University Hospitals Sussex
NHS Foundation Trust

Maternity service update

BHCC HOSC – 18 November 2026

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Excellent
Care
Everywhere

We are compassionate
We are inclusive
We are respectful

Today's briefing

1. Our service and current performance
2. Improvement journey
3. CQC and Amos findings
4. National learning and our response
5. Listening to women, families and staff
6. The Independent Maternity Review, chaired by Donna Ockenden
7. Current safety and quality at RSCH
8. Discussion



Our maternity and neonatal service

One service supporting communities across Sussex

- Around 9,000 babies a year
- Consultant-led maternity units in Brighton, Haywards Heath, Worthing and Chichester
- Community maternity and home birth services
- Specialist and personalised care for women with more complex needs
- Trust-wide safety, governance and improvement arrangements

Royal Sussex County Hospital

- Maternity care for Brighton and surrounding communities
- Specialist care for some of the most premature and seriously unwell babies in the region
- The only Level 3 Surgical Neonatal Intensive Care Unit (NICU) in Sussex
- One of only 14 neonatal intensive care units providing neonatal surgery in England

Recognising harm and listening to families

Every instance of avoidable harm is one too many

Our ambition is to provide the safest possible care for every woman and baby.

We know we do not always get things right.

Some women, birthing people, babies and families have experienced care or outcomes that fell below the standards they should expect.

We are deeply sorry when this happens, and our thoughts and deepest condolences remain with families who have experienced the tragic loss of a baby or harm while in our care.

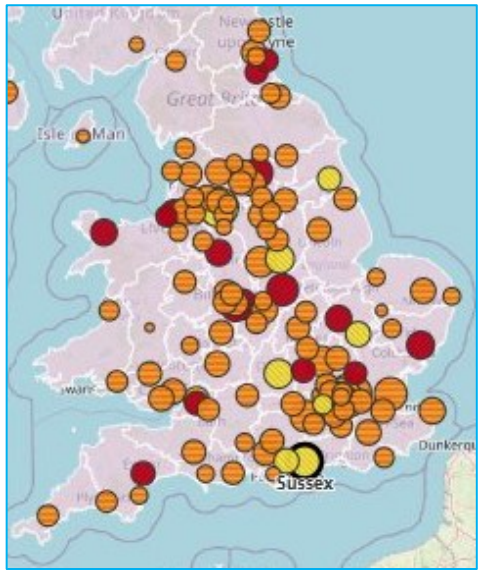
Before we look at the wider evidence

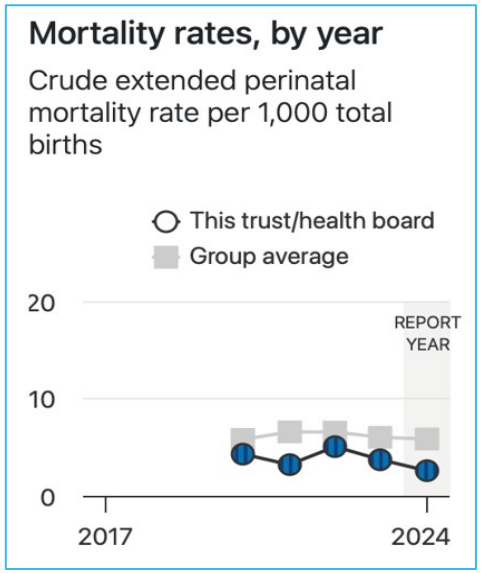
The data we share today in no way diminishes the experiences of individual families, or the terrible impact of harm or loss.

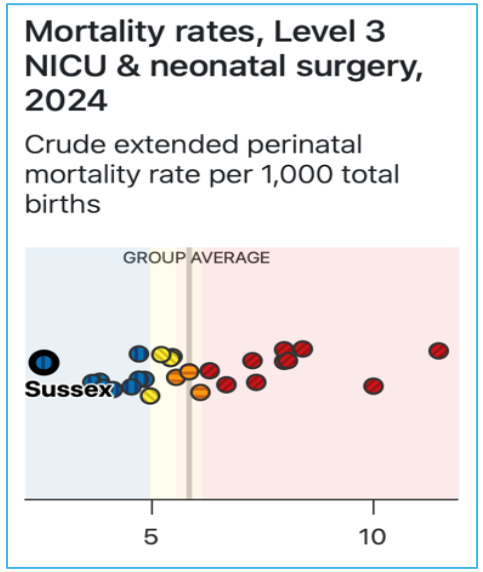
We share it to help the Committee understand how our services are performing overall, and where further improvement is needed.

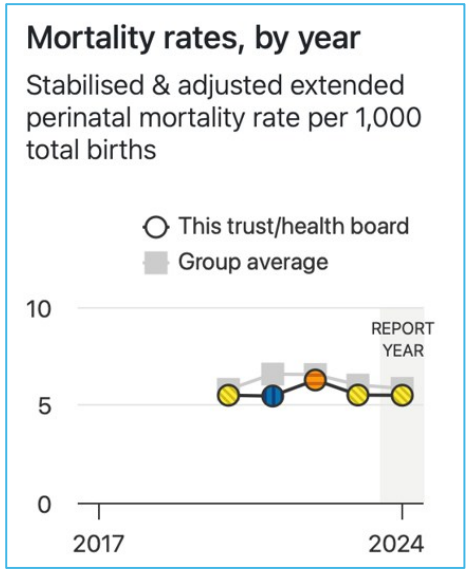
How do we compare to other maternity services?

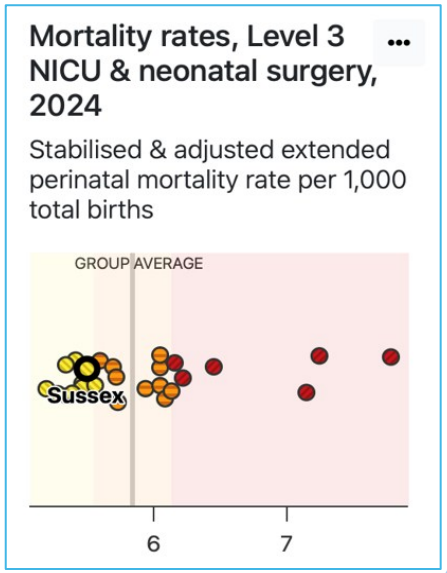
University Hospitals Sussex compares favourably to other maternity providers











Mortality rate compared with the group average

- Over 15% lower
- 5 to 15% lower
- Within 5%
- Over 5% higher
- Suppressed due to small numbers

*MBRRACE-UK is nationally recognised source of maternity safety benchmarking data, enabling reliable comparison of outcomes across NHS maternity services

What does the wider evidence tell us?

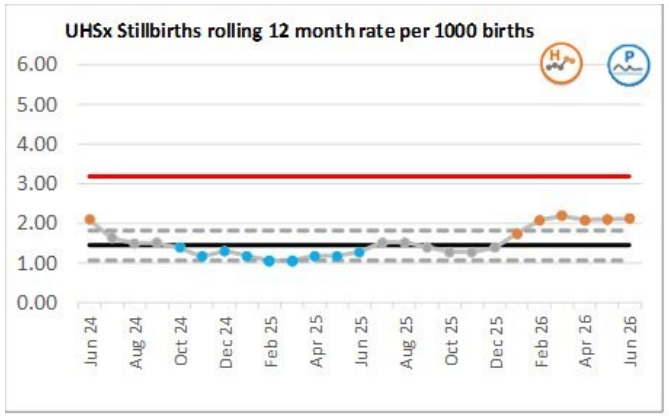
Independent evidence provides important assurance about our overall outcomes

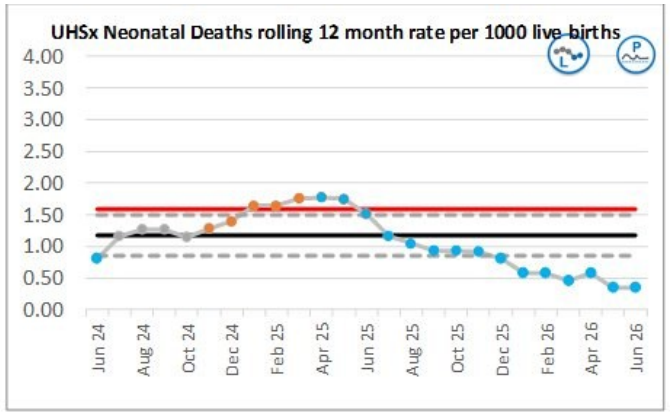
Stillbirths - rate is below national benchmark. July 2026 review concluded no concerns about care contributed to outcomes.

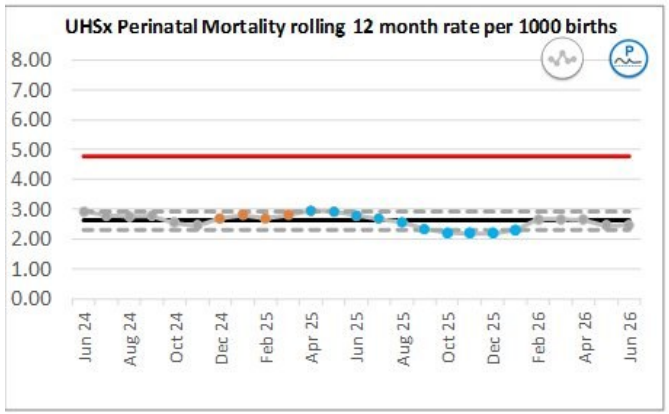
Neonatal deaths - sustained reduction. Less than half national rate. Last occurrence April 2026, before that none since November 2025.

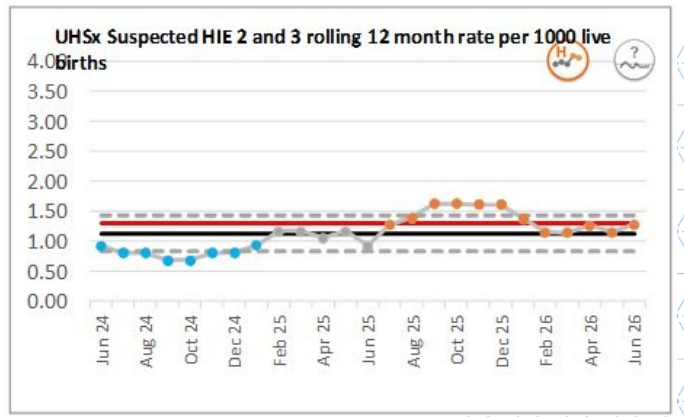
Perinatal mortality - stillbirths and neonatal deaths combined are much lower than national rates at 2.64/1000 births vs 4.77/1000 births.

Suspected Hypoxic Ischemic Encephalopathy - HIE and / or brain injury rates are currently equal to national average.









Experience of women and families

Overall feedback is positive, but individual experiences vary

Women commonly value

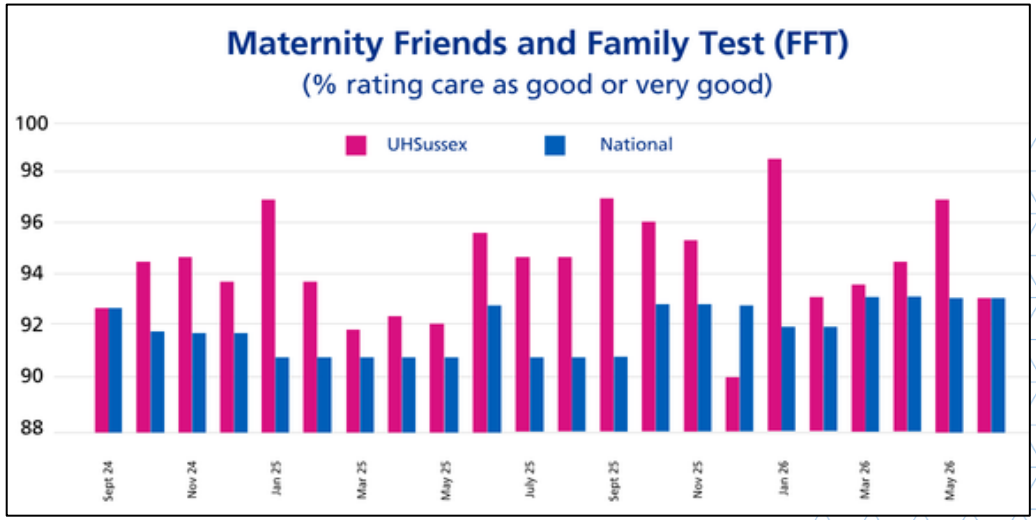
- Kind and compassionate staff
- Feeling supported and reassured
- Involvement in decisions

Women also tell us to improve

- Communication and consistency
- Responsiveness and waiting times
- Postnatal care and environment
- Listening when concerns are raised

Positive survey findings matter, but averages can obscure individual poor experiences.





Our improvement journey

Substantial progress has been made, with more still to do

2021

- RSCH maternity rated *Inadequate* by CQC
- Leadership, staffing, governance and safety assurance required

2022 onwards

- Entered NHS England's Maternity Safety Support Programme (MSSP)
- Original CQC "must do" and "should do" actions completed
- Improvement supported and independently monitored by NHS England

2025

- RSCH maternity improved to *Requires Improvement*
- MSSP said, "demonstrable improvements from ward to board noted by all stakeholders"

What has changed across the service?

Significant investment has strengthened our workforce, leadership and services

Workforce

- Midwifery vacancies reduced from 22% in 2022 to near-full establishment
- Birthrate Plus approved and fully funded, with recruitment underway to enhanced staffing model

Leadership and safety

- Site-based multidisciplinary leadership teams
- Stronger executive safety oversight and governance
- Enhanced safety forums and learning arrangements



Care and support

- Specialist maternity telephone triage.
- Improved bereavement care and facilities.
- Enhanced support for vulnerable women and families.
- Improvements co-produced with the Maternity and Neonatal Voices Partnership.

How have we responded to the RSCH CQC report?

Most actions completed and further improvement underway

Changes now embedded

- Audit findings routinely inform clinical guidance and practice
- Enhanced maternity triage using the Birmingham Symptom-specific Obstetric Triage System
- Planned caesarean lists moved away from the labour ward
- Improved monitoring and escalation of delays to induction of labour
- Dedicated maternity pharmacist recruited

Further work in progress

- Completing and ratifying remaining policies, with 77% now live
- Introducing digital clinical-record audits
- Increasing leadership visibility and staff support

Estates

- Infection prevention concerns identified during the inspection have been addressed.
- Wider constraints within Sussex House require a longer-term plan

What did the Amos review tell us?

Strengths and important areas requiring attention

Positive findings

- Strong performance against several safety measures
- Neonatal mortality below national and comparable Trust rates
- Examples of kindness, communication and culturally appropriate care



Areas requiring attention

- Neonatal staffing at RSCH
- Maternity and neonatal estate
- Consistency of learning
- Listening and responding to families
- Staff morale and workforce pressures
- Communication where English is not a family's first language

Neonatal care and staffing at RSCH

Significant investment has strengthened the workforce, with specialist training continuing

What Amos reported

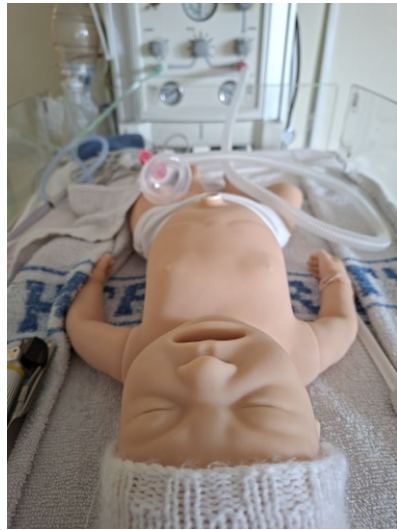
- 48.5% of shifts met the Qualified in Specialty (QIS) neonatal staffing standard in 2025
- The report does not specify the methodology or data source underpinning this figure

What we can evidence

- Previous funded workforce deficit addressed through NHS England investment
- Funded nursing establishment now meets British Association of Perinatal Medicine standard
- Shift fill rates are consistently above 90%
- Specialist neonatal nurse development remains a priority

Building capacity

- Seven nurses currently completing specialist training
- Further cohort planned for early 2027
- QIS workforce expected to reach approximately 60% by January 2027



National learning from maternity reviews

Reviews identify recurring themes across maternity services

- Listening to women and families
- Safe and sustainable staffing
- Risk assessment and escalation
- Multidisciplinary training
- Leadership and governance
- Incident investigation and learning
- Culture and staff voice
- Bereavement care



We have reviewed more than 200 national recommendations and consolidated the relevant actions within our improvement programme.

One comprehensive improvement programme

Our Maternity and Neonatal Improvement Plan (MNIP) brings all learning together

Sources of learning

- CQC, Amos and national Ockenden recommendations
- NHS England
- Incidents, complaints and mortality reviews
- Women, birthing people, families and staff

How delivery is assured

- Actions prioritised by safety risk
- Named accountable leads
- Evidence required before closure
- External input and challenge
- Reporting through executive governance and Trust Board



Listening and responding to women and families

Women and families must be central to improvement

- Family involvement in incident and mortality reviews
- Open communication following safety incidents
- Family Liaison and bereavement support
- Complaints and feedback informing improvement
- Partnership with the Maternity and Neonatal Voices Partnership
- Engagement with seldom-heard communities
- Accessible information and interpreting support

We must listen particularly carefully when families tell us they were not heard or their concerns were not acted upon.

Public confidence, families and staff

Maintaining confidence during a period of intense scrutiny is increasingly challenging

Impact on women and families

- Increased anxiety about maternity care among some expectant families
- More time needed in consultations to discuss concerns and provide reassurance
- Increased requests for intervention, including caesarean birth
- Some women choosing care outside their local maternity service

Impact on staff and services

- National conversation, sustained scrutiny and media coverage affects morale and wellbeing
- Sustained scrutiny and adverse coverage can have a significant emotional impact on staff
- Increased risk of sickness, burnout and retention pressures

Our priority is to support women and families to make informed choices,
while supporting our staff to continue providing safe, compassionate care.

Independent Sussex Maternity Review

Supporting families, staff and learning throughout the review

- Chaired by Donna Ockenden, families and staff will be able to contribute independently
- Established following representations from bereaved and harmed families
- Opportunity for families to seek answers to unresolved questions
- Preparatory work is underway, with the formal scope and Terms of Reference being finalised

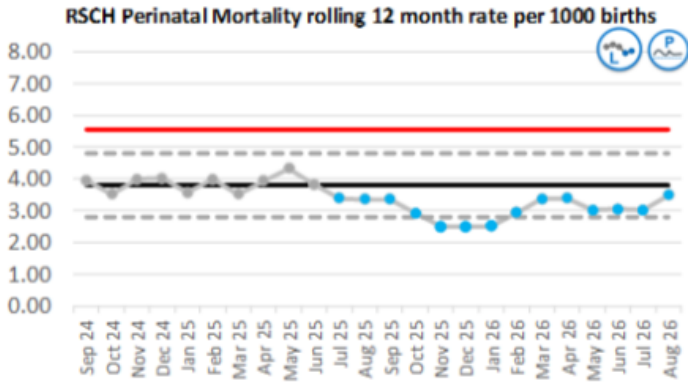
Our commitment

- Cooperate openly and transparently
- Dedicated review support, with Department of Health and Social Care funding
- Support staff and protect frontline clinical capacity
- Feed emerging learning directly into our improvement programme

We will act on learning as it emerges, rather than wait for the final report.

Summary – maternity and neonatal care at RSCH today

Current evidence provides important assurance, alongside areas for continued improvement



Safety, outcomes and experience

- Outcomes compare favourably with national benchmarks
- Perinatal mortality rate consistently better than national average

Women and families

- Women consistently describe compassionate and supportive care
- Overwhelming majority of service-user feedback is positive
- Some poor individual experiences continue to inform improvement

Service capability

- Sussex's only Level 3 Neonatal Intensive Care Unit
- Funded neonatal nursing establishment now meets the relevant standard
- Continued investment in specialist neonatal skills

Taken together, the evidence provides important assurance about the overall safety and quality of our care at RSCH, while identifying areas where further improvement is required.

Summary – our challenges and priorities

We have made significant progress, but important challenges remain

Public confidence and service resilience

- Managing the impact of national focus on maternity
- Increasing complexity of care and changing demand
- Delivering a sustainable service while meeting changing national standards

Estates and facilities

- Maternity and neonatal environments are constrained
- Longer-term solutions need to support safe, modern and resilient care
- Rising elective C-Sections and theatre capacity

Staffing and morale

- Sustained scrutiny and review activity is placing additional pressure on staff
- Recruitment, retention, wellbeing and support for colleagues are key priorities
- Continued need to grow specialist maternity and neonatal skills and resilience

Our commitment to local women, babies and families

University Hospitals Sussex NHS Foundation Trust

Safe care today. Continuing improvement for the future.

What the evidence shows

- Most women and babies receive safe, compassionate and high-quality care
- Outcomes and experience measures provide important assurance
- Our teams remain committed to excellent care every day

What we recognise

- Some families experienced care that fell below expected standards
- Workforce, estate and consistency challenges remain
- Families and staff must continue to be heard

What we will do

- Maintain focus on safe care every day
- Act on CQC, Amos and emerging IMR learning
- Be transparent with families, HOSC and our communities

Discussion