University Hospitals Sussex NHS Foundation Trust

Meeting of the Board of Directors

10:00 to 13:30 on Thursday 12 November 2026

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

AGENDA – MEETING IN PUBLIC

Item:1	Time: 10:00	**Welcome and Apologies for Absence** *Apologies: Bindesh Shah, Sarah-Jane Taylor*	*To note*	Verbal	Presenter: Philippa Slinger
		Confirmation of Quoracy *A meeting of the Board shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that at least half of the Board must be present this being eight Board members. With a minimum of two Executives and two Non-Executive Directors.*	*To agree*	Verbal	Presenter: Philippa Slinger
Item:2	10:00	**Declarations of Interests**	*To determine if any action is required*	Verbal	Presenter: All
Item:3	10:00	**Minutes of UHSussex Board Meeting held on 17 September 2026**	*To approve*	Enclosure	Presenter: Philippa Slinger
Item:4	10:05	**Matters Arising from the Minutes**	*To note*	Enclosure	Presenter: Philippa Slinger
Item:5	10:10	**Questions from the public** To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting.	*To respond*	Verbal	Presenter: Philippa Slinger
Item:6	10:20	**Service Presentation: Mortuaries**	*To receive*	Presentation on the day	Presenter: Paul Hartfield
Item:7 Item7.1	10:40	**Perinatal Service Update** ***Maternity Assurance report***	*To receive*	Enclosures	Presenter: Oliver White Emma Chambers Sophia Stone
Item:8	11:00	**Report from Chief Executive**	*To receive and note overview of the Trust's activities*	Enclosure	Presenter: Dr. Andy Heeps
Item:9	11:20	**Thirlwall Inquiry – self assessment**	*To receive*	Enclosure	Presenters Katie Urch Gail Byrne

		STRATEGY and CULTURE			
Item:10	11:35	**Strategy Delivery Improvement Plan**	*To receive and agree future Committee oversight arrangements*	Enclosure	Presenter: Rox Smith Joe Mills
	11:50	***5 Minute Break***			
		ASSURANCE REPORTS FROM COMMITTEES (*taken for information and assurance with escalation only being discussed*)			
		Escalated Items Only:			
Item:11	12.00	**Report from the Research Innovation & Digital Assurance Committee from the meeting held on the 4 November 2026** To note assurance and action recommendations from the Committee	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Prof. Jackie Cassell
Item:12	12.10	**Report from Patient & Quality Assurance Committee 15 September, 3 November 2026** To note assurance and action recommendations from the Committee	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Lucy Bloem
Item:13	12.20	**Report from People & Culture Assurance Committee from the meetings held on the 3 November 2026** To note assurance and action recommendations from the Committee	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Prof. Paul Layzell
Item:14	12:30	**Report from Finance & Performance Assurance Committee from the meetings held on the 8 October, 5 November 2026** To note assurance and action recommendations from the Committee	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Philip Hogan
Item:15	12:40	**Report from Strategy & Major Projects Assurance Committee from the meetings held on the 5 November** To note assurance and action recommendations from the Committee	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Prof. Paul Layzell
Item:16	12:50	**Report from Audit Committee from the meeting held on the 27 October 2026** To note assurance and action recommendations from the Committee	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Mike Driver
		PERFORMANCE & RISK			

Item:17	13.00	**Integrated Performance Report**	*To triangulate with Committee reports and agree actions*	Enclosure	Presenter: Dr. Andy Heeps
Item:18	13:10	**Board Assurance Framework**	*To approve*	Enclosure	Presenter: Glen Palethorpe
		OTHER			
Item:19	13.20	**Any Other Business** To receive any notified urgent business and action	*To receive any notified urgent business and action*	Verbal	Presenter: Philippa Slinger
Item:20	13.20	**Date and time of next meeting:** The next meeting in public of the Board of Directors is scheduled to take place at **10.00** on **Thursday 10 December 2026.** **To resolve to move to into private session** *The Board now needs to move to a private session due to the confidential nature of the business to be transacted*		Verbal	Presenter: Philippa Slinger

Supporting Appendices:

Item 7	**Maternity** Perinatal Quality Oversight Model Report NHSE 10-point Plan	*To receive and note*
Item 12	**Patient & Quality Assurance Committee:** Mortality and Learning from Deaths Q2	*To receive and note*
Item 13	**People & Culture Assurance Committee** Nursing Safer Staffing 6-month report	*To receive and agree*

Minutes

University Hospitals Sussex NHS Foundation Trust

Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 17 September 2026, held in the Washington Suite Boardroom, Worthing Hospital, Lyndhurst Road, Worthing and via Microsoft Townhall Live Broadcast.

Present:

Philippa Slinger	Chair
Professor Paul Layzell CBE	Deputy Chair / Non-Executive Director
Andy Hobart	Non-Executive Director
Bindesh Shah	Non-Executive Director (absent between items 12 – 15)
Professor Gordon Ferns	Non-Executive Director
Professor Jackie Cassell	Non-Executive Director
Jin Sahota	Non-Executive Director
Mike Driver	Non-Executive Director
Philip Hogan CB	Non-Executive Director
Dr Andy Heeps	Chief Executive
Alex Shaw	Chief Delivery Officer
Professor Catherine “Katie” Urch	Chief Medical Officer
Gail Byrne	Interim Chief Nurse
Jonathan Reid	Chief Financial Officer
Roxanne Smith	Chief Strategy Officer
Sarah-Jane Taylor	Chief People Officer

In Attendance:

James Watts	Managing Director Medicine
Maria Emmanuel	Managing Director Cancer & Specialist
Oliver White	Managing Director Women, Children & Clinical Support
Wilson Dodzo	Managing Director Medicine
Tori Cooper	Deputy Chief Nursing Officer (until Item 7)
Rebecca Goldsmith	Divisional Quality and Safety Manager, Surgery Division (until Item 7)
Emma Chambers	Director of Midwifery
Sophia Stone	Clinical Director – Perinatal and Neonatal
Glen Palethorpe	Company Secretary
Tamsin James	Board and Committees Manager (minutes)
Catherine Bridger	Board and Committees Manager (production support)

TB/09/26/1 WELCOME AND APOLOGIES FOR ABSENCE **ACTION**

1.2 The Chair noted apologies for absence were received from Lucy Bloem, Helen Brown, and Maggie Davies.

TB/09/26/2 DECLARATIONS OF INTERESTS

2.1 There were no interests declared.

TB/09/26/3 MINUTES OF THE MEETING HELD ON 11 JUNE 2026

3.1 The Board received the minutes of the meeting held on 11 June 2026.

3.2 The Board **APPROVED** the minutes of the meeting held on 11 June 2026.

TB/09/26/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

4.1 Bindesh Shah queried references recorded in the previous minutes that highlighted a follow-up presentation from the Wellbeing Team; and evaluation of the

effectiveness of violence and aggression initiatives beyond incident reduction metrics. Both Sarah-Jane Taylor and Paul Layzell reported that violence and aggression was routinely reviewed through the People & Culture Assurance Committee and had been the subject of a recent comprehensive report. It was also shared that the wellbeing team follow up presentation was part of the Board planner and was due to return early in the new year.

TB/09/26/5 QUESTIONS FROM THE PUBLIC

5.1 The Chair noted that 12 questions had been received from members of the public. In respect of Mr Gooderham's nine questions, it had been advised that, although all questions had been carefully considered and responses prepared, only one question from each of those asking a 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 would be made available on the UHSussex Trust website here: https://www.uhsussex.nhs.uk/about/board/board-meetings/

5.2 The one question from Mr Gooderham that was taken, asked whether consideration had been given to demerging the Trust into separate organisations. The Chair explained that the matter had been considered through development of the Trust's strategy and the consultation process that had taken place through its development. As an outcome, the Board had determined that remaining as a single integrated organisation, as One UHSussex, best supported service transformation, economies of scale, quality improvement and operational efficiency.

5.3 Anita McKenzie's question was raised in the meeting. Professor Katie Urch thanked Anita for their feedback and apologised that the experience was not as we would have wanted. Katie explained that the Trust introduced AVA (Automated Virtual Assistant) to assist with the challenges with dropped, unanswered calls. As the system had been established, there was now an average call answer time of 3 minutes, an improvement from the previous average of 30 minutes resulting in a reduced call abandonment rate from over 30% to less than 10%. The caller also has an opportunity to speak to a person, noting though that there was limited individuals available for this so could result in a caller queue.

5.4 In respect of the Palantir question raised, Jonathan Reid as the Trust's Senior Responsible Owner explained that the Trust recognised that some patients, staff and community groups have concerns about the Federated Data Platform and the national supplier., The Federated Data Platform is a national NHS programme, with trusts expected to implement it by 2028/29, and the Trust's focus was on using data safely and effectively to improve patient care.

TB/09/26/6 PATIENT STORY

6.1 The Board welcomed Tori Cooper, Deputy Chief Nursing Officer, and Rebecca Goldsmith, Divisional Quality and Safety Manager, Surgery Division. It was noted that the patient, Matt, had been unable to attend the meeting for personal reasons but had requested that his experience be shared within the meeting and used as a learning opportunity for the Trust.

6.2 The Board heard that the patient story arose from a Patient Safety Incident Response Framework (PSIRF) learning review whereby the case involving a patient named Matt. Matt's story highlighted the importance of recognising individual vulnerabilities that may not be immediately visible and understanding how chronic mental health conditions, substance misuse and emotional distress could influence a patient's presentation affecting assessment, decision making and outcomes. Tori shared that Matt wished the Board to focus on three key messages: recognising unseen vulnerabilities, balancing compassionate care with the need to protect staff

from violence and aggression, and developing personalised approaches to care through greater understanding of individual triggers and needs.

6.3 Rebecca Goldsmith summarised Matt's clinical journey. Matt had initially attended the Emergency Department in December 2024 whilst intoxicated and in distress, which had led to altercations with staff and security personnel, and resulted in him being asked to leave the department without receiving treatment for the condition that had led him to attend. Following further attendances, Matt was treated for an elbow dislocation surgically, which led to subsequent repeated attendances with pain, neurological symptoms and loss of motor function which culminated in the discovery of an ulnar nerve injury that had been sustained during surgery. This resulted in a Datix incident being raised and investigated through the PSIRF process after clinical governance reviews identified that the patient had come to harm whilst under the care of the Trust.

6.4 The Board heard that the learning review identified missed opportunities in Matt's assessment and diagnosis during multiple Emergency Department and Trauma & Orthopaedic presentations resulting in a delay in diagnosis of the nerve injury, with significant long-term consequences as Matt was no longer able to continue in his chosen profession because of the injury. Tori shared that Matt had openly discussed his mental health diagnosis, alcohol dependency and his awareness of how his physical stature and behaviour may have influenced how he was perceived by staff which may have contributed to diagnostic opportunities being missed and how those assumptions may have influenced the quality of clinical assessment.

6.5 The Chair reflected on whether unconscious bias may have influenced decision making of the patient's care and sought assurance on how the organisation was addressing this issue. Tori advised that work was underway with mental health and security colleagues to enhance training and education around hidden vulnerabilities, unconscious bias and patient centred approaches, and explained that the patient experience and voice was being more actively incorporated into service redesign and pathway development.

6.6 Paul Layzell queried what learning had arisen from the patient's repeated attendances and whether this should have prompted greater consideration of underlying issues. It was acknowledged that there had been missed opportunities to explore the reasons for the patient's behaviour at an earlier stage, and that future work would focus on encouraging staff to approach each attendance with a fresh perspective, supported by personalised care planning and "This is Me" style documentation to identify triggers and support needs.

6.7 Andy Heeps outlined the improvements to the clinical learning arising from the incident and the changes implemented following the review, along with strengthening of assessment training for Trauma and Orthopaedic junior doctors. Tori added that clinical governance processes and daily safety huddles were being used to reinforce escalation requirements where clinical concerns remained unresolved. Andy Heeps then highlighted the wider system implications of the case, including the need to work effectively with community, mental health and primary care partners. Tori reported that work was underway to standardise approaches across all sites in conjunction with community and mental health partners as ED's were often seen by patients as the only accessible route to support during times of crisis and that closer partnership working was required to improve outcomes.

6.8 The Board discussed the role of patient passports and personalised information in supporting care, and it was acknowledged that existing passport arrangements largely focused on recognised vulnerabilities such as dementia and learning disabilities, it was suggested that consideration should be given to expanding these approaches for patients with less visible vulnerabilities.

6.9 The Board reflected on the complexity of balancing staff safety, violence and aggression management, clinical assessment alongside delivering person centred care as Matt's case was recognised as a powerful reminder of the need to understand the drivers behind behaviours and ensure that assessments were not influenced by assumptions or stigma.

6.10 The Board thanked Matt for agreeing to share his experience and requested that the Board's sincere apologies were conveyed to him for the poor care received, along with their best wishes for the future. Tori concluded by stating that Matt had requested that the Board remember his story throughout its discussions and decision-making, and the Board recognised the importance of doing so.

[Tori Cooper and Rebecca Goldsmith left the meeting at this point.]

TB/09/26/7 CHIEF EXECUTIVE REPORT

7.1 Dr Andy Heeps opened by recognising the response of colleagues and partner organisations to two major incidents during the period, namely the Lewes train derailment and the Shoreham Sea tragedy, and he acknowledged the continuing impact on those individuals directly affected and thanked staff and emergency service partners for their professionalism, compassion and collaborative response.

7.2 Reflecting on the past year, Andy noted the publication of the well-led review and the Trust's significant progress that had been made through the introduction of Divisional Managing Directors, the appointment of a new Chief Delivery Officer, Alex Shaw, and strengthened operational leadership arrangements. Andy stated that the Executive Team was now increasingly focused on delivering the priorities set out within the Trust's strategy and ensuring that this translated into tangible improvements for patients.

7.3 Andy advised that the Trust had improved its position within the NHS Oversight Framework, moving from Segment 4 to Segment 3, and acknowledged that progress, but reinforced the need to accelerate change and ensure patients experienced meaningful benefits from improvement programmes.

7.4 Andy highlighted examples of excellent practice across the Trust, including achievements recognised within the Sussex and Surrey Cancer Alliance Annual Report and he thanked colleagues for their continued commitment and emphasised the importance of sustaining these improvements over the longer term.

7.5 In reference to the Trust's financial position Andy acknowledged the significant challenges facing the organisation and the impact of strengthened financial controls that required a consistent and disciplined approach to recovery, noting that the Trust could not continue providing services in the same way if it was to achieve longer term sustainability.

7.6 In respect of maternity services and preparations for the independent maternity review, Andy thanked the interim Chief Nurse Gail Byrne for her leadership to date and reflected positively on recent meetings he and the Chair had held with Donna Ockenden, NHS England's Chief Nursing Officer Duncan Burton and regional colleagues. Andy stressed the importance of supporting affected families, remaining open to feedback and ensuring concerns were acted upon. Andy also reflected on the wider lessons arising from the Thirlwall Inquiry, noting the importance of understanding how the Board could assure themselves that appropriate actions were being taken in response to concerns.

7.7 In response to questions regarding patient confidentiality, Andy Heeps confirmed that 14 incidents involving inappropriate access to patient records had been

reported during 2025/26, with all incidents having been investigated with proactive auditing arrangements remaining in place. It was shared that the Trust's future electronic patient record system would further strengthen role required access controls and monitoring arrangements.

7.8 Andy Heeps also reflected on the challenges associated with patient flow and discharge within the Trust and highlighted the importance of close working with system partners and local authorities to ensure patients received care in the right place at the right time. While recognising progress in partnership working, he noted that the scale and pace of improvement required remained significant which was the Executive Team's focus to ensure available resources were directed towards improvements that delivered measurable benefits for patients.

7.9 Gordon Ferns queried the regional developments, Andy confirmed that the developing arrangements involving Queen Victoria Hospital would not alter its role within specialist patient pathways or the Sussex Provider Collaborative and advised that discussions were underway regarding opportunities for joint workforce and service planning to ensure continued delivery of quality specialist services for patients across Sussex.

7.10 Responding to Bindesh Shah's question regarding NHS England's new elective patient experience standards, Andy shared that an organisational baseline assessment was underway, with early indications suggested that many of the requirements aligned with existing arrangements, and work was being focused on triangulating patient feedback and identifying areas where communication and patient experience could be strengthened.

7.11 The Board also reflected on the earlier patient story and the mental health pressures within emergency departments where it was recognised that approximately one in ten emergency department attendances related to mental health needs, and whilst standalone mental health emergency departments were not universally supported, there was agreement on the importance of clear pathways, timely access to specialist mental health support and continued collaboration with system partners as part of future emergency department redesign.

7.12 Philip Hogan reflected on progress made over the previous year, and Andy acknowledged that there remained significant areas of concern and challenge across the Trust. However, he expressed confidence that the strengthened approach to leadership, recovery and accountability provided a more robust foundation for improvement and encouraged the Board to continue providing both support and constructive challenge, with a greater focus on outcomes and evidence of delivery rather than process measures alone.

7.13 The Chair requested that mortuary services and Human Tissue Authority compliance be brought to a future Board meeting and this would outlined extensive assurance work undertaken in response to national recommendations, including reviews of mortuary facilities, perinatal bereavement pathways, security arrangements, access controls, partner relationships, and future capital investment requirements. Andy Heeps agreed, and paid tribute to mortuary colleagues, particularly Paul Hartfield, and expressed personal assurance, following his walkthrough of the bereavement pathways from all our maternity units, that perinatal bereavement pathways were operating as intended, with risks understood and compassion remaining central to the care provided for bereaved families.

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

TB/09/26/8 CQC MATERNITY SERVICE INSPECTIONS ST RICHARDS HOSPITAL AND PRINCESS ROYAL HOSPITAL

8.1 Oliver White presented a summary of the CQC inspection reports for maternity services at St Richard's and Princess Royal Hospitals which confirmed both services were rated “Requires Improvement”. The Board recognised the commitment of staff across maternity and neonatal services and noted positive findings relating to workforce, governance, leadership and collaborative working. Emma Chambers advised that all recommendations and actions arising from inspections had been incorporated within the Maternity and Neonatal Improvement Plan, with work continuing via oversight of the Maternity and Neonatal Improvement Group to deliver the required improvements.

8.2 In response to a question from Bindesh Shah regarding the drivers of maternity triage breaches against the national 15-minute standard, Emma advised that compliance challenges were primarily linked to staffing configuration and service model requirements and advised that recent reviews by NHS England had highlighted these issues and that further work was underway to address them.

8.3 Gordon Ferns sought assurance regarding estate limitations contributing to the CQC reported Regulation 12 breaches and queried the variation in staffing models across sites. Emma advised that estate assessments had identified that several triage areas were not fully compliant with current requirements and that increasing demand for maternity triage services had outgrown existing estate. Oliver White added that the ongoing national review of maternity triage requirements, including the Amos Review recommendations, was reframing expectations nationally and that the Trust was working closely with system partners to address emerging standards.

8.4 Andy Heeps sought assurance regarding the effectiveness of oversight arrangements of Maternity Services through Board Committee processes. Gail Byrne acknowledged the breadth of reporting arrangements and emphasised the importance of combining quantitative and qualitative assurance, including direct engagement with frontline staff and patients, and outlined the plans to further develop maternity performance dashboards to support oversight of key indicators and improvement activity.

8.5 The Chair commended the significant progress made in aligning and updating clinical guidelines and acknowledged the improvement in the service rating from “Inadequate” to “Requires Improvement”. It was shared that whilst substantial progress had been made on workforce, governance and process improvements, there remained significant estate challenges affecting maternity services. The Board agreed that a broader strategic discussion on maternity estate requirements should be brought to a future meeting. ***Action: A strategic discussion on maternity, including estate requirements and associated risks to be scheduled for a future Board meeting.*** **Oliver White**

8.2 The Board **NOTED** the update.

TB/09/26/9 PROGRESS ON NHSE SPRINT

9.1 Emma Chambers updated the Board on progress against the NHS England 10 Point Plan, Ockenden recommendations and the Baroness Amos review, explaining that a detailed gap analysis had been completed for the 10-Point Plan, with all but one action progressing to schedule, and the delayed action relating to the homebirth service review, which had been escalated following learning from a Prevention of Future Deaths case in Manchester. The Board was reminded that NHS England required an approved assurance return by 25 September 2026, setting out compliance, areas of non-compliance, mitigating actions and supporting evidence.

9.2 Emma drew out the progress in relation to deploying Martha's Rule, established to strengthen mechanisms for listening to women, families and the workforce, and improving the capture and use of service user feedback. It was added that updates on health inequalities continued to be reported through established Committee and Board reporting.

9.3 The Board noted that all actions arising from the 2022 maternity review had been completed along with high-level gap analyses having also been completed since the sharing of the Nottingham Ockenden report and the Amos review.

9.4 The Board **APPROVED** submission of the NHS England 10 Point Plan assurance return.

TB/09/26/10 INDEPENDENT MATERNITY REVIEW UPDATE

10.1 Gail Byrne provided an update on the Independent Maternity Review (IMR) reporting that a family listening event had been held on 5 September and that the receipt of the investigations' terms of reference was awaited. Work to appoint the IMR programme team was underway to provide support to ensure maternity services continue to deliver operational requirements by supporting on any requests made from IMR process.

10.2 The Board heard about the improvements to future maternity reporting would provide clearer oversight of recommendations, actions and progress across the service, and would focus on four key areas, Workforce; Estates; communication and engagement; and governance.

10.3 The Board were updated on emerging themes relating to communication and engagement with women and families, and the changing of delivery pathway choices increasing caesarean section rates, and concerns were raised regarding the sustainability of the obstetric medical workforce model, which would continue to be assessed.

10.4 The Chair updated the Board on the transfer of the Non-Executive Director maternity SRO role to Non-Executive Director Mike Driver. Mike acknowledged the comprehensive handover received from Lucy Bloem and confirmed plans for further engagement with maternity services. The Board thanked Lucy Bloem for her leadership and contribution to maternity oversight and assurance over the past few years.

10.5 The Chief Executive also reminded the Board that following national guidance maternity oversight is now jointly overseen by the Chief Medical Officer and the Chief Nurse.

10.6 The Board **NOTED** the update, the change of NED maternity champion and the dual executive oversight established.

TB/09/26/11 ONE UHSUSSEX UPDATE *INCLUDING WELL LED DEVELOPMENTAL REVIEW ACTION STOCKTAKE*

11.1 Andy Heeps shared the positive progress made in implementing the recommendations arising from the Niche well-led developmental review, with 13 of the 22 recommendations now assessed as complete by the NHSE NPIP support team with the remaining recommendations progressing. Andy acknowledged that a number of the outstanding actions related to longer term culture and organisational development work which would continue as part of the Trust's ongoing improvement journey, and further advised that future oversight of the remaining recommendations would be incorporated into the Strategy Delivery Improvement Framework Integrated Improvement Plan.

11.2 The Board discussed future assurance arrangements and the suggestion that a further developmental well-led review could be commissioned in the next year but the Board agreed that the timing and scope of any future review should be considered by the Board at later point, taking account of progress made against the remaining recommendations and wider organisational improvement priorities.

11.3 The Chair welcomed the progress reported and acknowledged that the ultimate measure of success would be the experience of staff working across the organisation.

11.4 The Board **NOTED** the report along with the importance of ensuring that improvements translated into meaningful outcomes for staff and patients.

TB/09/26/12 REPORT FROM AUDIT COMMITTEE FROM THE MEETING HELD ON THE 28 JULY 2026

12.1 Mike Driver presented their Audit Committee Chair's report whereby the Committee was assured regarding the improvements to the Trust's risk management arrangements and Board Assurance Framework (BAF), focusing on the maturity of underlying governance, risk and control processes.

12.2 The Committee received updates from Internal Audit and noted concerns regarding the pace of implementation of agreed audit recommendations whereby Executive colleagues confirmed that the tracking and delivery of recommendations had become a standing item at Executive Management Committee and that more robust oversight arrangements were being established.

12.3 The Committee noted a negative assurance opinion relating to the previous year's Premises Assurance Model (PAM), reflecting weaknesses in the design and operation of controls supporting the Trust's self-assessment process. The Committee had been assured that these improvements were being actively managed by the Director of Infrastructure and were being applied to the current year's return.

12.4 The Committee received the Quarter 1 Counter Fraud report and noted a steady level of fraud referrals, with approximately ten cases reviewed during the period. While the Trust's overall fraud risk profile remained moderate, cyber-enabled fraud continued to be assessed as a high-risk area.

12.5 The Committee also received confirmation that the Trust's Data Security and Protection Toolkit submission achieved a "Standards Met" assessment and considered the Data Protection Officer's annual report. Assurance was provided regarding compliance with data protection requirements and the importance of protecting patient information. Mike informed the Board that the Committee had reflected on the need for clarity over the roles of the nationally mandated IG training and the Trust's developed local Cyber Security Training.

12.6 The Committee received an update from External Audit and noted that the annual audit had been completed within the required timescales and had highlighted positive working relationships between auditors and the Trust.

12.7 The Board **NOTED** the Audit Committee Chairs report.

TB/09/26/13 REPORT FROM THE RESEARCH INNOVATION & DIGITAL STRATEGY ASSURANCE COMMITTEE

13.1 Jackie Cassell as the Committee Chair provided assurance on the continued progress across the Trust's research and digital portfolios, including development

of clinical research facilities, patient and community involvement in research, and the strength of research governance arrangements.

13.2 It was noted that the Committee reviewed the Digital and Data Delivery Plan, and its progress with the EPR programme and cyber resilience whereby learning from recent cyber exercises and training requirements was discussed, with assurance provided regarding organisational preparedness.

13.3 The Committee noted the successful completion of the Electronic Document Management System as a key EPR readiness milestone and welcomed confirmation of £1.5m NIHR capital funding to support research infrastructure across Trust sites.

13.4 The Board **NOTED** the Research Innovation and Digital Strategy Committee Chairs report.

TB/09/26/14 REPORT FROM STRATEGY & MAJOR PROJECTS ASSURANCE COMMITTEE

14.1 Paul Layzell, Chair of the Strategy and Major Projects Assurance Committee, reported that the Committee had received assurance on the developing Strategy Delivery and Improvement Framework, recognising the importance of focusing current improvement activity on recovery and core service delivery. The Committee also reviewed the Clinical Sustainability Tool in supporting service prioritisation and the deployment of improvement resources.

14.2 In relation to major projects, the Committee received assurance on both the Theatre Ventilation Programme and the Electronic Patient Record (EPR) Programme, and noted the complexity of the theatre programme, and the increasing focus on procedure room development to create additional capacity to then support wider theatre refurbishment works.

14.3 The Committee had reflected on strategic risk 6 within the Board Assurance Framework which highlighted concerns regarding the impact of wider financial pressures on the Trust's transformation ambitions and whether sufficient capacity and resource existed to deliver the required change programme. Andy Heeps shared that the Executive Team would consider whether current BAF risk allocation adequately reflected transformation delivery risks for further deliberation at the Committee meeting.

14.4 The Chair expressed concern regarding any loss of momentum within the Theatre Ventilation Programme, between theatre capacity, RTT performance and service recovery, and stated that delays should not undermine the Trust's recovery objectives. It was noted that work was underway to reduce inappropriate use of theatre space, increase use of procedure rooms and develop a broader theatre capacity programme to support both performance improvement and estate modernisation. The Chair requested that the Committee maintain regular oversight of progress and continue to review the programme through the lens of theatre capacity and operational outcomes. It was agreed that Strategy and Major Projects Assurance Committee would retain ongoing oversight of the Theatre Ventilation Programme through a wider Theatre Capacity Programme.

14.5 The Board **NOTED** the Strategy & Major Projects Assurance Committee Chairs Report.

TB/09/26/15 REPORT FROM PATIENT & QUALITY ASSURANCE COMMITTEE

15.1 In the absence of Lucy Bloem, Katie Urch provided an update on the Patient & Quality Assurance Committee meeting and highlighted the Committee had completed its annual reports which were being presented today for approval. The

Board noted progress in validating follow-up waiting lists and received assurance regarding the management of identified patient harms. Assurance was also received on Learning from Deaths processes, organisational learning from Prevention of Future Deaths notices, and continued strong performance in organ donation services.

15.2 The Board **NOTED** the assurances within the Patient and Quality Assurance Committee Chairs report and **APPROVED** the annual reports:

- Quarter 4 (2025/26) Mortality and Learning from Deaths Report
- Organ Donation Annual Report 2025-26
- Infection Prevention & Control Annual Report 2025-26
- Safeguarding Children and Adults Annual Report 2025-26

TB/09/26/16 REPORT FROM PEOPLE & CULTURE ASSURANCE COMMITTEE

16.1 As Committee Chair, Paul Layzell presented the report which highlighted progress in improving workforce data quality through self-service arrangements, thus supporting more timely updating of staff records and reduce payroll overpayments. There was a noted increase in Freedom to Speak Up cases with further analysis to be undertaken to understand the underlying drivers which would be presented at a future Committee meeting.

16.2 The Board noted the update on the cultural improvement programme outlined within the Annual Equality Report, describing improvements in staff confidence to declare disabilities, experiences of reasonable adjustments, and workforce diversity. It was recognised that further work was required to improve diversity within senior leadership roles and address inequalities experienced by staff from global majority backgrounds. Bindesh Shah welcomed the progress reported but observed that it was too early to assess the wider impact of inclusion initiatives and requested that future reports include measurable outcomes to demonstrate progress against equality, diversity and inclusion objectives.

16.3 The Chair queried the reported levels of sexual harassment and safety concerns and sought assurance that appropriate oversight was being maintained. Sarah-Jane Taylor confirmed that sexual safety formed part of the Committee's quarterly programme of work and that a range of communications and engagement initiatives were underway.

16.4 The Board **APPROVED** the Annual Equality Report for publication and **APPROVED** the Annual Medical Appraisal and Revalidation Statement of Compliance for submission.

TB/09/26/17 REPORT FROM FINANCE & PERFORMANCE ASSURANCE COMMITTEE

17.1 Philip Hogan as the Committee Chair shared that the meeting had received detailed oversight of financial and operational performance, the efficiency programme, capital expenditure and cash management, and while the Trust had reported performance broadly in line with its financial plan, there remained concerns about the underlying challenges, delivery of efficiency savings and operational performance, cash constraints, supplier payments and the affordability of further investment proposals, which continued to be below target.

17.2 The Chair queried the actions required to improve operational performance and address the underlying deficit, noting that continued discussion of the causes alone would not deliver improvement. Andy Heeps explained that, in the context of the Trust's financial position, any new investment or business case proposal must be considered alongside the corresponding reduction in expenditure elsewhere. He noted that there was no additional source of funding available and suggested that the organisation needed greater transparency regarding the trade-offs, risks and

consequences associated with investment decisions. Jonathan Reid reinforced the importance of maintaining grip and control over expenditure, improving operational performance and addressing the drivers of the deficit. He advised that stronger financial controls and messaging had been implemented across the Trust and that there remained no unallocated funding available for new investments outside of agreed priorities.

17.3 The Chair emphasised that the Trust received significant levels of funding and that the focus should be on identifying inefficiencies and ensuring available resources were directed towards improvements for patients.

17.4 The Board **NOTED** the Finance & Performance Assurance Committee Chairs report.

TB/09/26/18 MATERNITY PERFORMANCE ASSURANCE REPORT

18.1 The Board **NOTED** the Maternity Assurance report, which was taken as read.

TB/09/26/19 INTEGRATED PERFORMANCE REPORT

19.1 Andy Heeps reflected on the Integrated Performance Report, noting that the committee reports had demonstrated a high degree of consistency and clearly articulated the ongoing operational and financial challenges. Philip Hogan provided assurance that performance against the agreed 65-week plan continued to be closely monitored.

19.2 The Board **NOTED** the Integrated Performance Report.

TB/09/26/20 BOARD ASSURANCE FRAMEWORK

20.1 Glen Palethorpe presented the Board Assurance Framework, stating that Quarter 1 review had been completed and the Quarter 2 review was underway. The report highlighted challenges had continued into Q2 and the BAF had been reviewed to reflect risk prioritisation. There remained appropriate oversight arrangements for risks and further consideration regarding risks associated with financial and operational performance was given.

20.2 The Board **NOTED**:

- the assurance provided by the respective Committee review of their BAF segments.
- the referral to the Executives to consider if there is a need for a distinct strategic risk in respect of transformation delivery

20.3 The Board **APPROVED** the quarter 1 scores.

TB/09/26/21 COMPANY SECRETARY REPORT *INCLUDING REVIEW OF UHSUSSEX CONSTITUTION*

21.1 Glen Palethorpe introduced the Company Secretary Report, which reflected the constitutional amendments to increase the maximum number of Executive Directors from eight to nine, reflecting the creation of the Chief Infrastructure and Digital Officer role, along with a provision regarding Managing Director attendance at Board meetings.

21.2 The Board noted the proposed reappointments of Philip Hogan and Jackie Cassell, subject to ratification by the Council of Governors meeting on 1 October 2026.

21.3 The Board **RECOMMENDED** the constitutional amendments to the Council of Governors for approval.

TB/09/26/22 **ANY OTHER BUSINESS**

22.1 The Chair reflected that the meeting had highlighted the breadth of the Board's oversight responsibilities and acknowledged the significant pressures facing colleagues as the Trust balanced operational and financial delivery and thanked staff for their continued commitment. The Chair further shared that several matters were to be discussed in private, including financial recovery and service improvement proposals, which remained under development and once formulated they would be brought to the public Board.

TB/09/26/23 **DATE OF NEXT MEETING**

23.1 It was noted that the next meeting of the Board of Directors in Public was scheduled to take place at **10.00** on **Thursday 12 November 2026 in Worthing**

Tamsin James
Board & Committees Manager
September 2026

Signed as a correct record of the meeting.

…….. Chair

..... Date

MATTERS ARISING

Trust Board

	Meeting Date	Meeting Type	Minute Ref	Action	Person Responsible	Deadline	Update	Status
1	17-Sep	Public	**Public Board: CQC Maternity Update**	The Board agreed that a broader strategic discussion on maternity including its estate requirements should be brought to a future meeting.	Gail Byrne Oliver White	Nov-26	*Oliver White is presenting the update to Board on 12 November at Item 7. The report provides an overview of maternity and neonatal services across the Trust's four sites. Progress has been made in strengthening leadership, governance, workforce capacity and clinical outcomes, and continued oversight is required to ensure improvements are sustained and risks are effectively managed. The Trust will continue implementation of its maternity and neonatal improvement plans, deliver national recommendations, further strengthen workforce resilience, address estate and capacity constraints, and maintain focus on improving consistency of care and patient experience across all sites*	**Propose to Close**

University Hospitals Sussex NHS Foundation Trust

Agenda Item:	7.	**Meeting:**	Trust Board in Public	**Meeting Date:**	12 November 2026
Report Title:	Perinatal Service Update				
Sponsoring Executive Director:	Gail Byrne, Interim Chief Nurse Professor Katie Urch, Chief Medical Officer				
Author(s):	Oliver White, Managing Director – Women, Children and Clinical Support Services				
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)***

What
The report provides an overview of maternity and neonatal services across the Trust's four sites.

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
Progress has been made in strengthening leadership, governance, workforce capacity and clinical outcomes, and continued oversight is required to ensure improvements are sustained and risks are effectively managed.

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

What Next
The Trust will continue implementation of its maternity and neonatal improvement plans, deliver national recommendations, further strengthen workforce resilience, address estate and capacity constraints, and maintain focus on improving consistency of care and patient experience across all sites.

Recommendation
(linked to What Next section)

The Board is asked to:

1. *Note the progress within maternity and neonatal services.*
2. *Take assurance regarding current service performance, governance and improvement activity.*

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

Continued oversight is provided through QGSG and Patient & Quality Assurance 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						
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)***
	N/A	*N/A*	*N/A*	*Yes (CQC)*

NHS
University Hospitals Sussex
NHS Foundation Trust

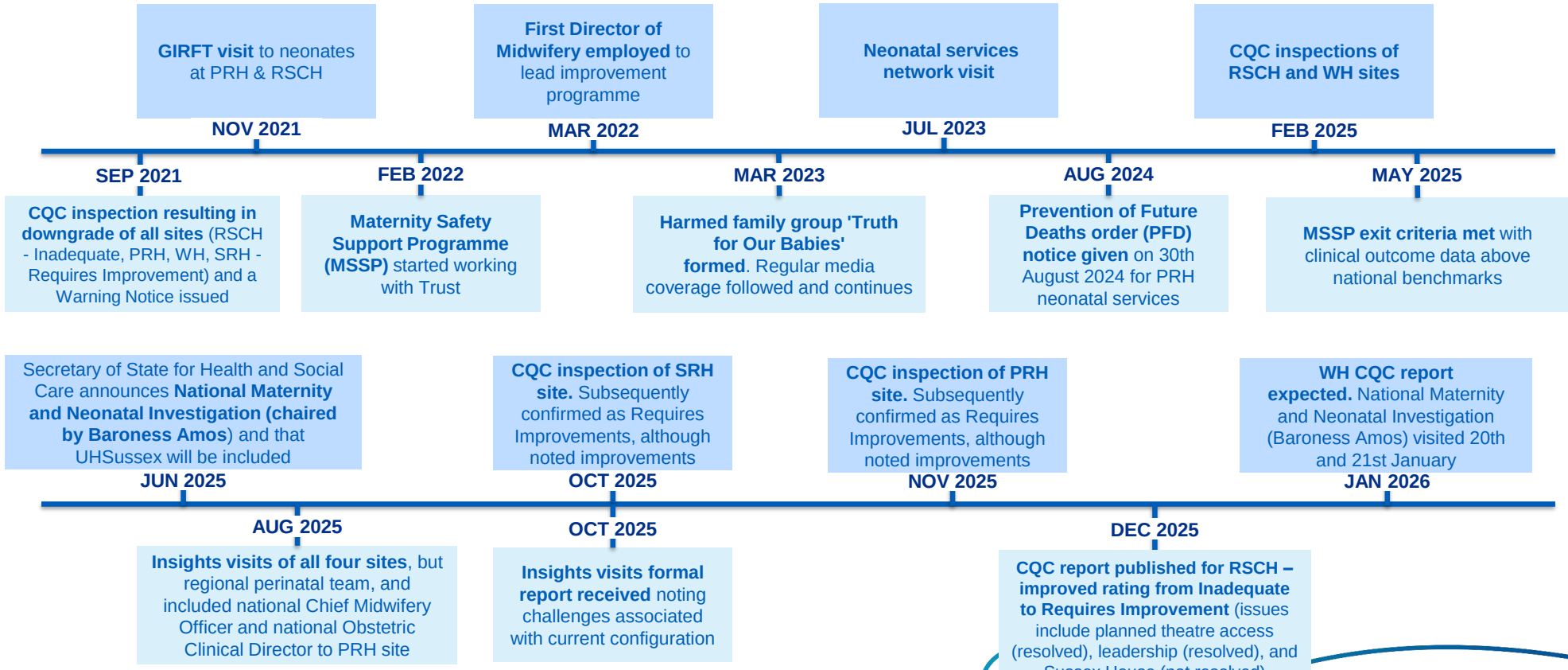
Perinatal Service Update

November 2026



UHSx Recent Maternity History

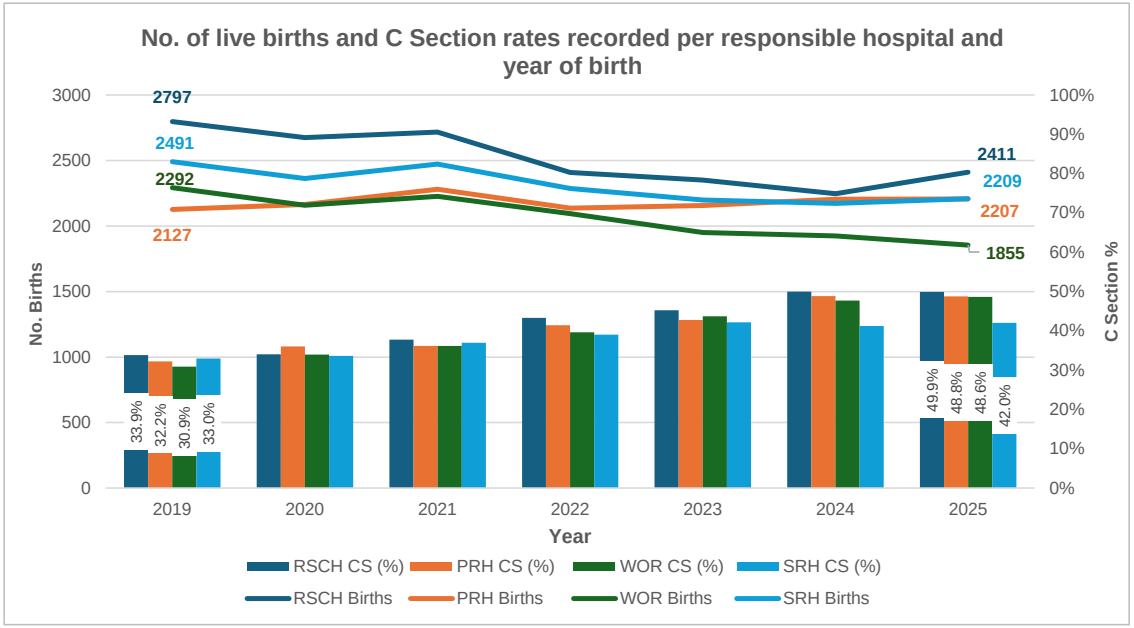
NHS
University Hospitals Sussex
NHS Foundation Trust



Demographics & Birth Rates

University Hospitals Sussex NHS Foundation Trust

- The **number of births at the Trust has reduced by 12% since 2019**
- Despite a 5% growth in population due to immigration, Sussex has **falling fertility and birth rates**, with Brighton and Hove having the third lowest total fertility rate (TFR) in England



- PRH is the only site to see a small increase in average annual births (**+0.7%**), although RSCH has seen a 7.3% increase from 2024 to 2025
- Since 2019, **the proportion of births recorded as caesarean sections has increased across all 4 sites to 47.4% in 2025,** this trend is expected to continue
- **This reflects a national trend toward higher rates of Caesarean section over vaginal births**

Perinatal Provision & Activity (2025)

NHS
University Hospitals Sussex
NHS Foundation Trust

St Richard's Hospital (2143.85m2)

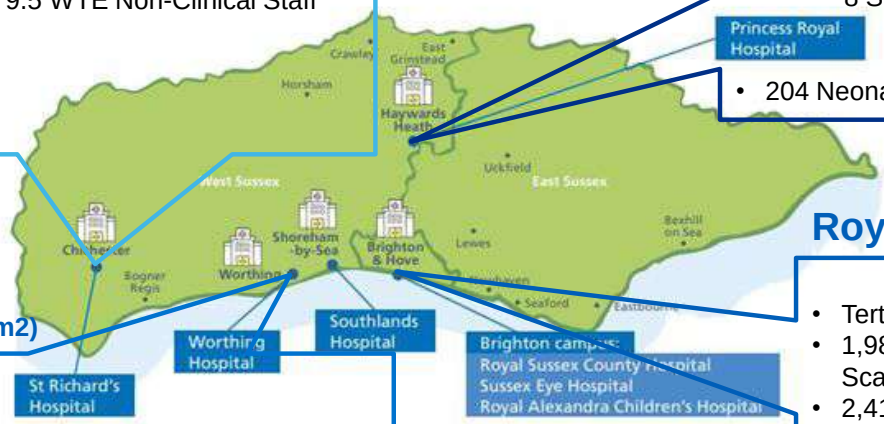
- 1,240 Obstetric Ultrasound Scans
- 2,209 Births
- Level 1 Neonatal Care (SCBU)
  - 10 Special Care Cots
  - 2 High Dependency Cots
- 206 Neonatal Admissions

- 34.2 WTE Doctors*
- 88.7 WTE Midwifes
- 35.4 WTE Nurses
- 9.5 WTE Non-Clinical Staff

Princess Royal Hospital (742.44m2)

- 228 Obstetric Ultrasound Scans
- 2,207 Births
- Level 1 Neonatal Care (SCBU)
  - 8 Special Care Cots
- 204 Neonatal Admissions

- 27.8 WTE Doctors*
- 57.3 WTE Midwives
- 31.8 WTE Nurses
- 2.2 WTE Non-Clinical Staff



Worthing Hospital (1,356.67m2)

- 985 Obstetric Ultrasound Scans
- 1,855 Births
- Level 1 Neonatal Care (SCBU)
  - 10 Special Care Cots
  - 2 High Dependency Cots
- 142 Neonatal Admissions

- 28.9 WTE Doctors*
- 76.2 WTE Midwifes
- 37.9 WTE Nurses
- 8.5 WTE Non-Clinical Staff

Royal Sussex County Hospital (3,963.64m2)

- Tertiary Perinatal Services
- 1,987 Obstetric Ultrasound Scans
- 2,411 Births
- Level 3 Tertiary Surgical Neonatal Care
  - 9 Intensive Care Cots
  - 8 High Dependency Cots
  - 10 Special Care Cots
- 311 Neonatal Admissions

- 41.35 WTE Doctors*
- 219.1 WTE Midwifes
- 50.2 WTE Nurses
- 28.6 WTE Non-Clinical Staff

Perinatal Provision & Activity (2025) – corrected data [post meeting]

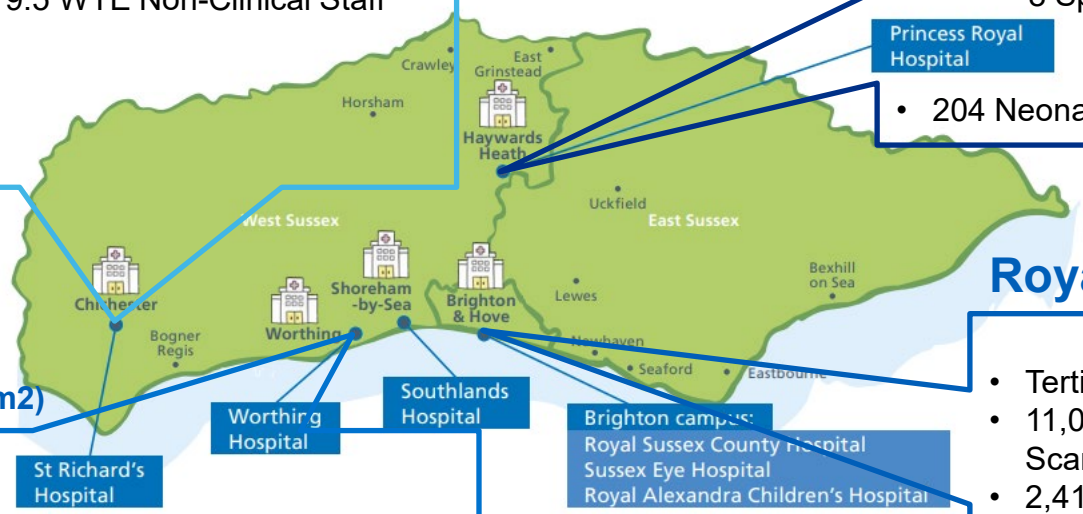
University Hospitals Sussex NHS Foundation Trust

St Richard's Hospital (2143.85m2)

- 12,163 Obstetric Ultrasound Scans
- 2,209 Births
- Level 1 Neonatal Care (SCBU)
  - 10 Special Care Cots
  - 2 High Dependency Cots
- 206 Neonatal Admissions
- 34.2 WTE Doctors*
- 88.7 WTE Midwives
- 35.4 WTE Nurses
- 9.5 WTE Non-Clinical Staff

Princess Royal Hospital (742.44m2)

- 9,967 Obstetric Ultrasound Scans
- 2,207 Births
- Level 1 Neonatal Care (SCBU)
  - 8 Special Care Cots
- 204 Neonatal Admissions
- 27.8 WTE Doctors*
- 57.3 WTE Midwives
- 31.8 WTE Nurses
- 2.2 WTE Non-Clinical Staff



Worthing Hospital (1,356.67m2)

- 11,836 Obstetric Ultrasound Scans
- 1,855 Births
- Level 1 Neonatal Care (SCBU)
  - 10 Special Care Cots
  - 2 High Dependency Cots
- 142 Neonatal Admissions
- 28.9 WTE Doctors*
- 76.2 WTE Midwives
- 37.9 WTE Nurses
- 8.5 WTE Non-Clinical Staff

Royal Sussex County Hospital (3,963.64m2)

- Tertiary Perinatal Services
- 11,009 Obstetric Ultrasound Scans
- 2,411 Births
- Level 3 Tertiary Surgical Neonatal Care
  - 9 Intensive Care Cots
  - 8 High Dependency Cots
  - 10 Special Care Cots
- 311 Neonatal Admissions
- 41.35 WTE Doctors*
- 219.1 WTE Midwives
- 50.2 WTE Nurses
- 28.6 WTE Non-Clinical Staff

Estates & Facilities Challenges

University Hospitals Sussex
NHS Foundation Trust

St Richard's Hospital

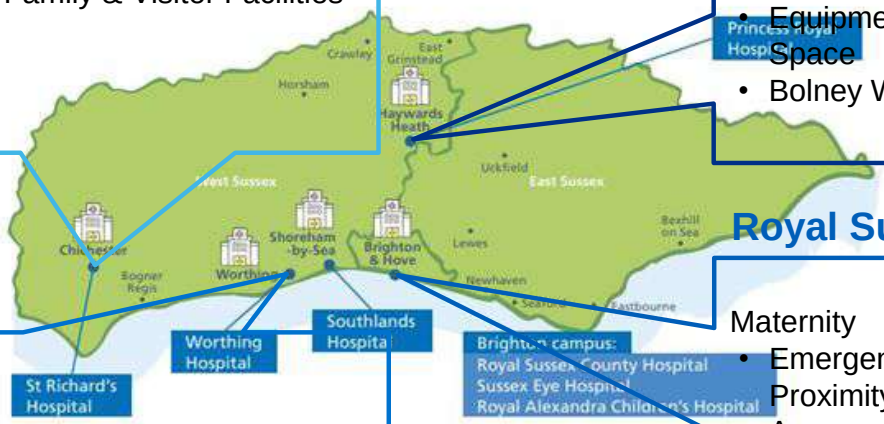
Maternity
- Assessment Room Size
- Planned Caesarean Theatre Capacity
- Staff Wellbeing Facilities

Neonates
- Temperate Control
- Lighting
- Family & Visitor Facilities

Princess Royal Hospital

Maternity
- Planned Caesarean Theatre Capacity
- Clinical Assessment & Waiting Space
- Equipment Storage Space
- Bolney Ward Bed Access

Neonates
- Family & Visitor Facilities
- Equipment & Cleaning Storage
- Temperate Control
- Lighting



Worthing Hospital

Maternity
- Assessment Room Size
- Bereavement Location
- Planned Caesarean Theatre Capacity
- Staff Wellbeing Facilities

Neonates
- Temperate Control
- Lighting
- Equipment & Clinical Stock Storage

Royal Sussex County Hospital

Maternity
- Emergency Theatres Proximity
- Assessment Room Size
- Planned Caesarean Theatre Capacity

Neonates
- Clinical Floor Space
- Temperate Control
- Lighting
- Family & Visitor Facilities

Trust Board Highlights

NHS
University Hospitals Sussex
NHS Foundation Trust

Evidenced Strengths

- Current maternity and neonatal outcomes compare favourably with national benchmarks.
- Investment has strengthened midwifery staffing, leadership, and governance.
- CQC, Amos, and Nottingham IMR actions and learning have associated and monitored plans in place against which progress is underway.
- Low turnover rates and successful recruitment programmes have supported consistent workforce improvements.
- Incident learning and family feedback continually inform our Maternity & Neonatal Improvement Plan which pulls together all our improvement actions.

Targeted Improvement

- Embed consistent standards, practice, and patient experiences across all four sites, demonstrating measurable improvements.
- Further strengthen obstetric and neonatal staffing to align to national standards, delivering on committed investments.
- Ensure necessary dedicated theatre capacity for the growing proportion of caesarean section births.
- Address estate and challenges where tactically possible and determine and deliver longer term solutions where necessary.
- Deliver on national learning, actions, and recommendations including the national ‘Ten Point Plan’.

NHS

University Hospitals Sussex

NHS Foundation Trust



University Hospitals Sussex NHS Foundation Trust

Agenda Item:	7.1.	**Meeting:**	Trust Board in Public	**Meeting Date:**	12 November 2026
Report Title:	Maternity Assurance Reports – Public Board				
Sponsoring Executive Director:	Gail Byrne, Interim Chief Nursing Officer Professor Catherine Urch, Chief Medical Officer				
Author(s):	Stephanie White, Divisional Head of Quality for Women & Children				
Purpose of the report: *(indicate as appropriate)*	**For Decision**	**For Assurance**	**For discussion**	**For Information only**	
	N/A	*Yes*	*Yes*	*N/A*	
Reason for not being taken in public *(indicate as appropriate)*	**Commercial confidentiality**	**Staff confidentiality**	**Patient confidentiality**	**Other exceptional circumstances (please detail)**	
	N/A	*N/A*	*N/A*	*N/A*	
Regulatory Reporting Requirement	*CNST*				

Summary of the report describing

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

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

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

PQOM with associated dashboard (August 2026 data)

What:

Perinatal Quality Oversight Model (PQOM) dashboard and report provide Board oversight of maternity and neonatal quality, safety, workforce and outcomes.

Key Message

Maternity and neonatal service outcomes continuing to compare favourably against national benchmarks.

So What:

Key assurances:

- Perinatal and neonatal outcomes remain favourable against national benchmarks.
- No Patient Safety Incident Investigations (PSIIs) or Maternity and Newborn Safety Investigations (MNSI) referrals were reported in August; CNST review requirements remain compliance.
- Progress continues across maternity safety, workforce training and improvement programmes.
- Thirlwall compliance actions remain in progress ahead of the March 2027 deadline.

What Next:

- Note the continued positive position against key safety and outcome indicators.
- Receive assurance regarding progress of CNST, Maternity and Neonatal Improvement Plan (MNIP) and maternity safety improvement programmes.
- Support continued executive oversight of workforce, neonatal capacity, homebirth resilience, new regulatory expectations and estate-related risks.
- Endorse ongoing monitoring of patient experience, health inequalities and safety-system improvements through established governance arrangements.
- External review compliance is strong and has been strengthened further to meet CNST Year 8 requirements.

NHS 10-Point plan sprint action implementation (Q2 update)

What:

A report describing Trust implementation programme following the publication of the Amos and Nottingham Ockenden Investigation recommendations.

So What:

	• Continued progress has been achieved, with five additional actions reaching full compliance. • No areas now remain fully non-compliant. What Next: Focus delivery on remaining partially compliant actions including Martha's Rule, health inequalities programmes, workforce establishment, triage compliance and workforce deployment arrangements.
Recommendation *(linked to What Next section)*	For the Trust Board to **NOTE** the contents of the assurance report. *(The Board is asked to provide approval for the NHSE 10point plan submission on 31st January once the Board has reviewed the assurance template and evidence in full on 10th December.)*
Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*	Maternity Quality & Safety October 2026 WCCS Divisional Quality & Safety Group Chair's approval QGSG October 2026 Patient & Quality Assurance Committee – November 2026

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)***
	N/A	*N/A*	*N/A*	*N/A*

University Hospitals Sussex NHS Foundation Trust

Agenda Item:	8.	**Meeting:**	Trust Board in Public	**Meeting Date:**	12 November 2026
Report Title:	Chief Executive's Report				
Sponsoring Executive Director:	Dr Andy Heeps, Chief Executive				
Author(s):	Dr Andy Heeps, Chief Executive				

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

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

Regulatory Reporting Requirement	
Summary of the report describing **What** *(summary of current position / issue & why it matters and evidence to support that position etc)* **So What** *(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)* **What Next** *(summary of intended action and benefits supporting the choices and recommendation(s)being made)*	This report provides the Board with an overview of key national, regional and local developments affecting UHSussex. It highlights the progress of the Health Bill, next steps in the independent review of maternity services in Sussex, new system-wide efforts to improve patient flow, regional plans to protect planned care during winter, and recent developments in our hospitals including service review, a new food and drink strategy, and the expansion of patient participation in research. It also sets out our focus on financial recovery and productivity, improvements in urgent and emergency care, and system leadership and partnership working.
Recommendation *(linked to What Next section)*	The Board is asked to: 1. **Note** the updates set out in the Chief Executive's Report. 2. **Consider** the implications of national, regional and system developments for UHSussex. 3. **Seek assurance** that risks are being managed appropriately, with further detail to be provided through the relevant Committees where required. 4.
Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*	This is the Chief Executive's standing report and is presented directly to the Board. Where specific issues require deeper assurance, these are considered through the relevant Board Committees (e.g. People & Culture Assurance Committee for workforce and culture; Patient & Quality Assurance Committee for safety and maternity).

Link to Trust Strategy (note which theme)	**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**
	N/A	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*

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

Chief Executive's Report – 12 November 2026

Since the September Board meeting, the executive team and I have been finalising the second phase of our operating model and reviewing our plans for the rest of the year. Our priorities remain reducing waits, improving care and restoring financial sustainability. The Integrated Improvement Plan, now accepted by NHS England, brings together our work on urgent and emergency care, planned care, cancer and financial recovery.

This report describes the progress we are making and the wider developments affecting the Trust. As we enter winter, we need to sustain that progress while addressing the underlying problems that continue to affect our patients, staff and finances.

National policy and regulation

Health Bill

The Health Bill completed its second reading in the House of Lords on 13 October and entered committee scrutiny on 28 October. Its principal structural change is the abolition of NHS England, with functions transferring mainly to the Secretary of State, the Department of Health and Social Care (DHSC) and Integrated Care Boards (ICBs).

The direction is towards a smaller national centre and a stronger strategic commissioning role for the Surrey and Sussex ICB. For UHSussex, this means taking greater responsibility with our partners for the health of our population and the development of care outside hospital. Alongside this, we should expect continued scrutiny of our finances, productivity and waiting times.

Single sex facilities and accommodation

NHS England has published revised guidance on privacy, dignity and safety in hospital accommodation, alongside guidance on staff facilities. We are reviewing what this means across our hospitals, including patient placement, toilets and changing facilities.

We will implement the guidance and work with our staff networks to understand its impact on colleagues. We recognise that staff hold differing views. Our approach will be compassionate and respectful, with clear communication and support as we work through the practical changes required.

AI in healthcare

The Government has accepted all 44 recommendations of the National Commission into the Regulation of AI in Healthcare. These propose proportionate regulation throughout an AI product's use, with less reliance on approval at the point of introduction. The Medicines and Healthcare products Regulatory Agency (MHRA) is taking forward implementation, including monitoring products after they enter use, regulating tools that change over time and developing staged authorisation.

For UHSussex, this reinforces the need to treat AI as a continuing clinical safety responsibility. As we introduce tools into diagnostics, clinical decision support and other pathways, we will need to understand whether they continue to work safely and effectively for our patients. This requires clinical, digital, safety, information governance and procurement colleagues to work together, with transparency for patients and staff. AI offers considerable potential to improve care and productivity, but we must be able to demonstrate its benefits and manage its risks throughout its use.

Independent maternity review

We expect the next step in Donna Ockenden's independent review of maternity services in Sussex to be publication of its terms of reference, possibly at the end of November.

We have continued recruiting the dedicated team that will coordinate our response and support families and staff. We have filled 90% of posts, and most of the core team will be in place by the beginning of December. Preparations for identifying cases, securing and checking records, coordinating communications with the division and managing governance are well advanced.

We are committed to being open, supporting the review and acting on what we learn. Families' experiences must remain central, and our approach must recognise the effects of trauma on those taking part. We also recognise the impact the review may have on maternity colleagues and are increasing the wellbeing, psychological and professional support available to them.

Your Voice

We encouraged maternity colleagues to take part in Your Voice, NHS England's three-week anonymous staff conversation following the findings and recommendations of Baroness Amos's national review of maternity and neonatal services. Colleagues were asked to share their experiences, both positive and difficult, and suggest how services could improve.

Their contributions will inform the National Maternity and Neonatal Taskforce's action plan. Each trust will also receive a report on what its staff believe needs to change. We will use ours to inform our maternity improvement plans.

Regional and ICB update

Improving patient flow across the pathway

We continue to work with NHS Surrey and Sussex, Sussex Community NHS Foundation Trust, local authorities and other partners to help patients leave hospital promptly when they no longer need acute care. Delays can harm patients through deconditioning and poorer outcomes, while reducing hospital capacity and increasing costs.

Some delays arise within our hospitals; others depend on the availability of home care, rehabilitation beds and community support, or on social care assessments, safeguarding and Court of Protection processes. Resolving them requires joint action.

We have agreed initiatives with our partners, building on virtual wards, urgent community response services and better use of care home capacity. The ICB will lead a review of need, demand and capacity to establish what discharge and community provision should be commissioned. Partners are also exploring earlier multi-agency discharge planning, closer collaboration with local authorities and pooled budgets where these could help overcome organisational barriers.

An ICB dashboard will make delays and their causes more visible across organisations. Partners will also review governance arrangements to clarify responsibility for improving discharge performance. I am grateful for their commitment to this work. Patients staying in hospital longer than they need to is a long-standing problem, and we need these commitments to produce practical improvements.

Winter planning

The regional winter plan, published at the end of September, recognises that emergency pressures put elective, cancer and diagnostic services at risk. Protecting these services is a core objective. Providers are expected to ring-fence capacity where possible, improve productivity, make full use of Community Diagnostic Centres and use mutual aid and additional capacity to minimise cancellations.

At UHSussex, our work includes rapid assessment on arrival, greater use of same day emergency care and frailty pathways, and earlier senior clinical decisions. On our wards, the priorities are consistent use of the SAFER patient flow approach, criteria-led discharge and reliable discharge arrangements throughout the week. Transfer of Care Hubs, Home First, reablement and Discharge to Assess will support patients to continue their recovery outside hospital.

We have set aside £1.5 million to support admission avoidance and improve flow through our hospitals.

The wider plan also aims to prevent people needing hospital care. Up to £19 million is being invested in neighbourhood health, including proactive support for those at greatest risk of admission. Up to £7 million will fund additional same-day general practice capacity. The ICB expects this to provide around 200,000 additional GP appointments over winter, potentially avoiding around 6,700 emergency department attendances.

Urgent Community Response, virtual wards, Hospital at Home, remote monitoring and community pharmacy will also contribute, alongside support for people with frailty and multiple long-term conditions. These services are intended to reduce ambulance journeys and admissions and help patients leave hospital earlier with appropriate support.

The plan depends on these interventions delivering their expected benefits, alongside careful management of staffing, respiratory illness, norovirus, ambulance handovers and discharge delays.

Strategic commissioning plan

The Surrey and Sussex ICB has approved its Five-Year Strategic Commissioning Plan for 2026–31, together with an implementation plan and commissioning intentions for 2027/28. Building on the Sussex Major Services Review, it focuses on prevention and earlier intervention, changes to models of care, better outcomes for disadvantaged communities, and structural reform to improve clinical and financial sustainability.

The plan signals a gradual shift of care and investment towards community and neighbourhood services, with further consolidation and redesign where this would improve quality, resilience and value.

Provider alliances and collaboratives are expected to lead parts of this work. Examples include single points of access for planned care and community pathways in gynaecology and gastroenterology. Collaboratives will be expected to identify at least two pathways each year where activity can safely move from hospitals to neighbourhood services, with the potential to take greater responsibility for pathways and budgets over time.

Through the Sussex Acute Provider Alliance, UHSussex has an important opportunity to help shape these changes. We will need to agree the capacity, funding and responsibilities required, and ensure alternative services are ready before hospital activity and resources move.

Strategic needs assessment of maternity services

The ICB is preparing a strategic needs assessment of maternity services across Surrey and Sussex. The proposed first stage would examine current provision, activity, outcomes and resources, alongside links with neonatal care, emergency surgery and other services. It would also assess future requirements in light of demographic change.

The assessment will identify unwarranted variation, opportunities for improvement and options for future services, informing commissioning strategy from 2028/29.

As a major provider of maternity and neonatal care, UHSussex will be closely involved in this review. This is an opportunity to consider the long-term resilience of services across our sites. Any proposals will need to address quality and safety, staffing, access, health inequalities and the wider services on which safe maternity care depends. Throughout this work, our immediate focus remains maternity safety, improvement and learning from national and local reviews.

Adult community health services

The ICB is beginning work to redesign and recommission adult community health services across Surrey and Sussex. The aim is to better reflect local needs and provide more joined-up, preventative care closer to home, in line with the national 10 Year Health Plan.

Service users and providers, including UHSussex, will take part in the design phase during the remainder of 2026/27. New arrangements are intended to begin in March 2029.

University Hospitals Sussex

Financial recovery and productivity

We have delivered our financial plan for the first six months of the year, but have relied on non-recurrent measures to do so. This does not yet represent a sustainable improvement in our underlying position.

The work I commissioned on becoming Chief Executive identified structural causes of our deficit, including prolonged hospital stays and the cost of sustaining fragile services across multiple sites. Workforce growth above planned levels over recent years has added to these pressures.

The weekly Recovery Board, which I chair, oversees our response, alongside the weekly cash committee led by the Chief Financial Officer. We are reducing whole-time equivalent staffing, tightening control of temporary staffing and scrutinising new starters at executive level. The Chief Nurse and Chief Medical Officer oversee quality impact assessments. Colleagues have told me during visits that they are feeling the effects of these measures. We must listen carefully and respond to the concerns they raise.

As we plan for 2027/28, we need to address the causes of the deficit and reduce our dependence on one-off measures. Reducing unnecessary time in hospital is central to this: it improves patients' experience and outcomes while releasing beds and resources. Safe, timely discharge must be a shared clinical and financial priority.

We must also examine how we use resources across our sites to sustain services. Our clinical, workforce and financial plans need to be developed together so that financial recovery supports better care.

System leadership and partnership

We continue to work with the ICB, local authorities, primary care, mental health and community services, universities and voluntary sector partners on shared priorities.

This includes support for people with mental health needs, those who frequently attend emergency departments, people experiencing homelessness and those living with multiple long-term conditions. Better coordinated care can help prevent avoidable hospital attendance and improve support for people whose needs span several services.

Our involvement in regional and Sussex-wide discussions also allows us to help shape future services, neighbourhood care and provider collaboration. This is an increasingly important part of our role, alongside delivering the improvements needed within UHSussex.

Royal Sussex County Hospital helipad

We are preparing a Section 73 planning amendment to allow more emergency flights to use the Major Trauma Centre helipad at the Royal Sussex County Hospital in Brighton. Since it opened in March, more than 50 emergency patients have been flown directly to the hospital,

exceeding the number anticipated when planning permission was granted more than a decade ago.

Direct access to specialist care is vital for seriously ill and injured patients and avoids the need for a road transfer. We also recognise the impact of frequent landings on our neighbours. Environmental surveys will inform our application and help us minimise noise and disruption while extending access to this important service.

Ophthalmology service review

Our clinically led review of ophthalmology is examining how we can reduce waits, address the condition of the 91-year-old Sussex Eye Hospital and provide sustainable services for the future. It will also consider opportunities to deliver more care in community, day case and outpatient settings.

Clinical working groups are comparing our services with recommendations from the Royal College of Ophthalmologists and the Getting It Right First Time programme. Alongside this, we are developing an engagement plan so that patients and other stakeholders can help shape options and their appraisal.

A public survey earlier this year provided substantial information and helpful feedback that has informed our plans. We will build on those contributions and invite further views as the review develops, with the aim of providing the best possible ophthalmology care for people across Brighton and Hove and West Sussex.

Brain tumour centre of excellence

UHSussex has been awarded Tessa Jowell Centre of Excellence status in recognition of our brain tumour treatment, care and research. The accreditation recognises the way our teams bring specialist expertise, research and innovation together to improve care.

The expert panel commended our imaging and neurology services, clinicians' comprehensive assessment of patients' needs, and the compassionate support provided through nurse-led care. This is an important achievement for the teams involved and recognition of the care they provide to patients and families.

Food and drink strategy

We launched our Food and Drink Strategy last month, setting out how we will improve nutrition, hydration and food services for patients and visitors over the next three years.

Priorities include timely nutrition screening for every patient and nutritious food that meets cultural, religious and dietary needs. The strategy also sets out the skills and tools staff need, stronger monitoring and governance, and improvements informed by patient feedback.

We will develop digital monitoring, reduce food waste and support nutrition champions in clinical areas. Progress will be measured against targets for nutrition screening, patient satisfaction and compliance with food standards.

Vascular outpatient care

Colleagues at Worthing Hospital brought together consultants, resident doctors, nurses and support staff for a single-day vascular outpatient initiative that saw 260 patients. Many had waited a year for assessment of conditions affecting their mobility, comfort and daily lives.

The event reduced waits and allowed the team to test a different way of organising outpatient care at scale. Too many patients are still waiting too long, but this work shows what teams can achieve through careful planning and a shared focus on timely care.

Inherited cardiac conditions

Our new Inherited Cardiac Conditions service gives patients and families better access to specialist screening and genetic testing. It is the first dedicated service of its kind available locally in the South East.

The service provides a formal programme of family screening and genetic testing to improve diagnosis, simplify referrals and provide timely specialist care. Around 300 relatives of patients with an inherited cardiac condition have already been screened, with 25 found to have features of the familial condition.

STAR Awards

Soon after our last Board meeting, I had the pleasure of presenting our annual STAR Awards. More than 500 teams and individuals were nominated by colleagues and patients across 10 categories linked to our Excellent Care Everywhere strategy and the values and behaviours that support it.

This is one of my favourite events of the year. It gives us the chance to hear about work that can otherwise go unrecognised and to thank colleagues for the difference they make. The stories shared were a reminder of the exceptional care being delivered across our hospitals and services every day.

Clinical research

Our Research and Innovation Annual Review records that more than 7,000 people took part in research in our hospitals during 2025/26, an increase of 38% on the previous year. This places UHSussex in the top 25% of acute trusts nationally for patient participation and the top 20% for actively recruiting studies.

We also welcomed Professor Lucy Chappell, DHSC Chief Scientific Adviser and Chief Executive of the National Institute for Health and Care Research (NIHR). She saw how UHSussex and Brighton and Sussex Medical School researchers are working with public and private partners across the region.

Her visit coincided with the first anniversary of the NIHR Commercial Research Delivery Centre Sussex. With 33 commercial trials active, the centre is expanding access to industry-sponsored studies and helping more people benefit from research closer to home, in support of Excellent Care Everywhere.

Other recent research includes a potential treatment for people living with heart failure and obesity, improvements to long-term follow-up for stroke survivors, and evaluation of the benefits of Family Integrated Care across our neonatal services.

Compass and Values Week

In October, we held our first Compass and Values Week to coincide with World Values Day and the first anniversary of Everyday Stars. It encouraged teams to reflect on our values and use the Behavioural Compass to consider how we work together, particularly under pressure.

Daily Compass Challenges gave teams a prompt for discussion in huddles and an opportunity to agree a small change in their practice. I also enjoyed speaking with NHS Online Chief Executive Dame Caroline Clarke in our latest Compass Conversation. We discussed leadership, organisational culture, digital innovation and her experience of leading large organisations through difficult change.

Everyday Stars allows colleagues to thank one another for showing compassion, inclusion and respect. More than 10,000 stars were awarded in its first year. Worthing and Southlands outpatients received the most team recognition, while Worthing library manager Sally Baker and communications digital editor Dun Stock were the most recognised individuals, receiving 51 stars between them. My thanks to everyone who has taken the time to recognise a colleague.

GMC National Training Survey

The 2026 GMC National Training Survey shows improvement across all four headline measures of resident doctors' experience at UHSussex. Of the 650 doctors who responded, 82% rated their training as good or very good and 87% said the same of their clinical supervision. The proportion of indicators flagged as areas of concern fell to its lowest level in three years, with particularly encouraging improvements in several specialties previously subject to deanery intervention. I welcome this progress and thank colleagues for their work. There are, however, continuing concerns about workload, supervision and culture, with 20 specialty areas requiring formal responses to the deanery. Targeted improvement plans have been submitted, with delivery monitored through our education governance arrangements and deanery oversight. We must ensure that improvements are sustained and that both resident doctors and their trainers have the time, support and working environment needed for good training and safe patient care.

University Hospitals Sussex NHS Foundation Trust

Agenda Item:	9.	**Meeting:**	Trust Board in Public	**Meeting Date:**	12 November 2026
Report Title:	Response to the Thirlwall Inquiry and NHS England correspondence published on 22 September 2026				

Sponsoring Executive Director:	Professor Catherine Urch, Chief Medical Officer Gail Byrne, Interim Chief Nursing Officer			
Author(s):	Claire Hunt, Divisional Director of Nursing for Children and Gynaecology			
Purpose of the report: *(indicate as appropriate)*	**For Decision**	**For Assurance**	**For discussion**	**For Information only**
		Yes	*Yes*	
Reason for not being taken in public *(indicate as appropriate)*	**Commercial confidentiality**	**Staff confidentiality**	**Patient confidentiality**	**Other exceptional circumstances (please detail)**
	N/A	*N/A*	*N/A*	*N/A*
Regulatory Reporting Requirement	*Yes*			

Summary of the report describing

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

This paper provides the Board with an initial assessment of the implications of the Thirlwall Inquiry for University Hospitals Sussex NHS Foundation Trust and an update on the immediate actions required by NHS England following publication of the Inquiry's final report.

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 paper seeks assurance on the Trust's initial response and proposes a coordinated programme of further review and improvement. This will enable the Board to test whether the Trust's systems, culture and leadership would reliably recognise, triangulate, escalate and act upon concerns about potential harm to babies, children or other patients.

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

Recommendation
(linked to What Next section)

Members of the Board are asked to: -

- Note the findings of the Thirlwall Inquiry and the immediate requirements issued by NHS England.
- Note completion of the initial SUDIC communication and the further work under way in relation to local guidance, bereavement care, safeguarding and insulin security.
- Recognise that further assurance is required to demonstrate that relevant controls are effective in practice, rather than relying solely on confirmation that policies and processes are in place.
- Support a coordinated Trust-wide programme of review, improvement and assurance, delivered through existing governance arrangements and aligned with the wider maternity and neonatal improvement programme.
- Require executive oversight of the delivery of CCTV covering neonatal insulin storage by 30 November 2026, with any risk to delivery escalated promptly.
- Receive a further assurance report setting out:
  - progress against each immediate NHS England requirement;
  - identified gaps, risks and mitigating actions;
  - evidence concerning the effectiveness of speaking-up, safeguarding and escalation arrangements;

	○ the outcome of the bereavement pathway gap analysis; ○ confirmation of insulin security implementation; and readiness for further national requirements arising from the Inquiry.
Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*	*Quality Governance Steering Group* *Patient & Quality Assurance Committee – 3 November 2026*

Link to Trust Strategy (note which theme)	**Patients**	**People**	**Future**	**Communities**	**One UHSussex**	**Culture**
	Yes	Yes	Yes	Yes	Yes / N/A	*Yes*

Link to annual delivery plan	*1.4 Fairness in access, experiences and outcome.*
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc	SR3 Improving safety and experience This paper outlines a requirement for greater assurance to demonstrate that relevant controls are effective in practice

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*

University Hospitals Sussex
NHS Foundation Trust

1. Executive summary

1.1. The final report of the Thirlwall Inquiry was published on 15 September 2026 following its examination of events at the Countess of Chester Hospital between 2015 and 2018. The Inquiry describes profound failures of management, governance and safeguarding and has implications extending beyond neonatal services and the circumstances of one organisation.

1.2. NHS England subsequently asked every Trust and integrated care board to consider the report at its next available public Board meeting and to reflect explicitly on whether similar events could occur within its own organisation. Immediate requirements were also set in relation to Sudden and Unexpected Death in Children processes, bereavement care, safeguarding and the security and storage of insulin.

1.3. The Trust has undertaken an initial review against these requirements. Communication confirming the application of the SUDIC process to unexpected neonatal deaths was issued to relevant clinical groups on 23 September 2026 and shared onwards with the Board. Further neonatal-specific local guidance is being developed.

1.4. Work is also progressing on the National Bereavement Care Pathway, safeguarding assurance and insulin security. The initial review has not identified an immediate issue requiring escalation comparable to the circumstances described by the Inquiry. However, further evidence is required before comprehensive assurance can be provided about the consistent operation and effectiveness of controls across the organisation.

1.5. The required response must therefore extend beyond confirmation that policies and reporting routes exist. The central question for the Board is: “Could similar circumstances occur here, and what evidence demonstrates that our systems and culture would identify and respond to concerns rapidly and effectively”?

1.6. The Trust has established mechanisms through which concerns may be raised, including safeguarding services, incident reporting, mortality review, Freedom to Speak Up, complaints, PALS, patient experience routes and executive escalation. The next phase of work will test whether those routes are understood, accessible, trusted and responsive; whether information from different sources is triangulated; and whether concerns reach people with the authority to act without avoidable delay.

2. Immediate national requirements and Trust position

2.1 SUDIC processes

NHS England required Trusts with neonatal units to communicate to relevant staff and Boards that the SUDIC process applies to every unexpected death, or collapse leading to death, of a baby or child where no pre-existing medical cause is apparent. This includes unexpected deaths within neonatal units and cases involving babies who have never left hospital.

The Trust issued communication to the Neonatal and Paediatric Consultant groups on 23 September 2026, setting out the requirement to follow SUDIC processes alongside the Trust’s internal incident reporting and investigation arrangements. The communication was shared onwards, including with the Board.

The neonatal team is developing further neonatal-specific local guidance for ratification through Trust governance and publication in an accessible location. Further assurance will be provided through ratification and implementation of the local guidance, together with evidence that relevant staff understand the process and know how to initiate it.

2.2 National Bereavement Care Pathway

The neonatal team has undertaken an initial review against the National Bereavement Care Pathway for neonatal death. This indicates that the pathway is substantially reflected in current Trust arrangements, but a more detailed cross-organisational gap analysis and evidence review is under way. This work will:

- assess implementation against all relevant standards;
- collate evidence to substantiate compliance;
- identify and address unnecessary variation between sites;
- ensure that the experience and needs of bereaved families inform the assessment
- report any unresolved risks through divisional and Trust governance.

2.3 Safeguarding

The Inquiry highlights the importance of recognising potential deliberate harm as a safeguarding concern and of acting on concerns without waiting for certainty. Patient protection must remain the primary consideration and must not be delayed by employment processes, professional relationships or concerns about organisational reputation.

There are established routes through which staff can raise safeguarding concerns and access to specialist advice and support. Safeguarding risks are reported through existing governance arrangements. However, the existence of a pathway does not demonstrate that staff understand or feel able to use it, or that concerns are consistently escalated and acted upon.

Safeguarding Children Level 3 training compliance was reported in the Trust's March 2026 training needs analysis as 80.9% across the Trust and 91.7% within the Women and Children's Division. These figures require continued scrutiny and improvement, alongside assurance staff have completed the level of training appropriate to their responsibilities. Most of the Board members have completed their level 1 safeguarding training with the exception being the newly appointed NED's. It is proposed that a Board development session includes a session on the overarching responsibilities of the Board on safeguarding.

Further assurance work will test: -

- staff knowledge of safeguarding and escalation routes;
- accessibility and responsiveness of specialist safeguarding support;
- the handling of concerns where deliberate harm cannot be excluded;
- interfaces between safeguarding, mortality, patient safety, workforce professional processes
- the prominence given to safeguarding babies and children within divisional and Board reporting.

2.4 Insulin safety and security

The GIRFT neonatal guidance sets expectations for safe storage, access, handling, prescribing, administration and disposal of insulin. These include individually identifiable and auditable access, restricted access to medicines storage areas, locked medicine fridges or cupboards, two-person checking, appropriate staff training and regular audit of insulin use and related incidents.

Within the Trust, insulin is stored only on the Neonatal Intensive Care Unit at the Brighton campus. Medicines are held within a room controlled by auditable swipe access, and insulin is stored in a digilocked refrigerator within that room. Biometric access is not currently available.

CCTV arrangements focused on the insulin storage area are being progressed. NHS England's specified implementation date is 30 November 2026, with recordings to be retained for at least 28 days. The wider GIRFT access-control and storage requirements are to be met by 31 March 2027.

2.5 **Work to develop plans for all cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video**)
This is so that parents can observe their baby remotely at any time. A national approach and standard operating procedure are being developed to support neonatal units to implement this and will need to be handled sensitively.

2.6 Wider organisational assurance
The significance of the Inquiry is not limited to neonatal medicines security or death-review processes. It challenges the Trust to consider whether apparently isolated signals could remain unrecognised because information is held across different services or governance routes. The next phase should therefore include a Trust-wide assessment of whether:

- concerns raised by staff, patients and families are listened to and acted upon;
- clinical incidents, mortality, complaints, safeguarding, workforce and speaking-up information are effectively triangulated;
- unusual patterns and repeated concerns are visible to senior leadership and the Board;
- professional challenge and curiosity are supported in practice;
- safeguarding action is initiated where potential deliberate harm cannot be excluded;
- decisions and rationales are recorded clearly and reviewed at an appropriate level;
- families receive open, compassionate and timely communication; and
- staff working in neonatal and other high-risk services can access appropriate wellbeing and psychological support.

This approach is consistent with the principles of the NHS England Insightful Provider Board guidance, which asks Boards to consider how leadership behaviours and organisational culture affect the information received and the action taken. [england.nhs.uk]

The work should be coordinated through existing Trust governance rather than creating a separate, duplicative reporting structure. The developing maternity and neonatal assurance arrangements provide a route for oversight of national reviews, learning from deaths, patient and family feedback, safeguarding, workforce, risk and improvement actions, with escalation to the Board where assurance is insufficient.

3. Conclusion

The Trust has responded to the immediate national requirements arising from the Thirlwall Inquiry. The required SUDIC communication has been completed, while work relating to bereavement standards, safeguarding assurance and insulin security remains in progress.

The Board cannot yet take full assurance solely from the presence of policies, committees and reporting mechanisms. Further work is required to demonstrate that controls operate

consistently in practice; that concerns from different sources are brought together; that unusual patterns are identified; and that action to protect patients is timely and effective.

A coordinated Trust-wide programme of review, improvement and assurance, delivered through existing governance arrangements, will provide the mechanism for this work and enable the Board to receive continuing evidence of implementation, effectiveness and sustained organisational learning.

University Hospitals Sussex NHS Foundation Trust

Agenda Item:	10.	**Meeting:**	Trust Board in Public	**Meeting Date:**	12 November 2026
Report Title:	Strategy Delivery & Improvement Plan (Integrated Improvement Plan) - November 2026 Update				
Sponsoring Executive Director:	Rox Smith, Chief Strategy Officer				
Author(s):	Joe Mills, Director Strategy, Jenny Preece, Deputy Director Strategy				
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	NHSE Undertakings 2026				

Summary of the report describing

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

Our Strategy Delivery & Improvement Plan (SDIP) sets out UHSussex's priorities for recovery and improvement in 2026/27 and was submitted to NHSE on 30 September 2026. It prioritises core operational standards, financial recovery and the foundational changes needed to sustain improvement, aligning resources and recovery actions behind them.

The plan responds to the Undertakings agreed between the UHSussex Board and NHSE in June 2026 and incorporates our financial recovery plan. **Undertaking 3.1 requires the plan to be place by 30 September 2026 this was achieved.**

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)***

Developed by the new Executive Leadership Team with strong clinical and operational engagement, the SDIP brings together national, regional and Trust priorities in support of our strategy, *Excellent Care Everywhere*.
Delivery of the plan is already underway:

- Our priority recovery outcomes for March 2027 are **improved RTT**, **cancer and urgent and emergency care performance, and financial recovery**. The weekly CEO-led Recovery Board oversees delivery, using early-warning indicators to trigger timely corrective action. Corporate delivery capacity and external support are aligned to these priorities, alongside investment in internal capability.
- Sustained recovery also requires stronger leadership and management, a more inclusive culture and significant service transformation. The plan also focuses on **quality, safety and learning; people, voice and inclusion; culture, leadership and the operating model; and governance and improvement**.
- These priorities form a single, coherent programme, with clear ownership, measurable milestones and outcomes, transparent monitoring and escalation. This provides a direct line of sight between the NHSE Undertakings, our strategic priorities, delivery actions and agreed performance measures.

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

A first report of the new SDIP was received by Strategy and Major Projects Assurance Committee on 5 November. Feedback from this meeting will be incorporated into subsequent updates of the SDIP and the Board will receive the full plan in December.
Final elements of the reporting cycle will be aligned through November, addressing temporary dual reporting. December Public Board will receive the full plan and

	October performance dashboards. During Q3, SROs will refine action plans and Board-level measures and initiate 2027/28 plans; Committees will receive Q3 dashboards in January/February 2027. The remaining Excellent Care Everywhere priorities will transition into the SDIF, aiming to cover all 20 by March 2027.
Recommendation *(linked to What Next section)*	The Board is asked to: 1. **Note** that the plan has been submitted in line with the requirements of the NHSE Undertakings. 2. **Agree** the proposed reporting cycle to Committees, as discussed at Strategy & Major Projects Assurance Committee on 5 November, including their role in driving delivery confidence, specifically: *The role of the Committees is to seek assurance from the Executive leads and SROs for the elements of the SDIF which report into them. Assurance must be gained on the plans being on track, KPIs being delivered and that we understand the risks or issues within them and have a plan to mitigate. Each Committee Chair will need to report back on the status and progress of the relevant SDIF programmes to the Board every quarter.*
Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*	EMC – 28 October 2026 & Strategy & Major Projects Assurance Committee - 5 November 2026, reviewed the assurance report and discussed the proposed reporting cycle.

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 SDIP sets out the Trust's 2026/27 recovery and improvement priorities, incorporating financial recovery and agreed operational trajectories to March 2027.*
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 SDIF sits across all our BAF risks and is fundamental to improving our provider capability.

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 an HEIA been completed?*)**	**Environmental**	**Legal**	**External Registrations *(if yes please indicate which)***
	Yes / N/A (Yes / No)	*Yes / N/A*	*Yes / N/A*	*Yes / N/A*

We are compassionate
We are inclusive
We are respectful

NHS
University Hospitals Sussex
NHS Foundation Trust

Strategy Delivery & Improvement Plan (Integrated Improvement Plan)

November 2026 Update

Trust Board

12 November 2026

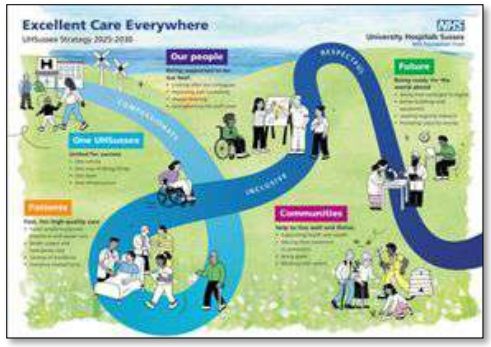


Excellent Care Everywhere

In September we submitted our Strategy Delivery & Improvement Plan (SDIP) to NHS England South East

University Hospitals Sussex
NHS Foundation Trust

- Our Strategy Delivery & Improvement Plan (SDIP) sets out UHSussex's priorities for recovery and improvement in 2026/27. **It prioritises core operational standards, financial recovery and the foundational changes needed to sustain improvement, aligning resources and recovery actions behind them.**
- The plan responds to the Undertakings agreed between the UHSussex Board and NHSE in June 2026 and incorporates our financial recovery plan. Undertaking 3.1 requires an integrated improvement plan to be place by 30 September 2026 and has now been achieved.
- Developed by the new Executive Leadership Team with strong clinical and operational engagement, it brings together national, regional and Trust priorities in support of our strategy, *Excellent Care Everywhere*.
- Delivery of the plan is already underway.
  - Our priority recovery outcomes for March 2027 are improved RTT, **cancer and urgent and emergency care performance, and financial recovery**. The weekly CEO-led Recovery Board oversees delivery, using early-warning indicators to trigger timely corrective action. Corporate delivery capacity and external support are aligned to these priorities, alongside investment in internal capability.
  - Sustained recovery also requires stronger leadership and management, a more inclusive culture and significant service transformation. The plan also focuses on **quality, safety and learning; people, voice and inclusion; culture, leadership and the operating model; and governance and improvement**.
- These priorities form a single, coherent programme, with clear ownership, measurable milestones and outcomes, transparent monitoring and escalation. This provides a direct line of sight between the NHSE Undertakings, our strategic priorities, delivery actions and agreed performance measures.
- An assurance report was reviewed by Strategy and Major Projects Assurance Committee on 5 November. We will bring the full plan and first update on progress to the Board in December.







The plan sets clear end year goals with early warning triggers, mapped to our statutory undertakings and Excellent Care Everywhere priorities

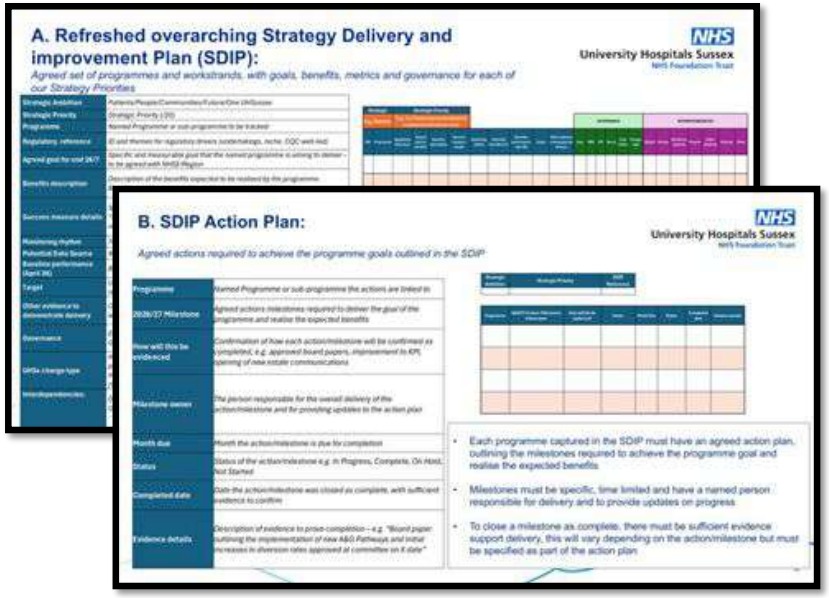
Delivering faster, safer and more productive care now, while building the foundations for sustainable improvement.

	RECOVERY/ IMPROVEMENT PRIORITY	OUR 2026/27 GOAL	PRINCIPAL DELIVERY PROGRAMMES	BOARD LEVEL SUCCESS MEASURES (BY MAR-27)	REGULATORY / NATIONAL CONTRIBUTION	ECE STRATEGIC PRIORITY
RECOVERY	**1 Faster Access to Planned Care**	**Deliver the annual elective recovery trajectory and reduce long waits through consistent core processes, productivity and targeted pathway transformation.**	• Outpatient & theatre productivity • Elective operating model • Priority specialties • Diagnostics • Cancer pathway transformation	**RTT recovery trajectory delivered ↑61%** **Cancer wait-time standards delivered ↑** Theatre utilisation ↑ >6-week diagnostics waits ↓	NHSE U2.1 RTT / cancer constitutional standards NOF elective / productivity	1.1 Faster Access to Planned Treatment and Cancer Care
RECOVERY	**2 Better Urgent & Emergency Care**	**Deliver safer, more timely emergency care through the right pathway first time, improved flow and discharge, and elimination of routine corridor care.**	• Front Door, Streaming & SDEC • Hospital Flow, LOS & Discharge • Escalation Space / Corridor Care • ED Quality, Safety & Experience	**4-hour performance ↑ nat. standard** 12-hour waits ↓ A&E handovers >45 mins↓ Corridor waits >45 mins ↓	NHSE U2.2 / U2.3 CQC safety; UEC constitutional standards NOF UEC / quality	1.2 Better Urgent and Emergency Care
RECOVERY	**3 Financial Sustainability & Productivity**	**Deliver the agreed year-end position, reduce the underlying run-rate and build a recurrent, productivity-led route to financial sustainability.**	• Financial recovery, grip & control • CIP / benefits; workforce efficiency • Trust-wide productivity; income & cash • 2027/28 financial sustainability	**Year-end financial position achieved** Efficiency programme delivered ≥4% productivity Bank / agency WTE ↓ liquidity improved	Financial sustainability / provider capability NOF finance / productivity	4.4 Providing Value for Money
IMPROVEMENT	**4 Quality, Safety & Learning**	**Improve outcomes while ensuring recovery, productivity and cost improvement are safe and clinically led.**	• Quality Improvement & Learning • DMS and FSC • Patient Safety & Experience • Health Inequalities • Strengthened QIA & Benefits Assurance	**Patient experience ↑** Harm reporting ↑ Repeat & serious harm ↓ SHMI Hosp Acquired infections Overdue safety investigations.	CQC Well-Led NHSE U1 requirements Niche findings • NOF quality	1.4 Fairness in access, experience and quality outcomes
IMPROVEMENT	**5 People, Voice & Inclusion**	**Improve staff experience, inclusion and psychological safety - speaking up leads to action.**	• Every Voice Matters • Speaking Up & Feedback • Inclusion & Workforce Experience • Wellbeing	**Staff Survey ↑ provider median** Speaking-up confidence ↑ Discrimination gap ↓ Sickness ↓ Overpayment ↓	NHSE U1.1.5/U1.1.6 CQC equality / speaking up Niche N10/N21 • NOF People	2.1 Looking after our colleagues 2.4 Strengthening the Staff Voice
IMPROVEMENT	**6 Culture, Leadership & Target Operating Model**	**Build a compassionate, inclusive and accountable culture with visible leadership at every level working together to lead One UHSussex**	• Values, Behaviours & Culture • Leadership & Management Development • One Team - TOM • Inclusive and collective leadership	**Behavioural compass** awareness ↑ Experimenteers ↑ Leadership training ↑ TOM implemented; accountability & decision-making clearer Leadership vacancies filled (Full cultural dashboard in development)	NHSE U1.1.4 CQC culture / leadership Niche N1/N4/N5 • NOF leadership	5.1 One UHSx Culture 5.3 One Team
IMPROVEMENT	**7 One UHSussex: Governance & Improvement**	**Create one coherent well-led organisation with clear accountability and consistent strategy, improvement, risk and assurance.**	• New Target Operating model, and accountability • Single framework aligning: • Strategy/improvement delivery • Risk/Assurance Framework • Integrated Assurance report	% SDIF programmes delivering to plan % SDIF extended to ECE priorities % Risk fully assessed [controls/mitigations/actions] % Risks actions & reviews delivered on time	NHSE U1/U3/U4 • CQC governance Niche N6/N9/N11/N13/N17 NOF leadership/capability	5.4 One Infrastructure
	ONE DELIVERY DISCIPLINE	• Weekly, monthly and quarterly assurance cycle – proportionate to delivery cycles, enabling real-time recovery action and broader strategic overview. • Agreed 'early warning triggers' which will lead to action at Weekly Recovery Board/Monthly Programme Board.				

Our plans have been developed with significant engagement and constructive challenge

University Hospitals Sussex NHS Foundation Trust

- With our **new Managing Directors and Chief Delivery Officer**, and Phase one of our Target Operating Model for divisional leadership in place, the development of this plan has given our new leaders the opportunity to set their priorities right from the start.
- We have benefited from constructive challenge and insight from **NHSE national and regional teams**, and the involvement of our new cadre of **Clinical Directors**.
- With its focus on 2026-27 recovery, delivery of this plan will consolidate the foundations of our journey to establish One UHSussex – Excellent Care Everywhere.











"This is the best cross-Trust and cross-site clinical engagement I have seen on these issues in years."
Divisional Medical Director, UEC challenge session

"It was a great session... We had some incredibly valuable conversations at our table, and it was clear how engaged and committed everyone is to making it work."
NHSE SE colleague at People challenge session

Assurance of delivery will be managed through our new cycle of weekly, monthly and quarterly reporting

University Hospitals Sussex NHS Foundation Trust

Weekly Recovery Board

- Chair: CEO
- Monitors **operational and financial** trajectories, with SROs accountable for slippage and for taking action where early warning triggers are identified.
- **Papers:** Recovery Dashboard showing performance against plan for key operational KPIs.

Monthly Programme Boards

- Chair: Exec or EMC-SRO
- Monitors **action plan milestones**, viewed **alongside KPIs**, every month.
- Responsible for **agreeing that milestones have been completed** (and must record evidence that demonstrates this), and for agreeing and monitoring **actions where milestones have slipped**.
- Regularly reviews overall programme performance and can adjust resourcing or priorities against the agreed plans where necessary to maximise impact on KPIs.
- **Papers:** Monthly SRO-level dashboard and Actions Due (from Monday.com)

Quarterly assurance reports to Assurance Committees

- Chair: Non-Exec Director
- Receives Quarterly report on progress against Action Plan Milestones and overview of performance against KPIs and agreed trajectories – as well as SRO reports from relevant programme boards, including where remedial actions have been taken.
- Strategy team will additionally provide advice on performance across the full SDIF, including issues of under performance or interdependencies which require action at Committee or Board level. These reports will go to Strategy and Major Projects Assurance Committee, copied to all Assurance Committees.
- **Papers:** Quarterly dashboard to all relevant Assurance Committees (from Monday.com). Strategic Analysis of performance from Strategy Team to SMPAC.

RECOVERY/ IMPROVEMENT PRIORITY	BOARD COMMITTEE	EXECUTIVE LEAD	EXECUTIVE MANAGEMENT COMMITTEE LEAD	REPORTING CYCLE
1 Faster Access to Planned Care	Finance & Performance Assurance	Alex Shaw Katie Urch	James Watts: Planned Care Maria Emmanuel: Cancer	weekly/monthly/quarterly
2 Better Urgent & Emergency Care	Finance & Performance Assurance	Alex Shaw Gail Byrne	Wilson Dodzo	weekly/monthly/quarterly
3 Financial Sustainability & Productivity	Finance & Performance Assurance	Jonathan Reid	Martin Sheldon	weekly/monthly/quarterly
4 Quality, Safety & Learning	Quality and Safety Committee	Gail Byrne	Tori Cooper Hannah Smith	monthly/quarterly
5 People, Voice & Inclusion	People & Culture Assurance	Roxanne Smith Sarah-Jane Taylor	Sarah Richardson* *from Nov 2026	monthly/quarterly
6 Culture, Leadership & Target Operating Model	People & Culture Assurance	Roxanne Smith Sarah-Jane Taylor	Martyn Clark	monthly/quarterly
7 One UHSussex: Governance & Improvement	Strategy & Major Projects Assurance/ Audit & Risk Committee	Andy Heeps Roxanne Smith	Glen Palethorpe	monthly/quarterly

The role of the Committees is to seek assurance from the Executive leads and SROs for the elements of the SDIF which report into them. Assurance must be gained on the plans being on track, KPIs being delivered and that we understand the risks or issues within them and have a plan to mitigate. Each Committee Chair will need to report back on the status and progress of the relevant SDIF programmes to the Board every quarter.



Next steps:

University Hospitals Sussex
NHS Foundation Trust

- Through November, **final elements of the new delivery and assurance cycle will be aligned**, including to address areas where we temporarily have dual reporting
- December Public Board will receive a **full report on the Plan**, and October performance dashboards
- **The SDIF has established a new delivery rhythm and discipline**, which will grow in maturity. SROs are expected to hold teams and colleagues to account for milestone delivery and updating the SDIF plans and Metrics.
- Through Q3, further iterations of the SDIF plans and dashboards will take place, with **reviews and updates to the Action Plans and Board level Metrics**, where SROs have additional information to add, expected across the seven Portfolios – including initiating **plans for 2027/28**
- We will **transition the remaining *Excellent Care Everywhere* strategic priorities** into the SDIF, aiming for all 20 strategic priorities to be managed through this consistent approach by end March 2027
- All accountable Committees will receive SDIF dashboards, alongside updates on progress from their programme boards, for their **Q3 Committees in January/February 2027**
- We will continue to discuss the **resource required to achieve our plans** at each weekly recovery Board and what we may need to pause or stop to ensure core delivery is maintained

Excellent Care Everywhere

The Board is asked to

University Hospitals Sussex
NHS Foundation Trust

- **note** that the plan has been submitted, in line with the requirements in the NHSE Undertakings

- **agree** the proposed cycle of reporting to Committees, as discussed at SMPAC on 5 November, including the role Committees will playing in driving delivery confidence, as set out on slide 5.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	11.	**Meeting:**	Trust Board in Public	**Meeting Date:**	12 November 2026
Report Title:	Research, Innovation and Digital Assurance Committee Chair's Report				
Author(s):	Professor 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**
	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 provides information on the business undertaken at the Research, Innovation and Digital Strategy Assurance Committee on 4 November 2026. The meeting was quorate at its commencement. The meeting was quorate and the Committee received its scheduled business.

The Board can take assurance from the Committee's oversight of the Trust's research, innovation and digital portfolios. The Committee received positive assurance on research delivery and commercial research performance, the approach to digital inclusion, mobilisation of the Electronic Patient Record programme, progress across the digital workplan, and recovery action within the Sussex Pathology Network. This assurance was qualified by material risks concerning research workforce capacity, the Clinical Research Facility programme, cyber and information governance compliance, digital capacity and the interdependency of major digital changes planned for 2027.

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)*

Having triangulated the Board Assurance Framework with the reports received, the Committee supported Strategic Risk 7 remaining at 20 and recommended that Strategic Risk 9 increase from 16 to 20. The increase reflects reduced assurance over the Clinical Research Facility major project and research workforce capacity, both of which are central to delivery of the Trust's research ambitions.

What Next *(summary of intended action and benefits supporting the choices and recommendations made)*

The Board can receive the BAF with confidence knowing that the content and scores for the new strategic risks 7 and 9 have been scrutinised by the Research, Innovation and Digital Assurance Committee.

Recommendation *(linked to What Next section)*

The Board is asked to NOTE:
- **The Committee was quorate and considered all the expected reports in line with its schedule of business**
- **The Committee's assurance over the digital and research & innovation domains.**
- **The Committee's recommendation that Strategic Risk 7 remain at 20 and Strategic Risk 9 increase from 16 to 20.**

Assurance route already undertaken

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

Link to annual delivery plan

The Committee provides oversight of the delivery of the Trust's research, innovation and digital domains that are aligned to the Trust's Strategy which supports the delivery of the Trust's annual plan.

Link to BAF

The Committee has oversight of the key assurances referred to within the BAF for new strategic risks 7 and 9 and through their scrutiny of these recorded assurances consider and recommend to the Board their relevant current scores.

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

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

University Hospitals Sussex
NHS Foundation Trust

Research, Innovation and Digital Assurance Committee Chair's Report

The Research, Innovation and Digital Assurance Committee met on 4 November 2026 and was quorate, with the 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 November meeting are listed below, noting the full breadth of the meeting's activity is included in a table at the end of this paper.

Research and Innovation

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

Research Delivery, Performance and Finance

The Committee received the Quarter 2 Research Delivery Plan, performance and finance reports and took assurance from continuing growth in interventional and commercial research. The revised performance format was welcomed as clearer and more closely aligned with the national framework for NHS boards' oversight of research. The Committee noted 7,990 participants in NIHR portfolio studies over the 12 months to September 2026, including 4,602 in interventional studies, and 192 studies open to recruitment, including 49 commercial studies. UHSussex remained within the top 20% of acute trusts for participation and recruiting studies in 2026/27 year to date.

Commercial Research Delivery Centre performance remained strong. Performance was slightly below the 60-day target because of one protracted contract-signing process, but the delay was recovered through rapid recruitment, and all applicable studies met the 90-day measure. Members welcomed work to streamline internal delivery pathways, use digital approaches to identify participants, and particularly to widen access through primary and community care and develop a GP mentoring scheme for future commercial principal investigators.

The Committee agreed that commercial and non-commercial performance should increasingly be presented as an integrated view of the whole research portfolio. This would provide assurance that commercial growth is not being achieved at the expense of non-commercial and investigator-led research. Members also requested development of routine inclusion data, recognising the current concentration of research in particular specialties and sites, and the growing activity in primary community care. A future Research Engagement Network deep dive should support oversight of equality, diversity and inclusion in research participation.

The Committee noted that the Research and Innovation budget had reduced from a net cost of £2.19m to £1.33m following application of the Trust's financial recovery requirements, with a £0.067m adverse year-to-date variance at Month 6. Commercial income was expected to grow, but the supporting data and arrangements for ring-fencing capacity-building income

required further strengthening with directorate, commercial performance, commissioning and finance colleagues.

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

The Committee considered significant recruitment and backfill constraints affecting research delivery posts, externally funded roles, fellowships, secondments and specialist nursing capacity. Although eligible externally funded posts had been exempted from recruitment controls and were progressing to advert, the Committee was concerned that delays could undermine delivery of funded grants, commercial contracts and the wider research strategy. Members also noted the risk that staff would not see research as a practical element of career development if services could not release or backfill individuals.

The Committee recognised the mitigating work undertaken through the Trust Operating Model, research leadership roles, job-planning guidance and workforce restructuring. However, it concluded that a longer-term strategic workforce response was required rather than reliance on case-by-case arrangements. The matter was therefore referred to the People and Culture Committee to consider how the five-year strategic workforce plan will enable research careers, planned secondments, externally funded appointments and timely backfill, including for highly specialised nursing and multiprofessional roles

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 received reduced assurance over the Clinical Research Facility major project. The Princess Royal Hospital element was reported as approximately five months delayed, with completion forecast for August 2027 and the cost estimate increased. The Louisa Martindale Building element was forecast for completion approximately six months later than originally planned. The programme remained particularly exposed to design, procurement, premises condition, unresolved funding and partnership dependencies.

Members were concerned that delay or reduction in scope could adversely affect the strong progress to date in research activity and funding, our research partnership with other NHS Trusts, jeopardise current and future NIHR funding and compromise a core mitigation for the Trust's research estates risk. Given the importance of an operational central facility and the interconnected workforce risks, the Committee concluded that the evidence no longer supported retaining Strategic Risk 9 at 16 and recommended that the score increase to 20.

Innovation and Research Partnerships

The Committee considered the Trust's approach to adopting innovative technology. The review identified inconsistent uptake of nationally supported MedTech innovations and weaknesses in the interaction between clinical services, procurement, commissioning and finance. Members emphasised that NICE assessment of cost effectiveness does not in itself establish local affordability and that the pathway to any proposed adoption should be supported by an appropriate business case, benefits assessment, commissioning route and implementation plan. A further update will return with specific progress on the identified

technologies and processes for alignment with the Trust's wider technology-appraisal and adoption arrangements.

The Sussex Health and Care Research Partnership reported delivery of 18 of 22 first-year indicators and movement from an establishment phase towards demonstrable impact and sustainability. The Committee welcomed progress in collaborative grant development, community engagement, training and research infrastructure. It noted capacity pressures and asked for continued attention and support in Secure Data Environment and data-sharing arrangements, translation of research into practice, sustainable specialist expertise and clearer evidence of system-level impact.

Digital

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

Deep Dive / Digital Inclusion

The Committee received a deep dive on digital inclusion and took assurance that the issue is being addressed across the Trust. Existing activity includes ensuring accessible information, community outreach, library support, patient education, digital-service support and the retention of telephone, paper and face-to-face routes. Members emphasised that digital inclusion is not solely a technology issue. It is a collective organisational responsibility concerned with how patients and communities contact, understand and experience Trust services, and securing good outcomes for all groups.

The Committee supported a digital-first but not digital-only approach. Members recognised that some people may wish to choose not to use digital channels, while others face barriers associated with access, skills, confidence, language, disability, deprivation or trust. Digital channels should release capacity to provide more tailored support to people and communities who are require more support in the context of a digital-first offer. The Trust should continue to offer meaningful choice during transition and avoid assuming that NHS App uptake demonstrates equitable access or outcomes.

The Committee noted that the Director of Voice would have a convening role, supported by Digital, Patient Experience, Patient Education, the Library and Knowledge Service, clinical and operational teams and community partners. It asked that digital exclusion risks and opportunities to enhance communication and reach should be considered within each individual programme and pathway, including EPR design. In particular, EPR workflows should in future routinely prompt review and confirmation of a patient's communication needs and preference and whether that preference remains suitable. The importance of co-production and involving communities while avoiding making assumptions about particular groups was emphasised. The Committee requested regular assurance updates setting out the agreed governance, measures, patient involvement and support model.

Digital Data Delivery Plan

The Committee received the Quarter 2 Digital and Data Delivery Plan and noted that delivery had proceeded broadly as anticipated. Progress included remote data-centre resilience, Wi-Fi assessment and remediation, electronic observations and EPMA, speech recognition, patient-facing communications, Mindray deployment to medical wards at the Royal Sussex County Hospital and Princess Royal Hospital, development of the Strategic Data Platform and work on automation and artificial intelligence, including a controlled Microsoft 365 Copilot Premium trial.

Members noted that demand continued to exceed available digital and operational capacity. The Committee supported the safety rationale for the technical and resource change controls endorsed by the Executive Management Committee to protect the PAS and theatres

upgrade, EPR and Sussex Pathology Network. Members also discussed using future print-fleet replacement as an opportunity to support a managed transition towards less paper-dependent working. The Committee requested clearer future reporting of benefits realisation and outcomes, rather than activity and milestone delivery alone.

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 the phased EPR implementation plan, including technical go-live in April 2027 and the first functional phase in May 2027. The modular approach was intended to reduce implementation and productivity risks and to allow learning between phases. Members welcomed pathway-remapping work but emphasised the need to redesign and standardise pathways rather than digitise existing processes without sufficient challenge.

The most significant immediate risk remained recruitment and release of staff to programme design, testing, training and change roles because of the same backfill constraints affecting research. The Committee also noted the dependency on the February 2027 PAS upgrade and the need for clear Trust-wide communication ahead of technical and operational go-live, including use of the Chief Executive's briefing and divisional leadership routes.

Sussex Pathology Network

The Sussex Pathology Network digital programme had shown adverse readiness indicators and was in recovery, but the Committee received greater confidence in the mitigations and thanked the Chief Information Officer for strengthened oversight. The re-baselined programme indicated an earliest go-live in August 2027 for UHSussex parts of the Trust ar RSCH and PRH and Queen Victoria Hospital, followed by other partners and UHSussex (SRH and WH). Key risks remained specialist staffing and testing capacity, clinical leadership, technical foundations, finance, programme leadership and dependencies with the EPR and PAS upgrade.

The Committee discussed complexities arising from pathology pathways that cross Trust, integrated care and regional boundaries. It will continue to monitor the programme closely given its importance to digital maturity, diagnostic resilience and the retirement of legacy systems, while recognising that detailed programme delivery and investment assurance also sit in the Strategy and Major Projects and Finance and Performance governance routes.

Information governance and cyber security

The Committee received the 2026/27 Data Security and Protection Toolkit Cyber Assessment Framework Version 9 update, which had previously been considered by the Audit Committee. The revised framework increases requirements relating to threat intelligence, secure software development, behavioural monitoring, multi-factor authentication, supplier assurance and response to NHS England High Severity Alerts. The Committee agreed that the additional

independent audit outcome should cover D1.a Response Plan, including disaster recovery and cyber incident preparedness, with audit work planned for January 2027.

The Committee noted that cyber training compliance of 70.14% and information governance training compliance of 87% remained below the respective 95% and 90% targets in the report. Members discussed whether cyber and information governance training could be better aligned and consistency ensured while retaining local intelligence and targeted learning. Completion remained important so that expectations concerning confidentiality, cyber security and appropriate access were understood and evidenced.

The Committee also considered inappropriate access to patient records, including the current technical complexity of assessing individual cases, and the need for proportionate investigation and disciplinary action. The Head of Information Governance will return with more granular assurance on the nature, investigation and outcomes of inappropriate-access concerns, and this will become a regular report to the Committee within this item. The Committee noted that the EPR should strengthen audit and alerting capabilities, while safeguards are also required to ensure audit information is used fairly and does not expose staff to inappropriate targeting or victimisation.

Risk and Board Assurance Framework

The Committee reviewed the Research and Innovation and Digital risk registers. The Research and Innovation portfolio contained 10 risks, with four scored 12 or above, including research estates at 16 and research workforce capacity at 15. The Digital portfolio contained 30 risks, including 11 extreme risks, 17 high risks and two moderate or low risks. Cyber security remained a principal risk because of the external threat environment, legacy infrastructure and constrained replacement capacity.

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**

The Committee concluded that Strategic Risk 7, Analogue to digital: harnessing technology and data to transform healthcare, should remain at 20 with reasonable assurance over the current control framework and the extensive actions in progress. For Strategic Risk 9, Widening access to research and innovation, the Committee concluded that reduced assurance over the Clinical Research Facility programme, together with the risk that workforce delays could prevent delivery of funded research, justified increasing the score from 16 to 20. The Committee therefore recommends these scores to the Board

Referrals to other Committees

The Committee referred the strategic research workforce issue to the People and Culture Committee.

University Hospitals Sussex
NHS Foundation Trust

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	4 November 2026	**Chair**	Professor 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 Q2 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 Q2	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. The developing report format was welcomed with Integrated commercial/non-commercial and inclusion reporting required. The Meeting suggested further work to Develop inclusion data and a future REN deep dive
Clinical Research Facility Major Project update.	Director of Research & Innovation	To Note	The Committee **noted** the update on progress toward the Clinical Research Facility and took reduced assurance due to delay, cost, funding and partnership risk. Supports increase of SR9 from 16 to 20.
Research & Innovation Annual Report	Director of Research & Innovation.	To note	The committee **noted** the report and recognised the broad range of positive stories emerging from research activity. Processes for adoption, funding, business cases and benefits realisation need strengthening. **Specific progress report to return.**

Item	Presenter	Purpose of the paper	Action Taken
Sussex Health and Care Research Partnership (SHCRP) annual update	Chief Medical Officer and Director of Research & Innovation	To Note	The Committee **noted** the report which described the partnerships progressing, with further work on sustainability, data and demonstrable impact. The Committee seeks further updates on monitoring outstanding indicators and data-sharing arrangements.
Digital			
DEEP DIVE Digital Inclusion	Chief Information Officer	For Discussion and Noting	The Committee took assurance that work is progressing. Trust-wide governance, meaningful choice, supported routes and measurable outcomes remain necessary. To become a regular assurance update.
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. The Committee were supportive of the change controls to be implemented ahead of the EPR and major system updates; The committee discussed opportunities to strengthen benefits reporting.
Electronic Patient Record Update	Chief Information Officer	To note	Noted the update on the phased implementation that provides mitigation, but workforce release, PAS dependency and readiness remain key risks. The meeting discussed work to strengthen communications, pathway redesign & readiness assurance
Sussex Pathology Network IT Systems update	Chief Information Officer	To note	Noted the update that gave greater confidence in mitigations despite programme remaining red and in recovery. The Committee highlights need for close oversight through relevant programme and Board committees
Information Governance quarterly report, including: 10 DPST (cyber security) updates	Chief Information Officer and Head of Information Governance	For discussion and noting	The Committee noted the reports, **noted** V9 increases assurance requirements; training and inappropriate-access oversight require improvement. Internal audit reviews our submission in

University Hospitals Sussex
NHS Foundation Trust

			January 2027; A more granular inappropriate-access report to be brought back as a routine report.
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 that reflect risks to delivery of the 5-year delivery plan. Backfill challenges to releasing researchers and risks to progressing the clinical research facility had escalated. The Committee **noted** the Digital Risk Register and that all risks are managed actively and reported through governance. Cyber security risks remained high The Committee utilised this report when considering their allocated element of the Trust's BAF.
Board Assurance Framework	Company Secretary	To review and recommend to the Board the scores for the strategic risks 7 and 9	The Committee considered the relevant segments of the BAF and alongside the reports received at the meeting. The Committee concluded that Strategic Risk 7 should remain at 20 with reasonable assurance over the current control framework and the extensive actions in progress. For Strategic Risk 9, Widening access to research and innovation, the Committee concluded that reduced assurance over the Clinical Research Facility programme, together with the risk that workforce delays could prevent delivery of funded research, justified increasing the score from 16 to 20. The Committee therefore recommends these scores to the Board for Q2 2026/27.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	12.	**Meeting:**	Trust Board in Public	**Meeting Date:**	12 November 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*		

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)***

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

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

The Patient & Quality Assurance Committee (PQAC) met on 3 November for its quarterly assurance meeting, covering Quarter 2 2026/27, and September for an interim deep-dive session. The Committee was quorate, reviewed its programme of work and received the scheduled reports for assurance. Key points below with a fuller report in the main body.

In relation to BAF Strategic Risk 3: Improving Safety and Experience, the Committee noted evidence, in relation to the two areas below, that quality governance oversight is not operating as effectively as previously, coinciding with a period of organisational change with implementation of the Target Operating Model (TOM) in the corporate quality function and divisions and the impact on assurance processes, compliance and the delivery of improvement activity.

Clinical Outcomes and Health Inequalities: The Committee noted that progress against agreed improvement trajectories have plateaued, with some areas showing or predicting deterioration following earlier progress. This was evident across most areas in compliance with clinical documentation standards, implementation of NICE guidance, and completion of clinical audits. The Committee reflected that the challenge relates not only to oversight, but also to the consistent delivery by those assigned responsibility for deliverables. The Committee sought assurance that oversight and a focused approach to implementation and accountability would be adopted. A recovery and improvement plan to the Committee at its December meeting.

Patient Safety: The Committee noted the ongoing backlog of incident reviews and expressed concern about the on timely organisational learning. The Committee welcomed the Chief Nurse's proposed 'incident sprint' to address the backlog, with a progress update due in December. In addition, given the concerns about the impact of organisational changes and the backlog, it was agreed a rapid review of the incident governance arrangements and PSIRF (Patient Safety Incident Response Framework) compliance would be undertaken with findings and any associated action plan to be reported to the December meeting to provide assurance on patient safety governance.

Considering regulatory compliance, the Committee welcomed progress made to strengthen governance oversight, compliance and put in place tools to support inspection readiness with the CQC. Alongside this a comprehensive update was received on progress against CQC related activity and assurance on the management of actions arising from previous inspections. There remain a small

number of longstanding actions and Committee is requested clearer evidence of the status of these.

The Committee noted that the reporting period saw the highest volume of complaints received by the Trust to date. Despite this increase, response rates had been maintained, and the Committee welcomed evidence that alternative approaches to complaint management were helping to sustain performance and improve responsiveness to patients and families.

The Committee received assurance that maternity and neonatal safety indicators continue to perform at or below (better than) national benchmarks, with no Maternity Oversight Safety Signals reported during the period. Members considered the findings of the Thirlwall Report, the Trust's initial response, and proposals for further review and improvement. Whilst progress against the Maternity and Neonatal Improvement Plan (MNIP), CNST requirements and the NHS 10-Point Plan Sprint was noted, the Committee discussed significant risk associated with delivering a substantial programme of national, regional and local improvement requirements concurrently. Particular concern was expressed regarding workforce sustainability, infrastructure limitations and organisational capacity, given the scale and pace of change required. These risks have the potential to impact delivery of improvement trajectories, regulatory compliance and the sustainability of current performance. Assurance was provided on actions being taken to address workforce challenges including recruiting to Birthrate+, mitigate risks associated with BAPM compliance across the RSCH and PRH sites and improve homebirth provision. The Committee welcomed the clear focus on health inequalities within the review of perinatal outcomes, reflected across both the Quality Report and the PSIRF Report. The Committee recognised the significant progress in clinical documentation compliance in Maternity.

Finally, the Committee welcomed the launch of the revised Equality and Quality Impact Assessment process. Members requested that a future report be brought to the Committee and Board to demonstrate the impact of this and how the new approach is influencing decision-making and improving outcomes for patients and staff.

The Committee reviewed Strategic Risks 3 and 4 and considered Strategic Risk 8 through its quality and patient safety lens. Members concluded that the assurances they had received did not support a reduction in strategic risk 3 and recommended to the board that it remains at its significant risk score (20) and the other current scores remain appropriate:

- **SR3 Improving Safety and Experience: remains at 20**
- **SR4 Improving Equality of Access and Outcomes: remains at 16 but with limited assurance**
- **SR8 Better, More Sustainable Buildings and Equipment: remains at 20**

The themes outlined above supported this judgement.

University Hospitals Sussex
NHS Foundation Trust

Recommendation *(linked to What Next section)*	**Recommendation** The Board is asked to: - **NOTE** the business undertaken by the Patient & Quality Assurance Committee at its meetings on 15 September and 3 November 2026. - **NOTE** the assurance received in the specific areas identified in this report, together with the limitations, concerns and further actions described. - **ENDORSE** 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.					
Assurance / Scrutiny route already undertaken						
Link to Trust Strategy (note which theme)	**Patients**	**People**	**Future**	**Communities**	**One UHSussex**	**Culture**
	Yes	Yes	N/A	Yes	Yes	*Yes*
Link to annual delivery plan	*No specific link*					
Link to BAF	*No specific link (report addresses assurances against SR3, SR4 and SR8)*					
Link to CQC domain	**Safe**	**Caring**	**Effective**	**Responsive**	**Well-led**	**Use of Resources**
	Yes	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*
Other impacts	**Equality and Diversity (*if yes has HEIA completed)***		**Environmental**	**Legal**	**External Registrations *(if yes please indicate which)***	
	N/A		*N/*	*N/A*	*N/A*	

University Hospitals Sussex
NHS Foundation Trust

Patient and Quality Assurance Committee Chair's Report

The Patient & Quality Assurance Committee (PQAC) met on 3 November 2026. For its quarterly assurance meeting. 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 on 15 September to undertake to conduct deep dives into quality and safety in Urgent & Emergency Care, and into Estates and Facilities and review of maternity quality safety standards.

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 considered evidence that elements of the quality governance oversight remained in place during quarter 2 as the Trust has transitioned to its new operating model. However, it identified fragility and reduced effectiveness in parts of the corporate and divisional quality infrastructure, including gaps in governance activity, capacity and evidence of measurable improvement. Assurance was therefore partial or limited in a number of areas. The Committee noted a plateauing, and in some areas deterioration, in performance against agreed trajectories within the Clinical Outcomes and Health Inequalities programme. 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.

Patient Safety, Experience and Learning

The Committee reviewed the quarterly Patient Safety and Patient Experience report. The Committee reviewed Quarter 2 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. Whilst recognising the improvement by Divisions of the number in-date Patient Safety Incidents in Q2 the Committee noted that 40% of patient safety incidents, of moderate or above severity, were overdue and the even more significant backlog of low and no harm incidents. The incident sprint cited above will report back on progress in December. Taking into account the change in the organisational model the Committee agreed an action for a rapid review to be undertaken to provide assurance and identify any issues in the Patient Safety Incident Process, that it has the appropriate scrutiny and that early learnings are identified, captured and acted upon, and how learnings are embedded.

Complaints have continued to rise and are at their highest recorded level, reflecting increasing concerns regarding delays, appointments, communication and aspects of clinical care. Quarter 2 saw the highest number of complaints received in a quarter, a 36% increase same period in 2025 however response rates have been maintained. Evidence across papers received in the September and October PQAC meetings reflect the themes of patient delays and how this is communicated and emergency care. The communication point is evidenced through number of PALs contacts of 3,500 in Q2 largely from patient and families seeking information in areas including results and appointments. National inpatient survey reflected no significant difference with other Trusts and National Cancer survey showed the

Trust to be in line with or below other Trusts. The Committee heard Martha's rule has been embedded and the role this is playing in amplifying patient voice.

Triangulating across quality domains key themes continue to be delay of follow-up appointments, test results, diagnostics and first appointments with greater prevalence in particular services and experience in the Emergency Department, and communication.

Fundamental Standards of Care
The Committee received the Quarter 2 Fundamental Standards of Care report and sought assurance on how greater quality assurance can be achieved from Ward to Board through the Fundamental Standards of Care. The Ward accreditation scheme was noted but the committee challenged how this is triangulated with other sources of assurance (such as internal audits and regulatory assessments) and whether external challenge is applied. The Committee remains concerned regarding Trust's performance in recognising and responding to patient deterioration continues to feature in incidents, inquests and Prevention of Future Deaths reports. The ambition is to achieve reliable processes by end of 2026/27. An improvement plan had previously been requested but has yet to be presented. The Committee requested that this be prioritised for its Quarter 3 meeting.

Clinical Outcomes and Effectiveness:
The Committee identified a deterioration or loss of momentum across several clinical outcomes and effectiveness measures, including clinical document review, NICE guidance implementation, national clinical audit delivery and oversight of new interventional procedures. Members were concerned that elements of the supporting governance infrastructure had not operated consistently and that the report did not provide a sufficiently clear recovery trajectory. The Committee reflected that the challenge relates not only to oversight, but also to the consistent delivery by those assigned responsibility for deliverables. The Committee sought assurance that oversight and a focused approach to implementation and accountability would be adopted. A recovery and improvement plan to the Committee at its December meeting.

Safeguarding and Mental Health
The Committee was assured regarding statutory safeguarding governance arrangements, while noting continuing high 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. Delayed discharge for children and young people had doubled from Q1 to Q2 and remains a significant safeguarding risk. The Committee confirmed that an assured plan and oversight was in place to address the AGNI Judgement (Deprivation of Liberty) and regulatory and safety risks are being managed and a reduction in DOLs was evidenced. Level 3 Safeguarding training completion remains below the Trust target (Training needs analysis continues to identify additional teams and individuals requiring Safeguarding Children Level 3) and is being closely monitored and has a plan in place.

Increasing mental health demand in Emergency Departments and lengthy onward placement waits were also noted. These are being managed with partners, mitigations are in place as far as possible and have been escalated at system level. The Committee noted an issue with recording of evidence information with respect to Mental Health Act and asked for plan to come back in Q3.

Infection Prevention and Control
The Committee received the Quarter 2 IPC report and noted all except one reportable infections are expected to reach or exceed the national threshold however the Trust still benchmarks at or below South East rates. The Committee took assurance from analysis that had been undertaken and mitigations in place. Committee was concerned by the persistently elevated cardiac surgical site infection and increased cases in breast surgery but assured on the level of scrutiny and processes in place to mitigate this within the infrastructure constraints. The Committee noted positive progress with antimicrobial stewardship in response to the national call to action, with a plan in place to meet the specified requirements in this area. The Committee noted evidence of good progress made in achieving compliance with the IPC Board Assurance Framework (reported annually) with an additional of the IPC BAF domain now compliant relating to occupational health.

Deep dives (Urgent & Emergency Care)
At the September Deep Dive, the Committee received assurance that significant work was underway to strengthen patient safety oversight across urgent and emergency care, patient flow and preventing the situations where patients are treated in non-designated clinical areas, supported by stronger governance, cross-site collaboration, shared learning, digital solutions, Fundamental Standards of Care monitoring, admission avoidance initiatives and community partnership working. While these developments provided evidence of organisational learning and improvement, the Committee was not yet fully assured regarding delivery of the overall improvement programme and requested further evidence of measurable outcomes, delivery trajectories, governance arrangements and programme milestones to demonstrate that improvements were having the intended impact and were sustainable.

Deep dives (Estates & Facilities)
The Committee welcomed the substantially improved visibility of estates and infrastructure risks and the work undertaken through the Premises Assurance Model, which provided a clearer understanding of the scale and nature of the organisation's estate challenges. However, the Committee was only able to take limited assurance from the current submission due to inconsistencies between assurance ratings, supporting evidence and narrative, and requested further executive review before Board consideration. Members also sought greater clarity on the developing investment prioritisation framework, particularly how estate risks, quality requirements and capital investment decisions would be balanced across the organisation.

Follow up on Previous Deep Dives (Ophthalmology & Maxillofacial)
Ophthalmology and maxillofacial had both demonstrated the significant impact on patient experience of the follow-up waiting times and also potential harms. Each area had plans in place to mitigate risks for these areas. Committee has requested a review at the December meeting of the follow-up backlog waiting list to understand how lessons learnt are implemented across the divisions, learnings are being used from elsewhere and how risks have been mitigated.

Maternity
The Committee received the full suite of maternity assurance reports. 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 reports detailed the overall outcomes and then stratified to provide analysis by global majority and most deprived groups. The Committee has continued to give focus to the scale of operational and regulatory requirements facing maternity services. Concern remains regarding previously escalated obstetric theatre capacity particularly in the context of increasing levels of C-Sections, neonatal workforce capacity and maternity triage requirements. The homebirths suspension rate had also been increasing.

The committee received an update BAPM (British Association of Perinatal medicine) compliance risks in the neonatal service at PRH and RSCH. This has also previously escalated to the Executive.

Members reflected on the cumulative impact of, maternity improvement programmes, national reviews, local action plans and other regulatory expectations. Whilst noting progress against a number of individual actions and safety requirements, members sought further work to improve visibility of the totality of requirements, associated resource implications and areas where delivery remains challenging. In addition to the reviews, the Thirlwall Review recommendations into neonatal care and security have been added.

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.

Estates, Infrastructure and Strategic Risk
The Committee welcomed the clearer articulation of estates risks, the revised PAM baseline and the development of a costed three-year action plan. It did not consider that the evidence supported an improved assurance rating, given the scale of outstanding remedial work, weaknesses in evidence and competency arrangements, and the underlying condition of the estate. The committee requested that future reports should more clearly connect infrastructure priorities to patient safety, clinical outcomes and service productivity.

Quality Governance and Safety Group
Chief Medical Officer briefed the Committee on areas covered by QGSG by exception which included Medicines Management, controlled drugs management. The Committee particularly reviewed the Fuller review requirements and HTA agreed action plan and the work to address the shortcomings in the inspection report findings around the Trust's Mortuary. The Committee noted that strong progress had been made in response.
The consent audit (both internal and internal audit) was noted with particular interest given the Committee had triangulated issues raised in the clinical outcomes area in both oversight and implementation in this important area for assurance. The internal audit cycle was outlined and the plan to mandate of training in this area discussed and the committee asked for this to be confirmed at the next meeting.

Endoscopy JAG Accreditation: Whilst an outline plan (including a bid for capital redevelopment and strengthened governance with transition to Medicine Division) has been noted, there is a significant investment needed to achieve re-accreditation in RSCH and

PRH. SRH/WH are accredited. The Trust will be evaluated in separately at SRH/WH and RSCH/PRH in the next review and the executive were asked to progress this item.

Outsourced Services: In response to previous risks identified, the Committee received a paper and noted plans for improvement in the oversight and governance in outsourced imaging and diagnostic services.

Board Assurance Framework

The Committee reviewed SR3, SR4 and SR8. It concluded that the evidence received did not support a reduction of SR3 from 20 to 16 and therefore recommended that SR3 remain at 20. SR4 remained at 16, with limited assurance, and SR8 remained at 20. The Committee requested clearer articulation of the outcome measures and thresholds that would need to be achieved before future reductions could be supported.

University Hospitals Sussex
NHS Foundation Trust

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**3 November 2026**	**Chair**	Lucy Bloem	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

Patient Safety & Experience			
Patient Safety and Engagement Q2 2026/27 Medico-legal and CQC Report Q2 2026/27 and Complaints Review	**Presenter** Director of Patient Experience	**Purpose** For Assurance	**Outcome /Action taken** Noted the report that showed increased incident & complaint activity. It requested a rapid review of incident governance, organisational learning and backlog recovery, with an initial update in December.
Fundamental Standards of Care Q2 2026/27	**Presenter** Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted update and data. Committee was unable to draw clear assurance from the report. At the next meeting there will be focus on the deteriorating patient recovery plan and the ward accreditation scheme as priorities
Infection Prevention and Control Q2 2026/27	**Presenter** Chief Nurse	**Purpose** For assurance	**Outcome /Action taken** Noted. The Committee welcomed clearer reporting, IPC BAF progress and antimicrobial stewardship work, while noting continuing concerns regarding some fundamental practice, surgical-site infections and estate-related risks.
Facilities & Estates- Q2 2026/27	**Presenter** Director of Estates and Facilities / Chief Finance Officer	**Purpose** For information	**Outcome/Action taken** Noted the update on work taking place. The Committee asked that future reports link priorities more clearly to patient safety and clinical impact.
Safeguarding (Adults, Children and Maternity) Q2 2026/27	**Presenter** Director of Safeguarding	**Purpose** For assurance	**Outcome/Action taken** The Committee noted positive evidence regarding core safeguarding arrangements and Section 11 compliance, alongside continuing risks from delayed discharge, training compliance, deprivation of liberty and the need to demonstrate the impact of learning.
Clinical Outcomes & Effectiveness & Health Inequalities Q2 2026/27 Report Mortality & Learning from Deaths Q2 2026/27	**Presenter** Chief Medical Officer	**Purpose** For Assurance	**Outcome /Action taken** Noted the compliance processes. The Committee sought assurance that oversight and a focused approach to implementation and accountability would be adopted. A recovery and improvement plan will be brought to the Committee at its December meeting.

University Hospitals Sussex
NHS Foundation Trust

Maternity			
Perinatal Quality Oversight Model Report (August 2026)	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted the Perinatal Quality Oversight Model Report. Noted positive outcome indicators, health inequalities data, no MOSS alerts, balanced against continuing neonatal workforce, BAPM compliance, theatre, home-birth and infrastructure risks require sustained oversight and a report to be **brought back** to the next meeting.
Maternity Claims Scorecard Q1 2026/27	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** The Committee noted the claims profile and requested future reporting distinguishes the age of claims and settlements so that historic liabilities are not interpreted as current service outcomes.
Maternity PSIRF and Maternity Claims Scorecard Q2 2026/27	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted the investigation and learning processes described, together with continued staffing and governance pressures and a backlog of low and no-harm incidents requiring management.
Perinatal Mortality Review Tool (PMRT) Q4 2025/26	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted completion of 12 reviews, strong external reviewer involvement and the planned thematic review of intrauterine deaths. One Grade C case related to concerns outside UHSussex care. The report also included health inequality analysis,
Saving Babies Lives Q1 2026/27	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted overall compliance of 90% and actions address smoking cessation, sonography capacity, fetal wellbeing leadership and outstanding clinical guidance.
NHSE 10-point plan progress update	**Presenter** Interim Chief Nurse / Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted progress and the scale of work required ahead of the 31 December submission, including areas expected not to be fully compliant and actions requiring delivery through 2027
Thirlwall Report update	**Presenter** Interim Chief Nurse and Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Received the update and considered immediate neonatal safety and security actions & wider implications for safeguarding, listening to concerns and speaking-up culture. Noted that assurance on cultural change cannot be derived from policy compliance alone.

University Hospitals Sussex
NHS Foundation Trust

Reporting Group			
QGSG Chair's Report Q2 2026/27 including: a) Quality Scorecard & SPC Charts b) QGSG Divisional Reports c) Pharmacy and Medicines Governance Q2 2026/27 - Updates: Endoscopy/JAG	**Presenter** Interim Chief Nurse & Chief Medical Officer	**Purpose** For assurance	**Outcome /Action taken** Noted updates and key exceptions, including medicines governance, consent, endoscopy accreditation and outstanding clinical governance actions, and sought clearer oversight of whether subsidiary governance groups had met as planned.
Care Quality Commission / Regulatory Updates			
CQC Update / Action Plans -	**Presenter** Interim Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted and welcomed consolidation of regulatory actions but requested clearer confirmation of the status, timeliness and closure of longstanding and legacy requirements.
Risk			
Patient and Quality Risk Report	**Presenter** Chief Nurse/ Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted the thematic risk analysis and work undertaken through the Risk Improvement Sprint, including review of the highest-scoring quality risks.
Board Assurance Framework	**Presenter** Chief Nurse/ Chief Medical Officer	**Purpose** For Decision	**Outcome /Action taken** The Committee reviewed its allocated segments and recommended BAF scores.

University Hospitals Sussex
NHS Foundation Trust

Meeting Details					
Meeting Date	**15 September 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: Urgent and Emergency Care	**Presenter** Medicine Division Managing Director/ Division Medical Director/ Division Director of Nursing	**Purpose** To discuss and agree actions	**Outcome /Action taken:** Noted the strengthened governance & improvement activity across urgent and emergency care but was not yet fully assured regarding delivery and sustainable impact. It requested clearer outcome measures, trajectories, milestones and programme accountability.
Deep Dive: Estates and Facilities	**Presenter** Infrastructure Director	**Purpose** To discuss and agree actions	**Outcome /Action taken:** The Committee welcomed the improved identification of estates risks through the PAM but took limited assurance because of inconsistencies between ratings, narrative and evidence. **Escalation** for Further executive review and clearer prioritisation of investment against safety and quality risks were requested
Patient Safety & Experience			
Mental Health Update	**Presenter** Chief Nurse / Deputy Chief Nurse: Quality & Safety	**Purpose** *To discuss and agree any further actions*	**Outcome /Action taken** Noted the update. Also noted plans for system-level improvement work and mitigations but concluded that pressure in emergency care had not yet materially reduced. It sought clearer assurance on programme governance, resourcing and anticipated impact.
Maternity			
Perinatal Quality Surveillance Report and Dashboards to June 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.

University Hospitals Sussex
NHS Foundation Trust

Update on NHSE Sprint	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted progress against sprint actions but sought continued visibility of the combined programme, resource implications and areas where delivery remained at risk.
Maternity Care Bundle Q1 2026/27	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted current performance and outstanding actions, including areas where compliance or delivery remained below expectation. Ongoing monitoring was required through maternity governance.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	13.	**Meeting:**	Trust Board in Public	**Meeting Date:**	12 November 2026
Report Title:	People & Culture Assurance Committee Chair's Report				
Author(s):	Professor Paul Layzell – NED & Committee Chair				
Purpose of the report: *(indicate as appropriate)*	**For Decision**	**For Assurance**	**For Discussion**	**For Information only**	
	Yes	*Yes*	*N/A*	*N/A*	
Reason for not being taken in public *(indicate as appropriate)*	**Commercial confidentiality**	**Staff confidentiality**	**Patient confidentiality**	**Other exceptional circumstances (please detail)**	
	N/A	*N/A*	*N/A*	*N/A*	
Regulatory Reporting Requirement					

Summary of the report describing

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

This report summarises the business considered by the People and Culture Assurance Committee on 3 November 2026.

The meeting was quorate. The Committee considered its scheduled business, including progress with 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 from the Committee's scrutiny of workforce performance and culture, education and training, the Resident Doctor 10-Point Plan, safe working hours, speaking up, staff wellbeing and nursing safer staffing.

The Committee:

- Reviewed the NHS England education self-assessment and agreed that it should be submitted to NHS England.
- Endorsed development of the proposed health and wellbeing strategy, described in the papers as covering 2026/27–2029/30.
- Approved the revised Health and Wellbeing Steering Group terms of reference.
- Considered the six-monthly nursing safer staffing report and recommended Board approval of its publication.
- Reviewed its allocated BAF strategic risks and recommended their quarter 2 scores to the Board.

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

The Committee scrutinised the content and quarter 2 scores for strategic risks SR5, SR11 and SR12. Its recommendations are set out in this report.

The Board is asked to approve publication of the Trust's six-monthly nursing safer staffing report, following the Committee's review.

Assurance remains qualified in relation to sustainable staffing, speaking-up outcomes, trainer capacity and the resources underpinning strategic mitigations, as set out in the report below.

Recommendation
(linked to What Next section)

The Board is asked to NOTE:

- that the Committee met and considered its scheduled assurance reports.

University Hospitals Sussex
NHS Foundation Trust

	- its agreement to submission of the NHS England education self-assessment, development of the proposed health and wellbeing strategy described as covering 2026/27–2029/30, and the revised Health and Wellbeing Steering Group terms of reference. - its request for development of a strategic workforce plan. - its recommended quarter 2 scores for strategic risks SR5, SR11 and SR12. The Board is asked to APPROVE: - publication of the six-monthly nursing safer staffing report.
Assurance / Scrutiny route already undertaken (please explain where matter previously considered, and assurance provided)	Most items had previously been considered by the People and Culture Steering Group and its reporting groups. The BAF had been considered by the Executive Management Committee, with the underlying process subject to Audit Committee oversight.

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 oversees the people and culture priorities supporting 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 lead oversight of people-related strategic risks SR5, SR11 and SR12.					

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

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

University Hospitals Sussex
NHS Foundation Trust

People and Culture Assurance Committee Chair's Report

The People and Culture Assurance Committee met on 3 November 2026. The meeting was quorate, with at least two Non-Executive Directors and two Executive Directors in attendance. Report presenters included the Director of Human Resources, Director of Integrated Education, Director of Communications, Associate Director of Leadership, Culture and Development, Guardian of Safe Working Hours and Freedom to Speak Up Guardian.

The Committee received its scheduled reports on people performance; embedding values and behaviours; Freedom to Speak Up; safe working hours for quarter 2; staff health and wellbeing; nursing safer staffing; national trainee and trainer survey findings; medical education, including the NHS England education self-assessment; and the Resident Doctor 10-Point Plan. It also considered the quarter 2 Board Assurance Framework (BAF) for 2026/27, focusing on the strategic risks for which it has lead oversight.

The principal areas of discussion and assurance are summarised below.

People Performance Overview Report

The Chief Executive presented the report on behalf of the Chief People Officer. The Committee considered the People Scorecard and the actions being taken in response to workforce growth, declining appraisal compliance and sickness absence. It noted that sickness absence remained below the national average and discussed the challenges in recording return-to-work discussions. The Committee requested more granular information on workforce changes to support its scrutiny of the scorecard.

The Committee agreed the proposed arrangements for overseeing the relevant elements of the Trust Strategy Delivery and Improvement Framework Plan.

Alongside work on the annual workforce plan, the Committee agreed that a strategic workforce plan should be developed and brought to a future meeting. It noted that the strategic workforce learning and development plan under development would complement the wider workforce plan.

The September scorecard reports appraisal compliance of 85.7%, mandatory training of 91.6% and recorded return-to-work interviews of 42.79%. The more granular reporting requested by the Committee should identify service-level exceptions, recovery actions and accountable leads. The strategic workforce plan should also reconcile service requirements, funded establishment, affordability and future skills supply, so that improved Trust-wide vacancy figures can be assessed alongside local staffing risks.

Culture Programme

The Committee received an update on embedding the Trust's values and behaviours. It took assurance from the report and discussion led by the programme's Senior Responsible Owner, the Director of Integrated Education.

The Committee noted progress in rolling out the Behavioural Compass, including the launch of modules 3–5. Contributions from staff in Bands 2–4 about their experience of using the Compass have informed further training and engagement.

The report provided assurance on implementation and the integration of the Behavioural Compass into routine processes, including recruitment and appraisal. Further work is needed to develop measures of its impact on organisational culture.

The Committee recognised the risks posed by resource constraints, particularly the ability to secure external support for developing cultural impact measures. It nevertheless received assurance that work was progressing and that the newly appointed Director of Voice, Improvement and Partnerships would provide leadership.

The remaining assurance gap is whether implementation changes staff experience consistently across services. Measures of cultural impact should triangulate staff feedback, recurring speaking-up concerns and workforce indicators, with particular attention to teams reporting poor experiences. Resource or management-capability gaps that prevent delivery should be made explicit.

Integrated Education Reports

NHS England Provider Self-Assessment Education Return

The Committee reviewed the Trust's NHS England Provider Self-Assessment, which assesses the quality of education and training and compliance with the NHS Education Funding Agreement.

The 2026 return draws on evidence from professional education teams across the Trust. It covers education quality and governance, funding, learner and educator experience, equality and inclusion, and the quality and safety of learning environments.

The Committee considered the return reasonable and consistent with the information it had received during the year and took positive assurance from it. The return described strengthened multi-professional education governance, investment in educators and supervisors, improved learner support and more consistent arrangements for identifying and responding to educational concerns. It confirmed Board-level oversight of education and training and reported no material breaches of the Education Funding Agreement.

Following its review and discussion, the Committee agreed that the return should be submitted to NHS England.

The Committee's agreement to submission should be read alongside the pressures acknowledged in the return, including placement and supervision capacity, learner support and education funding. These matters should remain visible through education governance after submission, with the required final approval confirmed. This would provide continuing assurance that the self-assessment leads to improvement as well as annual compliance reporting.

GMC National Trainee and Trainer Surveys

The Committee considered the GMC national trainee and trainer survey results. It took assurance from the arrangements for overseeing improvement plans through the Healthcare Education Development Group. It noted the alignment between actions, including those within the cultural improvement programme, and the reduction in reported concerns.

The results provided positive assurance about the quality of training. The Committee particularly welcomed the feedback on General Surgery and reports that trainees wished to pursue their careers at the Trust.

The Committee discussed areas requiring further improvement and received assurance that the planned actions would support continued progress in culture and trainee wellbeing.

Guardian of Safe Working Hours Report

The Committee received the Guardian of Safe Working Hours report and took assurance from the continued operation of exception-reporting processes and the prompt action reported in response to concerns.

The Committee welcomed the successful recruitment of Deputy Guardians to support the Guardian's workload, addressing a capacity concern raised at previous meetings.

Freedom to Speak Up Guardian Report

The Committee considered the Freedom to Speak Up Guardian's six-monthly report and recommendations. It agreed that the People and Culture Steering Group would develop an action plan and monitor delivery.

The Committee supported enhancements to induction to help managers listen to concerns, respond effectively and provide feedback, with the aim of strengthening staff confidence in speaking up.

The Guardian advised that the themes raised at the Trust were broadly similar to those experienced by other organisations using the service. The Committee also received assurance that no serious patient safety concern referred through the service had remained unaddressed.

Nursing Safer Staffing Report

The Committee considered the six-monthly safer staffing update and the latest review findings. It noted improvements in vacancies, shift fill rates and SafeCare compliance, together with the use of dynamic staff deployment to manage staffing pressures during shifts.

The Committee welcomed the retention of registered nurses and healthcare assistants, which compared favourably with local and national benchmarks.

The Committee supported publication of the assessment on the Trust's website in line with national requirements, and recommended Board approval of publication.

Resident Doctor 10-Point Plan

The Committee noted continued progress in delivering the national Resident Doctor 10-Point Plan and remained assured about oversight of the action plan. It welcomed the Trust's strong position relative to local and national peers.

Staff Induction

The Committee noted the redesigned Welcome Day as part of staff induction, alongside gaps in reaching non-desk-based staff and achieving consistent onboarding across staff groups. Further assurance is sought to show that staff understand changes affecting them and that all new starters receive effective local and profession-specific induction. The Committee noted there were around 800 new starts per annum.

Risk Report and Board Assurance Framework

The Committee noted the alignment between the highly rated workforce and cultural risks and the issues discussed during the meeting. These themes informed its scrutiny of the BAF.

The Committee scrutinised strategic risks SR5, SR11 and SR12, relating respectively to a happy, healthy and supported workforce; living the Trust's values; and having the right people and skills working towards common goals.

The Committee endorsed the executive recommendations for the quarter 2 scores of 16, 16 and 20 for SR5, SR11 and SR12 respectively. It took assurance from the planned mitigating actions and their intended contribution to achieving the target scores. It asked the People and Culture Steering Group to assess carefully whether the actions taken and planned during quarter 3 would justify a reduction in the score for SR12.

Referrals to Other Committees

The Committee agreed that no matters required referral to other committees.

University Hospitals Sussex
NHS Foundation Trust

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

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

Items received at the Committee meeting			
People Performance Overview, including People Scorecard and quarter 2 performance report	**Presenter** Chief Executive on behalf of the Chief People Officer	**Purpose** For discussion and assurance	**Outcome /Action taken** The Committee used the overview to focus its discussion and review the People Scorecard. It considered workforce growth, declining appraisal compliance and sickness absence, noting that sickness absence remained below the national average. It also discussed difficulties in recording return-to-work discussions. The Committee agreed the proposed arrangements for overseeing the relevant elements of the Trust Strategy Delivery and Improvement Framework Plan. The Committee agreed that a strategic workforce plan should be developed and brought to a future meeting. The Committee requested more granular information on workforce changes to support the People Scorecard.
Culture Programme Update — embedding values and behaviours	**Presenter** Chief Strategy Officer and Director of Integrated Education as SRO for cultural improvement workstreams	**Purpose** For information	**Outcome /Action taken** The Committee received an update on embedding the Trust's values and behaviours. It took assurance from the report and discussion led by the programme's Senior Responsible Owner, the

			Director of Integrated Education. The Committee noted the continued rollout of the Behavioural Compass, including the launch of modules 3–5. The Committee noted that the newly appointed Director of Voice, Improvement and Partnerships would lead further cultural improvement and development of cultural impact measures.
Freedom to Speak Up Guardian's six-monthly report	**Presenter** The Guardian Service	**Purpose** For assurance	**Outcome /Action taken** The Committee received and discussed the Freedom to Speak Up Guardian's report. The Committee noted the engagement work undertaken by the Guardians. The Committee agreed that the People and Culture Steering Group would oversee development and delivery of an action plan responding to the Guardian's recommendations. The Committee supported further enhancements to the Trust's induction processes.
Health and wellbeing update, including the delivery plan	**Presenter** Associate Director, Leadership, OD & Engagement Head of Equalities and Inclusion	**Purpose** For discussion	**Outcome /Action taken** The Committee received and discussed the health and wellbeing update. The Committee reviewed areas of improvement and those requiring further action. The Committee took assurance from the actions supporting the reported improvements and the plans to address areas requiring further attention.

			The Committee endorsed the strategic direction and principles of the proposed health and wellbeing plan, described in the papers as covering 2026/27–2029/30. Following the annual review, the Committee approved the revised terms of reference for the Health and Wellbeing Steering Group.
Six-monthly communications report	**Presenter** Director of Communications	**Purpose** For information	**Outcome /Action taken** The Committee received the update and noted activity undertaken over the previous six months. The Committee noted practical improvements made in response to staff feedback and the contribution of the staff panel to testing and developing communication channels.
Induction update	**Presenter** Director of Integrated Education	**Purpose** For information	**Outcome /Action taken** The Committee welcomed evaluation feedback indicating that changes to induction had been well received. It noted the development of local IRIS pages to help staff access information during their early months in clinical areas. The Committee revisited plans to strengthen support for staff during their first 30, 60 and 90 days at the Trust.
Mechanisms to align education with changing learner expectations and workforce requirements	**Presenter** Director of Integrated Education	**Purpose** For information	**Outcome /Action taken** The Committee received the requested report from the Director of Integrated Education. The Committee agreed the proposed approach to reporting across the year, enabling fuller discussion and

			assurance on training outcomes and effectiveness. The Committee agreed that this assurance should cover both trainees and trainers. The Committee also discussed education beyond clinical training, including T Levels and apprenticeships.
National trainee and trainer surveys	**Presenter** Director of Integrated Education	**Purpose** For information and assurance	**Outcome /Action taken** The Committee received the report on the quality of training provision. It noted improvements in the survey results and planned actions to address remaining concerns. The Committee took assurance from improvements in trainee feedback and reports that trainees wished to pursue their careers at the Trust.
NHS England education self-assessment return	**Presenter** Director of Integrated Education	**Purpose** For discussion and assurance	**Outcome** The Committee reviewed the NHS England Provider Self-Assessment on education quality and compliance with the NHS Education Funding Agreement. The Committee took assurance from the relevant groups' engagement and oversight. It considered the return reasonable and noted the positive overall assurance and the absence of reported material breaches of the Education Funding Agreement during the previous 12 months. The Committee agreed that the return should be submitted to NHS England.

Guardian of Safe Working Hours quarter 2 report	**Presenter** Trust's Guardian of Safe Working Hours	**Purpose** For assurance	**Outcome /Action taken** The Committee took assurance from the established exception-reporting processes and the action reported in response to concerns.
Six-monthly nursing safer staffing report	**Presenter** Deputy Chief Nurse – Workforce	**Purpose: review and recommend publication**	**Outcome /Action taken** The Committee reviewed the report and took assurance on its completeness. The Committee noted improvements in vacancies, shift fill rates and SafeCare compliance, alongside dynamic deployment of staff to manage pressures during shifts. The Committee welcomed registered nurse and healthcare assistant retention, which compared favourably with local and national benchmarks. The Committee supported publication on the Trust's website in line with national requirements and recommended Board approval.
Resident Doctor 10-Point Plan	**Presenter** Director of Workforce	**Purpose** For assurance	**Outcome** The Committee noted continued progress and took assurance from oversight of delivery. It welcomed the Trust's strong position. The Committee noted the appointment of resident doctor peer leads.
People risks update	**Presenter** Company Secretary on behalf of the Chief People Officer	**Purpose** To note	**Outcome /Action taken** The Committee noted the report and the planned work to strengthen the recording and management of organisational risks.

University Hospitals Sussex
NHS Foundation Trust

Board Assurance Framework	**Presenter** Company Secretary	**Purpose** To review and recommend to the Board	**Outcome /Action taken** The Committee endorsed the quarter 2 scores of 16 for SR5, 16 for SR11 and 20 for SR12.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	14.	**Meeting:**	Trust Board in Public	**Meeting Date:**	12 November 2026
Report Title:	Finance & Performance Assurance Committee Chair's Report				
Author(s):	Philip Hogan, NED and Committee Chair				

Purpose of the report:	**For Decision**	**For Assurance**	**For discussion**	**For Information only**
	No	*Yes*	*Yes*	*N/A*

Reason for not being taken in public	**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)*** **So What** ***(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these*** **What Next** ***(summary of intended action and benefits supporting the choices and recommendation(s)being made)***	This report summarises the principal business considered by the Finance and Performance Assurance Committee at its meetings on 8 October and 5 November 2026. The Committee maintained oversight of operational recovery, the financial recovery plan, cash, capital, efficiency and productivity, workforce controls, business cases and the strategic risks assigned to it. The October meeting identified significant performance gaps and limited assurance over delivery of the operational and financial recovery trajectories, notwithstanding stronger governance and emerging recovery actions. The November meeting received clearer reporting and evidence of some early improvement, but the Committee did not consider sustained recovery or delivery of the year-end financial position to be assured. The Committee's key message is that progress against rebased trajectories and stronger control processes is welcome, but must now translate into recurrent cost reduction, improved operational outcomes and demonstrable month-to-month delivery. Cash remains severely constrained and the year-end financial forecast carries material delivery risk. The Committee continues to require a forward-looking, integrated view of performance, finance, quality, delivery ownership and the choices or compromises needed to close remaining gaps.
Recommendation *(linked to What Next section)*	The Board is asked to: • NOTE the Committee's report and the limited assurance available over sustained operational and financial recovery. • NOTE the severe and continuing cash constraint, dependence on external cash support and arrangements for weekly executive oversight and escalation. • NOTE that the Committee supported continued development of the financial recovery measures described in this report, subject to the conditions and further assurance set out, and did not treat emerging or unvalidated benefits as assured. • NOTE that the Committee reviewed the strategic risks allocated to it and did not recommend a change to the current scores, with assurance remaining limited.
Assurance / Scrutiny route already undertaken	The matters reported were considered at the Committee meetings on 8 October and 5 November 2026, drawing on the meeting papers, approved or draft minutes, management presentations and Committee challenge.

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

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

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

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

University Hospitals Sussex
NHS Foundation Trust

Finance and Performance Assurance Committee Chair's Report

The Finance and Performance Assurance Committee met on 8 October and 5 November 2026. Both meetings were quorate and received Executive and Non-Executive attendance in accordance with the Committee's Terms of Reference. Paul Layzell chaired the October meeting in Philip Hogan's absence; Philip Hogan chaired the November meeting.

The Committee's principal focus was whether strengthened recovery arrangements were producing sustainable operational and financial improvement. Members welcomed clearer reporting and tighter governance, but consistently distinguished evidence of activity or performance against rebased trajectories from evidence that the Trust would achieve its year-end objectives.

The key areas of focus are set out below. The full breadth of business received at both meetings is summarised in Appendix 1.

Operational performance and recovery

In October, the Committee noted a challenging operational position, with urgent care, RTT and diagnostics behind plan and cancer performance remaining below required standards despite some improvement. The Committee noted strengthened performance governance and the development of recovery actions across the constitutional standards. Members nevertheless considered that the reporting did not yet provide sufficient visibility of trends, delivery against actions or their impact on performance and requested a clearer trajectory-based approach to future reporting.

The October Winter Plan provided substantial assurance under the national methodology overall, but only moderate or qualified assurance in important areas including patient flow, discharge capacity, community provision, SDEC consistency and protection of elective and cancer capacity. The residual January bed gap was described as manageable with contingency arrangements, but system partner delivery remained a significant dependency. The Committee requested finalisation of the quality and equality impact assessments, defined escalation triggers and clear arrangements for tracking delivery.

In November, the Committee welcomed the revised performance report. UEC and diagnostics had improved against the Recovery Plan, RTT was in line with its revised trajectory and cancer was in line with its recovery baseline. The report nevertheless assessed overall management assurance as Limited, reflecting the need to demonstrate sustained delivery against the revised trajectories, complete robust recovery plans through to March and address remaining delivery gaps.

The Committee noted that material recovery gaps remained, particularly in RTT, UEC and diagnostic capacity. The November paper identified productivity improvements in outpatient and theatre activity as important components of recovery, alongside targeted capacity measures where required. The Committee requested greater clarity on the scale and affordability of the remaining interventions needed to achieve the March trajectories.

In response to the matter referred by the Board, the Committee heard about the compromises, risks and consequences associated with concurrent pursuit of delivery of the operational and financial plans. The revised reporting represented a step forward but did not yet provide a sufficiently clear and integrated assessment of the operational, financial and quality consequences of the choices required. The Committee therefore obtained limited assurance and requested that future reports identify the scale, sustainability, funding, ownership and patient-care implications of the actions required to close each recovery gap.

Financial performance, recovery and cash

At the October meeting, the Committee noted that the reported position remained consistent with the planned year-to-date position, but continued to depend materially upon non-recurrent mitigations. The underlying recurring deficit was approximately £10m per month, efficiency delivery was behind plan and a fully assured plan for all required expenditure reductions had not been achieved. The principal test identified was whether recurring expenditure and workforce run-rates reduced during the following months.

The Month 6 report showed the Trust remaining on its year-to-date financial trajectory, including a £0.5m in-month surplus and a year-to-date deficit of £20.1m, although the reported position continued to rely materially on non-recurrent measures. Temporary staffing expenditure had begun to reduce, but not at the pace required, and the underlying in-month deficit remained above £9m.

The recovery route map anticipated movement away from the original submitted plan from Month 7, with a £7.7m deficit expected before later recovery measures. The Committee was advised during the meeting that significant risk remained within delivery of the full-year position, with management indicating an overall delivery risk in the region of £20m. The Committee requested that future reports make the scale and composition of this risk explicit.

Cash remained severely constrained. The Committee continued to scrutinise supplier-payment pressures, external cash-support requirements and the associated operational risks. Management described strengthened weekly cash oversight, supplier prioritisation and escalation arrangements, while making clear that cash pressure was expected to remain a significant issue beyond the current financial year.

Efficiency, productivity and workforce controls

The October Seagry workforce review identified sustained workforce growth, recurrent pay overspends, historic misalignment between workforce and financial plans and insufficiently effective controls over temporary staffing and recruitment. The Committee noted controls introduced since the review period, but requested a comprehensive management response demonstrating both immediate impact and longer-term workforce redesign.

In November, the Committee received more granular reporting on recovery initiatives. Assured efficiency schemes had increased, but assured classification did not equate to forecast delivery, and material gaps remained. Bank, agency, insourcing and outsourcing expenditure continued to present significant delivery risks. The Committee requested a clear reconciliation between workforce and finance data, including separately identifying externally funded posts.

The Committee discussed the development of a more explicit Trust-wide approach to productivity, including an initial 4% aggregate ambition, subject to further work to validate the baseline, opportunity and accountability arrangements. Members emphasised the need to ensure that this complemented existing financial recovery and transformation programmes and that benefits were measurable and validated by Finance.

The Committee remained concerned about the pace and delivery certainty of theatre productivity improvement. Management was asked to return with a clearer operating model, accountable ownership, milestones and quantified operational and financial benefits.

Investment decisions and strategic enablers

The Committee noted in October that the Board-approved wholly owned subsidiary remained dependent on regulatory and staff-side support. In November, the Committee received an update on alternative options being explored to secure the anticipated financial

benefit. These remained subject to further development and discussion with the Board and did not represent approval of an alternative outsourcing model.

The Committee approved continuation of external recovery support to the next monthly review point, subject to evidence of measurable benefits, clear Trust ownership, value for money and effective knowledge transfer.

Work with NHS Professionals remained strategically supported but was not ready for business-case approval. Further work remained necessary on the workforce model, medical staffing, contract arrangements, benefits and implementation before any commitment was made.

The Committee supported replacement of the Thomas Kemp Tower MRI scanner following confirmation of £2m external funding, while requiring future capital proposals to set out quantified productivity and quality benefits, the prior scrutiny route, completed impact assessments and arrangements for benefits realisation. The five-year large medical-device investment programme was deferred to December pending the more detailed report.

Planning for 2027/28 and sustainable recovery

The Committee considered the developing approach to the 2027/28 planning round. Members emphasised the importance of establishing a realistic baseline, aligning activity, workforce, capacity and finance, and identifying recurrent recovery measures sufficiently early to support implementation from the start of the financial year. In November, management described the scale of the emerging financial challenge and the level of efficiency and productivity opportunity being explored. The Committee noted that these remained planning assumptions and opportunities under development rather than assured savings.

Commercial, sustainability and capital matters

The Committee noted an improved line of sight over the Commercial Directorate CIP target and supported development of the 2027-2030 Commercial and Partnerships Strategy. It requested closer alignment of commercial reporting with cash, supplier prioritisation and the Trust's most material contracts, including reconciliation of amounts owed with the finance cash report.

The Committee endorsed the strategic direction and governance for Reduce and Reuse by Default, subject to clinical safety, regulation, operational feasibility, whole-life financial assessment and sterile-services capacity. No funding decision was made. The policy will proceed through consultation and the normal Executive approval route.

Risk and Board Assurance Framework

The Committee reviewed the strategic risks within its remit and considered the reported controls, actions and assurance. The Committee agreed that the current scores should remain unchanged and that assurance remained limited. Members continued to request clearer evidence connecting mitigating actions to demonstrable reductions in strategic risk.

Referrals and matters for the Board

No matters were referred to another Committee. The principal matters to be drawn to the Board's attention are the limited assurance over sustained operational and financial recovery, the continuing severe cash constraint, the material delivery risk within the year-end forecast, and the need for recurrent, implementation-ready recovery plans for 2027/28.

University Hospitals Sussex
NHS Foundation Trust

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**8 October 2026**	**Chair**	Professor Paul Layzell	**Quorate**	Yes
Meeting Date	**5 November 2026**	**Chair**	Philip Hogan	**Quorate**	Yes
Declarations of Interest	No new declarations were raised. A professional relationship with Deloitte was recorded in October and managed when the engagement was subsequently considered, with the relevant member not participating in the decision.				

Items received at the Committee meeting

Item	Oct	Nov	Presenter	Purpose	Outcome / Action taken
Operational Performance / Constitutional Standards	Oct	Nov	Chief Delivery Officer / Director of Performance	To discuss and agree actions	November: Noted limited assurance, early UEC and diagnostic improvement, RTT in line with rebased trajectory and cancer stability. Requested clearer links between operational recovery, quality and finance, differentiation of short-term and sustainable actions, and a quantified route to the March RTT target. October: Noted that UEC and RTT were behind plan, cancer remained below standard despite improvement, and diagnostics had deteriorated in August but remained comparatively strong nationally. Requested clearer trend reporting linking trajectories, recovery actions, impacts and resource choices.
Winter Plan Assurance Model	Oct		Chief Delivery Officer / Deputy Chief Delivery Officer	For assurance	Noted substantial overall assurance, with qualified assurance on patient flow, discharge, capacity and system delivery. Required finalisation of the QIA/EIA, delivery tracking and escalation triggers, and a post-winter review.
Wholly Owned Subsidiary / Strategic Estates Programme	Oct	Nov	Chief Finance Officer / Financial Improvement Consultant	To endorse and note	October: Noted progress and the dependency on staff-side support. November: Received an update on alternative options being explored to secure the anticipated financial benefit. These remained subject to further development and Board discussion and did not represent approval of an alternative outsourcing model.
TKT MRI Scanner replacement		Nov	Chief Finance Officer / Director of Strategic Finance	To approve	Approved the £2m replacement scheme after external NHSE capital funding was secured. Requested that productivity, financial and patient benefits, prior governance scrutiny and equality assessment be made explicit.

NHS Professionals managed bank	Oct	Nov	Chief Finance Officer / Chief Medical Officer	To endorse and note	October: Supported continued development, subject to stronger workforce, medical and governance assurance. November: Noted progress but no final business case or contract approval. Supported further work, with A4C staff as the more straightforward initial scope and no material 2026/27 saving assumed.
Seagry Workforce Review	Oct		Chief People Officer / Chief Finance Officer	For assurance	Noted historic workforce growth, temporary staffing reliance and weaknesses in planning alignment and controls. Require comprehensive management response and evidence of the impact of recruitment, bank and agency controls.
External Financial Recovery Delivery Support		Nov	Chief Finance Officer / Financial Improvement Consultant	To approve continuation subject to gateway review	Approved continuation to the next monthly review point, subject to evidence of measurable benefits, clear Trust ownership, value for money and effective knowledge transfer.
Financial Performance, cash, capital and efficiency delivery	Oct	Nov	Chief Finance Officer / Director of Operational Finance / Director of Strategic Finance	For assurance and to agree actions	October: Noted Month 5 position, continuing underlying deficit, severe cash pressure and capital affordability risks; supported a £30m cash application. November: Noted Month 6 remained on plan through non-recurrent measures, but the underlying deficit and full-year recovery remained unassured. Approved a further cash-support application of at least £10m, subject to the outcome of the £30m request, and requested clearer forecasting, escalation and supplier-risk reporting.
Financial Recovery Plan / Efficiency and Productivity Programme	Oct	Nov	Chief Finance Officer / Financial Improvement Consultant / Director of Efficiency and Productivity	For assurance and discussion	October: Noted that full assurance on recovery could not yet be provided; run-rate reduction was identified as the principal test. November: Noted progress in controls but material delivery risk remained. Management indicated during discussion that the overall delivery risk was in the region of £20m. Requested clearer reconciliation of CIP, recovery and non-recurrent benefits, workforce data, costed mitigations and quality safeguards.
Trust-wide Productivity Programme		Nov	Chief Finance Officer / Director of Efficiency and Productivity	To discuss development	Discussed a more explicit Trust-wide approach to productivity, including an initial 4% aggregate ambition subject to validation of the baseline, opportunity and accountability. Requested avoidance of duplication and measurable, Finance-validated benefits.

Planning 2027/28	Oct	Nov	Chief Finance Officer / Chief Delivery Officer	To discuss and note / approve approach	October: Noted the planning timetable and need for realistic, integrated activity, workforce and financial assumptions, with early Board engagement. November: Considered the emerging scale of the financial challenge and opportunities under development. Emphasised early identification of recurrent measures for implementation from April 2027; planning figures were not treated as assured savings.
Business Case Benefits Realisation	Oct		Director of Strategic Finance	To discuss and note	Supported development of a proportionate, risk-based benefits-realisation framework covering financial and clinical outcomes, with further detail to return.
Corporate Services Benchmarking	Oct		Chief Finance Officer	To note	Noted benchmarking findings and opportunities for measured cost reduction, technology and AI-enabled productivity.
Commercial Report Quarter 2 including Commercial and Partnerships Strategy 2027–2030,		Nov	Chief Procurement Officer	To discuss and note	Noted strong procurement and supply-chain performance, progress on the Commercial and Partnerships Strategy and a £7.94m CIP pipeline against a £7.84m target, while Q2 delivery remained £0.53m behind plan. Requested stronger alignment with cash and supplier management and future reconciliation of supplier spend and amounts owed.
National Cost Collection post-submission report	Oct		Director of Strategic Finance	To note	Noted successful submission and the importance of the reference cost index for benchmarking, tariff and productivity assessments.
DHSC Sponsorship Pilot Programme and MoU	Oct		Chief Procurement Officer	To approve and note	Approved entry into the DHSC Memorandum of Understanding; noted the pilot scope; supported further development subject to normal procurement, governance and approval routes.
Sustainability Reduce and Reuse by Default		Nov	Chief Procurement Officer / Green Clinical Lead	To endorse and note	Endorsed the strategic direction, Product Selection Committee governance model and progression of the draft policy to EMC. Noted that no funding decision was sought and that sterile-services capacity, whole-life cost, staff engagement and benefits evidence must inform implementation.
Board Assurance Framework and Finance & Performance risks		Nov	Chief Finance Officer / Company Secretary	To consider and recommend to Board	Reviewed the strategic risks within the Committee's remit and agreed that current scores should remain unchanged, with limited assurance. Requested clearer links between controls, actions, outcomes and expected reductions in risk.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	15.	**Meeting:**	Trust Board in Public	**Meeting Date:**	12 November 2026
Report Title:	Strategy and Major Projects Assurance Committee Chair's Report				
Author(s):	Professor Paul Layzell – NED & Committee Chair				
Purpose of the report: *(indicate as appropriate)*	**For Decision**	**For Assurance**	**For Discussion**	**For Information only**	
	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 report summarises the business considered by the Strategy and Major Projects Assurance Committee at its meeting on 5 November 2026.

The meeting was quorate and considered all scheduled business. This included the Strategy Delivery and Improvement Plan, the major project portfolio overview, detailed reviews of Theatre Ventilation and Ophthalmology, and the Committee's allocated element of the Board Assurance Framework (BAF).

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 Committee's scrutiny of the major project portfolio and the actions to manage delivery risks. Delays to key projects, including Theatre Ventilation and Acute Floor Reconfiguration, remain a concern because of their importance to the Trust's recovery.

The detailed review of Ophthalmology provided assurance that the delivery plan is well structured, with clinical leadership of its workstreams and intended benefits focused on improving patient care.

The Board should note that NHS England welcomed the Strategy Delivery and Improvement Plan. The plan provides a framework for overseeing the Trust's improvement priorities, including its undertakings to NHS England.

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

The Board can have confidence that the Strategy Delivery and Improvement Plan is aligned with the Trust's overarching strategy and is designed to support delivery of its agreed undertakings. The relevant Board Committees will oversee delivery of the elements allocated to them.

The Committee noted the limited direct reporting it receives on its allocated strategic risk. It welcomed the explicit inclusion of current system financial challenges and their implications for the Trust, as requested at the previous meeting. The Committee received no information indicating that the proposed quarter 2 score should change and accepted the score of 16.

Recommendation *(linked to What Next section)*

The Board is asked to NOTE:

- **The Committee was quorate and considered all scheduled reports.**

University Hospitals Sussex
NHS Foundation Trust

	- **The Committee's review of the Strategy Delivery and Improvement Plan and its endorsement of oversight by the relevant Board Committees.** - **The Committee's scrutiny of the major project portfolio and its detailed reviews of Theatre Ventilation and Ophthalmology.** - **The Committee's review and acceptance of the proposed quarter 2 score of 16 for strategic risk 6, noting the limited direct reporting available.**
Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*	The Strategy and Major Projects Board reviewed the items before they were reported 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 oversees the delivery of major projects that are aligned with the Trust's strategy and support its 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)	The Committee scrutinises the assurances recorded in the BAF for strategic risk 6 and recommends the current risk score to the Board.					

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

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

University Hospitals Sussex
NHS Foundation Trust

Strategy and Major Projects Assurance Committee Chair's Report

The Strategy and Major Projects Assurance Committee met on 5 November 2026. The meeting was quorate, with at least two Non-Executive Directors and two Executive Directors present, including the Chief Financial Officer as the Committee's alternate lead executive. Other attendees included the Directors of Strategy, Infrastructure, Strategic Finance and HR, and the Company Secretary. The Managing Director for Surgery and the Project Manager joined to present the Ophthalmology update.

The Committee considered all scheduled business. Its principal areas of focus are summarised below, with a full account of the items received in Appendix 1.

Trust Strategy Delivery and Improvement Plan

The Committee reviewed the developed Strategy Delivery and Improvement Plan. It discussed how the plan establishes clear, measurable milestones aligned with the Trust's strategy, its undertakings to NHS England and the agreed well-led recommendations.

The plan is underpinned by individual delivery plans. Work is underway to link reporting on completed actions to the achievement of intended outcomes. The Committee was advised that NHS England was content that the plan addressed the expected areas for improvement, including the undertakings.

The Committee provided feedback on the plan's content, structure and future reporting. It emphasised that reports should include the assessments of the Senior Responsible Owner (SRO) and Executive Sponsor of the risks to achieving the intended outcomes.

The Committee was updated on the principal delivery risks and work to improve the use of digital systems to update and track actions.

The Committee endorsed the proposal for the relevant Board Committees to receive performance dashboards and delivery reports for their allocated elements of the plan. It asked for consistent workstream terminology so that these reports can be readily linked to the Strategy Delivery and Improvement Framework (SDIF), supporting effective use of Committee time.

The Committee noted that the paper assessed overall delivery confidence as amber. Although 27 of 31 action plans were on track, this represented progress against milestones rather than assurance that the intended outcomes would be achieved. The Board should therefore distinguish assurance about the framework's design from assurance about delivery of the required improvements. This latter issue will be for the work of the appropriate oversight committees.

Major Project Portfolio Overview

The portfolio overview continued to provide clarity on project risks and the actions being taken to maintain progress. The Committee requested that the next report set out the expected benefits of each project, how these will be tracked, and a forward view of their delivery.

The Committee reviewed progress across the portfolio and the actions to manage delivery risks. It highlighted delays to Theatre Ventilation and Acute Floor Reconfiguration and requested focused attention on these projects because of their importance to the Trust's recovery.

The portfolio paper described a mixed assurance position. Material unresolved risks included NHS England's non-approval of the SRH RAAC Strategic Outline Case and a 16-week delay in EPR recruitment, with potential consequences for implementation dates, costs and contractual liabilities. These sit alongside procurement, workforce and infrastructure dependencies affecting delivery across the portfolio.

The Committee suggested a briefing on EPR should be made to the Board in the near future, given its pivotal role across the Trust and its contribution to future operating efficiency.

The Committee welcomed the opportunity to extend the strategic thinking around the SRH RAAC project and to take advantage of a rare opportunity for substantial capital investment.

Major Projects – Ophthalmology Update

The Committee reviewed the Ophthalmology improvement project, including its plan, progress and oversight of future phases. The first two phases addressed estates deficiencies. Phase 3 will review the service against best practice and develop pathways that improve patient care and meet rising demand.

The Committee noted that the phase 3 workstreams are clinically led and supported by clinical practitioners and stakeholder engagement. These arrangements will support the development of robust options for future service delivery. The intended benefits are focused on improving patient care.

Assurance over delivery therefore remains dependent on completing engagement, the options appraisal and establishing a clear timetable.

Major Projects – Theatre Ventilation Update

The Committee reviewed the Theatre Ventilation report and the complexity of its four workstreams: decant capacity, major refurbishment, moderate refurbishment and procedure-room improvements.

The Committee noted that the delivery plan drew on lessons from previous complex projects. Changes to the initial design and scope have nevertheless affected the programme's timescales. It received an update on the actions to address these changes and manage dependencies with other projects across the Trust's hospitals.

The Committee highlighted the difficulties caused by allowing insufficient time to define the project's full scope. It asked that this lesson be considered carefully when planning and managing the wider project portfolio.

Board Assurance Framework

The Committee scrutinised strategic risk 6, its allocated element of the BAF, which relates to collaborating to improve the health and wellbeing of our communities.

The Committee noted that it receives limited direct reporting to support its oversight of this risk. It received no information indicating that the proposed quarter 2 score of 16 should change and accepted that score. It also noted that current system financial challenges had been explicitly reflected in the BAF entry.

The Executive Team's review of whether this strategic risk should remain allocated to the Committee was still in progress.

University Hospitals Sussex
NHS Foundation Trust

Referrals to Other Committees

No matters from the November meeting required referral to another Committee. The relevant Board Committees will routinely receive reports on their allocated elements of the Strategy Delivery and Improvement Plan.

University Hospitals Sussex
NHS Foundation Trust

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	5 November 2026	**Chair**	Professor 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 and Improvement Plan	Director of Strategy	To discuss the plan and endorse oversight by the relevant Board Committees.	The Committee reviewed the Strategy Delivery and Improvement Plan. It provided feedback on the plan's content and future reporting and noted that NHS England was content that the plan addressed the expected areas for improvement. It endorsed oversight of the plan's allocated elements by the relevant Board Committees.
Major Project Portfolio Overview	Director of Strategy	To review the portfolio, consider the admission of new major projects and agree the closure of completed projects.	The Committee reviewed progress across the portfolio and the actions to manage delivery risks. It noted delays to key projects, including Theatre Ventilation and Acute Floor Reconfiguration. It requested focused attention on these projects because of their importance to the Trust's recovery.
Ophthalmology Project	Managing Director for Surgery	To note project governance and oversight.	The Committee discussed the Ophthalmology report presented by the SRO. It noted progress in the initial phases, plans for phase 3, clinical leadership and stakeholder engagement. The intended benefits are focused on improving patient care.
Theatre Ventilation Major Project Update	Director of Infrastructure	To note project governance and oversight.	The Committee discussed the Theatre Ventilation report presented by the SRO.

			It noted the project's complexity, delivery challenges and actions to mitigate risks.
Board Assurance Framework	Company Secretary	To review strategic risk 6 and recommend its score to the Board.	The Committee reviewed its allocated element of the BAF. It noted the limited direct reporting available and received no information indicating that the proposed quarter 2 score of 16 should change. It accepted the score.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	16.	**Meeting:**	Trust Board in Public		**Meeting Date:**	12 November 2026	
Report Title:	Audit Committee Chair's Report						
Author(s):	Mike Driver – NED & Committee Chair						
Purpose of the report: *(indicate as appropriate)*	**For Decision**	**For Assurance**	**For Discussion**	**For Information only**			
	N/A	*Yes*	*Yes*	*N/A*			
Reason for not being taken in public *(indicate as appropriate)*	**Commercial confidentiality**	**Staff confidentiality**	**Patient confidentiality**	**Other exceptional circumstances (please detail)**			
	N/A	*N/A*	*N/A*	*N/A*			
Regulatory Reporting Requirement							

Summary of the report describing

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

The report provides an update on the business undertaken at the Audit Committee on 27 October 2026.

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 improvement programme.

The Committee also received reports detailing the Trust's management oversight regarding the use of single tender waivers and the mitigations for any losses and 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 processes for ensuring that the oversight of fraud risks are effective and that the Trust has effective systems of control over its use of tender waivers (supported by the LCFS benchmarking review).

The Board can also take assurance that the Trust is engaging with the 2026-27 data security and protection toolkit; the committee agreed with the scope of external assurance to be provided over the submission content.

The Board can take assurance that the Committee continues to provide supportive challenge to secure delivery of agreed internal audit actions with a specific request that all overdue actions meet their revised implementation date of December 2026.

The Board should also note that action it has taken in respect of requesting information on the barriers to the extension of the Trust's STAM programme to include consent and controlled drugs training.

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.

In respect of the two areas of limited assurance provided by Internal Audit on consent and controlled drugs the Board should note the executive assurance

University Hospitals Sussex
NHS Foundation Trust

	provided that appropriate action is being taken to improve the application of the adequately designed internal control frameworks.
Recommendation *(linked to What Next section)*	**The Board is asked to NOTE that:** - **The Committee was quorate and considered all the expected reports in line with its schedule of business.** - **The Committee's assurance over the continuation of the underlying BAF processes.** - **The Committee's request that action is taken to achieve the revised implementation date of December 2026 for the overdue Internal Audit Recommendations.** - **The Committee's request for an update on the barriers to the extension of the Trust's mandatory training in respect of consent and controlled drug training given how important the extension to the Trust's training programme is to address the weaknesses in the application of controls in these areas.**
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 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*

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

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

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

University Hospitals Sussex
NHS Foundation Trust

Audit Committee Chair's Report

The Audit Committee met on the 27 October and was quorate. It received all its planned business. In attendance were the Chief Finance 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 along with the Director of Integrated Governance and Director of HR Operations. The Data Protection Officer also attended to present the report on the Data Security and Protection Toolkit. The Chief Medical Officer attended the meeting to support the discussion on the Internal Audit reports covering Consent Governance and Controlled Drugs. The Chief Pharmacist also joined the meeting for the discussion on the controlled drugs internal audit report.

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.

BAF report

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 described within the risk management update will provide clearer information on the risk drivers affecting the achievement of the Trust's strategic objectives captured within the BAF. The Committee **noted** that the Patient and Quality Committee will provide close scrutiny of the proposed reduction to Strategic Risk 3 to enable a recommendation to be made to Board.

The Committee **agreed** to the deferral of the complementary review of people and cultural element of the BAF to its January meeting.

Risk Management

The Committee **considered** the risk management update and noted the progress made within the first phase of the risk improvement programme. The Committee **discussed** the development of a tiered approach to risk registers and the process for the overall oversight of key divisional and key trust wide risks. The Committee **endorsed** the approach adopted through the risk improvement sprint. The Committee **noted** the positive engagement with the improvement work and the development of the associated updated risk management policy and supporting developed pocket guides, the draft of which were provided to the Audit Committee for information.

The Committee **agreed** with the request that Internal Audit (BDO) be asked to comment on the Trust's revised processes and draft policy and guidance prior their final adoption.

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 operation of the Trust's system of internal control in respect of the consent and controlled drugs,

The Committee **discussed** the drivers for the limited assurance provided over the application of the controls in these areas and received an update from the Chief Medical Officer and Chief Pharmacist (the Trust controlled drugs accountable officer) as to the actions being taken. The Committee **noted** a key element to the improvement in the application of control is the extension to the Trust's current mandatory training programme to

cover both consent and controlled drugs. The Committee **requested** that an update is provided to the Committee on the dates for the extension of this programme of training and if the programme cannot be extended the barrier to achieving this give how crucial this is to the actions required to improve the application of the designed control environment. The Committee also **discussed** the need to see robust 2nd Line Assurance of both processes to provide assurance that the training is leading to an improvement in consistent compliance with the Trust's polices in both areas. It will be necessary for the Patient and Quality Committee to assure itself that improvements in the end-to-end systems are occurring.

The Committee **recognised** that there had been an improvement in the level of engagement with Internal Audit in respect of taking the action agreed in respect of internal audit recommendations. The Committee **asked** that further work be undertaken to ensure that the revised dates of December 2026 be achieved for each of the 11 overdue recommendations. The Director of Operational Finance **agreed** to undertake that work. The Committee further **discussed** that the enhanced oversight of the engagement with internal audit recommendation delivery needed to ensure that if recommendations become aged that there is a robust dialogue with internal audit where systems or processes have changed to agree an alternative action.to address the identified weakness.

The Audit Committee **received and discussed** the Internal Auditors report on their conformance with the Global Internal Audit Standards. The Committee discussed and **agreed** the Internal Auditor's conformance assessment and their proposal regarding standard 8.4.

The Committee **discussed** the proposed changes to the Internal Audit Plan and supported these in principle but **requested** that a further conversation be held with the Chief Finance Officer as to the possibly of retaining the HFMA checklist audit (given the degree of finance challenge facing the Trust) whilst also undertaking an audit into the Trust's actions flowing from the national Thirwell Inquiry report.

Data Security Protection Toolkit Submission and Data Protection Officers Annual Report

The Committee **received** the report providing an update to the NHS Data Security and Protection Toolkit for 2026-27. The Committee **noted** the Trust's actions to address the changes in standards for this year and endorsed the plan to undertake a gap analysis of the Trust's current processes against the new standards whilst recognsing that the work undertaken for the 2025-26 toolkit coupled with a more proactive approach to the identification and management of cyber risks places the Trust in a good position. The Committee **considered and agreed** the recommended breadth of the independent assurance work to be undertaken by Internal Audit in respect of the toolkit standards.

The Committee **discussed** the challenges within the new toolkit but **noted** the confidence provided by the Trust's Data Protection Officer that the Trust is in a strong position to again achieve "standards met".

Local Counter Fraud activity

The Committee considered the Local Counter Fraud progress report for Quarter 2 of 2026/27 in relation to work undertaken in respect of 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 that needed to be actioned urgently.

The Committee noted the progress made through the e-learning programme with budget holders raising the profile of fraud risk and the processes staff should undertake it address these and this training also raises the profile and work of the LCFS.

The Committee, in receiving the LCFS benchmarking report in respect of the level of Single Tender Waivers at the Trust in comparison to their other clients the Committee, noted that the Trust's use of these waivers was significantly below the RSM NHS Sector average.

Based on the quality of the work undertaken by RSM the Committee endorsed the recommendation to extend the LCFS contract for the period 1 November 2026 to 30 October 2027.

Referrals to other Committees

The Committee did not formally refer any matters to another committee noting that the Patient and Quality Committee would exercise oversight of the two internal audit reports where limited assurance was provided which will support oversight and the testing of the assurance that agreed actions are being taken in line with the prepared action plans.

University Hospitals Sussex
NHS Foundation Trust

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	27 October 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
Internal Audit Reports - Activity Progress Report - Recommendation Follow Up Report - Global Internal Audit Standards conformance 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. The Committee **noted** the negative assurance opinions in respect of the application of the systems of internal control within consent governance and controlled drugs. In respect of both reports the Committee received assurance that agreed actions will be undertaken. The Committee requested that the Patient and Quality Committee support in oversight of the actions and the testing of the assurance that action has achieved its stated outcome. The Committee **noted and agreed** the Internal Audit conformance report The Committee whilst recognising an improvement in the level of engagement with Internal Audit Recommendations requested further work be undertaken to ensure that the revised implementation dates of December 2026 are achieved for all overdue recommendations.
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, noting that the Patient and Quality Committee will provide

			close scrutiny of the proposed reduction to Strategic Risk 3 to enable a recommendation to be made to Board. 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 January meeting.
Risk Management Update	Company Secretary	For information and agree request to have Internal Audit undertake a review of the proposed changes to the Trust's risk management policy and processes	The Committee **received** the risk management update and noted the progress made within the first phase of the risk improvement programme. The Committee **discussed** the approach to the tiering of risks and the respective oversight arrangements for each tier. The Committee **noted** the positive engagement with the improvement work and the development of the associated updated risk management policy and supporting developed pocket guides, the draft of which were provided to the Audit Committee for information. The Committee **agreed** with the request that Internal Audit be asked to comment on the Trust's revised processes, draft policy and guidance prior their final adoption.
Counter Fraud - Q2 progress report - Single Tender Waiver 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. The Committee **noted** that the benchmarking undertaken provided confidence that the Trust's single tender waiver use was appropriate as their use was significantly below RSM's NHS sector average.
External Audit Update - Progress report	GT (External Audit)	To note status of the External Audit work	The Committee **noted** that the planning for the 2026/27 external audit had commenced and early engagement has been undertaken with the Trust's finance team.

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 two update noting the analysis provided and discussed the work undertaken to recover outstanding amounts. The Committee **discussed** the actions being taken to minimise losses and the risk of wastage through better cross site working both in the use of stock and through stock system harmonisation. The Committee **sought** for the next report information on longer term trends for the categories of payroll, overseas visitor debt and pharmacy stock along with an analysis of the impact of actions taken from specific learnings individual cases. 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. The Committee **noted** the tracking of identified learning where waivers were applied supported the Trust to further reduce.
Data Security and Protection Toolkit 2026/27	The Trust's Data Protection Officer	To note the progress made and receive an update on the Trusts processes	The Committee **received** the report providing an update to the NHS Data Security and Protection Toolkit for 2026-27. The Committee **noted** the Trust's actions to address the changes in standards for this year and the breadth of the independent assurance work to be undertaken by Internal Audit. The Committee **endorsed** the preparation of a clear gap analysis between the Trust's current processes and those required to meet the revised standards and **noted** the

			proactive nature of the work being undertaken by the Trust to minimise the impact of cyber risks.
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.
Appointment of LCFS	Assistant Deputy Director of Finance - Operational Finance	To approve contract extension	The Committee **approved** the application of the contract extension.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	17.	**Meeting:**	Trust Board in Public	**Meeting Date:**	12 November 2026
Report Title:	Integrated Performance Report				
Sponsoring Executive Director:	Dr. Andy Heeps, Chief Executive				
Author(s):	Various Executives				

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

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

Regulatory Reporting Requirement	The Board is expected to receive routine reporting on the Trust's performance.

Summary	Please see enclosed the integrated performance report for University Hospitals Sussex. It shows our performance to September 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 1 of 2026/27) 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.
Recommendation *(linked to What Next section)*	The Board is asked to **NOTE** and **DISCUSS** this report.
Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*	This is the standing report and is presented directly to the Board, however specific elements of performance have been scrutinised via the relevant Board Committees.

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

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

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

University Hospitals Sussex
NHS Foundation Trust

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

NHS
University Hospitals Sussex
NHS Foundation Trust

Integrated Performance Report

September 2026 *(reporting period)*

Excellent
Care
Everywhere

We are compassionate
We are inclusive
We are respectful

Chief Executive summary

Excellent
Care
Everywhere

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

Chief Executive Summary

NHS
University Hospitals Sussex
NHS Foundation Trust

Please see enclosed the integrated performance report for University Hospitals Sussex. It shows our performance to September 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 1 of 2026/27) 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

Chief Executive Summary Page 2

Q2 2026/27 performance remains challenging for elective access, cancer and emergency care. September saw improvements in emergency waits, falls and workforce capacity. The deficit is on plan, but efficiency delivery, temporary staffing and cash control are continued areas of focus. The latest National Outcome Framework which has broadened its scope in 2026/7 shows an improved segmentation to Segment 3 from Segment 4 in Q1 2026/7.

Our Patients

The Summary Hospital-level Mortality Indicator (SHMI) is 103 for July 2025–June 2026, within the expected range. Monitoring and investigation of diagnostic-code outliers continue.

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. August incident reporting is 66.6 per 1,000 bed days, above the aim of 60. No/low-harm incidents account for 97% of reports. Falls, pressure damage and medication incidents remain common themes. September recorded 249 falls, or 4.17 per 1,000 bed days against a 4.2 target. The rolling-year rate is 4.37. Pressure ulcers fell to 131, with a September rate of 2.2 and a rolling-year rate of 2.52 per 1,000 bed days against a 2.0 target. Risk assessments, lying/standing blood pressures and continence education remain priorities. Mattress replacement is complete, with further inspections planned.

September registered nurse/midwife fill rates are 92.8% by day and 94.4% by night. HCA rates are 92.8% and 95.9%, respectively, against a target above 95%. Care hours per patient day are 9.3. Establishment reviews and roster optimisation support safer staffing and lower agency use.

September RTT under-18-week performance fell to 52.0% against 52.0% planned and a 61% March 2027 ambition. The waiting list reached 118,874 against 117,646 planned. Over-52-week waits rose to 6,415 from 5,634 in August, against 6,500 planned. Over-65-week waits rose to 946 from 594. Six priority specialties, productivity, validation and patient-level long-wait plans underpin recovery.

September diagnostic six-week breaches improved to 16.0% from 16.5%, against 17.4% planned and an August national comparator of 24.7%. The list grew by 971 and the backlog by 53. Weekly governance targets non-obstetric ultrasound, neurophysiology and colonoscopy, with capacity support and recruitment.

Cancer - Faster diagnosis fell to 72.7% against 73.0% planned and 78.6% nationally. The 31-day standard fell to 75.6% against 76.0% planned and 92.1% nationally. The 62-day standard improved to 66.3% against 66.0% planned and 71.9% nationally. September's over-62-day backlog reached 818, including Skin 462, Colorectal 112 and Urology 70. Weekly tumour-site reviews, additional Skin capacity, radiotherapy recovery and improved theatre and diagnostic access underpin recovery.

Chief Executive Summary Page 3

September A&E four-hour performance improved to 65.7% from 64.7% in August, against the 65.7% plan and 74.4% national performance. Approximately 39,100 attendances were 7.4% above September 2025. Long stays and patients with no criteria to reside constrain flow. September waits over 12 hours fell to 2,700 from 3,160 in August and 2,823 a year earlier, representing 6.9% of attendances versus 8.1% in August. Year-to-date delays remain 27.5% higher than last year. St Richard's recorded 767 September delays, 32% more than a year earlier, while Royal Sussex County and Worthing improved. Ambulance handovers over 45 minutes fell to 492 (7.2%) in September from 642 (8.9%) in August. Royal Sussex County accounted for 232 and St Richard's for 133. Model ED, UTC/SDEC streaming, GIRFT FOCUSED flow and seven-day discharge support underpin recovery, including mental-health pathways and site interventions.

Our People

September sickness absence fell to 4.2%, from 4.4% in August and 4.6% a year earlier. Reported national and South East comparators are 4.7%. Work targets 72 nursing/midwifery sickness hotspots, return-to-work meetings and HCA/ancillary action plans.

September vacancy factor fell to 3.6% from 9.2% a year earlier, with 643 whole-time-equivalent vacancies. Band 5 RN vacancies are 5% and HCA vacancies 9.7%. Patient-critical recruitment continues under tighter controls, balancing safe delivery and temporary staffing costs.

September Statutory and Mandatory Training compliance is 91.6%, down from 91.9% but above 90% for twelve months. Medical staff compliance is 83%, with other groups above 90%. Expiry reminders and improved resuscitation-training access support compliance.

September non-medical appraisal compliance improved to 85.5%, below 90%. Including medics, compliance is 85.7%. Healthcare Scientists and corporate divisions remain challenged. Weekly oversight and removal of access barriers support recovery. Positive appraisal feedback is 91.4%.

Our Communities

September Friends and Family Test satisfaction fell to 90.4% from 90.9%, above the 90% target and 90.0% a year earlier. A&E remains most challenged at 76.9% in August versus 78.1% nationally. Complaints and concerns rise, led by delays and communication. September's new feedback platform, ward audits and doctors' communication training support improvement.

Chief Executive Summary Page 4

University Hospitals Sussex
NHS Foundation Trust

Our Future

The Q2 deficit is £20.1m, in line with plan, with Q3/Q4 surpluses required for breakeven. Efficiency delivery is £28.5m adverse year-to-date. Cash pressures delay supplier payments beyond 30 days. Better Payment Practice Code performance is 31% by volume against a 95% target. Capital expenditure is £4.4m below plan, including £4.1m at the 3Ts cancer centre through lower contingency use and slippage. The forecast assumes timing differences unwind by year-end. A financial improvement consultant, monthly run-rate targets and fortnightly CFO reviews support recovery. October's cash-support application has regional approval and awaits national consideration for November payment.

Bank/agency expenditure to September is £61.30m against £53.52m planned, £7.78m adverse (£6.33m bank, £1.45m agency). The annual £95.98m plan comprises £85.57m bank and £10.41m agency, down 31.3% from 2025/26. Industrial action and the heatwave incident contributed to bank pressures. Ward reviews, medical e-rostering and spending controls support recovery.

Q2 research recruitment reached 3,548 participants, ranking 29th of 134 acute trusts against a target of 27th or better. Studies open to recruitment rank 23rd of 134. Priorities include the Sussex Commercial Research Delivery Centre, cross-site research facilities, faster study set-up and five Joint Clinical Academic Directorates with Brighton and Sussex Medical School.

The Trust also provides an update in the body of the report regarding the progress for the major projects underway within the trust, including the helideck, stroke centre, RSCH acute floor, electronic patient record, theatre ventilation and St Richard's RAAC replacement.

One UHSussex

September's monthly Pulse engagement score is 6.5/10, up from 6.2 a year earlier but below the target above 6.9. The 6.68 national comparator is from the annual 2025 NHS Staff Survey. Local actions and 'You Said, We Did' communications continue. The 2026 Staff Survey runs from 16 September to 27 November, with early participation below 2025 levels.

National performance assessment framework

The NHS Oversight Framework 2026/27 marks a significant shift by introducing 30 scoring indicators and 6 contextual measures evaluated against fixed national statistical thresholds. 9 are entirely new metrics introduced for the 2026/27 cycle, designed to reflect the 10-Year Health Plan's focus on shifting care from acute hospitals to the community and driving operational accountability
The transition into the Q1 2026/27 reporting cycle saw University Hospitals Sussex (UHS) shift from Segment 4 up to Segment 3 (an improvement)
University Hospitals Sussex NHS Foundation Trust in Segment 3, ranking 100th nationally among tracked provider trusts with a baseline average metric score of 2.66
The most challenging domain is access to services, with RTT lowest ranked for UHS.

Summaries

Excellent
Care
Everywhere

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

Summary Performance
Metric Summary

University Hospitals Sussex
NHS Foundation Trust

Strategic Ambition	Performance Measure	Latest	Latest Month	Previous Month	Direction	25/26 Month	Target	Operating Plan	Recovery Plan	National
Patients	A&E and Emergency flow - % treated and admitted/discharged within 4 hours	Sep-26	65.7%	64.7%	Increase	68.9%	82% (March-27)	74.9%	**65.7%**	74.4%
	A&E and Emergency flow - Ambulance Handovers > 45 minutes	Sep-26	7.2%	8.9%	Decrease	7.3%	< 2025/6	5.2%	**7.4%**	
	A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments	Sep-26	2,700	3,160	Decrease	2,823	< 2025/6	2,823	**3,106**	10.6%
	Cancer - 28 day faster diagnosis standard	Aug-26	72.7%	74.0%	Decrease	72.5%	80.0%	77.8%	**73.0%**	78.6%
	Cancer - 31 day treatment standard	Aug-26	75.60%	76.79%	Decrease	78.21%	94% (March-27)	86.4%	**76.0%**	92.1%
	Cancer - To achieve the 62 day standard	Aug-26	66.3%	65.2%	Increase	60.4%	80% (March-27)	75.1%	**66.0%**	71.9%
	Diagnostics - % Breaching 6 week target (DM01 modalities)	Sep-26	16.0%	16.5%	Decrease	14.0%	<5%	14.0%	**17.4%**	24.7%
	RTT 52 Weeks	Sep-26	6,415	5,634	Increase	4,977	3782 / 3.7% (March-27)	4667	**6500**	1.5%
	RTT Elective care - >=65 Weeks	Sep-26	946	594	Increase	491	0	0	**950**	
	RTT Elective care - 18 Week Performance	Sep-26	52.0%	52.6%	Decrease	51.6%	60% (March-27)	54.9%	**52.0%**	65.2%
	Safer Staffing - Average fill rate - registered nurses/ midwives (day shifts)	Sep-26	92.8%	92.5%	Increase	90.9%	95%			
	Safer Staffing - Average fill rate - registered nurses/ midwives (night shifts)	Sep-26	94.4%	93.8%	Increase	94.4%	95%			
	Safer Staffing - Average fill rate - care staff (day shifts)	Sep-26	92.8%	91.4%	Increase	83.6%	95%			
	Safer Staffing - Average fill rate - care staff (night shifts)	Sep-26	95.9%	95.4%	Increase	93.3%	95%			
	Care Hours Per Patient Day	Sep-26	9.30	9.39	Decrease	8.23				
	Incidents/1000 beddays	Aug-26	66.65	70.42	Decrease	57.50				
	Falls	Sep-26	4.17	4.41	Decrease	4.58				
	Pressure Ulcers	Sep-26	2.20	2.89	Decrease	2.57				
	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	Jun-26	103.0	103.4	Decrease	102.6	100 (as expected range)			100.0
People	Training & development - Appraisals completed	Sep-26	85.5%	84.9%	Increase	87.1%	>90%			
	Training & development - STAM Weighted Average	Sep-26	91.6%	91.9%	Decrease	92.7%	>90%			
	Workforce capacity - Vacancy Factor (Substantive contracted FTE) - monthly	Sep-26	3.6%	4.3%	Decrease	9.2%	<10%			
	Workforce efficiency - Absence Sickness in month	Sep-26	4.2%	4.4%	Decrease	4.6%	<4.5%			4.7%
Communities	Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good	Sep-26	90.4%	90.9%	Decrease	90.0%	>=90%			91.3%
Future	Financial Stability - Variance from breakeven plan YTD	Sep-26	£20.1m	£20.5m	Decrease		£0	£20.1m		
	Bank and Agency Spend against planned trajectory	Sep-26	£61.3m	£51.7m	Increase		£0	£53.5m		
	Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies	Sep-26	29th	32nd	Decrease	30th	<27th			
One UHSX	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	Sep-26	6.46	6.69	Decrease	6.21	>6.9			6.68

Statistical Process Control

How to Read the charts

University Hospitals Sussex
NHS Foundation Trust

Statistical process control

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

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

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

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

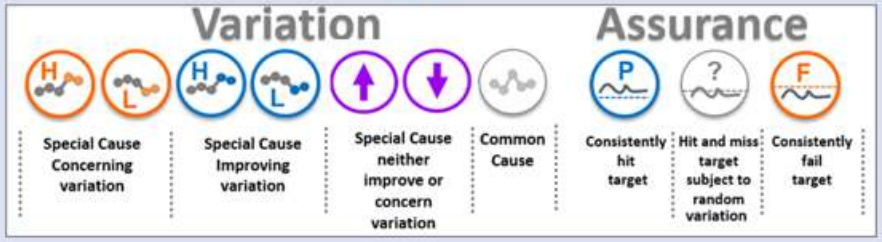
The rules (please note the rules are ordered to priortised in the order trend, shift, 2 out of 3, single point)

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

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

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

Icon key



Excellent Care Everywhere

Summary Performance
SPC Assessments

NHS
University Hospitals Sussex
NHS Foundation Trust

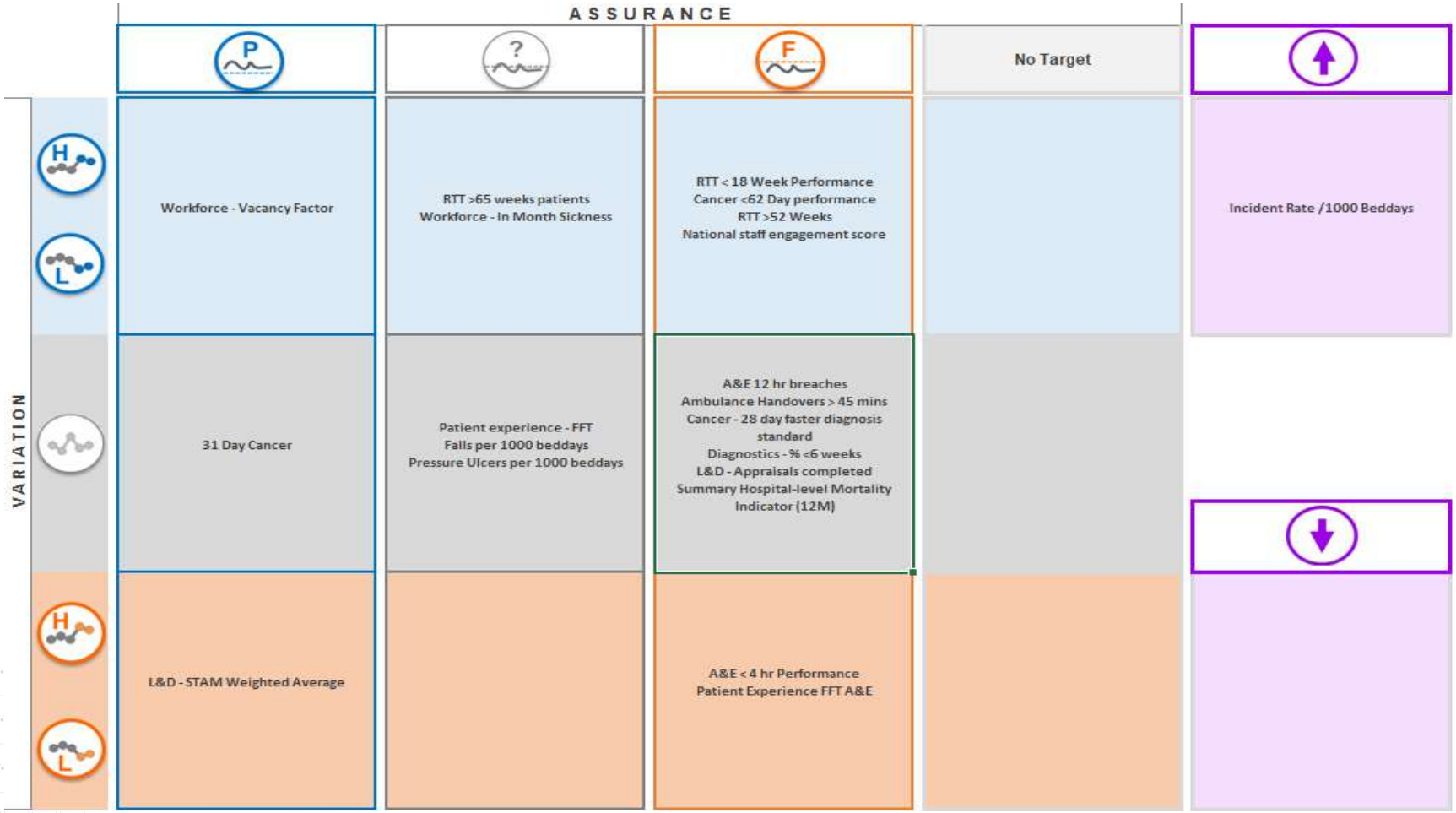
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT < 18 Week Performance	Sep 26	52.0%	61.0%			50.5%	48.3%	52.7%
A&E < 4 hr Performance	Sep 26	65.7%	82.0%			69.6%	66.4%	72.7%
A&E 12 hr breaches	Sep 26	2700	1498			2815	1927	3702
Ambulance Handovers > 45 mins	Sep 26	7.2%	4.0%			9.2%	4.5%	13.9%
Cancer - 28 day faster diagnosis standard	Aug 26	72.7%	83.0%			74.5%	66.6%	82.4%
Cancer <62 Day performance	Aug 26	66.3%	80.0%			63.1%	53.9%	72.2%
RTT >52 Weeks	Sep 26	6415	3782			6499	5009	7988
Diagnostics - % <6 weeks	Sep 26	16.0%	11.0%			16.1%	11.4%	20.8%
RTT >65 weeks patients	Sep 26	946	400			1009	204	1815
L&D - Appraisals completed	Sep 26	85.5%	90.0%			86.1%	83.9%	88.2%
L&D - STAM Weighted Average	Sep 26	91.6%	90.0%			92.2%	91.2%	93.2%
Workforce - Vacancy Factor	Sep 26	3.6%	10.0%			7.8%	6.4%	9.2%
Workforce - In Month Sickness	Sep 26	4.2%	4.5%			4.6%	4.0%	5.3%
National staff engagement score	Sep 26	6.46	6.90			6.44	6.08	6.80
Summary Hospital-level Mortality Indicator (12M)	Jun 26	103.02	100.00			102.73	101.22	104.25
Patient experience - FFT	Sep 26	90.4%	90.0%			90.9%	89.1%	92.6%
Incident Rate /1000 Beddays	Aug 26	66.65	-			59.68	51.97	67.39
Patient Experience FFT A&E	Sep 26	78.4%	90.0%			82.1%	77.3%	86.9%
	Sep 26	9.30	-			8.28	7.56	9.01
	Sep 26	249	-			261	213	309
	Sep 26	131	-			155	99	211
Falls per 1000 beddays	Sep 26	4.17	4.20			4.39	3.57	5.21
Pressure Ulcers per 1000 beddays	Sep 26	2.20	2.00			2.60	1.73	3.48
31 Day Cancer	Aug 26	75.60%	94.00%			78.96%	70.99%	86.92%

Excellent Care Everywhere

Statistical Process Control

Assurance and Variation

NHS
University Hospitals Sussex
NHS Foundation Trust



Excellent Care Everywhere

Patients



Excellent
Care
Everywhere

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

Faster Access to Planned Treatment and Cancer Care

RTT <18 Week Performance

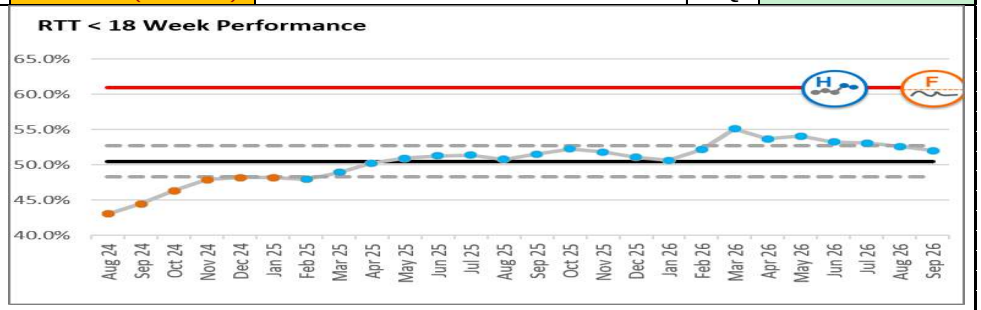
NHS
University Hospitals Sussex
NHS Foundation Trust

Elective Care: RTT <18 Week Performance	Target	60% by March-27	
Latest Month Recovery Plan	52.00%	National Rank	143 of 145 Trusts
Latest Month Operating Plan	54.90%		
Latest Month Actual	52.00%	National Performance	65.2% Aug-26
Latest Month Trend	Decreased (worsened)	NPAF Area: Access to Services	DQ: Green

Key Messages

- **RTT<18 Week performance** was 52.0% for UHSX Trust Sep-26, a reduction of -0.6% since Aug-26 and +0.4% since Sep 25.
- It is on the Trust trajectory plan for September (of 52.0%). **(Rebased Plan)**
- National performance for Aug-26 was 65.2%.

- **The waiting list size** grew to 118,874 in Sep-26. This is behind the plan of 117,646 for Sep-26
- The heatwaves throughout summer 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

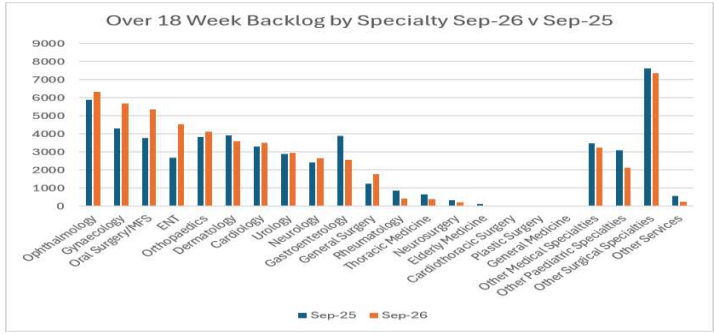


Key Actions

- **Deliver outpatient productivity improvement** and restore outpatient activity to plan, with additional over-plan activity where achievable.
- **Improve theatre productivity and restore IP/DC activity to plan**, with theatre utilisation targeted at **>80%**.
- **Reduce the routine referral triage/ processing backlog from approximately 3,300 to ≤1,000 by March 2027**, improving access to first appointment.
- **Increase administrative clock stops and waiting-list validation through Netcall**, alongside standby lists for short-notice cancellations and appointment reminders.
- **Deliver targeted recovery plans in the six priority specialties**, backed by dedicated intensive support
- **Use the Elective Co-ordination Centre** to move patients between UHSussex sites and, where affordable and agreed, to external providers for earlier treatment

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Rec Plan	52.9%	53.8%	53.9%	53.3%	52.6%	52.0%	52.0%	54.7%	55.0%	57.0%	58.5%	61.0%
Op Plan	52.9%	53.8%	53.9%	53.3%	54.2%	54.9%	54.5%	55.6%	57.1%	57.5%	58.7%	61.0%
Actual	53.7%	54.1%	53.2%	53.1%	52.6%	52.0%						
Variance	0.8%	0.2%	-0.7%	-0.2%	0.0%	0.0%						

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 Alex Shaw **SRO** James Watt

Excellent Care Everywhere

Faster Access to Planned Treatment and Cancer Care

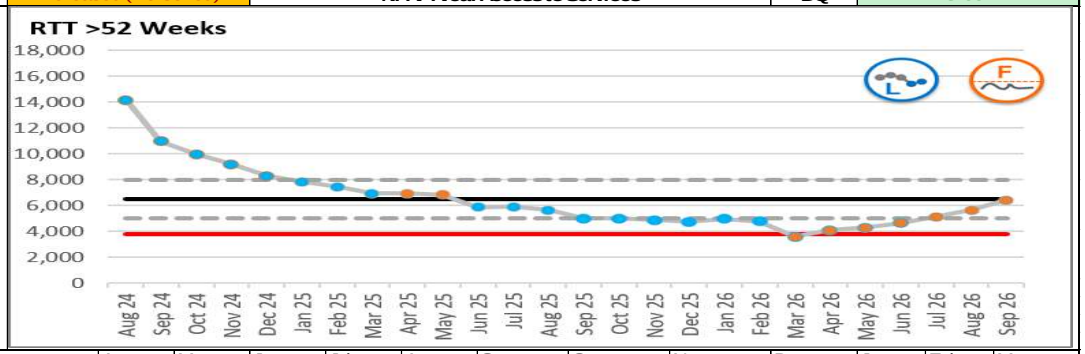
RTT > 52 Week Waits

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Patients: Faster Access to Planned Treatment and Cancer Care			
Elective Care: RTT> 52 Week Waits	**Target**	<=3300 March-26	
Latest Month Recovery Plan	6500	**National Rank**	Aug 26 125/128
Latest Month Operating Plan	4667		
Latest Month Actual	6415 (5.4%)	**National Performance**	1.5% Aug-26
Latest Month Trend	Increased (worsened)	**NPAF Area: Access to Services**	**DQ** Green

Key Messages

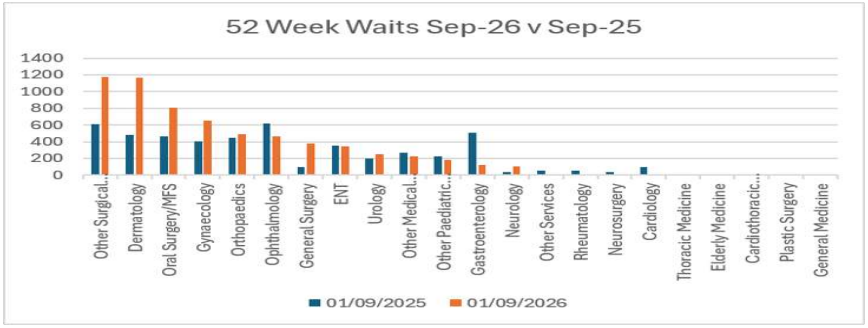
- **52ww** grew to 6,415 in Sep-26. This is marhinly ahead of plan of 6500 for Sep-26 **(Rebased Plan)**
- Specialties with most 52 week waits Jun-26 are Dermatology–1163 patients—compared to 946 the preceding month, Oral/max facial surgery (808 patients, compared to 845 last month), gynaecology (655 patients compared to 620 last month), and ophthalmology (465 compared to 432 last month)
- There were 946 65-week waits in Sep-26, 352 more than Aug-26, 455 more than Sep-25



Key Actions

- **Implement targeted recovery plans for the six priority specialties**, supported by intensive recovery support
- **Refresh the long-wait forecast** to give a current view of cohort ageing, risk and recovery requirements
- **Maintain patient-level plans for >65-week waiters**, incorporated into weekly governance.
- **Undertake systematic waiting-list validation**, initially within Surgery and proposed across other divisions.
- **Stand up additional activity aligned to recovery plans** to increase treatment capacity and reduce the long-wait cohorts.
- **Maximise core Mon–Fri capacity and prioritise the correct waiting-list cohorts**, reducing dependency on WLI and ensuring additional activity tackles the patients driving long waits.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Rec Plan	5048	4861	4851	4976	5634	6500	6500	5944	5325	4902	4335	3782
Op Plan	5048	4861	4851	4976	4786	4667	4736	4533	4267	4197	3982	3782
Actual	4076	4297	4638	5121	5634	6415						
Variance	-972	-564	-213	145	0	-85						



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 Alex Shaw **SRO** James Watt

Excellent Care Everywhere

Better urgent and emergency care

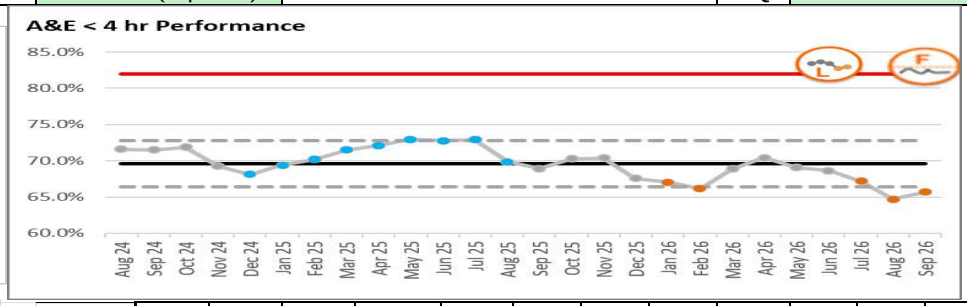
A&E <4Hour % Performance

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Patients: Better urgent and emergency care			
A&E <4Hour % Performance	Target	82% by March-27	
Latest Month Recovery Plan	65.70%	National Rank	99 of 114 (Sep-26)
Latest Month Operating Plan	74.90%		
Latest Month Actual	65.70%	National Performance	74.4% (Sep-26)
Latest Month Trend	Increased (Improved)	NPAF Area: Access to Services	DQ: Green

Key Messages

- **A&E <4-hour performance** was 65.7% in Sep-26. This is 1% higher than Aug-26, and 3.2% lower than Sep-25. National performance was 74.4% in September. It is on the Trust planned improvement trajectory of 65.7% for Sep-26. The Trust including catchment saw 39,166 attendances, 7.4% higher than Sep-26. **(Rebased Plan)**
- **Patients in A&E for 12 hours** reduced to 2700 in Sep-26 from 3160 in Aug-26, and 2,823 Sep-25
- There were 39146 attendances, compared to 36455 in Sep-25 (+7.4%).
- There are 45 more 21day+ patients Sep-26 than Sep-25, and 64 more NCTR



Key Actions

- **Implement Model ED across all sites**, including initial assessment within 15 minutes, streaming to UTC, acuity tools, Criteria to Admit, SDEC, high-intensity-user pathways and CFS scoring
- **Increase SDEC and admission-avoidance pathways**, including specialty SDEC for Neurosciences, Vascular, Cardiology and Oncology
- **Optimise ward and discharge processes**, including daily board/ward rounds, seven-day senior decision makers, home-before-lunch, Therapy/Pharmacy support and reduction in NCTR patients.
- **Implement GIRFT FOCUSED principles**, including right patient/right bed first time, clear escalation triggers and the Full Capacity Protocol
- **Increase discharge-lounge utilisation**, including the RSCH plan for 10 discharges identified before 10am and **30–40 patients per day through the lounge, equivalent to 70% of eligible discharges**.
- **Embed performance grip**, through weekly CDO reviews, daily cross-site and two-hourly huddles, alongside the RSCH sprint and corridor-care programme.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Rec Plan	71.9%	72.6%	73.4%	73.4%	65.0%	65.7%	66.1%	67.8%	72.2%	72.2%	75.1%	82.0%
Op 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%	67.2%	64.7%	65.7%						
Variance	-1.5%	-3.6%	-4.8%	-6.2%	-0.3%	0.0%						

A&E4hr	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
UHS<4hr %	70.4%	69.1%	68.6%	67.2%	64.7%	65.7%
Plan	71.9%	72.6%	73.4%	73.4%	72.6%	74.9%
RSCH	59.7%	58.2%	60.7%	57.1%	56.0%	54.7%
PRH	60.4%	63.0%	66.7%	60.3%	56.2%	56.0%
RACH	94.4%	94.6%	94.1%	94.3%	91.7%	91.1%
Worthing	62.2%	59.1%	57.9%	57.3%	55.4%	59.5%
SRH	64.2%	63.0%	57.9%	58.2%	53.5%	54.1%
Variance	76.9%	75.7%	75.0%	75.4%	75.0%	74.4%
A&E 12 hours in department	2,508	2,729	3,133	3,379	3,160	2,700
Patients with a stay in ED Corridors 45 mins +	1971	2134	3118	2908	2647	2116
A&E Attendances	37,704	39,194	38,694	40,477	38,963	39,166
Time to Triage	21	22	23	22	23	24
Time to Treatment	139	145	143	157	167	167
Mean Waiting Time	335	339	345	355	354	341
Ambulance Handover >45 minutes	7.4%	7.0%	10.3%	8.9%	8.9%	7.2%
Ambulance Handovers >45 mins Plan	5.7%	4.7%	3.6%	4.3%	3.7%	4.2%
Occupied Beds	1,702	1,731	1,720	1,787	1,739	1,719
Average LOS (Excl LOS 0)	10.60	12.10	10.60	10.80	10.00	10.90
>= 7 day LOS Patients	1,061	1,093	1,060	1,084	1,057	1,014
>=21 day LOS Patients	505	497	466	506	502	483
Ave. DRD per day	383	376	371	415	400	410

Interdependencies with other performance indicators

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

Exec Owner Alex Shaw **SRO** Wilson Dodzo

Excellent Care Everywhere

Better urgent and emergency care

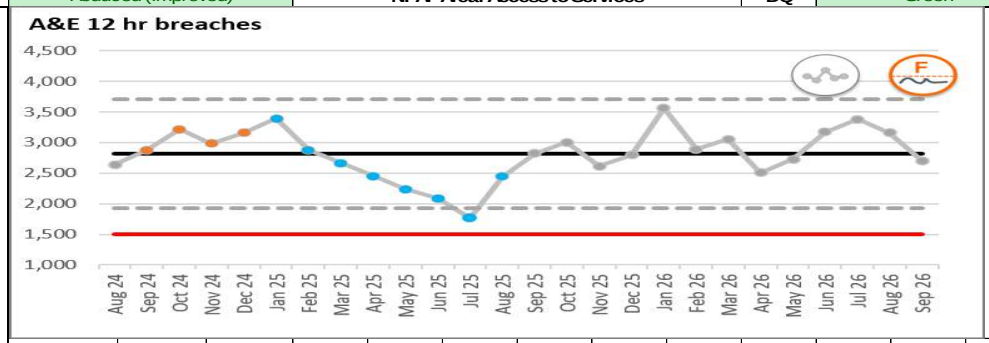
A&E > 12 Hour waits

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Patients: Better urgent and emergency care			
A&E > 12 Hour waits	**Target**	A reduction in 2026/7 compared to 2025/6	
Latest Month Recovery Plan	3106	**National Rank**	56/112 week of 5th October
Latest Month Operating Plan	1686		
Latest Month Actual	2747	**National Performance**	10.60%
Latest Month Trend	Reduced (Improved)	**NPAF Area: Access to Services**	**DQ** Green

Key Messages

- The Trust has seen a 27.5% increase in 12 hour delays in 2026/27 to end Sep-26. This in the context of growth in attendances of 3.2%
- This improved Sep-26 however, to 2747 , below the equivalent month 2025.
- Of 2747 patients who waited over 12 hrs in A&E, prior to leaving the department, 941 were at the Royal Sussex County . Sep-26 was 17% lower than Sep-25 at RSCH however.
- SRH had 767 12 hour delays, 32% more than Sep-25
- Worthing saw a material drop in 12 hour delays, to 561 , 148 fewer than Sep-25
- The % 12 hours was 6.9% compared to 7.7% Sep-25, and 8.1% Aug-26



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Rec Plan	2448	2240	2088	1765	3174	3106	3061	2681	2572	2446	1901	1498
Op Plan	1897	1916	1715	1842	1517	1686	1877	1734	1861	1973	1664	1498
Actual	2508	2729	3133	3379	3160	2700						
Variance	60	489	1045	1614	-14	-406						

Key Actions

- **Deliver the revised UEC Improvement Programme** across its three programme buckets: Front Door, Wards & Departments and Discharge.
- **Reduce NCTR and long-stay occupancy** through better ward, discharge and system processes.
- **Implement GIRFT FOCUSED flow**, accelerating movement from ED to the right ward and reducing internal delays and bed moves
- **Improve discharge**, including discharge-lounge utilisation, earlier discharge, weekend planning and seven-day Pharmacy/Therapy support.
- **Continue the RSCH Sprint** and targeted site-level recovery, while addressing the higher 12-hour delays at SRH.
- **Strengthen Mental Health pathways and escalation**, specifically targeting

A&E >12 hours in Department	2026/27						Last Year		Last Month	
Site:	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Var.	% Var.	Var.	% Var.
RSCH	917	954	894	1,030	944	941	-202	-17.7%	-3	-0.3%
PRH	414	418	342	390	404	431	45	11.7%	27	6.7%
RACH	3	1	0	3	2	0	-5	-100%	-2	-100.0%
SRH	518	502	849	972	867	767	187	32.2%	-100	-11.5%
WSH	661	854	1,048	983	943	561	-148	-20.9%	-382	-40.5%
UH Sussex ALL	2,508	2,729	3,133	3,379	3,160	2,700	-123	-4.4%	-460	-14.6%

As % of all Attendances	2026/27						Last Year		Last Month	
Site:	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Var.	% Var.	Var.	% Var.
RSCH	12.37%	11.80%	11.15%	12.15%	11.73%	11.73%		-3.2%		0.0%
PRH	8.92%	8.93%	7.31%	7.82%	8.24%	9.12%		0.4%		0.9%
RACH	0.12%	0.04%	0.00%	0.12%	0.09%	0.00%		-0.2%		-0.1%
SRH	6.91%	6.47%	11.23%	12.47%	11.14%	10.39%		2.1%		-0.8%
WSH	7.31%	9.08%	11.45%	10.37%	10.17%	5.96%		-2.3%		-4.2%
UH Sussex ALL	6.65%	6.96%	8.10%	8.35%	8.11%	6.89%		-0.9%		-1.2%

Interdependencies with other performance indicators

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

Exec Owner Alex Shaw **SRO** Wilson Dodzo

Excellent Care Everywhere

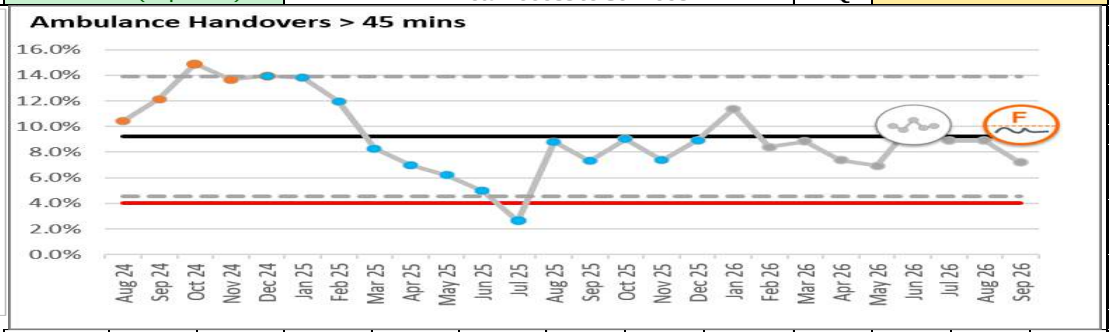
Better urgent and emergency care

Ambulance Handovers >45 mins

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Patients: Better urgent and emergency care					
Ambulance Handovers >45 mins	**Target**	A reduction in 2026/7 compared to 2025/6			
Latest Month Recovery Plan	7.40%	**National Rank**	Best Performing Region		
Latest Month Operating Plan	4.00%				
Latest Month Actual	7.20%	**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 this year , relative to 25/6 with 60% more to date.
- This has coincided with extreme demand pressures with summer heatwaves.
- There was a drop in Sep-26 to 492 patients over 45 minutes, relative to August (642). In % terms 7.2% of ambulance handovers were over 45 minutes Sep-26, compared to 8.9% Aug-26 and 7.3% Sep-25.
- Of the 492 delays in September 232 were at RSCH, 133 at SRH, 66 at Worthing and 61 at PRH.



	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	649	642	492						
Variance	62	108	418	279	336	136						

Key Actions

- **Implement the ambulance handover component of Model ED**, alongside the wider Front Door redesign.
- **Stream patients rapidly to UTC/ SDEC and appropriate pathways**, reducing congestion at the ED front door and avoidable admissions.
- **Reconfigure bed capacity and flow** through the Capacity and Configuration Group to enable more seamless hospital flow and discharge.
- **Implement GIRFT FOCUSED and the Full Capacity Protocol** to create hospital-wide rather than ED-only responsibility for flow.
- **Continue the RSCH Corridor Care Sprint**, given RSCH accounted for 232 of the 492 September delays, with further focus at SRH.
- **Complete the external diagnostic of pre-DRD processes**, alongside the wider review of discharge and inpatient flow.

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.

Handovers:	2026/27						Last Year	
Site	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Var.	% Var.
RSCH	2,357	2,534	2,394	2,592	2,476	2,347	-134	-5.4%
PRH	889	815	804	805	818	760	-90	-10.6%
SRH	1,777	1,927	1,891	1,861	1,849	1,763	-49	-2.7%
WSH	2,117	2,157	2,094	2,020	2,031	1,996	-117	-5.5%
UH Sussex ALL	7,140	7,433	7,183	7,278	7,174	6,866	-390	-5.4%

>45 Minute Handovers:	2026/27						Last Year	
Site	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Var.	% Var.
RSCH	296	270	284	231	244	232	-78	-25.2%
PRH	93	90	87	81	44	61	12	24.5%
SRH	36	61	202	97	92	133	71	114.5%
WSH	101	94	267	290	262	66	-43	-39.4%
UH Sussex ALL	526	515	740	649	642	492	-38	-7.2%

% >45 Mins Handover	2026/27						Last Year	
Site	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Var.	% Var.
RSCH	12.6%	10.7%	9.8%	8.9%	9.9%	9.9%		-2.6%
PRH	10.5%	11.0%	4.6%	3.9%	5.4%	8.0%		2.3%
SRH	2.0%	3.2%	10.7%	5.2%	5.0%	7.5%		4.1%
WSH	4.8%	4.4%	12.8%	14.4%	12.9%	3.3%		-1.9%
UH Sussex ALL	7.4%	6.9%	10.3%	8.9%	8.9%	7.2%		-0.1%

Exec Owner Alex Shaw **SRO** Wilson Dodzo

Excellent Care Everywhere

Faster Access to planned treatment and cancer care

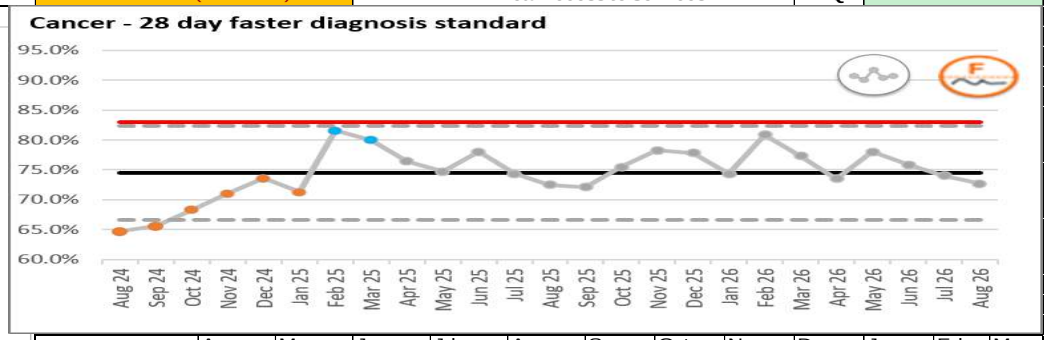
28 Day FDS

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Patients: Faster Access to planned treatment and cancer care					
Cancer Care :<28 Day Faster Diagnosis Standard	**Target**	80% by March-27			
Latest Month Recovery Plan	73.0%	**National Rank**	119 of 140 -Aug-26		
Latest Month Operating Plan	78.0%				
Latest Month Actual	72.7%	**National Performance**	78.6%		
Latest Month Trend	Decreased (worsened)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

- **Faster Diagnosis Standard (FDS) performance** was 72.7% in August 2026, a decline of 1.3 percentage points from both the previous month and 0.2 % higher than the same period last year.
- This deterioration was primarily driven by an increase in Skin pathway diagnostic breaches.
- National performance was 78.6%.
- The Trust has committed to hitting the 80% Faster diagnosis standard - ie 80% of patients diagnosed with or without cancer within 28 days, by March-26.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Rec Plan	81.3%	80.6%	82.3%	77.5%	73.0%	71.7%	73.4%	78.1%	83.9%	80.6%	83.3%	83.0%
Op Plan	81%	81%	82%	77%	78%	76%	77%	81%	86%	82%	84%	83%
Actual	73.5%	78.0%	75.8%	74.0%	72.7%							
Variance	-7.8%	-2.6%	-6.5%	-3.5%	-0.3%							

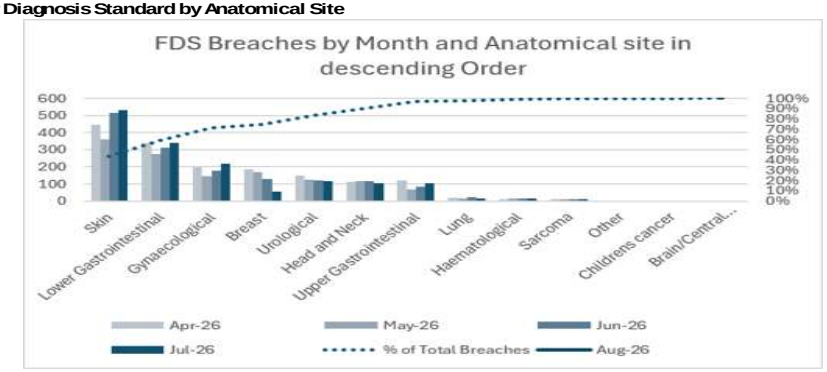
Key Actions

- **Provide additional performance support to Skin**, the most challenged anatomical site.
- **Hold weekly tumour-site driver meetings** focused on the most challenged pathways.
- **Use pathway analyser and KPI reporting** to identify and target delays within cancer pathways.
- **Track pathway intervals from referral through diagnosis and treatment**, directing recovery effort to points where delay occurs.
- **Target cancer diagnostic bottlenecks**, particularly CT, pathology, Lower GI imaging and endoscopy.
- **Complete priority workforce, capacity and pathway actions**, with dedicated improvement support to Skin and Lower GI.

Interdependencies with other performance indicators

- Delays to cancer treatment can impact patient experience and outcomes

Faster Diagnosis Standard by Anatomical Site



Exec Owner Alex Shaw **SRO** Maria Emmanuel

Excellent Care Everywhere

Faster Access to planned treatment and cancer care

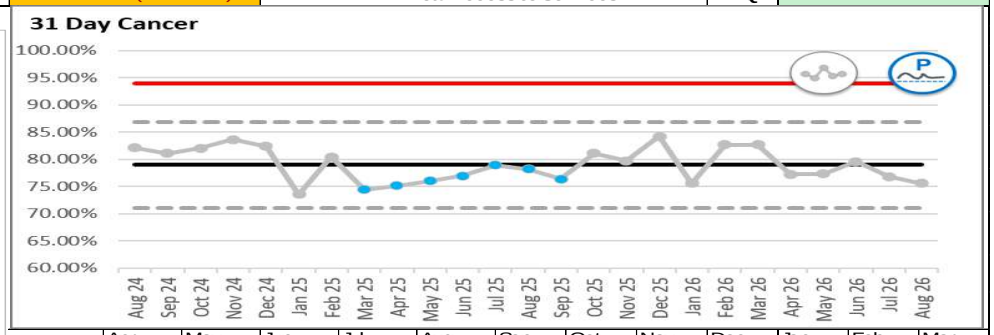
31 Day Care Performance

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Patients: Faster Access to planned treatment and cancer care					
Cancer Care : 31 Day Performance	**Target**	94% by March-27			
Latest Month Recovery Plan	76.0%	**National Rank**	136 of 139 Aug-26		
Latest Month Operating Plan	86.0%				
Latest Month Actual	75.6%	**National Performance**	92.10%		
Latest Month Trend	Decreased (worsened)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

- **31-Day** Decision to Treat to First Treatment performance worsened to 75.6% in August 2026, compared with 76.8% in July 2026, but remained below the national position of 92.1%.
- Performance continues to be affected by increased radiotherapy activity and the prioritisation of CAT2 patients to meet NHS England requirements to eliminate waits of over 100 days for Breast cancer patients and over 150 days for Prostate cancer patients. In addition, limited access to timely theatre capacity across multiple tumour sites has delayed surgical first treatments and contributed to breaches of the 31-day standard
- Highest numbers of breaches in August were for Urological cancers, breast and skin which account for 80% of all breaches.

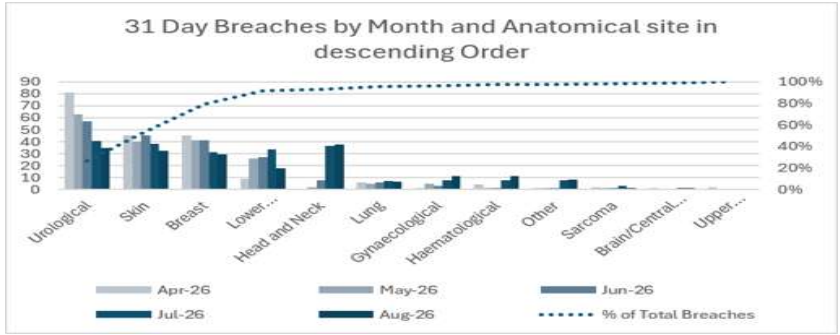


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Rec Plan	86.4%	86.6%	87.1%	88.4%	76.0%	79.4%	83.9%	85.3%	86.7%	89.1%	91.6%	94.0%
Op Plan	86.4%	86.6%	87.1%	88.4%	86.4%	88.4%	90.5%	90.6%	91.2%	92.4%	93.2%	94.4%
Actual	77.3%	77.4%	79.6%	76.8%	75.6%							
Variance	-9.2%	-9.2%	-7.5%	-11.7%	-0.4%							

Key Actions

- **Recover radiotherapy pathways**, particularly CAT2 activity and the consequences of prioritising long-wait Breast and Prostate patients.
- **Increase timely surgical treatment capacity**, addressing theatre access constraints affecting first treatments.
- **Address Breast operative capacity across sites**, including independent-sector support.
- **Focus recovery on Urology, Breast and Skin**, which together account for 80% of the reported August breaches.
- **Maintain weekly tumour-site driver reviews and pathway analyser/ KPI reporting** to identify and act on delays
- **Target diagnostic dependencies**, particularly CT, pathology, Lower GI imaging and endoscopy, alongside treatment-capacity recovery

31 Day breaches by anatomical site



Interdependencies with other performance indicators

- Delays to cancer treatment can impact patient experience and outcomes

Exec Owner Alex Shaw **SRO** Maria Emmanuel

Excellent Care Everywhere

Faster Access to planned treatment and cancer care

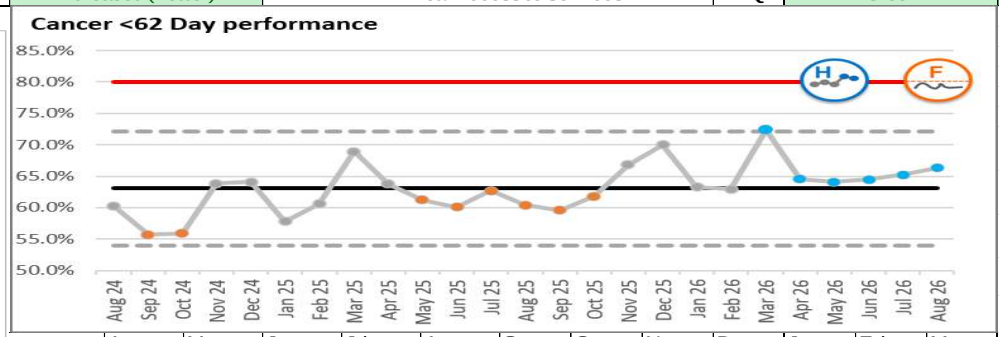
62 Day Performance

NHS
University Hospitals Sussex
NHS Foundation Trust

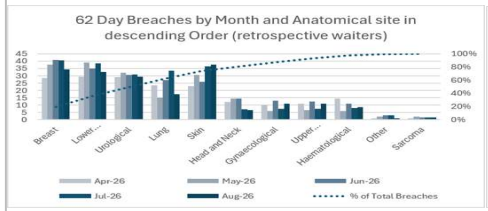
Our Ambition: Patients: Faster Access to planned treatment and cancer care					
Cancer Care : 62 Day Performance	**Target**	80% by March-27			
Latest Month Recovery Plan	66.00%	**National Rank**	110 of 143 Aug-26		
Latest Month Operating Plan	75.00%				
Latest Month Actual	66.30%	**National Performance**	71.90%		
Latest Month Trend	Increased (Better)	**NPAF Area: Access to Services**		**DQ**	Green

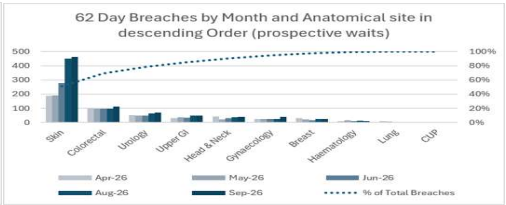
Key Messages

- **62-Day** Urgent Referral to First Treatment performance improved to 66.3% in August 2026, compared with 65.2% in July 2026, and was 6.7 percentage points higher than in August 2025. However, performance is on plan but below the national position of 71.9%. Performance was adversely impacted by reduced achievement across several tumour sites, most notably Skin, Breast and Colorectal. **(Rebased Plan)**
- The number of patients waiting more than 62 days stood at 818 at the end of September 2026, compared with 543 in Sep-25. Skin cancer accounts for 56.5% of the total backlog and increased by 13 patients during September, and compared to 543 Sep-25. A reduction in the backlog will require a sustained focus on treating long-waiting patients and improving retrospective performance.
- At the end of September 2026, the tumour sites with the largest 62-day backlogs were Skin (462 patients, up 13), Colorectal (112 patients, up 14), and Urology (70 patients, up 7). The overall backlog is 275 patients higher than in September 2025, with the increase overwhelmingly due to the growth in the Skin cancer backlog.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Rec Plan	76.1%	76.0%	76.8%	75.5%	66.0%	69.3%	71.6%	72.9%	75.1%	76.4%	77.7%	80.0%
Op 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%	65.2%	66.3%							
Variance	-11.6%	-11.9%	-12.3%	-10.3%	0.3%							





Key Actions

- **Reduce the >62-day backlog through focused oversight**, with additional Skin capacity already beginning to impact the backlog.
- **Prioritise Skin recovery**, given its disproportionate contribution to the >62-day backlog.
- **Target Colorectal and Urology alongside Skin**, with September backlogs of **112 and 70 respectively**.
- **Track pathway intervals and hold weekly tumour-site driver meetings**, enabling earlier intervention where patients are accumulating delay.
- **Address Breast operative capacity**, working across Trust sites and using independent-sector support.
- **Remove cancer diagnostic constraints**, particularly CT, pathology, Lower GI imaging and endoscopy.

Interdependencies with other performance indicators

- Delays to cancer treatment can impact patient experience and outcomes

Exec Owner Alex Shaw **SRO** Maria Emmanuel

Excellent Care Everywhere

Faster Access to planned treatment and cancer care

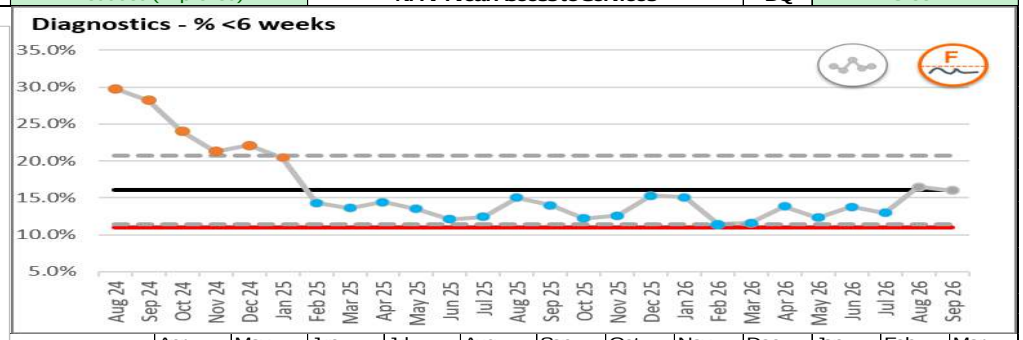
Diagnostic <6 Week Waits

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Patients: Faster Access to Planned Treatment and Cancer Care					
Elective Care :Diagnostic <6 Week Waits	**Target**	<=5% by March-26			
Latest Month Recovery Plan	17.40%	**National Rank**	63 of 156 Aug-26		
Latest Month Operating Plan	14.00%				
Latest Month Actual	16.0%	**National Performance**	24.7% (Aug-26)		
Latest Month Trend	Reduced (Improved)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

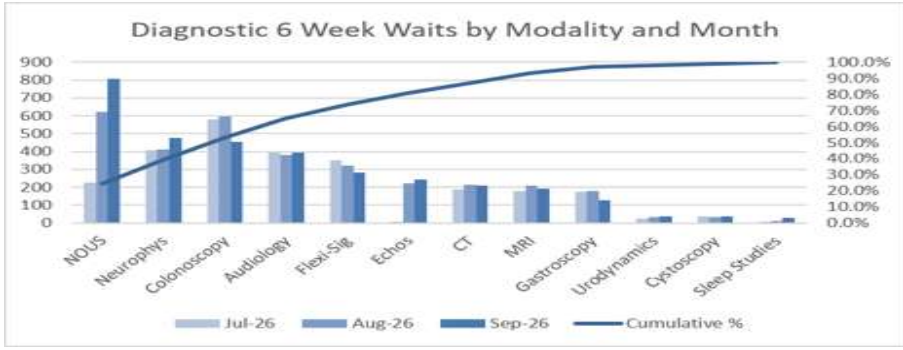
- **Diagnostic Performance** improved by -0.5% to 16.0% in Sep-26 from 16.5% in Aug-26, but 1.9% higher than Sep-26. This is 8.7% lower (better) than National average Aug-26 (24.7%). This is 3.5% higher (behind) than plan (13%) **(Rebased Plan)**
- The waiting list size increased by 971 patients in September. The 6 week backlog increased by 53 patients.
- Highest backlog numbers in Sep-26 are NOUS which has seen an increase this month of 186 to the backlog, Neurophysiology (+66) and Colonoscopy where recovery is being targeted with a reduction of -141 this month.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Rec Plan	13.0%	13.0%	13.0%	13.0%	17.0%	17.4%	15.9%	14.3%	13.7%	12.1%	12.6%	11.0%
Op 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%	12.9%	16.5%	16.0%						
Variance	0.8%	-0.7%	0.8%	-0.1%	-0.5%	-1.4%						

Key Actions

- The Trust has now refreshed its Diagnostic governance, with a weekly Diagnostic & DM01 Improvement Group, chaired by the Trust SRO, established and focused on the top five breach contributing modalities.
- Improvement projects are now underway across the five modalities, with initial actions focussed on ensuring legacy data feeds are integrated into wider Trust infrastructure to ensure transparent and consistent reporting.
- NOUS challenges driven by an imbalance in capacity and demand as a result of significant workforce challenges are to be addressed in the short term with agency and insourcing, while recrtuiment and training is undertaken the ensure a sustainable solution.



Interdependencies with other performance indicators

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

Exec Owner Alex Shaw **SRO** Oliver White

Excellent Care Everywhere

Patients: Fairness in access, experiences and outcomes

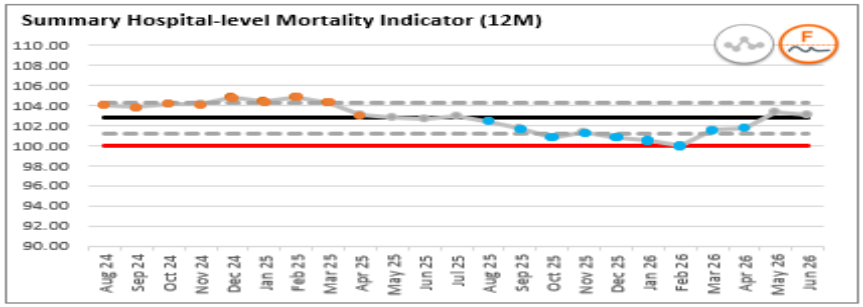
Standardised Hospital Mortality Indicator

University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Patients: Fairness in access, experiences and outcomes					
Standardised Hospital Mortality Indicator	**Target**	In Expected Range			
25/26 Actual	102.60	**National Rank**	In expected range		
26/27 Actual	103.00	**National Performance**	100		
Latest Month Trend	Reduced (Improved)	**NPAF Area : Patient Experience**		**DQ**	Green

Key Messages

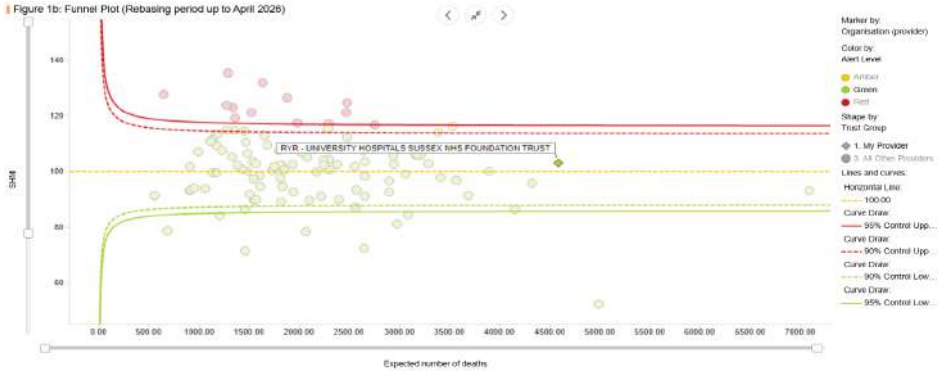
- The SHMI (Summary Hospital-level Mortality Indicator) is a measure used in to monitor mortality. The SHMI gives an indication of whether the number of deaths in a hospital is higher or lower than expected, based on the types of patients they treat. It does this by comparing the actual number of patients 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 103 (Jul 2025 - Jun 2026). This result is 'as expected' and is not an outlier.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
25/26 Actual	103.0	102.7	102.6	103.0	102.6	101.7	100.8	101.3	100.8	103.0	102.1	101.8
26/27 Actual	101.8	103.4	103.0									
Variance	-1.2	0.6	0.4									

Key Actions

- Continued montioring and investigation of SHMI diagnostic code outlier status



Interdependencies with other performance indicators

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

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

Excellent Care Everywhere

Patients: Fairness in access, experiences and outcomes

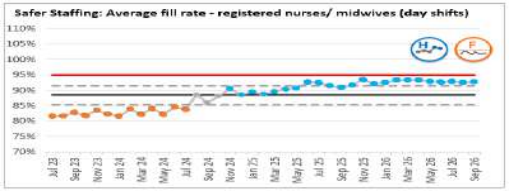
Safer Staffing % Staffing against planned rota

NHS
University Hospitals Sussex
NHS Foundation Trust

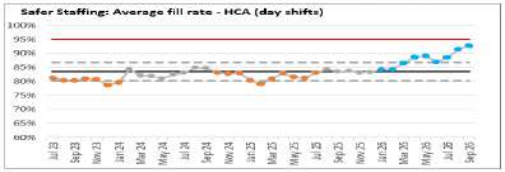
Our Ambition: Patients: Fairness in access, experiences and outcomes					
Safer Staffing % Staffing against planned rota	Target	>95%			
Latest Month Plan		National Rank			
Latest Month Actual	Table below	National Performance			
Latest Month Trend	Variable per staff group/shift as below	NPAF Area: Patient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

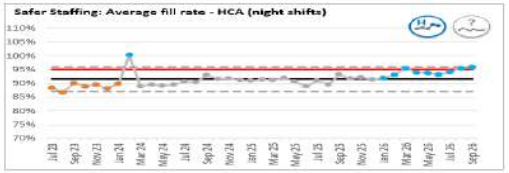
Key Messages

- Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN, 2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board).
- As of M1 CHPPD reporting in line with benchmarking with other organisations with over 1500 beds includes maternity, neonates and ITU previously excluded. The CHPPD for M3 remained consistent at 9.3, excluding maternity, ITU and neonatal CHPPD is 8.5. All areas below 7 are monitored closely and are being reviewed in response to SNCT recommendations, quality & safety outcomes and professional judgment for workforce planning for 26/27.
- The fill rate for registered nurses and midwives during the day remained consistent at 93% and 94% at night. There is a direct correlation with substantive recruitment and less reliance on agency. There is a clear strategic plan for agency exit with enhanced controls in place. RN band 5 vacancy for August was 5.4%
- The fill rate for HCA's has increased from 89% July to 93% in August for the day shifts and from 94% to 96% for the night shifts. Band 2/3 vacancy has decreases to 9.6% against a target of 10%









		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%	92.9%	92.5%	92.8%						
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%	93.8%	93.8%	94.4%						
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%	88.7%	91.4%	92.8%						
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%	94.1%	95.4%	95.9%						
Care Hours/Patient Day	25/26	8.0	9.0	8.9	9.2	8.2	8.2	8.20	7.80	8.00	7.6	7.8	7.8
	26/27	9.4	9.2	9.3	9.3	9.4	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, CNS job planning and sickness management. The Deputy Chief Nurse (DCN) for Workforce along with the clinical workforce team undertook establishment reviews using the safer nursing care tool (SNCT) for all inpatient areas in the september/October 26.
- 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 Agency. Agency is now minimal with under 30 shifts for RN agency used per week, where agency is required this as a last resort with Divisional Director of Nursing approval.
- Band 5 vacency is at 5.4% and HCA band 2/3 vacency is 9.6%

Interdependencies with other performance indicators

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

Exec Owner	Gail Byrne	SRO	Annette Gerricke

Excellent Care Everywhere

Patients: Fairness in access, experiences and outcomes

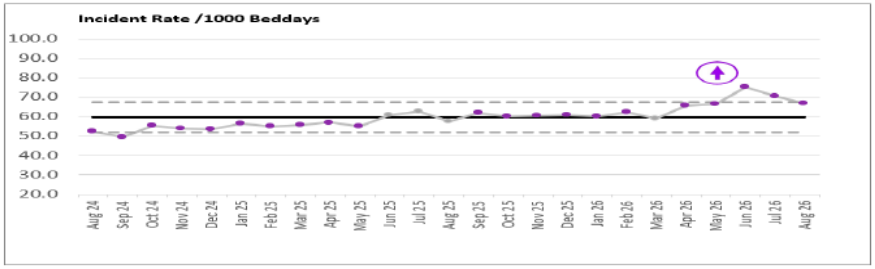
Incidents per 1000 beddays

University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Patients: Fairness in access, experiences and outcomes			
Incidents per 1000 beddays	**Target**		
2025/26	59.68	**National Rank**	
26/27 Latest Month Actual	66.56	**National Performance**	
Latest Month Trend	Increased(improved)	**NPAF Area: Patient Safety**	**DQ** Green

Key Messages

- Local targets are based on national Benchmarking
- The NHS England Learning from Patient Safety Incidents (LfPSE) which demonstrates the reporting rate per 1000 bed days within Trusts. Recording rates (per 1,000 bed days) ranged from 7 to 130 incidents in acute trusts.
- UHSussex has increased the reporting rate per thousand bed days from 52 in August 2024 to 66 in August 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, and medication incidents 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	56.9	54.8	60.9	62.5	57.5	61.8	60.1	60.5	60.7	59.9	62.2	58.9
2026/27	65.7	66.2	75.1	70.4	66.6							
Variance	8.8	11.4	14.2	7.9	9.1							

Key Actions

- Weekly Patient SAfety Incident Response Group (PSIRG) reviews all incidents graded as moderate, severe or fatal, to ensure investigations and reviews are appropriately undertaken, notifiable icnidents are appropriately reported, and themes are extracted to support learning.
- A review of higher risk specialties is underway, including Ophthalmology and OMFS, including with GIRFT and using risk stratification of waiting patients to reduce harms from waits for follow ups.
- Actions to address falls and pressure damage are included in the fundamental standards of care and professional standards programmes of work.
- To improve the quality of Regulation 20 Duty of Candour compliance reporting, the 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.
- Patient stories are produced to ensure the expeirence of patients and learning from incidents is translated into Trust-wide improvements.

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

Excellent Care Everywhere

Patients: Fairness in access, experiences and outcomes

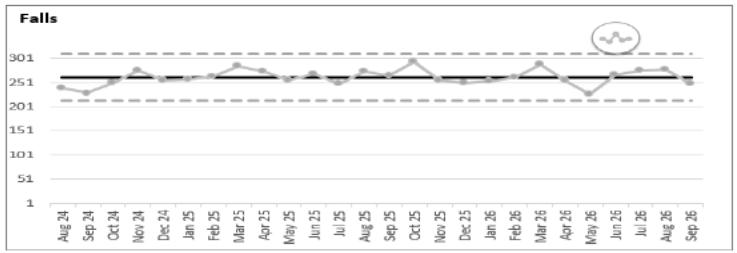
Falls

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Patients: Fairness in access, experiences and outcomes					
Falls	**Target**	To reduce falls by 30% 4.2, per 1,000 bed days			
25/26 Actual	265	**National Rank**			
26/27 Latest Month Actual	249	**National Performance**			
Latest Month Trend	Decreased (improved)	**NPAF Area: Patient Safety**		**DQ**	Green

Key Messages

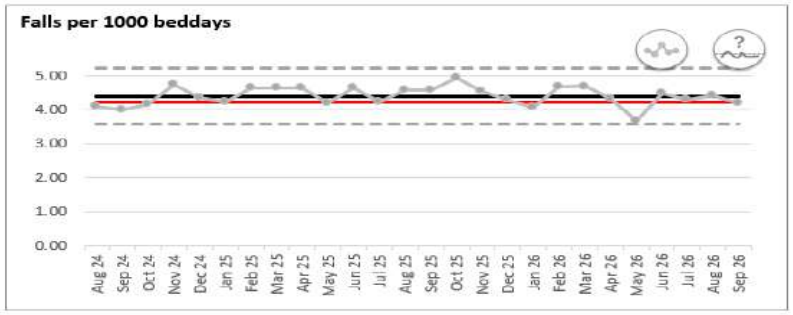
- Falls are a top contributor in terms of harms across UHSussex, and therefore key focussed work area to minimise them.
- There has been a decrease in falls since March 2025, 285 to September-26, 249.
- 65.46% of falls (163 patients) in September 2026 reporting no harm.
- Falls Rate per 1,000 bed days September 2026, 4.17. Average rolling year 4.37. Target 4.2. Overall, Trust data is tracking along the mean average and within the upper control limit, for both the number of falls and the number of falls per 1,000 bed days.
- Moderate harm and above falls since April 2024 have not identified pattern or trend currently.



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.
- Falls risk education focusing on collaborative care planning with the MDT using the "Planning Care Together" tool
- Intentional Rounding has been updated to incorporate the Antecedent–Behaviour–Consequence (ABC) chart for patients experiencing distress or unmet need, reducing duplication within written documentation. Planning is underway for Phase 2 of the Intentional Rounding for Care Planning Pilot, with proposed expansion to further wards to test and refine the approach

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	275	278	249						
Variance	-17.00	-29.00	-2.00	26.00	5.00	-16.00						
/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	4.27	4.41	4.17						
Variance	-0.33	-0.52	-0.17	0.05	-0.16	-0.41						



Interdependencies with other performance indicators

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

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

Excellent Care Everywhere

Patients: Fairness in access, experiences and outcomes

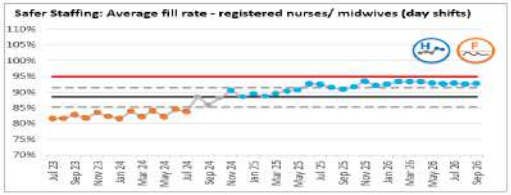
Safer Staffing % Staffing against planned rota

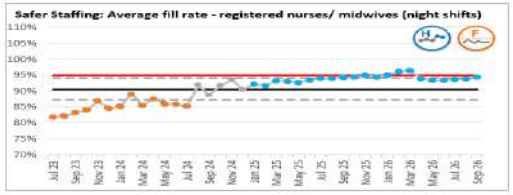
NHS
University Hospitals Sussex
NHS Foundation Trust

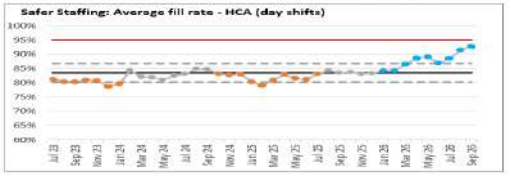
Our Ambition: Patients: Fairness in access, experiences and outcomes			
Safer Staffing % Staffing against planned rota	Target	>95%	
Latest Month Plan		National Rank	
Latest Month Actual	Table below	National Performance	
Latest Month Trend	Variable per staff group/shift as below	NPAF Area: Patient Safety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

Key Messages

- Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN, 2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board).
- As of M1 CHPPD reporting in line with benchmarking with other organisations with over 1500 beds includes maternity, neonates and ITU previously excluded. The CHPPD for M3 remained consistent at 9.3, excluding maternity, ITU and neonatal CHPPD is 8.5. All areas below 7 are monitored closely and are being reviewed in response to SNCT recommendations, quality & safety outcomes and professional judgment for workforce planning for 26/27.
- The fill rate for registered nurses and midwives during the day remained consistent at 93% and 94% at night. There is a direct correlation with substantive recruitment and less reliance on agency. There is a clear strategic plan for agency exit with enhanced controls in place. RN band 5 vacancy for August was 5.4%
- The fill rate for HCA's has increased from 89% July to 93% in August for the day shifts and from 94% to 96% for the night shifts. Band 2/3 vacancy has decreases to 9.6% against a target of 10%









		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%	92.9%	92.5%	92.8%						
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%	93.8%	93.8%	94.4%						
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%	88.7%	91.4%	92.8%						
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%	94.1%	95.4%	95.9%						
Care Hours/Patient Day	25/26	8.0	9.0	8.9	9.2	8.2	8.2	8.20	7.80	8.00	7.6	7.8	7.8
	26/27	9.4	9.2	9.3	9.3	9.4	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, CNS job planning and sickness management. The Deputy Chief Nurse (DCN) for Workforce along with the clinical workforce team undertook establishment reviews using the safer nursing care tool (SNCT) for all inpatient areas in the september/October 26.
- 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 Agency. Agency is now minimal with under 30 shifts for RN agency used per week, where agency is required this as a last resort with Divisional Director of Nursing approval.
- Band 5 vacency is at 5.4% and HCA band 2/3 vacency is 9.6%

Interdependencies with other performance indicators

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

Exec Owner	Gail Byrne	SRO	Annette Gerricke

Excellent Care Everywhere

Our People



Excellent
Care
Everywhere

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

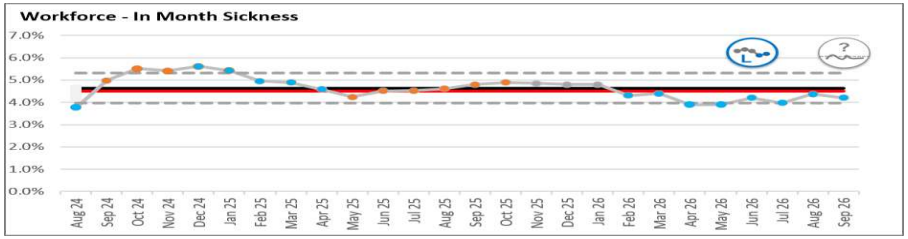
Our People
Sickness Absence Rates

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Our People			
Sickness Absence Rates	**Target**	**<4.5% sickness**	
25/26 Month Actual	4.60%	**Regional Rank**	
26/27 Month Actual	4.20%	**National Performance**	4.7% (May-25)
Latest Month Trend	Decreased (improved)	**NPAF Area: People and Workforce**	**DQ** Green

Key Messages

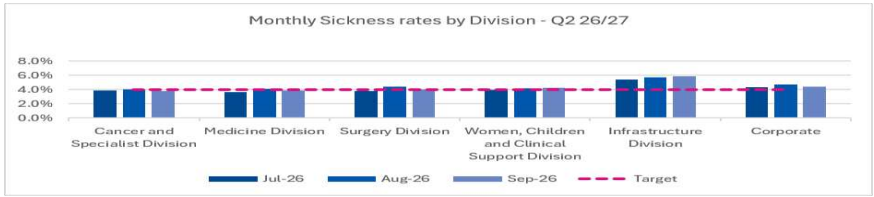
- Sickness rates measure the percentage of staff absence due to illness and reflect staff health and wellbing and workforce capacity. There are in month and rolling average measures, below focuses on Q2.
- Sickness rates have continued to decline on the previous year with two of Q2 in month rates showing a reduction compared to 25/26, most noticeably in Sept 26 where the rate has dropped from 4.6% the previous year to 4.2%. For comparison UHSx is below both the national rate of 4.7% the SE Regional rate of 4.7% and Sussex ICB position of 4.8%.
- In M6 of Q2 of 2026-27 three of the clinical Divisions were at or below the Trust target of 4%, with only Women, Children and Clinical Support slightly higher at 4.3%.
- At the end of Q2 the Infrastructure Service 12 month average rate fell to 6.1%, its lowest level for well over a year.
- Also at the end of Q2 the Additional Clinical staff 12 month rate stood at 5.9% maintaining its lowest level for over a year and reflecting much of the positive work undertaken in this area during the last year e.g. HCA Advocates.



	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%	4.0%	4.4%	4.2%						
Variance	-0.7%	-0.3%	-0.1%	-0.3%	-0.1%	-0.5%						

Key Actions

- **Nursing and Midwifery** - workstream with a focus on 72 hotspot areas for sickness. Hotspots have been updated to ensure focus is in the right areas. A current focus in on improving return to work meeting rates.
- **Systems** - further training for N&M staff in the rostering aspects of sickness is being delivered in Q3.
- **Governance** - The focus continues to be on driving further improvements in the new Trust structure to achieve the Trust sickness target.
- **Mental Health Action Plan** – MH Action plan continues to work through its phases of implementation.
- **Medical Workforce** - the medical sickness is overseen in the Medical Workforce Efficiency Sterring group.
- **Staff Group** - tailored action plans in place for HCAs and Ancillary staff.
- **Assurance** - The People & Culture Assurance committee continues to have oversight of sickness.





Interdependencies with other performance indicators

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

Exec Owner Sarah Jane Taylor, Chief People Officer **SRO** Helen Weatherill

Excellent Care Everywhere

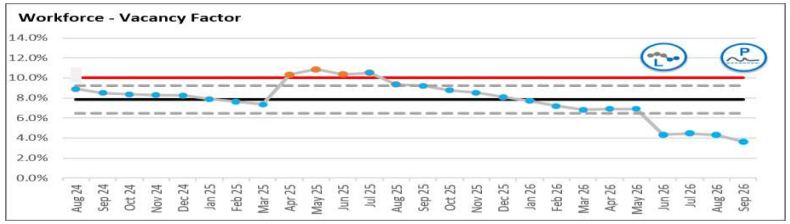
Our People
Vacancy Factor

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Our People			
Vacancy Factor	**Target**	**<10%**	
25/26 Month Actual	9.20%	**National Rank**	**Not available**
26/27 Month Actual	3.60%	**National Performance**	Not available
Latest Month Trend	Decreased (improved)	**NPAF Area: People and Workforce**	**DQ** Green

Key Messages

- The vacancy rate expresses, as a percentage of the Trust's overall budgeted establishment in month, the proportion of posts that are vacant. Vacant posts can impact service delivery, safety and temporary staffing costs.
- The Trust's budgeted establishment is 17,795 (decrease of 185 from prior year). There are 16,814 wte staff in post (increase of 575 wte from prior year and an increase of 107 between M1-M6). The Trust had 643 wte vacancies resulting in a vacancy rate of 3.6% in M6.
- Band 5 RN vacancy factor is at 5% for M6 and HCA vacancies are at 9.7%.



	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	6.9%	6.9%	4.3%	4.5%	4.3%	3.6%						
Variance	-3.4%	-4.0%	-6.1%	-6.0%	-5.0%	-5.6%						

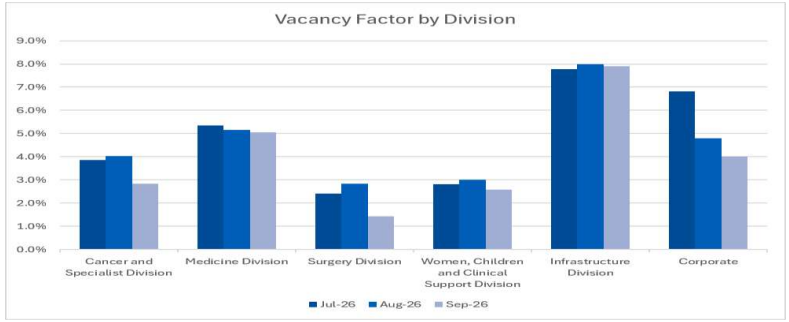
Key Actions

The organisation's financial position is resulting in a significant slowdown in recruitment as tighter workforce controls are implemented. This has also reduced recruitment marketing activity and paused planned employer branding work.

In the last reporting period, Resourcing has developed a draft values-based interviewing toolkit, including a bank of supporting interview questions, to strengthen consistency and quality across recruitment.

Recruitment into patient-critical roles continues; however, new starter volumes are expected to reduce materially over the next quarter. Current financial controls mean the organisation is expected to appoint only a limited proportion of candidates already in the recruitment pipeline, currently estimated at approximately 25%.

As a result, the Resourcing team's focus is shifting towards supporting workforce and recruitment controls, alongside actively managing candidates already in the pipeline. Maintaining clear, consistent and timely candidate communications will be critical to minimising withdrawals, managing expectations and



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 **SRO** David Vincent

Excellent Care Everywhere

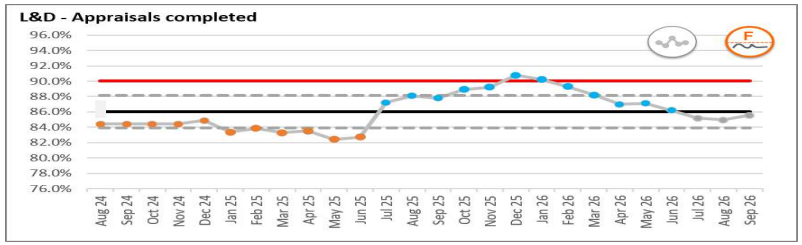
Our People
Annual Appraisal % Compliance

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Our People			
Annual Appraisal % Compliance	Target	>90%	
25/26 Actual	87.10%	National Rank	Not available
26/27 Actual	85.50%	National Performance	Not available
Latest Month Trend	Increased (improved)	NPAF Area: People and Workforce	DQ: Green

Key Messages

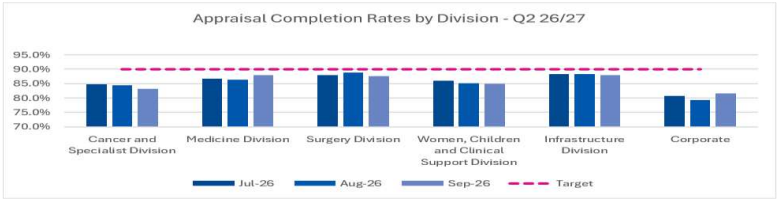
- The metric reports the proportion of eligible non-medical staff who have an Appraisal recorded as complete within the previous 12 months.
- Compliance **increased to 85.5%** in September 2026, but remains below the 90% target. This follows eight consecutive monthly declines from a peak of 90.3% in December 2025—the only month in the past year when the target was achieved.
- There is substantial variation across the Trust:
  - **Cost centres**: 202 (28%) achieved 100% compliance, while overall 45% met or exceeded 90%, covering 6,645 staff (47%). Conversely, 84 cost centres (12%) recorded 60-75% compliance, and 72 (10%) were below 60%.
  - **Staff groups**: Healthcare Scientists remain the lowest-performing group (77.9%), having recorded the lowest compliance in 11 of the past 12 months. Performance has declined further over the past three months, contrasting with improvements in other staff groups.
  - **Divisions**: The four lowest-performing Divisions are all corporate: CSO (77.9%), CMO (77.2%), CNO (77.1%) and Deputy CEO (65.5%). All show declining performance. Although their smaller staff populations limit the impact on overall Trust performance, this represents a missed opportunity to role-model (as well as the impact on appraisees themselves).
- **Appraisee experience** remains strongly positive. Rolling appraisee survey feedback shows that 91.1% found the feedback helpful, 91.4% rated their appraisal positively overall, 94.1% felt safe discussing personal issues, and 94.4% covered the topics they wanted to discuss.



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%	85.9%	85.5%	85.7%						
Variance	3.5%	4.6%	3.4%	-1.4%	-2.6%	-2.1%						
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%	85.2%	84.9%	85.5%						
Variance	4.5%	5.7%	4.8%	-1.0%	-2.4%	-1.6%						

Key Actions

- **Strengthening support**: Further resources for managers and staff have been introduced, including new e-learning and guidance on multi-rater ('360-degree') feedback.
- **Targeted performance improvement**: HRBPs are supporting Divisions with weekly, directorate-level oversight of appraisal compliance across all cost centres to identify and address gaps.
- **Addressing access barriers**: Some staff without full M365 access report difficulties accessing or completing the Word appraisal form. IT and Corporate Communications are progressing a resolution.
- **Strengthening leadership focus**: The People & Culture Steering Group (16 October) considered how to promote appraisal as a positive opportunity for recognition, development and Behavioural Compass conversations, supporting financial recovery rather than focusing solely on compliance. The impact of TOM2 changes on corporate performance was acknowledged, although poorer performance predates these changes.





Interdependencies with other performance indicators

- Effective appraisals support staff engagement, recognition, development and performance, with potential benefits for retention, productivity and quality of care. However, operational pressures can constrain managers' capacity to prioritise them. **Improving both appraisal coverage and quality is therefore important to workforce effectiveness and organisational performance**, rather than simply achieving a compliance target.

Exec Owner Sarah Jane Taylor, Chief People Officer **SRO** Nick Groves

Excellent Care Everywhere

Our People

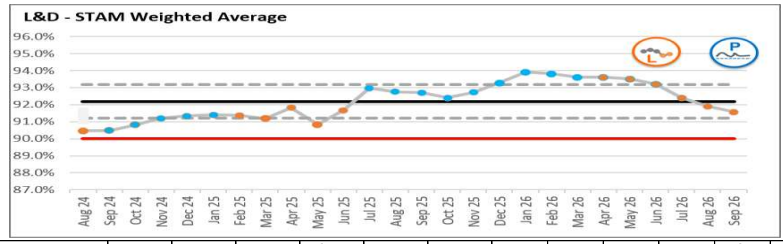
Statutory and Mandatory Training Compliance %

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Our People					
Statutory and Mandatory Training Compliance %	Target	>90%			
25/26 Month Actual	92.70%	National Rank	Not available		
26/27 Month Actual	91.60%	National Performance	Not available		
Latest Month Trend	Decreased (Worsened)	NPAF Area: People and Workforce		DQ	Green

Key Messages

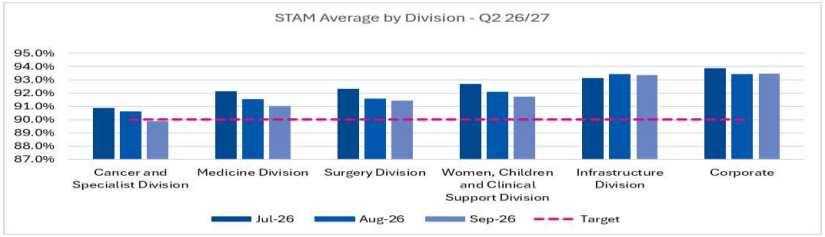
- UHSussex has set a target for all Statutory and Mandatory (STAM) training to have a compliance rate of 90%. The report shows the breakdown of the STAM weighted average (i.e. the average level of compliance across STAM subjects). This training is important in ensuring the safety of patients, staff and the public Some of it is a regulatory or statutory requirement.
- The UHSussex STAM compliance rate continues to be strong, with a rate of 91.6% in M6 (September), 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 83% (a full12 months in a row within the 80% range), all other groups are compliant above 90%. It should be noted that August/September/October see fluctuations in terms of compliance due to resident doctors in training rotational changes.
- Divisionally, the picture has declined slightly and there are two divisions as an outlier for M09. These have been flagged and remediation is actively taking place.

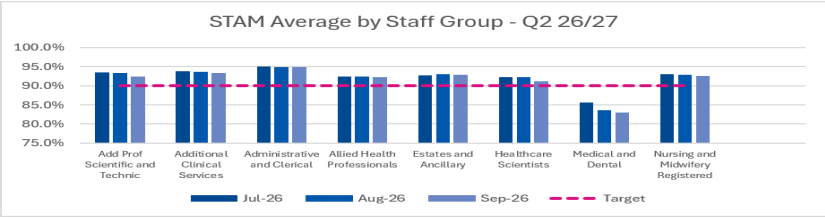


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
25/26	91.8%	90.8%	91.7%	93.0%	92.7%	92.7%	92.4%	92.7%	93.3%	93.9%	93.8%	93.6%
26/27	93.6%	93.5%	93.2%	92.4%	91.9%	91.6%						
Variance	1.8%	2.7%	1.5%	-0.6%	-0.8%	-1.1%						

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 and this always falls across August/September/October as new resident doctors in trainig are onboarded. 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	SRO	Martyn Clark

Excellent Care Everywhere

Communities

Excellent
Care
Everywhere

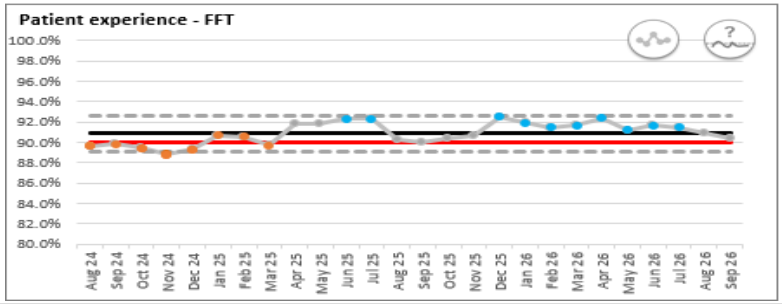
We are compassionate. We are inclusive. We are respectful.

Communities
Friends and Family Test

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Communities					
Patient Experience: FFT	**Target**	>90%			
25/26 Actual	90.0%	**National Rank**	73rd of 119 A&E, 99 of 126 Inpatients, 19th of 125 outpatients		
Latest Month Actual	90.4%	**National Performance**	91.3% (Aug-26)		
Latest Month Trend	Decreased (Worsened)	**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 by care touchpoint.
- Based on available FFT data, the significant majority of patients (over 90% at the end of Q2 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 and lack of info/updates about the anticipated waiting time and the reason for delays (whether on a wait list or in a clinic/ED).
- Increases continue to be noted in complaints about the behaviour of doctors.
- The Trust introduced a new web survey tool in Sept 2026 for collecting wider patient feedback in real-time as well as FFT. The FFT survey has improved presentation, easier navigation and better user-friendly graphics and translation options to help support and increase participation. Each ward/dept now has their own QR code/link to the survey to support boosting response rates and ways to include digitally excluded groups. The platform offers improved fully interactive and customised dashboards with real-time data and visual tracking of themes/trends for every ward/dept. to support analysis of areas for improvement. Compliments are also collected and shared to increase visibility of good practice.

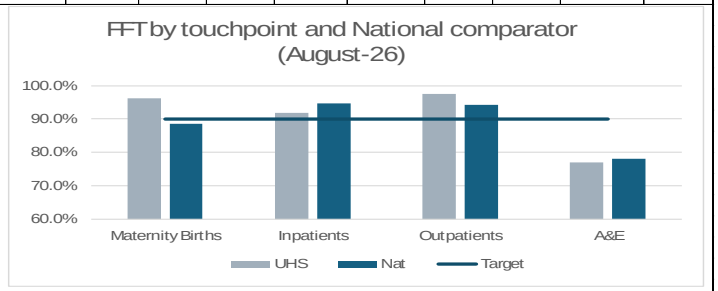


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
25/26	91.8%	91.8%	92.3%	92.3%	91.7%	90.0%	90.4%	90.7%	92.5%	91.9%	91.5%	91.7%
26/27	92.4%	91.2%	91.7%	91.5%	90.9%	90.4%						
Variance	0.6%	-0.6%	-0.7%	-0.8%	-0.8%	0.4%						

Breakdown Latest Month

Aug-26

FFT Scores	UHS	Nat
Maternity Births	96.3%	88.6%
Inpatients	91.9%	94.6%
Outpatients	97.4%	94.3%
A&E	76.9%	78.1%



- 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.

- 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** Tori Cooper

Excellent Care Everywhere

Future

Excellent
Care
Everywhere

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

Excellent Care for the Future

Financial Stability/variance from Breakeven Plan

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Excellent Care for the Future					
Financial Stablility/ variance from Breakeven Plan	**Target**	£0			
2026/27 Plan YTD (£m)	£20.1m deficit	**National Rank**			
2026/27 Actual YTD (£m)	£20.1m 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 for the year to the end of Q2 offset by surpluses in Q3 and Q4. The Trust delivered a deficit to Q2 of £20.1m, in line with plan.
- Efficiency programme delivery is £28.5m 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 beyond the 30 days payment terms; Better Payment Practice Code (BPPC) performance has further dropped to 31% by volume (target 95%).
- Capital programme expenditure is £4.4m less than plan. The key driver is the 3Ts cancer centre which is £4.1m behind plan due to the Trust not needing to fully utilise contingency funds and slippage on the programme. It is anticipated that timing differences will unwind and programme expenditure will be on plan at year-end.

2026/27 M06 £m	Annual Plan	YTD Plan	YTD Actual	YTD Variance Fav/(Adv)
I&E (Surplus) / Deficit	0.0	20.1	20.1	0.0
Efficiency	140.0	52.4	23.9	(28.5)
Cash	3.0	3.0	1.2	(1.8)
BPPC (volume)	95%	95%	31%	(64%)
Capital	155.6	74.3	69.9	4.4

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	20.5	20.5	20.1						
Variance	0.0	0.0	0.0	0.0	0.0	0.0						

Key Actions

- The Trust has appointed a financial improvement consultant to support delivery of the efficiency progrmamme and implement financial recovery actions including enhanced grip and control measures on areas of variable expenditure.
- A route map to delivery of the year-end breakeven position has been collated; divisions and corporate services have been set monthly run-rate targets for the remainder of the financial year that are aligned to the route map.
- Divisional performance continues to be monitored through monthly divisional accountability meetings (DAMs) where divisional leadership teams meet with members of the executive team and Trust directors. In addition the CFO is meeting fortnightly with divisonal managing directors to review their financial forecasts and action plans to reduce the expenditure run-rate.
- During October the Trust submitted an application for 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 November.

Interdependencies with other performance indicators

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

Exec Owner Jonathan Reid **SRO** Naeem Uddin

Excellent Care Everywhere

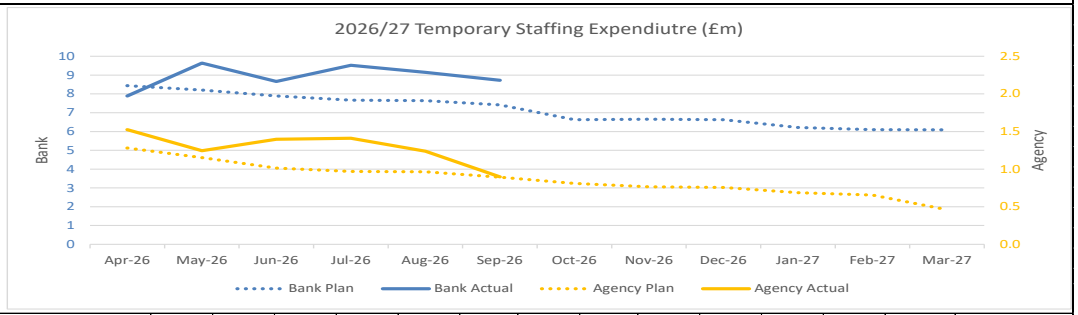
Excellent Care for the Future

Temporary Staffing Expenditure against Plan

NHS
University Hospitals Sussex
NHS Foundation Trust

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)	53.52	**National Rank**			
2026/27 Actual YTD (£m)	61.30	**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 £96.0m (-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 M6 is in excess of plan by a cumulative total of £6.3m. 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 M6 is in excess of plan in all months giving a cumulative total overspend of £1.5m 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



£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	6.07	47.26	85.57
Bank Actual	7.89	9.64	8.66	9.52	9.15	8.73							53.59	
Variance	0.55	(1.44)	(0.76)	(1.86)	(1.51)	(1.31)							(6.33)	
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	6.26	10.41
Agency Actual	1.53	1.24	1.40	1.41	1.24	0.90							7.71	
Variance	(0.25)	(0.09)	(0.39)	(0.44)	(0.28)	(0.01)							(1.45)	
Combined Plan	9.72	9.35	8.91	8.63	8.60	8.31	7.44	7.43	7.39	6.91	6.76	6.53	53.52	95.98
Combined Actual	9.42	10.88	10.06	10.93	10.39	9.63							61.30	
Variance	0.30	(1.53)	(1.15)	(2.30)	(1.79)	(1.32)							(7.78)	

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.
- The Trust's route map to delivery of a year-end breakeven position includes grip and control measures with targeted reductions in bank and agency expenditure for each directorate.

Interdependencies with other performance indicators

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

Exec Owner Jonathan Reid **SRO** Naeem Uddin

Excellent Care Everywhere

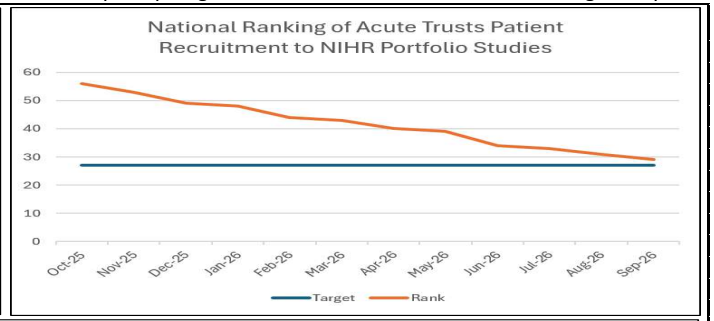
Excellent Care for the Future

Recruitment to studies national ranking

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: One UHSx					
Recruitment to studies national ranking	**Target**	27th or less			
24/25 Actual	55th	**National Rank**	29th/134		
25/26 Actual	30th	**National Performance**			
Latest Month Trend	Improved	**NPAF Area: Access to Services**		**DQ**	Green
Key Messages	Opportunities for patients to benefit from participating in research have widened, recruitment ranking has improved				

- 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 quarter opportunities for patients to benefit from participating in research have widened. This chart shows shows the 12-month *rolling* Acute Trust ranking in terms of total recruitment to studies on the NIHR portfolio. This quarter (Q2) the Trust was ranked 29th putting it just outside the top 20% of recruiting Acute Trusts. Recruitment stood at 3,548 participants. This indicator is subect to our hospital sites being selected for high recruiting studies, this is dependent on factors such as having the relevant population required to answer the reserach question. The Trust consistently perfoms well in respect of the number of studies it has open to recruitment. This quarter the Trust was ranked 23rd out 134.



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

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

Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

Strategy and Major Projects

Portfolio Highlight Report

November 2026



Excellent Care for the Future

Major Projects Portfolio Overview (1/2)

The major projects portfolio continues to progress but due to a combination of challenges faced by the Trust the overall assurance position is mixed.

Delivery is being affected by the TOM process of organisational restructuring, operational pressures as Winter pressures begin to be felt across all our sites with several regularly entering business continuity, active recruitment controls, procurement delays and the Trust's financial position which has led to a few small incidents of delayed supplier payments and resulting hiatus.

The most material areas where assurance is partial are:

- the non-approval of the SRH RAAC Strategic Outline Case by NHS England
- affordability and clinical-model risks within the RSCH Acute Floor programme
- delays to EPR recruitment
- delays and cost pressures within Clinical Research Facility programmes and delays within Ventilation
- higher than anticipated initial costs for the Southlands Theatres

Positively, the Sussex Cancer Centre remains ahead of its original construction programme and several projects are advancing through design, procurement and implementation.

During the next reporting period, the attention of the portfolio will be to focus on:

- agreeing the scope, governance route and resubmission timetable for the SRH RAAC SOC;
- confirming the affordability, clinical workforce and safety mitigations for the RSCH Acute Floor;
- resolving critical EPR recruitment and infrastructure dependencies;
- agreeing credible handover dates and recovery actions for the mobile theatres and delivery of procedure rooms
- addressing CRF procurement, building-safety and cost pressures

Excellent Care for the Future

Major Projects Portfolio Overview (2/2)

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 (Oct-Dec 26):

- SRH RAAC Project – revised SOC submission for internal Trust approval
- RSCH AFR – Enabling Works paper for approval

Major Decisions in previous period (Jul-Sep 26)

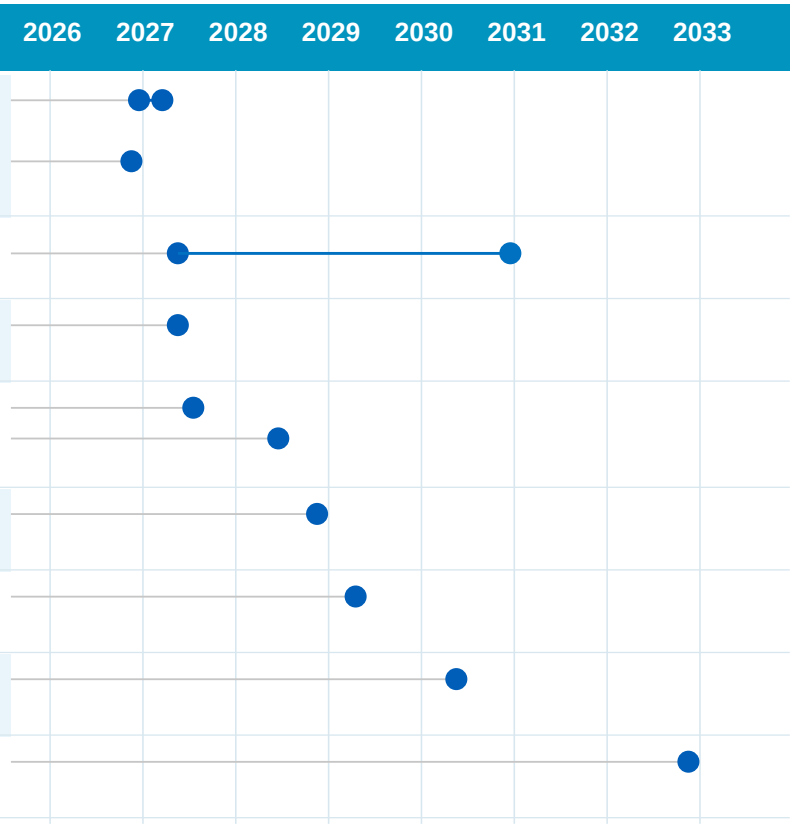
- SRH RAAC Project – Board approved SOC submitted but **NOT** approved by NHSE

Alert	**EPR**: Trust restrictions on recruitment has led to delays in planned recruitment to support EPR rollout. The CIO is working with HR Directors, Execs & Divisional leads to unblock the situation **CRF**: Cost increases have emerged following supplier submissions due to increased works needed to deliver, mainly due to backlog maintenance. Delays have occurred through procurement routes and building safety act requirements. SRO is working with capital to identify potential mitigations. **SRH RAAC**: The Strategic outline case was not approved by NHSE. National require a better cost/benefit ratio & stronger evidence against a do minimum approach. Region are looking for the project to support greater transformation at SRH. Queries will be addressed; an additional transformation option will be explored. SOC will be modified, approved & re-submitted **Southlands Theatres:** Following the return of tenders, the 4% over budget position was returned. This will be mitigated during the next formal design phase and prior to receipt of the guaranteed maximum price. Work progressing with capital team to ensure project is not funding out of scope activity and will reduce costs or source funding as part of next phase
Advise	**RSCH AFR:** Clinical model for stages 2&3 is identifying the need for an uplift in staffing to meet safety standards and achieve safety and flow in the new footprint. Model is being challenged with MD & CDO oversight. **Theatre ventilation:** Due to technical issues, mobilisation of mobile theatres has experienced multiple delays. Mobile theatres are required to support robot installation, theatre productivity. Procedure room opportunity is lacking resources to proceed at pace
Assure	**Stages 2&3:** Continues to run ahead of programme and is progressing well. **Stroke Reconfiguration:** Staff consultation has commenced. Transfer of programme to new leaders post TOM is in action **Property Rationalisation:** Outpatient buildings due to got to CIG for approval to market

Excellent Care for the Future

Major project openings and go-live timeline

Major project	Opening / delivery milestone
Ventilation remediation	Mobile theatres: Dec 2026–Mar 2027 Procedure rooms: TBC Minor works: Commences Q3 2026/27 Major works: FY 2027/28
Electronic Patient Record	EPR programme: May 2027–Dec 2030
Stroke reconfiguration	Open to patients: May 2027
Clinical Research Facility	PRH Open to service: Q2 2027/28 RSCH open to service: Q1 2028/29 Worthing: opening date not specified
Southlands theatres	Open to Patients : Q3 2028/29
Sussex Cancer Centre	Open to Patients: Q1 2029/30
RSCH Acute Floor	Stage 2&3 Open to patients: Q1 2030/31
SRH RAAC remediation	Open to service: Q4 2032



Property rationalisation: ongoing decants and disposals, with no single opening date.

Blue dots show stated months or quarter midpoints. Joined dots show a date range. Undated milestones are not plotted.

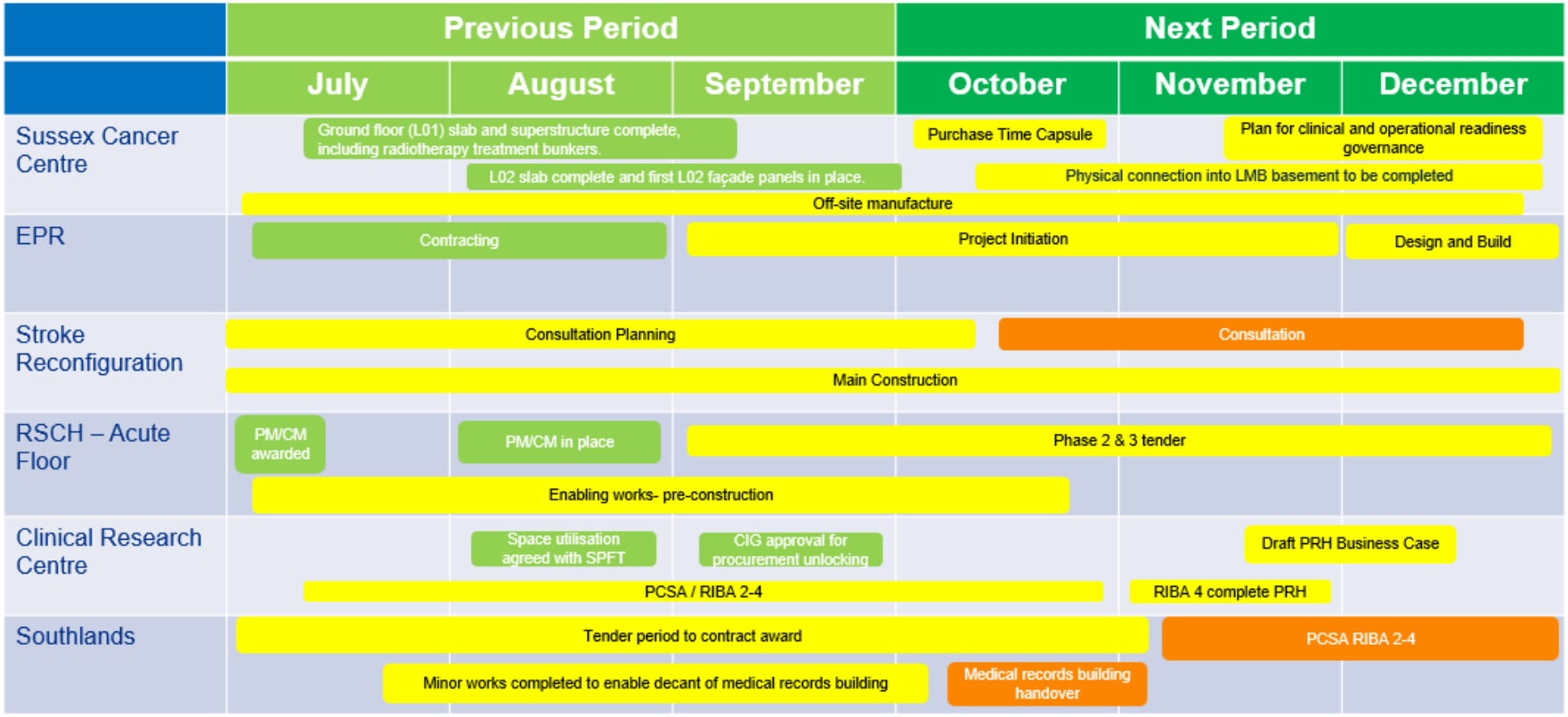
Excellent Care for the Future

Focus in the next period

Major project	Challenges and Actions in Next Period
EPR	• Recruitment of key resource • System design progression
CRF	• Challenges to budget due to PRH building repairs required such as roof repairs and ventilation – continued review with cost advisor • Challenges to project timeline due to unlocking of procurement process.
SRH RAAC Remediation	• Following the requirement by NHSE to improve elements of the SOC further work is required with divisions to make the revisions. • The timeline needs to be established to align with Joint investment committee dates and will be a focus in the next period
RSCH AFR	• Enabling works scheduled to complete in FY27/28. Engaging with NHSE on spend profile and expected deliverables and benefits for this financial year. • Gap in budget stands at £1.5m; contingency of £6m to be reviewed against costed risk register • Medicine division to develop plan for reduced corridor care capacity and elimination of MH ward – SRO is managing actions • Expected revenue case to support clinical model. Workforce model being robustly tested against national standards. • Progress Early Works cost paper through approvals route
Southlands Theatres	• Cost report from tender submission is more than financial envelope and must be mitigated in next design phase • Provide updated cashflow to NHSE • Compliance with BREEAM regulation and mitigation of imposed cost
Ventilation programme	• Still proving challenging to solidify the programme and finalise commissioning of mobile theatres • Focus in next period needs to be on contracting and delivering of minor works to theatres including obstetrics theatres • 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.
Stages 2&3 – Cancer Centre	• Align clinical commissioning with the construction programme. • Plan clinical and operational readiness governance.
Stroke	• Focus will be to onboard new SRO following TOM changes and increase engagement of Medicine division representation • Workforce consultation started on 19th October – affects 182 staff across 14 professional groups. • Out of project scope but the divisional team have been asked to review LOS and how more focus can be brought to this as this remains a risk • Recruitment process begins in December 2026. Agreement on correct VCG/approval process with current recruitment constraints is required
Property Rationalisation	• Secure approval to market Outpatients Building in Brighton for sale • Relocation of EBME from SMH to LMB

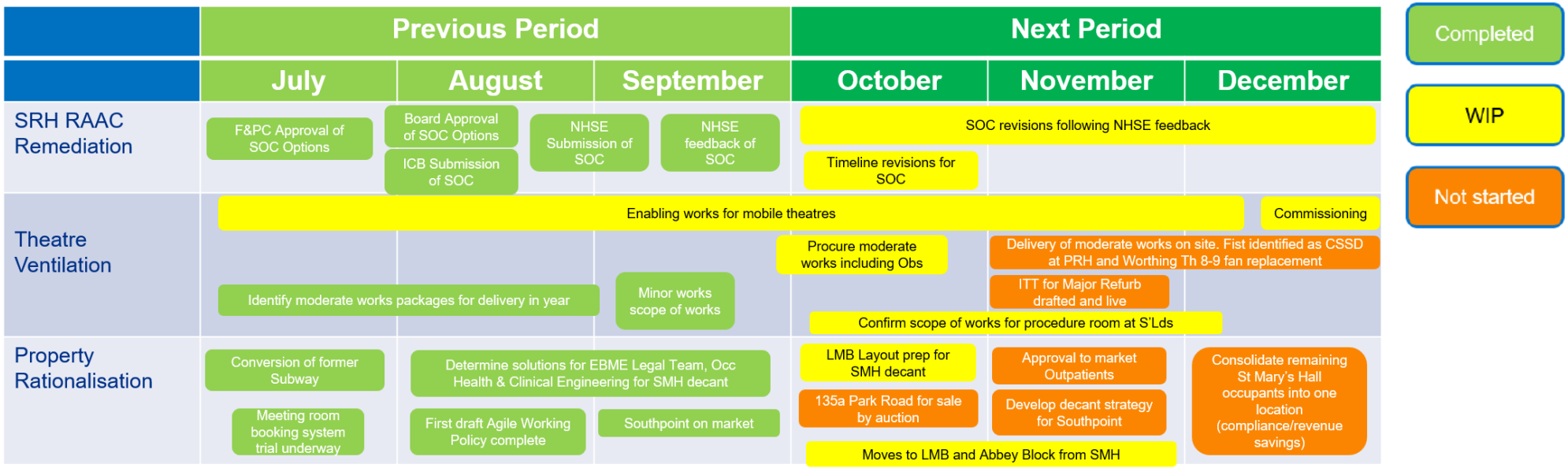
Excellent Care for the Future

Key Milestones in previous and next period



Excellent Care for the Future

Key Milestones in previous and next period



One UHSussex



Excellent
Care
Everywhere

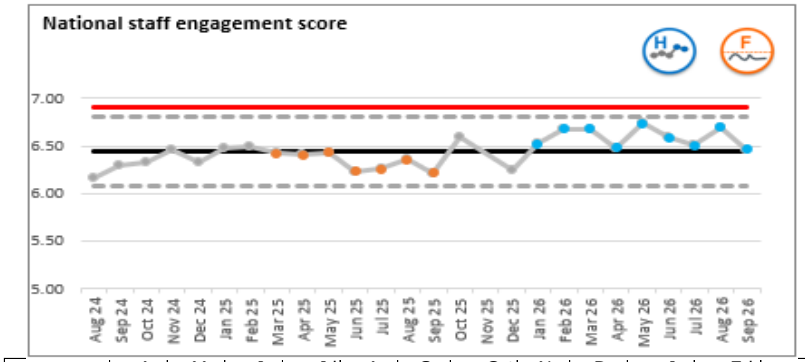
We are compassionate. We are inclusive. We are respectful.

One UHSX
Staff Engagement Scores

	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	6.5	**National Performance**	6.68 - Annual 2025 national NHS Staff Survey		
Latest Month Trend	Reduced (worsened)	**NPAF Area: People and Workforce**	**DQ**	Green	

Key Messages

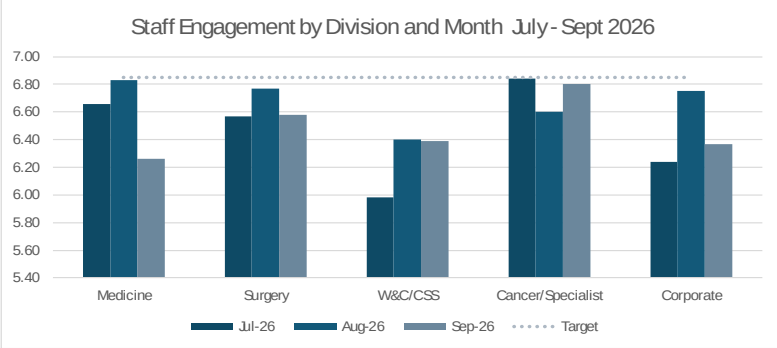
- Staff engagement is measured nationally through the annual NHS Staff Survey and quarterly People Pulse survey, and locally through the monthly UHSussex Pulse Survey.
- The second quarter of the 2026/27 year has remained below the national average staff engagement score in the monthly UHSussex Pulse Survey, ending with a score of 6.5 (out of 10) in September 2026 (Q2 score range: 6.46 to 6.69). This is compared to our 6.2 score in September 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
24/25	6.4	6.4	6.2	6.3	6.4	6.2	6.6		6.2	6.5	6.7	6.7
25/26	6.5	6.7	6.6	6.5	6.7	6.5						
Variance	0.1	0.3	0.4	0.2	0.3	0.3						

Key Actions

- Divisions and Corporate areas have used their 2025 NHS Staff Survey results to develop and communicate local improvement actions, supported by 'You Said, We Did' communications demonstrating how staff feedback is driving change and improving staff experience.
- The 2026 NHS Staff Survey launched on 16 September and remains open until 27 November 2026. Participation is being supported through Staff Survey Roadshow Specials, promotional posters and team meeting slides, manager toolkits and FAQs, e-mail signatures and MS Teams backgrounds, and weekly £25 gift-voucher incentives.
- Early participation figures indicate that the Staff Survey completion rate is lower than at the same stage in 2025.
- People & Culture improvement activity continued during Q2 through programmes focused on staff voice, health and wellbeing, inclusion, leadership development, workforce development and organisational culture, supporting the Trust's commitment to improving staff experience and engagement.
- Alignment between People & Culture priorities, strategic objectives, performance measures and evidence of impact continues to be strengthened through the phased



Interdependencies with other performance indicators

- When triangulating a low staff engagement score with other workforce metrics, it is common to see a correlation with high sickness absence and turnover rates. However, these rates are comparatively positive (4.6% and 5.7% respectively) and our stability rate is 92.6%.

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

Excellent Care Everywhere

National Performance Assessment Framework and League Tables New Framework 2026/7

Excellent
Care
Everywhere

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

Oversight Framework

National Performance Assessment Framework to Q1 2026/7

University Hospitals Sussex
NHS Foundation Trust

- The **NHS Oversight Framework 2026/27** marks a significant shift by introducing **30 scoring indicators** and **6 contextual measures** evaluated against fixed national statistical thresholds. **9 are entirely new metrics** introduced for the 2026/27 cycle, designed to reflect the 10-Year Health Plan's focus on shifting care from acute hospitals to the community and driving operational accountability
- The transition into the Q1 2026/27 reporting cycle saw **University Hospitals Sussex (UHS) shift from Segment 4 up to Segment 3 (an improvement)**
- **University Hospitals Sussex NHS Foundation Trust in Segment 3**, ranking **100th nationally** among tracked provider trusts with a baseline average metric score of **2.66**
- A summary of domain performance, comparison to Q4 2025/6 is shown below. This shows Access to services is the most challenged domain, whilst effectiveness of care and population health ranks highest:

Domain	Trust score Q1 2026/7	Peer median	Variance	Rank	Peer N	Relative percentile	Position	Q4 2025/26	Change vs Q4	Direction	Comparability
Effectiveness of care and population health	2.1	2.24	-0.14	52	134	62%	Above median			Not comparable	Not comparable: 2025/26 combined Effectiveness
Finance, productivity and innovation	2.39	2.5	-0.11	56	134	59%	Above median	2.28	0.11	Worsened	Indicative only: Innovation added to the domain in
People	2.35	2.42	-0.06	58	134	57%	Above median	2.16	0.19	Worsened	Indicative only: domain renamed and metric set
Experience of care	2.49	2.33	0.16	77	134	43%	Below median			Not comparable	Not comparable: 2025/26 combined Effectiveness
Patient safety	2.5	2.27	0.24	91	134	32%	Below median	3.05	-0.55	Improved	Broadly comparable
Access to services	3.33	2.53	0.8	122	131	7%	Bottom quartile	3.11	0.22	Worsened	Broadly comparable

Oversight Framework
Access to Services

University Hospitals Sussex
NHS Foundation Trust

- The below table illustrates the metrics used for the access to services domain scoring. This is the most challenged domain for UHS in Q1. RTT poses the most challenge for the Trust, with metrics in descending order of national ranking

Access to services | Domain score 3.33 | Rank 122/131

Sub-domain	Metric	Trust result	Units	Peer median	Rank	Peer N	Relative position	Q4 2025/26	Change vs Q4	Direction	Comparability
Diagnostics	Percentage of referrals where the patient is waiting six weeks or longer for a test or procedure	13.75	%	17.06	51	131	62%			Not comparable	New Metric 2026/7
Urgent care	Percentage of patients spending 12 hours or longer in an emergency department without being admitted, discharged or transferred	10.69	%	10	69	122	44%	9.85	0.84	Worsened	Comparable; description wording updated
Cancer care	Percentage of cases meeting the 28 day faster diagnosis standard	75.77	%	79.51	83	116	29%	77.48	-1.71	Worsened	Comparable; description wording updated
Cancer care	Percentage of cases treated within 62 days of referral	64.37	%	70.39	96	118	19%	66.39	-2.02	Worsened	Comparable; description wording updated
Elective care	Percentage of cases where a patient is waiting more than 52 weeks for community treatment	15.59	%	0.72	66	79	17%	18.21	-2.62	Improved	Comparable; description wording updated
Urgent care	Percentage of A&E patients admitted, transferred or discharged within four hours of arrival	69.3	%	75.6	103	123	16%	67.41	1.89	Improved	Comparable; description wording updated
Elective care	Percentage of cases where a patient is waiting less than 18 weeks for community treatment	41.33	%	81.06	71	79	10%			Not comparable	New Metric 2026/7
Elective care	Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	3.99	%	1.07	128	129	1%	3.18	0.81	Worsened	Comparable; description wording updated
Elective care	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	53.24	%	65.45	128	129	1%	55.11	-1.87	Worsened	Comparable metric ID

Oversight Framework
Other Domain Performance

University Hospitals Sussex
NHS Foundation Trust

The table below shows each metric for Q1 2026/7, the Trust's performance , how this compares to its national peers, and relative position, which indicates in descending order and via RAG rating where the metric is most challenging

Effectiveness of care and population health | Domain score 2.10 | Rank 52/134

Sub-domain	Metric	Trust result	Units	Peer median	Rank	Peer N	Relative position	Q4 2025/26	Change vs Q4	Direction	Comparability
Preventing ill health	Percentage of inpatients referred to and seen by an in-house tobacco treatment services who make a supported attempt to stop smoking	44.13	%	24.76	34	126	74%			Not comparable	Not comparable: no 2025/26 value for this metric ID
Outcomes	Delayed inductions rate	98.3	per 1,000 deliveries	31.2	108	119	9%			Not comparable	Not comparable: metric introduced in 2026/27

Finance, productivity and innovation | Domain score 2.39 | Rank 56/134

Sub-domain	Metric	Trust result	Units	Peer median	Rank	Peer N	Relative position	Q4 2025/26	Change vs Q4	Direction	Comparability
Innovation	Overall Data Quality Maturity Index	96.8	index	93	10	134	93%			Not comparable	New Data Item 2026/7
Finance	Variance to plan year-to-date	0	%	0	52	134	62%	0.27	-0.27	Improved	Comparable metric ID; wording updated
Finance	Planned surplus/deficit	-0.03	%	-0.38	64	134	53%	-1.62	1.59	Improved	Comparable metric ID
Productivity	Relative cost difference (National Cost Collection Index)	102.05	%	100.14	78	134	42%			Not comparable	New Data Item 2026/7
Innovation	Percentage of clinical trials set up within 90 days	30	%	50	90	121	26%			Not comparable	New Data Item 2026/7

People | Domain score 2.35 | Rank 58/134

Sub-domain	Metric	Trust result	Units	Peer median	Rank	Peer N	Relative position	Q4 2025/26	Change vs Q4	Direction	Comparability
People and culture	Sickness absence rate	4.62	%	5.36	28	134	80%	4.81	-0.19	Improved	Comparable metric ID
People and culture	Percentage of frontline healthcare workers to receive a flu vaccination	51.4	%	50.35	54	134	60%			Not comparable	New Data Item 2026/7
People and culture	National Education and Training Survey overall experience sub-score	75.95	%	76.34	71	134	47%			Not comparable	New Data Item 2026/7
People and culture	NHS staff standards sub-score	7.49	out of 10	7.52	77	134	43%			Not comparable	New Data Item 2026/7
People and culture	NHS staff survey engagement theme sub-score	6.68	out of 10	6.8	84	134	38%	6.68	0	No change	Comparable metric ID

Experience of care | Domain score 2.49 | Rank 77/134

Sub-domain	Metric	Trust result	Units	Peer median	Rank	Peer N	Relative position	Q4 2025/26	Change vs Q4	Direction	Comparability
Experience	NHS staff survey advocacy sub-score	6.38	out of 10	6.67	89	134	34%			Not comparable	New Data Item 2026/7

Patient safety | Domain score 2.50 | Rank 91/134

Sub-domain	Metric	Trust result	Units	Peer median	Rank	Peer N	Relative position	Q4 2025/26	Change vs Q4	Direction	Comparability
Safe culture	NHS Staff survey - raising concerns sub-score	6.09	out of 10	6.32	110	134	18%	6.09	0	No change	Comparable metric ID

Oversight Framework

Indicators stood down from 2025/6 framework

University Hospitals Sussex
NHS Foundation Trust

2025/26 domain	Indicator	Last reported	Last value	Units	Q1 2026/27 status
Effectiveness and experience	Average number of days from discharge ready date to actual discharge date (including zero days)	Q4 2025/26	1.95	days	Absent from Q1 2026/27 framework
Patient safety	Proportion of E. coli bacteraemia	Q4 2025/26	1.13	rate	Raw indicator absent; banded score remains
Finance and productivity	Implied productivity level	Q4 2025/26	2.5	%	Absent from Q1 2026/27 framework
Patient safety	Proportion of C. difficile infections	Q4 2025/26	1.09	rate	Raw indicator absent; banded score remains
Access to services	Difference between planned and actual 18 week performance	Q4 2025/26	0.1	percentage points	Absent from Q1 2026/27 framework

- These measures have either been removed or changed format in 2026/7.
- Cdiff and ecoli both ranked 3 of 4 in Q1 2026/7 whereas this was an actual rate in 2025/6.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	18.	**Meeting:**	Trust Board in Public	**Meeting Date:**	12 November 2026
Report Title:	Board Assurance Framework report Q2 2026/27				
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 2 scores.

The Audit Committee in its meeting in October 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 that there has been no reduction to any of the scores for quarter 2, this review has seen a net increase in the risks being significantly scored with the movement of the research risk (SR 9) from 16 to 20.

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 based on the review at the Audit Committee

The Board is asked to note the recommendations of the respective committees that there should be one increase in score for SR9 and for each other Strategic Risk they remain as they were scored for quarter 1.

The Board is asked to note the Finance and Performance oversight committee comment in respect of 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 an increase in score for SR9 (research) and there should be no change to the other scores, and that this sees the Trust operating with 8 of its strategic risks significantly scored. The Board is also asked to consider the respective comments from the 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.

University Hospitals Sussex
NHS Foundation Trust

Recommendation *(linked to What Next section)*	The Board should **NOTE** the assurance provided by the respective Committee review of their BAF segments. The Board is asked **AGREE** the quarter 2 scores, noting the support for an increase in score for SR9 from the Research, Innovation and Digital Committee seeing the Trust operating with 8 of its 12 strategic risks being significantly scored. The Board is asked to **CONSIDER** the comments provided by the Finance and Performance Committee reflection on the continued 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.
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 October.* *Each of the respective oversight committees considered their element of the BAF at their meetings in November.*

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 At the Board in 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.

1.2 The BAF for 2026/27 is aligned to the Trust's new strategic ambitions.

2 BAF processes

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

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

2.2 The BAF itself will continue to be presented on a quarterly basis to the Board Committees, with the next scheduled reporting taking place to the Committee meetings at the start of August 2026.

2.3 The quarter 2 BAF was considered by the Executives and Senior Leaders through the Executive Management Committee at its meeting in September and supported it progressing to the respective Board Committees.

3 BAF Structure

3.1 The Trust's BAF for 2026/27, is structured for each Strategic Risk in three sections,

- the first section shows at a glance the current risk score relative to its annual target score and the Board's stated appetite along with an assessment of the assurance strength. This first section also records a summary of the challenges and key actions being taken to achieve the target score.
- the second section records the delivery of agreed actions to further mange the risk and to bring a focus to the actions taken and being taken in respect of each of its identified strategic risks.
- the third section shows a mapping of the assurances received to their respective key controls and for each assurance whether this provided by operational management (1st line), corporate service led assurance activities (e.g. peer review or ward accreditation), executive, group or committee oversight (2nd line) or by an independent source (3rd line).

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

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

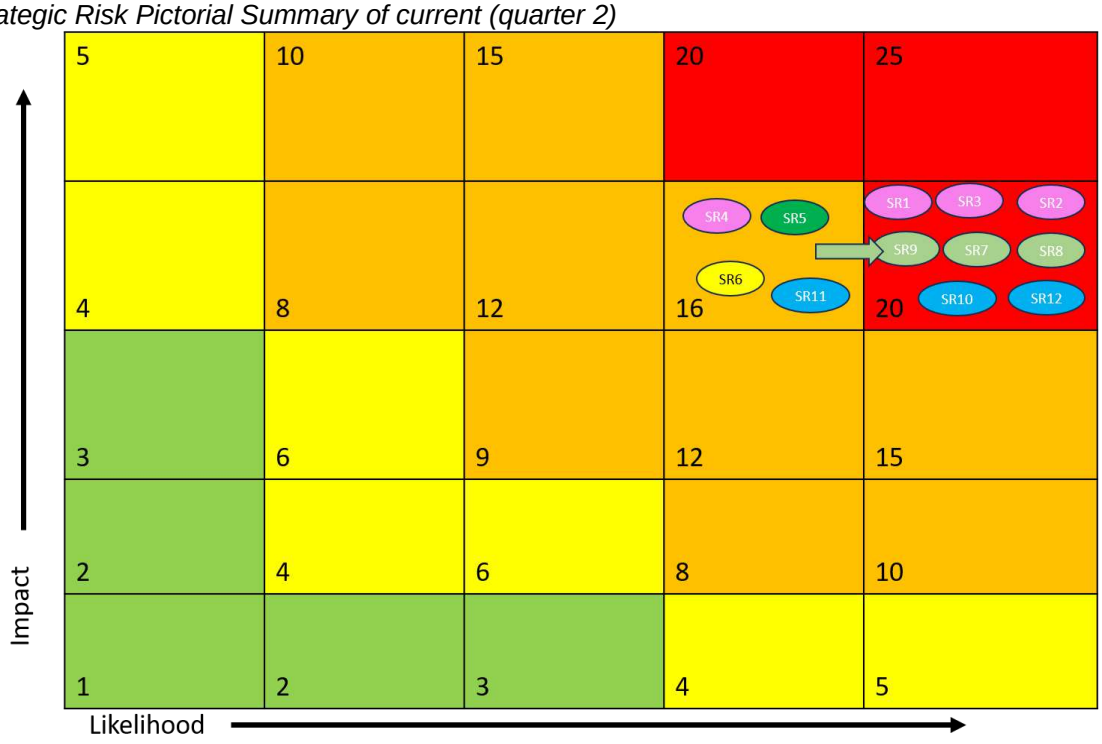
3.4 Through the risk improvement sprint work the BAF will be updated to show the linkages to the Strategic Risk of the Trust Wide Risks and the key Divisional Driver risks thus showing the influence these trust wide (corporate) and operational risks have on the Strategic Risk itself.

4 BAF summary

4.1 The overall risk profile for the Trust remains high as over quarter 2 as there is an increase in the number of significantly scored risks, following the respective lead Committee's review that recommended a change to Strategic Risk 9 to increase this from 16 to 20, with all other risks remaining as scored for quarter 2. Therefore, at the end of quarter 2, there are now 8 of the 12 Strategic risks remain 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)

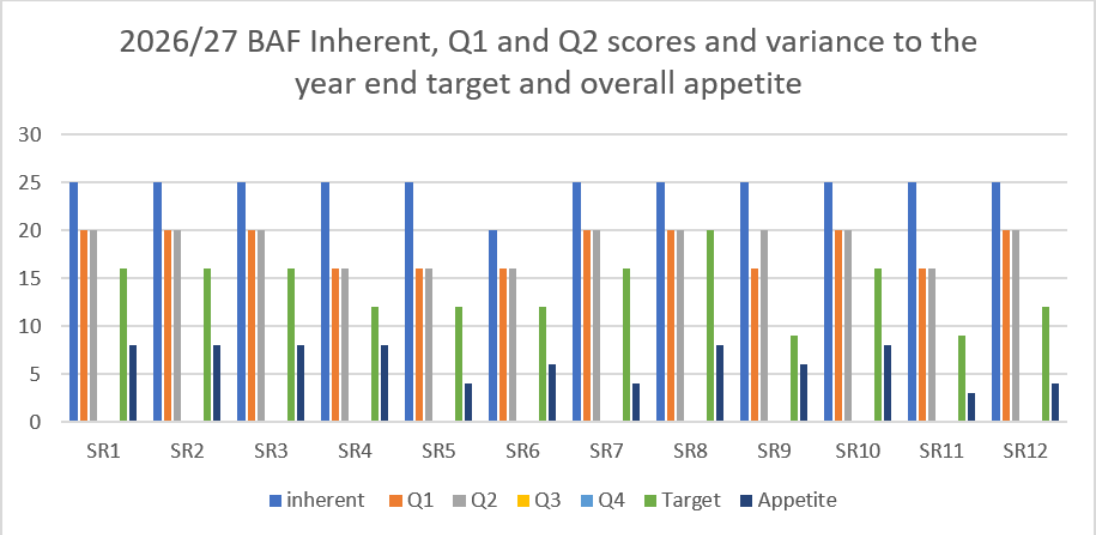
4.2 At the end of quarter 2 for the Trust's other two strategic ambitions Excellent Care for Communities (coloured yellow) and Excellent Care for our people (coloured dark green) there are risks scoring 16.

Strategic Risk Pictorial Summary of current (quarter 2)



4.3 It should be noted that risk SR8 aligned to the ambition of 'Better, more sustainable buildings and equipment' retains a year-end target score of 20, which is the same as its current score at the start of 2026/27 as work has yet to conclude on determining the impact the developed estates improvement plan will have over 2026/27. Noting this is the only strategic risk not planned to reduce during the year. As was agreed by the respective committee and the Board that the mitigation of this risk will be overseen by the Patient and Quality Committee.

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



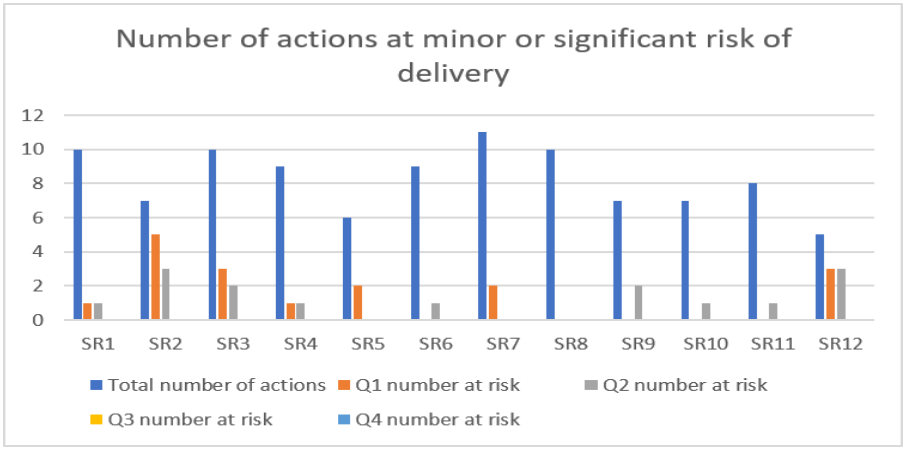
4.5 The table below shows the overall assurance level for each of the Strategic risks, showing that for quarter 2, 8 of the 12 risks have been assessed as having limited assurance that the action being taken are yet to be effective. This sees a change for SR4, where following the challenge by that risks oversight committee (Patient and Quality) more work was undertaken to secure wider assurance than reliance on the tracking of delivery of the Trust's overall health inequality plan. This has resulted in receipt of limited assurance over the referral to wait time tracking by deprivation indices and the ability to robustly measure continuity of carer provision for expectant families, thus changing with these broader sources of assurance a move to limited assurance overall.

	Q1 assurance rating	Q2 assurance rating
SR1	limited	limited
SR2	limited	limited
SR3	limited	limited
SR4	reasonable	limited
SR5	reasonable	reasonable
SR6	limited	limited
SR7	reasonable	reasonable
SR8	limited	limited
SR9	reasonable	reasonable
SR10	limited	limited
SR11	reasonable	reasonable
SR12	limited	limited

4.7 Over quarter 2 management assurance has been received over the delivery of the agreed improvement actions with for 4 of the 12 risks there has been a reduction in the number of actions at minor or significant risk of delivery, these cover SR2, SR3, SR5 and SR7. Noting for both SR5 (workforce) and SR7 (digital) all actions are now back on track.

4.8 However, the delivery of actions for SR6 (inequalities), SR9 (research), SR10 (financial sustainability) and SR11(culture) there is an increased risk in the delivery of the actions due to delays in progress.

4.9 Below is a chart showing the number of actions at risk relative to the number of actions being taken for each strategic risk.



5 Committee review

5.1 Each BAF Strategic Risk 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.

5.2 Each Committee met in the first week in November as planned and reviewed their allocated elements of the BAF and recommended score provided by the lead Executive Director.

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

5.3.1 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 2 was considered, the Committee considered the suggestion from the Executives that sufficient action had been taken to enable the risk to reduce to 16 from a prior score of 20. The Committee discussed the information within the reports it had received and determined that insufficient assurance had been provided that the action taken is delivering their intended outcomes to support a reduced score. The Committee therefore determined the score should remain scored significantly at 20.

The profile of assurance provision was a mix of operational, executive and committee oversight, but there was also a degree of external assurance however this overall provided limited assurance on the delivery of actions.

The Committee **agreed** the score should remain at 20.

SR4 aligned to Improving Equality of Access and Outcomes

The assessed score for this risk at the end of quarter 2 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.

Following the request made at the end of quarter 2 further assurance was obtained to build on the assurance provision provided through the delivery of the Trust's overall health inequality plan. The quarter 2 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, through the wider assurance obtained these show the delivery of actions to improve health inequalities is behind the agreed plan.

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 2 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 if a reduced mitigated position may be possible 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 2 was limited which supported no change to the score of 20 in quarter 2.

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.

5.3.2 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 2 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 2 is 20 from an inherent risk score of 25 with a target score of 9 for the year end. The Committee considered the increase in the

operational risks relating to the capital resourcing for the clinical research unit development and the ability to recruit sufficient staff to provide the level of research activity within the Trust's plan. In considering these risk the Committee felt the recommendation to maintain the score at 16 was inappropriate and that the strategic risk should increase to 20.

The Committee **agreed** that the score for quarter 2 should be increased to 20.

5.3.3 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 2 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 2 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 2 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 2 score of 20 reflects that whilst the Trust has had an active UEC Improvement Programme, all of the Trust's 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 2 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. The profile of assurance provision was primarily through executive and committee oversight, with the overall profile of assurance in quarter 2 being limited which is driven by the need to ensure integrated finance and performance reporting, maintain rigorous efficiency programme governance, the development of robust forecasting and scenario planning with clear actions to course correct and adherence to escalation triggers, the tightening of workforce cost control, the need to rebuild cash balances and to ensure quality impact assessments are undertaken as part of the decision making. This is supporting no change to the score of 20 in quarter 2.

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

5.3.4 People and Culture Assurance Committee

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

SR5 Ensuring our workforce is happy, healthy and supported

The assessed score for this risk at the end of quarter 2 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 the BAF reflects a set of mitigations developed and noted that for quarter 2 those actions in quarter 1 at risk have been brought back to be on track.

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 2 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 2 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 were considered to be 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 2 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 2 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 BAF reflects that the overall level of assurance is limited.

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.

5.3.5 Strategy and Major Projects Assurance Committee

The Strategy and Major Projects 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 2 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 whilst receiving little direct reports linked to this risk recognised it has not received any information that would suggest a change to the recommended score from the executives of 16 for quarter 2 score. Based on this the Committee accepted the score of 16 and that this should be provided to the Board for approval.

The Committee reflected that the referral to Executives to consider the alignment of this strategic risk to the Committee remains under consideration.

5.3.6 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. The Committee also received a report on the risk improvement work that continues and noted the good buy in from both clinical divisions and corporate teams. The endorsed the work being undertaken to crystalise a Trust Wide Operational Risk Register (tier 2) which it agreed will then support an iterative change to BAF with the inclusion of explicit linkages to the Strategic Risk from the Trust Wide Risks (tier 2 risks).

The Audit Committee noted that as part of the risk improvement work then there is a work package looking at how to align the SDIF (plan) actions to the BAF to allow a read across from SDIF progress to strategic risk mitigation.

6 Conclusion

6.1 The quarter 2 BAF reflects a change to Strategic Risk 9 which is supported by the review at the Research, Innovation and Digital Committee, this changes sees an increase in this score

from 16 to 20, which itself sees an increase to the total number of strategic risks significantly scored risks at the end of Quarter 2 increase to 8. The review by the Finance and Performance Committee reflected that for Quarter 2 three key risks (Planned Care (SR1), UEC (SR2) & Financial sustainability (SR10)) remain at significant risk of delivering their intended benefits by the year end.

7. Recommendations

7.1 The Board is asked to **NOTE** the assurance provided by the Audit Committee over the underpinning processes supporting the BAF.

7.2 The Board is asked **AGREE** the quarter 2 scores, noting the support for an increase in score for SR9 from the Research, Innovation and Digital Committee seeing the Trust operating with 8 of its 12 strategic risks being significantly scored and that the Patient and Quality Committee recommended no reduction in risk score for SR3.

7.3 The Board is asked to **CONSIDER** the Finance and Performance Committee feedback on the continued 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.

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	5	**20** ⟷							4	4	**16**
	Assessed overall assurance level				***Limited***			***Limited***												
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	5	**20** ⟷							4	3	**12**
	Assessed overall assurance level				***Limited***			***Limited***												
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	5	**20** ⟷							4	4	**16**
	Assessed overall assurance level				***Limited***			***Limited***												

University Hospitals Sussex NHS Foundation Trust

Strategic Objectives	Strategic Risks	Risk Scores (Key: I = Impact L = Likelihood T = Total																	
		Inherent (uncontrolled)			2026/27 Q1			2026/27 Q2			2026/27 Q3			2026/27 Q4			2026/27 Target		
		I	L	T	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
Oversight provided by the Patient and Quality Assurance Committee																			
SR3 Improving safety and experience	*If we fail to have robust quality governance systems and processes, use our data intelligently, and develop a strong safety culture that supports learning then we will not know how safe, effective and high quality care our care is or fail to identify and address key risks and issues resulting in potential avoidable harm, adverse outcomes, poor patient experience, excess costs, reputational damage and regulatory action.*	5	5	25	4	5	20	4	5	20							4	4	16
	Assessed overall assurance level				***Limited***			***Limited***											
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	4	16							4	3	12
	Assessed overall assurance level				***Reasonable***			***Limited***											
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							4	5	20
	Assessed overall assurance level				**Limited**			**Limited**											
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	4	16							4	3	12
	Assessed overall assurance level				***Reasonable***			***Reasonable***											

NHS University Hospitals Sussex NHS Foundation Trust

Strategic Objectives	Strategic Risks	Risk Scores (Key: I = Impact L = Likelihood T = Total																	
		Inherent (uncontrolled)			2026/27 Q1			2026/27 Q2			2026/27 Q3			2026/27 Q4			2026/27 Target		
		I	L	T	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
SR11 Living our values in everything we do	*If we do not develop our organisational culture to make UHS a more inclusive place to work that celebrates our diversity and tackles discrimination then our staff will not feel valued, empowered or psychologically secure resulting in lower staff engagement, poorer staff wellbeing, challenges with recruitment and retention, and lower quality of care to patients.*	5	5	25	4	4	16	4	4	16 ↔							3	3	9
	Assessed overall assurance level				***Reasonable***			***Reasonable***											
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	5	20 ↔							4	3	12
	Assessed overall assurance level				***Limited***			***Limited***											
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	5	20 ↔							4	4	16
	Assessed overall assurance level				***Reasonable***			***Reasonable***											
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	4	5	20 ↑							3	3	9
	Assessed overall assurance level				***Reasonable***			***Reasonable***											

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	4	**16**							4	3	**12**
	Assessed overall assurance level				***Limited***			***Limited***											

NHS
University Hospitals Sussex
NHS Foundation Trust

Trust Board of Directors Meeting in Public

Thursday 12 November 2026

APPENDICES

We are compassionate
We are inclusive
We are respectful

NHS
University Hospitals Sussex
NHS Foundation Trust

Perinatal Quality Oversight Model (PQOM) Exception Report

Monthly Update

August 2026 Data

Excellent Care Everywhere

Introduction

University Hospitals Sussex
NHS Foundation Trust

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

NHS
University Hospitals Sussex
NHS Foundation Trust

Assurances 🟢

- Perinatal mortality, neonatal mortality and suspected HIE rates remain below or at national benchmarks, providing continued assurance of safe clinical outcomes.
- No maternity or neonatal PSII or MNSI referrals were reported in August, with CNST compliance maintained for PMRT and mortality review processes.
- Progress continues across maternity safety, training and improvement programmes, including achievement of CNST training milestones and on-going delivery of MatNeo improvement actions.

Escalations 🔴

- Gap analysis of Neonatal service against Thirlwall Inquiry recommendations (see paper for full detail) has highlighted a number of actions required to achieve compliance by the March 2027 benchmark.
- Workforce sustainability remains the principal strategic risk, particularly neonatal nursing vacancies, ANNP shortages, QIS compliance, Tier 2 Neonatal rota and recruitment constraints associated with the Trust-wide recruitment pause operating in August.
- Capacity and infrastructure challenges persist, including obstetric theatre capacity, TMBU operational resilience, estate limitations and neonatal service configuration requirements.

Achievements

- Neonatal death rates remain substantially below the national benchmark, and perinatal mortality continues to perform favourably against national comparators.
- Patient feedback, although diminishing in rate of returns, remains overwhelmingly positive, highlighting compassionate, respectful and personalised care across maternity services.

PQOM Dashboard Overview –
National/Regional Benchmark in red font

NHS
University Hospitals Sussex
NHS Foundation Trust

Registrable Births August 2026	Stillbirth 12 month Rolling Rate	Neonatal Death 12 Month Rolling Rate	Suspected HIE 2 & 3 rate per 1000 live births	ATAIN	Perinatal Mortality
•694	•1.99/1000 •3.18/1000	•0.35/1000 •1.59/1000	•0.94/1000 •1.3/1000	•4.49% of full term babies (=>37/40) admitted to NNU •5%	•2.35/1000 •4.77/1000

Assurances

As can be seen, most 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.

Suspected HIE 2 & 3 cases is illustrated in a rolling rate for a more specific clinical picture. The 12-month rolling rate of Suspected HIE on slide 5 shows the Trust trending below or equal to the benchmark.

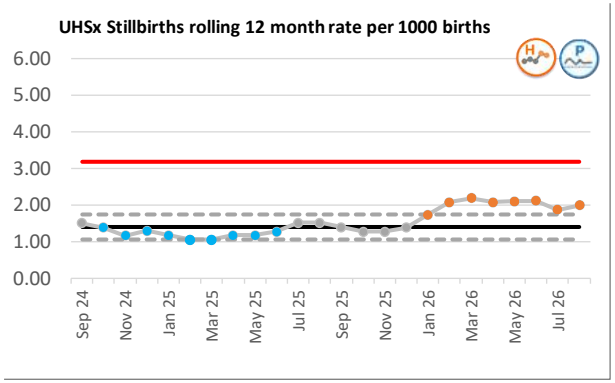
In the content slides following, assurance and improvements are noted but to summarise:

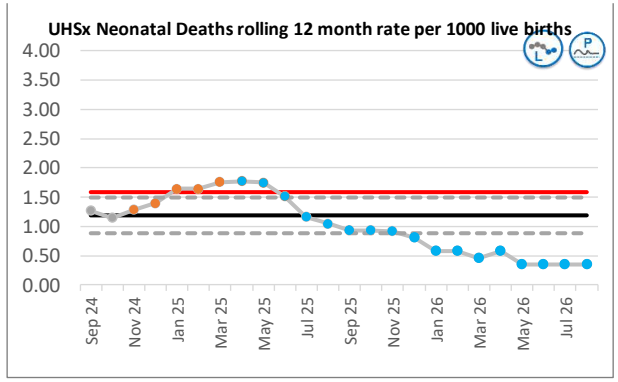
Indicator	Position
Perinatal Mortality	
HIE	
Voice of the User	
Training	/
Workforce	

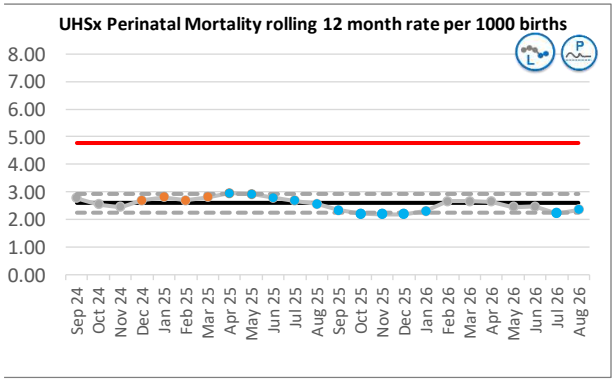
Data source for Stillbirth, Neonatal death and Perinatal Mortality rates 2026 MBRRACE Perinatal Mortality Report: Perinatal mortality surveillance reports | MBRRACE-UK | NPEU > MBRRACE-UK
HIE and ATAIN rate were set by the Regional team

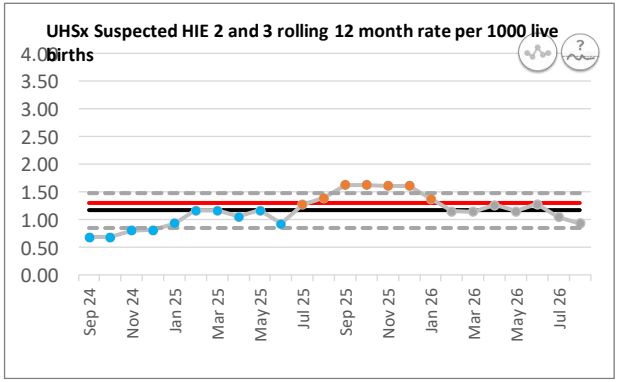
Deaths and Harm
Perinatal Mortality Statistical Process Control (SPC) charts

University Hospitals Sussex NHS Foundation Trust









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; there were no causative themes found, coincidental learning is being addressed.

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 (2.35/1000 births vs. 4.77/1000 births)

Suspected Hypoxic Ischemic Encephalopathy (HIE or Brain Injury):

Rates reduced following late 2025 increase. Currently equal to national rate.

Top Perinatal Strategic Risks Requiring Board Oversight

University Hospitals Sussex NHS Foundation Trust

Workforce
- ANNP Shortages
- Tier 2 Neonatal Compliance
- Gaps in Continuity of Care for Health Inequality groups
- Qualified in Specialty (QIS) Nursing Workforce

Infrastructure & Capacity
- Obstetric theatre capacity
- TMBU Estate
- Ventilation/Temperature management

Risk Theme	Direction
Workforce & Staffing	↔ Stable/Planned Improvement
Infrastructure & Capacity	↗ Deteriorating
Safety Systems	↗ New regulatory recommendations
Learning and Assurance	↗ Increased oversight

Safety Systems
- Abnormal result escalation
- Homebirth compliance against national Prevention of Future Deaths notice (Manchester case)
- Governance of clinical documents
- Neonatal compliance against Thirlwall recommendations

Learning and Assurance
- National scrutiny
- BAPM compliance

Executive oversight remains focussed on workforce sustainability, infrastructure constraints, safety-system resilience, and delivery of actions arising from investigation and regulatory findings.

Full details on slides 13 & 14

Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

Risk



Risk Register

University Hospitals Sussex NHS Foundation Trust

Risks graded 16 or above opened in August 2026:

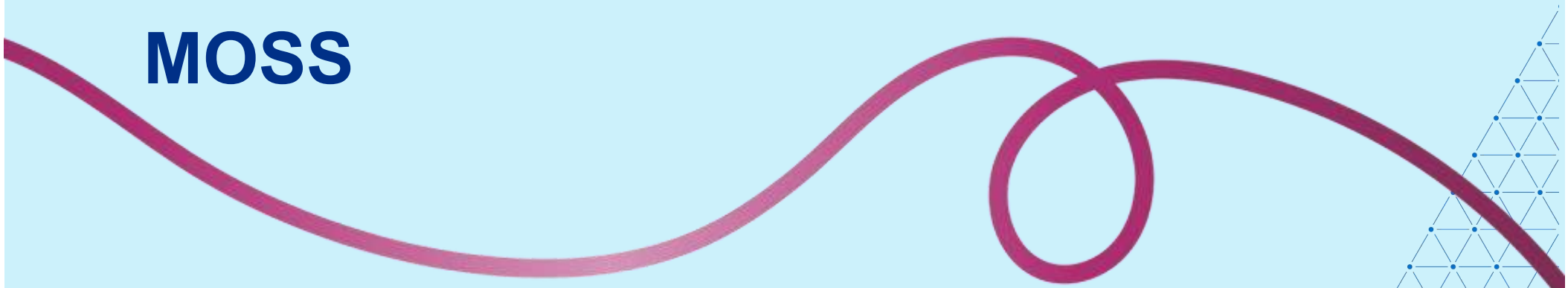
ID	Title	Risk Register	Type	Subtype	Risk Review Date	Current Risk Grading	Escalated?	Status	Location	Service
3382	Lack of Preterm obstetric lead consultant in post covering RSCH and PRH	Obstetrics & Gynaecology	Service Delivery	Breach of Target / Standard	14/10/2026	16	No	Active	PRH/RSCH	Obstetrics

Risks graded 16 or above closed in August 2026: None

Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

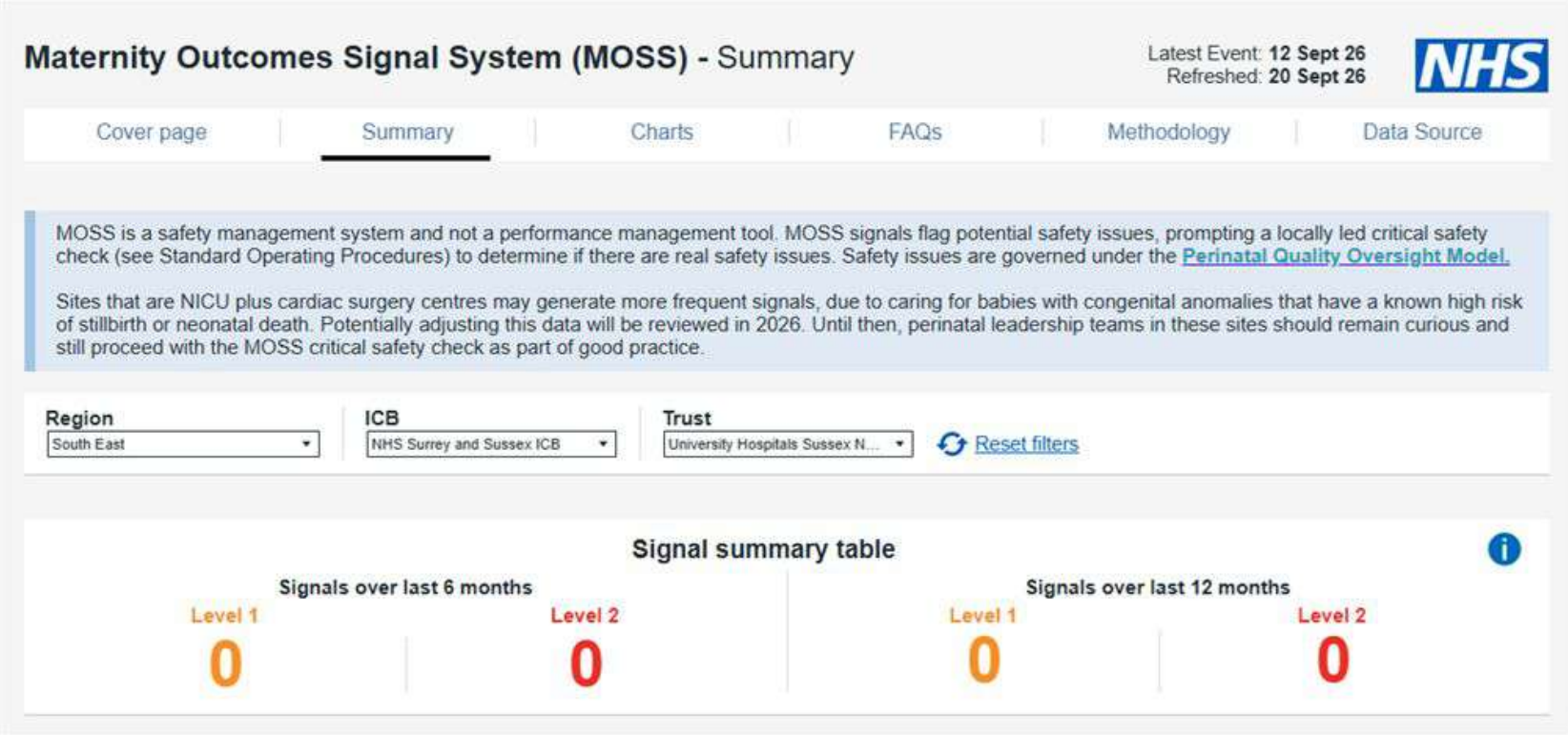
MOSS



Maternity Outcomes Signal System (MOSS)

University Hospitals Sussex
NHS Foundation Trust

[NHS England » Maternity Outcomes Signal System (MOSS) standard operating procedures]



Maternity Outcomes Signal System (MOSS)



Analysis of the charts

- A term stillbirth occurred during June and September at PRH and also during August at RSCH

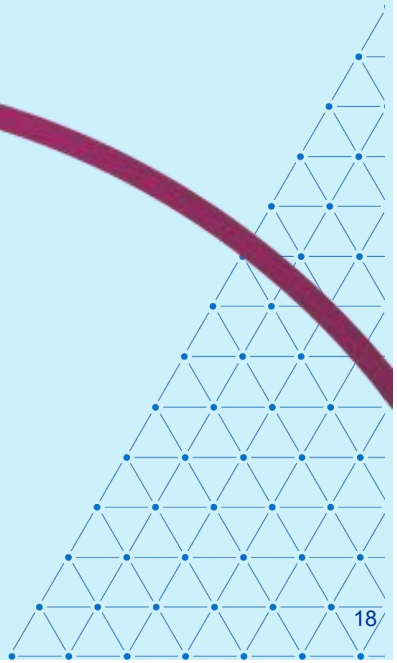
Further implementation plan

- SOP and Action cards drafted and out for consultation – action cards ranging up to executive team members and external assurance
- 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, covering two sites each. Both drills must happen by CNST reporting (30/11). Drills imminent.

Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

Health Inequalities



Health inequalities

University Hospitals Sussex NHS Foundation Trust

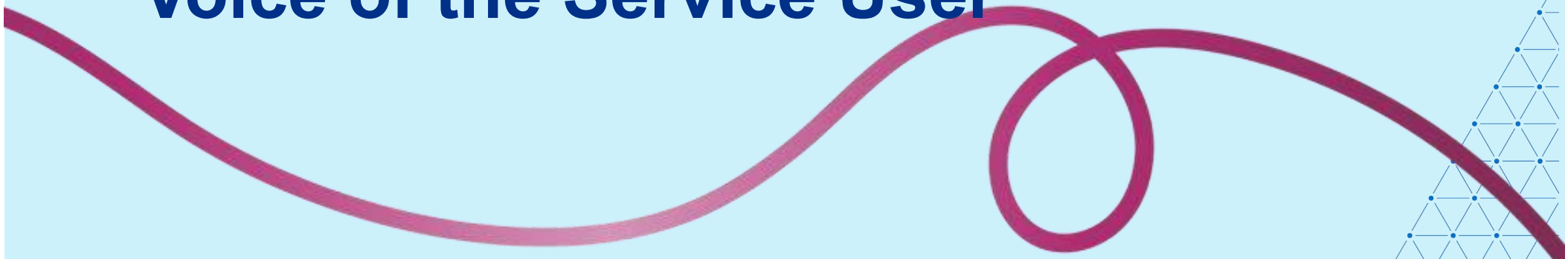
- Statistical Process Control (SPC) charts for key indicators stratified to Global Majority groups and most deprived groups are compiled by the Integrated Care Board (ICB) for individual sites. These charts are now included in appendix 2.

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.

Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

Voice of the Service User



3c) Voice of the user – Maternity

NHS
University Hospitals Sussex
NHS Foundation Trust

Voice of the user	Princess Royal, Haywards Heath	Royal Sussex County Hospital, Brighton	St Richards Hospital, Chichester	Worthing Hospital, Worthing
FFT (% and response rate)	100% (RR 2.65%)	100% (RR 3.95%)	90.91% (RR 6.67%)	100% (RR 2.65%)
Complaints	2	2	2	1
Legal Claims	0	0	2	0
MNVP concerns	0	0	0	0

/

The national benchmark for Maternity FFT (all questions combined) for August 2026 was 92% positive. This was not achieved at St Richards Hospital; 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 on the other sites. It is also worthwhile mentioning that a national IT problem with the Badgernet system prevented FFT surveys for the first two weeks of August. This was escalated to the highest levels and triggered business continuity plans for the local Badgernet system for documentation reasons. This did however affect the recorded response rates. Because of the dramatically reduced response rates, a full breakdown of themes has not been provided this month but will be provided with the aid of the new trust software covering September data next month.

Whole numbers of new complaints received (6) in August dropped dramatically in comparison to the previous several months. As reported in previous months, the themes of complaints consistently note that patients are most concerned about Clinical Care and Communication. The source of the complaints were from various stages of pregnancy/labour and all Clinical Care complaints related to a perceived delay and/or failure in treatment. These themes are triangulated with patient safety and claims data to provide a more detailed analysis and further quality improvement in the Q2 legal claims scorecard available this month.

Voice of the user - Neonatology

NHS
University Hospitals Sussex
NHS Foundation Trust

Voice of the user	Princess Royal, Haywards Heath	Royal Sussex County Hospital, Brighton	St Richards Hospital, Chichester	Worthing Hospital, Worthing
Complaints	0	1 (re-opened)	0	0

/

Patient Reported Experience Measures (PREMS, such as the national Friends & Family Test or FFT) is an element of improvement for Neonatology.

Improvement priorities:
In August, the go live of the new Smart Survey FFT platform was delayed for technical reasons but has now gone live in September.

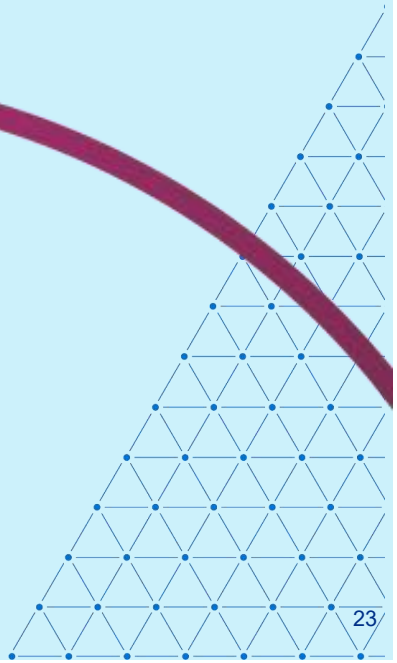
We are in the process of securing and readying 4 rooms close to Worthing Hospital, for families to stay close to their babies whilst in SCBU.

Formal Complaints:
Family complaint, concerns and questions raised, and is being responded to in a Local Learning Review of their care, with their agreement for this learning response to include their concerns.

Excellent Care Everywhere

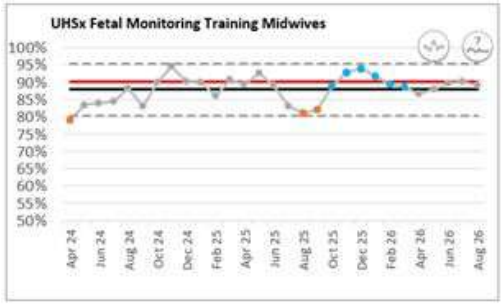
NHS
University Hospitals Sussex
NHS Foundation Trust

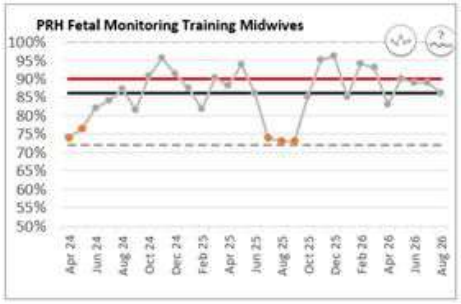
Workforce Safety

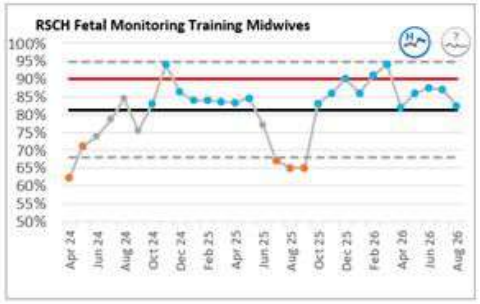


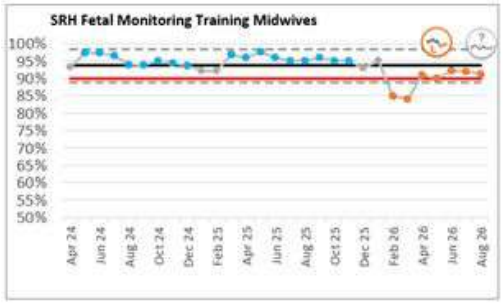
Leadership and training: Fetal Monitoring Midwives

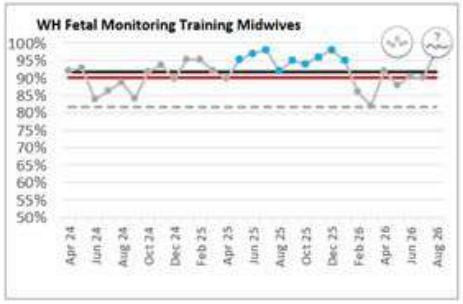
University Hospitals Sussex
NHS Foundation Trust











RSCH and PRH

Compliance continues to improve across both sites following strengthened oversight and monitoring. Ongoing leadership support is required to sustain progress and maintain compliance

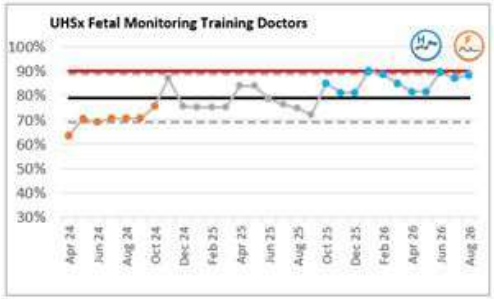
WH and SRH

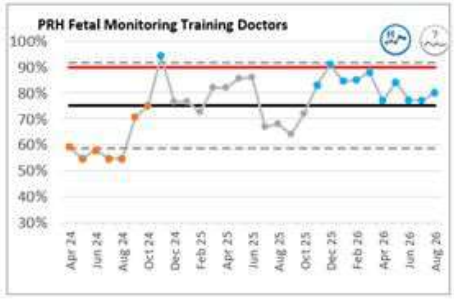
The change in training schedule can at times appear to reduce compliance levels however, this is settling now with 90% compliance achieved on both sites.

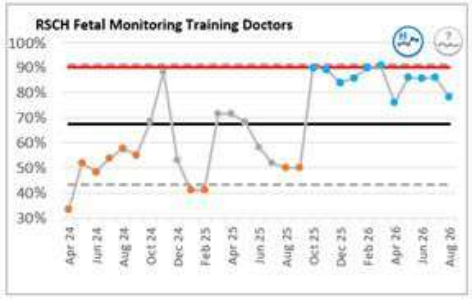
As is reported in later slides, training compliance for the first CNST training compliance checkpoint (scheduled 31/07/2026) was achieved by 15/07/2026.

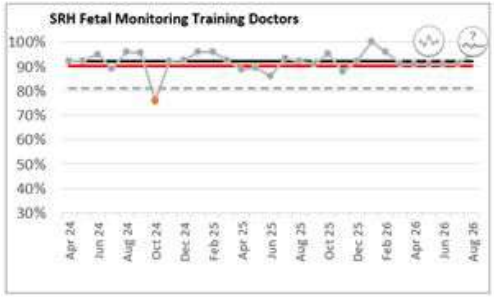
Leadership and training: Fetal Monitoring Doctors

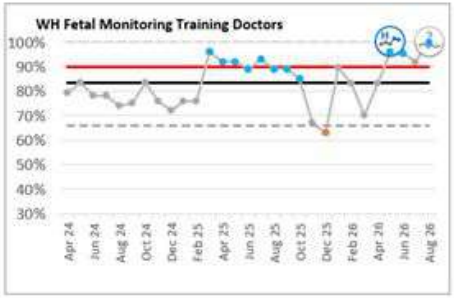
University Hospitals Sussex
NHS Foundation Trust











/

RSCH and PRH
Consultant compliance remains strong (PRH 89%, RSCH 88%). Compliance amongst Career Grade Doctors, SHOs and Registrars remains below target and continues to be the primary focus of improvement activity and monitoring.

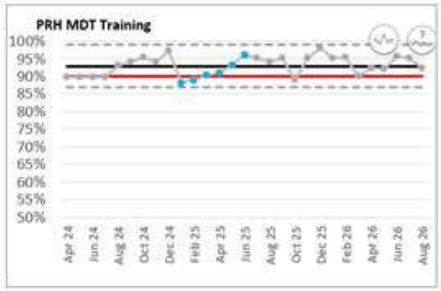
WH and SRH have achieved the 90% compliance required for CNST.

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)

University Hospitals Sussex NHS Foundation Trust











/

All sites achieved the July 2026 CNST MDT PROMPT milestone.

Impacted Fetal Head training has been successfully delivered at Worthing and St Richard's Hospitals.

Maintaining compliance amongst our junior doctor groups

Limited senior obstetric faculty capacity may impact wider delivery of IFH training.

Monthly compliance monitoring and targeted follow up of non -attendance, outstanding re-bookings,

Ongoing engagement with senior obstetric teams to increase IFH training capacity and support achievement of the November 2026 CNST target.

Team feedback – Divisional measures





Position 🟢 / 🟡

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

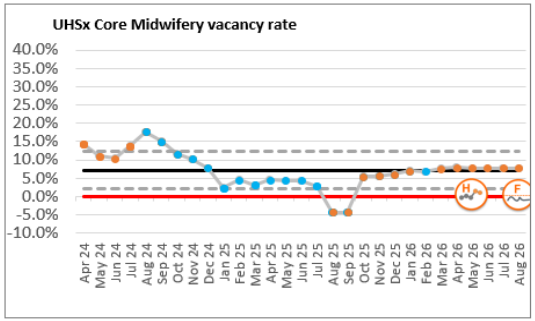
The new appraisal document in the trust has launched recently therefore will be used for FY26/27

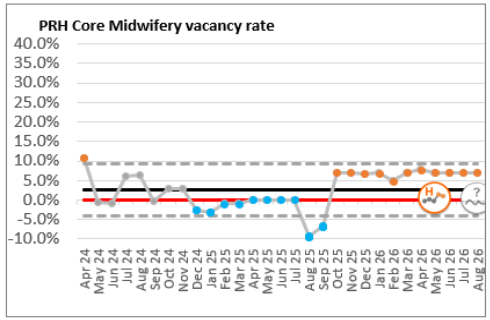
Listening Events being held across Directorates. Bespoke Listening Events have been held for the perinatal teams to brief the team on the upcoming Maternity and Neonatal investigation. These events included talks from the legal team regarding social media safety, and the communications team regarding media coverage and behaviour.

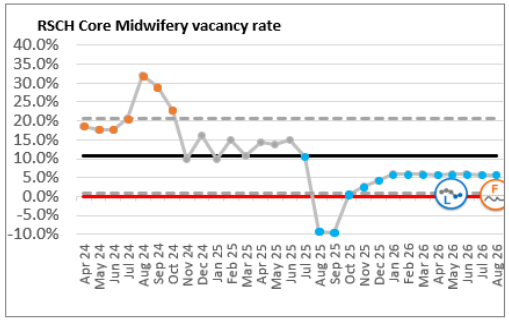
Separate Listening Events have been completed to prepare and support staff for the media coverage.

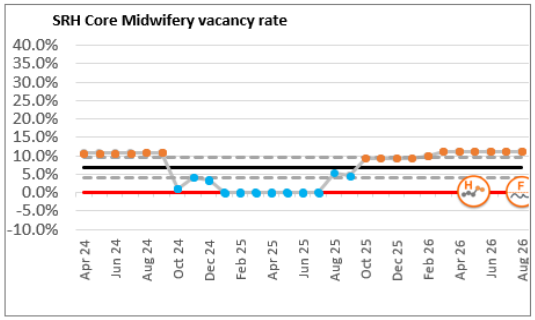
Perinatal workforce – Midwifery vacancy rate

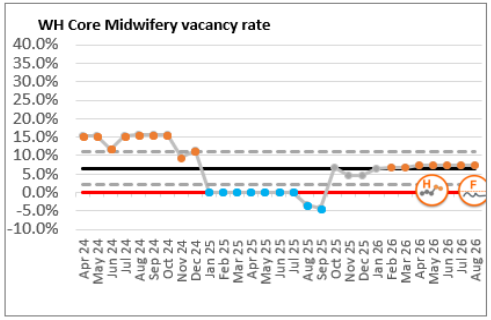
University Hospitals Sussex NHS Foundation Trust







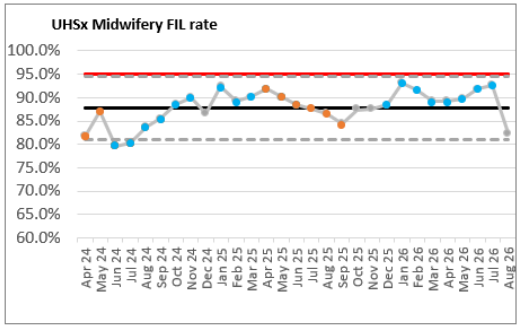


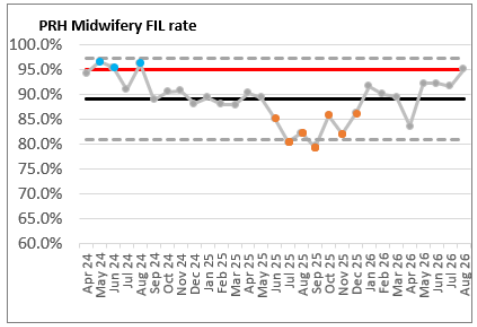


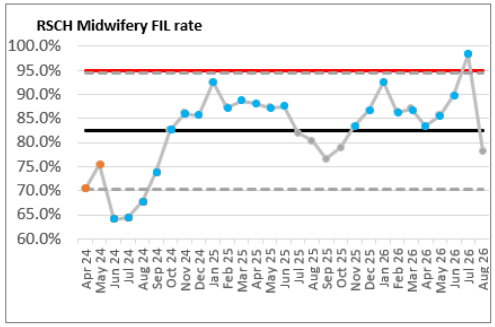
- Substantive midwifery vacancies remained at 0% at end of August 2026 although that position has now changed. When parental leave and secondments are included, the vacancy rate was 5%, with recruitment underway and improvement expected in coming months.
- Annual preceptorship progression creates temporary workforce gaps, which will be mitigated through fixed-term Band 5 contracts and consideration of two recruitment cohorts per year.
- Recruitment is significantly impacted by Trust wide recruitment freeze. Student midwives have been agreed October start dates as planned, however other midwifery candidates remain in the pipeline without start dates. Resolution is being urgently sought with clear risk profiling of posts remaining vacant.
- The BR+ review uplift has been approved by the Board and recruitment commenced September 2026

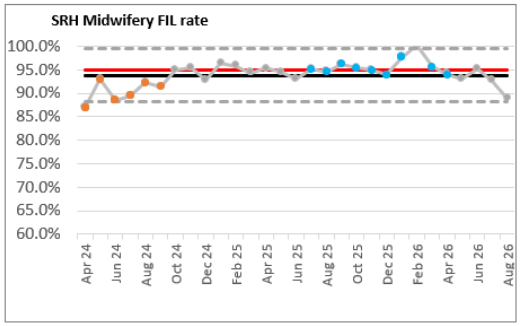
Perinatal workforce – Midwifery Fill rate

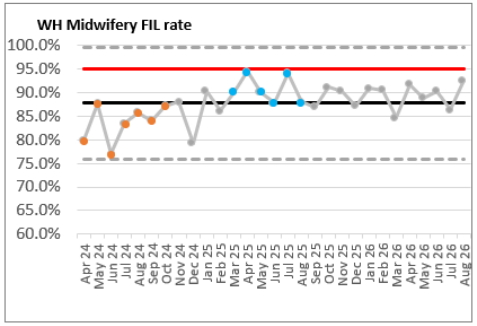
University Hospitals Sussex NHS Foundation Trust







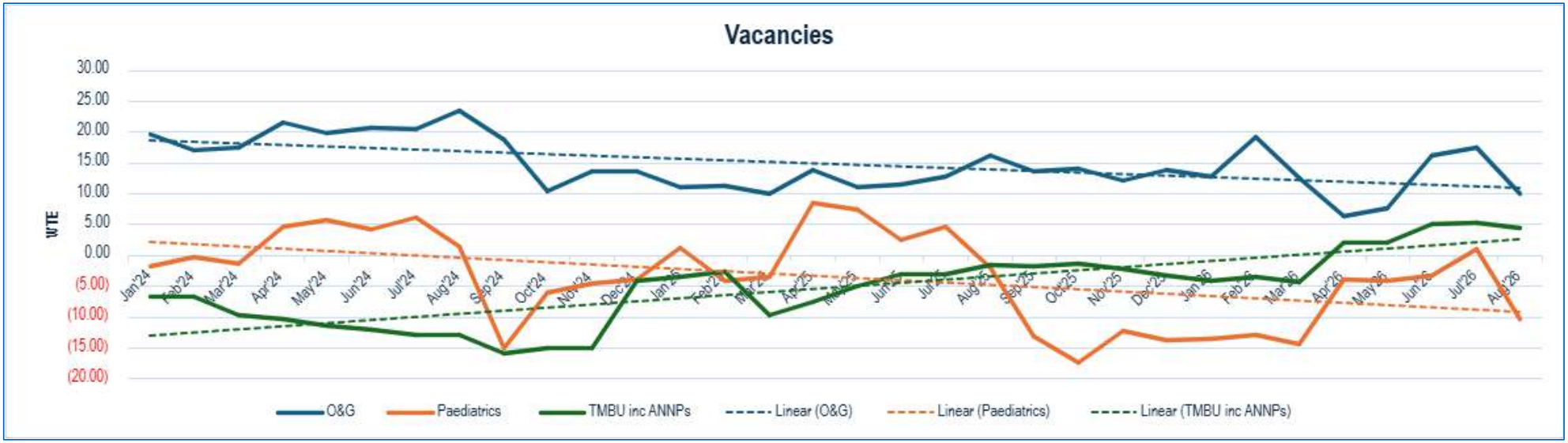




Fill rates remain significantly improved compared with summer 2024, although some variation persists with a data drop noted at RSCH specifically in month. This was due to a change in the denominator with a wider staff group being included in the planned (denominator) and actual (numerator) being heavily affected by sickness and absence. Agency use has ceased and bank usage has reduced. Workforce pressures continue to arise from sickness absence, parental leave and preceptorship progression.

- 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.
- Escalation of risk to progress with Trust wide recruitment freeze since July 26

Perinatal workforce - Medical

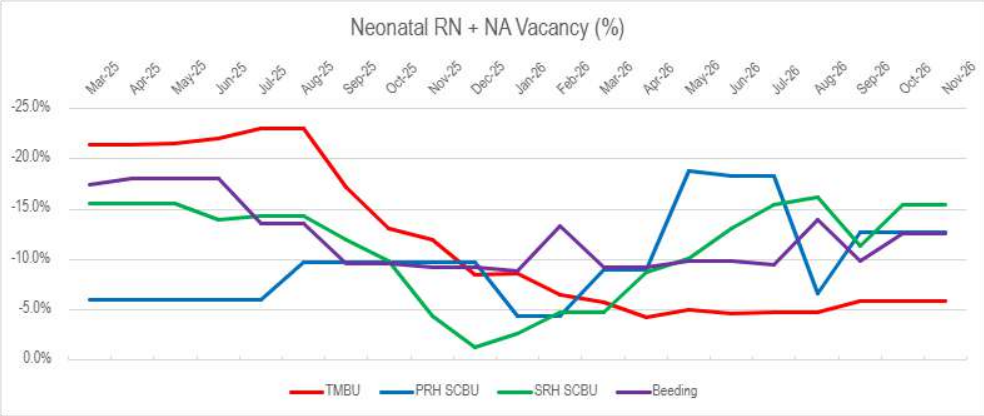


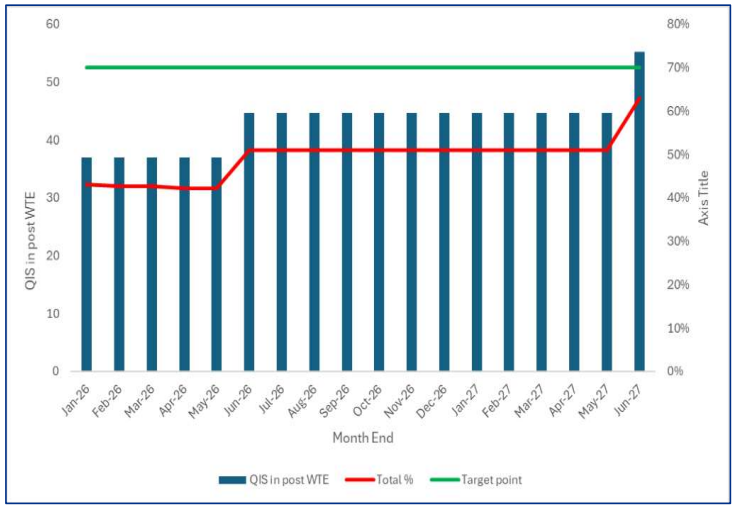
/

Obstetrics: Obstetric work force remains fragile at **RSCH**: Shortfall of 3 WTE obstetric consultants (sick leave (until Nov & March) and maternity leave until March) on the rota; Mat-fetal med consultant 0.6WTE FT locum covering their high risk clinics started 21st Sept; RSCH/PRH fetal med will continue to be supported by Kings in short term but, in the planning stage, is aim of developing a level 2 commissioned fetal med service in UHSx with inhouse sub-spec fetal med cons. The middle grade (registrar) tier has 3 vacant post from October – 2 LED posts failed at shortlisting stage : proposed ROC (resident on call cons x2) JD developed and escalated with finance support to cover (similar to SRH) and in development with DME, a 4 -year LED cross Trust rotation to attract and provide resilience for other sites in future years. **PRH**: Fully staffed consultants' tier with one fixed term locum consultant covering a sabbatical/ additional consultant posts in planning for elective CS lists; middle grade (registrar) tier fully staffed.
WH & **SRH** fully staffed cons from Sept. SRH middle grade (registrar) tier - two recently appointed ROC (resident on call consultants). From October the middle grade tier will be fully staffed but both WH and SRH will have 3 very junior registrars (ST3) each who will require close supervision and additional on-site support out of hours.
Neonatology: Difficulties in ANNP staffing at PRH continue (sickness and maternity). A BC is in progress to offer 2 resident staff at PRH 24/7 - ANNP and medical mixture. This would help with BAPM staffing requirements . Consultant interview in Nov to replace retiring colleague

Perinatal workforce – Neonatal Nursing

University Hospitals Sussex NHS Foundation Trust





In August the clinical registered nursing vacancies across a 4 sites (B7-B4) remains at 14.3%. This is due to some whilst TMBU, PRH & SRH SCBUs vacancy are all around 8%, Beeding has a vacancy of around 16% - as a smaller team, small changes can make a big difference to the percentage. Recruitment to these vacancies has been impacted by Trust wide recruitment controls, which perinatal services continue to seek an exemption for.
TMBU Quality in Speciality (QIS) staffing;
43.9WTE = 49% (with a 70% target).
A further planned increase to 55.2 WTE (63%) is projected for June 2027.

Actual verses Planned
Overall, in August there was no large variation/difficulties within registered staffing.

Nursing Vacancy

Aug	WTE
TMBU	7.8
PRH	0.89
SRH	2.21
Beeding	3.09

Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

Safety Improvement Plan via MNIST / CNST / MNIP*

*every two months

Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

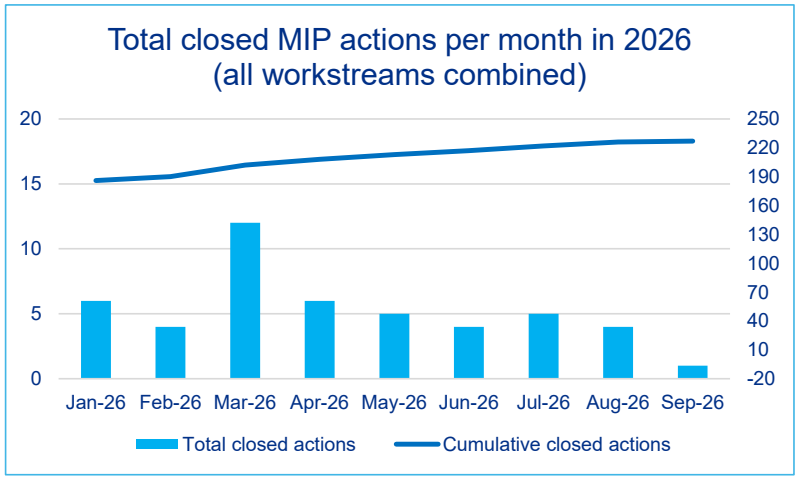
MatNeo Improvement Plan (MNIP)

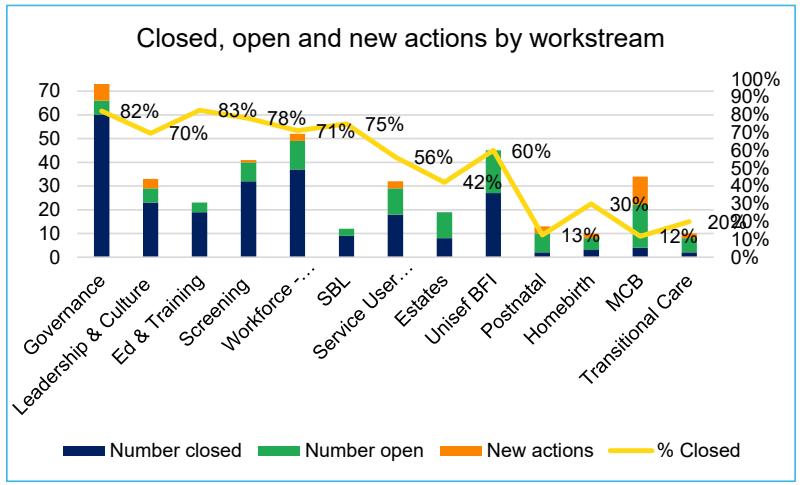
Updates provided from MatNeo Improvement Group (MNIG)

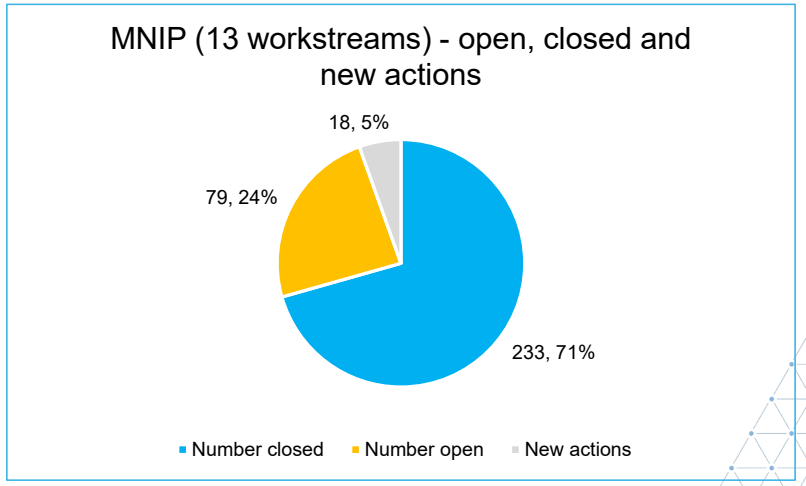
- October programme overview and six workstreams' exception report
- August Leadership and Culture MNIG update, for Board oversight

Progress overview across MNIP (October MNIG)

NHS
University Hospitals Sussex
NHS Foundation Trust





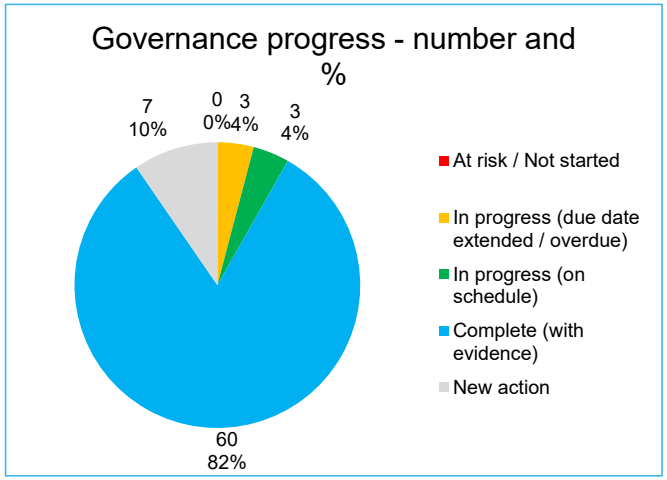


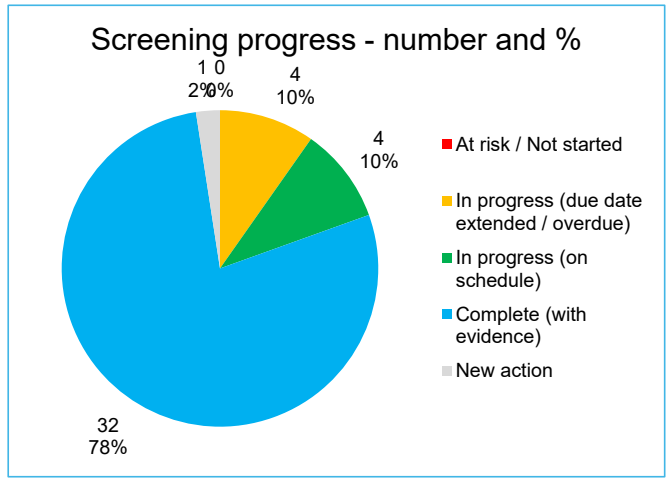
Excellent Care Everywhere

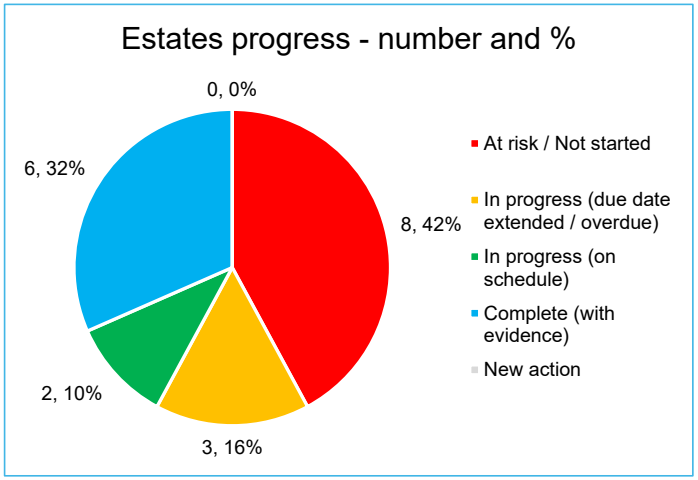
We are compassionate. We are inclusive. We are respectful.

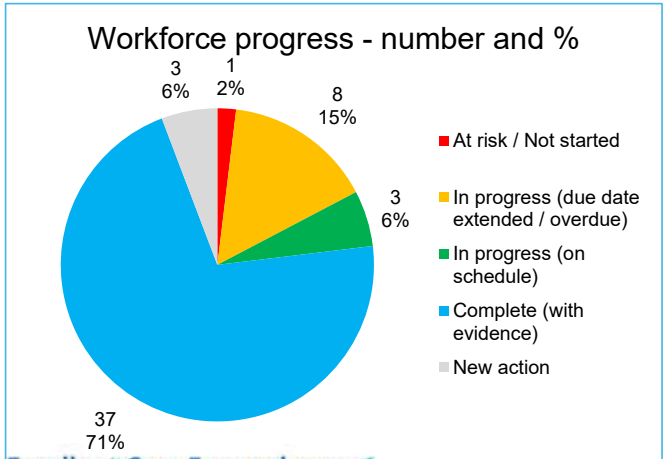
Workstream RAG overview (October MNIG)

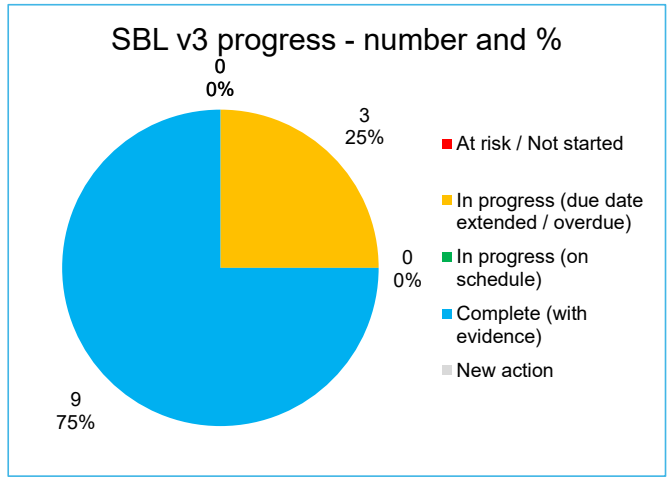
University Hospitals Sussex NHS Foundation Trust

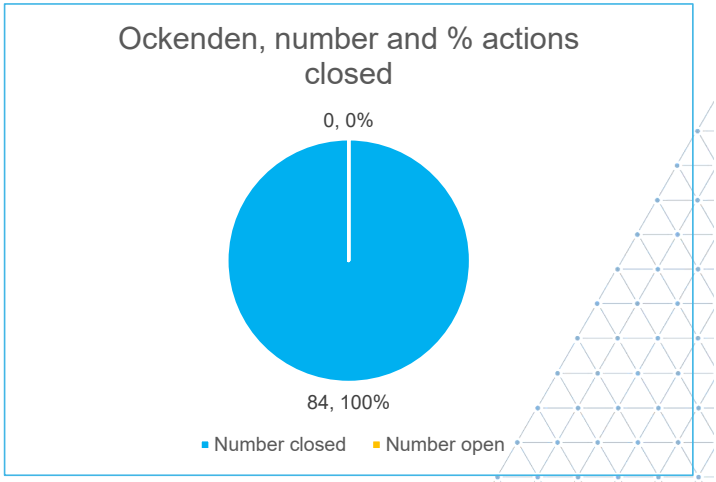












Excellent Care Everywhere

PQOM Monthly Update Aug 2026 data

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

Mat Neo Improvement Plan – Summary of six reporting workstreams October 2026

Summary

- *Programme continues to incorporate new recommendations and internal improvement actions, with BAU workstreams meeting less frequently*
- *Challenging to obtain consistent input from estates*
- *Programme Manager on maternity leave from 30/11. Some slippage may occur while cover is recruited into post.*

Celebrations

- *BR+ funding now approved and in budgets*
- *Improvement work on avoidable repeat newborn blood spot has seen the lowest rate for RSCH/PRH in recent years. Further work ongoing.*
- *As at end of 14/10 Clinical guidance 71% in date compared to lowest point in 09/25 at 37%.*
- *Preterm birth and Fetal Monitoring Lead Consultants all in post*

Escalations

- *Recruitment freeze impacts – awaiting confirmation of exemption for perinatal teams. If exemption not granted, resolution for lateral moves/increase in hours required (no increase to headcount, some mitigation of risk).*
- *A significant reduction in fetal medicine capacity during summer months, resulting from a combination of annual leave and sickness absence, led to the cancellation of approximately 50 fetal medicine appointments.*
- *Engagement improvements are needed from maternity and obstetric leads to implement actions from themes identified by the governance teams.*
- *Smoke Free team midwife post vacant and capacity to deliver SBL requirements challenged.*

Decisions required from group:

- *Permission to close Ockenden (2022) and Three Year Delivery Plan reporting with 10 Point Plan and incoming National Action Plan the national focus from June 2026.*
  - *Assurance:*
    - *Ockenden 2022 100%*
    - *Three Year Delivery Plan incorporated into MNIP workstreams*

Mat Neo Improvement Plan – Leadership and culture *(update as required by CNST, from August MNIG)*
PMA Lead (linking with PNAs)
August 2026

Summary

- *All historic actions developed with the MSSP have been closed*
- *Site leads, PMA and others are gathering themes via multiple sources (staff survey, GMC / LFG surveys, on site engagement, recent reports etc) to identify where progress has been made and areas of challenge. These are also triangulated against 2024 SCORE survey themes .*

Celebrations

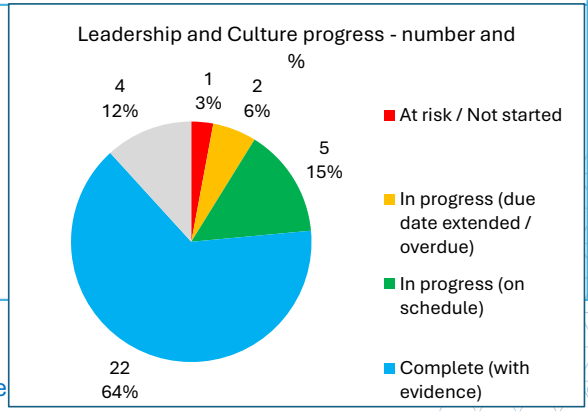
- *Increased staff wellbeing offer for all staff groups approved as part of Ockenden package of support.*
- *ImproveWell funding approved*

Escalations

- *Ongoing media attention, upcoming Ockenden review and recent reports continue to impact morale*
- *Recent external reports highlight that some staff are still not feeling listened to – a review of engagement activities is underway, including ways to free up site leadership for better accessibility and visibility to teams*

Areas of focus in the next quarter

- *Develop actions to improve site leadership availability and in-person engagement*
- *BR+ recruitment*
- *Further restorative culture training and sessions*



Excellent Care Everywhere

We ctful.

Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

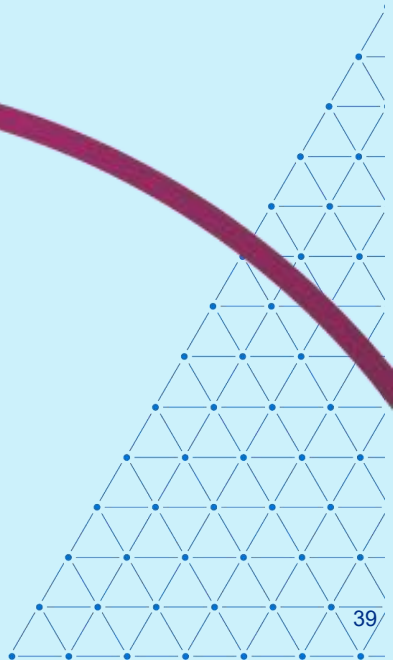
Maternity Incentive Scheme (CNST)

(See separate paper)

Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

MatNeo Improvement Support Team (MNIST)



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. Considering expansion based on demand and capacity modelling.
PRH	ELCS provision in place only on labour ward; awaiting approval from Business Case Scrutiny Panel.	16 hours of operating time required.	PRH approved, logistics to be confirmed.
WH	ELCS provision in place only on labour ward	16 hours of operating time required.	WH business case to be developed based on PRH
SRH	One all-day operating list.	Requirement for an additional all-day list.	Pursuing an additional 8 hours of operating capacity.

Newly added MNIST actions as requested by NHSE South East

University Hospitals Sussex NHS Foundation Trust

Theme	Action	Owner	Deadline	Update
Obstetric staffing, triage and recruitment	1. Participate in benchmarking of maternity triage across all four sites against national guidance. 2. Undertake Trust-wide benchmarking of resident and consultant obstetric staffing and availability, accounting for gynecology commitments, sickness absence, maternity leave, other leave and less-than-full-time working. 3. Review the balance of obstetric staffing and support for triage across the four sites. 4. Continue work to strengthen resident doctor recruitment, including promotion of relevant training opportunities.	Perinatal CD	Still being established	1. Benchmarking with MNIST MIA underway 2. Perinatal CD reviewing PAs and staffing equity across 4 sites 3. Obstetric staffing in triage part of the above benchmarking process 4. Update on resident doctors
Clinical guidelines	Accelerate the review and updating of outstanding clinical guidelines, using shared regional guidance and appropriate artificial intelligence support where agreed.	Perinatal Quad	Nov 2026	On track to update all guidelines with extraordinary measures in place to do so
Estates, neonatal capacity and pathways	1. Maintain oversight of the impact of the Sussex House estate on inpatient access to fetal medicine. 2. Review neonatal capacity, the development of Transitional Care and the impact on access and overcrowding. 3. Urgently review the Princess Royal Hospital neonatal medical staffing model or the configuration of the service	Director of Estates, Women and Children's Division	Still being established	• Execs have commissioned work for reconfiguration, with option to be decided by April 2027 which will incorporate all actions • Interim BAPM Transitional Care implemented with business case being developed for fully compliant BAPM staffing

Newly added MNIST actions as requested by NHSE South East

University Hospitals Sussex NHS Foundation Trust

Theme	Action	Owner	Deadline	Update
Home birth service	1. Undertake a structured, independently facilitated mediation process between the home birth team and maternity leadership as an immediate priority. 2. Ensure the current consultation process demonstrably enables staff concerns, feedback and alternative proposals to be heard, considered and responded to, with evidence of how feedback has informed decision-making. 3. Submit the home birth competency document to education and clinical governance for review and integration into relevant guidance. 4. Collect and present clear evidence on missed breaks, overtime, service suspensions and the impact of current working arrangements on staff wellbeing, safety and access to home birth services. 5. Nominate home birth team representatives to participate in the mediated discussions and utilise a structured approach to identifying issues, impacts and required actions. 6. Review home birth staffing requirements, including the proposal to increase the establishment from 10 to 11 whole-time equivalents across Princess Royal Hospital and Royal Sussex County Hospital	Community matron		1. Mediation process has taken place 2. Consultation underway 3. Competency framework being implemented, including enhanced emergency training 4. An update on missed breaks/staff experience is awaited and will be included in the next update 5. Mediation process has taken place 6. Homebirth staffing review undertaken and increase included in BR+, but awaits outcome of consultation

Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

In Summary

Conclusion

NHS
University Hospitals Sussex
NHS Foundation Trust

Maternity and neonatal services continue to demonstrate strong clinical outcomes, with key harm indicators performing favorably against national benchmarks and no new PSII or MNSI referrals reported during August.

The principal risks requiring Board attention remain workforce sustainability, service capacity and infrastructure constraints, alongside delivery of actions arising from national scrutiny, MNIST support and local improvement programmes.

Improvement work remains extensive and active with continued progress against CNST, MNIP, Thirlwall, and safety improvement priorities across maternity and neonatal services.

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, Nicky Greenfield, Community Midwifery, Rosie Jennings, Recruitment and Retention Lead Midwife, and Raili Frost, Divisional Improvement Programme Manager

In Summary

University Hospitals Sussex
NHS Foundation Trust

Key Board Message:

Maternity and neonatal continue to demonstrate positive clinical outcomes and progress against pre-existing key safety improvement programmes with on-going assurance across quality and governance metrics; however, workforce sustainability, service capacity, new regulatory oversight recommendations, and infrastructure challenges remain the principal risks requiring continued executive oversight.

Recommendations:

- **Note** the continued positive position against key safety and outcome indicators.
- **Receive assurance** regarding progress of CNST, MNIP and maternity safety improvement programmes.
- **Support continued executive oversight** of workforce, neonatal capacity, homebirth resilience, new regulatory expectations and estate-related risks.
- **Endorse ongoing monitoring** of patient experience, health inequalities and safety-system improvements through established governance arrangements.

Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

Appendix 1
Morbidity and Mortality Outcome Data
May 2026 – ICB Contribution

HIE rates in the Appendix include HIE1

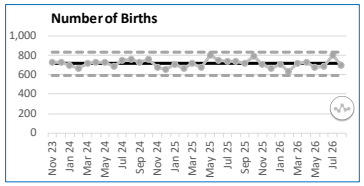
UHSx

Maternity overview

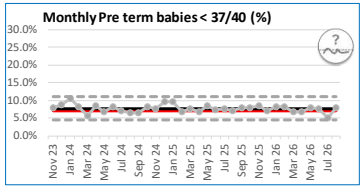
UHSX NHS Foundation Trust (monthly SB & NND rates)

University Hospitals Sussex
NHS Foundation Trust

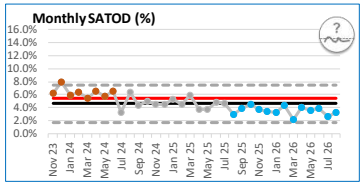
Latest month 01/08/26
Number of Births 694
No significant change



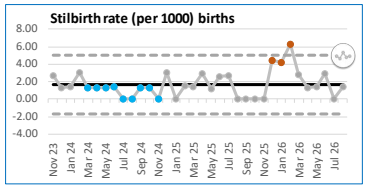
Latest month 01/08/26
Monthly Pre term babies < 37/40 (%) 7.8%
No significant change



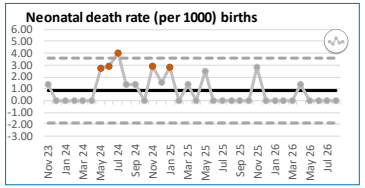
Latest month 01/08/26
Monthly SATOD (%) 3.2%
Significant Improvement



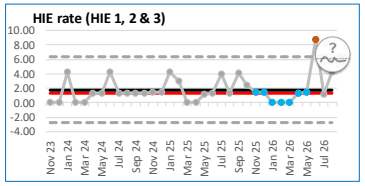
Latest month 01/08/26
Stilbirth rate (per 1000) births 1.45
No significant change



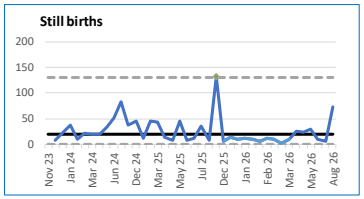
Latest month 01/08/26
Neonatal death rate (per 1000) births 0.00
No significant change



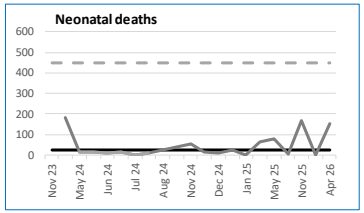
Latest month 01/08/26
HIE rate (HIE 1, 2 & 3) 4.32
No significant change



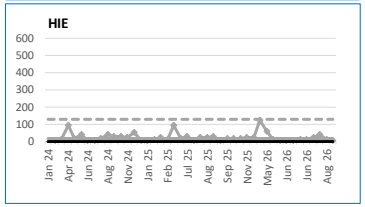
Date of last stillbirth 18/08/26
Average days between stillbirths 25.7
No significant change



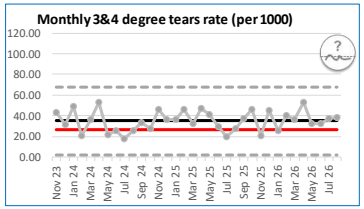
Date of last neonatal death 17/04/26
Average days between deaths 44.8
No significant change



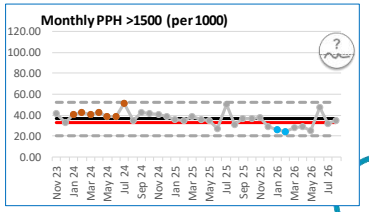
Date of last HIE 30/08/26
Average days between HIE 22.4
No significant change



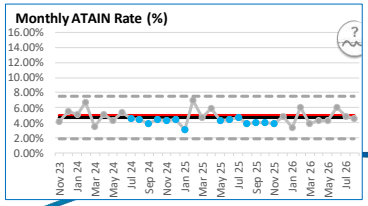
Latest month 01/08/26
Monthly 3&4 degree tears rate (per 1000) 38.1
No significant change



Latest month 01/08/26
Monthly PPH >1500 (per 1000) 35.19
No significant change



Latest month 01/08/26
Monthly ATAIN Rate (%) 4.5%
No significant change

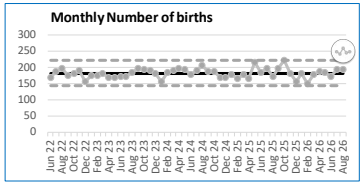


Haywards Heath

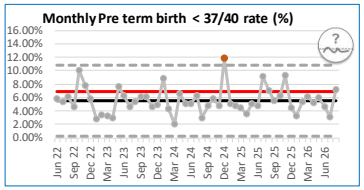
NHS
University Hospitals Sussex
NHS Foundation Trust

Maternity overview PRH

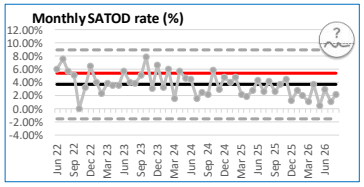
Latest month 01/08/26
Number of births 193
No significant change



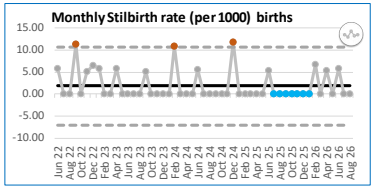
Latest month 01/08/26
Pre term babies < 37 weeks 7.25%
No significant change



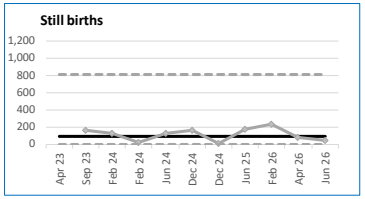
Latest month 01/08/26
Monthly SATOD rate (%) 2.1%
No significant change



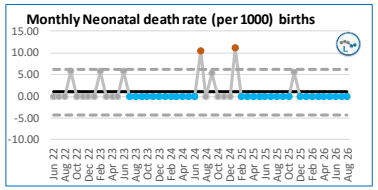
Latest month 01/08/26
Still birth rate/1000 0.00
No significant change



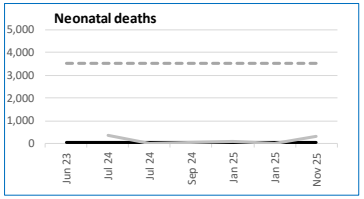
Date of last stillbirth 07/06/26
Average days between stillbirths 114.3
No significant change



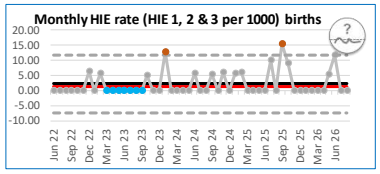
Latest month 01/08/26
Neonatal Death rate/1000 0.00
Significant Improvement



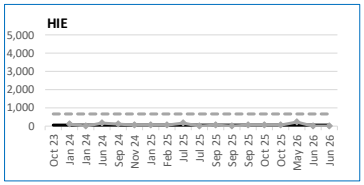
Date of last neonatal death 13/11/25
Average days between deaths 148.4
No significant change



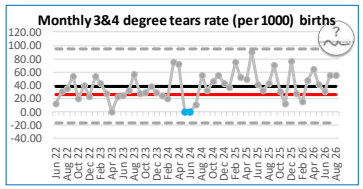
Latest month 01/08/26
HIE rate/1000 0.00
No significant change



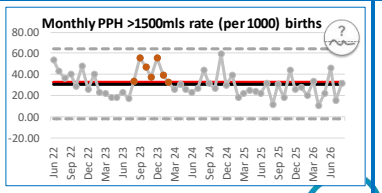
Date of last HIE 07/06/26
Average days between HIE 57.2
No significant change



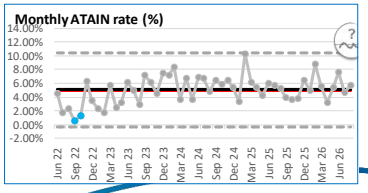
Latest month 01/08/26
3&4 degree tears (per 1000) 55.0
No significant change



Latest month 01/08/26
PPH >1500 (per 1000) 31.8
No significant change



Latest month 01/08/26
ATAIN 5.70%
No significant change

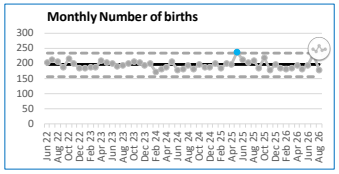


Brighton

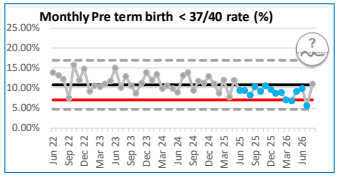
University Hospitals Sussex
NHS Foundation Trust

Maternity overview RSCH

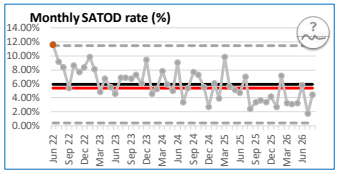
Latest month 01/08/26
Number of births 178
No significant change



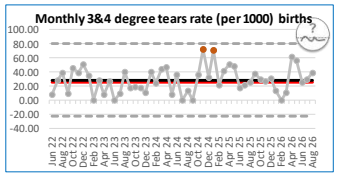
Latest month 01/08/26
Pre term babies < 37 weeks 11.11%
No significant change



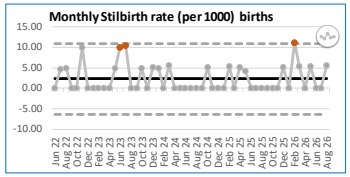
Latest month 01/08/26
Monthly SATOD rate (%) 4.5%
No significant change



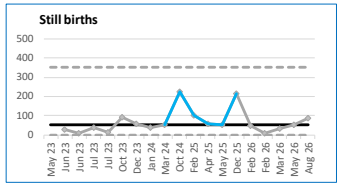
Latest month 01/08/26
3&4 degree tears (per 1000) 39.0
No significant change



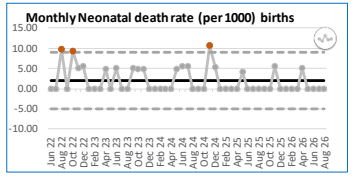
Latest month 01/08/26
Still birth rate/1000 5.62
No significant change



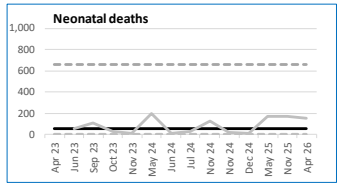
Date of last stillbirth 18/08/26
Average days between stillbirths 66.8
No significant change



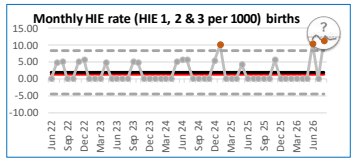
Latest month 01/08/26
Neonatal Death rate/1000 0.00
No significant change



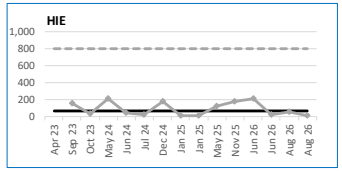
Date of last neonatal death 17/04/26
Average days between deaths 84.7
No significant change



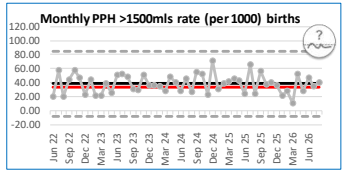
Latest month 01/08/26
HIE rate/1000 11.30
Significant deterioration



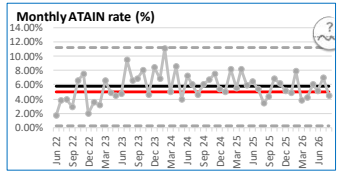
Date of last HIE 30/08/26
Average days between HIE 88.6
No significant change



Latest month 01/08/26
PPH >1500 (per 1000) 39.6
No significant change



Latest month 01/08/26
ATAIN 4.49%
No significant change

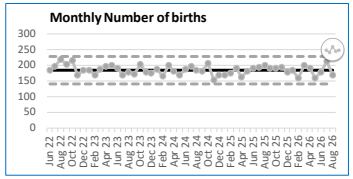


Chichester

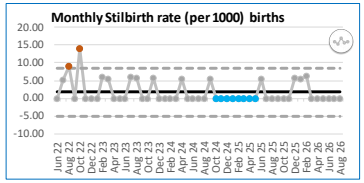
NHS
University Hospitals Sussex
NHS Foundation Trust

Maternity overview SRH

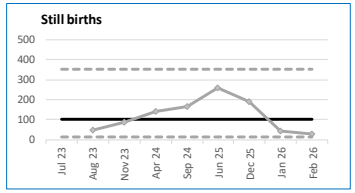
Latest month 01/08/26
Number of births 167
No significant change



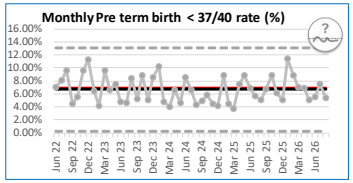
Latest month 01/08/26
Still birth rate/1000 0.00
No significant change



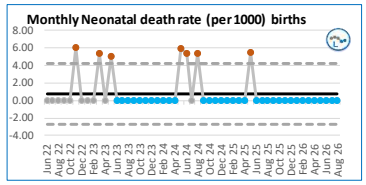
Date of last stillbirth 25/02/26
Average days between stillbirths 120.5
No significant change



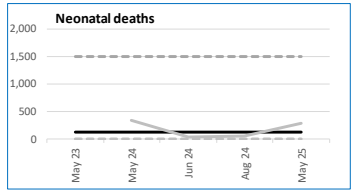
Latest month 01/08/26
Pre term babies < 37 weeks 5.39%
No significant change



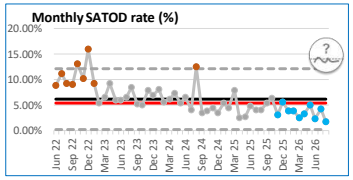
Latest month 01/08/26
Neonatal Death rate/1000 0.00
Significant Improvement



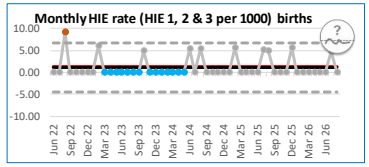
Date of last neonatal death 26/05/25
Average days between deaths 181.8
No significant change



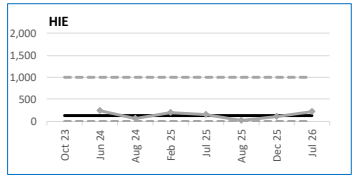
Latest month 01/08/26
Monthly SATOD rate (%) 1.8%
Significant Improvement



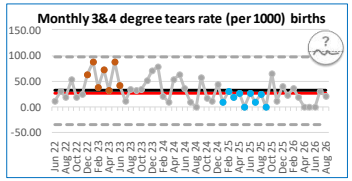
Latest month 01/08/26
HIE rate/1000 0.00
No significant change



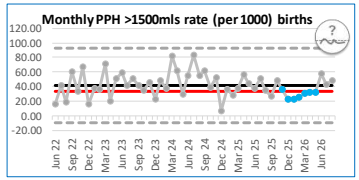
Date of last HIE 11/07/26
Average days between HIE 140.7
No significant change



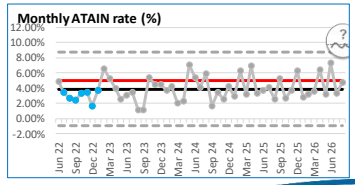
Latest month 01/08/26
3&4 degree tears (per 1000) 21.7
No significant change



Latest month 01/08/26
PPH >1500 (per 1000) 48.5
No significant change



Latest month 01/08/26
ATAIN 4.79%
No significant change

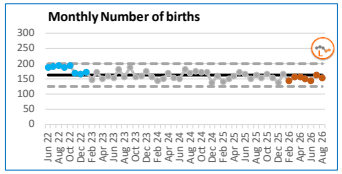


Worthing

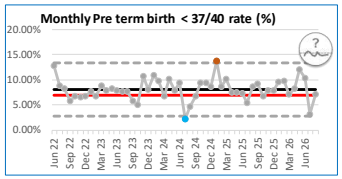
University Hospitals Sussex
NHS Foundation Trust

Maternity overview WH

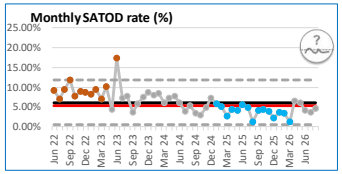
Latest month 01/08/26
Number of births 153
Significant deterioration



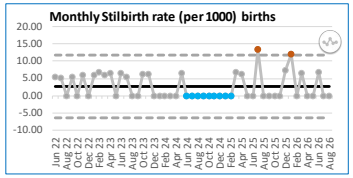
Latest month 01/08/26
Pre term babies < 37 weeks 7.14%
No significant change



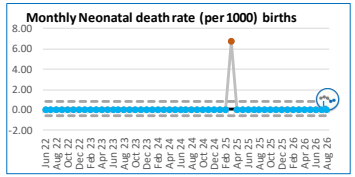
Latest month 01/08/26
Monthly SATOD rate (%) 4.6%
No significant change



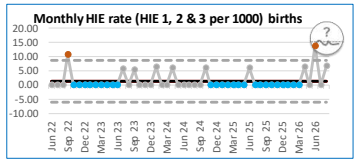
Latest month 01/08/26
Still birth rate/1000 0.00
No significant change



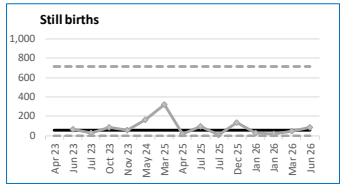
Latest month 01/08/26
Neonatal Death rate/1000 0.00
Significant Improvement



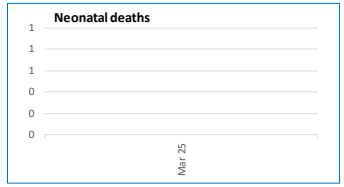
Latest month 01/08/26
HIE rate/1000 6.58
No significant change



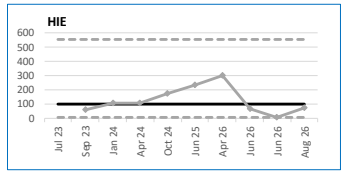
Date of last stillbirth 01/06/26
Average days between stillbirths 82.5
No significant change



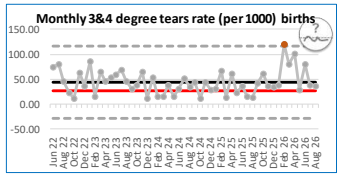
Date of last neonatal death 08/03/25
Average days between deaths
No significant change



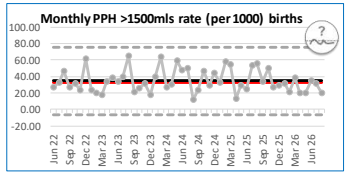
Date of last HIE 28/08/26
Average days between HIE 125.0
No significant change



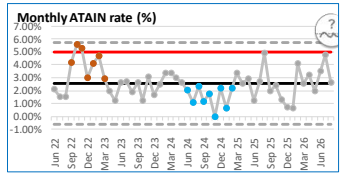
Latest month 01/08/26
3&4 degree tears (per 1000) 37.0
No significant change



Latest month 01/08/26
PPH >1500 (per 1000) 19.9
No significant change



Latest month 01/08/26
ATAIN 2.61%
No significant change



Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

Appendix 2
Health Inequalities Segmented Data
Aug 2026 – ICB Contribution

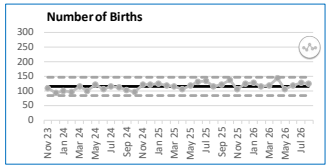
HIE rates in the Appendix include HIE1

UHSx– Global Majority

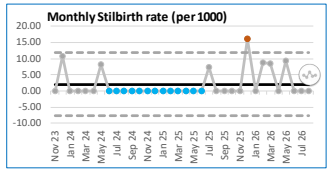
University Hospitals Sussex
NHS Foundation Trust

Maternity overview | **UHSX BME**

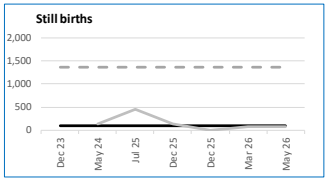
Latest month 01/08/26
Number of Births 125
No significant change



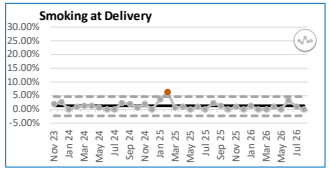
Latest month 01/08/26
Monthly Stillbirth rate (per 1000) 0.00
No significant change



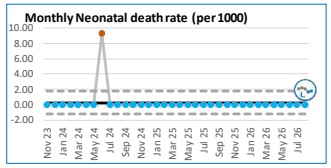
Date of last stillbirth 22/05/26
Average days between stillbirths 147.3
No significant change



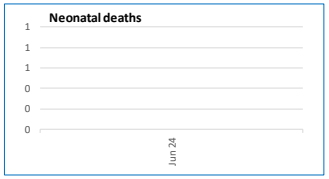
Latest month 01/08/26
Smoking at Delivery 0.0%
No significant change



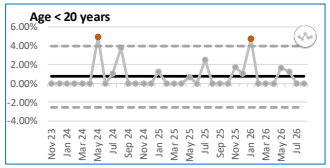
Latest month 01/08/26
Monthly Neonatal death rate (per 0.00
Significant Improvement



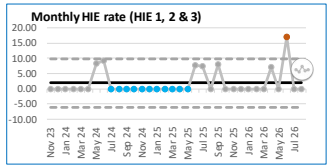
Date of last neonatal death 07/06/24
Average days between deaths
No significant change



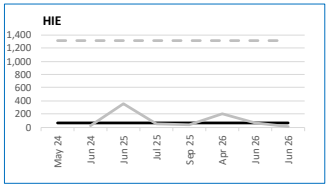
Latest month 01/08/26
Age < 20 years 0.0%
No significant change



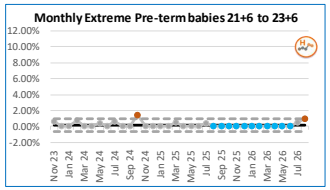
Latest month 01/08/26
Monthly HIE rate (HIE 1, 2 & 3) 0.00
No significant change



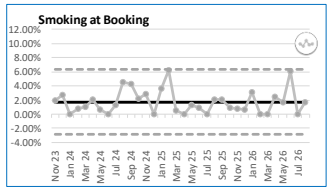
Date of last HIE 21/06/26
Average days between HIE 110.3
No significant change



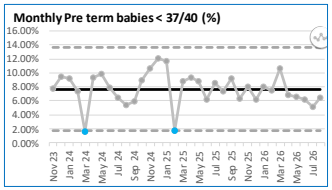
Latest month 01/08/26
Monthly Extreme Pre-term babies 21+6 to 23+6 1.0%
Significant deterioration



Latest month 01/08/26
Smoking at Booking 1.7%
No significant change



Latest month 01/08/26
Monthly Pre term babies < 37/40 (%) 6.5%
No significant change

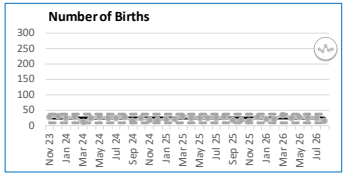


UHSx– 10% most deprived

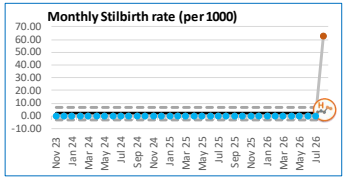
University Hospitals Sussex
NHS Foundation Trust

Maternity overview | **UHSX 10% Most Deprived**

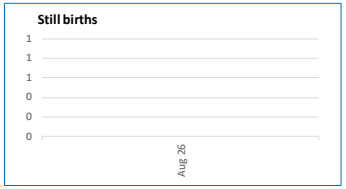
Latest month 01/08/26
Number of Births 16
No significant change



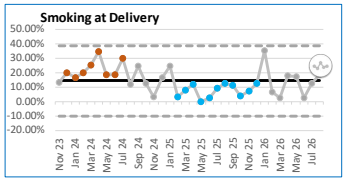
Latest month 01/08/26
Monthly Stilbirth rate (per 1000) 62.50
Significant deterioration



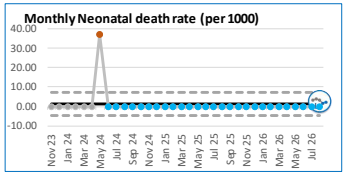
Date of last stillbirth 18/08/26
Average days between stillbirths
No significant change



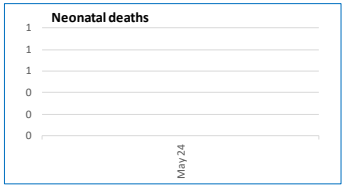
Latest month 01/08/26
Smoking at Delivery 18.8%
No significant change



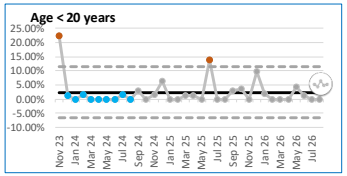
Latest month 01/08/26
Monthly Neonatal death rate (per 0.00
Significant Improvement



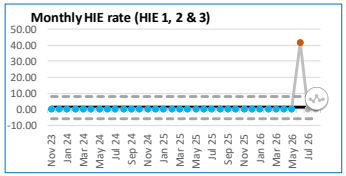
Date of last neonatal death 06/05/24
Average days between deaths
No significant change



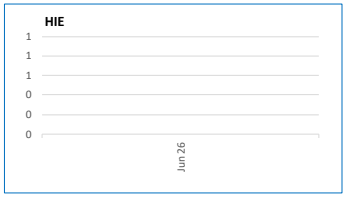
Latest month 01/08/26
Age < 20 years 0.0%
No significant change



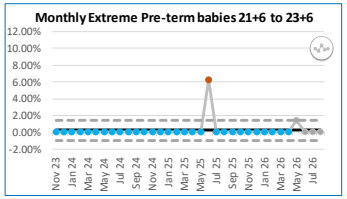
Latest month 01/08/26
Monthly HIE rate (HIE 1, 2 & 3) 0.00
No significant change



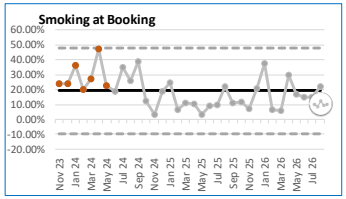
Date of last HIE 14/06/26
Average days between HIE
No significant change



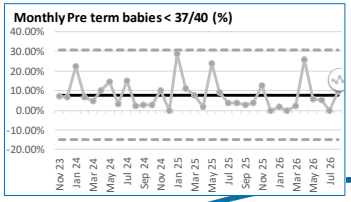
Latest month 01/08/26
Monthly Extreme Pre-term babies 21+6 to 23+6 0.0%
No significant change



Latest month 01/08/26
Smoking at Booking 21.9%
No significant change



Latest month 01/08/26
Monthly Pre term babies < 37/40 (%) 9.4%
No significant change

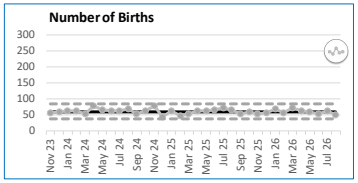


UHSx – 20% most deprived

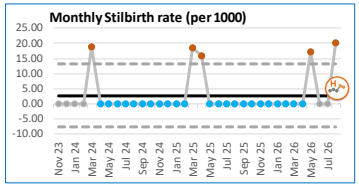
University Hospitals Sussex
NHS Foundation Trust

Maternity overview | **UHSX 20% Most Deprived**

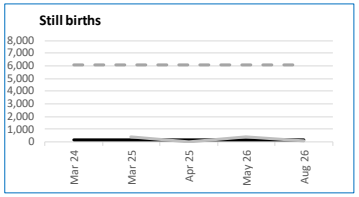
Latest month 01/08/26
Number of Births 50
No significant change



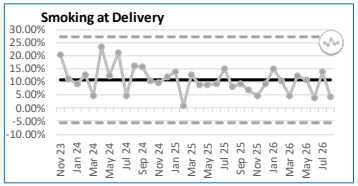
Latest month 01/08/26
Monthly Stillbirth rate (per 1000) 20.00
Significant deterioration



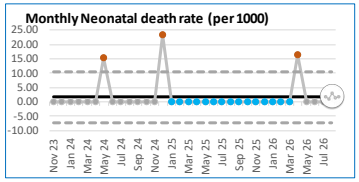
Date of last stillbirth 18/08/26
Average days between stillbirths 220.5
No significant change



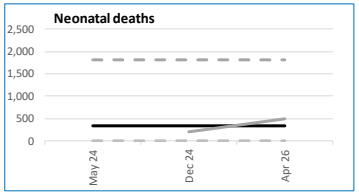
Latest month 01/08/26
Smoking at Delivery 4.4%
No significant change



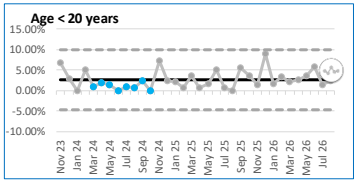
Latest month 01/08/26
Monthly Neonatal death rate (per 0.00
No significant change



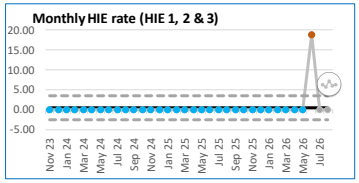
Date of last neonatal death 17/04/26
Average days between deaths 355.5
No significant change



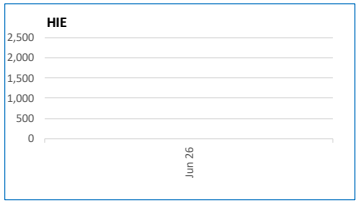
Latest month 01/08/26
Age < 20 years 2.5%
No significant change



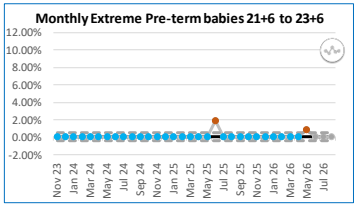
Latest month 01/08/26
Monthly HIE rate (HIE 1, 2 & 3) 0.00
No significant change



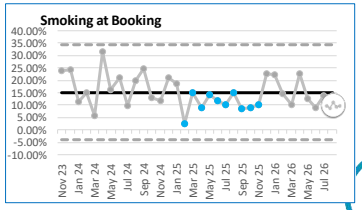
Date of last HIE 14/06/26
Average days between HIE
No significant change



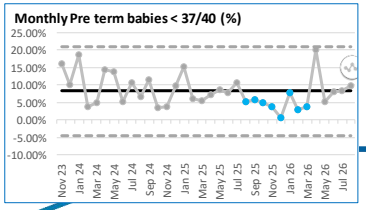
Latest month 01/08/26
Monthly Extreme Pre-term babies 21+6 to 23+6 0.0%
No significant change



Latest month 01/08/26
Smoking at Booking 13.8%
No significant change



Latest month 01/08/26
Monthly Pre term babies < 37/40 (%) 9.9%
No significant change

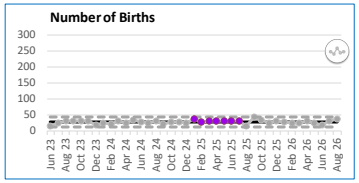


Haywards Heath – Global Majority

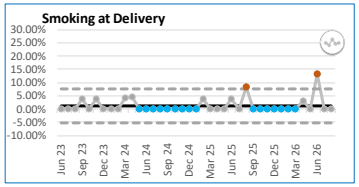
University Hospitals Sussex NHS Foundation Trust

Maternity overview PRH BME

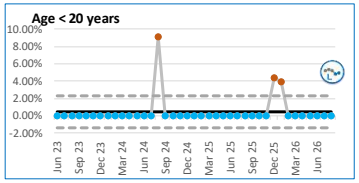
Latest month 01/08/26
Number of Births 37
No significant change



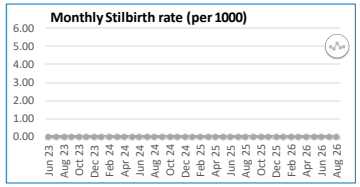
Latest month 01/08/26
Smoking at Delivery 0.0%
No significant change



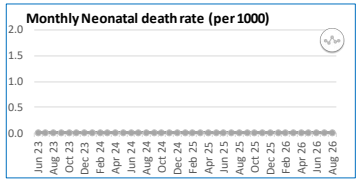
Latest month 01/08/26
Age < 20 years 0.0%
Significant Improvement



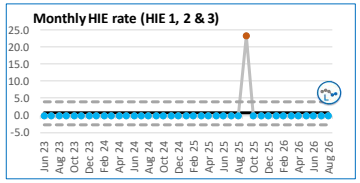
Latest month 01/08/26
Monthly Stilbirth rate (per 1000) 0.00
No significant change



Latest month 01/08/26
Monthly Neonatal death rate (per 0.00
No significant change



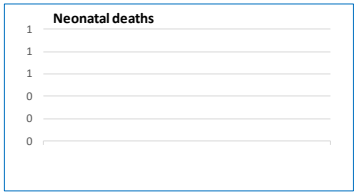
Latest month 01/08/26
Monthly HIE rate (HIE 1, 2 & 3) 0.00
Significant Improvement



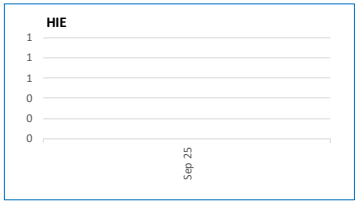
Date of last stillbirth
Average days between stillbirths
No significant change



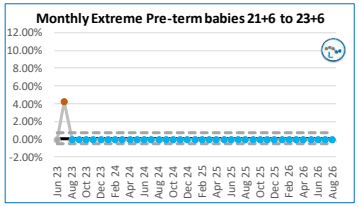
Date of last neonatal death
Average days between deaths
No significant change



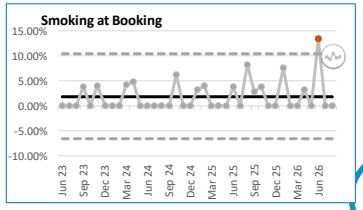
Date of last HIE 09/09/25
Average days between HIE
No significant change



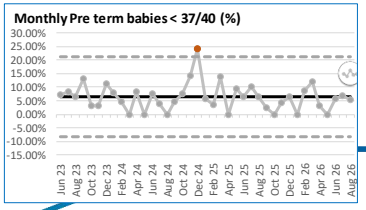
Latest month 01/08/26
Monthly Extreme Pre-term babies 21+6 to 23+6 0.0%
Significant Improvement



Latest month 01/08/26
Smoking at Booking 0.0%
No significant change



Latest month 01/08/26
Monthly Pre term babies < 37/40 (%) 5.4%
No significant change

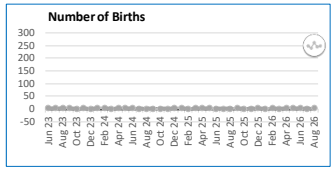


Haywards Heath – 10% most deprived

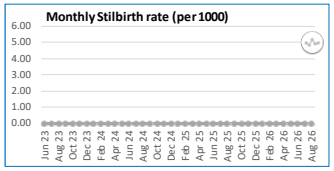
University Hospitals Sussex
NHS Foundation Trust

Maternity overview | **PRH 10% most deprived**

Latest month 01/08/26
Number of Births 2
No significant change



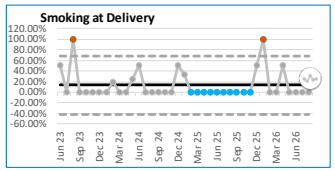
Latest month 01/08/26
Monthly Stilbirth rate (per 1000) 0.00
No significant change



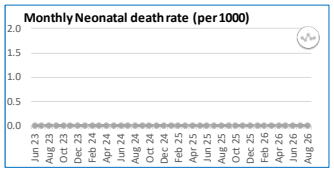
Date of last stillbirth
Average days
No significant change



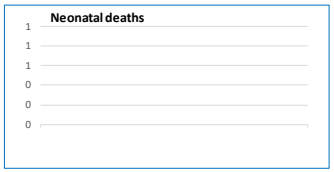
Latest month 01/08/26
Smoking at Delivery 0.0%
No significant change



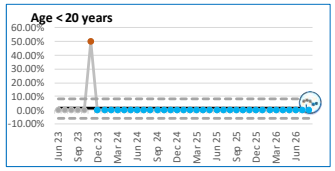
Latest month 01/08/26
Monthly Neonatal 0.00
No significant change



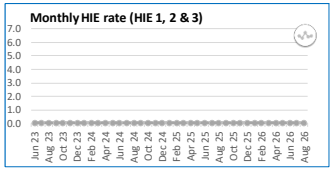
Date of last
Average days
No significant change



Latest month 01/08/26
Age < 20 years 0.0%
Significant Improvement



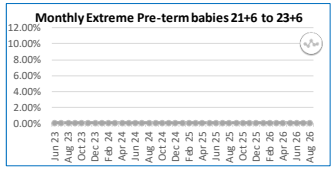
Latest month 01/08/26
Monthly HIE rate (HIE 1, 2 & 3) 0.00
No significant change



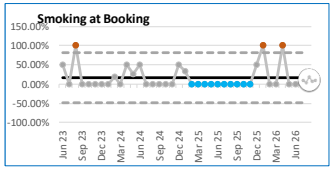
Date of last HIE
Average days
No significant change



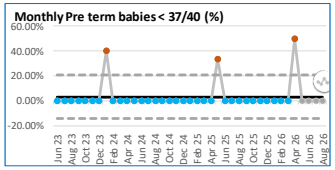
Latest month 01/08/26
Monthly Extreme Pre-term babies 0.0
No significant change



Latest month 01/08/26
Smoking at Booking 0.0%
No significant change



Latest month 01/08/26
Monthly Pre term babies < 37/40 (%) 0.0%
No significant change

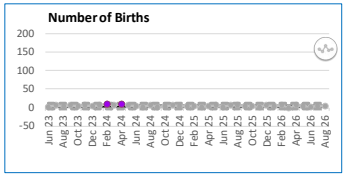


Haywards Heath – 20% most deprived

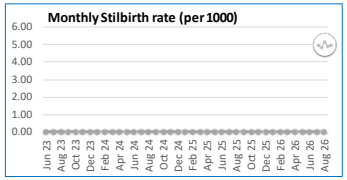
NHS
University Hospitals Sussex
NHS Foundation Trust

Maternity overview | **PRH 20% most deprived**

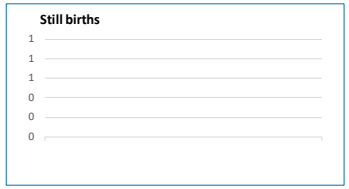
Latest month 01/08/26
Number of Births 3
No significant change



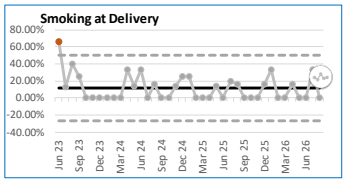
Latest month 01/08/26
Monthly Stillbirth rate (per 1000) 0.00
No significant change



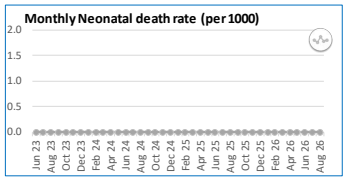
Date of last stillbirth
Average days between stillbirths
No significant change



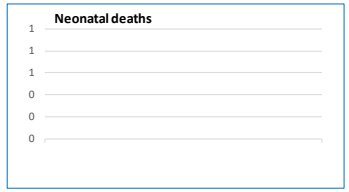
Latest month 01/08/26
Smoking at Delivery 0.0%
No significant change



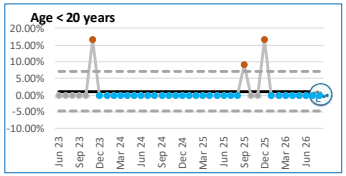
Latest month 01/08/26
Monthly Neonatal death rate (per 0.00
No significant change



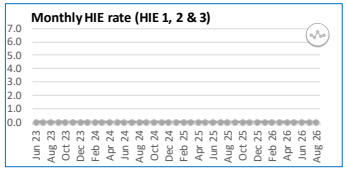
Date of last neonatal death
Average days between deaths
No significant change



Latest month 01/08/26
Age < 20 years 0.0%
Significant Improvement



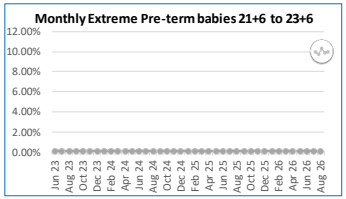
Latest month 01/08/26
Monthly HIE rate (HIE 1, 2 & 3) 0.00
No significant change



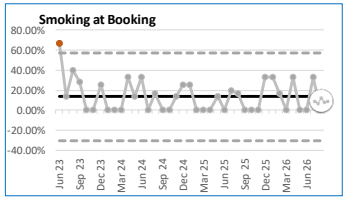
Date of last HIE
Average days between HIE
No significant change



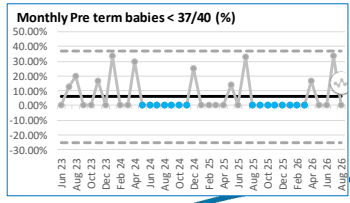
Latest month 01/08/26
Monthly Extreme Pre-term babies 21+6 to 23+6 0.0
No significant change



Latest month 01/08/26
Smoking at Booking 0.0%
No significant change



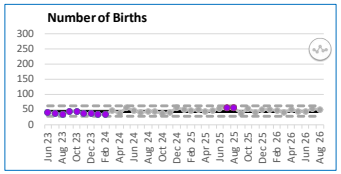
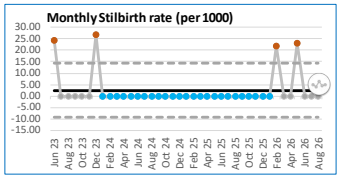
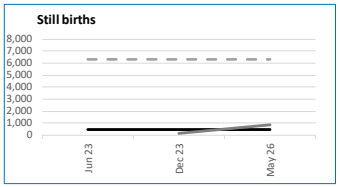
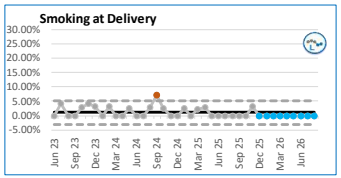
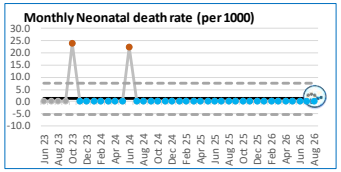
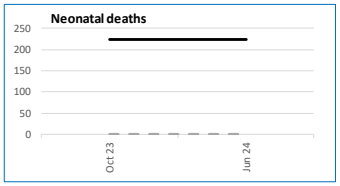
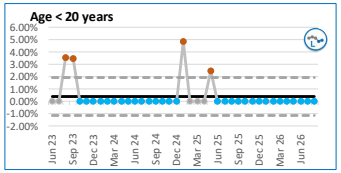
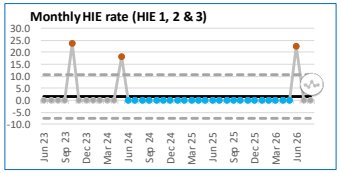
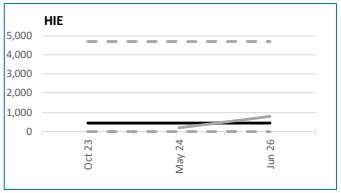
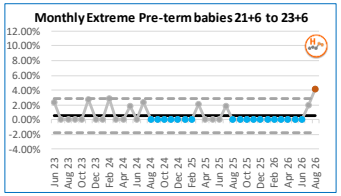
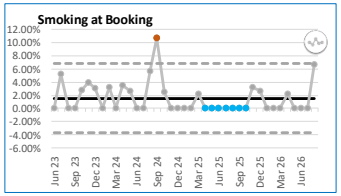
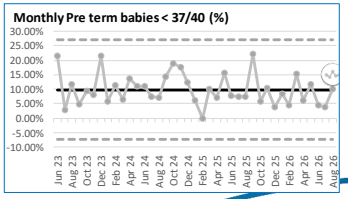
Latest month 01/08/26
Monthly Pre term babies < 37/40 (%) 0.0%
No significant change



Brighton – Global Majority

University Hospitals Sussex
NHS Foundation Trust

Maternity overview RSCH BME

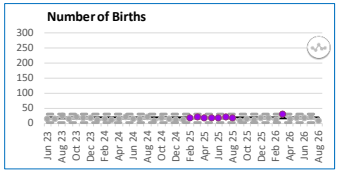
Latest month 01/08/26 Number of Births 49 No significant change		Latest month 01/08/26 Monthly Stilbirth rate (per 1000) 0.00 No significant change		Date of last stillbirth 22/05/26 Average days between stillbirths 543.0 No significant change	
Latest month 01/08/26 Smoking at Delivery 0.0% Significant Improvement		Latest month 01/08/26 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 01/08/26 Age < 20 years 0.0% Significant Improvement		Latest month 01/08/26 Monthly HIE rate (HIE 1, 2 & 3) 0.00 No significant change		Date of last HIE 21/06/26 Average days between HIE 492.0 No significant change	
Latest month 01/08/26 Monthly Extreme Pre-term babies 21+6 to 23+6 4.1% Significant deterioration		Latest month 01/08/26 Smoking at Booking 6.7% No significant change		Latest month 01/08/26 Monthly Pre term babies < 37/40 (%) 10.2% No significant change	

Brighton – 10% most deprived

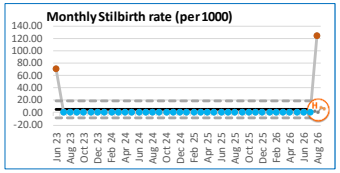
NHS
University Hospitals Sussex
NHS Foundation Trust

Maternity overview | **RSCH 10% most deprived**

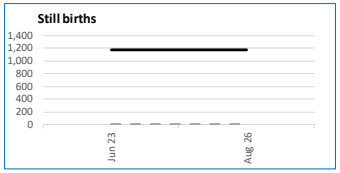
Latest month 01/08/26
Number of Births 8
No significant change



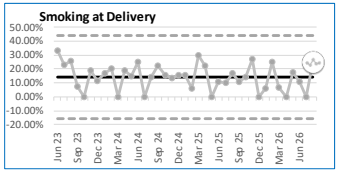
Latest month 01/08/26
Monthly Stilbirth rate (per 1000) 125.00
Significant deterioration



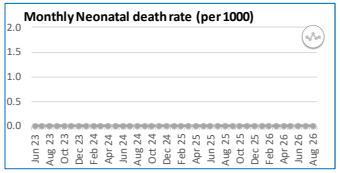
Date of last stillbirth 18/08/26
Average days 1174.0
No significant change



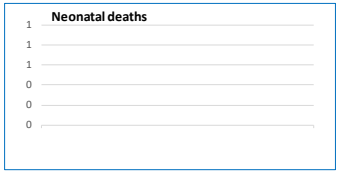
Latest month 01/08/26
Smoking at Delivery 25.0%
No significant change



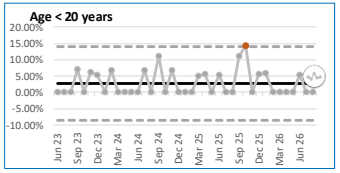
Latest month 01/08/26
Monthly Neonatal 0.00
No significant change



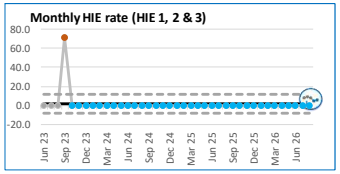
Date of last [illegible]
Average days
No significant change



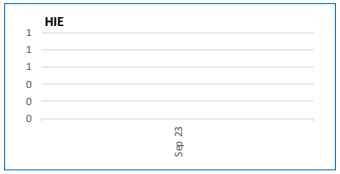
Latest month 01/08/26
Age < 20 years 0.0%
No significant change



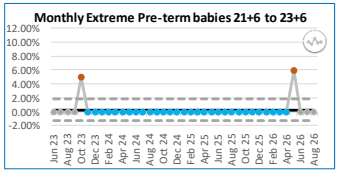
Latest month 01/08/26
Monthly HIE rate (HIE 1, 2 & 3) 0.00
No significant change



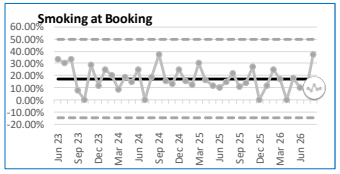
Date of last HIE 05/09/23
Average days
No significant change



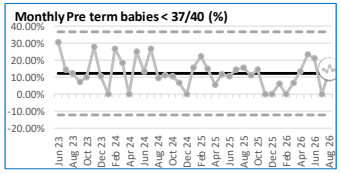
Latest month 01/08/26
Monthly Extreme Pre-term babies 0.0
No significant change



Latest month 01/08/26
Smoking at Booking 37.5%
No significant change



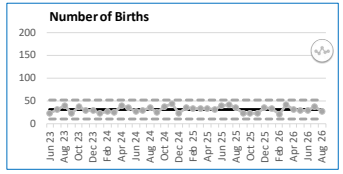
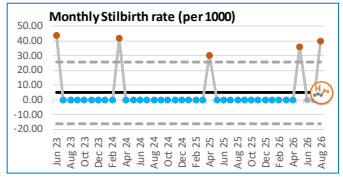
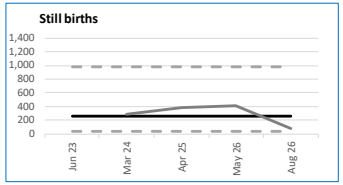
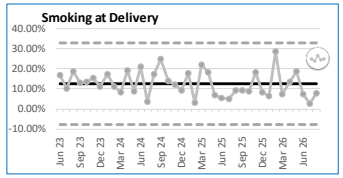
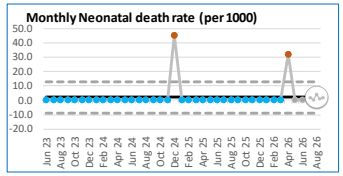
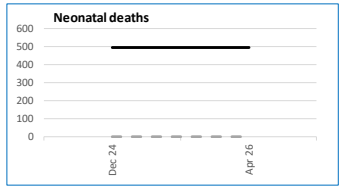
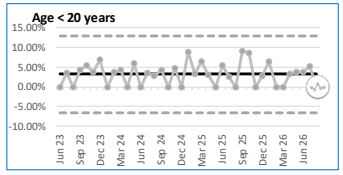
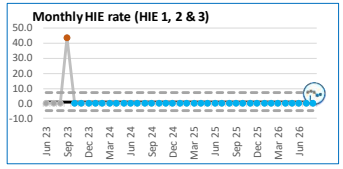
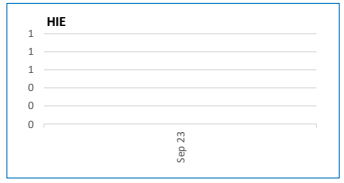
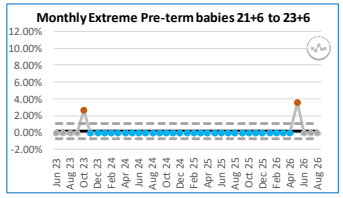
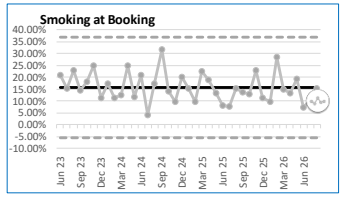
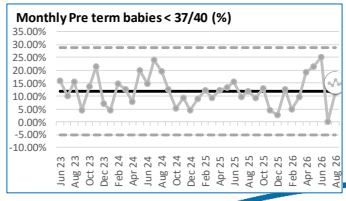
Latest month 01/08/26
Monthly Pre term babies < 37/40 (%) 12.5%
No significant change



Brighton 20% most deprived

University Hospitals Sussex
NHS Foundation Trust

Maternity overview | **RSCH 20% most deprived**

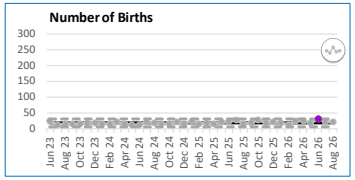
Latest month 01/08/26 Number of Births 26 No significant change 	Latest month 01/08/26 Monthly Stilbirth rate (per 1000) 40.00 Significant deterioration 	Date of last stillbirth 18/08/26 Average days between stillbirths 293.5 No significant change 
Latest month 01/08/26 Smoking at Delivery 7.7% No significant change 	Latest month 01/08/26 Monthly Neonatal death rate (per 0.00 No significant change 	Date of last neonatal death 17/04/26 Average days between deaths 493.0 No significant change 
Latest month 01/08/26 Age < 20 years 0.0% No significant change 	Latest month 01/08/26 Monthly HIE rate (HIE 1, 2 & 3) 0.00 Significant Improvement 	Date of last HIE 05/09/23 Average days between HIE No significant change 
Latest month 01/08/26 Monthly Extreme Pre-term babies 21+6 to 23+6 0.0 No significant change 	Latest month 01/08/26 Smoking at Booking 15.4% No significant change 	Latest month 01/08/26 Monthly Pre term babies < 37/40 (%) 11.5% No significant change 

Chichester – Global Majority

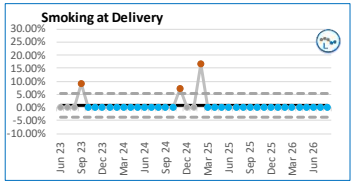
University Hospitals Sussex
NHS Foundation Trust

Maternity overview SRH BME

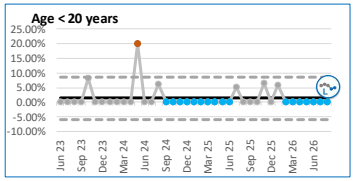
Latest month 01/08/26
Number of Births 20
No significant change



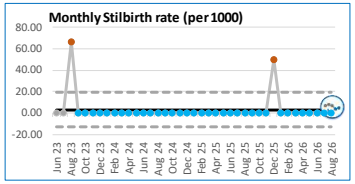
Latest month 01/08/26
Smoking at Delivery 0.0%
Significant Improvement



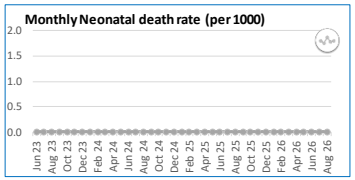
Latest month 01/08/26
Age < 20 years 0.0%
Significant Improvement



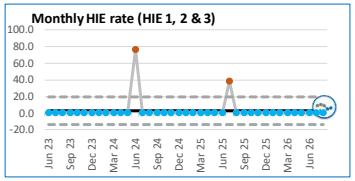
Latest month 01/08/26
Monthly Stilbirth rate (per 1000) 0.00
Significant Improvement



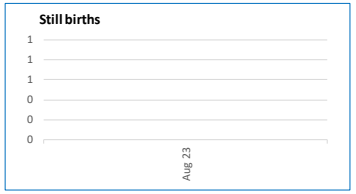
Latest month 01/08/26
Monthly Neonatal death rate (per 0.00
No significant change



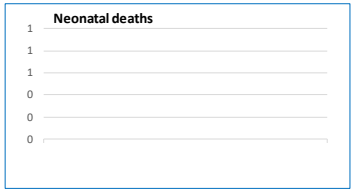
Latest month 01/08/26
Monthly HIE rate (HIE 1, 2 & 3) 0.00
Significant Improvement



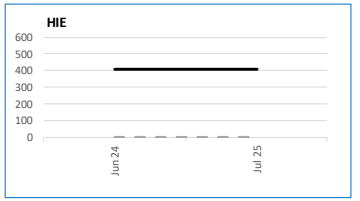
Date of last stillbirth 25/08/23
Average days between stillbirths
No significant change



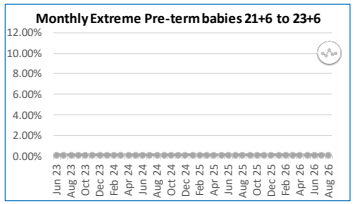
Date of last neonatal death
Average days between deaths
No significant change



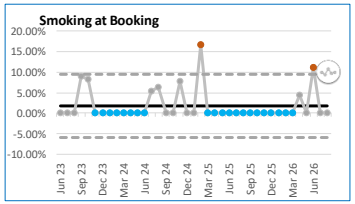
Date of last HIE 29/07/25
Average days between HIE 407.0
No significant change



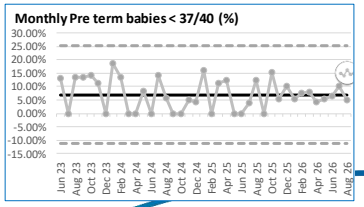
Latest month 01/08/26
Monthly Extreme Pre-term babies 21+6 to 23+6 0.0%
No significant change



Latest month 01/08/26
Smoking at Booking 0.0%
No significant change



Latest month 01/08/26
Monthly Pre term babies < 37/40 (%) 5.0%
No significant change

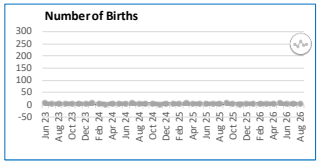


Chichester – 10% most deprived

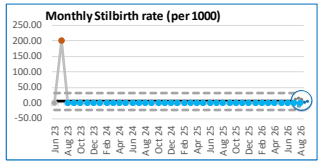
University Hospitals Sussex NHS Foundation Trust

Maternity overview | **SRH 10% most deprived**

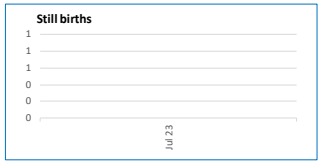
Latest month 01/08/26
Number of Births 4
No significant change



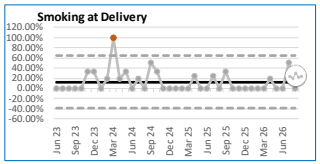
Latest month 01/08/26
Monthly Stilbirth rate (per 1000) 0.00
Significant Improvement



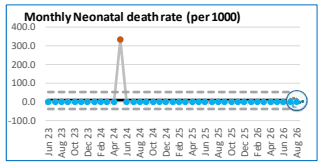
Date of last stillbirth 07/07/23
Average days
No significant change



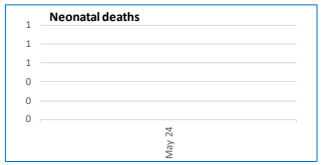
Latest month 01/08/26
Smoking at Delivery 0.0%
No significant change



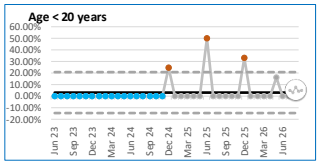
Latest month 01/08/26
Monthly Neonatal 0.00
Significant Improvement



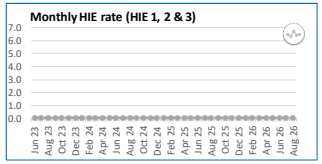
Date of last 06/05/24
Average days
No significant change



Latest month 01/08/26
Age < 20 years 0.0%
No significant change



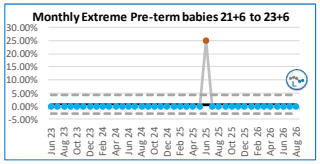
Latest month 01/08/26
Monthly HIE rate (HIE 1, 2 & 3) 0.00
No significant change



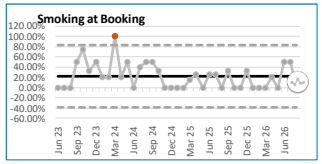
Date of last HIE
Average days
No significant change



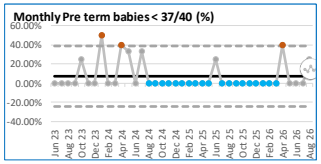
Latest month 01/08/26
Monthly Extreme Pre-term babies 0.0
Significant Improvement



Latest month 01/08/26
Smoking at Booking 0.0%
No significant change



Latest month 01/08/26
Monthly Pre term babies < 37/40 (%) 25.0%
No significant change

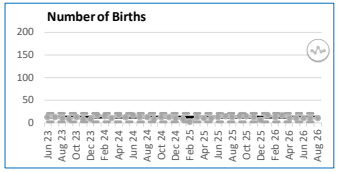


Chichester – 20% most deprived

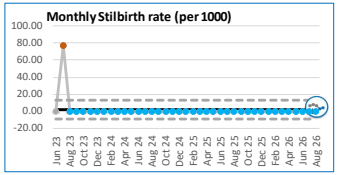
NHS
University Hospitals Sussex
NHS Foundation Trust

Maternity overview | **SRH 20% most deprived**

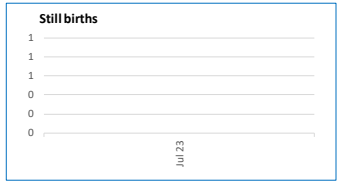
Number of Births
Latest month 01/08/26
Number of Births 10
No significant change



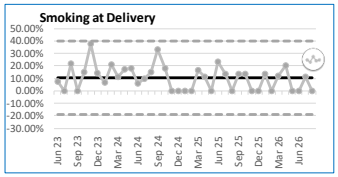
Monthly Stillbirth rate (per 1000)
Latest month 01/08/26
Monthly Stillbirth rate (per 1000) 0.00
Significant Improvement



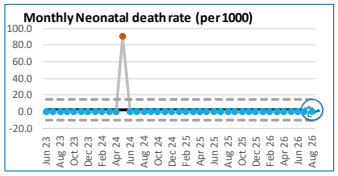
Date of last stillbirth 07/07/23
Average days between stillbirths
No significant change



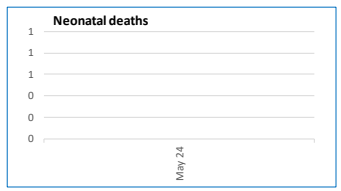
Smoking at Delivery
Latest month 01/08/26
Smoking at Delivery 0.0%
No significant change



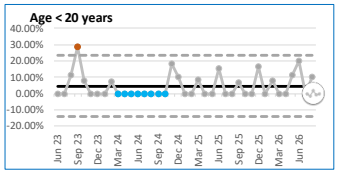
Monthly Neonatal death rate (per 1000)
Latest month 01/08/26
Monthly Neonatal death rate (per 0.00
Significant Improvement



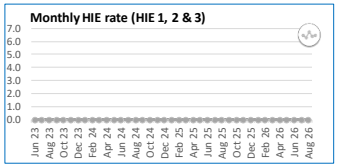
Date of last neonatal death 06/05/24
Average days between deaths
No significant change



Age < 20 years
Latest month 01/08/26
Age < 20 years 10.0%
No significant change



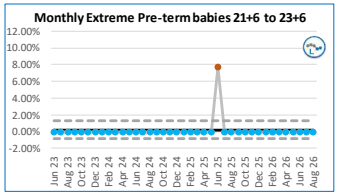
Monthly HIE rate (HIE 1, 2 & 3)
Latest month 01/08/26
Monthly HIE rate (HIE 1, 2 & 3) 0.00
No significant change



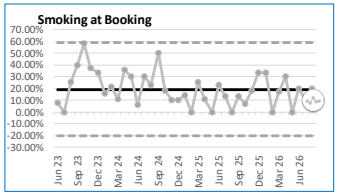
Date of last HIE
Average days between HIE
No significant change



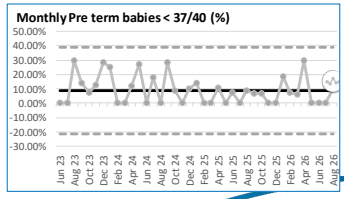
Monthly Extreme Pre-term babies 21+6 to 23+6
Latest month 01/08/26
Monthly Extreme Pre-term babies 21+6 to 23+6 0.0
Significant Improvement



Smoking at Booking
Latest month 01/08/26
Smoking at Booking 20.0%
No significant change



Monthly Pre term babies < 37/40 (%)
Latest month 01/08/26
Monthly Pre term babies < 37/40 (%) 10.0%
No significant change

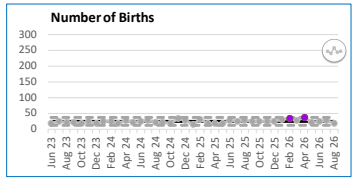


Worthing – Global Majority

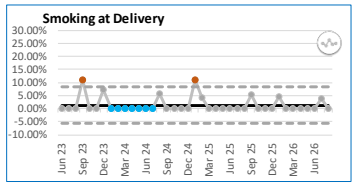
University Hospitals Sussex
NHS Foundation Trust

Maternity overview WH BME

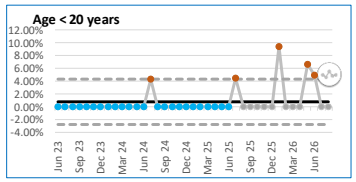
Latest month 01/08/26
Number of Births 19
No significant change



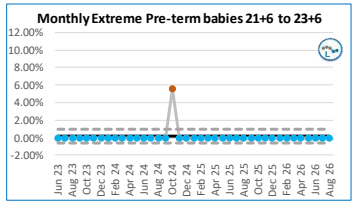
Latest month 01/08/26
Smoking at Delivery 0.0%
No significant change



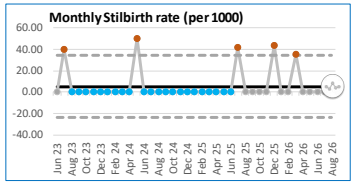
Latest month 01/08/26
Age < 20 years 0.0%
No significant change



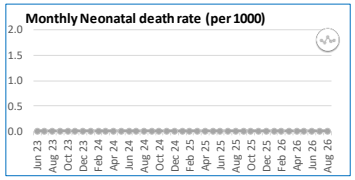
Latest month 01/08/26
Monthly Extreme Pre-term babies 21+6 to 23+6 0.0%
Significant Improvement



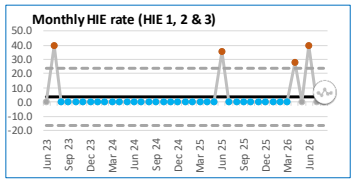
Latest month 01/08/26
Monthly Stilbirth rate (per 1000) 0.00
No significant change



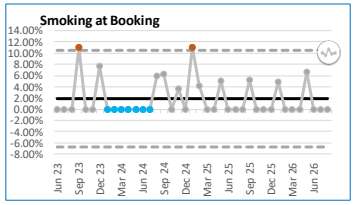
Latest month 01/08/26
Monthly Neonatal death rate (per 0.00
No significant change



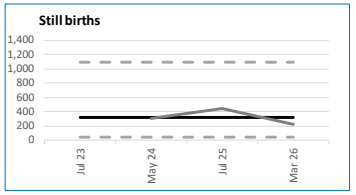
Latest month 01/08/26
Monthly HIE rate (HIE 1, 2 & 3) 0.00
No significant change



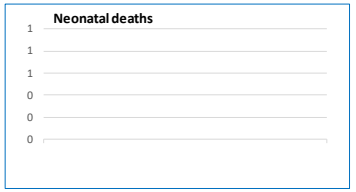
Latest month 01/08/26
Smoking at Booking 0.0%
No significant change



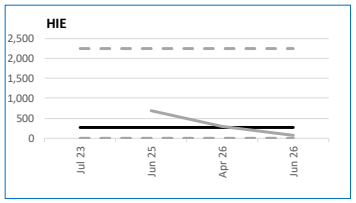
Date of last stillbirth 06/03/26
Average days between stillbirths 323.3
No significant change



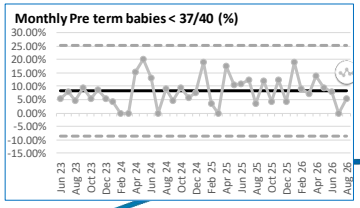
Date of last neonatal death
Average days between deaths
No significant change



Date of last HIE 14/06/26
Average days between HIE 350.0
No significant change



Latest month 01/08/26
Monthly Pre term babies < 37/40 (%) 5.3%
No significant change

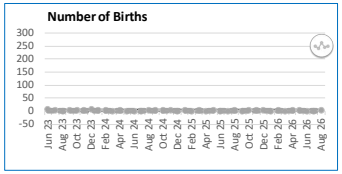


Worthing – 10% most deprived

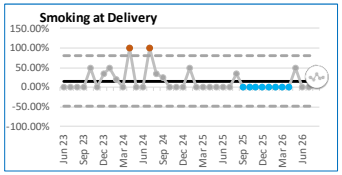
NHS
University Hospitals Sussex
NHS Foundation Trust

Maternity overview | **WH 10% most deprived**

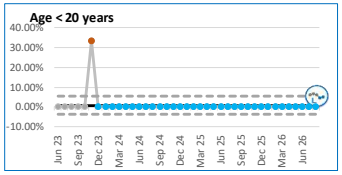
Latest month 01/08/26
Number of Births 2
No significant change



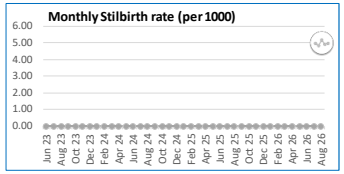
Latest month 01/08/26
Smoking at Delivery 50.0%
No significant change



Latest month 01/08/26
Age < 20 years 0.0%
Significant Improvement



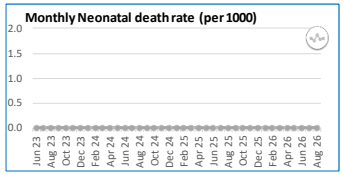
Latest month 01/08/26
Monthly Stilbirth rate (per 1000) 0.00
No significant change



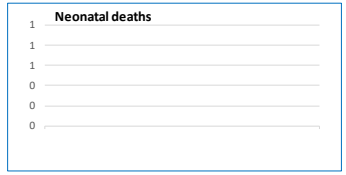
Date of last stillbirth
Average days
No significant change



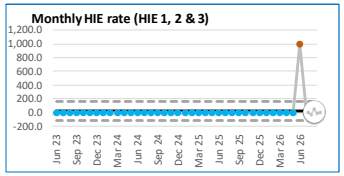
Latest month 01/08/26
Monthly Neonatal 0.00
No significant change



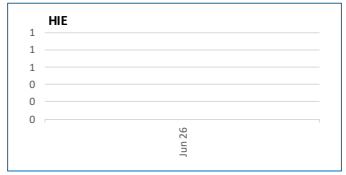
Average days
No significant change



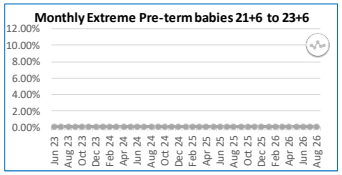
Latest month 01/08/26
Monthly HIE rate (HIE 1, 2 & 3) 0.00
Significant Improvement



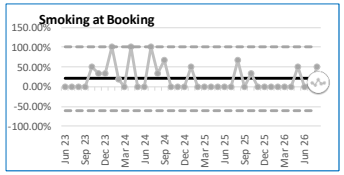
Date of last HIE 14/06/26
Average days
No significant change



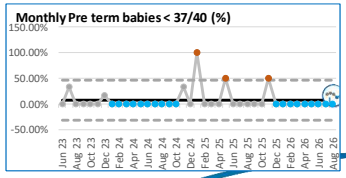
Latest month 01/08/26
Monthly Extreme Pre-term babies 0.0
No significant change



Latest month 01/08/26
Smoking at Booking 50.0%
No significant change



Latest month 01/08/26
Monthly Pre term babies < 37/40 (%) 0.0%
Significant Improvement

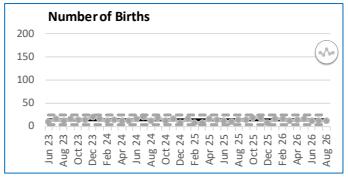


Worthing – 20% most deprived

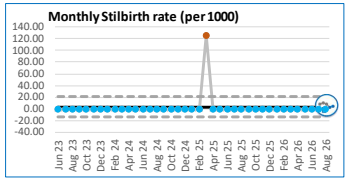
University Hospitals Sussex NHS Foundation Trust

Maternity overview | **WH 20% most deprived**

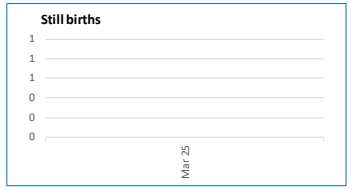
Latest month 01/08/26
Number of Births 11
No significant change



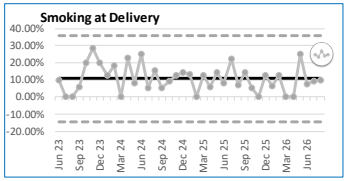
Latest month 01/08/26
Monthly Stilbirth rate (per 1000) 0.00
Significant Improvement



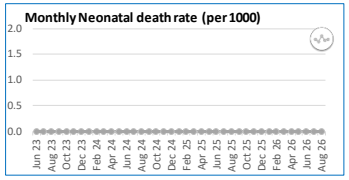
Date of last stillbirth 24/03/25
Average days between stillbirths
No significant change



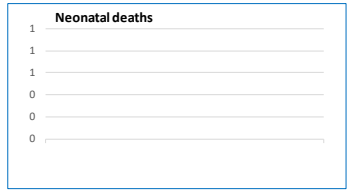
Latest month 01/08/26
Smoking at Delivery 10.0%
No significant change



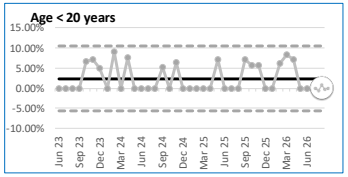
Latest month 01/08/26
Monthly Neonatal death rate (per 0.00
No significant change



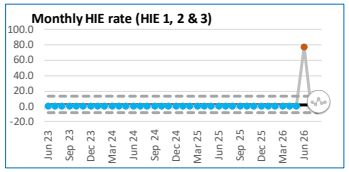
Date of last neonatal death
Average days between deaths
No significant change



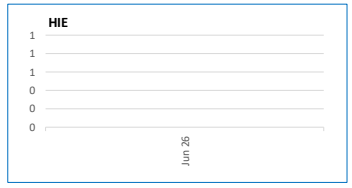
Latest month 01/08/26
Age < 20 years 0.0%
No significant change



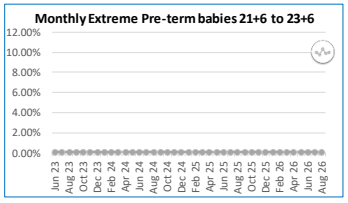
Latest month 01/08/26
Monthly HIE rate (HIE 1, 2 & 3) 0.00
No significant change



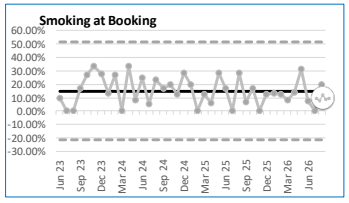
Date of last HIE 14/06/26
Average days between HIE
No significant change



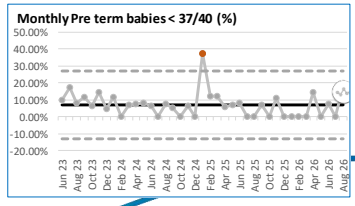
Latest month 01/08/26
Monthly Extreme Pre-term babies 21+6 to 23+6 0.0
No significant change



Latest month 01/08/26
Smoking at Booking 20.0%
No significant change



Latest month 01/08/26
Monthly Pre term babies < 37/40 (%) 18.2%
No significant change



PERINATAL SURVEILLANCE DASHBOARD

DOMAINS										
Perinatal Quality Surveillance and National Ambitions	**Unit of measurement**	**Numerator**	**Denominator**	**Benchmark**	**Mar-26**	**Apr-26**	**May-26**	**Jun-26**	**Jul-26**	**Aug-26**
Monthly number of stillbirths	Number	Stillbirths occurring at or after 24 weeks gestational age excluding TOP's			1	0	1	0	0	1
Monthly rolling number of Stillbirths	Number	Stillbirths occurring at or after 24 weeks gestational age excluding TOP's			6	5	5	5	5	6
Stillbirth rate (rolling 12 months)	Per 1000 births	Stillbirths occurring at or after 24 weeks gestational age excluding TOP's	Livebirths plus stillbirths occurring at or after 24 weeks gestational age excluding TOPs	3.60	2.53	2.11	2.16	2.17	2.15	2.61
Monthly number of NND	Number	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding TOP's			0	1	0	0	0	0
Monthly rolling number of NND	Number	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding TOP's			2	3	2	2	2	2
Neonatal rate (rolling 12 months)	Per 1000 births	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding TOP's	Livebirths occurring at or after 24 weeks gestational age excluding TOPs	1.60	0.85	1.27	0.86	0.87	0.86	0.87
Overall Perinatal Mortality (Total NND & stillbirths) - rolling 12 months data	Per 1000 births	All Stillbirths and Neonatal deaths > 24 weeks gestational age excludes TOP's	Total of stillbirths and neonatal deaths rates combined	5.20	3.37	3.38	3.02	3.05	3.01	3.48
Maternal deaths (rolling 12 months)	Number	Number of people who died during or up to one year after end of pregnancy	Total number of people who gave birth		0	0	0	0	0	0
Brain injury	Per 1000 births	Birth episodes containing a diagnosis of HIE	Total birth episodes (includes every birth episode with no exclusions made)		0.00	0.00	0.00	10.31	0.00	11.30
Pre term births between 24-26+6 weeks gestation	Per 1000 births	Total number of births before 27 weeks gestation	Total number of people who gave birth		16.48	0.00	5.52	0.00	0.00	11.30
ATAIN	Percentage	Number of live born singleton babies born => 37 weeks gestation admitted to a neonatal unit	Number of live singleton babies born => 37 weeks gestation		3.85%	4.15%	6.04%	5.15%	6.96%	4.49%
Apgar score < 7 @ 5 mins of age	Per 1000 births	Number of single babies born to a person => 37 weeks gestation and APGAR score between 0 and 6	Number of single babies born to a person +> 37 weeks gestation and APGAR score between 0 and 10		29.41	17.05	36.36	17.54	14.02	39.22
	Percentage	Number of people reaching 29 weeks gestation with a valid continuity of carer pathway status	Number of people reaching 29 weeks gestation		21.23%	19.61%	14.35%	16.57%	12.63%	5.29%
	Percentage	Number of Black/Asian people reaching 29 weeks gestation with a valid continuity of carer pathway status	Number of Black/Asian people reaching 29 weeks gestation		34.48%	21.05%	4.65%	9.09%	7.14%	2.50%
Continuity of Carer	Percentage	Number of people living in the most deprived reaching 29 weeks gestation with a valid continuity of carer pathway status	Number if people living in the most deprived area reaching 29 weeks gestation		27.78%	31.58%	26.67%	27.27%	25.00%	7.14%
Number of MNSI referrals	Number	Term babies sent for cooling, HIE grade 2 & 3, term intrapartum stillbirths, term NND's and maternal deaths	N/A		0	0	0	0	0	0
Number of SI's declared	Number	Number of SI declared	N/A		0	0	0	0	0	0
Number of incidents reported as Moderate Harm	Number	Incident that causes moderate harm where investigation has identified learning (date of event)	N/A		0	1	0	2	0	1
Operational Delivery										
Midwifery safe staffing	Hours	Number of actual hours worked	Number of actual hours planned		6818/7843 (86.93%)	6706.75/8043 (83.39%)	7073.25/8273 (85.5%)	7073.25/7877 (89.8%)	6872.5/6995 (98.25%)	6695/8560 (78.21%)
Obstetric cover on the delivery suite	Hours	Number of actual hours worked	Number of actual hours planned		326.5/326.5 (100%)	305/305 (100%)	301/301 (100%)	305/305 (100%)	335/335 (100%)	309.5/309.5 (100%)
Consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week- number of days x2 LW ward rounds have taken place.	Number	Number of days x 2 twice daily ward rounds have taken place	Number of days per month x 2		57/62 (92%)	43/60 (72%)	45/62 (72.58%)	47/60 (78.33%)	43/62 (69%)	40/62 (64.52%)
1:1 Care in labour	Percentage	Number of people who received 1:1 care in labour	Total number of people who gave birth		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Maternity service has identified capacity issues and the trust escalation procedure has been activated. Demand is being managed with the Trust with no requirements to divert pregnant women to other Trusts	Number	Escalation requirements: Number of times patients are transferred as an inpatient or asked to attend another site within the Trust, due to acuity	N/A		no data	0	0	1	2	8
Maternity service is unable to manage demand and has escalated to the temporary suspension of admissions to the service, and all amber actions will have been implemented	Number	Escalation requirements - Number of times Red declared	N/A		0	0	0	0	0	0
Ockenden										
Training compliance - % currently trained staff	Percentage	Fetal monitoring Midwives (rolling 12 months)			81.40%	81.30%	81.43%	82.25%	83.46%	84.77%
	Percentage	Fetal monitoring Doctors (rolling 12 months)			71.48%	71.85%	73.23%	75.56%	78.24%	81.32%
	Percentage	MDT skills (rolling 12 months)			91.58%	92.07%	92.33%	92.58%	92.84%	93.01%
Progress with Ockenden audits - Board oversight of the completion of Ockenden audits which support specific IEAs	Yes/No	N/A	N/A		Yes	Yes	Yes	Yes	Yes	Yes
Safety Champions & NED Walkabout this month - provide board oversight of completed walkabouts	Yes/No	N/A	N/A		No	Yes	No	No	No	Yes
MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Yes/No	N/A	N/A		No	No	No	Yes	No	No
Coroner Reg 28 made directly to Trust (A Coroner has the power to make a report to prevent future deaths)	Yes/No	N/A	N/A		No	No	No	No	No	No
Maternity Workforce Midwives										
Monthly vacancy rate	Percentage	Monthly vacancy rate	N/A		5.83%	5.83%	5.83%	5.83%	5.83%	5.83%
Sickness	Percentage	% of staff per month who are sick (ALL)	N/A		7.2%	5.5%	5.9%	6.4%	4.3%	8.4%
Parental/Maternity leave	Percentage	% of staff per month on parental/maternity leave	N/A		7.6%	6.1%	5.1%	6.6%	5.4%	5.8%
Voice of the user										
Friends & Family recommended rate	Percentage	% of women (against total number of responses received) who would recommend our service to			94.4%	94.7%	91.7%	86.7%	96.2%	100.0%
Formal Complaints	Number	Number of monthly formal complaints that have gone through complaints team	N/A		3	1	5	5	5	2
Duty of candour compliance	Percentage	% of compliance	N/A		100%	100%	100%	100%	100%	100%
Number of potential Obstetric claims	Number	Number of Obstetric legal claims	N/A		0	1	1	0	1	0
MVP meeting held on alternate months	Yes/No	Did a MVP meeting take place on alternate months	N/A		Yes	Yes	n/a	Yes	n/a	Yes
Team feedback										
Board level Maternity Safety Champion meeting held	Yes/No	N/A	N/A		Yes	Yes	Yes	Yes	Yes	Yes
Freedom to Speak up cases	Number	Numer of cases per month	N/A		0	0	0	0	0	0

PERINATAL SURVEILLANCE DASHBOARD

DOMAINS										
Perinatal Quality Surveillance and National Ambitions	**Unit of measurement**	**Numerator**	**Denominator**	**Benchmark**	**Mar-26**	**Apr-26**	**May-26**	**Jun-26**	**Jul-26**	**Aug-26**
Monthly number of stillbirths	Number	Stillbirths occurring at or after 24 weeks gestational age excluding TOP's			0	1	0	1	0	0
Monthly rolling number of Stillbirths	Number	Stillbirths occurring at or after 24 weeks gestational age excluding TOP's			2	3	3	3	3	3
Stillbirth rate (rolling 12 months)	Per 1000 births	Stillbirths occurring at or after 24 weeks gestational age excluding TOP's	Livebirths plus stillbirths occurring at or after 24 weeks gestational age	3.30	0.91	1.35	1.37	1.38	1.38	1.37
Monthly number of NND	Number	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding			0	0	0	0	0	0
Monthly rolling number of NND	Number	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding			1	1	1	1	1	1
Neonatal rate (rolling 12 months)	Per 1000 births	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding	Livebirths occurring at or after 24 weeks gestational age excluding TOPs	1.40	0.46	0.45	0.46	0.46	0.46	0.46
Overall Perinatal Mortality (Total NND & stillbirths) - rolling 12 months data	Per 1000 births	All Stillbirths and Neonatal deaths > 24 weeks gestational age excludes TOP's	Total of stillbirths and neonatal deaths rates combined	4.70	1.37	1.80	1.83	1.84	1.84	1.82
Maternal deaths (rolling 12 months)	Number	Number of people who died during or up to one year after end of pregnancy	Total number of people who gave birth		0	0	0	0	0	0
Brain injury	Per 1000 births	Birth episodes containing a diagnosis of HIE	Total birth episodes (includes every birth episode with no exclusions made)		0.00	0.00	5.43	11.70	0.00	0.00
Pre term births between 24-26+6 weeks gestation	Per 1000 births	Total number of births before 27 weeks gestation	Total number of people who gave birth		0.00	0.00	5.46	0.00	0.00	0.00
ATAIN	Percentage	Number of live born singleton babies born => 37 weeks gestation admitted to a neonatal unit	Number of live singleton babies born => 37 weeks gestation		5.59%	3.21%	5.43%	7.60%	4.64%	5.70%
Apgar score < 7 @ 5 mins of age	Per 1000 births	Number of single babies born to a person => 37 weeks gestation and APGAR score between 0 and 6	Number of single babies born to a person +> 37 weeks gestation and APGAR score between 0 and 10		30.12	5.81	23.12	0.00	0.00	5.75
	Percentage	Number of people reaching 29 weeks gestation with a valid continuity of carer pathway status	Number of people reaching 29 weeks gestation		10.61%	13.14%	10.05%	9.63%	4.39%	0.50%
	Percentage	Number of Black/Asian people reaching 29 weeks gestation with a valid continuity of carer pathway status	Number of Black/Asian people reaching 29 weeks gestation		5.88%	14.81%	4.76%	12.50%	0.00%	0.00%
Continuity of Carer	Percentage	Number of people living in the most deprived reaching 29 weeks gestation with a valid continuity of carer pathway status	Number if people living in the most deprived area reaching 29 weeks gestation		0.00%	50.00%	0.00%	0.00%	0.00%	0.00%
Number of MNSI referrals	Number	Term babies sent for cooling, HIE grade 2 & 3, term intrapartum stillbirths, term NND's and maternal deaths	N/A		0	0	0	2	0	0
Number of SI's declared	Number	Number of SI declared	N/A		0	0	0	2	0	0
Number of incidents reported as Moderate Harm	Number	Incident that causes moderate harm where investigation has identified learning (date of event)	N/A		2	1	0	1	0	0
Operational Delivery										
Midwifery safe staffing	Hours	Number of actual hours worked	Number of actual hours planned		5744.25/6417 (89.52%)	5192.5/6210 (83.62%)	6300.7/6833.25 (92.21%)	6110.25/6627.5 (92.2%)	6291.6/6868.25 (91.6%)	6277.2/6610 (94.97%)
Obstetric cover on the delivery suite	Hours	Number of actual hours worked	Number of actual hours planned		249.5/249.5 (100%)	235/235 (100%)	234.5/234.5 (100%)	235/235 (100%)	254.5/254.5 (100%)	239.5/239.5 (100%)
Consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week- number of days x2 LW ward rounds have taken place.	Number	Number of days x 2 twice daily ward rounds have taken place	Number of days per month x 2		38/62 (61%)	42/60 (70%)	53/62 (85.48%)	47/60 (78.33%)	54/62 (87%)	44/62 (70.97%)
1:1 Care in labour	Percentage	Number of people who received 1:1 care in labour	Total number of people who gave birth		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Maternity service has identified capacity issues and the trust escalation procedure has been activated. Demand is being managed with the Trust with no requirements to divert pregnant women to other Trusts	Number	Escalation requirements: Number of times patients are transferred as an inpatient or asked to attend another site within the Trust, due to acuity	N/A		2	5	0	0	0	4
Maternity service is unable to manage demand and has escalated to the temporary suspension of admissions to the service, and all amber actions will have been implemented	Number	Escalation requirements - Number of times Red declared	N/A		0	0	0	0	0	0
Ockenden										
Training compliance - % currently trained staff	Percentage	Fetal monitoring Midwives (rolling 12 months)			86.74%	86.29%	85.91%	86.17%	87.22%	88.31%
	Percentage	Fetal monitoring Doctors (rolling 12 months)			79.72%	79.30%	79.24%	78.62%	79.72%	80.63%
	Percentage	MDT skills (rolling 12 months)			93.90%	93.94%	93.85%	93.76%	93.69%	93.57%
Progress with Ockenden audits - Board oversight of the completion of Ockenden audits which support specific IEAs	Yes/No	N/A	N/A		Yes	Yes	Yes	Yes	Yes	Yes
Safety Champions & NED Walkabout this month - provide board oversight of completed walkabouts	Yes/No	N/A	N/A		No	No	Yes	No	No	No
MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Yes/No	N/A	N/A		No	No	No	Yes	No	No
Coroner Reg 28 made directly to Trust (A Coroner has the power to make a report to prevent future deaths)	Yes/No	N/A	N/A		No	No	No	No	No	No
Maternity Workforce Midwives										
Monthly vacancy rate	Percentage	Monthly vacancy rate	N/A		7.00%	7.80%	7.00%	7.00%	7.00%	7.00%
Sickness	Percentage	% of staff per month who are sick (ALL)	N/A		5.60%	10.00%	8.40%	7.10%	5.20%	6.30%
Parental/Maternity leave	Percentage	% of staff per month on parental/maternity leave	N/A		8.40%	8.10%	5.80%	9.10%	8.10%	7.50%
Voice of the user										
Friends & Family recommended rate	Percentage	% of women (against total number of responses received) who would recommend our services to Friends & Family			100.00%	100.00%	100.00%	100.00%	96.00%	100.00%
Formal Complaints	Number	Number of monthly formal complaints that have gone through complaints team	N/A		4	2	0	4	1	2
Duty of candour compliance	Percentage	% of compliance	N/A		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Number of potential Obstetric claims	Number	Number of Obstetric legal claims	N/A		1	2	2	0	3	0
MVP meeting held on alternate months	Yes/No	Did a MVP meeting take place on alternate	N/A		Yes	Yes	n/a	Yes	n/a	Yes
Team feedback										
Board level Maternity Safety Champion meeting held	Yes/No	N/A	N/A		Yes	Yes	Yes	Yes	Yes	Yes
Freedom to Speak up cases	Number	Numer of cases per month	N/A		0	0	0	0	0	0

PERINATAL SURVEILLANCE DASHBOARD

DOMAINS										
Perinatal Quality Surveillance and National Ambitions	**Unit of measurement**	**Numerator**	**Denominator**	**Benchmark**	**Mar-26**	**Apr-26**	**May-26**	**Jun-26**	**Jul-26**	**Aug-26**
Monthly number of Stillbirths	Number	Stillbirths occuring at or after 24 weeks gestational age excluding TOP's			1	0	0	1	0	0
12 Month rolling number of Stillbirths	Number	Stillbirths occuring at or after 24 weeks gestational age excluding TOP's			7	6	6	7	5	5
Stillbirth rate (rolling 12 months) **National Benchmark 2.6/1000**	Per 1000 births	Stillbirths occuring at or after 24 weeks gestational age excluding TOP's	Livebirths plus stillbirths occuring at or after 24	**3.3**	3.72	3.19	3.23	3.82	2.71	2.72
Monthly number of NND	Number	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding TOP's			0	0	0	0	0	0
12 Month rolling number of NND	Number	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding TOP's			0	0	0	0	0	0
Neonatal rate (rolling 12 months) **National Benchmark 1.5/1000**	Per 1000 births	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding TOP's	Livebirths occuring at or after 24 weeks	**1.4**	0.00	0.00	0.00	0.00	0.00	0.00
Overall Perinatal Mortality (Total NND & stillbirths)- rolling 12 months data **National Benchmark 4.1/1000**	Per 1000 births	All Stillbirths and Neonatal deaths > 24 weeks gestational age excludes TOP's	Livebirths plus stillbirths occuring at or after 24	**4.7**	3.72	3.19	3.23	3.82	2.71	2.72
Maternal deaths (rolling 12 months)	Number	Number of people who died during or up to one year after end of pregnancy			0	0	0	0	0	0
Brain injury	Per 1000 births	Birth episodes containing a diagnosis of HIE	Total birth episodes		0.00	6.41	0.00	13.89	0.00	6.58
Pre term births	Per 1000 biths	All liveborn babies born < 27 weeks gestation (by place of birth)	Total number of liveborn babies		12.82	0.00	0.00	7.04	0.00	6.62
ATAIN	Percentage	Number of live born singleton babies born => 37 weeks gestation admitted to a neonatal unit	Number of live singleton babies born => 37 weeks gestation		2.58%	3.21%	2.00%	3.50%	4.76%	2.61%
Apgar score < 7 @ 5 mins of age	Per 1000 births	Number of single babies born to a person => 37 weeks gestation and APGAR score between 0 and 6	Number of single babies born to a person => 37 weeks gestation and		13.79	28.78	30.77	31.25	12.82	28.99
Continuity of Carer	Percentage	Number of people reaching 29 weeks gestation with a valid continuity of carer pathway status	Number of people reaching 29 weeks gestation		0%	0%	0%	0%	0%	0%
	Percentage	Number of Black/Asian people reaching 29 weeks gestation with a valid continuity of carer pathway status	Number of Black/Asian people reaching 29 weeks gestation		0%	0%	0%	0%	0%	0%
	Percentage	Number of people living in the most deprived reaching 29 weeks gestation with a valid continuity of carer pathway status	Number if people living in the most deprived area reaching 29 weeks gestation		0%	0%	0%	0%	0%	0%
Number of MNSI referrals	Number	Term babies sent for cooling, HIE grade 2 & 3, term intrapartum stillbirths, term NND's and maternal deaths	N/A		0	1	0	0	0	0
Number of SI's declared	Number	Number of SI declared	N/A		1	1	0	0	0	0
Number of incidents reported as Moderate Harm	Number	Incident that causes moderate harm where investigation has identified learning (date of event)	N/A		0	0	0	1	0	1
Operational Delivery										
Midwifery safe staffing (hand counted data)	Hours	Number of actual hours worked	Number of actual hours planned		4992.5/5890 (84.76%)	5400.5/5895 (91.61)	5221/6216.5 (88.81%)	5149/5700 (90.33%)	5416.5/6269.5 (86.39%)	5999.05/7390.5 (81.17%)
Obstetric cover on the delivery suite	Hours	Number of actual hours worked	Number of actual hours		320/320 (100%)	300/300 (100%)	297.5/297.5 (100%)	300/300 (100%)	327.5/327.5 (100%)	305/305 (100%)
Consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week- number of days x2 LW ward rounds have taken place.	Number	Number of days x 2 twice daily ward rounds have taken place	Number of days per month x 2		48/62 (77%)	55/60 (92%)	60/62 (96.77%)	57/60 (95%)	58/62 (94%)	57/62 (91.94%)
1:1 Care in labour	Percentage	Number of people who received 1:1 care in labour	Total number of people who gave birth		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Maternity service has identified capacity issues and the trust escalation procedure has been activated. Demand is being managed with the Trust with no requirements to divert pregnant women to other Trusts	Number	Escalation requirements - Number of times Amber declared	N/A		6	7	3	8	5	7
Maternity service is unable to manage demand and has escalated to the temporary suspension of admissions to the service, and all amber actions will have been implemented	Number	Escalation requirements - Number of times Red declared	N/A		0	0	0	0	0	0
Ockenden										
Training compliance - % currently trained staff	Percentage	Fetal monitoring Midwives (rolling 12 months)			93.10%	93.25%	92.60%	92.05%	92.08%	92.58%
	Percentage	Fetal monitoring Doctors (rolling 12 months)			83.45%	82.61%	82.85%	83.27%	83.71%	84.56%
	Percentage	MDT skills (rolling 12 months)			89.10%	88.54%	87.71%	87.97%	88.51%	89.30%
Progress with Ockenden audits - Board oversight of the completion of Ockenden audits which support specific IEAs	Yes/No	N/A	N/A		Yes	Yes	Yes	Yes	Yes	Yes
Safety Champions & NED Walkabout this month - provide board oversight of completed walkabouts	Yes/No	N/A	N/A		No	No	No	No	Yes	No
MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Yes/No	N/A	N/A		No	No	No	Yes	No	No
Coroner Reg 28 made directly to Trust (A Coroner has the power to make a report to prevent future deaths)	Yes/No	N/A	N/A		No	No	No	No	Yes	No
Maternity Workforce Midwives										
Monthly vacancy rate	Percentage	Monthly vacancy rate	N/A		6.90%	7.46%	7.46%	7.46%	7.46%	7.46%
Sickness	Percentage	% of staff per month who are sick (ALL)	N/A		10.00%	7.70%	9.60%	10.90%	7.40%	2.30%
Parental/Maternity leave	Percentage	% of staff per month on parental/maternity leave	N/A		3.50%	3.10%	2.90%	4.90%	5.30%	5.60%
Voice of the user										
Friends & Family recommended rate	Percentage	% of women (against total number of responses received) who would recommend our services to Friends & Family			92.31%	93.33%	92.86%	100.00%	84.21%	100.00%
Formal Complaints	Number	Number of monthly formal complaints that have gone through complaints team	N/A		4	3	2	1	2	1
Duty of candour compliance	Percentage	% of compliance	N/A		100%	100%	100%	100%	100%	100%
Number of potential Obstetric claims	Number	Number of Obstetric legal claims	N/A		0	1	0	1	0	0
MVP meeting held on alternate months	Yes/No	Did a MVP meeting take place on alternate months	N/A		Yes	Yes	n/a	Yes	n/a	Yes
Team feedback										
Board level Maternity Safety Champion meeting held	Yes/No	N/A	N/A		Yes	Yes	Yes	Yes	Yes	Yes
Freedom to Speak up cases	Number	Numer of cases per month	N/A		0	0	0	0	0	0

PERINATAL SURVEILLANCE DASHBOARD

DOMAINS										
Perinatal Quality Surveillance and National Ambitions	**Unit of measurement**	**Numerator**	**Denominator**	**Benchmark**	**Mar-26**	**Apr-26**	**May-26**	**Jun-26**	**Jul-26**	**Aug-26**
Monthly number of Stillbirths	Number	Stillbirths occuring at or after 24 weeks gestational age excluding TOP's			0	0	0	0	0	0
12 Month rolling number of Stillbirths	Number	Stillbirths occuring at or after 24 weeks gestational age excluding TOP's			4	4	4	3	3	3
Stillbirth rate (rolling 12 months) **National Benchmark 2.6/1000**	Per 1000 births	Stillbirths occuring at or after 24 weeks gestational age excluding TOP's	Livebirths plus stillbirths occuring at or after 24	**3.3**	1.80	1.78	1.80	1.36	1.34	1.36
Monthly number of NND	Number	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding TOP's			0	0	0	0	0	0
12 Month rolling number of NND	Number	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding TOP's			1	1	0	0	0	0
Neonatal rate (rolling 12 months) **National Benchmark 1.5/1000**	Per 1000 births	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding TOP's	Livebirths occuring at or after 24 weeks gestational	**1.4**	0.45	0.45	0.00	0.00	0.00	0.00
Overall Perinatal Mortality (Total NND & stillbirths)- rolling 12 months data **National Benchmark 4.1/1000**	Per 1000 births	All Stillbirths and Neonatal deaths > 24 weeks gestational age excludes TOP's	Livebirths plus stillbirths occuring at or after 24 weeks gestational age excluding TOPs	**4.7**	2.26	2.23	1.80	1.36	1.34	1.36
Maternal deaths (rolling 12 months)	Number	Number of people who died during or up to one year after end of pregnancy			0	0	1	1	1	1
Brain injury	Per 1000 births	Birth episodes containing a diagnosis of HIE	Total birth episodes		0.00	0.00	0.00	0.00	4.69	0.00
Pre term births	Per 1000 births	All liveborn babies born < 27 weeks gestation (by place of birth)	Total number of liveborn babies		0.00	0.00	0.00	0.00	4.74	0.00
ATAIN	Percentage	Number of live born singleton babies born => 37 weeks gestation admitted to a neonatal unit	Number of live singleton babies born => 37 weeks gestation		3.52%	6.35%	3.16%	7.30%	3.29%	4.79%
Apgar score < 7 @ 5 mins of age	Per 1000 births	Number of single babies born to a person => 37 weeks gestation and APGAR score between 0 and 6	Number of single babies born to a person +> 37 weeks gestation and		43.01	35.09	13.42	24.54	10.42	32.47
Continuity of Carer	Percentage	Number of people reaching 29 weeks gestation with a valid continuity of carer pathway status	Number of people reaching 29 weeks gestation		0%	0%	0%	0%	0%	0%
	Percentage	Number of Black/Asian people reaching 29 weeks gestation with a valid continuity of carer pathway status	Number of Black/Asian people reaching 29 weeks gestation		0%	0%	0%	0%	0%	0%
	Percentage	Number of people living in the most deprived reaching 29 weeks gestation with a valid continuity of carer pathway status	Number if people living in the most deprived area reaching 29 weeks gestation		0%	0%	0%	0%	0%	0%
Number of MNSI referrals	Number	Term babies sent for cooling, HIE grade 2 & 3, term intrapartum stillbirths, term NND's and maternal deaths	N/A		0	0	1	0	0	0
Number of SI's declared	Number	Number of SI declared	N/A		0	0	1	0	0	0
Number of incidents reported as Moderate Harm	Number	Incident that causes moderate harm where investigation has identified learning (date of event)	N/A		1	0	0	0	2	0
Operational Delivery										
Midwifery safe staffing (hand counted data)	Hours	Number of actual hours worked	Number of actual hours planned		6703.5/7014 (95.57%)	6406.5/6807.5 (94.11%)	6500/6987.5 (93.02%)	6470/6801 (95.13%)	6226.5/7047 (92.61%)	6219.5/6993 (88.94%)
Obstetric cover on the delivery suite	Hours	Number of actual hours worked	Number of actual hours		320/320 (100%)	300/300 (100%)	297.5/297.5 (100%)	300/300 (100%)	327.5/327.5 (100%)	305/305 (100%)
Consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week- number of days x2 LW ward rounds have taken place.	Number	Number of days x 2 twice daily ward rounds have taken place	Number of days per month x 2		54/62 (87%)	53/60 (88.33%)	49/62 (79.03%)	50/60 (83.33%)	59/62 (95%)	59/62 (95.16%)
1:1 Care in labour	Percentage	Number of people who received 1:1 care in labour	Total number of people who gave birth		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Maternity service has identified capacity issues and the trust escalation procedure has been activated. Demand is being managed with the Trust with no requirements to divert pregnant women to other Trusts	Number	Escalation requirements - Number of times Amber declared	N/A		0	1	0	2	7	0
Maternity service is unable to manage demand and has escalated to the temporary suspension of admissions to the service, and all amber actions will have been implemented	Number	Escalation requirements - Number of times Red declared	N/A		0	0	0	0	0	0
Ockenden										
Training compliance - % currently trained staff	Percentage	Fetal monitoring Midwives (rolling 12 months)			93.7%	93.3%	92.6%	92.2%	92.0%	91.7%
	Percentage	Fetal monitoring Doctors (rolling 12 months)			91.5%	91.8%	91.9%	92.5%	92.7%	92.9%
	Percentage	MDT skills (rolling 12 months)			89.1%	89.5%	89.6%	90.0%	90.8%	92.0%
Progress with Ockenden audits - Board oversight of the completion of Ockenden audits which support specific IEAs	Yes/No	N/A	N/A		Yes	Yes	Yes	Yes	Yes	Yes
Safety Champions & NED Walkabout this month - provide board oversight of completed walkabouts	Yes/No	N/A	N/A		Yes	No	No	Yes	No	No
MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Yes/No	N/A	N/A		No	No	No	Yes	No	No
Coroner Reg 28 made directly to Trust (A Coroner has the power to make a report to prevent future deaths)	Yes/No	N/A	N/A		No	No	No	No	No	No
Maternity Workforce Midwives										
Monthly vacancy rate	Percentage	Monthly vacancy rate	N/A		11.20%	11.20%	11.20%	11.20%	11.20%	11.20%
Sickness	Percentage	% of staff per month who are sick (ALL)	N/A		4.80%	5.50%	7.70%	6.70%	9.10%	9.30%
Parental/Maternity leave	Percentage	% of staff per month on parental/maternity leave	N/A		2.90%	2.80%	3.90%	6.70%	5.90%	5.90%
Voice of the user										
Friends & Family recommended rate	Percentage	% of women (against total number of responses received) who would recommend our services to Friends & Family			92.86%	85.71%	100.00%	100.00%	100.00%	90.91%
Formal Complaints	Number	Number of monthly formal complaints that have gone through complaints team	N/A		1	1	2	1	3	2
Duty of candour compliance	Percentage	% of compliance	N/A		100%	100%	100%	100%	100%	100%
Number of potential Obstetric claims	Number	Number of Obstetric legal claims	N/A		0	1	1	0	0	2
MVP meeting held on alternate months	Yes/No	Did a MVP meeting take place on alternate months	N/A		Yes	Yes	n/a	Yes	n/a	Yes
Team feedback										
Board level Maternity Safety Champion meeting held	Yes/No	N/A	N/A		Yes	Yes	Yes	Yes	Yes	Yes
Freedom to Speak up cases	Number	Numer of cases per month	N/A		0	0	0	0	0	0

NHS
University Hospitals Sussex
NHS Foundation Trust

NHSE 10 point plan (in response to Amos National Maternity and Neonatal Investigation

Assurance template request

Progress update due 31st December 2026

Excellent
Care
Everywhere

We are compassionate
We are inclusive
We are respectful

Background

- Following the publication of Baroness Amos' independent investigation into maternity and neonatal services in England and Donna Ockenden's independent review of maternity services at the Nottingham University Hospitals NHS Trust, NHSE senior maternity and neonatal leaders developed a 10 Point Plan of urgent actions for maternity and neonatal services.
- In September, a baseline assessment was received by the Patient Quality Committee and Board before being sent to NHSE South East on 25th September. (Links below).
- The next progress update is due 31st December 2026 but due to PQC and Board timings (early November), this paper is providing an early view of progress, with the full assurance template to be sent to December's Strategic Board on 10th December.
  - This was agreed by DoM, CNO, CMO and Company Secretary via email on 6th October

- *Baseline assessment assurance template and evidence log: PRN02631iii-maternity-and-neonatal-services-reporting-template.xlsx*
- *Evidence: Evidence*

NHS
University Hospitals Sussex
NHS Foundation Trust

Summary based on Sept baseline assessment

Summary by Action - Baseline	Total	Compliance			
Action		Not applicable	Non-compliant	Partially compliant	Compliant
1. Listening to women and families by rolling out Martha's Rule	**1**	0	0	1	0
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	**3**	0	0	1	2
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	**2**	0	0	1	1
5. Addressing inequalities in maternity and neonatal outcomes	**3**	1	0	1	1
6. Ensuring 24/7 safety and responsiveness of services	**7**	0	1	4	2
7. Trust review of homebirth services	**2**	0	0	0	2
8. Responding to incidents, complaints and concerns with humanity and candour	**3**	0	0	0	3
9. Deliver safe and effective triage in maternity services	**3**	0	0	3	0
10. Post death care	**2**	0	0	1	1

Gaps

- A review of specialist midwifery teams, completed in 2025, will inform latest review to establish redeployment opportunities to ensure safe staffing levels.
- The NHSE Perinatal Equity Programme launch webinar taking place, with details to be provided so planning can take place.
- Triage baseline assessments complete, estates remains biggest barrier.

Baseline assessment compliance and anticipated progress for December progress update

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Forecast December rating	Updates
1. Listening to women and families by rolling out Martha's Rule				
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Partially compliant	Partially compliant	Requires national Badgernet update
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.				
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Compliant	Compliant	Unchanged
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Compliant	Compliant	Unchanged
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant	Partially compliant	Annual review of experience data to be completed (due January 2027)
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care				
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Partially compliant	Compliant	Chief Medical Officer appointed, ToRs updated.
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Compliant	Compliant	Unchanged
5. Addressing inequalities in maternity and neonatal outcomes				
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Not applicable	Partially compliant	Programme launching in November with SLT planning to attend. Full details to be received in launch webinar.
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant	Partially compliant	Relates to 2.3
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Compliant	Compliant	Unchanged

Excellent Care Everywhere

Please note: Action 4 is a national action and not included in the assurance template

NHS
University Hospitals Sussex
NHS Foundation Trust

Baseline assessment compliance and anticipated progress for December progress update

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Forecast December rating	Updates
6. Ensuring 24/7 safety and responsiveness of services				
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	Compliant	Unchanged
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	Compliant	Compliant	Unchanged
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	Partially compliant		To be confirmed
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	Partially compliant	Compliant	BR+ funding approved and recruitment beginning.
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? *(In line with MIS Year 8)*	Partially compliant	Partially compliant	Awaiting anaesthetic assistant rota, likely compliant.
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Partially compliant	Compliant	Six-monthly report updated in line with CNST Year 8 standard.
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Non-compliant	Partially compliant	Review to be completed by December, with Board oversight early in 2027.
7. Trust review of homebirth services				
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Compliant	Compliant	Unchanged
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Compliant	Compliant	Unchanged

NHS
University Hospitals Sussex
NHS Foundation Trust

Baseline assessment compliance and anticipated progress for December progress update

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Forecast December rating	Updates
8. Responding to incidents, complaints and concerns with humanity and candour				
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant	Compliant	Unchanged
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Compliant	Compliant	Unchanged
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Compliant	Compliant	Unchanged
9. Deliver safe and effective triage in maternity services				
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant	Compliant	Completed
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Partially compliant	Partially Compliant	Dependent on inequalities data
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant	Partially Compliant	Dependent on estates
10. Post death care				
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	Compliant	Unchanged
10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	Partially compliant	Compliant	Evidence in place

Excellent Care Everywhere

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

NHS
University Hospitals Sussex
NHS Foundation Trust

Recommendation

- The Board is asked to review the forecast update as at mid-October.
- The Board is asked to provide approval for submission on 31st January once the Strategic Board has reviewed the assurance template and evidence in full on 10th December.

We are compassionate
We are inclusive
We are respectful

NHS
University Hospitals Sussex
NHS Foundation Trust

Mortality and Learning from Deaths 2026/27 Q2 Report

Caroline Wiggs - Mortality & Learning from Deaths Lead

October 2026

Excellent Care Everywhere

Mortality & Learning from Deaths 2026/27 Q2 Report
Assurance Rating Definitions

NHS
University Hospitals Sussex
NHS Foundation Trust

Rating	Definition
No Assurance	Limited or no evidence that mortality surveillance, Learning from Deaths processes, Medical Examiner scrutiny or governance arrangements are operating effectively. Significant gaps prevent meaningful assessment of mortality patterns, learning and opportunities for improvement.
Partial Assurance	Key mortality governance, Learning from Deaths and Medical Examiner processes are in place, but notable gaps remain in data quality, review coverage, thematic analysis, oversight or implementation of learning. Further work is required to provide confidence in organisational understanding of mortality and improvement activity.
Assurance	Mortality surveillance, Learning from Deaths and Medical Examiner processes are operating effectively. Mortality data, demographics, causes of death and emerging themes are routinely reviewed, with learning identified, shared and acted upon through established governance arrangements.
Significant Assurance	Comprehensive and well-embedded mortality governance, Learning from Deaths and Medical Examiner processes provide a high level of confidence in organisational oversight. Mortality trends, demographics, causes of death, inequalities and emerging risks are proactively monitored, with demonstrable evidence that learning has led to sustained improvements in patient safety, quality of care and clinical outcomes.

Mortality & Learning from Deaths 2026/27 Q2 Assurance Summary

University Hospitals Sussex NHS Foundation Trust

Item	Assurance	Rationale
Crude Mortality	Assurance	Significantly improved compared to 2025 levels. Increasing mortality rates at WGH require ongoing monitoring and investigation.
SHMI (Summary Hospital-Level Mortality Indicator)	Assurance	SHMI within expected range. Weekend SHMI remains significantly high at Trust level, primarily driven by RSCH and WGH. However, the overall trend continues to show improvement.
HSMR (Hospital Standardised Mortality Ratio)	Assurance	HSMR lower than expected.
VLAD (Variable Life Adjusted Display) Alerts	Assurance	VLAD alerts regularly reviewed with coding. Sustained improvement compared with historical performance.
Coding Depth & Data Quality	Partial	Coding depth continues to improve, with further quality improvement work ongoing.
Mortality Surveillance: Deprivation and Ethnicity	Partial	Ethnicity completeness in Q2 2026/27 was 47.4% and remains an improvement focus.
Ward and Speciality Distribution of Deaths	Assurance	Distribution of deaths reflects expected acuity, complexity and end-of-life care needs.
Common Causes of Death	Assurance	Pneumonia remains the leading cause of death, although declining over the last three quarters, with a corresponding rise in brain injury and subdural haemorrhage.
Screening Panel and Structured Judgement Reviews	Assurance	10.64% of acute adult deaths were referred for Learning from Deaths review, including 7.33% for SJR. A robust multidisciplinary screening process ensures appropriate case selection for review.
Mortality Panel Outcomes	Assurance	33 SJRs were completed, with 28 cases reviewed at Mortality Panel. Of those discussed, 53.6% were assessed as Poor or Very Poor Care, compared to 18.2% at initial reviewer scoring, reflecting the added value of multidisciplinary review.
LeDeR, Learning Disability and Severe Mental Health Adult	Assurance	External LeDeR reviews have reduced significantly, while deaths among people with known learning disabilities and/or severe mental illness remain low overall despite a slight increase in Q2 2026/27.
Medical Examiner Service	Partial	Medical Examiner workforce pressures have contributed to an increase in average time from referral to MCCD completion to 2.3 days, creating a risk to the timely scrutiny of deaths, particularly Coroner referrals.

SHMI **within expected range**

HSMR **lower than expected**

LfD review referral rate **10.64%**

No cases identified as **'may have been avoidable'**

Coroner referral rate **20.7%**

NHS
University Hospitals Sussex
NHS Foundation Trust

Key Information 2026/27 Q2

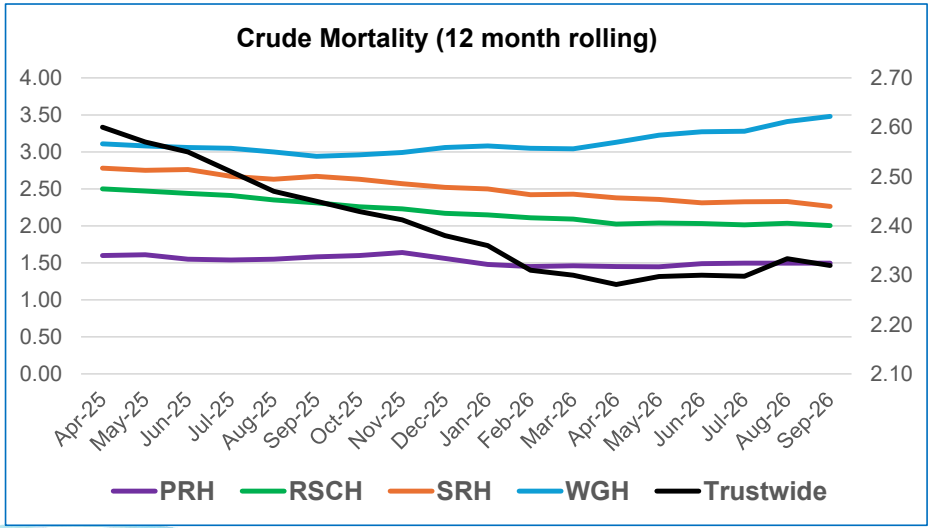
- **Weekend SHMI** remains significantly high and continues to be monitored through the Mortality & Morbidity Steering Group.
- **Acute adult deaths** increased slightly to **846** in Q2 2026/27 (834 in Q2 2025/26), while **child deaths** remained stable **(4.)**
- **Average time from referral to issuing MCCD** increased to **2.3 days** in Q2 2026/27 (2.0 days in Q1 2026/27 and 1.7 days in Q2 2025/26), reflecting temporary workforce pressures within the Medical Examiner Service.
- **Inpatient mortality** remained concentrated within high-acuity medical specialties, while pneumonia-related deaths reduced by 43% compared with Q3 2025/26, reflecting a substantial improvement in this leading cause of inpatient death.
- **20.7%** of acute adult deaths were **referred to Coroner** in Q2 2026/27, compared to 21.2% in Q2 2025/26.
- **12.8%** of acute adult deaths were **investigated by Coroner** in Q2 2026/27, compared to 13.2% in Q2 2025/26.
- **24.2%** of adult deaths were among patients from the most deprived areas (D1-4) compared with **48.4%** from the least deprived areas (D7-10); corresponding SJR review rates were **27.7%** and **55.3%**.
- **7.33%** of adult deaths were referred for SJR; **44%** progressed to comprehensive review, predominantly involving patients with **autism, learning disability or severe mental illness.**
- **33 SJRs completed** in Q2 2026/27 compared to 21 in Q2 2025/26.
- **Average SJR completion time** improved from **44 days** in Q1 2026/27 to **40 days** in Q2 2026/27, with most reviews completed within the 60-day target.
- **53.6%** were graded as **Poor or Very Poor Care** at Mortality Panel, up from 43.8% in Q1 2026/27 but below levels reported during much of 2024/25 and early 2025/26.

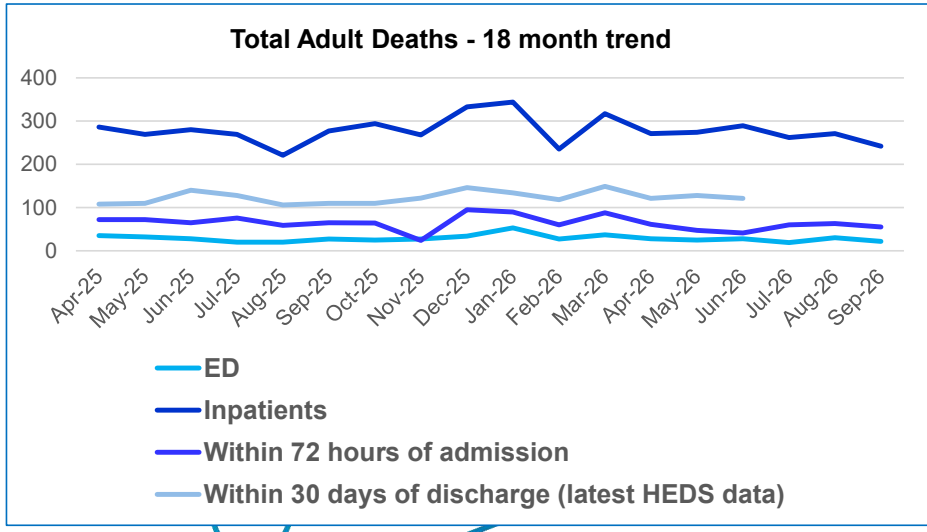
Learning from Deaths Mortality Overview - 2026/27 Q2

University Hospitals Sussex NHS Foundation Trust

*Data source SHMI HED Module and includes of out of hospital deaths.

Crude Mortality	No Assurance	Partial Assurance	Assurance	Significant Assurance
Please see Rating Definitions on slide 3	Overall Trust mortality performance remains **significantly improved compared with 2025 levels**; however, the Trust-wide 12-month rolling crude mortality rate has plateaued in recent months, increasing slightly from 2.30 in July 2026 to 2.33 in August 2026 before remaining broadly stable at 2.32 in September 2026. Sustained reductions at RSCH and SRH, alongside stable performance at PRH, continue to be offset by increasing mortality rates at WGH, which remains an outlier and warrants ongoing monitoring and investigation. Total adult deaths, deaths within 72 hours of admission, and deaths within 30 days of discharge remain broadly stable, demonstrating expected seasonal variation with winter peaks and subsequent reduction.			





Learning from Deaths Mortality Overview - 2026/27 Q2

University Hospitals Sussex NHS Foundation Trust

*Data source SHMI HED Module and includes of out of hospital deaths.

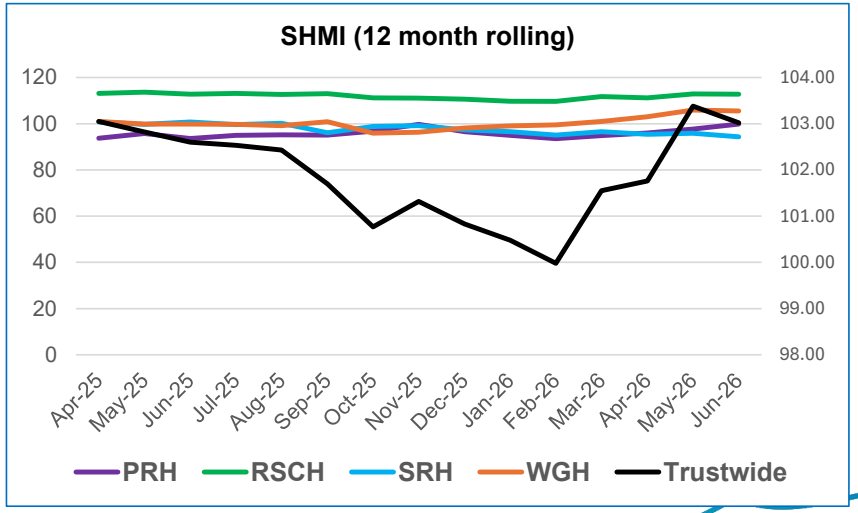
.

Summary Hospital-Level Mortality Indicator (SHMI)	No Assurance	Partial Assurance	Assurance	Significant Assurance
Please see Rating Definitions on slide 3	SHMI remains **within the expected range** (NHSE 101.27; HED 101.55). The 12-month rolling trend demonstrates **sustained improvement since early 2025**, narrowing the gap to peer organisations and the national benchmark, although progress has plateaued in recent months. RSCH continues to report the highest SHMI, albeit with gradual improvement, while PRH (93.54), SRH (96.25) and WGH (100.84) remain within expected limits. A small number of diagnostic groups remain above expected mortality levels, notably COPD and bronchiectasis (132.62) and complications of devices, implants or grafts (135.81), and continue to be monitored. Whilst weekend SHMI remains significantly higher than expected at Trust level, primarily driven by RSCH and WGH, the overall trend continues to improve.Weekday SHMI is broadly aligned with the national baseline, with only RSCH remaining significantly elevated. Overall, mortality performance remains markedly improved compared with historic levels and continues to be monitored through established mortality governance processes.			

Deaths per 1000 Bed Days	PRH	RSCH	SRH	WGH	UHSx Total
2025/26 Q1	3.21	5.04	5.73	4.95	4.95
2025/26 Q2	3.85	4.58	5.29	4.38	4.59
2025/26 Q3	4.30	5.05	5.45	5.90	5.30
2025/26 Q4	3.90	4.89	5.88	6.10	5.35
2026/27 Q1	3.70	4.54	5.18	5.39	4.83
2026/27 Q2	**4.09**	**4.33**	**4.59**	**4.60**	**4.45**

Note: Bed days taken from SQL

Note: Deaths per 1000 bed days have increased due to methodological refinements rather than a deterioration in performance. The measure now includes same-day deaths and is limited to the adult inpatient population, excluding day cases, births and children, providing a more accurate indicator of inpatient mortality.



Q2 2026/27 Total Adult Deaths	PRH	RSCH	SRH	WGH	UHSx Total
Jul-26	28	98	81	74	281
Aug-26	30	109	59	103	301
Sep-26	41	81	65	77	264
Total	**99**	**288**	**205**	**254**	**846**

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.

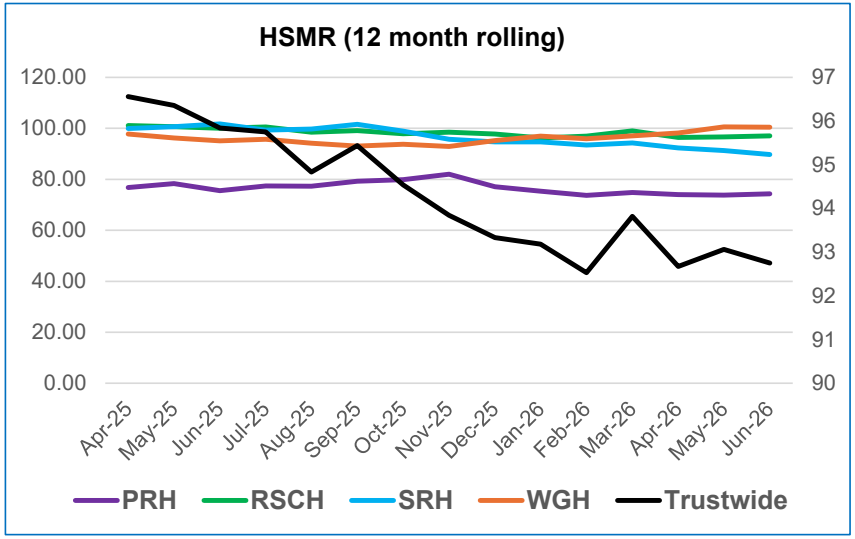
Learning from Deaths Mortality Overview - 2026/27 Q2

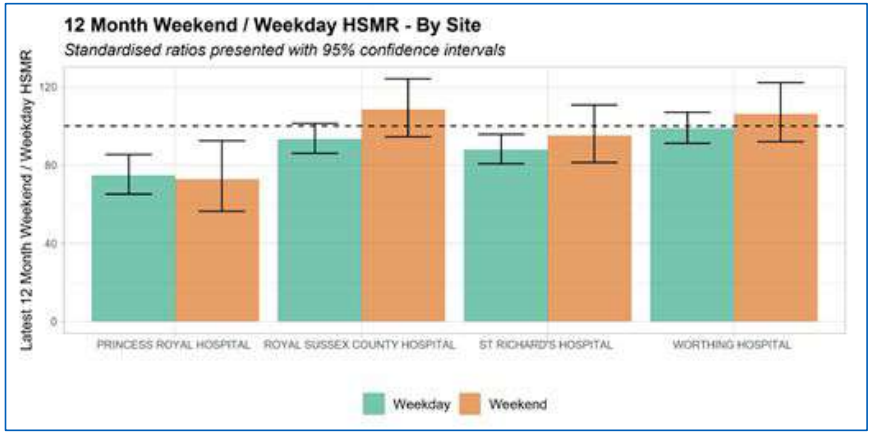
University Hospitals Sussex NHS Foundation Trust

*Data source SHMI HED Module and includes of out of hospital deaths.

.

Hospital Standardised Mortality Ratio (HSMR)	No Assurance	Partial Assurance	Assurance	Significant Assurance
Please see Rating Definitions on slide 3	HSMR **remains below the national baseline** (HED 92.75), indicating fewer deaths than expected across the Trust. The 12-month rolling HSMR has shown **overall improvement since early 2025** and remains consistently below 100. All sites remain at or below expected mortality levels, with PRH (74.28) continuing to demonstrate particularly strong performance. There are no HSMR mortality outliers by diagnostic group and no statistically significant weekday or weekend HSMR outliers at either Trust or site level. Overall, HSMR continues to provide assurance that mortality performance remains better than expected and is monitored through established mortality governance processes.			





HSMR compares observed deaths with those expected after adjustment for patient case mix. A score of 100 represents the national average; scores below 100 indicate fewer deaths than expected.

Learning from Deaths Mortality Overview - 2026/27 Q2

University Hospitals Sussex NHS Foundation Trust

*Data source SHMI HED Module and 13/10/2026 HED report.

.

Variable Life Adjusted Display (VLAD) Alerts Please see Rating Definitions on slide 3	No Assurance	Partial Assurance	Assurance	Significant Assurance
	Trust-wide VLAD monitoring continues to demonstrate **sustained improvement compared with historical performance**, with no new specialty-level mortality signals of significant concern identified during the reporting period. A small number of diagnosis-group alerts have undergone detailed review, with findings predominantly attributable to patient case-mix, frailty, coding and palliative care factors rather than systemic quality-of-care concerns. Robust mortality surveillance arrangements remain in place, with all VLAD alerts reviewed through established governance processes to support early identification, investigation and organisational learning from emerging risks.			

Improvement alerts

- **120: Fracture of neck of femur (hip)**
- **132: Poisoning by nonmedicinal substances, Poisoning by other medications and drugs, Poisoning by psychotropic agents**

VLAD is a statistical process control tool used for mortality monitoring. Unlike SHMI or HSMR funnel plots, which assess mortality over a fixed period (typically 12 months), VLAD charts monitor performance over time and can detect earlier changes in mortality outcomes.

Deterioration alerts

- **66: Acute cerebrovascular disease** had four VLAD deterioration alerts in the last 12 months, with the most recent alert being in June 2026.
- **113: Other connective tissue disease** had three VLAD deterioration alerts in the last 12 months, with the most recent alert being in June 2026.
- Review using the SHMI methodology adjusted for palliative care suggests the mortality signals are partly influenced by end-of-life care coding. Acute cerebrovascular disease moves to within expected limits, while other connective tissue disease improves from a 95% to a 90% warning-level outlier, although it remains above expected mortality.

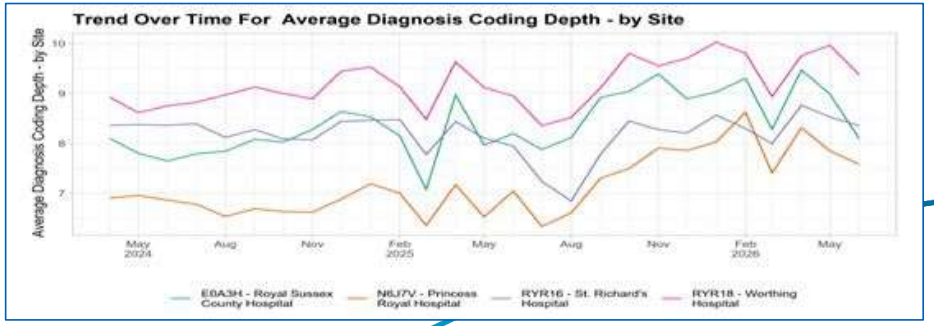
Learning from Deaths Mortality Overview - 2026/27 Q2

University Hospitals Sussex NHS Foundation Trust

*Data source SHMI HED Module and 13/10/2026 HED report.

HED case study Please see Rating Definitions on slide 3	**113: Other connective tissue disease** Diagnosis Group 113 remains under review following **three VLAD alerts and a SHMI above expected levels** (84 observed deaths vs 56.3 expected; SHMI 149.2). Mortality is concentrated in an older, frailer population, with 36% of deaths occurring in patients aged ≥90 years and 81% associated with falls-related coding (R296). The signal is largely driven by activity at Worthing Hospital and appears to reflect frailty and end-of-life complexity rather than connective tissue disease itself. Mortality remains above expected levels after palliative care adjustment, and the cohort will continue to be monitored through established mortality surveillance and governance processes.

Coding Depth & Data Quality Please see Rating Definitions on slide 3	No Assurance	**Partial Assurance**	Assurance	Significant Assurance
	Coding depth **continues to improve** across the Trust, supporting more accurate capture of patient complexity and mortality risk adjustment. Average comorbidity scores have also increased, reflecting enhanced recording of co-existing conditions. The proportion of episodes assigned non-specific symptom-based ("R") primary diagnoses remains above peer benchmarks and continues to be a coding quality focus. Clinical coding quality remains on an **improving trajectory**, strengthening confidence in mortality data and benchmarking, with ongoing work to reduce use of non-specific primary diagnoses.			



Learning from Deaths: Deprivation & Ethnicity - 2026/27 Q2

University Hospitals Sussex NHS Foundation Trust

Deaths by IMD Decile (1 = most deprived, 10 = least deprived) Breakdown of deaths by underlying population.

Demographics for Adult Deaths 2026/27 Q2	No. of adult deaths	Underlying population	Deaths per 1000
1	30	30919	0.97
2	28	43807	0.64
3	37	68282	0.54
4	63	54516	1.16
5	75	93678	0.80
6	104	122144	0.85
7	93	113860	0.82
8	74	99685	0.74
9	72	104283	0.69
10	77	110984	0.69
2026/27 Q2 UHSussex Total	**653**	**842158**	**0.78**
No. in most deprived postcodes (D1-4)	**158**	**197524**	**0.80**
% in most deprived postcodes (D1-4)	**24.2%**	**23.5%**	
No. in least deprived postcodes (D1-4)	**316**	**428812**	**0.74**
% in least deprived postcodes (D7-10)	**48.4%**	**50.9%**	
Note: Horsham, Crawley and East Sussex Local Authorities excluded as UHSussex do not serve the whole of the population.			

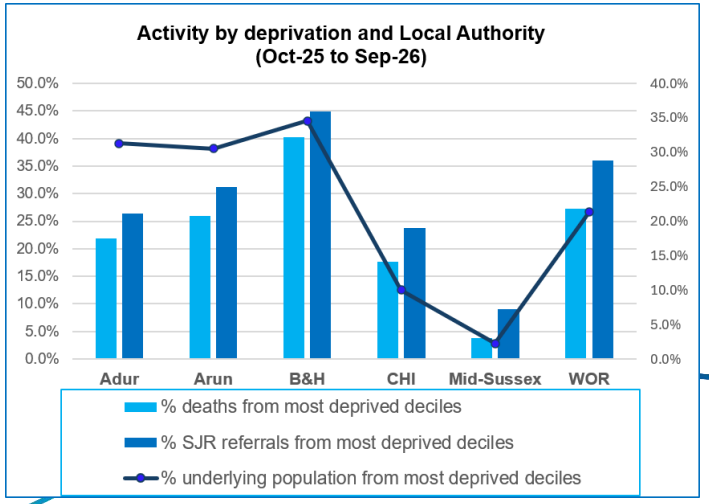
Mortality Surveillance: Deprivation and Ethnicity

Please see Rating Definitions on slide 3

No Assurance	Partial Assurance	Assurance	Significant Assurance

24.2% of acute adult deaths related to those within the most deprived postcodes (D1-4) compared to 48.4% of adult deaths which related to those within the least deprived postcodes (D7-10.) Of these, 27.7% of most deprived deaths were referred for SJR compared to 55.3% of least deprived deaths. Ethnicity data was available for 47.4% of cases, with 93% of recorded cases identified as White: English, Welsh, Scottish, Northern Irish or British. Improvement work to enhance ethnicity data completeness continues. Mortality demographic data will be monitored through the Health Inequalities portfolio to identify potential disparities and inform targeted improvement activity. Mortality and health inequalities also featured in the inaugural *COE Connect: Learning & Safety Bulletin* to support organisational awareness and learning.

Over the 12-month period, deaths and SJR referrals broadly reflected local deprivation profiles. SJR referral rates from the most deprived deciles were generally higher than the proportion of deaths in these groups, providing assurance that patients from more deprived communities are appropriately represented within the Trust's mortality review processes. Ongoing monitoring will continue through the Health Inequalities and Learning from Deaths governance frameworks.

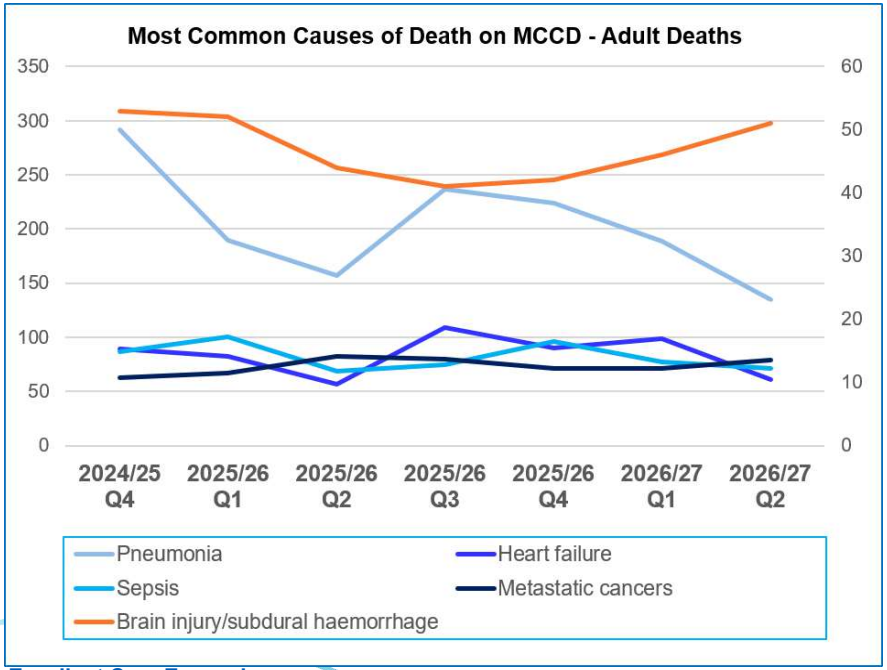


Learning from Deaths: Cause of Death & Ward Distribution - 2026/27 Q2

Most common causes of acute adult deaths listed on death certificate (MCCD).

University Hospitals Sussex NHS Foundation Trust

Ward and Specialty Distribution of Deaths Please see Rating Definitions on slide 3	No Assurance	Partial Assurance	Assurance	Significant Assurance
	The majority of inpatient adult deaths occurred within ICU/Acute, General and Elderly Medicine, Respiratory and Stroke services, reflecting the higher acuity, clinical complexity and volume of end-of-life care managed within these specialties. No unexpected specialty variation was identified. Overall, 38.2% of patients died within five days of admission, while 25.4% had a length of stay exceeding 15 days. Patients aged 75 years and over were more likely to experience prolonged admissions prior to death, consistent with increased frailty and clinical complexity in older populations. The overall pattern remains consistent with the expected profile of inpatient mortality and provides no indication of significant areas of concern.			



Common Causes of Death Please see Rating Definitions on slide 3	Assurance
Pneumonia remains the leading diagnosis associated with inpatient deaths; however, deaths have reduced substantially from 237 in Q3 2025/26 to 135 in Q2 2026/27, a decrease of 43%. In contrast, deaths associated with brain injury/subdural haemorrhage have increased from 41 to 51 over the same period, although absolute numbers remain relatively low. Heart failure, sepsis and metastatic cancer deaths have shown expected quarter-on-quarter variation without a sustained upward trend. Overall, no emerging patterns of significant concern have been identified.	

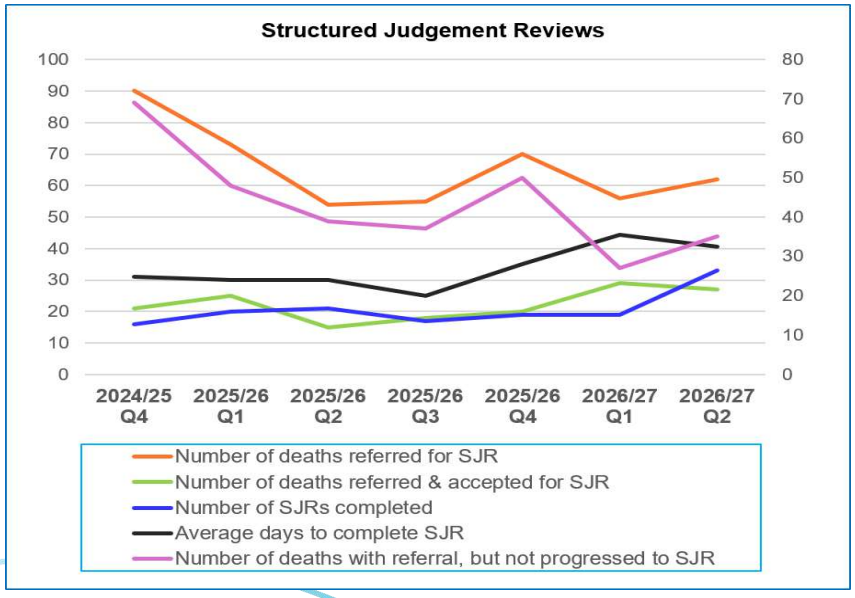
Note:

- Multiple causes of death may be listed on the death certificate.
- Cause of death fields will be blank where there is onward referral to the Coroner. The Coroner will issue their own documentation after an investigation or post-mortem.
- Any death involving trauma or accidents must be reported to the Coroner. This includes traumatic head injury or a fall causing a fracture (e.g. Neck of Femur fracture).

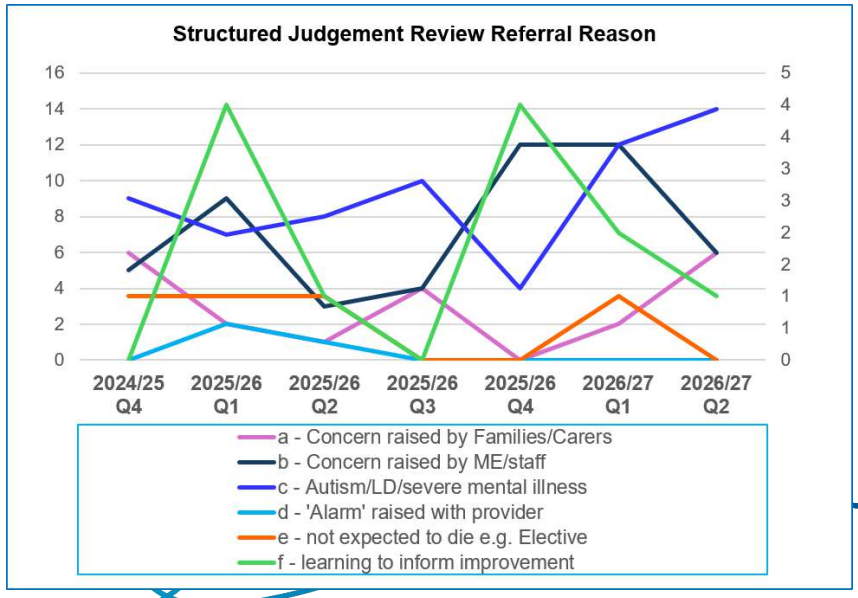
Learning from Deaths: Screening Panel & Structured Judgement Reviews - 2026/27 Q2

NHS
University Hospitals Sussex
NHS Foundation Trust

Screening Panel & Structured Judgement Reviews Please see Rating Definitions on slide 3	No Assurance	Partial Assurance	Assurance	Significant Assurance
	The SJR referral rate increased to 7.33% of deaths in Q2 2026/27 (62/846). Combined with 28 additional reviews recommended through alternative governance routes, the overall Learning from Deaths review rate reached 10.64%, exceeding the national 10% benchmark. The SJR Screening Panel continued to provide robust oversight, ensuring review activity remained proportionate and targeted. Following multidisciplinary scrutiny, 27 referrals (44%) progressed to SJR, while the remainder were directed to alternative specialty, governance or external review processes where these offered the most appropriate route for assurance and learning. Referrals were predominantly associated with patients with autism, learning disability or severe mental illness, alongside concerns raised by families/carers and Medical Examiners or staff. A total of 33 SJRs were completed during the quarter. Average completion times improved from 44 days in Q1 to 40 days in Q2, with most reviews completed within the Trust's 60-day target. A small number of delays related to reviewer availability and access to scanned records.			



33 SJRs completed in Q2 2026/27; 21 in Q2 2025/26.



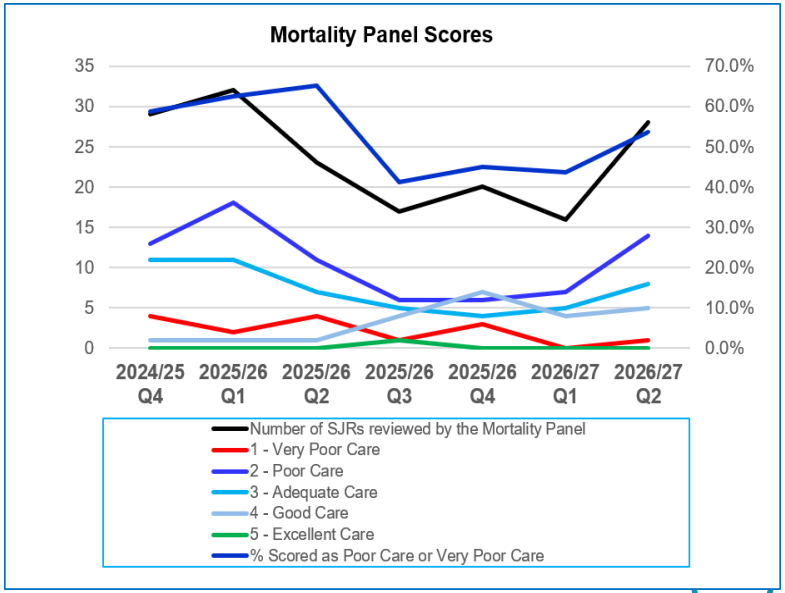
Learning from Deaths: Mortality Panel Outcomes - 2026/27 Q2

University Hospitals Sussex NHS Foundation Trust

Mortality Panel Outcomes	No Assurance	Partial Assurance	Assurance	Significant Assurance
Please see Rating Definitions on slide 3	The Mortality Panel reviewed 28 SJRs in Q2 2026/27. Of these, 53.6% were graded as Poor or Very Poor Care, an increase from 43.8% in Q1 2026/27 but below levels reported during much of 2024/25 and early 2025/26. One case was reclassified from Poor Care to Very Poor Care following multidisciplinary Mortality Panel discussion. Themes continued to relate primarily to ongoing care and end-of-life care. No potentially avoidable deaths were identified, reflecting the exclusion of most Coroner cases from routine SJR review. Examples of excellent practice were shared with clinical teams to support organisational learning and improvement.			

53.6% of completed SJRs were graded as **Poor or Very Poor Care**, an improvement from 65.2% in Q2 2025/26 but higher than Q1 2026/27 (43.8%).

Note: Scores remain subject to multidisciplinary review, with one case reclassified from **Poor to Very Poor Care** through Mortality Panel discussion.



Structured Judgement Reviews Outcome Scores	Completed Q2 2026/27	Mortality Panel Q2 2026/27	Variance
Total	**33**	**28**	**-5**
1 - Very Poor Care	0	1	**1**
2 - Poor Care	6	14	**8**
3 - Adequate Care	11	8	**-3**
4 - Good Care	11	5	**-6**
5 - Excellent Care	5	0	**-5**
% Scored as Poor Care or Very Poor Care	18.2%	53.6%	**35.4%**

5 SJRs were graded as **Excellent Care** by the SJR Reviewer who undertook the review, with examples of positive practice shared with the relevant clinical teams.

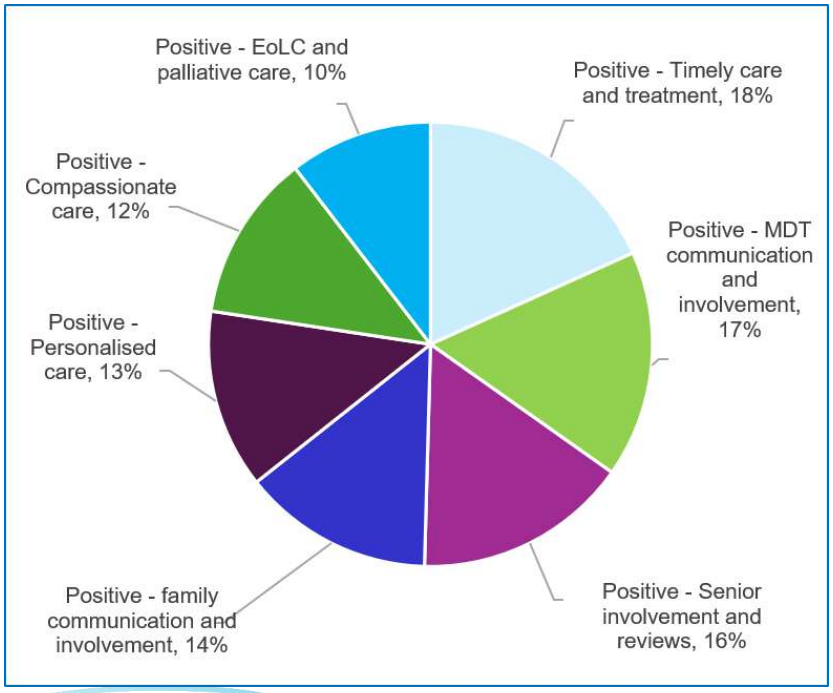
Learning from Deaths: Mortality Panel Learning Themes - 2026/27 Q2

NHS
University Hospitals Sussex
NHS Foundation Trust

Top 3 positive learning themes:
- Timely care and treatment
- MDT communication and involvement
- Senior involvement and reviews

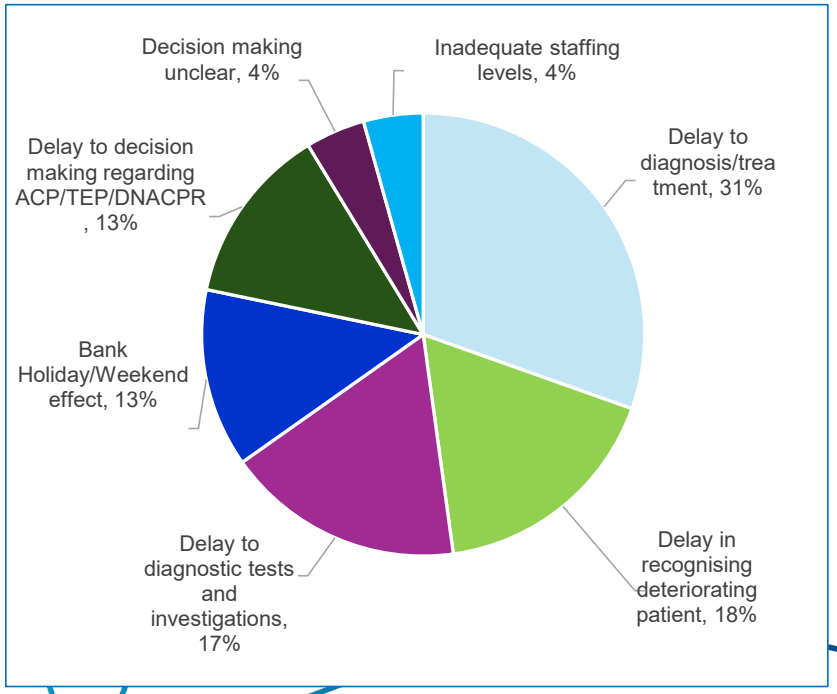
Top 3 learning themes:
- Delay to diagnosis/treatment
- Delay in recognising deteriorating patient
- Delay to diagnostic tests and investigations

Positive learning themes



The Mortality & Morbidity Surveillance Group (MMSG) meets quarterly and is tasked with developing improvement plans in relation to themes identified from deaths.

Learning themes



Learning from Deaths: Coroner & Patient Safety Incident Learning Themes 2026/27 Q2

University Hospitals Sussex NHS Foundation Trust

Prevention of future death (PFD) Regulation 28 learning themes identified

Patient Flow and Access

- Capacity pressures impacting timely access to specialist care and treatment.

Diagnostic Testing and Clinical Escalation

- Delays in recognising deterioration and acting on abnormal results.

Communication and Care Coordination

- Communication and escalation gaps between teams and organisations.

Information Management

- Incomplete transfer and follow-up of critical patient information.

Learning from Patient Safety Incident Investigations and Early Learning Reviews

Recognition and Response to Deterioration

- Delayed recognition and escalation of deterioration, including management of high-risk patients.

Safe Clinical Environments and Staffing

- Risks associated with care environment, patient observation and staffing alignment.

Communication, Handover and Escalation

- Communication failures affecting transfers, escalation planning and documentation of care ceilings.

Diagnostics and Follow-up

- Delays in investigation tracking, result review and management of abnormal findings.

Learning from Deaths: Coroner & Patient Safety Incident Learning Themes 2026/27 Q2

University Hospitals Sussex NHS Foundation Trust

Learning from PSIRG (Fatal Cases)

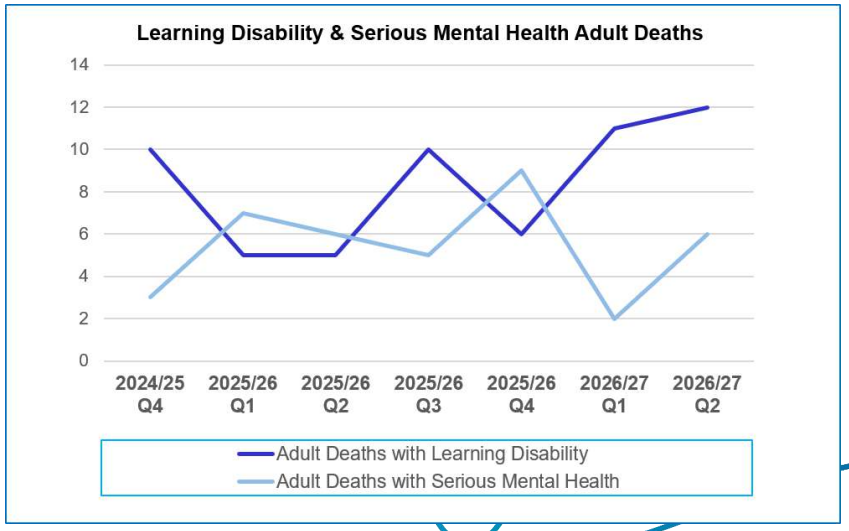
1. **Failure to Monitor, Follow Up and Track Patients:** Missed surveillance appointments, delayed reviews, lost referrals and inadequate safety-netting arrangements were recurring factors.
2. **Delayed Diagnosis and Failure to Act on Clinical Findings:** Missed opportunities to identify serious pathology and delayed responses to abnormal investigations occurred across specialties.
3. **Communication and Handover Failures:** Ineffective handovers, incomplete documentation and poor transfer of information contributed to adverse outcomes.
4. **Falls Prevention and Post-Fall Management:** Repeated themes included inadequate falls risk management, unwitnessed falls and delayed recognition of deterioration following falls.
5. **Recognition and Escalation of the Deteriorating Patient:** Warning signs were often present but not consistently recognised or escalated.
6. **Medication Safety and High-Risk Medicines:** Anticoagulation and other high-risk medication processes featured repeatedly.
7. **Capacity and Service Constraints:** Workforce pressures, pathway delays and limited service availability amplified existing risks.

Learning from Deaths: LeDeR, Learning Disability & Severe Mental Health Reviews - 2026/27 Q2

University Hospitals Sussex NHS Foundation Trust

LeDeR, Learning Disability and Severe Mental Health Adult Deaths Please see Rating Definitions on slide 3	No Assurance	Partial Assurance	Assurance	Significant Assurance
	External LeDeR focused reviews remain lower than historically following organisational changes to the review process. Learning identified through reviews continues to inform improvements in professional practice, care provision, learning disability awareness and safeguarding. Deaths involving patients with learning disabilities increased slightly in Q2 2026/27 but remain low overall. Deaths involving patients with serious mental health conditions increased slightly from Q1 to Q2, returning to levels more consistent with previous reporting periods. Ongoing monitoring will continue to ensure that case identification, referral processes and recording practices remain robust.			

Note: While 14 cases were referred under the criterion of **autism, learning disability or severe mental illness** in Q2 2026/27, some patients had both a learning disability and a serious mental health condition. As a result, the combined total (18) shown in the graph opposite exceeds the number of individual referrals.



Medical Examiner Office Update 2026/27 Q2

Information provided by Lead MEOs, on behalf of independent ME Service.

NHS
University Hospitals Sussex
NHS Foundation Trust

	No Assurance	Partial Assurance	Assurance	Significant Assurance
Medical Examiner Service Please see Rating Definitions on slide 3	The Medical Examiner Service continues to experience workforce pressures arising from sickness absence, maternity leave and annual leave, creating a potential risk to the timely scrutiny of deaths, particularly Coroner referrals. This is reflected in an increase in the average time from referral to issuing an MCCD to 2.3 days in Q2 2026/27 (2.0 days in Q1 and 1.7 days in Q2 2025/26). The service has also identified an increasing number of deaths occurring in patients awaiting planned assessment, investigation or treatment, highlighting the importance of effective mortality surveillance and escalation processes across clinical pathways. Plans are progressing to establish a single hosted Medical Examiner Service, which would become the largest in the South East, providing independent scrutiny for approximately 9000 deaths annually, with consultation expected in Q3 2026/27. The proposed model will support greater standardisation of practice, improve workforce resilience and enable future digital transformation, including preparation for Electronic Patient Record implementation. Despite current pressures, feedback remains overwhelmingly positive, with Medical Examiner teams receiving 115 positive comments compared with 4 concerns relating to delayed Medical Examiner Officer contact. Areas identified for improvement continue to focus on communication, end-of-life care and nursing care.			

1251 community deaths in Q2 2026/27 compared to 1246 in Q2 2025/26.

Data Quality - Community Deaths
The quality of information provided at initial referral for West Sussex community deaths remained a challenge, with missing information identified in 16% of referrals in July 2026, improving to 12% in August and 9% in September, indicating a positive trend but ongoing opportunities to strengthen referral quality and completeness.

Medical Examiner Office Update 2026/27 Q2

Information provided by Lead MEOs, on behalf of independent ME Service.

NHS
University Hospitals Sussex
NHS Foundation Trust

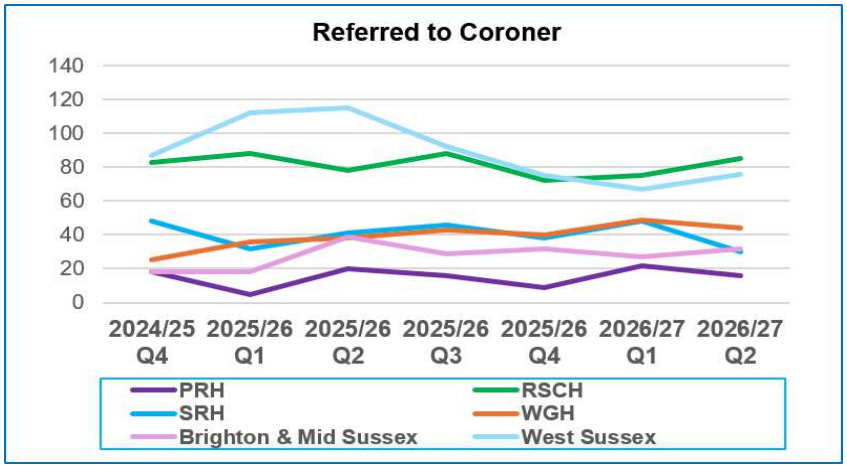
Medical Examiner Scrutiny - Adult Deaths (by ME office)		Adult Deaths (No.)	Average time taken to complete MCCD (Days from referral to sending)	Average time taken to complete MCCD (Days from death to sending)	Referred to Coroner (No.)	Referred to Coroner (% of total adult deaths)	Investigated by Coroner (No.)	Investigated by Coroner (% of total adult deaths)	Investigated by Coroner (% of referred to Coroner)	Positive NoK feedback on MEO contact	Concerns raised by NoK regarding MEO contact
Brighton & Mid Sussex	PRH	99	3.1	4.9	16	16%	10	10%	63%	12	0
	RSCH	288	3.2	4.7	85	30%	55	19%	65%		
	Community deaths	313	2.7	6.3	32	10%	10	3%	31%	11	1
		700	**3.0**	**5.3**	**133**	**19%**	**75**	**11%**	**53%**	**23**	**1**
West Sussex	SRH	205	1.3	3.8	30	15%	19	9%	63%	29	1
	WGH	254	1.7	4.3	44	17%	24	9%	55%		
	Community deaths	938	1.6	4.5	76	8%	23	2%	30%	63	2
		1397	**1.5**	**4.2**	**50**	**13%**	**22**	**7%**	**49%**	**92**	**3**
2026/27 Q2		**2097**	**2.3**	**4.7**	**183**	**16%**	**97**	**9%**	**51%**	**115**	**4**

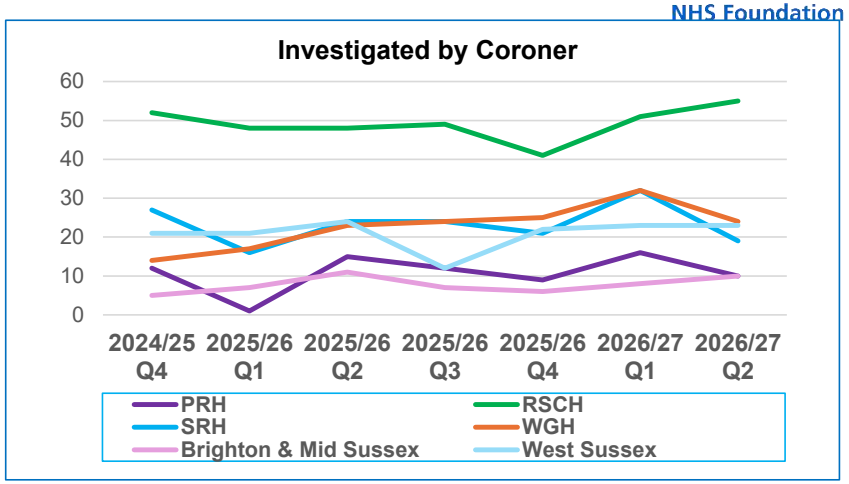
Medical Examiner scrutiny performance remained broadly stable in Q2 2026/27, with 2097 adult deaths reviewed. Coroner referral and investigation rates remained consistent with historical levels (16% referred; 9% investigated), while feedback from bereaved families remained overwhelmingly positive. Workforce pressures contributed to a modest increase in the average time from referral to MCCD completion, although timeliness remains comparable with peer services. Delays in receiving community death referrals continue to impact MCCD turnaround times, highlighting the importance of timely referral processes across General Practice and partner organisations.

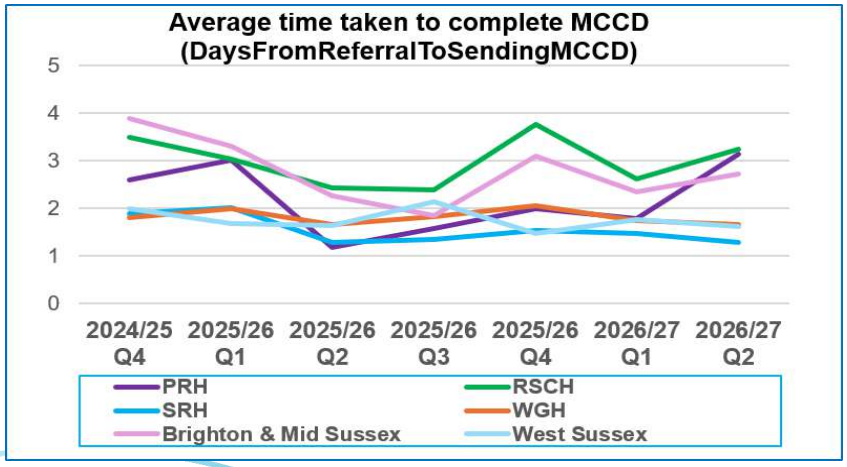
Medical Examiner Office Update 2026/27 Q2

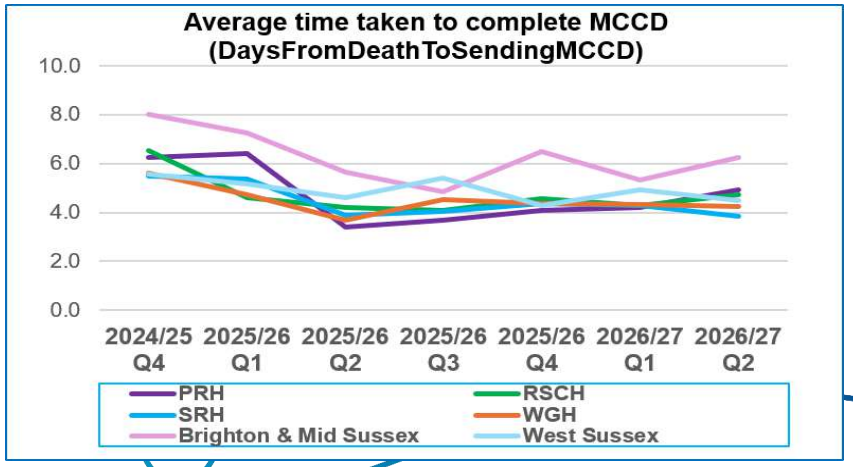
Information provided by Lead MEOs, on behalf of independent ME Service.

University Hospitals Sussex NHS Foundation Trust







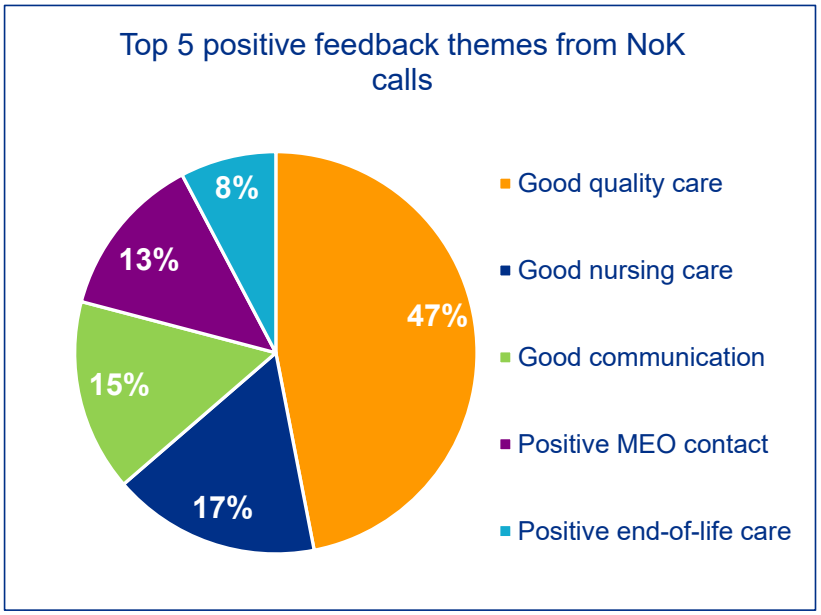


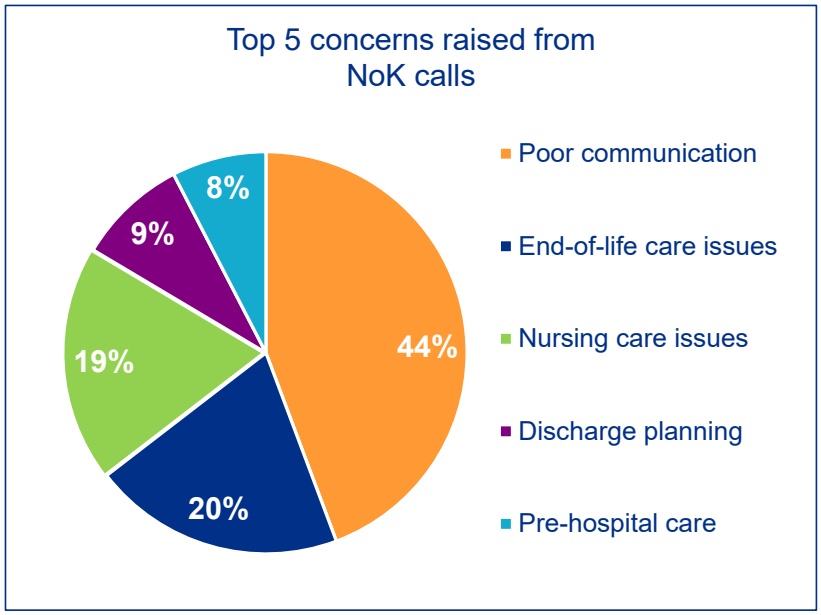
Medical Examiner Office: Next of Kin Feedback Themes 2026/27 Q2

Information provided by Lead MEOs, on behalf of independent ME Service.

University Hospitals Sussex NHS Foundation Trust

Inpatient deaths





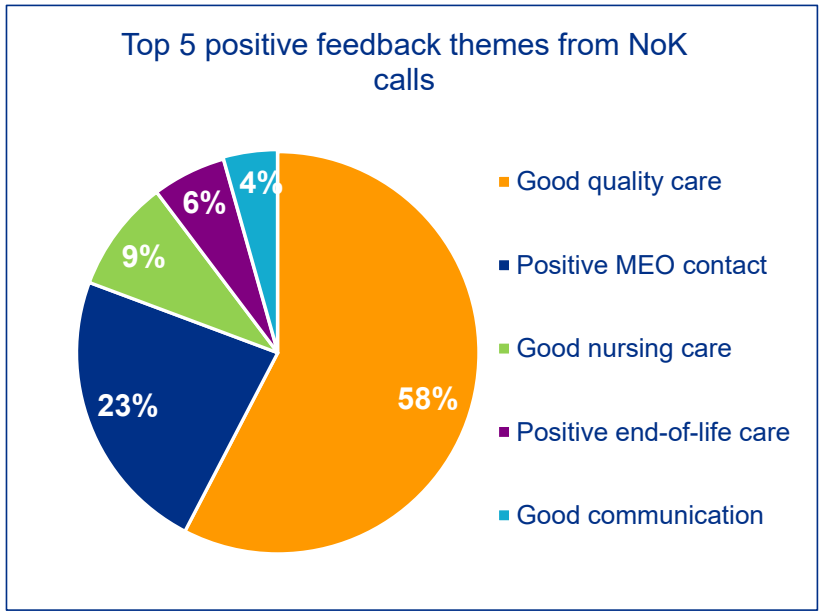
Feedback from bereaved relatives continued to highlight high-quality care, particularly nursing care, communication and end-of-life care, with Medical Examiner Officers receiving notable positive recognition for their support and compassion. Communication with patients and families remained the most frequently reported concern, followed by end-of-life care and nursing care. Nursing care concerns primarily related to fundamental care provision, including personal care, pain management and mouth care, together with communication and continuity of care during periods of deterioration and end-of-life care. An increase in concerns relating to pre-hospital care was also identified, warranting further review to understand underlying themes and opportunities for improvement.

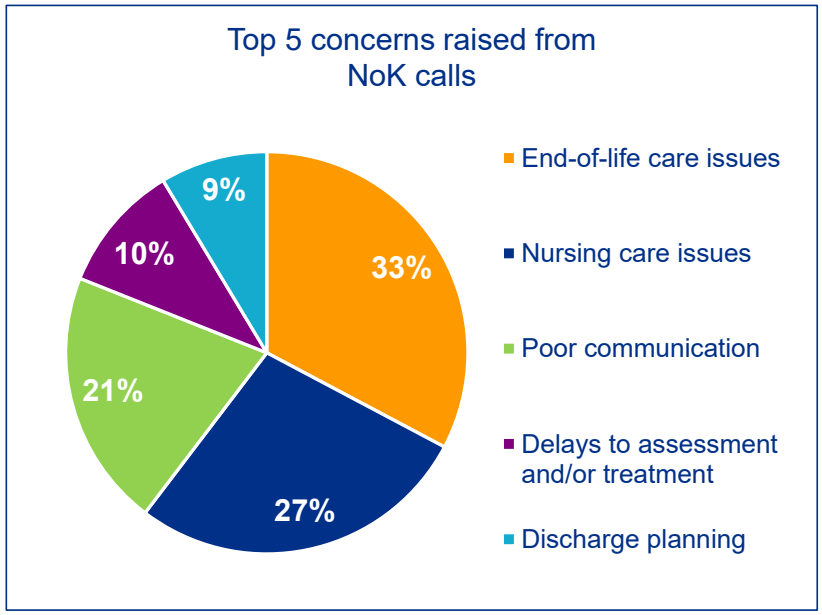
Medical Examiner Office: Next of Kin Feedback Themes 2026/27 Q2

Information provided by Lead MEOs, on behalf of independent ME Service.

University Hospitals Sussex NHS Foundation Trust

Community deaths





Community feedback remained largely positive, with good-quality care identified as the predominant positive theme and positive contact with Medical Examiner Officers reflecting the value families place on the support provided throughout the bereavement process. The most common concerns related to end-of-life care, nursing care and communication, which continue to represent key areas for quality improvement. An increase in concerns relating to delays in assessment and/or treatment was also identified, reflecting ongoing funding and capacity pressures across community services, which are likely to have influenced the experience of patients and families at end of life.

Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

“As we move forwards together, our ambition is to always keep improving and provide excellent care, every time, for our patients.”

Dr Andy Heeps

Chief Executive

University Hospitals Sussex
NHS Foundation Trust

Safer Staffing Paper- 6-monthly update

by Annette Gericke,

Deputy Chief Nurse for Workforce, Professional Standards and Strategy

October 2026

Contents

Safer Staff Paper July 25- March 26 2
1. Introduction 2
1.1 Executive Summary 2
1.2 Board Assurance 2
2. Key Summary – Annette to update 2
3. Expectation one – the right staff – Annette to update 2
3.1 Evidence Based Workforce Planning 3
3.1.1 Specialist and Cancer Division 3
3.1.2 Surgical Division 3
3.1.3 Medicine Division 3
3.1.4 Women, Children's and CCS Division 3
3.1.5 Maternity - Birthrate Plus 3
3.1.6 Neonatal All sites 4
3.2 Recruitment and Retention 4
3.3 Fill rate 5
3.4 CHPPD 6
4. Expectation two – the right skills 7
4.1 NMAHP Workforce Development and Education 7
4.1.1 Healthcare Assistant Development 7
4.1.2 T Level Partnership and Workforce Pipeline Development 7
4.1.3 Preceptorship 8
4.1.4. Continuous Professional Development (CPD) 8
5. Expectation three - the right place and time 9
5.1 SafeCare 9
5.2 Red Flags 9
5.3 Efficient Deployment and Flexibility 10
5.4 Agency and Bank Reduction 10
5.4.1 RN Agency Reduction 10
5.4.2 RMN Usage 11
5.4.3 Bank Deployment 11
6. Uplift and Supervisory Time 13
7. Request to the Board of Directors 14

Safer Staffing Paper April 26 - September 26

1. Introduction

1.1 Executive Summary

This report provides the Trust Board and the People and Culture Committee with an overview of ward staffing levels across University Hospitals Sussex, in accordance with guidance from the National Quality Board (NQB).

The purpose of this report is to provide assurance that ward staffing levels remain safe and that robust processes are in place to monitor staffing, mitigate risks and escalate concerns when staffing falls below optimal levels. It also highlights any areas of workforce pressure and identifies where further action or investment may be required.

1.2 Board Assurance

The Board is asked to:

- Note the report and the processes in place to monitor and maintain safe staffing levels.
- Receive assurance that appropriate governance arrangements and escalation mechanisms are in place to support safe patient care.

2. Key Summary

Table 1 outlines the key performance workforce indicators for Nursing and Midwifery mapped against the trust target in three increments throughout the year. Note the vacancies increased in May 25 following investment in registered nursing and Health Care Assistant (HCA) posts because of establishment setting in April 25.

Staffing Measure	Jul-25	Feb-26	Mar-26	Sep-26	Target	Trend	RAG
Vacancy Band 5	14.1%	9.0%	7.3%	5.4%	10%	Improving	□
Vacancy Band 2/3	15.2%	12.6%	10.8%	9.7%	10%	Improving	□
Annual Turnover Band 5	6.4%	5.6%	–	–	5%	Improving	□
Stability (12 month)	89.9%	92.5%	–	–		Improving	□
Agency (% of staffing)	2.2%	1.7%	–	–		Improving	□

Table 1

3. Expectation one – the right staff – Annette to update

3.1 Evidence Based Workforce Planning

The Deputy Chief Nurse (DCN) for Workforce along with the clinical workforce team undertook nursing establishment reviews (NER) in November 2025 using the Safer Nursing Care Tool (SNCT) for all 76 inpatient areas (excluded from this review was Albourne ward in PRH and AAU in RSCH due to moving units) plus all Emergency departments. Those not included within the

SNCT audit were neonatal, theatres, and critical care. The 2026 cycle of establishment reviews in currently in progress. Recommendations from the 2025 were as follows:

3.1.1 Specialist and Cancer Division

Within the division all areas except 3 meet the acceptable level of staffing for the acuity and dependency of patients. SNCT recommended moving 6.37 wte HCA within the division to balance establishment and meet dependency level. This recommendation is being validated as part of the 26/27 cycle.

3.1.2 Surgical Division

All areas within surgery met the required staffing for the acuity and dependency of the patients. There are unfunded posts of 2.59wte RN on both Middleton and Wittering ward. These posts are being reviewed as part of the 26/27 review cycle.

3.1.3 Medicine Division

All areas within medicine RSCH/PRH except for AMU ward at PRH met the required staffing needs for the acuity and dependency of the patients. Early indication from the current review identifies there is establishment rebasing from RSCH still required.

Staffing across Medicine at Worthing and St Richard's Hospital (SRH) remains more challenged. Risk is mitigated daily through use of SafeCare to deploy staff and, where risk cannot be mitigated, temporary workforce is used appropriately with Divisional Director of Nursing oversight. SNCT in December 2025 recommends and increase of 2.72 wte RN and 17.28 HCA. The development of a supporting business case was discussed, however not progressed. Vacancy levels have been a contributory factor and recruitment between March and August has improved fill rate and reduced the gap required. Early indication from the current establishment review identifies opportunity to re-base staffing within the division.

3.1.4 Women, Children's and CCS Division

3.1.5 Maternity - Birthrate Plus

The principles of the Birthrate Plus methodology are consistent with recommendations in the NICE safe staffing guidelines for midwives in maternity settings and is endorsed by the Royal College of Midwives and Royal College of Obstetrics and Gynaecology. Of note, the methodology does not account for the increased responsibilities of the perinatal services from CNST, the Three-Year Delivery Plan or recommendations for the Amos or Ockenden reports, both published in 2026. The tool assesses staffing requirements based on birth numbers, case mix and the acuity of women and babies. It supports safer staffing recommendations by aligning workforce capacity with clinical activity and complexity across the service. Trusts must be funded to the recommended Birthrate plus establishment to meet CNST compliance.

A Birth Rate Plus (BR+) assessment was completed in summer/Autumn 2025, with the final report received in January 2026, assessing the midwifery and maternity support worker (MSW) workforce. The report recommended reconciliation of existing templates alongside a 28.01 WTE uplift. The business case was agreed in August 2026 with funding from October 2026. The 28.01 WTE business case posts are exempt from the recruitment restrictions and being actively recruited to. There are a further 28.66 WTE vacancies across the service requirement recruitment (5% vacancy), comprising of registered midwives and MSW roles. The vacancy is likely to increase if Birthrate Plus business case roles are recruited to internally. Internal recruitment is being reviewed to fill the MSW roles.

The recommendations from BR+ do not include neonatal services or reflect the co-dependency within the tool and a further review is required to evaluate the implications for neonatal services.

3.1.6 Neonatal All sites

There has been a significant improvement in neonatal nursing vacancies over the past 12 months. The neonatal nursing workforce trajectory includes both registered staff (Bands 5–7) and unregistered staff (Band 4), reflecting that both groups contribute to the clinical staffing numbers required to safely deliver ITU/HDU and SCBU care. The service vacancy rate is currently 8.9%. Vacancy levels are higher at Worthing (13%), due to the internal promotion of a Band 7 post, which generated a subsequent Band 6 vacancy, in addition to a Band 5 vacancy. TMBU Band 6 Qualified in Specialty (QIS) has increased to ~50% (national recommendation is 70% of qualified workforce is to be QIS) with a further two staff expected to complete their QIS qualification by January 2027. An additional seven staff commenced their final QIS module in September 2026, while seven staff enrolled on the SCBU course in June 2026. Opportunities to further strengthen the QIS workforce are being explored, with up to 10 additional staff potentially commencing training through TVW Southampton, subject to university confirmation.

Neonatal services provide quarterly (January/April/July/October) workforce returns to their relevant Operational Delivery Networks (TVWODN and KSS ODN). These returns provide essential assurance on safety, standards compliance and service sustainability, while also supporting regional workforce planning, investment decisions and national reporting requirements.

3.2 Recruitment and Retention

Recruitment

Between March 2026 and September 2026, external offers were made to 95 Band 5 Registered Nurse and ODPs. These offers comprised of newly qualified students and experienced nurses joining from other organisations. Internal recruitment of 54 nurses has been through our own Registered Nurse Degree apprentices and internationally educated nurses progressing internally from Band 3 Healthcare Support Worker roles following successful OSCE completion and NMC registration. The vacancy rate as at September 2026 for Band 5 nurses is reported as 5.48%.

For the same period Band 2/3 Healthcare Support Worker we offered to 72 externally and internally 19, with a vacancy rate in September of 9.72%. We did see a reduced talent pool briefly due to the changes to the government sponsorship, which came into effect in April 2026. However, following the pay increase this appeared to resolve.

We remain in contact with the Department for Work and Pensions in order to maintain a partnership although they are aware that we are currently not looking to recruit.

Retention

Registered Nurse retention remains stable at 3.2% (Sept 2026) against the Trust target of 6.51%. Similarly for unregistered staff at 6.4% against the Trust target of 7.84%. The aim of the Retention Workstream is to improve retention by listening to staff, strengthening support and career development, enabling a more stable workforce and better patient outcomes.

Over this reporting period the workstream have focused on listening events with our Band 5 nurses with plans to reach out further to hear from this, our largest group of nursing staff, understand the feedback and formulate our actions.

The workstream has also supported a review of the Induction Policy which sets out clear guidance for all managers on the time required for mandatory STAM and Trust induction and the expectation for supernumerary time. This has been reviewed by the specialisms, and the Divisional Directors of Nursing have approved the revised supernumerary periods. Additionally, the Practice Development Team are working on specialty road maps which will direct staff to what training is required at what stage. These will be added to IRIS.

The Healthcare Support Worker Advocate (HCA Advocate) pilot has also been an area of focus over this period. The role purpose is to act as a peer supporter and role model for HCAs and unregistered learners, prompting professional standards, development opportunities and the HCA voice. We currently now have 85 HCA Advocates across the Trust who have attended the introduction workshop. The final HCA workshop was held on 9th October.

The Professional Nurse Advocate (PNA) is a subset to the retention workstream. PNAs create protected space for reflection, help staff manage stress and moral injury and strengthen professional voice, which ultimately supports a healthier workforce and better outcomes for patients. The aim is to increase UH Sussex PNA numbers to meet national required standards, improve wellbeing, engagement and retention. The target which is set nationally is a ratio of 1:40. We currently have a ratio of 1:73.

3.3 Fill rate

Charts 3 to 6 present the average staffing fill rates for both registered and non-registered nursing staff across day and night shifts from March 26 to Sept 2026.

For registered nurses and midwives during day shifts, the average fill rate has remained stable at 93% over the reporting period. Non-registered care staff day fill rates showed an overall upward trend, rising from 87% in March to 93% in September. This improvement reflects targeted recruitment activity and improved workforce deployment of Healthcare Support Workers.

Registered nurse/midwife night fill rates remained consistent at 94% between June and September, increasing overall from approximately 92% in February 2025 to 96% in March 2026. Non-registered night fill rates remained consistently high, following a reduction to 94% in April 2026, rates remained stable at 94% through July before increasing to 95% in August and 96% in September, indicating sustained and improving overnight coverage. Overall, these trends demonstrate sustained workforce stability across registered and non-registered roles, with improving fill rates among non-registered staff and consistently strong coverage maintained across both day and night shifts.



Chart 3-6 – Average fill rates for Reg Nurses and Non- registered (HCA)

3.4 CHPPD

Care Hours Per Patient Day (CHPPD) is the national measure used to assess workforce deployment within inpatient ward settings. Introduced nationally in 2016, CHPPD enables organisations to monitor staff deployment over time and benchmark against comparable wards and peer organisations. It supports workforce planning, establishment and skill-mix review and identification of variation in staffing deployment. CHPPD should be considered alongside relevant quality and safety indicators to support assessment of whether staffing deployment is appropriate to patient need and to inform delivery of safe, high-quality care.

From April 2026, maternity services, NICUs, children's inpatient areas and intensive care areas have been incorporated into the Trust's CHPPD reporting. This has resulted in an increase in the overall Trust CHPPD to 9.4 and provides a more comprehensive measure of workforce deployment, supporting more meaningful benchmarking with comparable organisations.

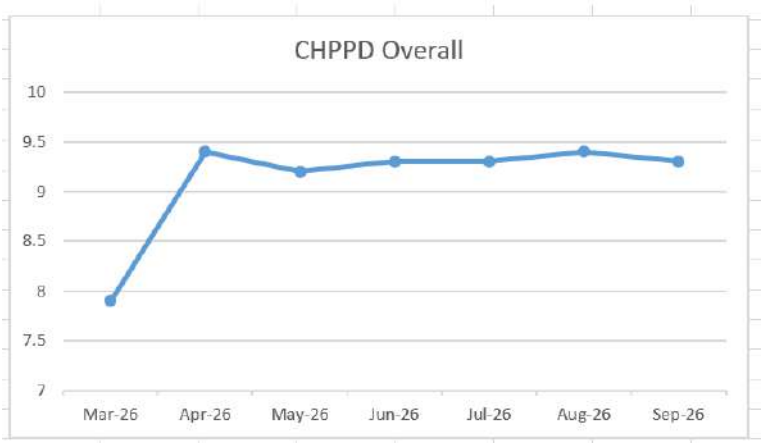


Chart 7- Overall CHPPD

4. Expectation two – the right skills

4.1 NMAHP Workforce Development and Education

Building on last year's progress, the Nursing, Midwifery and Allied Health Professional (NMAHP) Education Teams have continued to develop comprehensive career pathways across University Hospitals Sussex. Over the past year, the focus has been on increasing staff awareness of development opportunities and enhancing the quality of the learner experience through the triangulation of education, patient safety, learner feedback and patient experience data. These pathways ensure that clinical staff can access high-quality education and apprenticeship routes, supporting progression from Healthcare Support Worker through to Registered Nurse, Midwife or Allied Health Professional and onward into advanced practice roles underpinned by continuing professional development.

4.1.1 Healthcare Assistant Development

During the past year, our Healthcare Assistants have successfully transitioned from Band 2 to Band 3. The NMAHP Education Team has supported this uplift by facilitating the extension of skills in clinical practice and formalising further development pathways. This has improved retention and strengthened the role profile, diversity and calibre of the HCA workforce.

4.1.2 T Level Partnership and Workforce Pipeline Development

The NMAHP Education Team has continued to strengthen its partnership with local education providers to develop sustainable workforce pipelines into healthcare careers. Building on the established collaboration with Chichester College Group, the Trust has expanded opportunities for T Level Health students to undertake high-quality clinical placements across UH Sussex. These placements provide young people with meaningful exposure to healthcare careers while enabling the Trust to identify and nurture future talent at an early stage. The T Level placement induction and placement experience curriculum is designed to develop the competencies required of Band 3 Healthcare Assistants, creating a valuable pipeline of work-ready candidates for support workforce roles.

In parallel, the Trust continues to develop apprenticeship and Nursing Associate pathways, providing opportunities for existing healthcare support workers to progress their careers whilst remaining in employment. These structured pathways support workforce retention, career development and succession planning, enabling staff to progress from Healthcare Assistant roles through to Nursing Associate and onto Registered Nurse careers. This approach supports the Trust's ambition to "grow our own" workforce, strengthening local recruitment, widening participation and improving workforce sustainability.

Together, these initiatives create an integrated workforce pipeline from education into employment and professional registration, supporting the future supply of skilled nursing support workers and registered professionals while reinforcing the Trust's role as an anchor institution within the communities it serves.

4.1.3 Preceptorship

The Trust continues to provide Preceptorship modules for Nurses, Nursing Associates, Midwives and AHPs. The modules support newly registered professionals as they transition into their roles, helping to build confidence, competence and a sense of belonging within the organisation.

Engagement with preceptorship study days remains high, with very positive evaluations from preceptees, educators and managers. Feedback demonstrates the value placed on the modules and the support they provide during this important stage of professional development. From autumn 2026, nursing preceptees are also being offered the opportunity to gain academic accreditation at Level 6 or Level 7 through their engagement with the module.

The Trust's multi-professional Preceptorship provision continues to hold the NHS England National Preceptorship Quality Mark, providing recognition of the Trust's established approach to supporting newly registered professionals.

4.1.4. Continuous Professional Development (CPD)

The Trust’s academic partnership with the University of Chichester has successfully completed its first year. Annual partnership monitoring has demonstrated a positive impact on staff development and retention within their professional roles with over 350 staff completing one or more of the modules offered. Additional in-house modules have now been accredited, resulting in cost savings for the Trust by reducing reliance on externally commissioned programmes. Work has also commenced on reintroducing a credit transfer scheme with local universities and developing academic awards such as post graduate certificates and masters.

Following the launch of the Trust Education Plan, continued investment in the educator workforce has strengthened the academic development and mentoring support available to educators across the organisation.

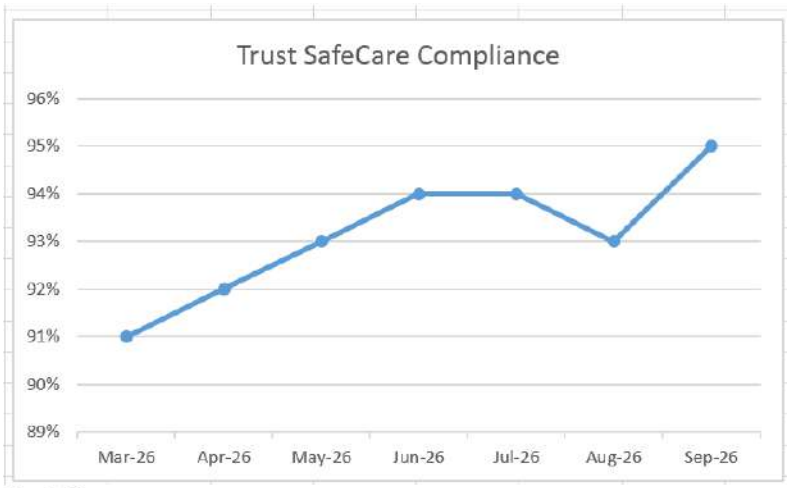
For 2026/27, NHS England provided £1.9 million in Continuing Professional Development (CPD) funding for Nursing Associates, Nurses, Midwives and Allied Health Professionals (AHPs). This funding has supported specialty qualifications, leadership programmes and a wide range of clinical and professional development opportunities. Governance of CPD has also been strengthened through enhanced quality assurance reporting and the introduction of revised study leave and study funding policies. Access to learning resources has been expanded through

investment in Knowledge and Library Services, including additional electronic resources, improved search functionality and enhanced study skills support.

5. Expectation three - the right place and time

5.1 SafeCare

SafeCare live (acuity and dependency staffing tool) is the clinical workforce management tool used across the Trust to help match staffing levels to real-time patient care needs by measuring patient acuity and dependency and comparing those needs to available staff on the ward or unit. Throughout 2025, SafeCare was embedded as the primary tool to support safe staffing deployment, alongside the application of professional judgement. SafeCare compliance has remained consistently high, increasing from 91% in March to 95% in September 2026, representing the highest compliance level in the period and an overall 4 percentage-point improvement since March.



Graph 8

5.2 Red Flags

Targeted training was delivered during 2025 on the appropriate use of red flags within the SafeCare tool. Red flags identify potential risks to patient safety and provide a prompt for timely escalation and review by the Matron. During 2026, the training focus has shifted to ensuring that red flags are acknowledged, appropriately actioned through resolution or mitigation, and documented within SafeCare. This supports proactive identification of emerging concerns and enables timely implementation of mitigating actions to support the delivery of safe care.

Red Flags	Sep-25 Number raised	Actioned	% actioned	Mar-26 Number raised	Actioned	% actioned	Sep 26 number raised	Actioned	% actioned
Less than 2 RNs per shift	169	36	21.3	100	50	50	7	3	42.8 🔴
Missed intentional rounding	1046	246	23.5	332	166	50	176	173	98.3 🟢
Shortfall in RN time	2896	574	19.8	1952	1103	56.5	294	225	76.5 🟠

Unplanned omission in providing medication	165	82	49.7	17	5	29	19	18	94.7
Vital signs not assessed or recorded	550	136	24.7	244	151	61.8	69	67	97.1
Delay 30 mins or more in providing pain relief	701	137	19.5	156	88	56.4	56	53	94.6
Totals	**5527**	**1211**	**21.9**	**2801**	**1563**	**55.8**	**621**	**539**	**86.8**

Table 9

Table 9 demonstrates a significant improvement in red flag management. The number of red flags raised reduced by 89%, from 5,527 in September 2025 to 621 in September 2026, while the proportion actioned increased from 21.9% to 86.8%.

By September 2026, four of the six red flag categories had actioning rates above 94%, providing assurance of improved responsiveness to identified patient safety risks. Shortfall in RN time remains the main area requiring continued oversight, with 76.5% of flags actioned.

Overall, the data indicates that the 2026 training focus is supporting more timely and proactive management of patient safety concerns.

5.3 Efficient Deployment and Flexibility

The Trust continues to embed a coordinated approach to workforce deployment, supported by e-rostering and centralised staffing oversight through SafeCare. This provides real-time visibility of staffing levels and supports timely redeployment to areas of greatest need in response to changes in patient acuity and demand.

Deployment data demonstrates sustained workforce flexibility across the Trust. Staff deployments increased from 5,659 in 2024 to 5,824 in 2025. A further 5,086 deployments have been recorded so far in 2026, demonstrating continued use of flexible workforce deployment to respond to staffing pressures and service demand. As 2026 is not yet a full year, the figure should not be directly compared with the full-year totals above.

5.4 Agency and Bank Reduction

5.4.1 RN Agency reduction

Agency usage is subject to weekly review through the Agency Control Meeting, with the aim of achieving full exit. As demonstrated in chart 10, there has been a continued sustained reduction in weekly RN agency shifts. All agency shifts require Divisional Director of Nursing (DDoN) or Director of Midwifery (DoM) sign-off. Access to create agency shifts on HealthRoster has also been restricted to authorised approvers only, supported by the Temporary Staffing Office (TSO), strengthening oversight and supporting the Trust to become agency-free.

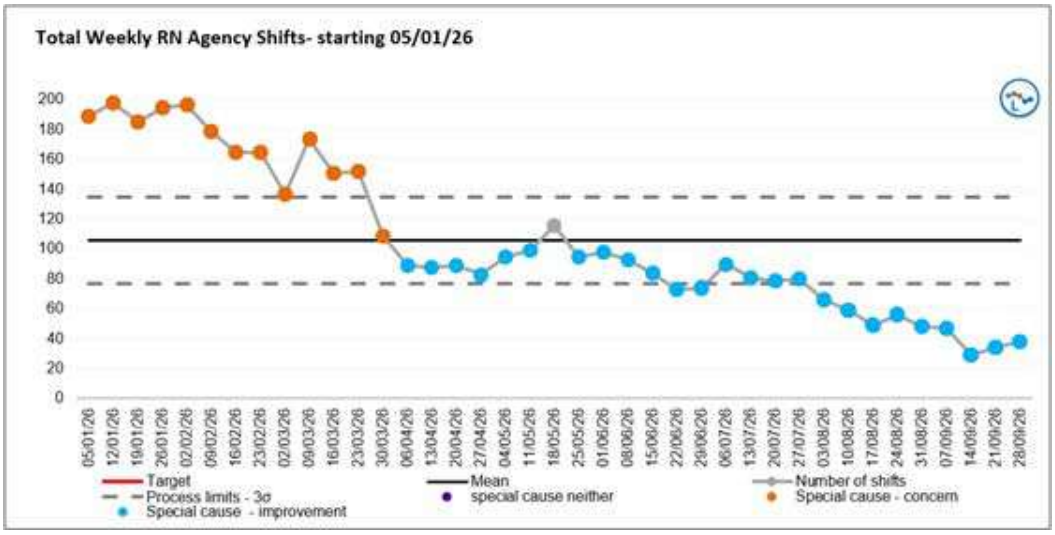


Chart 10 – Agency Shifts

5.4.2 RMN usage

There has consistent improvement in the reduction of RMN agency use, with a clear focus on risk assessing Enhanced Therapeutic Observations of Care (ETOC), with a shift to ensuring RMNs are only provided to the patients who need them. Overall, the trend from March 2026 indicates a gradual reduction in reliance on agency staffing. This improvement is likely associated with targeted recruitment activity of ECSWs, increased HCA fill rate, improved rostering practices and strengthened workforce controls. Departments have been working hard to manage patients who require additional care needs with the appropriate level of staffing and where possible by working differently to monitor patient safety within the establishment without additionality (chart 11). Continued monitoring of these trends will support the Trust in maintaining safe staffing levels while reducing dependency on agency staff and associated financial pressures

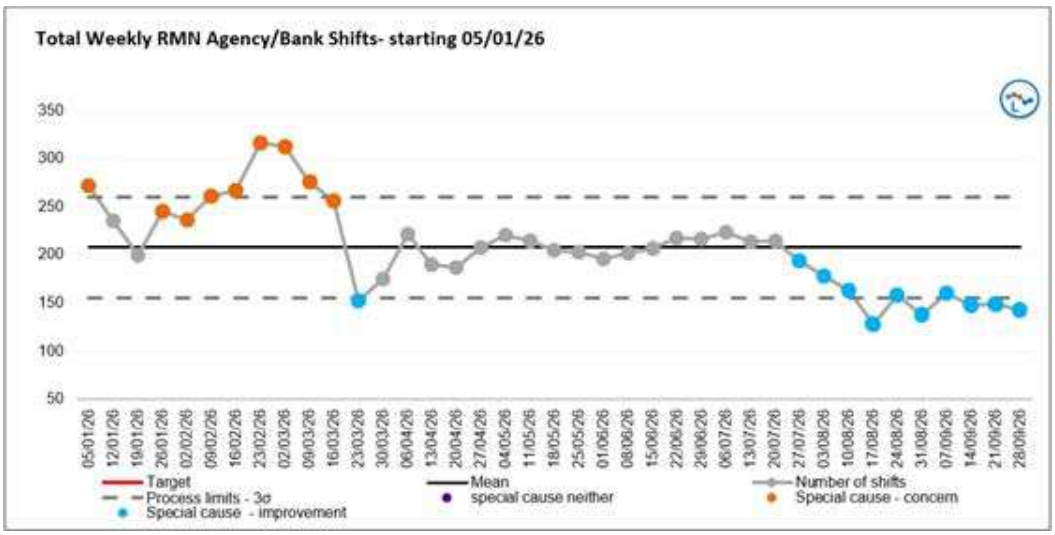


Chart 11 – RMN Agency Shifts

5.4.3 Bank Deployment

Since the start of the financial year there has been an overall reducing trend in Bank registered nurses and midwives as seen in (chart 12). More improvement is predicted as newly qualified nurses and midwives are being onboarded in October/November. Enhanced controls have been added to the rosters with Head of Nursing approval for all bank shifts registered nurses and HCAs. Bank KPIs are set for all departments and agreed by the senior nursing leadership, theses KPIs are set monthly and monitored weekly as part of the control meeting.

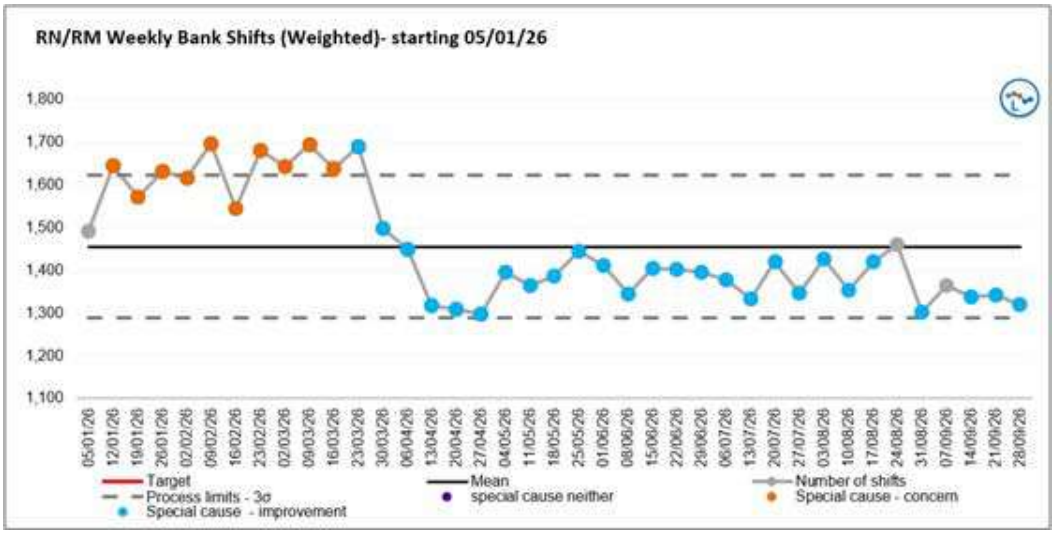


Chart 12 – RN/RM bank

HCA bank has seen a reducing trajectory throughout the year (Chart 13). This improvement is likely associated with increased HCA fill rate, improved rostering practices and strengthened workforce controls. Departments have been working hard to manage patients who require additional care needs with the appropriate level of staffing and where possible by working differently to monitor patient safety within the establishment without additionality.

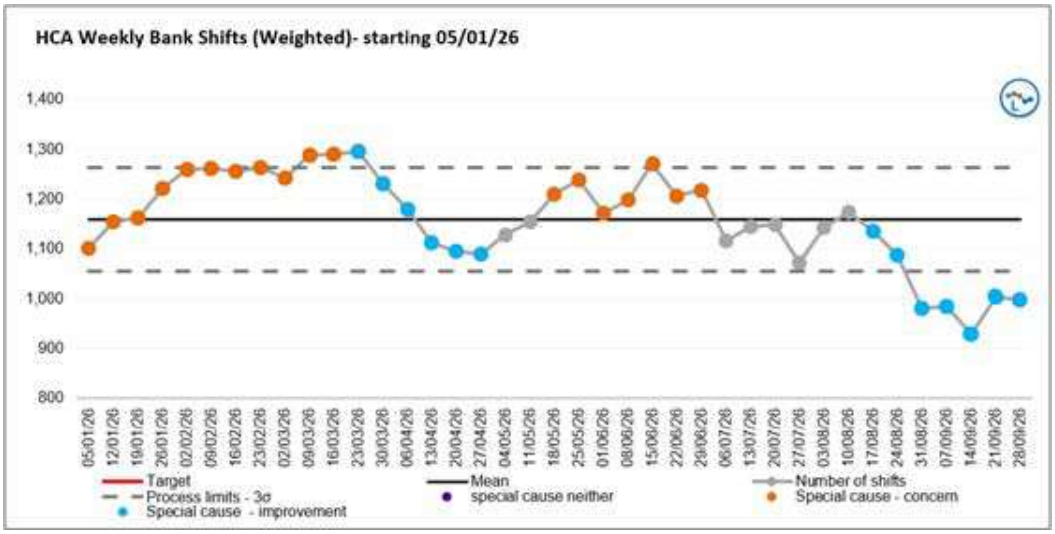


Chart 13 – HCA Bank

A focus on overtime has seen an overall reduction in the numbers of overtime hours worked by registered nurses, ODPs and HCAs. Activity is monitored through grip and control measures overseen by the Deputy Chief Nurse for Workforce and Divisional Directors of Nursing. Tighter controls around booking overtime have been applied at divisional level adhering the overtime approval process agreed as part of Nursing and Midwifery Steering Group.

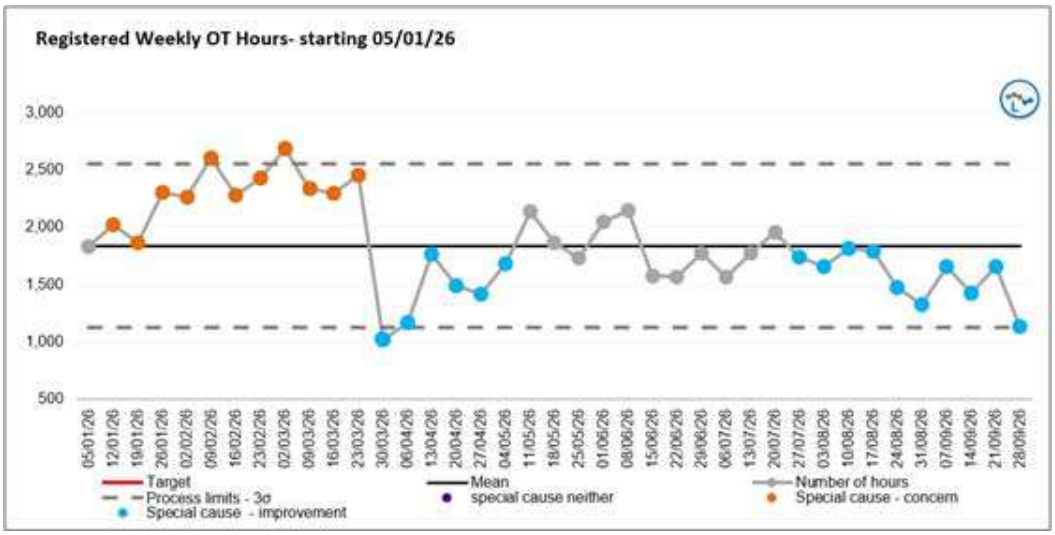


Chart 14 – Registered Nursing Overtime (Hours)

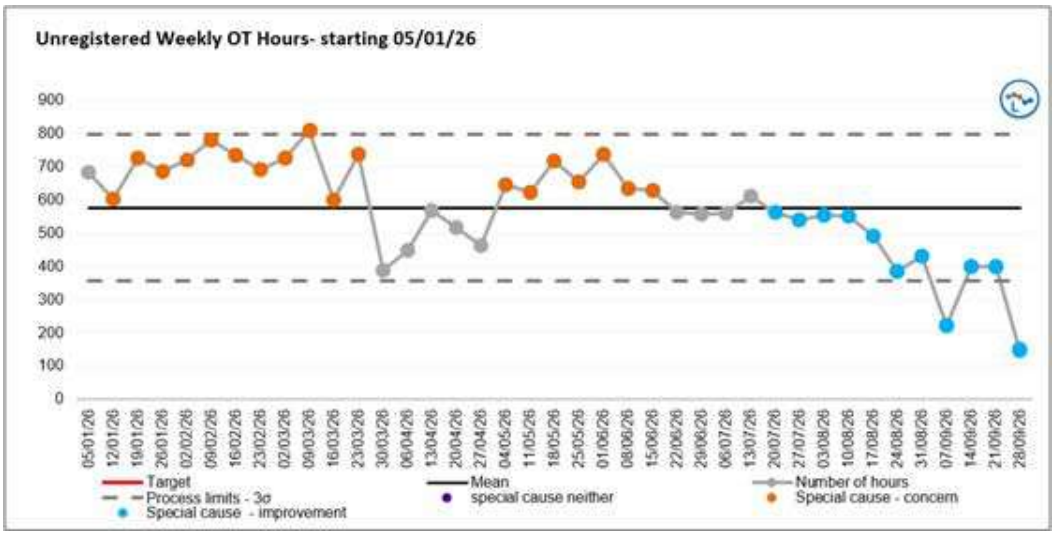


Chart 15 – Unregistered Nursing Overtime (Hours)

6. Uplift and Supervisory Time

- Variation remains across UHSussex regarding budgeted uplift, 20.5% headroom at the Royal Sussex County and Princess Royal sites and 23.16 % at Worthing and St Richard's.
- Ward managers supervisory time across the legacy organisations is varied.

7. Request to the Board of Directors

- Note the report and the processes in place to monitor and maintain safe staffing levels.
- Receive assurance that appropriate governance arrangements and escalation mechanisms are in place to support safe patient care.
- Acknowledge the variation across UHSussex regarding budgeted uplift, ward managers supervisory time and that there are plans in place to address this.
- Note the improving fill rate and reduction in agency and temporary staff deployment
- Note that establishment reviews are currently underway.