



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**

20th OCTOBER 2026, 09:30 – 12:45



East Sussex Healthcare NHS Trust Board Agenda

Date: Tuesday 20th October 2026

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.	Declarations of Interest	Chair	Information		No
4.	Minutes of Trust Board Meeting in public on 18 th August 2026	Chair	Approval	09:50	Yes
5.	Matters Arising	Chair	Discussion		Yes
6.	Board Committee Chairs' Reports	Committee Chairs	Assurance	10:00	Yes
7.	Thirlwall Inquiry: Immediate Requirements and Trust Assurance	CNO	Assurance / Approval	10:10	Yes
8.	Chief Executive's Report	CEO	Information	10:25	Yes
Quality, Safety and Performance					
9.	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 CNO/DCMO DCEO COO CFO	Assurance	10:35	Yes
10.	Maternity Overview Q1 and 10 Point Plan	DMS / CW&C	Assurance	11:10	Yes

Break – 10 minutes

Governance and Assurance					
11.	Winter Planning Update (verbal)	COO	Information	11:40	Yes
12.	Q2 Board Assurance Framework	COS	Approval	11:50	Yes
13.	Equality Annual Report	DCEO	Assurance	12:00	Yes
14.	Annual Review of Trust Governing Documents	CFO	Approval	12:10	Yes

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

Steve Phoenix
Chair

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

Board Meetings in public: Etiquette

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

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

Board Meetings in public 2026:

Date	Location	Timing	Any other information
15 th December	Lecture Theatre, Conquest Hospital	0930-1245	



Report To/Meeting	Trust Board	Date of Meeting	20 October 2026
Report Title:	Colleague Recognition		
Key question	How does the Trust recognise and thank colleagues for their contribution, effort and loyalty?		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐		
Report Sponsor:	Greig Woodfield, Head of OD, Leadership and Culture	Presenter(s):	Steve Phoenix, Chair
Report Author:	Melanie Adams, People Experience Manager		
Outcome/Action requested:	The Board is asked to receive this report for information and assurance about the formal recognition of our people over the last two months.		
Executive Summary	East Sussex Healthcare NHS Trust recognises that the high standard of care and quality of service it provides is dependent on the contribution, effort and loyalty of its people. This is an opportunity for the Trust to acknowledge the exceptional performance, behaviour, achievements and contribution that our colleagues and volunteers have made to the organisation.		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	9	Appendices	1
Governance and Engagement pathway to date:	None		
What happens next?	Rolling delivery of the colleague recognition programme		
Publication	Yes		

1. Introduction

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

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

2. Celebrating our people

2.1 Trust Awards 2026

Colleagues, volunteers and guests attended this year's Trust Awards on 17 September to celebrate the outstanding individuals and teams who make a difference every day across our Trust.

The awards are an opportunity to recognise the dedication, compassion, innovation and professionalism demonstrated by colleagues in every service and department. Throughout the evening, colleagues heard inspiring examples of kindness, innovation, leadership and teamwork, showcasing the impact individuals and teams have on patient care, colleague wellbeing and the continuous improvement of services across the Trust.

The evening celebrated not only our award winners and finalists, but also the many colleagues who were nominated by their peers, patients and members of the public. These colleagues have each received a copy of their nomination to encourage local celebrations and recognition.

The evening also included recognition for colleagues who have reached the incredible milestone of 40 years of service, together with the People's Choice Award, voted for by patients and members of the public.

The evening was a special celebration of our colleagues who reflect the very best of our Trust and the values we share.

See Appendix 1 for award winners and their winning nominations.



Compere – Dr Simon Merritt

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.

June 2026: Pathology Whole Team – EDGH and Conquest Hospital – Core Services Division

"In the early hours of Wednesday 24th June, the pathology service for the Trust lost its main and back-up servers, immediately stopping all electronic processing of lab samples.

Several members of the team were notified and attended site during the night to try to re-start the system. This proved not to be possible, but while Digital repaired the servers the wider Pathology team stepped up over the course of the next three days. They worked late into the evening to ensure manual processes were put in place to safely process patient samples. Staff stepped up in a way I have not seen before, doing different roles and supporting one another throughout. They displayed kindness towards one another and all the way through they put patients first trying to save as many of the samples as possible.

The situation was recovered within 3 days, which given the impact was on many thousands of samples, was absolutely remarkable.

This has to be a team award as there are simply too many people to mention individually. This was genuinely a team response, a team effort and they all played their part and worked together just as the best teams always do in challenging times. The team spirit they showed across Pathology makes them worthy winners of the Heroes of the Month award and Trust recognition at the highest level."

July 2026: Sara Biscoe – Westham Ward – Medicine and Urgent Care Division

"Having recently experienced care from a relative's perspective while a family member was seriously unwell in hospital, I witnessed first-hand the extraordinary compassion, professionalism and dedication that Sara brings to her role every single day. What makes Sara's contribution remarkable is that she continues to give so much of herself to our patients despite waiting on a transplant. The reality for Sara is that if a call comes, she has a small window to reach the hospital where the procedure will take place, or she misses the offer of a transplant. She juggles this urgent and personal health challenge with her role for us. She demonstrates an exceptional level of courage, resilience and selflessness, while never losing sight of the individual needs of patients and families. She is an outstanding ambassador for our organisation and a powerful example of the difference that one person can make.

During a series of demanding 12-hour shifts, she consistently went above and beyond to ensure not only that the patients in her care received outstanding clinical attention, but that their families felt informed, supported and reassured throughout what was an incredibly difficult and emotional time.

Sara does not allow her personal challenges to diminish the care she provides; instead, she seems to draw upon her own experiences to demonstrate an even greater level of empathy, understanding and humanity towards those around her. Her resilience is inspiring, but it is the way she channels that resilience into supporting patients and families that truly sets her apart.

Throughout our experience, Sara treated our relative with dignity, respect and genuine warmth. Equally importantly, she recognised that illness affects entire families, not just individual patients. She always found time for a reassuring conversation, a thoughtful update, or simply a moment to listen. Nothing was ever too much trouble. In an environment where staff are under extraordinary pressure, Sara never made us feel rushed or burdensome. Instead, she made us feel seen, heard and cared for. The impact of these acts should not be underestimated. At a time when we felt vulnerable, anxious and overwhelmed, Sara's kindness provided reassurance and comfort. Her ability to combine clinical excellence with emotional intelligence transformed our experience of care. What may have appeared to

be small gestures had a profound effect on our wellbeing and our confidence that our loved one was receiving the very best care possible.

Sara demonstrates that values are most meaningful when they are lived in practice. She embodies compassion, respect and excellence in everything she does. Her approach reminds us that healthcare is not solely about treatment and interventions; it is about human connection, dignity and the experience of those we serve.

I am profoundly grateful for the care Sara provided to our family. Her kindness, compassion and dedication left a lasting impression at a time when we needed it most. I can think of no more deserving recipient of this award, nor a better example of someone who genuinely changes lives through the way she cares for others.”

2.3 Long service recognition

The number of long service awards issued August - September 2026:

Month	5 years	10 years	15 years	20 years	25 years	30 years	35 Years	40 years	45 years	50 years	Extras	Total
August 2026	56	37	12	2	7	6	2	0	0	0		122
September 2026	70	38	13	8	22	1	3	4	2	0		161

The figures shown in the yearly columns are extracted from the ESR report for each award on a monthly basis. The ‘Extras’ column reflects awards received via nomination forms in cases where they may not yet be captured within the ESR report. This can occur where individuals hold more than one employment record, for example due to retire-and-return arrangements or changes in job roles.

2.3.1 Celebrating our long service colleagues

Five year awards:



Christina Debenedictis



Sreejith Poroli



Fay Stevensova



Grenita Villaneuva and Claiza Espera

10 and 20 Year awards:



Elizabeth Maddison



Sangam Khatiwada



Sue Stevenson



Henrietta (Hetty) Holman



Reynald Sison



**Monica Sikirica – 10 years
and Abbie Schulz – 20 years**



Ashley Barker



Serena Finch

25 Year awards:



Dymphna Lonergan



Emma Pope



Sally Gallagher

2.4 Our retiring colleagues

The Trust recognises colleagues who are retiring after 20 or more 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 are 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.

Attendees have expressed how valued they feel by the gesture and how much they appreciate the personal touch. The events are always joyful occasions, filled with warmth and appreciation.

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

September 2026

In September we celebrated the retirement of two colleagues:



**Carol Hobbs, SCBU Staff Nurse
– Conquest Hospital**



Gillian Matthews, OPD Staff Nurse – Eastbourne DGH

3. Conclusion

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

4. Recommendations

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

Trust Award Winners 2026



Enhancing Patient Safety, Experience and Care - Julia Breden, Dietetic Assistant

Winning nomination: "Julia is a huge asset to our team who excels at supporting patients and colleagues. She has made a very real and measurable difference to the experience of so many gastroenterology patients suffering with difficult chronic conditions. The work she is doing is groundbreaking within the dietetic assistant role and we are in the process of writing the pathway up for publication."

Improving the Health and Wellbeing of our People - Professional Midwifery Advocate Team

Winning nomination: "Their weekly Tea and Toast sessions – simple, warm and welcoming – have become an essential wellbeing anchor, giving colleagues a moment to breathe, connect and reset before continuing with their day. Alongside this, they provide regular support sessions, making themselves available as often as needed."

Inspiring our People through Leadership - Myleen Spry, Matron, Medical Day Unit

Winning nomination: "Myleen has positively transformed patient experience through her compassionate leadership and dedication to high-quality care. She creates a supportive and inclusive environment for both patients and colleagues, improving team morale and confidence."

Inspiring Colleagues through Personal Development - Damian Atherton, Senior Project Manager, Estates and Facilities

Winning nomination: "Damian will always go out of his way to be kind and help anyone in need. If someone asks Damian for help, he will drop what he is doing and show them how things work. Damian does whatever brings the most benefit to the trust and least disruption to the wards and colleagues."

Living the Trust Values - Joint Community Rehabilitation Service

Winning nomination: "The Joint Community Rehabilitation Team consistently lives the trust values through the way we work with both colleagues and clients. Kindness is shown in daily interactions, supporting one another through challenges, celebrating achievements, and creating a genuinely caring, family-like atmosphere."

Team Contribution to Support Outstanding Patient Care - Clinical Engineering (EME), Eastbourne

Winning nomination: "I am nominating the Clinical Engineering team for their vital, often unseen, contribution to safe and effective patient care. Their expertise ensures that critical medical equipment is reliable, accurate, and available when needed, directly supporting clinicians in delivering life-saving treatment."

Making a difference Behind the Scenes (Key clinical supporting role Bands 2-4) - Nikki Harris, Clinical Support Worker

Winning nomination: "When I started my role as a Clinical Support Worker, Nikki took her time to patiently teach me all my clinical roles. She is so supportive and she keeps telling me, 'you can do it'."

Making a difference Behind the Scenes (Key non-clinical supporting role Bands 2-4) - Teresa Husher, Care Coordinator

Winning nomination: "Teresa has been an exceptional and inspirational member of the team. She consistently delivers outstanding emotional and practical support to patients and their families, enabling nursing and therapy staff to focus more effectively on achieving rehabilitation outcomes."

Leading by example – Inclusion and Diversity Award - Staff Network Chairs and Vice Chairs

Winning nomination: "The Staff Network Chairs and Vice Chairs show outstanding leadership, commitment and passion in driving equality, diversity and inclusion. They have created safe and supportive spaces where colleagues feel heard, represented and empowered to contribute to positive change."

Colleague of the Year – Temporary Workforce Service (TWS) - Darius Khaledi, Senior House Officer

Winning nomination: "Dr Darius has an exceptional ability to adapt to different wards and clinical settings, often at very short notice and during extremely busy shifts. No matter where he is placed, he quickly becomes a valued and trusted member of the team."

People's Choice - Anish Abraham, Nurse

Winning nomination: "I personally witnessed Anish's incredible attentive care. Both of us cannot fault him and his love of his job truly shines through. Anish has reminded me what it means to be a nurse, and that is priceless."
and

People's Choice - ITU Patient Support Group, Bexhill Hospital

Winning nomination: "The support and aftercare provided has been a godsend. Offering care beyond just for my original illness, making sure I have never felt alone during my recovery after a lengthy stay in Critical Care. Nothing has been too much trouble."

Chairman's Special Recognition Award - Councillor Colin Belsey

Councillor Colin Belsey received his award for his "support and hard work over the years to hold the trust to account and scrutinise the work we are doing. Under his guidance and challenge, Councillor Colin Belsey has fostered collaboration, cooperation and overall, improvements with a focus on wellbeing, both of our community and our workforce."

Chairman's Cup - Nick McNeill, Chief of Diagnostics, Anaesthetics and Surgery

Nick was commended for the "significant improvements over the services he is responsible for over the last 12 months, making us the best performing trust in the region in several areas. Nick has tackled difficult issues with a great deal of energy, vigour and determination, but also with passion and care. Nick has played a crucial part in bringing the trust some of its newest facilities, transforming the care we provide."



East Sussex Healthcare NHS Trust Board Minutes

Date: 18th August 2026
Time: 09:30 – 12:45
Venue: St Mary's Boardroom, EDGH

		Actions
	Attendance: Steve Phoenix, Chair and Non Executive Director Jayne Black, Chief Executive (CEO) Amanda Fadero, Non-Executive Director Simon Merritt, Chief Medical Officer (CMO) Charlotte O'Brien, Chief Operating Officer (COO) Paresh Patel, Vice Chair and Senior Independent Director Spencer Prosser, Non-Executive Director Frank Sims, Non-Executive Director Andrew Strevens, Chief Finance Officer (CFO) Carys Williams, Non-Executive Director <u>Non-Voting Directors</u> Steve Aumayer, Deputy Chief Executive and Chief People Officer (DCEO) Amber Lee, Associate Non-Executive Director Richard Milner, Chief of Staff (COS) <u>In Attendance</u> Ama Agbeze, Associate Non-Executive Director (via MS Teams) Claire Bishop, Deputy Chief Nurse (DCN) Matthew Clark, Chief of Division, Women and Children's Division (COD) Amanda Combes, Advanced Practitioner Neurology, Headaches & Injectables (APNHI) Hannah Horne, Director of Maternity (DOM) Mike Roberts, Board Advisor (BA) Pete Palmer, Board Secretary (BS) (minutes) <u>Observing</u> Kate Murray Six members of the public were in attendance at the meeting.	
	Apologies: Vikki Carruth, Chief Nurse & Director of Infection, Prevention and Control (CNO)	
61/26	Chair's Opening Remarks Steve, Chair welcomed everybody to the meeting.	
62/26	Colleague Recognition Steve, Chair reported that April's Hero of the month had been Patra Baxendale from Murray Ward who had won the award for her hard work, dedication and kindness; she has regularly gone above and beyond for both patients and colleagues. Sam Godwin and Charlotte Smith from the Urgent Community Response Team had won the award in May, for their care of a patient who they had supported in mobilising for the first time in months.	

	The CEO explained that one member of staff, Jan Humber, had recently retired after 57 years of service, noting that this was an amazing milestone. There were a number of other staff who had also worked for the organisation for a significant time and she thanked them all for their dedication.	
63/26	Acute Migraine Treatment Service Amanda Combes, APNHI delivered a presentation on the Acute Migraine Treatment service and provided an overview of its development and impact. Spencer, NED asked about feedback from patients about the service. Amanda reported that feedback had been extremely positive; patients valued not having to attend the Emergency Department and had regarded the service as highly successful. She explained that work was underway to explore an out-of-hours service and direct referrals to the virtual ward in order to further streamline the patient pathway. The CFO praised the work that had been done by the service, noting that he was supportive of initiatives that promoted preventative care and a left shift in service provision. He asked what discussions had taken place with commissioners regarding the service and whether there should be a commissioned pathway to support it. Amanda responded that conversations with commissioners had not yet taken place, but that there were plans to engage with them. The Chair agreed that the service was the right approach for patients and represented a sensible use of resources, noting the importance of getting agreement with commissioners as soon as possible. Paresh, NED asked how the Board could support the expansion of the service. Amanda responded that having headache specialist nurses within the Emergency Department would be beneficial. She explained that service prevented the majority of patients seen from needing a hospital admission. Paresh, NED asked about whether patients with migraines should be managed within primary care. Amanda confirmed that patients were normally managed in primary care until they reached a stage of requiring advanced treatments. GPs should be prescribing these treatments and she acknowledged that considerable work remained to ensure care was delivered in the most appropriate setting. Educational work with GPs was underway, although progress had been slow. Mike, BA commended the work, describing it as an excellent initiative. He emphasised the importance of engaging with the finance team as soon as possible and remarked that the service represented a positive news story for the Trust that deserved greater publicity. The CEO described the service as a fantastic initiative and was interested in how this could be incorporated into neighbourhood working. She welcomed the links between the service and the virtual ward and requested that a presentation be prepared for a future Trust briefing so that the wider organisation could be informed of the work. Amanda, NED praised the presentation and asked whether, as a predominantly adult-orientated service, there were any links with paediatric services. Amanda advised that there were currently no formal connections, as the service cared for patients aged 16 years and over; none of the team had paediatric training. Discussions had taken place about the possibility of transition arrangements and she would be happy to explore this area further. The Board noted the presentation.	
64/26	Declarations of Interest There were no interests declared for any item to be considered on the agenda. All declarations of interest were noted as held on the Register of Directors' Interest.	

65/26	Minutes The minutes of the Trust Board meeting held on 16th June 2026 were reviewed. No clarifications were made and they were agreed as a correct and accurate record of the meeting.	
66/26	Matters Arising <u>73/23 – Trust IPR</u> This action was not yet due. The DCEO advised that changes were currently being finalised to reporting arrangements for divisional IPR meetings with changes to be introduced from September. The updated Board IPR was due to be introduced later in the year and would incorporate community services within its scope.	
67/26	Trust Response to National Maternity Reviews The DCN reported that the Board had recently convened for an extraordinary meeting to discuss maternity services and thanked colleagues for the constructive discussions that had taken place. She noted that the paper being presented reflected the findings of recent national maternity briefings and confirmed that the Trust's key concerns and planned actions were aligned with recommendations within those national reports. The DOM reported that the outcomes of the Ockenden and Amos national maternity reviews had been published during the previous two months. These consolidated and built upon previous national reviews and work was being undertaken by the maternity leadership team to review and benchmark the Trust's services against national recommendations. The DOM highlighted that while the Trust had access to good quality maternity data, this information did not always feed effectively into an overarching organisational view and work had commenced to strengthen reporting arrangements. Staffing had been identified as a key issue within the Amos review, particularly regarding specialist roles, and it was important to ensure that any workforce changes did not adversely affect patient care. A review was being undertaken to ensure that staffing capacity would support future improvements. The COD advised that NHS England colleagues had requested completion of a maternity assurance spreadsheet by 25th September; the submission would require both divisional and Board sign-off prior to submission. The DOM added that there would be a further submission in December, followed by regular quarterly reporting to NHSE. The DCN hoped that this revised reporting would help inform future reporting to the Board so would be beneficial in the long term for the organisation. The Chair noted that the Trust had large amounts of maternity data with extensive information having historically been reported to the Board. The challenge was in identifying what the data was actually saying. The COD agreed and acknowledged the need to improve the way information was presented to the Board to ensure that it was meaningful and useful. The CEO commended the significant amount of work being undertaken within maternity services and thanked colleagues for their efforts. A maternity dashboard was being developed which would provide improved visibility of maternity data and increased assurance for the Board. She explained that it was important to be honest about the Trust's current position and any areas requiring further improvement. The DOM agreed, explaining that the national reports provided a helpful framework for improvement. Paresh, NED commented that it would be helpful for future reports to clearly identify data gaps, setting out both the current position and the desired state. He noted that while Board assurance was important, it was equally important that reporting arrangements delivered value at an operational level.	

Amanda, NED praised the insight and leadership provided by the new maternity leadership team. She felt that the recent national reviews provided an opportunity for improvement, and noted the considerable support provided to the service by the Maternity and Neonatal Voices Partnership (MNVP), particularly in providing insight on engagement. It was important that sufficient time was taken to ensure arrangements were developed effectively rather than rushing implementation.

Frank, NED cautioned about the risk of becoming overwhelmed by large volumes of data and emphasised the importance of understanding the messages behind the information presented; he suggested that reporting should triangulate quantitative data with qualitative feedback from staff, patients and visitors.

Amber, ANED asked whether the Trust was still required to report separately in response to each individual review. The DOM confirmed that some individual reporting requirements remained in place; however, a new ten-point plan introduced by Jim Mackey would result in a single overarching report encompassing all requirements moving forward. She had been invited to work with other regional Directors of Midwifery on reducing repetitive maternity reporting; a feedback mechanism existed through the national midwife to highlight duplication where it occurred. The Chair reported that NHS Chairs had recently met with Penny Dash and had provided feedback regarding the burden of repetitive reporting requirements.

Spencer, NED noted there was a possibility that additional funding might become available and asked whether this could be used to improve the maternity estate. The DOF reported that only a small amount of funding was available nationally across a large number of organisations; the Trust would develop a pipeline of schemes that could be utilised if more funding became available in the future.

Ama, ANED asked how maternity staff were feeling about the changes being implemented. The DOM reported that feedback had been positive; time had been spent working alongside midwives in both community and acute settings and staff had been open in expressing their views. Feedback had been generally optimistic about the future; the staff voice would be included within future Board reporting.

The CEO noted that this was the COD's final attendance at the Board and thanked him for his significant contribution and hard work over the previous four years. She explained that the division was now in a stronger position and expressed confidence that improvement would continue. The Chair echoed these comments, praising the work undertaken under the COD's leadership and noting that the division had been a recipient of the Chairman's Award at the Trust's annual staff awards a couple of years before in recognition of the outstanding work that had been done.

68/26 Board Committees Chairs' Reports

Audit Committee

There was no report from the Audit Committee as this had been postponed due to exceptional circumstances and was due to meet the following day.

Finance and Performance Committee

Paresh, NED presented the Finance and Performance Committee (F&P) report. He noted the significant challenge facing the Executive team in ensuring that the Trust maintained its financial performance and he thanked the CEO and CFO for their financial leadership. Cash remained an ongoing issue for the organisation and applications had been made for additional cash. The Committee had approved business cases which should lead to improved efficiency and performance.

The CEO reported that divisions had been extremely supportive of the actions being taken to manage financial performance. She hoped that the recently approved business cases would lead to improvements for patients as well as savings for the Trust.

People and Organisational Development Committee

Frank, NED, presented the People and Organisational Development (POD) Committee report. He advised that POD had begun to shift its focus away from a reliance solely on key performance indicators (KPIs) and towards a broader range of workforce measures that could help identify emerging concerns at an earlier stage. TPOD had also sought to obtain direct feedback from divisions in order to capture softer intelligence about how it felt to work within the organisation and to gain a better understanding of staff experience.

While the workforce metrics reviewed by POD had remained broadly stable, there was evidence that workforce pressures continued to be felt across the organisation. He noted that this position was reflected within the risk profile presented through the Board Assurance Framework (BAF). POD would begin applying a Continuous Quality Improvement (CQI) approach to its work, which would include reviewing how it operated and how it could most effectively provide assurance and support improvement across the organisation.

Quality and Safety Committee

Amanda, NED presented the Quality and Safety Committee (Q&S) report. She reported that the most recent meeting had been significant in terms of changing the focus of discussions and adopting a different approach to assurance. Quality metrics across the organisation continued to remain stable, but Q&S was concerned that maintaining these standards was coming at a cost to staff wellbeing due to ongoing operational pressures.

Q&S was therefore seeking to triangulate a wider range of information in order to better understand the impact of these pressures and identify any actions required to mitigate them. A number of areas of concern had been identified and plans were in place to provide support and address these issues. Q&S had received the first version of a new triangulation report, which brought together quantitative data, qualitative information and emerging themes to provide a more comprehensive view of quality and safety performance. Q&S was working closely with other Committees as it was important to be able to consider data from different perspectives.

The Board noted the Committees Chairs' reports

69/26

Chief Executive's Report

The CEO presented her report, highlighting a number of significant organisational developments. The Trust's Allyship Programme had been shortlisted for a 2026 HSJ Award and she was very proud of the national recognition the initiative had received. The programme had been developed in response to concerns identified through staff feedback and the Staff Survey and had been launched at the Staff Awards the previous year. It aimed to strengthen the staff voice and encouraged colleagues to speak up about bullying, harassment and discrimination.

The Care Quality Commission (CQC) had recently withdrawn a Section 29 Warning Notice that had been issued following its review of the Emergency Department. The CEO explained that the Trust had responded comprehensively to the concerns raised and had submitted additional evidence, following which the CQC had withdrawn the notice. While welcoming this outcome, she emphasised that significant work remained to improve emergency care services and acknowledged the challenges posed by ongoing operational pressures. The Trust was also awaiting the full report from the inspection visit.

The CEO reported that the findings of the Lord Mann Review had been published and had highlighted concerns relating to antisemitism within the NHS. These findings were deeply concerning and she advised that Board members would undertake training and would adopt the NHS Race Equality principles. She stressed the importance of ensuring that this work formed part of the organisation's broader culture improvement programme and became embedded across the Trust.

Mike, BA asked whether there was a plan to disseminate learning from maternity services across the wider organisation and how information relating to culture would be standardised to provide assurance to the Board. The CEO advised that considerable learning had already emerged from the maternity improvement programme and that the Trust's Quality Management System would be used to support dissemination across the organisation. Work was underway to develop divisional dashboards containing both driver and watch metrics. She added that there was further work to do in strengthening governance arrangements and ensuring that learning generated at divisional level was captured and shared more effectively. Opportunities to share learning would include quarterly senior leadership meetings, Trust briefings, governance forums and Continuous Quality Improvement (CQI) processes.

Ama, ANED welcomed the Trust's response to the Lord Mann Review and asked how this work would be embedded throughout the wider organisation. The CEO explained that further work was being undertaken to determine how best to implement and sustain the review's recommendations. This would be supported through CQI methodologies and the Quality Management System. She stressed that the work was not solely about training, but about defining the culture and behaviours expected within the organisation and ensuring that these expectations were reflected through formal governance arrangements and embedded in everyday practice. She emphasised the importance of ensuring that colleagues not only received training but also consistently demonstrated expected behaviours.

A recent BBC News report had been published concerning a cultural review of General Surgery in the Trust earlier in the year following concerns raised by staff about behaviours within the department. The Trust did not tolerate bullying, discrimination or harassment and the CEO thanked members of staff who had been courageous in raising concerns. She acknowledged that speaking up could be difficult and was pleased that staff felt that they were able to do so. Executive colleagues had since met with both the wider team and the consultant body and would continue to work with them, taking action where appropriate to foster a positive working culture. She stressed the importance of ensuring that all staff received appropriate support when raising concerns.

She provided an update on partnership working across East Sussex, reporting on a number of collaborative initiatives, including neighbourhood working arrangements and plans by Sussex Partnership NHS Foundation Trust (SPFT) to establish a mental health service within the Emergency Department at EDGH. This was an important development that would improve care and experience for patients presenting with mental health needs, with benefits expected to begin being realised in 2027.

The Chair asked whether revenue funding and staffing arrangements had been agreed for the proposed mental health service. The CEO reported that discussions had recently taken place with SPFT who were reviewing their existing services and service models to identify how the new provision would be funded. She stressed the importance of establishing appropriate pathways and confirmed that the Trust would continue to work closely with SPFT on the development of the service. The COO added that some services would be co-located within the Emergency Department and that the intention was for the service to operate on a 24-hour, seven-day basis. The Chair welcomed the proposal and observed that it would provide significant benefits for patients.

The CEO outlined the ongoing programme of Gemba visits undertaken by Executive Directors and senior leaders, explaining that these visits, undertaken at least twice each week, provided opportunities to speak directly with staff, understand their experiences and identify areas where additional support might be required. Learning and themes arising from the visits were taken to improvement huddles and she expressed the hope that, in future, these insights would also be routinely reported through POD and to the Board to further support triangulation and provide assurance.

	The CEO informed the Board that the Chair would be leaving his role in January having reached the end of his term; she thanked him, on behalf of both the Board and Executive Team, for his significant contribution to the organisation. She noted that his expertise and support would continue to be highly valued during his remaining time with the Trust. <i>The Board noted the CEO's report.</i>	
70/26	Integrated Performance Report (IPR) for Month 3 (June) The IPR was jointly reported by the DCN, CMO, DCEO, CFO and COO. <u>Quality and Safety</u> The DCN presented the update. Highlights from this section included: • There had been 986 patient safety incidents reported in June, with levels of harm remaining low and below the national average. No Never Events had been reported. • The most common theme was slips, trips and falls; this was part of Trust's CQI improvement programme. Medication errors was the second most common theme, followed by patient discharge and transfer. • Quality metrics remained good, but the Trust was conscious of the impact of organisational pressures on staff; it was expected that the sustained level of demand might lead to a reduction in performance over time as this was impacting on the organisation's ability to fill shifts. • Complaints rates were low and remained within targets; family and friends feedback remained good. • Patient safety weeks continued and were focussed on following safety processes. The CEO reported that the Trust continued to experience exceptionally high levels of operational pressure. Attendance and demand within Emergency Departments (EDs) had increased significantly, creating challenges for staff across the organisation. Additional capacity had been opened to manage demand, with pressures exacerbated by annual leave and lower staffing fill rates during the summer holiday period. Executive Directors met daily to maintain oversight of operational pressures, including ED activity, the number of patients being cared for in corridor areas, and the actions being taken to mitigate associated risks. She acknowledged the additional impact of the recent hot weather and commended staff for their continued efforts to provide safe, high-quality care under challenging circumstances. Paresh, NED commented that he had visited the ED and had seen the significant pressures being experienced; there had been 84 patients in the department at 0900 that morning. He noted the positive position regarding MRSA, with no reported cases since April, and asked how confident the Board could be that the data was accurate and how the Trust compared with peer organisations. The DCN explained that the good performance position reflected the effectiveness of the Trust's infection prevention and control arrangements. MRSA rates had reduced significantly, while occasional MSSA cases tended to be associated with pneumonia and therefore reduced during the summer months. There had been no hospital-acquired cross-infections identified and she was confident about the organisation's reporting culture. Mike, BA asked what level of Trust performance should be considered aspirational when benchmarked against national comparators. The CMO explained that the answer depended on the specific metric being considered; for some indicators, being around the national midpoint could represent a positive outcome given factors outside the Trust's direct control, such as estate limitations and structural challenges. Mike, BA questioned how NEDs could determine whether a performance position was satisfactory without additional context and suggested that clearer indicators would	

support Board assurance. The DCN agreed and advised that triangulation reports being developed for both Q&S and POD would provide greater context and help the Board understand how various improvement initiatives were influencing performance. The Chair reflected that the organisation had traditionally sought to achieve performance within the upper half of national rankings for constitutional standards. However, he stressed the importance of understanding what was realistically achievable within the current context of delivering unprecedented financial savings for a second year in a row alongside increasing demand. Ultimately, the key test was whether the organisation was providing the best possible care for patients; there were many areas of strong performance but also areas where patient care needed to improve.

The CMO presented an update on mortality reporting that the Summary Hospital-level Mortality Indicator (SHMI) was currently 107.1 and within the expected range. He explained that a more significant improvement was anticipated in the next reporting cycle. He reported NHS Digital would be changing how Same Day Emergency Care (SDEC) activity was applied to SHMI to make this consistent across organisations. It would be based on admitted patient datasets moving forward and the change was expected to reduce the Trust's SHMI by about 5%.

A series of detailed mortality reviews and deep dives had been undertaken over the previous 12 to 18 months in areas including sepsis, stroke and chronic obstructive pulmonary disease (COPD). These reviews had not identified significant concerns regarding the quality of care provided. While some issues had been identified relating to the timely administration of antibiotics, delayed recognition of patients approaching the end of life, high levels of patient frailty and coding accuracy, there had been no evidence of avoidable deaths.

Spencer, NED noted that SDEC data had been discussed previously and asked whether future SHMI reporting would now allow comparison with organisations using the same methodology. The CMO confirmed that this would be the case. The reporting methodology had changed in October 2024 and SDEC patients generally represented some of the fittest patients within the cohort. As not all organisations had applied the methodology consistently, comparisons had historically been difficult. There remained concerns nationally regarding the validity of SHMI as a comparator for integrated trusts who were disadvantaged when compared solely with acute trusts.

Frank, NED asked whether assurance regarding mortality performance was based on a broader range of evidence than SHMI alone. The CMO explained that although SHMI remained an important indicator, assurance was supported by a range of processes including structured mortality reviews, thematic deep dives and other governance mechanisms. He reiterated that SHMI was expected to improve further in future reports and that the wider evidence base provided greater confidence regarding mortality outcomes within the Trust.

Frank, NED asked whether the diagnostic themes emerging from mortality reviews were consistent with those seen elsewhere. The CMO explained that he was not certain how closely they aligned with other organisations, although the conditions identified reflected leading national causes of mortality. There was nothing within the Trust's data that suggested a significant differentiating issue when compared with similar organisations. The CEO added that several of the diagnostic themes identified formed key priorities within neighbourhood alliance programmes focused on prevention and population health. Work was being undertaken collaboratively with partner organisations to strengthen preventative interventions and reduce avoidable illness and it was hoped that these initiatives would have a positive impact on future mortality indicators.

The CMO concluded by noting that crude mortality rates had reduced since the previous report, which provided additional reassurance about performance.

Our People – Our Staff

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

- Additional escalation capacity was opened during the month. Despite this increase in demand, the Trust reduced its workforce establishment by 17 WTE compared with the previous month.
- Pay expenditure for the month was £500k below plan. This was achieved through effective management of the substantive workforce and continued control of bank and agency staffing usage.
- Sickness absence remained relatively stable, increasing by only 0.1% during the month. Although significant effort continued to be focused on reducing long-term sickness absence, long-term cases increased as a proportion of overall sickness absence and continued to have a significant impact on the organisation.
- While the findings of the General Surgery review were disappointing, undertaking the review was important. It demonstrated that concerns raised by colleagues were taken seriously and that appropriate action was taken in response.
- A group of matrons who completed the Operational Excellence programme as part of their leadership development were shortlisted for a national award. The recognition related to work undertaken within outpatient services to improve coding consistency and provides an excellent example of the positive impact of the Trust's Continuous Quality Improvement (CQI) approach.

Spencer, NED asked what more could be done to reduce sickness rates. The DCEO explained that employees' day-to-day experience at work was a significant factor, particularly in relation to stress, anxiety and depression. Considerable effort was being made to ensure that operational services ran as smoothly as possible, as this had a direct impact on staff experience and wellbeing. Phase Two of the Trust's Mental Health Awareness Programme was being rolled out, which was expected to have a positive impact. The Trust was also increasing the number of Wellbeing Champions, had restructured HR services to embed wellbeing alongside operational support, and was beginning to see improved links with Occupational Health making a meaningful difference. Further investment was being made in Trauma Risk Management (TRIM), with an additional 16 members of staff being trained, while restorative supervision arrangements were being developed to support staff working in particularly pressured environments. The leadership development programmes would also contribute to improving workplace culture and experience. The Trust was keen to review emerging data from NHS England regarding sickness rates by geography and demographics.

Amber, ANED observed that the Trust appeared to have many appropriate measures in place to support staff wellbeing but noted that sickness absence was rising across a range of sectors nationally. She asked whether a higher level of sickness absence should now be regarded as the new norm. The DCEO responded that the COVID-19 pandemic had changed attitudes towards health and attendance at work, with staff being more cautious about attending work when unwell. In addition, awareness of mental health and the importance of protecting personal wellbeing had increased significantly, resulting in different expectations and behaviours in the workforce.

Paresh, NED praised the substantial amount of positive work that was being undertaken and asked whether the overall staffing establishment would be able to continue to be reduced given the continuing operational and financial pressures facing the organisation. The DCEO advised that the Trust was actively seeking to reduce costs while simultaneously improving staff experience, delivering constitutional and quality standards, and responding to ongoing operational demands. Balancing these competing priorities was extremely challenging and difficult decisions would need to be made regarding the most appropriate course of action. He expressed concern that sustained pressures could contribute to increased sickness absence, higher staff turnover and earlier retirements over the longer term.

The CEO reflected that the Trust needed to think and respond differently, recognising that the current approach was not sustainable. While the organisation had made significant progress, there were limits to what could be achieved through existing models of care. There were opportunities available as an integrated trust, including delivering services differently within community settings and strengthening partnership working; the Trust would adopt a strong leadership role in driving system-wide change, with neighbourhood-based approaches providing a particular opportunity to support this ambition. Current pressures were having a significant impact on staff and she warned that, without meaningful change, capacity constraints would continue to intensify.

Access and Responsiveness

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

- The Trust's EDs had been extremely busy in June and performance against the four hour standard had been 76.8% against the 78% target. The Trust had seen a 7% increase in all ED attendances, and a 12% increase in type one attendances, in 2026.
- EDs were not built to manage the numbers of patients that were attending. High attendances had continued into July and then increased further in August with more patients remaining in ED for more than 12 hours and an increase in patients with no criteria to reside.
- Escalation capacity had been opened to manage the increased demand and remained open. A bed modelling paper had been presented to F&P which would help offset some of the pressure and included work to support an improved acute medical model.
- Elective performance remained strong and the Trust remained in the second quartile nationally with a reduction in patients waiting for over 52 weeks for treatment.
- Cancer performance in June for the 62 day pathway had been 64% against a trajectory of 75%; work was being undertaken to stabilise this, with daily meetings taking place to review performance. Performance had improved in July to 69%, with delays escalated and work with tertiary providers to improve performance. There had been a 6% growth in suspected cancer referrals.
- The Trust was delivering its diagnostic recovery plan, and further improvement was expected in July.
- The community paediatric waiting list had reduced in May and remained an area of focus.
- Adult community waiting time performance was at 86.3% against the 70% 2 hour target.

The Chair asked whether the Trust was the best performing for Referral to Treatment (RTT) in the South East, and the COO confirmed that this was the case.

Spencer, NED asked whether it would be possible for the Board to receive trend data showing the increase in patient activity over the past three years, correlated with quality and cost measures. The COO advised that there had been significant growth in activity over recent years and that the Trust was an outlier in this regard. Data had been shared with the ICB about the conditions contributing to this increased demand, including the impact of the Trust's geography. The CEO explained that the increase reflected the demographics of the local population and emphasised the importance of developing acute medicine and frailty models to effectively manage patients through the system. Demand was expected to increase further given the projected growth in the population aged over 85 years locally, so it was important to fully understand these demographic changes and to develop different approaches to managing demand. It was also important to maintain strong relationships local ambulance services to ensure patients were conveyed to Urgent Community Response (UCR) services where appropriate.

Spencer, NED emphasised the importance of recognising both current and future demand pressures. The COO agreed, noting that bed modelling undertaken for the

current year indicated that the Trust did not have sufficient bed capacity to meet the anticipated demand at the front door; the Trust's transformation programme would therefore be critical. The Chair noted that the Trust had experienced substantial growth in ED attendances over a number of years but had not received corresponding funding to reflect that increase in demand. He hoped that commissioners would recognise the Trust's position as an integrated organisation and the work that was already taking place to provide care closer to patients' homes.

Paresh, NED noted that the Trust now appeared to experience summer surges in demand as well as traditional winter pressures and felt that this should be recognised. The COO agreed and advised that periods of extreme heat during the year affected patient acuity, resulting in higher numbers of very unwell patients requiring treatment. This in turn had increased the length of time required to prepare patients for discharge. The CEO reported that during a recent visit to ED a member of staff had expressed concern regarding the likely impact of winter pressures given the significant challenges already being experienced. She emphasised the importance of implementing mitigations in advance of winter and noted that while a number of positive initiatives were in place which should improve resilience, close partnership working would be essential to managing demand effectively.

Frank, NED asked whether the number of patients presenting with mental ill health had increased. The COO reported that activity levels continued to fluctuate; while numbers were relatively low at the time of reporting, demand had been considerably higher only a few weeks earlier.

Mike, BA asked whether sufficiently detailed data was available to understand why the Trust was experiencing different levels of demand from comparable organisations as a deeper understanding of the factors driving demand would help identify actions to address those pressures. He also suggested seeking feedback from patients to better understand why they attended ED. The COO explained that Healthwatch had previously supported the Trust in collecting this information and that they were currently undertaking further work; the scope of this work could be expanded to collect additional insight into patterns of demand and patient behaviour.

Financial Control and Capital Development

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

- Operational issues because of the heatwave continued to impact on staff.
- The Trust had received £10m cash and would make a further application at the end of August. A dividend of £5.5m would need to be paid in September.
- The Trust had an extremely challenging savings scheme of £74m for the year. Divisions had responded positively to the challenge, with innovative ideas. Grip and control had been increased, including vacancy control and discretionary spend panels.
- Transparent conversations with system partners had taken place about financial challenges.
- Conversations would take place with the ICB about differences in funding versus plans and how these would be addressed.

The CEO reported that the conversations with the ICB would include discussion of community services which had previously been funded by a block contract. It was important that funding appropriately reflected the growth in demand seen by the organisation.

The Board noted the Integrated Performance report.

71/26	Maternity Overview Q4 The DOM presented the Maternity Overview, noting that it demonstrated that services remained safe, with high-quality care delivery, effective governance arrangements and a strong focus on quality improvement. The service continued to meet the requirements of the Clinical Negligence Scheme for Trusts (CNST) and the Saving Babies' Lives Care Bundle. Challenges remained in relation to staffing and sickness absence, with the majority of continuity of carer resource currently being utilised to support and backfill frontline staffing requirements; significant work had been undertaken to improve this position. Future reports would be presented in a more qualitative format to provide improved insight into service performance and improvement activity. The COD noted the importance of monitoring of stillbirth rates to provide a consistent measure of performance across organisations. The national average was just below four per 1,000 births and, while the Trust's rate had risen above this level earlier in the year, it had subsequently reduced and was now below the national benchmark. The DCN reflected on previous discussions regarding the benefit of fresh perspectives brought by new leadership and noted that improvements in both frontline culture and staff experience were beginning to be reflected within the data since the change in maternity leadership. Patient and staff feedback following the changes had been very positive. The service's improvement trajectory was already aligned with national guidance and expectations. <i>The Board noted the report.</i>
72/26	Integration and Strategic Direction The COS presented a paper outlining the wider strategic intent and future development of integration across East Sussex. The paper was a discussion document, setting out what future arrangements could look like and building on ongoing conversations with ICB colleagues regarding integration and the development of an East Sussex integration model. The ICB recognised the long-established history of collaborative working across East Sussex, which placed local partners in a position to progress at a different pace due to the strength of existing relationships. The COS emphasised that functional integration would need to be developed before any consideration of changes to organisational form, with a focus on shared outcomes, governance arrangements and care pathways. The greatest opportunity for impact was likely to be through the improvement of frailty pathways. Work would be undertaken collaboratively with system partners and the paper outlined the actions required to progress this agenda. Carys, NED welcomed the paper and highlighted the voluntary, community and social enterprise (VCSE) sector as a particular strategic strength within East Sussex, noting the effectiveness with which local charities already worked together. She suggested that building on these established relationships could provide an early opportunity for progress. The COS confirmed that discussions with local authority colleagues were planned later in the year and advised that existing VCSE relationships would form an important part of those conversations. The Chair noted that East Sussex had developed strong partnership working over many years but there was scope to improve the pace at which tangible improvements were delivered. He reflected that patients did not wish to navigate organisational boundaries and that partners therefore needed to move beyond traditional partnership discussions towards taking collective action that met patient needs regardless of organisational structures. He acknowledged that this represented a challenge for both the Trust and its partners. Amanda, NED expressed support for the proposed direction of travel but highlighted concerns regarding capacity and deliverability. She noted that firm commitments from partner organisations would be essential and that clear gateways would be required to determine progression between phases of the programme and asked how this would be managed. The COS advised that work was underway to develop a three-year roadmap

	incorporating specific actions and outcomes, with six key dependencies having already been identified as prerequisites for progression. He noted that the adoption of the proposed model would fundamentally change how Trust operated. The Chair observed that the proposals aligned closely with the policy direction of the current Government and the wider agenda of shifting care closer to home. Previous attempts to progress similar models had been constrained by the policy environment; however, he felt that circumstances were now far more favourable. He emphasised that the involvement of primary care would be critical to the success of the approach, and hoped that the Trust's positive relationships with primary care partners would provide a strong foundation for the work. The CEO agreed, noting the importance of also being involved in shaping future organisational and service models. Amanda, NED felt that the work needed to form part of the broader effort to address system-wide challenges, suggesting that adopting a CQI approach would be beneficial. She felt that a clear commitment from the ICB through including the initiative within their future commissioning intentions would represent a significant demonstration of support. The COO highlighted the East Sussex Musculoskeletal (MSK) Partnership as a source of valuable learning, noting that lessons from that programme could inform future integration work. The Chair agreed and noted that the Trust's experience of collaborative working with other providers in a range of settings would provide further useful insight. Frank, NED welcomed the proposals and noted the importance of ensuring that services for children, young people and their families were considered alongside adult services. The success of the proposed model would ultimately depend upon the quality of relationships between organisations, which would require considerable time and effort. It was important to also draw upon expertise available across partner organisations. The Chair agreed, noting that the Trust had already begun to strengthen its work with Public Health; under the proposed approach, such relationships would move from the periphery to the centre of service delivery. Amanda, NED added that existing all-age population health management approaches were not delivering effectively for children and young people and that the proposed work offered an important opportunity to place their needs at the forefront. Mike, BA expressed support for the overall direction of travel but stressed the importance of clearly defining the intended outcomes. He noted the importance of agreeing specific improvements the programme was seeking to deliver and cautioned against attempting to address issues that were beyond its scope. He suggested that the primary objective should be to create a more seamless patient experience through integrated care provision across organisational boundaries. The Chair agreed, noting that it was important to remain realistic about what could be achieved; delivering faster, higher-quality and more coordinated care for patients would represent a meaningful and valuable measure of success. The COS advised that meetings with system partners were scheduled for September and October. Following those discussions, a more detailed proposal, including a roadmap for implementation, would be brought back to the Board for consideration. <i>The Board noted the report.</i>	
73/26	2025/26 Data Security and Protection Toolkit The COS presented an update on the Trust's submission to the Data Security and Protection Toolkit (DSPT). DSPT was an annual submission and the Trust had achieved a strong overall position. Performance was noted to be ahead of NHSE's expected year-end position for the organisation, demonstrating significant progress in relation to data security and information governance requirements. Internal Audit had undertaken an independent review and had provided assurance that the scores and assessments submitted by the Trust were accurate.	

	The COS highlighted two residual areas of risk relating to cyber security which had not yet achieved the required standard, specifically device management and cyber resilience. Active work was underway to address these areas and strengthen the Trust's overall cyber security position. Cyber resilience was increasingly important due to the dependence on digital systems within the organisation. Paresh, NED noted that digital systems and cyber security were becoming increasingly complex and highlighted the importance of having sufficient digital resources and expertise available to the organisation. He asked that any gaps should be reviewed and suggested that specialist digital expertise could be shared with system partners. <i>The Board noted the update.</i>	
74/26	Q1 Board Assurance Framework The COS presented the Q1 BAF and explained that it showed that principal risks did not arise in isolation and increasingly interacted with one another. He expected that the risks relating to finance, workforce and quality were unlikely to reduce in the short term and would become increasingly interdependent. The Board's role would therefore be to develop a collective understanding of how the risks interacted and to consider whether the mitigations being developed and monitored through individual Committees were sufficient when viewed in combination, and to ensure that actions taken to address one challenge could unintentionally create pressures elsewhere. Carys, NED asked whether some of the strategic risks had now become issues and whether this should be explicitly recognised within reporting arrangements. Cyber-attacks were no longer simply a theoretical risk but an inevitability and she asked whether these should therefore be considered as issues, supported by scenario-based planning and internal governance. The COS reported that a recent review of the Corporate Risk Register had resulted in a distinction between risks and issues; it was therefore helpful to ask the same question of the BAF as many of the risks were now challenges that the organisation was actively living with and managing on a day-to-day basis. Reporting arrangements needed to evolve to reflect how these risks were being managed in practice and to ensure that Board attention and organisational resources were focused appropriately. The DCEO noted that discussion of cybersecurity would be included on the agenda for the upcoming Board Development Day. <i>The Board noted the update.</i>	
75/26	Patient Experience and Engagement Strategy The COS presented the Patient Experience and Engagement Strategy, explaining that it was the first strategy of its kind developed by the Trust. The strategy had been informed through engagement with patients, staff and system partners, who had been asked what they wanted the organisation to prioritise in bringing the patient voice into decision-making and service delivery. The feedback had been remarkably consistent, focusing on the importance of being listened to, receiving clear and effective communication, being treated with kindness and compassion, and being involved in decisions about care. Staff feedback had closely aligned with these themes. The COS explained that the strategy represented a shift towards creating a culture of continuous listening, engagement and co-production. While the Trust's CQI programme focused on how patient feedback and communication should be embedded within everyday practice, the strategy articulated what the organisation was seeking to achieve. The strategy would play a key role in delivering the Trust's breakthrough objective relating to communication during the year. The CMO welcomed the strategy, commenting that it was an important development and aligned closely with the organisation's CQI work. The interconnected nature of the two programmes was noted. Frank, NED also welcomed the strategy and observed that it provided an important opportunity to better understand the needs and experiences of the populations served	

by the Trust. He asked how the information collected would be used as part of decision-making processes to ensure that patient engagement translated into meaningful improvements. The COS explained that organisational learning needed to be firmly grounded in patient feedback. He advised that new divisional Integrated Performance Reports were expected to include a dedicated section presenting feedback from a range of sources, distilled into key themes and messages. In addition, weekly discussions would be held with divisional nursing teams to ensure that actions arising from feedback were implemented and monitored. The Trust already received a significant volume of learning and feedback but there was a need to bring these sources together more effectively to maximise their impact. The DOM noted maternity investigations as an example of this approach in practice and commented that this reflected the type of learning and improvement process that NHS organisations were increasingly being encouraged to adopt across all services.

Paresh, NED praised the report and expressed the hope that the introduction of Netcall would help address some of the issues identified through patient feedback. The COS agreed and advised that both Netcall and Quail would support the Trust's ability to triangulate information from multiple sources. He explained that much of this work was currently undertaken manually and that automation would be extremely valuable, both in reducing administrative burden and in strengthening the organisation's ability to identify themes and trends in a timely manner.

Ama, ANED asked how triangulation could help the Trust balance patient experience alongside staff experience and whether this approach would be applied consistently across services. The COS explained that effective triangulation enabled the organisation to understand issues in their full context. Using maternity complaints as an example, he noted that it was important not only to review the complaint itself but also to consider related factors such as staffing levels, operational pressures and other contextual information. Bringing these sources together provided a more comprehensive understanding of why issues had occurred and how they could be addressed. The introduction of the new systems would allow complaints, PALS data, incidents and other intelligence to be aggregated and analysed without relying on manual reviews, enabling richer and more timely insights. This approach would be embedded within governance processes to improve organisational learning and oversight. The CMO observed that there were currently a number of common themes emerging across the organisation, with different teams often developing separate action plans to address similar issues. The strategy and new systems provided an opportunity to consolidate these approaches in order to avoid duplication of effort and ensure that improvement activity was coordinated more effectively across the Trust.

The Board noted the update.

76/26

Annual Reports

1. Patient Experience

The Board noted the report which had previously been reviewed by Q&S.

2. Medical Revalidation

The CMO explained that the report provided assurance about revalidation and appraisal for medical staff, thanks so a small but dedicated team

The Board noted the annual reports and agreed that the CEO and Chair should approve and sign the Statement of Compliance in the Medical Revalidation report prior to submission to the Secretary of State for Health.

77/26

Use of Trust Seal

One use of the Trust Seal since the last Board meeting was reported.

78/26

Questions from members of the public

The Chair reported that Mr Campbell had submitted a number of questions to the Board in advance of the meeting, several of which had been addressed during the course of earlier discussions.

Mr Campbell referred to the appointment process when the current Chair had been appointed and noted that at that time members of the public had formed part of the stakeholder engagement process. He asked whether a similar approach would be adopted for the appointment of the next Chair. The Chair explained that the appointment process was managed by NHSE and was not under the Trust's direct control. However, he felt that involving a wider range of external stakeholders, beyond the statutory bodies, would be a positive approach. Mr Campbell observed that the current Chair would be difficult to replace and expressed the hope that the new Chair would have a strong understanding of the requirements of the role and the organisation.

The Chair noted that Mr Campbell had submitted a question about the Netcall programme and the benefits expected to arise from its implementation. The DCEO explained that the Converse CX platform, which brought together telephone and digital communications, had gone live overnight and was operating smoothly. Two further key components of the programme were the Patient Hub and clinic utilisation tools. While reducing Did Not Attend (DNA) rates was one benefit, the Trust already performed comparatively well in this area, with a DNA rate of around 4%. The primary objective was to ensure that every available appointment slot was utilised effectively through greater automation and improved productivity. Enhanced communication and appointment reminders would be expected to further improve the patient experience. Mr Campbell asked whether the programme would also contribute to understanding what information patients would find useful through platforms such as Patients Know Best (PKB) or the NHS App. The DCEO advised that the long-term aim was for patient communications to be channelled through the NHS App wherever possible. Netcall and the associated clinic utilisation tools would improve communication regarding late-notice appointments and opportunities to change appointment times, while supporting prioritisation processes to ensure that patients with the greatest clinical need could be seen sooner.

Mr Hardwick referred to comments within the CEOs report regarding a fairer deal for Band 5 nurses and requested further details. The DCNO explained that Band 5 was the standard grade for newly qualified nurses; historically, Band 6 positions had been associated with specialist expertise and leadership responsibilities. National expectations around this were changing, with proposals for nurses to progress from Band 5 to Band 6 through a competency framework over a period of 12 to 18 months. The proposals were currently being considered with staff-side representatives and, once agreed, all nursing roles would be reviewed against the framework. The Trust had long since recognised that many nurses remained at Band 5 for extended periods and that similar arrangements had already been introduced within midwifery services. The changes were being driven nationally through Government policy and engagement with trade unions.

Mrs Walke raised concerns regarding waiting times within community paediatric services and referenced a significant number of children waiting beyond expected timescales. She asked why children had not been seen more quickly. The COO explained that the service did not currently have sufficient capacity to manage all referrals received. Additional external capacity had been procured discussions were ongoing with commissioners regarding the future design and resourcing of the service. The waiting list included assessments for conditions such as ADHD and other developmental needs and commissioner support would be required to deliver the level of activity necessary to eliminate the backlog. The CEO added that the issue was not solely financial but reflected a national workforce challenge, with specialist shortages being experienced across the country. The Trust had sought external support to increase

capacity and significant work had already been undertaken to reduce waiting times. She stressed the importance of ensuring that the service was commissioned appropriately and that any improvements achieved could be sustained. Ama, NED noted that Q&S had recently reviewed the position and that, while approximately 500 assessments were currently being undertaken annually, around 900 would be required to reduce the waiting list substantially.

Mrs Walke also raised concerns regarding maternity services. She recalled assurances provided at the time obstetric services were single-sited that consultant capacity would be maintained and suggested that consultant vacancies had persisted within the Trust. She asked whether these vacancies were related to occasions when performance or outcomes had fallen short. The CMO explained that the reconfiguration had originally been driven by the inability to safely staff two obstetric units alongside declining birth numbers at one site and noted that consultant on-call rotas were currently fully staffed and that there were no unfilled sessions affecting safe service delivery. He acknowledged that maternity services, like all services, would not always get everything right but remained firmly of the view that concentrating obstetric services on a single site had made services safer. He recalled that evidence presented at the time of the decision had demonstrated that concentrating specialist expertise on one site improved safety and effectiveness. The CHair observed that several organisations experiencing significant maternity challenges continued to operate obstetric services across multiple sites. Current maternity performance indicators were generally positive and reflected the benefits of the model adopted by the Trust. While continual improvement remained necessary, including responding rapidly to concerns raised by staff, the Chair explained that he could see no circumstances in which returning obstetric services to Eastbourne would represent good clinical care.

Mrs Walke reflected on her recent experience of the Emergency Department. She described being concerned by reports of corridor care but noted that, during a visit the previous day, a friend receiving treatment had been accommodated in an area that provided a greater degree of privacy and dignity than had previously been available. She praised staff for their support and attentiveness and commented positively on the improvements she had observed. The Chair thanked her for the feedback and noted that both Emergency Departments had originally been designed for approximately half of their current activity levels. Without significant capital investment, both sites would continue to face challenges arising from demand and limited space. The CEO also welcomed the positive feedback but stressed that the Trust's tolerance for corridor care must remain zero and never become normalised. Nursing teams worked hard to reduce its occurrence across the Trust and the position was closely monitored to ensure that high standards of safety and quality were maintained for all patients.

Ms Burt referred to the age profile of the local population and asked whether the Trust sufficiently highlighted that many of the challenges currently being experienced in East Sussex would become commonplace elsewhere in the country over the next five to ten years. The Chair explained that that this point was frequently made and commented that East Sussex often experienced demographic trends earlier than many other areas. Ms Burt HB suggested that there was a strong argument for using East Sussex as an opportunity to get ahead of future demographic challenges. The Chair agreed and noted that this formed part of the rationale behind proposals for greater integration across East Sussex. He reiterated his long-held view that closer vertical integration between services offered greater benefits than more traditional forms of horizontal integration and would represent one of the most effective ways of responding to increasing demand in a financially constrained environment.

Ms Burt expressed concern that patient safety incidents might only be investigated where a formal complaint had been submitted by a patient or family member, suggesting that this could disadvantage some groups. The CMO firmly advised that this was not the case, explaining that all moderate and high risk complaints were reviewed by senior nursing and quality leaders, with a proportion being investigated under the Patient

	Safety Incident Response Framework (PSIRF). Investigations were not dependent upon receipt of a complaint and could be initiated through several mechanisms. All serious patient safety incidents were investigated appropriately irrespective of whether concerns had been formally raised by patients or families. The Chair acknowledged the importance of clarity in this area and agreed that the Trust’s processes could be communicated more clearly to avoid any misunderstanding. Paresh, NED noted that there were no financial constraints preventing the Trust from investigating patient safety incidents and that patient safety concerns would always be subject to appropriate review and investigation.	
79/26	Any Other Business None.	
80/26	Agenda Forward Plan The Board’s forward plan was noted.	
81/26	Date of Next Trust Board Public Meeting Tuesday 20th October, 2026 at Cooden	





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	Steve Aumayer	September 2026	<u>04.12.25</u> This enhanced information will be included from the month 8 (November) IPR onwards. <u>16.12.25</u> It was agreed these actions should remain open until the new reporting was shared. <u>17.02.26</u> Action to remain open until KPI's emerging from neighbourhood alliance are included within IPR to enhance reporting about community services. <u>21.04.26</u> Enhanced community services data, aligned with neighbourhood alliance developments and Trust's strategic management system expected to be included in IPR from Q2 2026/27. <u>18.08.26</u> Changes to divisional IPR meetings to take place from September 2026, to be followed by updated Board IPR, including community services, to the Board later in the year.
ACTIONS COMPLETED					
None					



Report to:	Board of Directors	Agenda Item:	7
Date of Meeting	20 th October 2026		
Title of Report:	Audit Committee – Chair’s Report		
Status:	For Discussion		
Sponsor:	Spencer Prosser, Chair of Audit Committee		
Author:	Spencer Prosser, Chair of Audit Committee		
Appendices:	None		
Purpose			
This report summarises the discussions, recommendations and approvals made by the Audit Committee on 30 September 2026 to provide the Board with an update of the Committee’s activities.			
Background			
The Audit Committee holds delegated responsibility from the Board of Directors as set out in ToRs; this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.			
Business Undertaken			
Security			
Violence and aggression incidents had increased from 794 to 875 compared to the previous year. The Committee received assurance on strengthened controls, training, reporting and partnership working that was taking place to manage the increases and protect staff.			
Internal Audit			
An audit of Data Quality and Performance received reasonable assurance. The audit programme remained deliverable.			
External Audit			
Previous-year work was substantially complete. The Committee requested earlier visibility of the 2026/27 programme and progress against financial sustainability actions.			
Tenders Month 12 Deep Dive			
The deep dive reviewed an apparent discrepancy in the reported authorisation level for a Month 12 single tender waiver. It was confirmed that the waiver had been correctly authorised and that the discrepancy resulted from a typographical error when the report was prepared, rather than a failure of the underlying control. A process was being developed to reduce future transcription errors, and the matter was closed.			
Board Assurance Framework and Risk Register			
The Committee reviewed the BAF and the new approach of collective sufficiency, suggesting some improvement actions which would be taken forward.			
Alert, Advise and Assure			
Alert			
Violence and aggression incidents had increased, with the security risk remaining at 12.			
Advise			
Earlier assurance was requested on external audit planning and financial sustainability actions.			
Assure			
- The data quality and performance audit received reasonable assurance. - The month 12 tender waiver issue was a reporting error, not a control failure. - The committee welcomed the revised BAF presentation.			

Key Risks or Opportunities and their impact on the Trust
- Increased violence and aggression incidents 3 BAF risks remained outside tolerance, including estates infrastructure, - Limited flexibility within the quarter four Internal Audit programme.
Key Decisions
- The Committee accepted the Annual Security Report and received assurance from the Internal Audit position. - The month 12 Tender Waiver matter was closed. - The revised BAF approach was welcomed and noted.
Exceptions and Challenges
- Rising violence and aggression incidents. - Outstanding DSP Toolkit actions and limited quarter four audit flexibility. - Further evidence was required that BAF actions were reducing strategic risks.
Recommendations
The Board is asked to note this report.



Report to:	Trust Board	Agenda Item:	7
Date of Meeting	20 th October 2026		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the Finance & Performance Committee on 30 Sept 2026.

Background

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

Business Undertaken

Month 5 Financial Performance

- August deficit £4.2m; year-to-date deficit £17.9m (£7.4m adverse to plan).
- CIP delivery £3.6m behind target.
- Forecast year-end deficit remains £29.5m.
- Committee concerned about deficit run rate and pace of recovery.
- Executive team increasing focus on recovery actions.

Cost Improvement Programme (CIP) Delivery

- Focus on reducing agency spend, improving productivity, outpatient transformation and tighter vacancy controls.
- Recovery programme management strengthened.
- Need for realistic forecasting and accelerated delivery of existing schemes.
- 2027/28 financial planning to begin immediately.
- SLR highlighted as key to addressing loss-making services.

Forecast Outturn & Route Map

- Committee agreed current forecast must improve.
- Discussion focused on recovery risks, system dependencies and delivery assumptions.
- Revised recovery submission to be prepared for NHS England.

Cash Report

- Cash position remains critical, with creditor balances at c.£57m.
- Over 13,500 invoices outstanding.
- Cash support requested from NHS England.
- Concerns raised regarding supplier confidence, operational risk and management burden.
- Cash recovery plans to align with realistic revenue recovery.

Capital Programme Report

- Capital programme slightly behind plan.
- Endoscopy and digital schemes remain on track.

- Cardiology investment options under review.
- Asset disposals being reviewed to maximise value.
- Focus on affordability, benefits realisation and patient safety impacts.

System Update

- Trust remains one of several organisations forecasting a deficit.
- Importance of realistic reporting and accelerated recovery emphasised.

Transformation & Improvement Update

- Sussex Pathology Network remains on track for October 2027 go-live.
- Additional governance and controls implemented.
- Committee supported the contract extension proposal.

Operational Performance Report

- Positive performance in RTT, diagnostics, urgent care, cancer standards and elective activity.
- Improvement required in ED performance, cancer 62-day standard, length of stay and discharge flow.
- Recovery actions in place including PTL management, frailty pathways, virtual wards and winter planning.
- Committee emphasised protecting high-performing areas while delivering recovery plans.

Alert, Advise and Assure

None

Key Risks or Opportunities and their impact on the Trust

- Financial recovery delivery.
- Cash liquidity.
- Capital affordability.
- Patient flow and discharge performance.
- Reliance on system partners.

Key Decisions

Business Case Approval – Imaging Network RIS

- Outline Business Case supported.
- Further evidence required on value for money, productivity gains and patient benefits before Full Business case is agreed.

Exceptions and Challenges

- Financial deterioration and recovery requirements.
- Cash and liquidity risks.
- Capital programme review outcomes.
- Operational performance challenges.
- Financial recovery progress.

Recommendations

The Board is asked to note this report.



Report to:	Trust Board	Agenda Item:	7
Date of Meeting	20 th October 2026		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the POD Committee on 23rd September 2026 to provide the Board with an update of the Committee's activities.

Background

The POD 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

POD undertook some routine business for assurance on key items, but had dedicated the bulk of the committee, which met face to face, to use the ESHT continuous quality improvement methodology as applied to the True north metric, "staff recommend ESHT as a Place to work". This followed previous POD discussions where it was considered important that the committee better understood drivers of workforce pressures.

POD participated in a facilitated workshop, which reviewed a draft A3 for the True North metric and looked to strengthen this to ensure the drivers were well understood.

As input to the workshop, members reviewed the working draft A3 alongside emerging findings from staff survey analysis and focus groups. Key themes included workload and staffing pressures, leadership and management quality, and staff feeling valued and recognised. Participants noted the strength of immediate teams and pride in patient care, whilst also recognising concerns relating to inconsistent leadership, culture, communication, development opportunities and organisational responsiveness.

POD began considering how the committee might take forward the work, especially in terms of how assurance might be sought. The approach was well-received at committee and further work is to follow.

Alert, Advise and Assure

Alert

None.

Advise/Inform/Update

Further work to be undertaken to develop a way for POD to gain assurance on the True North metric and how that will change how the committee works going forward.

Assurances

None.

Key Risks or Opportunities and their impact on the Trust
Not applicable for September's POD Committee due to interaction CQI session.
Key Decisions
None.
Exceptions and Challenges
None.
Recommendations
The Board is asked to note this report.



Report to:	Trust Board	Agenda Item:	7
Date of Meeting	20 th October 2026		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the QSC on 30 September 2026 to provide the Board with an update on the Committee's activities.

Background

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

Business Undertaken

IGM Update

The Committee welcomed reductions in patient safety investigation backlogs, improved Duty of Candour compliance and positive mortality trends. Continued focus was required on timely and routine communication with families while investigations remained ongoing.

DAS Divisional Report

The Committee noted progress with the new care group structure, patient safety reporting, delayed investigations and staff engagement. National accreditation for Same Day Emergency Care and positive external feedback on critical care were welcomed. Data maturity, nursing assessment compliance and mandatory training remained areas of focus.

Maternity Dashboard and Ockenden Perinatal Quality Surveillance Report

Safety outcomes remained stable, with no new stillbirths or neonatal deaths reported. Perinatal mortality had reduced, neonatal admissions to special care were below the national average and training compliance remained strong. Workforce pressures, vacancies and sickness absence continued, although recruitment had improved the staffing trajectory.

Quality Dashboard Report

The Committee noted continuing pressures relating to discharge delays, bed occupancy and escalation capacity. Friends and Family Test scores remained positive, but response rates required improvement. Midday discharge performance remained below target and work was under way to strengthen ward-level visibility, accountability and patient flow.

Quality Governance Report

The Committee received assurance regarding the reporting culture and incident reporting rates. Work continued to reduce overdue investigations and improve communication with families. Further analysis was planned regarding diagnostic incidents involving specimen labelling errors.

High-Level Risk Register

Seven QSC-aligned corporate risks remained active with no changes to scores. The reduced maternity dietetics risk would remain under review until mitigation was shown to be sustainable. The Committee also considered acute bed capacity, winter planning, escalation capacity and work with system partners to address patients not meeting the criteria to reside.

Infection Prevention and Control Board Assurance Framework

Compliance challenges remained in equipment cleanliness, estate infrastructure, high-consequence infectious disease preparedness and mask fit testing. Improvements were reported in clinical engagement, environmental audits, infection prevention monitoring and antimicrobial stewardship. A revised treatment pathway for *Clostridioides difficile* was discussed.

Quality Account Priorities

Progress was reviewed against the 2026/27 priorities of falls reduction, recognition of the dying patient and improved communication. Members supported continuing the priorities beyond one year to allow improvements to be achieved and embedded.

Board Assurance Framework

Although the paper was not included in the meeting pack, verbal assurance was provided that the two QSC-aligned risks were regularly reviewed. No changes to scores were proposed. Further Board discussion was requested on whether the quality risk score remained appropriate in the context of workforce and operational pressures.

Maternity Overview Board Report

Priorities included workforce sustainability and improved capture, analysis and presentation of inequalities data. The Committee supported development of a consistent reporting framework, potentially using the NHS England ten-point maternity plan as the overarching structure.

Mortuary Compliance

The Committee reviewed progress against the Sir Jonathan Michael Inquiry recommendations, an NHS England return and a retrospective review of mortuary incidents. Some historic incidents required notification to the Human Tissue Authority. Further follow-up was required on the Trust-wide CCTV review and recruitment to the mortuary manager role.

Organ Donation Report

The Committee noted that two donors proceeded to donation, benefiting five recipients, and that two corneal donations had been recorded. Further work would focus on awareness, education, tissue donation and communication with families following bereavement.

NCTR Harm Reviews

The Committee agreed not to reinstate individual NCTR harm reviews. Existing systems would be explored to identify patterns between length of stay and harm, with an initial reporting model to return to the Committee in November.

Deferred Reports

The medical devices and sepsis reports were deferred to the October meeting because the papers had not been received.

Committee Effectiveness and Assurance

Members agreed that an extended in-person development session should be planned for March. The Chair raised concern about providing sufficient independent assurance when only one Non-Executive Director was present and asked that this be considered through the Terms of

Reference and effectiveness review. Further assurance was also sought on capacity, flow, winter pressures, corridor care and patients awaiting discharge.

Alert, Advise and Assure

Alert

Capacity, patient flow and winter pressures required further assurance. Workforce sustainability remained a concern, particularly within maternity services. The Committee also noted limitations arising from incomplete meeting papers and reduced Non-Executive Director attendance.

Advise/Inform/Update

Individual NCTR harm reviews would not be reinstated. A revised, data-led reporting approach would be developed for consideration in November.

Assure

Patient safety investigation backlogs and Duty of Candour compliance had improved, mortality trends remained positive, maternity safety outcomes were stable, and the seven QSC-aligned corporate risk scores remained unchanged.

Key Risks or Opportunities and their impact on the Trust

Key risks remained workforce sustainability, discharge delays, bed occupancy, winter capacity, corridor care, communication with families during patient safety investigations, infection prevention compliance and mortuary governance. Opportunities included stronger ward-level flow reporting, improved triangulation through existing data systems, a consistent maternity reporting framework and an in-person Committee development session.

Key Decisions

The Committee agreed that the existing Board Assurance Framework risk scores should remain unchanged, subject to further discussion at Board. It agreed to close the previous individual NCTR harm-review action and requested an initial model for a revised reporting approach in November. The Committee also agreed to plan an extended in-person development session for March.

Exceptions and Challenges

Workforce pressures, discharge and patient-flow performance, winter capacity, incomplete meeting papers, reduced Non-Executive Director attendance, communication with families during investigations, infection prevention compliance and outstanding mortuary governance actions.

Recommendations

The Board is asked to note the report, the assurances provided by the Committee and the areas requiring continued oversight, particularly capacity, flow, winter preparedness, workforce sustainability and the effectiveness of Committee assurance arrangements.



Report To/Meeting	Trust Board	Date of Meeting	20.10.26
Report Title:	Thirlwall Inquiry: Immediate Requirements and Trust Assurance		
Key question	The Thirlwall Inquiry identified serious failures in the protection of babies, including failures to act on concerns, weaknesses in safeguarding, and organisational cultures that did not support effective challenge and escalation. On Sept 21st 2026 NHS England advised that the findings are relevant to every NHS Trust and Integrated Care Board, not only organisations providing neonatal services. Every Board is expected to consider the report at its next available public meeting and ask whether similar events could occur within its own organisation.		
Decision Action:	For approval ☒ For Assurance ☒ For Information ☐ For Discussion ☐		
Report Sponsor(s):	Chief Nurse – Vikki Carruth Chief Medical Officer – Simon Merritt	Presenter(s):	Chief Nurse – Vikki Carruth
Outcome/Action requested:	The Board is asked to: 1. Note the findings and immediate requirements arising from the Thirlwall Inquiry. 2. Confirm that the Inquiry has been considered at a public Board meeting, as requested by NHS England. 3. Seek assurance that the immediate requirements set out in section 4 are being met. 4. Approve a structured Trust-wide review of safeguarding, speaking up, escalation, mortality surveillance and patient safety intelligence. 5. Request that identified gaps are reported to the Quality and Safety Committee, with a consolidated assurance report and action plan returned to the Board.		
Executive Summary	The Thirlwall Inquiry identified serious failures in the protection of babies, including failures to act on concerns, weaknesses in safeguarding, and organisational cultures that did not support effective challenge and escalation. On Sept 21st 2026, NHS England advised that the findings are relevant to every NHS Trust and Integrated Care Board, not only organisations providing neonatal services. Every Board is expected to consider the report at its next available public meeting and ask whether similar events could occur within its own organisation.		

	A structured, evidence-based review is proposed, overseen by a new Thirlwall Taskforce reporting through the Quality and Safety Committee and returning to the Board with identified gaps, actions, owners and completion dates.		
Regulatory/legal requirement:	Recommendations provided by NHS England.		
Business Plan Link:	Quality ☒	People ☐	Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	A Taskforce with key executives and senior leaders has been established and will include a number of workstreams to progress work and actions as outlined in the Inquiry and in this paper.		
Risk:	Not all actions have national guidance yet including use of surveillance cameras.		
No of Pages	6	Appendixes	None
Governance and Engagement pathway to date:	This has been discussed at the Executive Leadership Meeting with Trust Wide Communications to all staff including information regarding the SUDIP/C protocol. Thirlwall Taskforce established and met Oct 5th.		
What happens next?	The Board is asked to note the national requirements, endorse the proposed assurance review, require immediate confirmation of time-critical compliance, and receive a further evidence-based report setting out gaps, actions and residual risks.		
Publication	No restrictions as in Trust Board in Public		

Thirlwall Inquiry: Immediate Requirements and Trust Assurance

1. Executive summary

The Thirlwall Inquiry identified serious failures in the protection of babies, including failures to act on concerns, weaknesses in safeguarding, and organisational cultures that did not support effective challenge and escalation.

On Sept 21st 2026, NHS England advised that the findings are relevant to every NHS Trust and Integrated Care Board, not only organisations providing neonatal services. Every Board is expected to consider the report at its next available public meeting and ask whether similar events could occur within its own organisation.

For East Sussex Healthcare NHS Trust, the immediate priorities are to:

- Confirm that the process for responding to a sudden and unexpected death of a child is understood and consistently applied.
- Confirm appropriate safeguarding training and clear routes for raising and escalating concerns.
- Review the security, access and storage arrangements for insulin in neonatal services.
- Assess whether staff concerns, unusual patterns of harm and emerging safety risks would be identified and acted upon promptly.
- Confirm that bereaved families and staff working in neonatal services receive appropriate support.

A structured, evidence-based review is proposed, reporting through the Quality and Safety Committee and returning to the Board with identified gaps, actions, owners and completion dates.

2. Decisions required

The Board is asked to:

1. **Note** the findings and immediate requirements arising from the Thirlwall Inquiry.
2. **Confirm** that the Inquiry has been considered at a public Board meeting, as requested by NHS England.
3. **Seek assurance** that the immediate requirements set out in section 4 are being met.
4. **Approve** a structured Trust-wide review of safeguarding, speaking up, escalation, mortality surveillance and patient safety intelligence.
5. **Request** that identified gaps are reported to the Quality and Safety Committee, with a consolidated assurance report and action plan returned to the Board.

3. Background

On 21 September 2026, NHS England wrote to NHS Trusts and Integrated Care Boards following publication of the Thirlwall Inquiry report.

The national letter states that the Inquiry is relevant to every organisation and asks Boards to consider:

- Whether similar events could occur within their services.
- Whether sufficient measures are in place to protect babies and children in every care setting.
- Whether staff and Board members are empowered to speak up, challenge and escalate concerns without fear.
- Whether safeguarding is given sufficient prominence.
- Whether information is used effectively to identify risks and patterns of harm.

4. Immediate national requirements

4.1 Sudden and unexpected deaths of children

The national process for responding to a sudden and unexpected death of a child applies to every death, or collapse leading to death, of a person under 18 where the death would not reasonably have been expected 24 hours earlier and no pre-existing medical cause is apparent.

This applies irrespective of where the death occurs, including within neonatal units, and operates alongside the Trust's internal reporting processes.

Trusts with neonatal units were asked to communicate this requirement to relevant staff and the Board by 28 September 2026. (Completed on time)

4.2 Safeguarding

The Trust must assure itself that:

- Staff and Board members meet safeguarding training requirements at the appropriate level.
- Staff know how and where to raise concerns.
- Escalation routes are understood and effective.
- Safeguarding of babies and children receives appropriate Board attention.

4.3 Insulin security

By **31 March 2027**, neonatal units must meet the access-control and storage requirements in the national guidance on safe insulin use.

Pending biometric access arrangements, relevant Trusts are expected to install cameras focused on neonatal insulin storage areas by **30 November 2026**, with recordings retained for at least 28 days.

4.4 Bereavement care

Integrated Care Boards and providers are expected to take immediate action to improve support for families experiencing stillbirth or neonatal death, including continued implementation of the National Bereavement Care Pathway.

4.5 Parents and staff

NHS England asks organisations to consider:

- How parents are reassured about the safety and quality of neonatal care.
- Whether appropriate psychological and wellbeing support is available to staff caring for very sick babies.

5. Proposed Trust assurance review

A structured review should assess whether there is sufficient evidence that:

- Staff concerns are heard, investigated and escalated promptly.
- Staff can speak up without fear of adverse consequences.
- Safeguarding concerns can be raised directly across professional and organisational boundaries.
- Unexpected deaths and serious incidents trigger the appropriate external and internal processes.
- Incident, mortality, safeguarding, complaints, workforce and speaking-up information is triangulated.
- Unusual patterns of harm or clinical outcomes can be identified at an early stage.
- Concerns about an individual's practice are considered alongside wider patient safety information.
- Families are listened to, supported and involved appropriately.
- Executive and Board escalation arrangements are clear.
- Actions arising from reviews are completed and their effectiveness tested.

The review should cover neonatal, maternity, paediatric and emergency care, as well as the wider Trust systems for safeguarding, mortality, speaking up and patient safety.

The proposal is that this work is Trust wide and covers all services including and beyond neonatal care.

6. Governance and next steps

A trust wide Thirlwall Taskforce has been established (first meeting on Oct 5th 2026) and will report to Executive Committee and Q&SC monthly with board assurance provided in Trust Board reports as required.

Oversight is provided by the CNO and CMO with other Directors/Executives as SROs for various actions given the number and breadth of recommendations.

An action tracker is in place with named Executive/Director leads and a small number of working groups will be reporting into the main Taskforce. Work is already underway for several actions with a focused review on existing systems and processes to determine what additional work and or assurance is required.

Benchmarking has been requested for some actions to ensure there is clear evidence of embedded work as well as impact and outputs.

The Board is asked to note the national requirements, endorse the proposed assurance review, require confirmation of time-critical compliance, and receive a further evidence-based report setting out gaps, actions and residual risks.

Vikki Carruth Chief Nurse

Simon Merrit, Chief Medical Officer.

Thirlwall Inquiry Recommendations: ESHT Action Tracker

Purpose: To coordinate ESHT readiness, assurance and implementation against the 17 recommendations. Roles and local dates below are proposed for confirmation by the Executive Team. National deadlines are shown where specified. Status should be recorded as Not started, In progress, Complete or Awaiting national guidance.

ESHT implementation and assurance tracker							
No.	Required action / deliverable	Accountable role	Supporting roles	Target / review date	Proposed workstream / forum; status / evidence	Updates	RAG status
1	Complete a neonatal monitoring and remote parental-viewing gap analysis; prepare an options and implementation plan aligned to the NHS England roadmap.	Chief Digital Information Officer	Chief Nurse; W&C Div Leadership team; Information Governance; Estates	Gap analysis: 31 Dec 2026; implementation plan: 30 Apr 2027, following national roadmap due Mar 2027	Forum: Neonatal Digital Monitoring Workstream, reporting to Women's and Children's Divisional Governance. Status/evidence: Awaiting update — gap analysis, options appraisal and approved plan	Awaiting update	Not rated
2	Review insulin storage, access controls, stock reconciliation, incident escalation and laboratory testing arrangements; implement interim controls pending national guidance.	Chief Pharmacist	DIPC/Chief Nurse; Chief Medical Officer; Pathology Clinical Director; Digital; Security	Review: 30 Nov 2026; interim controls: 31 Jan 2027; quarterly thereafter	Forum: Medicines Safety and Security Workstream, reporting to the Medicines Governance Committee. Status/evidence: Awaiting update — audit, risk assessment, SOP and action log	Awaiting update	Not rated
3	Benchmark bereavement services against the National Bereavement Care Pathway and develop a proposed implementation plan.	Chief Nurse	Women's and Children's Division; Palliative Care; Patient Experience; People Directorate	Baseline: 31 Jan 2027; full compliance: 31 Aug 2027	Forum: Bereavement Care Workstream, reporting to the Patient Experience Steering Group. Status/evidence: Awaiting update — benchmark, workforce plan, training and family feedback	Awaiting update	Not rated
4	Confirm safeguarding training compliance for all staff and Board members; review contracts and policies for explicit compliance with safeguarding guidance and the deliberate harm protocol.	Chief People Officer	Chief Nurse/Executive Safeguarding Lead; Chief of Staff; Legal; Learning and Development	Compliance review: 30 Nov 2026; contracts/policies: 31 Mar 2027	Forum: Safeguarding Workforce Compliance Workstream, reporting to the Safeguarding Committee. Status/evidence: Awaiting update —	Awaiting update	Not rated

					training data, Board record, revised clauses and policies		
5	Map interoperability gaps affecting real-time safety monitoring and data sharing; align the digital roadmap and investment plan with national requirements.	Chief Digital Information Officer	Chief Medical Officer; Chief Nurse; Finance; Information Governance	Gap analysis: 31 Mar 2027; annual review; national route expected by 31 Dec 2028	Forum: Digital Clinical Safety and Interoperability Workstream, reporting to the Digital Governance Committee. Status/evidence: Awaiting update — architecture map, risks, dependencies and roadmap	Awaiting update	Not rated
6	Establish Board-level reporting of baby and child deaths, including agreed indicators, trend analysis, thresholds and predetermined escalation routes.	Chief Medical Officer	Chief Nurse; Associate Director of Clinical Governance; Women's and Children's Division; Medical Examiner	Framework approved: 31 Dec 2026; first Board report: 31 Jan 2027; monthly thereafter	Forum: Child Mortality Surveillance Workstream, reporting to the Mortality Surveillance Group and Quality and Safety Committee. Status/evidence: Awaiting update — dashboard, escalation protocol, minutes and actions	Awaiting update	Not rated
7	Appoint a named neonatal mortality and safety data lead with written responsibilities for review, Board escalation, investigations and action-plan oversight.	W&C Div Leadership team	Neonatal Clinical Lead; Head of Midwifery; Quality Governance; Business Intelligence	Named lead: 31 Oct 2026; first assurance report: 31 Dec 2026	Forum: Neonatal Mortality and Safety Data Workstream, reporting to Women's and Children's Divisional Governance. Status/evidence: Awaiting update — appointment, terms of reference, reporting schedule and action log	Awaiting update	Not rated
8	Update the local SUDIC pathway to confirm its application to babies who have never left hospital; brief all relevant staff and simplify documentation where possible.	Chief Nurse / Executive Safeguarding Lead, Chief Medical Officer	Paediatrics; Neonatology; Emergency Care; Medical Examiner; Sussex safeguarding partners	Policy review: 30 Nov 2026; staff briefing and audit: 31 Jan 2027	Forum: SUDIC Pathway Workstream, reporting to the Safeguarding Committee and Child Death Review partnership. Status/evidence: Awaiting update — approved pathway, communication record, training and audit	Completed on time Sept 28 th 2026	Green
9	Adopt and operationalise a suspicion of deliberate harm protocol covering immediate safety action, safeguarding, police liaison,	Chief Nurse / Executive Safeguarding Lead	Chief Medical Officer; Chief People Officer; Security; Legal; Communications	Interim protocol: 31 Oct 2026; full exercise/test:	Forum: Deliberate Harm Protocol Workstream, reporting to the Safeguarding Committee and	Awaiting update	Not rated

	evidence preservation, staff management and executive escalation.			31 Jan 2027; annual review	Executive Team. Status/evidence: Awaiting update — protocol, contact tree, simulation record and learning log		
10	Define how ESHT will identify cases requiring rapid independent expert review and access the national panel once established; maintain an interim external-review route.	Chief Medical Officer	Chief Nurse; Associate Director of Clinical Governance; Procurement; Legal	Interim route: 31 Jan 2027; review within one month of national panel launch	Forum: Independent Clinical Review Workstream, reporting to the Patient Safety Incident Review Group. Status/evidence: Awaiting update — criteria, approved external experts and commissioning route	Awaiting update	Not rated
11	Review neonatal death scrutiny with the Medical Examiner service, including direct safeguarding questions, access to neonatal expertise and escalation of unexplained concerns.	Chief Medical Officer	Lead Medical Examiner; Chief Nurse; Neonatal Clinical Lead; Safeguarding Team	Review: 31 Dec 2026; revised process: 28 Feb 2027	Forum: Neonatal Death Scrutiny Workstream, reporting to the Mortality Surveillance Group. Status/evidence: Awaiting update — pathway, standard questions, audit and case-review evidence	Awaiting update	Not rated
12	Assess access to paediatric and perinatal pathology expertise, identify resilience gaps and agree regional escalation or commissioning arrangements.	Chief Medical Officer	Pathology Clinical Director; Women's and Children's Division; Finance; regional partners	Capacity assessment: 31 Jan 2027; mitigation plan: 31 Mar 2027	Forum: Paediatric and Perinatal Pathology Resilience Workstream, reporting to the Clinical Services Strategy and Workforce forum. Status/evidence: Awaiting update — workforce/capacity assessment, service agreement and risk entry	Awaiting update	Not rated
13	Undertake a readiness review for strengthened manager regulation, barring arrangements and individual duty of candour; ensure leadership standards explicitly prioritise patient safety.	Chief People Officer	Chief Executive; Chief of Staff; Legal; Freedom to Speak Up Guardian	Readiness review: 31 Mar 2027; update within three months of national requirements	Forum: Leadership Regulation and Duty of Candour Workstream, reporting to the People and Organisational Development Committee. Status/evidence: Awaiting update — policy gap analysis, fit and proper person checks and leadership framework	Awaiting update	Not rated

14	Strengthen CQC readiness for unannounced, clinically led inspection, with evidence focused on actual patient safety outcomes and frontline assurance.	Chief Nurse, Chief Medical Officer	Deputy Chief Nurse Quality & Policy, Associate Director of Clinical Governance, Chief Operating Officer; Divisional leadership teams	Baseline review: 31 Dec 2026; quarterly assurance thereafter	Forum: CQC Readiness Workstream, reporting to the Quality and Safety Committee. Status/evidence: Awaiting update — mock inspection, evidence library, safety walkround findings and actions	Awaiting update	Not rated
15	Monitor national changes arising from independent review of CQC performance and assess implications for ESH T assurance arrangements.	Chief of Staff	Associate Director of Clinical Governance; Chief Nurse; Chief Medical Officer	Quarterly from 31 Dec 2026 and within one month of new guidance	Forum: Regulatory Response Workstream, reporting to the Executive Team and Quality and Safety Committee. Status/evidence: Awaiting national guidance — briefing and governance impact assessment	Awaiting update	Not rated
16	Review how complaints, Ombudsman findings and family concerns are triangulated with incidents, claims, mortality and safeguarding intelligence to identify emerging safety risks.	Chief Nurse, Chief Medical Officer	Patient Experience; Clinical Governance team; Legal; Business Intelligence	Process review: 31 Jan 2027; first integrated report: 31 Mar 2027; quarterly thereafter	Forum: Integrated Patient Safety Intelligence Workstream, reporting to the Quality and Safety Committee. Status/evidence: Awaiting update — triangulation report, themes, escalations and learning actions	Awaiting update	Not rated
17	Create a single governance mechanism to log, assign, monitor and close recommendations from inquiries, inquests, investigations and external reviews, with overdue escalation to the Executive Team and Board.	Chief of Staff	Chief Nurse; Chief Medical Officer; Associate Director of Clinical Governance; all executive leads	Tracker and governance route: 30 Nov 2026; first Board assurance: 31 Jan 2027; quarterly thereafter	Forum: Thirlwall Recommendations Oversight Group, reporting to the Executive Team and Quality and Safety Committee. Status/evidence: Awaiting update — central register, owners, evidence, overdue actions and closure approvals	Awaiting update	Not rated

Governance: Monthly reporting to Executive Committee and Q&SC and assurance to Trust Board.



Report To/Meeting	Trust Board	Date of Meeting	20 th October 2026
Report Title:	Chief Executive's Report		
Key question	What key news from the Trust does the Chief Executive want to highlight to the board?		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐		
Report Sponsor:	Jayne Black Chief Executive	Presenter(s):	Jayne Black Chief Executive
Outcome/Action requested:	The board is asked to note the Chief Executive's report.		
Executive Summary	September has been a month characterised by sustained operational pressure, continued organisational improvement and important reflection on culture, leadership and patient safety. Alongside the day-to-day focus on delivering services, we have continued to progress key priorities relating to financial sustainability, productivity, digital transformation and workforce engagement. The month has also provided opportunities to celebrate the achievements of colleagues and strengthen relationships with our partners and stakeholders. I would like to place on record my thanks to colleagues for the professionalism, compassion and resilience they continue to demonstrate in challenging circumstances. Culture, Leadership and Patient Safety The publication of the Thirlwall Inquiry has prompted important conversations across the NHS regarding organisational culture, leadership behaviours and the creation of environments where concerns can be raised and acted upon. These themes have been discussed across the trust through leadership forums, engagement sessions and conversations with teams. Whilst the trust has well-established arrangements to support speaking up and organisational learning, the Inquiry serves as an important reminder that patient safety is inseparable from culture, transparency and leadership. The recent senior leadership seminar provided an opportunity for detailed reflection on the implications of the Inquiry and the actions		

required to strengthen our organisational culture further. Significant work is underway across the trust in response to the report, including reinforcing speaking up arrangements, reviewing governance and escalation processes, strengthening leadership accountability, and ensuring that learning is translated into meaningful improvement for patients and colleagues.

Executive visits across clinical services (Gembas) have continued throughout the month and have provided valuable opportunities to hear first-hand from frontline colleagues. These discussions consistently demonstrate both the pressures facing services and the commitment of staff to delivering safe, compassionate care for patients.

Financial Sustainability

Our financial position continues to require sustained attention. Whilst we have improved the forecast position since the start of the year and have greater clarity regarding the actions required to achieve further improvement, the scale of the challenge remains the greatest we have faced as an organisation.

What is encouraging is that the discussion has increasingly moved beyond short-term cost control towards more fundamental questions of productivity, workforce deployment and service redesign. These are the changes that will ultimately determine whether improvement is sustainable over the medium term.

The coming months will be critical in demonstrating that identified opportunities can be translated into recurrent financial benefit whilst maintaining our commitment to quality, safety and patient outcomes. We continue to work and take action towards improving our year end forecast position. The Board will receive more detailed consideration of these matters through the finance reporting agenda.

Operational Improvement and Transformation

We have continued to make progress against a number of improvement priorities during September.

Work has continued to focus on patient flow, reducing unwarranted variation, improving productivity and strengthening operational grip. Increasingly, these programmes are being brought together as part of a more coherent improvement approach, recognising that operational performance, financial sustainability and quality improvement are interdependent rather than separate objectives.

Alongside this, progress has continued through the EmPower programme and wider digital transformation agenda. The implementation of MediViewer represents a further step in improving access to information for clinicians and supports our ambition to make better use of digital technology to improve patient care and organisational efficiency.

Our People

Understanding the experience of our workforce remains central to delivering sustainable improvement.

During the month, colleagues have continued to participate in staff listening events, engagement sessions and preparations for the NHS Staff Survey. These activities have provided valuable insight into both the strengths of our culture and the areas where colleagues wish to see further improvement.

Creating an environment where people feel valued, respected and able to contribute remains fundamental to our ambition to be an outstanding place to work and to receive care.

Celebrating Success and Working with Partners

September has also provided opportunities to recognise the exceptional contribution of colleagues and strengthen engagement with stakeholders.

The Trust Awards celebrated the dedication, innovation and compassion shown by staff across the organisation. National recognition for both services and individuals further demonstrates the expertise and commitment that exists throughout East Sussex Healthcare NHS Trust.

The accreditation of the Sussex Surgical Centre represents a particularly important achievement and reflects the hard work of clinical and operational teams over a sustained period.

We have continued to engage actively with partners across the health and care system, elected members and wider stakeholders. The Trust's Annual General Meeting also provided an opportunity to reflect on the achievements of the past year and to recognise the significant contribution made by Steve Phoenix during his tenure as Chair.

We were pleased to present our views regarding future plans for an integrated partnership in East Sussex to the ESCC Health and

	Wellbeing Board 'deep dive', chaired by the Leader of the council, elected representatives, senior executive officers from ESCC and leaders from the voluntary and third sector. It was a fascinating insight into the scope and ambition that the health and care sector has regarding transformation and supporting patients/families/carers. Conclusion The defining themes of September have been resilience, improvement and reflection. Whilst operational and financial challenges remain significant, there is clear evidence of progress in strengthening culture, advancing transformation, improving productivity and supporting our workforce. Most importantly, colleagues across the Trust continue to demonstrate an unwavering commitment to delivering high-quality care for the communities we serve. As we enter the second half of the year, our focus will remain on translating improvement activity into measurable outcomes for patients, staff and taxpayers, whilst maintaining the values and behaviours that underpin safe and compassionate care.		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☐ People ☐ Sustainability ☐		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	4	Appendixes	None
Governance and Engagement pathway to date:	Not applicable		
What happens next?	Not applicable		
Publication	This report is for publication		

Integrated Quality & Performance Report



Prepared for East Sussex Healthcare NHS Trust
Board



KINDNESS



INCLUSIVITY



For the Period August 2026 (Month 5)



INTEGRITY

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

The Integrated Performance Review will outline how the Trust is delivering against the 2026/27 Operational Plan for finance, quality, workforce and performance domains.

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?

The Trust ambition is :

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



Balanced Scorecard

Safety	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Number of Patient safety events (severity 1-5)		1064	999		Concern	Target required
Number of Patient safety events (severity 3)	0	13	23		Common Cause	Not Met
Number of Patient safety events (severity 4 ...)	0	5	2		Common Cause	Inconsistent
Never Events	0	0	0		Common Cause	Inconsistent
Inpatient Falls per 1,000 Bed days	4.8	5.04	4.27		Common Cause	Inconsistent
Cat 3 ESHT Acq. PU (rate) per 1,000 bed days		0	0		Common Cause	Target required
Cat 4 ESHT Acq. PU (rate) per 1,000 bed days		0.0388	0.0395		Common Cause	Target required
Healthcare Associated MRSA Bacteraemia (r...	0	0	0		Improvement	Inconsistent
Healthcare Associated C Diff Infections (rate...	0.23	0.233	0.118		Common Cause	Inconsistent
Healthcare Associated MSSA Bacteraemia (r...	0.11	0.0388	0.0790		Common Cause	Inconsistent
RAMI	100	87.5	85.5		Common Cause	Achieving
SHMI (NHS Digital monthly)	100	106	104		Common Cause	Not Met
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	91.2%	88.8%		Concern	Not Met
Patient Safety Incident Investigation Events		0	0		Improvement	Target required
Maternity and Newborn Safety Investigation...		0	0		Common Cause	Target required
Patient Experience	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Complaints received		44	56		Common Cause	Target required
Complaints Response Compliance (60 work...	80%	90.2%	82.7%		Common Cause	Inconsistent
Reopened Complaints		7	7		Common Cause	Target required
A&E FFT Score	85%	80.1%	78.4%		Improvement	Inconsistent
A&E FFT Response Rate	15%	14.0%	7.20%		Concern	Inconsistent
Inpatient FFT Score	95%	97.9%	96.4%		Concern	Achieving
Inpatient FFT Response Rate		3.92%	3.77%		Concern	Target required
Maternity FFT Score	95%	84.8%	94.4%		Common Cause	Inconsistent
Maternity FFT Response Rate		12.9%	8.45%		Common Cause	Target required
Outpatient FFT Score	95%	95.7%	95.7%		Concern	Inconsistent
Our People	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Establishment (WTE) All		7,983	7,984		Concern	Target required
Agency Rate	1%	0.360%	0.302%		Improvement	Inconsistent
Vacancy Rate	5%	1.20%	0.633%		Improvement	Inconsistent
Staff Turnover	10.6%	8.20%	8.23%		Improvement	Achieving
Sickness - Average Days Lost per Fte	18.6	20.8	21.0		Concern	Not Met
Staff Appraisals	85%	80.5%	80.6%		Common Cause	Not Met
Statutory & Mandatory Training	90%	91.0%	91.2%		Common Cause	Achieving
Annual Sickness - Absence %	5%	5.71%	5.76%		Concern	Not Met
Medical Job Plan Compliance Rate		60.6%	57.4%		Concern	Target required

Our Performance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
4 hour standard	78%	75.2%	71.3%		Common Cause	Inconsistent
4 hour standard with additional mappe...		76.9%	73.3%		Common Cause	Target required
A&E waits over 12 hours from DTA	0	246	288		Concern	Inconsistent
A&E > 12 hours from arrival to discharge	789	1352	1384		Concern	Inconsistent
% Type 1 A&E > 12 hours from arrival t...		10.9%	11.1%		Concern	Target required
Conveyance handover >30 mins	0%	8.88%	8.40%		Improvement	Not Met
Conveyance handover >45 mins		2.27%	2.31%		Improvement	Target required
Non Elective Length of Stay (Acute)		4.63	4.39		Improvement	Target required
1+ Non Elective LoS (Acute)		6.98	6.68		Improvement	Target required
Average daily NCTR		163	167		Improvement	Target required
Intermediate Care Length of Stay	30	40.8	42.2		Common Cause	Inconsistent
Number of Deferred visits/ care plans		8217	6709		Common Cause	Target required
RTT 65 week wait	0	0	1		Improvement	Not Met
RTT proportion waiting over 52 weeks		0.628%	0.609%		Improvement	Target required
RTT under 18 weeks	65.1%	69.0%	69.0%		Improvement	Not Met
RTT Total Waiting List Size	55355	56051	55478		Improvement	Not Met
Diagnostic <6 weeks	9.76%	5.27%	5.88%		Common Cause	Inconsistent
Urgent Community Response within 2 h...	70%	88.0%	87.6%		Improvement	Achieving
Community waits within 18 weeks	80%	71.7%	70.8%		Concern	Not Met
104 day Backlog	0	50	44		Concern	Not Met
28 Day General FDS	80%	83.3%	84.2%		Common Cause	Inconsistent
Cancer 31 Day Combined	91.3%	95.5%	98.2%		Common Cause	Inconsistent
Cancer 62 Day	75%	69.0%	67.0%		Common Cause	Inconsistent
Elective Activity (ELIP,DC,OPFA, OPFUP P...		99.4%	95.7%		Concern	Target required

Finance	Target/ Limit	Month 5	Assurance
Surplus/(deficit) (£'000) - in month	(599)	(4,238)	Not met
Surplus/(deficit) (£'000) - YTD	(10,537)	(17,937)	Not met
ERF (£'000) - in month	12,248	11,452	Not met
ERF (£'000) - YTD	60,502	61,851	Achieving
Efficiency (£'000) - in month	6,235	2,612	Not met
Efficiency (£'000) - YTD	21,568	14,117	Not met
Capital (£'000) - YTD	11,592	10,045	Achieving
Capital (£'000) - FOT	39,125	36,736	Achieving

The Trust continues to deliver against a number of key operational priorities despite sustained pressure across urgent care, cancer services and the financial position. Elective recovery and diagnostic performance remain comparatively strong, while quality and safety indicators remain stable.

The principal strategic risk facing the Trust remains financial delivery. The YTD deficit is £17.9m, £7.4m adverse to plan. The scale of the efficiency challenge, combined with underlying operational pressures and a reduced funding envelope, means delivery of the year-end position will require accelerated implementation of recovery actions. Executive-led programmes are in place to strengthen efficiency delivery and improve financial grip and control.

Urgent and emergency care remains a significant operational challenge. Demand continues to exceed planned assumptions, contributing to ongoing pressure at the front door. Recovery actions are focused on flow throughout the hospital, improving same-day emergency pathways and reducing discharge delays.

Planned care performance continues to provide positive assurance. Referral to Treatment and diagnostic standards remain ahead of trajectory. Cancer performance remains mixed, with Faster Diagnosis and 31-day treatment standards being achieved, while delivery of the 62-day standard continues to be impacted by diagnostic turnaround times, pathway complexity and sustained growth in demand. Targeted tumour-specific recovery plans remain under close executive oversight.

Quality and safety indicators remain broadly stable, with no MRSA bacteraemia or Never Events reported in August and patient safety incident reporting remaining within statistical control limits. The Trust-wide positive FFT rate was 93.1%, while 83% of complaints closed in month met the 60-working-day standard.

The workforce position continues to improve, with reductions in agency and bank utilisation. However, sickness absence remains above target and continues to represent a risk to operational resilience during periods of sustained pressure.

Constitutional Standards | Benchmarking

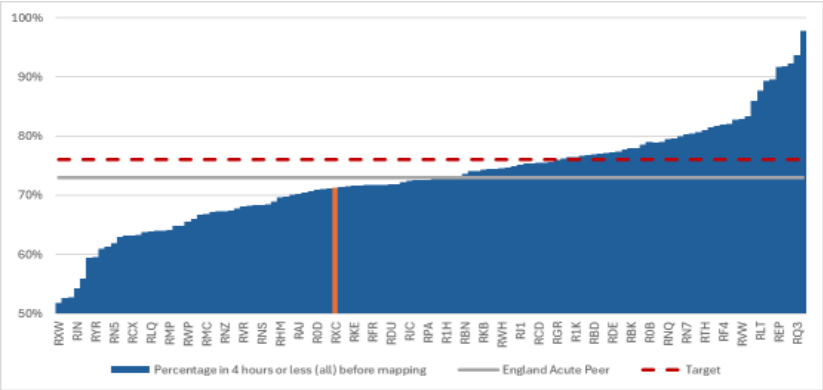
*NHS England has yet to publish all August 2026 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

August 2026 Peer Review

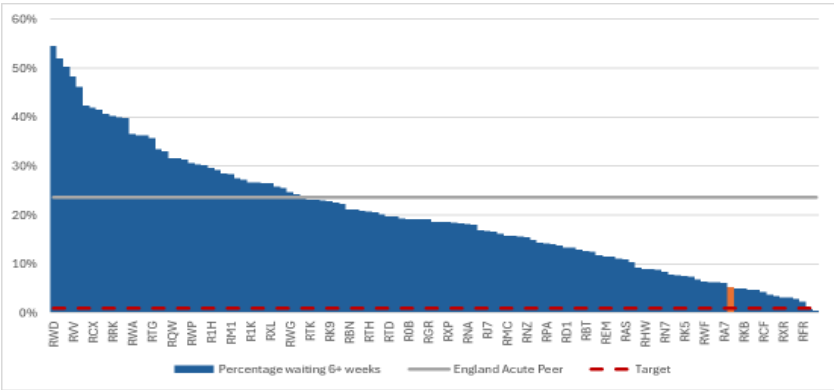
National Average: 73.0% ESHT Rank: 77/122



Planned Care – Diagnostic Waiting Times

July 2026 Peer Review*

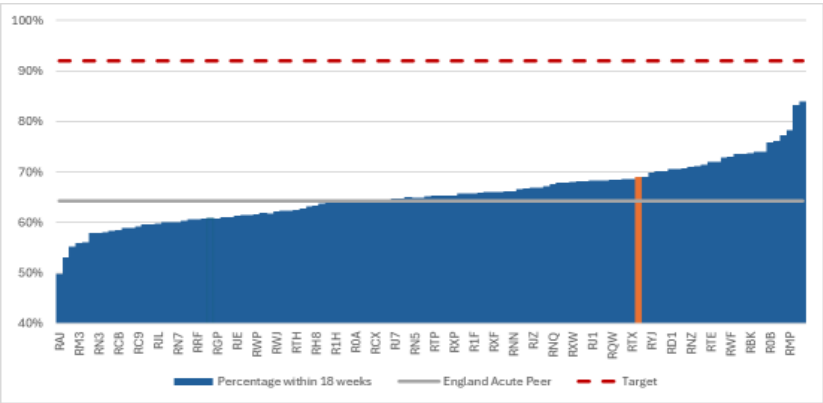
National Average: 23.6% ESHT Rank: 14/117



Planned Care – Referral to Treatment

July 2026 Peer Review*

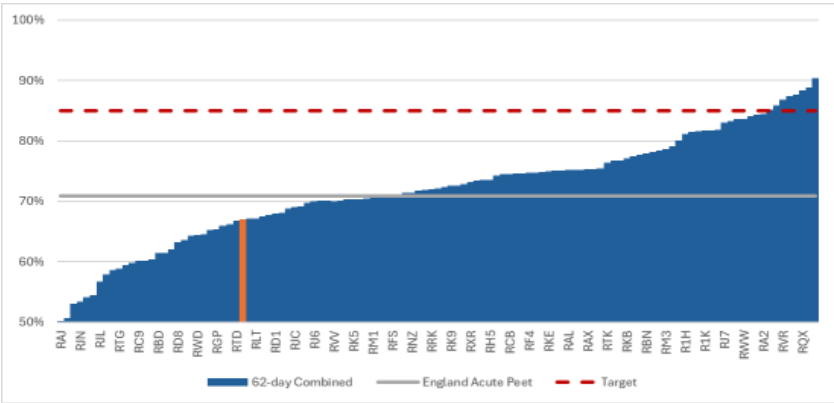
National Average: 64.3% ESHT Rank: 26/114



Cancer Treatment – 62 Day Combined Standard

July 2026 Peer Review*

National Average: 70.8% ESHT Rank: 89/117



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

Infection Control

Standard contract limits for 2026/27 for ESHT have now been set by NHSE: *C. difficile* 67 (same as 2025/26), *E. coli* 103 (a 10% decrease on 2025/26), *P. aeruginosa* 19 (same as 2025/2), *Klebsiella spp.* 30 (a 10% decrease).

No MRSA bacteraemia have been reported since 1st of April. Two MSSA infections were reported in August, one HOHA possibly avoidable due to peripheral cannula and one COHA, reported as unavoidable, following removal of ureteric stent.

Four *C. difficile* infections were reported in August, two HOHA and two COHA. Post infection review assessed one case as a lapse in care due to antimicrobial prescribing, lessons learnt shared with the clinical team. The patient recovered from CDI.

Patient Safety Events

999 patient safety incidents of a total 1,423 incidents were reported in August 2026. Reporting trend remains stable within statistical control limits.

The proportions of harm have remained consistent with previous months and better than National data;

- 97% reported as 'No/Low harm/Near miss'
- 2.4% as 'Moderate' harm
- 0.3% as 'Severe' harm
- 0% as 'Fatal' harm
- No PSIs met the 'Never Events' definition.

All harm incidents are reviewed to identify gaps in care or service delivery that might have resulted in the harm for learning and improvement.

The top three categories of incidents reported were;

1. Slips, Trips and Falls – 138 incidents reported. Majority were No/Low harm except 6 reported as 'moderate' harm. The inpatient falls rate in April was 4.30, relatively stable with no evidence of outliers.
2. Diagnosis and Diagnostic Services – 107 incidents were reported of which the majority were reported as no/low harm. 4 reported with 'moderate harm' and 1 with 'severe' harm.
3. Medication Errors and other Medication Related Incidents - 98 incidents reported, of which the majority were no/low harm. 4 were reported as 'moderate' harm and 1 with 'severe' harm.

It should be noted that the final level of harm of these incidents may change once the reviews are completed and gaps in care or service delivery are confirmed.

Safeguarding

Following a Task and Finish group process the Domestic Abuse Steering group met for the first time in September. The forum will provide a space to have oversight of the work of domestic abuse champions, the HIDVA and seek to advance routine enquiry across the organisation. The organisation that the HIDVA works with changed to Advance in May, we are still experiencing challenges in obtaining data whilst they align their systems.

There has been challenges in starting a forum that will consider Learning Disabilities and Mental ill health, a further meeting is planned.

Self neglect has remained a key theme in adult safeguarding however the self neglect forum has been paused due to poor attendance and to allow a re-refresh.

Themes within Children's safeguarding referrals are Emotional harm and Domestic Abuse, with the mental ill health of children remaining as a key feature.

Author(s)



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



Simon Merritt
Chief Medical Officer

Patient Experience: We received 56 new complaints, which is an increase of 13 against July's number. 100% complaints were acknowledged within 72 working hours. Of the 56 complaints received in August 66% came from 2 categories: Clinical Treatment =23 (delay in treatment/diagnosis issues) and Communications =12 (communication with patients/relatives).

Top complaint location in August was (this does not necessarily relate to care provided in August): Emergency Department =11 (CQ=7 and EDGH =4), Outpatients Department =4 (CQ =3 and EDGH), Frand Shaw = 3, BETU =3 and SPH =3.

Reviewing the monthly risk rating of all complaints, most were 'moderate' in common with the general pattern: 2 high risk (July =0), 40 moderate risk (July =36) where aspects of clinical care appear suboptimal and 14 low risk (July =7) where clinical quality does not form part of the complaint.

We take re-opened complaints/PHSO contacts as proxies for where we can learn, 7 complaints were reopened (July =7), 2 to Medicine and Urgent Care, 2 to DAS, 2 to CHIC and 1 to Obstetrics.

The Trust received 6 contacts from the PHSO in August (4 enquiries and 2 outcomes, where the PHSO decided not to investigate both cases)

Against our internal targets (60 working days), 8 complaints were overdue at the end of August. Of the 52 complaints closed in-month: 83% were completed in time (July =90%), against our local target response, which is 80%.

695 contacts were recorded by PALS in August, which is a decrease of 58 when compared to July (=753). Of these contacts, 371 PALS contacts were recorded as "concerns" (July =417).

Top 3 locations of PALS concerns: Emergency Department (=54) (EDGH =32 and CQ =22), Outpatients Department (=39) (CQ =29, EDGH =9, and Bexhill =1) and Cardiology Outpatients (=8) – Patients trying to contact department or chasing appointments/referrals.

The top three primary PALS subjects recorded as a "concern" were as follows: Communication =91 (of these 40% related to communication with patients/relatives, 21% related to communication between staff and 18% related to delay in giving information/results), Appointments =79 (of these 29% related to long waiting times, and 23% to cancelled appointments) and Clinical Treatment =61 (of these 26% related to delays in treatment and 21% related to diagnosis issues).

The top three primary PALS subjects recorded as a "concern" were as follows: Communication =91 (of these 40% related to communication with patients/relatives, 21% related to communication between staff and 18% related to delay in giving information/results), Appointments =79 (of these 29% related to long waiting times, and 23% to cancelled appointments) and Clinical Treatment =61 (of these 26% related to delays in treatment and 21% related to diagnosis issues).

The Trust-wide positive FFT feedback rate was 93.11%, which is in line with the last six-month average of 93.13%.

There is a decrease in UC responses, this can be attributed to the change in provider but we will monitor this going forward.

Over the past 12 months we have seen a decline in inpatient FFT responses, we can attribute this to the supplier no longer inputting paper surveys, areas are now required to input their own surveys. We are also unable to confirm if patients were completing more than one survey (paper survey before discharge and then text survey post discharge).

Author(s)



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Simon Merritt
Chief
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Workforce

We have continued with high level of attendances to the Emergency Departments and high occupancy, which has required additional escalation and boarding capacity to be opened, putting significant pressure on the available workforce. This is noted in increase in short notice sickness and lower than average nurse fill rate. We continue to focus on improvement programmes for discharge and length of stay and work with SPFT to ensure the safety and quality of care for our patients requiring specialist Mental Health support/skills.

Acute and Community staffing remained stretched to cover the additional requirements and the focus continues on workforce wellbeing and support and rostering and efficiency, job planning and use of additional nursing workforce.

There are significant improvements noted regarding the reduction in use of additional capacity, agency including security and additional shifts through roster efficiency, mental health outreach team support and senior nursing oversight.

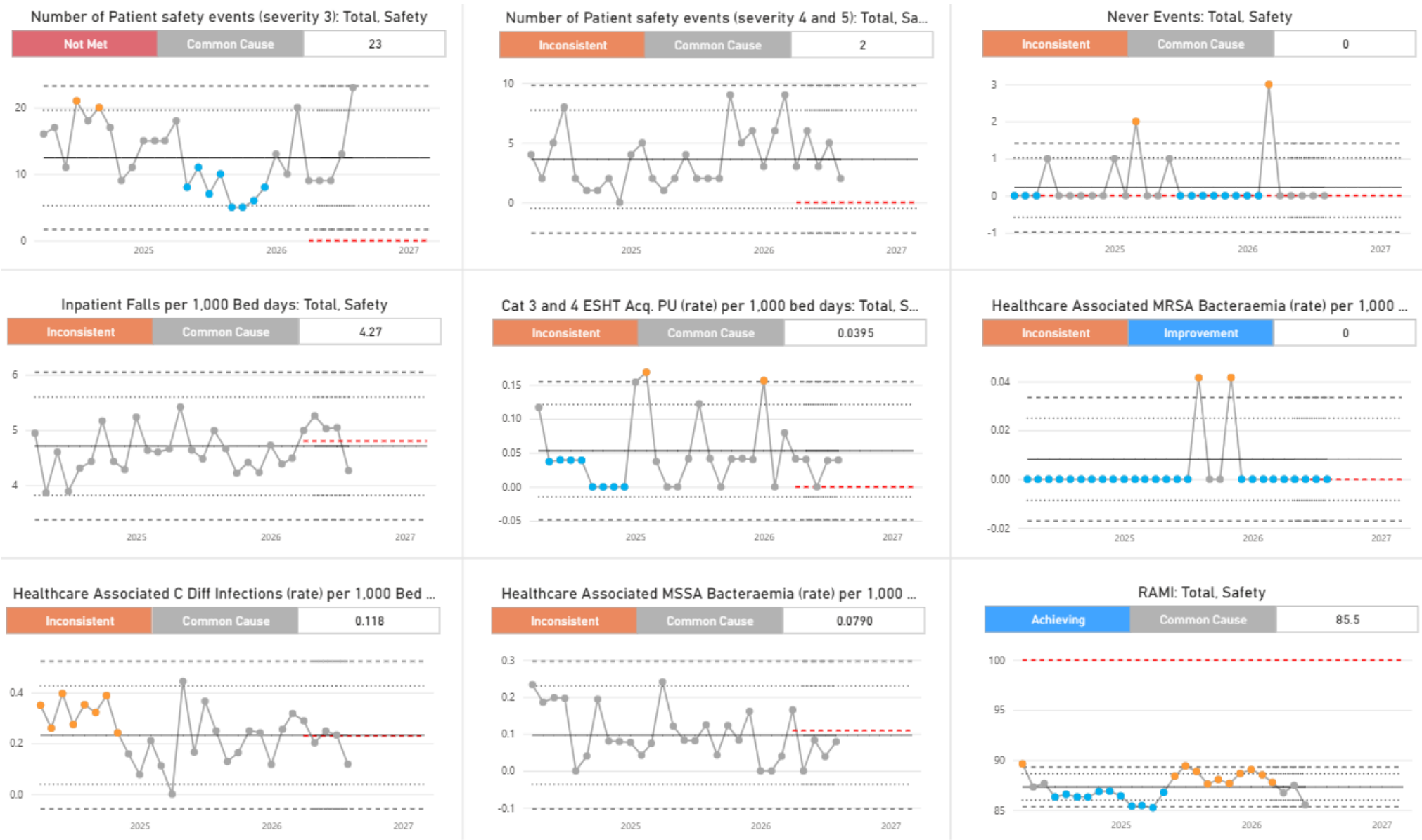
Mortality

RAMI 23 rolling 12 months is 86 for the current period and positioned at 50 out of 119 Acute Peer Trusts. SHMI is showing an overall value of 104.4 and is within the expected range. EDGH has an index of 108 and Conquest 100.

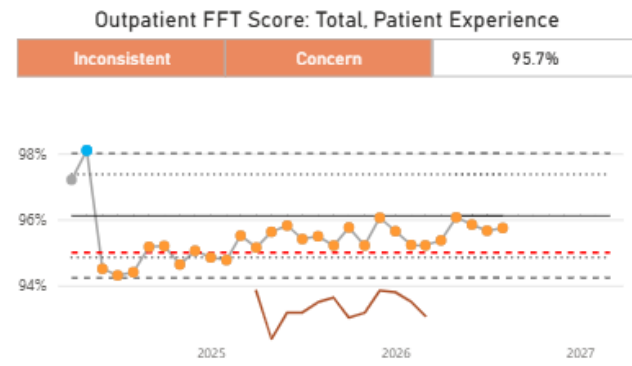
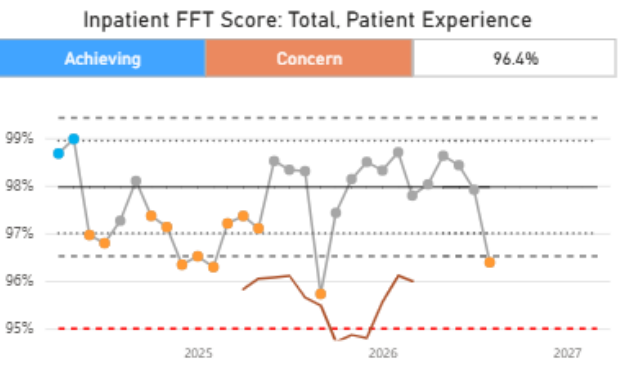
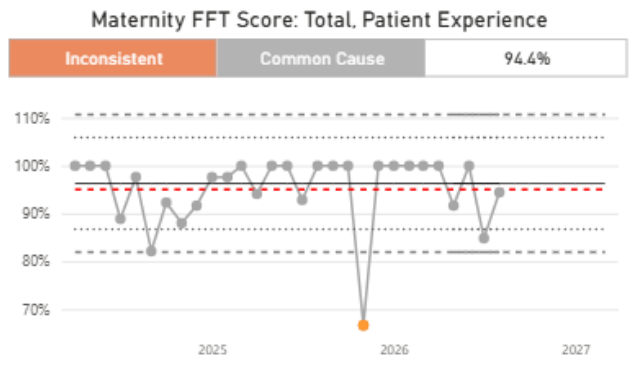
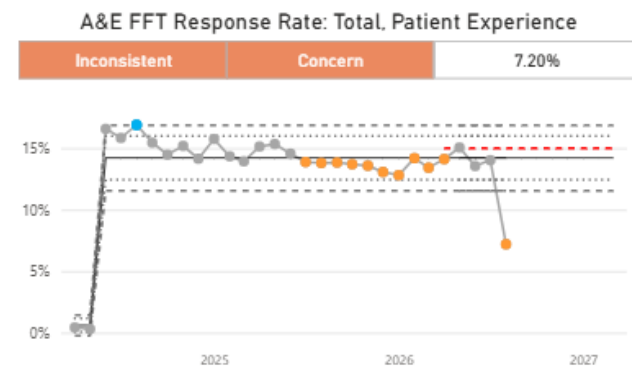
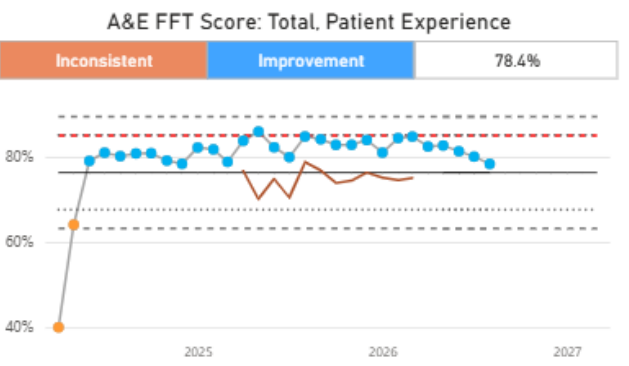
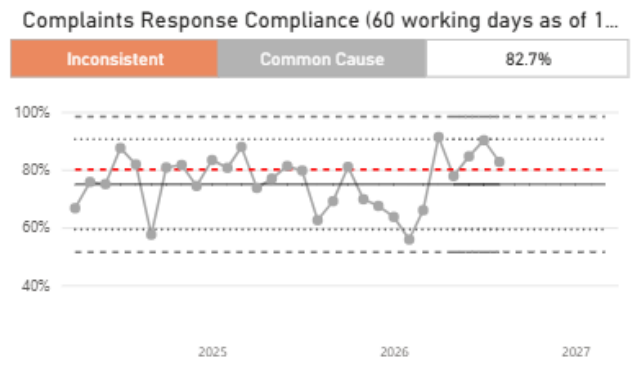
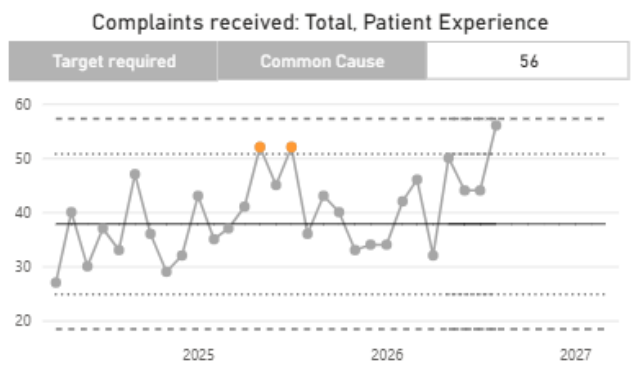
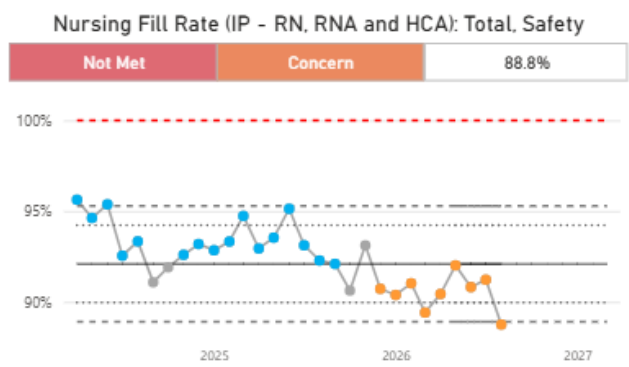
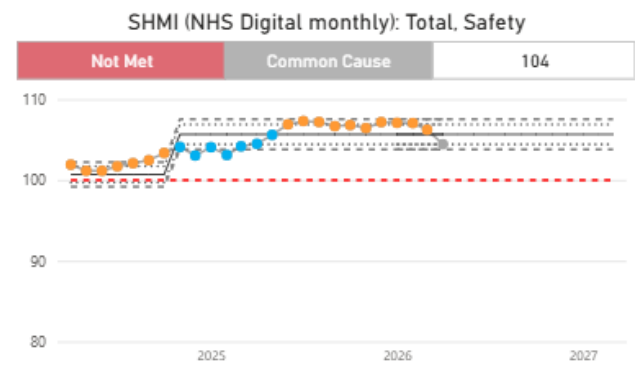
Both sites are within the expected range.

Weekend RAMI continues to show a value below the national average for HES Acute peers. Weekend SHMI has been showing an increase, but there is a deep dive in progress to investigate. Initial data shows a drop in admissions at the weekend affecting the denominator.

Quality and Safety Core Metrics



Quality and Safety Core Metrics



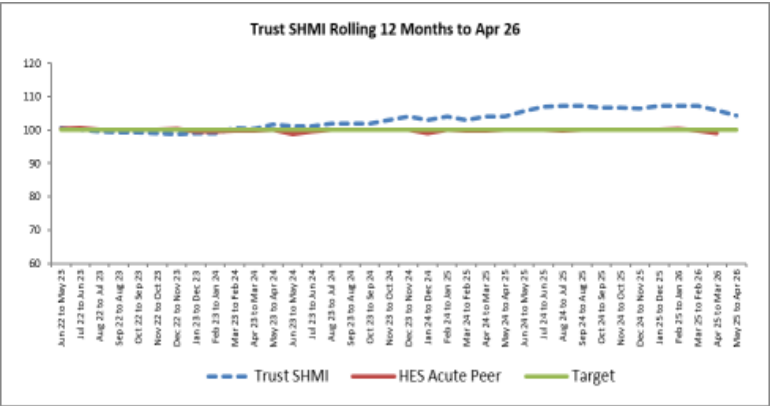
Title	Summary	Actions
Patient Safety Incident Response Framework (PSIRF)	Duty of Candour (DoC) compliance has improved across the board and continues to be monitored. A review of the applicable incidents in a 12-month rolling period is undertaken monthly to check compliance. At the end of August 2026, compliance was 90% for verbal DOC and 84% for written (was 84% and 72% respectively, in July 2026).	• The Incident Management Policy has now been ratified. • Focused PSIRF training courses being held in October/November for all relevant staff involved in PSIRF responses & engaging families and patients are now available for booking via MyLearn. • Actions planned to improve DoC compliance include; Offering targeted training, strengthening divisional accountability and oversight, further streamlining the DoC recording section on DCIQ and providing guidance on how / where to record completion of each stage of DoC on DCIQ • The above are supported by phased improvement to the Datix incident reporting & management system.
Never Event (NE) Patient safety Incidents	There were no reported Never Events in August 2026.	
Nursing & Midwifery Workforce	During August occupancy remained high and we have opened additional capacity and used pre-emptive boarding in corridors alongside this we have significant numbers of patients requiring enhanced observation in relation to high risk of falls or patients with challenging/violent behaviour. Controls remain in place to ensure staffing continues to meet the needs of our patients. Ward nursing CHPPD overall was 7.4 for August (noting distortion by specialist areas) reflecting the additional demands on our nursing workforce and the current levels of occupancy and numbers of beds open. Nursing fill rates for day shifts = RN 88% and HCSW 69%. Nursing fill for night shifts = 97% for RN and 101% for CSW.	• The annual Nursing Establishment Review (NER) for 2025, report was presented at Board and investments in nurse template levels was approved for the identified areas. Current data collection for Spring 2026 completed and next data collection is in Autumn • Non-medical job planning, education and supervision frameworks are in progress • Recruitment to the Mental Health Outreach team continues and they working in our Emergency Department and are deployed to support our most complex patients. Training opportunities for staff as part of the MH Strategy are also underway. The Trust is continuing to work with SPFT to offer enhanced assessment and initial care plans for those patients who present with an acute mental illness crisis and have agreed to roll out the body worn cameras for teams working in our urgent care areas • Nursing/Midwifery monthly Roster Compliance sessions continue, led by the Chief/Deputy Chief Nurse to ensure effective/efficient nursing rosters. There is a weekly vacancy control panel in place to review all recruitment requests. There is evidence of good control to support enhanced observations and requests for additional staff and we continue to work on reducing reliance on Agency and bank staffing, including security • Analysis of the job specific skills and leadership training needs is on going and we are working with NHS Elect to identify the skills gap and plan an education framework to ensure training meets the needs of our people • We offer training and support with the restorative supervision programme and the network of practice educators and current education/preceptorship resources • The senior nursing teams continue to help plan to meet the additional operational demands and offer support to our frontline teams and promote staff wellbeing.

Title	Summary	Actions
Inpatient Falls	The falls rate for all falls for ESHT per 1000 inpatient bed days for August 2026 was 4.30, remaining within the control limits with no cause for concern. 6 x moderate harm incidents were reported in August 2026 but no severe or fatal harm. 13 patients had multiple falls in August 2026 (consistent with the average monthly numbers), with majority sustaining two falls (11 of the 13) of the remaining; 1 patient sustaining 4 falls and 1 patient sustaining 3 falls. Of the 29 falls reported only 1 was reported as moderate harm.	•Completed SWARM forms continue to be monitored, and peer reviewed in the PSIRF Review Group • Divisional themes and trends are reported to the Falls Steering Group for oversight and consideration for quality improvement activities.
Patient Experience	Increase in the number of new complaints received. Friends and Family Test (FFT) Update.	Frank Shaw, BETU and SPH feature in the top 3 complaint locations (each receiving 3 complaints). During August, the Trust completed the transition to Smart Survey as the new provider for the FFT. This has involved the migration of survey processes and reporting arrangements from the previous supplier. Access to the new Smart Survey dashboards, staff training, and the implementation of automated reporting are scheduled to commence during September. As a result, some FFT reporting functionality remains in development while the new system is embedded. Full access to reporting dashboards and routine automated reporting will be available once the implementation programme is completed. This change is expected to enhance the accessibility, timeliness, and functionality of FFT reporting, supporting teams to make greater use of patient feedback to inform service improvement. There is a decrease in UC responses, this can be attributed to the change in provider but we will monitor this going forward. Over the past 12 months we have seen a decline in inpatient FFT responses, we can attribute this to the supplier no longer inputting paper surveys, areas are now required to input their own surveys. We are also unable to confirm if patients were completing more than one survey (paper survey before discharge and then text survey post discharge).

Title	Summary	Actions
Harm reviews	The NCTR Harm Review Process was redesigned based on staff feedback, and the request to start completing the updated version of these was sent out again in mid October of last year, the intent being to allow approximately three months of data to be collected before January's Q&S.	Following further discussion, it has been determined that, in circumstances where the demand on staff is so high, this process be archived. The Governance Team will look at ways in which we may able to triangulate harm and LOS via existing routes
Pressure Damage	In-Patient reported Moderate harm and above One Category 4 pressure ulcer to the sacrum, was reported as a Moderate harm incident in August 2026. It is currently being investigated to establish whether any gaps in care or service delivery contributed to its occurrence. Community reported Moderate harm and above 2 x Category 3 and 1 x Category 4 reported as Moderate harm in August 2026.	• The newly improved Power BI PU dashboard report which includes all categories of pressure damage, by division and by ward to be integrated into divisional processes for reporting and monitoring • A new Learning Response for Pressure Ulcer Incidents tool has been developed and is being piloted over the next few months. Once refined will be developed into an electronic form in DCIQ.

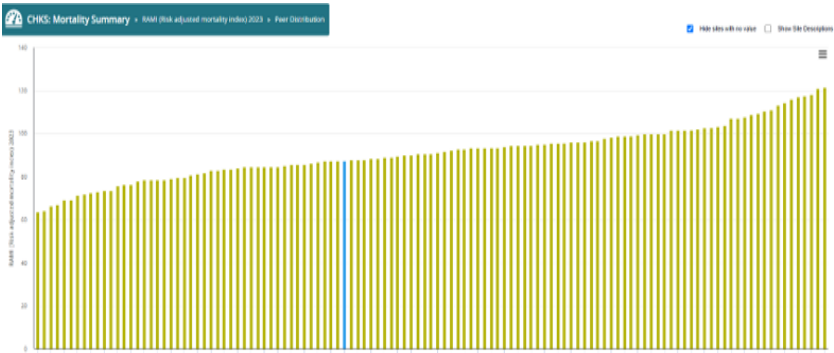
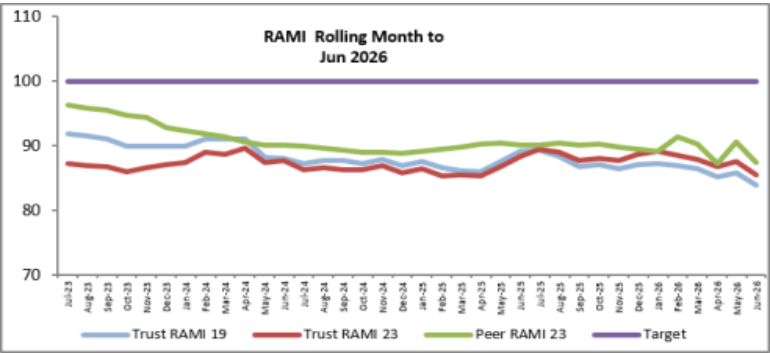
Why we measure Mortality – it’s used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

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 2025 to Apr 2026 is showing an index of 104.4 and is within the expected range and showing a reduction from the last period. EDGH has an index of 108 and Conquest is 100, both also within the expected range.
- The Trust is submitting Same Day Emergency Care (SDEC) data to the Emergency Care Data Set (ECDS) rather than the Admitted Patient Care (APC) dataset. SHMI is calculated using APC data. Removal of SDEC activity from the APC data affects the Trust’s SHMI value. This is due to change.
- SHMI is rebased each time it is published whereas RAMI is not.
- RAMI 23 –Jul 2025 to Jun 2026 (rolling 12 months) is 86 and 88 for the same period last year. Peer RAMI was 87 for this period
- The line graph below shows the rolling 12 month figure.
- Crude mortality shows Jul 2025 to Jun 2026 at 1.38% compared to 1.60% for the same period last year.
- The new mortality database was rolled out in November 2025. The Consultant acknowledgement rates of the Medical Examiner reviews for Jul 26 was 69% within the timescale allowed

Risk Adjusted Mortality Index (RAMI)

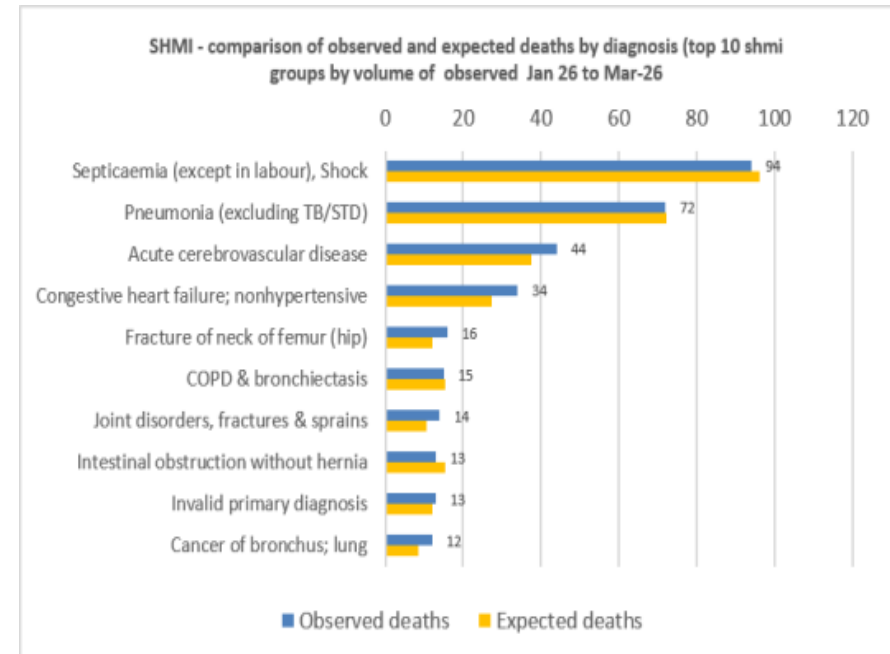


This shows our position nationally against other acute trusts – currently 50/119

Aug 2026 Main Cause of In-Hospital Death Groups

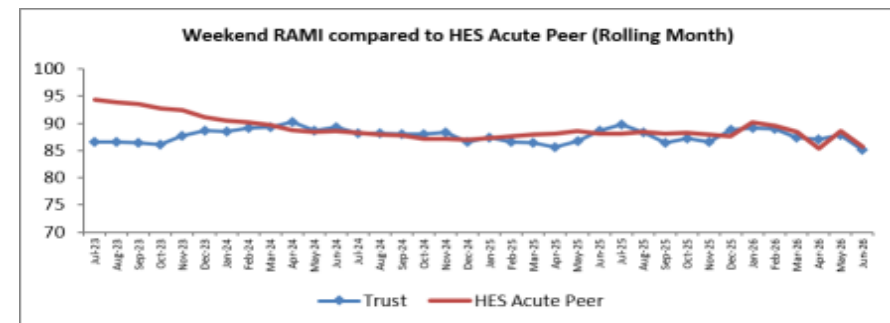
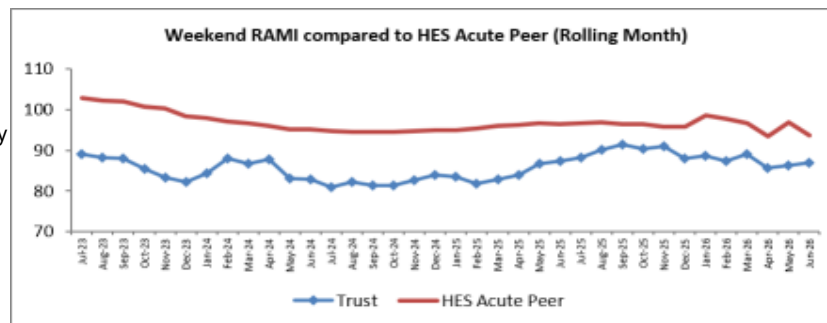
Description	Aug 2026	2026/27
Atrial Fibrillation	0	1
Acute Kidney Injury	0	0
Bowel Obstruction	1	7
Bowel Perforation	0	2
Cancer	18	98
Chronic Obstructive Pulmonary Disease	1	17
COVID-19	0	0
Dementia	2	2
Frailty of Old Age	6	34
Liver Disease	1	12
Heart Failure	4	38
Myocardial Infarction	3	22
Pneumonia	5	36
Aspiration Pneumonia	7	32
Community Acquired Pneumonia	3	21
Hospital Acquired Pneumonia	3	11
Sepsis/Septicaemia	17	82
Stroke	9	42
Urosepsis	7	13
Other	27	127
Unspecified	9	39
Total	123	636

SHMI Diagnosis Main Groups



Risk Adjusted Mortality Index (RAMI)

Weekend and Weekday Mortality Trends





Summary Hospital-level Mortality Indicator (SHMI)

Funnel plots

[Return to contents](#)



Select trust or site level data

Trusts

Select trusts / sites

East Sussex Healthcare NHS Trust

Select diagnosis group (trust level data only)

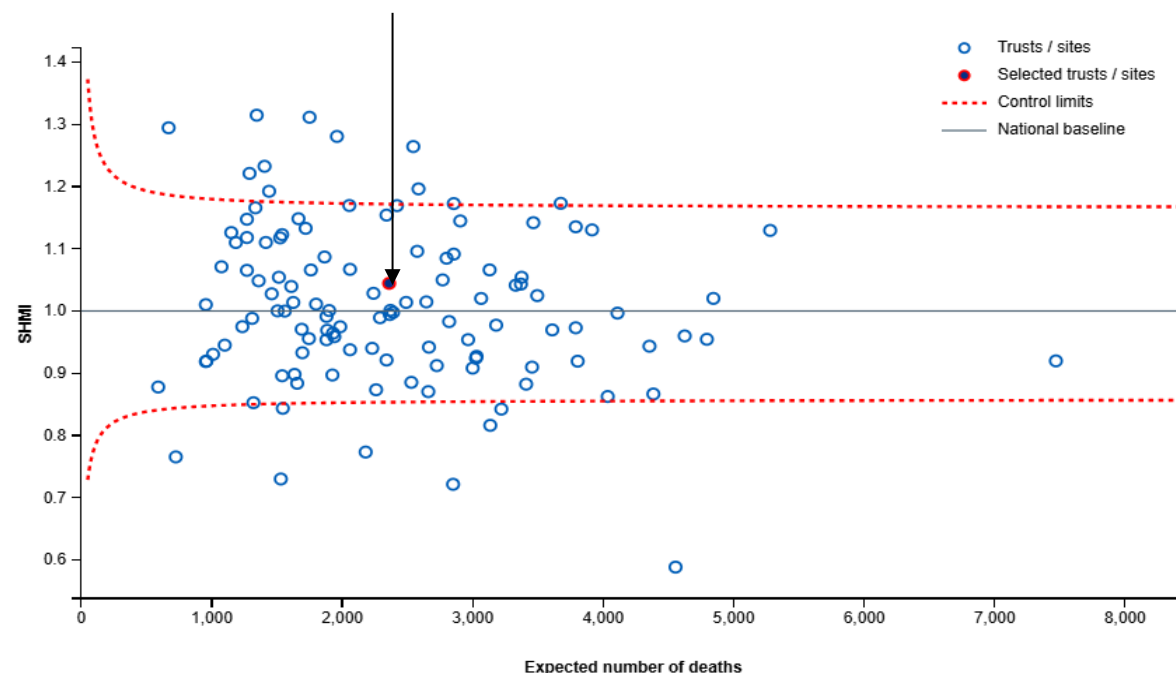
All diagnosis groups

Select a reporting period

May 2025 - April 2026

[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).

Our People

Recruitment and retention

Staff turnover / sickness

Our quality workforce

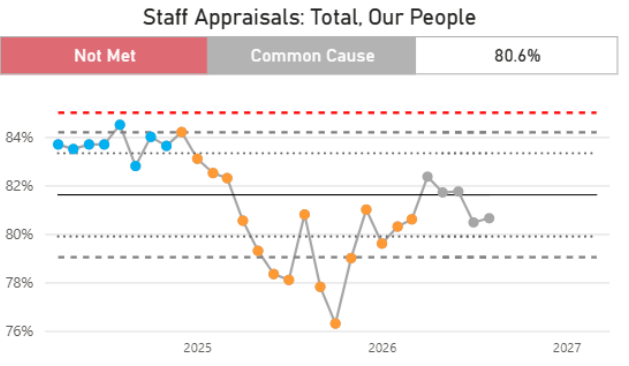
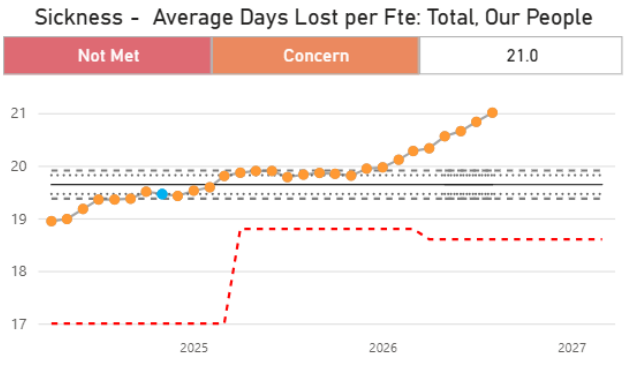
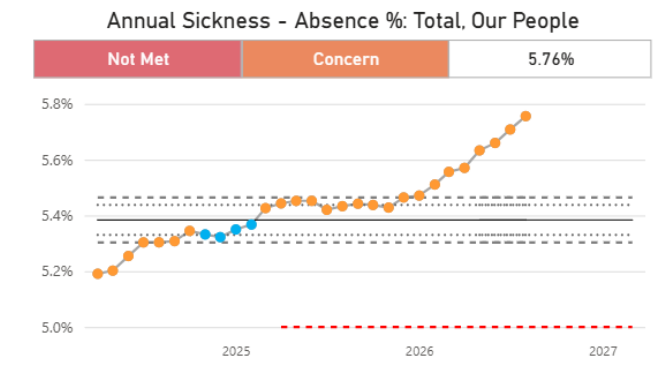
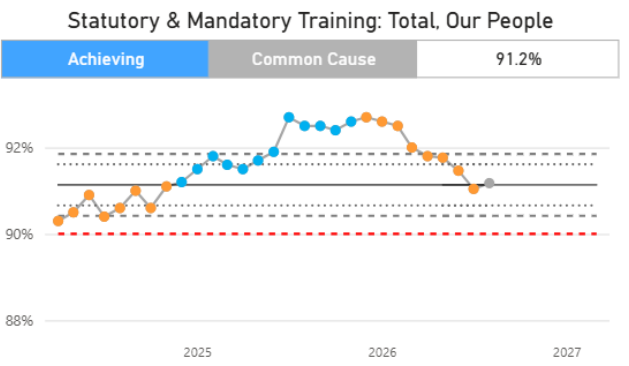
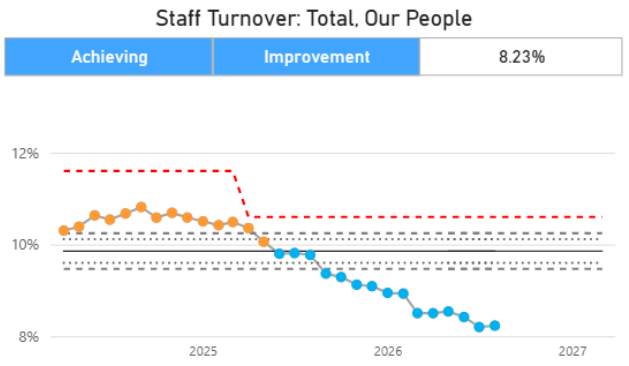
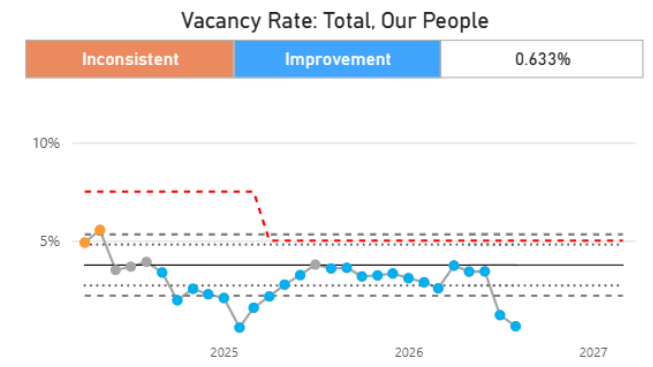
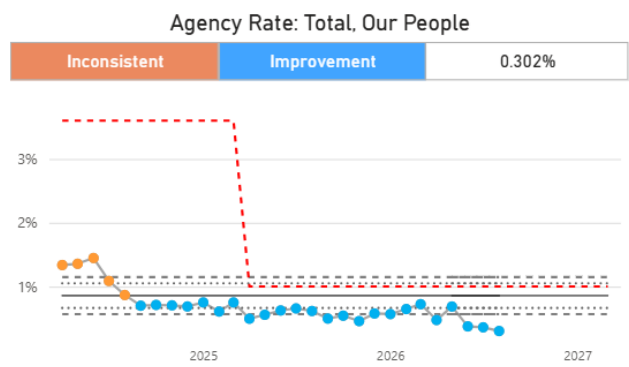
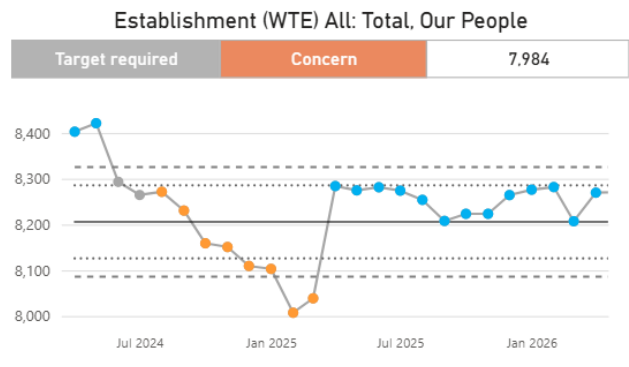
What our staff are telling us?

**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

Responsive	Positives: -13% reduction in bank usage reduction since March of (-83 wte) -59% agency reduction since March of 35 wte (year end target exceeded) - Run rate reduction in pay spend of £0.4m against last month	Challenges and Risks: - Overspend by £2.1m against budget this month - Monthly sickness increased from 5.8% to 5.9% (459 wte lost) - Appraisal rate increased slightly to 80.6% but not achieving target of 85%	Author 
Overview:	Year to date, from M1- M5 inclusive, shows an overspend of £3.8m against budget. The gap is largely as a result of cost improvement initiatives originally in plan but have not yet been realised. The onboarding of a new Director of Efficiency & Improvement will support the continued focus to review outlined CIP opportunities and push to provide the required detail to support route to cash. Utilisation of temporary workforce has significantly reduced by 117 wte since March 2026, from 8.6% to 7.2%. This has been partially offset by successful substantive recruitment, which is most notable in areas like Acute Medicine, Emergency Care and Cardiology. Bank has seen a trending wte reduction since March 2026 with June as the only exception to this. August 26 compared to March 26 shows -83 wte reduction in usage. May 26 saw the highest usage this year at 55.9 wte however the last 3 months have seen usage hover around the 30 wte mark. The reductions in temporary workforce continue despite ongoing high levels of sickness. This is being primarily driven by increased frequency of long-term absence associated with mental health or MSK/back problems related absence. 1 in 8 colleagues have been absent due to mental health in the last year ❖ Average length of each episode being 26 days before returning to work ❖ 31 mental health referrals and 29 MSK referrals recorded by the Occupational Wellness Team.		Steve Aumayer Chief People Officer

Our People Core Metrics



Title	Summary	Actions
Turnover & Retention	Turnover rate remained at a historic low of 8.2% (591 leavers wte each year)	During August, the People Experience Team continued to enhance colleague engagement, recognition, and the onboarding experience across the Trust. Preparations for the forthcoming Trust Awards progressed, supporting the celebration of colleague achievements and contributions across the organisation. The team also maintained its commitment to welcoming new starters through the ongoing delivery of weekly corporate welcome and induction sessions, with 73 new colleagues welcomed to the Trust during the month. Significant work continued to support the planning and implementation of the NHS Annual Staff Survey ahead of its launch on 21 September, helping to maximise colleague participation and feedback. In addition, the team continued to foster a culture of appreciation and recognition through activities celebrating the contributions of both serving and retiring colleagues, reinforcing the Trust's commitment to valuing and supporting its workforce throughout their career journey.
Vacancy Rate	Vacancy rate reduced to 0.6% (49 fte vacancies), 4.4% under target.	Recruitment has been continuing to support the organisational changes as we transition to Care Groups, alongside ongoing support for any displaced staff. Recruitment to the Care Group Clinical Director roles remains ongoing and is expected to be completed by the end of the month. The recruitment of Specialty Leads has commenced Targeted and bespoke campaigns for HCSW assessment days with proactive recruitment screening calls prior to interview have resulted in 100% attendance success with 87 successful offers and a talent pool ready – further assessment days for rehab support workers are planned this month Onboarding activities for the September and October resident doctor intakes are almost complete. Targeted recruitment activity continues to address hard-to-fill vacancies, resulting in offers being made for Locum Consultant posts in Stroke, Breast Radiology, Radiology Chest, Head and Neck, and Emergency Medicine onboarding continues and is closely monitored so switch off dates of high cost agency and TWS can be correlated with start in post dates

Our People | Areas of Focus

Title	Summary	Actions
Sickness	Monthly sickness increased by +0.1% to 5.9% Average sick days per fte increased by +0.2 days 21 days	Demand for Occupational Health, wellbeing and psychological support services remains high, with particularly strong utilisation across CHIC, Medicine and Surgery. Recruitment health clearance processes continue to operate efficiently, while TRiM and restorative supervision activity indicate ongoing support for staff exposed to traumatic or challenging workplace events. The Fit to Work and Clear to Work workstream remain 1FTE reduced in capacity whilst recruitment processes are ongoing. Fit to Work • MRT demand remained high, with 224 referrals received and 218 triage appointments completed. Performance against the temporary 20-day KPI was strong, with 98% of appointments booked within target and the average wait reducing to 6 days from the previous month average of 14 working • Mental health and musculoskeletal issues remained the most common referral themes, with 31 mental health referrals and 29 MSK referrals recorded. Additional referral themes included, 11 work-related stress referrals, and 6 pregnancy-related referrals Well to Work / TRiM • The most common triggers for TRiM intervention were violence/aggression/abuse/conflict and patient death/traumatic outcome /resus, mental health-related incident and trauma exposure/triggering event. • Activity remains concentrated within Urgent Care and Medicine • 100% of new referrals (4) were responded to within 2 working days Wellbeing Support • A total of 72 contacts were made in relation to wellbeing support, demonstrating sustained utilisation of wellbeing services by colleagues across the Trust • 89% of individual wellbeing support requests were responded to within 2 working days

Our People | Areas of Focus

Title	Summary	Actions
Statutory & Mandatory Training	Trust compliance reduced slightly to 91.2%	BLS has reduced slightly by -0.8% to 77.1%. All of the new FY1 have had their BLS. Operational Pressures is having an impact on compliance and is evident in Information Governance, Fire and MCA /DoLS which has fallen below 90% over the last 4 weeks. Introduction of the new Tier 1 & 2 Oliver McGowan Training. A total of 30 webinars have been commissioned for Tier 1 and 55 Full Day courses commissioned for Tier 2 for the period May to Mar 2027. Majority of events are now fully booked, working with the specialist providers we have been able to negotiate an increase in cohort size and secure additional sessions. Target is to achieve 30% compliance across both Tiers by March 2027, based on current numbers training to date and booked sessions we anticipate achieving the regional target by March 2027.
Appraisal	Compliance increased by +0.1% to 80.6%, 4.4% below target	Appraisal compliance has remained consistent with July 2026. The ongoing priority divisional focus on completing Appraisal for staff and then upload onto ESR remains a key focus, it is the uploading of the data that is an ongoing issue for some Divisions. Nationally NHSE have announced that in 2027 it will be launching a new appraisal process, there are as yet no further details. The paper version of the appraisal process remains ongoing, however there are some changes being made to form to enhance the process.

Access and Responsiveness

Delivering the NHS Constitutional Standards

Urgent Care – Front Door

Urgent Care – Flow

Planned Care

Our Cancer services

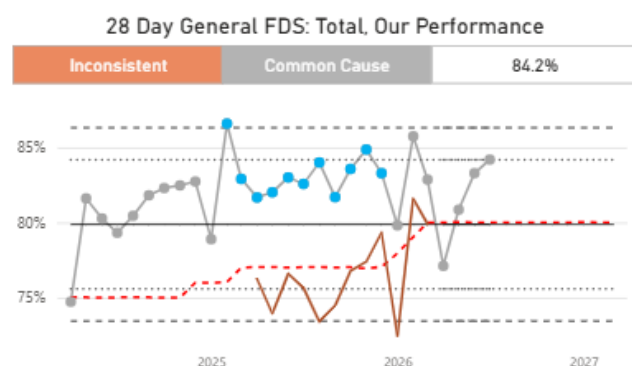
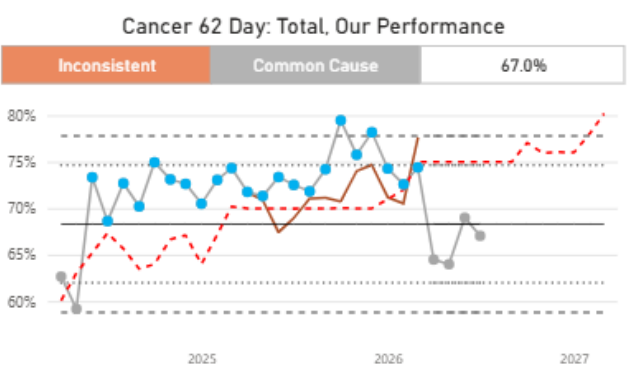
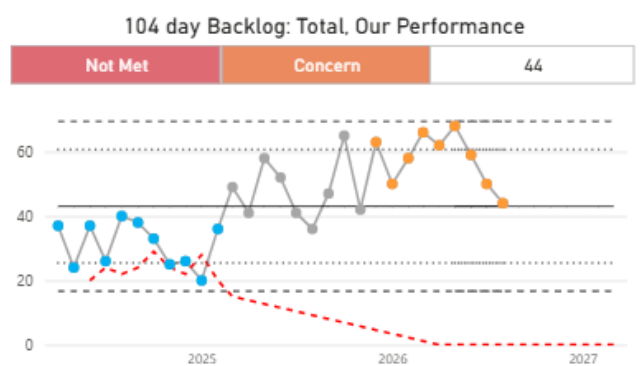
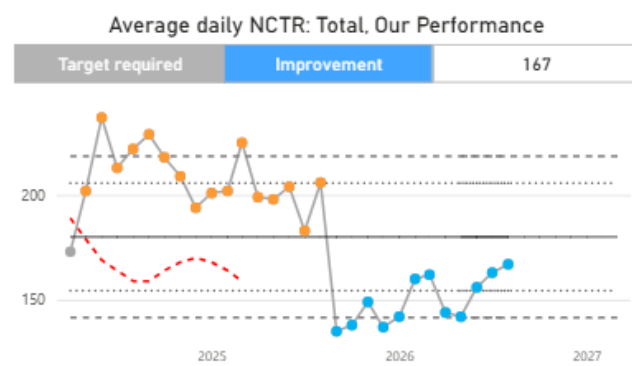
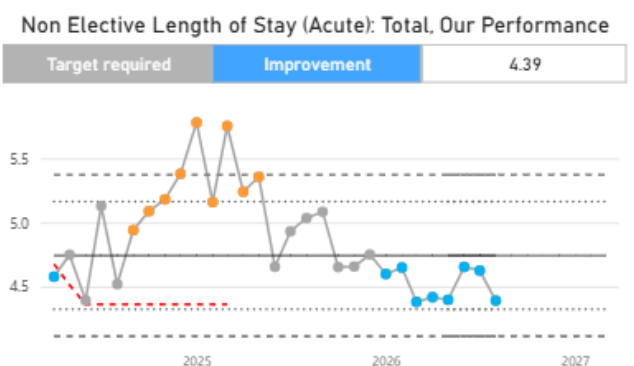
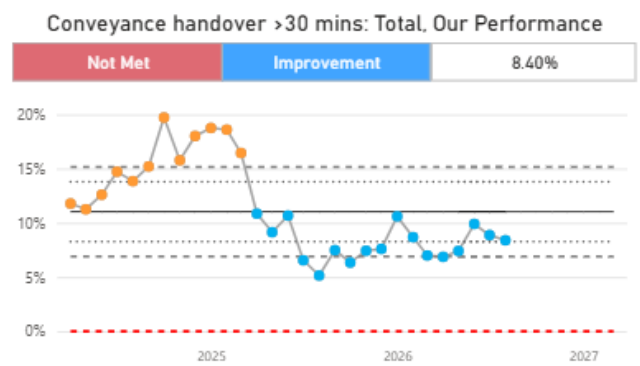
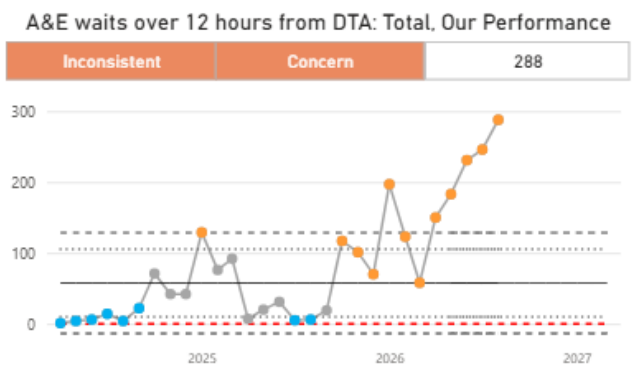
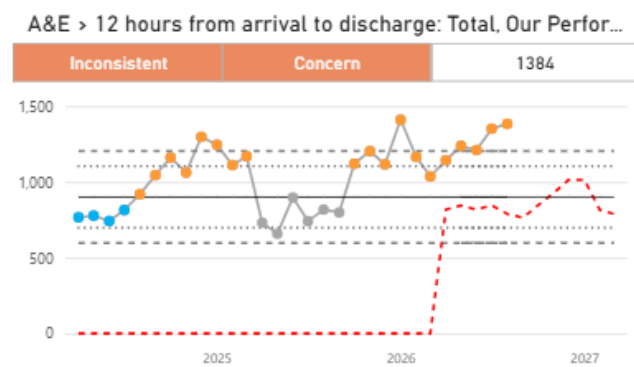
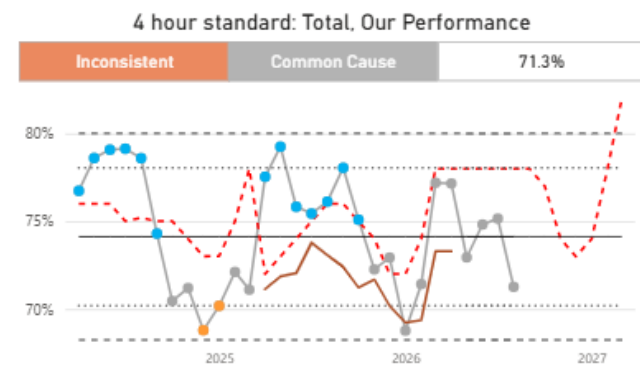
We will operate efficiently & effectively

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

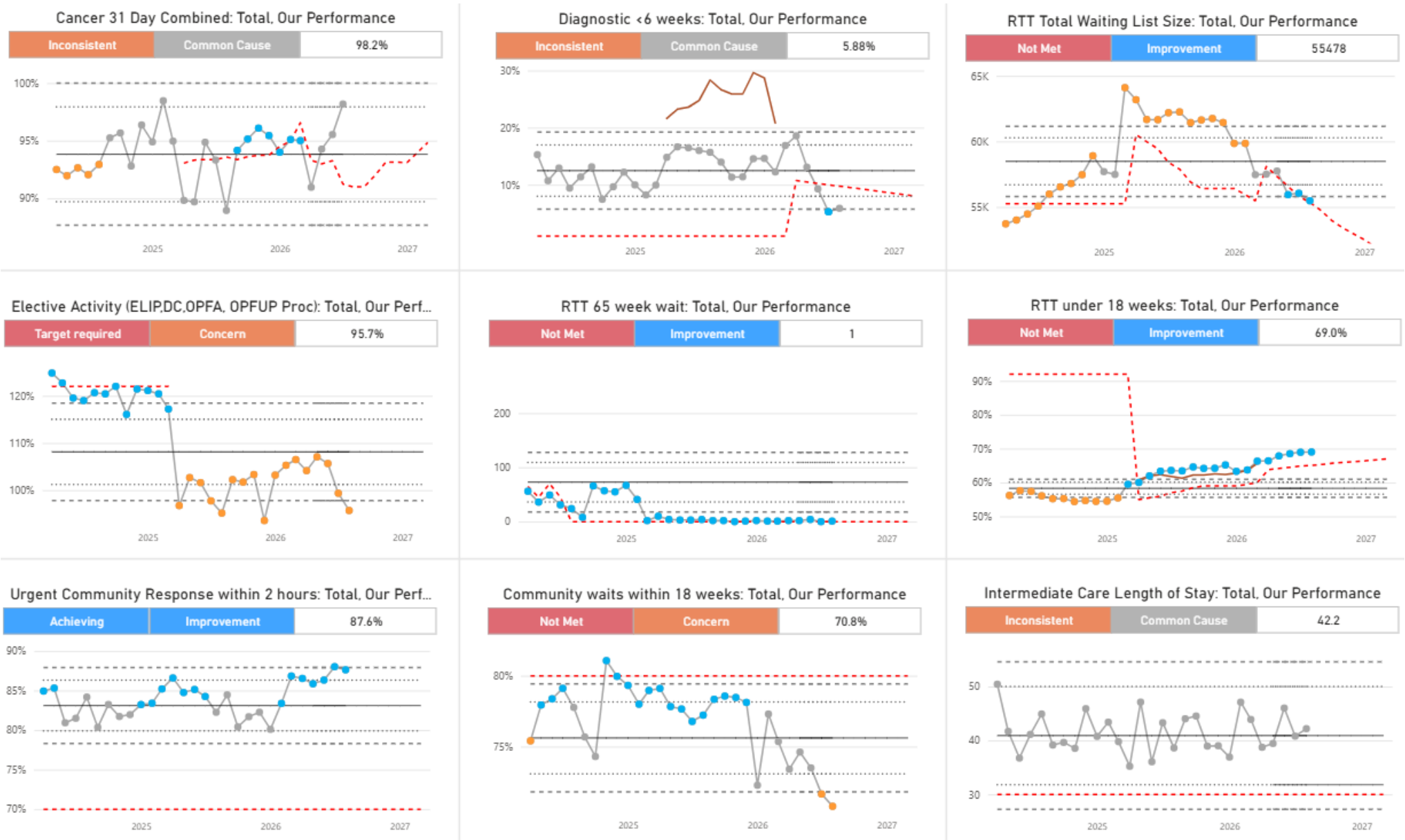
Access and Responsiveness | Executive Summary

	Positives	Challenges & Risks	Author
Responsive	Urgent Community Response (UCR) The UCR standard of 70% has been achieved consistently in the Trust, with 87.6% of patients seen within 2 hours. Cancer July FDS 84.2% against a trajectory of 80%. Performance against the 31-day treatment standard was 98.2%, against a trajectory of 91.3%. RTT Performance In August, the Trust achieved 69% against a trajectory of 65.1% for RTT performance. The Trust reported a small number of patients waiting >65 weeks in August. The number of patients waiting over 52 weeks has been reducing month on month since April 26 (426). In August, the trend continued and there were 338 patients who waited more than 52 weeks, this is 23 adverse to submitted trajectory (315). Diagnostic DM01 performance was 5.88% versus a trajectory of 9.8%	4 Hour Emergency Access Clinical Standard In August 71.3% of patients were seen and discharged or treated and admitted within 4 hours, against a planning trajectory of 78%. With additional mapped activity, aggregate performance in August was 73.3%. Paediatrics performance was 93.8% Cancer July 62-day performance remains challenged at 67% against trajectory of 75%. The volume of patients waiting over 62 days at the end of July was 287, versus a trajectory of 216. To support recovery, focussed PTL meetings are in place and PTL meeting governance has been enhanced. Length of Stay (LoS) Non-elective LoS in August was 4.72 days an increase from 4.62 last month. The driver for this is an increase in length of stay across P2 and P3 pathways. The UEC Delivery Group is overseeing an action plan which is focussed on improving processes at the Front Door and supporting more timely discharge.	 Charlotte O'Brien Chief Operating Officer
Actions:	- Improve Emergency Department flow and reduce non-admitted breaches to consistently achieve the 78% Emergency Access Standard and minimise corridor care - Deliver cancer recovery priorities by improving pathway performance and reducing treatment backlogs - Maintain zero 65+ week waits and fully eliminate remaining 52+ week elective pathways by March 2027. - Reduce waiting lists in community paediatrics through focused backlog recovery and capacity optimisation.		

Access and Responsiveness Core Metrics



Access and Responsiveness Core Metrics



Title	Summary	Actions
Emergency Access Clinical Standard	In August, 71.3% of patients were seen and discharged or treated and admitted within 4 hours, against a planning trajectory of 78%. Treating 17 more patients per day, per site, within the 4-hour standard, would have achieved 78% performance. This places the Trust 77 out of 122 Trusts nationally, and in the third quartile for performance against the 4-hour Emergency Clinical Access Standard. The national average is 73%. With additional mapped activity, aggregate performance in August was 73.3%. ED demand has increased by 7% this financial year compared to 2025/26, T1 attendances have increased by 12% (which equates to 6559 more attendances).	• Introduction of booked appointments, initially at Conquest Hospital. • Implementation of Waiting Room Rapid Assessment and Treatment (RAT) model at Conquest, • Review of Tracker role to ensure all patients approaching three hours in the department have a plan in place to support treatment or discharge within 4 hours • Strengthening of RAT staffing arrangements at EDGH, underpinned by revised nursing rotas and dedicated medical cover between 10:00 and 19:00 • Review of CDU utilisation and Length of Stay • Ongoing review of ED roles and responsibilities and handover processes • Introduction of an enhanced patient allocation process, in alignment with the Nottingham model of care.
Patients in department over 12 hours from arrival to discharge	In August 2026, 1384 patients spent more than 12 hours in ED, this equates to 11.1% of T1 attends, against a plan of 7.0% (n = 789). In August, 288 patients waited over 12 hours following a decision to admit, displaying special cause variation.	• Timely escalation within the ED department to enable ED and divisional teams to create capacity. Overnight escalation to On Call Consultant where wait to be seen exceeds six hours • 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 • Additional support on Board Rounds to help facilitate discharges with focus on virtual ward and UCR referrals • Acute Medical Model now approved, and task and finish group established to support implementation. • Reduction of >12hr waits in ED is a key areas of focus for the Divisional Management Team.
Conveyance Handover >45 mins	The Trust is aiming to have zero 45-minute off load delays. In August, conveyance handover more than 45 minutes was 2.31% (n=81), within lower end of control limit, where low represents good.	• Continued focus on ambulance handover times, early escalations and actions to mitigate delays have been embedded, supporting decompression in the department • Escalations to site managers and ED operational leadership team for inbound conveyances with no capacity to support offloading • Focused work with SECamb on timely electronic recording of all ambulance arrivals and validation of 45-minute off-load delays.

Access and Responsiveness| Areas of Focus

Title	Summary	Actions
Non elective Length of Stay (LOS)	Non-elective LoS was 4.39 days in August, and within control limits, displaying common cause variation. Pre and post-NCTR LoS are showing increase in P2 patient pathways (peaking at 23 and 11 days respectively) and P3 pathways (peaking at 20 and 11 days respectively) . The total number of patients who Do Not Meet the Criteria to Reside was 167 in August, within control limits. The range over last 6 months is 140 to 167.	- Continued focus on supporting discharge planning from admission, including the revised use and reporting of estimated dates of discharge (EDDs), supporting patients to return their homes before midday - Work continues with system partners to improve pathways for patients not meeting criteria to reside with a focus on P2 and P3 pathways.
Community Waiting Times (Paediatric)	The number of children waiting for a first outpatient appointment in August decreased to 2013 from 2126 in July (was 2923 in Aug 25). There were 27 children waiting over 78 weeks (all school age). A reduction from 43 in July. The number of children waiting over 65 weeks (all school age) reduced to 236 (596 in Aug 25). Zero children waited over 2 years in Aug.	- Waiting list validation continues and PTL meetings are now in place - Work continues with NHS Sussex to develop new models of care for ASD assessments and aligning processes - External provider contract for School Age is running well and supporting a reduction in the waiting list size. Arrangements for 2027/28 are being considered. Updated trajectory has been shared at Divisional IPR, QSC and awaiting decision from Exec Comm as to agreed plan.
Community Waiting Times (Adult)	Urgent Community Response has consistently achieved the 2-hour response target of 70% - August performance 87.6%. As per national guidance, the Trust is reporting on community health service waits within 18 weeks. The national ambition is 78% by the end of 2026/27. In August, 70.8% of patients were seen within 18 weeks. Neurorehabilitation, Podiatry, Orthotics and Speech & Language Therapy are challenged pathways.	- Clinical prioritisation of caseloads to mitigate clinical risk - Review of community contract underway - Ongoing discussions with commissioners regarding the level of funding required to support delivery of waiting time standards for community services - Implement productivity opportunities where possible.

Access and Responsiveness| Areas of Focus

Title	Summary	Actions
Cancer	In July the Trust continued to perform above trajectory for the Faster Diagnosis Standard (FDS), achieving 84.2% against a trajectory of 80%, representing a further improvement from June's position Performance against the 31-day treatment standard also improved in July to 98.2%, compared to 95.5% in June, with 325 of 331 patients treated within the standard, and exceeded the trajectory of 91.3%. Performance against the 62-day treatment standard remains challenged, with 67.0% of patients treated within 62 days in July, against a trajectory of 75%. Breach analysis continues to identify diagnostic delays within imaging, biopsy and pathology pathways as key contributory factors across several tumour sites. Sustained growth in demand and increasing pathway complexity have further impacted performance. A targeted recovery programme remains in place across all specialties, supported by tumour-specific improvement actions and close operational oversight. The number of patients waiting over 62 days remains above trajectory at the end of July (287 versus a trajectory of 216).	• Recovery plans are in place across all tumour sites • Progress is monitored through weekly performance reviews, supported by senior operational and executive oversight • Strengthened front-end pathway management is in place for patients requiring tertiary treatment • Enhanced monitoring of diagnostic turnaround times • Additional treatment capacity continues to be secured across specialties, focused on reducing the number of long-waiting patients • Increased scrutiny in the PTL meetings, ensuring early escalation.

Access and Responsiveness| Areas of Focus

Title	Summary	Actions
RTT long wait position and waiting list size	In August, the Trust achieved 69% against a trajectory of 65.1% for RTT performance. The Trust reported a small number patients waiting >65 weeks in August. The number of patients waiting over 52 weeks has been reducing month on month since April 26 (426). In August, the trend continued and there were 338 patients who waited more than 52 weeks, this is 23 adverse to submitted trajectory (315). 52 week waits represent 0.6% of the RTT PTL (55,478). The trajectory for August was 0.6%. August RTT PTL size is 55,478 against a trajectory of 55,355. This is primarily driven by increases in T&O, Gastro and General Surgery.	• RTT performance and waiting list trajectories are being closely monitored at specialty and service level, with performance reviews focused on sustaining delivery against the March 2027 RTT recovery trajectory • Enhanced monitoring and escalation arrangements are in place for patients approaching the 52-weeks • Validation resource is focussing on long-waiting pathways, supporting the Trust's continued reduction in 52+ week waits and delivery of the elective recovery programme • Work is ongoing to strengthen validation processes associated with increasing levels of pathway activity and clock stops ensuring pathway accuracy and timely RTT reporting • Clinic templates, consultant job plans and outpatient capacity continue to be reviewed and optimised to maximise utilisation, improve patient flow and support both RTT performance and sustainable PTL reduction

Access and Responsiveness| Areas of Focus

Title	Summary	Actions
Elective Activity	The Trust achieved 90% of the local target for August. This is expected to further improve once August activity has been verified.	• Outpatient capacity is being maximised through more effective clinic utilisation, with continued focus on lowering DNA rates, improving slot utilisation, and directing capacity to areas of greatest demand • Follow-up pathways are undergoing active redesign, with wider use of Patient Initiated Follow-Up (PIFU) and alternative models to free up capacity for new patients and enhance overall pathway efficiency • Enhanced governance and oversight are supporting reductions in cancellations and avoidable downtime, alongside better scheduling and list planning to optimise use of available theatre sessions • The implementation of Netcall will support elective recovery through increased digital engagement with patients, helping to reduce DNAs and late cancellations, automating administrative processes, improving patient communication, and streamlining pathway management. This is expected to enhance capacity utilisation across outpatient and elective services while improving the overall patient experience.
Diagnostic DMO1	Performance for August was 5.88%. This is in line with the diagnostic recovery plan, the Trust achieved less than 10% of patients waiting over 6 weeks by the end of Q1 and is now working towards achievement of <5%. Reduction in breaches from 435 in July to 430 in August Waiting list size also reduced by 944 to 7,312 Improvement in MRI (6.35%), CT (0.45%) and NOUS (0.82%) Echo cardiology 21.09% is under performing modality.	• All modalities are monitored closely with weekly meetings to oversee progress and agree corrective actions • Focus remains on full recovery of Cardiac Echo during August, September and into early October • Close monitoring of MRI performance in place to maintain <5% performance • Cardiac CT backlog has been cleared and will be monitored closely.

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

	Positives	Challenges & Risks	Author
Responsive	- M5 closed with a £4.2m deficit, £3.6m adverse to plan. The YTD deficit is £17.9m, £7.4m adverse to plan. - Year-to-date capital expenditure is within budget and the trust expects to remain within the annual capital resource limit. - Temporary staffing costs reduced by £0.4m, reflecting a 12-month low in bank-request fill rates. Underlying non-pay expenditure was broadly in line with M4, pressures persist in theatres, drugs and pathology. - M5 income was lower, consistent with the seasonal profile of elective activity.	- The 2026/27 breakeven plan requires £74m of CIP. Nine executive-led workstreams are in place to address this significant requirement. - The plan assumes scheme development in Q1 and planned early-year deficits; delivery becomes progressively more challenging from M4. A further £39.1m of CIP was devolved to divisions in M4, supported by CEO- and CFO-led meetings to identify additional opportunities. - The 2026/27 contract income envelope has reduced by approximately £40m, reinforcing the need to deliver efficiencies and reduce the cost base. - The Trust has delivered £2.6m of efficiencies in month 5 against a plan of £6.2m, an adverse position of £3.6m, resulting in a YTD variance of £7.5m. The Trust has not managed to fully develop and deliver the additional schemes which were expected to come in from month 4. Executive-led recovery work is in progress. - The September route map sets out upside, most likely and downside scenarios and will inform the financial recovery plan.	 Andrew Strevens Chief Finance Officer
Overview:	I&E position At month 5, the Trust reported a £4.2m deficit against a £0.6m deficit plan, an adverse variance of £3.6m. The YTD deficit was £17.9m against £10.5m planned, an adverse variance of £7.4m. The forecast remains breakeven, contingent on managing in-year pressures and delivering the efficiency programme in full. The Trust's route map, submitted to NHS England on 14 September, sets out three year-end scenarios, delivery of plan (best case), a £29.5m deficit (most likely) and a £49.6m deficit (worst case). The £29.5m most-likely outcome represents the current net unmitigated risk. Executive led recovery and transformation programmes are under way, and the route map is being converted into a financial recovery plan aligned with the draft financial strategy. Capital expenditure Capital spend is £10.0m YTD against a £11.6m plan. The capital programme is being reviewed, including the sale of land and building. This is to manage the programme in light of some slippage and the constrained cash position which may result in the need for rephasing. The Trust is on track to deliver the capital plan and maintain expenditure within the capital expenditure limit. Cash Cash remains very constrained and is reported at the minimum threshold, with a closing balance of £3.1m. NHSE cash support of £10m was awarded in month 5. Efficiencies CIP delivery is below plan in month 5 with £2.6m of £6.2m achieved, a variance of £3.6m. Overall CIP achieved is £14.1 YTD. However, the full-year profile is highly challenging, and sustained executive and divisional focus will be needed to deliver the in-year target		

Finance – Income and Expenditure

Income and expenditure

At month 5, the Trust reported a £4.2m deficit against a £0.6m deficit plan, an adverse variance of £3.6m. The YTD deficit was £17.9m against £10.5m planned, an adverse variance of £7.4m. The month 5 plan included £6.2m of CIP, £0.7m below month 4 but above the M1–M3 average of £2.8m.

- Total income was £1.1m adverse to plan in month. Divisional income was £1.4m below plan due to CIP non delivery, the YTD variance reflected central CIP (£2.7m) and private patient income (£0.8m). Contract income was £0.2m favourable, including £0.3m of Q2 mental health support income redirected to ESHT.
- In month ERF performance was £0.8m below plan for the first time this year, although it remains above plan YTD. Income assumptions will continue to be aligned to contracts and system requirements for deliverable additional activity.
- Pay was £2.1m over budget, primarily due to non delivery against the £4.2m CIP plan. Temporary workforce costs decreased by £0.4m as shift fill rates fell. Escalation and corridor bed pressures continued in Medicine & Urgent Care and Corporate (£0.2m).
- Non pay was £0.4m over budget, primarily due to £0.6m of undelivered central CIP. Other pressures included Minerva (£0.3m) in Urgent Community and Rehabilitation, drugs and Pathology outsourcing (£0.4m), partly offset by £0.5m of Corporate accrual adjustments. Pressure remains on drugs formally classified as High Cost and are currently exploring options to manage.

The forecast outturn is covered by the NHSE route map and a separate paper, with worst case, most likely and best-case scenarios. Breakeven remains the objective and the forecast remains aligned to the plan which is consistent with

the NHSE-mandated approach.

Cost improvement programme

£14.1m of efficiencies had been delivered by month 5 YTD. The full-year CIP target remains highly challenging, divisional stretch targets have been allocated, with residual challenges held centrally.

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Plan	Act	Var	Plan	Act	Var
Income						
Contract income	54,354	54,588	234	274,215	276,567	2,352
Divisional	6,017	4,643	(1,374)	26,483	22,968	(3,516)
Total Income	60,370	59,231	(1,140)	300,699	299,535	(1,164)
Operating Expense						
Pay						
Permanent	(37,960)	(38,195)	(234)	(197,156)	(190,234)	6,921
Temporary	(1,392)	(3,274)	(1,883)	(7,262)	(18,015)	(10,754)
Total pay	(39,352)	(41,469)	(2,117)	(204,417)	(208,250)	(3,832)
Non-Pay						
Drugs	(1,718)	(1,745)	(26)	(8,606)	(9,032)	(426)
TEDD	(3,724)	(3,791)	(67)	(18,618)	(17,768)	850
Clinical supplies	(4,758)	(5,225)	(467)	(24,347)	(25,943)	(1,596)
Purchased services	(1,560)	(1,019)	541	(7,711)	(8,071)	(361)
Finance costs	(3,097)	(3,078)	19	(15,484)	(15,414)	71
Other	(6,760)	(7,141)	(381)	(32,052)	(32,995)	(942)
Total Non-Pay	(21,617)	(21,999)	(382)	(106,818)	(109,222)	(2,404)
Total Expense	(60,969)	(63,468)	(2,499)	(311,236)	(317,472)	(6,236)
Surplus/(Deficit)	(599)	(4,238)	(3,639)	(10,537)	(17,937)	(7,400)

Finance - Capital

Capital Scheme	Funding	Planned End Date	Fcast End Date	Month 5			Year to Date			Full Year		
				Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Fcast £'000	Variance £'000
Backlog	Core			278	311	(34)	1,054	1,455	(401)	3,365	3,365	-
Fire	Core	Jan-25	Mar-25	29	198	(169)	110	311	(201)	350	350	-
Endoscopy	Core	Sep-25	Sep-26	64	32	32	241	681	(439)	770	2,000	(1,230)
Rolling ward refurbishment	Core	Mar-27	Mar-27	234	49	185	889	922	(32)	2,838	2,338	500
Audiology	Core	Mar-26	Sep-26	32	61	(28)	123	251	(128)	392	600	(208)
Cardiology	Core	Mar-26	Oct-27	669	75	594	2,542	530	2,012	8,112	4,312	3,800
A&E Improvements	Core	Mar-27	Mar-28	165	8	157	165	83	82	2,000	2,000	-
CIR Estates Safety Plan				489	21	468	1,857	215	1,642	5,927	5,927	-
Lift Replacement	PDC	Mar-27	Feb-27	36	1	36	139	1	138	442	442	-
Fire Alarm	PDC	Mar-27	Mar-27	106	8	99	404	95	308	1,288	1,288	-
Fire Remedials	PDC	Mar-27	Mar-27	169	9	160	644	42	602	2,054	2,054	-
CCTV Access Control	PDC	Mar-27	Dec-26	133	3	129	504	5	499	1,609	1,609	-
HV Replacement	PDC	Mar-27	Dec-26	44	0	44	167	72	95	534	534	-
Constitutional Standards				-	10	(10)	-	11	(11)	660	660	-
UEC	PDC	Mar-27	Mar-27	-	10	(10)	-	11	(11)	660	660	-
Diagnostic Schemes	PDC	Mar-27	Mar-27	-	-	-	-	-	-	-	-	-
Community Schemes	PDC	Mar-27	Mar-27	-	-	-	-	-	-	-	-	-
Total Estates				1,959	765	1,193	6,982	4,458	2,523	24,414	21,551	2,862
Digital	Core	Mar-27	Mar-27	227	228	(1)	862	962	(101)	2,750	2,750	-
EPR	Core	Mar-27	Mar-27	305	292	14	1,159	1,516	(356)	3,700	3,700	-
Sussex Pathology Network	Core	Mar-27	Mar-27	165	597	(432)	627	1,196	(569)	2,000	2,000	-
Our Care Connected	Strategic	Mar-27	Mar-27	165	167	(2)	627	833	(207)	2,000	2,000	-
Imaging Network	PDC	Mar-27	Mar-26	-	18	(18)	-	445	(445)	-	850	(850)
Total Digital				862	1,301	(439)	3,275	4,953	(1,678)	10,450	11,300	(850)
Medical Equipment	Core	Mar-27	Dec-26	165	19	146	627	264	363	2,000	2,125	(125)
Total Medical Equipment				165	19	146	627	264	363	2,000	2,125	(125)
Clinical Priorities	Core	Mar-27	Mar-27	181	0	181	689	290	400	2,200	1,560	640
Other	Core	Mar-27	Mar-27	16	-	16	63	81	(18)	200	200	-
Total Other				198	0	198	752	371	381	2,400	1,760	640
Total Capital				3,184	2,085	1,098	11,635	10,045	1,590	39,264	36,736	2,527
Slippage	Core			(11)	-	(11)	(44)	-	(44)	(139)	-	(139)
Welkin Sale	Core			-	-	-	-	-	-	-	-	-
Bexhill Land Sale	Core			-	-	-	-	-	-	-	-	-
Total Charge to CRL				3,172	2,085	1,087	11,592	10,045	1,546	39,125	36,736	2,389

Capital overview

- Overall spend YTD is £10.0m vs plan of £11.5m.
- The programme is being reviewed, including the sale of land and building. This is to ensure the investments and asset sales deliver value for money.
- No significant issues have been identified in month regarding specific schemes.
- The Trust is on track to remain within the capital resource limit.

Specific schemes

- *Estate Safety Fund*: Delays in NHSE approvals have delayed MTD and YTD spend, however it is not anticipated any challenges in completing the projects within year.
- *Cardiology*: Revised and updated business case being developed to support future ways forward and reaffirm approval to proceed.
- *Endoscopy*: Experiencing some delays and currently reforecasting the project programme.
- *Constitutional Standards*: Delays in NHSE approvals are delaying funds being made available to commence work. Completion of projects is still expected to conclude within timeframe.
- *Asset sales*: These are being reviewed to ensure they deliver the best value for money as undertaking them too quickly may result in lower proceeds. The proposed timing of any sales will be considered as part of the revised capital plan.

Use of Resources – YTD position

Workstream	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	RAF
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income Growth	716	135	(581)	2,467	875	(1,591)	9,023	3,579	(5,444)	2,769
Surgical & DAS	686	120	(566)	1,925	704	(1,221)	6,755	1,797	(4,958)	1,681
Operational Flow	297	0	(297)	1,114	0	(1,114)	3,191	0	(3,191)	0
Digital	8	8	0	53	53	0	291	91	(200)	90
Workforce	1,099	834	(265)	2,161	2,857	696	9,303	8,830	(473)	7,637
Commissioning	628	360	(268)	1,761	1,812	51	10,208	6,437	(3,772)	5,908
Outpatient Transformation	51	(10)	(61)	55	(77)	(131)	1,494	958	(535)	854
Estates	137	122	(15)	520	445	(76)	1,684	700	(985)	629
Procurement and Pharmacy	399	251	(148)	1,898	1,815	(83)	4,630	3,272	(1,359)	3,058
Divisions & Central	2,215	793	(1,422)	9,614	5,632	(3,982)	27,454	8,708	(18,746)	8,381
Total	6,235	2,612	(3,623)	21,568	14,117	(7,451)	74,032	34,371	(39,661)	31,006

26/27 Efficiency Progress Update

Division	All Identified Schemes with Value		Supported QIAs	Fully Developed* Schemes		Schemes with Value Left To Develop		Ideas To be Developed
	£'000	#		£'000	#	£'000	#	
CHIC & Older People	8,113	16	15	5,113	15	3,000	1	14
Core	6,939	24	23	4,767	23	2,172	1	15
DAS	17,522	57	50	10,620	48	6,901	9	59
Medicine & Urgent Care	16,448	52	47	10,360	47	6,088	5	3
WAC	3,037	20	18	1,637	19	1,400	1	6
SPH	879	10	9	679	9	200	1	2
E&F	2,659	37	35	2,009	35	650	2	5
Corporate	5,993	37	36	5,193	36	800	1	4
Divisional Total	61,587	253	233	40,376	232	21,211	21	108
Centrally Held	12,445	18	3	0	2	12,445	17	3
Total	74,032	271	236	40,376	234	33,656	38	111

* Fully developed = Supported QIA and Financial validation both in place

55%

Efficiency delivery

The Trust has delivered £2.6m of efficiencies in month 5 against a plan of £6.2m, an adverse position of £3.6m, resulting in a YTD variance of £7.5m.

The £7.5m adverse variance is largely due to the high-level assumptions that no longer present an opportunity such as non-elective and emergency care £1.4m, elective and outpatient productivity improvements £2.1m, neighbourhood alliance £0.7m, community estate £0.2m. The remaining £3.1m is due to slippage on the system wide Sussex Surgical Centre (SSC) £0.7m, system wide Sussex Endoscopy Unit (SEU) £0.7m, MARS £0.9m this scheme was phased equally, however we have incurred the costs prior to savings being realised in future months, capture and coding £0.2m, plus a number of smaller schemes across the workstreams and divisions including the legal challenge on outsourced reporting £0.2m.

At the time of writing the value of fully developed schemes is £40.4m (55%), with further schemes in development. There are 101 divisional ideas that are being worked up to close the gap.

The Risk Adjusted Forecast (RAF) has been included in the reporting, this is currently showing £31m against the £74m, but this does not include any assumptions relating to the 103 divisional ideas and only £0.8m of the £20m that has been allocated to Divisions.

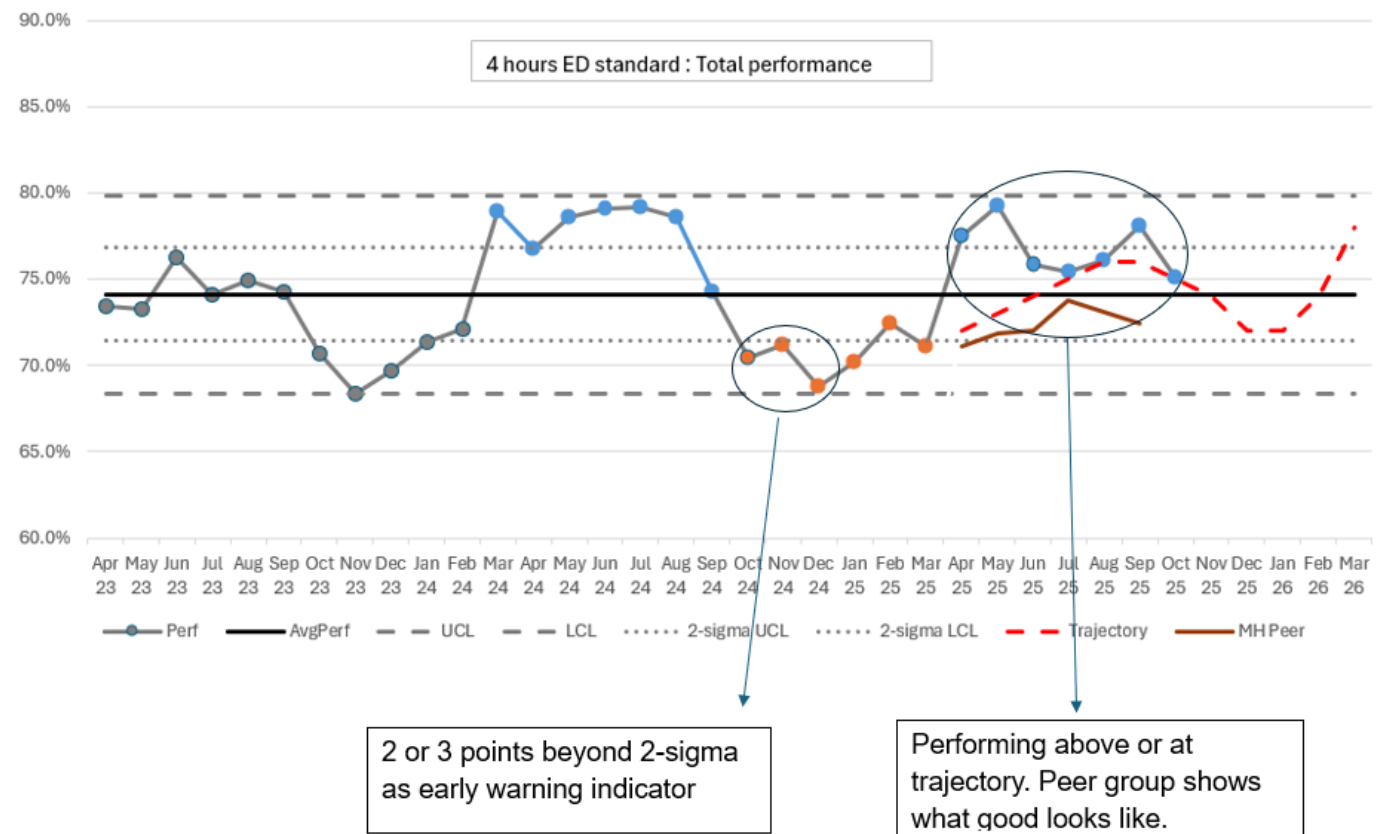
Exec-led sessions were held with the divisions in the week ending the 2nd of October to identify further recovery actions

All the permanent Programme Managers are now in place, one project manager started on 21 September and it is anticipated that other two will start by end of October, the Head of Efficiencies has been appointed with the start date to be confirmed.

IPR graphs

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

What does the chart tell you – illustrative graph



Model Hospital Peer Group

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

Calderdale and Huddersfield NHS Foundation Trust

Croydon Health Services NHS Trust

James Paget University Hospitals NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Rotherham NHS Foundation Trust

Torbay and South Devon NHS Foundation Trust

University Hospitals Plymouth NHS Trust

Warrington and Halton Hospitals NHS Foundation Trust

Wrightington, Wigan and Leigh NHS Foundation Trust

Wye Valley NHS Trust



Report To/Meeting	Trust Board	Date of Meeting	20 October 2026
Report Title:	Q1 Maternity Services Overview Board Report		
Key question	Does the data and insight presented provide sufficient assurance to the Board regarding maternity safety and quality?		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☐ For Discussion ☒		
Report Sponsor:	Vikki Carruth Chief Nurse	Presenter(s):	Hannah Horne Director of Midwifery and Maternity Services
Outcome/Action requested:	The Trust Board is requested to note performance within the Quarter 1 reporting period.		

Executive Summary	Maternity and Neonatal Services have continued to deliver safe and effective care throughout Q1 2026/27 despite ongoing workforce and operational pressures. Performance remains strong across key national quality and safety programmes, with 97% compliance against the Saving Babies' Lives Care Bundle, full compliance with Perinatal Mortality Review Tool (PMRT) requirements, and continued delivery of improvement actions arising from the CQC National Maternity Survey 2025. The Maternity Clinical Bundle (MCB) programme continues to make good progress across all five workstreams, with significant activity focused on updating clinical guidance, strengthening care pathways, embedding digital solutions and developing assurance processes. While many standards are partially implemented, the majority of remaining work relates to evidencing compliance through audit, reporting and policy ratification rather than introducing new clinical processes. Key achievements during the quarter included a stabilised and adjusted stillbirth rate of 2.84 per 1,000 births, positive clinical audit outcomes, closure of several maternity survey actions, strong bereavement and mortality review processes, and continued collaboration with the East Sussex Maternity and Neonatal Voices Partnership (MNVP) Ongoing challenges include workforce shortages, sickness absence, community and acute service pressures, documentation compliance, fetal monitoring compliance (including fresh-eyes, and CTG interpretation), and health inequalities. Community services remain significantly impacted by redeployment activity and staffing gaps, affecting continuity of care and access to out-of-hospital birth options.
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	Learning from incidents, complaints, claims, PMRT reviews and Maternity and Newborn Safety Investigation (MNSI) reports identified recurring themes relating to communication, documentation, escalation, triage, fetal monitoring and continuity of care. Improvement plans are in place to address these areas through audit, training, governance oversight and service redesign. Priority areas for Q2 include workforce sustainability and visibility across the maternity MDT, completion of outstanding diabetes and maternity survey actions, strengthening governance and assurance processes, improving documentation and triage compliance, and continuing work to reduce maternity inequalities and improve service-user experience.
Regulatory/legal requirement:	CQC, NHSE and NHS Resolution
Business Plan Link:	Quality ☒ People ☒ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration
Resource Implication/VFM Statement:	NHSR Maternity Incentive Scheme: An additional 10% CNST maternity premium is paid into the MIS fund. Full compliance enables NHS Trusts to recover this contribution and, where applicable, access further unallocated funding.
Risk:	Failure to provide care that consistently meets or exceeds performance and quality standards
No of Pages	8 Appendixes
Governance and Engagement pathway to date:	All supporting assurance reports have been presented to and scrutinised through the Women and Children's Quality and Safety Forum (QSF), with key themes, risks, learning and areas of assurance informing this overarching report
What happens next?	Present and monitor progress at Trust Board
Publication	This report can be published



Q1 2026/27 Maternity Services Overview Report

Introduction/Background

Quarter 1 (April to June 2026) has seen continued delivery of safe maternity and neonatal services across East Sussex Healthcare NHS Trust, despite significant workforce, operational and system pressures. The service has maintained compliance with key national requirements including the Saving Babies' Lives Care Bundle, Maternity Incentive Scheme, Perinatal Mortality Review Tool (PMRT) standards and ongoing implementation of actions arising from the CQC National Maternity Survey.

The quarter has been characterised by strong safety performance, substantial quality improvement activity, robust governance oversight and continued collaboration with the East Sussex Maternity and Neonatal Voices Partnership (MNVP). However, workforce shortages, increasing complexity within the maternity population, community service pressures and ongoing infrastructure challenges continue to affect service delivery.

Performance remains positive in a number of areas, including a 97% compliance rate with the Saving Babies' Lives Care Bundle, full compliance with PMRT reporting standards, strong training compliance, positive outcomes from clinical effectiveness audits and closure of several maternity CQC survey improvement actions.

Issues

Workforce Pressures and Service Sustainability

Community services continue to experience significant workforce pressures. Although community redeployment reduced by 20% compared to the previous quarter, 512 hours of community staffing were redeployed to support acute services during Q1. The service remains 4.22 WTE below funded establishment and approximately 15.6 WTE below recommended staffing levels identified through workforce review. Sickness absence remains high, reaching 10.8% in May. Staff continue to report fatigue, burnout and reduced morale.

Community Service Disruption

Frequent suspension of out-of-hospital birth services occurred due to staffing and acuity pressures. Ten women who planned home or midwifery-led unit births were required to give birth in the obstetric unit. Whilst no significant safety concerns arose, this reduced women's choice of birthplace and impacted personalised care.

Clinical Documentation and Governance

Multiple reports identified recurring concerns regarding documentation quality, including:

- CTG reviews and fresh eyes documentation.
- Maternity handovers.
- Transfer documentation.
- Postnatal blood glucose monitoring records.
- LMWH administration records.
- Student midwife countersigning.
- General clinical record keeping.

The MNSI Investigation identified documentation as a significant contributory learning theme and highlighted digital system limitations affecting clinical recording and retrieval of information.

Fetal Surveillance and Triage

Areas requiring improvement continue to include:

- BSOTS 15-minute triage compliance (74%).
- Uterine artery Doppler compliance (55%).
- Reduced fetal movement surveillance pathways.
- Fresh-eye CTG review compliance.
- Consistency of escalation processes.

These themes also feature within incidents, complaints, PMRT reviews and MNSI recommendations.

Diabetes Services

The only outstanding area within the Saving Babies' Lives programme relates to Element 6: Pre-existing Diabetes. There remains no dedicated diabetes-only multidisciplinary clinic and ongoing concerns persist regarding dietetic provision, diabetic ketoacidosis guideline review and documentation of postnatal blood glucose monitoring. These issues remain reflected on the Trust risk register.

Health Inequalities

The maternity population continues to demonstrate high levels of vulnerability:

- 52.1% report mental health concerns.
- 48.3% live within the most deprived national quintiles.
- 15.3% report domestic abuse histories.
- 13.6% report substance misuse histories.

Booking before 10 weeks remains below target at 64%, with particularly poor performance among some ethnic minority and deprived populations.

Governance and Regulatory Assurance

The CQC Self-Assessment identified ongoing challenges relating to:

- Governance clarity.
- Communication of learning.
- Safety intelligence pathways.
- Demonstration of assurance.
- Governance infrastructure and reporting processes.

Whilst improvement activity is evident, greater assurance and visibility of outcomes is required.

Consequences for Not Taking Action

Failure to address identified issues may result in:

- Reduced resilience across maternity and community services due to ongoing workforce shortages and sickness absence.
 - Increased risk of delayed assessment, escalation and intervention for women and babies through continued variation in documentation, triage and fetal monitoring practices.
 - Reduced compliance with national safety standards, including Ockenden, Saving Babies' Lives and Maternity Incentive Scheme requirements.
 - Deterioration in patient experience through loss of continuity, service suspensions and delayed improvement actions.
 - Worsening health inequalities and delayed access to maternity care for vulnerable populations.
 - Reduced organisational readiness for future external review, including potential Care Quality Commission inspections and national assurance processes.
 - Missed opportunities to learn from incidents, complaints, PMRT reviews and MNSI investigations.
-

Conclusion

During Q1 2026/27, maternity services have continued to demonstrate strong performance against national safety and quality standards despite considerable operational challenges. Significant achievements include high compliance with the Saving Babies' Lives programme, full PMRT compliance, positive clinical audit outcomes, strong bereavement review processes and continued delivery of coproduced improvement work.

Learning from audits, incidents, complaints, PMRT reviews, MNSI investigations and service-user feedback demonstrates recurring themes around communication, documentation, escalation, workforce resilience and equity of care. These themes are well understood within existing work programmes and improvement plans are in place.

Overall, the service can provide assurance that maternity and neonatal care remains safe, responsive and improvement focused, whilst recognising the need for continued action to address workforce pressures, governance maturity, inequalities and service sustainability.

Recommendations

1. **Continue workforce recruitment and retention initiatives** to reduce vacancy rates, minimise redeployment and improve community service resilience.
2. **Complete outstanding Saving Babies' Lives Element 6 actions**, including implementation of a dedicated pre-existing diabetes clinic and review of diabetes pathways.
3. **Strengthen documentation standards and compliance monitoring**, focusing on CTG reviews, handovers, medication administration records and student documentation processes.
4. **Improve triage, fetal monitoring and escalation compliance**, particularly BSOTS standards, fresh-eye reviews and reduced fetal movement pathways.
5. **Complete delivery of outstanding CQC maternity survey actions**, particularly those relating to postnatal care, communication and continuity.
6. **Strengthen governance and safety intelligence arrangements**, ensuring clear routes for learning, assurance and escalation from frontline services to Trust Board
7. **Continue targeted work to address maternity inequalities**, including improving early booking rates and engagement with vulnerable and underserved populations.
8. **Embed learning from PMRT, MNSI investigations, incidents and complaints**, ensuring actions are monitored through existing governance structures and evidenced through audit and assurance reporting.
9. **Support ongoing co-production with the MNVP**, ensuring service-user voice remains central to maternity improvement activity.
10. **Maintain focus on regulatory readiness and CQC assurance**, using the new self-assessment framework to demonstrate continuous improvement and evidence of impact

Overview Report: Maternity Clinical Bundle (MCB) Implementation Progress

Introduction / Background

The Maternity Clinical Bundle (MCB) programme is progressing across all five workstreams, with significant activity underway to establish compliance with national standards relating to venous thromboembolism (VTE), maternal deterioration, epilepsy in pregnancy, perinatal mental health and obstetric haemorrhage. Evidence collection, policy development, pathway review, digital system enhancements and audit methodology development continue across the programme. Current emphasis is focused on embedding sustainable processes, strengthening governance arrangements and ensuring reliable reporting mechanisms are in place to demonstrate compliance against MCB measures.

Issues

1. Venous Thromboembolism (VTE)

Good progress has been made in developing the revised VTE guideline, which is currently in final draft and progressing towards ratification. Early pregnancy VTE assessment pathways are largely established; however, several elements remain dependent on publication of regional network guidance and integration within wider clinical systems. Reliable identification and reporting of women requiring LMWH prior to booking remains challenging, with current BadgerNet reporting methodology requiring further refinement and validation.

2. Maternal Early Warning Scores (MEWS) and Maternal Deterioration

MEWS is fully embedded within maternity services and supported through PROMPT training. However, implementation across acute non-maternity settings remains dependent on the wider Trust EmPowerR/NerveCentre deployment programme, which has experienced delays. Associated SOPs, escalation guidance and audit arrangements are therefore still in development. Work continues to strengthen referral pathways into the Maternal Medicine Network (MMN), including incorporation into local clinical guidance.

3. Epilepsy in Pregnancy

Development of a specialist epilepsy in pregnancy service is progressing, with neurology and maternity teams working collaboratively to establish an appropriate clinic model. Referral pathways are established, and EPISAFE interventions have commenced. The principal outstanding issues relate to publication of the updated epilepsy guideline, confirmation of multidisciplinary teaching attendance, and demonstrating compliance with review timeframes for self-referring women.

4. Perinatal Mental Health

Perinatal mental health measures represent one of the largest remaining programmes of work. Whooley and EPDS screening processes are not yet live within BadgerNet, and implementation is dependent upon completion of digital builds, protocol development, staff training and agreed escalation pathways. Significant planning work has been completed, and collaboration with other BadgerNet organisations is helping establish a standardised approach; however, evidence against most indicators is not yet available.

5. Obstetric Haemorrhage

Strong foundations are already in place through existing OBS UK work, clinical guidance and audit activity. The main focus now is establishing ongoing quarterly audit processes that align with MCB technical definitions and demonstrate compliance with blood loss measurement, escalation and multidisciplinary review requirements. Additional evidence is required regarding implementation of emergency equipment, Clauss fibrinogen turnaround standards and point-of-care coagulation testing protocols.

Consequences of Not Taking Action

Failure to complete the outstanding actions could result in an inability to demonstrate compliance with national MCB requirements and limit assurance regarding the effectiveness of clinical pathways designed to reduce maternal morbidity and mortality. Delays in guideline ratification, implementation of digital functionality and establishment of audit reporting mechanisms may reduce the organisation's ability to provide evidence of improvement and monitor outcomes effectively. In particular, the absence of robust reporting arrangements for VTE, mental health screening, maternal deterioration and obstetric haemorrhage indicators presents an ongoing risk to assurance and performance management.

Conclusion

Overall progress across the MCB programme is positive, with substantial work completed to establish governance arrangements, update clinical guidance and strengthen maternity safety processes. Two standards have already been evidenced as achieved, while many further measures are partially implemented and progressing through established action plans. The greatest areas of focus for the coming months are completion of guideline ratification, implementation of digital solutions within BadgerNet, progression of MEWS into non-maternity settings, development of mental health pathways and establishment of sustainable audit and reporting processes.

Recommendations

1. Continue prioritisation of outstanding guideline ratification and publication, particularly for VTE, maternal deterioration, epilepsy and mental health pathways.
2. Accelerate development of audit methodologies and reporting processes, focusing on VTE identification, obstetric haemorrhage measures and future Whooley/EPDS reporting requirements.
3. Maintain engagement with digital and clinical informatics teams to support implementation of BadgerNet developments and wider EPR integration.
4. Progress implementation of MEWS within non-maternity settings as wider Trust digital infrastructure becomes available.
5. Complete the remaining evidence-gathering activity, including MMN arrangements, epilepsy training records, laboratory service agreements and haemorrhage implementation evidence, to support future assurance and MCB compliance reviews.



Report To/Meeting	Trust Board	Date of Meeting	20 October 2026
Report Title:	NHS England Maternity and Neonatal 10 Point Plan: Baseline Assessment		
Key question	Can the Trust Board be assured that East Sussex Healthcare NHS Trust has appropriate governance, oversight and improvement plans in place to deliver the requirements of the NHS England Maternity and Neonatal 10 Point Plan?		
Decision Action:	For approval ☒ For Assurance ☒ For Information ☐ For Discussion ☐		
Report Sponsor:	Vikki Carruth Chief Nurse	Presenter(s):	Hannah Horne Director of Midwifery and Maternity Services
Outcome/Action requested:	The Trust Board is requested to note, endorse and support the improvement actions outlined within this report and take assurance that appropriate governance arrangements are in place to oversee delivery of the NHS England Maternity and Neonatal 10 Point Plan.		
Executive Summary	East Sussex Healthcare NHS Trust has completed a baseline assessment against the NHS England Maternity and Neonatal 10 Point Plan to provide assurance on the quality, safety and governance of maternity and neonatal services. The assessment identified strong compliance across a number of key areas, including workforce standards, maternity and neonatal governance, the homebirth safety review, maternity triage, and post-death care arrangements. Established governance processes provide regular oversight of clinical outcomes, patient experience, workforce metrics and service performance. Several areas requiring further development were identified, including implementation of Martha's Rule in maternity services, strengthening Board oversight of health inequalities, formalising executive accountability arrangements, continued delivery of the Maternal Care Bundle, and further embedding learning from incidents, complaints and strengthening patient feedback through PSIRF governance processes. Overall, the assessment provides assurance that the Trust has robust foundations in place and is compliant with the majority of the requirements of the NHS England 10-Point Plan. Action plans have been developed for the remaining areas, with executive oversight to support delivery and ongoing monitoring through existing governance structures.		

	The Trust Board is asked to note the findings of the assessment, support the identified improvement actions, and take assurance that maternity and neonatal services are making good progress towards full compliance with the national programme.		
Regulatory/legal requirement:	NHSE, Maternity Incentive Scheme (MIS), CQC and NHS Resolution		
Business Plan Link:	Quality ☒	People ☒	Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	NHSR Maternity Incentive Scheme: An additional 10% CNST maternity premium is paid into the MIS fund. Full compliance enables NHS Trusts to recover this contribution and, where applicable, access further unallocated funding.		
Risk:	Failure to provide care that consistently meets or exceeds performance and quality standards		
No of Pages	5	Appendixes	None
Governance and Engagement pathway to date:	The 10 point plan has been reviewed by the Chairman and Chief Executive		
What happens next?	Present and monitor progress at Trust Board		
Publication	This report can be published		

NHS England Maternity and Neonatal 10-Point Plan Baseline Assessment

Introduction / Background

Following publication of the NHS England 10-Point Plan in response to Baroness Amos' Independent Investigation into Maternity and Neonatal Services, all Trust Boards are required to provide assurance regarding compliance with the actions set out within the national programme. The Trust has completed a baseline assessment against the required standards to establish its current position, identify gaps in assurance and agree improvement actions to support full compliance.

The assessment demonstrates that ESHT has strong governance arrangements in place across maternity and neonatal services, with significant areas of compliance already achieved through existing Maternity Incentive Scheme (MIS), Ockenden and Quality & Safety governance processes. Areas requiring further development have been identified and are supported by improvement plans and executive oversight.

Issues

The baseline assessment identified several areas where compliance is not yet fully achieved and where further service and Trust Board assurance is required.

Key Areas of Strength

The Trust demonstrated full compliance in a number of significant domains including:

- Comprehensive monthly review of maternity and neonatal outcomes, patient experience, workforce and quality metrics through established governance structures.
- Strong workforce assurance with compliance against national maternity and neonatal staffing standards, including consultant presence, Birthrate Plus workforce requirements, neonatal medical standards and anaesthetic cover.
- Completion of the Homebirth Service Safety Review, with findings reviewed through Trust governance processes and action plans established.
- Completion of maternity triage benchmarking and implementation of continuous quality improvement processes.
- Compliance with national post-death care and mortuary assurance requirements.

Areas Requiring Further Development

Despite substantial progress, several areas remain partially compliant or non-compliant:

1. Martha's Rule

The Trust has commenced preparatory work; however, implementation remains at an early stage with local policies and operating procedures currently under development

2. Health Inequalities

The assessment identified limited Board-level oversight of maternity inequalities. Whilst ethnicity and deprivation data are available within existing reports, a consolidated inequalities dashboard is not currently presented routinely to the Trust Board. This resulted

in a non-compliant assessment against the requirement for six-monthly review of inequalities data and actions.

3. Board-Level Accountability

Whilst the Chief Nurse and Chief Medical Officer provide executive oversight of maternity and neonatal services, formal evidence demonstrating joint Board accountability arrangements requires further strengthening through revised governance documentation and Board Terms of Reference.

4. Maternal Care Bundle

Initial planning has commenced; however, a detailed implementation plan requires further development before Board approval can be secured in line with national expectations.

5. Learning, Complaints and PSIRF

The Trust has established PSIRF governance arrangements; however, further work is required to demonstrate clear triangulation of learning from incidents, complaints, concerns and patient feedback, together with evidence that learning outcomes and Duty of Candour processes are fully embedded across maternity and neonatal services.

6. Workforce Deployment Review

Existing escalation and redeployment processes provide assurance regarding workforce management. However, further review is required to ensure full alignment with the expectations set within the 10-Point Plan, particularly regarding specialist midwifery roles and workforce resilience.

Consequences of Not Taking Action

Failure to address the identified gaps would present several risks to the organisation:

- Reduced assurance that maternity and neonatal services are meeting the requirements of the national 10-Point Plan.
- Inability to demonstrate effective Board oversight of health inequalities and equity in outcomes for women, babies and families.
- Potential regulatory challenge regarding governance, accountability and learning systems across maternity and neonatal services.
- Reduced confidence that service improvements arising from incidents, complaints and patient feedback are consistently embedded and monitored for impact.
- Risk of delayed compliance with emerging national programmes including Martha's Rule, the Maternal Care Bundle and the Perinatal Equity and Anti-Discrimination Programme.

Conclusion

The baseline assessment demonstrates that ESHT has established robust governance, workforce and quality assurance arrangements across maternity and neonatal services, with compliance achieved in the majority of assessed areas. The Trust has strong foundations through existing maternity governance processes, Board reporting arrangements and national programme delivery.

The assessment has also highlighted a number of areas requiring further development, principally relating to inequalities reporting, formalisation of executive accountability, implementation of Martha's Rule, strengthening PSIRF assurance and delivery of national improvement programmes. Improvement actions have been identified and executive leads assigned to support progress towards full compliance.

The Trust Board can therefore take reasonable assurance that significant progress has been made towards delivery of the NHS England 10-Point Plan, whilst recognising that a number of key actions require continued oversight and monitoring through existing governance structures.

Recommendations

The Trust Board is requested to:

- Note the findings of the baseline assessment against the NHS England Maternity and Neonatal 10-Point Plan.
- Recognise the strong level of compliance achieved across maternity workforce, governance, homebirth review, triage and post-death care requirements.
- Support development of a consolidated maternity inequalities dashboard and routine Board reporting to strengthen oversight of health inequalities and equity outcomes.
- Approve continued executive oversight of actions relating to Martha's Rule implementation, Maternal Care Bundle delivery and formalisation of joint executive accountability arrangements.
- Request regular progress updates through the Quality & Safety Committee and Trust Board to monitor delivery of identified improvement actions and progression towards full compliance.
- Approve submission of the baseline assessment to NHS England as evidence of Board assurance and organisational commitment to delivery of the national 10-Point Plan



Report To/Meeting	Trust Board	Date of Meeting	20 th October 2026
Report Title:	Q2 BAF and corporate risk register update		
Key question	Review and note the Q2 position of the BAF risks and associated corporate risks. Furthermore, consider whether the collective response is proportionate to the Trust's total strategic exposure, including secondary impacts and system dependencies.		
Decision Action:	For approval ☒ For Assurance ☐ For Information ☐ For Discussion ☒		
Report Sponsor:	Richard Milner, Chief of Staff	Presenter(s):	Richard Milner, Chief of Staff
Outcome/Action requested:	The Board is asked to consider, discuss and note the report and endorse the proposed strengthening of cross-risk, outcome and system-level assurance.		
Executive Summary	• Primary risk management is broadly robust, with named ownership, oversight, controls and action plans; however, evidence of sustained reduction in exposure is not consistently outcome led. • Most risks are interconnected. For example, BAF 2, 4, 8 and 9 create significant secondary impacts across quality, workforce, finance, performance and reputation. • While primary risks are largely well addressed, this interrelationship means that our collective exposure is greater than the sum of the individual risks because several mitigations rely on the same constrained capital, specialist capacity, leadership attention, analytics and partner action. • This reports suggests considering and managing the BAF risks as three connected clusters that require collective oversight: workforce, culture and delivery; infrastructure, digital and intelligence; and flow, access and quality. • Given the scale and interconnected nature of exposure more work is required to strengthen our exposure across the three areas. BAF 4, 8 and 9 require additional action; BAF 2 and 3 require targeted strengthening. • As regards the corporate risk movement, this is predominantly towards de-escalation, but more robust reporting should better evidence the control improvements supporting score reductions and changes in governance route		
Regulatory/legal requirement:	The Trust Board is required to maintain a Board Assurance Framework as a key source of evidence supporting the Annual Governance Statement.		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	No separate resource request is made. The report highlights reliance on leadership bandwidth, programme and analytical capacity, workforce, capital, revenue and system-partner action.		
Risk:	Failure to consider risks collectively may understate cumulative exposure, shared dependencies and risk transfer, and may result in an		

	organisational or system response that is not proportionate to total exposure.		
No of Pages	14 (full BAF not included)	Appendixes	3
Governance and Engagement pathway to date:	Each BAF risk has been reviewed through executive ownership and Board sub-committee oversight. The Q2 review brings together primary controls, assurance, actions, secondary impacts, collective dependencies and movement in associated corporate risks.		
What happens next?	Comments from the Board will inform the next BAF update. Future reporting will strengthen quantified triggers, evidence of outcomes, aggregate delivery-capacity assessment, system dependencies and escalation routes.		
Publication	This front sheet and the Q2 BAF are appropriate for publication		

Report overview & purpose

- The purpose of this report is, as standard, to share the quarterly progress of the eleven Board Assurance Framework risks and associated risks from the corporate risk register.
- Additionally, the report seeks to deepen the Board's understanding of strategic exposure by testing both the robustness of primary risk management and whether collective actions are proportionate to secondary and cumulative impacts.
- This revised report reflects the full Q2 2026/27 BAF. It replaces the earlier analysis based on nine risks and incorporates BAF 10, service reshaping and commissioning alignment, and BAF 11, patient feedback and reputation.

1. Executive summary

- 1.1 Our review of the Q2 BAF suggests a coherent primary risk-management architecture, with named ownership, oversight, controls, action plans and assurance. The strongest entries connect causes to delivery actions and oversight. Some entries describe governance and activity more clearly than measurable risk reduction. Primary management is therefore broadly robust but not consistently outcome led.
- 1.2 The Q2 BAF comprises eleven strategic risks. The highest current scores are BAF 1, staff support and engagement; BAF 2, financial sustainability; and BAF 3, estate and infrastructure, each scored 20. BAF 7, flow, and BAF 8, emergency access, remain scored 16 and continue to create significant secondary exposure across quality, workforce and performance.
- 1.3 Most risks are not isolated. Staff pressure can weaken delivery; constrained finance can delay infrastructure and transformation; poor flow increases harm, cost and workforce pressure; and deteriorating quality or access can weaken patient, public and regulatory confidence.
- 1.4 While individual action plans are broadly credible, collective exposure is greater than the sum of the eleven BAF risks. Several mitigations rely on the same scarce capital, specialist capacity, leadership attention, analytics and partner action. The Board needs assurance that the portfolio is deliverable in aggregate and that action in one area does not transfer risk elsewhere.
- 1.5 BAF 9, 10 and 11 create an additional strategic chain. The Trust must shape the care landscape with partners, reshape services in line with commissioning intent, and retain patient and public confidence. These risks influence whether transformation is aligned, legitimate and deliverable.
- 1.6 Overall, the collective response is only partly sufficient. The greatest gaps relate to structural estate constraints, financial delivery, system-dependent flow and access, and evidence that transformation and patient feedback are shaping strategic decisions. The associated improvements should be incorporated into the Q3 report.

2. Our approach and 'collective sufficiency'

- 2.1 The review uses the information available in the Q2 paper and considers risk descriptions, current assessments, controls, assurance, gaps, actions and forward look.
- 2.2 Primary management was tested for clarity of cause and consequence; controls addressing causes; actions with ownership, milestones and intended effect; and assurance demonstrating outcomes rather than activity alone.
- 2.3 The consideration of secondary impact includes consequences beyond the primary domain. Collective sufficiency considers shared dependencies, capacity, risk transfer and mitigations requiring system partners.
- 2.4 A risk may have credible controls but still be assessed as only partly or conditionally sufficient where the wider exposure remains significant or material mitigation sits outside the Trust's direct control. The Board question is: given the total exposure created by this risk, is the overall organisational and system response proportionate?

Figure 1: Sufficiency assessment

BAF risk no. & primary area	Secondary impacts	Primary management	Collective sufficiency assessment	Trigger / further action test	Q2
1 Staff support & engagement	Quality, productivity, retention, finance, reputation	Credible controls; outcomes slow-moving	Partly sufficient	Sickness, staff survey, FTSU, violence, retention	20
2 Financial sustainability	Quality, workforce, access, transformation, autonomy	Strong grip; delivery gap material	Conditionally sufficient	Run rate, recurring savings, cash, quality safeguards	20
3 Estate & infrastructure	Safety, continuity, workforce, productivity, reputation	Prioritisation credible; cause structural	Not fully sufficient	Critical failures, backlog, compliance, disruption	20
4 Cyber resilience	Safety, continuity, finance, workforce, reputation	Technical controls broadly credible	Proportionate	CAF gaps, legacy assets, incidents, slippage	16
5 Business intelligence	Decision quality, finance, performance, workload	Direction credible; outputs decisive	Conditionally sufficient	Reporting delay, manual work, data quality, recruitment	16
6 Digital transformation	Quality, productivity, workforce, finance, experience	Programme credible; adoption decisive	Proportionate	Milestones, adoption, capacity, benefits, cost	12
7 Flow / extended stay	Harm, deconditioning, staff pressure, cost, access	Strong consequence management; system causes	Not fully sufficient	Discharge-ready patients, long stays, boarding, partner delay	16
8 Emergency access	Harm, workforce, finance, regulation, reputation	Controls credible; dependent on flow	Not fully sufficient	ED waits, handovers, crowding, staffing, harms	16
9 Shape care landscape	Transformation pace, influence, partnership, delivery	Relationships and forums credible	Proportionate	Partner alignment, joint milestones, dependencies	8
10 Fit for commissioning	Strategy, finance, quality, capacity, confidence	Governance emerging; choices need clarity	Partly sufficient	Commissioning change, governance, benefits, resources	16
11 Patient feedback & reputation	Confidence, workforce, scrutiny, legitimacy	Routes credible; triangulation decisive	Conditionally sufficient	Complaints, FFT, surveys, themes, response, learning	8

3. Collective implications

- 3.1 The eleven risks group into four interconnected clusters. The clusters do not replace individual ownership or committee oversight; they provide an additional Board-level view of aggregate deliverability, common dependencies and cumulative consequences.

Figure 2: Cumulative exposure is concentrated across four clusters

1. Workforce, culture & delivery BAF 1-2	2. Infrastructure, digital & intelligence BAF 3-6	3. Flow, access & quality BAF 7-8	4. System transformation & confidence BAF 9-11
Recovery can increase workload and uncertainty; weaker engagement can reduce productivity and change capacity.	Plans compete for the same capital, specialist capability and leadership attention. Aggregate sequencing is decisive.	Discharge constraint drives occupancy, boarding and ED delay. Current actions manage consequences more than system capacity & root causes.	Partner influence, commissioning alignment and patient confidence determine whether service reshaping is legitimate and deliverable.
STRENGTHEN	MIXED	ENHANCE NOW	DEVELOP

- 3.2 BAF 1 and 2 form a workforce-culture-delivery loop. Financial recovery depends upon engaged staff and sufficient capacity; pressure, uncertainty and change fatigue may in turn weaken productivity and delivery. Finance, workforce, quality and patient experience should be triangulated around each major recovery programme.

- 3.3 BAF 3 to 6 share capital, technical and analytical capability, programme capacity and leadership attention. Individually credible plans may collectively be undeliverable. Assurance should show sequencing, critical paths, capacity constraints and consequences of delay.
- 3.4 BAF 7 and 8 form a flow-access-quality chain. Discharge constraint increases occupancy and extended stay, which drives boarding, crowding and delay, with consequences for harm, staff welfare, cost, elective delivery, experience and reputation.
- 3.5 BAF 9 to 11 form a system-transformation-confidence chain. The ability to shape the care landscape and reshape services depends upon commissioner and partner alignment. Patient experience and stakeholder confidence provide evidence of whether change remains credible and legitimate.
- 3.6 Reputation is both a discrete risk and a cumulative consequence. BAF 11 should therefore be managed through its own controls while also operating as a cross-cutting assurance lens across quality, access, estate reliability, digital resilience, workforce experience, financial grip and transformation.
- 3.7 System dependencies include social care and community capacity, mental health provision, commissioning choices, shared pathways, neighbourhood models, system finance and joint transformation. These should be explicit within controls, actions, milestones and escalation routes.

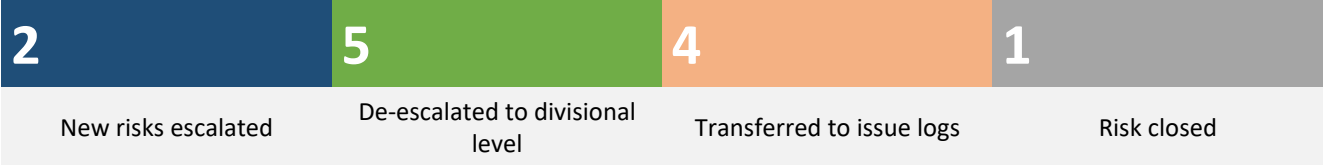
4. Sufficiency of collective actions

- 4.1 The actions are mostly appropriate but not wholly sufficient for the scale and interconnected nature of exposure. The concern is not absence of activity, but shared constraints, external dependencies and outcome evidence that remains organised risk by risk.
- 4.2 BAF 4, 6 and 9 can remain under trigger-based monitoring while milestones and assurance remain credible. No major additional programme is indicated at this stage.
- 4.3 BAF 1, 2, 5, 10 and 11 require targeted strengthening. Reporting should connect financial recovery to workforce and quality safeguards; BI to timely decision support; service reshaping to commissioning choices and benefits; and patient feedback to demonstrable learning and strategic decisions.
- 4.4 BAF 3 requires continuing Board scrutiny of critical infrastructure red lines, failure contingencies, service continuity options, investment priorities and escalation to system, regional and national partners.
- 4.5 BAF 7 and 8 require the strongest system response. Named partner commitments, capacity and pathway trajectories, joint measures, decision rights and escalation should demonstrate how root causes, not only consequences, will be addressed.
- 4.6 The Board should test aggregate delivery capacity across leadership bandwidth, programme & analytical capability, workforce, capital/revenue, and whether action on one risk transfers exposure elsewhere.

5. Performance of Corporate Risks Linked to Board Sub-Ctees

- 5.1 The BAF and Corporate Risk Register continue to be overseen through the Trust's Board sub-committee structure. The September review records movement through de-escalation, transfer to divisional management or issue logs, closure and escalation of new risks. The governance decisions are visible; evidence demonstrating improved control effectiveness and criteria for future re-escalation are less consistently articulated.

Figure 3: Summary of risk management activity



Finance and Performance Committee

- The committee oversees eleven corporate risks. Four risks were removed from corporate oversight and one was closed; new risks concern cancer pharmacy and aseptic staffing resilience and the ageing Laboratory Information Management System. Material exposure remains in estates, digital resilience, cash and statutory compliance.

People and Organisational Development Committee

- The committee oversees four corporate risks. Five risks were transferred to issue logs or reduced below the corporate threshold.

Quality and Safety Committee

- The committee oversees seven corporate risks. Two risks reduced in score and were proposed for removal or transferred to divisional management.

Audit Committee

- The committee continues to oversee one corporate risk concerning fraud, bribery and dishonest conduct. No material movement was recorded.

- 5.2 The overall direction is one of de-escalation rather than increasing corporate exposure. This is positive only if reductions reflect genuine control improvement rather than governance reclassification. Q3 reporting should articulate the evidence supporting reductions, residual exposure, why divisional or issue-log management is sufficient, and the trigger for re-escalation.

6. Recommendations

6.1 The Board is asked to:

- Note that the Q2 BAF comprises eleven strategic risks and that primary management is broadly robust, while evidence of sustained impact remains uneven
- Endorse four collective assurance clusters: workforce, culture and delivery; infrastructure, digital and intelligence; flow, access and quality; and system transformation and confidence
- Endorse collective sufficiency judgments in Figure 1, with strongest Board & system focus on BAF 3, 7 & 8
- Require targeted strengthening of BAF 1, 2, 5, 10 and 11, including clearer outcome measures, trigger thresholds and cross-risk safeguards
- Require BAF 11 to operate both as a discrete risk and as a cross-cutting assurance lens across the portfolio.
- Require system-level causes, dependencies, partner commitments, milestones, decision rights and escalation routes to be explicit in future BAF reporting
- Ask committees and risk owners to demonstrate aggregate delivery capacity and that corporate risk score changes reflect improved control effectiveness rather than governance reclassification

Q2 Board Assurance Framework

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



KINDNESS



INCLUSIVITY



INTEGRITY



Audit Committee, September 2026

2026/7 BAF: Q2 summary position

BA F Ref	Risk Summary	Monitoring Committee	Inherent Risk	2026/27 Quarterly Position				Change	Risk Tolerance	Risk Appetite
				Q1	Q2	Q3	Q4			
1	Insufficient support and engagement impacts staff sickness, patient experience and recruitment and retention	PO D	20	20	20			◄ ►	No higher than 16	Cautious
2	Failure to deliver sustainable financial position impacts patient care, increases the likelihood of regulatory intervention and reduces the ability to deliver strategic goals	F&P	20	20	20			◄ ►	No higher than 16	Seek
3	Insufficient capital to maintain ageing critical estate and infrastructure risks operational inefficiency, disruption, statutory compliance and patient care	F&P	20	20	20			◄ ►	No higher than 16	Seek
4	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack	F&P	20	16	16			◄ ►	No higher than 16	Minimal
5	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
6	Failure to transform digitally and deliver associated improvements to patient care	F&P	16	12	12			◄ ►	No higher than 16	Seek
7	Absence of flow impacts delivery of safe, high-quality care	Q&S	20	16	16			◄ ►	No higher than 16	Cautious
8	Failure to deliver the Emergency Access Standard impacts the provision of safe, high-quality care	F&P	20	16	16			◄ ►	No higher than 16	Cautious
9	Failure to shape the care landscape with peers and patients slows pace of transformation/innovation	Ex- Comm	12	8	8			◄ ►	No higher than 12	Open
10	Failure to reshape services as ‘fit for commissioning purpose’ stifles organisational ambition	Ex- Comm	16	12	16			▲	No higher than 16	Cautious
11	Weakening patient feedback damages wider reputation	Q&S	16	8	8			◄ ►	No higher than 16	Cautious

1. Risk Summary							
Reference & title	BAF 1: Insufficient support and engagement impacts staff sickness, patient experience and recruitment and retention			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.			Integrated	Patient Centred	Sustainable	
						✓	
Lead executive	Director of People	Lead Committee	People and Organisational Development		Date last reviewed	04/09/2026	
Risk(s) rated 15 and over aligned	248 - Staff engagement 274 - Delivery and Loading activities 347 - Kipling/SSPAU environment 381 - Violence and Aggression Trust wide						
2. Risk Scoring							
Inherent risk <i>If there were no mitigations</i>		Current risk level <i>Assessment based on evidence</i>				Rationale for current risk level <i>Evidence that provides assurance of current risk level</i>	Risk tolerance <i>Acceptable range/boundaries of risk score</i>
		Q1	Q2	Q3	Q4	The outcomes of the annual staff survey demonstrate that there has been a decline in staff engagement scores compared with 2025 and that the organisation's score is significantly worse than sector average. Morale score has not decreased in year and is not a sector outlier. The survey denotes that there has been a decline in the sub-score of work pressure.	No higher than 16
Likelihood	5	5			Risk appetite <i>Amount/type of risk accepted/taken</i>		
Impact	4	4					Cautious
Risk level	20	20					
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 risk will remain unchanged. Whilst our broad workforce relating to recruitment and retention, and quality and safety metrics, remain good, more sensitive indicators relating to sickness and freedom to speak up themes continue to demonstrate pressure highlighting high workload pressures and anxiety related sickness. A new barometer has been developed to identify monthly changes in staff morale as most workforce metrics measuring this are on a quarterly or yearly basis. Divisional leadership teams, supported by leadership and OD are developing communication strategy for upcoming staff survey which runs from 21 st September through to 18 th November. People CQI measures have all been agreed with divisions; outcomes will be monitored through newly designed performance review meetings. Organisationally, learning and OD team continue to conduct Trustwide staff focus groups supported by staff partnership forum and network leads. Thematic review will be conducted during this quarter with themes identified and presented to POD.							

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Understanding the key drivers that are impacting on staff wellness and engagement

No	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Development of actions from the staff survey	DoP	Oct 2026	- CQI catchball with Executive team has taken place and people priorities have been agreed with each division. - Divisional A3s are under construction and supported by the TSI team - PRMs are new performance review meetings will be in place from October which will monitor outcomes and impacts	Green
2	Wellness strategy and seasonal vaccination plan	DoP	Oct 2026	26/27 Seasonal Vaccination plans are completed and are included in our winter planning submission. We have significantly increased peer vaccinators this year. Goes live in October. - Wellness and OH strategy agreed at POD. Communication strategy in place and will be disseminated throughout the organisation	Green
3	Trust Awards	DoP	Sept 2026	- Date set for 2026 Trust awards of 17th September at De La Warr Pavilion - Event planning in progress.	Blue
4	Measures to support staff and leaders in managing work-based stress	DoP	Sept 2026	- Comprehensive package of support for staff impacted by Trauma related events i.e TriM - Restorative Support already in place and embedded. - Psychological Wellbeing Safety of Staff Policy updated to strengthen management of workplace stress, alongside Occupational Wellness Strategy. - Mental Health Awareness Training Phase 1 for all staff was launched on MyLearn in April 2026, with 116 staff having completed the training. Phase 2 due to launch in October 2026.	Amber
5	Listening to colleagues to ensure that Board and senior leaders fully understand what impacts staff morale	DoP	Oct 2026	POD will run face to face meeting in September 2026, with a key focus on what it feels like to work at ESHT. Outcomes and themes will be reviewed and incorporated into information for broader staff focus groups	Green

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Ongoing monitoring of, and response to, key workforce metrics/staff survey • DME monitors and reviews 'trainees in difficulty' register • Workforce efficiency and availability reviews considering registered and unregistered nurses, and AHPs • Ongoing reviews of effectiveness and efficiency of rostering • Task and finish focus groups in place to support key remedial actions in response to staff/GMC surveys • Sickness monitoring and divisional support • Improving doctors working lives • Equality inclusion group established, with a focus on all EDI metrics	• 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 • Staff standards group established; first meeting in November; to monitor position against staff standards and develop trust strategy within the five domains.	• 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 2: Failure to deliver sustainable financial position impacts patient care, increases the likelihood of regulatory intervention and reduces the ability to deliver strategic goals. Failure also increases the risk of having insufficient cash to pay suppliers and staff, impacting on the ability of the organisation to deliver high-quality care.				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. Included within the plan is a cash application which will be required to cover expected commitments. NHS England has been clear that organisations need to live within their financial envelopes.				Integrated		Patient Centred		Sustainable		
										✓		
Lead executive		Chief Finance Officer		Lead Committee		Finance and Performance		Date last reviewed		25/08/26		
Risk(s) rated 15 and over aligned		334 – Working capital – cash										
2. 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	
			Q1	Q2	Q3	Q4					No higher than 16	
Likelihood	4	4	4			The Trust is forecasting a breakeven position but has significant risks. The developed CIP plans show a significant shortfall to that required to deliver the breakeven position. The Trust reported an adverse variance at Month 4. The additional controls put in place during the previous financial year, including a vacancy control panel, remain. Progress on schemes is being monitored on a weekly basis. Monthly reports go to the Finance and Performance Committee. Additional resource has been brought in to help develop CIP plans for 2026/27 and beyond. Cash is monitored on a weekly basis and there are ongoing conversations with NHSE regarding our cash application.				Risk appetite Amount/type of risk accepted/taken		
Impact	5	5	5									
Risk level	20	20	20							Seek		
Forward forecast of risk level												
Dynamic, in quarter assessment of how - based on current evidence and confidence in future position – the risk owner sees this BAF risk level moving. Either to YE or as far forward as is reasonable/realistic based on the evidence and forecasts available												
We anticipate that this will remain the same throughout 2026/27.												

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

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

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

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Currently developing new Standard Operating Procedure (SOP) for business cases	CFO	April	• Due to report in April • This has been developed and the new SFIs would be brought to the Audit Committee on 26.08.26	Blue
2	Capital decisions are approved within the CRG with any larger capital items needing approval at Ex Comm, both of which have divisional representation	CFO	Ongoing	• Divisions have been involved in final capital plan for 2026/27 and beyond. • Work is complete	Blue
3	Recruitment is taking place within the finance team to address the gaps	CFO	July	• We have recruited into the business case role and have recruited into the PMO.	Ongoing
4	Solutions have been developed within the finance team to enable more regular reporting of service line reports	CFO	October	• As part of the larger Finance restructuring and prioritisation	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 Management Office on progress of schemes • Vacancy control panel approves internal and external recruitment on a weekly basis.	• Oversight by Efficiency Programme Group (EPG) • 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 EPG	• Internal audit review reports • NHSE oversight

1. Risk Summary								
Reference & title	BAF 3: Insufficient capital to maintain ageing critical estate and infrastructure risks operational inefficiency, disruption, statutory compliance and patient care				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				Integrated	Patient Centred	Sustainable	
							✓	
Lead executive	Chief Finance Officer	Lead Committee	Finance and Performance			Date last reviewed	25/08/2026	
Risk(s) rated 15 and over aligned	64 – Maintenance & Refurbishment 65 – External cladding 154 – UCR and virtual ward estate size 333 – Paediatric audiology service 337 – Fire safety Conquest 338 – Fire safety EDGH 351 – Key Clinical Environments (BMS) 354 – Fire safety Bexhill							
2. Risk Scoring								
Inherent risk <i>If there were no mitigations</i>		Current risk level <i>Assessment based on evidence</i>				Rationale for current risk level <i>Evidence that provides assurance of current risk level</i>		Risk tolerance <i>Acceptable range/boundaries of risk score</i>
		Q1	Q2	Q3	Q4			No higher than 16
Likelihood	5	5	5					Risk appetite <i>Amount/type of risk accepted/taken</i>
Impact	4	4	4					
Risk level	20	20	20					
						The Trust's capital budgets are insufficient to support the aging infrastructure (estates, equipment, digital). The impact of this is temporary solutions to resolve urgent issues. National funding is uncertain and opaque and therefore it is very difficult to plan in a strategic manner.		
						Analysis has been performed to identify capital needs in relation to backlog maintenance, replacement of medical equipment and digital investment. This information will be used to prioritise capital awarded for the medium-term financial plan.		
						On 6 January 2026 the power supply to EDGH was interrupted and back up power failed leaving the site without electricity for circa two hours. This was caused by external and internal factors but primarily due to aging infrastructure. Consequently, power failure is a question of when rather than if and therefore the likelihood score has moved to 5.		
						The infrastructure does not support working during periods of extreme weather, impacting on the care that we can deliver to our patients.		Seek
Forward forecast of risk level								
<i>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</i>								
We have compiled a ten-year investment backlog programme which has been presented to the Executive Leadership Team and F&P. This has provided a focus on five key areas of risk and prioritisation about how we address those over the next 5-10 years. In addition, future bids will be made as we understand £5bn has been earmarked nationally for critical infrastructure risks for the next four years. However, there is no certainty as to the levels that may be awarded to the Trust, having submitted estates safety fund bids to the South East region NHSE.								

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Longer term capital programme has been produced; however, significantly more capital is required to address this than is available to the Trust.
- New Hospital Programme/BFF funding envelope delayed until at least 2037 and timeframe and scope/extent of work against the funding allocation is not clear at present
- There is no sustainable estates strategy

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

No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Trust undertook a medium-term financial plan. Several bids were made for national money, including to the strategic estates safety fund; we are awaiting outcome confirmation.	CFO	Q2 26/27	• The medium-term plan was submitted • Awaiting guidance from national and regional teams	Blue
2	External funding opportunities	CFO	As opportunities arise	• The Trust will continue to bid for funding through ICS and national programmes as and when opportunities occur, supported by F&P and the Trust Board	Amber
3	A new estates strategy to be developed and published	CFO	Q4	• The newly appointed Director of Estates and Facilities has been tasked to create an Estates Strategy aligned to the Clinical 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	• Day to day management of infrastructure and prioritisation by services	• Oversight by Finance and Performance Committee • Estates and Facilities IPR • Clinical procurement group in place • Prioritisation decisions about capital expenditure are made by CRG and F&P	• Capital business cases reviewed by NHSE • External review report of critical infrastructure

1. Risk Summary						
Reference & title		BAF 4: 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			Integrated	Patient Centred
					✓	✓
Lead executive		Deputy CEO		Lead Committee	Finance and Performance	Date last reviewed
						24/09/2026
Risk(s) rated 15 and over aligned		• 15 - Software vulnerabilities • 17 - Cyber attack • 52 – Network connectivity				
2. Risk Scoring						
Inherent risk <i>If there were no mitigations</i>		Current risk level <i>Assessment based on evidence</i>			Rationale for current risk level <i>Evidence that provides assurance of current risk level</i>	
		Q1	Q2	Q3	Q4	Risk tolerance <i>Acceptable range/boundaries of risk score</i>
Likelihood	5	4	4			No higher than 16
Impact	4	4	4			Risk appetite <i>Amount/type of risk accepted/taken</i>
Risk level	20	16	16			Minimal
					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 several attacks on NHS Trusts or provider organisations.	
					We still have several Legacy systems which are reducing very slowly. Cyber maturity has further improved over the last six months, which keeps the Trust at a medium risk status.	
Forward forecast of risk level						
<i>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</i>						
The cyber action plan, which is presented to the Audit Committee, has four elements: Internal Audit recommendations, CAF Self Assessment, External Penetration Test recommendations, Top 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

- Reduce Legacy system
- 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	DCE O	June 27	• Started this year submission • December 2027 interim submission • June 27 for final submission	Green
2	Legacy Devices	DCE O	Dec 26	• Good progress on upgrade or remove of legacy systems used across the Trust	Green
3	Medical devices with network connectivity asset list	DCE O	Dec 26	• Increased visibility across EDGH and risks identified • Further work required to enable greater visibility across Conquest, this will be delivered as we build the new network	Amber
4	LAN Refresh EDGH	DCE O	March 27	• Migration of Edge network has continued slowly and will continue over the year • Delay due to lack of resources in the Network team • Large dependency on Estates work	Red
5	LAN Refresh Conquest	DCE O	March 27	• Replace the Core Network and Fibre connections to the Edge Switches • Edge Switch replacement underway via 3rd party supplier • Planning underway for Core cut over • Large dependency on Estate work	Amber
6	Active directory migration	DCE O	Dec 27	• Work underway now to migrate Servers and Services	Green
7	Windows 11 migration	DCE O		• Migration is now complete, there are 212 devices that are being tracked down and replaced.	Complete

	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 5: 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.			Integrated	Patient Centred
					✓
Lead executive	Deputy CEO	Lead Committee	Finance and Performance	Date last reviewed	10/09/2026
Risk(s) rated 15 and over aligned	While there are no current risks on the Corporate Risk Register that align, gaps in divisional analytical support relating to planning, improvement projects and operational management has been identified.				

2. Risk Scoring									
Inherent risk <i>If there were no mitigations</i>		Current risk level <i>Assessment based on evidence</i>				Rationale for current risk level <i>Evidence that provides assurance of current risk level</i>			Risk tolerance <i>Acceptable range/boundaries of risk score</i>
		Q1	Q2	Q3	Q4				
Likelihood	4	4	4			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.			No higher than 16
Impact	4	4	4						Risk appetite <i>Amount/type of risk accepted/taken</i>
Risk level	16	16	16						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

The current risk rating remains at 16. The risk level is expected to reduce from significant (16) to high (12) in Q3. The reduction in risk score aligns with recruitment of 2 senior posts within the BI team due to start in Nov 26.

2026/27 Q3 to Q4, risk level expected to fall to medium (9) as skills mix model is deployed, pipeline to T- level students is established, automation of BI processes and upskilling of existing BI staff is completed. Key dashboard build such as Mixed Sex Accommodation and Corridor Care, is being supported by external consultancy. Information reports and dashboards are being utilised from the Federated Data Platform.

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

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

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

Additional actions that can be undertaken to support mitigations and/or address gaps in existing controls/assurance					
No.	Action	Exec lead	Due date	Status update (for current quarter)	BRAG
1	Enhance BI Structure and Investment	DCE O	Dec 26	Recruitment against BI vacancies complete. External candidates for 8B and 8A expected to commence in November 26.	Green
2	Update BI Tools	DCEO	Sept 26	Implementation of LoIS (BI platform) hosting PowerBI dashboards completed.	Green
3	Enhance BI Training Programs	DCEO	Dec 26	- Continued Microsoft/NHS BI training uptake; targeted SQL and Power BI training completed. - Active learning set sessions implemented in Jan 26 for continued development. - NHSE Demand and Capacity training to be arranged in Q2 (for BI team and wider divisional colleagues).	Green
4	Improve Reporting Mechanism, Automation First and Self Service	DCE O	Dec 26	- Automation of BI process scheduled for external consultancy to complete in Q2 and Q3. - Corridor Care dashboard build by external consultancy scheduled for September. Mixed Sex Accommodation dashboard built, tested by stakeholders, following refinements, to be rolled out end of September.	Green
5	Data Warehouse development for new EPR	DCE O	Feb 27	- Specification of Tier 2 reporting tables for the Trust data warehouse completed by BI team by August. - Dependency on CIS Development Team to build Tier 2 reporting tables in Q2/Q3. Amber status reflects conflict with other EPR priorities. Mitigation being explored to out-source development work.	Amber

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

1. Risk Summary						
Reference & title	BAF 6: 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				Integrated	Patient Centred
Lead executive	Deputy CEO	Lead Committee	Finance and Performance		Date last reviewed	24/09/2026
Risk(s) rated 15 and over aligned	• None currently on the CRR at this stage – we keep this under review					

2. 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	
		Q1	Q2	Q3	Q4			No higher than 16	
Likelihood	4	3	3			To enable the Trust to transform digitally and develop a culture which embraces significant change there is a dependency on investment and resources. However, currently the Trust is reliant on non-recurrent funding making it challenging to plan for large scale changes or recruit to roles. The long-term impact of not embracing the changes needed to support a digital transformed trust are significant, as the population/patient will expect the Trust to deliver services using enhanced digital solutions. The progress on Electronic Patient Record (EPR) procurement has increased the level of engagement across the organisation as well as the need for digital and structured data.		Risk appetite Amount/type of risk accepted/taken	
Impact	4	4	4						
Risk level	16	12	12					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 design and build 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 2: Nov 26 Tranche 3: Feb26	• T2 Delayed by two months to allow training • Good Clinical and Operational engagement • Design T2 Complete. • End date of implementation will be July 2027	Green
2	Digital transformation	DCEO	Ongoing	• EPR Optimisation planning underway • Early engagement with Digital on Trust transformation	Green
3	Digital Literacy	DCEO	Ongoing	• Digital literacy- identifying skills requirement for EPR implementation • Developing training needs analysis for tranche 2 go live	Amber
4	Increase digital culture	DCEO	Ongoing	• Communications strategy and engagement – digital matters newsletter. • Multidisciplinary team working to deliver EmPowerR • Good level of engagement across operational and clinical divisions	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 • Alignment to Trust true north • 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 • Internal audit review reports

1. Risk Summary					
Reference & title	BAF 7: Absence of flow impacts delivery of safe, high-quality care			Fit with Trust corporate priorities	
Description	The Trust has a significant number of patients who do not need to be cared for in an acute hospital setting (discharge ready) resulting in a requirement for 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 extended length of stay of some of these patients. In addition, there is a negative impact on patient experience as a result.			Integrated	Patient Centred
				✓	✓
Lead executive	COO/CNO/CMO	Lead Committee	Quality and Safety	Date last reviewed	03/07/2026
Risk(s) rated 15 and over aligned	69 - Insufficient acute beds in winter 102 - Psychological support for long term and rehab patients				

2. Risk Scoring									
Inherent risk <i>If there were no mitigations</i>		Current risk level <i>Assessment based on evidence</i>				Rationale for current risk level <i>Evidence that provides assurance of current risk level</i>			Risk tolerance <i>Acceptable range/boundaries of risk score</i>
		Q1	Q2	Q3	Q4				
Likelihood	5	4	4			Evidence on a daily basis of the impact of over 120 patients who are discharge ready and the impact that this has on flow and increasing risk to patients and staff. This leads to the use of additional bedded capacity and also includes patients waiting for mental health beds. In addition, it is necessary to pre-emptively place (board) additional patients on wards and to provide care in corridors for extended periods of time until a bed space is available.			No higher than 16
Impact	4	4	4						Risk appetite <i>Amount/type of risk accepted/taken</i>
Risk level	20	16	16						Cautious

Forward forecast of risk level <i>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</i>	
Currently it is likely that the significant challenges will continue. We are continuing to work through the implementation of the NHSE “Principles for Providing Patient Care in Corridors”. We will report progress to Q&S and to the Trust Board.	

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Lack of Adult Social Care capacity / timely assessment
- Lack of Nursing Home capacity
- Lack of mental health capacity / timely assessment resulting in stranded patients with Significant Mental Illness (SMI)
- Lack of suitable clinical space and workforce to accommodate additional patients

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	Discussions 5x a day	• Workforce pressures have increased further • Escalation processes and de-escalation processes in place • Adherence to the new Corridor Care Guidance	Red
2	Ensure that patients are placed as safely and appropriately as conditions permit	COO/ CNO/ CMO	Discussions 5x a day	• Escalation capacity and surge and boarding capacity utilised as appropriate • Revised dynamic patient risk assessment already in use and all areas have had recent review regarding environmental risks • Additional escalation capacity open on James Ward at time of writing	Red
3	Ensure complex/high risk patients are assessed and flagged appropriately	COO/ CNO/ CMO	Daily PTL meetings	• Meetings to review and escalate patients with LOS in excess of 7, 14 and 21 and 100 days take place each weekday with ASC and therapy attendance • As required on a case-by-case basis, divisions escalate particularly complex patients	Amber

	1st line of Defence (service delivery and day to day management of risk and control)	2nd Line of Defence (specialist support, policy and procedure setting, oversight responsibility)	3rd Line of Defence (Independent challenge on levels of assurance, risk and control)
Assurance	• Robust management of all capacity • 5x 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 • 5x a day discussion about escalation, supersurge and boarding • System escalation calls to discuss the number of supersurge/boarding 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; daily calls with SPFT • Full capacity protocol rewritten	• Use of any additional specialist advice or support, including visits to ESHT and ESHT staff visiting other locations • Daily patient pathway review for all patients	• Challenge at Quality and Safety Committee and Trust Board • Provider assurance meetings and system clinical quality review meetings

1. Risk Summary					
Reference & title	BAF 8: Failure to deliver the Emergency Access Standard impacts the provision of safe, high-quality care			Fit with Trust corporate priorities	
Description	Due to ongoing challenges with patient flow there is a risk that patients spend longer than they need to in the emergency department. There is evidence to suggest that patients who spend more than four hours in emergency departments may come to harm.			Integrated	Patient Centred
				✓	✓
Lead executive	COO/CNO/CMO	Lead Committee	Finance and Performance	Date last reviewed	03/07/2026
Risk(s) rated 15 and over aligned	69 - Insufficient acute beds in winter 102 - Psychological support for long term and rehab patients				

2. Risk Scoring									
Inherent risk <i>If there were no mitigations</i>		Current risk level <i>Assessment based on evidence</i>				Rationale for current risk level <i>Evidence that provides assurance of current risk level</i>			Risk tolerance <i>Acceptable range/boundaries of risk score</i>
		Q1	Q2	Q3	Q4				
Likelihood	5	4	4			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. Q1 and Q2 have been challenging but the risk level has not increased from 16.			No higher than 16
Impact	4	4	4						Risk appetite <i>Amount/type of risk accepted/taken</i>
Risk level	20	16	16						Cautious

Forward forecast of risk level	
<i>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</i>	
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. However, there are external factors outside the Trust's control which impact on internal flow.	

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- We do not have a mechanism for immediately decompressing emergency departments.
- We cannot immediately respond to significant surges in activity.
- Workforce plan does not match increase in activity.
- Both emergency departments are not right sized to meet current demand

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.	COO	Ongoing	• We have two ICW wards in place, one on each site	Blue
2	Priority actions identified and include work regarding culture, education and roles and responsibilities. (SAFER and Reconditioning work)	CNO	Q2	• SAFER continues to be embedded • Increasing focus on reconditioning moving forward • Breakthrough priority focussing on discharges before midday to support getting patients home before lunch • Emergency Access Standard Recovery Plan in place	Amber
3	KPIs and dashboard in place 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	• UEC delivery group has been established • Workstreams with clear priorities identified • Some dashboards have been completed; wait time for therapies and mental health are outstanding	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	• 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 escalated to CMO/CNO/COO	• Bed strategy programme reporting through Efficiency Programme, 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

1. Risk Summary					
Reference & title	BAF 9: Failure to shape the care landscape with peers and patients slows pace of transformation/innovation			Fit with Trust corporate priorities	
Description	We fail to drive with partners a collaborative approach to thought leadership, leading to us collectively lacking pace and/or delivery of the necessary changes to meet the new commissioning environment (i.e. trust-based and Alliance based)			Integrated	Patient Centred
	NB: <i>This is designed to be a risk that links with wider system challenges – the assumption of a risk for which we are responsible alongside other organisations is intentional</i>			✓	
Lead executive	Chief of Staff	Lead Committee	Executive Committee	Date last reviewed	09/09/2026
Risk(s) rated 15 and over aligned	None currently on the CRR at this stage – we keep this under review				

2. 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
		Q1	Q2	Q3	Q4	
Likelihood	3	2	2			There are currently two key areas of work - of which Board members are aware – that impact the risk score: 1) Our presence and direction in the Neighbourhood Alliance – to drive changes to the care landscape as regards the left shift. Shared with executives and clinical leaders via ExCom updates. 2) Our separate and concurrent ongoing conversations with ICB colleagues re: our strategic intent and direction (as ESHT), which is aligned to continued transformation of care in East Sussex Colleagues are kept apprised as to progress in both of these – currently positive.
Impact	4	4	4			
Risk level	12	8	8			
						Risk tolerance Acceptable range/boundaries of risk score
						No higher than 12
						Risk appetite Amount/type of risk accepted/taken
						Open

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
Based on current expectations and progress in Q1, on the basis of our relationships, focus and progress to date, we have not received feedback from either the ICB or NHSE SE region that suggests ESHT is anything other than well-positioned as regards the taking forward change and considering new models/approaches to improve services

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

There are currently no perceived gaps in either assurance or controls, and this is kept under monthly review. In the event that gaps were deemed to be evident the actions and assurance would be completed, below

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					
2					
3					

	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	Operational & clinical leaders actively participate in Sussex-wide transformation programmes, Integrated Community Team (ICT) development, neighbourhood health initiatives, provider collaboratives and pathway redesign work. Transformation programmes are supported through programme management arrangements, clinical leadership, patient engagement and improvement methodologies to ensure that opportunities for innovation & partnership working are identified and progressed.	Progress against transformation objectives is monitored through programme boards, executive-led groups and Board sub-committees, with regular review of opportunities, risks and dependencies affecting delivery. Alignment with Trust strategy, the BEST framework and wider ICS priorities provides assurance that transformation activity remains coordinated, evidence-based and responsive to system needs.	Independent assurance is provided through Trust Board scrutiny, Board sub-committees, internal audit, external audit, Care Quality Commission engagement and oversight from Sussex Integrated Care Board and NHS England. External partnership forums, system governance arrangements and programme reviews provide additional independent challenge regarding the Trust's contribution to service transformation, population health improvement and collaborative system working.

1. Risk Summary					
Reference & title	BAF 10: Failure to reshape services as 'fit for commissioning purpose' stifles organisational ambition			Fit with Trust corporate priorities	
Description	The risk is either that we fail to reshape services when aligned to commissioning intention or commissioning intentions are not aligned with our strategic ambition. In either case, we will either fail to deliver on the national strategy, lose the support of our key regional and ICB stakeholders and/or we will expend resources/make poor decisions trying to force alignment and/or meet too many priorities. A major change in the political environment would also be a significant cause of the risk.			Integrated	Patient Centred
				✓	
Lead executive	Chief of TSI	Lead Committee	Executive Committee		Date last reviewed
					28/08/2026
Risk(s) rated 15 and over aligned	None currently on the CRR at this stage – we keep this under review				

2. Risk Scoring									
Inherent risk <i>If there were no mitigations</i>		Current risk level <i>Assessment based on evidence</i>				Rationale for current risk level <i>Evidence that provides assurance of current risk level</i>	Risk tolerance <i>Acceptable range/boundaries of risk score</i>		
		Q1	Q2	Q3	Q4		No higher than 16		
Likelihood	4	3	4			Our close engagement with the neighbourhood alliance, acute alliance and provider collaborative executive plus the developing relationship with key ICB and Regional stakeholders (at Chair and CEO level in particular) mitigate the risk. Our overarching strategy and several key in-year programmes are well aligned with the ambition in the intentions. However, the political climate is uncertain and the current financial pressure increases the risk of misalignment in terms of quantified outcomes – this is a material issue driving the risk level – e.g. meeting constitutional standards and/or ‘avoiding admissions’ whilst delivering the level of efficiency required whilst delivering ‘transformation’ with minimal up-front investment. Given in Q2 we have not met the financial plan, that increases the risk.	Risk appetite <i>Amount/type of risk accepted/taken</i>		
Impact	4	4	4				Cautious		
Risk level	16	12	16						

Forward forecast of risk level	
<i>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</i>	
Political/regulatory uncertainty is increasing. Financial pressure is set to increase across the year for the NHS. The combination will impact behaviours and increase the conflict between the strategic ambition and in-year delivery. This risk has increased in Q2 and may still increase further.	

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

- Strength of governance for major transformation programmes. The CQI programme is moving to a phase where we specifically plan to address this gap.
- Absence of an up-to-date clinical strategy, however we have now launched the process for developing it.

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	Strengthen Governance through the Executive Committee	CTSI	Q2	• Ex Comm agenda now has section for this • Currently includes major transformation or 'reshaping' programmes Acute Alliance, Neighbourhood Alliance, Networks (Path and Imaging) • The CQI programme is moving a to a phase where we design and implement governance for Strategic Initiatives and corporate projects.	Green
2	Refresh clinical strategy	CTSI	Q4	• We have a plan to develop the new Clinical Strategy, and we have launched the steering group for it. The next challenge will be confirming resources.	Amber
3	Defining strategic initiatives	CTSI	Q3	• As part of the CQI system implementation the Executive will set out 5 or 6 'strategic initiatives' with a specified approach to delivery and governance	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	• Appropriate engagement – clinical and operational – at service level where the risk is material • Business case, service change and BAU governance through Ex Comm mitigate risk	• For the majority of programmes (Acute Alliance, Neighbourhood Alliance, Networks) there is a named Executive SRO with active oversight • Business case policy and procedure has been updated • Efficiency Programme Group	• Trust Board governance • Provider Collaborative Executive (informal) with additional governance with ICB, Regional leadership and NHS E quarterly reviews

1. Risk Summary					
Reference & title	BAF 11: Weakening patient feedback damages wider reputation			Fit with Trust corporate priorities	
Description	Declining patient experience, weak feedback, increased complaints, negative media coverage or reduced confidence from patients, carers and communities could damage the reputation of the Trust. A deterioration in patient perception could reduce confidence in the quality of services, impact staff morale, risk external scrutiny and undermine the Trust's ability to maintain public trust and support. The Trust seeks to mitigate this risk through systematic collection and review of patient feedback, complaints management, patient engagement activity, FFT results, PE Strategy delivery and Board oversight of relevant metrics.			Integrated	Patient Centred
				✓	
Lead executive	Chief of Staff	Lead Committee	Quality and Safety (via IGM)	Date last reviewed	09/09/2026
Risk(s) rated 15 and over aligned	None currently on the CRR at this stage – we keep this under review				

2. 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	
		Q1	Q2	Q3	Q4	Patient experience (PE) indicators remain broadly stable with no significant deterioration evident across complaints, PALS contacts, FFT feedback, patient surveys or stakeholder engagement mechanisms. Feedback themes are subject to routine triangulation through Q&S ctee & governance meets, with learning/improvement actions monitored by operational teams The Trust is developing a PE Strategy that strengthens collection, analysis and use of patient feedback to drive improvement. Complaints are reviewed through established governance processes and emerging themes escalated. While reputational risk can escalate rapidly following significant incidents or sustained deterioration in experience measures, current evidence suggests the risk remains within tolerance.	Risk tolerance Acceptable range/boundaries of risk score
Likelihood	4	2	2				No higher than 16
Impact	4	4	4				Risk appetite Amount/type of risk accepted/taken
Risk level	16	8	8				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	
The risk is expected to remain stable during the year. Continued implementation of the PE Strategy, improvement in complaint responsiveness, enhanced patient engagement and routine monitoring of experience metrics should maintain the current risk level. However, external scrutiny, adverse incidents, significant service pressures or emerging negative patient experience themes could result in an increase in risk score if not addressed promptly	

3. Providing assurance

Additional actions that can be undertaken to support mitigations

Gaps in existing controls or assurance

There are currently no perceived gaps in either assurance or controls, and this is kept under monthly review. In the event that gaps were deemed to be evident the actions and assurance would be completed, below

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					
2					
3					

	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	Operational services collect and respond to patient feedback through complaints management, PALS, FFT processes, patient surveys and local engagement activity. Service managers review themes and implement improvement actions through routine quality governance arrangements.	PE Team oversight, Quality Governance processes, Patient Experience Strategy delivery, corporate reporting, triangulation of complaints and experience data, and scrutiny through the Q&S Committee provide assurance that feedback mechanisms are effective & learning implemented.	Independent oversight is provided by the Board, Care Quality Commission inspections, National Patient Surveys, external reviews, Internal Audit and other independent assurance processes

Appendix: Year End 2025/6 BAF

BA F 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.	PO D	15	9	9	9	9	◀▶	No higher than 16	Significant
2	Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.	PO D	20	16	16	16	20	▲	No higher than 16	Cautious
3	We fail to use our resources as efficiently as possible and do not improve services for patients.	F&P	20	15	20	20	20	▶▶	No higher than 16	Seek
4	The Trust's aging estate and capital allowance limits the way in which services and equipment can be provided in a safe manner for patients and staff.	F&P	20	16	16	20	20	◀▶	No higher than 16	Seek
5	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack.	F&P	20	16	16	16	16	◀▶	16	Minimal
6	Failure to attract and develop business intelligence limits insightful and timely analysis to support decisions.	F&P	16	16	16	16	16	▶▶	No higher than 16	Seek
7	Failure to transform digitally and deliver associated improvements to patient care.	F&P	16	12	12	12	12	◀▶	No higher than 16	Seek
8	Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that are discharge ready with an extended length of stay	Q&S	20	16	16	16	16	▶▶	No higher than 16	Cautious
9	Failure to meet the four-hour clinical standard.	Q&S	20	16	16	16	16	▶▶	No higher than 16	Cautious

 Risk tolerance exceeded



Report To/Meeting	Trust Board	Date of Meeting	20 October 2026
Report Title:	Annual Equality Report 2025/2026		
Key question	What does our workforce equality data for 2025/26 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):	Sarah Feather, Equality, Diversity and Inclusion Lead - workforce
Outcome/Action requested:	The Board is asked to: • Review the Annual Equality Report 2025/26 • Receive assurance that the Trust continues to meet its statutory duties under the Equality Act 2010 and national NHS equality reporting requirements. • Approve publication of the Annual Equality Report 2025/26 • Endorse the Equality, Diversity and Inclusion Priorities for 2026-2028 • Note that new Equality Objectives for 2026-2030 will be developed during 2026/27 in line with the Public Sector Equality Duty.		
Executive Summary	This report presents the Trust's Annual Equality Report for 2025/26, providing assurance regarding compliance with the Equality Act 2010, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), gender pay gap reporting and NHS England ethnicity and disability pay gap reporting requirements. The report reviews workforce equality outcomes across all protected characteristics and demonstrates progress in embedding equality, diversity, inclusion and belonging throughout the organisation. It draws upon workforce information, NHS Staff Survey findings, recruitment data, employee relations information and pay gap analysis. During 2025/26 the Trust has demonstrated positive progress across several areas including: • Returning to the NHS England non-adverse range for the WRES recruitment indicator for the first time in four years. • Increased workforce diversity and improved declaration rates across disability, religion and sexual orientation. • Continued improvement in recruitment outcomes for disabled applicants. • Further embedding of the centralised Reasonable Adjustments process. • Growth in colleague engagement through staff networks and the Allyship Programme. • Achievement of the Ministry of Defence Gold Defence Employer Recognition Scheme and the HSJ Military and Civilian Health Partnership Award.		

	Whilst encouraging progress has been made, the report also identifies continued inequalities experienced by some protected groups, particularly relating to bullying and harassment, career progression, leadership representation and workforce experience. The report includes a refreshed Equality, Diversity and Inclusion Action Plan for 2026–2028 designed to address these priorities. The Equality, Diversity and Inclusion Priorities for 2026–2028 build directly on the findings of this report, the Trust's existing Equality Objectives and emerging national priorities. They place particular emphasis on developing inclusive succession planning and leadership pipelines, strengthening talent management and career development for under-represented groups, embedding equality within workforce governance and decision-making, and addressing the workforce inequalities identified through the report. They also support delivery of wider national expectations, including the NHS Staff Standards and the recommendations of the Lord Mann Review, particularly in relation to creating inclusive, respectful workplaces, tackling racism, improving organisational culture and strengthening the Trust's approach to sexual safety. Together, these priorities support the Trust's ambition to develop a more representative leadership population and create equitable opportunities for progression at all levels of the organisation.		
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. The priorities also support implementation of relevant national NHS expectations, including the NHS Staff Standards and recommendations arising from the Lord Mann Review.		
Business Plan Link:	Quality	☐	People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	This report directly relates to EDI objectives and evidences 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	6	Appendixes	Appendix A: Annual Equality Report 2025/26 and action plan 2026/2028 31 pages

Governance and Engagement pathway to date:	WRES/WDES reports submitted to NHS England – May 2026 People and OD Committee – August 2026 (for assurance)
What happens next?	Subject to Board approval, the Annual Equality Report 2025/26 will be published. Delivery of the 2026–2028 priorities will be monitored through workforce equality governance, with progress reported to the People and OD Committee.
Publication	Can be published

Introduction/Background

The Annual Equality Report is produced each year to fulfil the Trust's statutory duties under the Equality Act 2010 and to provide assurance regarding workforce equality performance.

The report demonstrates progress against the Trust's Equality Objectives, NHS England Workforce Equality Standards and wider organisational inclusion priorities. It also provides transparency regarding workforce experiences and identifies priorities for continued improvement.

The report also supports the Trust's wider ambitions to be an inclusive employer, improve staff experience, strengthen leadership capability and ensure the workforce reflects the diverse communities it serves. Equality, diversity and inclusion are integral to delivering safe, effective, high-quality care and meeting the expectations of regulators, NHS England and our local population.

The report includes analysis across all protected characteristics together with workforce race, disability and gender equality standards, ethnicity, disability and gender pay gap reporting, Armed Forces, organisational inclusion and progress against the NHS England Equality, Diversity and Inclusion Improvement Plan.

Issues

The Annual Equality Report demonstrates continued progress in embedding equality, diversity, inclusion and belonging across the Trust whilst identifying areas where further improvement is required. 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.

Key areas of progress include:

- Improved recruitment outcomes for multicultural applicants, with the Trust returning to the NHS England non-adverse range for the WRES recruitment indicator.
- Continued growth in workforce diversity and improved declaration rates across disability, religion and sexual orientation.
- Improved recruitment outcomes for disabled applicants and continued embedding of the centralised Reasonable Adjustments process.
- National recognition through achievement of the Gold Defence Employer Recognition Scheme and HSJ Award for Military and Civilian Health Partnership.
- Continued growth of staff networks, allyship initiatives and colleague engagement.

The report also identifies areas where inequalities remain, including:

- Persistent disparities in bullying, harassment and discrimination experienced by multicultural, disabled and LGBTQIA+ colleagues.
- Lower perceptions of fair career progression amongst some protected groups.
- Continuing gender, ethnicity and disability pay gaps, largely reflecting workforce distribution across professional groups.
- Under-representation of some protected groups within senior leadership roles.

The accompanying Equality, Diversity and Inclusion priorities for 2026–2028 have been developed using workforce data, NHS Staff Survey findings, WRES and WDES indicators, pay gap analysis, colleague feedback and national policy developments to ensure they target the areas of greatest inequality and organisational risk.

The priorities for 2026–2028 have been developed in response to the evidence presented within the report, national NHS priorities and regulatory expectations. The priorities also support the Trust's ambitions to strengthen evidence against the CQC Well-Led framework, particularly in relation to representative leadership, culture and governance.

The priorities have also been developed to support delivery of emerging national expectations, including the NHS Staff Standards and recommendations arising from the Lord Mann Review, particularly around organisational culture, anti-racism, psychological safety, respectful behaviours and sexual safety.

The proposed Equality, Diversity and Inclusion Priorities for 2026–2028 focus on:

- Inclusive leadership and increasing representation at senior levels.
- Talent management, career development and succession planning for under-represented groups.
- Reducing bullying, harassment and discrimination.
- Embedding equality within governance, workforce planning and Equality Impact Assessments.
- Improving workforce experience through reasonable adjustments, allyship and staff networks.
- Using workforce data and lived experience to drive continuous improvement.

Together, these priorities provide a strategic framework for reducing workforce inequalities, strengthening inclusive leadership and organisational culture and creating a more representative and inclusive organisation that delivers better outcomes for colleagues and patients. Delivery of the priorities will be overseen through the Workforce Inclusion and Culture Meeting, with progress reported to the People and OD Committee through regular assurance reporting and aligned to the Trust's People Strategy.

Consequences for not taking action

Failure to implement the actions identified within the report could result in continued workforce inequalities, reduced staff experience, increased regulatory and reputational risk, and failure to meet statutory equality duties. It may also adversely impact recruitment, retention, organisational culture and the Trust's ability to deliver equitable, high-quality care.

Failure to implement these priorities may limit the Trust's ability to evidence improvement against CQC Well-Led expectations, NHS Staff Standards and national equality frameworks, as well as impacting staff experience, recruitment, retention, leadership diversity and organisational culture.

Conclusion

The Annual Equality Report demonstrates continued progress in advancing equality, diversity, inclusion and belonging across the Trust during 2025/26. The report provides assurance regarding compliance with statutory equality duties whilst identifying areas where sustained organisational focus is required.

The proposed Equality, Diversity and Inclusion priorities for 2026–2028 build upon this year's progress and provide a strategic framework for addressing the remaining inequalities through inclusive leadership, succession planning, talent management, workforce governance and continuous improvement.

The Board is therefore asked to receive assurance from the report, approve publication of the Annual Equality Report 2025/26 and endorse the Equality, Diversity and Inclusion priorities for 2026–2028.

Recommendations

The Board is asked to:

1. Review the Annual Equality Report 2025/26
2. Receive assurance that the Trust continues to meet its statutory duties under the Equality Act 2010 and national NHS equality reporting requirements.
3. Approve publication of the Annual Equality Report 2025/26
4. Endorse the Equality, Diversity and Inclusion Priorities for 2026-2028
5. Note that new Equality Objectives for 2026-2030 will be developed during 2026/27 in line with the Public Sector Equality Duty.

**Annual
Equality
Report
2025/2026**



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

CONTENTS

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esht.workforceinclusion@nhs.net 1

FOREWORD3

SUMMARY4

INTRODUCTION6

RACE (including ethnicity pay gap).....7

RELIGION AND BELIEF.....12

SEX (including Gender Pay Gap).....14

SEXUAL ORIENTATION.....17

DISABILITY (including disability pay gap).....19

AGE.....24

ARMED FORCES.....26

ORGANISATIONAL INCLUSION27

Summary of Actions for Equality, Diversity, and Inclusion 2026-2028 .28

FOREWORD

Welcome to the East Sussex Healthcare NHS Trust (ESHT) Annual Equality Report for 2025-26. This document reviews our progress in advancing equality, diversity, inclusion and belonging within our Trust and covers the period between April 2025 and March 2026.

Over the past year, we have worked to create an environment where all colleagues and patients feel valued, respected and supported. This report provides information on our Ethnicity, Disability and Gender Pay Gap analysis, Workforce Equality Standards, and progress in delivering the NHS England Equality, Diversity and Inclusion Improvement Plan. It also highlights our wider work to promote fairness across our organisation.

We recognise that achieving equality requires ongoing reflection, learning and action to address the diverse needs of our workforce and the communities we serve. This report outlines our achievements and identifies areas for further progress, supporting transparency and accountability.

We aim to embed equality, diversity, inclusion and belonging into all aspects of our work. A diverse workforce where people feel they belong strengthens our ability to deliver high-quality care and improves patient experience.

Patient information is published separately to maintain confidentiality and to ensure this report remains focused on workforce-related matters. We encourage colleagues, patients and community partners to engage with this report and support our efforts to build a fairer healthcare system.

Thank you for your interest in our equality journey. Together, we can continue to build an organisation where everyone belongs, can thrive and is able to deliver outstanding care for our patients.

Equality Objectives 2022-2026 (summarised)

- 1) Implementing inclusive talent management strategies to address diversity
- 2) Specific and measurable EDI objectives for senior leaders
- 3) Develop and implement improvement plans to eliminate pay gaps
- 4) Create and execute a plan to reduce workforce health inequalities
- 5) Implement a comprehensive programme for onboarding and developing international staff
- 6) Foster a workplace environment free from bullying, discrimination, harassment, and violence.



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 Appointment Likelihood: Multicultural colleagues make up 25.5% of the workforce, with Board representation decreasing slightly at 13.33%. Multicultural applicants are 0.4 times less likely to be appointed from shortlisting compared to white applicants, showing improvement from the previous year and placing ESHT in the non-adverse range.

ii. Training and Disciplinary Processes: White people are less likely to access non-mandatory training compared to multicultural colleagues. Multicultural individuals were 0.41 times less likely than white individuals to enter the formal disciplinary process

iii. Harassment and Discrimination: 32.64% of multicultural colleagues reported experiencing harassment from patients and 25.56% from colleagues. Additionally, 14.99% experienced discrimination at work from their manager, which is 8.2% higher than their white counterparts.

iv. Promotion Opportunities: 47.11% of multicultural colleagues believe the Trust provides equal opportunities for promotion, which is lower than the 54.17% reported by white staff.

v. The Board's composition includes 86.7% white and 13.3% multicultural colleagues, indicating a -12% 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 80.2%, a 1.2% increase over the past 12 months. However, 19.8 % of colleagues still choose not to disclose their religion.

vii. Faith and Belief Network Growth: The Faith and Belief Network has increased membership to 87. The network has been working with the Multicultural Network to

host joint events recognising intersectionality.

viii. Harassment and Discrimination: There has been a decrease in reported incidents of bullying and harassment from patients or their carers among Buddhists, Hindus however Muslim and Jewish have experienced an increase.

ix. Career Progression Opportunities: On average, 52.45% of colleagues felt ESHT provides fair treatment in promotions. By religion, the group with the lowest proportion was Buddhist, at 26.19%.

SEX (page 13)

x. Workforce Distribution: The workforce is 74.8% female and 25.2% male, with a slight increase of 0.4% in male employees over the past year. Representation data for Trans or non-binary individuals remains unavailable.

xi. Bullying and Discrimination: In the past twelve months, the gap between the percentage of female employees (17.5%) and male employees (17.01%), who reported instances of harassment, bullying, or abuse from colleagues, has decreased by nearly 3% making them nearly equal. Non binary experienced an increase of 15% over the past twelve months making this group the highest

xii. Gender Pay Gap: women earned £0.82 for every £1 that men earned when comparing mean wages. When comparing median hourly wages, women's mean hourly pay is 11.4% lower than men's and an increase of 5.4% than the previous twelve months.

xiii. Currently, women hold 65.4% of the highest paid positions and 78% of the lowest paid positions within the organisation.

SEXUAL ORIENTATION (page 16)

xiv. LGBT 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 LGBT compared to other bands.

xv. 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 decrease.

xvi. Career Progression: 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

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

DISABILITY (page 18)

xviii. Disability Representation: 8.3% of the workforce shared that they identify as disabled on their electronic staff record, with 5.6% choosing not to share their disability status. This represents a nearly 7% reduction in people who previously did not share their disability status over the past 12 months.

xix. Appointment Likelihood: The appointment ratio improved to 0.92 this year, indicating that disabled applicants were slightly more likely to be appointed from shortlisting than non-disabled applicants. This result is within the non-adverse range as per NHS England guidance, demonstrating equitable recruitment outcomes.

xx. Harassment and Bullying: 29.24% of disabled colleagues reported experiencing harassment, bullying, or abuse from patients, relatives, or the public, which is a small reduction from 29.72% the previous year and fourth consecutive annual decrease. Reports of harassment from managers also dropped to 14.5% continuing a five-year downward trend. However, this remains notably higher than the rate reported by non-disabled colleagues at 8.92%.

xxi. Workplace Adjustments and Promotion: 76.6% of disabled colleagues felt that ESHT made adequate adjustments to enable them to work. Whilst this represents a 2.06% decrease from the previous year, it remains above the NHS Staff Survey benchmark median of 73.65%, indicating that most disabled colleagues continue to feel supported through workplace adjustments. 47.06% of disabled colleagues felt ESHT provided equal opportunities for promotion, a 0.67% decrease from the previous year.

AGE (page 18)

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 69.23% and 55.51% respectively. The lowest score was recorded by the 51-65 year age group at 49.63%.

ARMED FORCES (page 19)

xxii. ESHT continues to actively support the Armed Forces community, advocating for awareness and engagement through partnerships, events and support.

xxiii. In September 2025, ESHT was awarded in the Gold Defence Employee Recognition Scheme by the Ministry of Defence (MoD) and in November 2025, ESHT won the HSJ Award for Military and Civilian Health Partnership of the Year.

ORGANISATIONAL INCLUSION (page 20)

xxiv. 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

xxv. The findings indicate areas of progress, particularly increasing representation, with some barriers to inclusion still requiring action. Whilst progress continues across many measures, persistent inequalities remain for some groups; a focus for the 12 months ahead.

xxvi. Across 2026-28 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 2025-26

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 wider organisational strategies, particularly those relating to patient experience and staff wellbeing.

The report is made up of nine sections that reflect our aspirations across: age, armed forces 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 in our work to eliminate discrimination, including harassment.
- Each section then ends with next steps to address the findings that underpin the 2026/28 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 13*) 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 18*).

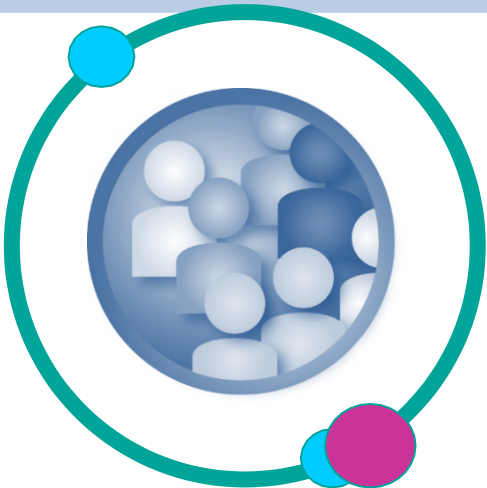
It also provides the progress on our Equality, Diversity and Inclusion objectives 2025-2026. Organisational objectives for EDI will need to be developed in 2026 as part of the public sector equality duty.

RACE (including ethnicity pay gap)

The proportion of our multicultural colleagues grew by 3.5% over three years across ESH. In 2025, multicultural colleagues represented 25.5% of the workforce.

Multicultural individuals were 0.41 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 2025-26 ESH's Multicultural Network brought people together from different backgrounds committed to valuing individuality, supporting inclusion and promoting diversity. Key achievements include:
- Successful system wide Black History Month event and multiple networking events held.
 - ESH introduced the allyship pledge following listening events with the networks.
 - The multicultural network membership grew to 275 a 59% increase in members.

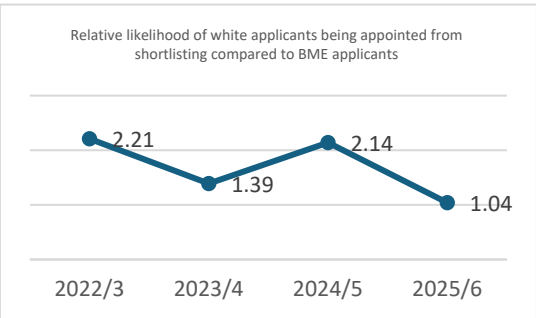
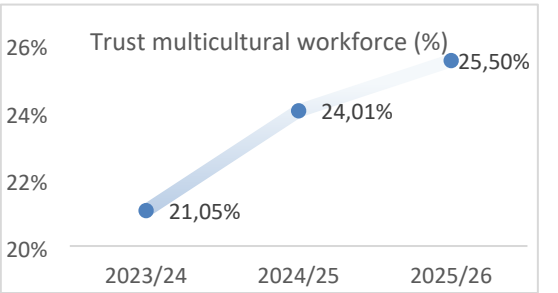
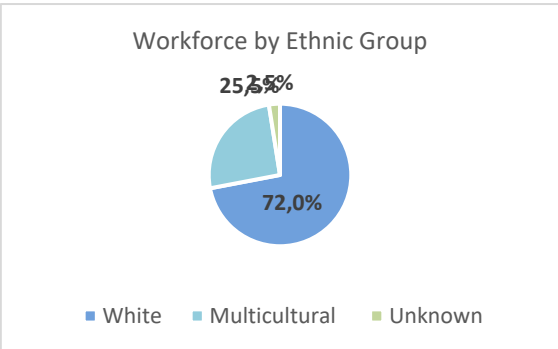


KEY FINDINGS: RACE

Workforce ethnicity representation (WRES 1)



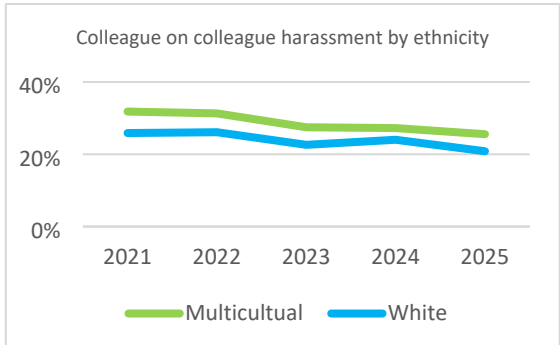
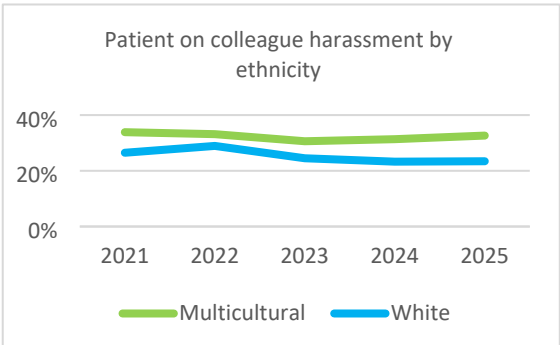
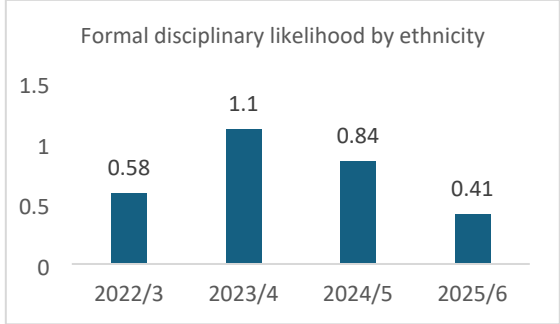
- 1.2. The number of multicultural people in the workforce as of 31st March 2026 was 2216, or 25.5% of the workforce overall. The Trust's multicultural workforce has grown by over 3.5% over the past three years.
- 1.3. Multicultural representation in Medical and dental colleagues was 55.3% (n.512). Clinical staff was 27.7% (n. 1507). Clinical Staff on Agenda for Change (AfC) pay band 5 had the largest proportion of multicultural colleagues in any AfC pay band at 50.45% (n.617), followed by band 6 at 27.04% (n.338), then band 3 at 25.9% (n.344).
- 1.4. Multicultural representation in non-clinical workforce was 8.7% (n.207) an increase of just over 1% in the last 12 months. The largest representation of multicultural colleagues was AfC band 8d at 33.3% (n.3).
- 1.5. Non-clinical AfC 8c- 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 2025-26, 282 individuals from a multicultural background and 557 white individuals were appointed. Multicultural applicants are 0.4 times less likely to be appointed from shortlisting compared to white applicants. This represents a positive trend from the previous year, when white individuals were 2.14 times more likely to be appointed and puts us in the non-adverse range for the first time in 4 years.



Formal disciplinary likelihood by ethnicity (WRES 3)

1.7. Multicultural individuals were 0.41 times less likely than white individuals to enter the formal disciplinary process. In 2025-26, 0.14% (n.16) of the total workforce underwent the formal disciplinary process. Whilst the ratio score of 0.41 falls outside the non-adverse likelihood range set by the NHS WRES strategy team, small numbers should be interpreted with caution.

Non-mandatory training (WRES 4)

1.8. White people were 0.66 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, 32.64 % of multicultural colleagues reported experiencing harassment, bullying, or abuse from patients, relatives, or the public, marking an increase of 1.29% from 2024 and. ESHT's figure is 3.66% higher than the provider benchmark of 28

1.10. In the past 12 months, 25.56% of multicultural colleagues experienced harassment, bullying, or abuse from other colleagues, which is 1.69% lower than 2024 and the lowest score in 5 years. ESHT remains higher than the provider benchmark by 1.5% but ESHT's target of reducing this to 25.9% over two years has been met. Addressing this issue will remain a priority for ESHT.

Racial equality of opportunity for promotions (WRES 7)

1.11. 47.17% of multicultural colleagues reported that the Trust provides equal opportunities for promotion, showing a positive increase of 2.42% from 2024. ESHT sits below benchmark average by 2%.

Manager on staff discrimination by ethnicity (WRES 8)

1.12. In 2024, 14.99% of multicultural colleagues experienced discrimination at work from their manager or team leader. This represents an 8.72 % difference compared to the 6.27% of white colleagues reporting the same experience. ESHT figures are slightly above benchmark average at 14.70%.

Board ethnicity membership (WRES 9)

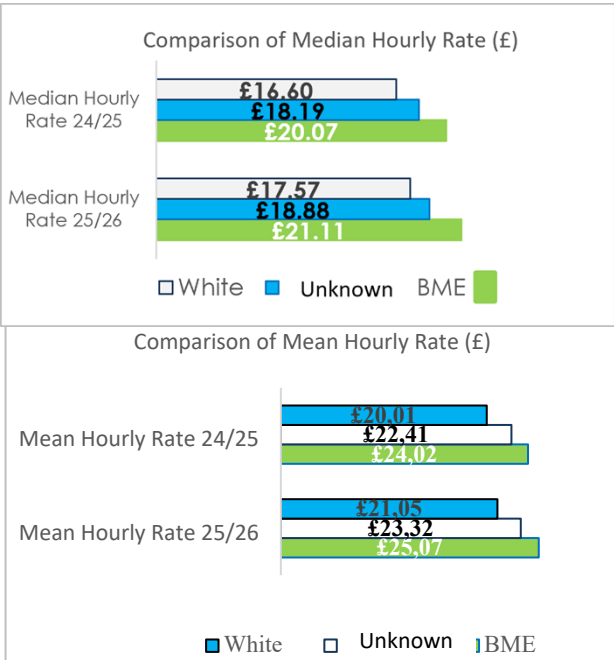
1.13 The Board, including voting and executive members, was composed of 86.7% white and 13.3% multicultural. There is a -12% difference between multicultural representation in the overall workforce.

Ethnicity Pay Gap

Mean ethnicity pay gap

1.14 The mean ethnicity pay gap is a positive gap of +19.1%. This has decreased (-0.9%) from the previous year. The mean hourly rate for staff from ethnic minority groups (£25.07) remains higher than that of White staff (£21.05). However, over the past year, white staff experienced a slightly higher increase in mean hourly rate of +5.2% compared to staff from ethnic minority groups at +4.4%.

Median ethnicity pay gap 1.15 The median ethnicity pay gap is 20.2% in favour of staff from ethnic minority groups. This represents a slight decrease - 0.7% compared to the previous year. The median hourly rate for staff from ethnic minority groups is £21.11, compared to £17.57 for White staff. Both groups have experienced increases in median hourly pay since 2024/25, with an increase of 5.8% for White staff and 5.2% for staff from ethnic minority groups.



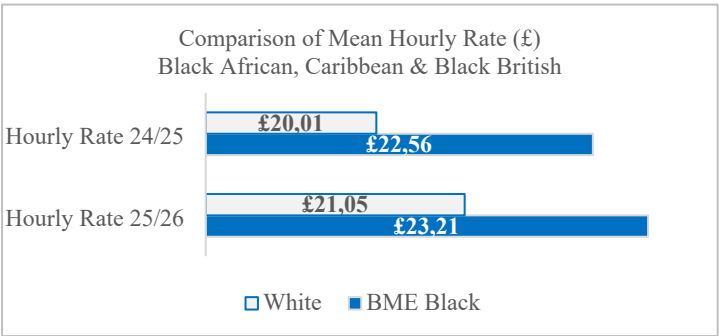
Pay gap by ethnicity	Ethnic minority groups	White	% gap
Mean hourly rate	£25.07	£21.05	+19.1
Median hourly rate	£21.11	£17.57	+20.2

Disparity between the mean and median pay gaps for Black African/Caribbean/Black British staff and Asian/Asian British staff

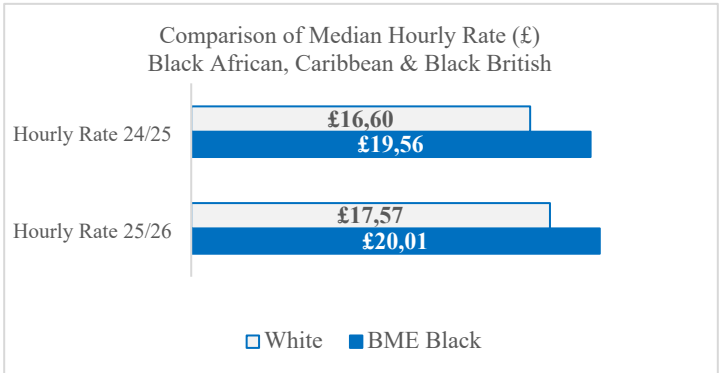
1.16 Black African, Caribbean, and Black British staff make up 16.1% of those who identify as BME, and 4.1% of the Trust’s overall workforce.

Pay gap by ethnicity	Black African/ Caribbean/Black British	White	% gap
Mean hourly rate	£23.21	£21.05	+10.3%
Median hourly rate	£20.01	£17.57	+13.9%

1.17 For Black African, Caribbean and Black British staff, the mean pay gap is +10.3% in their favour. This represents a reduction of -4.1% compared to 2024/25, indicating a narrowing of the pay advantage for this group. The mean hourly rate for Black African, Caribbean and Black British staff is £23.21.



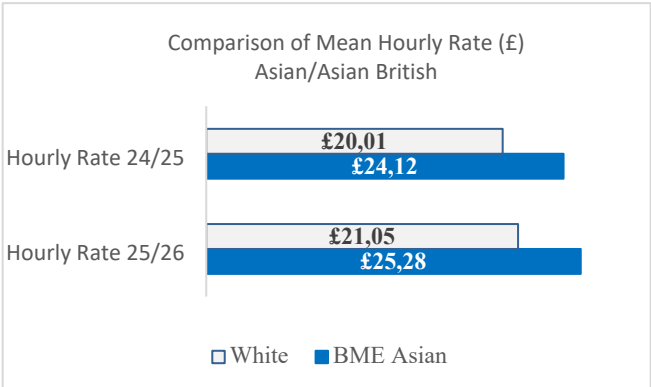
1.18 The median pay gap for Black African/Caribbean/Black British staff is a positive gap of +13.9%. This is a reduction of -3.9% since 2024/25. The current median hourly rate for Black African/Caribbean/Black British staff is £20.01.



1.19 Asian/Asian British staff, staff make up 65.5% of those who identify as BME, and 16.7% of the Trust’s overall workforce.

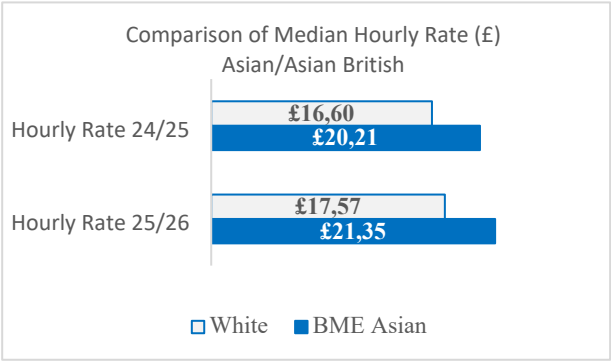
Pay gap by ethnicity	Asian/Asian British	White	% gap
Mean hourly rate	£25.28	£21.05	+20.1%
Median hourly rate	£21.35	£17.57	+21.5%

1.20 For Asian/Asian British staff, the mean pay gap is a positive gap of +20.1%. This is a decrease of -0.4% from 2024/25. The mean hourly rate for Asian/Asian British staff is £25.28.



1.21 The median pay gap for Asian/Asian British staff is positive gap of 21.5%. This is light decrease of 0.2% from the 2024/25 period. The median hourly rate for Asian/Asian British staff is £21.35

1.22 Based on the entirety of the Total full pay relevant Employees in ESHT, 9.6% of all Asian/Asian British staff and 12.2% Black African/Caribbean/Black British colleagues are in the lowest pay quartile compared to 30.5% of White colleagues.

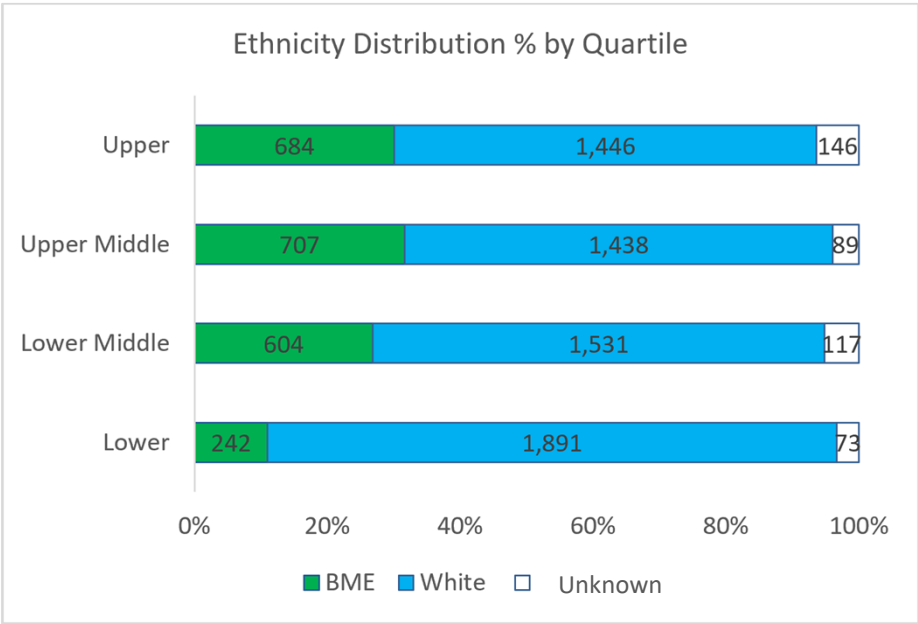


1.23 Within the Medical and Dental group, Asian colleagues are proportionally well represented (37.9%), with 349 staff equating to nearly a quarter of the Trust’s Asian workforce. Black colleagues account for 6.8% (n.63), representing a smaller but still notable proportion of the overall Black workforce (17.5%), while White colleagues, despite being the largest workforce group overall (n.6306), are less represented in these roles (5.6%).

Ethnicity distribution by pay quartiles

1.24 Quartiles are calculated by ranking the hourly pay rates for each member of staff from lowest to highest, before splitting the ranking into four equal-sized groups and calculating the percentage of staff from ethnic minority groups and the percentage of white staff in each group.

1.25 Pay quartiles divide all colleagues into four equal groups based on their pay, ranging from the lowest to the highest earners. The lower quartile contains the lowest-paid 25% of staff, while the upper quartile contains the highest-paid 25%.



1.26 While BME colleagues make up 25.5% of the Trust’s workforce, their representation varies across pay quartiles. They are more highly represented in the upper pay bands (30.1% in the upper quartile and 31.6% in the upper middle), broadly aligned in the lower middle quartile (26.8%), but not proportionately reflected in the lowest pay quartile at 11.0%, (a gap of 14.5%)

NEXT STEPS FOR RACE EQUALITY 2026-28

- Implement reciprocal mentoring, targeted leadership development and transparent career pathways to improve progression opportunities and career confidence for multicultural colleagues.
- Embed ethnicity equality measures within workforce governance arrangements, ensuring recruitment, disciplinary, promotion and leadership diversity data are reviewed annually and action taken where disparities are identified.
- Embed the Allyship Programme, behavioural framework and speaking-up initiatives to reduce experiences of bullying and harassment experienced by multicultural colleagues.
- Embed the recommendations from the Lord Mann Review.

RELIGION AND BELIEF

The proportion of colleagues (80.2%) sharing their beliefs has grown by 1.2% over the past 2 years.

Reporting of harassment, bullying and abuse from patients, relatives or carers increased across most religion groups, suggesting greater confidence in speaking up and reporting concerns.

- 2.1. ESHT’s Faith and Belief Network grown to 87 members over the last 12 months, a 33% increase. Key achievements included:
- Continuing to provide support for Ramadan celebrations.
 - Hosting the Hastings and Rother Multifaith Forum, featuring an evening talk on healthcare and faith.
 - Supporting the LGBTQIA+ Network to host a Trans Remembrance Day event.

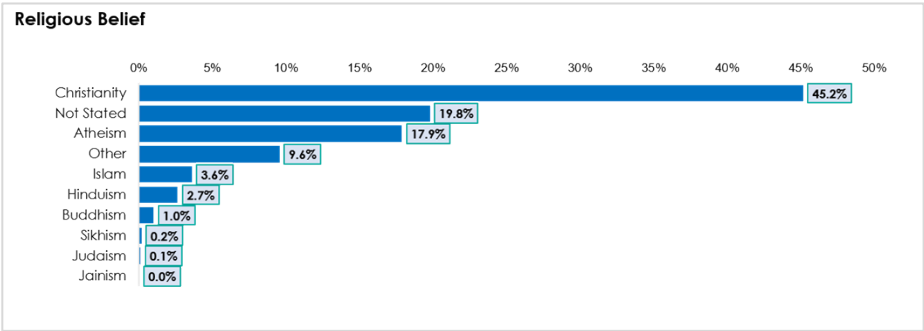


KEY FINDINGS: RELIGION AND BELIEF

Workforce religion and belief representation

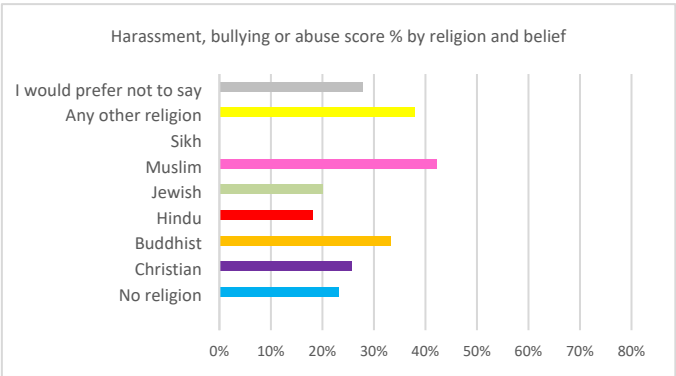


- 2.2. The number of people sharing their religion or belief with the Trust at 31 March 2026 was 80.2% of the workforce. Colleagues in agenda for change (AfC) pay band 9 had the largest proportion sharing their religious status at 91.7%, followed by band 5 at 84.1%. Over 12 months the proportion of colleagues sharing their belief information increased by 1.2%, a positive trend over the last three years.
- 2.3. Colleagues sharing, they were Christian was the largest belief group at 45.2%, followed by Atheism at 17.9%.
- 2.4. The proportion of all colleagues sharing that they identify as religious remained relatively static over five years.



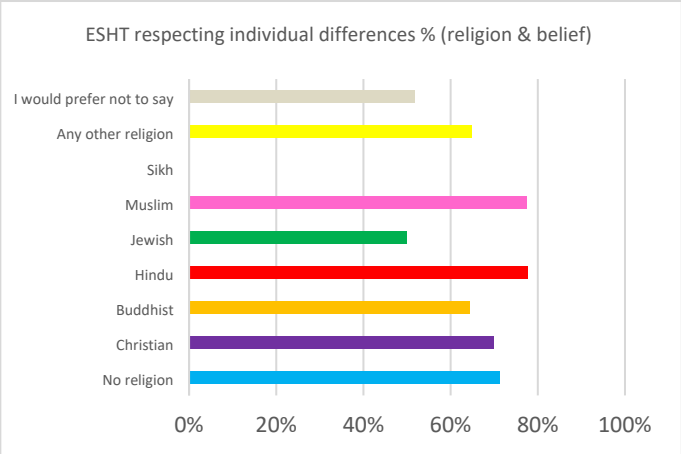
- 2.5. There is an increase in representation for Christianity, Atheism, Islam and Hinduism over the last 12 months. The score is rated green because of the increase in colleagues choosing to share their religion with us.

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



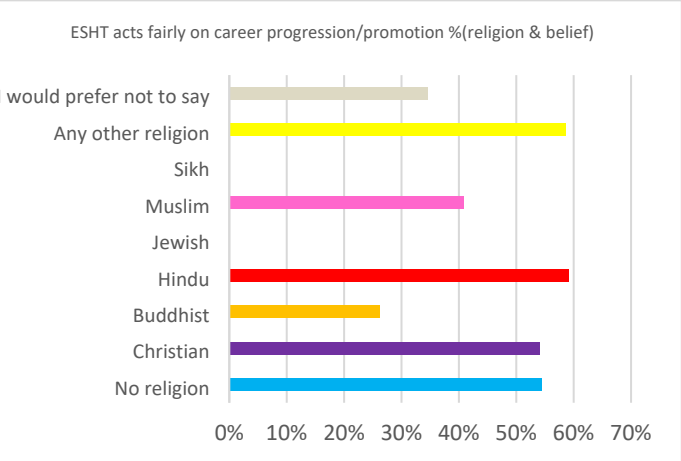
2.6 In the past year, "We are safe and healthy" measured responses from the staff survey 2025 concerning personal experiences of harassment, bullying, or abuse from patients, relatives, members of the public, managers, and colleagues through nine specific questions. There has been a decrease in reported incidents of bullying and harassment from patients or their carers among Buddhist, Hindu colleagues, however Jewish and Muslim colleagues have experienced an increase.

Religion and belief: We are compassionate and inclusive.



2.7. "We are compassionate and inclusive" pertains to a series of eight questions drawn from the staff survey 2025 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 Buddhist colleagues who choose not to disclose their religion recorded the lowest score at 26%, with colleagues preferring not to share religion following at 35%. Conversely, Hindu colleagues achieved the highest score at 59%.



Religion and belief equality of opportunity for career progression/promotions



2.9 Overall, on average, 52.45% of colleagues indicated that ESHT provides fair treatment in promotions. By religion, the group with the lowest proportion was those who are Buddhist, at 26.19%, with colleagues preferring not to share religion following at 35%. Conversely, Hindu and those colleagues stating 'any other religion' achieved the highest scores at 59%.

NEXT STEPS FOR RELIGION AND BELIEF EQUALITY 2026-28

- Increase diversity of membership with the Faith and Belief Network to encourage open conversation between different faith groups.
- Embed the recommendations from the Lord Mann Review.
- Organise and host multifaith events to promote understanding and inclusivity among employees of different faiths and beliefs.
- Working in collaboration with other networks to promote intersectionality, allyship and increase confidence discussing faith at work.

SEX (including Gender Pay Gap)

Over the past year, the male workforce has seen an increase of 0.4%, resulting in a current distribution of 74.8% female and 25.2% male employees. Representation data for Trans or non-binary individuals remains unavailable.

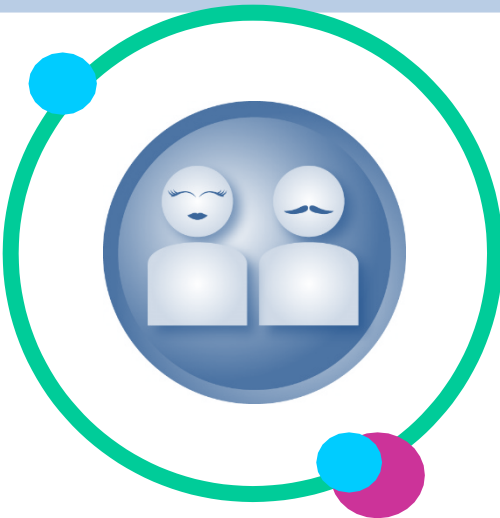
Regarding pay equity, for those in AfC bandings for every £1 earned by men, women earned £0.99 but this is reduced to £0.82 when taken as the organisation overall. In terms of job distribution, women occupy 65.4% of the senior positions (Upper quartile). However, their representation is lower in medical and dental roles at 46.5%.

The Women’s network is ESHT’s largest network with an increase in membership of over 100 making the network 340 colleagues strong.

- 3.1. Across 2025-26 ESHT continued its work to promote gender equality between men, women, non-binary people and trans people. Key achievements include:
- Successfully organising and hosting an engaging event in celebration of International Women's Day and Trans Remembrance Day

• Continues monthly Fireside chats with inspirational women in business and health hosted by the Women’s Network including themes such as Inspiring Allies and hearing from ESHT’s own women in leadership.

• Promotion of Allyship within the Women’s network with members taking part in the introductory video.

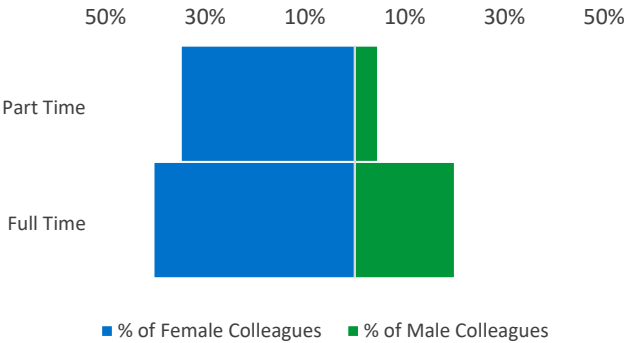


KEY FINDINGS: SEX

Workforce gender representation

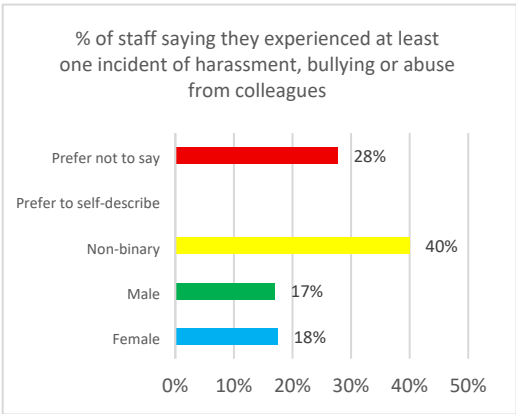
- 3.2. Out of 8,741 staff, 74.8% were recorded as female and 25.2% as male on their Electronic Staff Records (ESR). The proportion of the male workforce grew by 0.4%%.
- 3.3. The female workforce in Agenda for Change pay bands was 76.8% compared to 43.8% of females with medical and dental contracts.
- 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.

Gender Distribution - Part Time / Full Time
Headcount % of the Organisation

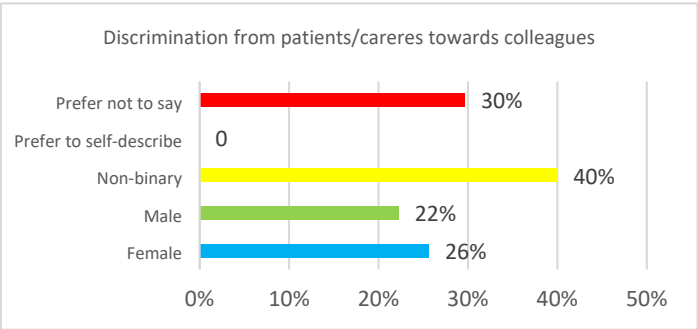


Harassment, bullying or abuse from staff (Female, Male, Non-binary, Prefer to self-describe, Prefer not to say)

- 3.5. In the past twelve months, the gap between the percentage of female employees (17.5%) and male employees (17.01%), who reported instances of harassment, bullying, or abuse from colleagues, has decreased by nearly 3% making them nearly equal. Non-binary experienced an increase of 15% over the past twelve months, making this group the highest with individuals identifying as ‘prefer not to say’ reported a reduction in incidence from 34.6% to 27.74%.



Discrimination from patients, relatives, or members of the public (Female, Male, Non-binary, Prefer to self-describe, Prefer not to say)



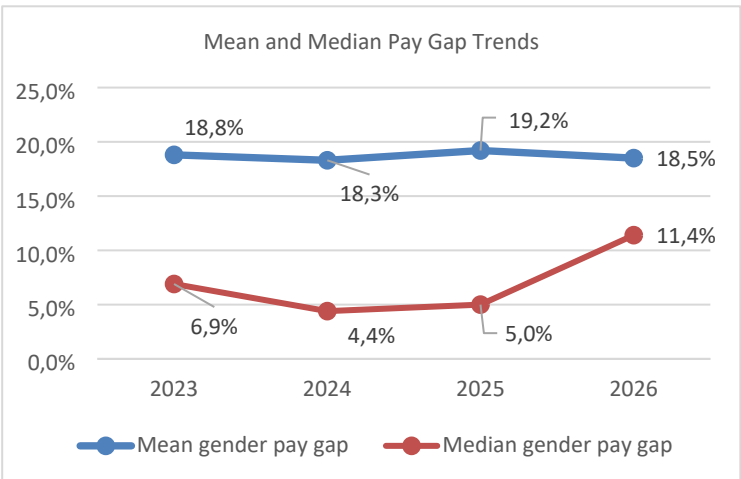
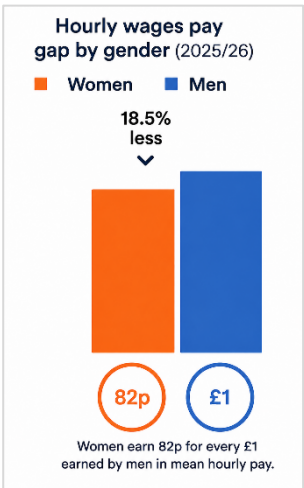
3.6 There was a 4% disparity between the percentage of males (22%) and females (26%) reporting discrimination from patients, relatives, or members of the public in the last twelve months, marking a decrease in disparity over the last twelve months trend. Those who selected ‘Non-binary’ reported the highest incidence of discrimination at 40%.

Gender Pay

3.7. In ESHT, women earned £0.82 for every £1 that men earned when comparing mean hourly wage. A decrease from the previous 12 months. In ESHT, women earned £0.89 for every £1 that men earned when comparing median wages.

3.8. When comparing mean hourly wages, women’s mean hourly pay is 18.2% lower than men’s. This has been a decrease in the previous 12 months. Their median hourly wages are 11.4% lower than men’s, an increase of 5.4%.

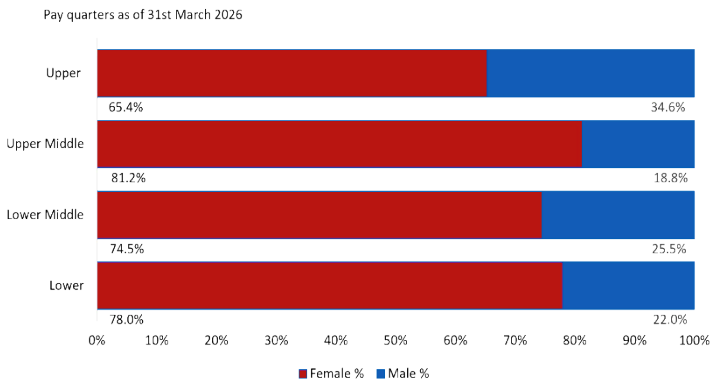
3.9. Both mean and median pay gaps are reported because they provide different insights into pay equality. Together, these measures show that the gender pay gap is driven by the distribution of men and women across occupations and grades rather than unequal pay for equal work.



3.10. 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 increased by 0.8% in 25/26 whilst the difference for Agenda for Change & Executive staff, has decreased by 0.4% with males earning more than females in two consecutive years.

Agenda for Change and Medical & Dental	Male	Female	% diff
Agenda for Change - Median hourly rate 31/3/24	£16.40	£16.62	-1.3%
Agenda for Change - Median hourly rate 31/3/25	£17.81	£17.72	0.5%
Agenda for Change - Median hourly rate 31/3/26	£18.67	£18.65	0.1%
Medical & Dental - Median hourly rate 31/3/24	£37.98	£31.31	17.6%
Medical & Dental - Median hourly rate 31/3/25	£43.72	£36.55	16.4%
Medical & Dental - Median hourly rate 31/3/26	£44.99	£37.27	17.2%

Proportion of women in each pay quarter

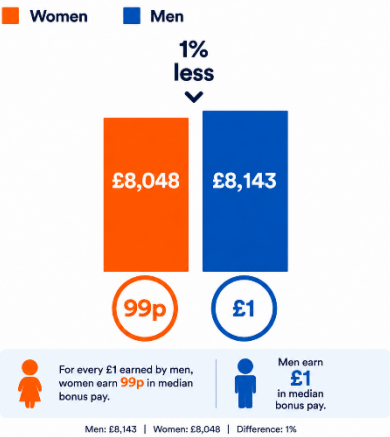


3.11. Pay quarters are determined by dividing all employees into four equal groups based on their pay. Analysing the representation of women in each quartile provides insight into their distribution across different levels within ESHT. Currently, women hold 65.4% of the highest paid positions and 78% of the lowest paid positions within the organisation.

Gender bonus gap



Median gender bonus gap 2025/26



3.12. In ESHT, women earn £0.99 for every £1 that men earn in terms of median bonus pay, indicating a gender pay gap of 1.0%. In regard to mean bonus pay, the gender pay gap for 25/26 is 23.2%.

3.13. The percentage of female staff receiving bonus payments in 2024-2025 increased by 0.9% to 24.6%. However, as these bonuses apply exclusively to medical staff, the most meaningful comparison is against the gender profile of the eligible group, specifically Consultant medical staff.

3.14. Within the Trust’s 322 Consultants, 33.9% are female and 66.1% are male. When comparing this to the proportion of bonus recipients, there is a - 9.2% point gap for female staff, indicating that women are under-represented among those receiving bonuses relative to their share of the Consultant workforce.

NEXT STEPS FOR GENDER EQUALITY 2026-28

- Increase the representation of women in senior leadership and underrepresented staff groups through career development and supported by the Leadership and Management Framework.
- Embed the Trust’s Sexual Safety Charter and continue to promote a culture where sexual misconduct is challenged, concerns are reported confidently and colleagues feel safe at work.
- Develop and embed an inclusive talent management approach.
- Use lived experience, staff engagement and network feedback to co-produce actions that address barriers to progression.
- Review policies, guidance and workplace facilities to ensure continued compliance with changes to equality legislation and support an inclusive environment for all colleagues

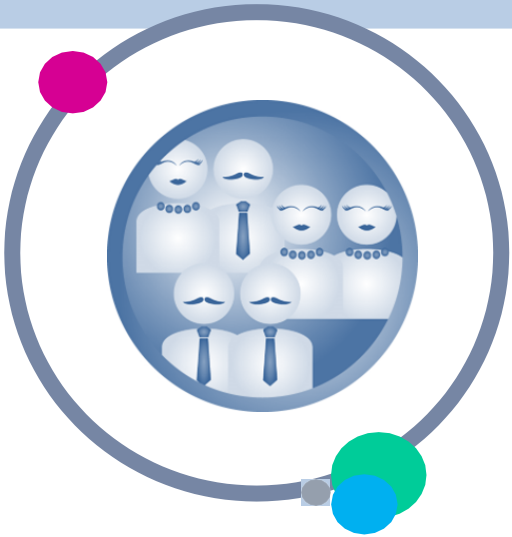
SEXUAL ORIENTATION

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.

Almost all sexual orientation groups experienced a slight rise in discrimination from patients and carers whilst those describing as 'Other' reported a decrease.

Currently, there are 150 registered members in the LGBTQIA+ network a 45% increase from 2024/25.

- 4.1. Across 2025-26 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 new Chair, Vice-Chair and Executive Sponsor to the LGBTQIA+ Network
 - Strengthening its internal governance and expanding external partnership working, including supporting a local charity through a quiz fundraising event.
 - Participation in Hastings and Eastbourne Pride Parades.



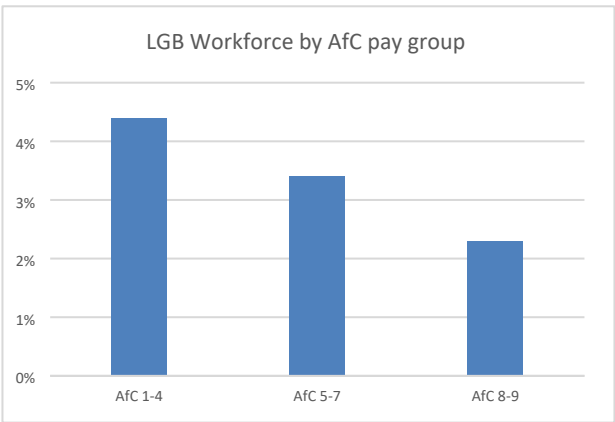
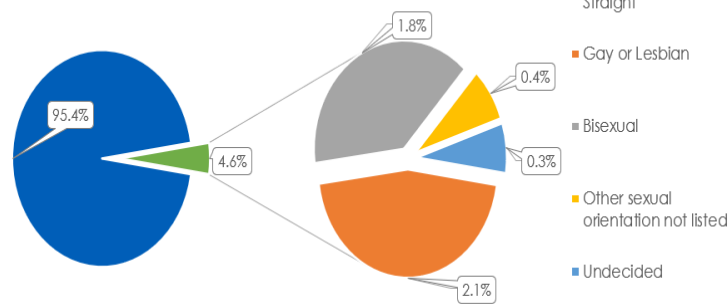
KEY FINDINGS: SEXUAL ORIENTATION

Workforce sexual orientation representation

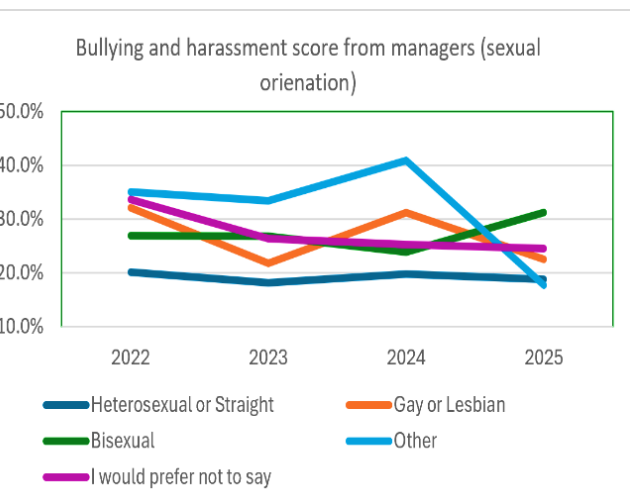
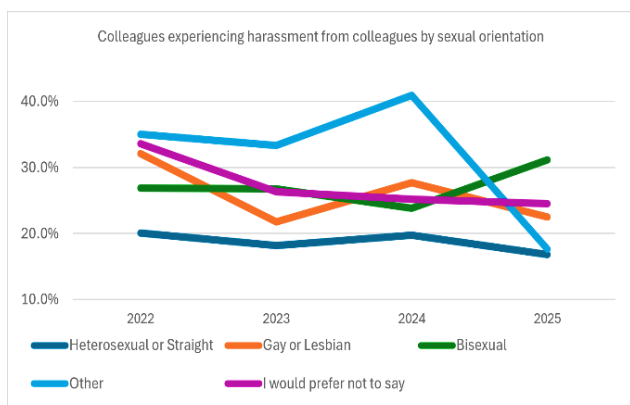
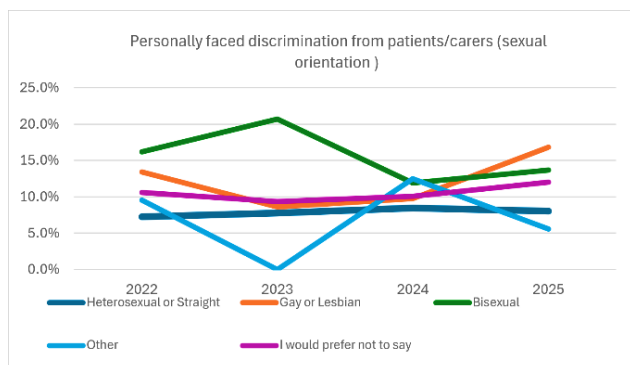
- 4.2. The number of people sharing their sexual orientation as LGB with the Trust at 31 March 2026 is 293.
- 4.3. In terms of sexual orientation, the breakdown among the workforce is as follows:
- Heterosexual: The largest group comprising 95.4% of colleagues.
 - Gay or lesbian: Representing 2.1%
 - 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 4.4% each, compared to 3.8% in the workforce overall.
- Correspondingly the lowest proportion of LGB on ESR was in Agenda for Change pay bands 8a-9 at 2.3%.

Sexual Orientation

This information does not include sexual orientations that are not stated



Safe environment (bullying and harassment) by sexual orientation



4.5. 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 8.89% of 4271 responding to the staff survey. The group with the lowest score was those colleagues describing their sexual orientation as Other at 4.6%. Gay and lesbian colleagues experienced a marked increase of 7.14%, whilst Bisexual colleagues also saw an increase of 1.8% in 2025.

Colleagues experiencing harassment from colleagues by sexual orientation

4.6. In ESHT 31.2% of employees who identified as "Bisexual" in terms of sexual orientation reported experiencing at least one incident of bullying, harassment, or abuse from colleagues. The next highest group was those preferring not to say, with 24.5% reporting such incidents. All groups experienced a decrease in incidents apart from Bisexual colleagues. Heterosexual, gay or lesbian and 'other' colleagues experience the largest decreases.

Colleagues experiencing harassment from managers by sexual orientation

4.7. 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 decrease.

Equality of opportunity for career progression/promotions by sexual orientation

4.8. 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 Trans Awareness Week 2025

The LGBTQIA+ Network also marking Trans Awareness Week for the first time in ESHT, with awareness stands, information resources and a reflective space working alongside the Faith and Belief Network and hosted by Chaplaincy for Transgender Day of Remembrance, helping to increase understanding and visibility of trans inclusion across the organisation.

NEXT STEPS FOR SEXUAL ORIENTATION EQUALITY 2026-28

- Enhance online training provision for LGBTQIA+ learning opportunities to improve understanding of LGBTQIA+ inclusion and create psychologically safe working environments.
- Continue to grow LGBTQIA+ network and strengthen allyship across the Trust through awareness, education and engagement
- Review policies, guidance and workplace facilities to ensure continued compliance with changes to equality legislation and support an inclusive environment for all colleagues.

DISABILITY (including disability pay gap)

According to electronic staff records, 8.3% of the NHS workforce identifies as disabled, while 5.6% chose not to disclose their disability status. Disabled individuals were 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, 76.60% of disabled colleagues felt that adequate adjustments were made to enable them to work, marking an decrease of 2.06% from the previous year. The (dis)Ability network has 247 registered members, and the Neurodiversity Network has 183 registered members.

5.1 Across 2025-26 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 of embedding the Centralised reasonable adjustments process.
- Introduction of AccessAble Guides for ESHT sites.
- The Neurodiversity Network celebrating its first anniversary, reflecting sustained engagement and growing visibility of neurodivergent colleague voices within the organisation.

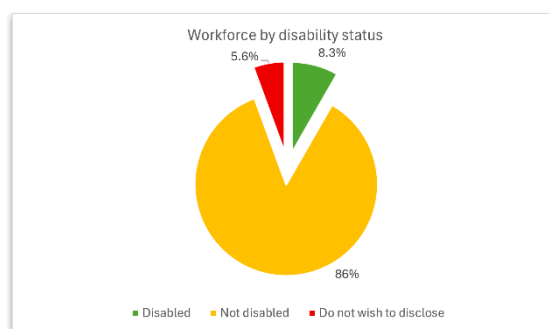


KEY FINDINGS: DISABILITY

Workforce disability representation (WDES 1)



5.2 The number of people sharing their disability with the Trust at 31 March 2026 on their staff record was 621, or 8.3% of the workforce marking an increase on the previous 12 months. The group not wishing to share their disability status is at 5.6%, which is a decrease of 6.47% over the preceding 12 months. There were 27% (n.1110) of 4298 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 1-4 had the largest proportion of disabled colleagues at 8.2% closely followed by bands 8a-9 with 8.1%. The lowest proportion of disability representation was at AfC band 1-4 with 7.8% sharing they have a disability. Showing increases across all paybands

Shortlisting-to-appointment by disability (WDES 2)



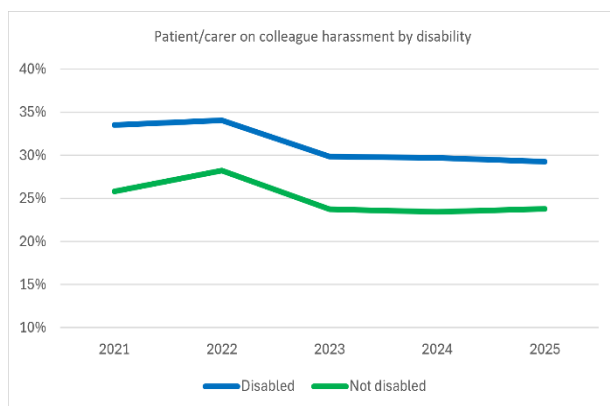
5.4 People without a disability were 0.08 times more likely to be appointed from shortlisting than people with a disability. This is an improvement from last year's score of 1.04 and falls within the non-adverse range as detailed by the NHS national reporting team.

Formal capability likelihood by disability (WDES 3)



5.5 People with a disability (n.2.5) were 1.5 times more likely to enter the formal disciplinary process than people without a disability (n.11). This is a decline from last year's score of 1.2 where disabled colleagues were 20% more likely to enter the formal disciplinary process. A score of 1.5 is outside the 0.8 – 1.2 threshold the NHS national reporting team regards as non-adverse, although small numbers should be interpreted with caution.

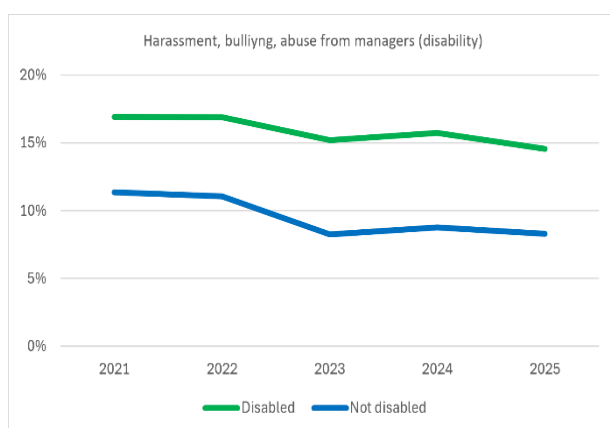
Harassment, bullying or abuse by disability (WDES 4)



5.6 In the 2024 staff survey 29.2% of disabled colleagues reported experiencing harassment, bullying, or abuse from patients, relatives, or the public in the past 12 months. This figure represents a 5.47% difference compared to the 23.8% of non-disabled colleagues who reported similar experiences. The difference has decreased by 0.5% over the past 12 months and it remains lower than benchmark average.



5.7 The survey showed that 14.45% of disabled colleagues reported experiencing harassment, bullying, or abuse from managers, significantly higher than the 8.29% reported by non-disabled colleagues.

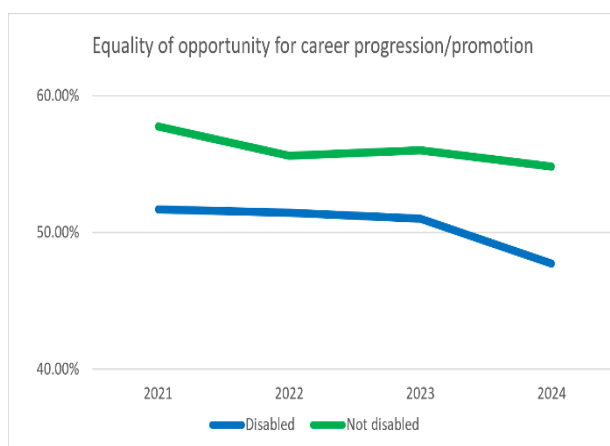


5.8 Additionally, 24.5% of disabled colleagues faced similar issues from other colleagues, over an 8-point difference compared to the 15.57% of non-disabled colleagues. This represents a decrease in experience for disabled colleagues and non-disabled colleagues by 1.83% and 2.76% respectively.

Disability equal opportunities for promotion (WDES 5)



5.9 47.06% of disabled colleagues felt ESHT provided equal opportunities for promotion in 2025. There is a 7.3% difference in results from disabled colleagues in comparison at 54.36% figure reported by non-disabled staff. ESHT falls 0.73% lower than benchmark average for disability equality in opportunities for promotion.



Pressure to work when unwell by disability (WDES 6)



5.10 20.10% of disabled colleagues felt management pressure to come to work when not feeling well enough, which is an improvement of 3.59% over the past 12 months and a positive trend over two years.

5.11 The difference between disabled and non-disabled colleagues reduced to 4.53%, which is a 3.21% decrease 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)



5.12 32.88% of disabled colleagues felt the Trust valued their work. This is a 11.8% difference from the 43.90% of reported by non-disabled staff, indicating decline since 2024 figures. Both scores are similar to that of the disabled provider benchmark.

Adequate adjustments for disabled people (WDES 8)



5.13 76.60% of disabled colleagues felt ESHT made adequate adjustment(s) to enable them to carry out their work. A decrease of 2% over the previous twelve months. This score is still 3% higher than the benchmark average and when looking at numbers of respondents there is a 40% increase in numbers of respondents since the centralising of reasonable adjustments was put in place.

Staff Engagement Score (WDES 9a)



5.14 The staff engagement score for disabled colleagues (6.31) remains below that of non-disabled colleagues (6.81) although almost equal to that of the benchmark group (6.29).

Board disability membership (WDES 10)



5.14 Board workforce representation, including voting and executive members, was 66.67% non-disabled, 13.99% disabled and 20% undeclared.

Disability pay gap 2025

5.15 ESHT made further progress in reducing its disability pay gap. The mean pay gap decreased from -6.9% to -5.6%, while the median pay gap narrowed to -2.2%.

5.16 Although hourly pay rates declined across the workforce during 2025/26, the gap between disabled and non-disabled colleagues has continued to reduce, demonstrating gradual progress towards more equitable pay outcomes.

Disparity between the disability category: Learning disability/difficulty, Long-standing illness, Mental Health Conditions, Physical Impairment, Sensory Impairment and Unspecified disability.

Learning Disability/Difficulty

5.17 Individuals with learning disabilities/difficulties make up 2.3% (n.188) of the Trust's total workforce and 24.4% of colleagues declaring a disability.

5.18 For colleagues with a learning disability/difficulty, the mean pay gap declined from -5.7% in 2025 to -8.9% in 2026. The median gap shifted from -11.8% to +1.3%, indicating higher median pay compared to non-disabled colleagues.

Long-standing Illness

5.19 Individuals with long-standing illness make up 2.3% (n.194) of the Trust's total workforce and 25.1% of colleagues declaring a disability, making it the largest disability category.

5.20 For colleagues with long-standing illness, the mean pay gap improved slightly from -10.4% in 2025 to -9.5% in 2026. The median pay gap reduced more significantly, from 26.9% to -6.2%, indicating a substantial shift in median pay position relative to non-disabled colleagues.

Mental Health Conditions

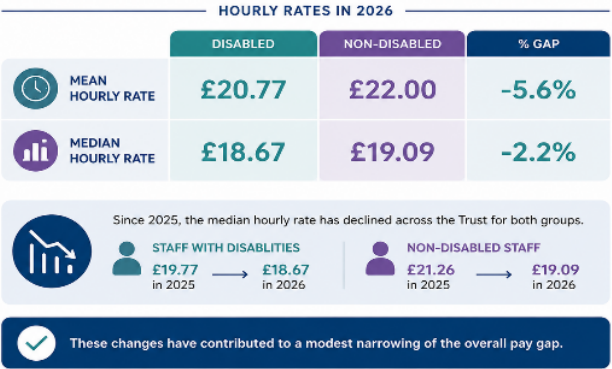
5.21 Individuals with mental health conditions make up 1.1% (n.91) of the Trust's total workforce and 11.8% of colleagues declaring a disability.

5.22 For colleagues with mental health conditions, the mean pay gap widened from -11.6% in 2025 to -13.9% in 2026, equating to an average hourly difference of £3.06. The median pay gap improved from -27.7% to -18.3%, indicating a partial narrowing in typical pay differences despite the increase in the mean gap.

PAY GAP

We continue to make progress in reducing our disability pay gap.
Our mean disability pay gap has decreased by 1.3 percentage points, from -6.9% in 2025 to -5.6% in 2026.

£ This equates to an average hourly pay difference of £1.23, with staff with disabilities earning less than their non-disabled colleagues.



Pay gap by disability	Learning Disability/ Difficulty	Non-Disabled	% gap
Mean hourly rate	£20.03	£22.00	-8.9%
Median hourly rate	£19.34	£19.09	1.3%

Pay gap by disability	Long-Standing Illness	Non-Disabled	% gap
Mean hourly rate	£19.91	£22.00	-9.5%
Median hourly rate	£17.91	£19.09	-6.2%

Pay gap by disability	Mental Health Condition	Non-Disabled	% gap
Mean hourly rate	£18.94	£22.00	-13.9%
Median hourly rate	£15.60	£19.09	-18.3%

Physical Impairment

Pay gap by disability	Physical Impairment	Non-Disabled	% gap
Mean hourly rate	£21.85	£22.00	-0.7%
Median hourly rate	£17.52	£19.09	-8.2%

5.23 Individuals with physical impairment make up 0.9% (n.75) of the Trust's total workforce and 9.7% of colleagues declaring a disability.

5.24 Between 2025 and 2026, the mean pay gap for colleagues with physical impairments shifted from +0.7% to -0.7%, moving from a small advantage to a slight disadvantage. However, the median gap improved from -18.9% to -8.2%, indicating a narrowing in typical pay differences.

Sensory Impairment

Pay gap by disability	Sensory Impairment	Non-Disabled	% gap
Mean hourly rate	£22.95	£22.00	+4.3%
Median hourly rate	£19.85	£19.09	+4.0%

5.25 Individuals with sensory impairment make up 0.9% (n.72) of the Trust's total workforce and 9.3% of colleagues declaring a disability.

5.26 From 2025 to 2026, the mean pay gap for colleagues with sensory impairments reduced from +7.3% to +4.3%, indicating a smaller relative pay advantage. Over the same period, the median pay gap shifted from -9.7% to +4.0%, moving from a disadvantage to a slight advantage and reflecting a positive change in typical pay experience.

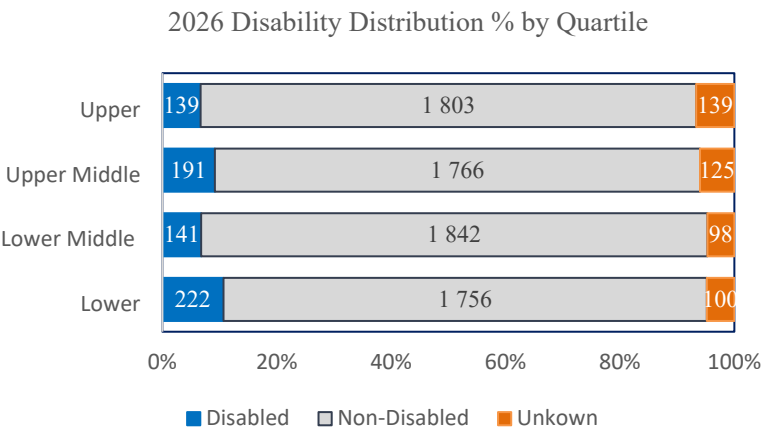
Unspecified Disability

5.27 Individuals with unspecified disabilities make up 0.5% (n.41) of the Trust's total workforce and 5.3% of colleagues declaring a disability.

Pay gap by disability	Unspecified Disability	Non-Disabled	% gap
Mean hourly rate	£22.94	£22.00	+4.3%
Median hourly rate	£23.59	£19.09	+23.5%

5.28 From 2025 to 2026, the mean pay gap for colleagues with unspecified disabilities reduced from +4.0% to +4.3%, indicating a increasing pay advantage. Over the same period, the median pay gap shifted from +13.3% to +23.5%, indicating a widening pay advantage in the typical experience of staff with unspecified disabilities.

Disability distribution by pay quartiles



5.29 Based on the 2026 workforce profile, colleagues living with a disability remain over-represented in the lower quartile (11.2% vs 8.3% workforce representation).

5.30 However, compared to 2025, where over-representation was limited to the lowest quartile, there has been positive movement, with slight over-representation now also evident in the upper middle quartile (9.8%). Under-representation persists in the lower middle (7.1%) and upper quartiles (7.2%), indicating improving distribution across pay bands, but continued imbalance at the most senior levels.

NEXT STEPS FOR DISABILITY EQUALITY 2026-28

- Implement disability declaration campaigns and continue delivery of inclusive recruitment practices, including reasonable adjustments and inclusive recruitment training.
- Continuing implementation of the Allyship Programme, Speaking Up initiatives and behavioural culture work arising from the Trust's listening events
- Promote structures that support career progression and opportunities for disabled staff through talent management strategies.
- Implement reciprocal mentoring, targeted development opportunities and inclusive leadership initiatives to improve career progression, belonging and engagement for disabled colleagues.

AGE

Colleagues in the 16-20 age group have the highest perception of equality of opportunity of 69.23%.

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

- 6.1. Across 2025-26 the Trust continued its work to promote age equality between people of different ages. Key achievements include:
- Collaborating with the Prince's Trust to help young people re-enter the workforce.
 - Celebrating 10 years of partnering with Project SEARCH, a supported employment initiative, to provide opportunities for young people with learning difficulties and disabilities.
 - Dedicated age section supporting younger and older colleagues in Allyship pack and training.

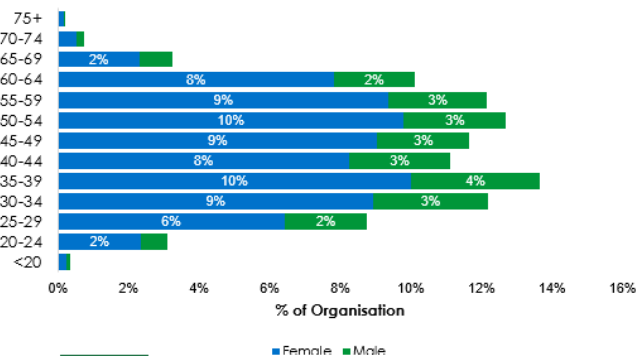


KEY FINDINGS: AGE

Workforce age representation

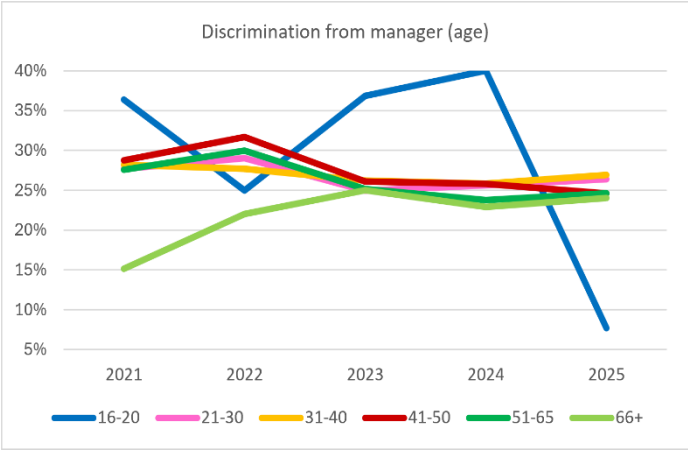
- 6.2. ESHT Colleagues in post changed over twelve months from 8741 in April 2025 to 8711 in April 2026.
- 6.3. The percentage in the workforce across all age groups over the past twelve months was consistent with the previous year.

Age Distribution

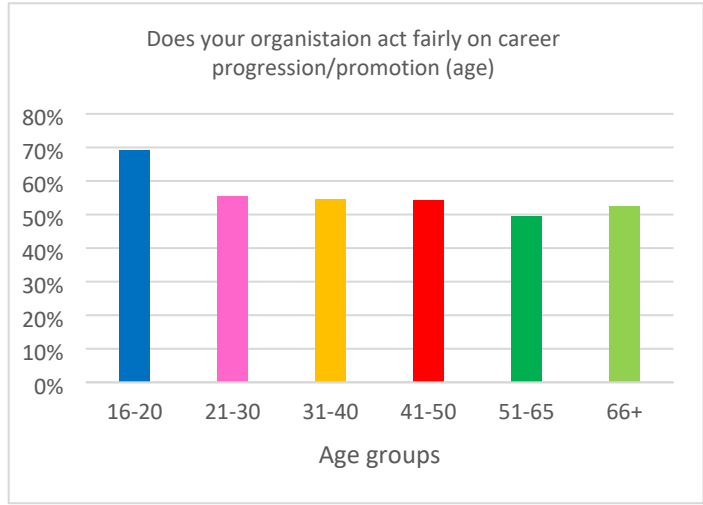


We are safe and healthy (bullying and harassment) by age.

- 6.4. Experiences of harassment, bullying and abuse from patients, service users, relatives or members of the public were broadly consistent across most age groups during 2025/26, ranging between 24.0% and 26.9%. The lowest reported rate was among colleagues aged 66+ (24.00%), while colleagues aged 31–40 years reported the highest rate (26.91%).
- 6.5. The 16–20-year age group reported the lowest overall level (7.69%), although this should be interpreted with caution due to the relatively small number of respondents. Overall, the findings suggest that inappropriate behaviour from the public continues to affect colleagues of all ages, with no single age group experiencing a disproportionate burden.
- 6.6. Across all age groups, the majority of colleagues agreed that their immediate manager takes a positive interest in their health and wellbeing. The 16–20-year age group reported the highest positive response (76.92%), followed by colleagues aged 16–20 years and 66+ years (74.32%). The 21–30-year age group reported the lowest positive response (68.96%), although this remained broadly comparable with colleagues aged 51–65 years (69.77%).
- 6.7. Compared with the previous year, the largest improvement was seen amongst colleagues aged 66+ years, increasing by 2.89 percentage points, while the 21–30-year age group experienced the largest decline (3.03 percentage points). Overall, the findings suggest that positive perceptions of line manager support remain strong across all age groups, with relatively little variation between groups



6.8. Reporting of harassment, bullying or abuse from managers remained broadly consistent across most age groups in 2025. The highest reporting rates were amongst colleagues aged 31–40 years (26.91%) and 21–30 years (26.38%), while the most notable improvement was seen in the 16–20 age group, where reporting reduced substantially compared with the previous year. Although reporting varies between age groups, the findings suggest colleagues continue to have confidence in raising concerns, and the Trust will continue to promote a culture where everyone feels safe to speak up.



Age equality, we are compassionate and inclusive.
6.9 Younger colleagues continued to report the most positive perceptions of fairness in career progression. Colleagues aged 16–20 years reported the highest level of confidence (69.23%), followed by those aged 21–30 years (55.51%). The lowest positive response was reported by colleagues aged 51–65 years (49.63%), with the remaining age groups reporting broadly similar levels of confidence.

6.10. These findings suggest opportunities to better understand and address the experiences of colleagues in later career stages, ensuring equitable access to development and progression opportunities throughout working life.

6.11. Overall, the 2025/26 Staff Survey shows relatively consistent experiences across age groups, with no widespread evidence of significant age-related disparities. Younger colleagues reported the greatest confidence in fair career progression, while colleagues in the 51–65-year age group were more likely to report concerns relating to management behaviours and less likely to perceive career progression as fair. These findings will continue to inform the Trust’s approach to creating an inclusive working environment where colleagues of all ages are able to thrive and progress.

NEXT STEPS FOR AGE EQUALITY 2026-28

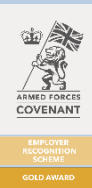
- Where possible support social mobility and improve employment opportunities across healthcare through education programmes.
- Continue to increase awareness of age discrimination across the ESHT through the allyship pledge and programme.

ARMED FORCES

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



In September 2025, ESHT was awarded in the Gold Defence Employee Recognition Scheme by the Ministry of Defence (MoD) and November 2025, ESHT won the HSJ Award for Military and Civilian Health Partnership of the Year.



KEY UPDATES: ARMED FORCES

Workforce armed forces representation 7.1 ESHT Colleagues in post changed over twelve months from 8741 in April 2025 to 8711 in April 2026.

7.2 The total number of those working for ESHT from the armed forces community is declared at 50, an increase of 14 declarations over the previous twelve months. This is made up of 4 recorded Reservists, 20 Military Family members, 25 Veterans and 2 Cadet Force Adult Volunteer (CFAV).

Key highlights include:

7.3 East Sussex Healthcare NHS Trust continues to demonstrate its commitment to the Armed Forces Community through employment, healthcare and advocacy. During 2025/26, the Trust further strengthened its support for veterans, reservists, service families and military spouses, embedding the principles of the Armed Forces Covenant across both workforce and patient services.

7.4 A significant milestone was achieved in September 2025, when ESHT was awarded the Gold Defence Employer Recognition Scheme (ERS) Award, the Ministry of Defence's highest employer recognition, acknowledging the Trust's outstanding commitment to supporting the Armed Forces Community.

7.5 This was followed by national recognition in November 2025, when ESHT won the HSJ Award for Military and Civilian Health Partnership of the Year, recognising the Trust's innovative work to improve healthcare and employment outcomes for the Armed Forces Community.



NEXT STEPS FOR ARMED FORCES 2026-28

- Maintain Defence Employer Recognition Scheme (Gold) and continue to embed Armed Forces Covenant through training.
- Promote self-declaration of Armed Forces status to better improve our understanding of our workforce.
- Renew attempts to work with our local cadet forces.
- Prepare for revalidation of Veteran Aware accreditation.

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.

The allyship programme was launched at the Trust Awards, valuing lived experience, and creating positive cultural change across the organisation.

8.1 In addition to the progress highlighted in each section, across 2025-26 ESHT continued certain trust-wide initiatives to advance equality of opportunity eliminate discrimination and foster good relations. Key achievements include:

- Launched the Trust’s Allyship Programme and Allyship Pledge, accompanied by a colleague-led film showcasing the importance of allyship and everyone’s role in fostering an inclusive culture.
- Conducted listening events with the disAbility staff network to understand the Staff Survey engagement scores.
- Continued to improve the centralised Access to Work process and maintained Leader status in the Disability Confident Scheme through external assessment.
- Celebrated the Black History Month, Disability History Month, Armed Forces Week, International Women’s Day, Trans Awareness Week, Pride Month, Neurodiversity Celebration Week, and Interfaith Week.
- Contributed to Trust development programmes such as 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 68.84%. This was just below the average provider benchmark of 68.91%.

We are compassionate and inclusive: Inclusion



9.2 ESHT overall score for colleagues feeling a strong personal attachment to their team was 63.62%, this is higher than the provider benchmark of 62.88%.

NEXT STEPS FOR ORGANISATIONAL INCLUSION 2025-26

- Develop and publish new equality objectives for ESHT for 2026-2030 in line with the Public Sector Equality Duty.
- Strengthen governance and assurance arrangements to support delivery of the Trust’s inclusion strategy and equality objectives.
- Strengthen the quality, consistency and governance of Equality Impact Assessment.
- Embed inclusion within organisational development, talent management and leadership programme to support sustainable cultural changes.
- Continue to use workforce data, staff feedback and lived experience to evaluate progress and inform continuous improvement.
- Embed the recommendations from the Lord Mann Review.

Summary of Actions for Equality, Diversity, and Inclusion 2026-2028

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 and organisational goals.

Objective	Actions
Race	
1. Fair Career Progression and Development.	Implement reciprocal mentoring, targeted leadership development and transparent career pathways to improve progression opportunities and career confidence for multicultural colleagues. Embed the Allyship Programme, behavioural framework and speaking-up initiatives to reduce experiences of bullying and harassment experienced by multicultural colleagues.
2. Leadership accountability and Representation	Embed ethnicity equality measures within workforce governance arrangements, ensuring recruitment, disciplinary, promotion and leadership diversity data are reviewed annually and action taken where disparities are identified.
3. Inclusive Culture, Allyship and Speaking Up	Embed the Allyship Programme, behavioural framework and speaking-up initiatives to reduce experiences of bullying and harassment experienced by multicultural colleagues. Adopt the seven anti-racism principles of the NHS Race and Health Observatory as per the Lord Mann review
Objective	Actions
Religion and Belief	
1. Grow Faith and Belief Network	Increase diversity of membership with the Faith and Belief Network to encourage open conversation between different faith groups.
2. Organise multifaith events	Organise and host multifaith events to promote understanding and inclusivity among employees of different faiths and beliefs
3. Implement Trust wide allyship programme.	Arrange different events through the Faith and Belief network working in collaboration with other networks to promote intersectionality and increase confidence discussing faith at work.
4. Implement the recommendations from the Lord Mann review	Subject to Government consultation, include wherever possible, Jewish and Sikh as ethnicities in data collection.

Objective	Actions
Gender (Sex)	
1. Increase the representation of women in senior leadership an underrepresented staff groups	Increase the representation of women in senior leadership an underrepresented staff groups through career development and supported by the Leadership and Management Framework. Develop and embed an inclusive talent management approach. Continue to monitor workforce and pay gap trends.
2. Implement Trust wide allyship programme to encourage understanding and awareness of gender equality issues.	Host regular events and workshops to promote gender inclusivity and raise awareness about gender equality issues.
3. Strengthen Support Systems	Embed the Trust's Sexual Safety Charter and continue to promote a culture where sexual misconduct is challenged, concerns are reported confidently and colleagues feel safe at work..
4. Embed changes arising from equality legislation	Review policies, guidance and workplace facilities to ensure continued compliance with changes to equality legislation and support an inclusive environment for all colleagues

Objective	Actions
Sexual Orientation	
1. Continue to grow LGBTQIA+ network membership	Continue to grow LGBTQIA+ network and strengthen allyship across the Trust through awareness, education and engagement
2. Improve understanding of LGBTQIA+ inclusion and create psychologically safe working environments.	Continue implementation of the Trust wide allyship programme and enhance online training provision for LGBTQIA+ learning and allyship initiatives.
3. Embed changes arising from equality legislation	Review policies, guidance and workplace facilities to ensure continued compliance with changes to equality legislation and support an inclusive environment for all colleagues

Objective	Actions
Disability	
1. Continue to embed Reasonable Adjustment process throughout the Trust.	Implement disability declaration campaigns and continue delivery of inclusive recruitment practices, including reasonable adjustments and inclusive recruitment training.
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. Implement reciprocal mentoring, targeted development opportunities and inclusive leadership initiatives to improve career progression, belonging and engagement for disabled colleagues.
3. Support neurodiverse colleagues	Continuing implementation of the Allyship Programme, Speaking Up initiatives and behavioural culture work arising from the Trust's listening events.
Objective	Actions
Age	
1. Support social mobility and employment opportunities	Improve employment opportunities through education programmes.
2. 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. Maintain Defence Employer Recognition Scheme (Gold)	Continue to embed Armed Forces Covenant through training.
2. Increase those declaring their armed forces status	Promote the value of declaring Armed Forces status through internal campaigns and staff stories. Promote self-declaration of Armed Forces status to better improve our understanding of our workforce.
3. Prepare for revalidation of Veteran Aware accreditation.	Gather evidence for submission for reaccreditation 2027

Objective	Actions
Organisational Inclusion	
1. Develop new equality objectives for ESHT for 2026-2030	Develop and publish new equality objectives for ESHT for 2026-2030 in line with the Public Sector Equality Duty.
2. Strengthen governance and assurance arrangements for inclusion and culture work	Strengthen governance and assurance arrangements to support delivery of the Trust's inclusion strategy and equality objectives through revised Workforce Inclusion and Culture Group.
3. Strengthen the quality, consistency and governance of Equality Impact Assessment.	Review and simplify the Equality Impact Assessment process. Develop guidance and practical resources to support the completion of Equality Impact Assessments Strengthen governance and quality assurance arrangements for Equality Impact Assessments
4. Strengthen career progression pathways for disabled staff through talent management	Embed inclusion within organisational development, talent management and leadership programme to support sustainable cultural changes. Continue to use workforce data, staff feedback and lived experience to evaluate progress and inform continuous improvement.
5. Embed the recommendations from the Lord Mann review	Subject to Government consultation, include wherever possible, Jewish and Sikh as ethnicities in data collection. Implement the national guidance on uniform and NHS-issued equipment and how we should respond to racist behaviour from the public. Adopt the seven anti-racism principles of the NHS Race and Health Observatory. Trust Board to undertake antiracism training when it is available.

Looking Ahead

Over the next four years ESHT will continue to embed equality, diversity and inclusion and belonging within everyday practice. By combining robust workforce data, lived experience and meaningful engagement with colleagues, we will continue to reduce inequalities, strengthen inclusive leadership and create a culture where everyone feels safe, valued and able to thrive.



Report To/Meeting	Trust Board	Date of Meeting	20 th October 2026
Report Title:	Annual Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation		
Key question	What changes are proposed to the Trust's governing documents following their annual review?		
Decision Action:	For approval ☒ For Assurance ☐ For Information ☐ For Discussion ☐		
Report Sponsor:	Andrew Strevens, Chief Finance Officer	Presenter(s):	Andrew Strevens, Chief Finance Officer
Report Author:	Pete Palmer, Board Secretary		
Outcome/Action requested:	The Trust Board is asked to endorse the proposed changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.		
Executive Summary	The Trust Board is required to review the Standing Orders, Standing Financial Instructions and the Scheme of Delegation on an annual basis. The Audit Committee reviews and makes recommendation to the Board. The documents reviewed are: • Standing Orders: cover all aspects of the conduct of the Trust, including governance, committees and their duties and responsibilities. • Standing Financial Instructions: detail the financial conduct and governance of the Trust and requirements therein. • Scheme of Delegation: lays down in detail the specifics of committee responsibilities and duties together with that of the executive and the officers to which delegated authority has been designated. The review is undertaken jointly by the Head of Financial Services and Board Secretary, with input from the Chief Finance Officer. All of the documents were subject to a full review. They have been transferred on to the Trust's new policy template and in addition a number of non-material changes, to improve clarity and consistency, were made throughout the documents to bring them up to date. In addition, a number of material changes are proposed to the Standing Orders, Standing Financial Instructions and the Scheme of Delegation and these are detailed below. Standing Orders: • No material changes proposed. Standing Financial Instructions: • Throughout the SFIs, changes have been made to approval thresholds to bring the Trust in line with system partners.		

- In summary, these changes are:
 1. A full business case is now required for services changes of over £100k; previously this was £50k.
 2. Approvals for capital replacement, capital investment, revenues investment and partnership investment with a value of between £100k and £250k require the approval of the Chief Financial Officer and the Chief Operating Officer.
 3. With a value of between £250k and £1m also require the approval of the Executive Committee.
 4. With a value of between £1m and £5m also require the approval of the Finance and Performance Committee.
 5. With a value of over £5m also require the approval of the Board.

	Documentation			CRG	OMG	Partnership	CFO/COO	Executive Committee	F&P	Board
	Capital Plan	Business Case Brief (BCB)	Business Case (BC)							
Capital Replacement	✓	✓		All			< £250k	< £1,000k	< £5,000k	> £5,000k
Capital Investment	✓	< £100k	> £100k	All	All		< £250k	< £1,000k	< £5,000k	> £5,000k
Revenue Investment		< £100k	> £100k		All		< £250k	< £1,000k	< £5,000k	> £5,000k
Partnership Investment		< £100k	> £100k			All	< £250k	< £1,000k	< £5,000k	> £5,000k

Scheme of Delegation:

- No material changes proposed.

A full version of the documents, including tracked changes, can be found as an appendix to the Board papers.

Regulatory/legal requirement:	NHS organisations are required to have robust and effective governing documents.		
Business Plan Link:	Quality ☒	People ☒	Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	None identified		
Risk:	None identified		
No of Pages	2	Appendixes	1
Governance and Engagement pathway to date:	The proposed changes have been reviewed and endorsed by Audit Committee on 26 th August.		
What happens next?	Subject to the Board's endorsement, the updated governing documents will be published on the Trust's website and extranet.		
Publication	This report can be made public.		



Report To/Meeting	Trust Board	Date of Meeting	20 th October 2026
Report Title:	Use of Trust Seal		
Key question	Has the Trust Seal been used since the last Trust Board meeting?		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐		
Report Sponsor:	Andrew Strevens, Chief Finance Officer	Presenter(s):	Steve Phoenix, Trust Chair
Report Author:	Pete Palmer, Board Secretary		
Outcome/Action requested:	The Board is asked to note the use of the Trust Seal.		
Executive Summary	The Trust Seal has not been used since the last Board meeting in public.		
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		

ESHT Trust Board Meeting in Public 12-month forward plan

15th December 2026

Conquest

Agenda sections	
Standing Items	Staff Recognition Service Presentation Board Committee Chair's Reports CEO's Update IPR Use of Trust Seal Questions from members of the public (15 mins)
Service Presentation	Anaesthetic Learning Disability Team
General	
Quality, Safety and Performance	Maternity Overview Q2 Avoidability of Inpatient Deaths Q3
Human Resources incorporating workforce targets and staff survey	
Strategy	
Other monitoring	
Governance and Assurance	Speak Up Guardian Update Guardian of Safe Working hours Mortuary Update
Annual Reports	Infection Control Safeguarding Annual Report Guardian of Safe Working Hours Annual report
Items for Information	Meeting Dates for 2027