East Sussex Healthcare
NHS Trust

East Sussex Healthcare NHS Trust Board Agenda

Date: Tuesday 21st April 2026

Time: 09:30 – 12:45

Venue: The Relais Cooden Beach, Cooden Sea Rd, Bexhill-on-Sea TN39 4TT

	Opening Business	Lead	Action	Time	Paper
1.	Welcome and apologies	Chair	Information	09:30	
2.	Colleague Recognition	Chair	Information	09:35	Yes
3.	Declarations of Interest	Chair	Information		No
4.	Minutes of Trust Board Meeting in public on 17th February 2026	Chair	Approval	09:40	Yes
5.	Matters Arising	Chair	Discussion		Yes
6.	Board Committee Chairs' Reports	Committee Chairs	Assurance	09:50	Yes
7.	Chief Executive's Report	CEO	Information	10:00	Yes
Quality, Safety and Performance					
8.	Integrated Performance Report, Month 11 (February) (i) Chief Executive Summary (ii) Quality & Safety (iii) Our People (iv) Access and Responsiveness (v) Financial Control and Capital Development	 CEO CNO/CMO DCEO COO CFO	Assurance	10:15	Yes
9.	Maternity Overview Q3	CNO / CW&C / IDMS	Approval	11:00	Yes
Break – 10 minutes					
Strategy					
10.	ESHT Five Year Integrated Delivery Plan	CFO	Assurance	11:25	Yes
Governance and Assurance					
11.	NHS Staff Survey Results	DCEO	Assurance	11:40	Yes
12.	Board Assurance Framework Q4	COS	Approval	11:55	Yes
13.	Delegation of Approval of Annual Report and Accounts	COS	Approval	12:05	Yes

For Information					
14.	Use of Trust Seal	Chair	Information	12:10	Yes
15.	Board Forward Planner	Chair	Information	12:15	Yes
16.	Questions from members of the public	Chair		12:30	No
17.	Date of Next Meeting: 16th June 2026	Chair	Information		
18.	Close	Chair			

Steve Phoenix
Chair

Key:	
Chair	Trust Chair
CEO	Chief Executive
CFO	Chief Finance Officer
CNO	Chief Nurse and DIPC
COO	Chief Operating Officer
COS	Chief of Staff
CMO	Chief Medical Officer
CW&C	Chief of Women & Children's Division
DCEO	Deputy Chief Executive
DCN	Deputy Chief Nurse
DOP	Director of People
DTSI	Director of Transformation, Strategy & Improvement
IDMS	Interim Director of Maternity Services

Board Meetings in public: Etiquette

Please be aware that there are a number of things that we know contribute to productive meetings and show respect to all members in the room. If you are attending the meeting then we would be grateful if you would consider the following:

- Mobile devices that are not used solely for the purpose of following the meeting ought not to be brought into the meeting
- If you are required to have a mobile device about your person, please keep the use to a minimum, and ensure that it is on silent mode. If you are required to take a call, please do so outside the meeting
- All members of the public are asked to sign in
- Recording devices should not be used in the meeting
- The Trust Board is a meeting in public, not a public meeting. As such, the Chair leads and directs the meeting. Papers are presented to the chair (not to the public) so where points are raised/responses are made these should be directed to the Chair
- Questions from members of the public may only relate to items on the agenda, and these will be considered in the time set aside on the agenda
- If several members of the public wish to raise questions, the Chair will seek to ensure a fair allocation of time among questioners

Board Meetings in public 2026:

Date	Location	Timing	Any other information
16th June	Lecture Theatre, Conquest Hospital	0930-1245	
18th August	St Mary's Boardroom, EDGH	0930-1245	
15th September	Relais Cooden Beach, Bexhill	1400-1600	Annual General Meeting
20th October	Relais Cooden Beach, Bexhill	0930-1245	
15th December	Lecture Theatre, Conquest Hospital	0930-1245	

Agenda Item: 2

Report To/Meeting	Trust Board	Date of Meeting	21st April 2026

Report Title:	Colleague Recognition
Key question	How does the Trust recognise and thank colleagues for their contribution, effort and loyalty?
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐

Report Sponsor:	Jacquie Fuller, Assistant Director of HR – People Engagement	Presenter(s):	Steve Phoenix, Chair
Report Author:	Melanie Adams, People Experience Manager – People Engagement		

Outcome/Action requested:	The Board is asked to receive this report for information and assurance about the formal recognition of our people over the last two months.
Executive Summary	East Sussex Healthcare NHS Trust recognises that the high standard of care and quality of service it provides is dependent on the contribution, effort and loyalty of its people. This is an opportunity for the Trust to acknowledge the exceptional performance, behaviour, achievements and contribution that our colleagues and volunteers have made to the organisation.
Regulatory/legal requirement:	Not applicable
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration
Resource Implication/VFM Statement:	Not applicable
Risk:	Not applicable

No of Pages	6	Appendixes	0

Governance and Engagement pathway to date:	None
What happens next?	Rolling delivery of the colleague recognition programme
Publication	Yes

1. Introduction

Recognising the contributions of our colleagues is more than a gesture of appreciation, it is a key part of fostering a positive and inclusive culture at the Trust. Every day, individuals and teams go above and beyond to deliver compassionate care, support each other and drive improvement in patient outcomes. By celebrating these efforts, we not only boost morale and engagement but also reinforce our values which underpin the service we provide to the people of East Sussex.

This report highlights the incredible work of our colleagues and the impact of meaningful recognition in strengthening our workforce and enhancing the overall experience for our colleagues and our patients.

2. Celebrating our people

2.1 Trust Awards 2026

The annual Trust Awards celebrate the dedication, compassion and innovation our people demonstrate every day. They provide an opportunity to recognise individuals and teams who go above and beyond to deliver exceptional care and support to our patients and communities. A key part of the Trust's colleague recognition programme, the awards align with our People Strategy and reinforce our commitment to valuing, engaging and supporting colleagues at ESHT.

This year's award nominations launched on 1 April. There are 12 award categories, which include the People's Choice award, voted for by the public, and the Chairman's Award, a special award chosen by the Chairman recognising an individual or team who has inspired colleagues and set a high standard for others to follow.

Anyone can nominate a colleague, team, ward or service, and it makes a real difference for individuals and teams to know their work has been recognised. Everyone who nominates will be entered into a prize draw to win a voucher as a thank-you.

We are returning to the De La Warr Pavilion in Bexhill on Sea for this year's awards ceremony, which will take place on the 17 September.

2.2 Hero of the month

Colleagues can nominate an individual or team who has gone above and beyond their job role to help a patient, family member or colleague, demonstrating the Trust values of kindness, integrity and inclusivity. At the end of each month nominations are scored against the three trust values. Each division will have a winner and the individual or team with the highest overall score will be announced as the Trust's Hero of the Month.

December 2025 – Newington Ward Team and Nurse Kathy: Urgent Care & Medicine Division

A member of the public has nominated the incredible team on Newington Ward at Conquest Hospital, and in particular Kathy Clifford, for their outstanding care and compassion.

"Sadly, my mum passed away yesterday on Newington Ward. While there were challenges earlier in her care journey, the staff and doctors on this ward truly deserve recognition for the exceptional support they provided during her final days. They were wonderful, caring, and consistently showed empathy and respect to both my mum and our family.

I want to give special mention to Kathy, who was simply brilliant. Despite some spirited moments with my mum, Kathy cared for her with unwavering patience and kindness. She gave me peace of mind during an incredibly difficult time and treated us all with a loving, compassionate manner. The way she spoke to our family and continued talking to mum in her last days was deeply comforting and made us feel she was in the best possible hands.

Please consider this heartfelt nomination for a team award for Newington Ward and, if possible, a solo award for Nurse Kathy. Their dedication and humanity made an immeasurable difference to our family."

January 2025 – Pathology PPCs Team: Cellular Pathology, Conquest Hospital – Core Division

The Pathology PPC team, made up of Sarah Cocks and Natalie Ades, has had an extraordinary impact on the department. Their commitment consistently goes far beyond what is expected, often using their own time to ensure that patients' results are reported promptly. They are frequently the ones who must chase others for information or actions, an unenviable task that is not always well received, yet they manage to remain positive, professional, and unwavering in their integrity. Their contribution has become absolutely vital to the functioning of the department, even though the breadth of their role is not always fully understood or appreciated by others. They carry out an exceptional range of responsibilities: tracking, chasing, monitoring, expediting, and stepping in to support the laboratory whenever staffing has been short.

Despite this additional workload, they still catch up on PPC duties in their own time to ensure that every patient has the best possible chance of receiving the right treatment as quickly as possible. Their work is not only diligent but also forward-thinking. They regularly propose innovative improvements to processes that help expedite cases and strengthen the department's efficiency. They also provide continuous support with outsourcing providers, raising issues promptly and ensuring appropriate follow-up. December was a particularly challenging period, with reduced consultant capacity and annual leave within the PPC team.

Despite these pressures, Sarah and Natalie prioritised effectively, highlighted unreported cases, and ensured timely follow-up, ultimately preventing multiple cases from breaching. Their dedication, resilience, and proactive approach make them an indispensable part of the department, and their contribution deserves meaningful recognition.

2.3 Long service recognition

The number of long service awards issued between February and March 2026:

Month	Year										Combined Total
Month	5 years	10 years	15 years	20 years	25 years	30 years	35 Years	40 years	45 years	50 years	Total
February 2026	51	42	6	9	5	2	3	0	1	0	119
March 2026	62	29	11	4	2	6	1	0	0	0	115

2.3.1 Celebrating our long service colleagues

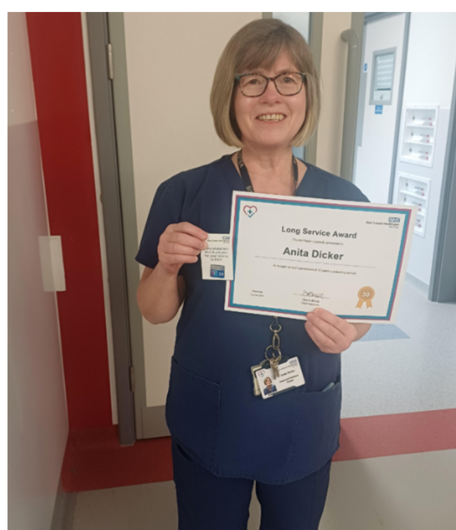
Ajesh Kochupurayil – 5 years

Gary Carter – 5 years

Lianne Legg – 10 years

Anisha Persand – 10 years

Cherie Weston – 15 years



Anita Dicker – 30 years

2.4 Our retiring colleagues

The Trust recognises colleagues who are retiring after 20 years of dedicated service to the NHS. Each month a retirement celebration is hosted alternately across our sites, led by the Chairman. Retiring colleagues are invited to attend with a family member and/or a work colleague or manager.

These events provide a meaningful opportunity for the Trust Board to formally express gratitude for the contributions of our long-service staff. Each retiree is presented with a framed certificate of appreciation, acknowledging their commitment and service.

Feedback from attendees has been overwhelmingly positive, with many expressing how valued they feel by the gesture. Those attending consistently share how much they appreciate the personal touch, and the events themselves are always joyful occasions, filled with warmth and appreciation.

We extend our sincere thanks to all colleagues who have dedicated many years to supporting our patients and communities. Below are retiring colleagues receiving their Appreciation and Recognition certificates from Steve Phoenix, Chairman.

January 2026

Tonia Wilmshurst – Healthcare Science Practitioner Haematology

Julie Ball – Staff Nurse, Benson Ward

3. Conclusion

Over the past two months, the Trust has continued to prioritise colleague recognition, reinforcing a strong culture of appreciation that is essential for sustaining staff morale and engagement. Recognising achievements and service milestones not only showcases the dedication and excellent of individuals and teams but also strengthens staff connection to our Trust values. These activities support a sense of belonging, highlighting the value of long-term commitment, and contribute to a motivated workforce focused on delivering compassionate, high-quality care for our patients and service users.

4. Recommendations

Continued investment in colleague recognition initiatives is key to encouraging and sustaining a positive workplace culture of thanks and respect, which plays a valuable role in people engagement at ESHT.

East Sussex Healthcare NHS Trust Board Minutes

Date: 17th February 2026

Time: 09:30 – 12:45

Venue: St Mary's Boardroom, EDGH

		Actions
	Attendance: Steve Phoenix, Chair and Non Executive Director Jayne Black, Chief Executive (CEO) Amanda Fadero, Non-Executive Director Simon Merritt, Chief Medical Officer (CMO) Charlotte O'Brien, Chief Operating Officer (COO) Paresh Patel, Vice Chair and Senior Independent Director Spencer Prosser, Non-Executive Director Frank Sims, Non-Executive Director Andrew Strevens, Chief Finance Officer (CFO) Carys Williams, Non-Executive Director Non-Voting Directors Ama Agbeze, Associate Non-Executive Director (via MS Teams) Jenny Darwood, Director of People (DOP) Amber Lee, Associate Non-Executive Director Richard Milner, Chief of Staff (COS) In Attendance Julie Allen, Dementia Care Associate Practitioner (DCAP), for item 03/26 only Claire Bishop, Deputy Chief Nurse (DCN) Aly Hulme, Interim Director of Midwifery (IDM), for item 10/26 only Sharon Sheldrick, Dementia Care Associate Practitioner (DCAP), for item 03/26 only Dawn Urquhart, Assistant Director - HR – Education (EDHRE), for item 15/26 only Pete Palmer, Board Secretary (BS) (minutes) Observing Nicky Hughes, Executive Assistant Zoe Urban, Executive Assistant Five members of the public were in attendance at the meeting.	
	Apologies: Steve Aumayer, Deputy Chief Executive and Chief People Officer (DCEO) Vikki Carruth, Chief Nurse & Director of Infection, Prevention and Control (CN) Simon Dowse, Director of Transformation, Strategy & Improvement (DTSI)	
01/26	**Chair's Opening Remarks** Steve, Chair welcomed everybody to the meeting.	
02/26	**Colleague Recognition** Steve, Chair reported that December's Heroes of the Month had been the Touch of Gentleness Team, from Critical Care, Conquest. He explained that retirement lunches had been a recent introduction in the Trust, which provided a way to thank colleagues	

	who were retiring after long service. These had been well received and were very enjoyable.	
03/26	**Dementia Training** Julie, DCAP, and Sharon, DCAP, delivered a presentation on dementia training to the Board. Steve, Chair, praised the presentation, noting that as individuals aged, they become increasingly exposed to dementia and therefore a deeper understanding of the implications of the illness was essential. Spencer, NED, also thanked the presenters and asked how many patients with dementia were currently known to the Trust. Julie, DCAP, responded that the Trust were treating approximately 150 patients at any given time who were identified as having dementia, with higher numbers at EDGH than at CQ. Sharon, DCAP, added that many cases remained undiagnosed and highlighted that there was currently a year-long waiting list for diagnostic testing. Younger patients, including those in their sixties, were increasingly being diagnosed with dementia. The DCN praised the presentation and commented that the level of care and support provided by the team was exceptional. She endorsed the training provided by the team, observing that it gave staff valuable insight into how patients with dementia felt and how best to support them. Work continued to enhance the training, with targeted training, particularly within assessment areas, and work with community partners ongoing. Julie, DCAP, confirmed that a one-day study session had recently been made mandatory for the elderly care team; she aspired to incorporate virtual training, which offered powerful insight into patient behaviours, into the training being offered. Frank, NED, thanked the presenters; he noted that there was a request for some additional space for training and equipment storage and felt that this was relatively modest in relation to the potential benefit. The CFO noted the positive impact that the training and service was having on patients and explained that she would be meeting with the team to discuss their requests. Frank, NED, noted the statistical information provided about diet in the presentation and asked how the Trust could ensure consistent delivery of feeding, interaction and support for patients, given the positive impact this could have on patient wellbeing and reduced length of stay. Julie , DCAP, explained that the dementia team encouraged dementia champions to work closely with HCAs to promote good practices. Dementia boxes, designed to engage patients, were also utilised and the team undertook fundraising to purchase equipment that enhanced patient experience. Small interventions could make meaningful differences. Paresh, Vice Chair, added his thanks for the insightful presentation and confirmed his intention to attend training. He asked whether an application had been made to the ESHT Charity for support. Sharon, DCAP, advised that no approach had been made. Steve, Chair, noted that the Friends of the Hospital might also be supportive of equipment purchases and were keen to support bids from services. Steve, Chair, asked how staff could access the training. Sharon, DCAP, explained that staff could contact the team directly and that the training was also available via MyLearn. She confirmed that the training could be adapted to meet the needs of different groups. Steve, Chair, thanked the presenters again for their contribution and for the vital work they carried out on a daily basis.	
04/26	**Declarations of Interest** There were no interests declared for any item to be considered on the agenda. All declarations of interest were noted as held on the Register of Directors' Interest.	

05/26	**Minutes** The minutes of the Trust Board meeting held on 16th December 2025 were reviewed. No amendments were and they were agreed as a correct and accurate record of the meeting.	
06/26	**Matters Arising** • *73/23 and 72/24 – Trust IPR* The new format Integrated Performance Report (IPR) was included in the Board pack. The COS explained that reporting arrangements had been reviewed in December and as a result, activity and referral data were now being reported through the Finance and Productivity (F&P) Committee; this approach would be kept under review. Improvements to broader Board reporting were also being considered and the recommendations for improving reporting from a recent governance review by the Good Governance Institute would be discussed further in the private meeting. Carys, NED, questioned whether the IPR in the Board papers provided sufficient assurance regarding community services. The COS explained that during recent reviews with Committee Chairs, no concerns had been raised about any gaps in reporting. Steve, Chair, noted the growing significance of community services and their planned transformation. He asked what dataset would be required to ensure that reporting captured the emerging picture, both for the Trust and for patients receiving care. Carys, NED, reiterated that she did not yet feel assured by the current reporting for community services. The COS advised that negotiations regarding the Neighbourhood Alliances would result in a set of KPIs which would be incorporated into future IPRs. The CEO reported that some elements of the negotiation were ongoing; the redesign of divisions, including the proposed movement of frailty into CHIC, would be followed by a further review of IPR reporting. Steve, Chair, agreed that action 73/23 should remain open until this work had been completed. Steve, Chair, asked when metrics relating to Integrated Neighbourhood Teams would be included within the IPR. The CEO explained that the service was due to go live on 1st April, with data available following this. Carys, NED noted that one-off deep dives could occasionally be commissioned to provide additional assurance if necessary. Paresh, Vice Chair, thanked the team for the improved reporting to F&P. He asked whether it was possible in the IPR for the KPIs to be reviewed to ensure a consistent matrix of reporting across Committees and the Board so that a single, reliable source of data was used throughout. JB agreed that consistency was important but emphasised the need to avoid over-reporting or presenting data that was not relevant to the audience. The new reporting approach would remain under review. • *118/25 – Board Forward Planner* This was included in the Board pack.	
07/26	**Board Committees Chairs' Reports** Audit Committee Spencer, NED, presented the Audit Committee's report to the Board. He confirmed that the Committee had received and discussed an informative Emergency Preparedness, Resilience and Response (EPRR) report,. The Committee had also held a constructive discussion regarding the cyber risks facing the organisation. He reported that external audit work remained on target to enable delivery of the annual accounts by year-end.	

	Carys, NED, referred to the Committee's discussion on cybersecurity and asked whether the organisation had approved the Committee's recommendation that cybersecurity training be made mandatory. The DOP confirmed that this had been agreed and would be implemented; monitoring of compliance would be reported to the People and Organisational Development (POD) Committee. Finance and Performance Committee Paresh, Vice Chair, presented the Finance and Performance Committee (F&P) Committee's report, advising that the Trust's financial performance remained challenging and that active discussions were ongoing with system partners regarding the financial position. It was likely the organisation would require a cash draw-down in the region of £22–25 million in the future. CIP delivery remained on target despite the high target for the current year and was expected to remain similarly high in 26/27. Plans were in place to accelerate capital expenditure during the final six weeks of the financial year in order to meet the agreed programme. People and Organisational Development Committee Frank, NED, presented the POD Committee report. He advised that a number of items related to national changes had been considered by the Committee, including developments affecting leadership programmes, the apprenticeship levy, and leadership development funding. He noted that these areas were subject to potential delays or reductions in national funding allocations. The organisation was taking internal steps to mitigate the impact of these changes, though it was disappointing to face reductions in available funding. The Trust had achieved a 50% response rate in the recent annual staff survey, which was a very positive outcome. He drew particular attention to the improvement among resident doctors, where a 10% increase had been recorded. Quality and Safety Committee Amanda, NED, presented the Quality and Safety Committee (Q&S) report. The Committee had reviewed maternity performance and noted a rise in stillbirth rates, which was currently being investigated with outcomes brought back to the Committee in due course. Discussions had taken place about the community paediatrics waiting list for autism assessments as the position remained challenging; a fundamental review with commissioners was required to address the underlying issues. Good progress had been made with the audiology improvement programme, but there remained significant work to do. The Committee had reviewed the impact of the recent MADE Perfect Week. There had been considerable effort involved in preparing for and delivering the event which had generated a positive operational impact. Amanda, NED, noted that proactive discussions with commissioners prior to winter would be beneficial to explore how the improvements achieved during these events could be sustained more consistently. Despite the pressures associated with two recent business continuity events and the winter period, key quality and safety metrics were broadly holding steady. This was testament to the dedication and hard work of staff across the organisation. ***The Board noted the Committees Chairs' reports***	
08/26	**Chief Executive's Report** The CEO presented her report. She expressed her thanks to all colleagues, system partners and local communities, noting that the beginning of the year had been exceptionally challenging, particularly in the context of the recent power outage. She praised colleagues from across the organisation who had worked extremely hard to maintain safety and the continuity of patient care throughout this period. The Care Quality Commission had recently undertaken an unannounced visit to the Emergency Department at EDGH. Early feedback had been broadly positive, although a	

	number of actions had been identified for follow-up. She highlighted that, despite the department's high activity levels, the Care Quality Commission (CQC) had recognised strong foundations of care, compassion and professionalism. She offered her thanks to all staff involved. Ian Smith, Chair of NHS Sussex, had recently visited EDGH and had expressed an intention to visit Conquest Hospital in March, as well as community services. The CEO thanked colleagues for supporting these visits. She announced that Professor Scarlett McNally had been awarded an OBE and extended congratulations on behalf of the Trust. She extended her thanks to the Friends of the Hospitals for their ongoing support, noting that the Trust could not achieve what it did without their contributions. Donations from the Friends made a significant difference to the services the Trust was able to provide. Steve, Chair, asked about the Trust's productivity and the CEO explained that the HSJ had recently published work undertaken by NHSE on productivity across Trusts, which had highlighted a significant increase in ESHT's productivity; the Trust had ranked fourth nationally. She congratulated colleagues on this achievement, noting that the outcome reflected improvements in efficiency across theatres, outpatients and other services. The Trust had made strong progress in improving efficiency through better use of its available resources. Steve, Chair, added that a new metric for productivity covering the first six months of 2025/26 was forthcoming. While further clarity would be needed on the methodology behind the measurement, he described the achievement as excellent. The CFO noted that, viewed simply, activity levels had increased while workforce usage had decreased, and that ESHT was one of the few Trusts nationally to have achieved this. ***The Board noted the CEO's report.***	
09/26	**Integrated Performance Report (IPR) for Month 9 (December)** The IPR was jointly reported by the DCN, CMO, DOP, CFO and COO. <u>Quality and Safety</u> The DCN presented the update. Highlights from this section included: • A decreased number of patient safety events had been reported in December, 97% of which had a low score. • Focussed work on falls had been undertaken; the Patient Safety Incident Response Framework (PSIRF) had been used to identify areas for improvement as slips, trips and falls remained the top category for incidents in the Trust. • The majority of medication errors reported were near misses, and were due to incorrect administration. Work was being undertaken with the pharmacy team to improve timely administration of medicines following a complaint from a patient about Parkinson's medication; the work was linked to a Royal College of Nurses campaign. • Antenatal, labour and postnatal care were the top three maternity categories; numbers of incidents in maternity were small. • The maternity team continued to embed learning with a current focus on still births. The Trust had recruited substantively to the Head of Midwifery and Director of Midwifery roles. The Trust was fully compliant with the Maternity Incentive Scheme (MIS) with a detailed paper included on this meeting's agenda. • Top themes for complaints were around communication and waiting times for appointments. • Positive Friends and Family Test (FFT) feedback continued to be received around staff and care; this had also been highlighted by the CQC during their recent visit.	

- A number of workforce projects were taking place within divisional teams, including support due to ongoing operational pressures. Increased senior leader visibility had also been put in place.
- 20 new Clinical Support Workers (CSWs) had been employed by the Trust each month as part of the NHS New to Care programme and to address the substantive vacancy gap.
- Work to improve mandatory training compliance continued with a recent focus on Oliver McGowan training, PSIRF Level 2 and the Management of Patients with Mental Ill Health.

Paresh, Vice Chair asked for more information about incidents relating to difficulties contacting the Audiology service and about Sussex Premier Health (SPH). The DCN explained that the Audiology issues had been temporary and had since been resolved; the SPH issue had related to expectation management and involved small numbers of cases arising from clinician sickness.

The CMO provided an update on mortality metrics. He reported continued improvement in the Summary Hospital-level Mortality Indicator (SHMI), which remained comfortably within the acceptable range; crude mortality remained stable. The Risk Adjusted Mortality Index (RAMI) was reported at 88, compared to the benchmark of 100, placing the Trust just below its peer group. Deep-dive reviews were ongoing in areas where excess mortality had been identified, including sepsis. Reviews into fractured neck of femur and fluid and electrolyte disorders had already been completed and had resulted in improvement actions.

Spencer, NED referred to the graph on page 49 of the report and commented that while the overall trajectory was positive, the graph did not reflect this. The CMO agreed that the scale of the graph was unhelpful; a deep dive undertaken the previous year had identified challenges relating to the coding of frailty, as frailty did not exist as a single clinical code but instead needed to be represented through multiple comorbidities. The SHMI was not considered a reliable mortality measure for integrated trusts due to the impact of community beds, but remained the nationally mandated metric. The Trust had removed Same Day Emergency Care (SDEC) patients from its mortality dataset, whereas other trusts had not, and he anticipated that improvements would continue to emerge over the coming months.

Carys, NED asked for an update on sepsis. The CMO explained that while the results of the recent deep dive were not yet available, current data was used to identify areas where further review might be needed. IPR data indicated that sepsis screening performance was not consistently meeting expected standards and he hoped that the deep dive would provide more definitive conclusions.

Our People – Our Staff
The DOP presented the update. Highlights from this section included:

- There was continued stability in core workforce metrics in December; pressure from seasonal sickness was in line with normal trends.
- Temporary staff usage had fallen despite the increase in demand for nursing.
- Current workforce priorities were well being, retention and recruitment into hard to fill roles.
- Turnover remained at a historically low rate. Vacancy rates had increased slightly but remained within tolerance.
- Mandatory training rates had improved to 92.7%.
- Sickness rates had increased and remained challenging. Annual sickness had increased to 5.5%, although 74% of this increase had been due to coughs, colds and flu so a reduction was anticipated.
- The Sickness Reduction Group had done a lot of work to look at the causes of illness; the Trust had a maturing workforce, and it had been found that while there were less incidents of sickness, more sick days were being taken. Work in

conjunction with NHSE had demonstrated a link between the age of the workforce and sickness levels and a deep dive into this was being undertaken.

- Mandatory training compliance remained high, but face to face training for Basic Life Support remained an outlier, with an improvement plan developed.
- A submission for a grant from NHS Charities Together had been made to support wellbeing and engagement programmes, restorative supervision and mediation. The outcomes of this bid were awaited.
- A remedial process had been undertaken to review incomplete appraisals recorded on MyLearn, which had improved compliance to 81%. There was now a focus on outlying teams and ensuring that appraisals were properly recorded once completed.

Spencer, NED noted that the sickness rate appeared to be quite high and asked what a reasonable expectation might be for reducing it. The DOP explained that achieving a rate below 5% would be challenging; the national target stood at 4% but the organisation was unlikely to reach that level given the nature of its workforce profile. Work was underway to benchmark the Trust's performance against organisations with a similar workforce composition.

Carys, NED noted that sickness rates that were too low could indicate that staff were attending work when unwell, which was not desirable. She stated that she would be content with a reduction to around 5% and thanked the DOP for undertaking the deep-dive review, looking forward to seeing the outcomes when available.

Access and Responsiveness
The COO presented the update. Highlights from this section included:

- Elective and cancer performance continued to be good in December, with only a small number of patients waiting for more than 65 weeks. The number of patients waiting for more than 52 weeks was reducing.
- Referral to Treatment (RTT) performance had improved and the Trust was in the second quartile nationally.
- The Trust was ahead of trajectory and for both the Faster Diagnostic Standard and 62 day cancer performance. Diagnostic performance had reduced in December, but a recovery plan had been put in place.
- Emergency Department (ED) performance had been 72.9% in December, but had reduced in January due to increased demand and infection control challenges. Additional capacity had needed to be opened as a result. A MADE event would be held the following week as part of plans to recover performance.
- Performance against the Urgent Community Response standard had been 82.6% and virtual wards had seen 90.6% occupancy. Community paediatric waiting times were beginning to improve following the appointment of a new provider.

Frank, NED, observed that, given the wider context, the Trust's metrics were holding up relatively well. He highlighted concerns regarding 12-hour waits, noting the risk of normalising extended waits that would previously have been considered unacceptable and asked how the organisation assured itself regarding the safety, quality and experience of patients waiting for prolonged periods. The COO explained that all patients who experienced long waits in ED were reviewed, prioritising their movement through the department wherever possible and balancing waiting times with clinical priority. The DCN noted that EPIC and the nurse-in-charge processes were also used to assure patient safety. The CQC had commended the Trust's approach, although they had indicated that formal patient assessments should occur at least every two hours. Improvements had been made to triage processes, supporting clinical safety and ensuring that patients requiring immediate care were identified promptly. She stressed the importance of prioritising acutely unwell patients while also working with community services to ensure that patients who did not require admission received appropriate alternative care. The COO added that while improvements had been made, further work

was required, particularly at weekends; however, daily reviews and discussions continued to drive progress.

The CEO explained that the Trust had been deliberate in ensuring the right actions were taken for patients. The MADE event prior to Christmas had provided an opportunity to review practices and develop sustainable improvements across clinical teams. She anticipated that further improvement would follow through the use of Continuous Quality Improvement (CQI), which would enable better measurement and assessment of performance. Neighbourhood teams and partnership working would help clarify when patients genuinely needed to attend hospital and what could be managed differently by system partners.

Amanda, NED, asked about care for patients in ED with mental ill health. The COO explained that patients requiring admission for mental health related reasons were admitted to an acute bed rather than remaining in ED, and this approach had been commended by the CQC. She confirmed that there were daily escalation meetings with Sussex Partnership NHS Foundation Trust (SPFT) to ensure appropriate support was provided. While some patients presented significant challenges, the relationship with SPFT was strongly collaborative; nine mental health patients were in the Trust that day, which was lower than previous levels. The Trust had been commended for appointing a Head of Nursing for Mental Health Services and for training CSWs to provide enhanced support. She expressed a desire to improve the environment further for patients with poor mental health waiting in ED.

Steve, Chair, asked whether the mental health team that had been established was having an impact on overall numbers, particularly given that patient numbers appeared to be reducing. The COO responded that demand fluctuated and numbers were not directly linked to the presence of the team, but the Board could be assured that strong support and oversight was in place. The DCN explained that the team contributed to a reduction in security incidents, that the quality of care had improved, and that initial assessments and liaison with SPFT were now stronger. She noted, however, that retaining the team remained challenging, given the unique nature of the role in an acute setting. Extending the model to paediatrics and community patients was being explored. The team had been very effective in signposting regular attenders to community services, reducing unnecessary admissions. SPFT were due to visit the Trust the following day to discuss how joint working could be further improved.

Amanda, NED, noted that the Board could be more fully sighted on this issue, despite it being a significant organisational risk. Steve, Chair, agreed, noting that while the topic was discussed frequently, it was not formally reported at Board level. The DCN advised that mental health-related activity was reported through the Violence and Aggression group for incidents and through Harm data for patient safety. She explained that measuring the impact of the mental health team was challenging, as improvements often resulted from multiple small interventions. She flet that improvements to date suggested the risk position had strengthened.

Financial Control and Capital Development

The CFO presented the update. Highlights from this section included:

- The Trust remained on plan for month nine, although maintaining financial performance was challenging.
- A cash call down would be required during the next financial year as part of medium term financial plan.
- The Trust recognised the importance of reaching a break even financial position for the year but doing so would be extremely challenging. If this was achieved then deficit support funding would be retained.

Steve, Chair, noted that the Board had held an Extraordinary Private Board meeting the previous week to discuss financial performance. The Trusts CIP target for the year was around 10% and meeting this would be extremely challenging.

The Board noted the Integrated Performance report.

10/26	**Maternity Incentive Scheme Year 7 Submission** The DCN and the IDM presented the report, noting that the Maternity Incentive Scheme (MIS) had already been reviewed by the Q&S Committee. The IDM explained that the MIS was a mandated process forming part of the Clinical Negligence Scheme for Trusts (CNST), and that the Trust was now in its seventh year of participation. Failure to achieve compliance carried both financial and reputational risks. The scheme provided assurance across several domains, including patient safety, training, workforce, data quality, governance, and the "Saving Babies' Lives" bundle. The submission had been reviewed and approved by the Trust's external auditors, issuing a highly positive report on the robustness and detail of the processes undertaken. The report was presented to the Board for approval of the declaration, prior to onward submission to the Integrated Care Board (ICB). The DCN and IDM emphasised that this was a positive outcome for maternity services and for the Trust as a whole. Amanda, NED, confirmed that the Q&S Committee had reviewed the submission in detail and praised the maternity team for the work they had done in supporting this submission. She noted the exceptional achievement in achieving compliance for seven consecutive years. Spencer, NED, explained that he had previous experience with the scheme and acknowledged the significant amount of work involved and offered congratulations to the team. He asked what financial incentive was associated with the scheme. The CFO noted that compliance with the scheme involved a rebate mechanism and the potential for additional funding. The DCN added that the financial incentive was not the only benefit of compliance; it also affected the Trust's CNST rating and set benchmarks for quality and safety standards. She thanked the IDM and others who had provided support throughout the process. Amber, ANED, asked whether the Trust would be required to repeat the process in the following year. The IDM confirmed that year 8 of the scheme would commence in April, noting that the annual presentation to NHS Resolution varied each year, making future requirements difficult to predict. Compliance provided valuable assurance to regulators, commissioners, and the public. Steve, Chair, requested that a formal note of thanks from the Board be sent to all those involved in the work. ***The Board approved the MIS Year 7 submission.***	
11/26	**Avoidability of Inpatient Deaths** The CMO presented the report, prepared in line with the Royal College of Physicians (RCP) template. Every patient who died under the Trust's care had their death reviewed by a medical examiner. Additional detailed reviews took place for deaths meeting specific criteria. The report covered the first quarter of 2025/26 and identified one death that was considered to have been probably avoidable. No deaths had been found to be avoidable amongst Learning and Development patients. Four deaths from 2020/21 had not yet been discussed. These cases pre-dated the appointment of the current Learning Disability Nurse and the Trust had not received the associated LeDeR reports. The Mortality Audit Group would therefore discuss the cases at its next meeting, despite the absence of the LeDeR reports. Carys, NED, asked for more information about families or carers raising a concern that did not become a complaint and asked how these concerns were differentiated from formal complaints. The CMO explained that such concerns were typically raised through contact with PALS, usually by telephone or in person. Although not processed as formal complaints, these concerns were still used for learning and formed part of the wider	

	review process. The majority of contacts received were not formal complaints but nonetheless contributed to organisational learning. ***The Board noted the Avoidability of Inpatient Deaths report.***	
12/26	**EDGH Power Outage** The COS presented the report, thanking the EPRR and Estates teams for their work in preparing its content. He explained that the power outage had been resolved within 38 hours and that the impact on elective and emergency activity had been minimised throughout. All patients whose treatment had needed to be deferred due to the outage had since been rebooked. There were ongoing concerns regarding the condition of the estate, particularly high and low voltage electrical networks at EDGH. These issues were longstanding, would require significant capital investment to address, and were now reflected on the Board Assurance Framework (BAF) through the capital risk entry. The report set out the lessons learned from the incident and referenced ongoing engagement with local MPs to seek support in securing the substantial funding, running into tens of millions of pounds, required to resolve the infrastructure challenges. The matter was also being escalated within the NHS. The CEO thanked colleagues for their responses during the incident, noting that their performance had been exemplary. She observed that had improvements under the New Hospital Programme (NHP) commenced as initially planned, many of the issues underlying the outage would likely have been rectified. The organisation needed to actively explore all potential sources of capita as it was not viable to wait 12 years for NHP funding to address infrastructure issues. Steve, Chair, added that any major new capital investment was increasingly likely to involve a form of PFI style financing rather than traditional NHS capital. Amanda, NED, thanked the COS for the report and for the organisation's response to the incident. She noted that delays to the NHP had exposed a range of estate related risks, several of which had been reported to the Q&S. She asked how these risks were being assessed and prioritised, and how the organisation was determining which areas would be most compromised. The CEO explained that the Trust had already identified the issues and understood the estate related impacts but needed to consider more thoroughly the implications for teams and services. This work would form part of the wider strategy review exploring the impact of estate constraints over the next three to five years, across all of the Trust's sites. Steve, Chair, highlighted that the Trust, had over £300 million in backlog maintenance and that addressing this was beyond the Trust's direct control. The COS reported that the organisation had recently strengthened its focus on risk and improved its governance structures. Additional risk meetings had been established to review divisional, corporate and operational risks in greater depth. He noted that a new Head of Risk would join the Trust at the end of March and would lead work to enhance risk-management training across the organisation. Improvements in risk processes would also inform the development of the 2026/27 BAF. The CFO confirmed that a 10 year estates strategy had been developed to address critical infrastructure risks. The Trust had submitted bids for additional estates funding and was awaiting national outcomes. Work was underway to broaden engagement across the organisation in determining the 26/27 capital programme, scoring potential projects against a range of metrics to ensure a robust pipeline of works. The CEO noted that the impact on staff and services had not yet been quantified but that doing so would be essential. Steve, Chair, noted that the scale of the estate issues was debilitating for the organisation. Frank, NED praised the huge amount of work by colleagues in responding to the power outage. He asked whether preventative maintenance processes should be strengthened within future planning as had been one factor in the outage. The CFO agreed, noting	

	that testing protocols also needed enhancement to identify issues proactively. The CEO reported that she had visited the estates team to thank them personally, recognising the significant impact the incident had had on them. A constructive discussion had taken place about how the Trust could ensure essential maintenance was completed and expertise retained. ***The Board noted the report***	
13/26	**Medium Term and Five Year Planning** The CFO presented an update on the Trust's financial plans for 2026/27. The plan represented a continuation of existing organisational direction and the development of priorities for the coming years. The CFO emphasised that CQI would form the foundation of the Trust's work going forward. Steve, Chair, noted that the Trust was continuing to finalise plans for 2026/27 and that a number of uncertainties still needed to be resolved. Further conversations about the plan would take place in the Board Meeting in private. ***The Board noted the report***	
14/26	**Local Government Reorganisation** The COS presented the report, explaining that it outlined the Trust's rationale for supporting the One East Sussex model. This model was expected to strengthen relationships and enhance existing processes; alternative approaches would be unlikely to achieve the same benefits. He noted that an announcement had been made earlier that day regarding the mechanics of upcoming elections and their timing. This announcement related solely to the electoral process and structural changes associated with the new authorities were not expected to be affected. Frank, NED was pleased that the report had remained apolitical. He asked whether the reorganisation process and forthcoming elections would impact on the progress being made with neighbourhood working, which was a significant priority for the Trust. The COS explained that he believed the reorganisation was unrelated to the progress achieved to date, as substantial work on restructuring and engagement was already underway. Steve, Chair, added that concerns had previously been raised under the former ICB administration regarding whether aligning integrated neighbourhood teams to local authority boundaries was the correct approach. While he noted that there was logic in doing so, particularly as population data was based on local government wards and boundaries, he cautioned that this rationale might weaken when district-level structures were removed. He observed that some of the original principles behind the alignment could be undermined by these changes. Amanda, NED, asked when the Board could expect to see progress from the Hastings and Rother Neighbourhood Team pilot. The CEO reported that the COS and DCEO were members of the steering group overseeing the neighbourhood work. The pilot remained in its early stages but had now been more formally integrated into the wider programme. She anticipated that progress should become visible within the next three to four months, enabling lessons to be learned for the broader transformation work. The COS explained that a significant element of the work had involved establishing effective engagement with GP practices, and that further development was required to ensure strong collaboration. The pilot was being coordinated through the Neighbourhood Alliance, which included primary care and provider organisations, and the ICB. The CEO noted that discussions were ongoing with the ICB to define which patient cohorts would be included, recognising that these may differ across areas. Steve, Chair, asked when the government was expected to confirm which structural options it intended to pursue. The COS explained that an announcement had been expected in late February, but this was now likely to change following the morning's developments. ***The Board noted the report***	

15/26	**Improving Working Lives Report** The CMO and EDHRE presented the report. The CMO explained that he was the Executive Lead for the NHSE programme on improving the working lives of doctors. The programme was being led locally by Dr Charlotte Rowe, the Trust's Lead Resident Doctor, who had jointly authored the report. Dr Rowe had sent her apologies for being unable to attend the meeting but hoped to be present at future meetings in her role as a link between the frontline medical workforce and the Board. The EDHRE outlined the findings of the survey undertaken by the Lead Resident Doctor, which were being used to identify areas requiring focus. Significant work had been undertaken with non-medical colleagues and efforts were being made to ensure that improvements applied equally across medical and non-medical staff groups. A key priority identified was self-development time, which was time in addition to study leave allocated for activities such as QI projects and supervision. There was consensus that entitlement to such time varied between staff groups, and work was underway to standardise this. She also reported on issues relating to rest and welfare facilities, including access to mess rooms, rest areas and lockers. Both sites had good mess facilities, but an audit of locker access was underway, as many staff were not aware of their location or how to obtain access. The Trust had installed smart vending machines across sites for food provision but awareness among doctors was inconsistent. Work would continue to improve both the quality and range of items available, and meetings were planned with the hotel services manager and the vending contractor to discuss these improvements. Rota notifications were 95% compliant, although some late changes persisted and work to reduce these further was ongoing. National processes for annual leave and study leave were being reviewed, and the Trust would work with relevant leads to ensure local systems aligned with emerging national expectations. Payroll accuracy had been raised as an area for improvement, and work was actively underway with the payroll team to address errors. National discussions regarding changes to junior doctor rotation patterns were ongoing, although no final decisions had been made and the impact on the Trust remained uncertain. Steve, Chair, asked how the Trust was performing compared with other organisations. The CMO explained that the Trust was performing better than average. The EDHRE added that the Trust was considered an exemplar in the South East, and that the survey developed by Dr Rowe had been shared nationally for use by other organisations assessing resident doctor experience. Steve, Chair, asked whether the Trust's status as an integrated organisation created additional complexity in delivering improvements. The EDHRE replied that no significant impact had been felt to date but acknowledged that challenges might arise in relation to food access and self-development time within community services, and that achieving consistency across the organisation would be essential. Amanda, NED commented that Dr Rowe had been extremely impressive when presenting to POD and asked whether she had sufficient support in place. The EDHRE confirmed that she had an educational supervisor, divisional support from the Divisional Associate Director, and access to the educational structures within the Trust. She also had open access to the CMO and CEO. Steve, Chair, explained that he would welcome the opportunity to meet with Dr Rowe. ***The Board noted the report***	
16/26	**Board Assurance Framework Q3.** The COS presented the Quarter 3 Board Assurance Framework (BAF), explaining that it set out the Trust's strategic risks and was reviewed by relevant Committees. There had been a small number of changes since the previous quarter with the ratings for BAFs 3	

	and 4 above expected risk levels. Work continued to ensure that risks recorded on the corporate risk register aligned appropriately with the BAF risks. These risks were reviewed at the relevant sub-committee meetings, and this process would be further strengthened with the appointment of the new risk lead. Carys, NED, welcomed the alignment of risks to Board Committees and asked whether the Board should consider undertaking deep-dives into the inherent risks and their mitigations over the next 18 months, noting that several risks were highly significant. The COS agreed that this was a valuable suggestion. He observed that the existing mechanism, where sub-committee chairs presented their reports to the Board, could be used to help identify when such deep-dives might be warranted. He proposed that the Audit Committee could be an appropriate forum to bring forward deep-dives, particularly where risks were increasing or becoming more complex. He would be happy to have a discussion about how this could work outside the meeting and supported strengthening the Board's oversight. ***The Board noted the Q3 BAF.***	
17/26	**Annual Reports:** 1. **Emergency Preparedness, Resilience and Response** The COO presented the EPRR annual report. She confirmed that the report had been reviewed by the Audit Committee. The Trust had achieved full compliance with EPRR core standards for the second consecutive year, reflecting the strength of its preparedness processes and governance. She noted that the organisation had experienced several real-time incidents in recent weeks, which had effectively tested the Trust's emergency response arrangements. Learning from these events would be captured and incorporated into future preparedness activity. 2. **ESHT Charity Annual Report and Accounts** Steve, Chair presented the Charity Annual Report and Accounts, noting that these had been approved by the Charity Trustees in January. ***The Board noted the EPRR and Charity Annual Reports***	
18/26	**Use of Trust Seal** Two uses of the Trust Seal since the last Board meeting were noted.	
19/26	**Questions from members of the public** Steve, Chair reported that Mr Campbell had submitted a number of questions to the Board prior to the meeting, some of which had been answered during the course of the meeting. Mr Campbell asked about potential underspend on the 25/26 capital programme. The CFO explained that the Trust had schemes in place to ensure that any shortfall was minimised. Capital processes were well controlled and a number of items had been approved in recent weeks that would be on site and invoiced by the end of the financial year. In response to a question from Mr Campbell about government reorganisation, Steve, Chair, explained that Integrated Community Teams (ICTs) would form an integral part of the local health system. Government and Trust policy was for a left shift into the community which would improve the care and experience of patients in local settings, with the additional benefit of reducing costs for the acute sector. It was important that the design of teams was correct with a focus on prevention and health promotion in the shorter term, which would then lead to a reduction in demand on hospital services. The Trust was closely involved in the design of the teams and hoped that this would lead to the most positive impact. He noted that being an integrated trust meant that the impact of ICTs might not be as great for ESHT as it was for other providers. The CEO noted	

that the ICB would be taking money from acute providers in 26/27 to form an improvement fund, which would help to bring about this change to the way care was provided. Work was being undertaken to identify changes to pathways which would ensure that the maximum benefit was realised.

Mr Campbell asked when benefits from the John Hopkins risk stratification tool would be seen. The CEO explained that the Trust was using this tool for its work on ICTs and hoped that there would be positive outcomes. Amanda, NED, reported that she had seen the tool used very effectively at Frimley Park to look at deprivation and need, incentivising different approaches to care. It was a helpful tool to understand population needs and frailty. Mr Campbell noted that it could be challenging to find evidence of the improvement delivered for individual trusts by the tool. Amanda, NED, explained that she thought there would be greater evidence available in the future. The COS agreed, noting that the principles of the tool had been utilised during the pilot of a screening tool for frail patients on admission.

Mrs Walke noted how busy the Trust's EDs were, and asked whether 111 calls by patients always resulted in a referral to A&E, and whether the Trust monitored attendances by this route and provided feedback to the 111 service. The COO confirmed that attendances were monitored and the Trust had seen an 11% increase in type 3 attendances from 111 and GP referrals. Ongoing conversations about this were taking place with the ICS.

Mrs Walke noted that Specsavers had started to send patients to A&E if they had a slight change to their vision; these episodes were not emergencies and were contributing to how busy A&E was. The COO explained that she was not aware of this and would follow up on the matter. Steve, Chair, noted that Specsavers were individual franchises, so this might not be the case for every branch.

Mrs Walke asked about the long waiting times for community paediatric appointments. The COO explained that discussions were ongoing with commissioners about the funding the Trust received for this service as it was insufficient and whether they were the best provider as numbers of referrals had increased.

Mrs Walke asked whether a further power outage could occur. Steve, Chair, explained that this could happen again. The Trust was speaking to NHSE about funding as it could not fund improvements alone. Other routes were also being pursued, including conversations with local MPs, to try to resolve the issue.

Mr Taylor asked about Terms of Reference for ophthalmology improvements taking place in Hastings and Rother, noting that the West Midlands ICB had a single pathway for patients, noting that including the ambulance service might lead to greater improvements. The COS confirmed that the ambulance service was already involved with the neighbourhood alliance.

Mr Hardwick noted that he had been pleased to see free parking reintroduced, but noted that this was for 15 minutes only when previously it had been for 30 minutes. The CFO explained that this change maximised parking spaces for patients. Free parking was available for 15 minutes which was sufficient time to drop off patients or items. Engagement had taken place with patient groups about the decision. Steve, Chair, noted that the charges were kept under review and feedback from Mr Hardwick would be considered as part of the next annual review.

Mr Hardwick asked whether MPs and Councillors were invited to the Trust's AGM. Steve, Chair, confirmed that they were, but uptake was low as it was not easy for them to attend. The CFO noted that MPs had other avenues of asking questions of the Trust.

Mr Campbell explained that the five-year plan contained a descriptor addressing the impact of block contracts, and added that, with the transition toward alliance

	arrangements and changes in commissioning, there might be an opportunity to minimise the effect of block contracts by distributing them across alliance members. The CFO clarified that the Government had previously indicated an intention for community providers to move towards an outcomes-based system, whereas they had historically operated under block contract arrangements. Although such opportunities might emerge as changes progress, they had not yet materialised for the 2026/27 contract. There was a need to ensure appropriate payment for both community and acute activity, while significant areas, including diagnostics, remained on block contracts. These elements needed to shift to a tariff-based system. The CFO explained that prior guidance had suggested contracts might be issued on a neighbourhood basis rather than through a global approach, although this shift had since been delayed. Such a development could still occur within approximately three years. Steve, Chair, cautioned that moving towards neighbourhood-based contracting carried risks of fragmentation and financial instability if not implemented carefully.	
20/26	**Agenda Forward Plan** The Board's forward plan was noted.	
21/26	**Date of Next Trust Board Public Meeting** Tuesday 21st April, 2026 at Cooden	

East Sussex Healthcare NHS Trust

Matters Arising from Public Board meetings

MEETING DATE	MINUTE NO:	ACTION	BY WHOM	BY WHEN	COMMENTS – INCLUDING ANY UPDATES
OPEN ACTIONS					
10.10.23	73/23	Consider how to increase the focus on community services data within the Trust IPR	Richard Milner	November 2025	04.12.25 This enhanced information will be included from the month 8 (November) IPR onwards. 16.12.25 It was agreed these actions should remain open until the new reporting was shared. 17.02.26 Action to remain open until KPI's emerging from neighbourhood alliance are included within IPR to enhance reporting about community services.
NOT YET DUE					
None					
ACTIONS COMPLETED					
None					

NHS
East Sussex Healthcare
NHS Trust

Report to:	Trust Board	Agenda Item:	6.1
Date of Meeting	25 March 2026		

Title of Report:	Audit Committee – Chair's Report
Status:	For Discussion
Sponsor:	Spencer Prosser, Chair of Audit Committee
Author:	Spencer Prosser, Chair of Audit Committee
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the Audit Committee on 25 March 2026 to provide the Board with an update of the Committee's activities.

Background

The Audit Committee holds delegated responsibility from the Board of Directors as set out in ToRs; this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

Review of Q4 Board Assurance Framework (BAF)

- The Committee received the Q4 BAF, noting an increase in the staff welfare risk from 16 to 20 following staff survey findings.
- A new risk lead would be joining, and the risk-to-BAF mapping process strengthened for 2026/27.

Accounting Policies, Estimates & Auditor Questionnaire Responses

- No major changes to national accounting manuals affecting the Trust.
- Materiality increased to £14.9m, triviality to £750k.
- The Committee discussed understanding of the "triviality bucket", inter-organisational agreement of balances, and an unused financial instrument discount rate.
- An internal adjustment was requested to wording around compliance monitoring (to reflect Chief of Staff responsibilities).

Tenders and Waivers

- Significant discussion on Omnicell maintenance waiver. Committee requested a clearer timeline and better coordination in relation
- James Consulting waiver – narrative correction required; total value £120k.
- Estates and Facilities had the highest number of waivers
- A deep dive into month-12 waivers was planned for the next meeting.

External Audit Plan

- External auditors confirmed resource is sufficient to meet the tight national timelines.
- Interim work showed no significant issues; Value for Money work was ahead of prior years.
- Delegated authority will be sought from the Board to allow the Audit Committee to approve final accounts in June.

Internal Audit Progress & Opinion

- New reports on financial controls and risk/BAF processes received reasonable assurance.
- Follow-up actions relating to CAFM (estates maintenance system) and DSP Toolkit remain delayed but progressing.

- Draft Head of Internal Audit Opinion: Moderate/Reasonable Assurance, reflecting strong progress and some remaining areas requiring refinement.

Counter Fraud Report
- The Trust achieved “Green” compliance against Counter Fraud Functional Standards.
- Cultural fraud survey and e-learning engagement were among the highest regionally.
- Noted two cases with identified losses but potential for recovery through HR processes.

Alert, Advise and Assure

Alert
None.

Advise
- Internal Audit follow-up on estates systems and DSP Toolkit remained in progress.

Assure
- Reasonable assurance ratings from Internal Audit on finance and risk.
- Improved risk management processes and refined BAF methodology.
- Strong counter-fraud compliance and engagement.

Key Risks or Opportunities and their impact on the Trust

- Staff welfare risk increased to 20 (BAF).

Key Decisions

- Approved Internal Audit Plan 2026/27.
- Approved Counter Fraud Plan 2026/27.
- Agreed to seek Board delegated authority to approve final accounts in June.
- Approved external, internal, and charitable funds audit fees.

Exceptions and Challenges

- Delays in Omnicell business case completion and need for greater coordination between divisions.
- Delay in Computer-Aided Facilities Management system going live, affecting estates maintenance control.
- Increase in single-tender waivers, particularly due to year-end pressures.

Recommendations

The Board is asked to note this report.

Report to:	Trust Board	Agenda Item:	6.2
Date of Meeting	21st April 2026		

Title of Report:	Finance & Performance (F&P) Committee
Status:	For Discussion
Sponsor:	Paresh Patel, Chair of F&P Committee
Author:	Paresh Patel, Chair of F&P Committee
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the Finance & Performance Committee on 25th March 2026.

Background

The Finance & Performance (F&P) Committee holds delegated responsibility from the Board of Directors as set out in Terms of Reference; this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

The Committee received updates on the following matters:

1. Board Assurance Framework

The Committee reviewed the Q4 BAF, noting that the ratings had not changed since Q3. A conversation would take place with the Board to discuss and agree the 2026/27 BAF risks.

2. Financial Performance

Month 11 performance had remained on plan, although the year to date position had been £1.1m adverse to plan. The Trust had reached agreement with the ICS to provide an additional £6m funding which meant that the Trust was expecting to reach a breakeven financial position for 2025/26. An application for an additional £25m cash would be made before the end of the March.

3. CIP Delivery

Month 11 CIP delivery was £5.5m, with year to date delivery of £46.3m. Work had commenced on identifying schemes for 2026/27, with a new Efficiency Programme Group being established to provide further support for CIP Delivery in the new financial year. Additional support would be provided to divisions for the delivery of CIPs moving forward.

4. Capital Update

Capital spend remained behind plan due to delays in receiving confirmation for come capital schemes. The Trust remained confident that it would utilise its full capital allocation for 25/26 through the purchase of equipment before year end, with all spend anticipated being appropriately receipted before the end of the financial year.

5. Transformation and Improvement Update

An update on system wide improvement programmes, including LIMS and the Radiology Information System (RIS) was received. These were programmes that were being undertaken collaboratively by Trusts across the ICS which meant that there should be interoperability and financial benefits for all involved.

7. Performance Update

Planned care and cancer standards continued to perform well, but A&E performance remained challenging despite improving to 71.4% in February. Paediatric and adult community waiting times were discussed with recent positive progress seen for paediatric performance.

8. Green Plan

A five year green plan was presented to the Committee. This had been developed in collaboration with Sussex Community NHS Foundation Trust and set out the Trust's objectives for the next five years. The Committee supported the Green Plan.

Alert, Advise and Assure

Key Risks or Opportunities and their impact on the Trust

Key Decisions

The Committee:

- Approved the application for an additional £25m cash.
- Endorsed the Q4 BAF.
- Supported the Green Plan.
- Supported the proposal to jointly procure RIS with system partners.

Exceptions and Challenges

Recommendations

The Board is asked to approve the updated Committee Terms of Reference and to note this report.

Finance and Performance Committee ("the Committee") -Terms of Reference

1. Constitution

The Trust Board has resolved to establish a committee of the Board to be known as the Finance and Performance Committee ("the Committee"). The Committee is a committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Purpose

The Finance and Performance Committee is designed to oversee the effectiveness and efficiency of our financial and operational performance within the context of providing safe care for patients. It should provide recommendations and assurance to the Board relating to:

- ***Financial planning, strategy and development***:
  - Development and oversight of the Trust's financial and capital plans and strategies
  - The process for business case assessments and scrutiny including a review of future financial challenges and opportunities
  - Approve/recommend to Board business cases in line with Standing Financial Instructions (SFIs) and tracking of associated benefits.
  - Understanding the financial risk environment in which the Trust operates including reviewing relevant Board Assurance Framework (BAF) risks, providing assurance on mitigations (requesting plans where relevant) and helping the Board to set the financial risk appetite for the Trust
  - The effectiveness and robustness of financial planning
  - Understanding the financial (revenue and capital) and performance environments in which the Trust operates

- ***Financial monitoring and assurance***
  - Tracking monthly financial and capital performance against budget, and reviewing and approving changes to forecast if required
  - Monitoring balance sheet risks and the cash position
  - Reviewing productivity and efficiency delivery
  - Undertaking substantial reviews of issues and areas of concern
  - Tracking performance against planned productivity improvement trajectories
  - Considering any impact resolving financial compliance might have on the Trusts performance metrics

- **Cash Management**
  - Reviewing of cash forecasts, the reasons for the Trust's cash position, and performance against cash key performance indicators

- Reviewing and monitoring of the management of financial risk and the availability of cash to meet operational requirements
- Ensuring that the Trust settles with its creditors in accordance with the Government's Better Payment Practice Code;
- Reviewing the level of funds owed to the Trust is minimised through effective credit control
- Overseeing the cash impact of capital investments
- Reviewing a monthly cash report
- Reviewing the management of any surplus cash in line with the Trust's treasury management policy.
- Making recommendations to the Board in respect of applications for revenue public dividend capital from NHS England.

- **Operational performance**
  - Reviewing Trust performance against local (NHS Sussex) and national (NHS England) priorities and operating guidance; incorporating and not exclusively reviewing planned care waiting times, cancer performance, diagnostic performance and performance against the 4 hour emergency clinical care standard
  - Understanding all-type activity against plan income expectations and its contribution to improvements or deterioration to performance standards
  - Escalating issues of non-delivery to the Board
  - Considering any impact resolving performance standards might have on the Trusts financial sustainability

Membership and attendance

The Committee membership shall comprise of:

- at least three non-executives
- Chief Executive
- Chief Finance Officer
- Chief Operating Officer
- Director of Transformation and Improvement
- Chief Nursing Officer/Chief Medical Officer

To ensure that non-executive directors hold the majority of votes on the Committee, only the Chief Financial Officer and Chief Operating Officer shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.

Where executive directors are in attendance at a Committee meeting, attendance of their deputies is optional, other than where such deputies are presenting an agenda item. Other members of staff including members of the divisional leadership and the finance teams will attend by invitation.

4. Quorum

Quorum of the Committee shall be four members which must include at least two non-executive director and the Chief Financial Officer (or deputy). Nominated deputies will count towards the quorum.

5. Frequency

Meetings shall meet at least ten times a year. Additional meetings may be arranged as required.

6. Duties

The Committee shall review and monitor the longer-term financial health of the Trust. In particular its duties include:

- Reviewing the financial and performance environment in which the Trust operates, and supporting the Board to ensure that its focus on financial and performance issues continually improve
- Monitoring the productivity of the Trust, scrutinising the opportunities for improvement and challenging the organisation to increase efficiency as appropriate with reference to the Trust's broader strategy and values as well as performance against agreed metrics
- Monitoring the overall cash position and management of capital expenditure and working capital balances.
- Supporting the Board to understand and secure the financial, fiscal, productivity and operational performance data and reporting it needs to discharge its duties
- Understanding the market and business environment in which the Trust operates and ensuring the capacity and capability of the Trust to respond to the demands of the market under review
- Understanding the business risk environment within which the organisation operates, providing assurance on mitigations (requesting plans where relevant) and helping the Board to agree an appropriate risk appetite for the Trust
- Supporting the Board to agree an annual capital and financial plan
- Supporting the Board to agree an integrated business plan
- Approving or recommending to the Board business cases according to the SFIs. In 2024 this included approving business cases between £500k-£2.5m and recommending cases above £2.5m to the board.
- Ensuring that business cases submitted for approval are in line with the priorities identified in the Trust's strategy
- Receiving assurance and scrutinise the effectiveness of demand and capacity planning. Ensuring that the overall financial strategy of the ICS, and any decisions relating to finance made by the ICB, are considered
- Escalating material deviation from planned financial and operating performance to the Board.

The Board may from time to time delegate to the Committee the authority to agree specific investment decisions over and above the annual financial plan provided that the amended plans:

- Do not compromise the Standing Orders and Standing Financial Instructions
- Do not adversely affect the strategic risk facing the Trust
- Do not adversely affect the organisation's ability to deliver its operational plans and delivery against constitutional standards

The Committee may as appropriate review the work of other Committees within the organisation whose work can provide relevant assurance to the Finance and Performance Committee's own scope of work.

7. Decision making

Every decision put to a vote at a Committee meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding, (i.e. Chair of the Committee) shall have a second and casting vote.

8. Reporting arrangements

The Chair of the Finance and Performance Committee will provide an upward report on key items for escalation to the Board which will be issued at the next Public Board meeting. However, in some instances including commercial, sensitive and confidential issues and early discussions on the forecast a report will be presented at the Private Board.

The Chair of the Committee shall make recommendations to the Board deemed appropriate by the Committee to be (on any area within the Committee's remit where disclosure, action or improvement are needed).
The Committee shall undertake a self-assessment of its effectiveness on at least an annual basis. In collaboration with the Chair of the Committee the CFO, COO the EA to the CFO will support the Committee to develop and implement an annual work programme

These terms of reference shall be reviewed by the Board of directors at least annually.

Terms of Reference approved by the Finance & Performance Committee on 29 May 2025

Ratified by the Board of Directors on 24 June 2025.

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NHS Trust

Report to:	Trust Board	Agenda Item:	6.3
Date of Meeting	21st April 2026		

Title of Report:	People & Organisational Development (POD) Committee
Status:	For Discussion
Sponsor:	Frank Sims, Chair of POD Committee
Author:	Frank Sims, Chair of POD Committee
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the People & Organisational Development (POD) Committee on 26th March 2026 to provide the Board with an update of the Committee's activities.

Background

The People & Organisational Development (POD) Committee holds delegated responsibility from the Board of Directors as set out in Terms of Reference; this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

POD Workforce Insight Report

The Committee reviewed the February workforce position, noting continued operational pressures, including escalation capacity and staff movement to maintain safe patient care. Workforce metrics remained broadly stable, with reduced variance to budget and a year-to-date workforce underspend of £3.9m. Sickness absence continued to improve, appraisal completion increased, and leave uptake supported staff wellbeing, albeit contributing to operational challenge.

Progress was noted in relation to centralised recruitment, including a pilot for registered nurses which has reduced operational burden and improved time to hire. The "new to care" and "new to care plus" programmes have commenced, creating a pipeline of 10–20 new starters per month. Work continues to reduce reliance on bank and locum staffing by converting legacy temporary uplift into substantive roles, particularly within the medical workforce.

Training compliance gaps, particularly for basic life support and information governance, were highlighted. Targeted interventions are being developed to improve consistency across clinical and non-clinical areas.

Alert, Advise and Assure

Workforce Planning – Maternity and Medical Workforce

The Committee identified the need for more comprehensive assurance in relation to maternity workforce planning beyond the Birthrate Plus assumptions. An update will be scheduled for a future Committee meeting following presentation to the Quality & Safety Committee, alongside confirmed timelines for a maternity workforce review that includes community services and strengthened internal governance.

Members also highlighted the need for greater understanding of medical workforce efficiency and sustainability. Work is underway with GIRFT and system partners, and a future deep-dive update will focus on workforce impact and constraints rather than financial return.

Q4 Board Assurance Framework (BAF)

The Committee reviewed BAF risks 1 and 2:

BAF 1 – Recruitment:
Recruitment risks are now considered well managed, with low vacancy rates and effective local and national recruitment approaches. Subject to integration of key metrics into BAF 2 and continued monitoring through divisional risk registers, the Committee agreed to recommend removal of BAF 1 as a principal strategic risk.

BAF 2 – Staff Engagement and Wellbeing:
This remains a significant risk, reinforced by staff survey results. The Committee agreed that countermeasures require a refreshed focus on "hygiene factors" including workload, daily working

experience, local support and process improvement, rather than reliance on traditional engagement activity alone.

Guardian of Safe Working Hours

The Committee received the quarterly Guardian of Safe Working Hours report and noted the implementation of a new anonymised exception reporting framework in February. Early indications show increased reporting, consistent with national trends, and improved confidence amongst resident doctors.

Pressure areas were identified for some services and discussed. Recruitment activity, rota redesign and national rostering training for supervisors were underway. The Committee noted improved morale and engagement amongst resident doctors, linked to the 10-point plan, increased senior visibility, and strengthened feedback mechanisms.

Staff Survey – Organisational Update

The Committee reviewed the 2025 staff survey results, which achieved a 50% response rate. Improvements were noted in kindness, respect, inclusion and reduced discrimination. However, concerns remain regarding staffing adequacy, presenteeism and burnout, with fewer than one-third of staff reporting sufficient staffing to undertake their roles effectively.

A new interactive dashboard was demonstrated, enabling more granular analysis for both bank and substantive staff and supporting localised action planning. The Committee emphasised the need for a refreshed and practical action plan focused on improving day-to-day working experience, which will be brought to the next meeting.

Mental Health Strategy

The Committee received an update on the Trust's mental health strategy, noting progress in outreach capacity, staff training and system collaboration. Ongoing challenges remained in relation to estate suitability, workforce capacity and financial pressures. Members emphasised the need for sustainable, system-wide solutions, including for paediatric mental health, and acknowledged the limitations of local mitigations in the context of national demand.

Equality, Diversity and Inclusion (WRES/WDES)

The Committee noted continued progress in inclusivity work, including a green rating under the NHS Inclusivity Framework, significant growth in staff networks, and the successful launch of an allyship programme. The Trust has also introduced AccessAble guides across sites and strengthened reasonable adjustments processes. Early evidence suggests positive impact on bullying and harassment indicators within staff survey results.

Items for Information

- National transformation of people services – assurance was provided that the Trust is proactively responding.
- Apprenticeship funding changes – mitigating actions are in place to minimise financial impact through alternative development pathways.

Key Risks or Opportunities and their impact on the Trust

Staff engagement, wellbeing and daily working experience remain key risks for the Trust and are reflected within BAF 2. Recruitment risk has reduced significantly but requires continued monitoring to ensure sustainability.

Key Decisions

- Agreement to recommend removal of **BAF 1 (Recruitment)** from the Board Assurance Framework, subject to integration within BAF 2 and ongoing monitoring.
- Actions agreed to strengthen assurance over maternity workforce planning and medical workforce efficiency.

Exceptions and Challenges

Recommendations

The Board is asked to note this report.

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Report to:	Trust Board	Agenda Item:	6.4
Date of Meeting	21st April 2026		

Title of Report:	Quality & Safety Committee (QSC) – Chair's Report
Status:	For Discussion
Sponsor:	Amanda Fadero, Chair of QSC
Author:	Amanda Fadero, Chair of QSC
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the QSC on 25th March 2026 to provide the Board with an update of the Committee's activities.

Background

The QSC holds delegated responsibility from the Board of Directors as set out in Terms of Reference; this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

IGM Update: CNO updated the committee on the recent change to the Patient Identification Policy and currently waiting National Guidance on how to proceed.

Divisional Report – Medicine: The Committee noted that the Hyper Acute Stroke Unit on Cuckmere is now fully operational alongside the Stroke Same Day Emergency Care (SDEC) service. The team has reported positive feedback regarding the new environment. Headache Service: Kate highlighted the establishment of a new Headache Service, led by a Headache Nurse Practitioner. This service is the first of its kind and is designed to support patients in the community, helping to prevent unnecessary attendances at acute sites for chronic headaches and migraines.

Maternity Regulation and Insight: Maternity provided various reports including CQC Inspection Action Plan, and Summary of Independent Investigation into Maternity and Neonatal Services in England confirming 9 of the 12 actions from the CQC inspection have been closed.

Recovery Plan for Improving SSNAP Data and Performance: The Committee noted a positive update on SSNAP Data, detailing improvements in swallow screening and SALT assessments for stroke patients.

Corridor Care: The Committee noted the efforts to monitor and eradicate corridor care, focusing on developing a meaningful report and actions, with the Chair confirming Board-Level commitment to eliminating the practice.

Alert, Advise and Assure

Key Risks or Opportunities and their impact on the Trust

Key Decisions
Maternity Care Bundle Publication: It was agreed that progress updates would be incorporated into the Integrated Performance Report (IPR), with escalation to the Q&S Committee as required. Confirmation that a Senior Reporting Officer has been appointed and outlined the associated governance arrangements.
Exceptions and Challenges
Recommendations
The Board is asked to note this report.

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Agenda Item: 7

Report To/Meeting	Trust Board	Date of Meeting	21 April 2026

Report Title:	Chief Executive's Report

Key question	What key news from the Trust does the Chief Executive want to highlight to the Board?

Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐

Report Sponsor:	Jayne Black Chief Executive	Presenter(s):	Jayne Black Chief Executive

Outcome/Action requested:	The Board is asked to note the Chief Executive's report.

Executive Summary	**NHS Oversight Framework** The new NHS Oversight Framework (NOF), in place since August 2025, sets out how NHS England assesses organisations against performance, safety, workforce, finance and productivity. It is a consistent and transparent approach to assessing all NHS organisations, with the purpose of ensuring public accountability for performance, promoting improvements and identifying organisations in need of support. The latest results place us in the top one-third of trusts across the entire NHS (43rd out of 134 organisations), and our position has improved steadily over the course of this year (from 61st position in Q1 and 44th position in Q2). This sustained improvement in our performance comes during highly challenging times and is testament to the continued hard work of our clinical and non-clinical teams who remain instrumental in delivering care to local people. **National nomination for our apprenticeship team** Our apprenticeship team has been shortlisted for the 'Best Employer (Large)' category at the 2026 Apprenticeship Guide Awards being held later this month. The nomination was made by East Sussex College in recognition of the strong partnership working between the organisations, and the trust's continued commitment to high-quality apprenticeship opportunities. **High Commendation in the HSJ Partnership Awards** Our emergency department team, in partnership with Frontier Health, has received a 'High Commendation' at the recent HSJ Partnership Awards for their contribution to improving urgent and emergency care. Together they developed Juno, an AI-supported system designed to ease the burden of repetitive administrative tasks, such as monitoring diagnostics, identifying bed availability and validating breaches. Co-designed with clinicians, Juno has improved access to real-time information, supporting quicker decision-making and enhancing clinical safety by providing clearer oversight of potential risks. This national

recognition reflects strong collaborative working and the trust's commitment to innovation in emergency care.

Successful first Go-Live for our 'EmPoweR' Programme
Our Electronic Patient Record programme, 'EmPoweR' has achieved a major milestone with the successful completion of its first Go-Live. This included the migration of Nervecentre, the clinical system that supports clinicians to track and record patient flow, to a cloud-based Software as a Service (SaaS) platform. This upgrade enables faster and more responsive updates to our Electronic Patient Record, and makes the organisation the first Nervecentre user trust nationally to adopt this approach, setting an example for others.

This achievement represents an important step toward becoming a fully digital trust, with learning from this phase helping prepare for the next major Go-Live in September.

Paper Picnic brings colleagues together to help digitise patient records
Our ongoing 'Paper Picnic' is providing valuable insight into the volume and variety of clinical documentation still in use across services. By gathering forms, assessments, checklists and locally created tools from across the organisation, teams can visualise the scale of paper-based processes, highlight duplication and outdated documents, and better understand the complexity clinicians face in their daily work. This work is forming an important foundation for our preparation for our new electronic patient record. Hundreds of colleagues have contributed, helping to build a complete picture of current workflows and identify opportunities to streamline documentation and support the shift toward digital solutions.

Expansion of our Cardiac Nurse Practitioner Team
Our Cardiac Nurse Practitioner (CNP) team has expanded to support cross-site working, following last year's centralisation of inpatient cardiology services at Eastbourne DGH. Previously based at Conquest Hospital, the team has now doubled in size and operates across both hospitals. Working alongside cardiology registrars, the CNPs will form the new Cardiac Response Team, providing rapid triage and assessment in emergency departments, early access to specialist cardiology input, and timely referral for cardiac catheter lab intervention. They will also support inpatient cardiology reviews and treatment planning.

First Urology WetLab: Making Surgery Safer
We hosted our first Urology WetLab, an important step in enhancing surgical education and patient safety. Delivered in our state-of-the-art simulation suite by the simulation and human factors team, the session was led by consultant urologist Mr Quraishi, with support from Mr Spiteri and Mr Calleja. Core surgical trainees from across the Kent, Surrey and Sussex Deanery were able to practise key urological procedures, including TURP, TURBT, HoLEP and Aquablation, using high-fidelity simulation equipment in a realistic but risk-free environment.

The event has strengthened multidisciplinary training and supports the development of future surgeons in minimally invasive techniques. Our clinical and simulation leads highlighted the value of high-quality simulation in improving confidence, skills and long-term learning, ultimately benefiting patient care. The WetLab was supported by medical

	device partners Storz, Procept and Boston Scientific, marking a significant milestone in the our ongoing commitment to innovative training and clinical excellence. **Speak Out! Programme for people with Parkinson's** Our community speech and language therapy teams continue to receive positive feedback on their Speak Out! programme for people with Parkinson's. Developed by the Parkinson Voice Project, the programme helps individuals with Parkinson's and related neurological conditions regain and maintain their speech through a structured combination of education, individual and group therapy, daily home practice and ongoing follow-up support. Recent patient testimony has highlighted the impact of the programme, with one participant describing significant improvements in vocal strength, clarity and confidence. He praised the therapists for their empathy, encouragement and ability to make sessions engaging, noting that the skills learned are helping him manage the changes Parkinson's has brought to his speech and daily communication. **New detailed accessibility guides launched for services in Bexhill** Detailed AccessAble accessibility guides are now available for several of our services, including Bexhill Hospital, Bexhill CDC, the Irvine Unit and Egerton Park Clinic. Developed in partnership with AccessAble, the guides provide clear, step-by-step information about parking, entrances, gradients, lifts, waiting areas and accessible toilets to help patients, carers and visitors feel more confident and prepared before attending appointments. The initiative was proposed by our Disability Network and funded through Charitable Funds, making the trust the first in Sussex to offer this level of independent accessibility information. The Network's Chair highlighted the positive impact the guides will have in reducing uncertainty and improving the experience of disabled people and their families when accessing our services.

Regulatory/legal requirement:	Not applicable

Business Plan Link:	Quality	☐	People	☐	Sustainability	☐

Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration

Resource Implication/VFM Statement:	Not applicable

Risk:	Not applicable

No of Pages	4	**Appendixes**	None

Governance and Engagement pathway to date:	Not applicable

What happens next?	Not applicable

Publication	This report is for publication

NHS
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NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

KINDNESS

INCLUSIVITY

For the Period February 2026 (Month 11)

INTEGRITY

Content

East Sussex Healthcare NHS Trust

1.	About our Integrated Performance Report (IPR)
2.	Chief Executive Summary
3.	Balanced Scorecard and Benchmarking
4.	Quality and Safety
5.	Our People
6.	Access and Responsiveness
7.	Financial Control and Capital Development

About our IPR

East Sussex Healthcare
NHS Trust

Our IPR outlines how the Trust is currently working and how the on-going journey of improvement and excellence, as reflected within our 2025/26 Operational Plan, is being delivered.

Throughout our work we remain committed to delivering and improving on:

- Care Quality Commission Standards
  - Are we safe?
  - Are we effective?
  - Are we caring?
  - Are we responsive?
  - Are we well-led?
- Constitutional Standards
- Financial Sustainability in the long-term plan

Our IPR, therefore, aims to narrate the story of how we are doing and more importantly how we will be doing as we look towards the future.

Our vision describes our ambition for the organisation over the five years of this plan:

- **To develop outstanding services, building a reputation for excellence in care, becoming the best integrated care provider**
- **To lead a modern organisation for our people, enabled by technology, agile working and a light environmental footprint**
- **To harness existing strong relationships to forge a vanguard collaborative tackling the social and health challenges that face our coastal towns**
- **To make a demonstrable economic and social impact through our partnership commitments; on health, employment, education, training and skills development across Sussex**
- **To develop as a financially sustainable and innovation-led organisation**

Chief Executive Summary

East Sussex Healthcare
NHS Trust

Executive-led reviews secured an additional £1.8m of mitigations for Month 11, strengthening the Trust's in-year financial position. Further negotiations with the ICB, including settlement of ERF over-performance and additional non-recurrent support, have enabled the expectation of delivering a breakeven plan for 2025/26.
The Trust will be eligible for additional Deficit Support Funding on achieving a breakeven position.

Operational performance remains strong for elective constitutional standards with cancer and Referral to Treatment (RTT) achieving trajectories.
Diagnostics, although showing improvement in M11 (12.3%) remains non-compliant. The Trust is working to having no more than 10% patients waiting more than six weeks in M12, as agreed with the ICB.
The Emergency Department continues to see growth in attendances, impacting M11 performance of 71.4%. Plans are in place to achieve 78% in M12.

The high level of attendances to the Emergency Departments and high occupancy, has required additional escalation capacity to be opened, putting significant pressure on the available workforce.
The Trust continues to manage its workforce within financial envelope constraints while ensuring safe staffing and maintaining workforce wellbeing. February saw a reduction of £0.5m in pay expenditure despite winter-related increases in bank and agency usage, supported by strengthened governance through the Temporary Approval Panel.

The Trust-wide positive FFT feedback rate was 93.58%, which is in line with the last six-month average of 93.40%. Emergency Department FFT continues to show improvement and is above Model Hospital peer levels.
C. Diff (Clostridioides difficile) has exceeded threshold for the year and a period of increased incidence is under investigation. Post infection review has been undertaken.

Balanced Scorecard

East Sussex Healthcare NHS Trust

Safety	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Number of Patient safety events (severity 1-5)		1057	959		Common Cause	Target required
Number of Patient safety events (severity 3)		18	15		Common Cause	Target required
Number of Patient safety events (severity 4 ...		7	10		Concern	Target required
Never Events		0	0		Improvement	Target required
Inpatient Falls per 1,000 Bed days		4.67	4.14		Common Cause	Target required
Cat 3 ESHT Acq. PU (rate) per 1,000 bed days		0.0778	0.0422		Common Cause	Target required
Cat 4 ESHT Acq. PU (rate) per 1,000 bed days		0	0		Improvement	Target required
Healthcare Associated MRSA Bacteraemia (r...		0	0		Common Cause	Target required
Healthcare Associated C Diff Infections (rate...		0.117	0.253		Common Cause	Target required
Healthcare Associated MSSA Bacteraemia (r...		0	0		Common Cause	Target required
RAMI		87.7	88.7		Concern	Target required
SHMI (NHS Digital monthly)	100	107	107		Concern	Not Met
Nursing Fill Rate (IP - RN, RNA and HCA)		90.4%	91.0%		Common Cause	Target required
Patient Safety Incident Investigation Events		0	0		Improvement	Target required
Maternity and Newborn Safety Investigation...		0	0		Improvement	Target required

Patient Experience	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Complaints received		34	42		Common Cause	Target required
Complaints Response Compliance (60 work...	80%	63.6%	55.8%		Common Cause	Inconsistent
Reopened Complaints		7	7		Common Cause	Target required
A&E FFT Score	85%	81.0%	84.4%		Improvement	Inconsistent
A&E FFT Response Rate		12.8%	14.2%		Concern	Target required
Inpatient FFT Score	95%	98.3%	98.7%		Common Cause	Achieving
Inpatient FFT Response Rate		3.71%	5.18%		Concern	Target required
Maternity FFT Score	95%	100%	100%		Common Cause	Inconsistent
Maternity FFT Response Rate		1.69%	0.450%		Concern	Target required
Outpatient FFT Score	95%	95.6%	95.2%		Concern	Inconsistent

Our People	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Establishment (WTE) All		8,276	8,282		Common Cause	Target required
Agency Rate	1%	0.568%	0.647%		Improvement	Inconsistent
Vacancy Rate	5%	3.1%	2.88%		Improvement	Inconsistent
Staff Turnover	10.6%	8.94%	8.93%		Improvement	Achieving
Sickness - Average Days Lost per Fte	18.8	20.0	20.1		Concern	Not Met
Staff Appraisals	85%	79.6%	80.3%		Concern	Not Met
Statutory & Mandatory Training	90%	92.6%	92.5%		Improvement	Achieving
Annual Sickness - Absence %	5%	5.47%	5.51%		Concern	Not Met
Medical Job Plan Compliance Rate	95%	62.1%	67.3%		Concern	Not Met

Our Performance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
4 hour standard	74%	68.8%	71.4%		Common Cause	Inconsistent
4 hour standard with additional mappe...		68.8%	73.0%		Common Cause	Target required
A&E waits over 12 hours from DTA	0	197	123		Concern	Inconsistent
A&E > 12 hours from arrival to discharge	0	1411	1166		Concern	Not Met
% Type 1 A&E > 12 hours from arrival t...		12.5%	11.2%		Concern	Target required
Conveyance handover >30 mins	0%	10.6%	8.69%		Improvement	Not Met
Conveyance handover >45 mins		3.88%	2.64%		Common Cause	Target required
Non Elective Length of Stay		4.61	4.65		Common Cause	Target required
1+ Non Elective LoS (Acute)	8.1	6.47	6.72		Improvement	Inconsistent
Average daily NCTR		142	160		Common Cause	Target required
Intermediate Care Length of Stay	30	34.7	43.4		Common Cause	Inconsistent
Number of Deferred visits/ care plans		9731	8311		Concern	Target required
RTT 65 week wait	0	2	1		Improvement	Not Met
RTT proportion waiting over 52 weeks	1%	1.14%	0.999%		Improvement	Not Met
RTT under 18 weeks	59.5%	63.3%	63.7%		Improvement	Not Met
RTT Total Waiting List Size	55944	59853	59853		Concern	Not Met
Diagnostic <6 weeks	1%	14.6%	12.3%		Common Cause	Not Met
Urgent Community Response within 2 h...	70%	80.1%	83.3%		Common Cause	Achieving
CHIC wait times < 13 weeks	80%	71.8%	71.7%		Concern	Inconsistent
104 day Backlog		50	58		Common Cause	Target required
28 Day General FDS	78.0%	83.3%	79.8%		Improvement	Inconsistent
Cancer 31 Day Combined	94.5%	95.5%	94.0%		Common Cause	Inconsistent
Cancer 62 Day	71.0%	78.2%	74.3%		Improvement	Inconsistent
Elective Activity (ELIP,DC,OPFA, OPFUP P...		103%	103%		Concern	Target required

Finance	Target/ Limit	Previous Month	Current Month	1920 Same period	Variation	Assurance
Surplus/(deficit) (£'000) - in month	(359)	(847)	(356)	n/a	n/a	Achieving
Surplus/(deficit) (£'000) - YTD	(1,808)	(2,596)	(2,952)	n/a	n/a	Not met
ERF (£'000) - in month	11,589	10,613	11,219	n/a	n/a	Not met
ERF (£'000) - YTD	124,427	114,942	126,161	n/a	n/a	Achieving
Efficiency (£'000) - in month	8,913	4,924	5,594	n/a	n/a	Not met
Efficiency (£'000) - YTD	69,055	40,763	46,357	n/a	n/a	Not met
Capital (£'000) - YTD	35,124	19,591	24,468	n/a	n/a	Not met
Capital (£'000) - FOT	48,420	46,535	48,152	n/a	n/a	Achieving

Constitutional Standards | Benchmarking

*NHS England has yet to publish all February 2026 Provider based waiting time comparator statistics

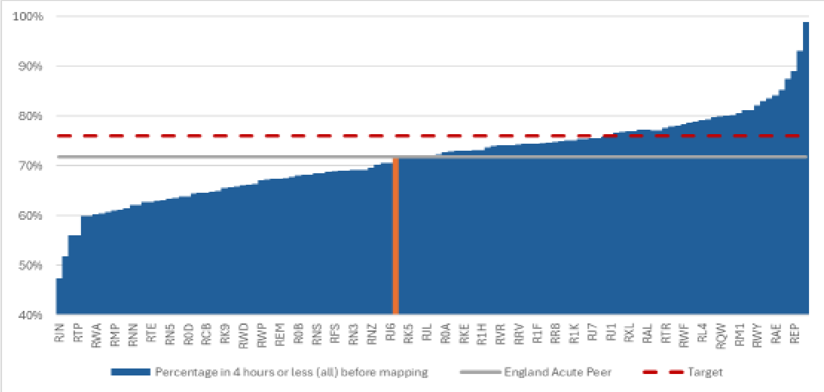
East Sussex Healthcare
NHS Trust

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

February 2026 Peer Review

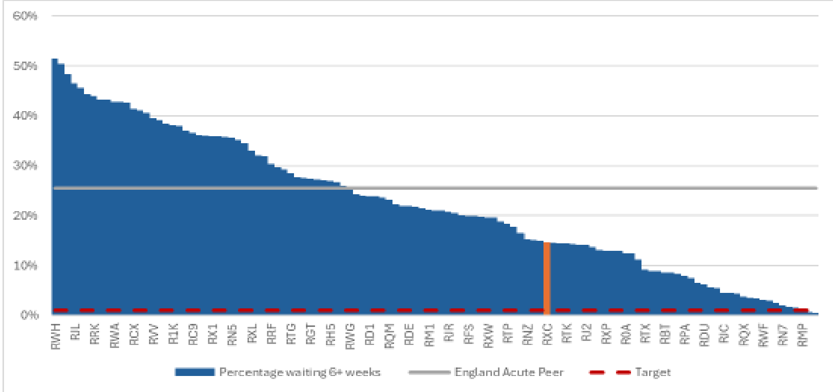
National Average: 71.7% ESHT Rank: 68/123



Planned Care – Diagnostic Waiting Times

January 2026 Peer Review*

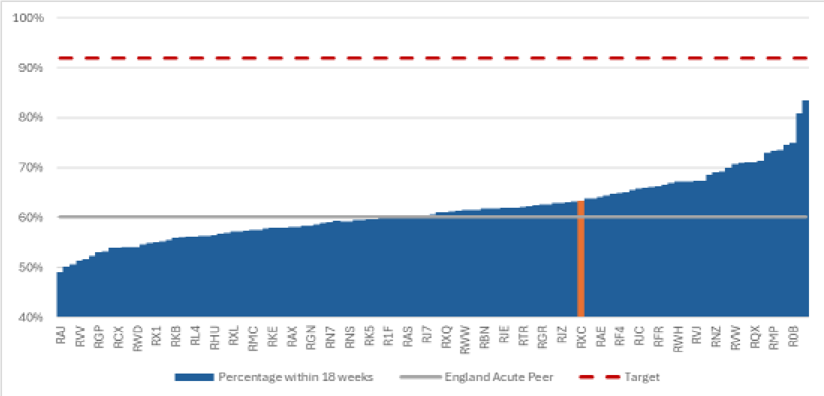
National Average: 25.5% ESHT Rank: 42/117



Planned Care – Referral to Treatment

January 2026 Peer Review*

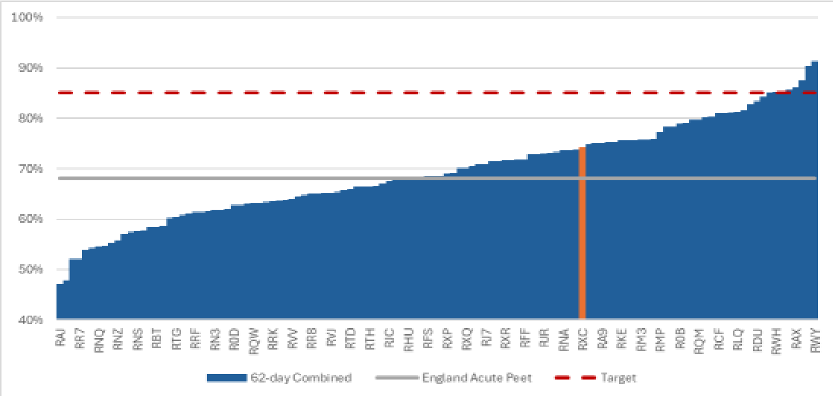
National Average: 60.2% ESHT Rank: 36/117



Cancer Treatment – 62 Day Combined Standard

January 2026 Peer Review*

National Average: 68.2% ESHT Rank: 37/118



Quality and Safety

Delivering safe care for our patients

What our patients are telling us?

Delivering effective care for our patients

Safe patient care is
our highest priority
Delivering high quality clinical services that achieve and demonstrate the best outcomes and provide excellent experience for patients

Quality and Safety | Executive Summary

East Sussex Healthcare NHS Trust

Infection Control
Healthcare Associated Infection limits have been set by NHSE for 2025/26. Current performance against thresholds is: Three unavoidable MRSA bacteraemia against a limit of zero avoidable. CDI 66/67, E. coli 104/109 and Pseudomonas 21/19. Klebsiella 34/44.
No MRSA reported for February. One community onset MSSA infection was reported in February, which was assessed as unavoidable due to discitis. Seven *C. difficile* infections were reported in February, three HOHA and four COHA. In February, seven CDI cases were reported against a monthly limit of five, three HOHA and four COHA. Five of the seven cases were reported at Conquest. A period of increased incidence is under investigation relating to Benson Egerton orthopaedic unit. Post infection review has been undertaken, the outcome of PIRs is pending the outcome of ribotyping results that have not yet been received.

Patient Safety Events
1339 incidents were reported in February 2026 of which 972 were ESHT patient safety incidents.
97% were reported as 'No/Low harm/Near miss' (Sev 1 & 2) consistent with previous months, and National benchmarks.
0.2% were reported as 'Fatal' harm (severity 5), 0.9% as 'Severe' harm (severity 4) and 2% as 'Moderate' harm (severity 3). There were no 'Never Events' incidents. All harm incidents are reviewed to identify gaps in care or service delivery that might have resulted in the harm for learning and improvement.
The top three categories of incidents reported were;

1. **Slips, Trips and Falls** – 134 incidents reported. Majority were No/Low harm except 3 reported as 'moderate' harm and 1 as 'fatal' harm (an unwitnessed fall being reviewed to confirm whether there are gaps in care). The inpatient falls rate in February was 4.15, a common cause variation with no concerns.

2. Medication Errors and other Related Medication Errors – 107 incidents were reported of which 2 were reported as 'moderate' harm, 1 as 'severe' and 1 as 'fatal' . The rest were no / low harm and near misses (96%).
3. Diagnosis and Diagnostic Services - 90 incidents reported, of which 3 were reported as 'moderate' harm, and 4 as 'severe' harm
It should be noted that the final level of harm of these incidents may change once the reviews are completed and gaps in care or service delivery are confirmed.

Safeguarding
The team undertook an audit at the end of 2025 to ascertain staff understanding of safeguarding processes, this has now been drafted and submitted to clinical effectiveness.
104 staff across divisions contributed to the audit, most of whom were spoken to face to face. Of these 68% indicated that they knew how to submit a referral, when asked whether staff knew how to contact the Safeguarding team this figure rose to 79% with 94% reporting awareness of the Safeguarding extranet pages.
The audit also considered whether staff were aware of external resources provided by the safeguarding adults and children's boards, this is an area for development with 54% indicate knowledge of the pan-Sussex Safeguarding procedures. In response information has been re-circulated via communication regarding the Pan-Sussex procedures and the information on the extranet refreshed to ensure these resources are more prominent.

The Children in Care team continue to experience challenges, the process to source the LVA funds, via reporting to SUS, requires a read code that will extract the information from System 1, as yet ,we have not sourced a read code that works.

Mortality
RAMI 23 rolling 12 months is 89 for the current period and positioned at 54 out of 119 Acute Peer Trusts. SHMI is showing an overall value of 106.81 and is within the expected range. EDGH has an index of 107.3 and Conquest 106.4. Both sites are within the expected range.
Weekend RAMI continues to show a value below the national average for HES Acute peers. Weekend SHMI has been showing an increase - a deep dive has been initiated to investigate.

Author(s)

Vikki Carruth
Chief Nurse and Director of Infection Prevention & Control (DIPC)

Simon Merritt
Chief Medical Officer

Quality and Safety | Executive Summary

East Sussex Healthcare NHS Trust

Patient Experience: We received 42 new complaints, which is an increase of 8 against January's number. Against our internal targets, 7 complaints were overdue at the end of February (the oldest being 22 working days over). Of the 43 complaints closed in-month: Against the timeframe of 60 working days, 56% were completed in time (January =64%), against our local target response, which is 80%.

Reviewing the monthly risk rating of all complaints, most were 'moderate' in common with the general pattern:
2 high risk (January =1), 34 moderate risk (January =27) where aspects of clinical care appear suboptimal and 6 low risk (January =6) where clinical quality does not form part of the complaint.

We take re-opened complaints/PHSO contacts as proxies for where we can learn:
7 complaints were reopened (January =7), 3 to Medicine, 1 to Urgent Care, 1 to CHIC, 1 to DAS and 1 to W&C, (5 where further queries were raised, 1 unhappy with response and 1 meeting request).

The Trust received 5 contacts from the PHSO in February (3 for Medicine and 2 for Urgent Care). These are old cases and we have enquired with the PHSO if this cluster is due to their backlog. 4/5 contacts relate to bereavement cases.

Of the 42 complaints received in February, 64% came from 2 categories:
Clinical Treatment =16 (treatment delays/diagnosis issues)
Patient Care =11 (unhappy with overall care provided).

Top complaint location in February was (this does not necessarily relate to care provided in February):
Emergency Department =12 (EDGH =8 and CQ =4)
Outpatients Department =7 (EDGH =5 and CQ =2).

663 contacts were recorded by PALS in February, which is a decrease of 51 when compared to January (=714). Of these contacts, 366 PALS contacts were recorded as "concerns" (January =451).

4% of PALS concerns (=15) were escalated to formal complaints.

The top three primary PALS subjects recorded as a "concern" were as follows:
Communication =105 (of these 46% related to communication with patients/relatives. 23% related to communication failure within speciality and 11% related to delay in giving information/results).
Appointments =61 (of these 67% related to long waiting times and cancelled appointments).
Patient Care =52 (of these 71% related to where a patient's care needs were not adequately met).
Clinical Treatment =52 (of these 29% related to delays in treatment and 27% related to diagnosis issues).

Top 3 locations of PALS concerns
Outpatients Department (=47) (CQ =25 and EDGH =22)
Emergency Department (=42) (EDGH =24 and CQ =18)
Podiatry Clinic (=11).

The Trust received 9,625 FFT responses; this is a slight reduction on January responses (=10,351) but is in line with the last six-month average of 9,712. However, this is a 19.4% reduction compared to February 2025 (=11,939). Clinical Coding have confirmed there are delays outcoming patient activity and this reduces the number of SMS FFT's we can send. The Trust-wide positive FFT feedback rate was 93.58%, which is in line with the last six-month average of 93.40%.

Workforce
Due to seasonal variation, we have continued with high level of attendances to the Emergency Departments and high occupancy, which has required additional escalation and boarding capacity to be opened, putting significant pressure on the available workforce. We continue to focus on improvement programmes for discharge and length of stay and work with SPFT to ensure the safety and quality of care for our patients requiring specialist Mental Health support/skills.
Acute and Community staffing remained stretched to cover the additional requirements and the focus continues on workforce wellbeing and support and rostering and efficiency, job planning and use of additional nursing workforce.
There are significant improvements noted regarding the reduction in use of agency including security and additional shifts through roster efficiency, mental health outreach team support and senior nursing oversight.

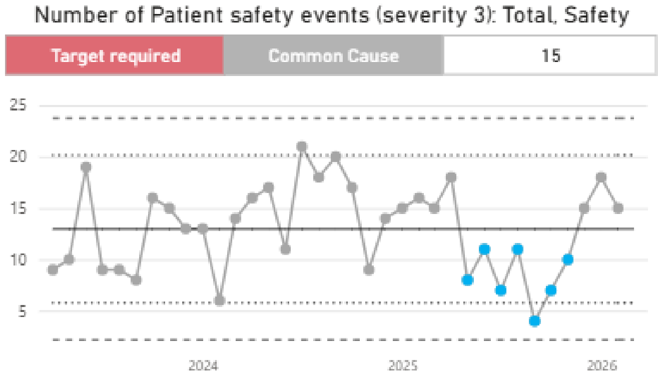
Author(s)

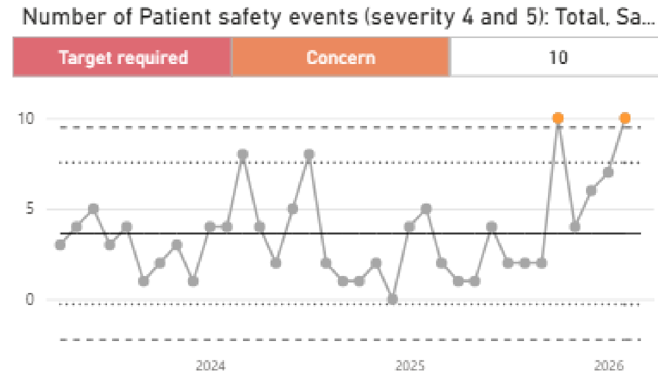
Vikki Carruth
Chief Nurse and Director of Infection Prevention & Control (DIPC)

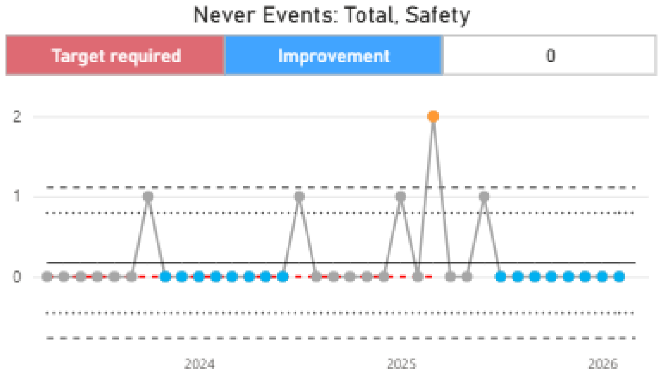
Simon Merritt
Chief Medical Officer

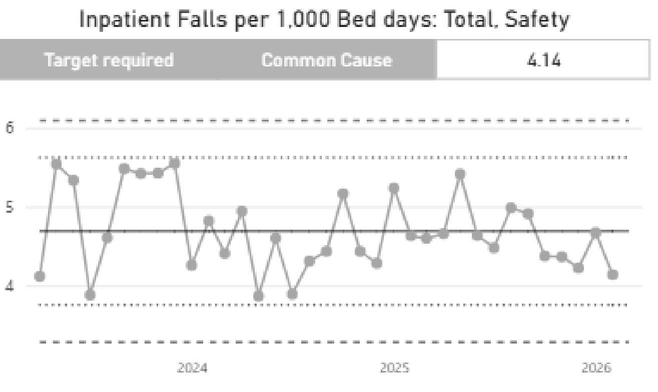
Quality and Safety Core Metrics

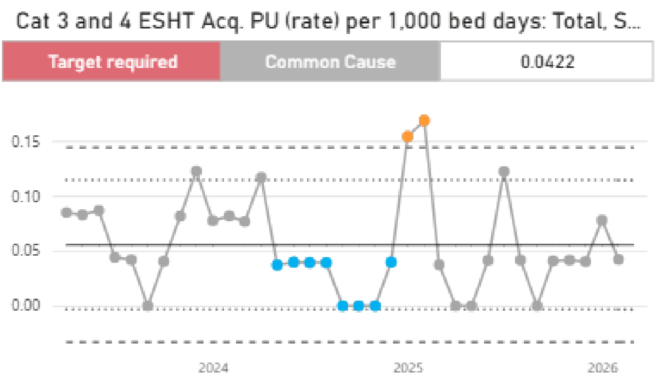
East Sussex Healthcare NHS Trust

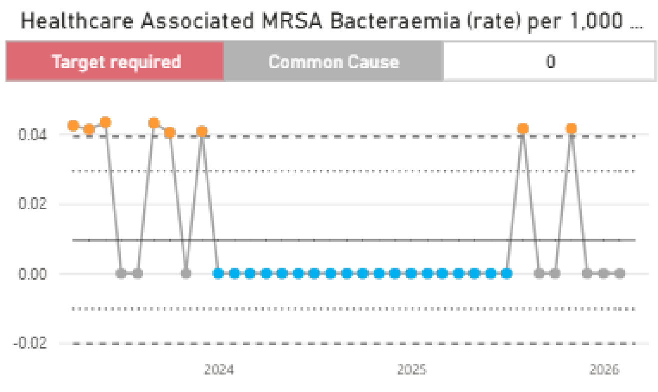


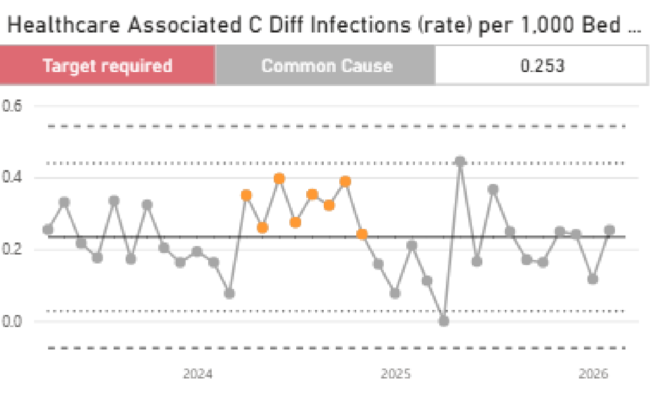


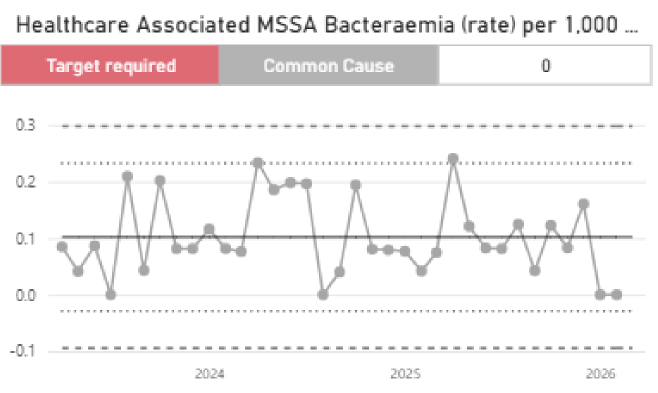


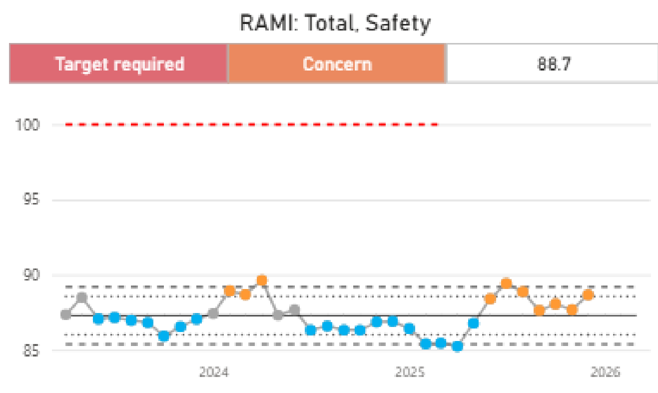






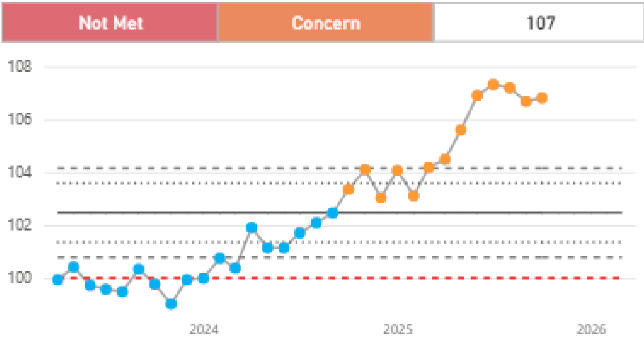


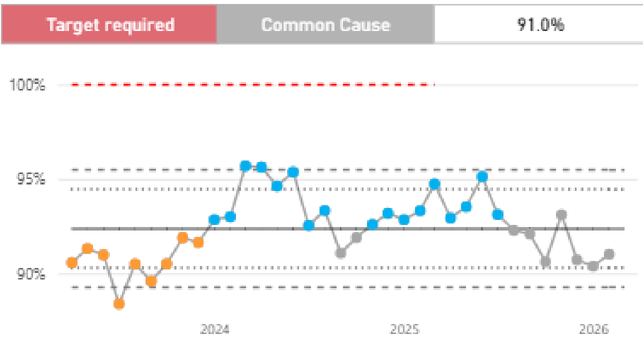


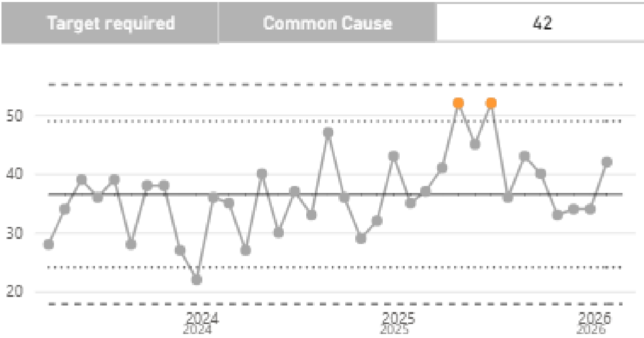


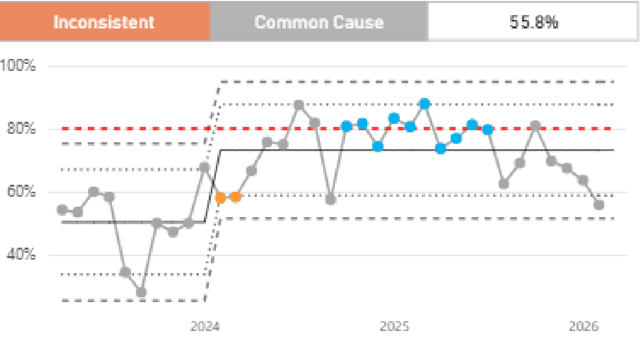
Quality and Safety Core Metrics

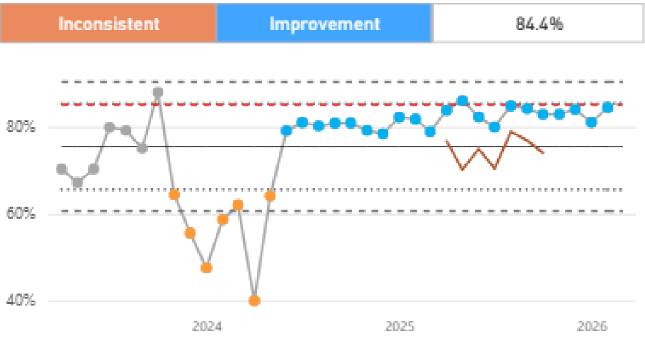
East Sussex Healthcare NHS Trust

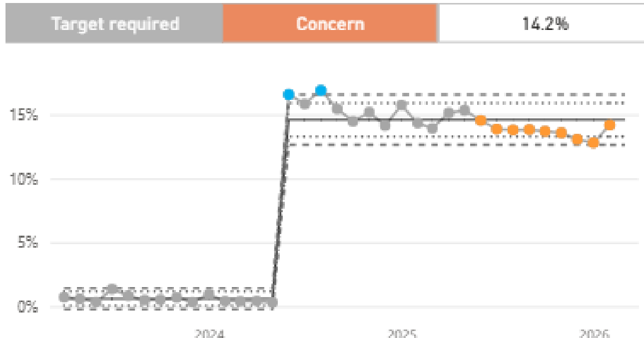


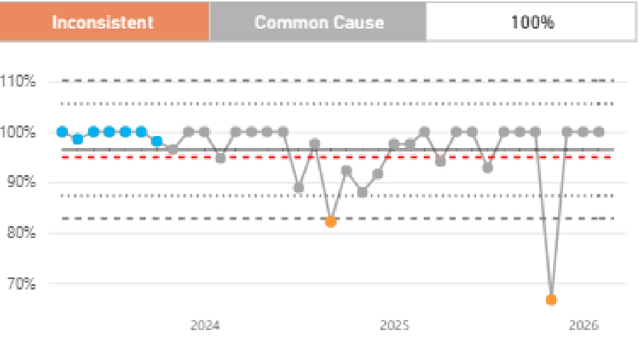


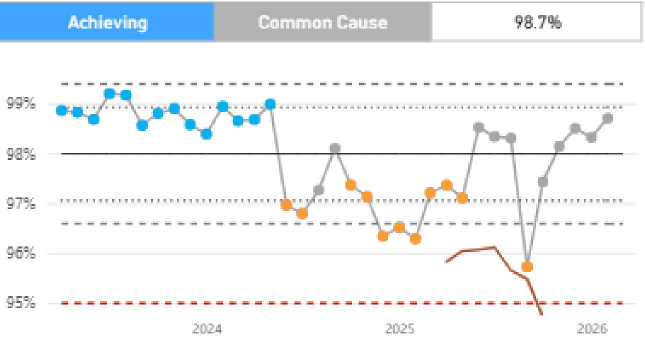


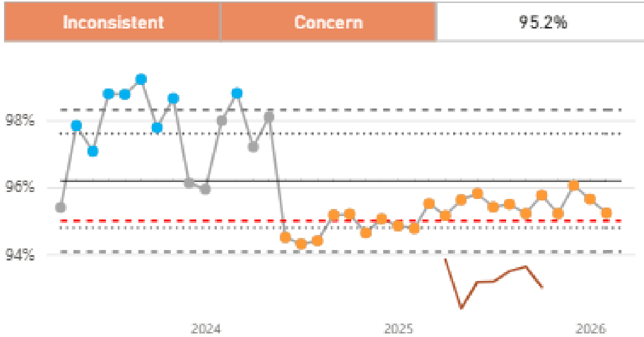












Quality and Safety | Areas of Focus

Title	Summary	Actions
Patient Safety Incident Response Framework (PSIRF)	Duty of Candour (DoC) compliance continues to be monitored, and Divisions supported to complete in a timely manner. A review of the applicable incidents in a 12-month rolling period is undertaken monthly to check compliance. At the end of February 2026, compliance was 71% for verbal DOC and 70% for written (compared to 78% and 71% in January 2026, respectively). PSIRF templates have continued to be updated to improve consistency and clarity as part of the updates to the PSIRF Plan and Policy.	• Phased approach to Datix improvement plan has progressed. This includes; ◦ Updates to the Incident Reporting Form ◦ Investigation Fields ◦ Categories & Sub-categories ◦ User Group Securities • Incident Reporting Policy and the PSIRF Policy & Plan to be ratified in Q4 • PSIRF Templates continue to be reviewed / updated with staff involvement via the PSIRF Peer Review Group using a PDSA approach • Actions planned to improve DoC compliance include; Offering targeted training, strengthening divisional accountability and oversight .
Nursing & Midwifery Workforce	During February occupancy remained very high with ongoing use of additional capacity and pre-emptive boarding in corridors and significant numbers of patients requiring enhanced observation in relation to high risk of falls or patients with challenging/violent behaviour. Controls remain in place to ensure staffing continues to meet the needs of our patients. Ward nursing CHPPD overall was 7.5 for January (noting distortion by specialist areas) reflecting the additional demands on our nursing workforce and the current levels of occupancy. Nursing fill rates for day shifts = RN 91% and HCSW 83%. Nursing fill for night shifts = 98% for RN and 96%.	• The annual Nursing Establishment Review (NER) for 2025, report is being compiled for Board. Current data collection for 2026 underway • Non-medical job planning, education and supervision frameworks are in progress • Recruitment to the Mental Health Outreach team continues and they are deployed to support our most complex patients. Training opportunities for staff as part of the MH Strategy are also underway. The Trust is continuing to work with SPFT to offer enhanced assessment and initial care plans for those patients who present with an acute mental illness crisis and have agreed to roll out the body worn cameras for teams working in our urgent care areas • Nursing/Midwifery monthly Roster Compliance sessions continue, led by the Deputy Chief Nurse to ensure effective/efficient nursing rosters. There is a weekly vacancy control panel in place to review all recruitment requests. There is evidence of good control to support enhanced observations and requests for additional staff and we continue to work on reducing reliance on Agency and bank staffing, including security • Analysis of the job specific skills and leadership training needs is on going and we are working with NHS Elect to identify the skills gap and plan an education framework to ensure training meets the needs of our people • We offer training and support with the restorative supervision programme and the network of practice educators and current education/preceptorship resources • The senior nursing teams continue to help plan to meet the additional operational demands and offer support to our frontline teams and promote staff wellbeing.

Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

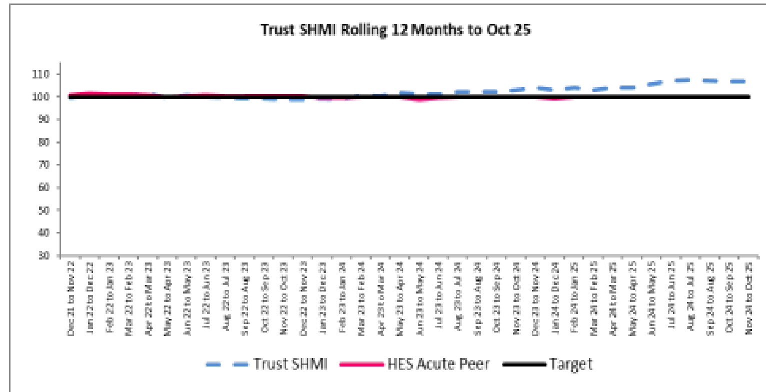
Title	Summary	Actions
Inpatient Falls	The falls rate for all falls for ESHT per 1000 inpatient bed days was 4.15 and remains within the control limits with no cause for concern. 10 patients had multiple falls in February (consistent with the average monthly numbers), with 1 of these patients sustaining 4 falls, and the rest 2 falls each. Majority of the reported falls were where patients were mobilising independently. There are no hotspots in relation to wards / sites. Of the patients who had multiple falls, one was reported as moderate harm. All falls incidents undergo SWARM reviews to identify potential gaps in care or service delivery to support learning and improvement.	•Completed SWARM forms continue to be monitored, and peer reviewed in the PSIRF Review Group • Divisional themes and trends are reported to the Falls Steering Group for oversight and consideration for quality improvement activities •The Falls policy is being reviewed to strengthen falls in the community / CHIC. Division.
Patient Experience	Podiatry featured in the top 3 PALS locations and accounted for 32% (12 out of 37) of all cases. Decline in complaints response rate. Decline in the number of FFT surveys returned.	"Communication" was the main theme recorded under podiatry due to patients not being able to contact the department. This has been feedback to the team who are experiencing staff shortages and increase in demand. 10/19 complaints responses were due to divisional delays, 9/19 were complaints team and exec delays. The team will be meeting regularly with divisional leaders to monitor compliance against at our local target and highlights areas causing delays. Clinical Coding have confirmed there are delays outcoming patient activity and this reduces the number of SMS FFT's we can send.
Harm reviews	The NCTR Harm Review Process was redesigned based on staff feedback, and the request to start completing the updated version of these was sent out again in mid October of last year, the intent being to allow approximately three months of data to be collected before January's Q&S	• On checking the data for review, only five had been submitted as of w/c 19/01. This clearly presents inadequate data with which to draw any firm conclusions • Recommendation: the main reasons cited for this not being completed was the winter staffing plan (reduced management time), and winter pressures. A further attempt should be made to embed this process starting in May or June, with closer supervision of submissions, and the data be reviewed two months following.
Pressure Damage	The rate of cat 3 or 4 PUs per 1000 beds days for inpatients remains within control limits. One new Category 3 pressure damage incident was reported in an inpatient on the bridge of their nose related to a medical device (Non-Invasive Ventilation Mask). One new Category 3 pressure ulcer was reported in a patient in their own home.	• Learning reviews will be undertaken of each Cat 3 case reported • The newly improved Power BI PU dashboard report which includes all categories of pressure damage, by division and by ward to be integrated into divisional processes for reporting and monitoring • A new PU learning review tool has been developed and will be piloted over the next few months. Once refined will be developed into an electronic form in DCIQ.

Effective Care - Mortality

East Sussex Healthcare NHS Trust

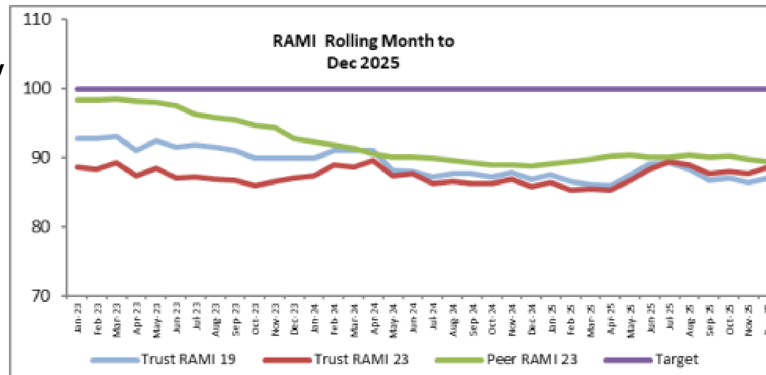
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

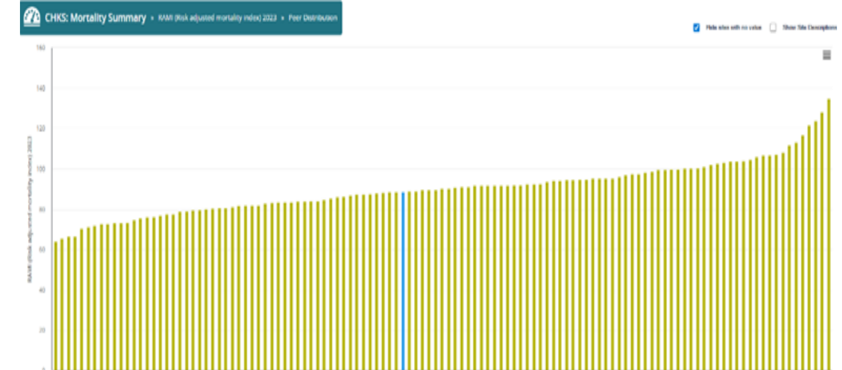
Summary Hospital Mortality Indicator (SHMI)
Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures



- SHMI – November 2024 to October 2025 is showing an index of 106.81 and is within the expected range and similar to the last period.. EDGH is showing 107.3 and Conquest is 106.4, both also within the expected range.
- The Trust is submitting Same Day Emergency Care (SDEC) data to the Emergency Care Data Set (ECDS) rather than the Admitted Patient Care (APC) dataset. SHMI is calculated using APC data. Removal of SDEC activity from the APC data affects the Trust's SHMI value.
- SHMI is rebased each time it is published whereas RAMI is not.
- RAMI 23 – January 2025 to December 2025 (rolling 12 months) is 89 and 86 for the same period last year. Peer RAMI was 89 for this period
- The line graph below shows the rolling 12 month figure.
- Crude mortality shows Jan 2025 to Dec 2025 at 1.54% compared to 1.55% for the same period last year.
- The new mortality database was rolled out in November 2025. The Consultant acknowledgement rates of the Medical Examiner reviews for January 26 was 42% within the timescale allowed

Risk Adjusted Mortality Index (RAMI)





This shows our position nationally against other acute trusts – currently 54/119

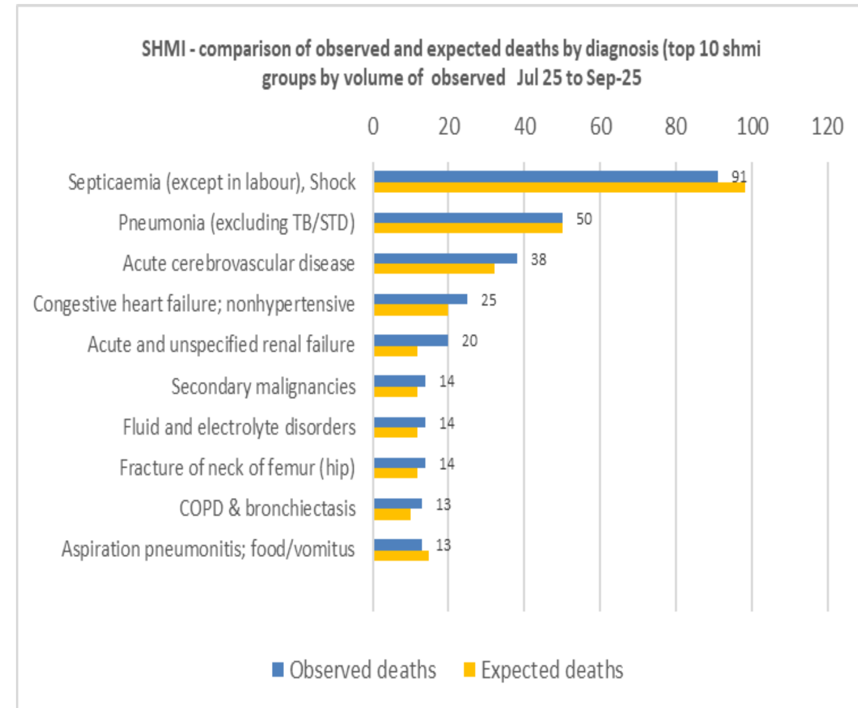
Effective Care - Mortality

East Sussex Healthcare NHS Trust

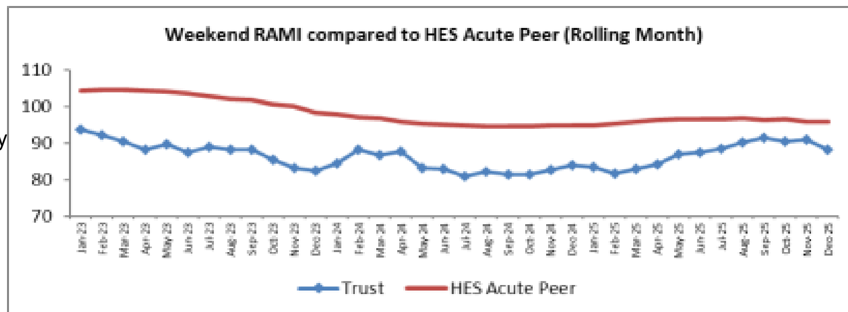
Feb 2026 Main Cause of In-Hospital Death Groups

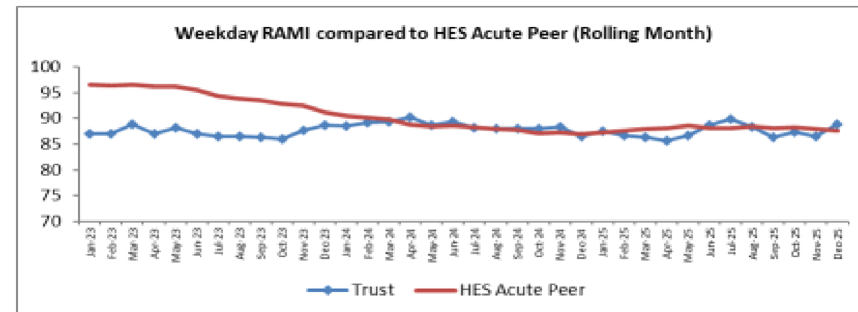
Description	Apr 25 - Feb 26	Feb-26
Acute Kidney Injury (AKI)	10	
Alcoholic liver disease	4	
Aspiration Pneumonia	64	3
Atrial Fibrillation (AF)	13	1
Bowel Obstruction	15	2
Bowel Perforation	6	
Bronchopneumonia	9	
Cancer	208	17
Cellulitis	3	
Cerebrovascular Accident	2	
Chronic Obstructive Pulmonary Disease (COPD)	46	2
Community-acquired Pneumonia	75	9
Congestive Cardiac Failure	10	
COVID-19	3	
Dementia	12	2
Frailty of Old Age	108	9
Heart Failure	120	10
Hospital-acquired Pneumonia	58	5
Intersitial lung/pulmonary disease	3	
Ischaemic Bowel	4	
Liver Disease	19	4
Multiple Organ Failure	26	
Myocardial Infarction (MI)	37	4
Pneumonia	128	8
Pulmonary Embolism	10	
Pulmonary Oedema	1	
Sepsis/Septicaemia	190	17
Spontaneous Intracerebral Haemorrhage	15	
Spontaneous Upper Gastrointestinal Haemorrhage	5	
Stroke	77	7
Type 1 Respiratory Failure	7	
Type 2 Respiratory Failure	9	
Urosepsis	22	2
Other not specified	250	30
[Uncertified]	116	7
Total	**1685**	**139**

SHMI Diagnosis Main Groups



Risk Adjusted Mortality Index (RAMI)
Weekend and Weekday Mortality Trends





Effective Care Mortality

Summary Hospital-level Mortality Indicator (SHMI)

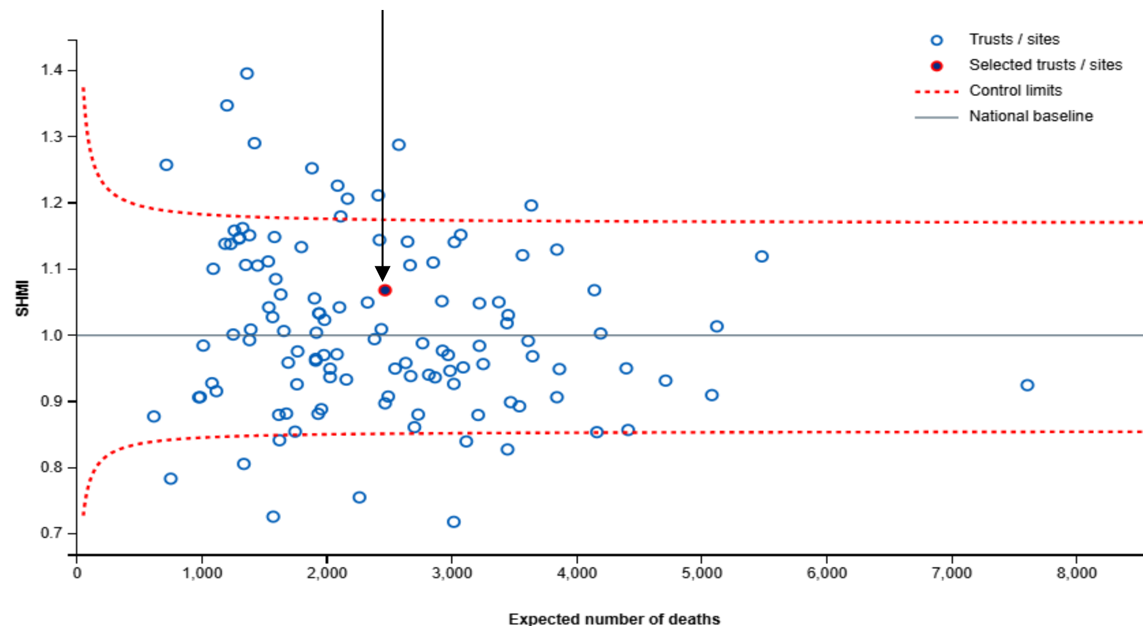
Funnel plots

Return to contents

Select trust or site level data	Select trusts / sites	Select diagnosis group (trust level data only)	Select a reporting period
Trusts	East Sussex Healthcare NHS Trust	All diagnosis groups	November 2024 - October 2025

Reset filters

SHMI funnel plot



For any given number of expected deaths, a range of observed deaths is considered to be 'as expected'. If the observed number of deaths falls outside of this range, the trust or site in question is considered to have a higher or lower SHMI than expected. The extremes of this range are called **control limits**.

- Trusts / sites whose SHMI falls above the upper control limit are categorised as '**higher than expected**'.
- Trusts / sites whose SHMI falls between the upper and lower control limit are categorised as '**as expected**'.
- Trusts / sites whose SHMI falls below the lower control limit are categorised as '**lower than expected**'.

The SHMI is made up of 144 different diagnosis groups and these are aggregated to calculate the overall SHMI. For a subset of diagnosis groups, a SHMI value and banding are also calculated.

The site level SHMI data are official statistics in development. A site level SHMI value is not calculated if: (a) the site has fewer than 1,000 spells in the 12 month reporting period or (b) the name of the site indicates that it is a specialist site or (c) over 35% of spells in the 12 month reporting period are in a single diagnosis cluster, indicating that it is a specialist site.

Use the menu at the top left of the page to select whether to display the data for trusts or sites. Use the next menu to select trusts / sites to highlight on the plot. Use the next menu to select the diagnosis group (for the trust level data only).

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Some values may be suppressed for the purposes of disclosure control or due to data quality issues.

Our People

Recruitment and retention

Staff turnover / sickness

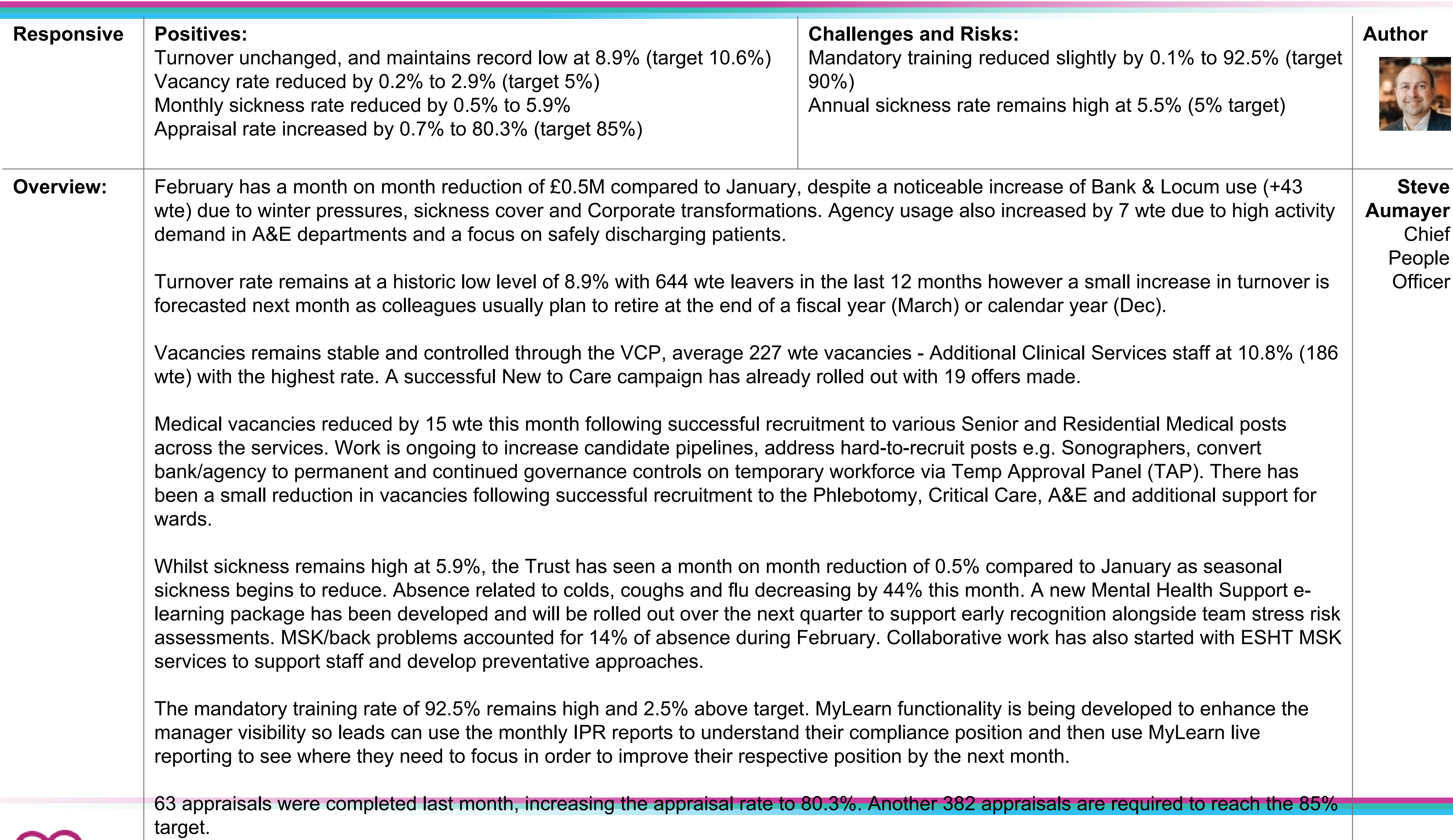
Our quality workforce

What our staff are telling us?

Safe patient care is
our highest priority
Delivering high quality clinical services that achieve and demonstrate the best outcomes and provide excellent experience for patients

Our People | Executive Summary

NHS
East Sussex Healthcare
NHS Trust



Responsive	Positives:	Challenges and Risks:	Author
	Turnover unchanged, and maintains record low at 8.9% (target 10.6%) Vacancy rate reduced by 0.2% to 2.9% (target 5%) Monthly sickness rate reduced by 0.5% to 5.9% Appraisal rate increased by 0.7% to 80.3% (target 85%)	Mandatory training reduced slightly by 0.1% to 92.5% (target 90%) Annual sickness rate remains high at 5.5% (5% target)	
Overview:	February has a month on month reduction of £0.5M compared to January, despite a noticeable increase of Bank & Locum use (+43 wte) due to winter pressures, sickness cover and Corporate transformations. Agency usage also increased by 7 wte due to high activity demand in A&E departments and a focus on safely discharging patients. Turnover rate remains at a historic low level of 8.9% with 644 wte leavers in the last 12 months however a small increase in turnover is forecasted next month as colleagues usually plan to retire at the end of a fiscal year (March) or calendar year (Dec). Vacancies remains stable and controlled through the VCP, average 227 wte vacancies - Additional Clinical Services staff at 10.8% (186 wte) with the highest rate. A successful New to Care campaign has already rolled out with 19 offers made. Medical vacancies reduced by 15 wte this month following successful recruitment to various Senior and Residential Medical posts across the services. Work is ongoing to increase candidate pipelines, address hard-to-recruit posts e.g. Sonographers, convert bank/agency to permanent and continued governance controls on temporary workforce via Temp Approval Panel (TAP). There has been a small reduction in vacancies following successful recruitment to the Phlebotomy, Critical Care, A&E and additional support for wards. Whilst sickness remains high at 5.9%, the Trust has seen a month on month reduction of 0.5% compared to January as seasonal sickness begins to reduce. Absence related to colds, coughs and flu decreasing by 44% this month. A new Mental Health Support e-learning package has been developed and will be rolled out over the next quarter to support early recognition alongside team stress risk assessments. MSK/back problems accounted for 14% of absence during February. Collaborative work has also started with ESHT MSK services to support staff and develop preventative approaches. The mandatory training rate of 92.5% remains high and 2.5% above target. MyLearn functionality is being developed to enhance the manager visibility so leads can use the monthly IPR reports to understand their compliance position and then use MyLearn live reporting to see where they need to focus in order to improve their respective position by the next month. 63 appraisals were completed last month, increasing the appraisal rate to 80.3%. Another 382 appraisals are required to reach the 85% target.		**Steve Aumayer** Chief People Officer

Our People Core Metrics

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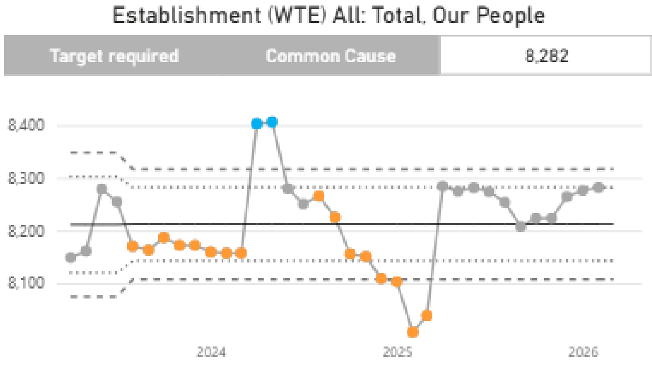
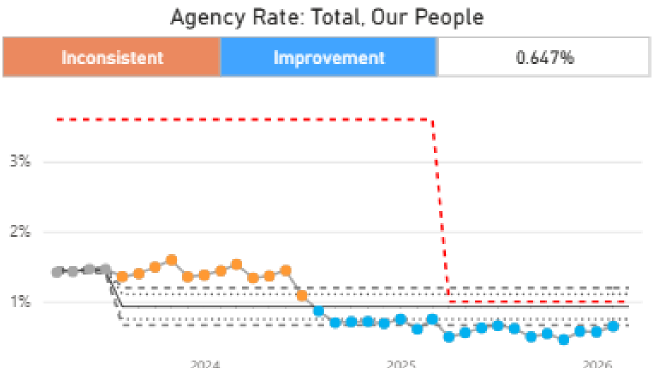
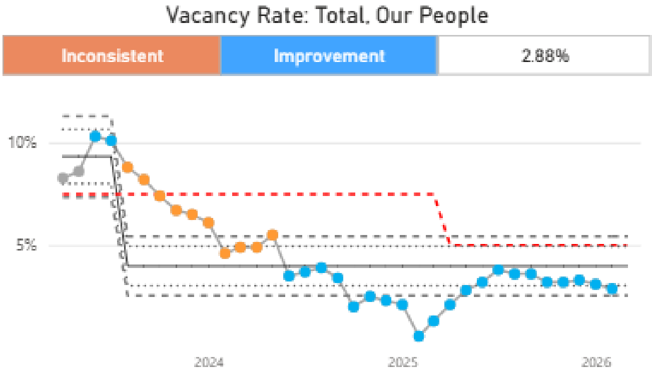
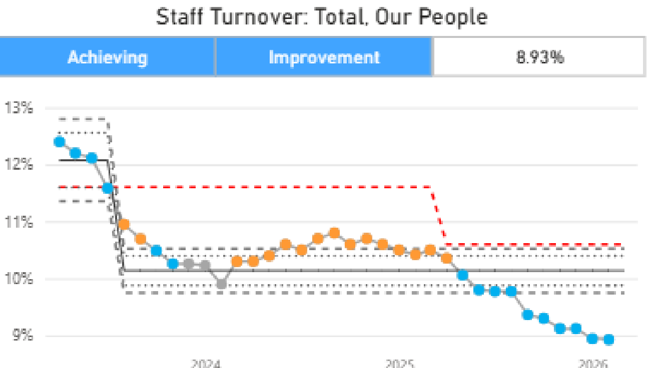
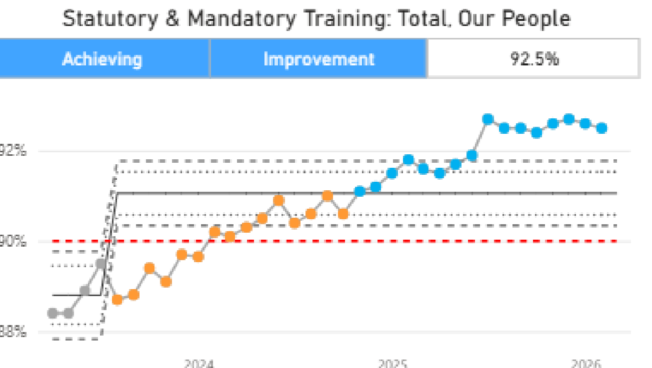
East Sussex Healthcare
NHS Trust

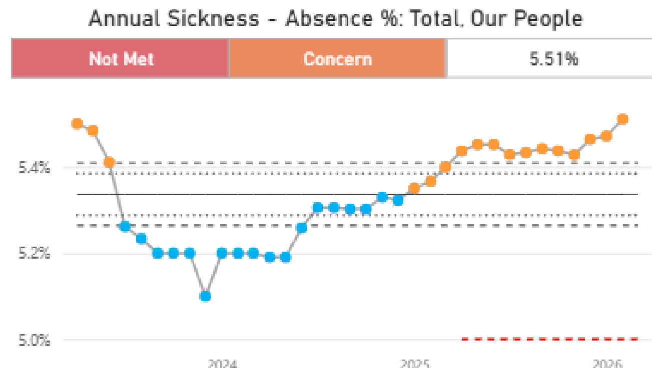


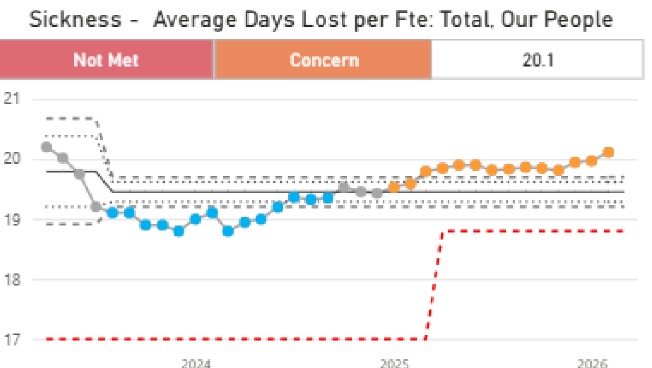


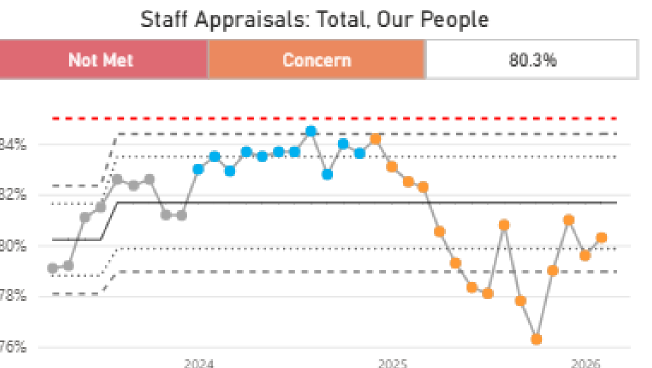












Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Turnover & Retention	Turnover rate reduced by 0.2% at 8.9%,1.7% under target	**Restorative Supervision** The Restorative Supervision programme continues, with phase 3 of the training starting in mid-March this year. Improvements to the way in which colleagues can access Restorative Supervision via an electronic self-referral process, have proved very effective, particularly during periods of immense pressure and business continuity. Endorsement of the programme and encouragement from senior leaders during challenging times has coincided with a noticeable increase in requests for support, demonstrating the importance of senior level backing to this programme. **TRiM** The TRiM team have been reviewing the delivery and impact of this work with a view to identifying improvements and efficiencies. This has resulted in the introduction of an electronic referral form for TRiM, reducing the administrative burden in setting up access to the service. In addition, it has been recognised that the fundamental principles of TRiM can be utilised as an immediate response to support colleagues experiencing trauma at work – Team Immediate Meet (TiM). Colleagues can then be referred onto the structured TRiM assessment if required. The TRiM team are working towards introducing this over the coming months. **Stress (Individual & Team)** As part of the review of the Psychological Wellbeing and Safety policy for staff, the approach to identifying and supporting colleagues with individual stress and the Team Stress Process, has been improved. Once the policy has been ratified in March, changes will be communicated to all colleagues. **Team in Need:** The People Engagement Team continues to actively support 15 teams across the Trust. The recently introduced feedback form is helping to evaluate the impact of this work aligning with the Trust's leadership and culture ambition to provide sustainable approaches to supporting leaders and teams.
Vacancy Rate	Vacancy rate reduced by 0.2% 2.9% (227 wte vacancies), 2.1% under target.	• Successful New to Care campaign commenced. Over 90 initial applications, shortlisted by Recruitment team. 2 days of interviews,19 offers made. 95% conversion rate. Inductions planned together with assessment and selection dates, circa12 per cohort • Ongoing support with temporary workforce agencies to increase candidate pipelines for such areas as ED, Escalation and Community, whilst conscious of NHS England requirement to reduce bank usage. Activity to convert/promote agency and bank to permanent • Support for redeployment activity within Corporate areas • Working with Divisions/workforce and HRBPs to understand both current and future requirements • Ongoing governance to ensure TWS and Agency spend on target (weekly Temp Approval Panels-TAP in conjunction with VCP); Chairing of South-East Temporary Staffing group to ensure governance and consistency across the ICB. • Focussed recruitment activity to address hard to recruit posts.eg AHPs-NHS Funding for Sonographers. • Continued activity to support recruitment for 'Art of the Possible' posts within Community areas. • Continued activity with HRBPs, review actions to support Divisions achieve 30% reduction in both agency and TWS usage. All posts now being advertised for two weeks, internal only, with Executive sign off for external advertising.

Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Sickness	Monthly sickness reduced by 0.5% to 5.9% and annual sickness remained at 5.5% (0.5% above target). Average sick days per WTE increased by 0.1 to 20.1, 13 above target.	Sickness absence levels remain high and continue to be a concern for the Sickness Reduction Group. A number of actions are underway to address this and strengthen prevention. A new Mental Health Support e-learning package has been developed and will be rolled out over the next quarter to support early recognition, prevention of mental health illness, and timely access to support for staff. Work is also continuing on the development of the Psychological Wellbeing Policy to provide clearer organisational guidance, promote preventative approaches, and strengthen support pathways. The Occupational Health Manager will offer targeted support to HR Business Partners working with teams that have higher levels of absence, helping to identify opportunities for earlier intervention and preventative action. In addition, analysis is commencing to triangulate areas with high mental health-related absence alongside team stress risk assessments to identify potential links. Collaborative work has also begun with ESHT MSK services to support staff and develop preventative approaches to reduce musculoskeletal-related absence across the organisation. Hotspot areas are reviewed with leads on an ongoing basis ensuring all appropriate and relevant support is signposted. The Trust continues to review long term absence on a case-by-case basis and re-evaluate proactive interventions ensuring management progresses in line with policy. **Estates & Facilities / DAS** There has been an upward trend in sickness of Anxiety & Stress, Chest & Respiratory, Gastro & MSK. To proactively manage this, work is underway to ensure that Mental Health First Aiders and Wellbeing Champions are in place.
Statutory & Mandatory Training	Trust compliance reduced by 0.1% to 92.5%, 2.5% above target.	Basic Life Support remains low and continues to be a Trust outlier. All colleagues who are non-compliant in key areas continue to be contacted and signposted to the Resuscitation Service to book themselves onto a training programme. DNA rates for BLS continue to remain an issue, more frequently recorded reason is service pressures.
Appraisal	Compliance rate increased by 0.7% to 80.3%, 4.7% below target	Divisions continue to remind that all staff complete the final stage of the appraisal process before it can be confirmed as being formally completed. This rate equates to 1,595 staff overdue for appraisal. Rates are lowest in Womens & Childrens at 71.7%, followed by Medicine Division at 73.2%. Another 382 appraisals are required to reach the 85% target.

Access and Responsiveness

Delivering the NHS Constitutional Standards

Urgent Care – Front Door

Urgent Care – Flow

Planned Care

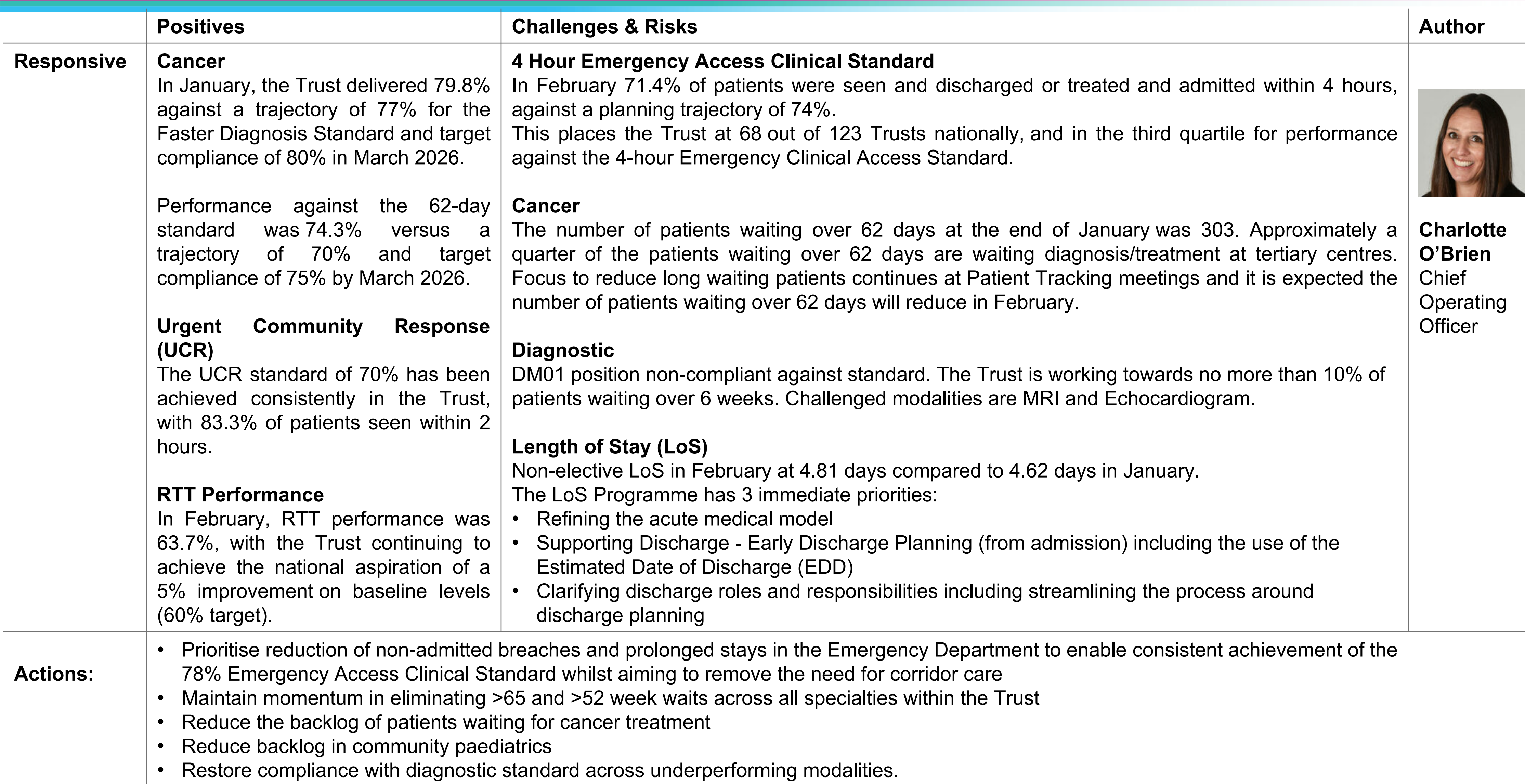
Our Cancer services

We will operate efficiently & effectively

Diagnosing and treating our patients in a timely way that supports their return to health

Access and Responsiveness | Executive Summary

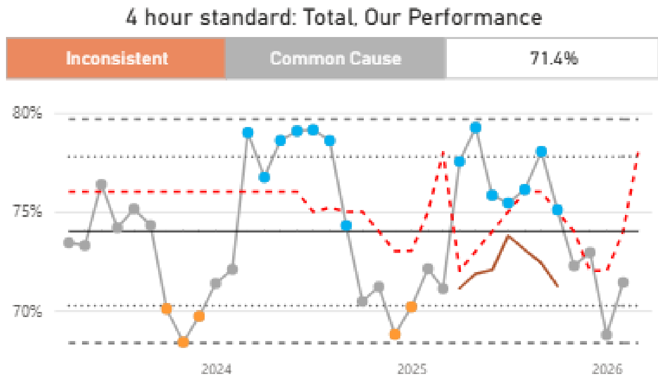
East Sussex Healthcare NHS Trust

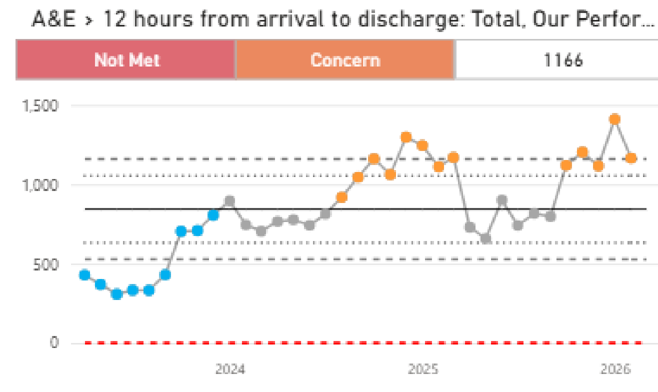


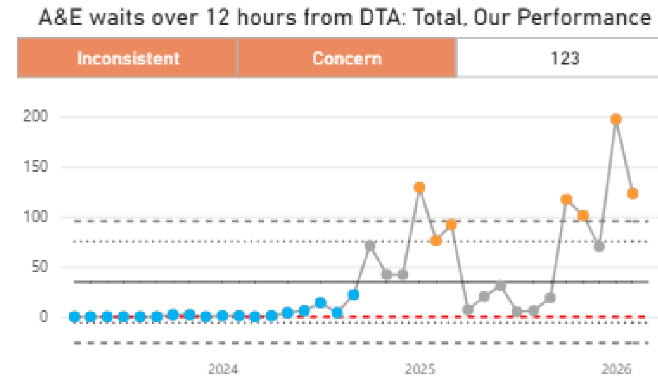
	Positives	Challenges & Risks	Author
Responsive	**Cancer** In January, the Trust delivered 79.8% against a trajectory of 77% for the Faster Diagnosis Standard and target compliance of 80% in March 2026. Performance against the 62-day standard was 74.3% versus a trajectory of 70% and target compliance of 75% by March 2026. **Urgent Community Response (UCR)** The UCR standard of 70% has been achieved consistently in the Trust, with 83.3% of patients seen within 2 hours. **RTT Performance** In February, RTT performance was 63.7%, with the Trust continuing to achieve the national aspiration of a 5% improvement on baseline levels (60% target).	**4 Hour Emergency Access Clinical Standard** In February 71.4% of patients were seen and discharged or treated and admitted within 4 hours, against a planning trajectory of 74%. This places the Trust at 68 out of 123 Trusts nationally, and in the third quartile for performance against the 4-hour Emergency Clinical Access Standard. **Cancer** The number of patients waiting over 62 days at the end of January was 303. Approximately a quarter of the patients waiting over 62 days are waiting diagnosis/treatment at tertiary centres. Focus to reduce long waiting patients continues at Patient Tracking meetings and it is expected the number of patients waiting over 62 days will reduce in February. **Diagnostic** DM01 position non-compliant against standard. The Trust is working towards no more than 10% of patients waiting over 6 weeks. Challenged modalities are MRI and Echocardiogram. **Length of Stay (LoS)** Non-elective LoS in February at 4.81 days compared to 4.62 days in January. The LoS Programme has 3 immediate priorities: • Refining the acute medical model • Supporting Discharge - Early Discharge Planning (from admission) including the use of the Estimated Date of Discharge (EDD) • Clarifying discharge roles and responsibilities including streamlining the process around discharge planning	**Charlotte O'Brien** Chief Operating Officer
Actions:	• Prioritise reduction of non-admitted breaches and prolonged stays in the Emergency Department to enable consistent achievement of the 78% Emergency Access Clinical Standard whilst aiming to remove the need for corridor care • Maintain momentum in eliminating >65 and >52 week waits across all specialties within the Trust • Reduce the backlog of patients waiting for cancer treatment • Reduce backlog in community paediatrics • Restore compliance with diagnostic standard across underperforming modalities.		

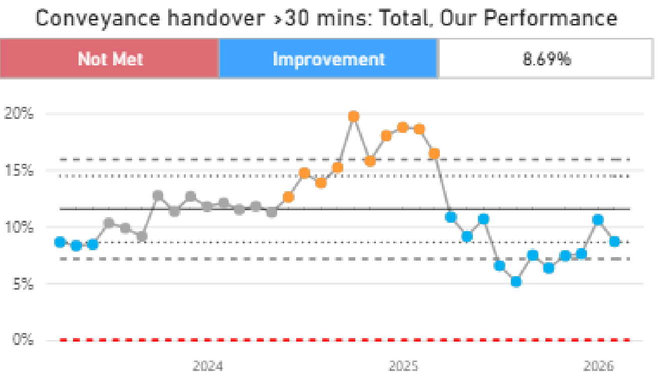
Access and Responsiveness Core Metrics

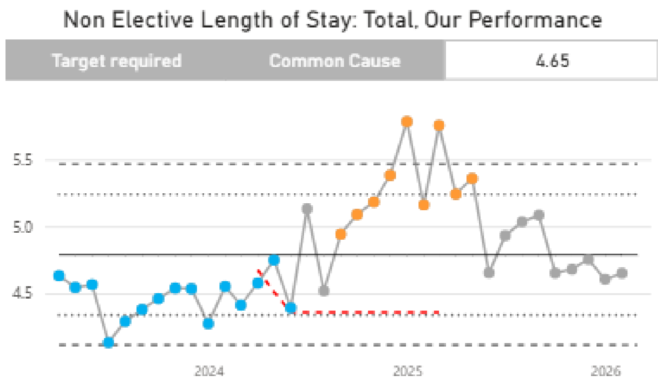
NHS East Sussex Healthcare NHS Trust

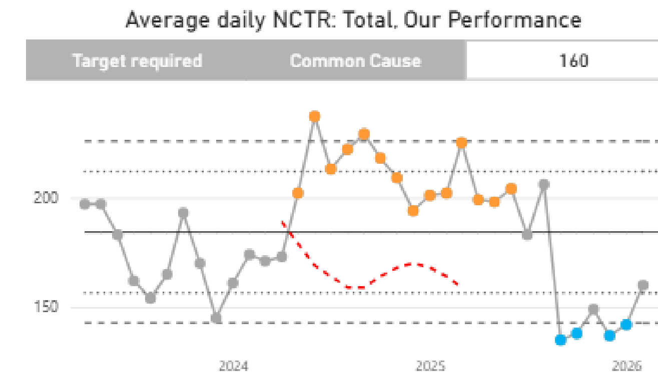


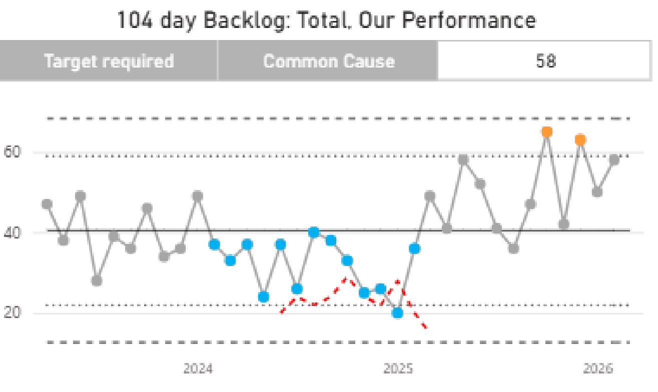


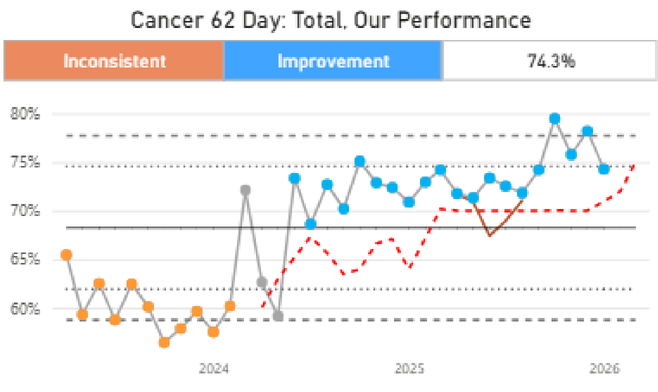


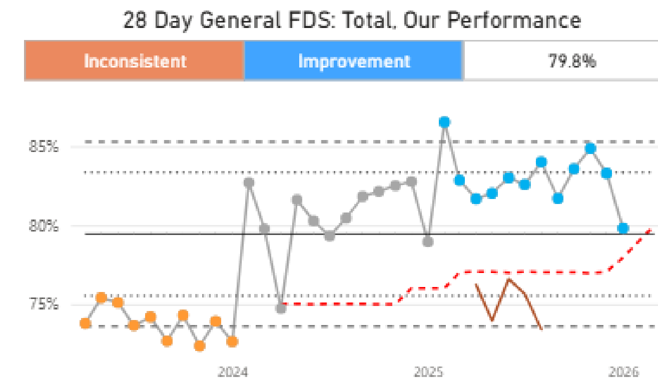






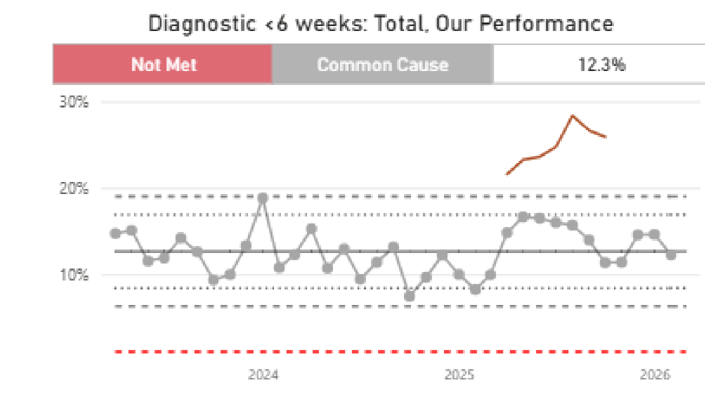


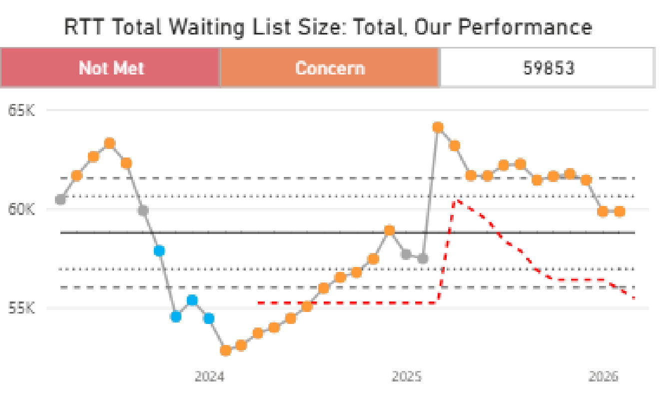


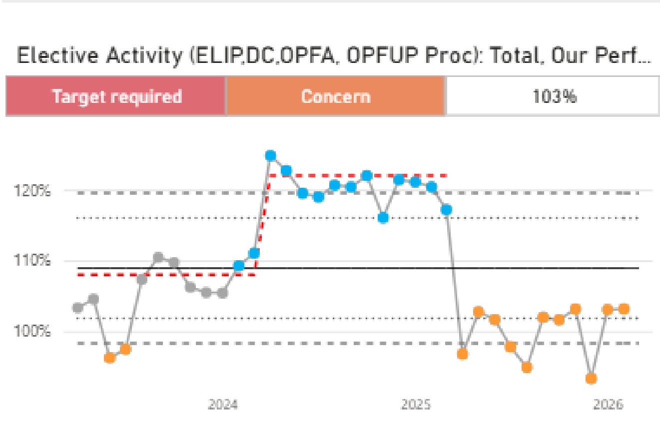


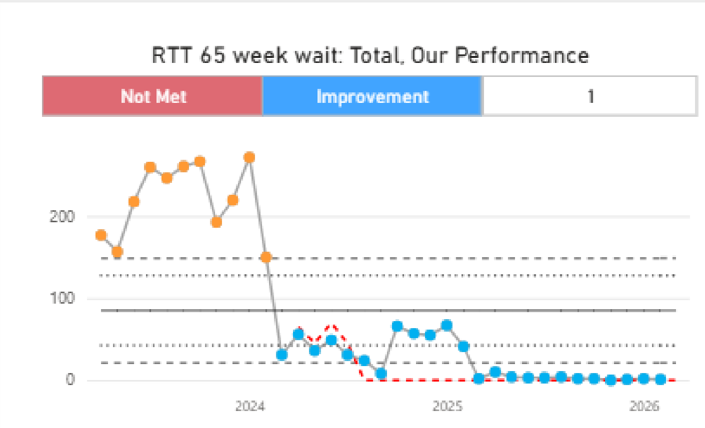
Access and Responsiveness Core Metrics

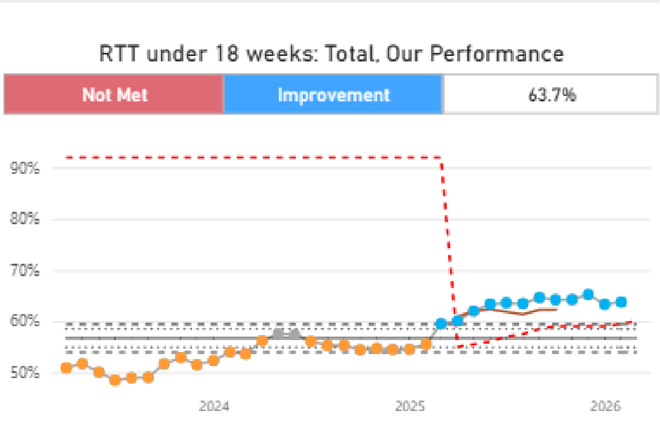
East Sussex Healthcare NHS Trust

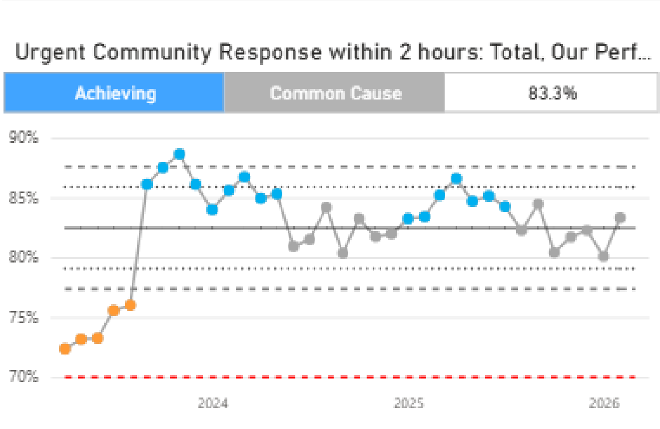


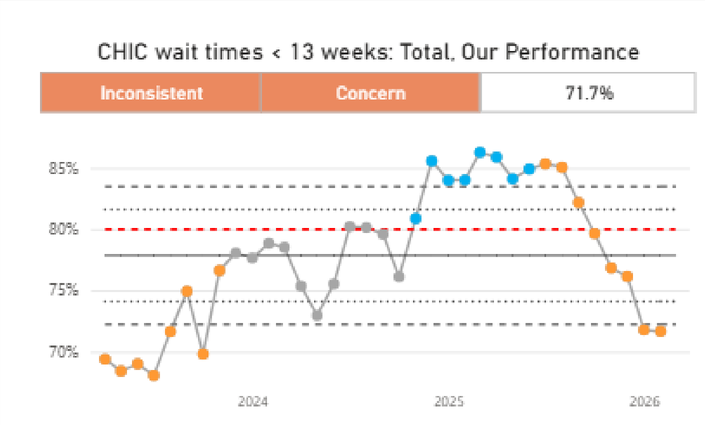


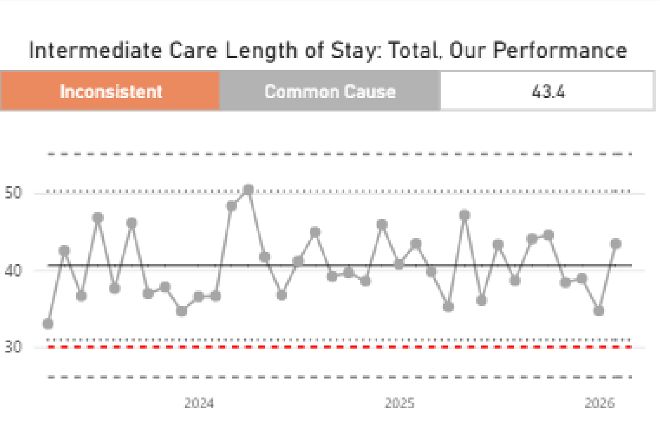












Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Emergency Access Clinical Standard	In February 71.4% of patients were seen and discharged or treated and admitted within 4 hours, against a planning trajectory of 74%. This places the Trust at 68 out of 123 Trusts nationally, and in the third quartile for performance against the 4-hour Emergency Clinical Access Standard. Achievement of 78% in February would have required approx. 32 less breaches per day (cross site) ED demand has increased by 6% this financial year compared to 2024/25, T1 and T3 increasing by 5% and 6% respectively.	• Review attendance trends and workforce capacity • Escalation of delays and pathways that are not optimised with support from all divisions • Trust wide focus to achieve 78% 4-hour clinical standard • Focus on roles and responsibilities to support overnight resilience • Ringfence CDU for Emergency Department • Full review of the Trust 'Full Capacity' protocol • Review the opportunity to improve T1 minors performance
Patients in department over 12 hours from arrival to discharge	The number of patients waiting over 12 hours from arrival to discharge decreased to 1167 (11.2% of T1 attends) from 1411 (12.5% of T1 attends) in January. In February, 123 patients waited over 12 hours following a decision to admit, compared to 197 in January.	• Timely escalation within the ED department when at full capacity to enable ED and divisional teams to create capacity • Continued focus on reducing LOS and the number of patients not meeting the criteria to reside to enable flow • Focus on timely escalation of patients at risk of >12-hour LOS.
Conveyance Handover >45 mins	The Trust is aiming to have zero 45-minute off load delays. Conveyance handover more than 45 minutes was 2.6% (n=73). 45-minute handover times have been increasing since Aug 25 low of 0.6% (n=19), but still within control limits, displaying common cause variation.	• Continued focus on ambulance handover times, early escalations and actions to mitigate delays have now been embedded, supporting decompression in the department • Escalations to site managers and ED operational leadership team for inbound conveyances with no capacity to support offloading • Focused work with SECAmb on timely electronic recording of all ambulance arrivals and validation of 45-minute off-load delays • Daily staffing review to consider requirements for escalation areas.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Non elective Length of Stay (LOS)	Non-elective LoS was 4.81 days in February, and within control limits, displaying common cause variation. The total number of patients who do Not Meet the Criteria to Reside increased from 142 in January to 160 in February. Small increases were identified in P2 and P3 pathways.	• Review of acute medical model • Support discharge planning from admission, including the revised use and reporting of estimated dates of discharge (EDDs) • Improvement actions are in place to increase P1 capacity, which will support same day/next day discharges 7 days a week using a Home First approach. • Work continues with system partners to improve pathways for patients not meeting criteria to reside.
Community Waiting Times (Paediatric)	The number of children waiting for a first outpatient appointment in February decreased to 2373 from 2520 in January (the same size as it was in February 2025). There were 153 children waiting over 78 weeks (289 in Dec), a 47% reduction in month. The number of children waiting over 65 weeks reduced to 385 (796 in Oct, 685 in Nov, 550 in Dec, 457 in Jan), a 51% reduction since Oct 25. A small number of children waited over 2 years in February. Outsourcing to an independent sector provider continues for school age children.	• A number of job planning actions continue to increase medical capacity • Digital redesign work continues • Waiting list validation continues • Work continues with NHS Sussex to develop new models of care for ASD assessments • External provider contract for School Age is running well and supporting a reduction in the waiting list size.
Community Waiting Times (Adult)	Urgent Community Response achieved a 2-hour response of 83.3%. An improvement on January (80.1%), achieving the 70% national target. In February 71.6% of patients were seen within 13 weeks against a target of 80% (similar to January performance 71.6%). There has been an increase in referrals and in acuity. Activity levels continue to exceed those the Trust is contracted to provide e.g. 20% increase in MSK referrals.	• Clinical prioritisation of caseloads to mitigate clinical risk • Review of community contract underway • Ongoing work with commissioners regarding the level of funding required to support delivery of constitutional standards.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Cancer	In January, the Trust delivered 79.8% against the 77% Faster Diagnosis standard and remains on track to deliver the 80% waiting time standard by March 2026. The Trust delivered 94.0% against the 96% national cancer waiting times 31-Day diagnosis to treatment standard in January (in line with trajectory). Performance against the 62 Day standard in January was 74.3%. This was a slight reduction from the December performance as some patients chose to delay their treatment over the festive period and were treated in January. 303 patients waiting over 62 days at the end of January 2025. It is anticipated that the number of patients waiting over 62 days will reduce in February.	• Detailed tumour site Cancer Action Plans underpinned by improvement trajectories • Tiering in place to support challenged specialties with fortnightly meetings to support improvement • Weekly review of in month and future month performance to support delivery of tumour site level trajectories • Enhanced focus on patients early in the pathway and weekly monitoring to improve transfer dates to tertiary providers by day 38 • Review of options for insourcing to support the backlog of patients waiting robotic treatments in urology • Focus on long waiting patients to reduce the number of patients waiting over 62 days. This includes working with tertiary centres • Additional capacity in challenged pathways including Urology
Elective Activity	To date, the Trust has achieved 103% of the local target for February. This is expected to further improve once February activity has been verified.	• Continue to maximise outpatient capacity through improved clinic utilisation • Ongoing review of follow-up pathways, with increased adoption of Patient Initiated Follow-Up (PIFU) • Maintain and enhance validation processes to ensure waiting list accuracy, appropriate prioritisation, and timely management of long-waiting patients • Strengthened governance and oversight measures are in place to minimise cancellations, reduce avoidable downtime, and ensure full utilisation of available theatre sessions • Increased use of the newly opened Sussex Surgical Centre to bolster elective capacity • Providing additional FOPA across all specialties, particular Gynaecology.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
RTT long wait position and waiting list size	The Trust reported a small number of 65-week waiters in February and remains committed to achieving and sustaining a zero-position going forward. Efforts continue to focus on reducing the number of patients waiting over 52 weeks. The number of patients waiting over 52-weeks reduced from 682 in January to 598 in February (unvalidated). This represents 0.99% of the total PTL. In February, the Trust waiting list remained stable at 59,853. During February, the Trust accepted the transfer of 350 pathways from UHSx in support of elective recovery across Sussex. RTT compliance for February was reported at 63.7%, compared to 63.3% in January with the Trust having already achieved the national aspiration of 5% improvement by March 2026.	• Structured PTL reviews are undertaken twice a week for all patients approaching the 65-week threshold these reviews have been expanded to include patients at risk of waiting >52 weeks, ensuring early intervention, proactive case management, and timely escalation • Clinic templates and consultant job plans continue to be systematically reviewed and refined to maximise available capacity. • Focus remains on increasing first outpatient appointment slots, supporting improved pathway flow and reducing waiting times across high-volume specialties • A strengthened programme of pathway validation remains in place to improve RTT data quality, support operational delivery, and drive sustainable performance. Validation resource is prioritised to support high-volume specialties and pathways with known data-quality challenges, improving accuracy and mitigating unwarranted waiting list growth • The Trust launched the FDP Validation Tool in January, which is expected to provide further benefit by increasing the speed, consistency, and efficiency of validation activity, supporting RTT performance improvements and an overall waiting list reduction.
Diagnostic DMO1	February Performance 12.3% (improved from 14.6% January) Target <10% by end March 2026 •Improved position compared to January •Challenges due to equipment failure (MRI Conquest heat exchanger) and staff sickness across radiographers and sonographers, although improving through February •Audiology, Endoscopy performance <1% •Cardiac Echo continues to improve and now booking to 4.5 weeks. Recovery slightly ahead of plan and on track to be at 1% for March •CT delivered 7%, Ultrasound 8% Main challenge remains MRI with waiting list of 3,712 and 813 breaches. Demand still high from referrals and wards/ED and USC. •Waiting list across DM01 increased to 11,500	• CT scanning and non-obstetric ultrasound showing improved performance going into March and on track with recovery trajectory. • Additional NOUS capacity in place to recover decrease in performance over January/February • MRI Deep Resolve now installed in both Conquest scanners, releasing additional 4-5 scanning slots per day. • Further refinement of PowerBI waiting list tool to better aid booking prioritisation and plan further ahead.

Financial Control and Capital Development

Our Income and Expenditure

Our Elective Recovery

Our Run Rate

Efficiency

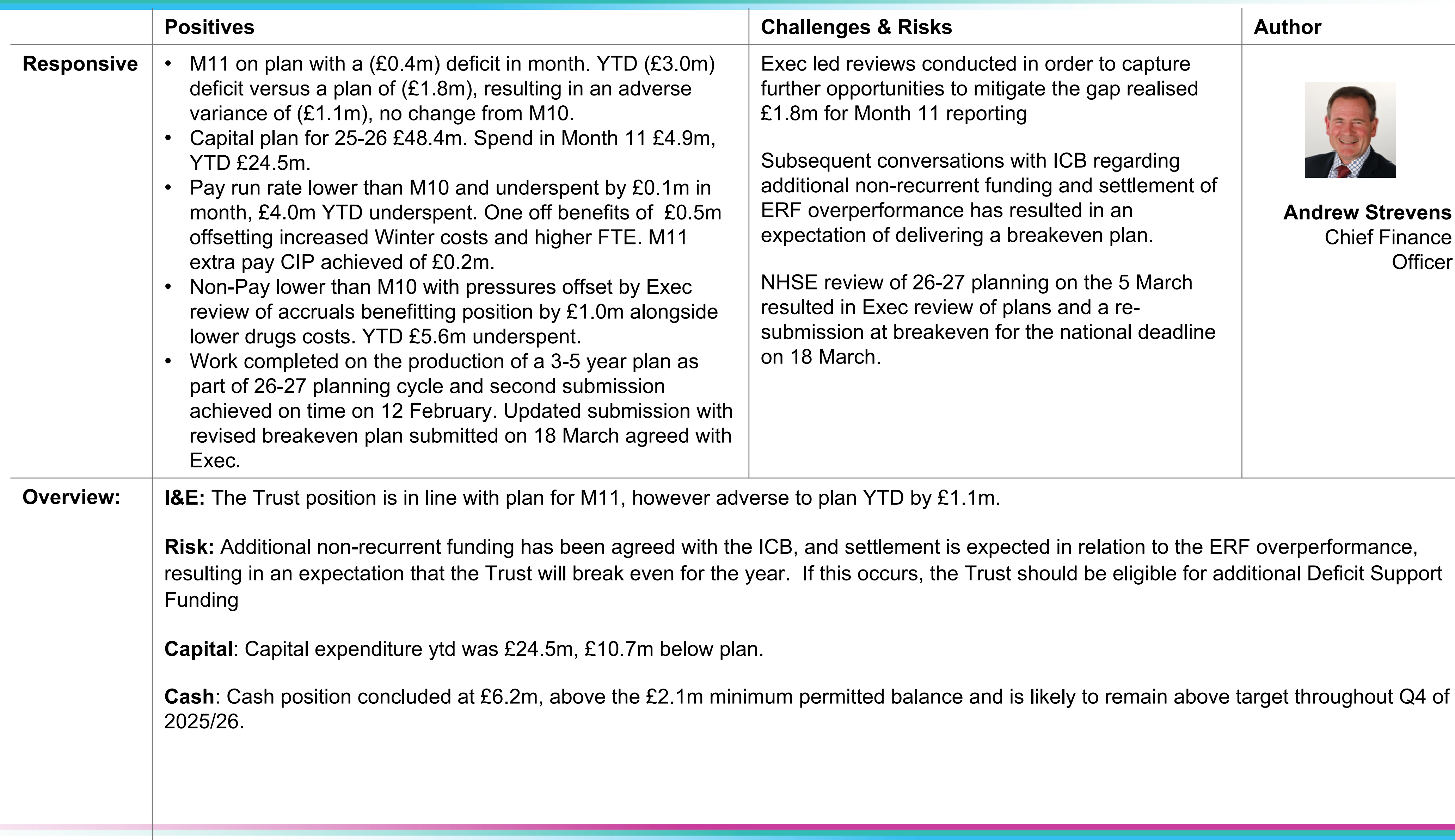
Capital

We will use our resources economically, efficiently and effectively
Ensuring our services are financially sustainable for the benefit of our patients and their care

Finance | Executive Summary

NHS
East Sussex Healthcare
NHS Trust

Finance



	Positives	Challenges & Risks	Author
Responsive	• M11 on plan with a (£0.4m) deficit in month. YTD (£3.0m) deficit versus a plan of (£1.8m), resulting in an adverse variance of (£1.1m), no change from M10. • Capital plan for 25-26 £48.4m. Spend in Month 11 £4.9m, YTD £24.5m. • Pay run rate lower than M10 and underspent by £0.1m in month, £4.0m YTD underspent. One off benefits of £0.5m offsetting increased Winter costs and higher FTE. M11 extra pay CIP achieved of £0.2m. • Non-Pay lower than M10 with pressures offset by Exec review of accruals benefitting position by £1.0m alongside lower drugs costs. YTD £5.6m underspent. • Work completed on the production of a 3-5 year plan as part of 26-27 planning cycle and second submission achieved on time on 12 February. Updated submission with revised breakeven plan submitted on 18 March agreed with Exec.	Exec led reviews conducted in order to capture further opportunities to mitigate the gap realised £1.8m for Month 11 reporting Subsequent conversations with ICB regarding additional non-recurrent funding and settlement of ERF overperformance has resulted in an expectation of delivering a breakeven plan. NHSE review of 26-27 planning on the 5 March resulted in Exec review of plans and a re-submission at breakeven for the national deadline on 18 March.	**Andrew Strevens** Chief Finance Officer
Overview:	**I&E:** The Trust position is in line with plan for M11, however adverse to plan YTD by £1.1m. **Risk:** Additional non-recurrent funding has been agreed with the ICB, and settlement is expected in relation to the ERF overperformance, resulting in an expectation that the Trust will break even for the year. If this occurs, the Trust should be eligible for additional Deficit Support Funding **Capital**: Capital expenditure ytd was £24.5m, £10.7m below plan. **Cash**: Cash position concluded at £6.2m, above the £2.1m minimum permitted balance and is likely to remain above target throughout Q4 of 2025/26.		

Finance – Income and Expenditure

East Sussex Healthcare NHS Trust

Income and Expenditure

At month 11 the Trust is reporting on plan with a deficit of (£0.4m). YTD is a (£3.0m) deficit versus a (£1.8m) deficit plan, an adverse variance of (£1.1m). In order to help achieve the position £2.2m of opportunities were recognised. Key areas to highlight are:

- Income adverse overall in month by (£1.9m), but £0.6m of one-off benefits from Exec reviews.
- ERF Income ahead of plan by £1.7m YTD and ahead of the Sussex ICB financial envelope by £2.7m. Lower ERF in month due to fewer working days during February (£0.4m).
- Non pay underspent in month with lower Drugs costs within , offset by lower costs in CORE and Exec reviews realising £1m of benefit in month.
- Pay underspent in month, due to Winter pressures, Bank & Agency cover for sickness offset by £0.5m of one off benefits related to Capitalisation and salary reclaims. There is an fte increase linked to above pressures in month.

The **Use of Resources** plan shows under achievement at (£22.7m) YTD.

Income: Below plan (as expected given plan assumptions). Diagnostic income for variable activity removed from actuals as confirmed as part of block (actioned M4) continues for the rest of financial year. Divisional ERF below plan in month by (£0.4m) with fewer working days in February, offset by £0.6m of one-off benefits in CORE and CHIC.

Pay: Pay is under plan by £0.1m with continuing Winter pressures alongside increase temporary staffing and substantive usage, offset by further Rev to Cap transfers of £0.2m and Salary reclaim values estimated at £0.3m.

Non-Pay: Underspent in month by £1.8m. Divisional opportunities from reviews of £1m and lower Drugs costs of £0.4m with other reserves budget also benefitting the bottom line.

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Plan	Act	Var	Plan	Act	Var
Income						
Contract income	43,104	41,413	(1,691)	471,103	459,188	(11,916)
Divisional	6,920	7,050	130	79,617	78,963	(654)
ERF	11,589	11,219	(370)	124,427	126,161	1,734
Total Income	**61,613**	**59,682**	**(1,931)**	**675,147**	**664,311**	**(10,836)**
Operating Expense						
Pay						
Permanent	(38,599)	(35,983)	2,616	(422,116)	(396,661)	25,455
Temporary	(1,644)	(4,127)	(2,484)	(19,691)	(41,102)	(21,411)
Total pay	**(40,243)**	**(40,111)**	**132**	**(441,807)**	**(437,763)**	**4,045**
Non-Pay						
Drugs	(1,565)	(947)	618	(17,235)	(17,776)	(542)
TEDD	(3,899)	(3,379)	520	(42,888)	(40,788)	2,101
Clinical supplies	(4,684)	(4,909)	(224)	(52,702)	(53,979)	(1,277)
Purchased services	(1,824)	(1,738)	86	(19,128)	(17,644)	1,484
Finance costs	(3,030)	(2,934)	97	(33,328)	(31,862)	1,466
Other	(6,726)	(6,021)	705	(69,867)	(67,453)	2,414
Total Non-Pay	**(21,729)**	**(19,927)**	**1,802**	**(235,148)**	**(229,502)**	**5,646**
Total Expense	**(61,972)**	**(60,038)**	**1,934**	**(676,955)**	**(667,264)**	**9,691**
Surplus/(Deficit)	**(359)**	**(356)**	**3**	**(1,808)**	**(2,953)**	**(1,145)**

Finance - Capital

NHS East Sussex Healthcare NHS Trust

Capital Scheme	Funding	Planned End Date	Fcast End Date	In Month Plan £'000	In Month Actual £'000	In Month Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000	Full Year Plan £'000	Full Year Fcast £'000	Full Year Variance £'000
Backlog	Core			69	397	(328)	543	741	(198)	700	1,835	(1,135)
Fire	Core	Jan-25	Mar-29	124	3	121	969	169	799	1,250	1,000	250
Endoscopy	Core	Sep-25	Oct-25	742	427	315	5,813	3,388	2,425	7,500	5,700	1,800
Sussex Surgical Centre	Core	May-25	Sep-25	124	(0)	124	969	1,250	(281)	1,250	1,250	-
Cardiology	Strategic	Mar-25	Oct-26	346	179	167	2,713	2,462	250	3,500	3,000	500
CIR Estates Safety Plan				1,323	1,070	253	8,194	4,414	3,780	10,278	10,278	-
Conquest Decant Space creation	PDC	Mar-26	Mar-26	202	177	25	1,709	1,170	540	2,114	2,114	-
Maternity & SCBU Refurbishment	PDC	Mar-26	Mar-26	96	45	50	809	218	591	1,000	1,000	-
Eastbourne Midwifery Unit	PDC	Mar-26	Mar-26	185	664	(479)	1,567	1,812	(245)	1,938	1,938	-
Sub 4 Switchgear	PDC	Mar-26	Mar-26	43	52	(9)	364	164	200	450	450	-
Distribution Boards	PDC	Mar-26	Mar-26	50	(0)	51	425	60	365	525	525	-
Fire Doors - Cq	PDC	Mar-26	Mar-26	108	(11)	119	914	621	293	1,131	1,131	-
Fire Doors - Eb	PDC	Mar-26	Mar-26	108	18	90	914	59	855	1,131	1,131	-
Old Macerators	PDC	Mar-26	Mar-26	20	-	20	170	14	155	210	210	-
Sub Station Tripping Batteries	PDC	Mar-26	Mar-26	5	4	1	44	4	40	55	55	-
Estates Safety Phase 2	PDC	Mar-26	Mar-26	505	119	386	1,278	291	987	1,725	1,725	-
Total Estates				2,728	2,075	653	19,200	12,424	6,776	24,478	23,063	1,415
Digital	Core	Mar-26	Mar-26	252	112	140	1,976	1,326	651	2,550	2,550	-
Our Care Connected	Strategic	Mar-26	Mar-26	247	208	39	1,938	2,292	(354)	2,500	2,500	-
EPR	PDC	Mar-26	Mar-26	1,504	225	1,279	3,872	3,301	571	5,376	5,376	-
LIMS - DDC	PDC	Mar-26	Mar-26	271	287	(16)	813	559	254	1,084	1,084	-
OCS - DDC	PDC	Mar-26	Mar-26	74	-	74	223	-	223	297	297	-
Imaging Network	PDC	Mar-26	Mar-26	472	24	448	1,415	24	1,391	1,886	1,886	-
Shared Care Record	PDC	Mar-26	Mar-26	72	-	72	145	-	145	217	217	-
Frontline Underspend - OCC	PDC	Mar-26	Mar-26	-	-	-	-	-	-	1,270	1,270	-
Secure Data Environments	PDC	Mar-26	Mar-26	-	-	-	-	-	-	200	200	-
Total Digital				2,893	857	2,036	10,381	7,501	2,880	15,380	15,380	-
Medical Equipment	Core	Mar-26	Mar-26	495	1,054	(559)	3,875	3,082	794	5,000	6,500	(1,500)
Histopathology Modernisation	PDC	Feb-26	Feb-26	-	506	(506)	689	598	91	689	689	-
Decontamination Equipment	PDC	Mar-26	Mar-26	-	-	-	-	-	-	29	29	-
C-Arm & Imaging Table	PDC	Mar-26	Mar-26	-	-	-	-	-	-	340	340	-
Cystoscopes	PDC	Mar-26	Mar-26	-	-	-	-	-	-	300	300	-
Maternity Rotem	PDC	Mar-26	Mar-26	-	-	-	-	-	-	54	54	-
Constitutional Standards				36	263	(228)	212	263	(52)	1,160	1,160	-
Diagnostics	PDC	Mar-26	Mar-26	36	-	36	212	-	212	253	253	-
Audiology Paediatrics	PDC	Mar-26	Mar-26	-	-	-	-	-	-	595	595	-
Echocardiography Machines	PDC	Mar-26	Mar-26	-	263	(263)	-	263	(263)	264	264	-
DM01 Equipment	PDC	Mar-26	Mar-26	-	-	-	-	-	-	48	48	-
Total Medical Equipment				530	1,823	(1,293)	4,776	3,943	833	7,572	9,072	(1,500)
Business Cases				99	-	99	775	422	353	1,000	422	578
Aquablation	Core	Sep-25	Sep-25	-	-	-	-	422	(422)	-	422	(422)
Other	Core	Mar-26	Mar-26	82	122	(40)	644	179	465	831	215	616
Total Other				181	122	59	1,419	601	818	1,831	637	1,194
Total Capital				6,332	4,877	1,455	35,776	24,469	11,308	49,261	48,152	1,109
Slippage	Core			(429)	-	(429)	(3,365)	-	(3,365)	(4,341)	-	(4,341)
Brokerage	Core			346	-	346	2,713	-	2,713	3,500	-	3,500
Total Charge to CRL				6,249	4,877	1,372	35,124	24,469	10,656	48,420	48,152	268

	Full Year Plan £'000	Full Year Fcast £'000	Full Year Variance £'000
Core	19,240	19,472	(232)
Strategic	6,000	5,500	500
PDC	23,180	23,180	-
	48,420	48,151	268

As of month 11, cumulative capital expenditure totals £24.5m. Most of the cumulative expenditure is attributable to Estates Safety (£4.4m), Digital Electronic Patient Record (£3.3m), Medical Equipment (£3.1m), Cardiology (£2.5m), Our Care Connected schemes (£2.3m) and Endoscopy (£3.4m).

PDC capital funding of £23.2m has been received for National Programmes, including funding of £10.3m for CIR Estates Safety, across a range of schemes. Expenditure of £4.4m has been incurred to month 11, mostly on Eastbourne Midwifery, Decant Space and Fire Doors at the Conquest.

Backlog Maintenance and Fire schemes have incurred £0.9m of the £2.0m allocated, however is forecast to maximise expenditure. Digital is also expected to meet their plan and forecast of £15.4m which is spread across various schemes that are mostly funded by additional PDC, all of which has been drawn.

The forecast as of month 11 reflects an estimated underspend on Endoscopy of £1.8m and includes the start on the refurbishments of EDGH residences. Overall, the forecast shows an underspend of £0.3m, however the position will be managed as delivery of schemes near completion and a reserve list will be used to ensure the allocation is maximised.

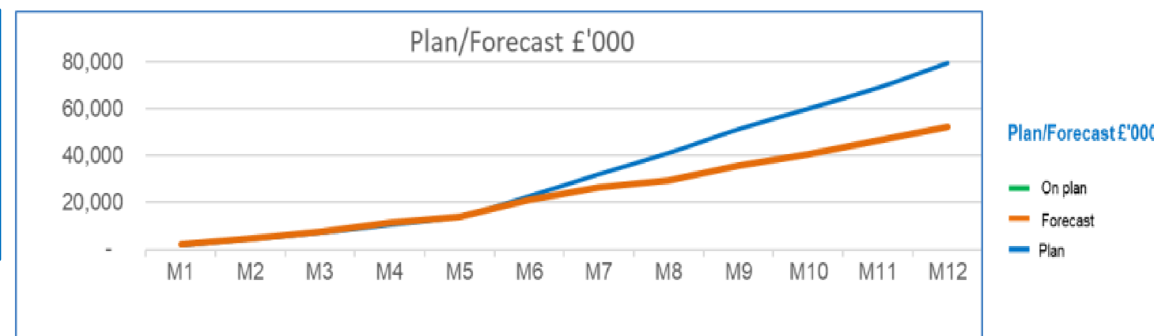
Stakeholders have given assurances that their forecasts will deliver to the expected level of expenditure.

Use of Resources – YTD position

East Sussex Healthcare NHS Trust

Division	M11 Plan	M11 Act	M11 Var	M11 YTD Plan	M11 YTD Act	M11 YTD Var	Full Year Plan	Full Year F'cast	Full Year Var
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
CHIC	56	53	(3)	356	324	(32)	422	386	(35)
Core	461	374	(87)	4,072	4,003	(68)	4,533	4,418	(115)
DAS	656	407	(249)	4,962	4,133	(830)	5,619	4,567	(1,051)
Medicine	745	(361)	(1,106)	6,202	5,589	(613)	6,947	6,276	(671)
Urgent Care	535	499	(35)	4,086	3,982	(104)	4,621	4,469	(152)
WAC	128	104	(24)	1,780	1,673	(107)	1,908	1,780	(128)
SPH	139	10	(129)	526	100	(426)	665	110	(555)
E&F	252	214	(38)	2,044	1,804	(239)	2,326	2,051	(275)
Corporate	399	319	(80)	3,515	3,047	(467)	3,922	3,377	(545)
Central	1,865	1,535	(330)	16,778	12,810	(3,969)	18,654	14,094	(4,560)
Original plan	**5,236**	**3,154**	**(2,082)**	**44,320**	**37,465**	**(6,855)**	**49,615**	**41,529**	**(8,087)**
Executive led Central	3,677	2,440	(1,237)	24,735	8,892	(15,843)	29,985	10,725	(19,260)
Total	**8,913**	**5,594**	**(3,319)**	**69,055**	**46,357**	**(22,698)**	**79,600**	**52,254**	**(27,347)**

At Month 11 we are expecting savings delivery of £52.2m, which is higher than the original plan, but significantly lower than the revised targets the Trust set itself in month 5. However, given non-recurrent measures enacted during the year, additional ERF income from 24/25 and 25/26 and grip and control measures, the savings should be sufficient to enable the delivery of a break-even plan



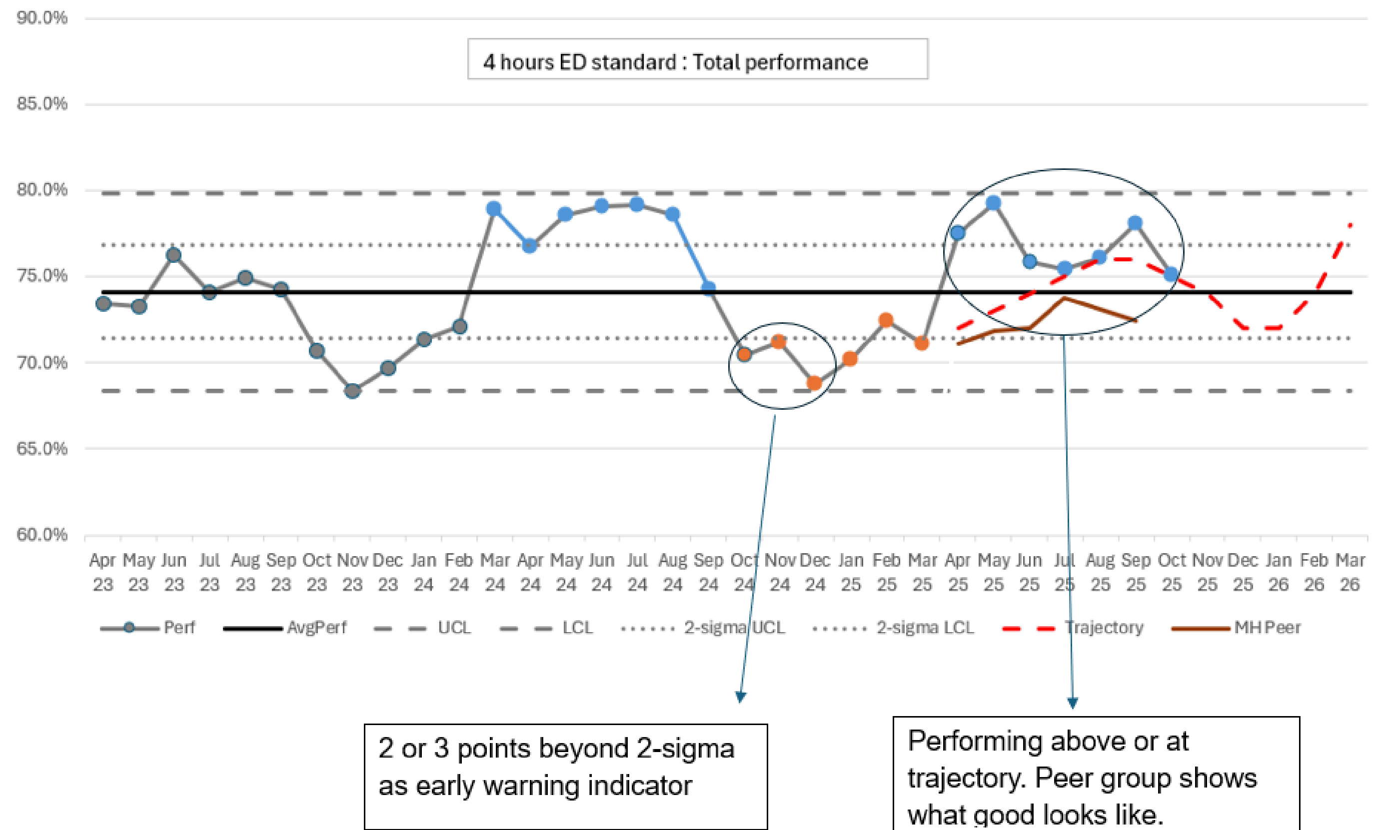
APPENDIX - IPR Graph Changes (1)

East Sussex Healthcare NHS Trust

IPR graphs

- The SPC charts now show over 3 years, last two years activity/performance, one year forward view of trajectory
- Early warning sign methodology – introduction of 2-sigma control limits, 2-3 consecutive months of not meeting standard
- Benchmarking to Model Hospital peer group – see next slide for details.

What does the chart tell you – illustrative graph



Model Hospital Peer Group

- The Trust is benchmarked against the Model Hospital recommended peer group
- The peer group contains similar Trusts (shown adjacent), those of comparable size, activity, services and case mix
- Comparator performance is calculated on available national datasets (constitutional standards and FFT) .

Calderdale and Huddersfield NHS Foundation Trust

Croydon Health Services NHS Trust

James Paget University Hospitals NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Rotherham NHS Foundation Trust

Torbay and South Devon NHS Foundation Trust

University Hospitals Plymouth NHS Trust

Warrington and Halton Hospitals NHS Foundation Trust

Wrightington, Wigan and Leigh NHS Foundation Trust

Wye Valley NHS Trust

Agenda Item: 9

Report To/Meeting	Trust Board	Date of Meeting	21 April 2026

Report Title:	Maternity Safety and Quality Q3 and Combined Insights Report
Key question	Does the data and insight presented provide sufficient assurance to the Board regarding maternity safety and quality, including any associated implications.
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☒

Report Sponsor:	Vikki Carruth, Chief Nurse and Executive Maternity Safety Champion	Presenter(s):	Matthew Clark, Chief of Division – Appendix A Aly Hulme, Interim Director of Maternity Service – Appendix B-D
Report Author:	Aly Hulme, Interim Director of Maternity Service Claire Croft, Acting Deputy Head of Midwifery		

Outcome/Action requested:	The Trust Board is requested to **note**: 1. Performance within Quarter 3 reporting period and the Enhanced Support and Oversight support from NHSE. 2. Response provided following the recent HSJ article and media enquiry (Appendix A section 4.2). 3. Results of the CQC Survey 2025 and Homebirth Audit. 4. Independent Investigation into Maternity and Neonatal Services in England Reflections and Initial Impressions and implications for ESHT.

Executive Summary	This report provides an overview of maternity safety and quality performance for Q3, focusing on key drivers of safe, high-quality care, including mortality, workforce, clinical effectiveness, and service user experience. **Key points:** **Mortality:** An upward trend in stillbirths with the rate over 3.6 per 1,000 births. This increase has prompted enhanced oversight and support from NHSE to monitor contributing factors and ensure appropriate interventions are in place. **Workforce:** WF pressures remain a significant concern, with increased staff absence and vacancies affecting service resilience. Specialist Midwives have been deployed as a mitigation measure to maintain continuity of care. **Training and Development**: Performance remains challenged in Basic Life Support (BLS), currently at 87%, and appraisal completion at 75%. **Shoulder Dystocia**: Rates exceeding the national benchmark for Q3 –all reported SD will be reviewed to assess reporting accuracy. **Post-Partum Haemorrhage**: Assurance response provided following the HSJ publication in February 2026 and the subsequent media enquiry.

	This report also provides an overview of: 1. CQC National Maternity 2025 Survey 2. Home Birth Service Safety Review Audit and, 3. The Independent Investigation into Maternity and Neonatal Services in England Reflections and Initial Impressions report.

Regulatory/legal requirement:	CQC NHS Resolution
Business Plan Link:	Quality ☒ People ☒ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration.
Resource Implication/VFM Statement:	**NHSR Maternity Incentive Scheme**: An additional 10% CNST maternity premium is paid into the MIS fund. Full compliance enables NHS Trusts to recover this contribution and, where applicable, access further unallocated funding.
Risk:	Failure to provide care that consistently meets or exceeds performance and quality standards

No of Pages	4	**Appendixes**	**Appendix A** Q3 Overview Report **Appendix B** CQC Survey 2025 **Appendix C** Homebirth Audit **Appendix D** Independent Investigation into Maternity and Neonatal Services in England Reflections and Initial Impressions

Governance and Engagement pathway to date:	QSF - 18/3/26 QSC- 25/3/26
What happens next?	Homebirth Audit findings will be submitted to NHSE Regional Team and ICB
Publication	The report contains no confidential or commercially sensitive information.

Introduction

This report provides an overview of maternity safety and quality performance for Q3, including an update on Post Partum Haemorrhage following the February 26 HSJ publication and subsequent media enquiry. It highlights performance against key drivers required to deliver and maintain a safe, high-quality maternity service, with a focus on mortality, workforce, effectiveness, and service-user experience. The report also includes findings from the CQC Maternity 2025 Survey, the Home Birth Service Safety Review Audit, and the Independent Investigation into Maternity and Neonatal Services in England Reflections and Initial Impressions report.

A.Q3 Quality and Safety Overview Report (Appendix A)

Key Findings:

Perinatal Mortality: There were three stillbirths**,** reflecting an upward trend with the rate over 3.6 per 1,000 births. This increase has prompted enhanced oversight and support from NHSE to monitor contributing factors and ensure appropriate interventions are in place.

Maternal Mortality: There were no reported maternal deaths during the period**.**

Workforce: WF pressures remain a significant concern, with increased staff absence and vacancies affecting service resilience. Specialist Midwives have been deployed as a mitigation measure to maintain continuity of care. The midwife-to-birth ratio remained stable at 98.3%. Supernumerary coordinator status was not maintained on several occasions, resulting in five Red Flag notifications. A workforce review is in progress.

Training & Development: Excellent performance in several training areas ≥90% compliance in Mental Capacity Assessment (MCA), PROMPT, Blood Transfusion, and Safeguarding.

Performance remains challenged in Basic Life Support (BLS), currently at 87%, and appraisal completion at 75%. BLS performance is being strengthened through bespoke sessions delivered by the Resuscitation Training Team, with line managers supporting staff attendance and duty cover. The division is also working closely with the People Team to improve appraisal completion rate.

Perinatal Mortality Review Tool (PMRT): All four cases reported achieved 100% compliance with PMRT and MBRRACE-UK standards, meeting MIS Year 7 safety actions.

Obstetric Anal Sphincter Injury / Third & Fourth-Degree Tears: Performance in this area remains strong, with rates consistently below both national and regional averages.

Saving Babies' Lives (SBL) Care Bundle: Performance across the six evidence-based elements remains high, achieving 94%.

ATAIN: Strong performance is sustained, with rates remaining well below the national <5% target.

HIE Grades 2 & 3: Performance continues to improve, with rates falling steadily and sustained progress observed since March 2025.

BR+: Compliance reached 84.4%, demonstrating strong performance and narrowly missing the ≥85% target.

Postpartum Haemorrhage (PPH): A continued reduction in PPH rates was observed. An assurance response has been provided within the Q3 report following the recent HSJ article and media enquiry.

Shoulder Dystocia: Seven cases were recorded, with rates exceeding the national benchmark on two occasions. Two cases did not meet the true definition and should not have been reported. All shoulder dystocia cases will be reviewed, and only those that meet the correct definition will be entered into the reporting system.

East Sussex Maternity and Neonatal Voices Partnership: For this reporting period (n = 48 service users), feedback highlighted strong praise for compassionate care, continuity, and specialist support, with BadgerNet generally viewed as helpful.

FFT: Response rates remain low and work is underway to explore how this can be improved.

Complaints PALS and Claims: A total of seven complaints, 28 PALs contacts and no claims were received during this period. Themes identified will be triangulated against serious incidents, driving improvement in multiple internal processes across maternity and neonates.

B. CQC Maternity Survey 2025 (Appendix B)

The Care Quality Commission Maternity Survey 2025 forms part of the wider NHS Patient Survey Programme (NPSP). The 2025 survey represents the twelfth iteration. Findings from the survey are used by the CQC to understand the quality of maternity services and to identify potential risks within care systems and organisations.

Key findings:

- ESHT results from the 2025 survey showed no significant change from 2024 results (which were excellent). No areas fell below the expected standard to warrant a concern.
- Small sample (n=104). Majority respondents were white and aged 30 or above. One-third were living with a long-term health condition.
- Top five highest scores were above the national scores.
- **Communication during antenatal care:** There was a marked improvement, with 89% of respondents reporting they were *always* spoken to in a way they could understand.
- **Mental health:** Support offered during pregnancy continued its upward trend, reaching 90%.
- **Birthing partners:** More respondents (72%) reported that their partner could stay with them as much as they wanted after birth.
- **Postnatal support:** Support for infant feeding continues to require focused improvement.

C. Home Birth Service Safety Review Audit (Appendix C)

ESHT Home Birth Service Safety Review Audit was completed in response to national scrutiny arising from a Prevention of Future Deaths (PFD) report and a subsequent NHS England directive (26 November 2025), requesting assurance that homebirth services remain safe, sustainably staffed, and aligned with national standards.

Key findings:

- The homebirth service, delivered by community and continuity midwives via a 24/7 on-call model, is under significant pressure due to high sickness levels, vacancies, and the need to redeploy staff to the acute unit during high-acuity periods.
- Homebirth suspensions: 3.8% of birthing people intended a homebirth in 2025; 1.6% (n=45) achieved one.
- 40% of completed homebirths were outside clinical guidance.
- Emergency events (two major haemorrhages, one neonatal resuscitation) were managed effectively with good outcomes.
- One intrauterine death occurred during the latent phase of a planned homebirth and was investigated through PSIRF.
- Overall documentation quality is good, transfer documentation is missing in 99% of cases, preventing audit of transfer times.
- Learning from incidents is evident, but systematic triangulation with national datasets is not yet embedded.

Next steps:

- Safety actions will be developed in line with key findings.
- NHSE regional team /ICB to receive final report for assurance.
- The National Framework and Standards for Home Births, including care outside of guidance, will be rolled out in the summer.

Summary: The homebirth service has maintained a level of safety, remaining responsive and committed to personalised care, but this has come at a cost, with periods of suspension affecting choice. Workforce issues continue to make the service vulnerable. In response, the on-call rota has been revised to ensure adequate cover and rest, while longer-term workforce challenges are being addressed through the wider workforce review.

D. Independent Investigation into Maternity and Neonatal Services in England Reflections and Initial Impressions[1] (Appendix D)

23 June 2025 Secretary of State announced a rapid national independent investigation into 14 (now 12) NHS maternity and neonatal service. Baroness Amos published Reflections and Initial Impressions report.

Key Themes Identified:

- Listening and shared decision-making
- Compassion and psychological safety
- Equity and inclusion
- Joined-up, family-centred care
- Care quality and safety
- Transparency and learning
- Trauma-informed, long-term support

The key themes were reviewed against current practice.

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[1] [1] Independent Investigation into Maternity and Neonatal Services in England - Reflections and Initial Impressions - National Maternity and Neonatal Investigation

Key Findings:

- No significant gaps.
- Themes are consistent with previous national maternity reviews.
- Themes align with existing programmes of work, including NHSE enhanced support, MSNI and SBL, and Maternity Care Bundle.
- Focus on reinforcement and embedding learning and good practice.

Investigation Next Steps:

- Call for evidence – Picker survey.
- National Maternity and Neonatal Taskforce group.

Overall Implications for ESHT:

- Expect heightened scrutiny of maternity and neonatal governance, safety and equity.
- Full implementation of the Maternal Care Bundle.
- Ensuring robust triage and escalation processes are in place.
- High-quality bereavement support aligned with national expectations.
- Lived experience and user engagement will be a core assurance requirement.

MatNeo Quality and Safety Overview Report – Q3

Purpose of the paper					
This paper provides an overview of maternity and neonatal progress, and activity during Quarter 3, 2025/26 and offers assurance regarding the quality and safety of perinatal services.					
For Decision		For Assurance	x	For Information	x
Sponsor/Author					
***Executive Director**: Vikki Carruth, Chief Nurse and Executive Maternity Safety Champion.* ***Author:** Aly Hulme Interim Director of Maternity Services.* *Data taken from monthly Q and S reports.*					
Governance Overview (Meetings or Executive directors that have had sight)					
MatNeo QSF and QSC respective Monthly Reports *QSC 25/3/26*					
Strategic Objectives					
Quality	x	People	x	Sustainability	x
Our Values					
Kindness	x	Inclusivity	x	Integrity	x

Executive Summary

This report provides assurance and oversight on maternity and neonatal services at East Sussex Healthcare NHS Trust (ESHT), in line with the NHS England Perinatal Quality Surveillance Model (PQSM) and Ockenden requirements. This report highlight's performance against key areas for October, November and December 2025. It includes an update on progress in meeting the perinatal clinical quality surveillance standards and outlines the actions taken to proactively identify and mitigate any quality and safety concerns or risks. All benchmarks have been aligned to regional and national datasets where available. The focus remains on delivering and maintaining a safe, high-quality maternity service by concentrating on the following key areas:

a) Well-led
b) Safety
c) Effective
d) Experience - Responsive and Caring

(S) Situation

Robust governance processes have been maintained in line with the Perinatal Quality Surveillance requirements and CNST MIS standards during this reporting period. The monthly quality and safety reports summarised in this paper have been reviewed, challenged, and confirmed at the Quality and Safety Forum.

(B) Background

Data within this report provide evidence of the delivery of high-quality services against PQSM and Ockenden requirements and ongoing compliance against all CNST MIS 10 actions areas.

(A) Assessment

Key heads lines of the report are presented below:

Well-led

- Interim senior leadership team in place

Safety

- **Maternal Deaths –** None.
- Stillbirths - 3
- Upward trend in still-births over 3.6/1000 births – oversight and support from NHSE.
- Workforce – increase trend in absence and vacancies also impacting on community maternity services as escalation of community staff to support acute units. Specialist Midwives deployed as risk mitigation.
- Training and Development - BLS 87% Appraisals 75%.

Effective

- **PMRT:** Four cases were reported, achieving **100% compliance** with all PMRT and MBRRACE-UK standards, fully meeting MIS Year 7 safety actions. This included timely notifications, completed reviews, and parental engagement. There were **no breaches**, despite some PMRT meetings being postponed pending MNSI reports. Feedback highlighted strong bereavement support, with minor communication issues addressed by partner trusts.
- **Shoulder Dystocia:** Seven cases were recorded, with rates exceeding the national benchmark on two occasions. Outcomes demonstrated **prompt recognition and effective management**, resulting in good neonatal outcomes.
- **ATAIN:** admission rate of 2.89%, meeting the <5% target. Overall, 90% (n=18) of admissions were considered unavoidable with appropriate management, while 10% (n=2) were considered potentially avoidable.
- **HIE Grades 2 & 3:** Rates continue to fall, with **sustained improvement since March 2025**.
- **Third- & Fourth-Degree Tears:** Rates remain **below both national and regional averages**.
- **BR+ Compliance:** Achieved **84.4%** against a target of ≥85%.
- **Red Flags:** Five incidents were reported during the period.
- **Midwife-to-Birth Ratio:** Maintained at **98.3%**
- **PPH:** Ongoing reduction in PPH rates was observed. An assurance response has been provided following the recent HSJ article and media enquiry

Experience - Responsive and Caring

- ESHT Maternity department continues to have a robust working relationship with East Sussex Maternity and Neonatal Voices Partnership. For this reporting period (n = 48 service users for), feedback highlighted strong praise for compassionate care, continuity, and specialist support, with BadgerNet generally viewed as helpful.
- CQC Maternity Survey 2025 – Positive results.

(R) Recommendation

The committee is requested:

a) **Review** the contents of this report and **consider** if any further information is required for their assurance.

b) **Note** improvements made within Quarter 3 reporting period and ongoing challenges with workforce capacity and achieving 90% for Appraisals and Basic Life Support.

c) **Note** the Enhanced Support and Oversight support from NHSE.

1. Purpose

This report provides assurance and oversight of maternity and neonatal services at East Sussex Healthcare NHS Trust (ESHT) in line with the NHS England Perinatal Quality Surveillance Model (PQSM) and the Ockenden requirements to deliver and maintain a safe, high-quality maternity service. All benchmarks have been aligned with regional and national datasets where available. This report highlights performance against the following key areas for October, November, and December 2025.

a) Well-led
   - Maternity-Neonatal Leadership
b) Safety
   - Perinatal mortality and morbidity relating to both woman and foetus/baby
   - Patient Safety Incidents
   - Community Midwifery - Safety Report
   - Workforce
   - Training and Development
   - CQC Self-Assessment
   - Risk and Issues
c) Effective
   - Perinatal Quality Surveillance – Activity and Clinical Indicators
   - HSJ Postpartum Haemorrhage Article and Enquiry
   - Perinatal Quality Surveillance – Public Health
d) Experience - Responsive and Caring
   - Service user feedback
   - FFT
   - Complaints PALs and Claims
   - CQC Maternity Survey 2025 – Overview

2. Well-led

2.1 Maternity Neonatal Leadership

The Midwifery and Neonatal Unit has recently experienced changes in senior midwifery leadership. To ensure stability and mitigate risks interim arrangements have been put in place with effect from December 2025[1].

3. Safety

3.1 Patient Safety Incidents

A total of 305 incidents were report for this period. There were no Early Notification Scheme (ENS) or Never Events. Three incidents were reported to the Maternity Newborn Safety Investigation unit where one met their criteria for a full investigation. A breakdown of the number of patient safety incidents and level of harm as defined by PSIRF is presented below. The two incidents that have been graded as 'Fatal' are also considered in the perinatal mortality and morbidity section below.

Month	No Harm	Low	Moderate	Severe	Fatal	Never Events	ENS	Total Reported
Oct	77	27	0	0	1	0	0	105
Nov	68	33	0	0	1	0	0	102
Dec	71	26	1	0	0	0	0	98
Total	**216**	**86**	**1**	**0**	**2**	**0**	**0**	**305**

[1] In January 2026 the division have successfully appointed a Head of Midwifery and Neonatal and February 2026 and a Director of Maternity and Neonatal services both are due to start May 2026.

3.2 Perinatal Mortality and Morbidity

The Sussex local maternity and neonatal system (Sussex LMNS) have a defined perinatal quality surveillance reporting dashboard to ensure a standardised reporting process and meet monthly with providers to scrutinise and assure quality. The dashboard includes data by ethnicity and deprivation to ensure health inequalities are understood and are monitored monthly by the divisional leadership teams.

Intrauterine Deaths Oct-Dec 2025

Month	National/1000 births	Number	Rolling births	Rate/1000	Trend	MNSI Reported	MNSI Investigation
Oct	3.6	2	4.39		↑	2	1
Nov	3.6	1	4.38		↑	1	0
Dec	3.6	0	4.29		↓	0	0

For this period there was one Antepartum (not in labour) death and two intrapartum (in labour) still-births. The 12-month national benchmark for still-births is 3.6/1000 births and division's rolling rate has seen a further increase to reaching 4.39/1000 birth in October. This upward trend of still-births within a six-month period triggered a multidisciplinary review in December to analyse these cases in this time interval, with the objective of identifying any common themes and implementing targeted improvements. The review was supported by members from the divisional team including the senior midwifery and obstetric staff, as well as NHSE Quality and Improvement team members.

No common contributory factors or system-level patterns were identified that may have influenced the outcome. The following themes were identified for learning:

a) Triage Service
b) Antenatal assessment
c) Social vulnerability
d) Risk factors/holistic assessment
e) Review of foetal monitoring guidelines and audit processes
f) Documentation
g) Communication
h) Bereavement pathways -review of timeliness for debriefing bereaved families

These themes have been identified in various Maternity reviews and in the recent Baroness Amos initial findings report December 2025[2]. To mitigate risk and ensure improvement the division is being supported by NHSE Quality and Safety Improvement team as part of their Maternity and Neonatal Enhanced Support and Oversight. An action plan has been developed under the leadership of the Deputy CNO and Chief of Division.

Maternal Deaths

There have been no maternal deaths in this reporting period.

3.3 Community Midwifery – Safety Report

The Community Midwifery Safety Report provides assurance that ESHT's community midwifery teams deliver safe, effective care across antenatal, intrapartum, and postnatal pathways, supporting choice and reducing health inequalities. In this reporting period there were n= 809 antenatal bookings, 68.3% of them were completed within ten weeks.

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[2] Independent Investigation into Maternity and Neonatal Services in England - Reflections and Initial Impressions - National Maternity and Neonatal Investigation

The following table presents the activity within the community midwifery services.

Month/Year	Out of Hospital Place of Birth	Total	West	East	% of ESHT Births
Oct 2025	Homebirth	9	2	7	**0.93%**
Nov 2025	BBA	11	3	8	**1.46%**
Dec 2025	MLU Births	21	21	NA	**2.79%**
	Total	**41**	**26**	**15**	**5.44%**

During this reporting period, there were n= 41 out of- hospital- births (5.44% of total births) and there were no serious safety incidents. Out of the n=41 n=11 were babies born before arrival (BBA). There were no practice or process concerns identified in any of these cases. Key challenges include high caseloads, escalation of community staff to acute units', limitation with estates, and workforce gaps, while continuity teams show positive outcomes compared to national averages; actions focus on staffing review, improved documentation, and enhanced training.

3.4 Workforce

Fill Rates

Maternity fill rates are currently calculated as a percentage, over each 24-hour period, across the month. The table below outlines percentage fill rates for the inpatient service by month.

Month/Year	Planned Hours	Actual Hours	Shortfall	Total Fill Rate %
Oct 2025	5889	5158	-731	87.6
Nov 2025	6284	5526	-759	88.0
Dec 2025	7220	5538	-1681	76.7
Average	**6464**	**5407**	**- 1057**	**84.1**

The average fill rate for the previous quarter was 88.4%. Staffing the current template remains a concern, and mitigation measures are in place. In December, the escalation policy was activated, and most specialist midwifery services were temporarily stood down to release staff into the acute unit. Although full escalation is no longer in place, some support measures continue. Specialist midwives now provide a proportion of their contracted hours for clinical support when required, and continuity and Eastbourne Maternity Unit on-call midwives remain available to the acute unit if needed.

Sickness and Absenteeism

The table below shows the rates of sickness absence, maternity leave and vacancy over Q3 across the whole maternity service.

Month/Year	Sickness %	Maternity Leave %	Vacancy %
Oct 2025	8.5	4.1	2.5
Nov 2025	8.2	4.5	2.9
Dec 2025	8.9	5.2	3.2
Average	**8.53**	**4.6**	**2.87**

During this period there has been a marked increase in sickness absence, as well as slight increases in maternity leave and vacancies There is ongoing recruitment with new posts. 1.9 FTE AfC B5 Midwives are due to start imminently, and 1.8 FTE MSW are awaiting final HR checks. Remaining vacancies are being advertised, with four AfC B6 Midwives in the recruitment pipeline.

Ongoing concerns about the workforce have been escalated where it will be assessed and placed on the risk register where relevant.

3.5 Training and Development

The table below present the average percentage of appraisal and training completion between October 2025 and December 2025.

Area							
Oct- Dec 2025	**Target (%)**	**Level 3 safeguarding**	**BLS**	**BT**	**MCA**	**PROMPT**	**Appraisals**
Average	90	91 %	87 %	91 %	97 %	90%	75 %

During this period, on average the department exceeded the Trust's 90% target for training in Level 3 safeguarding, blood transfusion and MCA which is to be commended. To improve BLS training consistency, actions have been taken to engage with the Resuscitation Training Team to arrange bespoke sessions, and line managers have been updated to ensure that staff requiring training are supported and that their duties are appropriately covered.

Achieving target of 90% for appraisal compliance remains to be challenging for several reasons, including changes to the Trust's appraisal systems and limited capacity among line managers. The division is working closely with Peoples Team to improve performance in this area.

In addition, community midwives are required to attend training in out of hospital emergencies, which is delivered bi-annually. Current compliance is 44% within the past 12 months, and 72% have attended the training within the past two years. The next session is scheduled for March 2026.

3.6 CQC Self-Assessment

The Maternity Self-Assessment Tool aims to help maternity services benchmark themselves against national standards and best practice. It supports providers seeking to improve CQC ratings by focusing on leadership, governance, safety culture, and quality improvement. Developed from the Maternity Safety Support Programme, the tool aligns with national initiatives such as Better Births, Ockenden recommendations, and the Maternity Incentive Scheme, MIS (CNST) safety actions. The assessment tool was updated by the divisional leadership team in November 2025 and results are presented below. The next review in due in March 2026.

Standard	Green	Amber	Red
Leadership & Infrastructure	6	8	2
Governance	5	9	3
Safety Culture	4	6	2
National Standards	8	7	2
Business Planning	5	6	1
Total	28	36	10

3.7 Risk and Issues

The tables below present key risks and issues across the maternity department.

Risks

Risk Number	Description	Current Rating
147	**Obstetric Theatre & Annex Safety and Efficiency**	12
330	**Dietitian service withdrawal from Joint Obstetrics Diabetes clinic**	16

Issues

Number	Description	Current Rating
84	**Lack of available clinical space in the maternity/obstetrics/gynaecology footprint due to overcrowding**	15
150	**Lack of capacity in joint Antenatal clinics**	12
167	**Lack of capacity for community clinics**	6

Risk and issues are monitored and reviewed monthly at the Maternity Neonatal Quality and Safety Forum.

4. Effective

4.1 Perinatal Quality Surveillance – Activity and Clinical Indicators

4.1.1 Activity

The table below present the activity throughout maternity services for this reporting period.

	National (%)	Regional (%)	Oct (%)	Nov (%)	Dec (%)	Total
Bookings			**269**	**278**	**262**	**809**
Home Births	1.20	1.70	4 (1.49)	3 (1.21)	2 (0.8)	9 (1.18)
SVD	44.7	45.10	152 (56.7)	104 (41.9)	99 (39.76)	355 (46.41)
AVD	9.90	10.40	28 (10.4)	27(10.89)	24 (9.64)	79 (10.33)
Inductions	29.20	27.20	91 (33.96)	100 (40.32)	94 (37.75)	285 (37.25)
Elective LSCS	<20.8		39 (14.56)	38 (15.3)	48 (19.3)	125 (16.34)
Emergency LSCS	<26.2		67 (25)	72 (29.03)	77 (30.9)	216 (28.24)
Total Births			**268**	**248**	**249**	**765**

There has been an increase in inductions and a corresponding rise in LSCS. While no clear cause has been identified, this trend should be reviewed in the context of individualised maternity care. An increase in LSCS activity whether planned or emergency has significant implications for staffing, skill mix, theatre capacity, and overall resource allocation across maternity services. The department SLT will be monitoring LSCS activity to understand trends and implications at Quality Safety Forum.

4.1.2 Clinical Indicators

Full Termed Admission to Neonatal Unit

For this period n=20 termed babies were admitted to the Neonatal Unit remaining below the national benchmark of 5%.

Avoiding Term Admissions into Neonatal units

ATAIN (Avoiding Term Admissions into Neonatal units) is a national NHS programme aimed at reducing unnecessary admissions of full-term babies (≥37 weeks) to neonatal units, focusing on four key areas: respiratory conditions, hypoglycaemia, jaundice, and perinatal asphyxia. The service achieved a term admission rate of 2.89%, meeting the <5% target. The main reason for admission this quarter was the need for respiratory support. Overall, 90% (n=18) of admissions were considered unavoidable with appropriate management, while 10% (n=2) were considered potentially avoidable.

Apgar Scores <7 at 5 at Minutes

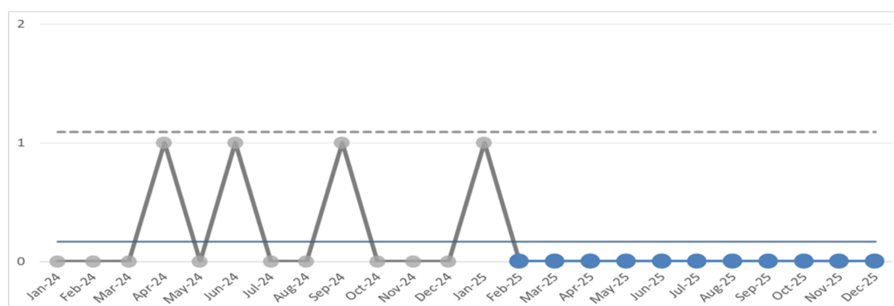
The table below present performance against the Apgar's Scores <7 at 5 minutes for this reporting period.

	National Average (%)	Regional Average (%)	Oct 25	Nov 25	Dec 25
Rate per 1000 births	13.0	12.0	20.49	13.76	13.33
Number			5	3	3

There has been a decrease in numbers compared with the national average, and a slight increase against the regional benchmarking average. While no clear cause has been identified, this trend should be considered in the context of individualised maternity care.

Hypoxic Ischaemic Encephalopathy (HIE Grade 2 & 3)

The chart below presents the ongoing measures in reducing cases for HIE. For this reporting period there have been no cases of HIE grades 2 or 3 which has been sustained since March 2025.



Shoulder Dystocia

The national benchmark for shoulder dystocia is 0.7%. The table below presents the number of shoulder dystocia for each month.

Month	National Benchmark %	%	Number
Oct	0.7	2.63%	4
Nov	0.7	0.75%	1
Dec	0.7	3.03%	3

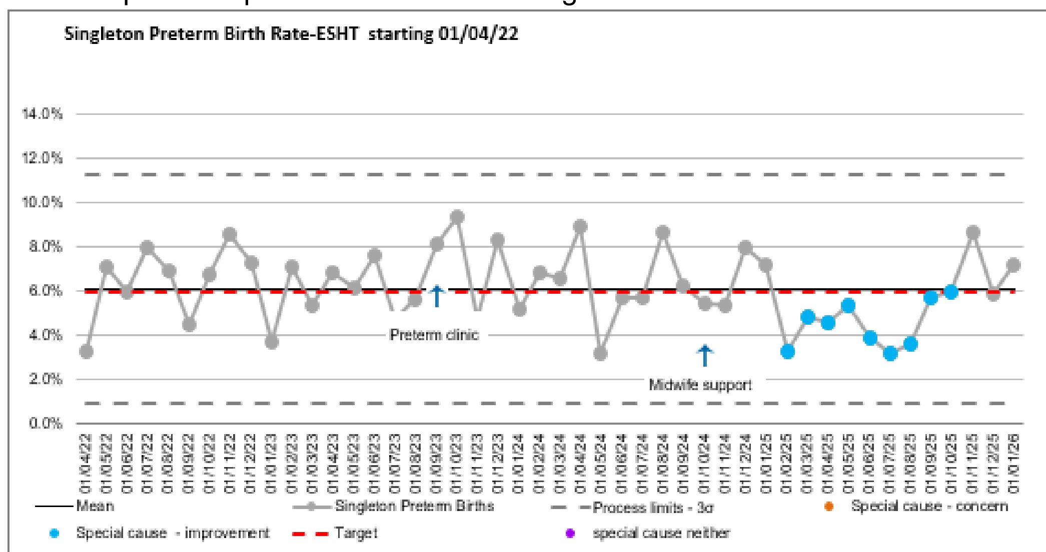
There were four cases (2.63%) in October which is above the national target of 0.7%. However, two of these four did not require any specialist manoeuvres to facilitate the births, which raises the question as to whether these are potentially being over-reported, and some may fit more appropriately in the category of ‘difficulty with shoulders’, rather than being true shoulder dystocia’s. All four of these babies had Apgar scores of above 7 at 5 minutes old, and none of them required admission to SCBU or had any adverse outcomes.

Shoulder dystocia rates for December were 3.03%, equating to three cases. One of these babies required admission to SCBU, while the other two did not. Although this rate is above

the national benchmark, the outcomes demonstrate prompt recognition and effective management of the emergency, resulting in good neonatal outcomes.

Preterm Birth Rates

The chart below presents preterm birth rates aiming to below the national benchmark of 6%.



All preterm births were reviewed individually by the preterm lead, and no themes were identified. For the year 2025/26 to date, the preterm birth rate is 5.3%, which remains below the national target. As numbers are small, monthly variation is expected, and trends should be interpreted over a longer period.

Third- and Fourth-Degree Tears
ESHT Maternity department rates of third- and fourth-degree tears are below the national and regional average demonstrated below.

Month/Year	National /1000 Births (%)	Regional /1000 Births (%)	ESHT/1000 Births (%)
Oct 2025	28.8	34.2	24
Nov 2025	28.8	34.2	4.58
Dec 2025	28.8	34.2	26.26

Obstetric Anal Sphincter Injury (OASI)
OASI rates remains consistently under the national and regional benchmarks demonstrated in the table below.

Month/Year	National/1000 Births (%)	Regional/1000 Births (%)	ESHT/1000 Births (%)
Oct 2025	28.8	34.2	24.0
Nov 2025	28.8	34.2	4.58
Dec 2025	28.8	34.2	26.66

Perinatal Mortality Review Tool (PRMT)
The PMRT is a national system for reviewing perinatal deaths to ensure learning and improvements in care. For Q3, four cases were reported, achieving 100% compliance with all PMRT and MBRRACE-UK standards and meeting MIS Year 7 safety actions, including timely notifications, reviews, and parental engagement. No breaches occurred, despite cancelled PMRT meetings due to pending MNSI reports. Feedback highlighted strong bereavement support, with minor communication concerns addressed by partner trusts.

Saving Babies Lives

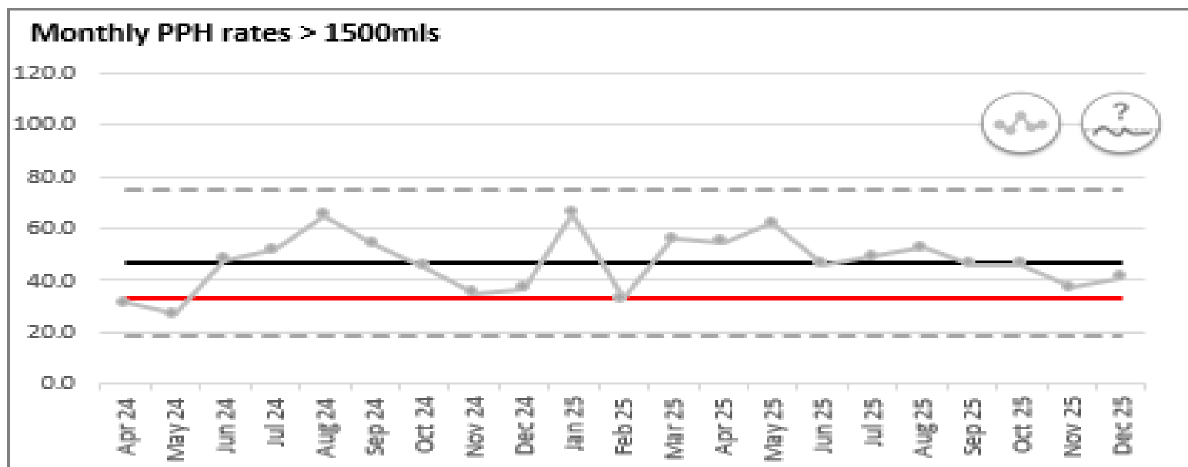
The Saving Babies' Lives (SBL) care bundle is a national initiative designed to reduce stillbirth, neonatal mortality, maternal mortality, and serious brain injury through six evidence-based- elements, including smoking cessation, foetal growth surveillance, and preterm birth prevention. In Q3, the maternity services achieved 94% compliance, maintaining strong performance across most components, particularly in smoking cessation and foetal monitoring. Partial compliance was recorded in foetal growth surveillance and preterm birth, primarily due to staffing gaps and the absence of a dedicated preterm midwife. A business case is currently progressing to address these capacity issues.

Acuity and Red Flags

- **Birthrate + (BR+) Acuity Tool**
  Birthrate+ (BR+) is the nationally recognised, evidence-based workforce planning and acuity tool used in maternity services. It provides a systematic method for determining safe midwifery staffing levels based on clinical activity, case mix, and the real-time acuity of women and birthing people across all maternity settings. Compliance for the reporting period was 84.4% (target ≥85%). Of the scheduled n=552 assessment periods, n=466 were completed within the required timeframe, giving a compliance rate of 84.42%. An additional n=51 assessments were completed outside the 30minute submission window. If these late submissions were included, overall compliance would increase to 94%
- **Red flags**
  The main contributing factors were delays in the induction of labour and twelve occasions where supernumerary co-ordinator status was lost. The supernumerary Labour Ward Co-ordinator (LWC) is allocated to every shift. When a substantive AfC B7 LWC is not available, the role is covered by a supernumerary AfC B6 Midwife who has completed the required competencies for the co-ordinator role. This enables the department to maintain compliance for MIS requirements. In this quarter, of the twelve reported occasions where supernumerary status was lost, five occurred at the start of a shift which incurred a red flag. On review they were escalated and appropriately managed.
- **Midwife to- birth- ratio**
  One to one care in labour was maintained at 98.3%.

Vulnerable Service Users
The Maternity Department recognises the diversity within the community and the increasing complexity of pregnancy. A considerable proportion of pregnant women/people booking with ESHT live in the most socially deprived areas within our geographical boundaries and require additional support, including mental health input, safeguarding, and healthy lifestyle interventions such as smoking cessation. In Q3, there were n=144 service users from BME backgrounds, and n=32 service users who could not speak or understand English at the point of delivery. Within this reporting period, 16.6% of service users with registerable births lived in the top 10% most deprived areas, and 28.2% lived in the top 20% most deprived areas.

Postpartum Haemorrhage (PPH)
The chart below presents the ongoing reduction in PPH rates. The national and regional benchmarks are both set at 32 cases per1000 births. There was n=10 cases in October, n=9 cases in November and n=10 cases in December 2025.



4.2 HSJ Postpartum Haemorrhage Article and Enquiry

Although not part of this reporting period the recent HSJ[3] coverage and media enquiry highlighting national work to reduce postpartum haemorrhage (PPH) and improve maternal outcomes has been welcomed. The article reflects a growing national commitment to improving the accuracy of blood loss measurement, particularly in areas with high levels of deprivation and ethnic minority populations, with a call to strengthening multidisciplinary responses to reduce obstetric haemorrhage.

We are aware that recorded PPH rates have been higher than the national average and those across the region. Since February 2024, the department has participated in the OBSUK Study to improve the management and the accuracy of recorded PPH rates. Consistent with other maternity services that have moved from estimates to quantitative measurement of blood loss -which is more accurate and reliable - naturally leads to an initial rise in documented PPH rates.

Although our documented PPH rates have increased, including those in the 1-1.5 litre category, patient outcomes have improved. For instance, admission rates to ITU remain stable, and interventions such as, blood transfusion have reduced. This mirrors national findings that better measurement and coordinated care improve safety, even when reported volumes rise.

An internal review of PPH data has been completed including profiling to identify any trends relating to ethnicity and found no specific areas of concern. OBSUK investigators have reassured ESHT that PPH rates are similar to other Trusts participating in the study, and the rates of blood transfusion have not increased. To increase the level of assurance provided, the research team has been asked to produce data showing PPH rates for all participating sites.

To provide further assurance around performance the Maternity Department also reviews data from CHKS, a UK based healthcare analytics and benchmarking service. CHKS uploads all ESHT coded PPH's on a national data base. On a monthly basis data can be compared with peers (maternity providers) across the country. This data can be used as further assurance against PPH performance including identifying red flags.

The table below presents ESHT performance against other maternity providers.

CHKS Period	Local Numerator	Local Denominator	Rate (%)	Peer Value (%)	Flagging Red/Amber
Nov 25	80	234	28.03	31.53	No
Dec 25	80	228	35.09	30.51	No

[3] Revealed: The trusts with 'unacceptable' outcomes for Black and low-income women | News | Health Service Journal

The Risk Lead Consultant has delivered additional training to both obstetricians and midwives in suturing techniques and encouraging the use of tranexamic acid (TXA), a medication widely used in maternity care to help reduce bleeding. The department will continue to monitor data closely and support workforce through training ensuring care remains aligned with national best practice.

Importantly, while recorded PPH rates have risen due to more accurate measurement, our services remain safe, effective, and focused on early recognition and timely intervention, echoing the direction of travel highlighted in the HSJ article.

4.3 Perinatal Quality Surveillance – Public Health

Smoking at Booking and at the Time of Delivery
The national benchmark for smoking at booking is 9.30% and the regional benchmark is 9.40%. Apart from November, rates were below the threshold and have been decreasing since March 2025.

The national benchmark for smoking at the time of delivery is 6.10%, with a regional benchmark of 6.60%. This target was achieved or remained below the threshold throughout this reporting period.

Vaccination Programme

The table below present progress made against the vaccination programme.

Vaccination	National Average Target (%)	Q 3 Average (%)
Flu	41	32.6
Pertussis	NA	49.4
RSV	63.6	54.4

The vaccination programme is progressing steadily. Ways to address disparities among ethnic groups and in areas of deprivation are being explored, including the development of additional information resources in collaboration with NHS England.

Contraception

Contraception services are offered to over 90% of women.

Healthy Weight

ESHT are participating in a health needs assessment working with East Sussex County Council and other departments such as paediatrics and oncology. Looking into best practise, shared learning. Some initial findings are being finalised, recommendations are anticipated in the next few months

5.0 Experience - Responsive and Caring
Maternity and Neonatal Voices Partnership (MNVP)

ESHT Maternity department continues to have a robust working relationship with East Sussex Maternity and Neonatal Voices Partnership. For this reporting period (n = 48 service users for Quarter 3), feedback highlighted strong praise for compassionate care, continuity, and specialist support, with BadgerNet generally viewed as helpful.

Areas for improvement included consistency of communication, emotional sensitivity, feeding support, discharge processes, and partner facilities. Technical issues with BadgerNet and perceptions of understaffing were also noted. Neonatal feedback was largely positive; however, some parents reported emotional strain, rushed discharge, and discomfort within

rooming in facilities. These findings have prompted actions to improve induction processes and the care environment.

Friends and Family Test (FFT)

FFT response rates remain low and local work is underway to increase response rates, we have been having additional QR codes printed to be highlighted to service users by staff at the point of discharge, and we are also working with the patient experience team to facilitate the return of paper feedback, which will then need to be entered onto the system by a member of staff.

Complaints PALs and Claims

There were seven complaints, n= 28 PALs contacts and no new claims received during this period. The top themes from PALs contact and complaints for this reporting period are presented below.

Complaints	PALs	Claims
Clinical Treatment	Clinical Treatment	NA
Patient Care	Patient Care	NA
	Values & Behaviours (Staff)	NA
	Appointments	NA
	Communications	NA

Further work is required to triangulate these themes with other areas of intelligence such as incidents, surveys and reviews.

CQC Maternity Survey 2025 – Overview

The Care Quality Commission Maternity Survey 2025 forms part of the wider NHS Patient Survey Programme (NPSP) and was first conducted in 2007. The 2025 survey represents the twelfth iteration. The programme is commissioned by the Care Quality Commission (CQC), the independent regulator of health and adult social care in England.

The Survey provides a nationally benchmarked assessment of service users' experiences across the maternity pathway. The survey covers seven domains of care, including antenatal services, labour and birth, postnatal care, triage, and the complaints process. Results provide an important source of intelligence for assessing quality, safety, and the effectiveness of maternity services. Findings from the survey are used by the CQC to understand the quality of maternity services and to identify potential risks within care systems and organisations. A more detailed report will be presented separately. Key findings include:

- ESHT results from the 2025 survey showed no significant change from 2024 results (which were excellent)
- No areas fell below the expected standard to warrant a concern.
- **Communication during antenatal care:** showed a marked improvement where 89% of respondents feeling they were "always" spoken to in a way they could understand.
- **Mental health:** support offers during pregnancy continued an upward trend, reaching 90%.
- **Birthing partners:** more respondents (72%) reported that their partner could stay with them as much as they wanted after birth.
- **Postnatal support** especially with infant feeding requires attention

NHS
East Sussex Healthcare
NHS Trust

Care Quality Commission (CQC) Maternity Survey 2025

<table>
<tr><td colspan="6">Purpose of the paper</td></tr>
<tr><td colspan="6">This report provides a summary of findings from the Care Quality Commission Maternity Survey 2025 including the methodology, outcomes, any significant risks and areas for improvements.</td></tr>
<tr><td>For Decision</td><td>⚐</td><td>For Assurance</td><td>⚐</td><td>For Information</td><td>⚐</td></tr>
<tr><td colspan="6">Sponsor/Author</td></tr>
<tr><td colspan="6">Executive Director: Vikki Carruth, Chief Nurse and Executive Maternity Safety Champion.
Author: Aly Hulme, Interim Director of Maternity Services. Action Plan: Coproduced.</td></tr>
<tr><td colspan="6">Governance Overview (Meetings or Executive directors that have had sight)</td></tr>
<tr><td colspan="6">MatNeo Quality Safety Forum (QSF) 18/02/26.
Quality & Safety Committee (QSC) 25/03/26 (Appendix to Overview Board Report).</td></tr>
<tr><td colspan="6">Strategic Objectives</td></tr>
<tr><td>Quality</td><td>⚐</td><td>People</td><td>⚐</td><td>Sustainability</td><td>⚐</td></tr>
<tr><td colspan="6">Our Values</td></tr>
<tr><td>Kindness</td><td>⚐</td><td>Inclusivity</td><td>⚐</td><td>Integrity</td><td>⚐</td></tr>
<tr><td colspan="6">Executive Summary</td></tr>
</table>

The Care Quality Commission Maternity Survey 2025 was published December 2025. Findings from the survey are used by the CQC to understand the quality of maternity services and to identify potential risks within care systems and organisations.

At East Sussex Healthcare NHS Trust (ESHT), 300 were invited to take part, and 104 women chose to share their experiences which is a **35%** response rate (lower than average across all trusts at **39%**, and a **10%** reduction in the response rate for the Trust in 2024).

This report provides an overview of key findings including the methodology, outcomes, any significant risks and areas for improvements.

ESHT Five Highest-Scoring Areas (Compared with the National Average) are presented below.

Theme	Area of Care	ESHT Score (10)	National Score (10)
Care in the Ward	Women felt staff allowed them to stay with their baby/partner as wanted.	8.7	8.1
Care in the Ward	Women felt they could get staff attention when needed.	8.2	7.7
Antenatal Care	Women felt mental health was asked about.	9.4	8.7
Antenatal Care	Midwives/doctors were aware of medical history.	9.1	8.4
Postnatal Care at Home	Women felt informed about their physical recovery.	7.7	7.2

ESHT Lowest- Scoring Areas (Compared with the National Average) are presented below.

Theme	Area of Care	ESHT Score (10)	National Score (10)
Postnatal Care at Home	Getting help when needed during evenings/nights/weekends -with support or advice about feeding their baby.	5.4	6.8
Complaints	Considering making a complaint about maternity care.	6.4	6.7

When compared with 2024 results, performance remained stable, with 51 questions showing no statistically significant change. Two questions demonstrated a statistically significant improvement, and there were no areas of statistically significant deterioration.

Overall, the findings highlight a positive trajectory, particularly in communication, involvement in care decisions, and staff interactions, reinforcing the Trust's commitment to delivering high-quality maternity services.

While no areas fell below the expected standard to warrant a concern there were areas identified as opportunities to learn and improve. Areas identified as opportunities to improve have been addressed in *Appendix A Draft Action Plan.*

(S) Situation

Overall, the Trust's performance in the Care Quality Commission Maternity Survey 2025 is largely in line with national expectations. Many survey questions (n= 51) were rated as performing about the same as other Trusts.

The Trust performed **better than expected** on a small number of questions, including:

- 1 question rated "much better than expected"
- 2 questions rated "better than expected"
- 4 questions rated "somewhat better than expected"

No questions were rated **worse** or **much worse than expected** compared with other trusts.

When compared with **2024 results**, performance remained largely **stable**, with:

- 51 questions showing no statistically significant change
- 2 questions **demonstrating statistically significant improvement**
- 0 areas of statistically significant deterioration

Overall, the survey data indicates consistently strong performance within expected ranges, with targeted areas of relative strength and **no negative outliers**.

(B) Background

The Maternity Survey forms part of the wider NHS Patient Survey Programme (NPSP) and was first conducted in 2007. The 2025 survey represents the twelfth iteration. The programme is commissioned by the Care Quality Commission (CQC), the independent regulator of health and adult social care in England. A survey was sent to all women who gave birth in February 2025. The survey included more than **16,750** women and pregnant people across **119** NHS Trusts.

At East Sussex Healthcare NHS Trust (ESHT), 300 were invited to take part, and 104 women chose to share their experiences which is a **35%** response rate (lower than average across all trusts at **39%**, and a **10%** reduction in the response rate for the Trust in 2024).

(A) Assessment

Overall, the findings highlight a positive trajectory, particularly in communication, involvement in care decisions, and staff interactions, reinforcing the Trust's commitment to delivering high-quality maternity services.

Results showed:

- Improvement in antenatal communication and mental health support.
- Ongoing areas for improvement around postnatal support, communication and consistency of care especially with infant feeding.

Notably, ongoing themes identified in this survey align with findings from other data sources, including complaints, incidents, maternity reviews and health inequalities. While no areas fell below the expected standard to warrant a concern there were areas identified as opportunities to learn and improve. Areas identified as opportunities to improve have been addressed in *Appendix A Draft Action Plan*, coproduced following a multidisciplinary review of the survey report, including analysis of the free-text comments. Representation for this work included key midwifery leads, medical staff, and the Maternity and Neonatal Voices Partnership (MNVP).

To avoid duplication actions will be aligned with NHS England Enhance and Oversight Support Action Plan, NHS England 2026-Maternity and Neonatal Equalities dashboard , NHS England 2026 The Maternal Care Bundle. and other reporting systems where relevant.

(R) Recommendation

The Committee is requested to:

1. **Note** the positive results of the 2025 Maternity Survey and national benchmarking context.
2. **Review** the contents of this report and **consider** if any further information is required for their assurance.
3. **Endorse** targeted areas identified where improvement is required and draft action plan.

Care Quality Commission Maternity Survey 2025

1. Introduction

The Care Quality Commission Maternity Survey 2025 forms part of the wider NHS Patient Survey Programme (NPSP) and was first conducted in 2007. The 2025 survey represents the twelfth iteration. The programme is commissioned by the Care Quality Commission (CQC), the independent regulator of health and adult social care in England.

The Survey provides a nationally benchmarked assessment of service users' experiences across the maternity pathway. The survey covers seven domains of care, including antenatal services, labour and birth, postnatal care, triage, and the complaints process. Results provide an important source of intelligence for assessing quality, safety, and the effectiveness of maternity services.

Findings from the survey are used by the CQC to understand the quality of maternity services and to identify potential risks within care systems and organisations.

This report summarises key elements of the 2025 Maternity Survey, including the methodology, outcomes, significant risks and areas for improvement where relevant.

2. Methodology and Context

2.1 Administration and Sample

The 2025 Maternity Survey was administered by the Survey Coordination Centre (SCC) at Picker.

- **Total invited:** 43,955 maternity service users
- **Participating NHS trusts:** 119
- **Completed surveys:** 16,755
- **Adjusted response rate:** 38.53% (Adjusted to exclude undelivered questionnaires)

2.2 Eligibility Criteria

Service users were eligible to participate if they met the following criteria:

- Aged **16 years or over** at the time of delivery,
- Had a **live birth** at an NHS Trust between **1 February and 28 February 2025,**
- Where fewer than **300 births** occurred in February, births from **January 2025** were included to achieve the required sample size.

2.3 Fieldwork

Fieldwork took place between **April and July 2025**.

2.4 Limitations

Limitations of the survey remain in cases where electronic records are incomplete or where specialist care is delivered across multiple providers, which may result in a small number of misattributed responses. If fewer than 30 responses were received from maternity service users at a site, no

scores are displayed for that site. In some cases, where there is only one site within a trust, the trust score and banding may differ from the site score and banding. This is because benchmarking is calculated separately at trust and site levels.

3. ESHT Survey Respondents

3.1 Response Rate 2025

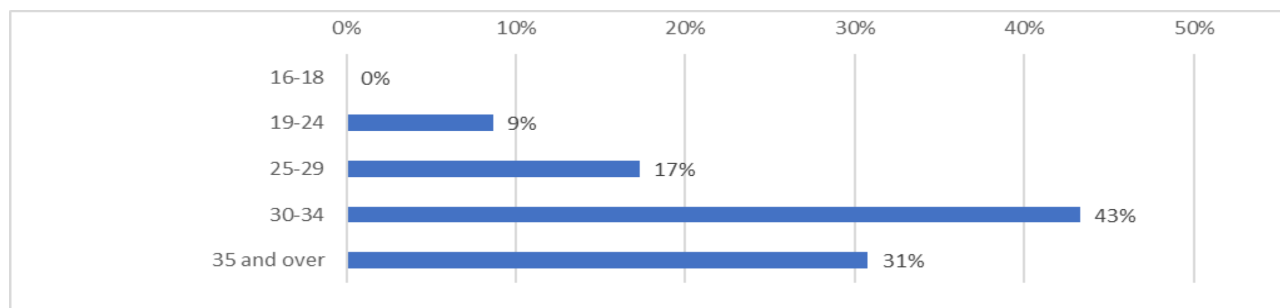
Numbers Invited	Numbers Returned	Response Rate 2025 (%)	Response Rate 2024 (%)	All NHS Trusts Response Rate 2025 (%)
300	104	35	45	39

At ESHT, 300 were invited to take part, and 104 women chose to share their experiences which is a 35% response rate (lower than average across all trusts at 39%, and a 10% reduction in the response rate for the trust in 2024).

3.2 Respondents Profiles and Demographics

3.2.1 Age

The age profile of respondents shows that the majority were aged **30–34 (43%)**, followed by **35 and over (31%)**. Smaller proportions were aged **25–29 (17%)** and **19–24 (9%)**, with no respondents aged **16–18**.

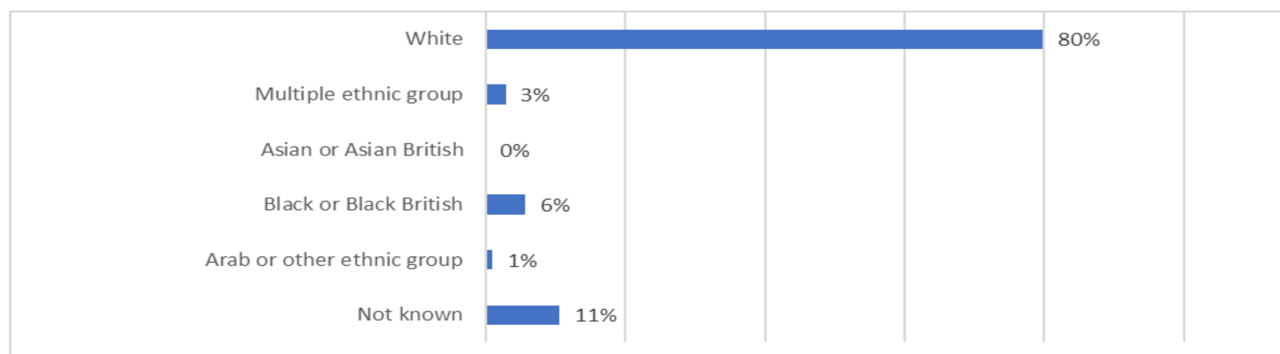


This distribution reflects a predominantly older maternity population, with over two-thirds (74%) of respondents aged 30 or above.

3.2.2 Parity

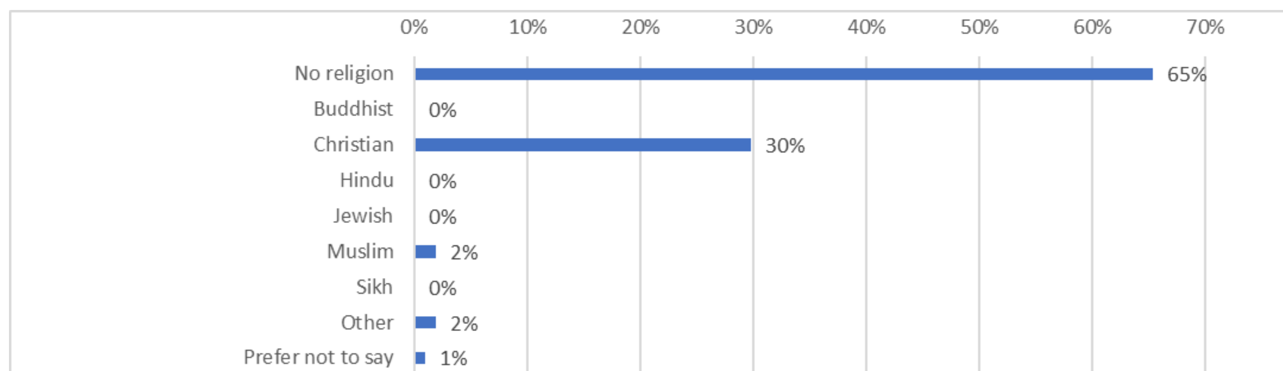
Out of the respondents **58%** gave birth to their first baby.

3.2.3 Ethnicity Profile



Most respondents identified as White (80%), reflecting the predominant demographic within the survey population. Smaller proportions identified as belonging to minority ethnic groups, including Black or Black British (6%), Multiple ethnic groups (3%), and Arab or, other ethnic group (1%). No respondents identified as Asian or Asian British. A further 11% of respondents did not state their ethnicity. This distribution should be considered when interpreting results, particularly where experiences may vary across different ethnic groups.

3.2.4 Religion



Most respondents reported having **no religion (65%)**, followed by **Christian (30%)**. Small proportions identified as **Muslim (2%)** or **other faiths (2%)**, while **1%** preferred not to disclose their religion. No respondents identified as Buddhist, Hindu, Jewish or Sikh.

This profile indicates that the respondent group is predominantly non-religious or Christian, with minimal representation from other faith communities.

3.2.5 Sexuality

Most respondents identified as **heterosexual/straight (94%)**. Small proportions identified as **gay/lesbian (2%)**, **bisexual (2%)**, or **preferred not to say (2%)**. No respondents selected “other.” This distribution indicates that the respondent group is predominantly heterosexual, with minimal representation from other sexual orientations.

3.2.6 Language and Communication

The majority (92%) of maternity service users reported **English** as their main language and almost all respondents (98%) indicated that they had no communication needs. Only very small proportions required specific adjustments, including translation or interpreter support (1%), Easy Read materials (1%), or large print materials (1%). No respondents reported needing sign language or Braille materials, and none selected other communication needs. This indicates that communication accessibility requirements were minimal within the respondent group.

Although only a small proportion of service users disclosed communication needs, this may mask unmet requirements. Some women may choose not to report language or communication barriers due to stigma, limited awareness of available support, or assumptions about eligibility. Despite just 1% indicating a need for translation support, services must continue to meet the NHS Accessible Information Standard and ensure sufficient interpreter and translation capacity. Strengthening proactive communication checks at key points in the maternity pathway booking particularly for women with fluctuating health conditions or perinatal mental health challenges.

3.2.7 Health

a. Physical and Mental Health: Out of the 119 respondents 29% reported having a physical or mental health condition or illness that has lasted, or is expected to last, for 12 months or more. Indicating that nearly **one-third of service users** are living with a long-term health condition during pregnancy or the postnatal period, highlighting the importance of accessible, supportive, and appropriately tailored maternity care.

Notably, these health profiles should be considered alongside the latest MBRRACE-UK perinatal mortality surveillance report Saving Lives, Improving Mothers' Care 2025 MBRRACE-UK highlighting the 257 women who died during pregnancy or within six weeks after the end of pregnancy. Blood clots (thrombosis and thromboembolism) remain the leading cause of maternal death, followed by heart disease.

The report also identifies mental health related conditions as the leading cause of late maternal deaths, defined as occurring between six weeks and one year after the end of pregnancy. Assessment and implementation of the NHS England 2026-Maternity and Neonatal Equalities dashboard, NHS England 2026 The Maternal Care Bundle across the Trust may support improvements in these areas.

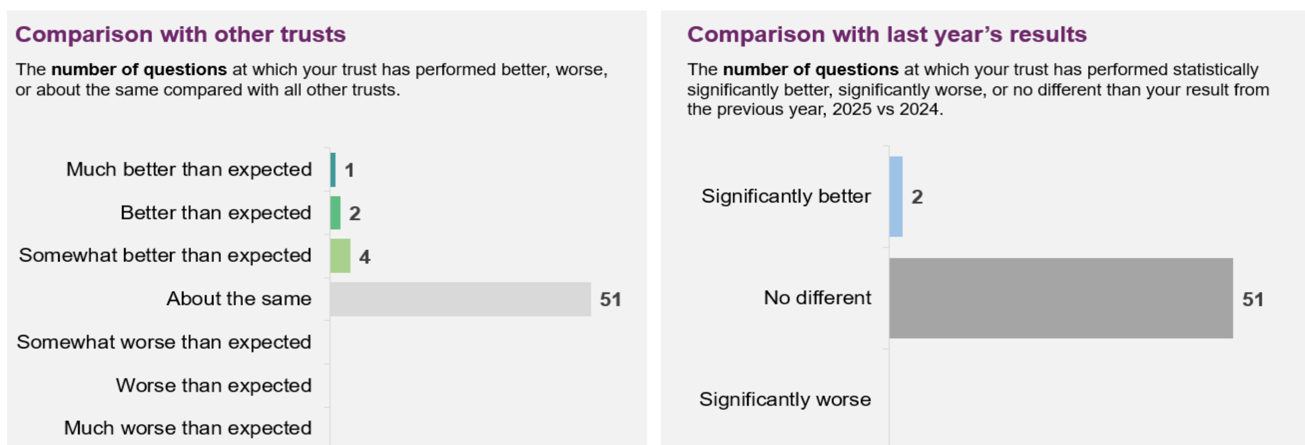
b. Pregnancy Related: Just over half of respondents (**53%**) reported experiencing **no pregnancy-related health conditions**. Among those who did report health issues, 29% experienced another pregnancy-related health condition, while 27% reported pelvic health problems. No respondents selected "prefer not to say." This indicates that almost half of respondents experienced at least one pregnancy-related health concern during their maternity journey.

c. Neonatal Health Related: 23% of respondents reported that their baby received care and treatment following birth.

4. Findings

Overall, the findings highlight a positive trajectory, particularly in communication, involvement in care decisions, and staff interactions, reinforcing the Trust's commitment to delivering high-quality maternity services.

ESHT performed strongly in several areas when compared with all other participating NHS Trusts presented below.



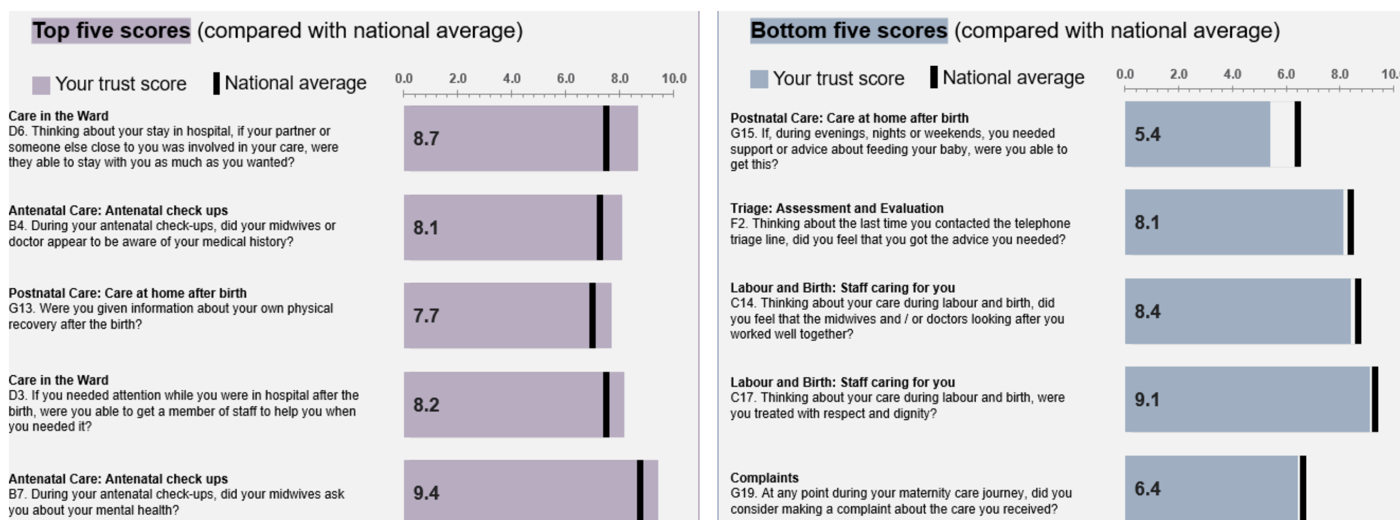
In short, the above findings show:

- **1 question** where performance was **much better than expected**
- **2 questions** where performance was **better than expected**
- **4 questions** where performance was **somewhat better than expected**
- **51 questions** where performance was **about the same** as other trusts
- **No areas** were rated as worse or much worse than expected

Overall, the survey indicates stable performance with areas of improvement and no deterioration, demonstrating sustained service quality compared with both national benchmarks and previous years. For a breakdown of the questions where ESHT has performed better or worse compared with all other trusts, please refer to Care Quality Commission Maternity Survey 2025.

4.2 Performance Relative to the National Average Summary of Findings

The below compares ESHT maternity survey scores with the national average across England, highlighting the five highest-scoring and five lowest-scoring questions **relative** to the national benchmark.



ESHT Top Five Scores (Compared with the National Average)

1. **Care in the Ward:** Women felt staff allowed them to stay with their baby/partner as wanted.
2. **Care in the Ward:** Women felt they could get staff attention when needed.
3. **Antenatal Care:** Midwives/doctors were aware of medical history.
4. **Antenatal Care:** Women felt mental health was asked about.
5. **Postnatal Care at Home:** Women felt informed about their physical recovery.

ESHT demonstrated improvement in the following areas:

1. **Communication during antenatal care:** showed a marked improvement where 89% of respondents feeling they were "always" spoken to in a way they could understand.
2. **Mental health:** support offers during pregnancy continued an upward trend, reaching 90%.
3. **Birthing partners:** more women (72%) reported that their partner could stay with them as much as they wanted after birth.

ESHT Bottom Five Scores (Compared with the National Average)

1. **Postnatal Care: Care at Home:** Getting help when needed during evenings/nights/weekends - being able to get support or advice about feeding baby.
2. **Triage:** Getting the help needed when calling the unit.
3. **Labour and Birth:** Being spoken to in a way that built confidence
4. **Labour and Birth:** Being treated with respect and dignity.
5. **Complaints:** Considering making a complaint about maternity care.

The weakest finding centres on postnatal support at home. Although the survey identified three questions relating to triage and to labour and birth as being among ESHT's bottom five scores compared to the national average, the Trust performed well on these questions, each achieving scores above 8 out of 10. Despite this the themes that centre on responsiveness, escalation/triage, and aspects of interpersonal care during labour that might pose safety risks plus slightly more negative perceptions that might lead to complaints and reputational issues. These areas have been identified for improvement within NHS England's Enhance and Oversight Support action plan.

For the score relating to complaints which asks whether women considered making a complaint during their maternity care journey, ESHT performed in line with the national average. Although this measure was highlighted among ESHT bottom five scores relative to England, ESHT result still reflects a **positive overall experience**, achieving a score of **over 6 out of 10**, positioned firmly within the *"about the same"* range on the benchmark scale. This indicates that, while comparatively lower than some other indicators, ESHT continues to perform at a broadly acceptable level on this aspect of patient experience.

Overall, the findings highlight a positive trajectory, particularly in communication, involvement in care decisions, and staff interactions, reinforcing the Trust's commitment to delivering high-quality maternity services. ESHT strengths lie mainly in antenatal continuity, communication, and aspects of ward-based postnatal care particularly awareness of medical history and attention to mental health.

5.0 Implications and Risks

Based on the key findings, the following have been identified as potential risks or areas of care that may be implicated:

Postnatal Community Care Implications

- Potential safety risks if women cannot access timely advice.
- Women may stop breastfeeding earlier than intended, which could negatively impact their baby's health[1][2][3].
- Reduced access to support may adversely affect early postnatal physical and emotional wellbeing.

Triage Responsiveness

- Risk of missed clinical deterioration or delayed presentations.

[1] North et al, 2022
[2] World Health Organization (WHO, 2011; 2024)
[3] Victora et al, 2016

- An important area for governance review, including escalation processes and protocol compliance.

Labour Ward Interpersonal Skills

- Direct impact on patient experience and psychological wellbeing.
- Potential implications for the Trust's reputation and future CQC assessments, particularly in relation to the "caring" and "responsiveness" domains.

Respondents Profiles (Health and Demographics)

- Strengthening proactive communication checks at key points in the maternity pathway particularly for women with fluctuating health conditions or perinatal mental health challenges.
- The importance of accessible, supportive, and appropriately tailored maternity care for those with long-term health conditions and mental health related conditions

6.0 Opportunities to Learn and Improve

While no areas fell below the expected standard to warrant a concern there were areas identified as opportunities to learn and improve presented below.

Key Areas of Learning Identified:

- Strengthen postnatal community availability, particularly evenings/weekends and support with infant feeding.
- Review triage call-handling, staffing levels, and escalation pathways.
- Introduce staff training focused on communication, confidence-building, and respectful care in labour.
- Use antenatal strengths as a foundation to improve continuity across the entire maternity pathway.
- Address the importance of accessible, supportive, and appropriately tailored maternity care for those with existing long-term conditions during pregnancy or the postnatal period.
- Address gaps in health inequalities, to achieve equality in these services for vulnerable groups to improve safety and health outcomes.

The above areas have been addressed in *Appendix A Draft Action Plan*, coproduced following a multidisciplinary review of the survey report, including analysis of the free-text comments. Representation for this work included key midwifery leads, medical staff, and the Maternity and Neonatal Voices Partnership (MNVP). The action plan has been developed with consideration of learning from previous CQC Survey action plans and will be aligned with ongoing themes from other data sources, including complaints, incidents, maternity reviews and health inequalities.

7.0 Summary

This report summarises the key elements of the Care Quality Commission Maternity Survey 2025 providing a snapshot to understand the quality of maternity services and to identify potential risks within care systems and organisations. It has outlined the methodology and context while identifying

key findings, risks, and areas for improvement. Overall, the findings highlight a positive trajectory, particularly in communication, involvement in care decisions, and staff interactions, reinforcing the ESHT commitment to delivering high-quality maternity services. Based on the survey, ESHT strengths lie mainly in antenatal continuity, communication, and aspects of ward-based postnatal care particularly awareness of medical history and attention to mental health.

Appendix A – Draft Action Plan

CQC National Maternity Survey 2025 Results – Coproduced action plan for 2026

Blue	Complete (business as usual process)
Green	On target for completion
Amber	At risk of meeting target
Red	Target overdue

NHS
East Sussex Healthcare
NHS Trust

Action outcome	Action to take	Responsible person	Deadline	Potential challenges/ Mitigation	Key updates > Result/Outcome	Completion Evidence	RAG
Theme 1: Postnatal continuity - Access to Feeding Support Information (namely evenings & weekends)							
1. Create dedicated Infant Feeding page on the Trust maternity website (Scheule for Socials already live)	Publish infant feeding information page on maternity website (keeping changeable information on social media)	Content: **Ella Jackson** Infant Feeding Lead Linking with: **Stevie Walker** MNVP Lead Website support: **Lisa Yeo-Toft** Business Manager	Finalise/ agree content by: 31/03/26 Website to be updated by: 30/04/26	Communication Dept availability to action timely change. Risk of outdated content > review date to be agreed (e.g. annually via specialist mw)		Live webpage URL	G
2. Feeding support infographic (poster with QR codes)	Confirm display poster (inspired by MNVP social infographic), to include QR codes, display poster in clinical and outpatient areas	**Stevie Walker** MNVP Lead Linking with: **Ella Jackson** Infant Feeding Lead	Finalise/ agree content by: 31/03/26 Laminates on display by: 30/04/26	-	The Infant Feeding Padlet is being co-produced by the MNVP Infant Feeding working group, and it will hold the most up-to-date information, reviewed monthly by MNVP leads. The poster can simply link via a QR code to the community support section of the Padlet, removing the need for frequent updates to printed materials.	Photos	G
3. Matron for Maternity Triage & Outpatient Services to join the Infant Feeding Working Group	To be added to membership, contribute social prescribing input to triage work	**Lina Tinka** Matron for Maternity Triage	23/02/26	-	02/02/26 HR added LT to IF working group invites as well as main membership meetings.	Updated membership list; meeting minutes	G
Theme 2: Postnatal continuity - communication of postnatal plans & encouraging continuity							
4. Improve postnatal experience and care	Improvement forum to be restarted which will inform workstreams. This will include toolkit implementation. (Consider adding template brief prompt to review on BadgerNet)	*Please refer to Improvement Forum action plan*	-	-	*Please refer to Improvement Forum action plan*	-	-
5. Discharge video (Carried forward from previous plan)	Finalise and publish discharge video which includes key support and standardised information. *(On action 7 completion a QR code to this video will be displayed via TV in discharge lounge).*	**Claire Croft** DHoM for Acute	01/03/26	Communication Dept resource to support.	(Comms unable to support until Autumn 2025, completion expected Dec 25). Feb 26: with Comms for editing and publish.	Live webpage URL	A
6. Discharge/ multipurpose room (Carried forward from previous plan)	Complete the workstream to establish a dedicated space for discharge conversations	**Kaia Vitler** Divisional Director of Operations (Women & Children's Division)	June 2026		Minor improvement submitted in 2025 to convert the unused sluice area into a multipurpose quiet room and improve/repurpose Frank Shaw Seminar Room. Advised		A

DRAFT

Blue	Complete (business as usual process)
Green	On target for completion
Amber	At risk of meeting target
Red	Target overdue

NHS East Sussex Healthcare NHS Trust

Action outcome	Action to take	Responsible person	Deadline	Potential challenges/ Mitigation	Key updates > Result/Outcome	Completion Evidence	RAG
	and personalised care planning. Work is currently in development.	**Claire Croft** DHoM for Acute/ Postnatal Ward Matron **Sam Padain** Consultant midwife			needs business case due to estimated cost being over the threshold. Awaiting suitable person/capacity to write. Jan 26: TBC case is still a requirement (site inspection rumoured to have occurred). Feb 26: Target date extended to Jun 26 on account of business case requirement.		
Theme 3: Triage communication for 'green' BSOTS group							
7. Explore and implement suitable communication method/s that allow service users in the 'green' BSOTS triage group to leave the immediate area and be reliably called back. (Carried forward from previous plan)	Investigate and evaluate communication options (including BadgerNet push notifications, SMS, phone calls, and pager/buzzer systems).	**Alice Jeavons** Deputy Head of Midwifery, Outpatient Services **Lina Tinka** Matron for Maternity Triage	31/03/26	Budget approval for associated costs, e.g. hardware, installation.			G
Theme 4: Communication and Standards of Care							
8. Hold Fundamentals of Care Week (Carried forward from previous plan previously 'Back to Basics', incudes BRAIN)	Aligned with Trust values, balanced and evidence-based conversation in public, service users feeling listened to without judgement.	**Alice Jeavons** Deputy Head of Midwifery, Outpatient Services **Claire Croft** DHoM for Acute	Plan, schedule in place by: 31/03/26 To have taken place by: 30/04/26				G
9. Ward rounds: investigate how to improve embedding learning, civility and confidence in day-to-day practice (not just risk factors). NB: missed opportunities with having split handovers	**TBC** *FAO EW: Is action required regarding broader joint handover processes and improving situational awareness, if so, please specify what actions are needed.*	**Ellie Watson** Labour Ward Lead Obstetrician	TBC				TBC
Theme 5: Complaints							
10. Strengthen governance for tracking complaint and PALS themes,	a) Review/confirm governance team capacity to undertake	**Mark Standen** Divisional Director of Nursing & Clinical Professions, WAC	**TBC** *(FAO MS)*	Governance team capacity			TBC

Blue	Complete (business as usual process)
Green	On target for completion
Amber	At risk of meeting target
Red	Target overdue

NHS
East Sussex Healthcare
NHS Trust

Action outcome	Action to take	Responsible person	Deadline	Potential challenges/ Mitigation	Key updates > Result/Outcome	Completion Evidence	RAG
learning, actions and improvement.	b) Provide agreed outcomes	**Nick James** Divisional Governance Lead					
Theme 6: System Coordination and Equity							
11. Confirm GP lead contact for future improvement work	Confirm contact details of GP lead (known by/ engaging with MNVP)	**Hannah Russell** MNVP Lead	31/03/26			Confirmation email	G
12. To address women and birthing people with existing long-term conditions and gaps in health inequalities - the importance of accessible, supportive, and appropriately tailored maternity care that is joined up.	a) To implement the Maternity Care Bundle with training and support and b) NHSE [2026 Maternity and Neonatal Equalities Dashboard]()	**Gayle Clarke** Quality Improvement and Assurance lead Nurse / Midwife with **Sam Padain** Consultant midwife **Nicky Roberts** Consultant Obstetrician and Gynaecologist Clinical Lead **Aly Hulme** Interim Director of Maternity Services	TBC		MDT approach: A multidisciplinary team led by a named healthcare professional should involve a pregnant woman and birthing people with a medical condition in preparing an individualised plan for intrapartum care.		TBC
Theme 7: MDT Teamwork & Cultural Safety							
13.Cultural awareness/emotional intelligence training embedded as part of staff training	Confirm online training module completed by all staff groups. Investigate possibility of adding to mandated requirements, refresher and for all new starters.	**Gayle Clarke** Quality Improvement and Assurance lead Nurse / Midwife	TBC		Online module information shared with staff (TBC when/who by/ did this capture all staff groups as needed)	TBC	TBC
14.**TBC:** Promote staff speak up channels & support staff confidence to speak up. Pathways for feedback and learning from this in place.	**TBC:** Strengthen and promote speciality/ divisional level speaking-up processes so all staff feel confident raising concerns through the proper channels before escalating to Freedom to Speak Up Guardians.	**TBC:** **Sam Padain** Consultant midwife *With:* PMA leads and the Wellbeing Lead for medics	TBC			TBC	TBC

Blue	Complete (business as usual process)
Green	On target for completion
Amber	At risk of meeting target
Red	Target overdue

NHS
East Sussex Healthcare
NHS Trust

Action outcome	Action to take	Responsible person	Deadline	Potential challenges/ Mitigation	Key updates > Result/Outcome	Completion Evidence	RAG
15. **TBC if action desired:** Reminder and guidance on discussing concerns privately before joint conversation	**TBC:** Issue reminder guidance; support transparent, joint discussions, reinforce private discussion first to avoid causing stress, reinforce via handovers	**TBC**	TBC			Feedback	TBC
Theme 8 – Pain relief delays & epidural communication							
16. Audit analgesia response & epidural waiting times to inform learning and action/s	Audit to be undertaken against pathway.	**Lorna Paszke** Clinical Effectiveness Midwife	TBC			Audit report	TBC

Homebirth Service Safety Review   Appendix C

Purpose of the paper					
To provide assurance and information regarding the safety of the homebirth service					
For Decision		For Assurance	⚐	For Information	⚐

Sponsor/Author

Executive Director: Vikki Carruth, Chief Nurse and Executive Maternity Safety Champion.
Interim Director of Midwifery: Aly Hulme
Authors: Alice Robinson-Jeavons (Deputy Head of Midwifery) and Sam Padain (Consultant Midwife)

Governance Overview (*Meetings or Executive directors that have had sight*) *– if applicable*

MatNeo Quality Safety Forum (QSF) (18/03/26).
Quality and Safety Committee (25/3/2026)
Trust Board (21/04/2026)

Strategic Objectives

Quality	⚐	People	⚐	Sustainability	⚐

Our Values

Kindness	⚐	Inclusivity	⚐	Integrity	⚐

Executive Summary

This Homebirth Service Safety Review was undertaken in response to national scrutiny following a Prevention of Future Deaths (PFD) report and subsequent directive from NHS England (26 November 2025), requiring the ICB to seek assurance that homebirth services are safe, sustainably staffed, and compliant with national standards. The review evaluates East Sussex Healthcare NHS Trust's (ESHT) homebirth service across operational delivery, workforce, care planning, governance, and risk management, as defined in the Southeast LMNS audit framework.

Activity data for 2025 shows that **3.8%** of ESHT birthing people intended a homebirth and **1.6%** (n45) achieved it, 43% of those planning a homebirth were doing so outside of clinical guidance. **40% of people who birthed at home had out of guidance plans**. Among **57** people labouring at home, **12 intrapartum** and **4 postnatal transfers** occurred. There were **no incidents of moderate or severe harm**, with emergency cases (two major haemorrhages, one neonatal resuscitation) managed effectively and without poor outcomes. One intrauterine death occurred during the latent phase of a planned homebirth; this was investigated via the PSIRF process.

The homebirth service is delivered by community and continuity midwives operating a 24/7 on call system with two midwives attending. However, the service is under significant pressure due to **high sickness rates**, **vacancies**, and the need for midwives to support the acute unit during high acuity periods. This has resulted in **26 homebirth suspensions** (Dec 2025–Mar 2026) and **559 hours of escalation to support the acute unit**, impacting birthplace choice for **seven women**.

The current on call system can result in some cases whereby the midwife does not have adequate rest before the on call, this will be reviewed at pace considering the Preventing Future Death Report.

Training compliance is high for PROMPT (90%), though gaps exist in homebirth specific emergency training (45% compliant) and the absence of a formal intrapartum homebirth competency framework. Equipment is standardised, though inconsistencies in checking processes and stock shortages (e.g., SATS monitors) require action.

Governance structures are in place, with data flowing through MatNeo QSF to the Integrated Performance Review and Trust Board. However, whilst documentation quality is good, transfer documentation is missing in 99% of cases, preventing audit of transfer times. Learning from incidents is evident, but systematic triangulation with national datasets is not yet embedded. Guidelines are aligned with NICE, however the Personalised Care Guideline, Routine care of the Healthy Pregnant Woman and immediate care of the neonate require updating. A new SOP for Out of Guidance Homebirth and Freebirth is currently awaiting approval.

Overall, the review confirms that the homebirth service is **fundamentally safe**, responsive, and committed to personalised care, but **system sustainability, documentation standards, and workforce resilience require strengthening** to ensure compliance with PQOM domains and national standards.

(S) Situation

Following the Prevention of Future Deaths (PFD) report issued by the Senior Coroner for Manchester North, and the subsequent letter from Kate Brintworth (Chief Midwifery Officer for England) dated **26 November 2025**, NHS Sussex Integrated Care Board (ICB) is required to obtain assurance that **homebirth services across the system are safe, high quality, and compliant with national standards**.

This requirement falls within the ICB's commissioning and quality oversight responsibilities under the **Perinatal Quality Oversight Model (PQOM)**, specifically:

- **PQOM Quality Domain 1: Safe Care**
- **PQOM Quality Domain 5: Well-Led**

In response, the Southeast Local Maternity and Neonatal System (LMNS) has agreed an audit tool structured around three domains:

1. **Operational Service Delivery and Workforce**
2. **Care Planning, Risk Assessment, and Informed Choice**
3. **Governance, Oversight, and Continuous Improvement**

Nationally, homebirth services are under heightened scrutiny, with NHS England emphasising the need for **robust governance**, **clear escalation pathways**, and **consistent multidisciplinary communication**. Trusts have been asked to demonstrate evidence that their Homebirth Services are **safe**, **sustainably staffed**, and supported by the necessary **infrastructure for decision making, transfer, and emergency response**.

This report presents consolidated findings from **local audits**, **workforce assessments**, **training records**, **risk reviews**, and **multidisciplinary feedback**.

The review supports compliance with statutory duties under the **NHS Act 2006** (as amended by the **Health and Care Act 2022**) and aligns with the following national frameworks and standards:

- **NICE Guideline CG190: Intrapartum Care for Healthy Women and Babies**
- **NMC Code (2018): Professional Standards of Practice and Behaviour**
- **RCM Standards for Midwifery Services (2021)**
- **NHS England Maternity Safety Standards (2024)**

(B) Background

In 2025, 3.8% of ESHT birthing people intended to have a homebirth, with 1.6% ultimately doing so. Of those who chose a homebirth, 40% had planned to birth outside clinical guidance (OOG). Among 57 individuals who laboured at home, there were 12 intrapartum transfers and 4 postnatal transfers. No serious incidents involving moderate or severe harm occurred.

27% of those who birthed at home and 58% (n7) of those who were transferred in labour were Primigravida. Five of these birthed by emergency caesarean section. Of the Six Multigravida's transferred in labour, one delivered by emergency caesarean section. Only one woman sustained Obstetric Anal Sphincter Injury.

(A) Assessment

DOMAIN 1: OPERATIONAL SERVICE DELIVERY AND WORKFORCE

The ICB requires assurance that your homebirth service operates safely on a 24/7 basis with appropriately trained and equipped staff.

The homebirth service staffing is appropriately planned in line with NICE guidance (two midwives attend), however this is impacted when the community staff are used to support the acute service. The homebirth midwives have 24/7 access for advice from senior midwifery team (labour ward coordinator, senior midwifery team and senior midwife on call).

Midwives are given compensatory rest following a call out in line with WTD and are encouraged to report fatigued to the shift coordinator to ensure they can be replaced. The review found that instances whereby midwives were returning to work before adequate rest periods had been taken. There are concerns that adequate rest was not always achieved prior to an on call resulting from working all day and up to 8 hours overnight.

This review found some vacancy within the teams that could affect the sustainability of the homebirth service, however there were various factors resulting in the suspension of the service (26 episodes dec-mar) including escalation to support the acute unit and high levels of sickness, burnout and stress. During Quarter 3, the service recorded 559 hours of escalation (equating to 1.24fte RM) and 26 homebirth suspensions. Whilst suspending services safeguards overall service delivery, they limit birthplace choice, with seven service users unable to proceed with their planned homebirth. Staffing and acuity are reviewed daily by senior midwifery leaders—including community managers, matrons, and labour ward coordinators—to ensure safe facilitation of homebirths. Overnight, responsibility sits with the labour ward coordinator and senior midwife on call. A maximum of five

midwives are available overnight to cover intrapartum homebirth care, the midwifery led unit, and continuity of carer caseloads.

There were two intentional freebirths in 2025. In both cases an out of guidance care plan was in place. There was one incidence of an unintended freebirth during a temporary suspension; the family declined ambulance attendance, and no adverse outcomes were reported.

Midwives contributing to the homebirth on call rota are band 6, having completed all their competencies. Midwives are trained as experts in physiological birth. Those that are new to community complete a supernumerary period and have extra support from their peers when attending homebirths until they are confident. When completing the rota, the experience of the midwives is considered and support plans made. 58% of the homebirths were attended by the same 7 midwives (The Ivy Team) – demonstrating consistency of attendance by experienced homebirth midwives.

Compliance for attending mandatory training for emergency drills is 90%, with additional bi-annual emergencies training for community midwives. The review found that 72% of community midwives had attended this training in previous 2 years and 45% in the previous year.

Homebirth equipment is standardised in line with the resuscitation council recommendations and checking is required after attending a birth and monthly. The review found that there were some inconsistencies with the check lists on different sites and with adherence to the monthly checking. The safety lock was not utilised in one area. It was noted that there was not adequate oxygen saturation monitors available in the kit.

Transfer protocols are documented within the Trust Homebirth Guideline. There was a lack of auditable documentation regarding transfers, however there was non-standardised evidence of transfer protocols being followed and no delays in transfer reported. Families are informed of potential delays in ambulance transfer in the antenatal period to inform their decision making. A SECAMB information leaflet expected in March/April 2026. SECAMB are alerted in advance of any risks to staff or extreme out of guidance homebirths planned.

DOMAIN 2: CARE PLANNING, RISK ASSESSMENT AND INFORMED CHOICE

The ICB requires assurance that women receive comprehensive, evidence-based information to make informed decisions about place of birth, with systematic risk assessment throughout the pathway.

A Homebirth information leaflet for families is available in over 100 languages on the Trust website. This aligns with NICE recommendations and includes evidence from the Birthplace Study.

Group homebirth information sessions are offered to those planning a homebirth and individual homebirth discussions take place within the home at 36-week gestation and including an assessment of the environment. The review found consistent use of homebirth risk assessment documentation on Badgernet. Identified risks are escalated to team leads and the safeguarding team where applicable.

Interpreting services are available for non-English speaking service users. There are further opportunities to discuss concerns at 38 and 40 weeks' gestation during routine appointments. For those seeking to birth at home outside of recommended guidance, a senior midwife undertakes an in-depth risk discussion using the BRAINS decision making tool and standardised template.

The review found that homebirth discussions were well documented using Badgernet Smart Forms and alerts were noted for those high-risk pregnancies. The out of guidance plans were consistently of high quality, although there were some instances where this was not uploaded onto the Badgernet system.

An MDT meeting occurs to discuss out of guidance homebirths; the terms of reference are currently being updated. A review of out of guidance outcomes is underway.

There is clear Trust guidance available regarding responding to and communicating escalating intrapartum risks. There was good evidence of gaining consent and documenting when aspects of care are declined. An Badgernet SBAR form is available to ensure comprehensive handover.

DOMAIN 3: GOVERNANCE, OVERSIGHT AND CONTINUOUS IMPROVEMENT

The ICB requires assurance that homebirth services are subject to robust governance with appropriate executive oversight and drive continuous quality improvement.

Governance and oversight are achieved via a quarterly community safety report submitted to MatNeo Quality and Safety Forum. Homebirth incidents are reported via DCIQ and the PSIRF process is followed for high severity incidents. Outcome data is analysed and presented in the report. 2025 Data is included above as part of this review. The review noted that rates of suspension, out of guidance plans and transfer times are currently omitted from this report, improvement of auditable documentation is required.

There is currently no triangulation of national data, this will be considered and embedded in future reporting.

The maternity governance structure is currently under review to align with the Good Governance Institute standards.

There were two major haemorrhage's and one neonatal resuscitation reported in 2025, these were well managed in line with trust policy and no adverse outcomes.

There was one Intrauterine Death associated with a planned homebirth; however, this occurred during the latent phase. An MNSI investigation was declined by the family, and the case was investigated via the PSIRF process. Learning informed changed to the reduced fetal movement guideline and triage training was disseminated. A telephone triage service evaluation has commenced.

The review found twelve clinical guidelines relating to homebirth, including five obstetric emergencies guidelines, all aligning with NICE clinical standards. One of these

are currently under review awaiting approval, one being reviewed and one requires updating. There is also a new standard operating procedure for out of guidance homebirth and freebirth awaiting approval.

The service users voice is predominantly captured via the MNVP survey and the Trust friends and family test. The Ivy Team receive feedback via their social media pages. This review concluded that seeking feedback should be proactive and as such a homebirth specific survey and personalised care survey and a homebirth improvement group is planned for development in collaboration with the MNVP.

The findings and recommendations from this review will inform an action plan for improvements and will be presented to the wider team for learning and information.

(R) Recommendation

Key Safety Actions

1. Workforce and Service Sustainability:

- **Complete a full workforce review** to address vacancies, sickness levels, and workload distribution, ensuring the on-call model is sustainable.
- **Develop and consult on a whole service on call system** to reduce disparity between teams and minimise avoidable homebirth suspensions.
- **Ensure compliance with rest period policies**, with community managers monitoring and preventing early return to duty after overnight callouts.

2. Training, Competency, and Skills Maintenance

- **Develop a competency framework** for intrapartum care in the community, including homebirth-specific skills.
- **Review rotation opportunities** for midwives with limited homebirth exposure to maintain skill currency.
- **Increase compliance with homebirth emergency workshops**, ensuring targeted attendance for those overdue training.

3. Equipment, Resources, and Safety Processes

- **Standardise and monitor equipment checking processes** across all teams, ensuring monthly checks and appropriate tagging.
- **Procure and maintain sufficient stock** of essential equipment (e.g., SATS monitors).
- **Ensure documentation of transfer forms** and embed improvement through training and audit.

4. Governance, Documentation, and Learning

- **Strengthen documentation standards**, including timely upload of personalised care plans and completion of BadgerNet transfer forms.
- **Introduce routine audit of transfer times and outcomes** once documentation improves.

- **Enhance triangulation of outcomes data** with national datasets (MBRRACE, NMPA, PFD learning).
- **Include homebirth suspension rates** in quarterly governance reports.

5. Service User Experience and Co-Production

- **Develop and launch a Homebirth Experience Survey** and a dedicated OOG cohort survey.
- **Establish a service user working group** to codesign improvements and support transparent communication around service pressures and suspensions.

6. Policy and Clinical Standards Alignment

- **Complete pending guideline reviews**, including PPH/MOH, immediate neonatal care, and routine healthy pregnancy guidance.
- **Ensure full mapping and implementation** of updated NICE guidance (CG235, NG201, NG194) and Saving Babies' Lives v3.
- **Formalise Terms of Reference for MDT review meetings** to ensure consistency and accountability.

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Independent Investigation into *Maternity and Neonatal Services in England- Reflections and Initial Impressions Report*[1] 9 December 2025

Purpose of the paper					
This paper presents a summary of findings from the initial impressions report. Reflecting on the key themes, which have been reviewed against the Trust's current standards of practice and procedures and actions have been considered where gaps were identified.					
For Decision	⚐	For Assurance	⚐	For Information	⚐
Sponsor/Author					
Executive Director: Vikki Carruth, Chief Nurse and Executive Maternity Safety Champion. **Author (s):** Aly Hulme, Interim Director of Maternity Service and Sam Padain Consultant Midwife					
Governance Overview (*Meetings or Executive directors that have had sight*) – *if applicable*					
MatNeo Quality Safety Forum (QSF) 18/02/26. Quality & Safety Committee (QSC) 25/03/26					
Strategic Objectives					
Quality	⚐	People	⚐	Sustainability	⚐
Our Values					
Kindness	⚐	Inclusivity	⚐	Integrity	⚐
Executive Summary					
Baroness Amos, the Chair of the investigation, has provided an update on its progress since the publication of its Terms of Reference in September 2025. She outlines the activities undertaken as part of the investigation to date, as well as her initial reflections from engagement with families, staff, community organisations, and Members of Parliament. The following themes have been identified from this initial report: **a) Listening, Communication and Shared Decision Making** **b) Compassion, Culture and Psychological Safety** **c) Equity, Inclusion and Reducing Disparities** **d) Holistic, Joined-Up and Family-Centred Care** **e) Quality, Safety and Fundamentals of Care** **f) Transparency, Accountability and Learning** **g) Trauma-Informed and Long-Term Support** The above themes will help to inform practice and support effective risk management. They have been reviewed against current standards of practice and procedures, and where gaps have been identified, actions and recommendations have been considered.					

[1] Independent Investigation into Maternity and Neonatal Services in England - Reflections and Initial Impressions - National Maternity and Neonatal Investigation

(S) Situation
The initial impressions report has been reviewed where key themes have been identified which have been reviewed against current standards of practice and procedures, actions have been considered where gaps were identified.
(B) Background
On 23 June 2025, the Secretary of State for Health and Social Care announced a rapid, national, independent investigation into 14 NHS maternity and neonatal services. A *Reflections and Initial Impressions Report* was published on 9 December 2025.
(A) Assessment
Baroness Amos' initial findings[2] highlight *consistent, systemic failures* across maternity and neonatal services in England. Issues raised by families, staff and advocacy groups reveal profound weaknesses in communication, safety culture, equity, and accountability. These failures are recurrent across multiple Trusts and mirror concerns from previous national reviews. The findings reinforce the need for **urgent, system-wide reform**, a reset in culture, and improved transparency and collaboration with families.
(R) Recommendation
The committee is requested to: 1. **Note** the key themes found from the initial impressions report[3]. 2. **Review** the contents of this report and **consider** if any further information is required for their assurance.

[2] Report findings are based on seven visits to NHS Trusts and the experiences of 170 families.

[3] Independent Investigation into Maternity and Neonatal Services in England - Reflections and Initial Impressions - National Maternity and Neonatal Investigation

Independent Investigation into Maternity and Neonatal Services in England- Reflections and Initial Impressions Report[4] December 2025

1.0 Background

On 23 June 2025, the Secretary of State for Health and Social Care announced a rapid, national, independent investigation into 14 NHS maternity and neonatal services.

Baroness Amos, the Chair of the investigation, has provided an update on its progress since the publication of its Terms of Reference in September 2025. She outlines the activities undertaken as part of the investigation to date, as well as her initial reflections from engagement with families, staff, community organisations, and Members of Parliament.

Baroness Amos' initial findings[5] highlight *consistent, systemic failures* across maternity and neonatal services in England. Issues raised by families, staff and advocacy groups reveal profound weaknesses in communication, safety culture, equity, and accountability. These failures are recurrent across multiple Trusts and mirror concerns from previous national reviews. The findings reinforce the need for **urgent, system-wide reform**, a reset in culture, and improved transparency and collaboration with families.

2.0 Purpose

This report provides an overview of the initial report findings and identify any early warning signs and implications for East Sussex Healthcare NHS Trust (ESHT).

3.0 Findings

In this initial report, Baroness Amos highlights that the following set of themes

a) **Listening, Communication and Shared Decision Making**

A pervasive theme is women[6] and birthing people, partners, and families not being listened to, believed, or provided with clear, timely information affecting decision-making, safety, and trust. Women's knowledge of their own bodies and important information essential to clinical decision making about their care, such as reduced foetal movement, sometimes being disregarded. Fathers and non-birthing partners feeling unsupported.

b) **Compassion, Culture and Psychological Safety**

Experiences reflect a wider cultural problem: lack of empathy, insensitive communication, poor behavioural standards, and a culture that can leave families feeling blamed, dismissed, or unsupported. Ultimately this impacts on trust and ensuring a safe place for women and their families to raise concerns.

c) **Equity, Inclusion and Reducing Disparities**

Discrimination, explicit or implicit, against women of colour, younger parents, working-class women and those with mental health needs threads through many issues, affecting outcomes and experiences.

d) **Holistic, Joined-Up and Family-Centred Care**

[4] Independent Investigation into Maternity and Neonatal Services in England - Reflections and Initial Impressions - National Maternity and Neonatal Investigation

[5] Report findings are based on seven visits to NHS Trusts and the experiences of 170 families.

[6] This term includes birthing people throughout the report.

Women and babies need continuity and integration, yet services often operate in silos. Poor coordination between maternity, neonatal, mental health, bereavement, and post-natal services fragments care.

e) Quality, Safety and Fundamentals of Care

Fundamental care and safety essentials such as cleanliness, hygiene, feeding, checks, documentation are not consistently delivered, undermining trust and contributing to avoidable harm.

f) Transparency, Accountability and Learning

Families often struggle to access notes, feel excluded from reviews, and perceive organisations as defensive or legalistic. Investigations, regulatory processes, and oversight frequently lack openness, timeliness, and family involvement.

g) Trauma-Informed and Long-Term Support

Experiences show that maternity and neonatal trauma has long-lasting effects mental health, bereavement, family dynamics, child health yet follow-up and emotional support remain insufficient or poorly coordinated.

4.0 ESHT Position:
ESHT Maternity and Neonatal Senior Leadership Team acknowledges and welcome these early findings as they help to inform practice and support effective risk management. The above has been reviewed against current standards of practice and procedures, and where there are gaps, actions have been developed.

a) Listening, Communication and Shared Decision Making
These themes are included in ESHT Core Competency Framework study days, with a focus on personalised care to support effective shared decision-making. This area for improvement will be reinforced at staff meetings and triangulated with similar themes identified in complaints, claims, and incidents.

b) Compassion, Culture and Psychological Safety
This has been identified by the Governance Team as an area requiring improvement to strengthen engagement with families. A Duty of Candour approach has been adopted and embedded across the Maternity and Neonatal Department, with good collaboration evident with the bereavement team. However, further work is needed to ensure harmed families receive timely debriefs.

c) Equity, Inclusion and Reducing Disparities
ESHT have a pathway for continuity of care for women whose first language is not English, as well as for those with additional social and mental health complexities in the Hasting area. Consideration is needed to ensure equity in the Eastbourne region side. Improvement work on interpreting services is ongoing. There is a low threshold for inviting non-English-speaking families to attend in person when contacting triage. An interpretation service is provided, and an alert system has been recently introduced on BadgerNet along with an "opt-out" option if the women does not require an interpreter. Other aspects of this theme are considered in the NHS England *Saving Babies' Lives* Bundle[7] and the NHS England *Maternal Care Bundle 2026*[8], which have been implemented and are in the process of implementation, respectively.

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[7] NHS England Saving Babies Lives Bundle
[8] NHS England The Maternal Care Bundle 2026

d) Holistic, Joined-Up and Family-Centred Care
Pathways need to be reviewed in partnership with service provider and commissioners, to ensure continuity and integration of care for women and babies. This includes establishing structured communication and referral processes between maternity, neonatal, mental health, bereavement, and postnatal services. There is a multidisciplinary working group set up to oversee alternative birth choices and this group could consider pathways, reduce siloed working, and ensure timely, joined-up support for families.

e) Quality, Safety and Fundamentals of Care
This theme will be partly addressed in the above theme concerning core competency framework along with the implementation of 'Back to Fundamentals" with the aim to reinforce core maternity fundamentals across all clinical areas to ensure consistent, safe, and compassionate care. This includes refreshing staff on essential clinical skills, communication standards, risk recognition, documentation, and escalation pathways. Compliance will be strengthened through targeted training sessions, on-the-floor coaching, and regular audit and feedback cycles. Working with the interim Director of Maternity Services the governance team will be undertaking a review of complaints, claims and serious incidents to understand top three safety risks and underlying themes.

NHS England have introduced **Maternity Outcomes Signal System (MOSS**) a new real-time to support early detection of potential safety issues during maternity and neonatal investigations. MOSS identifies unusual patterns in maternity data and issues an urgent alert for immediate safety checks. Data and alerts are visible at Trust, ICB, regional, and national levels to ensure transparency and rapid escalation from "ward to board" seven days a week. Once a signal is generated, units must complete a critical safety check within eight working days, and report actions taken to regional and national teams. The system is expected to improve early detection and prevent future harm. It is being rolled out across the Trust, and the governance team, with support from colleagues, will develop procedures to embed the process.

f) Transparency, Accountability and Learning
By involving women who have experienced poor care or bereavement as equal partners from the earliest stages of the investigation process. This includes developing a standardised approach for early engagement, ensuring their voices inform the investigation scope, learning outcomes, and improvement actions. Staff will receive guidance and support to embed this practice consistently working in partnership with Maternity and Neonatal Voices Partnership (MNVP).

g) Trauma-Informed and Long-Term Support
Strengthen trauma-informed care and ensure coordinated long-term support for women, babies, and families affected by maternity or neonatal trauma. This will include developing a clear multidisciplinary follow-up pathway that incorporates mental health, bereavement, neonatal, and community support services. As part of the Core Competency Training Staff will receive training in trauma-informed communication and care. Reinforcing at every opportunity with staff that emotional support, follow-up appointments, and signposting must be offered consistently and in a timely manner, reducing gaps in support and improving continuity across services.

5.0 The Investigation Next Steps
Baroness Amos initial report states that the investigation will:

- Launch a call for evidence in January 2026, which will be open for 8 weeks
- Publish a further update in February 2026 on the initial findings of the investigation following the conclusion of site visits to hospital Trusts.

- Publish reports on the 12 local investigations of maternity and neonatal services in NHS Trusts following the conclusion of site visits.
- Publish a final report in Spring 2026 which will include one set of national recommendations to improve safety and experience of maternity and neonatal care.

6.0 Recommendations

The Board is requested to:

1. **Note** the key themes found from the initial impressions report[9].
2. **Review** the contents of this report and **consider** if any further information is required for their assurance.

[9] Independent Investigation into Maternity and Neonatal Services in England - Reflections and Initial Impressions - National Maternity and Neonatal Investigation

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Agenda Item: 10

Report To/Meeting	Trust Board	Date of Meeting	21st April 2026

Report Title:	Final version of the Trust's Five Year Integrated Delivery Plan
Key question	Final version of the Trust's Five Year Integrated Delivery Plan, submitted for Board assurance and ongoing oversight.
Decision Action:	For approval ☐ For Assurance ☒ For Information ☐ For Discussion ☐

Report Sponsor:	Andrew Strevens, Chief Finance Officer	Presenter(s):	Andrew Strevens, Chief Finance Officer
Report Author:	Debbie James, Strategic Consultant		

Outcome/Action requested:	The Board is asked to note the final version of the plan, as submitted to NHS England, and to take assurance that the plan was updated to reflect the revised numerical information submitted to NHS England, as well as latest progress on the Trust's continuous quality improvement work.
Executive Summary	This paper presents a summary of the final version of the Trust's Five Year Integrated Delivery Plan, which was submitted to NHS England on 18 March 2026. The Plan has been updated since the earlier submission to reflect revised medium-term numerical plans, approved by the Board and submitted to NHS England, alongside the latest progress in development of the Trust's continuous quality improvement approach. The updated plan continues to set out the Trust's strategic context, delivery approach, medium-term activity, workforce and financial plans, key delivery priorities, enabling programmes, governance arrangements and principal risks over the planning period. It also reflects the Trust's developing True North domains, continuous quality improvement roadmap and related improvement metrics work.
Regulatory/legal requirement:	NHS England requires submission of a Five Year Integrated Delivery Plan as part of the national planning process.
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration
Resource Implication/VFM:	The plan sets out the Trust's medium-term activity, workforce and financial plans.
Risk:	The plan sets out the key risks and mitigations associated with delivery.

No of Pages		Appendixes	

Governance and Engagement pathway to date:	The Five Year Integrated Delivery Plan has been developed through the Trust's established planning and governance processes, including executive, committee and Board oversight.
What happens next?	The Trust will use the Five Year Integrated Delivery Plan as the framework for ongoing planning, delivery and oversight, with progress monitored through the Trust's governance arrangements and future plan refreshes undertaken as required through the national planning cycle.
Publication	This report can be published.

East Sussex Healthcare NHS Trust

ESHT Five Year Integrated Delivery Plan Executive Summary

KINDNESS

INCLUSIVITY

INTEGRITY

18 March 2026

Executive summary: overview

East Sussex Healthcare
NHS Trust

This is an exciting, transitional year

Year one of this plan, 2026/27, will be a transitional year for East Sussex Healthcare NHS Trust (ESHT), as we launch our new continuous quality improvement (CQI) programme, embed delivery against our new True North s and reset how we plan, prioritise and deliver change.

In the context of rising demand and complexity, widening health inequalities, sustained operational pressures and a significant financial challenge, we will focus on a small number of priorities that protect and improve patient care and safety while improving productivity and value for money.

We do not underestimate the scale of the challenge ahead, but we also recognise the strengths we can build on, and the opportunities and enablers that will help us deliver sustainable improvement over the next five years.

Our emerging new strategy, Building Excellence and Sustainability Together, and our five-year integrated delivery plan are built around our three True North Domains.

To meet the challenges, build on our opportunities and deliver improved patient experience and care, we will use our three True North Domains as guiding principles for our plans, keeping delivery focused on what matters most for patients, partners and long-term sustainability.

We are uniquely positioned to deliver the 'three shifts' set out in the national 10-year plan for health

As an integrated acute and community provider, we have long held an ambition to shift activity from hospital to community, to tackle access and health inequalities, embrace digital solutions and prevent the need for hospital services unless necessary. We have achieved notable successes across these areas including virtual ward expansion to support admission avoidance and early supported discharge, innovative Home First solutions to support Pathway 1 discharges and provide short-term support for patients at home, and targeted acute therapies investment to reduce waiting times for therapy assessments.

Our refreshed clinical framework is organised around four pillars: shift, integrate, prevent and improve, providing a clear, consistent structure for how we improve outcomes, reduce variation and deliver the three shifts at scale.

We are building from a strong platform of quality and delivery. Our CQC rating is Good, with outstanding for Caring and Effective. We have a stable core workforce and a strong appetite for data-driven improvement, with engaged clinicians and motivated teams. We have sustained delivery against 2025/26 activity trajectories and are performing strongly against key standards, despite growing demand, demonstrating resilience and a credible platform for ongoing improvement. External benchmarking reinforces this, and we are ranked joint 44th out of 134 trusts in the NHS National Oversight Framework acute trust league table.

We are also ambitious to become a foundation trust and to be ready, subject to national policy and assurance, to take on an integrated healthcare organisation (IHO) role, strengthening our autonomy and accountability to align resources and services around the specific population health needs of our local communities.

Executive summary: strategic context

East Sussex Healthcare NHS Trust

The challenges we face

- Demand for our services is rising, driven by population growth and increased complexity. The population is projected to grow by around 4% by 2029, with the biggest growth in older age groups; by 2028 there are expected to be around 20,000 more people living with two or more long-term conditions than a decade earlier. A&E attendances are growing by c.5.5% per year, driving non-elective admissions growth of just under 3%, and diagnostics growth is forecast at 8% in year 1.
- Health risk factors and unwarranted variation are significant. Hypertension, for example, is higher than the England average (17.9% vs 14.8%), smoking rates are high and varied across the county, and c.25% of residents have mental health support needs, adding pressure on urgent care pathways and the wider system.
- Sustained pressure on urgent and emergency care, diagnostics, discharge and community pathways continues to affect access, experience and flow. There are also workforce and productivity pressures, including 5.5% sickness absence and recruitment and retention challenges in some roles and specialties.
- Alongside these demand pressures, the Trust faces a significant financial challenge, with a 2025/26 underlying position of £52.4m deficit, and the New Hospitals Programme timeline shift means a further 18-20 years in ageing infrastructure, which increasingly disrupts operations and performance, including a significant power outage and sustained period of business continuity at Eastbourne hospital in 2025/26.

What gives us confidence

- As an integrated provider, we are uniquely positioned to align acute and community pathways, reduce fragmentation between services, deliver more care in the community and develop and ensure interoperability between digital systems to improve coordination, flow and patient experience.
- Our new CQI system will provide the methodology, tools, capability and governance to identify, prioritise and optimise improvement opportunities.
- There is a significant system opportunity to strengthen and empower emerging Integrated Community Teams (ICTs) to support prevention, reduce health inequalities and shift more care from hospital to community.
- The Sussex Neighbourhood Health and Sussex Acute Provider Alliances provide the vehicles to deliver integrated care at scale, improve resilience of smaller scale services, and take increasing responsibility for the health of our communities.
- NHSE benchmarking indicates productivity opportunities of around £109m over three years. This number is being validated and explored to enable schemes which further improve flow and reduce length of stay in non-elective care, improve elective and theatre productivity and reduce variation in resource and capacity use.
- We can make better use of our assets and partnerships, including the capacity and scope of the new Sussex Surgical Centre day surgery unit, and by growing private income through our private healthcare arm, Sussex Premier Health.

What could stop us

- Discussions are ongoing in a challenging financial environment to ensure the funding and investment required for key areas of activity and service transformation are available over the medium term.
- The scale of the financial challenge increases delivery risk. We need to deliver productivity and cost improvement while improving access and standards, and there is a risk that savings do not deliver quickly enough or that the balance between productivity improvement and workforce change is not achievable.
- Flow constraints could continue to limit improvement, particularly where they depend on system factors outside our direct control.
- Ageing, constrained infrastructure and lack of capital to address critical infrastructure risks limit improvement opportunities and are likely to increase disruptive incidents and business continuity events.
- If workforce gaps, sickness absence and training funding cuts persist, we will rely more on temporary staff and have less capacity to deliver new ways of working.
- If digital and data improvements do not happen quickly enough, it will be harder to standardise pathways, track benefits and sustain productivity gains.
- We also know that major service changes may take longer where public consultation is needed, delaying benefits; and there is a risk that we try to do too much at once, stretching leadership and operational capacity and slowing delivery of the highest impact changes.

Executive summary: our immediate priorities

NHS East Sussex Healthcare NHS Trust

Through delivery of this plan, we will provide consistently safe, high-quality care for our communities, strengthening governance and improvement so patient safety and clinical quality improve alongside performance against constitutional standards.

We will embed our new continuous quality improvement (CQI) system and prioritise transformation, cost improvement and productivity initiatives that improve patient care and experience, improve productivity and efficiency, and sustain performance.

Workforce priorities

We will focus on stabilising and reshaping our workforce to improve resilience and support delivery of the three shifts. We will reduce reliance on bank and agency, strengthen recruitment and education pipelines, and progress role and service redesign so more care can be delivered closer to home, supported by better use of digital and AI.

Digital enablers

We will continue delivery of our phased digital roadmap, including priority work on our electronic patient record, patient communication portals, targeted automation and artificial intelligence (AI). We will focus on getting the basics right for staff, including reliable connectivity and easier access, embedding a digital culture, to support safer, more efficient care.

Estate enablers

We will seek the capital required to deliver our prioritised critical infrastructure risk programme and develop a phased strategic estates plan across acute and community settings, while strengthening estates' delivery capability and implementing improved asset management to support safer, more reliable delivery of care.

Continuous quality improvement

2026/27 will be a transitional year, as we embark on a change journey to embed our new continuous quality improvement (CQI) system and True North Domains, and refresh our organisational strategy. This will provide a consistent framework for improving patient care, aligning the organisation around shared strategic priorities and building quality, shared data and strategic demand and capacity planning into everything we do.

System transformation

We will work collaboratively with Sussex health and care partners to deliver agreed system-wide priority schemes in alignment with the 10 Year Health Plan, Major Services Review for Sussex, Sussex Provider Collaborative priorities and Health and Wellbeing Board priorities.

Productivity, efficiency and sustainability

Our immediate priorities include the operational productivity and cost improvement changes necessary to realise significant in-year efficiency requirements, while transforming, protecting and improving patient safety, quality and experience; setting the foundation for long-term sustainability and improvement.

Executive summary: our delivery schemes at a glance

East Sussex Healthcare NHS Trust

Continuous quality improvement

True North Domains: Patient-centred, Sustainable

Over the next 18 months we will deliver our CQI roadmap:

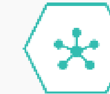
- **Leadership development:** build empowered leaders who can adapt and deliver.
- **Strategy deployment:** cascade a small number of objectives with clear improvement targets and prioritisation of schemes.
- **Quality management:** embed routines, behaviours and tools that give Trust-wide visibility of priorities and metrics and support daily improvement.
- **Centre of excellence:** build central capability to lead critical initiatives, build CQI skills and spread best practice.
- **Comms and engagement:** ensure credible communications and staff support to shift culture and sustain change.
- **BI and analytics:** strengthen performance management, data availability, root cause analysis and data literacy to support accountability and decisions.

How we will measure impact: we will measure impact against our True North Metrics: access standards, avoidable admissions, avoidable harm, patient feedback, staff recommend as a place for care, sustainable breakeven, staff recommend as a place to work, and carbon dioxide (CO_2) emissions. Each has an executive lead and will be continuously measured through the True North metric A3 process to track improvement and support strategic leadership.

Next steps: workshops to agree breakthrough objectives, year 1 measures and reporting.

System transformation

True North Domains: Integrated, Patient-centred, Sustainable

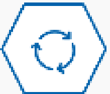


We will deliver system-wide integrated neighbourhood models of care and acute service redesign through Sussex Provider Collaborative (SPC) alliances and place priorities:

- **Cross-cutting care models:** implement new models for Urgent and Emergency Care and Rehab and Intermediate Care Services to improve access, flow and outcomes.
- **Neighbourhood Alliance:** embed Integrated Community Teams (ICTs) as the delivery mechanism for proactive and preventative care for high-need populations, aiming for a 10% reduction in avoidable emergency admissions by March 2027 and a 15% increase in vaccination, screening and cardiovascular checks (focused on underserved communities).
- **Acute Alliance:** deliver key acute redesign programmes including maternity services review, ENT reconfiguration, elective single point of access and advice and guidance and collaborative solutions for fragile services.
- **Place delivery:** develop the Neighbourhood Health Plan, deliver the National Neighbourhood Health Implementation Programme focusing on Hastings and Rother, and progress discharge and joint working across health, housing and care through ICTs and system partners.
- **System networks:** progress Sussex Pathology Network and imaging network delivery, including shared governance, common digital platforms (PACS and LIMS), and the move towards shared reporting and resilient operating models.
- **Art of the possible (shifting care closer to home):** the third year of our programme will include ongoing virtual ward and Home First enhancements and further patient and pathway improvement to support the three shifts.

Productivity, efficiency and sustainability

True North Domains: Sustainable, Patient-centred



We will deliver a focused productivity and sustainability programme to meet our efficiency challenge while protecting patient safety, quality and experience.

- **Programme themes:** income and commercial, commissioning and redesign, surgical and diagnostic productivity, workforce optimisation, operational flow, estates efficiency, digital automation and data maturity, outpatient transformation, procurement and pharmacy.
- **Flow and non-elective improvement:** we are developing schemes to reduce avoidable bed days through delayed transfer of care improvements (c.£4.7m opportunity 2026/27), urgent care productivity (c.£1.9m 2026/27) and community capacity review (c.£3.7m 2026/27).
- **Planned care productivity:** we are targeting improved theatre utilisation (currently 74.2% vs. 80.3% peer average) and reduced variation across elective and diagnostic pathways.
- **Non-pay and digital:** we are developing schemes to deliver procurement and pharmacy savings (medicines c.£1.0m 2026/27, contracting c.£1.0m 2026/27) and targeted automation (digital AI c.£0.10m, robotic process automation c.£0.10m, ambient AI c.£0.03m, 2026/27).

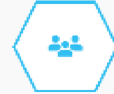
How we will measure impact: delivery of the efficiency requirement, improved reference costs, and gains in theatre utilisation, outpatient utilisation and avoidable additional bed days.

Next steps: validate benchmarking assumptions, building in recent productivity gains achieved through our Clinical Improvement Programme and develop detailed business cases for each scheme, with clear Executive SRO ownership, project management, reporting and governance.

Executive summary: our enabling priorities at a glance

NHS East Sussex Healthcare NHS Trust

Workforce priorities



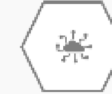
True North Domains: Sustainable, Patient-centred, Integrated

We will strengthen workforce resilience and capability to deliver new models of care, improve retention, and reduce reliance on temporary staffing.

- **Workforce resilience:** improve recruitment and retention, strengthen controls, and reduce reliance on bank and agency.
- **Skills and role redesign:** develop roles and skills aligned to care closer to home, including virtual wards, urgent community response, and integrated community team delivery.
- **Learning and development**: expand supply routes and development pathways, including healthcare support worker induction and care certificate, nursing associate, assistant practitioner, and registered nurse degree apprenticeships, alongside consistent T Level placements across clinical areas.
- **People function capacity:** reshape the People Directorate in line with the human resources target operating model to strengthen capacity and capability for sustained delivery.

How we will measure impact: reduced bank and agency reliance, improved retention and vacancy position, and workforce capacity aligned to the delivery of integrated neighbourhood models and improved flow.

Digital enablers



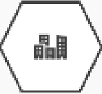
True North Domains: Sustainable, Patient-centred, Integrated

We will strengthen our digital foundations and scale targeted digital change to improve patient pathways, staff experience, safety and productivity.

- **Streamlined patient pathways:** embed digital into pathway redesign from the start, with clear clinical and operational governance.
- **Ease of use and user experience:** reduce friction for staff through simpler access, improved onboarding and leaver processes, and more reliable day-to-day tools.
- **Capabilities and tools for success:** ensure the right equipment and tools, strengthen clinical digital roles for safety and informatics, and support agile working.
- **Data-driven, reliable insights:** improve data quality at source, strengthen reporting and modelling (including demand and capacity), and develop more self-serve insight and decision support.
- **Digital culture, best practice and innovation**: improve digital and data literacy, strengthen communications and engagement, and move towards fewer, better-connected systems.

How we will measure impact: improved user experience and reduced time spent on administrative tasks, improved data quality and timeliness of reporting, and measurable pathway and productivity benefits from targeted automation and artificial intelligence (AI) use cases.

Estates enablers



True North Domains: Sustainable, Patient-centred, Integrated

We will reduce critical infrastructure risk and optimise our acute and community estate to enable safer care, improved flow and delivery of care closer to home, while mitigating the impact of the delayed New Hospitals Programme timeline by seeking additional capital funding beyond the Capital Departmental Expenditure Limit (CDEL).

- **Critical infrastructure risk:** deliver a risk-based, costed programme prioritising high voltage and low voltage electrical infrastructure, alongside ventilation, hot and cold-water systems, lifts, alarms and communications, and building fabric.
- **Strategic estates planning:** develop a phased strategic estates plan across acute and community settings to improve utilisation, support pathway redesign, and enable care closer to home.
- **Delivery capacity and resilience**: ensure sufficient estates delivery capacity (including project management, decant and phasing capability) to deliver investment while minimising service disruption.
- **Asset management and grip:** strengthen asset management and operational oversight to prioritise investment, manage risk and support long-term sustainability.

How we will measure impact: reduced critical infrastructure risk, improved estate utilisation and functional suitability, progress against prioritised investment delivery milestones, supporting safer care and improved flow.

Executive summary: our delivery metrics

East Sussex Healthcare
NHS Trust

Through delivery of our plans over the medium term, supported by an embedded continuous improvement culture, a more resilient workforce, a stronger financial position, and robust governance, data and performance oversight, we aim to consistently meet national standards and expectations and establish the foundation for sustained improvement.

Metric	December 25 position	2026/27 plan	2027/28 plan	2028/29 plan
True North metric – access standards:				
% patients waiting no longer than 18 weeks for treatment	65.2%	67.0%	79.5%	92.0%
Cancer 28-day faster diagnosis standard (FDS)	84.9%	80.0%	80.0%	80.0%
Cancer treatment started within 31 days of decision to treat	96.1%	94.8%	96.0%	96.0%
Cancer treatment started within 62 days of urgent referral	75.8%	80.0%	83.0%	85.0%
Diagnostics – waiting over 6 weeks for a test (DM01)	14.6%	8.0%	5.0%	1.0%
ED 4-hour performance	72.9%	82.0% (year-end)	80.0% (full year average)	85.0% (full year average)
True North metrics – avoidable admissions, avoidable harm, patient feedback, staff recommend as a place for care, sustainably breakeven, staff recommend as a place to work and CO_2 emissions				
Other True North metrics are currently being defined through CQI leadership workshops. These will be added to the plan before the start of 2026/27 to provide a robust framework to monitor the impact of our 5-year plan delivery.				
Workforce metrics				
Total staffing	8,071 WTE	7,937 WTE	7,690 WTE	7,567 WTE
Bank and agency staffing	578 WTE	452 WTE	343 WTE	244 WTE
Finance metrics				
Reported financial position	£1.7m deficit	£0 break-even	£0 break-even	£0 break-even
Efficiency	£35.1m	£74m (9.6%)	£50m (6.9%)	£25.1m (3.4%)

Agenda Item: 11

Report To/Meeting	Trust Board	Date of Meeting	21St April 2026

Report Title:	NHS Staff Survey results 2025
Key question	How will the Board ensure that the proposed unified HR operating model, strengthened executive voice and clearer divisional accountability lead to measurable, sustained improvements in the areas where staff report feeling least heard, least supported, and under the greatest pressure?
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐

Report Sponsor:	Jenny Darwood Director of People	Presenter(s):	Steve Aumayer Deputy CEO/CPO

Outcome/Action requested:	The Trust Board is asked to note the NHS Staff Survey 2025 results for ESHT and the key themes requiring improvement and targeted intervention. The Board is further asked to note that options to strengthen the Divisional delivery model, developed with strategic HR advice, challenge and oversight, will be reviewed and agreed at the Executive meeting in April. This will provide assurance that there is a robust and accountable approach to embedding people experience as a core driver of organisational trust, performance and quality of care.
Executive Summary	This paper provides an overview of the 2025 NHS Staff Survey results for ESHT, highlighting where progress has been made and where focused improvement is required. Over the last year, the Trust has strengthened how insight from the survey informs action: visibility of plans has increased, divisional access to data is improved, and engagement activities have become broader and more inclusive. These changes have contributed to higher response rates across both substantive and Bank colleagues. The results show encouraging signs of cultural progress. Colleagues report stronger experiences of kindness, respect and team working, higher levels of trust in their teams, and pride in the impact they have on patient care. These improvements reflect a resilient and compassionate workforce. However, longstanding cultural and system level challenges continue to limit sustained improvement. Inconsistent executive messaging, variable ownership of people experiences at divisional level, limited triangulation of workforce and patient data, and capacity constraints across both HR and operational teams remain significant barriers. The survey also highlights ongoing concerns around workload, wellbeing, flexible working and development opportunities, also areas where colleagues do not yet feel fully supported or able to influence change. A paper will be presented to the Executive Team outlining proposals for a unified HR operating model, strengthened and consistent executive voice,

	clearer accountability, and Trust-wide people priorities centred on advocacy and experience. Embedding people experience metrics into routine governance and performance forums will be key to delivering sustainable improvement. The Trust Board is asked to note the results and continue to provide strategic oversight as the Trust moves into the next phase of action and improvement planning.

Regulatory/legal requirement:	None identified

Business Plan Link:	Quality ☒	People ☒	Sustainability ☒

Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration

Resource Implication/VFM Statement:	None identified

Risk:	Repeated survey themes with limited improvement undermines morale, retention and patient experience

No of Pages	6	**Appendixes**	0

Governance and Engagement pathway to date:	Full report presented by IQVIA (survey contractors) to executives on 10th February 2026 and to the full Trust board on the 17th February 2026 Paper presented to POD on 26th March 2026

What happens next?	The Embargo lifted on the 12th March 2026. Full results were then made available for all staff to view including access to a fully accessible 'ESHT Dashboard' which will allow any individual staff member to drill down into their teams' results (providing the criteria of more than 10 + completed). A paper to Executives for decisions on the proposal moving forward of a unified HR operating model, which will see assurance and oversight moving to HRBP's. Further changes see a consistent executive voice, strengthened accountability at IPR's and Trust-wide people priorities linked to advocacy: • Recommend as a place to work • Recommend as a place to receive care and treatment. Routine integration of people experiences metrics into IPR, POD and senior leadership forums will help embed a strategic, system wide approach focused on measurable improvement.

Publication	Yes

What is the NHS Staff Survey

The NHS Staff Survey is one of the largest workforce surveys in the world and has been conducted every year since 2003. Each autumn NHS staff in England are invited to take part in the NHS Staff Survey. The survey offers a snapshot in time of how people experience their working lives, gathered at the same time each year.

Its strength is in capturing a national picture alongside local detail, enabling a range of organisations to understand what it is like for staff across different parts of the NHS and work to make improvements. In 2021 the questions were aligned with the NHS People Promise to track progress against its ambition to make the NHS the workplace we all want it to be. The NHS Staff Survey is key to delivery of the NHS Long Term Workforce Plan.

In 2023 the NHS Staff Survey was extended to bank only workers and general practice staff in participating systems following successful pilots.

On the 12th March 2026 the embargo was lifted for us to now share the results for ESHT of the 2025 NHS Staff Survey.

NHS Staff Survey: How improvement is measured

Key NHS Staff Survey indicators:

- Staff engagement score
- Morale theme score
- Advocacy scores:
- ‘Recommend the Trust as a place to work’
- ‘Recommend the Trust as a place for care and treatment’
- ‘You Said, Together We Did’ – evidence of closing the feedback loop which are shared with staff
- Increased participation in the Staff Survey demonstrates improved engagement and confidence

Local workforce metrics:

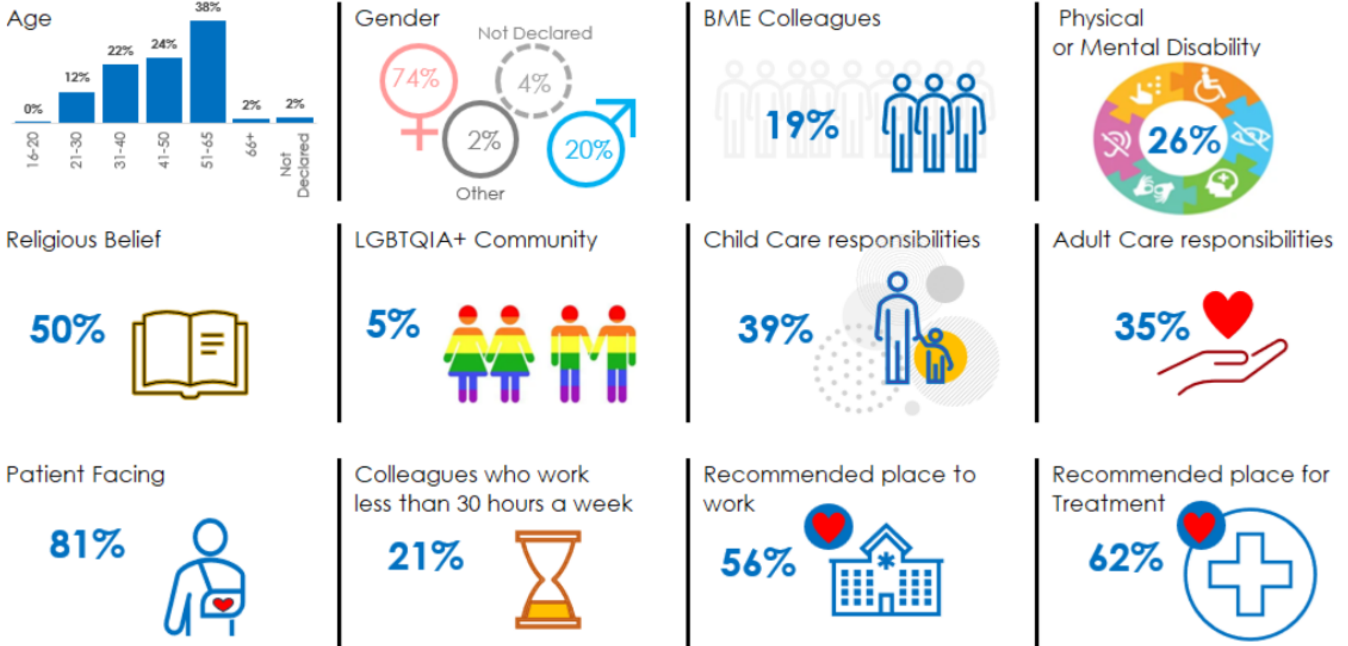
- Sickness absence trends, particularly stress-related absence
- Turnover and retention rates, particularly in high pressure areas
- Employee Relations case numbers e.g. bullying, grievance and misconduct
- DCIQ incident volume and themes, particularly concerning civility and behaviour
- Patient experience measures e.g. FFT and PALS
- Culture and Leadership

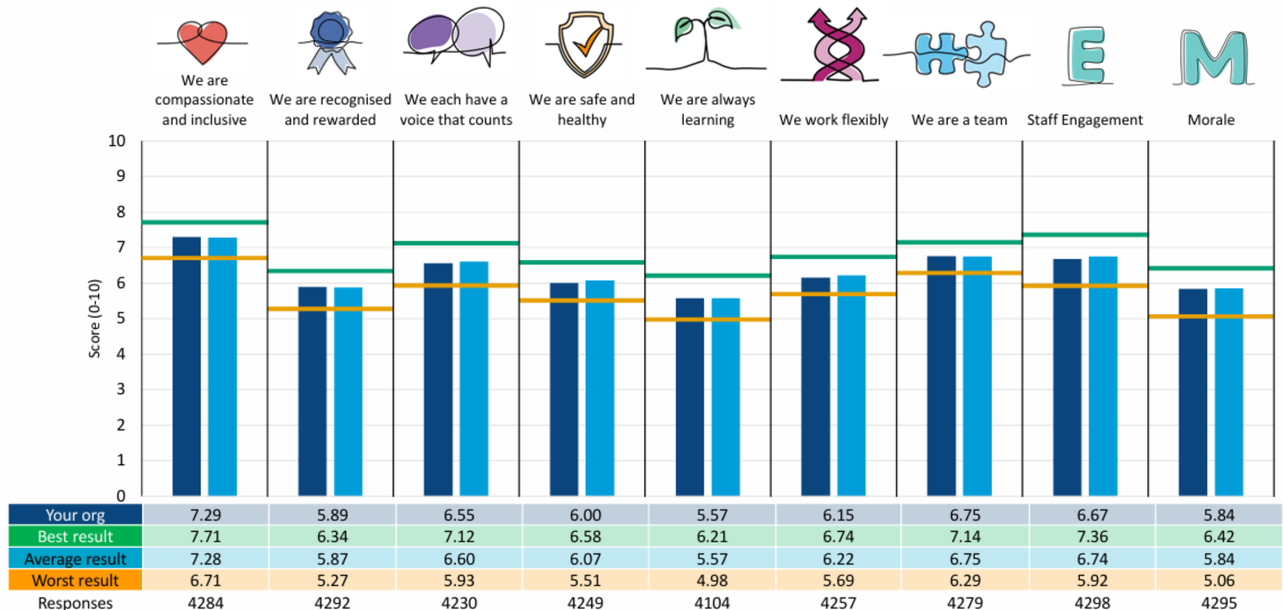
Summary of NHS Staff Survey 2025 results for ESHT

Bank staff – there has been a delay from the co-ordination centre on the breakdown of participant profiles and at the time of writing this report this have not been available.

Number of surveys sent – **591**
Number of surveys returned – **198**
Response Rate – **33.5%**
Number of surveys not completed – **393**

Our response rate for bank staff is the highest within the system





	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.29	5.89	6.55	6.00	5.57	6.15	6.75	6.67	5.84
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	4284	4292	4230	4249	4104	4257	4279	4298	4295

What do the results tell us

People's honest reflection has given us a vital understanding of what it feels like to work here. The results show that kindness, respect and team working continue to strengthen, and many of our colleagues told us they feel trusted by their colleagues and proud of the difference they make for patients every day. These strengths speak to the compassion and dedication at the heart of our organisation

The survey highlighted important areas where we have opportunities to improve. Many colleagues want a stronger voice in decisions that affect their work, more consistent support with workload and wellbeing, and better access to meaningful development.

Flexible working also remains a priority, but colleagues feedback tells us that experiences vary across teams. These insights give us a clear focus for change and reinforce our commitment to improving the things that matter most to our people.

Positive Improvements and Strengths

Compared with 2024, we achieved nine significant improvements at question level, including:

- Feeling that our roles make a positive difference to patients (+2.3%)
- Improvements in kindness, understanding, respect and team cohesion (several questions improving by +2-3%)
- A decrease in experience of harassment, bullying or abuse from other colleagues (+2.9%)
- Reductions in discrimination experienced from managers or colleagues (improvements of –1% to –1.6%)

Bank colleagues also reported positive experiences in several areas, including strong team relationships, kindness from colleagues and high levels of trust to do their job. They also told us they feel their work makes a real difference to patients.

Our trust, like many others in the NHS, faced a tough year. These gains reflect the incredible spirit of our workforce in their ability to make cultural progress toward compassion, respect and psychological safety, despite often difficult conditions

Strong People Promise Subthemes NHS England Our People Promise

Although no overall People Promise theme scored significantly better than similar organisations, the 'Inclusion' subtheme under 'We are compassionate and inclusive' was significantly better, marking a key organisational strength.

For Bank colleagues the People Promise areas of compassion, inclusion and teamwork were also strong and Bank staff scored highly on feeling respected by colleagues and being part of supportive teams. These results highlight the strong foundations we have built around kindness, fairness and respect.

Stability in Engagement and Morale

Overall Staff Engagement and Morale remain stable compared to 2024 for both substantive and Bank colleagues, despite wider organisational challenges, which is an indicator of continued dedication across our workforce. However, there remain important areas that need greater focus and improvement to make a difference when we all come to work.

Where Action is Needed: People Promise Themes Requiring Action

Three People Promise themes scored significantly worse than similar organisations:

- We each have a voice that counts
- We are safe and healthy
- We work flexibly

Additionally, under 'We are always learning' there has been a significant decline compared with what our results in 2024 told us for both substantive and Bank colleagues, with colleagues sharing challenges around influence and empowerment.

Key statistics included:

- Only 25.3% felt their appraisal helped them improve their work.
- Just 23.5% reported rarely experiencing unrealistic time pressures

Bank colleagues also fed back that they feel less involved in decisions affecting their work, and many told us they would welcome more opportunities to contribute their ideas to help shape how services run.

These findings show that many colleagues do not yet feel fully heard, involved or supported to drive improvement. Improvement in healthcare is made through many small steps – improving a patient's experience, refining processes, supporting colleagues, or finding smarter ways to work. While the individual improvements might seem small, together they amount to steady progress, and it is vital that everyone in our trust feels empowered to be able to stand up and promote opportunities to makes things better. We are working hard to ensure this is the case for everyone. A paper to executives with recommendations and priorities will be presented in late March. We will return to POD with the outcome of that paper.

In Health, Safety and Wellness, key concerns included:

- Only 27.8% feel there are enough staff to do their job properly.
- 58.1% have come to work despite not feeling well enough.
- Increased experience of burnout, with the burnout subtheme scoring 4.86.

Where focused interventions and leadership attention were sustained in 2025, the Trust saw positive improvement in priority cultural areas, including:

- Sexual safety – work aligned with the NHS England Sexual Safety Charter has strengthened governance, reporting mechanisms and support for managers through user feedback and learning sessions.

- Discrimination and bullying/harassment reporting – collaborative work with the Safety, Effectiveness and Compliance team has begun to improve DCIQ user experience, reduce delays and rebuild trust in reporting.

- Burnout and stress reduction – enhanced wellbeing interventions, including restorative supervision and action learning sets, contributed to the Trust achieving the East Sussex County Council Gold Award for Wellbeing at Work, demonstrating organisational commitment to staff wellbeing. The strengthened Team Stress process has supported managers and teams to co-develop actions that reduce work-related stress, improving team climate and local working relationships.

- Our Values and Behaviours Framework and Behaviour Charter are being integrated into core people processes including recruitment, induction (with a strong presence at the Corporate Welcome), appraisal, career progression and recognition. Clear guidance and resources are available on the extranet to help teams translate our values into everyday practice, and we have worked with medical colleagues to embed these behaviours into medical appraisal.

- To support colleagues in applying these principles we launched Living our Trust Values – Behaviours and Allyship, a practical bite-sized learning session designed to show what kindness, inclusivity and integrity look like in action. The session focuses on how we work together and treat each other, helping strengthen team cultures of safety and belonging, and will shortly be accessible via MyLearn.

- In October 2025, we also introduced the Allyship Programme, with a toolkit and bitesize learning to help colleagues feel confident in taking meaningful everyday action and demonstrating visible advocacy for underrepresented groups.

- All actions from the Too Hot to Handle listening events have now been completed, with delivery embedded across four workstreams—Process and Policy, Engagement, Communications, and Training and Education. This ensures continued focus on improving how we prevent and respond to bullying, harassment and discrimination while building confidence in speaking up.

- Our staff networks continue to expand in reach and influence, supported by strengthened governance and clearer roles. Networks provide vital routes for colleague voice, peer support and co-production, and this year we also continued to build on our commitments as a Veteran Aware Trust, strengthening support for the Armed Forces community. In October, we were proud to host the Sussex-wide Black History Month Conference, bringing colleagues together to reflect, learn and celebrate, reinforcing our commitment to tackling inequalities and fostering inclusion.

- To provide more regular insight into colleague experience, the quarterly National People Pulse Survey was relaunched in January 2026. The survey will complement the annual NHS Staff Survey by offering real-time feedback that can be triangulated with workforce and patient experience data, enabling quicker and more evidence-based action.

- The Partnership Forum is also being refreshed to make it stronger and more engaging. Improvements include clearer governance to track progress, meeting debriefs that close feedback loops, and a development framework to help members make the most of their role in shaping staff experience across ESHT.

In Conclusion and proposed changes under consideration.

Integrated HR approach
A strengthened collaborative approach between People Engagement, HR Business Partners and Workforce Systems will deliver an insight-driven model across all divisions, with triangulated divisional insights.

Consistent Executive Voice
Shared key messages reinforcing the importance of prioritising people experience, named executive leads for each priority and clear escalation routes will provide strengthened, aligned leadership across the Trust.

Clear Divisional Accountability
Triumvirates will own their results and demonstrate measurable impact through IPR and POD, supported by targeted insight and challenge from People Engagement and HR Business Partners.

Structured Improvement
A programme of regular insight-driven activity will be strengthened to support divisions to take timely, evidence-based action on persistent survey themes:

Monthly Insight Reviews
Each month, People Engagement, HR Business Partners and Workforce Systems will jointly review divisional data, including Staff Survey and People Pulse themes, workforce indicators such as sickness, ER cases and turnover.

Quarterly Divisional Improvement Workshops
Facilitated workshops to include the divisional triumvirate, HR Business Partner and People Engagement to review trends, share learning and prioritise persistent cultural themes and use triangulated data to strengthen the evidence base for decision-making. It is anticipated that this approach will enhance accountability, with responsible leads being identified and shared problem-solving.

Targeted Support for Persistently Challenged Divisions
Divisions showing little progress or recurring themes will receive dedicated support, including deep-dive analysis, training on data interpretation and hands-on action plan development. This approach will speed up progress in areas with long-standing issues.
Meaningful progress has been made in improving visibility, engagement and access to survey insights and staff confidence in the value of providing feedback continues to grow. To deliver lasting cultural change we will be looking further strengthen our approach with clear priorities, better triangulation of data to continue building a culture where colleagues feel heard, valued and confident that raising concerns leads to action, and where colleague experience is recognised as fundamental to high-quality, safe patient care.

NHS East Sussex Healthcare NHS Trust

Agenda Item: 12

Report To/Meeting	Trust Board meeting in public	**Date of Meeting**	25th March 2026
Report Title:	Q4 2025/26 Board Assurance Framework		
Key question	The Board is asked to: 1. Review and note the position of the BAF risks assigned to it		
Decision Action:	For approval ☒ For Assurance ☐ For Information ☐ For Discussion ☒		
Report Sponsor:	Richard Milner, Chief Of Staff	**Presenter(s):**	Richard Milner, Chief Of Staff
Report Authors:	Richard Milner, Chief Of Staff and Pete Palmer, Board Secretary		
Purpose/Outcome/Action requested:	The Board is asked to consider, discuss and note the report.		
Executive Summary	This report provides an overview of the risks on the BAF; these are reviewed by the Finance and Performance Committee, People and Organisational Development Committee and Quality and Safety Committee and overseen by the Audit Committee. BAF 1 continues to be rated at 9, reflecting the buoyant recruitment market for ESHT which is driven in part by pressure in other parts of the health and care sector. BAF 2's rating has increased to 20 following the outcomes of the annual staff survey which demonstrate that there has been a decline in staff engagement scores compared with 2025 and that the organisation's score is significantly worse than sector average. The rating for BAF 3 remains at 20, reflecting the increased financial challenges faced by the organisation in 2025/26. The Trust is forecasting a breakeven position but has significant risks with a most likely outturn of circa £5m deficit at the time of writing. BAF 4's rating remains at 20 reflecting that the Trust's capital budgets are insufficient to support the aging infrastructure. Without significant financial support, the future risk profile is unlikely to change. BAF 5 remains at 16 which is the limit of our risk tolerance. The primary aim for this risk during 2025/26 is to ensure that it does not exceed risk tolerance. BAF 6 also remains at 16, the limit of our risk tolerance. Again, the primary aim for this risk during 2025/26 is to ensure that it does not exceed risk tolerance. It is hoped that the risk level will reduce from 16 to 12 in Q4 once fixed term resource is procured and information reports and dashboards are utilised from the Federated Data Platform. The rating for BAF 7 remains at 12 reflecting continued positivity about EPR implementation and the potential benefits that AI initiatives they might bring to the organisation.		

	BAFs 8 and 9 remain at 16 reflecting a challenging winter period; the rating did not reduce in Q4 as the impact of winter pressures continued to be seen, with delivery requiring collaborative and concerted efforts of the health and wider care sector, which are similarly stretched. Looking forward, we anticipate that many if not all of these risk areas will persist throughout 2026/7 and so we are aligning these against the new trust strategic approach, with the True North domains and breakthrough metrics ahead of the Q1 report.

Regulatory/legal requirement:	The Trust Board is required to have a Board Assurance Framework in place as it one of the key sources of evidence to support for the preparation of the Annual Governance Statement.
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration
Resource Implication/VFM Statement:	Outcomes focus: achieving the best sustainable outcomes for patients and service users by encouraging continuous improvement, clinical excellence and value for money
Risk:	Failure to monitor risks may result in the Trust not monitoring triggers which will prevent

No of Pages	2	**Appendixes**	1

Governance and Engagement pathway to date:	Each BAF risk has been reviewed by the Executive Risk Owner and the Chief of Staff. Collectively the full BAF is reviewed at Executive Directors and shared quarterly with the Audit Committee before going to the next scheduled Trust Board. Each Board sub-committee is expected to review the BAF risks it oversees four times a year. This typically takes place one month after the end of each FY quarter.
What happens next?	Work will continue on agreeing the strategic risks which will be included within the 2026/27 BAF.
Publication	This front sheet and the Q4 BAF are appropriate for publication.

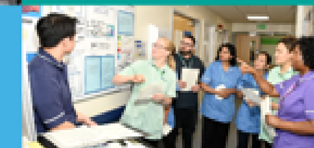
East Sussex Healthcare NHS Trust

Q4 Board Assurance Framework

- Summary of current & future strategic risk profile
- Risk-by-Risk analysis

KINDNESS

INCLUSIVITY

INTEGRITY


Trust Board Meeting in Public, 21st April 2026

2025/6 BAF: Overview of changes made and Q4 view on current and future risk profile

Summary of **Q4** risks

- The Q4 assessment reflects significant risks that the Trust has faced in terms of quality, people and finance over 2025/26. Only two BAF risks are below the limit of the risk tolerances set for this year and three risks, BAF 2, BAF 3 and BAF 4, exceed their risk tolerances reflecting the significant degree of risk we recognise that we are carrying around staff morale, finances and estates.
- There continues to be confidence going forward as regards BAF 1 (attracting, retaining and developing the right people) due to the buoyant recruitment market for ESHT, driven in part by pressure in other parts of the health and care sector.
- The rating for BAF 2 has increased in Q4 from 16 to 20 following the outcomes of the annual staff survey which demonstrate that there has been a decline in staff engagement scores compared with 2025 and that the organisation score is significantly worse than sector average, and we recognise there is more work to do in this area
- The rating for BAF 3 remains at 20 in Q4, reflecting the significant challenge of delivering savings schemes of around £80m in 2025/26. The Trust is forecasting a breakeven position but retains significant risks with a most likely outturn of circa £5m deficit at the time of writing.
- BAF 4's rating remains at 20 reflecting that the Trust's capital budgets are insufficient to support the aging infrastructure. Without significant financial support, the future risk profile is unlikely to change.
- BAF 5 and 6 scores reflect the structural challenges we have faced in these areas – with both sitting at their tolerance levels. The primary aim this year in these two areas will be undoubtedly the prevention of exceeding their tolerances, rather than reducing the scores in year
- BAF 7 reflects the positive moves on EPR implementation, the increased activity around AI initiatives and the potential benefits these may together bring
- BAF risks 8 and 9 remain at 16 reflecting a challenging winter period; the rating did not reduce in Q4 as the impact of winter pressures continued to be seen, with delivery requiring collaborative and concerted efforts of the health and wider care sector, which are similarly stretched.

Forward look to Q1 2026/7

- We are aligning our strategic risks to the revised set of true north domains and breakthrough metrics for the Q1 review
- Perhaps unsurprisingly, we anticipate little change in the focus of the strategic risks for next year – our key areas will continue to include finance (breakeven), culture (morale) and the environment (estates) as well as cybersecurity, quality and performance
- We are also considering whether any of these risks would need to remain a BAF risk next year (or move to the corporate risk register). Currently we are considering whether the recruitment risk is better dealt with as a corporate risk – based on its score during the year and the changed marketplace

2025/6 BAF: Q4 summary position

BAF Ref	Risk Summary	Monitoring Committee	Inherent Risk	2025/26 Quarterly Position				Change	Risk Tolerance	Risk Appetite
				Q1	Q2	Q3	Q4			
1	Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time.	POD	15	9	9	9	9	◄ ►	No higher than 16	Significant
2	Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.	POD	20	16	16	16	20	▲	No higher than 16	Cautious
3	We fail to use our resources as efficiently as possible and do not improve services for patients.	F&P	20	15	20	20	20	◄ ►	No higher than 16	Seek
4	The Trust's aging estate and capital allowance limits the way in which services and equipment can be provided in a safe manner for patients and staff.	F&P	20	16	16	20	20	◄ ►	No higher than 16	Seek
5	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack.	F&P	20	16	16	16	16	◄ ►	16	Minimal
6	Failure to attract and develop business intelligence limits insightful and timely analysis to support decisions.	F&P	16	16	16	16	16	◄ ►	No higher than 16	Seek
7	Failure to transform digitally and deliver associated improvements to patient care.	F&P	16	12	12	12	12	◄ ►	No higher than 16	Seek
8	Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that are discharge ready with an extended length of stay.	Q&S	20	16	16	16	16	◄ ►	No higher than 16	Cautious
9	Failure to meet the four-hour clinical standard.	Q&S	20	16	16	16	16	◄ ►	No higher than 16	Cautious

Risk tolerance exceeded

1. Risk Summary

Reference & title	BAF 1: Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time.		
Description	There is a risk that the available workforce does not meet the organisation's resource requirements in the short, medium and long term		
Lead executive	Director of People	Lead Committee	People and Organisational Development
Date last reviewed	04/03/2026		

Fit with Trust corporate priorities

LOS	Workforce	Income	Bus Case	Digital
✓	✓	✓		

Risk(s) rated 12 and over aligned

- Delay in Surgical treatment
- Delay in out of hours patient assessment
- Nursing vacancies
- Cellular pathology consultant vacancies
- Delayed radiology reporting
- Children's ED services
- SDEC operation
- Paediatric dietetic appointments
- Occupational therapist vacancies
- Delays to triage assessment
- Cardiology staffing
- Stroke service staffing
- Enhanced observation staffing
- SALT demand
- Cellular pathology staffing
- Mortuary staffing
- Ultrasound staffing
- Phlebotomy service demand
- Specialist MRI staff
- Pharmacy staffing
- ODP staffing
- Orthotic service delivery
- 24/7 Blood sciences service
- District Nursing provision
- CIC service team capacity

2. Risk Scoring

Inherent risk *If there were no mitigations*		Current risk level *Assessment based on evidence*			
		Q1	Q2	Q3	Q4
Likelihood	5	3	3	3	3
Impact	3	3	3	3	3
Risk level	15	9	9	9	9

Rationale for current risk level
Evidence that provides assurance of current risk level

There are recognised national shortages of roles within some specialities. We have small pockets where we have higher risk, such as stroke and microbiology which are requiring short to medium term temporary workforce solutions. The Trust's vacancy level as of January 2026 was 3.1%.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Significant

Forward forecast of risk level

Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

It is anticipated that the risk rating will remain as a 9 due to the buoyant recruitment market and planned apprenticeship pathways. We also have workforce reduction programmes where staff will be redeployed into vacant roles; nationally the NHS recruitment external market is subdued and NHS workforce reduction programmes are being undertaken nationwide. We have national hard to fill specialities of which we have mitigations in place to maintain a minimum service level.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- None identified

3. Providing assurance
Additional actions that can be undertaken to support mitigations

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Local outreach initiatives	CPO	March 2026	• Campaign to increase volunteer numbers across the Trust in progress; recruitment campaign planned for March. • Formalised agreement for construction students for estates and facilities workforce pipeline • Apprenticeships developed for estates and facilities staff • Targeted campaigns with Eastbourne College to support candidate pipelines • Designing, in conjunction with Eastbourne College, placement opportunities for non-clinical placements • Plan for 20 short term placements for 2025/26 for hair and beauty and sports students	Amber
2	NHSE requires five-year workforce plan	CPO	Feb 2026	• Submitted our first draft of the workforce plan • Next full plan submission to regional team due in February 2026	Green
3	Implementation of the Improving Resident Doctors Working Lives 10 point plan	CPO	April 2025	• Appointed two fixed term interim resident doctor leads, who report to CMO • Quarterly presentations of progress against 10 point plan at ELT, POD and Board • Monthly meeting with resident doctor leads and integrated education lead	Green
4	Areas or services with vacancies due to national shortage and where international recruitment has not been successful. Targeted support to design an alternative workforce model able to respond to increase of surge of activity.	CPO	June 2026	• Establish task and finish group and TORs • Progress action plan and recruitment strategy • Reporting into HRSLM	Red

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy/procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Monthly reviews of vacancies together with vacancy/turnover rates • Review of nursing establishment six monthly as per Developing Workforce Safeguards • Workforce efficiency metrics and monitored • Regular meetings with Regional Post Graduate Deans for Acute and Primary care • Quarterly reviews in place to determine workforce planning requirements. • NHSE five-year workforce plan • Improving Resident Doctors Working Lives leads • Flexible working request audit • Nursing and midwifery monthly rostering review panel • Strengthened rostering systems controls to ensure roster changes are signed off at senior nursing level	• Vacancy control panel ToRs revised to incorporate all workforce requests • Workforce strategy aligned with workforce plans, strategic direction and other delivery plans and metrics reviewed by POD and Trust Board • Establish quarterly reviews of NHS grip and control measures • Wellbeing offering enhanced (includes Pastoral Fellows support) and reviewed by POD • Skills for the future audit undertaken to map educational programmes against future clinical strategies	• Triangulation of National Staff Friends and Family Test reports, reviewed by POD • ICB Quarterly Workforce meetings • Internal audit review reports on effectiveness of workforce policies and processes • NHS Staff Surveys and Pulse Surveys and benchmarking data

1. Risk Summary

Reference & title	BAF 2: Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.
Description	There is a risk that any decline in staff motivation negatively impacts on our ability to deliver the required levels of activity to the standards we require.

Fit with Trust corporate priorities

LOS	Workforce	Income	Bus Case	Digital
✓	✓	✓		

Lead executive	Director of People	Lead Committee	People and Organisational Development	Date last reviewed	04/03/2026

Risk(s) rated 12 and over aligned

- Violence and Aggression in Urgent Car
- Staff absence
- Lone worker device training compliance
- Triage delays
- Cardiology staffing
- Joint antenatal clinic capacity
- Admin space in cardiology
- UCR and Virtual Ward team environment
- V&A in Intermediate Care
- JCR demand
- EDGH Phlebotomy clinic environment
- Cellular path lab staffing
- Microbiology freezer
- Phlebotomy service demanc
- Radiology dept. security
- Pharmacy capacity
- Ventilation systems
- V&A Trustwide
- Impact of V&A on staff wellbeing
- Staff engagement
- Community equipment prescribin
- Delivery and Loading activities
- Waste storage capacity
- EDGH Digital leaking roof
- Acute physio and OT environment
- Kipling/SSPAU environment
- EDGH Digital Hub environment
- Neuro physio O/P appointments
- Bexhill DSU theatre light

2. Risk Scoring

Inherent risk *If there were no mitigations*

Current risk level *Assessment based on evidence*

	Inherent risk	Q1	Q2	Q3	Q4
Likelihood	5	4	4	4	5
Impact	4	4	4	4	4
Risk level	20	16	16	16	20

Rationale for current risk level *Evidence that provides assurance of current risk level*

The outcomes of the annual staff survey demonstrate that there has been a decline in staff engagement scores compared with 2025 and that the organisation's score is significantly worse than sector average. Morale score has not decreased in year and is not a sector outlier. The survey denotes that there has been a decline in the sub-score of work pressure.

Risk tolerance *Acceptable range/boundaries of risk score*

No higher than 16

Risk appetite *Amount/type of risk accepted/taken*

Cautious

Forward forecast of risk level

Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

Improved communication and wider dissemination of staff survey results to improve awareness and engage staff through a wider platform to develop meaningful actions that will improve the organisation as a place to work. Executives have identified priorities of recommending the place to work is a key objective for all divisions and services to improve. We recognise that the annual survey is a snapshot recorded yearly and therefore quarterly pulse surveys will monitor progress against this objective. We hope to see some improvement by Q2 2026/27.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- None identified

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Development of actions from the staff survey	DoP	April 2026	• A Staff Survey dashboard has been developed and will be shared with divisions • Engagement of wider stakeholder groups i.e Staff Partnership Forum and Networks to support communication and improvement actions aligned to the staff survey results. • Revised engagement plan to be developed and approved at ELT • Embed Quarterly Pulse Survey.	Green
2	Winter wellness and seasonal vaccination plan	DoP	July 2026	• Seasonal vaccination group to undertake a review of 2025 vaccination and wellness programme. • Develop 26/27 Seasonal Vaccination plans- incorporating best practise from both National and Local feedback .	Green
3	Trust Awards	DoP	Sept 2026	• Date set for 2026 Trust awards of 17th September at De La Warr Pavilion • Initial event planning in progress.	Green
4	Measures to support staff and leaders in managing work-based stress	DoP	Sept 2026	• Comprehensive package of support for staff impacted by Trauma related events i.e TriM- Psychological Support already in place and embedded • Review of Psychological Wellbeing Safety of Staff Policy focusing on update of Team Stress Assessments. • Procurement of Psychology Service supporting Restorative Supervision • Review and development of new programme for colleagues and leaders - Mental Health Awareness Training	Green

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Ongoing monitoring of, and response to, key workforce metrics/staff survey • DME monitors and reviews 'trainees in difficulty' register • Workforce efficiency an availability reviews considering registered and unregistered nurses, and AHPs • Ongoing reviews of effectiveness and efficiency of rostering • Task and finish focus groups in place to support key remedial actions in response to staff/GMC surveys	• Workforce metrics reported to executive team, POD and Trust Board – increased compliance with completion of risk assessments • Oversight and monitoring by Health and Safety Steering Group • Deep dive cultural reviews	• Health and Safety Executive review of violence and aggression • GMC outcomes have action plans with quality virtual visits in place to provide assurance to HEEKSS/Trust • Improving doctors working lives

1. Risk Summary

Reference & title	BAF 3: We fail to use our resources as efficiently as possible and do not improve services for patients.			Fit with Trust corporate priorities			
Description	The Trust has agreed a breakeven plan with detailed supporting schemes (both recurrent and non-recurrent) which will help move the organisation to become financially sustainable. NHS England has been clear that organisations need to live within their financial envelopes.			LOS ✓	Workforce ✓	Income ✓	Bus Case ✓ / Digital ✓
Lead executive	Chief Finance Officer	Lead Committee	Finance and Performance	Date last reviewed	04/03/2026		
Risk(s) rated 12 and over aligned	• District nurse responsiveness • Working capital – cash • Building CQI culture • Paediatric allergy service						

2. Risk Scoring

Inherent risk *If there were no mitigations*

Current risk level *Assessment based on evidence*

	Inherent risk	Q1	Q2	Q3	Q4
Likelihood	4	3	4	4	4
Impact	5	5	5	5	5
Risk level	20	15	20	20	20

Rationale for current risk level

Evidence that provides assurance of current risk level

The Trust is forecasting a breakeven position but has significant risks with a most likely outturn of circa £5m deficit for 2025/26. The Trust submitted a non-compliant plan with a deficit of £21.2m for 2026/27 and a CIP target of £53m (6.8%).

Additional controls have been put in place during the year including a vacancy control panel and discretionary non-pay control panel. These have decreased the level of spend but will probably not mitigate all of the financial risks.

Progress on schemes is being monitored on a weekly basis. Monthly reports go to the Finance and Performance Committee. Additional resource has been brought in to help develop CIP plans for 2026/27 and beyond.

Risk tolerance

Acceptable range/boundaries of risk score

No higher than 16

Risk appetite

Amount/type of risk accepted/taken

Seek

Forward forecast of risk level

Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

We anticipate that this will remain the same for 2026/27.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Lack of clarity about business case approval.
- Lack of divisional influence in capital prioritisation.
- There are some skills gaps within the finance team which are being addressed.
- Service level reporting has been reintroduced on a quarterly basis. The aim is to move this to monthly reporting in Q4 2026/27.

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Currently developing new Standard Operating Procedure (SOP) for business cases	CFO	April	• Due to report in April	Amber
2	Work has been undertaken to increase divisional influence in capital prioritisation	CFO	March	• Divisions have been involved in final capital plan for 2026/27 and beyond. • Work is complete	Blue

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Weekly report to Executive Leadership Team (ELT) from Project Support Office on progress of schemes • Vacancy control panel approves internal and external recruitment on a weekly basis. • Non-pay review panel meets weekly	• Oversight by Use of Resources Programme • Regular reporting to Trust Board and relevant committees • Divisions held to account for overall financial performance through IPR process based on budgets agreed through the Divisions and Executive. • Monthly Use of Resources meeting	• Internal audit review reports • ICB oversight • NHSE oversight

1. Risk Summary

Reference & title	BAF 4: The Trust's aging estate and capital allowance limits the way in which services and equipment can be provided in a safe manner for patients and staff.	Fit with Trust corporate priorities				
		LOS	Workforce	Income	Bus Case	Digital
Description	There is a risk that there may be unplanned outages in equipment, buildings and facilities not being available for clinical purposes	✓		✓	✓	

Lead executive	Chief Finance Officer	Lead Committee	Finance and Performance	Date last reviewed	04/03/2026

Risk(s) rated 12 and over aligned

- Lift failures CQ and EDGH
- Ward decant capacity
- Isolation facilities
- Clinical environment maintenance
- External cladding
- Insufficient acute winter beds
- Radiology reporting
- Critical Care environment
- Oxygen provision
- ED environment for children
- Maternity/obstetric footprint
- Conquest SDEC
- Children and YP with psycho-socia challenges
- Face to face triage
- SPH medical record capacity
- EDGH and CQ roofs
- HSDU roof
- Access control system
- Roads and pathways
- Oxygen admin on medical wards
- Obstetric theatre annex
- Cardiology clinical & admin space
- UCR and virtual ward environment
- Physiotherapy facilities
- EDGH phlebotomy
- Pathology environment
- Radiology air conditioning
- Microbiology freezer
- Radiology emergency alarm call
- Radiology security
- Ventilation systems
- Pneumatic tube system
- Nurse call systems
- Heating failure
- Obsolete medical devices
- Plant room waste storage
- Wheelchair accessible cubicles, radiology
- General radiology modality
- Audiology sound treated rooms
- UIS Fire doors
- Paediatric audiology
- Fire safety, Conquest
- Fire safety, EDGH
- Bed rails and bed grab handles
- Digital hub roof
- Acute physio environment
- Kipling/SSPAU environment
- Building management system
- IPS and UPS systems
- Fire safety, Bexhill
- Digital Hub environment
- Bexhill DSU theatre light
- Mortuary premises and equipment

2. Risk Scoring

	Inherent risk *If there were no mitigations*	Current risk level Q1	Q2	Q3	Q4
Likelihood	5	4	4	5	5
Impact	4	4	4	4	4
Risk level	20	16	16	20	20

Current risk level: Assessment based on evidence

Rationale for current risk level
Evidence that provides assurance of current risk level

The Trust's capital budgets are insufficient to support the aging infrastructure (estates, equipment, digital). The impact of this is temporary solutions to resolve urgent issues. National funding is uncertain and opaque and therefore it is very difficult to plan in a strategic manner.

Analysis has been performed to identify capital needs in relation to backlog maintenance, replacement of medical equipment and digital investment. This information will be used to prioritise capital awarded for the medium-term financial plan.

On 6 January 2026 the power supply to EDGH was interrupted and back up power failed leaving the site without electricity for circa two hours. This was caused by external and internal factors but primarily due to aging infrastructure. Consequently, power failure is a question of when rather than if and therefore the likelihood score has moved to 5.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Seek

Forward forecast of risk level
Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

We have compiled a ten-year investment backlog programme which has been presented to the Executive Leadership Team and F&P. This has provided a focus on five key areas of risk and prioritisation about how we address those over the next 5-10 years. In addition, future bids will be made as we understand £5bn has been earmarked nationally for critical infrastructure risks for the next four years. However, there is no certainty as to the levels that may be awarded to the Trust, having submitted estates safety fund bids to the South East region NHSE.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Longer term capital programme has been produced; however, significantly more capital is required to address this than is available to the Trust.
- New Hospital Programme/BFF funding envelope delayed until at least 2037 and timeframe and scope/extent of work against the funding allocation is not clear at present

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Trust undertook a medium-term financial plan	CFO	Q4	• Submitted	Blue
2	External funding opportunities	CFO	As opportuni-ties arise	• The Trust will continue to bid for funding through ICS and national programmes as and when opportunities occur, supported by F&P and the Trust Board	Amber

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Day to day management of infrastructure and prioritisation by services	• Oversight by Finance and Performance Committee • Estates and Facilities IPR • Clinical procurement group in place • Prioritisation decisions about capital expenditure are made by CRG, BDG and F&P	• Capital business cases reviewed by NHSE • External review report of critical infrastructure

1. Risk Summary

Reference & title	BAF 5: Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack.	Fit with Trust corporate priorities				
		LOS	Workforce	Income	Bus Case	Digital
Description	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack			✓		✓

Lead executive	Deputy CEO	Lead Committee	Finance and Performance	Date last reviewed	16/ 03/2026

Risk(s) rated 12 and over aligned

- Network infrastructure devices
- Software vulnerabilities
- Cyber attack
- Multi factor authentication
- Unsupported servers
- Password control
- Control of network connectivity
- Firewall vulnerability

2. Risk Scoring

Inherent risk *If there were no mitigations*		Current risk level *Assessment based on evidence* Q1	Q2	Q3	Q4
Likelihood	5	4	4	4	4
Impact	4	4	4	4	4
Risk level	20	16	16	16	16

Rationale for current risk level
Evidence that provides assurance of current risk level

A number of elements of the cyber action plan have been delivered, reducing our cyber exposure. There are a number of robust controls in place, but further mitigation can be achieved by implementing a formal programme of work that addresses the wider information security agenda.

A significant amount of work has been done to increase the robustness of the Trust Cyber security posture.The current security risk status has reduced which has been a great achievement, but the threat level in the NHS has increased with a number of attacks on NHS Trusts or provider organisations.

Cyber maturity has improved over the last six months, which has reduced the Trust from a high to a mediumrisk status. We are no longer looking to deliver Cyber Essentials as this has now been incorporated into a new version of the Data Security Protection Toolkit (DSPT) called Cyber Assurance Framework (CAF).

Risk tolerance
Acceptable range/boundaries of risk score

16

Risk appetite
Amount/type of risk accepted/taken

Minimal

Forward forecast of risk level

Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

The cyber action plan, which is presented to the Audit Committee, has four elements: Internal Audit recommendations, CAF Self Assessment, External Penetration Test recommendations, 10 risks on the trust risk register

Two of the key actions to achieve the anticipated risk level of 12 will be to deliver the active directory migration and a further reduction in unsupported legacy systems along with the Conquest core LAN migration.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Deliver on the CAF action plan
- Obtain CAF to provide assurance on reliability and security of systems and information
- Continue with patching programme and address points raised by internal audit
- Cyber Action plan developed which sets out all of the actions that would need to be taken to mitigate cyber risks

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Cyber Assurance Framework	DCEO	June 26	• Internal CAF self-assessment completed which identifies gaps in compliance • Gaps have been used to create the cyber action plan • CAF action plan agreed with Regional teams • Refreshed cyber five-year strategy and awaiting approval	Green
2	Medical devices with network connectivity asset list	DCEO	March 27	• Increased visibility across EDGH and risks identified • Further work required to enable greater visibility across Conquest • Anticipate that full visibility will be delivered at EDGH by end of March 2026 • Conquest delivery anticipated in 2026/27	Amber
3	LAN Refresh EDGH	DCEO	March 26	• Migration of Edge network over the course of 2025/26- now moving to 2026/27 • Delay due to contractor and staff sickness	Red
4	LAN Refresh Conquest	DCEO	March 27	• Replace the Core Network and Fibre connections to the Edge Switches • Edge Switch replacement underway • Fibre network now installed and should be complete by end of March • Planning underway for Core cut over • Large dependency on Estate work	Red
5	Active directory migration	DCEO	May 26	• Migration of users and devices has started and is over 65% complete • Migration of services during 2026	Amber
6	Windows 11 migration	DCEO	May 26	• Migration of client devices to latest supported operating system • 58% complete	Amber

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Self-assessment against CAF to support development of actions for protection against threats, reviewed by division • Cyber security testing and exercises e.g. ICB cyber simulation event with all NHS organisations in Sussex & two internal events with senior leaders • We have run in-house email phishing campaigns	• Regular quarterly security status report to IG Steering Group and every six months to Audit Committee • Integrate Cyber action plan into EPRR planning	• RSM internal audits reports • Feedback from NHS Digital on Cyber Exposure score • Advice and guidance provided by third party security operation centre

1. Risk Summary

Reference & title	BAF 6: Failure to develop business intelligence limits insightful and timely analysis to support decisions.			Fit with Trust corporate priorities			
Description	It is likely there will continue to be delayed, inaccurate, or incomplete data analysis due to a failure to attract/recruit/develop business intelligence resource. The impact of this is significant/major, ultimately leading to poor decision-making or missed opportunities not meeting objectives and efficiency goals. Mitigating actions described will reducing the risk likelihood.			LOS ✓	Workforce ✓	Income ✓	Bus Case ✓	Digital ✓
Lead executive	Deputy CEO	Lead Committee	Finance and Performance	Date last reviewed	28/01/2026		
Risk(s) rated 12 and over aligned	• While there are no current risks on the Corporate Risk Register that align, gaps in divisional analytical support relating to planning, improvement projects and operational management has been identified.						

2. Risk Scoring

	Inherent risk *If there were no mitigations*	Current risk level *Assessment based on evidence* Q1	Q2	Q3	Q4
Likelihood	4	4	4	4	4
Impact	4	4	4	4	4
Risk level	16	16	16	16	16

Rationale for current risk level
Evidence that provides assurance of current risk level

This risk has the potential to severely impact strategic decision-making and operational efficiency, as the failure to develop robust business intelligence capabilities can hinder timely and accurate insights. Such limitations are likely to have a high impact on both financial performance and patient outcomes. The likelihood of this risk materialising is considerable, given the rapid advancements in BI technologies and the growing demand for specialized talent, making it increasingly challenging to attract and retain the necessary expertise.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Seek

Forward forecast of risk level

Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

reduce from significant (16) to high (12) in Q4 with the following mitigations in place:

- 2025/26 Q4 – procure fixed term resource that will automate BI processes freeing up substantive BI capacity. Reporting infrastructure development will also take place during this quarter, to enable accurate and timely extraction of data. Access to SQL platform for the fixed term resource has taken longer than envisaged, hence 16 score in Q4. Programme of work to deliver Mixed Sex Accommodation validation file and dashboard in 3 weeks has been agreed. Thereafter to work on reporting infrastructure development.
- Information reports and dashboards are being utilised from the Federated Data Platform.

2026/27 - Q1 to Q3, risk level expected to fall to medium (9) as skills mix model is deployed, pipeline to T- level students is established and upskilling of existing BI staff is completed. Fixed term resource will continue during Q1 and may extend into Q2 depending on recruitment of substantive posts. 2 X B8b Senior Information Manager substantive posts scheduled to go out to advert on 20/03/2026.

2026/27 end of Q4, risk rating expected to fall to medium (6) when remaining elements of BI Development Plan is completed e.g. Apha accreditation, analytical maturity assessments.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Limited Data Integration: Challenges integrating data from disparate clinical systems/sources into a central data warehouse, resulting in incomplete or inaccurate insights.
- Insufficient Data Governance: Weak data governance practices that fail to ensure data quality, consistency, and security across systems.
- Outdated BI Tools: Use of outdated or incompatible BI tools that do not support advanced data analytics or real-time reporting.
- Fragmented Reporting: Ineffective reporting mechanisms that do not provide timely, accurate, or actionable insights to decision-makers.
- Inadequate BI Training Programs: Insufficient or outdated training for staff on BI tools and data management, leading to skill gaps and ineffective use of BI systems.
- Clear national guidance reduces the risk of inaccurate data being reported and is not available for all metrics.
- Level of automation. Significant manual intervention increases the risk of human input errors.
- Complexity of rules, where the rules set out in national guidance are highly complicated and risk misinterpretation.

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Enhance BI Structure and Investment	DCEO	Dec 25	Recruitment of BI staff has been challenging, but a new targeted drive is underway. This will involve: Immediate – fixed term resource to automate BI processes and reporting infrastructure development Medium term – new recruitment model (T-level students and skills mix to allow internal lower grade entrants into BI team), upskilling of BI team. Timescales and risk impact scores shown in forward forecast section above.	Red

2	Update BI Tools	DCEO	Sept 25	Power BI Online Service implemented and SharePoint front end development complete	Green
3	Enhance BI Training Programs	DCEO	Dec 25	Continued Microsoft/NHS BI training uptake; targeted SQL and Power BI skills programme to complete by deadline. Training completed by analysts. Active learning set sessions to be implemented in Jan 25 for continued development.	Green
4	Improve Reporting Mechanism, Automation First and Self Service	DCEO	March 26	• New developments are being produced on a web front automated first approach; including elective programme utilisation reporting, A&E , flow, quality and safety and theatre reporting. • Theatre reporting complete, Outpatient reporting complete. • Scoping and requirements for other areas such as Radiology in progress.	Amber
5	Engage External Partners	DCEO	Sept 25	BI consultancy and visualisation partnerships secured to accelerate key developments by deadline.	Green
6	Design and Implement a New Data Warehouse	DCEO	March 26	Technology assessment and data migration planning are progressing to support delivery by the deadline. The upcoming implementation of the new PAS system over the next two years will significantly impact data structures and integration requirements. An agreed plan for the data warehouse approach pre-merger is needed to ensure alignment and reduce the risk of continuing data disparity. This will support clarity on interim and longer-term solutions in line with organisational priorities.	Amber

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Risk Assessment and Monitoring: Regular assessment and monitoring of BI-related risks, including evaluating the effectiveness of BI systems and controls. • Review of Risk Management Practices: Evaluating the effectiveness of risk management and compliance processes related to BI capabilities.	• Regular status and progress updates reported to ELT • Providing independent reports and recommendations to ELT and Executive Committee for review, regarding the adequacy of BI controls and risk management practices.	• Independent Audit review reports of BI Systems • Internal Audit review reports

1. Risk Summary

Reference & title	BAF 7: Failure to transform digitally and deliver associated improvements to patient care.	Fit with Trust corporate priorities				
Description	Failure to transform digitally and deliver associated improvements to patient care and develop a digital culture	LOS	Workforce	Income	Bus Case	Digital
		✓	✓	✓	✓	✓

Lead executive	Deputy CEO	Lead Committee	Finance and Performance	Date last reviewed	16 /3/2026

Risk(s) rated 12 and over aligned	• Integration of patient info systems • Follow up appointment database • National e-referral system • Firewall vulnerability

2. Risk Scoring

Inherent risk *If there were no mitigations*		Current risk level *Assessment based on evidence* Q1	Q2	Q3	Q4
Likelihood	4	3	3	3	3
Impact	4	4	4	4	4
Risk level	16	12	12	12	12

Rationale for current risk level
Evidence that provides assurance of current risk level

To enable to Trust to transform digitally and develop a culture which embraces significant change there is a dependency on investment and resources. However, currently the Trust is reliant on non-recurrent funding making it challenging to plan for large scale changes or recruit to roles.

The long-term impact of not embracing the changes needed to support a digital transformed trust are significant, as the population/patient will expect the Trust to deliver services using enhanced digital solutions. The progress on Electronic Patient Record (EPR) procurement has increased the level of engagement across the organisation as well as the need for digital and structured data.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Seek

Forward forecast of risk level

Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

Embedding clinical and operational staff within the digital system delivery is greatly supporting the digital culture across the organisation. Digital awareness across the organisation has greatly improved; divisions are looking to embed digital processes. EPR deign and build is underway to improve digital maturity acrossthe organisation. The implementation of EPR/LIMS/OCS order comms should lead to a reduction of this risk rating.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance
• Level of automation. Significant manual intervention impacts on the acceptance of change within the Trust • We need a training plan to increase digital literacy and add digital into all job descriptions

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	EPR implementation	CMO	Tranche 1: March 26 Tranche 2: Sept 26	• Implementation started, initiation stage signed off • Good Clinical and Operational engagement • Design sessions in progress. • Upgrade to 9.2.11 complete. SaaS migration underway – T1 go live planned end of March 26 • End date of implementation will be July 2027	Green
2	Digital transformation roadmap to support digital strategy	DCEO	Feb 26	• New Strategy still awaiting ELT sign off as needs alignment to the Trust priorities • Presentation tabled to ELT for May • Strategy Updated to reflect changes in 10-year plan	*Red*
3	Digital Literacy	DCEO	*Ongoing*	• Digital literacy- identifying skills requirement for EPR implementation • Developing training needs analysis for tranche 1 go live • Working with SCFT and USHx on a Digital literacy framework	Amber
4	Increase digital culture	DCEO	Ongoing	• Communications strategy and engagement – digital matters newsletter. • Multidisciplinary team working to deliver EmPoweR • Deputy CCIO recruited. Established clinical leads in inpatients/ theatres/ outpatients.	Green

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Project Prioritisation Matrix used to track and manage priorities for digital • Process Mapping utilised to monitor and facilitate change acceptance and benefits management	• Regular reports to Exec, F&P & Trust Board • Regular presentation to Digital IPR • Regular reports to OMG • Regular reports to Digital Steering Group	• Capital Business cases reviewed by ICS • Internal audit review reports

1. Risk Summary

Reference & title	BAF 8: Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that are discharge ready with an extended length of stay.
Description	The Trust has large numbers of patients who do not need the specialist inpatient care provided by ESHT (discharge ready) resulting in a requirement for significant additional capacity and staffing. There is an impact on flow of patients and an increased risk of deconditioning and harms (both physical and mental health) due to the very extended length of stay of some of these patients. In addition, there is a negative impact on patient experience as a result.
Lead executive	COO/CNO/CMO
Lead Committee	Quality and Safety
Date last reviewed	02/03/2026
Risk(s) rated 12 and over aligned	• Inpatient flow from ED • Insufficient acute beds in winter • Delayed ambulance transfers • Psychological support for long term and rehab patients • Bed management at full capacity • Waiting times for specialist nursing home placement • Staffing

Fit with Trust corporate priorities

LOS	Workforce	Income	Bus Case	Digital
✓	✓	✓		

2. Risk Scoring

Inherent risk
If there were no mitigations

Current risk level
Assessment based on evidence

	Inherent risk	Q1	Q2	Q3	Q4
Likelihood	5	4	4	4	4
Impact	4	4	4	4	4
Risk level	20	16	16	16	16

Rationale for current risk level
Evidence that provides assurance of current risk level

Evidence on a daily basis of the impact of over 100 patients who are discharge ready and the impact that this has on flow and increasing risk to patients and staff.

Situation continues with large numbers of patients who are discharge ready with use of additional bedded capacity.

In addition, it is necessary to pre-emptively place (board) additional patients on wards and in provide care in corridors for extended periods of time until a bed space is available.

January and February have been especially challenging but the Q4 risk level has not increased from 16 as this was not the case for November and December.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Cautious

Forward forecast of risk level

Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

Currently, and for the rest of March, it is likely that the significant challenges will continue. We are continuing to work through the implementation of the NHSE “Principles for Providing Patient Care in Corridors”. We will report progress to Q&S and to the Trust Board.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Lack of Adult Social Care capacity / timely assessment
- Lack of Nursing Home capacity
- Accuracy and timeliness of data on NerveCentre
- Lack of mental health capacity / timely assessment resulting in stranded patients with Significant Mental Illness (SMI)
- Lack of suitable clinical space and workforce to accommodate additional patients
- Currently unable to easily report on all of the requirements of the new Corridor Care Guidance

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Ensure clinical areas are staffed as safely as possible	COO/ CNO/ CMO	Q4	• Workforce pressures have increased • Escalation processes and de-escalation processes in place • MH Outreach team in place; ongoing discussions regarding review of skill mix • Agreement to invest in therapy resource for inpatients with recruitment well underway and all posts recruited to • Adherence to the new Corridor Care Guidance	Red
2	Ensure that patients are placed as safely and appropriately as conditions permit	COO/ CNO/ CMO	Q4	• Escalation capacity and surge and boarding capacity utilised as appropriate • New guidance received December 11th 2025 regarding Corridor Care; currently being worked through • Revised dynamic patient risk assessment already in use and all areas have had recent review regarding environmental risks	Amber
3	Ensure complex/high risk patients are assessed and flagged appropriately	COO/ CNO/ CMO	Q3	• Meetings to review and escalate patients with LOS in excess of 7,14 and 21 and 100 days take place each weekday with ASC and therapy attendance • As required on a case-by-case basis, divisions escalate particularly complex patients	Amber

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Robust management of all capacity • Thrice daily reviews of staffing • Redeployment of staff as required • Safety huddles in all clinical areas • Real time bed state/information available • Monitoring of quality and safety KPIs • Daily capture and monitoring of escalation and supersurge capacity • System escalation calls to discuss the number of Super Surge patients being cared for at the Trust and the number of patients not meeting the criteria to reside • Regular escalation of patients awaiting a mental health bed	• Use of any additional specialist advice or support, including visits to ESHT and ESHT staff visiting other locations • Daily patient pathway review for all patients • System wide discharge improvement workstream focussed on improving discharge processes and reducing length of stay in acute hospital and community hospital beds	• Challenge at Quality and Safety Committee and Trust Board • Provider assurance meetings and system clinical quality review meetings

1. Risk Summary

Reference & title	BAF 9: Failure to meet the four-hour clinical standard.	Fit with Trust corporate priorities				
		LOS	Workforce	Income	Bus Case	Digital
Description	Due to ongoing challenges with patient flow there is a risk that patients spend longer than they need to in the emergency department once they are clinically ready to proceed. This is due to a number of factors and also impacts those patients who wait longer than they should to access the emergency department. There is evidence to suggest that patients who spend more than six hours in emergency departments may come to harm.	✓	✓	✓		

Lead executive	COO/CNO/CMO	Lead Committee	Quality and Safety	Date last reviewed	02/03/2026

Risk(s) rated 12 and over aligned

- Inpatient flow from ED
- Delayed out of hours patient assessment
- Insufficient acute beds in winter
- Staff absence
- Delayed face to face triage
- Bed management at full capacity

2. Risk Scoring

	Inherent risk *If there were no mitigations*	Current risk level *Assessment based on evidence* Q1	Q2	Q3	Q4
Likelihood	5	4	4	4	4
Impact	4	4	4	4	4
Risk level	20	16	16	16	16

Rationale for current risk level
Evidence that provides assurance of current risk level

There is robust data/evidence on a daily basis that describes the length of time patients stay in the department and that the standard/ambition is not being met.

January has been challenging but the Q4 risk level has not increased from 16.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Cautious

Forward forecast of risk level

Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available

There are a variety of actions underway which form part of the length of stay programme which all aim to address this risk. If all of those programmes of work progress in a timely manner, we could cautiously expect the risk score to remain at 16.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- We do not have a mechanism for immediately decompressing emergency departments.
- We cannot immediately respond to significant surges in activity.
- Workforce plan does not match increase in activity.
- Both emergency departments do not have sufficient capacity for increase in attendances and activity

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Continue to invest in Home First and community capacity and transformation of the acute footprint, including ongoing rollout of intermediate care wards.	COO	Q4	• Work is underway; we have two ICW wards in place, one on each site • We are reducing our acute footprint and investing in community services	Green
2	Priority actions identified and include work regarding culture, education and roles and responsibilities. (SAFER and Reconditioning work)	CNO	Q2	• SAFER continues to be embedded • Increasing focus on reconditioning moving forward	Amber
3	Still working on KPIs and dashboard to support work on Length of Stay and internal/external processes e.g. wait times for therapies, Adult Social Care and Mental Health.	COO/ CNO	Q2	• Length of stay programme refresh has been completed • Workstreams with clear priorities identified • Some dashboards have been completed; wait time for therapies and mental health are outstanding	Amber

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Live bed state provides accurate information regarding occupancy and available bedded capacity • Breach compliance assurance across divisions • Long length of stay reviews across divisions • Complex/high risk patient reviews escalated to CMO/CNO/COO	• Bed strategy programme reporting through Use of Resources, with programme of work to reduce LOS in addition to areas described above	• Internal Audit Reports • Healthwatch feedback following visits • Family and Friends survey feedback from ED patients • ICB and NHSE South East region oversight of four hour performance

Agenda Item: 14

Report To/Meeting	Trust Board	Date of Meeting	21st April 2026
Report Title:	Use of Trust Seal		
Key question	Has the Trust Seal been used since the last Trust Board meeting?		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐		
Report Sponsor:	Andrew Strevens, Chief Finance Officer	Presenter(s):	Steve Phoenix, Trust Chair
Report Author:	Pete Palmer, Board Secretary		
Outcome/Action requested:	The Board is asked to noted the use of the Trust Seal.		
Executive Summary	The Trust Seal has been used to seal one document since the last Board meeting in public: **Sealing 128** Agreement with Cloud21 Ltd for implementation services in support of Sussex Pathology Network Digital Programme.		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☐ People ☐ Sustainability ☐		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	1	Appendixes	None
Governance and Engagement pathway to date:	Not applicable		
What happens next?	Not applicable		
Publication	Report is for publication		

Agenda sections	16th June 2026 Conquest	18th August 2026 Eastbourne	15th September 2026 Cooden	20th October 2026 Cooden	15th December 2026 Conquest
Standing Items	Staff Recognition Service Presentation Board Committee Chair's Reports CEO's Update IPR Use of Trust Seal Questions from members of the public (15 mins)	Staff Recognition Service Presentation Board Committee Chair's Reports CEO's Update IPR Use of Trust Seal Questions from members of the public (15 mins)		Staff Recognition Service Presentation Board Committee Chair's Reports CEO's Update IPR Use of Trust Seal Questions from members of the public (15 mins)	Staff Recognition Service Presentation Board Committee Chair's Reports CEO's Update IPR Use of Trust Seal Questions from members of the public (15 mins)
Service Presentation					
General		Board Committee Annual Reviews and Annual Reports	AGM		
Quality, Safety and Performance	Maternity Overview Q4 Avoidability of Inpatient Deaths Q2			Maternity Overview Q1 Avoidability of Inpatient Deaths Q3	Maternity Overview Q2 Avoidability of Inpatient Deaths Q4
Human Resources incorporating workforce targets and staff survey				Annual Equality Report	
Strategy					
Other monitoring					
Governance and Assurance	Speak Up Guardian Update Delegation of approval of Quality Account 2025/26 Nursing Establishment Review	BAF Q1 Guardian of Safe Working hours - report Annual Review of Trust Governing Documents Winter Planning		BAF Q2 Winter Planning Update	Speak Up Guardian Update Guardian of Safe Working hours
Annual Reports		Medical Revalidation		Annual Equality Report	Infection Control Safeguarding Annual Report
Items for Information					Meeting Dates for 2027