Brighton & Hove City Council

Health Overview & Scrutiny Committee

Agenda Item 14

Subject: **Maternity Services at the Royal Sussex County Hospital**

Date of meeting: **18 November 2026**

Report of: **Chair of the Health Overview & Scrutiny Committee**

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Ward(s) affected: (All Wards);

Key Decision: No

For general release

Glossary	
University Hospitals Sussex NHS Foundation Trust (UHSx)	UHSx is an NHS acute trust which manages hospitals in Brighton, Haywards Heath, Worthing, Shoreham and Chichester
Amos Review	Baroness Amos chaired the National Maternity and Neonatal Enquiry which reported in June 2026
Ockenden Review	Ockenden reviews are a series of investigations, chaired by Donna Ockenden, of maternity services at individual NHS trusts, including Shrewsbury & Telford (2022), Nottingham (2026) and Leeds (2026 – not yet concluded)
Care Quality Commission (CQC)	The CQC is the national NHS and social care regulator. Part of its duties is to inspect individual NHS services, including maternity

1. Purpose of the report and policy context

1.1 This report provides information about maternity services at the Royal Sussex County Hospital (RSCH). It includes some context about the recently concluded Amos review of maternity services, the Ockenden maternity reviews, and Care Quality Commission (CQC) inspections.

1.2 Information provided by University Hospitals Sussex NHS Foundation Trust (UHSx) is included as Appendix 1 to this report.

2. Recommendations

2.1 Health Overview & Scrutiny Committee notes the report.

3. Context and background information

3.1 UHSx provides consultant-led maternity units at each of its 4 Sussex general hospital sites, RSCH in Brighton, Princess Royal in Hayward's Heath, Worthing, and St Richard's in Chichester. In recent years, maternity and neonatal services have received a good deal of attention via the Amos National Maternity and Neonatal Enquiry and a series of Ockenden reviews of services at individual trusts. The Amos review and the Ockenden Nottingham review both include national recommendations for improvement at all NHS maternity and neonatal units. UHSx was one of 12 NHS trusts inspected as part of the Amos review, and an Ockenden review of UHSx services has recently been announced. In addition, the CQC regularly inspects and rates maternity services, with reports on UHSx published in 2021 and 2025. More information on all of these processes is provided below.

3.2 Amos Review

3.2.1 In 2025, Baroness Valerie Amos was appointed to chair a National Maternity and Neonatal Investigation. The Amos team inspected services across 12 individual trusts, using the information gathered to make recommendations for national improvement. The 12 trusts were selected for a variety of reasons including feedback from patients, but also to ensure the review included a wide range of services in terms of geography and patient demographics. The review was published on 30 June 2026. It includes a series of national recommendations which must be considered by all NHS acute trusts. The report and recommendations can be accessed here: NMNI-Final-Report-and-Recommendations.pdf

3.2.2 In addition to the national report, the Amos review also published reports on each of the trusts it inspected. These do not include trust-specific recommendations but do include comments on trust performance and feedback from staff and from bereaved families. The UHSx report is available here: University-Hospitals-Sussex-NHS-Foundation-Trust-Report.pdf

3.2.3 Amos notes that UHSx does well in terms of maternity safety metrics. For example, the UHSx neonatal mortality rate per 1000 live births was 2.1 for the year ending December 2025, which is lower (i.e. better) than the national average and the rate for comparable trusts.

3.2.4 However, Amos also notes that in the 12 months ending Dec 2025, only 48.5% of neonatal nursing shifts at RSCH were staffed in line with guidance and service specifications. This is lower than the national average and also lower than UHSx units at Chichester and Worthing.

3.2.5 The review team reported that RSCH maternity feels cramped; that there are some real practical difficulties in running maternity services across 4 relatively distant hospital sites; that a learning culture appears not to be fully embedded across services; that staff morale is low and is impacted by negative media coverage; and that staff express concerns about staffing levels.

3.2.6 Bereaved families praised aspects of RSCH services highlighting the work of community midwives, communication, and the kindness of staff, and sensitive and culturally appropriate services for some Black and racially minoritised communities. Families also made some negative comments about UHSx services, including noting that families weren't listened to, that services appear overstretched, and that some people for whom English is not their first language experienced problems communicating with staff.

3.3 Ockenden Review

3.3.1 The Ockenden Reviews are a series of independent reviews of maternity services at individual trusts. A review of Shrewsbury & Telford NHS Hospital Trust reported in 2022, and a review of Nottingham University NHS Hospitals Trust was recently published. A reviews has recently commenced at Leeds and one is planned at UHSx. There is no single rationale for the establishment of an Ockenden Review, and the reasons for reviewing UHSx have not yet been disclosed. However, Ockenden Reviews to date have focused on trusts with serious performance concerns.

3.3.2 **Nottingham Review.** The Ockenden Review of maternity services at Nottingham University NHS Hospitals Trust made a number of recommendations for service improvement Findings, conclusions and essential actions from the independent review of maternity services at Nottingham University Hospitals NHS Trust. Some of these are specific to the Nottingham acute trust, but others are recommendations for trusts across England. The national recommendations are lengthy, covering themed areas including listening to women and families; workforce planning and safe staffing; training; risk assessment during pregnancy; incident investigation and family involvement; governance; culture; and post death care.

3.3.3 Details of and timelines for the UHSx Ockenden Review have not yet been finalised and the trust will consequently not be able to discuss plans for this review with the HOSC.

3.4 Care Quality Commission (CQC)

3.4.1 The CQC is the national NHS and social care regulator, responsible for inspecting hospital services. In December 2021, the CQC published inspection reports on all UHSx maternity units, rating Chichester, Worthing and Hayward's Heath as Requires Improvement, and Brighton as Inadequate (the CQC rates services as either Inadequate, Requires Improvement, Good, or Outstanding). In January 2022, Brighton & Hove HOSC received a report on UHSx improvement planning in response to the CQC inspection report. This was followed up with an update report in October 2022, with UHSx reporting good progress across its maternity improvement targets. There was a further update to HOSC in November 2024.

3.4.2 The most recent CQC inspection of RSCH maternity was published in December 2025, rating RSCH maternity as Requires Improvement, an improved position from the previous inspection, but still with areas of under-performance.

3.5 UHSx, alongside all NHS trusts managing maternity and neonatal services, is required to develop plans to address the national recommendations in the Amos Review and the Nottingham Ockenden Review, as well as reflecting on the comments on trust performance included in the UHSx-specific Amos report. UHSx must also respond to CQC inspection report recommendations. Information provided by the trust which outlines their approach to maternity and neonatal improvement is included as Appendix 1.

4. Analysis and consideration of alternative options

4.1 Not relevant for this information report.

5. Community engagement and consultation

5.1 None for this information report.

6. Financial implications

6.1 No direct financial implication arising from this information only report.

Name of finance officer consulted: Ishemupenyu Chagonda Date consulted: 09/11/26

7. Legal implications

7.1 There are no direct legal implications arising from this report which is to note.

Name of lawyer consulted: Victoria Simpson Date consulted 09/11/26

8. Risk implications

8.1 None for this information report.

9. Equalities implications

9.1 None directly for this information report.

10. Sustainability implications

10.1 None identified.

10. Health and Wellbeing Implications:

10.1 None directly for this information report.

Other Implications

11. Procurement implications

11.1 None identified.

12. Crime & disorder implications:

12.1 None identified.

13. Conclusion

13.1 Members are asked to note the update on RSCH maternity services.

Supporting Documentation

1. Appendices

1. Information provided by UHSx.