University Hospitals Sussex
NHS Foundation Trust

Developmental well-led review

University Hospitals Sussex NHS Foundation Trust

July 2025
Final report

niche
HEALTH & SOCIAL CARE CONSULTING

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Conveyed to:
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Our Final Report has been written in line with the Terms of Reference for the developmental well-led review. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

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1 Introduction

Background and scope

1.1 Niche were commissioned in December 2024 to undertake an independent developmental review using the well-led framework at University Hospitals Sussex NHS Foundation Trust (UHSx, or 'the Trust). We were commissioned by the Trust Board, and our scope was to assess the Trust against the eight '*we statements'* included in the updated guidance[1].

1.2 Our work took place between January and May 2025.

Method

1.3 To fulfil this scope, we:

- Undertook a comprehensive desktop review of key strategies, policies, action plans and meeting minutes and papers.
- Analysed the results of a survey[2] previously issued to all members of the Board (circa November 2024), assessing the well-led domains. 18 Board members completed the survey. Responses are split between non-executive directors and executive directors in the resultant charts in this report.
- Analysed the results of a survey also previously issued to all members of the staff at the Trust, assessing the well-led domains. The survey was completed by 1192 members of staff, of which 648 were in clinical roles, and 544 in non-clinical roles. This represents 7% of the 17,352 whole-time equivalent staff employed by the Trust.

  Surveys x-axis key

SA	**Strongly agree**
A	Agree
SIA	Slightly agree
SID	Slightly disagree
SD	Strongly disagree
CS	Cannot say

  Benchmarking analysis comparing UHSx to other Trusts has been included, which is identified by the blue line (B - Clinical) and green line (B- Non-Clinical) on the graphs. Benchmarking analysis was unavailable for some recently added questions.

- Conducted clinically-led visits to all seven hospital sites, to speak to staff and to find out what it is like to work at UHSx.
- Conducted focus groups with: a sample of governors, non-executive Board members, each Hospital Leadership Team, a sample of the Trust's divisional leadership teams, a group of consultants, and a sample of clinical directors.
- Conducted 'drop-in sessions' for staff who were unable to speak to us while we were onsite.

[1] https://www.cqc.org.uk/guidance-regulation-nhs-key-question-well-led

[2] Both the Board and the staff surveys were run by another provider and Niche did not have access to the raw data returned.

- Observed a sample of key meetings, including the Board of Directors.
- Undertook a range of interviews with the Trust's senior leaders, including those in executive roles, the Trust Chair, divisional leaders and those whose portfolio touches directly on the well-led framework 'we statements'.
- Interviewed 12 representatives from the Trust's external partners, including from the Care Quality Commission (CQC), NHS England, Healthwatch, the Integrated Care Board (ICB), other NHS provider organisations, higher education and local authorities.

1.4 In total we spoke to around 200 people directly as part of this review. We would like to thank everyone who made the time to contribute so openly and generously to our work.

Structure of this report

1.5 This report contains chapters on:

- Our executive summary and recommendations made
- Each well-led framework 'we statement', namely:
  - Shared direction and culture
  - Capable, compassionate, and inclusive leaders
  - Freedom to speak up
  - Workforce equality, diversity and inclusion
  - Governance, management and sustainability
  - Partnerships and communities
  - Learning, improvement and innovation
  - Environmental sustainability
- A glossary of acronyms used throughout the report.

1.6 The well-led framework, which was updated in April 2024, is expansive and covers many intersecting topics. To support the readability of this report and to ensure that its key messages are clear, we have used cross-references where possible and sought to avoid duplication of similar themes.

2 Executive summary

Context

2.1 University Hospitals Sussex (UHSx) was formed in April 2021, in the midst of the COVID-19 pandemic, from two legacy organisations: Brighton and Sussex University Hospitals NHS Trust (BSUH) and Western Sussex Hospitals NHS FT (WSHFT). The merger formed one of the largest trusts in the country, employing nearly 20,000 staff across seven hospitals in Sussex, with an operating budget of more than £1 billion annually. Its populations and their health needs are diverse, from Brighton to Chichester.

2.2 The Trust is facing many challenges which are important for the context of this report:

- Having taken place during the pandemic, the merger remains yet to be fully realised. For example, information systems remain disparate and staff terms and conditions are still to be fully standardised.
- Despite some recent improvements, operational performance at the Trust benchmarks poorly in many areas, particularly referral-to-treatment (RTT) times and the urgent and emergency care standard at the Royal Sussex County Hospital.
- A significant financial deficit has been planned for 2025/26, which has been the subject of recent challenging discussions with the Trust's partners.
- There have been some critical recent external reviews of the organisation, including from the Royal College of Surgery (invited service review) and the CQC, who rated the Trust as 'inadequate' overall for the well-led domain. A further CQC inspection took place at Brighton and Worthing in March 2025; the resultant report is not yet available.
- The Trust continues to respond to *Operation Bramber*, which was launched in 2023 by Sussex Police following two instances of whistleblowing in relation to clinical practice in neurosurgery and general surgery. This is leading to a high degree of media scrutiny on the organisation and its leaders.

2.3 This review was commissioned, in part, to gain an external perspective on the extent of progress and improvement made against this challenging backdrop.

Key findings

2.4 UHSx was formed from two very different legacy organisations which had highly distinct organisational cultures and leadership norms and styles. The COVID-19 pandemic, as well as the scale of operational challenges the Trust is responding to, has greatly delayed the realisation of the merger in practice.

2.5 As a result, the organisation currently feels like a collection of hospitals, each with distinct legacy identities, rather than a single trust. A strategic ambition to become 'One UHSx' has been stated in the new Trust Strategy, and there needs to be a realism among the organisation and its partners that this will take some years to become a reality.

2.6 Within this context, the current leadership of the Trust has been able to make some notable improvements. For example:

- There have been significant reductions in the RTT waiting list, and the list of patients waiting for more than 65 weeks for treatment.
- Cancer diagnosis and treatment standards are much improved from historic performance levels.
- Improvements in Maternity care have been sustained (in terms of patient outcomes, experience and staffing levels) since the CQC inspection in 2022.

2.7 At a strategic level, there have been several changes to the Board and executive team membership over the last 18-24 months, which have provided a more stable base to reset the vision for the organisation. At the time of writing, the Trust Strategy is going through Board ratification processes, and this document will be key in determining and guiding the next steps for the organisation.

2.8 The Executive Team, led by the Chief Executive Officer (CEO), has made significant efforts to reset the reputation of the Trust with its external stakeholders and has sought to improve relationships with partners. This has been challenging given the nature of the difficulties faced by the Trust, as well as the system's financial position, but those we spoke to externally were able to recognise the positive intent in this area.

2.9 These steady improvements are leading to cautious optimism among some internal and external stakeholders, who were keen to underline to us that things in the Trust are slowly getting better, and that what is now needed is time and longevity of leadership to enable this. In support of this, we tended to find strong levels of awareness about what some of the Trust's key improvement areas are, and how the organisation is working to drive these.

2.10 Culture change and compassionate leadership which engages staff in the future of the Trust will be fundamental to driving these changes. Despite some notable practice we observed in relation to culture mapping for example, we were left with the impression that significantly more focus is needed on organisational culture, at every level, if the required changes are to be driven and sustained.

2.11 There are several presenting and notable issues with culture in the Trust. These have all been identified previously – either by the organisation or through other external reviews. We were unconvinced, however, that sufficient prioritisation, pace and resource has been given to making the required improvements. In this we include:

- A lack of an overarching, single 'Trust' culture. There are several legacy cultures and a pervasive 'othering' of different parts of the organisation. This presents specific challenges in relation to how the Board communicates cogently with colleagues across the organisation.
- Significant issues with psychological safety at every level. People do not feel universally able to raise concerns or speak up, which is causing a detriment to team effectiveness throughout the organisation. This also has the potential to be corrosive to patient safety, and the impact of this is currently unknown (i.e. what has not or is not being reported, and what is the impact of this?).
- Despite some notable improvements in parts of the organisation, such as the Women's and Children's division, incivility and poor behaviours appear to be pervasive in several areas, and there is a strong view that these are tolerated by leaders. Many people have become inured to these stories over time, such that they have become accepted as 'normal'. Linked to this, a theme emerged around gender dynamics, particularly women in some areas and roles reporting that they feel psychologically unsafe in their working environment; this has been insufficiently recognised and acted upon, even when reported.
- There is a disconnect between the Board and clinical leaders, and the nursing voice in the organisation does not always receive sufficient attention.
- A paternalism between the executive and senior leadership of the organisation in several areas, which was often described to us as a "*parent-child dynamic*".

2.12 We heard of tensions at Board and executive level, particularly in 2023 and 2024, which seem to have been distracting. This situation, broadly speaking, is improved. It is key that healthy relationships at this level are maintained to create resilience and mutual support among the most senior leaders in the organisation, so that the challenges we describe can be met with unity and determination.

2.13 In terms of its governance structures and processes, the Trust is at an inflection point in many areas. The emergent strategy has given the opportunity for the Board to reflect on its key priorities

and what it will be actively seeking to drive. Agendas, committee workplans, key performance reports and the Board Assurance Framework (BAF) are currently being reviewed in light of these updated priorities.

2.14 The Board should also seek assurance that these are being reflected throughout divisions and directorates, to support a 'golden thread' of focus. This is especially key given the scale of the organisation, which means that the Board's line of sight into services is impeded without consistency in its approach to governance.

2.15 Likewise, the Clinical Operating Model (COM) – a core part of how the Trust functions – is currently under review. This presents an opportunity to simplify accountabilities and clarify decision-making, but also to reset the tone of how the executive wants to work with the Trust's most senior leaders, with a focus on ensuring mutual support and healthy challenge. Co-production in the COM will be key to its successful implementation.

2.16 The Patient First Improvement System (PFIS) is the final pillar of the organisation's governance fabric which we suggest requires review. Having been implemented with great success at WSHFT, PFIS has now lost momentum and has not launched successfully or uniformly in the enlarged organisation. There is a significant disparity in views around how this should be taken forward, but a clear decision is needed. We would recommend that the approach taken should be one which supports simplicity, maximum engagement and underlines the desired culture which the Board is seeking to drive.

Next steps

2.17 How the Board responds to this report will be key. We have sought to describe the nuanced and complex environment the Trust's leaders are working in, and to describe the various improvements made in this difficult context. While the difficult messages we describe will not themselves be new to the Board, we have sought to triangulate them in a way which emphasises the scale of work left to do on the Trust's culture. Without a relentless focus on transforming this, the upcoming work on the strategy, COM and quality improvement will be significantly impeded.

2.18 To do this, it is key that all Board members role model a problem-sensing culture and signal strongly to the organisation that it is listening and acting.

Recommendations

2.19 We have made 22 recommendations:

Recommendation 1 Prioritise and expedite the work to embed the Trust values and build these into all people processes (such as recruitment, development, appraisal, job planning and raising concerns processes). Make explicit how behaviours not in line with the Trust values will be dealt with, regardless of seniority or role.
Recommendation 2 Clarify the timescale and process for updating supporting plans to align these to the new strategy. This includes: the Delivery Plan, all underpinning strategic plans (including clinical, estates, workforce), and the process for ensuring that these will be coherent and mutually supportive of each other.
Recommendation 3 Review the draft Strategy in light of the findings of this report and its recommendations, to identify any areas where remedial work may be required and how the strategy can support this.
Recommendation 4 Agree as a Board how assurance will be sought about the organisation's culture, and particularly in light of thew findings within this report. Consider: • Introducing staff stories at Board meetings. • How existing intelligence (such as the culture heat maps) can be used to better affect to improve Board insight. • How to drive a 'problem-sensing' approach to culture within the Board environment. • How the Board will continuously review its role in setting the tone at the top of the organisation.
Recommendation 5 Introduce 360 feedback into Board member appraisal processes. Where relevant, this should include feedback external to the Board, including from stakeholders and senior leaders. The process should align to the refreshed vision and values.

Recommendation 6 Agree how relationships will be developed between the executive (and wider board) and the Top 70 Trust leaders, with a focus on building mutual trust, and balancing challenge and support in performance conversations. As part of this, discuss explicitly the perceptions around paternalism in the Trust's culture.
Recommendation 7 Agree how learning from good practice and excellence in the Trust can be adopted. For example, appreciative enquiry into how changes in maternity were able to be made, and how this can be adapted into challenged parts of the organisation.
Recommendation 8 The risks of clinical leadership accountability models are potentially high and all aspects of this must be considered through a proper evaluative process. Ensuring the right people with the right training are fulfilling the most appropriate roles is key.
Recommendation 9 Benchmark the Trust's People directorate (to include HR and OD) to understand how its resourcing compares to trusts of a similar scale and complexity. The recent merger during the pandemic needs to be factored into decision-making arising from this process.
Recommendation 10 Use a forthcoming Board development session to reflect on the findings within this report in relation to discrimination, and initiate discussions about the Board's role in leading a more visible campaign to tackle this across the Trust.
Recommendation 11 As part of the annual reviews of committee effectiveness and terms of reference, consider the feedback relating to each Board committee in Chapter 7 of this report. All committees need to ensure that reports submitted clearly identify the material issues, areas of key risk, and action requested from the committee.
Recommendation 12 Any redesign of the COM needs to be coproduced with those involved in implementing it successfully. The review underway needs to have a key focus on the behaviours, attitudes and operating principles required to make the new model work week. See also Recommendation 6.

Recommendation 13

As part of the review of the COM, evaluate the efforts to standardised approaches to divisional governance meetings after six months.

Recommendation 14

Further develop the emerging quality impact assessment process to include training and support for divisions, as well as how the Trust will undertake post-implementation reviews of efficiency schemes for any adverse quality/equality impacts.

Recommendation 15

Refresh the Board Assurance Framework's strategic risks. Ensure that the Board's subcommittees have routine and robust oversight of these, seeking assurance around risk management and reduction where possible.

Recommendation 16

Consider whether the Trust has appropriately calibrated its response to how technology will underpin the success of its new strategy. This should include a review of leadership structures, capacity and the Board's line of sight to the management of associated risks.

Recommendation 17

Simplify the strategic deployment reviews to focus on:

- The mutual review and discussion of key priorities for each division (this should also encompass corporate support functions).
- The agreement of next steps and any support required.
- The identification of any cross-trust issues requiring executive intervention.

See also recommendations relating to shared ways of working.

Recommendation 18

Service changes implemented as part of the Strategy Delivery Plan must be co-produced with patients, and specific attention given to potential health inequalities.

Recommendation 19

Work with partners to plan (together) a series of cross-system strategy sessions in 2025/26 in order to develop longer-term and sustainable care models. These will need:

- Executive and clinical contribution,
- Learning from established and mature systems,

and may benefit from external facilitation.

Recommendation 20

Agree a corporate approach to improvement, which reflects the feedback in this report. The approach taken should be supportive of the culture the Trust is seeking to drive, and build on existing strengths. We would suggest that a model which enables local, grassroots engagement, and feels intuitive to the widest group of staff would be helpful.

Recommendation 21

Review the safety culture of the Trust in full in light of the findings in this report in relation to psychological safety and wider organisational culture.

Recommendation 22

Agree and re-confirm, as a Board, the level of organisational commitment to the Green Plan (and wider Green agenda), the realistic goals aligned to this, and how they will be monitored. Re-confirm this to staff and clarify how they can contribute to these goals.

3 Shared direction and culture

This means: ***We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.***

The trust has an aspirational vision and a statement of values, with a realistic strategy and robust plan for delivery with clear objectives and timescales. These have been produced together with people who use the trust's services, staff and system partners.

Strategy development

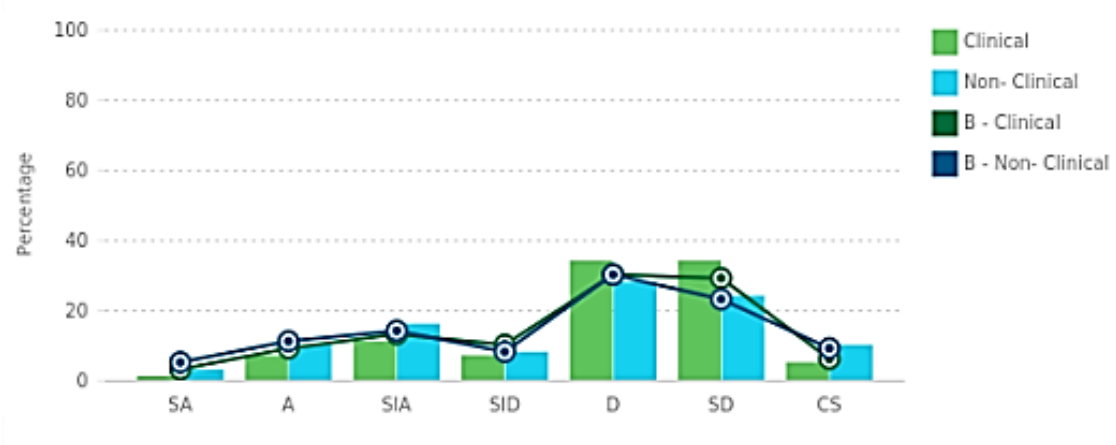
3.1 The Trust's strategy (*Excellent Care Everywhere* – Trust Strategy 2025-30) is currently in development. The Board has, at the time of writing, agreed the strategic vision, the five ambitions of the strategy and 20 'areas of action'. In developing the strategy, Trust leaders have:

- Reviewed a relevant evidence base, including national benchmarking data, Trust performance data, analysis from the Integrated Care System (ICS) Major Services Review, and local Joint Strategic Needs Assessments.
- Undertaken a listening exercise ('the Big Conversation') with staff, patients and the public. We understand that this work garnered around 12,500 pieces of feedback.
- Engaged with local partners in the Integrated Care System.
- Developed thematic priorities from these sources.
- Agreed the strategic direction and key deliverables through a series of Board workshops.
- Undertaken a final engagement exercise with stakeholders, including the ICB.

This process by which the strategy has been developed has been robust, and external stakeholders we spoke to generally felt that there had been opportunities for them to comment on its direction.

3.1 When we visited the Trust's wards and services, however, staff felt that they had not been engaged, despite the efforts through the *Big Conversation* process. This is reflected in the chart below.

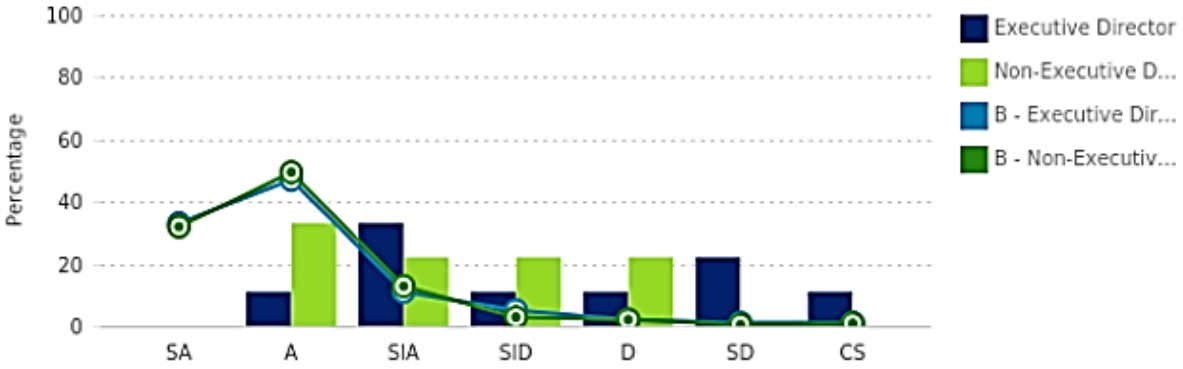
Fig 1. I have been engaged in the development and setting of the Trust strategy.



3.2 There was a sense from many staff and leaders that the development of this strategy has taken a long time given that the merger took place in 2021. We understand that this is due to some turnover in Board membership, and also because of a need to agree the role of Patient First (the Trust's improvement system).

3.3 This frustration with pace was also expressed by some Board members. During the board meeting we observed in April 2025 we also saw different expectations around the level of detail put forward in the draft strategy. This point is reflected in the survey analysis below:

Fig. 2 I am assured that there are appropriate plans are in place to support the delivery of the strategy covering areas such as: clinical strategy, workforce, patient experience, estates, digital and partnership working.



3.4 We understand that a Delivery Plan will be developed over the Summer, which clarifies the underpinning detail. This document will be key in guiding the work of the Board over the coming months (and years). This detail will also be important in ensuring that the strategy feels relevant to the local work of staff, and so that they can see how their area contributes to the overall direction of the Trust as 'one UHSx'. We discuss this further at Chapter 4.

3.5 The Trust has defined its values as *Compassionate, Inclusive and Respectful*. These have been re-emphasised through the new strategy. Board members reflected that the Trust values needed to be 'reinvigorated' and that the strategy presents the ideal opportunity to do this. There was a clear preference for them not to be changed, but rather, more emphasis on making them a reality for all staff. A key comment in this area was "*the values are the right ones… it's what we do with them that matters*."

3.6 During our engagement with staff, many did not know these values, and it was unclear how People or Human Resources (HR) processes in the Trust (such as recruitment, development and appraisal) are used to ensure that these values are lived in practice. This was a recent topic of discussion at the People and Culture Committee (P&CC). We frequently heard of some groups of staff behaving in ways which are explicitly at odds with these values, and explore this further at Chapter 4.

3.7 Early work has started to develop a behavioural framework to embed the values in practice, led by the Trust Board. It is important that, in taking this work forward, the findings and recommendations from this review are taken into account.

Recommendation 1: Prioritise and expedite the work to embed the Trust values and build these into all people processes (such as recruitment, development, appraisal, job planning and raising concerns processes). Make explicit how behaviours not in line with the Trust values will be dealt with, regardless of seniority or role.

The trust's strategy and plan considers the wider local and national context.

3.8 As outlined above, reviewing the local evidence base, and consulting with ICS partners have been key steps in the development of the strategy. Several relevant risk factors are identified, including:

- delayed transfers of patient care
- unwarranted variation across different parts of the Trust
- a need for longer term financial sustainability planning, including income generation

- the need to create a sense of ‘one team’ across UHSx staff groups
- a need to create an open safety culture

3.9 The strategy does not incorporate the action plans to address all of these, nor is this the purpose of this document. More granular plans will now need to be developed to map out this work, and we propose that the Delivery Plan is the starting point for this, as is the development of a suite of clear underpinning strategies.

3.10 We note various risks presented in the 2025/6 financial plan and BAF which are not fully reflected in the strategy. This is to be expected, given the broad audience for which the Strategy must be accessible, as a public document. The supporting detail, risk and mitigation plans will now need to be considered in the Delivery Plan, and the overseeing governance framework.

Recommendation 2: Clarify the timescale and process for updating supporting plans to align these to the new strategy. This includes: the Delivery Plan, all underpinning strategic plans (including clinical, estates, workforce), and the process for ensuring that these will be coherent and mutually supportive of each other.

Staff feel positive and proud to work in the trust. They understand the vision, values and strategic goals and their role in achieving them. Most staff are aware of, and demonstrate, the vision and values of the trust.

3.11 Given the emergent nature of the strategy at this stage, having only just been agreed, it is unrealistic at this time to expect all staff to know and support its vision and goals, although this should remain the ambition.

3.12 The concept of ‘shared vision’ is particularly important to this Trust, having formed in April 2021 (in the middle of the COVID-19 pandemic) from two legacy trusts, which were very different in terms of performance, cultures, quality improvement maturity, and reported leadership styles.

3.13 Those leading the merger at this time were doing so under the national restrictions in place linked to the pandemic, including social distancing, isolation and working from home. The health service nationally was under huge operational pressures at this time, from which it is still recovering. Equally, the long-term effects on staff working during this time (which involved trauma, moral injury and exhaustion for many) are still being researched. It is known, however, that all of these elements are at odds with the typical conditions necessary to enable a successful merger, including bringing colleagues together physically, and prioritising organisational development.

3.14 There remain strong allegiances to the former ‘east’ and ‘west’ services among staff, which is identified in the draft Strategy:

“Our culture enquiry identified persistent ‘othering’ in our culture - with people feeling positive about their own team but blaming problems on other teams or senior leaders.”

3.15 In particular, our service visits highlighted varying degrees of anger towards the former BSUH hospitals, with staff in the West tending to feel that these sites occupy most of the Trust’s time, attention and resources.

3.16 As a result, we found that: a) the merger has not been realised for many staff working in the Trust, and b) for many others, the merger has come to be associated with a time of loss and trauma. These factors present a particular challenge for the Trust Board is setting a strong, collective and positive vision for the future in the merged UHSx.

The trust has mechanisms to identify and address behaviours that are inconsistent with the values of the NHS. These enable staff to raise concerns without fear of reprisal or repercussions.

Inherited cultures and context

3.17 The Trust is aware of the need to improve its culture and an Interim Chief Culture Officer (CCO) was appointed in 2023 to support this work. In their 100 day report, the Interim CCO reported:

"There are cultural tensions and differences stemming from variations in work design, management approaches and historical practices… Challenges such as resistance to change, bureaucratic structures, disparities in resource allocation and access to decision-making may impede the integration process and require intervention."

3.18 Through our fieldwork, it became quickly clear that there is no single, coherent UHSx culture, nor shared understanding of whether or not this is the overall aim. This is summarised in the same report, which posits that:

"*The organisational culture at UHSussex is characterised by variation, underpinned with a commitment to patient care and a stronger allegiance with team and site rather than the UHSussex brand."*

3.19 This is, in our opinion, unsurprising in light of diverse populations which work at and use each hospital site, as well as historic differences in performance, leadership styles, terms and conditions and working norms across sites. In some cases these variations may be helpful and welcome (e.g. pride in and allegiance to place), and in others, are likely to be unhealthy and slow down the Trust's improvement journey. These include differential approaches to quality improvement, and tackling poor behaviours on account of custom and practice.

3.20 In its work to take the culture of the Trust forward, it is important that the Board is explicit about: a) what elements of culture need to be standardised (a 'UHSx way of doing things') and, b) where local nuance should be encouraged and nurtured.

Previous feedback on culture and behaviours

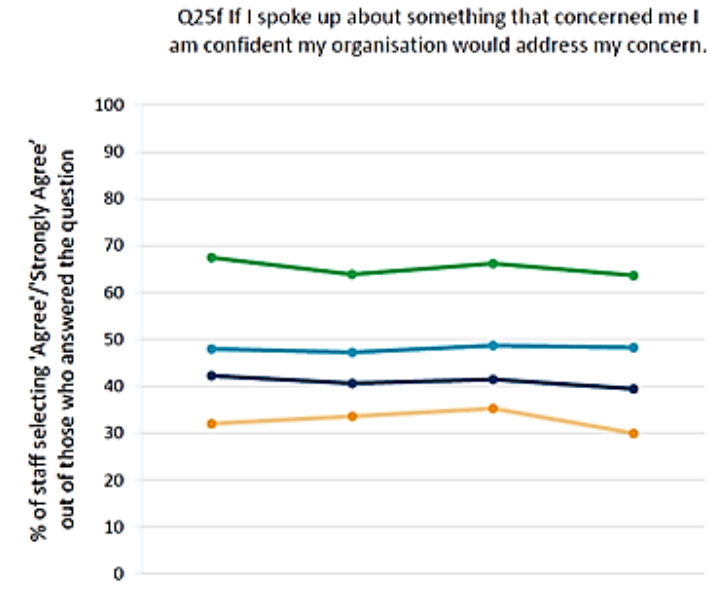
3.21 Poor culture, team working and behaviours have previously been cited in other external reviews, including:

- Getting it Right First Time (GIRFT) General Surgery focussed support visit, January 2025
- Royal College of Surgeons Review of General Surgery Department, RSCH, January 2024
- GIRF UEC Review (RSCH and PRH sites), July 2024
- CQC routine inspection, (report dated) May 2023

3.22 The latest (2024) National Staff Survey scores for the Trust show steady improvements in the last few years across many scores; some of these do relate to behaviours and culture in parts of the organisation. The RCSH site in particular (at which three of the external reviews above took place) had the most improved scores overall, following a series of planned interventions. However, at a Trust level, 6 of the 7 People Promises remain below the national average. The 'advocacy' scores (which relate to staff engagement), worsened between 2023 and 2024.

3.23 The Trust is also consistently scoring lower than average in relation to how staff feel in speaking up about concerns they may have, and this area worsened in 2024:

Fig. 3 National staff survey result scores relating to confidence in speaking up



	2021	2022	2023	2024
Your org	42.23%	40.63%	41.47%	39.45%
Best result	67.43%	63.83%	66.16%	63.63%
Average result	47.94%	47.23%	48.67%	48.23%
Worst result	32.01%	33.59%	35.24%	29.95%
Responses	7992	7304	8358	8068

3.24 The staff survey run as part of this review returned 376 comments from staff in this area, and over 300 of them were negative or very negative, and often citing a fear of reprisal. The comments below were typical of dozens in the survey:

"The problem with saying what you have seen/experienced is that there could be a comeback which will affect your career in a negative manner and therefore the safety and security of your family. Despite what people say to encourage you to speak out, there is a fall out (unspoken) for the people strong enough to speak up about what is actually going on."

"I've been told directly to not share data/info as it will look bad on the trust and we've got enough going on. Transparency is just a word - I haven't seen it in practice."

"I raised concerns. It put a target on my back. Management lied, gaslit me, would circumvent the issue, would dismiss my concerns."

"I feel no one listens."

Psychological safety

3.25 During our interviews with senior leaders across different disciplines and roles, we heard a common theme that there is a need to develop psychological safety[3] at a senior (including executive) level. We heard from various individuals that:

- 'Bad news' is discouraged at an executive level.
- Difference of opinion is unwelcome and dismissed.

[3] We have used the definition of psychological safety from the NHS England Patient Safety Strategy (2022): "*Psychological safety is defined as "a shared belief held by members of a team that the team is safe for interpersonal risk-taking." (Managing the risk of learning: Psychological safety in work teams (2002). It is about being open, willing to admit mistakes and feeling supported to speak up."*

- There is a predominance of direct and authoritative leadership styles, and a sense that those who do not fit this mould or have different preferences are less valued. The Executive Team's development programme has done some work to surface this, but the wider impacts of this in the organisation are not always being felt.
- There can be an inappropriate tone in emails, which some felt bordered on bullying in manner.

3.26 For balance, here, we also note that around half of the senior leaders we interviewed reported that the Trust is a "*nice place to work*", that executive directors are highly supportive and that things are continuously improving. What is pronounced, is the extreme divergence in this feedback.

3.27 There was a tendency for women to report this to us more than men, and six senior women in the organisation used the term '*misogyny'* in describing the behaviours of their senior male colleagues, which is also felt to be prevalent in quarters of the consultant body. Anonymised examples of the kind of behaviours described included:

- Eye rolling and other signs of non-verbal irritation and dismissiveness among male colleagues when contributing as a woman in meetings.
- Contributions ignored and overlooked when trying to speak in meetings as a woman. In surgical specialties, we heard that "*women are constantly excluded in meetings*".
- Pejorative references to sexuality being made when trying to lead as a woman.
- One account of a young woman having experienced unwanted romantic advances and inappropriate comments, with no actions taken months after reporting this to various senior leaders.
- People also referred to the organisational gender pay gap as a signal of institutional sexism.

3.28 In some cases, we heard that this had been reported and acted on, with improvements evidenced. In others, people continued to feel fearful about speaking up, and unvalued as a result. We consistently heard of a "*reluctance to put things in writing*". It is important to note that the most improved score relating to discrimination in the 2024 National Staff Survey results related to gender, and scores relating to the experience of harassment improved from 2023. This is promising, although the Board must retain a zero-tolerance approach to these matters.

3.29 We know that psychological safety is a core component of running safe services, and of leading high-performing teams. It is imperative that part of the Trust's culture is improved. Chapters 5 and 6 explore Speaking Up and Equality, Diversity and Inclusion in further detail.

Recommendation 3: Review the draft Strategy in light of the findings of this report and its recommendations, to identify any areas where remedial work may be required and how the strategy can support this.

3.30 There are currently mixed views among members of the Board (both executive and non-executive) around levels of confidence in the Trust's culture, and the extent to which it is given sufficient focus at Board. These are shown in the Board survey charts below:

Fig. 4 I am assured that staff and leaders are supported to demonstrate a positive, compassionate, listening culture that promotes trust and understanding between them and people using the service.

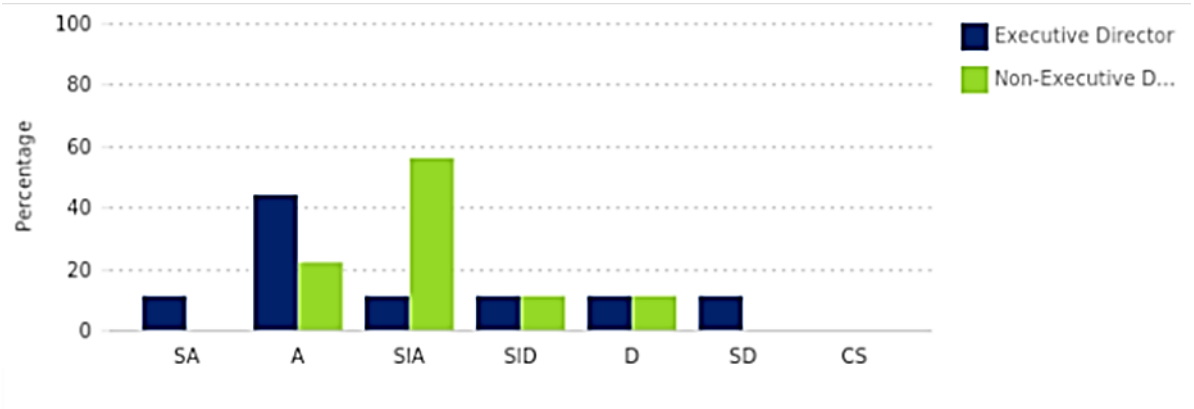
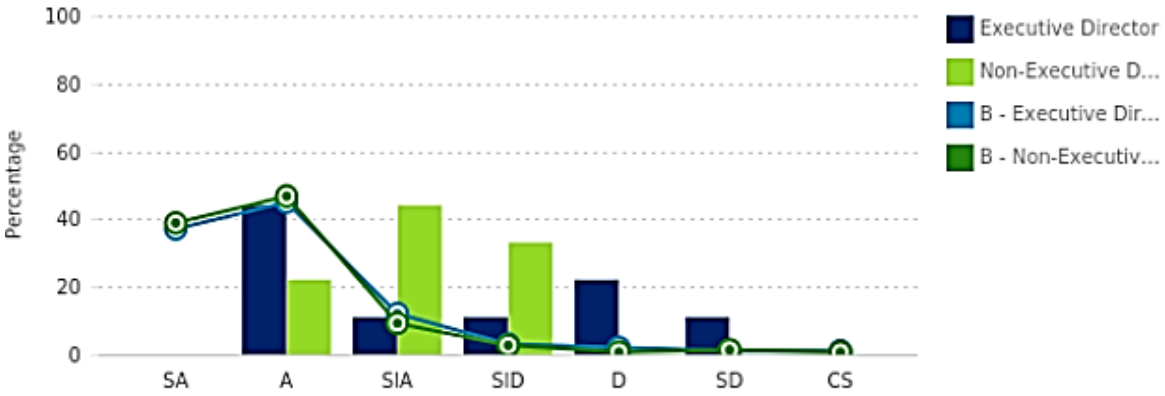


Fig. 5 As a Board, we have an appropriate level of focus on culture and people within the board and committee structure.



3.31 This last chart is key; a core part of a well-led board is the extent to which it sets and monitors a healthy culture.

Recommendation 4: Agree, as a Board, how assurance will be sought about the organisation's culture, and particularly in light of this report. Consider:

- **Introducing staff stories at Board meetings.**
- **How existing intelligence (such as the culture heat maps) can be used to better affect to improve Board insight.**
- **How to drive a 'problem-sensing' approach to culture within the Board environment.**
- **How the Board will continuously review its role in setting the tone at the top of the organisation.**

4 Capable, compassionate and inclusive leaders

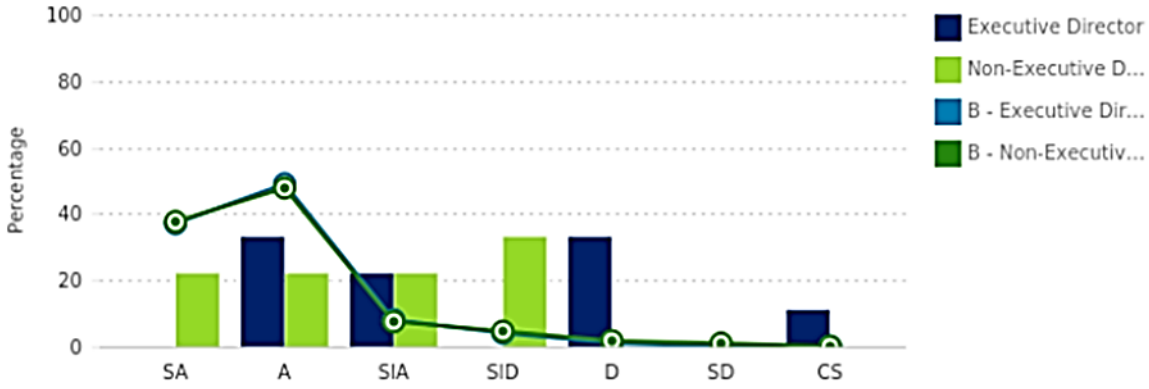
This means: ***We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively and do so with integrity, openness and honesty.***

The trust's leaders have the experience, capacity, capability and integrity to ensure that the trust's strategy and plan are put into practice through practical actions to benefit patients and address risks to quality (including safety) and performance.

Trust Board

4.1 Board members bring a range of skills and experience to the Trust, and this has been strengthened by recent appointments. The Chair and wider Board are aware that the skills profile of the Board needs to be further expanded to support the strategic direction and risks faced by the Trust, and a recruitment process is underway to bring more IT, transformation and clinical experience to the Board; we support this work. See also the Board survey chart below, demonstrating an awareness of the need to further develop the Board's skills profile.

Fig. 6 The Board has the right blend of experience, knowledge, and skills to ensure delivery of the corporate strategy.



4.2 We heard that, until more recently (prior to 2025), Board dynamics had at times been strained and sometimes difficult. This was attributed to both the operational, media and regulatory pressures faced by the Trust, but also a need for more transparency in information sharing, and a healthier way of relating to each other. Board members described dynamics having previously felt clearly 'split' across the executive and non-executive cohorts, a need for a more unitary way of working. We were also told that this has improved during 2025. Our observation of the Board in early April 2025 would confirm this. There were several effective contributions from many members of the Board, points of challenge were delivered appropriately, and this was generally responded to well by executive colleagues.

4.3 Several Board members reported mixed contributions, however, from the Non-Executive Directors (NEDs), and we would agree with this view. Our observation and review of meeting minutes found that some NEDs bring limited contributions to meetings. There is a need to ensure that the Trust is getting the best value and commitment from all of its Board members, particularly given its current challenges. This includes ensuring that all members of the Board are visible and present to staff, as much as possible. A key comment in this area from one member of the Board was

"some non-execs feel semi-detached from the organisation".

4.4 We also heard an appetite for NED skills and expertise to be better used by their executive colleagues. Both executives and NEDs told us that there is scope for more "*generative*" thinking to be done in Board meetings, and a sense that at present, NEDs are 'presented' with ideas for their approval or critique. That this has been recognised is a positive step and there is an opportunity through the Board development programme and current recruitment process to shift this forward.

Executive Team

4.5 The scale of challenges faced by this Executive Team are striking, and responding to the scrutiny in the external environment (including the police, media and regulators) is impacting on its capacity. These challenges require high levels of resilience, tenacity and support to navigate successfully as individuals and a team. Linked to this, we are aware of high levels of churn among previous executive teams at the former BSUH. Creating a safe and supportive environment in which colleagues can work together to drive improvements, and provide longevity as leaders for the organisation, is critical to its future success.

4.6 The Executive Team is, in many ways, new in its current form, with new roles having been created and new appointments made. For example:

- A standalone Chief Operating Officer (COO) role has been created, and appointed to in March 2025. This disaggregated the portfolio from that of the Deputy CEO, enabling the latter to provide additional support to the CEO
- The Chief Finance Officer (CFO) joined the Trust in November 2024
- The Chief Strategy Officer joined the Trust in November 2023
- The Chief Medical Officer (CMO) and Interim CCO (the latter a new post) both joined the Trust in April 2023.
- The Chief Governance Officer - who had responsibility for corporate governance, communications and engagement, business performance and information, and aspects of quality improvement - recently left the Trust, and these functions have been distributed amongst other executive portfolios;
- The restructuring and creation of senior leadership posts to support each Executive portfolio, including senior finance posts.

As a result, the team in its current composition is still embedding and maturing.

4.7 We heard consistently that dynamics within the Executive Team had previously lacked cohesion. Some complex formal HR processes relating to members of the executive team also took place between late 2023 and 2024, which we understand further strained relationships and collaboration.

4.8 We heard broadly that this is a much improved picture, which has been enabled by several factors, including feedback and reflection, formal development sessions and changes to team structures and composition. There remains further work to do and this should be kept under review. Regular informal meetings are now in place for the team, which should engender more reflective and developmental time together. In particular, there is a need to:

- Ensure the collective skills and experience are used fully, and that decision-making takes this into account. Some work has been done to understand individuals' preferences and styles, and it is important that this awareness is used to best effect.
- Ensure that the Executive Team is a safe environment for healthy disagreement, and to ensure that all members are able to speak openly

- Ensure that colleagues are able to support each other to act as corporate directors, particularly in light of the challenges faced by the organisation. i.e. where do portfolios need to be mutually supportive to enable improvement?

4.9 Divisional leaders consistently cited the leadership style of the new CFO, and praised their '*calm'*, '*measured'* and '*human'* approach. This is seen to have driven a psychologically safe environment in which colleagues can work together to collaboratively improve the Trust's financial position. We heard a real ambition for this way of working to be replicated more widely across the Trust.

Recommendation 5: Introduce 360 feedback into Board member appraisal processes. Where relevant, this should include feedback external to the Board, including from stakeholders and senior leaders. The process should align to the refreshed vision and values.

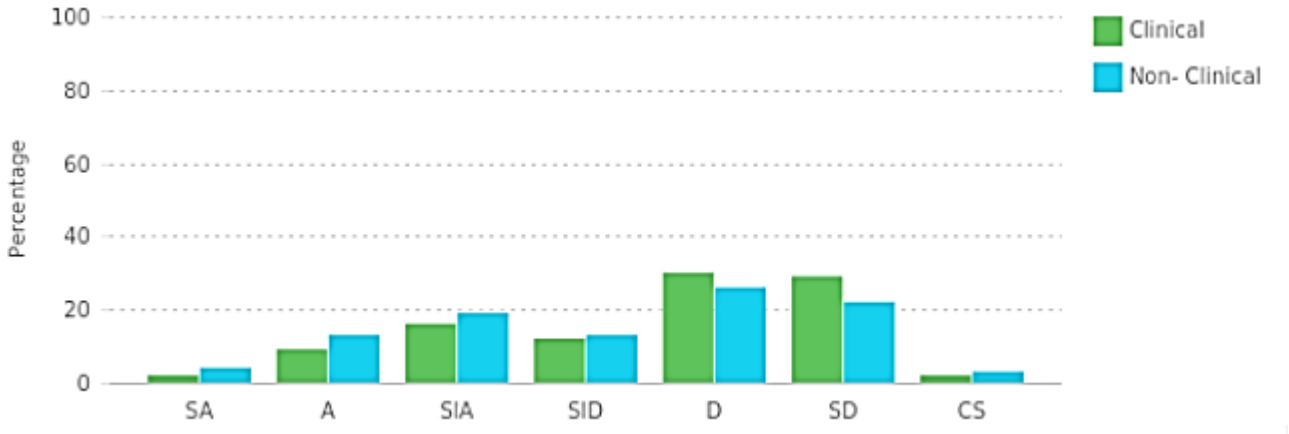
Leadership visibility

4.10 Some of the boards and executive teams previously held in the predecessor trusts were highly visible, operating as they were across a smaller geographical footprint. Two former CEOs in particular were frequently referenced, and it appears that some staff have become accustomed to this way of working and standard over time. Despite significant efforts from some executive directors, including the CEO, being visible to staff across so many sites is no longer feasible in the same way.

4.11 In our view, this should be discussed openly with the organisation, with a view to understanding where the visibility of the Executive in particular is meaningful and useful (for example in ensuring that the most senior leaders in the organisation understand the reality of delivering care day-to day), and where more local leadership visibility is helpful.

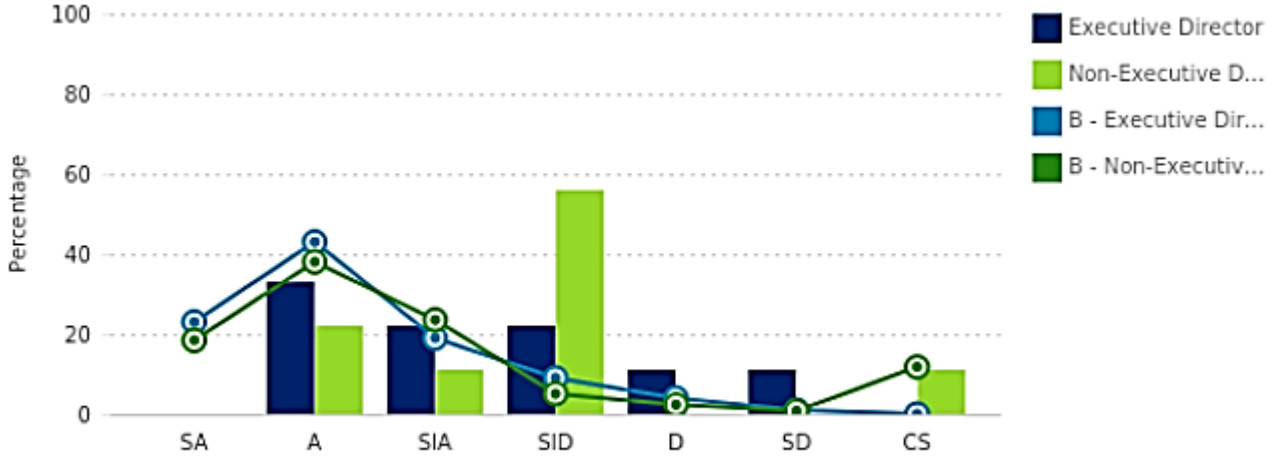
4.12 The chart below shows that there are mixed views from staff on how visible and approachable leaders in the organisation are, with many reporting negative views in this area. This was echoed during our visits to services.

Fig. 7 Leaders at every level are visible and approachable and lead by example, modelling inclusive behaviours.



4.13 The Board survey which tests a similar question returned a more positive response:

Fig. 8 Leaders at every level are visible to staff and are approachable



4.14 There is a need to review and reset expectations around Board visibility post-pandemic. As outlined above, being visible to all staff across so many sites poses an inherent challenge, but it is key that all Board members have a shared understanding of the operating environment and the day-to-day staff experience. In our view, the Board should collectively agree how this will be achieved in a way which is value-adding to the Trust's improvement journey and commit to this.

They demonstrate and actively encourage compassionate, inclusive and supportive relationships among staff so that they are all respected and valued equally. They understand that successful leadership is not just about what they deliver as an organisation, but how it is delivered.

4.15 As outlined several times in this report, merging as it did during the pandemic has affected the extent to which the Trust's most senior leaders have been able to build effective working relationships with each other, with the Executive Team and the wider Board. We were left with the strong impression that efforts are needed to build closer and trusted working relationships – particularly across the Executive Team, corporate directors and divisional and site leaders.

4.16 This need for more trusting and closer working relationships is currently manifesting in several notable ways:

- Difficult conversations, including about performance, can feel challenging (both to deliver and to receive). As outlined, there is also a need to build psychological safety in the organisation. A lack of time and space together as a senior team is inhibiting relationship building so that this skill can be developed together.
- Many leaders working in corporate teams are unclear about how they can contribute to decision-making, with some feeling their voice is not heard or valued.
- Staff (including senior leaders) have different expectations about executive role and presence, depending on what they are accustomed to in the legacy sites. This has not been 'named' and openly discussed, with standards and expectations re-set and recalibrated, and is leading to misaligned expectations.
- A view from many senior leaders (and indeed executives) that there is a dominant paternalistic culture in the organisation, whereby all decisions must be passed through the executive. We heard repeatedly that "*there is a parent-child dynamic in this organisation*". The reasons for this are many and varied, and some appear to be historic. While there are also exceptions to this, where present, this is causing frustration that leaders are not operating at the right levels and leading to inefficiencies, and exacerbating challenges with capacity. See also commentary about the COM at Chapter 7.

4.17 Work has started to address this gap, including the start of a programme of development for the Trust's 'top 70' leaders. A Trust Management Committee is also in place, which brings together much of this group, although this is at present focussed on cascading information, and has not been set up as a space for dialogue. More work needs to be done on effective decision making at the right levels, to avoid the continuous upwards delegation observed.

Recommendation 6: Agree how relationships will be developed between the executive (and indeed wider board) and the Top 70 Trust leaders, with a focus on building mutual trust and balancing challenge and support in performance conversations. As part of this, discuss explicitly the perceptions around paternalism in the Trust's culture.

Clinical engagement

4.18 Cultures within UHSx were often described to us as 'medically dominated'. By this, people tended to mean that doctors (particularly consultants) within the organisation hold more situational power than other staff groups, including nursing and allied health professional peers, as well as operational management colleagues. There was a strong sense, in some divisions, of relationships between medics and other professional groups feeling oppositional at times. One senior manager told us "*if the doctors don't want to do something, they just don't do it… we pander to them because we are scared of them leaving."*

4.19 There are various contextual factors at play which exacerbate this situation:

- There have historically been very high levels of executive turnover at the former BSUH hospitals. There has therefore been an inherited lack of credibility in the executive from some consultants on these sites. One person told us "*The Brighton consultants have become accustomed to 'waiting the executive out'. They had a new CEO with a different way of doing things almost every year*".
- Linked to this point, consultants are some of the lowest participants in the National Staff Survey. There is a risk of disengagement and of this group's views being missed in improvement work.
- Waiting lists are high, and doctors remain on an enhanced rate card to support performance, with Trust leaders having been unable to successfully renegotiate this to date. One external stakeholder commented "*the fact that we have to pay people more to do the waiting lists tells you a lot about the culture*."

4.20 We also note the very low levels of signed-off consultant job plans (34% versus a target of 95%), and a recent (May 2025) discussion about this at the P&CC anticipated that some of these conversations would be difficult. We see this as a key indicator of low medical engagement.

4.21 Some clinical leaders also talked about the ongoing non-compliance with job plans, over-booking of annual leave, and failure to engage with basic Trust processes, such as appraisal. These were described as long-standing in some cases. We heard low levels of confidence that the organisation would support these leaders in challenging such issues, and a sense that they were left feeling ill-prepared in their roles for these cultural challenges. Refer to Recommendation 8 in relation to leadership development.

4.22 These issues must be looked at in the light of those reported through other external reviews (including from GIRFT and the Royal College of Surgeons, (RCS)) who have also highlighted concerns with behaviours from parts of the consultant body. These are explored elsewhere in this report.

4.23 It must also be stated that there are areas in which multidisciplinary working appears to be effective, collaborative and mutually supportive, including in paediatrics and maternity. Appreciative inquiry into how effective teams have been developed in these areas would be of benefit.

Recommendation 7: Agree how learning from good practice and excellence in the Trust can be adopted. For example, appreciative enquiry into how changes in maternity were able to be made, and how this can be adapted into challenged parts of the organisation.

4.24 We also note the significant efforts that the CMO is undertaking to improve things in these areas, including job planning and showing visible leadership around concerns raised. The scale of the challenge remains significant, however, and is likely to have become entrenched over many years. A joined up approach will be needed, with appropriate resource, to make the required changes.

4.25 We understand that NHS England is supporting the Trust is establishing 'Consultant Cabinets' to facilitate engagement between the Executive Team and consultant body. This is positive, and we have seen these models work well in other organisations (albeit smaller trusts). What remains critical is that, when poor behaviours are reported, that they are dealt with swiftly and in a manner which puts the Trust values at the forefront of the response in order to move the Trust culture forward.

4.26 Finally, in considering clinical engagement, we found the profile and voice of nursing to be low in the organisation. For example, there has been a tendency in the Trust to focus on medics when considering 'clinical engagement', and the voice of nursing within multidisciplinary and triumvirate leadership teams did not always seem to be afforded the same weight as their medical and operational colleagues. Given that nurses are by some distance the largest (clinical) professional group in the organisation, it is key that their voice is heard and valued.

The trust proactively sustains compassionate, inclusive, collaborative and capable leadership

Leadership development

4.27 We heard unanimous agreement that organisational development (OD) resource to support the merger (which in our view is very much an ongoing process) has been insufficient. The current leadership development offer in place has now been mapped, so that there is a clear understanding of the 'as-is' offer. We understand that the offer has been enhanced over the last year, and now includes, for example, new consultants and new Band 7s support. This is a positive step.

4.28 There is also an acknowledgement that more is needed, but given the financial context, further programmes are not currently planned. Some specific work has been undertaken where issues have surfaced, for example, in general surgery.

4.29 The area we most keenly identified a need for further work is in relation to the Trust's clinical leaders. We heard of a significant knowledge, skills and confidence gap for those who are promoted to become clinical leaders. People in these roles broadly told us that they had had to learn on the job, often with very little oversight from their line manager (due to their own capacity) and stretched HR resources who had little availability to spare.

4.30 We heard for example:

- Of high levels of vacancies in clinical leads roles, due to these being seen as "*un-doable' roles*".
- Many clinical leaders feeling 'exposed' or vulnerable, whereby they hold accountability for their service(s) without budgetary or staffing control to support this.
- Similarly, a lack of confidence and support in tackling poor behaviours, and a perception that the organisation may not support them in doing so.
- A lack of clarity in the organisation about what it wants and expects from its clinical leaders, and supporting infrastructure (governance, accountability model and resource) to enable this.
- A lack of time for clinical leaders to meaningfully support strategic development and service redesign.

4.31 These issues are not uncommon where models of clinical leadership have been driven by organisations. We find frequently that whilst the idea of clinically-led models is well-intentioned, there are many factors which in reality inhibit its implementation, including:

- Making clinical leadership posts attractive to appointees can be difficult (particularly when those roles are accountable). This can lead to vacancies and ineffective appointments
- Evidence suggests that clinicians can find it difficult to switch into the leadership of peers and clinicians being managed by their peers is not always well received. Consensus based decision-making cannot be assumed or assured. A whole scale corralling of the clinical body behind clinical strategic plans is difficult to achieve.
- Availability for clinical work is reduced, but clinical leaders also tend to report insufficient time for their leadership responsibilities, leading to a no-win scenario. There may also be a potential impact upon waiting lists / capacity / clinical cover. This can have a financial and performance impact on the organisation.
- Line management consistency is important. Doctors will need both professional competency line management and operational line management and this can cause fragmentation and disconnect.

We understand that some of these issues have been recognised by the new CMO, who is seeking to improve this situation. However, the issues extend to factors beyond clinical leadership development. Getting the operational governance framework of the organisation is crucial to delivery and culture.

Recommendation 8: The risks of clinical leadership accountability models are potentially high and all aspects of this must be considered through a proper evaluative process. Ensuring the right people with the right training are fulfilling the most appropriate roles is key.

Succession planning

4.32 Succession planning has been identified as an area for further development, both in the Board's well-led self-assessment and in recent Board and committee discussions. It has been acknowledged that:

- Succession planning will require additional resource, with a strategic direction set, if this is to be prioritised; and
- There is further work to do to ensure that recruitment processes are reflective of both the Trust's EDI ambitions and values.

There is a risk of succession planning becoming a critical issue within the current model of operational governance unless clinical leadership roles are attractive and well designed.

Refer to recommendations made in Chapter 7.

Leaders are alert to any examples of poor culture that may affect the quality of people's care and have a detrimental impact on staff. They address this quickly.

Culture mapping

4.33 Pulse surveys are run monthly to test staff engagement levels. We heard that these are helpful as a barometer for morale, but do not help the Board to understand the underlying reasons for poor engagement. The interim CCO has introduced culture heat maps, which are run on an annual basis to identify culture 'bright spots and hot spots' at a cost-centre level. To date, these have tested: strategic leadership, engaging managers, employee voice and organisational integrity.

4.34 They have been used to inform conversations with Chiefs of Service (where applicable) about areas of potential concern, and some specific interventions have been commissioned as a result, such as in Clinical Support Services.

4.35 The 'organisational integrity' pillar consistently returns the lowest scores. This is consistent with feedback from the recent National Staff Survey and our findings from this review. This pillar tests the following questions:

Care of patients / service users is my organisation's top priority
In your safety huddles/ team meetings do you discuss Patient First True North targets and objectives?
Senior leaders are aware of frontline issues and challenges and take action to support teams
My manager aims to live the Trust values at work

4.36 We understand that the scope of these will be expanded moving forward to reflect the new strategy. There are also intentions to triangulate the outputs with patient care moving forward, to better understand any adverse impact of poor or closed culture on quality. Should this be successfully implemented, this will be an example of outstanding practice.

Capacity in the People directorate

4.37 In ensuring that the Board is driving a healthy culture, within which its strategy can be successfully delivered, it needs to assure itself that the People directorate is appropriately resourced. Understanding the significant financial pressures the Trust is facing, we consistently heard that leaders struggle to get the advice they need from HR when facing challenging and / sensitive personnel matters. We heard of occasions in which this has led to a lack of confidence, assertiveness and pace in tackling poor behaviours.

4.38 We also heard consistently, particularly from Board members, that the OD function has been significantly underpowered in seeking to bring the merger to life, and at such a difficult time for the health service. Gaps people cited to us included:

- Supporting effective matrix working in the COM
- Supporting dysfunction within teams
- Seeking to proactively identify closed or unhealthy cultures
- Work to improve relationships with the consultant body

4.39 There was a sense that Patient First resource had taken priority, and that there was scope to review this in light of the culture challenges faced. The Trust is currently looking to appoint a Director of Improvement and OD to bridge this gap, although in our view, the scale of the potential OD gap still needs to be understood to drive forward the Trust's culture and to proactively address some of the issues described in this report.

Recommendation 9: Benchmark the Trust's People directorate (to include HR and OD) to understand how its resourcing compares to trusts of a similar scale and complexity. The recent merger during the pandemic needs to be factored into decision-making arising from this process.

5 Freedom to speak up

This means: ***We foster a positive culture where people feel that they can speak up and that their voice will be heard.***

The trust has a culture of speaking up. All staff at all levels within the trust are equally encouraged and empowered to speak up. They feel safe to speak up without fear of detriment, that is without experiencing disadvantageous and/or demeaning treatment as a result.

5.1 Since August 2023, the Trust has outsourced its Freedom to Speak Up (FtSU) team to an independent provider, The Guardian Service. This function provides a dedicated Guardian to support the Trust, and UHSx is in the process of recruiting another part-time Guardian to strengthen capacity. The current contract with The Guardian Service expired in January 2025 and has been extended for six months while the contract is retendered. People we spoke to felt that the outsourcing of this function provided a helpful sense of independence.

5.2 The results of the NHS Staff Survey 2024 show two questions linked to FtSU which worsened from 2023 to 2024. This trajectory of the results between 2023 and 2024 is a concern. Statement 25f ("If I spoke up about something that concerned me I am confident that my organisation would address my concern") had a negative change of 2.17% (42.27% vs 40.10%). See also the commentary made about psychological safety at Chapter 4.

5.3 Similar survey results were returned from the staff survey run as part of this review:

Fig. 9 Staff and leaders act with openness, honesty and transparency.

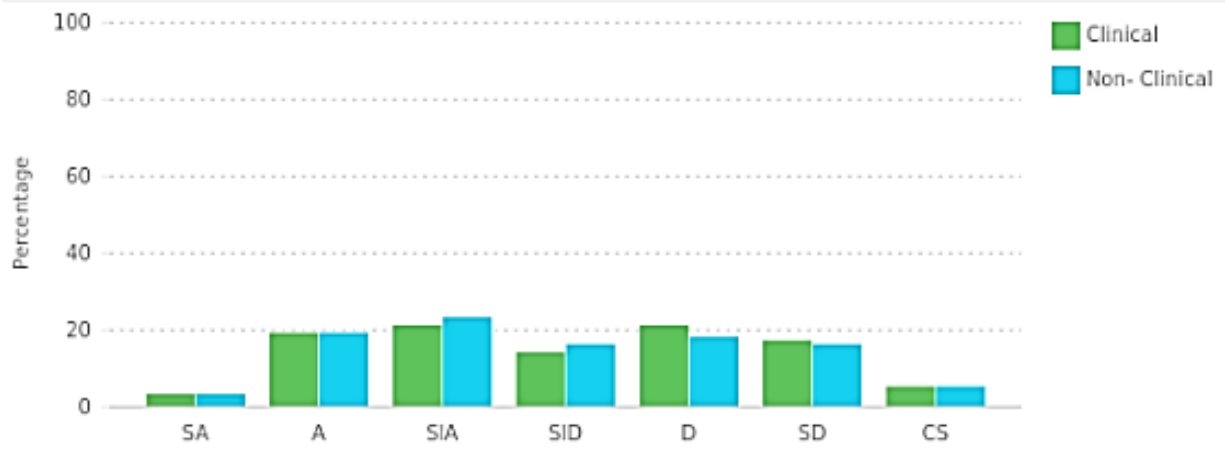
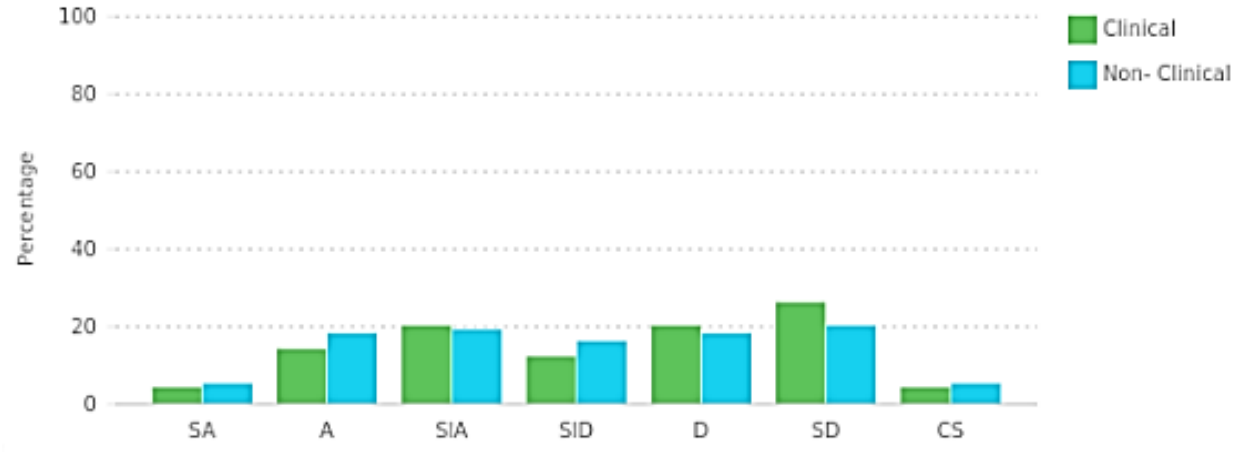


Fig. 10 I am confident that my voice will be heard if I raise a concern.



5.4 The ability of staff to speak up safely has been raised in previous external reports, including those from the CQC and RCS, who in 2024 reported that "*staff were reluctant to respond to whistle-blowing requests, given they had experienced instances of other staff members raising concerns through such mechanisms reportedly facing bullying and being dismissed*."

5.5 We repeatedly heard concerning examples of staff, often at a senior level, being ignored, dismissed, and sometimes ridiculed when speaking up. There is the perception that this occurs when:

- Adverse information or 'bad news' is shared, including with some members of the Executive Team.
- Pressure from regulators and the media can negatively drive behaviours that undermine psychological safety; this was also reflected by some external stakeholders.
- That staff marked as having the potential to disagree will be deliberately ignored in meetings when they attempt to contribute to discussion.

5.6 The recurrence of this finding, including amongst experienced and senior staff, presents a material risk for the Board: if many senior leaders are feeling increasing reluctance to speak up and share their views, what will staff throughout the organisation be experiencing?

Managers across the trust feel confidence to listen and act when someone speaks up and improvements happen as a result. These are communicated back to those who raise matters. Leaders are seen to promote Freedom to Speak Up through actively demonstrating positive behaviours.

5.7 Board-level engagement in the FtSU process, and the response to highly sensitive and serious speak ups was described as positive. The NED Chair of the P&CC is also designated as the FtSU Champion. However, it was less clear how leaders at a divisional level downwards are supported to respond to issues stemming from speak-ups. As outlined above, we heard that the support from HR in this regard is limited which, when combined with the need to strengthen leadership development, presents a risk that the factors underpinning speak ups are not effectively addressed.

5.8 Concerns most recently reported (namely in the FtSU report to the November 2024 P&CC) highlight management issues, systems and processes and bullying and harassment as the most reported themes. There is currently no separate categorisation for sexual misconduct, although we have seen that sexual safety is a key priority in the updated People Plan.

5.9 As outlined at Chapter 4, the staff survey run as part of this review highlighted that many staff do not raise concerns because of both fear of reprisal and a lack of confidence that anything will change as a result.

5.10 The RSC review of general surgery (published January 2024) highlighted issues associated with behaviour, executive visibility, and civility. This led to a programme of work in the division, including:

- Civility Saves Lives, a national programme designed to promote respectful teamwork and its link to improved safety and clinical outcomes for patients;
- Active Bystander programme, which aims to give staff the tools and confidence to speak up when they are involved in potentially harmful situations; and
- Human Factors programmes.

5.11 The above programmes feature in a Trust-wide Safety Culture workstream, which is striving towards the adoption of initiatives such as Civility Saves Lives throughout the Trust. Given that culture and behaviours have been highlighted extensively in this and other external reviews and survey activity, it would be useful to review and refresh this workstream. Refer to Recommendation 4.

5.12 There is also a need to ensure that the behaviours of the organisation's most senior leaders are consistently reflective of the Trust's values. This is both to ensure that the right tone is set at the top of the organisation, and that all staff have confidence in the integrity of the Board.

Appropriate training and support is available to equip freedom to speak up leads to actively support the Freedom to Speak Up Guardian. The trust's policies and procedures positively support this process.

5.13 The Trust's FTSU processes were assessed internally and shared at the P&CC in January 2025. This led to the development of an action plan and supporting communications plan. The plan focusses on:

- Strengthening the content on FTSU at corporate induction.
- Ensuring that FTSU reporting categories enable transparent reporting on sexual safety.
- Active Bystander training which has been developed in response to the Trust's focus on sexual safety and behavioural misconduct.

5.14 There are three e-learning modules available on the Trust's training platform, Iris, which outlines the FtSU process, and what staff are expected to do in response to a colleague speaking up. The Guardian Service has recommended that the Trust improves training compliance for managers on the FtSU process, with a particular emphasis on following up with staff after they have raised concerns. Implementation of this recommendation could be stronger; a recent report to the P&CC notes that the training is "*strongly recommended*" and that "*the benefit and impact of mandating completion will be reviewed*". This review has not yet been completed.

5.15 The Trust has a 'how to speak up and who to see' guide for staff who have a concern which is available on its external website and intranet. This details the steps a staff member should take for different types of concern, such as those linked to an individual's job, their working environment, line manager behaviour, or patient safety. To supplement this guide, there is a one-page infographic which also linked links to key policies, such as the FtSU policy, the EDI policy, and sexual safety in the workplace policy.

6 Workforce equality, diversity and inclusion

This means: We foster a positive culture where people feel that they can speak up and that their voice will be heard.

The trust takes an anti-discriminatory approach to continually review and improve the culture of the organisation in relation to equality, diversity and inclusion (EDI). All staff are treated equitably, including those with protected equality characteristics under the Equality Act 2010 and those from excluded and marginalised groups. The trust takes necessary steps to fully empower these staff in their roles throughout their employment.

Strategic plan

6.1 The Trust had a three-year EDI plan which commenced in 2022. The objectives in this plan included:

- Board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
- Embed fair and inclusive recruitment process and talent management strategies that target under-representation and lack of diversity.

- Develop and implement an improvement plan to eliminate pay gaps and to address health inequalities within the workforce.
- Implement a comprehensive induction, onboarding and development programme for internationally recruited staff.
- Create an environment that eliminates the conditions in which bullying, harassment and physical violent at work occur.

6.2 Our findings throughout this report outline that significantly more progress is needed in most of these areas. It appears that the focus of the last two years has been on rebuilding an EDI infrastructure which we heard had weakened significantly during the pandemic, ostensibly because the Trust was focusing on essential care delivery during this time. For example, restarting and establishing staff networks, and ensuring compliance with core processes, such as gender pay gap reports.

6.3 We were left with the impression that the EDI agenda remains in its infancy. The Board survey shows that this remains an area for development, particularly considering the benchmarking line versus the UHSx Board members' views:

Fig. 11 We have developed an EDI strategy that is understood across the organisation, and we regularly receive reports on our progress in delivering it.

6.4 Through the survey, several members of the Board expressed concerns with the degree of focus and maturity in this:

"There is a long way to go to being a board that is comfortable with EDI and having the capability to discuss it and understand the nuances of power, diversity and intersectionality. Equality Impact Assessment is invisible. I have not seen any discussion of health inequalities and I am unsighted on what the priorities are in this area."

"Our EDI strategy has focused on fixing basics, but it is very immature compared to things I've seen elsewhere. As those basics are fixed, we are encouraging a greater focus on proactive interventions to encourage, for example, a more diverse talent pipeline into senior roles."

"EDI is low-profile across the Trust and at Board."

6.5 Some people we spoke to shared the view that the Trust's EDI approach would benefit from looking to other organisations both within and outside the NHS to be confident that its approach is rooted in best practice.

6.6 A new Workforce Inclusion Plan 2025-26 has recently been developed. We have seen a draft of this plan which is expected to be formally approved in coming weeks.

The trust develops equitable processes and structures, ensuring that all staff are treated ethically. It uses national mandated programmes relating to workforce equality to achieve this aim. Any interventions taken as a result are monitored to evaluate their impact.

6.7 There is now a new Workforce Inclusion Plan, which highlights the following inequalities that it needs to address:

- Recruitment and career progression for disabled and minoritised ethnic employees;
- Disabled staff feel a lack of organisational support for their health and well-being;
- Harassment from colleagues and manager of Sikh, Muslim, internationally recruited staff and those identifying outside binary genders is worse than many other Trusts;
- A high proportion of staff reporting incidents of sexual harassment and unwanted sexual behaviour; and
- Many internationally recruited staff report discrimination.

6.8 Two out of four Workforce Race Equality Standards indicate better performance in this area than the national average. Workforce Disability Equality Standards are more mixed. The Annual Equality Report 2024 also shows that the Trust's efforts in relation to gender pay gaps have not yet been not effective:

Gender Hourly Pay Gap	Mean Hourly Pay		Median Hourly Pay	
	2023	2024	2023	2024
Male	22.26	24.01	16.84	18.10
Female	18.73	19.97	16.84	17.69
Difference	3.53	4.04	0.00	0.41
Pay Gap %	15.86%	16.83%	0.00%	2.29%

6.9 The Trust has established an Inclusion Hub on the Iris Platform to provide staff with resources and tools to better deliver its EDI vision. We are not aware of any assessment thus far of whether staff use this resource and their views on how helpful it is.

6.9 We note that a significant portion of the Trust's People Plan and FtSU planned improvements focus on sexual safety. This was also identified in the recent trainee experience survey, reported to the P&CC (in May 2025), which noted a concerning level of sexual harassment being reported (both from patients and colleagues) by learners in the Trust. Recently developed plans, such as the Workforce Inclusion Plan, may reference the need for improved equality and behaviour monitoring, but do not clearly outline actions to tackle sexual safety and gender-based discrimination. See also commentary at Chapter 4 about perceptions of sexist behaviour among senior leaders and some consultants.

6.10 We saw very little discussion of this in the meetings we observed, and the Board must assure itself that it has not become inured to this topic. This is an issue which is pronounced at this Trust and uncommon from our experience in undertaking similar reviews elsewhere.

6.11 Due to recent employment tribunals involving claims associated with reasonable adjustments, the P&CC has sought assurance that the Trust has a process that is committed to inclusivity. The Trust is in the process of centralising its approvals and budget for reasonable adjustments to ensure consistency and equity across the organisation.

There is evidence of actions the trust has taken to prevent and address bullying and harassment at all levels. This has a clear focus on those with a protected equality characteristic and those from excluded and marginalised groups.

6.12 Further work is required to ensure that staff feedback mechanisms provide insight into the impact of any action taken. A key example would be FTSU; the current approach does not give clear insight into speak ups linked to sexual safety, gender-based discrimination, or concerns raised by those with protected characteristics.

Recommendation 10: Use a forthcoming Board development session to reflect on the findings within this report in relation to discrimination and initiate discussions about the Board's role in leading a more visible campaign to tackle this across the Trust.

People and communities, particularly those who are more likely to have poor access, experience and outcomes from care, are involved and empowered to take part in identifying clinical and care needs, research opportunities, and in developing and co-producing improvements and innovations. This aims to actively tackle and reduce health inequalities.

6.13 The Workforce Inclusion Plan sets out the Trust's intention to "*Develop and implement an improvement plan to address health inequalities within the workforce*". The Big Conversation initiative referenced earlier used a range of mechanisms to capture a range of voices and perspectives, including liaison with third-sector organisations. The Trust is engaged in a project led by the Sussex Integrated Care System and the Health Research Partnership which is focused on improving access to research and the diversity of participants.

7 Governance, management and sustainability

This means: ***We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.***

The trust's board members and senior leaders can show evidence that they understand and effectively meet their personal accountability for the organisation's: quality of care and outcomes for patients; workforce; and operational and financial performance.

Board member portfolios

7.1 As described at Chapter 4, the structure of the Executive Team has been under development over the past two years. The work to refine the structure and underpinning architecture of the Executive Team was welcomed by many we spoke to who felt that there is increasing clarity and stability associated with Executive roles.

7.2 We also heard a number of ongoing concerns about elements of Executive portfolios that are not sitting in the right place, with some also being potentially under-resourced. These include:

- Non-clinical and clinical policy compliance sits between two portfolios and has different assurance routes to Board. We were told that there is a tendency to focus on non-clinical policy compliance which is generally stronger, and therefore less visibility of the risks associated with clinical policies.
- Compliance, particularly in relation to statutory and regulatory requirements, is not clearly defined within portfolios and we heard that this can lead to an overly reactive approach to business such as licence conditions and regulatory inspections.

- Human resources would benefit from an increase in capacity and capability with a particular focus on employee relations support to divisions, recruitment, and also organisational development capability.

7.3 The representation of technology, information, digital innovation, and cyber security at Board (by executives and NEDs) was raised as an area for development by several interviewees. The Chief Information Officer sits beneath the Executive Team; whilst this is not necessarily atypical, we are increasingly seeing providers consider ways to strengthen the profile of this agenda. We also heard concerns about the capacity supporting this post. The risk of this is that the Executive Team and Board are not sufficiently sighted on the scale of change needed across the Trust's information agenda nor resourced to implement change required, particularly in relation to the EPR implementation.

7.4 This risk is exacerbated by a gap in the NED skill-set around digital transformation; this has been recognised by the current Chair and recruitment is underway to address this.

Unitary and corporate directors

7.5 There is increasing awareness of the need for a more corporate response to some of the Trust's more intractable issues at Executive, Board and committee-level. We heard recognition that challenges such as the Trust's efficiency programme have historically been viewed in silos by corporate functions. Steps have been initiated to ensure that there is more collective ownership and consideration of how different parts of the Trust impact each other. Examples include:

- Analysis of how the efficiency programme impacts the profile of the workforce.
- Greater focus on the potential quality impacts of cost improvement plans; and
- Changes to the NED membership of committees to ensure that there is joined-up oversight of plans from a financial and a quality and safety perspective.

The trust has clear governance, assurance, risk and accountability structures. These interact well with each other and support effective decision making. They provide robust assurance that risks are effectively and sustainably mitigated, and the quality of care is consistently sustained. Trust staff at all levels are clear about roles and responsibilities.

Committee structure

7.6 The committee structure which underpins the work of the Board is both consistent with what we would expect for a Trust of a similar size, portfolio and complexity. Board members tended to agree that recent changes to the structure have made assurance seeking processes more effective.

7.7 There remain some areas where committee effectiveness could be further improved, centring on the analysis of information provided and extent to which non-executive directors are able to contribute strategically to discussions. We were frequently told, and saw during some of our observations, that discussion can become overly detailed, operational and, at times, directive in nature. Some contributing factors are:

- Underpowered management committees that sit beneath Board committees. We were told that there is a need to reset the expectation for forums that 'feed' into Board committees and to be disciplined at Board committees about not duplicating the work of these other forums. This applies in general to the Board's governance structure, with the Trust-wide sub-groups underpinning the P&QC being one example given.
- A need for greater clarity regarding assurance and reporting flows across all committees.
- Committee workplans to be reviewed and updated (work which we believe to already be underway).

- To set the expectation that reports need to have Executive scrutiny prior to review at Board-committee level. Currently, we heard accounts of this not happening which can increase the tendency for Board committees to discuss papers in significant detail and less through the lens of assurance-seeking.
- Ensuring that the right people are in the right meetings to ensure that decisions are rounded and views are fully informed before committing to actions.

7.8 Chairing of committees was roundly perceived to be effective, and we share this view based on the meetings we observed. NED attendance at committees had been inconsistent of late; we also observed some meetings in which NEDs were present but contributed very little to discussion, as outlined in Chapter 4.

7.9 Prior to our work commencing, the Board agreed to establish a Major Projects Committee to address the need for more dedicated time for Board members to discuss significant capital investments, their strategic impact, and progress of delivery against agreed plans.

7.10 The terms of reference (ToR) for the committee describe its responsibilities as ranging from ensuring adequate project governance and oversight, assessing the delivery of intended project outcomes and realisation of benefits, to ensuring that system partners are effectively engaged on major projects. Given the scale of the Trust, the legacy of merging, and the issues it continues to face which we have referenced throughout this report, creating an additional forum to enable the focused oversight of major strategic projects is a sound decision. We would urge the Board to ensure that the criteria for projects considered in the new forum is closely monitored, and that its effectiveness is formally reviewed in 6-12 months.

7.11 There was some inconsistency in how people described the role of the Major Projects Committee in relation to Quality Impact Assessments (QIAs) with some stating that the new forum will provide oversight of the new process. We would typically see a well-functioning finance committee and quality committee align their workplans and process of cross-referral and information sharing to oversee QIA intelligence. There is a risk that bringing a third Board-committee into this aspect of Board assurance leads to duplication and, once the new forum is fully established, we would encourage the Board to assess the Major Projects Committee's role in relation to QIAs and how it interacts with other Board committees.

7.12 Findings specific to each key committee or subgroup are outlined below.

Patient and Quality Committee (P&QC)	• The committee is widely regarded to be well-chaired with a healthy dynamic (i.e. challenging but supportive) between the Non-Executives and Executives. Both characteristics were visible in the meeting we observed in February 2025. • Several people described the need for the committee to elevate its focus to more strategic topics. We would suggest that there is scope for QIAs to have more prominence, and for time to be afforded at least twice a year to assurances and risks associated with the Trust's safety culture and the extent to which it enables the Trust's Patient Safety Incident Response Plan (PSIRP) (see Chapter 9). • Papers are highly detailed and there is scope to reduce the amount of supporting information, provided the impact of QGSG (see below) can be optimised.
Quality Governance Steering Group	• This forum, which is the management forum that sits underneath PQSC would benefit from a refresh to ensure its purpose and delineation from the P&QC is sufficiently well-understood. • The meeting we observed ran for over four hours and we were told that this is not unusual. The meeting Chair is inclusive and directive when required. However, the work programme for the committee is unwieldy, and its sub-groups are not yet established properly to provide succinct information on

	clearly defined elements of the agenda, all of which is exacerbated by high attendance and a need to refine membership. This is a particular issue in the second half of the agenda which concentrates on assurance flowing from cross-Trust sub-groups. • Divisional escalation reports are presented at each meeting. The content of such reports, particularly in relation to risk and matters for escalation, is variable; a Quality Governance Manual was launched in August 2024 in a bid to improve consistency and work continues to ensure it is applied as intended. • Aspects of the meeting provide a strong foundation for such a refresh, notably: the positive dynamic between the Chief Nursing Officer (CNO) and CMO, and the consistent focus on themes within reports which, once other aspects of the meeting have been addressed, is a helpful approach to identifying areas requiring a more systematic and sustained response.
Finance and Performance Committee (F&PC)	• During the meeting we observed, there were several references to areas of business that NEDs do not feel confident are captured within the committee and its underpinning structure. These were: ○ The impact of efficiency programmes on quality and safety, although this is an area currently being addressed under the leadership of the CMO. ○ Divisional delivery of efficiency programmes and how areas of slippage and risk are escalated in an appropriate and consistent way. ○ The link between financial planning and workforce planning, and how the F&PC and P&CC should interact on this topic. ○ There is broad support for the new Major Projects Committee but also cognisance that its scope has the potential to overlap or even duplicate that of the F&PC. ○ The Trust's cash position is very fragile and consumed a large proportion of time in the meeting. This was appropriate given the severity of the Trust's cash flow position which is approximately £17m under the planned position – however it was clear that Committee members are not assured that the Trust has effective and standardised cash controls (including procurement, standing financial instructions, and scheme of delegation). ○ The insight into and oversight of estates. • The focus of the committee tends to be more directed towards finance than performance, and we observed a tendency for verbal presentations to be more positive that the tone of supporting written assurance reports. • There was no reference to clinical strategy despite most of the meeting focusing on efficiency and opportunities for transformation.
People and Culture Committee (P&CC)	• Given the wider findings in this report relating to culture, we found that there is scope to strengthen the assurance reporting to P&CC on culture. Consideration should be given to: ○ Developing metrics aligned to the culture programme's priorities. ○ Triangulating these and other relevant metrics in a culture dashboard to each meeting. • The Trust is in the process of applying workforce planning tools, such as Safer Nursing Care Tool, to improve its insight into capacity and demand. This should be complete across most services within the next six months. The work of the committee would benefit from forward planning to understand how this work will be triangulated with efficiency programmes overseen by F&PC. • Matters of escalation from subgroups were afforded little time in the meeting we observed which suggests the need for the committee to consider whether

	the purpose and remit of such subgroups in the context of the P&CC's agenda is fit-for-purpose. • We understand the ToR for this committee are under review. We suggest that core membership is considered as part of this work to ensure that those with strategic influence on core aspects of the P&CC agenda are included, such as the CMO.
Research, Innovation and Digital Committee (RIDC)	• Established in early 2024, this committee's role is to provide the Board with assurance relating to research, cyber security, innovation, and digital transformation. The committee Chair provides a report directly to the Board to summarise assurances received and risks identified. • We identified some features of the committee and its role within the Board's governance framework which currently reduce its impact, namely: ○ A busy Board agenda in which RIDC's Chair's report to Board is often rushed. ○ Chair's reports have lacked clear articulation of risks. For example, the February 2025 report notes "emerging risks around digital also raised" but does not state what the risks were, nor what their potential impact could be. ○ A need for more Executive-led focus and capacity on technology. • Several interviewees recognised that the committee is still developing and there is cognisance of the need for the Board to maintain frequent focus on how its remit and function needs to adapt in order to strengthen the Board's oversight of the digital, technology and innovation agendas. This is explored further at 7.31.

Recommendation 11: As part of the annual reviews of committee effectiveness and terms of reference, consider the feedback relating to each Board committee in Chapter 7 of this report. All committees need to ensure that reports submitted clearly identify the material issues, areas of key risk, and action requested from the committee.

7.13 A NED-Chaired Single Improvement Plan (SIP) Committee has met monthly since June 2024 to give time-limited enhanced capacity to receive assurance regarding the delivery of the SIP. The SIP was developed in response to required undertakings applied to the Trust by NHS England in quarter three 2023/4. The March 2025 Board received and approved a recommendation to de-establish the SIP Committee and incorporate the components of the SIP into established governance forums. The focus of the recommendation was on the mapping of each SIP workstream to an Executive lead, a management forum, and a NED-Chaired Committee, as opposed to the progress made to date, the regulatory climate, and the Board's readiness to remove oversight capacity in an area of critical business.

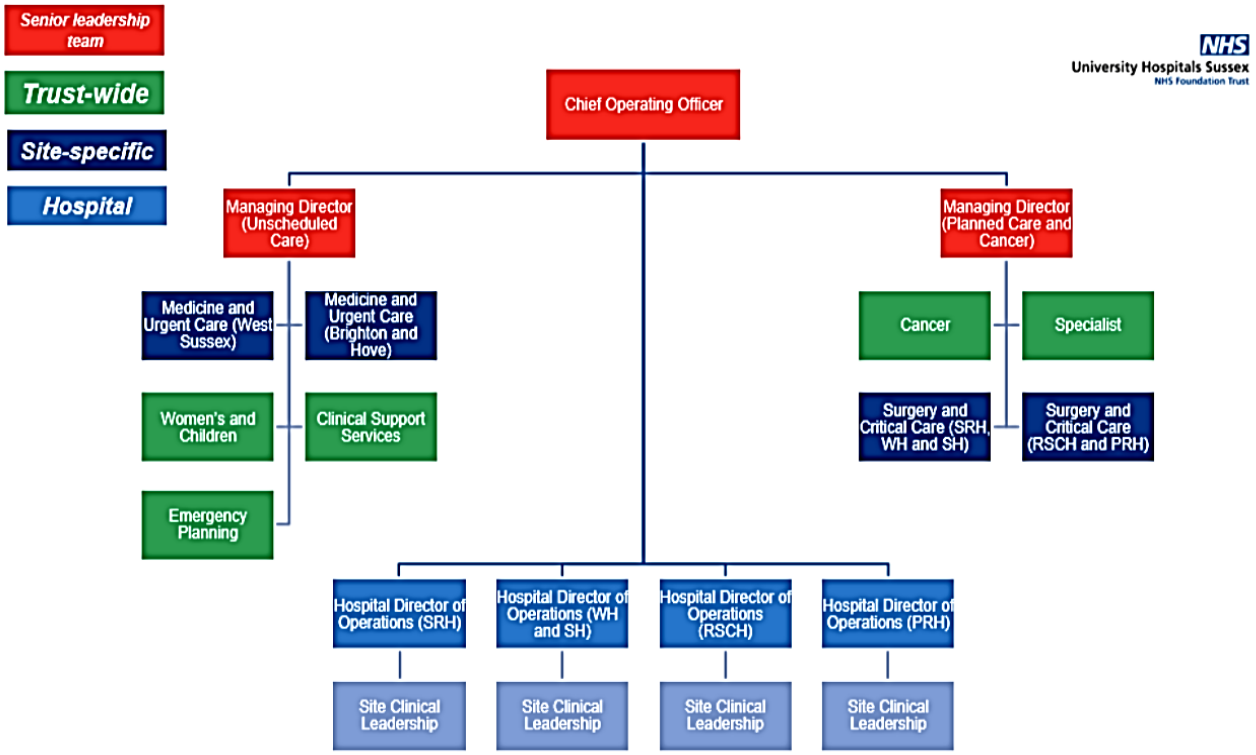
Operational structure

7.14 The Trust has put a lot of consideration into its existing (Clinical) Operating Model (or COM), and has considered the operational structures of other large and multi-site acute trusts in arriving at its current arrangements. We heard that since the inception of the merger, there has been a strong preference for the Trust not to operate as a group model (whereby individual hospital sites are encouraged to act autonomously as far as possible, and may have their own site executive teams, for example).

7.15 At present, all divisions report to the Managing Director of Planned Care, or Managing Director of Unplanned Care. Four divisions operate across the Trust, and four are split by East and West services. There are four Hospital Directors, who report to the Chief Operating Officer. Each division is accountable to a divisional triumvirate leadership team, led by a Chief alongside a Divisional Director of Nursing and Allied Health Professionals (DDN), and a Divisional Director of Operations (DDO). These arrangements were rolled out in a phased way, starting in July 2022.

7.16 In 2023 an engagement exercise took place, which resulted in an intention to create nine cross-trust divisions. These plans were abandoned due to some key leadership changes, as well as concerns raised in relation to: the number of leadership positions required, and potential difficulties in recruiting to these, differential sizes of divisions, with some likely being unwieldy, and the inherent challenges of being visible across so many sites. The existing model is shown below.

Fig. 12 Clinical Operating Model – April 2023



7.17 The COM is now under review again. There was a unanimous view that, despite good intentions, the current arrangements are not working effectively (please see also 4.31). The key challenges described include:

- A lack of clarity around what decisions can be made by the site team versus the divisional team (despite documented frameworks for this being in place).
- A strong perception that this leads to "*paralysis*" in decision making.
- A reliance on managing by influence, where leaders do not hold budgets or line management responsibilities, but are held to account for matters contingent on these things.
- Accordingly, everything being run by the COO.
- Missed opportunities to share learning where services are not managed cross-Trust.
- Missed opportunities to reduce unwarranted variation.
- The role and authority of hospital directors is unclear to many. We repeatedly heard an appetite for these roles to function as 'site-based CEOs' to reinforce place-based approaches where appropriate.

7.18 We heard that divisional governance meetings operate differently in terms of attendance, focus and escalation processes. The review of the COM provides a key opportunity to standardise approaches

to divisional governance, so that the Board can be assured that each division is reviewing a baseline set of metrics (including quality standards) with comparable focus and frequency, and that these are being reported and escalated up in a standardised way. This is particularly important given the size of the Trust and inherent need for devolved governance.

Recommendation 12: Any redesign of the COM needs to be coproduced with those involved in implementing it successfully. The review underway needs to have a key focus on the behaviours, attitudes and operating principles required to make the new model work. See also Recommendation 6.

Recommendation 13: Any redesign of the COM needs to be coproduced with those involved in implementing it successfully. The review underway needs to have a key focus on the behaviours, attitudes and operating principles required to make the new model work week. See also Recommendation 6.

When planning services, improvements or efficiency changes, the trust understands the impact of decisions on its workforce, quality of care, and financial sustainability, including for the wider health and care system. The trust has a robust financial governance framework. It manages financial risk effectively and actively engages with system partners to support the delivery of system-wide financial balance.

7.19 We found that these had been a historic weakness in terms of quality impact assessing efficiency schemes. Until very recently, the focus of QIAs was on operational and financial delivery rather than the impact on quality of cost improvements, and there has been an absence of Board assurance in relation to this.

7.20 This has been recognised by the CMO and Chair of the P&QC who has requested quarterly QIA reports within the regular cycle of business (proposed to commence in quarter 1 of 2025/26). The Trust's internal auditors have also agreed to add this to their 2025/26 Audit Plan.

7.21 The P&QC ToR (dated February 2024) also include the duty to "*review and monitor Equality and Quality Impact Assessments (EIA) relating to Efficiency and Transformation Programmes to gain assurance that there will be no unforeseen detrimental impact on quality of care for patients*".

7.22 In addition to the lack of assurance on assessments pre-implementation, all staff who we spoke to were unaware of a formalised process for assessing the impact of schemes post implementation to ensure that there has been no unintended adverse impact on the quality of services delivered or patient safety. Divisions will need support in this area given the scale of the programmes and savings proposed.

Recommendation 14: Further develop the emerging QIA process to include training and support for divisions, as well as how the Trust will undertake post-implementation reviews of efficiency schemes for any adverse quality/equality impacts.

The trust's governance and management of partnerships, joint-working arrangements and third parties is effective and supported by effective and robust assurance systems.

7.23 The Trust is part of a Committee in Common (CiC) which is the main shared oversight forum for the Sussex ICS. The CiC is responsible for overseeing a major services review across Sussex, as well as the work of the Provider Collaborative.

7.24 The March 2025 Board received a paper outlining the extensive work that the Board, predominantly via the Chair and CEO, are involved in via the CiC. The paper referenced:

- The approval of a System Strategic Narrative which is designed to serve as a reference point for all member Boards for the history underpinning the CiC and its future ambitions;

- The development of a Clinical and Care Professional Leadership approach with particular focus on individuals working in areas of joint working, such as urgent and emergency care, rehabilitation and intermediate care, and integrated community teams; and
- The development of a 30-month roadmap, governance principles and resourcing plan equating to a £4m initial investment to deliver the CiC's ambitions.

7.25 The work of the CiC and broader ICS is included as a standing agenda item for both F&PC and the Board. The Trust's financial position in the context of the Sussex system was a recurring topic throughout our work and it was evident that there are different views amongst Board members about how partnership working and relationships should be managed within this context.

7.26 Finally, we note that the ICS has moved to a single (acute and community) Provider Collaborative since April 2025, with a focus on: reducing unwarranted variation, improving resilience across providers, and ensuring that consolidation can occur where this provides better outcomes and value. This forum will be chaired by the UHSx CEO, and will be represented by seven other local providers. The Provider Collaborative has self-assessed its maturity as "*developing*" (as at December 2024). Its next steps involve developing a revised memorandum of understanding between members and developing decision-making and risk/gain sharing agreements.

The trust has clear processes, robust data and suitable information systems to effectively identify, manage, escalate and sustainably mitigate current and future risks.

Risk management

7.27 In light of the new Strategy, there is a need to ensure that the Trust's performance monitoring and governance structures are aligned to the updated ambitions. This includes a need to refresh the BAF and processes aligned to this, including the setting of Board and committee agendas to ensure a strong and routine focus on the Trust's areas of highest strategic risk.

7.28 It is also essential within the BAF to consider the primary risks within the 'system' and the primary risks of key partners to reduce siloed strategic thinking.

Recommendation 15: Refresh the Board Assurance Framework's strategic risks. Ensure that the Board's subcommittees have routine and robust oversight of these, seeking assurance around risk management and reduction where possible.

7.29 Risk management is an area causing concern for many senior leaders we spoke to. There was broad acceptance that the approach to risk identification and response needed an overhaul; a view that was consolidated by an internal audit report on risk management published in September 2024. Throughout our work, we saw limited evidence of improvement to address the developmental internal audit findings. In particular, we observed:

- A large number of highly scored risks, many at 20 or above, and many which have been on the risk register for extended periods of time. Several interviewees felt that this was symptomatic of a risk approach that does not contextualise a local risk within the Trust's overall risk profile, and noted that it further confuses which issues should receive the most management focus. Others suggested that these risks were real issues with harms or negative impacts on operational and financial performance occurring but with no mitigations currently being achieved.
- A need to strengthen the focus of meetings such as the Risk Oversight Group on controls and action taken in response to an identified risk. It needs to be clearer what levels of support divisions can expect when cross-Trust issues are identified, versus where autonomous action at a divisional level is needed. This is causing tension in some areas.
- A large number of risks (140 in April 2025) with a score of 12 or more or a consequence of 5 (catastrophic) which have been added to the risk register but not yet approved by the divisions, some of which have been listed since 2022. We were told that this is due to the

large numbers of risks that the divisions are dealing with. Delays in divisional approval and review at QGSG and the Risk Oversight Group will, however, limit the ability of the Board to fully understand the risk profile of the Trust or to ensure that appropriate risk mitigations are applied.

- A lack of clarity around the robustness of the QIA process for efficiency programme schemes, with all staff that we spoke with unaware of a formalised process for assessing the impact of schemes post-implementation. This has been recognised by the Chair of the P&QC who has requested quarterly QIA reports within the regular cycle of business. This has also been added to the internal audit plan for 2025/26.

7.30 Further, there could be better alignment between risk management processes and the operational structures of the Trust. Given many risks relate to the estate and environmental experience for patients, several people we spoke to expressed their frustration that risks are managed on a divisional as opposed to hospital basis. Hospital directors can see individual Datix reports for new risks; however, they do not routinely receive more holistic/aggregated reporting on risks in order to understand the risk profile of their site. We heard that this can contribute to tensions between divisional and hospital-based leaders in relation to capital funding for remedial works.

The trust implements appropriate measures and training to minimise the impact of incidents, such as software or hardware failures, cyber-attacks and or/data breaches.

7.31 As previously stated, the Board's direct insight into digital transformation and cyber security is lower than we would expect for a Trust of its size, service portfolio, and digital challenge. The Trust was given a score of 1.9/5 in the NHS Digital Capability Framework[4] which is well below the national and regional average, yet the profile of digital transformation at Board-level is low. In addition to this, some of those we spoke to were concerned that the Board's focus on risks associated with cyber attacks and data breaches is insufficient. The Board established a Research, Innovation and Digital Committee in 2024 to expand the time afforded to the digital and cyber security agenda, however the concerns outlined above indicate that further time needs to be spent as a Board to consider the effectiveness of this forum.

Recommendation 16: Consider whether the Trust has appropriately calibrated its response to how technology will underpin the success of its new strategy. This should include a review of leadership structures, capacity and the Board's line of sight to the management of associated risks.

The trust has clear structures and systems of accountability, and it uses performance information to hold staff to account. Data is triangulated with clinical insight, observation and feedback from staff and patients to gain robust assurance.

7.32 Aligned to the points above, in the absence of a single EPR, several patient information systems remain in place from legacy organisations, which is a significant impediment to realising the benefits of the merger. This is a huge source of frustration to staff, particularly those working across more than one site, and is reflected in staff and stakeholders' feedback that it can be challenging to arrive at a 'single version of the truth' about key issues.

7.33 Strategic Deployment Reviews (SDRs) have been the primary mechanism for ensuring delivery against agreed priorities at a divisional level and Trust-wide level. Risks and matters for escalation from SDRs are reported to the Trust Management Committee (TMC). We heard little support for SDRs in their current form. Many (but not all) senior leaders expressed their frustration that the discussion at SDRs can feel overly directive with little space for discussion and dialogue on any support the division may need from colleagues. Several interviewees shared the perception that

[4] The NHS Digital Capability Framework is a list of requirements setting out what NHS provider organisations must do in order to achieve digital maturity.

‘bad news’ was not tolerated at SDRs and there was unanimous support for a rethink of these forums.

7.34 There was a degree of frustration that these deficiencies have been discussed for a long time without clear resolution. We understand that the external review of the COM will consider a new accountability framework for divisions; some people we spoke to stressed the need for the output of this to be much simpler than the current approach and to focus on the need for a monthly “*touchpoint*” between the executive and divisions which centres on the delivery of the operational plan, areas of risk, and support required from outside the division.

7.35 The concept underpinning SDRs is also linked to the PFIS. The terminology used throughout SDR reporting packs is aligned to that of PFIS and refers to, for example, driver metrics, watch metrics and True North objectives. Given the findings outlined in Chapter 9 associated with the PFIS, structure and content of SDRs needs to be revisited to ensure that this process focuses on the top priorities for the Trust.

Recommendation 17: Simplify the strategic deployment reviews to focus on:

- **The mutual review and discussion of key priorities for each division (this should also encompass corporate support functions).**
- **The agreement of next steps and any support required.**
- **The identification of any cross-trust issues requiring executive intervention.**

See also recommendations relating to shared ways of working.

7.36 The CFO introduced Operational Delivery Groups (ODGs) on a bi-weekly basis in early January 2025 to provide an opportunity for improved dialogue on performance against the plan. We understand that these are temporary forums designed to ‘fill a gap’ that the SDR process does not currently enable. As outlined at Chapter 4, colleagues praised the tone of these meetings and the sense of open dialogue engendered in them. It was felt that much could be learned from this approach in resetting an ‘adult-to-adult’ conversation in accountability meetings.

8 Partnerships and communities

This means: ***We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.***

Leaders at the trust invest time in building relationships, understanding perspectives, and constructively engaging with partners.

8.1 The Sussex system, like most nationally, is financially challenged, and has a deficit of £39.2m. All organisations have an efficiency plan of 5%, and around 50% of efficiency schemes have been identified as being at high risk of non-delivery at the time of writing. There have been extensive conversations in recent weeks and months about both the realism of plans submitted, and the 'ownership' of this deficit (with significant UHSx overspend being attributed to 'no criteria to reside' (or medically fit for discharge) patients.

8.2 Beyond the financial context, every external stakeholder we spoke to acknowledged the significant pressures the executive and Board are under and voiced a genuine desire to be supportive and to see UHSx leaders succeed.

8.3 We were frequently told that Sussex as a system is 'immature' in its partnership working. Those who were newer to the ICS were struck by this, compared to other places where they had worked. By this, they typically were referring to under-developed working relationships and proactive partnership models to support patient care, including flow.

8.4 Nonetheless, overall we heard that the Trust's work with partners has significantly improved in the last two years. We heard that, historically, relationships among senior system partners had been poor, and in some cases, overtly dysfunctional. Partners frequently told us that the CEO in particular has made a concerted effort to improve this and there was more willingness to talk openly about the Trust's position and challenges.

8.5 We acknowledge that it will take time to overcome some of the historic tensions which have been in place, and the executive and Board need to keep this under close attention. In particular, there is a need to:

- Ensure that leaders are able to remain open to feedback. There remains a perception that the Trust can still come across as 'defensive', in large part due to the scale of scrutiny it is facing.
- Ensure that the executive gives a consistent response. Some partners described a lack of cohesion in messaging from the Trust. This is also linked to comments made elsewhere in the report about the COM, and how current arrangements are giving rise to confusion about decision-making.
- Ensure that information is shared in a timely and transparent manner.
- Ensure that there is a consistent focus on mutual support; some partners described a perceived lack of empathy for the challenges of other organisations, with one for example stating, "*you only hear from them when they have a problem they need fixing*." The single Provider Collaborative provides a helpful infrastructure to develop this.

8.6 Experiences below executive level were more variable. We heard on several occasions about incivility from UHSx clinicians and managers with other providers, which had led to some recent difficult conversations. The need to focus on behaviours and psychosocial safety internally outlined at length at Chapters 3 and 4 also applies to the Trust's work with its external partners.

The trust's board can demonstrate that it is meaningfully taking the views of partners into account, to understand impacts for the wider health and care system and what is in the best interests of local populations, as part of the decision-making process.

8.7 Clear efforts have been made to engage external partners in the development of the strategy; NEDs have presented on this to stakeholders and four external workshops took place. Some of those we spoke with acknowledged that the opportunity had been presented, but their own capacity limited their ability to engage with the work. An evidence base relating to the system, its performance and challenges also informed the strategy's content.

8.8 Communities is a pillar of the new strategy, including improved partnership and community working to shape services, and bringing care closer to home. We heard that the Hospital Alternative Oversight (HALO) programme focused on addressing congestion in emergency departments has been an example of where this has worked well, but also heard other examples of 'missed opportunities' for closer partnership working.

8.9 We were frequently told of stories of medically fit for discharge patients waiting for days or weeks (in one case even months) in the Trust's care due to a lack of onward provision (be that mental health, social care or safe accommodation). We noted that it could be challenging for partners to understand each others' frustrations or perspectives, and wondered if more developmental time and 'headspace' is needed to collaborate on proactive solutions.

Leaders at all levels support a culture of proactively seeking the views of, listening to and acting on feedback from patients, carers and communities. It acts on people's views and concerns to shape culture and deliver high-quality services for all while addressing health inequalities.

8.10 We heard positive feedback from stakeholders in this area, and that there is a transparency and willingness to listen the voice of patients. One stakeholder told us that the Trust is "*open, transparent and responsive*" and that there is a clear and swift response to any concerns raised. Again, this had much improved in the last two years.

8.11 The Friends and Family Test[5] (FFT) is a True North (core Board) objective, with the aim being that 90% or more of patients rating their care as Very Good or Good. The most recent data available (March 2025) showed a performance of 88.5%, based on 30,000 responses. Poor responses have been more likely to be returned from Emergency Departments, where patients have praised the compassion of staff, but complained of overcrowding and corridor care. Inpatient scores are higher (average 92%).

8.12 There is a stated ambition in the strategy for more codesign of pathways, and a user group will be established in each service to ensure that the changes "*make sense and are well-communicated*". Service redesign is likely to impact patient (and staff) experience in some areas and may mean, for example, significantly longer travel time. This will need to be quality and equality impact assessed, to ensure the safety of any changes made, and impacts on health equality. This is already causing anxiety among staff, and various comments in the staff survey alluded to this, such as:

"We are expecting our patients to happily travel across the county to access their appointments without a care as to whether they have the capacity."

Recommendation 18: Service changes implemented as part of the Strategy Delivery Plan must be co-produced with patients, and specific attention given to potential health inequalities.

[5] A quick and anonymous way for patients to rate the care they have received.

The trust is open, transparent and collaborative with all relevant stakeholders about performance. This is to build a shared understanding of challenges to the system and the needs of the population, and to design improvements to meet them.

8.13 We heard that the Trust had a history of agreeing to financial and operational plans which may have been unachievable, and witnessed significant efforts to ensure that the latest annual plan submission was based on evidence and engagement with operational and clinical leaders. As outlined elsewhere in this report, divisions have welcomed this more collaborative and open approach.

8.14 This has, however, led to the submission of a non-compliant financial plan, with a planned deficit of £39.2m. All other provider trusts in Sussex are planning breakeven this financial year, which has led to UHSx being a national 'outlier' in its planned deficit position. There remains an ambition to breakeven by the end of the 2026/27 financial year. A non-compliant operational plan was also submitted for planned care.

8.15 This has been the subject of extensive recent discussion in the system, and has surfaced issues around 'ownership' of the deficit, transparency and openness in planning discussions, and the need for transformational change to drive financial sustainability.

8.16 It is key that this is driven forward through the Delivery Plan, with clarity around changes to service design co-produced with patients and partners.

Recommendation 19: Work with partners to plan (together) a series of cross-system strategy sessions in 2025/26 in order to develop longer-term and sustainable care models. These will need:

- **Executive and clinical contribution**
- **Learning from established and mature systems**

and may benefit from external facilitation.

9 Learning, improvement and innovation

This means: ***We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.***

The trust has a systematic approach to improvement. It works to embed a quality improvement method aligned with the NHS improvement approach to support increased productivity and enable improved health outcomes for people.

9.1 The PFIS is the Trust's corporate approach to quality improvement. It was previously in place at WSHFT (which was rated Outstanding by the CQC) to great effect, and became known nationally for its quality improvement maturity as an organisation. Many former WSHFT leaders remain very wedded to this way of working, and convinced of its efficacy, but there was broad agreement that Patient First has "*lost its way*" since the merger. We heard a significant array of perspectives, including:

- Some leaders (mostly former WSUH) who have seen the proven benefits of PFIS and regret its loss of traction.

- Many people who feel it has overstretched, and has lost its sense of direction. This group cited its 'unnecessary reach' into matters such as governance and strategy for example, and feel it should be brought back to the basics of frontline quality improvement.
- Another group of people who feel that PFIS is 'exclusive' in its approach, with overly jargonistic language. These people also felt that the model is overly bureaucratic, and can deter busy frontline staff from improvement with its paperwork requirements.
- Some colleagues felt that the ongoing commitment to PFIS is reflective of a 'nostalgia' for the former WSHFT, and feel that there should be more openness to fresh approaches that take into account the increased complexity and size of the merged organisation.

9.2 A key comment from the staff survey in this area included:

"Are we still striving for Patient First as it's rarely talked about?"

Board members similarly reflected:

"The identity of Patient First is seen as legacy and 'west' to some degree."

"Patient First is all but dead at the front line - look at what staff in ED [emergency departments] say."

9.3 The Trust has an extensive and challenging improvement agenda, and we were made aware of some targeted interventions which are showing signs of producing tangible improvements in the past 6-12 months, namely:

- Compliance against the Faster Diagnosis Standard (77%) has improved from 65% in mid-2024 to exceeding 80%.
- The Trust HALO programme to address congestion in emergency departments by working closely with system partners, such as the ambulance service and some local care homes. There is still significant and challenging work ahead but there are signs of positive impact, such as a reduction in attendances and length of stay of patients from care homes participating in the programme.
- Maternity services received a rating of 'requires improvement' from the CQC in May 2023. Following an extensive improvement programme, the service is now reporting statistically significant improvements across a range of metrics including: perinatal mortality rates, Hypoxic Ischaemic Encephalopathy (brain injury) rates, and in relation to the experience reported by women and families.

9.4 Given the Trust's size and complexity, and the scale of the improvement agenda, the need for a single and supported improvement model is self-evident. At present, there is confusion about how this should be done. It is likely that, by scaling up and standardising a quality improvement approach, successes like those listed above could go faster and further.

Recommendation 20: Agree a corporate approach to improvement, which reflects the feedback in this report. The approach taken should be supportive of the culture the Trust is seeking to drive, and build on existing strengths. We would suggest that a model which enables local, grassroots engagement, and feels intuitive to the widest group of staff would be helpful.

Improvement capability is enabled across the trust. All teams can access in-house expertise and/or an external partner for support to improve.

9.5 The Trust has a Kaizen (continuous improvement) team, however the majority of people we spoke to felt that the visibility and impact of this team was limited. Given that the Kaizen team is purported to be integral to the delivery of PFIS training, we suggest that the role, function and profile of this team is carefully considered and potentially relaunched.

Leaders build a shared purpose and vision that provides the strategic goals for all the trust's improvement activities and alignment of improvements to individual processes. There are clear goals for research, improvement, and innovation in terms of outcomes for people who use services and staff. There is evaluation against these goals.

9.6 As outlined at Chapter 3, a new strategy has very recently been finalised, and a suite of supporting strategies and delivery plans is now required. This includes a need to clarify the future of the Trust's improvement model.

9.7 Under the historic PFIS approach, the Trust designated research and innovation as one of its 'true north' (core Board) metrics. The specific aim was to "*within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies*". Most recent data on this metric report to the Board shows that there has been a marked improvement since December 2023. However, there is still significant progress to be made if achieving this metric remains relevant under the new strategy.

9.8 In 2023, the Trust launched a five-year Research and Innovation Strategy. Central to the Trust's vision is the Clinical Research Facility (CRF) which is planned to be on the Royal County Hospital site. A joint venture with the University of Surrey, the CRF will be a purpose-built facility which supports the delivery of early translational and experimental medicine research, from studies testing new treatments in patients for the very first time (first-in-human trials) through to early safety and efficacy trials. There is a NED-chaired committee overseeing this agenda.

9.9 There has not been any form evaluation of the Trust's efforts since the launch of the research and innovation strategy in 2023 with the focus thus far being on establishing divisional-level research and innovation plans, ensuring that there is internal capacity and expertise, and infrastructure to deliver the strategy's aims. We understand that further work is still required to ensure that the job planning exercise actively considers research capacity on a consistent basis across the Trust, to develop plans for site-based research hubs, and to further develop research leadership and capacity in the non-medical workforce.

The trust has a structured approach to quality assurance, quality management, quality improvement and quality planning, as recommended by the National Quality Board. Insights gained from responding to patient safety incidents feed into the trust's improvement efforts. The trust's patient safety incident response plan (PSIRP) demonstrates a thorough understanding of ongoing improvement work and demonstrably takes this into consideration as part of patient safety incident response planning.

9.10 A Quality Governance manual was launched in August 2024 which sets out the Trust's approach to "*enabling, delivering and overseeing quality practice and governance*". The document is a useful repository of information such as portfolios, links to policies, and an overview of governance structures. The alignment of the manual to the new strategy, and the relevance of reference to PFIS, needs consideration in light of feedback throughout this report. We found scope for components of the manual, such as Leader Standard Work, to be more actively and consistently applied throughout the organisation.

9.11 Feedback from divisions was broadly consistent that quality governance structures and processes beyond divisions would benefit from reclarification. Some of this was attributed to the need to refresh sub-groups that feed into the QGSG as described at Chapter 7. However, there is also the perception that this is symptomatic of quality governance being subordinate to other parts of the Board's agenda, namely finance and efficiency.

9.12 A key component of any Trust's quality governance processes is the PSIRP which sets out its approach to implementing the nationally-mandated PSIRF. At an operational level, the Trust was an early adopter of PSIRF and has an-established approach to learning from patient safety events. We

heard that some Board members, including the Chair, have demonstrated visible and positive engagement on the PSRIP; however, the systematic focus at Board-level could be improved. Examples of this could include six-monthly Board workshops which provide insight into the Trust's response to and learning from complex incidents.

9.13 Key to implementing the PSIRF successfully is having a healthy safety culture. The wider findings in this report in relation to speaking up, psychological safety, valuing diversity and behaviours have the potential to undermine the work undertaken thus far to ensure a mature and effective patient safety governance framework.

Recommendation 21: Review the safety culture of the Trust in full in light of the findings in this report in relation to psychological safety and wider organisational culture.

10 Environmental sustainability – sustainable development

This means: ***We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.***

The trust's leaders demonstrate a commitment to environmental sustainability. The trust has appropriate governance and support from leaders, with a board member who is responsible for approving and delivering their net zero targets and Green Plan.

The trust can demonstrate that it has taken all reasonable steps to minimise the adverse impact of climate change on health. It does this through processes and interventions to simultaneously improve patient care and reduce carbon emissions and environmental harm, while tracking their progress. The trust communicates these actions to its workforce, patients and partners in the system.

10.1 The Trust Strategy has a clear commitment to 'going green' and sets out five commitments to achieving this. The Trust's Green Plan, 'Patient First, Planet First' was published in August 2023. The stated goal is for UHSx to become net zero for direct carbon emissions by 2040, and indirect emissions by 2045. There are currently no agreed targets for indirect emissions.

10.2 We understand that these targets have been continuously rebased and heard that there appeared to be no consequences to missing these. This has led to low levels of confidence in achieving the Trust's Green Plan and there was no sense from anyone we spoke to in the Trust that this is a priority.

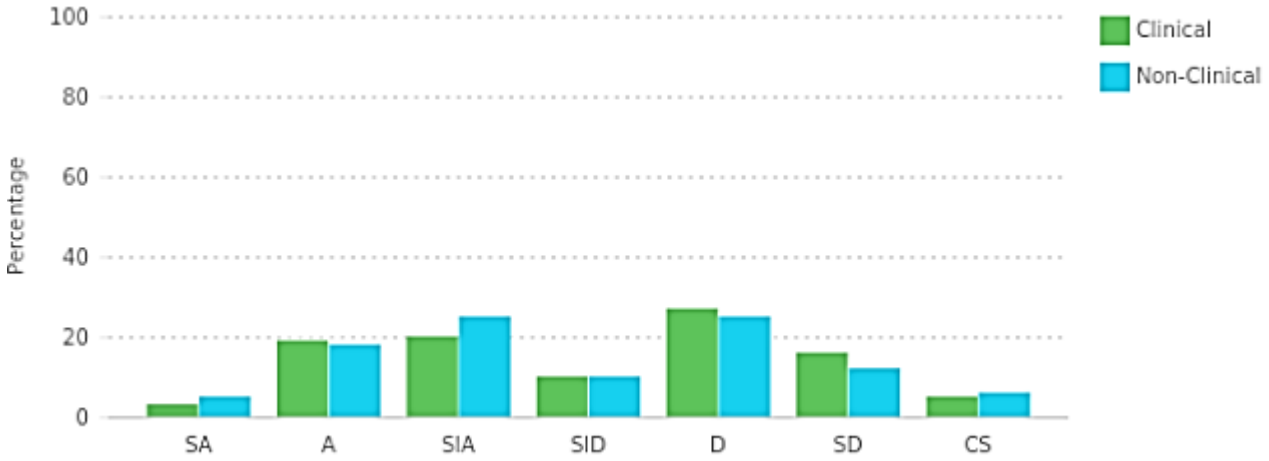
10.3 A clear view emerged that, in the face of such significant operational, financial and subsequent safety pressures, the risks associated with non-delivery of the Green Plan are too distant to meaningfully occupy the Board's agenda for the foreseeable future.

10.4 The Board's self-assessment outlines that there is an estimated cost of £120m to decarbonise the estate. In light of the financial pressures described throughout in this report, it is difficult to see how this can be re-prioritised without significant external resourcing and support.

The trust makes its workforce aware of their individual carbon footprint in the context of their role and enables and supports them to reduce this.

10.5 The survey issued to staff shows mixed awareness of the Trust's Green Plan:

Fig. 13 I am familiar with the key objectives of the Trust's Green Plan.



10.6 Comments added to the survey showed a common frustration with the lack of resources to recycle while at work.

10.7 A high number of comments returned expressed frustration that staff are being asked to consider these factors within the current challenges on demand:

"Patients are dying in the corridors, this is not the time to be Greenwashing the Trust."

"We cannot meet BASIC human needs with our current standards of care - hydration, nutrition, privacy, toileting so please stop wasting resources on 'green issues' when there are elderly vulnerable people lying in urine on trolleys in the corridor for days with virtually no fluid or food and no dignity, privacy, or basic care."

10.8 None of the staff we met during our visit to each of the seven sites knew about the Trust's green agenda. On analysing the comments returned in the staff survey, we noted two clear themes: the first was that there is a group of staff who see this agenda as an add-on and one which they are too busy to engage with, and not core part of their role.

10.9 The second feedback there was the very high numbers of staff who are personally engaged with this agenda, and are frustrated by what they perceive to be a lack of senior commitment. There is a feeling that environmental impact is contingent on the individual rather than a corporate agenda. Common frustrations were expressed, for example, in relation to:

- An ongoing reliance on paper and printing.
- A reliance on disposable or single use clinical equipment.
- Poor recycling facilities.
- A perception that leaders fly internationally to receive training (we did not corroborate this).
- A perception of unnecessary patient travel due to the clinical pathways in place:

"Why are we making pts travel 2 hours to Brighton to get certain treatments when there is a 20 minute option of going to Portsmouth??"

- Insufficient facilities to support cycling to work.

Recommendation 22: Agree and re-confirm, as a Board, the level of organisational commitment to the Green Plan (and wider Green agenda), the realistic goals aligned to this, and how they will be monitored. Re-confirm this to staff and clarify how they can contribute to these goals.

Appendix 1 - Glossary

BAF	Board Assurance Framework
BAME	Black and Minority Ethnic
BSUH	Brighton and Sussex University Hospitals NHS Trust
CCO	Chief Culture Officer
CEO	Chief Executive Officer
CFO	Chief Finance Officer
CiC	Committee in Common
CNO	Chief Nursing Officer
CMO	Chief Medical Officer
COM	Clinical Operating Model
COO	Chief Operating Officer
CQC	Care Quality Commission
CRF	Clinical Research Facility
CRR	Corporate Risk Register
DDN	Divisional Director of Nursing
DDO	Divisional Director of Operations
EDI	Equality, diversity and inclusion
EPR	Electronic Patient Record
F&PC	Finance and Performance Committee
FFT	Friends and Family Test
FTSU	Freedom to Speak Up
GIRFT	Getting It Right First Time[6]
HALO	Hospital Alternative Oversight
ICB	Integrated Care Board
ICS	Integrated Care System
IPR	Integrated Performance Report
LGBTQ+th	Lesbian, gay, bisexual, transgender, queer (or questioning), intersex, asexual, and others.
NED	Non-executive director
OD	Organisational Development
ODG	Operational Delivery Group
P&CC	People and Culture Committee
P&QC	Patient and Quality Committee
PFIS	Patient First Improvement System
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
QGSG	Quality Governance Steering Group

[6] An NHS England programme designed to improve patient care through reviews of services and benchmarking.

QIA	Quality Impact Assessment
RCS	Royal College of Surgeons
RIDC	Research, Innovation and Digital Committee
RSCH	Royal Sussex County Hospital
RTT	Referral-to-treatment
SDR	Strategic Deployment Reviews
SIP	Single Improvement Plan
TMC	Trust Management Committee
ToR	Terms of Reference
UHSx	University Hospitals Sussex NHS FT
WSHFT	Western Sussex Hospitals NHS FT

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