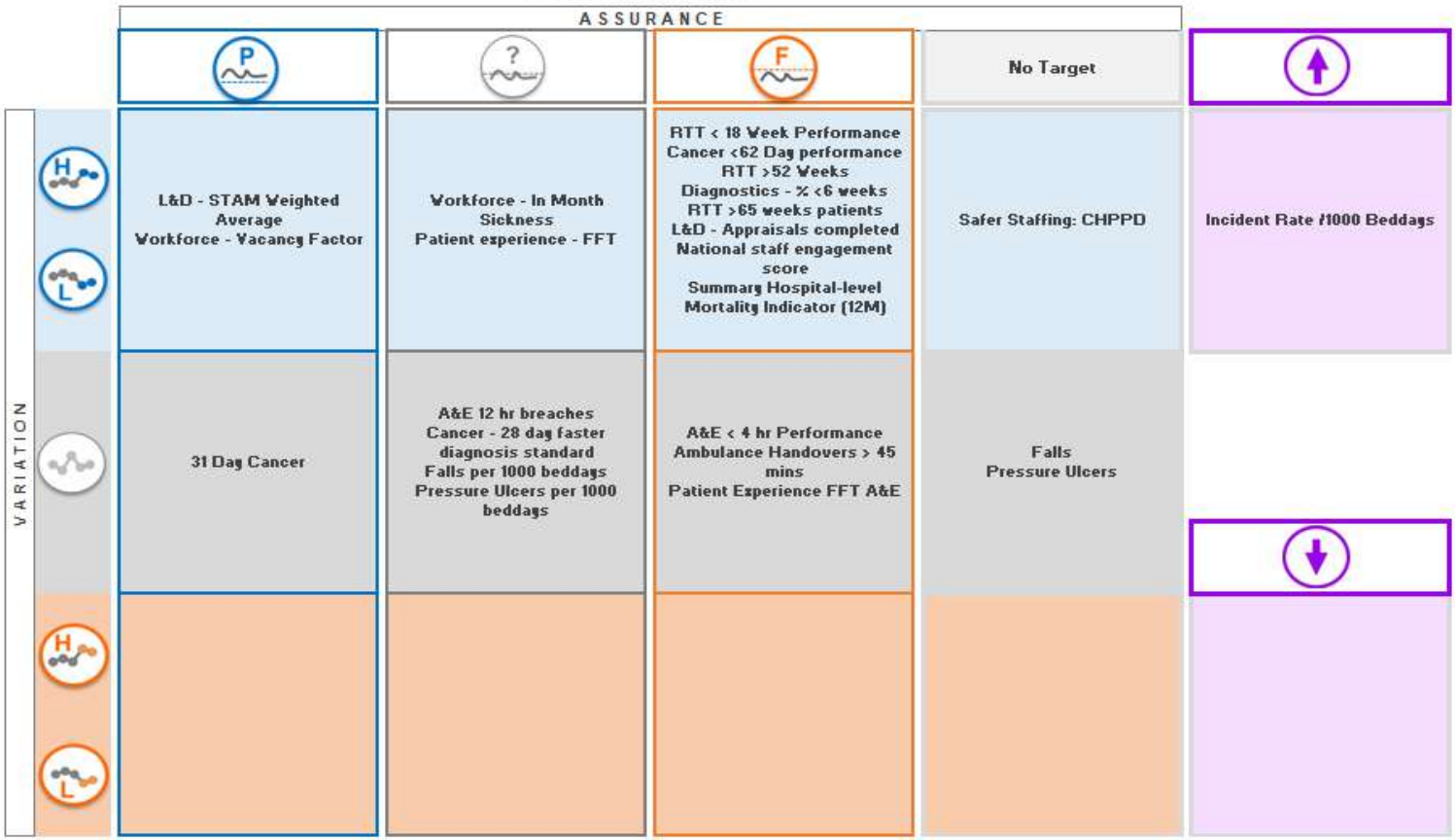
## IPR SPC Summaries

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# Patients

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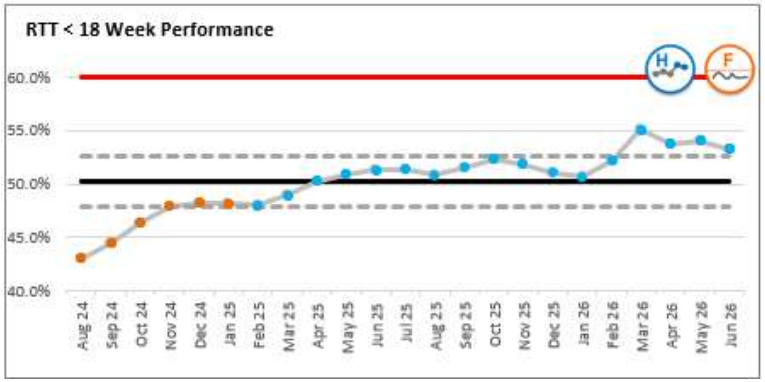
| | Our Ambition: Patients: Faster Access to Planned Treatment and Cancer Care | | | | | |
|---|---|---|---|---|---|---|
| **Elective Care: RTT <18 Week Performance** | **Target** | 60% by March-27 | | | | |
| **Latest Month Plan** | 53.90% | | **National Rank** | 148/150 | | |
| **Latest Month Actual** | 53.20% | | **National Performance** | 65.6% May-26 | | |
| **Latest Month Trend** | Decreased (worsened) | | **NPAF Area: Access to Services** | | **DQ** | Green |

**Key Messages**

- RTT <18 Week performance was 53.2% for UHSX Trust Jun-26, 0.7 percentage points worse than the improvement trajectory.
- This was a fall of 0.9% from May-26, and +1.9% from Jun-25.
- Performance remains challenged compared to national average, which was 65.6% for May-26.

- The waiting list size marginally reduced Jun-26 to 116,136, but this is 978 above planned levels, and 3006 higher than Jun-25.
- The heatwave at the end of June had some impact with theatre cancellations. Demand has also remained relatively high.
- Activity to date has been lower than planned for elective care, and the Trust is working across the operational divisions to recover this activity to planned levels

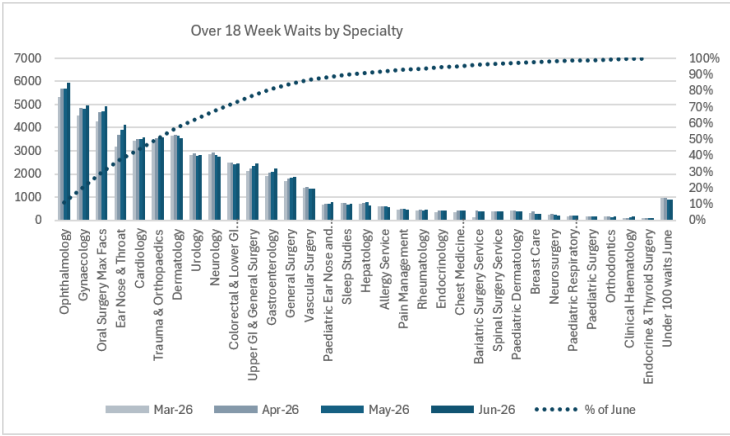



**Key Actions**

- Delivery of activity and productivity plans, to ensure enough patients are treated to reduce waiting list size and backlog over 18 weeks. Within this, the trust is focused on reducing waits for first appointment both to support this reduction but also to increases downstream time available for subsequent stages of the pathway.
- Reducing backlog of routine referrals waiting longer than 7 days for triage and processing from ~3.3k to <=1k by Mar-27.
- Expand use of A&G/SPoA to reduce referral demand. First five specialties by Oct-26 and 10 by Mar-27
- Redesign outpatients delivery, through 12-week sprint focused on templates and follow-up reduction (Nov-26), transform outpatient pathways including digitisation and increased 'straight to test' or one stop (Mar-27); UHSX is being supported by GIRFT with this
- Integrate and improve specialty pathways in One UHSX model (starting with Derm, OMFS, T&O, and Ophthalmology) - Mar-27
- Improve theatre productivity through weekly 'Improvement Room' approach (Mar-27)

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Plan** | 52.9% | 53.8% | 53.9% | 53.3% | 54.2% | 54.9% | 54.5% | 55.6% | 57.1% | 57.5% | 58.7% | 60.0% |
| **Actual** | 53.7% | 54.1% | 53.2% | | | | | | | | | |
| **Variance** | 0.8% | 0.2% | -0.7% | | | | | | | | | |

**Breakdown Latest Month**




**Interdependencies with other performance indicators**

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

**Exec Owner** Nigel Kee **SRO** Huw Edwards

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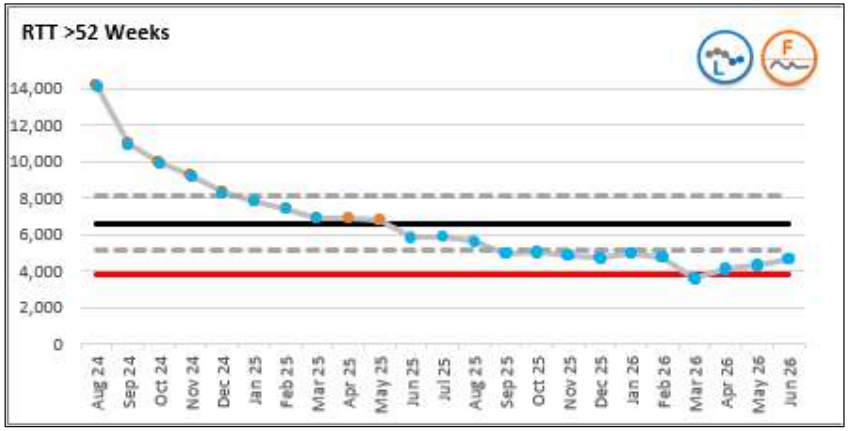
| Our Ambition: Patients: Faster Access to Planned Treatment and Cancer Care | | | | | |
|---|---|---|---|---|---|
| **Elective Care: RTT > 52 Week Waits** | **Target** | <=3782 March-27 | | | |
| **Latest Month Plan** | 4851 (4.2%) | **National Rank** | May 26 133/134 | | |
| **Latest Month Actual** | 4638 (4.0%) | **National Performance** | 1.4% May-26 | | |
| **Latest Month Trend** | Reduced (improved) | **NPAF Area: Access to Services** | | **DQ** | Green |

**Key Messages**

- 52 Week breaches by 341 patients at Jun-26 month end – to 4,638 patients. This is 122 fewer than June-26, and 213 lower (better) than the planned recovery trajectory.
- 52-week waits comprised 4.0% of WL, better than improvement trajectory (4.2%). However, this was supported by waiting list being higher than plan.
- Specialties with most 52 week waits Mar-26 are Dermatology (755 patients), Oral Surgery Max Facs (709 patients), and gynaecology (534 patients)
- There were 394 65-week waits in Jun-26, an increase of 40 compared to May-26.

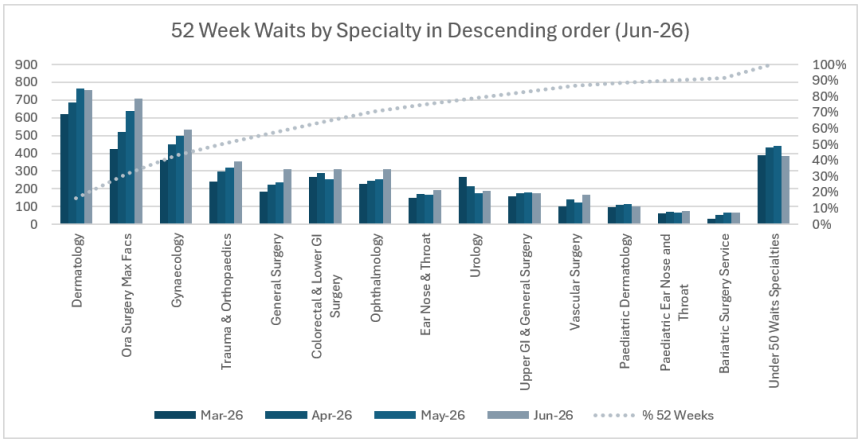



**Key Actions**

- Delivery of activity and productivity plans, to ensure enough patients are treated to reduce backlog over 52 weeks.
- Targeted plans have been agreed with Divisions to drive 65-week breaches back to virtually zero by Dec-26.

Redesign outpatients delivery, through 12-week sprint focused on templates and follow-up reduction (Nov-26), transform outpatient pathways including digistisation and increased 'straight to test' or one stop (Mar-27); UHSX is being supported by GIRFT with this
Integrate and improve specialty pathways in One UHSX model (starting with Derm, OMFS, T&O, and Ophthalmology) - Mar-27
Improve theatre productivity through weekly 'Improvement Room' approach (Mar-27)

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Plan** | 5048 | 4861 | 4851 | 4976 | 4786 | 4667 | 4736 | 4533 | 4267 | 4197 | 3982 | 3782 |
| **Actual** | 4076 | 4297 | 4638 | | | | | | | | | |
| **Variance** | -972 | -564 | -213 | | | | | | | | | |




**Interdependencies with other performance indicators**

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

| **Exec Owner** | **Nigel Kee** | **SRO** | **Huw Edwards** |
|---|---|---|---|

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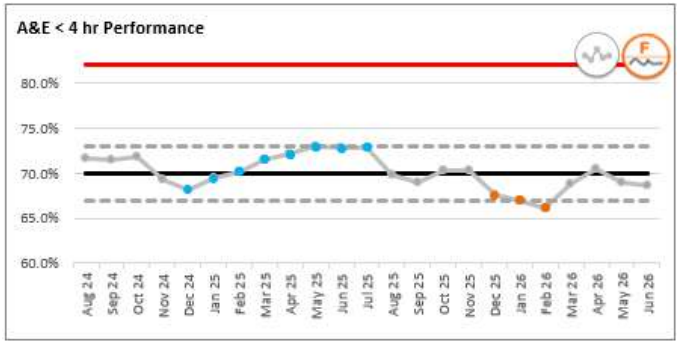
| | | | | | |
|---|---|---|---|---|---|
| | **Our Ambition: Patients:** Better urgent and emergency care | | | | |
| **A&E <4Hour % Performance** | **Target** | 82% by March-27 | | | |
| **Latest Month Plan** | 73.40% | **National Rank** | 103 of 121 Trusts (Jun-26) | | |
| **Latest Month Actual** | 68.60% | **National Performance** | 75.0% (Jun-26) | | |
| **Latest Month Trend** | Reduced (worsened) | **NPAF Area: Access to Services** | **DQ** | Green | |

**Key Messages**

- **A&E<4-hour performance** was 68.62% in Jun-26. This is 0.4% lower than May-26, and 4.2% lower than Jun-25. National performance was 75.0% in June. It is below the Trust planned improvement trajectory of 73.4% for Jun-26.
- **Patients in A&E for 12 hours** increased to 3,133 in Jun-26, from 2,729 May-26 and 2,088 Jun-25.
- 45-Minute handovers increased to 10.3% from 7% last month (and compared to 5% in Jun-26).
- A&E attendances were 3.9% higher in Jun-26 compared to Jun-25 with ambulance handovers being 0.2% higher between years, and walk ins being 4.8% higher
- Long stays constrained discharges and emergency flow, with 485 patients in hospital more than 21 days Jun-26 compared to 432 Jun-25, and no criteria to reside patients (NCTR) were 382 on average in Jun-26 compared to 357 Jun-25




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Plan** | 71.9% | 72.6% | 73.4% | 73.4% | 72.6% | 74.9% | 76.4% | 77.2% | 75.7% | 74.2% | 77.2% | 82.0% |
| **Actual** | 70.4% | 69.1% | 68.6% | | | | | | | | | |
| **Variance** | -1.5% | -3.6% | -4.8% | | | | | | | | | |

**Key Actions**

- Refreshed UEC improvement programme, led by newly appointed MD for Medicine, has been agreed with NHS England.
- Revised UEC Improvement programme has been agreed with 3 programme 'Buckets' 1) Front Door 2) Wards & Departments 3) Discharge. Each has an executive SRO. Delivery Leads for each discrete piece of work within the buckets have been identified, all lead names now agreed.
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- RSCH Sprint Continues
- Joint work with the ICB re the model and provision of the UTC continues, with ngoing productivity metrics now receiving focus in order to improve performance, increase speed, and ultimately reduce high spend intrinsic in the initial programme delivery.

**Interdependencies with other performance indicators**

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

| A&E4hr | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 |
|---|---|---|---|---|---|---|---|
| UHS<4hr % | 67.6% | 67.0% | 66.1% | 68.9% | 70.4% | 69.1% | 68.6% |
| RSCH | 56.1% | 57.5% | 59.3% | 63.4% | 59.7% | 58.2% | 60.7% |
| PRH | 60.9% | 60.3% | 57.3% | 58.8% | 60.4% | 63.0% | 66.7% |
| RACH | 83.6% | 89.3% | 91.3% | 90.0% | 94.4% | 94.6% | 94.1% |
| Worthing | 54.6% | 56.1% | 54.1% | 59.6% | 62.2% | 59.1% | 57.9% |
| SRH | 67.1% | 59.6% | 54.9% | 57.6% | 64.2% | 63.0% | 57.9% |
| *National* | 73.8% | 72.5% | 74.1% | 77.1% | 76.9% | 75.7% | 75.0% |
| A&E 12 hours in department | 2,793 | 3,560 | 2,890 | 3,052 | 2,508 | 2,729 | 3,133 |
| A&E Attendances | 36,827 | 37,241 | 33,159 | 38,471 | 37,704 | 39,194 | 38,694 |
| Time to Triage | 19 | 20 | 21 | 23 | 21 | 22 | 23 |
| Time to Treatment | 140 | 141 | 142 | 146 | 139 | 145 | 143 |
| Mean Waiting Time | 329 | 370 | 362 | 345 | 335 | 339 | 345 |
| Ambulance Handovers | 7,583 | 7,717 | 6,697 | 7,407 | 7,140 | 7,433 | 7,183 |
| Ambulance Handover <15 minutes | 53.3% | 45.7% | 52.6% | 50.1% | 52.9% | 52.8% | 46.9% |
| Ambulance Handover >45 minutes | 8.9% | 11.4% | 8.4% | 8.8% | 7.4% | 7.0% | 10.3% |
| Ambulance Handovers > 60 minutes | 2.8% | 3.6% | 2.8% | 2.5% | 1.9% | 1.9% | 2.7% |
| Emergency Admissions > 1 LOS | 6055 | 5847 | 5155 | 5765 | 5429 | 5602 | 5583 |
| Occupied Beds | 1,618 | 1,726 | 1,715 | 1,706 | 1,702 | 1,731 | 1,720 |
| Bed Occupancy | 94.7% | 95.8% | 95.4% | 95.1% | 94.1% | 94.4% | 93.7% |
| Average LOS (Excl LOS 0) | 9.60 | 11.90 | 10.80 | 10.50 | 10.60 | 12.10 | 10.60 |
| >= 7 day LOS Patients | 951 | 1,050 | 1,068 | 1,063 | 1,061 | 1,093 | 1,060 |
| >=21 day LOS Patients | 401 | 437 | 478 | 477 | 502 | 495 | 485 |
| Ave. DRD per day | 306 | 362 | 377 | 390 | 385 | 388 | 382 |

**Exec Owner** Nigel Kee **SRO** David Coyle

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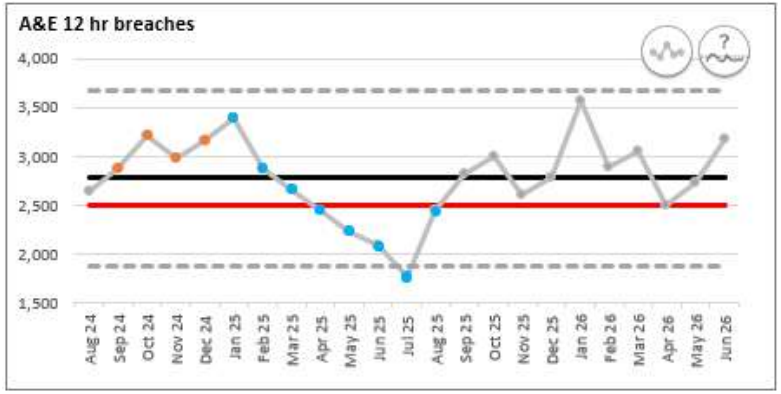
|---|---|---|---|---|---|
| **A&E > 12 Hour waits** | **Target** | A reduction in 2026/7 compared to 2025/6 | | | |
| **Latest Month Plan** | 2088 | **National Rank** | 75/118 week of 5th July | | |
| **Latest Month Actual** | 3133 (8.1%) | **National Performance** | 9.25% | | |
| **Latest Month Trend** | Increased (worsened) | **NPAF Area: Access to Services** | | **DQ** | Green |

**Key Messages**

- The Trust has seen a 23.5% increase in 12 hour delays in 2026/27 to end Jun-26. This in the context of growth in attendances of 3.2%
- This worsened in Jun-26 to 3133, the highest 12 hour waits since Jan-26
- Of 3133 patients who waited over 12 hrs in A&E, prior to leaving the department, 894 were at the Royal Sussex County. Jun-26 was 15% lower than Jun-25 at RSCH however.
- Worthing site had an extremely challenging month with 1048 over 12 hr waits, 190% higher than June-25 (361).
- SRH also saw an increase to 849 patients compared to 674 Jun-25, +137%.
- The % 12 hours was 8.1% compared to 6.7% Jun-25, and




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2025/26** | 2448 | 2240 | 2088 | 1765 | 2443 | 2823 | 3007 | 2641 | 2793 | 3560 | 2890 | 3052 |
| **2026/27** | 2508 | 2729 | 3133 | | | | | | | | | |
| **Variance** | 60 | 489 | 1045 | | | | | | | | | |

**Key Actions**

- Refreshed UEC improvement programme, led by newly appointed MD for Medicine, has been agreed with NHS England.
- Revised UEC Improvement programme has been agreed with 3 programme 'Buckets' 1) Front Door 2) Wards & Departments 3) Discharge. Each has an executive SRO. Delivery Leads for each discrete piece of work within the buckets have been identified, all lead names now agreed.
- Capacity and configuration group established to support Hospital flow
- RSCH Sprint Continues
- As of 14th July, SRO for the Programme is Nigel Kee
- Capacity and configuration group established to support Hospital flow
- RSCH Sprint re-implemented
- Mental Health delays in ED now being focussed on in a robust way.

| A&E >12 hours in Department: | 2025/26 | | | 2026/27 | | | Last Year | | Last Month | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Site:** | **Jan-26** | **Feb-26** | **Mar-26** | **Apr-26** | **May-26** | **Jun-26** | **Var.** | **% Var.** | **Var.** | **% Var.** |
| RSCH | 1,075 | 884 | 979 | 917 | 954 | 894 | -159 | -15.1% | -60 | -6.3% |
| PRH | 481 | 433 | 454 | 414 | 418 | 342 | 29 | 9.3% | -76 | -18.2% |
| RACH | 4 | 6 | 0 | 3 | 1 | 0 | -3 | -100% | -1 | -100.0% |
| SRH | 882 | 802 | 688 | 513 | 502 | 849 | 491 | 137.2% | 347 | 69.1% |
| WSH | 1,118 | 765 | 931 | 661 | 854 | 1,048 | 687 | 190.3% | 194 | 22.7% |
| **UH Sussex ALL** | **3,560** | **2,890** | **3,052** | **2,508** | **2,729** | **3,133** | **1,045** | **50.0%** | **404** | **14.8%** |

| As % of all Attendances | 2025/26 | | | 2026/27 | | | Last Year | | Last Month | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Site:** | **Jan-26** | **Feb-26** | **Mar-26** | **Apr-26** | **May-26** | **Jun-26** | **Var.** | **% Var.** | **Var.** | **% Var.** |
| RSCH | 13.94% | 13.13% | 12.47% | 12.37% | 11.80% | 11.15% | | -2.7% | | -0.7% |
| PRH | 10.46% | 11.07% | 9.79% | 8.92% | 8.93% | 7.31% | | 0.5% | | -1.6% |
| RACH | 0.15% | 0.26% | 0.00% | 0.12% | 0.04% | 0.00% | | -0.1% | | 0.0% |
| SRH | 12.42% | 12.51% | 9.28% | 6.91% | 6.47% | 11.23% | | 6.3% | | 4.8% |
| WSH | 12.36% | 9.59% | 10.29% | 7.31% | 9.08% | 11.45% | | 7.3% | | 2.4% |
| **UH Sussex ALL** | **9.56%** | **8.72%** | **7.93%** | **6.65%** | **6.96%** | **8.10%** | | **2.5%** | | **1.1%** |

**Interdependencies with other performance indicators**

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

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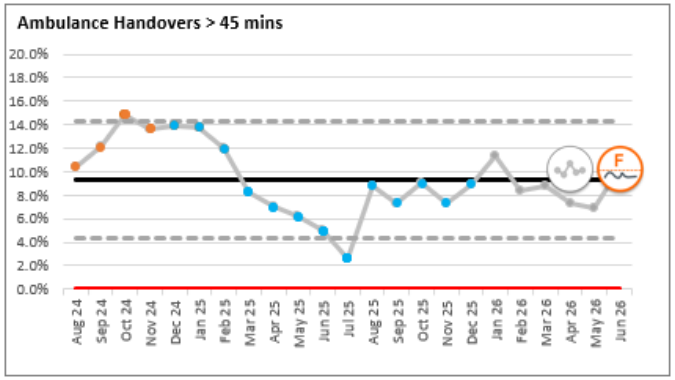
|---|---|---|---|---|---|
| **Ambulance Handovers >45 mins** | **Target** | A reduction in 2026/7 compared to 2025/6 | | | |
| **24/25 Actual** | 5.00% | **National Rank** | Best Performing Region | | |
| **Latest Month Actual** | 10.30% | **National Performance** | n/a | | |
| **Latest Month Trend** | Reduced (improved) | **NPAF Area: Access to Services** | | **DQ** | Amber |

- The Trust saw a 41% improvement in 45 minute handovers in 25/6 compared to 24/5. However, there has been an increase Jun-26 to 740 (10.3%) patients waiting more than 45 minutes compared to May 515 (6.9%) and Jun-25 356 (5.0%). This coincided with increases in demand for A&E, and constrained onward flow/discharges, compounded during the heatwave of the last week in June.
- Of the 740 delays in June, 267 of these were at Worthing, 234 at RSCH, 202 SRH and 37 PRH.




**Key Actions**

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- Capacity and configuration group established to support Hospital flow
- RSCH Sprint Continues
- Joint work with the ICB re the model and provision of the UTC continues, with ngoing productivity metrics now receiving focus in order to improve performance, increase speed, and ultimately reduce high spend intrinsic in the initial programme delivery.

**Interdependencies with other performance indicators**

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

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Plan** | 464 | 407 | 322 | 370 | 306 | 356 | 436 | 401 | 409 | 405 | 351 | 337 |
| **Actual** | 526 | 515 | 740 | | | | | | | | | |
| **Variance** | 62 | 108 | 418 | | | | | | | | | |

| >45 Minute Handovers: | 2025/26 | | | 2026/27 | | | Last Year | |
|---|---|---|---|---|---|---|---|---|
| **Site** | Apr-25 | May-25 | Jun-25 | Apr-26 | May-26 | Jun-26 | Var. | % Var. |
| RSCH | 353 | 336 | 283 | 296 | 270 | 234 | -49 | -17.3% |
| PRH | 36 | 35 | 28 | 93 | 90 | 37 | 9 | 32.1% |
| SRH | 82 | 68 | 38 | 36 | 61 | 202 | 164 | 431.6% |
| WSH | 19 | 15 | 7 | 101 | 94 | 267 | 260 | 3714.3% |
| **UH Sussex ALL** | **490** | **454** | **356** | **526** | **515** | **740** | **384** | **107.9%** |

| % >45 Mins Handover | 2025/26 | | | 2026/27 | | | Last Year | |
|---|---|---|---|---|---|---|---|---|
| **Site** | Apr-25 | May-25 | Jun-25 | Apr-26 | May-26 | Jun-26 | Var. | % Var. |
| RSCH | 14.6% | 13.3% | 11.4% | 12.6% | 10.7% | 9.8% | | -1.7% |
| PRH | 4.4% | 4.4% | 3.6% | 10.5% | 11.0% | 4.6% | | 1.0% |
| SRH | 4.7% | 3.7% | 2.1% | 2.0% | 3.2% | 10.7% | | 8.6% |
| WSH | 0.9% | 0.7% | 0.3% | 4.8% | 4.4% | 12.8% | | 12.4% |
| **UH Sussex ALL** | **7.0%** | **6.2%** | **5.0%** | **7.4%** | **6.9%** | **10.3%** | | **5.3%** |

**Ambulance Conveyances:**

| | 2025/26 | | | 2026/27 | | | Last Year | |
|---|---|---|---|---|---|---|---|---|
| **Site** | Apr-25 | May-25 | Jun-25 | Apr-26 | May-26 | Jun-26 | Var. | % Var. |
| RSCH | 2,604 | 2,742 | 2,697 | 2,576 | 2,760 | 2,612 | -85 | -3.2% |
| PRH | 858 | 817 | 821 | 930 | 848 | 836 | 15 | 1.8% |
| SRH | 1,799 | 1,920 | 1,850 | 1,849 | 1,981 | 1,963 | 113 | 6.1% |
| WSH | 2,130 | 2,221 | 2,217 | 2,252 | 2,298 | 2,292 | 75 | 3.4% |
| **UH Sussex ALL** | **7,391** | **7,700** | **7,585** | **7,607** | **7,887** | **7,703** | **118** | **1.6%** |

**Exec Owner** Nigel Kee **SRO** David Coyle

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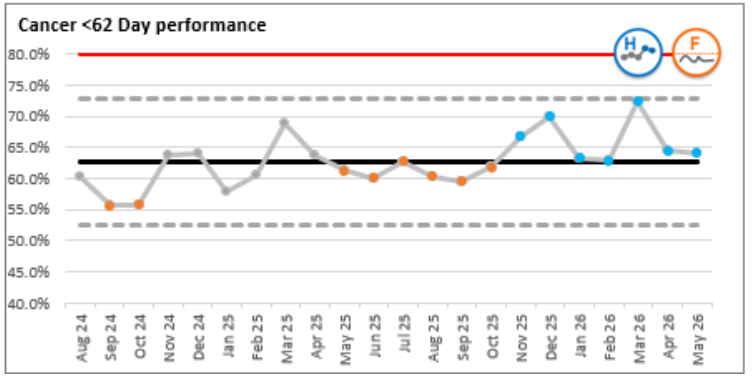
| Our Ambition: Patients: Faster Access to planned treatment and cancer care | | | | | |
|---|---|---|---|---|---|
| **Cancer Care : 62 Day Performance** | **Target** | 80% by March-27 | | | |
| **Latest Month Plan** | 76.8% | **National Rank** | 87 of 143 Jun-26 | | |
| **Latest Month Actual** | 64.5% | **National Performance** | 69.6% | | |
| **Latest Month Trend** | Increased (Better) | **NPAF Area: Access to Services** | | **DQ** | Green |

**Key Messages**

- **62 day Urgent Referral to First Treatment** performance June-26 increased marginally to 64.5% from 64.1% May-26 , 4.4 % better than June-25. It is 12.3% behind planned trajectory. National Performance was 69.9%. Performance was impacted by reduced performance across a number of tumour sites but most notably Skin & Breast.
- The **62-day backlog increased to 562 patients at the end of June 2026**, compared with **489 in June 2025**. **Skin cancer remains the largest contributor, representing 32.4% of the backlog**, with patient numbers increasing from **182 to 279 during July (+97 patients)**. Reducing the backlog will require a sustained focus on treating long-waiting patients and improving retrospective performance.
- **Skin, colorectal and urology** remain the largest contributors to the 62-day backlog, with **279, 134 and 67 patients respectively**. Compared with June 2026, the backlog increased by **97 patients in skin, 24 in colorectal and 2 in urology**. Overall, the Trust's 62-day backlog is **142 patients higher than July 2025, driven solely by the increase in skin cancer waits.**

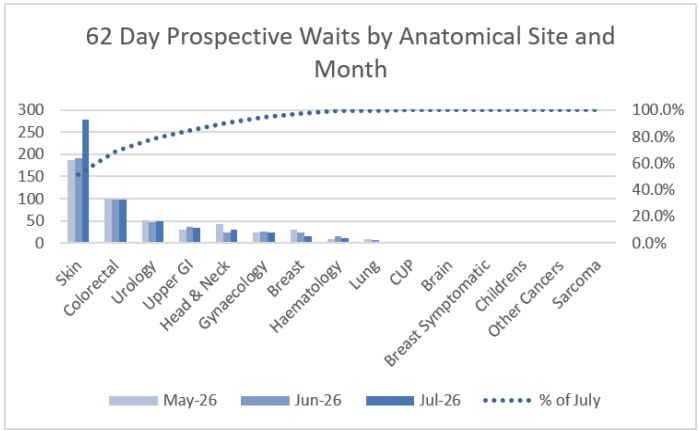



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Plan** | 76.1% | 76.0% | 76.8% | 75.5% | 75.1% | 76.6% | 77.9% | 77.9% | 79.5% | 78.7% | 78.8% | 80.1% |
| **Actual** | 64.5% | 64.1% | 64.5% | | | | | | | | | |
| **Variance** | -11.6% | -11.9% | -12.3% | | | | | | | | | |

**Key Actions**

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

**62 Day prospective waits by Month**




**Interdependencies with other performance indicators**

- Delays to cancer treatment can impact patient experience and outcomes

**Exec Owner** Nigel Kee **SRO** Huw Edwards

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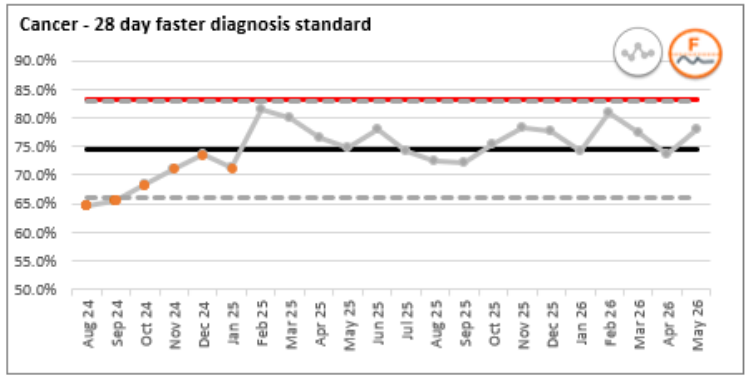
| **Our Ambition: Patients:** Faster Access to planned treatment and cancer care | | | | | |
|---|---|---|---|---|---|
| **Cancer Care :<28 Day Faster Diagnosis Standard** | **Target** | 83% by March-27 | | | |
| **Latest Month Plan** | 82.3% | **National Rank** | 104 of 139 - Jun-26 | | |
| **Latest Month Actual** | 75.8% | **National Performance** | 79.0% | | |
| **Latest Month Trend** | Increased (improved) | **NPAF Area: Access to Services** | | **DQ** | Green |

**Key Messages**

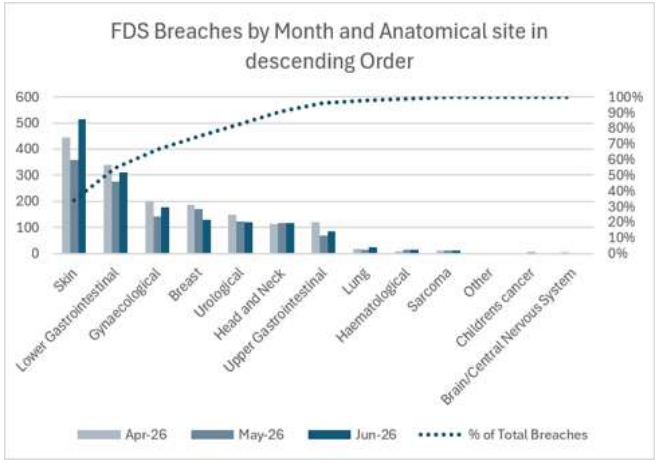
- **Faster Diagnosis Standard** performance was 75.8% in June 2026, an in-month reduction of -2.2%, and also -2.2% lower than a year ago. This deterioration largely driven by an increase in skin patient breaches. National performance was 79%
- National performance was 79%
- This is 6.5% behind plan for Jun-26
- This deterioration largely driven by an increase in skin patient breaches.
- The Trust has committed to hitting the 80% Faster diagnosis standard - ie 80% of patients diagnosed with or without cancer within 28 days, by March-27.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Plan** | 81.3% | 80.6% | 82.3% | 77.5% | 77.8% | 76.3% | 77.0% | 80.9% | 85.9% | 82.1% | 83.6% | 83.2% |
| **Actual** | 73.5% | 78.0% | 75.8% | | | | | | | | | |
| **Variance** | -7.8% | -2.6% | -6.5% | | | | | | | | | |

**Key Actions**

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




**Interdependencies with other performance indicators**

- Delays to cancer treatment can impact patient experience and outcomes

**Exec Owner** Nigel Kee **SRO** Huw Edwards

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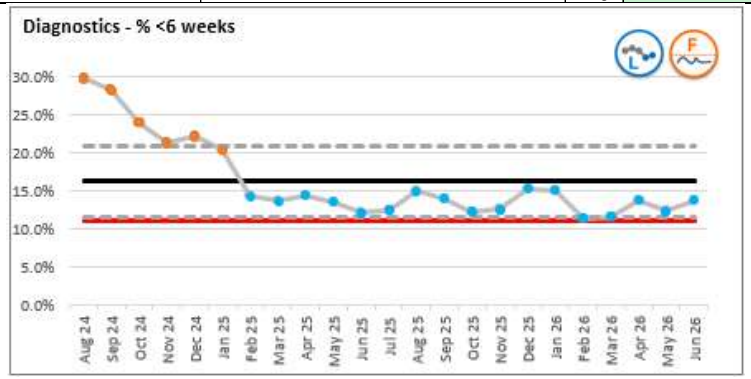
|---|---|---|---|---|---|
| **Elective Care :Diagnostic <6 Week Waits** | **Target** | <=11% by March-27 | | | |
| **Latest Month Plan** | 5.00% | **National Rank** | 40th of 116 (NHS providers >5000 WL size) Feb-26 | | |
| **Latest Month Actual** | 11.60% | **National Performance** | | 20.2% (Feb-26) | |
| **Latest Month Trend** | Increased (worsened) | **NPAF Area: Access to Services** | | **DQ** | Green |

**Key Messages**

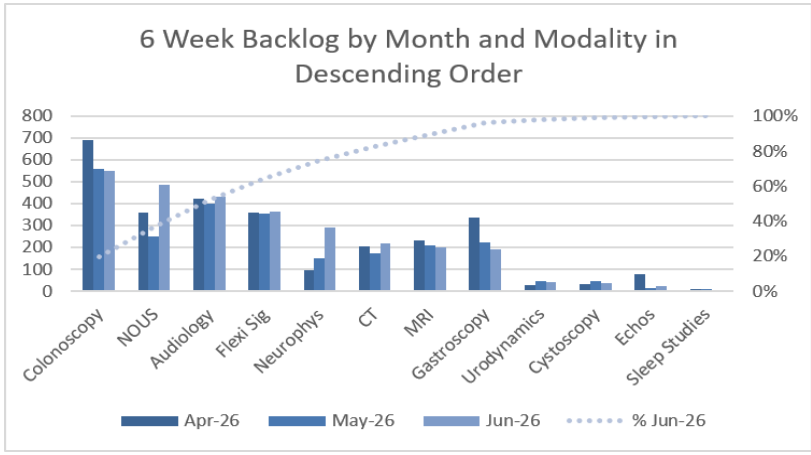
- Diagnostic Performance increased by +1.5% to 13.8% in Jun-26 from 12.3% in May-26, and 1.7% higher than Jun-25. This is 10.2% lower (better) than National average May-26 (24.0%). This is 0.8% behind plan (13%)
- The waiting list size increased by 784 patients in June. The 6 week backlog increased by 401 patients.
- Highest backlog numbers in Jun-26 are endoscopic modalities, non-obstetric ultrasound and audiology and there is an endoscopy recovery program to increase activity to target reducing the backlog within these modalities. This whilst slowed, continued to impact positively in Jun-26 with 35 fewer 6 week waits compared to May-26. Imaging saw an increase of 271 6 week waits, and Neurophysiology saw an increase of 138 backlog in June. The divisional teams are looking to recover these areas.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Plan** | 13.0% | 13.0% | 13.0% | 13.0% | 13.0% | 14.0% | 13.0% | 12.0% | 12.0% | 11.0% | 12.0% | 11.0% |
| **Actual** | 13.8% | 12.3% | 13.8% | | | | | | | | | |
| **Variance** | 0.8% | -0.7% | 0.8% | | | | | | | | | |

**Key Actions**

- The Trust is refreshing recovery plans to target improvement to the 11% Operational Standard March-27 (a reduction of 3% relative to 2025/6) with additional scrutiny at modality level
- Recovery plans will be consolidated and delivered through a new Diagnostic & DM01 Improvement Group. This will provide a single cross-Divisional forum where recovery will be held and driven
- Delivery of diagnostic services is currently reliant on a high degree of both in and outsourcing. Significant focus will be placed on workforce and pathway transformation to both increase efficiency and productivity
- Specific endoscopy transformation actions include a focus on transitioning to TNE endoscopies and ensuring consistent and Trust wide ten point lists




**Interdependencies with other performance indicators**

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

**Exec Owner** Nigel Kee **SRO** Oliver White

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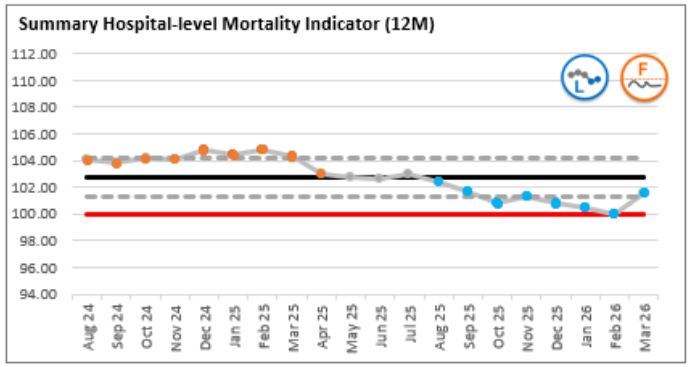
| Our Ambition: Patients: Fairness in access, experiences and outcomes | | | | | |
|---|---|---|---|---|---|
| **Standardised Hospital Mortality Indicator** | **Target** | In Expected Range | | | |
| **24/25 Actual** | 104.3 | **National Rank** | In expected range | | |
| **25/26 Actual** | 101.6 | **National Performance** | 100 | | |
| **Latest Month Trend** | Reduced (improved) | **NPAF Area : Patient Experience** | | **DQ** | Green |

**Key Messages**

- The SHMI (Summary Hospital-level Mortality Indicator) is a measure used in to monitor mortality. The SHMI gives an indication of whether the number of deaths in a hospital is higher or lower than expected, based on the types of patients they treat. It does this by comparing the actual number of patients who die following hospital treatment (either during their stay or within 30 days of discharge) with the number expected to die. The expected number of deaths is calculated using a statistical model that predicts the number of deaths we would expect for a given group of patients, the case mix model used to calculate the expected number of deaths is based on the patients age, gender, primary diagnosis, comorbidities, admission method and socioeconomic factors (like deprivation index)

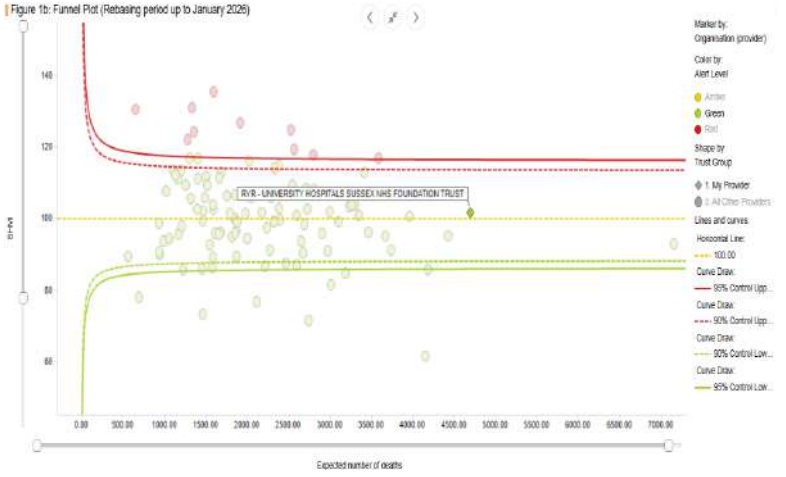
- The SHMI for UHSx is 101.6 (Apr 2025 - March 2026). This result is 'as expected' and is not an outlier.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **24/25 Actual** | 104.2 | 103.1 | 103.6 | 104.3 | 104.1 | 103.8 | 104.2 | 104.1 | 104.8 | 104.4 | 104.8 | 104.3 |
| **25/6 Actual** | 103.0 | 102.7 | 102.6 | 103.0 | 102.6 | 101.7 | 100.8 | 101.3 | 100.8 | 100.5 | 100.0 | 101.6 |
| **Variance** | -1.2 | -0.4 | -1.0 | -1.3 | -1.5 | -2.1 | -3.4 | -2.8 | -4.0 | -3.9 | -4.8 | -2.7 |

**Key Actions**

- Continued montioring and investigation of SHIMI diagnostic code outlier status




**Interdependencies with other performance indicators**

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

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

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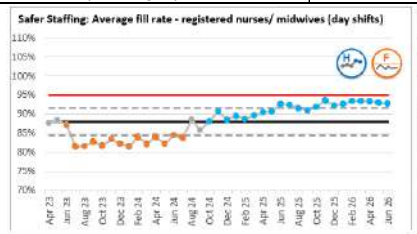
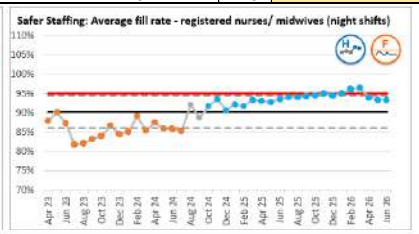
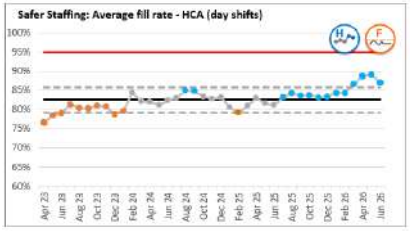
| | **Our Ambition: Patients: Fairness in access, experiences and outcomes** | | | | |
| | **Safer Staffing % Staffing against planned rota** | **Target** | >95% | | |
| | **Latest Month Plan** | | **National Rank** | | |
| | **Latest Month Actual** | Table below | **National Performance** | | |
| |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

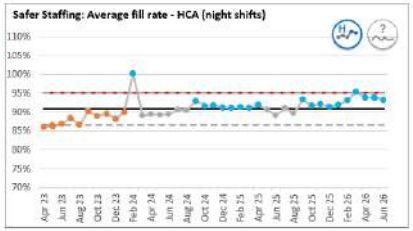
**Key Messages**

- Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN, 2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board).
- Care Hours Per Patient Per Day (CHPPD) trust wide has seen a gradual increase from April 25 . The current position at the end of Q1 is 9.3 , benchmarking with peers was undertaken, ITU, Maternity inpatients paediatrics and neonates were included in their inclusion criteria from April 2026.
- The charts shows the stable fill rate % for Day and Night shifts for Registered Nurses/midwives and Health Care Assistants. Recruitment of our Newly Qualified nurses in Sept will impact this within Q2.




| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Registered Day** | **25/26** | 90.4% | 90.7% | 92.7% | 92.5% | 91.6% | 90.9% | 91.8% | 93.5% | 92.2% | 92.6% | 93.4% | 93.4% |
| | **26/27** | 93.4% | 92.9% | 92.7% | | | | | | | | | |
| **Registered Night** | **25/26** | 93.1% | 92.8% | 93.5% | 94.0% | 94.1% | 94.4% | 94.4% | 95.0% | 94.5% | 95.0% | 96.1% | 96.4% |
| | **26/27** | 93.9% | 93.4% | 93.4% | | | | | | | | | |
| **HCA Day** | **25/26** | 83.0% | 81.6% | 81.2% | 83.2% | 84.3% | 83.6% | 83.7% | 83.1% | 83.3% | 84.3% | 84.3% | 86.6% |
| | **26/27** | 88.7% | 89.1% | 87.0% | | | | | | | | | |
| **HCA Night** | **25/26** | 91.9% | 90.6% | 88.9% | 91.0% | 89.6% | 93.3% | 91.7% | 92.1% | 91.4% | 91.9% | 93.1% | 95.4% |
| | **26/27** | 93.9% | 93.8% | 93.2% | | | | | | | | | |
| **Care Hours/ Patient Day** | **25/26** | 8.0 | 9.0 | 8.9 | 9.2 | 8.20 | 8.23 | 8.20 | 7.80 | 8.00 | 7.6 | 7.8 | 7.8 |
| | **26/27** | 9.4 | 9.2 | 9.3 | | | | | | | | | |

**Key Actions**

- The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce with the skill and experience to deliver quality care.
- There are subgroups focusing on agency/bank reduction, recruitment, targeted retention, roster optimising, enhanced care, workforce diversification and sickness management new KPI's for 26/27 have been set and active deliver is underway.
- Clinical workforce team undertook SNCT audit collection with the plan to undertake reviews using the safer nursing care tool (SNCT) for all inpatient areas in the Sept 26- Nov26 .
- Due to robust recruitment and onboarding there is a direct correlation with the gradual improvement in fill-rate, resulting in a significant reduction in RN and RMN agency. This is reviewed weekly in a agency meeting with the DCN and workforce HON. Further plans are ahead in Q2 to turn it off fully within non specialist areas. Where agency is required this as a last resort with Director of Nursing or Deputy Chief nurse approval.
- Band 5 vacency is at 6.6% and HCA band 2/3 vacency is 10.6%.
- New to care Band 2's are increasing in Worthing and SRH with continued collaboration with DWP
- Retention - we are lower turnover against national average and currently sit at a table 3.4% against trust against 6.51% for registered nurses/midwives and unreg 6.3% against 7.84% .

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

| | | | |
|---|---|---|---|
| **Exec Owner** | **Gail Byrne** | **SRO** | **Annette Gerricke** |

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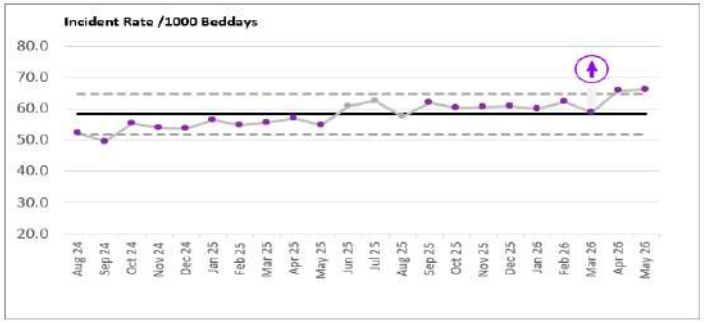
| | **Incidents per 1000 beddays** | **Target** | | | | |
| | **2025/26** | 54.79 | **National Rank** | | | |
| | **26/27 Latest Month Actual** | 66.17 | **National Performance** | | | |
| | **Latest Month Trend** | Increased(improved) | **NPAF Area: Patient Safety** | | **DQ** | Green |

**Key Messages**

- Local targets are based on national Benchmarking
- UHSussex has increased the reporting rate per thousand bed days from 55 in May-25 to 66 in May 2026, thus meeting the Trust target of >60. LfPSE are not currently providing a national benchmark for what organisations will be measured against, although an increase in reporting is indicative of an improving safety culture.
- For actual harms (approved) graded as low, moderate, severe and death the numbers reported for the highest percentage of reported patient safety incidents are graded as no/low harm (97%). Pressure damage and falls, medication incidents and hospital acquired thrombosis are the most common themes within the low harm categories.
- However delays to appointments, diagnosis and lost to follow-up, along with harm free driver such as falls and pressure damage are now the highest recorded categories for both severe and moderate harms.




| Incident Rate | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2025/26** | 56.88 | 54.79 | 60.90 | 62.52 | 57.50 | 61.82 | 60.11 | 60.53 | 60.72 | 59.94 | 62.20 | 58.92 |
| **2026/27** | 65.68 | 66.17 | | | | | | | | | | |
| **Variance** | 8.8 | 11.4 | | | | | | | | | | |

**Key Actions**

- Collaboration with clinical simulation and learning and development with regard to human factors training in patient safety incidents.
- A review of higher risk specialties is underway, including Ophthalmology and OMFS, including with GIRFT and using risk stratification of waiting patients to reduce harms from waits for follow ups.
- Actions to address falls and pressure damage are included in the fundamental standards of care and professional standards programmes of work.
- To improve the quality of Regulation 20 Duty of Candour, the DCIQ incident module has revised the data collection tools and process to ensure Trust compliance, and an audit of DoC letters is supporting quality improvement.
- An RLDatix (DCIQ) training video is now available on Iris to support the understanding of the incident reporting and handling processes.
- The UHSussex Patient Safety Partners support audit of patient safety approaches.

**Interdependencies with other performance indicators**

- Relationship with the top themes from complaints, the fundamentals standards of care (improvement on falls and pressure damage reduction) and waiting times for appointment.

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

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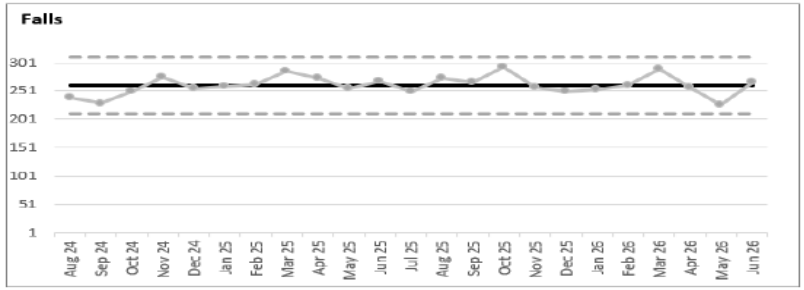
| **Falls** | **Target** | To reduce falls by 30%; 4.2, per 1,000 bed days | |
| **25/26 Actual** | 265 | **National Rank** | |
| **26/27 Latest Month Actual** | 266 | **National Performance** | |
| **Latest Month Trend** | | **NPAF Area: Patient Safety** | **DQ** Green |

**Key Messages**

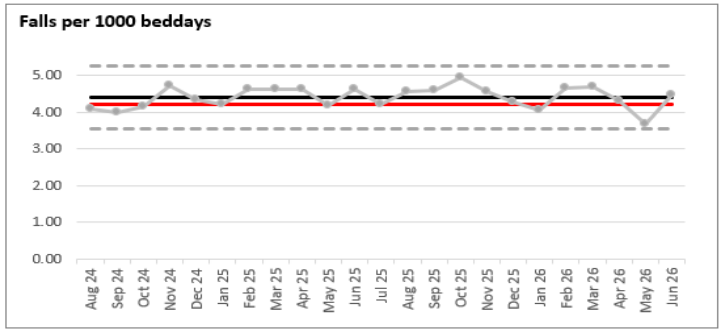
- Falls are a top contributor in terms of harms across UHSussex, and therefore key focussed work area to minimise them.
- There has been a decrease in falls since March 2026, 289 to June 2026 , 266
- 71% of falls (185 patients) in June 2026 reporting no harm.
- Falls Rate per 1,000 bed days March 2026, 4.68. Average rolling year 4.46. Target 4.2. Overall, Trust data is tracking along the mean average and within the upper control limit, for both the number of falls and the number of falls per 1,000 bed days.
- Moderate harm and above falls since April 2026 have not identified pattern or trend currently.




| Numbers | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **25/26** | 273 | 255 | 268 | 249 | 273 | 265 | 293 | 256 | 250 | 253 | 261 | 289 |
| **26/27** | 256 | 226 | 266 | | | | | | | | | |
| **Variance** | -17.00 | -29.00 | -2.00 | | | | | | | | | |
| **/1000 beddays** | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| **25/26** | 4.63 | 4.19 | 4.64 | 4.22 | 4.57 | 4.58 | 4.93 | 4.55 | 4.27 | 4.05 | 4.66 | 4.68 |
| **26/27** | 4.30 | 3.67 | 4.47 | | | | | | | | | |
| **Variance** | -0.33 | -0.52 | -0.17 | | | | | | | | | |

**Key Actions**

- KPIs have been set for falls per 1000 beddays across UHSussex at 4.2 or less.
- The harm free care and education team continue to work with sites and divisions to support quality improvement workstreams.
- The divisions have been driving up improvement opportunities by focussing on the top themes such as completing falls and bedrail risk assessments and undertaking lying/standing blood pressures. This has enabled the identification of actual or potential issues earlier so that mitigations can be put in place.
- Rate of falls will continue to be monitored via the weekly Harm Free Care Group, monthly QGSG and two monthly FSoC patient safety group.




**Interdependencies with other performance indicators**

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

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

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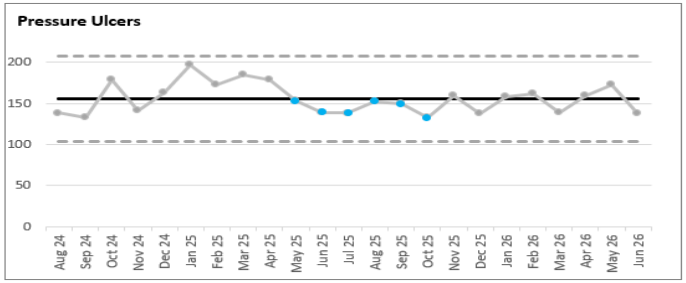
| **Grade 2+ Pressure Ulcers** | **Target** | 2.0 per 1,000 bed days | | | |
| **25/26 Actual** | 150 | **National Rank** | | | |
| **26/27 Latest Month Actual** | 137 | **National Performance** | | | |
| **Latest Month Trend** | Increased(improved) | **NPAF Area: Patient Safety** | | **DQ** | Green |

**Key Messages**

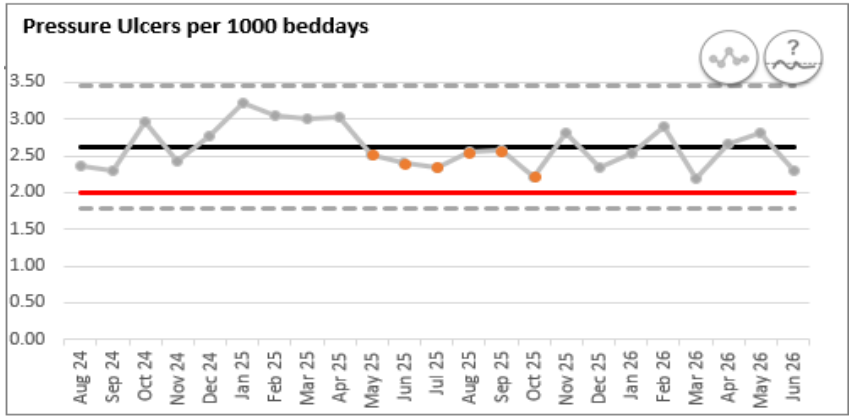
- Risk factors for developing a hospital-acquired pressure injury include older age, immobility, altered mental condition, urinary or faecal incontinence, hospitalisation for fracture, surgical intervention, reduced appetite and nasogastric tube or intravenous nutrition. Research has shown that pressure injuries are preventable. The strategy for preventing pressure injuries relies on two interdependent domains: pressure injury risk identification and pressure injury risk mitigation.
- HAPD –The number of category two HAPU has reducing since March 2026 from 139 to 137 in month.
- The 12 month rolling rate of category two HAPU per 1000 bed days is has reduced from 2.72 to 2.19 (target 2.0).




**Key Actions**

- Purpose T risk assessment being completed on time June 2026 is 87% ( previously 81.4%) across the Trust. The impact of this is that any actual or potential risk factors for pressure damage prevention are identified in a timely manner.
- There has been a decrease in category two HAPU since March 2025, 185 to September, 149. With HAPU Category 2 pressure damage being the most prevalent category.
- PU rate per 1,000 bed days September 2.19 ( Target 2.0) Overall, Trust data is tracking along the mean average and within the upper control limit, for both the number of presure ulcers and the number of pressure ulcers per 1,000 bed days.
- There has been an increase in HA MASD reported in june and the Harm Free Care Team and Essity will be providing education / training to ensure that appropriate continence products are available for all wards. It is thought the recent heat wave has contributed.
- A mattress replacement programme has been completed at PRH, RSCH and St Richards Hospital. WOrthing Hospital is scheduled for September. Further audits are scheduled over the next 12 months as part of a rolling inspection/ replacement plan
- The TVN team in-person teaching and education sessions across UHSussex have been well attended and evaluated.

| Numbers | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **25/26** | 178 | 153 | 139 | 138 | 152 | 149 | 132 | 159 | 137 | 158 | 162 | 139 |
| **26/27** | 159 | 173 | 137 | | | | | | | | | |
| **Variance** | -19.00 | 20.00 | -2.00 | | | | | | | | | |
| **/1000 beddays** | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| **25/26** | 3.02 | 2.52 | 2.40 | 2.35 | 2.55 | 2.57 | 2.22 | 2.82 | 2.34 | 2.53 | 2.89 | 2.19 |
| **26/27** | 2.67 | 2.81 | 2.30 | | | | | | | | | |
| **Variance** | -0.35 | 0.29 | -0.10 | -2.35 | -2.55 | -2.57 | -2.22 | -2.82 | -2.34 | -2.53 | -2.89 | -2.19 |




**Interdependencies with other performance indicators**

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

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

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# Our People

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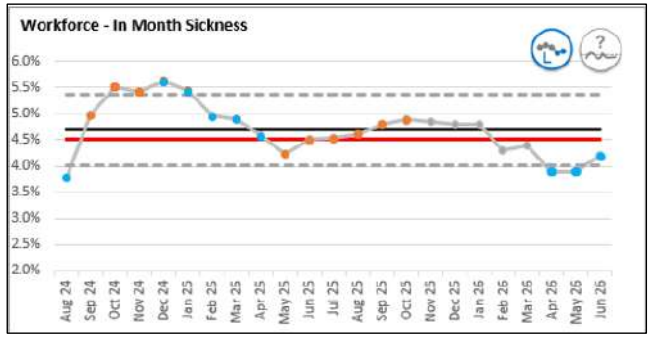
| **Our Ambition: Our People** | | | | | |
| **Sickness Absence Rates** | **Target** | <4.5% sickness | | | |
| **24/25 Month Actual** | 4.30% | **Regional Rank** | | | |
| **25/26 Month Actual** | 4.20% | **National Performance** | 4.7% (May-25) | | |
| **Latest Month Trend** | Increased (Worsened) | **NPAF Area: People and Workforce** | **DQ** | Green | |

**Key Messages**

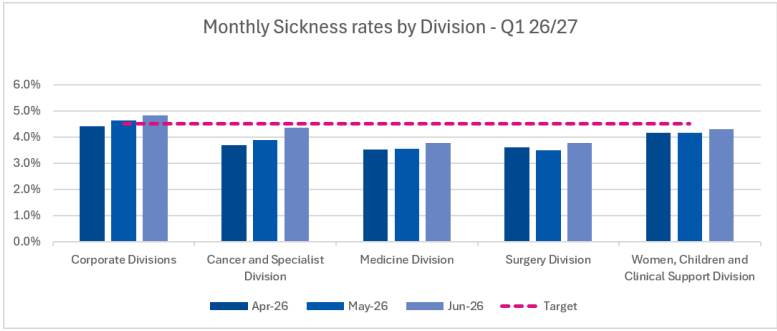
- Sickness rates measure the percentage of staff absence due to illness and reflect staff health and wellbing and workforce capacity. There are in month and rolling average measures, below focuses on Q1.
- Sickness rates have continued to decline on the previous year maintaining 12 month position of 4.6% consistently since December 2025. The in month performance of 3.9% for M1 and M2 of Q1 were the lowest rates seen for some years but rose to 4.2% in M3. For comparison UHSx is below both the national rate of 5.8% and the ICB position of 4.7% but just above the SE Regional rate of 4.4%.
- In M3 of Q1 Surgery and Medicine Divisions were in that month at or below the Trust target of 4%.
- Facilities and Estates continued to deliver improvements in sickness absence during Q1 2026/27. The 12-month rolling sickness absence rate reduced from 6.8% in April to 6.6% in June 2026, continuing the sustained downward trend seen throughout the previous year.
- Estates and ancillary staff continued to demonstrate a sustained reduction in sickness absence during Q1, with the 12-month rolling rate falling to 7.2% in June 2026.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **25/26** | 4.6% | 4.2% | 4.3% | 4.3% | 4.4% | 4.6% | 4.7% | 4.7% | 4.6% | 4.6% | 4.3% | 4.4% |
| **26/27** | 3.9% | 3.9% | 4.2% | | | | | | | | | |
| **Variance** | -0.7% | -0.3% | -0.1% | | | | | | | | | |

**Key Actions**

- **Nursing and Midwifery** - workstream with a focus on 72 hotspot areas for sickness.
- **Governance** - the focus is now on driving further improvements in the new Trust structure to achieve the new Trust sickness target for 2026/7 of 4.5%.
- **Medical Workforce** - a workstream to improve the recording and management of doctors' absence is underway with a range of actions. Further work is needed in this area.
- **Staff Group -** tailored action plans in place for HCAs and Ancillary staff.
- **Winter Preparedness** - planning for Winter 2026/27 has commenced and flu vaccination corporate teams. Target to increase uptake.
- **Health & Wellbeing Plan 2026-2029 -** A refreshed three-year workforce wellbeing plan is being developed, with a draft due to launch in Q2 2026/27 and aligned to the Trust's Strategy. The overall aim is to improve staff wellbeing and reduce ill health and sickness absence by targeting resources more effectively and using evidence-based approaches to deliver the greatest impact.




**Interdependencies with other performance indicators**

- Excessive sickness can impact operational performance and bank and agency spend, and staff morale and motivation

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|---|---|---|---|
| **Exec Owner** | **Sarah-Jane Taylor, Chief People Officer (CPO)** | **SRO** | **Helen Weatherill** |

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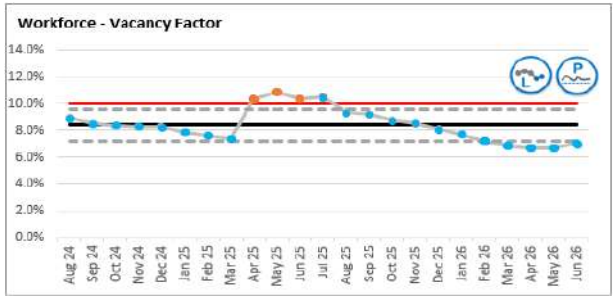
| **Vacancy Factor** | **Target** | <10% | | | |
| **24/25 Month Actual** | 10.40% | **National Rank** | **Not available** | | |
| **25/26 Month Actual** | 7.00% | **National Performance** | Not available | | |
| **Latest Month Trend** | Increased (Worsened) | **NPAF Area: People and Workforce** | **DQ** | Green | |

**Key Messages**

- The vacancy rate expresses, as a percentage of the Trust's overall budgeted establishment in month, the proportion of posts that are vacant. Vacant posts can impact service delivery, safety and temporary staffing costs.
- The Trust's budgeted establishment is 18,217 (increase of 201 from prior year). There are 16,952 wte staff in post (increase of 830 wte from prior year and an increase of 49 wte between Q4-Q1). The Trust has 1,265 wte vacancies as at M03 resulting in a vacancy rate of 7% for M03.
- There has been a significant investment in substantive budgeted establishment (including the N&M workforce to reflect safer staffing tool outputs) and a very successful recruitment drive to fill these newly created posts and to keep vacancy levels with target.
- The Trust has increased its substantive registered nurse workforce by 326 wte staff in the previously 12 months as part of a coordinated approach to reduce agency spend and further improve the continuity of care for our patients.
- The organisation remains in a generally strong position regarding vacancy factor for Q1.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **25/26** | 10.3% | 10.9% | 10.4% | 10.5% | 9.3% | 9.2% | 8.8% | 8.5% | 8.1% | 7.7% | 7.2% | 6.9% |
| **26/27** | 6.7% | 6.7% | 7.0% | | | | | | | | | |
| **Variance** | -3.6% | -4.2% | -3.5% | | | | | | | | | |

**Key Actions**

- The Trust is moving from a proactive recruitment and onboarding strategy to a period of workforce stabilisation to help support financial recovery.
- Work continues to develop the Trust's employer brand **"Excellent Care Starts with You"** including strategies to recruit locally for values and attitude.
- Website content has been refreshed in line with employer brand including talking heads.
- Vehicle wrapping graphics has been developed and agreed to support the brand **"Excellent Care Starts with You"** campaign.
- Work continues to develop a direct sourcing strategy for niche and hard to recruit roles using our in-house Resourcing Partner.
- The Trust continues to build a strong, newly qualified nurse pipeline with candidates scheduled to commence in Q3.
- Key appointments have been made including substantive Chief Delivery Officer and Chief People Officer.

**Interdependencies with other performance indicators**

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

| **Exec Owner** | Sarah-Jane Taylor, Chief People Officer (CPO) | **SRO** | David Vincent |
|---|---|---|---|

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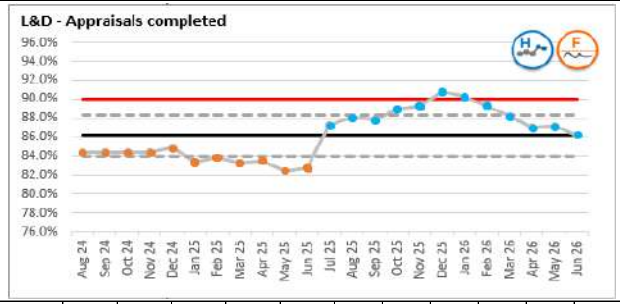
| Annual Appraisal % Compliance | Target | >90% | |
| 25/26 Actual | 82.70% | National Rank | Not available |
| 26/27 Actual | 86.20% | National Performance | Not available |
| Latest Month Trend | Decreased (worsened) | NPAF Area: People and Workforce | DQ: Green |

**Key Messages**

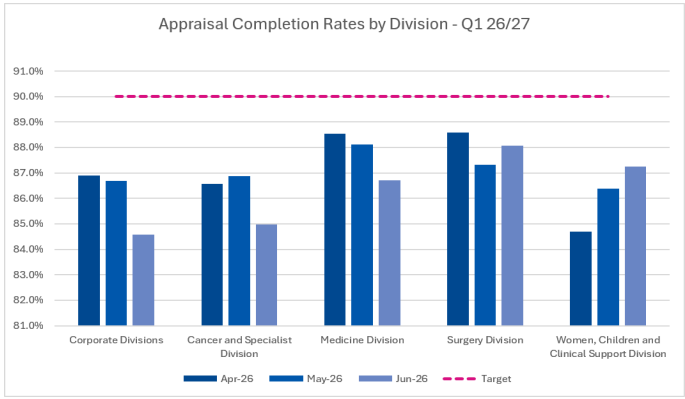
- The metric reports the proportion of eligible non-medical staff who have an Appraisal recorded as complete within the previous 12 months.
- Compliance **fell further** from 86.2% in June to **85.2% in July 2026**, and represents a **continuing month-on-month fall** since December 2025 (90.8%) and is notably lower than July 2025 (87.2%).
- The pattern is seen **across-the-board**, with **8/13 Divisions falling** (from -2.7% pts in CDO and -2.6% pts in CPO, to -.03% pts in CSO). Similarly **8/8 Staff Groups declined** (from -7.2% pts among Students to -0.1% pts among Additional Clinical Services).
- Notably, the two largest % point **falls were in Corporate Divisions** (CDO, CPO), although these are relatively smaller by headcount. The only **notable increase was in CNO** (by +2.2% pts), although this is again a fall since the high of 94.4% in December 2025.
- **Operational pressures** and **organisational change** following the TOM implementation are both likely factors in the reduced compliance (vs 90.0% target).




| Incl Medics | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 25/26 | 83.5% | 82.4% | 82.7% | 87.2% | 88.1% | 87.8% | 88.9% | 89.2% | 90.8% | 90.2% | 89.3% | 88.2% |
| 26/27 | 87.0% | 87.1% | 86.2% | | | | | | | | | |
| Variance | 3.5% | 4.6% | 3.4% | | | | | | | | | |
| **Non-medics** | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| 25/26 | 82.3% | 81.1% | 81.4% | 86.2% | 87.3% | 87.1% | 88.3% | 88.6% | 90.3% | 89.7% | 88.5% | 87.3% |
| 26/27 | 86.8% | 86.8% | 86.2% | | | | | | | | | |
| Variance | 4.5% | 5.7% | 4.8% | | | | | | | | | |

Key Actions

- **New Non-Medical Appraisal documentation** has been introduced to streamline the process, along with a range of guidance tools for appraisers and appraisees. A new **Appraisal E-Learning module** will also shortly be introduced.
- The **quality of appraisals remains positive**. Latest data from the rolling appraisee feedback survey: 79.9% felt it was a positive experience overall, 90.5% agreed they felt safe talking about health and wellbeing, and 91.0% agreed they could discuss all the topics they wanted to.
- Continuing work to build Appraisal into the **Divisional Accountability Meetings** and **with HRBPs** to target support to teams with lowest scores or notably falling rates.
- Staff (who do not have full M365 access) are reporting they **cannot access (complete) the Word form**. This has been escalated to IT.




**Interdependencies with other performance indicators**

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

**Exec Owner** Sarah-Jane Taylor, Chief People Officer (CPO) **SRO** Nick Groves

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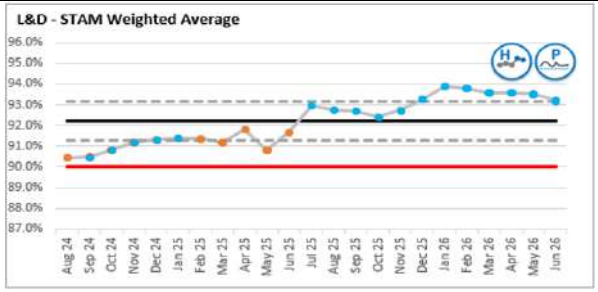
| Our Ambition: Our People | | | | | |
|---|---|---|---|---|---|
| Statutory and Mandatory Training Compliance % | Target | >90% | | | |
| 24/25 Month Actual | 91.67% | National Rank | Not available | | |
| 25/26 Month Actual | 93.16% | National Performance | Not available | | |
| Latest Month Trend | Decreased (Worsened) | NPAF Area: People and Workforce | | DQ | Green |

**Key Messages**

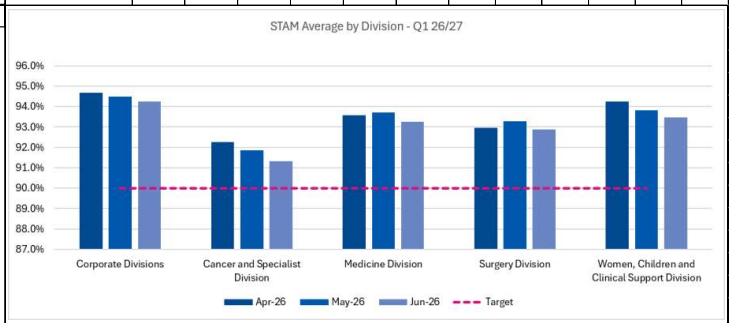
- UHSussex has set a target for all Statutory and Mandatory (STAM) training to have a compliance rate of 90%. The report shows the breakdown of the STAM weighted average (i.e. the average level of compliance across STAM subjects). This training is important in ensuring the safety of patients, staff and the public Some of it is a regulatory or statutory requirement.
- The UHSussex STAM compliance rate continues to be strong, with a rate of 93.2% in M03 (June), and rates of over 90% for twelve months in a row.
- Compliance rates for Medical staff continue to be a bit of an outlier but are rising and now stand at 87.6% (a full 12 months in a row within the 80% range), all other groups are compliant above 90%.
- Divisionally, the picture has improved and no single division is an outlier for M03. This is consistent on M12 where there were no divisional outliers.

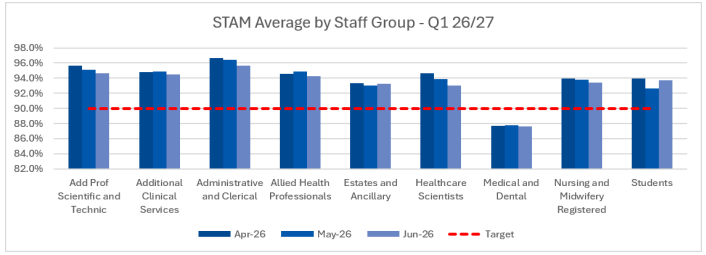



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 25/26 | 91.82% | 90.82% | 91.67% | 92.97% | 92.75% | 92.70% | 92.4% | 92.7% | 93.3% | 93.9% | 93.8% | 93.6% |
| 26/27 | 93.64% | 93.55% | 93.16% | | | | | | | | | |
| Variance | 1.8% | 2.7% | 1.5% | | | | | | | | | |

**Key Actions**

- The maintained rate of compliance has been achieved through targeted staff reminders when they hit the three-month expiry period. Staff are being encouraged to complete before they expire. There is also capacity mapping exercise that is taking place to ensure that we are providing the right number of places across our sites, and this has worked with M&H training which has seen a sustained increase in compliance over the last few months.
- Resus training continues to underperform although compliance has fallen slightly (84.5%). The updated approach has addressed the issue i.e. you can now undertake the practical before theory which has seen better sign up and attendance rates are slowly starting to rise. We are now looking at delivering some training in situ in departments or as part of wider simulation training.




**Interdependencies with other performance indicators**

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

**Exec Owner** Sarah-Jane Taylor, Chief People Officer (CPO) **SRO** Martyn Clark

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# Communities

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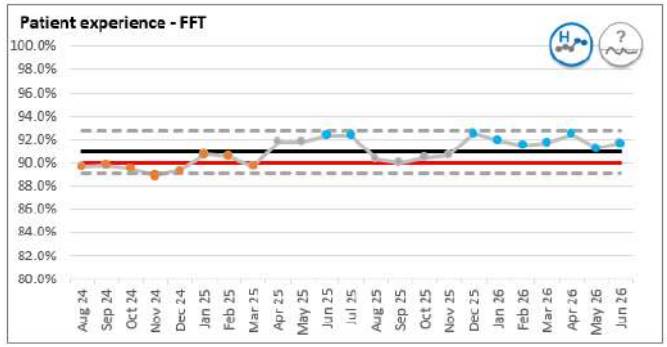
University Hospitals Sussex NHS Foundation Trust

| Our Ambition: Communities | | | | | |
|---|---|---|---|---|---|
| **Patient Experience: FFT** | **Target** | >90% | | | |
| **25/26 Actual** | 92.3% | **National Rank** | 34th of 123 A&E, 103 of 130 Inpatients, 35th of 129 outpatients | | |
| **Latest Month Actual** | 91.7% | **National Performance** | 91.9% (May-26) | | |
| **Latest Month Trend** | Increased (improved) | **NPAF Area: Patient Experience** | | **DQ** | Green |
| **Key Messages** | | | | | |

- The Friends and Family Test (FFT) is a survey being distributed to ask patients to rate their care on a scale of very good (1) to very poor (5) and to give a reason for their score. The survey is grouped into four touchpoints – ED, maternity, inpatients and outpatients.
- Based on available FFT data, the significant majority of patients (91% at the end of Q1 2026/27) are satisfied that they have a good or very good experience of care, based on more than 30,000 responses.
- Patient reported experience of ED closely aligns to 4-hour performance
- The positive experience of care episodes identified through FFT is in contrast to trajectories for volumes of complaints and concerns, which are steeply upward. Triangulated data across complaints, PALS and other patient feedback identifies that the most prevalent causes of poor patient experience are delays to treatment, follow up, referral onward, results and tests, and the communication with the patient (including responsiveness by phone and email). Increases continue to be noted in complaints about the behaviour of doctors.




**Key Actions**

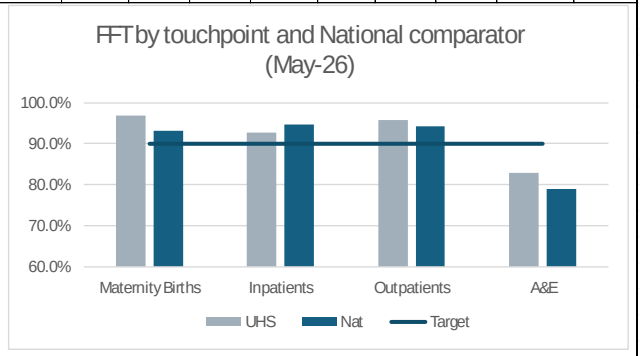
- Emergency department improvements and waits are integrated within the new strategy, and drivers such as 4-hour performance and RTT targets are integrated within the IPR. Patient reported experience via FFT will improve with reducing 4 hour and 12 hour waits, and ambulance handover times.
- To improve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

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **25/26** | 91.8% | 91.8% | 92.3% | 92.3% | 91.7% | 90.0% | 90.4% | 90.7% | 92.5% | 91.9% | 91.5% | 91.7% |
| **26/27** | 92.4% | 91.2% | 91.7% | | | | | | | | | |
| **Variance** | 0.6% | -0.6% | -0.7% | | | | | | | | | |

**Breakdown Latest Month**

May-26

| FFT Scores | UHS | Nat |
|---|---|---|
| Maternity Births | 96.9% | 93% |
| Inpatients | 92.6% | 95% |
| Outpatients | 95.9% | 94% |
| A&E | 82.8% | 79.0% |




**Interdependencies with other performance indicators**

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

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

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# Future



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| Our Ambition: Excellent Care for the Future | | | | | |
|---|---|---|---|---|---|
| **Financial Stablility/ variance from Breakeven Plan** | **Target** | £0 | | | |
| **2026/27 Plan YTD (£m)** | £20.0m deficit | **National Rank** | | | |
| **2026/27 Actual YTD (£m)** | £20.0m deficit | **National Performance** | | | |
| **Latest Month Trend** | Decreased (improved) | **NPAF: Finance and Productivity** | | **DQ** | Green |
| **Key Messages** | | | | | |

- The Trust submitted a breakeven financial plan for 2026/27, with a deficit in Q1 offset by a surplus in Q4. The Trust delivered a deficit in Q1 of £20.0m, in line with plan. There were £9.3m of non-recurrent mitigations supporting the Q1 position.
- Efficiency programme delivery is £5.0m adverse against the internal plan YTD.
- The planned and underlying deficit position is contributing to an increasingly challenging cash position. Prioritisation of cash to ensure the payroll can be paid means that many suppliers are being paid at 90 days beyond the 30 days payment terms; Better Payment Practice Code (BPPC) performance has further dropped to 40% (target 95%).
- Capital programme expenditure is £2.7m greater than plan. The primary driver is expenditure on deferred/multi-year schemes taking place ahead of plan (£6.7m adverse YTD) with partly offsetting delayed expenditure on PDC funded schemes. It is anticipated that timing differences will unwind and programme expenditure will be on plan at year-end.

| **2026/27 M03 £m** | **Annual Plan** | **YTD** | | |
|---|---|---|---|---|
| | | **Plan** | **Actual** | **Variance Fav/(Adv)** |
| I&E (Surplus) / Deficit | 0.0 | 20.0 | 20.0 | 0.0 |
| Efficiency | 140.0 | 17.2 | 12.2 | (5.0) |
| Cash | 3.0 | 3.0 | 3.2 | 0.2 |
| BPPC (volume) | 95% | 95% | 40% | (55%) |
| Capital | 169.7 | 29.6 | 32.3 | (2.7) |

| YTD as at | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Plan** | 7.6 | 14.1 | 20.0 | 20.5 | 20.5 | 20.1 | 17.7 | 14.9 | 12.1 | 8.4 | 4.3 | 0.0 |
| **Actual** | 7.6 | 14.1 | 20.0 | | | | | | | | | |
| **Variance** | 0.0 | 0.0 | 0.0 | | | | | | | | | |

**Key Actions**

- The Trust has appointed a financial imporvement consultant to support maturing the efficiency progrmamme and implementing financial recovery measures including enhanced grip and control measures on areas of variable expenditure.
- A financial recovery plan (FRP) has been constructed; divisions have been set monthly run-rate targets for the remainder of the financial year that are algined to delivery of the FRP.
- Divisional performance continures to be monitored through monthly divisional accoutnability meetings (DAMs) where divisional leadership teams meet with members of the executive team and Trust directors. Where particular concerns are identified at the DAMs, these are supplemented by performance review group (PRG) meetings that provide the opporutunity for a more in depth assessment of the issues and support in developing actrion plans to address them.
- At the end of July the Trust submitted an application for £20m cash support to NHSE. This has been given regional approval and is now under consideration from the national cash team. If successful, cash support would be paid to the Trust in September.

**Interdependencies with other performance indicators**

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

**Exec Owner** Jonathan Reid **SRO** Naeem Uddin

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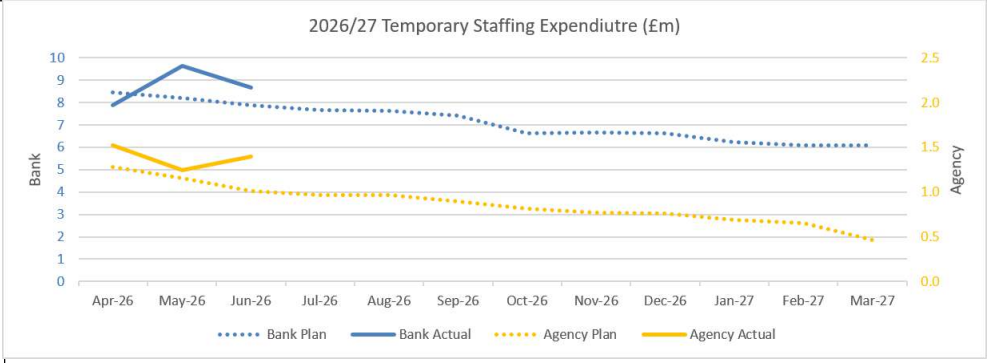
| Our Ambition: Excellent Care for the Future | | | | | |
|---|---|---|---|---|---|
| **Temporary Staffing Expenditure against Plan** | **Target** | For the year 2026/27 less than £85.57m Bank and less than £10.41m Agency | | | |
| **2026/27 Plan YTD (£m)** | 27.98 | **National Rank** | | | |
| **2026/27 Actual YTD (£m)** | 30.35 | **National Performance** | | | |
| **Latest Month Trend** | Decreased (improved) | **NPAF: Finance and Productivity** | **DQ** | Green | |
| **Key Messages** | | | | | |

- The 2026/27 financial plan includes a year-on-year reduction in temporary staffing expenditure of £43.6m from £139.6m in 2025/26 to £95.9m (-31.3%). This comprises a reduction in bank staff expenditure from £115.1m to £85.6m (-25.6%) and a reduction in agency staff expenditure from £24.6m to £10.4m (-57.6%). The financial values given are for revenue expenditure only; temporary staff are also used in delivering some capital projects.
- The reductions in temporary staffing expenditure, particularly the premium agency costs, contribute to delivery of the Trust's efficiency programme and support delivery of high quality care.
- Planned monthly bank expenditure reflects monthly reductions from £8.4m in M1 to £6.1m in M12.
- Actual bank expenditure to M3 is in excess of plan by a cumulative total of £1.7m. This includes the impact of industrial action and the business continuity incident, related to the heatwave at the end of June and early July.
- Agency expenditure is planned to reduce on a monthly basis from £1.3m in M1 to £0.5 m in M12.
- Actual agency expenditure to M3 is in excess of plan in all months giving a cumulative total overspend of £0.72m year-to-date.
- Notes on temporary staffing classifications:
- - Waiting list initiative payments are reported within bank expenditure.
- - Staff employed under the direct engagement route are reported within agency.




| £m | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 | YTD | Annual Plan |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bank Plan | 8.44 | 8.20 | 7.90 | 7.66 | 7.64 | 7.42 | 6.63 | 6.66 | 6.63 | 6.22 | 6.10 | 6.09 | 24.53 | 85.57 |
| Bank Actual | 7.89 | 9.64 | 8.66 | | | | | | | | | | 26.18 | |
| Variance | 0.55 | (1.43) | (0.76) | | | | | | | | | | (1.65) | |
| Agency Plan | 1.28 | 1.15 | 1.01 | 0.97 | 0.96 | 0.89 | 0.81 | 0.77 | 0.76 | 0.69 | 0.66 | 0.46 | 3.45 | 10.41 |
| Agency Actual | 1.53 | 1.24 | 1.40 | | | | | | | | | | 4.17 | |
| Variance | (0.24) | (0.09) | (0.38) | | | | | | | | | | (0.72) | |
| Combined Plan | 9.72 | 9.35 | 8.91 | 8.63 | 8.61 | 8.31 | 7.44 | 7.42 | 7.38 | 6.90 | 6.76 | 6.55 | 27.98 | 95.98 |
| Combined Actual | 9.41 | 10.88 | 10.06 | | | | | | | | | | 30.35 | |
| Variance | 0.30 | (1.53) | (1.15) | | | | | | | | | | (2.37) | |

**Key Actions**

- Bank rates have been held at 2025/26 levels with the exception of rates for Agenda for Change Band 2 and some Band 3 staff; these increased to ensure payments were not below minimum wage.
- Electronic rostering of medical staff continues to be rolled out which will support the optimisation of the deployment of staff and provide greater visibility of issues such as sickness enabling appropriate management actions to be taken.
- Information on nursing and midwifery agency usage and addtional shifts booked above templated rosters is shared with managers on a weekly basis to highlight areas where investigation or further action is required.
- The Deputy Chief Nurse is leading detailed reviews of bank usage on a ward-by-ward basis.

**Interdependencies with other performance indicators**

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

**Exec Owner** Jonathan Reid **SRO** Naeem Uddin

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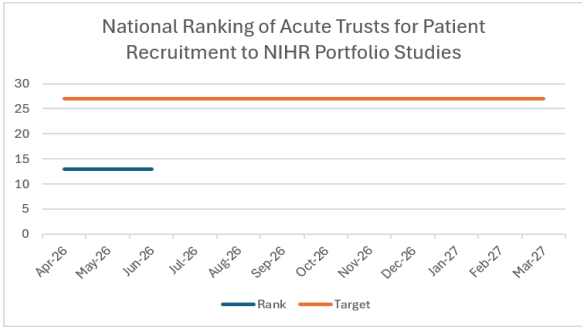
| Our Ambition: One UHSx | | | | | |
|---|---|---|---|---|---|
| **Recruitment to studies national ranking** | **Target** | 27th or less | | | |
| **25/26 Actual** | 30th | **National Rank** | 13/134 | | |
| **26/27 Actual** | 13th | **National Performance** | Q1 | | |
| **Latest Month Trend** | Increased (improved) | **NPAF Area: Access to Services** | | **DQ** | Green |
| **Key Messages** | Opportunities for patients to benefit from participating in research have widened, recruitment ranking has improve | | | | |

- Research and innovation are central to high-quality, sustainable healthcare, ensuring patients benefit from the latest advances. Beyond individual studies, a strong research culture improves care quality, strengthens community engagement, and supports system resilience. It also enhances staff development and helps attract and retain talent. For these reasons, the Trust has placed research and innovation at the heart of its strategy.
- This year opportunities for patients to benefit from participating in research have widened. This chart shows shows the the 2026-27 Q1 Acute Trust ranking in terms of total recruitment to studies on the NIHR portfolio. At Q1 the Trust was ranked 13th putting it just outside the top 10% of recruiting Acute Trusts. Recruitment stood at 2095. This indicator is subect to our hospital sites being selected for high recruiting studies, this is dependent on factors such as having the relevant population required to answer the reserach question. The Trust consistently perfoms well in respect of the number of studies it has open to recruitment.




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

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

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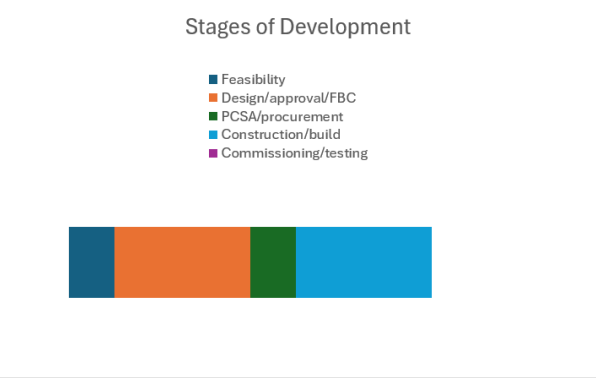
# Major Projects Portfolio Overview

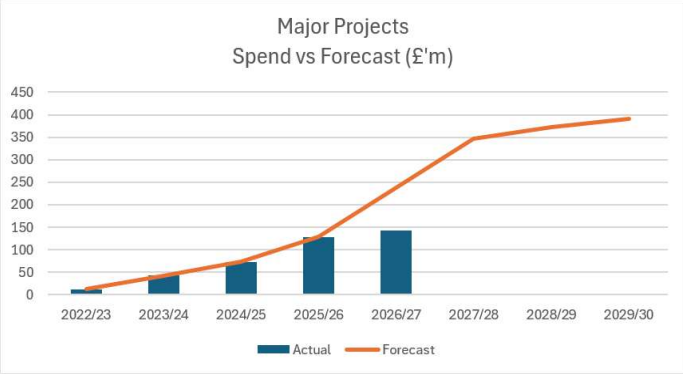
The health of the Major Projects Portfolio has remained positive & stable over the period with only 1 project becoming challenged. The **3Ts Stage 2 - Sussex Cancer Centre** continues to run ahead of programme providing a buffer should challenges arise. In the current period we presented our operational commissioning programme to the New Hospitals team which cemented confidence in our plans. The **SRH RAAC** strategic outline business case, seeking £280 million to replace RAAC at St Richard's will be recommended by FPC to Board this week to enable onward submission to NHSE and Joint Investment Committee. The **EPR** programme is progressing well and running to plan, it is subject of a deep dive at SMPB/EMC giving the opportunity for greater visibility. The **Stroke Reconfiguration** project is moving into a key phase with planned bed closures occurring from August, preparation for the workforce consultation (October commencement). There is a requirement to appoint a new Project SRO following implementation of the TOM. Agreement on enabling works for the next stage of **RSCH Acute Floor reconfiguration** is being finalised and new cost advisors are being appointed. The tender for **Southlands Theatre** works is now live, with the future planned utilisation solidifying around Ophthalmology service supporting the development of a detailed clinical model. The **Southlands Theatres** project is interdependent with elements of the Ventilation programme and its delivery of procedure room capacity to support move of activity out of theatres. The **Ventilation** programme has been challenged in the last period with delays to the installation and commissioning of the relocatable theatres and a change of approach to the ventilation work. The deep dive presented at SMPB/EMC will detail actions being taken to bring the programme back on track. In the coming period **Property Rationalisation** will deliver significant progress including the move of EBME out of SMH into LMB and the planned marketing of the Outpatients Building. **Clinical Research Facility** project is progressing with SPFT partnership contract discussions and the demand/capacity modelling. While the **Helipad** has been closed as a major project it is opportune to report it has been operating very successfully, with landings running at an average of around 2.9 per week, ahead of forecast, and we have commenced the lengthy process of applying for a change to planning conditions. We would not expect to receive any enforcement action during this process.

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

**Major Decisions in forthcoming period (July-Sep 26):**

- RAAC Project – Board approval to submit Strategic Outline Case for £280m to NHSE

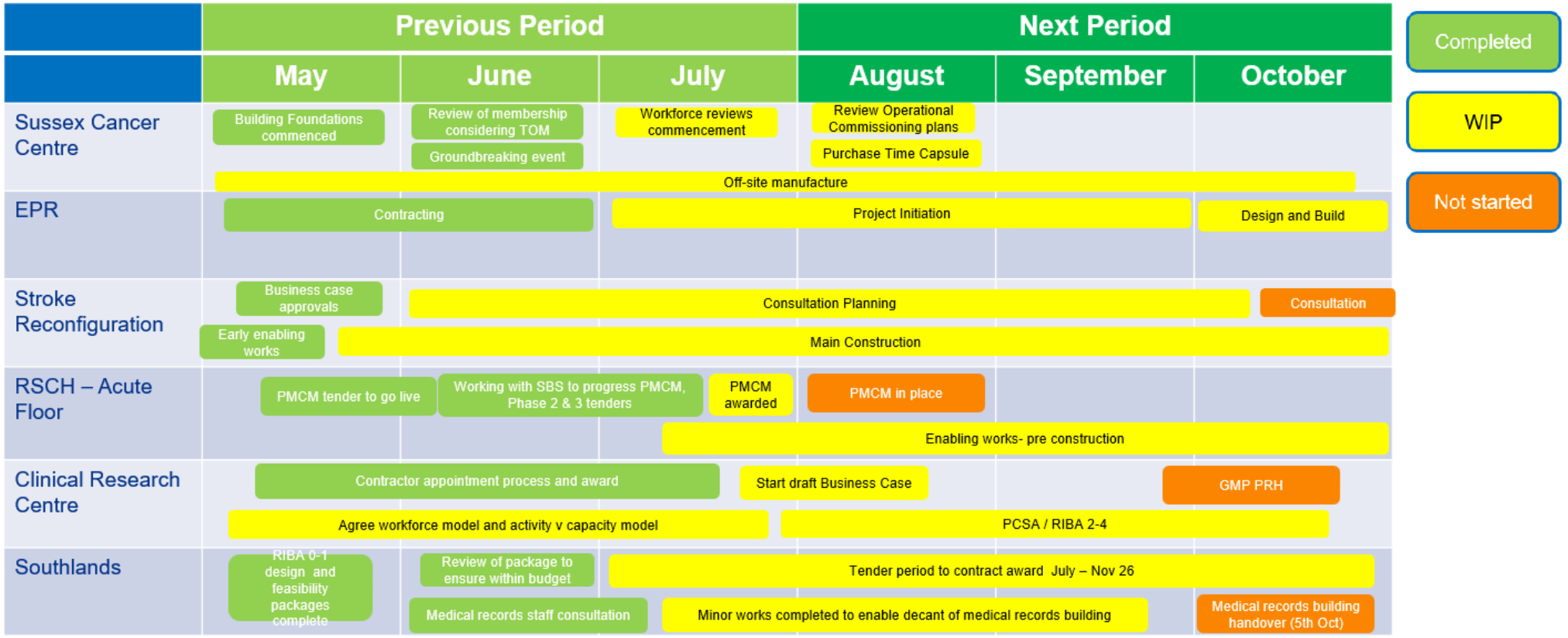


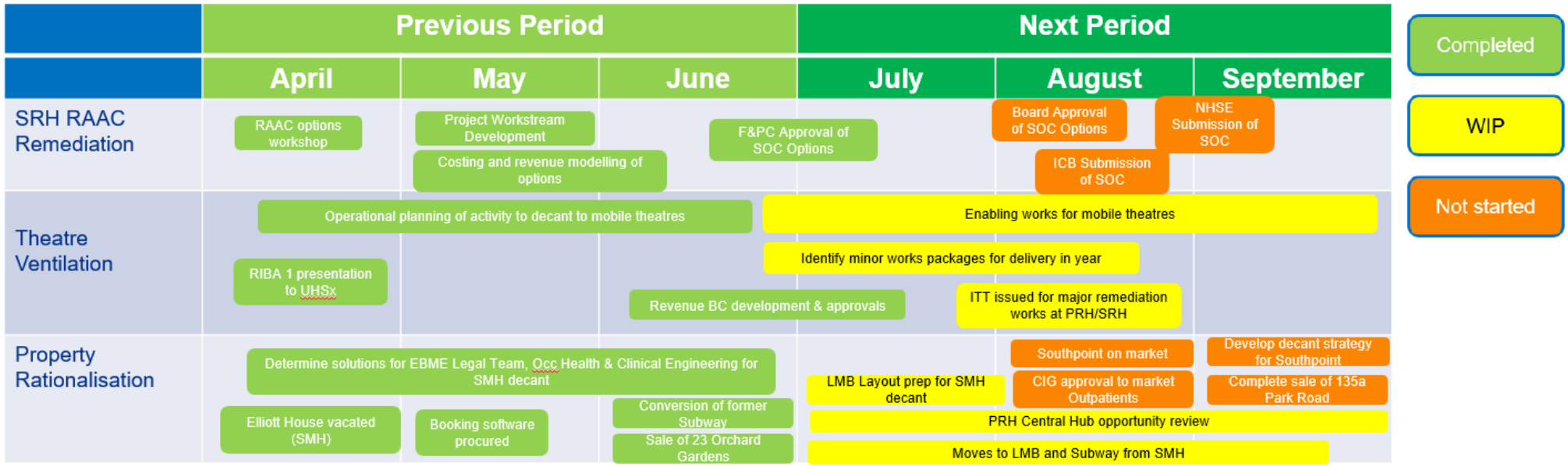
# Anticipated Challenges and focus in the next period

| Major project | Challenges and Actions in Next Period |
|---|---|
| Stroke | • Meeting with new Medicine team re Worthing beds and the therapy workforce model<br>• Handover of Boxgrove Ward on 24th August for 11 weeks with 27 beds closed – Agreed plan in place with SRH Hospital Director<br>• Workforce consultation preparation is advanced with mid October 2026 the anticipated start date – affects nearly 300 staff across 14 professional groups |
| RSCH AFR | • NHSE funding of £5m at risk as aligned to in-year spend FY26/27; Enabling works scheduled to complete in FY27/28. Engaging with NHSE with spend profile and expected deliverables and benefits for this financial year.<br>• Gap in budget stands at £1.5m; contingency of £6m to be reviewed against costed risk register<br>• Medicine division need to develop plan for reduced corridor care capacity and elimination of MH ward<br>• Expected revenue case to support clinical model. Workforce model being robustly tested against national standards. |
| Southlands Theatres | • Cost report within budget, tender is live<br>• Confirming support by NHSE for extended programme due to procurement framework changes and design changes<br>• Due to extended programme NHSE unable to confirm funding for entire programme, gap of £4 million. Finance reviewed as a low risk and agreed to progress programme with the intention to reengage with NHSE for funding opportunities.<br>• Compliance with BREEAM regulation and mitigation of imposed costs |
| SRH RAAC Remediation | • Trust Board approval of SOC required<br>• Continue NHSE engagement to secure support for preferred option with NHSE RAAC remediation fund- broadly accepting of current PWF<br>• Progress SOC to OBC |
| Ventilation programme | • Theatres have arrived on site, focus will be on connection, set up and commissioning this needs to be completed with urgency<br>• Decant options for RSCH agreed at CTB, 10 sessions a week, this allows work to commence however not at required pace. Further decant/capacity options being reviewed to support RSCH.<br>• Review of programme to reduce timelines to be instigated. Clear focus of works to deliver in year improvement to our ventilation systems across sites, engaging with contractor for works.<br>• Challenges raised from surgeons on decanting activity to vanguard theatres. Ops teams developing alternative plans to ensure utilisation. |
| Property Rationalisation | • Secure approval to market for sale the Outpatients Building in Brighton<br>• Relocation of EBME from SMH to LMB |

# Key Milestones in previous and next period – August 2026



# Key Milestones in previous and next period – August 2026 cont.



# One UHSussex

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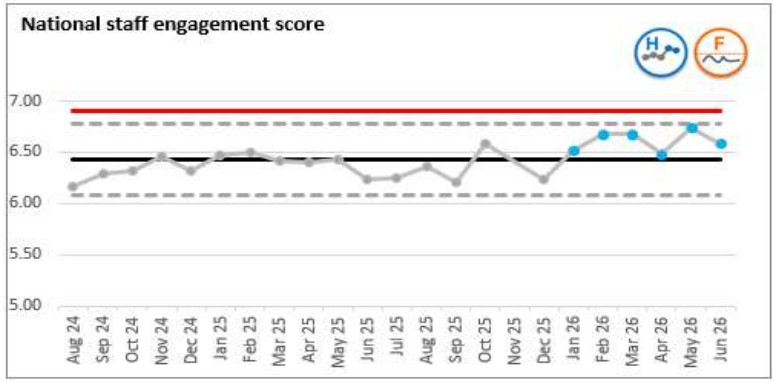
| Our Ambition: One UHSx | | | | | |
|---|---|---|---|---|---|
| **Staff Engagement Scores** | **Target** | >6.9 | | | |
| **25/26 Actual** | 6.2 | **National Rank** | UHSussex ranked 72 out of 121 (Actue/Acute & Community) - 2025 | | |
| **26/27 Actual** | 6.6 | **National Performance** | 6.68 - Annual 2025 national NHS Staff Survey | | |
| **Latest Month Trend** | Reduced (worsened) | **NPAF Area: People and Workforce** | | **DQ** | Green |

**Key Messages**

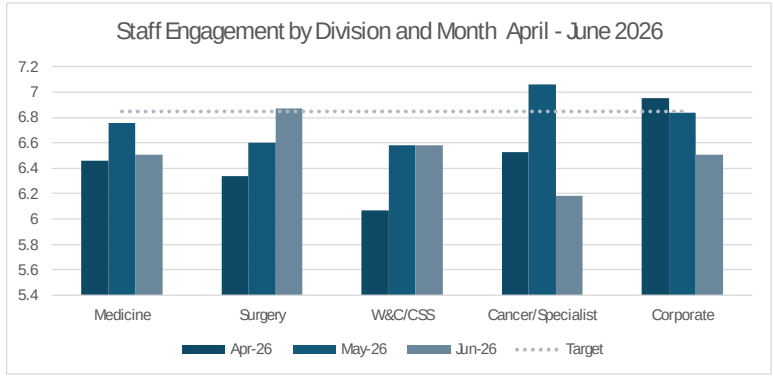
- Staff engagement is measured nationally through the annual NHS Staff Survey and quarterly People Pulse survey, and locally through the monthly UHSussex Pulse Survey.
- The first quarter of the 2026/27 year has remained below the national average staff engagement score in the monthly UHSussex Pulse Survey, ending with a score of 6.6 (out of 10) in June 2026 (Q1 score range: 6.48 to 6.74). This is compared to our 6.2 score in June 2025. The Trust achieved the staff engagement target in the first quarter of 2024 but it has been consistently below 7.0 from July 2024 onwards.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **25/26** | 6.4 | 6.4 | 6.2 | 6.3 | 6.4 | 6.2 | 6.6 | | 6.2 | 6.5 | 6.7 | 6.7 |
| **26/27** | 6.5 | 6.7 | 6.6 | | | | | | | | | |
| **Variance** | 0.1 | 0.3 | 0.4 | | | | | | | | | |

**Key Actions**

- Divisional action plans developed in response to the 2025 NHS Staff Survey continue to be implemented, with preparatory work underway to support the launch of the 2026 NHS Staff Survey in Q2, including development of a communications plan and reporting arrangements aligned to the Trust's new operating model (TOM).
- People, Culture and One UHSussex programmes remain aligned to the Trust's strategic Ambitions and Priorities and the NHS People Promise, ensuring delivery of workforce priorities that enhance staff experience, engagement, wellbeing, inclusion and organisational culture.
- The emerging Strategy Delivery and Improvement Framework (SDIF) will support greater alignment between Trust Strategy priorities, organisational improvement activity, statutory undertakings and assurance reporting, strengthening oversight of People, Culture and One UHSussex priorities through a single integrated framework.
- Progress continues to be monitored through established governance arrangements, with 10 of 13 People and Culture programmes (77%) rated on track at the end of Q1 2026/27. Key achievements during the quarter included continued implementation of the Trust-wide Occupational Health service, improved payroll accuracy, strengthened staff voice and speaking up arrangements, delivery of Integrated Education Plan milestones, leadership development activity, and ongoing embedding of the Behavioural Compass and One UHSussex culture initiatives.




**Interdependencies with other performance indicators**

- When triangulating a low staff engagement score with other workforce metrics, it is common to see a correlation with high sickness absence and turnover rates. However, these rates are comparatively positive (4.2% and 5.7% respectively) and our stability rate is 92.4%.

**Exec Owner** Sarah-Jane Taylor, Chief People Officer (CPO) **SRO** Helen Weatherill, Director of HRM

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# National Performance Assessment Framework and League Tables

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# National Performance Assessment Framework to Q4 2025/6

University Hospitals Sussex NHS Foundation Trust

| Score | Q1 | Q2 | Q3 | Q3 Segment | Q4 | Q4 Segment | Direction |
|---|---|---|---|---|---|---|---|
| Access to Services | 3.05 | 3.15 | 3.22 | 4 | 3.11 | 4 | -0.11 |
| Finance & Productivity | 1.67 | 1.75 | 2.5 | 3 | 2.28 | 3 | -0.22 |
| Effectiveness & Experience | 2.59 | 2.59 | 2.52 | 4 | 2.64 | 4 | 0.12 |
| Patient Safety | 3.35 | 3.21 | 3.23 | 4 | 3.05 | 4 | -0.18 |
| People & Workforce | 2.86 | 2.66 | 2.66 | 3 | 2.16 | 2 | -0.5 |
| Average Total Score | 2.82 | 2.84 | 2.95 | 4 | 2.81 | 4 | -0.14 |

| Ranking | Q1 | Q2 | Q3 | Q3 Segment | Q4 | Q4 Segment | Direction |
|---|---|---|---|---|---|---|---|
| Access to Services | 113 | 116 | 120 | 4 | 120 | 4 | 0 |
| Finance & Productivity | 19 | 28 | 60 | 3 | 68 | 3 | 8 |
| Effectiveness & Experience | 119 | 113 | 106 | 4 | 125 | 4 | 19 |
| Patient Safety | 129 | 121 | 127 | 4 | 116 | 4 | -11 |
| People & Workforce | 89 | 82 | 83 | 3 | 56 | 2 | -27 |
| Average Total | 117 | 113 | 121 | 4 | 121 | 4 | 0 |

- Latest NOF ratings published 11 June 26 for Q4 2025/6.
- @ Q4, UHSx remained Segment 4 overall rating
- Overall ranking static at 121 Q4 compared to Q3 despite improvement between quarters (as other Trusts also improved)
- The next update will be against a revised framework for Q1 2026/7 with 13 additional metrics, expected September-26

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# Summary of Q4 segmentation key drivers and actions

| Domain | Segment | Key Drivers | Key Changes Q4 v Q3 | Key Actions | BAF |
|---|---|---|---|---|---|
| Access to Services | 4 | RTT Performance, UEC | UEC worse for rank and % performance; RTT plan 18 week % hit improved; Whilst 28 day FDS improved , relative rank worsened; community waits 52+ improved but remains worst quartile | UEC Support; Planned Care board, and tactical transformation | SR1 SR2 |
| Finance & Productivity | 3 | Financial plan/break even; implied productivity | Plan hit for break even | CIP and productivity programme focus 2026/7 | SR10 |
| Effectiveness & Experience | 4 | Discharge ready to discharge date | Worsened in Q4 in actual and rank terms | Links to uec key actions/nctrs with system | SR1 SR6 |
| Patient Safety | 4 | Staff survey raising concerns sub score | Marginal improvement in 2025 staff survey but still material outlier | Q&S programme, and behavioural compass | SR3 SR11 |
| People & Workforce | 2 | Staff Survey - engagement theme sub score | Improved staff engagement score improved position to segment 2 | Behavioural compass and TOM, plus ongoing engagement work | SR11 SR12 |

# National Performance Assessment Framework Q4

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| Domain | Metric | Q1 | | | Q2 | | | Q3 | | | Q4 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Value | Score | Rank | Value | Score | Rank | Value | Score | Rank | Value | Score | Rank | Change from Q3 |
| Access to Services | % of patients meeting the 28 day faster diagnosis standard | 76.39 | 2.83 | 66/118 | 72.98 | 3.22 | 85/118 | 77.09 | 2.6 | 64/118 | 77.48 | 2.77 | 77/117 | 0.17 |
| Access to Services | % of patients treated within 62 days of referral | 61.60 | 3.53 | 98/118 | 60.93 | 3.58 | 101/118 | 66.08 | 3.14 | 85/118 | 66.39 | 3.20 | 85/118 | 0.06 |
| Access to Services | % of patients waiting less than 18 weeks for community care | 33.1% | 3.8 | 73/80 | 23.0% | 3.75 | 72/79 | 19.7% | 3.64 | 67/77 | 18.2% | 3.65 | 68/78 | 0.01 |
| Access to Services | % of patients waiting over 52 weeks for care | 5.2% | 3.92 | 127/131 | 4.4% | 3.80% | 121/131 | 4.1% | 3.83 | 123/131 | 3.2% | 3.87 | 126/130 | 0.04 |
| Access to Services | % of patients waiting up to 18 weeks for care | 51.3% | 3.86 | 125/131 | 51.6% | 3.88 | 126/131 | 51.1% | 3.93 | 128/131 | 55.1% | 3.98 | 129/130 | 0.05 |
| Access to Services | Difference between planned and actual 18 week performance | 64% | 1 | 70/131 | 6% | 1 | 62/131 | -187% | 2.65 | 69/131 | 2% | 1 | | -1.65 |
| Access to Services | % of patients admitted, discharged or transferred within four hours | 72.6% | 2.89 | 77/123 | 70.6% | 3.38 | 99/123 | 69.4% | 3.42 | 97/123 | 67.4% | 3.59 | 105/123 | 0.17 |
| Access to Services | % of patients spending over 12 hours in department | 8.9% | 2.55 | 64/123 | 9.1% | 2.6 | 64/119 | 8.2% | 2.52 | 63/123 | 9.9% | 2.81 | 74/122 | 0.29 |
| Effectiveness and Experience | Average days from discharge ready date to actual discharge date | 1.7 | 3.78 | 117/126 | 1.8 | 3.76 | 115/125 | 1.5 | 3.57 | 109/127 | 2.0 | 3.93 | 125/128 | 0.36 |
| Effectiveness and Experience | Summary Hospital Mortality Indicator | | 2 | | | 2 | | | 2 | | | 2 | | 0 |
| Effectiveness and Experience | CQC inpatient survey satisfaction rate | | 2 | | | 2 | | | 2 | | | 2 | | 0 |
| Finance and Productivity | Planned surplus/deficit | -1.6 | 3.00 | 67/134 | -1.6 | 3.00 | 69/134 | -1.6 | 3.00 | 69/134 | -1.6 | 3.00 | 69/134 | 0 |
| Finance and Productivity | Variance to plan year-to-date | 0.1 | 1.00 | 18/134 | 0.0 | 1.00 | 46/134 | -0.1 | 2.00 | 66/134 | 0.3 | 1.00 | 56/134 | -1 |
| Finance and Productivity | Implied Productivity Level | 6.4 | 1.34 | 16/134 | 5.9 | 1.50 | 23/134 | 3.8 | 1.99 | 45/134 | 2.5 | 2.56 | 70/134 | 0.57 |
| Patient Safety | NHS staff survey raising concerns sub-score | 6.0 | 3.75 | 123/134 | 6.0 | 3.75 | 123/134 | 6.0 | 3.75 | 123/134 | 6.1 | 3.46 | 110/134 | -0.29 |
| Patient Safety | Number of cases of MRSA in the last 12 months | 3.0 | 2.63 | | 2.0 | 2.33 | | 4.0 | 3.01 | | 5.0 | 3.12 | | 0.11 |
| Patient Safety | Rate of c-difficile | 1.3 | 3.41 | | 1.3 | 3.26 | | 1.2 | 2.63 | | 1.1 | 2.36 | | -0.27 |
| Patient Safety | Rate of e-coli | 1.2 | 2.79 | | 1.1 | 2.43 | | 1.1 | 2.50 | | 1.1 | 2.45 | | -0.05 |
| People and workforce | NHS staff survey engagement theme score | 6.6 | 3.55 | 114/134 | 6.6 | 3.55 | 114/134 | 6.6 | 3.55 | 114/134 | 6.7 | 2.87 | 84/134 | -0.68 |
| People and workforce | Sickness absence rate | 5.1 | 2.18 | 63/134 | 4.3 | 1.76 | 45/134 | 4.66 | 1.76 | 46/134 | 4.8 | 1.46 | 29/134 | -0.3 |

- Worse performance Q4 : 28 day FDS; 52+ Weeks (in rank terms), 4hr, 12 hr uec performance; MRSA worsened by 1
- Better: 62 day cancer; 18 week hitting plan; finance hitting break even; marginal improvement c-diff, e-coli, sickness absence, staff engagement scores 2025 staff survey, and raising concerns sub-score

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# New and Excluded Metrics 2026/7

| Status | Metric | Standard | Q4 Value | Q4 Score | Q4 Rank |
|---|---|---|---|---|---|
| New | % of diagnostic referrals waiting over six weeks | | 11.60 | 1.19 | 34/114 |
| Remove | Average days from discharge ready date to actual discharge date | | 2.0 | 3.93 | 125/128 |
| New | 30 day readmission rate band | | | 2.4 | 95/158 |
| New | Rate of pregnant women with a planned induction that are delayed | | | | |
| New | NHS staff survey advocacy rate | | 0.6 | 2.41 | 73/121 |
| Remove | Implied Productivity Level | | 2.5 | 2.56 | 70/134 |
| New | % of clinical trials set up within 90 days | | | 2.00 | |
| New | Data Quality Maturity Index | | | 1.00 | 44/198 |
| New | Relative cost difference (National Cost Collection Index) | | 102 (MFF Adjusted) | 2.50 | 113/207 |
| New | Breadth and depth of clinical audit outliers | | | 3.00 | |
| New | Healthcare Worker Flu Vaccination Rate | | Above Plan | 1.00 | |
| New | National Education and Training Survey satisfaction rate | | 0.7 | 2.60 | 79/122 |
| New | NHS staff standards score | | | | |
| New | Temporary staffing cost as a % of total pay bill | | 11.38% | 4.00 | |
| New | % of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service | | | | |

- These metrics are being added (New) or removed, in a revised framework for 2026/7. Initial review indicates a potentially improved position with the addition (and removal) of these metrics (as trust performance is better than 4 in Q4 estimates). Actual Q1 is anticipated in September 2026.

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| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 20. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 17 September 2026 |
| **Report Title:** | Board Assurance Framework report Q1 2026/27 | | | | |
| **Executive Sponsor** | Helen Brown – Interim Chief Corporate Affairs Officer | | | | |
| **Author(s):** | Glen Palethorpe – Company Secretary | | | | |
| **Purpose of the report:** *(indicate as appropriate)* | **For Decision** | **For Assurance** | **For discussion** | **For Information only** | |
| | *Yes* | *Yes* | *Yes* | *N/A* | |
| **Reason for not being taken in public** *(indicate as appropriate)* | **Commercial confidentiality** | **Staff confidentiality** | **Patient confidentiality** | **Other exceptional circumstances (please detail)** | |
| | *N/A* | *N/A* | *N/A* | *N/A* | |
| **Regulatory Reporting Requirement** | *NHS organisations are required to have effective risk management processes and are expected to have in place and effective Board Assurance Framework covering their Strategic risks* | | | | |

**Summary of the report describing**

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

The Board at its meeting in March it agreed 12 Strategic Risks, as part of this Board review, with the 2026/27 Board Assurance Framework (BAF) being orientated to these risks. Each strategic risk has an allocated Executive lead and oversight Committee.

The respective lead Executives have updated the BAF in respect of their review of the assurances received in quarter allowing them to provide of their proposed quarter 1 scores.

The Audit Committee in its meeting in July was assured over the continuing underpinning processes for the executive oversight and update of the BAF.

Each allocated oversight Committee considered their element of the BAF and agreed with the executives view that the reports and assurance received in quarter 1 did not support any change to the initial risk scores for 2026/27.

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

The Board can take assurance over the underpinning BAF oversight processes.

The Board is asked to note the recommendations of the respective committees that there should be no reduction in any of the strategic risk scores for quarter and the observations made the Patient and Quality and Finance and Performance oversight committees as to the degree of risk in the achievement of the planned actions for SR1, SR2 and SR10.

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

The Board is asked to note the recommendations of the respective committees that there should be no reduction in any of the strategic risk scores for quarter 1. The Board is also asked to consider the respective comments from the Patient and Quality and Finance and Performance oversight committees the degree of risk in the achievement of the planned actions for SR1, SR2 and SR10 to enable these risks to meet their agreed target scores.

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| | |
|---|---|
| **Recommendation** *(linked to What Next section)* | The Board should **NOTE** the assurance provided by the respective Committee review of their BAF segments.<br><br>The Board is asked **AGREE** the quarter 1 scores, noting the support for these scores by the relevant oversight committees.<br><br>The Board is asked to **CONSIDER** the comments provided the Patient and Quality Committee on the need for the Infrastructure Target risk score to the determined and the Finance and Performance Committee reflection on the degree of risk in the delivery of the respective planned mitigations for the operational and financial performance risks and **DETERMINE** if further support is needed.<br><br>The Board should **NOTE** the referral to the Executives to consider if there is a need for a distinct strategic risk in respect of transformation delivery |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*** | *The Audit Committee considered the underpinning processes at its meeting in July*<br><br>*Each of the respective oversight committees considered their element of the BAF at their meetings in August and September.* | | | | | |
| **Link to Trust Strategy (note which theme)** | **Patient** | **People** | **Future** | **Communities** | **One UHSussex** | **Culture** |
| | *Yes* | *Yes* | *Yes* | *Yes* | *Yes* | *Yes* |
| **Link to annual delivery plan** | *The BAF provides a mechanism to consider the strategic risks to the strategy achievement and thus the delivery of the annual delivery plan.* | | | | | |
| **Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)** | *This report covers all BAF risks* | | | | | |
| **Link to CQC domain** | **Patients** | **Caring** | **Effective** | **Responsive** | **Well-led** | **Use of Resources** |
| | *Yes* | *Yes* | *Yes* | *Yes* | *Yes* | *Yes* |

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

University Hospitals Sussex NHS Foundation Trust

# 2026/27 Board Assurance Framework Report

## 1 Introduction

1.1 The BAF for 2026/27 is aligned to the Trust's strategic ambitions as set out in 'Excellent Care Everywhere'.

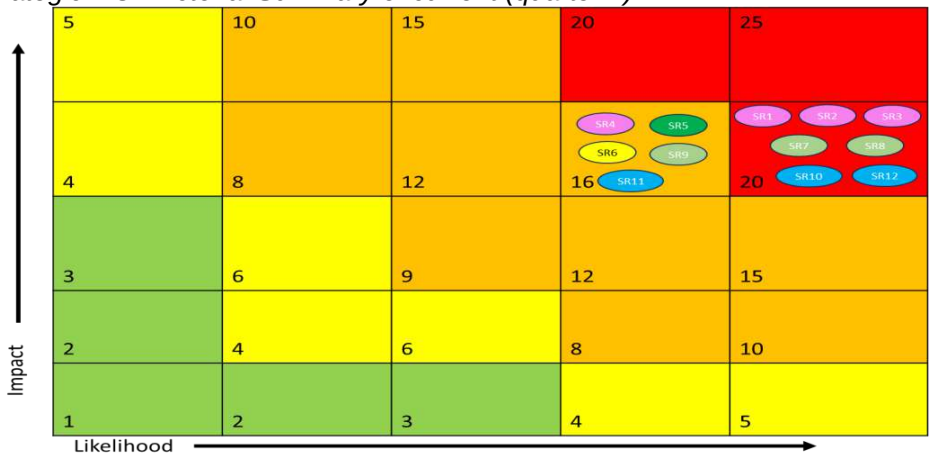
1.2 In March 2026, the Board agreed 12 strategic risks to the delivery of the Strategy that form the basis for the 2026/2027 Board Assurance Framework.

## 2 BAF summary

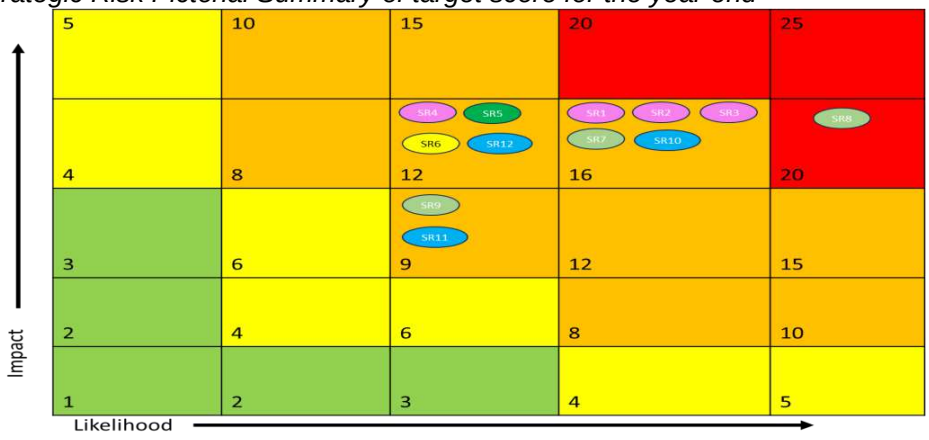
**2.1** The overall risk profile for the Trust remains high. Over quarter 1 there has been no movement in any risk score. As such, at the end of quarter 1, 7 of the 12 Strategic risks are significantly scored (scoring 20 or above), these cover the ambitions of Excellent Care for our patients (coloured pink), Excellent Care for the Future (coloured light green) and Excellent Care Together (One UHSx) (coloured blue)**.**

**2.2** At the end of quarter 1 for the Trust's other two strategic ambitions Excellent Care for Communities (coloured yellow) and Excellent Care for our people (coloured dark green) there are risks scoring 16.

*Strategic Risk Pictorial Summary of current (quarter 1)*



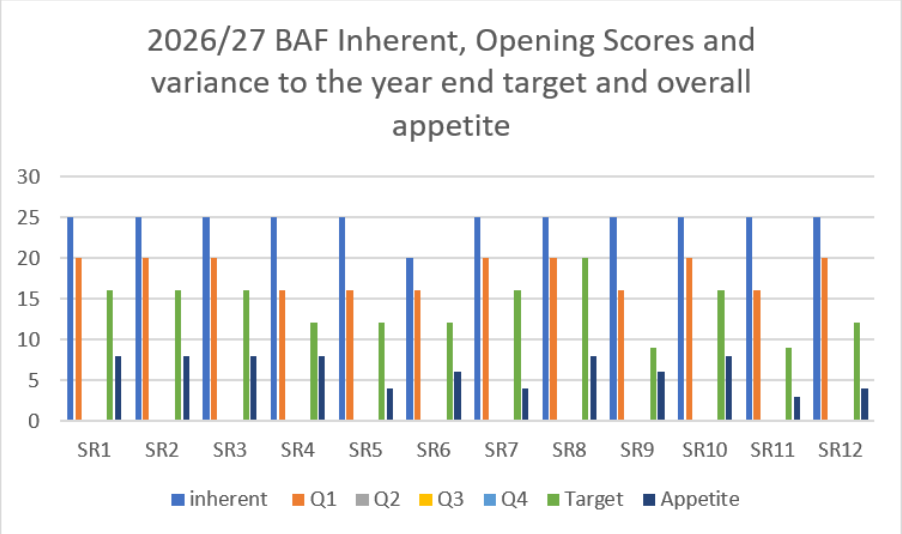

*Strategic Risk Pictorial Summary of target score for the year end*



2.3 SR8 'Better, more sustainable buildings and equipment' is the only SR where there is no movement shown between the opening risk score and the target year end risk score. The target year end risk score will be reviewed following the completion of the annual 'Premises Assurance Model' self-assessment. Current BAF actions to address this risk are focused on ensuring a greater baseline understanding of the position, to enable improvement plans to be developed. Both the Quality and Finance & Performance committees play an oversight and assurance role in relation to this risk. Respective roles and responsibilities are being clarified.

2.4 SR12 'Right people, right skills working towards common goals' has the largest target reduction from an opening score of 20 to a target score of 12. This reflects the expectation that organisational change related to the implementation of the Trust's new Target Operating Model (TOM) will be substantially complete. This risk is overseen by the People and Culture Committee.

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




2.6 Below is an analysis of the Trust's overall risk profile, showing the aggregate total score for the 12 strategic risks inherent scores, current quarter 1 score, the target score for 31 March 2027 and then comparing that to the overall appetite scores.

| | Inherent score | Current score | Target score | Appetite score |
|---|---|---|---|---|
| Total | 295 | 220 | 166 | 75 |
| % reduction against the inherent | | 25% | 44% | 74% |
| % reduction against current score | | | 25% | 55% |

2.7 This shows an overall reduction of some 25% from the inherent score to the quarter 1 score and that a further 25% reduction from this score is needed to achieve the aggregate target score by the year end. A further 55% from the 31 March 2027 target scores would be needed to reach the appetite scores.

## 3 Committee review

**3.1** Each BAF SR is owned by an overall Executive Director lead. The Executive lead provided a report to the relevant lead Board Assurance Committee with an assessment of the current score risk score based on their knowledge of the controls and assurances in place. Executive leads also provide an assessment of the level of confidence relating to delivery of the actions set out in the BAF and the progress towards achieving the target year end score / risk profile reduction.

**3.2** Each Committee met in August and September as planned and reviewed their allocated elements of the BAF and recommended score provided by the lead Executive Director.

**3.3** Below is a summary of each Board Committee's review of their allocated elements of the BAF.

3.3.1 Patient and Quality Assurance Committee

The Patient and Quality Committee has lead committee oversight for three Strategic Risks,

*SR3 aligned to Improving Safety and Experience*

The assessed score for this risk at the end of quarter 1 is 20 from an inherent risk score of 25 with a target score of 16 for the year end. The set of mitigations developed were considered by the Committee with key mitigations scheduled to deliver in the first half of the year through the development of divisional quality governance systems aligned with the new Trust Operating Model and to improve compliance with the Trust's core governance and polices.

The profile of assurance provision was a mix of operational, executive and committee oversight, but there was also a degree of external assurance that has been provided by CQC review of Children and Young People's services and the engagement of the Maternity Service Improvement Programme team. The mix of this assurance was agreed to be providing limited assurance over the current risk mitigations which supported the quarter score of 20. The quarter 1 score of 20 reflects that whilst significant progress on strengthening Trust, Divisional and Directorate oversight of quality has commenced this is not yet complete and will take time to embed to ensure consistent and effective divisional management governance processes.

The Committee **agreed** the executive recommended score of 20.

*SR4 aligned to Improving Equality of Access and Outcomes*

The assessed score for this risk at the end of quarter 1 is 16 from an inherent risk score of 25 with a target score of 12 for the year end. The set of mitigations developed were considered by the Committee with key mitigations aligned to the Trust's Health Inequality improvement work, noting that it will take time for this work to materialise into tangible improvement.

The profile of assurance provision is limited at this time to one source that being through the executive and committee oversight of the delivery of the Trust's health inequality plan. The quarter 1 score of 16 reflects that whilst the Trust has a Health Inequalities Improvement plan in place, monitored by the Clinical Outcomes and Health Inequalities Group and reporting to Patient and Quality Committee, the delivery of this plan has been impacted by resourcing challenges due to long term sickness and staff redeployment.

The Committee **agreed** with the executive recommended score of 16.

*SR8 aligned to Better, more sustainable buildings and equipment*

The assessed score for this risk at the end of quarter 1 is 20 from an inherent risk score of 25. As noted above, the current target year end score remains at 20. Work continues through the Estates Improvement Group to be able to determine a realistic mitigated position to be achieved by the year end. The Committee considered the set of mitigations developed through the estates improvement plan. The profile of assurance provision was primarily through executive and committee oversight however there had been some external assurance provided via internal audit. The overall profile of assurance within quarter 1 was limited which supported no change to the score of 20 in quarter 1.

The Committee **agreed** with the executive recommended score of 20 and sought an increased pace to the determination of the achievable target score along with a greater alignment of the BAF risk mitigations to the actions within the developed Estates Improvement Plan.

### 3.3.2 Research, Innovation and Digital Assurance Committee

The Research, Innovation and Digital Committee has lead committee oversight for two Strategic Risks

*SR7 Analogue to digital: harnessing technology and data to transform healthcare*

The assessed score for this risk at the end of quarter 1 is 20 from an inherent risk score of 25 with a target score of 16 for the year end. A set of mitigations were considered by the Committee. The Committee noted that these will take the whole year to deliver and recognised that the continued investment in digital infrastructure and transformational capacity needs to be managed against the financial resources available. The profile of assurance provision was a mix of operational, executive and committee oversight, and these provided a reasonable level of assurance over the current level of control. However, the BAF reflects that whilst actions are on track, the level of action needed will take the year to secure the improved control environment required to enable the score to reduce to its target score of 16.

The Committee **agreed** with the executive recommended score of 20.

*SR9 Widening access to research and innovation*

The assessed score for this risk at the end of quarter 1 is 16 from an inherent risk score of 25 with a target score of 9 for the year end. The Committee considered the set of mitigations which were aligned to developing the Trust's research delivery infrastructure, workforce capacity and developing a research orientated culture along with improving work with partners. The Committee noted the successful actions which have improved the Trust position on setting up studies and the work attracting commercial research studies. The profile of assurance received was through executive and committee oversight and was judged to provide an overall reasonable level of assurance over the designed controls. The quarter 1 score of 16 reflected the progress built on the action taken during the last quarter of 2025/26 on the establishment of an improved Clinical Research Facility.

The Committee **agreed** with the executive recommended score of 16.

### 3.3.3 Finance and Performance Assurance Committee

The Finance and Performance Committee has lead committee oversight for three Strategic Risks

*SR1 Delivering timely care for planned treatment and cancer care*

The assessed score for this risk at the end of quarter 1 is 20 from an inherent risk score of 25 with a target score of 16 for the year end. The Committee considered the set of mitigations which have been developed with the Committee noting that the majority of the planned mitigations are not due to conclude until the latter part of the year. The Committee noted that a key mitigation relating to the alignment of system and trust demand management plans was behind its planned delivery which increased the risk of delivering the benefit expected.

The profile of assurance provision was a mix of operational and executive and committee oversight, with the Committee noting that some external assurance has been provided by NHS England Teir 1 oversight and challenge. The mix of this assurance provided limited assurance over the current risk mitigations, which supported the score of 20.

The Committee noted that there was a high number of patients waiting longer than expected to access planned care and that whilst the Trust is seeking to strengthen its overall approach to the delivery of its planned care programme, with a programme that achieves a more transformative delivery approach in the year, there is a degree of risk to the achievement of the target score.

The Committee **agreed** with the executive recommended score of 20.

*SR2 Urgent and Emergency Care - improving access, quality, safety and environments.*

The assessed score for this risk at the end of quarter 1 is 20 from an inherent risk score of 25 with a target score of 12 for the year end. The Committee considered the set of mitigations noting that at the end of quarter 1 five of the seven key action were at risk of not delivering their intended benefit at the pace planned. The impact of these delays were evident in the poor UEC performance and failure to achieve the improvement trajectory within the Trust's submitted plan.

The profile of assurance provision was recorded as limited, this was from a mix primarily of operational, executive and committee oversight, but there was a degree of external assurance through recent GiRFT visit to RSCH UEC.

The Committee noted that the quarter 1 score of 20 reflects that whilst the Trust has had an active UEC Improvement Programme in place since 2024, all our hospitals continue to experience significant pressures across the end to end UEC pathway with the associated adverse impact on patient experience, quality, safety, delivery of access standards and productivity / cost.

The Committee **agreed** with the executive recommended score of 20.

*SR10 Improving value and financial sustainability.*

The assessed score for this risk at the end of quarter 1 is 20 from an inherent risk score of 25 with a target score of 16 for the year end.

The Committee had a full discussion on current status of the financial recovery delivery and planning. It noted that the current actions set out within the BAF do not reflect the current work underway or required and need to be strengthened / aligned to the current accelerated work programme.

The profile of assurance provision was primarily through executive and committee oversight, with the overall profile of assurance in quarter 1 being limited which is driven by two main areas, limited assurance in the maturity of the Trust's efficiency programme and the lack of reduction in workforce head count. This is supporting no change to the score of 20 in quarter 1.

The Committee **agreed** with the executive recommended score of 20.

3.3.4 People and Culture Assurance Committee

The People and Culture Committee has lead committee oversight for three Strategic Risks,

*3.2 SR5 Ensuring our workforce is happy, healthy and supported*

The assessed score for this risk at the end of quarter 1 is 16 from an inherent risk score of 25 with a target score of 12 for the year end. A set of mitigations were considered by the Committee noting that two of the actions were at risk due to slight delays with their delivery (development of workforce analytics tools and leadership and team development programme).

The profile of assurance provision was a mix of operational, executive and committee oversight, and whilst overall the level of assurance is assessed as reasonable the assurance provided by the freedom to speak up guardian is limited confirming work required increase staff confidence in speaking up and reduce fear of detriment. The quarter 1 score of 16 reflects that planned progress has been made but that the availability of resources (e.g. leadership development budget) is a critical enabler to the achievement of the target score.

The Committee **agreed** with the executive recommended score of 16.

*SR11 Living our values in everything we do*

The assessed score for this risk at the end of quarter 1 is 16 from an inherent risk score of 25 with a target score of 9 for the year end. A set of mitigations were considered by the Committee with all actions having commenced and on track.

The profile of assurance provision was a mix of operational, executive and committee oversight, and the overall the level of assurance was assessed as reasonable.

The impact of the Values and Behavioural Framework roll out has not yet been assessed to provide full assurance that the extensive programme of work is translating into meaningful improvement in culture.

The Committee noted that the quarter 1 score of 16 reflects that the Trust has moved from planning to active delivery of the Values & Behaviours programme with a Trust wide activation plan supported by refreshed governance, leadership reflection activities and with the work that has commenced on the alignment of induction, appraisal and recruitment processes with the Framework along with the policy rewiring.

The Committee **agreed** with the executive recommended score of 16.

*SR12 Right people, right skills working towards common goals*

The assessed score for this risk at the end of quarter 1 is 20 from an inherent risk score of 25 with a target score of 16 for the year end. A set of mitigations were considered by the Committee linked to the resourcing of required leadership training and OD resources along with a need to develop an integrated EIA/QIA process to support organisational change programmes.

The profile of assurance provision was primarily through executive and committee oversight with one piece of external assurance provided by NHS E confirming our reporting meets the regulatory requirements.

The Committee noted that the BAF reflects that there are resourcing challenges to deliver the planned actions for leadership development and OD support which are important to enable the risk score to reduce to the target score of 16.

The Committee **agreed** with the executive recommended score of 20.

3.3.5 Strategy and Major Projects Assurance Committee

The Research, Innovation and Digital Committee has lead committee oversight for one Strategic Risk.

SR6 - Collaborating to improve the health and well-being of our communities

The assessed score for this risk at the end of quarter 1 is 16 from an inherent risk score of 20 with a target score for the year end of 12.

Following the review of the BAF the Committee generally **agreed** with the executives view that the quarter 1 score for this risk at 16 but reflected that the BAF narrative did not represent the current system financial challenge and thus the implications of this on the Trust's risk may be understated.

The Committee reflected on its business transacted at the meeting and the discussions held were reflective of the change prioritisation and resource availability to deliver the transformational projects whilst working within the Trust's financial plan. The Committee **asked** that the Executive Team consider if the allocation of BAF risks is appropriate or if there is a need for a distinct strategic risk in respect of transformation delivery

3.3.6 Audit Committee

The Audit Committee received a report providing assurance in respect of the underpinning processes for the oversight and update to the BAF and concluded that the supporting processes were effective.

## 4 Conclusion

4.1 The quarter 1 BAF reflects no change to the Trust's opening position with seven of the 11 Strategic Risks significantly scored. Three key risks (Planned Care (SR1), UEC (SR2) & Financial sustainability (SR10)) are at significant risk of delivering their intended benefits by the year end.

4.2 The Strategic Risk relating to the Trust's infrastructure requires work to be concluded to determine an achievable year-end target score.

## 5 Recommendations

**5.1** The Board is asked to **NOTE** the assurance provided by the Committee review of their BAF risks**.**

**5.2** The Board is asked **AGREE** the quarter 1 scores, noting the scores have been reviewed and confirmed by the relevant Board oversight committees.

**5.3** The Board is asked to **NOTE** the comments provided the Patient and Quality Committee on the need an Infrastructure Target risk score to be determined.

**5.4** The Board is asked to **CONSIDER** the Finance and Performance Committee feedback on the degree of risk in the delivery of the planned mitigations for the operational Planned Care and UEC performance and financial sustainability risks and **DETERMINE** if further support is needed.

**5.5** The Board is asked to **NOTE** the feedback from the Strategy and Major Projects Committee that SR6 should be reviewed [during its next review for quarter 2] to ensure it correct reflects the implications of the current system financial challenge and **NOTE** the referral to the Executives to consider if there is a need for a distinct strategic risk in respect of transformation delivery

NHS University Hospitals Sussex NHS Foundation Trust

## APPENDIX 1

### BAF Summary

The table below shows by risk, their current score and their target risk score. The table as the year progresses will show the movement in risk between the current score for each quarter.
(No change, ⟷ an increase in risk ↑ and a decrease in risk ↓)

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

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

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

University Hospitals Sussex NHS Foundation Trust

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

***** shows move of oversight to Patient and Quality Committee**

University Hospitals Sussex NHS Foundation Trust

| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 21. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 17 September 2026 |
| **Report Title:** | Company Secretary Report | | | | |
| **Author(s):** | Glen Palethorpe – Company Secretary | | | | |
| **Purpose of the report:** ***(indicate as appropriate)*** | **For Decision** | **For Assurance** | **For discussion** | **For Information only** | |
| | *Yes* | *Yes* | | *Yes* | |
| **Reason for not being taken in public** ***(indicate as appropriate)*** | **Commercial confidentiality** | **Staff confidentiality** | **Patient confidentiality** | **Other exceptional circumstances (please detail)** | |
| | | | | | |
| **Regulatory Reporting Requirement** | | | | | |

*The following is a summary update of matters not covered elsewhere within the agenda or other reports*

***The Trust's Constitution***

*At the Board's Appointments and Remuneration Committee it agreed to the Chief Executive's proposal to strengthen the Executive Team with the creation of a new executive position, the Chief Infrastructure and Digital Officer. This requires a change to the Trust's constitution to allow up to 9 Executives, the current constitution only allows up to 8, consequently the constitution is required to reflect that the Trust must have at least 9 Non-Executives to maintain and Non-Executive with the Chair majority on the Board (as required by the NHS Code of Governance). These changes are to paragraphs 22.2.2 and 22.2.3, marked in red in the attachment*

*Given that changes were required, the opportunity was taken to add a new paragraph 22.2.10, for transparency, on the attendance at Board of the Trust's Managing Director. This change again has been marked in red in the attachment.*

***Non-executive director reappointments***

*The Governors took the decision at its Nomination and Remuneration Committee to reappoint Phil Hogan for a 2nd term to 31 December 2029 and Jackie Cassell for a 3rd term to 31 March 2030. This decision will be formally ratified at the Council of Governors meeting on the 1 October where the full report covering the breadth of that Committee meeting's activity will be taken.*

**Recommendation** *(linked to What Next section)*

*The Board is asked to **APPROVE** the proposed changes to the constitution, section 22.2.2, 22.2.3 and 22.2.10 and **RECOMMEND** these changes to the Council of Governors for their approval.*

*The Board is asked to **NOTE** the Council of Governors Nomination and Remuneration Committee's decision to reappoint Phil Hogan and Jackie Cassel each for a further term of up to 3 years*

**Assurance / Scrutiny route already undertaken (*please explain where matter***

| | | | | | | |
|---|---|---|---|---|---|---|
| ***previously considered, and assurance provided)*** | | | | | | |
| **Link to Trust Strategy (note which theme)** | **Patients** | **People** | **Future** | **Communities** | **One UHSussex** | **Culture** |
| | *Yes* | *Yes* | *Yes* | *Yes* | *Yes* | *Yes* |
| **Link to annual delivery plan** | *Not directly* | | | | | |
| **Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc** | *Not directly* | | | | | |

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

| | | | | |
|---|---|---|---|---|
| **Other impacts** | **Equality and Diversity (*if yes has HEIA completed)*** | **Environmental** | **Legal** | **External Registrations *(if yes please indicate which)*** |
| | *N/A* | *N/A* | *Yes* | *The Trust is required to maintain an effective constitution.* |

University Hospitals Sussex
NHS Foundation Trust

Trust Board of Directors Meeting in Public

Thursday 17 September 2026

# APPENDICES

SSCA

NHS
Surrey and Sussex
Cancer Alliance

# Annual Review

2025/26

Working together | Improving together

# Contents

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# Introduction

Welcome to our fourth Annual Review. On the following pages, we highlight some of the amazing work that we and our partners have delivered in 2025/26.

We have continued to make steady progress in diagnosing cancers at an earlier stage, when they are more treatable. The proportion of cancers diagnosed at Stage 1 or 2 across Surrey and Sussex has risen to 61.7%, above the national average of 59.7%.

In February, we were the top performing cancer alliance on the 28-day Faster Diagnosis Standard at **84.1%**, exceeding the national average of **80.5%**.

A sustained, targeted effort by our trust partners, supported by our performance experts, has led to strong improvement in our 62-Day Cancer Waiting Time (CWT) performance. This means more patients with suspected cancer are now starting their first definitive treatment within 62 days of a referral.

These improvements reflect a wide range of collective actions but, above all, the exceptional dedication, innovation and collaboration of staff working in cancer services to improve outcomes and experience for patients.

The new NHS Cancer Plan, published in February, sets out how outcomes, experience and equity will improve over the next decade. As this review shows, much of the work already underway across Surrey and Sussex aligns closely with these ambitions and provides a strong foundation for further progress.

This year also marks a change in our system landscape. From 1 April, Frimley Integrated Care Board (ICB) moved out of the Surrey and Sussex Cancer Alliance footprint. We thank our Frimley colleagues for their partnership and contribution. At the same time, we look forward to continuing our work with the newly-merged NHS Surrey and Sussex ICB and all our partners to build on this progress over the next 12 months.

Keri Torney
SSCA managing director

Louise Stead
SSCA chair

**Surrey and Sussex Cancer Alliance (SSCA) serves a population of 3.85 million. Across our footprint, in the space of 12 months:**

**227,500**
urgent suspected cancer and breast symptoms referrals were seen – an average of 19,000 per month **and an increase of 6% year on year**
**(monthly NHS England Cancer Waiting Times January to December 2025)**

**22,900**
new cancers diagnosed – an average of 1,900 per month **and an increase of 5% year on year**
**(NHS England Rapid Cancer Registration Dataset October 2024 to September 2025)**

**25,600**
first cancer treatments reported – an average of 2,100 per month **and an increase of 4% year on year**
**(Monthly NHS England Cancer Waiting Times January to December 2025)**

# Workforce funding by the Cancer Alliance in the 12 months to March 2026

| | |
|---|---|
| 40 | Nurses |
| 18 | Navigator / Trackers |
| 5 | Support workers |
| 6 | Administrators / Admin & IT Support |
| 7 | Programme / Project Managers |
| 11 | FDS Nurses |
| 2 | Programme / Diagnostic Directors |
| 10 | Advanced Clinical / Nurse practitioners |
| 3 | Dietitians |
| 3 | Booking Officers |
| 3 | Cancer Transformation Managers |
| 3 | Nurse consultant / associates |
| 9 | Pharmacist / Pharmacy technicians |
| 7 | Radiographers / Radiographer apprentices |
| 2 | Clinical fellows |
| 2 | Operational / Service Managers |
| 1 | Data Manager |
| 13 | Pathway Coordinators |
| 2 | Counsellors |
| 1 | Dosimetrist |

## Meet Fiona Huddy, SSCA clinical lead for oesophago-gastric dietetics.

One of the new roles funded by the alliance is the position of clinical lead for oesophago-gastric (OG) dietetics taken up by Fiona Huddy.

Fiona has 20-plus years of experience as a clinical dietitian and is currently working with patients diagnosed with OG cancers at the regional OG unit at Royal Surrey NHS Foundation Trust.

She aims to foster stronger communication and collaboration between dietetic teams across trusts to improve the nutritional status of patients diagnosed with OG cancers, enhancing treatment outcomes and patient experiences across the region.

"I look forward to being an active advocate for promoting the importance of nutrition at every stage of the OG patient pathway," says Fiona.

Dietetic teams can contact Fiona via the SSCA admin email: rsch.sscaadmin@nhs.net

## Workforce education

In 2025-26, our education team has trained almost **550** people across Surrey and Sussex and delivered nearly **400 hours of courses.**

Delegates came from all **seven trusts** plus **two hospices** and several **GP practices** and represented more than **15 different job roles** including cancer clinical nurse specialists, physiotherapists, dieticians, matrons and senior staff nurses, radiographers, cancer navigators, administrators and bookings clerks.

**almost 550 people trained**
**nearly 400 hours of courses**

Courses were funded by both SSCA and NHS England and covered a range of learning from Understanding Cancer Waiting Times to Advanced Communication Skills. Find out more here: The SSCA Cancer Academy

# Driven by data

**Martelie Isaacs, SSCA deputy director of data**

Our data team has introduced a number of new services in the past 12 months to support the work of the Cancer Alliance and our partners.

"Data anchors our work and focuses our efforts, turning complexity into clarity," says Martelie Isaacs, SSCA deputy director of data. "Through high quality, reliable insights, we support colleagues to reduce inequalities, strengthen performance and celebrate the progress they achieve."

Here are just some of the new data products. Click on the links to access the dashboards. You may need your NHS Futures login details.

## Diagnosing cancer earlier and improving prevention

- Early stage diagnosis and stage completeness dashboards: these provide a reliable and timely update of alliance progress by cancer type and national benchmarking.
- Cancer indicators dashboard: a tool for primary care on key cancer metrics and cancer screening coverage. The simplification of all the data in a single dashboard supports the Integrated Care Board (ICB) and primary cancer networks to identify and reduce variation.
- Upgrade of the lung cancer screening dashboard: this provides clear insights and enables effective planning and monitoring of the impact of the Lung Cancer Screening Programme as it is rolled out across our footprint.

Lung Cancer Screening

## Improving cancer performance

Inter-provider treatment (IPT) timeliness dashboard: a breakdown of the timeliness of the investigating and treating phases to identify barriers to meeting the 62-day standard.

> **"Data anchors our work and focuses our efforts, turning complexity into clarity."**

## Improving quality of life and outcomes

- Quality of Life dashboard: a breakdown of how quality of life may have changed for people diagnosed with cancer, with insights by cancer type and geography. The SSCA dashboard allows for comparison between trusts on our footprint
- Cancer metrics dashboard: a comprehensive overview of key cancer metrics from multiple data sources, brought together in a single, easy-to-use grid.

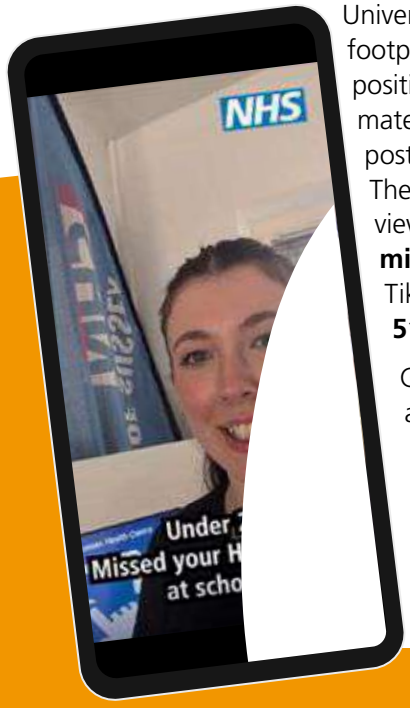
**If you need support to navigate any of the dashboards, email the data team: rsch.sscadata@nhs.net**

# HPV vaccination for the catch-up cohorts

Our early diagnosis team has continued its focus on increasing the uptake of the human papillomavirus (HPV) vaccine among the catch-up cohort, specifically those aged 18 to 25 who missed their vaccination at school.

Together with the Surrey and Sussex Screening and Immunisation Team, we developed a campaign targeting university students and their respective GP practices across our footprint in autumn 2025.

A short video co-created with local students and filmed at the University of Sussex health centre was produced to support a paid social media campaign and a range of printed resources.




Engagement was strong. Universities across our footprint responded positively to printed materials, distributing 400 posters and 10,000 flyers. The Snapchat advert was viewed more than **2.8 million times** and the TikTok video was seen **514,000 times.**

GP vaccination activity in university practices rose 117% between Sept–Dec 2025 compared to the same period in 2024.

## NHS 10-year Cancer Plan:

**'We will roll out catch-up HPV vaccinations to eliminate cervical cancer by 2040'**

**117%** increase in GP vaccination activity in university practices

**(Sept to Dec 2025 compared to the same period in 2024)**

# HPV Vaccination Resource Hub

In October 2025 we launched a new HPV vaccination resource page on our website. It includes information for healthcare professionals on who is eligible for the HPV vaccine, campaign materials to increase awareness and a signpost to our toolkit for general practice to improve opportunistic uptake among the catch-up cohort. This toolkit was the first of its kind to be developed in England and, since its launch in autumn 2024, has been downloaded almost 700 times and shared with other cancer alliances.

## Next steps for 2026/27:

We plan to rerun the public-facing campaign targeting university students. We will also work closely with the Surrey and Sussex Screening and Immunisation Team to agree work on improving the school-age boys' cohort and with sexual health services for men who have sex with men.

# Latest on Liver Surveillance Services

During 2025-26, we focused on embedding liver surveillance services across six trusts. These services were launched the previous year to provide early identification and monitoring for patients at high-risk of developing hepatocellular carcinoma (HCC), the most common form of primary liver cancer.

Working in partnership with hepatology teams, we supported trusts to focus on robust patient tracking, refining pathway processes and ensuring reliable call and recall systems are in place.

SSCA funding was provided for digital systems to identify, track and invite eligible patients to attend regular, proactive check-ups to monitor their liver health, including six-monthly ultrasound scans and blood tests. We funded workforce roles, including clinical nurse specialists and pathway coordinators. The alliance also hosted trust-wide shared learning events, both in-person and virtual.

All trusts now routinely identify and track patients at high risk of HCC, and patients are now invited systematically for six-monthly surveillance, in line with national guidance. Performance across the Cancer Alliance consistently exceeds national ambitions for both surveillance coverage and attendance.

These services support earlier detection of liver cancer, when treatment is more likely to be effective, and provide ongoing opportunities to manage liver disease and support patients' wider health.

**5,266** patients identified and registered with liver surveillance services

**4,599** patients invited for surveillance within the last six months (87.3% exceeding the NHS ambition of > 80%)

**4,287** patients attended surveillance within the last six months (93.2% exceeding the NHS ambition of > 60%)

**(SSCA/ Liver Surveillance Services Q4 2025/26)**

Ashford and St Peter's Liver Surveillance team:
L to R Julene Birde-Green, hepatology CNS; Peter Ogbonna, advanced chronic liver disease CNS; Ann Wells, pathway coordinator.

> **"We provide education and remind patients of signs and symptoms to look out for. Patients feel confident that someone is looking after them and they are actively on our radar."**

## Next steps for 2026/27:

SSCA will continue to support trusts to maintain strong performance across identification, invitation and attendance of eligible patients.

The benefits to patients of the Liver Surveillance Service are many, says Peter Ogbonna, advanced chronic liver disease clinical nurse specialist at Ashford and St Peter's NHS Foundation Trust.

"We provide education and remind patients of signs and symptoms to look out for. Patients feel confident that someone is looking after them and they are actively on our radar," he says.

"Through the surveillance, we have picked up several early indicators of cancer and these patients have been put on a cancer pathway and discussed in the multidisciplinary team meetings.

"We can pick up signs of liver failure early and can bring patients in to a clinic quickly or refer them for a consultant appointment in one of our 'hot hep' clinics. This has prevented patients ending up in A&E."

# Lung Cancer Screening hits new milestones

The Lung Cancer Screening Programme expanded into Surrey for the first time in autumn 2025 following a progressive rollout across Sussex and Frimley.

Since the programme was first launched on our footprint in summer 2022, more than 400 people have been diagnosed with lung cancer – three quarters at Stage 1 and 2, making it easier to treat.

New this year has been the development of the Surrey and Sussex Lung Cancer Screening website. It includes a GP search function so patients can check when lung screening is coming to their area.

People aged between 55 and 74 who smoke or have smoked in the past will automatically be invited to have lung cancer screening.

**"Lung Cancer Screening has been a game changer. We have been able to pick up lung cancers much earlier, much smaller, which means we have been able to treat them, with the intention of getting rid of them."**

Sue Quirin, lead lung cancer nurse specialist at Surrey and Sussex Healthcare NHS Trust

## What the patient says...

Surrey resident Mel Bond decided to take up her lung screening invite because her husband was diagnosed with Stage 4 lung cancer a few years ago.

"Had he been diagnosed earlier, it probably would have been a better prognosis," she says. "He's an ex-smoker and I'm an ex-smoker, so this was a perfect opportunity to get checked out."

Mel's lung cancer screening experience/ YouTube

**Celebrating the launch into Surrey are, back row, the InHealth team with SaSH lead lung cancer nurse specialist Sue Quirin. Front row: Yemisi Akinyegun, SSCA, Christopher Smith from Dorking Healthcare GP Federation, David Parker, SSCA, and local GP Dr Tom Rustom.**

**402** people diagnosed with lung cancer. 77% at Stage 1 and 2.

**137,627** invites sent

**79,929** number of health checks carried out

**36,857** number of CT scans performed

(Lung Cancer Screening across Surrey and Sussex. June 2022-March 2026)

## Next steps for 2026/27:

The Lung Cancer Screening Programme has reached 30% of the eligible population of Surrey and Sussex. In line with the National Cancer Plan, the programme will be rolled out to all eligible populations across our footprint by 2030.

# The Rapid Improvement Challenge

In October, we launched a focused reset to ensure more cancer patients begin treatment within 62 days of referral.

The Rapid Improvement Challenge set an ambitious goal: to improve alliance-wide performance against the 62-day Cancer Waiting Time (CWT) standard from 73% to 76% by December.

Our Performance and Improvement Team brought together a taskforce of experts from across the Cancer Alliance to work closely with trust partners. While the initial focus was on the breast and lung pathways, the challenge created an opportunity for improvement across all cancer pathways.

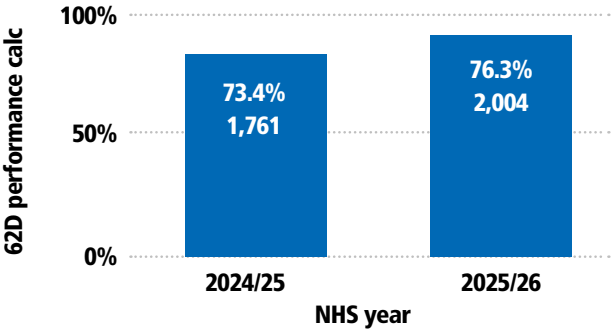
We produced a practical 62-day action plan toolkit to help trust teams carry out self-assessments, identify areas for improvement and develop targeted action plans. Training was also provided on the Pathway Analyser tool.

New education courses strengthened understanding of CWT standards and a series of face-to-face workshops focussed on improvements within lung, breast, urology and lower gastrointestinal pathways.

By Christmas, the phase one ambition had been achieved - performance had reached 76.3%, almost a three-percentage point improvement on the previous year. This meant 58 more patients received timely first cancer treatment - despite a 13% year-on-year increase in patient volumes.

The challenge continued until the end of March, with phase two focusing on improvements within the skin pathway.

**62-day performance – December Year on Year comparison – SSCA – All cancer types – All routes – All treatment types**




> This significant milestone reflects the commitment and collaboration of everyone involved. Behind every percentage point are people diagnosed and treated more quickly, experiencing less anxiety during waiting, and getting the care they need sooner.
>
> **Keri Torney, SSCA managing director**

**The NHS 10-year Cancer Plan ambition is that, by August 2029, 85% of patients should receive treatment within 62 days.**

**10** Pathway analyser deep dives
Pathway Analyser tools, templates and training videos

**11** workshops held in six trusts

**18** action plans developed to improve performance

**£860K** funding for 30 performance improvement projects

**180** people attended the Understanding Cancer Waiting Times course

## Next steps for 2026/27:

We will sustain momentum on 62-day performance through closer joint working with colleagues within the health and care system, increased on-site collaboration and clinically-led, executive-sponsored improvements.

> A very productive and energised meeting with good ideas from the team for further discussion and development to help the pathway.
>
> **Amanda Stern, service manager for respiratory medicine at East Sussex Healthcare NHS Trust, following a lung performance workshop**

# Gynaecological cancer pathway improvement

In 2024, the University Hospitals Sussex NHS Foundation Trust (UHSx) gynaecology pathway was selected for a Cancer Alliance deep-dive improvement project following a sustained decline in cancer waiting time performance.

Our performance improvement team worked closely with clinical and operational staff across the four UHSx sites to understand pathway variation and identify opportunities for improvement.

Key actions following the deep-dive included funding two Faster Diagnosis Standard (FDS) nurses and introducing a structured nurse-led triage process.

The nurses now review referrals in daily allocated time slots, interpreting clinical information and directing patients to the most appropriate next step - either a specialist outpatient appointment or direct diagnostic tests. They also liaise with patients to prepare them for appointments, which has reduced non-attendance.

Performance improved significantly and attracted the attention of NHS England. A team visited the trust in February to learn more about improvements made.

Celebrating gynaecological pathway improvement - members of our Performance and Improvement Team with colleagues from UHSx

Bronwyn Middleton, UHSx clinical director for gynaecology, says: "It has been positively rewarding working collaboratively with the Cancer Alliance on improvements to our cancer diagnostic and treatment pathways over the past year. Benefits to our patients include faster diagnostic times, improved treatment times and a more informative journey."

Bronwyn Middleton, UHSx clinical director for gynaecology, with a patient.

**Between April 2025 and February 2026, FDS performance has risen 10 percentage points to 71%** **71%**

**72%** **Between April 2025 and February 2026, 62-day performance has risen 30 percentage points to 72%**

## Next steps for 2026/27:

A newly-appointed SSCA-funded pathway navigator for UHSx will support patient communication and clinic bookings. This will enable FDS nurses to undertake additional clinical work, such as endometrial biopsies, allowing consultants to focus on more complex cases.

### FDS nurse Samantha Backley

Samantha was instrumental in establishing the new triage process. She says: "Teamwork is now robust between our booking teams, pathway coordinators, service managers, nurses, clinicians and consultants. All of whom can see the pathway from a patient's perspective from the point of referral.

"Getting the triage process right at the point of referral means our patients are being informed of a no cancer diagnosis quicker. This ensures those with a malignancy are being reviewed sooner, aiding improvement on our 62-day pathway."

### Hysteroscopy patient video

In collaboration with UHSx and community groups, we launched an information video to help prepare patients for a hysteroscopy procedure. Find it here: https://youtu.be/fIJ9OAMjJCg

# Lower GI pathway improvement - phase two

Following a successful deep dive into Faster Diagnosis Standard (FDS) performance in the Lower GI (gastrointestinal) pathway at Frimley Health NHS Foundation Trust, a second phase was launched to reduce delays for patients diagnosed with cancer.

Although diagnostic performance had improved, this had not translated into stronger 62-day treatment performance. Our Performance and Improvement Team worked with consultants, FDS nurses, MDT cancer pathway managers and radiography teams to review the pathway from diagnosis to first treatment. Three priority areas were identified: Patient Tracking List (PTL) management, surgical waiting lists and CT colon capacity.

PTL meetings were redesigned into proactive multidisciplinary reviews in which every patient was discussed and assigned a clear next action. Within three months, meetings became fully quorate and focused on maintaining pathway momentum.

Surgical waits were reduced through a centralised booking spreadsheet led by the lead Lower GI cancer clinical nurse specialist. This improved allocation across surgeons and reduced average waits from 32 to 20 days.

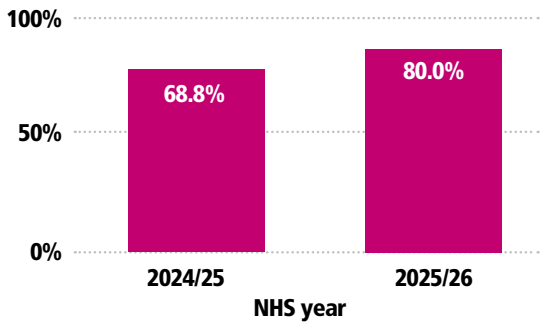
SSCA funding supported a radiographer and radiology department assistant, enabling CT colon scans to be completed in 20 rather than 30 minutes. This increased capacity and reduced delays.

By March 2026, Frimley had the lowest proportion of Lower GI patients waiting over 62 days, at 0.9%, compared with the national average of 6.6%. Frimley Integrated Care Board (ICB) also ranked first nationally for 62-day performance, achieving 84.4% in February 2026, compared with 68.6% nationally.

Lower GI performance improved from 68.8% to 80%, exceeding the national average of 59.1% and placing Frimley ICB fourth nationally.

**The Faster Diagnosis Standard is the diagnosis or ruling out of cancer within 28 days of an urgent suspected cancer referral.*

**62-day performance – February Year on Year comparison – Frimley ICB – Lower GI – All routes – All treatment types**




### Robust team-working

Lead Lower and Upper GI CNS, Cathy Riley, says the collaboration with the Cancer Alliance has "given us the confidence to believe in ourselves and the funding to make a difference."

"We now have very effective PTL meetings once a week with all the cancer disciplines represented," she says. "This has led to robust team work. We can see the flow of patients coming in and any breach dates. The changes to the PTL meetings have given the CNSs confidence to make decisions on best practice for patients."

"Seeing the recent PTL and 62-day performance data has given the team a real boost!" she adds.

Celebrating Lower GI pathway success! Pictured are some of the members of the FHFT team who support the 62-day Lower GI pathway.

Left to right is: Mercy Thuo, colorectal CNS; Sara Gallagher, FDS GI unit navigator; Michelle Goffey, stoma CNS; Mr Mohamed Alkashty, colorectal consultant; Catherine Riley, team lead for stoma and Upper/Lower/FDS CNSs; Mr Waseem Hameed, MDT lead and colorectal consultant; Jody Browning, team lead booking coordinator (theatres); Sheela Singh, colorectal/oncology CNS and Katarzyna Wierzbowska, MDT coordinator.

# MDT streamlin continues

The Cancer Alliance's work to support trusts in reviewing practice and streamlining multidisciplinary team (MDT) meetings continued this year. The new merged breast MDT at University Hospitals Sussex NHS Foundation Trust (UHSx) is one example of this work.

In July 2025, Ross Kenny, consultant onco-plastic breast surgeon for UHSx (pictured) led the transformation of a breast MDT at the trust.

The challenge was two-fold: to bring together the east and west MDTs covering Worthing and Chichester, while streamlining the combined patient caseload to focus on the more complex cases.

The merger created a single MDT initially reviewing over 130 cases and taking six hours every week.

"A key cultural shift was needed to move the MDT away from being a `safety net' for all patient cases if we were to improve the focus on the more complex cases," says Ross. "It was a challenging time, but I had a lot of support from the cancer alliance and our senior executives."

Clear guidance of which patient cases could be streamlined off the MDT agenda was introduced, alongside firm histology cut-off times to reduce pressure on pathology teams.

The MDT now runs as a four-hour hybrid meeting – face-to-face and online - once a week. The case load has reduced to around 80, and there is a consistent quorum ensuring participation from six core specialties – pathology, radiology, oncology, breast care nurses, MDT coordinators and surgeons.

**"We now have closer colleague working and patients are being treated quicker,"** says Ross.

"There is smoother transitioning of patients between sites and surgeons are working in unison while benefiting from being able to confer with each other and have second opinions for complex cases. East Sussex patients are also benefiting from the experience of oncoplastic surgeons from Brighton and Worthing, a service they didn't have before."

While progress has been significant, adds Ross, there are further opportunities to streamline lower-risk cases and maximise MDT focus on complexity in the near future.

Pictured are some of the members at the new UHSx breast MDT with their colleagues joining the meeting online

## MDT education

This year, our education team launched two training courses to support MDTs: **Inside the MDT Engine Room** - a workshop for MDT coordinators - and the MDT Leads Development Programme. The first cohort for the MDT Leads Development Programme began in March and a second will start in May 2026.

# New quality assurance process

This year, SSCA introduced a new quality assurance process to strengthen governance, improve patient safety and support consistency.

It was developed following the successful multi-disciplinary team (MDT) streamlining programme and enables teams to reflect on best practice, celebrate successes and identify areas for improvement.

The quality measures are based on NICE guidance, NHS England service specifications and recognised national and international best practice.

Between September and November, 40 services and MDTs completed self-assessments against these quality measures. SSCA experts then reviewed submissions and produced assurance reports which highlighted strengths, risks and development areas.

The process has delivered valuable system insight and has since been shared nationally, with a number of other cancer alliances interested in developing a similar process.

Mary Hayes, head of nursing for cancer at Frimley Health NHS Foundation Trust (FHFT), worked with her team to carry out quality assurance for SACT (Systemic Anti-Cancer Therapy).

"This gave us a framework to go in and see what was underpinning excellent service for patients and how can we make it better. It helps you stop, think and look. And it gave us the headspace to think outside the box. It refreshed ourselves and our service."

Following the quality assurance process, the Frimley SACT team is currently working on a project to improve the `hot bleep' emergency phone number service for people on chemotherapy.

## Early adopters

Dee Daly

Kelly Smith

"Quality assurance drives improvement and levelling up of care," says **Dee Daly**, quality and governance manager for cancer and core services at East Sussex Healthcare NHS Trust (ESHT). She worked with personalised care lead nurse, **Kelly Smith**, to develop a comprehensive method of carrying out the assessment with the clinical leads.

ESHT had already developed a self-assessment of MDTs and services and so was chosen to be a pilot trust for the SSCA quality assurance process for the breast and colorectal pathways.

"This process ensures we are compliant with NICE guidance on how to manage various cancers, have the right people at the MDTs and the right people on our teams," adds Dee. "We can assure ourselves we have patient safety first. We can identify problems and get engagement from the highest level to improve. This process gave us the opportunity to stand back and look at our cancer services properly."

### Next steps for 2026/27:

The quality assurance process will focus on the urology, gynaecology, skin, and lung pathways. Services assessed in year one will be reaudited on a three-year cycle.

# New tools to support prehabilitation of cancer patients

Physical activity is a powerful tool for cancer prevention, treatment tolerance and survivorship. In the past 12 months, we have launched a range of education resources to empower health professionals to have conversations about exercise with patients.

This has included a new Prehabilitation and Rehabilitation Resource Hub on our website with guidance for healthcare professionals to improve understanding and resources to share with patients.

We have also worked in partnership with Queen Victoria NHS Foundation Trust and Surgery Hero to fund a digital app to support cancer patients to prepare for surgery and recover well. The pilot started in January 2025 and has so far provided more than 170 patients with one-to-one personalised health coach support via an app before, during and after surgery.

"All patients should be told about keeping physically active," says Rachel Brown, SSCA prehabilitation clinical lead. "Physical activity is key in preparing our bodies for treatment and recovering well afterwards, improving long-term health and wellbeing."

> "My health coach demonstrated exceptional listening skills, accurately summarising my thoughts and feelings and recalling previous conversations. She was consistently compassionate and caring."
>
> **Feedback on the Surgery Hero app from a female patient, aged 61**

# What the patient says…

Charles took part in the Royal Surrey NHS Foundation Trust PRIME prehabilitation programme before his treatment for bladder cancer and says it was `one hundred percent' beneficial to his recovery.

"I tell people it is important to be physically active before an operation, to get as strong as you can. It gets you through it better and aids recovery."

"I recovered very quickly and was out walking within a couple of days of my operation. I did post-op physio and was advised to take up Pilates. I now still play tennis and go cycling. I can't praise it enough."

**Click here for the SSCA Prehabilitation and Rehabilitation Resource Hub**

## In patient feedback,

**71%** of patients rated the experience of the Surgery Hero digital app **9/10 or higher**

## Next steps for 2026/27:

We are funding a physical activity clinical champion to support the embedding of physical activity in cancer pathways across Surrey and Sussex. An educational video to provide guidance for health professionals will launch in May.

The evaluation of the Surgery Hero pilot will be available in Q1 and shared with alliance partners. It will be used to support plans to develop a digital offer at trusts.

# Treatment and care

## End of treatment summaries

In collaboration with primary and secondary care and patients, we have produced the first of a suite of updated End of Treatment Summaries to support the care of patients after treatment for cancer.

The first two revised End of Treatment Summaries are for oesophagogastric and prostate and can be found here: SSCA Personalised Care Interventions/End of Treatment Summaries.

They include SNOMED codes which support coding in general practice; information about ongoing management and continued medication; diagnosis, staging and treatment; long-term effects of treatment; symptoms that are possible signs of cancer recurrence and any requests for general practice.

They will be sent digitally from the trusts where patients have undergone treatment for uploading to patient records in general practice.

## Treatment variation

Our treatment experts carried out a comprehensive review of three cancer pathways (breast, bowel and ovarian) across all trusts on our footprint to identify how they compare to the National Cancer Clinical audits.

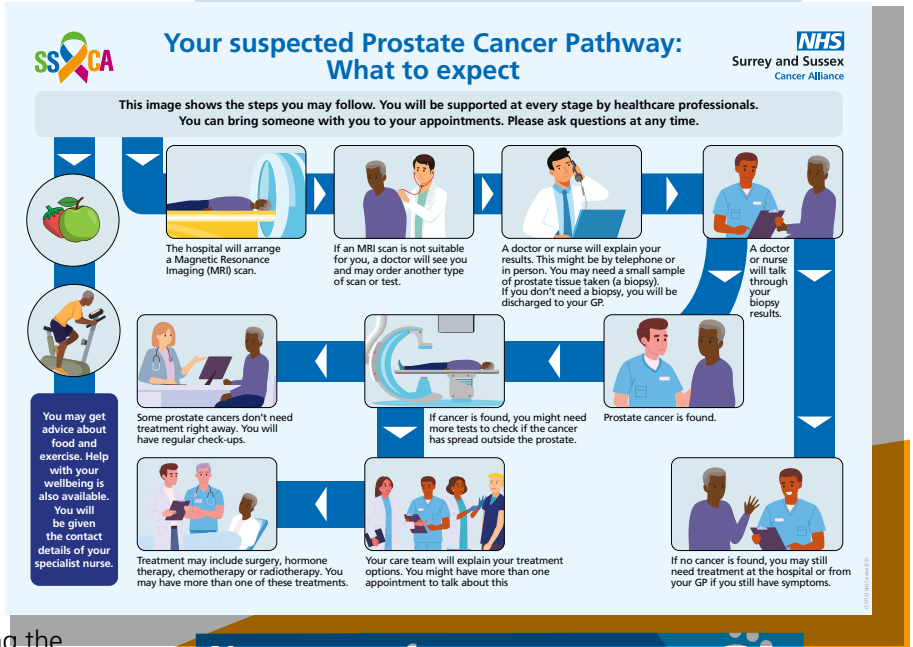
The audits aim to drive improvements in cancer care and outcomes by bringing the standard of all cancer teams in England to that of the best.

We worked with providers to help achieve the nationally required metric standard for these three pathways and also supported teams to improve data capture, particularly in the ovarian cancer pathway. Correct data ensures an accurate recording of performance, assurance that patients are being offered the appropriate treatment, and highlights any variations and areas for improvement.

## More patient visual pathways

With the support of patients and our Voluntary Community Sector Forum, we have expanded our cancer pathway visual guides to include the breast and prostate pathways.

These infographics can be used by clinicians to support discussions with patients. The guides explain what tests to expect, what the next steps will be if cancer is diagnosed and what to do if cancer is ruled out. Find the breast, oesophagogastric and prostate visual guides here: Cancer pathway visual guides. They can be downloaded for printing from our website or copies of the infographics can be requested by contacting the SSCA team directly at rsch.sscaadmin@nhs.net




## Next steps for 2026/27:

We are working on End of Treatment Summaries for breast, lower gastrointestinal (anal, colon and rectum) and skin cancer.

We will be publishing an endometrial cancer pathway visual guide this year.

We will carry out a comprehensive review of the lung, pancreatic, kidney and oesophagogastric cancer pathways against the national cancer audits while continuing to support trust teams to improve data capture.

# What's new

## Bleeding on HRT toolkit

In November 2025, we published a toolkit of information and resources for colleagues in general practice to support the management of patients presenting with **unscheduled bleeding** on hormone replacement therapy (HRT).

Developed in partnership with stakeholders from both primary and secondary care, it supports the British Menopause Society guidelines.

The toolkit has already been downloaded **350 times** (November 2025-April 2026). Find it here: SSCA Unscheduled Bleeding on HRT 2025.

## Lynch Syndrome Patient Information

**Your Guide to Lynch Syndrome** is an interactive online resource which provides comprehensive information for patients if they are being tested for Lynch Syndrome or have been newly diagnosed.

It was launched at the beginning of 2026 and was produced in collaboration with the South East Genomic Medicine Service and Guy's Cancer Academy. Find it on our website: SSCA Lynch Syndrome.

Lynch Syndrome is an inherited genetic condition. Around half of all people with Lynch Syndrome develop colorectal cancer. It is also responsible for a range of other cancers including endometrial, gastric, small bowel, urothelial and brain cancers.

## Cancer Care Review Toolkit

The Cancer Care Review Toolkit provides top tips and tools to allow for meaningful and holistic Cancer Care Reviews with patients.

The toolkit was developed following a comprehensive guide to Cancer Care Reviews produced by Macmillan nurses from NHS Sussex (now NHS Surrey and Sussex) and is designed to be a quick and practical reference guide: SSCA Cancer Care Reviews

A Cancer Care Review is a conversation between a patient and their GP practice about their cancer and its treatment and the issues they are facing.

## Urgent Suspected Cancer referral videos

Two short educational video guides have been produced to support colleagues working in general practice when referring patients with urgent suspected cancer.

One is for **SystmOne users** and the other for **users of EMIS**. They were created in partnership with Ardens, the clinical decision support tool, and reviewed by GPs.

Each provides a step-by-step guide to ensure the latest urgent suspected cancer (USC) referral forms are always used. Using the most up-to-date USC form ensures patients are referred for further investigations based on the latest national and local guidance. Find the videos here: SSCA Urgent Suspected Cancer Referral Forms and Guidance

## New immunotherapy training hub

Check out our new immunotherapy education and training resources page. Immunotherapy is changing the way we treat cancer and with these resources, we can help our workforce build the knowledge and skills they need to keep pace with developments in this area.

# Want to know more?

## Join us

### Be part of our Voluntary and Community Sector Forum

Our Voluntary and Community Sector Forum meets regularly to consider issues related to cancer patients and enables organisations to provide meaningful feedback to improve cancer patient experience. The forum includes community groups and cancer patient support groups. Would your organisation like to join? Email: **rsch.sscaadmin@nhs.net**

### Join our Communities of Practice:

We have tumour-specific Communities of Practice for cancer Clinical Nurse Specialists and Allied Health Professionals.

We also have Communities of Practice for cancer support workers and for lead cancer nurses. Join a Community of Practice for your job role by emailing: **rsch.sscaadmin@nhs.net**

## Stay in touch

### SSCA community bulletin

Our community bulletin is published quarterly. It contains the latest cancer news and information on cancer awareness campaigns and contact details for cancer support centres across Surrey and Sussex.

It includes handy media toolkits to enable community groups to support us in raising awareness about cancer through their websites, social media networks, e-newsletters and within their community settings.

Email: **rsch.sscaadmin@nhs.net** and we will add your group to our database.

### SSCA partner bulletin

We communicate the latest Alliance news to the systems through our monthly partner bulletin. It provides information and resources on Alliance projects and news; south east and national updates; cancer awareness campaigns; training opportunities, and webinars and events.

If you would like to receive the bulletin regularly, email **rsch.sscaadmin@nhs.net** with your job title and name of the organisation you work for.

**Visit our website**: surreyandsussexcanceralliance.nhs.uk

**Email us:** rsch.sscaadmin@nhs.net

**Follow us on our social media channels:**

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**Surrey and Sussex Cancer Alliance**

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CS58645 NHS Creative

LAP assessment report

# St Richard's Hospital

**LAP Assessment Report ID :** LAP-01862

**Inspection visit date(s):** 15 October 2025

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St Richard's Hospital
# Location findings

## Ratings for this location

| | |
|---|---|
| **Overall** | Requires improvement |
| **Safe** | Requires improvement |
| **Effective** | Good |
| **Caring** | Outstanding |
| **Responsive** | Requires improvement |
| **Well-led** | Requires improvement |

## Overall location summary

Date of assessment: 15 October 2025. University Hospital Sussex provides a range of NHS hospital services across 4 locations, providing care to the populations of parts of East Sussex, Brighton and Hove and West Sussex.

The maternity assessment took place at St Richard's Hospital in West Sussex. The rating from maternity has been combined with ratings of the other services from the last inspections at St Richard's Hospital. See our previous reports to get a full picture of all other services at St Richard's Hospital. The rating of St Richard's Hospital is, requires improvement.

At this assessment we identified a breach of regulations in relation to regulation 12: safe care and treatment and regulation 17: good governance.

## Safe

**Rating** Requires improvement

St Richard's Hospital

# Location findings

Our overall rating of safe at St Richard's Hospital was requires improvement. We looked at maternity services only and rated safe as requires improvement.

## Effective

Rating Good

Our overall rating of effective at St Richard's Hospital was good. We looked at maternity services only and rated effective as good.

## Caring

Rating Outstanding

Our overall rating of caring at St Richard's Hospital was outstanding. We looked at maternity services only and rated caring as good.

## Responsive

Rating Requires improvement

Our overall rating of caring at St Richard's Hospital was outstanding. We looked at maternity services only and rated caring as good.

## Well-led

Rating Requires improvement

Our overall rating of responsive at St Richard's Hospital was requires improvement. We looked at maternity services only and rated well-led as requires improvement.

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| | |
|---|---|
| **Overall** | Requires improvement |
| **Safe** | Requires improvement |
| **Effective** | Good |
| **Caring** | Good |
| **Responsive** | Good |
| **Well-led** | Requires improvement |

## Our view of the service

Date of assessment: 15 October 2026

St Richard’s hospital provides a range of NHS hospital services to women living in and surrounding area of Chichester. The assessment looked at maternity services.

The trust has obstetric led maternity units at St Richard’s hospital in Chichester, Worthing Hospital, Princess Royal Hospital in Haywards Heath and the Royal Sussex County Hospital in Brighton.

Alongside the obstetric service St Richard’s Hospital have a midwife led birthing unit and a home birth service was also provided by community teams across all four sites.

Around 9,000 babies are born in the trust each year. Within St Richard’s Hospital between October 2024 to September 2025 there were 2,364 births between the obstetric unit and the birthing centre.

In February 2022, the trust entered the Maternity Safety Support Programme (MSSP). The MSSP is a

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national support programme provided by NHS England to maternity services where significant concerns have been identified regarding the safety and quality of services.

There was a maternity improvement plan which was monitored via the twice monthly Maternity Improvement Group. The trust was on track to move into the sustainability phase of the MSSP programme mid-2025, and to exit the programme late-2025. However, this was delayed due to the trust being named as one of the trusts within the rapid national investigation into NHS maternity and neonatal services.

Maternity services were rated as requires improvement following the assessment.

The service was previously in breach of regulation 12: safe care and treatment due to checks not being completed on life saving equipment. During the assessment we found there was no longer a breach in relation to checks not being completed on life saving equipment.

There was a breach of regulation 12: safe care and treatment due to the design and environment of the maternity assessment unit did not meet the needs of women using the service due to a lack of space for women. The waiting area was outside of the maternity assessment unit and staff did not have a direct line of sight of women waiting within the waiting area. We found women did not receive a midwifery review within 15 minutes of arrival within the maternity care centre and women did not receive a medical review within a timely manner.

A breach of regulation 17: good governance due to the service not having an audit schedule and staff did not routinely complete local audits. Staff did not have access to up-to-date policies and guidance due to several being outside of the review date.

However, policies and guidance did reflect the current National Institute for Health and Care Excellence (NICE) guidance. During the inspection we found staff knew what incidents to report, they raised concerns and reported incidents and near misses in line with the trust policy.

Staff told us they worked well as a team and there was a good culture between midwives and obstetricians. Staff considered patients' individual needs, circumstances, ongoing care arrangements and expected outcomes during handovers and ward round meetings.

Leaders worked with the Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. Meeting minutes showed current work being undertaken between the local MNVP.

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We refer to women in this report, but we recognise that some transgender men, non-binary women and women with variations in sex characteristics or who are intersex may also use services and experience some of the same issues.

We have requested an action plan, this will be requested upon publication of the final report.

## People's experience of the service

We spoke to 6 women during the assessment and 5 partners who were positive about the service. Information from the Maternity survey 2025 benchmarking report showed that women were positive about their birthing experience at St Richard's Hospital. Many felt they were treated with dignity and respect throughout their care. Women told us they felt safe, well supported and cared for by both the midwifery and medical teams. Risks were explained by staff, and they were involved in decision making.

Staff were described as professional, understanding and kind. Women had access to contribute and feedback about their experiences through the local Maternity and Neonatal Voices Partnership (MNVP) who also feedback to the trust regularly.

## Safe

**Rating** Requires improvement

We looked for evidence that safety was a priority for everyone, and leaders embedded a culture of openness and collaboration. We checked that women were safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination.

At our last assessment we rated this key question requires improvement. At this assessment, the rating of safe had not changed and was requires improvement.

Following the inspection, we found there was a breach of Regulation 12: Safe care and treatment.

The layout of the maternity assessment unit and demand on the service meant women were at times required to wait in an external area, where staff did not always have direct visual oversight. While mitigation was in place, including CCTV and access to an emergency call system, this did not replace direct observation and posed a risk to safe monitoring.

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Data provided by the trust showed over a 6-month period, 84% of women received a midwifery review within 15 minutes of arrival. This was slightly below the trust target of 90%.

However, staff knew what incidents to report and raised concerns and reported incidents and near misses in line with the trust policy. The patient safety team had oversight of the grading and reviewing of incidents with a clear system to investigate incidents and to identify learning.

## Learning culture

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always have a proactive and positive culture of safety.**

The service combined the number of open low or no harm incidents with the sister location Worthing hospital. This meant there was no clear indication as to whether there were issues with closing incidents at a particular site.

At the time of the inspection there were 123 open low and no harm incidents reported, with 48 of those incidents being more than 20 days old. Although incidents were graded as low or no harm, delays in review and closure increased the risk that indicators of poor care were not identified. This limited the service's ability to recognise themes, trends, or areas of non-compliance requiring improvement.

Staff knew what incidents to report and raised concerns, reported incidents and near misses in line with the trust policy. The service used national risk tools, Patient Safety Incident Response Framework (PSIRF) and a Perinatal Quality, Safety Risk Framework to review and monitor risk.

The patient safety team had oversight of the grading and reviewing of incidents with a clear system to investigate incidents and to identify learning, using the PSIRF model. PSIRF was embedded within maternity and learning from incidents was shared with maternity teams, through email alerts and messages during daily handover.

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The perinatal mortality review tool (PMRT) is a tool to support objective and standardised local reviews of care if a baby dies. The service had 3 perinatal mortality review tool (PMRT) cases within the last 6 months.

Quarterly PMRT reports were submitted to the trust board and cases submitted to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBBRACE) within 7 days of a baby's death and duty of candour was given to all families.

MBBRACE is a national program focusing on improving maternal and infant health. Questions and feedback received from women and their families were presented to the PMRT review panel as part of the review and the trust responded to questions raised. PMRT reports were reviewed by a multidisciplinary team.

The service engaged with the Maternity and Newborn Safety Investigations (MNSI) programme. MNSI is a national strategy to improve maternity services. The service had 4 MNSI reported cases over the last year.

A multidisciplinary (MDT) or obstetric review of incidents took place weekly. In addition to these reviews the patient safety midwives met with ward leads weekly to discuss incidents which did not require an MDT or obstetric review. Community incident reviews were twice weekly and was community focused only.

Monthly situation, background, assessment and recommendation (SBAR) learning from incidents was shared with all staff and displayed on safety and staff notice boards throughout the unit.

Maternity staff had access to a team's channel which contained incident reviews, improvement plans and tools could be accessed.

Anonymised incidents and complaints presented within the maternity governance meetings and local maternity and neonatal system (LMNS) quality and safety meetings were used during trust maternity mandatory training.

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## Safe systems, pathways and transitions

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always work well with people to establish and maintain safe systems of care. They did not always manage or monitor people's safety.**

Systems and processes within maternity triage were not embedded to ensure women were safe. The service was not meeting the target of 90% for women to receive an initial review by the midwife within the maternity assessment unit and were not always prioritised appropriately.

The maternity assessment unit (MAU) was the service's maternity triage area. The MAU is an urgent 24-hour service to assess and treat pregnant women where there were urgent concerns. Midwives used a nationally recognised tool to rate risks consistently.

Monthly audits were completed to determine how long women waited for initial assessment and if they required a medical review.

At the time of our assessment the maternity assessment unit (MAU) was staffed with 1 band 6 midwife and 1 maternity support worker. The unit was small and confined, and women were required to wait outside the MAU. As a result, staff did not always have a direct line of sight, which meant continuous observation to identify deterioration was not consistently maintained.

Although the service had fewer than 3,000 births per year and did not routinely require two midwives in triage, we did identify concerns around staffing levels during times of increased activity. We shared our concerns regarding MAU staffing and following the assessment the service introduced a second midwife during peak times, to support the MAU when more women attended.

The maternity assessment unit standard operating procedure set the target for women to be seen and assessed within in the MAU within 15 minutes of arrival. Data between March 2025 to

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August 2025 showed the service were close to meeting the trust target of seeing and assessing women within 15 minutes. Target figures for those months were between 82% to 88%.

At the time of assessment, the service did not audit or record the times women waited for a medical review within MAU. A review of women's records within MAU identified that 50% of delays was due to women waiting for a medical review. Following concerns raised about limited oversight of medical reviews for women, the service introduced a resident doctor to be rostered on each shift within the MAU, where required.

However, there was no further data received to ascertain whether the times women had received a medical review had improved. The risks of not having a timely medical review meant delayed decision making, further complications to the woman and their unborn baby.

Although there were delays in reviewing women due to staffing within MAU, we did find staff were trained to respond to risk and were able to identify and act when women were at risk of deterioration. Staff completed risk assessments and took action to remove or minimise risks, and documentation was completed appropriately.

The CQC coordinates a national survey annually to look at the experiences of pregnant women and new mothers who used NHS maternity services. This survey looked at the experiences of pregnant women and new mothers who used NHS maternity services in 2025. It is CQC coordinated with other stakeholders, but it is reported by us at CQC. We reviewed the latest findings of the maternity survey 2025. We saw that when women were asked "Thinking about the last time you contacted the telephone triage line, did you feel that you got the advice you needed?", the service scored 8.9, which was above the national average of 8.3 when compared to all other trusts in England. For the question "Thinking about the last time, you attended triage face-to-face, did the midwife or doctor you spoke to listen to you?", the service score 9.1, which was above the national average of 8.7.

The service provided a centralised maternity telephone triage which received calls for all four of the trust maternity locations. The local maternity and neonatal systems (LMNS) insight visit in August 2025 recognised improvements in the centralised telephone triage service. There were no further maternity and newborn safety investigations linked to telephone triage, and there was a 40% reduction in born before arrival (BBA) cases. This meant there was improvement to women accessing advice and reducing avoidable risks for women.

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Staffing red flags in maternity care can identify a lack of adequate maternity staffing, which can lead to unsafe care for women and their babies. Red flags may also occur due to staffing shortages, which can affect the ability to provide safe care.

Red flag data was reviewed and we saw in June 2025 there were 21 incidences of the labour ward coordinator unable to maintain supernumerary status of not providing one to one care. In July 2025 and August 2025 there were 6 incidences reported each month of incidences where the service was unable to fill vacant shifts and there was unexpected staff absence.

The maternity dashboard was reviewed and from March 2025 to August 2025 the labour ward coordinator was 100% supernumerary in the delivery suite. This meant the labour ward co-ordinator was able to have full oversight of the maternity unit and were able to allocate resources to effectively meet the needs of women and their baby.

Staff attended two cross-site daily status (sitrep) meetings each morning where they discussed the current and emerging situation at both such as staffing levels and capacity at St Richard's Hospital and Worthing Hospital. The director of midwifery (DOM) or head of midwifery (HOM) chaired the meetings. The agenda included staffing, bed capacity and learning from recent incidents.

The second meeting covered all four hospital sites and used information from the first meeting to identify any areas of concern and address immediate concerns across the whole trust.

Staff of all grades attended regular safety huddles during their shift. This was an opportunity to share safety information. At the change of shift the medical and midwifery teams had handover meetings to discuss all women within the maternity unit. During the assessment we attended handover meetings and safety huddles. We found them well attended and used to fully discuss women and any emerging concerns.

Transitional care for babies provided extra support beyond the usual postnatal care but were well enough to be cared for at the bedside with their mother. Care for transitional care babies were provided by the midwifery and neonatal teams. All babies were reviewed daily by the neonatal team.

Staff completed newborn risk assessments using recognised tools such as the Newborn Early Warning Trigger and Track (NEWTT) tool to record observations and feeding. All babies who

needed special care or transitional care were discussed at an avoiding term admission into neonatal units (ATAIN) meeting. The ATAIN meeting focused on reducing unnecessary admissions of full-term babies to neonatal units by identifying and addressing potential issues.

## Safeguarding

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always work well with people and healthcare partners to understand what being safe meant to them and how to achieve that. They did not always concentrate on improving people's lives or protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. They did not always share concerns quickly and appropriately.**

During the assessments of the four maternity service locations, it was identified that the trust did not follow the Intercollegiate Document for Safeguarding Children and Young People 2025 or the Royal College of Nursing adult safeguarding: roles and competencies for health care staff (2024/2025) guidance sets out that health care staff engaged in assessing, planning and delivering care should be trained in adult level 3 safeguarding.

Data showed at the time of our assessment there were no midwifery staff trained to this level. However, since the inspection the trust had introduced a rolling programme of level 3 adult safeguarding training to midwives and obstetric teams.

Maternity and medical staff were 95% compliant in safeguarding adult level 2 training. Maternity staff met the trust compliance for level 3 safeguarding children's training with 95%. Medical staff had 87.7% compliance, which did not quite meet the compliance of 90%.

Staff told us they had access to the safeguarding lead midwife. The safeguarding midwife was located within the unit and offered support or guidance to staff when needed.

The safeguarding team had clear escalation pathways and reported to the board via the

hospitals safeguarding lead. Staff completed assessments for women to identify and support those at risk of self-harm and suicide. During a review of women's maternity records, we saw staff asked safeguarding questions at each antenatal contact if safe to do so.

Staff placed a flag on women's records if safeguarding issues were identified. This included staff in the emergency department. This allowed staff to easily identify women or babies at risk.

Women who did not attend hospital appointments were flagged to the community team for follow up. Women who regularly did not attend appointments were reviewed at risk meetings to support timely contact. Where concerns or continued non-engagement were identified, safeguarding referrals were made to relevant external agencies.

The trust had appropriate safeguarding policies that aligned with national guidance and a designated safeguarding midwife. Midwifery and obstetric staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff explained safeguarding procedures, how to make referrals and how to access advice.

The service supported vulnerable women throughout their pregnancy and birthing journey with a 'one stop clinic'. The clinic saw women with substance misuse and were provided support from the obstetric, safeguarding, smokefree pregnancy and paediatric teams.

There was a pathway to support perinatal women during a psychiatric emergency. Postpartum psychosis is a severe mental illness which can start suddenly during the final trimester of pregnancy or in the days or weeks after having a baby.

Staff followed safe procedures for partners and families visiting the wards. The service strictly controlled access to all areas. Staff undertook baby abduction drills, so they knew what to do in the event of an attempted baby abduction. Staff told us there had been a baby abduction drill within the last 12 months.

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## Involving people to manage risks

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The evidence showed some shortfalls. The service did not always work well with women to understand and manage risks. Staff did not always provide care to meet women's needs that was safe, supportive, and enabled women to do the things that mattered to them.**

The trust reviewed Cardiotocography (CTG) monitoring and intermittent auscultation through completing fresh eyes to gain reassurance of staff competence and completion. Cardiotocograph (CTG) and intermittent auscultation was a method of fetal monitoring during labour that involves listening to the fetal heart with a doppler ultrasound.

The electronic record system showed the compliance rate for completing 'fresh eyes' monitoring was below the trust compliance, with only 12.7% of fresh eyes completed. The service completed a paper-based review of 'fresh eyes' to identify potential issues with pulling information through within the electronic data system. The paper-based review identified the service continued to not meet the trust target with only 40% compliance.

'Fresh eyes' provide an independent and objective assessment, which is essential for improving the safety of women and reducing the risk of errors in the interpretation of fetal wellbeing during labour, and supporting safe and timely clinical decision-making.

The service did not provide information relating to why 'fresh eyes' compliance did not meet the trust target. However, despite the service not completing hourly 'fresh eyes' reviews, the service noted escalation of care was always appropriate.

Hypoxic-ischaemic encephalopathy (HIE) is a term for a brain injury that happens before, during, or shortly after birth when oxygen or blood flow to the brain is reduced or stopped. The maternity dashboard showed the service was slightly higher than the national average of 4.25 per 1000 births for HIE rates, with no cases in June 2025, 5.13 for July 2025 and 5.05 for August 2025. Following the reporting process the service reported the 12-month rolling rate for

suspected HIE cases for July 2025 was reported to be 1.4/1000 births. However, the service did not provide the updated confirmed number of cases.

Women attending the service for an induction of labour (IOL) were given an initial date for admission to start the induction process. Women were advised that this date may change based on acuity and the prioritisation according to clinical risk.

Information received from staff showed there were regular delays in women receiving the IOL. We requested the number of IOL delays and time of waits between May 2025 to October 2025 for the hospital. Although the service reported that 24% of women attending St Richard's hospital had an IOL, they did not collect data regarding the waiting times. Collecting wait times for IOL helps services identify delays that may increase risks to women and babies. It supports effective capacity planning, oversight, and assurance that care is provided in a timely and safe way in line with clinical guidance.

The service had recently updated their clinical guidelines and formed an IOL discussion group to listen to concerns and to explain emerging plans. However, without collecting waiting time data, the service could not clearly identify reasons, themes or trends for delays in induction of labour to improve women's experiences and fully alleviate risk.

The risk assessment (RAG) rating at birth tool was embedded within the electronic patient records and all babies were risk assessed within the first hour of birth. This identified whether babies were low or high risk at birth. This supported the identification of early onset of sepsis and babies who were higher risk of clinical deterioration.

Documentation audits were not completed as a standalone audit, instead the service completed a maternity incident review process which looked at the maternity journey of the woman. Any failures identified within the documentation practice triggered a shared learning review. The service recognised that this was not a usual documentation audit, noting specific triggers. However, they felt it provided assurance about practice within maternity as well as identifying trends.

Not completing stand-alone documentation audits reduces oversight of record-keeping standards and increases the risk that poor practice is not identified. This can affect patient safety, continuity of care, and the trust's ability to provide assurance of care quality.

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The service provided staff with a fluid balance 3-day workshop for fluid balance recognition as part of scenario training for multidisciplinary skills. This was following a decline in staff completing urine output and fluid balance documentation. Staff were reported to be 98% compliant in fluid balance training. However, the service did not report if there had been an improvement in documentation following the training.

The service had developed a hyponatraemia in labour guideline, and a hyponatraemia prevention communication was circulated to both women and staff. Hyponatraemia can occur during labour, particularly where labour is prolonged, oxytocin (a hormone used to stimulate uterine contractions to facilitate labour and delivery) is used, or fluid intake is not appropriately managed. If hyponatraemia is not effectively managed, it may increase risks to women and babies. Prompt identification and escalation help support safe care.

The service held consultant-led labour ward rounds twice daily, 7 days per week. Consultants also attended a weekly multidisciplinary meeting (MDT).

## Safe environments

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always detect and control potential risks in the care environment. They did not always make sure equipment, facilities and technology supported the delivery of safe care.**

The service provided a full range of maternity services. Maternity services included, antenatal clinics, maternity assessment unit, day assessment unit, Tangmere ward, which was an antenatal and postnatal ward, midwifery led unit, labour ward, 1 obstetric theatre, 1 high dependency delivery room which was used as a second theatre in emergencies, recovery area and a bereavement suite.

The design and the environment did not effectively meet the needs of women and babies. The

service had multiple estates issues which made it difficult for staff to deliver timely clinical care safely and contributed to a more stressful working environment. For example, we saw there was a lack of space in the maternity assessment unit, inappropriate waiting areas for women and insufficient rest areas for staff.

However, following the inspection the service told us there were alternative rest areas available for staff.

The service had birthing pools in the birthing unit and labour ward which were in accordance with best practice guidance and pool nets were also available in the event of a woman requiring emergency evacuation from the birthing pool.

The service lessened the risk of having 1 obstetric theatre by working with the day surgery unit to secure availability for an extra elective case list 1 day a week. The day surgery theatre list was staffed with a separate maternity/obstetric team with 3 registered midwives and a consultant lead. The service planned to extend the day surgery theatre session to 2 days in 2026.

The high-dependency delivery room was a prepared room which could be converted to a second theatre if required in an emergency and if the day surgery unit was not available. The head of midwifery (HOM) had completed an environmental risk assessment to make sure the area was safe for women. A draft statement of purpose (SOP) had been produced for the use of the day surgery unit for elective sections. The SOP was currently going through the governance processes, and this had been shared with staff.

The MAU was small and women attending were required to wait outside in the waiting area where staff did not always have a direct line of sight of the women attending.

The waiting area for women attending the maternity assessment unit (MAU) did not meet national guidance for maternity triage areas. The MAU was in the labour ward, and a separate bell was used to inform MAU staff that they had arrived and asked to remain in the waiting area outside of the labour ward. This was so the service could safely identify who entered the labour ward. However, this meant there was some confusion when women rang the wrong bell for the MAU or labour ward. This had the potential to delay timely access to the appropriate clinical team and initial assessment.

The service had a purpose-designed bereavement area to help support women and their

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families. The bereavement suite was located on the labour ward and was not fully soundproof, which meant there was a potential for parents to hear sounds from the labour ward and experience distress. A soundproof bereavement suite protects women and families from distressing external noise, supporting privacy, dignity and compassionate care. However, there were no incidents or concerns reported by families relating to the location of the bereavement suite. The bereavement suite was seen to be well equipped and provided a comfortable home environment for women and their families.

The maternity unit was clean, tidy and free of clutter. However, we did find stainless steel storage containers within labour ward which had areas of rust. Rust creates rough surfaces that trap dirt and bacteria, making the containers difficult to clean properly.

Staff completed daily checks on specialist equipment, including the post-partum (PPH) and major obstetric haemorrhage (MOH) trolley in labour ward. The emergency resuscitation trolleys were tagged. Resuscitaires were available on the labour ward and postnatal unit, and we found they were accessible and were well maintained.

Fire exits were clearly marked and unobstructed. There were birth pool evacuation nets and equipment in every room that had a birthing pool and staff completed evacuation of pool training.

## Safe and effective staffing

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The evidence showed a good standard. The service made sure there were enough qualified, skilled and experienced staff, who received effective support, supervision and development. They worked together well to provide safe care that met women's individual needs.**

The department recognised the impact of short staffing on the workforce and implemented a new divisional clinical operating model which included overarching cross site clinical director

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roles for both specialities alongside dedicated site-specific medical leadership.

The trust had recruited 2 full-time band 8a recruitment and retention matrons to support maternity and neonatal services with safer staffing. The perinatal development workforce report identified the current vacancy data across maternity services and what short-term and long-term strategies were being put in place to support staffing.

Student midwives across the trust were offered permanent hours at their chosen location, which would over-recruit against current establishments. However, it was too early for the service to know if this had a positive effect on staffing St Richard's hospital. Newly qualified midwives completed a 12 to 18-month preceptorship programme, to support them in their role.

The service was currently completing a Birth Rate Plus (BR+) assessment to assess the midwifery and maternity support worker workforce. The report was due to be completed in January 2026. The current staffing model for the service was reflected of the previous 2023 BR+ recommendations.

The October 2025 perinatal workforce report identified that staffing remained stable overall within the service. The BR+ assessment is usually completed every 2 years and is an evidence-based tool used to determine midwifery staffing requirements based on birth activity and case complexity. It supports safe staffing by ensuring workforce levels are aligned with clinical demand and risks to safe care are identified.

However, staff told us that staffing levels on Tangmere Ward felt unsafe. This was particularly when caring for women undergoing induction of labour and caesarean sections alongside routine antenatal and postnatal care. They reported this was made worse by working below established staffing levels and staff being redeployed to the delivery suite.

There was currently a high maternity vacancy rate. Head of midwifery (HOM) told us that staffing within both Tangmere and the maternity assessment unit were being reviewed in the most recent BR+. October 2025 the midwifery vacancy rate for the service was 9.4%. However, the service had seen an improvement within maternity staff sickness. Various support and well-being offers had been introduced across maternity services including listening events and newsletter updates.

The service had enough medical staff to keep women and their babies safe. St Richard's

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Hospital benefitted from a higher number of consultant obstetricians, than the other 3 maternity locations within the trust. The service had consistent consultant presence for twice daily ward rounds.

The service provided mandatory training data for August.2025 only, this included, skills and drills training or fetal monitoring training. The data showed 90.7% of doctors and 95% of midwives were compliant in fetal monitoring. Multidisciplinary (MDT) skills and drills data was not broken down into staffing groups and showed 87.2% compliance. However, we were told there was low compliance from obstetric and anaesthetic teams across the trust for fetal monitoring. Therefore, the clinical director and operational manager were currently developing a plan to address low compliance.

## Infection prevention and control

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The evidence showed a good standard. The service assessed and managed the risk of infection. They detected and controlled the risk of it spreading and shared concerns with appropriate agencies promptly.**

Matrons and ward leaders oversaw infection prevention and control across the maternity department.

All areas in maternity were visibly clean and had suitable furnishings which were clean and well maintained. However, there were large stainless steel storage boxes seen within the labour rooms, the top of the container had visible rust, which made it difficult to clean.

We found cleaning schedules and records were monitored through audit to check for compliance. Staff cleaned equipment after contact with women. Staff used ‘I am clean’ stickers to show equipment was clean and ready for use. Bathrooms and toilets were clean and there were laminated posters explaining hand washing technique.

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Privacy curtains were clean and labelled with their replacement date. Staff regularly checked birthing pool cleanliness, and the service had an effective system for legionella testing of the water supply.

Staff followed infection prevention and control principles and used personal protective equipment correctly (PPE). Staff were bare below the elbow, and we observed them cleaning their hands with alcohol-based hand gel. Staff prompted all visitors to clean their hands on entering the department. There was sufficient supply of PPE such as gloves, masks and aprons.

Hand hygiene audits were completed monthly within each clinical area and all areas scored 100%.

## Medicines optimisation

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service made sure that medicines and treatments were safe and met women's needs, capacities and preferences.**

The service had medicine administration guidelines for midwives. Midwives had access to the full list of midwives' exemptions, so they were clear about administering within their remit. Midwife's exemptions allow registered midwives to supply and administer certain medicines without a prescription, under specific legal and professional conditions.

Staff were trained to administer medicines safely. Staff demonstrated good understanding of how to monitor for and manage medical emergencies that can occur in pregnancy, including post-partum haemorrhages and sepsis. The trust prepared emergency medicines boxes centrally. These were available, tamper evident and in date.

The service reported that maternity services do not complete prescription audits as there had been no identified themes for concern and no recent incidents regarding prescribing.

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## Effective

Rating Good

We looked for evidence that women and communities had the best possible outcomes because their needs were assessed. We checked that women's care, support and treatment reflected these needs and any protected equality characteristics, ensuring women were at the centre of their care. We also looked for evidence that leaders instilled a culture of improvement, where understanding current outcomes and exploring best practice was part of their everyday work.

At our last assessment this key question was not rated. At this assessment the rating was good. This meant the effectiveness of people's care, treatment and support achieved good outcomes and was consistent.

The service worked with agencies involved in people's care for the best outcomes and smooth transitions when moving between services. They monitored people's health to support healthy living. Staff made sure people understood their care and treatment to enable them to give informed consent.

There were positive examples of person-centred care. Women were given information and advice about their health, prenatal and postnatal care. They told us during the assessment that they felt well supported by the multi-disciplinary team and felt they were involved in the assessment of their needs.

However, staff did not always have up-to-date guidance to follow legislation and current evidence-based good practice and standards. The trust did not effectively use benchmarking to ensure that outcomes were positive and consistent.

### Assessing needs

#### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The evidence showed a good standard. The service made sure people's care and treatment was effective by assessing and reviewing their health, care, wellbeing and communication needs with them.**

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Staff told us they were supported by senior colleagues, and they worked together to make sure women made informed decisions based on best practice guidelines. Staff were able to describe how they assessed and reviewed women's needs from the antenatal to postnatal period to provide holistic support. For example, birth plans were personalised and up to date.

We saw examples of feedback within the family and friends feedback such as, "Everyone went above and beyond to support and accommodate any of my needs from changing appointment dates to seeing specific consultants".

Women were given information and advice about their health, prenatal and postnatal care. They told us during the assessment that they felt well supported by the multi-disciplinary team and felt they were involved in the assessment of their needs.

There were positive examples of person-centred care, and we saw feedback from women who had previous birth traumas and long-term health conditions who felt well supported and listened to when making decisions about their pregnancy and birth.

The Maternity survey 2025 reported women felt involved in decisions about their antenatal and postnatal care, with the trust scoring higher than the national average for this question.

During our assessment we reviewed 7 care records which showed examples of person-centred care. Staff carried out risk assessments for women during antenatal care in line with national guidance. These included social assessments, risk assessments for blood clots and mental health assessments. Staff made referrals to consultant led clinics for women with medically high-risk pregnancies. Risk assessments for women were in line with national guidance.

Staff attended maternity huddles, which were held twice daily 7 days per week. We attended maternity huddles which were well attended by the maternity and obstetric team. Staff used the Situation, Background, Assessment and Recommendation (SBAR) tool to communicate important information about a woman's condition to the team. This ensured that assessments were informed by accurate and up-to-date information, supporting appropriate clinical decision-making and enabling the service to respond appropriately to women's assessed needs.

Consultant midwives worked between both St Richard's hospital site and Worthing Hospital site. The consultant midwife led on the physiological birth working group. The group was

collaborative initiative which involved midwives and obstetric staff from all 4 maternity locations. The working group focused on training of staff to support optimal maternal positioning during labour and strategies to improve care in the initial phase of labour.

## Delivering evidence-based care and treatment

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The evidence showed some shortfalls. The service did not always plan and deliver women's care and treatment with them, including what was important and mattered to them.**

The service reported the trust was experiencing challenge with clinical guidelines and the maternity service was working towards merging its current guidance across all maternity sites.

From October 2025 the safety and quality report showed 108 of maternity documents were out of date. This was on the maternity risk register due to the ongoing delay in updating guidance and the potential risk this may cause. For example, out of date documents may lead to poor decision making and non-compliance with regulatory requirements and inconsistencies in maternal and neonatal outcomes.

Key maternity guidance was out of date and not consistently aligned across the maternity locations. However, policies and guidance did reflect the current National Institute for Health and Care Excellence (NICE) guidance.

The guidance for postpartum haemorrhage (PPH) management was out of date. Staff currently used the University Hospital Sussex Obstetric Haemorrhage guidance which was also out of date and not aligned with the most recent National Institute for Health and Care Excellence (NICE) guidance. For example, using the correct dose of misoprostol and a flow chart which did not reflect the most recent safe actions and options for management of PPH a major obstetric haemorrhage over 1 litre. Out-of-date postpartum haemorrhage (PPH) may result in delayed or

inappropriate clinical responses and poorer outcomes for women.

The service did not have a maternity bereavement policy. The bereavement team followed actions outlined in the Intrauterine Death Policy, however, this policy was also out of date in November 2023. We were told bereavement midwives instead followed the National Bereavement Care Pathway. The potential impact of not having a trust maternity bereavement policy could lead to a lack of ability to support women and their families and staff may not have the tools or information to provide compassionate care.

Staff used nationally recognised tools, such as the maternity early warning score (MEWS) and the newborn early warning trigger and track (NEWTT2) tool, to identify women and babies at risk of deterioration. The trust had not implemented a MEWS or NEWTT2 audit due to the current electronic record system being unable to capture all required data.

Senior leaders told us MEWS and NEWTT2 were discussed within the trust guidance 'Recognition and Management of Severely Ill Pregnant women/women including Enhanced Maternal and Critical Care'. However, this guidance had not been updated and was out of date, expiring in November 2024. Senior leaders had drafted a standard operating procedure (SOP) to support staff completing MEWS and NEWTT2 prior to the upcoming electronic update. However, the SOP had not gone through the appropriate governance process therefore staff continued not to have guidance.

MEWS documentation was not currently audited by the trust. The service told us that the new version of the tool was due to be uploaded to the electronic notes system in March 2026. Without completing monthly audits, senior leaders were unable to identify areas of poor performance, reducing their assurance that women and babies were receiving safe care.

Maternal readmissions were not reported as location specific, with all 4 maternity locations reporting to the trust together. This meant it was difficult for the service to understand local performance and outcomes for women. The service did not provide us with the number of maternal readmissions to the service.

Monitoring readmission rates at individual hospital level allowed leaders to understand local performance and patient outcomes. Hospital-specific data helps to identify variations, assess the effectiveness of care and discharge processes, and take targeted action where

improvement is needed. Trust-level data alone may mask risks at site level, reducing oversight and assurance that care is effective for women using maternity services at that hospital.

Sepsis audits were not completed by the service which meant the service could not be assured staff were recognising and managing the early onset of sepsis. Sepsis was identified via review of electronic incident reports. However, this did not provide adequate assurance regarding the monitoring of sepsis and early deterioration. The service did not provide any data to identify whether there had been any sepsis cases over the last 3 months.

The service did contribute to some national audits, such as perinatal mortality, and Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK).

Managers communicated changes in national guidance through monthly newsletters, departmental alerts, during huddles and through presentations to staff.

## How staff, teams and services work together

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service worked well across teams and services to support women. They made sure women only needed to tell their story once by sharing their assessment of needs when women moved between different services.**

Teams had effective working relationship, with staff reporting they worked well as a team and there was a good culture between midwives and obstetricians.

Staff considered patients' individual needs and circumstances and we observed effective handovers. During safety huddles we observed maternity and obstetric teams actively having discussions around supporting women.

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services.

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There was a monthly service user workstream working group in place, chaired by the head of midwifery and MNVP. The group reported into the maternity and neonatal improvement group, which was chaired by the chief nurse and attended by stakeholders to support and advise the trust such as NHSE, LMNS, Maternity Safety Support Programme (MSSP), and MNVP. The MNVP provided friends and family feedback to improve antenatal appointments and discharge processes by identifying further information about women's background and history to support their maternity journey.

There was a continuity of carer team for all women who used the service where there were safeguarding concerns, long term conditions, mental health needs, or other additional needs. During midwifery safety huddles we observed active discussions around women with complex care who required support to have the birthing experience they wanted. The service had worked with external agencies and local trusts to develop a multi-agency birth plan.

Bereavement services had links with mental health teams and external support agencies to support women following loss.

## Supporting people to live healthier lives

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service supported women to manage their health and wellbeing to maximise their independence, choice and control. The service supported women to live healthier lives and where possible, reduced their future needs for care and support.**

Staff assessed women's health when admitted and provided support for any individual needs to live a healthier lifestyle. Women were asked about their smoking status at their booking appointment, and all women were offered carbon monoxide screening.

The trust website had a page dedicated to advice and support during pregnancy. Information on the website included pregnancy advice and antenatal education.

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Women could access information and advice about their health, care and support from the hospital maternity pages on the internet, printed leaflets and from staff during their appointments.

## Monitoring and improving outcomes

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always routinely monitor women's care and treatment to continuously improve it. They did not always ensure that outcomes were positive and consistent, or that they met both clinical expectations and the expectations of women themselves.**

The perinatal quality oversight model (PQOM) measured current performance and maternity clinical indicators. These indicators were used to assess outcomes and overall performance. However, the PQOM did not add benchmark data or target indicators. This meant it was not clear whether the service was improving, meeting national requirements, or performing as an outlier.

The trust told us following the inspection, the PQOM dashboard was not a trust-controlled dashboard but one requested by the local maternity and neonatal systems (LMNS) for the trust to use. The trust reported they had requested to report via a benchmarking dashboard, although this had not been put in place.

The guidance for postpartum haemorrhage (PPH) management was due to be reviewed in April 2024, therefore was out of date. The service was due to complete a thematic review into postpartum haemorrhage (PPH) following continued high rates of PPH reported. The national rate for PPH levels was reported to be 32% per 1000 births and the figures given for the service during our data request were 37.43% for June 2025, 51.55% for July 2025 and 35.35% for August 2025. High postpartum haemorrhage (PPH) rates may indicate variation in the prevention, recognition, or management of bleeding following birth. This increases the risk of harm to women and highlights the need for review of clinical practice, training, and guidance.

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Maternity services across the 4 sites did not meet the compliance to complete hip scans for babies who met the referral criteria within the required timeframe. This was due to issues with limited scan appointment capacity. Completing hip scans identified developmental hip conditions early, supported prompt treatment, and improved long-term musculoskeletal outcomes for babies. When scans were not completed as planned, this increased the risk of delayed diagnosis, potentially affecting mobility, development, and future quality of life.

Trust compliance with saving babies' lives (SBL) care bundle had gone from 97% compliance to 49%. The trust reported this was due to a delay in the service merging and ratifying guidelines required by SBL. Poor compliance with the SBL Care Bundle reduced the effectiveness of preventative measures, led to missed or delayed identification of risks, and contributed to variation in care. This negatively affected perinatal outcomes and increased the risk of harm to babies.

Women's smoking status at 36 weeks was not always completed by maternity staff. The trust target for completion was 80%, however, the service was only 62.5% compliant. Monitoring smoking rates in pregnancy identified a key preventable risk factor for poor birth outcomes. This enabled services to target higher-risk groups, assess cessation support, and reduce avoidable harm.

However, there had been improvements in the number of women who had, had a 3rd or 4th degree tear. The trust had been working with staff to implement the obstetric and sphincter injuries (OASI bundle) and to work on the correct technique and optimising maternal position. Between March 2025 to August 2025 the service had showed improved rates and the service were below the national average.

The service learned from neonatal deaths via a child death oversight panel. These were presented to the board through a series of meetings. Learning was also shared system wide via the LMNS quality and safety forum and the board. Neonatal outcomes across the trust had shown an improvement within neonatal mortality rates which were below the national average.

Acute services
# Maternity

## Consent to care and treatment

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service told women about their rights around consent and respected these when delivering person-centred care and treatment.**

Women we spoke with felt they had been given enough information, including risks and benefits, to make an informed decision about their care and treatment and that they were able to give informed consent.

Midwives understood how to assess women's capacity to make decisions. On our review of women's record's, we found completed consent forms for caesarean sections as well as when gaining verbal consent when completing care.

Staff had access to mental health/deprivation of liberty safeguards (DoLS) guidelines on the trust intranet. Staff were able to talk about DoLS and how this would impact a woman on the unit. Staff were aware of their responsibilities under the Mental Capacity Act 2005.

## Caring

Rating Good

We looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last assessment this key question was not rated. At this assessment the rating was good. This meant people were supported and treated with dignity and respect; and involved partners in their care.

Women received care that was person-centred and were given information and advice about their health, prenatal and postnatal care. Women told us during the assessment that they felt well supported by the multi-disciplinary team and felt they were involved in the assessment of their needs.

Acute services
# Maternity

## Kindness, compassion and dignity

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The evidence showed a good standard. The service always treated women with kindness, empathy and compassion and respected their privacy and dignity. Staff treated colleagues from other organisations with kindness and respect.**

Women and their families we spoke with felt they were treated with kindness, compassion, and dignity. During the assessment, we observed midwives taking time to interact with women and those close to them in a respectful and considerate way. Women staff listened to them and communicated with them appropriately.

Staff maintained women's privacy and dignity by asking for permission before entering bed spaces and drawing curtains around beds when they attended. They offered chaperones to women having intimate examinations.

Women told us, “The midwives were amazing”, “Everyone was friendly”, “I am happy with my care” and “From start to finish the wonderful staff at St Richard’s made our whole experience so special. Kind caring patient and so knowledgeable honestly couldn’t ask for more”.

The service received positive feedback from the women and their families who used it. Feedback from women and their families was gained through the friends and family test (FFT) and the birth stories service.

Patient experience audits were reviewed by matrons across maternity services. Feedback showed that women and their families consistently described staff at all levels as kind, supportive, professional and compassionate.

We reviewed the latest Maternity survey 2025, we saw that when women were asked “Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?”, the service scored 6.7, which was below the national average of 7.6, when compared to all other trusts in England. Women were asked if they felt that healthcare

professionals did everything they could to help manage your pain in hospital after the birth. The service scored 8.0, which was above the national trust average of 7.6.

When women were asked if they were treated with kindness and compassion during labour and birth the services scored 9.3, which was above the national trust average of 9.0. When women were asked about their post-natal care they received, were they treated with kindness the service scored 8.7, which was above the national trust average of 8.4.

Feedback was used to form reflective practice with maternity staff and for professional development. Staff achievements were shared, and we saw examples where staff had gone above and beyond to support women during their birthing experiences.

The service worked closely and had positive relationships with the local Maternity and Neonatal Voices partnership (MNVP). The MNVP engaged regularly with leaders to ensure voices of women were heard and feedback was passed on.

## Treating people as individuals

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The evidence showed a good standard. The service treated women as individuals and made sure women's care, support and treatment met women's needs and preferences. They took account of women's strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.**

Women's individual needs and preferences were understood, and this was reflected in the care, treatment and support they received during their pregnancy and birthing journey. Staff were understanding and had a non-judgmental attitude when caring for or discussing women with mental health needs.

Emotional support and advice to women was evident from talking to women during the assessment and from reviewing feedback and thank you emails and letters received from

women. Staff were reported to be readily available to women. Staff listened and were visible on the unit. For example, the friends and family test provided feedback from women and their families who attended the service.

The findings of the Maternity survey 2025 showed when women were asked if a midwife asked about their mental health, the service scored 9.6, which was above the national trust average for England. Women were also asked if they were given information about any changes they might experience to their mental health after having a baby, the service scored 7.5, which was above the national trust average of 7.4.

The service offered support for women from black and south Asian backgrounds to access antenatal results and choices counselling (ARC). This was because women from a black and south Asian background were less likely to access mental health services.

The trust had begun cultural improvement work to address staff attitudes and behaviours, and senior leaders had completed perinatal culture and leadership training. This supported kindness and compassion during labour and delivery, improved women's experiences, and promoted safer, more respectful care.

Maternity and neonatal voice partnership (MNVP) used various methods to engage with women using maternity services. The MNVP had successfully procured finance to purchase reclining chairs for partners staying overnight. This meant partners could comfortably stay and support women as well as also being able to establish a bond with baby.

The service had a comprehensive 7-day bereavement service across all 4 maternity sites to make sure there was consistent support for women and their families experiencing pregnancy loss or neonatal death.

However, during the inspection staff reported challenges in accessing translation services for women. Interpreters were not available for all required languages. Following our onsite inspection the trust reported the service was able to book face to face interpreters and a standard operating procedure (SOP) had been developed to make the process clearer for staff. The SOP was waiting for the final sign off by the trust's director of clinical outcomes and effectiveness prior to publication and availability to staff.

Lack of access to interpreting services led to misunderstandings, reduced involvement in

decision making, and increased the risk of unsafe or delayed care.

## Independence, choice and control

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The evidence showed a good standard. The service promoted women's independence, so women knew their rights and had choice and control over their own care, treatment and wellbeing.**

Women said that they had choice and control over their own care. We observed staff who supported and involved women in assessments and encouraged them to make decisions about their care.

We reviewed the Maternity survey 2025, women were also asked if they felt that if their partner or someone else close to them were involved in their care during labour and birth were they able to be involved as much as they wanted. The trust scored 9.8, which was above the national trust average of 9.5. When asked about their stay in hospital, if their partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted. The trust scored 9.0, which was above the national trust average of 7.4.

Feedback given in the family and friends feedback for the service said, "Everything was discussed so I could make informed choices, and they were completely respectful of the ones I made".

Women and their families could give feedback on the service and their treatment, and staff supported them to do this as well as maintain relationships that were important to them, for example, the service had introduced 'hope boxes' for mothers where the local authority was planning a separation at birth. Hope boxes included blankets, teddy and memory cards, to support the mother's needs.

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## Responding to people's immediate needs

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service listened to and understood women's needs, views and wishes. Staff responded to women's needs in the moment and acted to minimise any discomfort, concern or distress.**

Maternity staff were supportive and listened to women's needs. The service offered a birth reflections service, which gave women and their families the opportunity to talk about their personal birth experiences.

Bereavement midwives offered counselling to women who had experienced pregnancy loss under 24 weeks. Mother's over 24 weeks mothers could choose between the bereavement midwife and perinatal mental health team (PMHT). Women and their families could access the bereavement team for as long as they required support and the team supported women during any future pregnancies.

The trust had worked with patient safety specialists to provide meaningful and compassionate support to families through a bespoke supervision programme following the loss of their baby.

Staff acted to minimise any discomfort, concern or distress and they listened to and understood women's needs, views and wishes. However, staff on the postnatal ward told us they felt at times due to staffing issues and the delays within flow and discharge in the postnatal area, women often waited too long for support, pain relief and medicines.

## Workforce wellbeing and enablement

### Score

3. Evidence shows a good standard of care

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**We scored the service as 3. The service cared about and promoted the wellbeing of their staff and supported and enabled staff to always deliver person-centred care.**

Most staff we spoke to were positive and proud to work at St Richard's Hospital. They felt valued by all levels of leadership and were positive of the maternity senior leadership team.

Staff told us they were able to develop professionally, and student midwives were very much part of the team.

The leadership team completed perinatal culture work to improve staff wellbeing, with targeted action plans to improve cultural challenges. The service launched an app for staff to improve staff experience within the workplace alongside improving care for women.

Through the app, staff were able to submit ideas for improving the service, discuss within teams and work collaboratively, to boost staff morale and well-being.

Professional Midwifery Advocates (PMA) provided pastural support and restorative supervision to staff. All midwives were allocated a PMA, and support was also offered to maternity support workers.

Newly registered staff told us managers always protected their supernumerary status. This meant they were extra to the required staffing, which supported their training and development needs.

However, some staff told us staffing was often a challenge on Tangmere ward and there were some staff who were not always supportive or kind to junior midwives.

## Responsive

Rating Good

We looked for evidence that women and communities were always at the centre of how care was planned and delivered. We checked that the health and care needs of women and communities were understood, and they were actively involved in planning care that met these needs. We also looked for evidence that women could access care in ways that met their personal circumstances and protected equality characteristics.

At our last assessment this key question was not rated. At this assessment the rating was good. This

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meant people's needs were met through good organisation and delivery.

Women were involved in decisions about their care. The service provided information women could understand. Women knew how to give feedback and were confident the service took it seriously and acted on it.

Women were involved in planning their care and understood options around choosing to withdraw or not receive care.

## Person-centred care

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service made sure people were at the centre of their care and treatment choices and they decided, in partnership with women, how to respond to any relevant changes in women's needs.**

Women had the option of having a home birth and they were advised to have counselling to support them in making a choice regarding their birthing choice. Women felt involved in planning and making decisions about their care which was responsive to their needs. They reported staff worked together and supported them to plan their care and the birth of their baby.

The findings of the Maternity survey 2025 showed that when women were asked about being offered a choice on where to have their baby the service scored 9.4, which was above the national average of 8.5 when compared to all other trusts in England.

The service had 2 consultant midwives; part of their role was to support women who chose to birth outside of guidance and provided women with up-to-date guidance and options available to make decisions about their birthing journey.

Birth outside of guidance describes women who make decisions that are different from those

recommended by the trust or national maternity guidance. For example, women who have health conditions or risk factors which mean they are recommended to have their baby within the obstetric setting.

The service provided a patient triage telephone line 24 hours, 7 days a week for patients to speak with a trained midwife about any concerns they may have. Women felt they received the appropriate advice and support when contacting a midwife and the trust scored 9.1 out of 10 for advice given to women at the start of labour in the CQC Maternity survey 2025.

## Care provision, integration and continuity

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The evidence showed a good standard. The service understood the diverse health and care needs of women and their local communities, so care was joined-up, flexible and supported choice and continuity.**

The trust aimed to improve targeted interventions to reduce the risk of health inequalities particularly for women most affected.

The maternity service used statistical process control (SPC) charts to allow early identification of changing rates in maternity data and to action an early response to any concerns or themes or trends identified. For example, the trust monitored the percentage of women most at risk of health inequalities. This helped the trust understand the needs of women from diverse groups and co-produce targeted improvements and services to reduce health inequalities.

Specialist midwives identified and supported women with specific support which included the refugee service, drug and alcohol support and teenage pregnancy. There was a proactive approach to understanding the needs of different groups of people and delivering care that met their needs.

The community midwives offered an on-call system for homebirths. The homebirth midwife

would normally stay with women throughout the birth, even if the patient was transferred to hospital. The service reported that 2% of their births were homebirths in August 2025.

Midwives assessed women's mood during antenatal visits and were able to signpost women who required further support for anxiety and depression or fear of pregnancy or giving birth. The Maternity survey 2025 showed that when women were asked about their mental health the service scored 8.4, which was just below the national average of 8.6 when compared to all other trusts in England. The service scored 9, the same as the national average when women were asked if they were given enough support during their pregnancy for their mental health.

Staff could access emergency mental health support 24 hours a day, 7-days a week for women with mental health problems and learning disabilities. The service had systems and specialist staff to help care for women in need of additional support or specialist intervention. For example, they had fetal wellbeing midwives and birth after thoughts midwives.

Senior leaders planned and organised maternity services with the maternity and neonatal voice partnership (MNVP), women using maternity services and staff, so that the service could meet the needs of the local population.

The service recognised an increase in women using doulas and independent midwives during birth. In response, it organised a birth worker event in January 2026 to share learning and experiences, and to provide information and support on trauma-informed care and safer births.

## Providing information

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.**

The trust website included virtual tours of the maternity units and provided information on

maternity services.

Information on birth options and realistic expectations was provided to women and their partners during antenatal appointments and through information on the trust website.

Antenatal education on birth options and realistic expectations was provided to women and their partners. The aim of the antenatal education was to reduce fear, anxiety and postnatal depression and to improve birth experiences and wellbeing. The trust offered virtual and face to face antenatal sessions.

Managers communicated changes in national guidance through monthly newsletters, departmental alerts, during huddles and through presentations to staff. There were informative notice boards around the maternity unit displaying best practice guidance for breastfeeding.

The trust scored 7.4/10 for receiving the information and explanations they needed after birth in the Maternity survey 2025.

## Listening to and involving people

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service made it easy for women to share feedback and ideas, or raise complaints about their care, treatment and support. They involved women in decisions about their care and told them what had changed as a result.**

The trust recognised that women were becoming more informed and aware of their options during the pregnancy and birth of their baby and were working to improve birth experiences for women.

The trust had a ‘voice of the user’ section on their maternity dashboard, where maternity leaders monitored themes from women and their families. The dashboard showed friends and family test results, formal complaints, duty of candour compliance, number of obstetric claims

and maternity and neonatal voice partnership meetings (MNVP).

The service displayed information about how to raise a concern and give feedback on care or experience of the service on notice boards around the unit. Leaders told us they shared feedback from women with staff and the trust board.

In August 2025 for the percentage of women and their families who would recommend maternity services was 93.02%.

The service received 11 complaints between April 2025 to September 2025 and there were 3 complaints still open to an investigation, with 1 of those complaints exceeding their 60 working day closure target.

The most common theme of complaints was due to clinical incidents. These were broken down into failure to diagnose, inappropriate procedure, awareness under anaesthetic and delay or failure to undertake scans.

Complaints were shared within the monthly safety champions report and presented at the maternity and neonatal clinical leaders meeting and the maternity and neonatal patient safety meeting.

Staff knew how to handle complaints effectively and the head of midwifery reviewed all complaints and responses.

## Equity in access

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service made sure that women could access the care, support and treatment they needed when they needed it.**

Women had equal access to care, treatment, and support. The service worked with local maternity and neonatal systems (LMNS) and maternity and neonatal voice partnership (MNVP)

to identify barriers to women accessing maternity care and discuss improvements.

The trust's maternity dashboard showed in August 2025 74.74% of women who saw a midwife for their 10-week booking appointment.

The NHS guidance is for a first midwife appointment (also called the booking appointment) to be before the women is 10 weeks pregnant. This is because some tests may need to be done before 10 weeks. It was unclear whether the service was in the process of improving access for women.

From September 2024 to August 2025 there were 3 incidences where the maternity service had identified capacity issues and the trust escalation procedure had been activated. However, the demand was managed within the trust and there were no incidences of pregnant women diverted to other trusts. The maternity directorate discussed themes and learning from complaints at the monthly quality and safety meetings. At a divisional level, themes, learning, and timeline performance was discussed monthly at the divisional quality governance forum.

The trust provided data for all four maternity locations which showed there were 103 women readmitted into maternity from February 2025 to July 2025.

Following ongoing concerns with delays in induction of labour (IOL) had updated guidelines and formed an IOL discussion group to listen to concerns and explain emerging plans and next steps so all women having an induction of labour followed the same process.

The service had a pathway and were a pilot site for self-administration of medication on the postnatal wards, to allow women independence.

The service worked with local maternity and neonatal systems (LMNS) and maternity and neonatal voice partnership (MNVP) to identify barriers to women accessing maternity care and discuss improvements. The MNVP did this by providing a survey to women using maternity services, talking to women at baby groups and through accessing social media.

Women reported their additional needs and were supported by the service. For example, the service had mental health midwives and specialist bereavement midwives to support women.

The service gave women a discharge date when they booked in for a planned caesarean

section. This allowed women to plan discharge arrangements and family support if needed.

## Equity in experiences and outcomes

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. Staff and leaders actively listened to information about women who are most likely to experience inequality in experience or outcomes and tailored their care, support and treatment in response to this.**

Leaders monitored outcomes and investigated demographic data to identify when treatment and outcomes differed for different groups of women. Equity in experiences formed part of divisional quality meetings and was part of the work that the Maternal and Neonatal Voices Partnership (MNVP) were involved in.

The service provided 100% 1 to 1 care to women in labour, this meant women received personalised care and support during their labour and delivery. One-to-one care during labour improved outcomes for women and babies, reduced medical intervention, and supported more positive birth experiences by providing continuous support from a dedicated midwife or birth worker.

To improve women's experiences of birth, the service developed birth education classes online and face to face. and reduce the number of women experiencing a traumatic birth. The aim of the classes was to lower the risk of birth trauma, reduce fear, anxiety and postnatal depression and to improve birth experiences and wellbeing.

Staff and leaders actively listened to information about women who were most likely to experience inequality in experience or outcomes and tailored their care, support and treatment in response to this. For example, the service had a continuity of care team for homebirths. A continuity of care team for homebirths, often referred to as Midwifery Continuity of Carer (MCoC), improves safety, reduced intervention rates, and enhanced the overall experience for

Acute services
Maternity

the pregnant person.

## Planning for the future

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The evidence showed a good standard. Women were supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life.**

Women could get information and advice that was accurate, up to date, and provided in a way they could understand to plan for their birth. The service supported women to make informed choices about their care. This was achieved through health promotion information, antenatal classes, appointments with midwives, birth plan documents, information leaflets, and resources available on the maternity page of the trust's website.

Women were supported to make decisions to improve their overall health. This included stopping smoking and making healthy eating choices.

Women were clear about discharge plans and who to contact with any concerns. Discharge summaries were shared electronically with health visitors and GPs and follow up arrangements were made prior to discharge.

## Well-led

Rating Requires improvement

We looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last assessment we rated this key question as requires improvement. At this assessment the rating remains requires improvement. This meant the service management and leadership was

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inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

We found a breach of regulation 17 good governance, in relation to the service not being assured auditing systems, setting targets and benchmarking processes were embedded.

There was a lack of oversight regarding risk. The service did not have an audit schedule, and audits were not routinely undertaken or embedded within the service.

Staff did not have access to up-to-date policies and guidance due to several being outside of the review date. We found safeguarding training levels were not aligned to national standards and there was no formal audit plan.

However, policies and guidance did reflect the current National Institute for Health and Care Excellence (NICE) guidance. To develop the vision the trust used key words from feedback received from women and their families through the friends and family test. Key words were also obtained from feedback from staff within the maternity and clinical teams via the staff survey. The trust told us they were committed to fostering an inclusive and equitable working environment and there had been an investment in workforce race equality standard.

## Shared direction and culture

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service had a shared vision, strategy and culture. This was based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of women and their communities.**

Maternity services had co-produced with the local maternity and neonatal systems a vision and strategy ‘University Hospitals Sussex NHS Foundation Trust maternity vision and road map. The newly developed strategy was developed as part of the process of the trust coming out of the

Maternity Support Programme (MSSP).

To develop the vision the trust used key words from feedback received from women and their families through the friends and family test, MNVP quarterly survey and MNVP walkarounds. Along with feedback from staff within the maternity and clinical teams via the staff survey.

Following the last maternity assessment, maternity services across the trust entered the Maternity Safety Support Programme (MSSP) in February 2022. The service had a maternity improvement plan, and the maternity improvement group monitored this the maternity improvement group.

The divisional vision was, “To be a leading provider of maternity care where supportive compassionate care and kind communication create a safe, empowering and personalised experience for all families”.

Staff we spoke to during the assessment could tell the team key words within the vision and key values were displayed on boards around the maternity department.

The divisional goals were aligned with the NHS Three Year Delivery Plan for Maternity and Neonatal Services (2023) and the trust Maternity Improvement Plan. The goals included delivering the highest standards of safety and quality of care, reducing health inequalities, workforce development, enhancing service user experience, increasing innovation, technology, community and partnership.

## Capable, compassionate and inclusive leaders

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service had inclusive leaders at all levels who understood the context in which they delivered care, treatment and support and embodied the culture and values of their workforce and organisation. Leaders had the skills, knowledge, experience and credibility to lead effectively. They did so with integrity, openness and**

**honesty.**

The senior leadership team felt the executive team understood and supported their vision for the maternity service however, they acknowledged that there had been barriers to understanding and acting on risks.

There was now a clear leadership reporting structure with a head of midwifery (HOM) who covered both the St Richard's and Worthing sites who reported to the director of midwifery (DOM). The DOM reported to the trust board. The service had recently implemented a new divisional clinical operating model which included overarching cross site clinical director roles alongside dedicated site-specific medical leadership.

Staff told us their ward managers, matrons and HOM were visible and approachable on the maternity unit. Some leaders worked clinically with the maternity unit team and staff told us this had improved communication and trust in the leadership team.

The DOM had direct and regular access to the trust board through a series of meetings and could routinely monitor information about quality, including safety and take necessary action to improve quality.

Maternity and obstetric teams reported they worked very well together and there was a sense of community between the teams where they would have lunch or breaks together.

Trauma and Risk Management (TRiM) trained practitioners from both medical and midwifery backgrounds, assisted with debriefing if there was an incident. Staff had access to individual support and counselling services. The TRiM practitioners were trained to provide psychologically informed responses to traumatic events.

The maternity service had a team of professional midwifery advocates (PMA), who provided pastural support and restorative supervision to staff. All midwives had an allocated PMA; support was also offered to support workers by the PMA team.

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# Maternity

## Freedom to speak up

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The evidence showed a good standard. The service fostered a positive culture where women felt they could speak up and their voice would be heard.**

There were processes to promote the freedom to speak up guardians (FTSUG) to staff. The FTSU guardian reported back to the maternity leadership team to discuss themes and concerns. The FTSUG escalated directly to the director of midwifery or head of midwifery.

The NHS England peer review in August 2025 identified an increase in the number of staff contacting the freedom to speak up guardian (FTSU) to report concerns regarding maternity services within the trust. This raised concerns regarding a lack of confidence in the standard divisional processes of staff reporting directly to the maternity leadership team to address staff concerns.

The trust had rolled out civility training and promoted an open-door policy. The medical team had developed a questionnaire for staff, to find out more about their wellbeing and civility with other team members. Civility training promotes respectful and considerate behaviour from all staff members of the maternity and obstetric team.

There was a focus on providing a positive culture. However, some staff raised concerns regarding difficult working relationships between midwives working between night and day shifts. There were also reports of poor attitudes towards some junior midwives by more experienced staff. This was fed back during the assessment, and senior leaders were aware of the concerns raised and they told us the trust were working to address these concerns.

Women, and their families knew how to complain or raise concerns, and how to give feedback on the service and their treatment.

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# Maternity

## Workforce equality, diversity and inclusion

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always value diversity in their workforce. They did not always work towards an inclusive and fair culture by improving equality and equity for people who work for them.**

The 2025 trust staff survey identified concerns regarding discrimination, and an action plan was developed. The service was developing succession planning for future leaders, ensuring ethnicity of the workforce was reflected.

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services.

The service told us they were committed to fostering an inclusive and equitable working environment and there had been an investment in workforce race equality standard (WRES) staffing. The service planned to establish a divisional equality, diversity and inclusion group to make sure the service were working alongside national guidance.

Some staff across the trust were taking part in the NHSE regional reverse mentoring programme. The programme was a reflective approach to cultural learning, leadership development and to increase diversity across the trust.

## Governance, management and sustainability

### Score

1. Evidence shows significant shortfalls in the standard of care

**We scored the service as 1. The service did not have systems of accountability and good governance. They did not act on the best information about risk, performance and**

**outcomes, or share this securely with others when appropriate.**

Governance systems were not always operating effectively to ensure risk and performance issues were identified. Staff did not have access to up-to-date policies and guidance due to several being outside of the review date. We found safeguarding training levels were not aligned to national standards and there was no formal audit plan.

There were 108 policies and guidance that were outside of their review dates. This meant there was a risk staff did not always have access to the most up to date, best practice guidance and may not always practice in accordance with it. However, policies and guidance did reflect the current National Institute for Health and Care Excellence (NICE) guidance.

The trust reported they were experiencing challenge with reviewing and updating clinical guidelines. Updating maternity guidelines were currently on the women and children's risk register. The trust reported that it did not have the resources to keep up with updating all current guidelines across all 4 locations.

Senior leaders described a risk-based approach to incident review, with targeted reviews undertaken in response to identified themes. For example, any possible incident linked to sepsis would be reviewed. However, audits were not routinely completed, which meant there was a lack of continuous and systematic review of potential safety incidents, themes and trends. As a result, the service could not be assured of the overall quality and safety of the maternity service.

The trust recorded all maternity safety and quality information on the maternity dashboard. This information covered organisational aspects, such as closures, activity, workforce and clinical indicators. However, some maternity dashboard data was not benchmarked against targets, so the trust could not always be assured that the service was performing well against trust-wide or national standards.

The divisional meeting fed into the executive performance and quality meeting. Meeting minutes were reviewed and although there was a clear oversight of maternity services identified within the minutes, we found there was not always a clear action plan.

The service maintained a risk register which was regularly reviewed; however, some risks had limited mitigation and there were ongoing delays in resolving them and no clear action for

resolve.

The trusts maternity services were under a Maternity Safety Support Programme (MSSP) led by NHS England. The MSSP improvement plan was monitored as part of the maternity improvement group led by the chief nurse for the trust for compliance at twice monthly meetings attended by the trust and relevant stakeholders. This included action plan and workstream reviews of multiple aspects of governance, safety and outcomes. The action plan had 163 initial actions and following our assessment the trust told us 91 actions were completed and closed.

Staff could describe their role in the governance process and had regular opportunities to meet discuss and learn from the performance of the service. They knew how to escalate issues to the clinical governance team and divisional management team.

## Partnerships and communities

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The evidence showed a good standard. The service understood their duty to collaborate and work in partnership, so services work seamlessly for women. They share information and learning with partners and collaborate for improvement.**

Service leaders attended regular meetings with the Local Maternity Network System (LMNS) to review governance and incidents.

Leaders worked with the Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. Meeting minutes showed current work being undertaken between the local MNVP, maternity service and the LMNS.

The maternity safety champion and non-executive director supported services to monitor safety and outcomes. Maternity safety champions worked closely with the maternity and neonatal voice partnership (MNVP) and undertook walk arounds of the department.

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# Maternity

The maternity safety champions were leaders in maternity and neonatal care focused on improving safety and quality.

Information showed the team visited the maternity assessment unit (MAU) following its move to the main maternity unit in March 2025 to see how the service had improved and evolved since moving and to understand the issues the team have regarding the waiting area for women and their partners.

The maternity safety champion visit in September 2025 focused on the new elective theatre capacity and the use of the day surgery unit, to identify how this would improve capacity and safety for women.

## Learning, improvement and innovation

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always focus on continuous learning, innovation and improvement across the organisation and local system.**

The service did not consistently achieve effective and continuous learning, innovation, or improvement across the service.

Although, there were improvements seen throughout the service since our last assessment, we found a lack of oversight and improvement due to not completing maternity audits. A lack of clinical audits around sepsis and maternal readmissions meant the service could not identify any themes or trends to identify where learning is needed by maternity or obstetric teams.

Improvement huddles were well established on the postnatal ward, antenatal clinic and within the community midwifery teams. Improvement huddles are short, focussed team meetings used for various purposes such as patient safety, quality improvement and staff wellbeing. There were opportunities to suggest quick wins and celebrate things that had gone well.

The service introduced an electronic application as an alternative platform to enable staff to

engage with quality improvement at any time and to share ideas more flexibly with the service.

To provide staff with the opportunity to provide feedback, share learning and be up to date with new guidance, the fetal well-being team had launched a newsletter.

Staff contributed to programmes, such as the patient safety incident response framework (PSIRF) and multidisciplinary review meetings, which provided reflection and learning.

The service had strong external relationships to support improvement and innovation. We saw evidence of regular engagement of leaders and service users, to review and improve the service such as the Maternity and Neonatal Voices partnership (MNVP) steering group. Additionally, the service participated in national research, and specialist midwives were proactive in developing training sessions for staff. For example, the pelvic health team had developed a pelvic health study day.

St Richard's Hospital

# Action plan requests

## Regulation 12: Safe care and treatment

### Service

Maternity

### Regulated activities

- Maternity and midwifery services

### How the regulation was not being met

The design and environment of the maternity assessment unit did not meet the needs of women using the service due to a lack of space for women. The waiting area was outside of the maternity assessment unit and staff did not have a direct line of sight of women waiting within the waiting area. We found women did not receive a midwifery review within 15 minutes of arrival within the maternity care centre and women did not receive a medical review within a timely manner.

## Regulation 17: Good governance

### Service

Maternity

### Regulated activities

- Maternity and midwifery services

### How the regulation was not being met

The service did not have an audit schedule and staff did not routinely complete local audits. Staff did not have access to up-to-date policies and guidance due to several being outside of the review date.

Care Quality Commission

LAP assessment report

# Princess Royal Hospital

**LAP Assessment Report ID :** LAP-01863

**Inspection visit date(s):** 19 November 2025 and 15 December 2025

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Princess Royal Hospital
# Location findings

## Ratings for this location

| | |
|---|---|
| **Overall** | Requires improvement |
| **Safe** | Requires improvement |
| **Effective** | Good |
| **Caring** | Good |
| **Responsive** | Requires improvement |
| **Well-led** | Requires improvement |

## Overall location summary

Date of assessment: 19 November and 15 December 2025. University Hospital Sussex provides a range of NHS hospital services across 4 locations, providing care to the populations of parts of East Sussex, Brighton and Hove and West Sussex.

The maternity assessment took place at Princess Royal Hospital in East Sussex. The rating from maternity has been combined with ratings of the other services from the last assessment at Princess Royal Hospital. See our previous reports to get a full picture of all other services at Princess Royal Hospital. The rating of Princess Royal Hospital is, requires improvement.

The service continued to have poor staffing levels and remained in breach of regulation 18: Staffing.

At this assessment we identified breaches of regulations in relation to regulation 12: Safe Care and Treatment and regulation 17: Good Governance.

Princess Royal Hospital
# Location findings

## Safe

**Rating** Requires improvement

Our overall rating of safe at Princess Royal Hospital was requires improvement. We looked at maternity services only and rated safe as requires improvement.

## Effective

**Rating** Good

Our overall rating of effective at Princess Royal Hospital was good. We looked at maternity services only and rated effective as good.

## Caring

**Rating** Good

Our overall rating of caring at Princess Royal Hospital was good. We looked at maternity services only and rated caring as good.

## Responsive

**Rating** Requires improvement

Our overall rating of responsive at Princess Royal Hospital was requires improvement. We looked at maternity services only and rated responsive as good.

## Well-led

**Rating** Requires improvement

Our overall rating of responsive at Princess Royal Hospital was requires improvement. We looked at maternity services only and rated well-led as requires improvement.

Acute services
# Maternity

## Maternity

| | |
|---|---|
| **Overall** | Requires improvement |
| **Safe** | Requires improvement |
| **Effective** | Good |
| **Caring** | Good |
| **Responsive** | Good |
| **Well-led** | Requires improvement |

## Our view of the service

Date of assessment: 19 November 2025 and 15 December 2025

Princess Royal Hospital in Haywards Heath provides a range of NHS hospital services to women living in and surrounding area of Haywards Heath and West Sussex. The assessment looked at maternity services.

The trust has obstetric led maternity units at Princess Royal hospital in East Sussex, Worthing Hospital, St Richards Hospital in West Sussex and the Royal Sussex County hospital in Brighton.

There was also a home birth service provided by community teams across all four sites.

Around 9,000 babies are born in the trust each year. Within Princess Royal Hospital between October 2024 to November 2025 there were 2,174 births at the hospital.

In February 2022, the trust entered the Maternity Safety Support Programme (MSSP). The MSSP is a

Acute services
# Maternity

national support programme provided by NHS England to maternity services where significant concerns have been identified regarding the safety and quality of services.

There was a maternity improvement plan which was monitored via the twice monthly Maternity Improvement Group. The trust was on track to move into the sustainability phase of the MSSP programme mid-2025, and to exit the programme late-2025. However, this was delayed due to the trust being named as one of the trusts within the rapid national investigation into NHS maternity and neonatal services.

Maternity services were rated as requires improvement following the assessment.

At our last assessment the overall rating for maternity services was requires improvement.

The service was previously in breach of legal regulation 18: staffing. Following this inspection the service remains in breach of this regulation. The service did not have enough staff to keep women safe. During this inspection, staff told us they felt tired and burnt-out due to workforce pressures and the demands of the service. Shifts felt increasingly overstretched and sickness rates were high with 8% midwifery sickness, we were told this was mostly due to staff stress.

We also found a breach of regulation 12: safe care and treatment, we found women did not receive a midwifery review within 15 minutes of arrival within the maternity care centre and women did not receive a medical review within a timely manner. The service had 1 obstetric theatre which was frequently reported to be closed due to ongoing equipment failures and issues with the heating and ventilation. There were gaps identified in the medicines record keeping books where the anaesthetic team had not signed to identify drugs which had been administered to women in theatre.

There was a breach of regulation 17: good governance due to the service not having an audit schedule and staff did not routinely complete local audits. Staff did not have access to up-to-date policies and guidance due to several being outside of the review date.

However, policies and guidance did reflect the current National Institute for Health and Care Excellence (NICE) guidance. Staff knew what incidents to report. They raised concerns and reported incidents and near misses in line with the trust policy.

Staff told us they worked well as a team and there was a good culture between midwives and obstetricians. Staff considered patients' individual needs, circumstances, ongoing care arrangements and expected outcomes during handovers and ward round meetings.

Acute services
# Maternity

Leaders worked with the Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. Meeting minutes showed current work being undertaken between the trust and the local MNVP.

We refer to women in this report, but we recognise that some transgender men, non-binary women and women with variations in sex characteristics or who are intersex may also use services and experience some of the same issues.

We have requested an action plan, this will be requested upon publication of the final report.

## People's experience of the service

We spoke to 7 women during the assessment and 3 partners who were positive about the service. Information from the NHS Maternity survey benchmarking report showed that women were mostly positive about their birthing experience at Princess Royal Hospital. Many felt they were treated with dignity and respect throughout their care.

Women told us they felt safe, well supported and cared for by both the midwifery and medical teams. Risks were explained by staff, and they felt they were involved in decision making.

Staff were described as professional, understanding and kind. Women had access to contribute and feedback about their experiences through the local Maternity and Neonatal Voices Partnership (MNVP) who also feedback to the trust regularly.

## Safe

**Rating** Requires improvement

We looked for evidence that safety was a priority for everyone and leaders embedded a culture of openness and collaboration. We checked that women were safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination.

At our last assessment we rated this key question requires improvement. At this assessment, the rating of safe remains requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Acute services
# Maternity

The service remained in breach of regulation 18: staffing. We found staff were tired and burnt-out due to workforce pressures and the demands of the service. Shifts felt increasingly overstretched for staff and staff sickness rates were high due to stress. There was a lower number of consultants working within PRH compared to the other maternity locations across the trust.

We found a breach of regulation 12: safe care and treatment, we found women did not receive a midwifery review within 15 minutes of arrival within the maternity care centre and women did not receive a medical review within a timely manner. The service had 1 obstetric theatre which was frequently reported to be closed due to ongoing equipment failures and issues with the heating and ventilation. There were gaps identified in the medicines record keeping books, where the anaesthetic team had not signed to identify drugs which had been administered to women in theatre.

However, the service used past anonymised incidents and complaints to support staff in their training. Vulnerable women were supported throughout their pregnancy and birthing journey with a 'one stop clinic' and there was a pathway to support perinatal women during a psychiatric emergency. A psychiatric emergency is where a person experiences a mental health crisis and needs immediate support.

## Learning culture

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service had a proactive and positive culture of safety, based on openness and honesty. They listened to concerns about safety and investigated and reported safety events. Lessons were learnt to continually identify and embed good practice.**

Staff knew what incidents to report and raised concerns. Staff reported incidents and near misses in line with the trust policy. The service used national risk tools, Patient Safety Incident Response Framework (PSIRF) and a Perinatal Quality, Safety Risk Framework to review and monitor risk.

Acute services
# Maternity

The patient safety team had oversight of the grading and reviewing of incidents and there was a clear system to investigate incidents and identify learning, using the PSIRF model. PSIRF was embedded within maternity and learning from incidents was shared with maternity teams, through email alerts and messages during daily handover.

There was also a restorative culture programme in place, offering structured support for staff involved in challenging incidents or investigations. A restorative culture programme promotes a supportive, open environment that focuses on learning, reflection, and improvement rather than blame when issues arise. It encourages honest dialogue, accountability, and positive working relationships.

The perinatal mortality review tool (PMRT) is a tool to support objective and standardised local reviews of care if a baby dies. Between April 2025 to June 2025 the service had 1 PMRT case.

Quarterly PMRT reports were submitted to the trust board and cases submitted to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBBRACE) within 7 days of a baby's death and duty of candour was given to all families.

MBBRACE is a national programme focusing on improving maternal and infant health. Questions and feedback received from women and their families were presented to the PMRT review panel and as part of the review the trust responded to questions raised. PMRT reports were reviewed by a multidisciplinary team.

The service engaged with the Maternity and Newborn Safety Investigations (MNSI) programme. There were 3 incidences reported to the MNSI for investigation within the 6 months before the inspection, with 1 assessment completed.

There was no common theme reported for the MNSI cases, however, there were concerns around safety and delay in treatment.

A multidisciplinary (MDT) or obstetric review of incidents was held weekly. For Princess Royal Hospital there were around 4 incidents a week to be reviewed by the team. In addition to these reviews the patient safety midwives met with ward leads weekly to discuss incidents which did not require an MDT or obstetric review. Community incident reviews were twice weekly and was community focused only.

Acute services
# Maternity

The team at Princess Royal Hospital did not keep formal incident review minutes, instead outcomes were provided on the electronic incident reporting system. Following the review of incidents, learnings and actions were shared with the wider team through the maternity message of the week and discussed further within the safety and quality meetings.

Monthly situation, background, assessment and recommendation (SBAR) learning from incidents was shared with all staff and displayed on safety and staff notice boards throughout the unit. Maternity staff had access to a team's channel which contained incident reviews, improvement plans and tools could be accessed.

Anonymised incidents and complaints presented within the maternity governance meetings and local maternity and neonatal system (LMNS) quality and safety meetings were used during trust maternity mandatory training.

## Safe systems, pathways and transitions

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always work well with people and healthcare partners to establish and maintain safe systems of care. They did not always manage or monitor people's safety. They did not always make sure there was continuity of care, including when people moved between different services.**

Systems and processes within maternity triage were not embedded to ensure women were safe. The service was not consistently meeting the target for women to receive an initial review by a midwife within the maternity assessment unit, and women were not always prioritised appropriately.

The maternity assessment unit (MAU) was the service's maternity triage area. The MAU is an urgent 24-hour service to assess and treat pregnant women where there were urgent concerns. Midwives used a nationally recognised tool to rate risks consistently. Monthly audits were completed to determine how long women waited for an initial assessment and if they required

a medical review.

The MAU standard operating procedure set the target for women to be seen and assessed by a midwife within 15 minutes of arrival. The service did not meet the trust compliance of 90% to see women within 15 minutes. The service provided the data for 2 months which showed 79.4% of women were reviewed within 15 minutes in August 2025 and 78.9% in September 2025. This meant there was a continued risk to mother and the unborn baby by not identifying or addressing potential concerns quickly.

At the time of our assessment the MAU was staffed with 1 band 6 midwife, 1 band 6 peak midwife and 1 maternity support worker. The peak midwife was in place to support the MAU during peak times, when more women attended.

Staff told us the peak midwife was often redeployed from MAU to cover other areas within the unit which impacted greatly on women being seen for a timely review. This was not in line with the Royal College of Obstetrics and Gynaecology guidelines.

Women also experienced delays in receiving a medical review within MAU. Although there was no mandated target for the trust to achieve for women to receive a medical review, there was an ongoing risk to women who were not seen by a doctor in a timely manner. Data showed the number of women seen for a medical review within the expected timeframe on average between April 2025 to September 2025 was 46.8%.

We raised concerns with senior leaders following our assessment regarding the low compliance rate for women being seen within the specified timeframe by a midwife or for a medical review. The service was responsive and staff were told the peak midwife was not to be redeployed from the MAU. This had led to an improvement in the 15-minute triage compliance, with 79.6% of women being seen within 15 minutes in November 2025 and 82.4% December 2025. A review of peak midwife shifts showed the peak midwife had not been redeployed on any shift in December 2025 and the service leads was to continue to monitor the triage compliance and adjust staffing as required.

The service had also introduced a doctor daily on each shift within MAU which had led to improved timely reviews of women. For example, 16.7% of women were seen within 1 hour in November 2025 and following the medical daily allocation this had improved to 55.6% in

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# Maternity

December 2025. The service was completing improvement work to increase accurate reporting of times when women had received a medical review.

Although there were delays in reviewing women due to staffing within MAU, we did find staff were trained to respond to risk and were able to identify and act when women were at risk of deterioration. Staff completed risk assessments and took action to remove or minimise risks, and documentation was completed appropriately.

The CQC coordinates a national survey annually to look at the experiences of pregnant women and new mothers who used NHS maternity services. This survey looked at the experiences of pregnant women and new mothers who used NHS maternity services in 2025. It is CQC coordinated with other stakeholders, but it is reported by us at CQC.

We reviewed the latest findings of the maternity survey 2025. We saw that when women were asked “Thinking about the last time you contacted the telephone triage line, did you feel that you got the advice you needed?”, the service scored 8.9, which was above the national average of 8.3 when compared to all other trusts in England. For the question “Thinking about the last time, you attended triage face-to-face, did the midwife or doctor you spoke to listen to you?” the service score 9.1, which was above the national average of 8.7.

Staffing pressures meant labour ward coordinators were not consistently able to maintain supernumerary status. Data showed 60% of red flags were due to coordinators providing clinical support during shifts.

The labour ward coordinator not being supernumerary was worse at Princess Royal Hospital compared to the other 3 maternity locations within the trust. Staffing red flags in maternity care can identify a lack of adequate maternity staffing, which can lead to unsafe care for women and their babies. Red flags may also occur due to staffing shortages, which can affect the ability to provide safe care.

Staff attended two cross-site daily status meetings each morning where they discussed the current and emerging situation at both Princess Royal Hospital and Royal Sussex County Hospital. Meetings were chaired by the director of midwifery or head of midwifery. The agenda included staffing, bed capacity and learning from recent incidents.

The second meeting covered all four hospital sites and used information from the first meeting

to identify any areas of concern and address immediate concerns across the whole trust.

Staff of all grades attended regular safety huddles during their shift. This was an opportunity to share safety information. At the change of shift the medical and midwifery teams had handover meetings to discuss all women within the maternity unit. During the assessment we attended handover meetings and safety huddles and we found them well attended and used to fully discuss women and any emerging concerns.

The service provided a centralised maternity telephone triage which received calls for all four of the trust maternity locations.

The LMNS insight visit in August 2025 recognised the improvement of the centralised telephone triage service with no further maternity and newborn safety investigations linked to telephone triage. This included a reported 40% reduction in born before arrival cases. This meant there was improvement to women accessing advice and reducing avoidable risks for women.

Transitional care for babies provided extra support beyond the usual postnatal care, where babies were well enough to be cared for at the bedside with their mother. Care for transitional care babies were provided by the midwifery and neonatal teams and all babies were reviewed daily by the neonatal team.

Staff completed newborn risk assessments using recognised tools such as the Newborn Early Warning Trigger and Track (NEWTT) tool to record observations and feeding. All babies who needed special care or transitional care were discussed at an avoiding term admission into neonatal units (ATAIN) meeting. The ATAIN meeting focused on avoiding term admissions into neonatal units for babies over 37 weeks gestation, by identifying and addressing potential issues.

## Safeguarding

### Score

2. Evidence shows some shortfalls in the standard of care

Acute services
# Maternity

**We scored the service as 2. The service did not always work well with people and healthcare partners to understand what being safe meant to them and how to achieve that. They did not always concentrate on improving people's lives or protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. They did not always share concerns quickly and appropriately.**

During the assessments of the four maternity service locations, it was identified that the trust did not follow the Intercollegiate Document for Safeguarding Children and Young People 2025 or the Royal College of Nursing adult safeguarding: roles and competencies for health care staff (2024/2025) guidance, which sets out that health care staff engaged in assessing, planning and delivering care should be trained in adult level 3 safeguarding.

However, since the inspection the trust had introduced a rolling programme of level 3 adult safeguarding training to midwives and obstetric teams.

Data showed at the time of our assessment there were no midwifery staff trained to this level. Medical staff did not meet the trust requirement for level 3 safeguarding children's training with 86.9% compliance. Midwifery compliance was over the trust target of 90% and was 93.3%.

Staff told us they had access to the safeguarding lead midwife, and they visited the unit daily to offer support or guidance and to determine whether there were any women who required support.

The safeguarding team had clear escalation pathways and reported to the board via the hospitals safeguarding lead. Staff completed assessments for women to identify and support those at risk of self-harm and suicide. During a review of women's maternity records, we saw staff asked safeguarding questions at each antenatal contact if safe to do so.

Staff placed a flag on women's records if safeguarding issues were identified. This included staff in the emergency department. This allowed staff to easily identify women or babies at risk.

Women who did not attend hospital appointments were flagged to the community team for follow up. Women were discussed at risk meetings to ensure there was a follow-up contact when appointments were frequently missed. Where concerns or ongoing non-engagement were identified, appropriate safeguarding referrals were made to external agencies.

Acute services
# Maternity

The trust had appropriate safeguarding policies that aligned with national guidance and a designated safeguarding midwife. Staff understood and could describe how to protect women from abuse and could give examples which demonstrated their safeguarding understanding. Staff could recognise and knew how to report abuse.

Staff followed safe procedures for partners and families visiting the wards. The service strictly controlled access to all areas. Staff undertook baby abduction drills, so they knew what to do in the event of an attempted baby abduction. Staff told us there had been a baby abduction drill within the last 12 months.

The service supported vulnerable women throughout their pregnancy and birthing journey with a 'one stop clinic'. The clinic saw women with substance misuse and were provided support from the obstetric, safeguarding, smokefree pregnancy and paediatric teams.

There was a pathway to support perinatal women during a psychiatric emergency. Postpartum psychosis is a severe mental illness which can start suddenly during the final trimester of pregnancy or in the days or weeks after having a baby.

## Involving people to manage risks

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always work well with people to understand and manage risks. Staff did not always provide care to meet people's needs that was safe, supportive and enabled people to do the things that mattered to them.**

The trust reviewed Cardiotocography (CTG) monitoring and intermittent auscultation through completing 'fresh eyes' to gain reassurance of staff competence and completion. Cardiotocograph (CTG) and intermittent auscultation was a method of fetal monitoring during labour that involves listening to the fetal heart with a doppler ultrasound.

The electronic record system showed the compliance rate for completing 'fresh eyes'

monitoring was below the trust compliance with only 10% to 20% compliance.

The service completed a paper review of 'fresh eyes' to identify any potential issues with pulling information through within the electronic data system. However, the paper review still showed poor compliance of fresh eyes and there were inconsistencies within staff documentation.

'Fresh eyes' provide an independent and objective assessment, which is essential for improving the safety of women and reducing the risk of errors in the interpretation of fetal wellbeing during labour and supporting safe and timely clinical decision-making.

Themes of non-compliance for completion of 'fresh eyes' were related to activity in the service such as delays in completion due to handovers, epidurals being sited or being transferred to theatre. Despite the service not completing hourly 'fresh eyes' reviews, the service noted escalation of care was always appropriate. The maternity audit team were in the process of implementing a deep dive audit to gain a greater understanding regarding the poor compliance.

Hypoxic-ischaemic encephalopathy (HIE) is a term for a brain injury that happens before, during, or shortly after birth when oxygen or blood flow to the brain is reduced or stopped. We requested the number of cases of HIE within the last 3 months from the trust, and were provided with data that calculated both suspected and provisional HIE rates rather than confirmed diagnoses. HIE rates were 0 for June 2025, 10.31 for July 2025 which was way above the national average of 4.25 and 0 in August 2025. Following the reporting process the service reported the 12-month rolling rate for suspected HIE cases for July 2025 was reported to be 2.74/1000 births. However, the service did not provide the updated confirmed number of cases.

The service reported HIE rates had increased from September 2025, and the service reported they were completing thematic reviews into the increased rates. However, HIE rates between September 2025 to November 2025 were not provided by the service as this data had not been reviewed or approved by the trust board.

The service did not have a risk assessment for only having 1 obstetric theatre and there was no standard operating procedure for when the service used the main theatres for extra caesarean section lists.

The second emergency theatre cover at night relied on an on-call team based off site. There

was a 45-minute response time, which was identified by the service, to be unsafe and not able to meet the urgent response times for an emergency caesarean section. This was on the maternity risk register for the site. Governance processes to manage incidents for when the obstetric theatre was not accessible, included MDT planning meetings, flowcharts and SBAR documentation for each incident, with mitigations.

We shared our concerns regarding the regular closure of the obstetric theatre and high number of caesarean sections to senior leaders. Senior leaders shared the concerns raised to board and presented the information to the clinical transformation programme regarding theatre capacity. The outcome was for a 2-day theatre list in main theatres to start in March 2026 to accommodate the high number of elective caesarean sections. Staffing would be funded by the programme and will be separate to the maternity staffing establishment. The labour ward theatre had been prioritised for ventilation and heating improvement work and improved governance processes were in place to manage incidents when the labour ward theatre was not accessible. This included MDT planning meetings, flowcharts and SBAR documentation of each incident and mitigations.

Women attending the service for an induction of labour (IOL) were given an initial date for admission to start the induction process. Women were advised that this date may change based on acuity and the prioritisation according to clinical risk.

Information received from staff identified that there were regular delays in women receiving the IOL. We requested the number of IOL delays and times of waits between May 2025 to November 2025 for the hospital. We were told the service did not collect data regarding the waiting times and to identify the information would mean a review of women's case notes.

The service had recently updated their clinical guidelines and formed an IOL discussion group to listen to concerns and to explain emerging plans. However, without collecting waiting time data, the service could not clearly identify reasons, themes or trends for delays in induction of labour to improve women's experiences and to fully alleviate risk.

The risk assessment (RAG) rating at birth tool was embedded within the electronic patient records and all babies were risk assessed within the first hour of birth. This identified whether babies were low or high risk at birth. This supported the identification of early onset of sepsis and babies who were higher risk of clinical deterioration.

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Documentation audits were not completed as a standalone audit, instead the service completed a maternity incident review process which looked at the maternity journey of the woman. Any failures identified within the documentation practice triggered a shared learning review. The service recognised that this was not a usual documentation audit, noting specific triggers. However, they felt it provided assurance about practice within maternity as well as identifying trends.

There were around 4 incidents a week at Princess Royal Hospital which required an MDT review. Patient safety midwives met with ward leads weekly to discuss incidents which did not require an MDT review.

## Safe environments

### Score

1. Evidence shows significant shortfalls in the standard of care

**We scored the service as 1. The service did not always detect and control potential risks in the care environment. They did not make sure that equipment, facilities and technology supported the delivery of safe care.**

The service provided a full range of maternity services. Maternity services included, antenatal clinics, maternity assessment unit, day assessment unit, labour ward, 1 obstetric theatre, recovery area and a bereavement suite. The service did not have a midwifery led birthing unit.

We found the design and the environment did not effectively meet the needs of women and babies. The service had multiple estates issues which made it difficult for staff to deliver timely clinical care safely and contributed to a more stressful working environment.

For example, the service had only 1 dedicated obstetric theatre, which was used for both elective and emergency caesarean sections. The risk of having only 1 dedicated maternity theatre meant there were significant risks to the safety of mothers and their babies, as it left no contingency for emergencies that were happening at the same time.

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The service had worked with main theatre to run a series of elective caesarean section theatre list; this was to support with the demand of women having elective caesarean sections as part of a waiting list initiative.

We found the obstetric theatre was often closed due to ongoing equipment failures and issues with the heating and ventilation. From November 2024 to November 2025 the theatre had been closed 45 times. Staff told us that theatre closures occurred frequently each week. They also stated that the reported figures did not include short-term closures while waiting for the theatre to reach the required temperature. Staff told us due to the short time of closure this was not recorded as an incident.

Maintaining the correct temperature in obstetric theatres is essential for the safety and comfort of women and their baby. The temperature and humidity levels in the theatre must be carefully controlled to avoid risks associated with anaesthesia and prevent the woman and baby from becoming too cold which could lead to hypothermia or cardiac concerns.

During the assessment the obstetric theatre was closed due to being at an inadequate temperature for surgery, the main theatre was unable to be used due to one of the main theatres being closed for repairs and the other theatres being in use. As a result, all elective cases were delayed, leading to longer waits for women and a significant risk of theatres being unavailable for emergency caesarean section cases. We saw this have a negative impact on women and increasing their anxiety around the procedure.

The main theatres were 2 floors lower than the obstetric theatre and staff had priority passes for lifts to ensure transfers were managed in a time-appropriate way. However, lifts were situated in public corridors which did not maintain the privacy and dignity of women being transferred. During our assessment we also observed that one lift was out of order which would delay the transfer and movement of women within the maternity unit. The use of public lifts and reduced lift capacity, risked compromising privacy and dignity and delaying transfers, including in emergencies.

We raised concerns regarding theatre capacity and the temperature, ventilation and capacity issues within the obstetric theatre to the senior leadership team following the assessment and they took immediate action. An options appraisal was presented to the clinical transformation programme board on 5 January 2026. The outcome was to have 2 all day weekly theatre

sessions in main theatres to accommodate 10 caesarean section cases.

The obstetric theatre was also prioritised for ventilation and heating improvement work, with work to start in April 2026.

The MAU did not have enough CTG machines for each assessment bay area and at times the unit had to borrow machines from the labour ward. There were not incidents identified which related to a lack of CTG machines, however, not having enough CTG machines available meant there was a potential risk of delay in women being appropriately monitored.

We saw areas of the labour ward cluttered with equipment, which meant there was a possibility of contamination of equipment, difficulty in effectively cleaning the ward and hazardous in an emergency. Staff completed daily checks on specialist equipment, including the post-partum and major obstetric haemorrhage trolley in labour ward. The emergency resuscitation trolleys and resuscitaires were tagged, clean and appropriately stocked.

Fire exits were clearly marked and unobstructed. There were birth pool evacuation nets and equipment in every room that had a birthing pool.

The service had a purpose-designed bereavement area to help support women and their families. The bereavement area was located on the labour ward, along a separate corridor from the delivery suite. This provided a quiet, private, and sensitive environment where women and their families could create memories and spend time with their baby while grieving.

## Safe and effective staffing

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always make sure there were enough qualified, skilled and experienced staff. They did not always make sure staff received effective support, supervision and development. They did not always work together well to provide safe care that met people's individual needs.**

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The service recognised the impact of short staffing on the workforce and implemented a new divisional clinical operating model which included overarching cross site clinical director roles for both specialities, alongside dedicated site-specific medical leadership.

Staff told us they felt tired and burnt-out due to workforce pressures and the demands of the service. Shifts felt increasingly overstretched and sickness rates were high with 8% midwifery sickness, we were told this was mostly due to staff stress.

Staff told us there were not enough staff to manage the separate elective caesarean section list within main theatres. Senior leaders told us the separate theatre lists were staffed fully by the funding within the waiting list initiative. This meant midwives and support staff were brought in specifically for these maternity lists and the labour ward did not lose midwives to cover the extra theatre activity.

However, staff told us that although there were separate staff rostered for the extra theatre lists, senior leaders did not consider the impact on the flow and capacity within postnatal ward. This meant there were issues with the flow and capacity across the postnatal ward alongside caring for a larger number of women having elective caesarean sections. Staffing issues meant the extra theatre lists affected their ability to manage workload demands, respond to incidents promptly and provide safe care.

The service had 3 substantive consultant posts appointed in mid-September for Princess Royal Hospital (PRH), which were fixed term contracts. In line with current guidance, the requirement was to provide a twice daily consultant ward round. The service reported within the perinatal workforce report that this had been challenging at PRH due to vacancy and job planning restrictions. This meant consultants had attended ward rounds remotely, however, consultant ward round attendance was now being embedded into the service and attendance was improving.

There was a lower number of consultants working within PRH compared to the other maternity locations across the trust. This meant there was a challenge in ensuring equitable access to consultants which could impact on care delivery, escalation support and clinical oversight across the maternity service.

The service at the time of assessment was completing a Birth Rate Plus (BR+) assessment to

assess the midwifery and maternity support worker workforce. The report was due to be completed in January 2026. The current staffing model for the service was reflective of the previous 2023 recommendations. The BR+ assessment is usually completed every 2 years. A BR+ assessment is an evidence-based tool used to determine midwifery staffing requirements based on birth activity and case complexity. It supports safe staffing by ensuring workforce levels are aligned with clinical demand and risks to safe care are identified.

A staffing review of PRH identified staffing had been challenging between May to August 2025 which was reportedly due to short-term sickness, and vacant band 5 posts. This meant there was a challenge in staffing across the maternity unit and Princess Royal Hospital were not meeting the 85% trust target for adequate number of maternity staff to meet the needs of women.

The trust had recruited 2 full time band 8a recruitment and retention matrons to support maternity and neonatal services with safer staffing. The perinatal development workforce report identified the current vacancy data across maternity services and what short-term and long-term strategies were being put in place to support staffing.

Student midwives across the trust were offered a permanent position at their chosen trust location, which would over-recruit against current establishments. These hours would have been previously covered by bank and agency, with agency to stop and the number of bank shifts to be reduced. However, it was too early for the service to know if this had a positive effect on staffing at Princess Royal Hospital.

Newly qualified midwives completed a 12 to 18-month preceptorship programme, to support them in their role.

The current midwifery vacancy rates were 7%, however, with several midwives moving from hospital to community-based roles between May 2025 and June 2025, the vacancy rate increased to 10%.

The service did not provide the mandatory training figures for maternity and medical staff; therefore, we could not ascertain whether staff were up to date with key mandatory skills.

The trust provided Practical Obstetric Multi Professional Training (PROMPT) which was evidence based multi professional training package for obstetric emergencies including fetal

wellbeing and competencies. All maternity and obstetric staff other than consultants were compliant in fetal well-being training. There were 89% of consultants completed the fetal wellbeing training day, however, only 67% had completed the e-learning training.

There were only 51% of the midwifery workforce since 2023 at Princess Royal hospital had completed the video-based training for pool evacuation. Within the last year there had been no live training of pool evacuation simulation training. Although there was no national benchmark for completing the pool evacuation training, the service could not be assured all staff were up to date and competent in how to evacuate a woman having complications safely from the pool. Senior leaders told us the team were working toward formalising expectations around pool evacuation training and to benchmark the frequency of staff training and compliance.

## Infection prevention and control

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service a 2. The evidence showed some shortfalls. The service did not always assess or manage the risk of infection. Staff did not always detect and control the risk of it spreading or share concerns with appropriate agencies promptly. However, we saw there was oversight and governance of cleaning schedules.**

Matrons and ward leaders oversaw infection prevention and control across the maternity service.

The service had recently introduced a specific maternity uniform policy. However, due to staff demands and ordering delays, uniforms were being distributed to staff gradually.

Maternity staff who were not yet provided with the new maternity uniform, wore hospital scrubs. We saw some midwives wearing the new uniforms, however, there were several maternity and obstetric staff wearing different coloured scrubs. This meant it was difficult to identify the role of staff. Staff we spoke with reported there were insufficient numbers of scrubs available and at times were wearing different coloured scrub tops to bottoms. Staff told us they

often felt stressed as it was not always guaranteed they would have scrubs available for their shift and at times they have had to wear their own trousers whilst working. Although during the assessment we did not see this.

Band 2 and band 3 staff reported they were responsible for cleaning the labour suite rooms following a woman giving birth. However, they told us they had not received sufficient training or guidance on the effective cleaning of bodily fluids, which increased the risk of inadequate infection prevention and control.

We found cleaning schedules and records were monitored through audit to check for noncompliance. Hand hygiene across the unit showed maternity teams were 100% compliant.

## Medicines optimisation

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always make sure stock, and the administration of medicines was monitored appropriately.**

There were gaps identified in the medicines record keeping books where the anaesthetic team had not signed to identify drugs which had been administered to women in theatre. This meant the risk of proper identification of administered drugs could lead to accidental overdoses or incorrect doses given.

Although there were policies and processes in place for the secure storage of medicines including controlled drugs and medical gases, we found this was not always followed. There were issues with the management of the stock medicines, with some out-of-date medicines and gaps in medication checks.

The service completed a controlled drug audit on a 3 monthly basis in line with best practice recommendations e.g. NICE guidance 46, Controlled drugs: safe use and management and the Duthie Report (1988, revised 2005) The Safe and Secure Handling of Medicines. Two months of

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audits were provided for both the labour ward and Bolney ward (antenatal and postnatal ward). All audits showed both areas did not meet the required target.

The service had medicine administration guidelines for midwives. Midwives had access to the full list of midwives' exemptions, so they were clear about administering within their remit. Midwife's exemptions allow registered midwives to supply and administer certain medicines without a prescription, under specific legal and professional conditions.

Staff were trained to administer medicines safely. Staff demonstrated good understanding of how to monitor for and manage medical emergencies that can occur in pregnancy, including post-partum haemorrhages and sepsis.

## Effective

Rating Good

We looked for evidence that women and communities had the best possible outcomes because their needs were assessed. We checked that women's care, support and treatment reflected these needs and any protected equality characteristics, ensuring women were at the centre of their care. We also looked for evidence that leaders instilled a culture of improvement, where understanding current outcomes and exploring best practice was part of their everyday work.

At our last assessment this key question was not rated. At this assessment we rated effective as good. This meant the effectiveness of people's care, treatment and support achieved good outcomes and was consistent.

The service worked with agencies involved in people's care for the best outcomes and smooth transitions when moving between services. They monitored people's health to support healthy living. Staff made sure people understood their care and treatment to enable them to give informed consent. There were positive examples of person-centred care. Women were given information and advice about their health, prenatal and postnatal care.

However, staff did not always have up-to-date guidance to follow legislation and current evidence-based good practice and standards. The trust did not effectively use benchmarking to ensure that outcomes were positive and consistent.

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## Assessing needs

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always make sure people's care and treatment were effective because they did not always check and discuss people's health, care, wellbeing, and communication needs with them.**

The ongoing issues within the obstetric theatre meant there were frequent delays for women. Women's needs were not always met at the planned time and care delivery was influenced by theatre availability rather than clinical planning.

Women were not always reviewed in line with national guidance. Women's needs were assessed in triage by experienced midwives and doctors using the recognised triage review tool, but it was not always within the trust target of 15 minutes.

The risk register identified capacity risks within both fetal medicine and diabetes clinics at PRH. Women attending fetal medicine clinics with complex care were referred to other tertiary centres due to limited clinic capacity. This meant, that women were seen quickly to ensure safety, however, this did impact on continuity of care and the women's overall experience. Tertiary centres are specialist hospitals that provide advanced care for patients with complex, high-risk, or rare conditions, typically receiving referrals from primary and secondary care services.

Staff told us they were supported by senior colleagues, and they worked together to make sure women made informed decisions based on best practice guidelines. Staff were able to describe how they assessed and reviewed women's needs from the antenatal to postnatal period to provide holistic support.

Women were given information and advice about their health, prenatal and postnatal care and had access to specialist clinics where required, including women who had specific medical needs.

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During our assessment we reviewed 6 care records which showed examples of person-centred care and women were supported in choosing their birth options. Birth plans were personalised and up to date.

Leaders attended two cross site risk meetings each morning. Staff attended maternity huddles, which were held twice daily 7 days per week. We attended 2 huddles which were attended by midwives, midwifery support workers and doctors.

Staff were observed sharing key information using the Situation, Background, Assessment and Recommendation (SBAR) tool to communicate important information about a woman's condition. This made sure assessments were based on accurate and up-to-date information, enabling appropriate clinical decision-making and improving the service's ability to respond effectively to women's assessed needs.

The maternity team used the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths and the quality and safety committee and maternity safety champions meetings. The maternity safety champions were leaders in maternity and neonatal care focused on improving safety and quality.

## Delivering evidence-based care and treatment

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The evidence showed some shortfalls. The service did not always plan and deliver women's care and treatment with them, including what was important and mattered to them.**

The service reported the trust was experiencing challenge with clinical guidelines and the maternity service was working towards merging its current guidance across all maternity sites.

From October 2025 the safety and quality report showed 108 of maternity documents were out of date. This was on the maternity risk register due to the ongoing delay in updating guidance

and the potential risk this may cause. For example, out of date documents could lead to potential safety issues and risks, inconsistencies in maternity care given and differences in maternal health outcomes.

Staff were able to access guidelines on the trust's intranet system. Although guidance was available there continued to be key maternity guidance which was not in date or aligned across the maternity locations.

The guidance for postpartum haemorrhage (PPH) management was out of date. Staff currently used the University Hospital Sussex Obstetric Haemorrhage guidance which was also out of date and not aligned with the most recent National Institute for Health and Care Excellence (NICE) guidance. For example, using the correct dose of misoprostol and a flow chart which did not reflect the most recent safe actions and potions for management of PPH a major obstetric haemorrhage over 1 litre.

The service did not have a maternity bereavement policy. The bereavement team followed actions outlined in the Intrauterine Death Policy, however, this policy was also out of date in November 2023. We were told bereavement midwives instead followed the National Bereavement Care Pathway.

Throughout the maternity unit noticeboards with posters to show current learning and to share best practice and national guidance with maternity staff.

Maternity services did not have an audit schedule, and staff did not routinely carry out local audits alongside current national guidance. This meant there was a risk of not identifying areas for improvement, deterioration in care as well as a lack of overall learning.

Staff used nationally recognised tools, such as the maternity early warning scores (MEWS) and the newborn early warning trigger and track (NEWTT2) tool, to identify women and babies at risk of deterioration. The trust had not implemented a MEWS or NEWTT2 audit due to the current electronic record system being unable to capture all required data.

Senior leaders told us MEWS and NEWTT2 were discussed within the trust guidance 'Recognition and Management of Severely Ill Pregnant women/women including Enhanced Maternal and Critical Care'. However, this guidance had not been updated and was out of date, expiring in November 2024. Senior leaders had drafted a standard operating procedure (SOP) to

support staff completing MEWS and NEWTT2 prior to the upcoming electronic update. However, the SOP had not gone through the appropriate governance process, therefore staff continued not to have guidance.

MEWS documentation was not currently audited by the trust. The service told us that the new version of the tool was due to be uploaded to the electronic notes system in March 2026. Without completing monthly audits, senior leaders were unable to identify areas of poor performance, reducing their assurance that women and babies were receiving safe care.

Maternal readmissions were not reported by maternity location but instead reported as trust wide figures which included all 4 maternity locations. Sepsis cases were not reported to not be audited due to the low number of cases.

However, during a data review of the information provided by the trust following the inspection showed there was conflicting data reported in regard to both maternal readmission and sepsis rates. This meant the service could not be assured they were actively collecting the right data and information to identify any themes, trends or possible causes as to why women were being readmitted.

For example, it was reported there were no reports of sepsis on the cases of maternal readmissions between May 2025 to October 2025. A review of meeting minutes showed there was 1 maternal readmission to the service with sepsis found on admission.

The service did not routinely carry out local audits. Not completing local audits, limited the services ability to identify learning from adverse outcomes and national trends. This reduced opportunities to strengthen risk identification and clinical assessment, meaning women's and babies' needs may not be consistently informed by the most up-to-date evidence and learning. As a result, learning may not always be used as effectively as possible to support ongoing improvement in maternal and neonatal outcomes.

However, the service did contribute to some national audits, such as perinatal mortality, and Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK).

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## How staff, teams and services work together

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service worked well across teams and services to support people. They made sure people only needed to tell their story once by sharing their assessment of needs when people moved between different services.**

Teams had effective working relationship, with staff reporting they worked well as a team and there was a good culture between midwives and obstetricians.

Staff considered patients' individual needs and circumstances and we observed effective handovers. During safety huddles we observed maternity and obstetric teams actively having discussions around supporting women.

There was a continuity team for all women who used the service where there were safeguarding concerns, long term conditions, mental health or other additional support needs. During midwifery safety huddles we observed active discussions around women with complex care who required support to have the birthing experience they wanted. The service had worked with other agencies to develop a multi-agency birth plan.

The service worked collaboratively with system partners through the Local Maternity and Neonatal System (LMNS). The trust and LMNS were working to produce a training programme to support midwives to train for the high dependency course. The course gave midwives the advanced knowledge and skills required to care for critically ill and high risk pregnant or postpartum women.

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services.

There was a monthly service user workstream working group in place, chaired by the head of midwifery and MNVP. The group reported into the maternity and neonatal improvement group, which was chaired by the chief nurse and attended by stakeholders to support and advise the

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trust such as NHSE, LMNS, Maternity Safety Support Programme (MSSP), and MNVP. The MNVP provided friends and family feedback to improve antenatal appointments and discharge processes by identifying further information about women's background and history to support their maternity journey.

Bereavement services had links with mental health teams and external support agencies to support women following loss.

## Supporting people to live healthier lives

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service supported people to manage their health and wellbeing to maximise their independence, choice and control. The service supported people to live healthier lives and where possible, reduced their future needs for care and support.**

Staff assessed women's health when admitted and provided support for any individual needs to live a healthier lifestyle. Women were asked about their smoking status at their booking appointment, and all women were offered carbon monoxide screening.

The trust website included a dedicated page with advice and support during pregnancy, including antenatal education. Women could also access information about their health, care and support via the maternity pages online, printed leaflets, and from staff during appointments.

Posters were displayed around the unit for the 'swap to stop' campaign. The campaign promoted switching to an alternative as a step towards stopping smoking. The service monitored this using a dashboard which showed women were taking this advice and less women were smoking at delivery than at booking.

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## Monitoring and improving outcomes

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always routinely monitor women's care and treatment to continuously improve it. They did not always ensure that outcomes were positive and consistent, or that they met both clinical expectations and the expectations of women themselves.**

The perinatal quality oversight model (PQOM) measured current performance and maternity clinical indicators which measured maternity outcomes and performance. However, the trust did not add benchmark data or target indicators to identify whether the service was making improvements or significantly not meet national requirements and were an outlier.

The number of 3rd and 4th degree tears between April 2025 to August 2025 showed there was a significant increase above the national average. The trust had been working with staff to implement the obstetric anal sphincter injuries (OASI) bundle and to work on the correct technique and optimising maternal position. However, the rates at Princess Royal Hospital continued to be high. The Oasis bundle refers to interventions designed to improve outcomes for women experiencing OASI.

Maternity services across the 4 sites did not meet the compliance to complete hip scans for babies who met the referral criteria within the required timeframe. This was due to issues with scan appointment capacity. Completion of hip scans supported early identification of developmental hip conditions, enabled timely intervention, and improved long-term musculoskeletal outcomes for babies. Where scans are not completed as planned, there was an increased risk of delay in diagnosis, which could affect mobility, development, and future quality of life.

The trust did not meet the compliance with saving babies' lives (SBL) care bundle. Compliance had gone from 97% compliant to 49% over the four trust maternity locations. This was due to a change within the SBL guidelines and new requirements added. Compliance was low in improving the monitoring smoking status of women at 36 weeks of pregnancy and there was a

delay in accessing ultra sound scans. The trust was currently exploring options to work toward a 7-day scanning service to meet the needs of women and the requirements of SBL. The service had put in place urgent mitigations to improve the compliance rate by November 2025.

The national rate for PPH levels was reported to be 32% per 1000 births and the figures given for the service during our data request were 21.28% for June 2025, July 2025 31.58% and 11.90% for August 2025. Recognition and management of postpartum haemorrhage supported timely intervention and contributed to improved recovery and postnatal outcomes for women.

The service learned from neonatal deaths via a child death oversight panel. These were presented to the board through a series of meetings. Learning was also shared system wide via the LMNS quality and safety forum and the board.

Neonatal outcomes across the trust had shown an improvement within neonatal mortality rates which were below the national average.

## Consent to care and treatment

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service told women about their rights around consent and respected these when delivering person-centred care and treatment.**

Women we spoke with felt they had been given enough information, including risks and benefits, to make an informed decision about their care and treatment and that they were able to give informed consent.

Midwives understood how to assess women's capacity to make decisions. On our review of women's record's, we found completed consent forms for caesarean sections as well as when gaining verbal consent when completing care.

Staff had access to mental health/deprivation of liberty safeguards (DoLS) guidelines on the trust intranet. Staff were able to talk about DoLS and how this would impact a woman on the

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unit. Staff were aware of their responsibilities under the Mental Capacity Act 2005.

## Caring

Rating Good

We looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last assessment this key question was not rated. At this assessment we rated caring as good. This meant people were supported and treated with dignity and respect; and involved partners in their care.

Women received care that was person-centred and were given information and advice about their health, prenatal and postnatal care. Women told us during the assessment that they felt well supported by the multi-disciplinary team and felt they were involved in the assessment of their needs.

However, staff told us they felt they were not always listened to when raising concerns and they were "tired and burnt out" and did not always feel heard. Staff told us they could not always take breaks.

### Kindness, compassion and dignity

#### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service treated women with kindness, empathy and compassion and respected their privacy and dignity. Staff treated colleagues from other organisations with kindness and respect.**

Women and their families we spoke with felt they were treated with kindness, compassion, and dignity. During the assessment, we observed midwives taking time to interact with women and those close to them in a respectful and considerate way. Women felt staff listened to them and communicated with them appropriately.

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Women told us, “I felt my midwife was caring and listened to me”, “the midwives supported me throughout my pregnancy and birth” and “they were amazing”.

The service received positive feedback from the women and their families who used it. Feedback from women and their families was gained through the friends and family test (FFT) and the birth stories service.

Patient experience audits were reviewed by matrons across maternity services and highlighted how staff at all levels were reported to be consistently kind, supportive, professional, and compassionate by women and their families.

We reviewed the latest CQC Maternity survey 2025, we saw that when women were asked “Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?”, the service scored 6.7, which was below the national average of 7.6, when compared to all other trusts in England. Women were asked if they felt that healthcare professionals did everything they could to help manage your pain in hospital after the birth. The service scored 8.0, which was above the national trust average of 7.6.

When women were asked if they were treated with kindness and compassion during labour and birth, the service scored 9.3, which was above the national trust average of 9.0. When women were asked about their post-natal care they received, were they treated with kindness the service scored 8.7, which was above the national trust average of 8.4.

The service worked closely and had positive relationships with the local Maternity and Neonatal Voices partnership (MNVP). The MNVP engaged regularly with leaders to ensure voices of women were heard and feedback was passed on.

Feedback was used to form reflective practice with maternity staff and for professional development. Staff achievements were shared, and we saw feedback from women sharing where staff had gone above and beyond to support women during their birthing experiences.

The unit had a bereavement area where women and families could spend time after the birth of their baby. The area had specialist equipment such as cold cots, which would allow the family to spend several days with their baby after birth. There were specialist bereavement midwives who provided care to grieving parents.

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## Treating people as individuals

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service treated women as individuals and made sure women's care, support and treatment met women's needs and preferences. They took account of women's strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.**

Women's individual needs and preferences were understood, and this was reflected in the care, treatment and support they received during their pregnancy and birthing journey. Staff were understanding and had a non-judgmental attitude when caring for or discussing women with mental health needs.

Emotional support and advice to women was evident from talking to women during the assessment and from reviewing feedback and thank you emails and letters received from women. Staff were reported to be readily available to women. Staff listened and were visible on the unit. For example, one woman we spoke to had, had a difficult pregnancy and felt the kindness and support she had received from the midwives was excellent.

The findings of the Maternity survey 2025 showed when women were asked if a midwife asked about their mental health, the service scored 9.6, which was above the national trust average for England. Women were also asked if they were given information about any changes they might experience to their mental health after having a baby, the service scored 7.5, which was above the national trust average of 7.4.

The service offered support for women from black and south Asian backgrounds to access antenatal results and choices counselling (ARC). This was because women from a black and south Asian background were less likely to access mental health services.

Maternity and neonatal voice partnership (MNVP) used various methods to engage with women using maternity services. The MNVP had successfully procured finance to purchase reclining chairs for partners staying overnight. This meant partners could comfortably stay and support

women as well as also being able to establish a bond with baby.

The service had a comprehensive 7-day bereavement service across all 4 maternity sites to make sure there was consistent support for women and their families experiencing pregnancy loss or neonatal death.

As well as bereavement counselling for women, the service also identified bereavement counselling specifically for men. Emotional support following baby or pregnancy loss should be inclusive of men as well as women. Men can experience significant grief following pregnancy or baby loss. Where this grief is not recognised, it may negatively affect their wellbeing and their capacity to support their partner. Providing inclusive, compassionate support enables both parents to acknowledge and process their loss and promotes positive mental health outcomes.

Staff supported women whose first language was not English to use a service called 'B-Line', for translation services to access care and maternity assessment unit.

## Independence, choice and control

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service promoted people's independence, so people knew their rights and had choice and control over their own care, treatment and wellbeing.**

Women said that they had choice and control over their own care. We observed staff who supported and involved women in assessments and encouraged them to make decisions about their care.

Women and their families could give feedback on the service and their treatment, and staff supported them to do this as well as maintain relationships that were important to them. For example, the service had introduced 'hope boxes' for mothers where the local authority was planning a separation at birth. Hope boxes included blankets, teddy and memory cards, to support the mother's needs.

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We reviewed the Maternity survey 2025, women were also asked if they felt that if their partner or someone else close to them were involved in their care during labour and birth were they able to be involved as much as they wanted. The trust scored 9.8, which was above the national trust average of 9.5. When asked about their stay in hospital, if their partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted. The trust scored 9.0, which was above the national trust average of 7.4.

## Responding to people's immediate needs

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The evidence showed some shortfalls. Staff did not always respond to women's needs in the moment and women sometimes experienced delays. Staff acted to minimise any discomfort, concern or distress. The service listened to and understood women's needs, views and wishes.**

We observed staff were busy in all areas and working under pressure across during the inspection. We saw staff being deployed to clinical areas in most need to optimise safety.

There were delays to the elective caesarean section list due to the obstetric theatre not being in use at the start of our inspection and a lack of space within main theatres. This meant there was an ongoing delay to elective caesarean sections and women having an induction of labour.

Staff told us the obstetric theatre had to be closed due to heating and ventilation problems weekly and during the inspection the closure of the obstetric theatre had become normalised.

Maternity staff were supportive and listened to women's needs. The service offered a birth reflections service, which gave women and their families the opportunity to talk about their personal birth experiences.

Staff acted to minimise any discomfort, concern or distress and they listened to and understood women's needs, views and wishes.

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Bereavement midwives offered counselling to women who experienced pregnancy loss under 24 weeks. For losses over 24 weeks, mothers could choose support from either the bereavement midwife or the perinatal mental health team (PMHT). Women and their families could access bereavement support for as long as needed, including during future pregnancies. The PMHT also provided timely and supportive care, with staff reporting prompt responses.

The trust had introduced a bespoke restorative supervision programme, to provide meaningful, compassionate support to families who may have experienced negative outcomes or the loss of their baby.

## Workforce wellbeing and enablement

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. Staff did not always feel senior leaders listened to staff concerns. Staff felt there wellbeing was not always promoted and there was a lack of person-centred care.**

Staff told us they felt they were not always listened to, when raising concerns, and felt there was a disconnect between managers.

We had received several whistleblower concerns in relation to insufficient staffing. Staff said they were “tired and burnt out” and it was common for staff not to take their break due to low staffing.

Staff we spoke with felt there was a divide between Princess Royal Hospital and the closely linked other trust location. Staff felt there were inequities in workload and resources.

The leadership team completed perinatal culture work to improve staff wellbeing, with targeted action plans to improve cultural challenges. The service launched an app for staff to improve staff experience within the workplace alongside improving care for women. Through the app, staff were able to submit ideas for improving the service, discuss within teams and

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work collaboratively, to boost staff morale and well-being.

Professional Midwifery Advocates (PMA) provided pastural support and restorative supervision to staff. All midwives were allocated a PMA, and support was offered to maternity support workers.

## Responsive

Rating Good

We looked for evidence that women and communities were always at the centre of how care was planned and delivered. We checked that the health and care needs of women and communities were understood, and they were actively involved in planning care that met these needs. We also looked for evidence that women could access care in ways that met their personal circumstances and protected equality characteristics.

At our last assessment this key question was not rated. At this assessment we rated responsive as good. This meant people's needs were met through good organisation and delivery.

Women were involved in decisions about their care. The service provided information women could understand. Women knew how to give feedback and were confident the service took it seriously and acted on it.

Women were involved in planning their care and understood options around choosing to withdraw or not receive care.

However, the service did not always make sure that people could access the care, support and treatment when they needed it.

### Person-centred care

#### Score

3. Evidence shows a good standard of care

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**We scored the service as 3. The service made sure people were at the centre of their care and treatment choices and they decided, in partnership with women, how to respond to any relevant changes in women's needs.**

Women had the option of having a home birth or birthing on the labour ward. Women were advised to have counselling to support them in making a choice regarding their birth choice.

Women felt involved in planning and making decisions about their care which was responsive to their needs. They reported staff worked together and supported them to plan their care and the birth of their baby.

The findings of the Maternity survey 2025 showed that when women were asked about being offered a choice on where to have their baby the service scored 9.4, which was above the national average of 8.5 when compared to all other trusts in England.

The service had 2 consultant midwives; part of their role was to support women who chose to birth outside of guidance and provided women with up-to-date guidance and options available to make decisions about their birthing journey. Birth outside of guidance describes women who make decisions that are different from those recommended by the trust or national maternity guidance. For example, women who have health conditions or risk factors, meant they were recommended to have their baby within the obstetric setting.

Women may choose a midwife-led unit for personalised care in a calm, homely environment that supports normal birth, minimises unnecessary intervention, and maintains safety for low-risk pregnancies. There was no midwifery led unit (MLU) located at Princess Royal Hospital and the nearest one for women to access was some distance away, which meant travel and accessibility may be difficult for women and their families.

The service provided a patient triage telephone line 24 hours, 7 days a week for patients to speak with a trained midwife about any concerns they may have. Women felt they received the appropriate advice and support when contacting a midwife and the trust scored 9.1 out of 10 for advice given to women at the start of labour in the CQC Maternity survey.

We reviewed women's electronic records and saw they were comprehensive and there were no concerns regarding documentation. Records showed individualised care was provided, such as for those women who had complex care needs or whose pregnancy was high risk. However,

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staff told us during the assessment they did not always have sufficient time to complete records during their shift Delays in completing patient records can compromise continuity of care, increase safety risks, and reduce the trust's ability to provide assurance of safe, effective care.

## Care provision, integration and continuity

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service understood the diverse health and care needs of people and their local communities, so care was joined-up, flexible and supported choice and continuity.**

The trust aimed to improve targeted interventions to reduce the risk of health inequalities particularly for women most affected.

The maternity service used statistical process control (SPC) charts to allow early identification of changing rates in maternity data and to action an early response to any concerns or themes or trends identified. For example, the trust monitored the percentage of women most at risk of health inequalities, to understand the needs of service users from diverse groups and co-produce improvements and tailored services to reduce the risk of health inequalities.

Specialist midwives identified and supported women with specific support which included the refugee service, drug and alcohol support and teenage pregnancy. There was a proactive approach to understanding the needs of different groups of people and delivering care that met their needs.

Midwives assessed women's mood during antenatal visits and were able to signpost women who required further support for anxiety and depression or fear of pregnancy or giving birth. The Maternity survey 2025 showed that when women were asked about their mental health the service scored 8.4, which was just below the national average of 8.6 when compared to all other trusts in England.

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The service scored 9, the same as the national average when women were asked if they were given enough support during their pregnancy for their mental health.

Staff could access emergency mental health support 24 hours a day, 7-days a week for women with mental health problems and learning disabilities. The service had systems and specialist staff to help care for women in need of additional support or specialist intervention. For example, the service had fetal wellbeing midwives and midwives designated to supporting women following a difficult birthing experience.

There was a significant increase nationally in women choosing to have a planned caesarean birth due to what feels best for then, previous birth trauma or medical conditions. The service reported the same at Princess Royal Hospital and to support women in their choice and to support the high demand had introduced weekend caesarean lists. Although this was intended to support the service and mitigate risk of delay, we were told by staff that it had put further strain on the recovery and postnatal ward.

## Providing information

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.**

The trust website included virtual tours of the maternity units and provided information on maternity services including antenatal education.

Information on birth options and realistic expectations was provided to women and their partners during antenatal appointments, through the trust website and via antenatal education sessions. These sessions, delivered both virtually and face to face, aimed to reduce fear, anxiety and postnatal depression, and to improve birth experiences and overall wellbeing.

Managers communicated changes in national guidance through monthly newsletters,

departmental alerts, during huddles and through presentations to staff. There were informative notice boards around the maternity unit displaying best practice guidance for breastfeeding.

The trust scored 7.4 out of 10 for receiving the information and explanations they needed after birth in the CQC Maternity survey 2025.

## Listening to and involving people

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service made it easy for people to share feedback and ideas, or raise complaints about their care, treatment and support. They involved people in decisions about their care and told them what had changed as a result.**

The trust recognised that women were becoming more informed and aware of their options during the pregnancy and birth of their baby and were working to improve birth experiences for women.

The trust had a 'voice of the user' section on their maternity dashboard, where maternity leaders monitored themes from women and their families. The dashboard showed friends and family test results, formal complaints, duty of candour compliance, number of obstetric claims and maternity and neonatal voice partnership meetings (MNVP).

The service displayed information about how to raise a concern and give feedback on care or experience of the service on notice boards around the unit. Leaders told us they shared feedback from women with staff and the trust board.

In August 2025 the service received 93.88% friends and family positive feedback on care.

Complaints were shared within the monthly safety champions report and presented at the maternity and neonatal clinical leaders meeting and maternity and neonatal patient safety meeting.

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From May 2025 to the end October 2025 the service had received 10 complaints. Out of the 10 complaints there were 4 still open to an investigation, 3 of those complaints had exceeded their 60 working day closure target.

The most common theme of complaints was due to clinical incidents. These were broken down into failure to diagnose, inappropriate procedure, awareness under anaesthetic and delay or failure to undertake scans.

Complaints were shared in the monthly safety champions report and presented at the maternity and neonatal clinical leaders meeting and maternity and neonatal patient safety meeting.

Staff knew how to handle complaints effectively and the head of midwifery reviewed all complaints and responses.

## Equity in access

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The evidence showed some shortfalls. The service did not always make sure that people could access the care, support and treatment they needed when they needed it.**

The trust's maternity dashboard showed between June 2025 to November 2025 there were 71.9% of women who saw a midwife for their 10-week booking appointment.

The NHS guidance for a first midwife appointment (also called the booking appointment) is to be before the woman is 10 weeks pregnant. This is because some tests may need to be done before 10 weeks. It was unclear whether the service was in the process of improving access for women.

There was inequitable access to antenatal information across the 4 locations, at Princess Royal Hospital, antenatal education sessions were only available in person every other weekend and

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there were limited places available for women and their partners.

Infant feeding sessions were offered virtually and face to face, which was the preferred method for sessions. Women were given information and advice about their health, prenatal and postnatal care.

From September 2024 to August 2025 there were 58 incidences where the maternity service had identified capacity issues and the trust escalation procedure had been activated. This meant there were a higher number of women using the service and a higher number of operational pressures on the service. The service reported the demand was managed within the trust and there were no incidences of pregnant women diverted to other trusts.

Women attending the service for an induction of labour (IOL) were given an initial date for admission to start the induction process. Women were advised that this date may change based on acuity and the prioritisation according to clinical risk.

Information received from staff identified that there were regular delays in women receiving the IOL. We requested the number of IOL delays and times of waits between May 2025 to November 2025 for the hospital. However, we were told the service did not collect data regarding the waiting times and to identify the information would mean a review of women's case notes. This meant the service could not clearly identify reasons, themes or trends for delays in induction of labour to improve women's experiences and alleviate risk.

The service had recently updated their guidelines and formed an IOL discussion group to listen to concerns and to explain emerging plans. However, this did not lessen the potential risk for women experiencing long delays with IOLs.

The service worked with local maternity and neonatal systems (LMNS) and maternity and neonatal voice partnership (MNVP) to identify barriers to women accessing maternity care and discuss improvements. The MNVP did this by providing a survey to women using maternity services, talking to women at baby groups and through accessing social media.

Mental health midwives and specialist bereavement midwives supported women who required additional support.

Women were given a discharge date when they booked for a planned caesarean section to allow women to plan discharge arrangements and family support if needed.

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## Equity in experiences and outcomes

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. Staff and leaders actively listened to information about people who are most likely to experience inequality in experience or outcomes and tailored their care, support and treatment in response to this.**

The service developed online and face-to-face birth education classes to enhance women's experiences of birth. These classes aimed to support women by reducing fear, anxiety and postnatal depression, and lowering the risk of birth-related trauma while improving overall wellbeing.

Staff and leaders actively listened to information about women who were most likely to experience inequality in experience or outcomes and tailored their care, support and treatment in response to this. For example, the service had a continuity of care team established for women from the Gypsy, Roma and Traveller community, women with a history of substance misuse as well as other vulnerable women.

Leaders monitored outcomes and investigated demographic data to identify when treatment and outcomes differed for different groups of women. Equity in experiences formed part of divisional quality meetings and was part of the work that the Maternal and Neonatal Voices Partnership (MNVP) were involved in.

The trust was focused on improving interventions to reduce the risk of health inequalities. Through the perinatal quality surveillance model, the trust monitored health inequalities using electronic data charts. These showed the number of women accessing services through the continuity of carer model and asylum seeker specialist services, helping to identify where further support was needed. The trust worked with system partners and service user groups to better understand the needs of service users from diverse groups and co-produce improvements and tailored services.

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## Planning for the future

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. Women were supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life.**

Women could get information and advice that was accurate, up to date, and provided in a way they could understand to plan for their birth. The service supported women to make informed choices about their care. This was achieved through health promotion information, antenatal classes, appointments with midwives, birth plan documents, information leaflets, and resources available on the maternity page of the trust's website.

Women were supported to make decisions to improve their overall health. This included stopping smoking and making healthy eating choices.

Women were clear about discharge plans and who to contact with any concerns. Discharge summaries were shared electronically with health visitors and GPs and follow up arrangements were made prior to discharge.

## Well-led

**Rating** Requires improvement

We looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last assessment we rated this key question as inadequate. At this assessment the rating was requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

We found a breach of breach of regulation 17: good governance due to the service not having an audit schedule and staff did not routinely complete local audits. Staff did not have access to up-to-date

policies and guidance due to several being outside of the review date.

However, policies and guidance did reflect the current National Institute for Health and Care Excellence (NICE) guidance. To develop the vision the trust used key words from feedback received from women and their families through the friends and family test. Key words were also obtained from feedback from staff within the maternity and clinical teams via the staff survey.

## Shared direction and culture

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service had a shared vision, strategy and culture. This was based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and their communities.**

Maternity services had co-produced a vision and strategy 'University Hospitals Sussex NHS Foundation Trust maternity vision and road map'. The newly developed strategy was developed as part of the process of the trust coming out of the Maternity Safety Support Programme (MSSP).

To develop the vision the trust used key words from feedback received from women and their families through the friends and family test, MNVP quarterly survey and MNVP walkarounds. Along with feedback from staff within the maternity and clinical teams via the staff survey.

Following the last maternity inspection in 2021, maternity services across the trust entered the Maternity Safety Support Programme (MSSP) in February 2022. The service had a maternity improvement plan in place which was monitored every 2 months by the maternity improvement group.

The divisional vision was, "To be a leading provider of maternity care where supportive compassionate care and kind communication create a safe, empowering and personalised

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experience for all families".

Staff we spoke to during the assessment could tell the team key words within the vision and key values were displayed on boards around the maternity service.

The divisional goals were aligned with the NHS Three Year Delivery Plan for Maternity and Neonatal Services (2023) and the trust Maternity Improvement Plan. The goals included delivering the highest standards of safety and quality of care, reducing health inequalities, workforce development, enhancing service user experience, increasing innovation, technology, community and partnership.

## Capable, compassionate and inclusive leaders

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. There had been several changes to the leadership team which had caused some instability within the service and some services felt they were not integrated into the wider service. The service now had inclusive leaders who understood the context in which they delivered care and treatment.**

There had been several changes in the leadership team which had caused some instability within the service with some staff reporting they felt they were not integrated into the wider service. Staff told us they had raised concerns about risks due to poor staffing and high acuity within the service, but did not feel their concerns were heard.

Staff reported they were unhappy and this was further supported by senior leaders who told us they were aware staff were not happy. Senior leaders reported there was sickness within the team with some staff being off with stress and anxiety.

The maternity safety champions last visited the maternity unit in August 2025 following concerns reported around staffing. The maternity safety champions met with staff to discuss their concerns and to address the issues around staffing with both the head of midwifery (HOM)

and director of midwifery (DOM). Although there was no information to identify any potential outcome of the visit.

The divisional clinical operating model included overarching cross site clinical director roles alongside dedicated site-specific medical leadership. The recently in post head of midwifery (HOM) covered both Princess Royal hospital and Royal Sussex County Hospital. The director of midwifery (DOM) reported to the trust board.

The senior leadership team felt the executive team understood and supported their vision for the maternity service.

The maternity service had a team of professional midwifery advocates (PMA), who provided pastural support and restorative supervision to staff. All midwives and maternity support workers were supported by a PMA.

In the event of an incident, debriefing was facilitated by trauma and risk management (TRiM) trained practitioners from both medical and midwifery backgrounds with individual support and counselling services available. The TRiM practitioners were trained to deliver psychologically informed responses to traumatic events.

## Freedom to speak up

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. Staff did not always feel able to speak up and that their concerns would be heard and acted on to drive improvement.**

There were processes to promote the freedom to speak up guardians (FTSUG) to staff. The FTSU guardian reported back to the maternity leadership team to discuss themes and concerns. The FTSUG escalated directly to the director of midwifery or head of midwifery.

Staff told us they did not always feel able to raise their concerns with the FTSU guardians,

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without feeling that they would receive a negative response from the senior leadership team. The regional and LMNS insight visit in August 2025 identified in their report there had been an increase in the number of FTSU concerns raised in 2024 to 2025.

The maternity senior leadership team aim was to strengthen staff engagement and to provide direct feedback to staff. However, feedback from staff was, there was a lack of visible action or meaningful response to concerns raised regarding staffing and concerns around the flow of the maternity unit.

The trust had rolled out civility training and promoted an open-door policy. The medical team had developed a questionnaire for staff, to find out more about their wellbeing and civility with other team members. Civility training promotes respectful and considerate behaviour from all staff members of the maternity and obstetric team.

Women, and their families knew how to complain or raise concerns, and how to give feedback on the service and their treatment.

## Workforce equality, diversity and inclusion

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always value diversity in their workforce. They did not always work towards an inclusive and fair culture by improving equality and equity for people who work for them.**

Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services.

The trust 2025 staff survey identified concerns regarding discrimination, and an action plan was developed. The service was developing succession planning for future leaders, ensuring ethnicity of the workforce was reflected.

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Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services.

The trust told us they were committed to fostering an inclusive and equitable working environment and there had been an investment in workforce race equality standard (WRES). The service planned to establish a divisional equality, diversity and inclusion group to make sure the service were working alongside national guidance.

Some staff across the trust were taking part in the NHSE regional reverse mentoring programme. The programme was a reflective approach to cultural learning, leadership development and to increase diversity across the trust.

## Governance, management and sustainability

### Score

1. Evidence shows significant shortfalls in the standard of care

**We scored the service as 1. The service did not have systems of accountability and good governance. They did not act on the best information about risk, performance and outcomes, or share this securely with others when appropriate.**

Governance systems were not always operating effectively to ensure risk and performance issues were identified. Staff did not have access to up-to-date policies and guidance due to several being outside of the review date. We found safeguarding training levels were not aligned to national standards and there was no formal audit plan.

The divisional meeting fed into the executive performance and quality meeting. Meeting minutes were reviewed and although there was a clear oversight of maternity services identified within the minutes, we found there was not always a clear action plan.

There were several policies and guidance that were outside of their review dates. This meant there was a risk staff did not always have access to the most up to date, best practice guidance and may not always practice in accordance with it.

Acute services
# Maternity

However, policies and guidance did reflect the current National Institute for Health and Care Excellence (NICE) guidance.

The trust reported they were experiencing challenge with reviewing and updating clinical guidelines. Updating maternity guidelines were currently on the women and children's risk register. The trust reported that it did not have the resources to keep up with updating all current guidelines across all 4 locations.

Senior leaders described a risk-based approach to incident review, with targeted reviews undertaken in response to identified themes. For example, any possible incident linked to sepsis would be reviewed. However, audits were not routinely completed, which meant there was a lack of continuous and systematic review of potential safety incidents, themes and trends. As a result, the service could not be assured of the overall quality and safety of the maternity service.

The trust recorded all maternity safety and quality information on the maternity dashboard. This information covered organisational aspects, such as closures, activity, workforce and clinical indicators. However, some maternity dashboard data was not benchmarked against targets, so the trust could not always be assured that the service was performing well against trust-wide or national standards.

The service maintained a risk register which was regularly reviewed; however, some risks had limited mitigation and there were ongoing delays in resolving them. There were also several risks which had been added to the risk register since 2022 and 2023 with no clear action for resolve. For example, the concerns regarding the temperature and ventilation of the obstetric theatre at the Princess Royal Hospital was first added to the register in July 2022.

The trusts maternity services were under a Maternity Safety Support Programme (MSSP) led by NHS England. The MSSP improvement plan was monitored as part of the maternity improvement group led by the chief nurse for the trust for compliance at twice monthly meetings attended by the trust and relevant stakeholders. This included action plan and workstream reviews of multiple aspects of governance, safety and outcomes. The action plan had 163 initial actions and following our assessment the trust told us 91 actions were completed and closed.

Staff could describe their role in the governance process and had regular opportunities to meet

Acute services
Maternity

discuss and learn from the performance of the service. They knew how to escalate issues to the clinical governance team and divisional management team.

## Partnerships and communities

### Score

3. Evidence shows a good standard of care

**We scored the service as 3. The service understood their duty to collaborate and work in partnership, so services work seamlessly for people. They share information and learning with partners and collaborate for improvement.**

Service leaders attended regular meetings with the Local Maternity Network System (LMNS) to review governance and incidents.

Leaders worked with the Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. Meeting minutes showed current work being undertaken between the local MNVP, maternity service and the LMNS.

The maternity safety champion and non-executive director supported services to monitor safety and outcomes. Maternity safety champions worked closely with the maternity and neonatal voice partnership (MNVP) and undertook walk arounds of the service.

## Learning, improvement and innovation

### Score

2. Evidence shows some shortfalls in the standard of care

**We scored the service as 2. The service did not always focus on continuous learning, innovation and improvement across the organisation and local system. They did not always encourage creative ways of delivering equality of experience, outcome and quality**

Acute services
# Maternity

**of life for people. They did not always actively contribute to safe, effective practice and research.**

There were improvements seen throughout the service, however, there was still a lack of oversight due to not completing maternity audits and benchmarking all data against local and national outcomes.

There were gaps in governance, including the absence of a formal process for induction of labour (IOL) and CTG fresh eyes auditing, which limited assurance on how improvements were monitored. However, staff did contribute to programmes such as the Patient Safety Incident Response Framework (PSIRF) and multidisciplinary review meetings, supporting reflection and learning.

The service had strong external relationships to support improvement and innovation. We saw evidence of regular engagement of leaders and service users, to review and improve the service such as the Maternity and Neonatal Voices partnership (MNVP) steering group.

Senior leads met regularly to discuss and monitor risk as part of the trust maternity and neonatal improvement group.

The consultant midwife led a physiological birth working group which was a collaborative initiative involving midwives and obstetric staff from all 4 locations. Physiological birthing experience is the natural progression of labour without medical interventions such as epidural, inductions or caesarean sections. The group focused on how to support women with positional techniques and strategies for improving care during the latent phase of labour. It was also an opportunity to share learning between teams and provide evidence-based care.

Princess Royal Hospital

# Action plan requests

## Regulation 12: (Schedule 3) Statement of purpose

### Service

Maternity

### Regulated activities

- Maternity and midwifery services

### How the regulation was not being met

Women did not receive a midwifery review within 15 minutes of arrival within the maternity care centre and women did not receive a medical review within a timely manner.

The service had 1 obstetric theatre which was frequently reported to be closed due to ongoing equipment failures and issues with the heating and ventilation.

There were gaps identified in the medicines record keeping books where the anaesthetic team had not signed to identify drugs which had been administered to women in theatre.

## Regulation 17: Good governance

### Service

Maternity

### Regulated activities

- Maternity and midwifery services

Princess Royal Hospital
# Action plan requests

### How the regulation was not being met

The service did not have an audit schedule and staff did not routinely complete local audits. Staff did not have access to up-to-date policies and guidance due to several being outside of the review date.

## Regulation 18: Staffing

### Service

Maternity

### Regulated activities

- Maternity and midwifery services

### How the regulation was not being met

Following the inspection the service remained in breach of regulation 18: staffing.

The service did not have enough staff to keep women safe. Staff told us they felt tired and burnt-out due to workforce pressures and the demands of the service. Shifts felt increasingly overstretched and sickness rates were high with 8% midwifery sickness, we were told this was mostly due to staff stress.

University Hospitals Sussex
NHS Foundation Trust

To: Board via the Audit Committee

Date: 17 September 2026

From: Chair of the Audit Committee

Agenda Item: 12

**FOR ENDORSEMENT**

**ANNUAL REPORT FROM THE AUDIT COMMITTEE TO THE BOARD 2025-26**

## 1.0 INTRODUCTION

1.01 The purpose of this report is to formally report to the Board on the work of the Audit Committee during the period 1 April 2025 to 31 March 2026 and to set out how the Committee has met its terms of reference and key priorities.

1.02 The Audit Committee's Terms of Reference require it to report annually to the Board outlining the work it has undertaken during the year and where necessary, highlighting any areas of concern.

## 2.00 EXECUTIVE SUMMARY

2.01 The Audit Committee has the delegated authority to act on behalf of the Board in accordance with the Constitution, Standing Orders, Standing Financial Instructions and Scheme of Delegation. It follows best practice guidance as set out in the NHS Audit Committee Handbook providing a form of independent check upon the management of the Trust.

2.02 The Committee is responsible for providing assurance to the Board that appropriate systems of internal control and risk management are in place covering all corporate and clinical areas of the Trust. In carrying out this work the Audit Committee obtains assurance from the work of Internal Audit, External Audit and Counter Fraud Services.

2.03 The Committee independently reviews, monitors, and reports to the Board on the attainment of effective control systems and financial reporting processes supported by assurance from Internal Audit, External Audit, the Counter Fraud Services and from Management (through the BAF).

2.04 The Committee reviews the Annual Report and and the Annual Governance Statement with the External Auditor prior to Board approval and sign off.

2.05 The Committee continues to drive forward developments to the structure of the Trust's Board Assurance Framework to better support the work of each Board Committee with their assurance reporting to the Board.

2.06 The Audit Committee - through the membership of the respective Committee Chairs - has been able to focus time and energy on reviewing the strategic risks of the Trust and began a series of deep dives into those strategic risks.

2.07 The Audit Committee was presented with and endorsed an Internal Audit plan aligned to the Trust's Board Assurance Framework.

2.08 The Audit Committee has engaged with the Company Secretary to continue to enhance the format of the Board Assurance Framework to be clear on the impact of actions of the current risk scores and the development of an in-year target risk score to allow for better focusing of attention on those risks that are beyond the target score.

## 3.00 COMMITTEE MEMBERSHIP AND MEETINGS

3.01 The Audit Committee comprises solely of independent Non-Executive Directors in line with the Code of Governance for Foundation Trusts. There are five Non-Executive Directors who are allocated to the Committee: Chair of the Patient & Quality Assurance Committee (Lucy Bloem), the Chair of the People & Culture Assurance Committee and Strategy & Major Projects Committee (Paul Layzell), the Chair of the Research, Innovation & Digital Strategy Assurance Committee (Jackie Cassell), the Chair of the Finance & Performance Assurance Committee (Philip Hogan). Other l Non-Executive Directors, except for the Chair who attends by invitation only, can attend the meetings.

3.02 The Chief Financial Officer, Interim Chief Corporate Affairs Officer, Director and Deputy Director of Operational Finance, Company Secretary, Local Counter Fraud Services, Internal and External Auditors are regular attendees at meetings of the Committee. Other Executives and Senior Managers also attend Committee meetings for specific items at the Committee's request usually linked to Internal Audit activity.

3.03 The table below details the membership and attendance of Committee members in respect of the period 1 April 2025 to 31 March 2026.

| | Audit Committee |
|---|---|
| *Total number of meetings in the year* | 5 |
| Lucy Bloem, Non-Executive Director | 3 of 5<br>60% |
| Professor Jackie Cassell, Non-Executive Director | 4 of 5<br>80% |
| David Curley, Non-Executive Director (until 30.06.25) | 2 of 2<br>100% |
| Mike Driver CB, Non-Executive Director (from 01.08.25) | 2 of 2<br>100% |
| Philip Hogan, Non-Executive Director | 3 of 5<br>60% |
| Professor Paul Layzell CBE, Non-Executive Director | 5 of 5<br>100% |

## 4.00 CYCLE OF BUSINESS

4.01 The Audit Committee agenda is based upon an agreed forward work plan which is reviewed and approved at the start of the financial year.

4.02 Internal Audit activity is agreed jointly by both the Executive and the Non-Executive Committee members at the start of the year and are focused on areas of perceived highest risk alongside those areas required by the Head of Internal Audit to formulate their opinion. The Audit Committee receives the reports of these Internal Audits and tracks the implementation of recommendations at each of its meetings.

4.03 In order to maintain independent channels of communication, the Chair of the Audit Committee holds a private meeting with External Audit, Internal Audit and Counter Fraud Services throughout the year. This provides all parties the opportunity to raise any issues without the presence of management.

4.04 The Committee followed its agreed annual work plan throughout the year and received a series of executive presentations around Internal Audit, External Audit and Local Counter Fraud Services and

dedicated additional time at each meeting to scrutinise in detail the Board Assurance Framework, Corporate Risk Register and Risk Management Compliance.

## 5.00 INTERNAL AUDIT

5.01 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.

5.02 The Trust's Internal Auditor for the year was BDO. In January 2024 the Committee discussed the outline approach for the appointment of the Internal Auditor for the 3-year period commencing 01 July 2024. The Committee then endorsed the recommended approach for the appointment of the Internal Auditor for 3 years from 01 July 2024.

5.03 The Internal Audit plan for 2025/26 was approved by the Audit Committee in July 2025. Performance against the approved plan is attached as Appendix A. The plan was based upon discussions held with management and the Audit Committee and was constructed in such a way as to gain a level of assurance on the main financial and management systems reviewed.

5.04 The Head of Internal Audit presented a progress report to each of the Committee's meetings. The report sets out progress against the agreed audit plan, and the principal outcomes from audits completed in the period since the previous meeting. The Committee also receives a summary of all reports together with the full report of any audit with a below Moderate Assurance rating.

5.05 Internal Audit completed a total of 12 reviews (9 assurance audits and 3 advisory reviews. The advisory reviews related to Improvement Systems, Maternity Incentive Scheme Year 7 and Data Security and Protection Toolkit and did not carry an opinion. For the 9 assurance audits, 11% were rated substantial, 78% moderate and 11% limited in the design of the controls. For the 9 assurance audits, 22% were rated substantial, 44% moderate and 33% limited in their operational effectiveness. The seven reports for the year to date resulted in a total of 27 recommendations (High: 26%, Medium: 52% and Low: 22%), compared to the year before. The Trust over the year implemented 59% audit recommendations within the specified timeframes. As at the end of April 2026, there were 3 recommendations in progress (Medium: 1) and 1 recommendation overdue (High: 0, Medium: 1). The Audit Committee requested a more detailed update on performance in this area at it meetings in 2026/27.

5.06 Internal Audit Reports comprise two Assurance ratings; one relates to the Design of the system being reviewed whilst the other relates to the Effectiveness of the system being reviewed. Internal Audit was satisfied that sufficient internal audit work had been undertaken to allow them to draw a reasonable conclusion as to the adequacy and effectiveness of University Hospitals Sussex NHS Foundation Trust's risk management, control and governance processes, and provided the following positive overall opinion: *"Generally satisfactory with improvements required in some areas"*.

## 6.00 LOCAL COUNTER FRAUD SERVICE (LCFS)

6.01 The Counter Fraud service is provided by an external provider RSM, who report quarterly to the Committee. The team is responsible for day-to-day awareness and activities. The quarterly reports describe proactive work to prevent or deter fraud and also set out the results of reactive work undertaken in response to referrals about suspected fraud.

6.02 A work plan for 2025/26 was agreed with the Finance Director and approved at the Audit Committee in April 2025. The work plan outlined the core Local Counter Fraud Specialist (LCFS) activities to be undertaken during the financial year within the agreed resources. Key activities undertaken include areas of strategic governance, inform, and involve, prevent and deter and hold to account.

6.03 During the year the LCFS participated in a number of proactive projects to prevent or detect fraud. The LCFS also advised on improvements to policies and procedures, to reduce the risk of fraud.

6.04 The Local Counter Fraud Specialist reports annually on behalf of the Trust and has not identified any significant control weaknesses during their work. Where improvements have been identified then, similar to Internal Audit they make recommendations and the delivery of these is tracked and reported to the Audit Committee.

## 7.00 BOARD ASSURANCE FRAMEWORK

7.01 The Committee continues to drive forward developments to the structure of the Trust's Board Assurance Framework to better support the work of each Board Committee with their assurance reporting to the Board.

7.02 During the course of the year the Committee continued to dedicate a substantial amount of focus on ensuring that the BAF was used to structure the assurances that the Committee sought through its meetings. In conjunction with the BAF the Committee received the Risk Management Compliance report, supported by the newly formed Risk Oversight Group which further corroborated the reporting and assurances received through the BAF.

7.03 The Audit Committee over 2025/26 has engaged with the Interim Chief Corporate Affairs Officer and Company Secretary to enhance the format of the Board Assurance Framework to make clearer the impact of actions of the current risk scores and the development of an in-year target risk score to allow for better focusing of attention on those risks outside the yearly target score.

7.04 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.

7.05 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 led Risk and Governance Group has been established.

## 8.00 YEAR END REPORTING

8.01 The Committee reviewed and approved the Annual Report and Accounts and the Annual Governance Statement allowing the Audit Committee members to be appropriately engaged in the preparation of the Annual Report and Accounts.

8.02 The Committee also received information from the Chief Financial Officer that enabled the Committee to be assured that there were no matters that had not been disclosed to the Auditors.

8.03 The Committee received a report on the Trust's processes for registering declarations of interest, the receipt of gifts, hospitality, and sponsorship along with the compliance with the fit and proper persons' regime. The Committee was informed that no Board Member had declared any significant commitments that require disclosure or any management actions. 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 of 1314 (99%) 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.

8.04 The submission of the 2025/26 Accounts and Annual Report took place on the 25 June 2026. This was in line with the national timetable.

## 9.00 EXTERNAL AUDIT

9.01 External Audit report to the Trust on the findings from their audit work, in particular their review of the financial statements and the Trust's economy, efficiency, and effectiveness in its use of resources.

9.02 Grant Thornton reported quarterly to the Committee. These reports included approval of the approach to the audit of the financial statements. The table below summarises the key elements of external audit work undertaken during the year:

| Area of Work | Conclusion |
|---|---|
| **Opinion on the Trust's:** | |
| Financial statements | An unmodified audit opinion was issued, confirming that the Trust's financial statements give a true and fair view and have been properly prepared in accordance with the relevant accounting framework. |
| Parts of the remuneration and staff report to be audited | The audited elements of the Remuneration and Staff Report were properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual (FT ARM), and an unqualified opinion was issued on these disclosures. |
| Consistency of the annual report and other information published with the financial statements | The Annual Report and other information published alongside the financial statements were found to be consistent with the financial statements and with the auditor's knowledge from the audit. |
| **Reports by exception:** | |
| Value for money arrangements | The auditors identified significant weaknesses in arrangements relating to financial sustainability (delivery of savings), governance (culture), and performance (NOF4 rating), and issued key recommendations to address these. |
| Consistency of Annual Governance Statement | The auditors had nothing to report; the Annual Governance Statement was not misleading or inconsistent with audit knowledge. |
| Referrals to the NHS Regulator | |
| Public interest report and other auditor's powers | No Public Interest Report was issued, and no additional auditor powers were exercised. |
| Reporting to the Trust on their consolidation schedules | Audit work on consolidation schedules is ongoing pending NAO completion, but no issues have been identified; certification will follow NAO conclusion of group work. |
| Reporting to the National Audit Office (NAO) in line with group instructions | Reporting requirements to the NAO have been completed in line with group audit instructions, with the final audit certification issue dependent on the NAO completion of their consolidation work. |

9.03 It is normal practice for there to be a full debrief to the Audit Committee following the submission of the year-end accounts. The Audit Committee noted the positive engagement and the pragmatic approach to completing the audit.

## 10.00 Reporting to the Trust Board

10.01 The Committee reported to the Trust Board after each meeting. A summary of the key points of discussion at each meeting, for example highlights of the internal audit reports or any formal recommendations were provided to the Board.

## 11.00 Engagement with the Council of Governors

11.01 The Chair of the Audit Committee is scheduled to report to the Council of Governors on the work of this Committee and the engagement made by External Audit. This reporting supported the Governors discharge their responsibility for the appointment of the Trust's External Auditors.

## 12.00 Conclusion

12.01 The Audit Committee of University Hospitals Sussex NHS Foundation Trust is of the view that it has taken appropriate steps to perform its duties as delegated by the Board and it has no cause to raise any issues of significant concern with the Board arising from its work during 2025/26.

12.02 In making this statement, the Committee members acknowledge the support given to it by management, in particular the Chief Financial Officer, Interim Chief Corporate Affairs Officer, the Director of Operational Finance, and the Company Secretary, and their teams along with that given by the internal and external auditors along with the local counter fraud specialist.

12.03 The Committee recognises that improving the maturity and consistency of risk management across the Trust remains a key priority for 2026/27. A Risk Improvement Sprint, supported by NHS Providers, will commence in May to support the implementation of the new Trust Divisions and Corporate Team structures and will be expected to deliver a revised Risk Management Strategy and Policy, a refreshed articulation of high priority risks, and a programme of targeted training and risk improvement clinics, alongside the establishment of clear governance arrangements to ensure sustainability of improvement. This work will be complemented by continued deep dives into strategic risks that are not progressing towards their 31 March target scores, enabling the Board to better understand where risks remain outside of its appetite and where further action is required.

12.04 In their annual report for 2025/26, Grant Thornton made recommendations in respect of addressing both of their significant weaknesses. The Audit Committee noted the management actions agreed in respect of these recommendations and would receive an update on progress later in the year. The Audit Committee reported to the Board that whilst it would be receiving an update on the progress being made with the specific recommendations, the Board should also be seeking views from the respective Committee Chairs as to the assurance they are receiving in their committees showing the outcome of the management actions agreed are reducing the identified risks.

## 13.00 Recommendation

13.01 The Committee is asked to:

- **Endorse** that this Annual Report be provided to the Board

**Mike Driver**
**Chair of the Audit Committee**
**July 2026**

**APPENDIX A: INTERNAL AUDIT OPERATIONAL PLAN 2025/26 (extract of Internal Audit activity from the IA operational report)**

# INTERNAL AUDIT OPERATIONAL PLAN 2025/26

| AREA | BAF | TIMING | DESCRIPTION OF THE REVIEW | REASON FOR INCLUSION |
|---|---|---|---|---|
| **Core Assurance** | | | | |
| Establishment Control (ward focus) | 3.1 | Q2 | This review will assess how staffing levels are established and monitored at wards to determine if resources are utilised effectively. | Ensuring that resources are being used effectively. This is an area requested for review by the Chief Nurse when conducting our planning discussions. |
| Medicines Management | 4.1 | Q1 | This review will assess the Trust's controls for medicines management processes, including controls over stock balances to ensure that stock is physically protected, and accurately and effectively tracked. Additionally, we will review the processes for managing incidents involving controlled drugs. | Ensuring that resources are being used effectively. This is an area requested for review by the Chief Nurse and Chief Medical Officer when conducting our planning discussions. |
| Finance Grip and Control | 2.1 | Q2 | This review will assess the Trust against the HFMA's publication 'Improving NHS financial sustainability: are you getting the basics right?', with a focus on governance, core processes, and methodology for identifying, monitoring, and reporting the achievement of Cost Improvement Programmes (CIPs) within the Trust. | Ensuring that resources are being used effectively. This is an area requested for review by the Chief Financial Officer when conducting our planning discussions. |
| Health and Safety | 5.2 | Q1 | This review will evaluate whether the Trust has adequate health and safety arrangements in place | Ensuring compliance with statutory requirements. This is an area requested for review by the Chief |

| AREA | BAF | TIMING | DESCRIPTION OF THE REVIEW | REASON FOR INCLUSION |
|---|---|---|---|---|
| Key Financial Systems | 2.1 | Q3 | This cyclical review will assess key systems and controls to provide assurance on the core financial controls in place. | This is a core component required to deliver the Head of Internal Audit opinion and provides a core foundation for the Annual Governance Statement pertaining to the functionality of the Trust's internal controls. |

| AREA | BAF | TIMING | DESCRIPTION OF THE REVIEW | REASON FOR INCLUSION |
|---|---|---|---|---|
| **Future Focused Assurance** | | | | |
| Estates Compliance | 4.1 | Q1 | We will review the process to ensure estates management is effective and the Trust comply with regulations. We select a sample for testing, which will be agreed with the Chief Financial Officer. | Ensuring compliance with statutory requirements. This is an area requested for review by the Chief Financial Officer when conducting our planning discussions. |
| Strategy Implementation | 5.1 | Q4 | This review will assess the implementation of the Trust strategy for 2025-2030. | Ensuring strategic goals are met. This is an area requested for review by the Chief Strategy Officer when conducting our planning discussions. |
| Digital Transformation | 6.2 | Q2/3 | This review will evaluate the effectiveness and progress of the Trust's digital transformation initiatives, including the implementation of digital tools, staff training and adoption, and the impact on operational efficiency and client service. | Ensuring strategic goals are met. This is an area requested for review by the Chief Strategy Officer and Chief Information Officer when conducting our planning discussions. |
| **Total** | | | | |

| AREA | BAF | TIMING | DESCRIPTION OF THE REVIEW | REASON FOR INCLUSION |
|---|---|---|---|---|
| **Contract Management** | | | | |
| Planning / liaison / management | N/A | Q1 - Q4 | Creation of audit plan, meeting with Executive Directors | Effective contract management |
| Recommendations follow up | N/A | Q1 - Q4 | Assessment and reporting of status of implementation of recommendations raised | Assurance for Executive Team and AC |
| Audit Committees | N/A | Q1 - Q4 | Attendance at AC meetings, pre-meets and AC Chair liaison | Effective contract management |
| **Total** | | | | |

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# Mortality and Learning from Deaths 2025/26 Q4 Report

Caroline Wiggs - Learning from Deaths Lead

April 2026

# Learning from Death Mortality Overview - 2025/26 Q4

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

NHS University Hospitals Sussex NHS Foundation Trust

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

## Key Observations

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

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

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

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

# Learning from Death Mortality Overview - 2025/26 Q4

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

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

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

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

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

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

## Key Observations

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

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

*Data source SHMI Module HEDS. Latest data available.

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NHS Foundation Trust

## Key Observations

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

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

# Learning from Death Mortality Outliers - 2025/26 Q4

*Data source SHMI Module HEDS. Latest data available.

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

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

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

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

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

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

## Key Observations

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

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

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

# Learning from Death Mortality Outliers - 2025/26 Q4

*Data source SHMI Module HEDS. Latest data available.

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**VLAD alerts** help detect changes in mortality rates over time.

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

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

## Key Observations

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

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

# Learning from Death Mortality Demographics - 2025/26 Q4

University Hospitals Sussex NHS Foundation Trust

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

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

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

## Key Observations

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

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

Of all **1012** **acute** adult deaths:

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

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

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

# Learning from Death Mortality Demographics - 2025/26 Q4

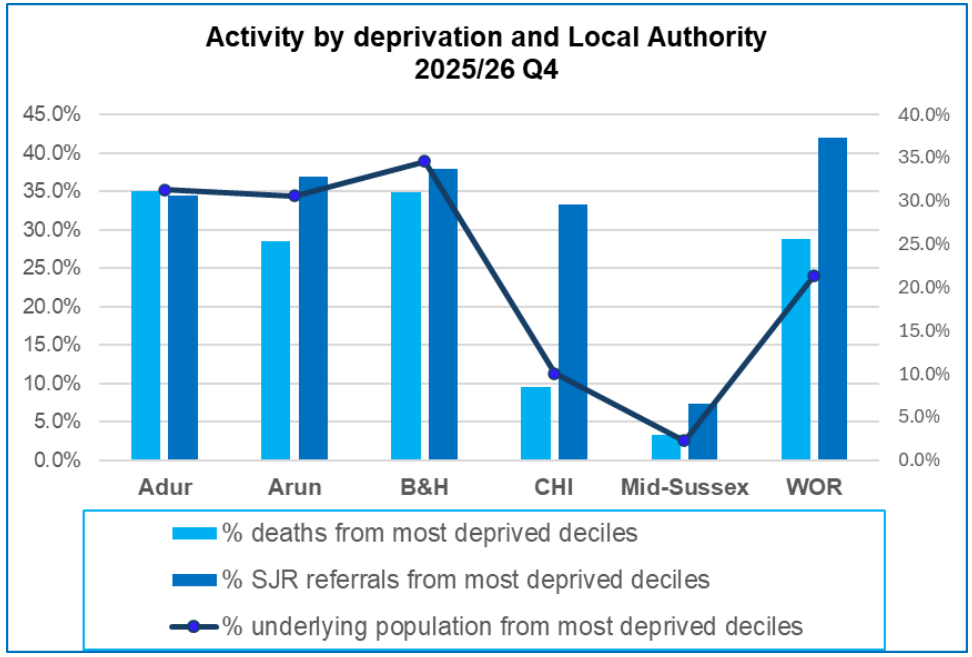
Deaths by IMD Decile (1 = most deprived, 10 = least deprived) Local Authority overview

NHS
University Hospitals Sussex
NHS Foundation Trust

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

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

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




## Key Observations

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

# Learning from Death Child Deaths Overview - 2025/26 Q4

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

Breakdown of acute child deaths by hospital site, ethnicity and underlying population.

University Hospitals Sussex NHS Foundation Trust

| Total Child Deaths | | | | | |
|---|---|---|---|---|---|
| | WGH | SRH | RACH | RSCH | UHSx Q4 Total |
| Jan-26 | 1 | 0 | 1 | 2 | 4 |
| Feb-26 | 0 | 1 | 0 | 0 | 1 |
| Mar-26 | 0 | 0 | 0 | 0 | 0 |
| **Q4 Total** | **1** | **1** | **1** | **2** | **5** |
| **Note: no child deaths recorded at PRH** | | | | | |

| Child Deaths by Ethnicity | | |
|---|---|---|
| **Adult Deaths by Ethnicity** | **UHSx Q4 Total** | **% of total** |
| White:English, Welsh, Scottish, Northern Irish or British | **5** | **100.0%** |
| White: Any other White background | **0** | 0.0% |
| White:Irish | **0** | 0.0% |
| Asian or Asian British: Indian | **0** | 0.0% |
| Mixed or multiple ethnic groups: White and Black Caribbean | **0** | 0.0% |
| Other ethnic group: Any other ethnic group | **0** | 0.0% |
| Other ethnic group: Arab | **0** | 0.0% |
| Not known | **0** | 0.0% |
| Please Select | **0** | 0.0% |
| **Q4 Total** | **5** | |

## Key Observations

- **5 acute** child deaths during 2025/26 Q4.
- **100%** identified as **White (English, Welsh, Scottish, Northern Irish or British).**
- **20% (1) acute** child death within most deprived postcodes (D1-4).
- Highest number of deaths in **D5 (40%, 2)**
- Due to the low number of deaths, caution should be taken when interpreting trends, as small numerical changes may result in disproportionate percentage variation.

| Demographics for Child Deaths | | | | | |
|---|---|---|---|---|---|
| | Jan-26 | Feb-26 | Mar-26 | UHSx | % of total |
| 1 | 0 | 0 | 0 | **0** | **0.0%** |
| 2 | 0 | 0 | 0 | **0** | **0.0%** |
| 3 | 0 | 0 | 0 | **0** | **0.0%** |
| 4 | 1 | 0 | 0 | **1** | **20.0%** |
| 5 | 1 | 1 | 0 | **2** | **40.0%** |
| 6 | 0 | 0 | 0 | **0** | **0.0%** |
| 7 | 0 | 0 | 0 | **0** | **0.0%** |
| 8 | 1 | 0 | 0 | **1** | **20.0%** |
| 9 | 1 | 0 | 0 | **1** | **20.0%** |
| 10 | 0 | 0 | 0 | **0** | **0.0%** |
| Missing | 0 | 0 | 0 | **0** | **0.0%** |
| **UHSx Q4** | **4** | **1** | **0** | **5** | |
| **No. in most deprived postcodes (D1-4)** | **1** | **0** | **0** | **1** | |
| **% in most deprived postcodes (D1-4)** | **25.0%** | **0.0%** | **0.0%** | **20.0%** | |

# Learning from Death Fractured Neck of Femur (#NOF) Mortality - 2025/26 Q4

University Hospitals Sussex NHS Foundation Trust

Overall performance/mortality related to fractured of neck of femur (#NOF) during the quarter.
Breakdown by hospital site. *Data sources National Hip Fracture Database/SHMI module. Latest data available.

| | | No. of patients | Hours to operation (annual) | 30 day mortality % (annual) |
|---|---|---|---|---|
| Jan-26 | WGH | 34 | 35.2 | 4.1 |
| | SRH | 33 | 33.3 | 6.3 |
| | RSCH | 49 | 27.7 | 3.7 |
| | National | | 39.1 | 5.0 |
| | | **116** | **32.1** | **4.7** |
| Feb-26 | WGH | 39 | 35.8 | |
| | SRH | 30 | 33.0 | |
| | RSCH | 55 | 27.9 | |
| | National | | 38.8 | |
| | | **124** | **0** | **0** |
| Mar-26 | WGH | 33 | 35.2 | |
| | SRH | 41 | 33.3 | |
| | RSCH | 58 | 28.2 | |
| | National | | 38.6 | |
| 2025/26 | | **132** | **32.2** | |
| **Q4** | **UHSx** | **372** | **21.4** | |

*Data source National Hip Fracture Database. Latest data available.

| #NOF listed on MCCD 2025/26 Q4 | | | | | |
|---|---|---|---|---|---|
| WGH | SRH | RSCH | PRH | UHSx Q4 Total | % of all Adult Deaths |
| 2 | 1 | 0 | 0 | 3 | 0.3% |

## Key Observations

- **372** patients treated for #NOF across **WGH, SRH** and **RSCH** in 2025/26 Q4; slight increase from **356** in 2025/26 Q3. Activity remains consistent with earlier quarters, when compared with 2025/26 Q2 **(371)** and 2025/26 Q1 **(372)**, indicating overall stability in #NOF caseload.
- **% 30 day mortality** for 2025/26 Q4 awaited. Available 2025/26 Q4 and 2025/26 Q3 data provided.
- **Hours taken to operate** remains consistently **less than national average**.
- **SRH** remains an outlier for **% 30 day mortality**; with **WGH** and **RSCH** consistently below national average.
- **RSCH** consistently **below national annualised crude mortality.**
- **WGH below national annualised crude mortality** in 2025/26 Q3 - reflective of improved outcomes following clinical transformation work.
- **SRH** has been **above national annualised crude mortality** across 2025/26 Q1-Q3. The reduction from **8.3** in Q2 to **8.1** in Q3 provides reassurance of early improvement but warrants continued monitoring.
- **3 (0.3%) acute** adult death MCCDs recorded #NOF in 2025/26 Q4 (**Nil** in Q3, **2** in Q2 and **2** in Q1). Consistently low numbers, with **as expected SHMI.**

| Crude Mortality (annualised) | | | | | |
|---|---|---|---|---|---|
| | 2024/25 Q3 | 2024/25 Q4 | 2025/26 Q1 | 2025/26 Q2 | 2025/26 Q3 |
| WGH | 8.8 | 6.5 | 5.0 | 5.3 | 3.8 |
| SRH | 5.0 | 5.1 | 6.7 | 8.3 | 8.1 |
| RSCH | 3.2 | 2.4 | 3.0 | 3.3 | 3.4 |
| National | 5.3 | 5.3 | 5.1 | 5.1 | 5.0 |

| | | No. of patients | Hours to operation (annual) | 30 day mortality % (annual) |
|---|---|---|---|---|
| Oct-25 | WGH | 42 | 36.8 | 3.9 |
| | SRH | 39 | 35.3 | 8.7 |
| | RSCH | 55 | 27.4 | 4.1 |
| | National | | 39.5 | 5.1 |
| | | **136** | **33.2** | **5.6** |
| Nov-25 | WGH | 33 | 36.0 | 4.2 |
| | SRH | 29 | 35.1 | 8.2 |
| | RSCH | 46 | 27.2 | 4.5 |
| | National | | 39.4 | 5.7 |
| | | **108** | **34.4** | **5.7** |
| Dec-25 | WGH | 37 | 37.5 | 4.5 |
| | SRH | 25 | 35.3 | 8.3 |
| | RSCH | 50 | 27.2 | 4.2 |
| | National | | 39.3 | 5.6 |
| 2025/26 | | **112** | **33.3** | **5.7** |
| **Q3** | **UHSx** | **356** | **33.6** | **5.6** |

*Data source National Hip Fracture Database.

PRH activity not captured as part of National Falls and Fragility Fracture Audit Programme

| Diagnosis group description | Diagnosis group number | Provider spells | Observed deaths | Expected deaths | SHMI value | Banding description |
|---|---|---|---|---|---|---|
| Fracture of neck of femur (hip) | 120 | 1,575 | 120 | 120 | 0.9966 | As expected SHMI |

*Data Source SHMI deaths associated with hospitalisation (Dec-24 to Dec-25)

# Learning from Death Mortality Deaths by Age Group - 2025/26 Q4

Breakdown of adult deaths by age group

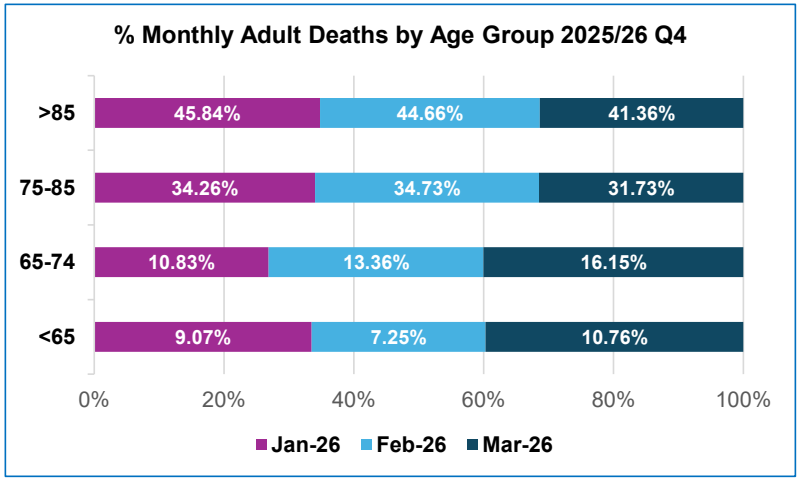
NHS Hospitals Sussex NHS Foundation Trust

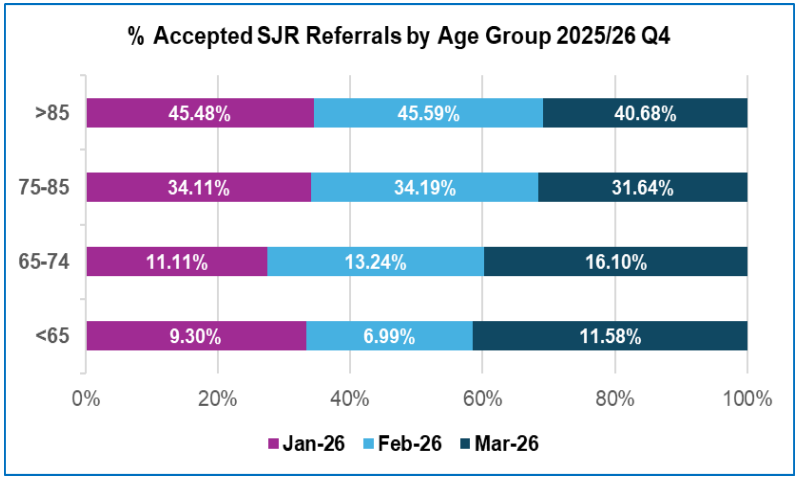
| % Adult Deaths by Age Group | | | |
|---|---|---|---|
| **Age** | **Jan-26** | **Feb-26** | **Mar-26** |
| <65 | 9.07% | 7.25% | 10.76% |
| 65-74 | 10.83% | 13.36% | 16.15% |
| 75-85 | 34.26% | 34.73% | 31.73% |
| >85 | 45.84% | 44.66% | 41.36% |

## Key Observations

- Minimal variance between the proportion of adult deaths and accepted SJR referrals, indicating proportionate, appropriate scrutiny.
- Highest proportion of **acute** adult deaths in **over 85 age group** - reflective of the older patient population served by **WGH** and **SRH**.
- Most adult deaths in **over 85 age group** occurred in the month of January 2026 **(45.84%)** - expected seasonal pattern during winter period.
- Consistently fewer deaths in **under 65 age group**, with majority of SJR referrals accepted.

| % Accepted SJR Referrals by Age Group | | | |
|---|---|---|---|
| **Age** | **Jan-26** | **Feb-26** | **Mar-26** |
| <65 | 9.30% | 6.99% | 11.58% |
| 65-74 | 11.11% | 13.24% | 16.10% |
| 75-85 | 34.11% | 34.19% | 31.64% |
| >85 | 45.48% | 45.59% | 40.68% |



# Learning from Death Mortality Deaths by Length of Stay (LoS) - 2025/26 Q4

Hospitals Sussex NHS Foundation Trust

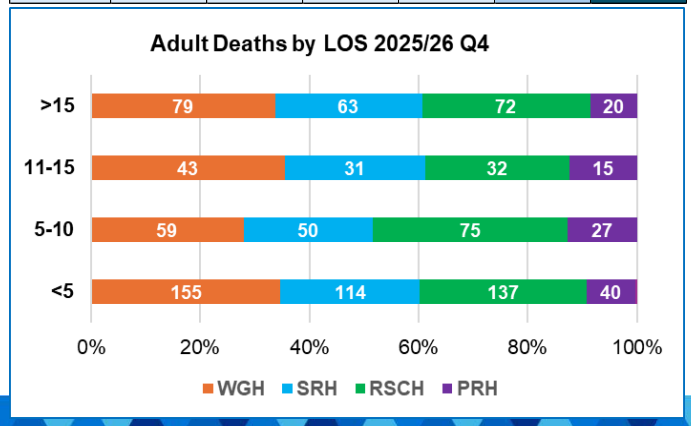
Breakdown of adult deaths by Length of Stay (LoS)

## Key Observations

- **44.1% (446)** **acute** adult deaths with **LoS less than 5 days**; increase from **42% (412)** in 2025/26 Q3.
- Slight decrease in number of adult deaths with **LoS greater than 15 days** from **24.8%** in 2025/26 Q3 to **23.1%** this quarter (Q4.)
- Highest proportion of **accepted** SJR referrals in 2025/26 Q4 related to patients with **LoS greater than 15 days (37.1.%, 14)**, **shift from LoS less than 5 days** in 2025/26 Q3 **(48.3%, 14).** However, variance between accepted referrals for LoS less than 5 days and greater than 15 days equates to a difference of only 1 additional accepted SJR, indicating broadly consistent scrutiny across LoS categories.

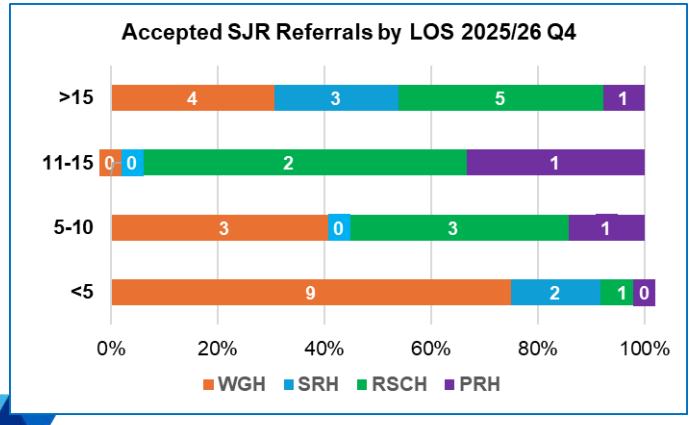
**Adult Deaths by LOS**

| No. of Days | WGH | SRH | RSCH | PRH | UHSx Q4 Total | % of total adult deaths |
|---|---|---|---|---|---|---|
| <5 | 155 | 114 | 137 | 40 | **446** | **44.1%** |
| 5-10 | 59 | 50 | 75 | 27 | **211** | **20.8%** |
| 11-15 | 43 | 31 | 32 | 15 | **121** | **12.0%** |
| >15 | 79 | 63 | 72 | 20 | **234** | **23.1%** |
| **Q4 Total** | **336** | **258** | **316** | **102** | **1012** | |




**Accepted SJR Referrals by LOS**

| No. of Days | WGH | SRH | RSCH | PRH | UHSx Q4 Total | % of accepted SJR referrals |
|---|---|---|---|---|---|---|
| <5 | 9 | 2 | 1 | 0 | **12** | **34.3%** |
| 5-10 | 3 | 0 | 3 | 1 | **7** | **20.0%** |
| 11-15 | 0 | 0 | 2 | 1 | **3** | **8.6%** |
| >15 | 4 | 3 | 5 | 1 | **13** | **37.1%** |
| **Q4 Total** | **16** | **5** | **11** | **3** | **35** | |



# Learning from Death Mortality Deaths by Ward - 2025/26 Q4

Breakdown of adult deaths by ward (by highest number of deaths and deaths per 1000 bed days.)

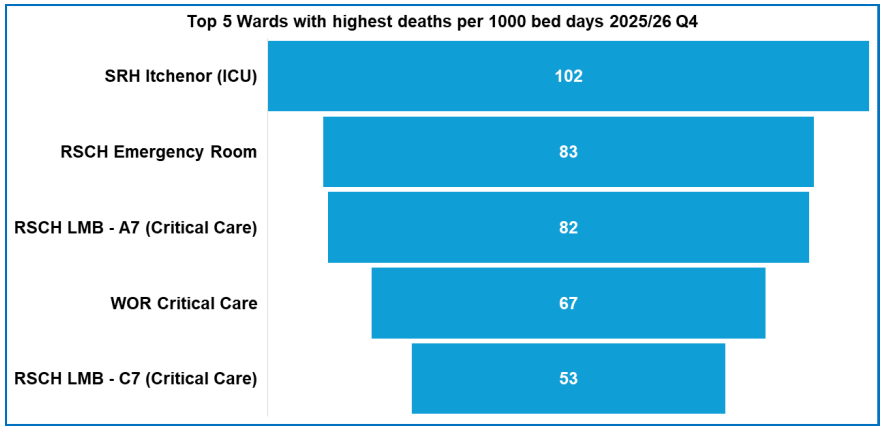
University Hospitals Sussex NHS Foundation Trust

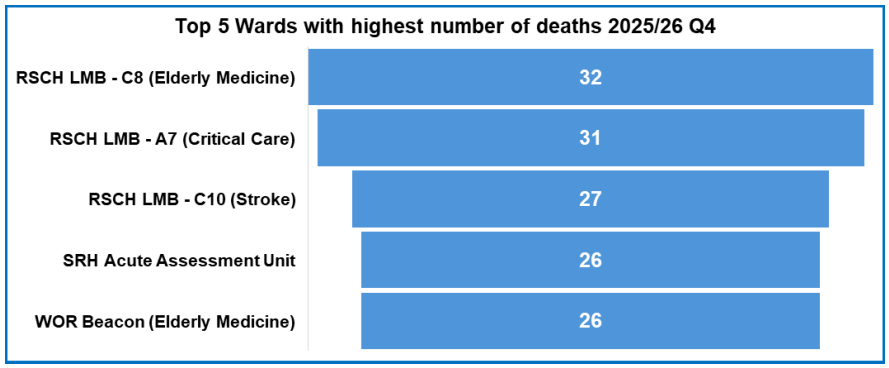
| Adult Deaths on Ward 2025/26 Q4 | | | | |
|---|---|---|---|---|
| **Adult Deaths on Ward** (order of incidence for no. of deaths) | No. of deaths | No. of deaths per 1000 bed days | % of site specific deaths | % of all adult deaths |
| RSCH LMB - C8 (Elderly Medicine) | 32 | 18.5 | 10.1% | **3.2%** |
| RSCH LMB - A7 (Critical Care) | 31 | 81.8 | 9.8% | **3.1%** |
| RSCH LMB - C10 (Stroke) | 27 | 17.1 | 8.5% | **2.7%** |
| SRH Acute Assessment Unit | 26 | 13.4 | 10.1% | **2.6%** |
| WOR Beacon (Elderly Medicine) | 26 | 8.8 | 7.7% | **2.6%** |
| SRH Petworth (Respiratory Medicine) | 25 | 15.1 | 9.7% | **2.5%** |
| SRH Itchenor (ICU) | 24 | 102.1 | 9.3% | **2.4%** |
| WOR EF Zone B | 24 | 44.0 | 7.1% | **2.4%** |
| WOR Botolphs (Stroke) | 24 | 19.4 | 7.1% | **2.4%** |
| SRH Ashling (General Medicine) | 24 | 11.6 | 9.3% | **2.4%** |
| PRH Balcombe (Acute Medicine) | 22 | 23.3 | 21.6% | **2.2%** |
| RSCH LMB - B8 (Elderly Medicine) | 22 | 13.3 | 7.0% | **2.2%** |
| WOR Critical Care | 21 | 66.9 | 6.3% | **2.1%** |
| WOR Byworth (Respiratory Medicine) | 21 | 14.4 | 6.3% | **2.1%** |
| WOR Durrington (Elderly Medicine) | 21 | 10.2 | 6.3% | **2.1%** |
| WOR Buckingham (Elderly Medicine) | 21 | 7.7 | 6.3% | **2.1%** |
| RSCH Acute Medical Unit | 20 | 18.7 | 6.3% | **2.0%** |
| SRH Bosham (Acute Medicine) | 20 | 10.7 | 7.8% | **2.0%** |
| SRH Lavant (Stroke) | 19 | 10.2 | 7.4% | **1.9%** |
| SRH Ford (Elderly Medicine) | 18 | 9.7 | 7.0% | **1.8%** |

Note: Bed days data taken from dashboard PB050 - LOS Programme dashboard

## Key Observations

- Majority of inpatient adult deaths across **ICU/Acute, General/Elderly Medicine, Respiratory and Stroke**, with top 20 ward areas having **between 18 and 32** deaths within 2025/26 Q4.
- **32** adult deaths on **RSCH LMB C8 (Elderly Medicine)**; **10.1%** at RSCH; **3.2%** across UHSx; with **18.5** deaths per 1000 bed days.
- **22** deaths on **PRH Balcombe**; **21.6%** at PRH; **2.2%** across UHSx, with **23.3** deaths per 1000 bed days. Expected finding, reflecting care of acutely unwell General Medicine patients.
- **SRH Itchenor (ICU)** had highest number of deaths per 1000 bed days at **102.1, 24** deaths.
- Highest deaths per 1000 bed days were seen in **ITU** and **Critical/Emergency Care.** Expected finding reflecting patient acuity and severity.

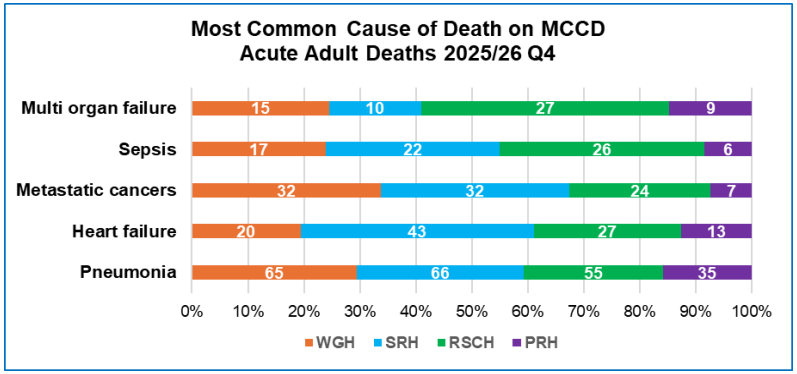


# Learning from Death Mortality Cause of Death - 2025/26 Q4

Most common causes of acute adult deaths listed on MCCD (1a, 1b, 1c, 1d and 2.) Breakdown by hospital site.

NHS Hospitals Sussex NHS Foundation Trust




**Note: A CoD may be missing from the ME referral if referred to the Coroner. Multiple CoD may be listed on the MCCD.**

| Common Cause of Death on MCCD Acute Adult Deaths 2025/26 Q4 | | | | | | |
|---|---|---|---|---|---|---|
| **Cause of Death (order of incidence)** | **WGH** | **SRH** | **RSCH** | **PRH** | **UHSx Q4 Total** | **% of all Adult Deaths** |
| Pneumonia | 65 | 66 | 55 | 35 | 221 | **21.8%** |
| Heart failure | 20 | 43 | 27 | 13 | 103 | **10.2%** |
| Sepsis | 32 | 32 | 24 | 7 | 95 | **9.4%** |
| Metastatic cancers | 17 | 22 | 26 | 6 | 71 | **7.0%** |
| Multi organ failure | 15 | 10 | 27 | 9 | 61 | **6.0%** |
| **Top 5 CoD Q4 UHSx Subtotal** | **149** | **173** | **159** | **70** | **551** | **54.4%** |
| Brain injury/subdural haemorrhage | 10 | 14 | 25 | 3 | 52 | **5.1%** |
| Frailty of old age | 12 | 12 | 16 | 5 | 45 | **4.4%** |
| Missing | 10 | 10 | 18 | 6 | 44 | **4.3%** |
| Stroke | 18 | 10 | 12 | 1 | 41 | **4.1%** |
| Respiratory failure | 11 | 2 | 9 | 0 | 22 | **2.2%** |
| Renal disease/failure | 3 | 5 | 10 | 3 | 21 | **2.1%** |
| Liver disease/failure | 4 | 6 | 3 | 0 | 13 | **1.3%** |
| Fractured neck of femur (#NOF) | 2 | 1 | 0 | 0 | 3 | **0.3%** |

## Key Observations

- **21.8% (221)** of all **acute** adult deaths had **pneumonia** listed on the death certificate - reduction from **24.2% (237)** in 2025/26 Q3.
- The top 5 common causes of deaths on MCCDs were **pneumonia, heart failure, metastatic cancers, multi organ failure** and **sepsis**. These remain the same top five causes as in 2025/26 Q3, although there was a change in ranking between sepsis and multi-organ failure. Collectively, these causes accounted for **54.4% (551)** of all acute adult deaths, representing a slight reduction from **55.9% (548)** in 2025/26 Q3.
- **4.3% (44)** cases had no given cause(s) of death on the ME referral form; % decrease from **4.9% (48)** in 2025/26 Q3. Attributed to cause of death not being agreed and/or referral to the Coroner.
- **Frailty of old age** was listed on MCCDs for **4.4% (45)** of all **acute** adult deaths; % increase from **3.1% (30)** in 2025/26 Q3.
- **3 (0.3%)** death certificates noted a recent **fractured neck of femur (#NOF)**; **0 (0%)** in 2025/26 Q3. Finding reflective of frailty within the older patient population served by **WGH** and **SRH**.

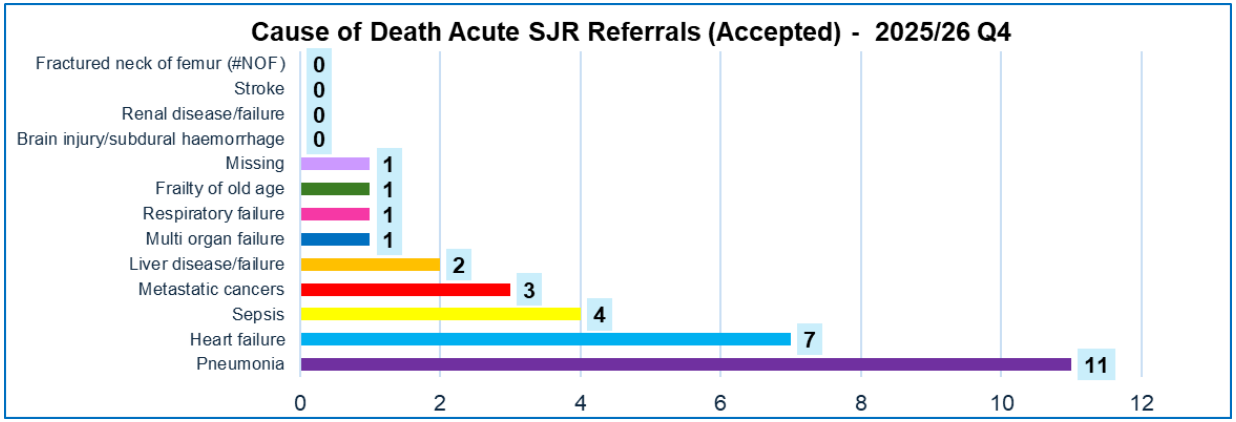
# Learning from Death Mortality Cause of Death - 2025/26 Q4

Most common causes of acute adult deaths listed on MCCD (1a, 1b, 1c, 1d and 2) in cases referred (**and accepted**) for SJR. Breakdown by hospital site.

NHS University Hospitals Sussex NHS Foundation Trust

| Most Common Cause of Death on MCCD Acute SJR Referrals (Accepted) 2025/26 Q4 | | | | | | |
|---|---|---|---|---|---|---|
| | WGH | SRH | RSCH | PRH | UHSx | % of accepted SJR referrals |
| Pneumonia | 3 | 3 | 3 | 2 | 11 | **31.4%** |
| Heart failure | 4 | 0 | 3 | 0 | 7 | **20.0%** |
| Sepsis | 3 | 0 | 1 | 0 | 4 | **11.4%** |
| Metastatic cancers | 1 | 1 | 0 | 1 | 3 | **8.6%** |
| Liver disease/failure | 2 | 0 | 0 | 0 | 2 | **5.7%** |
| **Q4 UHSx Total** | **13** | **4** | **7** | **3** | **27** | **77.1%** |

**Note: Table details accepted SJR referrals only.**




## Key Observations

- **31.4% (11)** of **acute** adult deaths with **accepted** SJR referrals had **pneumonia** listed on the death certificate. **13.8% (4)** in 2025/26 Q3.
- The top 5 common causes of deaths on MCCDs in cases referred for SJR were **pneumonia, heart failure, sepsis, metastatic cancers** and **liver disease/failure**. These accounted for **77.1% (27)** of **acute** adult deaths referred and **accepted** for SJR.
- **2.9% (1)** cases had no given cause(s) of death on the ME referral form; decrease from **6.9% (2)** in 2025/26 Q3. Attributed to cause of death not being agreed and/or referral to the Coroner.
- Relatively high % values due to low number of accepted SJR referrals (**35**.)
- Note: Fractured neck of femur (#NOF} no longer mandated reason for SJR (SHMI as expected.)

# Learning from Death Structured Judgement Review (SJR) Referrals - 2025/26 Q4

SJRs referrals received, accepted and completed during quarter.

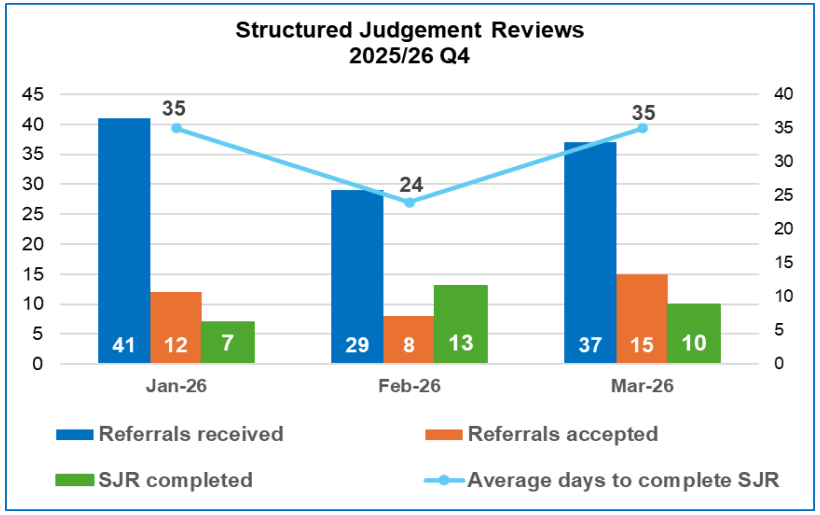
University Hospitals Sussex NHS Foundation Trust

| Adult Deaths Referred for SJR | WGH | SRH | RSCH | PRH | 25/26 Q4 | % of all Deaths referred for SJR | 24/25 Q4 |
|---|---|---|---|---|---|---|---|
| Jan-26 | 16 | 2 | 20 | 3 | 41 | 10.3% | 50 |
| Feb-26 | 10 | 5 | 11 | 3 | 29 | 11.1% | 50 |
| Mar-26 | 18 | 5 | 10 | 4 | 37 | 10.5% | 47 |
| **Q4 Total** | **44** | **12** | **41** | **10** | **107** | | **147** |
| % of all adult deaths referred for SJR | 13.1% | 4.7% | 13.0% | 9.8% | 10.6% | | 13.1% |

| SJR acceptance rate by site | WGH | SRH | RSCH | PRH |
|---|---|---|---|---|
| Jan-26 | 31.3% | 50.0% | 25.0% | 33.3% |
| Feb-26 | 20.0% | 20.0% | 36.4% | 33.3% |
| Mar-26 | 50.0% | 60.0% | 20.0% | 25.0% |

A Panel of senior SJR Reviewers and the LfD Clinical Lead review referrals to determine whether to progress to a comprehensive SJR. National Mortality Case Record Review (NMCRR) guidance is to review 10% of deaths and the Panel will look to increase SJR progression rate in 2026/27 Q1.

| Reason not progressed to comprehensive SJR | Jan-26 | Feb-26 | Mar-26 | UHSx |
|---|---|---|---|---|
| Referred to Coroner | 11 | 10 | 14 | **35** |
| Referred to local M&M | 8 | 5 | 6 | **19** |
| Other | 10 | 6 | 2 | **18** |
| **Q4 Total** | **29** | **21** | **22** | **72** |




## Key Observations

- **10.6% (107) acute** adult deaths referred for SJR; decrease from **13.1% (147)** in 2024/25 Q4. Of those**, 33% (35)** were **referred to the Coroner**; **18% (19)** to **M&M Review** and **17% (18)** categorised as **'Other**'. 'Other' is recorded where the Panel determines that an SJR is not indicated due to the absence of new learning, or where concerns relate to specific aspects of pre-admission care and are therefore directed to relevant teams rather than M&M Review.
- At site level, **WGH** accounted for the highest proportion of SJR referrals linked to adult deaths, representing **13.1%** of referrals (**44** cases). **RSCH 13%, 41.** This compares to **10% (38)** at **WGH** and **22.1% (76)** at **RSCH** in 2024/25 Q4. Reduction in **RSCH** SJR referral rate attributed to review of SJR 'alert' triggers.
- Lower number of SJR referrals in Feb-26 consistent with number of adult deaths recorded. Proportion referred for SJR each month stable, ranging **between 10.3% and 11.1%**.
- **30** SJRs completed; decrease from **64** in 2024/25 Q4, attributed to implementation of weekly SJR Screening Panel.
- SJR referral acceptance rate was **33%** for the quarter, consistent with **32%** in 2025/26 Q3, and higher than **24%** in 2024/25 Q4.
- Sustained improvement in average time taken to complete SJR - **31 days** in 2025/26 Q4, compared to **53 days** in 2024/25 Q4. However, average days to complete SJR in Mar-26 impacted by delay in obtaining relevant health records.

| Structured Judgement Reviews | Jan-26 | Feb-26 | Mar-26 | 25/26 Q4 | 24/25 Q4 |
|---|---|---|---|---|---|
| Referrals received | 41 | 29 | 37 | **107** | **147** |
| Referrals accepted | 12 | 8 | 15 | **35** | **36** |
| SJR completed | 7 | 13 | 10 | **30** | **64** |
| Average days to complete SJR | 35 | 24 | 35 | **31** | **53** |

**Note: 24/25 Q4 totals include previous backlog project.**

# Learning from Death Structured Judgement Review Referrals - 2025/26 Q4

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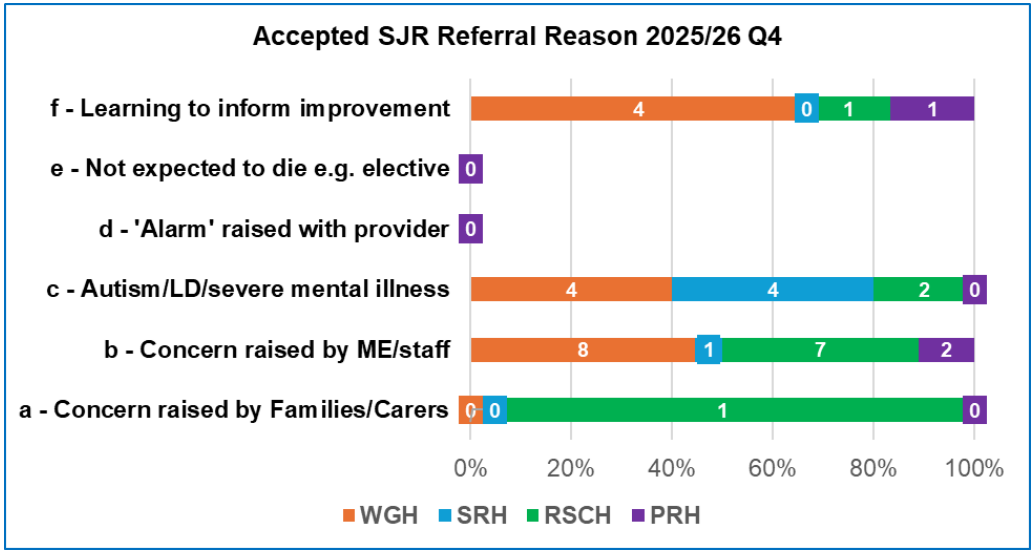
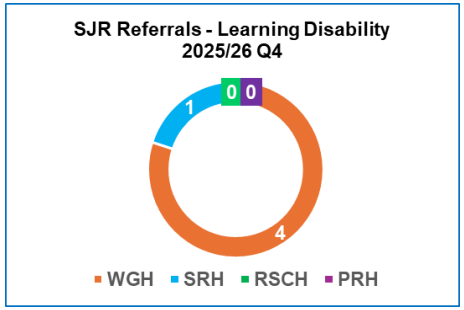
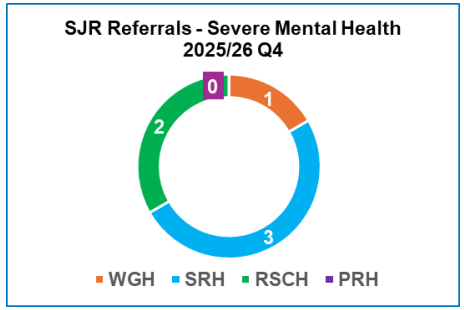
SJR referrals may be received from the ME office, DQSM, Medico-Legal and/or Patient Safety




| Accepted SJR Referral Reason | WGH | SRH | RSCH | PRH | 25/26 Q4 | % accepted SJR referrals | 24/25 Q4 |
|---|---|---|---|---|---|---|---|
| a - Concern raised by Families/Carers | 0 | 0 | 1 | 0 | 1 | 2.9% | 9 |
| b - Concern raised by ME/staff | 8 | 1 | 7 | 2 | 18 | 51.4% | 8 |
| c - Autism/LD/severe mental illness | 4 | 4 | 2 | 0 | 10 | 28.6% | 11 |
| d - 'Alarm' raised with provider | 0 | 0 | 0 | 0 | 0 | 0.0% | 4 |
| e - Not expected to die e.g. elective | 0 | 0 | 0 | 0 | 0 | 0.0% | 1 |
| f - Learning to inform improvement | 4 | 0 | 1 | 1 | 6 | 17.1% | 3 |
| **Q4 UHSx Total** | **16** | **5** | **11** | **3** | **35** | | **36** |

**Note: Table includes accepted referrals only. 1 x WGH case in Mar-26 with known LD and SMH.**

## Key Observations

- **Concern raised by ME/staff** was the highest reason for **accepted** SJR referrals related to **acute** adult deaths at **51.4% (18)**, significant increase from **22% (8)** in 2024/25 Q4. Reflective of appropriate ME referral practice.
- **28.6% (11) accepted** SJR referrals related to **Autism/LD/severe mental illness** compared to **31% (11)** in 2024/25 Q4.
- **2.9% (9) accepted** SJRs referred due to **Concern raised by Families/Carers**; decrease from **25% (9)** 2024/25 Q4. Attributed to referrals being appropriately redirected to M&M processes or the treating team to resolve next-of-kin concerns locally.
- **Nil** SJR referrals related to **'Alarm' raised with provider** during the quarter. This has been a consistent finding across all quarters of 2025/26.
- **4.7% (5) known Learning Disability** referrals; decrease from **6.8% (10)** 2024/25 Q3. **5.6% (6) known Severe Mental Health** referrals; decrease from **9.5% (14)** in 2024/25 Q4. All cases meeting mandated SJR criteria continue to be appropriately referred, with alternative statutory review pathways used where applicable.

# Learning from Death SJR Mortality Panel Outcome Scores - 2025/26 Q4

Mortality Panel scores following completion of SJRs by SJR Reviewers.

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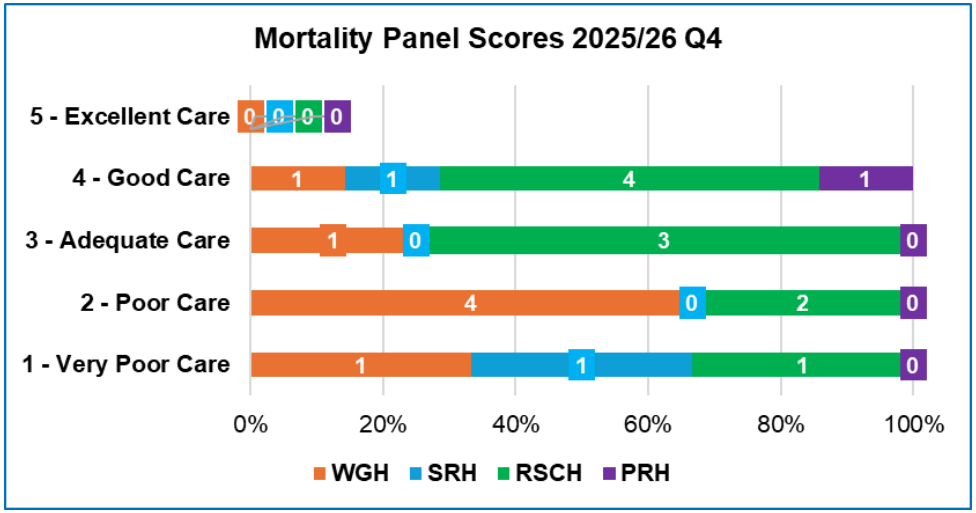


| SJRs Reviewed at Mortality Panel (Scores) 2025/26 Q4 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | WGH | SRH | RSCH | PRH | 25/26 Q4 | % SJR Reviewed | 24/25 Q4 |
| 1 - Very Poor Care | 1 | 1 | 1 | 0 | 3 | 15.0% | 4 |
| 2 - Poor Care | 4 | 0 | 2 | 0 | 6 | 30.0% | 13 |
| 3 - Adequate Care | 1 | 0 | 3 | 0 | 4 | 20.0% | 11 |
| 4 - Good Care | 1 | 1 | 4 | 1 | 7 | 35.0% | 1 |
| 5 - Excellent Care | 0 | 0 | 0 | 0 | 0 | 0.0% | 0 |
| **Q4 UHSx Total** | | | | | **20** | | **29** |

## Key Observations

- A combination of long-term sickness and annual leave within LfD team led to fewer Mortality Panels within the quarter.
- **20** SJRs reviewed at Mortality Panel; decrease from **29** in 2024/25 Q4.
- **45% (9)** of SJRs reviewed at Mortality Panel scored **1 (Very Poor Care)** or **2 (Poor Care)**; decrease from **58.9% (17)** in 2024/25 Q4.
- **30% (6)** of SJRs reviewed at Mortality Panel scored **2 (Poor Care)**; decrease from **44.8% (13)** in 2024/25 Q4.
- **65% (13)** of all SJRs reviewed at Mortality Panel **scored between 1 and 3**; significant decrease from **96.6% (28)** in 2024/25 Q4. Attributed to random selection of cases scoring **4** (**Good Care)** being discussed at Mortality Panel.
- **20% (4)** scored **3 (Adequate Care)**; decrease from **37.9% (11)** in 2024/25 Q4. Attributed to new processes and lower number of cases discussed at Mortality Panel.
- **35% (7)** scored **4 (Good Care)**; **3.4% (1)** in 2024/25 Q4 but at time when only cases scoring 1, 2 or 3 by SJR Reviewer were listed for Mortality Panel discussion.
- **Nil** cases scored **5 (Excellent Care)**; **equal to** 2024/25 Q4.

**A Panel of SJR Reviewers and the Mortality & Learning from Deaths Lead review completed SJRs with a score of 1 (Very Poor Care), 2 (Poor Care) or 3 (Adequate Care.) 2025/26 Q4 included random selection of cases scoring 4 (Good Care).**

# Learning from Death SJR Mortality Panel M&M Referrals - 2025/26 Q4

Cases where Mortality Panel identifies requirement for M&M Review.

University Hospitals Sussex NHS Foundation Trust

| Requirement for M&M Review identified at Mortality Panel | | | | | | |
|---|---|---|---|---|---|---|
| | WGH | SRH | RSCH | PRH | 25/26 Q4 | % Reviewed |
| Jan-26 | 1 | 0 | 2 | 0 | 3 | **75.0%** |
| Feb-26 | 2 | 0 | 0 | 0 | 2 | **25.0%** |
| Mar-26 | 2 | 0 | 3 | 0 | 5 | **62.5%** |
| **Q4 Total** | **5** | **0** | **5** | **0** | **10** | |
| **%Reviewed** | | | | | **50.0%** | |

## Key Observations

- **50% (10)** cases discussed at Mortality Panel referred for M&M Review.
- Significant monthly variation in the proportion of cases discussed at Mortality Panel and referred for M&M Review, ranging **from 25% to 75%**. Attributed to variance in number of Mortality Panels held within each month.
- Note: Benchmarking data is not available for 2024/25 as this was not previously recorded; however, this will be included in future quarterly reports.

**Mortality Panel, SJR and Panel discussion outputs routinely shared with the relevant DQSM to disseminate learning.**

# Learning from Death SJR Mortality Panel Identification of Potentially Avoidable Deaths - 2025/26 Q4

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Cases where the Mortality Panel identifies that the death may have been avoidable, for which a Datix will be raised.

**1** **Adult death identified as 'may have been avoidable' by Mortality Panel in 2025/26 Q4**

| Potentially Avoidable Deaths Identified by Mortality Panel | | | | | | | |
|---|---|---|---|---|---|---|---|
| | WGH | SRH | RSCH | PRH | 25/26 Q4 | % Reviewed | 24/25 Q4 |
| Jan-26 | 0 | 0 | 0 | 0 | 0 | 0.0% | 0 |
| Feb-26 | 1 | 0 | 0 | 0 | 1 | 12.5% | 0 |
| Mar-26 | 0 | 0 | 0 | 0 | 0 | 0.0% | 0 |
| **Q4 Total** | **1** | **0** | **0** | **0** | **1** | | **0** |
| **%Reviewed** | | | | | **5.0%** | | **0.0%** |

| Case No. | Site | DoD | Mortality Panel Date | Update |
|---|---|---|---|---|
| 1 | WGH | 17/12/2025 | 03/02/2026 | Datix is under review with the Division. |

## Key Observations

- **1** case identified by the Mortality Panel as '**may have been avoidable**'; increase from **Nil** in 2024/25 Q4. Datix raised by the LfD team and currently under review by Division.
- The sustained low or absence of cases across 2025/26 is attributed to the change in practice whereby SJRs are no longer routinely undertaken for cases referred to the Coroner.
- The Mortality Panel no longer routinely grades harm; decisions on harm grading will now be made at Divisional level or through the PSIRG process.
- Problems in care continue to most commonly occur during the **ongoing** and **end-of-life** phases of care, which remains a longstanding and consistent finding.

# Learning from Death SJR Mortality Panel Learning Themes - 2025/26 Q4

Recurrent and emergent learning themes identified during the reporting period.

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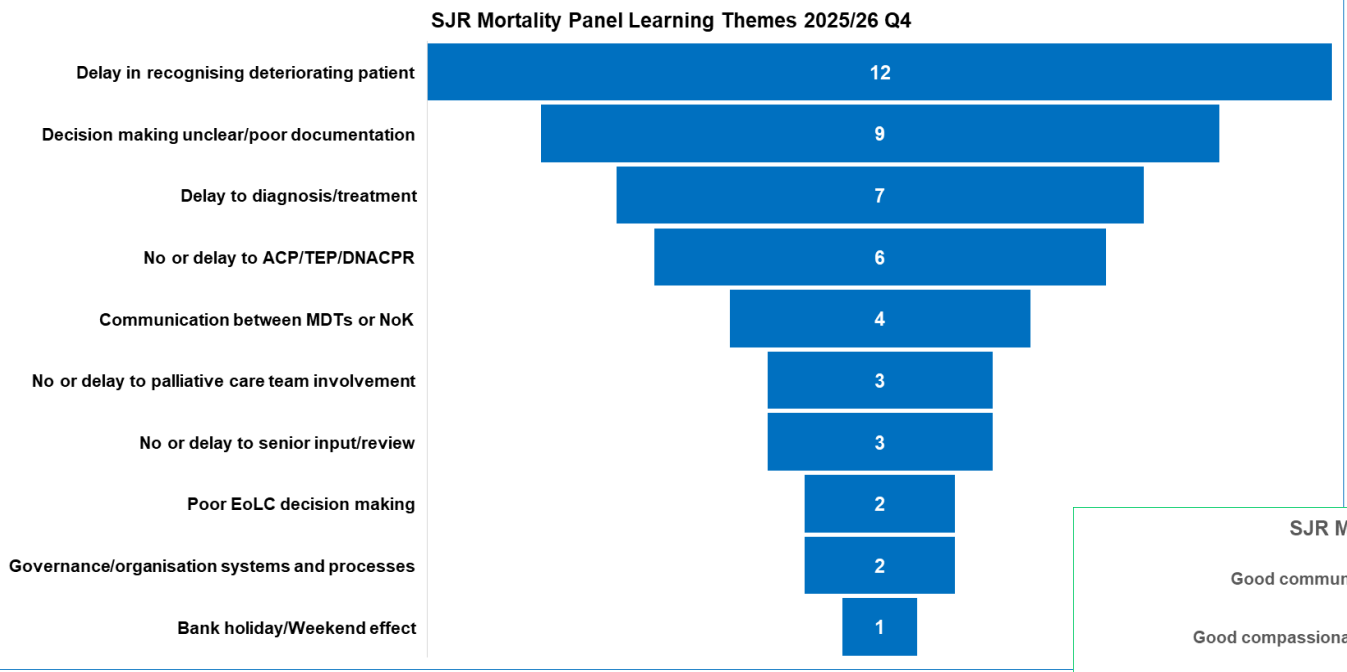


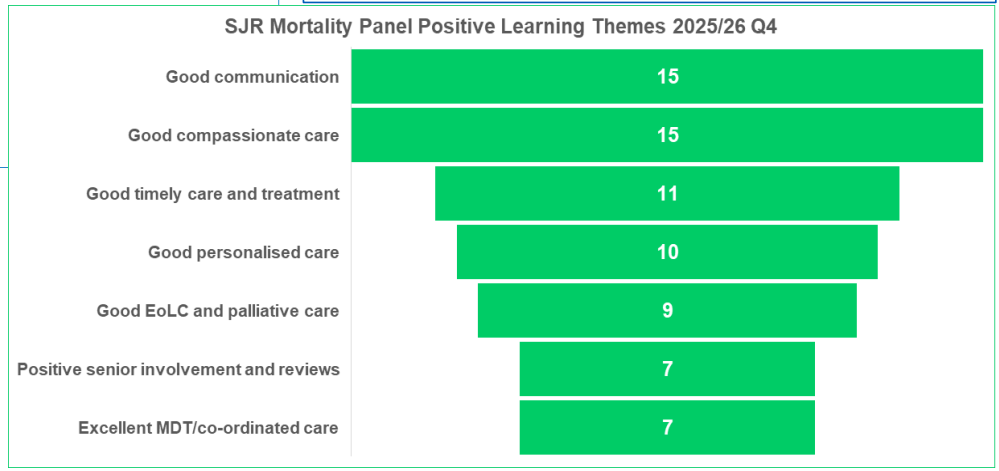

**Note: More than one theme may be identified on case discussion**

## Key Observations - learning

- **Delay recognising deteriorating patient (12, 24.5%)** was the top learning theme in 2025/26 Q4. This remains a high incidence theme.
- **Unclear decision making (9, 18.4%)** was the next highest learning theme in 2025/26 Q4.
- The top three learning themes accounted for **57.1%** of learning themes identified at Mortality Panel.
- **No or delay to ACP/TEP/DNACPR** equated to **12.2% (6)** of learning themes identified at Mortality Panel.

## Key Observations - positive learning

- **Good communication** and **compassionate care (15)** were the joint highest positive learning themes identified in Q4 2025/26, together accounting for **40.5%** of themes discussed at Mortality Panel and showing consistently high incidence across quarters.
- **Timely, personalised care** were the next highest categories.
- **Excellent MDT/co-ordinated care** was also recognised.



# Learning from Death LeDeR Focused Review Learning Themes - 2025/26 Q4

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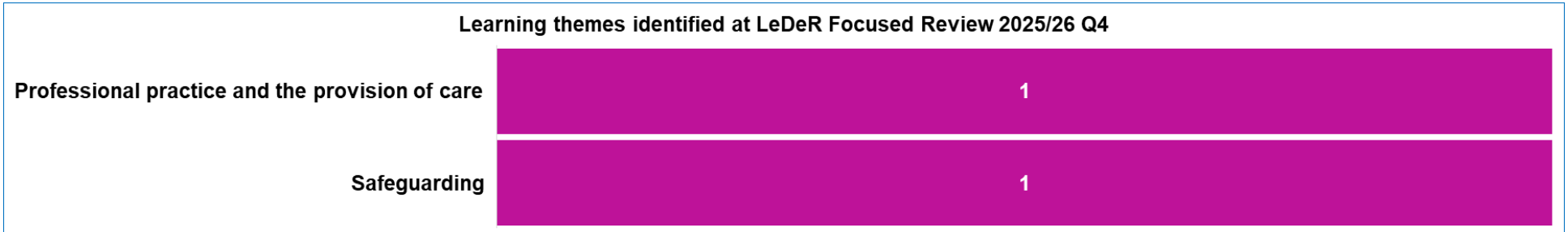
Learning from lives and deaths - People with a learning disability and autistic people (LeDeR.)
Learning themes identified at LeDeR Focused Review where UHSx was the main stakeholder during the reporting period.




## Key Observations

- The frequency of LeDeR Focused Reviews decreased in 2025/26 Q4, with continued uncertainty regarding future service provision.
- **1 (50%)** UHSx cases discussed at LeDeR Focused Review identified learning related to **Professional practice and provision of care** which is a recurrent theme. This represents a decrease from **2 (50%)** in 2025/26 Q3; **7 (58.3%)** in 2025/26 Q2; **2 (40%)** in 2025/26 Q1.
- **1 (50%)** UHSx cases discussed at LeDeR Focused Review identified learning related to **Safeguarding**; comparable to **none** in 2025/26 Q3; **2 (17%)** in 2025/26 Q2; **none** in 2025/26 Q1.
- **Key take aways - Discharge planning should incorporate consideration of the support required to transition from hospital care to the patient's local community, with a review of current policies required to ensure alignment with latest NICE guidance.**
- **Actions** - Review of multi-disciplinary team learning disability surgical pathway to inform service improvement.
  Develop service improvement plan regarding time frame and quality of S42 expectations.

**A Panel of system stakeholders led by LeDeR meet to discuss adult deaths reviewed by LeDeR Reviewers, to identify care issues, propose actions and disseminate learning to relevant teams/organisations. The Mortality & Learning from Deaths Lead and Safeguarding Lead attend on behalf of UHSx. Copies of UHSx SJRs and assurance regarding learning/actions taken routinely shared with LeDeR. Note: More than one theme may be identified on case discussion.**

# Medical Examiner Office Update - 2025/26 Q4

University Hospitals Sussex NHS Foundation Trust

ME Service overview during reporting period, including general update, observations and concerns, challenges and celebrations.

## Updates:

- **2026/27** Medical Examiner Office income (part of Sussex ICB contract) under review - proposed reduction in funding for Brighton & Mid-Sussex ME Office based on number of deaths.
- Review of Brighton & Mid-Sussex community deaths catchment area to include all GP practices in Haywards Heath, which are currently split with SASH ME Office.
- Consideration of single ME Office serving West Sussex, Brighton & Mid-Sussex.
- **2026/27** Planned reduction in community palliative care provision likely to lead to higher number of adult deaths in acute setting.

## Escalations:

- Protracted delay with PAS integration impacting move to Datix IQ - flagged with UHSx IT Network team, work on required server due to start in Apr-26. This has hampering ability to deliver Mortality & LfD Dashboard for Divisions to access real-time data.

## Challenges:

- Significant staffing pressures across teams, arising from long-term sickness absence and maternity leave and compounded by planned annual leave, have resulted in challenging workflows and delays in the completion of MCCDs.
- Lack of access to Plexus (GP records) - ongoing issue.
- Limited space in the ME Office at SRH, but new desk reconfiguration now in place to maximise available space and improve ergonomics.
- Currently no viable option for co-location of ME and Bereavement teams at SRH due to large desk requirement - Property Management Team advise expected to take >12 months.

## Celebrations:

- Sustained positive feedback from bereaved families regarding ME Service provision.

## Data limitations:

- Available benchmarking data across ME Offices in England and Wales remains limited. This has been flagged with the Regional Medical Examiner team by Lead Medical Examiners and Lead Medical Examiner Officers.

# Medical Examiner Office Update - ME Office Overview - 2025/26 Q4

Information provided by Lead MEOs, on behalf of independent ME Service.

University Hospitals Sussex NHS Foundation Trust

| | 2025/26 Funded ME FTE for Expected Deaths | 2025/26 Funded MEO FTE for Expected Deaths |
|---|---|---|
| West Sussex | 2.3 | 6.8 |
| Brighton & Mid Sussex | 1.7 | 5.0 |

| Medical Examiner Scrutiny - Adult deaths | | Adult Deaths (No.) | Average time taken to complete MCCD (Days from referral | Average time taken to complete MCCD (Days from death to | Positive NoK feedback on MEO contact | Concerns raised by NoK regarding MEO contact |
|---|---|---|---|---|---|---|
| West Sussex | Acute inpatient deaths | 594 | 1.8 | 4.4 | 41 | 0 |
| | Community deaths | 968 | 1.5 | 4.3 | 57 | 1 |
| | | **1562** | **1.6** | **4.3** | **98** | **1** |
| Brighton & Mid Sussex | Acute inpatient deaths | 418 | 2.9 | 4.3 | 12 | 1 |
| | Community deaths | 371 | 3.1 | 6.5 | 8 | 0 |
| | | **789** | **3.0** | **5.4** | **20** | **1** |
| **Q4 Total** | | **2351** | **2.3** | **4.9** | **118** | **2** |

**Medical Examiner Office Benchmarking**

**Available benchmarking data across England and Wales remains limited. The 2024 National Medical Examiner Report indicates that between October and December 2024, the median time from death to completion of the MCCD was 5 days or fewer for nearly three-quarters of Medical Examiner Offices in England (73%), 3 days or fewer for over a third (36%), and 8 days in Wales.**

## Key Observations

- **2351** adult (**acute** and **community**) deaths were reviewed in 2025/26 Q4, with activity higher in **West Sussex (1562**) than **Brighton & Mid Sussex (789).**
- Overall timeliness of MCCD completion remains strong, averaging **2.3 days** from referral and **4.9 days** from death.
- **West Sussex** demonstrates consistently quicker MCCD completion, averaging **1.6 days** from referral and **4.3 days** from death across adult **acute** and **community** deaths.
- **Brighton & Mid Sussex** shows longer timescales, particularly for adult **community** deaths (**6.5 days** from death), influencing the higher overall average for the area.
- Next of kin experience is overwhelmingly positive, with **118** positive feedback responses relating to **Medical Examiner Officer (MEO) contact.**
- Very few concerns were raised - only **2** across the entire system, indicating high-quality communication and engagement.
- No correlation is evident between longer MCCD timescales and family dissatisfaction, providing assurance that compassionate engagement is maintained.
- Overall, strong assurance on the effectiveness, quality, and compassion of the **Medical Examiner Service**, with targeted opportunities to improve timeliness in **community** settings.

# Medical Examiner Office Update - Acute Inpatient Data - 2025/26 Q4

Information provided by Lead MEOs, on behalf of independent ME Service.

University Hospitals Sussex NHS Foundation Trust

| Adult Deaths (Acute) | | Scrutinised (No.) | Scrutinised (%) | Average time taken to complete MCCD (Days from referral to sending) | Average time taken to complete MCCD (Days from death to sending) | Referred to Coroner (No.) | Referred to Coroner (% of total adult deaths) | Investigated by Coroner (No.) | Investigated by Coroner (% of total adult deaths) | Investigated by Coroner (% of referred to Coroner) |
|---|---|---|---|---|---|---|---|---|---|---|
| **Jan-26** | **WGH** | 132 | 100.00% | 2.1 | 4.8 | 13 | 9.85% | 7 | 5.30% | 53.85% |
| | **SRH** | 112 | 100.00% | 1.6 | 4.6 | 18 | 16.07% | 10 | 8.93% | 55.56% |
| | **RSCH** | 113 | 99.12% | 2.2 | 4.1 | 20 | 17.54% | 17 | 14.91% | 85.00% |
| | **PRH** | 39 | 100.00% | 2.0 | 4.0 | 2 | 5.13% | 2 | 5.13% | 100.00% |
| | | **396** | **99.78%** | **2.0** | **4.4** | **53** | **13.35%** | **36** | **9.07%** | **67.92%** |
| **Feb-26** | **WGH** | 90 | 100.00% | 1.8 | 3.9 | 11 | 12.22% | 8 | 8.89% | 72.73% |
| | **SRH** | 59 | 100.00% | 1.6 | 4.0 | 11 | 18.64% | 7 | 11.86% | 63.64% |
| | **RSCH** | 86 | 100.00% | 3.0 | 5.0 | 23 | 26.74% | 10 | 11.63% | 43.48% |
| | **PRH** | 27 | 100.00% | 1.9 | 3.8 | 4 | 14.81% | 4 | 14.81% | 100.00% |
| | | **262** | **100.00%** | **2.1** | **4.2** | **49** | **18.70%** | **29** | **11.07%** | **59.18%** |
| **Mar-26** | **WGH** | 114 | 100.00% | 2.2 | 4.3 | 16 | 14.04% | 10 | 8.77% | 62.50% |
| | **SRH** | 87 | 100.00% | 1.4 | 4.5 | 9 | 10.34% | 4 | 4.60% | 44.44% |
| | **RSCH** | 113 | 97.41% | 6.1 | 4.6 | 29 | 25.00% | 14 | 12.07% | 48.28% |
| | **PRH** | 36 | 100.00% | 2.1 | 4.5 | 3 | 8.33% | 3 | 8.33% | 100.00% |
| | | **350** | **99.35%** | **2.9** | **4.5** | **57** | **16.15%** | **31** | **8.78%** | **54.39%** |
| **Q4 Total UHSx** | | **1008** | **99.71%** | **2.3** | **4.3** | **159** | **15.77%** | **96** | **9.49%** | **60.38%** |

## Key Observations

- Significant staffing pressures across teams, arising from long-term sickness absence and maternity leave and compounded by planned annual leave.
- **99.35%** **acute** adult deaths scrutinised; **99.6%** in 2024/25 Q4. **Note**: There were **4** cases with police/coroner involvement sent without scrutiny to avoid delay.
- Average time taken from referral to issuing MCCD **2.3 days**; decrease from **2.9 days** in 2024/25 Q4.
- Average time taken from death to issuing MCCD **4.3** days; decrease from **5.2 days** in 2024/25 Q4.
- **15.77% (159)** **acute** adult deaths referred to Coroner; decrease from **19% (212)** in 2024/25 Q4.
- Of those referred, **60.38% (96)** investigated; **61.3% (130)** in 2024/25 Q4.
- **9.49%** of **acute** adult deaths investigated by Coroner; decrease from **11.6%** in 2024/25 Q4.

# Medical Examiner Office Update - Community Deaths Data - 2025/26 Q4

Information provided by Lead MEOs, on behalf of independent ME Service.

University Hospitals Sussex NHS Foundation Trust

| Adult Deaths (Community) | | Scrutinised (No.) | Scrutinised (%) | Average time taken to complete MCCD (Days from referral to sending) | Average time taken to complete MCCD (Days from death to sending) | Referred to Coroner (No.) | Referred to Coroner (% of total adult deaths) | Investigated by Coroner (No.) | Investigated by Coroner (% of total adult deaths) | Investigated by Coroner (% of referred to Coroner) |
|---|---|---|---|---|---|---|---|---|---|---|
| Jan-26 | West Sussex | 381 | 100.00% | 1.3 | 4.2 | 30 | 7.87% | 8 | 2.10% | 26.67% |
| | Brighton & Mid Sussex | 143 | 100.00% | 2.8 | 6.2 | 9 | 6.29% | 0 | 0.00% | 0.00% |
| | | **524** | **100.00%** | **2.0** | **5.2** | **39** | **7.44%** | **8** | **1.53%** | **20.51%** |
| Feb-26 | West Sussex | 284 | 100.00% | 1.5 | 4.4 | 9 | 3.17% | 7 | 2.46% | 77.78% |
| | Brighton & Mid Sussex | 101 | 100.00% | 2.8 | 6.2 | 13 | 12.87% | 4 | 3.96% | 30.77% |
| | | **385** | **100.00%** | **2.1** | **5.3** | **22** | **5.71%** | **11** | **2.86%** | **50.00%** |
| Mar-26 | West Sussex | 303 | 100.00% | 1.6 | 4.3 | 21 | 6.93% | 6 | 1.98% | 28.57% |
| | Brighton & Mid Sussex | 127 | 100.00% | 3.7 | 7.1 | 10 | 7.87% | 2 | 1.57% | 20.00% |
| | | **430** | **100.00%** | **2.7** | **5.7** | **31** | **2.32%** | **8** | **1.86%** | **25.81%** |
| **Q4 Total** | | **1339** | **100.00%** | **2.3** | **5.4** | **92** | **6.87%** | **27** | **2.02%** | **29.35%** |

## Key Observations

- **1339 community** adult deaths; **968** occurred in West Sussex and **371** in Brighton & Mid Sussex; increase from **1047** in 2024/25 Q4.
- **100% community** adult deaths scrutinised, **same** as in 2024/25 Q4.
- Average time taken from referral to issuing MCCD **2.3 days**. (West Sussex **1.5 days**; Brighton & Mid Sussex **3.1 days**.) **3.3 days** in 2024/25 Q4.
- Average time taken from death to issuing MCCD **5.4** days; **6.3 days** in 2025/26 Q4.
- **6.87% (92) community** adult deaths referred to Coroner; significant reduction from **12.1% (127)** in 2024/25 Q4.
- Of those referred, **29.3% (27)** investigated; significant increase from **17.3% (22)** in 2024/25 Q4.
- **2.02%** of adult deaths investigated by Coroner; similar to **2.1%** in 2024/25 Q4.

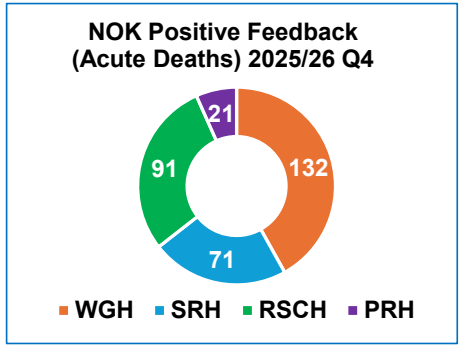
# Medical Examiner Office Update - Acute NOK Feedback - 2025/26 Q4

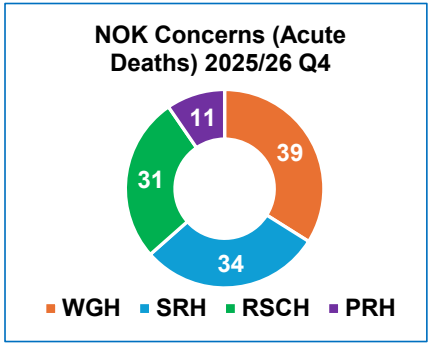
Key concerns raised by families/Next of Kin (NOK) calls are referred for SJR and learning is identified through the SJR outputs.

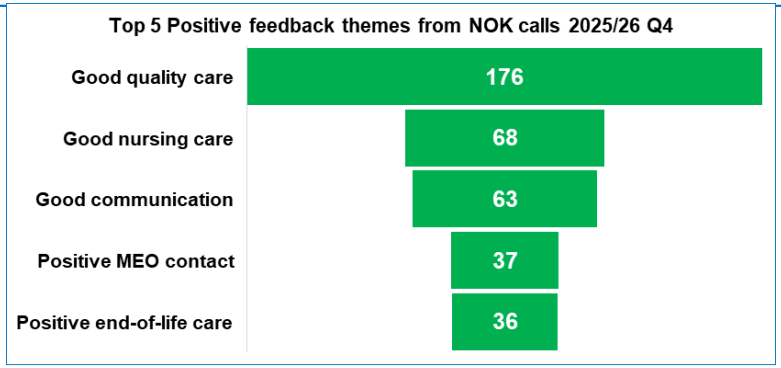
University Hospitals Sussex NHS Foundation Trust

## Key Observations

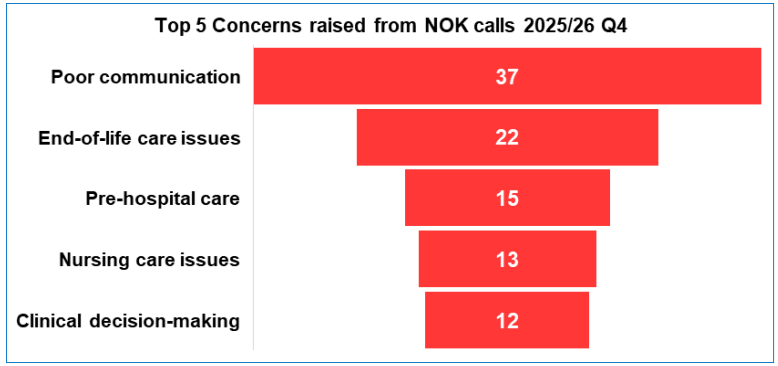
- **73.3% (315)** positive feedback responses; consistent with 2025/26 Q4 and representing an increase from **69% (257)** in 2024/25 Q4.
- **26.7% (115)** negative feedback responses, unchanged compared to 2025/26 Q4 and decrease from **31% (114)** in 2024/25 Q4.
- The highest volume of positive feedback continues to relate to **Good quality care**, with consistently strong feedback regarding interactions **with Medical Examiner Officers (MEOs)**. This indicates sustained confidence in both the standard of care delivered and the manner in which families are engaged by the ME Service.
- **Poor communication** remains highest proportion of negative feedback themes. **Pre-hospital care** and **Clinical decision-making** were identified as growing areas of concern and will require ongoing monitoring.




**Note: NOK may indicate more than one theme when giving feedback**




| Positive Feedback Received from NOK Calls (Acute Deaths) | | | | | |
|---|---|---|---|---|---|
| | WGH | SRH | RSCH | PRH | UHSx |
| Jan-26 | 41 | 31 | 31 | 9 | **112** |
| Feb-26 | 54 | 23 | 37 | 8 | **122** |
| Mar-26 | 37 | 17 | 23 | 4 | **81** |
| **Q4 Total** | **132** | **71** | **91** | **21** | **315** |

| Negative Feedback Received/Concerns Raised from NOK Calls (Acute Deaths) | | | | | |
|---|---|---|---|---|---|
| | WGH | SRH | RSCH | PRH | UHSx |
| Jan-26 | 14 | 7 | 12 | 3 | **36** |
| Feb-26 | 13 | 10 | 8 | 3 | **34** |
| Mar-26 | 12 | 17 | 11 | 5 | **45** |
| **Q4 Total** | **39** | **34** | **31** | **11** | **115** |

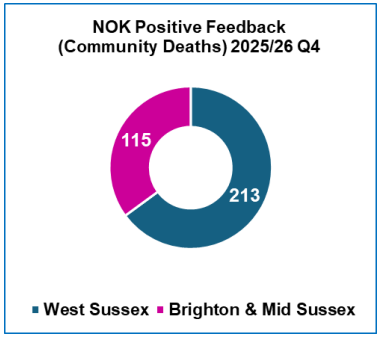
# Medical Examiner Office Update - Community NOK Feedback - 2025/26 Q4

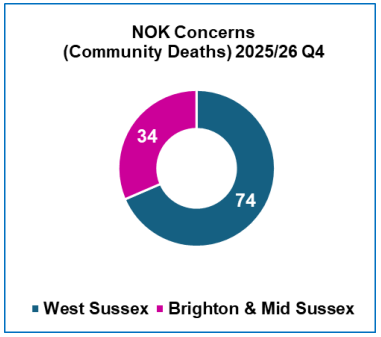
NHS University Hospitals Sussex NHS Foundation Trust

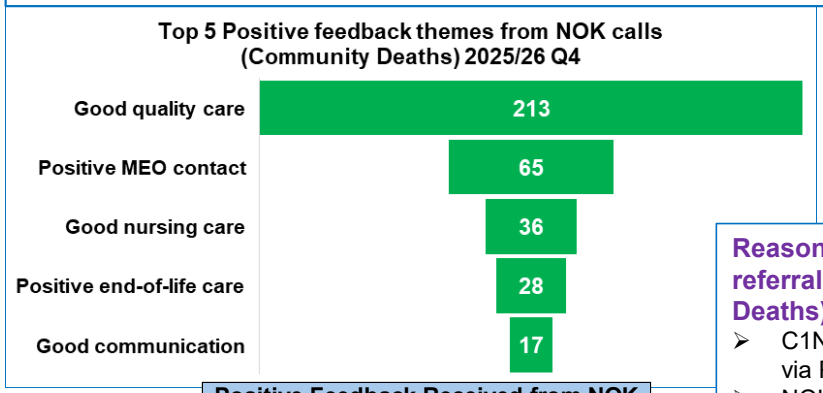
Key concerns raised by families/Next of Kin calls where deaths have occurred in the community.

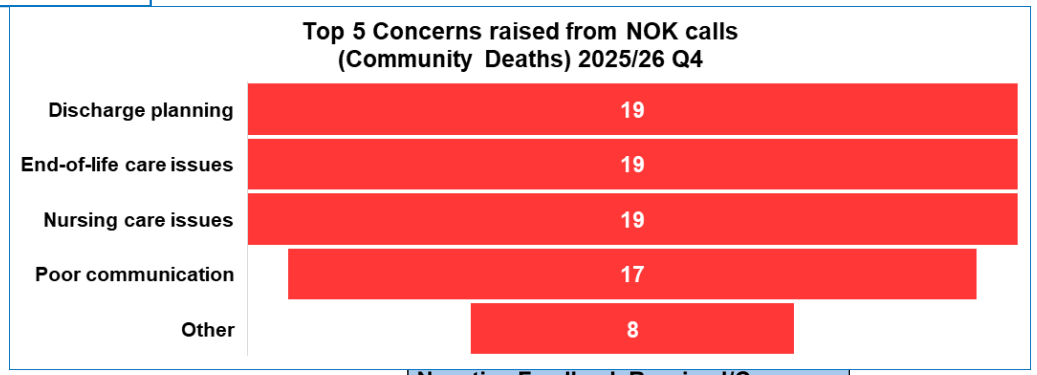
## Key Observations

- **75.2% (328)** positive feedback responses; **74.7% (215)** in 2024/25 Q4.
- **24.8% (108)** negative feedback responses; **25.3% (73)** in 2024/25 Q4
- Consistent balance between positive and negative feedback, with no significant change in sentiment compared with the previous quarter.
- Consistently high volume of positive feedback for **Good quality care,** with a notable increase in feedback relating to interactions with **Medical Examiner Officers (MEOs)**, rising from **46** responses in 2024/25 Q3.
- Highest number of concerns related to **Discharge planning, End-of-life care** and **Nursing care. Discharge planning** was identified as growing area of concern and will require ongoing monitoring.




**Positive Feedback Received from NOK Calls (Community Deaths)**

| | West Sussex | Brighton & Mid Sussex | Total |
|---|---|---|---|
| Jan-26 | 80 | 42 | **122** |
| Feb-26 | 78 | 44 | **122** |
| Mar-26 | 55 | 29 | **84** |
| **Q4 Total** | **213** | **115** | **328** |

**Reasons for Coroner referral (Community Deaths):**

- C1NA (often referred via Police)/C1NB
- NOK concern regarding cause of death
- Missed diagnosis
- Previous trauma
- Previous procedure
- Unknown cause

**Note: NOK may indicate more than one theme when giving feedback**

**Negative Feedback Received/Concerns Raised from NOK Calls (Community Deaths)**

| | West Sussex | Brighton & Mid Sussex | UHSx |
|---|---|---|---|
| Jan-26 | 29 | 11 | **40** |
| Feb-26 | 12 | 13 | **25** |
| Mar-26 | 33 | 10 | **43** |
| **Q4 Total** | **74** | **34** | **108** |

# Mortality & Learning from Deaths 2025/26 Q4 Report Highlights

NHS
University Hospitals Sussex
NHS Foundation Trust

- **106** fewer **acute** adult deaths in 2025/26 Q4 **(1012)** compared to 2024/25 Q4 **(1118.)** **24.2% (245) acute** adult deaths and **29.9% (32)** SJR referrals within most deprived postcodes (D1-4.) Corresponding increase in **community** deaths.
- Average time taken from referral to issuing MCCD **2.3 days** in 2025/26 Q4 compared to **2.9 days** in 2024/25 Q4.
- **15.77% (159) acute** adult deaths referred to Coroner and **9.49% (96)** investigated. Of those cases referred, **60.38%** investigated. Compares to **19% (212)** cases referred and **11.6% (130)** investigated in 2024/25 Q4**.**
- **21.8% (221)** of all **acute** adult deaths and **31.4% (11) accepted** SJR referrals had **pneumonia** listed on MCCD. Pneumonia has remained the highest cause of death on MCCD throughout 2025/26.
- Majority of inpatient adult deaths across ICU/Acute, General/Elderly Medicine, Respiratory and Stroke, with top 20 ward areas having **between 18 and 32** deaths within 2025/26 Q4. **RSCH LMB C8 (Stroke)** had highest number of deaths **(32)** in 2025/26 Q4.
- Sustained improvement in average time taken to complete SJR - **31 days** in 2025/26 Q4, compared to **53 days** in 2024/25 Q4. However, average time taken in Mar-26 impacted by delay in obtaining relevant health records.
- **40** more SJR referrals in 2024/25 Q4 **(147, 13.1%)** compared to 2025/26 Q4 **(107, 10.6%)** 2025/26 Q4 SJR acceptance rate **33%** with weekly SJR Screening Panel reviewing referrals, to decide on whether to proceed to comprehensive SJR. (Reasons recorded for 2025/26 Q4 - **35** referred to Coroner, **19** referred to local M&M and **18** Other.)

# Detailed Report

# Actual and Potential Deceased Organ Donation

# 1 April 2025 - 31 March 2026

## University Hospitals Sussex NHS Foundation Trust

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**Further Information**

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report and our Power BI reports with up to date Trust metrics are available at https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

**Source**

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2026 based on data meeting PDA criteria reported at 7 May 2026.

# 1. Donor Outcomes

## A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

## Data in this section is obtained from the UK Transplant Registry

Between 1 April 2025 and 31 March 2026, University Hospitals Sussex NHS Foundation Trust had 35 deceased solid organ donors, resulting in 74 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2024/25. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

**Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2025 - 31 March 2026 (1 April 2024 - 31 March 2025 for comparison)**

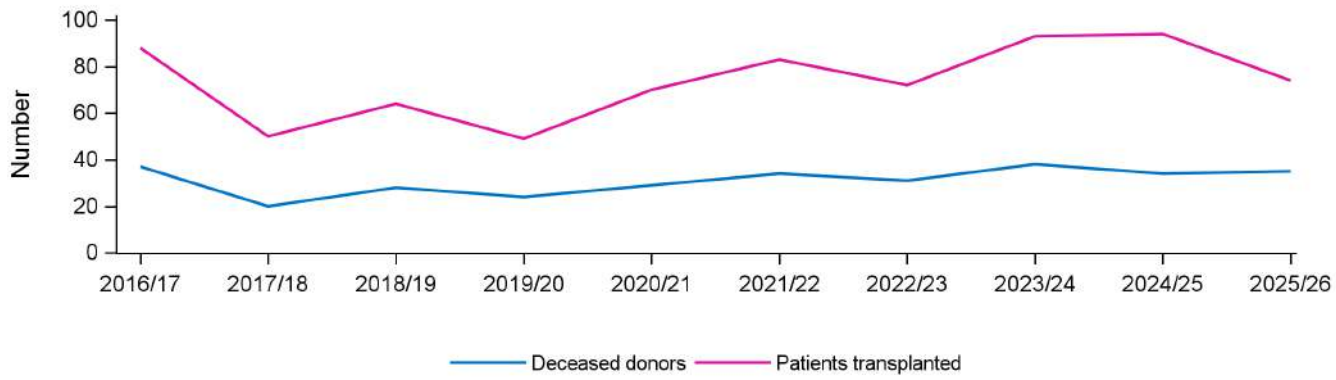
| Donor type | Number of donors | | Number of patients transplanted | | Average number of organs donated per donor Trust | | UK | |
|---|---|---|---|---|---|---|---|---|
| DBD | 5 | (21) | 15 | (68) | 3.4 | (3.9) | 3.7 | (3.6) |
| DCD | 30 | (13) | 59 | (26) | 2.8 | (2.9) | 3.1 | (2.9) |
| DBD and DCD | 35 | (34) | 74 | (94) | 2.9 | (3.5) | 3.4 | (3.2) |

In addition to the 35 proceeding donors there were 9 additional consented donors that did not proceed, one where DBD organ donation was being facilitated and 8 where DCD organ donation was being facilitated. Furthermore, 39 corneas were received by NHSBT Eye Banks from your Trust.

**Table 1.2 Organs transplanted by type, 1 April 2025 - 31 March 2026 (1 April 2024 - 31 March 2025 for comparison)**

| Donor type | Number of organs transplanted by type Kidney | | Pancreas | | Liver | | Heart | | Lung | | Small bowel | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DBD | 10 | (37) | 1 | (5) | 5 | (18) | 1 | (8) | 0 | (6) | 0 | (0) |
| DCD | 46 | (18) | 3 | (0) | 9 | (7) | 2 | (0) | 4 | (2) | 0 | (0) |
| DBD and DCD | 56 | (55) | 4 | (5) | 14 | (25) | 3 | (8) | 4 | (8) | 0 | (0) |

**Figure 1.1 Number of donors and patients transplanted, 1 April 2016 - 31 March 2026**



# 2. Key Rates in Potential for Organ Donation

## A summary of the key rates on the potential for organ donation

### Data in this section is obtained from the National Potential Donor Audit (PDA)

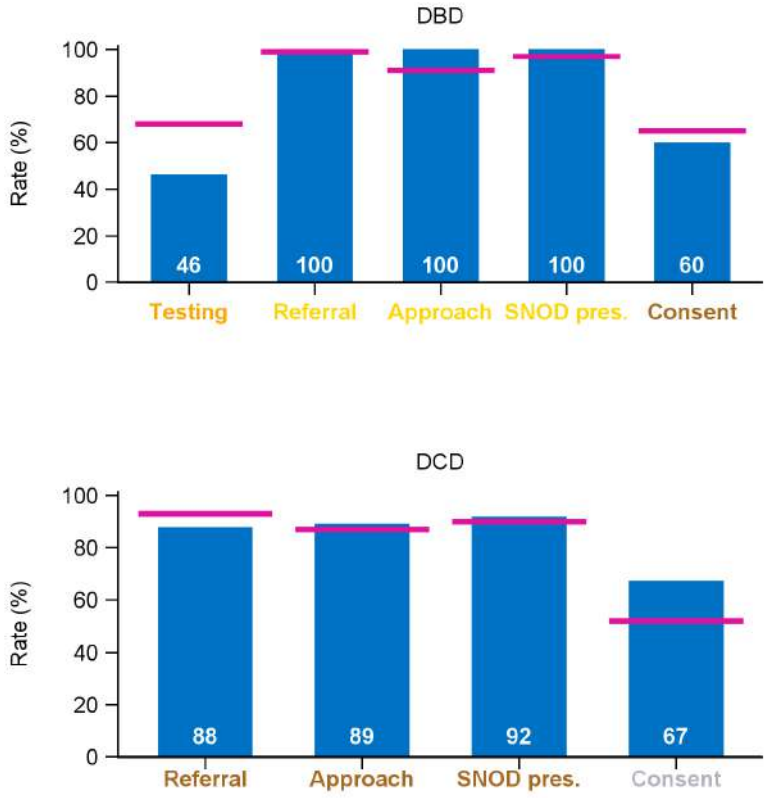
This section presents specific percentage measures of potential donation activity for University Hospitals Sussex NHS Foundation Trust.

Performance in your Trust has been compared with UK performance in both Figure 2.1 and Table 2.1 using funnel plot boundaries and the Gold, Silver, Bronze, Amber, and Red (GoSBAR) colour scheme. When compared with UK performance, gold represents exceptional, silver represents good, bronze represents average, amber represents below average, and red represents poor performance. See Appendix A.3 for funnel plot ranges used.

It is acknowledged that the PDA does not capture all activity. There may be some patients referred in 2025/26 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA.

Note that caution should be applied when interpreting percentages based on small numbers.

**Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2025 - 31 March 2026**



Trust — UK

Gold | Silver | Bronze | Amber | Red

**Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2021 - 31 March 2026**

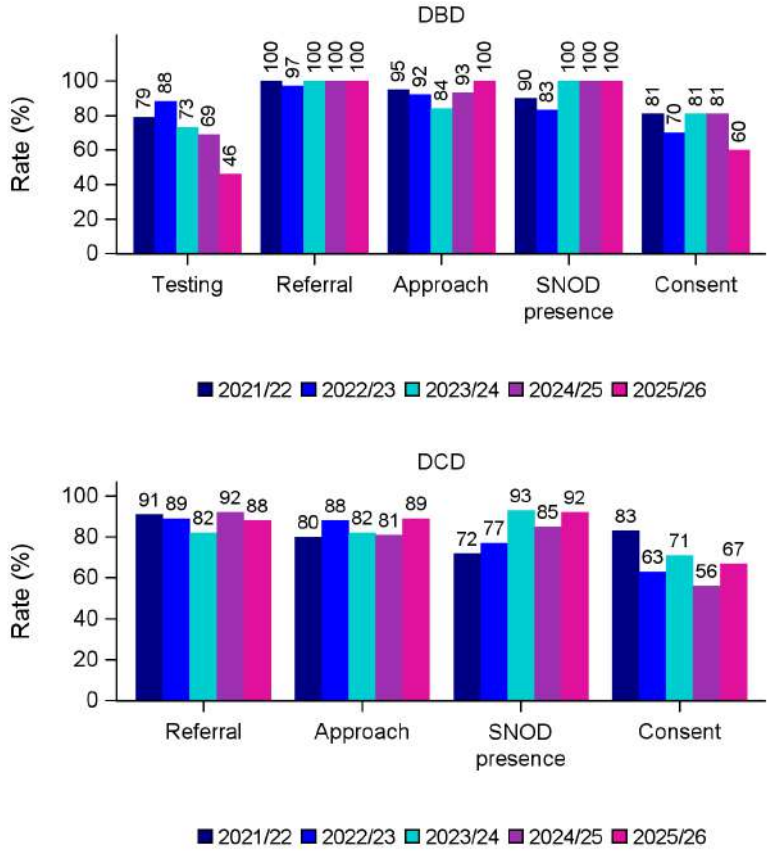


**Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2025 - 31 March 2026**

| | DBD | | DCD | | Deceased donors | |
|---|---|---|---|---|---|---|
| | Trust | UK | Trust | UK | Trust | UK |
| Patients meeting organ donation referral criteria[1] | 26 | 1853 | 107 | 5288 | 117 | 6552 |
| Referred to Organ Donation Service | 26 | 1840 | 94 | 4944 | 104 | 6203 |
| *Referral rate %* | G *100%* | *99%* | B *88%* | *93%* | B *89%* | *95%* |
| Neurological death tested | 12 | 1251 | | | | |
| *Testing rate %* | A *46%* | *68%* | | | | |
| Eligible donors[2] | 10 | 1138 | 81 | 3698 | 91 | 4836 |
| Medically suitable eligible donors[3] | 10 | 1138 | 55 | 2231 | 65 | 3369 |
| Family approached | 10 | 1033 | 49 | 1976 | 59 | 3009 |
| Family approached of medically suitable eligible donor | 10 | 1033 | 49 | 1939 | 59 | 2972 |
| *% approached of medically suitable eligible* | G *100%* | *91%* | B *89%* | *87%* | B *91%* | *88%* |
| Family approached and SNOD present | 10 | 1002 | 45 | 1785 | 55 | 2787 |
| *% of approaches where SNOD present* | G *100%* | *97%* | B *92%* | *90%* | B *93%* | *93%* |
| Consent ascertained | 6 | 676 | 33 | 1037 | 39 | 1713 |
| *Consent rate %* | B *60%* | *65%* | S *67%* | *52%* | B *66%* | *57%* |
| - Expressed opt in | 5 | 426 | 23 | 678 | 28 | 1104 |
| *- Expressed opt in %* | *100%* | *93%* | *88%* | *83%* | *90%* | *87%* |
| - Deemed Consent | 1 | 197 | 9 | 293 | 10 | 490 |
| *- Deemed Consent %* | *33%* | *53%* | *56%* | *41%* | *53%* | *45%* |
| - Other* | 0 | 52 | 1 | 64 | 1 | 116 |
| *- Other* %* | *N/A* | *51%* | *25%* | *32%* | *25%* | *39%* |
| Actual donors (PDA data) | 5 | 634 | 29 | 771 | 34 | 1405 |
| *% of consented donors that became actual donors* | *83%* | *94%* | *88%* | *74%* | *87%* | *82%* |

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

[3] Medically suitable eligible donor - An eligible donor with no DCD exclusions and not deemed unsuitable by the DCD screening process

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

**Gold** **Silver** **Bronze** **Amber** **Red**

Note that from 1 April 2025 to 31 March 2026 there were 2 eligible DCD donors for whom consent for donation was ascertained who are not included in this section because they were either over 80 years of age or did not die in a unit participating in the PDA.

# 3. Best quality of care in organ donation

## Key stages in best quality of care in organ donation

## Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Trust at the key stages of organ donation. The ambition is that your Trust misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

### 3.1 Neurological death testing

**Goal: neurological death tests are performed wherever possible.**

**Figure 3.1 Number of patients with suspected neurological death, 1 April 2021 - 31 March 2026**

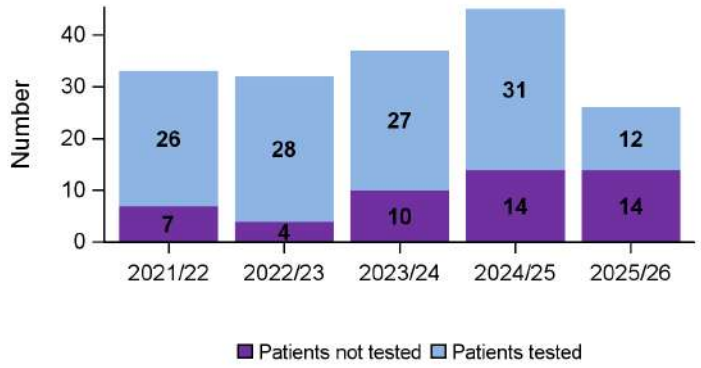



**Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2025 - 31 March 2026**

| | Trust | UK |
|---|---|---|
| Biochemical/endocrine abnormality | 1 | 30 |
| Clinical reason/Clinician's decision | 2 | 89 |
| Continuing effects of sedatives | - | 14 |
| Family declined donation | 1 | 48 |
| Family pressure not to test | 4 | 96 |
| Hypothermia | 2 | 38 |
| Inability to test all reflexes | - | 30 |
| Medical contraindication to donation | 1 | 10 |
| Other | - | 64 |
| Patient had previously expressed a wish not to donate | - | 9 |
| Patient haemodynamically unstable | 2 | 145 |
| SN-OD advised that donor not suitable | - | 11 |
| Treatment withdrawn | - | 9 |
| Unknown | 1 | 9 |
| **Total** | **14** | **602** |

If 'other', please contact your local SNOD or CLOD for more information, if required.

### 3.2 Referral to Organ Donation Service

**Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].**

**Aim: There should be no purple on the following charts.**

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

**Figure 3.2 Number of patients meeting referral criteria, 1 April 2021 - 31 March 2026**

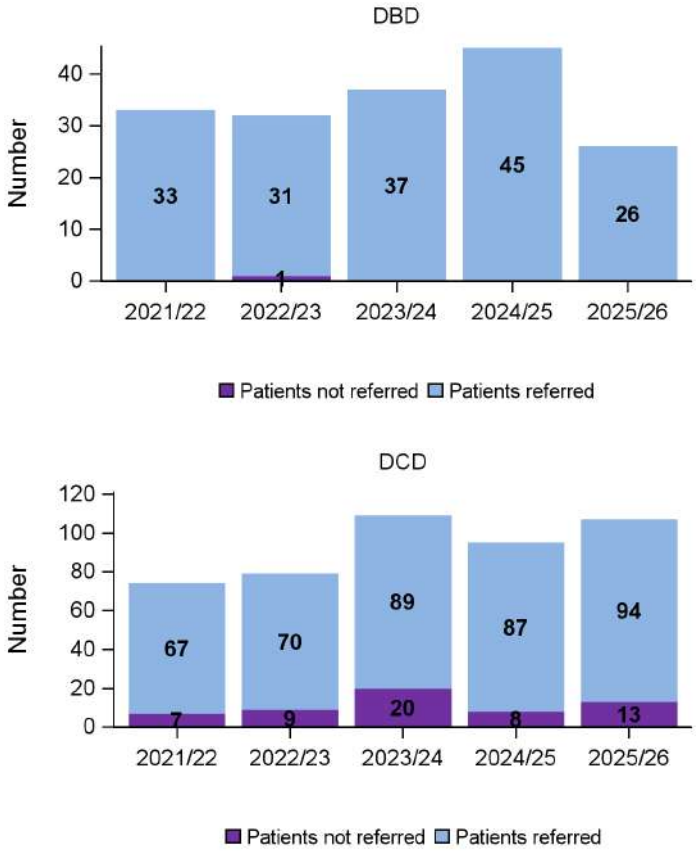



**Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2025 - 31 March 2026**

| | DBD | | DCD | |
|---|---|---|---|---|
| | Trust | UK | Trust | UK |
| Family declined donation following decision to remove treatment | - | - | - | 4 |
| Medical contraindications | - | 2 | 2 | 35 |
| Not identified as potential donor/organ donation not considered | - | 5 | 8 | 228 |
| Other | - | 2 | 1 | 13 |
| Patient had previously expressed a wish not to donate | - | 1 | - | 3 |
| Reluctance to approach family | - | - | - | 4 |
| Thought to be medically unsuitable | - | 1 | 2 | 55 |
| Uncontrolled death pre referral trigger | - | 2 | - | 2 |
| **Total** | **-** | **13** | **13** | **344** |

If 'other', please contact your local SNOD or CLOD for more information, if required.

### 3.3 Contraindications

In 2025/26 there were 26 potential donors in your Trust with an ACI reported, 3 DBD and 26 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

### 3.4 Approaches

**Goal: Every medically suitable eligible donor's family should be approached to consent to donation.**

**Aim: There should be no purple on the following charts.**

A medically suitable eligible donor is defined as either, an eligible DBD donor, or an eligible DCD donor with no DCD exclusion and not deemed unsuitable by the DCD screening process. It is not currently possible to account for the new DBD screening process introduced in October 2024.

**Figure 3.3 Number of medically eligible donor familes by approach, 1 April 2021 - 31 March 2026**

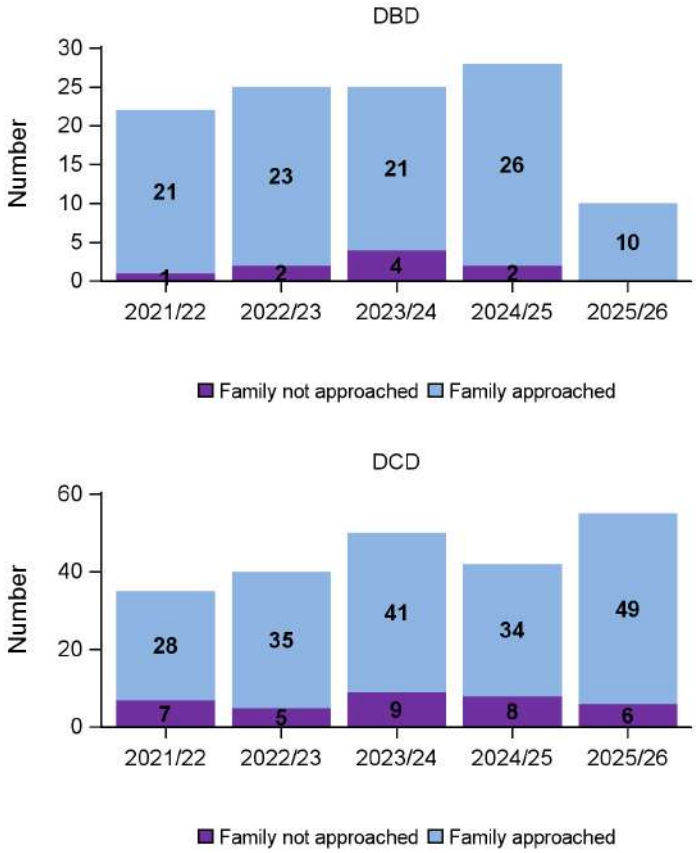



**Table 3.3 Reasons given why family not approached, 1 April 2025 - 31 March 2026**

| | DBD | | DCD | |
|---|---|---|---|---|
| | Trust | UK | Trust | UK |
| Cardiac arrest before approach could be made | - | - | - | 1 |
| Coroner/Proc Fiscal refused permission | - | 19 | - | 40 |
| Family stated they would not consent/authorise prior to donation decision conversation | - | 21 | - | 54 |
| Family untraceable - No first person consent (donation cannot proceed) | - | 11 | 1 | 18 |
| First person Consent or Expressed Authorisation / Family untraceable (donation can proceed) | - | - | 1 | 6 |

If 'other', please contact your local SNOD or CLOD for more information, if required.

**Table 3.3 Reasons given why family not approached, 1 April 2025 - 31 March 2026**

| | DBD | | DCD | |
|---|---|---|---|---|
| | **Trust** | **UK** | **Trust** | **UK** |
| Missing | - | 8 | - | 4 |
| Not identified as a potential donor | - | 6 | 4 | 145 |
| Pressure on ICU beds | - | - | - | 5 |
| Subsequently assessed to be medically unsuitable | - | 40 | - | 19 |
| **Total** | **-** | **105** | **6** | **292** |

If 'other', please contact your local SNOD or CLOD for more information, if required.

### 3.5 SNOD presence

**Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]**

**Aim: There should be no purple on the following charts.**

In the UK, in 2025/26, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 16% and 6%, respectively, compared with DBD and DCD consent/authorisation rates of 67% and 57%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known decision of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

**Figure 3.4 Number of families approached by SNOD presence, 1 April 2021 - 31 March 2026**

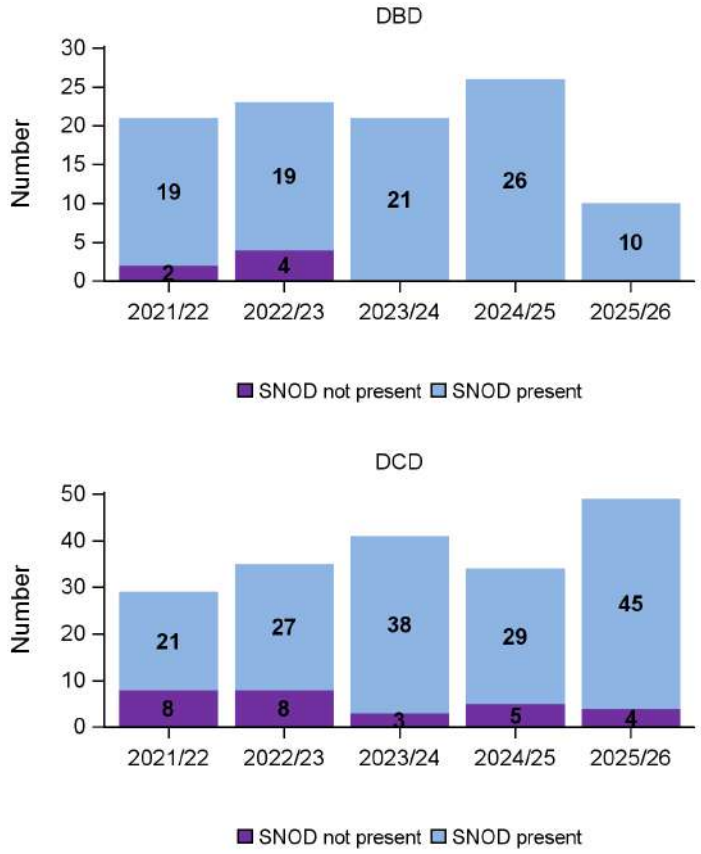



**Table 3.4 Reasons given why SNOD not present, 1 April 2025 - 31 March 2026**

| | DBD | | DCD | |
|---|---|---|---|---|
| | Trust | UK | Trust | UK |
| Approach made while ODS team member en-route | - | 2 | - | 20 |
| Change in plan not communicated to ODS team member | - | 1 | - | 8 |
| Conversation to confirm a registered opt-out decision | - | 5 | - | 32 |
| Family declined before donation decision conversation | - | 1 | - | 18 |

If 'other', please contact your local SNOD or CLOD for more information, if required.

**Table 3.4 Reasons given why SNOD not present, 1 April 2025 - 31 March 2026**

| | DBD | | DCD | |
|---|---|---|---|---|
| | **Trust** | **UK** | **Trust** | **UK** |
| ODS team member not available | - | 2 | - | 14 |
| ODS team member present but clinician declined ODS team member presence | - | 5 | 2 | 18 |
| Other | - | 3 | 1 | 17 |
| Oversight by unit staff | - | 2 | 1 | 30 |
| Planned to proceed without ODS team member | - | 10 | - | 34 |
| **Total** | **-** | **31** | **4** | **191** |

If 'other', please contact your local SNOD or CLOD for more information, if required.

[1] NICE, 2011.
*NICE Clinical Guidelines - CG135*
[accessed 7 May 2026]

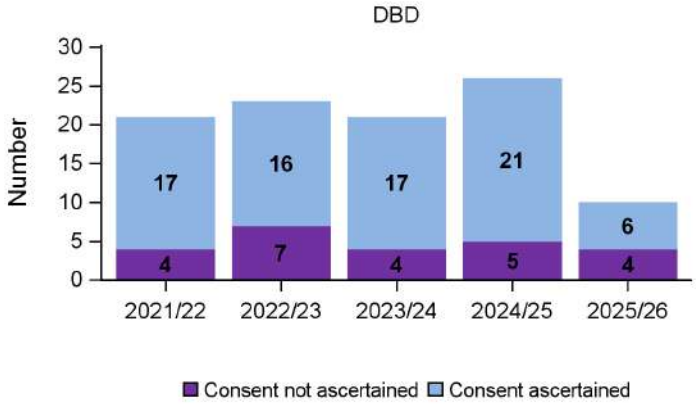
[2] NHS Blood and Transplant, 2012.
*Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice*
[accessed 7 May 2026]

[3] NHS Blood and Transplant, 2013.
*Approaching the Families of Potential Organ Donors – Best Practice Guidance*
[accessed 7 May 2026]

### 3.6 Consent

In 2025/26 the DBD and DCD consent rates in your Trust were 60% and 67%, respectively.

**Figure 3.5 Number of families approached, 1 April 2021 - 31 March 2026**



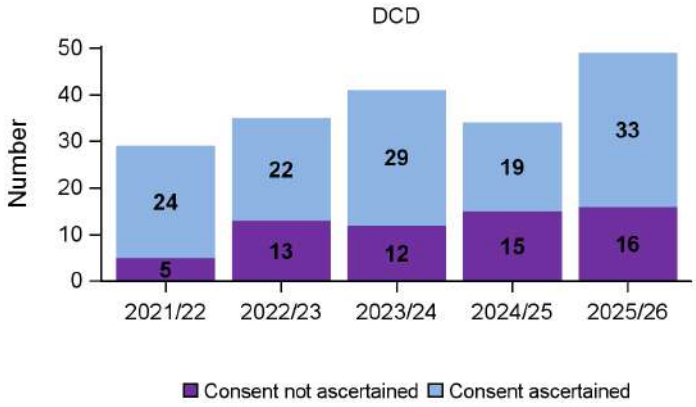




**Table 3.5 Reasons given why consent was not ascertained, 1 April 2025 - 31 March 2026**

| | DBD | | DCD | |
|---|---|---|---|---|
| | Trust | UK | Trust | UK |
| Family believe patient's treatment may have been limited to facilitate organ donation | - | - | - | 2 |
| Family concerned about organ allocation | - | - | - | 1 |
| Family concerned donation may delay the funeral | - | 1 | - | - |
| Family concerned other people may disapprove/be offended | - | 1 | - | 5 |
| Family concerned that organs may not be transplantable | - | 5 | - | 6 |
| Family did not believe in donation | - | 8 | - | 19 |
| Family did not want surgery to the body | - | 36 | 1 | 85 |
| Family divided over the decision | - | 10 | - | 23 |
| Family felt it was against their religious/cultural beliefs | - | 49 | 1 | 44 |
| Family felt patient had suffered enough | - | 16 | 1 | 70 |
| Family felt that the body should be buried whole (unrelated to religious/cultural reasons) | - | 17 | - | 24 |
| Family felt the length of time for the donation process was too long | 1 | 25 | 6 | 189 |

If 'other', please contact your local SNOD or CLOD for more information, if required.

**Table 3.5 Reasons given why consent was not ascertained, 1 April 2025 - 31 March 2026**

| | DBD | | DCD | |
|---|---|---|---|---|
| | **Trust** | **UK** | **Trust** | **UK** |
| Family wanted to stay with the patient after death | - | 2 | - | 13 |
| Family were not sure whether the patient would have agreed to donation | 1 | 50 | 2 | 120 |
| Other | - | 29 | 1 | 76 |
| Patient had previously expressed a wish not to donate | 2 | 73 | 3 | 172 |
| Patient had registered a decision to Opt Out | - | 16 | - | 56 |
| Strong refusal - probing not appropriate | - | 19 | 1 | 31 |
| **Total** | **4** | **357** | **16** | **936** |

If 'other', please contact your local SNOD or CLOD for more information, if required.

### 3.7 Deemed consent

In 2025/26 the DCD deemed consent rate in your Trust was 56%, less than 10 families of eligible DBD donors where deemed consent applies were approached therefore this consent rate is not presented.

England introduced deemed consent (Max and Keira's Law) in May 2020. Please see appendix for deemed consent criteria.

**Figure 3.6 Number of families approached where deemed consent applies, 1 April 2021 - 31 March 2026**

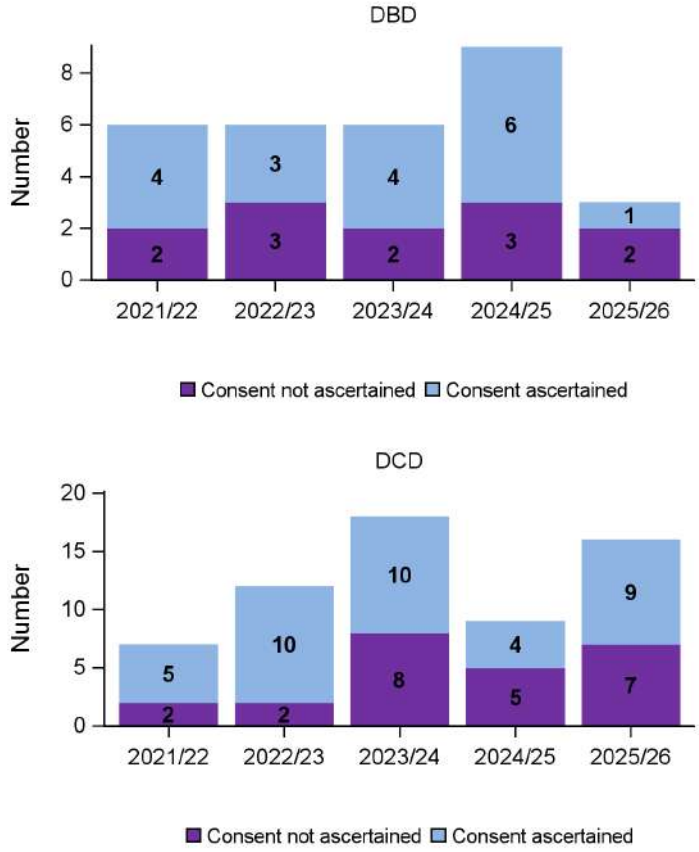



**Table 3.6 Reasons given why consent was not ascertained where deemed consent applied, 1 April 2025 - 31 March 2026**

| | DBD | | DCD | |
|---|---|---|---|---|
| | Trust | UK | Trust | UK |
| Family believe patient's treatment may have been limited to facilitate organ donation | - | - | - | 1 |
| Family concerned about organ allocation | - | - | - | 1 |
| Family concerned donation may delay the funeral | - | 1 | - | - |
| Family concerned other people may disapprove/be offended | - | 1 | - | 1 |
| Family concerned that organs may not be transplantable | - | 2 | - | 3 |
| Family did not believe in donation | - | 2 | - | 10 |
| Family did not want surgery to the body | - | 26 | 1 | 60 |
| Family divided over the decision | - | 7 | - | 12 |
| Family felt it was against their religious/cultural beliefs | - | 30 | - | 26 |
| Family felt patient had suffered enough | - | 14 | 1 | 44 |

If 'other', please contact your local SNOD or CLOD for more information, if required.

**Table 3.6 Reasons given why consent was not ascertained where deemed consent applied, 1 April 2025 - 31 March 2026**

| | DBD | | DCD | |
|---|---|---|---|---|
| | **Trust** | **UK** | **Trust** | **UK** |
| Family felt that the body should be buried whole (unrelated to religious/cultural reasons) | - | 8 | - | 17 |
| Family felt the length of time for the donation process was too long | 1 | 15 | 3 | 91 |
| Family wanted to stay with the patient after death | - | 1 | - | 9 |
| Family were not sure whether the patient would have agreed to donation | 1 | 39 | 1 | 89 |
| Other | - | 11 | 1 | 41 |
| Patient had previously expressed a wish not to donate | - | 3 | - | 7 |
| Strong refusal - probing not appropriate | - | 15 | - | 15 |
| **Total** | **2** | **175** | **7** | **427** |

If 'other', please contact your local SNOD or CLOD for more information, if required.

### 3.8 Solid organ donation

**Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted.**

**Table 3.7 Reasons why solid organ donation did not occur, 1 April 2025 - 31 March 2026**

| | DBD | | DCD | |
|---|---|---|---|---|
| | **Trust** | **UK** | **Trust** | **UK** |
| Clinical - Absolute contraindication to organ donation | - | 2 | - | 1 |
| Clinical - Considered high risk donor | 1 | 3 | - | 13 |
| Clinical - DCD clinical exclusion | - | - | - | 2 |
| Clinical - No transplantable organ | - | 4 | - | 7 |
| Clinical - Organs deemed medically unsuitable by recipient centres | - | 9 | 1 | 45 |
| Clinical - Organs deemed medically unsuitable on surgical inspection | - | 4 | 1 | 6 |
| Clinical - Other | - | 3 | - | 5 |
| Clinical - PTA post WLST | - | - | 2 | 138 |
| Clinical - Patient actively dying | - | 5 | - | 14 |
| Clinical - Patient's general medical condition | - | - | - | 2 |
| Clinical - Predicted PTA therefore not attended | - | - | - | 4 |
| Consent / Auth - Coroner/Procurator fiscal refusal | - | 6 | - | 10 |
| Consent / Auth - NOK withdraw consent / authorisation | - | 5 | - | 17 |
| Consent / Auth - Other | - | - | - | 1 |
| Logistical - Other | - | 1 | - | 1 |
| **Total** | **1** | **42** | **4** | **266** |

If 'other', please contact your local SNOD or CLOD for more information, if required.

# 4. Comparative Data

## A comparison of performance in your Trust/Board with national data

## Data in this section is obtained from the National Potential Donor Audit (PDA)

This section compares the quality of care in the key areas of organ donation in your Trust with the UK rate using funnel plots. The UK rate is shown as a green dashed line and the funnel shape is formed by the 95% and 99.8% confidence limits around the UK rate. The confidence limits reflect the level of precision of the UK rate relative to the number of observations. Performance in your Trust is indicated by a black cross. The Gold, Silver, Bronze, Amber, and Red colour scheme is used to indicate whether performance in your Trust, when compared to UK performance, is exceptional (gold), good (silver), average (bronze), below average (amber) or poor (red).

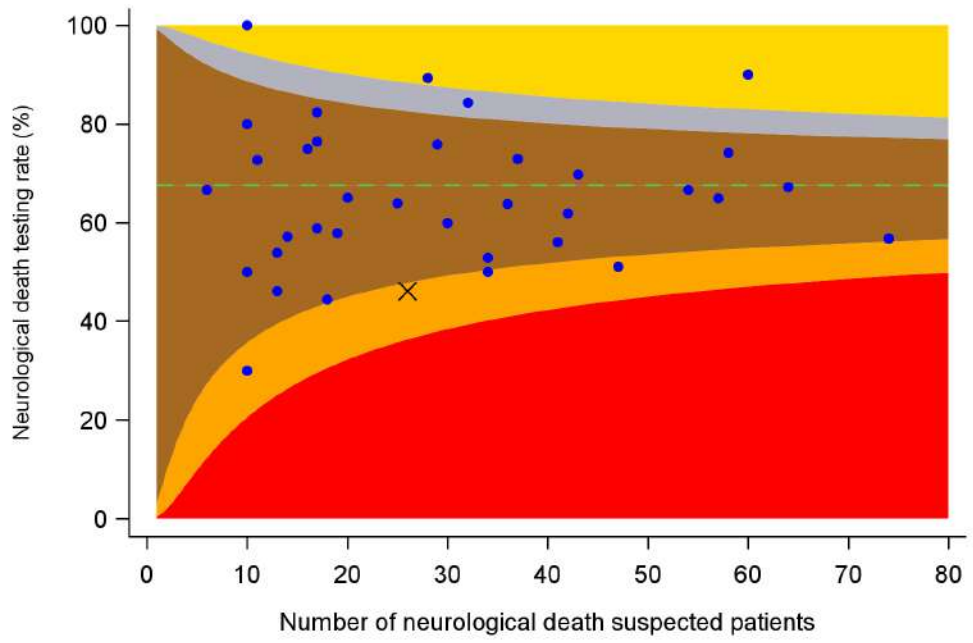
It is important to note that the differences in patient mix have not been accounted for in these plots. Further to these, separate funnel plots for DBD and DCD rates are presented in Section 7.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

### 4.1 Neurological death testing

**Goal: neurological death tests are performed wherever possible.**

**Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2025 - 31 March 2026**

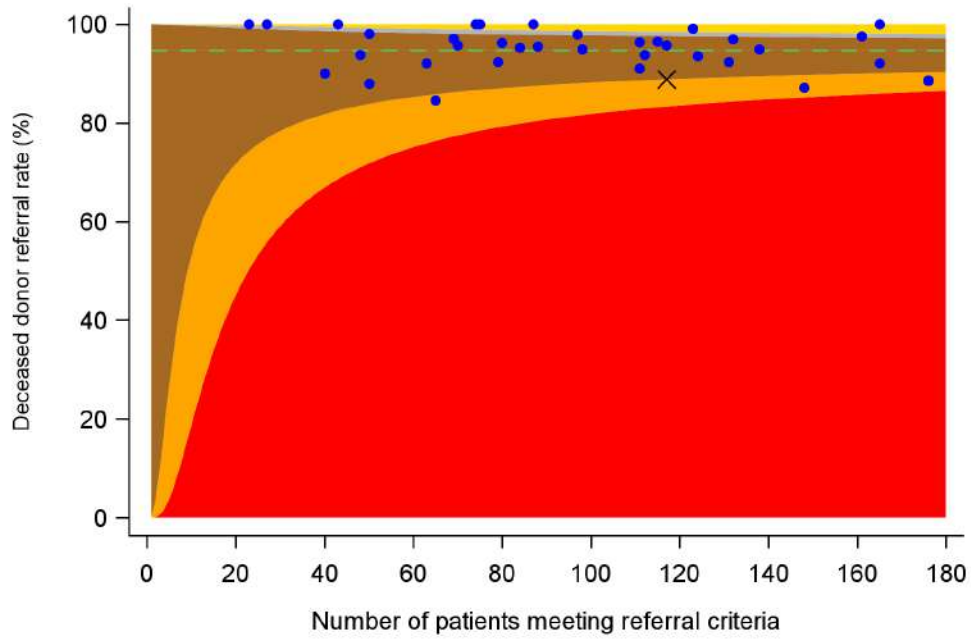



When compared with UK performance the neurological death testing rate in University Hospitals Sussex NHS Foundation Trust was below average (amber).

### 4.2 Referral to Organ Donation Service

**Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].**

**Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2025 - 31 March 2026**




**X** Trust • Other level 1 Trusts – – – UK rate

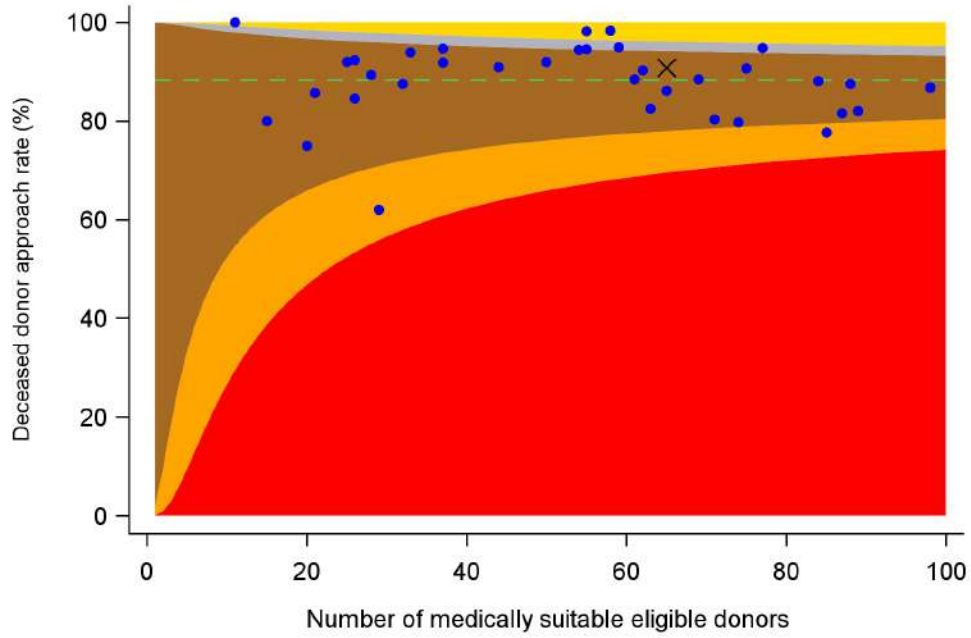
**Gold** **Silver** **Bronze** **Amber** **Red**

When compared with UK performance University Hospitals Sussex NHS Foundation Trust was average (bronze) for referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service.

### 4.3 Approaches

**Goal: Every medically suitable eligible donors family should be approached to consent to donation.**

**Figure 4.3 Funnel plot of deceased donor approach rate, 1 April 2025 - 31 March 2026**




**X** Trust • Other level 1 Trusts – – – UK rate

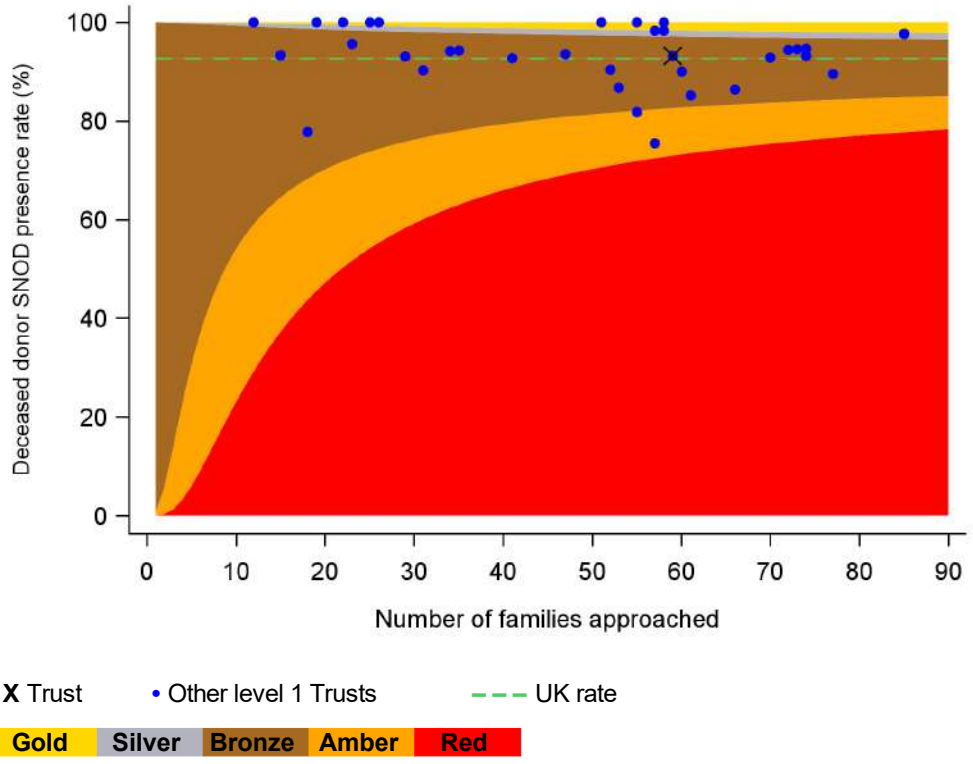
**Gold** **Silver** **Bronze** **Amber** **Red**

When compared with UK performance the approach rate in University Hospitals Sussex NHS Foundation Trust was average (bronze).

### 4.4 SNOD presence

**Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]**

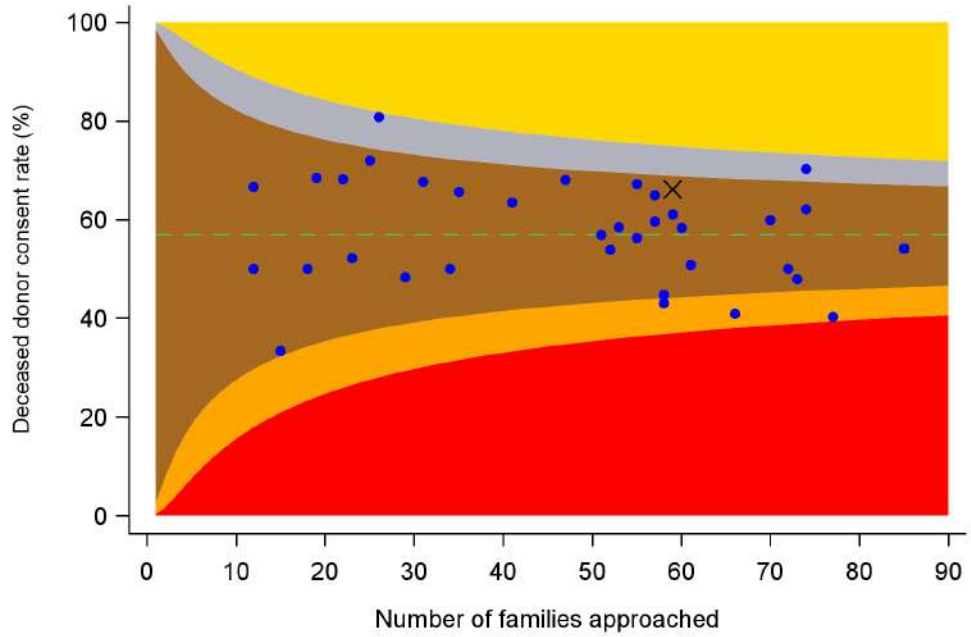
**Figure 4.4 Funnel plot of SNOD presence rate, 1 April 2025 - 31 March 2026**




When compared with UK performance University Hospitals Sussex NHS Foundation Trust was average (bronze) for Specialist Nurse presence when approaching families to discuss organ donation.

### 4.5 Consent

**Figure 4.5 Funnel plot of consent rate, 1 April 2025 - 31 March 2026**



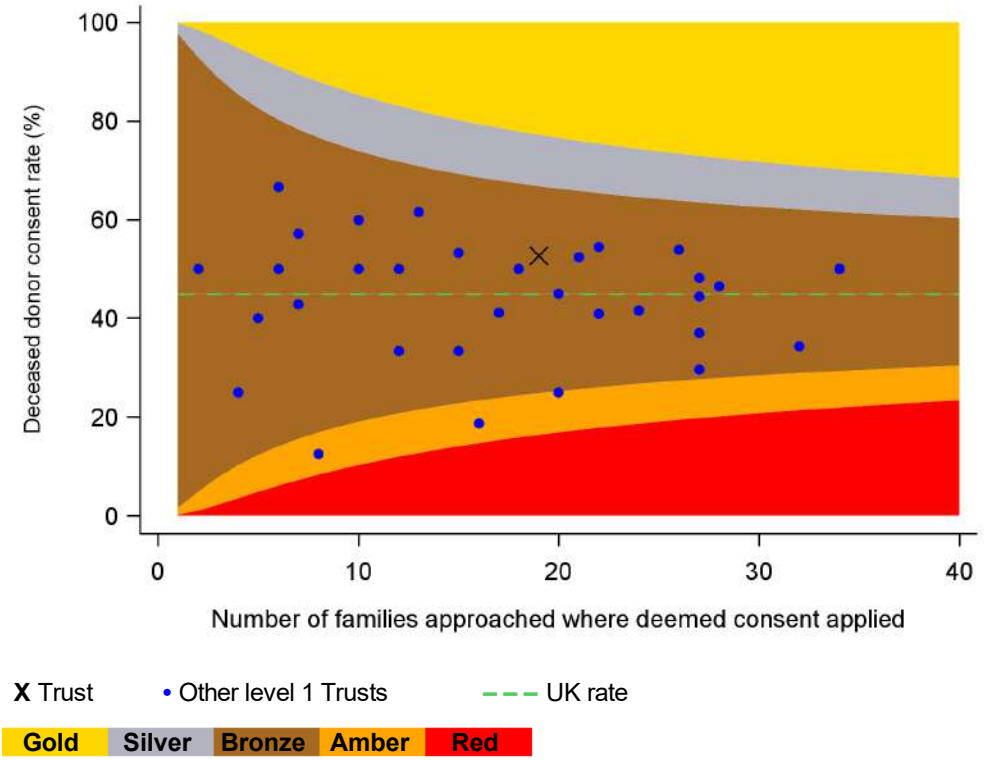

**X** Trust • Other level 1 Trusts – – – UK rate

**Gold** **Silver** **Bronze** **Amber** **Red**

When compared with UK performance the consent rate in University Hospitals Sussex NHS Foundation Trust was average (bronze).

### 4.6 Deemed consent

**Figure 4.6 Funnel plot of deemed consent rate, 1 April 2025 - 31 March 2026**



# 5. PDA data by hospital and unit

## A summary of key numbers and rates from the PDA by hospital and unit where patient died

## Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 5.1 and 5.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

### Table 5.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2025 - 31 March 2026

| Unit where patient died | Patients where neurological death was suspected | Patients tested | Neurological death testing rate (%) | Patients referred | DBD referral rate (%) | Patients confirmed dead by neurological testing | Eligible DBD donors | Eligible DBD donors whose family were approached | Approach rate (%) | Approaches where SNOD present | SNOD presence rate (%) | Consent ascertained | Consent rate (%) | Actual DBD and DCD donors from eligible DBD donors |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Brighton, Royal Sussex County Hospital* | | | | | | | | | | | | | | |
| A & E | 0 | 0 | - | 0 | - | 0 | 0 | 0 | - | 0 | - | 0 | - | 0 |
| General ICU/HDU | 20 | 8 | 40 | 20 | 100 | 6 | 6 | 6 | - | 6 | - | 3 | - | 3 |
| ICU - cardiothoracic | 0 | 0 | - | 0 | - | 0 | 0 | 0 | - | 0 | - | 0 | - | 0 |
| *Chichester, St Richard's Hospital* | | | | | | | | | | | | | | |
| A & E | 0 | 0 | - | 0 | - | 0 | 0 | 0 | - | 0 | - | 0 | - | 0 |
| General ICU/HDU | 2 | 1 | - | 2 | - | 1 | 1 | 1 | - | 1 | - | 1 | - | 1 |
| *Haywards Heath, Princess Royal Hospital* | | | | | | | | | | | | | | |
| A & E | 0 | 0 | - | 0 | - | 0 | 0 | 0 | - | 0 | - | 0 | - | 0 |
| General ICU/HDU | 0 | 0 | - | 0 | - | 0 | 0 | 0 | - | 0 | - | 0 | - | 0 |
| *Worthing, Worthing Hospital* | | | | | | | | | | | | | | |
| A & E | 0 | 0 | - | 0 | - | 0 | 0 | 0 | - | 0 | - | 0 | - | 0 |
| General ICU/HDU | 3 | 2 | - | 3 | - | 2 | 2 | 2 | - | 2 | - | 1 | - | 0 |
| ICU - general | 1 | 1 | - | 1 | - | 1 | 1 | 1 | - | 1 | - | 1 | - | 1 |

### Table 5.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2025 - 31 March 2026

| Unit where patient died | Patients for whom imminent death was anticipated | Patients referred | DCD referral rate (%) | Patients for whom treatment was withdrawn | Eligible DCD donors | Medically suitable eligible DCD donors | Medically suitable eligible DCD donors whose family were approached | Approach rate (%) | Eligible DCD donors whose family were approached | Approaches where SNOD present | SNOD presence rate (%) | Consent ascertained | Consent rate (%) | Actual DCD donors from eligible DCD donors |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Brighton, Royal Sussex County Hospital* | | | | | | | | | | | | | | |
| A & E | 2 | 0 | - | 2 | 2 | 1 | 0 | - | 0 | 0 | - | 0 | - | 0 |
| General ICU/HDU | 70 | 64 | 91 | 70 | 53 | 39 | 35 | 90 | 35 | 33 | 94 | 25 | 71 | 23 |
| ICU - cardiothoracic | 0 | 0 | - | 0 | 0 | 0 | 0 | - | 0 | 0 | - | 0 | - | 0 |
| *Chichester, St Richard's Hospital* | | | | | | | | | | | | | | |
| A & E | 0 | 0 | - | 0 | 0 | 0 | 0 | - | 0 | 0 | - | 0 | - | 0 |
| General ICU/HDU | 16 | 13 | 81 | 16 | 13 | 8 | 7 | - | 7 | 6 | - | 5 | - | 4 |
| *Haywards Heath, Princess Royal Hospital* | | | | | | | | | | | | | | |
| A & E | 0 | 0 | - | 0 | 0 | 0 | 0 | - | 0 | 0 | - | 0 | - | 0 |
| General ICU/HDU | 5 | 5 | - | 5 | 4 | 2 | 2 | - | 2 | 2 | - | 0 | - | 0 |
| *Worthing, Worthing Hospital* | | | | | | | | | | | | | | |
| A & E | 0 | 0 | - | 0 | 0 | 0 | 0 | - | 0 | 0 | - | 0 | - | 0 |
| General ICU/HDU | 13 | 11 | 85 | 13 | 8 | 4 | 4 | - | 4 | 3 | - | 3 | - | 2 |
| ICU - general | 1 | 1 | - | 1 | 1 | 1 | 1 | - | 1 | 1 | - | 0 | - | 0 |

Tables 5.1 and 5.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for University Hospitals Sussex NHS Foundation Trust in 2025/26 there were 2 such patients. For more information regarding the Emergency Department please see Section 6.

# 6. Emergency Department data

## A summary of key numbers for Emergency Departments

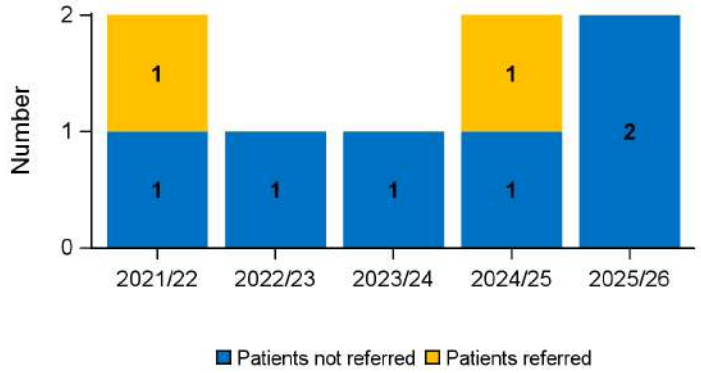
## Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a decision in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy† is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

### 6.1 Referral to Organ Donation Service

**Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.**
**Aim: There should be no blue on the following chart.**

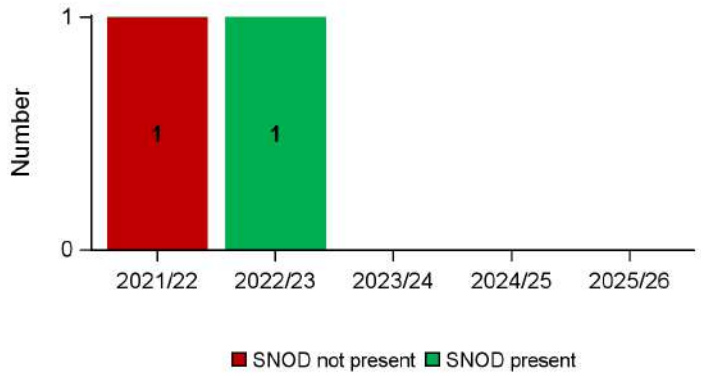
**Figure 6.1 Number of patients meeting referral criteria that died in the ED, 1 April 2021 - 31 March 2026**




### 6.2 Organ donation discussions

**Goal: No family is approached in ED regarding organ donation without a SNOD present.**
**Aim: There should be no red on the following chart.**

**Figure 6.2 Number of families approached in ED by SNOD presence, 1 April 2021 - 31 March 2026**




†NHS Blood and Transplant, 2016.
*Organ Donation and the Emergency Department*
[accessed 7 May 2026]

# 7. Additional data and figures

## Regional donor, transplant, and transplant list numbers

## Data in this section is obtained from the UK Transplant Registry

### 7.1 Supplementary Regional data

**Table 7.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data**

| | South East* | UK |
|---|---|---|
| **1 April 2025 - 31 March 2026** | | |
| Deceased donors | 175 | 1,428 |
| Transplants from deceased donors | 425 | 3,641 |
| Deaths on the transplant list | 43 | 431 |
| **As at 31 March 2026** | | |
| Active transplant list | 904 | 8,296 |
| Number of NHS ODR opt-in registrations (% registered) | 4,181,582 (45%)** | 28,794,504 (43%) |
| Number of NHS ODR opt-out registrations (% registered) | 282,432 (3%)** | 2,948,883 (4%) |

*Regions are defined using the NHS region definitions
** % registered based on population of 9.29 million, based on ONS 2021 census data

## Key numbers and rates on the potential for organ donation

## Data in this section is obtained from the National Potential Donor Audit (PDA)

### 7.2 Trust/Board Level Benchmarking

University Hospitals Sussex NHS Foundation Trust has been categorised as a level 1 Trust. Levels were reallocated in February 2023 using the most favourable (highest level) of the average number of donors over three years (2019/20, 2020/21, 2021/22) or the average number of donors over two years, excluding the COVID year (2019/20, 2021/22), Table 7.2 shows the criteria used and how many Trusts/Boards belong to each level.

**Table 7.2 Trust/Board level categories**

| | | Number of Trusts Boards in each level |
|---|---|---|
| Level 1 | 12 or more ( ≥ 12) proceeding donors per year | 36 |
| Level 2 | 6 or more but less than 12 ( ≥ 6 to <12) proceeding donors per year | 51 |
| Level 3 | More than 3 but less than 6 (>3 to <6) proceeding donors per year | 28 |
| Level 4 | 3 or less ( ≤ 3) proceeding donors per year | 37 |

Tables 7.3 and 7.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

**Table 7.3 National DBD key numbers and rate by Trust/Board level, 1 April 2025 - 31 March 2026**

| | Patients where neurological death was suspected | Patients tested | Neurological death testing rate (%) | Patients referred | DBD referral rate (%) | Patients confirmed dead by neurological testing | Eligible DBD donors | Eligible DBD donors whose family were approached | Approach rate (%) | Approaches where SNOD present | SNOD presence rate (%) | Consent ascertained | Consent rate (%) | Actual DBD and DCD donors from eligible DBD donors |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Your Trust | 26 | 12 | 46 | 26 | 100 | 10 | 10 | 10 | 100 | 10 | 100 | 6 | 60 | 5 |
| Level 1 | 1072 | 703 | 66 | 1061 | 99 | 653 | 629 | 570 | 91 | 553 | 97 | 358 | 63 | 334 |
| Level 2 | 477 | 327 | 69 | 476 | 100 | 318 | 305 | 276 | 90 | 262 | 95 | 181 | 66 | 173 |
| Level 3 | 170 | 127 | 75 | 169 | 99 | 124 | 121 | 112 | 93 | 112 | 100 | 84 | 75 | 77 |
| Level 4 | 134 | 94 | 70 | 134 | 100 | 89 | 83 | 75 | 90 | 75 | 100 | 53 | 71 | 50 |

## Table 7.4 National DCD key numbers and rate by Trust/Board level, 1 April 2025 - 31 March 2026

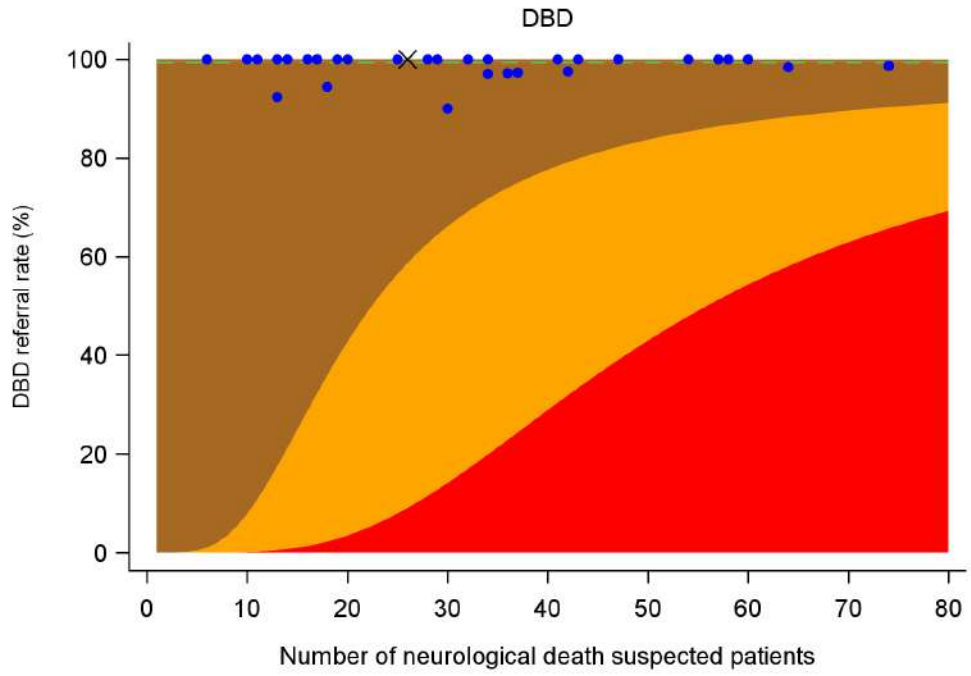
| | Patients for whom imminent death was anticipated | Patients referred | DCD referral rate (%) | Patients for whom treatment was withdrawn | Eligible DCD donors | Eligible DCD donors whose family were approached | Approaches where SNOD present | SNOD presence rate (%) | Medically suitable eligible DCD donors | Medically suitable eligible DCD donors whose family were approached | Approach rate (%) | Consent ascertained | Consent rate (%) | Actual DCD donors from eligible DCD donors |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Your Trust | 107 | 94 | 88 | 107 | 81 | 49 | 45 | 92 | 55 | 49 | 89 | 33 | 67 | 29 |
| Level 1 | 2762 | 2579 | 93 | 2697 | 2029 | 1145 | 1039 | 91 | 1299 | 1123 | 86 | 616 | 54 | 461 |
| Level 2 | 1567 | 1464 | 93 | 1530 | 1038 | 521 | 474 | 91 | 585 | 513 | 88 | 279 | 54 | 212 |
| Level 3 | 517 | 494 | 96 | 507 | 341 | 186 | 162 | 87 | 203 | 182 | 90 | 90 | 48 | 66 |
| Level 4 | 442 | 407 | 92 | 434 | 290 | 124 | 110 | 89 | 144 | 121 | 84 | 52 | 42 | 32 |

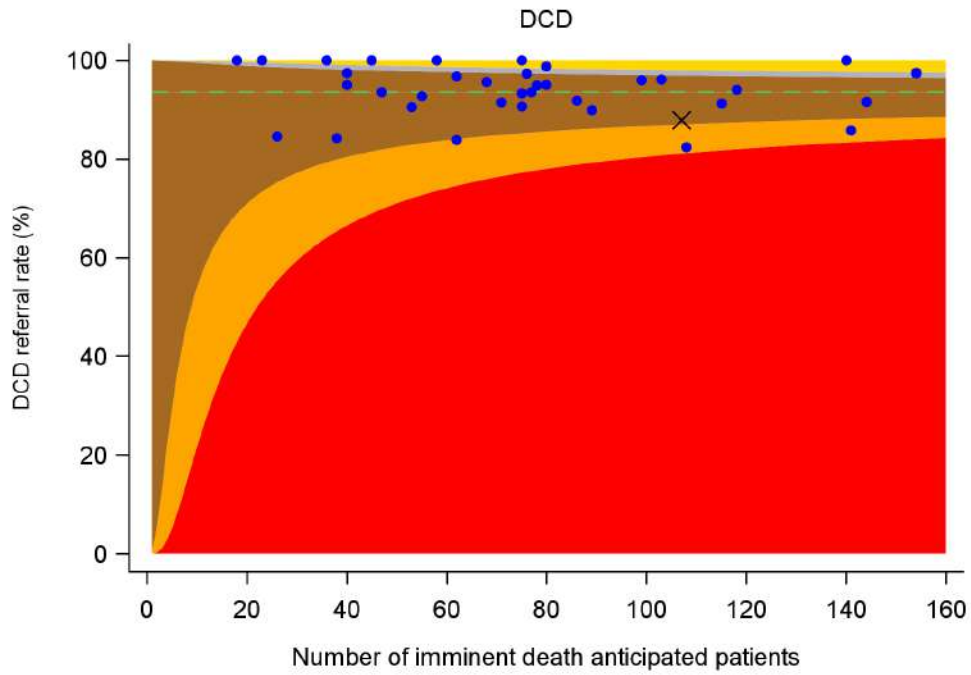
### 7.3 Comparative data for DBD and DCD deceased donors

Funnel plots are presented in Section 4 showing performance in your Trust against the UK rate for deceased organ donation. The following funnel plots present data for DBD and DCD donors separately.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

**Figure 7.1 Funnel plots of referral rates, 1 April 2025 - 31 March 2026**



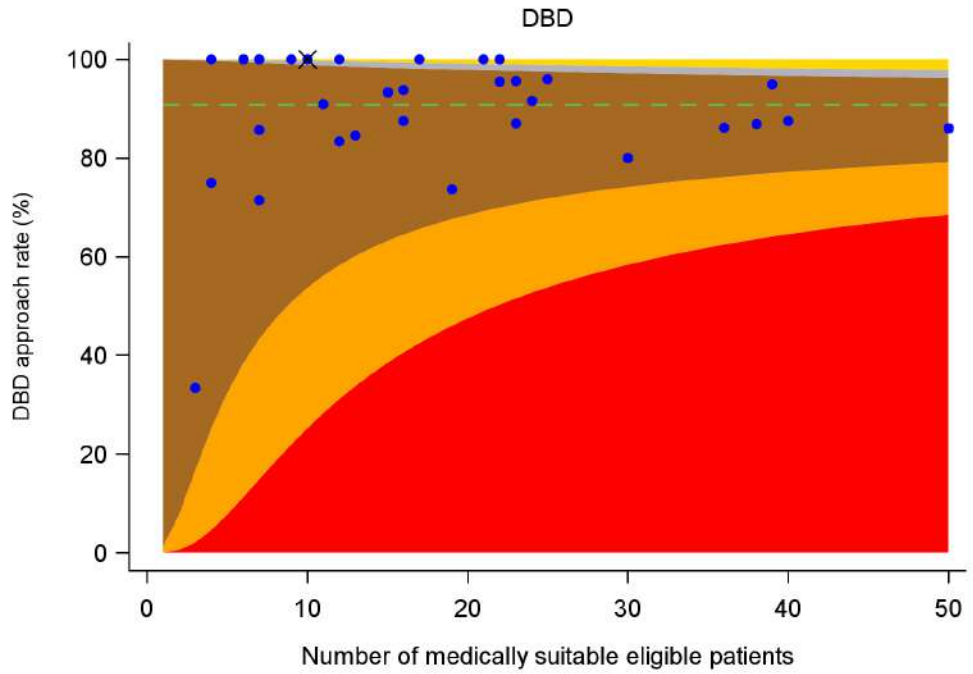



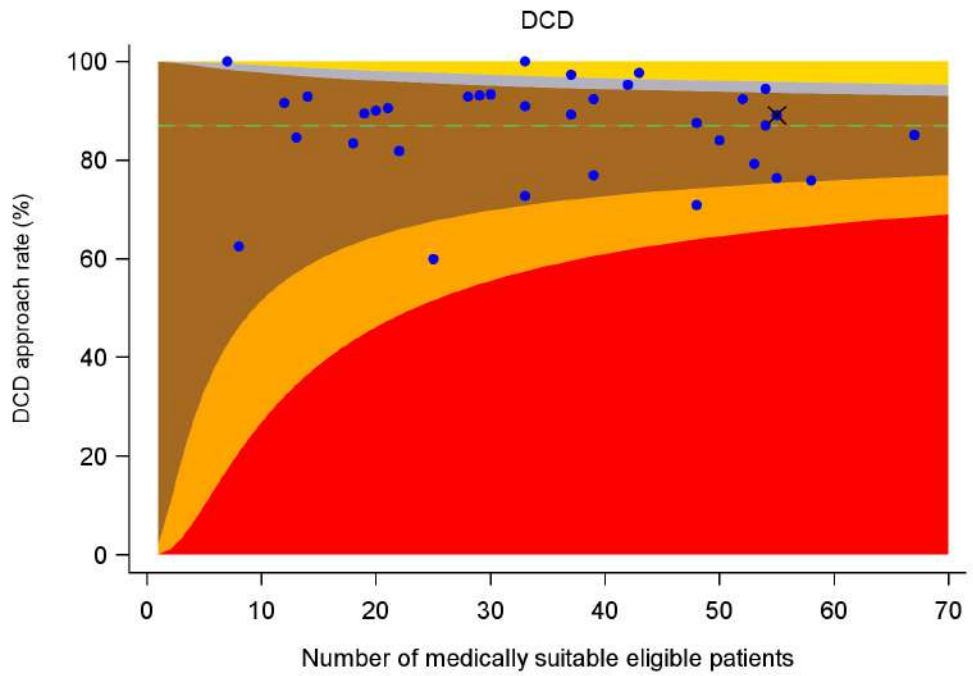
**X** Trust • Other level 1 Trusts – – – UK rate

**Gold** **Silver** **Bronze** **Amber** **Red**

When compared with UK performance University Hospitals Sussex NHS Foundation Trust was exceptional (gold) for referral of potential DBD organ donors and average (bronze) for referral of potential DCD organ donors to NHS Blood and Transplant's Organ Donation Service.

**Figure 7.2 Funnel plots of approach rates, 1 April 2025 - 31 March 2026**



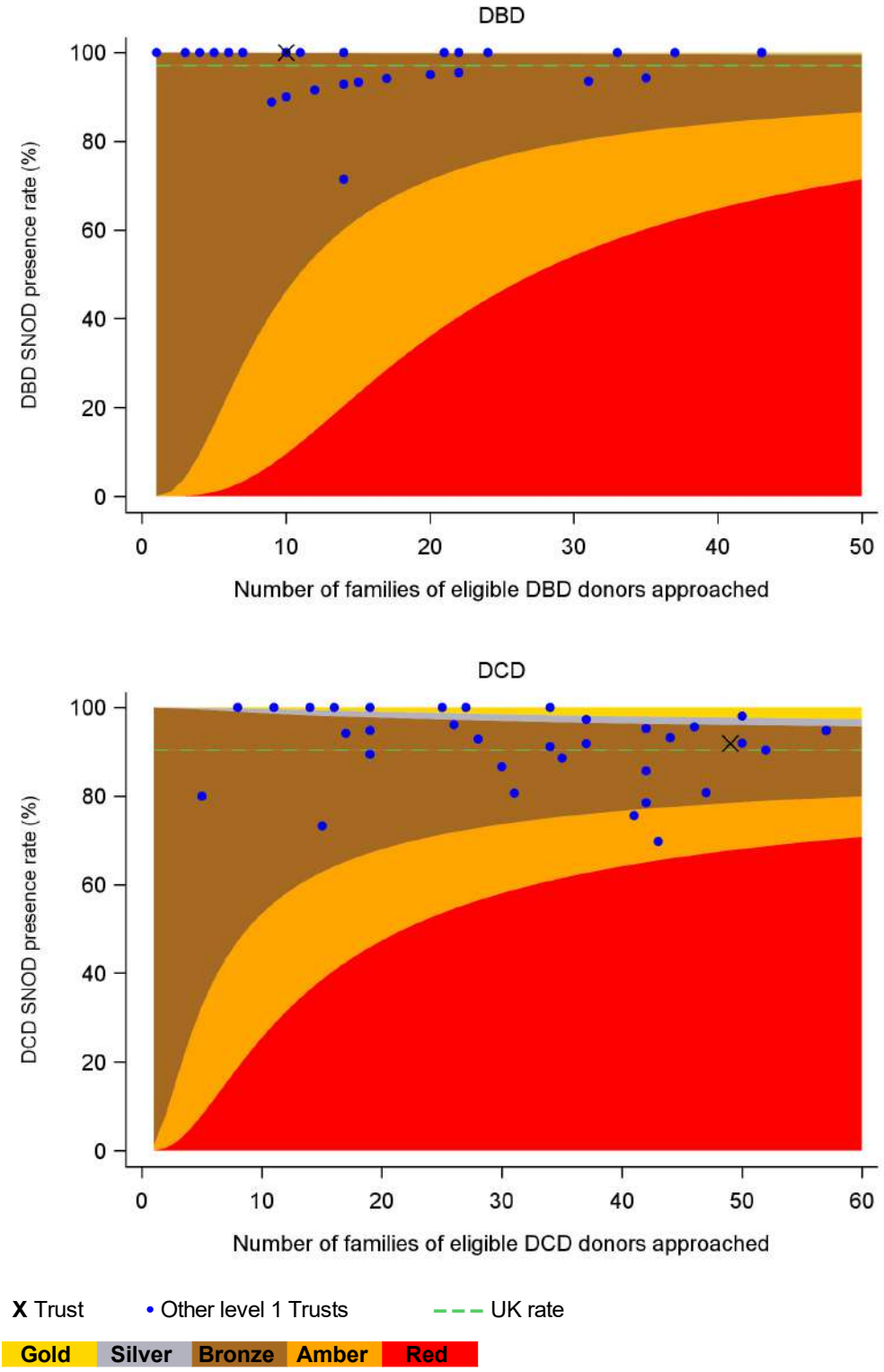




**X** Trust • Other level 1 Trusts – – – UK rate

**Gold** **Silver** **Bronze** **Amber** **Red**

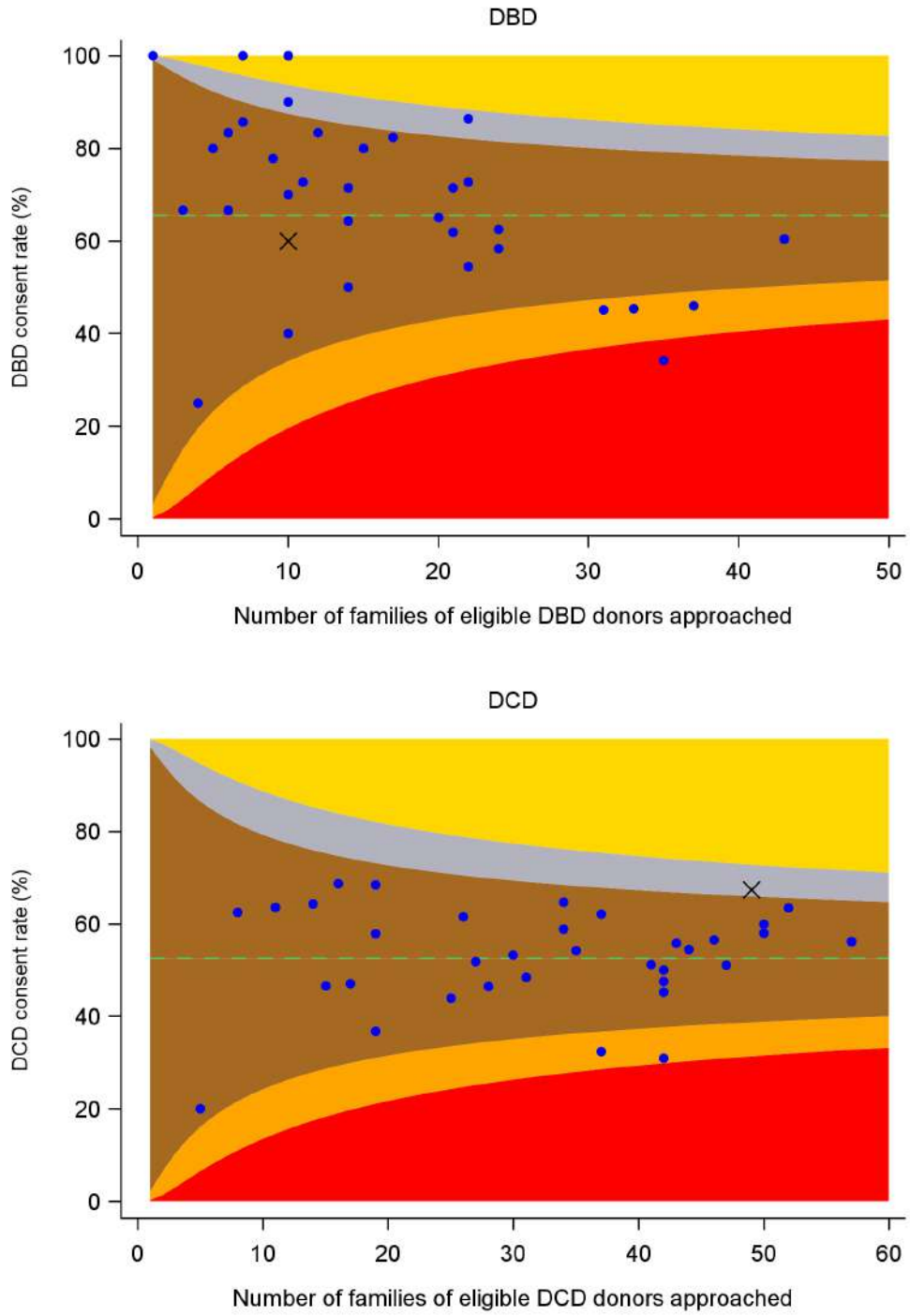
When compared with UK performance the DBD approach rate in University Hospitals Sussex NHS Foundation Trust was exceptional (gold) and the DCD approach rate was average (bronze).

**Figure 7.3 Funnel plots of SNOD presence rates, 1 April 2025 - 31 March 2026**



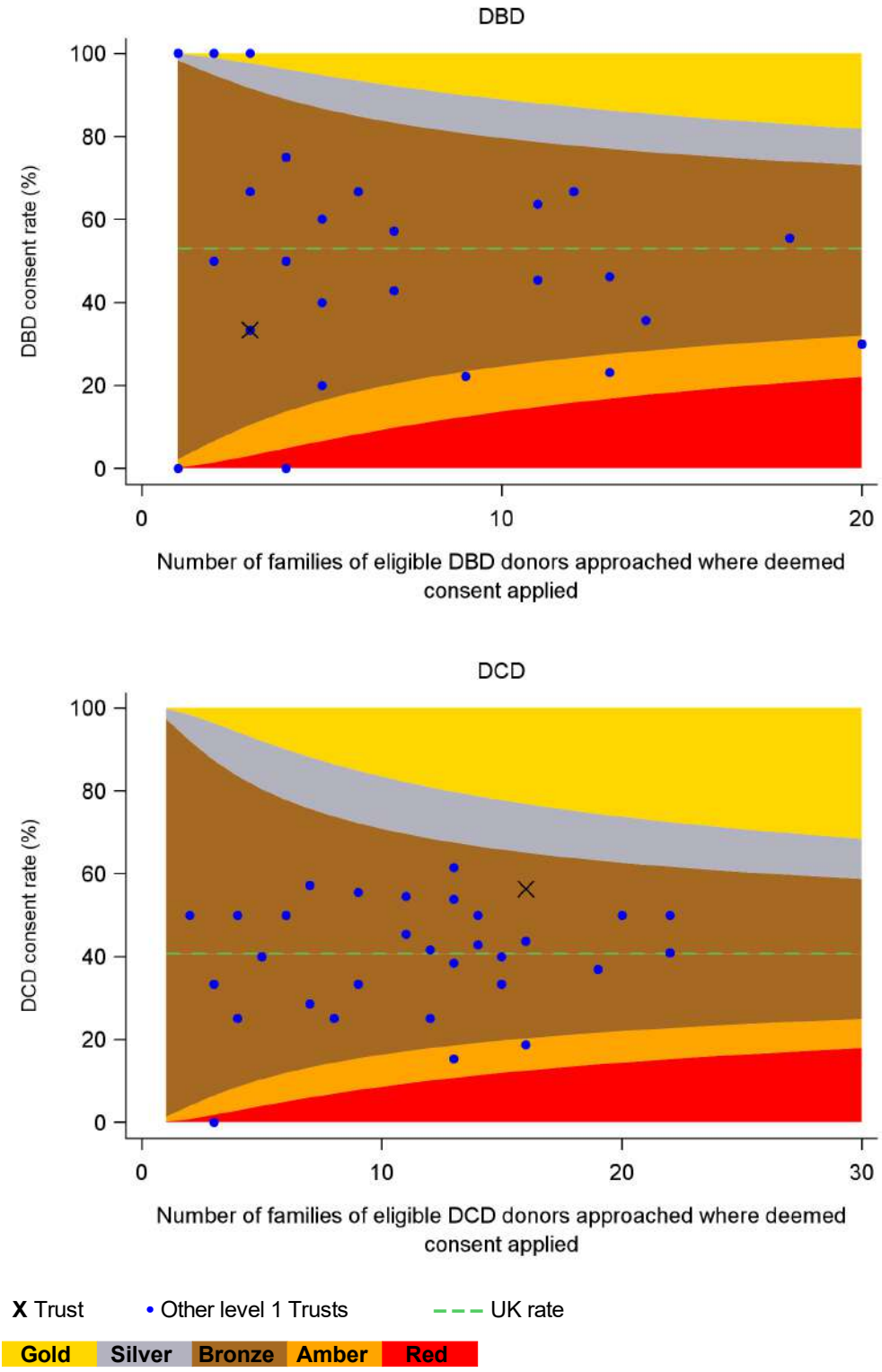

When compared with UK performance University Hospitals Sussex NHS Foundation Trust was exceptional (gold) and average (bronze) for Specialist Nurse presence in approaches to families of eligible DBD and DCD donors, respectively.

**Figure 7.4 Funnel plots of consent rates, 1 April 2025 - 31 March 2026**




When compared with UK performance the consent rate in University Hospitals Sussex NHS Foundation Trust was average (bronze) and good (silver) for DBD and DCD donors, respectively.

**Figure 7.5 Funnel plots of deemed consent rates, 1 April 2025 - 31 March 2026**



# Appendices

## Appendix A.1 Definitions

### Potential Donor Audit Definitions

| | |
|---|---|
| Potential Donor Audit inclusion criteria | 1 October 2009 – 31 March 2010<br>All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units<br>1 April 2010 – 31 March 2013<br>All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units<br>1 April 2013 onwards<br>All deaths in critical and emergency care in patients aged 80 and under (prior to 81st birthday) |

### Donors after brain death (DBD) definitions

| | |
|---|---|
| Suspected Neurological Death | A patient who meets all of the following criteria: invasive ventilation, Glasgow Coma Scale 3 not explained by sedation, no respiratory effort, fixed pupils, no cough or gag reflex. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – below 37 weeks corrected gestational age'. Previously referred to as brain death |
| Neurological death tested | Neurological death tests performed to confirm and diagnose death |
| DBD referral criteria | A patient with suspected neurological death |
| Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD) | A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse |
| Referred to Specialist Nurse – Organ Donation | A patient with suspected neurological death referred to a SNOD. A referral is the provision of information to determine organ donation suitability. NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests |
| Potential DBD donor | A patient with suspected neurological death |
| Absolute contraindications | Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188) Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf |
| Eligible DBD donor | A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation |
| Donation decision conversation | Family of eligible DBD donor asked to make or support patient's organ donation decision - This includes clarifying an opt out decision |
| Expressed opt in donation decision conversation | A donation decision conversation where the eligible DBD donor's last known decision was an expressed opt in decision. A patient's last known opt in decision can be expressed in writing or via the ODR in all nations and verbal opt in decisions are also included in Wales, England, Jersey and Guernsey. Verbally expressed opt in decisions are not included in Scotland. |
| Deemed consent/authorisation donation decision conversation | A donation decision conversation where the eligible DBD donor meets deemed criteria specific to each nation (see table below). In Scotland, this includes those who have verbally expressed a decision to opt in. |
| Expressed-opt out donation decision conversation | A donation decision conversation where the eligible DBD donor's last known decision was an expressed opt out decision. Opt out decisions can be expressed verbally, in writing or via the ODR in all nations. |
| Other donation decision conversation | A donation decision conversation where the eligible DBD donor has expressed no decision or deemed criteria are not met. Paediatric patients are included in this group. |

| | |
|---|---|
| Consent/Authorisation ascertained | Family of eligible DBD donor supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation |
| ODR opt in override | A donation decision conversation where the family do not support the patient's ODR opt in decision (irrespective of the patient's last known decision). |
| Actual donors: DBD | Patients who became actual DBD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research) |
| Actual donors: DCD | Patients who became actual DCD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research) |
| Neurological death testing rate | Percentage of patients for whom neurological death was suspected who were tested |
| Referral rate | Percentage of patients for whom neurological death was suspected who were referred to the SNOD |
| Approach rate | Percentage of eligible DBD donor families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision. |
| Consent/Authorisation rate | Percentage of donation decision conversations where consent/authorisation was ascertained |
| SNOD presence rate | Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations) |
| Consent/Authorisation rate where SNOD was present | Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above) |

### Donors after circulatory death (DCD) definitions

| | |
|---|---|
| Imminent death anticipated | A patient, not confirmed dead using neurological criteria, receiving invasive ventilation, in whom a clinical decision to withdraw treatment has been made and a controlled death is anticipated within a time frame to allow donation to occur (as determined at time of assessment) |
| DCD referral criteria | A patient for whom imminent (controlled) death is anticipated following withdrawal of life sustaining treatment (as defined above) |
| Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD) | A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse |
| Referred to SNOD | A patient for whom imminent death is anticipated who was referred to a SNOD. A referral is the provision of information to determine organ donation suitability NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests |
| Potential DCD donor | A patient who had treatment withdrawn and imminent death was anticipated within a time frame to allow donation to occur. |
| Absolute contraindications | Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188). Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf |
| Eligible DCD donor | A patient who had treatment withdrawn and imminent (controlled) death was anticipated, with no absolute medical contraindications to solid organ donation. |
| DCD exclusion criteria | DCD specific criteria determine a patient's suitability to donation when there are no absolute medical contraindications (see absolute contraindications documentation above) |
| DCD screening process | Process by which an organ may be screened with a local and national transplant centre to determine suitability of organs for transplantation |

| | |
|---|---|
| Medically suitable eligible DCD donor | An eligible DCD donor considered to be medically suitable for donation (i.e. no DCD exclusions and not deemed unsuitable by the screening process). |
| Donation decision conversation | Family of eligible DCD donor who were asked to make or support patient's organ donation decision - This includes clarifying an opt out decision. |
| Expressed opt in donation decision conversation | A donation decision conversation where the eligible DCD donor's last known decision was an expressed opt in decision. A patient's last known opt in decision can be expressed in writing or via the ODR in all nations and verbal opt in decisions are also included in Wales, England, Jersey and Guernsey. Verbally expressed opt in decisions are not included in Scotland. |
| Deemed consent/authorisation donation decision conversation | A donation decision conversation where the eligible DCD donor meets deemed criteria specific to each nation (see table below). In Scotland, this includes those who have verbally expressed a decision to opt in. |
| Expressed-opt out donation decision conversation | A donation decision conversation where the eligible DCD donor's last known decision was an expressed opt out decision. Opt out decisions can be expressed verbally, in writing or via the ODR in all nations. |
| Other donation decision conversation | A donation decision conversation where the eligible DCD donor has expressed no decision or deemed criteria are not met. Paediatric patients are included in this group. |
| Consent/Authorisation ascertained | Family of eligible DCD donor supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation |
| Actual DCD | DCD patients who became actual DCD as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research) |
| Referral rate | Percentage of patients for whom imminent (controlled) death was anticipated who were referred to the SNOD |
| Approach rate of medically suitable donors | Percentage of medically suitable eligible DCD donor families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision. |
| Consent/Authorisation rate | Percentage of donation decision conversations where consent/authorisation was ascertained. |
| SNOD presence rate | Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations). |
| Consent/Authorisation rate where SNOD was present | Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above). |

**Deemed Consent/Authorisation**

Deemed consent applies if a person who died in Wales, Jersey, England, Northern Ireland or Guernsey has not expressed an organ donation decision either to opt in or opt out or nominate/appoint a representative, is aged 18 or over, has lived in the country in which they died for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed consent for a significant period before their death.

Deemed authorisation applies if a person who died in Scotland has not expressed, in writing, an organ donation decision either to opt in or opt out, is aged 16 or over, has lived in Scotland for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed authorisation for a significant period before their death. Note that, in Scotland, a patient who has verbally expressed an opt in decision is included as a deemed authorisation, whereas a patient who has verbally expressed an opt out decision is not included.

**Consent/Authorisation groups**

| | |
|---|---|
| Expressed opt in | Patient had expressed an opt in decision. Opt in decisions can be expressed in writing or via the ODR in all nations and verbal opt in decisions are also included in Wales, England and Jersey. Verbally expressed opt in decisions are not included in Scotland |
| Deemed consent/authorisation | Patient meets deemed criteria specific to each nation as described above. In Scotland, this includes patients who have verbally expressed a decision to opt in |
| Expressed opt out | Patient had expressed an opt out decision. Opt out decisions can be expressed verbally, in writing or via the ODR in all nations |
| Other | Patient has expressed no decision or deemed criteria are not met. Paediatric patients are included in this group |

### UK Transplant Registry (UKTR) definitions

| | |
|---|---|
| Donor type | Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD) |
| Number of actual donors | Total number of donors reported to the UKTR |
| Number of patients transplanted | Total number of patients transplanted from these donors |
| Organs per donor | Number of organs donated divided by the number of donors. |
| Number of organs transplanted | Total number of organs transplanted by organ type |

## Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

## Appendix A.3 Table and Figure Description

| | |
|---|---|
| 1 Donor outcomes | |
| Table 1.1 | The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD). |
| Table 1.2 | The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD. |
| Figure 1.1 | The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart. |

| | |
|---|---|
| 2 Key rates in potential for organ donation | |
| Figure 2.1 | Key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented in a bar chart, using data from the Potential Donor Audit (PDA). The comparative UK rate, for the same time period, is illustrated by the pink line. The key rates labels are coloured using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below. |
| Figure 2.2 | Trends in the key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented for the past five equivalent time periods, using data from the PDA. |
| Table 2.1 | A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Note that caution should be applied when interpreting percentages based on small numbers. Appendix A.1 gives a fuller explanation of terms used. The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below). |

| | |
|---|---|
| 3 Best quality of care in organ donation | |
| Figure 3.1 | A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods. |
| Table 3.1 | The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided. |
| Figure 3.2 | Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods. |
| Table 3.2 | The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided. |
| Figure 3.3 | Stacked bar charts display the number of families of DBD and DCD patients approached and the number not approached in your Trust/Board for the past five equivalent time periods. |
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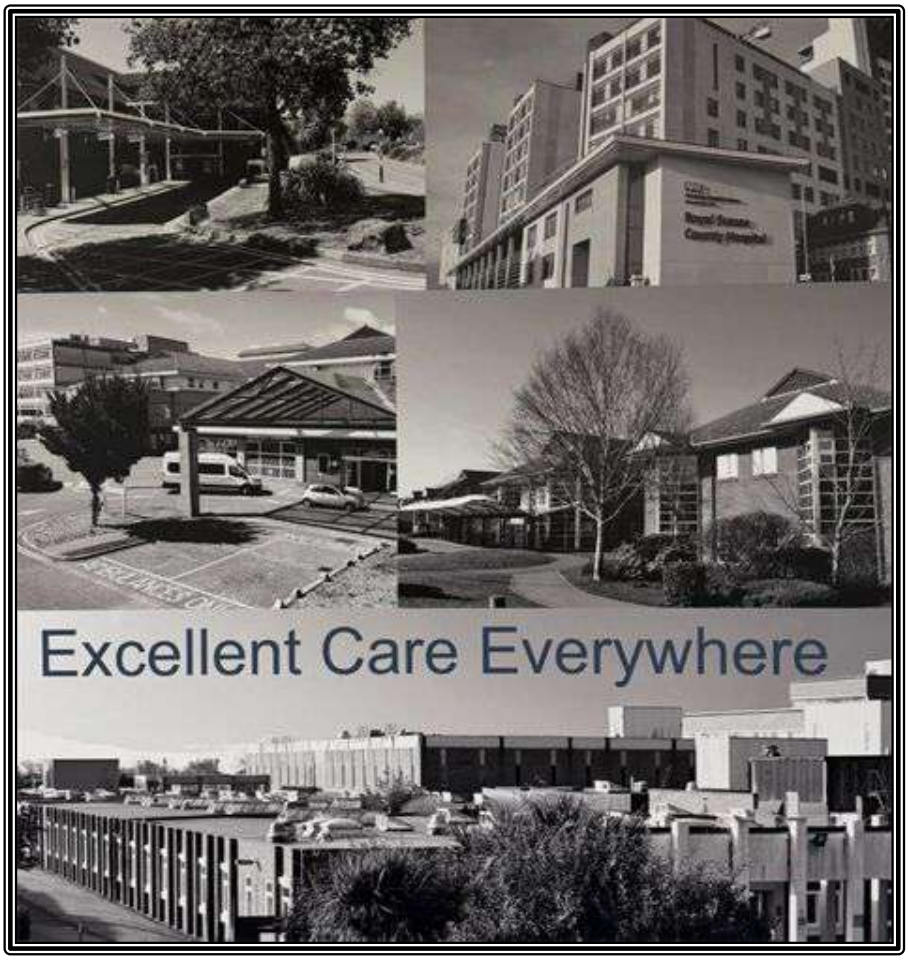
# Director of Infection Prevention and Control

# Annual Report

# Financial Year: 2025 - 2026



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## 2. Executive Summary

University Hospitals Sussex NHS Foundation Trust (UHSussex) continues to meet its statutory obligations under the Health and Social Care Act 2008 (the Hygiene Code).

The Trust's annual Infection Prevention and Control (IPC) Board Assurance Framework assessment confirms broad compliance, with 40 of 54 standards fully achieved and 14 partially achieved. Plans are in place to address these areas with oversight through the Trust IPC Committee (TIPC) and Quality Governance Steering Group (QGSG).

Previous improvement actions identified by the Care Quality Commission (CQC) are now embedded as part of "business as usual."

The Trust is fully compliant with the National Infection Prevention and Control Manual (NIPCM), a set of nationally authored IPC policies which form the minimum standard expected by NHS health care service providers.

### 2.1 Performance and Surveillance

- National mandatory surveillance incidence targets of healthcare-associated infections were not met, but as evidenced in Figure A, infection rates per 100,000 bed days benchmarked favourably against the South-East region and London as shown in the graph below.

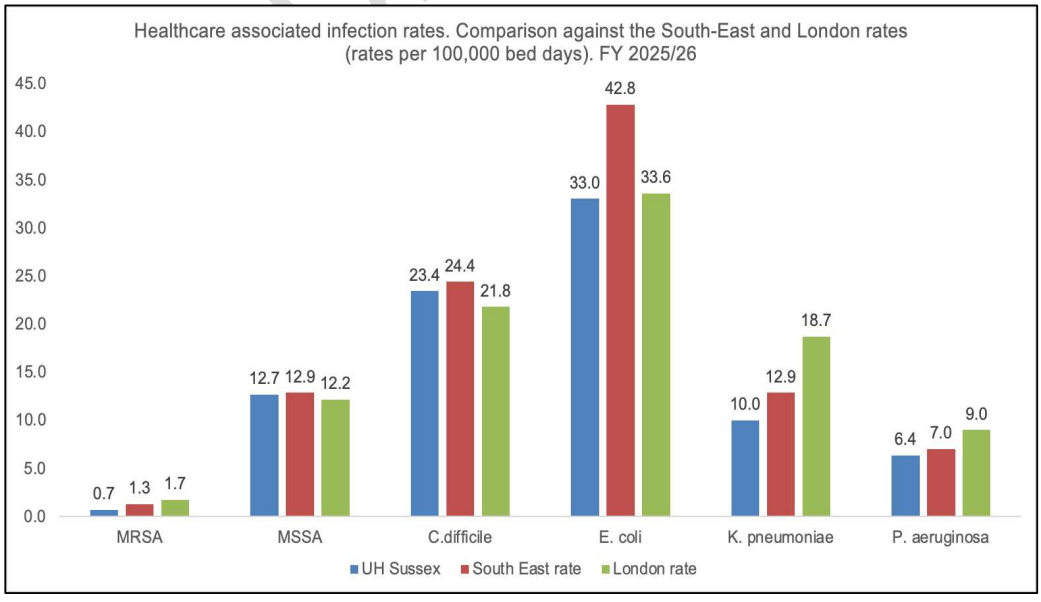


*Figure A: UHSussex Mandatory surveillance data benchmark per 100,000 bed days.*

- Following clinical review, there was learning around line-associated infections and antimicrobial stewardship.
- Trust-wide programmes have been launched to strengthen vascular access device management, commode cleaning standards and fundamentals of care.

### 2.2 Governance and Assurance

- Residual assurance gaps remain in relation to ageing infrastructure, workforce resilience within key specialist services, and the timely identification and management of infection risks across complex patient pathways.
- Water and ventilation safety remain critical areas of focus. The Trust has progressed a 10-year ventilation replacement plan, strengthened the Water Safety Group, and has continued to work with the NHS New Hospitals Programme to influence and improve national design guidance to reduce risks associated with waterborne pathogens.
- Decontamination services continue to be strengthened with central oversight, audits, and incident investigation.
- Surgical site infection (SSI) surveillance has expanded to include neurosurgery (both cranial and spinal). Collaborative work with divisions to review cases of SSI and initiate improvements is ongoing.
- IPC continued to be responsive and proactively managed outbreaks of respiratory viruses (influenza, COVID-19, RSV) and norovirus.
- Antimicrobial prescribing practices are highlighted in our response to the NHSE ‘Call to Action’.
- Antimicrobial stewardship has seen gradual improvement, although national consumption targets remain challenging. Workforce pressures in pharmacy and microbiology are being addressed.

### 2.3 Workforce, Education, and Research

- IPC STAM training compliance remains high across UHSussex at 94.3%, above the target of 90%.
- Capacity for fit testing respirators has been expanded across the Trust, with some areas at 100% compliance.



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- Staff vaccination uptake has improved, with 52% of substantive staff receiving influenza vaccine.
- During 2025–26, the IPC team at UHSussex strengthened its role as a leader in applied infection research, focusing on translating innovation into improved patient care, safety, and sustainability. Key developments included advancing pathogen genomics for infection prevention, establishing the GENOTIPE network as a national Specialist Interest Group and launching the Centre of Infection and Antimicrobial Research (CINAMR).
- The team expanded its research portfolio through major grant submissions, high-impact publications, and strong national and international engagement. Collectively, this work demonstrates a clear progression from research to implementation, positioning UHSussex at the forefront of efforts to address healthcare-associated infections, antimicrobial resistance, and sustainable healthcare delivery.

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### 2.4 Priorities for 2026/27

- **Achieve full compliance:** Aiming for full compliance with the IPC Board Assurance Framework, including antimicrobial stewardship and fit testing.
- **Strengthen surveillance and reduce healthcare-associated infections:** Expand SSI surveillance, strengthen post-discharge follow-up and case review processes, improve IV-line associated bloodstream infection prevention, and work collaboratively with clinical teams to identify contributory factors and deliver sustained reductions in surgical site infections across key specialties.
- **Embed audit and accountability:** Deliver robust audit feedback, ensure divisional accountability, and use PSIRF methodology for efficient capture and learning of infection investigations.
- **Assure environmental safety:** Support Facilities and Estates to maintain water, ventilation and environmental cleanliness standards across the Trust. Work with decontamination leads to maintain high standards of medical device cleaning.
- **Grow engagement:** Expand the IPC Link Champion programme and clinical engagement across all departments and sites.

- **Broaden research and innovation:** Enhance research skills and initiatives within IPC, promote sustainability projects, and increase regional and national impact through conferences and collaborations.

### 2.5 List of Abbreviations used in the document

| No. | Abbreviation | Full Text |
|---|---|---|
| 1 | 3Ts | Teaching Tertiary and Trauma |
| 2 | AMP | Anti-microbial pharmacist |
| 3 | BAF | Board Assurance Framework |
| 4 | BSI | Blood stream infection (bacteraemia) |
| 5 | CAG | Clinical Advisory Group |
| 6 | cDIPC | Corporate Director Infection Prevention Control |
| 7 | CDT | *Clostridioides difficile* toxin |
| 8 | CEO | Chief Executive Officer |
| 9 | CMO | Chief Medical Officer |
| 10 | CNO | Chief Nursing Officer |
| 11 | COCA | Community-onset community-associated |
| 12 | COHA | Community-onset healthcare-associated |
| 13 | COIA | Community-onset indeterminate-associated |
| 14 | COVID-19 | Coronavirus disease of 2019 |
| 15 | CPA | Clinical Pathology Accreditation |
| 16 | CPE | Carbapenemase-producing *Enterobacterales* |
| 17 | CQC | Care Quality Commission |
| 18 | CSSD | Central sterile services departments |
| 19 | DCS | Data Capture System |

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| | | |
|---|---|---|
| 20 | DDD | Defined Daily Dose |
| 21 | DIPC | Director of Infection Prevention Control |
| 22 | EDU | Endoscopy decontamination units |
| 24 | EUS | Endoscopic Ultrasound |
| 24 | ENT | Ear Nose and Throat |
| 25 | EPRR | Emergency preparedness resilience and response |
| 26 | EUCAST | European Committee on Antimicrobial Susceptibility Testing |
| 27 | FFP | Filtering Face Piece |
| 28 | HaSCA | Health and Social Care Act |
| 29 | HCAI | Healthcare-associated Infection |
| 30 | HOHA | Hospital-onset healthcare-associated |
| 31 | HPV | Hydrogen Peroxide Vapour |
| 32 | HTM | Health Technical Memorandum |
| 33 | ICB | Integrated Care Board |
| 34 | iGAS | Invasive Group A *Streptococcus* |
| 35 | IPC | Infection Prevention & Control |
| 36 | IPCT | Infection Prevention & Control Team |
| 37 | IPOG | Infection Prevention Operational Group |
| 38 | JAG | Joint Accreditation Group |
| 39 | JVCI | Joint Committee on Vaccination and Immunisation |
| 40 | ICD | Infection Control Doctor |
| 41 | IV | Intravenous |
| 42 | IVOS | Intravenous to oral switch |

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| | | |
|---|---|---|
| 43 | KPI | Key Performance Indicator |
| 44 | *K. pneumoniae, K. oxytoca, Klebsiella* spp. | *Klebsiella pneumoniae, Klebsiella oxytoca* and *Klebsiella* species |
| 45 | LIMS | Laboratory information management system |
| 46 | LMB | Louisa Martindale building |
| 47 | MDRO | Multi drug resistant organisms |
| 48 | MFU | Maxillofacial Unit |
| 49 | MPV | MPox virus (previously Monkeypox) |
| 50 | MRSA | Meticillin Resistant *Staphylococcus aureus* |
| 51 | MSM | Men who have Sex with Men |
| 52 | MSSA | Meticillin Sensitive *Staphylococcus aureus* |
| 53 | NHSE | National Health Service England |
| 54 | PA | Programmed activity |
| 55 | PLACE | Patient Led Assessment of the Care Environment |
| 56 | PPE | Personal protective equipment |
| 57 | PRH | Princess Royal Hospital |
| 58 | PSIRF | Patient Safety Incident Response Framework |
| 59 | QGSG | Quality Governance Steering Group |
| 60 | QSIP | Quality Safety Improvement Programme |
| 61 | RACH | Royal Alexandra County Hospital |
| 62 | RSCH | Royal Sussex County Hospital |
| 63 | SCFT | Sussex Community Foundation Trust |
| 64 | SRH | St Richards Hospital |

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| | | |
|---|---|---|
| 65 | SRO | Senior Responsible Officer |
| 66 | SSD | Sterile Service Department |
| 67 | SSI | Surgical Site Infection |
| 68 | SSISS | Surgical Site Infection Surveillance Scheme |
| 69 | STAM | Statutory and mandatory training |
| 70 | THR | Total hip replacement |
| 71 | TIPC | Trust Infection Prevention Committee |
| 72 | TKR | Total Knee replacement |
| 73 | UHSussex | University Hospitals Sussex NHS Foundation Trust |
| 74 | UKHSA | UK Health Security Agency |
| 75 | VIP | Visual infusion phlebitis |
| 76 | WGS | Whole-genome sequencing |
| 77 | WH | Worthing Hospital |
| 78 | WSP | Water Safety Plan |

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# 3. Introduction

Welcome to the annual Director of Infection Prevention and Control (DIPC) report for University Hospitals Sussex NHS Foundation Trust (UHSussex) for the financial year 2025-26. UHSussex serves a community of 1.9 million people and employs nearly 20,000 staff across seven main hospital sites and several smaller locations.

### 3.1 Remit of the report

This report summarises our infection prevention and control (IPC) and antimicrobial stewardship efforts and key learnings for the period April 1, 2025, to March 31, 2026. It includes all UHSussex sites.

- Royal Sussex County Hospital (RSCH)
- Royal Alexandra Children's Hospital (RACH)
- Sussex Eye Hospital (SEH)
- Princess Royal Hospital (PRH, Haywards Heath)
- Worthing Hospital (WH)
- Southlands Hospital (SH, Shoreham)
- St Richard's Hospital (SRH, Chichester)

Additionally, it covers services at Crawley & Worthing Sexual Health Service, Brighton General Hospital, Hove Polyclinic, Newhaven Hospital, and Park Centre for Breast Care. We also have IPC service contracts with two hospices in West Sussex.

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### 3.2 Compliance and Assurance

This report is based on the Hygiene Code framework (Table 1) and outlines our IPC arrangements. It highlights the projects and initiatives we have implemented over the past year to protect our patients from healthcare-associated infections (HCAIs). This demonstrates that our patients, staff, and the public can trust that we are meeting our obligations for patient safety and clinical governance.

We are pleased to report that UHSussex meets requirements of the CQC under the Health and Social Care Act 2008 regulations (otherwise known as the Hygiene Code). An overview of information for each of the criteria is found in the table below with the corresponding section of this report highlighted.

| Criteria | Health and Social Care Act (HaSCA) Criteria | Report Section and BAF RAG rating |
|---|---|---|
| 1 | Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of the service users and any risks that their environment and other users may pose to them. | 4 |
| 2 | The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. | 7 |
| 3 | Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance. | 8 |
| 4 | The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion. | 6 |
| 5 | That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people. | 5 |
| 6 | Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection. | 9 |
| 7 | The provision or ability to secure adequate isolation facilities. | 10 |
| 8 | The ability to secure adequate access to laboratory support as appropriate. | 11 |
| 9 | That they have and adhere to policies designed or the individual's care, and provider organisations that will help prevent and control infections. | 12 |
| 10 | That they have a system or process in place to manage staff health and wellbeing, and organisation obligation to manage infection, prevention and control. | 13 |

*Table 1: Health and Social Care Act 2008: Code of Practice on the prevention and control of infection (Hygiene Code).*

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## 4. Organisation and Governance of IPC Service

***HaSCA Criteria 1:*** *Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of the service users and any risks that their environment and other users may pose to them.*

**Compliance:** Green. Meets all required criteria with governance in place and CQC actions completed.

### 4.1 Governance framework

Every NHS Trust must designate a Director of Infection Prevention and Control (DIPC). At UHSussex, the Executive DIPC role is held by the Chief Nurse, Maggie Davies, with Corporate DIPC responsibilities undertaken by Pat Cattini, supported operationally by Sharon Reed as Deputy DIPC.

As part of the Trust's operating model restructure, the reporting arrangements for the Corporate DIPC function change during 2026. Whilst these arrangements align with the wider organisational structure, it remains important that governance arrangements continue to support a direct relationship between the Executive DIPC and the Trust's senior IPC professionals, ensuring the Executive DIPC receives timely expert advice, challenge and assurance in relation to infection prevention and control risks.

National guidance continues to emphasise the importance of the DIPC having sufficient authority, organisational influence and direct access to the Board to provide independent assurance regarding infection prevention and control risks. Maintaining clear lines of accountability and communication between the Executive DIPC and senior IPC professionals will remain an important component of effective IPC governance and organisational assurance.

The Trust’s Infection Prevention and Control Committee (TIPC) oversees all IPC activities and meets quarterly. The TIPC receives assurance reports from the Water Safety Group, Ventilation Safety Group, Decontamination Group, Antimicrobial Pharmacy, Surgical Site Surveillance Teams, Estates and Facilities, Capital development and Property, and Occupational Health. TIPC reports to the Quality Governance Steering Group (QGSG), which then reports to the Patient and Quality Committee, a sub-committee of the Executive Board.

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Monthly IPC Operational Group (IPOG) meetings, chaired by the Deputy DIPC, monitor progress on the IPC work plan. These meetings help address operational issues and escalate them to TIPC if needed. IPOG reports contribute to the quarterly TIPC report, summarizing IPC activities.

The statutory DIPC Annual Report and the Board Assurance Framework (IPC-BAF) are presented through TIPC.

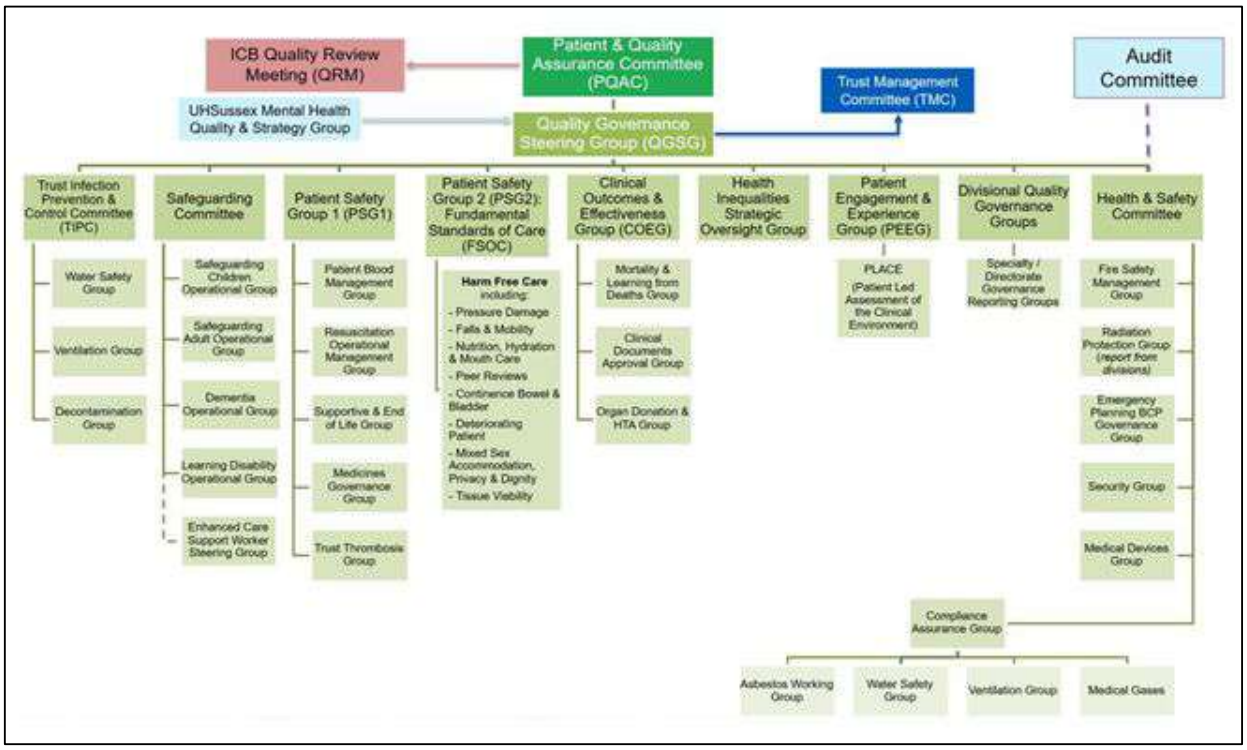


*Figure 1: University Hospitals Sussex Governance structure*

### 4.2 Infection Prevention and Control Team (IPCT)

Infection prevention is part of every role at UHSussex. The Infection Prevention and Control Team (IPCT) provides expert guidance and supports staff in maintaining high IPC standards. They ensure guidelines, policies, and protocols are up-to-date and effectively implemented to reduce HCAI. The IPCT focuses on educating staff, promoting proper antimicrobial use, advising on personal protective equipment (PPE), and the prevention and management of infection outbreaks and incidents.

The IPCT works closely with site and clinical teams to ensure safe patient placement and risk reduction. They are supported by Consultant Microbiologists and Virologists, an Infection Control Doctor (ICD, Dr James Price (4 PA's)), Infectious diseases physicians, antimicrobial pharmacists, and microbiology staff.

The team is structured to recruit and develop practitioners at various levels, ensuring sustainability and succession planning. Team members receive ongoing training and attend relevant professional development activities to maintain update skills. The IPCT has a presence on each of the four main sites, providing consistent advice across the organisation.

To address antimicrobial resistance, the IPCT works with the Trust's infection teams and Antimicrobial Pharmacists to promote safe antimicrobial use. IPC are key members of the antimicrobial stewardship group (lead by Dr Racheol Sierra and Joanne Munns)

IPC also work closely with the Estates and Facilities teams on environmental hygiene, decontamination, new builds, refurbishments, ventilation, and water safety.

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### 4.3 Key roles and responsibilities

The IPCT is responsible for all aspects of infection prevention and control across all staff groups. This includes managing outbreaks, alert organism management, environmental management, antimicrobial stewardship, education, and epidemiology. Their duties include:

- Providing expert advice to staff, patients, and visitors.
- Participating in surveillance, investigation, and management of HCAI and infectious diseases.
- Ensuring compliance with current legislation and guidance.
- Advising the trust staff on IPC legislation and compliance.
- Planning and implementing strategies to reduce HCAI, including mandatory training.

Ensuring all IPC policies and procedures are in place and up to date, to facilitate staff to deliver safe and effective care, such as hand hygiene, isolation and decontamination.

### 4.4 TIPC membership

The TIPC has a broad membership with representation from divisions and our partner organisations (see Appendix 1). TIPC terms of reference are reviewed and agreed annually.

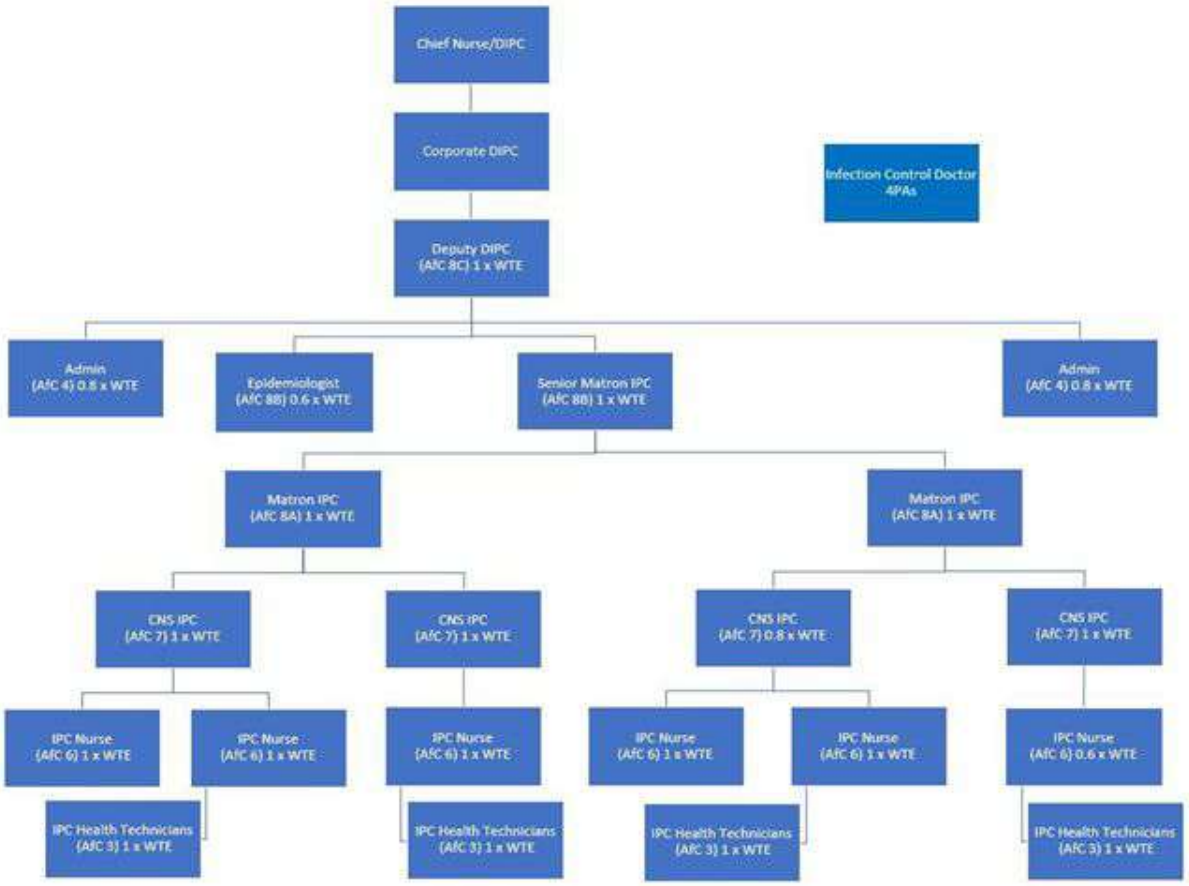


*Figure 2: Infection Prevention and Control Team structure at UHSussex*

### 4.5 IPC Board Assurance Framework (BAF)

The IPC BAF is formally updated annually and regularly reviewed to assure the Trust Board that IPC arrangements align with the National Infection Prevention and Control Manual (NIPCM) and the Health and Social Care Act 2008 (Hygiene Code).

The BAF includes 54 key lines of enquiry over the 10 domains of the Hygiene Code. The annual BAF assessment found that 6 domains are fully compliant and 4 partially compliant. Of the 54 elements, the trust is fully compliant against 40, and partially compliant against 14 with zero areas of non-compliance.

Areas of partial compliance were identified across aspects of Capital and Estates (Criterion 2), specifically relating to water safety, critical ventilation, laundry services, waste

management, and planned preventative maintenance. Mitigations and actions are in place to support delivery of full assurance.

Partial compliance was also noted in Antimicrobial Stewardship (Criterion 3), primarily due to limitations in Laboratory Information Management System (LIMS) provision, variable access to antimicrobial stewardship education, and restricted availability of data to support trend analysis and audit activity. A phased LIMS implementation is planned from March 2027 and will improve data quality, reduce manual data handling, and enhance the timeliness and consistency of surveillance reporting across UHSussex.

Staff fit testing (Criterion 6) has shown improvement, moving from a red to amber rating. The percentage of Trust staff who are fit tested has increased, however, compliance remains below the required level. Medical staff, whilst being fit tested, present a gap in assurance due to inability to document the skill on Health Roster systems. An electronic solution is being developed for implementation in 2026 to improve the accuracy, consistency, and assurance of fit testing data across all staff groups.

Occupational Health support (Criterion 10) was assessed as partially compliant, relating to response times for managing occupational exposure incidents in staff. It is anticipated that this risk will be mitigated through the Occupational Health service restructure implemented in 2026.

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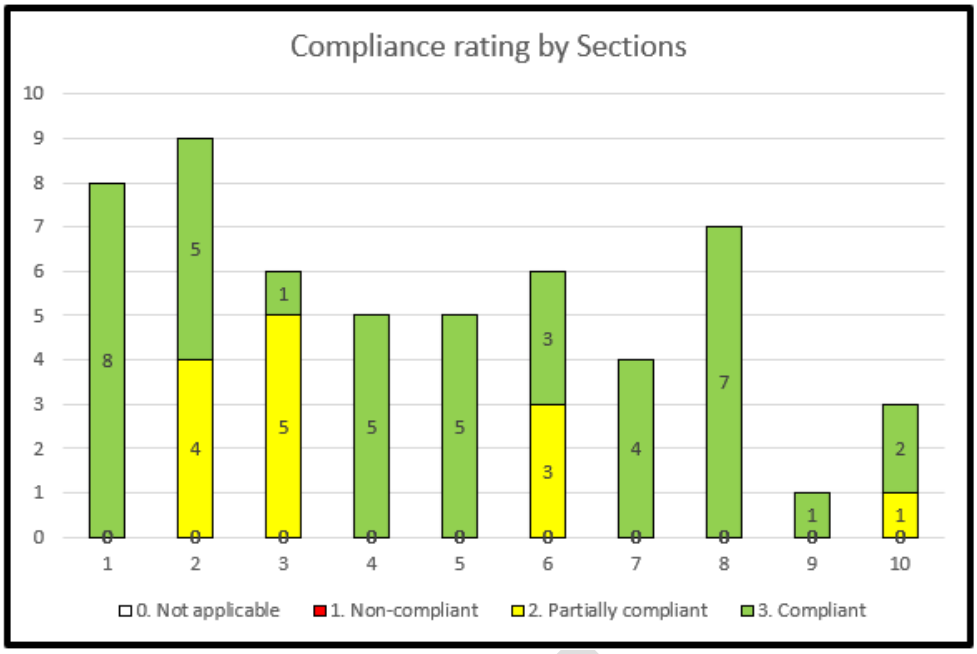


*Figure 3: Summary March 2026 BAF assessment of each section of the Hygiene Code (see table 2)*

The framework report acts as a gap analysis and allows us to prioritise areas for improvement going forward. Incomplete domains and elements are escalated through the QGSG for risk oversight. Key areas for improvement and actions are documented and a summary with associated actions is documented in Figure 3.

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### 4.6 BAF risks

In Table 2 we detail risks identified in the BAF with corresponding actions.

| Risk Identified | Actions |
|---|---|
| Critical ventilation failures | Physical mitigations are in place in non-critically ventilated areas (HEPA filtered air scrubbers, open windows/natural ventilation).<br>Trust wide plans for improvement of critical ventilation have been drawn up. Vanguard (modular) theatres will be introduced in 2026 to allow upgrade of the existing theatres on a rolling programme. Significant ventilation remedial work will be undertaken over the next 10 years. |
| Lack of planned preventative maintenance in some areas inhibiting environmental cleaning. | Estates are working with IPC and hospital leadership teams to effect repairs in prioritised areas. An Estates Improvement Group has overseen strategic plans for significant capital investment to improve the Estate. |
| Sub-optimal waste handling | Local audits are showing some non-compliance with correct segregation of waste at source. There is limited waste support and education across the Trust. Appointment of a new Waste Officer is expected to strengthen oversight and improve compliance. |
| Non-compliance with segregation of laundry at source | Non-compliance with segregation of laundry at ward level has led to an excess of red laundry bags, which is being addressed with support from the IPC team. |
| Limited antimicrobial stewardship service across UHSussex | A pharmacy recruitment drive last autumn has improved AMS support within clinical areas.<br>There is still a need to improve use of pathology data to understand prescribing data, trends and antimicrobial resistance patterns.<br>The AMS team have developed an action plan in response to the NHSE 'Call to Action' to address antimicrobial stewardship challenges. Impact will be monitored through Trust AMS meetings, which will report to quarterly TIPC meetings. |
| Sub-optimal fit testing for staff | Substantive fit testers have now been recruited and are making good progress in increasing staff fit testing compliance across the Trust. |
| Imperfect Occupational Health service provision at UHSussex sites | Planning for enhanced availability and service for screening; exposure risk assessments and staff vaccination support.<br>A single Trust wide OH service was launched in April 2026. It is anticipated this will harmonise OH services. |

*Table 2: Themes identified in 2025/26 BAF assessment*

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### 4.7 IPC Risk Register

The IPC risk register is reviewed and updated every two months.

Three significant risks (score over 12) are detailed on the IPC risk register, as detailed Table 3 below.

| Risk identified | Score | Risk Summary | Mitigations and actions |
|---|---|---|---|
| Critical ventilation failures | 16 | **Effective mechanical ventilation prevents transmission for infectious agents in the air.**<br>There are several reports of failure in critical ventilation systems across the Trust. This includes operating theatres and WH and SRH, additionally SSD on all main Trust sites. There are concerns about pharmacy and lack of clarity around mortuary and laboratories. Many of the wards are thought to be inadequately ventilated and do not meet HTM ventilation standards.<br>Theatres and SSD have repairs as needed but require significant PPM to maintain expected standards. | Mitigation at ward level include use of portable HEPA filter machines and opening windows.<br>Ventilation steering group meet monthly to review risks<br>Ventilation systems have been prioritised for PPM and for upgrades as needed.<br>Mobile theatres have been deployed at PRH and SRH to enable upgrade of existing infrastructure. |
| Delayed annual deep clean and hospital maintenance programme | 12 | **Effective cleaning prevention transmission of infectious agents from the environment.**<br>Health and Social Care Act Code of practice criterion 2 states the Trust 'must provide and maintain a clean and appropriate environment in managed premises which facilitates the prevention and control of infections'.<br>Annual deep cleaning and estates maintenance programme is behind schedule due to increase in capacity, workforce constraints and no decant areas being available. | The deep cleaning is planned within the summer 2026 to avoid clashing with winter pressures throughout the Trust.<br>Planned deep cleaning is scheduled at times when wards are closed for refurbishment. |
| Non-compliant clinical handwash basins in many | 12 | **Non-compliant sinks are associated with transmission of waterborne pathogens to patients.** | A programme to assess all basin compliance is being developed through WSG. |

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| | | | |
|---|---|---|---|
| areas of the Trust | | Many of the hand wash basins across the trust are non-compliant with national standards.<br>Defects include incorrect size, damage material, incorrect placement of taps and drains, incorrect tap design, strainers in situ, overflow in situ, inappropriate IPS panel, slow drainage, water pressure too high. Many sinks have multiple defects. | A replacement programme needs to be initiated to replace based on priority. |

*Table 3: IPC risk register*

### 4.8 CQC Action Plan

Following the CQC inspection in August 2023, the trust completed the required actions which include aspects of IPC. There were 7 identified areas for improvement. Evidence of compliance was collated and monitored by the CQC steering group. This work is now 'business as usual' and thus monitored through TIPC on a quarterly basis.

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## 5. Healthcare-associated Infection surveillance Mandatory Reporting

***HaSCA Criteria 5:*** *There is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.*

**Compliance: Green,** Assurance can be provided that all policies are current and are reviewed on a three-year cycle, with interim reviews undertaken where national guidance or regulatory requirements change.

At UHSussex, IPC and infection teams continuously monitor for infections to ensure early detection and effective management. During working hours, the IPCT visits clinical areas daily, attend operational site meetings, and reviews microbiology and virology results throughout the day. Outside of these hours, microbiology on call provides IPC specialist advice. Site teams monitor and manage patients with suspected or known infections, passing

information to the IPCT as soon as possible. The Microbiology team communicates any key infection indicators or early warnings to the IPCT.

### 5.1 Key Infection Categories

All Trusts in England are mandated to submit monthly data on 6 key healthcare-associated infections to the UK Health Security Agency (UKHSA) Data Collection Scheme (DCS). Healthcare-associated infections are defined as follows, and are attributed to the Trust:

- **Hospital Onset Healthcare Associated (HOHA):** Infections detected in the hospital two or more days after admission.
- **Community Onset Healthcare Associated (COHA):** Infections occurring in the community or within two days of admission, if the patient was an inpatient in the reporting Trust within the previous four weeks.

All NHS organisations are set specific HCAI thresholds, calculated annually based on Trust's previous infection rates, incorporating a 10% reduction. They do not consider the specialty or acuity of the individual organisations. To this end, IPC also review HCAIs as rates per 100,000 bed days, supporting more equitable comparisons with other trust accounting for size.

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### 5.2 Performance Summary:

- The UHSussex HCAI infection rates across all six mandatory surveillance metrics exceeded national thresholds (where available).
- When compared to other Trusts in the South-East, UHSussex infection rates per 100,000 bed days are comparable to (or in some cases better) than those of other hospitals (see Table 4).
- This highlights the importance of measuring infection rates rather than absolute numbers to understand acute trust level infection performance over the past year.
- IPC continue to utilise Microsoft Power BI tools to optimise mandatory national HCAI surveillance reporting, including risk factor collation and analysis. IPC have undertaken a Divisional level analysis, looking at trends in key reportable healthcare-associated infections, summary on which is provided alongside each 'key organism'.

| Mandatory reportable infections | Q1 | Q2 | Q3 | Q4 | Year to date cases | UKHSA Annual threshold F25/26 | Comparison to UKHSA annual threshold |
|---|---|---|---|---|---|---|---|
| Meticillin-resistant *Staphylococcus aureus* (MRSA) BSI | 1 | 0 | 2 | 2 | 5 | 0 | Over Threshold |
| Meticillin-sensitive *Staphylococcus aureus* (MSSA) BSI | 18 | 22 | 25 | 25 | 90 | No threshold | No Threshold |
| *Escherichia coli (E. coli) BSI* | 55 | 59 | 61 | 59 | 234 | 208 | Over threshold |
| *Klebsiella species* BSI | 18 | 21 | 18 | 14 | 71 | 67 | Over threshold |
| *Pseudomonas aeruginosa (P. aeruginosa)* BSI | 15 | 9 | 15 | 6 | 45 | 36 | Over threshold |
| *Clostridioides difficile (C. difficile)* infection | 45 | 45 | 41 | 35 | 166 | 152 | Over threshold |

*Table 4: Summary of mandatory reportable healthcare-associated infections at UHSussex by quarter. Results are RAG rated against national quarterly threshold (red = above threshold, orange = meets threshold, green = below threshold, grey = no national threshold provided). 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. DCS = UKHSA data capture system. YTD = year to date. Key: NA = no national ceiling available, MSSA = Meticillin resistant S. aureus, MRSA = Meticillin resistant S. aureus, BSI = blood stream infection*

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- The key takeaway from the Statistical Process Control (SPC) charts below which span the period March-2023 to March 2026, is the absence of upper control limit violations, indicated by red dots, i.e. the trend in hospital associated infections, across the 6 indicators, have fallen within the limit of expected variation. Note that the SPC charts below take into account number of infections only; with rates of infection understood to be a better indicator of performance as it takes into account activity – bed days.

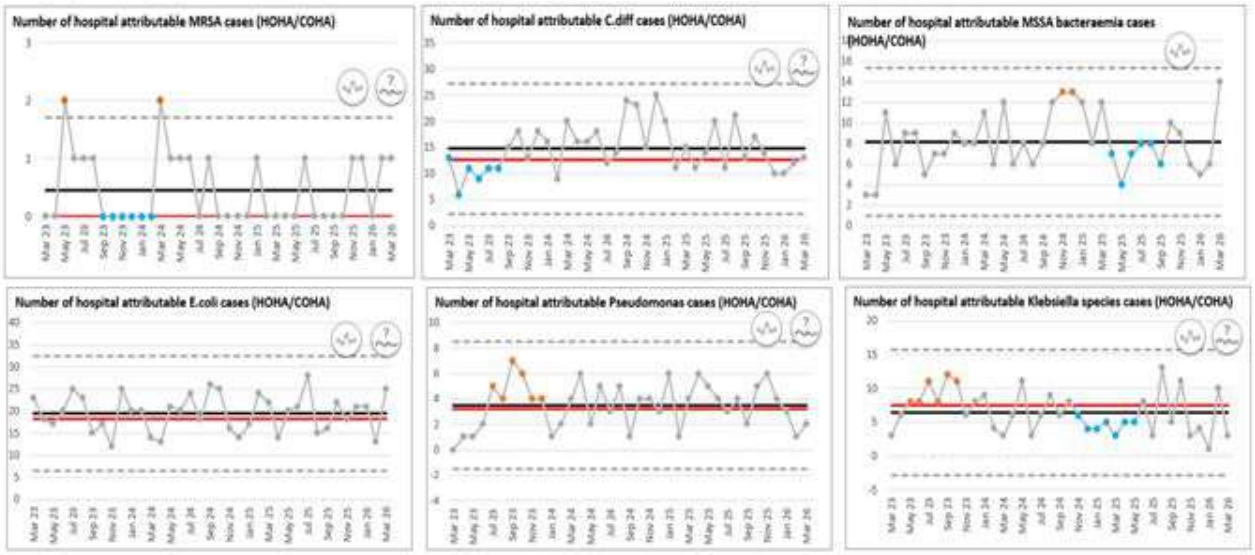


*Figure 4: Statistical Processing Control Charts as presented in the monthly integrated board report.*

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### 5.3 Healthcare-associated *Staphylococcus aureus* bloodstream Infections

Healthcare-associated *S. aureus* bloodstream infections, including both Meticillin-sensitive (MSSA) and Meticillin-resistant (MRSA) strains, are clinically significant due to their high morbidity and mortality rates, especially in vulnerable patients. These infections often result from invasive procedures and prolonged hospital stays. MRSA is particularly challenging due to its resistance to many first-line antibiotics. While MSSA can be treated with a broader range of antibiotics, prompt and effective management is crucial to prevent severe complications. Both MSSA and MRSA infections underscore the need for stringent IPC measures to prevent transmission and outbreaks. Early detection and targeted antimicrobial therapy are essential for improving patient outcomes and reducing the healthcare burden.

### 5.4 MRSA

- **Reported Cases:** In 2025/26, there were five healthcare-associated MRSA BSI against a UKHSA threshold of zero cases (Figure 5).
- **Infection Rates:** The cross-Trust rate was 0.7 per 100,000 bed days against a London rate of 1.73 and a Southeast rate of 1.27 (range 0.47-2.34) (Figure 6)

- **Hospital-Onset Cases:** Of the 5 reportable cases there were 2 HOHA's (1 case due to a contaminated specimen rather than patient infection but still meet the criteria to be reported) and 2 COHA.
- **Investigations and Actions:** Clinical and epidemiological evidence points to an increasing trend in MRSA and MSSA infections associated with vascular access devices. A Trust wide multidisciplinary group has been established to optimise management of peripheral IV access. The workstreams include:
    - Embedding learning by encouraging good practice
    - Ensuring policy and guidelines map to national practice and are up to date
    - Driving education and competency, including Aseptic-non-touch-technique (ANTT) and effective use of Visual Infusion Phlebitis (VIP) scores.
    - Driving effective monitoring and audit of cannula insertion and care.
    - Standardised incident investigation and management using the PSIRF framework

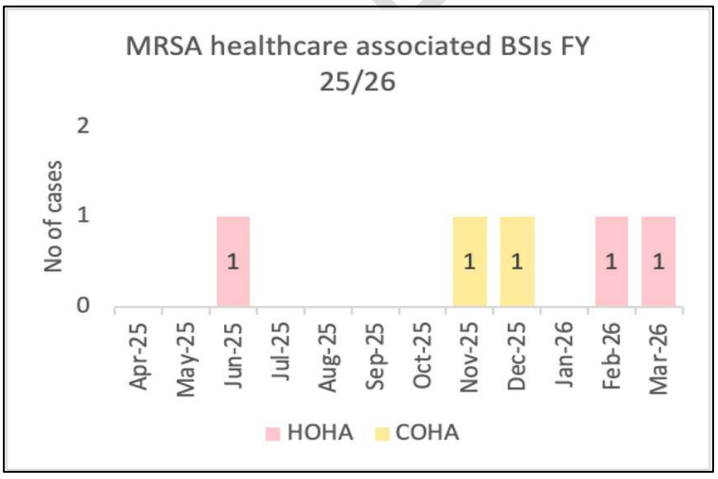


*Figure 5: Healthcare-associated MRSA BSIs at UHSussex by month.*

A separate group is looking more closely at MRSA and MSSA bacteraemia cases to identify learning. We are also working on a unified *Staphylococcus aureus* policy (MSSA and MRSA). Further work is ongoing to standardise use of suppression therapy, and timeliness of prescribing.

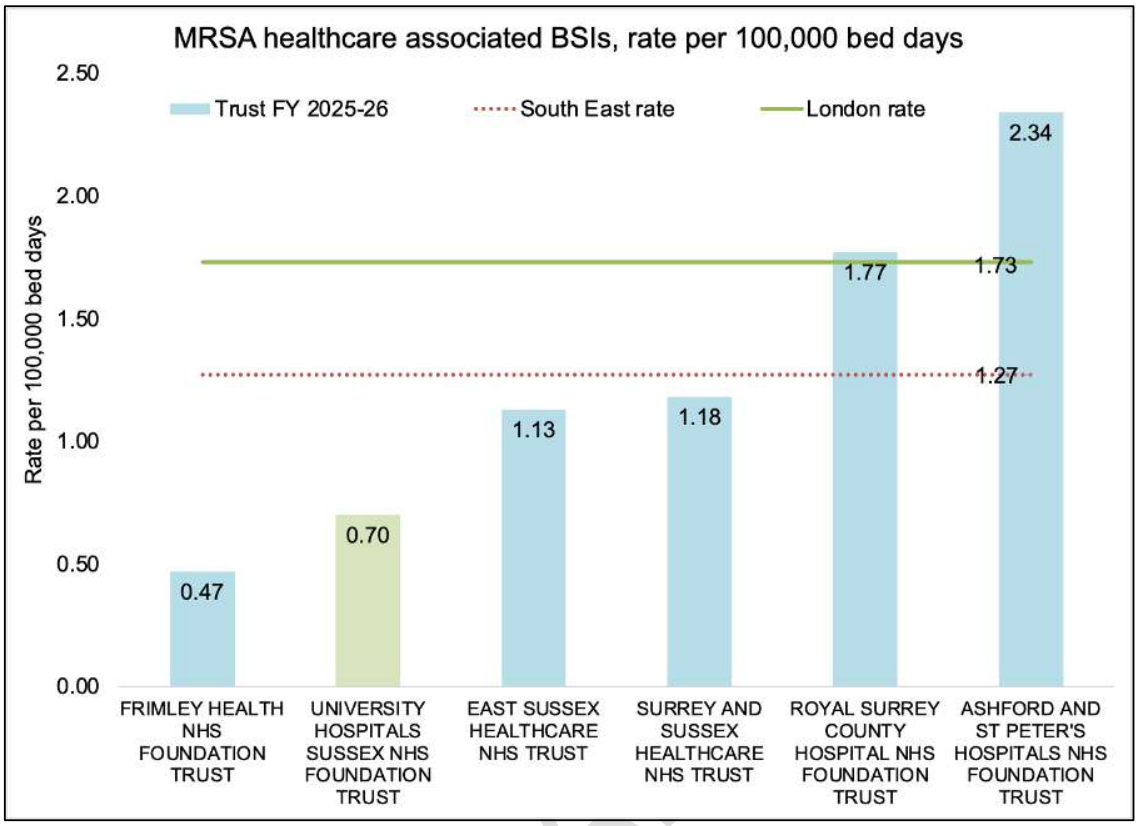


*Figure 6: MRSA healthcare associated BSI rate comparison – South-East region and London.*

### 5.5 MSSA

- **Reported cases:** In 2025/26 there was a total of 90 healthcare-associated MSSA BSI reported (Figure 7). There is no national target for these cases. This compares with 116 cases in 2024/25 representing a 22.4% reduction.
- **Infection rates:** We observed a rate of 12.7 per 100,000 bed days against a London rate of 12 and a Southeast rate of 13.18 (range 10.22 – 16.13) (Figure 8)
- **Investigations and Actions:** As noted above for MRSA, both clinical and epidemiological evidence points to an increasing trend in vascular access device associated cases, and work is ongoing with multidisciplinary colleagues to optimise IV device management.
- In addition, there is a weekly review of all *S. aureus* blood cultures with enhanced investigation of risk factors to establish learning. This work will then feed into the PSIRG.

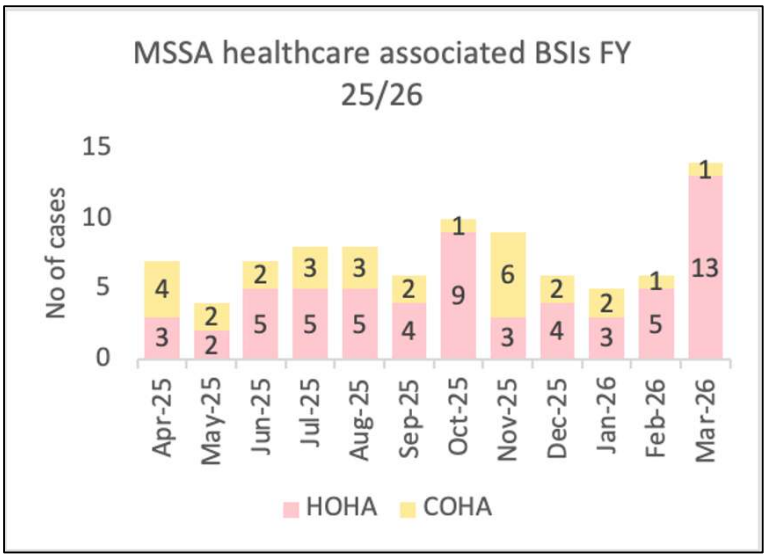


*Figure 7: Healthcare-associated MSSA BSIs at UHSussex by month.*

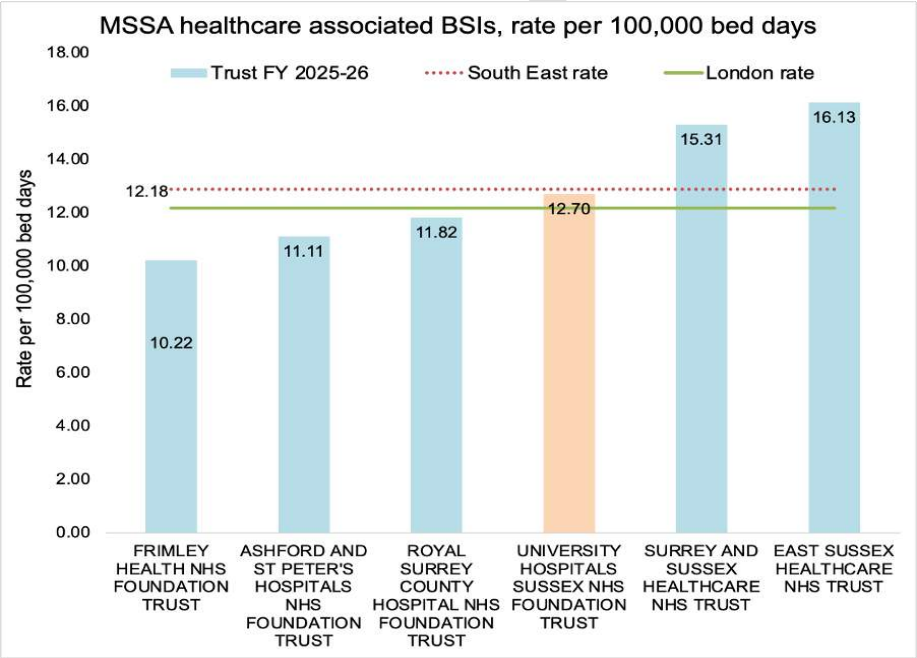


*Figure 8: MSSA healthcare associated BSI rate comparison – South-East region and London.*

### 5.6 *C. difficile* infections

*C. difficile* infections (CDI) are a major concern due to their high morbidity, mortality, and healthcare costs, especially among elderly and immunocompromised patients. These

infections often occur after antibiotic use, which disrupts normal gut bacteria, leading to severe diarrhoea and potentially life-threatening complications like toxic megacolon and sepsis. The recurrent nature of these infections makes treatment challenging and increases the risk of long-term health issues. As with other infections monitored as part of the DCS, CDI has shown a rise nationally since the COVID-19 pandemic.

- **Reported cases:** In 2025/26, there were 166 cases of healthcare-associated *C. difficile* infections reported, against a UKHSA threshold of 152 (Figure 9). This is a 20% year on year reduction when compared with 209 cases in 2024/25.
- **Infection rates:** UHSussex observed a rate of 23.43 per 100,000 bed days against a London rate of 21.8 and a Southeast rate of 24.4 (Figure 10). In 2024/25 the trust rate was 32.67 per 100,000 bed days, suggesting a local reduction of 28.3%.
- This reduction following our *C. difficile* action plan initiatives. Q4 had the lowest healthcare-associated *C. difficile* rates, and this was at a time of enhanced faecal sampling (due to Norovirus prevalence).

- **Investigations and actions:**
  - **Reinforcement of IPC Measures:** Hand hygiene, environmental cleaning, and careful antibiotic use are crucial to prevent the spread within healthcare facilities.
  - **Early Diagnosis and Management:** Prompt diagnosis through prompt faecal sampling and isolation of symptomatic patients, and targeted antimicrobial therapy are essential to improve patient outcomes.
  - **Characterising the type and relatedness of strains (Ribotyping)** helps support undertaking of whether a potential transmission has occurred between patients and allows identification of specific strains of *C. difficile* that are hard to control during outbreaks or may lead to poor clinical outcomes. This method is used when there is an increase in cases of suspected transmission within the same area and time frame.
  - Current thematic analysis of *C.difficile* cases highlights sub-optimal IPC practices, particularly in relation to untimely isolation due to lack of available side rooms (in 1/4$^{th}$ of cases), poor commode cleanliness and improper hand hygiene, within the context of extensive proton-pump inhibitor and antibiotic use in patients, adding to

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the risk of *C.difficile* acquisition. Themes are reviewed monthly at the IPC led CDI panel meetings, with case specific actions undertaken, including discussions at ward and speciality level regarding learning opportunities to take forward.

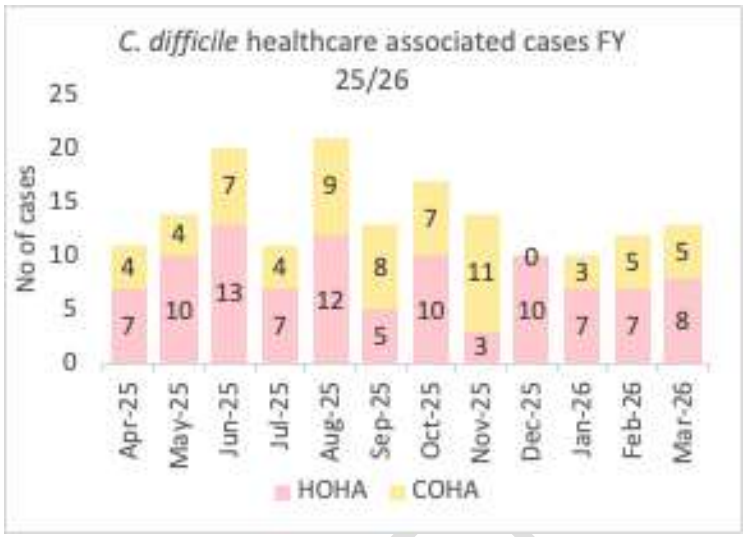


*Figure 9: Trend in healthcare-associated C.difficile infections, FY 2025/26*

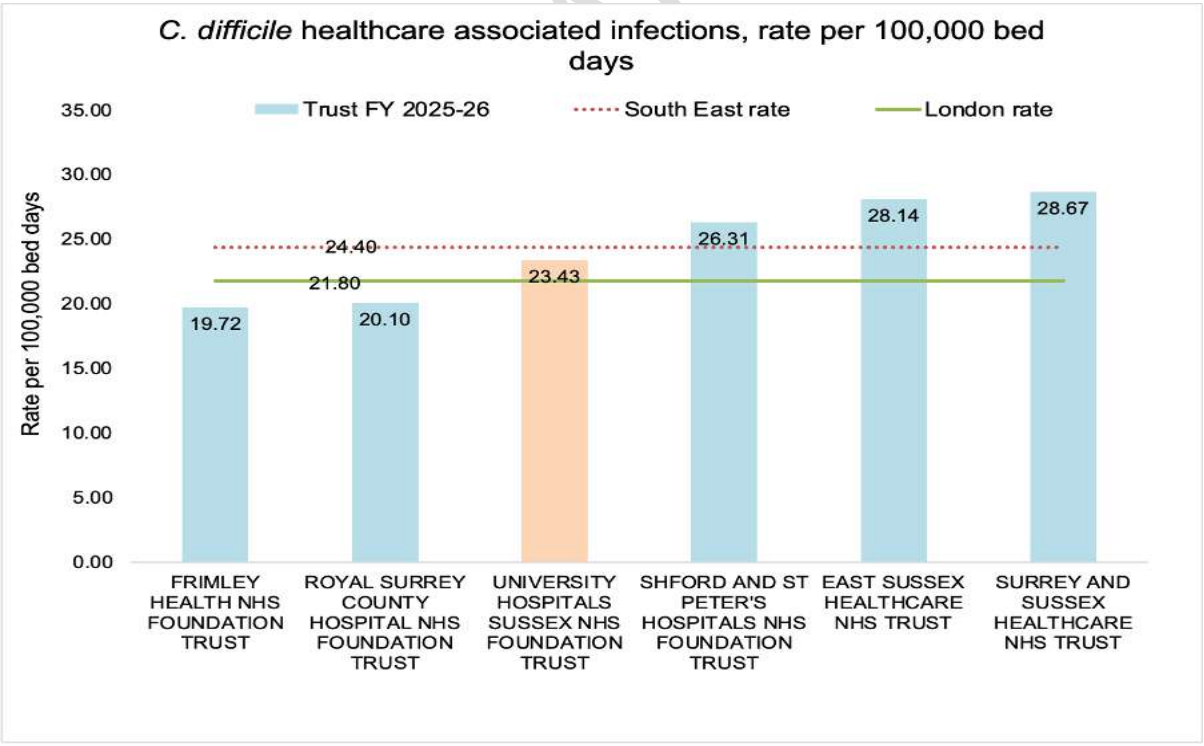


*Figure 10: C. difficile healthcare associated infection rate comparison – South-East*

### 5.7 Gram-negative blood stream infections

Infections caused by Gram-negative bacteria like *E. coli*, *P. aeruginosa*, and Klebsiella species are serious due to their high associated morbidity and mortality. This is complicated by theirability to develop resistance to multiple antibiotics, requiring (where available) treatments associated with significant patient side effects. Infections caused by these organisms are commonly associated with urinary or gastrointestinal sources. These infections often occur in patients with long hospital stays, invasive devices, or underlying health conditions, leading to severe complications such as septic shock and organ failure.

- Effective IPC Measures are Crucial to prevent the spread of these infections, and prompt diagnosis and targeted therapy is essential to manage infections and improve patient outcomes.

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### 5.8 *E. coli* Infections

- **Reported Cases:** There were 234 healthcare-associated *E. coli* BSI's, exceeding the UKHSA threshold of 208 cases (Figure 11).
- **Infection Rate:** The UHSussex rate (33.0) is comparable to rates observed in London (33.6) and below the average South-East rate of 42.8. UHSussex sits second lowest across South-East Trusts (Figure 12).
- **Investigations and Actions**
    - Thematic risk factor analysis showed that 23% of BSIs over a 10-month period were attributable to urinary tract infection with a further 12% linked to a hepatobiliary source.
    - Hydration is increasingly recognized as a crucial factor in reducing Gram-negative BSI. The Trust is part of a Sussex-wide project led by the ICB to explore how promoting hydration can help reduce these infections. This two-year collaborative project focuses on improving the hydration status of people over 65 living in their own homes. It involves using a hydration plan and addressing educational barriers to proper hydration. Additionally, we aim to better understand the origin and specialty of *E. coli* bacteraemia to develop a targeted strategy for reducing their incidence.

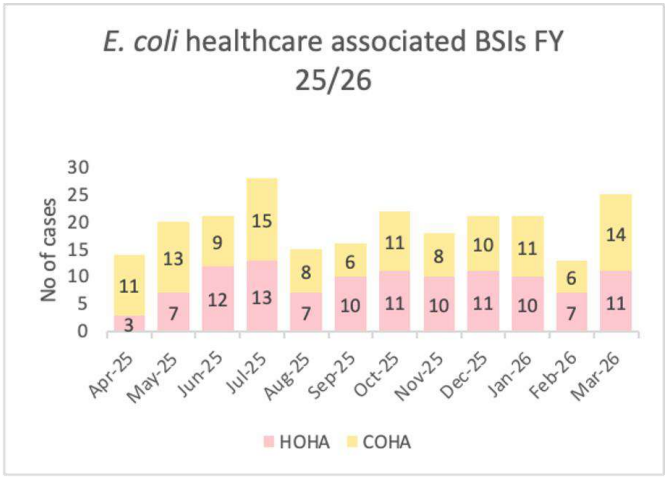


*Figure 11: Healthcare-associated E. coli BSIs at UHSussex by month*

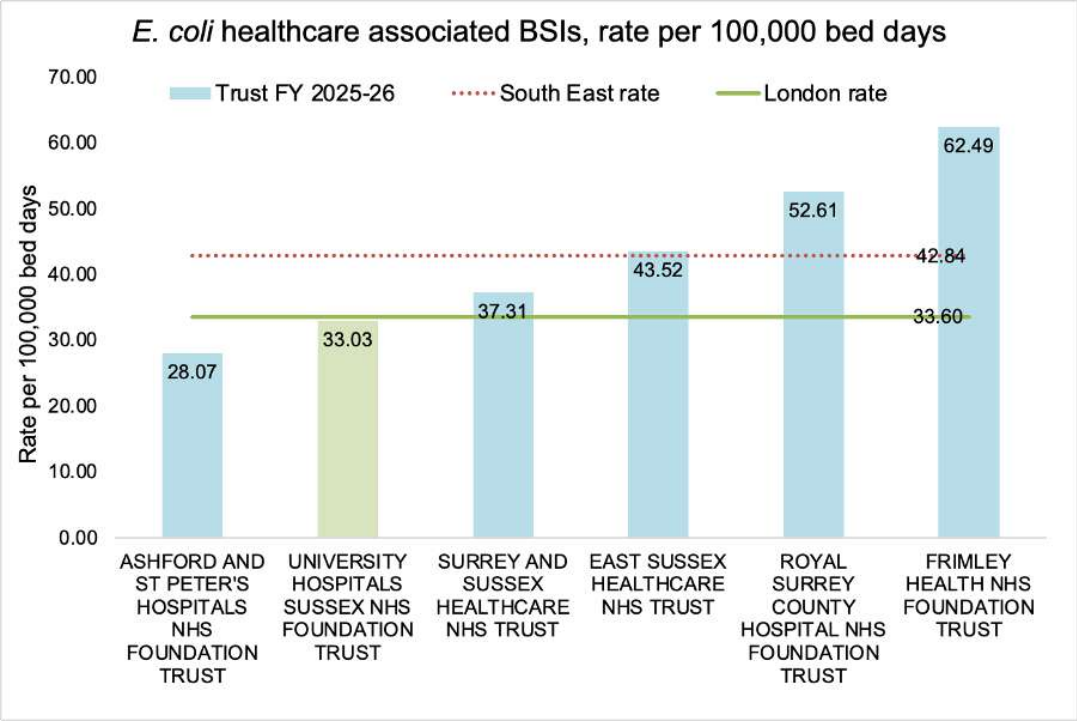


*Figure 12: E. coli healthcare associated infection rate comparison – South-East region and London.*

### 5.9 *Pseudomonas aeruginosa*

- **Reported cases:** There were 45 healthcare-associated *P. aeruginosa* BSIs reported, exceeding the UKHSA ceiling of 36 (Figure 13).
- **Infection rates:** The UHSussex rate (6.35) sits below both the London (9.0) and the South-East (7.0) rate (Figure 14).

- **Investigations and actions:** Risk factor thematic analysis showed that 20% of all BSIs over a 10-month period were attributable to urinary tract infections. Actions undertaken to reduce UTI incidence in *E. coli* apply here.

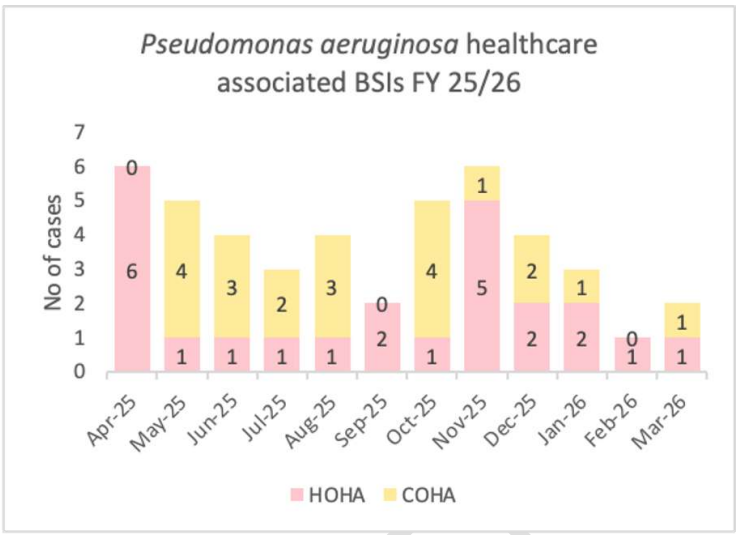


*Figure 13: Healthcare-associated P. aeruginosa BSIs at UHSussex by month.*

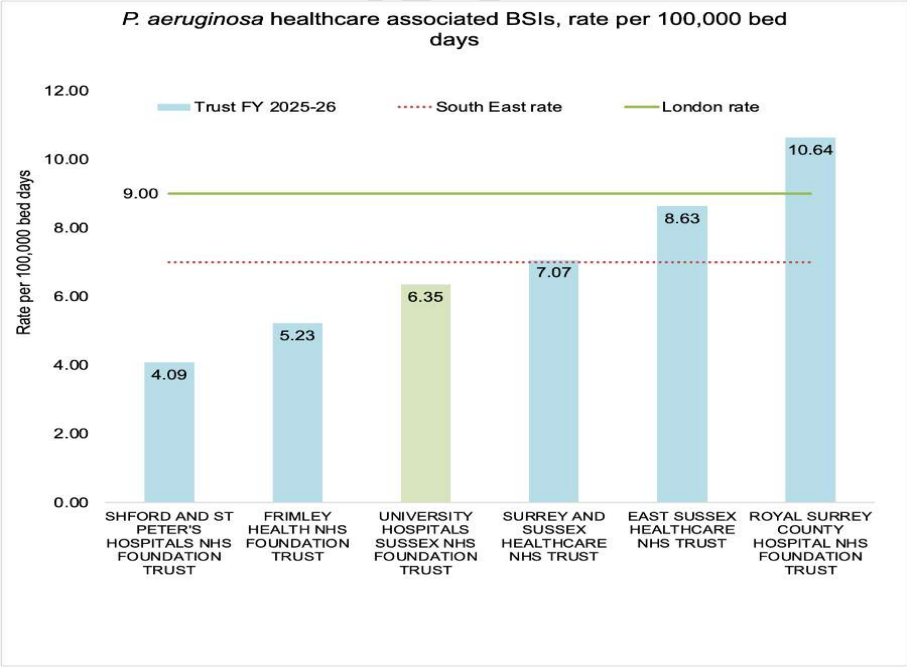


*Figure 14: P. aeruginosa healthcare associated BSI rate comparison – South-East region and London.*

### 5.10 Klebsiella species

Unlike *E. coli* and *P. aeruginosa* where we are mandated to report HCAI on individual species, UKHSA mandate reporting of all HCAI caused by all 13 Klebsiella species, with *Klebsiella pneumoniae and Klebsiella oxytoca* among the most common.

- **Reported cases:** There were 71 cases of healthcare-associated *Klebsiella* spp. BSI above the threshold of 67 (Figure 15). Nationally, healthcare-associated *K. pneumoniae* bloodstream infections have been consistently rising.
- **Infection rates:** The UHSussex rate (10.0) sits lowest amongst the South-East NHS Trusts, and lower than the London (18.7) and South-East (12.9) rate (Figure 16).
- **Investigations and actions**:
    - Risk factor analysis showed 23.4% of all *Klebsiella* spp. BSI are associated with urinary tract infections. Actions undertaken to reduce UTI incidence in *E. coli* apply here.
    - As part of our response to understand trends in Gram-negative BSI, and with access to whole-genome sequencing as part of IPC research, the IPC team are leading further investigation to identify any environmental links with patient cases.

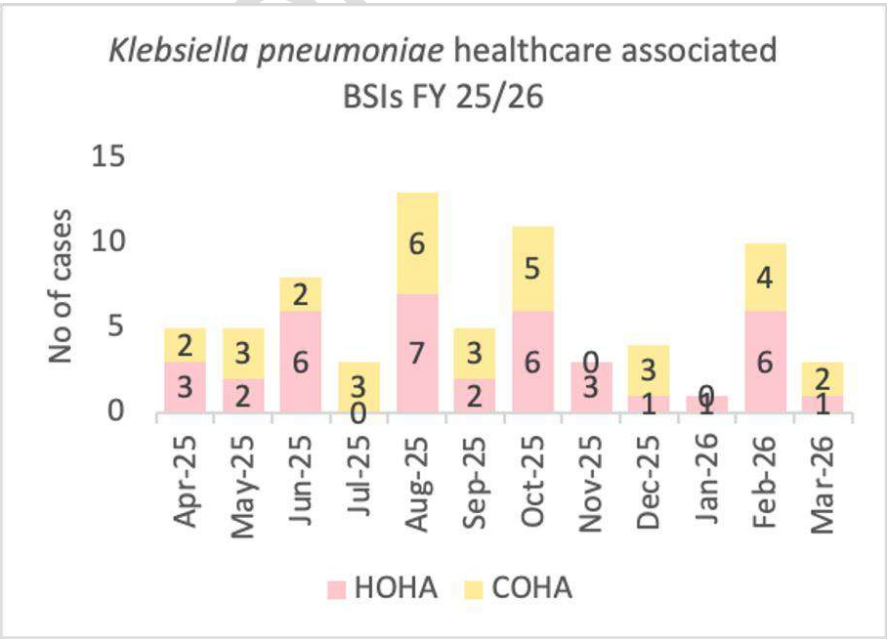


*Figure 15: Healthcare-associated Klebsiella. spp BSIs at UHSussex by month.*

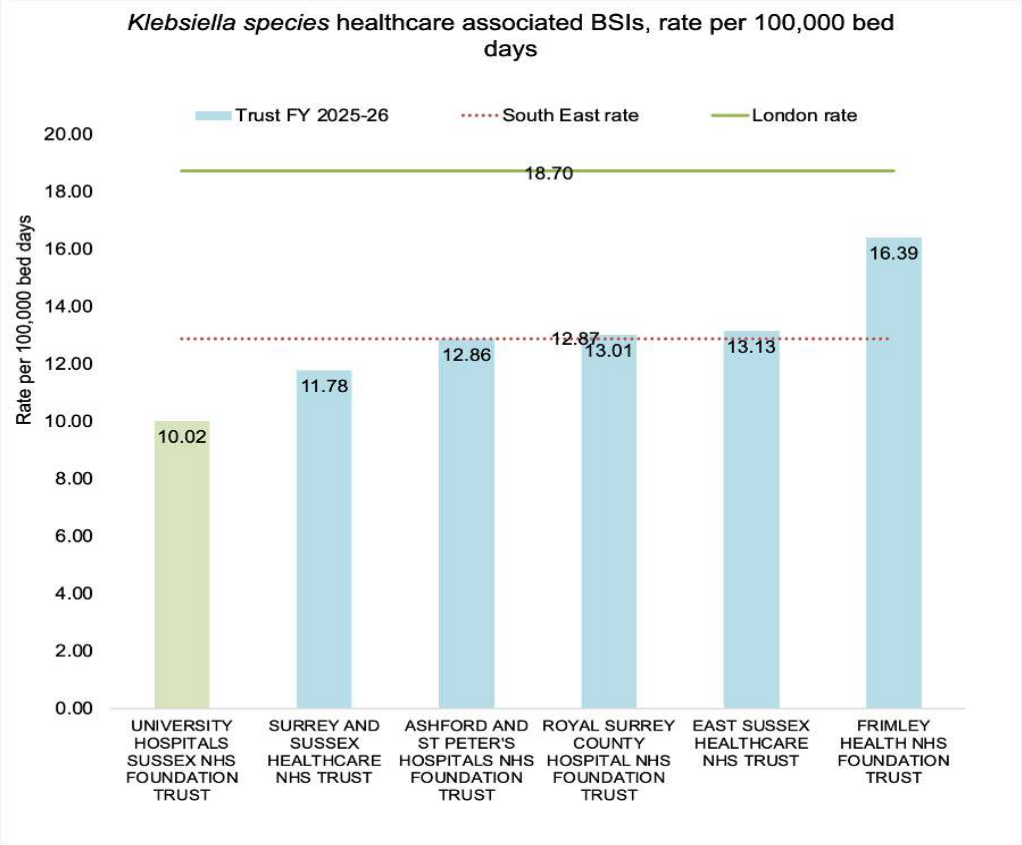


*Figure 16: Klebsiella species healthcare associated BSI rate comparison – South-East region and London.*

### 5.11 Multi-Drug Resistant Organisms (MDROs)

MDROs refer to organism resistant to multiple types of treatments, making infections difficult to treat. Most commonly there are bacteria resistant to multiple classes of antibiotics. At UHSussex, MDROs are not endemic, and cases remain sporadic. We have a screening programme for high-risk individuals, to enable early detection and appropriate management.

In summer 2025 a patient was admitted to UHSussex who returned from Greece to Worthing hospital with an organism (*Acinetobacter baumanii,* a pathogen that is known to cause severe HCAI, particularly for patients admitted to critical care*)* which was resistant to all antibiotic treatment options. The patient did not require treatment for this organism, they survived and there was no evidence of cross transmission to other patients. This is the second time UHSussex have successfully managed this type of pan-resistant organism, but this occurrence (alongside increasing observations nationally) provides a signal of the increased

periodicity with which we are observing these types of organism. With no effective treatments, prevention of infection is essential.

These organisms raise several IPC issues and pose a significant risk, as if they spread, they may cause untreatable infections. As these organisms live in the bowel and hence colonise wastewater in hospitals via excreta into toilets, preventing patients' excreta entering hospital wastewater (termed waste stewardship) is an approach pioneered at UHSussex to minimise risk of transmission into the hospital environment (in addition to standard IPC measures). Waste stewardship is now in place for patients colonised with MDROs (and those receiving last-line antibiotics) to reduce contamination of drains with the MDROs and reduce pressures of antibiotics which might drive resistance. This work has been published in the Journal of Hospital Infection, and a service evaluation is planned for Q1 2026 to inform on staff & patients' experience of waste stewardship.

### 5.12 Respiratory viruses

The IPC team promoted use of the quadruple lateral flow test that detects influenza A and B, RSV and COVID-19. The use of LFD is about 1/10$^{th}$ of the cost of a PCR test, and the result is available in 10 minutes (as opposed to 6–12-hour turnaround time offered by laboratory-based PCR testing).

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**5.12.1 Influenza A and B:** The 2025/26 influenza season was predicted to be severe and started much earlier than usual. Significant efforts were made to encourage staff to have their free flu vaccination. The season peaked in December 2025 and may have been due to the virus ‘drifting’ against the vaccine for this season. This is not unusual. Point of care test supported to prompt patient diagnosis, management and isolation supporting operational flow.

The 2025 staff influenza vaccination campaign ran from October 25 to January 26 delivering over 10,000 vaccinations to staff across the Trust. 52.5% of staff had an influenza vaccine. UHSussex were one of 23 (of 28 trusts) in the South-East region to exceed the targets set by NHSE, and the South East was third highest region in England for uptake. National NHS trust frontline healthcare worker uptake in 2025/26 was 45.0%.IPC produced and updated the ‘IPC Winter Action Cards’, which summarise key management aspects for confirmed or suspected

respiratory tract infections were reviewed and reissued across the trust. Outbreak control meetings were held daily or as needed to review cases and management and affected wards received daily support from the IPC team.

**5.12.2 COVID-19:** Symptomatic COVID-19 patients were seen throughout the year, with a small peak in early autumn. This led to bay closures but few full ward closures. Continuous education and training on IPC precautions were promoted. Healthcare workers were not offered a COVID-19 vaccine this year as per Joint Committee on Vaccination and Immunisation (JCVI) advice.

**5.12.3 RSV:** The RSV season was consistent with national rates, with no healthcare-associated outbreaks.

### 5.13 Norovirus

Throughout the year there were intermittent cases of Norovirus with most occurring during winter months, mirroring national trends. Several ward outbreaks occurred particularly in Q3 and Q4. During December 2025 there were multiple outbreaks at SRH. Some IPC practices fell short of the expected high-level standards and educational support was provided. During March 2026 there were multiple wards affected at Worthing Hospital. Again, some IPC practices fell short and were addressed during a post outbreak review. Daily outbreak meetings were held, and the IPC team provided intensive support to the affected wards.

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### 5.14 High Consequence Infectious Disease (HCID)

To ensure that the trust is prepared for any HCID the IPC Team, alongside the infection, site and ED teams, have ensured that the multi-disciplinary teams on each site have discussed the safest and least risk averse admission pathways for patients suspected of having a a HCID. Safe assessment, testing and admission pathways for all suspected HCID, are now in place for emergency departments across UHSussex. ‘Live’ action cards have been developed and are available on the intranet.

A HCID PPE ensemble training course is now available on the IRIS platform to relevant staff. In addition to which bespoke face-to-face PPE ensemble training is being delivered by IPC.

## 6. Information on infections

***HaSCA*** *Criteria 4 The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.*

**Compliance: Green,** The Trust continues to meet all UKHSA mandatory Surgical Site Infection surveillance requirements. Furthermore, surveillance activity extends beyond the mandatory programme to include a broader range of surgical specialties, providing enhanced assurance, supporting continuous quality improvement, and strengthening patient safety oversight.

### 6.1 Data Management

The IPCT is dedicated to supporting public health by effectively managing and communicating important IPC results to both internal and external stakeholders. Our IPC epidemiologist has enabled us to use data more effectively to identify trends and improve patient safety and quality outcomes. The procurement of the new pan Sussex Laboratory Information Management System (LIMS) will improve data management but has unfortunately been delayed.

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### 6.2 Surgical Site Infection surveillance

The National Surgical Site Infection Surveillance (SSIS) programme in England, established in 1999 and run by the UKHSA, monitors patient outcomes post-surgery to track and reduce the risk of SSI. This programme helps healthcare providers to collect and compare data, identify infection causes, and promote improvements. Providers receive quarterly reports comparing their data with others, and an annual report is published. Monitoring for orthopaedic surgeries (total hip and knee replacements) is mandatory for at least three months each year, with surveillance of SSIs in other surgical specialties remaining optional, albeit recommended. The UKHSA quarters run per calendar year rather than financial year.

### 6.3 SSIS at UHSussex

SSI are a common cause of HCAIs. Whilst most SSI are localised to the incision site they can develop in deeper tissues. Rates of SSI vary between specialities, with higher rates associated with operations undertaken on parts of the body that harbour a higher burden of micro-organisms.

At UHSussex, the SSIS program is well-established across both the Specialist and Surgical divisions.

Over the year SSI surveillance was carried out to review primary (elective) hip and knee replacements, fractured neck of femur surgery, breast surgery, coronary artery bypass graft (CABG) cranial and spinal surgery.

Table 5 below provides a quarterly view of SSI rates by operation and hospital site. SSI data is reported by calendar year quarters. The most recent data is up to end of UKHSA Q1 2026 (January to March). Please note that the UKHSA reporting system excludes patient-reported infections, as it focuses on infections detected by hospital clinicians or during readmissions, not via optional patient reports unless they are confirmed by a clinician. As such, patient reported data is not included in national benchmarks or outlier assessments because the patient-reported data method is optional and inconsistent across hospitals. Data may change from that previously published if further cases are added due to late diagnosis (Surgery involving an implant is followed up for a whole year rather than 30 days).

There is ongoing work using the OneTogether gap analysis framework to review and refine clinical pathways. Senior multidisciplinary groups led by the Chiefs in both surgical and the specialist divisions, meet to review all identified SSI cases, and determine learning and areas for improvement.

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| Surgery | 2025 Q2 (Apr-Jun) | 2025 Q3 (Jul - Sep) | 2025 Q4 (Oct-Dec) | 2026 Q1 (Jan-Mar) | UKHSA 5-year rolling average |
|---|---|---|---|---|---|
| **TKR PRH** | 0.00% | 0.00% | 2.80% | 0.00% | 0.40% |
| **TKR SRH** | 2.70% | 0.00% | 0.00% | 1.02% | 0.40% |
| **THR PRH** | 0.90% | 2.00% | 0.00% | 0% | 0.50% |
| **THR SRH** | 2.80% | 1.60% | 0.00% | 2.80% | 0.50% |
| **NoF WH** | - | 1.70% | 2.20% | - | 0.80% |
| **NoF SRH** | - | 2.30% | 0.0% | - | 0.80% |
| **Breast SRH** | 0.70% | 0.00% | 1.3% | 0% | 0.60% |
| **Breast WH** | 2.10% | 0.00% | 1.7% | 0% | 0.60% |
| **CABG** | 2.60% | 4.40% | 2.1% | 8.7% | 2.80% |
| **non-CABG** | 3.10% | 6.30% | 0% | 4.6% | 1.10% |
| **Spinal RSCH** | _ | 2.40% | 1.70% | 0% | 1.6% |
| **Cranial RSCH** | _ | 2.20% | 1.10% | 3.3% | 2.3% |

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*Table 5: Summary of SSI rates by procedure and site. Four quarter rolling table. Unavailable data is marked by a dash (-). Key: Total knee replacement (TKR), total hip replacement (THR), fractured neck of femur (#NOF).*

### 6.4 Orthopaedics

**SRH:**

Three superficial SSIs post hip replacement surgery (n = 109) were reported for Q1 2026. Key risk factors common to all three were high BMI, multiple co-morbidities, and were therefore considered high risk on formal assessment and candidates for the PICO 7 dressings.

One deep SSI post knee replacement surgery (n = 98) was reported for Q1 2026. The patient was a trauma admission, was very frail with poor skin integrity.

All cases were discussed at relevant speciality meetings and confirmed as SSIs.

**PRH:**

Zero SSIs post knee and hip replacement surgery were reported in Q1 2026. There continues to be reduced arthroplasty activity at SOTC due to ventilation issues within the theatres, with capacity reduced to Theatre 1 SOTC as the only laminar flow theatre at SOTC.

Key initiatives planned include homogenising the Trust prophylactic antibiotic guidance, highlighting the importance of blood glucose control perioperatively which is part of a perioperative 'hot-skills' study day, under development, which will parallel the sharing of learnings from SSIs at clinical governance meetings. Finally, the theatre care pathway at PRH now allows for preoperative washing/decolonisation to be documented, which is in the process of being rolled out.

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### 6.5 Cardiac

**RSCH:**

Four deep sternal wound infections post CABG surgery (n = 46) were reported in Q1 of 2026, a rate of 8.7%. Over the same period, three deep sternal wound infections post non-CABG surgery (n = 86) were reported.

In February 2026, a cluster of 3 wound infections, wherein patients' wound / tissue fluid cultures grew *Staphylococcus epidermidis* (a skin organism which can cause SSI) were identified, with patients having had cardiac surgery in the preceding 3-5 months at UHSussex. All 3 cases had the same antibiotic sensitivity profile and ultimately were confirmed as the same strain via genomic testing investigations undertaken as part of the incident meeting, led to the closure of the cardiac theatres, allowing for enhanced cleaning, environmental testing, and an audit of cleaning schedules. 2 more cases, belonging to a different strain, but similar to each other were identified in March 2026, suggesting multiple circulating strains of *Staphylococcus epidermidis* circulating at the time of surgery.

The IPC team have continued to provide support to the cardiac surgery team in reducing SSI among patients undergoing CABG and other cardiac surgeries. This has included support to

the weekly surveillance monitoring meeting and the quarterly review panels. The support for early recognition and intervention to prevent infection developing has resulted in improvements in infection rates in CABG and other cardiac surgeries.

All cardiac theatres have been reviewed and meet required ventilation standards. Some environmental improvements have been achieved, and there is a plan for cardiac theatres and cardiac ICU to be refurbished when an agreed move takes place to the ITU in the LMB. This has been delayed due to some adjacent fire regulations but planned for later in 2026.

Additional actions include reinforcing prompt escalation and senior surgical review, timely imaging and deep tissue sampling, early referral of relevant isolates for typing, clear wound-management plans and ongoing monitoring of SSI trends through cardiac SSI governance processes.

### 6.6 Breast

The IPC team continues to support the development and strengthening of voluntary SSI surveillance following breast surgery. Formal UKHSA SSI surveillance for breast procedures is established at SRH and WH, providing baseline data, however further work is required with the clinical team to identify learning.

Further work is also required to extend equivalent surveillance arrangements to PRH. This will require enhanced engagement with breast services to agree surveillance models, data flows, and clinical ownership. More proactive and sustained collaboration between IPC and the breast surgical teams is needed to embed SSI surveillance consistently across all sites, ensuring equitable assurance, early identification of trends, and shared learning to support patient safety and quality improvement.

### 6.7 Neurosurgery

Zero SSIs post spinal surgery (n = 115) were reported in Q1 2026 (Jan – Mar). This is the first quarter since commencing surveillance in July 2025 of spinal SSI and actioning learnings, where no SSIs were recorded.

In this period, three SSIs post cranial surgery (n = 91) were reported, marking an increase in rate from 1.7% to 3.3%, Oct – Dec 2025 and Jan – Mar 2026 respectively.



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All cranial and spinal SSIs were presented at panel review meetings to evaluate any learnings. There is an ongoing action plan utilising the OneTogether pathway in neurosurgery. The specialist division have also employed an SSI surveillance nurse which allows neurosurgery SSI surveillance to continue and provide ongoing improvement to patient care.

The three cranial SSI cases included one superficial SSI in a patient with increased risk factors due to childhood radiation. Another superficial case was treated with a washout and further antibiotics. The third case resulted in a meningitis SSI due to an unfortunate dislodging of graft in the community, they were successfully treated with antibiotics.

Neurosurgery theatres are now utilising an improved stock of Mayfield frames improving sterility in cranial and spinal surgery patients. Work is ongoing to improve the standardisation of record keeping and documentation regarding normothermia. Prophylactic antibiotic guidance has been addressed led by a specialist pharmacist.

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### 6.8 Blood culture contamination

Blood culture contamination is an important quality indicator, particularly of aseptic-non-touch-technique (ANTT) at the point of taking a culture from a patient. Over the FY 2025/26 an overall rate of 3.05% was calculated across the sites at UHSussex.

Scientific consensus is that a contamination rate more than 2-3% is a trigger for epidemiological investigation. In response the IPC team have encouraged a renewed focus on aseptic-non-touch-technique (ANTT) and teaching on blood culture contamination as part of the junior doctor induction, across the Trust.

## 7. IPC in built environment

***HaSCA Criteria 2:*** *The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.*

**Compliance: Amber**, due to estates infrastructure including water safety, critical ventilation, laundry services, waste management, and planned preventative maintenance

### 7.1 Facilities

The Trust manages its facilities contract in-house. Ward sisters conduct weekly checks of clinical areas against The Hygiene Code, with monthly validation by Matrons. Results are recorded on the Tendable electronic system.

The IPC team have a weekly meeting with Facilities to discuss any operational issues identified in the week and agree rectifications and solutions.

All NHS Trusts must conduct an annual National Patient Led Assessment of the Clinical Environment (PLACE) assessment, which evaluates non-clinical aspects impacting patient care, such as cleanliness, maintenance, privacy, food quality, and dementia-friendly facilities. At UHSussex, PLACE assessments are part of weekly routines, conducted by patient assessors and staff teams, including facilities, estates, and IPC. These assessments cover all clinical departments and some non-clinical areas like main receptions and gardens. Outcomes from weekly inspections lead to both immediate and future improvements in patient environments. Results are discussed at bi-monthly PLACE review meetings, and a quarterly report with an action plan is provided to the Patient Engagement and Experience Committee.

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### 7.2 Environmental Cleanliness

The Facilities and Estates Division ensures a safe, clean environment for patients, staff, and visitors. The Domestic department uses both manual and automated cleaning methods. Technical audits of all hospital areas are conducted, categorised into four risk levels, with very high-risk areas being the top priority. Audit results are reviewed monthly at IPOG meetings, with multi-disciplinary discussions to drive continuous improvements.

Where issues with the cleaning standards are identified these are discussed with Facilities for prompt rectification.

Work is in progress to improve clarity on cleaning responsibilities to ensure all necessary equipment receives adequate decontamination. This is especially notable at SRH and WH where the cleaning of patient tables and lockers has been devolved to the food delivery teams. It has been noted and escalated that this important work is not always completed to

the expected standard and IPC have requested that the responsibility is put back with domestic staff.

The F&E team have a comprehensive list of the areas which need improvement, particularly for the Estates team. This is managed on a weekly basis through the weekly PLACE inspections, work tickets for repairs. Larger pieces of work that need to be completed by the Estates or Capital Projects teams are listed and discussed with Hospital Directors and priority-rated in preparation for any minor works monies that become available.

The PLACE assessment is undertaken in the autumn every year. Table 6 shows how UHSussex compares with the national average score. Of note, UHSussex have done better in 2025 versus 2024.

| Domain | National Average Scores | Peer Trusts | UHSussex Scores 2025 | UHSussex Scores 2024 | % Change on 2024 |
|---|---|---|---|---|---|
| Cleanliness | 98.55% | 98.73% | 98.63% | 94.66% | 4% ↑ |
| Combined Food | 92.13% | 92.35% | 91.43% | 90.97% | 1% ↑ |
| Organisation Food | 92.79% | 91.87% | 98.09% | 98.42% | 0% ↔ |
| Ward Food | 92.30% | 93.35% | 89.51% | 88.05% | 2% ↑ |
| Privacy, Dignity & Wellbeing | 89.37% | 90.45% | 91.60% | 87.95% | 4% ↑ |
| Condition, Appearance & Maintenance | 97.00% | 97.17% | 96.63% | 92.62% | 4% ↑ |
| Dementia | 85.68% | 87.54% | 90.77% | 76.97% | 18% ↑ |
| Disability | 87.12% | 87.99% | 92.58% | 79.87% | 18% ↑ |

*Table 6: National PLACE inspection scores UHSussex 2025*

### 7.3 Automated Room Disinfection

Effective room decontamination is crucial to prevent cross-infection, especially for pathogens like *C. difficile* and multi drug-resistant organisms. Automated systems, such as Hydrogen Peroxide Vapour (HPV) and Ultraviolet-C (UV-C) light can be used for enhanced disinfection. HPV is available at SRH and WH. A planned trial and purchase of UV-C light technology for RSCH/ PRH has not been possible. A successful paper was submitted at the end of Q4 to Capital Investment Group for procurement and roll out of both HPV and UV-C cleaning adjuncts across all Trust sites. Further investment will be required for the staffing of this specialist kit.

### 7.4 Capital Projects

The IPC team collaborates with the Estates and Capital Project Teams to ensure facilities meet IPC standards.

Work has been undertaken to standardise equipment specifications in new build developments, including handwash basins and taps, floor and wall finishes. These standards have been consolidated into a formal paper to support consistent application and inform future capital and estates projects.

IPC have been involved in all the major capital builds including RSCH ED redevelopment, the Sussex Cancer Centre and SRH Acute Stroke Centre.

### 7.5 Planned Preventative Maintenance

Maintaining buildings and equipment is crucial for safe patient care. The Estates team conducts weekly and quarterly maintenance, servicing, and filter changes for ventilation systems. Like many NHS trusts, UHSussex has a significant backlog of maintenance work, and this has been reflected in the risk register. There are a significant number of hand wash basins which are not compliant with guidance, as highlighted in the BAF. Work is needed to identify and prioritise future replacements going forward. Significant progress has been made in replacing flooring in many areas, providing a safer patient environment.

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### 7.6 Ventilation

Effective ventilation is essential in healthcare settings to provide a safe environment and control odours. Specialised ventilation reduces airborne infection risks in areas like operating rooms and critical care. The Estates department manages ventilation systems, following HTM 03-01 guidelines. The Trust wide Ventilation Safety Group (VSG), a multidisciplinary team, oversees ventilation, monitors reports, and recommends improvements. The VSG met quarterly. Reports are taken at the TIPC meeting, and the Director of Estates and Facilities also reports into QGSG. Many theatre air handling units are nearing the end of their lifespan, as highlighted in the BAF [Section 3.5] causing frequent breakdowns and operational disruptions. A 10-year capital plan has been developed with funding for replacement of units according to priority. New mobile ‘Vanguard’ theatres will be installed in 2026 at PRH and SRH, which will allow closure of existing theatres for refurbishment on a rolling programme.

There has been engagement with clinical teams and agreement for annual operating theatre shutdowns to enable the annual validation and any planned preventative maintenance, though sometimes this is not possible due to the competing priority to reduce waiting lists. The VSG have requested robust logs be kept of each system, any failings and remedial works needed to ensure that the systems remain safe to use. The Table below gives details on theatre verification scores over the last 12-months, as per HTM 03-01.

| Site | No. Theatres | In date | % Total |
|---|---|---|---|
| SRH | 14 | 14 | 100% |
| WASH | 13 | 13 | 100% |
| PRH | 12 | 12 | 100% |
| RSCH | 20 | 14 | 70% |

*Table 7: Theatre Verifications percentage completed in the last 12 months (in date as per HTM 03-01)*

Critical ventilation for the trust sterile service departments (CSSD) is in urgent need of upgrade to maintain compliance standards. The Trust currently runs 4 CSSDs and each is in need of significant work. The trust is evaluating the long-term provision of this service including the possibility of centralisation, and prioritisation of work is dependent on the outcome of the final decision.

The Trust currently uses HEPA air scrubber machines in clinical areas affected by airborne infections. These machines take air in and pass it over a HEPA filter before recirculating it. They have been shown to be effective in reducing overall article counts in a given environment when sized and run appropriately. These machines require regular maintenance and changes of the filters. The cost of the replacement filters is currently unfunded and there is no formal asset register of the devices. IPC have recommended that they are managed through the equipment library with funding of filters to allow appropriate deployment, servicing and maintenance.

The VSG maintains logs of system performance and updates the trust risk register as required.



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### 7.7 Water

Water is essential in healthcare settings for keeping patients clean and hydrated, and for running equipment. Common water outlets include handwash basins, showers, toilets, hydrotherapy facilities, ice machines, and drinking fountains. However, these outlets can pose risks to patient safety by exposing them to waterborne pathogens like *P. aeruginosa* and *Legionella pneumophila*.

The Trust follows national guidance (HTM 04-01: Safe water in healthcare premises), monitored by the Trust wide Water Safety Group (WSG). This multidisciplinary group is responsible for developing and managing the water safety plan (WSP). They also advise on remedial actions when water systems or outlets are contaminated, with targeted water testing in augmented care areas. The WSG meet quarterly during the year and reports to TIPC and escalates identified risks to Quality Governance Steering Group (QGSG) for executive oversight.

The Trust continuously monitors for signs of *L. pneumophila* across all services and *P. aeruginosa* in augmented care areas, which provide advanced medical support and continuous monitoring for patients with critical or complex health conditions.

Work was progressed on the new Sussex Cancer Centre at RSCH and a project specific water safety group has been established and meets regularly to review and mitigate risks.

The opening of the new Acute Medical Unit at RSCH was delayed due to *P. aeruginosa* contaminating the clinical hand wash basin taps. The source of contamination was not clearly identified. Repeated chemical disinfection failed to eradicate the issue; and resolution was finally achieved only after using several cycles of thermal disinfection. The Unit fully opened on the 2nd of December 2025.

### 7.8 Decontamination of medical devices

The Trust-wide Decontamination Committee has met quarterly, and the terms of reference were updated.

UHSussex operates four Central Sterile Services Departments (CSSD), one at each main site. These departments are responsible for reprocessing instruments used in surgeries and



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other procedures that require sterile equipment. The performance of CSSDs is benchmarked against national regulations to ensure high standards.

The endoscopy unit at WH/SRH holds Joint Advisory Group on Gastrointestinal Endoscopy (JAG) Accreditation. The unit at RSCH/PRH does not hold JAG accreditation currently.

Local decontamination audits were completed at SRH, WH and PRH. The audits at RSCH have not been completed due to work force constraints.

There were two endoscopy incidents that were investigated.

- SRH 29th April 2025: An ENT Naso-Endoscope which had been discontinued and stored in a cupboard within MFU was used on a patient. Several learning outcomes and training opportunities were identified and actioned.
- Worthing 27th November 2025: A new Endoscopic Ultrasound (EUS) endoscope was used on a patient without being calibrated or processed through the EDU. Several learning outcomes and training opportunities were identified and actioned.

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### 7.9 Decontamination of Intra Cavity Medical Devices

Trans-vaginal (TVUS), trans-rectal (TRUS) ultrasound probes and Trans-oesophageal Echocardiogram (TOE) probes are classified as intracavity medical devices (ICMDs). All ICMDs are classified according to the risks of infection transmission they pose. This determines the required level of decontamination. The TVUS, TRUS and TOE are considered semi-critical devices and require high level disinfection.

An audit of disinfection practices has indicated that these devices may not be undergoing adequate decontamination, which may put patients at risk of cross infection from a variety of pathogens, bacterial, viral and fungal.

IPC have undertaken work with Divisions to validate a decontamination audit, wherein ICDMs were identified, and actions agreed to ensure consistent high-level disinfection following ICMD use between patients. All areas identified through the audit have now received training on the correct use of the approved cleaning and disinfection system following each use. A standard operating procedure, supported by documented validation, has been implemented with input from Procurement, the Infection Prevention and Control (IPC) team, and

Decontamination Leads. Further formal validation of the decontamination process will be undertaken in Q1 to ensure these practices are embedded as standard work across the Trust.

## 8. Antimicrobial stewardship

***HaSCA Criteria 3**: Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.*

**Compliance:** **Amber** due to limitations in Laboratory Information Management System (LIMS) provision, variable access to antimicrobial stewardship education, and restricted availability of data to support trend analysis and audit activity

Antimicrobial resistance (AMR) is one of the biggest challenges in modern healthcare, with significant social and economic impacts. AMR is driven by antimicrobial use, so eliminating unnecessary used and minimise use where needed to shorted duration is a priority to minimise and prevention further AMR.

2025-26 marked the 2nd year of the current 5-year national action plan 'Confronting Antimicrobial Resistance 2024-2029'. The key focus area within this for Acute trusts is to reduce the need for antimicrobials, preventing unintentional exposure to antimicrobials and optimising appropriate use to balance effective treatment of infection while limiting the development of resistance in the total population.

The Antimicrobial Stewardship Team across UHSussex oversees stewardship activities and reviews empiric guidelines. The governance of antimicrobial stewardship in the organisation is actioned through the Antimicrobial Stewardship Group (ASG) which meets quarterly and feeds into TIPC and the Medicines Governance Committee.

A successful business case released funding to support the recruitment of 2 WTE pharmacists from quarter 1 2026-27 who will focus on reviewing intravenous antimicrobial treatments in inpatients to prompt timely review to stop/switch to oral with gains to both stewardship through reduction in broad-spectrum antimicrobials in addition to supporting patient flow, reducing line infections by earlier removal of cannulas, environmental savings from reduced single use plastics and reduced nursing time burden.

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### 8.1 Antibiotic consumption

National antibiotic consumption targets as listed in the National Action Plan (NAP) are monitored by the stewardship group. Key targets are outlined below;

- Target 4a: Reduce total antibiotic use by 5% from the 2019 baseline by 2029
- Target 4b: Achieve 70% of total antibiotic use from the Access category by 2029

UHSussex has made progress against both parameters in the last 12 months but has not yet met either target. Whilst not an outlier, comparable organisations are performing better, demonstrating opportunity for further progress.

- Target 2a: Aim to increase healthcare professionals' knowledge on AMR by 10% from 2019 baselines by 2029

There is currently no UHSussex baseline data for healthcare professionals' knowledge on AMR. This is one of the key actions for FY 2026/27. The Antimicrobial Pharmacists provide some education at Foundation Year 1 induction and ad-hoc teaching to different divisions/clinical areas when requested. There is currently no statutory education requirement for clinical staff within the trust education mandatory training programme.

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### 8.2 CQUINS

There were no national CQUINs in 2025-26. In lieu of this the ASG have focused on the National Action Plan targets and IV to oral switch.

### 8.3 ASG meetings & Guidelines

The ASG have continued to meet quarterly to review antimicrobial stewardship activities at the trust including reviewing antimicrobial guideline updates, reviewing medication incidents reported involving antimicrobials, clinical trials and audits in infection, and progress with national and local KPIs. The committee is well attended by Microbiology, pharmacy and IPC colleagues but there is limited involvement from the clinical divisions.

### 8.4 NHSE 'Call to Action'

The ASG were invited to present to the Trust Board in March 2026 to respond to the 'Call to Action' letter issued from NHSE to report on local progress with the National Action Plan and implementation of Start Smart then Focus guidance. The letter requested the following actions be taken;

- A Board level review and executive oversight of the progress in this area with a formal annual review.
- The trust undertakes appropriate risk assessments
- 3 priority areas are defined, agreed and published, with measurable objectives, executive level accountability and established reporting mechanisms.

The 3 key priorities identified by the ASG and presented to the Board were;

- Enforce Start Smart and Focus Toolkit; Optimise IV to oral switch (IVOS) activity to reduce use of watch and reserve antimicrobials and embed IVOS in the Daily Management System Change
- Data and digital prioritisation to enable identification of antimicrobial prescribing trends, trends in antimicrobial resistance and understanding of local performance and progress
- Establishing Consultant Champions to provide AMS leadership within the divisions embedding AMS into all clinical areas

While the work of the ASG will develop and monitor progress against these measures, clinical engagement is essential in driving meaningful change.

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## 9. Health care worker responsibilities

***HaSCA Criteria 6:*** *Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.*

**Compliance:** **Amber,** Fit testing compliance remains below target, requiring continued improvement to achieve full assurance across the workforce.

### 9.1 Patient and Staff Communication

Information leaflets are available for staff to discuss with patients, and the IPCT provides additional support as needed. The IPCT also collaborates with the communications team to ensure important information is effectively communicated to staff and patients, promoting safe care and compliance with national guidelines. An example of this collaboration is the HCID and the Respiratory virus action cards.

### 9.2 Link Champions

IPC Link Champion meetings were held every other month. The sessions covered a variety of topics to promote and embed good practices across the Trust. IPC team members liaised with the Link Champions as a conduit to effective communication among clinical teams.

As part of their role the IPC Health care technicians spend a few hours each week supporting clinical practice.

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### 9.3 Education and training

All staff members, both clinical and non-clinical, receive IPC training during their induction. Clinical staff also complete annual virtual IPC training through the Health Education England e-learning tool. Currently, overall IPC training compliance is 94.3%. Face to face sessions are available and currently run on the Worthing site.

New resident doctors attend face to face sessions where they have the opportunity to meet with IPC, the antimicrobial pharmacy team and the IV team.

IPC Team members also provide ward based teaching sessions as requested.

The IPC team also use other opportunities such as the Annual General Meeting to showcase work and key messaging.

Staff training and engagement with FFP3 fit testing has been strong across clinical services; however, further work is required to increase compliance and ensure all frontline staff are fit tested and have access to appropriate respiratory protective equipment when required.

## 9.4 IPC Audit and monitoring

### 9.4.1 IPC Environmental spot check

The rolling programme of quarterly IPC environmental audits in clinical areas has continued via the Tendable programme in conjunction with the Matron and a member of the domestic team where possible. Feedback is given to ward and departmental staff, including domestics, to enable rectifications and communicate learnings. In addition, an IPC spot check audit is completed and available for the clinical teams to share and discuss during their patient safety huddles.

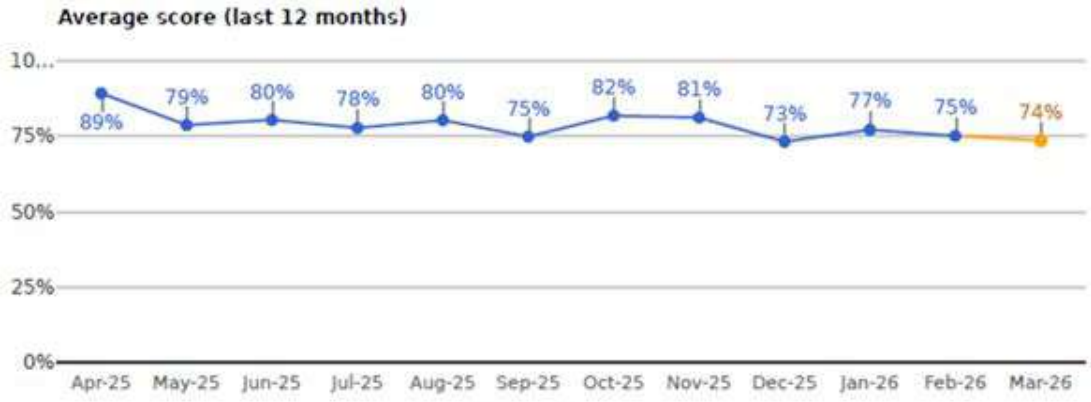


*Figure 18 Trend analysis of environmental spot check audit data over 1 year.*

### 9.4.2 IPC Weekly assurance audits

IPC Weekly Assurance audits are conducted using Tendable across the Trust and undertaken by the senior departmental nursing team.

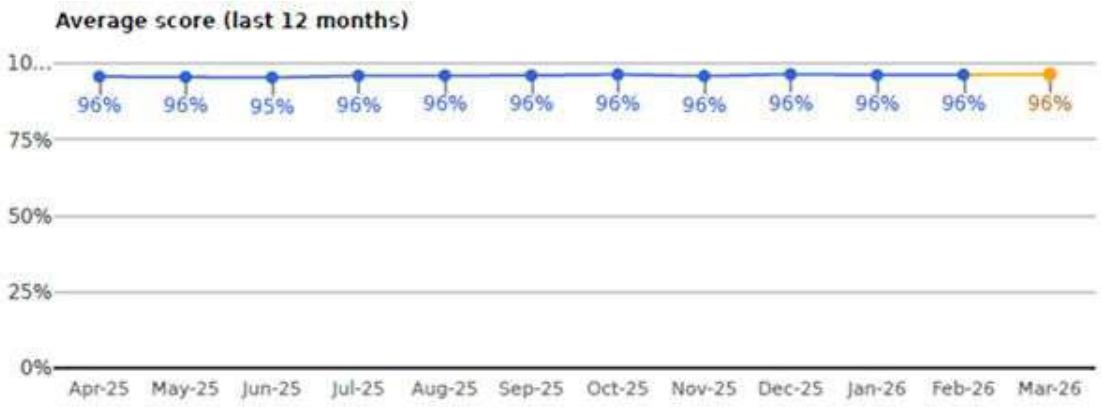


*Figure 19: Trend analysis of the IPC weekly assurance audit data over 1 year.*

The IPC weekly assurance audit allows clinical leads to directly review key aspects of IPC and action any issues identified.

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### 9.4.3 Hand Hygiene Compliance audits

The rolling programme of monthly IPC Hand Hygiene compliance audits in clinical areas continues conducted by clinical staff on the Tendable programme.

The average hand hygiene compliance score recorded on the wards for Q4 was 93%.

Hand Hygiene audit scores inform the IPC team of areas that require additional support with hand hygiene compliance through targeted education sessions.

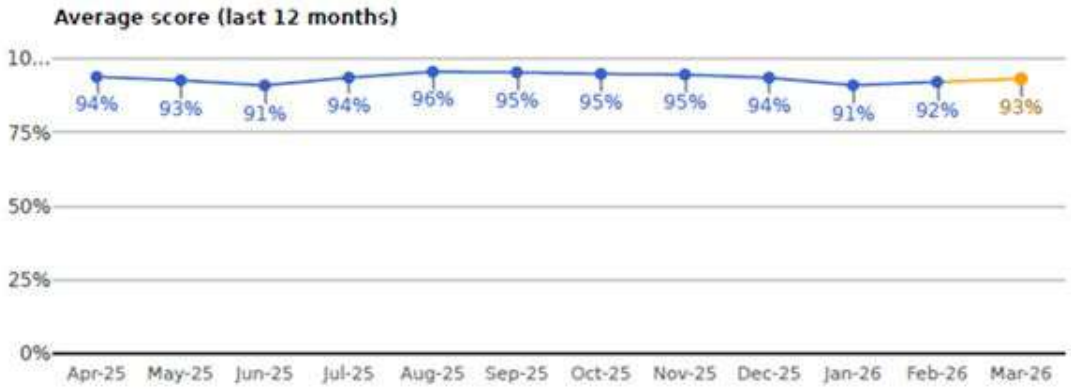


*Figure 20: Trend analysis of hand-hygiene audit data over 1 year, available on Tendable.*

### 9.4.4 IPC Commode Audits

The IPCT aim to complete monthly commode cleaning validation audits across all sites. These reviews include commodes, shower chairs, raised toilet seats and bed pans. The IPC team continue to work with clinical teams to promote the importance of commode hygiene in line with the 'Get It Right First Time (GIRFT) ethos.

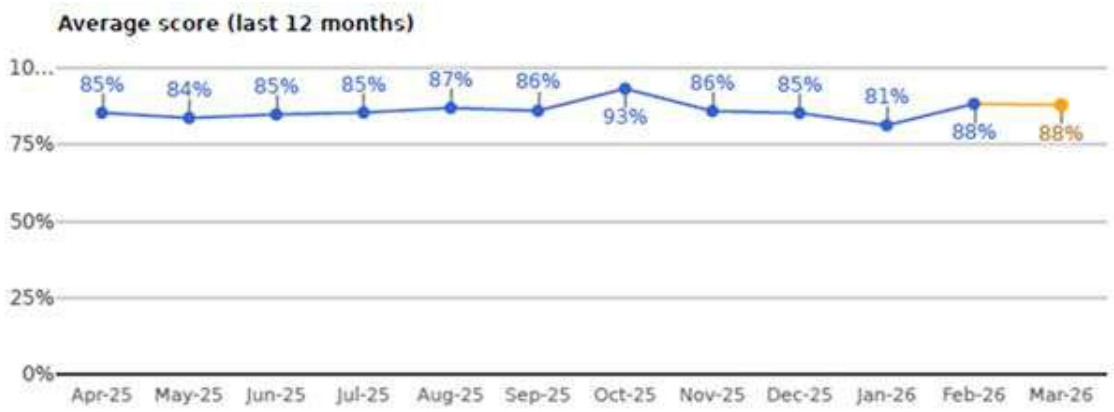


*Figure 21 Trend analysis of commode audit data over 1 year, available on Tendable.*

### 9.5 Response to audits

The Audit results above are discussed at monthly IPOG, NQAG, and Divisional meetings. Areas of good practice are highlighted and areas of poor compliance are challenged and improvement opportunities identified and planned. Progress is monitored through IPOG.

Additional auditing is undertaken in response to any outbreaks or incidents. These are discussed as part of outbreak/incident control team meetings and actions agreed for implementation. Ongoing monitoring is managed through these meetings and enhanced support to the affected area.

### 9.6 IPC supporting decarbonising healthcare

The IPC Team continue to support the national 'Gloves Off' campaign to reduce unnecessary use of gloves in healthcare.

Other areas where research work is being carried out includes looking at re-processing of some low-risk medical equipment and reusable fabrics in theatre.

## 10. Isolation facilities

***HaSCA Criteria 7:*** *The provision or ability to secure adequate isolation facilities.*

**Compliance: Green,** Assurance can be provided that adequate isolation facilities are available across the Trust to support infection prevention and control requirements.

UHSussex has sufficient isolation capacity to support the management of patients requiring transmission-based precautions, although the estate remains variable across sites. The Trust benefits from a significant proportion of single rooms, particularly within the Louisa Martindale Building (LMB) at RSCH, where approximately 60% of inpatient accommodation is provided in single rooms. In addition, dedicated isolation facilities are available within the Infectious Diseases Unit and Intensive Care Unit.

Whilst many of the Trust's older inpatient areas have fewer single rooms, limited en-suite provision and a lack of mechanically ventilated negative-pressure facilities, robust operational processes are in place to ensure that patients with known or suspected communicable infections are identified promptly and isolated appropriately. Daily IPC review, close working with bed management teams, and the use of formal risk assessments support prioritisation of available isolation facilities where demand exceeds capacity.

The distribution of isolation rooms remains uneven across the Trust, with a greater concentration at RSCH than other sites. However, no significant incidents have occurred during the reporting period where a lack of isolation facilities has prevented appropriate patient placement or outbreak control measures. The Trust continues to consider isolation requirements as part of future estate developments and refurbishment programmes.

Overall, the Trust can demonstrate adequate access to isolation facilities and effective processes to manage associated risks, providing assurance against this criterion.

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## 11. Laboratory support

***HaSCA Criteria 8:*** *The ability to secure adequate access to laboratory support as appropriate.*

**Compliance: Green,** Adequate facilities in place

Timely access to high-quality microbiology and virology services is fundamental to the Trust's ability to detect, investigate and manage healthcare-associated infections, outbreaks and emerging antimicrobial resistance threats.

UHSussex is supported by two UKAS-accredited microbiology laboratories located at the RSCH and SRH, providing a comprehensive diagnostic service across all Trust sites. Both laboratories operate 7 days per week and deliver rapid access to microbiological testing, antimicrobial susceptibility reporting, infection surveillance data and specialist diagnostic support. The laboratories work closely with the IPCT, Consultant Microbiologists, Antimicrobial Stewardship Team and clinical services to support patient management, outbreak investigations and mandatory surveillance requirements.

During 2025/26, laboratory services have continued to support the identification and investigation of healthcare-associated infections, respiratory virus outbreaks, multidrug-resistant organisms, bloodstream infections and surgical site infections.

The microbiology laboratories have strengthened collaborative working arrangements under a single laboratory management structure, improving standardisation of practices and supporting harmonisation of service delivery across the Trust. Development continues towards a Sussex-wide Laboratory Information Management System (LIMS), which is expected to further enhance integration of laboratory data, surveillance capability and timely access to results across the healthcare system.

The Trust continues to have reliable access to consultant microbiology and infection specialist advice, ensuring appropriate clinical support for complex infections, outbreak management, antimicrobial stewardship and infection prevention decision-making. No significant gaps in laboratory provision or diagnostic capability were identified during the reporting period.

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## 12. Policy and Guidelines

***HaSCA Criteria 9:*** *That they have and adhere to policies designed for the individual's care, and provider organisations that will help prevent and control infections.*

**Compliance: Green,** All Trust policies are in date, with the National Infection Prevention and Control Manual (NIPCM) fully embedded within UHSussex policies, ensuring alignment with national standards and best practice. Assurance is provided through compliance with NHS England requirements, the IPC Board Assurance Framework, external surveillance reporting, and regulatory oversight.

UHSussex maintains a comprehensive suite of Infection Prevention and Control (IPC) policies and guidelines, all of which are subject to formal review and governance processes to ensure alignment with current legislation, national guidance and emerging evidence. A full list of current policies is provided in Appendix 2. The Trust is fully compliant with implementation of the NIPCM for England, which provides the foundation for local IPC policies, procedures and clinical practice.

Policy implementation is supported through a range of assurance mechanisms including mandatory IPC training, audit and monitoring programmes, divisional governance processes, IPC link champions, routine ward visits and oversight through the TIPC. Where audits identify non-compliance or variation in practice, action plans are developed and monitored through established governance structures.

Clinical teams are supported by EOLAS, an electronic prescribing and clinical decision-support system that provides easy access to antimicrobial prescribing guidance and promotes evidence-based antimicrobial stewardship. During the year, the IPC Team has continued to work with pharmacy and digital teams to enhance the content available through EOLAS, including the incorporation of infection prevention advice alongside antimicrobial guidance to support safer and more consistent clinical decision-making.

No significant gaps in policy provision were identified during the reporting period. Policies remain accessible to staff through the Trust's document management systems and continue to support delivery of the Trust's statutory responsibilities under the Health and Social Care Act 2008 (Code of Practice on the prevention and control of infections).



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## 13. Staff Health

***HaSCA Criteria 10:*** *That they have a system or process in place to manage staff health and wellbeing, and organisation obligation to manage IPC.*

**Compliance:** Amber due to delayed response times dealing with staff occupational exposures.

### 13.1 Staff Winter Vaccination Programme

Staff were offered flu vaccination from October 2025. Covid vaccination was not available to health care staff on advice from the JCVI.

As above, UHSussex influenza vaccination uptake improved this year from 31% to 56% meeting targets set nationally. The IPCT continues to work with divisions, occupational health, communications team and pharmacy to optimise uptake through information giving and ease of access to the vaccine.

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### 13.2 FFP3 Respiratory Fit testing

Filtering Face Piece 3 (FFP3) respirators provide the highest level of protection against airborne particles, including viruses and bacteria, filtering at least 99% of airborne particles. They are commonly used in healthcare settings to protect against highly infectious diseases.

FFP3 respirator fit testing is mandated for patient-facing staff every two years, in line with NHS England resilience principles. This year we were able to recruit a team of 4 fit testers to work across site and improve the opportunity for staff to be fit tested. With over 8000 staff who need fit testing every 2 years, the team have been focussing on high risk areas. Following the launch of the fit testing programme, notable progress has been achieved within the first four months, with several clinical areas attaining 100% compliance. As at 31st March 2026, overall fit testing compliance among frontline staff (excluding medical staff) was 38%, with 62% of staff remaining to be tested. This represents a positive trajectory, with strong engagement across clinical services and continued focus on increasing compliance rates.

Medical staff fit testing data is not currently collated in the same manner as other frontline staff, resulting in limitations in the completeness of Trust-wide reporting. A programme of work is underway to enter all fit tests electronically onto Employee Staff Record during 2026,

which will provide a more comprehensive and consistent approach to data collection, monitoring, and assurance across all staff groups.

### 13.3 Occupational Health

Occupational Health support was assessed as partially compliant within the BAF due to delays in response times for management of occupational exposure incidents affecting staff. A Trust-wide Occupational Health service restructure, planned for completion in 2026, is expected to address this risk through the implementation of a single, standardised model of staff health provision. This will strengthen service resilience, improve consistency of practice, standardise referral and management pathways, and enhance the timeliness of responses to occupational exposure incidents. Progress will continue to be monitored through the Trust's governance framework, with the expectation that these improvements will support achievement of full BAF compliance and provide increased assurance regarding the management of staff health and safety risks.

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## 14. Research and scholarship

During 2025–26, the IPC team at UHSussex has continued to strengthen its position as a leader in applied research, with a focus on translating innovation into improvements in patient care, safety, and system sustainability. Activity has spanned local implementation, regional collaboration, and national and international leadership, with a consistent emphasis on ensuring that research delivers meaningful impact in practice.

### 14.1 New team members and research development

The IPC research portfolio has been strengthened through investment in people and career development:

- Dr Elizabeth Cross appointed as NIHR Clinical Lecturer in Infection, focusing on skin and soft tissue infections

- Dr Phil Norville appointed as Post-Doctoral Research Associate in IPC at Brighton and Sussex Medical School, contributing to research on sustainable healthcare and medical equipment reuse
- Ivan Martin-Jorge (Biomedical Scientist) awarded an NIHR Southeast Healthcare Professional Internship to develop a PhD proposal in pathogen genomics and IPC

In addition, medical students and early-career clinicians have been supported to undertake research projects, contributing to the development of future academic capacity in infection.

### 14.2 Key departmental achievements

- Establishment of the Genomics to optimise infection prevention (GENOTIPE) network as a national Specialist Interest Group hosted by the Healthcare Infection Society (HIS)
- Launch of the Centre of Infection and Antimicrobial Research (CINAMR), creating a regional hub for infection research and collaboration
- Appointment of Dr James Price as Academic Director of the Sussex Health and Care Research Partnership, strengthening integration between research and healthcare delivery
- Development of research programmes aligned to sustainability, including wastewater surveillance and safe reuse of medical equipment

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### 14.3 Research income and programme development

The team has continued to grow its research portfolio through both funding and programme development:

- Commercially supported research evaluating *Clostridioides difficile* infection across Sussex to inform local HCAI reduction strategies
- Award of university funding to support development of an NIHR-ready programme in pathogen genomics and IPC
- Submission of a Wellcome Trust grant to evaluate implementation of pathogen genomics in IPC

These activities demonstrate a clear trajectory towards larger-scale programme funding and implementation.

### 14.4 External representation and influence

Members of the IPC team have contributed extensively to national and international research, policy, and professional communities:

- **James Price:** (i) Secretary and Trustee of the Healthcare Infection Society, (ii) UK representative to the European Committee of Infection Control, (iii) member of the NIHR Efficacy and Mechanism Evaluation Funding Committee, (iv) expert panellist contributing to national guideline development
- **Pat Cattini**: (i) Expert Advisor Group to the New Hospitals Programme, (ii) Healthcare Infection Society Professional Development Committee, (iii) Infection Prevention Society Scientific Programme Committee, (iv) OneTogether Board, (v) Central Sterilising Club Board.
- **Sid Mookerjee**: Member of the Healthcare Infection Society Professional Development Committee
- **Sharon Reed**: Infection Prevention Society Wessex Branch Coordinator

In addition, the team has presented at major national and international conference contributing to the wider development of IPC practice and policy.

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### 14.5 Case studies

#### 14.5.1 Using genomics to improve infection prevention

Healthcare-associated infections remain a significant risk to patients. The IPC team has led work to apply pathogen genomics to better understand how infections spread within healthcare settings. Through the national network (now a national Specialist Interest Group) this work has brought together experts to develop approaches for using genomics in routine practice. This has the potential to enable faster and more precise identification of transmission events to support targeted interventions to improve patient safety and reduce outbreaks.

### 14.5.2 Sustainable infection prevention

Healthcare delivery has an environmental impact, including waste from single-use equipment. The IPC team has led research into sustainable approaches, including evaluating safe reuse of medical equipment and exploring wastewater surveillance to monitor antimicrobial resistance. This work contributes to developing safe, evidence-based approaches that reduce environmental impact while maintaining high standards of care.

### 14.5.3 Building a regional research hub

In February 2026, the Centre of Infection and Antimicrobial Research (CINAMR) was launched, bringing together clinicians, academics, and system partners across Sussex. The Centre provides a platform to develop collaborative research aligned to local and national priorities, strengthening partnerships and supporting translation of research into practice.

### 14.5.4 Targeted waste stewardship to reduce antimicrobial resistance

Healthcare waste, including pharmaceutical and clinical waste streams, can contribute to environmental antimicrobial resistance. The IPC team has developed and evaluated a novel targeted waste stewardship approach to reduce this risk. This work has demonstrated the feasibility of identifying high-risk waste streams and implementing interventions to minimise antimicrobial exposure in the environment.

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## 14.6 Selected Publications

Research outputs during the year reflect activity across genomics, antimicrobial resistance, sustainability, and clinical practice:

- Johnson T, Mason LCE, Wilson HJ, **Price JR**, Hopkins KL, Chattaway MA, Leanord A, Francino Marti O, Mayele-Tamina R, Johnson S, Flowers P, van Schaik W, Baker KS. *The role of microbial genomics in delivering the UK's national action plan for confronting antimicrobial resistance 2024–29.* Lancet Microbe. 2026 Mar 4:101372. doi: 10.1016/j.lanmic.2026.101372.
- Shutt AE, Ashiru-Oredope D, **Price J**, Padoveze MC, Shafiq N, Carter E, Ghataure A, Shariq S, Holmes AH, Charani E.*The intersection of the social determinants of health*

*and antimicrobial resistance in human populations: a systematic review.* BMJ Global Health. 2025;10(5):e017389.

- Krutikov M, **Price JR,** Fry Z, Longstaff V, Meacock K, Stephenson C, O'Reilly K, Singer A, Shallcross L. *The hidden iceberg: can wastewater transform infection surveillance and prevention in care homes?* Journal of Hospital Infection. 2026 Jan;167:187–191.
- Krutikov M, Munns J, Reed S, Cattini P, **Price JR**. *Targeted waste stewardship: a novel intervention to reduce environmental antimicrobial resistance.* Journal of Hospital Infection. 2026 Mar;169:24–28.
- Otter JA, Moore LSP, **Price JR**, Smith E, Hail L, Hodson J, Norville P. Impact, barriers, and facilitators of blood culture diversion devices to reduce blood culture contamination and improve patient safety: a scoping review. Journal of Hospital Infection. 2026 Jan;170:197–208.
- Fletcher MJ, **Price JR**. Lessons unlearned: sustaining preparedness and public health resilience beyond COVID-19. Journal of Hospital Infection. 2026 Feb;168:191–193.
- Stoneham S, Peters J, **Price JR**. Staphylococcal and streptococcal infections. In: Sepsis, Fever Syndromes and Serious Bacterial Infections. Medicine. 2025.
- Leiser R, McLeod J, Mapp F, Stirrup O, Blackstone J, Illingworth CJR, Nebbia G, **Price JR**, Snell LB, Saluja T, Breuer J, Flowers P. *Insights into the implementation of a whole genome sequencing report form (SRF) to reduce nosocomial SARS-CoV-2 in UK hospitals within an unfolding pandemic: a qualitative process evaluation using normalisation process theory.* PLoS One. 2025;20(4):e0321534.

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## 15. Other External Work

We have extended our contract to provide IPC cover and support to the local hospices across Sussex. This includes undertaking IPC audits and giving clinical support.

Engagement and leadership within the Sussex IPC cell which includes representatives from all acute, community and local authority providers.

Engagement with NHSE South-East IPC cell.

The IPC team is a key partner in the new Green Healthcare Hub at BSMS, leading research on safe, evidence-based reuse of medical equipment to reduce environmental impact.

## 16. Achievements

Sharon Reed was awarded the Chief Nursing Officer of England Silver award 2026 for outstanding service to Nursing.

## 17. Priorities for 2026-27

Our IPC annual programme of work is shown in appendix 3.

Our priorities focus on achieving full compliance with the IPC Board Assurance Framework, including improvement in IV Device care and antimicrobial stewardship We will strengthen surveillance of surgical site and line-associated bloodstream infections, extend IPC reviews across all Trust sites, and embed PSIRF methodology to ensure effective learning from investigations. Robust audit feedback and divisional accountability will remain central to our assurance processes. Alongside this, we will support Facilities and Estates in maintaining water and ventilation safety, while expanding engagement through the IPC Link Champion programme and wider clinical networks. Finally, we will broaden our research, innovation, and sustainability agenda—enhancing team capability, advancing projects such as hydration and mouth care, and increasing regional and national impact to support safer, greener healthcare.

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## 18. Conclusion

University Hospitals Sussex NHS Foundation Trust continues to demonstrate compliance with the requirements of the Health and Social Care Act 2008 Code of Practice (Hygiene Code), with assurance provided through the IPC Board Assurance Framework, Trust governance structures and a comprehensive programme of monitoring, surveillance, audit and review. Whilst a number of areas remain subject to ongoing improvement and oversight, no significant gaps in assurance have been identified that would prevent the Trust from meeting its statutory responsibilities.

The Infection Prevention and Control Team works collaboratively with clinical, nursing, operational, estates, facilities, pharmacy and laboratory colleagues across all Trust sites to ensure that infection prevention and control is embedded within everyday practice. This partnership approach is essential to protecting patients, staff and visitors from avoidable infections, reducing healthcare-associated harm and maintaining public confidence in the services provided by the Trust.

During 2025/26, the Trust has continued to strengthen its approach to environmental safety, antimicrobial stewardship, outbreak management, surveillance, education, research and quality improvement. Significant progress has been made in areas including ventilation governance, water safety, decontamination oversight, staff vaccination, fit testing and the expansion of surgical site infection surveillance.

Whilst overall compliance has been achieved, infection prevention and control remains an area of continuous improvement. The Trust recognises the importance of maintaining focus on reducing healthcare-associated infections, strengthening surveillance and assurance processes, and supporting clinical services to deliver sustainable improvements in patient outcomes. Priorities for 2026/27 include embedding learning from infection investigations, enhancing environmental assurance, strengthening clinical engagement and continuing to develop evidence-based approaches to reducing infection-related harm.

The comprehensive IPC programme for 2026/27 has been developed to address these priorities through innovation, research, surveillance, education and continuous learning. The Trust remains committed to strengthening assurance, improving patient outcomes and reducing healthcare-associated infections across all services.

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## 19. References

English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) report 2023 to 2023 (publishing.service.gov.uk)

NHS England » National infection prevention and control manual (NIPCM) for England

Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

https://www.gov.uk/government/statistics/mrsa-mssa-gram-negative-bacteraemia-and-cdi-quarterly-report/quarterly-infographic-mrsa-mssa-and-gram-negative-bacteraemia-and-cdi-data-up-to-october-to-december-2025

https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2024-to-2029/confronting-antimicrobial-resistance-2024-to-2029

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## 20. Appendices

### Appendix 1: TIPC Membership

TIPC membership includes:

- Chief Nurse /DIPC (Chair)
- Corporate DIPC (Co chair)
- Medical Director
- Infection Prevention & Control Doctor / Consultant Microbiologist
- Deputy DIPC
- Hospital Epidemiologist
- Infection Prevention Matron(s)
- Surgical Site Surveillance Lead Nurses
- Antimicrobial Pharmacist(s)
- Decontamination Lead(s)
- Divisional Director of Nursing (DDoN) /Head of Nursing (HoN) - Medicine
- DDoN/ HoN Surgery
- DDoN/ HoN Women & Children
- DDoN/ HoN Cancer
- DDoN/ HoN Women and Children
- Director of Estates & Facilities/ Associate Director of Estates & Facilities
- Health and Safety Lead(s)
- Occupational Health Manager(s)
- UKHSA representative
- NHS Sussex Integrated Care Board (ICB) Infection Prevention Lead Nurse(s)

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## Appendix 2: List of IPC Policies

| Policy Reference | Policy Title | Review Date |
|---|---|---|
| UHSIC001 | Infection Prevention and Control Organisational Management and Assurance Framework Policy | 19/06/2028 |
| UHSIC002 | Standard & Transmission Based Infection Prevention and Control Precautions Policy | 21/09/2026 |
| UHSIC004 | Isolation of Patients Policy | 21/03/2027 |
| UHSIC006 | Decontamination Policy | 21/11/2027 |
| UHSIC007 | Prevention and Control of MRSA Policy | 18/12/2026 |
| UHSIC008 | Clostridioides difficile Infection Policy | 18/12/2028 |
| UHSIC009 | Norovirus Policy | 21/03/2027 |
| UHSIC010 | Blood Borne Virus Policy | 19/02/2029 |
| UHSIC011 | Infection Control and Prevention Management of Tuberculosis Policy | 19/06/2028 |
| UHSIC012 | Aseptic Non-Touch Technique Policy | 19/06/2028 |
| UHSIC013 | Respiratory Viruses Policy | 19/02/2029 |
| UHSIC014 | Creutzfeld-Jakob disease (CJD) and Variant CJD (vCJD) Policy | 18/12/2028 |
| UHSIC015 | Policy for the Prevention of Surgical Site Infections | 19/02/2029 |
| UHSIC017 | Prevention of Aspergillosis and infection from other fungi during Demolition Policy | 19/06/2028 |
| UHSIC018 | Infestation Policy | 19/06/2028 |
| UHSIC020 | Control of Multi Drug Resistant Organisms (MDRO) | 19/06/2028 |
| UHSIC026 | Management of a Patient's Body Following Death with an Infection Policy | 18/09/2028 |
| UHSIC027 | Surgical Instrument Loan Policy | 22/01/2027 |
| USHC049 | High Consequences Infectious Diseases (HCID) Policy | 18/12/2028 |
| UHSC059 | Blood Culture Collection Technique Policy | 18/09/2028 |
| UHSTW014 | Animals and Pets in Hospital Policy | 19/06/2028 |
| UHSTW015 | Outbreak Management of Healthcare Associated Infection Policy | 21/09/2026 |

## Appendix 3: Summary of IPC Annual Programme 2025/26

Summary

The Infection Prevention and Control (IPC) Annual Plan 2025/26 sets out the proposed activities for the IPC service at University Hospitals Sussex NHS Foundation Trust. This plan will ensure that the Trust continues to meet the requirements of the Department of Health and Social Care, the Care Quality Commission, and other requirements such as alert organism reductions. The plan specifying Trust agreed actions as well as internal programmes of work that IPC will endeavour to support/deliver on.

The Trust has a series of policies and expert committees, along with strong engagement with the clinical divisions, to prevent and manage healthcare-associated infections (HCAI) and optimise antimicrobial usage. Actions arising from these committees underpin the programmes of work referenced in this plan.

This plan will be reviewed annually, with progress and evidence of completing actions will be regularly reviewed at the Trust Infection Prevention and Control Committee. Progress on actions will also be followed up through Infection Prevention Operational Group (IPOG).

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| Quarterly review RAG rating | |
|---|---|
| | Action complete |
| | Action on track |
| | Action underway |
| | Action not on track |

| 10 criteria of the Hygiene Code (2008) | Objectives | What steps need to be taken? | Who is responsible? |
|---|---|---|---|
| **Criterion 1 - Systems to manage and monitor the prevention and control of infection.** | 1.1 To fully implement, manage and upload all alert organisms to UKHSA DCS via Power Apps (Power BI) by September 2026. | Optimise power BI tool, educate users, validate data entries and include thematic data analysis. Close the DATIX | IPC team including Epidemiologist, Power BI team |
| | 1.2 Review alert organism thresholds for 2026/27and aim for a 5% reduction target in healthcare associated infections | Review and analyse HOHA/COHA attributed HCAI to identify action areas for improvement monthly. | IPC team, Divisional leads,<br>PSIRF team |
| | | Standardise IPOG divisional template (new TOM) to ensure hand hygiene, environmental audits, commode audits, indwelling insertion and on-going management is monitored consistently. | DDIPC,<br>Divisional leads. |
| | | Review outcomes of alert surveillance, thematic reviews, trend analysis at IPOG/TIPC and antimicrobial stewardship group meetings. | IPC team including Epidemiologist,<br>Divisional leads. |
| | 1.3 Develop new approaches to investigate HOHA/COHA HCAIs, hospital outbreaks, to seek learning opportunities to change future practice. | Following training, introduce PSIRF methodology into IPC service. | IPC team (band 8's), Epidemiologist, Patient safety team,<br>Datix team. |
| | | Transfer remaining alert organism RCA templates onto a PSIRF template. | Patient safety team |

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| | | Undertake thematic analysis using Datix and Power BI platforms. | Epidemiologist, Datix team. |
| | 1.4 The surgical site surveillance team will establish the burden of SSI in key surgical settings through optimisation of surveillance. | Undertake mandatory SSI surveillance in line with national recommendations. | SSI teams,<br>IPC support |
| | | Undertake voluntary SSI surveillance in key surgical areas and reactionary SSI surveillance in areas of increased infection rates. | Surgical site surveillance team.<br>Divisions with IPC support. |
| | 1.5 Implement the IPC audit programme for 2025/26. | All audits to be carried out as detailed in the approved audit programme and action plans automatically sent via Tendable. Divisions to report at IPOG any delayed actions that require IPC support to escalate. | IPC team, Divisions |
| | | IPC team to liaise with clinical teams post audit to offer face to face/interactive education and support completion of recommendations. | IPC team |
| | 1.6 Support relevant Trust auditing including National PLACE, PLACE lite and peer reviews. | IPC CNS to manage relevant audit requests by site. | IPC CNSs |
| **Criterion 2 - The provision and maintenance of a clean and appropriate environmentin managed premises** | 2.2 IPC will work with Estates to effect improvements across the trust (inclusive of water, ventilation, | Specialist (Water/Ventilation) group members to receive all commissioning, validation, interim/full reports for water and ventilation | IPC team,<br>Estates team,<br>Capital team |

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| **that facilitates the prevention and control of infections.** | capital builds) throughout the year. | results, ensuring AE (W/V) is involved at every opportunity. | |
| | | IPC to attend all capital projectmeetings to ensure HTM/HBN standards are delivered for every new build or refurbishment. | IPC team,<br>Capital team |
| **Criterion 3 - Appropriate antimicrobialuse and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.** | 3.1 There will be appropriate antimicrobial use and stewardship (AMS) across UHSussex, that is reviewed at each AMS meeting. | IPC to be an integral stakeholder on AMSG meetings and provide quarterly infection data. | AMSG,<br>IPC team |
| | | Gain an understanding of Trust antimicrobial resistance rates (Blood cultures, urine positive for gram negative infections) using PPS and thematic analysis. | Epidemiologist,<br>ICD |
| **Criterion 4 – The provision of suitable accurateinformation on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.** | 4.1 UHSussex will provide patient/visitor information in a variety of formats. | Ensure SharePoint, staff hub, switchboard phone messageand Trust webpage is kept up to date (winter guidance, clinical department closures). | IPC team,<br>Facilities team |
| **Criterion 5 - That there is a policy for ensuring that people who have or are at risk of developing an infection are identifiedpromptly and receive the** | 5.1 The IPC and micro teams will liaise closely for early identification and IPC measures to be initiated daily (working days). | Microbiology/Virology team to attend Clinical IPC weekly meeting. | Microbiologist,<br>Virologists,<br>IPC team<br>ICD |
| | | IPC to send updates to micro team in preparation for | IPC CNS |

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| **appropriate treatment and care to reduce the risk of transmission of infection to other people.** | | weekend work if appropriate. | |
| | 5.2 Pathology and IT will collaborate databases to ensure all patient results reach the IPC team for action as soon as the result becomes available. | IPC team to participate with Southeast LIMs project to align lab data feeds. | IPC team &Epidemiologist |
| | 5.3 IPC team to visit and support patients/NOK with education | IPC team to visit patients/ NOK and offer advice and support | IPC team |
| **Criterion 6 - Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventingand controlling infection.** | 6.1 The IPC team with support of the Divisions will strengthen and expand the IPC link champion scheme during the year. | IPC CNS to lead link champion programme. Quarterlymeetings to include appropriate use of PPE/gloves, standard precautions, staff health and hand hygiene initiatives (involve patients either at ward level or part of a group).<br><br>Visit and work with IPC champions in their place of work | IPC CNS<br>IPC Matrons for oversight. |
| | 6.2 The IPC team will support with Sustainability and Net Zero Target over the coming fiscal year: | IPC designated green ambassador(s). | IPC 8's to discuss and assign. |
| | 6.3 The IPC team will establish & review current education being delivered by IPC team in line with national IPC framework. | Collect data on current education delivered by IPC and develop a strategy to expand educational opportunities to support staff. | Senior IPC Matron, IPC team |

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| | 6.4 Develop and provide further education, learning opportunities for the IPC Team over the coming year. | Identify what education IPC team members wish to undertake in 2026/27 and formalise within a training need analysis document. Team being active members of the IPS and join relevant branch meetings | IPC Matrons/ Senior Matron |
| | 6.5 The IPC team will continue expanding, engaging and supporting research (local and national) relevant to IPC throughout the year and beyond. | ICD to highlight research opportunities. | ICD & Epidemiologist |
| | | IPC team members to attend and engage with CINAMR. | IPC Matrons/ Senior Matron |
| | | Revise and deliver High Consequence Infectious Diseases training following attendance at the two-day HCID train the trainer course | IPC/ Infectious Diseases/ ED practice educators |
| **Criterion 7 – The provision or ability to secure adequate isolation facilities.** | 7.1 Capital/ minor works will involve IPC in the plans for new builds throughout 2026/27 and beyond as standard collaboration. | Review plans for refurbishment and new builds to ensure the scheme includes adequate and appropriate isolation facilities. | IPC team<br>Capital Team |
| **Criterion 8 –** | 8.1 IPC will further strengthen | IPC team to explore visits/placements within the microbiology laboratories. In | IPC team,<br>ICD, |

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| **The ability to secure adequate access to laboratory support as appropriate.** | relationships with the wider infection department at UHSussex. | addition to exploring the development of an IPC rotation for infection trainees. | Lab leads |
| | | IPC team to join clinical infection ward rounds at all sites. | Micro leads,<br>IPC team |
| **Criterion 9 -Adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.** | 9.1 IPC will review, and update IPC polices as they approach expiry or when new information is published. | Policy updates and reviews will follow the Trust governance pathway and be uploaded to IPC policy page on SharePoint. | DDIPC,<br>Senior IPC Matron,<br>IPC secretaries |
| | 9.2 IPC will ensure audit processes are in place for policy compliance over the year 2026/27 | Disseminate policies as per local governance processes and support education as per criterion 6. | IPC team |
| **Criterion 10 –That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.** | 10.1 Substantive Trust Fit testing team to be recruited and trained to provide the service across all sites. | Job descriptions were approved and lead fit tester and fit testers employed. | DDIPC,<br>Band 8's,<br>IPC secretary, |

DRAFT

University Hospitals Sussex
NHS Foundation Trust

# UHSussex Safeguarding Children and Adults Annual Report

## April 2025- March 2026

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# 1.Introduction

Effective Safeguarding arrangements seek to prevent and protect individuals from harm or abuse, regardless of their circumstances. Safeguarding is firmly embedded within the core duties and statutory responsibilities of University Hospital Sussex NHS Foundation Trust (UHSussex). In discharging it duties for Safeguarding, UHSussex acknowledges that protecting children, young people, and adults who are at risk is a shared responsibility that requires efficient collaboration between UHSussex's staff members and partner agencies.

The context of safeguarding at UHSussex continues to change annually in line with listening to the lived experience narratives of our patients locally and nationally, including large scale inquiries and legislative reforms. It remains the responsibility of UHSussex, and each individual healthcare professional working in the Trust, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied when delivering care and support.

## 1.1 Purpose

UHSussex is required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver. It is required to submit an annual report for safeguarding to the trust board providing overall assurance on the effectiveness and quality of these safeguarding arrangements.

This report will:

- Provide an overview of the UHSussex safeguarding team activity in 2025/26.
- Provide accountability for the Trust's safeguarding responsibilities
- Identify emerging risks and trends related to safeguarding
- Outline the key safeguarding priorities for 2026/27

# 2. Executive Summary

This annual report outlines the progress, challenges, and strategic direction of the Safeguarding agenda across UHSussex for the period April 2025 to March 2026. It captures performance across the Trust, identifies risks, and provides assurance for statutory compliance at the backdrop of significant forward looking corporate changes and operational challenges for the organisations operational systems.

## 2.1 Statutory Responsibilities and Assurances

This report demonstrates that safeguarding continues to be embedded at every level in the organisation, with effective governance processes in place. The following statutory responsibilities have been met during 2025/26 as laid out in the NHS England Safeguarding Accountability and Assurance Framework (SAAF, 4th edition, 2024) which recognised the cross-cutting nature of safeguarding across both adults and children within NHS organisations and providers of NHS services.

It is key to note at this juncture that the 2026 SAAF (5th edition) builds on that foundation and reinforces commitment to ensuring the safety, protection and welfare of babies, children,

young people and adults – including the prevention of harm and upholding the dignity of the deceased for our 2026/27 work plan.

- The Chief Nurse is the SRO and Board Executive Lead for safeguarding children, adults at risk and Prevent. Alongside the Deputy Chief Nurse and Associate Director of Safeguarding provide strategic leadership and over-sight of safeguarding.
- A Lead Nurse including named nurses, named doctors and a named midwife for safeguarding children and children in care were in place in this reporting period.
- A Lead Nurse and named lead for adult safeguarding were in place in this reporting period.
- A Mental Capacity Act (MCA) lead was in place in this reporting period..
- Robust recruitment processes are in place, with pre-employment clearance for all new staff. UHSussex complies with guidance in relation to modern day slavery and human trafficking and undertakes enhanced Disclosure and Barring (DBS) checks for staff working with children and adults.
- Arrangements for dealing with allegations against staff in UHSussex is established. The Management of Allegations Policy is in place and supports robust management of any allegations with due regard to professional accountabilities.
- Policies, protocols, and processes are in place to support the assessment of need and vulnerability of children, young people and adults accessing UHSussex services. These are also aligned to Pan Sussex Policies and Procedures.
- A revised Safeguarding training programme and refreshed training Needs analysis for children are in place in response to the new guidance for children (Intercollegiate Document 2025 for Children & Looked after Children) to ensure UHSussex staff have received the requisite ‘essential-to-role’ safeguarding training, including Safeguarding Adults, Safeguarding Children, Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS) and Prevent training. Work continues to improve uptake of Level 3 safeguarding training across children.
- Safeguarding training is included in UHSussex induction programmes for all staff and volunteers as part of staff onboarding.
- Safeguarding supervision, (planned and ad hoc) is delivered by the safeguarding teams to support staff in decision making and prioritising the needs and wishes of children, young people, and adults, where there is a high level of complexity, risk, and vulnerability. Work continues to embed safeguarding supervision across safeguarding adults. Named Professionals receive safeguarding supervision from the ICB safeguarding team.
- A new Learning from safeguarding incidents, reviews, and audits framework has been introduced and learning continues to be systematically shared through divisional governance forums, Harm Free Care Panels, and the Safeguarding Operational and Strategy Committees. Key themes and lessons from Safeguarding Adults Reviews (SARs), Domestic Homicide Reviews (DHRs), and internal early learning reviews are embedded into 7-minute briefings, policy updates, training content, and supervision.
- A new Single Agency Quality Assurance Framework with associated Annual Audit Plan has been implemented providing assurance to partners of how we assure ourselves that safeguarding practice is improving across our services.
- Policies, arrangements and records, to ensure consent to care and treatment is obtained from patients at UHSussex in line with legislation and guidance is in place.

## 2.2 Key Achievements in 2025/26

- Launched the UHSussex Safeguarding Plan 2025–2028, establishing a clear strategic framework focused on effective leadership, trauma-informed practice, workforce development, digital innovation, and strengthened partnership working across all safeguarding portfolios.
- Strengthened safeguarding governance, assurance and risk oversight across Children, Adults, Maternity, MCA/DoLS and Prevent services. Improved committee reporting, risk management and multi-agency engagement.
- Maintained delivery of statutory safeguarding responsibilities despite increasing demand and workforce pressures. Continued to provide leadership, advice, training and specialist support across the Trust.
- Improved workforce capability and training compliance. Safeguarding Children Level 3 compliance increased from 79.2% to 86.8%, exceeding the Trust target, while Adult Safeguarding Level 3 compliance reached 86.6%. Updated Adult Safeguarding and MCA training programmes were aligned to Intercollegiate guidance and emerging case law.
- Enhanced identification of safeguarding concerns. Referrals to Children's Social Care increased by 16% in 2025/26, demonstrating improved recognition and appropriate referral of vulnerable children and young people.
- Reduced delayed discharge bed days for children and young people from 1,673 in 2024/25 to 707 in 2025/26, a 58% reduction achieved through early identification of barriers to discharge; strengthened early escalation pathways, including Executive-level review and escalation of complex cases; improved system working with mental health, ICBs and social care services; implementation of a more robust, risk-based approach to admissions. Changes within the wider system, including the Coast service and the closure of the Chalk Hill facility, which altered pathways and reduced some prolonged waits for some children. Strengthened MCA and DoLS governance through new governance groups, enhanced audit arrangements and improved oversight of practice across the Trust.
- Expanded safeguarding supervision and reflective practice across Adult, Maternity and Children's services. Supported staff development, decision-making and professional curiosity.
- Embedded learning from SARs, CSPRs, DARDRs, Rapid Reviews and patient safety investigations. Learning informed training, policy development, supervision and quality improvement activity.
- Improved integration of safeguarding within patient safety governance through representation at Harm Free Care Panels, PSIRG processes and Early Learning Reviews.
- Enhanced safeguarding data and assurance arrangements. Introduced monthly divisional safeguarding reports, strengthened oversight of safeguarding activity and Section 42 enquiries, and improved understanding of vulnerability and equality impacts.

- Strengthened the Trust response to domestic abuse through the HIDVA service, routine enquiry within maternity services and effective multi-agency collaboration.
- Introduced innovative maternity safeguarding initiatives, including the Safeguarding Complex Care Forum, Dependency Clinics, HOPE Box initiative and Birthing Arrangement processes. Enhanced support for women experiencing complex safeguarding circumstances.
- Strengthened collaborative working with Local Authorities, Safeguarding Partnerships, Mental Health Services and wider safeguarding networks to improve outcomes for vulnerable children, adults and families.
- Implemented the Children's and Adults' Safeguarding One Team models, improving collaboration, consistency and workforce resilience across UHSussex. Achieved full establishment of the Children's Safeguarding Specialist Nurse workforce by year end.

## 2.3 Challenges and Risks in 2025/26

- Workforce capacity pressures resulting from vacancies, recruitment challenges and periods of staff sickness impacted service resilience and delayed delivery of some planned audit and quality improvement activity. Despite these challenges, statutory safeguarding functions and governance requirements were maintained through.
- Increased safeguarding activity and system demand across Children, Adults and Maternity services, including higher levels of DARDR, safeguarding enquiry and complex case activity, placed additional pressure on safeguarding team capacity and resources.
- The absence of a consistent Trust-wide approach to supporting autistic and neurodiverse children, young people and adults remains a significant challenge. Further work is required to strengthen staff knowledge, reasonable adjustments and pathways to improve patient safety, experience and safeguarding outcomes.
- Variation in digital systems and referral processes across Sussex Local Authorities continued to present challenges for consistent data collection, information sharing and safeguarding oversight, requiring ongoing work to standardise processes and improve assurance.
- Changes to Training Needs Analyses and competency requirements increased the number of staff requiring higher levels of safeguarding training, creating implementation challenges whilst strengthening workforce capability.
- Increasing complexity of safeguarding presentations, including domestic abuse, self-neglect, exploitation, perinatal safeguarding concerns and cases involving legal proceedings, required enhanced multi-agency coordination and specialist safeguarding input.
- Ongoing system pressures within mental health services continued to impact patient flow and access to appropriate care environments, particularly for patients requiring

specialist mental health assessment, treatment or admission. These pressures increase safeguarding, legal and patient experience risks.

- Transitional safeguarding and support for vulnerable adolescents and young adults remain areas for further development. There is variation between childrens and adults safeguarding thresholds and service eligibility, limited provision for care-expereinced young adults to ensure safe discharge, young people with neurodiversity, mental health needs, exploitation risks or complex social circumstances not fitting into paediatric or adult pathways. Whilst progress has been made through training and partnership working, additional work is required to strengthen pathways for young people aged 16–25 years with known safeguarding risk.

- Embedding trauma-informed practice across all services remains a developmental priority. Learning from reviews and incidents has informed training and supervision; however, a more consistent organisational approach is required to support patients, families and staff experiencing trauma.

- Work is ongoing to strengthen organisational understanding, reporting and oversight of restrictive practice and restraint to ensure patients are safeguarded from potential physical and psychological harm.

### 2.4 Priorities for Safeguarding Children and Adults 2026/27

The following areas are set as priorities for 2026/27 and will form the basis of the safeguarding workplan:

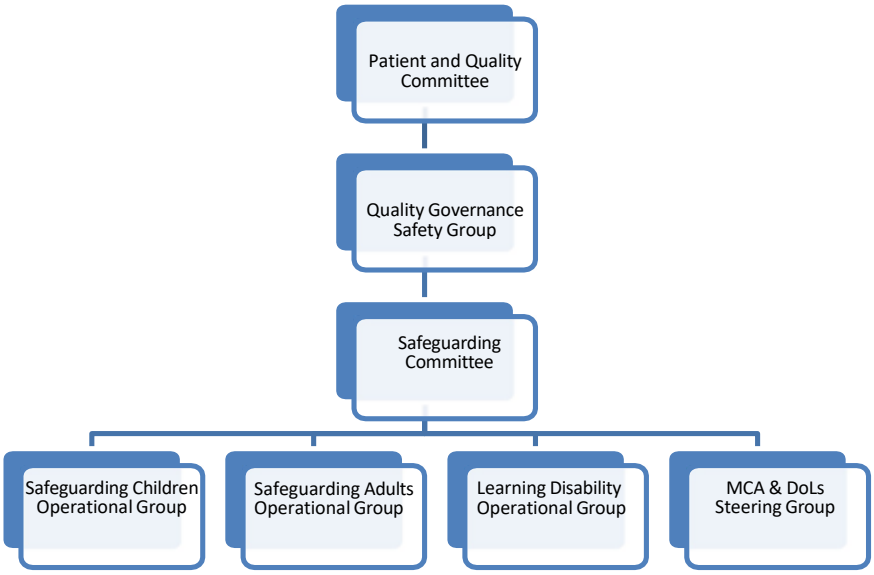
- Strengthen Transitional Safeguarding and young adult pathways.
- Embed Trauma-Informed Practice Across UHSussex.
- Strengthen Workforce Capacity, Supervision and Training Compliance.
- Deliver the single agency safeguarding audit, quality improvement and assurance programme.
- Improve safeguarding data, digital systems and referral processes.
- Strengthen MCA, DoLS and Legal literacy following national developments.
- Develop Domestic Abuse, Exploitation and Violence Reduction Approaches.
- Strengthen the voice of children, adults and families through co-production and engagement.
- Embed a consistent approach to supporting autistic and neurodiverse patients in ED.

## 3. Governance and Accountability

### 3.1 Safeguarding Governance Structure

The governance for Safeguarding is delivered through a quarterly Safeguarding Strategy Committee chaired by the Chief Nurse or Deputy Chief Nurse, with oversight from the Quality Governance Steering Group and Board Patient and Quality Committee. Safeguarding operational groups for adults and children provide monthly and quarterly reporting.

ICB Designated Safeguarding and Local Authority colleagues attend to ensure system-wide alignment and oversight of UHSussex arrangements. Divisional Director of Nursing representatives attend the committee to ensure safeguarding priorities are embedded at an operational level, and feed back to their local clinical governance meetings.




The following Operational Groups report to the Safeguarding Strategy Committee:

- Safeguarding Children Operational Group
- Safeguarding Adults Operational Group
- Learning Disability and Autism Steering Group
- MCA & Dols Steering Group

### 3.2 Reporting Framework

A quarterly report is provided to the Safeguarding Committee (SGC), Quality Group Steering Group (QGSG) and the Board Patient and Quality Committee (BPQC).

Quarterly reports include:

- Mandatory training and supervision performance
- Learning from local and national reviews
- Updates on partnership working
- Safeguarding activity
- Policy development
- Audit planning
- Risk management

This information is accessible to Integrated Care Board (ICB) colleagues, and a quarterly ICB Assurance Report is submitted. Additionally, monthly updates containing key safeguarding data are shared with the Divisional Quality meetings.

### 3.3 Roles and Responsibilities

The Chief Executive of UHSussex holds overall responsibility for safeguarding children, young people, and adults at risk, with the Chief Nurse designated as the Executive Lead and SRO for safeguarding and is responsible for providing overall assurance to the Trust Board on the effectiveness and quality of the safeguarding arrangements. The Associate Director for Safeguarding supports the Deputy Chief Nurse for Quality & Vulnerable Patients in providing the strategic direction for Safeguarding, Learning Disabilities & Autism.

The Chief Nurse's responsibilities include:

- Providing strategic leadership on all aspects of the Trust's contributions to safeguarding.
- Ensuring the Trust is represented at Local Safeguarding Adult and Children's Partnerships.
- Ensuring that appropriate safeguarding processes are in place, complying with all legal, statutory, and best practice requirements.

### 3.4 Statutory Safeguarding Responsibilities

The Trust is statutorily required to maintain the following roles within the organisation in relation to safeguarding. These have been fulfilled throughout 2025/26.

Safeguarding structures are established within the Trust, including the following designated roles:

- Executive Lead
- Named Doctor for Safeguarding Children
- Named Nurse for Safeguarding Children and Children in Care
- Named Midwife for Safeguarding Children
- Named Doctor for Children in Care
- Named Lead for Safeguarding Adults
- Mental Capacity Act (MCA) Lead

Named and lead practitioners play a crucial role in promoting good professional practice within the organisation. They provide advice and expertise to fellow practitioners and ensure that safeguarding training is effectively implemented.
These practitioners collaborate closely with the UHSussex leadership team, designated safeguarding professionals from the ICB, and other statutory safeguarding partners. As senior practitioners, they are experts in advocating the needs of children and adults at risk, responding to potential safeguarding concerns, and managing these issues within a multi-agency context.

Named Doctors offer support, guidance, and leadership to medical staff, primarily to senior paediatricians. They deliver and lead peer reviews (reflective safeguarding supervision for paediatricians) in addition to conducting safeguarding supervision sessions for other medical and multi-disciplinary teams.

The safeguarding team collaborates to:

- Identify children and adults at risk of harm and implement measures to protect them
- Ensure that the welfare of the child or adult at risk is paramount, with their voices central to all interventions
- Ensure compliance with local and national safeguarding procedures

- Implement national and local guidance related to safeguarding children and young people, children in care, and safeguarding adults
- Actively participate in the West Sussex and Brighton & Hove Safeguarding Children and Safeguarding Adults Partnerships and their subgroups
- Promote best practices throughout the Trust

## 4. Safeguarding Service at UHSussex

The safeguarding children team and the adults team work closely with staff and support them to respond appropriately to safeguarding concerns for children, young people and adults at risk who use UHSussex services, in line with their statutory duties.

Our safeguarding professionals are place based. However, the teams have started operating in a 'One Team' model across Sussex with clear evidence of integrated working across sites and with system partners. The introduction of a Duty Team and single safeguarding mailbox provides a consistent “front door” for safeguarding escalations and advice, strengthening responsiveness and standardisation across all sites.

Daily cross-site safeguarding huddles enable real-time collaboration, shared risk assessment and collective decision-making, ensuring a coordinated response to complex cases. This is further supported by established monthly liaison meetings with Local Authorities, demonstrating effective multi-agency partnership working and system alignment beyond the Trust. The Teams also undertake statutory multi-agency audits including single agency improvement audits and assurance activities across safeguarding themes.

Teams are working collaboratively to unblock complex discharges, providing a strong example of cross-agency problem-solving that supports patient flow while maintaining safeguarding oversight. In addition, the co-location of safeguarding teams covering in Worthing and St Richards Hospital is strengthening a “Think Family” approach, enabling closer integration between adult and children’s safeguarding practice and improving the identification and management of risk across family systems.

These arrangements underpin a true Trust-wide Adult Safeguarding team model, directly aligned to the One UHSussex ambition.

### 4.1 UHSussex Children Safeguarding Workforce

| | | |
|---|---|---|
| **Whole Time Equivalent exec Lead/Head of Safeguarding** | | |
| 1 | ADON Safeguarding | 1WTE |
| | | |
| **Named Nurses/Specialist Nurses/Practitioners Adults** | | |
| 2 | HON Children | 0.6 |
| 3 | Named Nurse | 1.6 |
| 4 | Specialist Nurse 7 | 4WTE |
| 5 | Safeguarding Practitioner | 5.11 WTE |
| 6 | Named Midwife | 1WTE |
| 7 | Specialist midwife | 4WTE |
| **Whole Time Project Support Children/Midwifery** | | |
| 8 | Safeguarding Admin | 3.11 |
| **Whole Time Named Doctors Children** | | |
| 9 | Named Doctor R | 2 PAs per week |

| | | |
|---|---|---|
| 10 | Named Doctor L | 2 Pas per week |
| 11 | Named Doctor J | 0.5 Pas per week |
| 12 | Named Doctor | 3 Pas per week |

### 4.2 UHSussex Adults Safeguarding Workforce

| | | |
|---|---|---|
| **Named Nurses/Specialist Nurses/Practitioners Adults** | | |
| 1 | HON Adults & Learning Disability | 1 WTE |
| 2 | Named Nurse | 1.6 WTE (0.8 in recruitment) |
| 3 | Specialist Nurse | 2 WTE |
| 4 | MCA Lead | 1 WTE |
| 5 | Safeguarding Practitioner | 0.8 WTE |
| | | |
| **Project Support** | | |
| 1 | Safeguarding Admin | 1.26 WTE |
| | | |

### Current establishment of the above Safeguarding Service

The Children safeguarding service is fully established by year end following implementation of the One Team model. The Adult safeguarding service has 1 Named Nurse vacancy which remained in recruitment (0.8 WTE) with a start date of October 2026.

Demand continues to increase across children's, adult and maternity safeguarding services. Children's safeguarding referrals increased by approximately 19%; rising Section 42 activity especially in RSCH; increased multi-agency complex review activity including DARDRs, greater complexity relating to mental health, exploitation, domestic abuse and self-neglect.

Whilst the Teams do not hold caseload, the primary risk is not failure to meet our statutory functions across training, supervision, advice, support and multi-agency case review and audit. These have been maintained. The risk relates to reduced capacity for audit; delays to internal quality improvement programmes, increased pressure on specialist staff and workforce resilience if demand continues to rise. Recruitment challenges and long term sickness have directly affected service capacity during the year.

The Safeguarding Plan includes succession planning and recruitment initiatives, embedding the use of the One Team model to improve resilience across sites, including ongoing review of the safeguarding workforce requirements against statutory activity and complexity.

## 5. Safeguarding Policies

UHSussex Safeguarding service collaborates with and aligns practices to partnership policies across Sussex and nationally. Trust-specific policies address the needs of the organisation and are regularly updated to reflect changes in legislation as well as local and

national learning. There are thirteen approved and in date safeguarding policies that can be accessed via UHSussex Safeguarding link.

The following policies have been updated and ratified in this reporting period:

- The Mental Capacity Act & DoLS Policy – routine update
- Safer Holding Policy – rewrite of policy to reflect national best practice guidance.
- Prevent Policy – National guidance changes.
- Safeguarding Adults Policy – national learning from serious incidents.
- Safeguarding Children Policy - national learning from serious incidents.

## 6. Safeguarding Children & Adult Training

Safeguarding training is guided by the Intercollegiate Documents published by the Royal College of Paediatrics and Child Health (RCPCH) alongside partner colleges like the Royal College of Nursing on behalf or multiple stakeholders.

The Intercollegiate document below outlines the roles and responsibilities associated with adult safeguarding and specifies the level of training required for various positions within the Trust.

Adult Safeguarding: Roles and Competencies for Health Care Staff | Publications | Royal College of Nursing (rcn.org.uk, 2024 edition)

The Intercollegiate document below was published in autumn 2025 and outlines the roles and responsibilities associated with children safeguarding and specifies the level of training required for various positions within the Trust. It merges and updates two previous frameworks (the 2019 Safeguarding Children and 2020 Looked After Children competency documents).

Safeguarding children and young people & children and young people in care: Competencies for health care staff (2025 edition)

Statutory Mandatory safeguarding Training Level 1,2 and 3 is accessible via the Iris learning platform. Bespoke essential yearly training reflecting local and national trends is delivered by the Safeguarding children and adult teams.

### 6.1 Safeguarding training requirements Adults and MCA

| Level | Staff Group | Method |
|---|---|---|
| Level 1 | All staff | Mandatory e-learning |
| Level 2 | All staff who have regular contact with patients, their families or carers, or the public | e-learning via the national programme |
| Level 3 | All staff who engage in assessing, planning and intervening and evaluating the needs of adults where there are safeguarding concerns. | e-learning via the national programme |

| | | |
|---|---|---|
| Essential Level 3 yearly updates | All staff who engage in assessing, planning and intervening and evaluating the needs of adults where there are safeguarding concerns. | Blended face to face/virtual and e-Learning |
| Level 4 | Named Professionals and safeguarding specialists | This is usually multi-agency training |

### 6.2 Safeguarding training requirements Children and young people

| Level | Staff Group | Method |
|---|---|---|
| Level 1 | All staff | Mandatory e-learning |
| Level 2 | Clinical and non-clinical staff who have contact with children, young people or their parents/carers | e-learning via the national programme |
| Level 3 (3yrly) | All clinical staff who are working with children and young people and who could potentially contribute to assessing planning intervening and evaluating the safeguarding needs of a child and their families. | e-learning via the national programme |
| Essential Level 3 yearly updates | All clinical staff who are working with children and young people and who could potentially contribute to assessing planning intervening and evaluating the safeguarding needs of a child and their families. | Blended face to face/virtual learning |
| Level 4 | Named Professionals and safeguarding specialists | This is usually multi-agency training |

### 6.3 UHSussex Safeguarding Training Needs Analysis (TNA) 2025/26

The Trust's TNAs in place are based on the intercollegiate document guidance for Children (2025) and Adults (2024). These have also been revised to satisfy the requirements of the 2025/2026 STAM arranges agreed by all providers nationally for Levels 1, 2, 3, including the requirements for the ICD 2025 for Children and Looked After Children. TNAs are reviewed regularly to ensure that the Trust is meeting national guidance.

From January 2026, Safeguarding Children L3 and Safeguarding Adults Level 3 training moved from an annual update to a three-yearly training cycle in line with the new national STAM arrangements. All staff who are required to hold Level 3 Safeguarding Children & Adults competence are required to complete the national e-learning programmes via UHSussex IRIS platform. In addition to the 3-yearly e-learning training on IRIS, all staff who require L3 Safeguarding children and adults training receive a minimum of 2 hours face-to-face/online essential CPD every year facilitated by the Safeguarding team and guest trainers.

### 6.4 Safeguarding Children Training Compliance

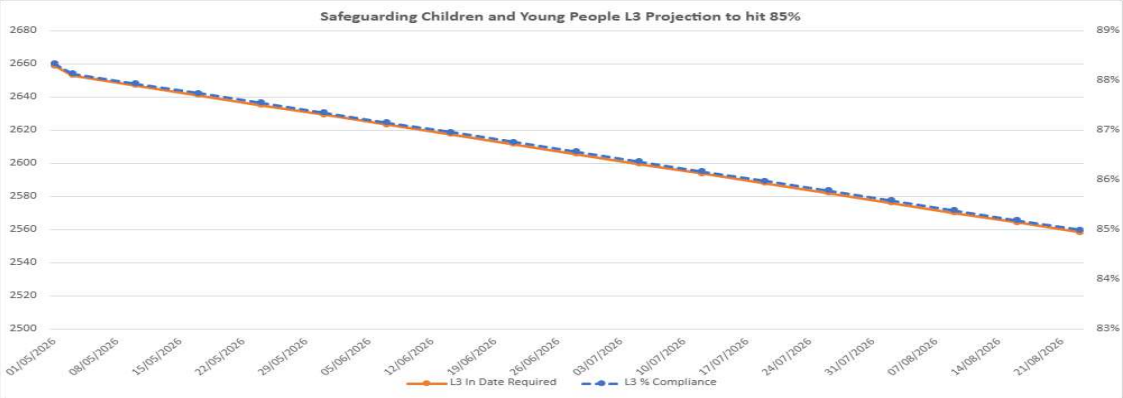
| | Mar 25 | Apr -25 | May 25 | Jun -25 | Jul-25 | Aug -25 | Sep -25 | Oct-25 | Nov -25 | Dec -25 | Jan-26 | Feb -26 | Mar -26 | Apr -26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Level 1 % | 96.1% | 96.5% | 96.1 % | 89.6% | 89.4 % | 94.0% | 94.9% | 95.0% | 95.5% | 95.7% | 95.7% | 95.8% | 95.1% | 95.1% |
| Level 2 % | 92.9% | 93.5% | 93.6 % | 93.1% | 93.6 % | 94.5% | 94.1% | 94.0% | 92.5% | 92.8% | 92.6% | 93.8% | 93.1% | 93.1% |
| Level 3 % | 78.5% | 78.2% | 77.8 % | 79.2% | 78.0 % | 80.1% | 83.6% | 83.2% | 82.8% | 82.9% | 85.4% | 86.3% | 87.2% | 86.8% |

The safeguarding L1 and L2 training for Children has been consistently above the national threshold of 85%, sitting at 95.1% and 93.1 % respectively. A 7% increase from 2024/25. The compliance for L3 for 2026 has steadily increased every quarter from 78.5% in 2025 to 86.8% of 2999 staff in 2026, above national targets. This trajectory strengthens assurance in the capability of our workforce who assess, plan, and support children and young people to recognise and respond to abuse and neglect across our most vulnerable populations.

For the Trust to meet its target of 85% compliance, the trajectory below was required:

| | |
|---|---|
| **Average Weekly Additional Staff Required to be in Date to Meet 85% Target** | -6 |

| | |
|---|---|
| **Additional Staff Required to be in Date to Meet 85% Target** | -101 |




The Trust has exceeded its compliance trajectory towards the 85% target, requiring no additional workforce uplift to achieve this standard. Analysis indicates an average weekly surplus of six staff already compliant, equating to 101 staff above the required threshold. This position provides strong assurance that safeguarding training compliance is not only being sustained but is exceeding planned expectations, thereby reducing organisational risk and strengthening workforce capability in recognising and responding to safeguarding concerns.

## 6.5 Adult Safeguarding Training compliance 2025/2026

| | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Level 1 | 95.6% | 96.0% | 95.9% | 89.5% | 89.2% | 94.0% | 95.2% | 95.3% | 95.1% | 95.5% | 95.5% | 96.1% | 95.4% |
| Level 2 | 91.4% | 92.3% | 92.4% | 92.0% | 92.3% | 93.7% | 93.2% | 92.8% | 91.5% | 91.5% | 91.6% | 92.2% | 92.2% |
| Level 3 | 81.6% | 80.7% | 83.3% | 83.6% | 84.7% | 85.4% | 86.1% | 86.3% | 86.1% | 86.6% | 88.8% | 76.5% | 75.2% |

Training compliance for Adults Level 1 and 2 remains consistently above 90%. in the last 2 years. Level 3 safeguarding training compliance has reflected both planned growth from 2025 and transitional impact during this reporting period. As projected within the Training Needs Analysis (TNA), the number of staff requiring Level 3 training increased significantly.

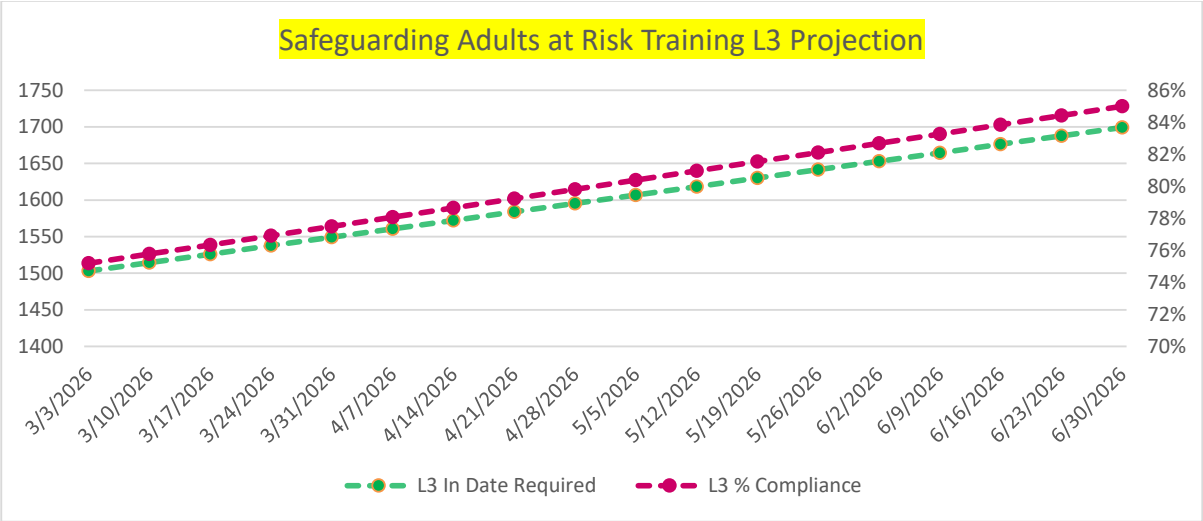
To address challenges associated with inconsistent job titles and role descriptions across the organisation, the Education and Learning Team implemented a revised approach using cost codes to more accurately align staff to training requirements.

While this has improved the accuracy and governance of workforce data, it has also resulted in an anticipated reduction in overall compliance, with performance reaching 75.2% at the end of the Q4. Presenting a renewed risk to maintaining required safeguarding standards. The following targeted recovery actions are therefore in place throughout 2026/27 to restore performance to the expected level and ensure continued assurance in staff competence to recognise and respond to safeguarding concerns:

- Focused training and support for areas below target
- Divisional compliance monitoring
- Using the National E-Learning for Health Training

Trajectories have been reviewed and for the Trust to meet its target of 85% national compliance, the following trajectories will need to be followed in the reporting period 2026/27:

| | | | |
|---|---|---|---|
| Average Weekly Additional Staff Required to be in Date to Meet 85% Target | 11 | Total Staff Required to be Trained to Meet 85% Target | 196 |




The key assurance point is that the issue has been identified, quantified and incorporated into the 2026/27 safeguarding priorities with a clear recovery plan.

### 6.6 Oliver McGowan Training

The Oliver McGowan Mandatory Training (OMMT) on Learning Disability and Autism is named after Oliver McGowan, whose tragic death highlighted the urgent need for improved training for health and social care staff. The Health and Care Act 2022 introduced a statutory requirement that regulated service providers ensure their staff receive training on learning disabilities and autism appropriate to their roles.

### 6.7 Oliver McGowan Mandatory Training Requirements

University Hospitals Sussex commenced the phased rollout of Oliver McGowan Mandatory Training (OMMT) in 2023. The programme comprises two tiers aligned to staff roles and responsibilities. Current compliance for the e-learning component across both tiers is at 96% in March 2026, representing a significant achievement and placing the Trust in a strong position ahead of the next phase of delivery.

Preparatory work, including agreement of the Training Needs Analysis (TNA), updates to ESR and the IRIS training platform, and implementation planning, is progressing in line with agreed timescales, with the next phase scheduled to launch in May 2026. Staff will be aligned to the appropriate training tier based on their role, responsibilities and the level of care they provide, ensuring a targeted and proportionate approach to workforce development.

**Tier 1** consists of the mandatory e-Learning and a 60 minute online interactive session for staff who require a general awareness of the support autistic people or people with a learning disability need

**Tier 2** consists of the mandatory e-Learning and a 1-day face to face training with a facilitator. This will be for staff who may need to provide care and support for autistic people or people with a learning disability.

### 6.8 Oliver McGowan Tier 1 & 2 e-learning Training Compliance

| | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % Compliance | 93.1% | 93.4% | 93.9% | 93.2% | 94.9% | 95.6% | 95.7% | 96.0% | 96.0% | 96.2% | 96.3% | 96.5% | 96.7% |

The above table demonstrates consistently strong performance across the reporting period, from 93.1% in 2025 to 96.7% by March 2026. Compliance has remained significantly above the Trust target (95%) with sustained upward trajectory and minimal variation, indicating a high level of workforce engagement and effective oversight.

## 7. Safeguarding Children & Adult Supervision

Staff at UHSussex have access to both informal and formal supervision through various group case discussions, peer reviews, with monthly supervision sessions offered to specialist services. The safeguarding teams also provide individual supervision and remain responsive to inquiries for advice and support.

There is a national standard set that requires the safeguarding teams to engage in regular supervision, with named professionals receiving supervision from the designated professionals in the local ICB. Restorative Reflective supervision is provided by the Professional Nurse Advocate Service to support the safeguarding teams.

## 8. Safe Recruitment and Management of Allegations against People who Work with Children and Adults at risk.

All staff at UHSussex continue to undergo enhanced DBS checks in line with NHS Safer Recruitment standards. The Trust meets its statutory duty to manage and investigate allegations relating to staff and volunteers working with children and adults at risk, including conduct in both professional and personal contexts.

Allegations are managed in accordance with Trust policy, with robust monthly oversight provided through a multi-disciplinary forum involving senior safeguarding, nursing, workforce, and HR leads. This ensures that all concerns are reviewed consistently, risk is appropriately assessed, and timely actions are taken. Where required, cases are escalated to external partners, including the Police, Local Authorities, and the Local Authority Designated Officer (LADO), in line with statutory guidance.

The Trust's policy applies where it is alleged that an individual has caused harm, may pose a risk of harm, or may be unsuitable to work with children or adults at risk. Management of allegations is recognised as a complex and sensitive area of practice, requiring close collaboration across safeguarding, HR, and system partners to ensure proportionate and legally compliant responses.

In 2025/26 there were 50 allegations reported, compared to 33 in 2024/25. Of these cases 20 involved individuals working with children and young people (14 in 2024/25). This increase reflects improved reporting and oversight through a centralised nhs.net mailbox, raising the profile of the policy. All cases were managed in line with policy, with outcomes including no further action, suspension, police referral, safeguarding referral, and internal investigation.

These arrangements provide assurance that the Trust has effective systems in place to manage and respond to allegations, thereby safeguarding patients while ensuring fair and proportionate processes for staff.

## 9. FGM Mandatory Reporting

Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act (2003). It is classified as a form of child abuse and violence against women. Regulated health professionals in England and Wales are required to report any known cases of FGM in individuals under 18 that they identify in the course of their professional work to the police. This reporting requirement came into effect on 31 October 2015.

Nationally, NHS England reported 6,980 women and girls with FGM-related attendances across 104 NHS trusts and GP providers during 2024/25, demonstrating that FGM remains an important safeguarding issue within healthcare services.

In 2025/26, there were 43 reported cases of Female Genital Mutilation (FGM), compared to 33 in 2024/25, indicating increased identification and reporting activity. This increase is also likely influenced by the growing number of women accessing maternity services through the **asylum seeker and refugee pathway**, reflecting the changing demographics of the local population and the associated safeguarding needs.

There have been no mandatory referrals for individuals under the age of 18 over the past two years. However, within this reporting period, FGM Information Sharing (FGM IS) submissions were completed for 19 female infants by safeguarding midwives, demonstrating strengthened compliance with national reporting requirements and proactive safeguarding practice within maternity services.

## 10. Child Protection Medicals

Child Protection Medical activity decreased slightly in 2025/26 (214) compared to 2024/25 (243), driven by reduced activity at WH/SRH, while RSCH/PRH remained stable. This variation is being monitored to ensure continued timely access and to maintain assurance that children requiring assessment are appropriately identified and seen.

| Child Protection Medicals | | | |
|---|---|---|---|
| | 2023/24 | 2024/25 | 2025/26 |
| WH/SRH | 126 | 146 | 113 |
| RSCH/PRH | 100 | 97 | 101 |
| Total | **226** | **243** | **214** |

## 11. Child Death Reviews

Unexpected child deaths that could not have been anticipated in the preceding 24 hours trigger a Joint Agency Response (JAR) aimed at establishing the cause of death and ensuring support for the family. A clinical practitioner and safeguarding specialist attend the JAR to consider any safeguarding issues, including the safety of other children.

### 11.1 Child Deaths 2024/25

| Hospitals | Deaths overall | Children over 1 year | Neonates | Expected | Unexpected |
|---|---|---|---|---|---|
| WH & SRH | 8 | 4 | 4 | 4 | 4 |
| RSCH & PRH | 14 | 3 | 11 | 11 | 3 |
| Total | 22 | 7 | 15 | 15 | 7 |

### 11.2 Child Deaths 2025/26

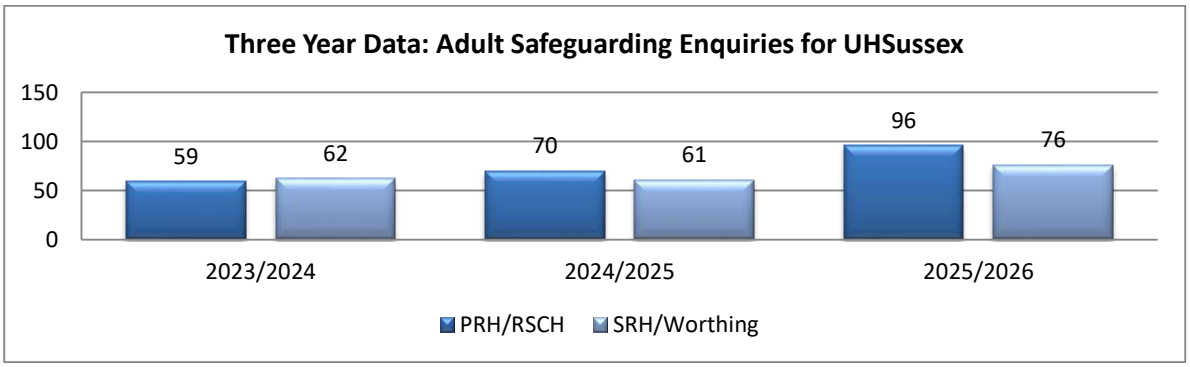
| Hospitals | Deaths overall | Children over 1 year | Neonates | Expected | Unexpected |
|---|---|---|---|---|---|
| WH & SRH | 12 | 4 | 2 | 2 | 4 |
| RSCH & PRH | 18 | 1 | 7 | 9 | 0 |
| Total | 30 | 5 | 9 | 11 | 4 |

Learning from unexpected child deaths is embedded within safeguarding training to strengthen professional curiosity and practice. In 2025/26, there were 4 unexpected deaths compared to 7 in 2024/25. Not all cases are attributable to abuse or neglect; therefore, learning is applied proportionately, focusing on risk factors and early intervention to improve safeguarding practice and multi-agency response.

## 12. Safeguarding Adults Section 42 Enquiries at UHSussex

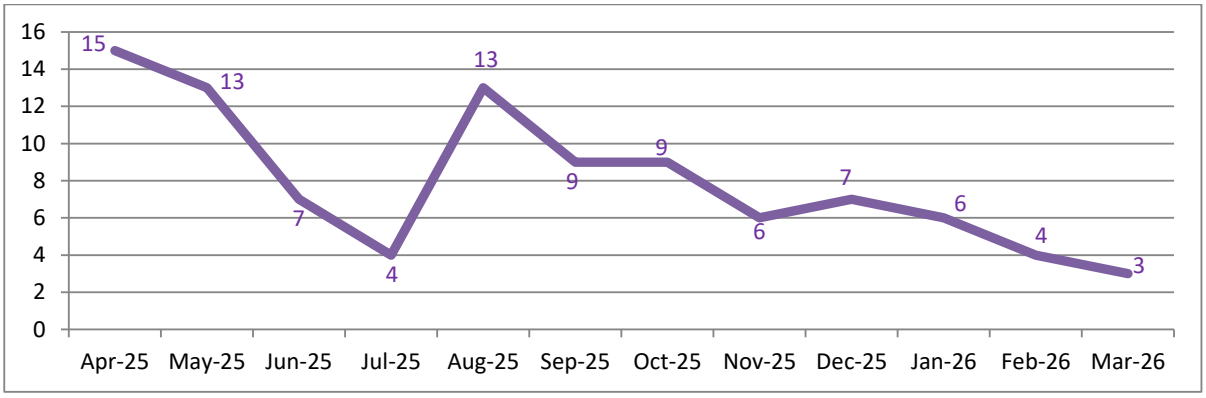
Local authorities have a statutory duty to make enquiries, or cause others to undertake enquiry, if they believe an adult is experiencing, or is at risk of, abuse or neglect. UHSussex provides services to the population of Sussex and may be caused to undertake enquiry by any of the three Sussex local authorities if there are concerns regarding the care provided by UHSussex hospitals or outpatient services.

The table below shows a three-year comparison of the total number of safeguarding enquiries received across UHSussex hospitals. Adult Safeguarding enquiries have increased over the three-year period, with PRH/RSCH rising from 59 in 2023/24 to 96 in 2025/26, and SRH/Worthing increasing from 62 to 76 over the same period. This upward trend indicates improved identification and reporting of safeguarding concerns across all sites. The increase is being monitored to ensure capacity and response remain effective, providing assurance that safeguarding risks are recognised and acted upon in a timely manner.




As part of maintaining effective oversight of safeguarding activity, the safeguarding team reviews not only the volume of enquiries but also the underlying categories and themes to identify trends and areas of risk. Figures 1 and 2 illustrate the number of safeguarding enquiries and associated themes relating to care provided by UHSussex across Newhaven, Brighton, and Haywards Heath hospitals. A single safeguarding concern may be linked to multiple themes.

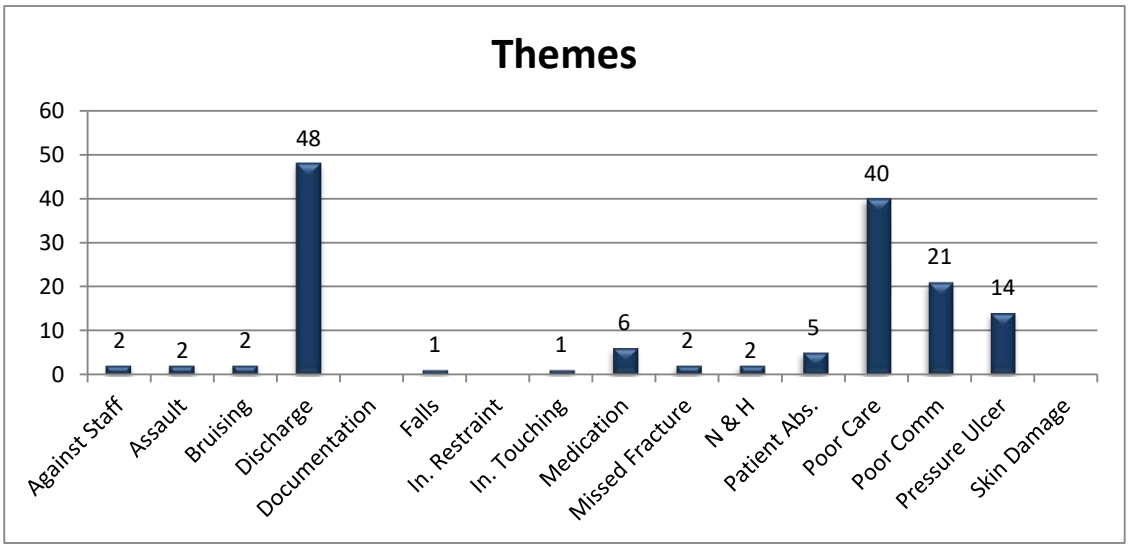
### 12. 1 Safeguarding Adults Section 42 Enquiries – RSCH & PRH - Total 96




Section 42 enquiries initiated by Local Authorities relating to RSCH/PRH have reduced overall from 15 in April 2025 to 3 in March 2026, with some variation across the year. This reflects fluctuation in external enquiry activity rather than a direct measure of safeguarding incidents.

The Trust continues to work closely with Local Authority partners to ensure appropriate application of Section 42 thresholds and consistent decision-making. This is supported through multi-agency oversight and review, including a monthly liaison meeting with the Local Authority providing assurance that safeguarding concerns are recognised, appropriately referred and managed effectively.

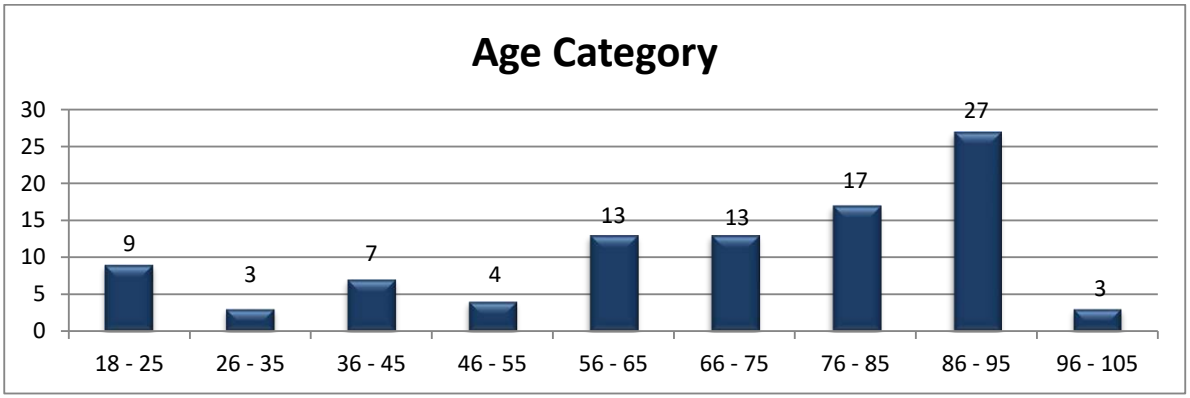
### 12.2 Themes raised in Safeguarding Section 42 Enquiries - RSCH & PRH




Analysis of safeguarding themes has identified that discharge, poor care, communication and pressure ulcer–related cases remain the predominant areas of concern at UHSussex. Discharge and poor care related section 42 enquiries have doubled (48 from 23 in 2024/5; 40 from 26 in 2024/25). This reflects ongoing system pressures across care quality and discharge pathways, which remain key priorities for improvement. While some reduction has been noted in medication management (6 from 10 in 24/25) indicating a shift towards improved processes and effective training for staff in this area. Safeguarding Adult Lead Nurses continue to contribute to the weekly Harm Free Care Panel, working in collaboration with Matrons and Heads of Nursing to identify learning and drive improvement actions.

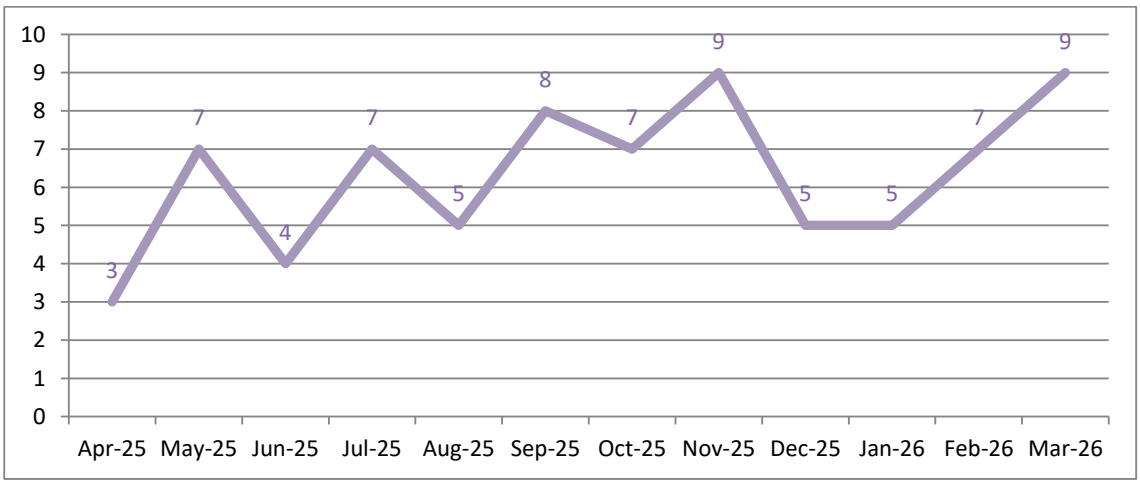
During 2025/26, this has been strengthened through closer alignment with Divisional Governance teams to integrate learning from safeguarding enquiries with wider quality and safety intelligence. This approach supports a more cohesive and proactive model of improvement, providing assurance that safeguarding insight is systematically used to inform practice and reduce risk.

### 12.3 Safeguarding Adults S42 Enquiries Received – Age - RSCH & PRH



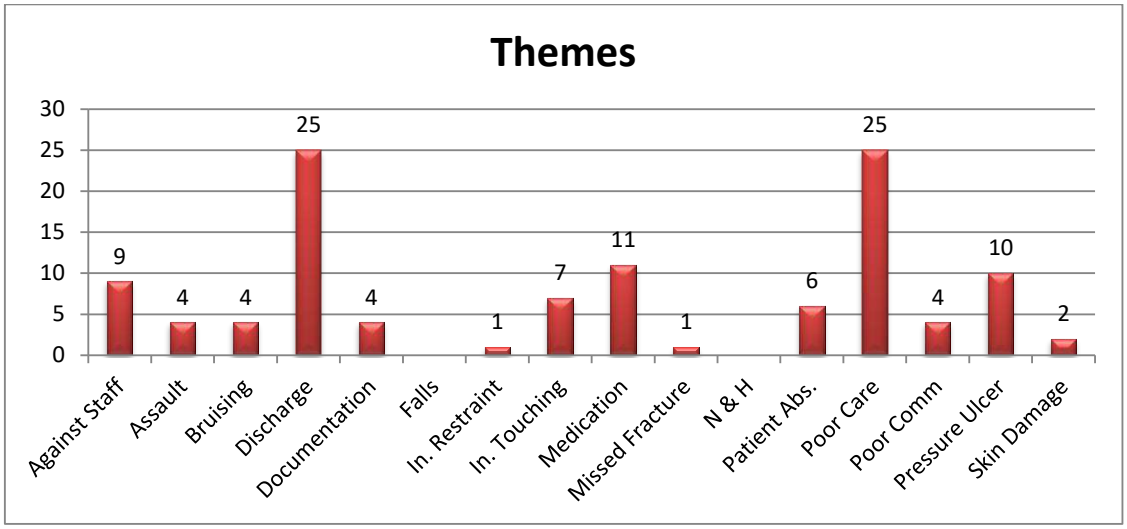

Analysis of safeguarding enquiries by age category indicates that the highest proportion of concerns relates to older adults, particularly those aged 86-95 (27), followed by 76-85 (17). Lower levels are observed across younger age groups. This reflects the increased vulnerability and complexity of need within older populations and will continue to inform targeted safeguarding focus and resource allocation.

### 12.4 Safeguarding Adults Section 42 Enquiries – WH & SRH - Total 76




When compared to the previous year, safeguarding enquiries from Local Authorities have increased from 61 to 71 in 2025/26, reflecting a broadly consistent but rising pattern in referral activity, which continues to be monitored to ensure appropriate response and oversight.

### 12.5 Themes raised in safeguarding enquiries - WH & SRH



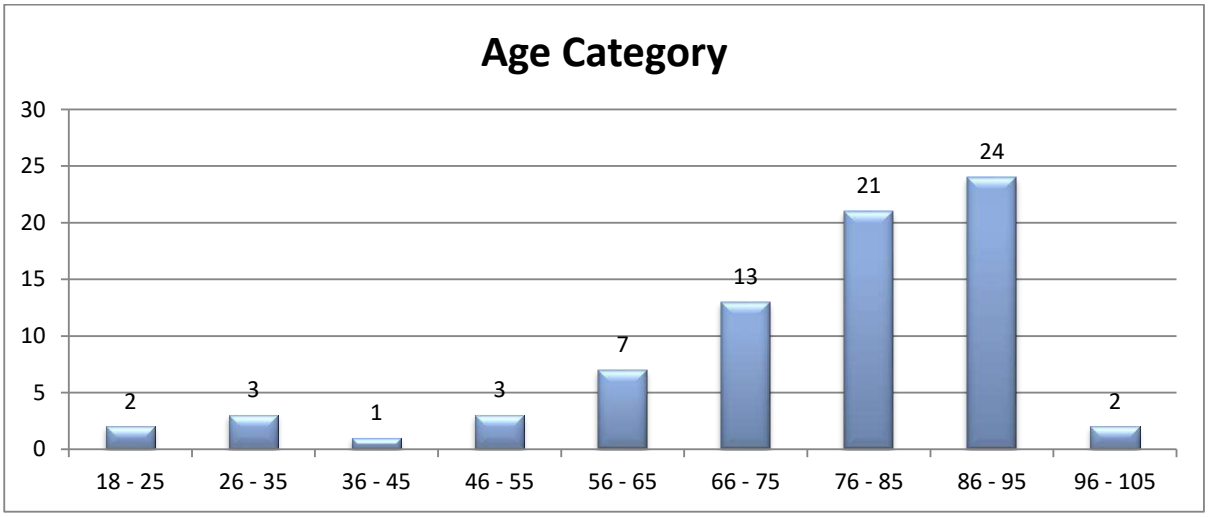

Analysis of themes at WH/SRH indicates that discharge and poor care remain the most frequently identified concerns, with both showing a significant increase compared to 2024/25 (discharge - 25 from 13; poor care- 25 from 15). This highlights ongoing pressures across care quality and discharge pathways, which remain key priorities for improvement and continued oversight.

Medication-related safeguarding concerns such as discharge medication issues creating risk after transfer of care and medication errors contributing to deterioration have increased from 2 in 2024/25 to 11 in 2025/26, highlighting an emerging area of risk. This is being monitored to inform targeted improvement actions and strengthen medication safety.

Pressure ulcer-related enquiries have reduced. (10 from 18 in 24/25). While previous analysis suggested some improvement in discharge-related concerns, current data indicates sustained activity alongside an increase in care quality-related themes. A thematic review of Category 2 and above hospital-acquired pressure ulcers undertaken in November 2024 did not identify any statistically significant themes at that time, suggesting that individual case factors rather than systemic failure may be contributory.

Safeguarding Adult Lead Nurses continue to play a key role within Harm Free Care Panels and Early Learning Reviews, working collaboratively with Matrons, Heads of Nursing, and Divisional Governance teams to triangulate learning from safeguarding enquiries with wider quality data and drive targeted improvement actions. This provides assurance that safeguarding intelligence is systematically used to identify risk, inform improvement, and strengthen patient safety across the Trust.

### 12.6 Safeguarding Adults S42 Enquiries Received – Age - WH & SRH




Safeguarding enquiries by age at WH/SRH show an increase among individuals aged 18–65 compared to the previous year (16 from 6 in 2024/25). These cases are primarily associated with patients with self-neglect, learning disabilities and mental health patients, reflecting increased complexity and vulnerability within this cohort. The Trust is also strengthening policies and enhancing collaborative system working with partners to support a more coordinated and effective clinical and safeguarding response.

The highest activity remains within older populations, particularly those aged 66–95, reflecting increased vulnerability and complexity of need. This continues to inform targeted safeguarding focus and oversight, providing assurance that resources and interventions are aligned to areas of greatest risk.

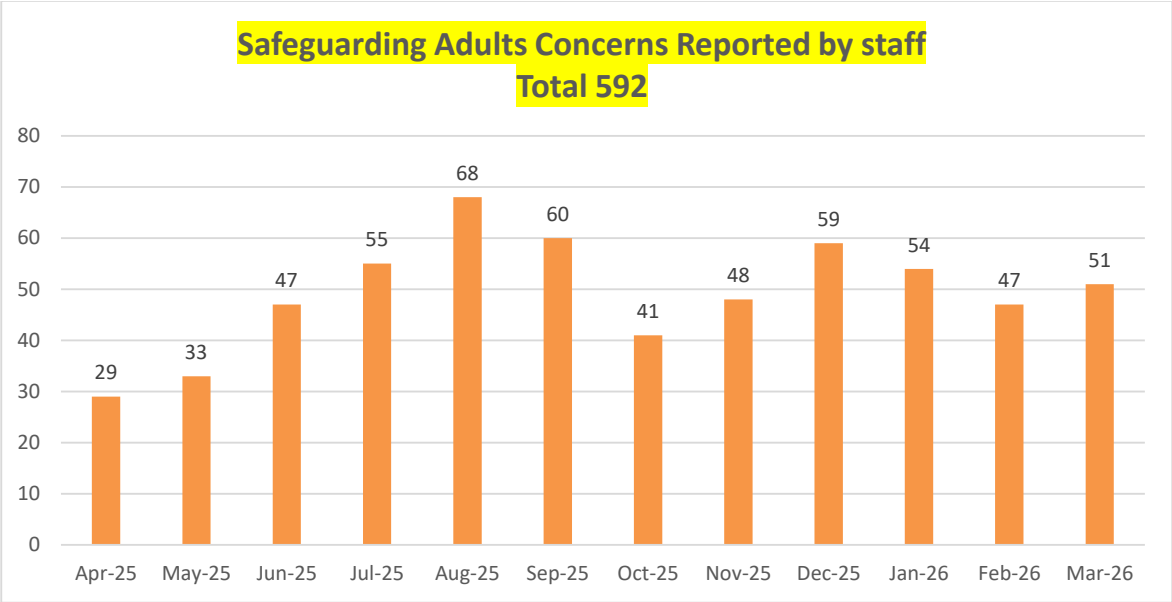
## 13. Safeguarding Adults Activity Across UHSussex

The Safeguarding Adults Team continues to monitor concerns raised by clinicians to Local Authorities on behalf of patients accessing UHSussex services. In 2025/26, a total of 592 concerns were recorded, consistent with the previous year, indicating stable reporting activity following the transition from paper to digital referral systems in 2024/25, which had previously impacted reporting volumes. Monthly variation was observed, ranging from 29 in April 2025 to a peak of 68 in August 2025, before stabilising towards year end.

Medicine divisions continue to generate the highest number of referrals, with key themes including self-neglect, psychological concerns, substance misuse, and domestic abuse, highlighting the complexity of vulnerabilities within this cohort.

Safeguarding is represented at the Patient Safety Incident Review Group (PSIRG), ensuring that safeguarding concerns are considered alongside patient safety incidents and supporting a coordinated approach to risk identification, learning, and improvement.

This provides assurance that safeguarding activity is increasingly recorded, reported, and monitored consistently across the Trust.




## 14. Mental Capacity Act (MCA) and Deprivation of Liberty safeguards

The Mental Capacity Act (2005) is a crucial piece of legislation designed to protect individuals who may lack the capacity to make specific decisions for themselves due to conditions such as mental health issues, learning disabilities, or other impairments. The Act sets out a framework for making decisions on behalf of individuals who cannot do so with an emphasis on respecting individuals' rights and autonomy.

### 14.1 MCA Education and Training

Strengthening workforce knowledge and application of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) has remained a key priority during 2025/26. The MCA component of safeguarding training has been revised and updated to align with the Intercollegiate Safeguarding Adults: Roles and Competencies framework and recent case law developments.

Core MCA training is delivered through the safeguarding adults training programme, with Level 1 and Level 2 compliance consistently maintained above target throughout the year. Level 3 safeguarding adults training compliance exceeded the 85% target during earlier quarters, although this reduced to 75% in Q4 following an increase in the number of staff requiring training in line with the updated Training Needs Analysis (TNA). Ongoing work is in place to review training trajectories and support recovery in 2026/27.

A blended learning approach has been introduced to strengthen the application of MCA and DoLS in practice, incorporating face-to-face training, case-based discussion. In addition, bespoke training continues to be delivered across sites to support clinical teams, with targeted sessions addressing specific patient groups and clinical contexts.

The introduction of safeguarding supervision and the establishment of the Mental Capacity Act Operational Group further strengthen oversight, governance, and consistency in the application of MCA across the Trust.

## 15. Deprivation of Liberty Safeguards activity & data

UHSussex acts as the 'Managing Authority' when depriving adults of their liberty when they lack the capacity to consent to the arrangements in place, necessary for them to access treatment and care. The trust has a statutory duty to comply with the legal processes in relation to DoLS and to seek authorisation from the appropriate local authority.

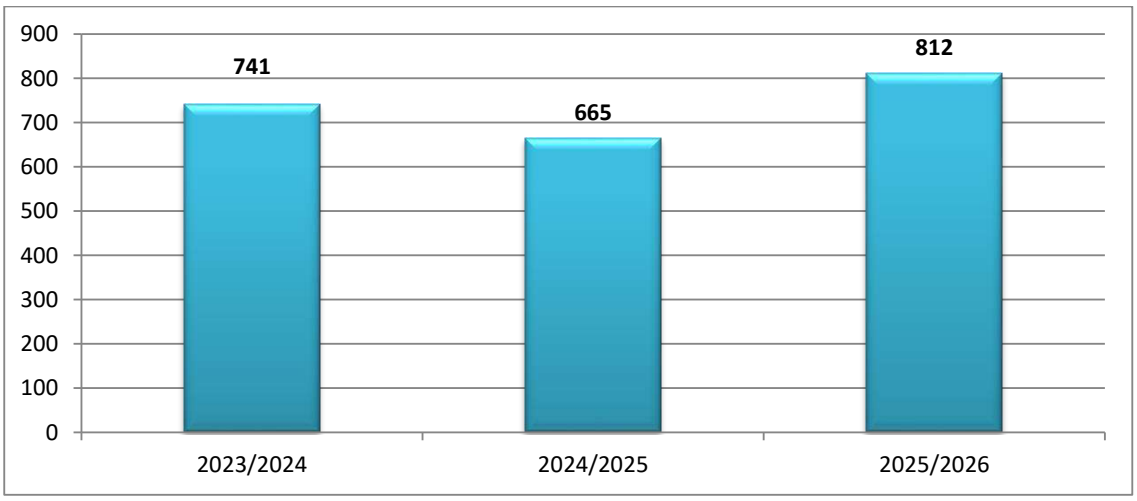
The data below illustrates the increasing number of DoLS authorisation requests made by all UHSussex hospitals to the local authorities across Sussex. As the Managing Authority, the Trust can grant itself urgent authorisation for a period of 7 to 14 days and must still submit this to the local authority to ensure external oversight. Standard DoLS authorisation for periods longer than urgent authorisation can only be granted by the relevant local authority.

UHSussex is also required to notify the Care Quality Commission (CQC) of all DoLS authorisations approved by the local authority, and processes are in place to facilitate this notification.

AUK Supreme Court judgment in June 2026 has overturned the Cheshire West "acid test," introducing a more person-centred, multi-factorial approach based on the patient's wishes and feelings; context and setting; degree of objection and purpose of care arrangements, to determine deprivation of liberty. This is a significant shift in practice. The implications of this change are being reviewed, and its impact on DoLS application and practice will be reflected in future reporting.

It should be noted that the increase in DoLS applications in 2025/26 is primarily evidence of improved recognition and application of legal safeguards rather than a consequence of the new judgment.

### 15.1 DoLS authorisation requests over last three years RSCH, PRH & Newhaven



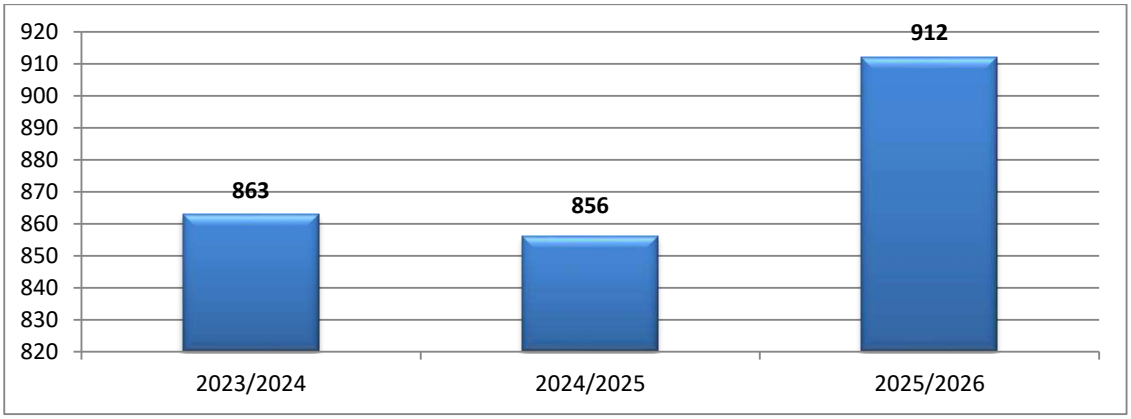
The increase in standard DoLS applications to 812 in 2025/26 (from 665 in 2024/25) is likely multifactorial. It reflects improved identification and application of the Mental Capacity Act across Brighton & Hove, supported by strengthened training, increased awareness among clinical teams and more consistent use of DoLS following system and process changes.

In addition, the rise aligns with increasing patient complexity, particularly among frail older adults, patients with cognitive impairment, and those presenting with mental health needs, where restrictions in care are more frequently required to ensure safety.

The transition to digital systems and improved visibility of safeguarding activity has also supported more consistent recording and monitoring of DoLS applications.

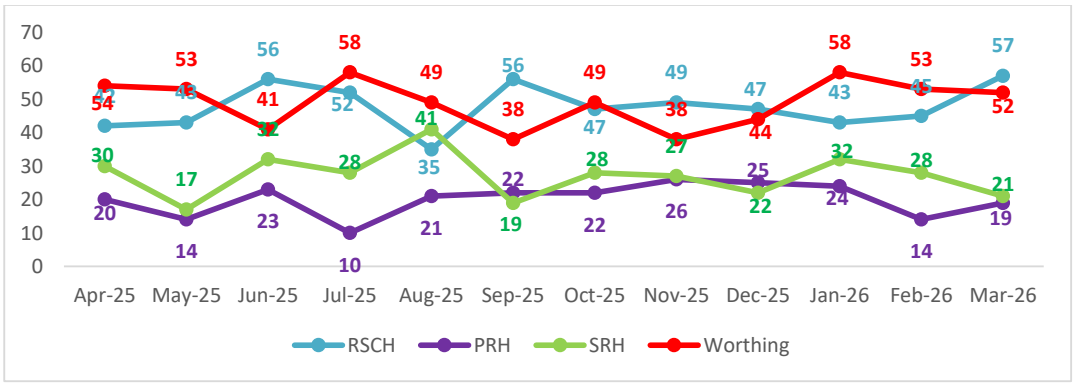
It is important to note that not all applications result in authorisation, as patients may be discharged, regain capacity, or no longer meet the threshold for deprivation of liberty.

### 15.2 DoLS Authorisation Requests for Past Three Years Worthing & SRH



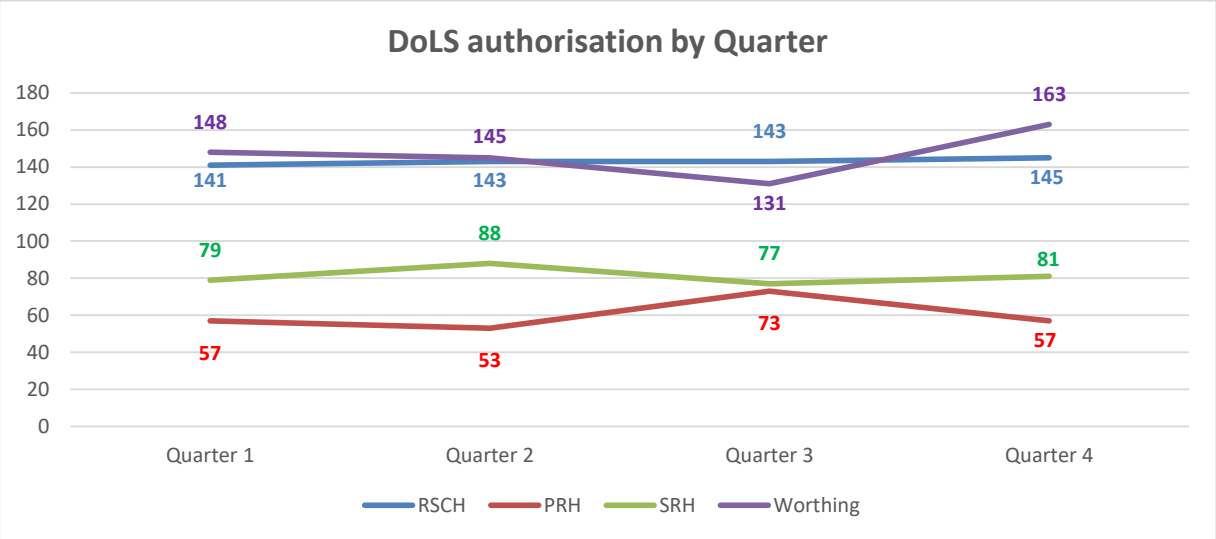

DoLS applications at Worthing and St Richard's increased by 56 to 912 in 2025/26, from 856 in 2024/25, reflecting sustained demand and improved identification. This provides assurance that appropriate recognition of deprivation of liberty is continuously improving and managed in line with the Mental Capacity Act.

### 15.3 DoLS authorisation requests per month across UHSussex (2025 - 26) – Total: 1724




Significant work was undertaken during 2025/26 to raise the profile of DoLS across RSCH and PRH, which has been effective in improving awareness and application in practice.

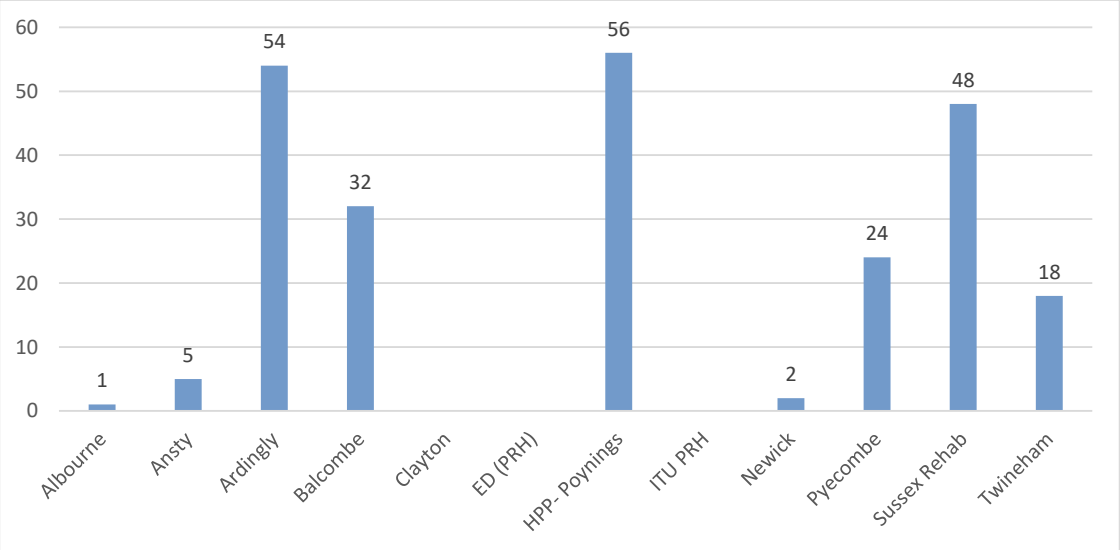
### 15.4 DoLS authorisation requests per quarter across UHSussex




The general picture for Dols activity shows an increasing trajectory on of DoLS authorisation requests made by all UHSussex hospitals to the local authorities across Sussex.

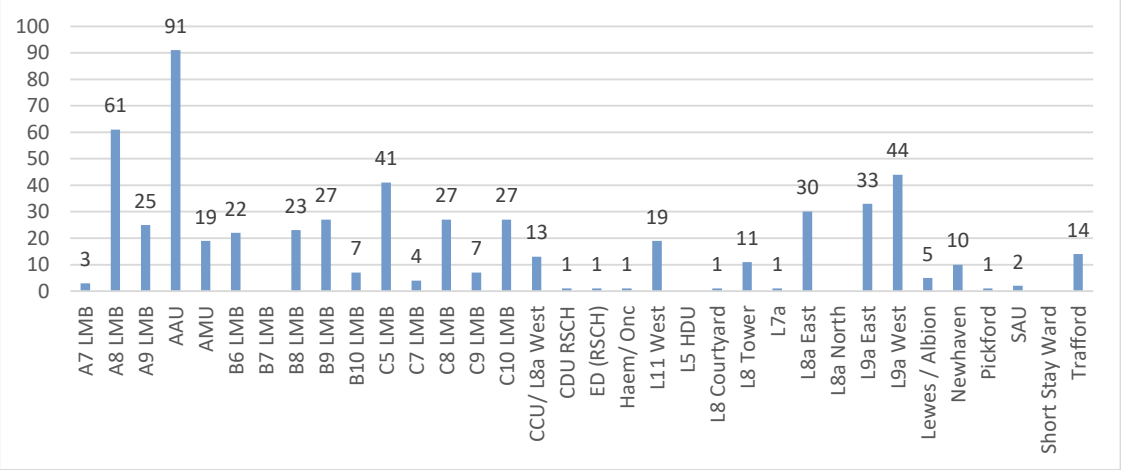
### 15.5 DoLS Authorisation Requests by Wards at PRH – (240)

Requests increased from 208 in 2024/25 to 240 in this reporting period. This is reflective of the work undertaken by the safeguarding team in collaboration with Wards.



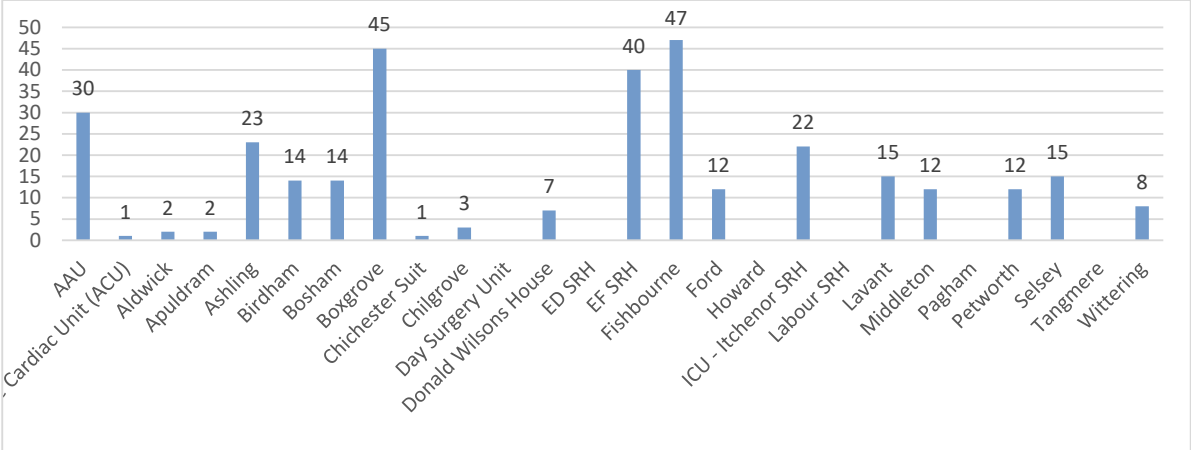
## 15.6 DoLS Authorisation Requests by Wards at RSCH – (572)

Requests increased from 457 in 2024/25 to 572 in this reporting period. Most applications are from AAU, A8 LMB, L9a West and C5 LMB reflecting the complexity and acuity of patients within these areas.



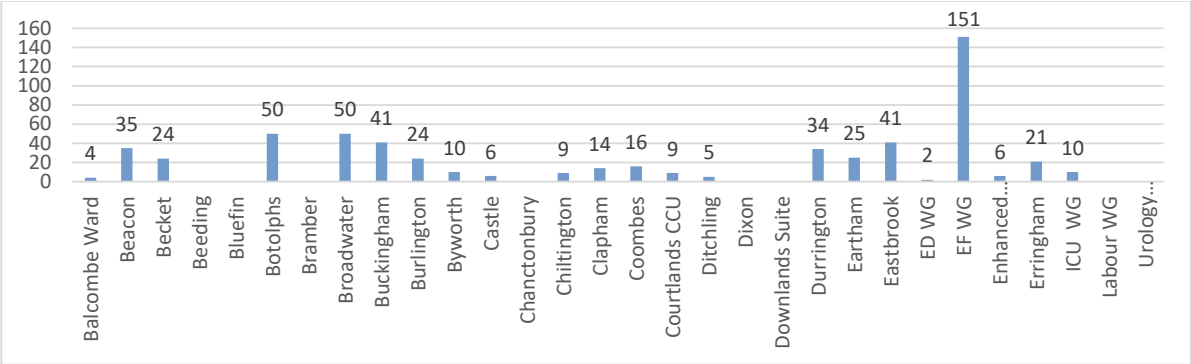

## 15.7 DoLS Authorisation Requests by Wards at SRH – (325)

DoLS applications have increased from 244 in 2024/25 to 325 in 2025/26. Most applications are from Fishbourne, Boxgrove, the Emergency Floor, and AAU, reflecting the complexity and acuity of patients within these areas.




## 15.8 DoLS Authorisation Requests by Wards at WH – (587)

DoLS applications have decreased from 619 in 2024/25 to 587 in 2025/26. Most requests continue to originate from the Emergency Floor, reflecting the acuity and complexity of patients presenting through this pathway.




## 16. Domestic Abuse and Violence

Specialist domestic abuse services in Brighton are provided by Victim Support, while Worth Domestic Abuse Services delivers specialist services across West Sussex. As part of their contract with the local authority and ICB, a Health Independent Domestic Abuse Advisor (HIDVA) from Victim Support is based at the RSCH. Similarly, Worth Services provides three HIDVAs who are stationed at PRH, WH and SRH. The HIDVAs offer specialist support to both patients and staff who disclose domestic violence or abuse.

Staff can refer individuals directly to the HIDVA service; however, if the adult has additional vulnerabilities, there may be a need to raise a safeguarding concern with the local authority as well.

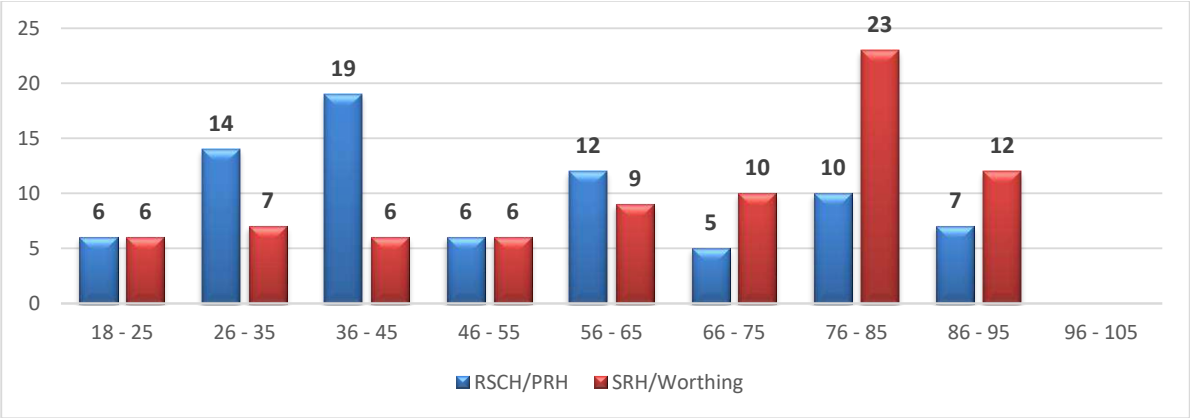
### 16.1 Domestic Abuse Referrals at RSCH/ PRH total – (79)

During 2025/26, UHSussex staff across RSCH and PRH raised 79 safeguarding concerns related to domestic abuse, compared to 48 in 2024/25, reflecting improved identification and reporting within clinical practice. Domestic abuse remains a key safeguarding theme, supported by the HIDVA and multi-agency collaboration, providing assurance that patients experiencing abuse are appropriately identified and supported. The HIDVA service has been recommissioned for 2026/27, ensuring continued specialist support for patients experiencing domestic abuse.

### 16.2 Domestic Abuse Referrals at SRH & Worthing total – (79)

During 2025/26, UHSussex staff across SRH and Worthing raised 79 safeguarding concerns related to domestic abuse, compared to 109 in 2024/25, representing a reduction in reported cases. However, domestic abuse remains a consistent safeguarding theme across the Trust and continues to feature prominently within wider referral patterns. Strengthening awareness, training, and collaborative system working, supported by the HIDVA service, remains a priority for 2026/27 to ensure patients experiencing domestic abuse are consistently identified and supported.

### 16.3 Domestic Abuse Concerns Raised by Age across UHSussex




During this reporting period, higher numbers of domestic abuse safeguarding concerns were recorded among patients aged 36–45 (25) and 76–85 (33). While older patients continue to represent a significant proportion, there has been a notable reduction in referrals across the 66–95 age group, decreasing from 110 in 2024/25 to 67 in 2025/26.

In contrast, reporting among the 26–55 age group has increased to 70 from 38 in 2024/25, particularly at RSCH and PRH, indicating a shift in identification and referral patterns. This may reflect improved awareness, more consistent enquiry, the contribution of the HIDVA service, and strengthened work within maternity services to support identification and response.

Domestic abuse remains a key safeguarding priority across the Trust and the wider system. Continued focus on workforce awareness, routine enquiry, and multi-agency working is required to ensure that all patient groups are consistently identified and supported.

## 17. Modern slavery

UHSussex actively addresses modern slavery and supports all staff to identify and mitigate risks of modern slavery, ensuring compliance with legislation like the Modern Slavery Act 2015. It does this through:

**Procurement -** UHSussex incorporates modern slavery requirements into procurement policies and contracts, leveraging its buying power to influence suppliers. This includes mandatory exclusion questions regarding the Modern Slavery Act during procurement of goods and services.

**Safeguarding Training and Awareness -** UHSussex provides training to staff, particularly frontline healthcare workers, to recognise potential victims of modern slavery and understand how to respond.

**Supply Chain Management -** UHSussex ensures suppliers adhere to relevant legislation and ethical standards, including those related to modern slavery.

**Reporting and Transparency -** UHSussex publishes an annual statement on modern slavery, outlining steps taken to address the issue, maintain transparency and ensuring compliance with the Modern Slavery Act 2015. The annual statement is published on the UHSussex website here: https://www.uhsussex.nhs.uk/resources/modern-slavery-statement/

It is also made available to all staff on the Staff intranet.

**Collaboration and Partnerships -** UHSussex collaborates with various agencies and organisations within the Sussex partnership to tackle modern slavery, including participating in multi-agency groups focused on exploitation and the National Referral Mechanism.

**Safeguarding Adults and Children -** UHSussex implements safeguarding policies and procedures to protect vulnerable individuals, including children and adults, who may be at risk of exploitation.

**Freedom to Speak Up -** The UHSussex "Freedom to Speak Up" policy encourages staff to raise concerns about potential harms, including modern slavery, related to healthcare service provision.

**Data Collection and Monitoring -** UHSussex tracks the number of concerns raised about exploitation and modern slavery to assess the effectiveness of its safeguarding efforts.

## 18. Prevent

The Prevent Duty under the Counter-Terrorism and Security Act 2015 requires all specified authorities to have “due regard to the need to prevent people from being drawn into terrorism”; local authorities and their partners therefore have a core role to play in countering terrorism at a local level and helping to safeguard individuals at risk of radicalisation

Under the Duty, NHS organisations are required to provide appropriate training in line with the Prevent Competency Framework; for staff to have an awareness of Prevent and radicalisation and how to spot the vulnerabilities that may lead to a person becoming radicalised. The purpose of Prevent is for staff to identify and report concerns where they believe young people or adults may be vulnerable to radicalisation or exploiting others for the purposes of radicalisation.  This may include staff and/ or patients.

NHS organisations are required to have a named Executive Lead. The Chief Nursing Officer is the SRO for Prevent and is supported by the Safeguarding Prevent leads in the implementation of the Prevent Duty within UHSussex.

UHSussex is represented at the Brighton and Hove Prevent Board and West Sussex Prevent Board and the safeguarding leads work in collaboration with the ICB Sussex Prevent Lead, as part of the ‘health’ contribution to the Counter-terrorism Local Profile and the Prevent Board action plan.

UHSussex has an internal Prevent policy accessible to all staff which outlines responsibilities for staff and the referral process for raising concerns.

Local Authority led Channel Panels, supported by Sussex Police, are multi-agency panels who meet to discusses the risk posed by vulnerable people who are believed to have become radicalised and threatening extreme violence who have been referred for multi-agency support. For any referrals made by UHSussex, the organisational Prevent Lead (or nominated replacement) will be invited to attend the Local Authority Channel panel. There has been 2 referrals from the Trust to the Channel Panel in the last 3 years (2023-26).

The Trust also submits a quarterly return to NHS England. The data submitted monitors the key elements of the prevent duties and responsibilities which include Identification of Prevent leads, strategic and operational, delivery of training, the levels of referrals made via the Channel process, representation, and engagement with local and regional Prevent leads.

### 18.1 Prevent Training 2025/26

During 2025/26, the Trust updated the Prevent training and competencies framework in line with national guidance. A Prevent Training Needs Analysis (TNA) has been developed as an addendum to the Safeguarding Adults TNA and is being implemented to support a structured and consistent approach to workforce training.

Training compliance remains strong, with Level 1 and 2 at 95.4% (increased from 88.27% in 2024/25) and Level 3 at 97.08% (increased from 91.3% in 2024/25), both exceeding the national target of 85%. This provides assurance that staff are appropriately trained and equipped to recognise and respond to risks of radicalisation, supporting effective safeguarding practice across the Trust.

**Basic Prevent Awareness Training BPAT)**
**Level 1-2 Questions**

| | Q1 25/26 | Q2 25/26 | Q3 25/26 | Q4 25/26 |
|---|---|---|---|---|
| Total number of employees and volunteers assessed as requiring to be in date with BPAT (to comply with the Prevent Duty). | **20448** | **20645** | **20623** | **20640** |
| Total number of employees and volunteers in your organisation currently in date with BPAT (of those who require BPAT to comply with the Prevent Duty) | **17641** | **18350** | **18878** | **19686** |
| Percentage of employees and volunteers currently in date with BPAT (of those who require BPAT to comply with the Prevent Duty) | **86.3%** | **88.9%** | **91.5%** | **95.4%** |

**Prevent Training for Staff at Level 3 and above questions**

| | Q1 25/26 | Q2 25/26 | Q3 25/26 | Q4 25/26 |
|---|---|---|---|---|
| Total number of employees and volunteers that your organisation has assessed as requiring to be in date with Prevent Training for Staff at Level 3 and above (to comply with the Prevent Duty) | 13201 | 13277 | 13541 | 13577 |
| Percentage of employees and volunteers assessed as requiring Prevent Training for Staff at Level 3 and above as a proportion of total staff and volunteers | 64.56% | 64.31% | 65.66 % | 65.78 % |

| | | | | |
|---|---|---|---|---|
| Total number of employees and volunteers in your organisation that are currently in date with Prevent Training for Staff at Level 3 or above (of those who require Prevent Training for Staff at Level 3 or above to comply with the Prevent Duty) | 11719 | 12156 | 12547 | 13181 |
| Percentage of employees and volunteers currently in date with Prevent Training for Staff at Level 3 or above (of those requiring Prevent Training for Staff at Level 3 or above training to comply with the Prevent Duty) | 88.77% | 91.56% | 92.66 % | 97.08 % |

## 19. Multi-agency Collaboration

Safeguarding Partnerships refer to statutory arrangements between agencies focused on protecting children and vulnerable adults from harm, abuse, and neglect. The Trust has a duty to engage with the Safeguarding Children and Safeguarding Adult Partnership arrangements in each of our local authorities and is actively involved in the work of the sub-groups.

Changes to statutory guidance, Working Together to Safeguard Children Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk), has enabled a joined up, Pan-Sussex approach which has helped to streamline some activities.

### 19.1 Local Safeguarding Partnership Meetings

The safeguarding team contributes to West Sussex and Brighton & Hove Safeguarding Children and Adult Partnerships and are engaged in the following subgroups.

### 19.2 Safeguarding Children Partnership meetings

| West Sussex Safeguarding Children Partnership | Frequency |
|---|---|
| Quality Assurance Subgroup | Quarterly |
| Child Safeguarding Liaison Subgroup | As required. |
| Learning and Development Subgroup | Quarterly |
| Exploitation Subgroup | Quarterly |
| Partnership Group (previously Board) | 6 monthly |
| Safer West Sussex Partnership (SWSP)<br>Domestic Violence and Sexual Abuse (DVSA) Steering Group | Quarterly |
| West Sussex Violence and Exploitation Board | Quarterly |
| Children's Health Safeguarding Forum | Bi-monthly |
| MASH Health Working Group | Quarterly |
| Children First Board | Quarterly |
| Myth of Invisible Men Task & Finish group | Bi- Monthly |
| Monitoring & Evaluation Sub-Group | Bi-monthly |

| | |
|---|---|
| Community Safety Partnership Board | Quarterly |
| **Brighton and Hove Safeguarding Children Partnership** | **Frequency** |
| Quality Assurance Sub Group | Quarterly |
| Neglect Steering Group | Quarterly |
| Children's Safeguarding Liaison Group | Quarterly |
| Partnership Group | 6 monthly |
| Exploitation Sub-Group | Quarterly |
| **Pan Sussex and or NHS Sussex** | |
| Operational Health Meeting (Children Looked After) | Quarterly |
| Learning and Development Sub-Group | Quarterly |
| Looked After Children NHS Professionals Meeting | Quarterly |
| Joint Targeted Area Inspection (JTAI) Health Providers Working Group | Monthly |
| NHS Professionals MCA Steering Group | Monthly |
| LMNS- Local Maternity & Neonatal System | Quarterly |
| Maternity Safeguarding Forum | Quarterly |
| ICON Forum | 6 monthly |
| **National and Regional Networks** | |
| National Safeguarding Maternity network | Quarterly |
| National Network for Safeguarding Children Named Professionals | Monthly |
| Southeast Region Safeguarding Maternity Network | Quarterly |
| Southeast Named Safeguarding Professionals Network | Quarterly |

### 19.3 Safeguarding Adult Partnership meetings

| **West Sussex SAB** | **Frequency** |
|---|---|
| Safeguarding Adults Board | Quarterly |
| Quality and Performance Subgroup | Quarterly |
| Learning and Development Subgroup | Quarterly |
| DVSA | Quarterly |
| Violence and Exploitation Board | TBC |

| **Brighton & Hove SAB** | |
|---|---|
| B&H Safeguarding Adults Board | Quarterly |
| Learning and Development Subgroup | Quarterly |
| Quality Assurance Subgroup | Quarterly |
| PREVENT Board | Quarterly |
| Sussex Anti – Slavery Network | Three times per year |
| Sussex Safeguarding Adults Board Self-Assessment | Bi - Annual |
| SAB - SAR subgroup | Monthly |
| **ICB/Region** | |
| NHS Professionals - Safeguarding | Monthly |
| NHS Professionals – Prevent | Bi - Monthly |
| MCA / LPS Network | Bi - Monthly |

## 20. Statutory and Mandatory Safeguarding Reviews

Safeguarding Reviews are systematic evaluations conducted to examine and assess safeguarding practices and incidents involving children or vulnerable adults. A multi-agency audit program reflects the learning from these reviews, and the Named and Lead Nurses actively participate in the Safeguarding Partnerships Learning and Development sub-groups.

There have been several requests for rapid reviews, with only a few proceeded to case review. Two LCSPR's continue and due process is being undertaken. The tables below outline UHSussex participation during 2025/26

### 20.1 Participation in Children and Young People Rapid reviews/LCSPRs

| **Local Authority** | **Date of Review** | **UHSussex Actions** | **Status** |
|---|---|---|---|
| **West Sussex** | | | |
| Rapid Review | Jul-25 | SGC team to attend CYPMH training.<br><br>SGC team request Strategy Discussion for | |

| | | | |
|---|---|---|---|
| | | children where life threatening injuries occur and follow escalation policy where this is not agreed.<br><br>Key professionals to attend MDT meetings. | |
| Rapid Review | Aug-25 | Was Not Brought guidelines embedded into practice. WNB referral pathway launched on Affinity to safeguarding service for oversight.<br><br>Safeguarding supervision to be offered to Audiology services. | |
| Rapid Review | Sep-25 | Supervision to be sought by staff where cases 'drift' and WSSCP *Neglect Forum* accessed where multi-agency review needed.<br><br>Neglect Matrix to be utilized by staff to assess need. | |
| Rapid Review | Dec-25 | Staff to follow the UHSx *Missing Persons Policy* where vulnerable young people abscond.<br><br>Refer to the CAHMS Duty & Liaison team where mental health needs indicate. | |
| **LCSPR Serin EFD** | Jul 2022 | Report published Sept 2026<br>Observation policy and Review in progress<br>HON- Mental Health - appointed and leading on mental health and enhanced oberservations work at UHSx | |
| **Brighton & Hove** | | | |

| | | | |
|---|---|---|---|
| Rapid Review | Sep-25 | UHSx and multi-agency collaborative working identified as good practice for this review. No recommendations for learning made. | |
| **East Sussex** | | | |
| Rapid Review | Sep-25 | Staff to contact Emergency Out of Hours Duty Children's Social Care team. | |

## 20.2 Themes from Childrens Reviews (2025/26)

Themes emerging from Reviews this year have included:

- Children and young people's mental health and emotional wellbeing, including self-harm, suicidal ideation, overdose and mental health crisis presentations.
- Exploitation, serious youth violence and extra-familial harm, including criminal exploitation, knife crime, missing episodes and contextual safeguarding risks.
- The importance of effective multi-agency information sharing, communication and timely safeguarding referrals.
- Strengthening professional curiosity, escalation and professional challenge where safeguarding concerns persist or thresholds are met.
- Ensuring the voice of the child is heard, understood and reflected in decision-making, particularly for children with neurodiversity, disability or complex needs.
- Adoption of a Think Family approach, recognising the impact of domestic abuse, parental mental ill health, substance misuse and neglect on children and young people.
- Improved identification and response to neglect and medical neglect, including use of the 'Was Not Brought' pathway and recognition of cumulative harm.
- Strengthening safeguarding responses for children and young people presenting in acute and emergency care settings, particularly where there are concerns relating to mental health, exploitation, overdose or parental capacity.
- Improving recognition and management of risk associated with vulnerable adolescents, including transition into adulthood and the need for stronger transitional safeguarding pathways.
- The importance of timely strategy discussions, clear documentation and appropriate safeguarding escalation to support effective child protection decision-making

These cases have informed local learning and are being used to strengthen safeguarding responses across the Trust and with multi-agency partners. Oversight is provided at Safeguarding Committee.

## 20.3 Participation in Safeguarding Adult Reviews (SARS)

The Care Act 2014 places a statutory duty for Safeguarding Adult Boards to arrange a SAR when an adult dies because of abuse or neglect (whether known or suspected), where there is concern that partner agencies could have worked more effectively together to protect the adult. The overall purpose of a SAR is to promote learning and improve practice; it is not to re-investigate or to apportion blame.

A SAR is considered if:

- an adult has died, and the SAB (Safeguarding Adults Board) knows or suspects that the death resulted from abuse or neglect (whether it knew about or suspected the abuse or neglect before the adult died); or
- an adult has experienced serious abuse or neglect which has resulted in permanent harm, reduced capacity, or quality of life (whether it knew because of physical or psychological effects), or the individual would have been likely to have died but for an intervention; and,
- there is concern that partner agencies could have worked more effectively to protect the adult.

The below tables outline the SARS in which UHSussex was involved or where learning from the review is applicable across health organisations.

| **Safeguarding Adults Board** | **Request Received** | **Status** |
|---|---|---|
| Brighton and Hove | Jan 2025 | Learning event held. Not yet published. |
| Brighton and Hove | Feb 2025<br>SAR Hussein | Published 2/04/2026. Lack of routine enquiry and potential unconscious bias due to gender and MH presentation. |
| Brighton and Hove | Dec 2025 | Review ongoing. Sol submitted. |
| Brighton and Hove | Sept 2023<br>SAR Frank & Paul | Published in 2026 |
| Brighton and Hove | July 2024<br>SAR Henry | Published Sept 2025 |
| Brighton and Hove | July 2025 | Statement of Intent submitted review ongoing. |
| Brighton and Hove | July 2025 | Statement of Intent submitted review ongoing. |

| | | |
|---|---|---|
| Brighton and Hove | Sept 2025 | Statement of Intent submitted review ongoing. |

Safeguarding Adult Reviews (SARs) and Domestic Abuse-Related Death Review (DARDRs) continue to inform safeguarding practice across UHSussex. The number of Safeguarding Adult Reviews (SARs) has reduced during this reporting period. This reflects a national shift in review processes, with the introduction and expanded scope of Domestic Abuse Related Death Reviews (DARDRs), which now capture a wider range of deaths, including those related to domestic abuse and suicide.

As a result, more cases are being reviewed through DARDR processes at an earlier stage, rather than progressing to SARs. This represents a change in the system approach to learning and review rather than a reduction in safeguarding need and continues to require robust engagement and oversight from safeguarding teams.

Learning from SARs has been actively incorporated into practice through safeguarding training programmes, supervision, and policy development. In addition, key messages are disseminated through targeted communications, including “7-minute briefings” to staff and leaders, supporting awareness and consistent application in practice.

UHSussex safeguarding teams have also contributed to system responses through participation in Multi-Agency Risk Management (MARM) processes and high-intensity user meetings within Emergency Departments, supporting coordinated and preventative approaches to risk.

This provides assurance that learning from SARs is systematically embedded within practice, supporting continuous improvement and strengthening multi-agency safeguarding effectiveness.

### 20.4 UHSussex participation in Domestic Homicide Reviews (DHRs) and Domestic Abuse Related Death Reviews (DARDRs)

A Domestic Abuse Related Death Review (DARDR), formerly known as Domestic Homicide Reviews (DHR), is carried out where a person has died because of abuse, violence or neglect by a relative, intimate partner or member of the same household. DARDRs were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

The purpose of a DARDR is to:

- Establish what lessons can be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply those lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic abuse and domestic homicides and suicides and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

The below table outlines the DHRs and DARDRs in which UHSussex was involved or where learning from the review is applicable across health organisations.

| Safeguarding Adults Board | Request Received | Status |
|---|---|---|
| West Sussex | Dec 2022 | Awaiting MoJ publication. |
| West Sussex | Aug 2023 | Draft report received and final panel meeting date agreed. |
| West Sussex | Sept 2023 | Comments returned on final draft. |
| West Sussex | March 2024 | Final report being drafted. |
| West Sussex | June 2024 | Draft report under review |
| West Sussex | March 2025 | Report being drafted. |
| West Sussex | May 2025 | Review ongoing |
| West Sussex | July 2025 | Summary of involvement submitted review ongoing. |
| West Sussex | October 2025 | Summary of involvement submitted and panel membership agreed. |
| West Sussex | Nov 2025 | Summary of involvement submitted |
| West Sussex | Mar 2026 | Statement of Intent submitted |
| Brighton and Hove | Jan 2025 | Review ongoing |
| Brighton and Hove | Mar 2025 | IMR being undertaken |
| Brighton and Hove | Mar 2025 | Report in draft |
| Brighton and Hove | April 2025 | IMR not required. No evidence of RE |
| Brighton and Hove | April 2025 | Report being drafted |

| | | |
|---|---|---|
| Brighton and Hove | June 2025 | Panels being attended |
| Brighton and Hove | Oct 2025 | Joint SAR/DARDR |
| Brighton and Hove | Oct 2025 | Summary of involvement submitted |
| Brighton and Hove | Oct 2025 | Summary of involvement nil return submitted |

Overall, UHSussex participated in 20 Domestic Abuse Related Death Reviews (DARDRs) during 2025/26, including 14 new cases and 6 ongoing from previous years. This represents a significant level of activity and has placed considerable demand on safeguarding team capacity, requiring sustained oversight, multi-agency engagement, and coordination of learning to support effective safeguarding practice.

### 20.5 Themes identified from SARs / DHR / DARDRs

- Self-neglect, including challenges associated with engagement, risk management, executive functioning and the balance between autonomy and safeguarding responsibilities.
- Mental Capacity Act application and legal literacy, including assessment of capacity, best interest decision-making, use of the statutory framework and application of the least restrictive principle.
- Domestic abuse and coercive control, including barriers to disclosure, professional curiosity, early identification and the importance of effective multi-agency responses.
- Mental ill health and multiple disadvantage, particularly where safeguarding concerns coexist with substance misuse, self-neglect, homelessness, social isolation and complex vulnerability.
- Professional curiosity, escalation and challenge, ensuring practitioners recognise cumulative risk, explore concerns in greater depth and appropriately escalate safeguarding concerns.
- Multi-agency working and information sharing, including timely communication, clear documentation, coordinated risk management and shared decision-making across agencies.
- Voice of the adult and person-centred safeguarding practice, ensuring the wishes, feelings, beliefs and desired outcomes of individuals remain central to safeguarding interventions.
- Think Family approaches, recognising the impact of adult safeguarding concerns on children, carers and wider family members.
- Risk assessment and management of complex safeguarding cases, particularly where there are concerns regarding self-neglect, domestic abuse, mental ill health, exploitation or repeated service involvement.
- Learning from deaths, serious incidents and safeguarding reviews, highlighting the importance of early intervention, clear safeguarding ownership and coordinated partnership responses to reduce risk and improve outcomes.

## 21. Quality Assurance and Improvement

During 2025/26, delivery of some planned single-agency audit activity was impacted by workforce vacancies, recruitment challenges, sickness absence and increasing operational demand across safeguarding services. As a result, elements of the audit programme progressed more slowly than anticipated and will continue into 2026/27.

Despite these challenges, safeguarding teams remained actively engaged in partnership quality assurance activity and external review processes. This included participation in the Brighton & Hove Joint Targeted Area Inspection (JTAI) focusing on Child Sexual Abuse and the NHS Sussex Health Safeguarding Children Audit focusing on Strategy meeting invitations and attendance. Embedding the Pan Sussex Section 11 Audit 2024-26 outcomes for CYP and the outcomes for the Pan Sussex Self Assessment 2024-2026 for Adults.

The key outcome from the JTAI was the identification of opportunities to strengthen pathways and inter-agency working between Mental Health Crisis services, the Children's Sexual Assault Referral Centre (CSARC) and partner agencies, with improvement work led through the ICB. UHSussex safeguarding teams prioritise attending strategy meetings for patients who have engaged with our services.

In addition, the Trust participated in two Brighton & Hove Safeguarding Adults Board (SAB) multi-agency audits focusing on homelessness and Mental Capacity Act practice, providing valuable opportunities to review partnership working, information sharing, risk assessment and application of statutory frameworks.

Safeguarding enquiry and safeguarding practice also continue to form part of the Trust's Ward Accreditation Programme, providing additional assurance regarding the identification, escalation and management of safeguarding concerns within clinical services.

These quality assurance activities have provided valuable assurance regarding safeguarding practice, partnership working and continuous improvement across UHSussex.

### 21.1 Audit Plan for 2025/26

There has been reduced capacity within the safeguarding team to undertake single agency safeguarding audits within UHSussex during 2024-25. The following audits are on the workplan for 2026-27.

| Audit Focus | Description |
|---|---|
| Quality of SGC Training Delivery - Level 3 | Evaluation of the quality and effectiveness of L3 safeguarding training delivery based on feedback from the IRIS platform. |

| | |
|---|---|
| Review of specific quality improvement projects related to | Injuries in Non-Mobile Infants Aged 12 Months and Under Assessment of reporting and responses to injuries in non-mobile infants. |
| | Patients Under 18 Who Abscond or Leave the ED Without Being Seen Analysis of incidents involving young patients leaving the Emergency Department before being seen. |
| | Appropriate Assessment of Psychosocial Risk in 12-17 Year Olds evaluation of how psychosocial risks are assessed for adolescents. |
| Quality of Referrals to Social Care | Examination of the quality and effectiveness of referrals made to Children and Adult Social Care services. |
| Was Not Brought/DNA | Analysis of missed appointments (Did Not Attend - DNA) for children and young people, including implications for safeguarding. |
| Child Protection Medical Standards | Audit of adherence to established medical standards for child protection assessments. |
| Safer Sleeping (Maternity & Neonates) | Review of the implementation of safer sleeping practices in maternity and neonatal services. |
| Pan Sussex S11 Audit<br><br>(Children)<br><br><br>Pan Sussex Self Assessment Audit (Adults) | Annual update and bi-annual report on compliance with Section 11 responsibilities regarding safeguarding children. |
| Children in Care | Assessment of services and support provided to children in care, ensuring safeguarding practices are effectively implemented. |
| Exploitation | Evaluation of strategies and responses to child exploitation, including contextual safeguarding considerations. |
| Supervision | Review of supervision practices within safeguarding teams and their effectiveness in supporting staff. |

## 22. Risk Management

### 22.1 Safeguarding Children and Adults Risks

The Safeguarding Service maintains oversight of safeguarding risks through the Trust Risk Management Framework. During 2025/26, the safeguarding risk profile reflected a combination of organisational and system-wide challenges, including mental health

pathways, autism and neurodiversity, information sharing, transitional safeguarding, safeguarding referral processes, and specialist workforce provision. The table below summarises thematically the active safeguarding risks recorded on the Trust risk register at year end.

| | Datix Ref | Risk Theme | Current Score | Target Score |
|---|---|---|---|---|
| 1 | 1940 | Autism and Neurodiversity | 12 | 6 |
| 2 | 1436 | Mental health patients in ED | 12 | 6 |
| 3 | 2297 | Restraint recognition and reporting | 12 | 8 |
| 4 | 3166 | Mental health environment and corridor care | 12 | 4 |
| 5 | 3111 | Child Protection Medical photography | 10 | 2 |
| 6 | 1896 | Information Sharing and Digital Records | 9 | 4 |
| 7 | 1909 | MARAC Capacity | 9 | 4 |
| 8 | 2064 | Adult Safeguarding Referrals | 9 | 2 |
| 9 | 2484 | Transitional Safeguarding | 9 | 3 |
| 10 | 3015 | MCA Specialist Capacity | 9 | 3 |
| 11 | 1557 | Children's Safeguarding Referrals | 6 | 3 |
| 12 | 1889 | Older People's Mental Health Support | 6 | 4 |

At the end of the reporting period, the highest-rated safeguarding risks related to autism and neurodiversity, prolonged stays of mental health patients within Emergency Departments, restrictive practice, and access to appropriate environments for patients experiencing mental health crises. Work continues through the Safeguarding Committee, Trust governance structures and partnership arrangements to implement mitigating actions and reduce risks to target levels. Several risks have been reduced during the reporting period as a result of strengthened controls, revised processes, and enhanced governance oversight.

## 23. Safeguarding Children Activity across UHSussex Hospitals.

The Trust’s safeguarding duties include all children seen by any UHSussex service and extend to children and young people who are not patients at the Trust and may not be physically seen by the staff member or clinical team. This commonly occurs when an adult patient is receiving treatment and potential risks to children or young people are identified. For instance, if an adult presents with issues related to domestic abuse, substance misuse, or poor mental health, it triggers a consideration of the impact on their children. This is referred to as a ‘Think Family’ approach, and this duty applies to all Trust staff, including those who seldom or never work with children as part of their day-to-day responsibilities.

### 23.1 Emergency and Urgent Care Attendances for CYP

The below tables show the attendance data for 2025/26 and 2024/25. The numbers of attendance have slightly decreased by 118 in year.

| | ED and Urgent Care attendances 2025/26 | | | | | |
|---|---|---|---|---|---|---|
| | 2024/25 | Q1 | Q2 | Q3 | Q4 | Total |
| WH ED + UTC | 21785 | 5314 | 4748 | 5634 | 5618 | **21,314** |
| SRH ED + UTC | 15,903 | 4136 | 3767 | 4423 | 4179 | **16,493** |
| RACH | 30,956 | 7374 | 6649 | 8597 | 7985 | **30,605** |
| RSCH | 1175 | 295 | 328 | 373 | 312 | **1,308** |
| SEH | 1554 | 496 | 416 | 357 | 407 | **1,676** |
| PRH | 5790 | 1514 | 1432 | 1373 | 1318 | **5,637** |
| Total | 77,163 | 19,129 | 17,340 | 20,757 | 19,819 | 77045 |

### 23.2 Safeguarding Children Referrals to local authority Integrated front doors (social care/early help)

Overall safeguarding referral activity has increased across the Trust, rising from 2,662 in 2024/25 to 3,176 in 2025/26, representing an increase of 514 cases (19.3%). This growth is primarily driven by increased activity at Worthing Hospital (including CDC) and St Richard's Hospital, indicating strengthened identification and reporting.

While overall demand has risen, this is set against a reduction in activity at Brighton, highlighting variation in reporting patterns across sites. This requires further review to ensure consistency and provide assurance that safeguarding practice is applied equitably across the Trust.

| | Total 2024/ 2025 | Q1 | Q2 | Q3 | Q4 | Total 2025/ 2026 |
|---|---|---|---|---|---|---|
| WH (includes CDC) | 952 | 287 | 279 | 309 | 285 | 1160 |
| SRH | 691 | 184 | 170 | 202 | 198 | 754 |
| Crawley | 19 | 20 | 8 | 2 | 8 | 38 |
| Brighton | 913 | 328 | 253 | 239 | 195 | 844 |
| PRH | 87 | 14 | 18 | 31 | 24 | 87 |
| Total | 2,662 | 833 | 850 | 783 | 710 | 3176 |

### 23.3 Principal Presenting Concern for Safeguarding Concerns/ Referrals

The following tables and charts provide a summary of the data captured during 2025-26, with comparative data from the last 2 years.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Child Mental & Emotional Health- (concerns relating to one or more of the following: mental health issues, eating disorders, self-harm, anxiety, challenging behaviour)** | | | | | | |
| | **2023/24 Total** | **2024/25 Total** | **Q1** | **Q2** | **Q3** | **Q4** | **2025/26 Total** |
| **WH/Crawley** | **568** | **469** | 140 | 128 | 124 | 148 | **540** |
| **SRH** | **362** | **308** | 58 | 67 | 83 | 86 | **294** |
| **Brighton** | **550** | **443** | 129 | 113 | 117 | 77 | **436** |
| **PRH** | **33** | **23** | 2 | 3 | 17 | 10 | **32** |
| **Total** | **1513** | **1243** | **329** | **311** | **341** | **321** | **1302** |

Data above shows an upward trend. Highest reporting across WH/Crawley, followed by Brighton.

| | **Physical abuse (concerns relating to one or more of the following: bruises, burns, fractures, cuts, poisoning, drowning, shaking, assault, kicking, hitting and any other method of causing non-accidental harm to a child, dog bite)** | | | | | | |
|---|---|---|---|---|---|---|---|
| | **2023/24 Total** | **2024/25 Total** | **Q1** | **Q2** | **Q3** | **Q4** | **2025/26 Total** |
| **WH/Crawley** | **131** | **54** | 19 | 8 | 19 | 8 | **54** |
| **SRH** | **112** | **37** | 6 | 12 | 11 | 8 | **37** |
| **Brighton** | **16** | **37** | 16 | 9 | 6 | 8 | **39** |
| **PRH** | **1** | **8** | 1 | 1 | 1 | 1 | **4** |
| **Total** | **260** | **136** | **42** | **30** | **37** | **25** | **134** |

Data above shows an upward trend. Highest reporting across WH/Crawley.

| | Neglect -concerns relating to one or more of the following; preventable injuries, lack of supervision, parenting, 'was not brought' to appointments and neglect due to persistent failure to meet a child's basic physical and/or psychological needs including emotional, depressed/passive, disorganised and severe deprivation neglect (Howe 2007). | | | | | | |
|---|---|---|---|---|---|---|---|
| | **2023/24** | **2024/25** | **Q1** | **Q2** | **Q3** | **Q4** | **2025/26 Total** |
| **WH/Crawley** | **134** | **175** | 67 | 58 | 62 | 44 | **231** |
| **SRH** | **253** | **145** | 66 | 34 | 51 | 42 | **193** |
| **Brighton** | **81** | **192** | 78 | 54 | 73 | 49 | **254** |
| **PRH** | **8** | **14** | 0 | 3 | 4 | 5 | **12** |
| **Total** | **476** | **526** | **211** | **149** | **190** | **140** | **690** |

Data above shows an upward trend. Highest reporting across Brighton and followed by WH/Crawley.

| | Child Sexual Abuse – CSA, FGM, CSE | | | | | | |
|---|---|---|---|---|---|---|---|
| | **2023/24 Total** | **2024/25 Total** | **Q1** | **Q2** | **Q3** | **Q4** | **2025/26 Total** |
| **WH/Crawley** | 0 | 7 | 1 | 1 | 2 | 0 | **4** |
| **SRH** | 0 | 2 | 0 | 1 | 2 | 2 | **5** |
| **Brighton** | 0 | 2 | 0 | 1 | 1 | 1 | **3** |
| **PRH** | 0 | 0 | 1 | 0 | 0 | 0 | **1** |
| **Total** | **0** | 11 | **2** | **3** | **5** | **3** | **13** |

Data shows an upward trend. Highest reporting across SRH and WH/Crawley.

| | **Think Family- whole family approach concerns relating to parenting capacity and/or family/environmental factors which negatively impact on the child due to one or more of the following: domestic abuse, adult mental health, adult drug and alcohol issues, dysfunctional household, care needs, housing and wider family functioning issues)** | | | | | | |
|---|---|---|---|---|---|---|---|
| | **2023/24 Total** | **2024/25 Total** | **Q1** | **Q2** | **Q3** | **Q4** | **2025/26 Total** |
| **WH/Crawley** | 312 | 148 | 33 | 51 | 69 | 61 | **214** |
| **SRH** | 204 | 106 | 31 | 32 | 30 | 26 | **119** |
| **Brighton** | 90 | 49 | 24 | 20 | 19 | 18 | **81** |
| **PRH** | 12 | 6 | 3 | 10 | 2 | 6 | **21** |
| **Total** | **618** | 309 | **91** | **113** | **120** | **111** | **435** |

Data above shows an upward trend. Highest reporting across WH/Crawley and SRH.

| | **Contextual Safeguarding/Extra familial Harm (concerns relating to one or more of the following: contextual safeguarding, exploitation, drug and alcohol misuse, vulnerable young person and teenage pregnancy)** | | | | | | |
|---|---|---|---|---|---|---|---|
| | **2023/24 Total** | **2024/25 Total** | **Q1** | **Q2** | **Q3** | **Q4** | **2025/26 Total** |
| **WH/Crawley** | 171 | 119 | 38 | 41 | 35 | 32 | **146** |
| **SRH** | 130 | 92 | 22 | 24 | 25 | 34 | **105** |
| **Brighton** | 189 | 179 | 71 | 53 | 43 | 34 | **201** |
| **PRH** | 25 | 10 | 4 | 1 | 7 | 2 | **14** |
| **Total** | **515** | 400 | **135** | **119** | **110** | **102** | **466** |

Data above shows an upward trend. Highest reporting across Brighton, following by WH/Crawley and SRH.

| UHSussex Total | 2023/24 | 3382 | 2024/25 | 2625 | 2025/26 | 3058 |
|---|---|---|---|---|---|---|
| **Principal Concern** | **n** | **%** | **n** | **%** | **n** | **%** |
| Child Emotional & Mental Health | 1513 | 45% | 1243 | 47% | 1302 | 43.% |
| Think Family | 618 | 18% | 309 | 12% | 435 | 14.% |
| Contextual/Extra-familial harm | 515 | 15% | 400 | 15% | 466 | 15.% |
| Neglect | 476 | 14% | 526 | 20% | 690 | 23% |
| Physical abuse | 260 | 8% | 136 | 5% | 134 | 4% |
| Child Sexual Abuse | 0 | 0% | 11 | 0.4% | 13 | 0.4% |

In the last 3 years 2023 - 2026, the predominant safeguarding concerns across UHSussex remain child emotional and mental health, accounting for 43% of referrals in 2026. This is followed by neglect in childhood accounting for 23% of all referrals this year, up from 20%%.

This highlights the continued high demand for safeguarding support linked to emotional distress, self-harm, and mental health presentations and neglect in children and young people. Continued monitoring will inform service planning and targeted training priorities.

### 23.4 Safeguarding CYP who have a delayed discharge

Delays in discharging children and young people can have a significant impact on their wellbeing and on wider service provision. The reasons for delayed discharge are complex and often reflect system-wide challenges in identifying suitable environments for ongoing therapeutic or specialist care.

The total number of excess bed days in 2025/26 was 707, representing a 58% reduction compared to 2024/25 and demonstrating significant improvement. This reduction is multifactorial, reflecting strengthened early escalation pathways, including Executive-level oversight, improved system working with the ICB, and the implementation of a more robust, risk-based approach to admissions. Additional contributory factors include the closure of the Chalk Hill facility.

However, safeguarding risks remain for complex cases, particularly where children and young people are not admitted to ward areas and remain in Emergency Departments. These cases require continued oversight to ensure that risks, including potential deprivation of

liberty, are appropriately identified and managed. The Safeguarding team continue to work collaboratively with partner agencies and in supporting the wards.

| | Delayed Discharges for Children & Young people <18 years from when medically fit | | | | | | |
|---|---|---|---|---|---|---|---|
| Excess Bed days Site | Total 2023/24 | Total 2024/25 | Q1 ≥ from Day 5 | Q2 ≥ from day 5 | Q3 ≥ from day 5 | Q4 ≥ from day 5 | Total 2025/26 |
| WH | 567 | 307 | 40 | 3 | 9 | 0 | **52** |
| SRH | 504 | 277 | 66 | 47 | 18 | 28 | **159** |
| RACH | 308 | 987 | 198 | 63 | 132 | 51 | **444** |
| RSCH | 40 | 102 | 12 | 18 | 15 | 7 | **52** |
| **Total** | **1419** | **1673** | **316** | **131** | **174** | **86** | **707** |

### 23.5 Mental Capacity Act (MCA) and Court Authorised Deprivation of Liberty (DOL)

No applications were made by UHSussex to the Court of Protection during 2025/26 to authorise deprivation of liberty for a child or young person. This is consistent with 2024/25. Court of Protection authorisation is required where restrictions for those under 18 meet the threshold for deprivation of liberty.

### 23.6 Children in Care and Adoption

The Worthing Child Development Centre continues to provide Initial Health Assessments as part of the Sussex Community Foundation Trust (SCFT) Children in Care hub. This service consists of two appointments per week for health assessments, which are managed and monitored in collaboration with SCFT to ensure that statutory time frames are met. Children in Care training is integrated with children's safeguarding training, emphasising an introduction to trauma-informed care. Additionally, children in care were highlighted as part of the Trust's theme of the week in quarter two.

## 24. Maternity Safeguarding

During 2025/26, the Maternity Safeguarding Team continued to strengthen safeguarding practice across all four maternity sites through enhanced training, safeguarding supervision and multi-agency partnership working. Learning from local and national reviews has been embedded into Level 3 safeguarding training, supervision and practice development, with a focus on professional curiosity, neglect, domestic abuse, risk assessment and child protection processes.

Key achievements included the further development of the Safeguarding Complex Care Forum, implementation of Trust-wide safeguarding supervision arrangements, expansion of

the HOPE Box and Birthing Arrangement initiatives, establishment of dependency clinics, development of an asylum seeker pathway, implementation of the Baby Abduction Guideline and maternity lockdown simulations and strengthened domestic abuse and perinatal mental health pathways.

These developments have improved communication, planning and support for vulnerable women, babies and families, providing assurance that safeguarding practice continues to evolve and strengthen across UHSussex.

The below table for provides comparison of the referral rate to children's social care compared to delivery rate for the last 3 years 2023-2026.

| **2023-2024 Q2-4 only** | **RSCH** | **PRH** | **WH** | **SRH** | **Total** |
|---|---|---|---|---|---|
| Referrals to children social care | 179 | 108 | 225 | 197 | **709** |
| Delivery Rate | 1761 | 1665 | 1480 | 1648 | **6554** |
| **2024-2025 Q1-4** | **RSCH** | **PRH** | **WH** | **SRH** | **Total** |
| Referrals to children social care between | 230 | 141 | 257 | 199 | 827 |
| Delivery Rate | 2255 | 2203 | 1904 | 2140 | **8502** |
| **2025-2026 Q1-4** | **RSCH** | **PRH** | **WH** | **SRH** | **Total** |
| Referrals to children social care between | 250 | 133 | 228 | 197 | 808 |
| Delivery Rate | 2364 | 2188 | 1871 | 2211 | **8634** |

Referrals to Children's Social Care reduced marginally from 827 in 2024/25 to 808 in 2025/26. However, delivery activity increased from 8,502 to 8,634 births over the same period. This indicates that safeguarding referral activity has remained broadly stable relative to maternity activity, providing assurance that safeguarding concerns continue to be identified and appropriately referred. Site-level variation remains evident, with increased referrals at RSCH offset by reductions at PRH and Worthing, and will continue to be monitored through maternity safeguarding governance arrangements.

## 25. Priorities for 2025/2026

### 25.1 Progress on priorities for 2025/26

| **No.** | **Action** | **Outcome / Challenges** |
|---|---|---|
| 1 | Standardise processes and data collection across UHSussex safeguarding teams | Progress made through development of standardised reporting, improved data collection and enhanced governance |

| | | |
|---|---|---|
| | | oversight. However, differences in local authority referral systems and digital limitations continue to affect data consistency and require further work in 2026/27. |
| 2 | Agree an annual audit and quality improvement plan | Achieved. Audit programmes were established across safeguarding portfolios and findings informed quality improvement activities. Delivery of some single-agency audits was impacted by workforce pressures, vacancies and competing operational priorities. |
| 3 | Data collection to capture further information related to children in care | Partially achieved. Improved recording of social care involvement and safeguarding outcomes at birth has strengthened oversight. Further development is required to improve visibility of Children in Care and care-experienced young people across Trust systems. |
| 4 | Focus on the internal-facing intranet page to improve communication | Partially achieved. Safeguarding information and resources have been expanded and promoted; however development of a fully standardised safeguarding intranet presence remains ongoing. |
| 5 | Work together with safeguarding adults, maternity teams and stakeholders | Achieved. Improved collaborative working has been evidenced through joint governance arrangements, safeguarding operational groups, maternity safeguarding forums, MCA Operational Group, PSIRG representation and multi-agency partnerships. |
| 6 | Develop an all-age Level 3 safeguarding children training programme with stronger focus on transitional safeguarding | Progress made through review of training content and greater emphasis on adolescent safeguarding, exploitation, contextual safeguarding and complex vulnerabilities. Further work remains required to fully embed transitional safeguarding for 16–25-year-olds. |

| | | |
|---|---|---|
| 7 | Improve safeguarding training compliance above 85% | Largely achieved. Training compliance remains above target across most programmes. Challenges remain in maintaining compliance where Training Needs Analysis requirements have expanded, particularly within Adult Safeguarding Level 3. |
| 8 | Develop an exploitation and violence reduction strategy with partners | Progress made through partnership working and exploitation networks. However, a formal Trust-wide exploitation and violence reduction strategy remains under development and should continue as a priority for 2026/27. |
| 9 | Strengthen provision of youth work support across UHSussex | Limited progress. Ongoing engagement has taken place with partners; however, provision remains variable and further development is required to support vulnerable adolescents attending Trust services. |
| 10 | Share key learning from reviews and embed into practice | Achieved. Learning from SARs, CSPRs, DARDRs, Rapid Reviews and incidents has been embedded through training, supervision, policies, briefings and governance reporting. |
| 11 | Strengthen the voice of the child and individual | Partial progress. Increased emphasis is evident within training, reviews and safeguarding assessments. Further work is required to develop formal service user engagement and measurable evidence of impact. |
| 12 | Implement Audit Plan and evidence improvement following Section 11 findings | Partially achieved. Audit programme implemented and actions progressed. Delivery timescales were affected by staff shortages, recruitment challenges and operational pressures within teams. |
| 13 | Develop a standard safeguarding intranet page for cross-site use | Progress made but not fully achieved. Work should continue in 2026/27 to improve accessibility and consistency of safeguarding information Trust-wide. |

| | | |
|---|---|---|
| 14 | Standardise referral processes across the Trust | Partially achieved. SOPs and guidance have been developed and referral pathways strengthened. Variations in local authority processes and digital platforms continue to present challenges. |
| 15 | Strengthen DoLS across sites | Achieved. Significant progress through establishment of the MCA Operational Group, strengthened governance, audits, training developments and improved monitoring of MCA and DoLS practice. |
| 16 | Strengthen monitoring and review of safeguarding risks | Achieved. Improved governance reporting, divisional dashboards, risk register oversight and committee scrutiny have strengthened organisational assurance. |

## 25.2 Priorities for Safeguarding Children, Maternity and Adults 2025/26

The following areas are set as Strategic priorities with associated operational tasks that the safeguarding teams will deliver during 2026/27.

### 25.2.1 Children's Safeguarding Priorities

**Strengthen Transitional Safeguarding**

- Develop an organisational approach to transitional safeguarding for young people aged 16–25 years.
- Strengthen pathways and joint working between children's and adult services.
- Improve support for care-experienced young adults and vulnerable adolescents.

**Strengthen child-centred practice**

- Further embed child-centred safeguarding practice.
- Improve evidence that children's views, wishes and lived experiences inform safeguarding decision-making.
- Incorporate learning from reviews into practice development.

**Strengthen Responses to Exploitation, Violence and Contextual Safeguarding**

- Strengthen organisational responses to child criminal exploitation, child sexual exploitation, serious youth violence and contextual safeguarding concerns.
- Build on learning identified through Rapid Reviews and partnership activity.

**Deliver the Safeguarding Quality Assurance and Audit Programme**

- Deliver the Single Agency Audit Plan.

- Complete outstanding audit activity delayed due to staffing pressures.
- Strengthen evidence of impact and quality improvement outcomes.

**Improve Information Sharing, Digital Systems and Safeguarding Supervision**

- Continue work to address IT system limitations.
- Improve recording, referral tracking and safeguarding information sharing across sites.
- Expand access to safeguarding supervision across clinical services.
- Strengthen professional curiosity and reflective practice.

### 25.2.2 Adult Safeguarding Priorities

**Strengthen MCA and DoLS Practice**

- Review MCA and DoLS practice in light of recent legal developments.
- Update policies, training and governance arrangements as required.
- Continue MCA Operational Group oversight.
- Deliver MCA and DoLS audit programmes.
- Improve consistency of MCA documentation and decision-making.

**Embed Safeguarding Supervision and Learning**

- Fully implement and evaluate the safeguarding supervision offer.
- Support reflective practice and embed learning from reviews.

**Improve Workforce Capability and Training Compliance**

- Maintain compliance following implementation of the revised Adult Safeguarding Training Needs Analysis.
- Continue targeted work with areas below compliance thresholds.

**Strengthen Responses to Self-Neglect and Multiple Compound Needs**

- Improve staff confidence in responding to self-neglect, homelessness, substance misuse and complex safeguarding presentations.
- Embed learning from SARs and partnership audits.

**Enhance Data, Quality Assurance and Outcomes Monitoring**

- Continue development of safeguarding datasets and divisional reporting.
- Improve understanding of vulnerability, inequalities and safeguarding outcomes.

### 25.2.3 Maternity Safeguarding Priorities

**Strengthen Domestic Abuse Identification and Response**

- Sustain high levels of routine enquiry.
- Continue partnership working with HIDVA services and safeguarding partners.

**Embed Trauma-Informed Maternity Care**

- Build on learning from separation at birth, domestic abuse and perinatal mental health reviews.
- Embed trauma-informed approaches within maternity pathways.

**Strengthen Support for Women with Complex Safeguarding Needs**

- Further develop Complex Care Forums, Dependency Clinics and multi-agency planning arrangements.
- Strengthen multi-agency working and support for women with significant mental health needs.

**Reduce Health Inequalities**

- Implement and embed asylum seeker and interpreting pathways.
- Improve access and outcomes for vulnerable populations.

### 25.2.4 Cross-Cutting Priorities

**Embed a consistent approach to supporting autistic and neurodiverse patients in ED.**

- Full implementation of the Oliver McGowan Mandatory Training programme.
- Further development of reasonable adjustment processes.
- Strengthening the role of the Learning Disability and Autism Steering Group.
- Better identification and flagging of neurodiverse patients.
- Development of more consistent pathways and support arrangements across all sites.
- Co-production with people with lived experience.

**Embed a Trust-Wide Trauma-Informed Approach**

- Develop a consistent Trust-wide trauma-informed approach across Children, Adults and Maternity services.

**Strengthen Workforce Sustainability**

- Address recruitment and retention challenges.

- Develop succession planning and workforce sustainability.

**Deliver the Safeguarding Quality Assurance and Improvement Programme**

- Deliver the 2026/27 audit programme.
- Increase completion of single-agency audit activity.
- Continue participation in multi-agency audits and quality assurance processes.
- Continue embedding learning from SARs, DARDRs, CSPRs, Rapid Reviews, JTAIs and patient safety investigations.

**Strengthen Assurance, Risk Management and Communication**

- Improve monitoring of safeguarding risks, action plans and outcome measures.
- Complete development of standardised safeguarding intranet resources and referral guidance across UHSussex.

## 26. Conclusion

The Safeguarding Service is expanding across UHSussex and partner organisations to meet the statutory requirements outlined in legislation, including Section 11 of The Children's Act (2004), Working Together to Safeguard Children (2018), The Care Act (2014), Mental Capacity Act (2005), Domestic Abuse Bill (2021) and the Care Quality Commission Regulation 13.

Significant multiagency collaboration has proved the trust's commitment to working together to improve concern identification and protect children and vulnerable individuals within the trust. All the work throughout the trust and partnerships would not be possible without the dedication of our front-line staff and safeguarding team, who are professionally curious and committed to protecting our patients.

## 27. Supporting Documents

- UHSussex Safeguarding Children 2025/26 Q1-4 Reports
- UHSussex Safeguarding Adults 2025/26 Q1-4 Reports
- UHSussex Safeguarding Maternity 2025/26 Q1-4 reports
- Working together to Safeguard Children (DfE 2026)
- Intercollegiate document: Safeguarding CYP and CYP in care 2025
- Section 11, Children's Act (2004)
- Information Sharing (DfE 2024)
- NHS England Safeguarding Accountability and Assurance Framework 6th ed (2026)
- Care Act 2014 (legislation.gov.uk)
- Mental Capacity Act 2005 (legislation.gov.uk)
- Care and Support Statutory Guidance- Section 14 Safeguarding
- Adult Safeguarding: Roles and Competencies for Health Care Staff 2024
- Female Genital Mutilation Act 2003

- Female Genital Mutilation, NHSE Annual Report - April 2024 to March 2025
- Modern Slavery Act 2015
- Domestic Abuse Act 2021
- Multi-agency statutory guidance for dealing with forced marriage and multi-agency practice guidelines.
- Serious Violence Duty 2023
- Prevent Duty 2023
- Online Safety Act 2023
- Mental Health Act 1983

NHS
University Hospitals Sussex
NHS Foundation Trust

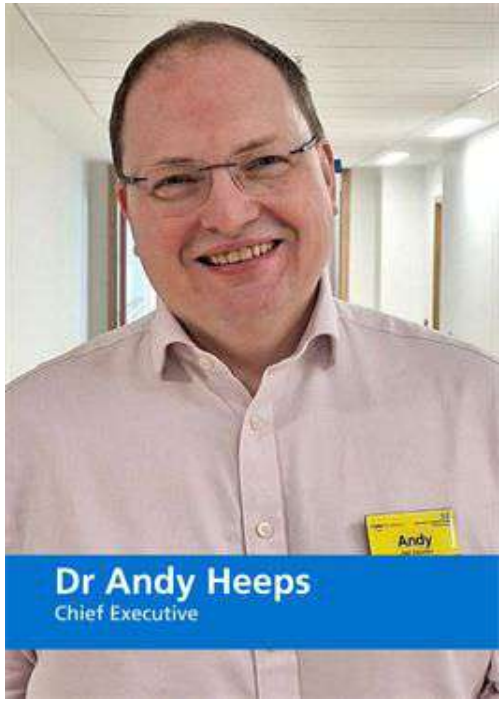
# Annual Workforce Equality Report 2026

If you would like this report in another format (e.g. large print) please contact uhsussex.inclusion@nhs.net

www.uhsussex.nhs.uk/equality

# CEO Foreword

“Colleagues across our hospitals have been working under sustained pressure throughout the last year in the face of rising demand for services and the increasingly complex needs of the communities we serve. It has also been a time of change and uncertainty for many of those communities, and for our workforce too. In this environment, how we support one another at work – and how inclusive we are as an organisation – is fundamental to the quality, safety and equity of the care we provide.




This report offers an important opportunity to reflect on that in practice. It brings together data and lived experience to help us understand where we are making progress, and where differences in experience or opportunity remain.

It highlights the progress we have made in strengthening staff voice, improving our use of equality data, and embedding inclusion through the Workforce Inclusion Programme. Above all, it shows the diversity of our workforce and communities is one of UHSussex’s greatest strengths.

However, diversity alone does not guarantee equity. Differences remain in representation, career progression, access to support, and experiences of bullying, harassment and discrimination. Recognising both our progress and the gaps that remain is essential if we are to deliver Excellent Care Everywhere.

That begins with understanding these differences. The report data highlights where we need to focus our efforts, and the experiences behind it help us understand how our culture and ways of working are felt in reality.

We also know that staff experience and patient care are closely connected. Where colleagues feel valued, respected and able to speak up, they are better able to deliver safe, high-quality care. Where inequities exist, they affect wellbeing, retention and ultimately outcomes for our communities.

For me, this underlines that inclusion must be at the heart of everyday practice; embedded in how decisions are made, how opportunities are accessed, and how we treat one another. That requires us to listen widely, act on what we hear, and be consistent in addressing behaviours and systems that do not align with our values.

There is of course more to do, and this work requires sustained focus. By continuing to understand our data, listen to our colleagues and act with purpose, we can build an organisation in which everyone feels supported to succeed and every patient receives equitable care.”

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# Summary

Welcome to the UHSussex Annual Workforce Equality Report 2026.

This report identifies workforce equality indicators that have improved, inequalities that have persisted or worsened, activity delivered during the year and areas where the available evidence remains incomplete or inconclusive. It supports our ambition to provide Excellent Care Everywhere by fostering an inclusive workplace where all colleagues feel valued, respected and able to thrive – in line with the commitments in the new national NHS Staff Standards.

The report is underpinned by the interim Workforce Inclusion Programme. During 2025/26, priorities included strengthening leadership accountability, inclusive recruitment and progression, pay and workforce disparities, reasonable adjustments, support for internationally recruited staff and tackling discrimination. Regional assurance feedback in January 2026 identified further work in relation to Board objectives, staff network sponsorship and equality impact assessments. During the year, the Trust has introduced additional recruitment controls, progressed the Career Sponsorship Scheme and introduced the centralised reasonable adjustments framework. Further implementation and evaluation are planned during 2026/27.

The report is structured around the three aims of the Public Sector Equality Duty: eliminating discrimination, advancing equality of opportunity and fostering good relations. It also includes sections on the Trust's equality objectives, workforce and service-user equality profiles, the Workforce Race Equality Standard, the Workforce Disability Equality Standard and pay gap analyses.

## Equality Profile

Workforce diversity continued to increase, particularly in relation to race and ethnicity, with colleagues from Global Majority backgrounds representing more than 30% of the workforce.

Representation was relatively balanced in some workforce groups and career pathways. However, substantial differences remained, particularly in senior clinical, non-clinical, and Medical and Dental roles. In many cases, this reflects patterns in the national NHS data.

## Eliminate Discrimination

Recruitment outcomes were broadly similar across several protected characteristics. However, White applicants remained more likely than Global Majority applicants to be appointed following shortlisting.

Experiences of discrimination, harassment, bullying and abuse continued to vary across workforce groups, with some minority and marginalised groups reporting substantially less favourable experiences.

Sexual harassment remains a particular concern. In the 2025 NHS Staff Survey, 10.7% of staff reported unwanted sexual behaviour from patients, relatives or members of the public, compared with 9.1% nationally, while 4.3% reported sexual harassment from a manager, team leader or colleague, compared with 3.5% nationally. Particularly high rates were reported by some younger, disabled, non-binary and bisexual staff, and by staff whose gender identity differs from their sex registered at birth. These findings are consistent with the Niche developmental Well-Led review, which identified sexual safety and gender-based discrimination as pronounced concerns requiring sustained and visible organisational action.

The available analyses indicate that pay gaps are associated mainly with differences in representation across pay bands, professions and senior roles. Further analysis is required to understand the relative contribution of these and other factors.

## Advance Equality of Opportunity

Satisfaction with workplace adjustments improved and was above the national average. However, approximately one in four staff who required adjustments did not feel that adequate support was in place. Disabled staff, carers and some minority groups continue to report fewer positive experiences in relation to feeling valued, work-related stress and career progression.

Participation in the Career Sponsorship Scheme increased and included colleagues from a diverse range of backgrounds. It is not yet possible to determine whether participation has resulted in improved progression or career outcomes.

## Foster Good Relations

Staff network membership and engagement continued to grow. Between the beginning of January and the end of March 2026, the number of staff registered with at least one Inclusion Staff Network increased from 1,304 to 1,477, an increase of 173 people or 13%.

Dedicated investment in staff network development through My UHSussex Charity provided additional capacity and opportunities for staff voice, representation, peer support and engagement. Evaluation of the effect of this investment on staff experience and organisational outcomes is continuing.

Staff network and wider inclusion activity included Carers Week 2025, Armed Forces Week 2025, Pride 2025, Black History Month 2025, Trans Day of Remembrance 2025, Race Equality Week 2026, LGBTQIA+ History Month 2026 and an International Women's Day programme held from 2 to 6 March 2026. Free dates and water were also made available to all staff during Ramadan and Lent. Staff networks continued to provide regular meetings, peer support and lived-experience insight to inform Trust activity.

## Conclusion

The report presents a mixed picture. Improvements are evident in some measures, including increased Global Majority and disabled staff representation, greater sharing of disability information, perceptions of equality of opportunity and satisfaction with workplace adjustments.

Other outcomes have deteriorated or remain inequitable, particularly senior representation, the continuing ethnicity gap in appointment from shortlisting, disparities affecting Global Majority staff in disciplinary and capability processes, the WDES capability disparity, experiences of discrimination, bullying and harassment, the prevalence and unequal distribution of sexual harassment, and pay outcomes.

A substantial programme of inclusion activity was also delivered, including investment in staff networks, career sponsorship, international staff support and strengthened reporting arrangements. In several areas, however, it is too early to determine whether this activity has resulted in measurable improvements in staff experience or workforce outcomes. Some findings also remain inconclusive because of incomplete information, small numbers or limitations in the available data.

The findings establish a baseline for targeted action through the Workforce Inclusion Programme and for monitoring whether activity results in sustained and measurable improvements.

# Notes

## Purpose and scope

In line with the Equality Act 2010, the Trust is legally required to publish equality information annually to demonstrate compliance with the Public Sector Equality Duty. This Annual Workforce Equality Report covers the period 1 April 2025 to 31 March 2026 and focuses on our workforce, providing insight into equality performance and supporting delivery of our strategic ambition of providing *excellent care everywhere* with an inclusive workforce representative of our communities.

This statutory report incorporates requirements from the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and national pay gap reporting. It also aligns with the NHS Equality, Diversity & Inclusion (EDI) Improvement Plan and applies consistent statistical approaches across protected characteristics. We report separately on other internal NHS requirements, such as the Equality Delivery System 2022. A summary of these requirements and any accreditation schemes is included.

### Use of Data and Information

This report draws on equality monitoring information collected when individuals join the organisation, including protected characteristics such as age, sexual orientation, disability, and ethnicity. This information is stored securely and confidentially within the Electronic Staff Record (ESR) system. Data used in this report is anonymised and handled in accordance with strict data protection requirements.

We analyse this information to identify differential outcomes and address inequalities affecting groups who share protected characteristics. Data sources include ESR, TRAC (the Trust's recruitment system), NHS Staff Survey results, and national datasets. Analysis is presented at both Trust and, where possible, divisional and site level. However, limitations in the recruitment system mean recruitment data can currently only be analysed at Trust level without extensive manual extraction.

The report uses a mixed-methods approach. Quantitative analysis includes disparity ratios, application of the four-fifths rule, pay gap analysis (mean and median), percentage point differences in staff survey responses, and representation and progression data. Qualitative insights, including staff feedback and organisational reviews, are used to contextualise findings.

Staff can review and update their personal information at any time through Employee Self-Service. However, this relies on staff having suitable digital access, confidence and time to use the system, so alternative support should be available for colleagues who may otherwise face barriers.

Some analyses within this report are based on relatively small numbers of respondents, particularly when NHS Staff Survey results are broken down by protected characteristic. In these circumstances, findings may be more sensitive to small changes in response numbers and may not provide sufficient statistical power to draw firm conclusions about differences between groups. Results for smaller groups should therefore be interpreted with appropriate caution and considered alongside other available sources of evidence.

## Terminology

This report recognises the complexity and evolving nature of equality terminology and aims to use language that is both accurate and inclusive.

We use the term Global Majority to refer to staff from ethnic groups other than White. This reflects the understanding that these groups represent the majority of the global population while also recognising that they may be under-represented or experience inequity within the Sussex and wider UK context. This terminology is used alongside standard NHS ethnicity categories. For national reporting requirements, including the Workforce Race Equality Standard (WRES), mandated definitions are retained.

Our staff network is referred to as the Multicultural and Ethnic Diversity Network, reflecting its updated and inclusive identity. Wherever possible, data is presented at a more granular ethnic group level to better reflect diversity and avoid masking differences within broad groupings.

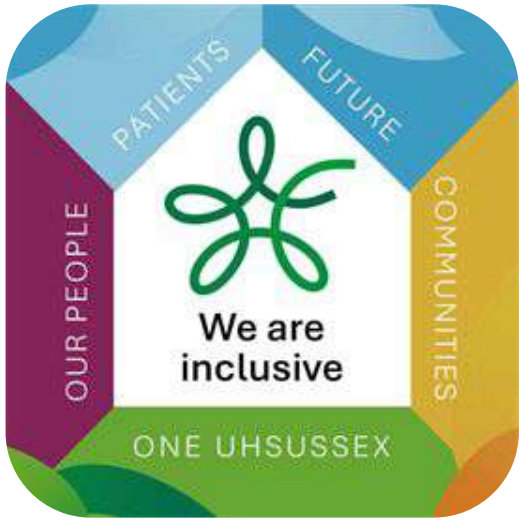
In relation to disability, the terms disability and long-lasting health condition may be used interchangeably, reflecting terminology used within the NHS Staff Survey.

We also refer to “distance from equity” to describe differences in outcomes or experiences between groups. In simple terms, this shows how far outcomes for one group differ from another, with larger gaps indicating greater inequity.

A ratio of 1 indicates equal outcomes between the groups being compared. Ratios between 0.80 and 1.25 are generally treated as broadly proportionate under the four-fifths rule[1]. Ratios outside this range are flagged for further investigation but do not, on their own, demonstrate discrimination.

[1] The four-fifths rule originates in the US Uniform Guidelines on Employee Selection Procedures. It treats a selection rate below 80% of the rate for the group with the highest rate as an indicator of potential adverse impact requiring further examination. It is used here as an analytical screening convention, not as a UK legal test or proof of discrimination. See 29 CFR §1607.4(D).

# Equality Objectives




The Trust publishes equality objectives to support delivery of the Public Sector Equality Duty and to address the most significant inequalities identified through workforce data, staff experience, engagement and external assurance.

The Trust's workforce equality objectives are delivered through the Workforce Inclusion Programme, embedded within the wider *Excellent Care Everywhere* Strategy Delivery Plan. They are intended to produce measurable improvements in workforce experience, opportunity, representation and organisational accountability.

The objectives are supported by annual delivery milestones informed by the Workforce Race Equality Standard, Workforce Disability Equality Standard, pay-gap analysis, NHS Staff Survey findings, employee-relations information, staff engagement and relevant external reviews.

The position below reflects information available at July 2026. The status statements describe the current stage of delivery and are not formal risk ratings.

# Objective 1: Strengthen leadership accountability for equality and inclusion

## Baseline

The Workforce Inclusion Steering Group and associated reporting arrangements were established during 2025/26.

Further work is required to:

- agree, embed and determine publication of Board senior leader inclusion objectives;
- translate Trust-level equality data into divisional ownership and action;
- establish consistent performance reporting;
- identify and escalate delivery risks; and
- demonstrate how equality information influences organisational decisions.

## Intended outcome

Leaders at every level understand and are accountable for the equality outcomes relevant to their responsibilities.

Progress will be assessed through:

- agreement and review of Board and senior leader objectives;
- Director sponsorship of staff networks;
- divisional equality data and improvement actions;
- effective escalation of risks and barriers; and
- evidence that equality information and staff insight inform decisions.

## Priorities for 2026/27

During 2026/27, the Trust will:

- develop a Workforce Inclusion Programme dashboard and reporting cycle;
- develop and pilot divisional inclusion packs;
- introduce structured divisional accountability conversations;
- strengthen the connection between equality reporting, organisational performance and assurance; and
- agree and embed Board and senior leader inclusion objectives for 2027/28.

## Accountability and assurance

Overall accountability sits with the Chief Executive, supported by the Chief People Officer.

Progress will be reviewed through the Workforce Inclusion Steering Group, People & Culture Committee and relevant Strategy Delivery Plan governance arrangements. Matters requiring further assurance or escalation will be reported through the appropriate Board route.

## Current position

Programme governance has been established. Board objectives, divisional accountability arrangements and the programme dashboard remain in development.

# Objective 2: Improve fairness in recruitment, career development and senior representation

## Baseline

Global Majority staff represented approximately 30.6% of the workforce at 31 March 2026 but remained under-represented in several senior clinical, management and consultant roles.

White applicants were reported to be 1.63 times more likely to be appointed from shortlisting than Global Majority applicants.

Although Staff Survey perceptions of equality of career opportunity improved, structural differences in senior representation remained.

## Intended outcome

Recruitment, development and advancement opportunities are experienced more equitably across protected groups.

Progress will be assessed through:

- appointment outcomes following shortlisting;
- representation by profession, pay band and level of seniority;
- participation in and outcomes from career-development services;
- promotion and appointment information, where available; and
- Staff Survey findings on access to career progression and promotion.

## Priorities for 2026/27

During 2026/27, the Trust will:

- introduce enhanced *Inclusive Recruitment MOTs* for senior recruitment and expand panel diversity;
- monitor recruitment outcomes following implementation;
- develop the ‘Explain or Comply’ model for senior recruitment;
- review and promote the Career Navigation Support Service, subject to available resources;
- continue delivery and evaluation of the Career Sponsorship Scheme;
- implement the local NHS England Step Up Career Development model; and
- develop further mentoring opportunities.

## Accountability and assurance

Overall accountability sits with the Chief People Officer, working with relevant professional and operational executive leads.

Progress will be reviewed through the Workforce Inclusion Steering Group, People & Culture Committee, relevant professional workforce governance and Strategy Delivery Plan reporting.

## Current position

Recruitment and career-development interventions are in delivery. Their longer-term effect on appointment outcomes and senior representation has not yet been established.

# Objective 3: Understand and reduce gender, ethnicity and disability pay gaps

## Baseline

The median gender pay gap was relatively narrow, but the mean gender pay gap remained material, reflecting differences in the distribution of women and men across professions and levels of seniority.

The overall ethnicity pay gap was close to parity but masked differences between individual ethnic groups, professions and pay levels.

Disabled staff continued to earn less on average than non-disabled staff.

Significant bonus-pay differences also remained across several characteristics.

## Intended outcome

The structural causes of pay gaps are understood and addressed through action on representation, recruitment, development, flexible working and access to senior and higher-paid roles. Progress will be assessed through:

- mean and median ordinary-pay gaps;
- bonus-pay gaps and bonus participation;
- workforce distribution across pay quartiles;
- representation across professions, grades and leadership roles; and
- delivery and impact of agreed action plans.

## Priorities for 2026/27

During 2026/27, the Trust will:

- complete root-cause analysis of gender, ethnicity and disability pay gaps;
- identify disparities hidden within aggregated figures;
- agree measurable actions and named executive ownership;
- monitor relevant recruitment and representation indicators; and
- report progress alongside the 2027 pay-gap position.

## Accountability and assurance

Overall accountability sits with the Chief People Officer, supported by the Chief Medical Officer and other relevant executive leads.

Progress will be reviewed through the Workforce Inclusion Steering Group, People & Culture Committee, relevant professional workforce governance and annual public reporting.

## Current position

Annual pay-gap reporting is now well established. Further work is required to strengthen disaggregated analysis, identify underlying causes and coordinate action across executive portfolios.

# Objective 4: Reduce workforce health inequalities and improve support for disabled staff

## Baseline

Disability was recorded for 7.2% of staff within the Electronic Staff Record, while 24.4% of Staff Survey respondents reported a physical or mental health condition lasting 12 months or more.

Among staff who reported requiring workplace adjustments, 75.1% said that adequate adjustments had been made. While consistently better than the national NHS benchmark, this still means approximately one in four did not feel adequately supported.

Disabled staff also reported poorer experiences across several Workforce Disability Equality Standard and Staff Survey measures.

## Intended outcome

Disabled staff and colleagues with long-term health conditions receive timely, consistent and effective support and experience equitable opportunities, wellbeing and employment outcomes.

Progress will be assessed through:

- sharing of staff disability status and data quality;
- satisfaction with workplace adjustments;
- the timeliness and completion of adjustment requests;
- capability, absence and retention outcomes; and
- relevant WDES and Staff Survey measures.

## Priorities for 2026/27

During 2026/27, the Trust will:

- evaluate the centralised reasonable-adjustments service;
- establish performance measures covering timeliness, consistency and staff experience;
- identify and address barriers to securing effective adjustments;
- strengthen manager capability in disability inclusion and workplace adjustments;
- improve the portability of adjustments when staff move roles or teams; and
- use WDES findings to inform divisional accountability and action.

## Accountability and assurance

Overall accountability sits with the Chief People Officer.

Progress will be reviewed through the Workforce Inclusion Steering Group, People & Culture Committee and relevant Health and Wellbeing, Occupational Health and workforce governance arrangements.

## Current position

The centralised reasonable-adjustments service has been introduced. Its performance framework, evaluation approach and longer-term outcome measures require further development.

# Objective 5: Strengthen the Experience, Inclusion and Development of Internationally Recruited Staff

## Baseline

International recruitment continues to play an important role in supporting workforce supply across the Trust. During 2025/26, 134 colleagues were recorded as joining the Trust from overseas, with most joining from non-EU countries.

The Trust has established dedicated support arrangements for some groups of internationally recruited staff joining from overseas, with a particular focus on clinically registered colleagues. During 2025/26, targeted pastoral and educational support was provided to internationally recruited Allied Health Professionals, Healthcare and Biomedical Scientists, International Medical Graduates and doctors joining on fixed-term contracts.

Specialist support arrangements are also in place for internationally recruited nurses, including a dedicated OSCE programme delivered through the Overseas Nursing Team.

Dedicated onboarding, educational and pastoral support arrangements are established and have been positively received by participants. Further work is planned to strengthen evaluation and outcome reporting.

## Intended Outcome

Internationally recruited colleagues experience effective onboarding, belonging, support, development and equitable access to opportunities. Progress Will Be Assessed Through:

- participation in onboarding and support programmes;
- retention and turnover;
- staff feedback and lived-experience insight;
- access to education, development and career opportunities;
- themes arising through staff networks, employee relations and Freedom to Speak Up; and
- evidence that identified concerns lead to improvement.

## Priorities for 2026/27

During 2026/27, the Trust will:

- maintain and develop the existing international staff support offer;
- evaluate participation, experience and outcomes;
- identify gaps in onboarding, pastoral and development support;
- gather qualitative insight from internationally recruited colleagues;
- assess access to career support and progression opportunities;
- evaluate the International Medical Graduate hybrid induction model and identify any further improvements required; and
- agree an improvement plan and ongoing performance measures.

## Accountability and Assurance

Overall accountability sits with the Chief People Officer, supported by relevant clinical, education and professional executive leads.

Progress will be reviewed through the Workforce Inclusion Steering Group, People & Culture Committee and relevant education and professional workforce governance arrangements.

## Current Position

Dedicated pastoral and educational support arrangements are established and continuing for a number of internationally recruited staff groups. Support currently includes bespoke induction programmes, pastoral support, educational development opportunities, information resources and access to initiatives such as The International Care Collective podcast, which shares the experiences of internationally recruited NHS staff adapting to life and work in the UK.

Available feedback has been positive. In addition, several International Medical Graduates from the 2025/26 cohort have expressed an interest in remaining within the Trust following completion of their initial placement. The International Medical Graduate induction programme is also being trialled as a hybrid model following feedback from previous cohorts.

Further work is required to strengthen evaluation, outcome measurement and reporting of longer-term impacts on retention, inclusion, development and progression.

# Objective 5: Strengthen the experience, inclusion and development of internationally recruited staff

## Baseline

International recruitment continues to play an important role in supporting workforce supply across the Trust. During 2025/26, 134 colleagues were recorded as joining the Trust from overseas, with most joining from non-EU countries.

The Trust has established dedicated support arrangements for some groups of internationally recruited staff joining from overseas, with a particular focus on clinically registered colleagues. During 2025/26, targeted pastoral and educational support was provided to internationally recruited Allied Health Professionals, Healthcare and Biomedical Scientists, International Medical Graduates and doctors joining on fixed-term contracts.

Specialist support arrangements are also in place for internationally recruited nurses, including a dedicated OSCE programme delivered through the Overseas Nursing Team.

Dedicated onboarding, educational and pastoral support arrangements are established and have been positively received by participants. Further work is planned to strengthen evaluation and outcome reporting.

## Intended Outcome

Internationally recruited colleagues experience effective onboarding, belonging, support, development and equitable access to opportunities. Progress Will Be Assessed Through:

- participation in onboarding and support programmes;
- retention and turnover;
- staff feedback and lived-experience insight;
- access to education, development and career opportunities;
- themes arising through staff networks, employee relations and Freedom to Speak Up; and
- evidence that identified concerns lead to improvement.

## Priorities for 2026/27

During 2026/27, the Trust will:

- maintain and develop the existing international staff support offer;
- evaluate participation, experience and outcomes;
- identify gaps in onboarding, pastoral and development support;
- gather qualitative insight from internationally recruited colleagues;
- assess access to career support and progression opportunities;
- evaluate the International Medical Graduate hybrid induction model and identify any further improvements required; and
- agree an improvement plan and ongoing performance measures.

## Accountability and Assurance

Overall accountability sits with the Chief People Officer, supported by relevant clinical, education and professional executive leads.

Progress will be reviewed through the Workforce Inclusion Steering Group, People & Culture Committee and relevant education and professional workforce governance arrangements.

## Current Position

Dedicated pastoral and educational support arrangements are established and continuing for a number of internationally recruited staff groups. Support currently includes bespoke induction programmes, pastoral support, educational development opportunities, information resources and access to initiatives such as The International Care Collective podcast, which shares the experiences of internationally recruited NHS staff adapting to life and work in the UK.

Available feedback has been positive. In addition, several International Medical Graduates from the 2025/26 cohort have expressed an interest in remaining within the Trust following completion of their initial placement. The International Medical Graduate induction programme is also being trialled as a hybrid model following feedback from previous cohorts.

Further work is required to strengthen evaluation, outcome measurement and reporting of longer-term impacts on retention, inclusion, development and progression.

## Objective 6: Prevent and address discrimination, harassment and inequity in workplace processes

### Baseline

Global Majority staff continued to report higher levels of harassment, bullying or abuse from patients, relatives or the public than White staff.

Global Majority staff also reported higher levels of discrimination from managers, team leaders or other colleagues.

Disparities remained within some disciplinary and capability processes. Wider organisational evidence also identified continuing concerns relating to disability discrimination, sexual safety, misogyny, hate incidents and confidence in reporting.

### Intended outcome

Staff experience a safer and more inclusive workplace, have confidence to report concerns and receive fair, timely and effective organisational responses. Progress assessed through:

- Staff Survey discrimination, harassment and bullying measures;
- disciplinary and capability process disparities;
- discrimination and hate-incident reporting;
- the quality and timeliness of organisational responses;
- post-incident support;
- speaking-up confidence;
- staff experience of formal employment processes; and
- evidence that learning from incidents and concerns leads to sustained improvement.

### Priorities for 2026/27

During 2026/27, the Trust will:

- complete and share learning from targeted hate-incident and cultural-safety work;
- improve discrimination and hate-incident reporting;
- strengthen monitoring of data quality and organisational response;
- Evaluate the HR Decision-Making Group pilot effects upon fairness within disciplinary and capability processes;
- deliver targeted hate-crime, race-equality and inclusion activity; and
- evaluate whether interventions improve reporting, organisational response and staff experience.

### Accountability and assurance

Overall accountability sits with the Chief People Officer and Chief Strategy Officer, supported by relevant operational leaders. Progress will be reviewed through the Workforce Inclusion Steering Group, People & Culture Committee, Freedom to Speak Up arrangements, violence prevention and reduction governance and relevant operational governance routes.

### Current position

Several interventions are in delivery. Further work is required to improve data quality, review formal processes, evaluate impact and ensure that learning is applied consistently across the organisation.

## Objective 7: Support an inclusive transition from analogue to digital

### Baseline

The Trust's increasing use of digital systems creates opportunities to improve how staff work, learn and communicate. However, staff do not have consistent levels of access, confidence or capability in using digital technology.

Differences in digital skills, access to equipment, protected learning time and familiarity with clinical and corporate systems may disadvantage some staff groups and create barriers to development, participation and effective working.

A consistent Trust-wide baseline for digital confidence has not yet been established.

### Intended outcome

Staff have equitable access to the skills, support, equipment and protected time required to use digital systems confidently and effectively.

Digital change is implemented in a way that does not disadvantage staff because of their role, grade, location, disability, age or other protected characteristic.

Progress will be assessed through:

- participation in digital skills training;
- staff confidence in foundational digital skills;
- confidence in using relevant clinical and corporate systems;
- confidence in using data, information and artificial intelligence appropriately;
- differences in digital confidence by role, grade and staff group;
- access to protected learning time;
- participation in the Digital Champions Network; and
- evidence that equality and accessibility are considered when digital systems and processes are introduced.

### Priorities for 2026/27

During 2026/27, the Trust will:

- develop and launch a digital skills curriculum covering foundational digital skills, clinical and corporate systems, Microsoft 365, information literacy, artificial intelligence and digital leadership;
- build digital skills development into relevant career pathways and placements;
- provide protected time for staff to develop digital skills;
- increase access to online learning, workshops and drop-in support;
- establish a Digital Champions Network to provide peer support and practical guidance;
- develop a baseline measure of staff digital confidence;
- analyse digital skills and confidence by role, grade and staff group; and
- ensure accessibility and equality considerations are included within digital change and implementation.

### Accountability and assurance

Overall accountability sits with the Chief Strategy Officer and Chief Information Officer, working with the Chief People Officer and relevant education and operational leads.

Progress will be monitored through the Workforce Inclusion Steering Group and the relevant digital, workforce and Strategy Delivery Plan governance arrangements.

### Current position

The proposed digital inclusion framework and indicators have been identified. Baseline data, detailed delivery arrangements and measurable targets require further development during 2026/27.

## Workforce Inclusion Programme 2026

The Workforce Inclusion Programme (WIP) 2026 sets out the Trust's approach to delivering its equality objectives and embedding inclusion across the organisation. It builds on the Trust's Equality, Diversity and Inclusion (EDI) Strategy and aligns with the NHS EDI Improvement Plan, particularly the six High Impact Actions. It is integrated within the wider *Excellent Care Everywhere* Trust Strategy Delivery Plan.

The Programme focuses on improving outcomes across key areas including recruitment and selection, career progression, staff experience, workforce health inequalities, and leadership accountability. It is informed by the data and evidence presented within this report, alongside staff engagement, national benchmarks, and regulatory expectations.

The Programme translates these priorities into targeted, measurable actions designed to reduce inequalities in experience and outcomes between different staff groups. Progress against the Programme is reported regularly and used to inform continuous improvement.

## Board and Executive accountability

During 2026/27, the organisational equality objectives will be supported by a shared Board objective and role-specific Executive objectives aligned to individual portfolios.

These objectives will clarify responsibility for areas including:

- workforce equality;
- inclusive leadership and organisational culture;
- patient and workforce inequalities;
- accessible services and communications;
- digital inclusion;
- operational culture and safety;
- inclusive governance and impact assessment; and
- organisational assurance and risk escalation.

Once formally agreed, the objectives will be reflected in appraisal and performance-review arrangements and monitored through the appropriate governance routes.

Individual Board and Executive objectives will provide an additional accountability mechanism. They will not replace the collective responsibility of the Board, and they complement the organisational equality objectives set out above.

## Monitoring and reporting

Progress against the equality objectives will be monitored through the Workforce Inclusion Programme and reported through the Workforce Inclusion Steering Group and People & Culture Committee.

Relevant risks, barriers and dependencies will be escalated through Strategy Delivery Plan, corporate risk and Board assurance arrangements where required.

The Trust will publish updated equality information annually. Future reports will include:

- progress against each objective;
- changes in the principal outcome measures;
- delivery against annual milestones;
- areas where improvement has not been achieved;
- barriers or risks affecting delivery; and
- any resulting changes to priorities or action.

## Governance

Robust governance arrangements are in place to ensure accountability for delivery of the Workforce Inclusion Programme and equality objectives.

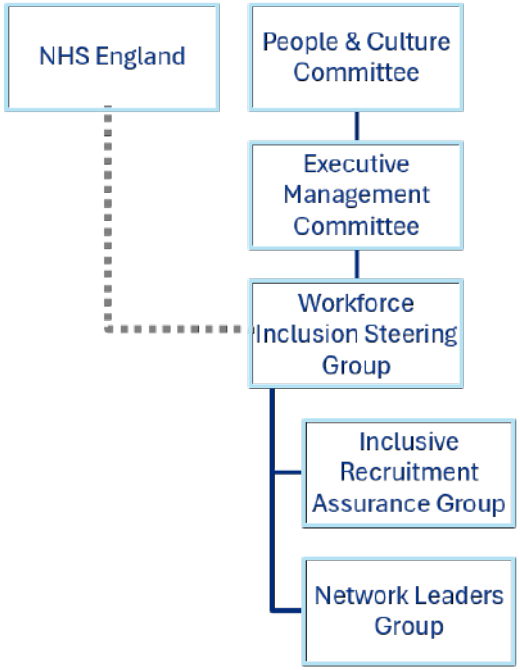
In April 2025, the Trust established a Workforce Inclusion Steering Group. This group provides oversight of progress against the WIP, monitors delivery of key actions, and ensures alignment with organisational priorities.

Progress is reported on a bi-monthly basis and escalated quarterly to the People & Culture Committee, providing Board-level assurance. Governance arrangements will be further strengthened in 2026/27 with the introduction of an overarching Workforce Steering Group, chaired by the Chief People Officer.

In addition, the Trust meets a range of national and regional reporting requirements, including:

- Workforce Race Equality Standard (WRES) submissions to NHS England
- Workforce Disability Equality Standard (WDES) submissions
- Annual gender and ethnicity pay gap reporting to the Cabinet Office
- NHS EDI Improvement Plan reporting via the Integrated Care Board (ICB)
- Contributions to the Trust Annual Report and statutory equality publications.

*Current governance arrangements:*



# Regulatory response: CQC Well-Led assessment

In its Well-Led assessment published in May 2026, the Care Quality Commission identified that further work was required to ensure the Trust makes effective use of the Workforce Race Equality Standard (WRES) and NHS Staff Survey findings so that staff from ethnic minority backgrounds are not disproportionately disadvantaged. The Trust submitted a Regulation 17 action plan in response, with delivery built into the Workforce Inclusion Programme for 2026/27.

## Action and accountability

The Trust's response prioritises fair recruitment and selection, senior career progression and representation, more equitable formal employment processes, prevention of discrimination and harassment, support for internationally recruited staff, and stronger Board and divisional accountability. Planned delivery includes enhanced inclusion controls for senior recruitment, divisional workforce inclusion data packs and accountability conversations, career sponsorship and navigation support, improved discrimination reporting, cultural safety interventions, inclusive leadership development and review of potential bias within disciplinary and capability processes.

Executive responsibility is shared between the Chief People Officer and Chief Strategy Officer. Delivery is phased over 2026/27, with key recruitment, reporting and divisional accountability milestones scheduled during 2026 and wider implementation and evaluation continuing to March 2027.

## Monitoring and assurance

Progress will be monitored through the Workforce Inclusion Steering Group, People & Culture Committee and relevant Strategy Delivery Plan reporting arrangements. Measures will include WRES indicators, NHS Staff Survey results, recruitment and employee-relations data, senior and Board representation, local pulse surveys, divisional analysis and qualitative insight from staff networks and other staff-engagement routes.

At the date of publication, established elements of the response remain in delivery, such as workforce equality reporting, inclusion governance, staff network oversight, career sponsorship and international staff support. Further controls, including divisional data packs, enhanced senior recruitment arrangements, improved discrimination reporting and review of formal employment processes, are being developed or implemented during 2026/27.

# Our framework for inclusion

How our vision, values, behaviours and leadership expectations support inclusion

NHS
University Hospitals Sussex
NHS Foundation Trust

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## Excellent Care Everywhere

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We work collaboratively, value difference and involve others.

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We behave professionally, fairly and with dignity.

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Five commitments that turn values into everyday behaviours

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Treat people with dignity and support wellbeing.

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Stay curious, value difference and involve those affected.

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Collaborate across roles, teams, sites and services.

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Act early, address issues and challenge discrimination.

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Create psychological safety, welcome challenge and learn.

## Inclusive and anti-discriminatory leadership framework

### How the Compass applies across four leadership levels for inclusion

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- Actively seeks and values input from people with different perspectives and experiences.
- Involves patients, carers or partners where this improves decisions or outcomes.
- Challenges exclusion, bias or power imbalance within the team

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- Actively seeks and values diverse professional and personal perspectives in decision-making.
- Encourages challenge and constructive dissent to improve quality and outcomes.
- Creates space for honest dialogue across teams, disciplines and services.

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- Seeks and values challenge from different professional, personal and lived perspectives.
- Actively addresses inequity, bias or power imbalance in systems and decisions.
- Involves staff, patients and partners in shaping priorities where it improves outcomes.

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- Seeks and values diverse perspectives in Board and Executive decision-making.
- Ensures staff, patient and partner insight meaningfully informs strategy and assurance.
- Challenges exclusion, bias or group-think at senior levels.

©Ñï ╗⅞×╩ňσ ⌟ a culture where everyone feels valued, heard, treated fairly, able to belong, and confident to speak up.

# Equality Profiles

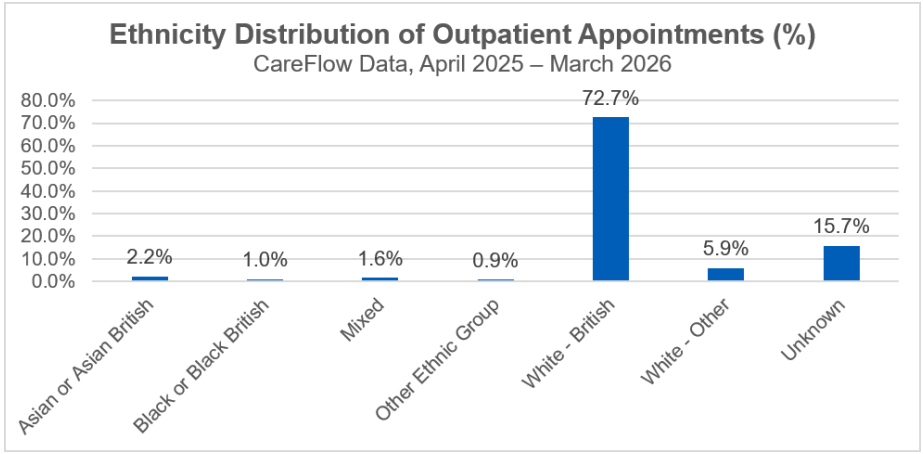
The following sections summarise the diversity and representation of the people who use our services and the workforce that delivers them. These themes bring together demographic, representation and progression data to provide context for understanding workforce experiences, opportunities and outcomes across the organisation.

## Service User Equality Snapshot

Understanding the demographic profile of people who use our services provides context for identifying potential differences in patterns of service use, patient experience and outcomes. Although this is primarily a *workforce* equality report, comparing service-user and workforce demographics also helps identify where the composition of the workforce differs from the populations it serves.

The activity data presented in this section describe recorded appointments, attendances and discharges. They do not, on their own, demonstrate whether access is equitable, because patterns of service use are also influenced by population need, age, case mix, referral routes, repeat activity, service catchments and the completeness of demographic recording. Incomplete data continue to limit more detailed analysis and underline the importance of improving data quality across clinical systems.

### Race and Ethnicity




Census 2021 data indicate that approximately 9.0% of residents across Sussex identified with an Asian, Black, Mixed or Multiple, or Other ethnic group, referred to in this report as Global Majority[2]. This compares with 19.0% across England. The proportion varied considerably by place, from 6.1% in East Sussex and 9.0% in West Sussex to 14.6% in Brighton & Hove. Across Sussex overall, approximately 3.7% of residents identified as Asian, 1.3% as Black, 2.7% as Mixed or Multiple ethnic groups and 1.3% as another ethnic group. CareFlow outpatient data, including attendances, cancellations and DNAs, show that 5.7% of recorded activity related to patients from Global Majority backgrounds and 78.6% to White patients, while ethnicity was not recorded for 15.7% of contacts. As this data is based on outpatient activity rather than unique patients, individuals with multiple appointments during the reporting period may been counted on more than one occasion. Ethnicity was recorded for 84.3% of appointments, above the national average of 77.1% for outpatient attendances.

[2] **Source:** Office for National Statistics, Census 2021 ethnic-group data for East Sussex, West Sussex and Brighton & Hove. For this analysis, "Global Majority" comprises the Census high-level Asian, Black, Mixed or Multiple, and Other ethnic-group categories and excludes all White ethnic-group categories. The Sussex percentage is population-weighted across the three areas.

Additional inpatient and Emergency Department data show a similar pattern. In inpatient activity, 81.6% of discharges related to White patients and 5.5% to Global Majority patients, while ethnicity was not recorded for 13.0%. In Emergency Department activity, 73.9% of discharges related to White patients and 6.8% to Global Majority patients, while ethnicity was not recorded for 19.4%.

Although ethnicity recording remains incomplete across all three care settings, with missing data ranging from 13.0% of inpatient activity to 19.4% of Emergency Department activity, ethnicity was recorded for between 80.6% and 87.0% of activity. This exceeds the national threshold of 60% and places the Trust amongst the top-performing organisations nationally. Nonetheless, further improvement is required to support more detailed analysis and reliable comparison with local population benchmarks. During Q4, face-to-face training and supporting materials were provided to increase staff confidence in collecting ethnicity data, alongside patient-facing leaflets and posters explaining why this information is important.

However, these figures alone do not establish whether access is equitable, as interpretation is influenced by differences in population need, age profile, service catchments, referral patterns, case mix, repeat activity and the remaining gaps in ethnicity recording.

### Disability

Approximately 18.2% of residents across Sussex identified as disabled under the Equality Act 2010 definition in the 2021 Census. This varies by place, from approximately 16.9% in West Sussex and 18.7% in Brighton & Hove to 20.3% in East Sussex. Comparable patient-level information is currently limited because disability status is not consistently recorded within clinical systems. This restricts the Trust's ability to assess whether disabled patients experience differences in access, experience or outcomes.

### Sex

Females represent approximately 51.6% of the local population (Census 2021). The proportion varies slightly by place, from 51.0% in Brighton & Hove and 51.5% in West Sussex to 52.0% in East Sussex.

Outpatient data show that 57.4% of appointments were attended by female patients and 42.6% by male patients. Male patients had a slightly higher did-not-attend rate than female patients, at 5.4% compared with 4.8%, while female patients had a higher cancellation rate, at 13.0% compared with 11.5%. A similar pattern is evident in other care settings. Females accounted for 54.2% of inpatient discharges and 52.4% of Emergency Department attendances, compared with 45.8% and 47.5% respectively for males. These activity patterns are broadly similar to the overall sex profile of the Sussex population. However, appointment,

attendance and discharge proportions alone cannot determine whether access is equitable, as they do not account for differences in healthcare need, referral patterns, age, case mix or repeat use of services.

### Gender Identity

Approximately 0.5% of residents aged 16 and over across Sussex reported that their gender identity was different from their sex registered at birth in the 2021 Census. This varied by place, from approximately 0.4% in both East Sussex and West Sussex to 1.0% in Brighton & Hove. Patient-level information on gender identity is not consistently recorded within clinical systems, limiting the Trust's ability to assess differences in access, experience or outcomes. The Census estimates should be treated as a broad indication rather than a precise measure, particularly at local level, because the question was voluntary and the Office for National Statistics has identified uncertainty affecting interpretation of the results.

### Sexual Orientation

Approximately 4.3% of residents aged 16 and over across Sussex identified as lesbian, gay, bisexual or another minority sexual orientation in the 2021 Census. This varied considerably by place, from 2.9% in West Sussex and 3.3% in East Sussex to 10.6% in Brighton & Hove. Across Sussex, approximately 2.3% identified as gay or lesbian and 1.6% as bisexual, with smaller proportions identifying as pansexual, asexual, queer or another sexual orientation. The Census question was voluntary, and these figures may not capture all residents with a minority sexual orientation. Patient-level information on sexual orientation is not consistently recorded within clinical systems, limiting the Trust's ability to assess differences in access, experience or outcomes.

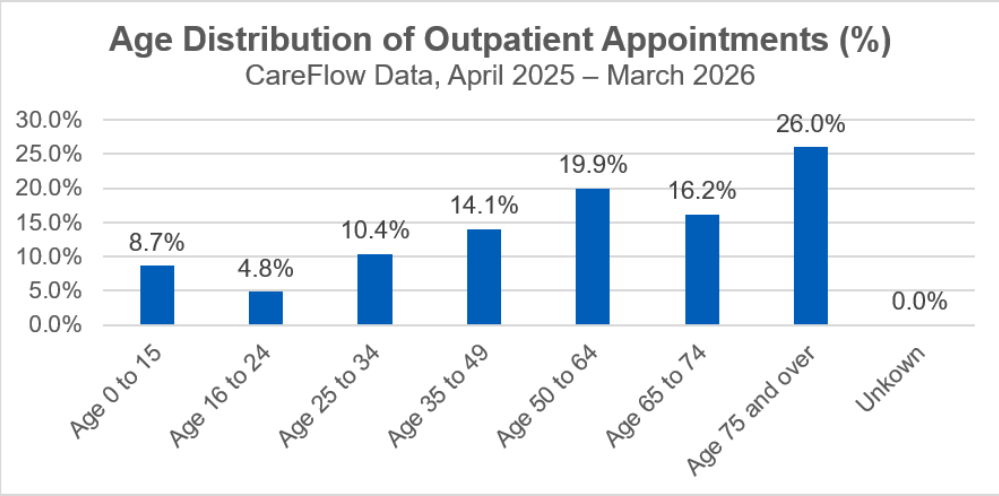
### Religion and Belief

Approximately 49.1% of residents across Sussex reported a religion in the 2021 Census. This varied by place, from approximately 37.7% in Brighton & Hove and 48.8% in East Sussex to 52.8% in West Sussex. Christianity was the most commonly reported religion overall, accounting for approximately 44.6% of the Sussex population, although this ranged from 30.9% in Brighton & Hove to 45.9% in East Sussex and 48.1% in West Sussex. Across Sussex, approximately 2.0% of residents identified as Muslim, 0.5% as Buddhist and 0.8% as Hindu. The Census question on religion was voluntary, and around 6–7% of residents did not provide an answer.

In inpatient data, 35.6% of patients were recorded as having a religion, including 33.0% recorded as Christian and 0.9% as Muslim, while 19.3% were recorded as having no religion. However, religion or belief information was missing from 45.0% of records, preventing reliable comparison with the Sussex population and limiting further analysis.

## Age

The age profile of the population varies considerably across Sussex. Brighton & Hove has a younger population, with approximately 14% of residents aged 65 and over, compared with around 23% in West Sussex and 26.1% in East Sussex. These differences are relevant when interpreting patterns of hospital activity, particularly because older populations are generally more likely to require inpatient and planned care.




Outpatient data show variation in recorded activity across age groups. Patients aged 75 and over accounted for the largest proportion of appointments, at 26.0%, while those aged 16–24 and 25–34 accounted for the smallest proportions, at 4.8% and 10.4% respectively.

Patterns differed across other care settings. In inpatient activity, the largest proportions of discharges were among patients aged 30–64, at 38.9%, and 65–84, at 34.8%, while patients aged 18–29 accounted for 7.7%. In Emergency Department activity, younger patients accounted for a greater share, including those aged 0–17, at 19.5%, and those aged 18–29, at 15.0%. This is consistent with differing patterns of service need and use across urgent, planned and inpatient care.

Younger outpatients also had higher did-not-attend rates. Patients aged 16–24 had the highest rate, at 9.4%, compared with a lowest reported rate of 3.3% among older patients. This indicates differing attendance patterns and may warrant further analysis of factors such as appointment type, communication method, transport, service location and the availability of flexible appointment options.

These activity figures should not be interpreted as direct evidence of equitable or inequitable access. Meaningful assessment would require analysis against the age profile and healthcare needs of the relevant service catchment, alongside referral rates, waiting times, repeat activity and outcomes.

### Caring Responsibilities

Approximately 8.9% of the population in Sussex provide unpaid care (Census 2021). This varies by place, from approximately 8.0% in Brighton & Hove and 8.6% in West Sussex to 9.9% in East Sussex. Patient-level data on caring responsibilities is not consistently recorded within clinical systems, limiting the Trust's ability to assess whether carers experience differences in access, experience or outcomes.

### Armed Forces

Approximately 3.6% of residents across Sussex have previously served in the UK Armed Forces (Census 2021). This varies across Sussex, from 2.4% in Brighton & Hove and 3.4% in West Sussex to 4.6% in East Sussex, indicating a higher concentration of veterans in East Sussex. The Census measure covers previous service only: people currently serving in the UK Armed Forces were instructed to answer "no" and are therefore not included in these figures. Separately, Ministry of Defence statistics recorded 183,410 UK Armed Forces service personnel nationally at 1 April 2026. This is a UK-wide personnel headcount rather than a Sussex estimate or a proportion of the general population and should not be added to, or directly compared with, the Census veteran percentage.

## Women and Children's Divisional Cultural Safety

Over the past year, we established the Divisional Cultural Safety Steering Group to provide a dedicated forum for addressing inequalities and promoting equity across our services. The group has brought together colleagues from across Women's Health Services, the EDI team, organisational networks and quality improvement leads to identify areas of disparity, share learning and develop actions to improve outcomes and experiences for both staff and the communities we serve. Through regular meetings, we have reviewed data and dashboards to better understand inequalities, received updates from organisational networks and EDI colleagues, and welcomed guest speakers to increase awareness and understanding of cultural safety and inclusion. These discussions have informed a number of quality improvement initiatives within the division, ensuring that equity and cultural safety are embedded within service development and improvement work. The Steering Group has provided an important platform for collaboration, accountability and shared learning, helping to shape a more inclusive and equitable culture across division.

## Translation and Interpreting services, 2025/26

Access to professional interpreting and translated information is essential to safe, equitable and person-centred care. It enables patients to understand their diagnosis and treatment, participate in decisions and provide informed consent. The Trust's policy requires staff to identify and record communication needs, offer professional support and avoid relying on relatives, children or unapproved translation applications for clinical communication.

During 2025/26, suppliers recorded **17,903 interpreting and translation bookings**, with associated invoice expenditure of **£891,549**. The source of this data is UHSussex supplier booking and invoice data, April 2025 to March 2026. Figures are operational data and do not reconcile directly to ledger expenditure because of invoice timing, inconsistent supplier coding and retrospective adjustments.

| Type of service | Bookings | Share of bookings | Recorded spend | Share of spend |
|---|---|---|---|---|
| **Remote telephone interpreting, international languages** | 9,381 | 52.4% | £124,362 | 13.9% |
| **Face-to-face interpreting, international languages** | 7,323 | 40.9% | £637,041 | 71.5% |
| **Face-to-face sign-language interpreting** | 892 | 5.0% | £114,750 | 12.9% |
| **Other remote, video and document translation services** | 307 | 1.7% | £15,396 | 1.7% |
| **Total** | 17,903 | 100% | £891,549 | 100% |

Remote telephone interpreting was therefore the most frequently used delivery method. However, face-to-face international-language interpreting continued to account for most expenditure because of longer minimum booking periods, interpreter travel and cancellation charges. This suggests that remote interpreting can provide a flexible and lower-cost communication option in appropriate circumstances, while face-to-face interpreting remains essential where the patient's needs, the complexity or sensitivity of the interaction, or a reasonable adjustment require it.

The most frequently recorded languages were **Arabic** (3,266 bookings), **Bangla/Bengali** (1,423), **Farsi/Persian** (1,337), **British Sign Language** (990), **Russian** (977) and **Portuguese** (917). The ten most frequently used languages accounted for 47.5% of activity across the full year, demonstrating both concentrated demand and the breadth of language needs across the Trust. Royal

Sussex County Hospital accounted for 11,052 bookings, approximately 62% of the total, although 921 records did not contain a reliable site identifier.

Further details on translation and interpreting activity, demand and service delivery are provided in Appendix 3: Translation and Interpreting.

### Service improvement and assurance

The Trust continued to embed the revised approval process for advance-booked, in-person interpreters. Staff are expected to consider telephone or video interpreting first, with individual divisional approval required for planned face-to-face bookings. The process explicitly retains face-to-face support where it is clinically or otherwise necessary and is intended to improve both timely access and financial oversight.

Late cancellations remained a material issue. **1,559 bookings**, equivalent to **8.7% of all recorded activity**, were identified as late cancellations. These incurred costs of **£93,712**, or **10.5% of total recorded expenditure**. Late cancellation is not solely a financial issue. Repeated cancellation or rescheduling can disproportionately affect patients who require interpreters, particularly Deaf patients and people experiencing barriers associated with migration, poverty, transport or digital exclusion. Further work is required with high-use services to distinguish cancellations arising from patients, clinical services or suppliers and to identify whether appointment confirmation, accessible communication or booking processes can be improved.

The Trust also continued to promote **CardMedic**, which provides staff with immediate access to pre-translated clinical conversations, British Sign Language content, Easy Read and read-aloud functions. By 31 July 2025, 1,007 UHSussex staff had registered, with midwives, doctors and nurses the most frequent users. International-language content remained its primary use, while BSL and Easy Read usage was comparatively low. Work during the year explored integrating access to live interpreting suppliers through a single digital route and improving booking, reporting and invoice validation.

### Priorities for 2026/27

Priorities are to:

- Reduce avoidable late cancellations, including targeted reviews where rates are unusually high
- Improve BSL and other accessible communication pathways
- Preserve access to face-to-face interpreting where this is clinically necessary or a reasonable adjustment
- Increase appropriate use of remote interpreting and CardMedic

- Improve consistency of supplier coding, site and department data
- Strengthen reconciliation between booking, invoice and financial-ledger information

# Workforce Equality Snapshot

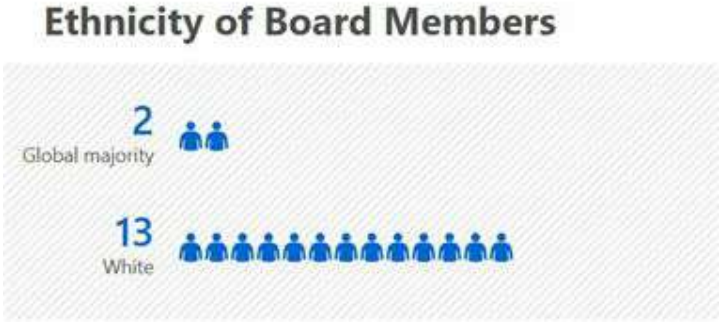
Understanding the demographic profile of our workforce helps identify how well the organisation reflects the communities it serves and provides context for understanding differences in staff experience, representation and outcomes.

## Board Composition

This section provides an overview of the composition of our Board, including both Executive and Non-Executive Directors at the snapshot date of 31 March 2026 (N = 16). Understanding the diversity of our Board is important in ensuring that decision-making reflects a range of perspectives and experiences. While sex representation is balanced, representation across several other characteristics remains limited, particularly ethnicity, disability and age.

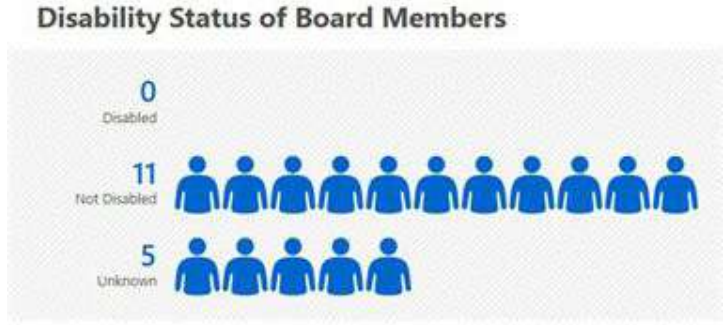
### Race and Ethnicity

Most Board members identify as White (13 members; 81.3%), with 12.5% (2 members) identifying as Global Majority. One member (6.3%) has not disclosed their ethnicity. Representation from Global Majority backgrounds is currently limited, with no representation at executive level.




### Disability

No Board members have declared a disability. Most members are recorded as not disabled (68.8%, 11 members), while 31.3% (5 members) have not disclosed their disability status.




### Sex

Sex representation across our Board is balanced overall, with equal numbers of female and male members (50.0% each; 8 members).

### Sexual Orientation

50% (8 members) of Board members disclosed their sexual orientation, while the other half have not.

## Religion and Belief

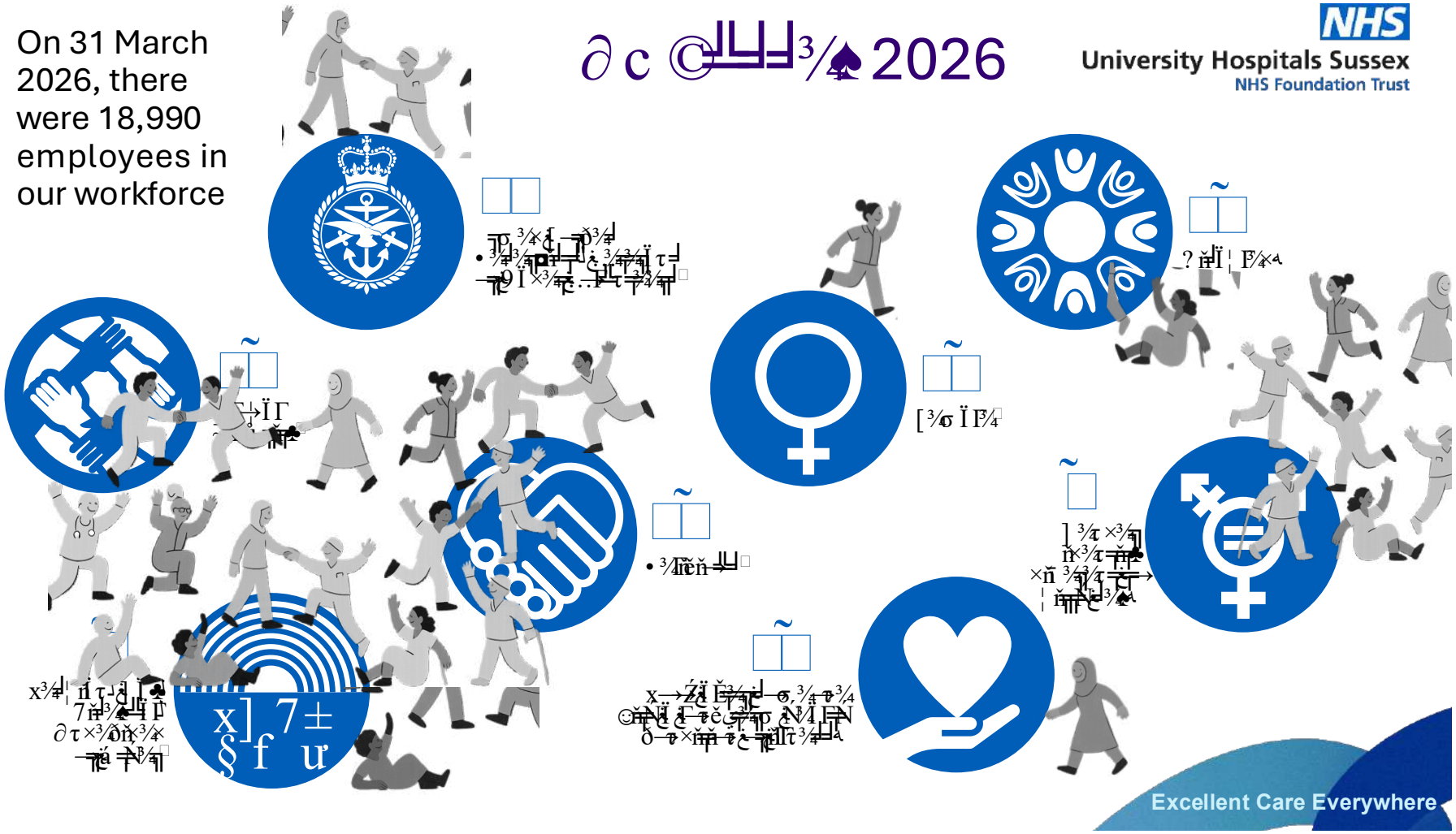
Over half of Board members (56.3%, 9 members) have reported having a religion, while a further 37.5% (6 members) have not disclosed their religion or belief.

## Age

The Board is predominantly made up of members aged 51 and over, with the largest groups aged 51–60 and 61–70. There is limited representation from younger age groups, with only one Board member aged 40 or under.

## Workforce Composition

On 31 March 2026, there were 18,990 employees in our workforce




‡ Source: Electronic Staff Records (ESR)

* Source: National Staff Survey – UHSussex results

This section provides an overview of our workforce composition using Electronic Staff Record (ESR) data, alongside Staff Survey 2025 responses to give additional context on how our colleagues identify themselves. Percentages are supported by the accompanying charts to support interpretation. Understanding workforce composition helps identify how well the Trust reflects the diversity of the communities it serves and provides important context for understanding differences in staff experience, representation and outcomes.

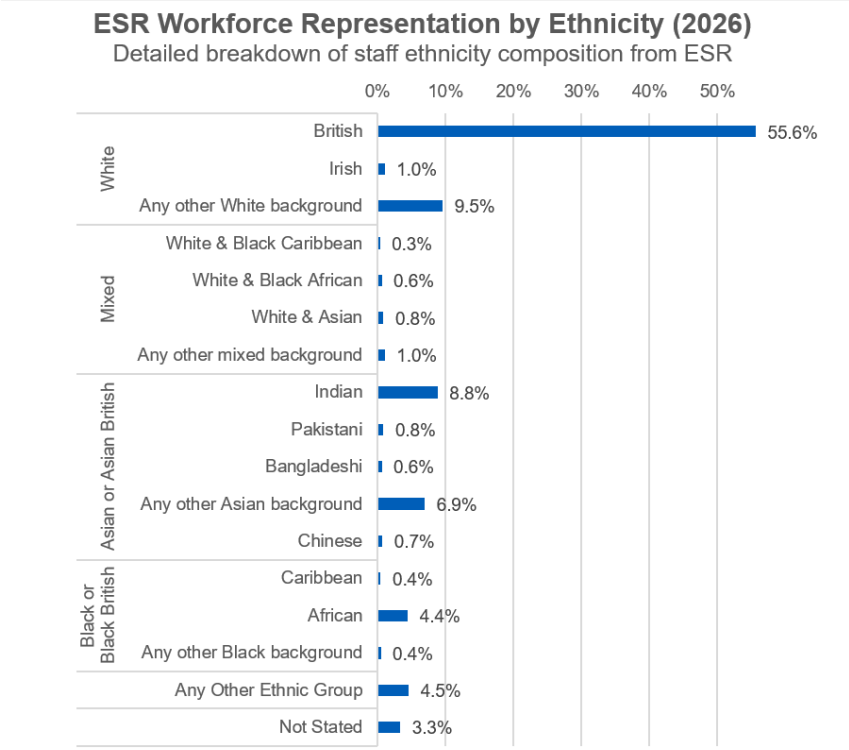
## Race and Ethnicity

Our workforce includes a diverse range of ethnic backgrounds. The majority of colleagues identify as White (66.2%, 12,541 staff), with colleagues from Global Majority backgrounds making up just under a third of our workforce (30.5%, 5,777 staff).

Staff Survey responses show a similar pattern, with 70.7% of respondents (5,905 staff) identifying as White. Within the survey, 4.6% identified as Black/African/Caribbean/Black British, 2.6% as Mixed/Multiple ethnic backgrounds, and 1.5% as from another ethnic group not listed (other). A small proportion (1.8%, 152 staff) did not provide ethnicity information.

The percentage of colleagues from Global Majority backgrounds has more than doubled over the past decade, increasing from 14.6% in 2014 and 2015. Growth was gradual up to 2021 (19.5%), followed by a more pronounced increase in recent years.

This growth reflects a steadily diversifying workforce and highlights the importance of ensuring that opportunities, experiences and outcomes remain equitable as workforce demographics continue to evolve.

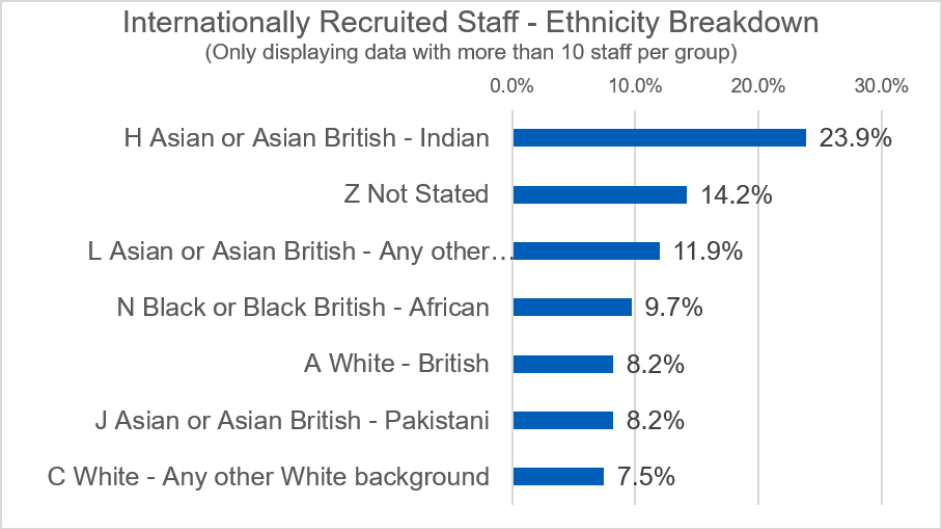


## International Recruitment

This diversity is further reflected in international recruitment, with colleagues joining the Trust from a range of countries over the past year, including the Philippines, Pakistan, Germany, South Africa, India, Brazil, Portugal, Canada, Singapore and Nigeria.

Data from the NHS Staff Movements Dashboard (ESR) indicates that 134 staff were recruited from abroad between 1 April 2025 and 31 March 2026. The majority of these recruits (94.0%) joined from non-EU countries. Over half were from India, the Philippines, Nigeria or Pakistan, highlighting the Trust's reliance on international workforce supply from these regions.

These internationally recruited colleagues are primarily based across Royal Sussex County Hospital (41.0%), Worthing (24.6%) and St Richard's (20.9%), and most commonly work within Medical and Dental roles, followed by Additional Clinical Services, Nursing and Midwifery, and Allied Health Professionals. Many were appointed to Medical Doctor, Registrar or Consultant roles, or Bands 2–5, reflecting recruitment across both clinical and support roles. Over half of these colleagues joined on permanent contracts (58.2%).




Demographic data shows that the majority identify as non-disabled (66.4%), Asian (44.0%), female (58.2%), and are aged between 26 and 35 (56.0%). A range of religions and sexual orientations are represented, although a notable proportion of staff (30.6%) chose not to disclose this information.

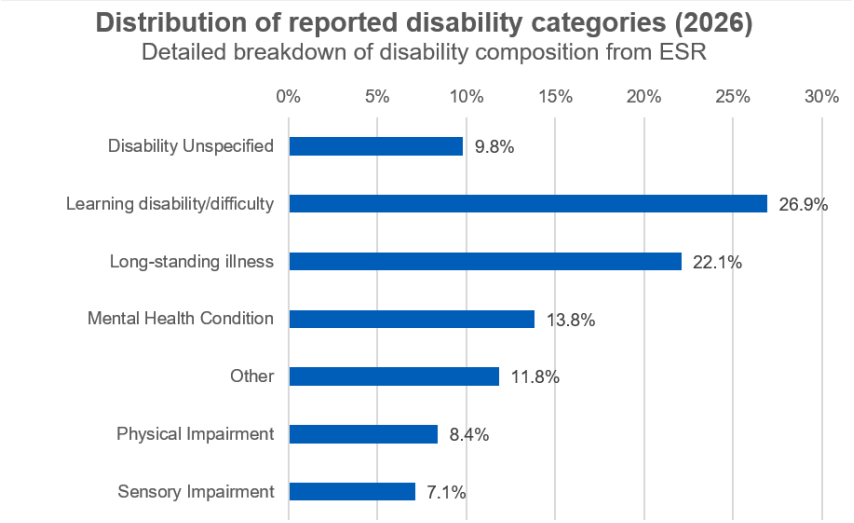
International recruitment continues to play an important role in supporting workforce supply across a range of professions and grades, reinforcing the Trust's reliance on a globally diverse workforce.

## Disability

Based on ESR data, 7.2% of our workforce (1,367 staff) have declared a disability, compared to 85.2% (16,178 staff) recorded as not disabled.

However, Staff Survey responses suggest that a larger proportion of our colleagues experience long-term health conditions, with 24.4% (2,037 staff) reporting a physical or mental health condition lasting 12 months or more, compared to 73.5% (6,143 staff) who reported they do not.

This difference suggests that disability may be underrepresented in ESR data and highlights the importance of continuing to create an environment where colleagues feel safe, supported, and confident to disclose. It may also reflect the use of more inclusive wording within the Staff Survey, which could encourage greater identification with disability and long-term health conditions.




The percentage of colleagues reporting a disability has increased over the past 10 years, rising from 4.2% in 2014. Growth was gradual up to 2022 (5.2%), followed by a more noticeable increase in recent years.

## Sex

Our workforce is predominantly female, with ESR data showing 72.2% of colleagues (13,719 staff) recorded as female and 27.8% (5,271 staff) as male. Staff Survey data closely reflects this profile, with 71.1% (5,939 staff) identifying as female and 23.4% (1,953 staff) as male. In addition, a small but significant proportion of colleagues identified as non-binary (0.4%), preferred to self-describe (0.2%), or chose not to disclose their gender (3.7%, 103 staff).

The proportion of female colleagues has decreased slightly over the past 10 years, from 76.3% in 2014. This reflects a gradual shift over time, with the proportion remaining relatively stable since 2023 (72.6%). While the workforce remains predominantly female, the gradual change over time reflects increasing gender diversity across the organisation.

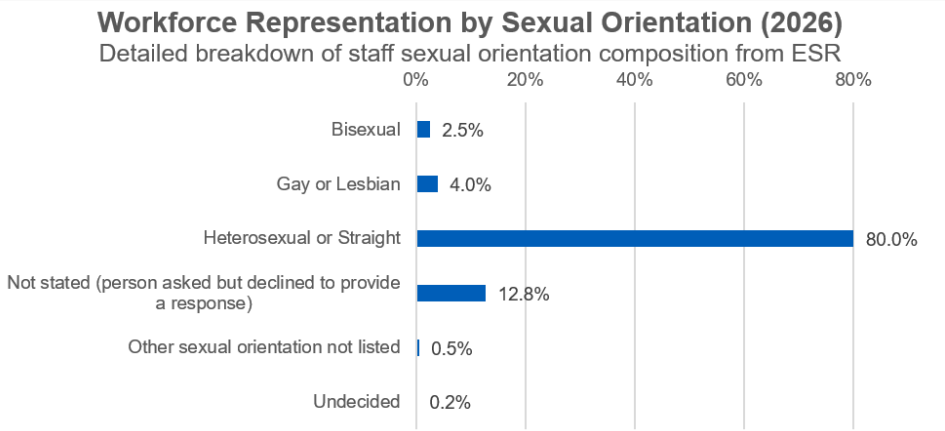
In terms of gender identity, 85.2% of colleagues (7,117 staff) reported that their gender identity is the same as the sex registered at birth, while 0.5% (45 staff) reported that it is different. 3.7% of respondents indicated they preferred not to disclose their gender identity (308 staff) and no data was available for a further 10.6% (888 staff).

## Sexual Orientation

The majority of our colleagues identify as heterosexual or straight (ESR: 80.0%, 15,148 staff; Staff Survey: 84%, 6,785 staff).

LGBUO[3] representation is captured as 7.2% (1,368 staff) in ESR data. Staff Survey data provides further insight, with 4.6% of colleagues (376 staff) identifying as gay or lesbian and 2.8% (234 staff) as bisexual.

A notable proportion of colleagues chose not to disclose their sexual orientation (ESR: 12.8%; Staff Survey: 8.4%), which may indicate ongoing barriers to disclosure and highlights the importance of maintaining an inclusive and supportive environment.




The percentage of colleagues identifying as LGBUO has increased steadily over the past decade from 3.2% in 2014, more than doubling over this period with consistent growth across the years. The increase in disclosure may reflect both changes in workforce demographics and growing confidence among colleagues to share information about their sexual orientation.

[3] LGBUO represents the sum of staff identifying as lesbian, gay, bisexual, undecided, or another sexual orientation (other)

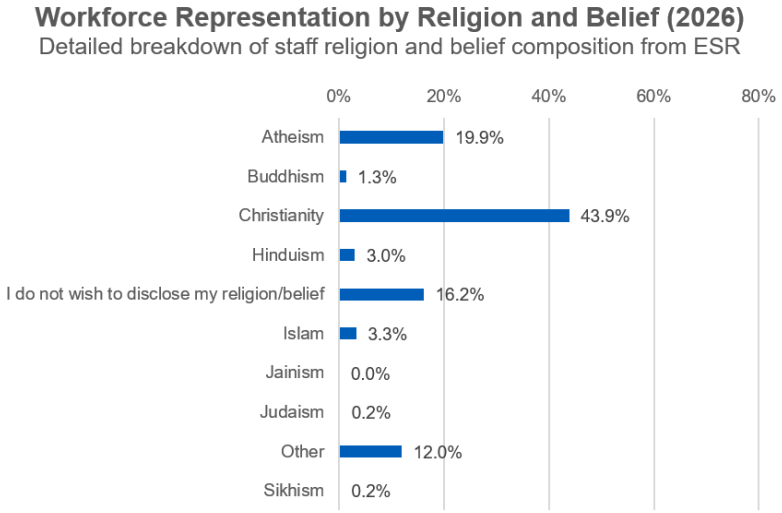
## Religion and Belief

Our workforce reflects a wide range of religions and beliefs. ESR data shows that 63.9% of colleagues (12,096 staff) identify as having a religion, while 19.9% (3,772 staff) identify as atheist.

Christianity is the most commonly recorded religion (43.9%), alongside smaller representations of Hinduism, Islam, Buddhism and other beliefs. A significant proportion of colleagues (16.2%) chose not to disclose their religion or belief.

Staff Survey data complements this, showing 52.7% of respondents holding a religion, of those 45.5% identify as Christian, while 40.1% report no religion, and 6.2% preferred to not share their religion.

The percentage of colleagues reporting a religion has remained relatively stable over the past decade, increasing slightly from 59.8% in 2014 with small fluctuations over time.




## Age

Our workforce spans a broad range of age groups, reflecting a mix of early career, mid-career and more experienced colleagues. ESR data shows that the largest proportions of colleagues are aged between 26 and 40, with 12.1% (2,406 staff) aged 26–30, 14.4% (2,874 staff) aged 31–35, and 14.9% (2,969 staff) aged 36–40. Together, these groups make up 41.3% of our workforce.

Staff Survey responses show a slightly older profile among respondents, with the largest groups aged 51–65 (32.9%), followed by 31–40 (25.3%) and 41–50 (24.4%). This difference is likely influenced by variation in survey response rates across age groups.

Overall, the workforce includes colleagues at all stages of their careers, bringing a broad range of perspectives, skills and experience to the organisation.

## Caring Responsibilities

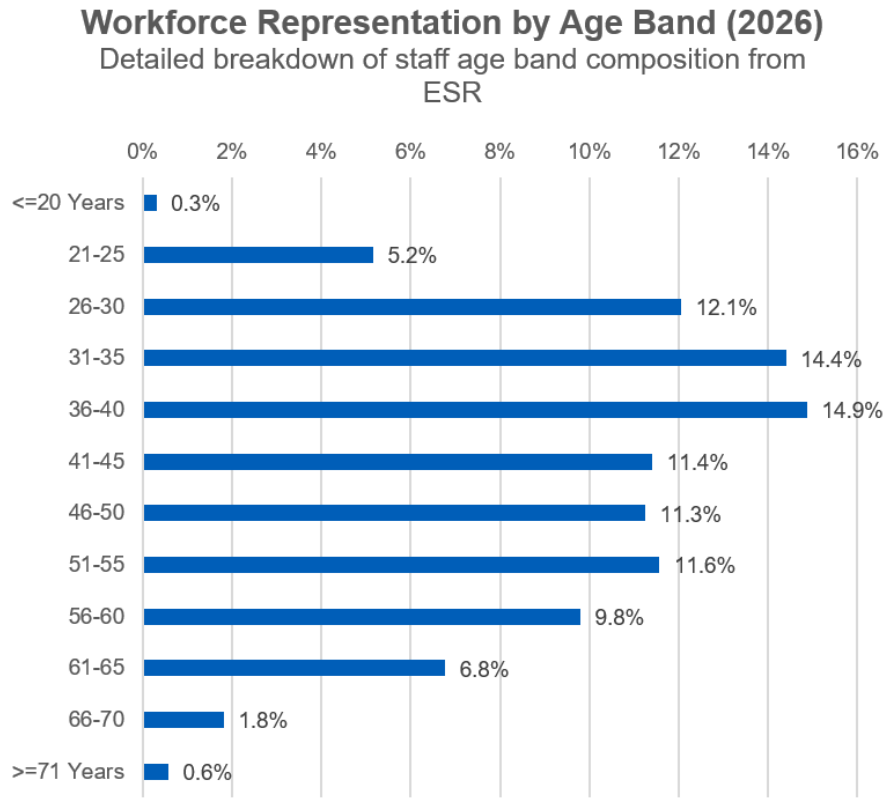
Caring responsibilities are not widely recorded in ESR, with 0.9% of colleagues (170 staff) identified as working carers.

In contrast, Staff Survey responses indicate that 29.1% of colleagues (2,378 staff) provide care or support to family members, friends, or others due to long-term health conditions, disability, or age.

This highlights that caring responsibilities are likely underreported in ESR data and reinforces the importance of recognising and supporting colleagues with caring roles.

## Armed Forces

A small proportion of our workforce are part of the Armed Forces community (0.2%, 44 staff), including 8 Reservists, 31 Veterans, and 5 Cadet Force Adult Volunteers




In addition, 42 colleagues identified as Armed Forces family members.

## Workforce Representation

Disparity ratios are used in this report to compare the representation of different staff groups across workforce levels and career pathways. A value of 1 indicates equal representation between groups, while values between 0.8 and 1.25 are considered to fall within the expected equality range and are highlighted in green in the tables below. Values outside this range indicate differences in representation and may highlight areas where further exploration is required.

This analysis helps identify where barriers to progression may exist and provides insight into how opportunities and outcomes are experienced across the workforce.

### Race and Ethnicity

Analysis of disparity ratios highlights that the largest differences in workforce representation are within clinical roles, particularly at more senior levels. Compared to their representation in support and newly qualified roles (Bands 1–5), White staff were around six times more likely to be in senior clinical roles (Bands 8 and above), an increase from five times in 2025. Similarly, White staff were three times more likely to be consultants than Global Majority staff, relative to their representation in non-consultant career grade roles, an increase from three times in the previous year.

Differences are also evident at earlier stages of progression. White staff were three times more likely to be in specialist or advanced clinical roles (Bands 6–7) compared to Global Majority staff relative to entry-level roles, and similarly twice more likely to progress from Bands 6–7 into senior roles. Both of these represent increases from the previous year.

In contrast, representation in non-clinical roles shows smaller disparities than those seen in clinical pathways, although differences remain. White staff were around 1.4 times more likely to be represented in junior management roles (Bands 6–7) compared with Global Majority staff relative to their representation in support and entry-level roles (Bands 1–5), a slight increase from 1.3 in 2025. Progression from middle to senior roles (Bands 8a–VSM) was closer to the expected equality range, with a disparity ratio of 1.26, improving from 1.61 in the previous year. Overall, non-clinical representation remains more balanced than clinical and Medical and Dental pathways, although inequalities in progression are still evident.

These findings indicate that representation gaps remain most pronounced within clinical and senior roles, suggesting that progression opportunities are not yet experienced equally across all staff groups. While improvement is evident within some non-clinical career pathways, continued focus is needed to understand and address the factors contributing to disparities in progression and representation at more senior levels.

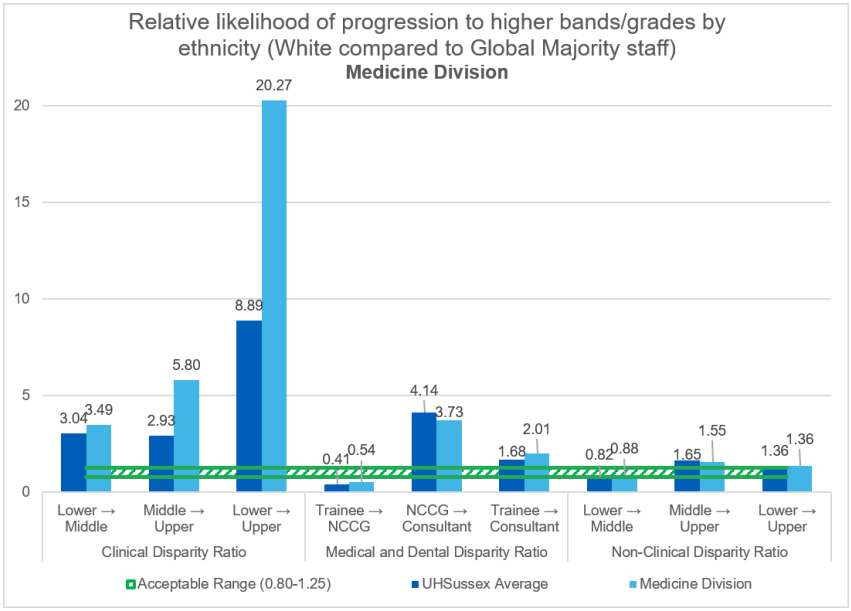
| Ethnicity (White / Global Majority) | UHSussex Mar-2023 | UHSussex Mar-2024 | UHSussex Mar-2025 | UHSussex Mar-2026 | Trend Line |
|---|---|---|---|---|---|
| Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 2.77 | 2.59 | 2.62 | 2.73 | |
| Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 1.73 | 1.84 | 1.91 | 2.30 | |
| Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 4.78 | 4.76 | 4.99 | 6.28 | |
| Medical and Dental Disparity ratio - Trainee to NCCG | 0.68 | 0.52 | 0.79 | 0.76 | |
| Medical and Dental Disparity ratio - NCCG to Consultant | 2.92 | 3.54 | 2.61 | 2.80 | |
| Medical and Dental Disparity ratio - Trainee to Consultant | 1.97 | 1.84 | 2.07 | 2.12 | |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 1.59 | 1.33 | 1.31 | 1.41 | |
| Non-Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 1.22 | 1.3 | 1.61 | 1.26 | |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 1.94 | 1.72 | 2.12 | 1.77 | |

***Note:*** Values highlighted in green fall within the equality range of 0.80 to 1.25 indicating no significant disparity compared with the reference group.

### *Divisional Variation*

Analysis of disparity ratios by division shows that differences in workforce representation are uneven across the organisation, with variation most pronounced in clinical progression to senior roles.

The greatest differences are seen in progression from lower to senior clinical bands, where all divisions show substantially higher disparity ratios than the expected equality range. However, the scale of these differences varies considerably. The Medicine Division stands out as a clear outlier, with markedly higher ratios than the Trust average, particularly for progression from lower to upper bands. Surgery also shows elevated ratios, although to a lesser extent. In contrast, Cancer and Specialist Services demonstrates higher than average ratios but is less extreme, while the Women, Children and Clinical Support Division shows comparatively lower ratios, although disparities remain present.




Within Medical and Dental grades, variation between divisions is also evident, particularly at senior transition points. Medicine and

Surgery display higher likelihood of progression to consultant roles compared to the Trust average, indicating more pronounced differences at senior levels. In contrast, Cancer and Specialist Services shows less pronounced differences, while the Women, Children and Clinical Support Division demonstrate comparatively lower ratios across several stages, suggesting relatively more balanced progression, although variation remains.

In non-clinical roles, variation between divisions is more limited, with most ratios closer to the Trust average or within the equality range. However, some differences remain, with a small number of divisions showing lower likelihood of progression to senior roles, while others remain closer to parity. This indicates a more consistent pattern of representation in non-clinical pathways compared to clinical and Medical and Dental roles.

These findings highlight that workforce representation varies across divisions, with the greatest disparities concentrated in clinical and Medical and Dental career pathways. This suggests that local workforce factors may play an important role in shaping progression and representation outcomes.

### Disability

Analysis of disparity ratios indicates a broadly balanced pattern of workforce representation for disabled staff across most areas, alongside some important differences in specific groups.

Within Agenda for Change clinical roles, disabled staff were similarly likely to be represented across all pay bands compared to non-disabled staff, with all

Within Agenda for Change clinical roles, representation of disabled and non-disabled staff remains broadly balanced across most stages of progression. Disparity ratios for progression from Bands 1–4 to Bands 5–7 (1.05) and from Bands 5–7 to Bands 8a and 8b (0.92) both fall within the expected equality range and have remained relatively stable over time. However, at the most senior clinical levels, non-disabled staff were 1.4 times more likely to be represented in Bands 8c–VSM compared to disabled staff relative to Bands 8a and 8b, resulting in an overall disparity ratio of 1.36 from Bands 1–4 to Bands 8c–VSM. This represents a notable change from previous years, when representation at these levels was closer to parity.

In non-clinical roles, representation is broadly balanced at earlier stages of progression, with a disparity ratio of 1.13 between Bands 1–4 and Bands 5–7. However, disabled staff are more highly represented at senior levels. Non-disabled staff were around 0.7 times as likely to progress from Bands 5–7 to Bands 8a and 8b, and around 0.6 times as likely to progress from Bands 8a and

8b to Bands 8c–VSM. Overall, non-disabled staff were approximately half as likely to be represented in the most senior non-clinical roles relative to entry-level bands, indicating an overrepresentation of disabled staff at these levels.

Within Medical and Dental grades, patterns vary across stages of progression. Representation between trainee and non-consultant career grade roles was broadly balanced in 2026, with a disparity ratio of 0.89 and a substantial reduction from higher ratios observed in recent years. However, non-disabled staff were approximately twice as likely to be represented in consultant roles compared to disabled staff relative to non-consultant career grade roles (2.01), resulting in an overall trainee-to-consultant disparity ratio of 1.80. This represents an increase compared to 2025 and suggests that differences in representation remain concentrated at consultant level.

Overall, workforce representation by disability remains broadly balanced across most clinical pathways and at earlier stages of progression. However, differences are evident at senior clinical grades and within consultant-level Medical and Dental roles, suggesting that representation becomes less equitable at the highest levels of some career pathways.

| Disability Status (Not Disabled / Disabled) | UHSussex Mar-2023 | UHSussex Mar-2024 | UHSussex Mar-2025 | UHSussex Mar-2026 | Trend Line |
|---|---|---|---|---|---|
| Clinical Disparity ratio - Bands 1-4 to Bands 5-7 | 1.29 | 1.18 | 1.12 | 1.05 | |
| Clinical Disparity ratio - Bands 5-7 to Bands 8a & 8b | 0.9 | 1.11 | 0.96 | 0.92 | |
| Clinical Disparity ratio - Bands 8a & 8b to Bands 8c - VSM | 0.45 | 0.61 | 0.85 | 1.40 | |
| Clinical Disparity ratio - Bands 1-4 to Bands 8c - VSM | 0.52 | 0.81 | 0.91 | 1.36 | |
| Medical and Dental Disparity ratio - Trainee to NCCG | 0.99 | 1.66 | 1.75 | 0.89 | |
| Medical and Dental Disparity ratio - NCCG to Consultant | 2.2 | 1.4 | 0.94 | 2.01 | |
| Medical and Dental Disparity ratio - Trainee to Consultant | 2.19 | 2.32 | 1.65 | 1.80 | |
| Non-Clinical Disparity ratio - Bands 1-4 to Bands 5-7 | 1.4 | 1.04 | 1.01 | 1.13 | |
| Non-Clinical Disparity ratio - Bands 5-7 to Bands 8a & 8b | 0.62 | 0.76 | 0.72 | 0.72 | |
| Non-Clinical Disparity ratio - Bands 8a & 8b to Bands 8c - VSM | 1.23 | 0.87 | 0.7 | 0.59 | |
| Non-Clinical Disparity ratio - Bands 1-4 to Bands 8c - VSM | 1.07 | 0.69 | 0.51 | 0.48 | |

***Note:*** Values highlighted in green fall within the equality range of 0.80 to 1.25 indicating no significant disparity compared with the reference group.

*Divisional Variation*

At divisional level, patterns of progression by disability status are less consistent, with variation evident across workforce groups and transition points.

Within Agenda for Change clinical roles, progression for disabled staff generally remains broadly aligned with non-disabled staff across most divisions, with many ratios falling within or close to the expected equality range. However, some variation is evident between divisions, with a small number of transitions falling outside the expected range, indicating that local factors may influence progression outcomes.

In non-clinical roles, variation between divisions is more mixed. While many transitions remain within or close to the equality range, some divisions show reduced likelihood of progression for disabled staff at higher bands, particularly at middle to upper transitions. In contrast, other areas demonstrate patterns closer to parity or slight overrepresentation at senior levels, indicating inconsistency in progression outcomes across divisions.

Within Medical and Dental grades, variation is more pronounced. Several divisions show elevated disparity ratios at key transition points, particularly from trainee to consultant roles and from trainee to non-consultant career grade roles, indicating that non-disabled staff are more likely to progress at these stages. However, this is not consistent across all divisions, with some showing less pronounced disparities or more variable patterns across pathways.

A small number of notable outliers are also evident at divisional level. For example, the Women, Children and Clinical Support Division show a substantially elevated disparity ratio for progression from middle-low to middle-upper clinical roles (8 times), while Cancer and Specialist Services shows a similarly high ratio within non-clinical roles (6 times). While these are likely influenced by smaller staff numbers, they highlight areas where progression differs markedly from the overall pattern and may warrant further local review.

Overall, divisional patterns suggest that progression outcomes for disabled staff are influenced by local workforce factors and are not experienced consistently across the organisation. While representation remains broadly balanced in many areas, the variation observed across some pathways and divisions highlights the importance of continued monitoring and local exploration of progression barriers where disparities emerge.

## Sex

Within Agenda for Change clinical roles, disparity ratios largely fall within or close to the expected equality range. Male staff were slightly less likely to be represented at higher clinical bands relative to entry-level roles, with ratios closer to the lower end of the range. Representation in progression from Bands 6 to 7 to senior roles remained within the expected range, with minimal change compared to 2025.

In non-clinical roles, representation is similarly balanced at earlier stages of progression, with ratios within the expected equality range. At more senior levels, ratios are slightly above the range, indicating a modest tendency towards higher representation of male staff. These patterns remain broadly consistent with the previous year.

Within Medical and Dental grades, ratios are slightly above the expected equality range for progression into consultant roles, indicating some variation in representation at senior levels. However, changes compared to 2025 are small and do not indicate a substantial shift in patterns.

Overall, these findings suggest that workforce representation by sex remains broadly balanced across most career pathways, with only limited variation at more senior levels. This indicates that progression and representation outcomes are generally comparable between male and female staff across the organisation.

| Sex (Male / Female) | UHSussex Mar-2025 | UHSussex Mar-2026 | Trend Line |
|---|---|---|---|
| Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 0.62 | 0.66 | |
| Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 1.16 | 1.22 | |
| Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 0.72 | 0.81 | |
| Medical and Dental Disparity ratio - Trainee to NCCG | 1.5 | 1.37 | |
| Medical and Dental Disparity ratio - NCCG to Consultant | 1.2 | 1.29 | |
| Medical and Dental Disparity ratio - Trainee to Consultant | 1.8 | 1.77 | |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 1.07 | 1.08 | |
| Non-Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 1.43 | 1.39 | |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 1.53 | 1.51 | |

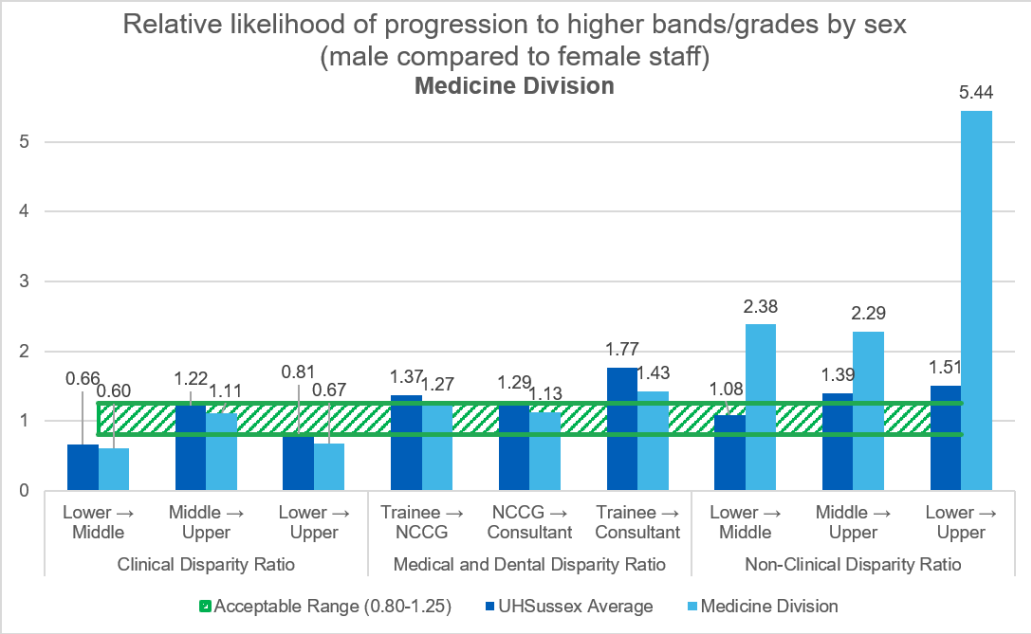
***Note:*** Values highlighted in green fall within the equality range of 0.80 to 1.25 indicating no significant disparity compared with the reference group.

### *Divisional Variation*

At divisional level, patterns of progression by sex remain broadly consistent with the overall Trust position, although some variation is evident across workforce groups and transition points.

Within Agenda for Change clinical roles, progression remains largely balanced across divisions, with most ratios falling within or close to the expected equality range. Some divisions show ratios slightly above or below the range at specific transition points, but these differences are generally small and do not indicate a consistent pattern of inequality.

In non-clinical roles, variation between divisions is more evident at senior levels. While many ratios remain close to the equality range, higher progression rates for male staff are observed in Medicine (5.4), Cancer and Specialist Services (3.0), and Women, Children and Clinical Support (2.7). This indicates that, despite broadly balanced overall patterns, representation at senior levels varies across some divisions. Within Medical and Dental grades, variation remains relatively limited across divisions, with most ratios falling modestly above the expected equality range. Some divisions show slightly higher likelihood of progression to consultant roles, typically in the range of around 1.6 to 2.0, but these differences are not as pronounced as those observed in non-clinical pathways and remain broadly consistent with the Trust-level pattern.




Overall, sex representation remains broadly balanced across divisions, with the greatest variation observed within non-clinical senior career pathways. Progression and representation outcomes are otherwise generally comparable between male and female staff.

## Sexual Orientation

Analysis of disparity ratios shows variation in workforce representation between heterosexual and LGBUO staff, with different patterns across clinical, non-clinical, and Medical and Dental roles.

Within Agenda for Change clinical roles, disparity ratios are largely within or close to the expected equality range. Representation across all stages of progression shows improvement over time, with earlier differences reducing and ratios aligning closely with parity in 2026.

In non-clinical roles, disparity ratios are consistently below the expected equality range across all stages of progression. This indicates that heterosexual staff are less likely to be represented at higher bands relative to LGBUO staff, with ratios of around 0.6 to 0.7, suggesting they are approximately half as likely to be represented in senior roles compared to lower bands. While some improvement is evident in progression from middle to upper bands, these differences remain outside the equality range.

Within Medical and Dental grades, variation is more pronounced. Heterosexual staff were around 3 times more likely to be represented in consultant roles than LGBUO staff relative to trainee grades, with this difference increasing over time. Similarly, heterosexual staff were around 2 times more likely to be represented in consultant roles than non-consultant career grade roles. In contrast, differences in progression from trainee to non-consultant career grades have reduced over time but remain above the equality range.

Overall, these findings suggest that representation patterns differ between workforce groups and career pathways for LGBUO staff. While representation is broadly balanced within clinical roles, notable differences remain within non-clinical and Medical and Dental pathways, particularly at more senior levels.

| Sexual Orientation (Heterosexual / LGBUO*) | UHSussex Mar-2024 | UHSussex Mar-2025 | UHSussex Mar-2026 | Trend Line |
|---|---|---|---|---|
| Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 1.02 | 1.1 | 1.01 | |
| Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 1.38 | 1.11 | 1.06 | |
| Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 1.41 | 1.21 | 1.07 | |
| Medical and Dental Disparity ratio - Trainee to NCCG | 2.2 | 1.7 | 1.45 | |
| Medical and Dental Disparity ratio - NCCG to Consultant | 0.94 | 1.61 | 2.09 | |
| Medical and Dental Disparity ratio - Trainee to Consultant | 2.08 | 2.74 | 3.03 | |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 0.76 | 0.65 | 0.71 | |
| Non-Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 0.76 | 0.93 | 0.87 | |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 0.58 | 0.6 | 0.62 | |
| **LGBUO includes staff selecting "Lesbian/Gay", "Bisexual", "Undecided" or "Other" as their sexual orientation* | | | | |

***Note:*** Values highlighted in green fall within the equality range of 0.80 to 1.25 indicating no significant disparity compared with the reference group.

### *Divisional Variation*

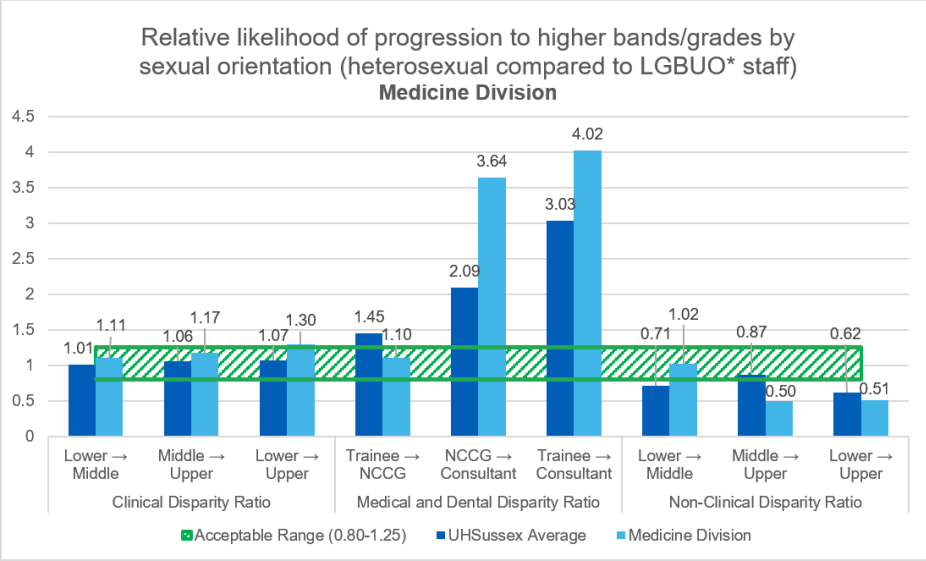
At divisional level, patterns of progression by sexual orientation show variation across workforce groups, with the most consistent differences evident in non-clinical roles and more pronounced disparities within Medical and Dental grades.

Within Agenda for Change clinical roles, progression remains broadly aligned across divisions, with most ratios falling within or close to the expected equality range. Some divisions show slightly elevated ratios at specific transition points, particularly from lower to upper bands, but these differences are limited and do not indicate a consistent pattern of inequality.

In non-clinical roles, a consistent pattern of lower disparity ratios is evident across all divisions, with most values falling below the expected equality range. These are typically in the range of approximately 0.5 to 0.7 for progression to higher bands, indicating that heterosexual staff are less likely to be represented at senior levels relative to LGBUO staff. While the scale varies slightly between divisions, this pattern is sustained across the organisation.

Within Medical and Dental grades, variation is more pronounced, particularly at senior transition points. Several divisions show elevated disparity ratios for progression to consultant roles, with the highest values observed in the Medicine Division (approximately 4 times for progression from trainee to consultant roles and 3.6 from non-consultant career grade roles). Elevated ratios are also observed in Cancer and Specialist Services (approximately 3 times) and Surgery (approximately 2 times), indicating a higher likelihood of progression to consultant roles for heterosexual staff within these divisions.

Overall, these findings suggest that progression patterns by sexual orientation vary across career pathways and divisions. While representation remains broadly balanced within clinical roles, differences are more evident within non-clinical and Medical and Dental pathways, particularly at senior levels.




## Religion and Belief

Analysis of disparity ratios indicates variation in workforce representation between staff with no religion and those reporting a religion, particularly within clinical and non-clinical roles.

Within Agenda for Change clinical roles, staff with no religion were just under two times more likely to be represented in middle and senior bands compared to entry-level roles, representing an increase compared to 2025. In contrast, progression from middle to senior bands remained within the expected equality range.

In non-clinical roles, a similar pattern is evident, with staff with no religion just under two times more likely to be represented in higher bands relative to lower bands. Representation from middle to senior bands remains within the expected equality range.

Within Medical and Dental grades, patterns vary across stages of progression. Staff with no religion were around a third less likely to progress from trainee to non-consultant career grade roles, while being almost twice as likely to be represented in consultant roles compared to non-consultant career grade roles. Progression from trainee to consultant roles remains below the equality range.

Overall, these findings suggest that representation patterns vary across workforce groups and career pathways by religion and belief. Differences are most evident at earlier career transitions and within consultant-level representation, while progression at more senior stages is generally more balanced.

| Religion and Belief (Atheist / Any Religion) | UHSussex Mar-2024 | UHSussex Mar-2025 | UHSussex Mar-2026 | Trend Line |
|---|---|---|---|---|
| Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 1.53 | 1.6 | 1.81 | |
| Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 0.95 | 0.83 | 0.94 | |
| Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 1.46 | 1.33 | 1.69 | |
| Medical and Dental Disparity ratio - Trainee to NCCG | 0.33 | 0.37 | 0.36 | |
| Medical and Dental Disparity ratio - NCCG to Consultant | 1.91 | 1.68 | 1.79 | |
| Medical and Dental Disparity ratio - Trainee to Consultant | 0.62 | 0.61 | 0.64 | |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 1.68 | 1.76 | 1.62 | |
| Non-Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 1.02 | 1.06 | 1.17 | |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 1.71 | 1.87 | 1.89 | |

***Note:*** Values highlighted in green fall within the equality range of 0.80 to 1.25 indicating no significant disparity compared with the reference group.

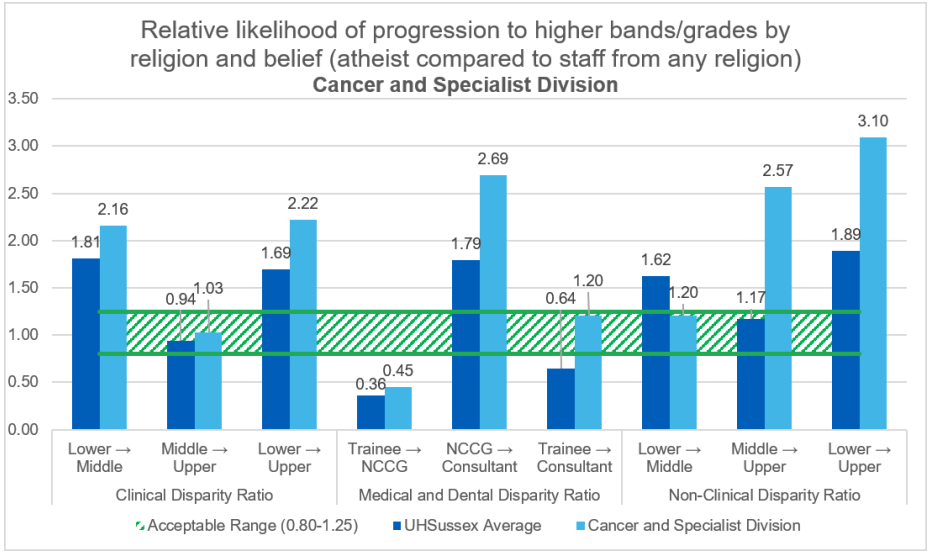
### *Divisional Variation*

At divisional level, patterns of progression by religion and belief show variation across workforce groups, with more consistent differences evident within clinical and non-clinical roles and greater variation within Medical and Dental grades.

Within Agenda for Change clinical roles, most divisions show elevated disparity ratios at progression from lower to upper bands, with values typically in the range of approximately 1.6 to 2.2. This indicates that staff with no religion are more likely to be represented at higher clinical bands relative to entry-level roles. In contrast, progression from middle to senior bands remains closer to the expected equality range across divisions, indicating a more balanced pattern at this stage.

In non-clinical roles, a similar pattern is observed, with higher representation of staff with no religion at senior levels across divisions. Several divisions show elevated ratios for progression from lower to upper bands, including values of approximately 3.1 in Cancer and Specialist Services and around 1.9 in both Medicine and Women, Children and Clinical Support. Progression from middle to upper bands remains closer to the expected equality range, indicating more balanced representation at this stage.

Within Medical and Dental grades, variation is more pronounced across divisions. Progression from trainee to non-consultant career grade roles consistently falls below the expected equality range, with values typically between approximately 0.2 and 0.6, indicating lower likelihood of progression at this stage. In contrast, progression to consultant roles shows elevated disparity ratios in several divisions, including approximately 2.7 in Cancer and Specialist Services and around 2.4 in Surgery, indicating higher representation of staff with no religion at senior levels. However, progression from trainee to consultant roles remains below the equality range across divisions, highlighting inconsistency across stages of progression.




Overall, these findings suggest that representation patterns by religion and belief vary across divisions and career pathways. Differences are most evident in clinical and non-clinical progression to senior roles, while Medical and Dental pathways show more mixed patterns across stages of progression.

## Equality Profiles Summary

Overall, these findings highlight both the diversity of the people who use our services and the workforce that delivers them. While representation is broadly balanced in some areas, differences remain across certain workforce groups, professions and levels of seniority. In many cases, these also reflect patterns in the national data, underscoring the extent to which disparities are long-standing and structural. Understanding these patterns provides important context for the staff experiences, workforce outcomes and inequalities explored in the following sections.

# Eliminate Discrimination

The following sections summarise key actions and outcomes relating to the Trust's commitment to providing a fair, safe and respectful workplace for all. These themes bring together evidence relating to equality, inclusion, employee experience and organisational culture.

## Fair

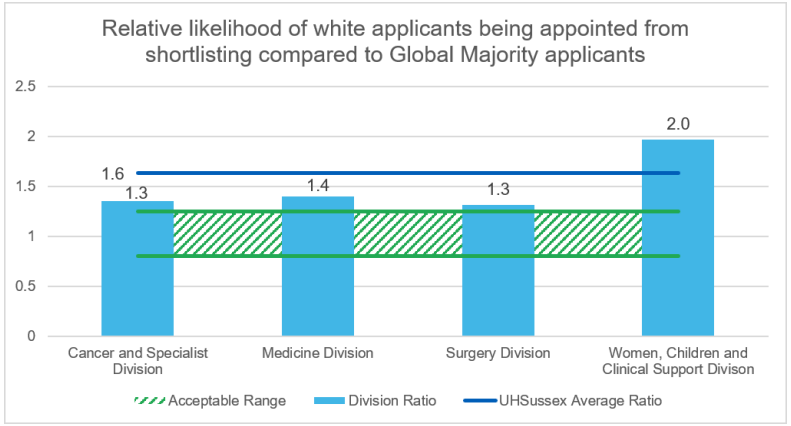
Ensuring fairness requires understanding whether workforce policies, processes and outcomes are experienced equitably across different staff groups. The following sections explore areas such as recruitment, pay and formal employment processes to identify where differences exist and where further action may be needed to support equitable outcomes.

### Inclusive Recruitment

As part of our commitment to eliminating discrimination, the Trust monitors recruitment outcomes, including the likelihood of appointment from shortlisting across different staff groups.

For ethnicity, White staff were 1.6 times more likely to be appointed from shortlisting than Global Majority staff. While this represents an improvement over time, the likelihood ratio remains above the expected range, indicating that differences in recruitment outcomes persist.

For disability, the likelihood ratio between non-disabled and disabled staff was 1.0. This indicates minimal difference in outcomes, with appointment from shortlisting broadly equitable between groups.




Analysis across other characteristics shows that outcomes for gender and sexual orientation fall within the expected equality range. The religion ratio (1.4) is slightly above this range, indicating atheist applicants were more likely to be appointed from shortlisting compared to staff from any religion.

Divisional analysis shows variation across the organisation. For ethnicity, the likelihood ratio is notably higher than the Trust average in the Women's & Children's Division, indicating greater differences in appointment outcomes. In contrast, the other three operational divisions are closer to the Trust average, although still above the expected equality range.

For disability, outcomes are broadly consistent with the Trust average across most divisions. An exception is Facilities & Estates (0.3), where results differ more significantly but should be interpreted with caution due to small numbers.

Across gender and sexual orientation, most divisions fall within the expected equality range, indicating relatively balanced outcomes. For religion, variation is more pronounced in some areas, including Women's & Children's (1.7) and Cancer & Specialist Services (1.4), where likelihood ratios are above (worse) compared to the Trust average.

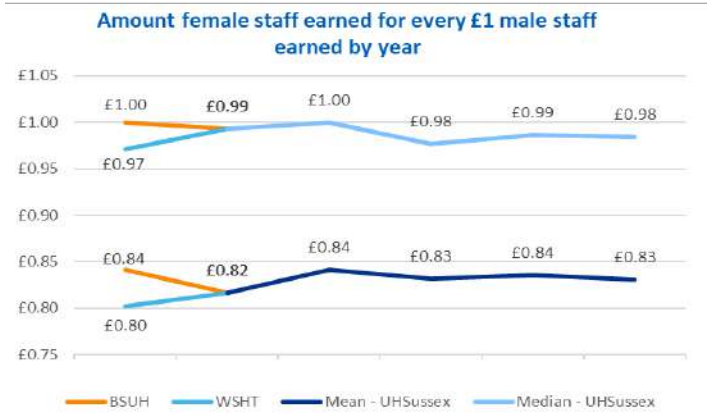
For gender identity, the Trust-level ratio (0.4) indicates a notable difference; however, this is based on small numbers so should be interpreted with caution.

Overall, recruitment outcomes are broadly equitable across most characteristics, with the notable exception of ethnicity, where differences in appointment rates persist despite gradual improvement over time. These findings suggest that while progress has been made, continued focus is needed to understand and address barriers affecting recruitment outcomes for some groups.

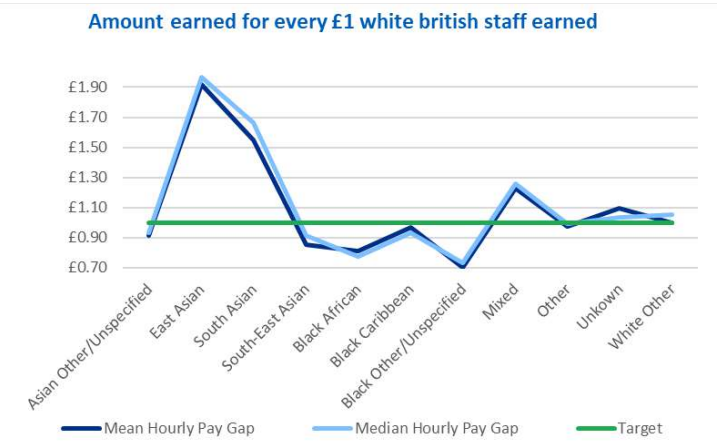
Further detail on the shortlisting to appointment indicator for race and disability is provided in the **Workforce Equality Standards** section of this report.

## Equal Pay

Monitoring pay gaps helps identify whether different groups experience equitable access to progression, senior roles and reward. While pay gaps do not necessarily indicate unequal pay for the same work, they can highlight structural differences in representation across grades, professions and leadership positions. As part of our commitment to eliminating discrimination, the Trust monitors pay gaps across gender, ethnicity and disability to understand differences in average pay and identify underlying structural inequalities.



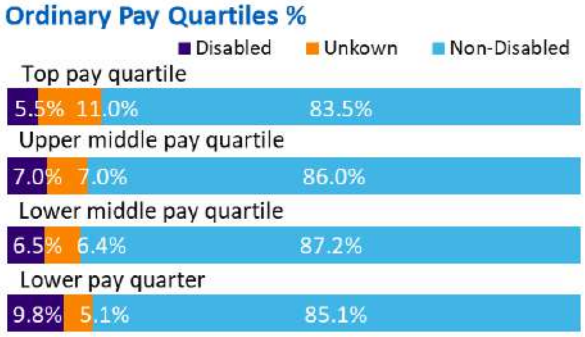
Our gender pay gap remains broadly consistent. Based on median hourly pay, women earn 98 pence for every £1 earned by men; based on mean hourly pay, they earn 83 pence. The wider mean gap reflects the concentration of men in some of the highest-paid roles, particularly senior management and consultant posts. Although women make up most of the workforce, they remain under-represented in the highest pay quartile, indicating a continuing structural imbalance in access to higher-paid roles.




Differences are also evident in bonus payments. A higher proportion of male staff receive bonuses, and the average value of bonuses remains higher for men. This is primarily linked to legacy consultant award schemes, which historically benefited a greater proportion of male staff.

Encouragingly, the overall ethnicity pay gap is now close to parity, reflecting continued improvement over recent years. However, more detailed analysis shows variation between ethnic groups, with some historically marginalised groups continuing to experience lower average pay.

The disability pay gap remains evident, with disabled staff earning less on average than non-disabled staff. This reflects differences in representation across pay bands, including lower representation of disabled staff in higher-paid roles.

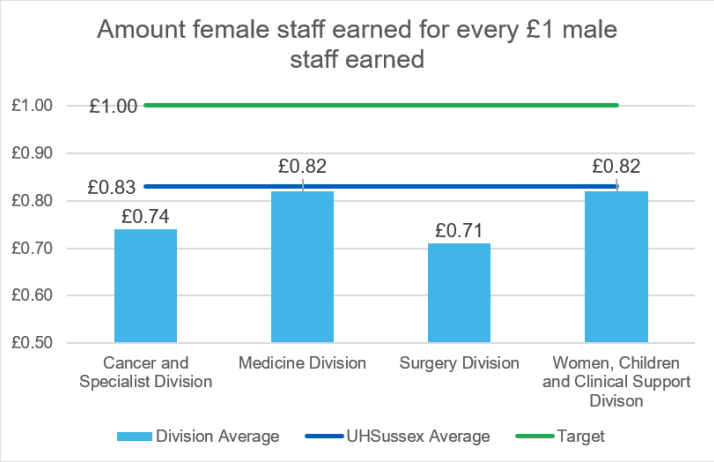



Taken together, these findings highlight that pay gaps within the Trust are primarily driven by differences in representation across roles and grades, rather than pay differences within the same roles. Addressing these structural differences remains a key priority to ensure equitable access to progression and reward across the workforce.

Divisional analysis shows variation in pay gaps across the organisation. Cancer and Specialist Services had wider pay gaps than the Trust average across all indicators, with larger differences in both ordinary and bonus pay for gender, ethnicity and disability.

Medicine and Surgery generally showed pay gaps similar to the Trust average for ordinary pay, but wider gaps for bonus pay across all three characteristics.

In contrast, Women, Children and Clinical Support demonstrated pay gaps broadly in line with the Trust average for gender, smaller ethnicity pay gaps, and larger disability pay gaps for ordinary pay. Bonus pay gaps within the division were generally similar to, or smaller than, the Trust average.




These findings highlight that pay gap patterns vary across divisions and characteristics, reinforcing the importance of understanding local workforce drivers alongside Trust-wide trends. Further detail on gender, ethnicity and disability pay gap analysis, including methodology and disaggregated findings, is provided in the Workforce Equality Standards section of this report.

## Resolving Disputes

Monitoring formal employee relations processes helps identify whether workplace concerns are being addressed fairly and consistently, and whether some groups of staff are more likely to experience formal processes than others.

Between 1 April 2025 and 31 March 2026, there were 55 investigation cases, 82 resolution cases, 80 disciplinary cases, 37 capability cases, 34 appeals, and 2 cases managed under Maintaining High Professional Standards (MHPS). Discrimination and inequality concerns are sometimes raised within resolution processes. Of the 82 resolution cases during the year, 17 (20.7%) related to discrimination or harassment. Of these, 3 cases were specifically categorised as race discrimination or harassment.

Average completion times varied across processes, with resolution cases taking an average of 109 days, investigations 79 days, and disciplinary processes 40 days.

While only a small number of resolution cases related specifically to discrimination or harassment, these findings highlight the importance of maintaining effective processes for addressing workplace concerns and monitoring outcomes to identify potential inequalities.

### Disciplinary Cases

There were 80 disciplinary cases during the reporting period. Of the colleagues involved, 36.3% (29 staff) were from Global Majority backgrounds, 48.8% female (39 staff). A smaller proportion identified as having a disability (7.5%) or as lesbian, gay or bisexual (6.3%).

Across the Trust, Global Majority staff were 1.4 times more likely than White staff to enter the disciplinary process. Disabled staff had a similar likelihood to non-disabled staff (1.0), and LGBUO staff were similarly likely to enter the disciplinary process (0.9), both falling within the expected equality range (0.8–1.25). Meanwhile, female staff were around half as likely as male staff to enter the disciplinary process (0.4). Variations in workforce composition across staff groups and services may contribute to this observed disparity.

### Capability Cases

During 2025/26, there were 37 capability cases recorded through the Employee Relations process, including both formal and informal capability cases. Of those involved, 48.6% were from Global Majority backgrounds (18 staff) and 62.2% were female (23 staff). Fewer than 10 staff recorded as disabled, lesbian, gay, bisexual or other.

Relative likelihood analysis of these capability cases indicates that Global Majority staff were 2.4 times more likely to enter the capability process than White staff. Female staff (0.6) were less likely to enter the capability process than their respective comparison group. Disabled staff (0.8) and LGBUO staff (0.8) had similar likelihoods of entering the capability process, with values falling within the expected equality range.

Separate analysis of formal capability proceedings only, covering the period 2024–2026, identified a different pattern for disability, with disabled staff being 1.58 times more likely than non-disabled staff to enter formal capability proceedings.

### Wider Process Insights

Looking across other employee relations processes, patterns vary. Global Majority staff had similar likelihoods to White staff for entering investigations (0.8), resolutions (0.8), and appeals (0.9), with these values falling within the expected equality range. However, they were more likely to enter capability processes.

Disabled staff were more likely to be involved in resolution (1.5) and appeals (1.4) processes, while having similar likelihoods of entering investigations (0.8) and capability processes (0.8) compared to non-disabled staff, with these values within the equality range. This finding relates to all capability cases (formal and informal); however, patterns may differ when considering formal capability proceedings only, where disabled staff were 1.58 times more likely than non-disabled staff to enter formal capability proceedings over the period 2024–2026.

For sex, female staff were consistently less likely than male staff to enter formal processes, including investigations (0.3), disciplinary (0.4), capability (0.6), and appeals (0.6).

For sexual orientation, LGBUO staff had similar likelihoods of entering most processes, including disciplinary (0.9), capability (0.8), and resolution (0.8) as heterosexual staff, with these values within the expected equality range. However, they were less likely to enter appeals (0.4) and more likely to be involved in investigations (1.7). However, as these findings are based on a small number of individuals, interpretation and further analysis are limited.

Overall, these findings indicate that experiences of formal employee relations processes vary across workforce groups. While many outcomes fall within the expected equality range, differences remain for some staff groups, particularly within disciplinary and capability processes. Understanding these patterns is important in ensuring that formal procedures are applied fairly and consistently across the organisation.

## Safe

A safe working environment is essential to ensuring all staff are treated with dignity and respect. The following sections explore experiences of speaking up, discrimination, harassment and violence to understand where inequalities may exist and where further action may be required.

## Freedom to Speak Up (FTSU)

Freedom to Speak Up themes provide valuable insight into staff experiences, helping the Trust identify areas for improvement and understand concerns relating to culture, inclusion, safety and wellbeing.

Between 1 April 2025 and 31 March 2026, a total of 264 cases were raised through FTSU. Of these, 14 cases (5.3%) related to discrimination or inequality as the primary reason for contact. Within this, 11 cases were recorded as discrimination and 3 as inequality. A further 34 cases included discrimination or inequality as a secondary theme, indicating that these issues can be part of more complex or interrelated concerns raised by colleagues.

Where a primary theme was recorded, the most common areas were disability (4 cases) and race (4 cases), followed by one case relating to gender reassignment discrimination. In 5 cases, the specific theme was not recorded, highlighting an opportunity to strengthen consistency in recording. One case involving discrimination or inequality as a primary concern was escalated.

Due to data protection and confidentiality requirements, particularly given the small number of cases, it is not possible to provide more detailed breakdowns without risking identification of individuals.

These findings suggest that discrimination and inequality concerns account for a relatively small proportion of Freedom to Speak Up cases but continue to be an important theme for some colleagues. Monitoring these concerns helps identify potential barriers to inclusion and ensures that issues relating to equality, diversity and inclusion can be addressed appropriately when they arise.

## Patient Safety

Between 1 April 2025 and 31 March 2026, one incident was identified that met the criteria for a Patient Safety Investigation (PSI) where discrimination was suspected. This related to concerns that a patient may have experienced differential treatment linked to alcohol dependency, poverty, and associated behaviours.

A local learning review was undertaken with Executive oversight, and safeguarding was involved as part of the process. It identified opportunities to strengthen clinical assessment, documentation, communication between services, and referral to appropriate support services, including the alcohol liaison team and community-based organisations such as Change, Grow, Live. It highlighted that the patient's presentation, including intoxication and challenging behaviour, may have contributed to missed opportunities in assessment and diagnosis.

The review reinforced the importance of ensuring that all patients receive equitable and thorough assessment, particularly where complex needs or behaviours are present, and that care decisions are not influenced by stigma or assumptions.

## Violence and Aggression

Between 1 April 2025 and 31 March 2026, a total of 3,721 Violence and Aggression incidents were recorded through Datix reporting. A post-incident support survey was completed by 43 staff members during the same period, providing insight into staff experience following incidents. Among respondents, 59.6% were aware of the support available to them, while 54.4% reported feeling supported in the first few hours after an incident. Just over half (50.8%) felt supported on their return to work or subsequent shift and continue to feel supported in the workplace. However, fewer than half (47.4%) felt that the support they received was culturally appropriate, highlighting an area for further development.

The Trust has developed Violence and Aggression heatmaps, including hotspot analysis at cost centre level. These bring together staff survey indicators relating to physical violence, harassment, bullying or abuse, discrimination, and unwanted sexual behaviour. Cost centres are identified as hotspots where they fall within the lowest 25th percentile across at least four of these measures, including both worsening scores between 2024 and 2025 and low overall performance in 2025.

This analysis is being used to target Violence Prevention and Reduction (VPR) activity across the Trust. A key focus has been the delivery of face-to-face Conflict Management and Physical Intervention training. In total, 774 staff have been trained, including 236 staff between 1 April 2025 to 31 March 2026. Of these, 131 staff were from the 71 identified hotspot areas.

Training completion rates within hotspot teams are highest in Paediatric Critical Care (45.2%), Acute Medicine and Endocrinology (52.1%), A&E Nursing (37.7%), Care of the Elderly (30.8%), and Ardingly Ward (31.4%).

Alongside training, targeted VPR awareness activity has been delivered through the Health and Wellbeing team in partnership with Security Team, including ward-based engagement, posters, guidance, and VPR action cards to support staff following incidents. More recently, the Inclusion team has further supported this work through targeted huddles, team consultations, and interventions focused on inclusion-related violence and aggression needs, including raising awareness of hate crime reporting as part of a wider programme of work.

Nikki Kriel, Health, Wellbeing & Engagement Programme Manager (centre), wearing a VPR Aware sash alongside ward staff.

These findings highlight the significant impact that violence and aggression can have on staff experience and wellbeing. While targeted interventions are helping to focus support where it is most needed, the survey results suggest there are

opportunities to improve awareness of available support and ensure that post-incident support is experienced as accessible, appropriate and effective for all colleagues.

### Harassment, Bullying or Abuse

Understanding experiences of harassment, bullying and abuse is important in creating a safe, respectful and inclusive workplace. Monitoring these experiences helps identify whether some groups are disproportionately affected and informs action to prevent harmful behaviours and better support colleagues who experience them.

The NHS Staff Survey captures experiences of harassment, bullying or abuse from three sources: patients, relatives or members of the public; managers; and other colleagues. While experiences vary across workforce groups, some consistent patterns are evident, particularly for disabled staff, staff whose gender identity differs from their sex registered at birth, staff with caring responsibilities, and some minority ethnic, religious and sexual orientation groups.

#### From Patients, Relatives or Members of the Public

Experiences of harassment, bullying or abuse from patients, relatives or members of the public remain higher for some groups than others. Global Majority staff reported higher levels (34.4%) than White staff (27.6%), with rates increasing from the previous year. The highest levels were reported by Black – Other staff (52.6%), meaning more than one in two respondents within this group reported experiencing harassment, bullying or abuse.

Disabled staff reported higher levels (32.7%) than non-disabled staff (28.5%), while staff whose gender identity differs from their sex registered at birth reported substantially higher levels (39.5%) than staff whose gender identity is the same as their sex registered at birth (28.9%). This gap has widened compared to 2024.

For gender, non-binary staff reported the highest levels (54.6%), although small numbers limit interpretation. Female staff also reported higher levels than male staff (30.2% compared to 26.2%), a pattern that broadly reflects national findings. Differences were also evident by sexual orientation, with bisexual staff (38.1%) reporting the highest levels, compared to 28.9% of heterosexual staff.

Variation was observed across religion and belief, with the highest levels reported by staff selecting Any Other Religion (36.1%) and those who preferred not to disclose their religion (34.3%). Age-related patterns were particularly pronounced, with the youngest staff aged 16–20 reporting the highest levels (40.0%), followed by a gradual reduction across older age groups. Staff with caring responsibilities also reported higher levels (33.5%) than those without (27.8%).

### From Managers

Reported harassment, bullying or abuse from managers was generally lower than that reported from patients and the public, although some disparities remain.

Unlike national findings, White staff at UHSussex reported slightly higher levels (10.6%) than Global Majority staff (8.0%). However, some ethnic groups reported notably higher levels, including White and Black African (15.9%), Any Other Mixed Background (14.6%), and Other Ethnic Group (16.5%) staff, although small sample sizes limit interpretation.

Disabled staff reported substantially higher levels (15.8%) than non-disabled staff (8.0%), mirroring the national picture. Similar disparities were seen for gender identity, where staff whose gender identity differs from their sex registered at birth (18.6%) and those who preferred not to disclose their gender identity (19.8%) reported around twice the level experienced by staff whose gender identity is the same as their sex registered at birth (9.4%).

Gender differences between male and female staff were relatively small, although the highest levels were reported by non-binary staff and staff who preferred not to disclose their gender (21.2% for both groups). By sexual orientation, heterosexual staff reported the lowest levels (9.0%), while those selecting "Other" (16.4%) reported the highest.

Religion and belief also showed variation, with Jewish staff (21.1%) and staff who preferred not to disclose their religion (18.3%) reporting the highest levels. Older staff generally reported higher levels than younger colleagues, while staff with caring responsibilities reported higher levels (12.3%) than those without (9.0%).

### From Other Colleagues

Patterns of harassment, bullying or abuse from colleagues were broadly similar to those reported for managers but were generally more pronounced.

Overall, White staff (18.0%) and Global Majority staff (18.5%) reported similar levels. However, some ethnic groups reported substantially higher rates, including White and Asian (30.0%), White and Black African (27.9%), Bangladeshi staff (28.1%), and staff from Other Ethnic Groups (29.0%), although interpretation should be cautious due to small sample sizes.

Disabled staff again reported markedly higher levels (25.7%) than non-disabled staff (15.8%). Staff whose gender identity differs from their sex registered at birth (32.6%) and those who preferred not to disclose their gender identity (30.2%) also reported considerably higher levels than staff whose gender identity is the same as their sex registered at birth (17.8%).

The highest levels by gender were reported by non-binary staff (40.6%) and those who preferred not to disclose their gender (31.3%), while experiences among male and female staff were more comparable. By sexual orientation, staff who preferred not to disclose their sexual orientation reported the highest levels (27.6%), compared to 17.1% among heterosexual staff.

Religion and belief showed a similar pattern, with the highest levels reported by Jewish staff (31.6%), staff selecting Other Religion (28.6%), and those who preferred not to disclose their religion (28.7%). Staff with caring responsibilities again reported higher levels (23.1%) than those without (16.6%).

## Sexual Harassment

Understanding experiences of sexual harassment is important in creating a safe, respectful and inclusive workplace. Monitoring incidents and staff survey responses helps identify which groups may be disproportionately affected and informs action to prevent unwanted behaviour and support colleagues who experience it.

Within Datix reporting, 47 Sexual Harassment incidents were recorded between 1 April 2025 and 31 March 2026.

Data from the NHS Staff Survey enables us to further understand both the prevalence of incidents of unwanted behaviour of a sexual nature (sexual harassment) experienced by colleagues, distinguishing between sexual harassment from patients, relatives or members of the public, and sexual harassment from managers, team leaders or colleagues.

### Sexual Harassment from Patients, Relatives or Members of the Public

In 2025, 10.7% of UHSussex staff reported experiencing sexual harassment from patients, relatives or members of the public, compared to 9.1% nationally.

Experiences varied considerably across demographic groups. The highest levels were reported by staff from White non-British backgrounds, particularly White Gypsy or Irish Traveller staff (33.3%) and White Irish staff (25.3%), followed by staff from Caribbean backgrounds, including Mixed White and Black Caribbean staff (19.2%) and Black Caribbean staff (17.7%). While national results show a similar pattern, the differences between ethnic groups are more pronounced at UHSussex.

Disabled staff reported higher levels of sexual harassment (14.2%) than non-disabled staff (10.1%), mirroring the national picture. By gender, 13.1% of female staff reported experiencing sexual harassment compared to 5.2% of male staff. The highest rates were reported by non-binary staff (29.4%) and those who preferred to self-describe (16.7%), however small numbers limit interpretation.

Differences were also evident for gender identity. One in four (25.0%) staff whose gender identity differs from their sex registered at birth reported experiencing sexual harassment, compared with 10.6% of staff whose gender identity is the same as their sex registered at birth. This represents an increase from 20.0% in 2024 and is substantially higher than the national average.

By sexual orientation, the highest levels were reported by bisexual staff (26.3%) and those selecting "Other" (21.3%), while heterosexual staff reported lower levels (10.4%). Similar patterns are seen nationally.

Variation was also observed by religion and belief. Jewish staff (23.5%) reported the highest levels of sexual harassment, followed by atheist staff (13.8%), whereas most other faith groups reported lower levels. Nationally, reported experiences among Jewish staff are considerably lower (8.6%), although small local sample sizes should be considered when interpreting these findings.

Age showed the strongest gradient across all characteristics. Staff aged 16–20 reported the highest levels, with 40.0% experiencing sexual harassment, increasing from 29.1% in 2024. Reported experiences decreased progressively with each successive age group. While a similar pattern is seen nationally, the difference is less pronounced, with 20.1% of staff aged 16–20 reporting sexual harassment.

Only marginal differences were observed between staff with caring responsibilities (11.6%) and those without (10.8%), consistent with the national picture.

### Sexual Harassment from a Manager, Team Leader or Another Colleague

Sexual harassment from managers, team leaders or colleagues was lower overall, although rates at UHSussex (4.3%) remained slightly above the national average (3.5%).

Differences by ethnicity were less pronounced than those reported for harassment from patients and the public. The highest levels were reported by Mixed White and Black African staff (9.1%), although numbers were small.

Disabled staff continued to report higher levels of sexual harassment (6.7%) than non-disabled staff (3.4%), reflecting a pattern also seen nationally. By gender, rates were relatively similar among female (3.8%) and male (4.6%) staff. However, considerably higher levels were reported by non-binary staff (24.2%) and those who preferred not to disclose their gender (11.1%), although interpretation is limited by small sample sizes.

The largest disparity was again evident for gender identity. 19.1% of staff whose gender identity differs from their sex registered at birth reported sexual harassment from a manager, team leader or colleague, compared with 3.7% of staff whose gender identity is the same as their sex registered at birth. This represents a marked increase from 10.8% in 2024 and exceeds the national average.

By sexual orientation, bisexual staff (13.8%) and those selecting "Other" (11.5%) reported the highest levels of sexual harassment, compared with 3.6% of heterosexual staff. While the pattern is similar to that seen nationally, disparities at UHSussex are somewhat less pronounced.

Variation by religion and belief was generally limited, although Jewish staff (11.1%) reported the highest levels. Staff who preferred not to disclose their religion also reported comparatively high levels. As with several other groups, small sample sizes mean these findings should be interpreted with caution.

Unlike sexual harassment from patients and the public, age-related patterns differed from those seen nationally. At UHSussex, the highest levels were reported among staff aged 21–30 (6.7%), while staff aged 16–20 reported lower levels (3.3%). Nationally, the highest levels were reported by the youngest age group, with rates decreasing progressively with age.

Staff with caring responsibilities reported slightly higher levels of sexual harassment (4.9%) than those without caring responsibilities (3.9%), although the difference was modest and similar to national findings.

## Respectful

A respectful workplace and care environment are essential to ensuring that everyone is treated with dignity, fairness and respect. Understanding experiences of discrimination helps identify where some groups may experience unequal treatment and informs action to promote inclusion and equitable experiences for both staff and patients.

### Discrimination

Understanding experiences of discrimination is essential to creating a respectful workplace where all colleagues are treated fairly and with dignity. Monitoring discrimination helps identify whether some groups are disproportionately affected and informs action to promote inclusion, reduce inequalities and improve staff experience.

Within Datix reporting, racial discrimination was the only available classification for discrimination, with 11 incidents recorded between 1 April 2025 and 31 March 2026.

Data from the NHS Staff Survey enables us to further understand both the prevalence and perceived causes of discrimination experienced by colleagues, distinguishing between discrimination from patients, relatives or members of the public, and discrimination from managers, team leaders or colleagues.

Among all UHSussex staff who reported experiencing discrimination in the staff survey, the most commonly cited grounds were race (50.8%), sex (19.8%), and age (17.4%). This broadly reflects the national picture, where race remains the most frequently reported basis for discrimination. UHSussex reported lower levels than the national average across most grounds, including age, disability, pregnancy and maternity, religion or belief, and race. However, a higher proportion of staff attributed discrimination to gender reassignment (2.7% compared to 1.5% nationally), sex (19.8% compared to 17.1%), and sexual orientation (5.7% compared to 4.0%). Given the Trust's comparatively diverse workforce and higher levels of disclosure across some characteristics, these differences should be interpreted with appropriate context.

### From Patients, Relatives or Members of the Public

In 2025, 10.5% of UHSussex staff reported experiencing discrimination from patients, relatives or members of the public, compared to 9.3% nationally.

The largest disparities were seen by ethnicity. While 6.1% of White staff reported experiencing discrimination, this increased to 24.8% of Global Majority staff. Rates were particularly high among Filipino staff (35.7%), Asian staff overall (26.0%), and Black staff (24.5%). Although these differences remain substantial, they are less pronounced than those reported nationally.

There was no meaningful difference between disabled and non-disabled staff, with both groups reporting discrimination at a rate of 11.4%. For gender, the highest rates were reported by staff who preferred to self-describe their gender (27.8%) and non-binary staff (20.6%), yet small numbers limit interpretation. Male staff reported slightly higher levels (12.7%) than female staff (10.6%).

Differences were also evident for gender identity, with 22.7% of staff whose gender identity differs from their sex registered at birth reporting discrimination, compared to 10.7% of other staff. While this disparity remains significant, it represents an improvement from 2024, when the figure was 30.7%.

By sexual orientation, the highest levels were reported by staff selecting "Other" (19.7%) and bisexual staff (16.7%), while heterosexual staff reported the lowest levels (10.9%). Similarly, differences were evident by religion and belief, with the highest rates reported by staff identifying with any other religion (21.3%), Hindu (17.6%), and Muslim (15.4%) faith groups.

Discrimination also varied by age, with reported experiences following a broadly bell-shaped distribution. Staff aged 31–40 reported the highest levels (16.0%), while colleagues aged 66 and over reported the lowest (2.6%).

Staff with caring responsibilities reported higher levels of discrimination (12.3%) than those without caring responsibilities (10.9%), mirroring the national pattern.

### Discrimination from a Manager, Team Leader or Another Colleague

In contrast, reported discrimination from managers, team leaders or colleagues was slightly lower at UHSussex (8.3%) than the national average (8.7%).

Ethnicity continued to show the largest disparity. 10.9% of Global Majority staff reported discrimination from colleagues or managers, compared with 7.2% of White staff. Encouragingly, this represents a significant improvement over recent years, having reduced from 14.1% in 2024 and 15.3% in 2023.

Disabled staff reported substantially higher levels of discrimination (13.0%) than non-disabled staff (6.7%), a pattern consistent with national findings. Similar disparities were seen for gender identity, where 15.9% of staff whose gender identity differs from their sex registered at birth reported discrimination, compared with 7.6% of other staff. Although this remains considerably higher, it has improved markedly from 32.3% in 2024.

For gender, differences were relatively small, with 8.1% of female staff and 7.4% of male staff reporting discrimination. Higher levels were reported by staff who preferred not to disclose their gender (19.5%), preferred to self-describe (16.7%) or identified as non-binary (14.7%), although small numbers limit interpretation.

By sexual orientation, staff who preferred not to disclose their sexual orientation (16.0%) and those selecting "Other" (16.4%) reported the highest levels of discrimination, compared with 7.4% of heterosexual staff. Religion and belief also showed notable variation. The highest levels were reported by Jewish staff (21.1%) and staff who preferred not to disclose their religion (17.7%), while atheist staff reported the lowest levels (5.9%). However, small sample sizes for some groups mean findings should be interpreted with caution.

Age-related patterns differed from those seen nationally. At UHSussex, the highest reported levels were among staff aged 16–20 (10.4%) and 41–50 (9.2%), while staff aged 21–30 reported the lowest levels (6.6%).

As with discrimination from patients and the public, staff with caring responsibilities reported higher levels of discrimination (11.1%) than those without (7.2%).

## Eliminate Discrimination Summary

Overall, these findings show that while progress has been made in several areas, some staff groups continue to report different experiences and outcomes across recruitment, employee relations processes, discrimination, harassment and workplace safety. Monitoring these patterns helps the Trust identify where inequalities persist and supports action to create a fairer, safer and more inclusive working environment for all colleagues.

# Advance Equality of Opportunity

The following sections summarise key actions and outcomes relating to the Trust's commitment to advancing equality of opportunity for all colleagues. These themes bring together evidence relating to accessibility, inclusion, career development and progression to understand whether opportunities are experienced equitably across the workforce.

## Accessible

Ensuring that work is accessible to all colleagues is an important part of advancing equality of opportunity. Removing barriers and providing appropriate support helps ensure that staff can fully participate in working life, perform at their best, and access opportunities on an equitable basis.

### Central Reasonable Adjustments Framework

A centralised approach to requesting workplace adjustments was introduced in February 2026, supported by a panel that meets weekly to ensure timely review and decision-making. This has enabled applications to be considered within a matter of days, supporting a more responsive and accessible process for colleagues.

Since the introduction of the process on 19 February 2026 a total of 8 applications were received, averaging approximately two applications per month. All applications were reviewed by the panel, with the majority either approved in full or partially approved where further checks, such as IT compatibility, were required.

Most requests related to assistive software and technology, including speech-to-text tools, captioning software, and productivity applications. Requests also included training, coaching, and support to enable effective use of these tools, as well as occasional requests for equipment such as a sit-stand workstation.

Overall, colleagues thus far most commonly require support to access digital systems and working environments, and adjustments often combine technology with training or coaching to maximise effectiveness.

### Adequate Workplace Adjustments

Among staff who indicated that they required workplace adjustments, 75.2% reported that the Trust had made reasonable adjustments to support them in carrying out their work. This represents a gradual improvement from 73.2% in 2023 and is broadly in line with the national average of 74.8%. However, the results also indicate that around one in four staff requiring adjustments do not feel adequate support has been put in place, highlighting an ongoing area for improvement.

There was limited variation across most protected characteristics, suggesting a broadly consistent experience of workplace adjustments. However, some ethnic groups reported lower levels of agreement, including staff from Mixed/Multiple ethnic backgrounds – White and Asian (54.6%) and White – Any Other White Background (60.2%). As these groups represent relatively small numbers of respondents, findings should be interpreted with caution.

These findings suggest that while progress has been made, further work is needed to ensure all colleagues who require workplace adjustments receive timely, effective and appropriate support.

## Inclusive

An inclusive workplace is one where colleagues feel valued, supported and able to contribute fully. Understanding differences in staff experience helps identify whether all groups feel equally included and whether workplace factors may be affecting wellbeing, engagement and sense of belonging.

### Feeling Valued at Work

The NHS Staff Survey found that perceptions of being valued by the Trust vary across workforce groups. Some of the most positive responses were reported by staff from Indian (69.9%) and Black African (63.6%) backgrounds. In contrast, lower levels of agreement were reported by staff from Mixed White and Black Caribbean (34.6%), Mixed White and Asian (33.3%), and Other Mixed backgrounds (29.4%), although some of these groups represent relatively small numbers of respondents.

Disabled staff were less likely to agree that the Trust values their work (31.0%) than non-disabled staff (44.8%), a pattern which broadly reflects the national picture. Gender differences were generally limited, with male staff reporting the highest levels of agreement (46.4%). However, staff who preferred not to disclose their gender reported substantially lower levels (21.6%). Similar patterns were seen for gender identity, sexual orientation and religion, where staff who chose not to disclose aspects of their identity consistently reported less positive experiences than other groups.

Differences by age were generally small, although younger staff aged 16–20 reported lower levels of agreement (31.3%) than other age groups. This pattern differs from the national position and may warrant further exploration.

Overall, staff who choose not to disclose aspects of their identity report less positive experiences of feeling valued by the organisation, highlighting the importance of fostering an inclusive culture where colleagues feel safe to be themselves at work.

### Work related stress

The proportion of staff reporting that they had felt unwell as a result of work-related stress during the previous 12 months also varied across workforce groups.

Global Majority staff reported slightly lower levels of work-related stress (40.1%) than White staff (44.5%), although some ethnic groups reported considerably higher levels. In particular, White Gypsy or Irish Traveller staff (72.7%) and Mixed White and Black African staff (62.2%) reported the highest levels, with the latter increasing substantially compared to the previous year.

Disabled staff were significantly more likely to report work-related stress (59.5%) than non-disabled staff (37.8%), mirroring the national pattern. Higher levels were also reported by non-binary staff (60.6%) and staff who preferred not to disclose their gender (57.9%). Similarly, staff whose gender identity differs from their sex registered at birth (56.8%) reported higher levels of work-related stress than staff whose gender identity is the same as their sex registered at birth (42.7%).

Variation was also evident by sexual orientation. Bisexual staff (59.5%) and those selecting "Other" (56.7%) reported the highest levels of work-related stress, compared with 41.2% of heterosexual staff. By religion and belief, higher levels were reported by staff identifying with another religion (53.7%), Jewish staff (52.6%), and those who preferred not to disclose their religion (55.8%), while Hindu staff reported the lowest levels (33.2%).

Younger and mid-career staff were more likely to report work-related stress than older colleagues, with the highest levels reported among staff aged 21–30 (51.6%) and the lowest among those aged 66 and over (31.4%). Staff with caring responsibilities also reported higher levels of work-related stress (49.4%) than staff without caring responsibilities (40.9%).

These findings suggest that experiences of work-related stress are not evenly distributed across the workforce, with particularly high levels reported by disabled staff, carers, staff with diverse gender identities and sexual orientations, and several minority ethnic and religious groups. Understanding these differences can help ensure that wellbeing support is accessible, targeted and responsive to the needs of all colleagues.

## Developing

Developing and retaining a diverse workforce requires colleagues to have equitable access to progression, development and career opportunities. Understanding how staff experience career progression, development programmes and retention helps identify where barriers may exist and where additional support may be needed to enable all colleagues to thrive.

### Equality of opportunity for career progression/promotion

The NHS Staff Survey asks staff whether they believe their organisation acts fairly with regard to career progression and promotion, regardless of protected characteristics. In 2025, 53.9% of UHSussex staff responded positively to this question, broadly in line with the national average of 53.7%.

Responses varied across workforce groups. For race and ethnicity, Global Majority staff reported a more positive experience (57.9%), which is the reverse of the national pattern where Global Majority staff typically report lower levels of agreement. Some individual ethnic groups reported more extreme scores, including White Gypsy or Irish Traveller (30.0%) and Mixed White and Black Caribbean (61.5%) staff, though small sample sizes limit interpretation. Other groups reported similar levels of agreement.

Differences were more apparent for disability. 48.3% of disabled staff agreed that career progression and promotion processes were fair, compared to 55.9% of non-disabled staff, closely reflecting the national picture. Similar patterns were seen for gender identity, where 40.9% of staff whose gender identity differs from their sex registered at birth agreed, compared to 55.2% of staff whose gender identity is the same as their sex registered at birth.

Variation was also evident for sexual orientation and religion. Staff who preferred not to disclose their sexual orientation (32.5%) and those selecting "Other" (30.0%) reported the lowest levels of agreement. Likewise, staff who preferred not to disclose their religion reported notably lower agreement (31.5%) than other religious groups, which otherwise reported broadly similar results.

For gender, 55.9% of female staff agreed that the organisation acts fairly regarding career progression and promotion. The lowest score was reported by staff who preferred to self-describe their gender (17.7%), although small numbers mean findings should be interpreted cautiously. Age-related differences were less pronounced, although younger staff were generally more positive, with 65.4% of staff aged 21–30 and 60.0% of staff aged 16–20 agreeing, compared with 45.1% of staff aged 66 and over.

Staff with caring responsibilities also reported lower levels of agreement (50.7%) than staff without caring responsibilities (55.3%).

Overall, perceptions of fair career progression are broadly in line with the national average. However, lower levels of agreement among disabled staff, staff with diverse gender identities, carers, and colleagues who choose not to disclose aspects of their identity suggest that some groups may experience greater barriers to progression than others.

### Career Sponsorship Scheme

The Trust has introduced a Career Sponsorship Scheme, launched at the end of August 2025 to support career progression and improve access to development opportunities for colleagues across the organisation.

Participation in the scheme has continued to grow over the reporting period, with total participants increasing from 88 in December 2025 to 110 (25% increase) by 31 March 2026. This includes a small increase in sponsors from 30 to 33 and larger increase in sponsees from 64 to 86, reflecting strong engagement, particularly among colleagues seeking development support.

As of 31 March 2026, there are 32 active sponsorship pairs, with 54 colleagues on the waiting list. This indicates demand continues to exceed available capacity and highlights an opportunity to further expand the number of sponsors.

A review of participant demographics collected from a follow-up form sent to sponsees only shows that the scheme is engaging a diverse range of colleagues, with representation across White and Global Majority ethnic groups. The majority of participants identify as female, and around one in five report a long-term physical or mental health condition. Participants also include a range of sexual orientations and religions or beliefs.

Analysis of relative likelihood suggests that some groups are more likely to access the scheme than others. Global Majority staff and disabled staff were more likely than their comparison groups to participate, as were colleagues identifying as lesbian, gay, bisexual or other. Female staff were slightly less likely than male staff to access the scheme, and colleagues reporting a religion were less likely to participate than those reporting no religion.

Overall, the scheme is supporting retention and development by enabling colleagues to access guidance, networks and progression opportunities. The strong uptake observed during its first-year highlights both the demand for career development support and the potential of the scheme to improve equitable access to progression opportunities.

As the numbers within some demographic categories are relatively small, further detailed analysis or breakdown has not been included to protect confidentiality and avoid the risk of identifying individuals.

### Turnover

Understanding who leaves the organisation, and whether some groups are more likely to leave than others, helps identify potential inequalities in staff experience, retention and opportunity.

Between 1 April 2025 and 31 March 2026, there were 3,994 leavers across the Trust. This includes all primary assignments, including bank and reserve roles, which results in higher levels of missing demographic data than standard ESR reporting. The majority of leavers were from the Reserve workforce (2,541 staff), with smaller numbers across the main divisions, including 162 in Cancer and Specialist Services, 329 in Medicine, 290 in Surgery, and 268 in Women, Children and Clinical Support, alongside 394 from Corporate divisions.

In terms of race and ethnicity, 25.7% of leavers (1,026 staff) were from Global Majority backgrounds, compared to 66.4% (2,653 staff) who identified as White and 7.9% (315 staff) where ethnicity was not recorded. Within the Global Majority group, the largest proportion identified as Asian (15.4%), followed by Black (5.1%), Mixed (2.8%) and Other ethnic groups (2.4%). The relative

likelihood of Global Majority staff leaving compared to White staff was 0.9, falling within the expected equality range, indicating similar likelihood of leaving. At divisional level, the Medicine Division had the highest proportion of Global Majority leavers (34.0%), while the Women, Children and Clinical Support Division had the lowest (29.1%).

For disability, 5.3% of leavers (210 staff) identified as disabled, while 80.4% (3,210 staff) did not, with 9.5% preferring not to say and 4.9% (195 staff) not recorded. The relative likelihood of disabled staff leaving compared to non-disabled staff was 0.8 times less likely, a figure within the expected equality range, indicating similar likelihood. Variation across divisions shows that the Women, Children and Clinical Support Division had the highest proportion of disabled leavers (9.3%), while Cancer and Specialist Services had the lowest (3.7%).

In terms of sex, 68.0% of leavers (2,717 staff) were female and 31.0% (1,277 staff) were male. The relative likelihood of female staff leaving compared to male staff was 0.9, also within the expected equality range, indicating similar likelihood of leaving. The Women, Children and Clinical Support Division had the highest proportion of female leavers (79.9%), while Surgery had the lowest (60.3%).

For sexual orientation, 7.8% of leavers (313 staff) identified as LGBUO, while 74.0% (2,956 staff) were heterosexual and 18.2% (315 staff) were not recorded. The relative likelihood of LGBUO staff leaving compared to heterosexual staff was 1.2, within the expected equality range, indicating similar likelihood of leaving. There was minimal variation across the four major divisions, with differences of around 1.7 percentage points.

In relation to religion and belief, 56.9% of leavers (2,271 staff) reported having a religion, including 35.0% identifying as Christian, while 22.5% (898 staff) reported no religion and 20.7% (825 staff) were not recorded. The relative likelihood of staff with a religion leaving compared to those with no religion was 0.8, within the expected equality range, indicating similar likelihood. Across divisions, Cancer and Specialist Services had the highest proportion of leavers reporting a religion (85.2%), while Surgery had the lowest (81.7%).

Age data shows that turnover is concentrated among younger and mid-career staff. The largest proportions of leavers were aged between 26 and 40, including 18.6% aged 26–30, 18.5% aged 31–35, and 13.4% aged 36–40, meaning that these groups together accounted for just over half (50.5%) of all leavers. This pattern is broadly consistent across divisions, although the Medicine Division had a relatively higher proportion of leavers aged 21–25, while Cancer and Specialist Services had a higher proportion of leavers aged 55–66 compared to other divisions.

Overall, turnover is broadly comparable across most protected characteristics, with relative likelihoods generally falling within the expected equality range. However, the concentration of leavers among younger and mid-career staff highlights the importance of understanding the factors that influence retention at different stages of colleagues' careers.

### Exit survey

Between 1 April 2025 to 31 March 2026, 282 leavers completed the exit survey, providing insight into reasons for leaving and staff experience. A relatively small proportion of respondents (7.1%) identified their reason for leaving as relating to abuse, bullying, harassment, ill-treatment at work, or victimisation following raising a concern. In addition, 25.5% of respondents indicated that their reason for leaving was negatively related to at least one protected characteristic, caring responsibilities, or Armed Forces status.

Among these, the most commonly cited factors were age (13.8%), disability (7.8%), and caring responsibilities (5.0%), indicating that personal and structural factors linked to equality and inclusion continue to play a role in staff turnover.

## Advance Equality of Opportunity Summary

Overall, these findings suggest that many colleagues experience equitable access to support, development and career opportunities. However, differences remain for some staff groups in areas including workplace adjustments, inclusion, career progression and work-related stress. Understanding and addressing these differences is important to ensuring that all colleagues are able to access opportunities, reach their potential and thrive at work.

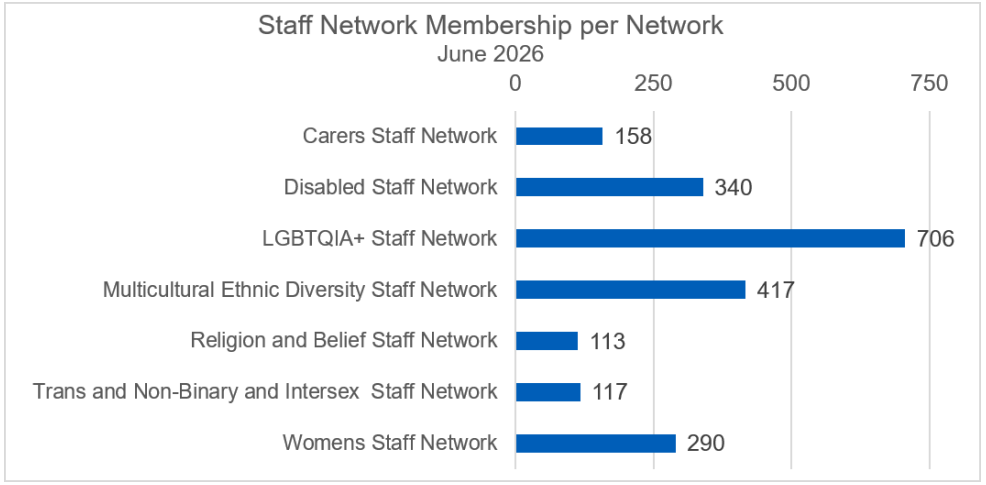
# Foster Good Relations

The following section summarises activity relating to staff voice and inclusion staff networks, highlighting opportunities for colleagues to connect, influence change and support a more inclusive workplace culture.

## Staff Voice

Staff voice is a key part of fostering good relations across the Trust. UHSussex has eight Inclusion staff networks providing opportunities for colleagues to connect, share experiences, and influence inclusive practice.

In January 2025, dedicated funding was secured through My University Hospitals Sussex Charity to support the development of all staff networks through a 20-month programme. This has enabled networks to expand activity, deliver staff-facing events, and enhance engagement. Two staff network project support managers have also been introduced in early 2026 to support six networks who chose to pool their funding, while the remaining networks have used their funding to support existing leads in delivering their programmes.




All networks are delivering against agreed 20-month plans, supporting increased engagement and a broader programme of activity across the organisation. Each network has provided a summary of its achievements over the past year, as well as key challenges and priorities for the future, these can be found in Appendix 2: Staff Networks.

Staff networks were delivering sustained engagement across the organisation, with an average of around 600 monthly views on network pages on the staff hub between January and March 2026. At 31 March, 1,477 staff (around 8% of the workforce) were recorded as members of at least one inclusion staff network, an increase of 13% since the start of the year. Total network memberships increased by 16%, from 1,646 to 1,909, reflecting membership of more than one network; 274 staff, or 19% of network members, belonged to multiple networks.

Growth was strongest in the Women's Network, which gained 94 memberships, followed by the Carers Network with 43, the Disabled Staff Network with 39, and the Multicultural and Ethnic Diversity Network with 32. Engagement with network activity was also strong: Race Equality Week generated more than 550 staff hub engagements and 205 video views, while 182 staff attended the International Women's Day webinars.

In-person events have also attracted significant participation, including 250 attendees at Philippine Independence Day activities, alongside smaller but consistent engagement for initiatives such as Lesbian Visibility Week (65 attendees) and Carers Week (29 attendees).

# Workforce Equality Standards (WES) Detailed Reports 2026

NHS
University Hospitals Sussex
NHS Foundation Trust

# Workforce Equality Standards Report 2026 Executive Summary

uhsussex.inclusion@nhs.net

www.uhsussex.nhs.uk/equality

## Background

This **Workforce Equality Standards Report** brings together the organisation's statutory workforce equality and pay reporting, including the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap and supporting pay gap analyses. It is – by design – an analytical report.

- **The nine WRES indicators** are derived from Electronic Staff Record (ESR) workforce data (indicators 1, 2, 3, 4 and 9) and NHS Staff Survey responses (indicators 5, 6, 7 and 8), alongside data from Trac recruitment systems (indicator 2), employee relations disciplinary records (indicator 3) and IRIS training platform (indicator 4) data.
- **The ten WDES indicators** are derived from ESR workforce data (indicators 1, 2, 3 and 10) and NHS Staff Survey responses (indicators 4, 5, 6, 7, 8 and 9), alongside data from Trac recruitment systems (indicator 2) and employee relations capability records (indicator 3).
- **Pay gap reporting** is derived from ESR hourly pay and bonus data, as of 31 March 2026.

This report sets out the Trust's statutory workforce equality standards and pay gap reporting, focusing on **nationally mandated indicators and metrics**. It does not include wider equality measures or additional analysis beyond these requirements. This report is necessary to meet the NHS England **May 2026 upload deadline** for the Trust's WRES / WDES data.

## Overall position

There is evidence of progress in representation, sharing and perceived equality of opportunity, but structural inequalities persist across race, disability and gender, particularly in senior roles, formal processes (disciplinary and capability), experiences of discrimination and pay outcomes, as they do amongst many NHS employers.

### Race (WRES)

- **Four of nine indicators improved**, including appointment from shortlisting and perceptions of career opportunity
- **Racial disparities remain** in disciplinary outcomes, senior progression, discrimination and Board representation
- **The ethnicity pay gap is close to parity**, but the bonus pay gap remains significant and masks variation between groups.

### Disability (WDES)

- **Three of ten indicators improved**, with increased sharing of disability information, workforce representation, reasonable adjustments and perceptions of opportunity

- **Disabled staff continue to experience inequity** in capability processes, senior clinical progression and experiences of bullying or harassment
- **The disability pay gap remains material**, with disabled staff earning less on average than non-disabled staff.

### Gender Pay Gap (GPG)

- **The average gender pay gap remains considerable**, driven by female under-representation in senior and consultant roles
- **The bonus pay gap remains substantial**, reflecting historic and consultant-level award scheme national eligibility, though newer schemes show early signs of improved balance.

### Focus for 2026-27

**Delivery of the Workforce Inclusion Programme (WIP)** will prioritise inclusive leadership accountability, fair recruitment and progression, safer and more equitable formal processes, improved data quality, and consistent access to reasonable adjustments, aligned to the NHS National EDI Improvement Plan.

University Hospitals Sussex
NHS Foundation Trust

# Workforce Race Equality Standard (WRES) 2026

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# Introduction

The Workforce Race Equality Standard (WRES) provides a nationally mandated framework for assessing the experiences of staff from different ethnic backgrounds within NHS organisations. It brings together workforce, recruitment, employee relations and staff survey data to identify disparities in experience, opportunity and outcomes. At UHSussex, the WRES supports a systematic approach to understanding racial inequality, monitoring progress over time, and informing targeted action through the Workforce Inclusion Programme and organisational strategy.

## Use of Data and Information

This report draws on workforce data required to meet national reporting standards that NHS organisations are mandated to complete annually, i.e. the Workforce Race Equality Standard (WRES). These standards set expectations regarding the scope, format, terminology and minimum reporting requirements, to support consistency and comparability across organisations. This report has been written as a standalone report, in line with national guidance.

Staff can update their personal information, including ethnicity, on their staff record via the Employee Self-Service online portal at any time. All data used for reporting is anonymised and handled in line with information governance and data protection requirements. Anonymised data is analysed to identify and respond to issues affecting groups of staff who share protected characteristics.

## Terminology

Throughout this report, we use the term Global Majority as a narrative descriptor to refer to staff from ethnic groups other than White, recognising that these groups represent the majority of the global population, while also acknowledging that they may be under-represented or experience inequity within the Sussex or wider UK context. The term is widely used across EDI research, public sector organisations and is starting to be adopted in various parts of the NHS. Use of this term does not replace standard NHS ethnicity categories or alter how WRES indicators are calculated, and in this context refers to the same staff as the term Black, Asian and Minority Ethnic.

We use the term ***"distance from equity"*** as a descriptive, non-technical phrase commonly used in equality analysis to explain the size of differences in outcomes or experiences between groups. For representation percentages, this refers to how far the number is from the Trust average. For likelihood questions, this refers to how far the number is from zero. For other indicators, it refers to the percentage difference between Global Majority and white experiences. For example, if 20% of White staff face bullying and harassment then it would be equitable if 20% of Global Majority staff also face bullying and harassment. Here, the greater the percentage difference, the greater the inequity.

### Data collection

The WRES is an annual benchmarking tool mandated by NHS England. Trusts are only required to submit data for indicators 1-4 and indicator 9. The data for indicators 5-8 comes from our staff survey results. Bank-only workers are excluded from this data submission. The WRES data must be submitted on the Data Collections Framework (DCF) system by 31 May 2026.

## Summary

### Overview

The report outlines the data from the **National Workforce Race Equality Standard (WRES)**. The WRES is an annual benchmarking tool introduced by NHS England to assess the progress made towards achieving race and disability equality within NHS organisations. It assesses how the trust has improved against 9 indicators designed to close the gap between the experiences of White and Global Majority colleagues. These include:

- Clinical and non-clinical diversity and representation across all bands and pay grades (from ESR workforce data)
- Successful job appointment and shortlisting (from ESR workforce and Trac recruitment systems data)
- Entering formal disciplinary processes (from ESR workforce and employee relations disciplinary records data)
- Access to CPD and non-mandatory training (from ESR workforce and IRIS training platform data)
- Incidents of bullying, harassment or abuse from public (from NHS Staff Survey data)
- Incidents of bullying, harassment or abuse from staff (from NHS Staff Survey data)
- Perceptions around equal opportunities for progression or promotion (from NHS Staff Survey data)
- Incidents of bullying, harassment or abuse from managers, team leads or other colleagues (from NHS Staff Survey data)
- Proportional representation of the overall workforce at board level (from ESR workforce data).

### Main Findings

**Four of the nine WRES Indicators improved in 2026** although there is **still disparity in key areas** such as disciplinary cases, appointments, career progression, experiences of discrimination and board representation. We do not have racial equity in 7 of our 9 WRES indicators. We have seen improvements in:

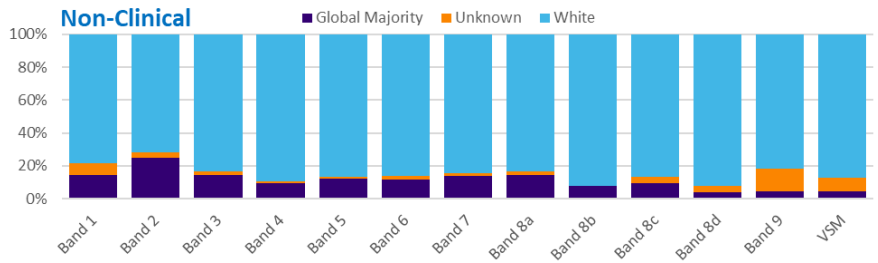
- the percentage of Global Majority staff in our workforce, especially in entry-level roles.
- the likelihood of Global Majority staff being appointed from shortlisting.
- the percentage of Global Majority staff believing in equality of opportunity for career progression or promotion.

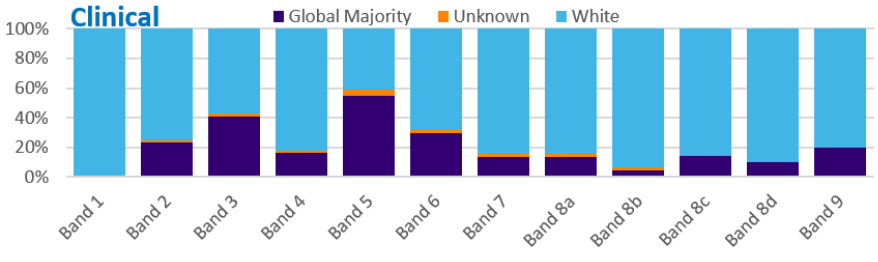
## Workforce Profile

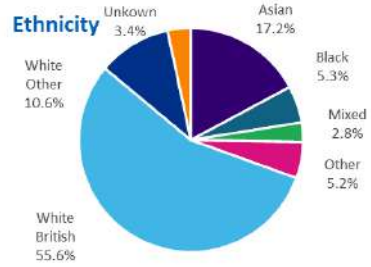
This section outlines the Trust's workforce profile by ethnicity, including overall representation and variation across pay bands and staff groups. The charts below show how staff are distributed across non-clinical, clinical, and medical and dental roles. The proportion of staff who chose not to share their ethnicity was 3.4%, representing a **small improvement** compared with 3.6% in the previous year (2025) and 4.4% in 2024.

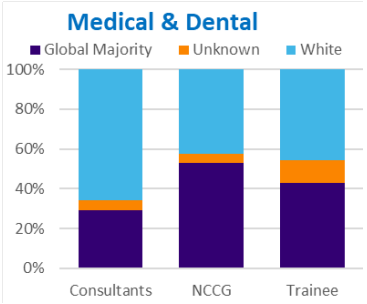
As of 31 March 2026, the Trust's permanent workforce comprised 30.6% Global Majority staff (5,796 individuals). This proportion is higher than the 19% Global Majority population across England and 9% across Sussex (Census 2021, ONS). This represents an **increase of nearly three percentage points** compared with the previous reporting year (2025: 27.7%) and five percentage points compared to 2024 (25.3%).

As the graphs below illustrate, the ethnic workforce profiles are highly structured by staff group and pay band. Staff from Global Majority backgrounds have higher representation in middle pay bands within clinical roles, with a reduction in representation at senior pay bands in both non-clinical and clinical staff groups, and at consultant level within medical and dental roles. The accompanying pie chart provides the overall Trust ethnicity context for these patterns.



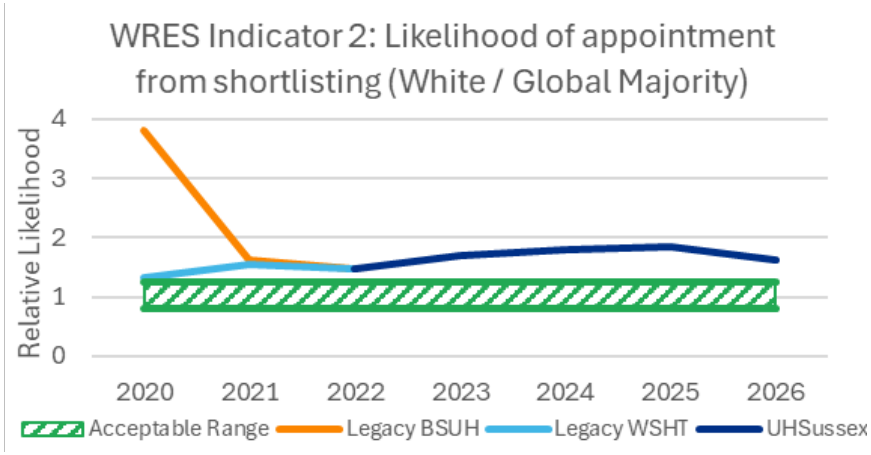
## Indicators derived from ESR Data

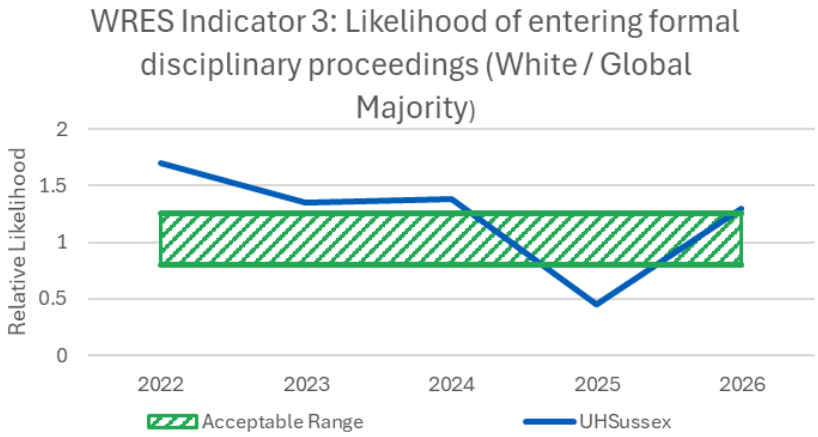
The table below brings together results for WRES indicators derived from our secure and confidential electronic staff record system (ESR) data, highlighting changes from 2025 and the relative distance from equity. The data shows progress in representation and recruitment, including increased Global Majority workforce presence and improved appointment outcomes. However, inequalities remain in disciplinary processes, training access and senior representation, particularly at Board level.

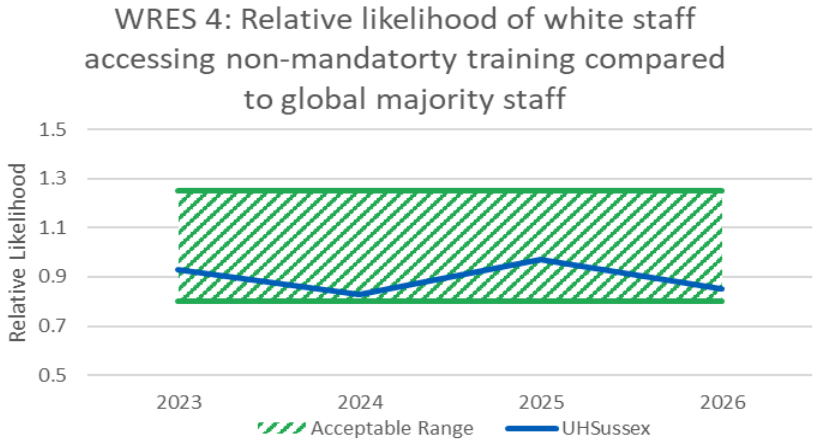
Improvement/Better
Decline/Worse

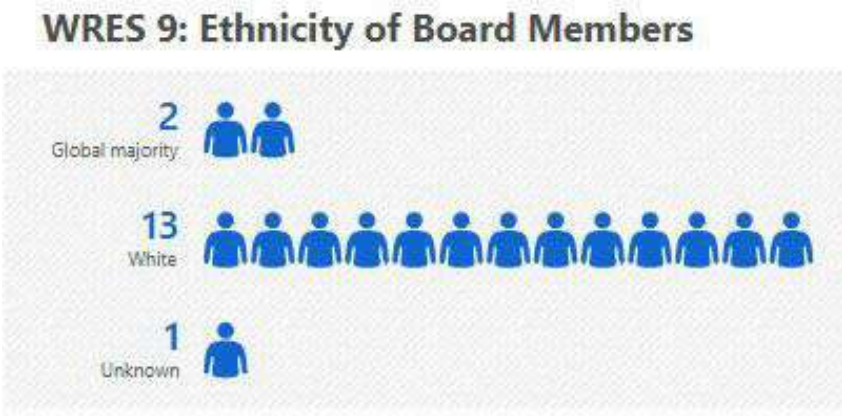
| Indicator number and description | Results | Change from 2025 | Distance from equity |
|---|---|---|---|
| Indicator 1: Global Majority representation in the workforce by pay band | | | |
| Overall | 30.6% | 2.9%-point increase | |
| Non-Clinical | 15.8% | 1.2%-point increase | |
| Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 1.41 | 0.10 increase | 0.41 |
| Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 1.26 | 0.36 decrease | 0.26 |
| Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 1.77 | 0.34 decrease | 0.77 |
| Clinical | 35.0% | 3.6%-point increase | |
| Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 2.73 | 0.12 increase | 1.73 |
| Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 2.30 | 0.39 increase | 1.30 |
| Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 6.28 | 1.29 increase | 5.28 |
| Medical & Dental | 38.2% | 2.1%-point increase | |
| Disparity ratio - Trainee to NCCG | 0.76 | 0.03 decrease | -0.24 |
| Disparity ratio - NCCG to Consultant | 2.80 | 0.19 increase | 1.80 |
| Disparity ratio - Trainee to Consultant | 2.12 | 0.06 increase | 1.12 |
| Indicator 2: Likelihood of appointment from shortlisting | | | |
| Likelihood ratio White / Global Majority | 1.63 | 0.21 decrease | 0.63 |
| Indicator 3: Likelihood of entering formal disciplinary proceedings | | | |
| Likelihood ratio Global Majority / White | 1.30 | 0.87 increase | 0.30 |
| Indicator 4: Likelihood of undertaking non-mandatory training | | | |
| Likelihood ratio White / Global Majority | 0.85 | 0.12 decrease | -0.15 |
| Indicator 9: Difference between Global Majority representation on the board and in the workforce | | | |
| Overall Global Majority representation on the Board | 12.5% | 3.5%-point decrease | -18.1%-points |
| Executive Director | 0% | unchanged | -30.6%-points |
| Voting Director | 12.5% | 5.1%-point decrease | -18.1%-points |

The charts below present WRES Indicators 2, 3, 4 and 9, showing trends in relative likelihood ratios. Taken together, these data show mixed progress across key WRES indicators, with improvements over time in appointment from shortlisting and access to non-mandatory training, alongside continued disparity in disciplinary outcomes and under-representation of staff from Global Majority backgrounds at Board level. Additional analysis relating to WRES Indicator 4 is included in the Appendix WRES 4: Non-mandatory training.



## Indicators derived from NHS Staff Survey Data

The data in the table below show changes across WRES indicators derived from annual NHS National Staff Survey data since 2025 and the relative distance from equity between staff from Global Majority backgrounds and White staff. The data indicate that two of the four indicators improved in 2026, while disparities remain across three indicators, including experiences of harassment, bullying or abuse and discrimination.

Improvement/Better
Decline/Worse

| Indicator number and description | Results | Change from 2024 | Distance from equity | National Average |
|---|---|---|---|---|
| **Indicator 5: Harassment, bullying or abuse from patients, relatives or the public in last 12 months** | | | | |
| Global Majority | **34.4%** | 1.7%-point increase | 6.8%-points | 29.0% |
| White | **27.6%** | 0.5%-point increase | | 22.9% |
| **Indicator 6: Harassment, bullying or abuse from staff in last 12 months** | | | | |
| Global Majority | **21.4%** | 0.7%-point increase | -1.5%-points | 24.1% |
| White | **23.0%** | 1.6%-point decrease | | 20.5% |
| **Indicator 7: Believing in equality of opportunity for career progression or promotion** | | | | |
| Global Majority | **57.9%** | 6.5%-point increase | 5.1%-points | 49.1% |
| White | **52.7%** | 1.0%-point decrease | | 55.5% |
| **Indicator 8: Discrimination from a manager/team leader or other colleagues in last 12 months** | | | | |
| Global Majority | **10.9%** | 0.3%-point decrease | 3.7%-point | 14.7% |
| White | **7.2%** | 3.2%-point decrease | | 6.4% |

Graphs and narrative relating to the above WRES indicators are included in the Appendix WRES 5-8: Staff experience indicators.

## Delivery actions linked to WRES from the Workforce Inclusion Programme (WIP)

| Indicator | Linked WIP action |
|---|---|
| WRES 1 & WRES 9 | Board and Top 70 leaders' inclusion objectives - Embed race equity objectives into Board and Top-70 leader goals, including accountability for WRES outcomes and inclusive leadership behaviours. |
| WRES 1 & WRES 2 | Enhanced panel briefings for NMAHP 8a+ roles - Design and deliver enhanced panel briefings and Post-Interview Development Needs feedback for 8a+ roles (including ESM/VSM) to improve fairness, transparency and progression. |
| WRES 1 | Build career development plans into the appraisal system - Integrate structured career development planning into appraisal conversations to support equitable progression for Global Majority staff. |
| WRES 1 | Career Navigation Support Service (CNSS) - Increased awareness and uptake of CNSS, particularly among Global Majority staff. |
| WRES 1 & WRES 7 | Career Sponsorship Scheme - Continue delivery and evaluation of the Career Sponsorship Scheme to address disparities in career progression and promotion at senior levels. |
| WRES 1 & WRES 7 | Reverse Mentoring Scheme funding case - Develop a funding case to sustain and scale the Reverse Mentoring Scheme, strengthening senior leader understanding of lived experience and race equity. |
| WRES 1 & WRES 5 | Top 1,000 Inclusive Leadership training offer – Develop a plan to deliver inclusive leadership training to the top 1,000 leaders, with a focus on race equity, psychological safety and accountability for WRES outcomes. |
| WRES 5 | Hate Incident and VPR hotspot intervention - Implement targeted interventions in identified hate incident and Violence Prevention & Reduction (VPR) hotspots to improve safety and reporting confidence. This includes reviewing discrimination coding and reporting, post-incident support and introduce inclusive investigation training. |

University Hospitals Sussex NHS Foundation Trust

# Workforce Disability Equality Standard (WDES) 2026

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www.uhsussex.nhs.uk/equality

# Introduction

The **Workforce Disability Equality Standard (WDES)** provides a nationally mandated framework for assessing the experiences of disabled staff and those with long-term conditions within NHS organisations. It brings together workforce, recruitment, employee relations and staff survey data to identify disparities in experience, opportunity and outcomes. At UHSussex, the WDES supports a systematic approach to understanding inequality, monitoring progress over time, and informing targeted action through the Workforce Inclusion Programme and our organisational strategy.

## Use of Data and Information

This report draws on workforce data required to meet national workforce equality reporting standards that NHS organisations are mandated to complete annually, i.e. the Workforce Disability Equality Standard (WDES). These standards set expectations regarding the scope, format, terminology and minimum reporting requirements, to support consistency and comparability across organisations. The WDES section has been written as standalone report, in line with national guidance.

Staff can update their personal information on their staff record via employee self-service at any time. All data used for reporting is anonymised and handled in line with information governance and data protection requirements. Anonymised data is analysed to identify and respond to issues affecting groups of staff who share protected characteristics.

The WDES utilises data from the Electronic Staff Record (ESR) and the national staff survey. The rate in 2026 that our staff shared their disability was 17.2%-points higher in the staff survey than in ESR. The former is representative for all other characteristics so we can assume that the staff survey rate for disability is more likely to be accurate than the ESR rate for disability.

## Terminology

Disability and long-lasting health conditions or illnesses may be used interchangeably in this report. This due to a change in language used nationally within the National Staff Survey which compiles qualitative data on the experiences of staff with long-term conditions (LTC) that may meet the legal criteria to be considered a disability.

Throughout this report, we will also mention **'Distance from Equity'**. For representation percentages, this refers to how far the number is from the Trust average. For likelihood questions, this refers to how far the number is from zero. For other metrics, it refers to the percentage difference between disabled and non-disabled experiences. For example, if 20% of Disabled staff face bullying and harassment then it would be equitable if 20% of non-disabled staff also face bullying and harassment. Here, the greater the percentage difference, the greater the inequity.

## Data collection

The WDES is an annual benchmarking tool mandated by NHS England. Bank-only workers are excluded from this data submission. The WDES data must be submitted on the Data Collections Framework (DCF) system by 31 May 2026.

# Summary

## Overview

The report outlines the data from the **National Workforce Disability Equality Standard (WDES)**. The WDES is an annual benchmarking tool introduced by NHS England to assess the progress made towards achieving disability equality within NHS organisations. It assesses how the trust has improved against 10 metrics designed to close the gap between the experiences of staff with declared disabilities and other colleagues. These include:

1. Clinical and non-clinical diversity and representation across all bands and pay grades (from ESR workforce data).
2. Successful job appointment and shortlisting (from ESR workforce and Trac recruitment systems data).
3. Numbers entering formal capability processes (from ESR workforce and employee relations disciplinary records data).
4. Incidents of bullying, harassment or abuse from
    a. Patients, relatives or the public (NHS Staff Survey responses data),
    b. Managers (NHS Staff Survey responses data),
    c. other colleagues (NHS Staff Survey responses data)
    d. Incidents of bullying, harassment or abuse reported by victims or colleagues compared to those without a disability (NHS Staff Survey responses data).Perceptions around equal opportunities for progression or promotion (from NHS Staff Survey responses data).
6. Pressure to work when not feeling well enough to do so (from NHS Staff Survey responses data).
7. Feeling valued by the organisation (from NHS Staff Survey responses data).
8. Receiving adequate adjustments to carry out work (from NHS Staff Survey responses data).
9. Engagement:
    a. compared to non-disabled staff and the trust average score (from NHS Staff Survey responses data) and
    b. ability to feel heard and listened to (from Disabled Staff Network).
10. Proportional representation of the overall workforce at board level (from ESR workforce data).

## Main Findings

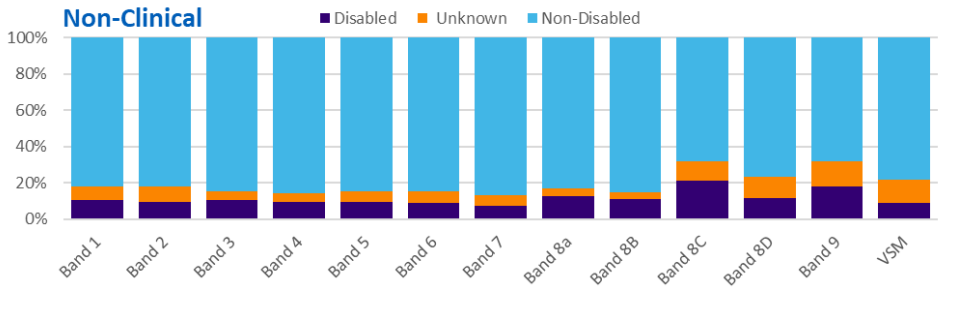
**Three of the WDES measures reported below improved in 2026**. There is still disparity in capability cases, appointments, career progression in senior clinical roles, experiences of harassment, bullying or abuse, and board representation. We have seen improvements in:

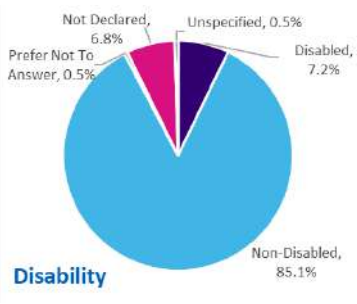
- the percentage of disabled staff in our workforce, and the percentage of staff stating their disability status.
- the likelihood of disabled staff progressing into senior non-clinical and mid-level clinical roles.
- the percentage of disabled staff believing in equality of opportunity for career progression or promotion
- the percentage of disabled staff receiving reasonable adjustments.

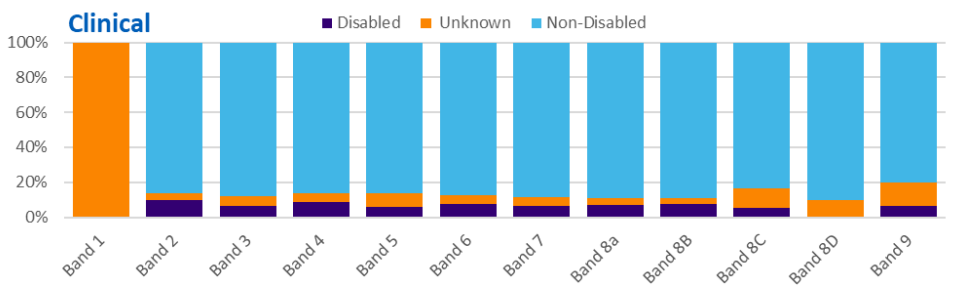
## Workforce Profile

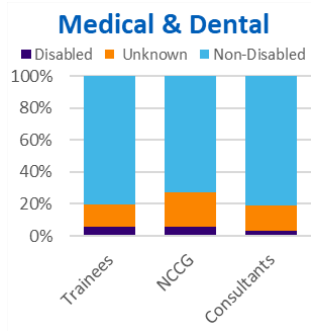
As of 31 March 2026, 7.2% (1,367) of the Trust's permanent workforce identified as disabled. This compares with 18% of the population across Sussex (Census 2021, ONS) and represents a **marginal increase** compared with the previous reporting years (6.7% in 2025 and 5.8% in 2024). Data from the 2025 NHS Staff Survey indicates that 24.4% of Trust respondents reported having a disability or long-term health condition.

The graphs below show differing patterns of disability representation across staff groups: higher representation of disabled staff at senior pay bands within non-clinical roles, lower representation at higher pay bands within clinical roles and at consultant level in medical and dental roles, and a notably higher proportion of unknown disability status across senior pay bands and medical and dental grades. The accompanying pie chart provides the overall Trust disability context for these patterns. The proportion of staff who chose not to share their disability status was 7.7%, **improved** from 8.5% in 2025 and 12.3% in 2024.



# Indicators derived from ESR Data

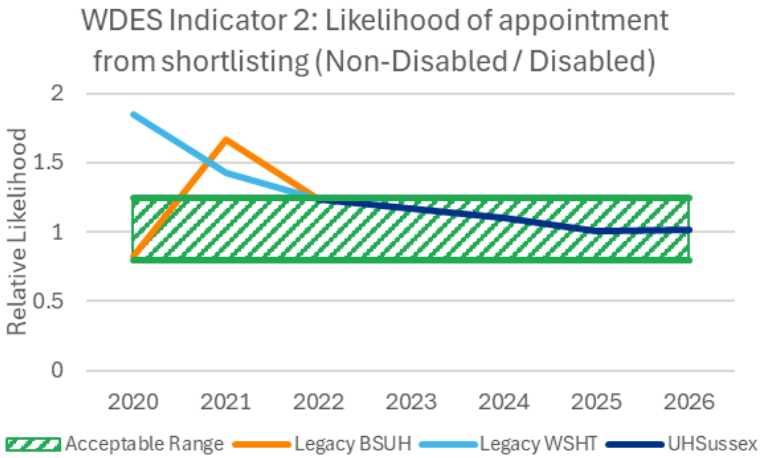
The data in the table below show changes across WDES indicators derived from ESR data since 2025 and the relative distance from equity between disabled and non-disabled staff. None of the four main indicators improved in 2026 (green) and disparities remain across all indicators, including capability, appointments, career progression in senior clinical roles, and board representation.

| Indicator number and description | Results | Change from 2025 | Distance from equity |
|---|---|---|---|
| Indicator 1: Disabled representation in the workforce by pay band | | | |
| Overall | 7.2% | 0.5%-point increase | |
| Non-Clinical | 9.8% | 1%-point increase | |
| Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 2 (Bands 5-7) | 1.13 | 0.12 increase | 0.13 |
| Disparity ratio - Cluster 2 (Bands 5-7) to Cluster 3 (Bands 8a & 8b) | 0.72 | -0.01 decrease | -0.28 |
| Disparity ratio - Cluster 3 (Bands 8a & 8b) to Cluster 4 (Bands 8c - VSM) | 0.59 | 0.11 decrease | -0.41 |
| Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 4 (Bands 8c - VSM) | 0.48 | 0.03 decrease | -0.52 |
| Clinical | 6.8% | 0.3%-point increase | |
| Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 2 (Bands 5-7) | 1.05 | 0.07 decrease | 0.05 |
| Disparity ratio - Cluster 2 (Bands 5-7) to Cluster 3 (Bands 8a & 8b) | 0.92 | 0.04 decrease | -0.08 |
| Disparity ratio - Cluster 3 (Bands 8a & 8b) to Cluster 4 (Bands 8c - VSM) | 1.40 | 0.55 increase | 0.40 |
| Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 4 (Bands 8c - VSM) | 1.36 | 0.44 increase | 0.36 |
| Medical & Dental | 4.6% | 0.7%-point increase | |
| Disparity ratio - Trainee to NCCG | 0.89 | 0.86 decrease | -0.11 |
| Disparity ratio - NCCG to Consultant | 2.01 | 1.07 increase | 1.01 |
| Disparity ratio - Trainee to Consultant | 1.80 | 0.15 increase | 0.80 |
| Indicator 2: Likelihood of appointment from shortlisting | | | |
| Likelihood ratio Non-disabled / Disabled | 1.02 | 0.02 increase | 0.02 |
| Indicator 3: Likelihood of entering formal capability proceedings | | | |
| Likelihood ratio Disabled / Non-disabled | 1.58 | 1.58 increase | 0.58 |
| Metric 10: Disabled representation on the board | | | |
| Overall | 0% | 5.6%-point decrease | -7.2%-points |
| Executive | 0% | 11.1%-point decrease | -7.2%-points |
| Voting | 0% | 5.9%-point decrease | -7.2%-points |



Improvement/Better
Decline/Worse

The charts below present WDES Indicators 2 and 10, showing trends over time in the relative likelihood of appointment from shortlisting for disabled staff compared with non-disabled staff, alongside the current disability composition of Board membership, highlighting progress over time in recruitment outcomes and under-representation of disabled staff at Board level, and a relatively high proportion of Board members with unknown disability status.



## Indicators derived from NHS Staff Survey Data

The data in the table below show changes across WDES indicators derived from annual NHS National Staff Survey data since 2025 and the relative distance from equity between disabled and non-disabled staff. The data indicates three of nine measures improved in 2026, while disparities remained across six indicators, including experiences of harassment, bullying or abuse and career progress, presenteeism and feeling valued. Further graphs and narrative are in Appendix WDES 4(2) and 6-7: Staff experience indicators.

| Indicator number and description | Results | Change from 2024 | Distance from equity | National Average |
|---|---|---|---|---|
| Metric 1 (equivalent): Proportion with a long-term condition or illness | | | | |
| Disabled | 24.4% | 0.3%-point decrease | | 24.45% |
| Indicator 4a: Harassment, bullying or abuse from patients, relatives or the public in last 12 months | | | | |
| Disabled | 32.7% | 0.3%-point increase | 4.2%-points | 29.1% |
| Non-disabled | 28.5% | 1.3%-point increase | | 22.6% |
| Indicator 4b: Harassment, bullying or abuse from line managers in last 12 months | | | | |
| Disabled | 15.8% | 0.6%-point increase | 7.8%-points | 14.1% |
| Non-disabled | 8.0% | 0.3%-point decrease | | 7.6% |
| Indicator 4c: Harassment, bullying or abuse from other colleagues in last 12 months | | | | |
| Disabled | 25.7% | 0.3%-point increase | 9.9%-points | 24.5% |
| Non-disabled | 15.8% | 0.2%-point decrease | | 15.6% |
| Indicator 4d: Reporting last incident of harassment, bullying or abuse | | | | |
| Disabled | 51.5% | 0.4%-point increase | -0.9%-points | 53.2% |
| Non-disabled | 52.5% | 2.8%-point increase | | 52.9% |
| Indicator 5: Career progression | | | | |
| Disabled | 48.3% | 0.9%-point increase | -6.6%-points | 47.8% |
| Non-disabled | 55.9% | 1.2%-point increase | | 55.1% |
| Indicator 6: Presenteeism | | | | |
| Disabled | 31.0% | 1.32%-point increase | 12.2%-points | 27.2% |
| Non-disabled | 18.8% | 0.6%-point decrease | | 18.2% |
| Metric 7: Feeling valued | | | | |
| Disabled | 31.0% | 0.7%-point decrease | -13.8%-points | 32.1% |
| Non-disabled | 44.8% | 3.0%-point increase | | 45.1% |
| Metric 8: Reasonable adjustments | | | | |
| Disabled | 75.1% | 0.3%-point increase | | 73.7% |
| Metric 9a: Staff engagement | | | | |
| Disabled | 6.19 | 0.01 decrease | 0.70 | 6.29 |
| Non-disabled | 6.89 | 0.15 increase | | 6.91 |

Improvement/Better
Decline/Worse

## Delivery actions linked to WDES from the Workforce Inclusion Programme (WIP)

| Indicator | Linked action in WIP |
|---|---|
| WDES 1 & WDES 2 | Enhanced panel briefings for NMAHP 8a+ roles - Design and deliver enhanced panel briefings for senior clinical recruitment to mitigate disability bias and improve appointment equity. |
| WDES 1 & WDES 2 | Accountability in Senior Recruitment (Imperial Explain or Comply Model) scope out the framework used by Imperial that requires recruiting managers to either follow agreed inclusive recruitment standards or clearly justify, with evidence, why they are departing from them to ensure accountability and reduce bias within senior recruitment (8a+ / ESM / VSM). |
| WDES 8 | Centralised Reasonable Adjustments - Evaluate the new centralised reasonable adjustments service to ensure timely, consistent and transferable adjustments for disabled staff across the organisation. |
| WDES 1 & WDES 4b,c | Top 1,000 Inclusive Leadership training offer – Develop a proposal to deliver inclusive leadership training focusing on disability inclusion, adjustment confidence, and accountability for WDES outcomes. |
| WDES 3 | Capability processes bias review - Undertake a focused review of capability processes to identify and address structural bias affecting disabled staff, including reasonable adjustment considerations. |
| WDES 3 | Inclusive investigation training - Deliver inclusive investigation training to reduce bias in disciplinary, capability and grievance processes and improve disabled staff experience. |

University Hospitals Sussex NHS Foundation Trust

# Gender Pay Gap (GPG) 2026

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# Introduction

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

- the level of gender equality.
- the balance of male and female employees in each of four salary range quartiles.
- how effectively talent is being maximised and rewarded

and to use this to identify any underlying root causes for the gender pay gap and put in place remedial actions to address and mitigate this.

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

## Important information

- This report follows the statutory gender pay gap reporting requirements for public authorities with 250 or more employees. The snapshot date is 31 March 2026. The mean and median ordinary pay gaps and pay quartiles are calculated using full-pay relevant employees employed on that date, based on ordinary pay received during the pay period that included 31 March 2026. A total of 18,346 employees were included in these calculations. The bonus pay calculations use all relevant employees employed on the snapshot date and include bonus payments made during the 12 months ending 31 March 2026. The number of employees included in the bonus calculations may therefore differ from the number included in the ordinary pay and quartile calculations.

**There are six mandatory calculations:**

- Proportion of males and females in each pay quartile
- Mean (average) gender pay gap for ordinary pay
- Median gender pay gap for ordinary pay
- Proportion of males and females receiving a bonus payment
- Mean (average) gender pay gap for bonus pay
- 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), while the mean result is 83p
- 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 1.5 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.

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 1 Chart showing average mean and median hourly pay

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

### The ordinary (hourly rates) pay gap has increased marginally.

In 2025/26, women earned £0.83 for every £1 earned by men, representing **a one-penny decrease compared to the previous year**. "Ordinary pay" refers to pay received in the pay period that includes the snapshot date, including basic pay, allowances and shift pay, but excluding bonus pay. Overall, the **ordinary pay gap has remained broadly consistent** over recent years, with limited movement. This gap is largely driven by the continued over-representation of male staff in senior management and consultant roles, particularly within the highest pay quartile.

### Our gender bonus gap has increased and remains substantial.

The proportion of male staff receiving a bonus was **over 346% 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.

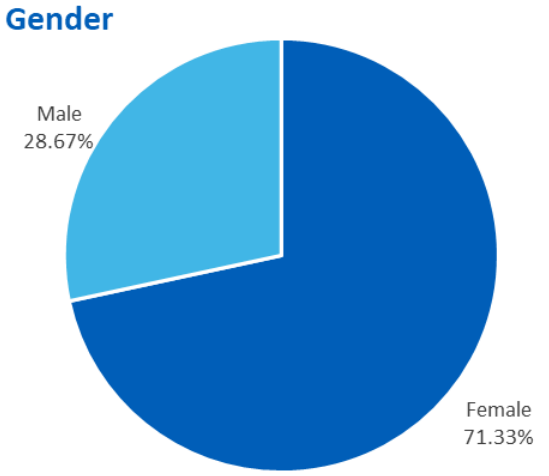
Representation across pay quartiles has shown **minimal year-on-year movement**. Despite women comprising the majority of the workforce, their representation decreases at higher pay levels, particularly within the top pay quartile.

### 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 (Specific Duties and Public Authorities) Regulations 2017, the ordinary pay and pay-quartile calculations include full-pay relevant employees who were employed on the snapshot date and received their usual full pay during the relevant pay period. The figures include substantive and bank staff who meet this definition and excludes those not receiving full pay e.g. due to long-term leave.

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

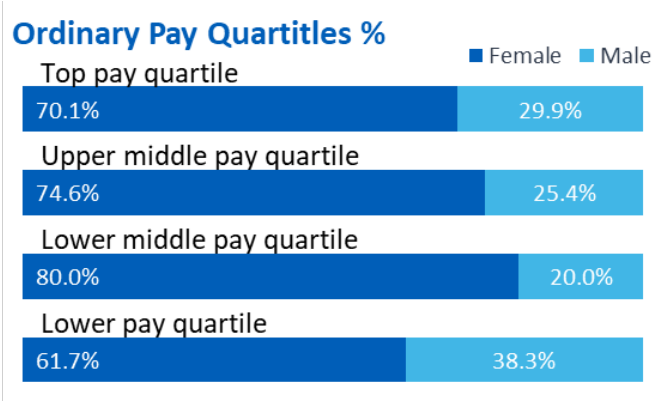
## Representation by Ordinary Pay Quartiles

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

The chart on the right shows the percentage of male and female employees in each pay quartile:

- 4,581 staff were in the lower pay quartile, of these 3,212 females.
- 4,475 staff were in the lower middle pay quartile, of these 3,337 females.
- 4,701 staff were in the upper middle pay quartile, of these 3,759 females.
- 4,589 staff were in the top pay quartile, of these 2,832 females.

This breakdown shows the percentage of male and female employees in each quartile, helping us assess gender balance across different pay levels.



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.

Male staff were **1.5 times more likely** to be in the top pay quartile than female staff, compared to their representation in the lowest pay quartile. This is up (marginally) from 1.4 times in 2025 and the same as in 2024.

Our quartile pay representation has remained consistent the past few years with limited movement.

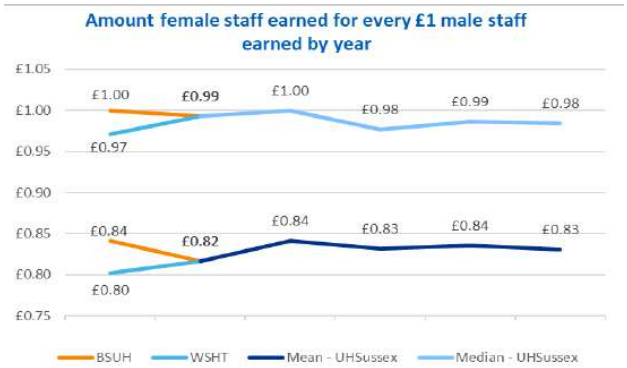
## Gender Pay Gap: Ordinary Pay

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**.

These figures are summarised in the below table and illustrated in the chart below. The table provides a snapshot of the 2026 position, while the chart 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.

| | 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** |

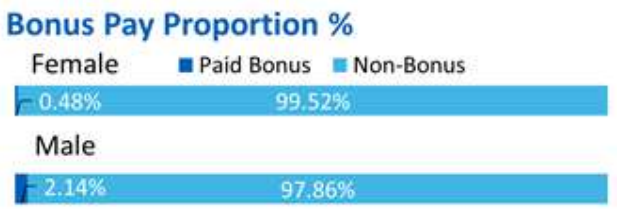


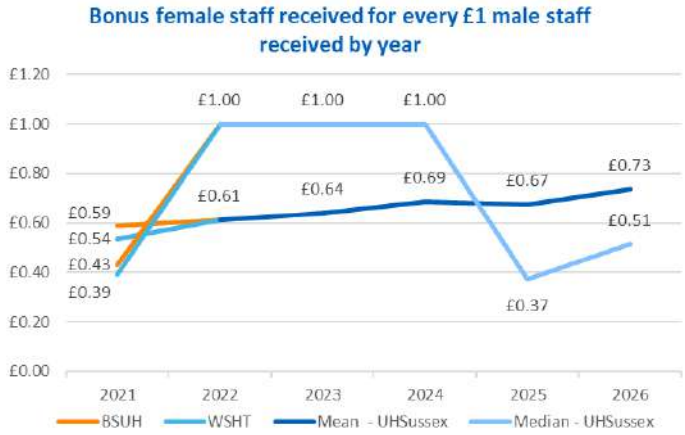
# Gender Pay Gap: Bonuses

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

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

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




## Who Received Bonus Pay?

The chart on the top right shows the percentage of male and female employees who received bonuses:

- 2.14% of male employees received a bonus
- 0.48% of female employees received a bonus
- This means the proportion of male employees receiving a bonus is 346% higher than the proportion of female employees.
- 137 male and 75 female staff received at least one type of bonus.

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

## Bonus Pay Differences

The second chart above right shows changes in the mean and median bonus pay gap over recent years; it shows that male continue to staff receive a higher overall amount in bonus pay compared to female staff. This disparity is primarily due to a greater proportion of male staff receiving bonuses, as well as some male staff receiving multiple types of awards.

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

### Discretionary Points Pay

- Discretionary Points are legacy consultant payments awarded to consultants in recognition of additional responsibilities under previous national arrangements and closed to new entrants. This was awarded to one male employee within the 12 months.

### Clinical Excellence Award

- Clinical Excellence Awards (CEAs) are intended to recognise consultants who make sustained contributions beyond the standard expectations of their role, including excellence in patient care, service development, teaching, research, and leadership. To be eligible, consultants must hold a substantive post and normally have completed at least one year of service at the Trust at the time of application. This includes:
- Local awards - granted by the Trust.
- National awards - granted by the Department of Health and Social Care but paid through the Trust's payroll.
- 129 (66%) male and 67 (34%) female staff received CEA-related payments within the 12-month reporting period.
- There have been national changes to the CEA scheme for consultant medical staff. Local CEAs are no longer awarded, and no new CEAs have been made under post-2018 contract arrangements. However, consultants who received awards prior to these changes retain them on a protected basis until they leave NHS service.

### National Clinical Impact Awards (NCIA)

- National Clinical Impact Awards (NCIAs) are the current national scheme intended to recognise consultants who demonstrate clinical impact beyond their employing organisation, such as regional or national leadership, guideline development, research, education, or service transformation. NCIAs replaced national Clinical Excellence Awards for consultants on newer contract arrangements and are awarded through a nationally managed process. This includes:
- National awards - granted by the Department of Health and Social Care but paid through the Trust's payroll.
- 8 female (53%) and 7 male (47%) staff received a National Clinical Impact Award within the 12 months.

# Gender Pay Gap: Menopause Action Plan

This section is included in line with current Government guidance on voluntary equality action plans alongside gender pay gap reporting. Employers with 250 or more employees may publish an action plan in conjunction with their gender pay gap data, and the guidance indicates that these plans may include actions to address the gender pay gap and to support employees experiencing menopause. This aligns with the Employment Rights Act 2025, which inserted section 78A into the Equality Act 2010, enabling the introduction of such requirements through regulations. Trust actions include:

### Manager Capability and Training

- Support for managers includes a **menopause e-learning module**, inclusion of menopause within the Mental Health Training for Managers programme, menopause-focused peer support sessions, and a managers' Menopause Guide. This guidance includes practical advice and information on recording menopause-related absence.]

### Peer Support and Awareness

- The Trust has delivered a **quarterly Menopause Café** since 2024, with approximately 400 members and around 800 cumulative attendees to date. Sessions typically attract 60-70 colleagues and include specialist input on menopause-related topics. **Resources** are shared via the staff intranet, and **Menopause Awareness Day** is marked annually. Feedback indicates the initiative is valued for both information and peer support.

### Workplace Adjustments

- Menopause Guidance outlines a range of **reasonable workplace adjustments** to support colleagues, enabling flexibility and supporting staff to remain in work.

### Café user quotes

"I know that going through this is a very lonely and frustrating time for women. I often felt that no one was listening and had not a clue what to do. This group is going to empower those women and be a much needed source of information."

- Tracy

"Love the menopause café and the community that's been built, it is such a relief to have a place to learn and not feel alone, thank you"

- Sue

# Delivery actions linked to GPG from the Workforce Inclusion Programme (WIP)

| Indicator | Linked action in the WIP |
|---|---|
| Pay Gap | Self-rostering implementation – Continue to progress self-rostering arrangements to improve flexibility, work-life balance and retention, particularly for staff with caring responsibilities, supporting participation and progression into higher-paid roles. |
| Pay Gap | Supervisor Self-Service implementation - Implement Supervisor Self-Service to improve data accuracy, timely workforce decisions and equitable management of pay, hours and progression. |
| Pay Gap | Flexible working job adverts – Continue to emphasise flexible working options in job advertisements to attract a more diverse applicant pool and reduce barriers to senior and higher-paid roles. |
| Pay Gap | Nursing position title modernisation – Explore modernisation of nursing position titles to better reflect role responsibility, skill and scope, supporting fair evaluation and progression pathways. |

University Hospitals Sussex NHS Foundation Trust

# Ethnicity Pay Gap (EPG) 2026

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www.uhsussex.nhs.uk/equality

# Introduction

As part of our duties under the Equality Act and under the NHS EDI Improvement Plan, we are conducting a comprehensive analysis of **pay disparities** and outlining actions we are taking to eradicate pay differences on the basis of protected characteristics.

Each pay gap is the difference between the average pay of different groups according to their characteristics. The **ethnicity pay gap** is calculated using a comparator approach in which White British staff are used as the reference group, in line with recommended methodology. This compares average hourly and bonus pay between White British staff and other ethnic groups across the workforce.

As with gender pay gap reporting, this does not measure differences in pay for the same role, but differences in average pay across the workforce, influenced by representation across roles, grades and pay bands.

UK employers with 250 or more employees are required to report their gender pay gap data annually. NHS Trusts are now additionally required to report Gender, Ethnicity and Disability pay gaps, with data taken from a 31 March snapshot date.

In 2026, we analysed data relevant for Ethnicity Pay Gap calculations from 18,346 employees. There are six mandatory calculations:

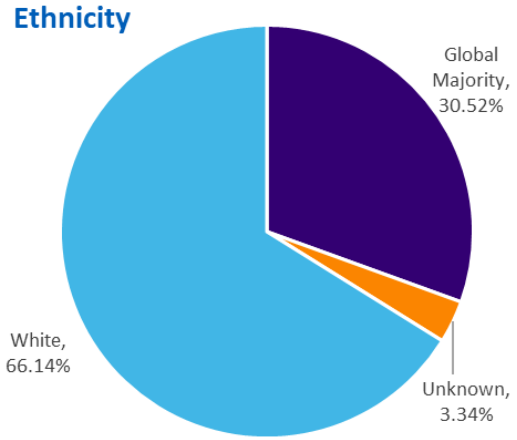
1. Proportion of ethnic groups in each pay quartile
2. Mean (average) ethnicity pay gap for ordinary pay
3. Median ethnicity pay gap for ordinary pay
4. Proportion of ethnic groups receiving a bonus payment
5. Mean (average) ethnicity pay gap for bonus pay
6. Median ethnicity pay gap for bonus pay

We also review:

- the proportion of our total UK workforce from different ethnic groups.
- the proportion of our employees who have shared their ethnicity.

# Summary

As on the 31 March 2026, the average hourly pay for white staff is £23.58, and £23.76 for Global Majority staff, making our average ethnicity pay gap -0.79% and the median ethnicity pay gap -0.33%. Our average bonus ethnicity pay gap is 28.78%. The pie chart shows the overall composition of staff counted for ethnicity pay gap reporting purposes, with Global Majority staff making up 30.52% and white staff 66.14%.




## The ordinary pay gap has decreased

The **pay gap has been slowly decreasing** year-on-year, improving by -3.75% (average) and -1.76% (median) from 2024 to 2025, and again by -2.91% (average) and -2.73% (median) from 2025 to 2026, bringing the overall position **close to parity**.

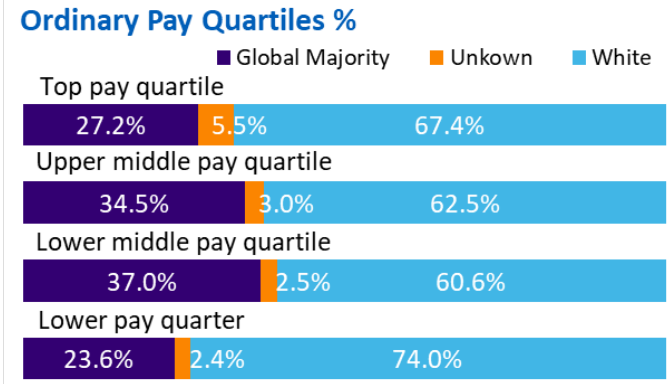
## Our ethnicity bonus gap remains substantial

**White staff were substantially more likely to receive a bonus** than Global Majority staff, with the proportion of white employees receiving a bonus around 70% higher. White British staff also received **higher average and median bonus payments** than most Global Majority groups. All percentages are based on staff included in the pay gap dataset (those in full pay on the snapshot date).

## Our quartile pay gap is slowly changing

The narrowing ethnicity pay gap coincides with increased representation of Global Majority staff in the lower and lower-middle pay quartiles, reflecting growth in entry-level and early-career roles. Improved ethnicity recording has also contributed by increasing the visibility of staff in lower-paid roles.

The chart to the right shows the percentage of Global Majority and white staff as well as the percentage of employees with unknown ethnicity in each pay quartile, indicating a lower percentage of Global Majority staff in lower and top pay quartiles.



## Disaggregated analysis highlights significant variation between ethnic groups

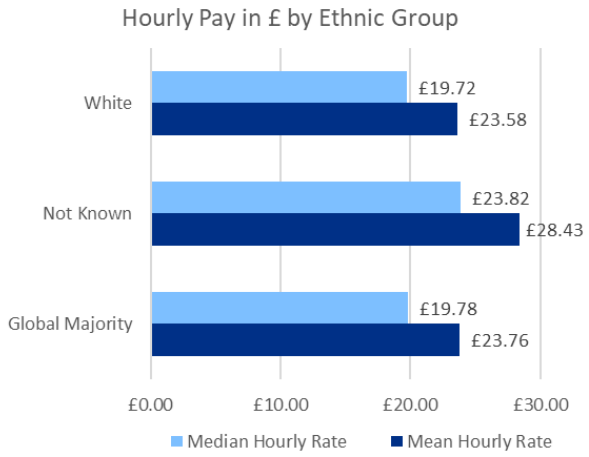
More detailed breakdowns highlight substantial differences in pay outcomes within aggregate ethnic categories. While some groups, including East Asian staff, have higher average and median pay, other historically marginalised groups, particularly South-East Asian and Black staff, continue to experience lower average pay.

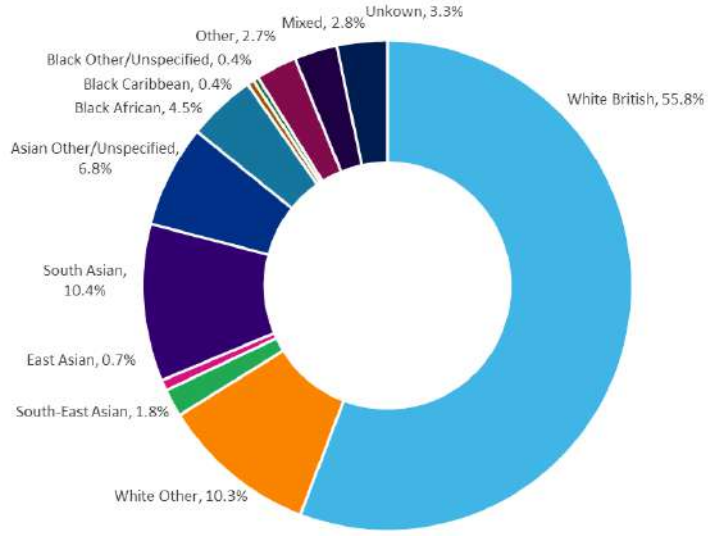
## Disaggregating Ethnic Groups

We provide a breakdown of ethnicity pay gaps that moves away from only a simple white and Global Majority model. Consistent with Government ethnicity pay reporting guidance, single aggregate pay gaps cannot adequately reflect differences between ethnic groups which more detailed breakdowns can. We utilised ONS categories to reflect our largest workforce demographic groups:

- Splitting White British groups (British, English, Scottish, Welsh, Cornish) from all other white groups.
- Splitting South-East Asian, East Asian and South Asian groups
- Splitting Black African and Black Caribbean.

The chart below compares mean and median hourly pay for White staff and Global Majority staff, providing a snapshot of how pay levels differ by broad ethnic group.




The chart above shows the workforce ethnicity profile disaggregated by detailed ethnic groups, which inform the following analyses.

# Ethnicity Pay Gap: Ordinary Pay

### Significant pay gaps exist between ethnic groups

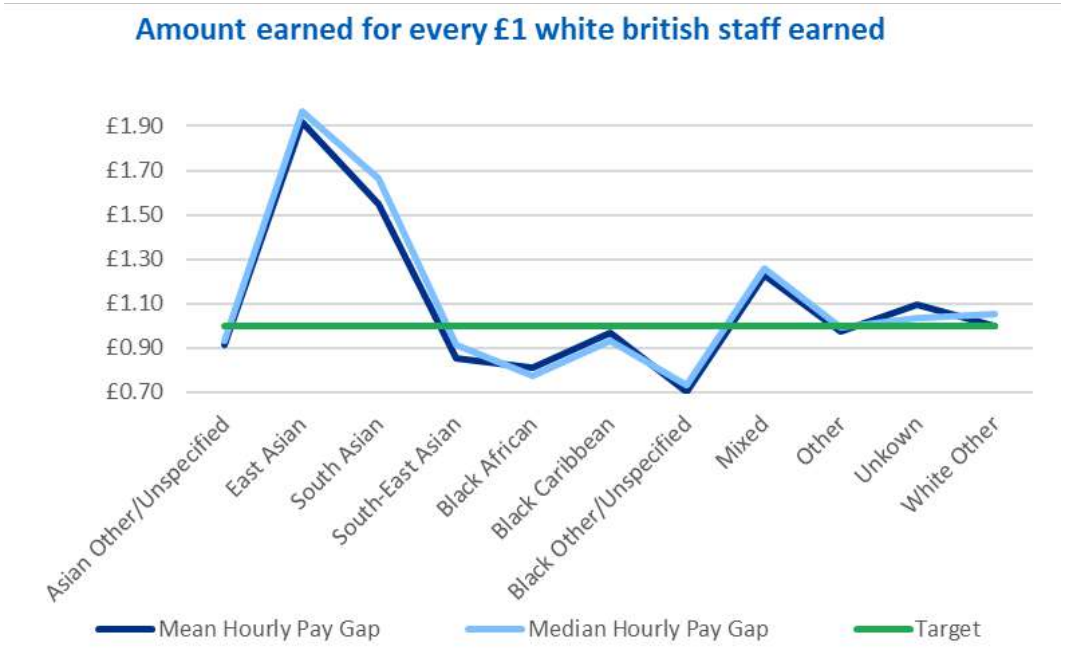
The graph below shows how mean and median hourly earnings compare across detailed ethnic groups, expressed as the amount earned for every £1 earned by White British staff, highlighting variation in pay outcomes between groups:

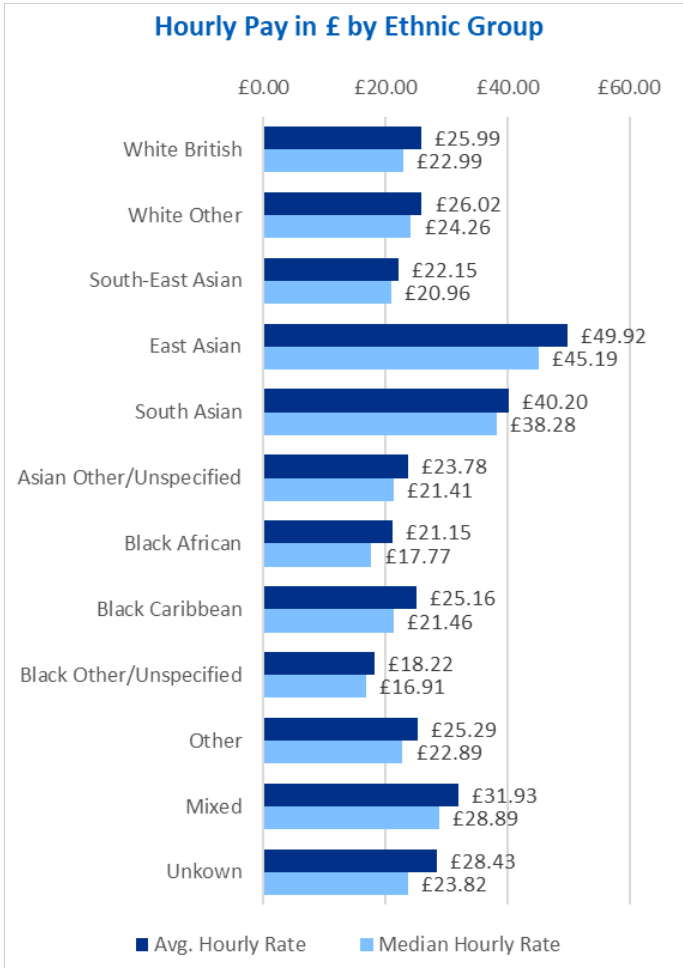
- **Highest Hourly Pay -** The ethnic group with the largest hourly pay is East Asian staff at £49.92 average and £45.19 median. This is significantly higher than the average Asian aggregate hourly pay of £24.03
- **Lowest Hourly Pay -** The ethnic group with the lowest hourly pay is staff from other or unspecified Black backgrounds at £18.22 average and £16.91 median. This is significantly lower than the average Black aggregate hourly pay of £21.30
- **The difference in hourly pay** between these groups is £31.70 / hour on average and £28.27 / hour on median. For reference, the National Living wage on 31 March 2026 was £12.21 / hour.

### Some historically marginalised ethnic groups continue to experience lower average pay

Historically marginalised groups, defined here as ethnic groups that have experienced structural disadvantage, including Global Majority groups, continue to face pay disparities.

This is particularly evident among South-East Asian and Black staff, who earn substantially less on average than several other ethnic groups. Smaller but persistent average pay gaps relative to White British staff are also observed among staff who selected 'Other' and Asian Other/Unspecified categories.






### White British and White Other groups show similar outcomes

The difference in average pay between White British and White Other staff is **small and has remained stable** in recent years, with White Other staff earning £1.00 for every £1 earned by White British staff. This is consistent with previous years (£1.02 in 2025 and £1.01 in 2024), indicating no material divergence in pay outcomes between these two groups.

### Significant variation in pay outcomes between Asian ethnic groups

The chart on the left compares mean and median hourly pay across detailed ethnic groups, providing a more granular view of pay levels beyond the broad demographic groupings.

Average hourly pay differs markedly between Asian ethnic groups. The disparity between East Asian and South-East Asian staff is particularly pronounced, with a difference of £27.77 per hour on average and £24.23 per hour at the median, indicating substantial heterogeneity in pay outcomes that is not visible when Asian groups are considered in aggregate.

### Pay differences by ethnicity and occupational distribution

Some ethnic groups, including East Asian, South Asian, staff from mixed ethnic backgrounds, and staff with unknown ethnicity, have higher average pay than White British staff. This is likely to be influenced by higher representation of these groups in medical and dental roles which attract higher average pay, such as Non-Consultant Career Grade (NCCG) roles.

# Ethnicity Pay Gap: Bonuses

Bonuses were given to eligible employees during the 12 months leading up to the March 2026. Anyone who received more than one type of bonus is counted only once. Bonus payments include:

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

## Who Received Bonus Pay?

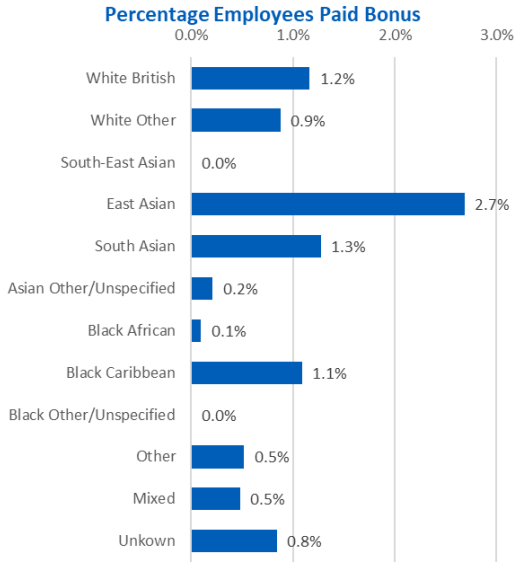
The chart on the right shows the percentage of employees who received bonuses:

- 1.12% of white employees received a bonus
- 0.66% of Global Majority employees received a bonus
- The proportion of white employees receiving a bonus is around 70% higher the proportion of Global Majority employees.

Percentages are calculated using all staff included in the ethnicity pay gap dataset as the denominator, while the counts below reflect the number of staff who received bonus payments during the 12-month reporting period. Only certain staff groups are eligible for these bonuses. In total: 161 white, 43 Global Majority, and 8 staff with unknown ethnicity received at least one type of bonus.

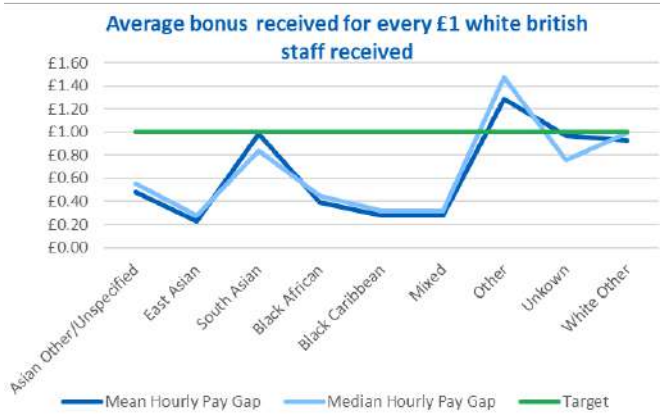
## Bonus Pay Differences

The chart opposite compares the mean and median bonus payments received by staff in each ethnic group. White British staff received higher mean and median bonus payments than most Global Majority groups, with the exception of staff recorded in the “Other” ethnic group. These figures describe the value of awards among staff who received bonus pay and are separate from the proportion of each group receiving a bonus. Differences in average award value may reflect the types and values of awards received, the distribution of eligible staff across roles and, in some cases, receipt of more than one type of award. The available data do not establish the relative contribution of each factor.




31

than



The largest difference in bonus pay to White British staff (with an average bonus of £10,875.29 and a median bonus pay of £9,496.77) was for East Asian staff (£2,516.27, and £2,612.21 respectively). This works out to a mean pay gap of 76.86% and a median pay gap of 72.49%.

University Hospitals Sussex NHS Foundation Trust

# Disability Pay Gap (DPG) 2026

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# Introduction

As part of our duties under the Equality Act 2010 and under the NHS EDI Improvement Plan, we are conducting a comprehensive analysis of pay disparities and outlining actions we are taking to eradicate pay differences on the basis of protected characteristics.

Each pay gap is the difference between the average pay of different groups according to their characteristics. The **disability pay gap** is the difference between non-disabled staff hourly and bonus pay compared to other groups.

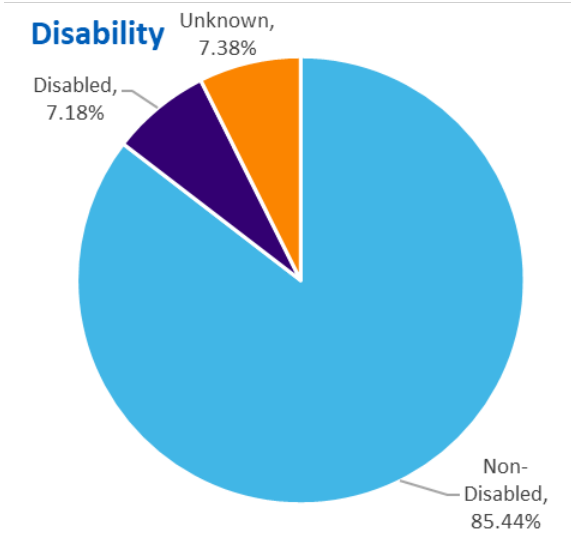
UK employers with 250 or more employees are required to report their gender pay gap data annually. NHS Trusts are now additionally required to report Gender, Ethnicity and Disability pay gaps, with data taken from a 31 March snapshot date.

Using the snapshot date of 31 March 2026, we analysed data relevant to the disability pay gap calculations for 18,303 employees. The analysis comprises six calculations::

1. Proportion of disability status in each pay quartile
2. Mean disability pay gap for ordinary pay
3. Median disability pay gap for ordinary pay
4. Proportion of disability status groups receiving a bonus payment
5. Mean disability pay gap for bonus pay
6. Median disability pay gap for bonus pay

# Summary

As on the 31 of March 2026, the average hourly pay for non-disabled staff is £23.44. It is £21.37 for disabled staff, making our average disability pay gap 8.85% and the median disability pay gap is 10.50%. Our average bonus disability pay gap is -64.13%. The top chart shows the overall composition of staff counted for disability pay gap reporting purposes, with disabled staff making up 7.18% and non-disabled staff 85.44%.




## The ordinary disability pay gap remains significant

As of 31 March 2026, the average disability pay gap was 8.85% and the median gap was 10.50%, with disabled staff earning £0.91 on average and £0.89 at the median for every £1 earned by not-disabled staff. This indicates a meaningful disparity in pay outcomes between disabled and not-disabled staff.

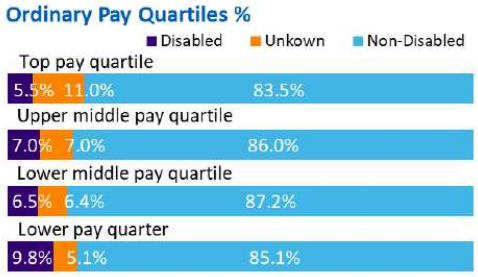
The bottom chart shows the percentage of disabled and non-disabled staff as well as the percentage of employees with unknown disability status in each pay quartile, indicating a lower percentage of disabled staff in the top pay quartile and a higher percentage of staff with unknown disability status in this quartile.

## Pay outcomes vary considerably across disability groups

Disaggregated analysis shows that most disability groups experience lower average pay relative to not-disabled staff, with the largest gaps observed among staff with long-standing illnesses, mental health conditions, and those reporting ‘other’ disabilities. The widest difference is between staff with ‘other’ disabilities and those who have not shared their disability status.

## Our disability bonus gap is mixed and reflects eligibility patterns

Non-disabled staff were around 70% more likely to receive a bonus than disabled staff. However, among those who did receive a bonus, disabled staff had a higher average bonus value, resulting in a negative average bonus gap (-64.13%). This reflects the very small number of disabled staff receiving bonuses and the concentration of awards within a limited number of roles.



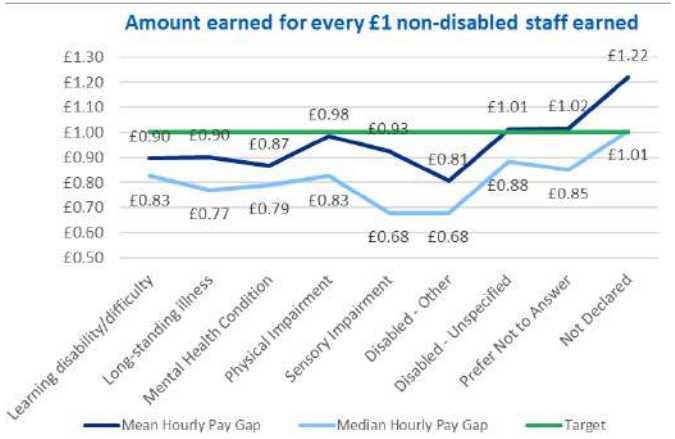
# Disability Pay Gap: Ordinary Pay

This section establishes the average and median differences in hourly rates of ordinary pay between disabled and non-disabled employees.

As on the 31 of March 2026, the average hourly pay for non-disabled staff is £23.44. It is £21.37 for disabled staff. This makes our average disability pay gap 8.85% and the median disability pay gap is 10.50%.

Comparing average hourly wages, disabled staff earned ninety-one pence for every £1 non-disabled staff earned.

Comparing median hourly wages (accounting for the effect of outliers), disabled staff earned eighty-nine pence for every £1 non-disabled staff earned.

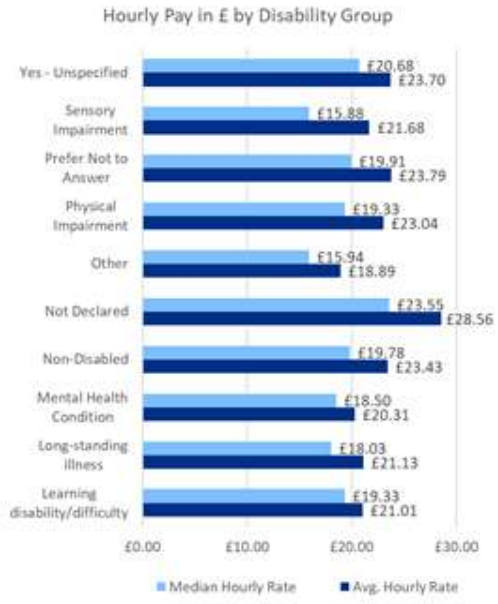



## Significant pay gaps exist between disability groups.

The disaggregated data reveals more information about pay disparity within disability types.

The top chart compares mean and median hourly earnings across disability types, expressed as the amount earned for every £1 earned by non-disabled staff. It highlights variation in relative pay outcomes by disability status. Average pay gaps relative to non-disabled staff are observed among most disability groups, with largest gaps for staff with long-standing illnesses, mental health conditions and 'other' disabilities.

The bottom chart compares mean and median hourly pay across disability types, highlighting how average hourly pay differs markedly between types. The largest disparity is between staff with 'other' disabilities and staff who have not shared their disability status, with a difference of £9.67 per hour on average and £7.61 per hour at the median.



# Disability Pay Gap: Bonuses

Bonuses were given to eligible employees during the 12 months leading up to the snapshot date. Anyone who received more than one type of bonus is counted only once. Bonus payments include:

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

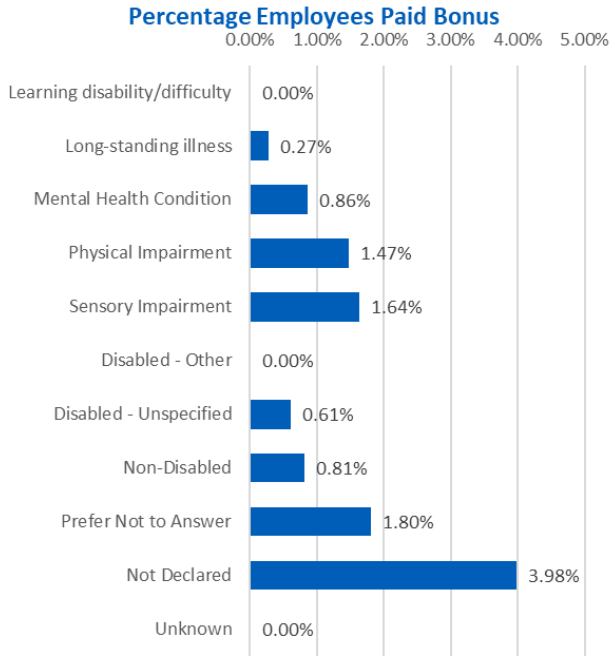
## Who Received Bonus Pay?

- 0.47% of disabled employees received a bonus.
- 0.81% of non-disabled employees received a bonus.
- This means the proportion of non-disabled employees receiving a bonus is around 70% higher than the proportion of disabled employees.

Only certain staff groups are eligible for these bonuses. In total:

- 151 non-disabled, 8 disabled staff, and 87 staff with unknown disability status received at least one type of bonus.

The chart on the right shows the proportion of employees receiving bonus payments by disability type, highlighting variation across types and a notably higher proportion of bonus recipients among staff with disability status not declared. Numbers in individual categories are small, which limits further detailed analysis by disability group.




## Bonus Pay Differences

Among staff who received bonus pay, disabled staff received a mean bonus payment of £22,301.58, compared with £13,587.82 for non-disabled staff. This produces a mean disability bonus pay gap of −64.13%. However, only eight disabled staff received a bonus, so the result is highly sensitive to the value of individual awards and should be interpreted with caution. Non-disabled staff remained more likely to receive a bonus overall. The available data do not establish why the mean award was higher among disabled recipients.

NHS
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NHS Foundation Trust

# Appendix

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# Appendix 1: WRES and WDES

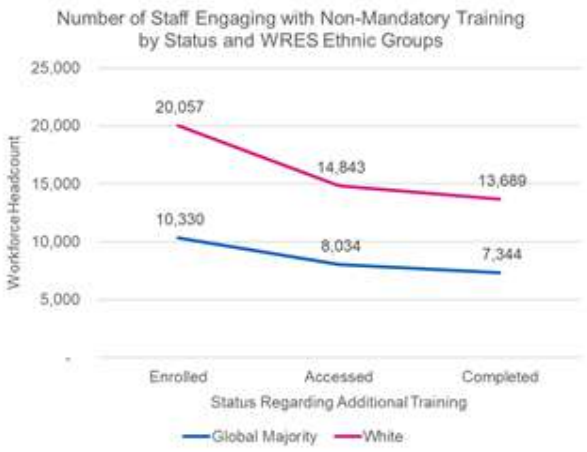
## WRES 4: Non-mandatory training

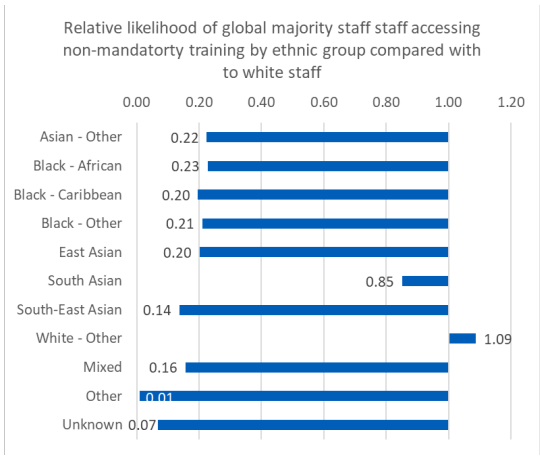
The WRES Indicator 4 assesses the relative likelihood of staff accessing non-mandatory training and Continuing Professional Development (CPD). Analysis shows that White staff (n = 14,843) were **as likely as Global Majority staff** (n = 8,034) to access non-mandatory training, with a relative likelihood ratio of 0.85. This ratio falls within the WRES equality range (0.8-1.25) and has remained stable over the past four years, indicating **sustained equity in access at an aggregate level**.

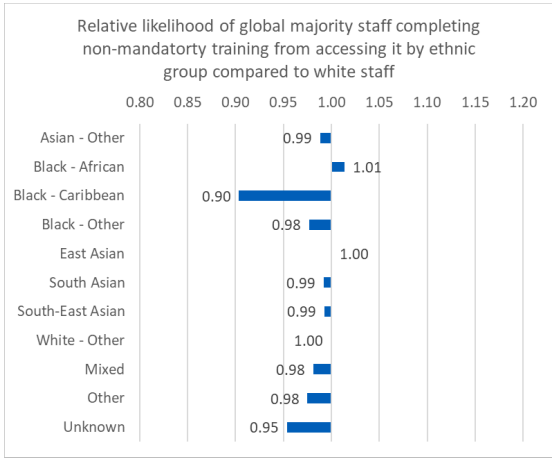
While the aggregate comparison suggests broadly equitable access, this can mask variation between individual ethnic groups.

To better reflect the Trust's ethnic diversity and move beyond the binary White versus Global Majority comparison, a more granular analysis was also undertaken. When comparing access to non-mandatory training, **most ethnic groups were found to be substantially less likely to access training opportunities than White British staff**. The exceptions to this pattern were South Asian and White Other staff, whose access rates were more comparable to those of White British staff.

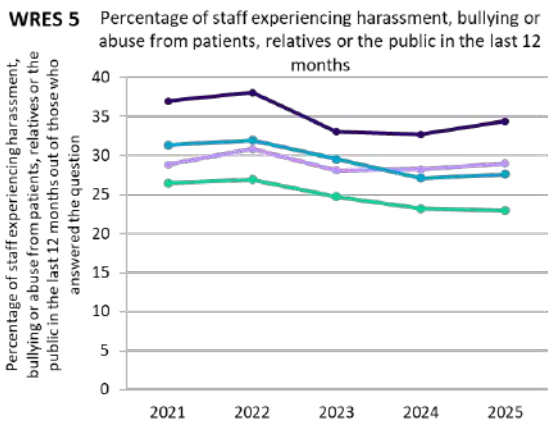
Importantly, once non-mandatory training was accessed, **completion rates were equitable across all ethnic groups**, indicating that observed disparities relate primarily to access rather than progression or completion.

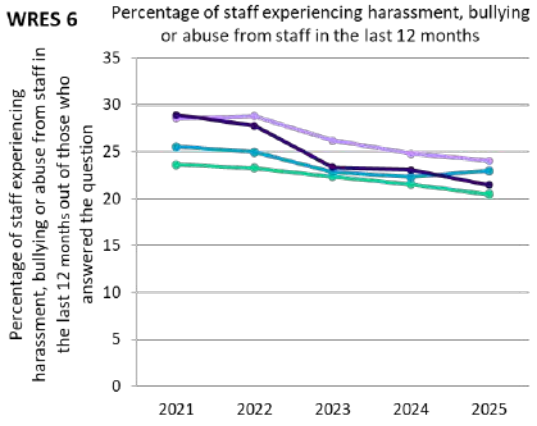

Number of Staff Engaging with Non-Mandatory Training by Status and WRES Ethnic Groups
25,000
20,000
15,000
10,000
5,000
-
Workforce Headcount
20,057
14,843
13,689
10,330
8,034
7,344
Enrolled
Accessed
Completed
Status Regarding Additional Training
Global Majority
White

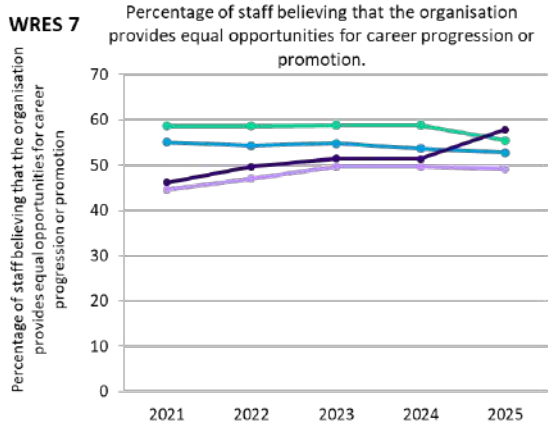

Relative likelihood of global majority staff staff accessing non-mandatorty training by ethnic group compared with to white staff
0.00
0.20
0.40
0.60
0.80
1.00
1.20
Asian - Other 0.22
Black - African 0.23
Black - Caribbean 0.20
Black - Other 0.21
East Asian 0.20
South Asian 0.85
South-East Asian 0.14
White - Other 1.09
Mixed 0.16
Other 0.01
Unknown 0.07

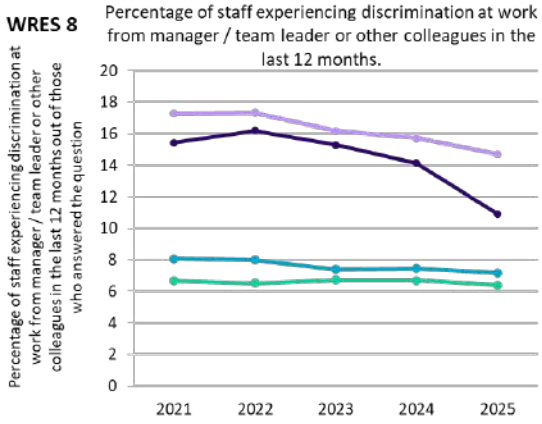

Relative likelihood of global majority staff completing non-mandatorty training from accessing it by ethnic group compared to white staff
0.80
0.85
0.90
0.95
1.00
1.05
1.10
1.15
1.20
Asian - Other 0.99
Black - African 1.01
Black - Caribbean 0.90
Black - Other 0.98
East Asian 1.00
South Asian 0.99
South-East Asian 0.99
White - Other 1.00
Mixed 0.98
Other 0.98
Unknown 0.95

# WRES 5-8: Staff experience indicators




White staff: UHSussex

All other ethnic groups*: **UHSussex**

White staff: National Average

All other ethnic groups*: National Average

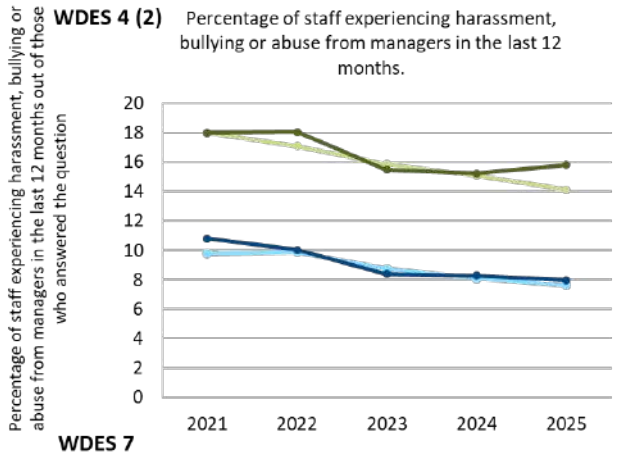
These charts show trends over time for staff survey indicators 5 to 8, comparing the experiences of White staff and all other ethnic groups at UHSussex with national averages.

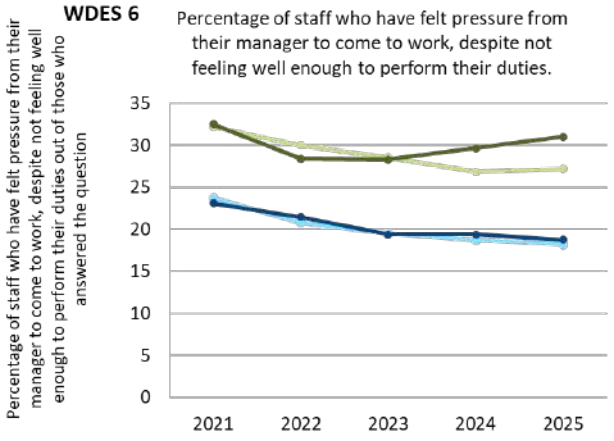
For indicator 5, UHSussex reports **higher levels of bullying, harassment or abuse from patients, relatives or the public** than the national average for both White staff and all other ethnic groups.

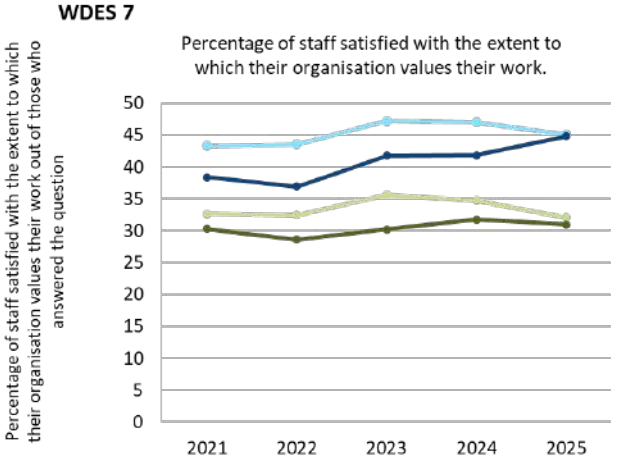
For indicator 6, White staff report **higher levels of bullying, harassment or abuse from staff than the national average**, while staff from all other ethnic groups report lower levels than the national average.

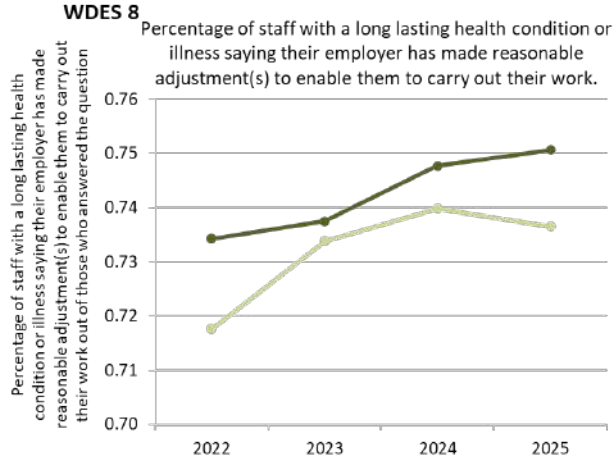
Indicator 7 shows a **marked increase in the proportion of staff from all other ethnic groups who believe the organisation provides equal opportunities for career progression or promotion**, now exceeding both White staff locally and national averages.

For indicator 8, reported **discrimination for staff from all other ethnic groups has decreased significantly** over time; while levels remain higher than for White staff, the **rate of improvement exceeds that seen nationally**. Overall, these indicators show a mixed position, with areas of poorer performance against national benchmarks alongside evidence of improvement over time.




## WDES 4(2) and 6-7: Staff experience indicators

These indicators show trends over time for staff with and without a long-term condition at UHSussex compared with national averages.

Across indicators 4 and 6, staff with a long-term condition consistently report poorer experiences than those without, including **higher levels of harassment and pressure from managers.**

Indicator 7 shows some improvement in staff satisfaction over time for both groups, but this has **stalled in the past year for staff with a long-term condition**.

- Staff with a LTC or illness: UHSussex
- Staff without a LTC or illness: UHSussex
- Staff with a LTC or illness: National Average
- Staff without a LTC or illness: National Average

Indicator 8 demonstrates an increase in the proportion of staff with a long-term condition reporting that reasonable adjustments have been made. Overall, while there is evidence of improvement in some areas, disparities in staff experience between those with and without a long-term condition persist.

# Appendix 2: Staff Networks

## Armed Forces Network

This has been a highly active and impactful year for the Armed Forces Network, with a range of initiatives aimed at supporting colleagues, strengthening community engagement and raising awareness of the Armed Forces community within the Trust.

Key highlights over the past year include the first-year anniversary of Veterans' Voices in April with interviews with many prominent veterans as well as service-focused content alongside recommendations to improve services for the Veteran cohort. The network has also delivered a number of high-profile fundraising and engagement events, including our first Regimental Dinner at Hove Club attended by SAS legend Billy Billingham to raise funds for Southlands Commemorative Garden and Coco's Spinnaker Tower abseil in April to raise funds for an RAMC Tommy statue.

The Network has also taken part in two Medical Endeavours, including a UHSussex team win. We have organised a strong presence in Southlands at key commemorative events such as Remembrance, VE Day and VJ Day services. Additional activities have included laying a wreath at the Chattri memorial service to honour the contribution of Sikh, Hindu and Muslim service personnel; hosting Armed Forces Network stands across Trust sites during Armed Forces Week and attending community remembrance events across East and West Sussex.

Alongside these activities, the network continues to provide direct support to Veteran staff members on HR issues. The Trust has also maintained its Veteran Aware status and successfully renewed "Gold" status for a further year.

The network has put forward a proposal for a PTSD Allotment Therapy Garden to support staff, patients and veterans, demonstrating a continued focus on wellbeing and therapeutic support.

Challenges remain, particularly in raising awareness and ensuring communications such as Veterans' Voices reach all staff. As with other networks, balancing network activity alongside day-to-day roles can be challenging and recruiting members to support events across sites remains an ongoing priority. There are also practical challenges in consistently recording and extracting Veteran status from patient administration systems.

Looking ahead, the network will focus on delivering planned projects, including the installation and unveiling of the Tommy statue and participation in further Medical Endeavours. Future fundraising activities include a proposed charity bike ride from Southlands to the National Arboretum to fund the installation of a plaque recognising the contribution of Sikh, Hindu and Muslim communities in both World Wars. The network is also developing an educational video to further raise awareness and understanding of the Armed Forces community.

*"I am really pleased to see the continued development of Veterans' Voices. The fact that this is grounded in Veterans' own experiences gives it real value and the recommendations feel both thoughtful and important"*

Andy Heeps, CEO

*"I read Veterans' Voices from the Armed Forces Network. Last Thursday I reviewed a man in his 70s in a Care Home […]. He mentioned […] that he'd been in the Army before but I didn't ask him more about it. Now, having read Veterans' Voices, I'd definitely explore it more next time. The signs of combat stress that Veteran Liz McConaghy talked about were all there in him as well"*

Dr Rafi Rogans-Watson, Consultant Geriatric Medicine

## Carers Staff Network

The Carers Network is now in its third year, and membership continues to grow.

The network holds monthly meetings where members can share experiences and offer peer support. Participants report that these sessions are a positive experience, helping to reduce feelings of isolation and supporting colleagues to address challenges related to their caring responsibilities. The network continues to explore ways to engage colleagues who are not yet aware of its work or are unable to attend events.

Carers Rights Day Conference 2026 – Panel Discussion

Panel members discuss support for carers in the workplace. From left to right: Jourdan Durairaj (Head of Inclusion), Zoe Larkai-Doherty (Carers UK), Dr Maggie Davies (Chief Nurse), Dom Duke (Carers Network Lead), Nick Groves (Associate Director, Leadership, OD & Engagement), and Faye Heffernan (Health, Wellbeing & Engagement Programme Manager).

In November 2025, the network hosted a Trust-wide conference to mark National Carers Rights Day, themed *Caring at a Distance*, recognising colleagues who provide unpaid care for loved ones who live far away. The event was attended by members of the Trust's Executive Team and included speakers covering financial and pastoral wellbeing, national initiatives to promote carers' rights, the realities of transnational caring, and strategies to support mental health and resilience. The event concluded with a panel discussion exploring how colleagues could be better supported through policies and targeted training for line managers.

Dom Duke, Carers Network Lead (left), and Michael Shann, Head of Carer Support at Carers UK (right).

The network continues to work closely with external organisations supporting unpaid carers at local and national levels, as well as with other staff networks and the Health and Wellbeing Team.

In June 2025, the network hosted information stalls across Trust sites as part of Carers Week. Several carers engaged directly with network representatives, and a number of staff members took away resources to share within their teams and work areas. Since the event, the network has seen increased awareness and growing membership.

Through funding from My Charity NHS Sussex, the Trust remains a member of Employers for Carers, providing all staff with access to a range of resources for carers, line managers, and senior leaders.

The network is grateful to Maggie Davies (Chief Nurse) for her support as Executive Sponsor since its inception. While this contribution is greatly valued, the network is pleased to welcome Nigel Kee (Interim Chief Delivery Officer) and Helen Brown (Interim Chief Corporate Affairs Officer) as new Executive Sponsors.

Carers Week 2025 – Carers Staff Network Information Stall at Princess Royal Hospital

Carers Week 2025 – Information Stall in the Louisa Martindale Building Foyer, Royal Sussex County Hospital

## Disabled Staff Network

The UHSussex Disabled Staff Network (DSN) continues to provide support, guidance and advocacy for disabled colleagues and those with long-standing health conditions. The network aims to improve staff experience, promote inclusion and ensure that disabled colleagues are supported to thrive within the Trust.

The DSN holds monthly meetings via Microsoft Teams. To maximise accessibility, sessions are scheduled on different days and at varying times to accommodate colleagues working non-standard or rotational shifts. This recognises that many staff do not work traditional Monday–Friday, 9–5 patterns and helps ensure equitable access to network support.

Network leads regularly attend Welcome Days and the annual Staff Conference to introduce the network to new and returning staff. These events provide opportunities to raise awareness of the DSN and its purpose, offer signposting to the Inclusion Team for guidance on legal rights and reasonable adjustments, direct managers to relevant training and resources, and engage directly with colleagues who may require workplace support.

Marce Quinn (former Disabled Staff Network Lead) at the National Deaf and Hard of Hearing Conference.

Lisa Bunt, Disabled Staff Network Lead, at a Coffee & Connect session.

Reaching staff with limited access to the intranet remains a key challenge. To address this, the DSN delivers monthly Coffee & Connect sessions across Trust sites, including Worthing, Brighton, Chichester and Haywards Heath. These sessions enable one-to-one conversations with colleagues in roles such as Housekeeping, Hospitality, Portering and Estates, who may otherwise be unaware of the network. This approach has increased membership and improved visibility of DSN support.

It was identified that some DSN members would benefit from additional support related to neurodiversity. In response, two members have established a Neurodiversity Group, with the first meeting scheduled to commence in July 2026.

Planning is underway for a half-day seminar in December 2026 to align with Disability History Month, focusing on awareness, education and celebrating the contributions of disabled colleagues across the Trust.

In addition, a member survey developed by the DSN Co-Lead is planned in 2026 to assess whether the network is meeting members' needs, identify gaps in support, and gather suggestions for future priorities. There are opportunities for DSN activities to be more consistently promoted across internal channels.

The DSN continues to expand its reach, strengthen engagement and provide meaningful support to colleagues across UHSussex. Ongoing challenges around communication and visibility remain, but the network's proactive initiatives demonstrate a sustained commitment to improving staff experience and fostering an inclusive workplace culture.

Staff members at a Coffee & Connect session.

## LGBTQIA+ Staff Network

The LGBTQIA+ Staff Network has had another active and impactful year. A relaunch under Emily Bevan's leadership significantly increased both visibility and the breadth of activity, followed by the appointment of Co-Chair Billie Strickland. Emily later stepped down after delivering an extensive programme of events and opportunities for members, which has provided a strong foundation for continued growth.

Emily Bevan (former LGBTQIA+ Staff Network Lead) at the Lesbian Visibility Week 2026 stall.

Chris Jepson (Project Uncut) delivering a seminar for the UHSussex LGBT+ History Month 2026 event.

Alongside the reintroduction of regular network meetings and guest speakers, the network expanded its offer to include a wide range of internal and external social events. Larger projects have also come to fruition over the past year, reflecting the continued development and ambition of the network.

Through meetings and recordings shared via the network's Teams channel, members have engaged with a diverse range of speakers, including artists and performers, Freedom to Speak Up Guardians, LGBTQIA+ colleagues, researchers in queer healthcare, senior leaders, and clinicians involved in inclusive outreach. These sessions have created valuable spaces for learning, visibility and dialogue.

Social events across the Trust's catchment area have included informal gatherings such as coffee mornings, pub socials, picnics and cultural events, as well as supportive spaces in response to recent national and political developments affecting LGBTQIA+ communities. The network has also contributed to conferences and staff inductions, delivered events during LGBTQIA+ History Month and Lesbian Visibility Week, and worked closely on preparations for Pride 2026.

A significant development this year has been the introduction of two administrative support roles, funded through pooled network charity funding. This has strengthened the network's capacity, enabled a more sustainable and coordinated programme of activity and increased its reach across the Trust.

The network continues to grow in both engagement and impact, providing a visible and supportive space for LGBTQIA+ colleagues and allies.

Dr Michael Brady (NHS England) speaking at the National LGBT+ Health Conference in London, attended by network members.

Staff celebrating Pride 2025 in the Louisa Martindale foyer at the Royal Sussex County Hospital.

Staff celebrating Pride 2025 at the LGBTQIA+ Community Parade in Brighton.

## Multicultural and Ethnic Diversity Staff Network

The Multicultural and Ethnic Diversity Staff Network has continued to grow its reach and influence, creating opportunities for connection, representation and meaningful dialogue across the organisation. Reflecting evolving language and feedback from members, the network has recently transitioned from its previous name, BAME/Global Majority, to its current name, alongside the introduction of a new logo. This change demonstrates a continued commitment to ensuring the network is inclusive and representative of the colleagues it supports. New site-specific leads have also been introduced to strengthen local engagement.

Staff celebrating Onam 2025 at the Princess Royal

Key events such as Race Equality Week**,** Onam, Philippines Independence Day, and Black History Month have provided valuable opportunities for celebration and engagement.

Staff celebrating Philippines Independence Day 2026.

The network continues to provide strong pastoral support through active group spaces and safe environments where colleagues can connect, share experiences, and support one another. This includes peer support, signposting, and opportunities to come together through activities such as Filipino mass and choirs.

However, some challenges remain, particularly in enabling staff to attend network activities due to limited release time, as well as improving engagement at formal meetings. Despite this, attendance at cultural celebrations and network-led activities has been strong, with events consistently well attended and positively received.

Looking ahead, the network aims to further strengthen in-person engagement and visibility across all sites. Plans include a hospital tour with stalls to introduce the refreshed network and encourage face-to-face engagement; closer working with ward managers to understand local challenges and identify opportunities for support; and increased participation in formal meetings. Upcoming

events, including Onam celebrations across all sites and Black History Month activities, will continue to support engagement and connection across the workforce.

Staff celebrating Onam 2025 with a traditional floral display (pookalam).

Staff gathered in front of food stalls during the Philippines Independence Day 2026 celebration.

## Religion and Belief Staff Network

The Religion and Belief Network provide a safe and inclusive space for colleagues of all faiths and none, where individual beliefs, values and identities are respected and supported. The network also welcomes allies who wish to listen and learn, supporting greater awareness and understanding across the Trust.

Jo Elliot (Religion and Belief Staff Network Lead) and Anthony Aboh (Staff Networks Project Support Manager) at the Inclusion and Health and Wellbeing Roadshow in Brighton.

The network operates in a collaborative and respectful way, with facilitated discussions that encourage open conversation while maintaining confidentiality. This approach aims to ensure that all participants feel welcomed, heard and supported.

Over the past year, the network has hosted a range of speakers and discussions on topics including fasting, with perspectives shared from Christian, Muslim and Jewish faiths, as well as sessions on staying safe at work, responding to hate speech, accessing support, and exploring themes such as mercy and prayer practices.

UHSussex Finance Conference – Corrinn Moustakim, Vital Azambourg, Johnathan Reid and Sam O'Mahoney at the My Charity stall.

The network has also supported colleagues observing Ramadan by sharing information on fasting times, helping colleagues who were working to identify when the fast would be broken. This provided practical support for colleagues who were away from home or their usual community during this important time.

Looking ahead, the network aims to further strengthen links with other staff networks and continue providing a supportive and inclusive space for colleagues across the Trust.

## Trans and Non-Binary and Intersex (TNBI) Staff Network

The Trans, Non-binary and Intersex (TNBI) Network, like the wider LGBTQIA+ Network, has seen a transition in leadership over the past year, with a valued Chair stepping down and a new Chair stepping into the role. Together, they have supported the continued delivery of social events and network meetings, creating safe and supportive spaces for members during a particularly challenging period, while also engaging with local, regional and national networks to influence decision-making and respond to ongoing developments following the Supreme Court judgement.

Over the past year TNBI people have experienced significant emotional impact from legislative updates, ramifications of the Cass Review, media campaigns, and draft EHRC guidance. Reports from TNBI network members highlight marked negative effects for in many areas of life. While this context has limited opportunities for celebration, it has strengthened the resolve of network members and leaders, resulting in a renewed focus on peer support, education initiatives and organisational engagement.

Key highlights include a meaningful Trans Day of Remembrance event delivered in collaboration with the Religion & Belief Network and collaborating with researchers to improve perinatal care for TNBI patients. The introduction of two administrative support roles, funded through pooled network charity funding, has also significantly strengthened the network's capacity to deliver activity and support members.

The TNBI Network aims to continue building on this work through expanded education initiatives, further provision of safe and inclusive spaces for members, and ongoing collaboration with national colleagues to support research and advocacy for TNBI communities.

## Women's Staff Network

The Women's Staff Network has built significant momentum over the past year, providing opportunities for networking, development and engagement.

Tori Cooper (Women's Staff Network Lead) and staff members at an International Women's Day 2026 Coffee & Connect session.

The Women's Network celebrated International Women's Day with a week-long programme of webinars and networking events centred on the theme Give to Gain. The initiative was designed to inspire collaboration, allyship, career development and meaningful connections across UHSussex. Featuring a diverse range of internal and external speakers, the programme created opportunities for colleagues to learn, share experiences and champion gender equality in the workplace. By increasing the network's visibility, fostering collaboration and raising awareness of its purpose, the campaign significantly boosted staff engagement and resulted in the Women's Network almost doubling its membership during the campaign period, strengthening its reach, influence and ability to represent the voices of women across the organisation.

Staff members attending the Trust's International Women's Day 2026 Coffee & Connect session.

Building on the success of the International Women's Day programme, the Women's Network is expanding opportunities for members to connect in person. Responding to feedback from colleagues, two face-to-face networking events have been scheduled for 17 July and 4 September 2026, providing dedicated spaces to build relationships, share experiences, strengthen peer support and continue growing an inclusive community across UHSussex.

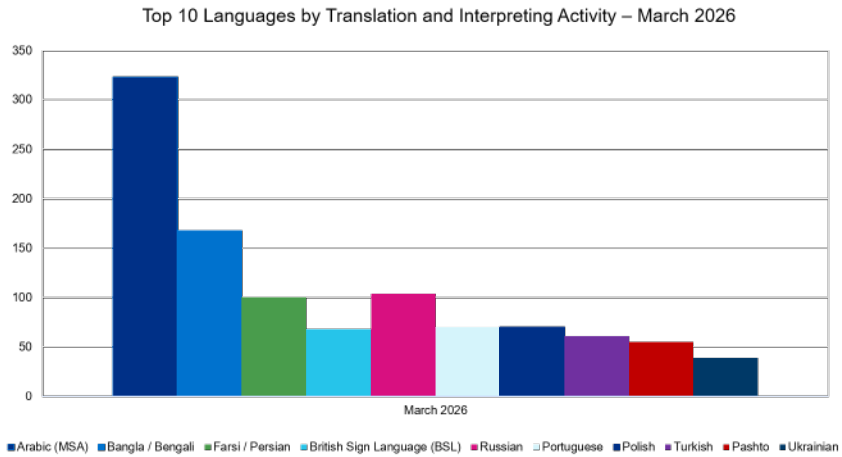
The continued growth of the Women's Network presents an exciting opportunity to strengthen its leadership. Over the coming months, we will appoint Site Leads across each hospital site, creating a network of local champions who will support members, drive engagement, identify local priorities and ensure the voices of women are represented and heard throughout UHSussex.

Staff members at an International Women's Day 2026 celebration.

# Appendix 3: Translation and Interpreting

This appendix provides a summary of translation and interpreting activity across University Hospitals Sussex during the 2025/26 financial year. Demand for communication support remained consistently high throughout the year, with activity and expenditure remaining stable.

## Understanding Patient Need




Translation and interpreting demand are concentrated within a relatively small number of languages. In March 2026, the ten most frequently requested languages accounted for approximately 60% of activity during that month. Arabic, Bangla/Bengali and Farsi/Persian were the most requested spoken languages, alongside continued demand for British Sign Language (BSL). This pattern highlights opportunities to target translated materials, patient communications and engagement activity where need is greatest. The continued demand for both spoken language and sign language support demonstrates the importance of accessible communication in enabling patients to understand information, engage in decision-making and access services equitably. Activity was concentrated at Royal Sussex County Hospital, which accounted for approximately 62% of all recorded bookings during 2025/26, reflecting its role as the Trust's largest acute site.

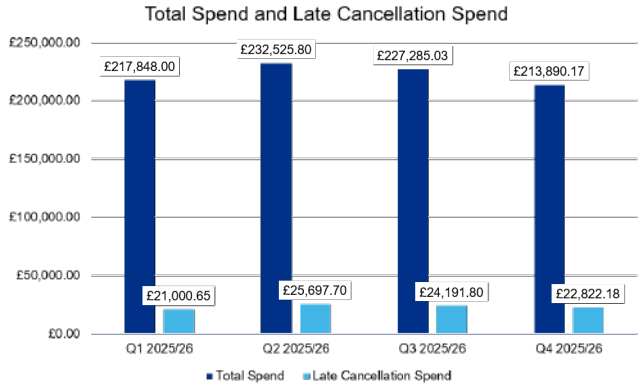
## How Services Are Being Delivered

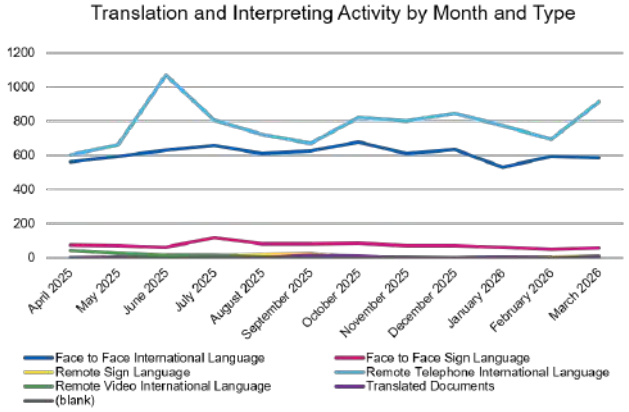
The Trust continues to utilise a range of interpreting methods, including face-to-face, telephone, video and sign language provision. Activity levels have remained broadly consistent across delivery models; however, remote telephone interpreting is now the most frequently booked interpreting modality and has continued to grow over the last year. This reflects increasing use of flexible access routes that enable timely communication support across a wide range of clinical settings. Translation of written documents remains a smaller but important component of overall activity.

Alongside formal interpreting services, the Trust continues to utilise digital communication tools such as CardMedic, which provides multilingual and accessible patient information in a range of languages and formats. Both usage and staff registrations have increased during the year, demonstrating growing adoption of accessible communication resources to support patient understanding, engagement and inclusion.

## Service Efficiency and Value

Demand and spend for translation and interpreting services remained stable throughout 2025/26, averaging approximately 1,300 bookings and £70,000 per month. While overall demand remains significant, late cancellation activity continued to decrease as a proportion of overall bookings, and late cancellation expenditure remained low and broadly stable as a proportion of total spend. Analysis of annual spend per activity also indicates that costs for several interpreting modalities have either stabilised or reduced over time.



# Appendix 4: Equality Delivery System (EDS) Grades 2026

This summary provides an indicative assessment of the Trust's progress against Domains 2 and 3 of the Equality Delivery System 2022. It draws on the Annual Workforce Equality Report 2026, the NHS Staff Survey, WRES and WDES, employee-relations and Freedom to Speak Up information, staff network insight and relevant external assurance.

These ratings will be confirmed through engagement with the relevant stakeholders.

## Domain 1: Commissioned or provided services

The assessment below provides a provisional Trust-level position based on the evidence available within the Annual Workforce Equality Report 2026. The formal EDS 2022 process requires assessment of three selected services, supported by engagement with patients, carers, communities and relevant voluntary, community and social enterprise organisations. The ratings should therefore be confirmed through the full service-level assessment process.

| Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|
| **1A: Patients and service users have required levels of access to the service** | • The Trust has begun to compare outpatient, inpatient and Emergency Department activity with the demographic profile of the Sussex population.<br>• The recorded proportion of activity relating to Global Majority patients was lower than the Sussex population benchmark across the three care settings reviewed. However, activity data alone cannot determine whether access is equitable because it does not account for population need, age, referral routes, service catchments, case mix or repeat use. | **1** | CDO / CNO |

| Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|
| | • Younger patients, particularly those aged 16–24, had the highest outpatient did-not-attend rate, at 9.4%, indicating a potential access or engagement issue requiring further investigation.<br>• Incomplete ethnicity recording ranged from 13.0% of inpatient activity to 19.4% of Emergency Department activity. Patient-level information is also not consistently available for disability, gender identity, sexual orientation, caring responsibilities or Armed Forces status.<br>• The Trust has therefore identified potential differences and data limitations, but cannot yet demonstrate consistently equitable access across protected and inclusion-health groups. | | |
| **1B: Individual patients' and service users' health needs are met** | • The service-user equality profile recognises that demographic information is required to understand differences in access, experience and outcomes.<br>• The available evidence provides some analysis by ethnicity, age and sex, and identifies the need for services to consider different population profiles and patterns of service use.<br>• Consistent patient-level information is not currently available for several characteristics, including disability, gender identity, sexual orientation, caring responsibilities and Armed Forces status. This limits assurance that individual accessibility, communication, cultural and support needs are being systematically identified and met.<br>• The report does not yet provide Trust-wide evidence that reasonable adjustments, accessible communication, personalised care and culturally responsive support are consistently recorded, delivered and evaluated.• Further development of demographic recording and service-level assessment is therefore required. | **1** | CNO |
| **1C: When patients and service users use the** | • During 2025/26, one incident met the criteria for a Patient Safety Investigation where discrimination was suspected. The concern related | **1** | CNO |

| Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|
| **service, they are free from harm** | to possible differential treatment associated with alcohol dependency, poverty and related behaviours.<br>• A local learning review was completed with Executive oversight and safeguarding involvement. It identified opportunities to improve assessment, documentation, communication between services and referral to appropriate support.<br>• This demonstrates that discrimination, stigma and exclusion can be considered within patient-safety review and organisational learning.<br>• However, the report does not yet provide systematic analysis of patient-safety incidents, harm, safeguarding outcomes or complaints by protected characteristic or inclusion-health group. It is therefore not possible to determine whether all groups are equally protected from avoidable harm. | | |
| **1D: Patients and service users report positive experiences of the service** | • The Trust has established patient-feedback, complaints and engagement arrangements, but the Annual Workforce Equality Report does not include detailed analysis of patient experience by protected characteristic or inclusion-health group.<br>• The available evidence does not yet demonstrate whether patients from different communities experience services equitably, whether identified differences have informed improvement action, or whether actions have resulted in measurable change.<br>• A developing rating is assigned provisionally, subject to confirmation through Friends and Family Test information, complaints, patient-experience data and engagement with patients, carers and communities during the formal service-level assessment. | **1** | CNO |

**Domain 1: Commissioned or provided services provisional rating = 4**

The provisional assessment indicates developing activity. The Trust has begun to improve its understanding of differences in patterns of service use and has identified significant limitations in the completeness and consistency of patient demographic information. There is also evidence that discrimination and stigma have been considered within patient-safety learning.

However, the available evidence does not yet provide sufficient assurance that access, individual needs, freedom from harm and patient experience are being systematically assessed across protected characteristics and inclusion-health groups. Priorities include improving demographic data quality, analysing access and experience at service level, strengthening equality analysis within patient-safety and complaints processes, and demonstrating that patient and community insight results in measurable improvement.

The Trust will need to complete a formal Domain 1 assessment using three selected services to fully comply:

- one service where the available evidence indicates relatively strong equality performance;
- one service where evidence indicates that improvement is required; and
- one service where equality performance is currently not sufficiently understood.

The final ratings would be informed by quantitative and qualitative evidence and engagement with patients, carers, communities and relevant voluntary, community and social enterprise organisations.

## Domain 2: Workforce health and well-being

| Outcome | Evidence and progress | Rating | Owner |
|---|---|---|---|
| **2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions** | • Work-related stress, pressure to work when unwell and workplace adjustments are monitored through the NHS Staff Survey and WDES, including analysis by protected characteristic<br>• Of staff who required workplace adjustments, 75.1% reported that adequate adjustments had been made. This has improved, although approximately one in four staff requiring adjustments did not feel adequately supported<br>• A centralised reasonable-adjustments service has been introduced to improve consistency and access. Its performance measures, evaluation | **2** | CPO |

| Outcome | Evidence and progress | Rating | Owner |
|---|---|---|---|
| | arrangements and longer-term outcome measures require further development<br>• Disabled staff and several other workforce groups continue to report substantially higher levels of work-related stress and less positive experiences of support. | | |
| **2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source** | • Harassment, bullying, abuse, violence and sexual harassment remain significant concerns and are experienced disproportionately by some protected groups.<br>• During 2025/26, 3,721 violence and aggression incidents and 47 sexual-harassment incidents were recorded through Datix<br>• In the NHS Staff Survey, 10.7% of staff reported sexual harassment from patients, relatives or the public, compared with 9.1% nationally. A further 4.3% reported sexual harassment from managers, team leaders or colleagues, compared with 3.5% nationally.<br>• Particularly high levels were reported by younger, disabled, non-binary, bisexual and trans or gender-diverse staff, although some findings are based on small numbers.<br>• Violence Prevention and Reduction heatmaps, hotspot analysis, targeted training, awareness activity and inclusion-focused interventions are in place. However, external assurance has identified continuing concerns about misogyny, sexual safety, psychological safety and whether concerns are consistently acted upon. | **1** | CPO |
| **2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment and** | • Freedom to Speak Up arrangements are established and provide an independent route outside line management. Discrimination and inequality were identified as primary or secondary themes within a number of cases during 2025/26.<br>• Eight Inclusion Staff Networks provide staff-led peer support, advice, representation and routes for lived-experience insight. Dedicated charitable investment and additional project support have increased network capacity. | **2** | CPO |

| Outcome | Evidence and progress | Rating | Owner |
|---|---|---|---|
| **physical violence from any source** | • Other support includes Staffside representation, psychological support, Health and Wellbeing services and Violence Prevention and Reduction post-incident support.<br>• The post-incident survey identified gaps in effectiveness: 59.6% of respondents were aware of available support, and 47.4% felt that the support received was culturally appropriate. Improving awareness, accessibility and cultural responsiveness remains necessary. | | |
| **2D: Staff recommend the organisation as a place to work and receive treatment** | • The Trust monitors staff advocacy, engagement, morale, retention and recommendation measures through the NHS Staff Survey and workforce reporting.<br>• Equality analysis shows that staff experience remains uneven. Disabled staff and some minority and marginalised groups report less positive experiences of feeling valued, workplace stress, discrimination, bullying, harassment and career progression.<br>• Exit-survey analysis found that 6.9% of respondents linked their departure to abuse, bullying, harassment, ill-treatment or victimisation following the raising of a concern. A further 25.7% identified a negative connection with a protected characteristic, caring responsibilities or Armed Forces status.<br>• The report does not yet demonstrate the sustained recommendation levels and equitable experience required to support an achieving rating. | **1** | CPO |

**Domain 2: Workforce health and well-being rating = 6**

## Domain 3: Inclusive leadership

| Outcome | Evidence and progress | Rating | Owner |
|---|---|---|---|
| **3A: Board members, system leaders and those with line-management responsibilities routinely** | • The Workforce Inclusion Steering Group provides senior oversight, with assurance reported to the People & Culture Assurance Committee. | **1** | Board |

| Outcome | Evidence and progress | Rating | Owner |
|---|---|---|---|
| **demonstrate their understanding of, and commitment to, equality and health inequalities** | • Executive and Managing Director sponsorship arrangements for staff networks have been refreshed, and Board and senior-leader equality objectives are being developed.<br>• The Behavioural Compass and inclusive and anti-discriminatory leadership framework establish expectations relating to fairness, inclusion, psychological safety, constructive challenge and action against bias and exclusion.<br>• These arrangements represent progress, but Board objectives, divisional accountability conversations and consistent performance review arrangements are not yet fully agreed or embedded. External reviews have also identified the need for more visible and consistent leadership on discrimination, misogyny, sexual safety and staff voice. | | |
| **3B: Board and Committee papers identify equality and health-inequality impacts and risks and explain how they will be mitigated and managed** | • Equality and health-inequality impact assessment arrangements are being strengthened, with work under way to embed assessment within corporate governance and decision-making.<br>• Regional assurance and external reviews have identified that equality impacts are not yet consistently visible in Board and Committee papers and that quality assurance, monitoring and evidence of follow-through require improvement.<br>• The Trust has therefore not yet demonstrated consistent application of impact assessment across all relevant policies, projects and decisions. | **1** | Board |
| **3C: Board members, system leaders and senior leaders ensure that levers are in place to manage performance and monitor progress with staff and patients** | • The Trust has established governance for the Workforce Inclusion Programme through the Workforce Inclusion Steering Group and People & Culture Committee.<br>• WRES, WDES, pay-gap reporting, the Annual Workforce Equality Report, Staff Survey analysis and the CQC Regulation 17 action plan provide established reporting and assurance mechanisms.<br>• Equality objectives identify accountable executives, intended outcomes, measures and 2026/27 priorities.• Divisional inclusion data packs, accountability conversations, the programme dashboard and strengthened | **2** | Board |

| Outcome | Evidence and progress | Rating | Owner |
|---|---|---|---|
| | discrimination reporting are being developed. The principal remaining requirement is to demonstrate that these mechanisms consistently result in local action and measurable improvement. | | |

**Domain 3: Inclusive leadership rating = 4**

## Overall assessment

Domain 2: Workforce health and well-being: **6**
Domain 3: Inclusive leadership: **4**

Indicative EDS score based on the domains assessed: **10**
Indicative rating: **Developing**

The assessment shows established structures and activity across workforce wellbeing, reasonable adjustments, staff support, staff networks, workforce equality reporting and governance. However, the evidence also identifies substantial remaining concerns relating to sexual harassment, bullying, violence, psychological safety, unequal staff experience, post-incident support, leadership accountability and the consistent use of equality and health-inequality impact assessment.

Priorities for 2026/27 include strengthening the organisational response to sexual harassment and gender-based discrimination, improving reporting and culturally appropriate support, embedding Board and senior-leader objectives, implementing divisional accountability arrangements, strengthening impact assessment and demonstrating that interventions result in sustained improvements in staff experience and workforce outcomes.

**Key:**
0 = Undeveloped activity
1 = Developing activity
2 = Achieving activity
3 = Excelling activity

Overall scores below 8 are rated Undeveloped, scores from 8 to 21 are rated Developing, scores from 22 to 30 are rated Achieving, and scores of 31 or above are rated Excelling.

*Sources: UHSussex Annual Workforce Equality Report 2026; NHS England, Equality Delivery System 2022 Ratings and Score Card Guidance; Niche Developmental Well-Led Review, July 2025.*

**University Hospitals Sussex NHS Foundation Trust**

**Designated Body Annual Board Report and Statement of Compliance**

This report sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

## Section 1 Qualitative/narrative

Reporting period 1 April 2025 – 31 March 2026

### 1A – General

The board/executive management team of University Hospitals Sussex NHS Foundation Trust can confirm that:
1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

| | |
|---|---|
| Y/N | Y |
| Action from last year: | N/A |
| Comments: | Prof. Catherine Urch is the responsible officer at University Hospitals Foundation Trust. Prof. Urch is a palliative care consultant with a current licence to practice. |
| Action for next year: | N/A |

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

| | |
|---|---|
| Y/N | Y |
| Action from last year: | N/A |
| Comments: | The responsible Officer is supported in their role by Dr Simona Caronia, Deputy CMO for Appraisal, Revalidation and Professional Standards, by James Claydon, Head of Medical Workforce, and by the medical appraisal and revalidation administrators.<br><br>A new role has been created as Medical Director for Maintaining High professional Standards, reporting to the CMO.<br><br>A budget to support the management and administration of medical appraisals and revalidation is agreed by finance at the start of each financial year. |
| Action for next year: | N/A |

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

| | |
|---|---|
| Y/N | Y |
| Action from last year: | N/A |
| Comments: | The web-based GMC Connect list of prescribed connections to the Trust is continuously updated by the medical workforce team, with new starters and leavers. |
| Action for next year: | N/A |

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

| | |
|---|---|
| Y/N | Y |
| Action from last year: | Review of medical appraisals and revalidations policy in the next 12 months to include policy for bank doctors with UHSussex as designated body. |
| Comments: | All policies which support medical revalidation are actively monitored and regularly reviewed. There is a policy review cycle in place for those policies that support medical appraisal and revalidation. The current Trust's medical appraisal and revalidation policy, which expires at the end of this year, is presently under review. |
| Action for next year | Embed the updated medical appraisal and revalidation policy |

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

| | |
|---|---|
| Y/N | Y |
| Action from last year: | Peer review to be arranged within the next 12 months |
| Comments: | Following a comprehensive review, the UHSussex medical appraisal and revalidation processes and current compliance was presented at the SE regional medical appraisal and revalidation group, attended by ROs and Deputies across the region. The forum meets regularly and focusses on different aspects of appraisal and revalidation, processes are peer reviewed and progress across the region is monitored. |
| Action for next year: | One to one peer review with neighbouring trust agreed, to be scheduled by March 2027. |

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

| Y/N | Y |
|---|---|
| Action from last year: | A comprehensive review of the Trust's policy regarding bank doctors is underway and should be completed and published within the next 12 months |
| Comments: | The review of the full management pathway for locums and bank only doctors was completed last year, and the process for appraisal of temporary staffing will be included in the Trust's medical appraisal and revalidation policy which will be updated by end of December 2026.<br>All doctors on fixed term employment with a prescribed connection to the Trust are offered an appraisal with the Trust appraisers if fixed term consultants/SAS doctors, or with their educational supervisor if any other grade of locally employed doctors (LEDs) or bank only doctors. |
| Action for next year | An audit of adherence to the new process is scheduled for this year, results will be presented at the People and Culture Committee by March 2027. |

**1B – Appraisal**

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

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| Y/N | Y |
| Action from last year: | Continue to support all doctors with a prescribed connection to UHSussex. |
| Comments: | Appraisals for doctors with a prescribed connection to the Trust are supported by the web-based appraisal system L2P (Licence to Practice), which has been introduced as single Trust-wide appraisal system since July 2023. Doctors are responsible for ensuring that sufficient supporting information, covering their whole scope of work, is uploaded to facilitate an effective appraisal discussion and doctors sign a declaration within the system to that effect. All relevant information relating to the doctor's fitness to practice, including clinical outcomes, are collated by the doctors and evidenced on L2P. The medical workforce team support the appraisal process with the compiling of the AMAR report, containing any information on complaints, reported incidents and significant events. The AMAR report is shared with the doctors prior to their appraisal, to give them time and opportunity for adding reflections to the appraisal portfolio.<br><br>The L2P contract has been renewed until June 2028.<br><br>In 2025/26, 98% of Doctors at UHSussex where offered an appraisal . It is anticipated that this high percentage will be maintained in 2026/27. |
| Action for next year: | Continue with established process |

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

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| Y/N | Y |
| Action from last year: | Continue to focus on raising the quality of appraisals through training and development. Maintain high level of communication and information about the appraisal process through regular emails, bulletins and information storage on the CMO intranet page.<br><br>Continue recruitment of new appraisers to achieve full resilience and future proofing. Additional training sessions for appraisers are planned during Autumn 2026. It is anticipated that the additional number will provide full compliance and resilience going forward.<br><br>Focus on ensuring standardisation of appraisers' time allowance through job planning review process. |
| Comments: | Actions taken this year to maintain UHSussex's appraisal performance and ensure ongoing high quality appraisals are as follows:<br><br>1. Recruitment and training of new appraisers, this year, we plan to recruit 2 additional cohorts of 15 appraisers, and we have 10 ad hoc appraisers training slots available to cover unexpected vacancies and manage demand.<br><br>2. Tima allowance for all Trust appraisers, supported by the trust's job planning process, has been set at 8 appraisals for 0.25 PA.<br><br>3. Annual quality of appraisal audit: conducted by the DCMO and MAAR team, presented at the appraisers workshop (last March 2026, next due March 2027) and published on the revalidation and appraisal intranet page and in regular revalidation and appraisal bulletins.<br><br>4. Appraiser development programme: ongoing programme of coaching and development for appraisers. In 2025/26, 89 appraisers (66%) attended the programme. We plan for the whole cohort of Trust appraisers to have attended the development programme at least once by March 2027. |

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| Action for next year: | Continue with established process.<br><br>Consistently achieve >90% completed appraisals as business as usual<br><br>Monitor quality of appraisal process to ensure that all doctors in the trust have consistent access to high quality appraisal. |

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

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| Y/N | Y |
| Action from last year: | Review of medical appraisal and revalidation policy in the next 12 months to include policy for bank doctors with UHSussex as designated body. |
| Comments: | The medical appraisal and revalidation policy approved in 2023 is currently under review. The new version will be published by December 2026. |
| Action for next year: | Embed and provide training and support to appraisers and appraisees on the new policy |

1B(iv) Our organisation has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

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| Y/N | Y |
| Action from last year: | Continue recruitment drive to achieve a surplus of appraisers which will guarantee future proofing and self-reliance going forward. It is anticipated that recruitment of additional 12 appraisers will achieve this. |
| Comments: | The Trust currently has 132 trained appraisers, which is close to make the appraisal service fully self-resilient. However, given the ongoing appointment of substantive consultants in the Trust, and allowing for a small annual turnover of appraisers who retire/leave the service, a plan is in place to recruit more appraisers. Two cohorts of new appraisers will be trained this year (30 in total); following this, 10 had hoc training slots will be available each year to cover the turnover. |

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| Action for next year: | Achieve a self-resilient state and continue to ad hoc recruit new appraiser to maintain the resilience. |

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements.

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| Y/N | Y |
| Action from last year: | Continue to gather feedback on training and development offer and monitor impact of training and development on appraisal quality. |
| Comments: | New appraisers are offered practical, web based training to use the L2P system and external appraisal training workshops (MIAD), which include an element of coaching. This training is also offered to educational and clinical supervisors who complete the annual reviews for LEDs and HEE trainees.<br><br>All current Trust appraisers are invited to attend an appraisal development programme, held by external consultants, comprising of a 4-hours workshop and 2 additional action learning sets. The programme is focussed on coaching techniques aimed at supporting, challenging and guiding the Trust doctors through their professional yearly review.<br><br>All Trust appraisers are also attending internal six-monthly appraisal workshops, chaired by the DCMO, where they are presented with a six-monthly Trust appraisal report, and where all aspects of the appraisal process are discussed, often with relevant guest speakers.<br><br>An annual quality of appraisal audit is conducted by DCMO. This consists of analysing a random sample of 40 appraisals done by 40 different appraisers in year, by using the nationally recognised ASPAT tool. The outcome of the audit is presented at the internal appraiser workshop and an action plan agreed with the appraisers. The results are also presented at the People's committee meeting and published on the trust wide MAAR medical appraisal bulletin. |

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| | The audit data for 2025/26, presented in March 2026, showed a collective ASPAT quality score of 42.1/50, which is in line with if not above national average. |
| Action for next year: | Continue with established process. Next appraisal audit due March 2027. |

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

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| Y/N | **Y** |
| Action from last year: | Continue with established process |
| Comments: | The DCMO for medical appraisal and revalidation regularly reports to the People and Culture Assurance Committee on progress with medical appraisals and trajectory to maintaining compliance and quality. A comprehensive annual report on appraisal and revalidation is submitted by the DCMO annually. This is inclusive of actions taken, outcomes of actions, feedback from appraisers and future.<br><br>Every doctor completing an appraisal is automatically asked by the system to provide appraisal feedback prior to signoff. The feedback is collated by MAAR and reported as follows:<br><br>- Each appraiser receives their annual feedback from appraisees, which is uploaded onto the L2P and reflected on during their appraisal process<br><br>- Any instance of poor feedback is flagged to the DCMO, who will contact the appraiser directly and invite immediate discussion and reflection. Further training is offered as required.<br><br>All Trust appraisers take part in the review and feedback of the appraisal process, through participation at the appraisal workshops, direct discussion with the medical workforce team or the DCMO, and offer of suggestions for improvement. Many improvement measures have been put in place as a result of direct feedback. |

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| | Formal feedback is also gathered for the internal appraisal workshops and for the appraisal development programme. The overall feedback is as follow:<br><br>Appraisal workshops: 97-99% rated good to excellent |
| Action for next year: | Continue with established process |

**1C – Recommendations to the GMC**

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

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| Y/N | Y |
| Action from last year: | The DCMO and medical workforce team to continue to focus on timely revalidation and on reducing the number of deferrals through timely review of appraisals and training of appraisers and medical workforce on the essential requirements for revalidation.<br>Review of indications for deferrals and number of deferrals allowed in a revalidation cycles. |
| Comments: | There were **190** GMC recommendations due during the 2025-26 year, 296 fewer than last year (2024-25).<br><br>a. 135 recommendations to revalidate were submitted<br>b. 55 deferral recommendations were submitted due to insufficient supporting information. This represents an increase from 28% of recommendations due in 2024-25 to 41% in 2025-26.<br><br>c. There were 18 late Responsible Officer recommendations to the GMC.<br><br>d. There were no non-engagement recommendations<br><br>This year, a comprehensive review of the revalidation recommendations and deferral processes has taken place. A |

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| | notable action arising form the review is the move to carry out the revalidation assessment, decision to revalidate and all related communications between the DCMO and medical workforce team electronically and in real time, via the L2P platform. This change has afforded a greater visibility and accuracy of data recording and auditing, and more timely recommendations. |
| Action for next year: | Continue with updated electronic process. |

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

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| Y/N | **Y** |
| Action from last year: | Minimise needs for revalidation deferral through boosting of doctors' engagement with the appraisal process<br><br>Review instances of multiple deferrals in conjunction with the GMC. |
| Comments: | As part of the action plan resulting from the review of the revalidation and deferral process, the medical workforce team are now assessing readiness for revalidation 3 months earlier compared to previously, from 3 to 6 months ahead of the revalidation date. If elements essential to revalidation are outstanding, the team will flag them to the doctor via the L2P platform, and regular prompts will follow.<br><br>The process for managing non engagement with appraisals has also been tightened and formalised, and the threshold for intervening on a non-engaging doctor has lowered. |
| Action for next year: | Continue with earlier assessment processes |

## 1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

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| Y/N | **Y** |
| Action from last year: | Continuous review of the governance processes through feedback |
| Comments: | The Trust fosters a continuous improvement culture with well embedded and effective governance arrangements in place. There are clear systems in place for reporting and reviewing incidents and complaints. Openness and reporting are encouraged. |
| Action for next year: | Continue with established process |

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

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| Y/N | **Y** |
| Action from last year: | Continue to streamline the process of recording and managing concerns, with focus on AMAR report link. |
| Comments: | The Trust's Maintaining High Professional Standards Policy is based on the national Maintaining High Professional Standards in the Modern NHS (MHPS) framework setting out the variety of ways that concerns can come to light and the actions to take when a concern arises. The policy was reviewed and ratified by the Trust Management Board in 2023.<br><br>This year, CMO, with the support of the DCMO for Appraisal, Revalidation and MPS, has consolidated the approach to monitoring and maintaining professional standards with the streamline of the MPS group review process, the appointment of a Medical Director for Maintaining High Professional Standards, and the training of 15 new MHPS case investigators and 6 MHPS case managers via NHS Resolution. |

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| | The Trust's Medical Appraisal and Revalidation Policy sets out the process for managing appraisals for a doctor under investigation or subject to a disciplinary process or GMC fitness to practice proceeding.<br><br>Doctors with a prescribed connection to UHSussex are provided with an Annual Medical Appraisal Return (AMAR) for their appraisal. |
| Action for next year: | Continue to review and output streamline governance for maintaining high professional standards |

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

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| Y/N | **Y** |
| Action from last year: | Continue to streamline AMAR process |
| Comments: | The AMAR report, patients and colleagues feedback, appraisee feedback (where required). The report is collated by the medical workforce team with input from the divisional/directorates leaders, and approved by the DCMO. This is uploaded on the doctor's appraisal portfolio. Continuous support is provided to doctors to enable a smooth appraisal process. |
| Action for next year: | Continue to monitor AMAR process |

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

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| Y/N | Y |
| Action from last year: | N/A |
| Comments: | The Trust's Maintaining High Professional Standards Policy sets out the established processes to follow when responding to concerns about doctors. This year, the CMO has strengthened the process for collating and managing concerns, as well as the links to the GMC and other organisations (i.e. independent sector providers). |
| Action for next year: | Continue with monitor robustness and adherence to existing process. |

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

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| Y/N | **Y** |
| Action from last year: | The Trust plans to increase the number of senior medical leaders with MPHS case investigators and case manager training |
| Comments: | This year, UHsx has funded the training of 15 additional MHPS case investigators and 6 additional MHPS case managers.<br><br>All formal and informal concerns about doctors in the Trust, both on substantive or temporary employment, are logged onto a live secure document which is maintained by the CMO office and accessed by the Medical Directors of Divisions, the CMO, DCMO for MPS and Employee Relations team. The above group meets monthly to share updates on each case, sharing knowledge , actions and management plans.<br><br>If a formal investigation is required, this is conducted in line with the MHPS principles: a Non-Executive Trust board member is allocated to each case to provide assurance and |

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| | oversight. The Trust's NHS Resolution Adviser is always approached to provide expert, independent advice, support and critique on handling complex concerns.<br><br>The Responsible Officer, the DCMO for medical Appraisals and Revalidation and the Head of Medical workforce meet quarterly with the GMC employment Liaison Advisor.<br><br>Formal performance management processes are Equality impact assessed to minimise potential for bias and disadvantage. |
| Action for next year: | Continue to follow and monitor adherence to establish process, |

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

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| Y/N | **Y** |
| Action from last year: | Continue to enhance communication with other ROs including via MPIT |
| Comments: | The Trust's RO and the DCMO meet regularly with the ROs of neighbouring independent sector organisations, to discuss any concerns for doctors connected to the Trust who work elsewhere, or doctors connected elsewhere who work for the Trust. The DCMO for Appraisal and revalidation provides ROs of other organisations with regular up to date audit data on relevant doctors' appraisals and revalidation.<br><br>Regular and ad-hoc transfers of information requests both to and from the organisation are responded to promptly and in line with national requirements<br><br>For Trust doctors on the GP performers List, the Responsible Officer meets twice yearly with the NHS England regional Responsible Officer's office to share any information of note and to ensure a consistent approach to concerns involving GPs. |

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| | The RO and Deputy regularly attend SE regional and national forum with other ROS, where subject knowledge and quality improvement projects are shared and discussed. |
| Action for next year: | Continue with established process |

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination.

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| Y/N | **Y** |
| Action from last year: | Continue with EDI assessment of each case |
| Comments: | As part of the Race Equality Standard, the Trust analyses the number of BAME staff going through disciplinary processes to assess whether there is a negative impact. This is reported through the People and Culture Committee. |
| Action for next year: | Communicate more widely the outcome of the EDI audit. |

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture.

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| Y/N | **Y** |
| Action from last year: | Arrange for peer review |

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| Comments: | Feedback, suggestions and opportunity for development are continually sought both internally and outside the organisation. The Responsible Officer and the Deputy CMO attend regional and national ROs update, where wider governance issues and reviews are presented, and share the information with the Trust's Divisional Medical Directors, Head of Medical workforce and governance team. The appraisers' coaching and development programme, the new consultants' development programme and the review of the process around capturing and sharing MPS concerns are the direct result of these interactions. |
| Action for next year: | Outcome of peer review to be presented at People and Culture Committee |

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible.

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| Action from last year: | Continue to increase the offer of leadership development at UHSussex |
| Comments: | The Trust applies the principles set out in the Messenger review with the following initiatives and processes:<br>- Inclusive and collaborative leadership where all leaders in the organisation regularly meet to share practices and information according with the Trust values and behaviours<br>- EDI impact assessment for every process related to MPS, BAME audits and information sharing<br>- Encourage MPS training and development, and maintain consistent standards through training and information sharing<br>- Standardise, user friendly online appraisal system<br>- Trust leadership and development programmes for all level of leaders in the organisation, including new consultants.<br>- Talent development and mentorship programmes for non-executive directors |

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| Action for next year: | Continue to deliver training opportunities and gather feedback |

**1E – Employment Checks**

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

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| Y/N | Y |
| Action from last year: | Review of the current temporary staffing policy to include medical bank doctors as above |
| Comments: | All substantive, fixed term and bank appointments are subjects to the full NHS Pre-employment Check Standards.<br><br>Guidelines are in place for agency recruitment, which include a medical agency worker pre-engagement checklist for Staff Direct and the authorising managers use<br><br>This year, the DCMO, Director of Workforce and Head of Medical Workforce have led a full review of the Trust's management of temporary staffing. This was conducted over the course of several months and supported by a multi-disciplinary working group. The review has produced the following outcomes:<br><br>- Revised temporary staffing policy<br>- Standardised approach to temporary staffing recruitment across all areas of the trust<br>- New process algorithm on managing temporary staffing concerns |
| Action for next year: | Monitor adherence to temporary staffing process. |

## 1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

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| Y/N | **Y** |
| Action from last year: | Review of all the culture and behaviour training and development offers contextually with the launch of the new Trust's strategy within the next 12 months |
| Comments: | UHSussex has recently launched a new behavioural compass to underpin the Trust values of compassion, inclusivity and respect. Every training and development initiative within UHSussex aims to promote the Trust values and it is routed in the Trust's behavioural compass.:<br>- Civility saves Lives campaign, a series of workshops for all staff around the impact of good interactions between clinicians on positive patients care and outcomes<br>- Human factor training: large group workshops to test and inform healthcare professional on the impact of human factors on patients' outcomes<br>- Safety culture (including sexual safety): continuous monitoring, audit and communication sharing aimed at minimising and effectively manage instances of violence, aggression and discrimination in the workplace.<br>- Positive culture of learning, development and support, through new consultant programmes, SAS training and development programme, strong links with medical Educations.<br>- Increase availability of on-line training and resources via intranet pages and the IRIS learning platform |
| Action for next year: | Continue with established process |

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

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| Y/N | **Y** |
| Action from last year: | Please see above |
| Comments: | Please see above |
| Action for next year: | Please see above |

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

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| Y/N | **Y** |
| Action from last year: | **N/A** |
| Comments: | Continuous encouragement of all staff to report concerns and incidents either formally, through the Datix system, or informally. All instances of reporting are taken seriously and investigated, and the outcomes shared as appropriate. Actions from learning are identified and implemented swiftly. The Trust openly shares with all staff regular updates on Datix reported incidents, outcomes of staff surveys, and relevant learning objectives. Regular reminders of the freedom to speak up guardian process are sent to all staff. |
| Action for next year: | Continue as above |

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

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| Y/N | **Y** |
| Action from last year: | N/A |
| Comments: | Feedback from doctors is sought through the following processes:<br>- Formal feedback on appraisals<br>- Staff survey including feedback on professional standards<br>- Posting on intranet pages<br>- Email communications<br>- Governance meetings, both inter- or cross specialities (Divisional), where outcomes of audits and feedback are shared<br>- Feedback on learning and development workshops (appraisal/safety culture/CSL, human factor, etc)<br>- Direct feedback of doctors to line manager |
| Action for next year: | Continue with established process |

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

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| Y/N | **Y** |
| Action from last year: | N/A |

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| Comments: | As described above, all instances of concerns and disciplinary processes are EDI assessed to avoid bias. Doctors involved in such processes are offered support and reasonable adjustments as required. |
| Action for next year: | Continue as above |

**1G – Calibration and networking**

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

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| Y/N | **Y** |
| Action from last year: | N/A |
| Comments: | The RO ensures consistency of MPS processes via RO network meetings, peer reviews and national benchmarking. Regular meetings with the GMC representatives ensure correct processes around managing formal concerns. |
| Action for next year: | N/A |

## Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

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| The number of doctors with a prescribed connection to the designated body on the last day of the year under review | 1,689 |
| Total number of appraisals completed | 1,518 |
| Total number of appraisals approved missed | 167 |
| Total number of unapproved missed | 4 |
| The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle | 190 |
| Total number of late recommendations | 18 |
| Total number of positive recommendations | 135 |
| Total number of deferrals made | 55 |
| Total number of non-engagement referrals | 0 |
| Total number of doctors who did not revalidate | 0 |
| Total number of trained case investigators | 19 |
| Total number of trained case managers | 9 |
| Total number of concerns received by the Responsible Officer[1] | 74 |
| Total number of concerns processes completed | 59 |
| Longest duration of concerns process of those open on 31 March (working days) | 596 – open cases<br>643 – case still open<br>Note: Includes GMC cases |

[1] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

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| Median duration of concerns processes closed (working days)[2] | 151 |
| Total number of doctors excluded/suspended during the period | 3 |
| Total number of doctors referred to GMC | 17 |
| Total number of appeals against the designated body's professional standards processes made by doctors | 2 |
| Total number of these appeals that were upheld | 0 |
| Total number of new doctors joining the organisation | 104 |
| Total number of new employment checks completed before commencement of employment | 104 |
| Total number claims made to employment tribunals by doctors | 2 |
| Total number of these claims that were not upheld[3] | Claims have not been heard by ET yet |

## Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

| General review of actions since last Board report |
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| Since the last board report we have maintained our position of high quantitative compliance, with >95% of doctors been offered an annual appraisal, and with 91% of revalidation recommendations being actioned in a timely way. We have focussed on reviewing and publishing the process of appraisal and managing concerns for bank doctors, which has now been adopted trust wide. We have established a process for carrying out regular quality appraisal audits, discussing the results and actioning findings. We have peer reviewed our medical appraisal and quality audit processes withing the context of the regional RO group and drawn on the learning and suggestions of the group. We have continued to recruit and train new appraisers, and to develop the existing appraisers, so to create a resilient and excellent workforce. |

[2] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

[3] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

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| We have reviewed and streamlined the process for assessing suitability for and recommending revalidation.<br><br>We have increased focus on maintaining professional standards, by training more case investigators and case managers, and appointing a Medical Director whose sole remit is to focus on MHPS. We have increased the offer of training and development of our consultant workforce, to include enhanced communication skills and managing issues of professional standards. |
| Actions still outstanding |
| Medical appraisals and revalidation peer review with individual trust |
| Current issues |
| No issues to report. |
| Actions for next year (replicate list of 'Actions for next year' identified in Section 1): |
| As above. |
| Overall concluding comments: |
| University Hospitals Sussex NHS Foundation Trust remained compliant with Responsible Officer Regulations during 2025/26, maintaining strong appraisal, revalidation and professional standards processes. Over 95% of doctors were offered an appraisal, supported by a strengthened appraiser workforce, quality assurance audits and ongoing development programmes. The Trust enhanced governance through additional MHPS investigators and case managers, a new Medical Director role for professional standards, improved revalidation processes and updated arrangements for temporary and bank doctors. Key priorities for 2026/27 include completing an external peer review, embedding revised policies and continuing to improve appraisal quality, compliance and governance oversight |

## Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body by the Chief Executive

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| Official name of the designated body: | University Hospitals Sussex NHS Foundation Trust |

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|---|---|
| Name: | Andrew Heeps |
| Role: | Chief Executive |
| Signed: | |
| Date: | |

| | |
|---|---|
| Name of the person completing this form: | Simona Caronia / James Claydon |
| Email address: | James.claydon1@nhs.net |

We are compassionate
We are inclusive
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# Perinatal Quality Oversight Model (PQOM) Exception Report

Monthly Update

May 2026 Data

*August 2026 Re-submission following corrections made to data as well as addition of Neonatal Patient Safety information on new slide 10*

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# Introduction

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## Purpose and Background

PQOM provides a framework for effective oversight of perinatal quality, supporting safe care and positive outcomes for women, babies and families through clear accountability and governance arrangements.

Following the 2022 Ockenden Review, UHSx adopted an NHS England maternity oversight dashboard to strengthen Board visibility of maternity quality and safety.

The monthly PQOM dashboard and exception report are reviewed through Maternity Quality and Safety governance processes and presented to Trust Board by the Director of Midwifery and Board Maternity Safety Champion.

The Trust Board retains overall responsibility for the quality, safety and continuous improvement of maternity and neonatal services, supported by the perinatal leadership team and Board Safety Champion.

# Executive Summary

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**Assurances**
No MOSS (Maternity Oversight Safety Signals) triggers requiring organisational response.
100% 1:1 care in labour maintained across all sites.
Perinatal mortality and morbidity indicators remain broadly stable across UHSussex.

**Escalations**
Maternal death at SRH under MNSI and PSII investigation.
Variation in fetal monitoring training compliance requires continued focus.
Communication, consent and listening to women remain recurring themes in complaints.

**Celebrations**
No MOSS safety signals identified in the last 12 months.
SRH achieved zero neonatal deaths per 1,000 births for the first time since May 2021.
Positive patient feedback increased, with PRH maintaining 100% FFT positivity for five consecutive months.

# PQOM Dashboard Overview –
# National/Regional Benchmark in red font

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| Births May 2026 | Stillbirth 12 month Rolling Rate | Neonatal Death 12 Month Rolling Rate | HIE rate per 1000 live births | ATAIN | Perinatal Mortality |
|---|---|---|---|---|---|
| •676 | •2.10/1000<br>•3.18/1000 | •0.35/1000<br>•1.59/1000 | •1.48/1000<br>•1.3/1000 | •4.3% of full term babies (=>37/40) admitted to NNU<br>•5% | •2.45/1000<br>•4.77/1000 |

## Assurances □

As can be seen, all 12-month rolling rates for the primary indicators are scoring below national benchmarks therefore giving good assurance of the safety and effectiveness of services. These are expounded further on slide 5.

## In the content slides following, assurance and improvements are noted but to summarise:

Data source for Stillbirth, Neonatal death and Perinatal Mortality rates 2026 MBRRACE Perinatal Mortality Report: Perinatal mortality surveillance reports | MBRRACE-UK | NPEU > MBRRACE-UK
HIE and ATAIN rate were set by LMNS as a Regional Rate

| Indicator | Position |
|---|---|
| Perinatal Mortality | □ |
| HIE | ◍ |
| Voice of the User | □ |
| Training | □ /□ |
| Workforce | ◍ |

PQOM Monthly Update May 2026 Data

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

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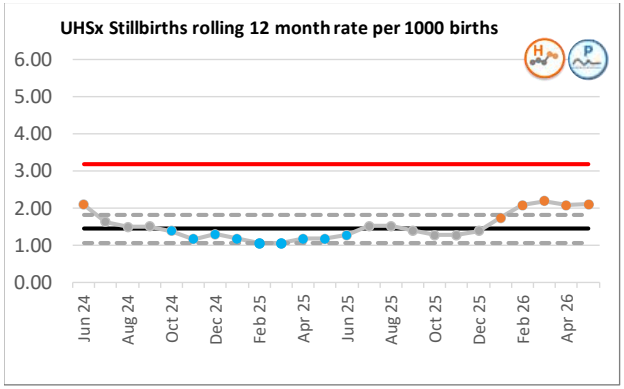


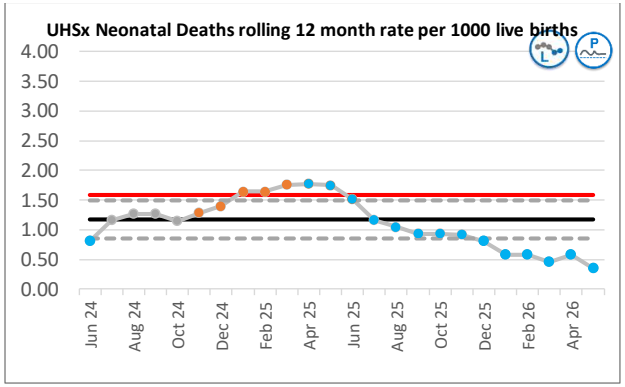


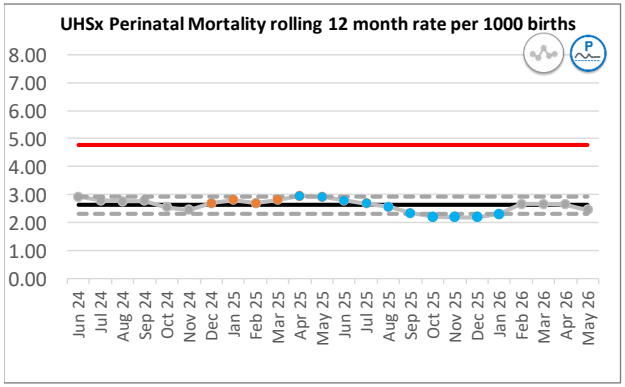


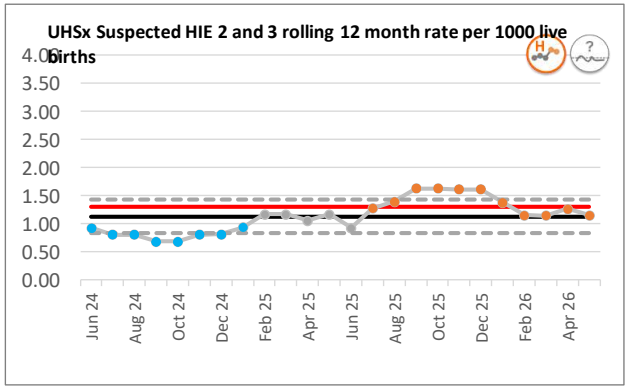


Rolling 24 month outcomes. Red line on the charts indicates National rate, latest available data 2024, published June 2026

**Stillbirths:**

A small increase resulting in special cause variation although rates remain below national benchmark. Thematic review conducted in July 2026; results pending. There was 1 stillbirth in May 2026.

**Neonatal deaths:**

A sustained reduction is seen and is less than half the national rate. Last occurrence in April 2026 and before that none since November 2025.

**Perinatal mortality (stillbirths and neonatal deaths combined):**

Rates remain much lower than national rates (2.64/1000 births vs. 4.1/1000 births) As above there was 1 stillbirth and 1 Maternal death in May 2026

**Suspected Hypoxic Ischemic Encephalopathy (HIE or Brain Injury):**

Rates reduced following late 2025 increase. No cases since October 2025.

# Top Perinatal Strategic Risks Requiring Board Oversight

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**Workforce**
- ANNP Shortages
- Tier 2 Neonatal Compliance
- Continuity of Care
- Qualified in Specialty (QIS) Nursing Workforce

**Infrastructure & Capacity**
- Obstetric theatre capacity
- TMBU Estate
- Ventilation/Temperature management

**Safety Systems**
- Abnormal result escalation
- Homebirth compliance
- Governance of clinical documents

**Learning and Assurance**
- Coroner actions
- National scrutiny
- BAPM compliance

| Risk Theme | Direction |
|---|---|
| Workforce & Staffing | ↔ Stable/Planned Improvement |
| Infrastructure & Capacity | ↗ Deteriorating |
| Safety Systems | ↔ Stable/Improving |
| Learning and Assurance | ↗ Increased oversight |

**Executive oversight remains focussed on workforce sustainability, infrastructure constraints, safety-system resilience, and delivery of actions arising from investigation and regulatory findings.**

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# Perinatal Mortality Review Tool (PMRT) and Patient Safety

# PMRT Cases occurring in May 2026

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| Site | Type |
|---|---|
| RSCH | 1 Stillbirth |
| WH | 1 Stillbirth |
| SRH | 1 MNSI & accommodating PSII (Maternal Death) |
| PRH | 0 |
| Total Reviewed | 3 |

| Key Patient Safety Findings |
|---|
| No recurring themes identified in initial reviews |
| Thematic review for PPH undertaken following special cause variation – results due in August 26 |
| Health inequalities considerations identified in one case |

| PMRT Learning Table | | |
|---|---|---|
| Theme | Learning | Action |
| Health Inequalities | Black African family/deprivation factors considered | Review through PMRT |
| Escalation and decision-making | No recurring concerns identified | Continue surveillance |

# Patient Safety - Maternity – *see Q1 PSIRF report for full detail and future Q1 Legal Claims Scorecard (due September)*

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| Site | PSII | MNSI |
|---|---|---|
| PRH | 0 | 0 |
| RSCH | 0 | 0 |
| SRH | 1 | 1 (same case) |
| WH | 0 | 0 |

| Metric | May Position |
|---|---|
| PSII Cases | 1 (SRH Maternal Death) |
| MNSI Referrals | 1 (SRH Maternal Death which is dually reported) |
| ELR/LLR | 0 |
| Significant Investigations | 1 (SRH Maternal Death) |

## Key Learning and Actions

### Emerging themes

**Emerging Themes from initial review, MNSI on-going**

- Deterioration and escalation occurred within guideline expectations in initial review
- Specialist external advice sought in line with expectations

(These are not full conclusions but overarching notations from the initial review; however full investigation is still ongoing and may discover variations to this.)

### Actions underway

- MNSI investigation in progress and has been reported to MBRRACE.
- Internal PSII investigation recorded but investigation defers to MNSI/MBRRACE
- Findings to be reported through governance processes.
- Learning to be shared through maternity safety forums.

# Patient Safety - Neonatology

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| Site | PSII | MNSI |
|---|---|---|
| PRH | 0 | 0 |
| RSCH | 0 | 0 |
| SRH | 0 | 0 |
| WH | 0 | 0 |

| Metric | May Position |
|---|---|
| PSII Cases | 0 |
| MNSI Referrals | 0 |
| ELR/LLR | 1 |
| Significant Investigations | 0 |

## New PSIRs

Moderate harm ELR raised in May.

# Homebirth suspensions

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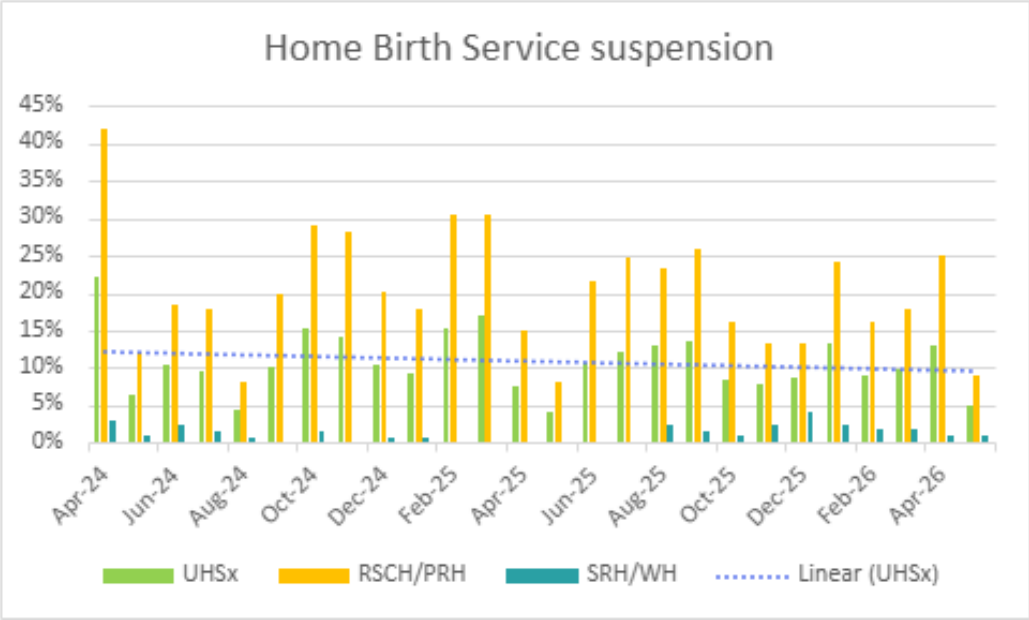


- May showed suspensions of 8% of the 12 hours shifts. This was due to sickness absence within the team. But a 9% reduction is suspensions compared with April's data.
- This meant that the Homebirth service was cancelled for 5 shifts out of 62.This translated to 2 women/people out of 27 (7%) having to give birth outside of their preferred birth location as a result of suspending the homebirth service.
- Continuity of care team continue to cover the gaps within the homebirth team to maintain a lower suspension rate.
- Rotation of core/community midwives taking bank shifts to continue to cover vacancy within the Homebirth team.
- The team will have a vacancy rate of 1.95 WTE.
- A consultation to align the model of home birth provision across the service has been delayed due to wider Trust on call consultations. This has been escalated.

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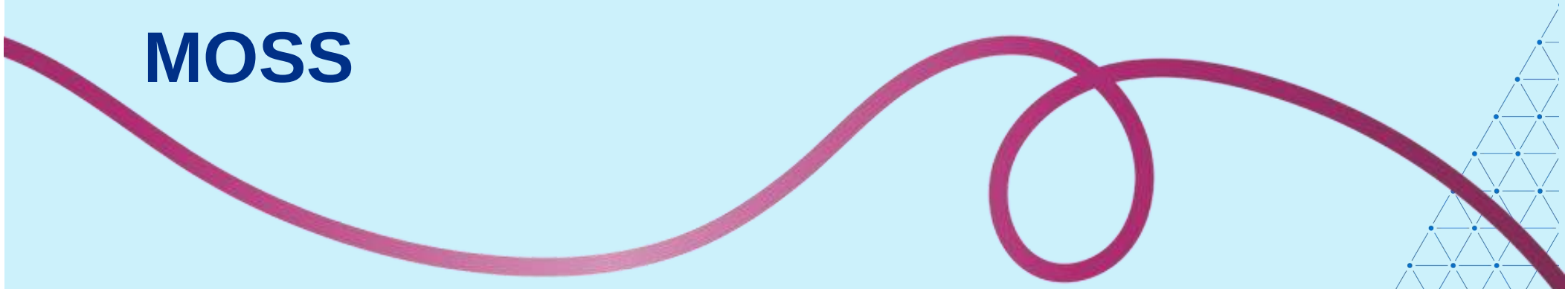
# MOSS



# Maternity Outcomes Signal System (MOSS)

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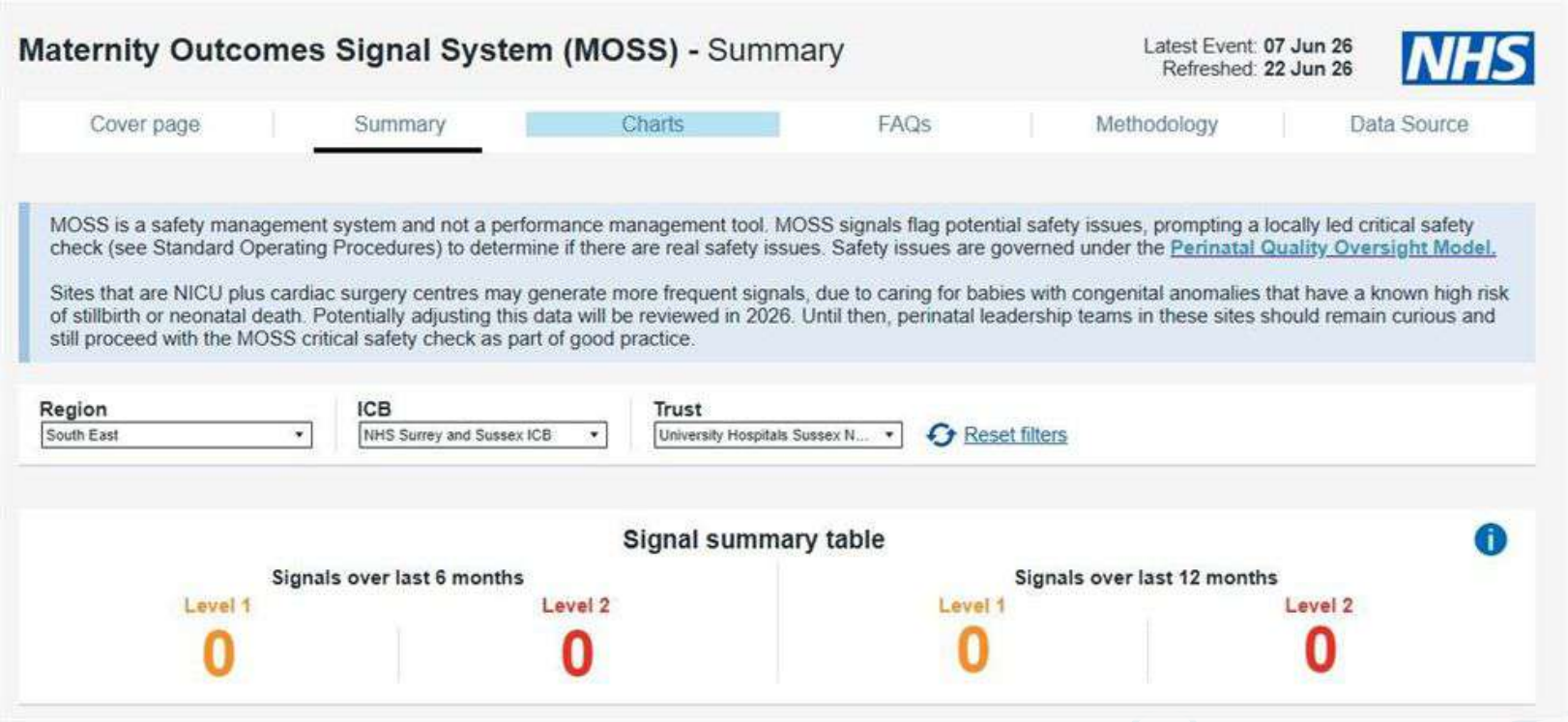
[NHS England » Maternity Outcomes Signal System (MOSS) standard operating procedures]



# Maternity Outcomes Signal System (MOSS)

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## Analysis of the charts

- The Trust has had no events requiring a response in the past 12 months

## Further implementation plan

- SOP and Action cards drafts to be shared this month for consultation
- CNST requirements state that if there are no signals to which to react, the trust must run a signal drill annually. It has been decided that this will be 2 drills, 1 covering PRH and RSCH and 1 covering SRH and WH. Both drills must happen by CNST reporting (30/11) therefore the process will be tested first in September and run again by end October.

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# Health Inequalities

# Health inequalities

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- Statistical Process Control (SPC) charts for key indicators stratified to Global Majority groups and most deprived groups are compiled by the Integrated Care Board (ICB) for individual sites. These charts are now included in appendix 2.

**Analysis of May data:** □

- The baby that was sadly stillborn at the RSCH site was Black African and in the lowest 20% postcodes for deprivation. This has contributed to the "significant deterioration" in the Stillbirth charts on pages 37, 41 and 43.
- There was an extremely premature baby (23 weeks 6 days) born at RSCH, transfer from the Conquest hospital in Hastings where the mother has a postcode in the lowest 20% for deprivation.

**Numbers of women in these groups are exceedingly small; therefore, any case can trigger a 'significant deterioration' flag. However, the stillbirth cases will be reviewed via PMRT with a focus on Health Inequalities and risks associated with Global majority groups in pregnancy to consider if the stillbirths could have potentially been avoided.**

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# Voice of the Service User

# 3c) Voice of the user – Maternity

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| Voice of the user | Princess Royal, Haywards Heath | Royal Sussex County Hospital, Brighton | St Richards Hospital, Chichester | Worthing Hospital, Worthing |
|---|---|---|---|---|
| FFT (% and response rate) | 100% (RR 11%) | 91.67% (RR 7%) | 100% (RR 11%) | 92.86% (RR10%) |
| Complaints | 2 | 7 | 1 | 5 |
| Legal Claims | 2 | 1 | 1 | 1 |
| MNVP concerns | 0 | 0 | 0 | 0 |

□ / □

The national benchmark for Birth FFT for May 2026 was 93% positive. This was not achieved at Worthing or Royal Sussex County; however, because response rates were low and comments to explain negative ratings were minimal, it is difficult to explain the variation in comparison to the 100% received at Princess Royal and St Richards. Sustainable improvement in this area is known to be difficult from national learning. The local QI mentioned in previous months is now underway with Head of Midwifery reinvigorating the use of QR codes and tablet responses supported by volunteer services.

Whole numbers of new complaints received (15) in May increased in comparison to the average. 2 of those complaints were historic requests falling outside of Trust policy (>1 year) but the division has agreed to review. The chief theme of those complaints across all sites was documented to be concerns related to Clinical Care although there were no overarching themes under that heading as the source of the complaints were from various stages of pregnancy/labour with different sub-subjects indicated within the content of the letters. These themes will be triangulated with patient safety and claims data to inform further quality improvement in the Q1 legal claims scorecard available in September 2026.

# FFT: Who responded and where was their care based? (June 2026) - Maternity

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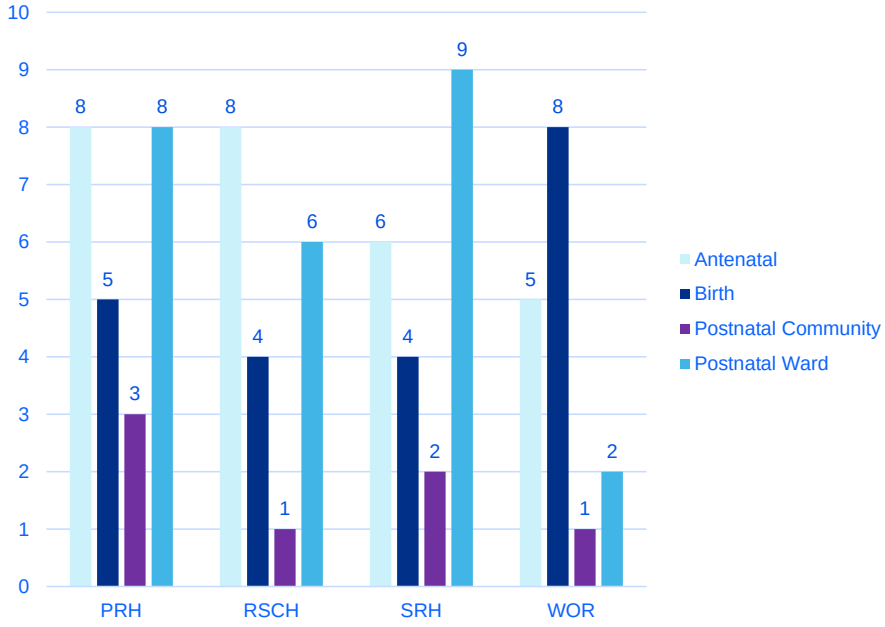
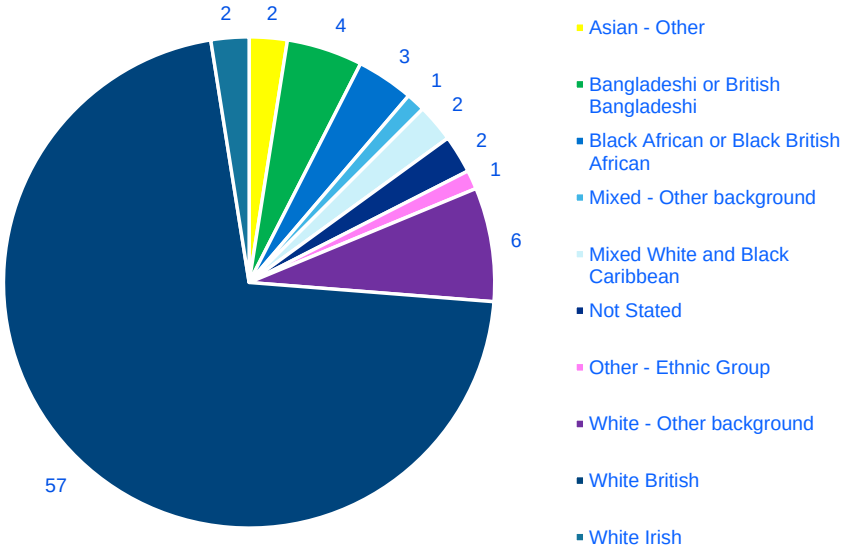
## Balance of comments by site and service area




## Mix of ethnicities providing FFT feedback




### Summary of comments and themes from non-white British service users ("White Irish" and "White other" included)

Feedback was overwhelmingly positive, with patients consistently praising the kindness, compassion, professionalism, and supportive care provided by staff. Many felt listened to, reassured, and well supported throughout their antenatal, birth, and postnatal care, with breastfeeding support and individual staff members receiving particular recognition.

A small number of respondents highlighted areas for improvement, including better communication and coordination between hospital and community services, reducing duplicated appointments and discussions, improving administrative processes, and enhancing the hospital environment.

Overall, patients reported a high standard of care and positive maternity experiences.

# FFT: Top three positive and negative themes (June 2026) - Maternity

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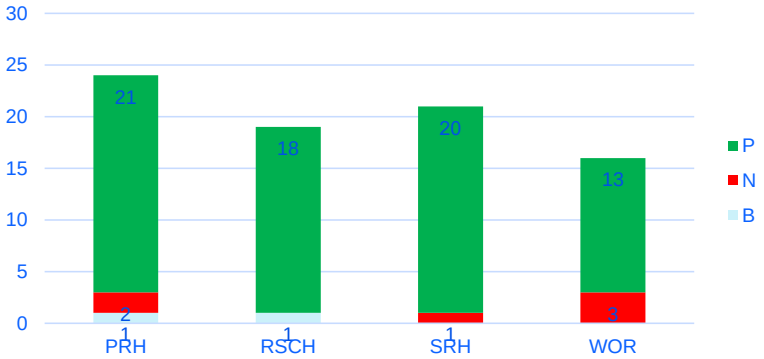
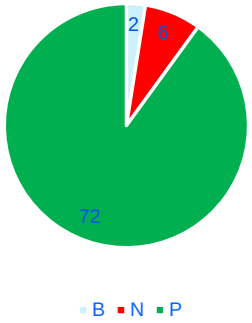
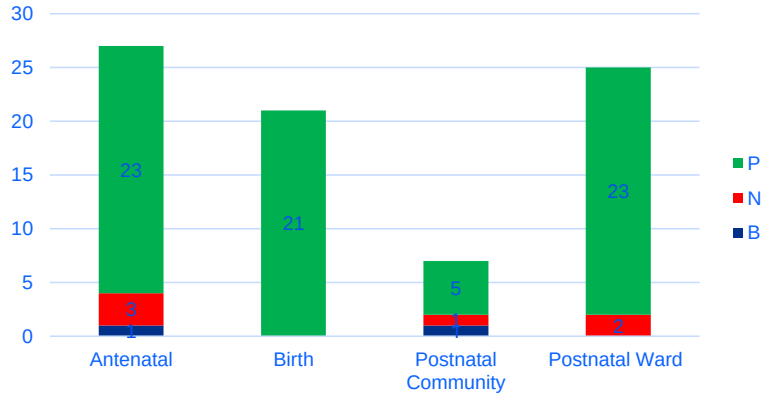
Balance of comments by site; positive, negative and both




Balance of comments = positive, negative and both




Balance of comments by service area




**Top 3 Positive Themes from 74 comments received**

**Compassionate, Supportive and Kind Staff**

- Patients consistently praised staff for being caring, friendly, attentive, and going above and beyond to provide emotional and practical support.

**Feeling listened to, respected and reassured**

- Many respondents valued being heard, involved in decision-making, treated with dignity, and reassured throughout their maternity journey, particularly during labour and caesarean births.

**High-quality care and professionalism**

- Patients highlighted excellent clinical care, clear communication, efficient service, and feeling safe and confident in the expertise of midwives, doctors, and the wider maternity team.

**Top 3 Negative Themes from the 8 responses received**

**Poor communication and lack of coordination**

- Some patients reported fragmented communication between hospital and community teams, repeated discussions, duplicated tests, and inconsistent information.

**Delays and inadequate continuity of care**

- There were a few concerns that mentioned delays in appointments and elective procedures, long waiting times, insufficient monitoring during labour, and limited postnatal support.

**Patient experience and quality of care concerns**

- Several patients felt pressured into decisions, received inconsistent breastfeeding advice, perceived a decline in service quality, or raised concerns about staff competency and the cleanliness of facilities.

# Voice of the user - Neonatology

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| Voice of the user | Princess Royal, Haywards Heath | Royal Sussex County Hospital, Brighton | St Richards Hospital, Chichester | Worthing Hospital, Worthing |
|---|---|---|---|---|
| Complaints | 0 | 0 | 0 | 0 |

□ / □

PREMs (Patient Reported Experience Measures like the national FFT) is an element of improvement for Neonatology. There was a noted 1 overall FFT response across all four sites for the specialty in May 2026 (100%). Currently, the service is impacted by limitations in the IT code facilitating the programme which is an improvement work in progress between the two teams. Also, as seen above, no complaints were received within month. The specialty is exploring how the FFT can be promoted within its parent groups to improve response rate as well as other PREM opportunities being initiated nationally.

Improvement priorities:

At WGH/SRH annual FICare (Family Integrated Care) update training is being planned for the teams based on feedback from the year. The themes will be skin to skin care, orientation to the unit, communication, celebrating the successes, firsts and milestones belong to parents. *FICare is a model which integrates families as partners in the Neonatology team. Preliminary research suggests that FICare decreases parent stress, results in fewer nosocomial infections, improves infant growth and breastfeeding rates, and improves patient safety. (*Home - Family Integrated Care)

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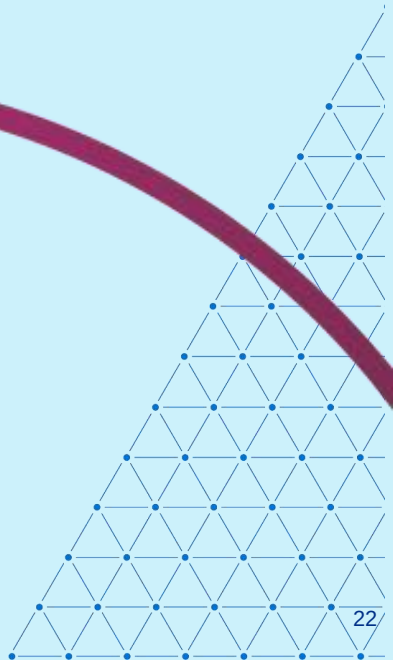
# Workforce Safety



# Leadership and training: Fetal Monitoring

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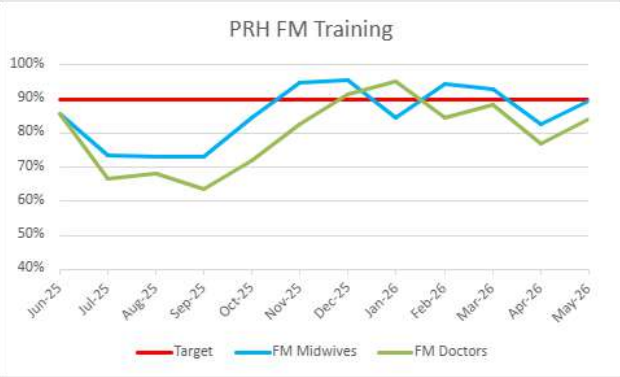


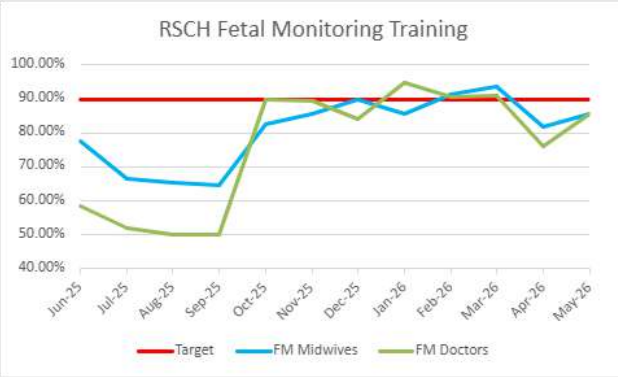


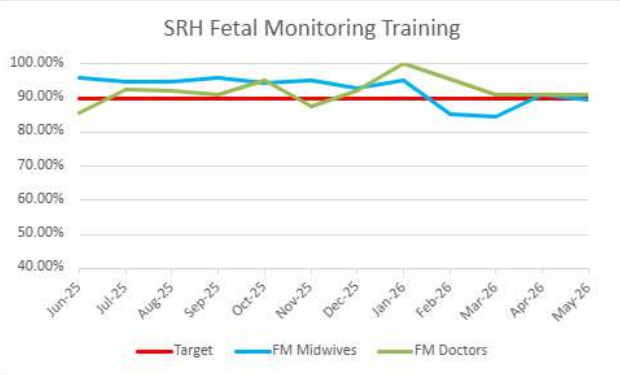


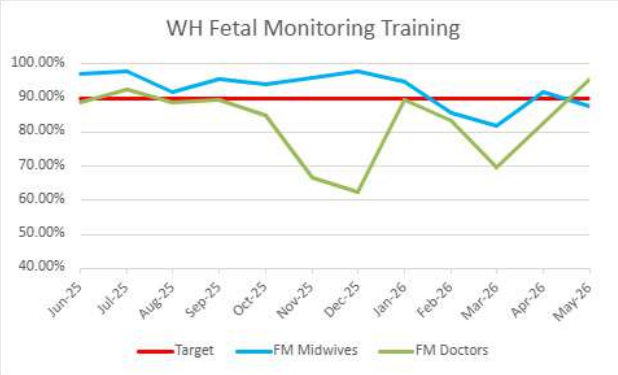


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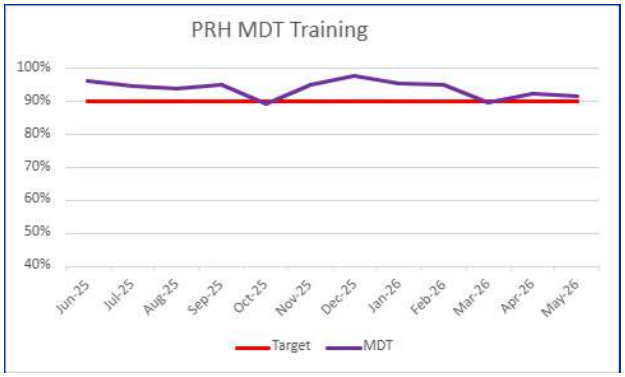
At PRH, there was a slight reduction in compliance towards the end of April partly related to strike action and staffing pressures.

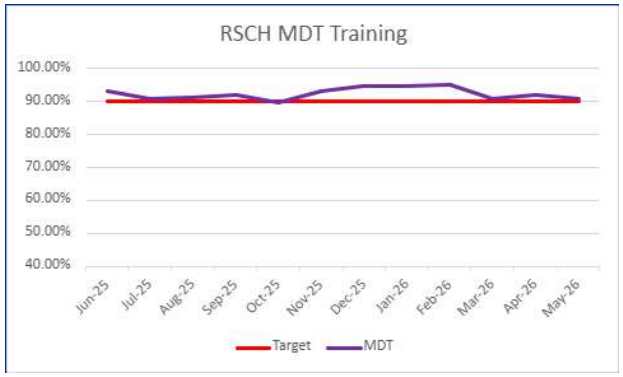
At RSCH, there has been a steady improvement overall with a similar drop as described for PRH .

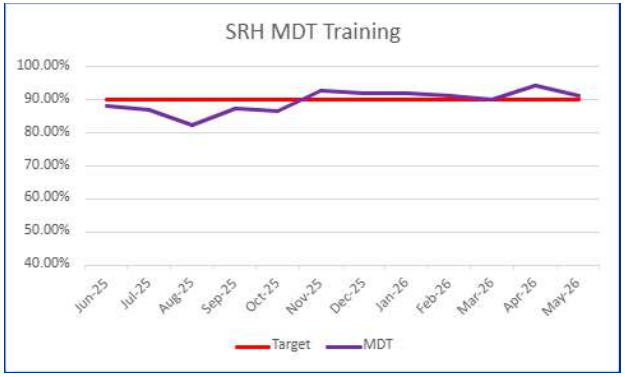
At WH and SRH, training patterns have changed from a twice per month to once per month which makes compliance appear dramatically lower prior to a study day.

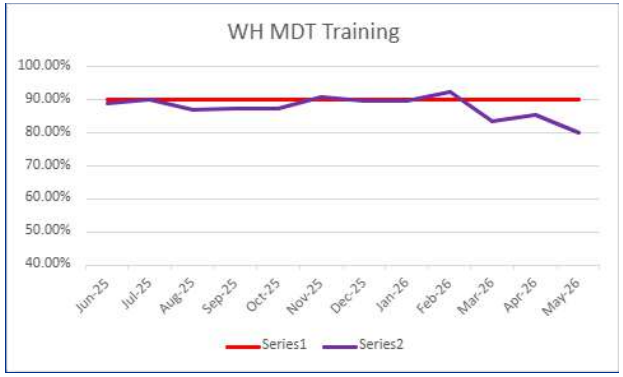
As is reported in later slides, training compliance for the first CNST training compliance checkpoint (scheduled 31/07/2026) was achieved by 15/07/2026.

# Leadership and training: Multidisciplinary Training – PROMPT (All Staff Groups)




For the **31st July checkpoint**, all sites have already successfully met the first **CNST MDT PROMPT training compliance checkpoint** as of 15th July.

For **Year 8 CNST compliance**, **90% compliance by the next checkpoint on 30th November** is required. Complexity surrounds the new doctors who must complete training within three months of their start date. A compliance breakdown by staff group is provided within the **CNST section** of this report.

The recent decline in compliance at **Worthing** was addressed with the relevant staff groups, and performance has since recovered in line with CNST requirements.

A sincere thank you to the **Education Teams** for their ongoing work behind the scenes to coordinate bookings and attendance at **MDT PROMPT training**, helping to ensure continued compliance across all sites.

# Team feedback – Divisional measures

**Position □ / □**

November 25 data is unfortunately unavailable due to a break in the survey link on the platform meaning the response rate low and therefore insignificant.

Perinatal leadership is looking at the staff survey around the two points that have fallen since last year: flexible working and value of appraisals.

Data above (from April 2026) now includes Clinical Support Services in the new division.

**Actions**

Exploring the issues surrounding flexible working as many staff members are on flexible working agreements; this will be done via ImproveWell

The new appraisal document in the trust has launched recently therefore will be used for FY26/27

Listening Events being held across Directorates. Bespoke Listening Events have been held for the perinatal teams to brief the team on the National Maternity and Neonatal investigation. These events included talks from the legal team regarding social media safety, and the communications team regarding media coverage and behaviour.

Separate Listening Events have been completed to prepare and support staff for the media coverage.

# Perinatal workforce – Midwifery vacancy rate

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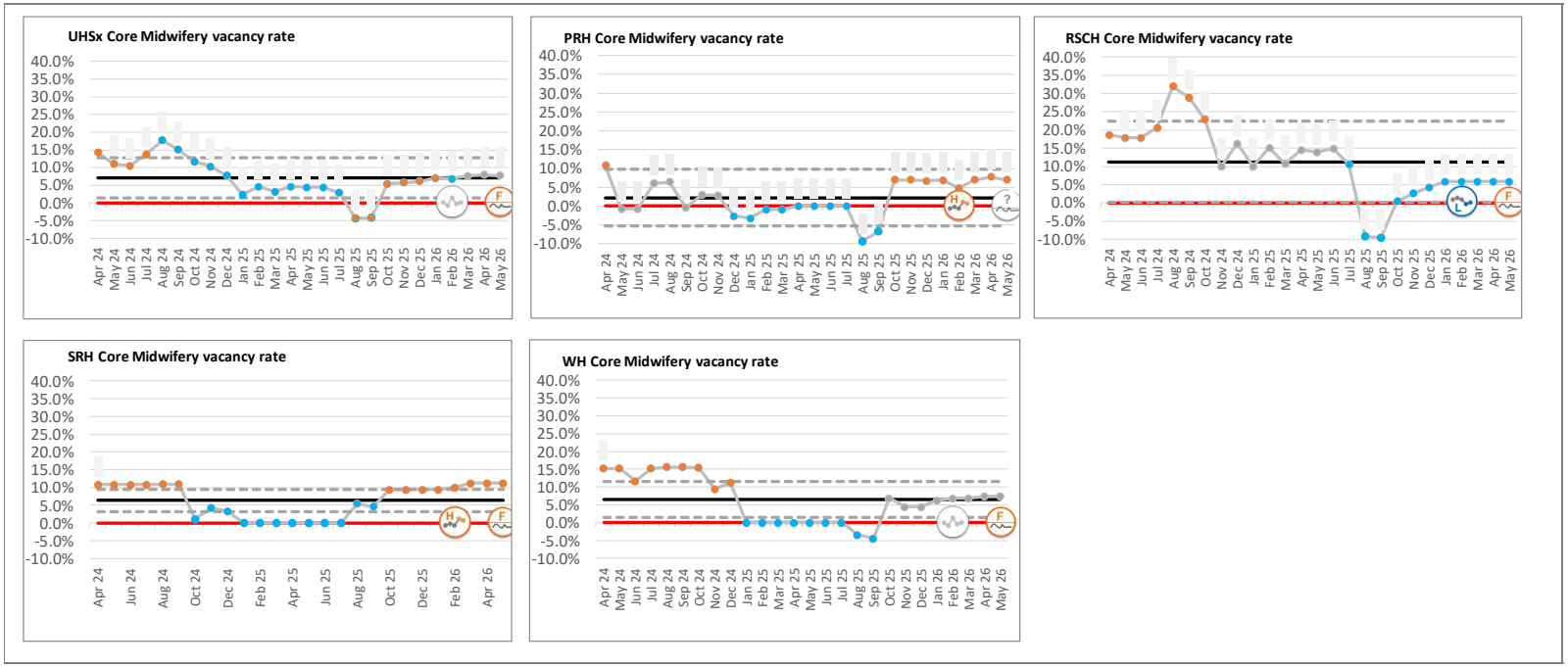


- Substantive midwifery vacancies remain at 0%. When parental leave and secondments are included, the vacancy rate is 7.1%, with recruitment underway and improvement expected in coming months.
- Annual preceptorship progression creates temporary workforce gaps, which will be mitigated through fixed-term Band 5 contracts and consideration of two recruitment cohorts per year. Recruitment activity is currently affected by vacancy controls and the temporary Trust-wide recruitment pause. The BR+ review uplift has been approved by the Board but remains unfunded.

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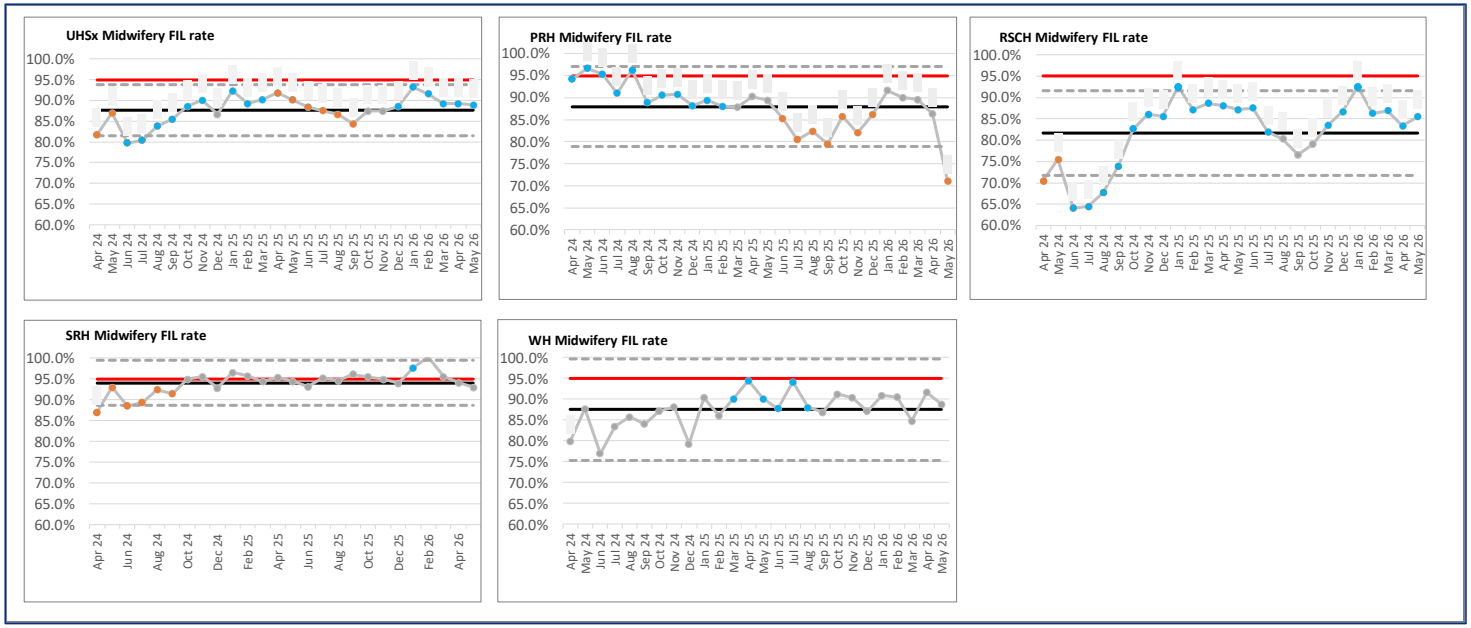
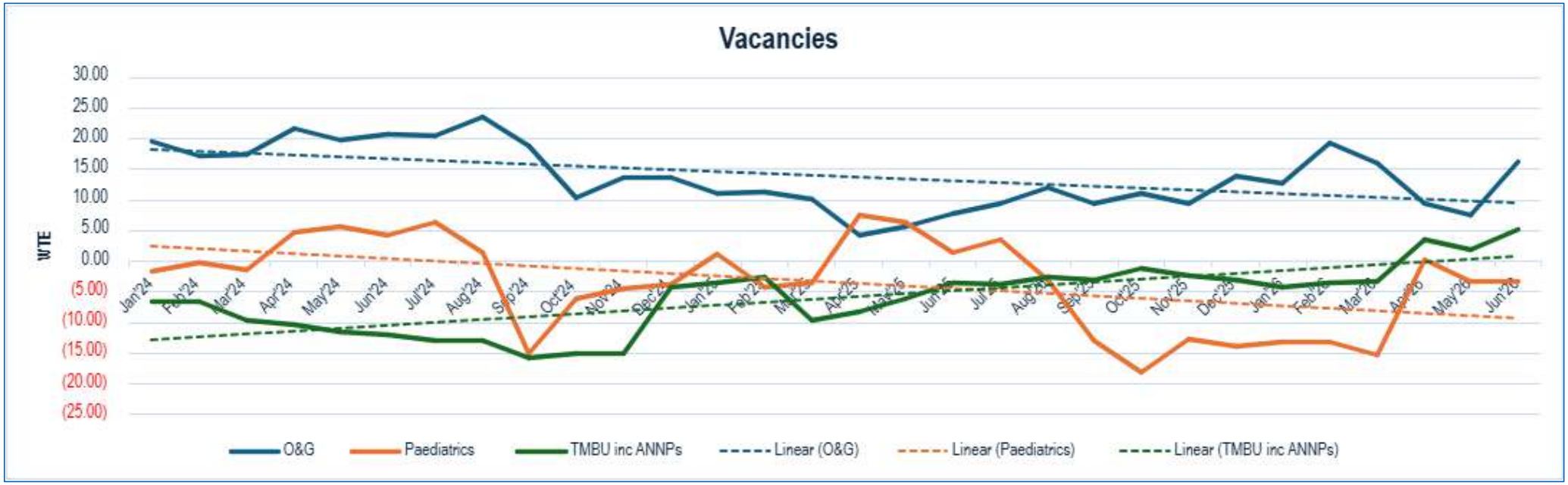
# Perinatal workforce – Midwifery Fill rate




Fill rates remain significantly improved compared with summer 2024, although some variation persists. Agency use has ceased and bank usage has reduced. Workforce pressures continue to arise from sickness absence, parental leave and preceptorship progression.

- Validation of the reported May PRH fill rate is underway.
- Introduction of 12-month Band 5 contracts from autumn 2026.
- Exploration of two annual preceptorship cohorts.
- Recruitment to parental leave cover and NHSE Graduate Scheme application.

# Perinatal workforce - Medical




/

**Obstetrics**: A fixed-term consultant has been appointed at PRH to cover a sabbatical, with the post designed to support the Endometriosis Centre and release additional fetal medicine time within other job plans. The medical workforce efficiency review has highlighted a very high locum spend to cover middle-grade rota gaps across all four sites, and work is underway to rationalise this spend and redirect funding towards substantive LED posts. The interviews for the ROC post for SRH took place in July.

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

# Perinatal workforce – Neonatal Nursing

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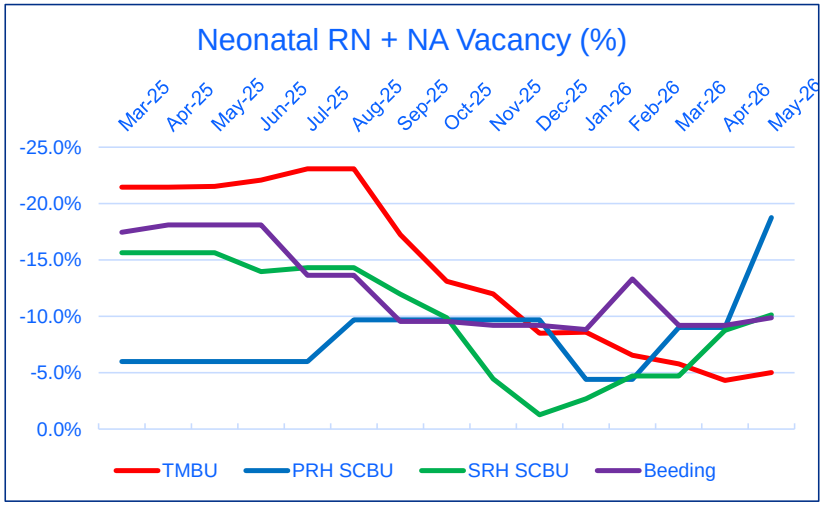


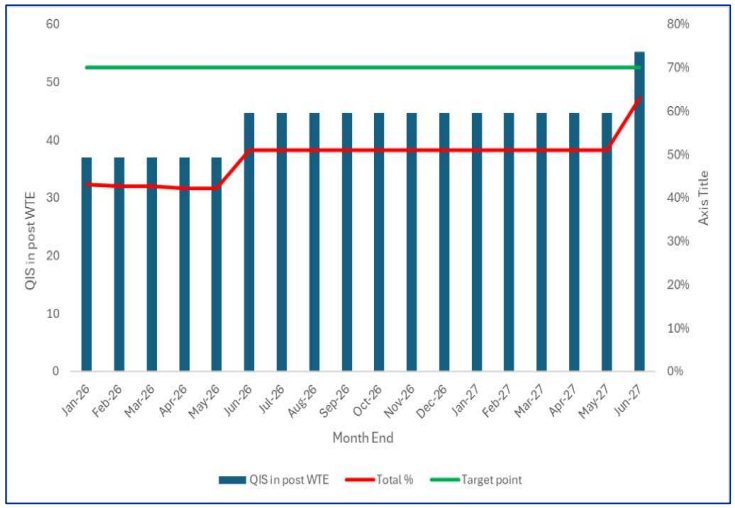


- In May, the clinical registered nursing vacancies across a 4 sites (B7-B4) has risen to an average of 10.9%. The is driven by increases at PRH from 1.49WTE to 3.10WTE (Band 6 and Band 4) and SRH from 1.99WTE to 2.3WTE (Band 6 & Band 5).
TMBU QIS staffing remains static at 37 WTE (42–43%) until this month May with 10 WTE's completing QIS course. This increases to 44.7 WTE (50.9%) from June 2026 and should be sustained through to May 2027. A further planned increase to 55.2 WTE (63%) is projected for June 2027.

**Actual verses Planned**
Overall, in May there was no large variation/difficulties within registered staffing.

## Nursing Vacancy

| May | WTE |
|---|---|
| TMBU | 4.95 |
| PRH | 3.10 |
| SRH | 2.30 |
| Beeding | 2.20 |

# TMBU refusals

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| | Surgical Babies | Extreme Prem 22Wks-29wks | Refused - Staffing | Refused - Maternity refusal | Refused - TMBU Full | Refused from Worthing | Out of Network | Refused Unknown | Refused Other | Total number of babies refused |
|---|---|---|---|---|---|---|---|---|---|---|
| Refusals IN Utero | 0 | 12 | 8 | 0 | 5 | 0 | 2 | 1 | 0 | 14 |
| Refusals Ex Utero | 2 | 0 | 2 | 0 | 1 | 0 | 0 | 1 | 0 | 4 |

March 24 referrals (15IUT/9 EUT, 6 being surgical)
April 45 referrals (29 IUT/16 EUT, 11 being surgical)
May 31 referrals (21 IUT/10 EUT, 2 being surgical)

- **Referrals accepted May 2026**

IUT (7/21) accepted. 14 refused.

EUT (6/10) accepted. 4 refused.

EUT (surgical) 0/2) accepted. 2 refused.

No repatriations identified within ITU to free capacity. There were 5-6 ventilated ITU babies for most of May, each needing a QIS nurse and intensive care space.

Refusals driven by:

- a combination of high acuity
- on occasions a full ITU and low QIS numbers

There was an 83% occupancy rate overall in May for TMBU of which 84% ITU, 56% HDU and 103% SCBU days.

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# Safety Improvement Plan via MNIST/Care Bundles/CNST

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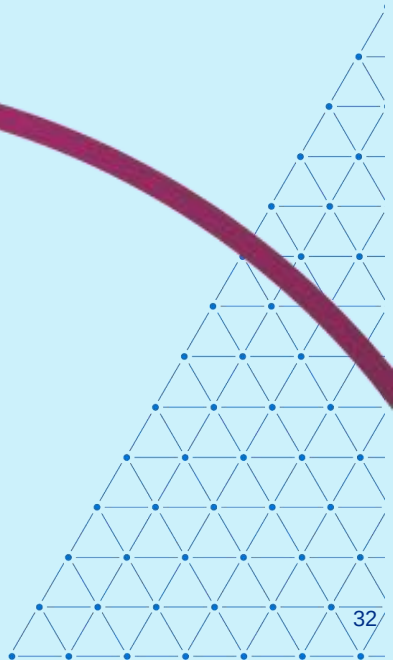
# MNIST/CNST



# Barriers and enablers

University Hospitals Sussex NHS Foundation Trust

Enablers

- Informal meeting with auditors to discuss new requirements and share learning from other Trust
- Workstream groups underway
- Service user experience and translation projects on track
- Strong governance processes meets standards

Barriers

- Budget setting implications impact ability to meet Safety Action A:
  - Neonatal workforce plans towards BAPM compliance
  - BR+ recommendations requiring approval by Nov 2026
  - More detail will be provided in a separate paper to PRG
- 90% training compliance across two points in the year (31/07/26 and 30/11/26)
  - Evidence of MDT faculty required – not achieved at WH/SRH
  - Issues with attendance at WH/SRH, specifically for anaesthetists
- Implementation plan for Maternal Care Bundle required by November, with no additional funding to implement from March 2027.

# Training compliance June 2026

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| UHSx | Skills Drills (inc NBLS) | | |
|---|---|---|---|
| Staff group | All staff | In date | % compliance |
| Obstetric Anaesthetic Consultant | 43 | 39 | 91% |
| Anaesthetic other | 99 | 87 | 88% |
| Obstetric consultants | 40 | 35 | 88% |
| Obstetric other | 59 | 53 | 90% |
| Midwives inc Bank | 558 | 529 | 95% |
| Support staff and nurses inc Bank | 202 | 187 | 93% |
| | ***1001*** | ***930*** | ***93%*** |

| UHSx | FM (attendance) | | |
|---|---|---|---|
| Staff group | All staff | In date | % compliance |
| Obstetric consultants | 39 | 36 | 92% |
| Obstetric other | 48 | 40 | 83% |
| Midwives inc Bank | 539 | 492 | 91% |
| | ***626*** | ***568*** | ***91%*** |

- End of July update – checkpoint 1:
  - As of 17th July, all staff groups across Maternity and Neonatal have achieved >90% compliance for NBLS, PROMPT and Fetal Monitoring. Full stats will be included in the August QGSG paper.
  - The next compliance checkpoint is 30 November, which will be challenging especially for doctors due to the new rotations of resident doctors that need to be trained by this date.

# Compliance risks and mitigations

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| Safety Action | Risks to compliance | Overall RAG | Next steps |
|---|---|---|---|
| A - Workforce and capacity | SAA3 Budget setting implications impact ability to continue previous plans towards BAPM compliance with neonatal nursing and medical establishment<br>SAA4 BR+ recommendations for midwifery establishment require additional funding | | Reviewed at Business Case Scrutiny Panel and Divisional DAM – requires re-discussion at Exec Management Team meeting WC 29/06/26.<br>Formal approval expected in July. |
| B - Training | SAB1 PROMPT MDT emergency training compliance forecast below 90% for 31/07 compliance checkpoint | | WCCS CD engaging with Surgery Divisional counterparts to ensure attendance, as well as plan to ensure anaesthetic involvement in planning and delivery of programme annually |
| C – Learning from reviews and investigations | External obstetrician to attend all remaining PMRT review meetings | | ESHT and UHSx developing plan, including resource, to support this – to ensure it begins from July. |

# Compliance overview

University Hospitals Sussex NHS Foundation Trust

| Safety Action | Risks to compliance | Overall RAG | Actions |
|---|---|---|---|
| D – Service-user voice and equity | None – standard requires us to be showing progress, which continues via service user workstream. | | Continue translation improvement plan<br>Continue work via MNIP workstream |
| E – Care Bundles | SAE2 Maternal Care Bundle plan developed with significant risks to delivery:<br>• Element 2 - MEWS to be rolled out across the Trust – IT system compatibility issues and requires central IT support. Maternity implementation plan in place.<br>• Element 3- Requires increase in Epilepsy Specialist Nurses which are currently not being approved by Vacancy Control Panel.<br>• Element 4 - Significant training and clinic capacity required to facilitate compassionate conversations about mental health for service users who score highly on EPDS. | | Action plan developed with leads<br>National implementation tool released and being reviewed by leads. Benchmarking for Q1 to take place.<br><br>Element 2 and 3 require Trust support and action.<br><br>Element 4 will require funding for clinic capacity.<br>Analytical support required to determine current demand due to issues with Badgernet data accessibility.<br><br>(See implementation plan next slides) |
| F – Board oversight, governance, culture and leadership | SAF2 MOSS critical safety check to be undertaken and sent via region, requires BI support | | Planning underway for test drills at each site |



Meeting of the Board of Directors in Public; Thursday 17 September; 10am; Worthing Hospital-17/09/26
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# Maternal Care Bundle

# Background and overview of progress

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- CNST requires that *"In collaboration with all relevant services, the provider agrees a plan with the Trust Board to implement the Maternal Care Bundle by March 2027. Progress with implementation is reviewed quarterly through established governance routes."*
- The Maternal Care Bundle programme remains largely on track for delivery by 31 March 2027, with implementation activity underway across all five bundle elements. The Q1 report will be a benchmarking exercise against the NHSE MCB implementation tool (due Sept 2026).
- However, there are some significant challenges to delivery, exacerbated by the lack of additional funding to deliver the interventions. These include:
  - Digital dependencies: Required BadgerNet developments for VTE, Whooley screening and EPDS remain dependent on supplier configuration and national escalation.
  - Workforce and clinic capacity: Epilepsy service model requires epilepsy specialist nursing and clinic capacity expansion. Additional capacity likely required for mental health assessment and support pathways also.
  - Cross-organisational implementation: VTE pathway relies on agreement across primary, acute and maternity services and establishment of prescribing arrangements before booking.

# Implementation Plan

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| Intervention | Key Actions | Lead(s) | Due Date | Status summary |
|---|---|---|---|---|
| **1.1 Early VTE identification** | Integrated pathway across services | System working group | Nov 2026 | Led by Sussex Maternity Medicine Network, ongoing. |
| **1.2 Early LMWH prescribing** | LMWH pathway and follow-up arrangements | System working group | Aug 2026 | Guideline developed and being reviewed by Mat Med Network. |
| **1.2 VTE capacity** | Capacity modelling and clinic planning | Service managers | Mar 2027 | Underway. |
| **1.3 VTE assessment** | BadgerNet digital risk scoring | Digital Team | Sept 2026 | Booking form being updated |
| **2.1 MEWS** | Trust-wide rollout and training | Maternity & IT | March 2027 | Maternity roll out planned and underway. Trust wide roll out requires IT and wider Trust leadership. |
| **2.2 Pre-alert system** | Communication and signage standardisation | Estates/Site Teams | Complete | Complete |
| **2.3 MMC referrals** | Referral pathways and SOPs | ED & MM Leads | Mar 2027 | Being developed by Maternal Medicine Network |
| **3.1 Epilepsy service** | Clinics, SOPs, workforce and training | Neurology/Obstetric/MM Leads | Mar 2027 | Requires increase in Epilepsy Specialist Nurses, currently not being approved at VCP. SRH unlikely to have provision. |
| **3.2 MMN MDT referrals** | No further action required | N/A | Complete | Complete |
| **4.1 Whooley screening** | Screening, referrals and digital changes | MH Leads & Digital | March 2027 | Badgernet roll out not yet available, could require manual upload of separate forms, making auditing challenging. |
| **4.2 EPDS** | Implementation, guidance and training | MH Leads & Digital | March 2027 | Requires Badgernet updates, could require manual upload of separate forms. Increased MH training required. Guideline being updated. |
| **4.3 EPDS response** | Clinic capacity, training and referrals | MH Leads, service leads | Mar 2027 | Will require increase in community clinic time to discuss results and create care plan, including referrals. |
| **5.1 Blood loss** | Training, equipment and guidance | Anaesthetic Leads | Jan 2027 | Equipment can be ordered, training and comms planned |
| **5.2 PPH escalation** | Compliant guidance | N/A | Complete | Complete |
| **5.3 MDT reviews** | ROTEM and governance | Anaesthetic Leads | Dec 2026 | Equipment ordered. Quality Control being established. |

# MNIST support – ELCS theatre progress update

University Hospitals Sussex NHS Foundation Trust

| Site | ELCS theatre provision | Gap | Next steps |
|---|---|---|---|
| RSCH | Two all-day ELCS lists. | None identified — service needs to be maintained at this level. | Ensure continuity of provision. |
| PRH | ELCS provision in place only on labour ward; awaiting approval from Business Case Scrutiny Panel. | 16 hours of operating time required. | The paper will be resubmitted to BCSP in August following further Executive discussion regarding funding and service impact. |
| WH | ELCS provision in place only on labour ward | 16 hours of operating time required. | Once the PRH paper is considered and approved, WH is likely to follow a similar model. |
| SRH | One all-day operating list. | Requirement for an additional all-day list. | Work is almost completed to recoup funding from the monthly budget-setting process. We are also pursuing an additional 8 hours of operating capacity. |

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# In Summary

# Conclusion and recommendations

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The Trust can take assurance that perinatal outcomes remain strong, with mortality rates stable, below national averages and among the best in comparable organisations.

However, several risks require continued oversight. Training compliance remains variable—particularly for fetal monitoring and MDT training—and poses a potential risk to CNST compliance if not improved at pace. Workforce pressures persist, including rota gaps, training attendance challenges, and neonatal capacity constraints impacting transfers and refusals.

Patient experience is generally positive but inconsistent across sites, with response rates and feedback requiring improvement. Homebirth service disruption and staffing gaps have affected choice for some women.

Overall, while quality outcomes remain strong, delivery risks relating to workforce, training compliance, and process consistency require focused executive oversight and sustained improvement

Report prepared by: Sally Harborow, Maternity Clinical Effectiveness Manager, Stephanie White, Head of Quality & Safety for Women and Children, Gail Addison, Head of Midwifery for SRH & WH, Frances Barnes, Head of Midwifery for RSCH/PRH, Fiona Stubbs, Head of Nursing for Neonatology, John Bell, Matron for Community Midwifery RSCH/PRH, Rosie Jennings, Recruitment and Retention Lead Midwife

# In Summary

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NHS Foundation Trust

**Key Board Message: Safety and operational performance remain stable across UHSussex maternity services, with no national safety signals and sustained 100% 1:1 care in labour. Focus remains on learning from the SRH maternal death investigation, strengthening training compliance and improving women's experience through better communication and personalised care.**

**What Next**:

- Complete MNSI/PSII investigation and implement learning from maternal death case.
- Improve fetal monitoring training compliance across all sites.
- Strengthen communication, consent and personalised care in response to patient feedback.
- Continue monitoring perinatal outcomes and MOSS indicators for emerging trends.
- Deliver MOSS implementation programme, including SOP ratification and simulation drills.
- Maintain workforce focus on vacancies, appraisal compliance and staff wellbeing

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# Appendix 1
# Morbidity and Mortality Outcome Data
# May 2026 – ICB Contribution

***HIE rates in the Appendix include HIE1***

UHSx

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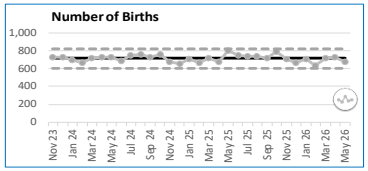
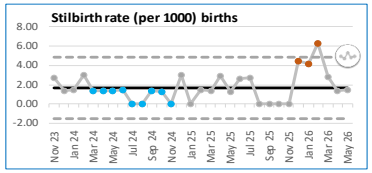
## Maternity overview — UHSX NHS Foundation Trust (monthly SB & NND rates)

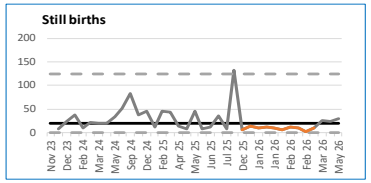
**Latest month** 01/05/26
**Number of Births** 676
No significant change



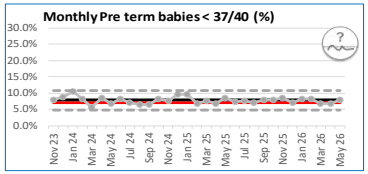

**Latest month** 01/05/26
**Stilbirth rate (per 1000) births** 1.48
No significant change



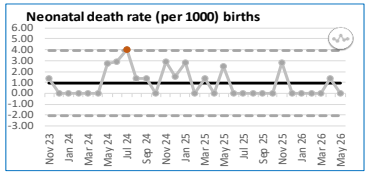

**Date of last stillbirth** 22/05/26
**Average days between stillbirths** 25.4
No significant change



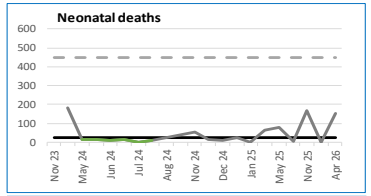

**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 8.0%
No significant change



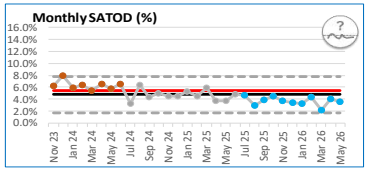

**Latest month** 01/05/26
**Neonatal death rate (per 1000) births** 0.00
No significant change



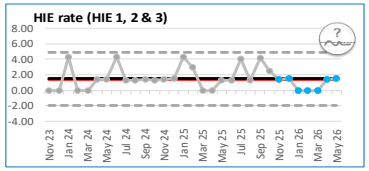

**Date of last neonatal death** 17/04/26
**Average days between deaths** 44.8
No significant change



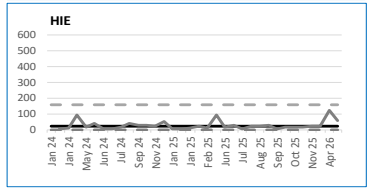

**Latest month** 01/05/26
**Monthly SATOD (%)** 3.6%
Significant Improvement



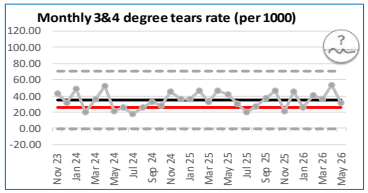

**Latest month** 01/05/26
**HIE rate (HIE 1, 2 & 3)** 1.48
Significant Improvement



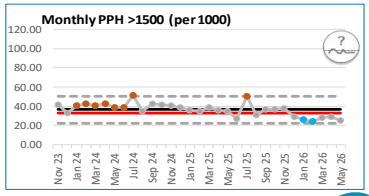

**Date of last HIE** 29/05/26
**Average days between HIE** 26.3
No significant change



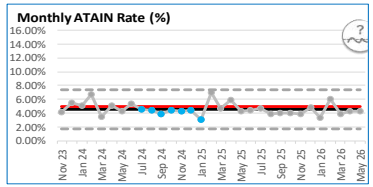

**Latest month** 01/05/26
**Monthly 3&4 degree tears rate (per 1000)** 31.9
No significant change




**Latest month** 01/05/26
**Monthly PPH >1500 (per 1000)** 25.49
No significant change




**Latest month** 01/05/26
**Monthly ATAIN Rate (%)** 4.3%
No significant change



# Haywards Heath

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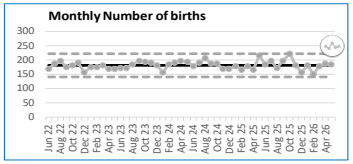
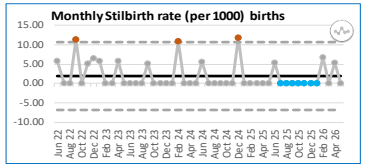
**Maternity overview** PRH

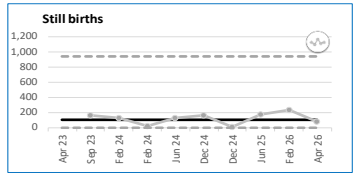
**Latest month** 01/05/26
**Number of births** 184
No significant change



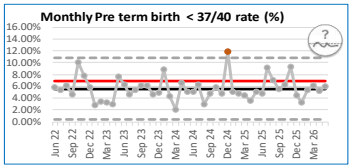

**Latest month** 01/05/26
**Still birth rate/1000** 0.00
No significant change



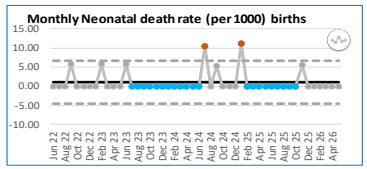

**Date of last stillbirth** 23/04/26
**Average days between stillbirths** 122.0
No significant change



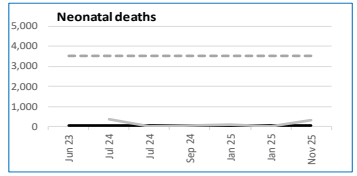

**Latest month** 01/05/26
**Pre term babies < 37 weeks** 5.98%
No significant change



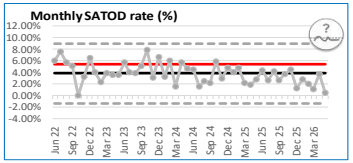

**Latest month** 01/05/26
**Neonatal Death rate/1000** 0.00
No significant change



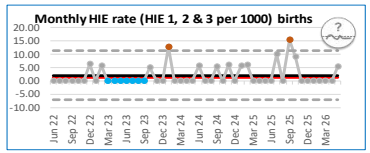

**Date of last neonatal death** 13/11/25
**Average days between deaths** 148.4
No significant change



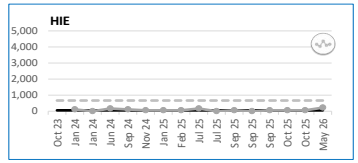

**Latest month** 01/05/26
**Monthly SATOD rate (%)** 0.6%
No significant change



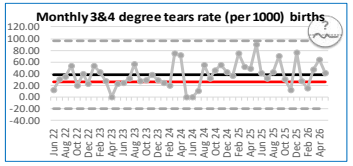

**Latest month** 01/05/26
**HIE rate/1000** 5.43
No significant change



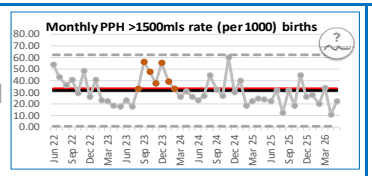

**Date of last HIE** 29/05/26
**Average days between HIE** 64.2
No significant change



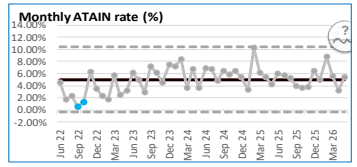

Latest month 01/05/26
**3&4 degree tears (per 1000)** 41.2
No significant change




**Latest month** 01/05/26
**PPH >1500 (per 1000)** 21.9
No significant change




**Latest month** 01/05/26
**ATAIN** 5.43%
No significant change

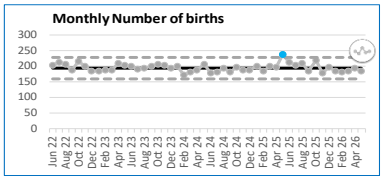


# Brighton

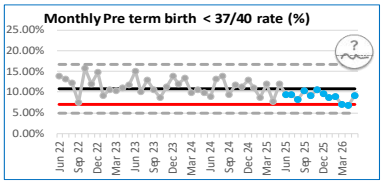
University Hospitals Sussex
NHS Foundation Trust

**Maternity overview** RSCH

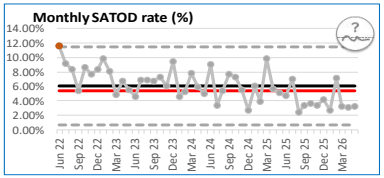
**Latest month** 01/05/26
**Number of births** 184
No significant change



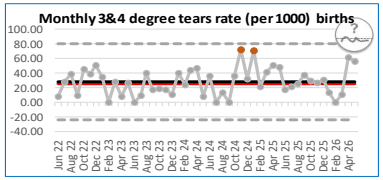

**Latest month** 01/05/26
**Pre term babies < 37 weeks** 9.24%
Significant Improvement



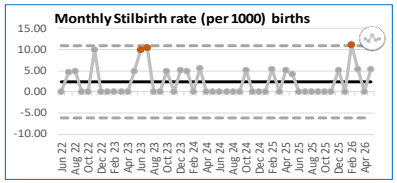

**Latest month** 01/05/26
**Monthly SATOD rate (%)** 3.3%
No significant change



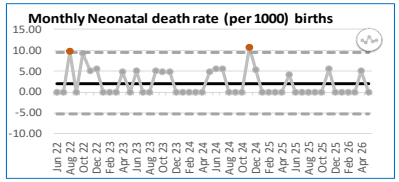

**Latest month** 01/05/26
**3&4 degree tears (per 1000)** 56.8
No significant change



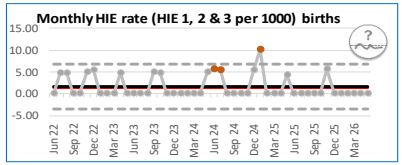

**Latest month** 01/05/26
**Still birth rate/1000** 5.46
No significant change



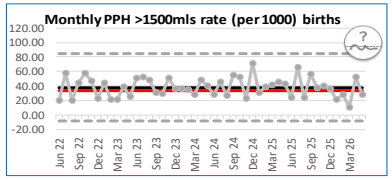

**Latest month** 01/05/26
**Neonatal Death rate/1000** 0.00
No significant change



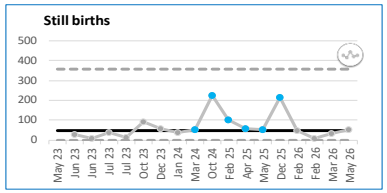

**Latest month** 01/05/26
**HIE rate/1000** 0.00
No significant change



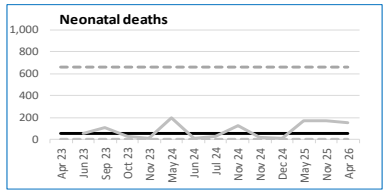

**Latest month** 01/05/26
**PPH >1500 (per 1000)** 27.6
No significant change



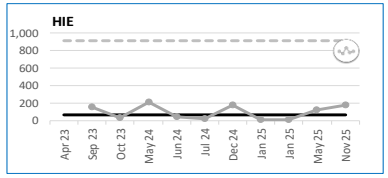

**Date of last stillbirth** 22/05/26
**Average days between stillbirths** 65.6
No significant change



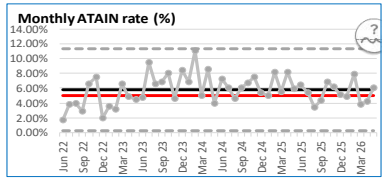

**Date of last neonatal death** 17/04/26
**Average days between deaths** 84.7
No significant change




**Date of last HIE** 14/11/25
**Average days between HIE** 95.2
No significant change




**Latest month** 01/05/26
**ATAIN** 6.04%
No significant change

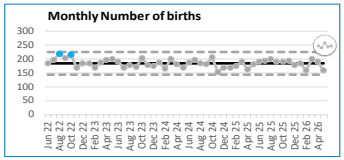


# Chichester

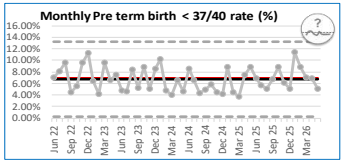
University Hospitals Sussex NHS Foundation Trust

**Maternity overview** SRH

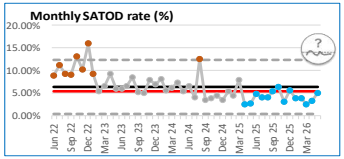
**Latest month** 01/05/26
**Number of births** 158
No significant change



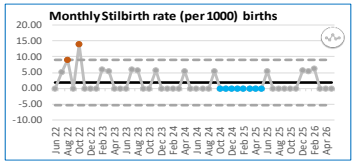

**Latest month** 01/05/26
**Pre term babies < 37 weeks** 5.06%
No significant change



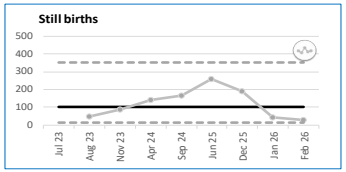

**Latest month** 01/05/26
**Monthly SATOD rate (%)** 5.1%
Significant Improvement



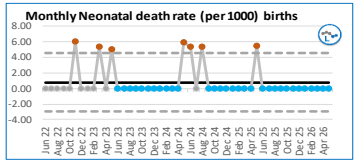

**Latest month** 01/05/26
**Still birth rate/1000** 0.00
No significant change



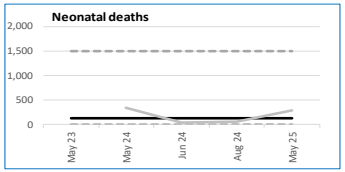

**Date of last stillbirth** 25/02/26
**Average days between stillbirths** 120.5
No significant change



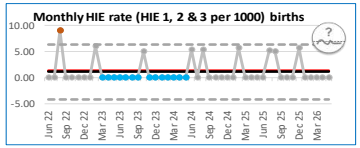

**Latest month** 01/05/26
**Neonatal Death rate/1000** 0.00
Significant Improvement



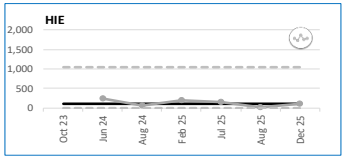

**Date of last neonatal death** 26/05/25
**Average days between deaths** 181.8
No significant change



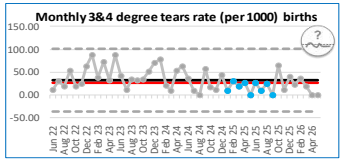

**Latest month** 01/05/26
**HIE rate/1000** 0.00
No significant change



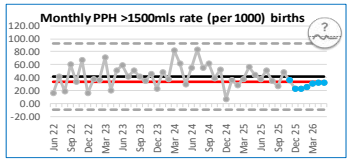

**Date of last HIE** 03/12/25
**Average days between HIE** 127.5
No significant change



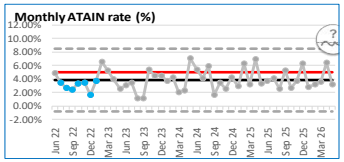

**Latest month** 01/05/26
**3&4 degree tears (per 1000)** 0.0
No significant change




**Latest month** 01/05/26
**PPH >1500 (per 1000)** 31.9
Significant Improvement




**Latest month** 01/05/26
**ATAIN** 3.16%
No significant change

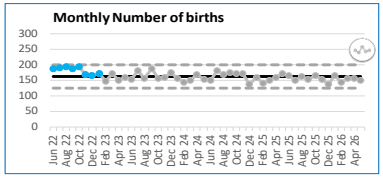


# Worthing

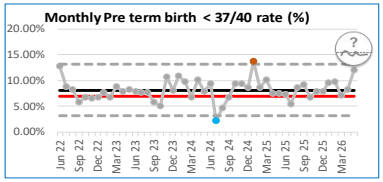
NHS
University Hospitals Sussex
NHS Foundation Trust

**Maternity overview** WH

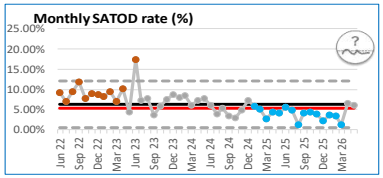
**Latest month** 01/05/26
**Number of births** 150
No significant change



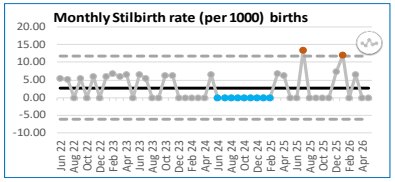

**Latest month** 01/05/26
**Pre term babies < 37 weeks** 12.00%
No significant change



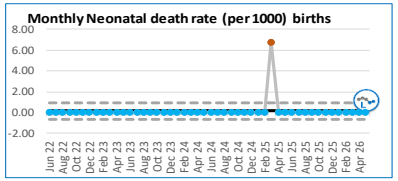

**Latest month** 01/05/26
**Monthly SATOD rate (%)** 6.2%
No significant change



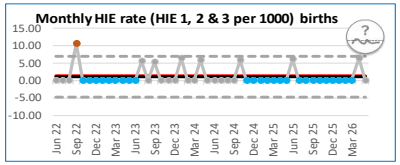

**Latest month** 01/05/26
**Still birth rate/1000** 0.00
No significant change



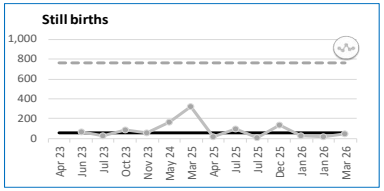

**Latest month** 01/05/26
**Neonatal Death rate/1000** 0.00
Significant Improvement



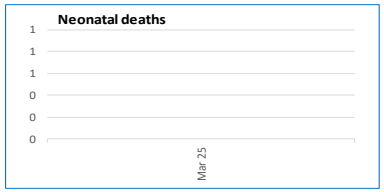

**Latest month** 01/05/26
**HIE rate/1000** 0.00
No significant change



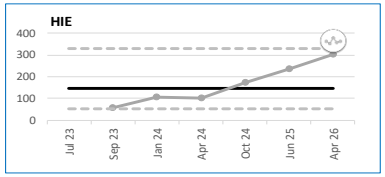

**Date of last stillbirth** 06/03/26
**Average days between stillbirths** 82.2
No significant change



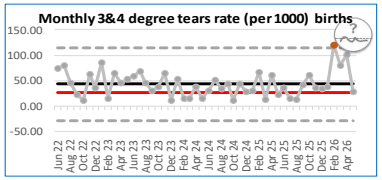

**Date of last neonatal death** 08/03/25
**Average days between deaths**
No significant change



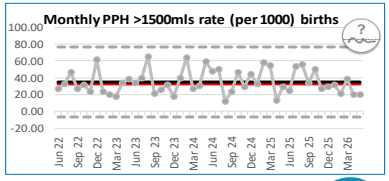

**Date of last HIE** 03/04/26
**Average days between HIE** 163.0
No significant change



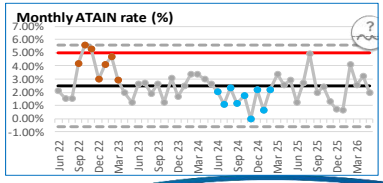

**Latest month** 01/05/26
**3&4 degree tears (per 1000)** 28.6
No significant change




**Latest month** 01/05/26
**PPH >1500 (per 1000)** 20.6
No significant change




**Latest month** 01/05/26
**ATAIN** 2.00%
No significant change



Excellent Care Everywhere

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# Appendix 2
# Health Inequalities Segmented Data
# May 2026 – ICB Contribution

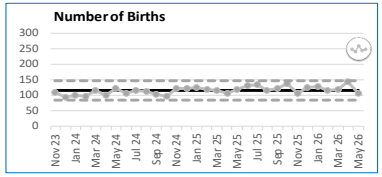
***HIE rates in the Appendix include HIE1***

# UHSx– Global Majority

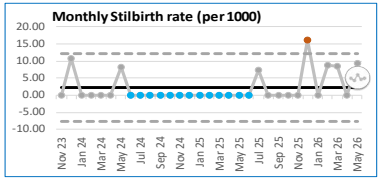
NHS
University Hospitals Sussex
NHS Foundation Trust

**Maternity overview** | **UHSX BME**

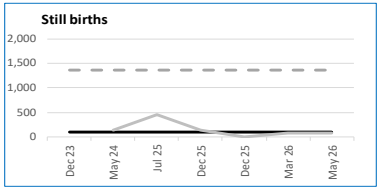
**Latest month** 01/05/26
**Number of Births** 107
No significant change



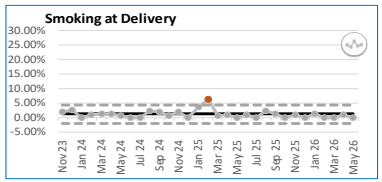

**Latest month** 01/05/26
**Monthly Stilbirth rate (per 1000)** 9.35
No significant change



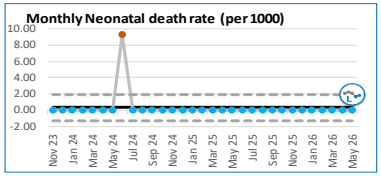

**Date of last stillbirth** 22/05/26
**Average days between stillbirths** 147.3
No significant change



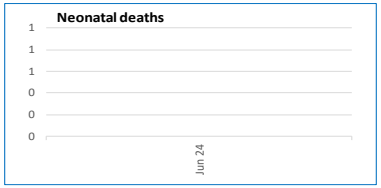

**Latest month** 01/05/26
**Smoking at Delivery** 0.0%
No significant change



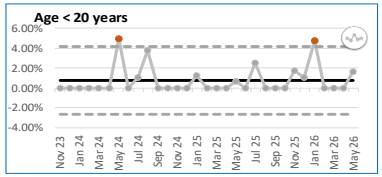

**Latest month** 01/05/26
**Monthly Neonatal death rate (per** 0.00
Significant Improvement



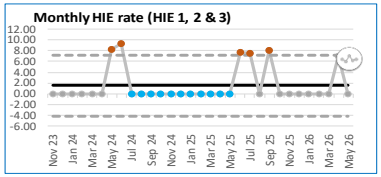

**Date of last neonatal death** 07/06/24
**Average days between deaths**
No significant change



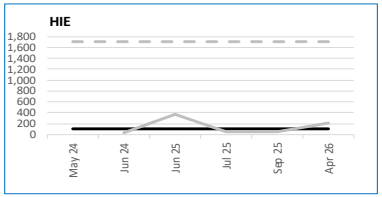

**Latest month** 01/05/26
**Age < 20 years** 1.7%
No significant change



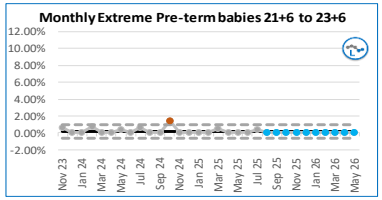

**Latest month** 01/05/26
**Monthly HIE rate (HIE 1, 2 & 3)** 0.00
No significant change



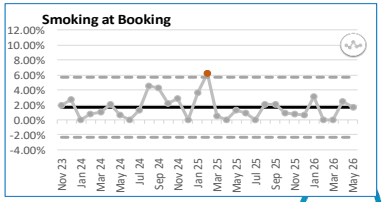

**Date of last HIE** 03/04/26
**Average days between HIE** 138.6
No significant change



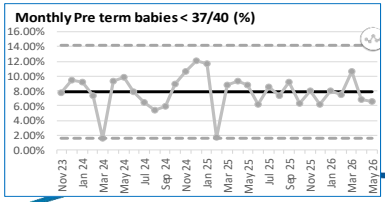

Latest month 01/05/26
**Monthly Extreme Pre-term babies 21+6 to 23+6** 0.0%
Significant Improvement




**Latest month** 01/05/26
**Smoking at Booking** 1.7%
No significant change




**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 6.6%
No significant change

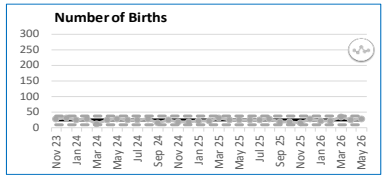


# UHSx– 10% most deprived

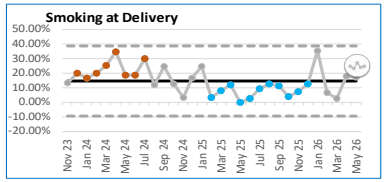
University Hospitals Sussex
NHS Foundation Trust

**Maternity overview** | **UHSX 10% Most Deprived**

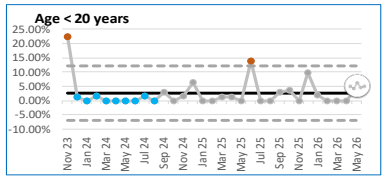
**Latest month** 01/05/26
**Number of Births** 27
No significant change



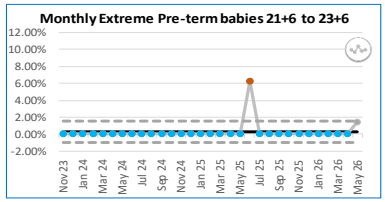

**Latest month** 01/05/26
**Smoking at Delivery** 16.9%
No significant change



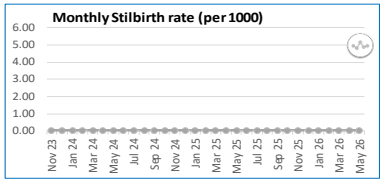

**Latest month** 01/05/26
**Age < 20 years** 4.2%
No significant change




**Latest month** 01/05/26
**Monthly Extreme Pre-term babies 21+6 to 23+6** 1.5%
No significant change

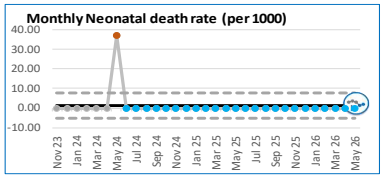



**Latest month** 01/05/26
**Monthly Stilbirth rate (per 1000)** 0.00
No significant change

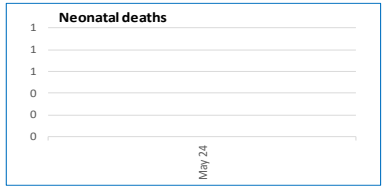



**Date of last stillbirth**
**Average days between stillbirths**
No significant change

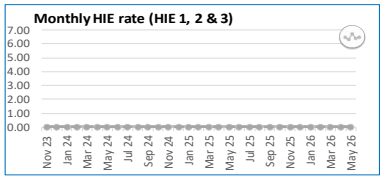
**Latest month** 01/05/26
**Monthly Neonatal death rate (per** 0.00
Significant Improvement




**Date of last neonatal death** 06/05/24
**Average days between deaths**
No significant change

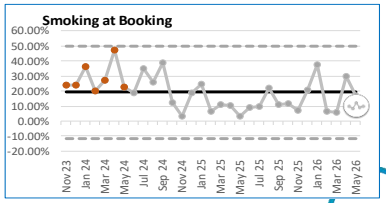



**Latest month** 01/05/26
**Monthly HIE rate (HIE 1, 2 & 3)** 0.00
No significant change

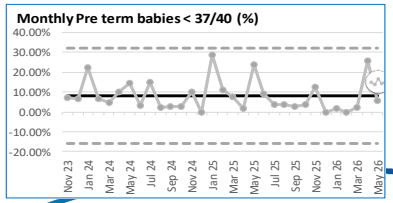



**Date of last HIE**
**Average days between HIE**
No significant change

**Latest month** 01/05/26
**Smoking at Booking** 16.9%
No significant change




**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 5.9%
No significant change

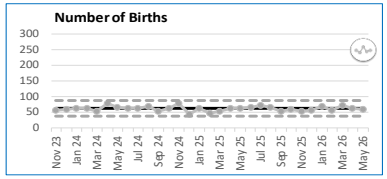


# UHSx – 20% most deprived

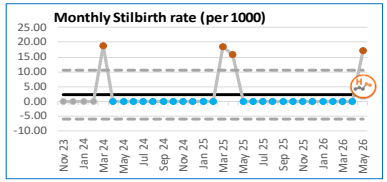
University Hospitals Sussex NHS Foundation Trust

**Maternity overview** | **UHSX 20% Most Deprived**

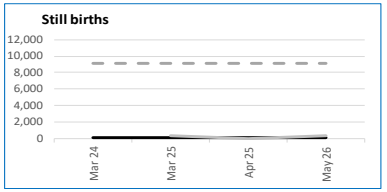
**Latest month** 01/05/26
**Number of Births** 58
No significant change



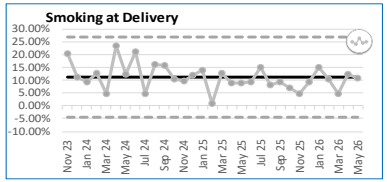

**Latest month** 01/05/26
**Monthly Stilbirth rate (per 1000)** 17.24
Significant deterioration



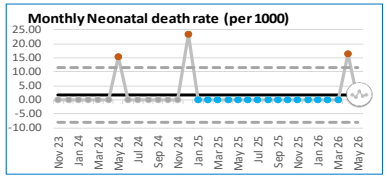

**Date of last stillbirth** 22/05/26
**Average days between stillbirths** 264.7
No significant change



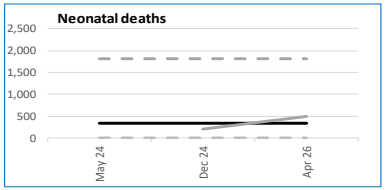

**Latest month** 01/05/26
**Smoking at Delivery** 10.9%
No significant change



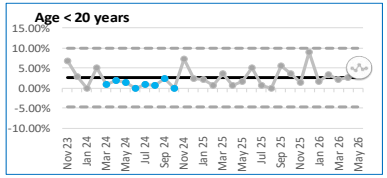

**Latest month** 01/05/26
**Monthly Neonatal death rate (per** 0.00
No significant change



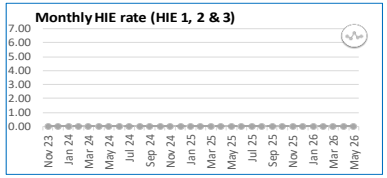

**Date of last neonatal death** 17/04/26
**Average days between deaths** 355.5
No significant change




**Latest month** 01/05/26
**Age < 20 years** 3.7%
No significant change

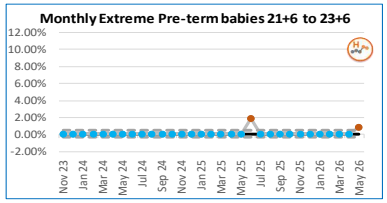



**Latest month** 01/05/26
**Monthly HIE rate (HIE 1, 2 & 3)** 0.00
No significant change

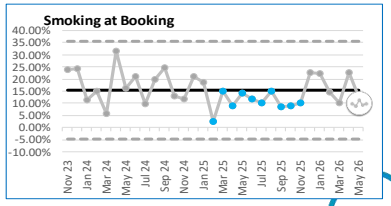



**Date of last HIE**
**Average days between HIE**
No significant change

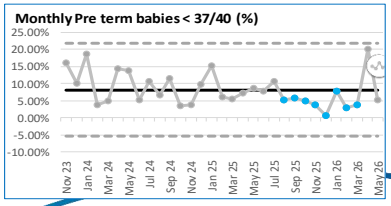
Latest month 01/05/26
**Monthly Extreme Pre-term babies 21+6 to 23+6** 0.9%
Significant deterioration




**Latest month** 01/05/26
**Smoking at Booking** 12.6%
No significant change




**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 5.4%
No significant change

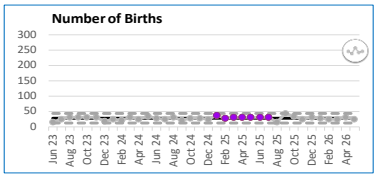


# Haywards Heath – Global Majority

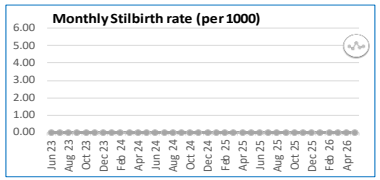
University Hospitals Sussex NHS Foundation Trust

**Maternity overview** PRH BME

**Latest month** 01/05/26
**Number of Births** 24
No significant change

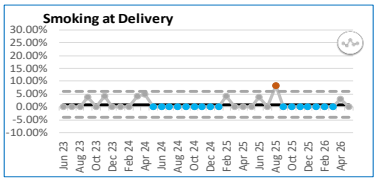



**Latest month** 01/05/26
**Monthly Stillbirth rate (per 1000)** 0.00
No significant change

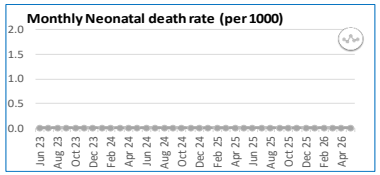



**Date of last stillbirth**
**Average days between stillbirths**
No significant change

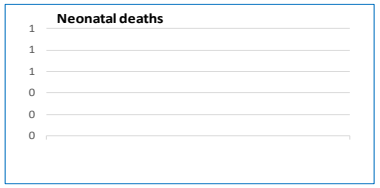
**Latest month** 01/05/26
**Smoking at Delivery** 0.0%
No significant change



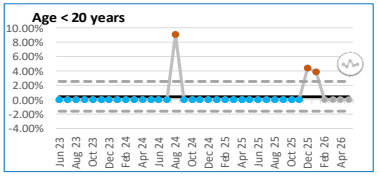

**Latest month** 01/05/26
**Monthly Neonatal death rate (per** 0.00
No significant change



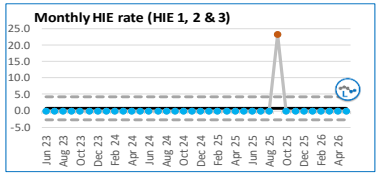

**Date of last neonatal death**
**Average days between deaths**
No significant change



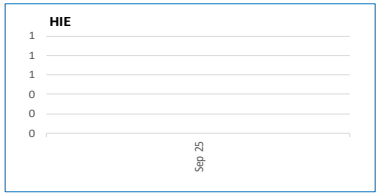

**Latest month** 01/05/26
**Age < 20 years** 0.0%
No significant change



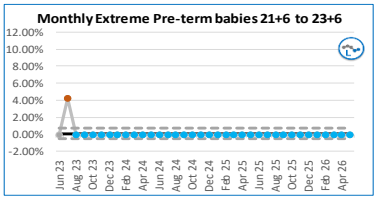

**Latest month** 01/05/26
**Monthly HIE rate (HIE 1, 2 & 3)** 0.00
Significant Improvement



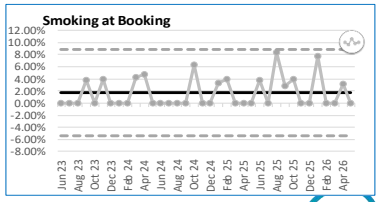

**Date of last HIE** 09/09/25
**Average days between HIE**
No significant change



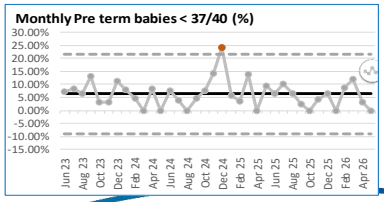

Latest month 01/05/26
**Monthly Extreme Pre-term babies 21+6 to 23+6** 0.0%
Significant Improvement




**Latest month** 01/05/26
**Smoking at Booking** 0.0%
No significant change




**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 0.0%
No significant change

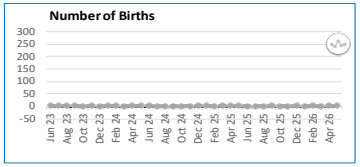


# Haywards Heath – 10% most deprived

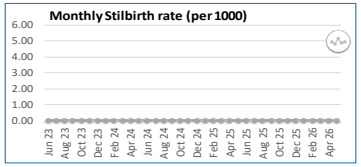
University Hospitals Sussex NHS Foundation Trust

**Maternity overview** | **PRH 10% most deprived**

**Latest month** 01/05/26
**Number of Births** 2
No significant change



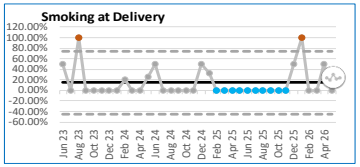

**Latest month** 01/05/26
**Monthly Stilbirth rate (per 1000)** 0.00
No significant change



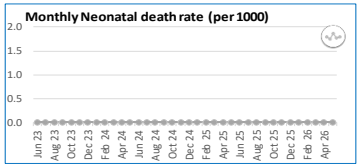

**Date of last stillbirth**

**Average days between stillbirths**
No significant change

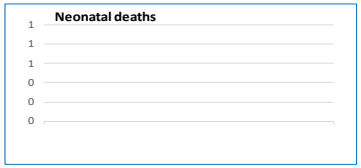
**Latest month** 01/05/26
**Smoking at Delivery** 0.0%
No significant change



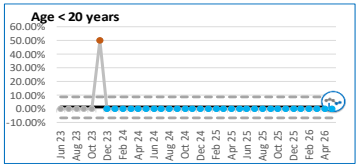

**Latest month** 01/05/26
**Monthly Neonatal death rate (per** 0.00
No significant change



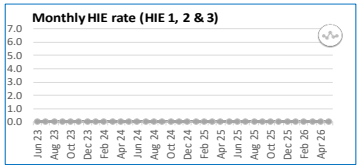

**Date of last neonatal death**
**Average days between deaths**
No significant change




**Latest month** 01/05/26
**Age < 20 years** 0.0%
Significant Improvement

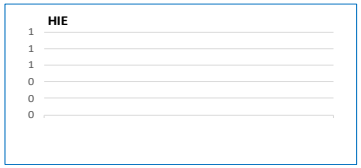



**Latest month** 01/05/26
**Monthly HIE rate (HIE 1, 2 & 3)** 0.00
No significant change

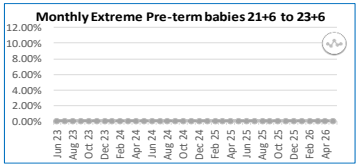



**Date of last HIE**

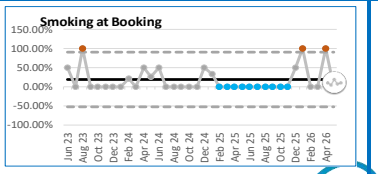
**Average days**
No significant change



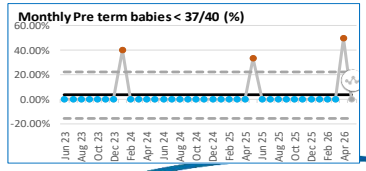

**Latest month** 01/05/26
**Monthly Extreme Pre-term babies 21+6 to 23+6** 0.0
No significant change




**Latest month** 01/05/26
**Smoking at Booking** 0.0%
No significant change




**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 0.0%
No significant change

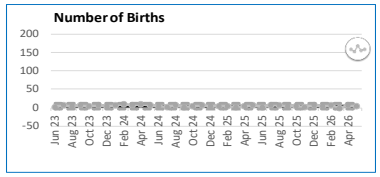


# Haywards Heath – 20% most deprived

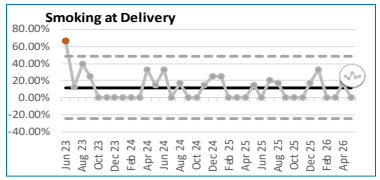
University Hospitals Sussex NHS Foundation Trust

**Maternity overview** | **PRH 20% most deprived**

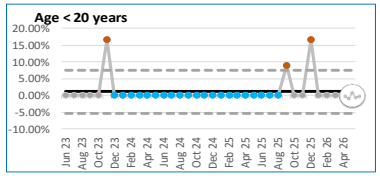
**Latest month** 01/05/26
**Number of Births** 5
No significant change



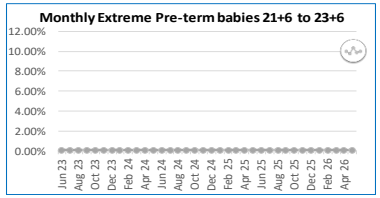

**Latest month** 01/05/26
**Smoking at Delivery** 0.0%
No significant change



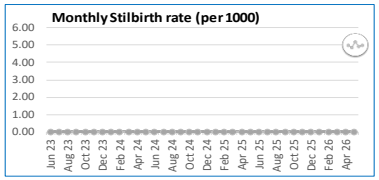

**Latest month** 01/05/26
**Age < 20 years** 0.0%
No significant change



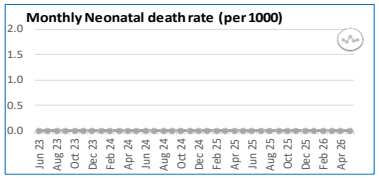

**Latest month** 01/05/26
**Monthly Extreme Pre-term babies 21+6 to 23+6** 0.0
No significant change



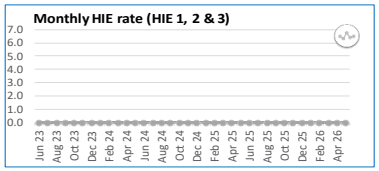

**Latest month** 01/05/26
**Monthly Stilbirth rate (per 1000)** 0.00
No significant change



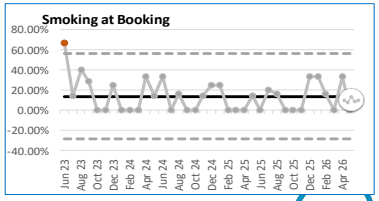

**Latest month** 01/05/26
**Monthly Neonatal death rate (per** 0.00
No significant change



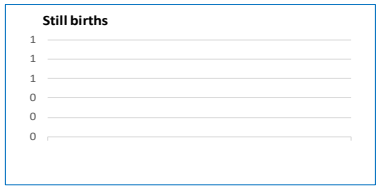

**Latest month** 01/05/26
**Monthly HIE rate (HIE 1, 2 & 3)** 0.00
No significant change



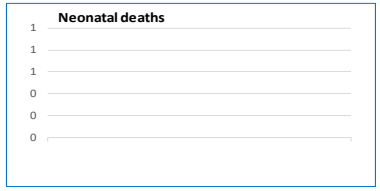

**Latest month** 01/05/26
**Smoking at Booking** 0.0%
No significant change



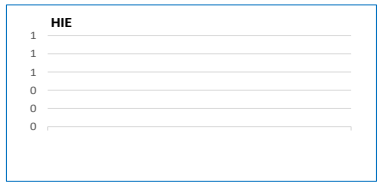

**Date of last stillbirth**
**Average days between stillbirths**
No significant change



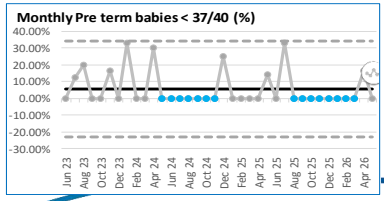

**Date of last neonatal death**
**Average days between deaths**
No significant change




**Date of last HIE**
**Average days between HIE**
No significant change




**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 0.0%
No significant change

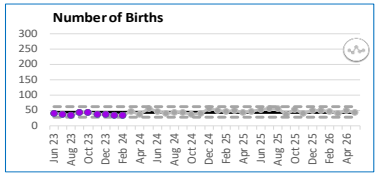


# Brighton – Global Majority

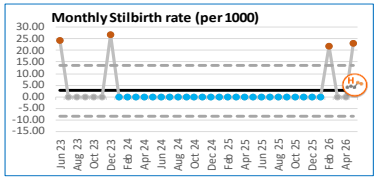
University Hospitals Sussex
NHS Foundation Trust

**Maternity overview** RSCH BME

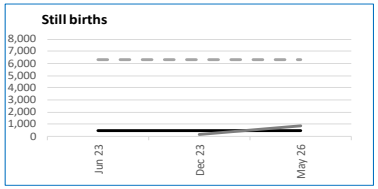
**Latest month** 01/05/26
**Number of Births** 43
No significant change



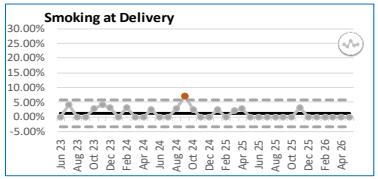

**Latest month** 01/05/26
**Monthly Stillbirth rate (per 1000)** 23.26
Significant deterioration



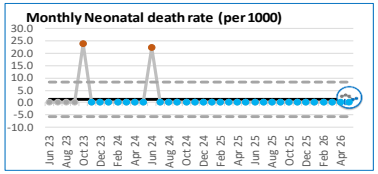

**Date of last stillbirth** 22/05/26
**Average days between stillbirths** 543.0
No significant change



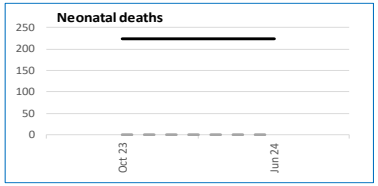

**Latest month** 01/05/26
**Smoking at Delivery** 0.0%
No significant change



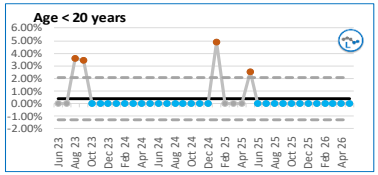

**Latest month** 01/05/26
**Monthly Neonatal death rate (per** 0.00
Significant Improvement



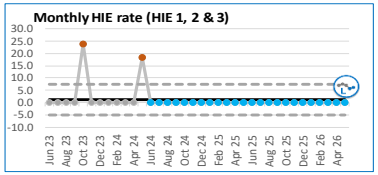

**Date of last neonatal death** 07/06/24
**Average days between deaths** 224.0
No significant change



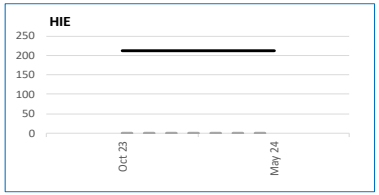

**Latest month** 01/05/26
**Age < 20 years** 0.0%
Significant Improvement



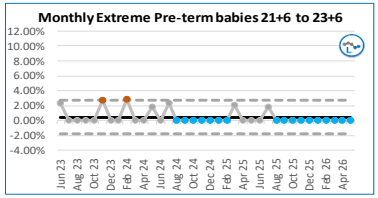

**Latest month** 01/05/26
**Monthly HIE rate (HIE 1, 2 & 3)** 0.00
Significant Improvement



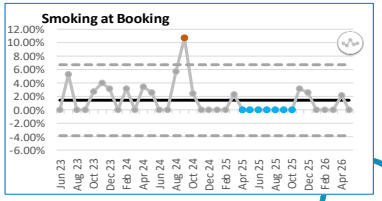

**Date of last HIE** 10/05/24
**Average days between HIE** 212.0
No significant change



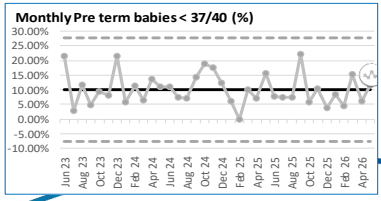

**Latest month** 01/05/26
**Monthly Extreme Pre-term babies 21+6 to 23+6** 0.0%
Significant Improvement




**Latest month** 01/05/26
**Smoking at Booking** 0.0%
No significant change




**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 11.6%
No significant change

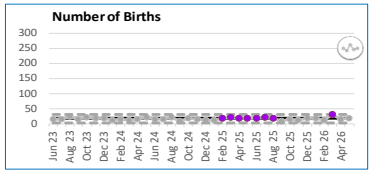


# Brighton – 10% most deprived

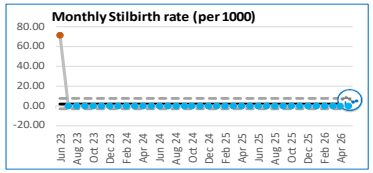
University Hospitals Sussex
NHS Foundation Trust

**Maternity overview** | **RSCH 10% most deprived**

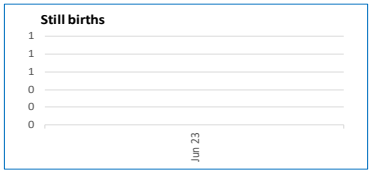
**Latest month** 01/05/26
**Number of Births** 17
No significant change



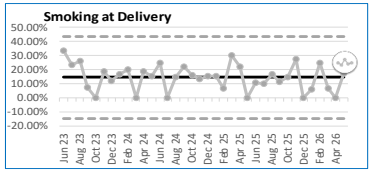

**Latest month** 01/05/26
**Monthly Stilbirth rate (per 1000)** 0.00
Significant Improvement



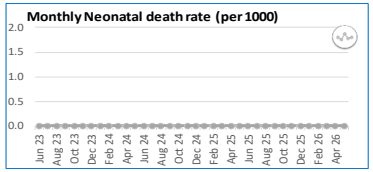

**Date of last stillbirth** 01/06/23
**Average days between stillbirths**
No significant change



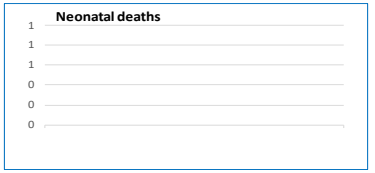

**Latest month** 01/05/26
**Smoking at Delivery** 17.6%
No significant change



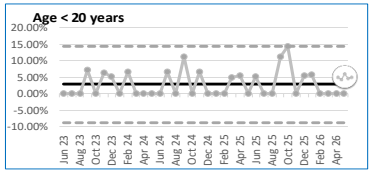

**Latest month** 01/05/26
**Monthly Neonatal death rate (per** 0.00
No significant change



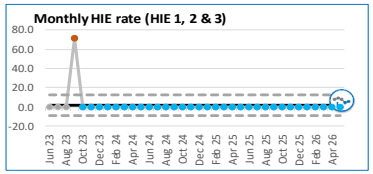

**Date of last neonatal death**
**Average days between deaths**
No significant change



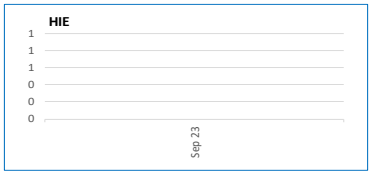

**Latest month** 01/05/26
**Age < 20 years** 0.0%
No significant change



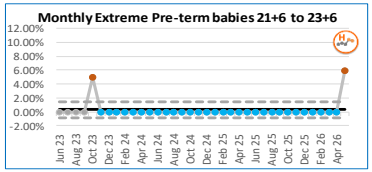

**Latest month** 01/05/26
**Monthly HIE rate (HIE 1, 2 & 3)** 0.00
No significant change



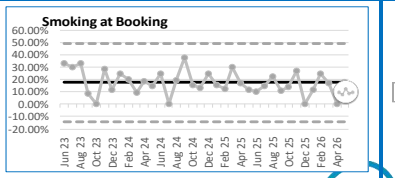

**Date of last HIE** 05/09/23
**Average days**
No significant change



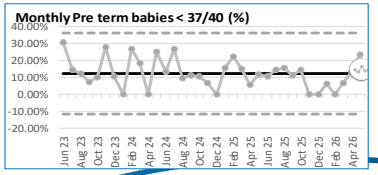

Latest month 01/05/26
**Monthly Extreme Pre-term babies 21+6 to 23+6** 0.1
Significant deterioration




**Latest month** 01/05/26
**Smoking at Booking** 17.6%
No significant change




**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 23.5%
No significant change

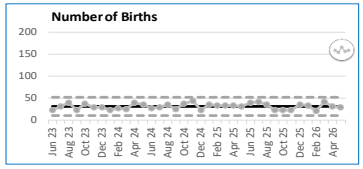


# Brighton 20% most deprived

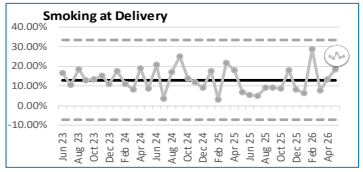
University Hospitals Sussex
NHS Foundation Trust

**Maternity overview** | **RSCH 20% most deprived**

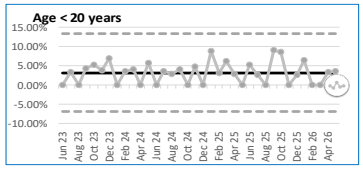
**Latest month** 01/05/26
**Number of Births** 28
No significant change



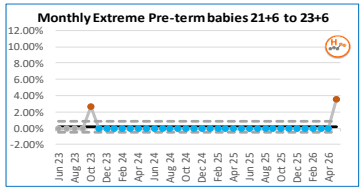

**Latest month** 01/05/26
**Smoking at Delivery** 18.5%
No significant change



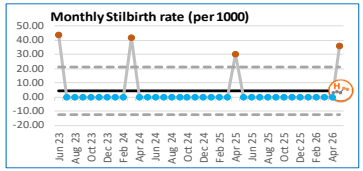

**Latest month** 01/05/26
**Age < 20 years** 3.7%
No significant change



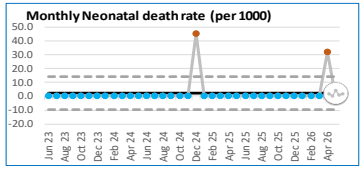

**Latest month** 01/05/26
**Monthly Extreme Pre-term babies 21+6 to 23+6** 0.0
Significant deterioration



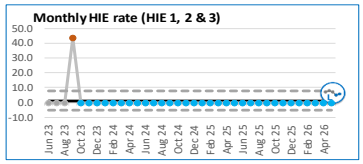

**Latest month** 01/05/26
**Monthly Stilbirth rate (per 1000)** 35.71
Significant deterioration



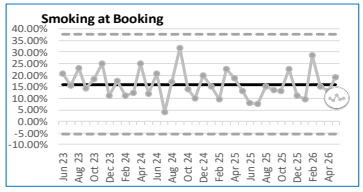

**Latest month** 01/05/26
**Monthly Neonatal death rate (per** 0.00
No significant change



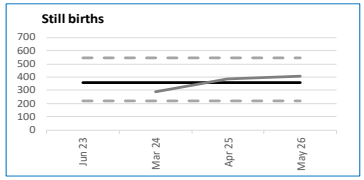

**Latest month** 01/05/26
**Monthly HIE rate (HIE 1, 2 & 3)** 0.00
Significant Improvement



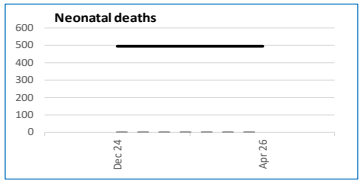

**Latest month** 01/05/26
**Smoking at Booking** 19.2%
No significant change



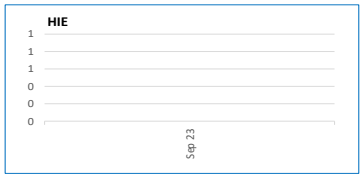

**Date of last stillbirth** 22/05/26
**Average days between stillbirths** 362.0
No significant change



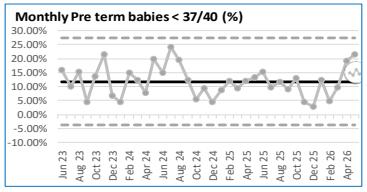

**Date of last neonatal death** 17/04/26
**Average days between deaths** 493.0
No significant change




**Date of last HIE** 05/09/23
**Average days between HIE**
No significant change




**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 21.4%
No significant change

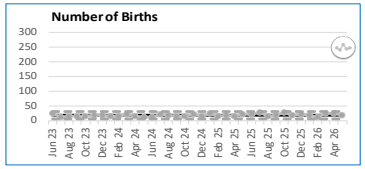


# Chichester – Global Majority

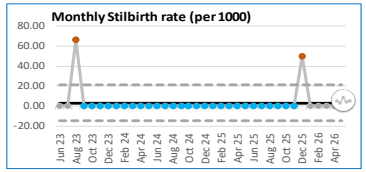
University Hospitals Sussex NHS Foundation Trust

**Maternity overview** SRH BME

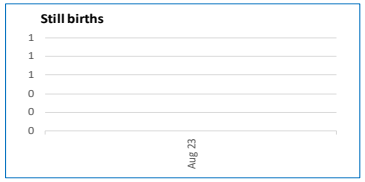
**Latest month** 01/05/26
**Number of Births** 19
No significant change



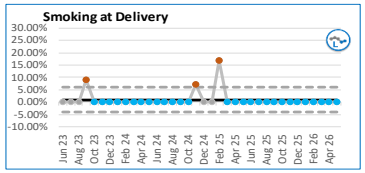

**Latest month** 01/05/26
**Monthly Stilbirth rate (per 1000)** 0.00
No significant change



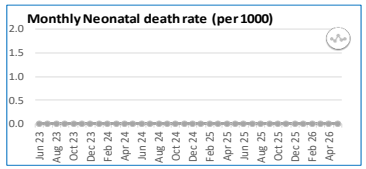

**Date of last stillbirth** 25/08/23
**Average days between stillbirths**
No significant change



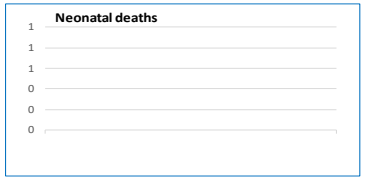

**Latest month** 01/05/26
**Smoking at Delivery** 0.0%
Significant Improvement



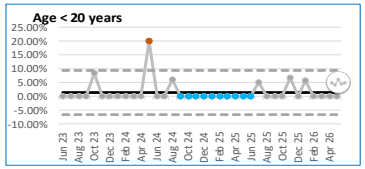

**Latest month** 01/05/26
**Monthly Neonatal death rate (per** 0.00
No significant change



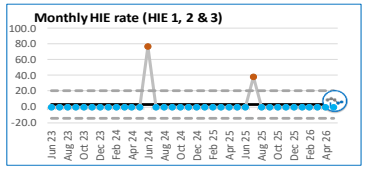

**Date of last neonatal death**
**Average days between deaths**
No significant change



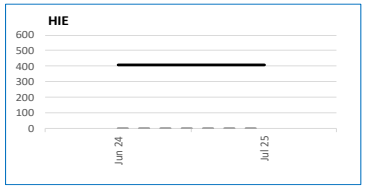

**Latest month** 01/05/26
**Age < 20 years** 0.0%
No significant change



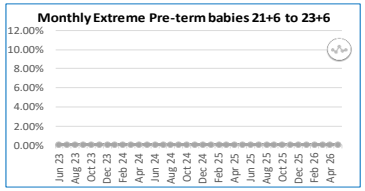

**Latest month** 01/05/26
**Monthly HIE rate (HIE 1, 2 & 3)** 0.00
Significant Improvement



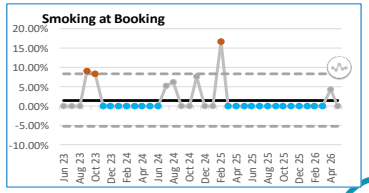

**Date of last HIE** 29/07/25
**Average days between HIE** 407.0
No significant change



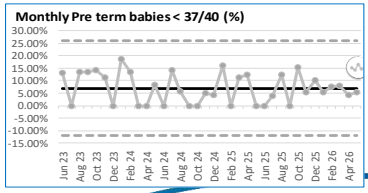

**Latest month** 01/05/26
**Monthly Extreme Pre-term babies 21+6 to 23+6** 0.0%
No significant change




**Latest month** 01/05/26
**Smoking at Booking** 0.0%
No significant change




**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 5.3%
No significant change

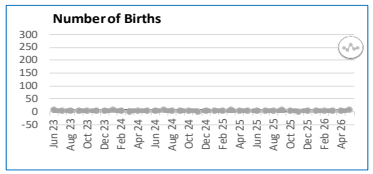


# Chichester – 10% most deprived

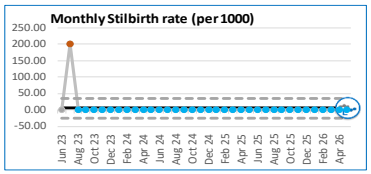
University Hospitals Sussex NHS Foundation Trust

**Maternity overview** | **SRH 10% most deprived**

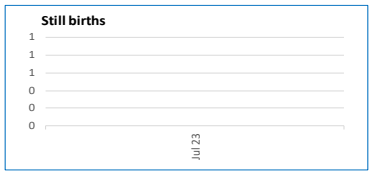
**Latest month** 01/05/26
**Number of Births** 6
No significant change



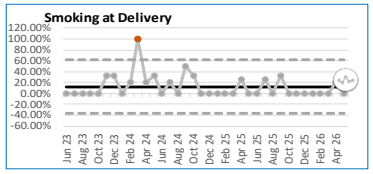

**Latest month** 01/05/26
**Monthly Stillbirth rate (per 1000)** 0.00
Significant Improvement



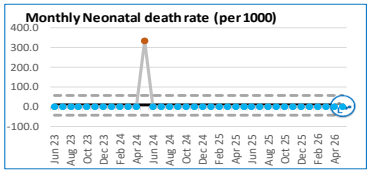

**Date of last stillbirth** 07/07/23
**Average days between stillbirths**
No significant change



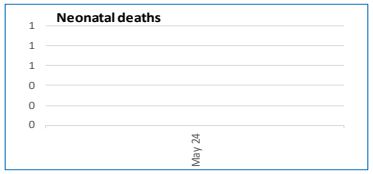

**Latest month** 01/05/26
**Smoking at Delivery** 0.0%
No significant change



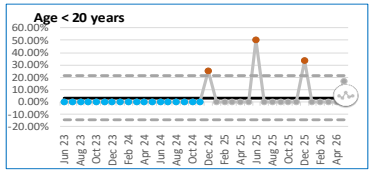

**Latest month** 01/05/26
**Monthly Neonatal death rate (per** 0.00
Significant Improvement



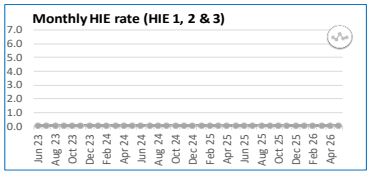

**Date of last neonatal death** 06/05/24
**Average days between deaths**
No significant change



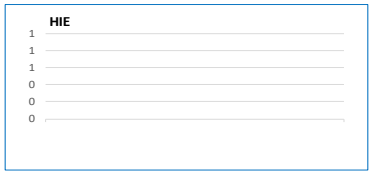

**Latest month** 01/05/26
**Age < 20 years** 16.7%
No significant change



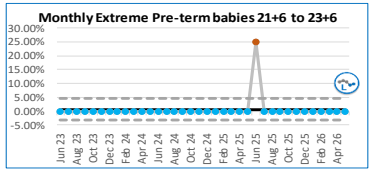

**Latest month** 01/05/26
**Monthly HIE rate (HIE 1, 2 & 3)** 0.00
No significant change



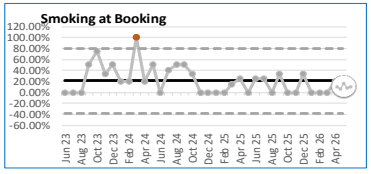

**Date of last HIE**
**Average days**
No significant change



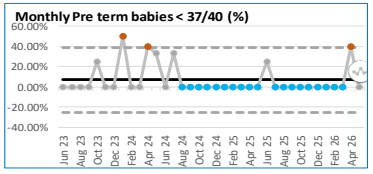

Latest month 01/05/26
**Monthly Extreme Pre-term babies 21+6 to 23+6** 0.0
Significant Improvement




**Latest month** 01/05/26
**Smoking at Booking** 0.0%
No significant change




**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 0.0%
No significant change

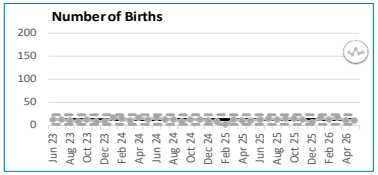


# Chichester – 20% most deprived

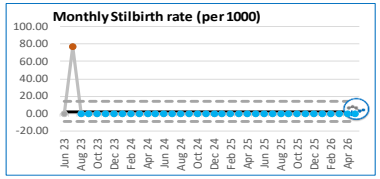
University Hospitals Sussex NHS Foundation Trust

**Maternity overview** | **SRH 20% most deprived**

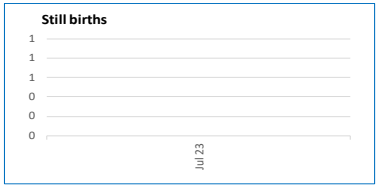
**Latest month** 01/05/26
**Number of Births** 9
No significant change



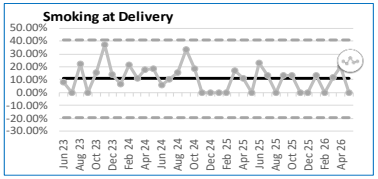

**Latest month** 01/05/26
**Monthly Stillbirth rate (per 1000)** 0.00
Significant Improvement



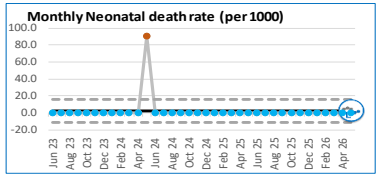

**Date of last stillbirth** 07/07/23
**Average days between stillbirths**
No significant change



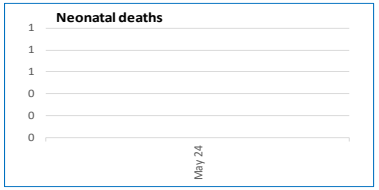

**Latest month** 01/05/26
**Smoking at Delivery** 0.0%
No significant change



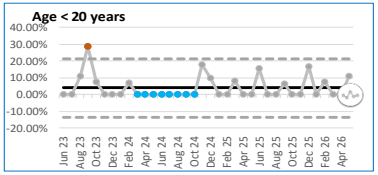

**Latest month** 01/05/26
**Monthly Neonatal death rate (per** 0.00
Significant Improvement



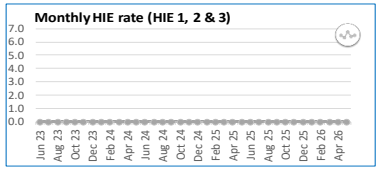

**Date of last neonatal death** 06/05/24
**Average days between deaths**
No significant change




**Latest month** 01/05/26
**Age < 20 years** 11.1%
No significant change

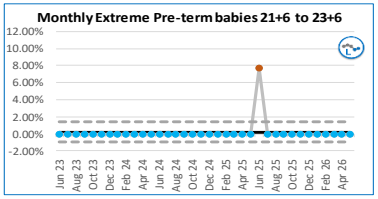



**Latest month** 01/05/26
**Monthly HIE rate (HIE 1, 2 & 3)** 0.00
No significant change

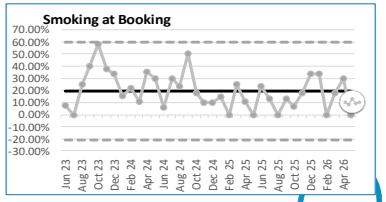



**Date of last HIE**
**Average days between HIE**
No significant change

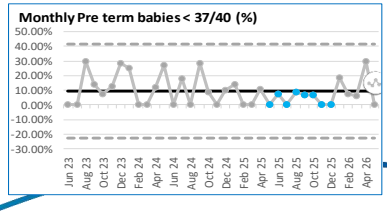
Latest month 01/05/26
**Monthly Extreme Pre-term babies 21+6 to 23+6** 0.0
Significant Improvement




**Latest month** 01/05/26
**Smoking at Booking** 0.0%
No significant change




**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 0.0%
No significant change

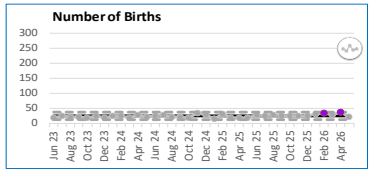


# Worthing – Global Majority

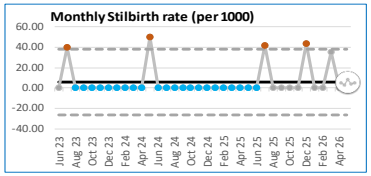
University Hospitals Sussex NHS Foundation Trust

**Maternity overview** | **WH BME**

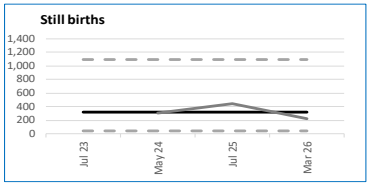
**Latest month** 01/05/26
**Number of Births** 21
No significant change



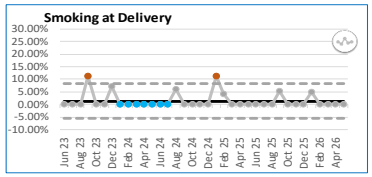

**Latest month** 01/05/26
**Monthly Stillbirth rate (per 1000)** 0.00
No significant change



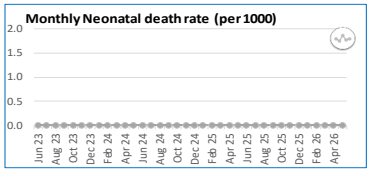

**Date of last stillbirth** 06/03/26
**Average days between stillbirths** 323.3
No significant change



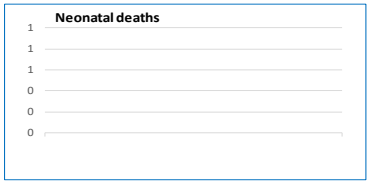

**Latest month** 01/05/26
**Smoking at Delivery** 0.0%
No significant change



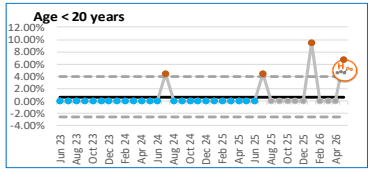

**Latest month** 01/05/26
**Monthly Neonatal death rate (per** 0.00
No significant change



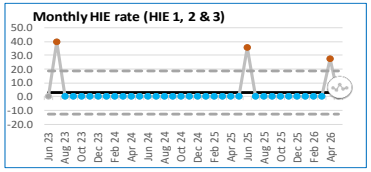

**Date of last neonatal death**
**Average days between deaths**
No significant change



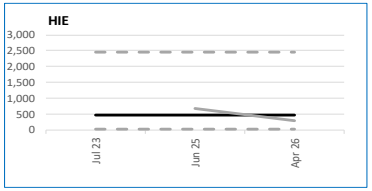

**Latest month** 01/05/26
**Age < 20 years** 6.7%
Significant deterioration



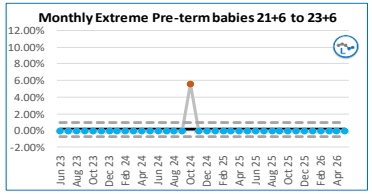

**Latest month** 01/05/26
**Monthly HIE rate (HIE 1, 2 & 3)** 0.00
No significant change



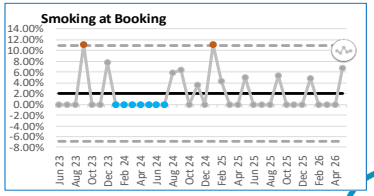

**Date of last HIE** 03/04/26
**Average days between HIE** 489.0
No significant change



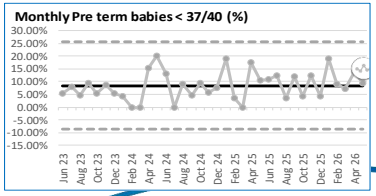

**Latest month** 01/05/26
**Monthly Extreme Pre-term babies 21+6 to 23+6** 0.0%
Significant Improvement




**Latest month** 01/05/26
**Smoking at Booking** 6.7%
No significant change



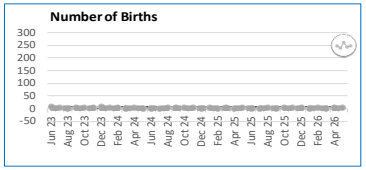
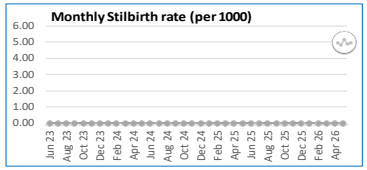
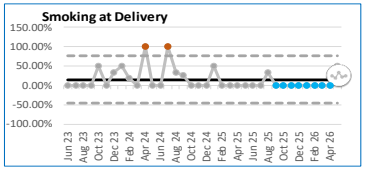
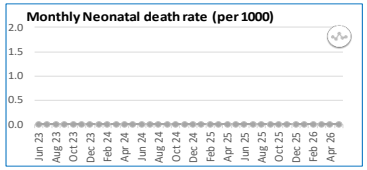
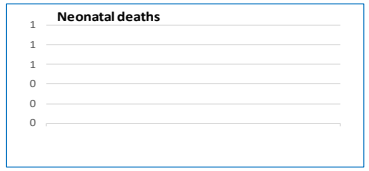
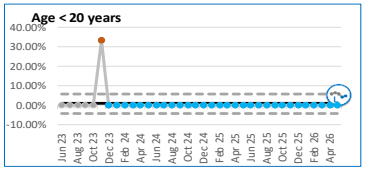
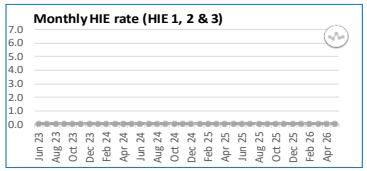
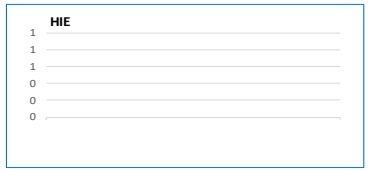
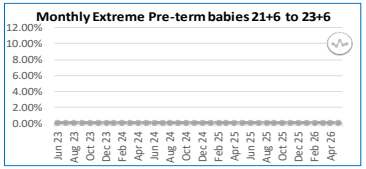
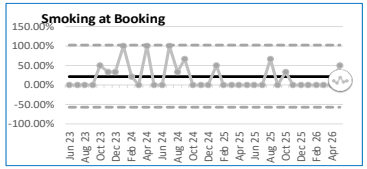
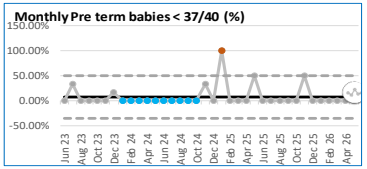

**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 9.5%
No significant change



# Worthing – 10% most deprived

University Hospitals Sussex
NHS Foundation Trust

**Maternity overview** | **WH 10% most deprived**

| | | | | | |
|---|---|---|---|---|---|
| Latest month 01/05/26<br>Number of Births 2<br>No significant change |  | Latest month 01/05/26<br>Monthly Stilbirth rate (per 1000) 0.00<br>No significant change |  | Date of last stillbirth<br>Average days between stillbirths<br>No significant change | |
| Latest month 01/05/26<br>Smoking at Delivery 50.0%<br>No significant change |  | Latest month 01/05/26<br>Monthly Neonatal death rate (per 0.00<br>No significant change |  | Date of last neonatal death<br>Average days between deaths<br>No significant change |  |
| Latest month 01/05/26<br>Age < 20 years 0.0%<br>Significant Improvement |  | Latest month 01/05/26<br>Monthly HIE rate (HIE 1, 2 & 3) 0.00<br>No significant change |  | Date of last HIE<br>Average days<br>No significant change |  |
| Latest month 01/05/26<br>Monthly Extreme Pre-term babies 21+6 to 23+6 0.0<br>No significant change |  | Latest month 01/05/26<br>Smoking at Booking 50.0%<br>No significant change |  | Latest month 01/05/26<br>Monthly Pre term babies < 37/40 (%) 0.0%<br>No significant change |  |



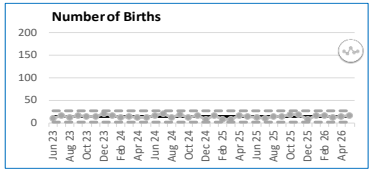
Meeting of the Board of Directors in Public; Thursday 17 September; 10am; Worthing Hospital-17/09/26

# Worthing – 20% most deprived

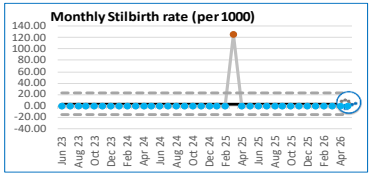
University Hospitals Sussex NHS Foundation Trust

**Maternity overview** | **WH 20% most deprived**

**Latest month** 01/05/26
**Number of Births** 16
No significant change

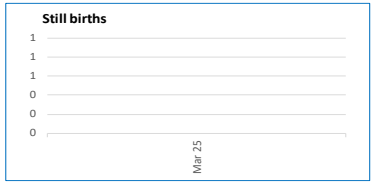



**Latest month** 01/05/26
**Monthly Stillbirth rate (per 1000)** 0.00
Significant Improvement

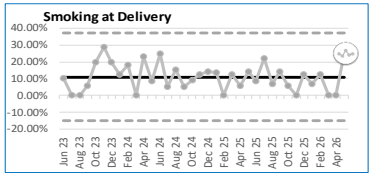



**Date of last stillbirth** 24/03/25

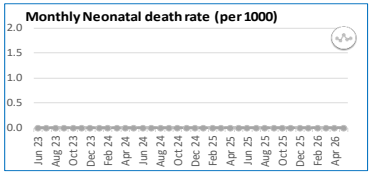
**Average days between stillbirths**
No significant change



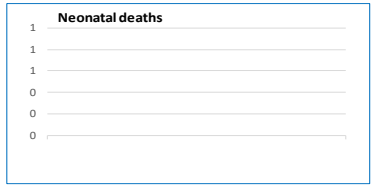

**Latest month** 01/05/26
**Smoking at Delivery** 25.0%
No significant change



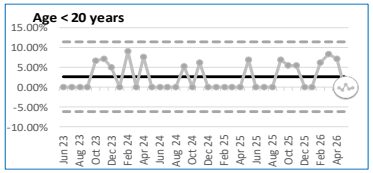

**Latest month** 01/05/26
**Monthly Neonatal death rate (per** 0.00
No significant change



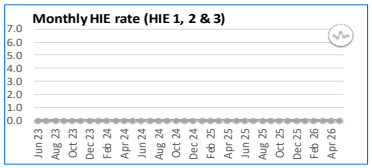

**Date of last neonatal death**
**Average days between deaths**
No significant change




**Latest month** 01/05/26
**Age < 20 years** 0.0%
No significant change

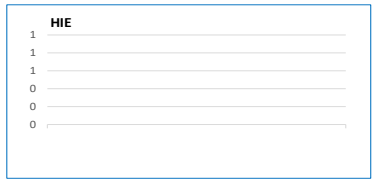



**Latest month** 01/05/26
**Monthly HIE rate (HIE 1, 2 & 3)** 0.00
No significant change

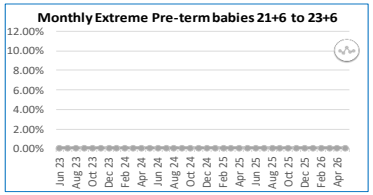



**Date of last HIE**

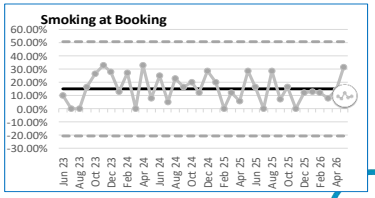
**Average days between HIE**
No significant change



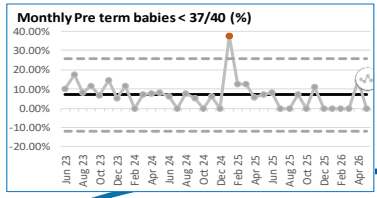

Latest month 01/05/26
**Monthly Extreme Pre-term babies 21+6 to 23+6** 0.0
No significant change




**Latest month** 01/05/26
**Smoking at Booking** 31.3%
No significant change




**Latest month** 01/05/26
**Monthly Pre term babies < 37/40 (%)** 0.0%
No significant change



University Hospitals Sussex
NHS Foundation Trust

# University Hospitals Sussex NHS Foundation Trust

# Constitution

Version 0.1 October 2020 (for enlarged FT)
Version 0.2 November 2020 (revised post capsticks review)
Version 0.3 Considered by Governors in December 2020
Version 0.4 January 2021 (revised definition of monitor following feedback from NHSI review)
Version 0.5 February 2021 (revision of public membership numbers)
Version 1.0 March 2021 approved by Board and Council of Governors including new name
Version 1.1 May 2022 (revised Annex 4, para 3.4.3 and Annex 5, para 1.19.2)
Version 1.2 March 2025 (removed gender specifics, adjust for NHS I being subsumed into NHS England, Annex 4: Additional Provisions Council of Governors removal of reference to formal Deputy Lead Governor and add clarity about pre-requisite values, and added Annex 10: Summary of Scheme of Reservation)
Version 1.3 September 2026 (adjusted to increase the number of executives)

University Hospitals Sussex
NHS Foundation Trust

# University Hospitals Sussex NHS Foundation Trust

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Annex 9 – Governor Code of Conduct
Annex 10 – Scheme of Reservation

## 1. Interpretation and definitions

Unless otherwise stated, words or expressions contained in this Constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

**the 2006 Act** is the National Health Service Act 2006.

**the 2012 Act** is the Health and Social Care Act 2012.

the **2022 Act** is the Health and Care Act 2022

**Acquisition Date** means the date of the acquisition by Western Sussex Hospitals NHS Foundation Trust (**WSHFT**) of Brighton and Sussex University Hospitals NHS Trust (**BSUHT**) being the date on which NHS England granted the application of WSHFT to acquire BSUHT pursuant to Section 56A of the 2006 Act.

**Annual Members Meeting** is defined in paragraph 10 of the Constitution.

**Constitution** means this constitution and all annexes to it.

**Initial Public Governors** means the elected public governors of the Trust who hold office with WSHFT immediately prior to the Acquisition Date, as set out in Part A of Annex 2.

**Initial Staff Governors** means the elected staff governors of the Trust who hold office with WSHFT immediately prior to the Acquisition Date, as set out in Part A of Annex 2.

**Monitor** is the body corporate known (together with the NHS Trust Development Authority) as NHS England is now NHS England and created pursuant to Section 61 of the 2012 Act.

the **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

**Code of Governance for NHS Provider Trusts** means the Code of Governance for NHS Provider Trusts published by NHS England in October 2022 or such similar or further guidance as NHS England may publish from time to time.

## 2. Name

The name of the Foundation Trust is University Hospitals Sussex NHS Foundation Trust (the **Trust**).

## 3. Principal purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfill its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

## 4. Powers

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

## 5. Membership and constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 a public constituency; or

5.1.2 a staff constituency

## 6. Application for membership

6.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust.

## 7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a

member of the Trust.

7.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the Public Constituency.

7.3 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

## 8. Staff Constituency

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into five descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 1 and being referred to as a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 1.

**Automatic membership by default – staff**

8.6 An individual who is:

8.6.1 eligible to become a member of the Staff Constituency, and

8.6.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the Trust as a member of the Staff Constituency and

appropriate class within the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

## 9. Restriction on membership

9.1 An individual, who is a member of a constituency, or of an area or class within a constituency, may not while membership of that constituency, area or class continues, be a member of any other constituency, area or class.

9.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

9.3 An individual must be at least 16 years old to become a member of the Trust.

9.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 7 – Further Provisions Part B (Membership of the Trust).

## 10. Annual Members' Meeting

10.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

## 11. Council of Governors – composition

11.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

11.2 The composition of the Council of Governors is specified in Annex 2 and shall change in accordance with the dates set out in Table 1 and Table 2 of Annex 2.

11.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are areas or classes within a constituency, by their area or class within that constituency.

11.4 To reflect the enlarged size of the Trust, the public constituency and the staff constituency and the number of governors to be elected by each constituency, or, where appropriate, by each area or class of each constituency, shall increase and shall be revised on the dates specified in Annex 2.

## 12. Council of Governors – election of governors

12.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules on the basis of

first past the post (FPP) polling and the Model Election Rules shall be construed accordingly.

12.2 The Model Election Rules as published by NHS Providers (previously the Foundation Trust Network) form part of this Constitution. The Model Election Rules current at the date of the Trust's Authorisation are attached at Annex 3.

12.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 43 of the Constitution (amendment of the Constitution).

12.4 An election, if contested, shall be by secret ballot.

## 13. Council of Governors – tenure

13.1 The composition of the Council of Governors as at the Acquisition Date is set out in Table 1 of Annex 2. In determining which Initial Public Governors and Initial Staff Governors transfer at the Acquisition Date, the process set out in paragraphs 13.2 – 13.6 below will apply.

*Lead governor*

13.2 The lead governor elected to represent the public constituency and holding office immediately prior to the Acquisition Date will transfer automatically to the same public constituency area to sit as lead governor from the Acquisition Date. For the avoidance of doubt, if no lead governor holds office immediately prior to the Acquisition Date than this paragraph 13.2 shall not apply.

*Initial Public Governors*

13.3 After applying paragraph 13.2, where the total number of Initial Public Governor posts that would qualify to represent a specific public constituency area is:

13.3.1 equal to or fewer than the number of posts available for that public constituency area, the Initial Public Governor(s) shall transfer automatically;

13.3.2 greater than the number of posts available for that public constituency area, then the process set out in paragraph 13.4 below will apply.

13.4 Where on the Acquisition Date there is a greater number of Initial Public Governors for any public constituency area those Initial Public Governors with the greatest aggregate consecutive length of service will automatically vacate office first with the Initial Public Governor with the next greatest aggregate consecutive length of service vacating office second until the remaining number of Initial Public Governors is equal to the relevant constituency area at which point all remaining Initial Public Governors shall transfer automatically.

*Initial Staff Governors*

13.5 Where the total number of Initial Staff Governors posts that would qualify to represent a specific staff class is:

13.5.1 equal to the number of posts available for that staff class, the Initial Staff Governor(s) shall transfer automatically;

13.5.2 greater than the number of posts available for that staff class then the process set out in paragraph 13.6 below will apply.

13.6 Where on the Acquisition Date there is a greater number of Initial Staff Governors for any staff class than available posts, those Initial Staff Governors with the shortest aggregate consecutive length of service will automatically vacate office first with the Initial Staff Governor with the next shortest aggregate consecutive length of service vacating office second until the remaining number of Initial Staff Governors is equal to the relevant staff class at which point all remaining Initial Staff Governors shall transfer automatically.

13.7 For the avoidance of doubt, as at the Acquisition Date there will be no elected public governors for the Brighton & Hove and Mid Sussex areas of the public constituency and no elected staff governors for the Princess Royal Hospital and Royal Sussex County Hospital staff class.

13.8 The first governor election held after the Acquisition Date to fill the governor vacancies identified in paragraph 13.7 above shall be conducted in such a way as to result in the initial terms of office for those elected governors to end on a phased basis to ensure that those elected governors do not all vacate the office on the same day and in order that future elections also occur on a phased basis. As demonstrated in the below table and summarised as follows: in relation to the first elections for the:

13.8.1 public governors; in respect of the candidates for Brighton & Hove and Mid Sussex, the candidate with the highest number of votes shall hold office for a period of three years and where more than one governor post is available, the candidate with the second highest number of votes shall hold office for a period of two years;

13.8.2 staff governor; in respect of the candidate for the Princess Royal Hospital class, the candidate with the highest number of votes shall hold office for a period of two years;

13.8.3 staff governor; in respect of the candidate for the Royal Sussex County Hospital class, the candidate with the highest number of votes shall hold office for a period of three years.

| Constituency | Class | 3-year terms | 2-year terms | Total |
|---|---|---|---|---|
| Public | Brighton & Hove | 1 | 1 | 2 |

| Constituency | Class | 3-year terms | 2-year terms | Total |
|---|---|---|---|---|
| Public | Mid Sussex | 1 | 1 | 2 |
| Staff | Princess Royal Hospital | 0 | 1 | 1 |
| Staff | Royal Sussex County Hospital | 1 | 0 | 1 |
| | Totals | 3 | 3 | 6 |

13.9 An elected governor may hold office for a period of up to 3 years from the date of nomination and at the end of this term they shall be eligible for re-election for up to two further terms of up to 3 years each (i.e. 9 years in total). For the avoidance of doubt, the Initial Public Governors and Initial Staff Governors that shall transfer after the Acquisition Date in accordance with the process set out in paragraphs 13.2 – 13.6 above will cease to hold office in accordance with the term set out in their original letters of appointment.

13.10 An elected governor shall cease to hold office if they cease to be a member of a constituency, area or class.

13.11 An appointed governor may hold office for a period of up to 3 years and at the end of this term they shall be eligible for re-appointment for up to two further terms of up to 3 years each (i.e. 9 years in total).

13.12 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them.

13.13 A governor whose tenure of office is terminated shall not be eligible for re-appointment or to stand for re-election for a period of at least one year from the date of removal from office or the date upon which any appeal against their removal from office is disposed of whichever is the later except by resolution carried by a two thirds of the voting members of the Council of Governors.

## 14. Council of Governors – disqualification and removal

14.1 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

14.2 The following may not become or continue as a member of the Council of Governors:

14.2.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

14.2.2 a person who has made a composition or arrangement with, or granted a Trust deed for, their creditors and has not been discharged in respect of it;

14.2.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of

imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

14.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 4.

14.4 Provisions as to the removal of Governors are set out Annex 4 of this Constitution and Annex 9 of the Code of Conduct for Governors.

## 15. Council of Governors – duties of governors

15.1 The general duties of the Council of Governors are –

15.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; and

15.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

15.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

15.3 All governors must comply with the Trust's Code of Conduct for Governors set out in Annex 9.

## 16. Council of Governors – meetings of governors

16.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 24.1 or paragraph 25.1 below) or, in their absence, the Deputy Chair (appointed in accordance with the provisions of paragraph 26.1 below), shall preside at meetings of the Council of Governors.

16.2 The Council of Governors shall appoint one of the governors, who is a member of the public constituency, to be the Lead Governor for such period, not exceeding the remainder of their term as a governor of the Trust and in accordance with the terms of appointment and role and description set out in Annex 8.

16.3 Meetings of the Council of Governors shall be open to members of the public unless the Council of Governors decides otherwise in relation to all or part of any particular meeting. Members of the public shall be excluded from meetings of the Council of Governors only where the business under discussion is commercially sensitive or is otherwise considered to be confidential.

16.4 For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their

duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

## 17. Council of Governors – standing orders

17.1 The standing orders for the practice and procedure of the Council of Governors as may be amended from time to time are attached at Annex 5.

## 18. Council of Governors – referral to the Panel

18.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation Trust may refer a question as to whether the Trust has failed or is failing –

18.1.1 to act in accordance with its Constitution; or
18.1.2 to act in accordance with provisions made by or under Chapter 5 of the 2006 Act

18.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

## 19. Council of Governors - conflicts of interest of governors

19.1 If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

## 20. Council of Governors – travel expenses

20.1 Governors shall not receive remuneration for acting as governors but the Trust may pay travelling and other expenses to members of the Council of Governors at rates, and in accordance with a policy, determined by the Trust.

## 21. Council of Governors – further provisions

21.1 Further provisions with respect to the Council of Governors are set out in Annex 4.

## 22. Board of Directors – composition

22.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors. The composition will be such that there will always be a majority of non-executive directors (including the Chair).

22.2 The Board of Directors is to comprise:

22.2.1 a non-executive Chair

22.2.2 at least 9 other non-executive directors, and

22.2.3 up to 9 executive directors.

22.3 One of the executive directors shall be the Chief Executive.

22.4 The Chief Executive shall be the Accounting Officer.

22.5 One of the executive directors shall be the finance director.

22.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

22.7 One of the executive directors is to be a registered nurse or a registered midwife.

22.8 The directors shall at all times have one vote each save that the Chair shall be entitled to exercise a second or casting vote where the number of votes for and against a motion is equal.

22.9 The post of an executive director (excluding the Chief Executive) may be held by more than one eligible person on a job share basis. Where such an agreement is in force then the two individuals may only exercise one vote between them at a meeting of the Board of Directors. In the case of disagreements, they must abstain from voting and no vote may be cast. This must be recorded in the minutes for the Board meeting.

22.10 The Board will have in attendance at its meetings the Trust managing directors. These will fully contribute at these meetings, taking an active part in the discussions and decision formulation, but, will not be voting members to the Board

## 23. Board of Directors – general duty

23.1 The general duty of the Board of Directors and of each director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

## 24. Board of Directors – qualification for appointment as a non-executive director

24.1 A person may be appointed as a non-executive director only if:

24.1.1 he is a member of a public constituency and he is not disqualified by virtue of paragraph 28 below.

## 25. Board of Directors – appointment and removal of Chair and other non-executive directors

25.1 The Council of Governors at a general meeting of the Council of Governors shall appoint and, where necessary, remove (with the approval of three-quarters of the Council of Governors) the Chair of the Trust and the other non-executive directors. The Council of Governors Nomination Committee may identify suitable candidates to fill non-executive director vacancies as they arise and may make written recommendations to the Council of Governors. The Council of Governors shall be required to appoint one non-executive director who exercises functions for Brighton and Sussex Medical School. This candidate will be nominated by Brighton and Sussex Medical School for the Council of Governors Nomination Committee to review and consider and, where appropriate, recommend to the Council of Governors.

25.2 The Council of Governors at a general meeting of the Council of Governors shall appoint and, where necessary, remove the Chair of the Trust and the other non-executive directors.

25.3 Removal of the Chair or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

## 26. Board of Directors – appointment of deputy Chair and senior independent director

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a deputy Chair.

26.2 The Board shall, following consultation with the Council of Governors, appoint one of the independent non-executive directors as a Senior Independent Director to act in accordance with the NHS Foundation Trust Code of Governance published by Monitor in 2013 and updated in July 2014 and the Board's Standing Orders.

26.3 The offices of Deputy Chair and Senior Independent Director may be held by the same Non-Executive Director.

## 27. Board of Directors - appointment and removal of the Chief Executive and other executive directors

27.1 The non-executive directors shall appoint or remove the Chief Executive.

27.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

27.3 A committee consisting of the Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

## 28. Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

28.1 A person who fails to meet the requirements of the CQC fit and proper person regulations.

28.2 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

28.3 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it.

28.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

## 29. Board of Directors – meetings

29.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

29.2 Before holding a meeting the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

## 30. Board of Directors – standing orders

30.1 The standing orders for the practice and procedure of the Board of Directors, as may be amended from time to time, are attached at Annex 6

30.2 The Board of Directors may adopt such procedures and protocols as

it shall deem to be appropriate for the good governance of the Trust from time to time.

## 31. Board of Directors - conflicts of interest of directors

31.1 The duties that a director of the Trust has by virtue of being a director include in particular –

31.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

31.1.2 A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

31.2 The duty referred to in sub-paragraph 31.1.1 is not infringed if –

31.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

31.2.2 The matter has been authorised in accordance with the Constitution.

31.3 The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

31.4 In sub-paragraph 31.1.2 “third party” means a person other than –

31.4.1 The Trust, or
31.4.2 A person acting on its behalf

31.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors

31.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

31.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

31.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

31.9 A director need not declare an interest –

31.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest:

31.9.2 If, or to the extent that, the directors are already aware of it:

31.9.3 If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –

34.9.3.1 by a meeting of the Board of Directors, or

34.9.3.2 by a committee of the directors appointed for the purpose under the Constitution.

31.10 A matter shall be authorised for the purposes of paragraph 31.2.2:

31.10.1 the Board of Directors by majority disapplies the provision of the Constitution which would otherwise prevent a director from being counted as participating in the decision-making process;

31.10.2 the director's interest cannot reasonably be regarded as likely to give rise to a conflict of interest; or

31.10.3 the director's conflict of interest arises from a permitted cause (as determined by the Board of Directors from time to time).

## 32. Board of Directors – remuneration and terms of office

32.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors.

32.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

## 33. Registers

The Trust shall have:

33.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are areas or classes within it, the area or class to which he belongs;

33.2 a register of members of the Council of Governors;

33.3 a register of interests of governors;

33.4 a register of directors; and

33.5 a register of interests of the directors.

## 34. Admission to and removal from the registers

34.1 Further provisions as to the registers are set out within Annex 7.

## 35. Registers – inspection and copies

35.1 The Trust shall make the registers specified in paragraph 33 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

35.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of –

35.2.1 any member of the Patients' Constituency; or

35.2.2 any other member of the Trust, if he so requests

35.3 So far as the registers are required to be made available:

35.3.1 they are to be available for inspection free of charge at all reasonable times; and

35.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

35.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

## 36. Documents available for public inspection

36.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

36.1.1 a copy of the current Constitution;

36.1.2 a copy of the latest annual accounts and of any report of the auditor on them; and

36.1.3 a copy of the latest annual report.

36.2 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

36.3 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

36.4 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

36.4.1 a copy of any order made under section 65D (appointment of Trust special administrator) 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (Trusts coming out of administration), or 65LA (Trusts to be dissolved) of the 2006 Act.

36.4.2 a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act.

36.4.3 a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act.

36.4.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

36.4.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

36.4.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report of the 2006 Act.

36.4.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

36.4.8 a copy of any final report published under section 65I (administrator's final report).

36.4.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

36.4.10 a copy of any information published under section 65M (replacement of Trust special administrator) of the 2006 Act.

36.5 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

36.6 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

## 37. External Auditor

37.1 The Trust shall have an external auditor.

37.2 The Council of Governors shall appoint or remove the external auditor

at a general meeting of the Council of Governors.

37.3 The external auditor shall carry out their duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by NHS England (previously Monitor / NSH Improvement) on standards, procedures and techniques to be adopted.

## 38. Audit committee

38.1 The Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate. The membership and terms of reference of the Audit Committee shall be subject to approval by the Board of Directors.

## 39. Accounts

39.1 The Trust must keep proper accounts and proper records in relation to the accounts.

39.2 NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

39.3 The accounts are to be audited by the Trust's external auditor.

39.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS England may with the approval of the of the Secretary of State direct.

39.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

## 40. Annual report, forward plans and non-NHS work

40.1 The Trust shall prepare an Annual Report and send it to NHS England.

40.2 The Trust shall give information as directed with regards its forward planning in respect of each financial year to NHS England.

40.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

40.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

40.5 Each forward plan must include information about –

40.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

40.5.2 the income it expects to receive from doing so.

40.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 40.5.1 the Council of Governors must –

40.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the Trust of its principal purpose or the performance of its other functions, and

40.6.2 notify the directors of the Trust of its determination.

40.7 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

## 41. Presentation of the annual accounts and reports to the governors and members

41.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

41.1.1 the annual accounts

41.1.2 any report of the auditor on them

41.1.3 the annual report.

41.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

41.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 41.1 with the Annual Members' Meeting.

## 42. Instruments

42.1 The Trust shall have a seal.

42.2 The seal shall not be affixed except under the authority of the Board of Directors.

42.3 A document purporting to be duly executed under the Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be executed or signed.

42.4 See further Annex 7 Part C (Custody of Seal and Sealing of Documents).

## 43. Amendment of the Constitution

43.1 The Trust may make amendments of its Constitution only if –

43.1.1 Over half of the membership of the Council of Governors of the Trust voting approve the amendments, and

43.1.2 Over half of the members of the Board of Directors of the Trust voting approve the amendments.

43.2 Amendments made under paragraph 43.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

43.3 Where an amendment is made to the Constitution in relation to the powers and duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –

43.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

43.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

43.4 If more than half of the members voting approve the amendment, the amendment continues to have effect, otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

43.5 Amendments by the Trust of its Constitution are to be notified to NHS England. For the avoidance of doubt, NHS England functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

## 44. Mergers etc. and significant transactions

44.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of over half of the members of the Council of Governors.

44.2 The Trust may enter into a significant transaction only if over half of the members of the Council of Governors voting approve entering into the transaction.

44.3 In this paragraph, the following words have the following meanings:

44.3.1 "Significant transaction" means a transaction which meets any one of the tests below:

the fixed asset test; or

the turnover test;

44.4 The turnover test is met if, following the completion of the relevant transaction, the gross income of the Trust will increase or decrease by more than 25%.

44.5 The fixed asset is met if the assets which are the subject of the transaction exceeds 25% of the fixed assets of the Trust.

44.6 A transaction:

44.6.1 includes all agreements (including amendments to agreements) entered into by the Trust

44.6.2 excludes a transaction in the ordinary course of business including the renewal, extension or entering into an agreement in respect of healthcare services carried out by the Trust;

44.6.3 excludes any agreement or changes to healthcare services carried out by the Trust following a reconfiguration of services led by the commissioners of such services;

44.6.4 excludes any grant of public dividend capital or the entering into of a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the Trust.

## 45. Indemnity

45.1 Members of the Board of Directors and Council of Governors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution of their functions, save where they have acted recklessly.

45.2 The Trust may purchase and maintain for members of the Board of Directors and Council of Governors insurance in respect of directors' and governors' liability to meet all or any liabilities which are properly the liabilities of the Trust under paragraph 45.1, including, without limitation, liability arising by reason of the Trust acting as a corporate trustee of an NHS charity.

# ANNEX 1 – CONSTITUENCY DETAILS

## THE PUBLIC CONSTITUENCY

Members of the public shall be eligible for membership of the public constituency areas as shown in the table below, which also sets out the minimum numbers required in each area.

| Public Constituency Area | Minimum Membership Per Area |
|---|---|
| Adur | 90 |
| Arun | 220 |
| Brighton & Hove | 100 |
| Chichester | 160 |
| East Sussex | 30 |
| Horsham | 130 |
| Mid Sussex | 35 |
| Worthing | 150 |
| Out of Area | 75 |

## THE STAFF CONSTITUENCY

The staff constituency is divided into a number of classes. Trust staff shall be eligible for membership of the class within the staff constituency as shown below.

| Staff Class | Minimum Number of Members Per Class |
|---|---|
| Peripatetic | 100 |
| Princess Royal Hospital | 100 |
| Royal Sussex County Hospital | 100 |
| St Richards Hospital | 100 |
| Worthing & Southlands Hospital | 100 |

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# ANNEX 2 – COMPOSITION OF COUNCIL OF GOVERNORS

## Table 1 - Elected Governors

For the period from the Acquisition Date until new governor elections are held and new governors are elected on around August 2021 (**Post Acquisition Elections**) the Elected Governors shall comprise:

| Constituency | Area/Class | Number |
|---|---|---|
| Public | Adur | 1 |
| Public | Arun | 1 |
| Public | Brighton & Hove | 0 |
| Public | Chichester | 2 |
| Public | Horsham | 1 |
| Public | Mid Sussex | 0 |
| Public | Worthing | 1 |
| Public | Out of Area | 1 |
| | | |
| Staff | Peripatetic | 1 |
| Staff | Princess Royal Hospital | 0 |
| Staff | Royal Sussex County Hospital | 0 |
| Staff | St Richards Hospital | 1 |
| Staff | Worthing and Southlands Hospitals | 1 |
| **Total Number of Elected Governors** | | **10** |

## Table 2 – Elected Governors

Following the Post Acquisition Elections the Elected Governors shall comprise:

| Constituency | Area/Class | Number |
|---|---|---|
| Public | Adur | 1 |
| Public | Arun | 1 |
| Public | Brighton & Hove | 2 |
| Public | Chichester | 2 |
| Public | Horsham | 1 |
| Public | Mid Sussex | 2 |
| Public | Worthing | 1 |
| Public | East Sussex and Out of Area | 1 |
| | | |
| Staff | Peripatetic | 1 |
| Staff | Princess Royal Hospital | 1 |
| Staff | Royal Sussex County Hospital | 1 |
| Staff | St Richards Hospital | 1 |
| Staff | Worthing and Southlands Hospitals | 1 |
| **Total Number of Elected Governors** | | **16** |

**Table 3 - Appointed Governors**

| Type | Governor Appointed By: | Number |
|---|---|---|
| Local Authority* | Brighton and Hove City Council<br>West Sussex County Council | 1<br>1 |
| Brighton & Sussex Medical School * | A governor would be appointed by agreement between Brighton & Sussex Universities. | 1 |
| Voluntary Sector | A governor shall be appointed, by agreement of the Council of Voluntary Services | 1 |
| Inclusion | A governor shall be appointed from the three Trust inclusion staff networks covering BAME, LGBT+ and Disability | 1 |
| **Total Number of Appointed Governors** | | **5** |
| **Total Number of Governors** | | **21** |

**Note: These Governors must be appointed under paragraphs 9(4) and 9(6) of Schedule 7 of the National Health Service Act 2006 (as amended from time to time).*

In summary, the total number of Governors:

On the Acquisition Date there shall be 10 elected governors plus 5 appointed governors (15 in total) (composed as set out above); and

From on or around August 2021 there shall be 21 Governors (composed as set out above).

# Annex 3 - Model Election Rules

## MODEL ELECTION RULES 2014

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**PART 1: INTERPRETATION**

## 1. Interpretation

1.1. In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"corporation" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"declaration of identity" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (published by Monitor in December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act and reference in these Model Election Rules to "Monitor" shall be read as reference to its statutory successor, "NHS England";

"*NHS England*" is the operational name for the organisation which consists of (inter alia) Monitor and the NHS Trust Development Authority;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"the text message voting system" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2. Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

## 2. Timetable

2.1. The proceedings at an election shall be conducted in accordance with the following timetable:

| Proceeding | Time |
|---|---|
| Publication of notice of election | Not later than the fortieth day before the day of the close of the poll. |
| Final day for delivery of nomination forms to returning officer | Not later than the twenty eighth day before the day of the close of the poll. |
| Publication of statement of nominated candidates | Not later than the twenty seventh day before the day of the close of the poll. |
| Final day for delivery of notices of withdrawals by candidates from election | Not later than twenty fifth day before the day of the close of the poll. |
| Notice of the poll | Not later than the fifteenth day before the day of the close of the poll. |
| Close of the poll | By 5.00pm on the final day of the election. |

## 3. Computation of time

3.1. In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas Day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2. In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

## 4. Returning Officer

4.1. Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2. Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

## 5. Staff

5.1. Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

## 6. Expenditure

6.1. The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of their functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

## 7. Duty of co-operation

7.1. The corporation is to co-operate with the returning officer in the exercise of their or her functions under these rules.

## PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

### 8. Notice of election

8.1. The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

### 9. Nomination of candidates

9.1. Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2. The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

### 10. Candidate's particulars

10.1. The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic

communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

**11. Declaration of interests**

11.1. The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

**12. Declaration of eligibility**

12.1. The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of their or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

**13. Signature of candidate**

13.1. The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2. Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

**14. Decisions as to the validity of nomination**

14.1. Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2. The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3. The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4. Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5. The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

**15. Publication of statement of candidates**

15.1. The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2. The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3. The statement must list the candidates standing for election in alphabetical order by surname.

15.4. The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

**16. Inspection of statement of nominated candidates and nomination forms**

16.1. The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2. If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

**17. Withdrawal of candidates**

17.1. A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

**18. Method of election**

18.1. If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2. If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3. If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

## 19. Poll to be taken by ballot

19.1. The votes at the poll must be given by secret ballot.

19.2. The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3. The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4. The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5. Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts their vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts their vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts their vote using the text message voting system.

## 20. The ballot paper

20.1. The ballot of each voter (other than a voter who casts their ballot by an e-voting method of polling) is to consist of a ballot paper with the persons

remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2. Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3. Each ballot paper must have a unique identifier.

20.4. Each ballot paper must have features incorporated into it to prevent it from being reproduced.

**21. The declaration of identity (public and patient constituencies)**

21.1. The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of their qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration

form") or the use of an electronic method.

21.2. The voter must be required to return their declaration of identity with their ballot.

21.3. The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

*Action to be taken before the poll*

**22. List of eligible voters**

22.1. The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2. The list is to include, for each member:

(a) a postal address; and,
(b) the member's e-mail address, if this has been provided

to which their voting information may, subject to rule 22.3, be sent.

22.3. The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

**23. Notice of poll**

23.1. The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined

by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

**24. Issue of voting information by returning officer**

24.1. Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2. Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast their vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,

(d) contact details of the returning officer,

("e-voting information").

24.3. The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4. If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5. The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

**25. Ballot paper envelope and covering envelope**

25.1. The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2. The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3. There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

**26. E-voting systems**

26.1. If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2. If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose

of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3. If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4. The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter their voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast their vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter’s voter ID number;

(ii) the voter’s declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) (the date and time of the voter’s vote,

(e) if the voter’s vote has been duly cast and recorded, provide the voter

with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5. The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter their voter ID number in order to be able to cast their vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6. The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide their voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast their vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) prevent any voter from voting after the close of poll.

*The poll*

**27. Eligibility to vote**

27.1. An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

**28. Voting by persons who require assistance**

28.1. The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2. Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

**29. Spoilt ballot papers and spoilt text message votes**

29.1. If a voter has dealt with their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2. On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3. The returning officer may not issue a replacement ballot paper for a spoilt

ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4. After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5. If a voter has dealt with their text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6. On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7. The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8. After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

## 30. Lost voting information

30.1. Where a voter has not received their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2. The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3. After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

**31. Issue of replacement voting information**

31.1. If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2. After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

**32. ID declaration form for replacement ballot papers (public and patient constituencies)**

32.1. In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

*Polling by internet, telephone or text*

**33. Procedure for remote voting by internet**

33.1. To cast their vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2. When prompted to do so, the voter will need to enter their voter ID number.

33.3. If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4. To cast their vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast their vote.

33.5. The voter will not be able to access the internet voting system for an election once their vote at that election has been cast.

**34. Voting procedure for remote voting by telephone**

34.1. To cast their vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2. When prompted to do so, the voter will need to enter their voter ID number using the keypad.

34.3. If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4. When prompted to do so the voter may then cast their vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5. The voter will not be able to access the telephone voting facility for an election once their vote at that election has been cast.

**35. Voting procedure for remote voting by text message**

35.1. To cast their vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2. The text message sent by the voter must contain their voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3. The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

*Procedure for receipt of envelopes, internet votes, telephone votes and text message*

*votes*

**36. Receipt of voting documents**

36.1. Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2. The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3. The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

**37. Validity of votes**

37.1. A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2. Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3. Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4. An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5. Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6. Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

**38. Declaration of identity but no ballot paper (public and patient constituency)[1]**

38.1. Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

**39. De-duplication of votes**

39.1. Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2. If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

voter ID number

39.3. Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4. Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

**40. Sealing of packets**

40.1. As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records,

telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

## PART 6: COUNTING THE VOTES

### 41. Interpretation of Part 6

41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

**41. Arrangements for counting of the votes**

41.1. The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

41.2. The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

**42. The count**

42.1. The returning officer is to:

(a) count and record the number of:
  (i) ballot papers that have been returned; and
  (ii) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

42.2. The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

42.3. The returning officer is to proceed continuously with counting the votes as far as is practicable.

**44. Rejected ballot papers and rejected text voting records**

44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules 44.2 and 44.3, be rejected and not counted.

44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules 44.2 and 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules 44.7 and 44.8, be rejected and not counted.

44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

44.8 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

**45. Equality of votes**

45.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

## PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

### 46. Declaration of result for contested elections

46.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

46.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

### 47 Declaration of result for uncontested elections

47.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the Chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

## 48. Sealing up of documents relating to the poll

48.1. On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

48.2. The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

48.3. The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

## 49. Delivery of documents

49.1. Once the documents relating to the poll have been sealed up and endorsed

pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

**50. Forwarding of documents received after close of the poll**

50.1. Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

**51. Retention and public inspection of documents**

51.1. The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

51.2. With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

51.3. A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

**52. Application for inspection of certain documents relating to an election**

52.1. The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

52.2. A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

52.3. The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

52.4. On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that their vote was given, and

(ii) that Monitor has declared that the vote was invalid.

## PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

### 53. Countermand or abandonment of poll on death of candidate

53.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

53.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

53.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

53.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39 and is to make up separate sealed packets in accordance with rule 40.

53.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

53.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

53.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the Chair of the corporation, and rules 57 and 58 are to apply.

## PART 10: ELECTION EXPENSES AND PUBLICITY

*Election expenses*

### 54. Election expenses

54.1. Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

### 55. Expenses and payments by candidates

55.1. A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

### 56. Election expenses incurred by other persons

56.1. No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or their family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

56.2. Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

*Publicity*

### 57. Publicity about election by the corporation

57.1. The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

57.2. Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

57.3. Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

**58. Information about candidates for inclusion with voting information**

58.1. The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

58.2. The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

**59. Meaning of "for the purposes of an election"**

59.1. In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

59.2. The provision by any individual of their own services voluntarily, on their

own time, and free of charge is not to be considered an expense for the purposes of this Part.

## PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

### 60. Application to question an election

60.1. An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

60.2. An application may only be made once the outcome of the election has been declared by the returning officer.

60.3. An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

60.4. The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

60.5. The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

60.6. If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

60.7. Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

60.8. The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

60.9. The IEAP may prescribe rules of procedure for the determination of an application including costs.

## 61. Secrecy

61.1. The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

61.2. No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

61.3. The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

## 62. Prohibition of disclosure of vote

62.1. No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

## 63. Disqualification

63.1. A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

**64. Delay in postal service through industrial action or unforeseen event**

64.1. If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

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## ANNEX 4 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

### 1. INTERPRETATION

1.1 In these Provisions, the clauses relating to Interpretation and definitions in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning.

### 2. APPLICATION OF THESE PROVISIONS

2.1 These Provisions apply to all meetings of the Council of Governors ("the **Council**") and all other relevant activities of the Governors. All Governors are required to abide by these Provisions, which also apply to any persons attending meetings of the Council.

2.2 Except where required by law or the Constitution, at any meeting of the Council, the Chair (or in their absence, the Deputy Chair or a person deputising for them) shall be the final authority on the interpretation of these Provisions (on which he should be advised by the Chief Executive and the Secretary).

2.3 Whilst the Secretary shall be responsible for ensuring that Governors are made aware of these Provisions, Governors are expected to familiarise themselves with the Provisions.

2.4 In the event of any actual or suspected non-compliance with these Provisions by a Governor, another Governor or member of staff identifying such actual/ suspected non-compliance shall report it to the Chair or Secretary and the Chair/ Secretary shall be responsible for taking such action as is necessary in accordance with the Code of Conduct for Governors set out in Annex 9 (specifically paragraph 7).

### 3. APPOINTMENT AND REMOVAL OF GOVERNORS

**Election and Appointment to Office**

3.1 Governors shall be elected or appointed by the means and on terms of office as prescribed by this Constitution.

3.2 A Governor shall, within 21 days of election or appointment, sign and deliver to the Secretary a declaration in the form prescribed at Appendix A. No Governor shall be entitled to vote or count in the quorum at a meeting of the Council of Governors until their declaration has been received by the Secretary. Such a declaration shall be valid for the Governor's term of office.

**Removal or Resignation from Office**

3.3 A person shall not be eligible to become or continue in office as a Governor if:

3.3.1 any of the grounds contained in paragraph 14 of the Constitution apply to them; or

3.3.2 in the case of an elected Governor, he ceases to be eligible to be a member of the Trust or constituency. For the avoidance of doubt and in accordance with paragraph 13.3 of the Constitution, a Public Governor who ceases to be eligible to be a member of that Public Constituency by virtue of moving to another

area, shall cease to hold office. Subject to the Provisions set out in this Annex 4 and the Constitutional provisions in respect of eligibility for holding office as a Governor, a person ceasing to hold office by the means described in this clause shall be eligible to stand for election in the area to which he has moved; or

3.3.3 he is a member of a Staff Class and any professional registration relevant to their eligibility to be a member of that Staff Class has been suspended for a continuous period of more than six months; or

3.3.4 in the case of an Appointed Governor, the appointing organisation withdraws its appointment of them or the organisation ceases to exist; or

3.3.5 he has within the preceding two years been lawfully dismissed otherwise than by reason of redundancy from any paid employment with a health service body; or

3.3.6 he is a person whose term of office as the chair or as a member or director of a health service body has been terminated on the grounds that their continuance in office is no longer in the best interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest; or

3.3.7 he has had their name removed by a direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act and has not subsequently had their name included in such a list; or

3.3.8 he has failed to make, or has falsely made, any declaration as required to be made under Section 60 of the 2006 Act; or

3.3.9 has spoken or voted in a meeting on a matter in which they have a direct or indirect pecuniary or non-pecuniary interest and they are judged to have acted so by a majority of not less than three quarters of the Council; or

3.3.10 NHS England has exercised its powers to remove them as a Governor of the Trust or has suspended them from office or has disqualified them from holding office as a Governor of the Trust for a specified period or NHS England has exercised any of those powers in relation to them on any other occasion whether in relation to the Trust or some other NHS Foundation Trust; or

3.3.11 he has received a written warning from the Trust for verbal and/or physical abuse towards any person; or

3.3.12 as a member of the public has been the subject to any form of review or investigation that has resulted in an exclusion, or any form of restriction placed on their access to any part of the Trust premises and or its staff;

3.3.13 he does not agree to (or, having agreed, fails to) abide by the values as published by the Trust; or

3.3.14 he has been placed on the registers of Schedule 1 Offenders

pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Act 1933 to 1969 (as amended) and their conviction is not spent under the Rehabilitation of Offenders Act 1974; or

3.3.15 he is incapable by reason of mental disorder, illness or injury in managing and administering their property and/or affairs; or

3.3.16 he is a member of the UK Parliament; or

3.3.17 he is a Director of the Trust or a Governor of another NHS Foundation Trust; or

3.3.18 he is a member of a relevant local authority Overview and Scrutiny Committee; or

3.3.19 he is not 16 years of age, or older, at the closing date for nominations for election or appointment; or

3.3.20 he has contravened any other provision of this Constitution; or

3.3.21 their term of office is terminated pursuant to paragraph 3.4 below;

**Termination of Office**

3.4 A Governor's term of office shall be terminated:

3.4.1 by the Governor giving notice in writing to the Secretary of their resignation from office at any time during that term of office;

3.4.2 by a majority of the Governors present and voting at a meeting of the Council if any grounds exist under paragraph 3.3 above

3.4.3 if the Council resolves to terminate their term of office on the grounds that in the reasonable opinion of over half of the Council of Governors voting at a meeting of the Council convened for that purpose that their continuing as a Governor would or would be likely to:

(a) prejudice the ability of the Trust to fulfill its principal purpose or of its purposes under this Constitution or otherwise to discharge its duties and functions; or

(b) prejudice the Trust's work with other persons or body with whom it is engaged or may be engaged in the provision of goods and services; or

(c) adversely affect public confidence in the goods and services provided by the Trust;

(d) the Governor has declared an interest which through the Council's management of that interest would significantly impact on that Governor's ability to actively deliver the role of a Governor or

(e) otherwise bring the Trust into disrepute or be detrimental to

the interests of the Trust.

3.4.4 if over half of the Council of Governors of the Council resolve that:

(a) it would not be in the best interests of the Trust for that person to continue in office as a Governor; or

(b) the Governor is a vexatious or persistent litigant or complainant with regard to the Trust's affairs and their continuance in office would not be in the best interests of the Trust; or

(c) the Governor has failed to or refused to undertake and/or satisfactorily complete any training which the Council has required them to undertake in their capacity as a Governor by a date six months from the date of their election or appointment; or

(d) They has in their conduct as a Governor failed to comply in a material way with the values and principles of the National Health Service or the Trust, the Constitution, and/or the Trust's Terms of Authorisation; or

(e) They have committed a material breach of any Role Description or Code of Conduct applicable to Governors of the Trust and/or these Provisions.

3.5 Where a person has been elected or appointed to be a Governor and he becomes disqualified from that appointment he shall notify the Secretary in writing of such disqualification as soon as practicable and in any event within 14 calendar days of first becoming aware of those matters which rendered them disqualified, and the Secretary shall report the matter to the Council and the Board.

3.6 Upon a Governor resigning or ceasing to be eligible to continue in office that person shall cease to be a Governor and their name shall be removed from the Register of Governors.

Vacancies

3.7 Where a Governor resigns or their office is terminated, elected Governors shall be replaced in accordance with paragraphs 3.8 and 3.9 below and, in the case of appointed Governors, the Trust shall within 30 days of the vacancy having arisen invite the appointing body to appoint a new Governor to hold office for the remainder of the term of office.

3.8 Where a Governor is declared ineligible or disqualified from office or their term of office as a Governor has been terminated (otherwise than as a consequence of their own resignation) and that person disputes the decision, he shall as reasonably practicable be entitled to attend a meeting with the Chair and Chief Executive of the Trust, who shall use their reasonable endeavours to facilitate such a meeting, to discuss the decision with a view to resolving any dispute which may have arisen but the Chair and Chief Executive shall not be entitled to rescind or vary the decision which has already been taken.

3.9 Where an elected Governor ceases to hold office during the first six months of their term of office, the Trust shall offer the unsuccessful candidate who

secured the highest number of votes in the last election for the area or class in which the vacancy has arisen, the opportunity to assume the vacant office for the unexpired balance of the retiring Governor's term of office. If that candidate is unwilling, or unable, to fill the vacancy it will then be offered to that unsuccessful candidate who secured the next highest number of votes.

3.10 If there is no reserve candidate, or the reserve candidate is unable or unwilling to fill the vacancy, the Council may seek to co-opt a non-voting associate governor from that constituency or agree to allow that office will stand vacant until the next scheduled election unless by so doing this causes the aggregate number of Governors who are public [ to be less than half the total membership of the Council. In that event an election will be held in accordance with the election scheme as soon as reasonably practicable.

3.11 No defect in the election or appointment of a Governor or any deficiency in the composition of the Council shall affect the validity of any act or decision of the Council.

## 4. DECLARATIONS AND REGISTER OF GOVERNORS' INTERESTS

4.1 In accordance with the Constitution, Governors are required to declare on election or appointment and in the manner prescribed below any direct or indirect pecuniary interest and any other interest which is relevant and material to the business of the Trust. The responsibility for declaring an interest is solely that of the Governor concerned.

4.2 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time setting out any interests required to be declared in accordance with the Constitution or these Provisions and delivering it to the Secretary within 28 days of a Governor's election or appointment or otherwise within seven days of becoming aware of the existence of a relevant or material interest. The Secretary shall amend the Register of Interests upon receipt of notification within one month.

4.3 If a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter and, if he has declared a pecuniary interest, he shall not take part in the consideration or discussion of the matter.

4.4 The term "relevant and material interests" may include (but may not be limited to) the following:

4.4.1 directorships, including non-executive directorships held in private or public limited companies (with the exception of those of dormant companies);

4.4.2 ownership or part-ownership or directorships of companies or other types of organisation which are likely to or are seeking to do business with the NHS;

4.4.3 a position of authority in a charity or voluntary organisation operating in the field of health and social care, including any which are contracting for or are commissioning NHS services;

4.4.4 any connection with an organisation, entity or company considering

entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks;

4.4.5 research funding/grants that may be received by an individual or their department;

4.5 Any traveling or other expenses or allowances payable to a Governor in accordance with this Constitution shall not be treated as a pecuniary interest.

4.6 Subject to any other provision of this Constitution, a Governor shall be treated as having an indirect pecuniary interest in a contract, proposed contract or other matter, if:

4.6.1 They, or a nominee of theres, is a director of a company or other body not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

4.6.2 he is a partner, associate or employee of any person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the same.

4.7 A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

4.7.1 of their membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

4.7.2 of an interest in any company, body, or person with which he is connected, which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

4.8 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of these Provisions to be also an interest of the other.

4.9 If a Governor has any doubt about the relevance of an interest, he must take advice from the Secretary.

## 5. STANDARDS OF CONDUCT

5.1 Governors shall comply with the terms of the Role Description for Governors which shall be approved by the Council and the Board, and which the Secretary shall issue to Governors upon election or appointment to the Council. The Governors shall also comply with any codes of conduct or other standards referenced in the Role Description.

5.2 In the event that there are concerns about a Governor's performance or conduct, the Chair, with the support of the Lead Governor and Secretary where necessary, will address these directly with the Governor concerned. Where necessary, the Chair will make recommendations to the Council, including in respect of any proposal that the Council should remove the Governor from office in which case the Provisions of section 3 of these Provisions shall apply.

5.3 For further information see Annex 9.

## 6. REMUNERATION AND BUSINESS EXPENSES

6.1 Governors shall not receive remuneration.

6.2 The Trust is permitted to reimburse traveling expenses to Governors for attendance at meetings of the Council, or for any other business authorised by the Chair as being reasonably within the role and duties of a Governor, at a rate and in accordance with a policy to be determined by the Board of Directors.

6.3 Expenses will be reimbursed by the Secretary on receipt of a completed and signed expenses form provided by the Secretary.

6.4 A summary of expenses paid to Governors will be published in the Annual Report.

## 7. COMPOSITION AND ROLE OF COUNCIL OF GOVERNORS

7.1 The composition of the Council shall be as set out in Annex 2 of the Constitution.

7.2 Subject to the 2006 Act (as amended and/or replaced from time to time), the role of the Council is defined in its Terms of Reference which shall be approved by the Council and the Board.

7.3 Subject to the 2006 Act (as amended and/or replaced from time to time), the role of the Chair shall be as defined in a Role Description which shall be approved by the Council and the Board.

7.4 The role of the Deputy Chair shall be as defined in a Role Description which shall be approved by the Council and the Board.

7.5 The role of the Lead Governor shall be as defined in a Role Description which shall be approved by the Council and the Board, this is contained within Annex 8.

## 8. COMMITTEES OF THE COUNCIL

8.1 Subject to the Constitution, the Terms of Authorisation and such binding guidance as may be given by NHS England, the Council may and, if so required by NHS England, shall appoint committees of the Council consisting wholly or partly of members of the Trust (whether or not they include Governors) or wholly of persons who are not members of the Trust (whether or not they include Governors). The Council shall not delegate any of its powers to a committee but committees may act in an advisory capacity to assist the Council in carrying out its functions.

8.2 These Provisions of the Council shall apply with appropriate alteration to any committees established by the Council.

8.3 Each such committee or sub-committee shall have such terms of reference. Such terms of reference and the membership of committees or sub-committees shall be subject to approval by the Council.

8.4 The Council shall approve the appointment of the Chair and members for each of the committees which it has formally constituted. Where the Council determines that persons who are neither Governors nor staff shall be appointed to a committee, the terms of such appointment shall be determined by the Council. The Council may request that external advisers assist them or any committee they appoint in carrying out its duties.

8.5 Elected and Appointed governors may form a sub-committee – the Pre-Council of Governors Committee – to prepare for forthcoming Council meetings.

## 9. SUSPENSION, AMENDMENT AND REVIEW OF THESE PROVISIONS

Suspension

9.1 These Provisions shall not be suspended except:

9.1.1 where urgent action is required and the Chair considers it to be in the interests of the Trust to waive one or more of the Provisions, he may do so subject to such action being reported to the next meeting of the Council

9.1.2 at a meeting of the Council, where at least half of the total number of Governors are present, such number to include not less than one third of the Public Governors, not less than one third of the Staff Governors and not less than one third of the Appointed Governors

9.2 Any decision to waive Provisions shall be recorded in the minutes of the next meeting of the Council and shall be reported to the Audit Committee.

Amendment and Review

9.3 These Provisions shall be reviewed one year after approval by the Council and then at least every three years thereafter.

9.4 These Provisions shall be amended only if:

9.4.1 the variation proposed does not contravene a statutory provision, the Terms of Authorisation or the Constitution; and

9.4.3 at least half of the Governors of the Council, including one staff Governor, one public Governor and one appointed Governor are in favour of amendment.

9.4.4 The proposed amendment(s) has/have been discussed the Board.

9.5 All amendments to these Provisions shall be subject to approval through any process prescribed by NHS England.

**APPENDIX A**

**DECLARATION BY GOVERNOR**

**University Hospitals Sussex NHS FOUNDATION TRUST**
**(the "Trust")**

I, ..... (insert full name)

of
.....
.....
.....(insert address)

Hereby declare that I am entitled to:-

(a) be elected to the Council of Governors as a Governor elected by one of the public constituencies/ the staff constituencies* because I am a member of one of the public constituencies/ /staff constituencies *; or

(b) be appointed to the Council of Governors as a governor because I have been appointed by a nominating organisation

and that I am not prevented from being a member of the Council of Governors of the Trust by paragraph 8 of Schedule 7 of the National Health Service Act 2006 or under the Constitution of the Trust and that I am entitled to vote at meetings of the Council of Governors as a governor pursuant to such appointment or election.

Signed .....

Print
Name…….....

Date of Declaration .....

## ANNEX 5 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

### 1. MEETINGS OF THE COUNCIL OF GOVERNORS

**Frequency of Meetings**

1.1 The Council of Governors ("the Council") shall decide the frequency of and calendar for its meetings, subject to the Council holding a minimum of four general meetings per year. The Secretary shall ensure that within the meeting cycle of the Council, general meetings are called at appropriate times to consider matters as required by the 2006 Act and the Constitution.

1.2 Notwithstanding clause 1.1 above, the Chair may at any time call a meeting of the Council. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the total number of Governors including at least two elected and two appointed Governors, has been presented to him/her, or if, without so refusing, the Chair does not call a meeting within 7 days after such requisition has been presented to him/her, at the Trust's Headquarters, such one third or more Governors may forthwith agree to call a meeting of the Council.

**Admission of the Public**

1.3 By effect of these Standing Orders only, the public shall be invited to attend all meetings of the Council unless the Council decides otherwise in relation to all or part of any particular meeting. The public shall be excluded from meetings of the Council only where the business under discussion is commercially sensitive or is otherwise considered to be confidential.

1.4 The Chair may exclude any member of the public from a meeting of the Council if the person is interfering with or preventing the proper conduct of the Council's business. The Chair's decision in this respect shall be final.

1.5 The Chair shall decide the arrangements through which any questions from members of the public will be asked and answered.

**Admission of Directors**

1.6 Subject to Provisions in relation to interests, any Director or their nominated representatives shall have the right to attend meetings of the Council and, subject to the decision of the Chair, to speak to any item under consideration.

**Chair for Meetings of the Council**

1.7 Subject to clause 1.9 below, the Chair of the Trust, or in their absence, the Deputy Chair shall preside at meetings of the Council. Neither the Chair nor any person deputising for them shall be a member of the Council and he shall not have a vote on matters considered by the Council.

1.8 The Deputy Chair may preside at meetings of the Council in the following circumstances:

1.8.1 when there is a need for someone to have the authority to chair any

meeting of the Council when the Chair is not present

1.8.2 when the remuneration, allowance and other terms and conditions of the Chair are being considered.

1.8.3 when the appointment of the Chair is being considered, should the current Chair be a candidate for re-appointment.

1.8.4 on occasions when the Chair declares a pecuniary interest that prevents them from taking part in the consideration or discussion of a matter before the Council.

1.9 If it would not be appropriate for the Chair or the Deputy Chair to preside, one of the other Non-Executive Directors shall preside. If in exceptional circumstances it would not be appropriate for any Non-Executive Director to preside, the Council shall appoint one of its members to preside at that meeting. This shall normally be the Lead Governor.

1.10 Statements made by Governors at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final and shall be observed at the meeting.

**Notice, Agenda and Papers for Meetings**

Notice of Meeting

1.11 Before each meeting of the Council, a notice of the meeting agreed by the Chair or by an officer of the Trust authorised by the Chair to approve on their behalf shall be published on the Trust website no less than five clear days in advance of the meeting. Clear days shall not include the date on which the notice is sent or the day of the meeting.

1.12 Except in the case of emergencies or in case of a need to conduct urgent business, the Secretary shall give to all Governors at least five clear days written notice of the date and place of every meeting of the Council. Written notice shall be deemed to include communication by email. The notice shall be published on the Trust's website and otherwise made available to members of the public as considered appropriate by the Trust.

1.13 In the case of a meeting called by the Governors in default of the Chair, the notice shall be signed by those respective Governors and no business shall be transacted at the meeting other than that specified in the notice. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of post or otherwise on the day following electronic or facsimile transmission. Lack of service of the notice on any Governors shall not affect the validity of a meeting.

Agenda and Notification of Business

1.14 At the direction of the Council, the Secretary shall draw up and maintain an agenda plan for the Council's meetings in each calendar year. The agenda plan shall take account of the work-plan for the Council, which it will agree with the Board of Directors ("the Board"). The agenda plan shall be approved by the Council at least once in each calendar year.

1.15 The Council may determine that certain matters shall appear on every agenda for a meeting of the Council and shall be addressed prior to any other business being conducted.

1.16 A Governor desiring a matter to be included on an agenda shall specify the question or issue to be included by request in writing to the Chair or the Secretary at least three clear business days before Notice of the meeting is given. Requests made less than three days before the Notice is given may be included on the agenda at the discretion of the Chair.

1.17 Before each meeting of the Council, an agenda setting out the business of the meeting, approved by the Chair or by an officer of the Trust authorised by the Chair on their behalf agreed by the Lead shall be posted online or delivered electronically to the membership of the Council of Governors, specifying the business proposed to be transacted at it at least five clear days before the meeting. The agenda shall include any items of business identified in the approved agenda plan, any items which the Council has directed to appear on any or all of the agenda for its meetings and any specific items or motions requested by one or more Governors and approved by the Chair. The agenda shall be published on the Trust's website prior to the meeting and otherwise made available to members of the public as considered appropriate by the Trust.

Papers for Meetings

1.18 The Secretary shall be responsible for compiling and distributing to Governors (and, where their attendance is permitted, members of the public) papers for meetings of the Council. Papers shall be issued at least five clear days prior to each meeting of the Council. Papers will only be tabled at the Council's meetings in exceptional circumstances and then only with the prior approval of the Chair.

**Quorum for Meetings**

1.19 A meeting of the Council shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that the following requirements are all satisfied:

1.19.1 there shall be present at the meeting at least one third of all Governors
1.19.2 of those present, at least 51% shall be elected Governors

A Governor shall be deemed as present if he joins the meeting by telephone or other means, provided that he can hear and be heard by all other Governors present at the meeting.

If the meeting is not quorate within 15 minutes after the due starting time, it shall be reconvened at time to be agreed by the Chair.

1.20 If a Governor has declared a direct pecuniary interest in any matter, the Governor must leave the meeting room, and will not count towards the quorum of the meeting, during the consideration, discussion and voting on the matter. If a quorum is then not available for the discussion and/or the passing or a resolution on any matter, that matter may not be discussed further or voted upon at that meeting.

1.21 Where a Governor:

1.21.1 has declared an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body; and

1.21.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

1.21.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

1.21.4 the Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty disclose their interest.

1.22. A Governor who has declared a non-pecuniary interest in any matter may participate in the discussion and consideration of the matter but may not vote in respect of it: in these circumstances the Governor will count towards the quorum of the meeting.

1.23 The minutes shall record any declarations of interests on the part of Governors and any action taken in respect of them.

**Conduct of Business**

1.24 Save as otherwise provided in the Constitution and/or the 2006 Act, if the Chair so determines or if a Governor requests, a question at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question and, in the case of any equality of votes, the Chair shall have a casting vote.

1.25 All questions put to the vote shall, at the discretion of the person presiding, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

1.26 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

1.27 If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

1.28 In no circumstances may an absent Governor vote by proxy.

**Minutes of Meetings**

1.29 The minutes of the meeting, which shall include the names of the Governors present, shall be drawn up and submitted by Secretary for the Council's approval at its next meeting. Subject to the Chair's approval, the minutes may be circulated in draft form to Governors prior to the Council's next meeting and made available to the public (including through the Trust's website).

1.30 No discussion shall take place upon the draft minutes except upon their accuracy or where the Chair considers discussion appropriate (for example, on matters arising). Any amendment to the draft minutes of the previous meeting shall be recorded in the minutes of the present meeting. Once draft minutes have been approved (including with regard to any amendments made), they shall be deemed ratified and signed by the person who presided at the meeting at which their accuracy was discussed.

**Written Resolutions**

1.31 Where the Council so decides in respect of any matter or, where it is necessary, at the discretion of the Chair, the Council may take decisions by means of a written resolution.

1.32 A resolution in writing sent to all Governors and signed by at least 75% of them shall be as valid and effective as if it had been passed at a meeting of the Council duly convened and held. Such a resolution may consist of several documents in the same form, each signed by one or more of the Governor.

## 2. SUSPENSION, AMENDMENT AND REVIEW OF THESE STANDING ORDERS

Suspension

2.1 These Standing Orders shall not be suspended except:

2.1.1 where urgent action is required and the Chair considers it to be in the interests of the Trust to waive one or more of the Standing Orders, he may do so subject to such action being reported to the next meeting of the Council

2.1.2 at a meeting of the Council, at least half of the total number of Governors are present, such number to include not less than one third of the Public Governors, not less than one third of the Staff Governors and not less than one third of the Appointed Governors

2.2 Any decision to waive Standing Orders shall be recorded in the minutes of the next meeting of the Council and shall be reported to the Audit Committee.

Amendment and Review

2.3 These Standing Orders shall be reviewed one year after approval by the Council and then at least annually thereafter.

2.4 These Standing Orders shall be amended only if:

2.4.1 the variation proposed does not contravene a statutory provision, the Terms of Authorisation or the Constitution; and

2.4.3 at least three quarters of the Governors present and voting at a meeting of the Council, including one Staff Governor, one Public Governor and one Appointed Governor are in favour of amendment.

2.4.4 The proposed amendment(s) has/have been discussed the Board.

2.5 All amendments to these Standing Orders shall be subject to approval through any process prescribed by NHS England.

## ANNEX 6 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

### 1. INTERPRETATION

1.1 In these Standing Orders, the provisions relating to Interpretation and definitions in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning.

### 2. APPLICATION OF STANDING ORDERS

2.1 These Standing Orders apply to all meetings of the Board of Directors ("the Board") and all other relevant activities of the Directors. All Directors are required to abide by these Standing Orders, which also apply to any persons attending meetings of the Board.

2.2 Except where required by law or the Constitution, at any meeting of the Board, the Chair (or in their absence, the Deputy Chair) shall be the final authority on the interpretation of these Standing Orders (on which he should be advised by the Chief Executive and the Secretary).

2.3 Whilst the Secretary shall be responsible for ensuring that Directors are made aware of these Standing Orders, Directors are expected to familiarise themselves with the provisions.

2.4 In the event of any actual or suspected non-compliance with these Standing Orders by a Director, the person identifying such actual/ suspected non-compliance shall report it to the Chair or Secretary and the Chair/ Secretary shall be responsible for taking such action as is necessary, which shall, where non-compliance is identified, include a report to the next scheduled meeting of the Board. Such a report shall be recorded in the minutes of the Board meeting.

### 3. MEETINGS OF THE BOARD OF DIRECTORS

**Frequency of Meetings**

3.1 The Board shall decide the frequency of and calendar for its meetings, subject to the Board holding not less than four per year. The Secretary shall ensure that within the meeting cycle of the Board, meetings are called at appropriate times to consider matters as required by the 2006 Act and the Constitution.

3.2 Notwithstanding clause 3.1 above, the Chair may at any time call a meeting of the Board. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the total number of Directors, has been presented to them, or if, without so refusing, the Chair does not call a meeting within 7 days after such requisition has been presented to him/her, at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting of the Board.

**Admission of the Public and Observers**

3.3 By effect of these Standing Orders only, the public shall be invited to attend all meetings of the Board unless the Board decides otherwise in relation to all or part of any particular meeting. The Board may also invite observers to attend its meetings.

3.4 The public shall be excluded from meetings of the Board only where the business under discussion is commercially sensitive or is otherwise considered to be confidential. The Chair may exclude any member of the public from a meeting of the Board if the person is interfering with or preventing the proper conduct of the Board's business. The Chair's decision in this respect shall be final.

3.5 The Chair shall decide the arrangements through which any questions from members of the public will be asked and answered.

**Chair for Meetings of the Board**

3.6 The Chair of the Trust, or in their absence, the Deputy Chair shall preside at meetings of the Board.

3.7 The Deputy Chair may preside at meetings of the Board in the following circumstances:

3.7.1 when there is a need for someone to have the authority to chair any meeting of the Board when the Chair is not present;

3.7.2 on occasions when the Chair declares a pecuniary interest that prevents them from taking part in the consideration or discussion of a matter before the Board.

3.8 If it would not be appropriate for the Chair or the Deputy Chair to preside, then the remaining Non-Executive Directors shall choose one of the other Non-Executive Directors to preside.

3.9 Statements made by Directors at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final and shall be observed at the meeting.

**Notice, Agenda and Papers for Meetings**

Notice of Meeting

3.10 Before each meeting of the Board, a notice of the meeting signed by the Chair or by an officer of the Trust authorised by the Chair to sign on their behalf shall be delivered to every member of the Board, or sent by post to the usual place of residence of such Director, no less than five clear working days before the meeting. Clear days shall not include the date on which the notice is sent or the day of the meeting.

3.11 Except in the case of emergencies or in case of a need to conduct urgent business, the Secretary shall give to all Directors at least 10 clear working days' written notice of the date and place of every meeting of the Board.

Written notice shall be deemed to include communication by email. Notice will also be published on the Trust's website.

3.12 In the case of a meeting called by the Directors in default of the Chair, the notice shall be signed by those respective Directors and no business shall be transacted at the meeting other than that specified in the notice A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of post or otherwise on the day following electronic or facsimile transmission. Lack of service of the notice on any Directors shall not affect the validity of a meeting.

Agenda and Notification of Business

3.13 At the direction of the Board, the Secretary shall draw up and maintain a plan for the agenda of the Board's meetings in each calendar year. The agenda plan shall take account of the work-plan for the Board, which it will agree with the Council. The agenda plan shall be approved by the Board at least once in each calendar year.

3.14 The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted.

3.15 A Director desiring a matter to be included on an agenda shall specify the question or issue to be included by request in writing to the Chair or the Secretary at least three clear business days before notice of the meeting is given. Requests made less than three days before the notice is given may be included on the agenda at the discretion of the Chair.

3.16 Before each meeting of the Board, an agenda setting out the business of the meeting, approved by the Chair or by an officer of the Trust authorised by the Chair on their behalf shall be delivered electronically to every member of the Board, specifying the business proposed to be transacted at it at least five clear days before the meeting. The agenda shall include any items of business identified in the approved agenda plan, any items which the Board has directed to appear on any or all of the agenda for its meetings and any specific items or motions requested by one or more Directors and approved by the Chair. The agenda shall be published on the Trust's website prior to the meeting and otherwise made available to members of the public as considered appropriate by the Trust.

Papers for Meetings

3.17 The Secretary shall be responsible for compiling and distributing to Directors (and, where their attendance is permitted, members of the public) papers for meetings of the Board. Papers shall be issued at least five clear days prior to each meeting of the Board. Papers will only be tabled at the Board's meetings in exceptional circumstances and then only with the prior approval of the Chair.

**Quorum for Meetings**

3.18 A meeting of the Board shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that at least half of the Board must be present, including two Non-executive Directors and two Executive Directors. A Director shall be deemed as present if he joins the meeting by telephone or other means, provided that he can hear and be heard by all other Directors present at the meeting.

3.19 If the meeting is not quorate within 15 minutes after the due starting time, it shall be reconvened at time to be agreed by the Chair.

**Declaring interests**

3.20 If a Director has declared a direct pecuniary interest in any matter, the Director must leave the meeting room, and will not count towards the quorum of the meeting, during the consideration, discussion and voting on the matter. If a quorum is then not available for the discussion and/or the passing or a resolution on any matter, that matter may not be discussed further or voted upon at that meeting.

3.21 Where a Director:

3.21.1 has declared an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body; and

3.21.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

3.21.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

3.21.4 the Director shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty disclose their interest.

3.22 A Director who has declared a non-pecuniary interest in any matter may participate in the discussion and consideration of the matter but may not vote in respect of it: in these circumstances the Director will count towards the quorum of the meeting.

3.23 The minutes shall record any declarations of interests on the part of Directors and any action taken in respect of them.

3.24 See further paragraph 4 (declarations and register of directors' interests) of Annex 7 (further provisions).

**Conduct of Business**

3.25 Save as otherwise provided in the Constitution and/or the 2006 Act, if the Chair so determines or if a Director requests, a question at a meeting shall be

determined by a majority of the votes of the Director present and voting on the question and, in the case of any equality of votes, the Chair shall have a casting vote.

3.26 All questions put to the vote shall, at the discretion of the person presiding, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

3.27 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.28 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.29 An officer who has been formally appointed to act for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director, and shall therefore count towards the quorum. An officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence in the absence of a formal acting arrangement (i.e. a proxy) shall not exercise the voting rights of the Executive Director or count towards the quorum. The minutes shall record the status of Directors attending to represent Executive Directors.

3.30 For the avoidance of doubt, in no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

**Minutes of Meetings**

3.31 The minutes of the meeting, which shall include the names of the Directors present, shall be drawn up and submitted by Secretary for the Board's approval at its next meeting. Subject to the Chair's approval, the minutes may be circulated in draft form to Directors prior to the Board's next meeting and made available to the public (including through the Trust's website).

3.32 No discussion shall take place upon the draft minutes except upon their accuracy or where the Chair considers discussion appropriate (for example, on matters arising). Any amendment to the draft minutes of the previous meeting shall be recorded in the minutes of the present meeting. Once draft minutes have been approved (including with regard to any amendments made), they shall be deemed ratified and signed by the person who presided at the meeting at which their accuracy was discussed.

**Written Resolutions**

3.33 Where the Board so decides in respect of any matter or, where it is necessary, at the discretion of the Chair, the Board may take decisions by means of a written resolution.

3.34 A resolution in writing sent to all Directors and signed by at least 75% of them shall be as valid and effective as if it had been passed at a meeting of the Board duly convened and held. Such a resolution may consist of several documents in the same form, each signed by one or more of the Directors.

## 4. SUSPENSION, AMENDMENT AND REVIEW OF THESE STANDING ORDERS

Suspension

4.1 These Standing Orders shall not be suspended except:

4.1.1 where urgent action is required and the Chair considers it to be in the interests of the Trust to waive one or more of the Standing Orders, he may do so subject to such action being reported to the next meeting of the Board

4.1.2 at a meeting of the Board, at least half of the total number of Directors are present, such number to include at least one Non-executive Director

4.2 Any decision to waive Standing Orders shall be recorded in the minutes of the next meeting of the Board and shall be reported to the Audit Committee.

Amendment and Review

4.3 These Standing Orders shall be reviewed one year after approval by the Board and then at least annually thereafter.

4.4 These Standing Orders shall be amended only if:

4.4.1 the variation proposed does not contravene a statutory provision, the Terms of Authorisation or the Constitution; and

4.4.3 at least three quarters of the Board present and voting at a meeting of the Board are in favour of amendment.

4.4.4 The proposed amendment(s) has/have been discussed with the Council.

4.5 All amendments to these Standing Orders shall be subject to approval through any process prescribed by NHS England.

## ANNEX 7 – FURTHER PROVISIONS RELATING TO THE BOARD OF DIRECTORS

### 1. INTERPRETATION

1.1 In these Provisions, the clauses relating to Interpretation and definitions in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning.

### PART A – PROVISIONS RELATING TO THE BOARD OF DIRECTORS

### 2. APPLICATION OF PROVISIONS

2.1 These Provisions apply to all meetings of the Board of Directors ("the Board") and all other relevant activities of the Directors. All Directors are required to abide by these Provisions, which also apply to any persons attending meetings of the Board.

2.2 Except where required by law or the Constitution, at any meeting of the Board, the Chair (or in their absence, the Deputy Chair) shall be the final authority on the interpretation of these Provisions (on which he should be advised by the Chief Executive and the Secretary).

2.3 Whilst the Secretary shall be responsible for ensuring that Directors are made aware of these Provisions, Directors are expected to familiarise themselves with the provisions.

2.4 In the event of any actual or suspected non-compliance with these Provisions by a Director, the person identifying such actual/ suspected non-compliance shall report it to the Chair or Secretary and the Chair or Secretary shall be responsible for taking such action as is necessary, which shall, where non-compliance is identified, include a report to the next scheduled meeting of the Board. Such a report shall be recorded in the minutes of the Board meeting.

### 3. APPOINTMENT AND REMOVAL OF DIRECTORS

The provisions of this Section 3 shall be subject always to paragraphs 21 to 31 (inclusive) of the Constitution.

#### Chief Executive

3.1 There shall be a Nominations & Remuneration Committee of the Board which shall be responsible for appointing the Chief Executive. When the Committee is considering the appointment of the Chief Executive, it shall comprise of the Chair and as many of the Non-Executive Directors as the Board decides. The Committee shall make a recommendation to the Chair and the other Non-Executive Directors, and their decision shall be subject to approval by the Council.

#### Executive Directors

3.2 The Board shall establish a Committee to appoint the Executive Directors. The

Committee shall comprise of the Chair, the Non-Executive Directors and the Chief Executive. The Committee's decision shall be final.

**Terms of Office and Process**

3.3 There shall be written policies and processes, approved by the Board, to set out the process by which the Chair, Non-Executive Directors, Chief Executive and Executive Directors shall be appointed, and through which their terms and conditions of appointment shall be decided. In the case of the appointment of the Chair, Non-Executive Directors and the Chief Executive, these policies and processes shall be subject to the approval of the Council.

3.4 Save for the initial Chair and initial Non-Executive Directors who shall be appointed for a term in accordance with their letters of appointment, the Chair and the Non-Executive Directors appointed after the Acquisition Date shall be appointed for a term of three years. Subject to other relevant provisions in the Constitution, Non-Executive Directors shall be subject to re-appointment thereafter at intervals of no more than 3 years. Non-executive Directors may serve for a term beyond 6 years subject to annual re-appointment. Non-Executive Directors may not serve for a term of more than nine years in aggregate.

**Appointments – Other Matters**

3.5 No defect in the appointment of a Director nor any deficiency in the composition of the Board shall affect the validity of any act or decision of the Board.

3.6 The Trust may confer on a person the title “Director” as an indication of their seniority and/or the corporate nature of their responsibilities within the Trust but such a person shall not be an Executive Director or Non-Executive Director of the Trust for the purposes of the 2006 Act unless he is a member of the Board of Directors as defined by the Constitution and, therefore, subject to Section 3.29 of Annex 6, he will have no right to vote at meetings of the Board.

**Removal or Resignation from Office**

3.7 A person shall not be eligible to become or continue in office as a Director if:

3.7.1 in respect of a Non-Executive Director, he does not meet the criteria for eligibility in paragraph 24 of the Constitution;

3.7.2 in respect of any Director, any of the grounds contained in paragraph 28 apply to them;

3.7.3 he has within the preceding two years been lawfully dismissed otherwise than by reason of redundancy from any paid employment with a health service body;

3.7.4 he has had their name removed by a direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act and has not subsequently had their name included in such a list;

3.7.5 NHS England has exercised its powers to remove them as a Director of the Trust or has suspended them from office or has disqualified them from holding office as a Director of the Trust for a specified period or NHS England has exercised any of those powers in relation to them on any other occasion whether in relation to the Trust or some other NHS Foundation Trust;

3.7.6 he has been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Act 1933 to 1969 (as amended) and their conviction is not spent under the Rehabilitation of Offenders Act 1974;

3.7.7 he is incapable by reason of mental disorder, illness or injury in managing and administering their property and/or affairs;

3.7.8 he is a Governor of the Trust or a director of another NHS Foundation Trust;

Termination of Tenure

3.8 A Director's term of office shall be terminated:

3.8.1 if he is a Non-Executive Director if he gives notice in writing to the Secretary of their resignation from office at any time during that term of office or under paragraph 25.2 of the Constitution;

3.8.2 if he is an Executive Director if he gives notice in writing to the Chief Executive of their resignation from office at any time or under paragraph 27.3 of the Constitution.

3.9 Where a person has been appointed to the Board and he becomes disqualified from that appointment he shall notify the Secretary in writing of such disqualification as soon as practicable and in any event within 14 calendar days of first becoming aware of those matters which rendered them disqualified.

3.10 A Director whose tenure of office is terminated shall not be eligible for re-appointment for a period of three years from the date of their resignation or removal from office or the date upon which any appeal against their removal from office is disposed of whichever is the later except by resolution carried by a majority of the Board present and voting at a meeting.

3.11 Upon a Director resigning or ceasing to be eligible to continue in office that person shall cease to be a Director and their name shall be removed from the Register of Directors.

Vacancies

3.12 Where a Director resigns or their office is terminated, the vacancy shall be filled through the processes agreed as set out in Section 3.4 above.

## 4. DECLARATIONS AND REGISTER OF DIRECTORS' INTERESTS

4.1 In accordance with the Constitution, Directors are required to declare on appointment and in the manner prescribed below any direct or indirect pecuniary interest and any other interest which is relevant and material to the business of the Trust.

4.2 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time setting out any interests required to be declared in accordance with the Constitution or these Provisions and delivering it to the Secretary within 28 days of a Director's appointment or otherwise within seven days of becoming aware of the existence of a relevant or material interest. The Secretary shall amend the Register of Interests upon receipt of notification within one month.

4.3 If a Director is present at a meeting of the Board and has an interest of any sort in any matter which is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter and, if he has declared a pecuniary interest, he shall not take part in the consideration or discussion of the matter.

4.4 The term "relevant and material interests" may include (but may not be limited to) the following:

4.4.1 directorships, including non-executive directorships held in private or public limited companies (with the exception of those of dormant companies);

4.4.2 ownership or part-ownership or directorships of companies or other types of organisation which are likely to or are seeking to do business with the NHS;

4.4.3 a position of authority in a charity or voluntary organisation operating in the field of health and social care, including any which are contracting for or are commissioning NHS services;

4.4.4 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks;

4.4.5 research funding/grants that may be received by an individual or their department;

4.5 Any traveling or other expenses or allowances payable to a Director in accordance with this Constitution shall not be treated as a pecuniary interest.

4.6 Subject to any other provision of this Constitution, a Director shall be treated as having an indirect pecuniary interest in a contract, proposed contract or other matter, if:

4.6.1 he, or a nominee of their, is a director of a company or other body not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

4.6.2 he is a partner, associate or employee of any person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the same.

4.7 A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

4.7.1 of their membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

4.7.2 of an interest in any company, body, or person with which he is connected, which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

4.8 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of these Provisions to be also an interest of the other.

4.9 If a Director has any doubt about the relevance of an interest, he must take advice from the Secretary.

## 5. STANDARDS OF CONDUCT

5.1 Subject to the 2006 Act (as amended and/or replaced from time to time), Directors shall comply with the terms of their relevant Role Descriptions which shall be approved by the Board and, as set out in these Provisions, the Council, and which the Secretary shall issue to Directors upon appointment to the Board. The Directors shall comply with any codes of conduct or other standards referenced in their Role Descriptions.

5.2 In the event that there are concerns about a Non-Executive Director's performance or conduct, the Chair, with the support of the Secretary where necessary, will address these directly with the Non-Executive Director concerned. Where necessary, the Chair will make recommendations to the Board, including in respect of any proposal that the Board should remove the Non-Executive Director from office in which case the provisions of Section 3 of these Provisions shall apply.

5.3 In the event that there are concerns about an Executive Director's performance or conduct, the Chief Executive, with the support of the Secretary and others where necessary, will address these directly with the Executive Director concerned. Where necessary, the Chief Executive will make recommendations and/or reports to the Board, including in respect of any proposal that the Board should remove the Executive Director from office in which case the provisions of Section 3 of this Annex 7 shall apply.

## 6. REMUNERATION AND BUSINESS EXPENSES

6.1 The Trust is permitted to reimburse traveling expenses to Non-Executive Directors for attendance at meetings of the Board, or for any other business authorised by the Chair as being reasonably within the role and duties of a Non-Executive Director, at a rate to be determined by the Council of Governors. The Chief Executive shall be responsible for authorising expenses incurred by Executive Directors, to be paid at a rate to be determined by the Chair and Non-

Executive Directors.

6.2 A summary of expenses paid to Directors will be published in the Annual Report.

## 7. COMPOSITION AND ROLE OF BOARD OF DIRECTORS

7.1 All of the Board's business shall be conducted in the name of the Trust.

7.2 Subject to the 2006 Act (as amended and/or replaced from time to time), the role of the Board is defined in its Terms of Reference which shall be approved by the Board of Governors and the Board of Directors.

7.3 Subject to the 2006 Act (as amended and/or replaced from time to time), the composition of the Board shall be as set out in the Constitution.

7.4 Subject to the 2006 Act (as amended and/or replaced from time to time), the role of the Chair and the role of Non-Executive Director shall be as defined in Role Descriptions which shall be approved by the Council and the Board.

7.5 The Council shall appoint one of the Non-Executive Directors to be Deputy Chair. The role of the Deputy Chair shall be as defined in a Role Description which shall be approved by the Council and the Board.

7.6 The Board shall appoint one of the Non-Executive Directors to be the Senior Independent Director ("SID"). The role of Senior Independent Director shall be as defined in the Role Description which shall be approved by the Board.

## 8. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

8.1 Subject to the Constitution, Terms of Authorisation or any relevant statutory provision, the Board may make arrangements for the delegation, on behalf of the Board, of any of its powers to a committee of directors or to an executive director.

8.2 The Board shall delegate responsibility and authority on any terms which it considers to be appropriate, such terms to be defined in written terms of reference approved by the Board.

8.3 The Board's arrangements for the exercise of functions through delegation shall be set out within a Scheme of Delegation to be approved by the Board. This shall include delegation to Committees and to Directors, and shall specify those matters which are reserved to the Board to decide.

## 9. COMMITTEES OF THE BOARD

9.1 Subject to the 2006 Act (as amended and/or replaced from time to time), the Board shall establish an Audit Committee and an Appointment & Remuneration Committee, whose role, responsibilities and authority shall be defined in terms of reference to be approved by the Board in accordance with

9.2 paragraphs 32 and 38 of the Constitution. The Board shall appoint the Chairmen and the Members of the Committees.

9.3 Subject to the Constitution, the Terms of Authorisation and such binding guidance as may be given by NHS England, the Board may and, if so required by NHS England, shall appoint other committees of the Board consisting wholly or partly of Directors or wholly of persons who are not Directors. The Board shall not delegate any of its powers to such committees but committees may act in an advisory capacity to assist the Board in carrying out its functions.

9.4 These Provisions of the Board shall as far as they are applicable apply with appropriate alteration to any committees established by the Board.

## 10. PROFESSIONAL ADVICE

10.1 The Board shall have direct access to any independent advice which it considers necessary for the proper discharge of its functions, such advice normally being obtained by the Secretary. Such advice shall be commissioned through terms of reference to be agreed by the Board and may be presented in written form and/or by advisors attending meetings of the Board. The Trust shall meet the cost of any such advice commissioned by the Board. The Board shall establish a policy to set out the circumstances in which and the arrangements through which advice shall be taken and reported to the Board.

## 11. DIRECTORS AND GOVERNORS: WORKING ARRANGEMENTS

### Engagement, Collaboration and Consultation

11.1 The Board and the Council shall agree work-plans for their meetings and activities, which shall be complementary and integrated. The work-plans shall identify the matters on which and, where possible, the timetable over which the Board and the Council shall consult each other about the business which they deal with. The work-plans shall take account of the Trust's strategy and business plans.

11.2 As a minimum, the Board shall consult the Council on the following matters:

11.2.1 proposals for the Trust's strategy and its annual Business Plan;

11.2.2 proposals for significant service developments;

11.2.3 the Trust's operational performance and delivery against plans generally;

11.2.4 service reviews and evaluations in respect of the Trust's services; and

11.2.5 development of the Trust's membership and plans for engagement with patients and the public generally.

11.3 The Board shall present to the Council the Trust's Annual Accounts, Annual Report and Auditors Report in accordance with the terms of this Constitution and of the 2006 Act.

11.4 The Board and the Council shall hold at least one joint meeting per year.

11.5 Directors and Governors may agree to attend each other's' meetings through a schedule to be agreed by the Board and the Council.

**Informal Communication**

11.6 The Chair shall use their reasonable endeavours to promote communication between the Board and the Council, including through:

11.6.1 participation of the Board in the induction, orientation and training of Governors;

11.6.2 development of special interest relationships between Non-Executive Directors and Governors;

11.6.3 discussions between Governors and the Chair and/or the Chief Executive and/or Directors through the office of the Chief Executive or their nominated officer;

11.6.4 involvement in membership recruitment and briefings at events organised by the Trust.

**Formal Communication**

11.7 Where it is otherwise necessary, such as where it is prescribed by the Constitution, these Provisions, Terms of Authorisation or elsewhere, the Board and the Council shall communicate formally by the means set out below:

11.7.1 the Council may and, where required, shall at any time ask for matters to be referred to the Board. Any such referrals shall be made through the Chair who shall arrange for the matter to be added to the agenda for the next scheduled meeting of the Board;

11.7.2 in the absence of the Council agreeing to refer a matter to the Board, any Governor may through the Chair refer a matter to the Board of Directors but if the Chair declines to refer any such issue the said Governor may refer it provided that two thirds of the Governors present approve their request to do so. The Chair shall then refer the matter to the Board and provide the response to the Council.

## 12. RESOLUTION OF DISPUTES

12.1 In the event of dispute between the Council and the Board then the dispute resolution procedure set out below shall be followed in order to resolve the matters concerned. The Council and the Board shall at all times recognise their roles and responsibilities as defined in the Constitution, these Provisions, Terms of Reference and any other documents approved.

12.2 The Chair or, in the event that the dispute is about the conduct or performance of the Chair, the Senior Independent Director, shall endeavour through discussion with Governors and Directors or, if it is

considered to be more expedient, appointed representatives of them, to resolve the matter to the reasonable satisfaction of both parties.

12.3 In the event that it is not possible to resolve the dispute through the process described in 12.2 above, the Chair or, in the event that the dispute is about the conduct or performance of the Chair, the Senior Independent Director, shall appoint a special committee comprising equal numbers of Directors and Governors to consider the circumstances and to clearly and concisely produce a recommendation statement to the Council and to the Board with a view to resolving the dispute (the "Recommendation Statement").

12.4 The Chair or, in the event that the dispute is about the conduct or performance of the Chair, the Senior Independent Director, shall ensure that the Recommendation Statement, without amendment or abbreviation in any way, shall be considered at the next scheduled meeting of both the Council and the Board. Where it is considered necessary or expedient to convene a meeting of the Council or of the Board earlier than is otherwise scheduled then the Chair shall do so and in this event the relevant provisions of these Provisions shall apply.

12.5 If in the opinion of the Chair or, in the event that the dispute is about the conduct or performance of the Chair, the Senior Independent Director, and following the further discussions prescribed in 12.4 there is no further prospect of a full resolution or, if at any stage in the process, in the opinion of the Chair or the Senior Independent Director (as the case may be) there is no prospect of a resolution (partial or otherwise) then he shall advise the Council and the Board accordingly. In the event that the dispute cannot be resolved, the decisions of the Board shall prevail. In the event that the dispute is resolved to the satisfaction of the Council and the Board, the Board shall implement the decisions taken.

12.6 Nothing in this procedure shall prevent the Council, through the Lead Governor, from informing NHS England that in the Council's reasonable opinion its concerns are such that if they remain unresolved, the Trust will be at risk of breaching the terms of its Authorisation.

## PART B – MEMBERSHIP OF THE TRUST

### 13. ELIGIBILITY FOR MEMBERSHIP

**General**

13.1 An individual shall not be eligible for membership of the Trust if he:

13.1.1 fails or ceases to fulfill the criteria for membership of any of the constituencies;

13.1.2 was formerly employed by the Trust or any health service body and in the preceding two years was lawfully dismissed other than by reason of redundancy;

13.1.3 has been involved as a perpetrator in a serious incident of violence or abuse, or has been excluded from the Trust's premises in any other capacity, in the last five years at any of the Trust's hospitals or against any of the Trust's Governors, Directors, staff members or patients;

13.1.4 has been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children & Young Person's Acts 1933 to 1969 (as amended) and their or her conviction is not spent under the Rehabilitation of Offenders Act 1974;

13.1.5 does not agree to abide by the Trust values as published by the Trust;

13.1.6 has been identified as a vexatious complainant or has been excluded from treatment at any of the Trust's hospitals due to unacceptable behaviour;

13.1.7 is deemed, in the reasonable opinion of the Trust, to have acted in a manner contrary to the interests of the Trust; or

13.1.8 is under the age of sixteen years.

13.2 It is the responsibility of members to ensure that they are eligible for membership but if the Trust is on notice that a member may be disqualified from membership, the Trust shall carry out all reasonable enquiries to establish whether or not this is the case.

13.3 Where an individual is held by the Trust to be ineligible and/or disqualified from membership of the Trust and disputes the Trust's decision in this respect, the matter shall be referred to the Secretary (or such other officer of the Trust as the Chief Executive may nominate) as soon as reasonably practicable thereafter.

13.4 The Secretary (or their nominated representative) shall:

(a) review the decision having regard to any representations made by the individual concerned and such other material, if any, as the Secretary considers appropriate;

(b) either confirm the decision or make some other decision as appropriate based on the evidence which he has considered; and

(c) communicate their decision and the reasons for it in writing to the individual concerned as soon as reasonably practicable.

13.5 If the member is aggrieved of the decision of the Secretary he may appeal in writing to the Council of Governors ("the Council") within 14 days of the Secretary's decision. The Council shall consider the matter at its next meeting and its decision shall be final

**Public Membership**

13.6 For the purposes of determining whether an individual lives in a public constituency, an individual shall be deemed to do so if;

13.6.1 their name appears on the electoral roll at an address within the said area and the Trust has no reasonable cause to conclude that the individual is not living at that address; or

13.6.2 the Trust is otherwise satisfied that the individual lives within the said area.

**Staff Membership**

13.7 An individual shall be deemed to be eligible for membership of the staff constituency if he meets the eligibility criteria set out in the Constitution.

## 14. APPLICATION FOR MEMBERSHIP

14.1 Where a person wishes to apply to become a member of the Trust, the following procedure shall apply

14.1.1 the Trust shall upon request supply them with a form of application for membership in a form determined by the Trust;

14.1.2 upon receipt of the said form of application duly completed and signed by the applicant (or in the Trust's discretion signed on behalf of the applicant) the Trust shall as soon as is reasonably practicable and in any event within 28 working days of receipt of the duly completed form consider the same;

14.1.3 unless the applicant is ineligible for membership or is disqualified from membership, the Trust shall cause their name to be entered on the Trust's Register of Members and shall give notice in writing to the applicant of that fact;

14.1.4 upon the applicant's name being entered on the Trust's Register of Members he shall become a member;

14.1.5 the information to be included in the Trust's Register of Members shall include the following details relating to that member:

(a) their full name and title;

(b) their date of birth;

(c) their full postal address;

(d) their home telephone number (if any);

(e) their email address (if any);

(f) the constituency and, where relevant, the area or class of which he/she is a member;

(g) the date upon which he/she became a member; and

(h) their gender and ethnicity.

14.2 For the avoidance of doubt and subject to the restrictions on making the Trust's registers available in accordance with paragraph 35.2 of the Constitution, where a member of the public makes a request to inspect the Register of Members, pursuant to paragraph 35 of the Constitution (Registers – inspection of copies), the Trust shall disclose only those parts of the Register that detail the members' names, constituency, and, where relevant, their area or class within that constituency in accordance with paragraph 20 and paragraph 22(3) of Schedule 7 of the 2006 Act and subject always to compliance with data protection requirements.

## 15. REGISTER OF MEMBERS

15.1 For the avoidance of doubt, an individual shall become a member on the date upon which their name is entered on the Trust's Register of Members and shall cease to be a member upon the date on which their name is removed from the Register of Members as provided for in this Constitution.

15.2 The Register of Members and all other Registers shall be maintained in accordance with this Constitution and in accordance with the 2006 Act. The Registers shall be reviewed and updated regularly and, in the case of the Register of Members, within 14 days of receipt of any new or amended information about members.

15.3 Where in the reasonable opinion of the Trust a member is no longer eligible or is disqualified from Membership of the Trust, the Trust shall be entitled to remove the name of that individual from the Register of Members and that individual shall thereupon cease to be a Member provided always that this power shall not be exercised until the Trust has given not less than fourteen days written notice to the member addressed to them at the address given in the Register of Members of its intention to remove them from the Register and that member has not within that period notified the Trust of their wish to continue as member and provided proof satisfactorily to the Trust of their continued eligibility.

## 16. TERMINATION OF MEMBERSHIP

16.1 A person shall cease to be a member if:

1.16.1 he resigns by notice in writing to the Trust;

1.16.2 he ceases to be entitled under this Constitution to be a member of any area within the Public Constituency or of any of the classes of the Staff Constituency;

1.16.3 he is expelled from membership in accordance with the provisions of this Constitution;

1.16.4 he dies.

16.2 An individual who is a member of the Public Constituency shall cease to be eligible to continue as a member if he ceases to live in the area of the Public Constituency of which he is a member save as provided elsewhere in these rules. In the event that a member moves to another Public Constituency area and requests to be a member in that area, if the Trust is satisfied that the individual concerned lives in such other area, that individual shall thereafter be treated as a member of that other area within the Public Constituency.

16.3 Where an individual is a member by virtue of their eligibility to be a member of a Staff Class and they cease to be eligible for membership of that Staff Class but are eligible for membership of some other Staff Class, then the Trust may give notice to that member of its intention to transfer them to that other Staff Class on the expiration of a period of time or upon a date specified in the said notice and shall after the expiration of that notice or date amend the Register of Members accordingly.

## PART C – OTHER PROVISIONS

### 17. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

17.1 The Common Seal of the Trust shall be kept by the Trust Secretary on behalf of the Chief Executive or designated officer in a secure place.

17.2 The seal of the Trust shall not be affixed to any documents unless the sealing has been authorised by a resolution of the Board, a committee, or, where the Board so decides, one or more Directors. The seal shall only be affixed in the presence of two Directors.

17.3 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by those who attested the seal. A report of all sealings shall be made to the Board at least quarterly. (The report shall contain details of the seal number, a description of the document and the date of sealing).

### 18. SIGNATURE OF DOCUMENTS

18.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

18.2 The Chief Executive or nominated Director(s) shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority.

### 19. SECRETARY

19.1 The Trust shall have a Secretary, who may be an employee. The Secretary shall not be a Governor, or the Chief Executive or the Finance Director.

19.2 The Secretary shall be appointed and, where necessary, removed only by the Chair and Chief Executive acting jointly, who shall report their actions to the Board and the Council.

19.3 The Secretary's functions shall be set out within a job description which shall be approved by the Chair and the Chief Executive.

### 20.0 INDEMNITY FOR GOVERNORS, DIRECTORS AND THE SECRETARY

20.1 Members of the Council; and the Board; and the Secretary, who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their duties, save where they have acted recklessly. Any costs arising in this way will be met by the Trust and the Trust shall have the power to purchase suitable insurance or make appropriate arrangements with the National Health Service Resolution to cover such costs.

**ANNEX 8 Lead Governor Role Description**

**Role Description**

**Accountability:**

The Lead is accountable to the Council of Governors collectively as a serving Member of the Council.

**The Role:**

- To be an external point of contact for NHS England (formerly Monitor / NSH Improvement) where it may be considered inappropriate for the Chair or the Deputy Chair, or for the Secretary to deal with a particular matter.

- To facilitate communications and a good working relationship between the Governors and the Executive Board and Trust Board including acting as the principle independent channel for communications between the Governors and Executive Board and Trust Board through the Chair, the Chief Executive, the Secretary or the Senior Independent Director.

- To consult routinely with the Governors, the Chair and the Secretary regarding the planning and preparation of the Council of Governors agenda.

- To be a member of the Nominations and Remuneration Committee.

- To contribute to the appraisal of the Chair by the Senior Independent Director, supported by the Secretary, in accordance with the process determined by the Council of Governors including the collation of input from other Governors and the Nominations and Remuneration Committee on the performance of the Chair.

- Contribute to the determination of the appraisal process of the Non-Executive Directors to be undertaken by the Chair and supported by the Nominations and Remuneration Committee.

- To recommend to the Council of Governors on behalf of the Nominations and Remuneration Committee any appointments/reappointments of Chair; Non-Executive Directors and/or the Chief Executive.

- To take an active role in the activities of the Council of Governors and to meet with the Chair and the Secretary on a regular basis to discuss relevant issues.

- Support the Chair and the Secretary in any action to remove a Governor due to unconstitutional behaviour in accordance with the Code of Conduct.

- To be involved in the induction process for any newly appointed Public Governor.

- The Lead Governor may call upon the support of the other Governors, the Chair, the Secretary and the Senior Independent Director to carry out their role effectively to the benefit of the Council of Governors.

- In liaison with the Chair and the Secretary, support the development of the skills and strengths of the Council of Governors and raise public awareness of all Governors.

- To chair meetings of Council of Governors where the Chair, Deputy Chair or other Non-Executive Director cannot chair the meeting due to a conflict of interest.
- Where approved by the Council and/or the Chair speak for and represent the Council at the AGM and on other occasions
- Other duties as requested by the Council of Governors or the Chair.
- Chair the Pre-Council of Governors meeting and any informal meetings.

**The Person:**

To fulfil this role effectively, the Lead Governor will need to:

- Be a publically elected Governor
- Have the confidence of Governor colleagues and members of the Executive Board and Trust Board
- Be able to forge constructive working relationships with colleagues
- Understand NHSI's role, the available guidance and the basis upon which NHSI may take regulatory action
- Be committed to the success of the Trust and understand the Trust's Constitution
- Have the ability to influence and negotiate
- Be able to present a well-reasoned, unbiased argument
- Demonstrate ability to maintain confidentiality of information.

**The Appointment:**

The tenure is two years with the option for re-election in accordance with due process, for up to the full tenure period of the elected Governor's 'appointment'.

In accordance with a process agreed by the Council of Governors, the Secretary will administer a bi annual nomination and election/re-election procedure that will require: -

- Submission of an expression of interest (for re-election and for new election candidates)
- Submission of a statement for support of no more than 250 words supporting candidature (only for NEW nominations and/or contested elections);
- Election by 'show of hands' or by secret ballot as determined by the relevant Council meeting.

**Additional:**

**ANNEX 9**

## Code of Conduct for Governors

**1.00 INTRODUCTION**

1.01 The Council of Governors (the Council) in support of the individual governors has established a Code of Conduct for Governors which codifies the expectations of its individual Governors and the process which will be followed should there be a need to consider if a Governor has deviated from this Code.

**2.00 FRAMEWORK FOR COUNCIL OF GOVERNORS**

2.01 The Trust operates within a legal, regulatory and governance framework established by the NHS Act 2006, the Health and Social Care Act 2012, the NHS Foundation Trust Code of Governance published by Monitor in 2013 and updated in 2014 (**Code of Governance**) and Monitor's Risk Assessment Framework updated in August 2015 (**Risk Assessment Framework**) and other regulatory requirements and the Trust's Constitution. The Constitution defines the membership of the Council and defines the arrangements for appointing (and where necessary, removing) Governors.

2.02 The Trust's regulatory and governance framework is supplemented by this Code of Conduct for Governors and the Role Description for Governors set out in Annex 8 of the Constitution, both of which reflect the statutory responsibilities for the Council. It should be noted that nothing within this Code of Conduct shall take precedence over or in any way amend the Constitution or any regulatory requirements.

**3.00 ROLE OF THE COUNCIL OF GOVERNORS**

3.01 The role of the Council is defined in law and in Monitor's reference guide for NHS foundation trust governors dated October 2009 and updated in August 2013, including the Constitution. Although the role is not repeated here it is important as context for this Code of Conduct to recognise that it is essential for the good governance of the Trust for the Council and the Board of Directors (the Board) to engage actively and constructively. Such an approach will ensure that the Council is able to contribute to the development of the Trust's strategy and plans, approve transactions where appropriate, hold the Non-Executive Directors to account (for the performance of the Board), and represent to the Board the views of members and the public. This approach will also ensure that the Board takes into account the views of the Council – for example, in relation to the Trust's strategy - and that it seeks the Council's timely approval for transactions and other proposals as defined in the Constitution.

**4.00 BOARD OF DIRECTORS/COUNCIL OF GOVERNORS ENGAGEMENT**

4.01 The Terms of Reference for the Board and for the Council (and relevant Role Descriptions) state that the Board and Council will engage actively and constructively, recognising the Board's responsibility for determining the Trust's strategy and for directing and controlling the organisation. The Terms of Reference and the Constitution commit to a jointly-agreed work-plan to set out for each financial year the way in which the Board and the Council will work together. This will ensure that the Board and the Council consider business in a co-ordinated way, ensuring that the Council has the opportunity to comment on or approve (as appropriate by reference to the Constitution) proposals at the correct time.

4.02 This Code of Conduct commits the Council as a whole and Governors individually to engaging proactively and constructively with the Board, acting through the Chair, the Senior Independent Director and any Lead Governor where appropriate according to their roles. The Council will work with the Board for the best interests

of the Trust as a whole, taking into account all relevant advice and information presented to or requested by the Council. The Council will not unduly delay responses to proposals from the Board, acting proactively to agree with the Board the information which the Council will need in order properly to consider proposals.

**5.00 CONDUCT OF GOVERNORS**

5.01 This section of the Code sets out the conduct which all Governors agree to abide by. These commitments are in addition to compliance with regulatory requirements, the Code of Governance, the Constitution, the Terms of Reference for the Council and the Role Description for Governors.

**Personal Conduct**

5.02 Governors agree that they will:

a) act in the best interests of patients and the Trust as a whole in the delivery of services within relevant financial and operational parameters;

b) be honest and act with integrity and probity at all times;

c) respect and treat with dignity and fairness, the public; patients; relatives; carers; NHS staff and partners in other agencies;

d) not seek to profit from their position as a Governor or in any way use their position to gain advantage for any person;

e) respect and value their fellow Governors as colleagues;

f) ensure that no person is discriminated against on grounds of religion or belief; ethnic origin; gender; marital status; age; disability; sexual orientation or socio-economic status;

g) show their commitment to team working by working constructively with their fellow Governors and the Board as well as with their colleagues in the NHS and the wider community;

h) accept responsibility for their actions and generally take seriously the responsibilities which are commensurate with the decision-making rights assigned to the Council through the legal and regulatory framework;

i) seek to ensure that the best interests of the public; patients; carers and staff are upheld in decision making and that those decisions are not influenced by gifts or inducements or any interests outside the Trust;

j) not make, permit or knowingly allow to be made any untrue, misleading or misrepresentative statement either relating to their own role or to the functions or business of the Trust;

k) at all times, uphold the values and core principles of the NHS and the Trust as set out in its Constitution;

l) conduct themselves in a manner which reflects positively on the Trust and not in any manner which could be regarded as bringing it into disrepute, whether they are on Trust property or fulfilling their public function in the wider community;

m) seek to ensure that the membership of the constituency from which they are elected is both properly informed and represented, or if they are appointed, then the body from which they are appointed is both properly informed and represented;

n) at all times, uphold the seven principles of public life as set out by the Committee on Standards in Public Life (also known as the Nolan Committee and the Wicks Committee) as below:

Selflessness: Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves; their family or friends or other interested parties.

Integrity: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity: In carrying out public business, including making public appointments; awarding contracts or recommending individuals for awards or benefits, holders of public office should make choices on merit.

Accountability: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness: Holders of public office should be as open as possible about all the decision and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership: Holders of public office shall promote and support these principles by leadership and example.

o) seek advice from the Chair or the Secretary on matters relating the Constitution, governance requirements or conduct, and have regard to the advice given to them.

**Confidentiality**

5.03 Governors will respect the confidentiality of the information to which they are made privy to as a result of their membership of the Council, except where information is made available in the public domain.

5.04 Governors will understand, endorse and promote the Trust's Information Governance and Security Policy in every aspect of their work.

5.05 Governors will make no public statements on behalf of the Trust or communicate in any way with the media without the prior consent of the Chair or a designated officer from the Trust's Communications department.

**Declaration of Interests**

5.06 It is essential for good corporate governance and to maintain public confidence in

the Trust that all decision making is robust and transparent. To support this, the Constitution and the Trust's Policy on Declaration of Interests set out requirements for Governors to declare relevant interests (as defined in the Constitution). Governors have a statutory responsibility to avoid interests which may conflict with the interests of the Trust.

5.07 Governors will declare interests on request from the Secretary or, as required by the Constitution, whenever they become aware of a potential conflict of interest in respect of a matter being considered by the Council. Governors should seek advice from the Secretary or the Chair where they are unsure as to whether an interest needs to be declared. Declared interests will be included in a Register of Interests, which will be published.

**6.00 PARTICIPATION IN MEETINGS AND IN TRAINING AND DEVELOPMENT**

6.01 The Council is required by the Constitution to hold meetings as required each year. The schedule for these meetings and for other activities will be proposed by the Secretary and is subject to approval by the Council. Governors will attend meetings of the Council, and of any committees or working groups to which they are appointed, or they will give apologies for absence where they are not able to attend.

6.02 The Trust has a statutory duty to support the Council to discharge its responsibilities, including through training and development for Governors. A programme of development and information seminars will be developed each year and it is expected that Governors will participate in such activities.

**7.00 UPHOLDING THIS CODE OF CONDUCT**

7.01 The Constitution provides that where there are concerns as to the conduct or performance of a Governor these are to be addressed in the first instance by the Chair, with support from the Secretary, to include training and development where is considered relevant and necessary. Where such concerns exist the Chair will write to the Governor concerned to set out the concerns and the action agreed to rectify or otherwise address them.

7.02 The Constitution provides for the circumstances in which a Governor can be removed from office, including where any Governor fails to comply with this Code of Conduct. It is for the Chair to propose removal from office if this is necessary after all other course of action, including training and development where relevant, have been exhausted. As required by the Constitution, it is for the Council to determine (in accordance with rules set out in the Constitution) whether any Governor should be removed from office following a proposal from the Chair.

**Process for investigating potential non-compliance with this Code**

7.03 The process outlined below is to provide a framework for reviewing any alleged non-compliance together with key principles to be followed. It should be noted that this process applies to all Governors irrespective of category (Public, Staff or Appointed).

7.04 Should a member of the Trust or a member of the Council of Governors be made aware that the behavior of a Governor is such that there may be a breach of the Code of Conduct they should inform the Chair or the Secretary as soon as possible. Upon receipt of such a notification the Chair will determine within 7 working days whether there is a prima facie case to address.

7.05 If the Chair in consultation with the Lead Governor believes there is a case, the Governor concerned will be notified and an initial investigation will be undertaken by a Governors' Compliance Committee which will be convened for the purpose

of investigating the complaint. The Governors Compliance Committee will consist of the Chair, 1 Staff Governor, I Public and 1 Appointed Governor (a total of 3 Governors). The Governors' Compliance Committee will not include any person who has already been involved in the complaint process.

7.06 An initial investigation will be conducted this will be undertaken by the Secretary or an appropriate member of their team. The initial investigation will seek to gather appropriate statements from the 'complainant' and/or witnesses. This should normally be completed within 15 working days.

7.07 Once information has been gathered the Governor concerned will be invited to meet with the Governors' Compliance Committee to respond to the issues. For personal support, on a non-professional basis, the Governor may choose at all times to be accompanied. The Committee should meet within 10 working days of the completion of the investigation.

7.08 The purpose of Governors' Compliance Committee meeting will be to establish whether there is sufficient information upon which a complaint could be upheld. At the conclusion of the meeting the Committee will decide if the matter should be referred to the Council and the Governors' Compliance Committee will make a recommendation to the Council in respect of the Governor. The recommendation to the Council of Governors will include the sanctions they deem appropriate. Such sanctions may range from the issuing of a written warning as to the Governor's future conduct and consequences, a requirement to undertake training, the suspension and/or removal of the Governor from office.

7.09 Following the Governors' Compliance Committee meeting the Governor under investigation will be formally written to within 5 working days setting out the recommendation prior to presentation to the Council.

7.10 The Council will in considering the most serious of sanctions (suspension or removal), require the approval of at least two-thirds of the total Council in order to implement. For all other sanctions a simple majority of those Governors in attendance will suffice.

7.11 Where there is any disagreement as to whether the proposal for removal of a Governor is justified, the Code of Governance, P34 para B.6.6 will apply. i.e. ", an independent assessor agreeable to both parties shall be requested to consider the evidence and determine whether the proposed removal is reasonable or otherwise."

7.12 All statements and reports to the Governors' Compliance Committee and the Council will be held by the Secretary's team.

**UHSUSSEX NHS FOUNDATION TRUST**

**ANNEX 10 - SCHEME OF RESERVATION**

| REF | **DECISIONS RESERVED TO THE BOARD** | |
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| 2.2.1 | COUNCIL OF GOVERNORS | The Council of Governors' statutory responsibilities are set out in the National Health Service Act 2006 and the Health and Social Care Act 2022.<br><br>Decide the remuneration and allowances, and the other terms and conditions of office, of the chair and non-executive directors;<br><br>Appoint and, if appropriate, remove the trust's external auditor; receive the trust's annual accounts, any report of the auditor on them and the annual report;<br><br>Approve, by a majority voting, "significant transactions" as defined within the trust constitution;<br><br>Approve, by a majority of all, an application by the trust to enter into a merger, acquisition, separation or dissolution;<br><br>Decide whether the trust's private patient work would significantly interfere with the trust's principle purpose, i.e. the provision of goods and services for the health service in England or the performance of its other services;<br><br>Approve, by a majority voting, any proposed increases in private patient income of 5% or more in any financial year; |
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| NA | THE BOARD | General Enabling Provision<br><br>The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers. |
| NA | THE BOARD | Regulations and Control<br><br>Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. |

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| | | Suspend Standing Orders.<br><br>Vary or amend the Standing Orders.<br><br>Approve a scheme of delegation of powers from the Board to committees, Officers or other bodies.<br><br>Ratify any urgent decisions taken by the Chair and Chief Executive in accordance with the SOs.<br><br>Approve and delegate authority from the Board to committees.<br><br>Require and receive the declaration of Board members' and Governors' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration.<br><br>Require and receive the declaration of Executive and Non-Executive Directors' interests that may conflict with those of the Trust. Approve arrangements for dealing with complaints.<br><br>Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. For clarity this would comprise details of the structure of the Board and its sub-committees and the Directorate structure of the Trust. Organisational structures below Executive and Clinical Director are the responsibility of the Chief Executive. Receive reports and/or minutes from committees including those that the Trust is required by regulation to establish and to take appropriate action on.<br><br>Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held by the trust.<br><br>Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.<br><br>Receive annual reports on the use of the Corporate Seal.<br><br>Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention.<br><br>Ensure compliance with the Code of Governance, the Risk Assessment Framework and the NHS Provider Licence.<br><br>Approve the "Going Concern" statement as part of the annual accounts approval process.<br><br>Non-Executive Directors shall appoint or remove the Chief Executive. |

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| | | The appointment of the Chief Executive shall require the approval of the Council of Governors.<br><br>Approve the incorporation of new subsidiaries, to include the terms of articles of association and standing financial instructions. |
| NA | THE BOARD | Executive: Appointments/Dismissal/Redundancy<br><br>Recommend the appointment of the Deputy Chair and the Senior Independent Director to the Council of Governors.<br><br>Appoint Chairs of Committees and dismiss committees (and individual members) that are directly accountable to the Board.<br>Confirm appointment of members of any committee of the Trust as representatives on outside bodies. |
| NA | THE BOARD | Strategy, Plans and Budgets<br><br>Define the strategic aims and objectives of the Trust.<br>Approve proposals for ensuring quality and developing governance in services provided by the Trust, having regard to any guidance issued by NHS England, the Care Quality Commission and the Secretary of State.<br><br>Approve the Trust's policies and procedures for the management of risk.<br><br>Approve Outline and Final Business Cases for Capital Investment in line with the investment policy and Standing Financial Instructions.<br><br>Approve the Trust's proposed organisational development proposals.<br><br>Ratify proposals for acquisition, disposal or change of use of land and/or buildings.<br><br>Approve PFI proposals.<br><br>Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to *over the defined limits within the SFIs and the investment policy*.<br><br>Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer (for losses and special payments) previously approved by the Board.<br><br>Approve individual compensation payments *above limits of delegation to Executive Directors.* |

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| | | Approve such business plans, budgets and capital programmes submitted by the Chief Executive on at least an annual basis, including the approval of Cost Improvement Programmes.<br><br>Approve business cases (requiring additional revenue resources) *above limits of delegation to Executive Directors*. |
| 8.1 | THE BOARD | **Executive Management Committee**<br><br>Overall responsibility for policy, procedural documents such responsibility to be delegated by a specific policy for developing and approval of policies and other procedural documents as appropriate, which shall be approved and monitored by the Policy Review Group.<br><br>The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.<br><br>The Committee shall be accountable to the Board of Directors of the Trust. The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board. The Committee shall refer to the Audit Committee, People & Culture Committee, Patient & Quality Committee, Finance & Performance Committee, any matters requiring review or decision-making in that forum. The Committee shall receive reports from all sub-groups, setting out any matters requiring escalation to the Finance & Performance Committee and provide assurance of effective standards and performance in their respective Departments. |
| 3.1. | THE BOARD | **Audit**<br><br>Review of the annual audit letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. |
| NA | THE BOARD | **Annual Reports and Accounts**<br><br>Receive and approve the Trust's Annual Report and Annual Accounts prior to the submission to NHS England and Parliament and presentation to the Council of Governors and, subsequently, members of the Trust.<br><br>Receive and approve the Annual Report and Accounts for funds held by the Trust's Charity. |
| NA | THE BOARD | **Monitoring of Committee Effectiveness** |

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| | | Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated or from Directors and Officers of the Trust.<br><br>Continuously appraise the affairs of the Trust by means of the provision of such reports to the Board as the Board may require from directors, committees, and officers of the Trust. All monitoring returns required by NHS England as outlined in the NHS Provider License shall be reported, at least in summary, to the Board.<br><br>Make such monitoring returns required by the Department of Health and/or NHS England (NHSE) and the Charity Commission where Board certification is required.<br><br>Receive reports from the Chief Finance Officer on financial performance against budget including how income contracts are performing. |
| 10.1 | APPOINTMENT AND REMUNERATION COMMITTEE | The Committee will:<br><br>A committee, consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint, discipline or remove the other Executive Directors.<br><br>Review regularly the remuneration and terms of service of the Chief Executive and other Executive Directors (and other Very Senior Officers) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements where appropriate;<br><br>Decide the appropriate remuneration of the Chief Executive and other Executive Directors. Any decisions made by the Nomination and Remuneration Committee shall be recorded in the minutes of the Nomination and Remuneration Committee meetings;<br><br>Monitor and evaluate the performance of individual Executive Directors;<br><br>Advise on and oversee appropriate contractual arrangements for such staff including scrutiny of termination payments taking account of such national guidance as is appropriate.<br><br>Approve senior staff redundancies. |
| 3.1 | AUDIT COMMITTEE | The Committee will:<br><br>Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control |

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| | | across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives, including approval of the Trust's policies and procedures for the management of risk, to gain assurance about the robustness of the system and controls.<br><br>Ensure the adequacy of the Risk Management Strategy in relation to the effective identification, assessment, mitigation and monitoring of risk within the Trust and ensure the implementation of the Strategy.<br><br>Review the adequacy of:<br><br>all statutory risk and control related disclosure statements (in particular the Annual Governance Statement, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board/governing body.<br><br>the underlying assurance processes (including the Board Assurance Framework and Corporate Risk Register) that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements; the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.<br><br>the policies and procedures for all work related to counter fraud, bribery and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority (NHSCFA).<br><br>Review the Annual Accounts~~,~~ Report, Financial Statements, and external audit opinion on the Financial Statements and Quality Account (if required) and make recommendations on the approval of the Annual Accounts and Annual Report to the Board.<br><br>Monitor and review the internal audit function to ensure that there is an effective internal audit function established by management that meets the mandatory NHS Internal Audit Standards, the Public Sector Internal Audit Standards, and provides appropriate independent assurance to the Audit Committee, to the Chief Executive as Accountable Officer, and to the Board of Directors.<br><br>Receive an annual report from the Internal Auditor and, where appropriate, make recommendations on actions to be taken to the Board.<br><br>Develop and implement a policy on the engagement of the External Auditor to supply non-audit services, taking into account relevant ethnical guidance regarding the provision of non-audit services by the External Audit firm.<br><br>Make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and approval of the terms of engagement of the external auditor<br>Review the work and findings of the External Auditor and consider the implications and management's responses to their work. The |

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| | | Committee shall also monitor and review the External Auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.<br><br>Review the work and findings of the Counter Fraud Service and consider the implications and management's responses to their work.<br><br>Review the findings of other significant assurance functions external to the organisation, and consider the implications to the integrated governance of the organisation.<br><br>Review the work of other committees and groups within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This includes the work of other Board Committees.<br><br>Review reports and positive and negative assurances from directors and managers on the overall arrangements for governance, risk management and internal control. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.<br><br>Ensure that the systems for financial reporting to the Board, including those of budgetary control, and formal announcements relating to the Trust's financial performance are subject to review as to completeness and accuracy of the information provided to the Board.<br><br>Review and approve write offs/losses and special payments in line with the limit set out in the Standing Financial Instructions.<br><br>Review the annual reports on the implementation of strategies for:<br>Health and Safety;<br>Data Security Protection Toolkit |
| 2.2. | PATIENT & QUALITY COMMITTEE | The Committee will:<br><br>Enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:<br>- promote safety and excellence in patient care<br>- identify, prioritise and manage risks within the Trust<br>- ensure the effective and efficient use of resources through evidence-based clinical practice<br>- protect the health and safety and wellbeing of Trust employees<br><br>Enable the Board to obtain assurance that the Trust has systems in place to ensure it is compliant with and delivers:<br>legal and statutory requirements<br>agreed clinical standards and quality objectives |

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| | | quality standards required by NHS England and the Care Quality Commission<br>Review the annual reports on the implementation of strategies for:<br>Safeguarding Adults and Children:<br>Infection Prevention Control<br>Complaints<br>Organ Donation<br>Mortality<br>Maternity & Perinatal care<br>Patient Experience and public involvement and patient-centred care.<br>Ensure effective arrangements are in place to assure high standards of clinical governance, including clinical effectiveness, management of clinical risk, practice standards and patient safety;<br>Ensure effective arrangements are in place to deliver Care Quality Commission registration, requirements and outcomes in response to any CQC inspections and reports;<br>Enable the Board to obtain assurance that the Trust has systems and procedures in plan to identify learning from deaths, Serious Incidents and other incidents, complaints, claims and ensuring they are shared across the Trust and implemented to improve patient safety, patient experience and colleague health and wellbeing;<br><br>Ensure the Trust has in place procedures to monitor and review the operational effectiveness of policies and procedures.<br><br>The Committee will:<br>Monitor the Trust's implementation of, and compliance with, current mental health legislation and proposed changes to such legislation, in particular the Mental Health Act 1983, within the Trust taking into account best practice;<br><br>Consider the implications of any changes to legislation and regulations within the policies, practices, procedures and resource requirements of the Trust and its partner organisations.<br>Monitor the processes relating to and outcomes of First Tier Tribunals (Mental Health) and of hearings held by the hospital managers' panels.<br><br>Ensure there is an appropriate number of Hospital Managers' panel members in place with the appropriate skills and experience to fulfil their role.<br><br>Monitor trends in compliance with and the application of the Mental Health Act 1983 (and any new Mental Health Acts or revisions to the existing Act) within the Trust and make recommendations where necessary.<br><br>Receive reports following Care Quality Commission Mental Health Act compliance visits for information and comment and ensure appropriate action is agreed and implemented within the organisation. |

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| | | To receive reports on the application of the Mental Capacity Act 2005 within the Trust and make recommendations where necessary.<br><br>Monitor delivery against the Trust's action plan developed as a result of the Care Quality Commission's Annual Report as instructed by Trust Board.<br>Approve policies in relation to the Mental Health Act and Mental Capacity Act across the Trust and scrutinise the application of these policies throughout the Trust in relation to both Acts.<br><br>Identify and address training issues in terms of delegation of responsibilities under the Mental Health Act 1983.<br><br>Identify and address quality issues in terms of delegation of responsibilities under the Mental Health Act 1983.<br><br>Manage risks identified and delegated by Trust Board and to identify and report to Trust Board any new risks that require escalation. |
| 10. | FINANCE & PERFORMANCE COMMITTEE | The Committee will:<br><br>Consider and keep under review the Trust's medium term financial sustainability plan, in relation to both revenue and capital and risk;<br><br>Review capital and revenue business cases above the Committee's authority limits as set out within the Trust's Standing Financial Instructions and Scheme of Delegation and make recommendation to the Board for approval.<br><br>Examine the key principles and assumptions for the Trust's business planning and budget setting processes.<br><br>Receive and monitor reports on financial performance including forecasts, cost improvement programmes and use of resources, noting any trends, exceptions and variances against plans on a Trust-wide and directorate basis and reviewing in detail any major performance variations.<br><br>Review and make submissions to NHS England as necessary on behalf of the Board.<br><br>Review major procurements and tenders.<br><br>Recommend to the Board approval of the Trust's annual operational plan, capital investment plan and revenue budgets.<br><br>Emergency Preparedness, Resilience and Response;<br><br>Keep under review key strategic, commercial contracts and seek assurance that appropriate due diligence is undertaken on any new contracts and/or renewals. |

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| | | Monitor performance of commercial activities as necessary and ensure that such activities deliver improved patient care and/or experience and that the Trust's principal purpose is not jeopardised by over-development of commercial activity.<br><br>Approve and review the Trust's treasury management and working capital policy as required;<br><br>Review and monitor the strategic five-year capital programme and the annual capital budgets and recommend actions or mitigations to the Trust Board.<br><br>Consider proposals for investment in the estate and technology to ensure alignment with Trust strategy.<br><br>Approve the National Cost Collection process. |
| 10. | PEOPLE & CULTURE COMMITTEE | Oversee the development and delivery of the People Strategy, and providing strategic direction to the Board in respect of the elements contained within it.<br><br>Identify and monitor key performance indicators relating to the delivery of the People Strategy, undertaking detailed review against these indicators and aspects of the People Strategy, as required, or as directed by the Board or another Committee of the Board.<br><br>Review arrangements by which staff may raise in confidence, concerns about possible improprieties of financial reporting and control, clinical quality, patient safety or other matters through the Staff Surveys, Freedom to Speak Up Guardian or Guardian of Safeworking Hours.<br><br>Review and implement strategies for:<br>Organisational Development;<br>Health & Wellbeing programmes<br>Annual Workforce Planning,<br>Equality and Diversity;<br>Employee Relations<br>Ensure that effective arrangements are in place to secure the availability of a competent and appropriately qualified workforce to deliver healthcare for the Trust. (including Medical Revalidation and Appraisal; Safer Staffing; Medical Education Exception reporting and GMC reporting.) |
| 10. | CHARITABLE FUNDS COMMITTEE | Ensure Funds Held on Trust (charitable funds) are managed in accordance with the Trust's SOs and SFIs, as approved by the Board.<br><br>Receive regular reports from the Chief Finance Officer covering: |

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| | | Number and value of funds<br>Purpose of funds<br>Income and expenditure analysis<br><br>Decide upon expenditure criteria.<br><br>Ensure that the requirements of the Charities Acts and the Charities Commission are met.<br><br>Provide reports to the Board of Directors (acting as the Corporate Trustee) as appropriate.<br><br>Review the Annual Accounts prior to submission to the Corporate Trustee for formal approval. |
| **SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM** | | |
| REF | **DELEGATED TO** | **DUTIES DELEGATED** |
| 2.2.10 | CHIEF FINANCIAL OFFICER | Duty to prepare the accounts in accordance with the NHS Act 2006. Duty to personally sign the accounts. Witness before the Committee of Public Accounts to deal with questions arising from the accounts or from any report made to Parliament by the Comptroller and Auditor General under the National Audit Act 1983. |
| 2.2 | CHIEF EXECUTIVE | Responsible to Parliament for resources under his control. |
| | CHIEF EXECUTIVE | Responsible for overall organisation, management and staffing of the Foundation Trust and for its procedures in financial and other matters. Ensure that:<br>a) there is a high standard of financial management in the Foundation Trust as a whole;<br>b) financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the Foundation Trust; and<br>c) financial considerations are fully taken into account in decisions on Foundation Trust policy proposals. |
| | CHIEF FINANCIAL OFFICER | Personal responsibility for:<br>the propriety and regularity of the public finances for which the Chief Executive is answerable;<br>the keeping of proper accounts;<br>prudent and economical administration in line with the principles set out in "*managing public money".*<br>avoidance of waste and extravagance;<br>the efficient and effective use of all the resources in their charge. |
| | CHIEF EXECUTIVE | Required to:<br><br>a) personally sign the accounts and accept personal responsibility for their proper form and content as prescribed by NHS |

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| | | England in accordance with the Act;<br>b) comply with the financial requirements of the NHS Provider Licence;<br>c) ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts;<br>d) ensure that the resources for which he is responsible are properly well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official;<br>e) ensure that assets for which he is responsible are controlled and safeguarded with similar care, and with checks as appropriate;<br>f) ensure that protected property (or interest in) is not disposed of without the consent of NHS England;<br>g) ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, the Council of Governors or the actions of advice of Foundation Trust staff; and<br>h) ensure that, in the consideration of policy proposals relating to the expenditure for which he is responsible, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account and brought to the attention of the Board of Directors. |
| | CHIEF EXECUTIVE | Ensure that effective management systems appropriate for the achievement of the Foundation Trust's objectives, including financial monitoring and control systems, have been put in place. Ensure that managers at all levels:<br>a) have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives;<br>b) are assigned well-defined responsibilities for making the best use of resources, including a clinical scrutiny of output and value for money; and<br>c) have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively. |
| | CHIEF EXECUTIVE | Ensure that their arrangements for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills. |
| | CHIEF EXECUTIVE | Responsibility to see that appropriate advice is tendered to the Board of Directors and the Council of Governors on all matters of financial propriety and regulation, and more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. Determine how and on what terms such advice should be tendered, and whether in a particular case to make reference to their own duty, as Accounting Officer, to justify to the Public Accounts Committee, transactions for which they are accountable. |
| | BOARD | Act in accordance with the requirements of propriety or regularity; including the Fit and Proper Persons Test requirements. |
| | CHIEF EXECUTIVE | Make written objections to proposals by the Board of Directors, Council of Governors or Chair which he considers to infringe the requirement to act with the requirements of propriety or regularity. If the Board of Directors, Council of Governors or Chair decides to proceed, seek a written instruction to take the action in question, and inform Monitor of the position (if possible, before the decision is implemented) |
| | CHIEF EXECUTIVE | If a course of action is contemplated which raises an issue relating to his wider responsibilities for economy, efficiency and effectiveness, draw the relevant factors to the attention of the Board of Directors or Council of Governors and advise them in |

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| | | whatever way he deems appropriate. If his decision is overruled, and the proposal is one which he would not feel able to defend to the Public Accounts Committee as representing value for money, seek a written instruction before proceeding. Inform NHS England of such an instruction, if possible, before the decision is implemented. If there is no time to submit advice in writing due to extreme urgency, ensure that if the advice is overruled, both the advice and the instructions are recorded in writing immediately afterwards. |
| | CHIEF EXECUTIVE | Appear before the Public Account Committee from time to time to give evidence on the reports arising from examinations undertaken by the Comptroller and Auditor General, and answer questions concerning expenditure and receipts for which he is Accounting Officer. |
| | CHIEF EXECUTIVE | Furnish the Public Accounts Committee with explanations of any weaknesses in the matters covered in paragraphs 8-15 of the NHS Foundation Trust Accounting Officer Memorandum, to which his attention has been drawn by the Comptroller and Auditor General or about which they may wish to question to Accounting Officer. |
| | CHIEF EXECUTIVE | Ensure that he is adequately and accurately briefed on matters which are likely to arise at any hearing of the Public Accounts Committee. |
| | CHIEF EXECUTIVE | Ensure that he is generally available for consultation, and that in any temporary period of unavailability, there will be a senior officer in the Foundation Trust who can act on his behalf if required. |
| | BOARD | Where it becomes clear that the Accounting Officer is so incapacitated that he or she will be unable to discharge his responsibilities over a period of four weeks or more, appoint an acting Accounting Officer (usually the Finance Director), until his return. |
| | ACTING ACCOUNTING OFFICER | Sign accounts where the Accounting Officer is unable to sign in time for printing. |
| **DECISIONS RESERVED TO THE BOARD** | | |
| | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
| | CHAIR | Final authority in interpretation of Standing Orders (SOs). |
| | CHAIR | Recommend the appointment of the Deputy Chair and the Senior Independent Director to the Council of Governors. |
| | COUNCIL OF GOVERNORS | To appoint the Chair and Non-Executive Directors at a general meeting of the Council of Governors.<br><br>To decide the period of office, remuneration and allowances, and other terms and conditions of office of the Chair and other Non-Executive Directors. |
| | CHAIR | Call meetings of the Board. |
| | CHAIR | Chair all Board meetings and associated responsibilities. |
| | CHAIR | Give final ruling in questions of order, relevancy and regularity of meetings. |
| | CHAIR | Having a casting vote in the event of a tie. |
| | BOARD | Suspension of Standing Orders |
| | AUDIT COMMITTEE | Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board) |
| | BOARD | Variation or amendment of Standing Orders |

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| | BOARD | Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference (terms of reference of sub committees may be approved by the Chief Executive.) |
| | CHAIR & CHIEF EXECUTIVE | The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members. |
| | CHIEF EXECUTIVE | The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion. |
| | ALL | Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible. |
| | BOARD | Declare relevant and material interests. |
| | CHIEF EXECUTIVE OR SECRETARY TO THE TRUST | Maintain Register(s) of Interests. |
| | ALL STAFF | Comply with national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff”.<br>Comply with Trust’s Ethical Standards Policy.<br>Comply with Nolan principles.<br>Fit and Proper Person requirements. (as required) |
| | ALL | Disclose relationship between self and candidate for staff appointment. (Chief Executive to report the disclosure to the Board.) |
| | CHIEF EXECUTIVE | Tendering and contract procedure. |
| | CHIEF EXECUTIVE | Waive formal tendering procedures. |
| | CHIEF EXECUTIVE | Report waivers of tendering procedures to the Audit Committee. |
| | CHIEF FINANCE OFFICER | Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE. |
| | CHIEF EXECUTIVE AND CHIEF FINANCE OFFICER | Where one tender is received will assess for value for money and fair price. |
| | CHIEF EXECUTIVE | No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive. |
| | CHIEF EXECUTIVE OR CHIEF FINANCE OFFICER | No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive. |
| | CHIEF EXECUTIVE | The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector. |
| | BOARD | All PFI proposals must be agreed by the Board. |
| | CHIEF EXECUTIVE | The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust. |
| | CHIEF EXECUTIVE | The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. |
| | CHIEF EXECUTIVE | The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in- |

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| | | house basis. |
| | CHIEF EXECUTIVE | Must ensure the Trust enters into contracts with service commissioners for the provision of NHS services. |
| | CHIEF EXECUTIVE | Approve the legally binding contract with the Integrated Care Board or successor body. |
| | CHIEF EXECUTIVE | Keep seal in safe place and maintain a register of sealing. |
| | CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR | Approve and sign all documents that will be necessary in legal proceedings. |
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| **SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS (SFIs)** | | |
| | DELEGATED TO | AUTHORITIES/DUTIES DELEGATED |
| | CHIEF FINANCE OFFICER | Approval of all financial procedures. |
| | CHIEF FINANCE OFFICER | Advice on interpretation or application of Standing Financial Instructions. |
| | ALL MEMBERS OF THE BOARD AND EMPLOYEES | Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible. |
| | CHIEF EXECUTIVE | Responsible as the Accounting Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control. |
| | CHIEF EXECUTIVE & CHIEF FINANCE OFFICER | Accountable for financial control but will, as far as possible, delegate their detailed responsibilities. |
| | CHIEF EXECUTIVE | To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions and that they understand the responsibilities. |
| | CHIEF FINANCE OFFICER | Responsible for:<br>implementing the Trust's financial policies and coordinating corrective action;<br>maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented;<br>ensuring that sufficient records are maintained to explain Trust's transactions and financial position;<br>providing financial advice to members of Board and staff;<br>maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties. |
| | ALL MEMBERS OF THE BOARD AND EMPLOYEES | Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures. |

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| | CHIEF EXECUTIVE | Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply. |
| | AUDIT COMMITTEE | Provide independent and objective view on internal control and probity. |
| | CHAIR OF AUDIT COMMITTEE | Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts. |
| | CHIEF FINANCE OFFICER | Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.) |
| | CHIEF FINANCE OFFICER | Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption. |
| | HEAD OF INTERNAL AUDIT | Review, appraise and report in accordance with NHS Internal Audit Manual and best practice. |
| | AUDIT COMMITTEE | Ensure cost-effective External Audit. |
| | CHIEF EXECUTIVE & CHIEF FINANCE OFFICER | Monitor and ensure compliance with the NHS Standard Contract, Service Condition 24 on fraud and corruption including the appointment of the Local Counter Fraud Specialist. |
| | CHIEF EXECUTIVE | Ensure the safety and security of officers, patients and visitors of the Trust, as part of the Trust's role as an employer and healthcare provider; safeguard Trust's premises and keep them secure. This includes the appointment of the Local Security Management Specialist. |
| | CHIEF EXECUTIVE | Compile and submit to the Board an Annual Plan. The content of the Annual Plan to comply with the NHS England Planning Guidance. |
| | CHIEF FINANCE OFFICER | Submit budgets to the Board for approval.<br>Monitor performance against budget; submit to the Board financial estimates and forecasts. |
| | CHIEF FINANCE OFFICER | Ensure adequate training is delivered on an ongoing basis to budget holders. |
| | CHIEF EXECUTIVE | Delegate budgets to budget holders. |
| | CHIEF EXECUTIVE & BUDGET HOLDERS | Must not exceed the budgetary total or virement limits set by the Board. |
| | CHIEF FINANCE OFFICER | Devise and maintain systems of budgetary control. |
| | BUDGET HOLDERS | Ensure that<br>a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board;<br>b) approved budget is not used for any other than specified purpose subject to rules of virement;<br>c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment |
| | CHIEF EXECUTIVE | Identify and implement cost improvements and income generation activities in line with the Integrated Business Plan, the three year |

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| | | financial plan and the Annual Plan for NHS England. |
| | CHIEF EXECUTIVE | Submit monitoring returns to requisite monitoring organisations. |
| | CHIEF FINANCE OFFICER | Preparation of annual accounts and reports ensuring that a copy of the annual accounts and any reports of the external auditor are laid before Parliament and then sent to NHS England and that the annual report is presented to the Council of Governors.<br>Prepare a report for approval by the Board on "Going Concern". |
| | CHIEF FINANCE OFFICER | Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. |
| | CHIEF FINANCE OFFICER | Develop and maintain income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash. |
| | ALL EMPLOYEES | Duty to inform Chief Finance Officer of money due from transactions which they initiate/deal with. |
| | BOARD | Establish an Appointment and Remuneration Committee, in accordance with the constitution. |
| | NOMINATION AND REMUNERATION COMMITTEE | The Committee will:<br>decide the appropriate remuneration and terms of office for the Chief Executive and other Executive Directors (and Very Senior Officers) including all aspects of salary; provision for other benefits including pensions and cars and arrangements for termination of employment and other contractual terms and to advise the Board of Directors of any decisions made.<br>regularly review, discuss and if necessary approve changes to the remuneration and terms of service of the Chief Executive and other Executive Directors (and other Very Senior Officers) to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements where appropriate and to advise the Board of Directors of any decisions made.<br>monitor and evaluate the performance of individual senior employees, including Executive Directors.<br>advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments. |
| | EXECUTIVE TEAM | Approval of variation to funded establishment of any directorate. |
| | CHIEF EXECUTIVE | Staff, including agency staff, appointments and re-grading. |
| | CHIEF FINANCE OFFICER | Payroll:<br>specifying timetables for submission of properly authorised time records and other notifications;<br>final determination of pay and allowances;<br>making payments on agreed dates;<br>agreeing method of payment;<br>issuing instructions |
| | NOMINATED MANAGERS* | Submit time records in line with timetable.<br>Complete time records and other notifications in required form.<br>Submit termination forms in prescribed form and on time. |
| | CHIEF FINANCE | Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal |

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| | OFFICER | controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies. |
| | CHIEF PEOPLE OFFICER | Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and<br>Deal with variations to, or termination of, contracts of employment. |
| | CHIEF EXECUTIVE | Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. |
| | CHIEF EXECUTIVE | Set out procedures on the seeking of professional advice regarding the supply of goods and services. |
| | REQUISITIONER* | In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. |
| | CHIEF FINANCE OFFICER | Shall be responsible for the prompt payment of accounts and claims. |
| | CHIEF FINANCE OFFICER | advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;<br>prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds;<br>be responsible for the prompt payment of all properly authorised accounts and claims;<br>be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable;<br>a timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;<br>instructions to employees regarding the handling and payment of accounts within the Finance Department;<br>be responsible for ensuring that payment for goods and services is only made once the goods and services are received |
| | APPROPRIATE EXECUTIVE DIRECTOR | Make a written case to support the need for a prepayment. |
| | CHIEF FINANCE OFFICER | Approve proposed prepayment arrangements. |
| | BUDGET HOLDER | Ensure that all items due under a prepayment contract are received (and immediately inform CFO if problems are encountered). |
| | CHIEF EXECUTIVE | Authorise who may use and be issued with official orders. |
| | MANAGERS AND OFFICERS | Ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer. |
| | CHIEF EXECUTIVE CHIEF FINANCE | Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE or other relevant guidance. The technical audit of these |

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| | OFFICER | contracts shall be the responsibility of the relevant Director. |
| | CHIEF FINANCE OFFICER | Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act. |
| | CHIEF FINANCE OFFICER | The CFO will advise the Board on the Trust's ability to pay dividend on Public Dividend Capital (PDC) and report, periodically, concerning the PDC debt and all loans and overdrafts. |
| | BOARD | Approve a list of employees authorised to make short-term borrowings on behalf of the Trust. (This must include the Chief Executive and Chief Finance Officer .) |
| | CHIEF FINANCE OFFICER | Prepare detailed procedural instructions concerning applications for loans and overdrafts. |
| | CHIEF EXECUTIVE OR CHIEF FINANCE OFFICER | Be on an authorising panel comprising one other member for short term borrowing approval. |
| | CHIEF FINANCE OFFICER | Will advise the Board on investments and report, periodically, on performance of same. |
| | CHIEF EXECUTIVE | Capital investment programme:<br>ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans<br>responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost;<br>ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences;<br>ensure that a business case is produced and presented to the Finance Committee. |
| | CHIEF FINANCE OFFICER | Certify professionally the costs and revenue consequences detailed in the business case for capital investment. |
| | CHIEF EXECUTIVE | Issue procedures for management of contracts involving stage payments. |
| | CHIEF FINANCE OFFICER | Assess the requirement for the operation of the construction industry taxation deduction scheme. |
| | CHIEF FINANCE OFFICER | Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure. |
| | CHIEF EXECUTIVE | Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender.<br>Issue a scheme of delegation for capital investment management. |
| | CHIEF FINANCE OFFICER | Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes. |
| | CHIEF FINANCE OFFICER | Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector. |
| | BOARD | Proposal to use PFI must be specifically agreed by the Board. |
| | CHIEF FINANCE | Maintenance of asset registers. |

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| | CHIEF FINANCE OFFICER | Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers. |
| | CHIEF FINANCE OFFICER | Calculate capital charges in accordance with International Financial Reporting Standards and accepted accounting policies. |
| | CHIEF EXECUTIVE | Overall responsibility for fixed assets. |
| | CHIEF FINANCE OFFICER | Approval of fixed asset control procedures. |
| | BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF | Responsibility for security of Trust assets including notifying discrepancies to CFO, and reporting losses in accordance with Trust procedure. |
| | CHIEF EXECUTIVE | Delegate overall responsibility for control of stores (subject to CFO responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.) |
| | CHIEF FINANCE OFFICER | Responsibility for systems of control over stores and receipt of goods. |
| | DESIGNATED PHARMACEUTICAL OFFICER | Responsibility for controls of pharmaceutical stocks |
| | DESIGNATED ESTATES OFFICER | Responsibility for control of stocks of fuel oil and coal. |
| | NOMINATED OFFICERS* | Security arrangements and custody of keys |
| | CHIEF FINANCE OFFICER | Set out procedures and systems to regulate the stores. |
| | CHIEF FINANCE OFFICER | Agree stocktaking arrangements. |
| | CHIEF FINANCE OFFICER | Approve alternative arrangements where a complete system of stores control is not justified. |
| | CHIEF FINANCE OFFICER | Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items. |
| | NOMINATED OFFICERS* | Operate system for slow moving and obsolete stock, and report to CFO evidence of significant overstocking. |
| | CHIEF EXECUTIVE | Identify persons authorised to requisition and accept goods from NHS Supply Chain (NHS Shared Business Agency) stores. |
| | CHIEF FINANCE OFFICER | Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers. |

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| | CHIEF FINANCE OFFICER | Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft. |
| | ALL STAFF | Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and CFO. |
| | BOARD | Approve write off of losses above the level delegated to nominated Executive Directors or other senior officers contained in the Financial Limits. |
| | CHIEF FINANCE OFFICER | Consider whether any insurance claim can be made. |
| | CHIEF FINANCE OFFICER | Maintain losses and special payments register. |
| | CHIEF FINANCE OFFICER | Responsibility for accuracy and security of computerised financial data. |
| | CHIEF FINANCE OFFICER | Satisfy himself/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation. |
| | DIRECTOR OF CORPORATE SERVICES | Shall publish and maintain a Freedom of Information Scheme. |
| | RELEVANT OFFICERS | Send proposals for general computer systems to CFO. |
| | DIRECTOR OF STRATEGY AND DIGITAL DEVELOPMENT | Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review.<br>Seek periodic assurances from the provider that adequate controls are in operation. |
| | DIRECTOR OF STRATEGY AND DIGITAL DEVELOPMENT | Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place. |
| | DIRECTOR OF STRATEGY AND DIGITAL DEVELOPMENT | Where computer systems have an impact on corporate financial systems satisfy himself that:<br>systems acquisition, development and maintenance are in line with corporate policies;<br>data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists;<br>the Director of Strategy and Digital Development and staff have access to such data;<br>Such computer audit reviews are being carried out as are considered necessary. |
| | CHIEF EXECUTIVE | Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission. |
| | CHIEF FINANCE OFFICER | Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff |

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| | | whose duty is to administer, in any way, the property of. |
| | MANAGERS | Inform staff of their responsibilities and duties for the administration of the property of patients. |
| | CHIEF FINANCE OFFICER | Shall ensure that each trust fund that the Trust is responsible for managing is managed appropriately. |
| | CHIEF FINANCE OFFICER | Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff. |
| | CHIEF EXECUTIVE | Retention of documents procedures in accordance with Records Management: NHS Code of Practice part 1 and part 2 (2006). |
| | CHIEF EXECUTIVE | Risk management programme. |
| | AUDIT COMMITTEE | Approve and monitor risk management programme. |
| | BOARD | Decide whether the Trust Board decides to use the risk pooling schemes administered by NHS Resolution if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board of Directors decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually. |
| | BOARD OF DIRECTORS | Where the Board decides not to use the risk pooling schemes administered by NHS Resilience for any one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed. |
| | CHIEF FINANCE OFFICER | Ensure documented procedures cover management of claims and payments below the deductible. |
| **DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES** | | **DECISIONS DELEGATED BY THE BOARD TO COMMITTEES** |
| | Audit Committee | Appointment of the Trust's Internal Auditors<br>Appointment of the Trust's local counter fraud service<br>Approve the Trust's accounting polices<br>To agreed writes offs |
| | Appointment and Remuneration Committee | Agree the renumeration of the Executive team<br>To agree the annual Fit and Proper Persons Return |
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| | Patient & Quality Committee | To receive the required Maternity Performance and Oversight Reports |
| | Finance & Performance Committee | To approve investments within their delegated limits |

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| | People & Culture Committee | To approve the Freedom to Speak up Guardian |
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The Overview of Financial Limits is attached for reference purposes.