EAST SUSSEX HEALTHCARE NHS TRUST

BOARD OF DIRECTORS

TRUST BOARD MEETING IN PUBLIC

THE RELAIS COODEN BEACH, COODEN SEA ROAD, BEXHILL-ON-SEA TN39 4TT

14th OCTOBER 2025, 09:30 – 12:45

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Board Agenda

Date: Tuesday 14th October 2025

Time: 09:30 – 12:45

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

	Opening Business	Lead	Action	Time	Paper
1.	Welcome and apologies	Chair	Information	09:30	
2.	Colleague Recognition	Chair	Information	09:35	Yes
3.	Sussex Surgical Centre Opening	Dr James Evans / Nadia Cruddis	Information		No
4.	Declarations of Interest	Chair	Information		No
5.	Minutes of Trust Board Meeting in public 26.08.25	Chair	Approval	09:50	Yes
6.	Matters Arising	Chair	Approval		Yes
7.	Board Committees Chairs' Reports	Committee Chairs	Assurance	10:00	Yes
8.	Chief Executive's Report	CEO	Information	10:10	Yes
9.	NHS League Tables	CEO	Information	10:20	Yes
Quality, Safety and Performance					
10.	Integrated Performance Report, Month 5 (August) (i) Chief Executive Summary (ii) Quality & Safety (iii) Our People (iv) Access and Responsiveness (v) Financial Control and Capital Development	CEO ACN/CMO DCEO COO CFO	Assurance	10:30	Yes
11.	Maternity Overview Q1	DOM / Matthew Clark	Assurance	11:05	Yes
12.	Avoidability of Inpatient Deaths Q4	CMO	Assurance	11:15	Yes

Break – 10 minutes

Strategy					
13.	Refreshing our Trust Strategy	CEO	Information	11:35	Yes
14.	Winter Planning (verbal update)	COO	Assurance	11:45	No

Governance and Assurance					
15.	Q2 Board Assurance Framework	COS	Assurance	11:55	Yes
16.	Annual Reports: • Annual Equality Report 2024/2025 • Organ Donation Annual Report 2024/2025	DCEO CMO	Approval	12:05	Yes
For Information					
17.	Use of Trust Seal	Chair	Information	12:15	Yes
18.	Questions from members of the public	Chair		12:15	No
19.	Date of Next Meeting: 16th December 2025	Chair	Information		
20.	Close	Chair			

Steve Phoenix
Chairman

Key:	
ACN	Acting Chief Nurse
Chair	Trust Chair
CEO	Chief Executive
CFO	Chief Finance Officer
CNO	Chief Nurse and DIPC
COO	Chief Operating Officer
COS	Chief of Staff
CMO	Chief Medical Officer
DCEO	Deputy Chief Executive
DOM	Director of Midwifery
DOP	Director of People

Board Meetings in public: Etiquette

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

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

Board Meetings in public 2025:

Month	Location	Timing	Any other information
16th December 2025	Lecture Theatre, Conquest Hospital	0930-1245	

Agenda Item: 2

Report To/Meeting	Trust Board	**Date of Meeting**	14th October 2025
Report Title:	Colleague Recognition		
Key question	How does the Trust recognise and thank colleagues for their contribution, effort and loyalty?		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐		
Report Sponsor:	Jacquie Fuller, Assistant Director of HR – People Engagement	**Presenter(s):**	Steve Phoenix, Chair
Report Author:	Melanie Adams, People Experience Manager – People Engagement		
Outcome/Action requested:	The Board is asked to receive this report for information and for assurance about the formal recognition of our people over the last two months.		
Executive Summary	East Sussex Healthcare NHS Trust recognises that the high standard of care and quality of service it provides is dependent on the contribution, effort and loyalty of its people. This is an opportunity for the Trust to acknowledge the exceptional performance, behaviour, achievements and contribution that our colleagues and volunteers have made to the organisation.		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	7	**Appendixes**	0
Governance and Engagement pathway to date:	None		
What happens next?	Rolling delivery of the colleague recognition programme		
Publication	Yes		

1. Introduction

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

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

2. Celebrating our people

2.1 Trust Awards 2025

Each year we hold an award ceremony to recognise the contribution and dedication of colleagues, either as individuals or teams, who deliver services directly or indirectly to patients. Our awards are closely aligned to our People Strategy and are one of the ways we can say thank you and well done to colleagues as part of our ongoing work to create a culture of inclusion and involvement.

There are 10 award categories in which colleagues can nominate individuals and teams in both clinical and non-clinical settings. Award categories are regularly reviewed to reflect new and improved ways of working. In addition to these, the awards also include the Chairman's Cup, awarded to an individual or team chosen by the Chairman, and the People's Choice award, voted for by the public.

This year 458 nominations were received and included a mix of individual and teams, both clinical and non-clinical. Each finalist was carefully selected by a panel of judges made up of colleagues from across the organisation to ensure fairness.

This year we are opening up the ceremony to all staff so they can come along to enjoy the occasion and support the fantastic award finalists.

Finalists will be celebrated and the winners announced at this year's Trust Awards ceremony at the De La Warr Pavilion in Bexhill on Sea on Tuesday 14th October.

To see our award finalists refer to appendix 1 below.

2.2 Hero of the month

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

July 2025 - Maisie Franco - Mortuary EDGH, Core Division

'Maisie has given her time, knowledge and experience to another Trust to help in a major incident. She has gone that extra mile to help colleagues in need and has been commended by the Director of Forensic services, City of London Police, for her support in enabling the team to identify persons and bring a swift resolution for the families concerned. Maisie is a valued member of the ESHT mortuary team and consistently gives her all to everything she does. Well done, Maisie, such an achievement.'

August 2025 - AMU Ward Team, EDGH, Urgent Care Division

We received the following feedback from a GP:

'I have just spoken with XXXX, the daughter of XXXX who died yesterday. They spoke so movingly about the care their mother received on MAU. We had hoped that we could keep her mum at home for end of life care, but a very sudden and extreme deterioration unfortunately made this impossible. XXXX said that everyone who cared for her mum was so respectful of her dignity and comfort and that they treated her with real warmth and kindness. Her family were able to surround her bed as she comfortably passed, which was her main wish. I know how hard it is to create such a peaceful environment in an acute medical environment, and I would like to add my thanks to those involved on behalf of the family.

This is an amazing plaudit for a team who work under extreme pressure in a high activity area. They should be very, very proud.'

2.3 Long service recognition

Long service awards issued August - September 2025

Month	5 years	10 years	15 years	20 years	25 years	30 years	35 years	40 years	45 years	50 years	Extras	Total
August	32	17	15	21	6	3	1	0	0	0	0	95
September	41	31	26	23	10	5	7	0	0	0	0	143

Celebrating our long service colleagues:

Sam Kirk - 5 years

Emma Fisk - 5 years

Emma Mitchener - 25 years

Sandra Murphy - 10 years

Jill Oakman - 45 years

Claire Webb – 20 years

Anita Ufton – 25 years

2.4 Our retiring colleagues

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

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

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

Below are colleagues receiving their retirement certificates from Steve Phoenix, Chairman, and Jayne Black, Chief Executive, over the last two months.

Carl Wilkinson with Jayne Black

Suzanne Bishop with Jayne Black

Jacqueline Harris with Steve Phoenix

Louise Wilson with Steve Phoenix

Patricia Karalis with Steve

3. Conclusion

Over the past two months, colleague recognition at the Trust has continued to thrive, with a growing number of nominations highlighting the exceptional contributions of our colleagues. This energy reflects an embedded culture of appreciation which is key to staff morale and engagement and, as we look ahead to the Trust Awards ceremony on the 14th October, we are reminded just how important recognition and feeling valued is to our colleagues. Celebrating staff achievements not only highlights individual and team excellence and commitment but also strengthens our commitment to compassionate, high-quality care to our patients and service users.

4. Recommendations

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

Appendix 1

Trust Awards Finalists 2025

Enhancing Patient Safety, Experience and Care

"A Touch of Gentleness" project team
Adam Oxley, Security Manager
Ross Webster, Advanced Speech and Language Therapist
Dr Amr Elmosalamy, Consultant Anaesthetist

Improving the Health and Wellbeing of our People

Caroline Strevett, Quality Support Officer
Charlotte Wood, Speech and Language Therapy Assistant
Daniel Shelton, Occupational Therapist
Sue Allen, Assistant Director Nursing

Inspiring our People through Leadership

Robert Tricker, Deputy Service Lead, Bereavement
Hannah Long, Respiratory Team Lead
Jo Byers, General Manager Outpatients and Clinical Administration
Mathew Fuller, Switchboard Team Manager

Inspiring Colleagues through Personal Development

Billy Pepper, EPRR Manager
David Rich, Cardiology/ Stroke Specialist Pharmacist
Laura Bennett, Specialist Speech and Language Therapist, ENT, Voice, Head and Neck Cancer
Ceri McEwan, IP Pharmacist working with Virtual Wards

Living the Trust Values

IBD Nursing Team (Inflammatory Bowel Disease)
The Oracle Newsletter Team
Caron Allen, Lead Phlebotomist
Tom Barham, Estates Supervisor

Team Contribution to Support Outstanding Patient Care

Jubilee Eye Suite Team
RESPS Team (Regional East Sussex Pulmonary Service)
Breast Surgery Team
Community Speech and Language Team

Making a difference (behind the scenes) to support delivery of outstanding care and treatment (Colleague in a key clinical supporting role Bands 2-4)

Kathryn Miller, Speech and Language Therapy Assistant
Nicola Jenkins, Infant Feeding Support worker

Liza Beaumont, Care co-ordinator, Speech and Language Therapy, MSK Outpatients
Bob Russell, Senior ATO

Making a difference (behind the scenes) to support delivery of outstanding care and treatment (Colleague in a key non-clinical supporting role Bands 2-4)

Harry Walker, Ward Administrator, Sussex Premier Health
Billie Lynch, Administration Lead
Francesco Simonit, Patient Pathway Co-ordinator for Prostate Cancer
Michael Moniz, Rapid Response Team Assistant

Leading by example – Inclusion and Diversity Award

Tricia Jenkins, Women's Network Chair
The Oracle Newsletter Team
Georgina Kemp, AHP Support Workforce Lead
Elizabeth Holland, Digital Change Analyst/Trainer

Colleague of the Year – Temporary Workforce Service (TWS)

Cheryl Funnell, Theatre Practitioner
Jean Kerr, Bank Speech and Language Therapist
Dr Darius Khalesi, SHO
Trauma Therapists Team; Claire Pooley, Helaine Wood, Joanna Head, Maddie Nixon, Michael Mulkerrin, Caroline Brett

People's Choice

Carly Carter, Infusion Service Ward Matron
Hubert Rudzinski, Staff Nurse, Medical Day Unit (previously Berwick ward)
Jeyssa Perez, Critical Care Staff Nurse
Virtual Ward, Hastings and Rother Team

East Sussex Healthcare NHS Trust Board Minutes

Date: Tuesday 26th August 2025

Time: 09:30 – 12:45

Venue: St Mary's Boardroom, EDGH

		Actions
	Attendance: Steve Phoenix, Chair and Non Executive Director Jayne Black, Chief Executive (CEO) Amanda Fadero, Non-Executive Director Simon Merritt, Chief Medical Officer (CMO) Charlotte O'Brien, Chief Operating Officer (COO) Paresh Patel, Vice Chair and Senior Independent Director Frank Sims, Non-Executive Director Andrew Strevens, Chief Finance Officer (CFO) Nicki Webber, Non-Executive Director Carys Williams, Non-Executive Director <u>Non-Voting Directors</u> Amber Lee, Associate Non-Executive Director <u>In Attendance</u> Claire Bishop, Deputy Chief Nurse (Workforce and Prof Standards) (DCN) Jenny Darwood, Director of People (DOP) Brenda Lynes, Director of Maternity Services (DOM) Duncan Robinson, EPR Programme Director (EPRPD) for item 63/25 only Pete Palmer, Board Secretary (BS) (minutes) Three members of the public were in attendance at the meeting.	
	Apologies: Ama Agbeze, Associate Non-Executive Director Steve Aumayer, Deputy Chief Executive and Chief People Officer Vikki Carruth, Chief Nurse & Director of Infection, Prevention and Control Richard Milner, Chief of Staff	
61/25	**Chair's Opening Remarks** Steve, Chair welcomed everybody to the meeting. It was confirmed that the notice of the meeting had been duly issued to the members of the Board entitled to receive notice and attend Board meetings. The meeting was quorate according to the Constitution of the Trust. He noted that this would be Nicki, NED's final public meeting following seven years with the Trust. The Chair thanked her for her significant contribution as a member of the Board, noting that her tenure had overseen the organisation's transition from a period of considerable challenge to one of greater stability and improved performance. He expressed gratitude for all that she had done during her time with the Trust noting that she had helped to drive a more data and evidence driven approach than had been present when she first joined. He also extended thanks for the support she had provided to him as Chair.	

	In response, Nicki, NED reflected that this had been her first role as a Non-Executive Director and thanked the Trust for the opportunity. She observed that there had been a substantial amount of change during her time with the organisation and recalled that the Trust had already been on an upward trajectory when she joined and that she had arrived in time to witness the results of that progress. Nicki, NED reflected on her experience of seeing the Trust through the COVID-19 pandemic, explaining that her return to the organisation after that period had been emotional and had demonstrated the challenges that staff must have faced throughout the pandemic. She expressed thanks to everyone around the table for the opportunity and for all that she had learned from her colleagues. She would miss the people and the privilege of being part of an organisation that carried out such important and inspiring work.	
62/25	**Colleague Recognition** Steve, Chair reported that Maddie Bloomfield, Ellie Hume, Baphiwe Pindela and the wider Occupational Therapy Team had won the award in May for the manner in which they responded to a very challenging clinical situation when a patient had a seizure during a phone call. Theresa Street, Clinical Nurse Specialist and Dr Eleni Ladikou, from the Haematology Team, were the winners for June. They stayed after their shifts to ensure that safety of a patient going through a mental health crisis, despite neither being experienced in providing this kind of care.	
63/25	**Electronic Patient Records** Duncan, EPRPD, presented an update on the progress made in introducing Electronic Patient Records (EPR) into the Trust. He reported that the implementation was proceeding as planned, with strong clinical engagement observed to date. Frank, NED asked what societal benefits the implementation would deliver. The EPRPD responded that the initiative would contribute to a reduction in the Trust's carbon footprint and reduce patient travel, explaining that wherever possible, processes would be digitised to achieve these outcomes. Frank, NED asked about the interoperability between SystemOne and the new EPR system, emphasising the importance of ensuring that this was effective. The EPRPD confirmed that integration was likely to occur either directly or via a data warehouse and provide assurance that all data would be shared appropriately. The Chair asked how the Trust would monitor benefit realisation. The EPRPD advised that a dedicated team of two had been appointed to track this, with reviews scheduled every six months to ensure iterative checking of benefits. Nicki, NED noted that her experience in other organisations had shown that this could be challenging. She asked whether any issues were foreseen. The EPRPD replied that all work was on track, explaining that the current on-premises solution was already cloud-based and was being migrated into NerveCentre's cloud. He added that while the Trust was not the first to join NerveCentre's cloud, it was the first to migrate from another cloud environment. Nicki, NED asked what would happen if NerveCentre experienced a major failure. The EPRPD explained that contractual measures, including escrow arrangements, would apply in such circumstances. He added that the Trust had been guided and supported by NHS England throughout the process and had received expert advice. Carys, NED noted that the Trust had not always set colleagues up for success when implementing change and asked what key lessons from the EPR programme could be applied to other initiatives. The EPRPD highlighted the value of working with	

	experienced delivery partners and stressed the importance of engaging with staff to ensure the fully understood changes. He noted that recent conversations about roles had been particularly helpful and that taking time to sense-check progress was essential. Amber, ANED raised concerns about process changes, noting that system rollouts often imposed changes on staff workflows. She asked whether the operational readiness group was addressing this. The EPRPD confirmed that stakeholders from across the organisation were involved in the system design; he noted the importance of having a standardised approach across the Trust in order to maximise benefits. Amber, ANED added that changes would need to be embedded into operating procedures for routine tasks; the EPRPD agreed, stating that this was why the programme was both clinically and operationally led. The CFO commented that EPR would be a key enabler for the organisation and welcomed the level of engagement that had been seen. He asked whether there was support from other functions, such as clinical coding. The EPRPD confirmed that strong support was being received across the Trust. The CMO added that the current digital coding system was not being used to its fullest potential and that consideration would be given about whether to optimise the existing software or transition to NerveCentre, noting that this decision could impact non-elective mortality. Nicki, NED asked whether there would ultimately be a goal to automate coding. The CMO confirmed that the majority of coding work was already automated but required human verification. The CMO concluded by advising that updates on progress would be provided to the Board two to three times a year and thanked the EPRPD for his presentation.	
64/25	**Declarations of Interest** There were no interests declared for any item to be considered on the agenda. All declarations of interest were noted as held on the Register of Directors' Interest.	
65/25	**Minutes** The minutes of the Trust Board meeting held on 24th June 2025 were reviewed. No amendment was noted and they were agreed as a correct and accurate record of the meeting.	
66/25	**Matters Arising** There were three matters arising, two not yet due. • *53/25 – Review of underlying reasons for record ED attendances* A report was due to be presented to the Finance and Performance (F&P) Committee later in the week. **Closed.** Carys, NED asked Executives how confident they were that the improved IPR would be available in November, as this action had now been progressing for two years. The CEO explained that she was confident that this deadline would be met. It was important to get the IPR correct, ensuring that it provided the right levels of data to Committees and to the Board.	
67/25	**Chief Executive's Report** The CEO presented her report to the Board. She advised that the NHS organisational league tables were expected to be published by the end of the month and would use a range of measures to rank organisations. She noted that the Trust's performance was currently within the main cohort but emphasised the ambition to improve further. She confirmed that the outcome would be brought back to the Board in due course.	

	The CEO reported that the Sussex Surgical Centre (SSC) was on track to see its first patients on 8th September, with the Endoscopy Unit scheduled to open at the end of September. She explained that this was an exciting development for both the Trust and the wider Sussex system. She provided an update on cardiology service changes, acknowledging recent media coverage and internal discussions. She explained that significant engagement work was being undertaken with staff to ensure understanding and support for the changes, with benefits being clearly communicated. The Trust was also learning from other organisations that had implemented similar changes and was working with external partners to demonstrate the benefits. The CEO informed the Board that the Trust had been shortlisted for an HSJ Award for its work on caring for veterans. She congratulated the team involved and expressed anticipation for the outcome. The Chair asked about the duration of the body camera trial in ED. The COO responded that the initial trial would run for one month, after which consideration would be given to extending it. She noted that the initiative had been well received by staff. Paresh, NED noted that incidents of violence and aggression were increasing in the NHS and encouraged wider use of body cameras, citing evidence that they helped reduce such incidents. The CFO asked whether the pilot would be extended to community settings. The COO confirmed that this was the intention, noting that lone worker devices were already in use, but emphasised the need to ensure that approach taken was appropriate for colleagues. ***The Board noted the CEO's report.***	
68/25	**Board Committees Chairs' Reports** <u>Audit Committee</u> Paresh, Vice Chair presented the Audit Committee's report. <u>Finance and Productivity Committee</u> Steve, Chair presented the F&P Committee's report. <u>People and Organisational Development Committee</u> Frank, NED presented the People and Organisational Development (POD) Committee report. Cays, NED asked about the recent launch of the new appraisal system, noting that this had not gone as well as hoped. She asked about lessons that had been learned. The DOP explained that the launch had gone well, but that the platform being used was clunky and unintuitive. There were multiple sign off points that a trial group had found no issue with and had only been identified when the process had launched in the wider organisation. <u>Quality and Safety Committee</u> Amanda, NED presented the Quality and Safety Committee (Q&S) report. She noted that helpful triangulation of IPR at Board came from reports from divisions to the Committee. She thanked Divisions for their reporting which helped the Committee receive assurance. ***The Board noted the Committees Chairs' reports.***	

69/25 **Integrated Performance Report (IPR) for Month 3 (June)**

The IPR was jointly reported by the DCN, CMO, DOP, CFO and COO. The CEO noted that it was important that information contained in the IPR was able to be triangulated, with a balanced overview across each of the domains.

Quality and Safety

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

- The consistent number of patient safety reports that were being submitted gave confidence in reporting. There had been a slight increase in level 3 and 4 incidents.
- There had been one Never Event related to wrong site injection. There had been no harm to the patient, but key learning themes had been identified. Reinforcing the importance of safety processes was a key focus for Gemba walks, reinforcing the importance of having such processes for all colleagues.
- Infection control data had remained good in month three, with no areas of concern.
- There had been two fatal harms identified in June, with work being undertaken to identify learning from these in order to improve care.
- Three severity four harms had been downgraded, with learning shared with colleagues.
- Discussions about safeguarding and the number of children in care who required assessment had been undertaking. This was an ongoing pressure on the Trust's workforce.
- There had been a low number of complaints received in June. Overall patient feedback had been very positive.
- A data breach had been reported during the month, which had already been addressed.
- The biggest concern was on the continued demands on the workforce. The Executive team regularly went out into the organisation to support teams and leaders. Work was being undertaken on rostering, and on ensuring that the Trust was able to meet increasing demand and the needs of increasing numbers of complex mental health patients.

Paresh, NED asked whether there were any particular areas experiencing staffing pressures. The COO responded that pressures were evident across the Trust, particularly in gateway areas which were experiencing exceptional demand. She explained that teams were working to ensure accurate rostering and noted a peak in patients presenting with severe mental health needs. Demand on services remained consistently high, which was a concern. The Chair cautioned against normalising the abnormal number of mental health patients, noting that there had been a recent peak of 35 patients. The CEO confirmed that this was extremely high and advised that discussions had taken place with Sussex Partnership Foundation Trust (SPFT) about how Trust staff could be supported differently while the system worked to identify alternative care pathways. A solution would require additional funding and a system-wide approach, as the current Trust environment was not appropriate for these patients and staff were not trained to provide the necessary care.

Amanda, NED observed that the issue of caring for patients with mental ill health had been raised at Board level for many years and noted that Q&S had discussed the Trust's mental ill health strategy at their last meeting. Despite long-standing discussions with system partners, the situation was not improving and patients were not receiving the right care. She suggested that it would be helpful if a clear implementation plan should be developed that was aligned to the Trust and system's strategies. The Chair noted that the significant increase in recent years was alarming. This was a national issue and the Trust would continue to provide the best care it could under the circumstances. Resolving this issue, alongside addressing delayed transfers of care, would deliver significant benefits for patients and to the system as a whole.

Carys, NED commented on the helpful level of information provided in the IPR regarding patient experience and suggested that the Board could consider how to address these issues at each meeting to better support staff.

Nicki, NED expressed concern about some of the health and safety metrics included in the IPR. The DCNO acknowledged the need to improve how information was reported to the Board to provide greater assurance and confirmed that no common themes had been identified from incident report, as the incidents were all different in nature. The Chair noted that more granular scrutiny of issues took place at Q&S. Amanda, NED noted a growing awareness at Q&S that there was a greater risk of deteriorating performance due to how tired and stretched the workforce was. She emphasised the importance of listening to early indicators and noted that discussions about the safety culture in the Trust were due to take place at an upcoming Q&S. Nicki, NED the importance of having robust scrutiny of incident downgrading and for reporting to the Board to be clear and helpful.

The CMO reported that the Trust's Summary Hospital-level Mortality Indicator (SHMI) remained at 103, consistent with the previous report, and confirmed that mortality was a good indicator of the quality of care provided. The Trust remained comfortably within normal limits for both SHMI and RAMI. A deep dive into fractured neck of femur SHMI was underway, and actions from a previous deep dive into congestive cardiology were being reviewed to ensure implementation and effectiveness.

Nicki, NED queried the position regarding fractured neck of femur. The CMO confirmed that performance was comfortably within acceptable limits for this measure, although SHMI was not. He explained that the Trust served a very frail population and might need to improve the capture of risk factors. The CEO highlighted the importance of accurate coding; the CMO agreed, noting that crude mortality was 1.58%, lower than the previous year, but SHMI remained higher. He suggested that some comorbidities were not being captured, particularly given the highly comorbid population in Hastings. The CEO stressed that accurate coding was essential for both quality of care and financial performance.

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

- Whole Time Equivalent usage in June had been 129 below budgeted plan, and spend had been £0.2m below budget
- Substantive staff use remained lower than plan with higher use of bank staff being seen, so the mix of staff would be reviewed. As services changed shape and size the Trust would look at redeploying colleagues; this process was progressing well.
- Vacancies remained lower than plan.
- There had been a slight increase in medical vacancies; this was usual for the time of year as speciality doctors were placed on training plans.
- Agency use had slightly increased in order to support the increased number of patients attending with , generally around supporting patients with SMI
- Turnover not cause for concern.
- Sickness increased by 0.3%, primarily driven by anxiety, depression and mental health issues; work had been undertaken to improve the depth of reasons for sickness which had improved understanding. Work was being undertaken to support colleagues.
- Appraisal rates had fallen for the sixth month in a ro. This had been due to the introduction of a new system which colleagues had found to be clunky and unintuitive, compounded by an unexpected change to the platform being used. A paper appraisal system would be implemented for four month while the platform was improved and regular updates on progress would be provided to POD.

Amber, ANED expressed concern about the increase in depression among colleagues as winter approached. The DOP explained that Occupational Health (OH) was transitioning its focus from a discrete wellbeing offer to a broader model that emphasised both the organisation's responsibilities and the practical steps colleagues could take outside of work to safeguard their own wellbeing.

Carys, NED observed that moving back to paper-based processes represented a poor outcome and asked what would have been done differently if the project were undertaken again. The DOP explained that end-user testing had been conducted with a single workforce group, which had not provided a sufficiently rounded understanding of the needs of other staff groups. In future, testing would be undertaken with multiple, diverse user cohorts to better capture the range of requirements across the workforce. The DCNO added that the platform had been upgraded by the supplier at the point of launch; the project team had been assured this would not materially change the platform, but that assurance had proved inaccurate.

Carys, NED highlighted a further lesson concerning the validation of reporting outputs and asked how this learning would be embedded in processes for future launches. The DOP explained that the lessons learned had been clearly articulated and shared to ensure organisational learning was captured and shared. The DCNO noted that while some teams were continuing to use the electronic version, the process had been more challenging for colleagues who were not confident with IT. It was important the digital solutions were user-friendly and future launches would be tested with colleagues who had lower digital confidence to ensure equitable adoption. Carys suggested that it would be helpful if POD had the opportunity to reflect on the learning from this episode in more detail. **PP**

<u>Access and Responsiveness</u>
The COO presented the update. Highlights from this section included:

- The Trust had achieved 75.8% against the 78% ED standard in June. A reduction of less than 11 breaches a day was required to meet the standard.
- An improvement in the number of long waiting patients in EDs had been seen, although there were continued challenges in managing the increased number of patients presenting who required mental health care.
- The number of patients with No Criteria to Reside in the Trust continued to be challenging; the position had deteriorated in the previous couple of week and discussions continued with the system about solutions.
- A small number of patients had waited for more than 65 weeks for treatment, but this number was expected to recue to zero in August; numbers of patients waiting for more than 52 weeks were reducing.
- Cancer performance continued to improve, and recovery plans were in place for areas of challenge. Diagnostic performance had also improved.
- The Trust was performing well for delayed ambulance transfers of more than 45 minutes.
- There had been a slight deterioration in productivity in June as a result of the junior doctor's action.
- Community paediatric waiting times had increased due to the re-procurement of the outsourcing service. A plan was in place to recover and improve the position, which would be discussed the following day at Q&S.

Amanda, NED asked how the current operational pressures felt on a day-to-day basis, noting that it appeared relentless as new issues seemed to arise as soon as others were resolved. The COO responded that planned care remained relatively stable, whereas non-elective activity was more variable due to fluctuating attendances and staff sickness. Virtual ward capacity had recently increased to 79 beds, with efforts underway to maintain occupancy above 80%. The "art of the possible" approach appeared to be working well, supported by investment in the Urgent Community Response (UCR)

service, and that from a community perspective, the organisation was moving in the right direction.

Frank, NED asked whether the September start date for the community paediatrics team remained on track and the COO confirmed that this was the case.

The CEO provided an update on work that was being undertaken to reduce length of stay, highlighting the importance of consistency and continuity in urgent care. There was a focus was on actions within the organisation's control, led by the COO, CNO and CMO. Reprovisioning of wards from acute to community settings was a key priority, with further work required both internally and across the East Sussex system.

Nicki, NED commented that the situation sometimes felt like "whack-a-mole," with the organisation having to constantly react to changing pressures. She asked whether the Quality & Safety Committee was providing overarching visibility of the pressures through deep dives into programmes. Amanda, NED advised that urgent care would present to Q&S the following day with a focus on ED performance. Demand was continually changing and the organisation needed to constantly adapt while maintaining quality and finance metrics. Current reporting focused on individual metrics and work was ongoing to "join the dots."

Nicki, NED asked how the organisation was planning to change reporting to meet these evolving needs. The Chair supported this point, adding that the number of delayed transfers of care was as critical to ED performance as attendance numbers. This link was not evident in the information currently presented to the Board. The COO explained that there had been a 7.8% year-to-date increase in ED attendances and acknowledged that inconsistent processes contributed to the challenge. Targeted work would be undertaken on weekend performance. The organisation was performing in the second quartile nationally for ED, which was positive in context, though improvement remained a priority. The Chair questioned whether a live, sophisticated model existed to capture all the relevant variables, observing that current reporting was periodic rather than continuous. A comprehensive dashboard would be the ideal solution.

Amanda, NED asked whether the move to a longer planning framework meant that there would no longer be a winter plan after this year. The Chair explained that, in his view, a winter plan would not have been required this year were it not for external requirements as planning of this nature was now a continuous process within the Trust. The CEO confirmed this position, noting that the plan was being produced solely to meet regulatory expectations.

<u>Financial Control and Capital Development</u>
The CFO presented the update. Highlights from this section included:

- F&P were due to meet later in the week where more detailed financial conversations would take place.
- The Trust had met its financial plan for month three, although was slightly behind on its capital plan. Discussions about the phasing of capital spend would take place at F&P later in the week.
- A face to face Sussex CFO meeting was due to take place later in the week where capital would also be discussed.
- The Trust was looking at additional schemes that would help it to achieve a breakeven position.
- Draft guidance had been received about the long term NHS plan, which was now a five-year plan. The shift from a three to a five-year plan would allow for more time for local budgets to be adjusted.

Paresh, NED asked about phasing of capital projects to improve delivery and financial planning. The CFO confirmed that this matter had been discussed at the Capital Group and explained that the approach involved phasing certain projects into future financial years where appropriate. A review was being undertaken to identify projects which could

	be deferred or could be brought forward within the current year to avoid a concentration of activity and expenditure at the end of the financial year. ***The Board noted the Integrated Performance report.***	
70/25	**Response to Fuller Enquiry Part 2 Report** The CMO presented a report in response to Phase 2 of the Fuller Enquiry. He reminded the Board that Phase 1 had been brought to the Board on several occasions and explained that only 37% of Trusts had held Board-level discussions on this matter. ESHT had been selected, along with 36 other Trusts, to participate in Phase 2, during which senior colleagues were interviewed and a substantial volume of documentary evidence was submitted. The CMO advised that Phase 2 had resulted in 21 recommendations; the majority of recommendations from Phase 1 had already been implemented by the Trust. As the Phase 2 report had only been published in July, work was ongoing to address some elements. Progress would be reported to the Mortuary Steering Group and Q&S. Nicki, NED thanked the CMO for the seriousness with which the Trust had approached this work and for ensuring that the Board's previous comments were reflected in the accompanying action plan. She referred to the recommendation that access data should be continually audited and asked whether this could be managed by artificial intelligence, given that the Trust had previously indicated a need for additional staffing resource to undertake this work. The CMO explained that the Trust currently used swipe access logs and CCTV, cross-checking one against the other. He anticipated that improved technological solutions would become available in the future to support this process. ***The Board noted the Response to Fuller Enquiry Part 2 Report***	
71/25	**Avoidability of Inpatient Deaths Q3** The CMO presented the report, noting that this was in a standardised quarterly format. He explained that the Mortality Review Audit Group reviewed all deaths that were considered to have a higher likelihood of avoidability, cases where the medical examiner had raised concerns, instances where care was suggested to have fallen below the expected standard, patient safety incidents graded 3 or above, complaints relating to deceased patients, deaths flagged by CHKS, suspected fatal hospital-acquired thrombosis, and learning disability reviews. He noted that some reviews were delayed due to the need to await Learning Disability Mortality Review (LeDeR) reports, which could take several months to be completed. ***The Board noted the Avoidability of Inpatient Deaths report Q3.***	
72/25	**Key policy updates** The CEO presented her report, highlighting three major documents that had been published in the last six months. She explained that the Ten-Year Health Plan, which set out a strategic shift from hospital-based care to community-based services, presented a significant opportunity for the Trust. The plan emphasised greater focus on preventative care. The CEO explained that the Trust was taking proactive steps in this direction, including the introduction of a new GP front-end service in EDs to reduce unnecessary admissions, which would also positively impact No Criteria to Reside (NCTR) performance. She further noted that virtual wards were an important element of the plan, delivering benefits for both patients and the Trust. The CEO explained that the Dash Review was focused on quality and safety culture and had produced nine recommendations. These would be embedded into the Trust's reporting processes going forward. In addition, she highlighted the Sussex draft commissioning intentions which had been published in early August, with preparatory work underway ahead of a system-wide workshop in September. The CEO explained	

	that the Trust was working with partners to form a Health Alliance to develop integrated care teams in collaboration with primary care, SPFT and other stakeholders. The Sussex Acute Provider Alliance, comprising the four major acute providers, would be meeting to discuss the future of acute care, with outcomes to be reported to the Board in due course. Frank, NED observed that some of these issues had been discussed previously and noted the recent release of the draft planning framework, which required plans to be credible, affordable, and deliverable. He asked how the Trust would ensure alignment and accountability for delivery. The CEO reported that discussions on accountability had already taken place, with discussions about agreeing a Memorandum of Understanding and contractual arrangements that would support collaborative working. She emphasised that this represented a different approach from previous models and needed to be implemented effectively to achieve the desired outcomes. Frank, NED, agreed, noting that partnership working was often challenging, particularly when financial pressures arose, and stressed the importance of addressing this from the outset. Amanda, NED asked how the Dash Review would influence planning and operational behaviours, and whether there was an opportunity to align this with the Jim Mackie review to ensure the Trust was well-positioned. The CEO agreed, stating that the Trust needed to assess its current position and next steps, with further updates to be provided to Committees and the Board in due course, emphasising the importance of balancing ambition against financial constraints. The Chair highlighted the immediate challenge of operationalising NHS Sussex's new approach to commissioning, which aimed to move towards strategic commissioning, potentially based on outcomes. He noted that this could be positive if aligned with available resources but cautioned that differing interpretations of strategic commissioning would need to be reconciled. The Trust was already implementing the core principles of the Ten-Year Plan, including a shift to community care, digital-first approaches, and prevention. Amanda, NED observed that the documentation lacked sufficient data to drive change and noted the significant investment in Sussex in population health management and data-driven transformation. She expressed hope that strategic commissioning would leverage data to ensure services delivered the intended outcomes. The Chair agreed, noting that data should underpin commissioning intentions and outcome-based approaches. It was important that the system worked to develop the sophistication required to achieve this. ***The Board noted the Key policy updates***	
73/25	**Winter Planning** The COO presented the winter planning Board Assurance Statement; there was a requirement to submit this to NHS England (NHSE) by the end of September. The COO advised that modelling work was underway to test bed capacity scenarios for winter. A Quality Impact Assessment (QIA) would follow the assurance exercise scheduled for early September. The COO confirmed that the Trust was compliant in all other areas. The statement was presented in line with NHSE's request, with the more detailed draft winter plan to be discussed in Part 2 of the Board meeting. Frank, NED queried whether the plan's actions relating to mental health services were supported by a corresponding plan from SPFT, particularly in relation to 35 patients currently within the Trust. The COO explained that SPFT would undertake the same planning process, but that she had not yet seen a system-wide response. The Trust had developed a plan to manage these patients, with bed requirements in the winter plan modelled on current activity, with allowances made for recent surges in demand as far as possible.	

	Amanda, NED asked how confident the Trust was in achieving a 5% increase in flu vaccination uptake, given recent declining trends. The DOP explained that vaccinations could not be mandated but confirmed that every frontline staff member would be offered the vaccine. Vaccinations would commence in September, supported by an executive-led communications campaign emphasising the importance of protecting staff, patients, and families. There would be peer vaccinators on wards and drop-in clinics to maximise accessibility. Uptake typically increased when flu cases were first observed on wards, and this would be used to encourage early vaccination. Amanda, NED highlighted the importance of the QIA process and asked how this would be undertaken. The COO advised that the timing of the assurance event on 8 September was intended to align with broader system discussions that would influence the plan. ***The Board approved the submission of the Board Assurance Statement to NHS England.***	
74/25	**Trust Response to Sir Jim Mackey's National Maternity Investigation** The DOM provided a verbal update on the National Maternity Investigation. The Board noted that a letter had been issued to all trusts on 23 June announcing an urgent national investigation in two parts, including a rapid review of ten trusts (of which this Trust was not one). The DOM advised that the Trust was awaiting the terms of reference and would establish a working group once these were received. The investigation would focus on five key themes: 1. **Tackling poor behaviour and culture**: Significant progress had been made in addressing poor behaviours and cultures within the Trust over the past year, although further work remained. 2. **Listening to families and learning from harm:** The DOM emphasised the importance of closing the feedback loop where harm had occurred. Systems and processes were in place, including complaints, PALS, the Maternity and Neonatal Voices Partnership (MNVP), and multiple channels for raising concerns, enabling timely action. 3. **Setting the right culture and partnership working:** The DOM highlighted strong collaboration with MNVP, including co-production of an annual action plan reviewed quarterly by Q&S. Regular meetings were held to review claims, concerns, and external reports, ensuring continuous improvement. A video had been produced to reflect on past failings and lessons learned, aimed at improving communication and transparency. 4. **Data review and monitoring:** The DOM confirmed that significant work had been undertaken to strengthen data review processes, including enhancements to the maternity dashboard in collaboration with the maternity and neonatal system. 5. **Addressing health inequalities, discrimination, and racism:** The DOM reported improvements over the past two years and confirmed that the Trust awaited the NHS England anti-discrimination programme due in August. Continuity of carer teams were in place to support equity across the Trust. The DCNO advised that these themes would be taken forward with divisional leaders to develop recommendations for review by Q&S and, if required, escalation to the Board. Amanda, NED observed that maternity care nationally remained under intense scrutiny and stressed the importance of maintaining focus on supporting colleagues, rather than being overwhelmed by regulatory requirements. She welcomed the letter and expressed	

	hope for simplification of reporting to enable staff to focus on delivering safe, high-quality care. She commended progress to date but acknowledged that further work was required, particularly on culture. The Chair agreed, noting that cultural improvement and teamwork were ongoing priorities. There was a current unprecedented complexity of regulatory oversight in maternity services and the Chair cautioned that the volume of reports and action plans required risked diverting attention from patient care. The DCNO emphasised the importance of aligning service delivery with the needs of service users and maintaining a supportive culture for staff and patients. The DOM emphasised the motivation and commitment of the workforce to deliver improvements. The Chair concluded by praising the Trust's ongoing work on tackling health inequalities. ***The Board noted the Trust Response.***	
75/25	**Medical Revalidation Annual Report** The CMO presented the annual report on medical revalidation and appraisal, confirming that the Trust had achieved a 100% compliance rate for revalidation. He reported that there had been no missed appraisals, although some had been deferred due to reasons such as sickness and maternity leave. The report required Board approval and then be signed by the CEO prior to submission. Amber, NED asked for more information about the number of postponed appraisals. The CMO clarified that these postponements were measured from the original appraisal date and that some delays were only for a few weeks, while others were due to legitimate reasons such as sickness. He confirmed that the metrics were broadly consistent with the previous year and assured the Board that the Trust worked closely with the General Medical Council (GMC) regarding appraisal processes. ***The Board approved the Medical Revalidation Annual Report***	
76/25	**Q1 Board Assurance Framework** The CEO presented the Quarter 1 Board Assurance Framework (BAF), which outlined the strategic risks facing the organisation. Changes had been made for 2025/26 to improve clarity, making the BAF more dynamic and forward-looking, with enhanced formatting and readability. A significant refresh of the corporate risk register had also been undertaken to ensure closer alignment with BAF risks and the work of subcommittees. Carys, NED thanked the team for the improvements but noted difficulty in reconciling inherent risk, risk tolerance, and risk appetite and asked whether further work was required to ensure that the risk appetite for BAF risks aligned with the organisation's overall risk appetite. It was agreed that this would be taken back for discussion by relevant Committees for review and retesting. Paresh, NED observed that some corporate risks did not align directly with BAF risks and therefore were not all represented within the framework. ***The Board noted the Update on the Q1 Board Assurance Framework***	
77/25	**Annual Review of Trust Governing Documents** The CFO presented the annual review of the Trust's Governing Documents, noting that the updates had been reviewed and endorsed by the Audit Committee. ***The Board approved the updated Trust Governing Documents.***	
78/25	**Use of Trust Seal** No uses of the Trust Seal had taken place since the last Board meeting.	

79/25 **Questions from members of the public**

The Chair reported that a number of questions had been submitted to the Board prior to the meeting.

Mr Campbell asked whether it would be possible to include average staffing levels within the Board pack, noting that this information was already published on the Trust's website. The CEO agreed to review this request, noting the need to ensure that the IPR contained appropriate information.

Mr Campbell queried whether the figures in the Use of Resources document were actual calculated figures and whether they could be verified. The CFO confirmed that the figures had been calculated. The Chair clarified that the approach being taken was not about moving patients into the community but about ensuring that patients received the right care in the right place at the right time, including care at home where appropriate. Current Trust plans related to existing community teams, which was why no additional financial allocation was shown. The CEO added that eight workstreams were supporting the ten-year plan, one of which focused on resourcing, and outcomes were expected over the coming months.

Mr Campbell observed that the ten-year plan document lacked detail on the resources required to deliver its recommendations and asked how the Trust would establish a group to gather patient feedback to inform optimal care models. The Chair noted that the absence of social care provision was a key omission from the national plan but confirmed that the Trust would work to deliver the best possible outcomes within these constraints.

Ms Burt raised concerns that digital improvements were not being tested with a sufficiently wide range of staff before being introduced. The DOP explained that the new appraisal process had been integrated into an existing system that had been thoroughly tested, but not by every workforce group, and that the process had been complicated by an unanticipated platform change during implementation. Lessons had been shared and would be applied to future rollouts.

Ms Burt asked whether the configuration of new IT data platforms that were due to be introduced for EPR had been used by other NHS trusts. The CMO confirmed that other trusts already used the data platform; the Trust was part of the West Midlands Acute group, which was already using the system. Learning from other implementations had been incorporated into the product design and deployment, and the Trust was well positioned to benefit from this experience.

Ms Burt queried whether contracts with digital suppliers included clauses covering non-performance, security breaches, or data leaks. The CMO advised that the EPR software was widely used and stable, provided by a UK-based company under a robust contract specifying functionality, cost, and staged payments. He was not aware of the detailed IT security provisions, but confirmed that the contract followed NHS England standard terms. The Chair explained that he understood that a specialist procurement group had been engaged to ensure that the system and contracts were as robust as possible; the CFO confirmed that the EPR system was cloud-based, with the provider responsible for cybersecurity, which was expected to apply to the new system.

Ms Burt asked whether the Trust recorded the hours and costs associated with caring for patients with mental health illness. The Chair confirmed that this data was recorded and discussed with the Integrated Care System (ICS).

Ms Burt asked whether the southern hemisphere flu season had started early as this usually reflected what would happen over winter in the UK. The DOP confirmed that this early start was the reason for the Trust's decision to commence its vaccination programme earlier this year.

	Ms Burt referred to a previous fine imposed on the Trust by the Human Tissue Authority (HTA) for poor storage of patient samples after death. The CMO clarified that the issue related to incomplete documentation of sample pathways rather than patients being left unattended and confirmed that the matter had been addressed following the HTA inspection. Ms Burt noted the appearance of long hyphens (m-dashes) in Board reports, suggesting that AI tools such as ChatGPT might have been used in their preparation, and wished to highlight this observation. Mr Sullivan raised concern that cancer figures were declining and suggested that one contributing factor was that GPs were unable to refer patients directly to hospital, instead requiring dermatology review first. The COO stated that she was unaware of this and would follow up with Mr Sullivan after the meeting.	
80/25	**Any Other Business** Carys, NED requested that end-of-life care be added to the Board planner for future discussion, seeking assurance that patients were receiving the most dignified care at the end of life. The DCNO confirmed that this was already on the agenda for review and that work was ongoing with neighbourhood teams and this would be discussed at a future Board Development Day.	
81/25	**Date of Next Trust Board Public Meeting** Tuesday 14th October 2025	

Matters Arising from Public Board meetings

MEETING DATE	MINUTE NO:	ACTION	BY WHOM	BY WHEN	COMMENTS – INCLUDING ANY UPDATES
OPEN ACTIONS					
None					
NOT YET DUE					
10.10.23	73/23	Consider how to increase the focus on community services data within the Trust IPR	Richard Milner	November 2025	29.04.25 As part of the wider review of information flows and reporting, a revised approach to IPRs and data that is subsequently shared with sub-committees and the Board is **expected to be in place from November**
08.10.24	72/24	Executives were asked to reflect on how reporting to the Board could be improved moving forward.	Execs	November 2025	29.04.25 As part of the wider review of information flows and reporting, a revised approach to IPRs and data that is subsequently shared with sub-committees and the Board is **expected to be in place from November**
ACTIONS COMPLETED					
None					

East Sussex Healthcare NHS Trust

Report to:	Board of Directors	**Agenda Item:**	7.1
Date of Meeting	14th October 2025		

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

Purpose

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

Background

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

Business Undertaken

- Emergency preparedness, resilience and response (EPRR) & Business Continuity:
  The Committee received an update on EPRR readiness, business continuity planning, and cyber security. Progress was noted on critical function identification and disaster recovery planning. A cyber exercise had been scheduled for November with London City Police.

- Board Assurance Framework (BAF):
  The Q2 BAF was reviewed. A discussion took place about improving alignment between strategic risks and corporate risks. Plans were also to improve clarity and potentially include detailed appendices for internal use.

- Financial Planning & Internal Audit:
  The internal audit report on financial planning gave 'partial' assurance. An action plan was agreed, with monitoring to move to Finance & Performance Committee.

- Internal Audit Progress:
  'Reasonable' assurance was achieved from the Patient Safety Incident Response Framework (PSIRF) audit. The benchmarking report showed a slight increase in partial assurance reports compared to the previous year.

- Counter Fraud:
  An update was provided on the new Failure to Prevent Fraud legislation. The Anti-Fraud & Bribery Policy was updated and approved. Conversations about increasing cyber awareness training would be escalated to the Executive Leadership Team meeting.

- External Audit:
  No significant updates; planning for next cycle in progress.

Alert, Advise and Assure

- Alert:
  • None

- Advise:
  • The BAF would be further refined to reflect the true risk landscape; work was ongoing.

- Assure:
  • Progress on EPRR business continuity and cyber security planning is positive.
  • Counter Fraud arrangements strengthened with updated policy and training initiatives.

Key Risks or Opportunities and their impact on the Trust

- Cyber security and digital resilience remain high-risk areas.
- Financial governance and SIP delivery require robust oversight to avoid adverse impact on Trust performance.

Key Decisions

- Approved updated Anti-Fraud & Bribery Policy.
- Agreed to escalate cyber training compliance to ELT.
- Endorsed internal audit action plan for financial planning.

Exceptions and Challenges

None.

Recommendations

The Board is asked to note this report.

Report to:	**Trust Board**	**Agenda Item:**	7.2
Date of Meeting	**14th October 2025**		

Title of Report:	**Finance & Productivity (F&P) Committee**
Status:	For Discussion
Sponsor:	Steve Phoenix, on behalf of Chair of F&P Committee
Author:	Steve Phoenix, on behalf of Chair of F&P Committee
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the Finance & Productivity Committee on 25th September 2025.

Background

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

Business Undertaken

Alert, Advise and Assure

The Committee received updates on the following matters:

1. Financial Performance

The Committee reviewed the Trust's Month 5 financial position, noting a £5m deficit mitigated by reserves; additional schemes are in development, and additional controls have been introduced. The Trust remains committed to break-even, though risks to quality and reputation were acknowledged.

2. Performance Update

Performance updates showed strong delivery against constitutional standards, with challenges in ED breaches, diagnostics, and community paediatrics. The Trust is managing the transfer of 1,800 patients from UHSx without impacting RTT metrics.

3. Capital Update

Capital spend is behind plan due to delayed approval of £8.55m infrastructure funding, with a sharp increase expected in coming months.

4. Board Assurance Framework (BAF)

The Board Assurance Framework was reviewed, with BAF 3 (financial efficiency) risk score increased to 20. Cyber and digital transformation risks remain under active management. The Committee discussed capital performance, noting delays in spend and risks related to contractor insolvency. A business case for a new CT scanner was submitted, and capital-to-revenue funding is supporting savings delivery.

5. Grip and Control Measures and Well Led Finance Review

Updates were provided on grip and control measures, the Well-Led Finance Review, and system-level financial planning.

6. System Issues

The Trust secured £3.5m in capital brokerage. Work is ongoing to refine block contract data and funding allocations, with national planning timelines under pressure. A recommendation for Q3 deficit support funding is pending; Q4 support will depend on Month 8 performance.

7. Histology Modernisation NHS MOU

The Committee approved the Sussex-wide pathology business case, now moving into implementation planning.

Key Risks or Opportunities and their impact on the Trust

Key Decisions

Exceptions and Challenges

Recommendations

The Board is asked to note this report.

Report to:	**Board of Directors**	**Agenda Item:**	7.3
Date of Meeting	**14th October 2025**		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the People & Organisational Development (POD) Committee on 25th September 2025 to provide the Board with an update of the Committee's activities.

Background

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

Business Undertaken

POD Workforce Insight Report

Workforce metrics remained stable, with WTE usage within budget and turnover steady at 9.8%. Mandatory training stayed above target at 92.5%, and vacancies slightly decreased to 3.6%. Sickness rates rose marginally to 5.4%, while appraisal compliance improved to 80.8%, though still below target. It was noted that changes to the way teams are reporting appraisals have now begun to show through in the data. Lessons around the digital implementation have been taken forward. Workforce usage showed continued reliance on temporary staff, especially in areas undergoing change.

Recruitment challenges persist in specialist roles, and the Core Division's underperformance prompted a revised recovery plan. Mitigation efforts include digitisation and team restructuring. Whilst POD maintains an overview of the people impact of cost improvement plans and will track the trajectory of wte and schemes, the detail of CIPs will be picked up by F&P committee.

Concerns were raised about urgent care pay increases despite reduced staffing, with further review underway. The Chair praised the upcoming Trust Awards, highlighting the importance of recognising staff achievements.

Alert, Advise and Assure

Health & Wellbeing

The workforce well-being report highlighted ongoing initiatives, including a successful suicide prevention event, progress toward the Gold Well-being Award, and continued delivery of mental health and resilience support. Flexible working approvals were high, though some requests remain unresolved. Leadership development is being shaped by well-being insights, with a focus on practical staff support. Further action was proposed to strengthen well-being strategies during high-pressure periods.

Supporting Staff when dealing with patients with a Mental Health need

An update was provided on mental health initiatives, including training, outreach, and environmental improvements, with strong collaboration noted with external partners. A pilot outreach team faced recruitment challenges, prompting plans to adjust the skill mix. Positive impacts were seen from therapeutic spaces and evolving security roles, with similar approaches being explored for dementia care. Staff support remained a priority, with listening events and cross-service collaboration underway. It was agreed that the work should align with the BAF and progress toward Board-level strategy discussions, with an emphasis on flexibility and responsiveness.

Leadership Development

The leadership development programme evolved to prioritise experiential and social learning, with Option 2 selected as an interim approach. It focused on foundational leadership skills such as budget management, delivered through improvement projects, coaching, and shadowing. While concerns were raised about the limited emphasis on softer skills, it was confirmed that future phases would incorporate coaching and staff

support, aligned with the NHS Leadership Code. Existing training and coaching remained available, and modular micro-courses were being developed. The programme was supported with minor amendments, recognising it as a first step toward a broader leadership strategy.

Staff Survey update – Sussex Premier Health (SPH)

The staff survey had a strong response rate of 89%, providing confidence in the results despite the division's small size. Key concerns included increased reports of low motivation, frustration, and unreported bullying, along with dissatisfaction around pay. Positive feedback highlighted strong patient care focus and flexible working support. In response, targeted actions were taken to improve culture, well-being, and collaboration, including staff recognition initiatives and enhanced mental health support. The division's approach was praised as a model for wider learning across the Trust.

Guardian of Safe Working Hours (GOSWH) Reports

Improvements were noted in respiratory and geriatrics following targeted interventions, while staffing issues in urology and ENT remain due to service relocations. Endocrinology continued to face challenges, with recent exception reports prompting escalation. A new exception reporting framework was being implemented, focusing on confidentiality and direct reporting. Changes at the Conquest site were highlighted, including ward restructuring to support staff well-being. The Trust will adopt the national Resident Doctor 10-Point Plan as a standing agenda item. A benchmarking exercise was requested to assess the cost of exception reporting compared to other providers.

Key Risks or Opportunities and their impact on the Trust

The Committee requested for update on the following risks: N/A

Key Decisions

Board Assurance Framework (BAF) Quarter 2

BAF 1: Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time

The workforce risk score remained at 9, below the inherent risk of 15, due to positive recruitment trends. Proposed marking recruitment and NHS GRIP review actions as green and updating the recruitment action's due date to "ongoing."

BAF 2: Decline in staff welfare, morale and engagement impacts on activity levels and standards of care

The current risk score was assessed at 16, reduced from an inherent score of 20, indicating it remains a significant concern. Continued internal action was emphasised as necessary, and it was confirmed that the Trust Awards-related action could now be marked as complete (green).

Workforce risks were linked to NHS Oversight Framework segmentation scores, with staff engagement and concerns placing the Trust in Segment 3, and sickness absence in Segment 2. Strengthening feedback mechanisms was highlighted as a priority, and the impact of mental health is now reflected in the BAF. A review of the staff survey action plan was proposed to assess progress, with a commitment to continue engagement efforts ahead of new survey results.

The discussion emphasised the need to balance patient safety, staff well-being, and financial pressures. Concerns were raised about the pace of change and its impact on staff stress, noting the importance of ensuring that quality improvement was not compromised. It was agreed that staff should feel empowered to raise safety and quality issues regardless of financial constraints. Support for leadership in navigating these challenges was also identified as a key focus.

Exceptions and Challenges

N/A

Recommendations

The Board is asked to note this report.

East Sussex Healthcare NHS Trust

Report to:	Board of Directors	Agenda Item:	7.4
Date of Meeting	14th October 2025		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the QSC on 24 September 2024 to provide the Board with an update of the Committee's activities.

Background

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

Business Undertaken

Division Report – Medicine

The Associate Director of Nursing for Medicine advised that falls numbers and rates (including harm) were being maintained below average levels. Responding to National Inflammatory Arthritis Audit was flagged as an area of challenge; a registrar had been allocated specific time for data entry so this could be addressed.

Governance Quality Report

A new reporting template was presented to the Committee. This included a matrix to summarise the quantity and of patient safety events initially classified at each of the five severity levels, as well as subsequent reclassifications following review at the Weekly Patient Safety Summitt. Approximately 71% of events reported were at the lowest severity level (near miss/no harm). It was explained that focusing broadly on the most common types of events was at least as important as exploring details of the most severe ones to continue improving patient safety.

Care Quality Commission – Key Lines of Enquiry (KLOEs) Updates

The Associate Director of Nursing have an updated self-assessment against the KLOEs. Estates work was central to progress against certain KLOE domains for several divisions. Peer-assessments had also been planned to gain different perspectives and consider new approaches.

Alert, Advise and Assure

Alert

None.

Advise/Inform/Update

Quality Dashboard

Rates of clostridium difficile remained slightly elevated. A multifactorial response was in place, with two of the key strands being the continued reduction of hospital occupancy and renewed focus on antimicrobial stewardship. Collaboration with regional and national teams was ongoing.

End of Life Care (EOLC) Update

•The National Audit of Care at the End-of-Life report indicated that there was scope for improvement around recognition of the dying phase and associated documentation.
• An EOLC dashboard was in development to monitor internal governance and improvement.
• Expired policies had been reviewed and presented to the End-of-Life Care Improvement Group.

Assurances

Patient Safety & Quality Group - Escalation and Assurance

• Overdue Patient Safety Incident Response Framework (PSIRF) templates continued to be monitored closely and were prioritised for completion
• The PSIRF Implementation Tool had been presented to senior colleagues as part of a cascading approach to embedding new practices
• Divisions were being encouraged to use a variety of PSIRF templates.
• The Pressure Ulcer Review Group had begun using the PSIRF compliant After-Action Review template. This was a new national tool to review how this damage occurs and is investigated

Key Risks or Opportunities and their impact on the Trust

None.

Key Decisions

Perinatal Quality Surveillance (PQS) Operating Model

The Committee noted and approved the recently updated Sussex Perinatal Quality Surveillance Operating Model. This would support:

- delivery of the revised arrangements for quality and safety in maternity and neonatal services
- development and local reporting of neonatal information and metrics.

ESHT was fully compliant with Local Maternity and Neonatal System (LMNS) requirements.

Exceptions and Challenges

None.

Recommendations

The Board is asked to note this report.

Agenda Item: 9

Report To/Meeting	Trust Board	**Date of Meeting**	14th October 2025
Report Title:	NHS Leagues Tables		
Key question	This paper outlines the NHS Oversight Framework, showing where ESHT is ranked nationally. Six metrics have been identified for improvement.		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☒		
Report Sponsor:	Jayne Black, CEO	**Presenter(s):**	Jayne Black, CEO
Report Author:	Sandeep Patel, Associate Director of Performance Improvement		
Outcome/Action requested:	The recommendation is to prioritise the six areas of under-performance, which will have a positive impact on patient outcomes and ESHT workforce. To monitor all metrics on a monthly basis for continued improvement in performance.		

Executive Summary

The NHS Oversight Framework (NOF) is how acute providers will be assessed for delivery of care, against a national backdrop (ranking / league tables).

Based on Q1 2025/26, ESHT average metric score is 2.3 (scores range from 1.0 high performing to 4.0 low performing).The score of 2.3 equates to segment 2 of the NOF.

Any trust reporting a financial deficit is defaulted to segment 3. Therefore, ESHT is in segment 3 after financial adjustment, ranking of 61 out of 134 acute trusts.

The following metrics are those that are low performing or below average. These are the areas that require focus in 2025/26:

- Discharge ready delays
- Planned deficit
- Implied productivity
- NHS staff survey – raising concerns
- NHS staff survey – engagement
- Sickness

Regulatory/legal requirement:	NHSE provider performance management.
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	The NOF is a national framework. Impact assessment has been completed during the consultation phase. The framework has wider contextual metrics (non-scoring) for EDI.
Resource Implication/VFM Statement:	Work in progress for the priority areas will be included within 2025/26 budget. If projects are identified to further improve the workstreams

	outlined in the detail of this report, a financial review will have to be carried out in year for the project proposed.
Risk:	Underperformance across the domains could result in ESHT dropping into the lower performing segments. Patient outcomes will deteriorate and the Trust could be placed into special measures.
No of Pages	6 **Appendixes** 0
Governance and Engagement pathway to date:	Discussed at Executive Committee and Senior Leaders Seminar.
What happens next?	Paper to be tabled for Trust public board meeting in October.
Publication	Fit for publication

Introduction/Background

The NHS acute trust league table has been created from aggregate metric rankings for acute trusts, which form part of the NHS Oversight Framework (NOF).

The NHS Oversight Framework is a 1-year framework which sets out how NHS England will assess providers. The framework will be reviewed in 2026/27 to incorporate ambitions and priorities in the 10 Year Health Plan. The framework is supported by a focused set of national priorities and wider contextual metrics (inequalities and outcomes).

The metrics falls within six domains. All individual metric scores are consolidated, averaged to derive a segment score. The segment score is then ranked to show trust position in relation to other national acute providers (includes trust types – small, medium, large, specialist and teaching trusts).

The six domains (and sub domains) are outlined below:

- **Access to services**
  - elective care
  - cancer care
  - urgent and emergency care
  - Mental health care
- **Effectiveness and experience of care**
- **Patient safety**
- **People and workforce**
- **Finance and productivity**
- **Improving health and reducing inequality (non-scoring)**
  - improving population health
  - primary prevention
  - inequalities

Current Performance

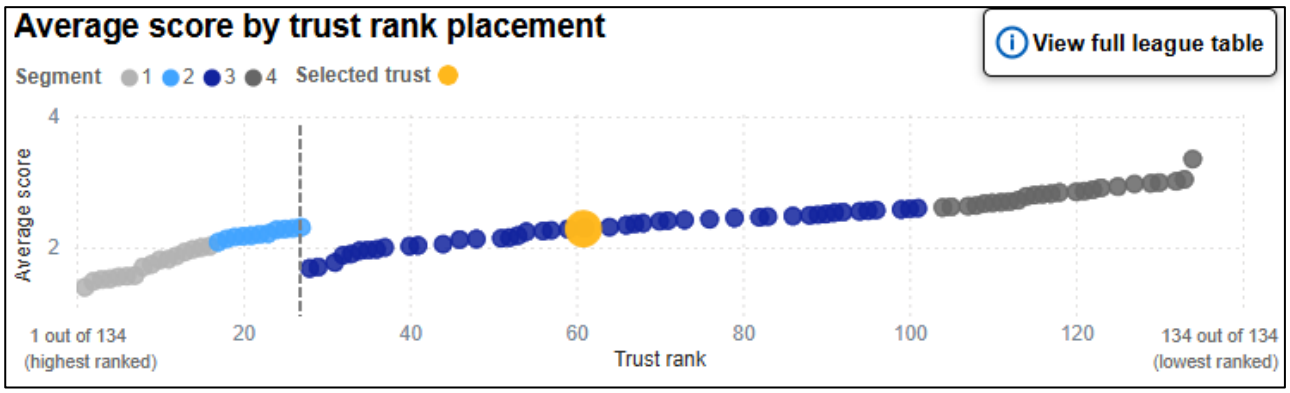
ESHT current performance shows average score of 2.3 (scores range from 1.0 high performing to 4.0 low performing).

The Trust in segment 3, with a ranking of 61 out of 134. Any trust reporting a financial deficit is defaulted to segment 3 regardless of scores in the other domains.

ESHT would in segment 2 if no financial adjustment was applied.

Table 1 – ESHT performance against NOF domains

Access to services	1 - High performing
Finance and productivity	3 - Below average
Effectiveness and experience of care	4 - Low performing
Patient safety	3 - Below average
People and workforce	3 - Below average



Low performing metrics

Domain: Effectiveness and experience of care

Metric: Discharge ready delays

NOF score = 3.78

The main contributors for the delay are the P2 (discharge to a community bed-based setting) and P3 (discharge to a residential setting) patient pathways.

The Trust is working collaboratively with system partners to discharge patients to their onward care destination. In addition, the following workstreams are in place to facilitate discharge:

- Optimising use of limited P2 resource, including roll-out of eligibility and exclusion criteria co-produced by system partners
- Application of Choice policy
- Assessments for ongoing care to be done outside of acute setting.

Below average metrics

Domain: Finance and Productivity

Metric: Planned surplus / deficit

NOF score = 3.0

The Trust has agreed a challenging breakeven plan for 2025-26, which includes an efficiencies target of £49.6m and has involved detailed plans worked up with divisions. Cost and other pressures has resulted in the need to identify other opportunities / efficiency schemes to the value of £8M, and the Trust is in the process of identifying these to enable the delivery of a break-even plan.

Domain: Finance and Productivity

Metric: Implied productivity

NOF score = 2.80

This metric calculates to M12 2024/25 vs 2023/24, units of activity divided by cost.

ESHT is improving productivity via:

- Clinical service reviews, including job planning
- Implement GIRFT – further faster best practice
- Theatre utilisation
    - Sussex Surgical Centre expansion
    - Focus on early finishes, on the day cancellations
- Outpatient utilisation

- Reduce ad-hoc outpatient clinics
- Maintain slot utilisation at 95% or above
- Introduce digital solutions to improve management of appointments.

Domain: Patient Safety

Metric: NHS Staff Survey – raising concerns

NOF score = 3.17

ESHT has the following programmes to strengthen the staff voice and reassure colleagues that when they raise a concern it will be taken seriously and addressed where action is required.

- Launch of the new Behaviour Charter
- Bullying and Harassment Listening events
- Corporate Welcome event includes a focus on the importance of speaking up and raising concerns, with information about the role of Freedom to Speak Up Guardians
- ESHT was among the first trusts to make Listening Up training mandatory
- CEO and Deputy CEO have reinforced the importance of speaking up through staff briefings
- A year-long communications plan is in place to maintain visibility and engagement, with targeted messaging throughout the year and a focused campaign during Speak Up October
- Freedom to Speak Up Guardians attend training events and actively support staff networks to promote safe routes for speaking up and ensure managers understand how to listen effectively
- Confidential support is offered to staff, with anonymised feedback shared at Board level to represent the staff voice while maintaining confidentiality
- All Trust executives have diarised Gemba walks, providing an opportunity for services to raise a concern direct with an executive
- Concerns are logged on Datix. The length of time for investigation is monitored, as are resulting actions and ensuring a response is provided for each concern.

Domain: People and Workforce

Metric: NHS Staff Survey – engagement

NOF score = 3.30

Involvement and advocacy scored low in relation to the engagement theme in the staff survey. ESHT have a number of targeted programmes to strengthen staff experience and engagement. These include:

- Staff award – improved accessibility and visibility for all staff members
- Reviewed and refreshed Corporate Welcome induction event
- A comprehensive Wellbeing programme is in place
- CQI strategy in development
- Mentoring and coaching programme
- Expanded the number of staff networks. Networks now have executive sponsors to help drive forward their agendas
- Introduced a Partnership Forum where colleagues from all roles and bands across the trust come together to share ideas, raise concerns, and influence positive change
- CEO weekly blog communicates successes and positive patient feedback
- Executive visibility via GEMBA visits, listening to/acting on issues
- LOS reduction programme
- Working with nursing leads to establish training/ support in rostering optimisation of substantive staff

Domain: People and Workforce

Metric: Sickness

NOF score = 2.78

ESHT has a range of resources and services available, to prevent sickness and to support staff during sickness.

- Resources for staff available on the extranet
  - Stress resources
  - Mental health support
- Counselling
- Support available following potentially traumatic experience at work
- Wellbeing resources
- Supporting staff through organisational change
- A Sickness Reduction Group has been established
- The impact of the new sickness policy shows positive impact on key sickness metrics
- Bitesize training on the Sickness Management procedure is offered as part of the Managers Toolkit
- Promotion of the flu vaccine has commenced. Introduction of flu clinics for front line and support staff.

Consequences for not taking action

The NHS Oversight Framework is NHSE's tool to ensure public accountability for performance and provide a foundation to support improvement. Underperformance across the domains could result in ESHT dropping into the lower performing segments. Patient outcomes will deteriorate and the Trust could be placed into special measures.

Recommendations

This paper is for information and discussion.

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

KINDNESS

INCLUSIVITY

For the Period August 2025 (Month 5)

INTEGRITY

Content

East Sussex Healthcare NHS Trust

About our IPR

East Sussex Healthcare NHS Trust

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

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

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

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

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

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

KINDNESS
INCLUSIVITY
INTEGRITY

Chief Executive Summary

East Sussex Healthcare NHS Trust

Financial sustainability remains our top priority, with focused efforts on improving efficiency and delivering cost-effective care. At the same time, we continue to maintain strong operational performance and uphold our commitment to providing high-quality, safe, and compassionate care to our patients. This balanced approach ensures that financial improvement does not come at the expense of service standards or patient outcomes.

The Trust delivered a £1.3m deficit in August, with a year-to-date deficit of £5.0m, both in line with plan.
The level of schemes to deliver efficiencies were lower than the efficiency target, thereby causing risk to the year end position. A review is in progress with Divisions and Central teams, to identify further schemes to enable ESHT to deliver its financial plan.

ESHT is in the highest performing segment for the Access to Services domain, in the NHS Oversight Framework. This domain includes the main constitutional standards against which the Trust is performance managed.

Inpatient falls rate per 1000 bed days was within the control limits and there were zero category 3 or 4 pressure ulcers reported amongst inpatient or in the community in August. Eat, Sleep, Move & Repeat campaign was launched in August to help fight patient deconditioning.
96% of the total patient events were no / low harm / near miss, comparable with the national average (96%), indicative of a good reporting culture at ESHT.

Substantive workforce usage was within budget. The focus is on reducing reliance on agency and bank staffing, including security costs. There remains a requirement for agency in A&E and for registered mental health nurses as A&E attendances continue to increase.

Balanced Scorecard

East Sussex Healthcare NHS Trust

Safety	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Number of Patient safety events (severity 1-5)		994	985	789	Common Cause	Target required
Number of Patient safety events (severity 3)		17	30	10	Concern	Target required
Number of Patient safety events (severity 4 ...		5	5	3	Common Cause	Target required
Never Events		0	0	1	Common Cause	Target required
Inpatient Falls per 1,000 Bed days		4.46	4.95	4.42	Common Cause	Target required
Cat 3 ESHT Acq. PU (rate) per 1,000 bed days		0	0	0	Common Cause	Target required
Cat 4 ESHT Acq. PU (rate) per 1,000 bed days		0.0810	0	0	Common Cause	Target required
Healthcare Associated MRSA Bacteraemia (r...		0	0.0416	0.0491	Common Cause	Target required
Healthcare Associated C Diff Infections (rate)...		0.365	0.249	0.294	Common Cause	Target required
Healthcare Associated MSSA Bacteraemia (r...		0.0810	0.125	0.0491	Common Cause	Target required
RAMI		86.8	88.4	88.5	Common Cause	Target required
SHMI (NHS Digital monthly)		104	104	96.4	Concern	Target required
Nursing Fill Rate (IP - RN, RNA and HCA)		93.1%	92.3%	95.3%	Improvement	Target required
Patient Safety Incident Investigation Events		0	0		Common Cause	Target required
Maternity and Newborn Safety Investigation...		3	0		Common Cause	Target required

Patient Experience	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Complaints received		52	36	37	Common Cause	Target required
Complaints Response Compliance (60 w...	80%	79.7%	62.5%	53.5%	Common Cause	Inconsistent
Reopened Complaints		10	6	5	Common Cause	Target required
A&E FFT Score	85%	79.9%	84.8%		Improvement	Inconsistent
A&E FFT Response Rate		13.9%	13.8%		Improvement	Target required
Inpatient FFT Score	95%	98.3%	98.3%		Common Cause	Achieving
Maternity FFT Score	95%	92.9%	100%		Common Cause	Inconsistent
Outpatient FFT Score	95%	95.4%	95.5%		Concern	Inconsistent

Our People	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Establishment (WTE) All		8,274	8,254	6,881	Common Cause	Target required
Agency Rate	1%	0.657%	0.616%	2.62%	Improvement	Inconsistent
Vacancy Rate	5%	3.8%	3.6%	-0.204%	Improvement	Inconsistent
Staff Turnover	10.6%	9.78%	9.78%	10.1%	Improvement	Inconsistent
Retention Rate	92%	91.7%	91.9%	92.5%	Common Cause	Inconsistent
Sickness - Average Days Lost per Fte	18.8	19.8	19.8	16.7	Concern	Not Met
Staff Appraisals	85%	78.1%	80.8%	75.8%	Common Cause	Not Met
Statutory & Mandatory Training	90%	92.7%	92.5%	86.9%	Improvement	Inconsistent
Annual Sickness - Absence %	5%	5.43%	5.43%	4.6%	Improvement	Not Met
Medical Job Plan Compliance Rate	95%	72.1%	70.4%		Common Cause	Not Met

Our Performance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
4 hour standard	78%	75.4%	76.1%	89.6%	Common Cause	Inconsistent
4 hour standard with additional mappe...		77.2%	77.7%		Common Cause	Target required
A&E waits over 12 hours from DTA	0	5	6		Common Cause	Inconsistent
A&E > 12 hours from arrival to discharge	0	742	818	0	Common Cause	Not Met
% Type 1 A&E > 12 hours from arrival t...		6.74%	7.40%		Common Cause	Target required
Conveyance handover >30 mins	0%	6.55%	5.15%	20.9%	Improvement	Not Met
Non Elective Length of Stay		4.96	5.16	3.58	Common Cause	Target required
1+ Non Elective LoS (Acute)	8.2	7.21	7.31	5.78	Common Cause	Inconsistent
Average daily NCTR		183	205		Common Cause	Target required
Total delay days from monthly Discharges	4324	5736	4580		Common Cause	Inconsistent
% Discharges delayed 1+ days		20.7%	23.7%		Common Cause	Target required
Intermediate Care Length of Stay	30	40.4	35.2	26	Common Cause	Inconsistent
Number of Deferred visits/ care plans		8630	9189	1566	Concern	Target required
RTT 65 week wait	0	3	4	5	Improvement	Not Met
RTT proportion waiting over 52 weeks	1%	1.38%	1.34%	0.628%	Improvement	Not Met
RTT under 18 weeks	67%	63.6%	63.5%	71.5%	Improvement	Not Met
RTT Total Waiting List Size	57890	62190	62249	24038	Concern	Inconsistent
Diagnostic <6 weeks	1%	16.0%	15.7%	28.1%	Common Cause	Not Met
Urgent Community Response within 2 h...	70%	84.3%	82.0%		Improvement	Achieving
CHIC wait times < 13 weeks	80%	84.4%	84.0%	44.1%	Improvement	Inconsistent
104 day Backlog		41	36	67	Common Cause	Target required
28 Day General FDS	80%	82.9%	82.5%	68.8%	Improvement	Inconsistent
Cancer 31 Day Combined	96.6%	95.5%	93.3%	92.3%	Common Cause	Inconsistent
Cancer 62 Day	75%	73.5%	71.9%	76.1%	Improvement	Inconsistent
Elective Activity (ELIP,DC,OPFA, OPFUP P...		97.5%	93.0%		Concern	Target required

Finance	Target/ Limit	Previous Month	Current Month	1920 Same period	Variation	Assurance
Surplus/(deficit) (£'000) - in month	(1,255)	707	(1,253)	n/a	n/a	Achieving
Surplus/(deficit) (£'000) - YTD	(5,046)	(3,768)	(5,021)	n/a	n/a	Achieving
ERF (£'000) - in month	6,707	15,224	9,426	n/a	n/a	Achieving
ERF (£'000) - YTD	53,784	42,474	55,405	n/a	n/a	Achieving
Efficiency (£'000) - in month	3,379	3,701	2,875	n/a	n/a	Achieving
Efficiency (£'000) - YTD	14,314	11,308	14,158	n/a	n/a	Achieving
Capital (£'000) - YTD	9,540	4,616	5,831	n/a	n/a	Not met
Capital (£'000) - FOT	36,913	39,812	39,668	n/a	n/a	Achieving

Constitutional Standards | Benchmarking

East Sussex Healthcare NHS Trust

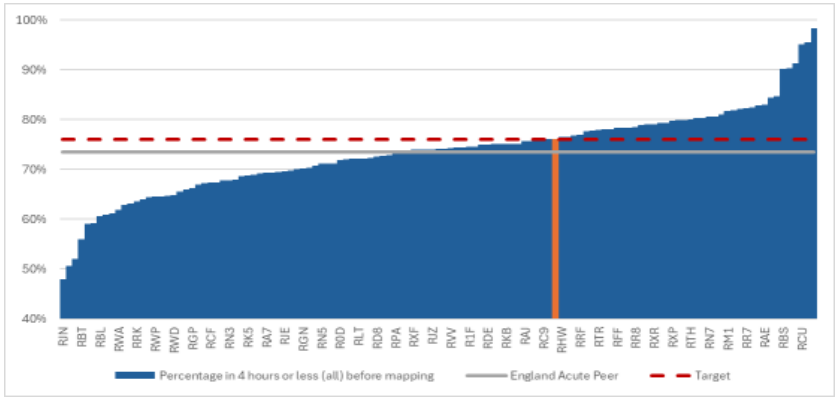
*NHS England has yet to publish all August 2025 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

August 2025 Peer Review

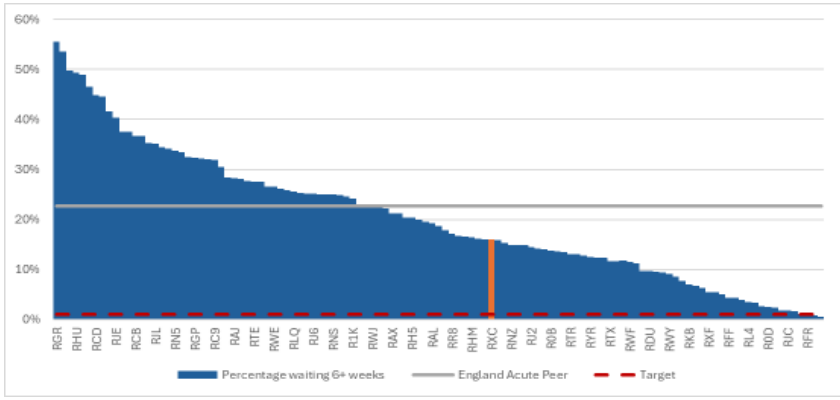
National Average: 73.4% ESHT Rank: 43/123



Planned Care – Diagnostic Waiting Times

July 2025 Peer Review*

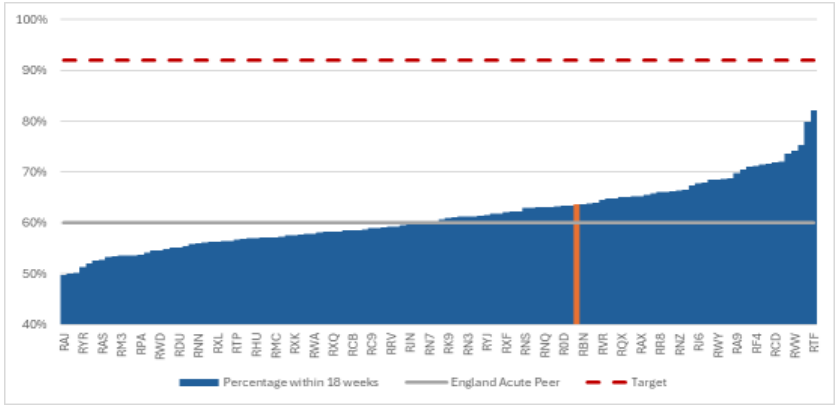
National Average: 22.7% ESHT Rank: 51/117



Planned Care – Referral to Treatment

July 2025 Peer Review*

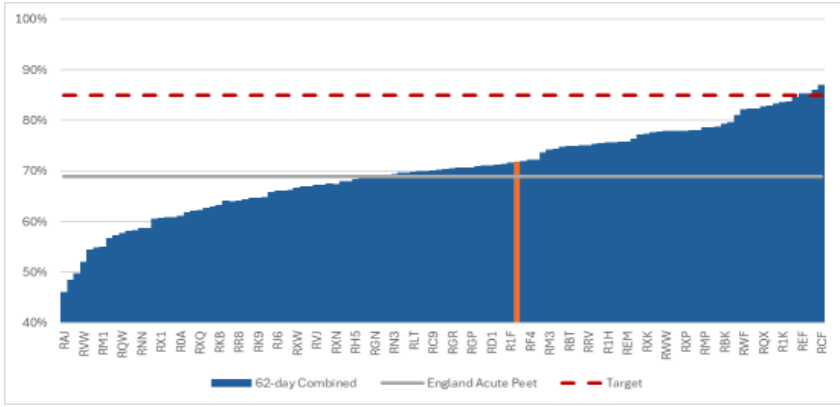
National Average: 60.1% ESHT Rank: 38/118



Cancer Treatment – 62 Day Combined Standard

July 2025 Peer Review*

National Average: 68.9% ESHT Rank: 48/118



Quality and Safety

Delivering safe care for our patients

What our patients are telling us?

Delivering effective care for our patients

Safe patient care is our highest priority

Delivering high quality clinical services that achieve and demonstrate the best outcomes and provide excellent experience for patients

Quality and Safety | Executive Summary

East Sussex Healthcare NHS Trust

Infection Control

Healthcare Associated Infection limits have now been set by NHSE for 2025/26. ESHT thresholds remain the same as last year for CDI = 67, E. coli= 109 and Pseudomonas = 19. Klebsiella threshold is 44 a 10% reduction on 24/25.
One MRSA bacteraemia reported for August. The HOHA case is from a skin/soft tissue infection assessed as unavoidable.
7 cases of CDI were reported against a monthly limit of 5. Five were hospital onset. There is no evidence that CDI was due to cross infection. Five MSSA infections were reported in August, two HOHA and three COHA. One hospital onset case due to skin/soft tissue infection, the other was of unknown source.
The overall number of infections reportable under the mandatory surveillance scheme is the highest since this time last year, mainly due to a seasonal increase E. coli bacteraemia.

Safety Events
985 incidents were reported in August 2025, comparable with the average numbers reported for ESHT only incidents. 96% of the total patient events were no / low harm/near miss, consistent with previous months, and comparable with the National average (96%) - indicative of a good reporting culture at ESHT.

Severity 3 events is showing special cause variation for August. Following investigation, most have been downgraded.

The top three categories of incidents reported were;
1. Slips, Trips and Falls – 152 reported incidents, all were No / Low harm except for 4 reported as Moderate harm (severity 3), and 1 reported as Severe (severity 4). The falls rate for ESHT in August 2025 was 4.95, a common cause variation with no concerns.

2. Patient Discharge & Transfers - 95 reported incidents, all were 'No / Low Harm' incidents, except 2 reported Moderate harm incidents one of which is being reviewed. One was regraded as Low harm following review.

3. Diagnosis & Diagnostic Services - 86 reported incidents for ESHT. All, except one reported Fatal Harm which was regraded as No harm following review, and 3 Moderate Harm were 'No / Low Harm.

Harm

One incident was reported as Fatal Harm (Severity 5), and 7 reported as Severe harm (severity 4) in August 2025. The reported Fatal harm was related to Diagnosis and Diagnostic services and was regraded as a No harm following review in WPSS. Three of the reported severe harm were regraded to No harm and one to Moderate Harm following review. Three are being reviewed to confirm level of harm caused..

Safeguarding

Level three Think family training has shown an improvement in compliance over the last two months with the overall figure currently standing at 74.3 %, most divisions are above 85% but the statistics are lower for the Resident Doctors.

The Children in Care team continue to experience difficulties particularly regarding the volume of work versus capacity. For those children placed in East Sussex by other local authorities, there continues to be waiting list for review health assessments of 5 months. Work has been undertaken with the team to look at how work is allocated and meetings held with the ICB to discuss the concerns.

The pilot of a self-neglect forum launched with the first meeting well attended and with four cases discussed.

Author(s)

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

Simon Merritt
Chief Medical Officer

Quality and Safety | Executive Summary

East Sussex Healthcare NHS Trust

Patient Experience:
We received 36 new complaints, a decrease of 16 vs. July's number. Against our internal targets of 60 working days, 7 complaints were overdue at the end of August (the oldest being 22 working days over). Of the 56 complaints closed in-month: Against the timeframe of 60 working days, 63% were completed in time (July =80%). This is a decrease against our local target response, which is 80%. Some complaint investigations required further clarification, which involved engaging with clinical teams to obtain additional details. This feedback provides an opportunity to strengthen the initial investigation process and ensure that responses are comprehensive and accurate from the outset.

Reviewing the monthly risk rating of all complaints, most were 'moderate' in common with the general pattern: 1 high risk (July =4), to continue through the complaints route, 26 moderate risk (July =33) where aspects of clinical care appear suboptimal and 9 low risk (July =15) where clinical quality does not form part of the complaint.

We take re-opened complaints/PHSO contacts as proxies for where we can learn.
6 complaints were reopened (July =10), 3 to W&C, 1 to DAS 1 to Medicine and 1 to Urgent Care (5 where further queries raised and 1 was unhappy with the Trust's response).The Trust received 1 contact from the PHSO in August.

Of the 36 complaints received in August, 42% came from 1 category: Clinical Treatment =15 (delay in treatment).

Top complaint location in August was (this does not necessarily relate to care provided in August):Emergency Department =9 (EDGH =6 and CQ =3) and Frank Shaw ward =3 (All relate to birth experiences but in different years in 2023, 2024 and 2025).

651 contacts were recorded by PALS in August, which is a decrease of 61 when compared to July (=712). Of these contacts, 367 PALS contacts were recorded as "concerns" (July =412)

The top three primary PALS subjects recorded as a "concern" were as follows: Communication =93 (of these 68% related to communication with patients/relatives), Appointments =70 (of these 66% related to long waiting times and cancelled appointments) and Clinical Treatment =57 (of these 39% related to delay in treatment and 16% related to diagnosis issues).

Top 3 locations of PALS concerns: Outpatients Department (=53) (CQ =36 and EDGH =17), Emergency Department (=39) (EDGH =23 and CQ =16) and Hailsham Urology Ward (=6), 5 of these relate to Urology patients (2 concern discharge arrangements) Booked Admissions (=6), three concerning waiting times for an operation / procedure (2 were Urology patients).

5% of PALS concerns (=17) were escalated to formal complaints

The Trust received 9,938 FFT responses; whilst this represents a 17% reduction compared to July (12,021), it also reflects the seasonal FFT response trend as shown in 2024 (July=12,766, August=9,299). The Trust-wide positive FFT feedback rate was 93.99%, which is in line with the last six-month average of 93.83%.

Workforce

Continued high level of attendances to the Emergency Departments and high occupancy, although we have reduced escalation beds open. We continue to focus improvement programmes for discharge and length of stay. There are still significant numbers of patients whose primary need is psychosocial in our Emergency Departments (ED) and gateway/inpatient areas, requiring specialist Mental Health support/skills, especially at EDGH.
Ward and Community staffing in August remained stretched to cover the additional requirements.
The focus continues on Healthroster efficiency and non-medical job planning, use of temporary nursing workforce, authorisation of additional shifts and supernumerary time. There are significant improvements noted regarding the reduction in use of agency and additional shifts through roster efficiency and fortnightly oversight from the Chief Nursing Officer and Deputy Chief Nurse for Workforce.

Author(s)

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

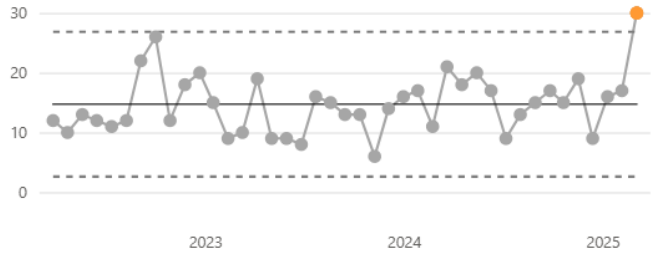
Simon Merritt Chief Medical Officer

Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

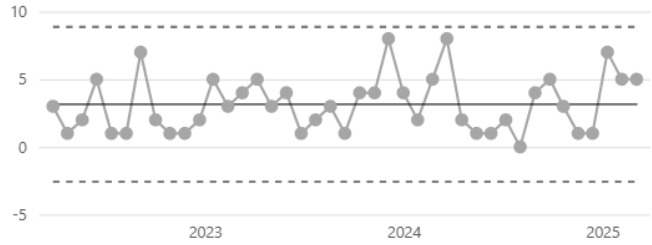
Number of Patient safety events (severity 3): Total, Safety

Target required	Concern	30



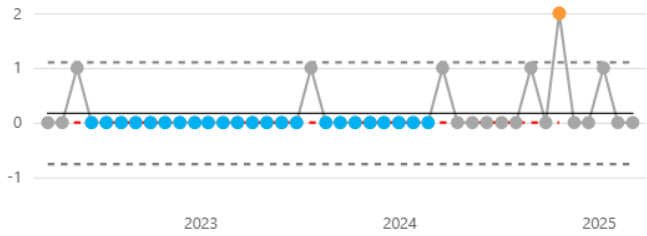
Number of Patient safety events (severity 4 and 5): Total, Sa...

Target required	Common Cause	5



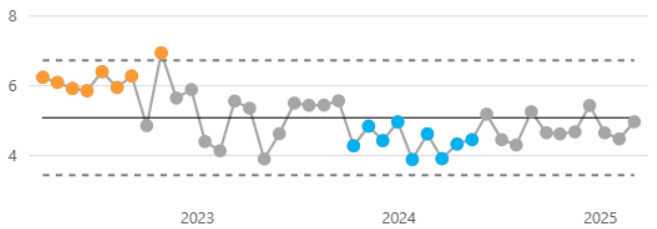
Never Events: Total, Safety

Target required	Common Cause	0



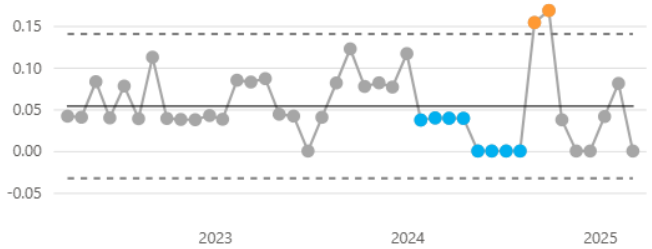
Inpatient Falls per 1,000 Bed days: Total, Safety

Target required	Common Cause	4.95



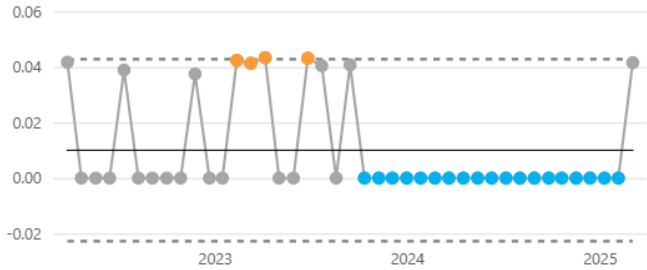
Cat 3 and 4 ESHT Acq. PU (rate) per 1,000 bed days: Total, S...

Target required	Common Cause	0



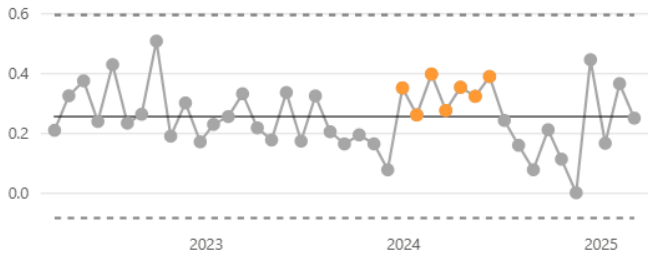
Healthcare Associated MRSA Bacteraemia (rate) per 1,000 ...

Target required	Common Cause	0.0416



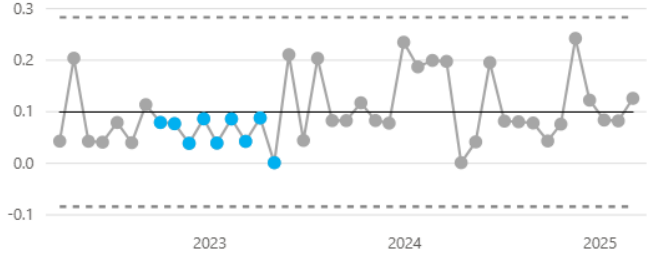
Healthcare Associated C Diff Infections (rate) per 1,000 Bed ...

Target required	Common Cause	0.249



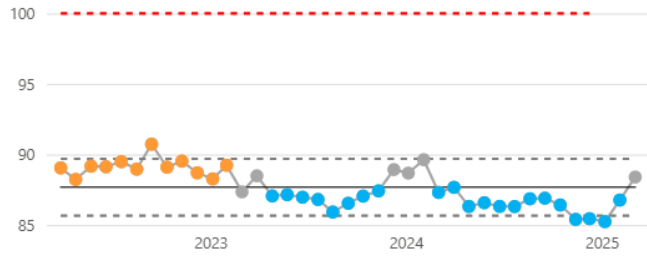
Healthcare Associated MSSA Bacteraemia (rate) per 1,000 ...

Target required	Common Cause	0.125



RAMI: Total, Safety

Target required	Common Cause	88.4

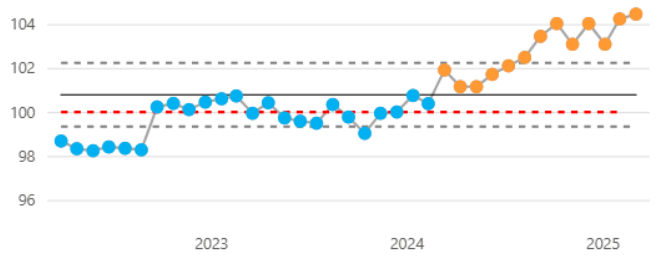


Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

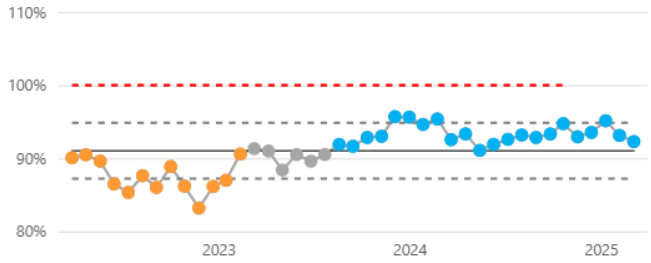
SHMI (NHS Digital monthly): Total, Safety

Target required	Concern	104



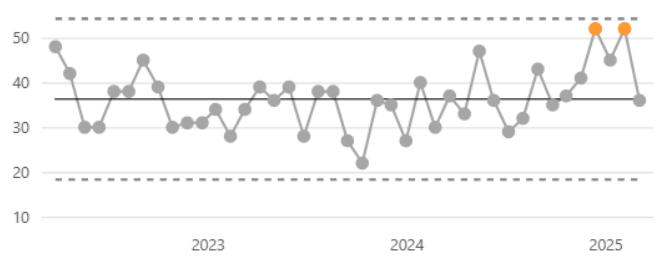
Nursing Fill Rate (IP - RN, RNA and HCA): Total, Safety

Target required	Improvement	92.3%



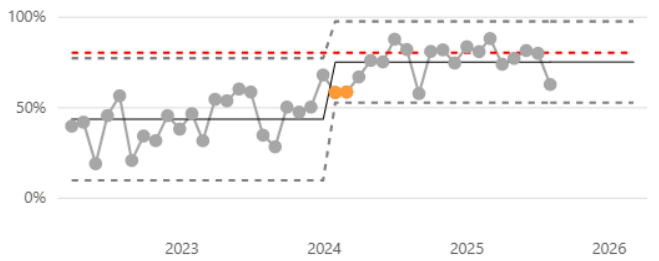
Complaints received: Total, Patient Experience

Target required	Common Cause	36



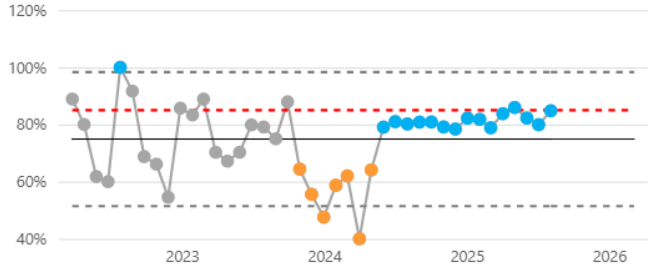
Complaints Response Compliance (60 working days as of 1...

Inconsistent	Common Cause	62.5%



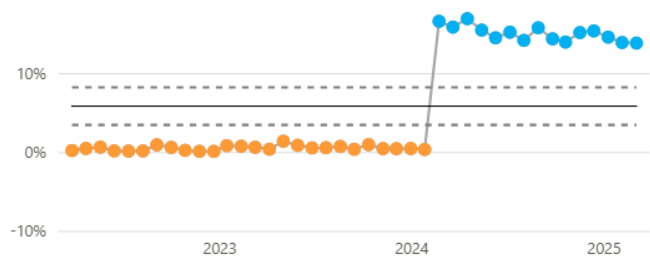
A&E FFT Score: Total, Patient Experience

Inconsistent	Improvement	84.8%



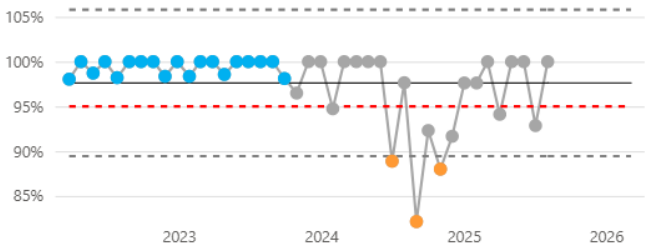
A&E FFT Response Rate: Total, Patient Experience

Target required	Improvement	13.8%



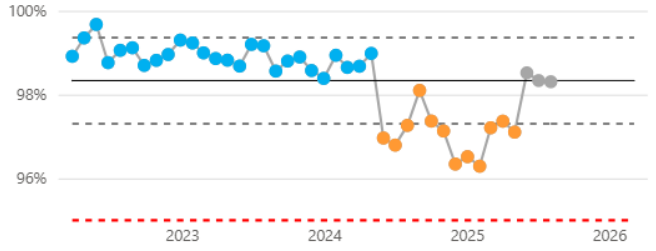
Maternity FFT Score: Total, Patient Experience

Inconsistent	Common Cause	100%



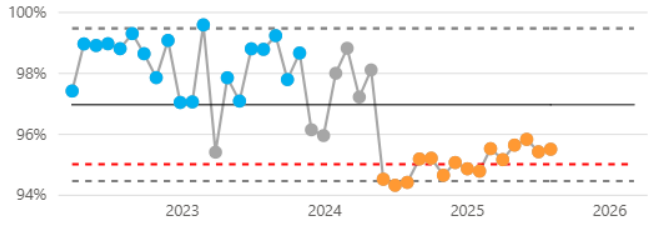
Inpatient FFT Score: Total, Patient Experience

Achieving	Common Cause	98.3%



Outpatient FFT Score: Total, Patient Experience

Inconsistent	Concern	95.5%



Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Patient Safety Incident Response Framework (PSIRF)	Duty of Candour (DoC) compliance continues to be monitored, and Divisions supported to complete in a timely manner. In August 2025, reviewing applicable incidents in a rolling 12-month period, 76% were confirmed to have had verbal DoC completed (same as in the previous month), and 76% had the written completed (comparable to previous months). The DoC policy has been refreshed for clarity. The PSIRF process remains in place for reporting, triaging and deciding on level of harm of events. The PSIRF Working group are reviewing the processes and templates for the learning responses. The 'Safety Learnings' module in DCIQ is undergoing review by key stakeholders. Progress with the review of incidents that are in the PSIRF learning response process are monitored weekly.	• Further DoC training workshops will be provided to support understanding and knowledge of the process over the next 3 months • The PSIRF Review Group reviews all completed review reports, and learning is shared across services and Divisions, where appropriate • Work to update the PSIRF Plan and Policy and the PSIRF templates is ongoing; The Chronology template has been fully reviewed. The AAR template is undergoing review. Processes are being reviewed with the aim to move from paper to digital documentation, through collaboration with the Datix team. Work has slowed due to capacity in the Patient safety Team, which is being resolved.
Nursing & Midwifery Workforce	During August occupancy remained very high with ongoing use of additional super surge beds, pre-emptive boarding in corridors and significant numbers of patients requiring enhanced observation in relation to high risk of falls or patients with challenging/violent behaviour. Controls remain in place to ensure staffing continues to meet the needs of our patients and there is an overall reduction in the reliance on agency nurse staffing. Ward nursing CHPPD overall was 8.4 for August (noting distortion by specialist areas) and we are continuing to reduce our escalation beds. Nursing fill rates for day shifts = RN 91% and HCSW 85%. Nursing fill for night shifts = 95% for RN and 102%. Changes to our inpatient services and bed base means a number of areas are currently under consultation and staff are being supported through our redeployment process.	• The annual Nursing Establishment Review (NER) for 2025, the first data collection for acute and community has been completed and is currently being analysed • A review of non ward nursing posts has commenced with a programme of work to look at non-medical job planning, education and supervision frameworks • Recruitment to the Mental Health Outreach team continues and they are deployed to support our most complex patients. New training opportunities for staff as part of the MH Strategy is also underway. The pilot in our Emergency Department at Eastbourne is to offer enhanced assessment and initial care plans for those patients who present with an acute mental illness crisis and we are trialling body worn cameras for nursing staff • Nursing/Midwifery monthly Roster Compliance sessions continue, led by the Deputy Chief Nurse to ensure effective/efficient nursing rosters. The fortnightly roster assurance panel continues, to support working within budget and review of temporary staffing requests. There is evidence of good controls to support enhanced observations and requests for additional staff. The focus is now on reducing reliance on Agency and bank staffing, including security costs • Analysis of the job specific skills and leadership training needs is on going and we are working with NHS Elect to identify the skills gap and plan an education framework to ensure training meets the needs of our people • We continuing to offer training and support in the clinical areas with the restorative supervision programme and the network of practice educators and current education/preceptorship resources.

Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

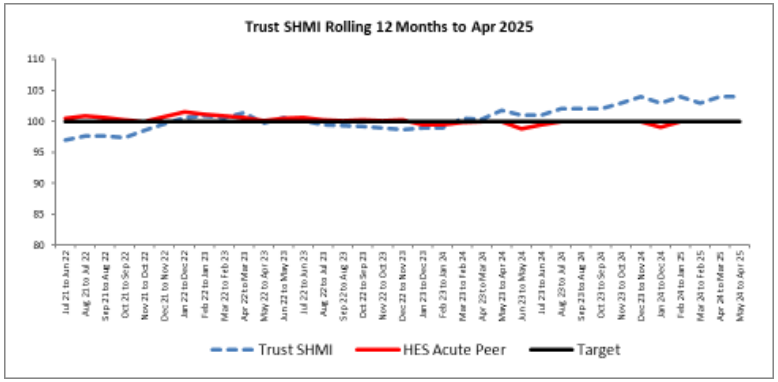
Title	Summary	Actions
Inpatient Falls	Slips, Trips and Falls - The inpatient falls rate for ESHT per 1000 bed days was 4.95 in August 2025 remaining within the control limits, a common cause variation. All incidents reported were No or Low harm except four Moderate and one Severe harm incidents for which SWARM reviews are being undertaken to determine whether there were any lapses in care delivery in line with the PSIRF policy. The top sub-category continues to be 'patient fall whilst mobilising independently' of which most reported as No / Low harm (except 2 Moderate). Falls incidents by service are discussed at the Trust Falls group bi-monthly. There were no hot spots in the services	•Completed SWARM forms continue to be monitored, and peer reviewed by the PSIRF Review Group • Divisional themes and trends are reported to the Falls Steering Group for oversight and consideration for quality improvement activities •Deep Dive report of Falls incidents has been undertaken with no issues identified.
Patient Experience	Frank Shaw featured in the top 3 complaints locations(=3). Urology was an area of higher contacts for PALS.	• Frank Shaw ward complaints all relate to birth experiences but in different years • Hailsham ward and Booked Admissions featured in the top 3 PALS locations, with Urology as the assigned speciality • Both themes have been shared with the relevant division.
Harm reviews	The NCTR Harm Review Process was last presented at Q&S in March, where the limitations of the current process were discussed and an undertaking was made to redesign and refine the process to ensure greater relevance and consistency. This has been trialled through August 2025.	• The process has been redesigned to narrow the parameters for those who are reviewed to only patients who have NCTR, and who have come to harm since that time • The process is being digitalised to ensure ease of data gathering and completion • Feedback has been incorporated into the final version of the review form.
Pressure Damage	Zero category 3 or 4 pressure ulcers were reported amongst inpatient or in the community in August.	• The new audit tool in line with CQUIN 12 to monitor compliance with PU assessments and prevention was piloted in July and implemented in August. Analysis of the findings has identified that one of the questions needs o be adapted for accurate interpretation • A quality improvement (QI) project has commenced and is currently being scoped to promote prompt assessment and implementation of prevention and treatment plans early on admission to hospital • An audit of documentation of PU treatment plans on discharge has commenced.

Effective Care - Mortality

East Sussex Healthcare NHS Trust

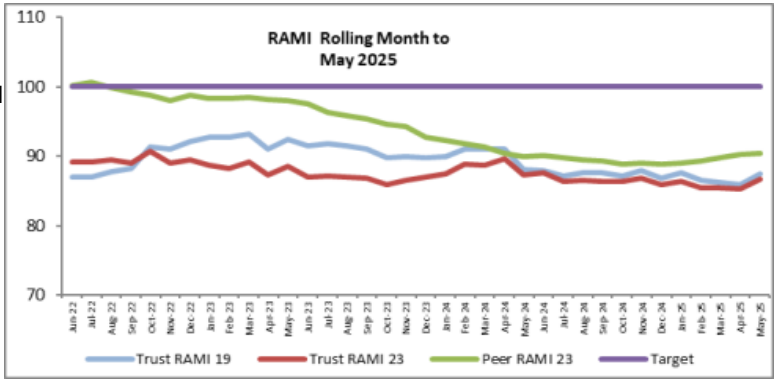
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

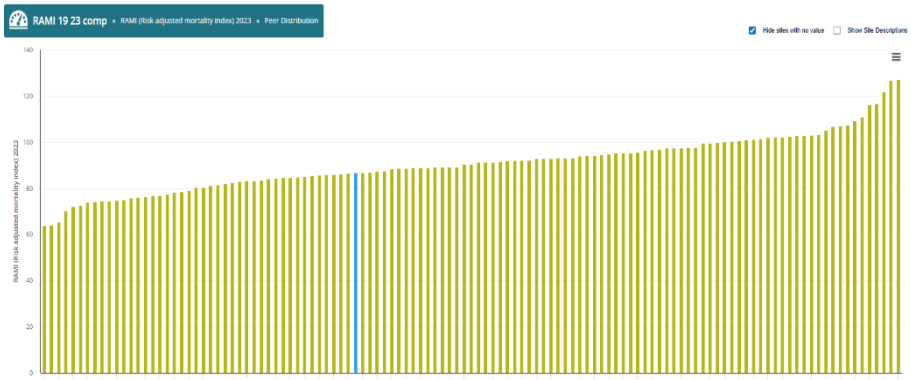
Summary Hospital Mortality Indicator (SHMI)
Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures



- SHMI – May 2024 to April 2025 is showing an index of 104 and is within the expected range. EDGH is showing 100 and Conquest is 110.6, both also within the expected range.
- SHMI is rebased each time it is published whereas RAMI is not.
- RAMI 23 – Jun 2024 to May 2025 (rolling 12 months) is 87, and 87 for the same period last year. Peer RAMI was 90 for this period
- The line graph below shows the rolling 12 month figure.
- Crude mortality shows Jun 2024 to May 2025 at 1.59% compared to 1.57% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 68% for July 2025 deaths compared to 72% for June 2025 deaths.

Risk Adjusted Mortality Index (RAMI) – without confirmed or suspected Covid-19





This shows our position nationally against other acute trusts – currently 44/119

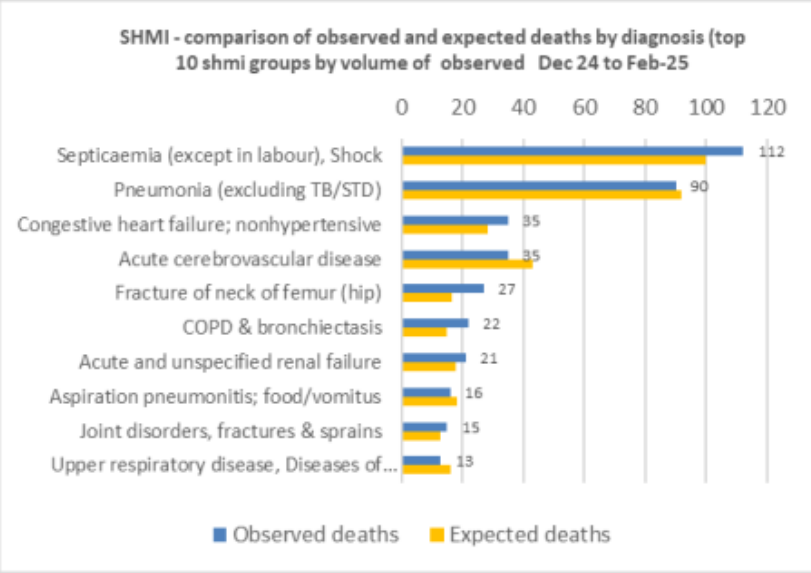
Effective Care - Mortality

East Sussex Healthcare NHS Trust

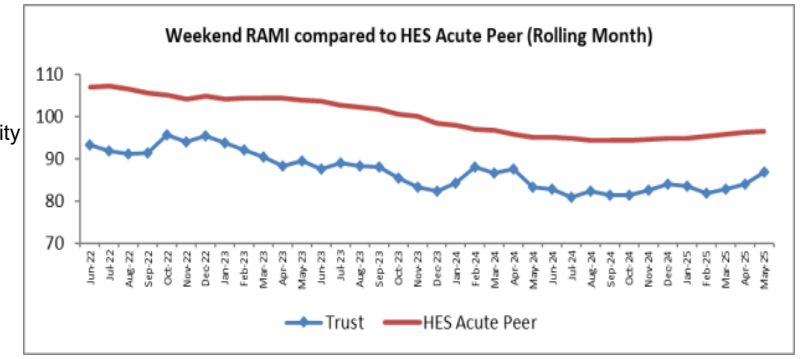
Aug 2025 Main Cause of In-Hospital Death Groups

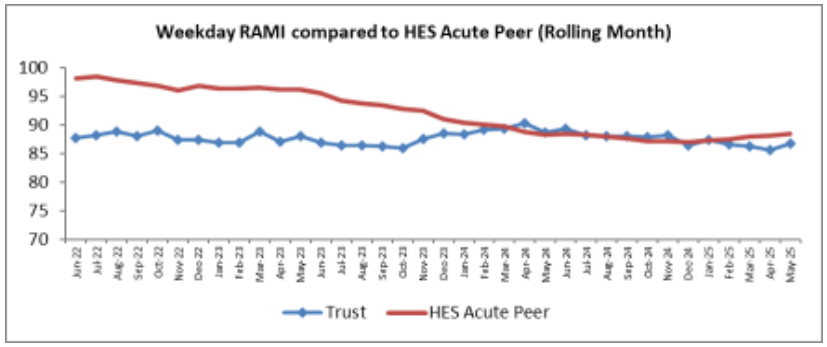
Description	Apr - Aug 25	Aug-25
Acute Kidney Injury (AKI)	5	
Alcoholic liver disease	1	
Aspiration Pneumonia	31	6
Atrial Fibrillation (AF)	8	2
Bowel Obstruction	8	1
Bowel Perforation	2	2
Bronchopneumonia	6	1
Cancer	89	17
Cellulitis	2	1
Cerebrovascular Accident	2	
Chronic Obstructive Pulmonary Disease (COPD)	21	3
Community-acquired Pneumonia	23	2
Congestive Cardiac Failure	7	1
Dementia	7	1
Frailty of Old Age	54	15
Heart Failure	57	11
Hospital-acquired Pneumonia	33	6
Intersitial lung/pulmonary disease	3	1
Ischaemic Bowel	2	
Liver Disease	6	2
Multiple Organ Failure	25	2
Myocardial Infarction (MI)	14	2
Pneumonia	49	5
Pulmonary Embolism	4	2
Pulmonary Oedema	1	
Sepsis/Septicaemia	70	14
Spontaneous Intracerebral Haemorrhage	9	1
Spontaneous Upper Gastrointestinal Haemorrhage	5	1
Stroke	30	6
Type 1 Respiratory Failure	5	
Type 2 Respiratory Failure	7	
Urosepsis	10	3
[Uncertified]	49	13
Other not specified	88	14
Total	733	135

SHMI Diagnosis Main Groups



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





Effective Care Mortality

East Sussex Healthcare NHS Trust

Summary Hospital-level Mortality Indicator (SHMI)

Funnel plots

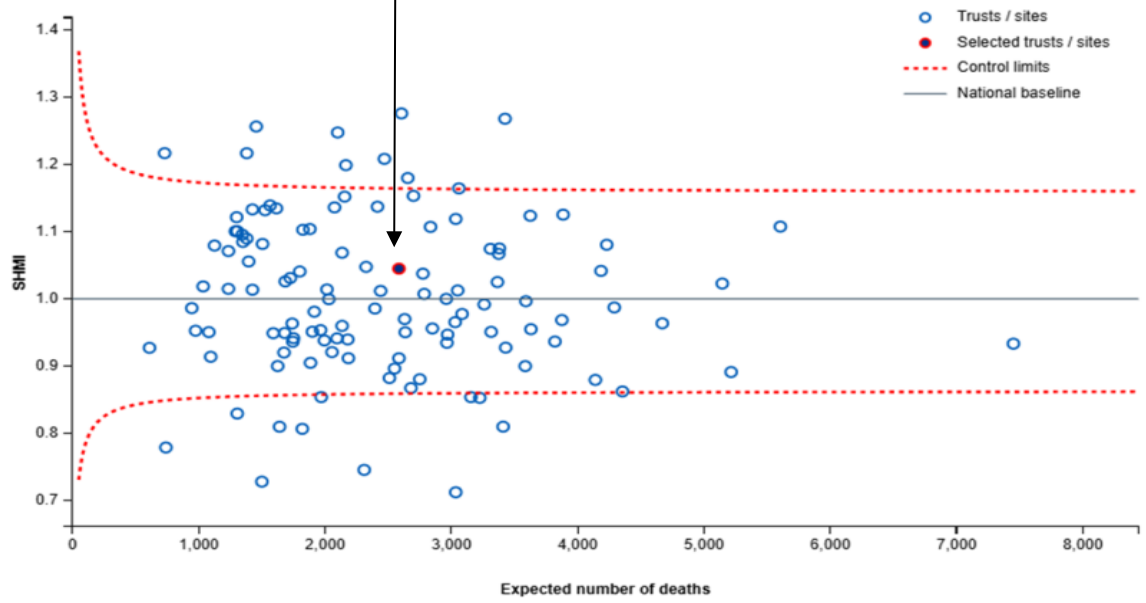
Return to contents

NHS England

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

Reset filters

SHMI funnel plot



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

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

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

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

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

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

Our People

Recruitment and retention

Staff turnover / sickness

Our quality workforce

What our staff are telling us?

Safe patient care is our highest priority

Delivering high quality clinical services that achieve and demonstrate the best outcomes and provide excellent experience for patients

Our People | Executive Summary

East Sussex Healthcare NHS Trust

Responsive	Positives:	Challenges and Risks:	Author
	Turnover was unchanged at 9.8%, 0.8% under target. The vacancy rate reduced by 0.2% to 3.6% and is 1.4% under target. Mandatory Training reduced by 0.2% to 92.5% but is still 2.5% above target.	Monthly sickness rate increased by 0.1% to 5.4%. Annual sickness rate was unchanged at 5.4% - still above the 5% target Appraisal rate increased for the first time in eight months, by 2.7% to 80.8% but is still 4.2% below target.	

Overview:

158 wte usage within budget with a reduction of 27 wte against last month. There were reductions in substantive usage (-27 wte) and agency usage (-3 wte) but bank & locum usage increased (+19 wte) largely due to the peak holiday period and increased sickness in areas requiring cover, such as Theatres. Bank usage has not seen the anticipated reductions as internal vacancies are filled and staff redeployed. There is also a continued residual requirement for agency in A&E, Theatres and for Registered Mental Health nurses.

The turnover rate remained at 9.8%, for the third consecutive month. The August figure correlates to 698.4 wte leavers annually. Turnover rates did increase for Medical & Dental staff (+0.9% to 10.3%), Admin & Clerical (+0.3% to 10.8%) and Estates & Ancillary (+0.3% to 11.4%) but this was offset by reductions for Allied Health Professionals (-1.4% to 9.3%), Registered Nursing & Midwifery (-0.1% to 8.4%) and Additional Clinical Service, largely HCAs and therapy helpers, (-0.2% to 10.0%).

The Trust vacancy rate reduced by 0.2% to 3.6% (282.7 wte vacancies). This is well within the Trust target rate of 5%. Vacancy rates are highest for Additional Clinical Services staff at 10.4% (179.1 wtes), however, there is a proposal to target this area with a refreshed New to Care initiative. The Medical & Dental vacancy rate was 5.3%, a reduction of 3.2% (45.4 wtes), whilst the rate for Registered Nursing & Midwifery staff was 2.5%, a reduction of 0.3% (56.0 wtes).

Monthly sickness increased slightly by 0.1% to 5.4%, whilst the annual sickness rate was unchanged, also at 5.4% (as monthly sickness was 5.5% in Jul 24). This is 0.4% above target. There was a reduction of 485 wte days lost for Anxiety, Stress & Depression illnesses, although they remain the most significant cause of sickness. This was offset, however, by increases of 128 wte days lost for Gastrointestinal illnesses and 116 for Other Musculoskeletal injuries.

The mandatory training rate reduced slightly by 0.2% to 92.5%, but this is still 2.5% above target. Basic Life Support compliance is the main outlier and reduced slightly this month by 0.3% to 74.7%. All other statutory & mandatory modules are above the 90% target, with the sole exception of Information Governance at 89.3% (-0.5%). The appraisal rate increased by 2.7% to 80.8%, the first increase in eight months, but still 4.2% below target. This equates to 1,548 staff overdue for appraisal. In Sept, the appraisals will revert to the previous system, whilst the on-line system is overhauled. Divisions have action plans in place to improve compliance. These measures should enable rates to continue to improve.

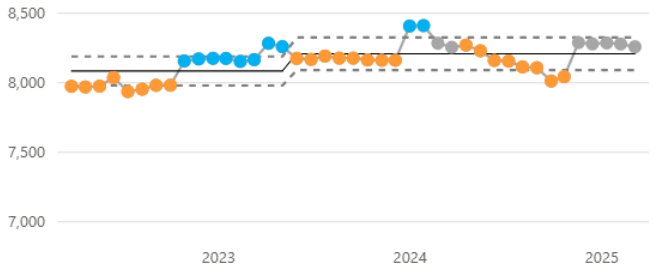
Steve Aumayer
Chief People Officer

Our People Core Metrics

East Sussex Healthcare NHS Trust

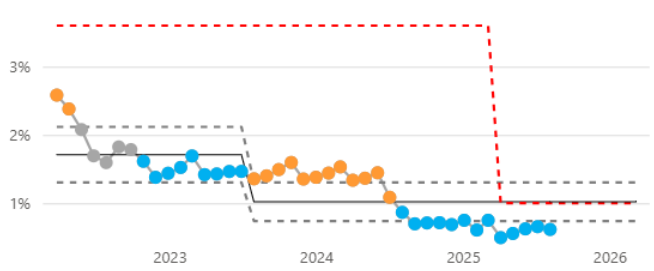
Establishment (WTE) All: Total, Our People

Target required	Common Cause	8,254



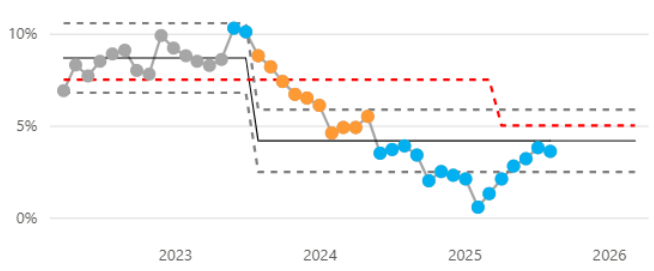
Agency Rate: Total, Our People

Inconsistent	Improvement	0.616%



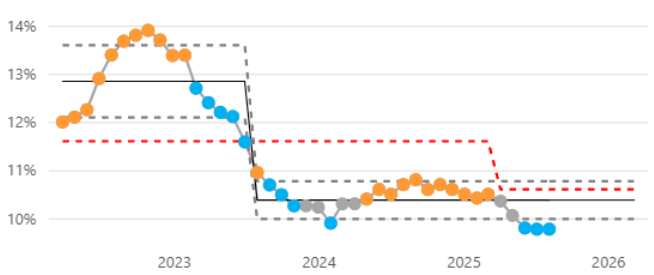
Vacancy Rate: Total, Our People

Inconsistent	Improvement	3.6%



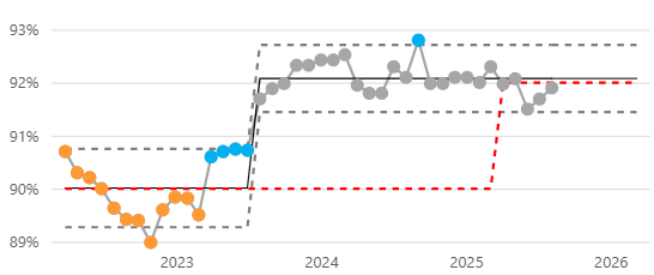
Staff Turnover: Total, Our People

Inconsistent	Improvement	9.78%



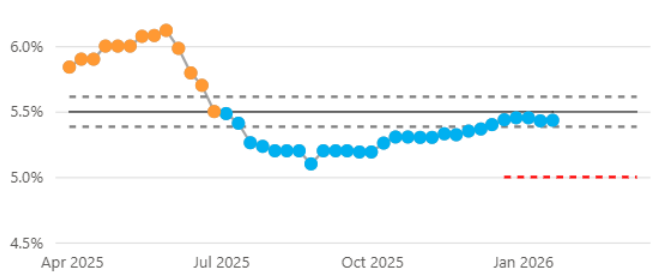
Retention Rate: Total, Our People

Inconsistent	Common Cause	91.9%



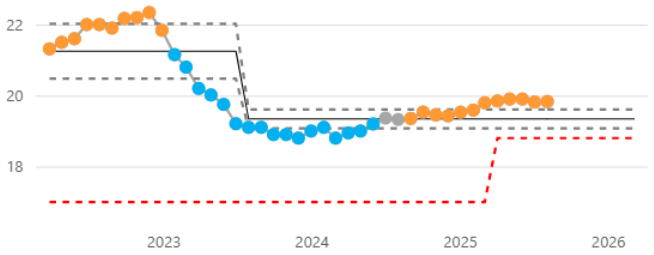
Annual Sickness - Absence %: Total, Our People

Not Met	Improvement	5.43%



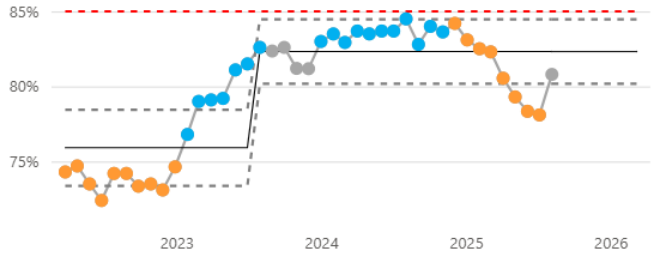
Sickness - Average Days Lost per Fte: Total, Our People

Not Met	Concern	19.8



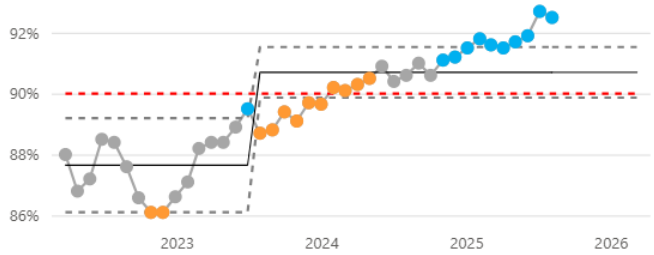
Staff Appraisals: Total, Our People

Not Met	Common Cause	80.8%



Statutory & Mandatory Training: Total, Our People

Inconsistent	Improvement	92.5%



Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Turnover & Retention	Turnover rate unchanged at 9.8%. The stability rate increased by 0.2% to 91.9%.0.1% under target	• Stress Guidance for managers on leading teams through the team stress process being well utilised and evaluated. Encouraging managers to link actions required from Team Stress Questionnaire with Staff Survey Action plan to reduce workload and sustain focus. Working with Occupational Health on reviewing approach to managing individual stress as part of wider sickness absence reduction agenda. • Restorative Supervision Extended cohort of lead supervisors through additional training. This is a critical element to the sustainable model for restorative supervision. Now that the community of restorative supervisors is increasing, exploring self-referral routes for colleagues to access this and hence increase access for all staff. • Resolution and Mediation Working with NHS Elect to consider best options for ESHT on providing early resolution and in-house mediation. Linking with University Hospitals Sussex in September to consider whether reciprocal arrangements are feasible to increase access to independent mediation • TRIM Working with Strategy, Development and Improvement team on reviewing the existing TRIM model and exploring alternative approaches to secure this programme and make improvements where needed.
Vacancy Rate	Vacancy rate reduced by 0.2% to 3.6% (282.7 wte vacancies). 1.4% under target.	• Ongoing support with temporary workforce agencies to increase candidate pipelines for such areas as ED, Escalation and Community. Activity to re-activate colleagues onto TWS bank c.45 staff • Activity to support recruitment for 'Art of the Possible' posts within Community areas, c.100 posts. Funding from Dept to assist with this project in terms of resources • All posts now being advertised for two weeks, internal only, with Executive sign off for external advertising • Continued support with redeployment activity and placing colleagues affected by this process. Support provided for both colleagues and hiring managers c.70 posts • Ongoing governance activity to ensure TWS and Agency spend on target (weekly Temp Approval Panels-TAP in conjunction with VCP); Chairing of South-East Temporary Staffing group to ensure governance and consistency across the ICB • Focussed recruitment activity to address hard to recruit posts. For example, Medics and Allied Health Professionals. Continued activity through headhunters for Microbiology and Stroke Consultants. • Activity to recruit and onboard c.40 newly qualified nurses has commenced.

Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Sickness	Monthly sickness increased by 0.1% to 5.4% whilst annual sickness was unchanged at 5.4%. Average sick days per WTE unchanged at 19.8, 1.0 above target	We continue to focus on the reduction of absence across the Trust, reviewing interventions and potential areas of concern. In some areas, we have seen an increase in Anxiety & Stress absences in recent months, however, whilst there are several consultations ongoing, there does not appear to be a correlation with specific consultations and absences linked to anxiety & stress. Where colleagues are absent for this reason, they are often longer term with an increasing number of days lost. Where possible a deep dive is undertaken to better understand whether the absence is work related or personal, recognising a lowered resilience from either can impact the other. Managers are being supported to ensure all appropriate support can be offered. Bitesize training on the Sickness Management procedure is offered as part of the Managers Toolkit. Promotion of the flu vaccine has commenced with early vaccination recommended; Flu clinics begin from 15 September, and a staggered approach will be implemented inviting frontline healthcare workers on ESR. Colleagues are being asked to check personal details on ESR to ensure they do not miss messages about the Flu Vaccine. .
Statutory & Mandatory Training	Trust compliance reduced by 0.2% to 92.5%, 2.5% above target.	Basic Life Support compliance reduced slightly by 0.3% to 74.7%. Information Governance compliance also reduced by 0.5% to 89.3% but all other modules are above the 90% target. Overall compliance remains well above target and is the second highest it has ever been. Non attenders for BLS sessions, remains an issue. August is the peak month for annual leave and it is anticipated that the rate should pick up again from September. Additional and bespoke sessions remain available to increase compliance rates.
Appraisal	Compliance rate reduced by 0.2% to 78.1%, 6.9% below target	Appraisal rates showed their first monthly increase for eight months. The reversion to the familiar paper-based system, from the end of September, whilst the on-line system is revised, will consolidate this improvement and it is expected that rates will continue to improve. A number of Divisions have put action plans in place to enhance compliance rates.

Access and Responsiveness

Delivering the NHS Constitutional Standards

Urgent Care – Front Door

Urgent Care – Flow

Planned Care

Our Cancer services

We will operate efficiently & effectively

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

Access and Responsiveness | Executive Summary

East Sussex Healthcare NHS Trust

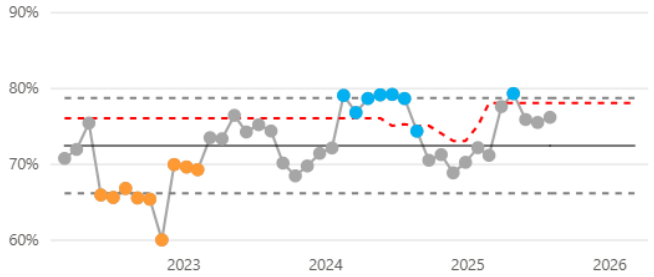
	Positives	Challenges & Risks	Author
Responsive	**4 Hour Emergency Access Clinical Standard** In August, 76.1% of patients were seen and discharged or treated and admitted within 4 hours, against a trajectory of 76%. This places the Trust at 43 out of 123 trusts nationally, second quartile. **Cancer** In July, the Trust delivered 82.5% against a trajectory of 77% for the Faster Diagnosis Standard and a target compliance of 80% in March 2026. Performance against the 62-day standard was 71.9% versus a trajectory of 70%. **Urgent Community Response (UCR)** The UCR standard of 70% has been achieved consistently in the Trust, with 81.6% of patients seen within the 2-hour response window in July. **Elective long waits (RTT)** The Trust reported a small number of patients who have been waiting more than 65 weeks in August.	**Cancer** The backlog of patients waiting over 62 days at the end of July was 235 against an internal trajectory of 236. This was a slight increase of 6 patients from the end of end of June position. Plans are in place at tumour site level to reduce the number of patients waiting more than 62 days. This is monitored weekly, alongside escalated actions and the status of transferred tertiary referrals. **Diagnostic** DM01 position non-compliant against 95% standard. Underperforming modalities are MRI and Echocardiogram. **Length of Stay (LoS)** Non-elective LoS for August was 4.95 days, compared to 4.82 in July. Four workstreams have been established as a part of the LOS programme: • Admission Avoidance • Clinical Care Pathways • Operational Flow • Discharge Planning.	 **Charlotte O'Brien** Chief Operating Officer
Actions:	• Prioritise reduction of non-admitted breaches and overnight stays in the Emergency Department to enable consistent achievement of the 78% Clinical Standard • Maintain momentum in eliminating >65 and >52 week waits across all specialties within the Trust • Restore compliance with diagnostic standard across underperforming modalities • Establish and agree performance metrics to underpin Length of Stay (LoS) improvement workstreams.		

Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

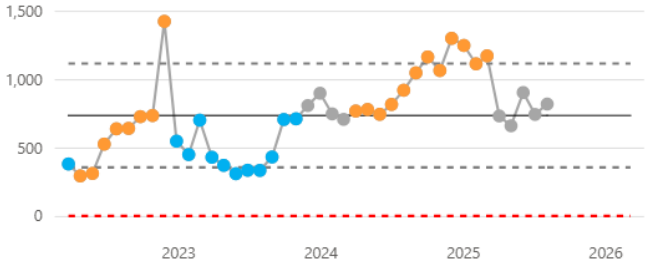
4 hour standard: Total, Our Performance

Inconsistent	Common Cause	76.1%



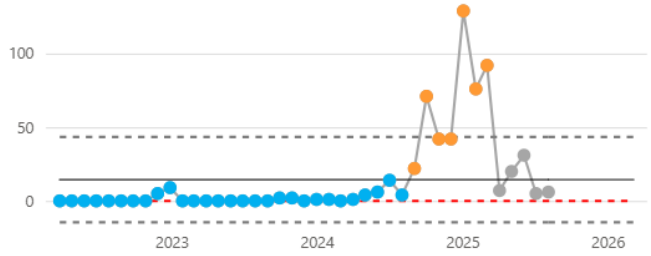
A&E > 12 hours from arrival to discharge: Total, Our Perfor...

Not Met	Common Cause	818



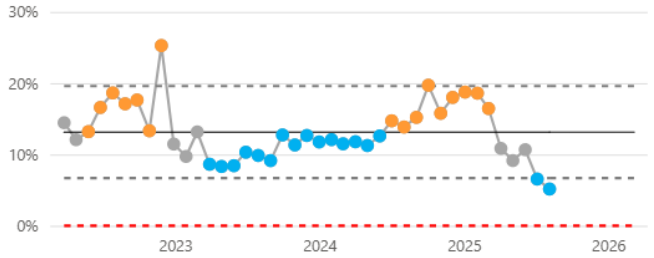
A&E waits over 12 hours from DTA: Total, Our Performance

Inconsistent	Common Cause	6



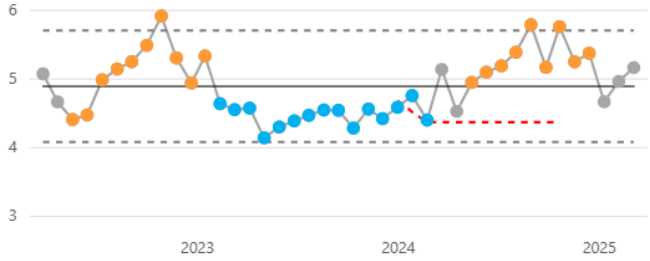
Conveyance handover >30 mins: Total, Our Performance

Not Met	Improvement	5.15%



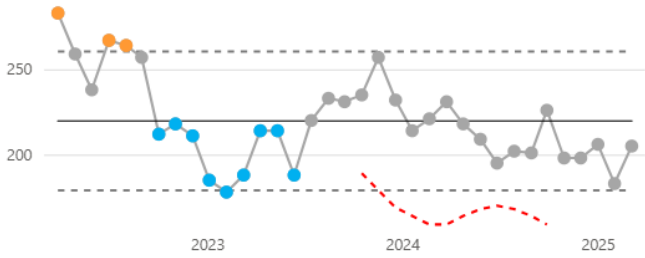
Non Elective Length of Stay: Total, Our Performance

Target required	Common Cause	5.16



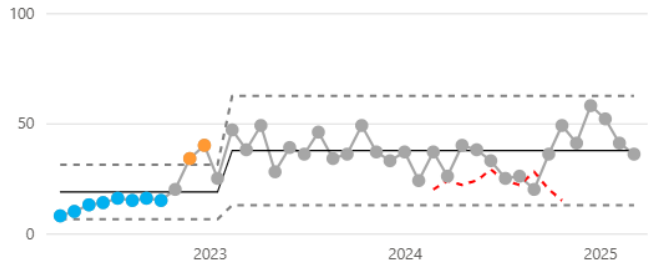
Average daily NCTR: Total, Our Performance

Target required	Common Cause	205



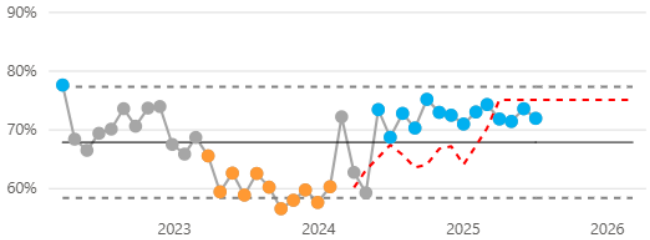
104 day Backlog: Total, Our Performance

Target required	Common Cause	36



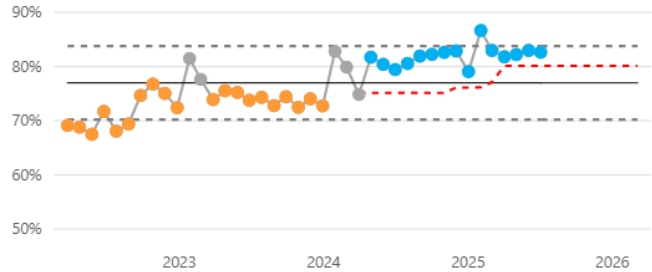
Cancer 62 Day: Total, Our Performance

Inconsistent	Improvement	71.9%



28 Day General FDS: Total, Our Performance

Inconsistent	Improvement	82.5%

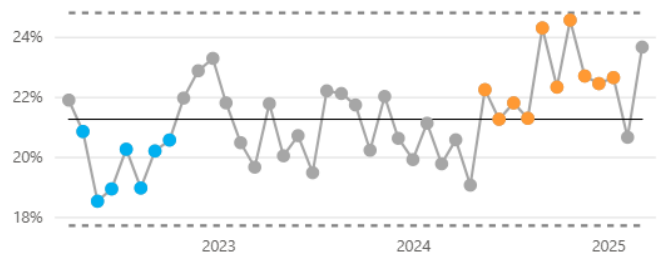


Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

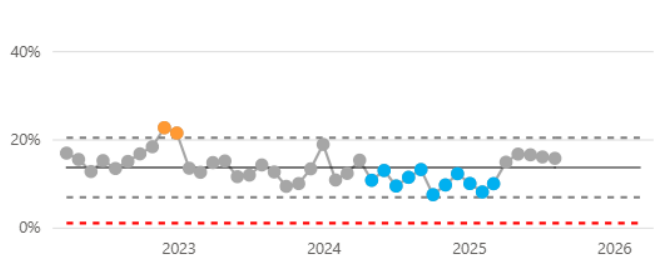
% Discharges delayed 1+ days: Total, Our Performance

Target required	Common Cause	23.7%



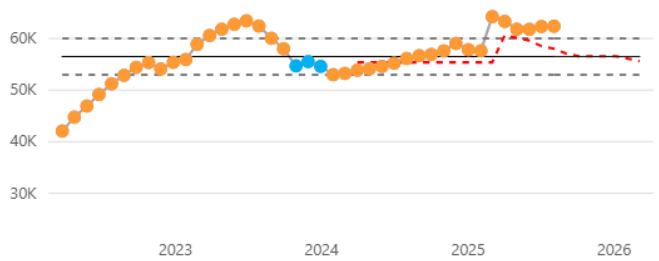
Diagnostic <6 weeks: Total, Our Performance

Not Met	Common Cause	15.7%



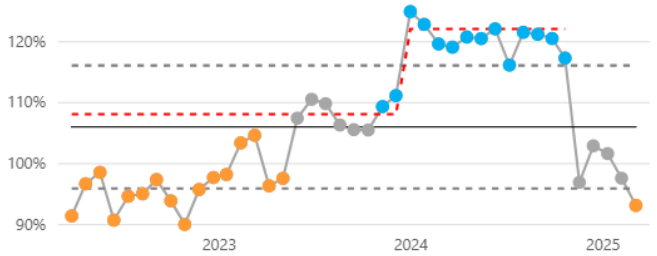
RTT Total Waiting List Size: Total, Our Performance

Inconsistent	Concern	62249



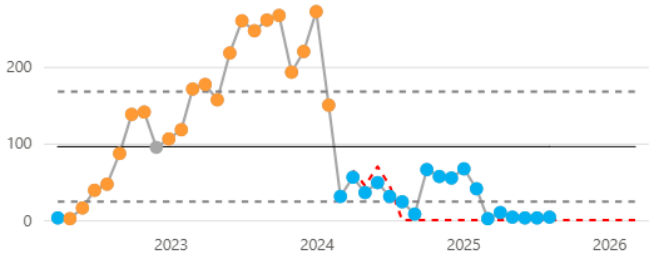
Elective Activity (ELIP,DC,OPFA, OPFUP Proc): Total, Our Perf...

Target required	Concern	93.0%



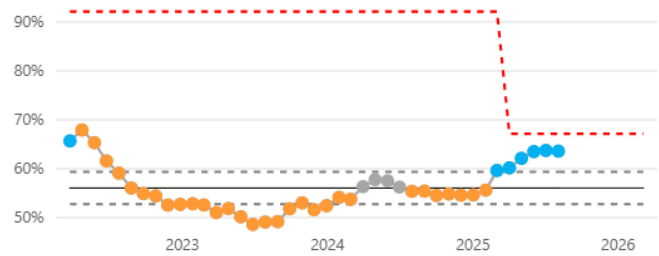
RTT 65 week wait: Total, Our Performance

Not Met	Improvement	4



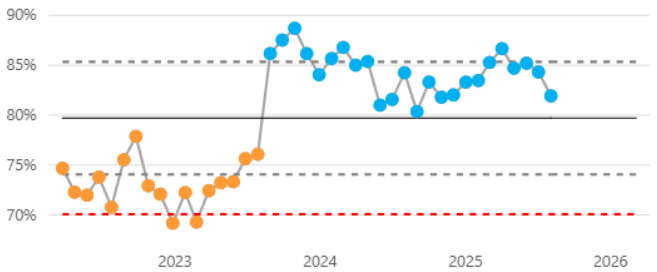
RTT under 18 weeks: Total, Our Performance

Not Met	Improvement	63.5%



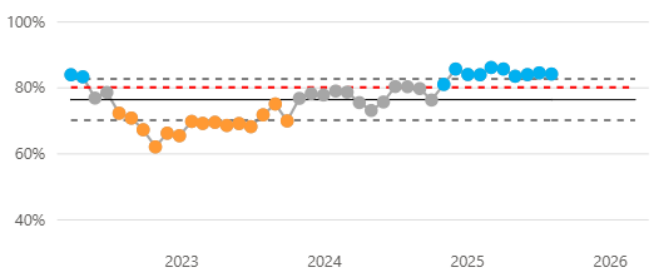
Urgent Community Response within 2 hours: Total, Our Perf...

Achieving	Improvement	81.9%



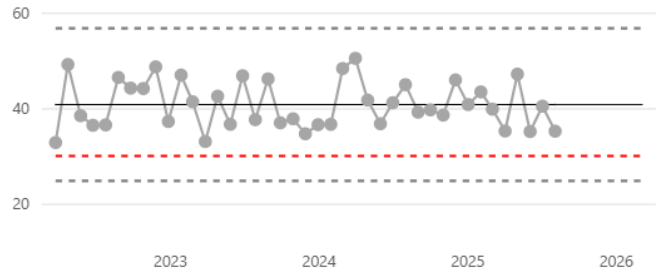
CHIC wait times < 13 weeks: Total, Our Performance

Inconsistent	Improvement	84.0%



Intermediate Care Length of Stay: Total, Our Performance

Inconsistent	Common Cause	35.2



Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Emergency Access Clinical Standard	In August, 76.1% of patients were seen and discharged or treated and admitted within 4 hours. To achieve 78%, the Trust would require a reduction of 9 breaches per day. This places the Trust at 43 out of 123 Trusts nationally, and in the second quartile for performance against the 4-hour Emergency Clinical Access Standard.	• Review attendance trends and workforce capacity, rota changes to support daily peaks • Escalation of delays and pathways that are not optimised with support from all division • Trust wide focus to achieve 78% 4-hour clinical standard • Focus on roles and responsibilities to support overnight resilience • Ringfence CDU for Emergency Department • Focus on re-direction for T3 patients and overnight appointment allocation.
Patients in department over 12 hours from arrival to discharge	The number of patients waiting over 12 hours from arrival to discharge increased to 830 patients in August (7.5% of T1 attends) , compared to 753 (6.9% of T1 attends) in July. In August, 6 patients waited over 12 hours following a decision to admit. This is a small increase from 5 in July, but significantly lower than levels observed towards the end of 2024/25.	• Timely escalation within the ED department when at full capacity to enable ED and divisional teams to create capacity • Continued focus on reducing LOS and the number of patients not meeting the criteria to reside to enable flow • Focus on timely escalation of patients at risk of >12-hour LOS.
Conveyance Handover >45 mins	The Trust is aiming to have zero 45-minute off load delays.	• Continued focus on ambulance handover times, early escalations and actions to mitigate delays have now been embedded, supporting decompression in the department • Escalations to site managers and ED operational leadership team for inbound conveyances with no capacity to support offloading • Improved staffing and flow through Rapid Assessment and Triage (RAT) to support rapid assessment of patients conveyed by ambulance. • Focused work with SeCAMB on timely electronic recording of all ambulance arrivals and validation of 45-minute off-load delays.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Non elective Length of Stay (LOS)	Non-elective LoS slightly increased in August to 4.95 days from 4.82 days in July. Reducing the pressure on inpatient capacity is a recognised challenge.	• LoS improvement programme is in the process of being embedded • Support for ward areas to plan discharge from point of admission • Increased P1 capacity to support same day / next day discharges, 7 days a week using a Home First approach • Working with system partners to improve pathways for patients not meeting the criteria to reside
Community Waiting Times (Paediatric)	Outsourcing to an independent sector provider had supported improvements in community paediatric waiting times over last 2 years. This was temporarily paused to enable a full procurement exercise to take place, this led to a short period of increased waiting times. The procurement was concluded in July and a new provider will commence in early October. The number of children waiting for a first outpatient appointment in August increased to 2854 compared 2819 the previous month. There were 266 children waiting over 78 weeks (177 in July), 592 children waiting over 65 weeks (477 in July). There are no children waiting over 2 years.	• Mobilisation of new community paediatric contract following the procurement exercise starting in Sept • Additional 50 assessments outsourced in interim until new provider starts • New provider to commence in early October. Plan to carry out a minimum of 600 assessments in the first six months, targeting longest waiting school age children. This will eliminate 65-week waiters by March 26. • Digital redesign work continues. • Working with NHS Sussex to develop new models of care for ASD assessments.
Community Waiting Times (Adult)	Urgent Community Response achieved a 2-hour response of 81.6% in August. Performance remaining stable financial year to date and continues to exceed the national target of 70%. In August, 84% of patients were seen within 13 weeks. Performance remains stable financial year to date and continues to exceed the target of 80%.	• No action as both emergency and elective standards have been consistently compliant in meeting their respective targets.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Cancer	In July the Trust delivered 82.5% against the 77% Faster Diagnosis standard and remains on track to deliver the 80% waiting time standard by March 2026. The Trust delivered 93.3% against the 96% 31-Day diagnosis to treatment standard. Performance against the 62 Day standard in July was 71.9% against a trajectory of 70% and the 75% waiting time standard by the end of March 2026. There were 235 patients waiting over 62 days at the end of July 2025 against an internal trajectory of 236. The Trust continues to receive high number of GP urgent suspected cancer referrals. In July 2025, 3378 referrals were received (22% increase on July 24). This is the highest number of referrals received in a month in the last two years. Significant increases have been noted in Skin, Urology and Gynaecology. In addition, the Trust receives Screening and Upgrade referrals.	• Detailed tumour site Cancer Action Plans underpinned by improvement trajectories • Weekly review of in month and future month performance to support delivery of tumour site level trajectories. • Enhanced focus on patients early in the pathway and weekly monitoring to improve transfer dates to tertiary providers by day 38 • Focus on long waiting patients to reduce the number of patients waiting over 62 days. This includes working with tertiary centres • Increased focus and challenge in some tumour sites with daily touchpoints • Options to explore insourcing to reduce long waiting patients in one tumour site • Capacity and demand review in tumour sites with a high increase of referrals • Initial discussions/consideration of AI option to support a high-volume tumour site • Planned Cancer Week in October • SSCA approved funds to support insourcing for Urology robotic surgery • Additional sessions/flexing of sessions to accommodate earlier treatment times for patients in some tumour sites.

Elective Activity	The Trust has achieved 93% of the local target set for August. This is expected to further improve once August activity has been verified.	• Enhance outpatient clinic utilisation to maximise the delivery of outpatient activity and improve patient access
		• Support outpatient productivity, focusing on:
		  ○ Targeted actions to reduce Did Not Attend (DNA) rates
		  ○ Robust validation of waiting lists
		  ○ Transitioning away from paper-based systems
		  ○ Improving follow-up appointment management
		• Advance Theatre Productivity actions, with emphasis on:
		  ○ Increasing utilisation including additional governance measures to minimise cancellations

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
RTT long wait position and waiting list size	The Trust reported a small number of patients waiting 65+ weeks in August. The patients have subsequently been treated or have a treatment plan in September. The Trust continues to work to eliminate 65week breaches by the start of Q3. In August, the Trust achieved 1.34% against a trajectory of 1.75% of patients waiting more than 52 weeks on the waiting list. The Trust is confident, that less than 1% patients on the waiting list will have been waiting more than 52 weeks by March 2026. RTT performance was 63.5% in August. Due to initiatives focused on validation and increasing elective capacity, over 70% of services have shown improvement in RTT performance.	• Proactive management of long-waiting patients, ensuring timely progression through care pathways and minimising delays (including a minimum of twice-weekly reviews of all patients at risk of waiting more than 65 weeks). • Continuous monitoring of specialty-specific trajectories, aligned with the 2025/26 RTT targets, to support delivery against national Referral to Treatment (RTT) standards • Ongoing optimisation of clinic templates to expand capacity for first outpatient appointments, contributing to reduced waiting times across all specialties • Sustained and targeted validation of patient pathways to improve RTT performance, ensuring accurate reporting and driving continuous improvement • Active investigation into PTL growth, with work underway to identify root causes and appropriate mitigating actions.
Diagnostic DMO1	In August, the percentage of patients waiting more than 6 weeks improved slightly with the Trust reporting 84.3% compliance against the 6-week standard. • The DM01 waiting list decreased by 1,000 patients to approx. 9,500 • The Echo waiting list and breach numbers remained stable. The modality continues to address staffing and capacity issues and expects an improvement in performance for September • Audiology waiting list and breach numbers decreased (97% compliance). • NOUS performance was 97% and Endoscopy above 99%. • CT improved slightly in month for the third consecutive month (87%). • MRI continues to drive under-performance against plan, despite waiting list and breaches reductions, and a small performance improvement.	• Recovery plans and trajectories are in place for all modalities with below 90% compliance. • MRI recovery plan in place • Opportunities to increase CT capacity continue to be explored through demand and capacity programme • WLIs are in place in Echo throughout September and October to increase capacity and reduce breaches • Improved process of daily validation and more frequent PTLs being introduced to provide more consistency and accuracy across modalities

Financial Control and Capital Development

Our Income and Expenditure

Our Elective Recovery

Our Run Rate

Efficiency

Capital

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

Finance | Executive Summary

East Sussex Healthcare NHS Trust

Finance

	Positives	Challenges & Risks	Author
Responsive	• M5 deficit of (£1.3m) in line with plan. YTD (£5.0m) deficit in line with plan. • Capital plan for 25-26 £36.9m. Spend in Month 5 £1.2m, YTD £5.8m. • Pay run rate in line with M4 once adjusted for Pay Award and underspent by £0.4m in month, £1.7m YTD. M5 extra pay CIP achieved. • Non-Pay run rate lower than M4 with some opportunities realised in month. YTD £3.7m underspent. • Use of Resources finished (£0.1m) adverse to plan YTD to Month 5. • Work is now commencing on the production of a 5-year plan and 26-27 planning cycle starting.	The Trust has agreed a challenging breakeven plan for 25-26, which includes an efficiencies target of £49.6m and has involved detailed plans worked up with Divisions over Q4 2024/25. Cost and other pressures has resulted in the need to identify other opportunities, and the Trust is in the process of identifying these to enable the delivery of a break-even plan. A workshop was held on 20 August in which additional schemes of £22m were proposed, and these are being worked up. £8m of other schemes are required and proposals are being shared with the ICB. This work will help deliver the 2025/26 financial plan and will give the Trust a good start into 2026/27. £0.5m of opportunities were utilised in Month 5 in order to stay on plan.	 **Andrew Strevens** Chief Finance Officer

Overview:

I&E: The Trust position is in line with plan, both for the month and YTD.

UoR: YTD delivery of £14.2m against plan of £14.3m, an under-delivery of £0.1.m.

Risk: The significant savings schemes need to be well managed to ensure the delivery of the balanced plan.

Capital: Capital expenditure YTD was £5.8m, £3.7m below plan.

Cash: Cash position concluded at £17.5m, well above the £2.1m minimum permitted balance and is likely to remain above target throughout Q3 of 2025/26.

Finance – Income and Expenditure

East Sussex Healthcare NHS Trust

Income and Expenditure

At month 5 the Trust has reported a deficit of (£1.3m), which is in line with plan. Key areas to highlight are:

- Income adverse overall in month. Diagnostic Income lower due to change in treatment identified in M4 continuing.
- Non pay underspent in month with some opportunities within reserves used to hit the month end plan.
- Pay underspent in month due to vacancies and lower enhancements in month. Pay Award M1-5 paid in month but no adverse effect.

The **Use of Resources** plan shows under achievement at (£456k) YTD.

Income was below plan. Diagnostic income for variable activity removed from actuals as confirmed as part of block (actioned M4) continues for the rest of financial year. Divisional ERF mainly on plan in month with some underachievement against Medicine. SPH income lower due to Aug holidays and review of activity ytd.

Pay Overall pay has seen an improvement on plan by £375k driven through vacancies. Pressures in Urgent Care continue for cost of premium medical staffing and extra nursing shifts for high acuity and observations. DAS overspend aligned to specialist locum costs and higher sickness in ODP's in month.

Pay Award paid to staff in month, A summary of Divisional budget increases is within the appendices.

Non Pay underspent in month. Divisionally, Security Costs mainly with Urgent Care and Medicine aligned to Mental Health and Violence & Aggression continue but with a lower impact in month. CORE pressures for send aways related to cancer demand higher in month, alongside Drugs pressures linked to activity. In month opportunities realised in month in order to hit plan.

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Plan	Act	Var	Plan	Act	Var
Income						
Contract income	50,509	46,363	(4,146)	218,587	213,122	(5,465)
Divisional	3,089	3,720	631	29,534	28,014	(1,520)
ERF	6,707	9,426	2,719	53,784	55,405	1,621
Total Income	**60,305**	**59,509**	**(796)**	**301,905**	**296,541**	**(5,364)**
Operating Expense						
Pay						
Permanent	(38,258)	(35,633)	2,626	(190,575)	(180,965)	9,610
Temporary	(2,005)	(4,256)	(2,251)	(10,484)	(18,405)	(7,921)
Total pay	**(40,263)**	**(39,888)**	**375**	**(201,060)**	**(199,370)**	**1,689**
Non-Pay						
Drugs	(1,545)	(1,957)	(413)	(7,727)	(8,359)	(632)
TEDD	(3,899)	(3,633)	265	(19,495)	(19,444)	51
Clinical supplies	(4,657)	(4,967)	(310)	(23,383)	(22,674)	709
Purchased services	(2,351)	(1,999)	352	(11,581)	(10,677)	905
Finance costs	(3,030)	(2,886)	145	(15,147)	(14,335)	812
Other	(5,815)	(5,432)	383	(28,559)	(26,703)	1,855
Total Non-Pay	**(21,297)**	**(20,874)**	**423**	**(105,891)**	**(102,192)**	**3,699**
Total Expense	**(61,560)**	**(60,762)**	**798**	**(306,951)**	**(301,562)**	**5,388**
Surplus/(Deficit)	**(1,255)**	**(1,253)**	**2**	**(5,046)**	**(5,021)**	**25**

Finance - Capital

East Sussex Healthcare NHS Trust

Capital Scheme	Funding	Planned End Date	Fcast End Date	In Month Plan £'000	In Month Actual £'000	In Month Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000	Full Year Plan £'000	Full Year Fcast £'000	Full Year Variance £'000
Backlog	Core			58	(26)	84	219	432.107	(213)	700	700	(0)
Fire	Core	Jan-25	Mar-29	103	-	103	392	-	392	1,250	1,250	-
Endoscopy	Core	Sep-25	Oct-25	619	85	534	2,350	123	2,228	7,500	6,500	1,000
Sussex Surgical Centre	Core	May-25	Sep-25	103	219	(116)	392	1,370	(978)	1,250	1,969	(719)
Cardiology	Strategic	Mar-25	Oct-26	289	64	225	1,097	222	875	3,500	3,500	-
CIR Estates Safety Plan				**708**	**108**	**600**	**2,884**	**866**	**2,018**	**8,553**	**8,553**	-
Conquest Decant Space creation	PDC	Mar-26	Mar-26	175	2	173	713	12	700	2,114	2,114	0
Maternity & SCBU Refurbishment	PDC	Mar-26	Mar-26	83	16	66	337	27	310	1,000	1,000	0
Eastbourne Midwifery Unit	PDC	Mar-26	Mar-26	160	80	81	653	662	(8)	1,938	1,938	0
Sub 4 Switchgear	PDC	Mar-26	Mar-26	37	5	33	152	8	143	450	450	0
Distribution Boards	PDC	Mar-26	Mar-26	43	-	43	177	-	177	525	525	-
Fire Doors - Cq	PDC	Mar-26	Mar-26	94	5	89	381	167	214	1,131	1,131	(0)
Fire Doors - Eb	PDC	Mar-26	Mar-26	94	1	93	381	(11)	392	1,131	1,131	(0)
Old Macerators	PDC	Mar-26	Mar-26	17	-	17	71	-	71	210	210	-
Sub Station Tripping Batteries	PDC	Mar-26	Mar-26	5	-	5	19	-	19	55	55	-
Total Estates				1,879	449	1,430	7,334	3,012	4,322	22,753	22,472	281
Digital	Core	Mar-26	Mar-26	210	42	168	799	216	583	2,550	2,550	(0)
Our Care Connected	Strategic	Mar-26	Mar-26	206	208	(2)	783	1,042	(258)	2,500	2,500	0
EPR	PDC	Mar-26	Mar-26	-	269	(269)	-	1,163	(1,163)	4,736	4,736	(0)
LIMS - DDC	PDC	Mar-26	Mar-26	-	35	(35)	-	(8)	8	1,038	1,038	-
OCS - DDC	PDC	Mar-26	Mar-26	-	-	-	-	-	-	297	297	(0)
Total Digital				416	555	(139)	1,582	2,413	(830)	11,121	11,121	(0)
Medical Equipment	Core	Mar-26	Mar-26	412	80	333	1,567	545	1,022	5,000	4,544	456
Constitutional Standards				**13**	**-**	**13**	**63**	**-**	**63**	**560**	**560**	-
Diagnostics	PDC	Mar-26	Mar-26	13	-	13	63	-	63	560	560	-
Histopathology Modernisation	PDC	Feb-26	Feb-26	-	-	-	-	-	-	689	689	-
Total Medical Equipment				425	80	345	1,630	545	1,085	6,249	5,793	456
Business case development				**82**	**-**	**82**	**313**	**422**	**(108)**	**1,000**	**422**	**578**
Aquablation	Core	Sep-25	Sep-25	-	-	-	-	422	(422)	-	422	(422)
Other	Core	Mar-26	Mar-26	69	131	(62)	260	(561)	821	831	(141)	972
Total Other				151	131	20	574	(139)	713	1,831	281	1,550
Total Capital				2,871	1,215	1,656	11,120	5,831	5,289	41,954	39,668	2,287
Slippage	Core			(416)	-	(416)	(1,580)	-	(1,580)	(5,041)	-	(5,041)
Total Charge to CRL				2,456	1,215	1,241	9,540	5,831	3,709	36,913	39,668	(2,754)

	Full Year Plan £'000	Full Year Forecast £'000	Full Year Variance £'000
Core	15,040	17,794	(2,754)
Strategic	6,000	6,000	0
PDC	15,874	15,874	0
	36,913	**39,668**	**(2,754)**

As of month 5, cumulative capital expenditure totals £5.8m. Most of the cumulative expenditure is attributable to the Sussex Surgical Centre with first patients being seen 8 September, refurbishment of Eastbourne Midwifery, Digital Electronic Patient Record and Our Care Connected schemes, Medical Equipment, and Aquablation.

The Sussex Surgical Centre is forecasting an overspend against budget by 58%.

Endoscopy is forecast to underspend by £1.0m, and of the £6.5m forecast to be spent to complete the clinical suite, only £0.1m has been incurred this year because of the payment bond of £5.5m that was paid in March 2025.The advance payment bond has been fully exhausted, and costs are expected to be incurred ahead of completion later this year.

The CIR Estates Safety fund of £8.6m has to date incurred £0.9m, mostly on Eastbourne Midwifery and Fire schemes.

Backlog Maintenance has incurred £0.4m of the £2.0m allocated, however is forecast to maximise expenditure, as is Digital who have a £11.0m budget across various schemes mostly funding from additional PDC.

Cumulative expenditure is lower than plan by £3.7m due to Endoscopy expenditure not yet spending against current year budget, and CIR Estates Safety running behind plan, and credits of £900k relating to a VAT reclaim on the EPR scheme.

Use of Resources – YTD positions

East Sussex Healthcare NHS Trust

Division	M5 Plan	M5 Act	M5 Var	M5 YTD Plan	M5 YTD Act	M5 YTD Var	Full Year Plan	Full Year F'cast	Full Year Var
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
CHIC	25	29	4	117	108	(9)	422	368	(54)
Core	348	284	(64)	1,543	1,744	201	4,353	3,875	(478)
DAS	399	367	(32)	1,255	1,180	(75)	5,050	3,330	(1,720)
Medicine	538	321	(216)	2,017	1,141	(875)	6,717	5,136	(1,581)
Urgent Care	294	255	(39)	1,108	1,020	(88)	4,595	4,511	(84)
WAC	116	110	(6)	524	983	458	1,908	1,787	(121)
SPH	27	10	(17)	63	40	(23)	665	215	(450)
E&F	149	138	(11)	758	727	(31)	2,326	1,955	(371)
Corporate	234	270	35	1,174	1,251	77	3,325	3,202	(123)
Central	1,679	1,238	(440)	6,546	6,828	282	43,380	41,014	(2,366)
Investment	(128)	(173)	(45)	(791)	(865)	(74)	(906)	(1,038)	(132)
Total	**3,680**	**2,849**	**(831)**	**14,314**	**14,158**	**(157)**	**79,600**	**64,354**	**(15,246)**

The tables show the in month and year to date delivery by Division, Priority area, recurrent/non-recurrent split and by category. The YTD position has deteriorated due to under delivery in Medicine (£875k YTD), due to uncertainty on some income schemes - a deep dive is underway and delay in medical staffing recruitment, Urgent Care (88k YTD) due to non implementation of a proposed roster system and DAS (£75k) due to under delivery on expected income related to Sussex Surgical Centre. Additionally, there were minimal one-off benefits identified in M5.

The over-delivery in Core is due to pharmacy savings above plan, and in WAC is due to the Maternity CNST rebate being received earlier than planned.

Performance against Trust priorities are being monitored as shown . “Other” relates to non-pay and other improvements that do not fall naturally into the defined groupings. Additional schemes with a value of c£22m have been identified and are implementation plans put in place at pace.

Priority Area	M5 Plan	M5 Act	M5 Var	M5 YTD Plan	M5 YTD Act	M5 YTD Var
	£'000	£'000	£'000	£'000	£'000	£'000
Length of Stay	388	371	(17)	1,223	1,193	(31)
Workforce	1,130	625	(505)	4,090	3,250	(840)
Income	966	774	(192)	3,962	3,997	34
Business Cases	627	549	(78)	2,479	2,325	(154)
Digitally Enabled Change	24	11	(13)	97	23	(73)
Other	546	521	(25)	2,464	3,370	907
Total	**3,680**	**2,849**	**(831)**	**14,314**	**14,158**	**(157)**

Recurrent/ Non-Recurrent	M5 Plan	M5 Act	M5 Var	M5 YTD Plan	M5 YTD Act	M5 YTD Var
	£'000	£'000	£'000	£'000	£'000	£'000
Recurrent	2,974	2,345	(628)	11,214	10,583	(631)
Non-Recurrent	707	504	(202)	3,100	3,574	474
Total	**3,680**	**2,849**	**(831)**	**14,314**	**14,158**	**(157)**

Category	M5 Plan	M5 Act	M5 Var	M5 YTD Plan	M5 YTD Act	M5 YTD Var
	£'000	£'000	£'000	£'000	£'000	£'000
Pay	1,463	922	(541)	5,258	4,075	(1,183)
Non-Pay	868	838	(30)	3,864	5,466	1,602
Income	1,350	1,089	(261)	5,192	4,617	(575)
Total	**3,680**	**2,849**	**(831)**	**14,314**	**14,158**	**(157)**

Agenda Item: 11

Report To/Meeting	Trust Board in Public	**Date of Meeting**	October 2025

Report Title:	Maternity Services Overview Board Report Q1 2025/26
Key question	As part of National reporting findings and Maternity Incentive Scheme (MIS) requirements all NHS Trusts are required to update Boards quarterly on the quality and safety aspects of our maternity and neonatal services. This report is presented for assurance following presentation to the Quality and Safety Committee.
Decision Action:	For approval ☐ For Assurance ☒ For Information ☐ For Discussion ☐

Report Sponsor:	Vikki Carruth, Chief Nurse & Executive Maternity Safety Champion	**Presenter(s):**	Brenda Lynes
Report Author:	Brenda Lynes, Director of Maternity Services		

Outcome/Action requested:	This report provides assurance that ESHT Maternity services are managed and monitored effectively, overall safety is maintained clinically and where concerns/incidents have been raised, appropriate effective action has been taken. Information within this report provides evidence overall of the delivery of high-quality services and ongoing compliance against all 10 Safety actions in line with MIS year 7 and the three-year delivery plan and action to mitigate where required.

Executive Summary	This paper provides an overview of maternity and neonatal planning, progress and activity during quarter 1 2025/26 and assurance of the quality and safety of our perinatal services, including an overview of progress in meeting the perinatal clinical quality surveillance standards and action taken to proactively identify and mitigate any quality and safety concerns or risks. **National Maternity Investigation** A rapid national investigation into NHS maternity services has been ordered by the Secretary of State for Health and Social Care. The review includes 14 trusts; ESHT are not one of those Trusts. Terms of reference have been developed (16/9/25). The investigation will publish some initial findings in December 2025 ahead of further findings in spring 2026. **Maternity Outcomes Signal System (MOSS)** The Maternity Outcomes Signal System (MOSS) developed by NHS England in response to the recommendations from the Kirkup Report into East Kent's maternity services, will be implemented in the South East Region from mid-October 2025. This system will 'signal' and alert on term stillbirths and neonatal deaths where there has been a recent doubling of these events compared to what is normally expected. These signals will be shared with the Regional Maternity and Neonatal Team who will cascade the information to the ICB and Trusts, with Trusts responding to NHSE. **Perinatal Quality Surveillance (PQS)** The governance process has been maintained in line with our Perinatal Quality Surveillance process during the reporting period. Overall Perinatal Mortality Rate (PMR), Stillbirth & Neonatal Deaths (NND) and Hypoxic Ischaemic Encephalopathy (HIE) grade 2&3 are all showing significant improvement (continued low numbers).

	Stillbirth rates for June 2025 show no significant change. Currently there is no assurance for stillbirths that ESHT will achieve the target reduction rate of 1.81 (red target line) per 1000 births without further improvement (slide 18). Sadly, we had a term neonatal death in June 2025. Overall performance continues to show improvement since November 24 Improvements in this area include a maintained high compliance in all areas of our Saving Babies Lives (SBL) V3.2 care bundle, we continue to embed our regional preterm optimisation quality Improvement initiative Prem 7+. We are currently 99% compliant with the SBL toolkit verified by the Integrated Care Board (ICB) and LMNS. Work continues in specific clinical areas such as our Diabetic/Endocrine service during pregnancy to achieve full compliance. **Preterm Optimisation Bundle (PREM7+)** The Kent Surrey and Sussex Health Innovations team have commended ESHT for their compliance rates across the 5 of the 9 optimisation interventions. The bundle is designed to improve outcomes for babies born prematurely by implementing seven evidence-based clinical interventions. These interventions are based on best practice guidelines from the British Association of Perinatal Medicine (BAPM) and aim to reduce brain injury and mortality rates among preterm infants.
Regulatory/legal requirement:	NHSE compliance requires the Board to review and approve this report
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration
Resource Implication/VFM Statement:	*Not applicable*
Risk:	During quarter 1 we have undertaken a period of reflection on the challenges and learning from 2024, which led to the commissioning of an external cultural review of our maternity services. The recommendations from this review are being systematically implemented, with a clear focus on improving organisational culture, leadership capability and staff engagement. Key progress includes: **Leadership development:** Completion of senior operational management leadership programmes, with band 7 leadership courses currently underway. These initiatives are designed to strengthen clinical leadership and operational resilience across maternity services. **Staff Engagement and Communication:** We are actively working to ensure that staff feel heard and valued. Mechanisms for feedback and transparent communication are being enhanced, reinforcing our commitment to a culture of listening and learning. **External Clinical Review** An external Clinical review was conducted during July/August 2025, as part of the recommendations from the external cultural review. The reviewers concluded that, the investigations by the Trust for each case were detailed and followed nationally agreed processes for mortality and patient safety incident review. There were no new recommendations identified, however two key areas were highlighted, Improving senior oversight of complex clinical/social cases and

	ensuring equity of continuity of care services for vulnerable families, both areas are being progressed within services. Two no/low harm Never Event discussed in Q4 report have been widely communicated within services with action taken to mitigate against a recurrence. A robust action plan and audit process is now in place.

No of Pages	3 slides	**Appendixes**	1

Governance and Engagement pathway to date:	Prior to this overview report being presented at Public Trust Board, this report and supporting informing reports were reviewed and assurance provided via the Quality and Safety Committee 24/09/25 on behalf of Trust Board. Areas covered in this report were addressed in MatNeo Governance and Accountability monthly meetings, MatNeo Assurance Meetings and MatNeo Clinical Board.
What happens next?	This report is provided for assurance. The subsequent quarter 2 2025/26 overview report is scheduled for presentation December 2025.
Publication	The report can be published.

East Sussex Healthcare NHS Trust

MatNeo Overview Board Report

Q1 2025/26 (April – June 2025)

KINDNESS

INCLUSIVITY

INTEGRITY

Author: Brenda Lynes, Director of Maternity Services

QSC 24/09/25 & Trust Board in Public 28/10/25

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Cover: Theme 1
Listening to and working with women & families with compassion

East Sussex Healthcare NHS Trust

The Maternity and Neonatal department have substantial evidence demonstrating effective co-production and collaborative working to proactively and positively improve services for our women and birthing people. During Q1 we have progressed work on our CQC National Maternity Survey action plan, improvements include a multipurpose quiet space within the acute unit. Work is ongoing to provide a communal discharge lounge. We continue to improve our maternity website and have purchased recliner chairs to support partners in line with our 24-hour visiting. We have aligned our Induction of labour pathway and processes across Sussex with ESHT's guidance due to be finalised at the end of September 25. Service users commented on the range of good quality information available throughout pregnancy.

We continue working to improve Service User experience, specifically around communication as to a baby's wellbeing when straddling the delivery suite and our Special Care Baby Unit (SCBU), ensuring early communication between families and the unit staff. Breastfeeding support is another area where improvements are required to ensure consistent advice is given, we have recently recruited two support workers who offer increased consistent support on the ward area, two low sensory feeding pods are now available on our postnatal ward. Our discharge coordinator is now in post, and we are on an improvement journey in this area with a discharge video currently in production.

We are actively working to improve our Equity and Equality data and have resourced targeted services to support stopping smoking for pregnant people and their families, with robust surveillance services for those people at greater risk during pregnancy. Our continuity teams continue to provided targeted support for under 21's and those women and people where English is not their first spoken language, complex homebirth requests from service users are also supported through our continuity teams. We have also introduced a neurodivergence training package for staff.

The Board Safety Champion(s) and the Maternity and Neonatal Voices Partnership (MNVP) lead meet regularly with maternity staff and the perinatal leadership team.

The MNVP are fully funded through the Local Maternity & Neonatal System (LMNS). Terms of Reference for the Women and Children's safety and governance meetings, show the MNVP Lead as a quorate member, quality, and safety meetings at speciality/divisional/directorate level including the following;

- Safety champion meetings
- MatNeo Governance and Accountability meetings

Cover: Theme 2
Growing, retaining and supporting our workforce

East Sussex Healthcare NHS Trust

Q1 has seen a period where we have taken stock on the events of 2024, which led us to complete an external cultural review, recommendations from this review continue to be delivered, currently we have completed a senior operational management leadership course, and the Band 7 leadership courses are underway. Following a local pulse survey, we are working with staff in smaller groups to hear their concerns and work together to improve systems and processes to support staff wellbeing. Cultural coaches, our Professional Midwife Advocate's (PMA's) and our Trauma Risk Management (TRIM) team, continue to focus on staff wellbeing. Listening events are a regular part of the MatNeo process for staff.

The clinical review has now completed, it was noted reviews are carried out in line with national guidance, fresh eyes noted 2 recommendations, surrounding improving MDT reviews for complex cases and a review of our continuity teams.

Maternity Services have remained stable, vacancy rate (3.9%), fill rates remaining static. Red flags have increased in Q1, none that resulted in clinical concern, however our acuity did rise in Q1 and it is an area we keep under continuous review.

Our budgeted establishment is in line with Birthrate+ (2022 analysis) and we have completed an updated review which is being processed. Neonatal nursing, medical services and Obstetric medical services are all commissioned and delivered in line with national requirement.

Our 2024 staff survey actions include supporting staff to Speak Up and seek support if they feel discriminated against and to report adverse interactions. Work continues in-regards to flexible working and self-rostering. Challenges continue in filling vacancy due to short term sickness which impacts on staff working additional hours on occasions, we are currently reviewing alternative processes to support short term vacancy and continue to support staff to return to work through our wellbeing services.

Maternity care is becoming increasingly complex and coupled with times of high acuity/workforce challenges, this has been highlighted as a concern related to staff wellbeing. The senior management team are working with staff to actively review ways in which to improve workforce availability and the environment to ensure the wellbeing of all our staff.

The maternity department is fully recruited to Obstetric Consultant posts and remains compliant with the requirement for twice daily consultant ward rounds, 7 days per week. Our middle-grade staffing improved during Q1 and there are currently no gaps in this rota.

Cover: Theme 3
Developing and sustaining a culture of safety, learning and support

East Sussex Healthcare NHS Trust

We continue to make progress with full Saving Babies Lives (SBL) V3.2 implementation and are currently at 99% on the SBL national toolkit. Our identified risks are lack of scanning capacity for growth and uterine scans to meet the national required timeframes and uterine artery doppler compliance, the department is working to review provision of all scans to enable focussed work on essential scans. Funding has been identified by NHSE to provide sonography training, with the aim to identify training by March 26. The department are working towards holding a stand-alone diabetic clinic for those with a pre-existing condition.

Avoiding Term admissions to SCBU are below national average for Q1 (3.6), a quality Improvement project continues to work to reduce admissions for respiratory distress syndrome.

We continue an ongoing review of caesarean section rates which have risen (as is the case nationally).

Work continues to reduce health inequalities include targeted smoking cessation support, vaccine uptake and healthy weight management, whilst ESHT do not follow national trends for inequalities relating to Black and Asian women and birthing people (see slides 11-14), numbers are very small and focussed work continues, specifically to ensure use of translation services at every contact where required. Currently across the LMNS cases are monitored in real time so we have an accurate picture of activity, we can currently see when these infrequent events are happening, further analysis will continue as data collection increases.

A total of nine in-utero transfers (IUTs) were recorded during Q1. Raising awareness and improving communication around IUTs has been a key focus both locally and regionally, work in this area continues.

Overall perinatal mortality rate (PMR) (Stillbirth & Neonatal deaths (NND) and Hypoxic ischaemic encephalopathy (HIE) grade 2&3 are all showing No significant change since January 2024

Review of Stillbirth - to improve outcomes, the following recommendations have been made:

- Review guidelines relating to ultrasound scanning, and for women of Black and Asian ethnicity offer induction of labour between 40-41 weeks' gestation.
- Improve communication with service users relating to their individual risk of stillbirth and the importance of attending antenatal appointments.
- Review and consider feasibility of implementing consultant led antenatal clinics in the most deprived communities.
- Review and consider continuity offer – enhanced antenatal/postnatal care for the most vulnerable service users.

Cover: Theme 4
Standards and Structures that underpin safer, more personalised and more equitable care

East Sussex Healthcare NHS Trust

Improvement continues across our partnership (LMNS) with improving oversight and assurance, driving significant joint working, data quality improvement, oversight of quality and safety and identifying areas to standardise and improve as a system through our Perinatal Quality Surveillance (PQS) Operating model, with significant work to improve our local dashboard.

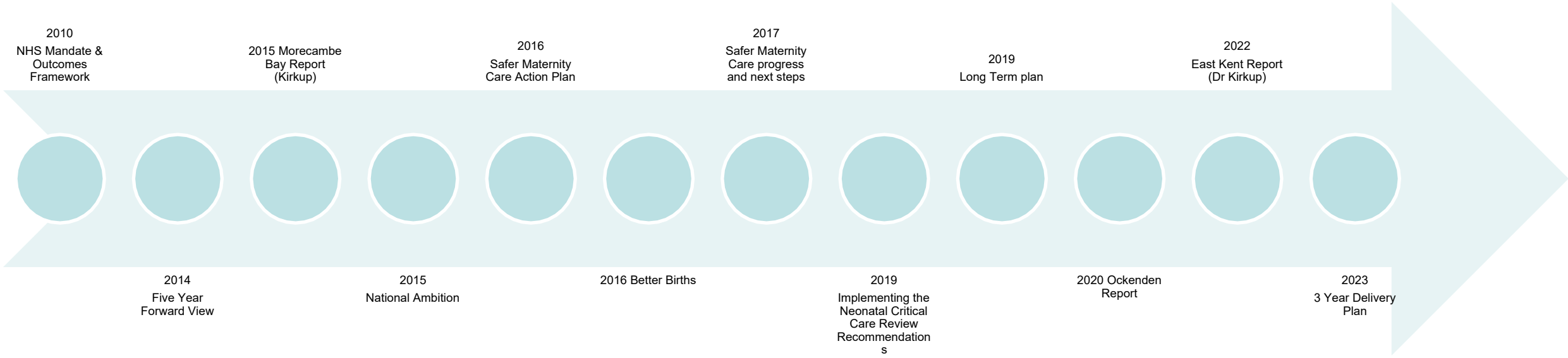
At a local level, with regards to our Claims, Complaints and Risk scorecard and Perinatal mortality reviews, our data is evidencing that we continue our journey of learning and for Q1 there were no avoidable perinatal deaths. 4 MDT cases closed during Q1, plus 1 MNSI case and 3 complaints. Actions include improving MDT working to improve situational awareness, including early escalation of concerns where required, there are also a number of guideline recommendations which have been implemented, plus work to review current guidelines in line with National Guidance, communication remains a theme and much work is underway to effect improvement in this area. Work continues with the neonatal network in line with Regional Intra uterine transfer guidance.

There were two low/no harm incidents which met the Never Event criteria in 2024/25. This has been discussed extensively at the Quality and Safety Committee (QSC). Action was taken at the time and since to reduce the risk of a reoccurrence, significant work continues to reduce the risk of reoccurrence, a full plan of action has been implemented and continues to be monitored against compliance.

The CQC action plan is complete apart from mandatory training with the aim to achieve 90% against the listed areas as soon as possible. (QSC have seen and agreed key actions to improve overall percentages with target dates agreed) – see slide 22

East Sussex Healthcare NHS Trust

The Journey to a national Maternity and Neonatal Safety Ambition



The 3 Year Delivery Plan

East Sussex Healthcare NHS Trust

Theme 1: Listening to and working with women and families with compassion

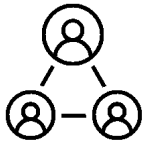
- Objective 1: Care that is personalised .....
- Objective 2: Improve equity for mothers and babies .....
- Objective 3: Work with service users to improve care.....

Theme 2: Growing, retaining, and supporting our workforce .....

- Objective 4: Grow our workforce.....
- Objective 5: Value and retain our workforce .....
- Objective 6: Invest in skills.....

Theme 3: Developing and sustaining a culture of safety, learning, and support.

- Objective 7: Develop a positive safety culture .....
- Objective 8: Learning and improving.....
- Objective 9: Support and oversight.....



Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care .....

- Objective 10: Standards to ensure best practice .....
- Objective 11: Data to inform learning.....
- Objective 12: Make better use of digital technology in maternity and neonatal services.....

Three Year Delivery Plan: Theme 1

Listening to and working with women & families with compassion

East Sussex Healthcare NHS Trust

Work with Service Users to Improve Care

- Open Space event held to consider neonatal services, included feeding, managing transition more effectively, communication between the wards and SCBU. Key actions underway.
- Coproduced ESHT and MNVP action plan following the national CQC maternity survey, this is reviewed as an MDT quarterly
- Lived experience videos to be used for staff training, bringing life examples of how we can improve care within services

Our Service User Voice	
You Said	**We Did**
Provide consistent advice around Induction of Labour and Discharge processes	• Ongoing work with the MNVP to provide system –wide service user information regarding IOL, worked with staff to ensure personalised advice and support is provided at all times. Back to Basics week in planning phase. Inclusion of lived experience films for multi-disciplinary staff training
24 hour visiting could be improved for partners	• Reclining chairs purchased • Refresh of guidance for partners
Provide meals for parents on SCBU	• Worked with the MNVP/ Neonatal unit to ensure provision for all parents

Celebrations & Plaudits

99 individual staff members were named as going 'Above and Beyond' along with lots more general positive comments. We pass on as many of those as possible to staff and create quarterly posters for display on the units.

What's going well

- Exceptional individual care
- Clear, kind supportive, empathic staff
- Specialist Infant feeding team – responsive & knowledgeable
- Positive birth experiences
- Excellent emotional support for complex or high-risk pregnancies
- Professionalism & calmness in emergencies

Listening to and working with women & families with compassion

East Sussex Healthcare NHS Trust

Improving Equity & Equality

- Improved data collection (18 months of data)
- Monthly equity and equality group
- Robust Public Health services within maternity
- Improving compliance with Saving Babies Lives (SBL) v3
- Vaccination programme in progress (pertussis, seasonal flu, RSV program)
- Preterm clinic established
- Targeted work on Folic Acid
- Targeted smoking cessation activity with positive outcomes
- Established Maternal Medicine service across Sussex
- Robust Pelvic Health and Perinatal Mental Health Services
- Targeted work following Stillbirth review
- Black & Asian data does not follow national trends
- Areas of deprivation require ongoing focussed work
- Early Pregnancy Unit improvements underway

Health Inequalities – Key themes

Findings suggest that areas of deprivation is where focus is required at ESHT

BME Population outcome measures

- 1 stillbirth in Q1– thematic review completed
- There have been no neonatal deaths since June 23
- 1 HIE grade 1 (normal MRI) since June 23.
- All other outcome measures are showing no significant change and are showing natural level of variation we would expect to see from the process.

10% most deprived outcome measures

- No stillbirths or HIE from 10% area of deprivation
- 1 neonatal death in March 24, since April has shown significant improvement
- All other outcome measures are showing no significant change and are showing natural level of variation we would expect to see from the process.

20% most deprived outcome measures

6 stillbirths since June 23- thematic review completed of all Stillbirths during 24/25

- 1 neonatal death in March 24, since April has shown significant improvement
- 1 HIE grade 1 June 24
- All other outcome measures are showing no significant change and are showing natural level of variation we would expect to see from the process.

Health Inequalities: BME Population

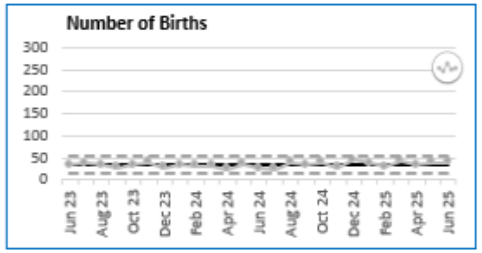
East Sussex Healthcare

Maternity overview ESHT BME

Latest month 01/06/25

Number of Births 40

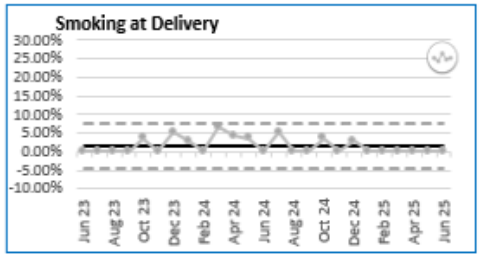
No significant change



Latest month 01/06/25

Smoking at Delivery 0.0%

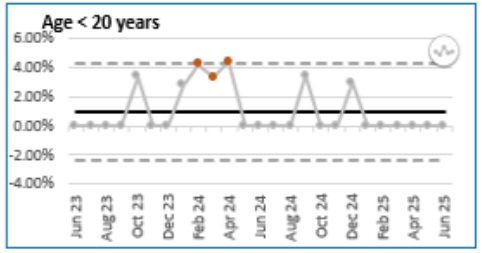
No significant change



Latest month 01/06/25

Age < 20 years 0.0%

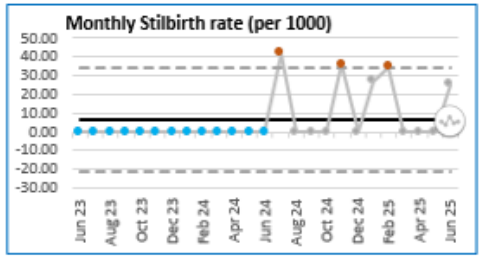
No significant change



Latest month 01/06/25

Monthly Stilbirth rate (per 1000) 25.00

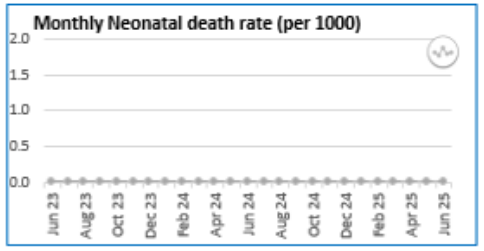
No significant change



Latest month 01/06/25

Monthly Neonatal death rate (per 1000) 0.00

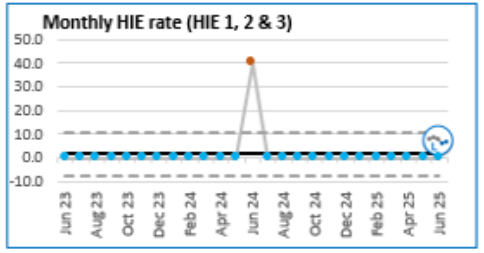
No significant change



Latest month 01/06/25

Monthly HIE rate (HIE 1, 2 & 3) 0.00

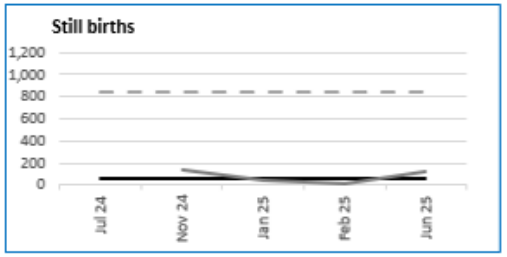
Significant Improvement



Date of last stillbirth 13/06/25

Average days between stillbirths 83.5

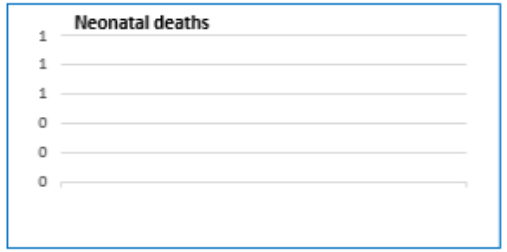
No significant change



Date of last neonatal death

Average days between deaths

No significant change



Date of last HIE 08/06/24

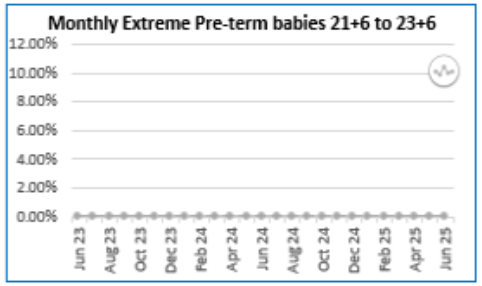
Average days between HIE

No significant change

Latest month 01/06/25

Monthly Extreme Pre-term babies 21+6 to 23+6 0.0%

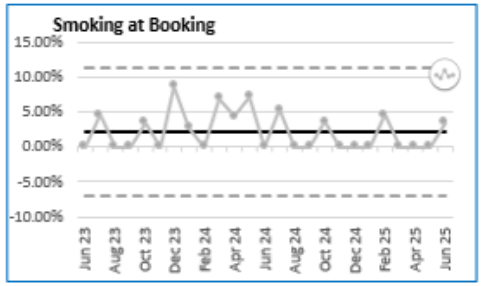
No significant change



Latest month 01/06/25

Smoking at Booking 3.5%

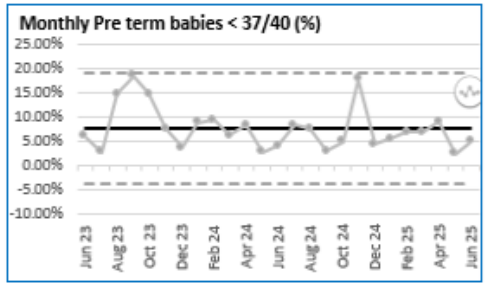
No significant change



Latest month 01/06/25

Monthly Pre term babies < 37/40 (%) 5.0%

No significant change

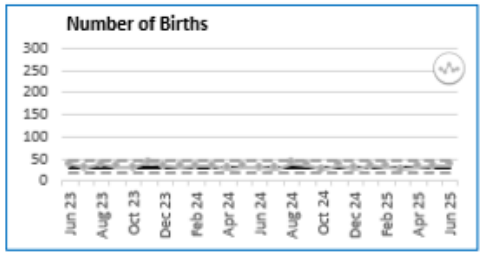


Health Inequalities: 10% most deprived

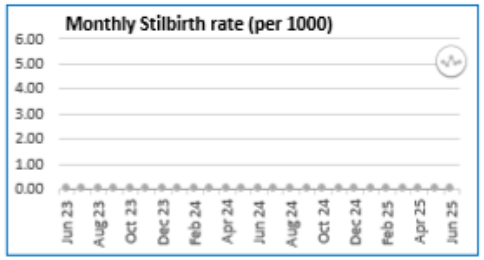
NHS East Sussex Healthcare

Maternity overview | **ESHT 10% most deprived**

Latest month 01/06/25
Number of Births 36
No significant change

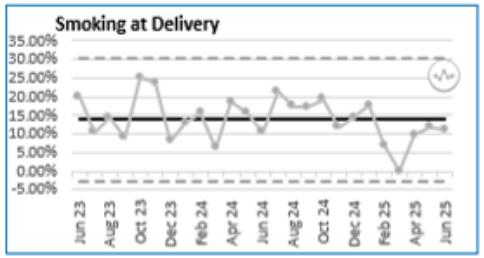


Latest month 01/06/25
Monthly Stilbirth rate (per 1000) 0.00
No significant change

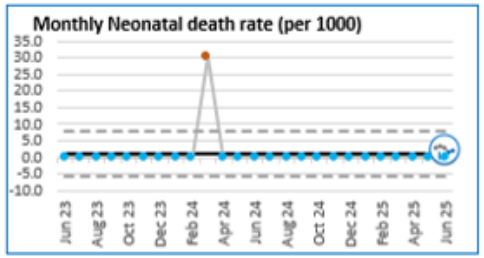


Date of last stillbirth
Average days between stillbirths
No significant change

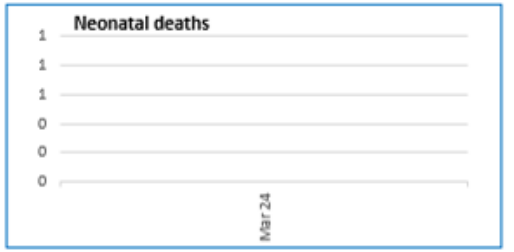
Latest month 01/06/25
Smoking at Delivery 11.1%
No significant change



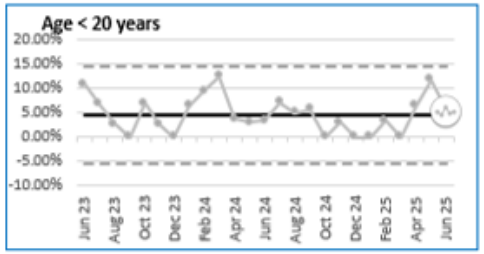
Latest month 01/06/25
Monthly Neonatal death rate (per 1000) 0.00
Significant Improvement



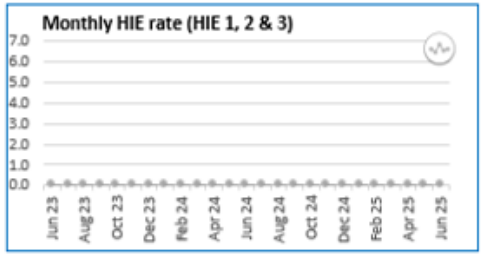
Date of last neonatal death 18/03/24
Average days between deaths
No significant change



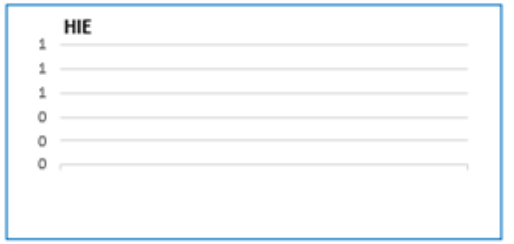
Latest month 01/06/25
Age < 20 years 5.6%
No significant change



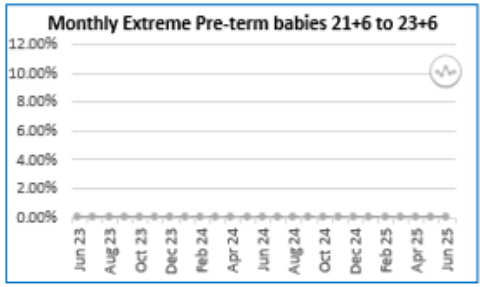
Latest month 01/06/25
Monthly HIE rate (HIE 1, 2 & 3) 0.00
No significant change



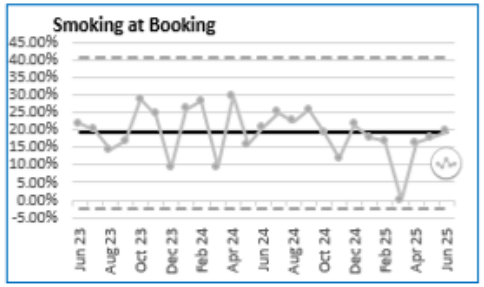
Date of last HIE
Average days between HIE
No significant change



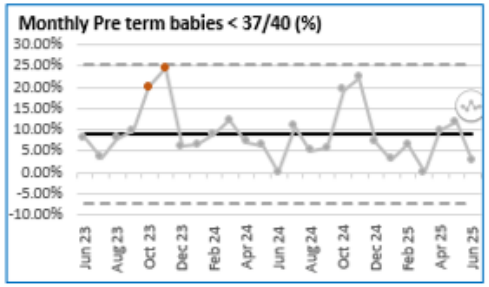
Latest month 01/06/25
Monthly Extreme Pre-term babies 21+6 to 23+6 0.0
No significant change



Latest month 01/06/25
Smoking at Booking 19.4%
No significant change



Latest month 01/06/25
Monthly Pre term babies < 37/40 (%) 2.8%
No significant change

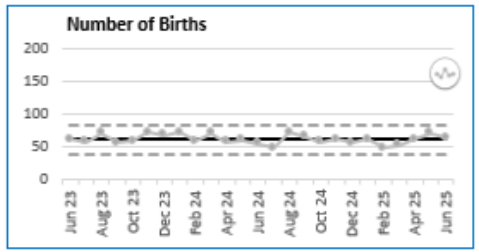


Health Inequalities: 20% most deprived

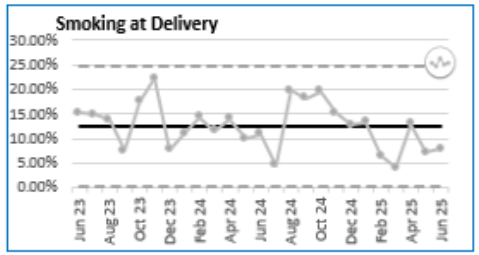
East Sussex Healthcare

Maternity overview | **ESHT 20% most deprived**

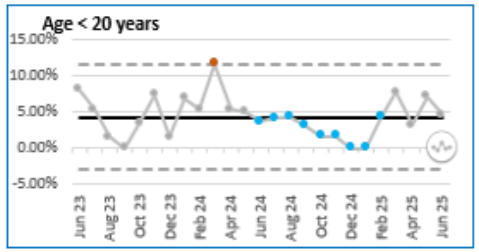
Latest month 01/06/25
Number of Births 64
No significant change



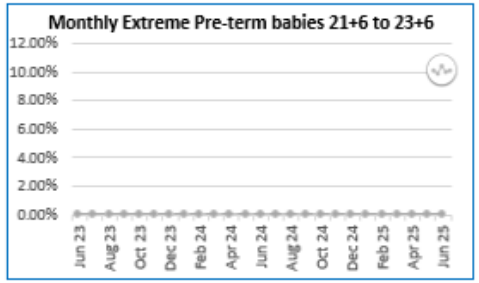
Latest month 01/06/25
Smoking at Delivery 7.8%
No significant change



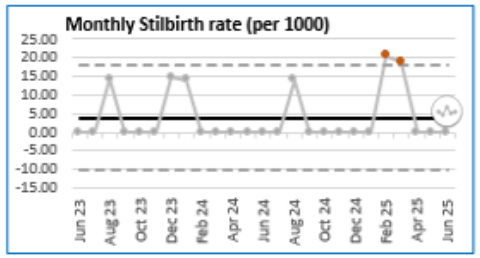
Latest month 01/06/25
Age < 20 years 4.7%
No significant change



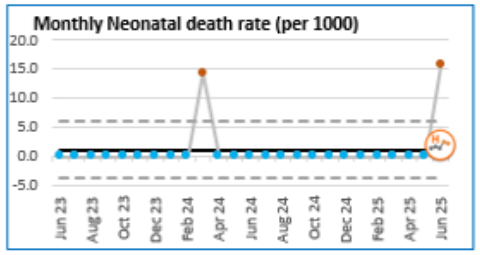
Latest month 01/06/25
Monthly Extreme Pre-term babies 21+6 to 23+6 0.0
No significant change



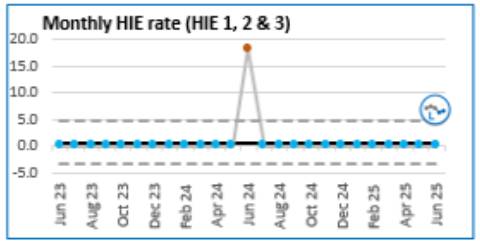
Latest month 01/06/25
Monthly Stilbirth rate (per 1000) 0.00
No significant change



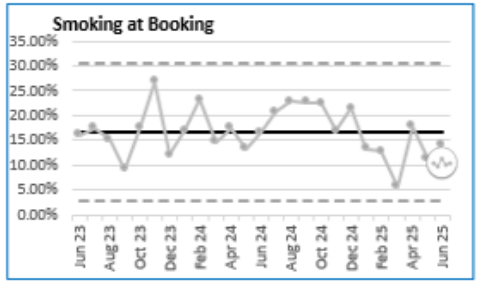
Latest month 01/06/25
Monthly Neonatal death rate (per 1000) 15.62
Significant deterioration



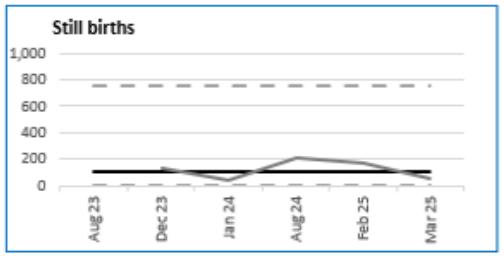
Latest month 01/06/25
Monthly HIE rate (HIE 1, 2 & 3) 0.00
Significant Improvement



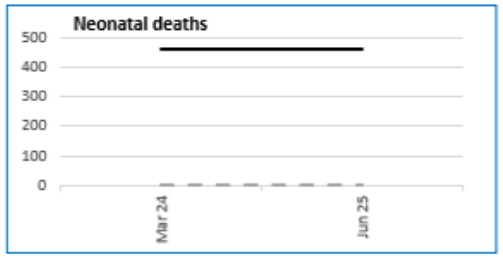
Latest month 01/06/25
Smoking at Booking 14.1%
No significant change



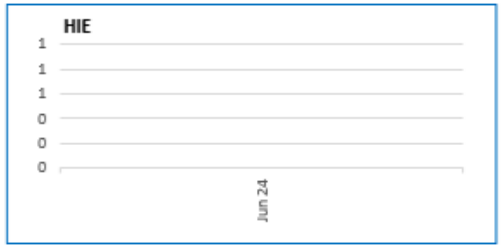
Date of last stillbirth 31/03/25
Average days between stillbirths 121.4
No significant change



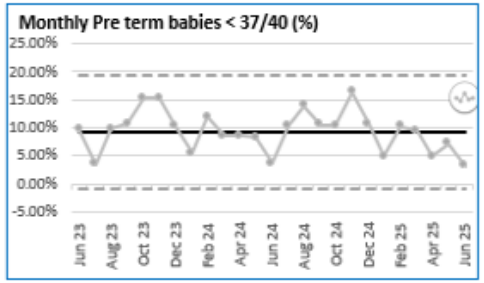
Date of last neonatal death 21/06/25
Average days between deaths 460.0
No significant change



Date of last HIE 08/06/24
Average days between HIE
No significant change



Latest month 01/06/25
Monthly Pre term babies < 37/40 (%) 3.1%
No significant change



Three Year Delivery Plan: Theme 2

Growing, retaining and supporting our workforce

Our workforce

East Sussex Healthcare NHS Trust

Maternity Workforce

Data Source	Q2 (24/25)	Q3 (24/25)	Q4 (24/25)	Q1 (25/26)
Sickness	7.5%	6.3%	5.06%	6.3%
Maternity Leave	4.23%	4.1%	4.1%	2.8%
Vacancy rate	0.66%	5.0%	6.6%	3.9%
Midwifery total fill rates	86.7%	86.8%	92.7%	95.1%

	Q2	Q3	Q4	Q1 (25/26)
1-2-1 Care in Labour	100%	100%	100%	100%
Supernumerary labour ward coordinator	100%	100%	100%	100%

Maternity			
	Budgeted June 24	**Budgeted April 2022**	
Specialist	27.67	21.3	
Combined Screening	4.25	4.05	
Community Midwifery Conque	21.00	18.27	
Community Midwifery EDGH	19.30	18.2	
Frank Shaw	92.97	80.62	
EMU	15.46	18.78	
Maternity Day Unit	14.54	12.78	
Case Load Teams	14.60	24.6	
Total	209.79	198.60	
3.4% of April 22		**6.75**	
Apr-22		198.60	
BR+ 3.4% uplift		6.75	
Total inc uplift		205.35	
Jun-24		209.79	
variance to 22 + 3.4%		4.44	over suggested BR+ increase to budgeted staff

The BR+ workforce assessment was presented to the Board in June 2022. The Board agreed with the workforce assessment, with a headroom uplift of 26.4%. This is reflected in current midwifery workforce budgets as demonstrated in the extraction. An updated BR+ paper is currently progressing through Trust Governance process

Medical workforce: Obstetrics

- 91% compliance with RCOG Roles and Responsibilities (audited quarterly), documentation of attendance is required to improve, medics educated regarding this
- Consultants: Compensatory rest, compliant with RCOG guidance
- Middle grades: full compliance with RCOG guidance on employing short and long term locums

Anaesthetic staffing

100% compliance Anaesthesia Clinical Services Accreditation (ACSA)

Neonatal staffing: Medical

Meets the British Association of Prenatal Medicine (BAPM) national standards of neonatal medical staffing

Three Year Delivery Plan: Theme 2

Growing, retaining and supporting our workforce

Our workforce

NHS East Sussex Healthcare NHS Trust

Neonatal staffing: Nursing

Levels meet Operating Delivery network (ODN) levels (ESHT has a 12 cot SCBU)

Qualified in Speciality (QIS)				
Target 70%	Q2 (24/25)	Q3 (24/25)	Q4(24/25)	**Q1 (25/26)**
	47.4%	48%	48%	47%
Action Plan in place with staff currently on training programme, expect to improve by October 25 to 57% (training program 18-24 months) Over the past quarter 0 shifts fell short for QIS trained staff per shift. 2 staff to complete training with completion target date 2026/27.				
Vacancy rate	Q2(24/25)	Q3(24/25)	Q4(24/25)	**Q1 (25/26)**
	2.2%	7%	7%	3.9%
Recruitment ongoing				

Clinical Maternity Red Flags Q1

Over the last quarter there have been an increasing number of red-flags in relation to delays in the induction of labour process, there has been no clinical harm. The Trust has recently adopted the NHS England SE Region, Induction of Labour Principles Framework, that recommends a red-flag where there is a six-hour delay in the Induction of Labour (IOL) process. IOL guideline review planned completion end September 2025 which is expected to improve patient flow and therefore minimise delays. A QI process will use the red flag data to map all areas for improvement.

Training Needs Analysis (TNA)

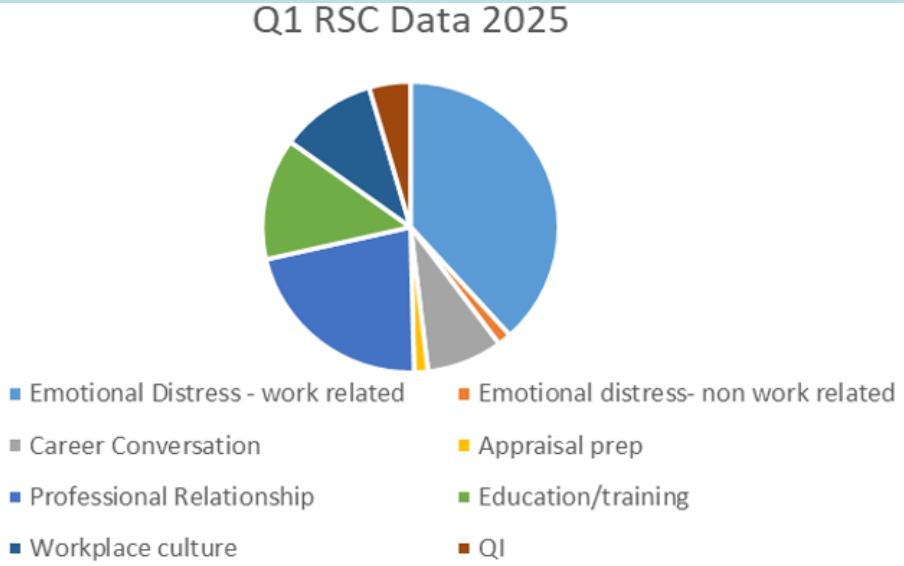
Comprehensive annual review competed. All staff training needs are reflected in line with NHSE requirements

Staff Feedback Themes Q1

- Data from the Safety Culture Operational Risk Resilience/ Burnout, Engagement (SCORE) survey, PMA quarterly report and staff listening events highlights staff emotional stress related to high acuity, increasingly complex care needs (mental health, safeguarding) and increasing levels of verbal abuse from service users and their companions.
- The senior management team are actively reviewing ways in which the working environment and workforce can be improved to ensure the wellbeing for all of our staff.

Other actions

- Support provided through PMA process, local listening events
- Self-Rostering (QI project - ongoing)
- Review of Maternity footprint to improve flow



Three Year Delivery Plan: Theme 2

Growing, retaining and supporting our workforce

Our workforce

NHS East Sussex Healthcare NHS Trust

MatNeo Staff Survey Score report/ Staff Survey (2024)

You Said

- Concern working unpaid/paid hours over contracted
- Express that colleagues are not always respectful & increase in those who have experienced bullying
- Expressed work related stress (busy unit/complexity in maternity increasing)
- Noted increased focus on wellbeing (trust-wide)
- A refocus on staff engagement sessions (following a spot survey relating to what our staff want)

Learning Points

- Supporting our leaders (commissioned leadership program – underway)
- Empowering staff to speak up and report adverse interactions/physical violence/unkind behaviour – this work is ongoing
- Work to support staff to speak up where they feel discriminated against
- Challenges in filling some shifts due to sickness/absence/vacancy – staffing review underway

Together we will

- Survey to all staff to understand how best to communicate with them – series of events now booked in line with responses
- Staff encouraged to report any adverse incidents/concerns (to enable leaders to truly tackle key concerns)
- Additional input from managers to support the management of reasonable adjustments/ flexible working
- Continue to improve high quality PDR's
- Communicate all OD/OH offers to our staff
- Work closely with our Professional Midwife Advocates and staff to hear key concerns and work together to bring improvement/change

Recruitment & Retention 3 year plan

Programme Aims

- Retention
- Psychological wellbeing and safety
- Recruitment
- Workforce pipeline
- Career mapping

Key risks & mitigations

Responding to recommendations from the Independent maternity review:

- Harnessing full engagement from colleagues at all levels, Trust investment to supporting strong leadership investment at all levels (Leadership program in progress)
- Tighter controls for recruitment

Three Year Delivery Plan: Theme 3

Developing and sustaining a culture of safety, learning and support

East Sussex Healthcare NHS Trust

Avoiding term admissions into neonatal units (ATAIN)
National Benchmark 5%

	Q2 (24/25)	Q3 (24/25)	Q4 (24/25)	**Q1 (25/26)**
Rate	3.8	3.7	3.8	3.6

Key actions:
- Quality Improvement project for Respiratory Distress Syndrome(RDS) progressing (improvement noted)
- Continued downward trend in caesarean section rates at 37 weeks
- Order further equipment for transitional care (hot cot equipment), (below the national average rate for Q1)
- 22 cases reviewed

Transitional Care (TC)

	Q2	Q3	Q4	**Q1**
No	47	27	31	37
Main treatments	• IV antibiotics • Treatment for Hypoglycaemia	• IV antibiotics • Temperature support	• IV antibiotics • Phototherapy for Jaundice	Main reason : feeding, jaundice, weight loss Hypoglycaemia
Actions	0 inappropriate admissions to SCBU	1 inappropriate admission to SCBU – could have been managed through transitional care	1 inappropriate admission to SCBU – feeding support	0 inappropriate admissions to SCBU

Saving Babies Lives (SBL) V3 Q1 2025/26

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	99%	Partially implemented	99%	CNST Met

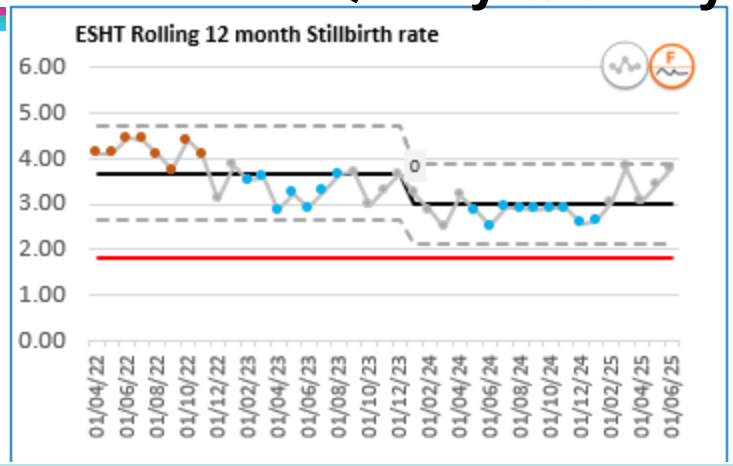
MDT Training target >90% at year end

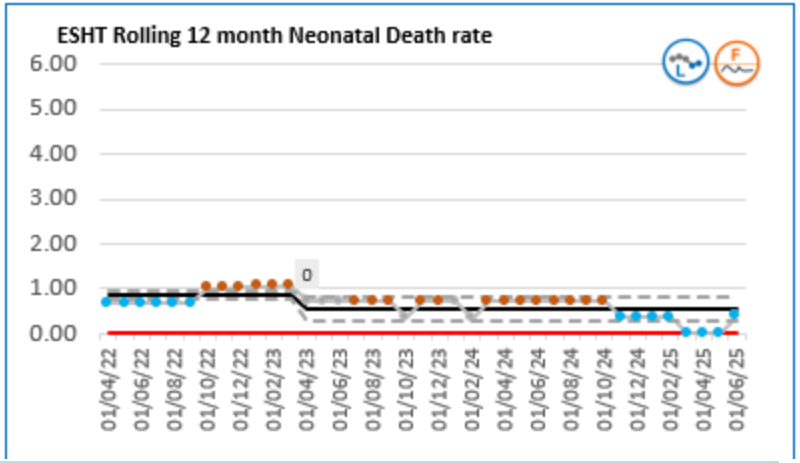
CTG & fetal monitoring training competency	Q2 (24/25)	Q3 (24/25)	Q4 (24/25)	**Q1 (25/26)**
Combined Medic & Midwives	94%	97%	98%	96%
PROMPT compliance	Q2 (24/25)	Q3 (24/25)	Q4 (24/25)	**Q1 (25/26)**
Combined Medic & Midwives	97%	93%	90%	90%

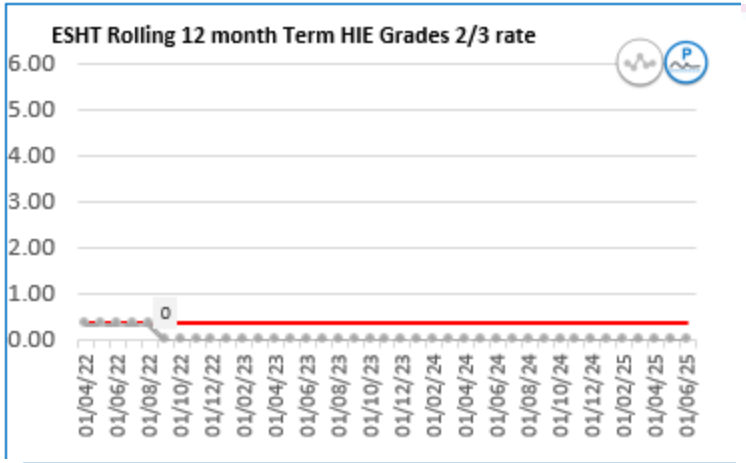
Developing and sustaining a culture of safety, learning and support

East Sussex Healthcare NHS Trust

Perinatal Quality & Safety





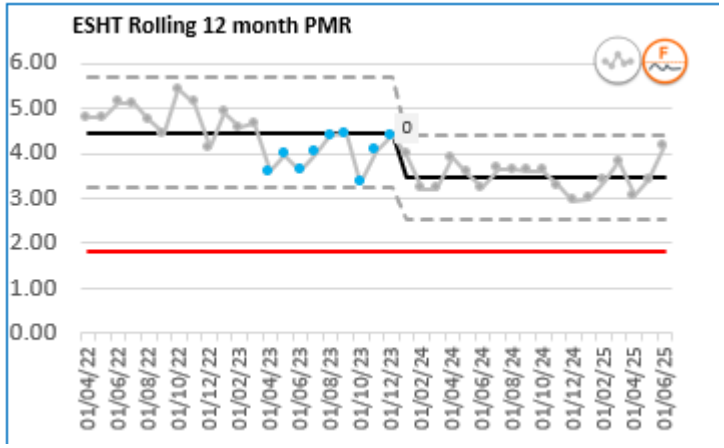


Rolling 12 month stillbirth rate
- Stillbirth rates for June 25 show no significant change
- Currently there is no assurance, for stillbirths that ESHT will achieve the target reduction rate of 1.81 (red target line) per 1000 births without further improvement.
- Average days in between each event is 45.5

Rolling 12 month Neonatal Death rate
- Term NND reported in June however, performance continues to show significant improvement, since November 2024
- Currently there is no assurance, for neonatal deaths that ESHT will achieve the target reduction rate of 0.00 (red target line) per 1000 births without further improvement.
- Average days in between each event is 298

HIE Grade 2/3
- Performance is showing no significant change since September 2022, assurance is showing the Trust will consistently meet the target if nothing changes.

Overall PMR
- No significant change since January 2024



Why are some SPC charts missing targets? There is no national or regional benchmark data for stillbirths or neonatal deaths. As per the technical annex to the 3-year delivery plan, the England level data used a different data source, so it is not appropriate to present side by side

Perinatal Mortality Rate (PMR): stillbirths and neonatal deaths combined

Hypoxic-ischaemic encephalopathy (HIE) (when baby's brain does not receive enough oxygen and/or blood flow around the time of birth)

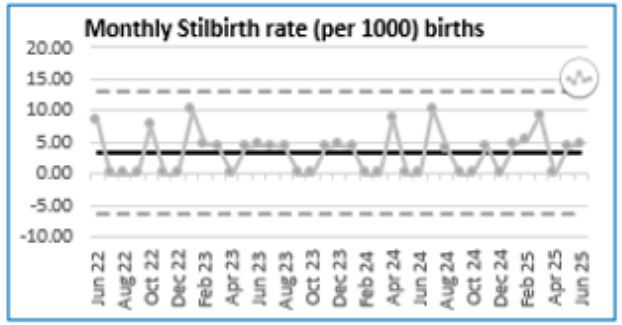
Developing and sustaining a culture of safety, learning and support

Perinatal Quality & Safety

East Sussex Healthcare NHS Trust

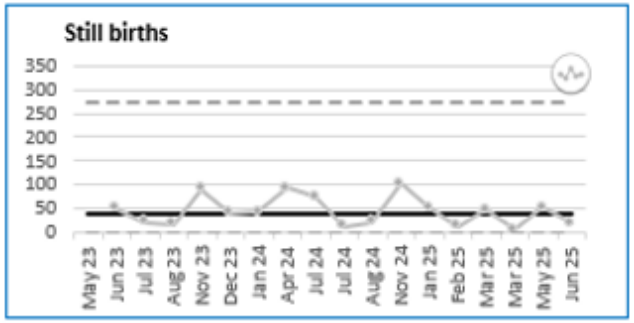
Latest month	01/06/25
Still birth rate/1000	4.65

No significant change



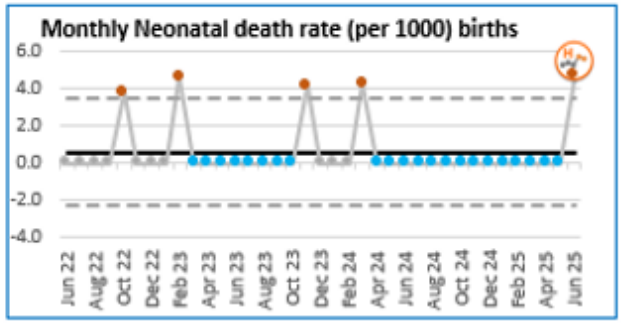
Date of last stillbirth	13/06/25
Average days between stillbirths	45.5

No significant change



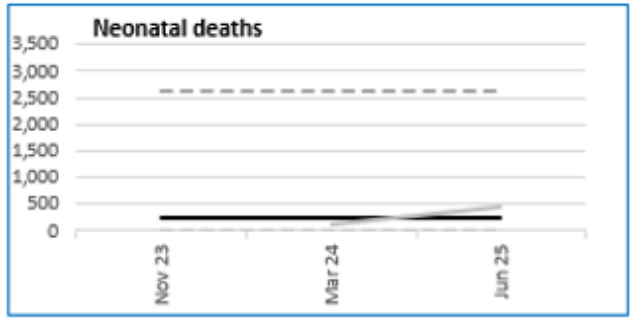
Latest month	01/06/25
Neonatal Death rate/1000	4.67

Significant deterioration



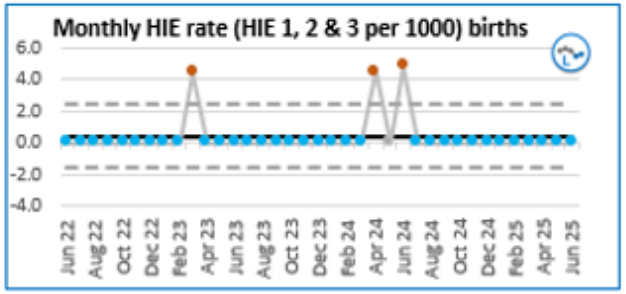
Date of last neonatal death	21/06/25
Average days between deaths	298.0

No significant change



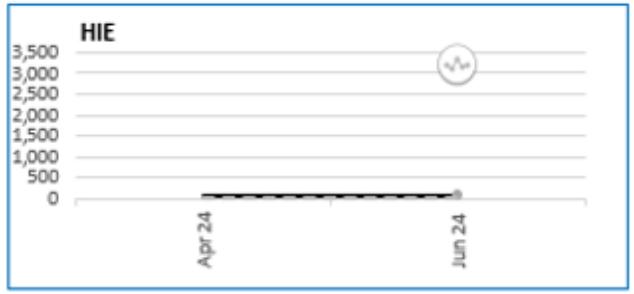
Latest month	01/06/25
HIE rate/1000	0.00

Significant Improvement



Date of last HIE	08/06/24
Average days between HIE	47.0

No significant change



Rare event charts are used to monitor stillbirths, neonatal deaths and brain injury in 'real time'. The charts highlight the events and if the frequency of those events is changing. Using these charts alongside SPC charts give a clear picture of how ESHT are performing and will highlight where you need to focus if a problem arises.

Step changes have been added to the rolling 12-month stillbirth, neonatal death, HIE grades 2 & 3 and overall PMR. The mean and process limits now describe the most recent performance

Perinatal Mortality Rate (PMR): stillbirths and neonatal deaths combined
Hypoxic-ischaemic encephalopathy (HIE) (when baby's brain does not receive enough oxygen and/or blood flow around the time of birth)

Developing and sustaining a culture of safety, learning and support

Perinatal Quality & Safety

Closed Incidents	
Incident type	**Recommendations/ actions**
Closed MDT Cases INC5287 (2024)	• Work/training to improve MDT working and maintaining situational awareness • Ensure RCOG guidance is followed in regard to consultant presence (audit ongoing quarterly), the main area for action is to ensure consultant presence is documented
INC8795 (2024)	• Residents discussion regarding early escalation of concerns to O&G consultant • Call list change made for neonatal emergencies call outs - now include the Consultant paediatrician
INC5494 (2024)	• Latent Phase of labour guidelines reviewed (no national criteria) • Safety Pin to all staff regarding frequency of examinations to reduce risk of infection
Closed MNSI/PSII INC3327 (2024)	• Local guidance updated to follow National guidance in the offering of a Keilhauer test which can detect fetomaternal haemorrhage
WEB168137(2024)	• Review of IOL guideline in view of fetal monitoring in high-risk pregnancy and management of prostaglandin, completed October, QI project to implement changes planned by the consultant midwife and clinical team

Developing and sustaining a culture of safety, learning and support

East Sussex Healthcare NHS Trust

Maternity Incentive Scheme (MIS)

YEAR 7:
- Full MIS year 7 document and accompanying resources published 02/04/25
- No key risks identified against compliance for MIS year 7 to date

Year 6 Fully compliant against all 10 safety actions
Maternity Incentive Scheme year 6 results have been published and can be accessed on their website

Year 7 Safety Actions	
SA1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?
SA2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
SA3	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?
SA4	Can you demonstrate an effective system of clinical workforce planning to the required standard? a) Obstetric medical workforce b) Anaesthetic medical workforce c) Neonatal medical workforce d) Neonatal nursing workforce
SA5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?
SA6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?
SA7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.
SA8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
SA9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?
SA10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Standards and Structures that underpin safer, more personalised and more equitable care

East Sussex Healthcare NHS Trust

MatNeo Claims, Complaints, Incident Scorecard

Provides volume value and cause of claims over 10 years
April 2014- March 2024 = 52 claims made to value of £73,269,202

0 closed claims during Q1, 3 closed complaints, 5 closed severity 3,4,5 incidents

Learning themes from closed claims, complaints & Severity 3,4 & 5 Incidents:
- Improve verbal communication between service users and staff, use of MDT for complex cases
- Improve written documentation, clear instruction documented within electronic records
- Ensure service users are advised regarding seeking and self –administration of pain relief
- Improved support in the unit and community surrounding infant feeding advice and support (included in mandatory training)

CQC Inspection action plan

Outstanding action is for mandatory training, to achieve 90% in areas listed within the report, June 2025 update:
- Appraisal: 86%
- Basic Life Support: 86%
- Blood Transfusion: 91%
- MCA: 95%
- Think Family L3: 93%

All other actions complete

Perinatal Mortality Review Tool (PMRT Q1)

- 100% compliant with all standards (MIS Yr7)
- 100% compliant for standard of 50% of the deaths reviewed, with an external member present at the multi-disciplinary review panel meeting

Key actions:
- Meeting to discuss parity of Intra Uterine transfers across Sussex with UH Sussex
- Carbon monoxide testing in place for all birthing people at booking
- Communication to staff regarding the importance of using Translation services including the sonography department (where it is clinically safe to do so)
- Embedding of the Asylum Seeker pathway progressing
- Further focus on managing reduced fetal movements (part of mandatory MDT training)

Demonstrating transitional care (TC) services quality improvement to minimise separation of parents and their babies
Good progress, reduction in Respiratory Distress Syndrome admissions (RDS).

Achievements and learning against the three-year delivery plan during Q1 2025/26

East Sussex Healthcare NHS Trust

Theme 1:

Work with Service Users to improve care (Coproduction)

- Purchased recliner chairs for partners – well received
- Co-production work with our Special Care Baby Unit – updated visiting process, meals for partners
- Work has commenced to improve our Early Pregnancy Unit

Theme 2:

Workforce: Sufficient staff across the whole MatNeo service (including trainees), who feel valued and supported; Local plans to reduce workforce Inequalities

- We are taking stock following events that led to an independent review during 2024, work continues to reset the culture within maternity services. The Leadership program continues, staff engagement sessions continue to truly understand concerns – to ensue management are hearing those issues and acting accordingly.

Theme 3

Developing and sustaining a culture of safety, learning and support

- Culture plays a crucial part in ensuring that ESHT develop and sustain our culture of safety, learning and support, as noted above, significant work continues to strengthen our overall governance and safety culture
- Celebration of improvements in 5 of 9 preterm optimisation interventions for a safer preterm birth.

Theme 4

Data Informing Learning

- Development of a Neuroinclusive Breastfeeding Clinic, the first in the country embeds neuro-affirming practice in supporting neurodivergent women and birthing people with breastfeeding. This has resulted in an increase in breastfeeding. Training has been developed for colleagues on how to adapt practice to support neurodivergent women, birthing people and families. This “Neurodivergent sensitive Maternity care” is being presented by the specialised midwife who spearheaded this innovation at the University of Brighton's Annual Midwifery Conference, and she has also been asked to contribute to midwifery textbooks on the topic.

Agenda Item: 12

Report To/Meeting	Trust Board	**Date of Meeting**	14th October 2025
Report Title:	Avoidability of Inpatient Deaths Q4		
Key question	To review a selection of deaths to ascertain whether there was any avoidability.		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐		
Report Sponsor:	Dr Simon Merritt Chief Medical Officer	**Presenter(s):**	Dr Simon Merritt Chief Medical Officer
Report Author:	Louise Holmes, Mortality and Learning from Deaths Programme Manager		
Outcome/Action requested:	All deaths in hospital are reviewed by our team of Medical Examiners and any cases requiring further scrutiny are highlighted to divisions and discussed at specialty Mortality and Morbidity meetings.		
Executive Summary	The current "Avoidability of Inpatient Deaths" report details the April 2017 – March 2025 deaths, recorded and reviewed on the mortality database. Learning disability deaths are subject to external review against the LeDeR (learning disability mortality review) programme. Trusts are now receiving feedback from these reviews, although the process is slow. We continue to review deaths of patients with learning disabilities internally due to the delays in the external process in order to mitigate any risk. There are two reasons as to why we are behind with regard to learning disability deaths; Firstly, we recently discovered that 15 cases dating back over 2 years had not been discussed, we have now discussed 9 of them. Four were found to have a learning difficulty rather than learning disability. The remaining two will be reviewed at the next meeting, if the LeDer report has been completed, but these have not been received yet., There is also a considerable time lag from death to external completion of the LeDeR report, without which we cannot proceed.		
Regulatory/legal requirement:	The reporting of "Learning from Deaths" to the Trust Board is a requirement in the Care Quality Commission review.		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☐		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	N/A		
Risk:	N/A		

No of Pages	3	Appendixes	1

Governance and Engagement pathway to date:	N/A
What happens next?	The Mortality Review Audit Group continues to review the deaths with a higher likelihood of avoidability, on a quarterly basis, to ensure accuracy in reporting. Deaths assessed as having an overall care rating of very poor, poor, or adequate, patient safety incidents severity 3 and above, complaints relating to bereavement, unexpected deaths, 'low risk' deaths, fatal hospital acquired thrombosis (HAT), concerns raised by Medical Examiners, Swarms, avoidable cardiac arrests and learning disability deaths are all reviewed for completeness. The Board are requested to note the report. "Avoidability of Inpatient Deaths" reports are presented on a quarterly basis
Publication	Published.

Avoidability of Inpatient Deaths Dashboard April 2017-March 2025 (Data as at 26/09/2025)

Department of Health

Organisation	**EAST SUSSEX HEALTHCARE TRUST**
Financial Year	**2024-25**
Month	**March**

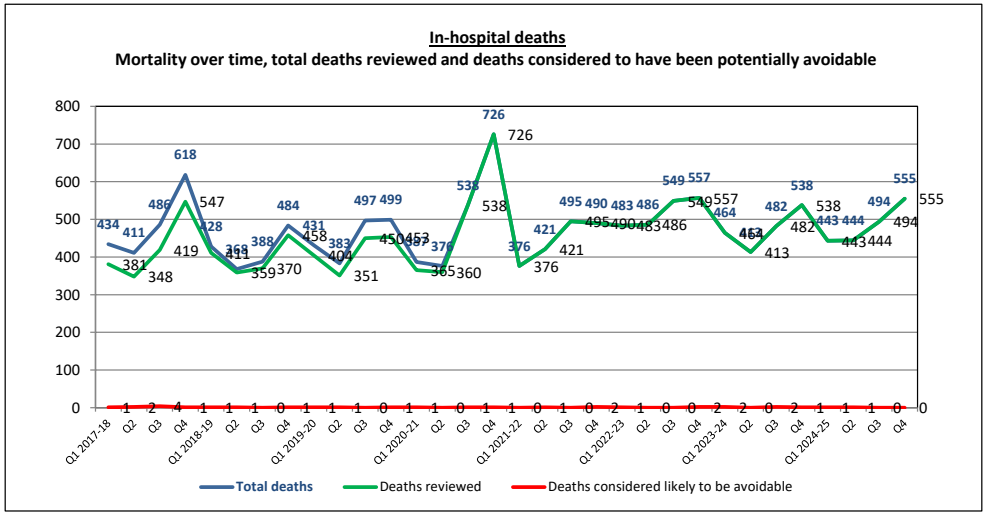
EAST SUSSEX HEALTHCARE TRUST: Avoidability of Inpatient Deaths Dashboard March 2024-25

Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 26/09/2025)

Time Series:	Start date	2017-18	Q1	End date	2024-25	Q4

Total number of deaths recorded in the mortality database - excluding Learning Disability		Total deaths reviewed by Medical Examiner		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
184	161	184	161	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
555	494	555	494	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1936	1897	1936	1897	2	5



Total deaths reviewed by RCP methodology score. Historically avoidability was recorded when the overall care was judged to be poor or very poor. From April 2023 all deaths reviewed and given an avoidability rating have been included.

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	10.0%	This Month	9	90.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	12.5%	This Quarter (QTD)	14	87.5%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	2	2.7%	This Year (YTD)	1	1.4%	This Year (YTD)	4	5.5%	This Year (YTD)	66	90.4%

Data above is as at 26/09/2025 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were two care concerns expressed to the Trust Bereavement team relating to Quarter 4 2024/25 deaths, neither were taken forward as complaints.
Complaints - Of the complaints closed during Quarter 4 2024/25 which related to to bereavement in hospital, most had an overall care rating of 'good care' and the remainder had an overall care rating of 'adequate care'.
There were three patients with an overall rating of 2, poor care. One has been reviewed at the Mortality Audit Review Group (MRAG)and was given an avoidability rating of 6 - definitely not avoidable.
Patient Safety Incidents - There were four severity 5 patient safety incidents raised in Q4 2024/2025 . One has already been discussed at MRAG and three are to be reviewed.
As at 29/09/2025 there are no September 2020 - March 2025 deaths outstanding for review on the Mortality database.

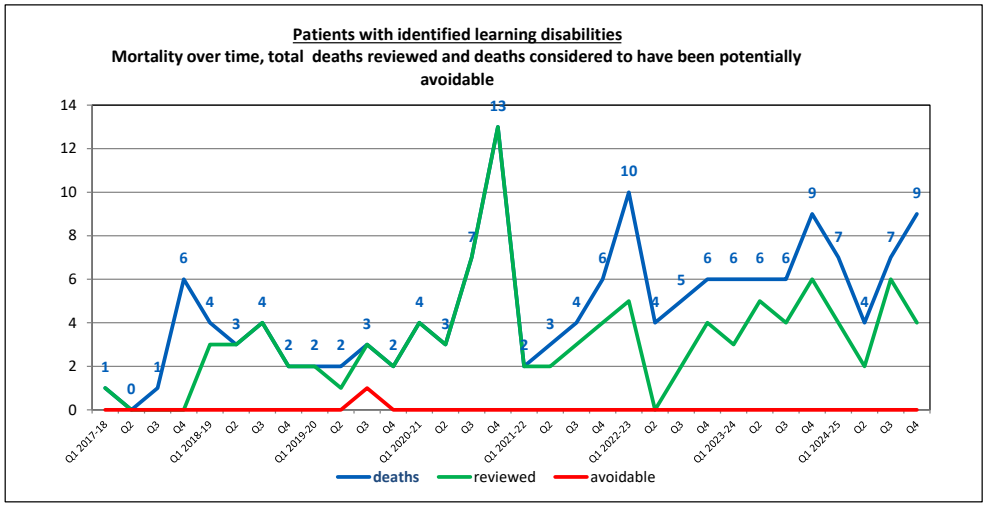
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 26/09/2025)

Total number of deaths, deaths reviewed and deaths deemed avoidable for patients with identified learning disabilities

Time Series:	Start date	2017-18	Q1

End date	2024-25	Q4

Total number of deaths recorded in the mortality database - Learning Disability		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
3	4	0	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
9	7	4	6	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
27	27	16	18	0	0



The LeDeR (learning disability mortality review) programme is now in place and the deaths of patients with a learning disability are being reviewed against the new criteria externally. Feedback from these external reviews is now being received by the Trust. There can be a significant delay in this process.
These deaths are also reviewed internally by the Acute Liaison Nurse for Learning Disabilities, who enters the review findings on the mortality database.

Agenda Item: 13

Report To/Meeting	Trust Board	**Date of Meeting**	14th October 2025
Report Title:	Update on Trust Strategy		
Key question	What progress is the Board making in the refreshing of the Trust Strategy?		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐		
Report Sponsor:	Jayne Black - CEO	**Presenter(s):**	Jayne Black - CEO
Report Author:	Simon Dowse – Director of Transformation, Strategy & Improvement		
Outcome/Action requested:	The Board is asked to note the work done to date		

Executive Summary

Now is the right time for the Trust to refresh its strategy:

- The NHS has a new 10 Year Plan that sets a new set of challenges
- Our 'Continuous Quality Improvement' journey requires a new vision and a clear articulation of the strategic priorities that will deliver it
- NHS England requires all providers to prepare a 5 Year Plan before the end of 2025/26
- Our previous Strategy expires next year

Refreshing our strategy begins with the Board setting a new Vision and the 'domains' that will drive us toward it.

The Board began the refresh process on 22nd July by reviewing our most critical challenges and aspirations over the next 5 years. In that review 5 themes emerged. These themes do not provide the final view; they begin the conversation.

We are now focused on how we engage and bring people with us as we finalise that Vision, we began that engagement with our colleagues first to understand what resonates with them and how they see our long-term priorities.

We engaged in several ways, acquiring hundreds of points of feedback Trust-wide, during August and September. We were helped in that process by our Staff Partnership Forum and our Networks.

The response from our staff has provided profoundly valuable feedback And we took the findings back to the Board for discussion on the 23rd September.

We are in the process of working through those findings and the Board's discussions, following which we will re-engage with colleagues with an outline 'Vision' and its priority domains.

	As we work through that, we will engage with the patients, public and our partners across the Sussex and East Sussex health and care system so we can analyse each Domain more precisely and finalise our Vision and strategic priorities. The refreshed Vision and Domains will then be central to our developing Continuous Quality Improvement system and our 5 Year Plan.
Regulatory/legal requirement:	The Trust Board is required to set the Organisation's Strategy
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI will be key principle in helping us test and implement our Strategy as it develops.
Resource Implication/VFM Statement:	The Trust's Strategy must, by definition, articulate how we expect to make the most effective use of our resources.
Risk:	None at this stage. Once the strategy is developed we will review the Board Assurance Framework and Corporate Risks with respect to the objectives it sets.

No of Pages	2	**Appendixes**	1

Governance and Engagement pathway to date:	An outline and summary of the work to date was discussed by the Board at the 23rd September Development Day
What happens next?	As set out in the paper – we refine our Vision and its 'domains' through ongoing engagement over the next 2 months.
Publication	It can be published – with the clear caveat that our strategy refresh is a work-in-progress

We are refreshing our Trust Strategy

East Sussex Healthcare NHS Trust

- We are in the process of refreshing our Trust Strategy
- To kick that process off, on the 22nd July the Board reviewed our ***key challenges and aspirations*** to help us think through our new **Vision** and the key areas of focus that will help us deliver it (what we call '**Domains**')
  - 5 themes emerged; and
  - The Board was clear that engaging our colleagues is the critical next step
- Therefore we have been engaging with our staff on the 5 themes since July
  - We've been to various meetings (Senior Leaders Seminar, Permanent Medical Staff, Staff Partnership Forum)
  - We made a video… which we shared with *everyone* on the intranet between and encouraged anyone to look and comment
  - The Staff Partnership Forum helped us engage, providing advice and feedback and the Networks helped in getting the video out there
- We want to thank everyone who fedback and helped - the process has involved several hundred staff so far

The Board developed 5 emerging themes

East Sussex Healthcare NHS Trust

- These were the ***INITIAL*** 5 themes that emerged. These are not the final answer – these were for discussion
- We asked our colleagues questions like - “Do these resonate?”, “Do you like or dislike the theme?”, “What is missing?”, “How would you describe this?” “Why?”

Unified/Integrated Care	Employer of Choice	Sustainability	Patient-led Improvement	Digital/AI for productivity
• Work across organisations, professions, services, wards, clinical areas • Share pathway responsibility • Share information	• How we lead • How we listen, communicate, learn • Make ESHT an easy place to do a good job • Empowering good decision making	• Getting efficient and productive – *in a sustainable way* • “Left-Shift” – meaning a more proactive, preventative and community based operating model • Hitting the financial plan	• Deeper understanding of what patients and the public value • Listen and learn together • Better communication	• Prioritising the right digitally enabled change • Ensuring we realise the benefits • Managing risk of new technology • Providing the Right infrastructure

We used the themes to engage with our staff

East Sussex Healthcare NHS Trust

- Overall the themes seemed to resonate well with colleagues. The feedback was very valuable and we now have work to do to refine the vision

Theme	Like	Dislike	Neither like nor dislike
Unified / Integrated Care	79%	14%	7%
Employer of Choice	59%	30%	11%
Sustainability	75%	17%	8%
Patient Led Improvement	72%	22%	6%
Digital/AI for Productivity	69%	25%	6%

Summary Messages

East Sussex Healthcare NHS Trust

In the feedback there was no sense that we are *missing* a domain as such - but we need to make them really clear, make sure that patients and people are central and recognise where we are now…

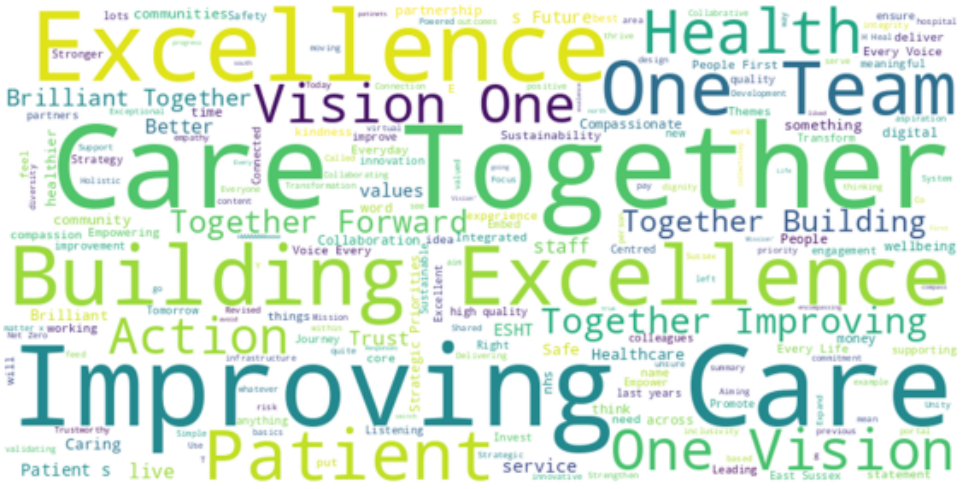
- ✓ People liked and understood '**integrated**' better than we expected (did not like 'unified')…see it as seamless, patient-centred care across all of acute, community, primary and social care
- ✓ Comfortable with **sustainability** *as long as* we are clear what we mean – not just finance, not just the environment, but also a sustainable workforce
- ✓ People liked **patient-led improvement *but*** prefer patient-*centred* and it's more about working together
- **Employer of Choice** – the phrase does not resonate *but* making ESHT a better place to work does. Workforce is a feature of *everything* though – so perhaps this is a central principle rather than a domain on its own
- **Digital/AI** – modernising digital capability is clearly critical to a successful, sustainable future *but* we have to focus on the right things for the right reasons… "AI may be fine, but we need to get the basics right first" was the message

We also got a clear steer to change our mission statement to frame the Vision

East Sussex Healthcare NHS Trust

Our Current statement is - “High Quality Care and Experience for our Colleagues and Communities”

The overall feedback was - Change this and keep it simple



Next Steps

East Sussex Healthcare NHS Trust

1. The feedback helped the Board make some clear decisions for the next iteration (*note – these slides are a very high-level summary, more detail informed the Board discussion*)
    - We will focus on three main Domains
    - "Digital" weaves into everything
    - Our people and our patients are not a domain, they are at the heart of this
    - We will not re-write a wordy mission statement – we will just have a simple, punchy, memorable name for our strategy that people will recognise and use
2. The key next step is to refine and propose a draft Vision and the priority domains and begin the next phase of engagement where we analyse each domain
    - Initially going back to our staff during October and November to help us examine each of the Domains in more detail
    - To support that we will also set up engagement sessions with patients and the public to understand their perspective and what they would value most

Agenda Item: 15

Report To/Meeting	Trust Board Meeting in Public	**Date of Meeting**	14th October 2025
Report Title:	Q2 2025/26 Board Assurance Framework		
Key question	The Board is asked to: 1. Review and note the position of the BAF risks assigned to it 2. Provide comment and share their views on the Risk Tolerance and Risk Appetite allocation		
Decision Action:	For approval ☒ For Assurance ☐ For Information ☐ For Discussion ☒		
Report Sponsor:	Richard Milner, Chief Of Staff	**Presenter(s):**	Richard Milner, Chief Of Staff
Report Authors:	Richard Milner, Chief Of Staff and Pete Palmer, Board Secretary		
Purpose/Outcome/Action requested:	The Board is asked to consider, discuss and note the report.		

Executive Summary

This report provides an overview of the risks on the BAF; these are overseen by the Finance and Performance Committee, People and Organisational Development Committee and Quality and Safety Committee. The Audit Committee maintains oversight of the entire BAF.

Committees were asked, in line with the request from the Trust Board meeting in public in August, to provide feedback about whether they feel that the Risk Tolerance and Risk Appetite for their risks remain correct. This feedback will be reflected in future updates of the BAF.

BAF 1 continues to be rated at 9, reflecting the buoyant recruitment market for ESHT which is driven in part by pressure in other parts of the health and care sector.

BAF 2's rating remains at 16 due to the significant challenges and changes that lie ahead for both the Trust and the wider NHS. It is recognised that the present NHS climate may contribute to a further decline in annual staff survey results for the Trust.

The rating for BAF 3 has increased to 20, reflecting the increased financial challenges faced by the organisation in 2025/26.

BAF 4 continues to be rated at 16 as even with an additional in-year capital award of £8.5m the criticality of infrastructure and estates risks means that the risk profile is unlikely to change during 2025/26 without significant additional financial support.

BAF 5 remains at 16 which is the limit of our risk tolerance. The primary aim for this risk during 2025/26 is to ensure that it does not exceed risk tolerance.

BAF 6 also remains at 16, the limit of our risk tolerance. Again, the primary aim for this risk during 2025/26 is to ensure that it does not exceed risk tolerance. The team will concentrate on progressing actions rated as amber and red over Q3.

	The rating for BAF 7 remains at 12 reflecting continued positivity about EPR implementation and the potential benefits that AI initiatives they might bring to the organisation. BAFs 8 and 9 continue to be rated at 16 for Q2 and remain at the limits of their tolerance; delivering improvements to both will require collaboration across the health and wider care sector.
Regulatory/legal requirement:	The Trust Board is required to have a Board Assurance Framework in place as it one of the key sources of evidence to support for the preparation of the Annual Governance Statement.
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration
Resource Implication/VFM Statement:	Outcomes focus: achieving the best sustainable outcomes for patients and service users by encouraging continuous improvement, clinical excellence and value for money
Risk:	Failure to monitor risks may result in the Trust not monitoring triggers which will prevent
No of Pages	2 **Appendixes** 1
Governance and Engagement pathway to date:	Each BAF risk has been reviewed by the Executive Risk Owner and the Chief of Staff. Collectively the full BAF is reviewed at Executive Directors and shared quarterly with the Audit Committee before going to the next scheduled Trust Board. Each Board sub-committee is expected to review the BAF risks it oversees four times a year. This typically takes place one month after the end of each FY quarter.
What happens next?	Comments from the Board received will be assessed and implemented accordingly. The Q3 BAF is due to be presented to the Trust Board in February.
Publication	This paper is appropriate for publication.

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Q2 Board Assurance Framework

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

Audit Committee, September 2025

2025/6 BAF: Overview of changes made and Q2 view on current and future risk profile

Changes made for 25/26 to the BAF

- As per papers to the May Board Development Day and the June Board, we have made several changes to the BAF this year designed to make it clearer, dynamic and more forward-looking
- We agreed a tighter set of BAF risks for this year (from 12 to 9, with three risks moving to the corporate risk register) and we have refocused the committees through which the BAF risks are assessed
- We have streamlined formatting to address readability issues and have included risk tolerance and appetite, replacing the YE 'target' risk. We believe that this will help colleagues to better understand our expectations and approach to each BAF risk
- We have been able to refresh the CRR so as to enable a draft allocation of CRR risks across the three main Board sub-committees and each one is being asked for its views

Summary of Q2 risks and forward look

- The Q2 assessment continues to reflect the significant risk in terms of quality, people and finance over the duration of 2025/26. Most BAF risks are at, or close to the limit of the risk tolerances set for this year – with one, BAF 3, now exceeding its risk tolerance
- There continues to be confidence going forward as regards BAF 1 (attracting, retaining and developing the right people) due to the buoyant recruitment market for ESHT, driven in part by pressure in other parts of the health and care sector
- BAF 2 reflects that the national mood music of significant changes ahead combined with the invocation of austerity is unlikely to support us as we seek to improve staff survey scores; it is also likely that there will be a negative impact of staff welfare, morale and engagement during the winter period
- The rating for BAF 3 (finance and delivery) has been increased from 15 in Q1 to 20 in Q2, reflecting the significant challenge of delivering savings schemes of around £80m in 2025/26. The rating will be reassessed once additional schemes have been worked up in November.
- BAF 4 notes that even with the additional in-year capital award of £8.5m, the criticality of the infrastructure and estate risks means that without significant financial support, the future risk profile is unlikely to shift before YE
- BAF 5 and 6 scores reflect the structural challenges we have faced in these areas – with both sitting at their tolerance levels. The primary aim this year in these two areas will be undoubtedly the prevention of exceeding their tolerances, rather than reducing the scores in year
- BAF 7 reflects the positive moves on EPR implementation, the increased activity around AI initiatives and the potential benefits these may together bring
- BAF risks 8 and 9 remain at the limits of their tolerance; delivery requires the collaborative and concerted efforts of the health and wider care sector, which are similarly stretched over the coming year

2025/6 BAF risk template: Aide memoire of formatting changes and their purpose

Risk Scoring

Inherent risk *If there were no mitigations*		Current risk level *Assessment based on evidence*				Rationale for current risk level *Evidence that provides assurance of current risk level*	Risk tolerance *Acceptable range/boundaries of risk score*	Risk appetite *Amount/type of risk accepted/taken*
		Q1	Q2	Q3	Q4		Score	*Single word description**
Likelihood	3							
Impact	5							
Risk level	15							

This is set at the beginning of the year and reflects the innate scale of risk. We would expect all of these to be high – because these are BAF risks and so their consequences/impact are de facto existential

This approach to monitoring remains unchanged from last year, and the scores should reflect the confidence/assurance that risk owners can take from the evidence they have seen (or not). In the event that the level is not moving and/or is outside the tolerance level, risk owners need to explain why in the next section (rationale)

This section is where the risk owner explains why the current score is what it is. We would expect reference in here to the evidence and any variation that has been seen in the last quarter

These two sections are new this year and replace the "target/anticipated" YE risk category from previous years. By using the tolerance and appetite approach it will be easier for Board members to understand a) whether the current level is a cause for concern (e.g. if it falls outside our tolerance level and so triggers extraordinary or additional actions) and/or our position toward the risk (e.g. are we prepared to innovate and so accept an open approach, or is this a risk where we will be conservative around the level/scale of risk that we accept

This is also new for this year and will help us share with the Board how we anticipate this risk evolving over the coming quarters – in response to the ask that we discuss the potential direction of the risks and any pre-emptive actions for consideration, rather than assessments being exclusively backward-looking

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

**As per the GGI categories used in our risk statement (June Board paper)*

2025/6 BAF: Q2 summary position

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

1. Risk Summary

Reference & title	BAF 1: Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time.			Fit with Trust corporate priorities					
Description	There is a risk that the available workforce does not meet the organisation's resource requirements in the short, medium and long term			LOS	Workforce	Income	Bus Case	Digital	
				✓	✓	✓			
Lead executive	Director of People	Lead Committee	People and Organisational Development	Date last reviewed	24/07/2025				
Corporate Risk(s) aligned	• Paediatric dietetic waiting times • Unchaperoned Ultrasound examinations • Pharmacy capacity	• 24/7 Blood Sciences service • District Nursing Capacity • NCEPOD Standards for ABO							

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	5
Impact	3
Risk level	15

Current risk level *Assessment based on evidence*				
	Q1	Q2	Q3	Q4
Likelihood	3	3		
Impact	3	3		
Risk level	9	9		

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

There are recognised national shortages of roles within some specialities. We have small pockets where we have higher risk, such as stroke and microbiology which are requiring short to medium term temporary workforce solutions. The Trust's vacancy level as of July 2025 was 3.8%.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Significant

Forward forecast of risk level

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

It is anticipated that the risk rating will remain as a 9 due to the buoyant recruitment market and planned apprenticeship pathways. We also have workforce reduction programmes where staff will be redeployed into vacant roles; nationally the NHS recruitment external market is subdued and NHS workforce reduction programmes are being undertaken nationwide.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- None identified

3. Providing assurance *Additional actions that can be undertaken to support mitigations*					
No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Continue with recruitment initiatives and international sourcing of candidates as required	CPO	August 2025	• Expanding agency recruitment initiatives to include retained recruitment; we now have live retained recruitment searches. • Initiated internal first recruitment which supports our present workforce to apply for promotion or try a different speciality • Applied for NHSE international recruitment for sonography • In conjunction with divisional leads reviewing alternative care pathways for hard to recruit areas • Agency cover approved to maintain clinical safety	Green
2	Local outreach initiatives	CPO	Nov 2025	• Campaign to increase volunteer numbers across the Trust in progress; recruitment campaign planned for October. • Formalised agreement for construction students for estates and facilities workforce pipeline • Apprenticeships developed for estates and facilities staff • Targeted campaigns with Eastbourne College to support candidate pipelines • Designing, in conjunction with Eastbourne College, placement opportunities for non-clinical placements • Plan for 20 short term placements for 2025/26 for hair and beauty and sports students	Amber
3	NHSE requires five-year workforce plan	CPO	Nov 2025	• Meetings scheduled to develop triangulated finance, activity and workforce plan • Due for Board sign off in November	Amber
4	Establish quarterly reviews of NHS grip and control measures	CPO	Oct 2025	• NHSE grip and control measures reviewed quarterly and reported to ELT	Amber

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy/procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Monthly reviews of vacancies together with vacancy/turnover rates • Review of nursing establishment six monthly as per Developing Workforce Safeguards • Workforce efficiency metrics and monitored • Regular meetings with Regional Post Graduate Deans for Acute and Primary care • Quarterly reviews in place to determine workforce planning requirements. • NHSE requires five-year workforce plan	• Vacancy control panel ToRs revised to incorporate all workforce requests • Workforce strategy aligned with workforce plans, strategic direction and other delivery plans and metrics reviewed by POD and Trust Board • Establish quarterly reviews of NHS grip and control measures • Wellbeing offering enhanced (includes Pastoral Fellows support) and reviewed by POD	• Triangulation of National Staff Friends and Family Test reports, reviewed by POD • ICB Quarterly Workforce meetings • Internal audit review reports on effectiveness of workforce policies and processes • NHS Staff Surveys and Pulse Surveys and benchmarking data

1. Risk Summary

Reference & title	BAF 2: Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.			Fit with Trust corporate priorities					
Description	There is a risk that any decline in staff motivation negatively impacts on our ability to deliver the required levels of activity to the standards we require.			LOS	Workforce	Income	Bus Case	Digital	
				✓	✓	✓			
Lead executive	Director of People	Lead Committee	People and Organisational Development		Date last reviewed	24/07/2025			
Corporate Risk(s) aligned	• Violence and Aggression in Intermediate Care • Impact of V&A on staff • Delivering and loading activities								

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	5
Impact	4
Risk level	20

Current risk level *Assessment based on evidence*			
Q1	Q2	Q3	Q4
4	4		
4	4		
16	16		

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

Multiple data sources such as staff surveys, Datix, Freedom to Speak Up Guardian feedback and sickness indicate a decrease in both engagement and morale within our workforce.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Cautious

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

Enhanced initiatives have been implemented to review and resolve key issues raised within the staff survey, such as feedback on Datix. The focus for the next quarter will be on improving engagement scores, but we recognise that staff engagement and morale may decline to the level of internal redeployment and organisational change that the Trust is undertaking. The impact may be greater over the winter period due to circulation of winter viral illness and seasonal rostering.

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

Gaps in existing controls or assurance

- None identified

3. Providing assurance *Additional actions that can be undertaken to support mitigations*					
No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Development of actions from the staff survey	DoP	Sept 2025	• Staff Survey Group has been established, focussing on feedback from Datix reporting and staff survey engagement. • The Violence and Aggression reduction group have revised the focus to four pillars: education, pathways, workforce and environment. • We have benchmarked ourselves on the national Violence, Prevention and Reduction (VPR) standards and we have increased our scores to 81% from 73% as a result.	Green
2	Winter wellness and seasonal vaccination plan	DoP	Oct 2025	• Winter wellness information booklet drafted for circulation to all staff in October • Seasonal flu vaccination programme to commence late September through flu clinics and peer vaccinations • Communication and engagement plan developed through Executive leaders and internal comms	Green
3	Trust Awards	DoP	Oct 2025	• Trust Awards planning in progress for event to be held on 14th October.	Amber
4	Measures to support staff in managing patients who present with Mental Health illness and issues	DoP	Q4 2025/ 26	• Mental Health Strategy • Comprehensive package of support for staff impacted by V&A – TriM- Psychological Support already in place and embedded • Specialist Training available including simulation training with IE and partnership with East Sussex College – Data from NHS Staff Survey and Trust security which identifies 'Hot Spots' and emerging trends – This will identify the need for focused support • Trauma informed approach – establishing a training package in Quarter 4 • Listening events with staff in identified areas planned for Quarter 4	Amber

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

1. Risk Summary

Reference & title	BAF 3: We fail to use our resources as efficiently as possible and do not improve services for patients.			Fit with Trust corporate priorities			
Description	The Trust has agreed a breakeven plan with detailed supporting schemes (both recurrent and non-recurrent) which will help move the organisation to become financially sustainable. NHS England has been clear that organisations need to live within their financial envelopes.			LOS	Workforce	Income	Bus Case	Digital
				✓	✓	✓	✓	✓
Lead executive	Chief Finance Officer	Lead Committee	Finance and Performance		Date last reviewed	23/07/2025		
Corporate Risk(s) aligned	• Audiology Sound Treated Rooms • Maternity Footprint	• Management at Capacity • Risk to provision of Specialist Pathology testing						

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	4
Impact	5
Risk level	20

Current risk level *Assessment based on evidence*			
Q1	Q2	Q3	Q4
3	4		
5	5		
15	20		

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

There are detailed plans by division and centrally which support the delivery of a balanced plan. Additional schemes have been identified to cover risks of non-delivery, cost and operational pressures. However, the total value of savings schemes is circa £80m, which is a significant challenge. The Trust needs to ensure that there is sufficient capacity and capability in order to deliver the plans. Steps have been taken to bring in additional expert transformation resource to enable the plans to succeed.

Progress on schemes is being monitored on a weekly basis. Monthly reports will be going to the Finance and Performance Committee.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Seek

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

We will probably remain at 20 until November due to the need for additional schemes being worked up. The risk level will be formally reassessed at this time.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Lack of clarity about business case approval.
- Lack of divisional influence in capital prioritisation.
- There are some skills gaps within the finance team which are being addressed.
- Service level reporting needs to be reintroduced.
- Non-pay review body to be established.

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

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Currently developing new Standard Operating Procedure (SOP) for business cases	CFO	Sept	• Due to report in September	Amber
2	Work being undertaken to increase divisional influence in capital prioritisation	CFO	Sept	• There are more conversations now happening with divisions on the use of capital.	Green
3	Non-payment review body to be established	CFO	Sept	• Different models are being investigated	Amber

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

1. Risk Summary

Reference & title	BAF 4: The Trust's aging estate and capital allowance limits the way in which services and equipment can be provided in a safe manner for patients and staff.			Fit with Trust corporate priorities					
Description	There is a risk that there may be unplanned outages in equipment, buildings and facilities not being available for clinical purposes			LOS	Workforce	Income	Bus Case	Digital	
				✓		✓	✓		
Lead executive	Chief Finance Officer	Lead Committee	Finance and Performance			Date last reviewed	23/07/2025		
Corporate Risk(s) aligned	• Fire Safety EDGH and Conquest • Failing clinical environments • Insufficient isolation space • Lack of capital	• Power loss to critical areas • Insufficient decant for deep cleaning • Maintenance Standards • Inadequate prep for major/critical incident		• Poor compliance with S&M requirements					

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	5
Impact	4
Risk level	20

Current risk level *Assessment based on evidence*			
Q1	Q2	Q3	Q4
4	4		
4	4		
16	16		

Rationale for current risk level

Evidence that provides assurance of current risk level

The Trust's capital budgets are insufficient to support the current EME medical equipment replacement priorities and is also insufficient to address the estates maintenance backlog.

A bid for capital funding for medical equipment and critical infrastructure risk (CIR) has been submitted to the ICS to help address 25/26 and 26/27. A report had been presented to ELT and ExCom to highlight the challenges in the next 5 years. We were awarded £8.55m of Critical Infrastructure Funding from NHSE/ICB which we will use the help in addressing elements of the Fire Compartmentation project, together with a start on some of the planning and design of the electrical infrastructure risks. We continue to work with Friends to support to address the equipment gap.

A report on estates backlog maintenance was submitted to the ELT and F&P Committee in May 2024; an update on medical equipment was presented to ELT in October and December 2024 and was then presented to the Executive Committee in January 2025. The delays to the New Hospital Programme (NHP) in the Trust to 2037 have led to a change of strategy to replace as opposed to repair as capital expenditure on infrastructure items is now a viable option.

Risk tolerance

Acceptable range/boundaries of risk score

No higher than 16

Risk appetite

Amount/type of risk accepted/taken

Seek

Forward forecast of risk level

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

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

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

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

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

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	ICS will undertake a medium-term financial plan	DEF	Q3	• Trust has been asked to provide a five-year capital plan to support the ICS' longer-term plan	A
2	Development of ten-year investment backlog programme	DEF	Q2	• Completed	G
3	External funding opportunities	DEF	As opportuni -ties arise	• The Trust will continue to bid for funding through ICS and national programmes as and when opportunities occur, supported by F&P and the Trust Board	A

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

1. Risk Summary

Reference & title	BAF 5: Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack.			Fit with Trust corporate priorities					
Description	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack			LOS	Workforce	Income	Bus Case	Digital	
						✓		✓	
Lead executive	Deputy CEO	Lead Committee	Finance and Performance		Date last reviewed	23/07/2025			
Corporate Risk(s) aligned	• Cyber attack • Unattached op systems vulnerability • Limited visibility / control over network	• Server vulnerable to cyber attack • Bereavement system overload with data • Legacy Radiology System							

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	5
Impact	4
Risk level	20

Current risk level *Assessment based on evidence*				
	Q1	Q2	Q3	Q4
Likelihood	4	4		
Impact	4	4		
Risk level	16	16		

Rationale for current risk level

Evidence that provides assurance of current risk level

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

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

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

Risk tolerance

Acceptable range/boundaries of risk score

16

Risk appetite

Amount/type of risk accepted/taken

Minimal

Forward forecast of risk level

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

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

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

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

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

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

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Cyber Assurance Framework	DCEO	June 26	• Internal CAF self-assessment completed which identifies gaps in compliance • Gaps have been used to create the cyber action plan • CAF action plan to be agreed with Regional teams • Refreshed cyber five-year strategy and awaiting approval	Amber
2	Medical devices with network connectivity asset list	DCEO	March 26	• Increased visibility across EDGH and risks identified • Further work required to enable greater visibility • Anticipate that full visibility will be delivered at EDGH by end of March 2026 • Conquest delivery anticipated in 2025/26	Amber
3	LAN Refresh EDGH	DCEO	March 26	• Migration of Edge network over the course of 2025/26 • Delayed due to winter pressures and fire compartmentalisation work	Green
4	LAN Refresh Conquest	DCEO	March 26	• Replace the Core Network and Fibre connections to the Edge Switches • Equipment delivered • Fibre network now installed and should be complete by end of March • Planning underway for Core cut over	Amber
5	Active directory migration	DCEO	Dec 26	• Migration of users and devices has started and is 20% complete • Migration of services during 2025	Amber
6	Windows 11 migration	DCEO	Oct 26	• Migration of client devices to latest supported operating system • Testing underway	Amber

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

1. Risk Summary

Reference & title	BAF 6: Failure to develop business intelligence limits insightful and timely analysis to support decisions.			Fit with Trust corporate priorities					
Description	It is likely there will continue to be delayed, inaccurate, or incomplete data analysis due to a failure to attract/recruit/develop business intelligence resource. The impact of this is significant/major, ultimately leading to poor decision-making or missed opportunities not meeting objectives and efficiency goals. Mitigating actions described will reducing the risk likelihood.			LOS	Workforce	Income	Bus Case	Digital	
				✓	✓	✓	✓	✓	
Lead executive	Deputy CEO	Lead Committee	Finance and Performance			Date last reviewed	23/07/2025		
Corporate Risk(s) aligned	• While there are no current risks on the Corporate Risk Register that align, there are risks on divisional risk registers that are linked to this strategic risk.								

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	4
Impact	4
Risk level	16

Current risk level *Assessment based on evidence*			
Q1	Q2	Q3	Q4
4	4		
4	4		
16	16		

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

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

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Seek

Forward forecast of risk level

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

Over 2025/26, the risk level is expected to reduce from significant (16) to high (9). The target risk score of 9 is dependent on recruitment of BI staff. Recruitment has been challenging, however, a new targeted drive is underway, benefiting from an increased candidate availability in the region due to the national changes in the structure of NHSE and ICS. Internal development is also progressing, with team members taking on expanded roles, enhancing resilience and capability. Key upcoming mitigations:

- Fill vacant BI posts by end of Q4 2025/26 to boost analysis capacity – third round of recruitment scheduled in September.
- Implement improved self-service BI reports by end of Q3 2025/26 to reduce routine demands and focus on strategic analytics – a BI platform hosting PowerBI dashboards has been implemented.
- Strengthen partner and consultancy support in Q2 and Q3 for expertise in key report development, data visualisation and advanced analytics.
- When the team is fully recruited, some team members will still require development - development completion will move the risk target score to moderate (6).
- Improvement on the reporting infrastructure (interdependency on Digital for data warehouse) will move the target risk score to low - this will not be achieved until Q1 2026/27.

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

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

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

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Enhance BI Structure and Investment	DCEO	Dec 25	Recruitment of BI staff has been challenging, but a new targeted drive is underway, benefiting from a tighter NHS job market and increased candidate availability. Internal promotions achieved, members taking on expanded roles, enhancing resilience and capability	Red

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

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

1. Risk Summary

Reference & title	BAF 7: Failure to transform digitally and deliver associated improvements to patient care.			Fit with Trust corporate priorities					
Description	Failure to transform digitally and deliver associated improvements to patient care and develop a digital culture			LOS	Workforce	Income	Bus Case	Digital	
				✓	✓	✓	✓	✓	
Lead executive	Deputy CEO	Lead Committee	Finance and Performance		Date last reviewed		23/07/2025		
Corporate Risk(s) aligned	• Bereavement / Mortality System • Integration of safety alerts								

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	4
Impact	4
Risk level	16

Current risk level *Assessment based on evidence*			
Q1	Q2	Q3	Q4
3	3		
4	4		
12	12		

Rationale for current risk level

Evidence that provides assurance of current risk level

change there is a dependency on investment and resources. However, currently the Trust is reliant on non-recurrent funding making it challenging to plan for large scale changes or recruit
to roles.

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

Risk tolerance *Acceptable range/boundaries of risk score*
No higher than 16
Risk appetite *Amount/type of risk accepted/taken*
Seek

Forward forecast of risk level

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

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

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Level of automation. Significant manual intervention impacts on the acceptance of change within the Trust
- We need a training plan to increase digital literacy and add digital into all job descriptions

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

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	EPR implementation	CMO	Tranche 1: July 26 Tranche 2: July 27	• A large number of posts being recruited to support implementation • Implementation started, initiation stage signed off • EmPoweR launch events complete • Familiarisation events started • Upgrade to 9.2.4 complete. SaaS migration underway – T1 go live mid Nov 25 • End date of implementation will be July 2027	Green
2	Digital transformation roadmap to support digital strategy	DCEO	Nov 25	• New Strategy signed off by ELT waiting on alignment of the Trust priorities • To be presented for approval to Trust Board at November's Board Development Day • Updated to reflect changes in 10 year plan	Green
3	Digital Literacy Assessment	DCEO	March 26	• Digital literacy assessment has started to be rolled out across clinical wards • Development of a plan to increase digital literacy • Developing links with education teams to embed digital literacy into workforce descriptions	Amber
4	Increase digital culture	DCEO	Ongoing	• Communications strategy and engagement • Multidisciplinary team working • Identifying a new Non-Executive Digital Champion • New CCIO in post • Digital is one of the five pillars in the Trust Strategy	Green

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

1. Risk Summary

Reference & title	BAF 8: Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that are discharge ready with an extended length of stay.			Fit with Trust corporate priorities					
Description	The Trust has large numbers of patients who do not need the specialist inpatient care provided by ESHT (discharge ready) resulting in a requirement for significant additional capacity and staffing. There is an impact on flow of patients and an increased risk of deconditioning and harms (both physical and mental health) due to the very extended length of stay of some of these patients. In addition, there is a negative impact on patient experience as a result.			LOS	Workforce	Income	Bus Case	Digital	
				✓	✓	✓			
Lead executive	COO/CNO/CMO	Lead Committee	Quality and Safety			Date last reviewed	24/07/2025		
Corporate Risk(s) aligned	• Risk of insufficient acute beds during winter								

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	5
Impact	4
Risk level	20

Current risk level *Assessment based on evidence*			
Q1	Q2	Q3	Q4
4	4		
4	4		
16	16		

Rationale for current risk level

Evidence that provides assurance of current risk level

Evidence on a daily basis of the impact of greater than 130 patients who are discharge ready and the impact that this has on flow and increasing risk to patients and staff.

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

In addition, it is necessary to pre-emptively place (board) additional patients on wards in corridors until a bed space is available.

Risk tolerance

Acceptable range/boundaries of risk score

No higher than 16

Risk appetite

Amount/type of risk accepted/taken

Cautious

Forward forecast of risk level

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

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

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance
• Lack of suitable physical space for surge capacity and boarding • Lack of space for additional equipment for surge capacity and boarding • Lack of Adult Social Care capacity • Lack of Nursing Home capacity • Accuracy and timeliness of data on NerveCentre • Lack of mental health beds resulting in stranded patients with Significant Mental Illness (SMI).

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

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Ensure clinical areas are staffed as safely as possible	COO/ CNO/ CMO	Q4	• Workforce pressures remain • Escalation processes and de-escalation processes in place • MH Outreach HoN now in post and recruitment and onboarding of rest of team underway • Agreement to invest in therapy resource for inpatients with recruitment well underway and all posts recruited to	Amber
2	Ensure that patients are placed as safely and appropriately as conditions permit	COO/ CNO/ CMO	Q4	• Escalation capacity and surge and boarding capacity utilised as appropriate	Amber
3	Ensure complex/high risk patients are assessed and flagged appropriately	COO/ CNO/ CMO	Q3	• Meetings to review and escalate patients with LOS in excess of 7,14 and 21 and 100 days under review • As required on a case-by-case basis, divisions escalate particularly complex patients	Amber
4	Need to roll out and embed process for capturing and reporting on the impact of deconditioning (harm reviews)	CNO/ CMO	Q2	• Harm review process being rolled out on wards with progress due to be regularly reported to IGM	Green

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Robust management of all capacity • Thrice daily reviews of staffing • Redeployment of staff as required • Safety huddles in all clinical areas • Real time bed state/information available • Monitoring of quality and safety KPIs • Daily capture and monitoring of escalation and supersurge capacity • System escalation calls to discuss the number of Super Surge patients being cared for at the Trust and the number of patients not meeting the criteria to reside • Regular escalation of patients awaiting a mental health bed	• Use of any additional specialist advice or support, including visits to ESHT and ESHT staff visiting other locations • Daily patient pathway review for all P1-P3 patients with system partners • Clear oversight and responsibility for operational delivery, and of quality and safety • Monitoring of patients admitted over establishment and their location in the Trust using NerveCentre • System wide discharge improvement workstream focussed on improving discharge processes and reducing length of stay in acute hospital and community hospital beds	• Scheduled meetings with CQC to discuss data, intelligence and KPIs • Challenge at Quality and Safety Committee and Trust Board • Provider assurance meetings and system clinical quality review meetings

1. Risk Summary

Reference & title	BAF 9: Failure to meet the four-hour clinical standard.			Fit with Trust corporate priorities					
Description	Due to ongoing challenges with patient flow (there remain around 130 patients with No Criteria to Reside), there is a risk that patients spend longer than they need to in the emergency department once they are clinically ready to proceed. This is due to a number of factors and also affects those patients who wait longer than they should to access the emergency department. There is evidence to suggest that patients who spend more than six hours in emergency departments are more likely to suffer harm.			LOS	Workforce	Income	Bus Case	Digital	
				✓	✓	✓			
Lead executive	COO/CNO/CMO	Lead Committee	Quality and Safety			Date last reviewed	24/07/2025		
Corporate Risk(s) aligned	• Risk of insufficient acute beds during winter								

2. Risk Scoring

Inherent risk *If there were no mitigations*	
Likelihood	5
Impact	4
Risk level	20

Current risk level *Assessment based on evidence*			
Q1	Q2	Q3	Q4
4	4		
4	4		
16	16		

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

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

The risk rating remains at 16 for Q2 due to ongoing challenges to sustain overall performance. Non-admitted performance has improved, but no sustained improvement has been seen in length of stay, or in the overall number of patients with no criteria to reside.

Risk tolerance
Acceptable range/boundaries of risk score

No higher than 16

Risk appetite
Amount/type of risk accepted/taken

Cautious

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

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

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- We do not have a mechanism for immediately decompressing emergency departments.
- We cannot immediately respond to significant surges in activity.
- It is not easy or possible to see ward level length of stay data; this is only available by speciality.
- Unsure that workforce plan matches increase in activity.

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

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Continue to invest in Home First and community capacity and transformation of the acute footprint, including ongoing rollout of intermediate care wards.	COO	Q4	• Work is underway; we have two ICW wards in place, one on each site • We are reducing our acute footprint and investing in community services	Green
2	Priority actions identified and include work regarding culture, education and roles and responsibilities. (SAFER and Reconditioning work)	CNO	Q2	• Programmes of work clear and work underway on pilot areas re SAFER and Reconditioning • Likely a requirement for programme management – now in place • Part of the length of stay programme of work • Forms part of a continual improvement programme	Amber
3	Still working on KPIs and dashboard to support work on Length of Stay and internal/external processes e.g. wait times for therapies, Adult Social Care and Mental Health.	COO/ CNO	Q2	• Length of stay programme refresh has been completed • Workstreams with clear priorities identified	Amber

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Live bed state provides accurate information regarding occupancy and available bedded capacity • Breach compliance assurance across divisions • Long length of stay reviews across divisions • Complex/high risk patient reviews escalated to CMO/CNO/COO	• Bed strategy programme reporting through Use of Resources, with programme of work to reduce LOS in addition to areas described above	• Internal Audit Reports • Healthwatch feedback following visits • Family and Friends survey feedback from ED patients • ICB and NHSE South East region oversight of four hour performance

We now have an updated BAF and significantly more focussed risk register

	POD – Frank Sims and CPO	F&P – Paresh Patel and CFO	Q&S – Amanda Fadero and CNO/CMO
BAF risks assigned to Board Sub-Ctees	1 Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time. 2 Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.	3 We fail to use our resources as efficiently as possible and do not improve services for patients. 4 The Trust's aging estate and capital allowance limits the way in which services and equipment can be provided in a safe manner for patients and staff. 5 Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack. 6 Failure to attract and develop business intelligence limits insightful and timely analysis to support decisions. 7 Failure to transform digitally and deliver associated improvements to patient care.	8 Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that are discharge ready with an extended length of stay 9 Failure to meet the four-hour clinical standard.
Associated CCR risks	**V&A in i/med care** (16) C Spokes **Rising delays for paed dietetic appts** (20) H Perry **District Nursing Capacity** (16) E Jones-Davies **Unchaperoned Ultrasound Exams** (16) K Howe-Bush **Pharmacy Capacity** (16) S Badcott **24/7 Blood Sciences Service** (16) M Thomas **NCEPOD standards for ABO** (16) N McNeillis Impact of V&A on Staff (16) J Fuller **Delivery and Loading Activities** (15) M Clements	**Failing clinical environments** (15) J Hinkley **Maintenance standards** (15) M Chewter **Fire safety compliance (CQ)** (16) M Chewter **Fascia debris falls** (15) M Chewter **Power loss to critical areas** (16) J Hinkley **Fire safety EDGH compartment'n** (20) M Chewter **Insufficient isolation space** (16) C Hodgson **Insufficient decant when deep cleaning** (16) C Hodgson **Poor compliance with S&M reqmts** (15) M Clements **Cyber attack** (15) S Crouch **Server vulnerable to cyber attack** (16) P Ouston **Unpatched op systs vulnerable** (16) R Kumar **Limited Visibility/ Control over Network** 16) R Kumar **Bereavement system overload with data** (16) N Turner **Inadequate prep major/crit incident** (16) L Blackwell **Lack of capital** (20) A Strevens **Audiology Sound Treated Rooms** (16) V Sharp **Specialist Pathology Testing** (16) C Hendon-Dunn	**Insufficient beds in Winter** (16) G East

Agenda Item: 16.1

Report To/Meeting	Trust Board	**Date of Meeting**	14th October 2025

Report Title:	Annual Equality Report 2024/2025
Key question	What does our workforce equality data for 2024/25 tell us about progress towards our EDI objectives and where we must focus further action?
Decision Action:	For approval ☒ For Assurance ☒ For Information ☐ For Discussion ☐

Report Sponsor:	Jenny Darwood, Director of People	**Presenter(s):**	Steve Aumayer, Deputy Chief Executive
Report Author	Sarah Feather, Equality, Diversity and Inclusion Lead - workforce		

Outcome/Action requested:	The Trust Board is asked to: 1. review and assure the content of the Annual Equality Report 2024/25; and 2. endorse the accompanying Equality, Diversity, and Inclusion (EDI) actions for 2025–2026.

Executive Summary	This Annual Equality Report summarises progress and challenges in advancing equality, diversity, and inclusion (EDI) across East Sussex Healthcare NHS Trust for the period 1 April 2024 to 31 March 2025. It presents findings from the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap, and equality indicators across all protected characteristics under the Equality Act 2010. The report evidences our compliance with statutory duties and our alignment to NHS England's High Impact Actions for EDI. It includes data insights from the 2024 NHS Staff Survey, Electronic Staff Record (ESR), TRAC recruitment data, and internal case management systems. Key findings are colour-coded using a RAG rating to highlight improvements, sustained progress, or areas needing urgent action. Significant progress includes: • Growth in ethnic minority representation (now 24.01%) and LGBTQIA+ visibility. • Reaccreditation as a Disability Confident Leader and Silver Defence Employer Recognition. • Launch of new staff networks including Neurodiversity and Faith & Belief. • Implementation of centralised reasonable adjustment processes. • Increased engagement with High Impact Actions and allyship initiatives.

	Ongoing challenges remain in addressing disparities in recruitment, promotion opportunities, bullying and harassment – particularly for disabled, multicultural, and LGBTQ+ colleagues. A refreshed set of EDI actions for 2025–26 has been developed in response to the findings. These will be monitored through the Workforce Equality meeting. The full Annual Equality Report 2024/2025 can be found as an appendix to the Board papers.
Regulatory/legal requirement:	The Equality Act 2010 (Specific Duties) Regulations require the Trust to publish annual information demonstrating compliance with the Public Sector Equality Duty. This includes WRES, WDES, gender pay gap and broader equality performance indicators.
Business Plan Link:	Quality ☐ People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	This report directly relates to EDI objectives and evidence compliance with national frameworks. It highlights EDI impacts across all protected characteristics.
Resource Implication/VFM Statement:	Included in budget. Workforce Equality work is delivered through the EDI team and embedded within existing systems and programmes. Some initiatives (e.g. AccessAble guides, training) may have future funding implications subject to prioritisation.
Risk:	Risks of non-compliance with the Equality Act 2010, NHS England standards, or internal cultural improvement plans. Failure to address workforce inequalities may lead to poor staff experience, recruitment/retention challenges, or reputational damage.

No of Pages	25	**Appendixes**	Appendix A: Annual Equality Report 2024/25 and action plan 2025/2026

Governance and Engagement pathway to date:	WRES/WDES reports submitted to NHS England – July 2025 POD Committee – August 2025 Workforce Equality meetings – August 2025
What happens next?	Following Board approval, the EDI actions will be integrated into workforce planning and monitored by the Workforce Equality Meeting and the People and Organisational Development Committee.
Publication	Can be published

Introduction/Background

This report is published annually to meet statutory requirements under the Equality Act 2010 and to provide transparency on the Trust's performance across workforce equality standards. It supports the Trust's strategic ambition to be an inclusive, equitable, and diverse employer.

Issues

The Annual Equality Report 2024/25 pulls together analysis from the Gender Pay Gap report, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and Equality Delivery System (EDS 2025). It also includes data and findings across other protected characteristics of age, religion or belief, sex, and sexual orientation, as well as Armed Forces and organisational inclusion.

Key measures within the report use a traffic light system to reflect progress, illustrated by a Red (R), Amber (A) or Green (G) rating:

- Green (G) indicates any gaps between groups that are within accepted thresholds.
- Amber (A) indicates work in progress or where differences are not yet fully addressed.
- Red (R) indicates a significant disparity or a decline beyond acceptable thresholds.

This summary highlights selected key indicators that were rated Red (R) in 2024/25:

WRES (page 7)

Indicator 2: Shortlisting to appointment

White applicants were 2.14 times more likely to be appointed from shortlisting than multicultural applicants – an increase from 1.39 the previous year. This falls outside NHS England's non-adverse likelihood range (0.8–1.25), highlighting a growing disparity in recruitment outcomes.

Indicator 7: Equal Opportunities for promotion

44.69% of multicultural colleagues felt the Trust provides equal opportunities for promotion, which is 5.82% lower than 2023 and 5.01% below the benchmark.

Indicator 8: Discrimination by manager/team Leader

16.53% of multicultural colleagues reported discrimination by their manager, compared to 7.91% of white colleagues – a significant difference of 8.62%.

The WRES action plan is reviewed quarterly by the Workforce Equality Meeting, with actions linked to NHS England's High Impact Actions (HIA) to improve fairness in recruitment, talent development, and culture.

Gender Pay Gap (page 12)

In 2024/25, women earned £0.95 for every £1.00 earned by men in median hourly wages — unchanged from last year. The mean hourly gender pay gap widened to 19.2%, and mean bonus gap stands at 22.1%. Women represent 67% of the highest paid roles overall but remain underrepresented in senior medical positions.

Agenda for Change pay bands now show a reversal of previous trends, with males earning slightly more than females in 2024/25. These findings indicate structural imbalances still exist, despite improvements in bonus award access for women.

Actions to address the gender pay gap follow national guidance and include monitoring bonus awards, encouraging shared parental leave uptake, all roles considered for part time working and supporting women into senior clinical roles.

WDES (page 17)

Indicator 4: Harassment and bullying

29.8% of disabled colleagues experienced harassment or abuse from patients or the public, compared to 23.4% of non-disabled colleagues. Additionally, disabled colleagues reported nearly double the rate of bullying by managers (15.72% vs. 8.77%).

Indicator 5: Equal opportunities for promotion

Only 47.73% of disabled colleagues felt they had equal opportunities for promotion — a 3.3% decrease from last year and 7% lower than non-disabled colleagues.

Indicator 3: Likelihood of entering formal capability process

Disabled colleagues were 1.22 times more likely to enter a formal capability process — a decline from the previous year and outside the equitable threshold by 0.02.

The WDES action plan is monitored quarterly, with additional focus this year on embedding the reasonable adjustments process, strengthening neurodiversity support, and reviewing management practices.

Bullying, Harassment and Discrimination (multiple sections)

Staff survey data continues to highlight disparities in bullying, harassment, and discrimination across multiple protected groups. Key findings include:

- Female, disabled, and LGBTQ+ colleagues report higher rates of bullying by patients and colleagues.
- Bisexual and “Other” sexual orientation groups experienced particularly high rates of discrimination from both colleagues and managers.
- Multicultural colleagues remain more likely to report experiencing discrimination from their managers or team leaders.

These findings are being addressed through a Trust-wide action plan led by the Bullying and Harassment Resolution Group and a Task and Finish Group. Interventions include listening events, leadership training, and an allyship programme launching in 2025/26.

Consequences for not taking action

Failure to act risks regulatory non-compliance, worsening staff experience, poor retention, and reputational harm. It would also compromise our commitments under the NHS People Promise and Equality Delivery System.

Conclusion

The Trust has made measurable progress across key equality areas. However, there is still significant work to do to achieve full inclusion for all colleagues. Sustained action and cultural change remain essential.

Agenda Item: 16.2

Report To/Meeting	Trust Board	**Date of Meeting**	14th October 2025

Report Title:	Organ Donation Annual Report 2024/2025
Key question	What progress has been made with organ donation policy, education and publicity to inform and support organ donation activity in the Trust during 2024/25?
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐

Report Sponsor:	Dr Simon Merritt, Chief Medical Officer	**Presenter(s):**	Dr Simon Merritt, Chief Medical Officer
Report Author	Dr Judith Highgate Clinical Lead for Organ Donation – outgoing June 25 Dr Sivanth Sivakumar Clinical Lead for Organ Donation – incoming June 25		

Outcome/Action requested:	The Trust Board is asked to: 1. note that the Organ Donation Committee will continue to oversee policy, education, and publicity to inform and support organ and tissue donation activity within East Sussex Healthcare NHS Trust. 2. support the organ donation committee to increase awareness of tissue donation across ESHT; 3. support with appropriate trust communications and social media content during national and local events; and 4. support the organ donation committee in the installation of a memorial bench at Eastbourne District General Hospital, in line with the bench already in place by the lake at Conquest Hospital.
Executive Summary	**Actual & Potential Donors:** Within ESHT, between 1st April 2024 & 31st March 2025, there were ten families who consented to donation. Eight patients proceeded as solid organ donors leading to 17 patients receiving transplants. In addition, eight patients proceeded as tissue donors with 12 corneas donated within the trust and three patients donating heart valves. The trust has again achieved 100% referral rates for donation after brainstem death and maintained the improvements seen in referral rates for donation after circulatory death achieved over the last two years with rates of referral increasing from 91% to 96%. Specialist nurse presence when approaching families to discuss donation is deemed to represent best practice. Previously this was identified as an area for improvement by the organ donation

committee and this work has now resulted in 100% specialist nurse presence for family discussions in the report period.

Consent to donation is a very personal decision for patients and their families. The consent rates of families at ESHT remain above the national average with 69% of families approached consenting to donation.

Funding:
Since 2018, trusts have received financial support from NHS blood & transplant in three ways:

1. Donor recognition funding: which is based on the number of proceeding donors in the previous financial year and is intended to support future donation activity,
2. Funding for the clinical lead position: to provide clinical leadership for donation, &
3. Clinical Lead & Organ donation committee expenses.

Donor recognition funding is allocated nationally and in recent years has not been allocated to trusts until late in the financial year. In 2024/25 ESHT received £4902.14 of donor recognition funding in November 2024. The funding was in part used to purchase refreshments for a memorial gathering at the organ donation bench at Conquest Hospital to mark the end of the organ donation week and also additional promotional material to raise awareness of organ donation locally. The Organ Donation Committee has been looking at options to utilise this money to support relatives and staff in other departments including in mortuary viewing rooms, emergency departments and also supporting staff training in advanced communications.

Organ Donation Week:
To mark the end of organ donation week in September 2024, the Organ Donation Committee arranged a non-denominational service of remembrance which was held at the remembrance bench at Conquest Hospital, with the families of local donors invited to attend. This was followed by refreshments in the atrium of the education centre.

It remains the intention of the organ donation committee to install a similar memorial bench at Eastbourne District General Hospital so that relatives of donors and recipients can have a location to reflect on their loved ones lives.

Research:
ESHT is enrolled as a research site for SIGNET – a national research study with the aim to examine the effect of a single dose of simvastatin given to consented, proceeding donors following neurological death on the outcome in cardiac recipients. This work is supported by the National Institute for Health Research. The study opened in 2022 and ESHT has enrolled three patients recruited at ESHT between April 24- March 25. The study was due to close in September but has been extended for the current time.

	The full Organ Donation Annual Report 2024/2025 can be found as an appendix to the Board papers.
Regulatory/legal requirement:	This report complies with Memorandum of Understanding between the trust & NHS Blood & Transplant Special Health Authority.
Business Plan Link:	Quality ☒ People ☒ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration
Resource Implication/VFM Statement:	Funding to support Organ Donation within ESHT provided directly from NHS Blood & Transplant. In the report year ESHT received £4902.14 for donor recognition funding. The role of Clinical Lead for Organ Donation is also externally funded from NHS Blood & Transplant.
Risk:	None identified

No of Pages	3	**Appendixes**	1

Governance and Engagement pathway to date:	Organ Donation Committee Clinical Excellence Group Quality & Safety Committee
What happens next?	The Organ Donation Committee will continue to oversee policy, education and publicity to inform and support organ and tissue donation activity within ESHT and East Sussex.
Publication	Can be published

Agenda Item: 17

Report To/Meeting	Trust Board	**Date of Meeting**	14th October 2025
Report Title:	Use of Trust Seal		
Key question	Has the Trust Seal been used since the last Trust Board meeting?		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐		
Report Sponsor:	Andrew Strevens, Chief Finance Officer	**Presenter(s):**	Steve Phoenix, Trust Chair
Report Author:	Pete Palmer, Board Secretary		
Outcome/Action requested:	The Board is asked to noted the use of the Trust Seal.		
Executive Summary	The Trust Seal has been used to seal one document since the last Board meeting in public: **Sealing 124** Agreement with Marcon Construction Ltd for Cardiology redevelopment at EDGH.		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☐ People ☐ Sustainability ☐		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	1	**Appendixes**	None
Governance and Engagement pathway to date:	Not applicable		
What happens next?	Not applicable		
Publication	Report is for publication		

East Sussex Healthcare NHS Trust

Annual Equality Report 2024/2025

KINDNESS INCLUSIVITY INTEGRITY

If you would like this report in another format (e.g. large print) please contact esht.workforceinclusion@nhs.net

CONTENTS

FOREWORD

Welcome to the East Sussex Healthcare NHS Trust (ESHT) Annual Equality Report for 2024-25. This document serves as a comprehensive review of our ongoing commitment and progress towards fostering equality, diversity, and inclusion within our Trust and covers the period between April 2024-March 2025.

Throughout the past year, we have strived to create an environment where all colleagues and patients feel valued, respected, and supported. This report provides detailed information on our Ethnicity, Disability and Gender Pay Gap analysis, Workforce Equality Standards, and the steps we have taken in alignment with the NHS England Equality, Diversity, and Inclusion High Impact Actions (HIA). Additionally, it highlights our broader efforts to promote inclusivity across our organisation.

We recognise that true equality goes beyond mere compliance with standards and regulations. It requires continuous reflection, learning, and action to address the diverse needs of our workforce and the communities we serve. This report not only documents our achievements but also identifies areas where further progress is needed, ensuring transparency and accountability.

As an organisation, we are committed to embedding equality, diversity, and inclusion into every aspect of our operations. We believe that a diverse and inclusive workforce enhances our ability to deliver high-quality care and improves the overall experience for our patients.

Patient information is published separately to maintain confidentiality and focus on workforce-related matters within this report. We encourage all stakeholders, including colleagues, patients, and community partners, to engage with this report and support our ongoing efforts to build a fairer and more inclusive healthcare system.

Thank you for your interest in our equality journey. Together, we can make a meaningful difference.

FIG. 1 NHS England High Impact Actions (summarised)

SUMMARY

Below is a summary of the key findings against each area of the ESHT's equality, diversity and inclusion (EDI) programme:

RACE (page 7)

i. Increased Representation and Decreased Appointment Likelihood: Multicultural colleagues make up 24.01% of the workforce, with Board representation 14.29%. White applicants are 2.14 times more likely to be appointed from shortlisting compared to multicultural applicants, showing decline from the previous year.

ii. Training and Disciplinary Processes**:** White people are less likely to access non-mandatory training compared to multicultural colleagues. Multicultural individuals were 0.84 times less likely than white individuals to enter the formal disciplinary process

iii. Harassment and Discrimination**:** 31.35% of multicultural colleagues reported experiencing harassment from patients, and 27.25% from colleagues. Additionally, 16.53% experienced discrimination at work from their manager, which is higher than their white counterparts.

iv. Promotion Opportunities and Board Representation: 44.69% of multicultural colleagues believe the Trust provides equal opportunities for promotion, which is lower than the 55.37% reported by white staff.

v. The Board's composition includes 85.71% white and 14.29% multicultural colleagues, indicating a -9.72% difference in multicultural representation compared to the overall workforce.

RELIGION AND BELIEF (page 11)

vi. Increased Disclosure: The proportion of colleagues sharing their beliefs grew to 79%, a 2.1% increase over the past 12 months. However, 21% of colleagues still choose not to disclose their religion.

vii. Faith and Belief Network Growth: The Faith and Belief Network has increased membership to 61. The network has been involved in creating a larger multifaith room at Conquest and hosting events like the Hastings and Rother Multifaith Forum.

viii. Harassment and Discrimination: There has been a decrease in reported incidents of bullying and harassment from patients or their carers among Christians, Muslims and 'Other' Religions however Jewish and Buddhist have experienced an increase.

ix. Career Progression Opportunities: On average, 51.4% of colleagues felt ESHT provides fair treatment in promotions. By religion, the group with the lowest proportion was those who preferred not to disclose their preference, at 38.65%, which is an increase of 3.49% over the past 12 months. Christian, Buddhist, Hindu and Muslim colleagues reported a decrease in opportunity falling to 52.57%, 44.12%, 55.88% and 51.43% respectively.

SEX (page 11)

x. Workforce Distribution: The workforce is 75.2% female and 24.8% male, with a slight increase of 1% in male employees over the past year. Representation data for Trans or non-binary individuals remains unavailable.

xi. Bullying and Discrimination: Female employees were more likely than males to report instances of bullying from patients or discrimination from colleagues. Both genders experienced an increase in reports of discrimination from patients, however this affected females more significantly. Individuals identifying as 'prefer not to say' reported the highest incidence at 34.6%.

xii. Gender Pay Gap: Women earned £0.95 for every £1 earned by men in median hourly wages, the same as last year. However, women's mean hourly pay is 19.2% lower than men's. Women occupy 67% of the highest-paid positions but have lower representation in medical and dental roles (43%).

xiii. Bonus Pay Gap: Women earn £0.93 for every £1 that men earn in terms of median bonus pay, indicating a gender pay gap of 6.9%. The percentage of female staff receiving bonus payments in 2024-2025 increased by 0.9% to 23%.

SEXUAL ORIENTATION (page 16)

xiv. LGB Representation: 4.6% of the workforce identify themselves as lesbian, gay or bisexual marking a 0.4% increase from the previous year. AfC employees at band 1-4 showed a higher likelihood of identifying as LGB compared to other bands.

xv. Discrimination and Harassment: Colleagues identifying as 'other' witnessed the highest level of bulling and harassment from patients and colleagues. All sexual orientations, apart from bisexuals, saw a reduction in discrimination from managers.

xvi. Career Progression: On average, 53.3% of LGB colleagues reported that ESHT acts fairly with promotions, in line with the benchmark group. The group with the lowest proportion were colleagues reporting 'Other' as their sexual orientation at 25%; 38.1% behind the highest score 63.1% colleagues sharing that they were bisexual

xvii. Inclusivity Initiatives: Key initiatives include the growth of the LGBTQ+ network, participation in Hastings Pride and Eastbourne Pride, partnership with local community organisations for awareness raising, and increasing opportunities for colleagues to socialise and build supportive connections.

DISABILITY (page 15)

xviii. Disability Representation: 7.1% of the workforce shared that they identify as disabled on their electronic staff record, with 12.07% choosing not to share their disability status. This represents a 3.03% increase in disclosed disabilities over the past 12 months.

xix. Appointment Likelihood: People with disabilities were 0.04 times less likely to be appointed from shortlisting than non-disabled individuals. This result is within the equitable range as per NHS England guidance.

xx. Harassment and Bullying: 29.8% of disabled colleagues reported experiencing harassment, bullying, or abuse from patients, relatives, or the public, which is a decrease of 4.2% from the previous year. However, 15.2% reported harassment from managers, nearly double that of non-disabled colleagues.

xxi. Workplace Adjustments and Promotion: 78.66% of disabled colleagues felt that ESHT made adequate adjustments to enable them to work, an increase of 4.55% from the previous year. 47.73% of disabled colleagues felt ESHT provided equal opportunities for promotion, which is a 3.3% decline from 2023/24.

AGE (page 17)

xxi. Workforce Distribution and Aging Workforce: A significant portion of the workforce (one quarter) is aged 45-55 years old. The age distribution across other groups has remained stable over the past year.

xxii. Career Progression and Young Workforce Satisfaction: The 16-20 and 21-30 year age groups provided the highest positive responses regarding ESHT's fairness in career progression with rates of 65% and 57% respectively. Both of these scores are a decline in comparison with 2023/24. The lowest score was recorded by the 51-65 year age group at 51%.

Equality Delivery System (EDS) (page 19)

xxii. Providing the position of ESHT in relation to demonstrating implementation of the EDS 2025.

ORGANISATIONAL INCLUSION (page 20)

xxiii. In addition to the progress highlighted in each section, across 2024-25 ESHT continued certain trust-wide initiatives to advance equality of opportunity, eliminate discrimination and foster good relations.

Conclusion

xxiv. The findings indicate areas of progress, particularly increasing representation, with some barriers to inclusion still requiring action. The findings also indicate pockets of negative experiences for some colleagues; a focus for the 12 months ahead.

xxv. We continue to align our work to the NHSE high impact actions (HIA) on equality, diversity and inclusion.

xxvi. Across 2024-25 we will increase support for colleagues to promote inclusive leadership, to highlight and remove cultural barriers to inclusion.

xxvii. The end goal remains thriving and culturally competent colleagues providing inclusive care to promote positive health outcomes and tackle health inequalities.

INTRODUCTION

Welcome to our annual equality report 2024-25

This report demonstrates what we have achieved and where we need to continue progressing towards equality in our mission of providing safe, compassionate and high-quality community and hospital care.

Our equality, diversity and inclusion (EDI) programme delivers our people plan commitment for thriving colleagues to be inclusive, diverse and fair, and supports our other strategies, particularly on patient and carer experience and involvement.

The report is made up of eight sections that reflect our aspirations across: age, disability, gender, race, religion and belief, sex and sexual orientation, and organisational inclusion.

- Each section begins with our key achievements to advance equality, including fostering good relations.
- There are then key findings including measures of workforce equality, in particular representation and recruitment rates
- There are measures of our work to eliminate discrimination, including harassment.
- Each section then ends with next steps to address the findings that underpin the 2024/26 equality, diversity and inclusion action plans and links to the NHS England high impact actions for equality, diversity and inclusion.

Key measures include a traffic light system of progress, illustrated by either a red (**R**), an amber (**A**) or a green (**G**) rating.

Green indicates any gaps between groups which are within accepted thresholds, and do not indicate concerns. Amber indicates work in progress and red indicates a decline beyond acceptable thresholds.

The data is taken from electronic staff records, employee relations case-trackers, staff surveys, pay gap reports and our WRES and WDES findings. Patient data is reported separately.

This report evidences compliance with our specific equality duty (Equality Act 2010), our duty to publish gender pay gap information (*on page 11*) and our obligations to publish information relating to the workforce race equality standard (WRES; on page 7) and the workforce disability equality standard (WDES; on page 15).

It also provides the progress on our Equality, Diversity and Inclusion objectives 2025-2026. Organisational objectives for EDI will need to be developed in 2026 as part of the public sector equality duty.

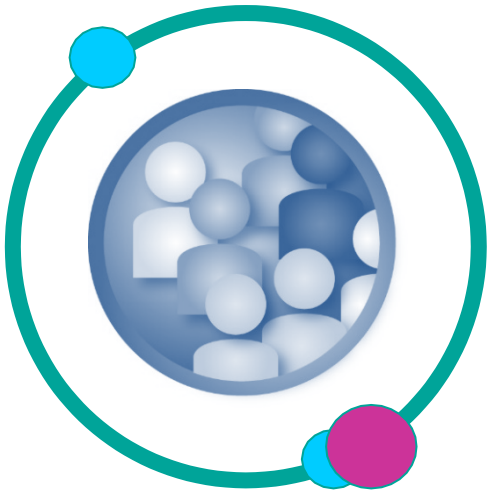
RACE

The proportion of our multicultural colleagues grew by 6.5% over four years across ESHT. In 2024, multicultural colleagues represented 24.01% of the workforce.

Multicultural individuals were 0.84 times less likely than white individuals to enter the formal disciplinary process. However, bullying and harassment remains a key area for improvement with multicultural colleagues being disproportionately affected.

1.1. Across 2024-25 ESHT's Multicultural Network brought people together from different backgrounds committed to valuing individuality, supporting inclusion and promoting diversity. Key achievements include:

- Successful appointment of Network chair and Vice Chair of the Multicultural Network.
- ESHT conducted listening events following publication of Too Hot to Handle Report to address bullying and harassment disparities.
- The multicultural network membership grew to 173.



KEY FINDINGS: RACE

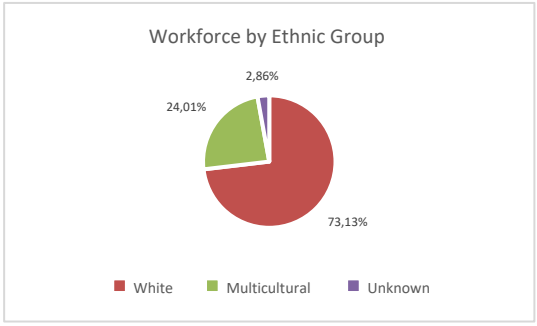
Workforce ethnicity representation (WRES 1)

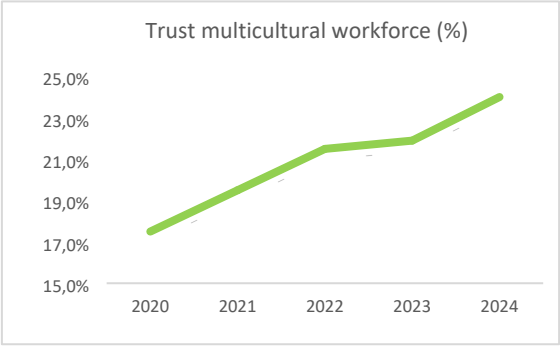
1.2. The number of multicultural people in the workforce as of 31st March 2025 was 2099, or 24.01% of the workforce overall. The Trust's multicultural workforce has grown by over 6.5% over the past four years.

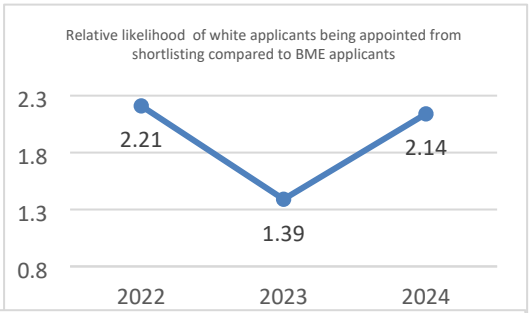
1.3. Multicultural representation in Medical and dental colleagues was 55.69% (n.470). Clinical staff was 26.9% (n. 1426). Clinical Staff on Agenda for Change (AfC) pay band 5 had the largest proportion of multicultural colleagues in any AfC pay band at 51.24% (n.639), followed by band 6 at 23.86% (n.293), then band 3 at 22.77% (n.314).

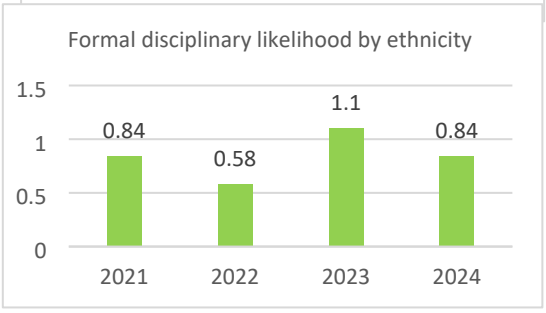
1.4. Multicultural representation in non-clinical workforce was 7.8% (n.203). The largest representation of multicultural colleagues was AfC band 8d at 30% (n.3).

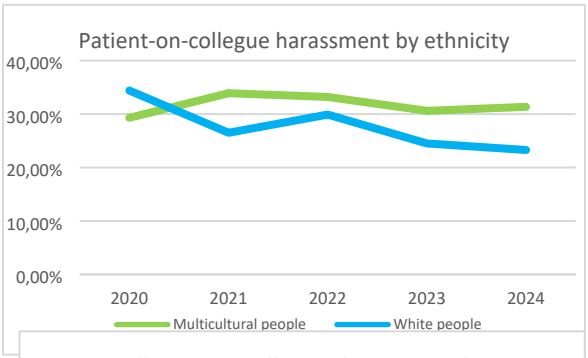
1.5. Non-clinical AfC 8c-9 and very senior managers (VSMs) is made up of 86.7% White British, and 13.3% people from multicultural backgrounds.

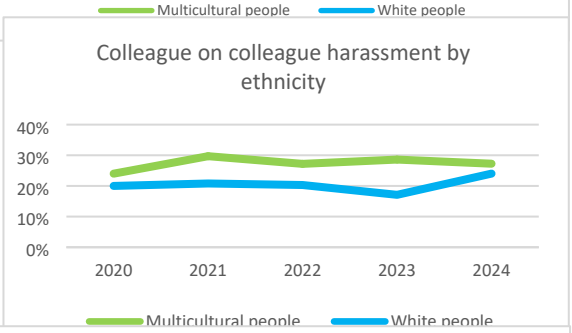


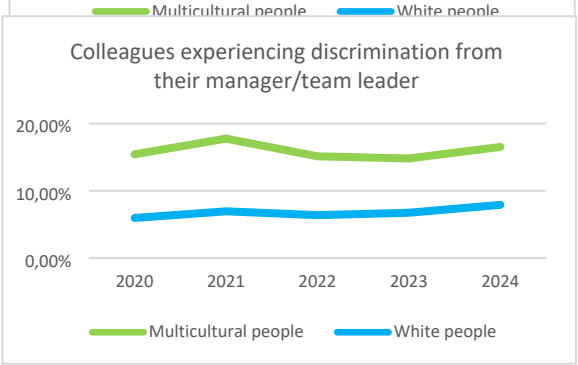












Ethnicity shortlisting-to-appointment likelihood (WRES 2)

1.6. In 2024-25, 278 individuals from a multicultural background and 709 white individuals were appointed. White applicants were 2.14 times more likely to be appointed from shortlisting compared to those from a multicultural background. This represents a negative trend from the previous year, when white individuals were 1.39 times more likely to be appointed.

Formal disciplinary likelihood by ethnicity (WRES 3)

1.7. Multicultural individuals were 0.84 times less likely than white individuals to enter the formal disciplinary process. Whilst the ratio score of 0.84 is below 1, it is within the non-adverse likelihood range set by the NHS WRES strategy team. In 2024-25, 1.12% (n.98) of the total workforce underwent the formal disciplinary process.

Non-mandatory training (WRES 4)

1.8. White people were 0.86 times less likely to access non-mandatory training and development compared to multicultural people.

Harassment, bullying or abuse by ethnicity (WRES 5-6)

1.9. In the past 12 months, 31.35 % of multicultural colleagues reported experiencing harassment, bullying, or abuse from patients, relatives, or the public, marking an increase of 0.75% from 2023 and. ESHT's figure is 3.08% higher than the provider benchmark of 28.27% and is 4.75% higher than ESHT's target of 26.5%.

1.10. In the past 12 months, 27.25% of multicultural colleagues experienced harassment, bullying, or abuse from other colleagues, which is 1.35% lower than 2023 and akin to 2022 levels. ESHT remains higher than the provider benchmark by 2.27% above ESHT's target of reducing this to 25.9% over two years. Addressing this issue will remain a priority for ESHT.

Racial equality of opportunity for promotions (WRES 7)

1.11. 44.69% of multicultural colleagues reported that the Trust provides equal opportunities for promotion, showing a negative trend with a decrease of 5.82% from 2023. ESHT sits below benchmark average by 5.01%.

Manager on Staff discrimination by ethnicity (WRES 8)

1.12. In 2024, 16.53% of multicultural colleagues experienced discrimination at work from their manager or team leader. This represents an 8.62 % difference compared to the 7.91% of white colleagues reporting the same experience. ESHT figures are slightly above benchmark average at 15.72%.

Board ethnicity membership (WRES 9)

1.13. The Board, including voting and executive members, was composed of 85.71% white and 14.29% multicultural. This is an increase in multicultural representation of 0.84% over the past 12 months. There is a 7.72% difference between multicultural representation in the overall workforce and on the Board which is an improvement on 2023 figure of 15.2%.

NEXT STEPS FOR RACE EQUALITY 2024-26

- Review and strengthen procedures for reporting and addressing discrimination and harassment as informed by the listening events.
- Celebrate the contribution of ethnic minority staff to the experience of patients at ESHT.
- Implement mentorship and sponsorship programmes to support career progression for multicultural staff.
- Host Sussex System Blask History Month Conference
- Regular review of recruitment processes to ensure they are fair and inclusive.
- Implement Trust wide allyship programme.

RELIGION AND BELIEF

The proportion of colleagues (79%) sharing their beliefs has grown by 2.1% over the past 2 years.

There has been a decrease in reported incidents of bullying and harassment from patients or their carers among Christians, Muslims and Other Religions however Jewish and Buddhist have experienced an increase.

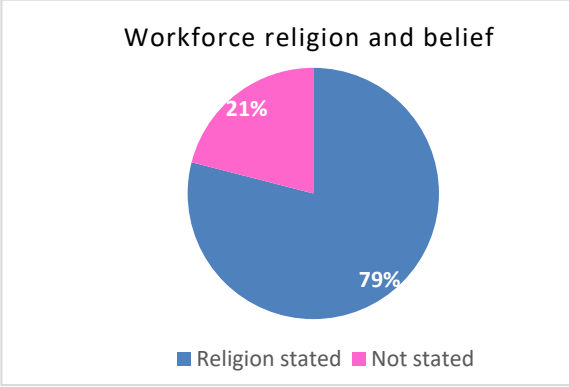
2.1. ESHT's Faith and Belief Network doubled in size over the last 12 months. Key achievements included:

- Creating a new, larger multifaith room at Conquest Hospital.
- Providing support for Ramadan celebrations.
- Hosting the Hastings and Rother Multifaith Forum, featuring an evening talk on healthcare and faith.

KEY FINDINGS: RELIGION AND BELIEF

Workforce religion and belief representation G

2.2. The number of people sharing their religion or belief with the Trust at 31 March 2025 was 79% of the workforce. Colleagues in agenda for change (AfC) pay band 5 and 6 had the largest proportion sharing their religious status at 82.2%. Over 12 months the proportion of colleagues sharing their belief information increased by 2.1%, a positive trend over the last two years.

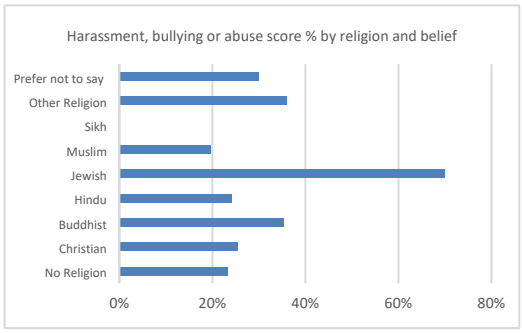


2.3. Colleagues sharing, they were Christian was the largest belief group at 45%, followed by the not stated group at 21% and then followed by Atheism at 16.6%.

2.4. The proportion of all colleagues sharing that they identify as religious remained relatively static over five years.

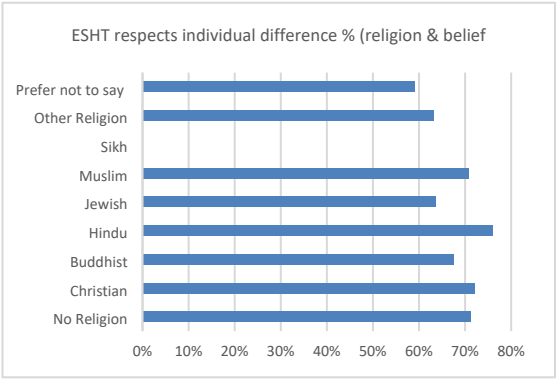
2.5. There is an increase in representation for Christianity, Atheism, Islam and Hinduism over the last 12 months. The score is rated green because of the increase in colleagues choosing to share their religion with us.

Religion and belief: We are safe and healthy by religion and belief.



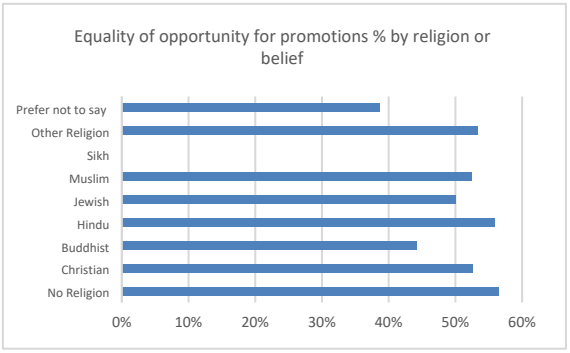
2.6 In the past year, "We are safe and healthy" measured responses from the staff survey 2024 concerning personal experiences of harassment, bullying, or abuse from patients, relatives, members of the public, managers, and colleagues through nine specific questions. There has been a decrease in reported incidents of bullying and harassment from patients or their carers among Christians, Muslims and Other Religions, however Jewish and Buddhist colleagues have experienced an increase. It's important to note that the analysis considers the relatively low response rates to this particular question.

Religion and belief: We are compassionate and inclusive. A



2.7. "We are compassionate and inclusive" pertains to a series of eight questions drawn from the staff survey 2024 that address equal opportunities in career advancement, workplace discrimination, and the recognition of individual differences.

2.8. ESHT's commitment to respecting individual differences reveals that colleagues who choose not to disclose their religion recorded the lowest score at 59.22%, with colleagues of 'Any other religion' following at 63.16%. Conversely, Hindu colleagues achieved the highest score at 76.06% (n. 71), however this is a decline of 2.73% on the previous year. All religions, apart from prefer not to say, experienced decline from the previous year.



Religion and belief equality of opportunity for career progression/promotions A

2.9 Overall, on average, 51.4% of colleagues indicated that ESHT provides fair treatment in promotions. By religion, the group with the lowest proportion was those who preferred not to disclose their preference, at 38.65%, which is an increase of 3.49% over the past 12 months. Christian, Buddhist, Hindu and Muslim colleagues reported a decrease in opportunity falling to 52.57%, 44.12%, 55.88% and 51.43% respectively.

NEXT STEPS FOR RELIGION AND BELIEF EQUALITY 2024-26

- Increase diversity of membership with the Faith and Belief Network to encourage open conversation between different faith groups.
- Organise and host multifaith events to promote understanding and inclusivity among employees of different faiths and beliefs.
- Implement Trust wide allyship programme to encourage sharing of religion or belief.

SEX (including Gender Pay Gap)

Over the past year, the male workforce has seen a increase of 1%, resulting in a current distribution of 75.2% female and 24.8% male employees. Representation data for Trans or non-binary individuals remains unavailable.

Regarding pay equity, for every £1 earned by men, women earned £0.95, the same as documented in 23/24. In terms of job distribution, women occupy 67% of the senior positions (AfC 8a – 9). However, their representation is lower in medical and dental roles at 43%.

The Women's network is ESHT's largest network with a membership of over 200 colleagues.

3.1. Across 2024-25 ESHT continued its work to promote gender equality between men, women, non-binary people and trans people. Key achievements include:

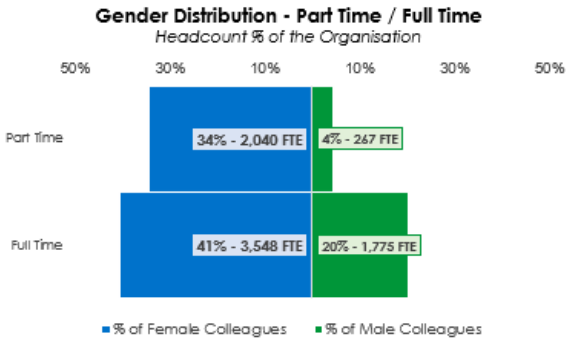
- Partnership between the LGBTQIA+ network and Women's network to encourage discourse on intersectionality
- Successfully organising and hosting an engaging event in celebration of International Women's Day.
- Monthly Fireside chats with inspirational women in business and health hosted by the Women's Network including themes such as Women in Advance Practice and How to maximise your LinkedIn profile to grow your career.

KEY FINDINGS: SEX

Workforce gender representation

A

3.2. Out of 8,741 staff, 75.2% were recorded as female and 24.8% as male on their Electronic Staff Records (ESR). The proportion of the male workforce grew by 1%.



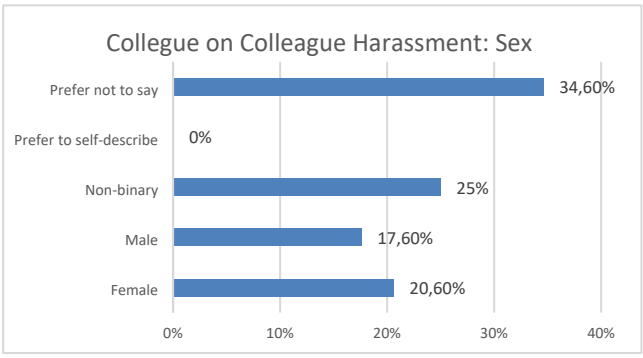
3.3. The female workforce in Agenda for Change pay bands was 78. %compared to 43% of females with medical and dental contracts.

3.4. At present the national ESR system cannot record staff members who do not identify with a specific binary sex or who prefer to self-describe, hence this measure is rated amber. The staff survey now provides this detail and so is reported below.

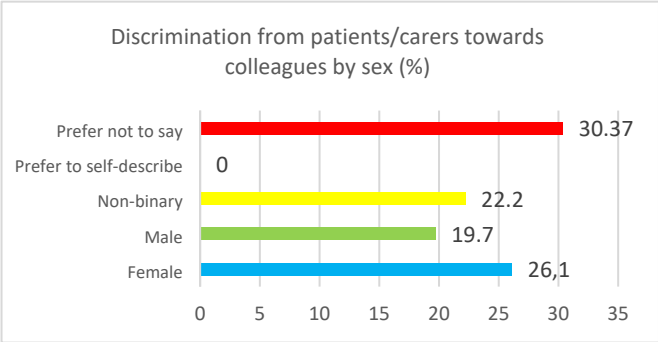
Harassment, bullying or abuse from staff by gender

A

3.5. In the past twelve months, there was a 3-point distinction between the percentage of female employees (20.6%) and male employees (17.6%) who reported instances of harassment, bullying, or abuse from colleagues. Both males and females experienced an increase over the past twelve months, however this affected females more significantly. Individuals identifying as 'prefer not to say' reported the highest incidence at 34.6%.



Discrimination from patients, relatives, or members of the public by sex

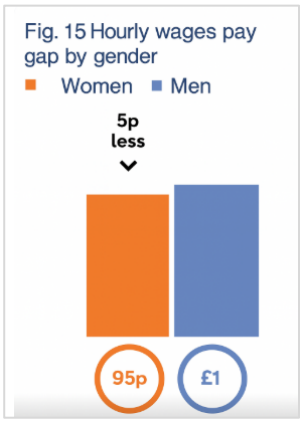


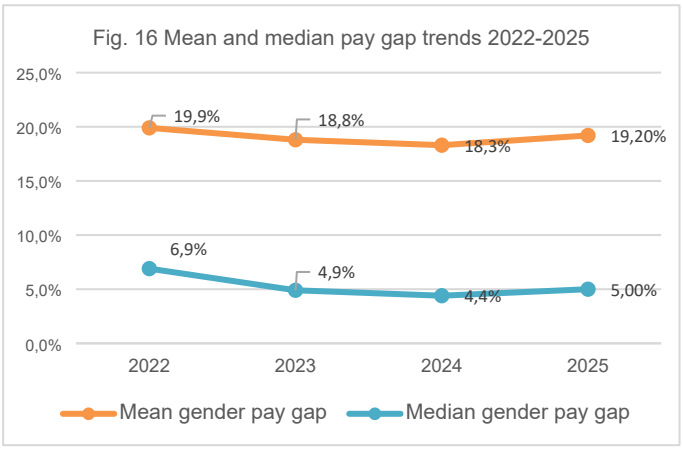
3.6 There was a 6.9% disparity between the percentage of males (19.7%) and females (26.1%) reporting discrimination from patients, relatives, or members of the public in the last twelve months, marking an increase in disparity over the last twelve months trend. Those who selected 'prefer not to say' reported the highest incidence of discrimination.

Gender Pay

3.7. In ESHT, women earned £0.95 for every £1 that men earned when comparing median hourly wage. No change from the previous 12 months. Their median hourly wages are 5% lower than mens.

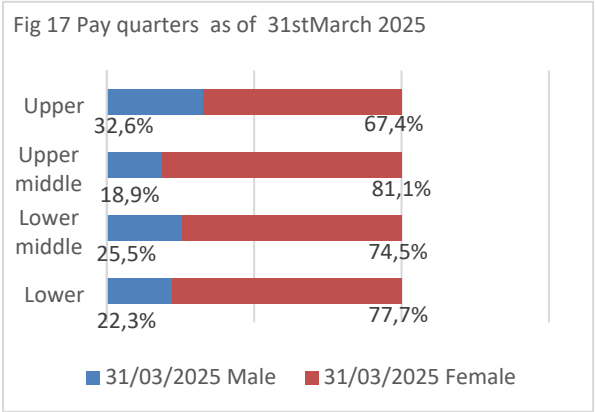
3.8. When comparing mean hourly wages, women's mean hourly pay is 19.2% lower than men's. This had previously been a decreasing trend.





3.9. The table below shows a breakdown of the mean pay rates split for Agenda for Change & Executive and Medical & Dental staff across the last 3 years. The % difference for Medical & Dental staff has reduced by 1.2% in 24/25 whilst the difference for Agenda for Change & Executive staff, has increased by 1.8% with males earning more than females for the first time in three years.

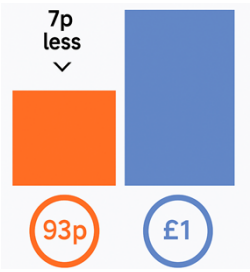
Agenda for Change and Medical & Dental	Male	Female	% diff
Agenda for Change - Mean hrly rate 31/3/23	£16.42	£16.70	**-1.7%**
Agenda for Change - Mean hrly rate 31/3/24	£16.40	£16.62	**-1.3%**
Agenda for Change - Mean hrly rate 31/3/25	£17.81	£17.72	**0.5%**
Medical & Dental - Mean hrly rate 31/3/23	£40.83	£32.78	**19.7%**
Medical & Dental - Mean hrly rate 31/3/24	£37.98	£31.31	**17.6%**
Medical & Dental - Mean hrly rate 31/3/25	£43.72	£36.55	**16.4%**



Proportion of women in each pay quarter

3.10. Pay quarters are determined by dividing all employees into four equal groups based on their pay. Analysing the representation of women in each quartile provides insight into their distribution across different levels within ESHT. Currently, women hold 67.4% of the highest paid positions and 77.7% of the lowest paid positions within the organisation.

Gender bonus gap



3.11. In ESHT, women earn £0.93 for every £1 that men earn in terms of median bonus pay, indicating a gender pay gap of 6.9%. In regard to mean bonus pay, the gender pay gap for 24/25 is 22.1%.

3.12. The percentage of female staff receiving bonus payments in 2024-2025 increased by 0.9% to 23%. These bonuses, which are Clinical Excellence awards, specifically pertain to medical staff, particularly consultant-level medical staff who are eligible for these awards. As of March 31, 2025, the gender breakdown among consultant staff was 66.6% male and 33.4% female, highlighting a significant disparity in bonus distribution.

NEXT STEPS FOR GENDER EQUALITY 2025-26

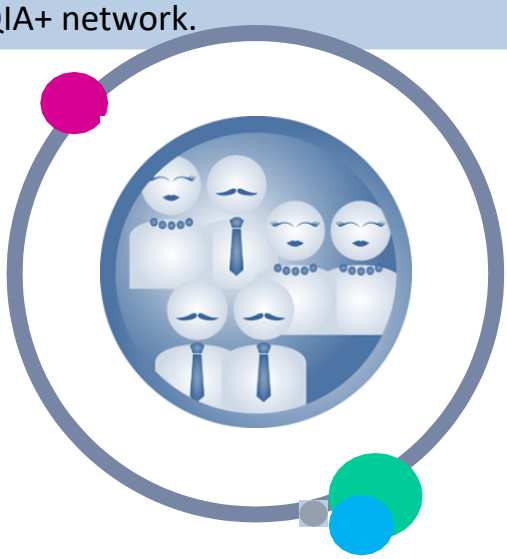
- Strengthen support systems to reduce harassment and discrimination against all sexes, with particular focus on those identifying as non-binary and women, who report higher rates of abuse. Regularly review and update training programmes to foster a safe and inclusive work environment.
- Explore the capability of systems to record and report on the representation and experiences of non-binary and trans staff.
- Host regular events and workshops to promote gender inclusivity and raise awareness about gender equality issues.
- Support growth of Women's Network and ensure executive sponsor engagement.

SEXUAL ORIENTATION

4.6 percent of the workforce identified themselves as lesbian, gay, or bisexual (LGB), marking a 0.4% increase from the previous year. AfC employees at bands 1-4 showed a higher likelihood of identifying as LGB compared to other bands.

Gay and lesbian colleagues experienced a slight rise in discrimination from patients and carers whilst bisexual colleagues reported a decrease.

Currently, there are 103 registered members in the LGBTQIA+ network.



4.1. Across 2023-24 ESHT continued its work to promote equality between people of all sexual orientations, including lesbian, gay, bisexual (LGB) and straight people. Key achievements include:

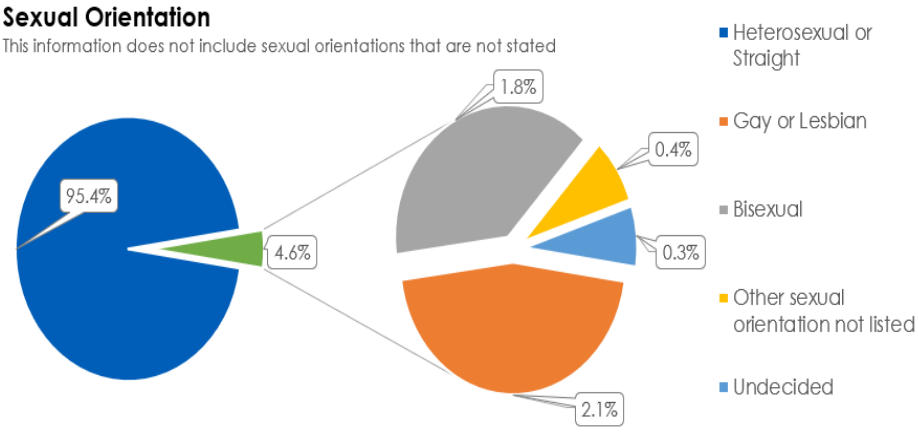
- Appointment of a Vice-Chair to the LGBTQIA+ Network
- Sessions delivered in partnership with local charity 'Bourne This Way' to educate colleagues on the experiences of LGBTQIA+ parents.
- Participation in Hastings and Eastbourne Pride Parades.

KEY FINDINGS: SEXUAL ORIENTATION

Workforce sexual orientation representation

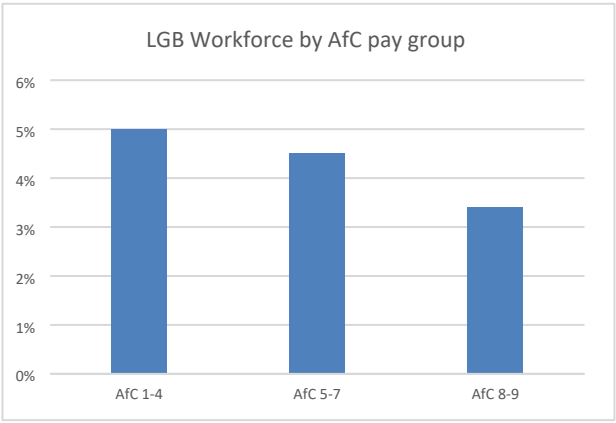
4.2. The number of people sharing their sexual orientation as LGBTQI+ with the Trust at 31 March 2025 is 402.

4.3. In terms of sexual orientation, the breakdown among the workforce is as follows:



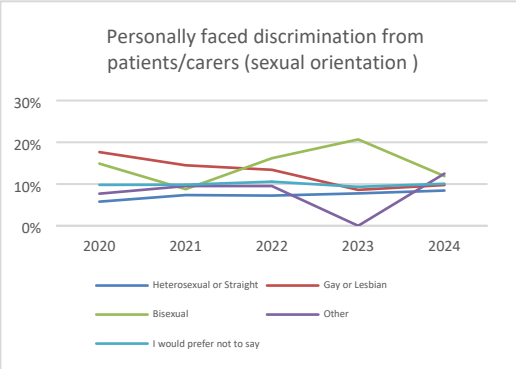
- Heterosexual: The largest group comprising 95.4% of colleagues.
- Prefer not to share: Constituting 19.2% of the workforce.
- Gay or lesbian: Representing 2.1%
- Bisexual: Making up 1.8%
- Undecided: Comprising 0.3%
- Other: Accounting for 0.4% of individuals who selected their sexual orientation as "other".

4.4. Colleagues in Agenda for Change (AfC) pay group 1-4 had the largest proportion identifying as LGB on their staff record at 5% each, compared to 4.6% in the workforce overall.

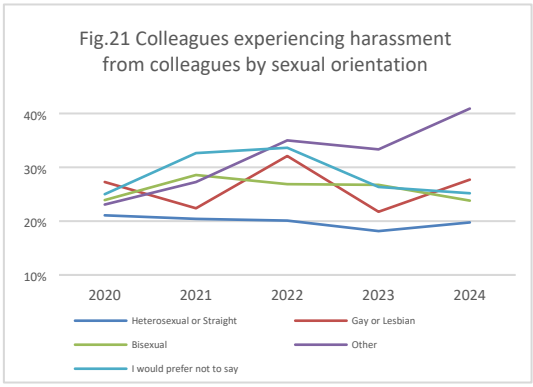


4.5. Correspondingly the lowest proportion of LGB on ESR was in Agenda for Change pay bands 8a-9 at 3.4.%.

Safe environment (bullying and harassment) by sexual orientation

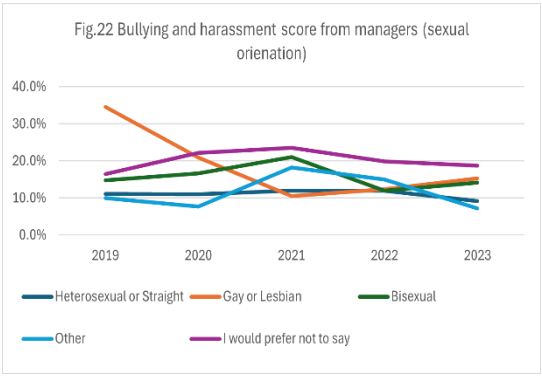


4.6. ESHT response to colleagues who have personally experienced discrimination from patients/services users, their relatives or other members of the public in the *preceding twelve months* was 26.3% of 4025 responding to the staff survey. The group with the lowest score was those colleagues describing their sexual orientation as heterosexual or straight at 8.44%. Bisexual colleagues saw a decrease of 8.79% in 2024, whilst gay and lesbian colleagues experienced a slight rise to 9.76%.



Colleagues experiencing harassment from colleagues by sexual orientation

4.7. In ESHT 40.91% of employees who identified as "Other" in terms of sexual orientation reported experiencing at least one incident of bullying, harassment, or abuse from colleagues. The next highest group was gay or lesbian employees, with 27.71% reporting such incidents, followed closely by those who 'Preferred not to Share' their sexual orientation, at 25.81% . Heterosexual, gay or lesbian and 'other' colleagues experience an increase in incidence whilst bisexual and those who 'Preferred not to Share' experienced a decline.



Colleagues experiencing harassment from managers by sexual orientation

4.8. All groups experienced harassment from managers with those identifying as Gay or Lesbian at the highest with 15.2% (n.14) and those identifying as Other the lowest at 7.14% (n.<10). Those identifying as Gay or Lesbian or as Bisexual saw an increase in harassment from managers where all other groups saw a decease.

Equality of opportunity for career progression/promotions by sexual orientation

4.9. On average, 53.3% of colleagues reported ESHT acts fairly with promotions in line with the benchmark group. The group with the lowest proportion were colleagues stating their sexual orientation as 'Other' at 25%; 38.1% behind the highest score of 63.1% which was documented by colleagues sharing that they were bisexual.

4.10 LGBTQ+ Rainbow Scheme

The NHS Rainbow Badge programme, designed to promote inclusivity for LGBTQ+ individuals in NHS secondary care settings, has ceased operations due to the loss of government funding. In 2018 at Evelina London Children's Hospital, the programme helped 77 NHS Trusts to review their policies and address the needs of LGBTQ+ patients, leading to significant improvements in healthcare outcomes and satisfaction rates. ESHT earned a bronze award in 2023, and we have already incorporated the associated action plan into their existing strategies.

Throughout 2024/25 numerous engagement events were held with NHS Trusts to form the new iteration of the programme which remains in consultation. ESHT remains committed and engaged with implementing the Rainbow Badge Scheme upon launch of its new format.

NEXT STEPS FOR SEXUAL ORIENTATION EQUALITY 2025-26

- Enhance online training provision for LGBTQIA+ learning and allyship initiatives
- Continue to grow LGBTQIA+ network membership
- Review external webpages to ensure inclusivity for LGBTQ+ patients and colleagues.
- Focus on reducing the incidence of discrimination and bullying, particularly for bisexual and "Other" identified colleagues who report higher rates of these issues.

DISABILITY

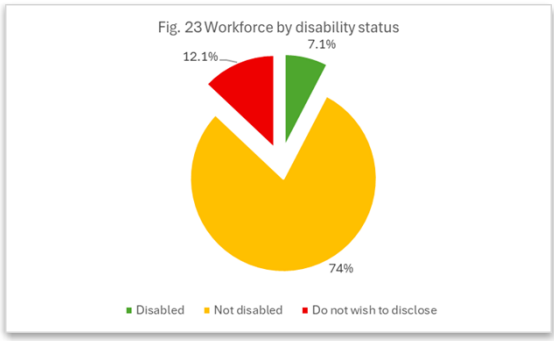
According to electronic staff records, 7.1% of the NHS workforce identifies as disabled, while 12.07% chose not to disclose their disability status. Disabled individuals were slightly more likely to enter the formal disciplinary process than people without a disability, according to a key national Workplace Disability Equality Standard (WDES) measure.

In terms of workplace accommodations, 78.45% of disabled colleagues felt that adequate adjustments were made to enable them to work, marking an increase of 4.21% from the previous year. The (dis)Ability network has 93 registered members, and the Neurodiversity Network has 87 registered members.

5.1. Across 2024-25 ESHT continued to advance disability equality and make reasonable adjustments for disabled people in our workplaces and to facilitate that their voices be heard (WDES 9). Key achievements include:

- Continuation and embedment of Centralised reasonable adjustments process
  (HIA 6)
- Introduction of Neurodiversity, Microaggression, Allyship and Deaf Awareness
  e-learning
- Establishment of Neurodiversity Network and corresponding meetings to promote neuroinclusive practices (HIA 4).

KEY FINDINGS: DISABILITY



Workforce disability representation (WDES 1) A

5.2. The number of people sharing their disability with the Trust at 31 March 2024 on their staff record was 621, or 7.1% of the workforce marking an increase of 1.2% on the previous 12 months.The group not wishing to share their disability status is at 12.07%, which is a decrease of 3.03% over the preceding 12 months. There were 26.1% (n.1030) of 3936 who answered the staff survey and selected they were disabled hence the amber rating remains.

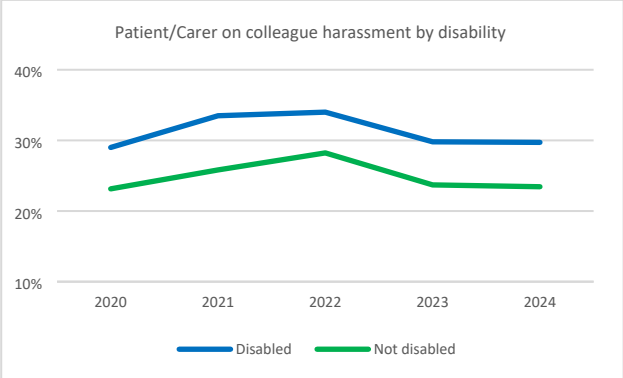
5.3. Colleagues in agenda for change (AfC) pay band 5-7 had the largest proportion of disabled colleagues at 8.72%. The lowest proportion of disability representation was at AfC band 8-9 with just 5.1% sharing they have a disability.

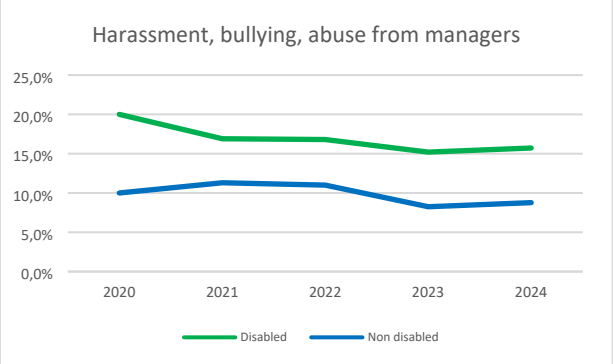
Shortlisting-to-appointment by disability (WDES 2) G

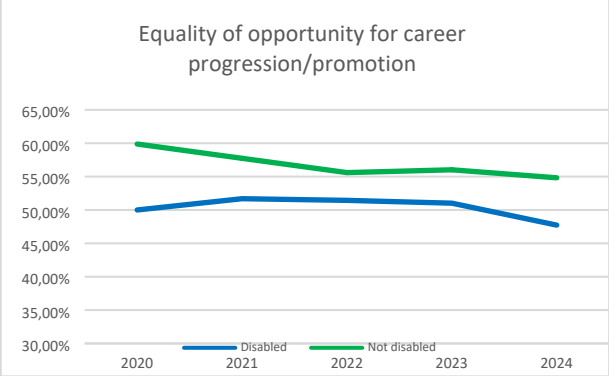
5.4. People without a disability were 1.04 times more likely to be appointed from shortlisting than people with a disability. This is an improvement from last year's score of 1.3 and falls within the non-adverse range as detailed by the NHS WDES national team.

Formal capability likelihood by disability (WDES 3) A

5.5. People with a disability were 1.22 times (22%) more likely to enter the formal disciplinary process than people without a disability. This is a decline from last year's score of 1.1 where disabled colleagues were 10% more likely to enter the formal disciplinary process. A score of 1.22 is slightly outside the 0.8 – 1.2 threshold the WDES national team regards as non-adverse.







Harassment, bullying or abuse by disability (WDES 4) A

5.6. In the 2024 staff survey 29.8% of disabled colleagues reported experiencing harassment, bullying, or abuse from patients, relatives, or the public in the past 12 months. This figure represents a 6.28% difference compared to the 23.44% of non-disabled colleagues who reported similar experiences. Whilst difference has increased by 0.28% over the past 12 month, it remains smaller than benchmark average.

R

5.7. The survey showed that 15.72% of disabled colleagues reported experiencing harassment, bullying, or abuse from managers, nearly double the 8.77% reported by non-disabled colleagues.

5.8. Additionally, 26.33% of disabled colleagues faced similar issues from other colleagues, an 8-point difference compared to the 18.33% of non-disabled colleagues. This represents an increase in experience for disabled colleagues and non-disabled colleagues by 1.41% and 1.33% respectively.

Disability equal opportunities for promotion (WDES 5) R

5.9. 47.73% of disabled colleagues felt ESHT provided equal opportunities for promotion, which is a 3.3% decline from 2023. There is a 7% difference in results from disabled colleagues in comparison to 54.82% figure reported by non-disabled staff. ESHT falls 3.57% lower than benchmark average for disability equality in opportunities for promotion.

Pressure to work when unwell by disability (WDES 6) A

5.10. 23.69% of disabled colleagues felt management pressure to come to work when not feeling well enough, which is an improvement of 3.88% over the past 12 months. The difference between disabled and non-disabled colleagues reduced to 7.74%, which is a 2.3% increase on the previous year. The rating remains amber due to the difference in experience between disabled and non-disabled colleagues.

Trust values their work by disability (WDES 7) G

5.11. 35.02% of disabled colleagues felt the Trust valued their work. This is a 10.6% difference from the 45.68% of reported by non-disabled staff, indicating an improvement of 1.3%. Both scores are equal to that of the disabled provider benchmark.

Adequate adjustments for disabled people (WDES 8) G

5.12. 78.66% of disabled colleagues felt ESHT made adequate adjustment(s) to enable them to carry out their work. An increase of 4.6% over the previous twelve months.

Board disability membership (WDES 10) A

5.13. Board workforce representation, including voting and executive members, was 64.29% non-disabled, 14.29% disabled and 21.43% undeclared.

NEXT STEPS FOR DISABILITY EQUALITY 2025-26

- Continue to embed Reasonable Adjustment process throughout the Trust.
- Promote structures that support career progression and opportunities for disabled staff through talent management strategies.
- Revalidate as Disability Confident Leader.
- Implementation of AccessAble access guides to raise awareness of the accessible environment of our sites.
- Support growth of the (dis)Ability and Neurodiveristy Network and ensure executive sponsor engagement.
- Embed changes following bullying and harassment listening events and task and finish group.

AGE

Colleagues in the 16-20 and 21-30 age group have the highest perception of equality of opportunity compared to the average provider sector benchmark of 57.7%.

Conversely, colleagues in the 51-65 age group report lower perceptions of equality of opportunity compared to all other age groups.

6.1. Across 2024-25 the Trust continued its work to promote age equality between people of different ages. Key achievements include:

- Celebrating the International Day of Older Persons on October 1st.
- Collaborating with the Prince's Trust to help young people re-enter the workforce.
- Partnering with Project SEARCH, a supported employment initiative, to provide opportunities for young people with learning difficulties and disabilities.

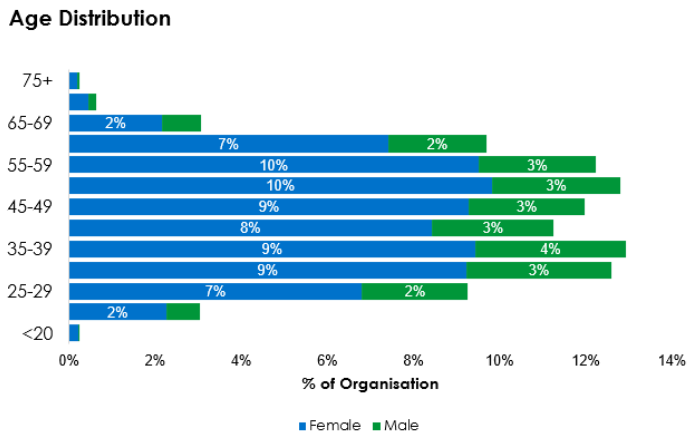
KEY FINDINGS: AGE

Workforce age representation

6.2. ESHT Colleagues in post changed over twelve months from 8702 in April 2024 to 8741 in April 2025.

6.3. The percentage in the workforce across all age groups over the past twelve months was consistent with the previous year.

Workforce age groups by %



We are safe and healthy (bullying and harassment) by age.

6.4. The 66+ year age group reported the lowest negative response rate at 22.89% regarding experiences of bullying and harassment from patients, service users, their relatives, or other members of the public. Similarly, the 51-65 years age group reported a rate of 23.79% (n. 21). Comparatively, the provider benchmark for all age groups stood at 24.68%, while ESHT averaged 26.11%.

6.5. The 21-30 years age group reported the lowest score for taking positive action on health and wellbeing at ESHT, with 52.94% . Meanwhile, the 66+ years age group saw the largest increase, with a 7.46% rise compared to the previous twelve months. Conversely, the 16-20-year-old group experienced the largest decline, decreasing by 12.8%.

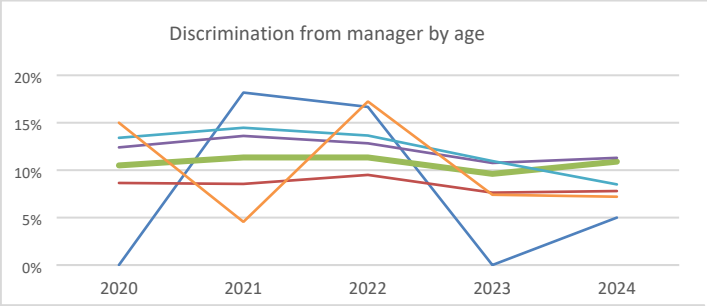
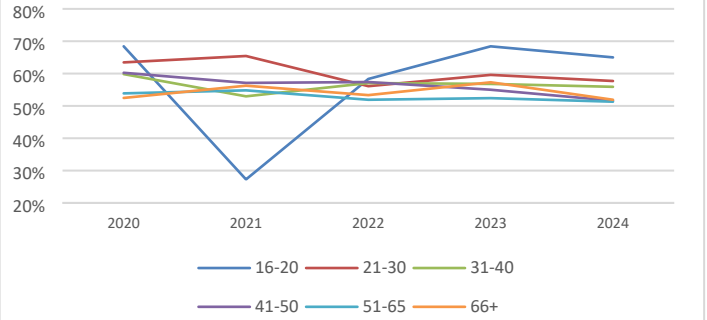


Fig.28 Does your organisation act fairly on career progression/promotion by age



6.6. The 16–20-year age group had the lowest positive response regarding experiencing discrimination from a manager or team leader, with 5%. In contrast, the highest response came from the 41-50-year age group, at 11.3%, compared to the organisational average of 9.87%.

Age equality, we are compassionate and inclusive.

6.7. The 16-20 and 21-30-year age groups provided the highest positive responses regarding ESHT's fairness in career progression, with rates of 65% and 57.7% respectively. Both of these scores are however a decline in comparison to 2023. The lowest score was recorded in the 51-65-year age group, at 51.3%.

6.8. All ages experienced a decrease in response over the last 12 months, the biggest decrease was experienced by 66+ year age group.

NEXT STEPS FOR AGE EQUALITY 2025-26

- Where possible support social mobility and improve employment opportunities across healthcare through education programmes.
- Review support systems available for colleagues specifically with a focus on vulnerable age groups.
- Increase the awareness of age discrimination across the ESHT through the allyship pledge and programme.

ARMED FORCES

East Sussex Healthcare NHS Trust actively supports the Defence and Armed Forces community, advocating for awareness and engagement through partnerships, events and support.

In September 2024, ESHT was awarded in the Silver Defence Employee Recognition Scheme by the Ministry of Defence (MoD).

In February 2025, ESHT passed its annual review for the Veteran Aware accreditation.

7 Pace and momentum have been sustained for the Armed Forces Workstream, with provisions in training, collaboration with Armed Forces services, number of Armed Forces champions and support for patients extending.

KEY UPDATES: ARMED FORCES

Workforce armed forces representation

7.1. ESHT Colleagues in post changed over twelve months from 8702 in April 2024 to 8741 in April 2025.

7.2. The total number of those working for ESHT from the armed forces community is declared at 36. Which is made up of 4 recorded Reservists, 13 Military Partners, 18 Veterans and 1 Cadet Force Adult Volunteer (CFAV). This is a notable increase from the previous year when only the Reservists had declared.

Key highlights include:

7.3 In 2024/25, we partnered with Combat Stress, the Royal British Legion, Eastbourne District Veterans Association, Blue Van, and the Breakfast Club during Armed Forces Week. These organisations visited Eastbourne District General Hospital, engaging with staff and patients to promote mental health, welfare, and social support services.

7.4 In September 2024, a group of healthcare professionals attended the Ministry of Defence's Medical Endeavour Leadership course which is designed to provide transferable skills for healthcare professionals. This was a collaboration with the 256 Multirole Medical Regiment, our local regiment.

7.5 For Remembrance Day 2024, we welcomed SSAFA to Conquest Hospital, where they provided guidance to colleagues on supporting serving personnel, veterans, and families, helping NHS staff signpost services effectively.

7.6 Armed Forces Champions: We have 36 trained Armed Forces Champions across the Trust, ensuring dedicated support for veterans, reservists, and military families. Through these initiatives, we remain committed to supporting and advocating for the Armed Forces community.

NEXT STEPS FOR ARMED FORCES 2025-26

- Pursue further achievement in the Defence Employer Recognition Scheme (Gold).
- Increase those declaring their armed forces status
- Renew attempts to work with our local cadet forces.
- Roll out of allyship programme that will include specific resources to support armed forces communities

HIGH IMPACT ACTIONS (HIA)

The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

8.1 The NHS England High Impact Actions (HIA) framework guides organisations to take evidence-based, measurable action on equality, diversity and inclusion (EDI).

At ESHT, the HIA have shaped our EDI objectives and supported targeted improvements across workforce and patient experience. Our focus has included:

- Setting specific and measurable EDI objectives for senior leaders to drive accountability and progress.
- Strengthening processes to reduce pay gaps and improve talent management strategies.
- Implementing programmes to reduce workforce health inequalities and improve the onboarding and development of international staff.
- Embedding a zero-tolerance approach to bullying, discrimination, harassment, and violence.
- Developing trust-wide allyship programme to build cultural competence and reduce bias.
- Aligning systems to embed inclusion within talent management and leadership development frameworks.
- Supporting growth and sustainability of staff networks to strengthen engagement and foster safe spaces for feedback and peer support.
- Enhancing data transparency and reporting to monitor progress and inform continuous improvement.

8.2 These actions have been overseen by the Inequalities Sub-Board Committee, ensuring alignment with national requirements and local priorities. We remain committed to delivering meaningful, lasting change through ongoing implementation of the HIA.

NEXT STEPS FOR NHSE HIA 2025-26

Update on EDI High Impact Actions Reporting

- NHS England has confirmed that quarterly reporting on the EDI High Impact Actions is no longer required from September 2025 due to internal process changes. ESHT has met all but one of the High Impact Actions — the development of a talent management pathway for under-represented groups. It is proposed that progress on this outstanding action is monitored through the Workforce Equality Meeting to ensure continued oversight and delivery.

ORGANISATIONAL INCLUSION

ESHT has continued to review and strengthen its Equality, Diversity and Inclusion (EDI) policies to ensure compliance with the Equality Act 2010 and reflect evolving best practice.

Diversity Dialogues were held quarterly with a focus on allyship, valuing lived experience, and creating positive cultural change across the organisation.

- Conducted listening events will all staff networks to investigate experiences of bullying and harassment following publication of Too Hot To Handle Report.
- Launched the Neurodiversity network.
- Quarterly diversity dialogue held with the theme of allyship.
- Embedded the centralised reasonable adjustment process.
- Celebrated Black History Month, Disability History Month, Armed Forces Week, International Women's Day, Neurodiversity Celebration Week, and Interfaith Week.
- Contributed to Trust development programmes such as Aspiring Leaders and Nurse and APH Preceptorship Programmes.

KEY FINDINGS: INCLUSION

We are compassionate and inclusive: diversity and equality

9.1 ESHT overall score for colleagues believing that ESHT respects individual differences was 67.62%. This was just below the average provider benchmark of 70.07%.

We are compassionate and inclusive: Inclusion

9.2 ESHT overall score for colleagues feeling a strong personal attachment to their team was 63.12%, this is similar to the provider benchmark of 63.16%.

NEXT STEPS FOR ORGANISATIONAL INCLUSION 2025-26

- Launch Trust-wide Allyship programme to provide opportunities for colleagues to develop cultural competence by increasing support to identify bias, to reduce prejudice and to eliminate systemic barriers.
- Align systems to strengthen the conditions for change; embedding inclusion within talent management.
- Develop a new action plan for equality, diversity and inclusion throughout 2026 to support Trust priorities.

Summary of Actions for Equality, Diversity, and Inclusion 2025-2026

This action plan outlines the specific steps and initiatives to advance equality, diversity, and inclusion across the organisation for the period 2024-2026, ensuring alignment with the NHS England High Impact Actions and organisational goals.

Objective	Actions
Race	
1. **Celebrate the contribution of ethnic minority staff to the experience of patients at ESHT.**	Host Sussex system Black History Month Conference 2025
2. Implement Trust wide allyship programme.	Implement Trust wide allyship programme to encourage understanding and awareness of gender equality issues.
3. Review and strengthen procedures for reporting and addressing discrimination and harassment as informed by the listening events.	Review and enhance procedures for reporting and addressing discrimination and harassment. Ensure all reports are handled promptly and effectively.
4. **Mentorship and sponsorship programmes**	Implement mentorship and sponsorship programmes to support career progression for multicultural staff. (HIA 2)
5. Regular review of recruitment processes to ensure they are fair and inclusive.	Ensure interview questions are sent in advance to all candidates Develop ways of allowing recruiting managers can demonstrate accountability around interview practices
6. **Middle management preparation**	Ensure those in middle management are prepared for senior roles.

Objective	Actions
Religion and Belief	
1. **Grow Faith and Belief Network**	Increase engagement through regular meetings and events catering to diverse religious and non-religious groups.
2. **Organise multifaith events**	Promote understanding and inclusivity among employees of different faiths and beliefs.
3. Implement Trust wide allyship programme.	Implement Trust wide allyship programme to encourage understanding and awareness of gender equality issues.
Gender (Sex)	
1. Improve system capability to capture data on non-binary and trans staff.	Explore the capability of systems to record and report on the representation and experiences of non-binary and trans staff.
2. Host regular events and workshops to promote gender inclusivity and raise awareness about gender equality issues.	Implement Trust wide allyship programme to encourage understanding and awareness of gender equality issues.
3. Strengthen Support Systems	Reduce harassment and discrimination against all genders, with a focus on non-binary individuals and women. Regularly review and update training programme to foster a safe and inclusive work environment. Support growth of Women's Network and ensure executive sponsor engagement.
4. Explore Shared Parental Leave	Explore shared parental leave and monitor its uptake.

Objective	Actions
Sexual Orientation	
1. Continue to grow LGBTQIA+ network membership	Regularly conduct meetings, support groups, and social events to encourage staff to share their sexual orientation. Foster a safe and inclusive environment.
2. Enhance online training provision for LGBTQIA+ learning and allyship initiatives	Implement Trust wide allyship programme.
3. **Review inclusivity of webpages**	Ensure external webpages are inclusive for LGBTQ+ patients and colleagues.
4. **Reduce discrimination and bullying**	Focus on reducing discrimination and bullying, especially for bisexual and "Other" identified colleagues by implementing actions from listening events.
Disability	
1. Continue to embed Reasonable Adjustment process throughout the Trust.	Increase efforts to assure confidentiality and reduce the percentage of colleagues who prefer not to disclose their status.
2. Strengthen career progression pathways for disabled staff through talent management	Promote structures that support career progression and opportunities for disabled staff through talent management strategies
3. **Support neurodiverse colleagues**	Support growth of the (dis)Ability and Neurodiveristy Network and ensure executive sponsor engagement.
4. Revalidate as a Disability Confident Leader	Review current evidence against all criteria in the Disability Confident Leader (Level 3) scheme. Conduct external validation through an agreed Disability Confident scheme partner.
5. **Collaboration with AccessAble**	Implementation of AccessAble access guides to raise awareness of the accessible environment of our sites.
6. **Embed outcomes from listening events.**	Work towards increasing the visibility of disabled individuals in leadership positions, including the Board.
Age	
1. **Support social mobility and employment opportunities**	Improve employment opportunities through education programmes.
2. **Review support systems**	Focus on support systems for vulnerable age groups especially in wellbeing initiatives.
3. **Increase awareness of age discrimination**	Increase the awareness of age discrimination across the ESHT through the allyship pledge and programme.

Objective	Actions
Armed Forces Community	
1. Pursue further achievement in the Defence Employer Recognition Scheme (Gold).	Complete gap analysis against Gold award criteria using ERS Gold checklist. Demonstrate sustained activity beyond Silver level, including patient and staff support initiatives. Submit Gold application to the Ministry of Defence by required deadline.
2. Increase those declaring their armed forces status	Promote the value of declaring Armed Forces status through internal campaigns and staff stories. Update ESR guidance and prompts to encourage accurate recording of Armed Forces affiliation.
3. Renew attempts to work with our local cadet forces.	Explore opportunities for partnership, such as: Work experience or insight days Joint attendance at remembrance events Guest talks or skills sessions with NHS staff
4. **Launch the trust wide Allyship programme**	Roll out of allyship programme that will include specific resources to support armed forces communities
Organisational Inclusion	
1. **Launch the trust wide Allyship programme**	Launch the pledge, eLearning, and toolkit in October 2025. Develop additional tools for learning and team development on allyship. (April 2026) Achieve the target of 1,200 sign-ups to the pledge by April 2026. Integrate allyship principles into appraisals, recruitment, and patient care where appropriate. Sept 2026
2. **Develop Cultural Competence**	Provide opportunities for allies and role models to develop cultural competence, reduce bias, and eliminate systemic barriers.

Appendix: Organ Donation Annual Report 24/25

1. Introduction

1.1. Recognition of a patient's wishes regarding organ donation and discussion with nominated representatives was highlighted as part of End-of-Life Care Pathways in the Department of Health End of Life Care Strategy, published in 2008.

1.2. The ESHT organ donation committee oversees policy, education, and publicity to educate and support organ donation within ESHT and East Sussex.

2. Background

2.1. On the 31st March 2025 there were 8096 people on the active transplant list in the UK, an increase on the number waiting in 2024. Over the last year 463 patients in the UK have died whilst waiting for a transplant; 39 across the Southeast.

2.2. In 2008 the Organ Donation Taskforce published 'Organs for Transplants' which set recommendations with the target of increasing deceased donor rates. By 2013 donation rates had increased by 50% with a 30.5% increase in transplants.

2.3. In England following public consultation, the Organ Donation (Deemed Consent) Bill received Royal Assent on the 15th March 2019 and was passed into law on the 20th May 2020. This means that all competent adults who are freely resident in England for >1 year are now considered as potential donors unless they specifically chose to opt out or are excluded. Under the law donation will still be discussed with families to ensure that the most up to date individual wishes are known and respected. People are still able to register their decision – either to donate their organs or to decline donation, via the NHS organ donor register. On the 31st March 2025, 28.4 million people (42% of the eligible population) had registered their decision to opt-in to organ donation across the UK.

2.4. Organ Donation and Transplantation 2030: Meeting the Need is a 10-year vision for organ donation and transplantation rolled out by NHSBT since 2020 which takes in to account the introduction of 'opt-out' legislation and the impact of the COVID-19 pandemic. The aim of the strategy is to build on past success and deliver future improvements for the diverse populations across the UK, particularly addressing health inequalities in donation and transplantation.

3. Main content

3.1. NHS Blood & Transplant Report 1st April 2024 to 31st March 2025:

Summary:

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2024 - 31 March 2025

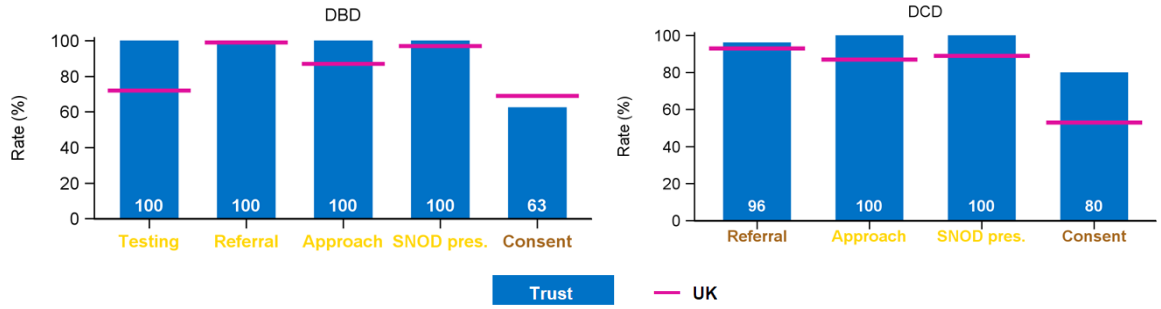


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2020 - 31 March 2025

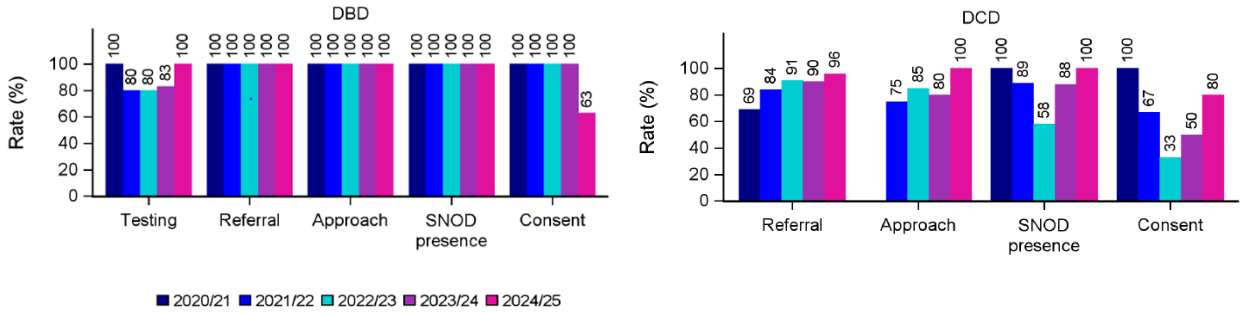


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2024 - 31 March 2025

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	8	1883	26	5503	34	6880
Referred to Organ Donation Service	8	1859	25	5118	33	6486
Referral rate %	G 100%	99%	B 96%	93%	B 97%	94%
Neurological death tested	8	1356				
Testing rate %	G 100%	72%				
Eligible donors[2]	8	1247	17	3735	25	4982
Medically suitable eligible donors[3]	8	1247	5	2077	13	3324
Family approached	8	1084	5	1827	13	2911
Family approached of medically suitable eligible donor	8	1084	5	1799	13	2883
% approached of medically suitable eligible	G 100%	87%	G 100%	87%	G 100%	87%
Family approached and SNOD present	8	1050	5	1622	13	2672
% of approaches where SNOD present	G 100%	97%	G 100%	89%	G 100%	92%
Consent ascertained	5	743	4	970	9	1713
Consent rate %	B 63%	69%	B 80%	53%	B 69%	59%
- Expressed opt in	5	473	3	644	8	1117
- Expressed opt in %	100%	94%	100%	82%	100%	86%
- Deemed Consent	0	216	1	267	1	483
- Deemed Consent %	0%	57%	50%	43%	25%	48%
- Other*	0	54	0	59	0	113
- Other %*	N/A	55%	N/A	29%	N/A	38%
Actual donors (PDA data)	5	694	3	703	8	1398
% of consented donors that became actual donors	100%	93%	75%	72%	89%	82%

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

[3] Medically suitable eligible donor - An eligible donor with no DCD exclusions and not deemed unsuitable by the DCD screening process

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

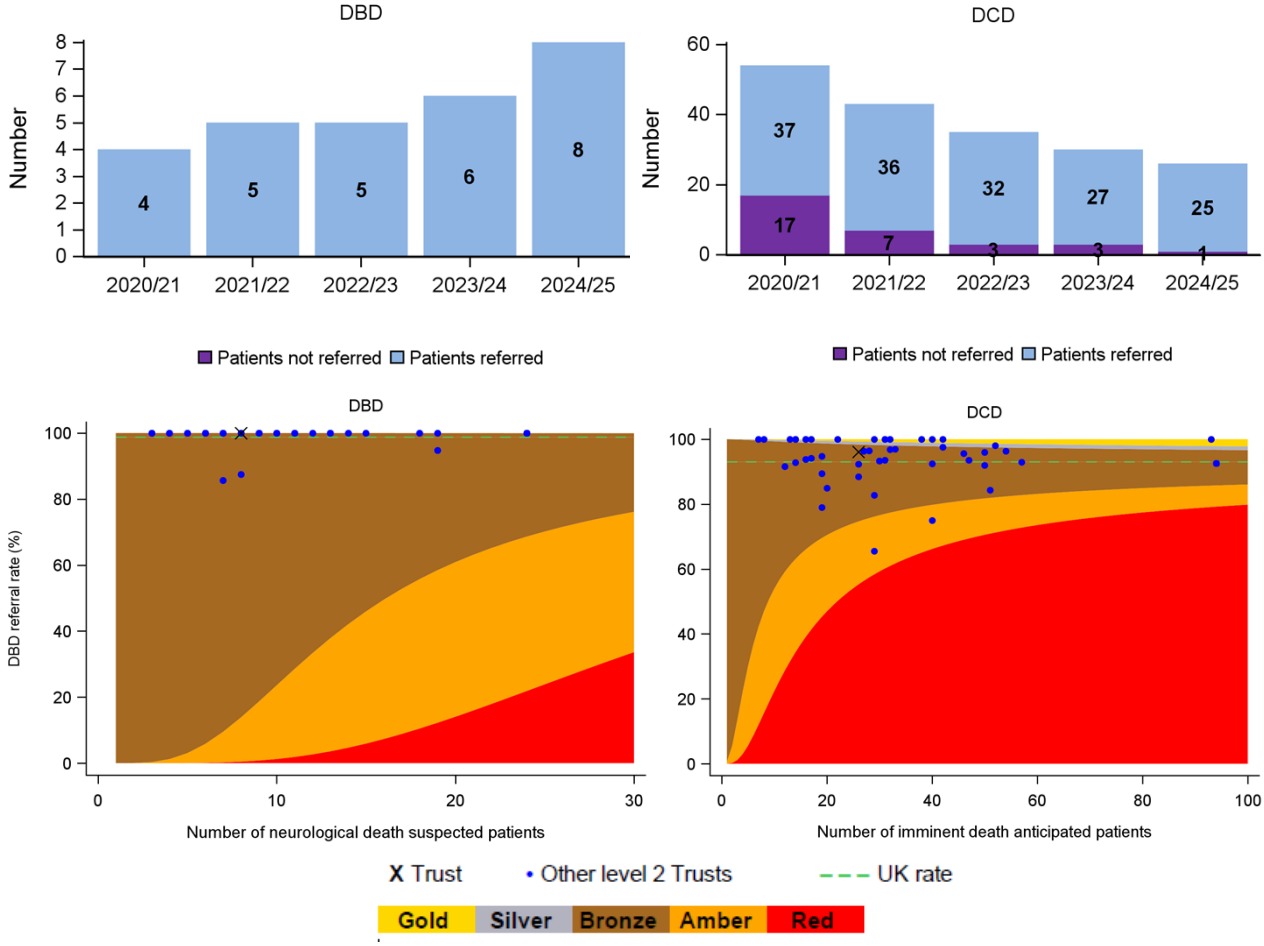
3.2. Referrals & Missed Opportunities:

3.2.1. Referrals:

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135 and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors.

Of 8 potential Donation after Brainstem Death (DBD) donors, all patients were referred to the Specialist Nurse for Organ Donation (SN-OD) and underwent neurological death tests. Of 26 potential Donation after Circulatory Death (DCD) donors, 25 patients were referred to the SN-OD and 5 families were approached regarding donation.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2020 - 31 March 2025



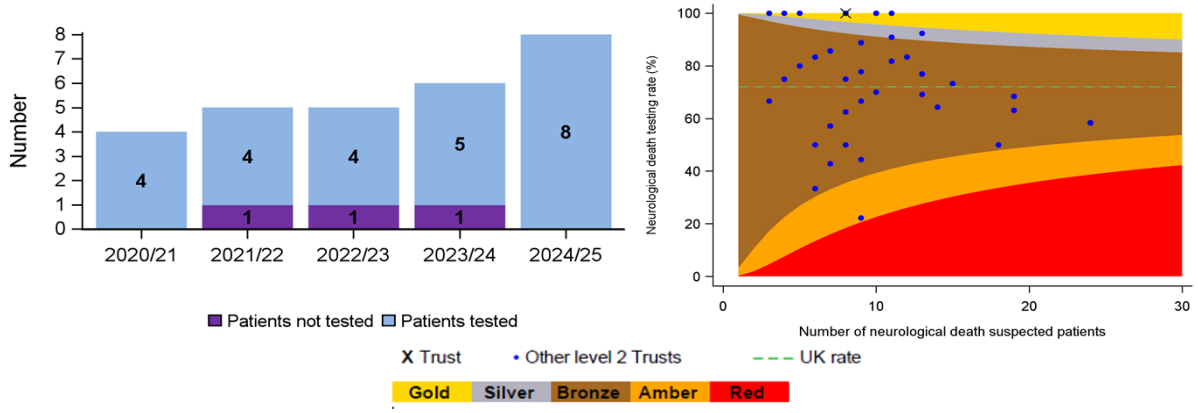
ESHT has been rated as excellent for potential DBD donors and average but improving rates of referral for potential DCD donors. The clinical lead and specialist nurse continue to provide training for ICU staff to raise awareness of organ donation with the aim of achieving 100% referrals.

3.2.2.Neurological Testing:

Goal: Neurological death tests are performed wherever possible.

Of 8 potential patients with suspected neurological death all patients underwent neurological death testing.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2020 - 31 March 2025



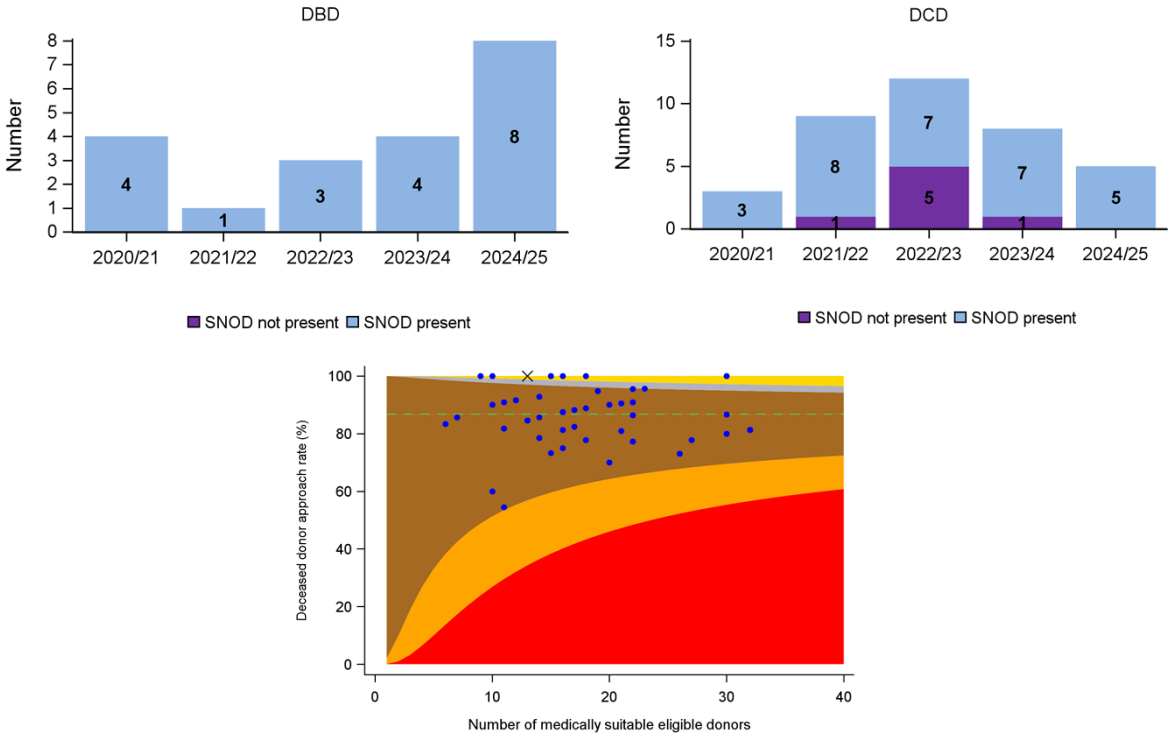
3.2.3.Specialist Nurse for Organ Donation presence:

Goal: A SNOD should be present during the formal family approach as per NICE CG135 and NHSBT Best Practice Guidance.

It has been determined that according to best practice a specialist nurse should be present when families are approached to discuss organ donation, to provide specialist support and answer any questions. In recent years, the number of families approached at ESHT without a specialist nurse presence dropped. Interventions were introduced by the clinical lead and specialist nurse at ESHT over the last 2 report periods that aimed to raised awareness and improve compliance with this target.

In the period of this report, ESHT has now had 100% of families approached with a specialist nurse, increasing the support offered to these families.

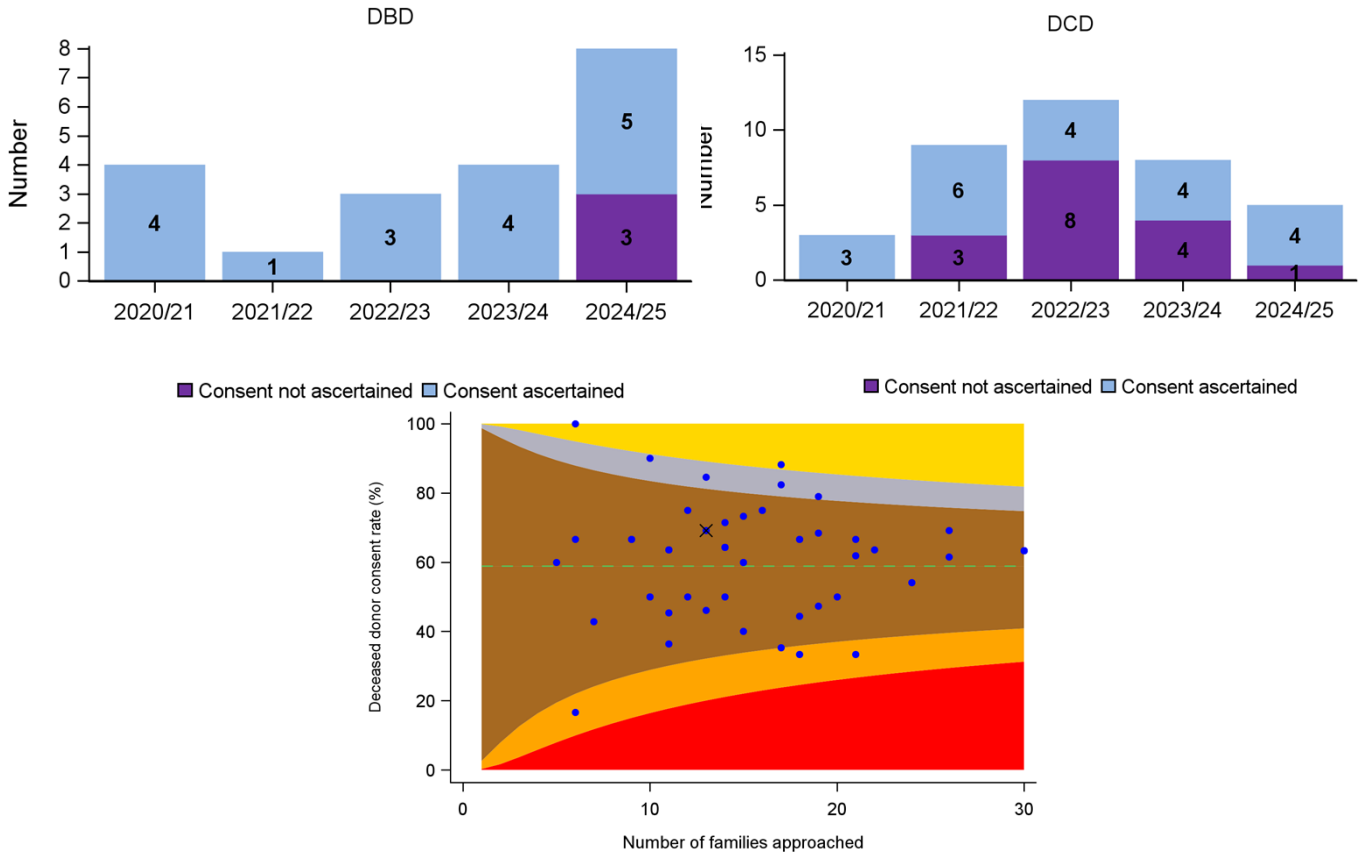
Figure 3.4 Number of families approached by SNOD presence, 1 April 2020 - 31 March 2025



3.2.4.Consent:

The consent rate of families approached at ESHT this year was above the national average at 69% (national average 59%). The decision to grant consent to organ donation is a very personal decision for families. This year there was a drop in the number of families consenting to donation following death of their relative, confirmed by neurological criteria. The reasons given for declining consent included families being unsure what their relative would want in that situation. This is an area that the organ donation committee can work on as it relates to local awareness and families discussing openly their wishes.

Figure 3.5 Number of families approached, 1 April 2020 - 31 March 2025



3.2.5.Emergency Department:

Goal: No one dies in ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.

In 2024-25 there were no patients identified as potential donors from A&E across ESHT.

3.2.6.Tissue Donation:

Donated tissues such as skin, corneas, bone and heart valves can transform the lives of patients and lead to significant improvements in their quality of life. Unlike solid organ donation, where only approximately 1% of patients die in circumstances where solid organ donation can be considered, tissue donation can occur up to 48 hours after death and almost anyone can be considered as a tissue donor. Over the last year, 50 potential donors have been referred to the tissue donation services with 8 proceeding donors, resulting in 12 corneal, 6 multi-tissue and 3 heart valve donations. This represents an increase in referrals when compared to last year (April 23 - Mar 24: 23 referrals) and is an area of development that the organ donation committee would like to focus on for the coming year, to ensure that all patients are given the opportunity to donate if they wish.

3.3. Training:

The organ donation team (SNOD & CLOD) have continued to undertake teaching and update sessions for ICU nursing & medical teams including through study days and the ICU M&M meetings. An area of development identified going forwards is to increase awareness in the trust about tissue donation via End Of Life teaching and departmental meetings.

3.4. Finances:

Donor recognition funding is allocated to the trust by NHS blood & transplant with the intended benefit of raising awareness of organ donation and improving the environment and support provided to family members. In the last 2 financial years, the allocated funds have not been received until November, making accurate allocation of these funds challenging.

In November 2024 the trust received £4902.14 from NHS Blood & Transplant and the organ donation committee has utilised some of these funds for refreshments for the organ donation memorial gathering at Conquest and promotional material for teaching sessions and events. At the end of each financial year any funds not utilised are incorporated into the trust finances.

The committee has been exploring other areas that these funds could be used to support including the update or improvement of relatives rooms in other departments such as ED or the mortuary. In addition, the committee is willing to support staff members in undergoing training that would be relevant to organ or tissue donation including but not limited to advanced communication course.

3.5. Publicity:

The clinical lead and specialist nurse, along with our excellent lay member, continue to liaise with the hospital communications team to publicise events throughout the year. As in previous years this has included intra and extranet promotion of organ donation week. In September 2024, to mark the end of organ donation week, the committee hosted a further non-denominational service of remembrance at the remembrance bench at Conquest Hospital. Members of the committee, staff from ICU and the families of local donors were invited to attend to remember donors.

The committee continues to work on the installation of a similar bench at Eastbourne DGH and also on other events throughout the year such as Airbourne.

3.6. CLOD Role:

Following the completion of 6 years in the role as Clinical Lead for Organ Donation, Dr Judith Highgate has taken the decision to stand down. Dr Sivanth Sivakumar (ICU & Anaesthetic Consultant) applied and was successful in interviewing for the position.

4. Conclusions & Recommendations

4.1. ESHT has been categorised as a level 2 trust by NHS Blood & Transplant (NHSBT). This is based on the average number of donors proceeding each year and remains unchanged from the previous years.

4.2. Over the last 3 years there has been sustained improvement in referral rates, neurological death testing and specialist nurse presence at ESHT. Overall consent rates have remained above the national average. The organ donation committee will continue this work, with the aim of achieving 100% referrals including from areas such as ED.

5. References

5.1. End of life care strategy (2008) Department of Health

5.2. Organs for Transplant – a report from the Organ Donation Taskforce (2008) Department of Health.

5.3. Taking Organ Transplantation to 2020. A UK strategy (2013) NHS Blood & Transplant & Department of Health.

5.4. Organ Donation and Transplantation 2030: Meeting the Need. A 10-year vision for organ donation and transplantation in the UK.

5.5. NICE Clinical Guidelines CG135, 2011

5.6. www.nhsbt.nhs.uk