East Sussex Healthcare
NHS Trust

Quality Account 2025/26

www.esht.nhs.uk
esh-tr.enquiries@nhs.net
0300 131 4500

Content

Part 1 - Statement of Quality from the Chief Executive	4
1.2 - About the Trust	6
1.3 - Purpose of the Quality Account	8
Part 2 - Priorities for Improvement and Statements of Assurance	9
2.1 - Priorities for improvement in 2026-27	9
2.2 - Statement of assurance from the Board	16
2.3 - Care Quality Commission	17
2.4 - Participation in Clinical Audit	19
2.5 - Participation in Clinical Research	26
2.6 - Commissioning for Quality and Innovation (CQUIN)	26
2.7 - Information Governance	27
2.8 - Data Quality	28
2.9 - Learning from Deaths	29

2.10 - Workforce	33
Part 3.1 - Review of our Quality Priorities in 2025-26	34
Part 3.2 - Reporting against Core Quality Indicators	58
Summary Hospital-level Mortality Indicator (SHMI)	58
Condition-specific outcomes	59
MEASURE: Percentage of children and young people over 5 years who had documented evidence of enquiry or screening for their mental health	60
Rate of Patient Safety Incidents	65
Pressure Ulcers	67
Venous Thromboembolism (VTE) Risk Assessment	68
Mandatory surveillance of healthcare associated infection	68
Patient Experience of hospital care	71
Summary of Performance	74
Appendix 1 - National Clinical Audit and National Confidential Enquiries Programme	78
Appendix 2: Participation in Mandatory Clinical Audits	80
Glossary	81
Part 4 - Stakeholder Statements	85
Statement from East Sussex Community Voice on behalf of Healthwatch in Sussex	85
Statement from East Sussex Health Overview and Scrutiny Committee (HOSC)	86
Statement from Commissioners	88
Statement of Directors' responsibilities for the Quality Account	91

Part 1 - Statement of Quality from the Chief Executive

I am pleased to present our Quality Account for 2025–26, which sets out how we have improved the quality of care over the past year and what we will focus on in 2026–27.

It has been another demanding year for the NHS, with more people needing care and many patients arriving with increasingly complex health needs. Despite these pressures, I am incredibly proud of our staff, who continue to provide safe, compassionate care and support to patients, families and communities every day.

At East Sussex Healthcare NHS Trust, everything we do starts with our patients and those who care for them. Behind every figure in this report is a person with their own story, and it is these experiences that drive our commitment to keep improving. We have seen the positive impact of more joined-up, person-centred care, and we have responded to feedback from patients—an example of this , is patients receiving mental health care—by expanding our Mental Health Outreach Team so that people receive more timely specialist and compassionate support.

Despite ongoing challenges, we have made important progress in quality and safety. We are working hard to build an open, learning culture where staff feel confident to raise concerns and act on them early. Most patient safety incidents result in little or no harm, reflecting this proactive approach. We have strengthened how we learn from serious incidents and deaths, ensuring we act where needed to improve care and reduce future risks. We have also improved how patients move through our services, with our “Home First” approach helping more people return home safely and recover in familiar surroundings.

Clinical outcomes remain strong in areas such as maternity care and urgent treatment, and we continue to learn through national benchmarking. Encouragingly, patient feedback shows more people feel they are treated with kindness, respect and compassion, something we are very proud of.

We also recognise that high-quality care depends on supported staff. Over the past year we have invested in staff wellbeing, expanding support and achieving a Gold 'Wellbeing at Work' Award.

We remain open about where we need to do better and continue to listen carefully to feedback from patients and communities. This feedback shapes our priorities for the year ahead.

This year, 2026-27, we will focus on improving communication, so patients receive clearer, more timely information about their care, supported by digital tools to make access easier and reduce missed appointments. We will improve how we recognise and respond when patients' conditions worsen, ensuring earlier intervention, better communication with families, and compassionate care, particularly for those nearing the end of life. We will also reduce harm from falls by identifying those most at risk, tailoring care plans, and learning from every incident.

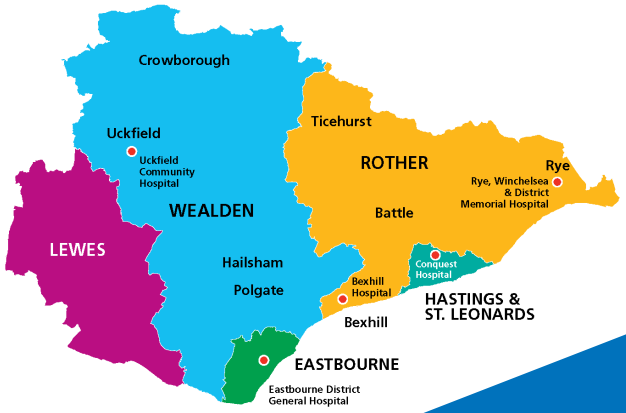
Your insight and feedback are vital to this work. I would like to thank our staff for their dedication and our patients, carers and partners for their continued support. Together, we will continue to improve care and outcomes for the people of East Sussex.

Jayne Black

Chief Executive
East Sussex Healthcare NHS Trust

1.2 - About the Trust

East Sussex Healthcare NHS Trust is committed to delivering safe, compassionate and high-quality hospital and community services for around half a million people living in East Sussex, as well as those who visit and work in our local area. Everything we do is guided by our values and by our ambition to continuously improve care and experience for patients, communities and our workforce.



As one of the largest employers in the county, with an annual income of £770 million, we are proud to be the only integrated provider of acute and community care in Sussex. More than 8,700 colleagues work across our organisation, united by a shared purpose to provide outstanding care and to support people to live healthier, more independent lives. Our services are delivered from two acute hospitals in Hastings and Eastbourne, community hospitals in Bexhill, Rye and Uckfield, The Trust strategy is to improve population health and reduce inequalities by delivering integrated, patient-centred care through partnership working, empowered staff, and innovative, sustainable service models.

Quality and safety remain central to our strategy. In 2020, the Care Quality Commission rated us as ‘Good’ overall, with ‘Outstanding’ ratings for Caring and Effective. Conquest Hospital and our Community Services were rated ‘Outstanding,’ and Eastbourne District General Hospital was rated ‘Good.’ These ratings reflect the compassion, professionalism and commitment of our teams, and our ongoing focus on learning, improvement and high standards of care.

Our two acute hospitals have Emergency Departments and operate 24 hours a day, providing a comprehensive range of medical, surgical, maternity and outpatient services, supported by diagnostics and therapies. Conquest Hospital is our centre for trauma and obstetric services, while Eastbourne District General Hospital is the centre for stroke and urology care. Together, they play a vital role in supporting urgent and planned care across the county.

Our community hospitals and services are a key part of our integrated model of care, supporting our strategic aim to provide more care closer to home. Bexhill Hospital delivers ophthalmology, outpatient, rehabilitation and intermediate care services. Rye, Winchelsea and District Memorial Hospital provide outpatient, rehabilitation and intermediate care services, and Uckfield Community Hospital currently offers outpatient care. We also deliver rehabilitation services in partnership with East Sussex County Council Adult Social Care, helping people to recover and regain independence.

In the community, our Integrated Locality Teams work closely with District and Community Nursing teams to support people with long term conditions and complex needs. By delivering care in people's homes, clinics, health centres and GP surgeries, we help reduce unnecessary hospital admissions and support people to live well in their own communities.

Partnership working underpins our Trust strategy. We work closely with East Sussex County Council and a wide range of partners across Sussex as part of a locally focused and integrated health and care system. Through collaboration, innovation and a strong focus on our people, we continue to strengthen services, improve outcomes and build a sustainable future for healthcare in East Sussex.

1.3 - Purpose of the Quality Account

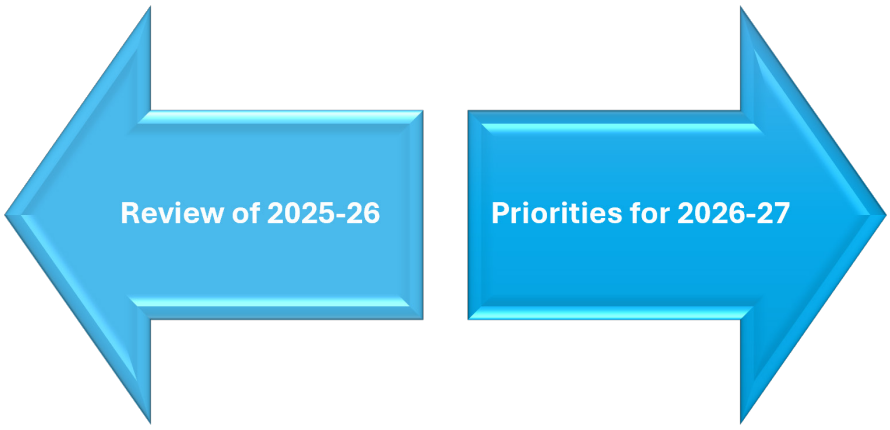
All NHS providers in England have a statutory duty to produce a report about the quality of services they deliver and are required to be open and transparent about the quality of its services. This report is called the Quality Account. The Quality Account aims to drive quality improvement within the NHS and increase public accountability. This is done by getting NHS organisations to review their performance over the previous year, identify areas for improvement and publish that information, along with a commitment to you about how improvements will be made over the next year.

The report incorporates mandatory sections covering areas such as our participation in research, clinical audits, a review of our performance against quality indicators and what our regulator says about the services and care we provide.

Alongside the mandatory elements of the Quality Account, we have engaged with staff, patients, the public, our commissioners and wider stakeholders to ensure the account reflects what matters most and provides an insight into our organisation and the improvement priorities that are important to us all.

The public and patients can view the Quality Accounts on the NHS Choices website:/www.nhs.uk

The dual functions of a Quality Account are to:



Scope of the Quality Account

The Quality Account for the East Sussex Healthcare NHS Trust (ESHT) is an annual report that provides a detailed overview of the quality of care delivered by the Trust's acute and community services.

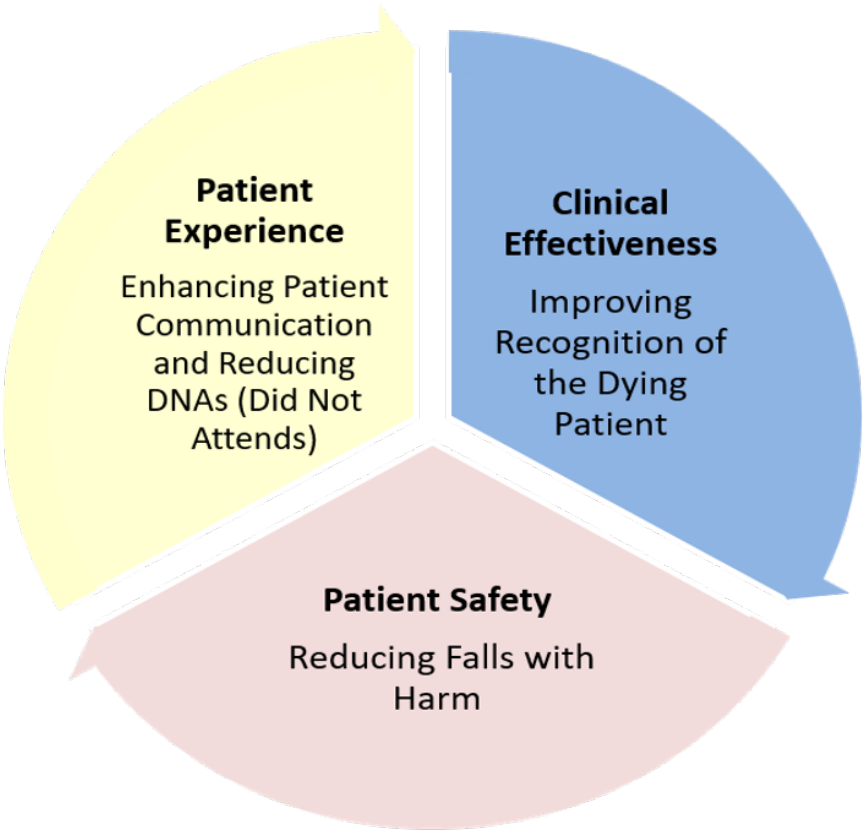
The report highlights performance across key areas such as patient safety, patient experience, and the clinical effectiveness of services provided throughout the year. It also includes information about ESHT's plans for enhancing care in the future.

Please note - Consent has been obtained from the patients or their relatives, where appropriate, whose care and experiences are referenced within this report. All information has been handled in accordance with relevant confidentiality and data protection requirements.

Part 2 - Priorities for Improvement and Statements of Assurance of the Quality

2.1 - Priorities for improvement in 2026-27

All NHS providers in England have a statutory duty to produce a report about the quality of services they deliver and are required to be open and transparent about the quality of its services. This report is called the Quality Account. The Quality Account aims to drive quality improvement within the NHS and increase public accountability. This is done by getting NHS organisations to review services.



Priorities for improvement in 2026-27

Patient Experience Priority - Enhancing Patient Communication and Reducing DNAs (Did Not Attends) Using the Netcall Platform

Why this is a priority

Better, more consistent communication with patients will reduce missed appointments, improve patient experience, and make best use of available clinic capacity.

Currently, communication with patients about appointments is often inconsistent and relies heavily on manual processes. We know that high volumes of calls and unclear messaging contribute to missed appointments (DNAs) and inefficient use of clinic time, and there is variation across services in how appointments are managed, with limited use of digital tools.

Improving communication will help patients receive the right information at the right time, reducing missed appointments and waiting times. This supports national NHS priorities to improve patient communication, expand digital access, and recover planned care services.

This priority aligns with NHS England expectations for improved patient communication, digital inclusion, and Planned care recovery.

What we plan to do

We will use digital tools to make communication clearer, faster, and more convenient, helping reduce missed appointments and improve patient experience. We will:

- Introduce a new digital system (Netcall) to improve how we communicate with patients and manage appointments.
- Send timely appointment reminders using text messages, phone calls, and other digital options.
- Enable patients to easily confirm, cancel, or request to rebook your appointment online.
- Use automation and AI to respond to routine queries more quickly.
- Improve call handling so patients can get through quicker and to the right team first time.
- Keep patients informed while they wait, with updates, advice, and when to seek help.
- Standardise processes across services to ensure consistent, reliable communication.
- Use patient feedback to continuously improve how we communicate and manage appointments.

What success will look like

More patients attending appointments, better use of capacity, and a smoother, more convenient experience for both patients and staff. There will be:

- Streamlined booking processes, reducing workload for staff.
- Better use of clinic time, with fewer unused and missed (DNA) appointments.
- More efficient scheduling, reducing the need for extra clinics.
- Improved patient experience, with fewer complaints and better feedback.
- Increased use of digital communication, making access easier and more convenient.

How we will monitor progress

- Monthly monitoring of DNA rates and trends.
- Clinic utilisation metrics, including reporting on unused slots.
- Patient experience feedback.
- Netcall reporting dashboards.
- Monitoring call volumes and call handling times.
- Review of waiting list validation activity and outcomes.

Clinical Effectiveness Priority - Improving Recognition of the Dying Patient

Why this is a priority

Earlier recognition of patients approaching the end of life will help ensure better care, clearer communication, and more time for patients and their families to prepare and be supported.

- National reviews show that, locally, patients nearing the end of life are often recognised later than they should be. This means there is less time to plan care, support patients, and involve families.
- Although there has been some improvement in ESHT, the Trust has not yet reached its target for recognising when death is expected. Records show missed opportunities to identify when patients are deteriorating and specialist palliative care teams are not always able to see patients in time, often because changes happen quickly or referrals are delayed.

What we plan to do

We aim to recognise earlier when a patient may be dying, communicate clearly, and ensure timely, compassionate, and well-coordinated care. We will:

- Improve training for all clinical staff on recognising and managing end-of-life care.
- Add simple prompts to care plans to help staff recognise when a patient may be nearing the end of life and act early.
- Strengthen recording, communication, and teamwork so care is timely and well-coordinated.
- Encourage earlier, honest conversations with patients and families about care preferences and what matters most.
- Make sure all patients identified as nearing the end of life are quickly referred to specialist palliative care teams.
- Work closely with escalation teams to identify when treatment may no longer help and focus on comfort and support.

What success will look like

Patients and families will experience earlier, clearer communication and more personalised, supportive care at the end of life.

- Faster and clearer recognition of when patients may be nearing the end of life, reflected in improved national audit results.
- More senior doctors trained in end-of-life care, building confidence and consistency in decision-making.
- Earlier, more open and compassionate conversations with patients and families about care and what matters most.
- Care plans that are flexible and guided by patient wishes, even when there is uncertainty.
- More patients receiving timely support from specialist palliative care teams.

How we will monitor progress

We will use national data, staff training records, and patient and family feedback to track progress and ensure care continues to improve. We will:

- Continue to take part in the national end-of-life care audit to measure how we are improving over time and compare our performance regularly with national results and nearby NHS Trusts.
- Track how many patients are referred to and seen by specialist palliative care teams.
- Monitor how many staff, including consultants, complete end-of-life care training.
- Listen to feedback from bereaved families to understand their experience and identify areas for improvement.

Patient Safety Priority - Reducing Falls with Harm

Why this is a priority

Slips, trips, and falls are one of the most common safety incidents for patients in our care. Although our overall falls rate is better than the national average, some patients are still experiencing harm from falling while in hospital.

Most reported falls cause little or no harm, but it is not always clear how many could have been prevented. In 2025, a small number of falls led to severe or moderate harm, highlighting the need for improvement.

Reducing falls, especially those that cause harm and better understanding which falls can be prevented will help keep patients safer during their care.

What we plan to do

Quality improvement projects will be undertaken within divisions in conjunction with the Breakthrough Trust Priority.

We will take forward a range of improvements to reduce patient falls and improve safety:

- Update our approach in line with the latest national guidance (NICE).
- Improve how we identify patients at risk of falls, including innovative approaches in Emergency Departments.
- Make sure all patients receive a falls risk assessment within 24 hours of admission.
- Ensure patients and families receive clear information and a personalised care plan to prevent falls.
- Regularly review staffing levels in areas with higher rates of falls.
- Strengthen specialist roles, including Falls Champions and introduce a Falls Lead role.
- Improve staff training on falls prevention and reporting processes
- Explore and introduce new initiatives, such as reducing caffeine-related falls risks.
- Strengthen oversight by introducing regular divisional reporting to identify trends and take action.

What success will look like

- Every patient is checked for their risk of falling, every time - We will regularly check that all patients are being assessed and all falls are reviewed.
- Every fall is reviewed so we can learn and prevent it from happening again - We will look at each fall to understand if it could have been prevented.
- Fewer people experience falls that cause serious harm - We will track the number of falls each month, including how many result in harm. We will aim to reduce serious harm from falls by at least 20%.
- Patients are supported to move safely and confidently during their care while in hospital. We will gather feedback from patients and staff to understand what is working and where we can improve.
- Results will be reviewed monthly by clinical teams and senior leaders, and progress shared across wards and departments. Any areas needing improvement will be supported to make changes quickly.

2.2 - Statement of assurance from the Board

During 2025/26, East Sussex Healthcare NHS Trust (ESHT/The Trust) provided or sub-contracted 86 NHS services.

A comprehensive review has been undertaken of all available data relating to the quality of care delivered across each of these 86 services.

The income generated by the NHS services reviewed in 2025/26 represents 100% of the total income generated from the provision of NHS services by the Trust 2025/26.

2.3 - Care Quality Commission

The Trust is registered with the Care Quality Commission (CQC) to carry out eight legally regulated activities from 17 registered locations with no conditions attached to the registration. No new locations were added in 2025/26.

The CQC monitors and review information from all available sources about the Trust and contacts us for further information whenever they identify any matters of concern.

The CQC rating for ESHT published in February 2020 is 'Good' overall and 'Outstanding' for caring and effective services, following an inspection in November and December 2019. In addition, we hold quarterly engagement meetings with the CQC which allows is to discuss any current issues that may be impacting on the delivery and quality of our services.

The CQC Maternity Survey in 2025

The report published in December 2025, provides insight into the quality of maternity services and helps identify potential risks across organisations. 300 women who received maternity care in ESHT were invited to participate. 104 responses were received, giving a 35% response rate which was 10% lower than in 2024, and 4% less than the national average of 39%.

ESHT's overall performance remained stable compared to 2024, with 51 survey questions showing no statistically significant change, two areas improving, and no areas deteriorating. Importantly, no results fell below expected standards, indicating that there are no significant risks requiring regulatory concern. Women reported positive experiences on the ward, during their antenatal care and in the postnatal period at home. ESHT's top five highest scoring areas (compared with the national average) are set out in the table below.

CQC Maternity Survey 2025 - ESHT Five Highest-Scoring Areas			
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	7.4
Care in the Ward	Women felt they could get staff attention when needed.	8.2	7.4
Antenatal Care	During antenatal check-ups, midwives asked women about their mental health.	9.4	8.6
Antenatal Care	Midwives/doctors were aware of medical history.	8.1	7.1
Postnatal Care at Home	Women felt informed about their physical recovery.	7.7	6.9

Findings show a positive overall trajectory for ESHT, particularly in communication, staff engagement, and shared decision-making, and there are no immediate concerns. Nonetheless, the Trust has identified targeted opportunities for improvement to continue enhancing the quality of maternity services.

During 2025-26, the CQC found no breaches that justified regulatory action, no requirement notices were issued, and no enforcement actions were taken.

2.4 - Participation in Clinical Audit Quality Commission

Clinical audit helps us improve the quality of care we provide by reviewing our performance against agreed standards and making changes where needed. Each year, we develop a Clinical Audit Plan based on national priorities and our own local improvement goals.

National Audits

We take part in national audits through the National Clinical Audit and Patient Outcomes Programme (NCAPOP). These allow us to compare our performance with other organisations and identify where we are doing well and where we can improve.

National Audit Activity in 2025-26 The Trust participated in 100% of all relevant national clinical audits in 2025-26 as listed below.	
National Audit and National Confidential Enquiries	The Trust participated in: ➢ 64 national Clinical Audits. ➢ 7 National Confidential Enquiries. Detailed list in Appendix 1.
Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE)	All maternal deaths, including those up to one year after pregnancy — as well as perinatal and infant deaths are reported to help understand causes and improve care. No maternal deaths were reported in 2025-26.
UKOSS UK Obstetric Surveillance System	The UK Obstetric Surveillance System is a national programme that studies rare and serious complications in pregnancy. The Trust did not have any eligible cases in 2025-26 for this study.

National Audit Activity in 2025-26

The Trust participated in 100% of all relevant national clinical audits in 2025-26 as listed below.

National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD) Reports	Four applicable NCEPOD reports were issued in 2025-26: ■ **Emergency surgery in children and young people – 2025** Three national recommendations identified, the Trust is currently working to ensure compliance in these areas, reporting progress via the Clinical Effectiveness Group and at divisional governance meetings. ■ **Acute limb ischaemia – 2025** Five national recommendations identified, the Trust is fully compliant with three of these. Work is underway regarding the remaining two recommendations, progress is reported via the Clinical Effectiveness Group and at divisional governance meetings. A Quality Improvement project has been initiated to support this. Patients likely to benefit most from an intervention (Rutherford category IIb) are not always directed to a vascular hub, causing a delay in their treatment beyond the accepted target of six hours. Key actions to track and take forward: • Use theatre booking systems and coordinators to access emergency theatres. • Record and audit time from symptoms to procedure (if needed). • Learn from patient safety incidents related to ALI, fasciotomies, amputations and related deaths. ■ **Blood sodium – 2025** Five national recommendations identified, the Trust is currently working to ensure compliance in these areas, reporting progress via the Clinical Effectiveness Group and at divisional governance meetings. • Care bundles for sepsis are currently being updating by the Clinical Lead. • Care bundles for AKI are in development. • IV fluids policy has been reviewed and updated. • Local audit to assess compliance to be completed in 26-27.

National Audit Activity in 2025-26

The Trust participated in 100% of all relevant national clinical audits in 2025-26 as listed below.

National Confidential Enquiries into Patient Outcome and Deaths (NCEPOD) Reports	■ **Rehabilitation following critical illness – 2025.** Five applicable national recommendations identified, the Trust is fully compliant with four of these. Work is underway regarding the remaining recommendation, progress is reported via the Clinical Effectiveness Group and at divisional governance meetings. Staffing capacity and resource is impacting achievement of the final recommendation.
National Clinical Audit Reports	The Trust reviewed 12 national audit reports in 2025-26 to assess care quality, identify good practice and highlight risks, with improvement actions tracked centrally to ensure delivery. Details of two of the reports are provided below:

Sentinel Stroke National Audit Programme (SSNAP)

Measures the quality of stroke care across the NHS and provides data to support continuous improvement.

SSNAP (Stroke) Audit 2025/26 at ESHT

Speech and Language Therapy (SaLT) is key to safe and effective stroke care. Timely swallow assessment is essential to reduce risks such as aspiration and ensure safe, appropriate care. The SSNAP audit measures how quickly patients receive assessment and support and in 2025-26, ESHT performance was below national standards:

- Swallow screening within 24 hours: 29% (vs 84.6% nationally).
- SaLT assessment within 72 hours: 37.5% (vs 85.4% nationally).

Improvement actions taken to strengthen stroke therapy services include:

- ✔ Increased staff numbers, including therapy assistants, to expand capacity.
- ✔ Introduced a six-day service and more group therapy sessions.
- ✔ Improved staffing consistency and reduced unplanned absences.
- ✔ Strengthened clinical oversight to improve quality and consistency.
- ✔ Upskilled staff to deliver more therapy sessions.
- ✔ Improved initial assessments, including better screening for patients' emotional wellbeing.

A real time SaLT audit of compliance continues, to ensure SSNAP figures reflect clinical actions and identify any barriers to achieving key targets.

The National Joint Registry (NJR) Programme

Collects information on joint replacement surgery, including hips, knees, and shoulders.

It aims to improve patient safety and outcomes by monitoring performance and providing feedback to clinicians and implant manufacturers. The NJR Quality Data Provider Award recognises hospitals that meet high standards for patient safety by submitting accurate and complete data, with gold, silver and bronze awards reflecting levels of achievement. Conquest Hospital received a silver award in 2025-26.

Conquest Hospital was awarded for being an NJR Quality Data Provider

Local Clinical Audit Activity in 2025/26

Local clinical audits and quality improvement projects are conducted by teams to improve care in specific services or pathways.

In 2025/26, the Trust reviewed 105 local audits and projects to assess quality, identify good practice and highlight any risks. Improvements are tracked through a central action plan to ensure progress. Two examples of these projects, and the actions taken, are highlighted below.

Two examples of completed local audits in 2025-26

1. MASCC Score in Febrile Neutropenia

The MASCC score is a nationally recommended tool used to assess risk and guide treatment for cancer patients with neutropenic sepsis. This audit reviewed whether the score was recorded at initial assessment and whether antibiotics were given promptly, in line with NICE guidance, for adult patients presenting to Eastbourne Emergency Department between March and August 2025.

Results

The audit showed a 20% increase in use of the MASCC score, though some inaccuracies remained. Time to antibiotics improved from 136 to 90 minutes, but this is still above the 60-minute target.

Key issues included poor awareness and documentation of the MASCC score, delays in recognition and triage, and inefficiencies in the antibiotics process. Patients did receive appropriate treatment once antibiotics were prescribed.

Improvement actions

- ✔ All planned actions to improve performance have been completed, including:
- ✔ Delivering teaching sessions for doctors, nurses and healthcare assistants.
- ✔ Sharing findings and discussing improvements with Emergency Department and Oncology teams.
- ✔ Displaying posters in the Emergency Department to raise awareness.
- ✔ Exploring digital options to support MASCC scoring.
- ✔ Strengthening staff awareness at triage.

A re-audit is planned for April 2026 to assess progress and ensure sustained improvement.

2. Re-audit of compliance with provision and use of safety sharps products

Sharps injuries remain a significant occupational risk in healthcare. All healthcare organisations must comply with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 to reduce the risk of sharps related injuries.

This re-audit was undertaken in response to an increase in sharps related incidents across the Trust, to assess whether safer sharps are available, used consistently, and supported by appropriate training and guidance and to check if any improvements has been made since the last audit on 2014.

Results

Standard 1: Access to Alternatives of Sharps
Sharps alternatives were widely available and used across most areas (88% compliance), however safer alternatives were not used across some areas, with blunt fill needles not used in 13 areas, filter needles in 17 areas, and Posiflush in 7 areas, indicating targeted areas for improvement.

Standard 2: Availability and Regular Use of Safety Engineered Sharps
Availability has improved, but consistent use remains the key safety gap.

Standard 3: Provision of Information and Training on the Use of Safety Sharps
Despite staff awareness of actions to be taken following sharps injury, gaps still exists with only 8% of the area displaying poster on safety sharps and 36% of staff reporting a need for further training.

Comparison with 2014 audit
The compliance has significantly increased across all standards since the 2014 audit, with the 2024 audit expanding its coverage from 38 to 103 areas. The only exception was the reduction in the availability of appropriate instructional posters from 32% in 2014 to 8% in 2024.

Significant improvement has been achieved since the 2014 audit, particularly in availability of safer sharps. However,

- Use remains inconsistent,
- Visibility of guidance is poor, and
- Training needs persist.

Actions Taken	Next Steps
✔ Develop and display safety sharps awareness posters ✔ Re-audit standard-1 compliance ✔ Improve sharps injury awareness (poster)	• Strengthen training via local programmes • Improve the consistent use of sharps alternatives

This clinical audit has been shortlisted for the 2026 Trust Clinical Audit / QI Awards

2.5 - Participation in Clinical Research

The Trust participates in national and international research studies, offering patients access to new and innovative treatments. All NHS research is approved by the Health Research Authority (HRA).

We currently support around 60 National Institute for Health and Care Research (NIHR) portfolio studies, including both academic and commercial trials. Since April 2023, research has been a key Trust priority, with a focus on expanding opportunities for our patients.

In 2025/26, 4,638 patients receiving Trust services were recruited to take part in HRA-approved clinical trials.

The top recruiting research studies in 2025-26 were:

Study Name	Number Recruited
Obstetric Bleeding Study	2880
Minder – Sleep Attitudes Survey	949
Digital Imagin versus Ophthalmology study: DIvO	417
OSCAR – Omics Approaches to Urological Cancer Diagnosis	76
Preterm Clinical Network Cohort Research Programme	41

2.6 - Commissioning for Quality and Innovation (CQUIN)

No CQUIN indicators were published for 2025/26.

2.7 - Information Governance

The Trust is committed to protecting patient information and strengthening cyber security. Staff receive ongoing training to help them recognise and respond to potential threats.

We follow strict legal requirements, including the UK GDPR and Data Protection Act 2018, to ensure personal information is handled safely and securely.

Thirty-three data security incidents were reported in 2025-26 (including near misses). Each incident is reviewed, with lessons shared where identified, to help prevent future risks.

All incidents were no harm, mostly related to human error, such as sending information to the wrong recipient. We continue to focus on improving awareness and adherence to procedures to reduce these risks.

The Caldicott Guardian

The Caldicott Guardian is a mandatory role for all NHS organisations, which holds responsibility for patient confidentiality. In the Trust, the awareness about the Caldicott Guardian role and the associated Caldicott principles is provided via the mandatory information governance training for all staff. The Chief Medical Officer (CMO) is the Trust's Caldicott Guardian and supports the Information Governance team to ensure the Caldicott principles and patient confidentiality are prioritised and respected.

Data Security and Protection Toolkit

The Data Security and Protection Toolkit (DSPT) is a national tool used to assess how well organisations protect data and respond to cyber security risks. It is aligned to national standards and supports oversight by the Care Quality Commission (CQC).

All NHS organisations must complete a yearly self-assessment against key areas including managing risk, preventing cyber-attacks, detecting incidents, minimising impact, and using information safely.

For 2024/25, the Trust achieved an 'Approaching Standards' rating, with internal auditors providing a moderate level of assurance. The 2025/26 submission is due by the end of June 2026, and work is ongoing to meet the required standards.

Clinical Coding Error Rate

Clinical Coding Accuracy - Clinical coding converts information from patient records into standard codes used across the NHS. This supports patient care, planning, and funding.

In 2025/26, the Trust achieved an overall coding accuracy rate of 96%, indicating a very high standard, with only a 4% error rate. External audit results confirmed performance at the highest advisory level across all key areas.

Some errors were linked to missing information, time pressures, and limited clinical documentation.

Actions to further improve accuracy and maintain high data quality standards are:

- Strengthen training and feedback for coding staff, working with teams to ensure all relevant information is captured.
- Improve access to scanned patient records and documentation in time for coding.
- Increase awareness among clinicians about accurate recording of clinical diagnosis.

2.8 - Data Quality

For the reporting periods April 2025 to February 2026 (for admitted patient and outpatient care) and April 2025 to March 2026 (for Accident and Emergency):

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.9% for admitted patient care.
- 100% for outpatient care.
- 99.5% for Accident and Emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care.
- 99.9% for outpatient care.
- 100% for Accident and Emergency care.

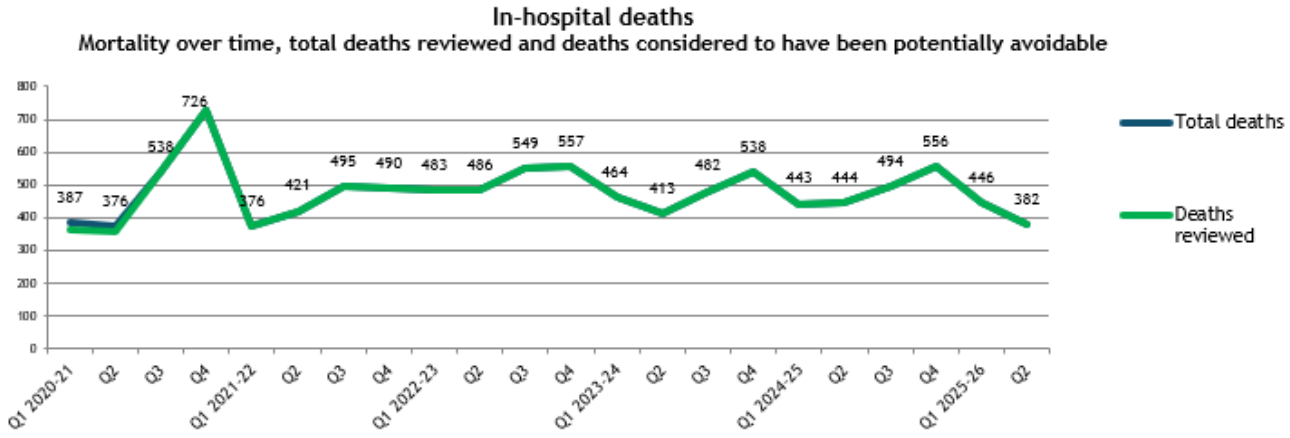
These results demonstrate robust performance in capturing accurate patient information.

2.9 - Learning from Deaths

The Trust remains committed to reporting and reviewing all reported deaths to identify learning in order to improve the quality of care. This is achieved by ensuring effective processes and mechanisms are in place for mortality reviews with appropriate input from relevant staff.

Number of patients who died

Between January and December 2025, a total of 1894 patient deaths occurred at the Trust, and each case was reviewed, and an assessment of the likelihood of the death being attributable to problems in care is made. Quarterly trends of in-hospital deaths remained stable across the year as shown in the chart below.



The Trust reviewed each death using a standard 5-point scale, with those scored 1 – 3 deemed more likely than not to have been due to problems in care (i.e. potentially avoidable). Scores of 4 – 5 are not considered avoidable.

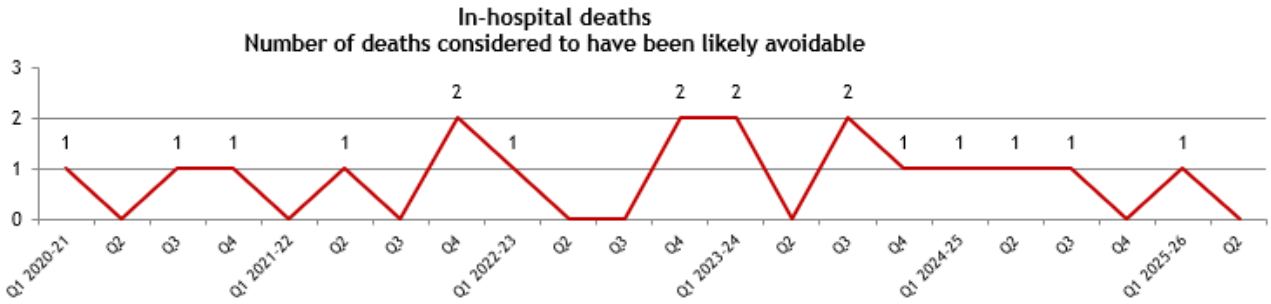
The table to the side sets out the number of deaths in each quarter of the reporting period, along with the one patient death (0.22% of total) assessed as likely avoidable death, which compares well with national average of 3-5%.

Standard 5 point clinical judgement scale

- **1 — Definitely avoidable**
  Clear evidence that problems in care caused the death
- **2 — Strong evidence of avoidability**
  Care issues very likely contributed to death
- **3 — Probably avoidable (>50:50 chance)**
  On balance, death likely linked to care problems
- **4 — Possibly avoidable (<50:50 chance)**
  Some concerns, but unlikely to have caused death
- **5 — Definitely not avoidable**
  Death expected due to underlying illness

Reporting period	Number of deaths	No of deaths assessed as 'likely avoidable'	% of patient deaths assessed as 'likely avoidable'
Q4 2024-25: January 2025 to March 2025	**564**	**0**	0
Q1 2025-26: April 2025 to June 2025	**455**	**1**	0.22%
Q2 2025-26: July 2025 to September 2025	**386**	**0**	0
Q3 2025-26: October 2025 to December 2025	**489**	**0**	0
Total: January 2025 to December 2025	**1894**	**1**	**0.05%**

The chart below sets out the trend of numbers of in-hospital deaths that were assessed to be likely avoidable over time, ranging between 0 and 2 over time.



Review of deaths of patients with identified learning disabilities

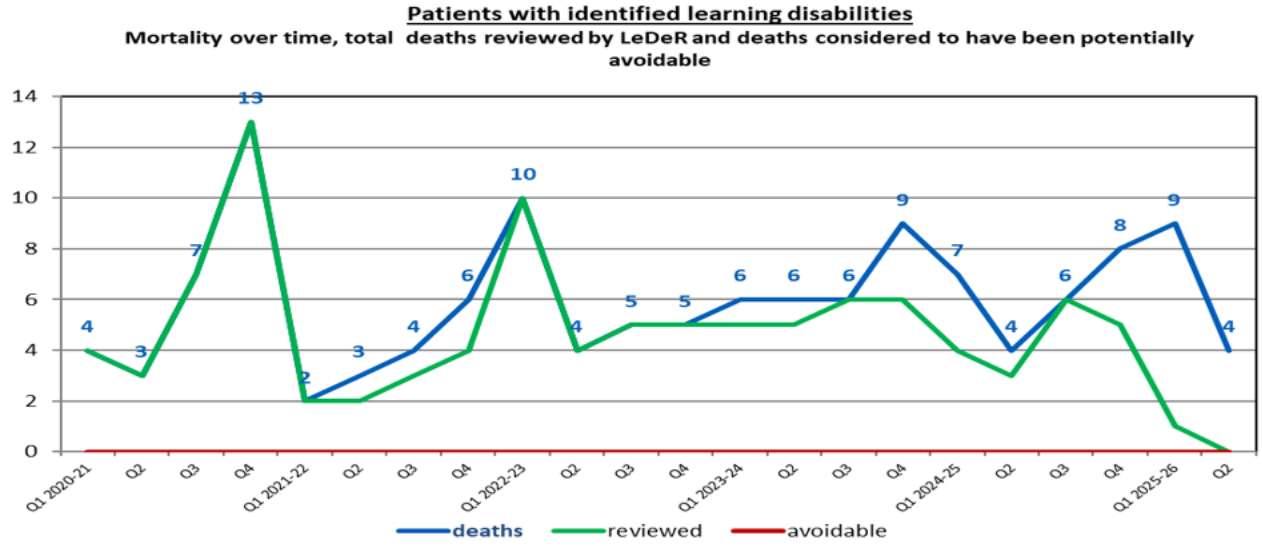
In-hospital deaths of patients with identified learning disabilities remain low but fluctuate over time, generally ranging from around 2 to 10 per quarter, with occasional peaks.

Reviews follow the LEDER programme which is a national NHS-led review process designed to improve care and reduce inequalities for people with learning disabilities and autistic people (LEDER stands for Learning from Lives and Deaths – People with a Learning Disability and Autistic People).

The number of reviews varies across the period, with some quarters showing close alignment between deaths and reviews, while more recent quarters indicate a decline in completed reviews relative to deaths.

Importantly, no deaths were assessed as potentially avoidable across the entire period, indicating no cases where death was judged more likely than not due to problems in care.

Overall, the data suggests low and variable mortality, inconsistent review rates, and no identified patient safety concerns in relation to avoidable deaths within this group.



Prevention of Future Deaths (PFD) Notification

A PFD report is written after an inquest when a coroner believes that action should be taken to prevent similar deaths in the future. The purpose is to ensure that learning from deaths leads to system change and risk reduction, rather than case-specific improvements.

In 2025-26, the Trust received a PFD following and inquest into the in-hospital death of a patient admitted in January 2024 and died in May 2025.

The PFD highlighted concerns identified during the inquest relating to issues in clinical assessment, monitoring, and/or escalation of care, which may have contributed to increased risk for the patient. The Coroner emphasised the need for clearer clinical decision-making, improved communication, and stronger adherence to established care pathways to prevent similar incidents in the future.

In response, ESHT reviewed the case and implemented systemic improvement actions, including strengthening clinical escalation processes, reinforcing staff training, and enhancing governance oversight to mitigate the risk of recurrence.

2.10 - Workforce

Freedom to Speak Up at ESHT

Freedom to Speak Up Guardians (FSUG) were introduced in the NHS in 2016 to support staff to raise concerns safely and ensure these are listened to, acted upon, and used for learning and improvement.

At ESHT, Guardians play a key role in promoting a positive speaking up culture, working both reactively (supporting individual concerns) and proactively (improving awareness, training, and organisational practices). They are part of the South-East regional network and regularly meet with Guardian colleagues to share best practice and ensure that all reporting requirements to the National Office are being met.

In 2025-26, 171 concerns were raised, with themes consistent with national trends, and low levels of anonymous reporting, indicating good levels of psychological safety.

Themes and learning from cases and anonymised data is shared at the People and Organisational Development Committee, a sub- committee of the Trust Board, and the Guardians report in person to the Trust Board every 6 months.

The Trust has strengthened visibility, training, and leadership support for speaking up, including mandatory learning for managers and active engagement with staff networks. Staff survey results show modest improvements in confidence to speak up, although perceptions of how concerns are acted on remain an area for continued focus.

Feedback on the Guardian service from the staff survey in 2025-26 was positive, and largely comparable with last year's. 58% of responses saying they feel safe to speak up about concerns, 70% saying they feel secure in raising unsafe clinical practice concerns and 100% of users reporting timely responses, feeling listened to and supported, and recommending the service.

Overall, Freedom to Speak Up continues to be an important mechanism for learning, improving safety, and supporting staff, with ongoing work to further strengthen culture and responsiveness.

Staff Wellbeing

Psychological Wellbeing and Safety

Over the past year, the psychological wellbeing and support needs of colleagues across our services have changed. There has been a reduction in the number of staff requiring individual trauma therapy related to work-based incidents, alongside increased engagement with Trauma Risk Management (TRiM) and Restorative Supervision services. While it is not possible to directly attribute these changes to one another, this may indicate a positive impact on staff wellbeing and early support interventions.

TRiM (Trauma Risk Management) continues to be an established and valued support service within ESHT. A growing number of trained TRiM Practitioners across the organisation are now providing support to colleagues following traumatic or distressing incidents, helping to strengthen local support within teams and reduce reliance on the central People Engagement team.

Since April 2025, the TRiM service has responded to 281 referrals, with all individuals offered a TRiM intervention. This included 91 initial TRiM assessments, 52 one-month follow-up reviews, and 2 three-month follow-up reviews. In addition, 14 supportive wellbeing conversations were provided to colleagues requiring further emotional support.

We continued to support the physical and emotional wellbeing of colleagues during 2025-26 and further adapted the range of support that we offered to our people to reflect the impact of work pressures. Some of our activities in 2025-26 are as follows:

- Strengthened our mental health training offers to staff to increase confidence in supporting themselves and others. Training includes the Mental Health First Aid qualification, Mental Health Awareness Training and Wellbeing Conversations training.
- Increased our Wellbeing Champions network to 162 staff members in the Trust.
- Embedded Trust wide quarterly wellbeing meetings (supported by the Non-Executive Wellbeing Guardian) and 8 weekly Trust wide Staff Smokefree Focus Group meetings.
- Introduced One You East Sussex (OYES) on site stop smoking clinics and provided 98 health checks in conjunction with OYES for colleagues aged between 40–74 (70.9% attendance).
- Delivered five sessions on men's health, covering topics such as men's wellbeing, physical health, nutrition, cancer awareness risk factors and prostate health to reduce the stigma of talking about men's health.

- Delivered five ‘Menopause Demystified/ Mind’ workshops. Menopause related absence is recorded and reviewed on ESR to support and signpost individuals where appropriate.
- Achieved a menopause café facilitator licence to enable us to deliver on site menopause cafés and have held six cafés over the past year with 70 colleagues in attendance.
- Introduced new ways of working including streamlined focus on Maternity support- updated maternity information support pack, automation of; signposting and self-serve option, table bookings process and OYES health check process, and further exploration of increased accessibility of the Discounts and Benefits brochure.
- Continued promotion of Vivup Employee Assistance Programme. 35.5% of Trust employees (2,840 people) have now registered with Vivup.
- Supporting flexible working, with the Work Life Balance and Special Leave Policy being updated following legislation changes and an electronic process to apply and record flexible working requests. The electronic application is live and to date 1678 requests have been made with 82% of requests being approved or approved with amendments.
- Throughout 2025/26 we have held and supported events to thank and celebrate the achievements of our people, including the Trust Awards and the Festive Refreshments events in December 2025.

Feedback received from staff who have accessed TRiM include:

Occupational Health

Following successful SEQOHS (Safe, Effective, Quality Occupational Health Service) accreditation in 2023, the Occupational Health service continued to demonstrate high standards of care and quality improvement throughout 2025. Annual renewal feedback recognised the service's strong clinical governance, audit processes, and commitment to continuous improvement.

During the year, the service improved access to Occupational Health support by:

- Reviewing referral and triage processes.
- Streamlining clearance for newly appointed doctors.
- Strengthening access to musculoskeletal services, and
- Increasing staff engagement with seasonal vaccination programmes.

Collaborative working across the Trust was also strengthened through partnership initiatives with Infection Prevention and Control, Human Resources, the Wellbeing Team, and Equality, Diversity and Inclusion colleagues. This included:

- The development of a Winter Wellness Handbook to holistically support staff in preparing for winter.
- Improvements to infectious disease exposure guidance.
- Enhanced workplace adjustment pathways recommended through Access to Work, working in partnership with the Equality, Diversity, Inclusion (EDI) team.
- Contributions to the development of Mental Health Awareness training due to launch in 2026.

Service-user feedback remained positive in 2025, with Occupational Health receiving average ratings of 4.7 stars for case management services, 4.92 stars for vaccination clinics, and 4.44 stars from managers accessing support (out of a maximum of 5 stars). Feedback has informed further improvements, including clearer referral guidance and the development of a manager's guide to the Occupational Health referral process.

Looking ahead, Occupational Health will continue to strengthen integrated wellbeing support through closer alignment with Wellbeing services, TRiM, and restorative supervision, helping to provide timely, high-quality support for staff and contributing to safe patient care across ESHT.
Safer Medical Staffing

Staffing Rota Gaps

The Trust has reviewed resident doctor staffing at Conquest Hospital, where levels have historically been lower than at EDGH. From August 2026, Foundation Year doctors in years 1 and 2 (FY1 & FY2) and Registrar numbers will be increased.

Staffing at ward level has also been strengthened by redistributing doctors following the transfer of cardiology from Conquest to EDGH and the conversion of a frailty ward to a nurse-led model.

Each year, the Trust receives an allocation of junior doctors from the Deanery, who are then assigned to clinical divisions. Where allocations are insufficient to fill rotations, gaps are escalated to Divisional clinical leads, and service managers are notified if services are affected so that Divisions fill gaps with existing doctors interested in staying on at the Trust at the end of their rotation. Any remaining gaps are then filled through recruitment or via locum or bank staff.

Supporting Safe Working Hours

The Trust employs two independent Guardians of Safe Working Hours (GOSWH), based at Conquest Hospital and Eastbourne DGH, to champion safe working for trainee doctors. Supported by the BMA, they promote safe hours, oversee exception reporting and rota gaps, and ensure compliance with the 2016 Terms and Conditions for Doctors and Dentists in Training.

Their role is to assure safe working practices and improve junior doctors' working lives. Doctors can raise concerns through exception reporting, enabling timely improvements. The GOSWHs provide quarterly and annual reports to the People and Organisational Development Committee and contribute to key governance meetings.

Annual NHS Staff Survey 2025

The annual NHS Staff Survey is scored on seven People Promise elements and two key themes of Staff Engagement and Morale. These two key themes remain performance indicators for organisations.

Staff Survey questionnaires were distributed to 8,644 substantive staff at East Sussex Healthcare NHS Trust. A total of 4,330 responses were received, representing a 50% response rate. This marks a 3% increase compared to the previous year and is slightly above the national survey provider average of 49%.

This year, 34% of bank staff completed the NHS Bank Staff Survey, maintaining the same response rate as the previous year. Once again, this figure ranks among the highest nationally, reflecting a highly engaged bank workforce.

Our staff's honest feedback helps us understand what it is really like to work here. The results show that kindness, respect and teamwork are continuing to grow. Many colleagues told us they feel trusted by those they work with and proud of the care they provide to patients every day.

These strengths highlight the compassion and commitment that sit at the heart of our organisation. The survey also highlighted areas where we need to do better. Many colleagues told us they would like a stronger say in decisions that affect their work, more consistent support with workload and wellbeing, and improved access to development opportunities.

Flexible working remains important, but staff experiences vary between teams. These insights help us clearly see where change is needed and strengthen our commitment to improving what matters most to our people.

Some improvement and strengths reported in the Staff survey 2025

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

1. Feeling that our roles make a positive difference to patients (+2.3%).
2. Improvements in kindness, understanding, respect and team cohesion (several questions improving by +2-3%)
3. Increases in reporting of harassment, bullying or abuse (+3.7).
4. 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.

Like many NHS organisations, our Trust faced a challenging year. Despite this, these improvements reflect the remarkable dedication of our workforce and their continued commitment to building a culture of compassion, respect and psychological safety, even in difficult circumstances.

Our NHS People Promise Results

The NHS People Promise is built around seven key themes, which describe the experience the NHS wants all staff to have at work:

- 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.

No People Promise theme scored significantly higher than comparable organisations overall. However, the Inclusion area within “We are compassionate and inclusive” was notably stronger and stands out as a key strength for our organisation.

Among our bank staff, compassion, inclusion and teamwork were also areas of strength. Bank colleagues reported feeling respected by those they work with and valued as part of supportive teams.

Together, these results underline the strong foundations we have built in promoting kindness, fairness and respect across our workforce.

Stability in Engagement and Morale

Overall, staff engagement and morale have remained stable compared to 2024 for both substantive and bank colleagues. This is encouraging given the wider challenges facing the organisation and reflects the ongoing commitment and dedication of our workforce.

However, there are still important areas where we need to improve to make a meaningful difference to everyday working experiences.

The People Promise themes scoring lower than similar organisations were:

- We each have a voice that counts.
- We are safe and healthy.
- We work flexibly.
- We are learning- Colleagues reported challenges around influence and feeling empowered.
- 25.3% felt their appraisal helped them improve their work.
- 23.5% said they rarely experience unrealistic time pressures.
- Health, Safety and Wellness.
- 27.8% feel there are enough staff to do their job properly.
- 58.1% said they have come to work despite not feeling well enough.
- Increased experiences of burnout (burnout score: 4.86).

This year's results offer a pivotal opportunity for change. With stronger engagement mechanisms, increased data visibility and rising participation in the survey, we are better equipped to act on what our people are telling us with precision and purpose. By adopting a more unified and accountable approach to people experience, supported by consistent leadership and system wide alignment, the Trust can create a more supportive, inclusive and empowering environment for all colleagues. Doing so will ensure that improvements are meaningful, measurable, sustainable and reflected in the care we deliver to our patients.

We remain committed to creating an environment where all colleagues can help drive positive change.

Part 3.1 - Review of our Quality Priorities in 2025-26

The Trust identified three quality improvement priorities for 2025/26 to contribute towards the delivery of our Quality and Safety Strategy.

This section describes the work undertaken at the Trust to deliver on our quality improvement priorities over the past year, setting out how we will continue to deliver the aims of each of our improvement priorities and where there is still room for improvement to be made.

Our 2025-25 quality priorities were:

Quality Domain	Priorities for improvement 2025-26
Patient Safety	Improving the care of patients with mental ill health
Clinical Effectiveness	Increasing the quality of WHO Safety Checklist compliance across the Trust
Patient Experience	Community Intermediate Care Rehabilitation Model

Patient Safety - Improving the care of patients with mental ill health

Why this was chosen as a priority for our Quality Account

Over the past three years, more people experiencing mental health (MH) problems came to emergency and acute hospital services. Between December 2022 and December 2024, East Sussex Healthcare NHS Trust (ESHT) saw 11,447 mental health attendances at Conquest Hospital and Eastbourne District General Hospital (EDGH).

During this time, patients often stayed in hospital longer because there were fewer specialist mental health beds available. As a result, people coming to hospital in mental health crisis were frequently admitted to general hospital wards.

This led to:

- Fewer beds being available for patients with physical health needs.
- Increased pressure on ward staff.
- More frequent involvement of security staff.
- Greater use of temporary staff, adding to costs.

Overall, this approach did not work well for patients or staff. Many hospital teams did not have specialist mental health training but were required to care for patients with complex needs. This sometimes meant care focused more on managing behaviour rather than providing therapeutic support. Accessing mental health support was also difficult, as referrals relied on a single telephone line, which could delay assessment and care.

What we did

To address these challenges, ESHT made several improvements to how mental health care was delivered:

- Set up a dedicated Mental Health Service within ESHT, led by a Head of Nursing.
- Introduced a Mental Health Outreach Team (MHOT) to provide specialist support and therapeutic care.
- Worked in partnership with the Mental Health Trust and Integrated Care Board (ICB) through a joint taskforce and strategy group.

- Put in place a clear and consistent approach to the use of security staff.
- Made it easier for wards to refer patients by introducing email referrals alongside the existing phone line.
- Created a direct and faster escalation process with Mental Health Trust partners to improve response times.

These changes aimed to improve patient care, support staff, and provide quicker access to mental health expertise.

What We Have Achieved

Workforce Development and Training – To support staff, ESHT introduced a range of training and development initiatives to build staff confidence and skills in caring for patients with mental health needs:

- Developed and delivered a Mental Health Enhanced Observation education programme for nurses and clinical support staff.
- Rolled out ongoing mental health training in partnership with Sussex Partnership NHS Foundation Trust (SPFT), aligned to Liaison Psychiatry and Paediatric Liaison Network (PLAN) standards.
- Made training easily accessible to all staff via the MyLearn platform.

Improved Clinical Care and Patient Flow – ESHT introduced several changes to reduce delays for patients in a mental health crisis:

- Established the Mental Health Outreach Team (MHOT) to provide specialist support and therapeutic care within the acute hospitals.
- Introduction of a ‘front of house’ approach in Emergency Departments with a Registered Mental Health Nurse (RMN) in post.
- Enabled parallel assessment, allowing mental and physical health needs to be assessed at the same time to stepped up care.
- Supported early referral to Liaison Psychiatry to help enable safe and timely discharge.
- Expanded the MHOT role to include mental health triage and initial risk assessments in ED, helping to ensure mental health patients receive the same priority as those with physical health needs.

Strengthened Partnership Working - ESHT also improved how teams work together across organisations to ensure a timelier, and coordinated care:

- Improved access to Mental Health Trust partners for timely referrals, reviews, and escalations.
- Enhanced joint working through the Mental Health Taskforce and shared escalation pathways.

Patient Experience and Co Production - ESHT took steps to make sure patients' voices are heard and involved in their care:

- Introduced a Patient Reported Experience Measure (PREM) called "My Voice!", which captures patient feedback on mental health care within ESHT, and helps guide service improvement.
- Implemented Dialog+, a care planning tool completed with patients and where appropriate their families at various stages of care, using simple rating scales to understand their needs.

Ongoing Priorities

To build on the progress so far, the Trust has identified these key areas for further improvement:

- Reduction in incidents involving challenging behaviours – Providing earlier therapeutic support and timely medication, with security staff used only as a last resort and regularly reviewed.
- Developing a Mental Health Dashboard – Creating a real-time dashboard within Nervecentre to track mental health activity, support audits, and ensure quality and compliance.
- Reviewing admission protocols for patients in mental health crisis admitted to ESHT beds to ensure care is appropriate and consistent.
- Improving information access – Developing a Mental Health Services section on the ESHT extranet.
- Recruiting to the full MHOT establishment – Reviewing the team structure and extending services to the Conquest Hospital with the current staffing template under review, and extension of MHOT services to the Conquest Hospital site.
- Quality Improvement Project - Delivering a project focused on reducing restrictive practices, promoting inclusivity and tackling stigma in mental health Care.

Clinical Effectiveness Priority – Increasing the quality of WHO Safety Checklist compliance

Why this was chosen as a priority

The World Health Organisation (WHO) developed the Surgical Safety Checklist to improve patient safety during operations. The checklist is structured around key stages of a procedure:

- **Sign In –** before anaesthesia is given.
- **Time Out –** before the first incision.
- **Sign Out –** before the patient leaves the operating room.
- **PACU –** Signed by PACU at handover of patient.

In each phase a checklist coordinator must confirm that the surgery team has completed the listed tasks before the operation begins.

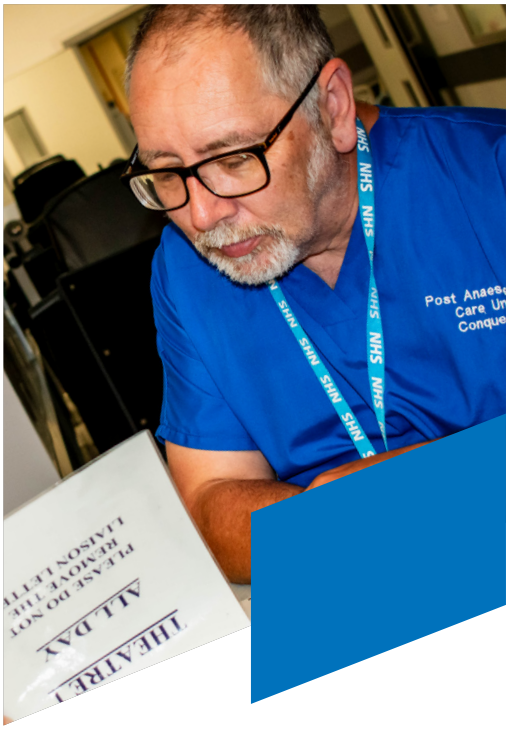
The WHO Surgical Safety Checklist was introduced to improve patient safety at key stages of an operation (Sign In, Time Out, Sign Out, and recovery handover). It was adopted in the NHS in 2009 via a National Patient Safety Agency (NPSA) alert, and compliance monitored in ESHT through monthly audits across 41 clinical areas.

Although the checklist aimed for 100% completion, concerns emerged that it had become a “tick-box” exercise in some areas. Live observational studies were introduced to assess how it was used in practice, but uptake remained low. In 2024/25, only 10 studies were completed, with most areas not participating.

What we did

- **Standardisation and Frequency -** Since April 2025, WHO Surgical Safety meetings were used to promote and support live process audits across all relevant areas. Although the original aim was for each department to complete two audits per year, this was revised at the April 2025 meeting to a more achievable target of at least one live audit per area during the first year, particularly for departments already undertaking monthly reviews.

- **Peer-review audits -** To ensure fairness, we used a peer-review approach, with staff from different departments conducting audits to provide an independent view. Auditors recorded who was present, highlighted good practice, identified any issues, and suggested improvements. They also conducted spot checks to confirm that safety checklists were completed correctly. Standard audit tools were used to review key stages of care:



- **Team Briefing and Debriefing:** Checking communication and safety planning at the start and end of operating lists.
- **Patient-Level Checks:** Observing safety checks before, during and after surgery (Sign In, Time Out, Sign Out).

- **Governance and Reporting -** Governance and oversight were maintained through bi-monthly WHO meetings, where audit findings were reviewed to identify trends and system-wide issues. Results were published in the Annual WHO Surgical Checklist Compliance Report, providing a clear overview of organisational compliance and patient safety performance.

What we achieved

- Audit results showed that, while some areas exceeded the required number of audits, overall coverage slightly declined compared to the previous year. This was mainly due to staffing pressures and the impact of medical industrial action, which shifted focus to frontline care over audit activity.
- Plans are now in place to strengthen processes and ensure more consistent audit coverage during periods of high operational demand.

Ongoing Priorities

We are committed to increasing the number of live audits to strengthen patient safety. To support this:

- We are involving more staff so there is enough capacity to conduct regular reviews. To maintain high standards, all departments are expected to complete at least one audit each year, with more frequent reviews encouraged where possible.
- We are also exploring the use of digital tools to make auditing quicker and more efficient.

Patient Experience priority – Community Intermediate Care Rehabilitation Model

Why this was chosen as a priority

Intermediate Care, supporting people to stay well, safe and independent at home is a National NHS priority. The latest national guidance on intermediate care in 2023 highlights the importance of short-term “step-down” care after a hospital stay to support recovery and reduce the need for readmission or long-term care. We focused on improving patients’ experience of moving from hospital to community care, by developing a joined-up intermediate care service.

Our aim was to:

- Provide faster access to the right care after discharge.
- Reduce delays, duplication and complex referral processes.
- Improve patient experience through a more coordinated “one team” approach.
- Lower the risk of deterioration while waiting for support.
- Free up hospital beds for those who need them most.

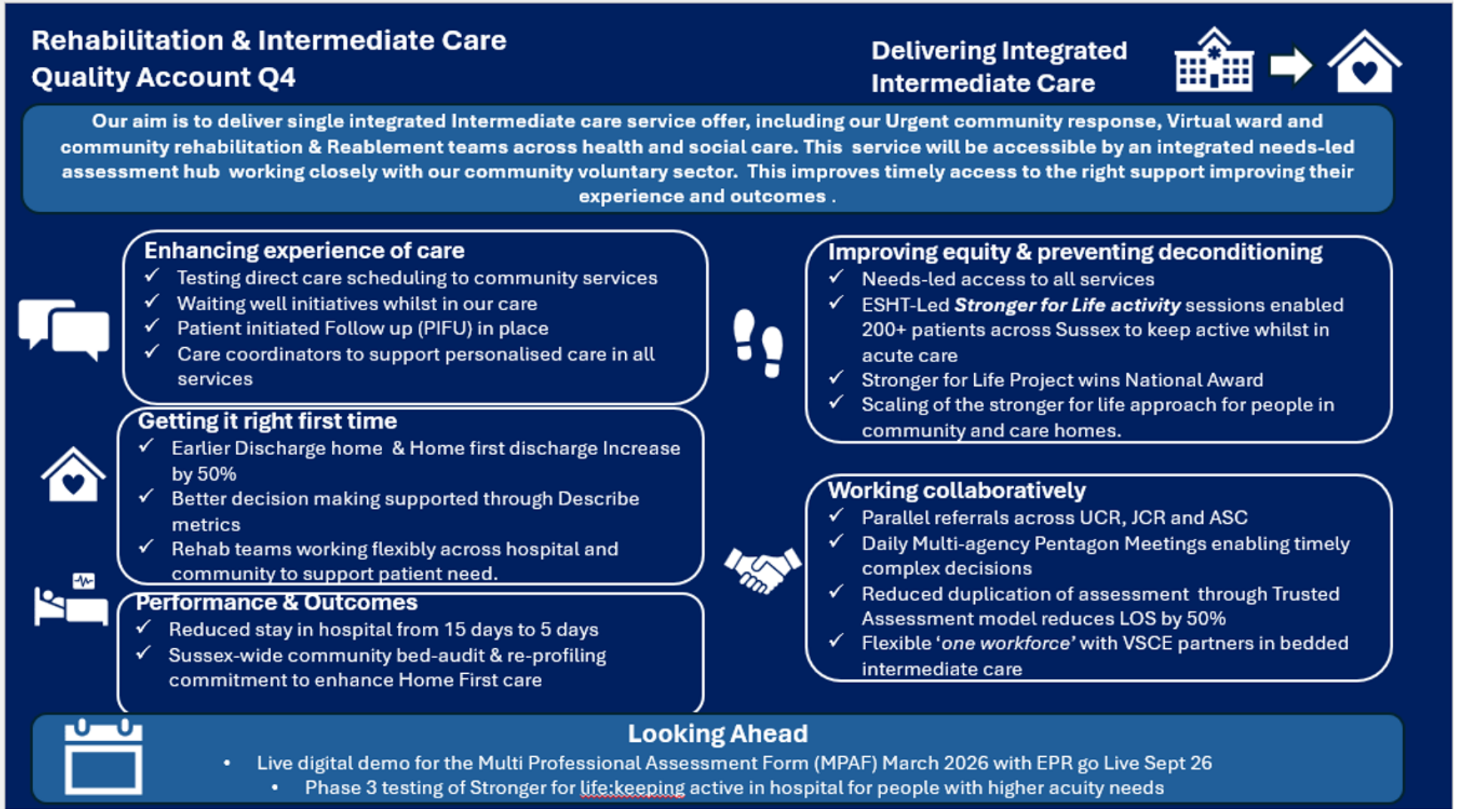
What we achieved

We developed a single, integrated intermediate care model, bringing together hospital teams, community services, and social care and voluntary partner organisations. That meant we had Urgent Community Response (UCR), Virtual Wards, and community therapy services, closely working with Adult Social Care, reablement services, and the voluntary sector.

Key improvements include:

- A **“Home First”** approach supported by increased capacity in acute therapy and Urgent Community Response (UCR) services to improve access to rehabilitation and support.
- A flexible, “one workforce” model with joined-up assessment of patients’ needs and care plans.
- Investment in digital tools and virtual ward support with improved access to care and efficiency.
- Closer collaboration with community and voluntary groups.

Figure 1 - Key results and outcomes of the Community Intermediate Care Rehabilitation Model



Key Results

- More patients returning directly home after a hospital stay – Numbers increased from around 45 per month in September 2025 to around 90 in March 2026 on the “Home First” pathway 1.
- Shorter hospital stays – Time spent in hospital after patients were ready to leave reduced from 25 – 30 days (mid-2024) to 5 days or less (early 2026).
- Reduced need for community rehabilitation beds (Pathway 2) - Patients needing bed based care fell from ~100 (July 2024) to ~50 (March 2026).
- Faster access to therapy to support discharge – Physiotherapy was often provided same day of referral, and Occupational therapy within 1 – 2 days. Thus, patients waiting for therapy before discharges reduced from ~50 to ~12.

- **Improved care and patient experience:**

- Patients now tell their story once through a shared assessment process using a Multi Professional Assessment Form (MPAF).
- Daily multi-agency reviews ensure quicker, coordinated decisions.
- People with more complex needs receive targeted support through a specialist panel.
- Waiting times for long-term care have halved through shared (“trusted”) assessments.
- Clearer information helps patients and carers feel more confident and informed.

- **Supporting recovery and independence -** We introduced programmes to help patients stay active and regain confidence, such as listed below.

- “Stronger for Life” reconditioning programme supporting around 200 patients.
- Activity sessions alongside therapy, including virtual and in person options.
- Support from community partners for practical help and social connection.

Patients reported feeling more motivated, supported and involved in their recovery. An example of a patient’s story of being helped to stay safely at home using the “Home First” model, rather than being admitted to hospital or long-term care. Is shown below:

Doris' Experience of the Home First Approach

Keeping Doris living well at home

A Home First Approach

Referral to UCR team
Doris is not managing well and reaching crisis point. Neighbours are worried

Holistic approach
Our Integrated support workers assessed all of Doris needs; her mobility, toileting and bladder management, medication and loneliness

Deteriorating mobility
In Hospital Doris had made progress but once home she had become stuck in her chair, lost confidence and not accessing her toilet

Rehabilitation not just care
Rehabilitation specialist worked with Doris to regain her confidence and mobility to be able to use her toilet, make her meals and get up to her own bed

Working collaboratively
The ISSW team co-ordinate nursing team, pharmacy, GP, therapy & RedCross

Supporting health & wellbeing
Redcross support Doris with her shopping, tasks around the home, befriending and connect her into local social groups.

Power of community partnership
Our Integrated support team also arrange for a fire safety check, alongside charitable organisations to ensure Doris' welfare is also supported

'What is most important to me is to stay living in my own home, feeling stronger and feeling supported'. Doris

- **Using Digital innovation –** Digital solutions have helped improved needs assessment and personalised care by:

- Enabling virtual home assessments and monitoring supported patients at home, with clinical input stepped up when needed.
- Reducing administrative time so staff can focus on patients with tools such as voice recording.
- Expanding access to therapy and rehabilitation by live-streamed activity sessions which enabled more patients across different sites to take part in rehabilitation.

- **Working together – Care** for patients with complex discharge needs is now delivered through stronger partnerships between NHS hospital and community teams, Adult Social Care, Voluntary and community organisations **(Pentagon Model)**. Patients at risk of delay are identified early and reviewed at daily meetings. This collaborative approach ensures more personalised, coordinated care such as the Edwina's story below.

Personalised Coordinated Care helped a Patient Restore Independence

Edwina's Story

A journey of personalised care

Discharged D2A with CSRT referral

Edwina was reviewed by CSRT and discharged. Considered to not have rehabilitation potential.

High Dependency Needs

Fully supportive seating. Most care provided in bed.

Pilot Role Review

Pilot role continues involvement with Edwina following discharge into the community to continue to support needs and rehabilitation goals.

Edwina Feels Misled

Edwina expresses disappointment that she has not been receiving the rehabilitation she expected on discharge.

Advocacy

Pilot Role understands Edwina's distress and takes action to support through advocacy and coordination of services.

Identifying Needs

Pilot role re-engages CSRT around clearly identified needs and goals.
Edwina wishes to be able to access a commode for dignity in personal care.

Therapy Intensity

Therapy intensity is increased through collaboration with multiple service providers and engagement with care home staff to take an enabling rather than a purely caring role.

'Rehab has changed my life'

Edwina has exceeded her goals and made progress from full dependency to standing and taking small steps with a frame.

Feedback: The increased volume of therapy has brought "a huge improvement in our Aunt's situation…giving her more dignity"

- **Intermediate Care bed audit -** Some patients cannot return home straight away and require short-term care in community beds (Pathway 2). To ensure the right number and type of beds are available in East Sussex, ESHT took part in a regional audit to better understand patient needs.

The findings showed there is an opportunity to support more patients at home, but many would need a higher level of community support than is currently available. This is helping shape plans to strengthen community services.

Work is underway with Sussex Community NHS Foundation Trust to develop a shared East Sussex community bed plan, alongside discussions with commissioners to secure funding and build ESHT's capacity to care for patients with more complex needs (NHSE Level 2 rehab).

- **Preventing Deconditioning –** Whilst patients are in our care it is important to reduce the risks of deconditioning (loss of strength and independence). We have been developing a reconditioning programme, delivered in three phases are described below:

- **Phase 1: Active Sussex: Reconditioning project –** With key partners organisations, we introduced tailored activity sessions alongside NHS therapy for patients in rehabilitation beds. More information on the benefits can be found here:

- Unlocking Stroke Recovery: The Power of Exercise
- Bexhill leads the way in innovative hospital project keeping patients active and independent
- Stronger-For-Life-The-Active-Sussex-Reconditioning-Project-Report.pdf

- **Phase 2: Stronger for Life: Reconditioning project - Testing a scalable virtual model –** We tested a livestreamed activity model delivered from the Irvine Unit to multiple hospital and community sites across Sussex. This supported around 200 patients to take part in additional activity alongside their rehabilitation.

  Early results showed that this approach improved access to activity and was well received by patients.

  The learning also highlighted that patients with more complex needs were less able to engage, which is now shaping Phase 3.

Patient feedback in Phase 2

"I want to get back to where I was. When you do the exercises, they do them so you can get better and move. You feel part of a team."
"I think most people who come here are happy because they are doing something that is useful to them, and I shall continue to do them because if I don't do the exercises, I will fail. It is as dead simple as that."
"I enjoy it, it is something different and good for you. And the exercises are quite fun."

- **Phase 3- Stronger for Life: Reconditioning project –** Testing a model for people with higher needs - Building on earlier learning, we identified that patients with more complex needs were not benefiting fully from the previous activity model. To address this, we are piloting a new approach in the acute stroke unit (launched in April 2026), working with Active Sussex and Wave Leisure to provide tailored, face-to-face activity sessions delivered by specialist health instructors. This pilot aims to improve recovery, increase activity levels, and reduce care needs for patients at highest risk of deconditioning, while also exploring a sustainable model for the future.

✔ **Improving access to community care:**

- We made it easier for patients to access community services by introducing direct referrals from hospital, helping people get the right support more quickly.
- We reduced waiting times by offering more flexible follow-up appointments, allowing care to be arranged when needed and helping more patients complete their treatment confidently.
- To support people while they wait, we introduced “waiting well” support, including clear information, self-help resources, and tailored programmes to help people stay healthy, independent, and active.

Ongoing Priorities

- **Understanding patients’ needs:** Introducing new measures and patient “personas” to better assess needs earlier and support discharge planning.
- **Shared records:** Rolling out shared digital joint assessment form (MPAF) across services.
- **Trusted assessment:** Expanding across services to speed up access to long-term care and further reduce delays.
- **Scaling reconditioning:** Increasing access to Stronger for Life so all at-risk patients can stay active and maintain independence.

Part 3.2 - Reporting against Core Quality Indicators

Amended regulations from NHS England require Trusts to include a core set of quality indicators in the Quality Account. The Trust's performance for the applicable quality indicators is set out in this section

Summary Hospital-level Mortality Indicator (SHMI)

SHMI has slowly increased but remains within the "expected" range.

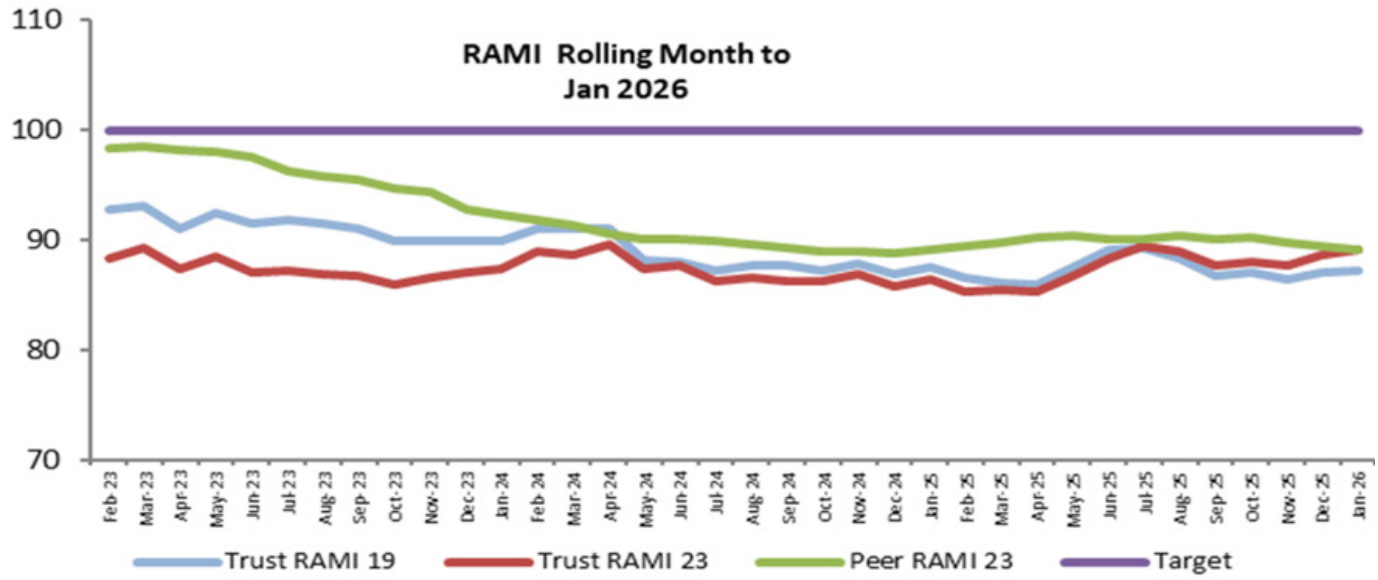
The Trust is submitting Same Day Emergency Care (SDEC) data to the Emergency Care Data Set (ECDS) rather than the Admitted Patient Care (APC) dataset. SHMI is calculated using APC data. Removal of SDEC activity from the APC data affects the Trust's SHMI value.

Indicator	Jan 21 – Dec 21	Jan 22 – Dec 22	Jan 23 – Dec 23	Jan 24 – Dec 24	Jan 25 – Dec 25
SHMI Value	0.96	1.00	1.00	1.03	1.07
Banding	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected

Risk Adjusted Mortality Index (RAMI)

This graph is showing the Risk Adjusted Mortality Index (RAMI) - a mortality indicator for deaths in hospital.

It compares East Sussex Healthcare Trust to our Acute England Peers. The data shows that the Trust has remained consistently below our peers throughout the period of February 2023 to January 2026 (where lower is better).



Condition-specific outcomes

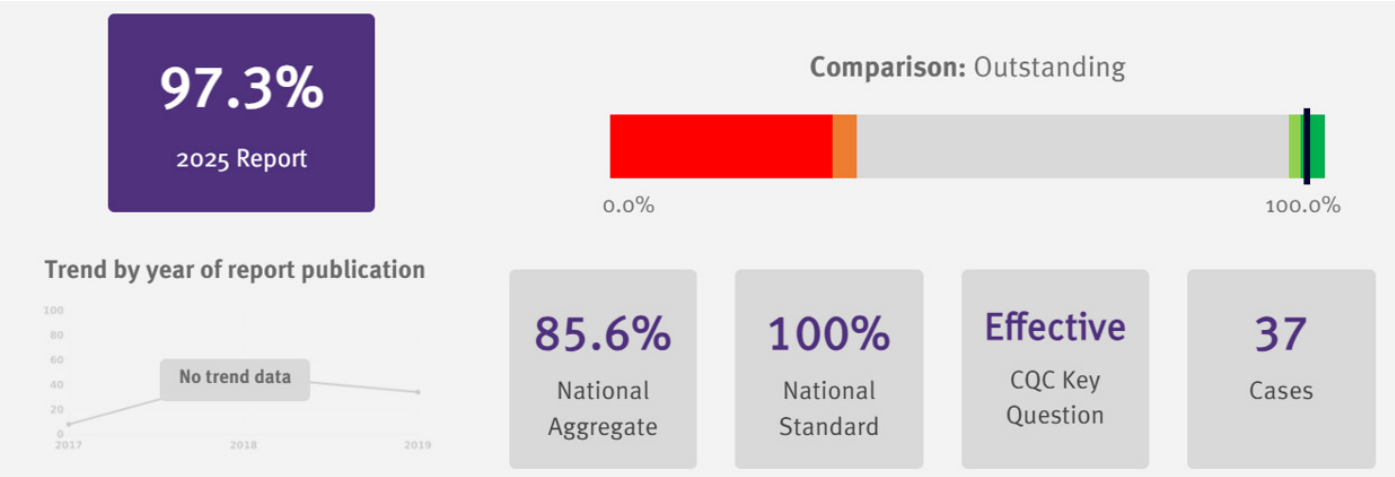
Condition-specific outcomes are clinical or patient reported measures that are designed to evaluate the results of healthcare interventions within the context of a single disease or condition. Unlike general health outcomes, which assess overall quality of life or general functioning, condition-specific measures target symptoms, complications, or functional limitations directly related to a specific health condition. Their main purpose is to provide a precise assessment of how effectively a treatment, therapy, or intervention addresses the particular needs associated with that condition.

A compilation of recent condition-targeted clinical outcome data for ESHT is listed below:

Epilepsy and Seizures in children and young people (source: Epilepsy 12 national audit)

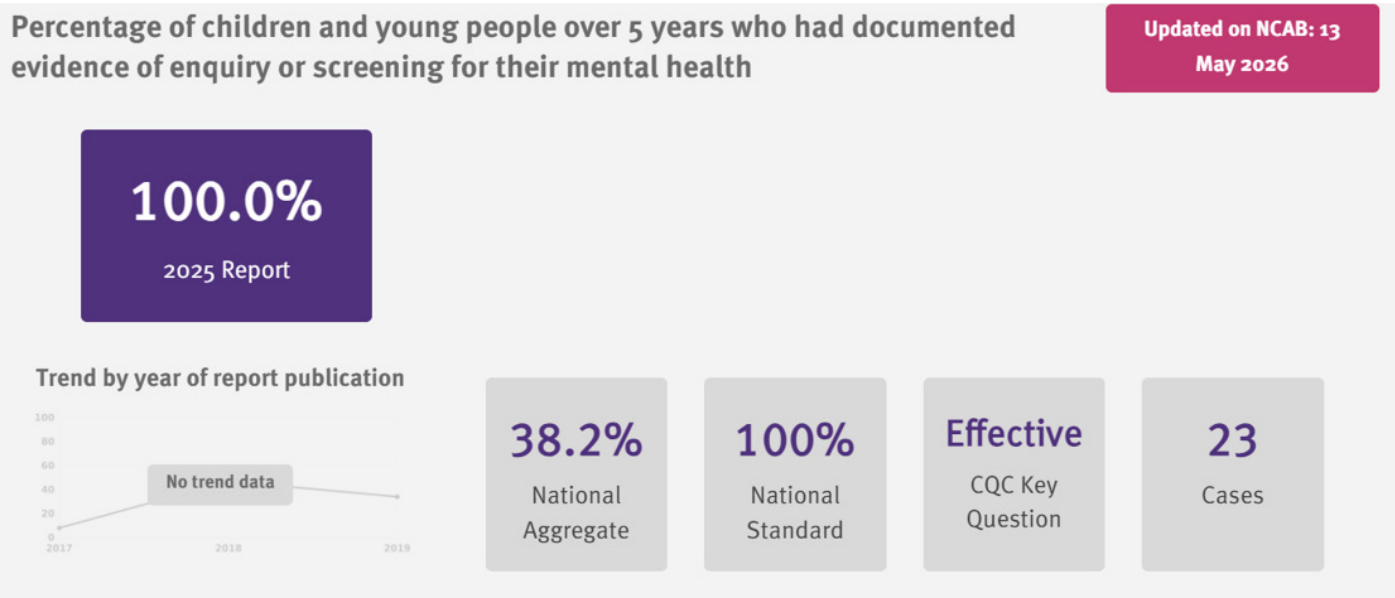
MEASURE: Percentage of children and young people seen by an epilepsy specialist nurse by first year.

In summary, the service is performing at a high level compared to national benchmarks, delivering good quality care, with only minor room for improvement:



MEASURE: Percentage of children and young people over 5 years who had documented evidence of enquiry or screening for their mental health.

This chart shows how often children and young people had their mental health needs checked as part of their care. All children in this review (100%) had a recorded check or screening for mental health, which meets the national standard and represents excellent performance. **This is much higher than the national average of 38.2%.**



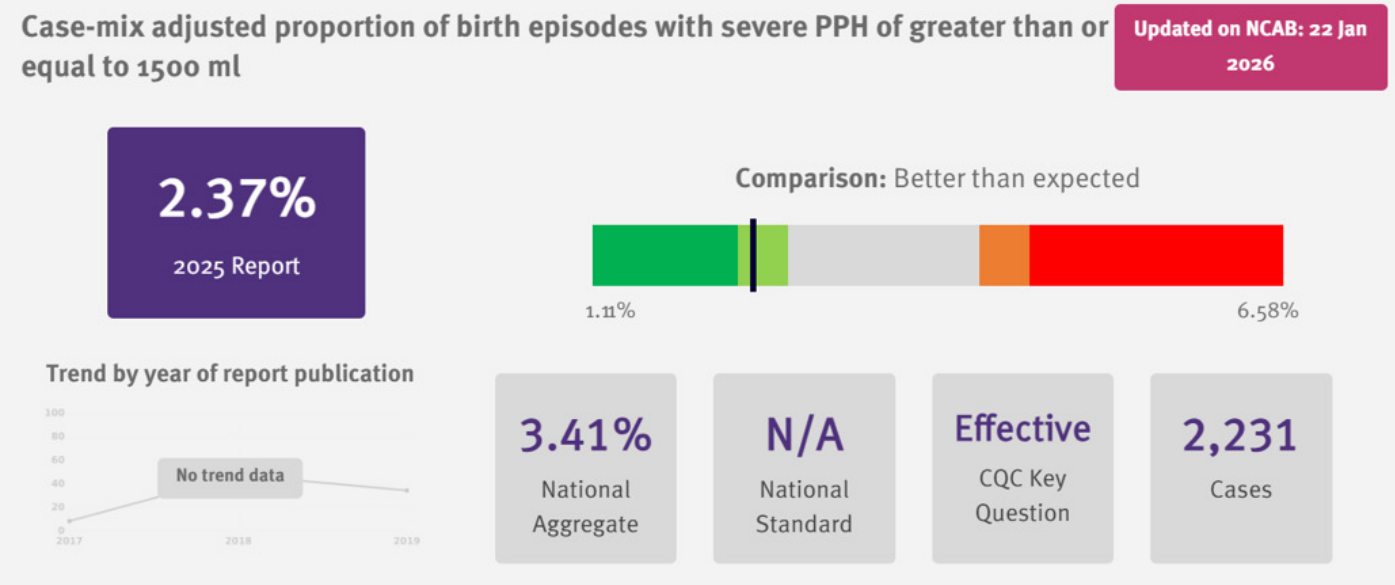
Maternity and Perinatal (source: NMPA national audit)

MEASURE: Case-mix adjusted proportion of birth episodes with severe PPH of greater than or equal to 1500 ml.

This chart looks at how often severe bleeding after childbirth (known as postpartum haemorrhage (PPH)) occurs.

The rate for this service is **2.37%,** which is **better than expected** and lower than the national average of **3.41%**. This means fewer people are experiencing this serious complication compared to typical results across the country.

A total of **2,231 cases** were included in the data, giving a strong and reliable picture of performance.

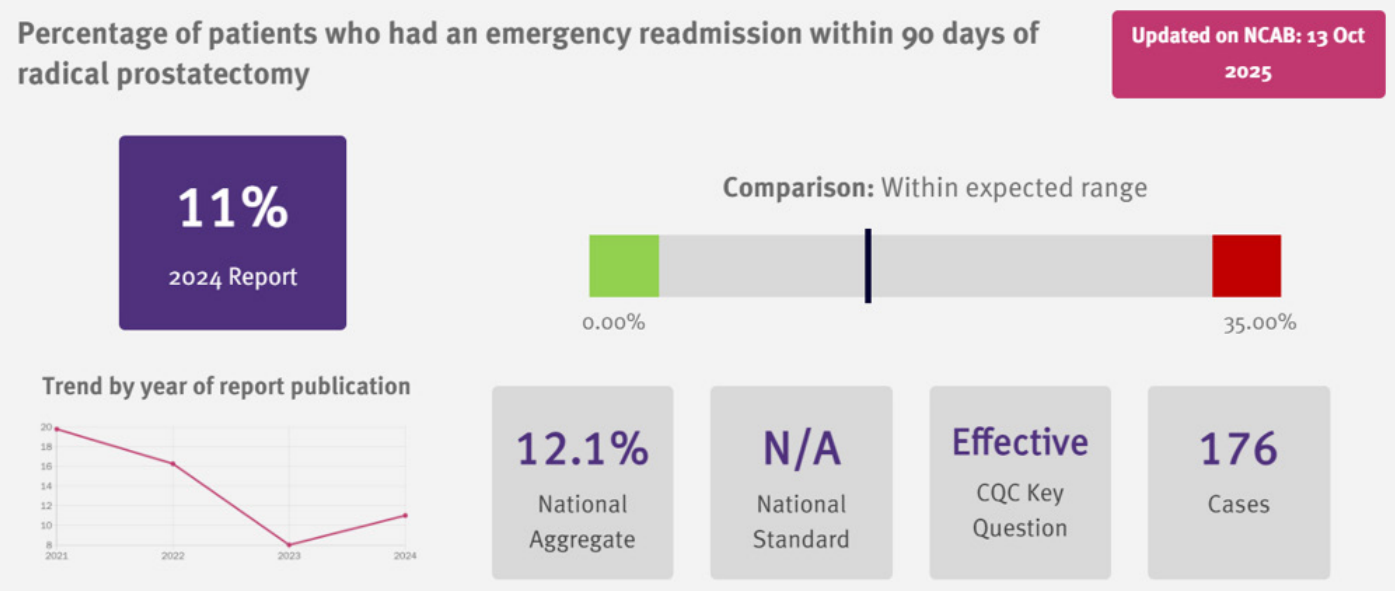


Prostate Cancer (source: National Prostate Cancer audit)

MEASURE: Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy.

This chart shows how often patients needed to be readmitted to hospital within 90 days after prostate cancer surgery.

The readmission rate is **11%,** which is **slightly better than the national average of 12.1%** and falls within the range expected for this type of care. This means outcomes are in line with what would normally be anticipated.

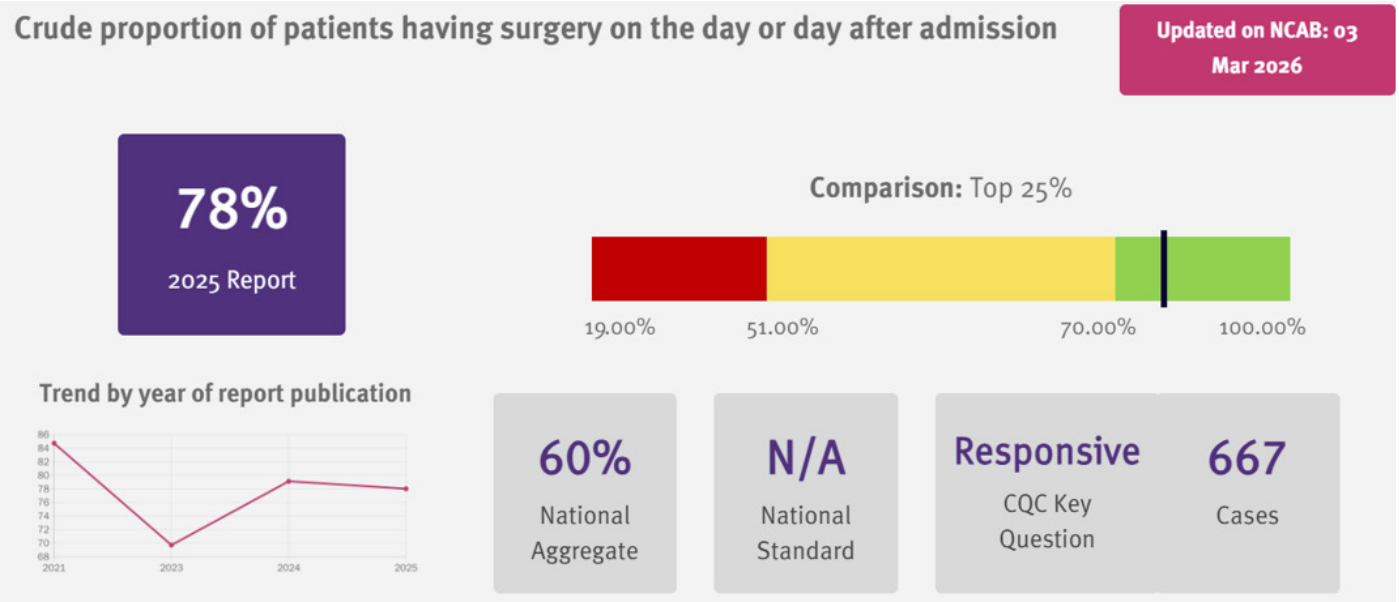


Hip Fractures (source: National Hip Fracture audit)

MEASURE: Crude proportion of patients having surgery on the day or day after admission.

This chart looks at how quickly patients receive surgery after being admitted to hospital.

In this service, **78% of patients had surgery on the same day or the day after admission,** which is **well above the national average of 60%.** This places the service in the **top 25% of performers,** showing that patients are generally treated quickly.

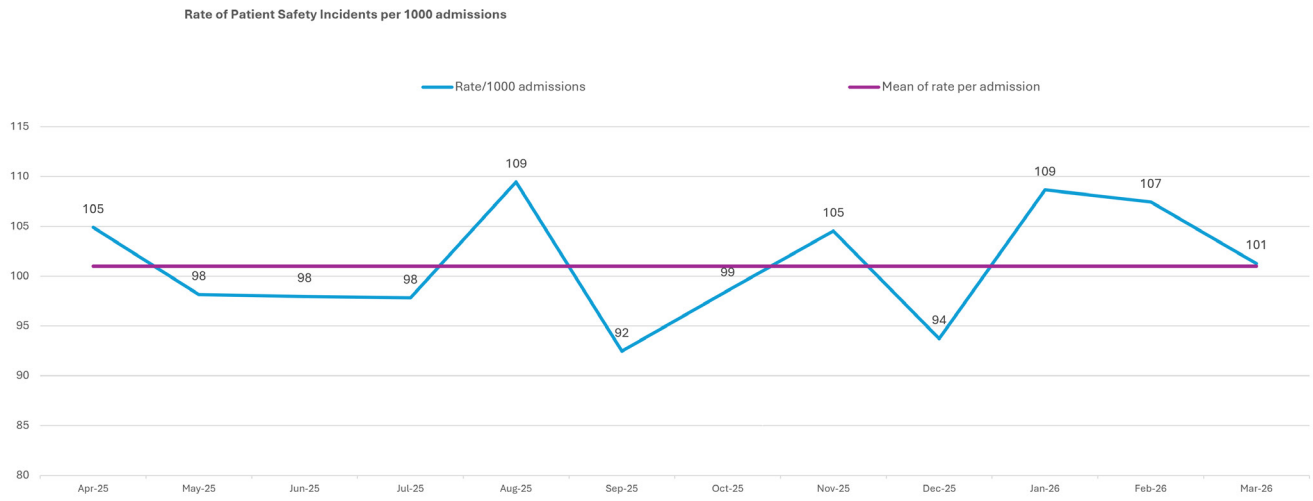


Rate of Patient Safety Incidents

The Trust introduced the new national approach to managing patient safety incidents (Patient Safety Incident Response Framework - PSIRF) in November 2023, replacing the previous framework. PSIRF focuses on learning, improvement, and a more open, supportive safety culture. We also adopted the new national reporting system (Learning from Patient Safety Events (LfPSE) system - LfPSE) in 2023 to strengthen how incidents are recorded, analysed, and learned from. The Trust continues to promote a culture where staff feel confident to report incidents, supported by clear policies and our incident reporting and management reporting system (Datix), to enable timely action and ongoing improvement in patient safety.

Patient Safety Incident Reporting Rates

In 2025–26, there were 101 patient safety incidents reported per 1,000 admissions. This equates to 11,714 incidents across 115,828 admissions. Monthly reporting rates for the year are shown in the chart below.



Proportions of severity of harm

Consistently, 96% and above of all reported incidents are reported as no, low harm or near-misses. This is indicative of a strong safety culture and staff confidence in reporting, and the Trust continues to encourage the reporting of incidents.

The proportion of incidents that result in moderate, severe or fatal harm (physically or psychologically remain low. These incidents undergo structured reviews in line with our PSIRF policy and plan to identify improvements, strengthen systems, and reduce future risk.
The proportion of patient safety incidents reported that resulted in severe harm was 0.2%, and those resulting in fatal harm accounted for 0.2% of all reported incidents.

Our patient safety incident reviews are multidisciplinary and collaborative to ensure that early improvement and/or corrective actions is taken to minimise further harm occurring, and lessons are shared across the Division. Duty of candour is initiated with patients and family from the outset of the review to ensure inclusion with the process.

Learning occurs via a variety of channels in the Trust including the Weekly patient Safety Summit (WPSS), Divisional Governance Meetings, Peer-review meetings and multi-disciplinary reviews. In addition, we launched our 'Patient Safety Week' learning events to reinforce lessons learnt and patient safety processes across the Trust. Three events were held in 2025-26 with different themes identified from triangulated reviews of incidents, complaints, feedback and litigation, as shown in the table below.

Patient Safety Week in	Theme
July 2025	Communication
November 2025	The Deteriorating Patient
March 2026	Time-Critical medications

During the patient safety week events, senior managers including Executive and Non-Executive Directors, Divisional Directors and other senior managers undertake GEMBA Walks to teams and wards, going where the care is delivered to see it first hand and learn from staff to drive improvements.

Pressure Ulcers

The prevention of pressure ulcers remains an important aspect of patient safety and quality of care within the Trust. Pressure ulcers are largely avoidable harms and are widely recognised as a key indicator of the standard of care provided, particularly in relation to fundamental nursing cares such as skin integrity, repositioning, nutrition and hydration.

The Trust is committed to reducing incidence of avoidable pressure ulcers and improving outcomes for patients through a proactive and systemic approach. This includes early identification of patients at risk, the implementation of timely and personalised preventative interventions, and ongoing reassessment throughout a patient's care pathway.

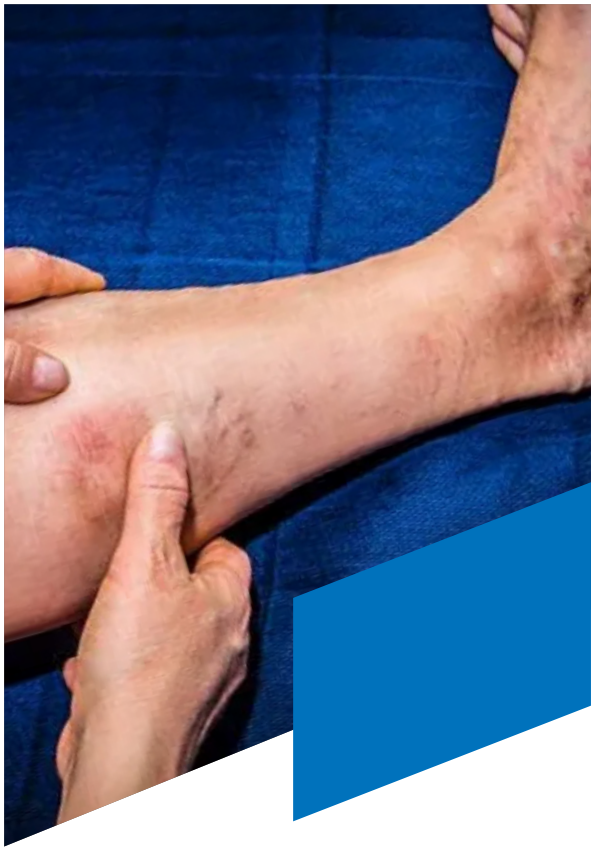
In addition, the Trust places a strong emphasis on continuous learning from incidents. Pressure ulcers are reviewed to identify contributory factors, assess avoidability, and support shared learning across clinical teams. This approach enables the organisation to strengthen practice, improve consistency in care delivery, and reduce the likelihood of recurrence. Through these measures, the Trust aims to minimise patient harm, enhance patient experience, and ensure that care is safe, effective, and responsive to individual patient needs.

During the reporting period (April 2025 to March 2026), the Trust reported a total of

- 494 Category 2 pressure ulcers
- 11 Category 3 pressure ulcers
- 1 Category 4 pressure ulcers

This represents a combined total of 12 Category 3 and 4 pressure ulcers over the year. The overall rate of Category 3 and 4 pressure ulcers was approximately 0.04 per 1,000 bed days. While the majority of pressure ulcers remained in the lower severity category (Category 2), incidents of higher severity harm were relatively low but remain a key focus for reduction.

Venous Thromboembolism (VTE) Risk Assessment



The Trust considers that this data is as described because the Trust has robust data quality assurance processes in place.

The percentage of patients aged 16 and over admitted in the year who were assessed for risk of VTE on admission to hospital 2024/25 the Trust achieved 90.96% compliance.

Mandatory surveillance of healthcare associated infection

ESHT considers that this data is as described because the Trust has robust data quality assurance processes in place.

The NHS Standard Contract 2025/26 includes quality requirements for NHS Trusts and NHS foundation Trusts to minimise rates of both Clostridioides difficile (C. difficile) and of Gram-negative bloodstream infections to threshold levels set by NHS England.

Trust thresholds

Trusts are required under the NHS Standard Contract 2025/26 to minimise rates of both C. difficile and of Gram-negative bloodstream infections so that they are no higher than the threshold levels set by NHS England. Overall expectation is to achieve the lower of two totals, either the 2024/25 threshold or a 10% reduction on 2024 calendar year cases.

Clostridioides difficile Infection

Since April 2017, reporting Trusts have been asked to provide information on whether patients with C. difficile had been admitted to the reporting Trust within the three months prior to the onset of the current case.

Gram-negative bloodstream infections

From April 2020, reporting Trusts were asked to provide information on whether patients with Gram-negative bloodstream infections had been admitted to the reporting Trust within one month prior to the onset of the current case.

Performance

East Sussex Healthcare NHS Trust	Case thresholds for 2025/26	Actual Cases reported for 2025/26		
Organism		**Total**	**HOHA**	**COHA**
C. difficile	67 (same as 2024/25 threshold)	75	55	20
E. coli	109 (same as 2024/25 threshold)	115	47	68
Pseudomonas	19 (same as 2024/25 threshold)	23	14	9
Klebsiella sp.	44 (a 10% reduction on 2024 calendar year cases)	34	14	20

Source: ESHT data is from the UKHSA Healthcare Acquired Infections (HCAI) Data Capture System. At the time of writing this report the annual 25/26 surveillance report had not been published so data is subject to slight variation.

The CDI threshold was exceeded in terms of number of reportable cases. A total of 75 cases of CDI were attributed to the Trust for 2025/26 from 68 patients (seven patients had two reportable CDI). This occurred due to 55 hospital onset healthcare associated infections and 20 community onset healthcare associated infections.

Overall, there has been an improved position in all mandatory reportable HCAIs for 25/26 compared to the previous year and the incidence of healthcare infections is stable.

To try to reduce the incidence of gram-negative bacteraemia such as E.coli as part of the National Action Plan for Antimicrobial resistance improvement; three key actions are being taken forward by ESHT. The Antimicrobial Stewardship Group (ASG) and Trust Infection Prevention Control Group (TIPCG) have agreed the following priorities:

1. **To monitor an IV to oral (IV→PO) ratio using DEFINE (Oracle/Business Intelligence reporting tool),** calculating how many doses or administrations are IV versus oral and expressing them as a ratio or percentage.
2. **Reduce catheter-associated urinary tract infection (CAUTI) rates,** particularly where CAUTI may be a source of Gram negative bacteraemia. This includes ensuring appropriate catheter changes with correct gentamicin prophylaxis, following the recommended one-hour interval between gentamicin administration and catheter change - work with the urology nursing teams, and Infection Control.
3. **Reduce inappropriate use of broad-spectrum antibiotics –** work with microbiology to provide antimicrobial stewardship ward rounds, measure broad spectrum antibiotic use, and Trust antibiotic prescribing compliance versus guidance.

Measure	2022	2023	2024
Average score	—	75.9% (+0.6%)	76.8% (+0.9%)
Better by 5% or more	0 questions	0 questions	2 questions
Less than 5% change	49 questions	45 questions	46 questions
Worse by 5% or more	2 questions	2 questions	0 questions

Patient Experience of hospital care

The results of the National Inpatient Survey 2024 were published on 9 September 2025. It relates to adult patients discharged in November 2024 following an inpatient episode (overnight stay). Six questions are either new or have been reworded, meaning their results are not directly comparable with previous years.

481 patients responded to the survey in 2024 and overall, the results have shown a gradual improvement in average scores, and a small but growing number of strong improvements, while the majority of responses remain stable since 2022 as shown in the table below.

The results of two questions that scored better by 5% or more and one that scored in the bottom 20% compared with 2023 scores are shown in the table below:

	Question which scored better by 5% or more	**2024 score**	**2023 score**
Q.2	How did you feel about the length of time you were on the waiting list before your admission to hospital?	81.2%	71.6%
Q.36*	To what extent did hospital staff involve your family or carers in discussions about you leaving?	58.8%	53.3%
	Question which scored in the bottom 20% or Trusts	**2024 score**	**2023 score**
Q.8.1	Were you ever prevented from sleeping at night by any of the following: noise from other patients	59.7%	62.6%

*this question featured in the worse by 5% or more in 2023

Overall, this is a positive report. The average score has improved, and comparisons with both previous years and national benchmarks show clear progress. The most notable improvements are seen in the national comparisons, with three additional questions now in the top 20% of Trusts and two fewer questions in the bottom 20%.

Number of compliments / plaudits

Plaudits and compliments are received in the form of letters, cards or emails addressed directly to the clinical services. These can be submitted in long form or via a patient or carer completing a Friends and Family Test (FFT).

Plaudits	Totals 2023-24	Totals 2024-25	Totals 2025-26
FFT Comments	24729	83366	87433
Thank you, cards / letters / emails / messages / online forms	1060	981	987
Positive Healthwatch feedback	11	6	1
Positive NHS reviews	72	57	2
Total Plaudits	25872	84410	88423

Digital FFT did not come into effect until June 2024, resulting in a large increase in the number of surveys and compliments that were received. Driven primarily by SMS FFT, this significantly increased patient engagement and participation in providing us with feedback, resulting in a surge in plaudits.

The top three positive and negative themes received from FFT feedback in 2025/26 were:

Top three positive themes	2024/25	2025/26
Staff Attitude	54,800	61,541
Implementation of Care	29,954	32,180
Environment	16,803	19,731

Top three negative themes	2024/25	2025/26
Staff Attitude	3,371	3,566
Environment	2,629	2,628
Waiting Time	2,298	1,513

Complaints

The Trust received 498 complaints in 2025/26; 426 complaints were received in 2024/25.

Complaints response rates

The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009) set out the rights of complainants to have their complaints investigated and formally responded to in an appropriate and timely timescale, six months or longer when in agreement with the complainant. The Trust aims to respond to complaints within 60 working days, and our local target for this is 80%. Monitoring takes place throughout the year to analyse where any delays occur in responding to complaints. This is often due to operational pressures within clinical divisions impacting staff ability to investigate and respond to a complaint.

Overall, the complaints response rate for 2025/26 was 71%.

Metric	April 25	May 25	June 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Total 25/ 26	Total 24/ 25
60 working days	74%	77%	81%	80%	63%	69%	81%	70%	67%	64%	56%	66%	71%	78%

100% complaints were acknowledged within three working days this year.

Summary of Performance

Operational performance is measured against key access targets and outcome objectives set out in the NHS Oversight Framework:

A&E standard: A&E maximum waiting time of four hours from arrival to admission, transfer or discharge

RTT Standard: Maximum time of 18 weeks from point of referral to treatment (RTT)

Cancer standard: 62 Day Referral to Treatment Standard.

Faster Diagnosis Standard (FDS) - patients receive a cancer diagnosis or have cancer ruled out within 28 days of an urgent referral. 31 Day Decision to Treat to Treatment Standard.

DM01 (diagnostics): Patients referred for an elective diagnostic, waiting no more than 6 weeks from referral to diagnostic.

Indicator	Detail (national standard)	2022/23	2023/24	2024/25	2025/26
Standards	Four-hour A&E (to achieve 78% target in March 26)	67.91%	73.18%	74.22%	75.02%*
	RTT (92% target)	57.35%	51.15%	55.92%	63.65%
	Cancer 28 Day General FDS (to achieve 80% in March 26)	72.63%	75.00%	81.19%	82.94%*
	31 Day General Treatment Standard	96.49%	93.47%	94.14%	93.46%
	Cancer 62 Day General Treatment Standard (to achieve 75% in March 26)	70.37%	61.17%	70.52%	74.12%
	Diagnostics (99% target)	83.85%	87.15%	89.14%	85.35%*

Indicator	Detail (national standard)	2022/23	2023/24	2024/25	2025/26
Length of Stay	Acute elective (days)	2.87	2.64	2.66	2.52
	Non-elective (days)	5.07	4.44	5.03	4.86
	Bexhill (days)	43.90	42.31	47.20	47.13
	Rye (days)	34.27	32.07	28.39	28.85
Community (seen within 13 weeks)	Podiatry	69.08%	64.31%	70.06%	64.08%
	Dietetics	74.42%	69.56%	74.71%	79.89%
	Speech and Language	66.42%	83.08%	75.99%	73.35%
	Neurological physiotherapy (all sites)	68.22%	58.39%	66.14%	64.95%
	MSK Hastings and Rother	74.41%	82.74%	90.81%	
	MSK Physiotherapy	74.68%	79.58%	86.55%	85.06%
	MSK Triage/ ESMSK (all sites)	89.25%	92.18%	84.65%	82.25%
	MSK Total (all sites)	74.68%	79.58%	86.35%	83.10%
Community nursing (District Nursing)	2 Hours	77.94%	72.00%	79.31%	80.00%
	24 Hours	96.41%	96.38%	93.79%	94.14%
	48 Hours	98.02%	97.16%	95.56%	92.59%
	Routine	93.37%	91.21%	87.60%	89.36%
Urgent Community Response (inc INS)	2 hour - Rapid Response (70% target)	72.71%	81.04%	82.96%	83.38%
	24 hours	76.29%	69.82%	74.68%	73.17%

* Final year data for these metrics not yet available.

A&E standard: maximum waiting time of 4 hours

A&E intermediary threshold target of 78% by March 2025 standard:
78% of patients attending the Emergency Departments at either EDGH or Conquest should have a maximum waiting time of four hours from arrival to admission, transfer or discharge.

During 2025/26, the Trust's aggregated performance was 75.02% of patients who attended our Emergency Departments and were seen within four hours. NHS England set a target to achieve 78% during March 2026. ESHT achieved 78.7% (with the inclusion of additional mapped activity and 77.2% without).
The Trust observed an increase in attendances to A&E in comparison to the previous year, and in the acuity and complexity of patients presenting to our Emergency Departments. A&E attendances increased by 5.5% in 2025/26 compared to the previous year.

The Trust relies on health and social care to support timely discharge for patients who are medically fit but may need additional support in returning to their home or to another care setting. Throughout 2025/26, the Trust averaged 160 non-criteria to reside patients, limiting the ability to discharge patients to their onward care destination. Bed occupancy has remained above 95% in 2025/26, patient flow through the hospital has, at times, been adversely affected.

Referral To Treatment standard: Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate

At the end of March 26, the Trust achieved 66.3% for the RTT standard. The Trust has achieved the national aspiration of a 5% improvement on baseline levels (60% target).

At the end of March 26, the Trust reported a small number of patients who had waited more than 65 weeks for treatment.

Patients waiting over 52 weeks reduced to 463, against a trajectory of 544 and this represents 0.83% of the total PTL (national target of 1%). This compares to 1,084 patients waiting over 52 weeks for treatment at the end of 2024/25.

Diagnostic standard: Maximum 6-week wait for diagnostic procedures

The Trust is working towards no more than 10% of patients waiting over 6 weeks. Throughout 2025/26, an average of 14.7% of patients were wating more than 6 weeks.

Cancer standard: All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer, NHS cancer screening service referrals and consultant upgrade onto a cancer pathway

The Trust has seen an increase in demand for suspected cancer and is now seeing an average of 2,910 referrals per month compared to a 2,650 average the previous year.

Throughout 2025/26, the Trust achieved 82.9%. for the Faster Diagnostic Standard- where patients receive a cancer diagnosis or have cancer ruled out within 28 days of an urgent referral. The national ambition was to achieve 80% in March 2026.

The Trust delivered 74.1% throughout 2025/26 against the 62-day standard (all patients with a cancer diagnosis to receive first treatment by day 62 of their pathway). The national ambition is to achieve 75% in March 26.

The Trust continues to work closely with healthcare partners and the Cancer Alliance to develop and share positive new pathways to support improvement in performance and enhance patient experience.

Appendix 1 - National Clinical Audit and National Confidential Enquiries Programme

The Trust participated in all applicable national audits and NCEs.

National Confidential Enquiries
Maternal, newborn and infant and perinatal mortality (MBRRACE- UK) (and all applicable studies)
Child Health Clinical Outcome Review Programme (and all applicable studies) and Mortality Database
NCEPOD – Stabilisation of the critically ill child: Receiving unit critical care
NCEPOD - Stabilisation of the critically ill child
NCEPOD – Rib Fracture
NCEPOD – Pleural Procedures
NCEPOD - Acute illness in people with a learning disability

National Clinical Audits
2025 National Comparative Audit of Blood Transfusion - Major Haemorrhage Protocols Audit
Adult Asthma Secondary Care
Age-related Macular Degeneration Audit (AMD)
Breast and Cosmetic Implant Registry
British audit on the Investigation and referral of women with recurrent urinary tract infection using guidance
British Spine Registry
BTS UK Interstitial lung disease registry
Care of Older People
Case Mix Programme (CMP)
COPD Secondary Care
Diabetes Prevention Programme
Evaluating the Management pathway for suspected testicular cancer referrals (EMPAST)
Fracture Liaison Service Database (FLS-DB)
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)
Mental Health Self Harm
Myocardial Ischaemia National Audit Project (MINAP)
National Audit of Cardiac Rehabilitation
National Audit of Cardiac Rhythm Management (CRM)
National Audit of Care at the End of Life (NACEL)
National audit of Dementia Mapping Exercise
National Audit of Inpatient Falls (NAIF)

National Clinical Audits
National Audit of Metastatic Breast Cancer (NAoMe)
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)
National Audit of Primary Breast Cancer (NAoPri)
National Bowel Cancer Audit (NBOCA)
National Cardiac Arrest Audit (NCAA)
National Cataract Audit
National Child Mortality Database (NCMD) Programme
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)
National Core Diabetes Audit
National Diabetes Footcare Audit (NDFA)
National Diabetes Inpatient Safety Audit (NDISA)
National Early Inflammatory Arthritis Audit (NEIAA)
National Emergency Laparotomy Audit (NELA)
National Emergency No Laparotomy Audit (noLap)
National Gestational Diabetes
National Heart Failure Audit
National Hip Fracture Database (NHFD)
National Joint Registry
National Kidney Cancer Audit (NKCA)
National Lung Cancer Audit (NLCA)
National Major Trauma Registry
National Maternity and Perinatal Audit (NMPA)
National Neonatal Audit Programme (NNAP) - 2025 data
National Non-Hodgkin Lymphoma Audit (NNHLA)
National Oesophago-Gastric Cancer Audit (NOGCA)
National Paediatric Diabetes Audit (NPDA)
National Pancreatic Cancer Audit (NPaCA)
National Pregnancy in Diabetes Audit (NPID)
National Prostate Cancer Audit (NPCA)
National Respiratory Audit Programme (NRAP) Paediatric Asthma (secondary care)
NDA Integrated Specialist Survey
Ovarian Cancer
PROMS
Pulmonary Rehabilitation
Sentinel Stroke National Audit Programme (SSNAP)
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme
Time critical medications
Transition (Adolescents and Young Adults) and Young Type 2 Audit
UK Parkinson's Disease

Appendix 2: Participation in Mandatory Clinical Audits

The national clinical audits and national confidential enquiries that East Sussex Healthcare NHS Trust participated in, and for which data collection was completed during 2025/26, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title	Number of Cases submitted	% Submitted of those required
National Adult Diabetes Audit	Trust - 4550	100% (all required data submitted)
National Pregnancy in Diabetes Audit	EDGH – 16 CONQUEST – 15	100% (all required data submitted)
National Paediatric Diabetes Audit	Trust – 186	100% (all required data submitted)
Age-related Macular Degeneration Audit (AMD)	Awaiting Data from the national team	Awaiting confirmation from the national team
Mental Health - Self Harm	EDGH - 77 CONQUEST - 245	EDGH – 30%* CONQUEST – 94%
UK Parkinson's Disease	EDGH- 9 CONQUEST - 10	EDGH – 90% CONQUEST –100%
National Comparative Audit of Blood Transfusion - Major Haemorrhage Protocols Audit	EDGH – 9 CONQUEST – 16	100% (all required data submitted)
British audit on the Investigation and referral of women with recurrent urinary tract infection using guidance	Awaiting Data from the national team	Awaiting confirmation from the national team
Evaluating the Management pathway for suspected testicular cancer referrals (EMPAST)	Trust - 24	100% (all required data submitted)
NCEPOD - Acute illness in people with a learning disability	7 Clinical Questionnaires 10 Case notes 2 Organisational Questionnaires	70% Clinical Questionnaires 100% Case notes 100% Organisational Questionnaires

*Reason for lower data entry to the Mental Health Self Harm Audit: Key challenges included time constraints, team changes, staff turnover and the loss of clinical attachment support that had previously assisted with data entry.

Glossary

Term	Definition
AKI - Acute Kidney Injury	Sudden damage to the kidneys causing reduced or complete loss of function.
Amniotic Fluid Embolism	Rare childbirth emergency where amniotic fluid enters the mother's bloodstream causing severe reaction.
Care Quality Commission (CQC)	Independent regulator of health and social care in England.
CHKS	Organisation providing healthcare intelligence and benchmarking services.
Clinical Audit	Process to assess and improve care against agreed standards.
Clostridium difficile (C. diff)	Bacteria causing diarrhoea, especially after antibiotic use.
Commissioning for Quality and Innovation (CQUIN)	Payment framework linking provider income to quality and innovation.
CT Scan	Imaging test using X-rays to create detailed 3D images of the body.
COVID-19	Disease caused by the SARS-CoV-2 virus.
Culture	Shared attitudes, beliefs, and values of a group.
Data Quality	Ensuring data is accurate, timely, and useful.
Data Security and Protection Toolkit (DSPT)	Tool for assessing compliance with data security standards.
Datix/DatixWeb	Incident reporting system used within healthcare organisations.
Department of Health (DOH)	UK government department responsible for health policy in England.
Deteriorating Patient	Patient whose condition is worsening based on clinical observations.
Diabetic Ketoacidosis in Pregnancy	Serious diabetes complication during pregnancy.
Discharge	When a patient leaves hospital or a service concludes.
Division	Group of clinical specialties under a management structure.
Duty of Candour (DoC)	Obligation to be open and honest with patients when harm occurs.
Deprivation of Liberty (DOLS)	Safeguards for patients deprived of liberty for safety reasons.

Term	Definition
Excellence in Care (EIC)	Framework for monitoring clinical performance and improvement.
Electronic Prescribing and Medicines Administration (ePMA)	Digital system replacing paper medication charts.
eTriage System	Digital system in Emergency Departments and Urgent Treatment Centres prioritising emergency patients based on need.
FeverPAIN Criteria	Clinical scoring tool to assess likelihood of bacterial throat infection.
Fontan	Congenital heart condition.
Friends and Family Test (FFT)	Patient feedback tool on care experience.
General Medical Council (GMC)	Regulator of doctors in the UK.
Glasgow Coma Scale (GCS)	Tool measuring consciousness (score 3–15).
Guardians of Safe Working Hours (GOSWH)	Role ensuring safe working hours for junior doctors.
Haemolysed	Blood sample with ruptured red cells affecting test accuracy.
Healthwatch	Organisation representing public views on health services.
Hospital Episode Statistics	National database of NHS hospital activity.
Hospital Standardised Mortality Ratio (HSMR)	Indicator comparing expected vs actual hospital deaths.
Integrated Performance Review (IPR)	Performance meeting involving senior stakeholders.
ICNARC	Intensive Care National Audit and Research Centre.
Integrated Care Board (ICB)	Body responsible for local NHS services and budgets.
Key Performance Indicators (KPIs)	Measures used to track organisational performance.
Lumbar Puncture	Procedure to collect spinal fluid via needle in lower back.
Methicillin Resistant Staphylococcus Aureus (MRSA)	Antibiotic-resistant bacterial infection.
Methicillin Sensitive Staphylococcus Aureus (MSSA)	Antibiotic-sensitive bacterial infection.
MBRRACE-UK	Mothers and Babies Reducing Risk through Audits and Confidential Enquiries – a programme reviewing maternal deaths in the UK.
Multidisciplinary	Involving multiple clinical specialties.

Term	Definition
National Audit of Care at the End Of Life (NACEL	A mandatory comparative audit that reviews the quality and outcomes of care experienced by patients in the last admission leading to death in acute hospitals.
National Audit of Dementia	Review of hospital dementia care standards.
National Clinical Audit Patient Outcomes Programme (NCAPOP)	National audits measuring care against standards.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Organisation reviewing patient outcomes and deaths.
National Institute for Health and Clinical Excellence (NICE)	Body providing national health guidance in the UK.
NerveCentre	Digital system for bed management and patient flow.
NHS Digital	Provider of NHS data and IT systems.
NHS England & NHS Improvement	Organisation overseeing NHS delivery and improvement.
Patient Reported Outcome Measures (PROMs)	Patient-reported measures of treatment outcomes.
Peripartum Hyponatraemia	Low sodium levels during pregnancy.
Personal Protective Equipment (PPE)	Equipment protecting against health and safety risks.
Posiflush	Posiflush is primarily available as a prefilled saline syringe designed for flushing indwelling vascular access devices, such as IV catheters.
Pressure Ulcers	Skin injury caused by prolonged pressure.
Providers	Organisations delivering NHS services.
Public Health England (PHE)	Agency providing health protection expertise.
Patient Safety Incident Response Framework (PSIRF)	Framework for responding to patient safety incidents.
Research	Clinical studies to improve treatments and outcomes.
Risk Adjusted Mortality Indicator (RAMI)	Mortality measure adjusted for patient risk.
Rupture of the Membranes	Breaking of amniotic sac at labour onset.
ReSPECT - Recommended Summary Plan for Emergency Care and Treatment	Plan for emergency care decision-making.
Sepsis	Life-threatening response to infection.
Serious Incident (SI)	Event causing or risking serious harm or death.
Speak Up Guardian	Role supporting staff to raise concerns.
SPINE	NHS system enabling data sharing across services.

Term	Definition
Step-down intermediate care	A time-limited, short-term (typically no longer than 6 weeks) health and/or social care provided to adults (aged 18 years or over) who need support after discharge from acute inpatient settings and virtual wards to help them rehabilitate, re-able and recover.
Strategy	Long-term plan to achieve goals.
SHMI - Summary Hospital-level Mortality Indicator	Indicator comparing hospital mortality to expected levels.
Surgical Site Infection	Infection occurring after surgery.
SSISS - Surgical Site Infection Surveillance Service	Service monitoring surgical infections.
SPICT - Supportive and Palliative Care Indicators Tool	Tool identifying patients needing palliative care.
Treatment Escalation Plan (TEP)	Plan to outline patient care preferences if condition worsens.
Trust Board	Governing body responsible for Trust strategy and performance.
TRiM - Trauma Risk Management	Programme supporting staff after traumatic events.
UK Obstetric Surveillance System (UKOSS)	System studying rare pregnancy conditions.
VTE - Venous Thromboembolism	Blood clot conditions including DVT and pulmonary embolism.
Virtual Wards	Care for acutely unwell patients at home using remote monitoring technology.

Part 4 - Stakeholder Statements

Statement from East Sussex Community Voice on behalf of Healthwatch in Sussex

Healthwatch welcomes the opportunity to review the Quality Accounts but cannot comment on the full content, much of which is outside of our remit. Healthwatch values the ongoing partnership working we have with East Sussex Healthcare NHS Trust, including sharing our insight, asking questions and escalating concerns on behalf of patients and service users. We also monitor Trust activity through local and national performance indicators.

It is paramount that NHS bodies clearly communicate how they've captured patient experiences, what they've heard and how they've used this to support change and improvement in satisfaction and health outcomes. This will become even more essential if government plans to abolish Healthwatch and the independent role and scrutiny we provide is implemented. NHS organisations must ensure they develop and publish engagement plans and use their Quality Accounts to describe what steps they have taken and what difference this has made.

Yours sincerely,

Simon Kiley

Deputy Chief Executive
East Sussex Community Voice (ESCV) on behalf of Healthwatch in Sussex

Statement from East Sussex Health Overview and Scrutiny Committee (HOSC)

Statement from East Sussex Health Overview and Scrutiny Committee

Thank you for providing the East Sussex Health Overview and Scrutiny Committee (HOSC) with the opportunity to comment on your Trust's draft Quality Account 2025/26.

HOSC has invited ESHT to attend three of its meetings over the past year to look at various issues, including monitoring of the recent changes to paediatric services at Eastbourne District General Hospital (EDGH), planned capital works, proposed changes to the Day Surgery Unit at Uckfield Community Hospital, the cardiology transformation programme, and the Sussex healthcare system's winter plan. The Committee thanks those Trust officers and clinicians who gave their time to attend meetings over the past year.

The HOSC recognises much of the Trust's efforts over the past year will have been focussed on maintaining its high standards of care whilst dealing with pressures in the healthcare system and welcomes the success ESHT has achieved in 2025/26.

The Committee also notes that construction of the Sussex Surgical Centre was completed this year. The HOSC welcomes its development and is pleased it has already started to deliver benefits for patients in East Sussex and beyond.

Quality Priorities

The 2025/26 priorities for improvement focussed on improving the care of patients with mental ill health, increasing the quality of WHO Safety Checklist compliance across the Trust, and the Community Intermediate Care Rehabilitation Model. The Committee is pleased to see that progress has been made in mental health care and community care rehabilitation, which facilitate patients moving to community care, and that the Trust is working to embed improvements, noting also the areas where the Trust will continue to make improvements in each of these.

The Committee also welcomes the Trust's chosen priorities for improvement in 2026/27. In particular, HOSC welcomes that Enhancing Patient Communication and Reducing Did Not Attends (DNAs) has been chosen as the patient experience priority. The Committee sees this as a priority for providing clarity to patients and reducing waits, by ensuring the efficient use of clinic time. HOSC welcomes the communications plan ESHT has outlined in this area, recognising that clear and consistent communication will improve patient experience, measured by patient feedback.

The HOSC notes the Learning from Deaths information provided in the Quality Account and the actions taken by the Trust to improve in response to these. The Committee believes that continuous learning and improvements to patient safety and experience should remain critical to the work of the Trust over the next year.

The Committee looks forward to continuing to work with the Trust during the coming year on areas that are of interest to the residents of East Sussex.

Councillor Johnny Denis

Chair
Health Overview and Scrutiny Committee

NHS
Surrey and Sussex

Statement from Commissioners

East Sussex Healthcare NHS Trust Quality Account 2025/2026

Thank you for the opportunity to comment on East Sussex Healthcare NHS Trust's (ESHT) Quality Account for 2025/26. We value the continued collaborative working with Trust colleagues through Quality Review Meetings (QRMs) and wider system forums.

We congratulate the Trust on its continued work to improve quality through its Quality, Strategy and Integrated model of care, with a clear focus on safety, experience and clinical effectiveness across acute, community and system partners.

The Trust has achieved several successes in 2025/26, including:

- Strong clinical outcomes in areas including maternity and surgery, with results in line with or better than national averages, and mortality indicators within expected ranges and below peer benchmarks.
- Good progress in service improvement programmes, including the integrated intermediate care model, supporting shorter stays, more patients returning home, and better patient experience.
- Strong participation in national audits and research, alongside improvements in staff engagement, wellbeing and speaking-up culture.

NHS Surrey and Sussex

NHS Surrey and Sussex recognises that 2025/26 has been challenging for the Trust, particularly due to rising demand, workforce pressures and wider system constraints. These factors have affected performance against key operational standards, including referral-to-treatment times, diagnostics and emergency department flow.
The Trust has also identified ongoing patient safety risks, including falls, healthcare-associated infections, and incidents involving communication and deterioration. The ICB welcomes the Trust's transparency and the actions being taken to reduce risk and improve performance.

NHS Surrey and Sussex recognises the important Trust's priorities for 2026/27, including improving patient communication and reducing DNAs through digital solutions, strengthening recognition of the deteriorating and dying patient, and reducing falls with harm. These priorities align with key safety risks,clinical effectiveness and national expectations.

The ICB welcomes the Trust's focus on earlier recognition of deterioration, better communication with patients, and stronger safety systems through training, governance and quality improvement. It's emphasis on measurable outcomes, patient experience and digital innovation gives assurance that these priorities are well targeted and achievable.

NHS Surrey and Sussex looks forward to continuing collaborative working with East Sussex Healthcare NHS Trust and system partners over the coming year.

Yours sincerely,

Naomi Ellis

Deputy Chief Nursing Officer
Director of Safeguarding
NHS Surrey and Sussex

Statement of Directors' responsibilities for the Quality Account

The Directors are required, under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements). In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.The data underpinning the measures of performance reported in the Quality Account is robust and reliable; conforms to specified data quality standards and prescribed definitions; is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Steve Phoenix
Chairman
Date: 24-6-2026

Jayne Black
Chief Executive
Date: 24-6-2026

Feedback

If you or someone you know needs help understanding this report, or would like the information in another format, such as large print, easy read, audio or Braille, or in another language, please contact our Communications Department by emailing esht.communications@nhs.net
For feedback or suggestions on how we might improve our Quality Report, please do let us know by emailing esht.communications@nhs.net
For a variety of ways to give feedback on the quality of the services we provide at East Sussex Healthcare Trust, go to

www.esht.nhs.uk/your-care/patient-experience/friends-and-family-test/

Acknowledgements

East Sussex Healthcare Trust would like to thank all the staff, service users and partner organisations who contributed to this report.

You can keep up with the latest Trust news on our website: www.esht.nhs.uk/

Follow us on

Facebook: @ESHTNHS

Instagram: @ESHTNHS

YouTube: @ESHTNHS

www.esht.nhs.uk

esh-tr.enquiries@nhs.net

0300 131 4500