East Sussex Healthcare NHS Trust

EAST SUSSEX HEALTHCARE NHS TRUST

BOARD OF DIRECTORS

TRUST BOARD MEETING IN PUBLIC

ST MARY'S BOARDROOM, EASTBOURNE DISTRICT GENERAL HOSPITAL

13th AUGUST 2024, 09:30-12:45

East Sussex Healthcare NHS Trust Board Agenda

Date: Tuesday 13th August 2024

Time: 09:30 – 12:45

Venue: St Mary's Boardroom, EDGH

	Opening Business	Lead	Action	Time	Enc.
1.	Welcome and apologies	Chair	Information	09:30	
2.	Staff Recognition	Chair	Information		Yes
3.	Project Search	Jacquie Fuller	Information	09:30	Yes
4.	Declarations of Interest	Chair	Information		
5.	Minutes of Trust Board Meeting in public 11.06.24	Chair	Approval	09:45	Yes
6.	Matters Arising	Chair	Approval		Yes
7.	Chief Executive's Report	CEO	Information	09:50	Yes
8.	Board Committees Chair's Reports	Committee Chairs	Assurance	10:00	Yes
Quality, Safety and Performance					
9.	Integrated Performance Report, Month 3 (June) (i) Chief Executive Summary (ii) Quality & Safety (iii) Our People (iv) Access and Responsiveness (v) Financial Control and Capital Development	CEO CNO/CMO DDOP COO CFO	Assurance	10.10	Yes
10.	Learning From Deaths Q3	CMO	Assurance	10:55	Yes
11.	Martha's Rule Implementation	CNO	Information	11:00	Verbal

Break – 10 minutes

Strategy					
12.	Financial Plan 2024/25	CEO/CFO	Decision	11:20	Yes
Governance and Assurance					
13.	Freedom to Speak Up Guardian: (i) Speak Up Guardian Report (ii) Management Response to Speak Up Guardian Report (iii) Freedom to Speak Up Reflection and Planning Tool	DDOP	Decision	11:30	Yes
14.	Mortuary Assurance	CMO	Assurance/ Information	11:40	Yes

15.	BAF Q1	COS	Decision	11:50	Yes
16.	Medical Revalidation Annual Report	CMO	Assurance	11:55	Yes
17.	NHS Provider Licence	COS	Decision	12:05	Yes
For Information					
18.	Use of Trust Seal	Chair	Information		Yes
19.	Questions from members of the public	Chair		12:15	
20.	Agenda Forward Plan	-	Information		
21.	Date of Next Meeting Tuesday 10th September 2024 (AGM)	Chair	Information		
22.	Close	Chair			

Steve Phoenix
Chairman

Key:	
ADCGC	Associate Director of Corporate Governance and Compliance
Chair	Trust Chair
CEO	Chief Executive
CNO	Chief Nurse and DIPC
COO	Chief Operating Officer
CFO	Chief Finance Officer
COS	Chief of Staff
CMO	Chief Medical Officer
CPO	Chief People Officer
DDOP	Deputy Director of People
DOM	Director of Midwifery

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: 2024

Month	Location	Timing	Any other information
10th September – Annual General Meeting	Bexhill – The Relais Cooden Beach	14.30 – 16.00	
8th October	St Mark's Church Hall, Green Lane, Bexhill	09.30 – 12.30	
10th December	Conquest – Lecture Theatre, Education Centre	09.30 – 12.30	

Staff Recognition

Purpose of the paper	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. As such, this is an opportunity for the Trust to demonstrate and acknowledge the exceptional performance, behaviour, achievements and contribution that our colleagues and volunteers have made to the organisation.					
	For decision		For assurance		For information	x
Sponsor/Author	Sponsor: Jacquie Fuller, Assistant Director of HR – Engagement and Wellbeing Author: Melanie Adams, People Experience Manager					
Governance overview	Trust Board					

Strategic objectives	Quality	People	Sustainability
		x	
Our values	Kindness	Inclusivity	Integrity
	x	x	x
Recommendation	N/A		

Executive summary

Hero of the Month

<u>April 2024</u>

Winner – Oliver Smith, Pharmacy – Conquest Hospital, Core Services Division

Nomination 1
'I would like to nominate Oliver as he is very hard working and always supports his colleagues. He is always willing to support the operational and clinical team. This includes supporting them through challenges and changes in the department. He always finds a way to put a smile on my face and brighten up my day.'

Nomination 2
'Oliver always goes above and beyond for not only patients, but also for the rest of the pharmacy team. He increases the morale of the department even when he and the pharmacy are under considerable pressure and always makes himself available to help others.'

May 2024

Winner – Callum Mead – Logistics team – Estates and Facilities Division

'Callum has worked all through the May Bank Holiday weekend at the Conquest Hospital to support the movement and distribution of bottled water and any other related equipment for the water incident caused by Southern Water.

Callum showed initiative and complete support. Callum went way above what would normally be expected. His efforts supported both the need of the hospital and that which was required in the community. Callum never questioned any request and was happy to assist with whatever was asked of him. During the weekend Callum worked and demonstrated that he achieved all the Trust values whilst working to support patients and colleagues alike during this time of uncertainty of whether there would water for people to use and have access too. He did an excellent job and was an asset to the Facilities Team.'

Long Service Awards

May 2024		
10 Years' Service	**25 Years' Service**	**40 Years' Service**
Amreen Ahmad	Shinal Amin	Debra Cranfield
Hollie Atherton	Philippa Hartland	Amelia Pamplin
Charli Brown	Samantha Holmes	Vivien Cox
Rachel Cox	Dionne Homewood	
Eleonora-Laura Emanuele	Amanda Howell	
Natalie Fletcher	Linda Johnson	
Sarah Jones	Stella Morgan	
Marlon Llentada	David Moulder	
Rosa Reis		
Geraldine Wash		
Katie White		

June 2024		
10 Years' Service	**25 Years' Service**	**40 Years' Service**
Sarah Allender	Heather Brown	
Clare Evans	Linda Carter	
Robina Fitch	Sheilah Curcher	
Lisa Grass	Helen Earley	
Alison Hagan	Clare Lippiatt	
Antonios Koumousidis	Romeo Velarde	
Andrew Marshall		
Andrew Meeks		
Aleksandra Nasir		
Mariela Nesheva		
Nigel Norman		
Kelly Simpson		
Rachel Swift		
Mollie Taylor		
Rachel Ward		

July 2024		
10 Years' Service	**25 Years' Service**	**40 Years' Service**
Stacey Burgess	Christopher George	Gilberto Da Silva
Sarah Day	Sally Scott	
Stephen Eadon-Rayner	Carol Sheffield	
Joao Abel Ferreira De Jesus	Syed Zaidi	
Gabriella Friedlander-Brown		
Elizabeth Grant		
Robert Hancock		
Paul Harvey		
Scott Heasman		
Carol Jackson		
Rosina Lomax		
Elizabeth Miah		
Louis Parsk		
Adriana Sardinha		
Leanne Wood		
Maria Zajaczkowska		

Next steps	The Colleague Reward and Recognition policy has been reviewed. An update of improvements in how we recognise and reward colleagues will be included in the next Staff Recognition report.

NHS
East Sussex Healthcare
NHS Trust

Project Search at ESHT

DFN Project | SEARCH

Celebrating 10 years

KINDNESS

INCLUSIVITY

INTEGRITY

What is Project Search ?

Project Search is a one year supported internship programme for young people aged 18 to 25 who have an education, health, and care plan in place. The programme is hosted by East Sussex College, and the placements are based at the Eastbourne District General Hospital. In June 2024 we celebrated our 10 year anniversary and hosted an event for past cohorts and current cohorts of students and their families.

The programme gives young people the opportunity to gain and develop work related skills, knowledge, and behaviour whilst they are on placement in different hospital departments. Job coaches and work mentors ensure that any barriers to accessing a work placement are removed and that the learners receive the right balance of support and challenge which they need to get ready for employment

Internships offer vital benefits to college students. Through diverse experiences, they explore career aspirations, acquire marketable skills, and gain confidence. They receive personalised instruction and build essential networks. Hosting interns also benefits our organisation: they enhance work capacity, provide disability awareness training, and improve recruitment practices, and boost our profile as an employer of choice.

Since 2014, the Trust will have facilitated 105 interns. 24 of these interns have gained successful employment at our organisation. This was only possible thanks to the support of our departments and placement mentors.

Special mentions must go to our Estates & Facilities, Pathology and Pharmacy teams who have consistently supported this programme.

Project Search at ESHT - Celebrating 10 years

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Board Minutes

Date: 11th June 2024

Time: 09:30 – 12:30

Venue: Lecture Theatre, Education Centre, Conquest Hospital

		Actions
	Attendance: Steve Phoenix, Chairman and Non Executive Director Joe Chadwick-Bell, Chief Executive (CEO) Vikki Carruth, Chief Nurse & Director of Infection, Prevention and Control (CN and DIPC) Charlotte O'Brien, Chief Operating Officer (COO) Karen Manson, Non-Executive Director Simon Merritt, Chief Medical Officer (CMO) Paresh Patel, Vice Chair and Senior Independent Director Damian Reid, Chief Finance Officer (CFO) Nicola Webber, Non-Executive Director <u>Non-Voting Directors</u> Ama Agbeze, Associate Non-Executive Director Steve Aumayer, Deputy Chief Executive and Chief People Officer (DCE and CPO) Richard Milner, Chief of Staff (COS) Frank Sims, Associate Non-Executive Director <u>In Attendance</u> Dan Asamoah, Associate Director of Corporate Governance and Compliance Imelda Donnellan, Chief of Diagnostics, Anaesthetics & Surgery (DAS) (for item 27/024 only) Michael Klimovskij, Consultant General and Colorectal Surgeon (for item 27/024 only) Brenda Lynes, Director of Midwifery Peter Palmer, Board Secretary (minutes) <u>Observing</u> Claire Bishop, Deputy Chief Nurse (Workforce and Prof Standards)	
	Apologies: Carys Williams, Non-Executive Director	
25/024	**Chair's Opening Remarks** The Chair welcomed everyone to the meeting. He welcomed Dan Asamoah to the Trust, noting that he had recently joined as Associate Director of Corporate Governance and Compliance. Claire Bishop, Deputy Chief Nurse was observing the Board as part of her professional development. The meeting was being held during a pre-election period which meant that no questions were being accepted from members of the public. It was confirmed that the notice of the meeting had been duly issued to the members of the Board entitled to receive notice and attend Board meetings. Apologies had been received from Carys Williams, NED The meeting was quorate according to the Constitution of the Trust.	

26/024	**Staff Recognition** The Chair reported that February's winners had been Adam Oxley and Billy Pepper, members of the Security Team. He praised the brilliant work that the Trust's security teams did in very challenging circumstances. March's winner had been Robyn Arno from the Paediatric Dietetic team. He noted that Mark Sully had completed 40 years of NHS service since the last Board meeting.	
27/024	**Da Vinci Robot** Miss Donnellan and Mr Klimovskij presented an update to the Board on the purchase of the new Da Vinci surgical robot at Conquest Hospital. Miss Donnellan explained that the purchase had been coordinated through collaboration between that colorectal and gynaecology departments and would help improve access for patients to the most up to date treatments available. It would also help to attract, recruit and retain a skilled and dedicated workforce. The benefits of robotic surgery included improved outcomes for patients with fewer complications, reduced pain and faster recovery following surgery. This should in turn lead to reduced lengths of stay, reduced readmission rates and reduced cancellations. Mr Klimovskij explained that the robot allowed surgeons incredibly precise control when undertaking operations. The robot had been delivered on 28th March 2024 with the first colorectal major robotic operation both in the Trust and in Sussex undertaken on 28th May. The first gynaecology operation using the robot had been carried out on 7th June. Mr Klimovskij reported that while it had been challenging to learn new skills, the first surgery had gone extremely well and the surgical team had been extremely enthusiastic to learnt to use the new equipment. Miss Donnellan explained that robot learned how each surgeon operated and was able to adapt to this to ensure the best outcomes for patients. Frank, NED asked whether processes for preparing patients for robotic surgery could also be used for normal procedures, and whether patient related outcomes were being recorded so that they could be compared to previous surgical methods. Miss Donnellan explained the process of selecting and preparing patients for robotic surgery, with decisions about the suitability of patients determined at an MDT meeting. Patients were asked to prehabilitate ahead of their surgery to ensure that they were as prepared as possible for their surgery. Mr Klimovskij reported that theatre recovery teams were undertaking a comprehensive audit on cancer admissions which would allow for outcomes to be compared. Nicki, NED noted that the team had been asked to present a post implementation review to the Finance and Productivity Committee in 2025 to check that assumptions included within the business case had been realised. The CEO thanked Mr Klimovskij and Miss Donnellan for their hard work in delivering this project for the Trust. She was delighted to see the enthusiasm for the robot, and hoped to come and watch a procedure being undertaken in theatres. She was excited to understand all of the benefits that the purchase would release, including improved outcomes for patients and benefits for colleagues.	
28/024	**Declarations of Interest** In accordance with the Trust's Standing Orders that directors should formally disclose any interests in items of business at the meeting, the Chair noted that no potential conflicts of interest had been declared. All declarations of interests were noted as being held on the Register of Directors' Interest.	
29/024	**Minutes** The minutes of the Trust Board meeting held on 9th April 2024 were approved as a true and accurate record of the meeting subject to one amendment:	

	• Nicki, NED clarified that on page 2 concerning Martha's Rule she had asked whether the Trust collaborated with other organisations when it felt that it did not have the internal expertise to be able to give a second opinion. The answer had been that this arrangement had already been in place for a number of years.	
30/024	**Matters Arising** The Chairman led discussion the Matters Arising and Action Log and the following were noted: • 24/026 – Martha's Rule – the Action was noted as complete as included in Board workplan for October • 24/030 – Works to improve on Trust IPR month 11 – action in progress. • 24/033 – Include Our Vision and Objectives 2024/25 on IPR report front sheet – the action was noted as complete	
31/024	**Chief Executive's Report** The CEO reported that the Trust had recently submitted an adjusted financial plan for 2024/25 which set at approximately £38m (5.2%) efficiency target for the year. If this plan was delivered then the Trust would record an £11.7m deficit for the year. The Trust had introduced a Use of Resources programme in support which continued to be developed and was being discussed widely within the organisation. There was also a current Trust focus on reducing discharge delays and supporting the overarching Sussex position for elective waiting lists. The Terms of Reference for the system Committee in Common (CiC) had been approved by the Trust Board at the previous meeting, and those for the Trust's CiC were included on the agenda for this meeting. The system CiC had met informally for the first time a couple of weeks before. On behalf of the system, the Trust was hosting Jessica Thom, Managing Director of Sussex Provider Collaboratives who would lead on the development of Provider Collaboratives. Work to develop integrated community teams continued. The CEO praised the recent improvements seen in urgent care performance in the Trust, noting that reducing waiting times for patients led to better outcomes. She thanked the COO, her team and divisions for their work in supporting the greatly improved performance and reported that this had resulted in an award of £2m additional capital for the organisation. Junior doctors would strike again at the end of June and a huge amount of planning was being undertaken to maintain patient safety during the industrial action. The Trust would try to avoid cancelling elective work during the strikes. A recent fire inspection at the Conquest had led to the issue of a fire enforcement notice by East Sussex Fire and Rescue. A detailed action plan had been developed in response which included physical improvements to ward and corridor areas, along with additional training for colleagues. A fire had occurred at Sussex Premier Health the previous week which had been well managed; no-one was harmed, but activity had been impacted. Karen, NED asked how the Elective Coordination Centre would operate; the COO explained that work was being undertaken across the system to support the reduction of the overarching 78 week elective waiting list. Its current focus would be to support the movement of patients from University Hospitals Sussex NHS Foundation Trust to other providers in the system to ensure that equitable access to care was provided to patients across the region. She explained that details of the support being provided would be included within reporting moving forward and that this support would not impact on the Trust's own elective waiting list.	
32/024	**Integrated Performance Report for Month 1 (April)** The CEO noted that the Trust continued to perform well and continued to focus on further improvements. The Trust had been open about the financial challenges that would be faced over the coming year and she explained that these should be viewed in the national context of a post-pandemic NHS. ESHT had been recognised externally as a high performing organisation which was playing its role in supporting the local system.	

Quality and Safety
The Chief Nursing Officer (CNO) reported that an increase in clostridium difficile (c.diff) and e.coli infections had been reported in April, both in the Trust and nationally. The reasons for the increase were being investigated, with HPV cleaning of bays being undertaken as part of the measures to address the issue. She thanked the housekeeping team for their support and the fantastic work that they did, noting that deep cleaning could be challenging due to a lack of decant facilities. An improvement had been seen in the Trust in May, and a 30% reduction in infections had been seen in comparison to the same period in 2023/24,

The CNO explained that pressure damage figures being reported included incidents that had taken place in patients' own homes and in care homes. Focussed work to reduce incidents during inpatient stays in hospital had been undertaken, including a forthcoming quality summit for teams to discuss new approaches to avoiding pressure ulcers. Work was being undertaken to reduce the risk of deconditioning in patients due to delayed discharge. The CNO explained that she had recently visited colleagues in the Emergency Departments (ED) and thanked them for their professional, compassionate care and patient focus despite the pressures that they were under.

Frank, NED asked whether any lessons had emerged through the use of the Patient Safety Incident Response Framework (PSIRF) which could be translated into action to address pressure ulcers. The CNO explained that PSIRF was a fundamental change to the way the NHS investigated and considered incidents, looking at themes and relationships rather than individual incidents. The Trust was focussing on ensuring that pathways for patients at the end of their life were optimised to manage any deterioration and ensure that risks were appropriately assessed and recorded.

Nicki, NED noted a disparity between the number of severity 3 and 4 patient safety events reported in the graphs in the IPR and the narrative and asked for the reasons for this. The CNO and DIPC explained that staff who reported events were responsible for the initial scoring, which was then reviewed at the weekly patient safety summit (WPSS) where scoring could be changed following a multi-disciplinary discussion. She would consider whether future reporting could be adapted to reflect both initial and adjusted scoring. Amanda, NED stated that the assurance that was provided to the Board during the transition to PSIRF was crucial in ensuring that staff understood the journey that the Trust was on. Regular reporting about the introduction of PSIRF was received at Q&S.

Paresh, NED asked how the Trust's reporting compared to that of other organisations and The CNO explained that the Trust was slightly ahead of peer organisations in reporting incidents, with the percentage of events that led to significant harm often below the national average.

The Chief Medical Officer (CMO) reported that the Trust's mortality metrics remained within accepted limits. The Risk-Adjusted Mortality Index (RAMI) had increased and a review of depth of coding in the Trust would to be undertaken to understand the reasons for this as a concomitant increase in crude mortality had not occurred as would be expected.

Nicki, NED noted that it would be helpful to be able to understand how the Trust's mortality data compared with peer organisations. The CMO explained the challenges of reporting this information, noting that improvements in other Trust's would lead to a change in the national mortality baseline.

Our People – Our Staff
The DCE and Chief People Officer reported that the Trust had achieved a total workforce usage reduction during month one of 300 whole time equivalents (wtes), due to a significant reduction in temporary workforce usage. This had led to a reduction in spend on temporary workforce during April of £126k. He noted that the Trust had overspent on

pay during April but explained that he was confident that an improving position would be seen over the coming months due to the significant work that was being undertaken.

The Trust's workforce statistics had stabilised following 18 months of continuous improvement. Current areas of focus included long term sickness, which made up around 47% of the Trust's total sickness. Every episode of long term sickness was subject to review, with colleagues being given support to return to work to appropriate duties more quickly through proactive intervention.

It was a requirement for all Trusts to complete a Freedom to Speak Up Guardian self-assessment before the end of June, and report on this to their Board. The DCE and CPO reported that this self-assessment had been completed; the results would be circulated to the Board following the meeting, and presented at August's Board alongside the full Freedom to Speak Up Guardian update.

Action: Freedom to Speak Up Guardian Self Reflection to be circulated to the Board following the meeting — **CPO**

The Trust had been awarded a Sliver Defence Award in May, only three months after receiving a Bronze Award. The award recognised the brilliant work that had been undertaken by a team of staff, and in particular the work of Garry East, Henry Alexander and Sarah Feather.

The Chief Executive reported that she had asked Executive colleagues to develop a clear narrative about the workforce controls being implemented and the reduction in the total spend on workforce that was required in order to meet the financial target for the year. The DCE and CPO noted that Waiting List Initiatives and additional activity were significant drivers of workforce costs in the Trust.

The Chair stated that he was pleased to see the Trust's mandatory training compliance at an all time high in April.

<u>Access and Responsiveness</u>
The COO reported that despite continued increases in attendances to Emergency Departments (EDs) performance had improved to 76.5% in April and to 78.6% in May against the 78% standard. Work was being undertaken with system partners to identify the drivers of increased attendances. The average non-elective stay increased to 4.65 days in April, with an increase in patients with no criteria to reside (NCTR). Immediate actions including additional therapy resource, reviews of patients in stroke and trauma beds and joint working with Adult Social Care to release capacity had been agreed with the system as Sussex was one of the worst performers in this area nationally.

At the end of April the Trust had reported 56 patients who had waited for more than 65 weeks for elective care. The COO anticipated that there would be no patients waiting for more than 65 weeks at ESHT by August. The Trust was currently focusing on improving cancer performance and diagnostic performance. There had been on 24 hour discharge to assess breach reported in April, for a patient whose condition had changed necessitating a critical care bed. A review of the patient's pathway was being undertaken as a result. Virtual wards continued to be well utilised, and the Trust was performing well for ambulance handovers with work being undertaken with South East Coast Ambulance Service NHS Foundation Trust (SECAmb) to improve this further.

The Chair praised the operational performance of the Trust which had continued to be good for a number of months. He noted that availability of social care assessors had previously been discussed as one of the barriers to discharging patients and asked if this had improved. The COO reported that six additional social workers would be coming into hospitals, with some already starting in this role. This change had taken place too quickly to be able to identify any resulting improvement.

The Chair asked about the impact system working was having on improving discharges from the Trust. The CEO reported that a complex programme of work had been undertaken over the previous 18 months which had seen initial improvements, followed by a subsequent deterioration in performance. Funding that had supported this work during 2023/24 was no longer available and the costs of care had increased which meant that capacity had reduced. Conversations had taken place with NHSE and the Department of Health (DoH) the previous week where funding and social care capacity had been discussed. There were improvements that the Trust could make, including reducing the deconditioning of patients waiting for discharge.

Nicki, NED noted that it cost more for patients to remain in hospital than to be cared for outside of an acute setting and asked why funding could not be reallocated to other services to improve discharge. The CEO explained that the Trust was looking at whether two hospital wards could be closed with funding used to provide care in community settings instead. The Trust's strategic plan included identifying services where additional investment would allow the closure of other services. Urgent community response services were being utilised to support Home First services.

Amanda, NED suggested that Home First services should be commissioned by the system, and noted concern about the mental health of patients who were waiting for 12 hours in EDs. The CEO explained that Sussex's shared delivery plan was looking to address issues such as long waits in ED. Community services were being developed by the system so that patients did not have to unnecessarily attend ED, but it would take time before the impact of these improvements was seen.

Karen, NED asked whether work was being undertaken to look at other systems to identify why discharge was a particular issue in Sussex. The COO explained that this had been discussed with NHSE and the DoH the previous week; regions managing discharge well would be identified so that best practice could be shared. The Chair noted that there were three upper tier authorities in Sussex, which was unusual and was a complicating factor in the region.

Karen, NED asked whether she should be concerned about the Referral to Treatment (RTT) waiting list not having decreased during the previous six months. The COO explained that the Trust had been focussing on treating patients with the longest waits, but would undertake additional validation work on the RTT waiting list moving forward.

Paresh, NED asked about the feedback that was being given to primary care providers about the increasing number of patients attending hospital, noting that the improving performance in ED was likely to encourage more members of the public to attend. The CEO explained that the Trust had formally escalated concerns about the 17% increase in attendances that had been seen. It was important that the Trust was commissioned to undertake the levels of activity that were required. The Chair noted that primary care providers were also extremely busy. The CNO and DIPC noted the impact that new housing had on primary care services, and the importance of ensuring that the system invested in the right places to ensure that patients did not attend hospital when they did not need to.

<u>Financial Control and Capital Development</u>

The CFO explained that 2024/25 would be a challenging year financially for the Trust. An annual budget had been set, but it was likely that the Trust may spend its entire deficit within the first three months of the year as it moved towards a monthly deficit position of £0.8m. The financial gap to plan in months one and two had been around £3m. The Trust would need to deliver close to 116.7% of 2019/20 elective activity levels during the year, with a large proportion of Cost Improvement Plans (CIPs) being driven by increased productivity in the organisation. Reductions in pay costs would be required alongside the challenge of improving non-pay costs under increasing inflationary pressures. The Trust had invested in services wherever possible, including acute therapy, community services to reduce pressure on wards, and resources to help treat the most challenging patients.

	Paresh, NED noted the importance of ensuring that the Trust's run rate was well controlled during the year. The CFO assured the Board that the CEO was driving the Use of Resources programme within the Trust, which had introduced a number of controls. Productivity improvements needed to be delivered within current capacity wherever possible. Most of the Use of Resources plan had been initiated and divisions were developing additional plans in support which would be shared with the Board when finalised. The CEO explained that the Use of Resources programme would include KPIs and trajectories with key milestones bringing together activity, strategic change, use of estates and other workstreams into a single place. A range of workforce controls had already been instigated with further controls to be introduced. This work would be further supported by a new performance oversight framework, with monthly meetings with divisions to review workforce numbers, budget compliance and activity, which would enable executives to provide challenge when controls were not working as anticipated.	
33/024	**Maternity Overview Q4** The Director of Midwifery presented the maternity update, reporting that the maternity team's focus on improving workplace culture continued. The vacancy rate in the team had been 3.2% for Q4, a reduction from Q3. Sickness rates had fallen and two substantive midwives had been employed to cover parental leave. Challenges relating to the complexity of birthing people and the treatment of patients with complex medical needs continued. Three actions from Healthcare Safety Investigation Branch (HSIB) referrals had been completed. A Badgernet electronic system lead had started in role who would ensure that staff had a greater understanding of the system. An improvement had been seen in perinatal mortality rates in Q4 and the Trust was below the national average rate. The Trust was 96% compliant with the requirements of the Saving Babies Lives Care Bundle v3 Saving and were working with the Local Maternity and Neonatal System (LMNS) to undertake quarterly audits. No themes had been identified following a thematic review of complaints. Obstetric and neonatal staffing rates remained within national guidelines and mandatory training rates remained high. Feedback was received from service users through Family and Friends Tests and the Maternity Voices Partnership, alongside the Trust's complaints and feedback processes. Recent improvements to 24 hour visiting had been well received by service users, along with improved feeding rooms in post natal wards and improvements to visual displays and the service's website. The Chair praised the reductions in sickness and vacancy rates that had been achieved, along with achieving 99% of mandatory training for midwives. The CEO asked if the Director of Midwifery was assured about the quality of the Trust's maternity services and the Director of Midwifery explained that she was. She explained that this was due to the hard work of the maternity staff who loved the jobs they did and the team they worked in. She felt that happy staff led to having good services. Amanda, NED praised the comprehensive report, noting that there had been a steady trajectory of improvement across all maternity indicators over the last three years. She congratulated the Director of Midwifery and her leadership team for this success and asked what progress was being made against the recommendations from the Ockenden report. The Director of Midwifery explained that the recommendations had been merged into a three year delivery plan for the service, which was progressing well. Focussed work on health inequalities was being undertaken. Nicki, NED noted that red flag incidents had dramatically decreased and asked whether this was related to the improved staffing levels being reported. The Director of Midwifery confirmed that this was the case, explaining that there had been a noticeable difference on wards since staffing levels had improved in recent months.	

34/024	**Trust 2024/25 Business Plan** The CEO noted that the Trust's 2024/25 priorities had been discussed at the previous Board meeting, and thanked Board members for their feedback on these. The plan would be subject to further update and presented to the organisation before the end of that week. The business plan set out organisational priorities for the year along with the Trust's strategic approach and the context of how this was linked to the system. It also set out key indicators which would be translated into an overarching dashboard. The plan included various trajectories, as well as the capital plan and use of resources and was deliberately kept at a relatively high level so that it could be used throughout the organisation. Detailed information on trajectories was presented to the Finance and Performance Committee. Frank, NED explained that he felt that the presentation of huge amounts of information worked well. He suggested that a super-summary could be produced that could be tailored to different audiences, which would allow colleagues to narrate the journey that the Trust was on. The CEO agreed that the plan would be tailored for different audiences. She explained that a new Associate Director of Performance would be joining the Trust and would be responsible for ensuring that trajectories were monitored, so that assurance could be provided to the Board and Committees for oversight. Ama, NED asked whether the measurable objective for reducing violence and aggression (V&A) should be included as it was not within the Trust's control. The CNO and DIPC explained that the objective concerned reducing the impact of V&A, and being clear about what was and was not acceptable. The objective was focussed on areas which the Trust could control and would have an impact on V&A. The DCE and CPO noted that the key areas where V&A from patients to staff were reported were ED, the Acute Ambulatory Unit and Frailty. It was important to understand the reasons for patients' frustration and work to address these by creating a better environment. The objective was also about supporting colleagues to be clear about which behaviours were not acceptable and ensure that they felt protected by the environment in which they worked. Nicki, NED explained that she really liked the business plan and looked for ward to seeing the associated KPIs.	
35/024	**ESHT Committee in Common** The COS noted that the Trust had approved the generic terms of reference for the Committee in Common at its last meeting; organisations across Sussex were now being asked to adopt the terms of reference for their own organisations and he sought the Board's approval. **The Trust Board approved the Terms of Reference for the ESHT Committee in Common**	
36/024	**Violence Prevention and Reduction Standard** The DCE and CPO reported that increases in V&A were being reported across the NHS. The report presented to the Board include the Trust's responses to NHSE visits that had taken place in 2019 and the work that was being undertaken as a system to address V&A. The Trust was not an outlier in the increase of V&A incidents being reported; five national workstreams had been developed to address the issue and the Trust was progressing well against each. KPIs were being developed to better understand the impact of the actions being taken and these would be included in the next report to the Board. Addressing V&A was a key priority for the organisation, as well as the local system and for the NHS nationally.	

	The CNO explained that a national framework that was aiming to ensure that patients were in the right place to receive the right care had been instigated; ESHT had been heavily involved with the framework. V&A had a considerable impact on health and social care, and the police force had proposed a change to how they would respond to incidents. The Royal College of Emergency Medicine had expressed concern about this change of approach particularly in relation in East Sussex. It was important that risks were appropriately described to the police to ensure that the correct response was received. Staff were given training to equip them with the skills that they needed to manage and deescalate situations. Karen, NED stated that training for staff was critical and was regularly discussed by Q&S. She was concerned that recent changes at Health Education England (HEE) would impact on the funding for staff training for patients without capacity. The DCE and CPO explained that training continued despite the changes at HEE.	
37/024	**Quality Account Priorities & Delegation of approval of Quality Account 2023/24** The CNO and DIPC requested delegated authority from the Board to Q&S to approve the Quality Account 2023/24. She also set out the three quality account priorities for 2023/24. **The Board delegated authority to the Quality and Safety Committee to approver the 2023/24 Quality Account.**	
38/024	**Board Committees Summaries** <u>Audit Committee</u> The Board noted the verbal update. <u>Finance and Productivity Committee</u> The Board noted the summary. <u>Inequalities Committee</u> The Board noted the summary. <u>People and Organisational Development Committee</u> The Board noted the summary. <u>Quality and Safety Committee</u> The Board noted the summary.	
39/024	**Clinical Research Annual Report** The CMO explained the importance of research to the Trust, noting that it helped with recruitment, improved care for patients and improved job satisfaction. He explained that the Trust had underestimated its target in 2023/24, overrecruiting to research projects during the year and he praised the hard work of the research team. Nicki, NED noted that the annual report had hinted that a business case would be presented in support of research in the Trust and was keen that this was considered when completed. The CEO agreed, noting that it had not been finalised. She explained that research had been a Trust priority in 2023/24 and it had been pleased to see the improved uptake as a result. Funding research could be challenging, so the Trust would need to either identify a new income stream to support this of consider whether it should continue on a loss making basis as it led to quality improvements and helped the Trust to recruit higher quality candidates. The Chair thanked the CMO and Dr Wilkinson for their support of research in the Trust.	

40/024	**Use of Trust Seal** One use of the Trust seal since the last Board meeting was noted.	
41/024	**Date of Next Trust Board Public Meeting** 13th August, EDGH	

Matters Arising from the Board meeting of 11th June 2024

MEETING DATE	MINUTE NO:	ACTION	BY WHOM	BY WHEN	COMMENTS – INCLUDING ANY UPDATES
	OPEN ACTIONS				
There are no open actions					
	NOT YET DUE				
There are no actions not yet due					
	ACTIONS COMPLETED				
11.06.24	32/024	Freedom to Speak Up Guardian Self Reflection to be circulated to the Board	Deputy CEO and CPO	Following June's Board meeting	Document was circulated to the Board on 5th July 2024.

East Sussex Healthcare NHS Trust

Chief Executive's Report

Purpose of the paper	To update on key items of information which are relevant but not covered in the performance report or other papers					
	For decision		For assurance		For information	x
Author	Joe Chadwick-Bell					
Governance overview	Not applicable					

Strategic objectives	Quality	People	Sustainability
	x	x	x
Our values	Kindness	Inclusivity	Integrity
	x	x	x

Recommendation	The Board is asked to note the updates and assurances provided by the Chief Executive

Executive summary

Chief Executive's report

The NHS in East Sussex continues to live in interesting times; since my last report to the Board in early June we have experienced a general election yielding a change in government for the first time in fourteen years, a ransomware cyber-attack by an international criminal group and a successful bid for the East Sussex Community MSK Contract.

General Election results

I wanted to bring to colleagues' attention that the local political environment for the Trust has changed, going from six conservative members of parliament to three conservative, two liberal democrats and one labour member.

I have congratulated all new and re-elected MPs and have sought to initiate a monthly joint meeting (virtually) for all with the Chair and Chief Executive. We have also offered site visits to all MPs so they can familiarise themselves with our sites, our people and the work we do.

Industrial Action over June - July

Colleagues will be aware that The British Medical Association (BMA) announced that junior doctors in England would take industrial action from Thursday 27 June through to Tuesday 2 July 2024. I would like to thank all staff who worked excellently together to ensure that we were able to maintain safe and high-quality services over this period.

As I have noted before, our experience of these events means that we have a well-tested process for ensuring support and cover arrangements and we are hopeful that recent acceptance of the independent pay bodies recommendations will yield a different future and greater stability for patients.

Reopening the Eastbourne Midwifery Unit to births from September

To provide certainty for families, in March we committed to undertaking a review with maternity colleagues to develop a new staffing arrangement that will enable

us to resume births at the midwifery led unit at Eastbourne DGH and provide safe community midwifery services. This work has now been completed and a plan has been proposed that will provide patient focused labour care both at home and in the maternity unit. This will enable us to deliver care flexibly, and ensure it is focused on supporting families with their choice of birth.

This follows the ongoing staffing challenges which meant we have had to suspend the option of births at the Eastbourne Maternity Unit to enable us to continue to provide safe maternity care within the community. This impacts around three births a week, but the unit has remained open throughout for outpatient antenatal and postnatal services.

Work is now underway to implement the new approach to ensure that we can provide a safe and resilient service, which will be in place from 2 September 2024 when births will resume at the unit.

Trust Annual Awards Celebration

The highlight of the last couple of months was undoubtedly our Trust Awards, which took place in July, where colleagues from across the organisation were recognised in an evening that celebrated the dedication, commitment and amazing work that takes place on a daily basis.

Getting together with over 250 wonderful colleagues for the awards is such a special night and being able to recognise the amazing work being done throughout the trust is a highlight of the year. I am so proud of everyone involved, be they finalists across the 18 categories, winners, or the team who helped put on the event.

Listening to our patients and partners to make care better

Last month our Community Health and Integrated Care division hosted a clinically-led patient experience event bringing together patient partners, Healthwatch, and different teams from across the division to share their experience of patient engagement.

The teams shared details of patient engagement methods that they have used to develop and deliver their projects, including digital patient feedback, prospective patient stories and verbal feedback. The event highlighted how the division have utilised a wide range of ways to gather patient insight to support the development and improvement of their services.

A significant conclusion from the day is that one size doesn't fit all and that we need to be flexible and varied in our approaches if we truly want to understand and reflect the needs and wants of our patients and the communities we serve.

National honour for Trust Orthopaedic surgeon

I am delighted to announce that Professor Scarlett McNally, who has been a consultant orthopaedic surgeon at East Sussex Healthcare NHS Trust since 2002, has been awarded Honorary Membership of the Faculty of Public Health in recognition of her national work improving the population's health.

She has worked on reducing pollution, increasing active travel, reducing bullying and valuing every member of staff, using 'bite-sized' education and

'perioperative care' so people having operations prepare well with good pathways to halve complications. Professor McNally now works part-time at the Trust and has teaching, leadership, writing and speaking roles. She writes a regular column in the British Medical Journal suggesting how to improve health and is an Honorary Clinical Professor at Brighton and Sussex Medical School.

Synnovis data leak and impact on patients

Despite not being one of the Trusts directly impacted by the cyber-attack, we experienced operational issues in the delay to some of the send away tests to Synnovis. The Information Commissioner's Office was notified of the breach by Synnovis, and we are awaiting further information on the data analysis and whether any of our patient data was involved in the breach.

Once we are notified, we will then take the appropriate actions and we remain in close contact with NHS Sussex. Guidance from NHS England suggests that the validation of data potentially exposed could take up to a year to sift, largely due to the volume of data involved.

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A significant conclusion from the day is that one size doesn't fit all and that we need to be flexible and varied in our approaches if we truly want to understand and reflect the needs and wants of our patients and the communities we serve.

A role for ESHT in Cancer Vaccine Launch Pad

The trust has been selected to support the Cancer Vaccine Launch Pad (CVLP) platform. This aims to speed up access to the mRNA personalised cancer vaccine clinical trials for people who have been diagnosed with cancer, which will play a crucial part in the increased development of cancer vaccines as a treatment for many different types of cancers.

Prototype Pottery project for cancer patients

People undergoing treatment for cancer in Eastbourne will soon be able to access a new form of support in a new and exciting collaboration.

The new "Prototype Pottery Project" is the idea of Issy O'Donnell, a Cancer Support Project Worker. In the project, people with cancer undertake a short, specialised course at the Eastbourne Pottery studio in crafting ceramics, with peer support in a relaxed environment alongside other people who are being treated for cancer.

Issy worked with the Public Health team at the county council to set up the project as part of our goal to provide new ways to support people with cancer, their

	families and their carers. The council have collaborated on the design of the Prototype Pottery Project and will be evaluating it to see how this "creative health" offer can support people with cancer.
Next steps	Not applicable

East Sussex Healthcare NHS Trust

Report to:	Board of Directors	**Agenda Item:**	8.1
Date of Meeting	**13 August 2024**		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the Audit Committee on 25 July 2024 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 Update

The Committee noted proposals to deploy a Mental Health Outreach (MHO) team, who would offer specialised support to patients with mental health issues and thereby decrease the reliance on security personnel. A Head of Nursing for Mental Health job role had been advertised and once a candidate was appointed then onboarding for the 13 support roles could begin. The MHO team was expected to be operational within three months.

Frontline colleagues would also be given additional training in how to deescalate potentially volatile situations. Confirmation was received that a wider review of site security would take place; its findings would be reported to the Committee in Spring 2025.

Review of Losses and Special Payments

Details of losses and special payments over the past financial year were brought to the Committee. Systemwide collaboration to drive further efficiencies was also being explored.

Tenders and Waivers

35 waivers were granted during 2023/24. The Committee asked what work was being done to move away from sole supplier contracts. It was explained in response that these arrangements were often linked to ongoing usage or specialised system maintenance.

Information was provided about the new contract management system, which could automatically send alerts for contracts nearing their expiry date. This would help in ensuring sufficient time for comprehensive tendering exercises wherever appropriate.

Cybersecurity Update

A discussion took place around the difference between the ESHT's cybersecurity risk ('medium') and the wider NHS risk ('high'). There was increasing evidence of sophisticated cyber attacks by state actors and the NHS was considered a prime target. ESHT was in a relatively strong position compared to other trusts and any further mitigations would need considerable financial resource to implement. The 'medium' risk assessment was derived in part from an external review by Qualys and it was confirmed that the protections described in the report were in place across the organisation.

Alert, Advise and Assure

Alert

None.

Advise/Inform/Update

Data Security and Protection Toolkit (Internal Audit Report)

RSM (internal auditors) had given an opinion of 'moderate' assurance against the Data Security and Protection Toolkit submissions for 2023/24 in terms of endorsing the Trust's self-assessment.

However, an opinion of 'limited' assurance was given regarding the overall data security and data protection control environment. The Committee requested further clarification about this disparity and whether different standards were being applied in each case.

Project Management & Benefits Realisation (Internal Audit Report)

A review by RSM confirmed robust project monitoring arrangements were in place for both the Bexhill CDC and Sectra PACS projects, and that both business cases had been approved by the Trust Board in line with guidance.

RSM noted there was not overarching procedural guidance in place at the Trust for project management; this could increase the risk that individual divisions work independently rather than cohesively and that inconsistent working practices may develop over time. The Committee were advised that some general upgrades to project management standards were underway, including a standardised business case template.

Assure

Rostering and Temporary Staffing (Internal Audit Report)

'Reasonable' assurance was given by RSM's audit on the current rostering and temporary staffing processes: confirming that rosters are created and approved in a timely manner, all shifts are appropriately staffed, and appropriate controls are put in place to minimise the use of agency staff, saving the Trust money.

As of 8th July 2024, a new fortnightly Rostering Assurance Panel had been established and was attended by key leaders to drive more effective, efficient, and compliant rostering. A core focus of this meeting would be ensuring that rosters were approved and entered onto the system at least eight weeks prior to commencement of shifts.

Key Risks or Opportunities and their impact on the Trust

None.

Key Decisions

None.

Exceptions and Challenges

Board Assurance Framework (BAF) Q1 & Corporate Risk Register

There was acknowledgement that the BAF should be updated to make the risks and controls clearer, as well as how senior leaders took assurance that source data was valid.

The Committee emphasised that the new template should be explicitly forward looking and give more detailed assurance that mitigations against risks were working. Furthermore, risk scoring should be standardised in relation to other risks and any changes highlighted.

Recommendations

The Board is asked to note this report.

Report to:	Board of Directors	**Agenda Item:**	8.3
Date of Meeting	13 August 2024		

Title of Report:	**Finance & Productivity (F&P) Committee**
Status:	For Discussion
Sponsor:	Nicki Webber, Chair of F&P Committee
Author:	Nicki Webber, Chair of F&P Committee
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the Finance & Productivity Committee on 18 July 2024.

Background

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

Business Undertaken

Post Project Evaluation: Discharge Lounge

The Committee received a post implementation benefits analysis on the discharge lounge established at EDGH. The average number of patients using the discharge lounge each day was slightly lower than planned levels largely due to the unit being used overnight to support patient flow. There was a plan to introduce a solution to capture Friends and Family Tests electronically which would be implemented by November 2024, but interim data (limited scale) indicated that patient experience had improved.

Post Project Evaluation: Infusion Suite

The Committee received a post implementation benefits analysis on the expansion of the Infusion Unit. There had been some delay starting the project as recruitment had been more challenging than anticipated, and this had impacted on the number of patients treated. However there were mitigations in place to catch up with this. Additional information was requested to allow greater understanding of whether the anticipated benefits had been achieved.

Alert, Advise and Assure

Endoscopy – Bexhill Digestive Diseases Centre

The Committee received an update paper on Endoscopy following the agreement at the June Committee to review three alternative options for the siting of the Digestive Diseases Centre. The paper presented outlined a number of alternative sites for the location of the Digestive Diseases Centre, and recommended that the centre be sited on the first floor of the surgical centre. The Committee supported the development of a final business case for the project. Conversations with the ICB are ongoing.

Community EPR Update

An evaluation process had been carried out collaboratively by all four Trusts within the Sussex & Surrey NHS Community & Mental Health Collaborative. The Committee supported the recommendation to award the contract to the highest scoring bidder, noting that due tendering processes had been followed.

Five-year Capital Plan update
A review of the Trust's five-year capital plan was presented. The challenges associated with capital for 2024/25 and 2025/26 were noted, with risks being actively managed by estates and finance teams to ensure that core programmes continued to be supported. A dynamic process had been introduced to ensure that the capital plan is subject to detailed review on a monthly basis.

Q3 Service Line Reporting (SLR)
The Committee received a paper on the Q3 SLR position for information and noted that this was being taken forward through the improving best practice part of the Use of Resources programme. The programme had identified the top five loss making specialities in the Trust with in-depth review of these specialities being undertaken; focussed action plans and support were being developed to try to improve performance in these areas.

Key Risks or Opportunities and their impact on the Trust

M3 Financial Performance
It was reported that the Trust's financial performance in month 3 had been below plan. The Committee sought assurance about the steps being taken to return to the planned financial position for the year. It was agreed that the key risks to the Trust's financial performance would be circulated to the Board by the Committee Chair following the meeting. An additional board meeting on 5 August would also consider additional detail on the Use of Resources programme.

It was noted that financial underperformance in Q1 impacted cash projections. I&E and capital spend impact on cash would continue to be closely monitored to ensure that any requirement for additional central funds could be escalated in an appropriate timeframe.

System Update
The Committee received an update on the financial performance of the Integrated Care System and the increased financial controls that were being introduced across the region.

Key Decisions

Endoscopy – Bexhill Digestive Diseases Centre
The Committee supported the recommendation that the Digestive Diseases Centre business case be drawn up on the basis of siting the centre on the first floor of the surgical centre.

Board Assurance Framework Q1
BAF 4:
Failure to deliver income levels/manage cost/expenditure impacts savings delivery
Currently at 16. It was agreed to increase the risk to 20.

BAF 5
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.
It was agreed that the rating for BAF 5 should remain at 16.

BAF 7
Failure to develop business intelligence weakens insightful and timely analysis to support decisions
It was agreed that the risk rating should remain at 16

BAF 8
Failure to transform digitally and deliver associated improvements to patient care.
It was agreed that the risk rating should remain at 12.

Exceptions and Challenges
The financial underperformance in Q1, and delays in finalising the UoR programme have been escalated to Board.
Recommendations
The Board is asked to note this report.

East Sussex Healthcare NHS Trust

Report to:	Trust Board	**Agenda Item:**	8.2
Date of Meeting	13th June 2024		

Title of Report:	Inequalities Sub Board Committee – Chair's Report
Status:	For Assurance
Sponsor:	Steve Phoenix, Chair of Inequalities Committee
Author:	Steve Phoenix, Chair of Inequalities Committee
Appendices:	None

Purpose

This report summarises the discussions, recommendations, and approvals made by the Inequalities Sub Board Committee on Thursday, 13th June 2024, to provide the Board with an update of the Committee's activities.

Background

The Inequalities Sub Board 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

People Experience:

The Deputy Chief Executive and Chief People 20Officer provided a consolidated report on various datapoints related to staff experience, noting consistency across reports. Emphasis was placed on splitting data into violence, aggression, and incivilities for better insights. Key findings included high job satisfaction among colleagues from multicultural backgrounds, but concerns around incivilities and psychological safety persist, especially in specific areas like AMU and ED. A six-month pilot panel for bullying and harassment incidents is underway, with feedback and resolution mechanisms being reviewed.

EDI High Impact Actions:

The Committee was provided with updates on several critical areas, including a draft talent management strategy, completion of the gender pay gap report, and ongoing work on the ethnicity pay gap. Collaboration with digital and procurement teams is ensuring clarity on responsibilities for reasonable adjustments. A communications campaign addressing incivility and poor behaviours is planned in three phases.

ESHT Network Visibility:

The Committee was provided with information on recent network roadshows, which were successful and resulted in significant new sign-ups across various networks. Efforts are ongoing to improve network outreach, including a new page on the external website for easier access.

Maternal Health:

The Committee received a presentation from the Director of Maternity Services on maternal health, highlighting links between deprivation and poor birth outcomes, higher rates of stillbirth, preterm birth, and foetal growth restrictions. Emphasis was placed on addressing high BMI and smoking rates among pregnant women.

Health Inequalities Strategy:

The Committee was provided with a draft strategy, from the Chief of Staff, which was reviewed and focused on realistic goals and progress tracking. Feedback from Public Health is pending.

Alert, Advise and Assure
Alert: None Advise: Continued monitoring and development in areas of staff experience, particularly incivilities and psychological safety. Ongoing work on the talent management strategy and completion of the ethnicity pay gap report. Assure: Positive feedback from network roadshows and increased membership. Successful implementation of EDI actions and ongoing collaborations.
Key Risks or Opportunities and their impact on the Trust
The Committee requested for update on the following risks: Completion of the ethnicity pay gap report. Implementation and communication of the bullying and harassment pilot panel outcomes.
Key Decisions
Approved the plan to split data into violence, aggression, and incivilities. Supported the ongoing development of the Health Inequalities Strategy.
Exceptions and Challenges
The ethnicity pay gap report data will be presented to the September 2024 meeting. The understanding our patients' through data and associated action plans, are pending and will be addressed at the September 2024 meeting.
Recommendations
The Board is asked to note this report.

Report to:	Board of Directors	Agenda Item:	8.4
Date of Meeting	13 August 2024		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the People & Organisational Development (POD) Committee on 18 July 2024 to provide the Board with an update of the Committee's activities.

Background

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

Business Undertaken

POD Workforce Insight Report

Key highlights of the workforce data for June 2024:

- Increase in total workforce usage –predominately related to substantive due to a commitment via the Use of Resources to commit to offers of employment
- Pay expenditure had increased - predominantly driven by escalation and waiting list initiatives
- TWS expenditure remained stable due to some specific and significant plans in place
- The Trust vacancy rate reduced significantly, by 2.0% to 3.5% (278.3 wte vacancies)
- The mandatory training rate continued to increase, up by a further 0.4% to 90.9%
- The appraisal rate increased by 0.2% to bounce back to 83.7% (the same rate as Jun 24, which represented the peak for the last four years)
- The Turnover rate showed an increase of 0.2% to 10.6% (756.2 wte leavers in the last 12 months; an increase of 18.2 since last month)
- The monthly sickness rate had increased by 0.4% to 5.2% and, consequently, the annual sickness rate had increased by 0.1% to 5.3%.

Staff Survey Feedback - CHIC Division

Key highlights:

- Process in place to invite any comments or feedback in terms of how we are using our staff survey feedback to really inform priorities and actions
- Co-Design meeting in place for senior staff to focus on different areas and specific sessions to review the staff survey results and devise actions (comparison to actions of the previous year)
- Worked with HRBP and People Experience Manager in supporting the teams to understand the data and to ask questions
- Thank you to the Insight Team who provided additional data for the division.

Challenges:

- Capacity and demand – working within block contracts
- Violence and aggression – an ongoing concern
- Resources – estates, equipment

Staff Engagement – Accreditation as a Mental Health First Aider

A verbal update was provided of Accreditation as a Mental Health First Aider. Once training had been delivered and qualification and accreditation received, there was no requirement to redo after any period of time but it would be important for the individual to maintain status. Refresher training was not a requirement but available at an additional cost to the Trust. Currently 216 people trained in mental health awareness across the Trust.

Career Pathway Report

Key highlights:

- The range of initiatives linked to the development of Career Pathways over the last 12 months- including those linked to the "Art of the Possible"
- The challenges that have been experienced and solutions that have been implemented over the last 12 months to sustain change
- The lack of context following the launch of the Long-Term Workforce Plan in 2023 which is impacting on organisations being able to develop robust career pathways
- The "temporary" suspension of proven career pathway opportunities impacting Medical Associate Professions, which has already led to posts being withdrawn and Universities suspending PA apprenticeship programmes
- The focus on maximising the potential of our current leadership, through the commissioning of a robust and sustainable Leadership and Coaching programme that will sustain a career pathway for the future as it will clearly set the competencies required.

Alert, Advise and Assure

Medical & Nursing Revalidation Reports

The Medical Revalidation Annual and the Nursing Midwifery Revalidation Annual Report were shared.

The POD Committee accepted the reports for approval and assurance, respectively.

Appraisal Compliance monthly update

The Appraisal data for June 2024 indicated that there had been some significant improvements in compliance across the divisions.

NHSI Workforce Submission

The NHSI Workforce Submission paper provided data on workforce reductions, numbers and plans in place. It also detailed a reduction in averages versus the reduction in actuals, which looked complicated but averages out mid-point within the year.

The POD Committee accepted the report for assurance.

Key Risks or Opportunities and their impact on the Trust

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

Key Decisions

Board Assurance Framework Q1

BAF 2:

Failure to attract, develop and retain a workforce that delivers the right care, right setting, right time.

The residual risk rating was unchanged at 15.

BAF 3:

Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.

The residual risk rating was unchanged at 16.

A conversation took place regarding possible rewording of the risk to include all eventualities. It was agreed to reword the risk with the score to remain at 15.

The POD Committee approved the BAF 2 and BAF 3 risk scorings.

Exceptions and Challenges
Art of the Possible (Entry Routes into Mental Health and Learning Disability Nursing) "Art of the Possible" update to be discussed at a future POD Committee.
Recommendations
The Board is asked to note this report.

Report to:	Board of Directors	**Agenda Item:**	8.4
Date of Meeting	13 August 2024		

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 18 July 2024 to provide the Board with an update of the Committee's activities.

Background

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

Business Undertaken

Division Report – CHIC

High levels of mandatory training compliance were noted within CHIC, but there was a request for more detail in future divisional reporting about professional training rates. It was agreed by the Committee that a paper assessing this across all ESHT divisions would be brought to QSC.

Governance Quality Report

The Committee noted ongoing challenges around data extraction, associated with the transition to Datix Cloud IQ (DCIQ).

Learn from Patient Safety Events (LFPSE) forms had undergone significant change, leading to a disruption in reporting. An update to the framework was scheduled for September 2024 and it was hoped this would go some way to addressing these difficulties, which were apparently being experienced nationally.

A deep dive on how the new Patient Safety Incident Response Framework (PSIRF) was being integrated across the divisions would be presented to the QSC in September. It was noted that in many ways processes were felt to be more robust under PSIRF but determining how best to communicate that assurance would be part of the next steps.

Alert, Advise and Assure

Alert

None.

Advise/Inform/Update

Maternity Dashboard & Ockenden Perinatal Quality Surveillance Report

Several recommendations were presented to and endorsed by the Committee:

- Review to be undertaken of Avoiding Term Admissions into Neonatal units (ATAIN) rates, with a focus on babies admitted because of transient tachypnoea of the newborn (TTN) or respiratory distress syndrome (RDS)
- Review of babies born with low Agpar scores, due to a small recent increase in cases per 1000 births

- Review cases of shoulder dystocia – audit requested
- Monitoring compliance with booking before 9+6 weeks' gestation, following a slight dip.
- The Sussex Local Maternity & Neonatal System (LMNS) would continue to receive all relevant reports to demonstrate learning, development, and safety at ESHT.

The learning from these reviews would be shared with the QSC.

High Level Risk Register

Risk mapping work had been undertaken to get an overview of areas which might benefit from greater focus. Although lots of risks were listed under the Core Services division, many of these were perhaps better categorised as Estate risks.

A refresh of the risk management processes was ongoing, and the Committee requested specific details on mitigations and assurance for the risks which linked with the QSC's BAF areas.

Assurances

Mortuary Compliance against Sir Jonathan Michael Inquiry Report (SJMIR) Recommendations

The Committee received updates on actions ESHT had undertaken after review of the 17 Phase 1 SJMIR recommendations. It was noted that Phase 1 focused specifically on Maidstone and Tunbridge Wells NHS Trust. Phase 2 had not yet been completed, but would consider nationwide policies and procedures regarding deceased individuals before making more tightly defined recommendations. Future reporting to QSC on this matter would include full details of any related Datix or HTA Reportable Incidents (HTARIs) to provide further assurance.

Key Risks or Opportunities and their impact on the Trust

None.

Key Decisions

BAF Q1

Risk scoring for BAFs 10 and 12 were discussed, with it being noted that the current and target levels were the same in each case. A challenge was raised that with some mitigations already in place and others planned, scoring could be reduced immediately and/or in the foreseeable future. The Committee highlighted that many challenges related to discharge could only be addressed with systemwide evolution which had not yet been fully mapped out. Furthermore, Emergency Department attendances had recently spiked. Although mitigations ESHT could undertake beyond those already listed on the BAFs were likely minimal, the Committee did not feel comfortable lowering their risk scoring due to the external factors at play.

Exceptions and Challenges

Quality Dashboard

There were ongoing Datix IQ technical issues which acted as barriers to comprehensive and accurate BI reporting within the Quality Dashboard. The Committee requested a paper to explain these in detail so an action plan could be made.

It was noted that the previous month's data for the Quality Dashboard was not always available for scrutiny at QSC under the current scheduling. A review of QSC meeting dates would be undertaken to develop better alignment of reporting from the Patient Quality and Safety Group, on to QSC, and ultimately the Trust Board.

Recommendations

The Board is asked to note this report.

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

KINDNESS

INCLUSIVITY

For the Period June 2024 (Month 3)

INTEGRITY

Content

East Sussex Healthcare NHS Trust

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

About our IPR

East Sussex Healthcare NHS Trust

Our IPR reflects how the Trust is currently working and how the on-going journey of improvement and excellence, reflected within our Strategy and Operational Plan (2023/24), is being delivered.

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

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

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

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

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

Chief Executive Summary

East Sussex Healthcare NHS Trust

The Trust has seen improvement across a number of key metrics. The Trust remained in the upper quartile for performance against the 4-hour Emergency Access Clinical Standard for the third consecutive month in June, delivering 79.1% against the 78% standard. Improvements were also seen in May for cancer performance; the Trust delivered 81.6% against the Faster Diagnosis standard of 77%. 31-Day performance was more challenged, and the trust delivered 92.0% against the national target of 96%. Performance against the 62 Day standard was 59.2% against a trajectory of 63%. Recovery Plans are in place to increase capacity and reduce the current delays to support improvement against this metric.

The Trust is working towards delivering the 2024/25 operational planning guidance and is focused on continuing to improve a number of key indicators and standards to support the provision of high-quality care for our patients, building upon the improvements already seen across elective and urgent care in 2023/24. The Trust continues to prioritise front door performance, length of stay optimisation, and efficient discharge processes to ensure that patients receive timely and effective non-elective care. Additionally, the Trust is committed to improving elective recovery, especially in critical areas including cancer treatment, diagnostics, routine long waits, and including supporting system partners with reducing the number of long waiting patients.

Key Areas of Success

- As a result of the ongoing efforts and hard work of our teams the Trust were amongst 20 trusts nationally that delivered the 78% standard in June.
- The trust delivered the 28-day Faster Diagnosis cancer standard for both April and May, ensuring that >77% of patients referred on a suspected cancer pathway received a diagnosis within 28 days from their referral being received.
- Cancer 62 Day performance reduced to 59.2% (against a trajectory of 69%). There were 115 patients waiting over 62 days at the end of June.
- The Trust are sustainably delivering above target for our 2-hour urgent community response.
- From a finance perspective, good progress is being made on our Use of Resource programme with the majority of workstreams now established

Key Areas of Focus

- Whilst 4-hour performance is again an improving picture, delivering the actions from our Urgent and Emergency care improvement plan to ensure sustainable delivery of the 4-hour performance continues to be a priority for the Trust.
- A key area of focus in the coming months is to address the average length of stay in our acute and community beds and overall bed occupancy rates.
- Improving performance against the cancer standards, with a focus on reducing waiting times and expediting treatments. Trajectories and Action Plans are being developed to support improvement across the cancer tumour sites.
- The Trust is supporting the wider Sussex System to eliminate 65ww by the end of September 2024. We are providing neighbouring trusts with Mutual aid across a number of specialties where patients are waiting longer than 65ww for treatment. This is being done alongside own ambitious plans to further recover our elective position and eradicate >65 week waits earlier than the national ask of September 2024.
- Continued focus on both Trust and Divisional level to improve productivity and ERF performance against plan.

Balanced Scorecard

East Sussex Healthcare NHS Trust

Safety	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Number of Patient safety events (severity 1-5)	0	985	864	794	Common Cause	Not Met
Number of Patient safety events (severity 3)	0	21	17	6	Common Cause	Not Met
Number of Patient safety events (severity 4 ...	0	1	5	2	Common Cause	Inconsistent
Never Events	0	0	0	0	Improvement	Inconsistent
Inpatient Falls per 1,000 Bed days		3.82	4.49	5.18	Common Cause	Target required
Cat 3 ESHT Acq. PU (rate) per 1,000 bed days	0	0.0371	0.0394	0	Common Cause	Inconsistent
Cat 4 ESHT Acq. PU (rate) per 1,000 bed days	0	0	0.0394	0	Common Cause	Inconsistent
Healthcare Associated MRSA Bacteraemia (r...	0	0	0	0	Common Cause	Inconsistent
Healthcare Associated C Diff Infections (rate)...	0	0.259	0.433	0.181	Common Cause	Inconsistent
Healthcare Associated MSSA Bacteraemia (r...	0	0.222	0.276	0.241	Concern	Inconsistent
RAMI	100	91.0	91.1	84.9	Concern	Achieving
SHMI (NHS Digital monthly)	100	100	101		Concern	Inconsistent
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	94.6%	95.4%	84.8%	Improvement	Not Met

Patient Experience	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Complaints received		40	30	19	Common Cause	Target required
Complaints Response Compliance		75.8%	75%	29.4%	Improvement	Target required
Reopened Complaints		5	6	2	Common Cause	Target required
A&E FFT Score	85%	64.1%	79.1%		Common Cause	Inconsistent
A&E FFT Response Rate		0.308%	16.6%		Improvement	Target required
Inpatient FFT Score	95%	99.0%	97.0%		Concern	Achieving
Maternity FFT Score	95%	100%	100%		Common Cause	Inconsistent
Outpatient FFT Score	95%	98.1%	94.5%		Concern	Achieving
Post Covid19 Assessment FFT Score	95%	42.9%	33.3%		Common Cause	Inconsistent

Our People	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Establishment (WTE) All		8,406	8,280	7,385	Improvement	Target required
Agency Rate	3.6%	1.37%	1.45%	2.91%	Improvement	Achieving
Vacancy Rate	7.5%	5.5%	3.5%	9.86%	Improvement	Inconsistent
Staff Turnover	11.6%	10.4%	10.6%	9.79%	Improvement	Inconsistent
Retention Rate	90%	91.8%	91.8%	92.4%	Improvement	Achieving
Monthly Sickness - Absence %	4.7%	4.82%	5.2%	4%	Common Cause	Inconsistent
Sickness - Average Days Lost per Fte	17	19	19.2	17.1	Improvement	Not Met
Staff Appraisals	85%	83.5%	83.7%	76.6%	Improvement	Not Met
Statutory & Mandatory Training	90%	90.5%	90.9%	86.3%	Improvement	Inconsistent

Our Performance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
4 hour standard	76%	78.6%	79.1%	95.0%	Improvement	Inconsistent
A&E > 12 hours from arrival to discharge	0	777	741	25	Concern	Not Met
A&E waits over 12 hours from DTA	0	4	6		Concern	Inconsistent
Conveyance handover >60 mins	0%	1.22%	1.98%	0.344%	Common Cause	Inconsistent
Non Elective Length of Stay	4.48	4.75	4.41	3.26	Common Cause	Inconsistent
Average daily NCTR	95	262	261		Concern	Not Met
104 day Backlog	35	11	25	96	Common Cause	Inconsistent
Elective Activity (ELIP,DC,OPFA, OPFUP P...	108%	122%	118%		Improvement	Inconsistent
RTT under 18 weeks	92%	57.6%	57.3%	68.6%	Concern	Not Met
RTT 65 week wait	280	36	49	0	Improvement	Achieving
RTT Total Waiting List Size	58968	54006	54467	23064	Common Cause	Achieving
Diagnostic <6 weeks	1%	10.7%	12.9%	32.7%	Common Cause	Not Met
Urgent Community Response within 2 h...	70%	85.3%	80.8%		Improvement	Achieving
CHIC wait times < 13 weeks	75%	79.0%	79.7%	91.1%	Concern	Achieving
Intermediate Care Length of Stay	30	41.7	36.2	17.5	Common Cause	Inconsistent
% Discharges delayed 1+ days		21.1%	19.8%		Common Cause	Target required
Total delay days from monthly Discharges		5183	3789		Common Cause	Target required
Number of Deferred visits/ care plans	0	6299	6800	1768	Concern	Not Met
Cancer 2WW	93%	81.7%	82.9%	93.8%	Common Cause	Inconsistent
Cancer 62 Day	85%	62.7%	59.2%	65.1%	Common Cause	Not Met
28 Day General FDS	75%	74.8%	81.6%	72.8%	Improvement	Inconsistent

Finance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance

Constitutional Standards | Benchmarking

*NHS England has yet to publish all June 2024 Provider based waiting time comparator statistics

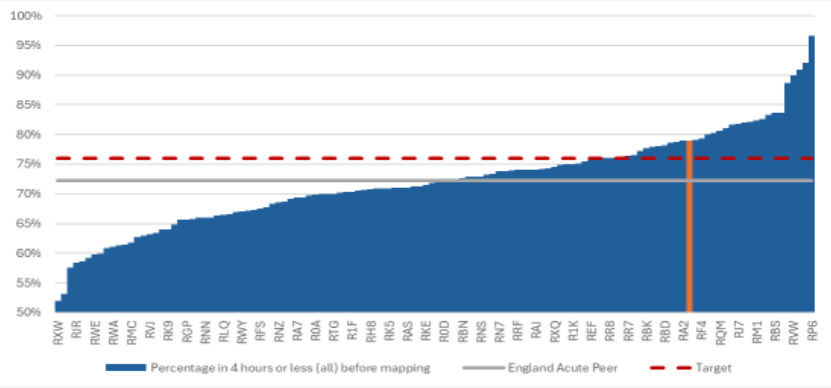
East Sussex Healthcare NHS Trust

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

June 2024 Peer Review

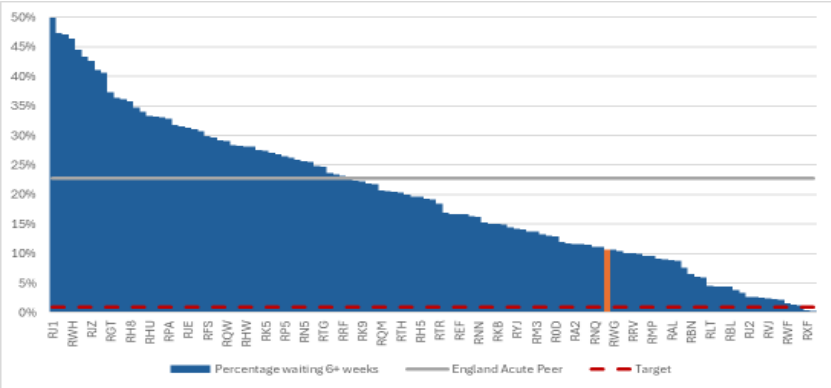
National Average: 72.2% ESHT Rank: 20/124



Planned Care – Diagnostic Waiting Times

May 2024 Peer Review*

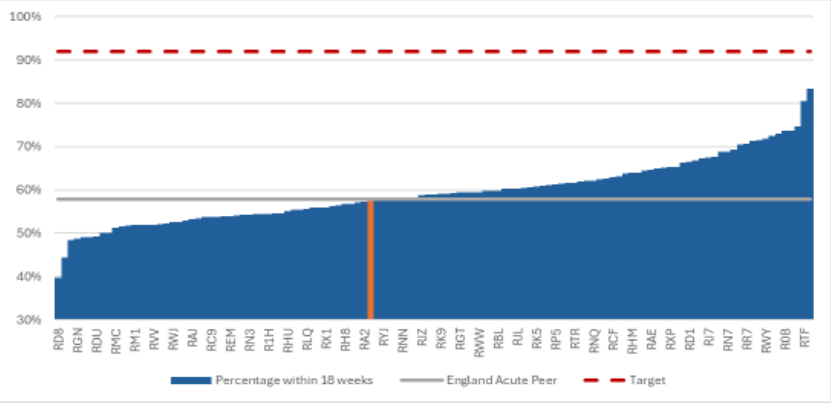
National Average: 22.8% ESHT Rank: 33/119



Planned Care – Referral to Treatment

May 2024 Peer Review*

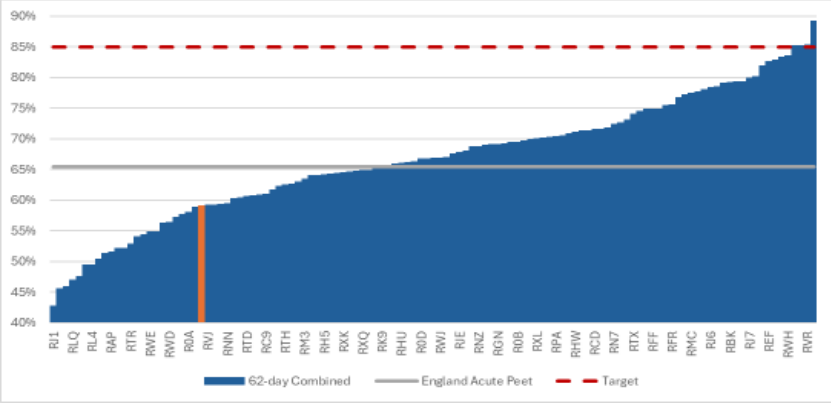
National Average: 57.9% ESHT Rank: 70/119



Cancer Treatment – 62 Day Combined Standard

May 2024 Peer Review*

National Average: 65.5% ESHT Rank: 96/119



Quality and Safety

Delivering safe care for our patients

What our patients are telling us?

Delivering effective care for our patients

Safe patient care is our highest priority

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

Quality and Safety | Executive Summary

East Sussex Healthcare NHS Trust

Data
The transfer of DatixWeb to DCIQ continues. DCIQ is a new system that will help theme and trend patient safety events as it is populated with information. As a result of this, our Information Management and Datix teams have had to rebuild the criteria by which the data is extracted. This has been a good opportunity to align codes that are extracted at the 'front end' by the Datix Team and the 'back end' by Information Management. Data only includes ESHT Patient Safety Events.

Infection Control – HOHA Hospital Onset Healthcare Associated, COHA Community Onset Healthcare Associated CDI Limits have not been set this year. For the month of June, we reported 11 cases of CDI. 5 were HOHA and 6 COHA. There has been an outbreak of CDI at EDGH relating to 002 strain. 6 cases (2 sovereign and 4 Litlington ward) subtyping has returned these 6 cases as indistinguishable. This suggests that there is a wider source of transmission which the DIPC and IPCT are monitoring. They are considering further actions to prevent future cases. This is still on going.

MRSA bacteraemia were reported in June. The one case reported in April was assessed as unavoidable. 11 MSSA bacteraemia were reported in June. 4 COCA (patient had not been an inpatient in the last 12 weeks), 2 COHA and 5 HOHA all the cases were either unavoidable or were from an unknown source.

Measles - UKHSA have reported an increase in cases nationally and locally in young adults as well as children who have not been vaccinated with the MMR vaccination. EDGH have had 1 confirmed case in ED only. Lessons - Clinical staff to be measles aware and consider a diagnosis of measles in those patients who meet the clinical criteria. Clinical staff to inform IPCT in a timely manner. Contact tracing and notifying UKHSA can be started on suspicion of measles.
The Trust continued to experience COVID bay closures with prevalence increasing and declining in a wave like pattern. Most patients did not require additional treatment. During June outbreaks affected Berwick, Glynde, Seaford and Sovereign at EDGH and Egerton/Benson and Murray at Conquest.

Safety Events
Reporting on Datix has reduced for the month of June 2024. 73% of the total patient events were no harm/near miss, with the national average at 71%. We have a good reporting culture at ESHT, with multiple changes happening concurrently with the introduction of PSIRF, DCIQ migration and National LFPSE reporting.

Harm Level based on reporting date & current severity:

There are 2 Catastrophic events (Severity 5) reported in June 2024.

- Potential prescribing error (SDEC), for suspected DVT. *This has since been downgraded to severity 2 post investigation*
- Patient had a neck fracture and limb weakness. This case has also resulted in an Inquest (ED at EDGH)
- Patient had an intracranial bleed and anticoagulation therapy as a contributory factor has not been ruled out. This is currently under investigation and is also an inquest.

2 Major events (severity 4) were also reported which were due to a fall at the Irvine Unit whilst patient was mobilising independently. The other was in the Urology Investigation Suite with a potential failure/delay to act on abnormal blood/lab test/radiological results. All of these events are now undergoing investigation.

Treatment and care for patients who do not meet the criteria to reside
ESHT are committed to ensuring that patients who are residing in hospital after their treatment are able to transfer to their next destination as soon as possible. Where this is not possible, we aim to manage risk to prevent those patients coming to harm in our care whether that be from physical or psychological harm. As a Trust we are looking at ways that we can grow our community teams to prevent admission, improve the discharge processes within the acute setting and community services to support the patients' onward journey.

Author(s)

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

Simon Merritt Chief Medical Officer

Quality and Safety | Executive Summary

East Sussex Healthcare NHS Trust

Patient Experience

30 new complaints received, a decrease of 10 compared to May.
Against our internal targets, 2 complaints were overdue at the end of June (the oldest being 16 working days over). Of the complaints closed in-month (against the timeframe of 60 working days), 77% were completed in time (May =76%). Reviewing the monthly risk rating of all complaints, most were 'moderate' in common with the general pattern:
3 high risk (May = 5)
8 low risk (June = 11)

Of the 30 complaints in June, 83% came from three categories: Patient Care = 15, Clinical Treatment = 5, Communications = 5.

6 complaints were reopened (May = 5), 2 were assigned to Urgent Care, 2 to Medicine, 1 to SPH and 1 to DAS (4 were unhappy with/seeking further clarification following the Trust's response, 1 was a meeting request and 1 was following the PHSO's investigation).

The Trust received 1 outcome from the PHSO in June.
Top complaint location in June was ED = 7 (EDGH = 5 and CQ = 2)
Richard Ticehurst SAU = 2 (May = 3), Jevington = 2, Tressell = 2.

530 contacts were recorded by PALS in June (May = 547) of these contacts, 282 PALS contacts were recorded as "concerns" (May = 289).

The top three primary PALS subjects recorded as a "concern" remain as follows: Communication = 87 (of these 48% related to communication with patients, relatives and carers), appointments = 54 (of these 63% related to long waiting times and cancelled appointments), clinical treatment = 28 (delay in treatment/care, acting on test results).

FFT change to Healthcare Communications during June, this was a phased implementation. All areas will be fully implemented by August. 9806 FFT surveys were returned in June (May = 2474), this is a significant increase. Highlight for June, ED positive score is now 79.07% (national avg = 79%) and has a response rate of 16.56% (May = 0.31%).

Workforce

We have continued to see an increase in demand in attendances to the Emergency Departments and inpatient beds, despite a continued focus on discharge and our improvement programmes for length of stay. There are still significant numbers of patients whose primary need is psychosocial in our Emergency Departments (ED) and gateway/inpatient areas requiring specialist Mental Health support/skills. The new Mental Health outreach team recruitment is underway. Ward and Community staffing in June remained stretched to cover the additional requirements. In all areas this is likely to have had an impact on key quality KPIs, access to training and at times staff wellbeing with sustained pressures. Although overall there continues to be an improvement in appraisals and mandatory training compliance. Focus continues on Healthroster efficiency, use of temporary workforce, authorisation of additional shifts and supernumerary time. There are significant improvements noted regarding the use of additional shifts and roster effectiveness and fortnightly oversight from the CNO and DCN.

Safeguarding

ESHT submitted the bi-annual section 11 self-assessment of children's safeguarding to the ESSCP, which was completed in collaboration with the Women's and Children's division. The quarterly Prevent data has been submitted to NHS digital which showed 94% compliance with prevent basic awareness and 86% with Wrap level 3. Information received from the Safer Communities partnership has advised that the term Domestic Homicide Reviews has changed to Domestic Abuse Related Death Reviews, this is to reflect the range of deaths that may come within the scope, such as the suicide of a person experiencing domestic abuse.

Mortality

RAMI indices of mortality rolling 12 months is 91 for the current period and positioned at 67 out of 121 Acute Peer Trusts. SHMI is showing a value of 101 and is within the expected range. EDGH has an index of 100 and Conquest 101.
Weekend SHMI & RAMI continue to show a value below the national average for HES Acute peers.

Author(s)

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

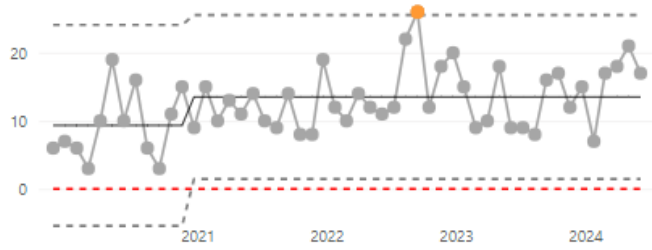
Simon Merritt Chief Medical Officer

Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

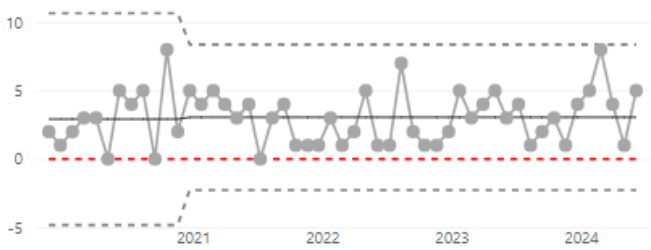
Number of Patient safety events (severity 3): Total, Safety

Not Met	Common Cause	17



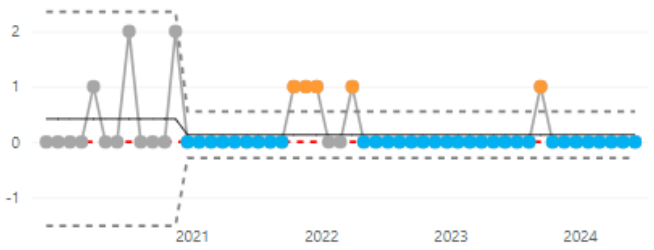
Number of Patient safety events (severity 4 and 5): Total, Sa...

Inconsistent	Common Cause	5



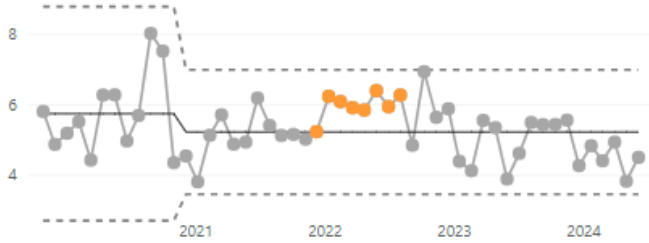
Never Events: Total, Safety

Inconsistent	Improvement	0



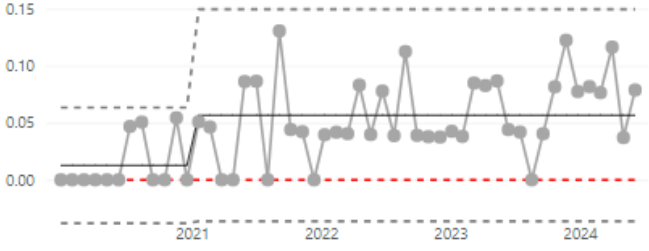
Inpatient Falls per 1,000 Bed days: Total, Safety

Target required	Common Cause	4.49



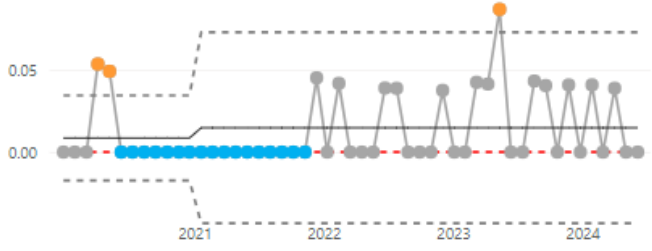
Cat 3 and 4 ESHT Acq. PU (rate) per 1,000 bed days: Total, S...

Inconsistent	Common Cause	0.0788



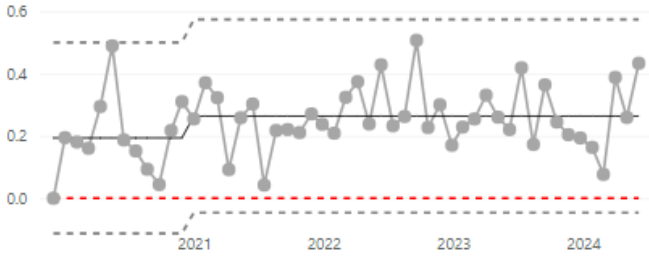
Healthcare Associated MRSA Bacteraemia (rate) per 1,000 ...

Inconsistent	Common Cause	0



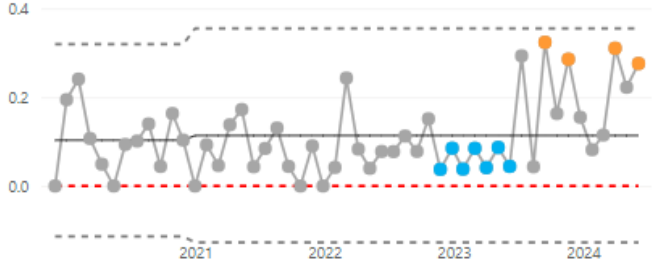
Healthcare Associated C Diff Infections (rate) per 1,000 Bed ...

Inconsistent	Common Cause	0.433



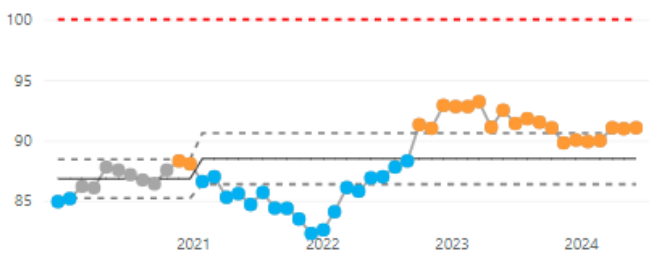
Healthcare Associated MSSA Bacteraemia (rate) per 1,000 ...

Inconsistent	Concern	0.276



RAMI: Total, Safety

Achieving	Concern	91.1

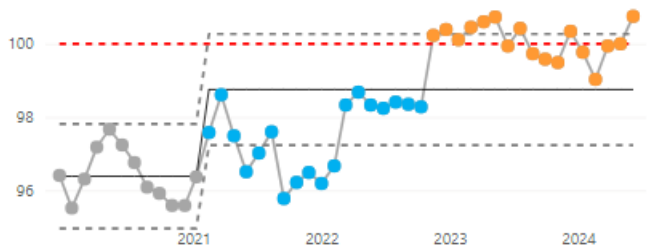


Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

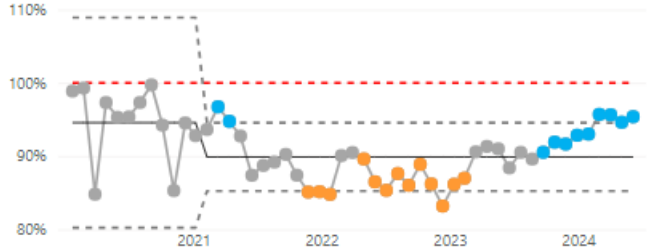
SHMI (NHS Digital monthly): Total, Safety

Inconsistent	Concern	101



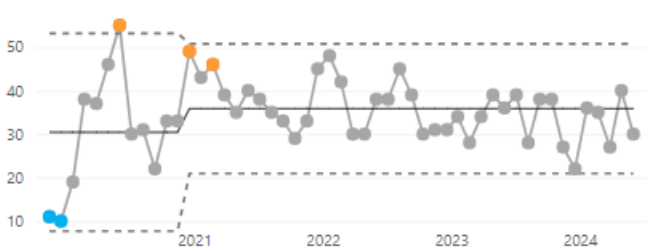
Nursing Fill Rate (IP - RN, RNA and HCA): Total, Safety

Not Met	Improvement	95.4%



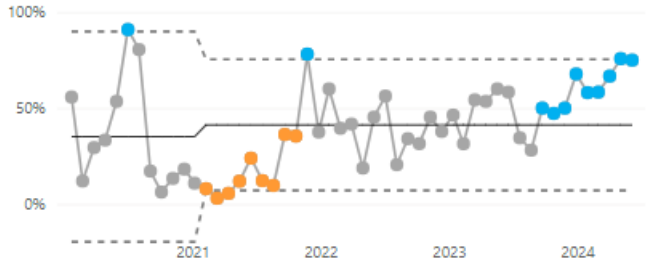
Complaints received: Total, Patient Experience

Target required	Common Cause	30



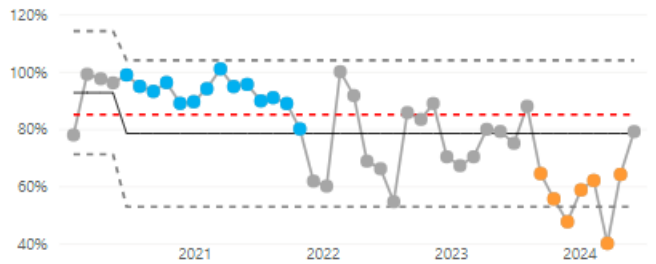
Complaints Response Compliance: Total, Patient Experience

Target required	Improvement	75%



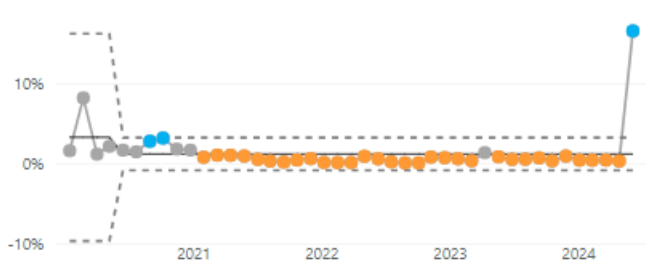
A&E FFT Score: Total, Patient Experience

Inconsistent	Common Cause	79.1%



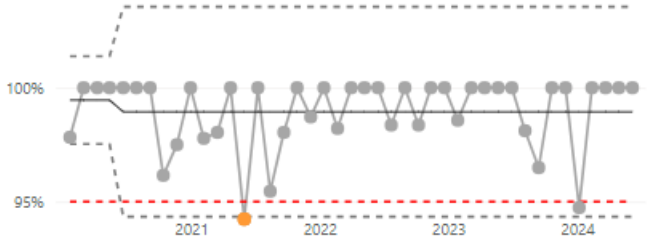
A&E FFT Response Rate: Total, Patient Experience

Target required	Improvement	16.6%



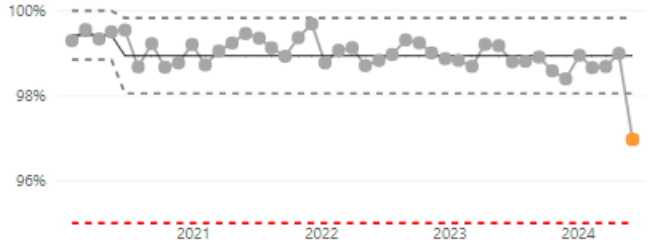
Maternity FFT Score: Total, Patient Experience

Inconsistent	Common Cause	100%



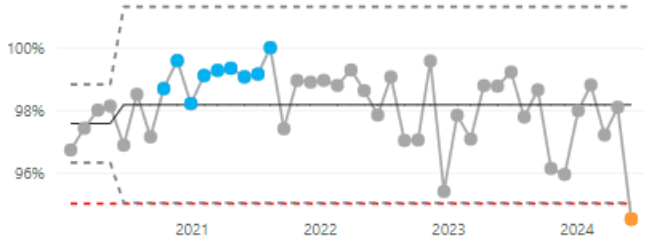
Inpatient FFT Score: Total, Patient Experience

Achieving	Concern	97.0%



Outpatient FFT Score: Total, Patient Experience

Achieving	Concern	94.5%



Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Patient Safety Incident Response Framework (PSIRF)	The Duty of Candour percentage has increased considerably for verbal at 90% although written remains lower at 68%There are reminders provided through various points in the process to follow-up on completing this, there is also the uploading of documents on DCIQ to record. The process remains in situ for reporting, triaging and deciding on level of harm of events at this time and will continue to be reviewed as PSIRF develops. The ICB are developing a set of metrics in discussion with the Patient Safety Leads Forum. This will continue to evolve, and the common goal is to put quality improvement, which is putting learning into action, for a pro-active approach to patient safety. This continues to be a challenge across the ICB due to this being a fundamental shift from quantitative heavy data collection to qualitative.	• The Patient Safety Team, with the Divisions continue to close cases under the SI framework. • Scoping has commenced to evaluate where the trust is in the implementation phase of PSIRF. • The draft PSIRP and PSIRP and PSIRF Policy are moving through internal governance in readiness for sharing with the ICB as update from the November 2023 go-live with the framework. • Weekly meetings with Senior Nursing Leadership within the Divisions and the CNO continue, to monitor PSIRF template compliance. • Datix team have moved to go-live on patient incidents/events on 01/05/2024, these will now change from “WEB” to “INC” as unique identifiers for each case. It is planned to move forward with documenting in the Datix system to improve reporting capability, i.e. Learning • Uptake of Training for All Staff Level 1 Training continues to improve month on month with the reporting at 82.9% for June 2024
Nursing & Midwifery Workforce	Additional super surge beds, pre-emptive boarding and significant numbers of patients requiring enhanced observation for cognitive impairment, high risk of falls or patients with challenging/violent behaviour during June resulted in ongoing additional staffing requirements via TWS. Ward nursing CHPPD overall was 8.8 for June (noting distortion by specialist areas). Nursing fill rates for day shifts RN 94% and HCSW 91% and night shifts 99% for RN and 101% for HCSW. National reprofiling of Band 2 to 3 Clinical Support workers project has commenced.	• The additional Nursing Establishment Review (NER) for 2024 to pilot the new tool has been completed and the data is being analysed meetings in place with Chief Nurse to review. • Recruitment to the MH Outreach team has commenced and enhanced training for staff as well as a review of the estate. • Nursing/Midwifery Roster and Budget compliance discussion continue, led by the CNO and DCN with evidence of good controls and work in progress to support enhanced observations and requests for additional staff. Focus is now on working within budget and a reduction in temporary staffing. • Job specific skills review and training needs analysis has commenced to ensure staff receive the training to meet the needs of our people. • We are working with integrated education on improving the education and career progression framework including restorative supervision and reviewing the role of practice educators.

Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

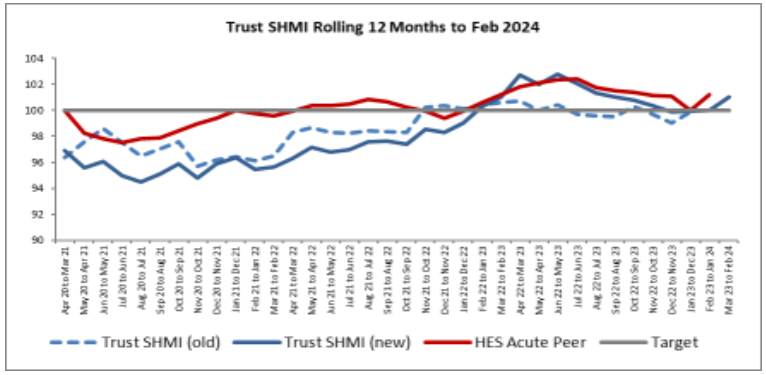
Title	Summary	Actions
Inpatient Falls	Slips, Trips and Falls (142) show an increase from May 2024 (118). There were no catastrophic events/incidents for Slips Trips & Falls, however there was 1 major severity 4 and 1 moderate severity 3 event. The falls rate of all falls for ESHT per 1000 bed days was **5.78** in June 2024; this is an increase from the **4.4** reported in May 2024. The top three sub-categories were fall whilst mobilising independently, fall from a trolley, bed or couch and patient found on the floor by staff was prevented from falling. With the top 3 falls by location being Devonshire Ward, Frailty Unit and Glynde Ward.	• The Quality Improvement Lead Nurse is working with ward areas and teams to close the loop in responding to the learning outcomes identified. • SWARM Forms continue to be reviewed at the PSIRF Review Group and a Task & Finish group has been established by the Falls Steering Group to review and update the template. • Falls events continue to be reviewed at WPSS for harm levels of moderate and above (severity 3+)
Patient Experience	Ensure the implementation of Healthcare Communications (change in FFT service) is fully implemented by August.	• Staff to have log in details • Training provided • Extranet and website updated
Deferred Visits	Within our community planned care services, demand is exceeding capacity so on occasions some patients' care visits are deferred to a different date.	• Within the community nursing teams there is a system of RAG rating patients based on the level of risk to harm if the visit is deferred. Patients at high risk are kept on a Red list and other patients are either on an Amber or Green list. Patients on the Red list are never deferred.
Pressure Damage	2 category 3 & 4 pressure ulcers (PU) were initially reported in June. • 1 Category 3 PU has since been assessed by a specialist Tissue Viability Nurse and been downgraded to Cat 2 damage. • 1 Category 4 PU was reported on an acute medical ward and is currently under investigation. • New national guidance related to pressure ulcers including their categorisation was published in 2023. Implementation of any changes is being reviewed by the PUSG and discussed with NHS Sussex.	• The Pressure Ulcer Steering Group (PUSG) is working with the Trust Patient Safety Lead, to implement a PSIRF approach to pressure ulcer prevention going forward. • An action plan is underway to improve compliance to meet CQUIN 12 – Pressure Ulcer Prevention in line with NICE Guidance • A new national PU categorisation tool was published in June 2024 and is under review by the PUSG for implementation.

Effective Care - Mortality

East Sussex Healthcare NHS Trust

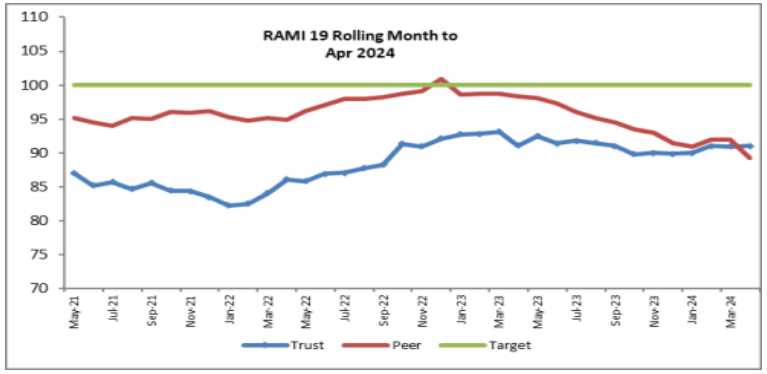
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

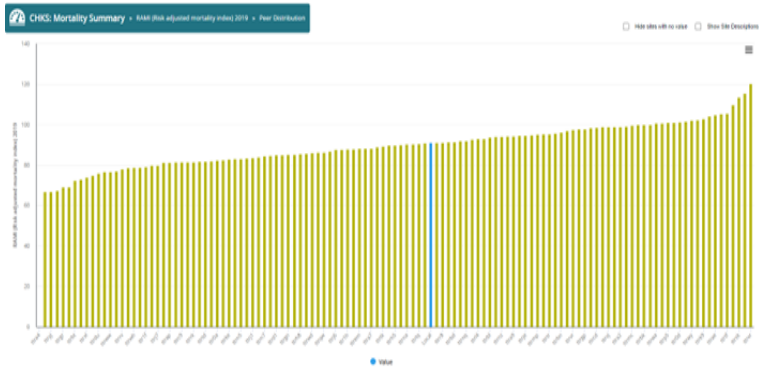
Summary Hospital Mortality Indicator (SHMI)
Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures



- SHMI – Mar 2023 to Feb 2024 is showing an index of 101 and is within the expected range. EDGH is showing 100 and Conquest is 101. Peer SHMI for the latest period is not yet available. The graph shows two lines for SHMI with the new methodological changes compared to the previous calculations. SHMI is rebased each time it is published but RAMI was last rebased in 2019. It is due to be rebased shortly.
- RAMI 19 – May 2023 to Apr 2024 (rolling 12 months) is 91 - also 91 for the same period last year. Apr 2023 to Mar 2024 was also 91.
- RAMI 19 was 88 for the month of April only and 94 for March. Peer value was 86 for April only. The line graph below shows the rolling 12 month figure
- Crude mortality shows May 2023 to Apr 2024 at 1.62% compared to 1.85% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 64% for April 2024 deaths compared to 67% for March 2024 deaths.

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





This shows our position nationally against other acute trusts – currently 67/121

Effective Care - Mortality

East Sussex Healthcare NHS Trust

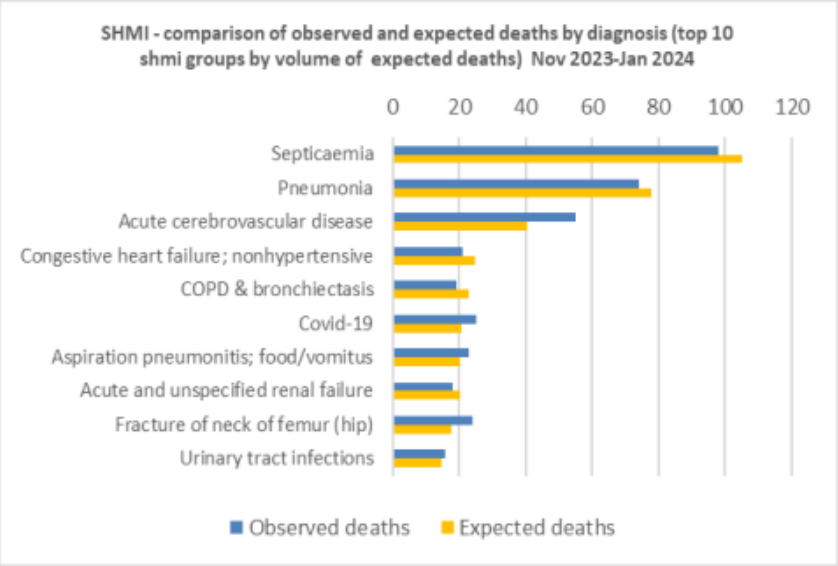
June 2024 Main Cause of In-Hospital Death Groups (ESHT)

Description	Deaths
Pneumonia	14
Sepsis/Septicaemia	14
Cancer	13
Frailty of old age	11
Community-acquired Pneumonia	8
Stroke	6
Chronic Obstructive Pulmonary Disease (COPD)	5
Heart Failure	5
Myocardial Infarction (MI)	4
Aspiration Pneumonia	3
Hospital-acquired Pneumonia	3
Atrial Fibrillation (AF)	2
COVID-19	2
Acute Kidney Injury (AKI)	1
Dementia	1
Urosepsis	1

There are:
36 cases which did not fall into these groups and have been entered as 'Other not specified'.

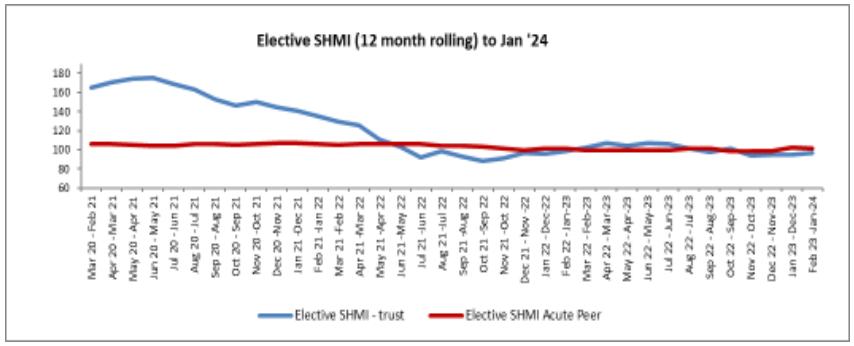
12 cases for which no CoD has been entered on the database and therefore no main cause of death group selected.

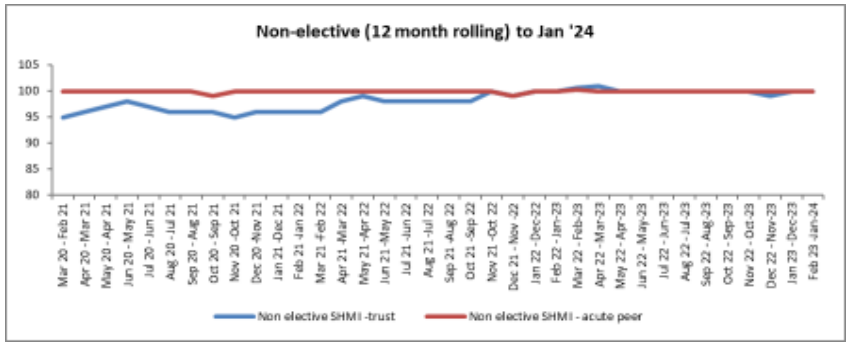
SHMI Diagnosis Main Groups



Summary Hospital Mortality Indicator (SHMI)

Elective and Non elective Inpatient Trends





Our People

Recruitment and retention

Staff turnover / sickness

Our quality workforce

What our staff are telling us?

Safe patient care is our highest priority

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

Our People | Executive Summary

East Sussex Healthcare NHS Trust

Responsive	*Positives*: **Vacancy rate** reduced by 2.0% to 3.5% (278.3 wte). (This is following further CIP reductions to budgets this month.) **Mandatory Training rate** increased by 0.4% to 90.9% **Appraisal compliance** increased by 0.2% to 83.7%	*Challenges and Risks*: **Turnover** has increased by 0.2% to 10.6% (756.2 wte leavers in the last 12 months.) **Monthly sickness** increased by 0.4% to 4.8% **Annual sickness** increased by 0.1% to 5.3%	Author

Overview:

The **Turnover rate** showed an increase of 0.2% to 10.6% (756.2 wte leavers in the last 12 months; an increase of 18.2 since last month). Registered Nursing & Midwifery turnover increased by 0.3% to 9.6% (209.2 wte leavers), Estates & Ancillary increased by 0.5% to 11.4% (73.9 wte leavers) and Admin & Clerical increased by 0.3% to 11.9% (179.2 wte leavers). Medical & Dental turnover, however, reduced by 0.3% to 10.7% (35.6 wte leavers).

The Trust **vacancy rate** reduced significantly, by 2.0% to 3.5% (278.3 wte vacancies). This is primarily due to embedding CIP wte reductions in the substantive wte budget as cost improvement targets. This has been applied this month to divisional budgets as a negative value and reduced the substantive wte budget, overall, by a further 138 wte. These reductions will progressively increase across the rest of the financial year. There has also been an increase in substantive staff in post of 48 wtes due to successful recruitment.

The **monthly sickness rate** has increased by 0.4% to 5.2% and, consequently**,** the **annual sickness rate** has increased by 0.1% to 5.3%. Wte days lost in month increased by 563. The largest increase in month was for Gastrointestinal problems (+132 wte days lost), with a notable increase for Additional Clinical Services staff in Medicine (+57). Contributing to this were a significant increase for Injury/Fracture absences (+106) particularly for Registered Nurses & Midwives (+57) and Additional Clinical Services staff (+47) but across several Divisions. Anxiety, Stress & Depression illnesses remain the highest identified reason for sickness at 2,181 wte days lost in month, though this was a reduction of 46 and these absences are trending downwards from a peak of 2,501 in Jan 24.

The **mandatory training rate** has continued to increase, up by a further 0.4% to 90.9%. The most significant increases this month were for Safeguarding compliance (Level 2) up by 3.6% to 96.2% and Mental Capacity Act & Deprivation of Liberties compliance which increased by 2.6% to 89.9%.

The **appraisal rate** increased by 0.2% to bounce back to 83.7% (the same rate as Jun 24, which represents the peak for the last four years). Registered Nursing & Midwifery compliance increased by 0.3% to 81.7%, Medical & Dental increased by 3.2% to 90.6% and Admin & Clerical increased by 0.7% to 82.0%. Scientific & Technical compliance reduced by 2.8% to 77.4, Allied Health Professionals reduced by 0.2% to 86.6% and Estates & Ancillary reduced by 0.8% to 89.4%.

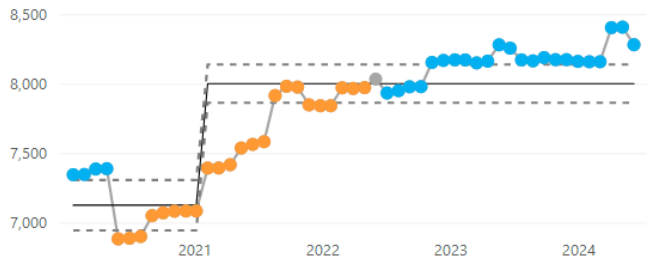
Steve Aumayer
Chief People Officer

Our People Core Metrics

East Sussex Healthcare NHS Trust

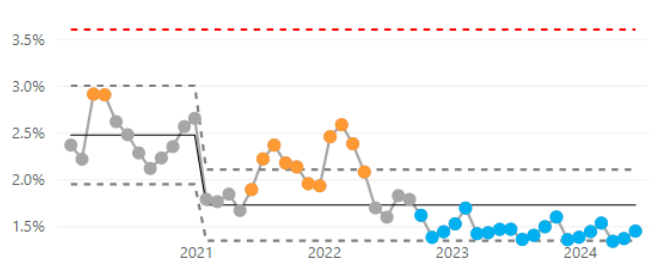
Establishment (WTE) All: Total, Our People

Target required	Improvement	8,280



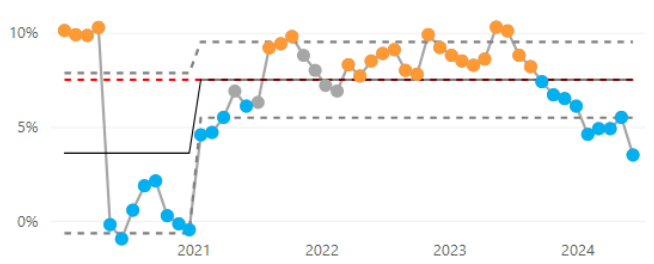
Agency Rate: Total, Our People

Achieving	Improvement	1.45%



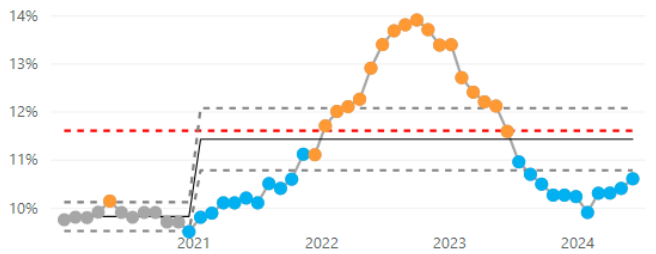
Vacancy Rate: Total, Our People

Inconsistent	Improvement	3.5%



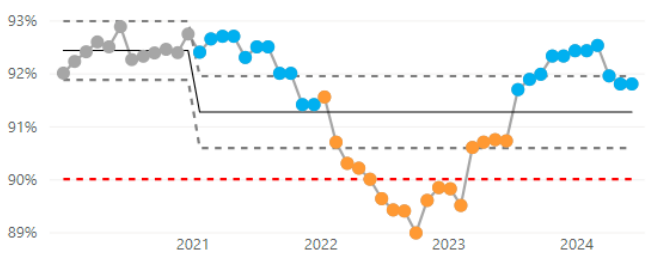
Staff Turnover: Total, Our People

Inconsistent	Improvement	10.6%



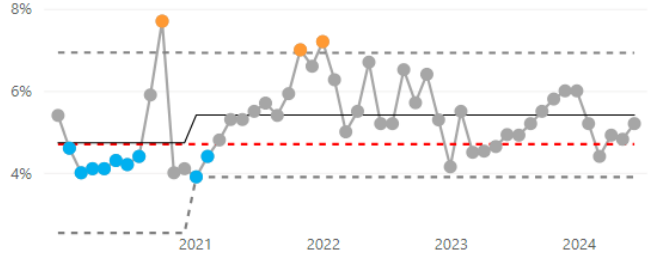
Retention Rate: Total, Our People

Achieving	Improvement	91.8%



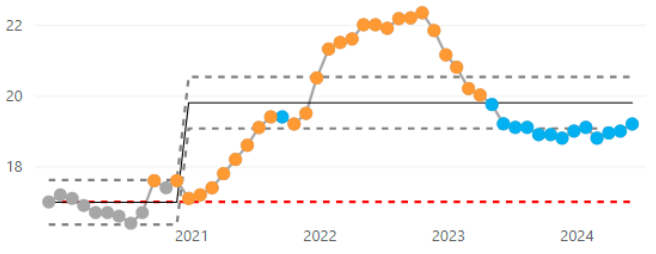
Monthly Sickness - Absence %: Total, Our People

Inconsistent	Common Cause	5.2%



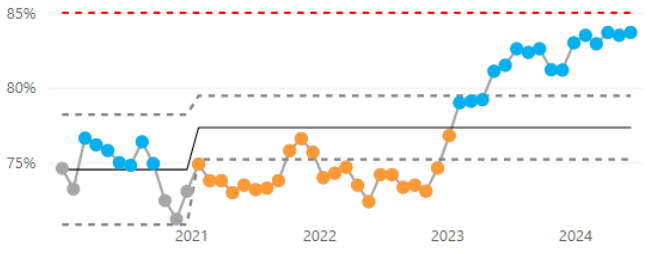
Sickness - Average Days Lost per Fte: Total, Our People

Not Met	Improvement	19.2



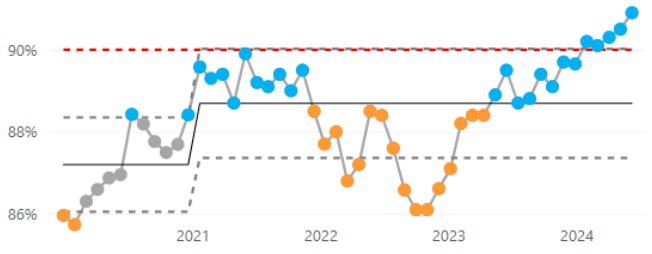
Staff Appraisals: Total, Our People

Not Met	Improvement	83.7%



Statutory & Mandatory Training: Total, Our People

Inconsistent	Improvement	90.9%



Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Turnover & Retention	Turnover rate increased by **0.2%** to **10.6%**	Retention update presented to POD where seven priorities for 2024/25, as aligned with the People Promise, were presented, shared and agreed. • Improved onboarding and first 100 days for new colleagues including those new to the NHS, newly qualified and internationally recruited colleagues. • Improve experience for those retiring and returning and extend the reach of the ESHT Alumni. • Improving the experience of those exiting or moving within the organisation. • Fully establish a restorative supervision framework within the Trust. • Enable colleagues to flourish through Thrive and Grow conversations – linking with talent management. • Establish a culture where flexible approaches to work are possible and positive for individuals and services. • Pilot Legacy Mentoring to improve team resilience and stability. Cruse Bereavement Care training was delivered to a small cohort of colleagues who are now Grief First Aiders. This cohort are now agreeing how best to implement new skills and learning which will include a review of the Trust package of support and guidance available.
Vacancy Rate	Vacancy rate reduced by **2.0%** to **3.5%** (278.3 wte vacancies). This reduction reflects the further application of CIP reductions to the substantive budget, this month. These reductions will progressively increase across the year.	Ongoing activity to address hard to recruit posts with recruitment activity around Medics, Community and AHPs. Some success with difficult to recruit medical posts at Consultant level, including Respiratory, Cardiology ,and General Medicine. Continued activity with TWS agencies for AHPs to improve candidate pipeline. The number of direct applicants remains high, with improved branding and referrals, assisting in overall vacancy rate drop. Activity continues with ESCC/DWP, with planned activity in the Autumn. Social media activity to promote Trust and hard to recruit posts. Band 2 & Band 3 recruitment activity to support the organisation continues.

Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Sickness	Monthly sickness increased by 0.4% to 5.2% whilst annual sickness increased by 0.1% to 5.3% Average sickness days per fte have increased slightly by 0.2 to 19.2 Largest identified reason for sickness increase in June was Gastrointestinal problems, which increased by 132 wte days lost. There was also an increase in absences due to Injury/Fracture (+106)	Although absence due to Chest & Respiratory problems is very slightly down, the Trust are aware, within this, of an increase in COVID. This, in turn, can lead to associated anxiety & stress. Fatigue and events within the workplace can be a contributory factor in lowering resilience to outside factors, so HR work closely with our Wellbeing teams in identifying those areas that may need additional support in improving morale and workplace environments. It is also noted that schools are reporting a high level of gastro absence which is likely a contributing factor for colleagues that have children at home. Each month the Trust also considers the percentage of long term over short term in Divisions, which allows for a greater focus on those hotspot areas in considering themes or supporting actions to maintain a regular attendance at work.
Statutory & Mandatory Training	Trust compliance increased by 0.4% to 90.9%. This is another new historic “high” compliance rate for the Trust.	The continued focus on Doctors in Training compliance has continued, however, there are some subject areas where progress is slow. The areas affected which are below 80% for doctors in training are Infection Control (78.8%), Info Gov.(78.4%) and MCA/DoLs (78.8%). A targeted approach to address areas of low compliance across the Trust will continue to be the focus over the coming months. The Trust has commenced reporting on other additional essential training in Divisional IPRs this month. This includes Resuscitation at 71.8% compliance rate across the Trust, Blood Transfusion at 73.6%. Prevent training at 91.0%, Falls Prevention at 91.3% and Oliver McGowan training (learning disability awareness) which had 69.0% compliance but is still in its first year since introduction. Over the last few days of the month a number of Resus and Blood Transfusion sessions were cancelled to due to Junior Doctor Industrial Action. Patient Safety Level 1 was introduced in Feb 2024, current compliance increased, to 82.8%. Level 2 training will commence in June.
Appraisal	Compliance rate increased by 0.2% to 83.7%. This is still historically high.	The Trust will be offering support and contacting the Divisional Governance Leads to identify any areas of concern or additional support required.

Access and Responsiveness

Delivering the NHS Constitutional Standards

Urgent Care – Front Door

Urgent Care – Flow

Planned Care

Our Cancer services

We will operate efficiently & effectively

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

Access and Responsiveness | Executive Summary

East Sussex Healthcare NHS Trust

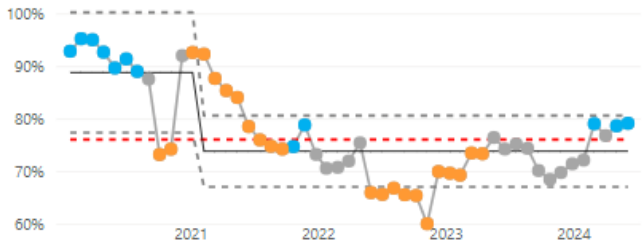
	Positives	Challenges & Risks	Author
Responsive	**4 Hour Emergency Access Clinical Standard** The Trust is committed to reducing the amount of time it takes to assess and treat patients within our emergency departments. The Trust delivered 79.1% against the revised Emergency Access Clinical Standard of 78% and were in the upper quartile nationally for performance. **DMO1** DM01 performance declined in June, down from 89.3% in April to 87.1%. Whilst the majority of modalities have remained stable or improved there were a number of breaches in MRI which have impacted the Trust overall. Action plans are in place to recover performance and bring back in line with internal trajectories and national standards by the end of March 2025. **Elective long waits (RTT and Cancer):** The Trust has seen a reduction in long waits in both Cancer and routine elective pathways. The volume of patients waiting >65 weeks for routine treatment in June was 49 against a trajectory of 70. The number of patients waiting >104 days (unvalidated) across the whole cancer PTL, reduced from 62 in April to 54 in May.	**4 Hour Emergency Access Clinical Standard** In order to sustainably deliver 78% against the revised Emergency Access Clinical Standard the Trust continues to work on embedding the actions in the Urgent Care Improvement plan. Work with system partners to reduce the number of patients who do not meet the criteria to reside continues. **Cancer** Performance improved in May for the Faster Diagnosis standard with an achievement of 81.6%, against a trajectory of 75% and the national standard of 77%. Recovery Plans are in place to increase capacity and reduce the current delays. .	 **Charlotte O'Brien** Chief Operating Officer
Actions:	• Improving and sustaining the progress made to deliver the revised 78% Emergency Access Clinical Standard, building on actions from the Urgent Care Improvement Plan to support delivery in 24/25. • Cancer pathways remain a trust priority and we will continue to focus on all elements of the patient journey to ensure patients are seen, diagnosed and treated in a timely way. • Building on the workstreams from both the outpatient and theatre productivity programmes to reduce waiting times for elective care and improving productivity		

Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

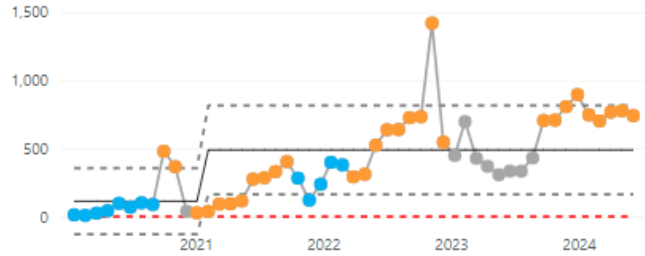
4 hour standard: Total, Our Performance

Inconsistent	Improvement	79.1%



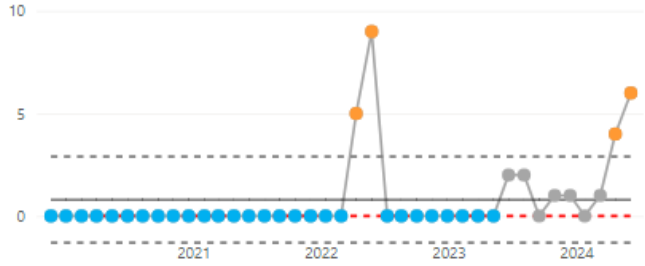
A&E > 12 hours from arrival to discharge: Total, Our Perfor...

Not Met	Concern	741



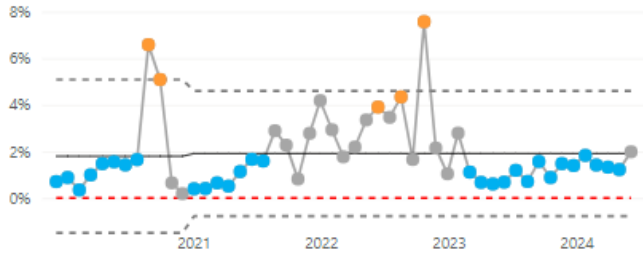
A&E waits over 12 hours from DTA: Total, Our Performance

Inconsistent	Concern	6



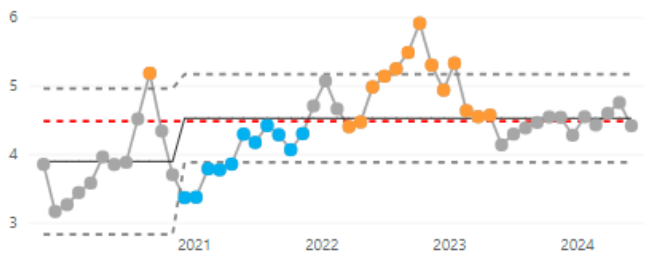
Conveyance handover >60 mins: Total, Our Performance

Inconsistent	Common Cause	1.98%



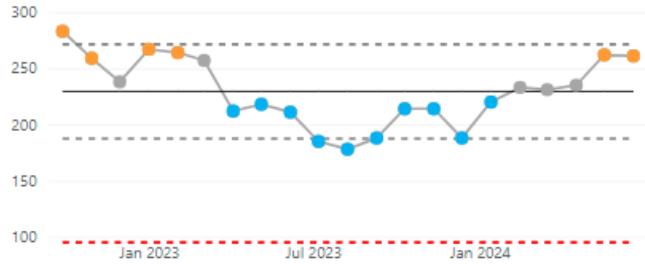
Non Elective Length of Stay: Total, Our Performance

Inconsistent	Common Cause	4.41



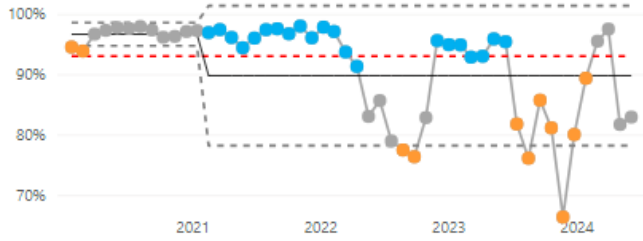
Average daily NCTR: Total, Our Performance

Not Met	Concern	261



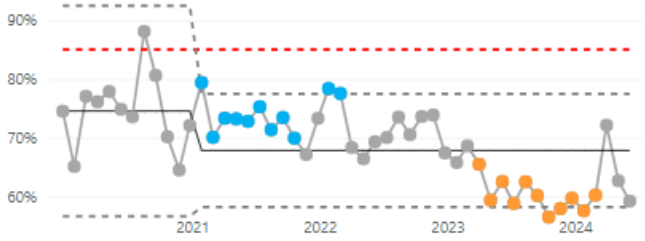
Cancer 2WW: Total, Our Performance

Inconsistent	Common Cause	82.9%



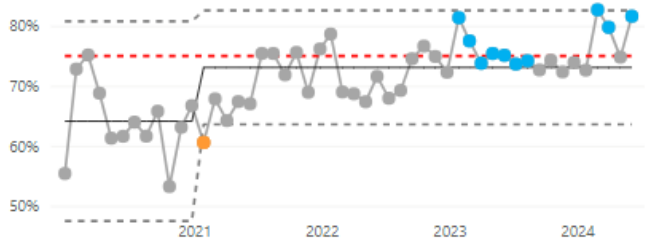
Cancer 62 Day: Total, Our Performance

Not Met	Common Cause	59.2%



28 Day General FDS: Total, Our Performance

Inconsistent	Improvement	81.6%

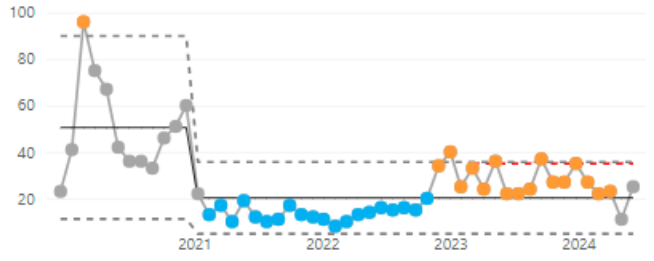


Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

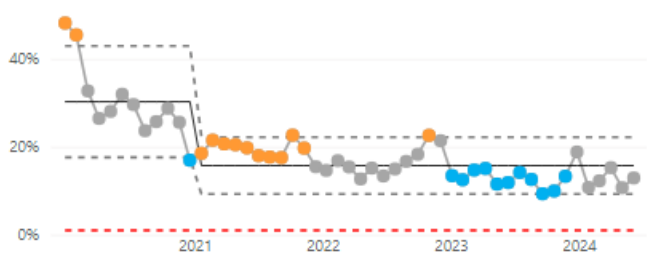
104 day Backlog: Total, Our Performance

Inconsistent	Common Cause	25



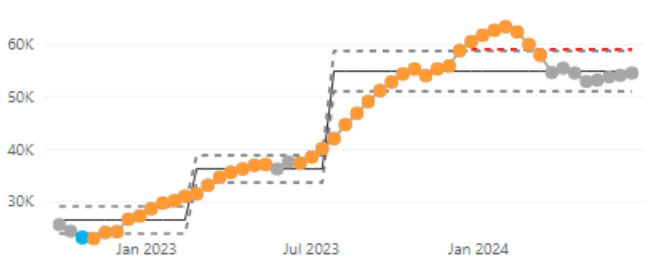
Diagnostic <6 weeks: Total, Our Performance

Not Met	Common Cause	12.9%



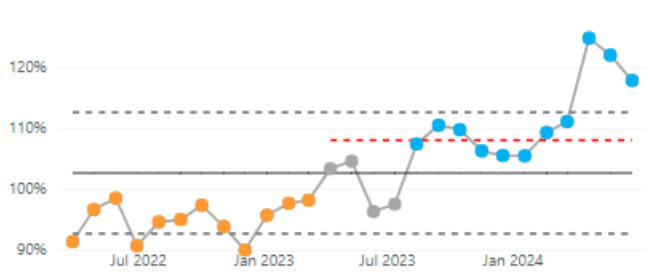
RTT Total Waiting List Size: Total, Our Performance

Achieving	Common Cause	54467



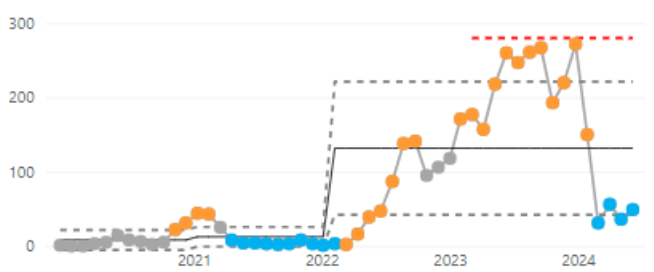
Elective Activity (ELIP,DC,OPFA, OPFUP Proc): Total, Our Perf...

Inconsistent	Improvement	118%



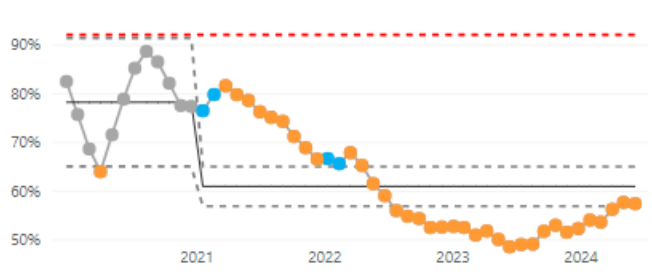
RTT 65 week wait: Total, Our Performance

Achieving	Improvement	49



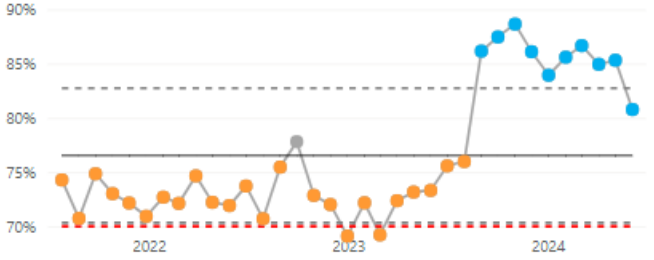
RTT under 18 weeks: Total, Our Performance

Not Met	Concern	57.3%



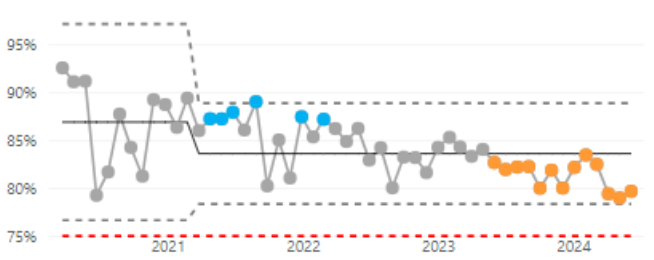
Urgent Community Response within 2 hours: Total, Our Perf...

Achieving	Improvement	80.8%



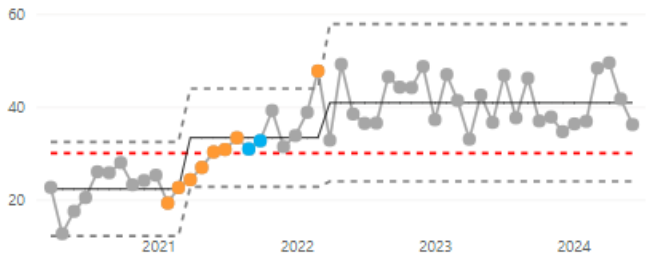
CHIC wait times < 13 weeks: Total, Our Performance

Achieving	Concern	79.7%



Intermediate Care Length of Stay: Total, Our Performance

Inconsistent	Common Cause	36.2



Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Emergency Access Clinical Standard	78% patients should be seen and discharged, treated or admitted within 4 hours; the Trust achieved 79.1% against the standard in June 2024. Our national ranking was 20 of 124 trusts, putting us in the upper quartile.	• Continue to work with SeCAMB to ensure crews are not waiting longer than 15 minutes. • Escalation of delays and pathways that are not working well with support of all divisions and site teams. • Optimising CDU capacity, keeping CDU for ED patients. • Improve streaming to specialty services • Continue work started with primary care.
Patients in department over 12 hours from arrival to discharge	There was a reduction in number of patients waiting over 12 hours from arrival to discharge, from 777 May to 741 in June. 8 patients remained in ED for >12 hours following a decision to admit in June.	• A detailed review has taken place for each of the patients who remained in ED for more than 12 hours following a decision to admit on 16th and 17th June, including an assessment of clinical harm. • A number of actions have been agreed by the Urgent Care Division to ensure timely and effective escalation. • Focus on reducing LOS and the number of patients not meeting the criteria to reside to enable flow
Conveyance Handover >60 mins	The percentage of patients handed over >60 mins was 1.98 % up from 1.22 % in May.	• Maintain improvements in Ambulance handover recovery (RAT/ RESUS) over 60 minutes whilst focusing on reducing over 45 minutes.
Non elective Length of Stay (LOS)	The Trusts non-elective LOS increased from 4.77 days in in May to 4.41 days in June.	Areas of focus to support a reduction in LOS and reduce the number of patients who do not meet the criteria to reside include : • Daily Discharge Ready reviews with senior MDT and partners for patients in the Acute Hospitals • East Sussex LLOS (long length of stay) over 30 days escalation call weekly with partners. • Transfer of Care (TOC) lead linking in with TOC leads in the region for OOA patients and for patients that have Out Of Area Ordinary Residence and have funding authority. • Divisional plans to reduce LOS in key specialties • Recruitment to additional therapy posts to reduce internal delays • Implementation of rapid improvement actions with system partners to reduce the number of patients who do not meet the criteria to reside • New Discharge Pathways and Delay Reasons (National Guidance) & SitRep reporting implemented, resulting in a change in pathway destination outcomes for patients. • Teaching and Education for Discharge to Ward Teams. • Developing “TOC Pentagon Model wit Art of the Possible RRP Programme”

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Cancer	The Faster Diagnosis Standard achieved 81.6% in May against a trajectory of 75% and the national target by March 2025 of 77%. The 31-Day standard remained challenged with achieving 92.0% against a national target of 96%. The 62 Day standard performance for May was 59.2% against a trajectory of 63%. There were 115 waiting over 62 days at the end of June. It is noted however, a third of the backlog patients are waiting at tertiary centres for treatment. This has been a particular issue at GSTT following the recent cyber-attack. The Trust continues to receive high number of urgent suspected cancer referrals and in May, received 2701 referrals via the GP referral route, which is the 2nd highest number of referrals received in month since 19/20 Significant increases of referrals for this year via the GP referral route have been to Skin, Urology and Upper GI.	• Detailed Divisional Cancer Action Plans in place to support recovery and improvement with individual tumour site trajectories developed for achievement for 2024/2025. • Regular Breach Analysis Reports circulated to identify bottlenecks in pathways. • Successful Cancer Month in May for DAS Division with internal tumour site predictions and acceleration of pathways. This has been continued into June. • Divisional expectation and standards in place for all Divisions outlining turnaround times and escalation process. • Recovery Plan in place for Skin to support a reduction in delays and timely patient treatment. • Trust Cancer Week planned for early August. • Establishment of Radiology Modality PTL to ensure vetting, booking and reporting are prioritised. • Development planned for Direct Access imaging for Brain and Pancreatic patients and exploring for patients referred with a neck lump. • Trial of Tele dermatology in place with planned implementation from Aug 2024. • Development of Breast triage planned to commence in September 24. • 2nd LATP Nurse appointed for Urology. • Robotic colorectal surgery commenced in June at the Conquest Hospital. • National Best Practice Timed Cancer Pathways and SSCA Optimal Pathways shared with Cancer Clinical Leads to support local adoption/alignment where appropriate.
Community Waiting Times	Outsourcing to an independent sector provider continues to support improvements in community paediatric waiting times. The number of children waiting >104 weeks at the end of June was 10 (compared to 209 in April 23).	• On going recruitment to both clinical & administrative roles in Community Paediatrics. • Redesign of service continues to be explored
Elective Activity	In June, the Trust delivered 114% of 2019/20 baseline activity levels.	• Outpatient productivity programme progressing with good progress reported. • New initiatives in 24/25 include a focus on validation of the Follow Up PTL, targeted action on DNAs, reducing paper in Outpatients, improving governance arrangements around insourced/outsourced clinical services (to maximise efficiency), and improving management of follow-ups. • Regular steering group meetings to support Theatre productivity • Review of counting and coding to ensure accurate capture of activity.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
RTT long wait position (78 and 65 weeks) and waiting list size	The RTT waiting list has continued to grow with 54467 patients on the PTL in June, The Trust has observed a increase over the last four consecutive months. Despite the increase the June RTT submission RTT compliance is largely unchanged, with the Trust achieving 57.3%. Focus continues on reducing long waits and in May the Trust report 49 65-week breaches, well below the trajectory of 70 that had been set. This Trust is committed to improving patient care and reducing waiting times for all patients and as such the Trust is currently accepting whole pathway transfers from other providers with the aim to support the system in achieving zero 65-week waits by September.	• Progressing mutual aid requests from neighbouring providers, both as whole pathway transfers and Admitted activity, to support a reduction in waiting times for patients in Sussex. • Insourcing/Outsourcing in place within challenged specialties, including Neurology, Vascular and Gynaecology • Continued focus on validation and pathway management ensuring a more accurate PTL, supporting the development of modernised pathways, training and better use of digital technology. • Additional grip and control for long waits, including specialty level trajectories with enhanced PTL output and management. • Daily monitoring of the longest waiting patients to ensure pathways are progressing. • Utilisation of SPH and other IS providers where possible to support long wait position. • Exploring mutual aid, both via the ICS and the Digital Mutual Aid System, including PIDMAS. • Increasing FOPA attendances.
Diagnostic DMO1	June performance fell slightly from 89.3% in May to 87.1% in June. Overall waiting list size decreased for the second consecutive month despite increasing referrals, dropping from 9,605 in May to 9,532 in June.	• Additional relocatable CT scanner remains on Conquest site until end June to reduce backlog. • 2nd Power Pad (for MRI) not completed at Bexhill CDC due to ESCC delay to installing power across road. MRI remains on Conquest site working 7 days a week. • MRI position still the focus for improvement and subject to detailed action plan focussing on (a) increased utilisation of lists (b) extended days and (c) extra sessions • NOUS improving overall, however, pressure remains in specialist scanning related to cancer diagnostics. • Endoscopy continue to deliver excellent performance. • Cardiac Echo Surveillance backlog now minimal. Insourcing has now ceased. Audiology recovery ongoing. Now 85% compliant and steady.

Financial Control and Capital Development

Our Income and Expenditure

Our Elective Recovery

Our Run Rate

Efficiency

Capital

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

Finance | Executive Summary

East Sussex Healthcare NHS Trust

Finance

	Positives	Challenges & Risks	Author
	• ERF overperformance in month with actual of £9,578k compared to plan of £8,922. • Capital overspent by £6,528k, however the plan is materially back phased so this does not at present mean there is an issue, we are currently redoing the phasing to better align to expected profile.	Risk adjusted forecast ranges from £54.8m (downside) to £11.7m (upside) deficit with a base case of £29.2m. For reference a straight line extrapolation of the Month 3 run-rate would result in deficit of £54.4m which would be £42.7m worse than plan. Main risk drivers are current run rate (with reference to block activity above plan), under-delivery of UoR programme and pay cost pressures from pay awards and HCA re-banding	 **Damian Reid** Chief Financial Officer

Overview:

I&E: The Trust plan was for a deficit of (£2.6m) in month 3 (noted the plan is phased based on CIP delivery and working days from a variable income perspective). Actual performance was a deficit of (£5.3m) or an adverse variance of (£2.7m). YTD adverse variance of (£4.9m). Variance ytd is driven by Pay premium costs, unfunded escalation, Pay CIP and non-pay CIP, old year invoices and higher activity related non-pay.

UoR: Total YTD delivery of £3,008k against plan of £3,074k, an under-delivery of £65k The most significant underperformance is in workforce (£845k) however this is due to where the savings are being reported in the current month (divisional schemes). External plan is phased more front loaded so external reported variance is £1.9m

Capital: Capital expenditure in month 3 was £9.1m, £3.8m above plan.

Cash: Cash is now becoming a serious concern. To maintain a cash position above £10m creditor payments would need to fall from £4.6m (ave last four weeks) to £2.5m-£3.8m.This is driven by underlying deficit, capital in excess of depreciation and allocations held by the ICB not being passed onto the Trust yet due to technical reasons.

Finance | Income and Expenditure

East Sussex Healthcare NHS Trust

Finance

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Plan	Act	Var	Plan	Act	Var
Income						
Contract income	36,287	36,251	*(36)*	108,285	108,278	*(7)*
Divisional	6,850	6,622	*(228)*	20,773	20,806	*33*
ERF	10,039	11,133	*1,093*	31,057	32,294	*1,238*
Covid - variable	-	-	-	-	-	-
Total Income	**53,176**	**54,006**	***830***	**160,114**	**161,379**	***1,264***
Operating Expense						
Pay						
Permanent	(35,971)	(34,130)	*1,841*	(108,866)	(101,426)	*7,440*
Temporary	(1,331)	(4,580)	*(3,248)*	(4,135)	(14,071)	*(9,936)*
Total pay	**(37,303)**	**(38,710)**	***(1,407)***	**(113,000)**	**(115,497)**	***(2,496)***
Non-pay						
Drugs	(1,394)	(1,456)	*(62)*	(4,181)	(4,268)	*(87)*
TEDD	(3,788)	(3,802)	*(14)*	(11,364)	(11,260)	*103*
Clinical supplies	(4,552)	(5,350)	*(798)*	(13,728)	(14,843)	*(1,115)*
Purchased services	(1,252)	(1,313)	*(61)*	(3,751)	(3,598)	*153*
Finance costs	(2,677)	(2,714)	*(37)*	(8,032)	(8,022)	*10*
Other	(4,792)	(5,974)	*(1,183)*	(14,762)	(17,461)	*(2,699)*
Total non-pay	**(18,454)**	**(20,609)**	***(2,155)***	**(55,817)**	**(59,451)**	***(3,634)***
Covid exp - block	-	-	-	-	-	-
Covid exp - variable	-	-	-	-	-	-
Total Expense	**(55,757)**	**(59,319)**	***(3,562)***	**(168,817)**	**(174,948)**	***(6,131)***
Surplus/(Deficit)	**(2,580)**	**(5,313)**	***(2,732)***	**(8,703)**	**(13,569)**	***(4,866)***

I&E position

- In M3 there is a deficit of £5.3m compared to plan of £2.6m resulting in an adverse variance to plan of (£2.7m). YTD the Trust is adverse to a £8.7m plan by (£4.9m) – see appendix 1 for plan phasing.

Income

- The position is surplus by (£1.3m) ytd, the main drivers being;
  - One-off CDC invoice for £0.2m
  - One off benefit from old year on contract income of £0.1m
  - Overperformance of elective against baseline of £1.2m
  - SPH Fire incident offsetting Div benefit by £0.3m

Expense

- The Trust has a (£2.5m) adverse pay position ytd. This is driven by £0.6m unfunded Escalation costs in Littlington Ward/BIU, £0.8m Premium costs for EC staffing (Medical), and £0.4m Premium staffing costs in Theatres (ODPs), with CIP the balance.
- Use of temporary staff at higher unit cost partially offset by WTE usage below budget but still overspent.
- Non Pay is overspent by (£3.6m) ytd. This is driven by one off old year invoices of £0.5m (Multifunctional Devices, Vascular, Oncology) that were above the accrued amount, Security costs £0.3m, Theatre activity £0.8m, £0.3m WAC outsourcing (offset in income) and CIP centrally held in M3 of £2.0m.

Finance | Variable income

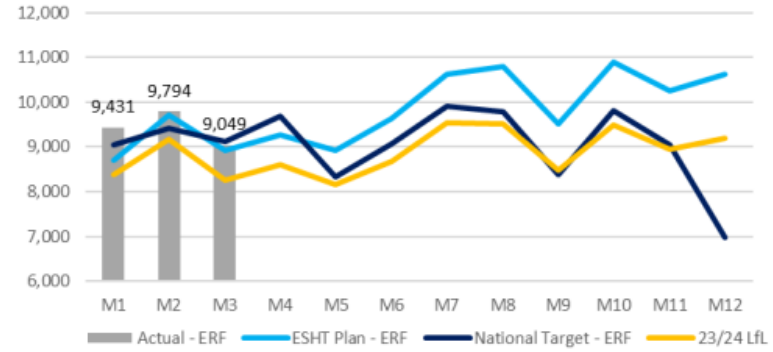
East Sussex Healthcare NHS Trust

Finance

ERF performance

- The Trust over-performed its ERF plan by £0.9m in month (of which £0.8m was catch up) with YTD over-performance of £0.9m. We expect this performance to increase as we report flex and freeze for previous months. There also appears to be some issues in the data for general surgery in particular which is being investigated.
- Outside of this Ophthalmology (known coding issue) and Respiratory have underperformed significantly.
- Other variable activity over-performed by £0.2m in month taking the total variable delivery to on plan in month and £0.3m over YTD.

ERF performance (£'000)



	In Month				YTD			
	Plan	Actual	Var		Plan	Actual	Var	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Daycase	3,083	3,514	431	14.0%	9,323	10,516	1,193	12.8%
Elective	1,974	1,670	(304)	(15.4%)	6,157	5,389	(767)	(12.5%)
Outpatients - First	1,662	1,652	(11)	(0.7%)	4,952	5,418	466	9.4%
Outpatients - Procedure	1,679	1,726	47	2.8%	5,334	5,214	(120)	(2.3%)
Ward Attenders	156	145	(11)	(6.9%)	474	478	4	0.8%
SPH	289	234	(55)	(18.9%)	881	936	55	6.2%
ERS	78	108	29	37.4%	220	323	103	46.6%
Prior month catch up	-	766	766	n/a	n/a	n/a	n/a	n/a
ERF activity	**8,922**	**9,814**	**893**	**10.0%**	**27,341**	**28,274**	**933**	**3.4%**
Unbundled diagnostics	590	727	137	23.3%	1,963	2,183	220	11.2%
Direct Access	252	285	34	13.3%	866	910	44	5.1%
Chemo	278	220	(58)	(20.8%)	897	929	32	3.6%
Prior month catch up	-	86	86	n/a	n/a	n/a	n/a	n/a
Other Variable	**1,120**	**1,318**	**199**	**17.8%**	**3,725**	**4,021**	**296**	**7.9%**
Total	**10,041**	**11,133**	**1,092**	**10.9%**	**31,066**	**32,294**	**1,229**	**4.0%**

	In Month			YTD		
	Plan	Actual	Var	Plan	Actual	Var
	£'000	£'000	£'000	£'000	£'000	£'000
General Surgery Service	1,063	645	(418)	3,092	2,075	(1,017)
Ophthalmology Service	1,271	1,145	(126)	3,774	3,354	(420)
Respiratory Medicine Service	176	96	(80)	530	332	(198)
Paediatric Service	193	138	(56)	574	424	(150)
SPH	289	234	(55)	881	936	55
Interventional Radiology Servi	37	1	(36)	124	62	(62)
Trauma and Orthopaedic Servi	1,502	1,467	(35)	4,690	4,721	31
Vascular Surgery Service	47	39	(8)	160	127	(33)
Diagnostic Imaging Service	6	-	(6)	7	-	(7)
Maxillofacial Surgery Service	144	139	(5)	446	400	(46)
Rheumatology Service	218	214	(4)	587	725	137
Paediatric Trauma and Orthop	8	4	(4)	16	13	(3)
Orthodontic Service	27	23	(3)	76	73	(2)
Paediatric Epilepsy Service	8	5	(3)	19	14	(5)
Paediatric Dermatology Servic	6	4	(2)	22	14	(8)
Transient Ischaemic Attack Se	38	36	(2)	127	124	(3)
Paediatric Surgery Service	11	11	(0)	34	35	1
Plastic Surgery Service	-	-	-	6	-	(6)
Emergency Medicine Service	-	-	-	-	-	-
Physiotherapy Service	-	-	-	-	-	-
BCSP	36	37	0	117	121	4
Hepatology Service	1	1	0	1	3	3
Palliative Medicine Service	0	1	0	1	3	1
Cardiac Rehabilitation Service	-	3	3	-	14	14
Anaesthetic Service	10	15	4	34	51	16
Elderly Medicine Service	21	26	5	62	81	19
Chemical Pathology Service	10	16	6	46	49	2
Stroke Medicine Service	2	11	9	12	41	29
Endocrinology Service	67	77	10	178	222	44
Breast Surgery Service	233	245	12	632	726	94
Neurology Service	120	133	14	375	412	37
Diabetes Service	17	33	16	41	120	79
Gynaecology Service	560	583	23	1,718	1,705	(12)
Acute Internal Medicine Servic	52	78	26	162	249	87
Dermatology Service	208	243	35	670	744	75
Ear Nose and Throat Service	332	379	47	983	1,189	205
Cardiology Service	560	620	60	1,721	2,094	372
Clinical Haematology Service	226	286	60	737	748	11
Clinical Oncology Service	134	194	61	367	473	105
General Internal Medicine Se	15	81	66	80	239	160
Urology Service	821	893	72	2,668	2,890	222
Respiratory Physiology Service	14	122	107	96	349	253
Gastroenterology Service	439	774	335	1,475	2,323	849
Prior month catch-up	-	766	766	-	-	-

Finance | Divisional summary

East Sussex Healthcare NHS Trust

Division	Variance to budget - M3							YTD overall Variance
	Contract Income	Divisional income	Pay	Non pay	Overall Variance	M2 Variance	WTE	
	£'000	£'000	£'000	£'000	£'000	£'000	WTE	£'000
CHIC	-	24	(74)	0	(50)	171	+2	81
Core Services	13	(77)	62	(446)	(447)	320	(27)	188
Estates & Facilities	-	23	10	232	265	164	(8)	480
Medicine	934	(52)	(198)	32	716	737	+26	1,439
DAS	(62)	47	(229)	(383)	(627)	(1,343)	+13	(1,999)
Urgent Care	31	5	(259)	(110)	(334)	(294)	+3	(943)
WCSH	17	89	0	(181)	(74)	(34)	(23)	(196)
Corporate Services	-	67	(82)	51	36	(178)	(21)	35
SPH	-	(346)	59	48	(239)	44	(17)	(69)
Central/Trust wide	123	(8)	(696)	(1,397)	(1,978)	(1,105)	(81)	(3,882)
ESHT	**1,057**	**(228)**	**(1,407)**	**(2,155)**	**(2,732)**	**(1,518)**	(132)	**(4,866)**

- **CHIC** – Month 2 investment into HomeFirst service meaning underspent on pay.
- **Core Services** – Underspend on pay driven by Pharmacy and radiology vacancies. Non-Pay driven by Radiology and Pathology activity and sourcing with some catch up from M2. Drugs devolved out to Divisions in Month 1, reversed in M3.
- **E&F** – Lower spend versus Utilities in Mth1-3 and vacancies ytd.
- **Medicine** – ERF overachieved in Gastro, Oncology and Cardiology (being investigated for possible coding issue versus DAS). Pay CIP devolved M2-3 causing in month pressure.
- **DAS** – Pressures against pay for premium cost ODP's partly offset by other vacancies. Non pay Theatre activity M1-3 higher than 23-24 trend. ERF income low (please see note above).
- **UC** – Premium costs for Medical staffing continuing to cause pressures alongside supernumerary staffing., plus non pay Security cost pressure.
- **Corporate services** – Pay underspent due to vacancies mainly in HR, Finance and IT Digital offset by movement of Escalation costs for M1-3 and devolvement of M3 Pay CIP. Non-Pay overspent due to one off old year MFD invoices higher than accrued amount.
- **SPH** – surplus in ytd due to vacancies, lower non pay and income down by £0.3m due to fire incident.
- **Central** – CIP held centrally for Month 1-3 in pay and non-pay to value of £14.5 with plans to devolve M4.

Finance | Capital

East Sussex Healthcare NHS Trust

Finance

Trust Lead	Capital Scheme	In Month Plan £'000	In Month Actual £'000	In Month Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000	Full Year Plan £'000	Full Year Fcast £'000	Fcast Risk	Variance £'000
	Original										
DIG	Digital Programmes	83	126	43	249	144	(105)	3,182	3,000	Low	(182)
DIG	Our Care Connected	-	-	-	-	-	-	2,500	2,500	Low	-
	Total Digital	**83**	**126**	**43**	**249**	**144**	**(105)**	**5,682**	**5,500**		**(182)**
EME	Diagnostic Equipment	433	16	(417)	433	188	(245)	2,659	2,605	Low	(54)
EME	MSC Implementation	83	-	(83)	249	-	(249)	476	476	Low	-
EME	Medical Equipment	47	27	(20)	142	196	54	500	500	Low	0
	Total Medical Equipment	**564**	**44**	**(520)**	**825**	**384**	**(441)**	**3,635**	**3,581**		**(54)**
EST	Fire	83	61	(22)	249	66	(183)	1,000	2,000	High	1,000
EST	Backlog	149	478	329	430	1,922	1,492	3,000	3,860	High	860
EST	EDGH Cat 3 Labs	9	-	(9)	27	-	(27)	125	125	Low	-
EST	ICU adaptations (Phase 1)	9	81	71	27	99	71	125	170	Med	45
EST	Clinical Priorities - Prior Year	18	76	58	55	254	199	250	350	Med	100
EST	Endoscopy (Internal)	125	-	(125)	374	-	(374)	1,700	1,700	Low	-
EST	Elective Hub (Trust Funded)	1,629	2,645	1,015	3,905	4,006	101	16,547	16,547	Low	0
EST	Ward Refurbishment	-	(313)	(313)	-	271	271	250	500	Med	250
EST	Ophthalmology Business Case	-	130	130	-	174	174	1,766	451	Low	(1,315)
EST	Cardiology business case	-	552	552	-	1,060	1,060	3,500	3,637	Med	137
	Total Estates	**2,023**	**3,709**	**1,687**	**5,068**	**7,853**	**2,785**	**28,263**	**29,340**		**1,077**
FIN	Divisional Small Works	12	1	(11)	35	5	(29)	175	175	Low	-
FIN	Minor Capital	130	57	(72)	130	57	(72)	500	432	Low	(68)
FIN	Planned slippage/prioritisation	(512)	-	512	(1,186)	-	1,186	(9,345)	(500)	High	8,845
FIN	IFRS16 Lease Schemes	-	-	-	-	-	-	-	43	Low	43
FIN	Emergency Department - WIS	-	-	-	-	-	-	2,000	2,000	Low	-
	Total Finance	**(371)**	**58**	**429**	**(1,022)**	**63**	**1,085**	**(6,670)**	**2,150**	**-**	**8,820**
	System Capital	**2,299**	**3,937**	**1,638**	**5,120**	**8,444**	**3,324**	**30,910**	**40,571**		**9,661**
	New										
EST	Building For Our Future	75	47	(28)	165	167	2	1,500	1,543	Low	43
EST	Elective Hub (TIF Funded)	-	-	-	-	-	-	9,271	9,271	Low	(0)
DIG	Diagnostics Digital Capability (LIMS)	-	35	35	-	50	50	607	315	Low	(292)
DIG	Diagnostics Digital Capability (OCS)	-	-	-	-	-	-	547	294	Low	(253)
DIG	Diagnostics Digital Capability (Image Sharing)	-	-	-	-	(26)	(26)	1,500	1,500	Low	(0)
DIG	Frontline Digitalisation (EPR)	-	163	163	-	393	393	8,000	8,000	Low	(0)
EST	NHP - Enabling Fees	-	-	-	-	11	11	15,000	15,000	Low	(0)
EST	Endoscopy (External)	-	7	7	-	70	70	10,000	10,000	Low	0
DIG	AI Diagnostics	-	-	-	-	-	-	165	165	Low	-
	Total Additional Capital	**75**	**252**	**177**	**165**	**665**	**500**	**46,590**	**46,088**	**(502)**	**(502)**
	Total Capital	**2,374**	**4,189**	**1,815**	**5,285**	**9,110**	**3,824**	**77,500**	**86,659**	**(502)**	**9,159**
FIN	Donated Expenditure	85	-	(85)	255	65	(190)	1,000	1,000	Low	-
FIN	Donated Income	(85)	-	85	(255)	(65)	190	(1,000)	(1,000)	Low	-
	Total Donated Capital	**-**	**-**	**-**	**-**	**(0)**	**(0)**	**-**	**-**		**-**
	Total Capital	**2,374**	**4,189**	**1,815**	**5,285**	**9,109**	**3,824**	**77,500**	**86,659**		**9,159**

Capital

- The planned capital allocation for 2024/25 is £77.5m.
- The capital expenditure incurred at month 3 totals £9.1m.
- Capital expenditure was largely driven by the following schemes:
  - Medical equipment £0.4m, including diagnostic equipment.
  - Estates works of £7.9m, the main schemes being, backlog maintenance (£1.9m), elective hub (£4.0m), ward refurbishments (£0.3m), and cardiology services at EDGH (£1.1m).
  - Building for Our Future £167k.
  - Frontline Digitalisation £393k
- The Elective Care Hub is scheduled to complete in February 2025 and is split funded in 2024/25 partly from system funding (£16.5m) and national PDC schemes (£9.3m). The project incurred costs of £4.0m in year.
- The Endoscopy Suite is scheduled to complete in 2025/26 and is split funded between system funding (£1.7m) and PDC funding (£10.0m). In year costs total £70k.
- The demand for capital is greater than the funding envelope and the original plan included an overplanning margin of £9.3m. This means to balance the programme, there would need to be slippage of £9.3m from planned programmes because the current list of schemes is not affordable.

Mortality Report: Learning from Deaths 1 April 2017 to 31st December 2023

Purpose of the paper	The reporting of "Learning from Deaths" to the Trust Board is a requirement in the Care Quality Commission review. All deaths in hospital are reviewed by our team of Medical Examiners and any cases requiring further scrutiny are highlighted to divisions and discussed at specialty Mortality and Morbidity meetings.					
	For decision		For assurance		For information	X
Sponsor/Author	Dr Simon Merritt					
Governance overview	N/A					

Strategic objectives	Quality	People	Sustainability
	x	x	
Our values	Kindness	Inclusivity	Integrity
			x

Recommendation	The Board are requested to note the report. "Learning from Deaths" reports are presented on a quarterly basis.
Executive summary	The current "Learning from Deaths" report details the April 2017 – December 2023 deaths, recorded and reviewed on the mortality database. Learning disability deaths are subject to external review against the LeDeR (learning disability mortality review) programme. Trusts are now receiving feedback from these reviews, although the process is slow. We continue to review deaths of patients with learning disabilities internally due to the delays in the external process in order to mitigate any risk.
Next steps	The Mortality Review Audit Group continues to review the deaths with a higher likelihood of avoidability, on a quarterly basis, to ensure accuracy in reporting. Deaths going to inquest, SIs, Amber reports, complaints and "low risk" deaths are all reviewed for completeness

Learning from Deaths Dashboard April 2017-December 2023 (Data as at 12/07/2024)

Department of Health

Organisation	**EAST SUSSEX HEALTHCARE TRUST**
Financial Year	**2023-24**
Month	**December**

EAST SUSSEX HEALTHCARE TRUST: Learning from Deaths Dashboard December 2023-24

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

Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 12/07/2024)

Time Series:	Start date	2017-18	Q1	End date	2023-24	Q3

Total number of deaths recorded in the mortality database - excluding Learning Disability

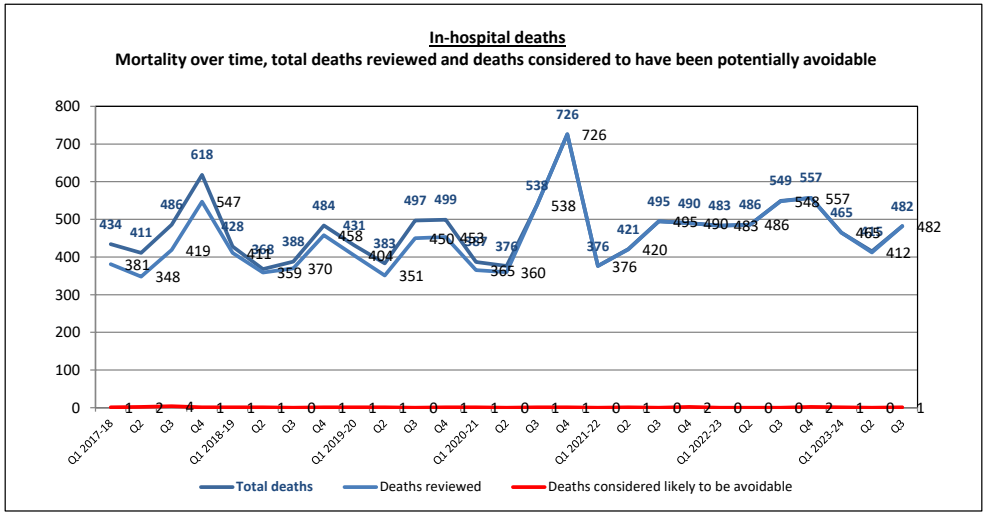
This Month	Last Month
193	136
This Quarter (QTD)	**Last Quarter**
482	415
This Year (YTD)	**Last Year**
1362	2075

Total deaths reviewed by Medical Examiner

This Month	Last Month
193	136
This Quarter (QTD)	**Last Quarter**
482	412
This Year (YTD)	**Last Year**
1359	2074

Total number of deaths considered to have been potentially avoidable (RCP Score <=3)

This Month	Last Month
0	1
This Quarter (QTD)	**Last Quarter**
1	0
This Year (YTD)	**Last Year**
2	2



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

Score 1 Definitely avoidable		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%

Score 2 Strong evidence of avoidability		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%

Score 3 Probably avoidable (more than 50:50)		
This Month	0	0.0%
This Quarter (QTD)	1	6.3%
This Year (YTD)	2	3.3%

Score 4 Possibly avoidable but not very likely		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	2	3.3%

Score 5 Slight evidence of avoidability		
This Month	1	12.5%
This Quarter (QTD)	2	12.5%
This Year (YTD)	5	8.2%

Score 6 Definitely not avoidable		
This Month	7	87.5%
This Quarter (QTD)	13	81.3%
This Year (YTD)	52	85.2%

Data above is as at 12/07/2024 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were no care concerns expressed to the Trust Bereavement team relating to Quarter 3 2023/24 deaths.
Complaints - Of the complaints closed during Quarter 3 2023/24 which related to to bereavement in hospital, most had an overall care rating of 'good care' , two with 'adequate care' and one with 'excellent care'.
There were three patients with an overall rating of 1 or 2, poor care. Two have been reviewed and the deaths have been found as definitely not avoidable The other patient has not yet been reviewed.
Serious incidents - There were 3 severity 5 serious incidents raised in Q3 2023/2024.
As at 20/03/2024 there are 519 April 2017 - December 2023 deaths, still outstanding for review on the Mortality database.

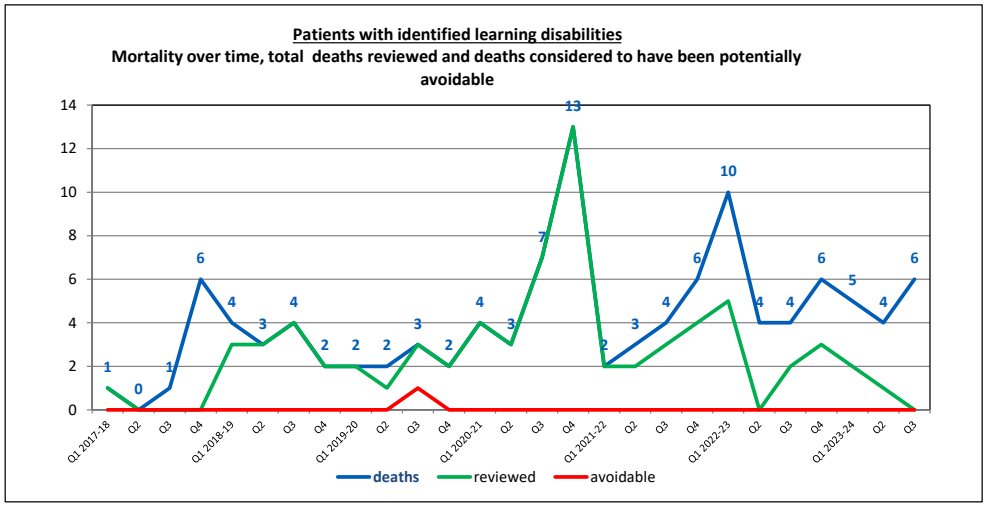
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 12/07/2024)

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

Time Series:	Start date	2017-18	Q1

End date	2023-24	Q3

Total number of deaths recorded in the mortality database - Learning Disability		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	2	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
6	4	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
15	24	3	10	0	0



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

2024/25 Financial Plan

Purpose of the paper	To provide an update on the 2024/25 Financial Plan and to seek Trust Board approval of the 24/25 Financial Plan for the Trust.					
	For decision	x	For assurance		For information	
Sponsor/Author	**Sponsor**: Damian Reid (damian.reid1@nhs.net) Chief Financial Officer **Author:** Kirsty Watts, Head of Financial Strategy and Business Development					
Governance overview	• Previous plan was presented at the June Trust Board meeting. • Planning updates have been provided at the January, February, March, April and June Finance and Productivity Committees. • The latest position has been reviewed by Executive Directors.					

Strategic objectives	Quality	People	Sustainability
			x
Our values	Kindness	Inclusivity	Integrity
			x

Recommendation	The Trust Board is asked to note the update and approve to the 24/25 Financial Plan.
Executive summary	The previous plan was for a planned deficit of £17.3m, at the last Trust Board meeting there was a discussion and agreement to improve this by £2.6m through an additional efficiency stretch, this has resulted in the efficiency target now being £36.7m (5.2%). This percentage increase brings the Trust in line with the rest of the system. Since that time there has been increasing pressure from the Integrated Care Board and NHSE to improve the financial position. This has resulted in a revised planned deficit of £11.7m; the £5.6m improvement on the £17.3m is made up by the £2.6m efficiency stretch and two other adjustments: • £1.5m Depreciation gain from additional income • £1.5m System redistribution of income The paper includes the key performance, activity, workforce and finance trajectories. In addition to the financial improvement of £5.6m there are a couple of other key changes from previous submissions: • Performance – zero 65 week waits have been pushed back from June to August to allow for the support we are providing to University Hospitals Sussex NHS Foundation Trust. • Activity – a shift from elective inpatient to daycase to reflect the proportions now being completed as daycase and an update to outpatients to align to the financial plan. The performance, activity and workforce plans have been submitted to the ICB and the financial plan has been submitted to NHSE through the national portal.
Next steps	• Monitor delivery of the planned trajectories for performance, activity, workforce and finance. • Take remedial action where necessary for any adverse deviation from the trajectories.

NHS
East Sussex Healthcare
NHS Trust

2024/25 Financial Plan

KINDNESS

INCLUSIVITY

INTEGRITY

A recap of the planning principles

The anchor point was agreed to be the budget and activity plan.

The starting point was 23/24 budgets adjusted for:

- Full year effect of business cases
- Non-recurrent CIP removal as well as unidentified CIP
- Any other non-recurrent items,
- Any technical issues that have been identified, and
- Re-costing of staff based on actuals.

There would also be adjustments for the following:

- A non-pay rebasing exercise, resulted in centrally rebasing non-pay costs in line with forecast outturn at M10,
- Specific inflationary pressures that are not covered by the non-pay rebasing, and
- Any approved baseline adjustment or service developments.

A proportion of growth would be used to create an Investment Fund and a Winter Fund and will be used to fund gaps identified in the baselining phase as well as service developments.

CIPs would not be allocated until plans had been developed, however Divisions were allocated a notional target of 0.5%.

The intention was to use demand and capacity plans to determine the activity and corresponding activity income plan, however due to unexpected circumstances this was not possible. As a workaround, the 23/24 actual activity has been used, adjusted for working days and adding back in lost activity as a result of industrial action.

Summarised Position

The previous financial plan submitted on 2nd May reported a deficit of £17.3m.

Since this time there has been increasing pressure from both the ICB and NHSE to improve the position. Following discussions the revised expectation is now a £11.7m deficit for the year. The table below summarises the changes from the interim financial plan:

	£'000
Version 1 deficit:	**(34,792)**
Inflation	3,640
Income change	7,957
Efficiency (4% to 4.5%)	3,263
29th Feb agreement	**(19,932)**
Deficit funding	(673)
8th/21st March submission	**(20,605)**
Efficiency (4.5% to 5%)	3,263
25th April/2nd May submission	**(17,342)**
Redistribution of income	1,500
Efficiency stretch to 5.2%	2,600
Depreciation gain	1,500
Revised Deficit 5th June for 12th submission	**(11,742)**

24/25 Financial Bridge

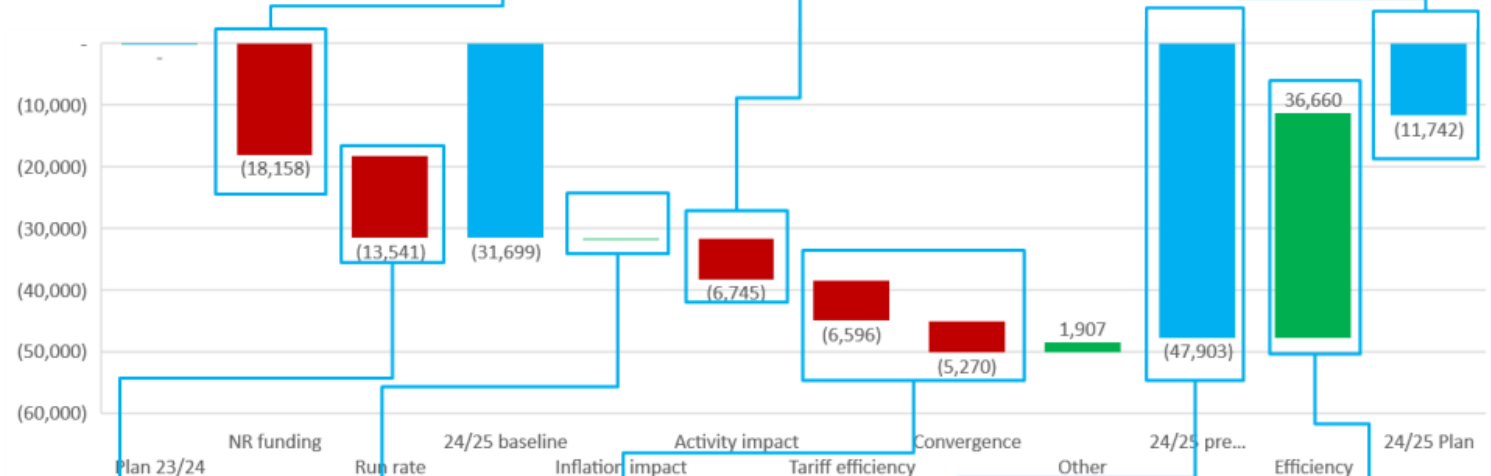
East Sussex Healthcare NHS Trust

Bridge
The bridge below sets out headline financial position expected for 24/25 and aligns to the medium-term financial plan, the detailed bottom-up budget is being developed to align to this.

In 23/24 the Trust received £18.2m of non-recurrent support (albeit a proportion of this is from recurrent commissioner allocations).

Net impact of expected funding of £4.4m and cost of £11.6m resulting in a net pressure of £6.7m.

Overall
Our planning deficit is £11.7m (based on the MTFP). This includes significant risk as it relies on an efficiency delivery of £36.7m. There is further funding currently held at ICB level and the expectation is that the overall system deficit is closed by 25/26 which will require further efficiencies of 4.5-5%.



This reflects the expected underlying run-rate gap of around £1.0m-£1.5m.

Inflation assumptions have been held at NHS guidance (aligned to funding in tariff), there is a significant risk above this.

Tariff efficiency and convergence total £11.9m

Pre-efficiency the likely deficit is £47.9m, this is £31.7m baseline and a total impact of 24/25 efficiency requirements and funding shortfall of £16.2m

We have agreed an 5.2% efficiency, this equates to £36.7m (incl. £0.7m of non-clinical benchmarking and £0.7m in EPR).

Key Assumptions

- The MTFP will be used as the basis for business planning. This has not been officially accepted by NHSE.
- Errors made by the ICB in the MTFP modelling will be resolved without additional pressure put on ESHT
- Trust is able to deliver £36.7m of CIP (c5.2%) – this includes our productivity gains through mitigating demand and delivering elective activity. The income plan includes no expectation of ERF funding other than the efficiency gain.
- Income assumptions are also recoverable against other commissioners outside of Sussex ICB.
- Activity funding will be used to fund cost pressures and any additional winter costs.

Exclusions from Plan

Currently two significant issues beyond the figures included in the MTFP which mean the deficit is likely to be £7.1m above that quoted on the bridge taking the deficit to £18.8m (before any delivery risk such as efficiency delivery), these will need to be discussed with the ICB and there are reasons not to include but must be flagged as a likely difference:

- Non-pay inflation is expected to be well over funded levels, current estimate is at least £2.0m. Funding is £3.7m and for context utility inflation alone is expected to be £2.5m. The £2.0m also includes an assumption that drug inflation is only 0.6% in line with national expectations, pharmacy team believe this is too low. Capital has been excluded from this analysis.
- Pay inflation assumptions (relating to drift and prior year) have been assumed to be in line with national funding equating to £3.6m (we do however understand that the CUF may be revisited to address this)
- ERF baseline 2% planned reduction in 23/24 has not been carried over into 24/25 and this is a pressure that has not been accounted for in arriving at the deficit target. The impact is £1.5m.

Key Performance Trajectories by Month

There has been a change to the 65 week wait, pushing out having zero patients from June to August, this allows for the ongoing support to UHSx as they have patients who are waiting beyond 78 weeks.

Performance	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Percentage of attendances at Type 1, 2, 3 A&E departments, excluding planned follow-up attendances, departing in less than 4 hours	76%	76%	76%	75%	75%	75%	75%	74%	73%	73%	75%	78%
Diagnostic Waiting times - % waiting greater than 6 weeks	12%	11%	10%	9%	8%	7%	6%	5%	5%	5%	5%	5%
% of patients waiting less than 28 days for Cancer Diagnosis (Faster Diagnosis Standard)	75%	75%	75%	75%	75%	75%	75%	75%	76%	76%	76%	77%
% of patients seen within 62 days for Cancer treatment	60%	63%	65%	67%	66%	63%	64%	67%	67%	64%	67%	70%
The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 65 weeks or more	65	45	70	45	0	0	0	0	0	0	0	0

Activity Trajectories

East Sussex Healthcare NHS Trust

There has been a small shift from elective inpatient activity to daycase to reflect the proportions now being performed as daycase activity and there has been an amendment to outpatients. On further review the outpatient figures included in the May submission did not fully align to the agreed finance plan and these have been updated.

The activity submission reflects the expected activity levels for 24/25 and the elective change from 23/24 represents the productivity changes that form part of the Use of Resources Programme

Elective Activity	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	24/25 Total	% change from 23/24
Elective Daycase Spells	4,725	4,515	4,478	4,925	4,308	4,550	5,023	4,858	4,268	4,855	4,474	4,684	**55,663**	**17.9%**
Elective Ordinary Spells	395	414	383	375	379	328	383	345	303	381	341	371	**4,398**	**(0.1%)**
Total Elective Spells	**5,120**	**4,929**	**4,861**	**5,300**	**4,687**	**4,878**	**5,406**	**5,203**	**4,571**	**5,236**	**4,815**	**5,055**	**60,061**	**16.4%**
First Outpatient Attendances	11,515	12,165	11,216	12,533	10,538	11,816	13,161	12,924	11,083	12,790	11,733	12,329	**143,803**	**13.5%**
Follow Up Outpatient Attendances	17,914	18,424	18,051	19,500	16,493	18,337	20,822	20,456	17,279	20,977	18,627	19,382	**226,262**	**(6.3%)**

Non-Elective Activity	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	24/25 Total	% change from 23/24
Type 1 Attendances	9,762	10,796	10,605	10,758	10,553	10,229	10,444	10,104	10,241	9,791	9,095	10,471	**122,849**	**3.7%**
Type 3 Attendances	3,211	3,551	3,488	3,538	3,471	3,364	3,435	3,323	3,368	3,220	2,991	3,444	**40,404**	**2.7%**
A&E Attendances	**12,973**	**14,347**	**14,093**	**14,296**	**14,024**	**13,593**	**13,879**	**13,427**	**13,609**	**13,011**	**12,086**	**13,915**	**163,253**	**3.5%**
Non-Elective Spells	4,277	4,601	4,582	4,435	4,355	4,281	4,401	4,327	4,381	4,310	4,014	4,373	**52,337**	**3.0%**
Diagnostics	13,863	13,863	13,203	15,182	13,863	13,863	15,182	13,863	13,203	14,523	13,203	13,863	**167,674**	**2.7%**

Workforce Trajectories

East Sussex Healthcare NHS Trust

There has been **no change** to the workforce plan and trajectories that were submitted in May.

The workforce submission reflects a reduction of 457 wte between March ’24 and March ’25, the plan will include further adjustments as CIP’s and cost pressures are identified at a service and divisional level

WTE	23/24 Outturn	24/25 March	Var	Var%
Substantive	7,646	7,280	(366)	-5%
Bank	563	483	(80)	-14%
Agency	112	101	(11)	-10%
Total	**8,321**	**7,864**	**(457)**	**-5%**
Var to budget	98	324	226	
Establishment	**8,419**	**8,188**	**(231)**	**-3%**

Monthly Trajectory	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Substantive	7,616.91	7,588.67	7,557.03	7,527.49	7,494.45	7,463.11	7,429.77	7,399.43	7,365.99	7,338.15	7,308.81	7,279.14
Bank	528.28	435.60	444.75	460.07	547.58	564.47	530.04	537.50	446.37	456.61	472.41	482.97
Agency	94.18	91.09	93.51	102.47	98.68	100.10	111.75	121.58	101.98	102.85	101.58	101.32
Total	**8,239.38**	**8,115.36**	**8,095.29**	**8,090.04**	**8,140.71**	**8,127.68**	**8,071.55**	**8,058.51**	**7,914.34**	**7,897.61**	**7,882.80**	**7,863.43**

Finance Trajectories

East Sussex Healthcare NHS Trust

The finance plan assumed deficit of £11.7m, this includes £36.7m of efficiencies to be delivered in year. Whilst efficiency has been phased this has currently been done within reserves and (income where relevant) and has been apportioned 70% pay and 30% non-pay with the unidentified value phased from June and increasing over the year.

£'000	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	24/25 Total
Income	52,711	54,225	54,010	54,463	54,149	55,044	55,615	55,652	54,631	56,030	55,851	56,049	**658,430**
Pay	(37,691)	(37,975)	(37,195)	(37,048)	(36,997)	(36,798)	(36,672)	(36,847)	(36,654)	(36,606)	(36,217)	(36,355)	**(443,055)**
Non-Pay	(17,966)	(18,252)	(18,804)	(18,682)	(18,674)	(18,777)	(18,070)	(18,051)	(18,321)	(18,117)	(18,279)	(18,071)	**(220,064)**
Operating Surplus/(Deficit)	(2,946)	(2,002)	(1,989)	(1,267)	(1,522)	(531)	873	754	(344)	1,307	1,355	1,623	**(4,689)**
Non-Operating Costs	(587)	(587)	(591)	(588)	(588)	(588)	(588)	(588)	(588)	(588)	(588)	(584)	**(7,053)**
Surplus/(Deficit)	**(3,533)**	**(2,589)**	**(2,580)**	**(1,855)**	**(2,110)**	**(1,119)**	**285**	**166**	**(932)**	**719**	**767**	**1,039**	**(11,742)**

We do need to be cautious that there is not the expectation to have a £12m+ surplus plan in 25/26 given the exit run-rate is £1m.

£'000	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	24/25 Total
Efficiencies	1,297	1,303	2,290	2,494	2,567	2,941	3,273	3,495	3,854	3,954	4,728	4,462	**36,660**

The efficiencies ramp up over the year to allow for the development of the Use of Resources Programme.

- Clearly this plan represents a significant challenge in 24/25 and will still leave a significant challenge in 25/26
  - The 5.2% efficiency improvement implied has been discussed and agreed by the Trust Board.

Freedom to Speak Up Report – Public Board

Purpose of the paper	This report seeks to provide an overview of the activity of the Freedom to Speak Up Guardians and includes the nature of concerns raised and an analysis of trends. We last reported to the Trust Board in December 2023. The FTSUG's are required to report to Trust board twice a year as a minimum and much of this report was presented at POD on June 11th 2024. This report seeks to provide assurance on the approach and activities of the Freedom to Speak Up Guardians and insight into the themes raised from cases, the learning opportunities identified and what has been actioned in response to casework. It also provides key national updates and development news.					
	For decision	x	For assurance		For information	
Sponsor/Author	Sponsor: Steve Aumayer, Deputy Chief Executive and Chief People Officer Authors: Ruth Agg and Dominique Holliman Freedom to Speak Up Guardians					
Governance overview	The main body of this report was presented to POD on 11th June 2024.					

Strategic objectives	Quality	People	Sustainability
		x	
Our values	Kindness	Inclusivity	Integrity
	x	x	x

Recommendation	1. The Board is asked to receive assurance that the Freedom to Speak Up (FTSU) Guardians continue to undertake both reactive and proactive work to ensure that all ESHT staff, including students, temporary workforce and volunteers feel able to raise concerns and/or to make suggestions for improvement. The FTSUG's endeavour to ensure that the reach extends to minority groups and those that may face barriers to speaking up. 2. Executive and Board support is sought to increase the training and compliance in speaking up and listening up modules as figures indicate the mandatory requirement for this to be completed has not been achieved. 3. Continued communication from the senior leadership is requested to support a culture where staff can speak up and do not fear futility or detriment.
Executive summary	• Review of ESHT data for FTSU and assurance that staff can speak up. Ongoing support to ensure consistency in timely responses thanking staff and providing feedback. • The trust's FTSU arrangements are compliant with guidance from the National Guardian's Office. • Ongoing marketing of the Guardian role continues • Planned workstreams and improvement. • The Guardians have been compliant with submitting anonymised, quarterly data to the National Guardians Office. • As in previous reports, the most commonly cited reasons for speaking up relates to inappropriate behaviours (incivility) and worker safety.
Next steps	• Potential for administrative support for FTSUGs being explored • New promotional routes for service and training being explored, including through Schwartz Rounds, via posters, medical education booklets, medical student inductions and updated website presence

	• New confidential database being developed • Enhanced feedback from colleagues who have used the service being sought to allow greater analysis of effectiveness and targeted involvements

Freedom to Speak Up Guardian's Update

Introduction

Data for concerns brought to the Speak Up Guardians in Q3 and Q4 is reported to the National Guardian's Office (NGO) quarterly

FYYear	FYQuarter	Anonymous	Detriment	Bullying	Patient Safety	Worker Safety	Attitude Behaviour	Total Issues Logged
⊞ 2023/24	3	0	0	2	7	15	21	45
	4	1	2	4	12	30	41	77
	Total	1	2	6	19	45	62	122
Total	**Total**	**1**	**2**	**6**	**19**	**45**	**62**	**122**

National and Local Data

8,690 cases were raised with Guardians nationally in Quarter 3 2023/24, a 21% increase in the number of cases reported compared to the previous quarter (7,188 cases) and a 25% increase compared to the same quarter in 2022/23.

Just under two-fifths (39%) included an element of inappropriate behaviours and attitudes, a 10% increase compared to the same quarter in 2022/23. In line with the national figures, cases of inappropriate behaviours reported to the Guardians in ESHT increased from 36% in Quarter 2 to 47% in Quarter 3 2023/24. Quarter 3 of 2022/23 was 46% in this category which shows that our figures for inappropriate attitudes and behaviours have not improved since last year and it remains the most common reason cited for raising concerns. Dominique and Ruth have met with Kezie Chukwudebelu, the Project Support Manager within the Engagement and Wellbeing team, as he is driving the implementation of our Violence and Aggression Reduction Project and we hope that our insights and data may help towards some of his work in this area.

What staff groups are speaking up

FYYear	Quarter	Profession	Anonymous	Detriment	Bullying	Patient Safety	Worker Safety	Attitude Behaviour	Total Issues Logged
2023/24	3	Additional Clinical Services	0	0	1	0	1	2	5
		Administrative and clerical	0	0	1	0	2	2	5
		Allied Health Professionals	0	0	0	0	0	0	3
		Estates and Ancillary	0	0	0	0	1	0	1
		Medical and Dental	0	0	0	2	2	0	3
		Not Known	0	0	0	0	0	0	1
		Nursing and midwifery registered	0	0	0	5	9	17	27
		Total	0	0	2	7	15	21	45
	4	Additional clinical services	0	0	2	2	7	7	18
		Administrative and Clerical	0	1	1	0	3	6	12
		Allied Health Professionals	0	0	0	0	1	1	1
		Estates and Ancillary	0	0	0	0	1	0	2
		Medical and Dental	0	1	1	1	0	1	4
		Not Known	1	0	0	0	0	1	3
		Nursing and midwifery registered	0	0	0	9	18	25	37
		Total	1	2	4	12	30	41	77
	Total	Total	1	2	6	19	45	62	122
Total			**1**	**2**	**6**	**19**	**45**	**62**	**122**

Divisions and staff speaking up

SpeakUp - Divisional Report Metrics

FYYear	Quarter	Division	Anonymous	Detriment	Bullying	Patient Safety	Worker Safety	Attitude Behaviour	Total Issues Logged
2023/24	3	CHIC	0	0	0	0	2	2	6
		Core Services	0	0	1	0	0	1	2
		Corporate	0	0	0	0	0	1	1
		DAS	0	0	0	2	2	3	5
		DIGITAL AND IT	0	0	0	0	0	2	2
		Estates and Facilities	0	0	0	0	2	0	2
		Human Resources	0	0	1	0	1	0	1
		Not specified	0	0	0	0	0	1	2
		SDEC URGENT CARE	0	0	0	0	0	1	1
		TWS	0	0	0	0	0	0	1
		Urgent Care & Medicine	0	0	0	3	6	9	17
		Women, Children & Sexual Health	0	0	0	2	2	1	5
		Total	0	0	2	7	15	21	45
	4	Administrative/Secretarial	0	0	0	0	0	1	1
		CHIC	0	0	2	1	4	8	12
		Core Services	0	0	0	0	2	3	4
		Corporate	0	0	0	0	1	1	4
		DAS	0	0	0	3	5	3	10
		DIGITAL AND IT	1	0	0	0	0	0	2
		Estates and Facilities	0	0	0	0	1	0	1
		Finance	0	0	0	0	0	1	1
		Human Resources	0	0	0	0	0	1	1
		Not specified	0	0	0	0	0	0	3
		TWS	0	0	0	0	0	0	1
		Urgent Care & Medicine	0	1	1	7	5	11	20
		Urgent care medicine Devonshire ward	0	1	1	0	0	0	1
		Women, Children & Sexual Health	0	0	0	1	12	12	16
		Total	1	2	4	12	30	41	77
	Total	Total	1	2	6	19	45	62	122
Total			**1**	**2**	**6**	**19**	**45**	**62**	**122**

National updates

Speaking Up Support Scheme

When Sir Robert Francis published his Freedom to Speak Up review in 2015, it highlighted the importance of enabling NHS workers to raise concerns in their place of work without fear of reprisals. The review recognised that, after speaking up, some workers were leaving NHS employment, to the detriment of them personally and the organisations they worked for. This caused a significant adverse impact on NHS workers and a loss of expertise and resource to the NHS.

Following this, NHS Improvement (now part of NHS England) launched a Whistleblowers' Support Scheme to implement the recommendations under principle 12 of this review, which helped current and former NHS workers who had raised concerns to remain in or get back into NHS employment.

The scheme found that people experienced challenges in moving forward in their professional and personal lives. The Whistleblowers' Support Scheme was redesigned and renamed as the Speaking Up Support Scheme. This new scheme was aligned to the NHS people promise which states that "we each have a voice that counts".

NHS England have offered the Speaking Up Support Scheme again in 2024 for people who have experienced a negative impact from speaking up.

The scheme provides a range of support for past and present NHS workers who have experienced a significant adverse impact on both their professional and personal lives following the completion of a formal speak up process. It offers a structured online support programme including a health and wellbeing session, psychological support, career coaching and personal development workshops.

In January 2024, an independent evaluation of the speaking up support scheme was published. The findings of the evaluation are detailed and can be found at this link: NHS England » Speaking Up Support Scheme evaluation report 2023

For the purposes of this report, we share two key findings that have the potential to impact upon how we seek to support and develop the Guardian role. The first recommendation stated that:

- **1st recommendation**: The psychological safety of people who speak up must be protected. Human resources departments should improve their levels of support and ensure Freedom to Speak Up Guardians have the autonomy and independence required to fulfil their role.

We feel that we have the autonomy and independence to fulfil our role and, importantly, this enables us to maintain an impartial stance. Colleagues are always reminded that we are not aligned to divisions or HR and therefore all speak up concerns are received without judgement or bias. It is also important for us to reiterate that any colleague can approach the Guardians, irrespective of role or banding. After involvement with a Guardian, we routinely check whether the individual perceives that they have suffered detriment from speaking up. They are reminded that, even if detriment is not immediately obvious, they are always welcome to report this at any time to a Guardian. Numbers of those suffering detriment are reported quarterly to the National Guardian Office. FTSUG discussions with HR as 2 staff members raised perceived detriment. Whilst there is guidance in the policy staff received different guidance on next steps. One was advised to fill in the local resolution template and another was advised to seek a formal Grievance. Both staff had been in a previous formal process following the concerns raised. Ongoing discussion with HR to look at this and any other guidance.

We speak widely across the organisation on the topic of psychological safety and this forms a key part of the mandatory speak up training for line managers.

Guardians now attend the monthly HRSLM meetings and this enables us to share soft intelligence and discuss the proactive aspects of our work across divisions. It is anticipated that this regular contact with our HR colleagues will continue to support working relationships and a shared understanding of our role. Guardians are now using an engagement letter to explain our remit to all those who present to us with a speak up issue. This reinforces that we are independent and impartial and explains that we do not perform an HR function, nor replace Union representation. It is anticipated that this clarity will enable appropriate use of, and referral to, the Freedom to Speak Up Guardian service.

- **2nd recommendation**: The Speaking Up Support Scheme should be extended to more participants to meet demand for the scheme.

Upon entering the scheme, participants reported feeling ostracised, psychologically unsafe, despondent and having experienced personal toll with significant career impact. It is recognised that the scheme has been hugely beneficial in supporting affected colleagues to stay in work and minimise the long-term negative impacts upon their wellbeing and career. Whilst this is very pleasing, the scheme is over-subscribed and there are

strict criteria applied to those who are seeking to be considered for the programme. We keep in close contact with the National Office and the scheme facilitators to ensure that we are up to date with programme developments and can guide potential applicants through the application process and manage their expectations.

Proactive Involvements

Alongside caseload work, the Guardians undertake a significant number of promotional activities to share the importance of speaking up and to offer colleagues an understanding of how they can speak up, what to expect from the process and assurance that their feedback will be listened to, appreciated and explored. Since we last reported to the POD committee, the following are examples of proactive activities that have taken place:

- Bespoke sessions and walkabouts at Bexhill Hospital
- Bespoke sessions and walkabouts at Rye Hospital
- Six bespoke training and updates for ophthalmology and pharmacy teams
- Attended ESHT career day – met with T-level students to hear experiences of their placements in our Trust and to promote the culture of our organisation and the value of speaking up for staff and patient safety.
- Presented speak up sessions at inductions for international nurses.
- Presented bitesize training to newly appointed staff and those undertaking their preceptorship module.
- Worked in partnership with some Heads of Nursing and colleagues in their first leadership role to guide and support them in how to respond to more complex concerns.
- Presented speak up sessions to nursing students at the University of Brighton
- Delivered a speak up session at the monthly meeting for Core Services
- Regularly attended the National Guardian's Office regional meetings and contributed to their strategy discussions.
- Supported the launch of the new Trust values at two roadshow events.
- Dominique has mentored 17 Guardians who are new to role and sited across the country in ICB's, primary care, the hospice network, mental health trusts and NHS providers.
- Attended regular organisational culture team meetings to discuss speaking up and share soft intelligence with our OD colleagues.
- Attended the National Guardian's Office annual conference.
- Participated in 1:1 interviews with Deloitte to discuss our work within the well-led domain.
- Presented a speak up update at the LGBTQI+ staff network group.
- Attended the multi-cultural staff network meeting & discussed recent speak up issues
- Regularly attended the bullying, harassment & resolution group to provide speak up updates and to contribute to action planning.

We regularly review the soft intelligence from cases and use this to determine areas that may benefit from a bespoke speak up session or to prioritise areas to visit to increase awareness and promote discussion. In response to demand and specific requests, increased walkabouts have been undertaken during times of industrial action and increased operational pressure.

New reporting guidance

In February 2024, the National Guardian's Office published new guidance to assist Guardians in accurately recording cases and consistently reporting case data to the National Office. This is a lengthy, detailed document and the Guardians wish to assure the committee that we are already complaint with all of the content within the latest guidance. The full document can be found here: Updated Recording Cases and Reporting Data Guidance - National Guardian's Office

Data collection & protected characteristics

Colleagues who speak up to the FTSUG are given the option to share their age, race, gender, sexual orientation, religion or belief and disability status. As part of our data submissions to the National Guardian's Office, there is currently no mandatory requirement to collect or report protected characteristics (i.e. specific attributes legally safeguarded against discrimination under the Equality Act 2010). However, starting from 2025/26, this may change as consideration is being given to the quarterly collection of protected characteristics data, although this information will be voluntary.

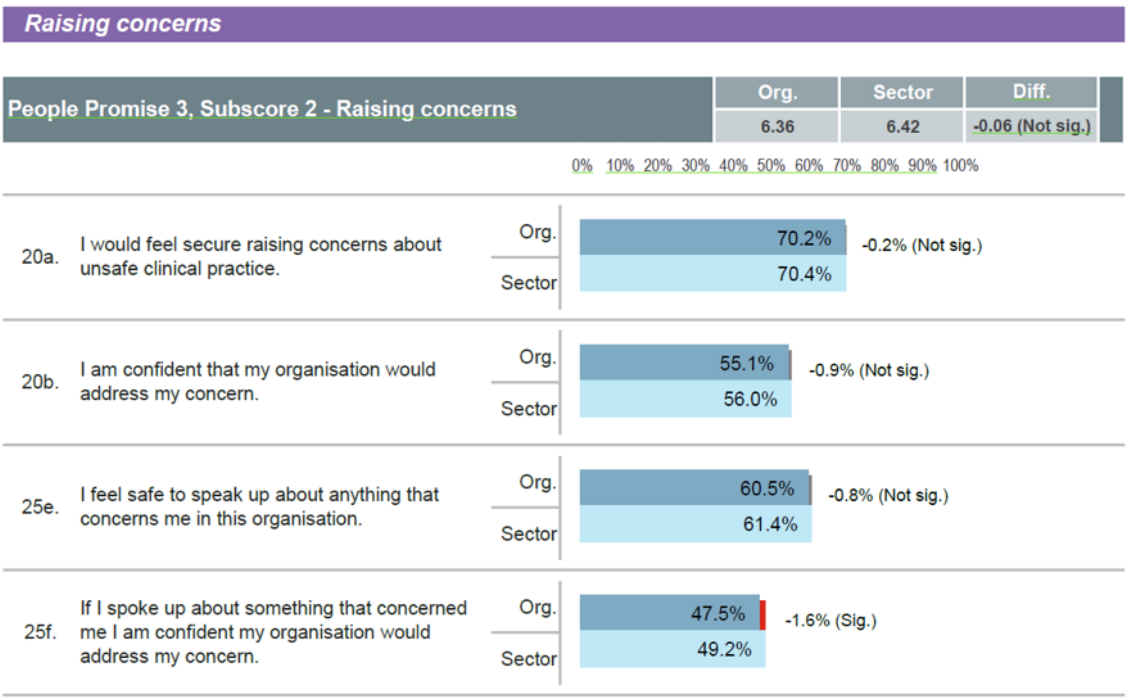
In anticipation of this, the Guardians are exploring how best to capture this data and ensure that it is used meaningfully to identify groups that may face barriers to speaking up and to ensure that all colleagues benefit from equitable access and outcomes. Dominique is currently liaising with other Guardians in the region to exchange insights on good practices and challenges. We have also been advised that next year's mandatory annual refresher training for Freedom to Speak Up guardians will be focused on equity, diversity and belonging to give all guardians a deeper understanding of discrimination and the implications for practice.

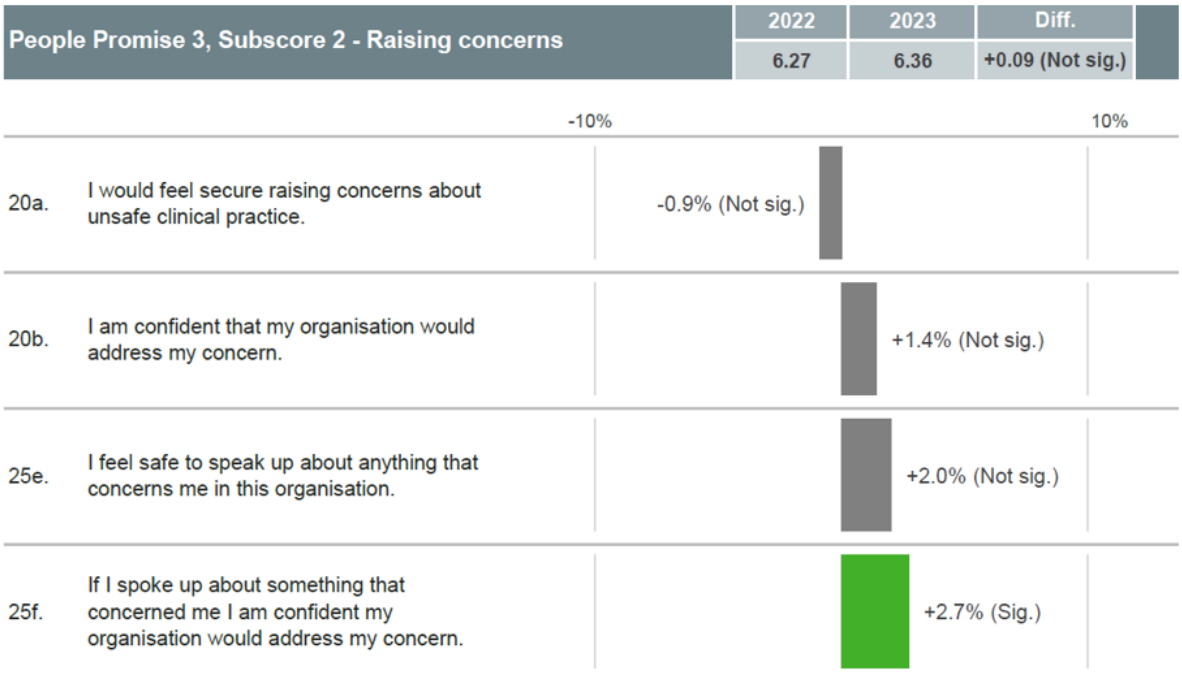
Staff survey results

This year's staff survey results were published in March and show a pleasing set of workforce feedback regarding speaking up. Data sets below show that our results were closely aligned with sector comparisons and 60.1% of ESHT substantive staff reported that they feel safe to speak up, compared with 58.5 % in 2022. 47.3% reported confidence in their concern being addressed – a 2.4.% increase on last year.

It is of note that bank staff also reported feeling safe to report concerns and confident that their concerns would be addressed. In fact, bank staff results in these categories were slightly higher than those of their substantive colleagues with 92% reporting that they feel secure to raise concerns about unsafe clinical practice.

Overall, results for raising concerns have improved from last year with a statistically significant increase for the question "If I spoke up about something that concerned me, I am confident my organisation would address my concern". We remain 1.6% lower than the sector for this question, but this is a clear improvement from our position last year and offers further scope to promote the effective handling of concerns in our proactive work and training sessions.





25e. I feel safe to speak up about anything that concerns me in this organisation.	2022		2023		Comparator	
Strongly disagree	138	4.1%	152	3.8%	11,647	4.5%
Disagree	365	10.7%	399	9.9%	25,150	9.7%
Neither agree nor disagree	907	26.7%	1,050	26.2%	63,240	24.4%
Agree	1,595	46.9%	1,869	46.6%	120,079	46.4%
Strongly agree	393	11.6%	541	13.5%	38,723	15.0%
Missing	55		60		2,878	
Positive Score	**58.5%**		**60.1%**		**61.4%**	
Negative Score	**14.8%**		**13.7%**		**14.2%**	
Base	3,398		4,011		258,839	

25f. If I spoke up about something that concerned me I am confident my organisation would address my concern.	2022		2023		Comparator	
Strongly disagree	199	5.9%	211	5.3%	14,840	5.7%
Disagree	440	13.0%	495	12.3%	30,342	11.7%
Neither agree nor disagree	1,232	36.3%	1,407	35.1%	86,183	33.3%
Agree	1,217	35.9%	1,478	36.9%	96,257	37.2%
Strongly agree	306	9.0%	418	10.4%	30,903	12.0%
Missing	59		62		3,192	
Positive Score	**44.9%**		**47.3%**		**49.2%**	
Negative Score	**18.8%**		**17.6%**		**17.5%**	
Base	3,394		4,009		258,525	

Good Medical Practice

Good Medical Practice, the GMC's updated guidance for doctors on standards of care and behaviour, came into effect on 31st January 2024. As the guidance sets out the standards of care and behaviour expected of all medical professionals, the National Guardian's Office worked alongside GMC colleagues to ensure that speaking up and listening up is firmly embedded within the guidance. Good medical practice - professional standards - GMC (gmc-uk.org)

Speaking up embedded in The NHS Leadership Competency Framework

NHS England has published The NHS Leadership Competency Framework (LCF) for all board members of NHS providers, ICBs and NHS England's Board.

The LCF provides a framework for board member recruitment and appraisal and will inform future board leadership and management training and development. The LCF provides a consistent competency and

skills benchmark against which board members will individually self-assess as part of the annual 'fitness' attestation.

In response to the publication of the Leadership Competency Framework, Dr Jayne Chidgey-Clark, National Guardian for the NHS, said:

"Over 100,000 cases have been raised with Freedom to Speak Up guardians since they were established in 2017. That's 100,000 opportunities for learning and improvement – essential intelligence for an organisation. Encouraging a supportive listening culture ensures that leaders tap into that knowledge, swiftly address issues, and improve patient safety.

"I am delighted that NHS England have so firmly included speaking up in their competency framework for leaders, and that chairs will be appraised accordingly. This highlights not just the central importance of creating a safe speaking up environment, but also the requirement that leaders themselves speak up and challenge appropriately.

"When leaders actively listen and take action, it strengthens organisations, and fosters a culture of ongoing improvement and innovation in delivering healthcare." The full document can be found here: NHS England » NHS leadership competency framework for board members

Review of ambulance trusts

In February 2024, the findings of a review commissioned by NHS England were published. The full report can be found here: NHS England » Culture review of ambulance trusts

The independent review considers the core factors impacting cultural norms within ambulance trusts and offers actionable recommendations for improvement**.** This review followed on from a National Guardian's Office report in 2023 which highlighted significant challenges within ambulance trusts and reported that the culture was having a negative impact on workers' ability to speak up (Speak Up Review of Ambulance Trusts in England - National Guardian's Office.)

Based on insights from key stakeholders, this latest report identifies six recommendations for NHSE, ICBs and ambulance trusts. Whilst the recommendations do not directly impact upon ESHT, we think it is important to keep abreast of NHSE reviews concerning agencies that we work closely with, and we use the recommendations to help inform and examine our own culture and practices. This forms an integral part of keeping a watchful brief on external media reports about speaking up in the public sector. By doing so, we seek to capture learning points and recognise that these do prompt discussion and can generate questions among our people.

Feedback

When a case is closed by the Guardian, the person who spoke up is invited to participate in an anonymous online survey about their experience.

97% of respondents stated that they would recommend the Speak Up Guardian and would use the service again.

100% reported receiving a timely response from the Guardian.

97% felt supported by the Guardian.

Comments included:

"Thank you for your help and thank you so much for the session you delivered. I have received feedback from the nurses that it was truly very encouraging and made them feel safe."

"Thank you so much for spending considerable time talking with me. I can't thank you enough for your care and understanding at a difficult time for me."

“Thanks so much for your kindness Dominique, its much appreciated.”

“Thank you so much for your kind words and support today. Always feel so much better after speaking with you.”

“It’s such a crucial service you provide, I only wish all staff were as compassionate, understanding and professional as you are”.

“It was so nice to speak to someone who really understood, I can’t thank you enough – it made me feel much better.”

“What we have in place is great. At times when times are tough the email asking how you are and knowing someone is there to listen to you is immensely helpful.”

“I thought I would have to leave my role following long term sickness but was able to return to my role feeling supported and guided.”

72% of survey respondents had raised their concerns elsewhere first, but three quarters of those reported that they did not feel supported by the person they had initially approached. When invited to give further detail on this, the comments received were

“Escalations were done to my line manager but issues were not addressed or not in a timely manner or communicated properly.”

“Poor management of situation from manager and conflicting info from HR”

“It felt like it was my problem for reacting, not that the behaviours were actually completely unacceptable”.

“There has never been much support in the department, just a get on with it attitude”.

“3 months of emails with no action taken”.

“Nothing to do with Freedom Guardian. We spent over a year going through the process and it ended with a thank you letter, nothing else. Felt a little underwhelming after everything we've been through. The guardians have been very supportive and helpful though.”

The Guardians continue to promote the Speak Up, Listen Up, Follow Up training available on the MyLearn platform. We hope that the mandatory ‘Listen Up’ module for line managers will equip them to respond to concerns in a timely and effective fashion. Regrettably, uptake of this training has been slow and, due to limitations of the ESR system in reliably identifying those with line management responsibilities, many colleagues have reported being unaware that they should undertake this training as it does not appear on their training dashboard.

The current training numbers for the 3 modules are
Speak up 548
Listen up 604
Follow up 43

Next Steps

In mid-March, another comms briefing was distributed which promoted the speak up training and gave links and further information. It is hoped that this will prompt colleagues to complete the module.

- In readiness for National Speak Up month and to help during busy periods in caseload demand, the Guardians are exploring some administrative support to optimise the planning and delivery of promotional activities and to help maintain the database and reporting functions.

- Planning is underway to facilitate a Schwartz round to coincide with National Speak Up month in October which will be entitled 'The time I spoke up'
- New posters which promote the routes for speaking have been printed and there will be a planned launch to reach all staff and sites with communication and promotion of speaking up and how it is welcomed at ESHT.
- Dominique is working with workforce analysts and our systems team to develop a new confidential database to record speak up concerns which will inform data collection, improve caseload management and better fulfil our mandatory reporting requirements to the National Guardians Office.
- FTSUG's will be joining the Internationally Recruited Colleagues task and finish group.
- Within the anonymous feedback survey, we will be adding a new metric to ask the reason why colleagues chose to approach the Guardian. This may help to identify areas in which to target our proactive involvements and generate deeper intelligence regarding use of the Guardian service and routes for resolution.
- We continue to promote the availability and value of the speak up training online, with a particular emphasis on encouraging line managers to complete the mandatory 'listen up' module.
- Concerns were recently raised from the NHS National Education & Training survey which showed that 35.6% of learners and trainees in ESHT were not aware of who their local FTSUG is. FTSU is not a scheduled session in the face to face induction but it is covered by the Executives in their welcome address. In response to this finding, the medical education booklet and webpages have now been updated with photos and contact details of the Guardians Trainee Support – ESHT Medical Education.
- We will be meeting main cohorts of medical students at their inductions alongside the pastoral fellows. We have previously been invited to contribute to the holistic half-hour session to introduce our service and would be keen to repeat these. To further improve reach and visibility, we are exploring the availability of a Guardian at the cross-site inductions.

Management Response to Speak Up Guardian Report / Freedom to Speak Up Reflection and Planning Tool

Purpose of the paper	To provide a Trust response to the Freedom to speak up Guardian's report. To provide a further briefing on the Freedom to Speak Up Reflection and Planning Tool and next steps to be taken.					
	For decision		For assurance	X	For information	
Sponsor/Author	Steve Aumayer, Deputy Chief Executive and Chief People Officer					
Governance overview	The Freedom to speak up National Guidelines require a twice yearly update to Board by a Guardian. These papers are reviewed by POD but have been updated slightly based on more recent information and feedback from POD. The Board asked for a management response to the Guardians report and for an update on the reflection and planning tool. These actions are delivered through this paper.					

Strategic objectives	Quality	People	Sustainability
	x	x	x

Our values	Kindness	Inclusivity	Integrity
	x	x	x

Recommendation	The Board is asked to receive the report and to support the development of plans to improve Speak Up in line with the speak up reflection and planning tool.
Executive summary	This paper welcomes the Freedom to Speak up Guardians six monthly report to Board and discusses actions that align with the report contents. It recognises that, whilst our speak up arrangements are good, there is always room for improvement. The report also presents the outcomes of our self-assessment against the National Freedom to Speak Up Reflection and Planning Tool and recommends that a full plan based on the outcomes is presented, along with progress against it at the next Freedom to Speak Up.
Next steps	The plan in response to the Freedom to Speak Up Reflection and Planning Tool will be developed and implemented. A further report by the Guardians will come to Board in December.

Management Response to Speak Up Guardian Report / Freedom to Speak Up Reflection and Planning Tool

Introduction

This report provides:

- a brief response to the Freedom to speak up Guardian's report
- a briefing on the Freedom to Speak Up Reflection and Planning Tool.

For ease, the paper is split into separate parts, one for each of the above topics.

PART 1 – MANAGEMENT RESPONSE TO SPEAK UP GUARDIAN REPORT

1.1 The report from the Freedom to Speak Up Guardians is welcomed and its contents accepted. As stated in the report, our speak up processes remain fully compliant with the guidance from the National Guardians Office.

1.2 The report demonstrates once again the willingness of colleagues to speak up and the value that is added by our guardians in promoting and supporting this process.

1.3 The Trust is working hard to continue to promote the importance of speak up. This includes Executives talking face to face about it to all new starters, the inclusion of speak up in induction programmes and a face to face session for all new medical trainees from a guardian on their induction evening which takes place on their first day with the Trust. Additional marketing along with enhanced visibility of guardians also supports promotion of the service.

1.4 It is noted that the primary reasons for speak up remain attitudes and behaviour (incivility) and worker safety and that it is primarily (but not exclusively) from clinical and community settings that such concerns are raised. It is also noted that the majority of concerns are raised by nursing and midwifery colleagues.

1.4.1 The Trust Violence and Aggression Reduction group is actively working to tackle issues relating to attitudes and behaviour and worker safety. This includes looking and estates and other broader issues which my contribute to people feeling frustrated and behaving in an inappropriate manner.

1.4.2 The Trust is introducing a Violence and Aggression Datix review panel which will ensure that all Datix's linked to Violence and Aggression are reviewed appropriately and in a timely fashion. This will also improve feedback loops to individuals once they have raised a concern.

1.4.3 The new PSIRF approach to patient safety events is becoming embedded into the organisation and all patient safety speak ups that come to guardians are forwarded to the appropriate clinical leads for review and for any action that is necessary.

1.4.4 The Engagement Team are developing a new way of working which is based on creating multidisciplinary teams to deal with repeating or common issues relating to culture.

1.4.5 The Trust has recently instigated two independently supported deep dives into culture in particular areas which have been signposted by guardians as being areas of concern.

1.5 We recognise the importance of managers being fully trained regarding speaking up and continue to mandate and promote Speak Up training. Take up has not been at the level we would have wished for and we are further promoting the importance of completing this training.

1.6 The Trust seeks to continually improve its approach to speaking up and we welcome the opportunity to complete the reflection and planning tool described in part 2 of this report.

PART 2 – FREEDOM TO SPEAK UP REFLECTION AND PLANNING TOOL

2.1 The Freedom to Speak Up Reflection and Planning Tool is a tool that is designed to help identify strengths and any gaps that require work, for the Speak Up Guardians, Trust Leadership and the organisation.

2.2 The tool is set out in three stages and based around 8 principles for speak up.

2.3 The 3 Stages are described below:

3 Stages:

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

2.4 Self-Assessment was undertaken by the Deputy Chief Executive / Chief People Officer with the assistance of the Speak Up Guardians. The relevant section of assessment was also completed by the Lead Non Executive Director for Speaking Up (Deputy Chair). It was confirmed to the Board on 11 June 2024 that the assessment had been completed.

The outcome of the Assessment against the 8 principles is detailed below:

Principle 1: Value Speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Summary of areas of strength to share and promote	High-level development actions for improvement – next 6-24 months
• Audit commissioned into Speak Up arrangements • Policy revised in line with National Template • Guardian report line moved to Deputy CEO • Face to Face meetings for CEO/DCEO • Guardians are exclusive in function • Board Sessions and People & Organisational Development (POD) Committee attendance • Open access to Non-Executive Directors.	• KPIs to be re-evaluated to ensure they provide an effective overview of our speak up culture and

Principle 2: Role-model speaking up and set a health Freedom to Speak up Culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Summary of areas of strength to share and promote	High-level development actions for improvement – next 6-24 months
• All Board Mandate to follow up module • Board session on FTSU • Guardians provide mentoring for leads new to post where needed • Knowledge at senior level of Speak Up support scheme • Report to Public and Private Board for deeper insight.	• Continue to push for all leaders to undertake training • Role model speak up success outcomes • Effective links with staff networks to provide minutes and share information. Need to formalise further. • Action needed to provide additional administration support at times of pressure

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Summary of areas of strength to share and promote	High-level development actions for improvement – next 6-24 months
• Clear and effective communications to publicise guardians • Utilise internal communication strategies (Connect/Briefing etc) and optimise speak up month.	• Annual Plan to raise profile – more organic – proactive plans to be better implemented • Tell positive stories – to use case studies more.

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Summary of areas of strength to share and promote	High-level development actions for improvement – next 6-24 months
• Freedom to Speak up features in the corporate induction as well as local team-based inductions • We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared.	• All Senior Leaders training to be mandated as well as training beyond managers • More support for FTSUGs to measure and feedback. • Better IT support for guardians to track, report on and follow up cases.

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Summary of areas of strength to share and promote	High-level development actions for improvement – next 6-24 months
• Guardians supported to identify potential areas of concern and to follow up • Triangulated data to inform overall cultural and safety improvement programmes • Regularly identify good practice from others. • Areas of multiple concerns escalated for deeper cultural reviews	• Continue with current practices • Guardians / speak up management leads to attend national conference and other events furthering speak up and safety

Principle 6: Support Guidelines to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Guardians are recruited, trained, supervised and supported in a way that ensures that both they and the organisation can fulfil their speak up duties and responsibilities.

Summary of areas of strength to share and promote	High-level development actions for improvement – next 6-24 months
• Guardians have been trained and registered with the National Guardian Office • Guardians have annual refresher training and are supported to attend annual conferences • Guardians receive 1:1 support from senior lead and other relevant executives • Guardians have access to a confidential source of emotional support or supervision.	• Need to develop better KPIs to measure that cases are progressed and dealt with in a timely manner (see also final action for Principle 4).

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Summary of areas of strength to share and promote	High-level development actions for improvement – next 6-24 months
• Proactive listening events / bespoke sessions with committee/junior doctors • Meetings with pastoral fellows • Confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment.	• No new actions – ongoing escalation of issues and review of staff survey and other data to identify issues and hotspots

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Summary of areas of strength to share and promote	High-level development actions for improvement – next 6-24 months
• Evidenced that we have a comprehensive and up to date strategy to improve speaking up culture (People Strategy) • Plan in place to measure whether there is an improvement in how safe and confident people feel to speak up • Seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement.	• Ongoing review of strategies and plans to ensure still relevant.

2.5 Conclusions from the Self-Assessment

Overall, our performance against the self-assessment was good with many areas of positive practice. The assessment did, however, identify opportunities for improvement and further development which we accept and will action.

2.6 Next Steps

Following the self-assessment presentation to Board through this paper, a full plan will be developed to ensure an effective response to the opportunities and actions raised. This plan, along with progress against it, will be presented to the Board for assurance at the next Freedom to Speak Up board update in December 2025.

Mortuary Update

Purpose of the paper	This paper sets out updates on the actions that were agreed following a review of the 17 recommendations published in the Phase 1 report into the Maidstone & Tunbridge Wells NHS Trust (M&TW) Mortuary inquiry					
	For decision		For assurance	x	For information	x
Sponsor/Author	Sponsor: Dr Simon Merritt CMO Authors: David Garrett, Divisional Director of Operations, Core Services Division Charlotte Hendon-Dunn, Head of Pathology Quality and Governance					
Governance overview	HTA Governance Meeting June 2024 Quality & Safety Committee July 2024					

Strategic objectives	Quality	People	Sustainability
	x	x	

Our values	Kindness	Inclusivity	Integrity
	x	x	x

Recommendation	This report is for the Board's information and assurance.
Executive summary	It is important to note that although the phase 1 report only applies to the M&TW Trust these guidelines are likely to be applied to all Trusts in the phase 2 report. As a result, the phase 1 inquiry report recommendations were reviewed in December 2023 to identify that might be required to ensure that ESHT was compliant. These actions were reported to the Quality & Safety Committee in January 2024 and it was agreed to present further updates on progress made against these actions every six months. There have been three Human Tissue Authority (HTA) reportable incidents at ESHT over the last 18 months.
Next steps	Actions will continue to be progressed with the support of the Trust.

Six monthly update on the response to the Independent Inquiry into issues raised by the David Fuller case

1. Executive summary

The phase 1 inquiry report recommendations were reviewed in December 2023 to identify any actions necessary to enable ESHT to comply (it should be noted that although the phase 1 report only applies to the M&TW Trust these guidelines are likely to be applied to all Trusts in the phase 2 report). These actions were reported to the Quality and Safety committee in January 2024 and it was agreed to present further updates on progress made against these actions every six months. The table below describes that progress. Also included, for information, is a list of all HTA reportable incidents occurring in ESHT over the last 18 months.

1.1. Table of Phase 1 report actions and progress

Please refer to Appendix 1 for details of the recommendations made in the Phase 1 report.

Action	Date	Latest update	RAG status
Mortuary Access Policy to be written (combining current out of hours policy with the mortuary security procedure). *(Recommendation 1)*	Sep-24	Changes in process have been implemented including non-mortuary staff only being able to enter the mortuary out of hours in pairs. A trial is ongoing allowing the coroner's crew to only access the mortuary accompanied by a Trust porter, rather that having their own swipe access. Once finalised these improved processes will be incorporated into the updated mortuary access policy.	Green = On track
Understand what level of DBS checks non-mortuary staff and non-ESHT staff have including maintenance staff, coroner's crews etc. *(Recommendation 3)*	Jun-24	Coroner's DBS process now understood, the coroners office hold a list and photographs of all staff with DBS checks. Information from Assistant Director of Resourcing: All Porters and maintenance staff receive standard DBS checks.	Blue = Complete
Work towards uplift in role for the Deputy Mortuary Manager to become Mortuary Manager *(Recommendation 4)*	Sep-24	Appraisal occurred in June. Next steps is to refresh 8a JD, secure pay budget to allow for 8a and band 7 to be in place. then take through recruitment process for 8a to be filled, followed by vacant band 7 to be filled.	Green = On track
Complete training of current staff (over the next 4 years) *(Recommendation 5)*	2028	Portfolio submitted for one member of staff for level 4 and should be evaluated in the next few months. 1 apprenticeship (level 3 diploma) started, next one due to begin Jan 25.	Green = On track
Backfill to Deputy Manager role *(Recommendation 5)*	Dec-24	See 'Uplift in role for Deputy Mortuary Manager' above.	Green = On track

Need to establish security of porters keys at EDGH and Conquest *(Recommendation 6)*	Mar-24	Porter's key has now been removed. There is still a master key at Conquest that can open all Trust locks including the mortuary. Minor Improvements have been submitted to remove the locks from the mortuary doors.	Green = On track
Look at the feasibility of the mortuary being a 24/7 staffed service. *(Recommendation 6)*	Dec-24	To be reviewed later this year. Will require capacity v demand to occur as existing staffing cannot meet service needs and cover hours already in place.	Green = On track
Annual audit to be set up to review who has swipe access and whether this is still appropriate. *(Recommendation 7)*	Sep-24	Audit completed in June. Ongoing audits added to the audit schedule.	Blue = Complete
Further support required from the trust security team for reviewing swipe access patterns particularly out of hours. *(Recommendation 7)*	Sep-24	Discussed with head of security. The mortuary team already review swipe access records for those denied access and cross reference to CCTV footage. There is a lack of capacity within Mortuary or Trust security to review the records for unusual patterns of access for those authorised to enter. Pathology Quality and governance team looking at how this could be achieved.	Green = On track
Consider how to enhance CCTV audit. *(Recommendation 7)*	Dec-24	Discussed with Head of Security, no concerns reported with CCTV monitoring. The Mortuary team do review CCTV footage in the event of an incident or where swipe access has been denied.	Green = On track
Implement a reciprocal auditing programme with other mortuaries in the region. *(Recommendation 7)*	Sep-24	Deputy Head of Mortuary has approached other local Trusts but has yet to receive a response. This will be raised at the next Sussex-wide mortuary services meeting.	Green = On track
ESHT to further consider how security can be treated as a corporate concern. *(Recommendation 8)*	Mar-24	Walkarounds conducted with Adam Oxley and Chris Hodgson - discussed: • Police and Coroner access arrangements • Maintenance and porters access arrangements • Risk assessment • Out of hours emergency access and team availability • CCTV monitoring • Access records monitoring • Blind spots • External inspections	Green = On track

		• Governance reporting No concerns on the above so the only actions: 1. DGH roller shutter door needed 2. DGH external lighting being checked 3. CON mag locks/access control to be installed Mortuary team are receiving a lot of support from the Security team. Need to find out if Trust security monitor external mortuary doors as a special area of interest? Do they also do a physical check of the estate which covers the mortuary on a daily basis and especially late evenings/weekends? Can we test if our doors can be bashed opened easily?	
To include mortuary representation at Trust security forums *(Recommendation 8)*	Mar-24	Deputy Head of Mortuary attends Trust Security Forum	Blue = Complete
Ensure that all security procedures are adequately recorded in the new policy. *(Recommendation 8)*	Sep-24	This will be progressed once the new processes are finalised.	Green = On track
Risk assess the possibility of the Trust security team being involved in CCTV audits. *(Recommendation 8)*	Dec-24	Currently there is limited capacity for this, but will continue to work with the security team to progress.	Green = On track
Review current CCTV governance e.g. DPIA *(Recommendation 9)*	Jun-24	Being reviewed by Head of Pathology quality and governance.	Green = On track
Risk assessment of CCTV coverage in the PM room. Need to balance extra security with privacy and dignity of the patient. *(Recommendation 9)*	Sep-24	To be reviewed once the phase two report is published.	Green = On track

Consider the feasibility of installing swipe access to all doors, including fridge doors. *(Recommendation 9)*	Dec-24	Arcool have confirmed that this can be done but would have a significant cost. Access to storage areas is already under swipe control.	Green = On track
ESHT require further guidance on the meaning of "appropriately trained" staff. *(Recommendation 10)*	Jun-24	This relates to security audits including CCTV. Awaiting further information from the Phase 2 report.	Green = On track
Include HTA reports during contract review meetings. *(Recommendation 11)*	Ongoing	Waiting for the next HTA report to be published following the inspection in August	Green = On track
Check that retrieval and donation teams have auditing in place. *(Recommendation 11)*	Sep-24	Has been raised with the retrieval and donation teams. Further discussions to take place.	Green = On track
Include council and coroner's representation at HTA Governance meeting. *(Recommendation 11)*	Jun-24	There is now coroner's office and council office representation at the HTA governance meetings.	Blue = Complete
During contract renewal ensure that the contract is reviewed to ESCC's as well as ESHT's satisfaction that the safety and dignity of the deceased is included. *(Recommendation 12)*	Mar-24	Contract (including safety and dignity) has now been signed by ESHT and ESCC.	Blue = Complete
Report regarding the response to this enquiry to be submitted to the Trust board in Feb. *(Recommendation 13)*	Mar-24	The report has been submitted to the Board.	Blue = Complete
Agreed for DI at ESHT to report 6 monthly to Board from February 2024 onwards and quarterly to Trust Quality & Safety Committee. *(Recommendation 14)*	Ongoing	Report being submitted 6 monthly.	Blue = Complete
Review HTA governance membership e.g. consider additional divisional representation. *(Recommendation 14)*	Jun-24	Membership now includes Heads of Nursing.	Blue = Complete

Ensure ongoing attendance of all personnel with HTA responsibilities at the HTA governance meeting. *(Recommendation 16)*	Ongoing	Invites sent for the forthcoming year, scheduled to ensure the licence holder and DI can attend all meetings Good attendance at meetings.	Green = On track
Trust to ensure that the Mortuary team and those with HTA responsibilities are involved in the ongoing review of the End of Life Care Policy. *(Recommendation 17)*	Mar-25	The mortuary team will be involved in the policy review, due in March 2025.	Green = On track

Appendix 1: List of recommendations made in the Phase 1 Report

1. The trust must ensure that non-mortuary staff and contractors, including maintenance staff employed by the Trust's external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs.

2. The trust must assure itself that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen.

3. The trust must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements

4. The trust must assure itself that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within the Trust's management structure and must be adequately managed and supported.

5. The role of Mortuary Manager at the trust should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across two sites, that requires the appropriate level of management attention.

6. The trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.

7. The trust must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.

8. The trust should treat security as a corporate not a local departmental responsibility.

9. The trust must install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.

10. The trust must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.

11. The trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary.

12. The trust should ensure that the Local Authority has examined contractual arrangements with the trust to ensure that they are effective in protecting the safety and dignity of the deceased.

13. The Trust board must ensure that the trust reviews it governance and monitoring processes in light of this report.

14. The trust board must have greater oversight of licensed activity in the mortuary. It must ensure that the Designated Individual is actively involved in reporting to the Board and is supported in this.

15. The trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work.

16. The executive should be made explicitly responsible for assuring the trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.

17. The trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.

Board Assurance Framework (BAF), Quarter 1

Purpose of the paper	Consistent with our approach to the ratification of the BAF on a quarterly basis, this paper is coming to the Board for approval of the Q1 position.					
	For decision	x	For assurance		For information	
Sponsor/Author	Richard Milner, Chief of Staff					
Governance overview	All the BAF risks contained herein have been discussed and reviewed at the relevant committee (excluding BAF 11 which is submitted in draft, having moved committees to the inequalities committee, which meets every three months and will go to the September meeting).					

Strategic objectives	Quality	People	Sustainability
	x	x	x
Our values	Kindness	Inclusivity	Integrity
	x	x	x

Recommendation	The Trust Board is asked to note the completed summary position for BAF risks and Q1 positions of each risk.
Executive summary	This paper reflects the views of the Board sub-Committees as regards the key risks to the Trust as at the end of the opening quarter of 2024/25. These risks are those that would prevent the Trust from delivering on its short-term aims/priorities, as well as three areas that, although not Trust aims/priorities are material and central to effective operational delivery and performance (these are senior management bandwidth, IT network and risks and Business Intelligence capability). As part of our ratification process, the BAF is shared first with the preceding month's Audit Committee before coming to the Board. After discussions at the Audit Committee, we are proposing three suggestions for incorporation into the BAF quarterly report that we believe: • Strengthen executive oversight and discussion of the BAF • Manage the balance between detail and digestibility of the BAF • Improve the articulation of how assurance is taken in sub-Committees
Next steps	All BAF risks will be brought on an exception-led basis monthly for executive discussion and review. These risks are shared quarterly at the relevant Board sub-Committees before being presented collectively to Audit Committee and then the Trust Board quarterly.

1. Introduction

1.1 The Q1 Board Assurance Framework (BAF) was presented to the Audit Committee in July ahead of coming to Trust Board in line with our approach to monitoring the most important risks facing the Trust and delivery of our aims/objectives. Following discussion at the Audit Committee, this brief paper seeks to a) Summarise the position as regards the BAF risks at Q1 and b) Provide assurance as regards the process of monitoring the BAF over 2024/25.

2. Preparation for 2024/25

2.1 Colleagues will recall that we began our preparations for this year's BAF from February, concluding at the April Board seminar with a proposed approach on the 2024/25 risks, to be finalised by the Chairs and EDs of sub-Committees. As shown in the two charts below, earlier this year we looked at our annual priorities and our 3-year goals and considered the risks to these and the extent to which the BAF covered these already (noting, as above, that the sub-Committees may wish to bring further amendments).

Figure 1: Short-term priorities/goals and associated risks vs. BAF coverage

Key risks to goals/priorities	In current BAF? (Y/N)	Proposal (subject to sub-committee Chair/ED views)
• Not being able to deliver high quality care: • how long patients wait, • how long patients stay • how efficiently/effectively they leave our care	Y – BAF risk 10 and 12 address these	No major changes to existing BAF risks (10 and 12) covering this risk area
• Failing to maximise planned activity and understand how delays impact our patients	In part – BAF 11 covers "fair and equal access" but nothing explicit re: planned activity	Suggest wording amendment to include specific comments about maximising planned activity Suggest BAF 11 is moved to the inequalities committee
• Not using clinical incidents/events to drive improvements	Y – BAF risk 10, but need to reflect the PSIRF aspect more clearly in the narrative	Suggest that PSIRF is referenced to ensure that we note how PSIRF links to improvement culture by learning from incidents/events
• Not creating a great place to work with the right culture (values-driven, safe, open and engaged)	Y – between BAF risk 2 and 3 we are already covering these areas	No major changes to existing BAF risks (2 and 3) covering this risk area
• Not developing people-led improvements	Y – BAF risk 9. Narrative currently reflects the CQI work	As above
• Not creating a financially sound (productive, cost-effective, efficient) organisation	Y – BAF risk 4 covers this	No major changes to BAF risk 4 – Chair and ED of F&P may have specific changes they wish to make in order to reflect the highly challenging situation in 24/25
• Failing to deliver a sustainably-focused estate or service models	Y – BAF risk 5 addresses this directly	No major changes suggested given the current focus of BAF risk 5
• Inability to deliver news models (including digital access) or transform services	In part – BAF 8 deals specifically with digital, but the narrative lacks wider comments on transformation risk	Suggest consideration of how we look at transformation risk or change more generally

NB: there are other relevant risk areas (as enablers) woven into the BAF, 1: Senior management bandwidth (via StratCom), BAF 6: IT network and risks (F&P) and BAF 7: BI capability (F&P)

2.2 This approach reflects good practice and as referenced in the Deloitte report, respects good practice in terms of risks devolved to sub-Committees for determination. Final sign-off includes scrutiny at Audit Committee and subsequent collective review as a Board, providing the

opportunity for Committee Chairs and lead Executives to respond to cross-question on matters as required.

3. BAF Q1 update

3.1 The Q1 BAF reflects the key risks to our short-term goals/annual objectives and the scoring has been reviewed by the relevant Committees (with the exception of BAF 11 that has transitioned from StratCom to the quarterly Inequalities Committee and is due to the September meeting).

3.2 The summary of the Q1 BAF is shown below, and the full documentation reflects additional conversations with the CFO regarding the F&P Committee risks. The Executive Team is confident that the risk scoring presented here is a fair and accurate reflection of both the risks and mitigations/controls either in place or in development.

3.3 The 'change' column in the summary shows that, compared with the scores in Q4 last year, all risks in Q1 have either remained the same (7 of 12) or have increased (4 of the 12) reflecting what we anticipate will be a challenging year for the Trust.

3.4 The summary also shows that 'inherent risk' (without effective controls/mitigation) is the same as the Q1 position in 5 out of the 12 risks. This is either because a) we are awaiting the impact of the controls to be effective, or because we recognise that additional controls are now required to strengthen our position against the risk. In 4 of these 5 risks, we expect to see improvements over the course of the year (i.e. having 'anticipated risk' levels lower than the Q1 actual risk levels).

Figure 2: Summary of Q1 BAF

BAF Ref	RISK SUMMARY	Monitoring Committee	Strategic Aims Impacted				Inherent Risk	Current position (Residual risk)				Change	Risk Appetite	Anticipated Risk
								2024/25						
								Q1	Q2	Q3	Q4			
1	Capacity constraints associated with supporting the collaborative infrastructure	Strat	X			X	9	6				◄►	Seek/ Significant	6
2	Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time.	POD		X	X	X	15	15				◄►	Open	15
3	Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.	POD		X	X	X	20	16				◄►	Cautious/ Open	16
4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery	F&P			X	X	20	20				▲	Cautious	16
5	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		X	X	X	20	16				◄►	Cautious	16
6	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack	Audit	X	X	X	X	16	16				▲	Minimal	12
7	Failure to develop business intelligence weakens insightful and timely analysis to support decisions	F&P			X	X	16	16				◄►	Open	12
8	Failure to transform digitally and deliver associated improvements to patient care	F&P			X	X	16	12				▲	Significant	8
9	Failure to maintain focus on improvement	Strat		X		X	16	16				▲	Open	12
10	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	X	X	X	X	20	16				◄►	Open/Seek	16
11	Failure to demonstrate fair and equal access to our services	Ineq	X			X	15	12				▲	Cautious/ Open	8
12	Failure to meet the four-hour standard	Q&S	X	X	X	X	20	16				◄►	Cautious	16

3.5 Additionally, following discussion at the Audit Committee, further assurances are provided on the matters below:

Executive oversight – discussion of the BAF is scheduled monthly to ensure that relevant executive directors account for progress on actions and implications for movement on the

overall risk scores for those BAF risks that will be reviewed quarterly in the Board sub-Committees.

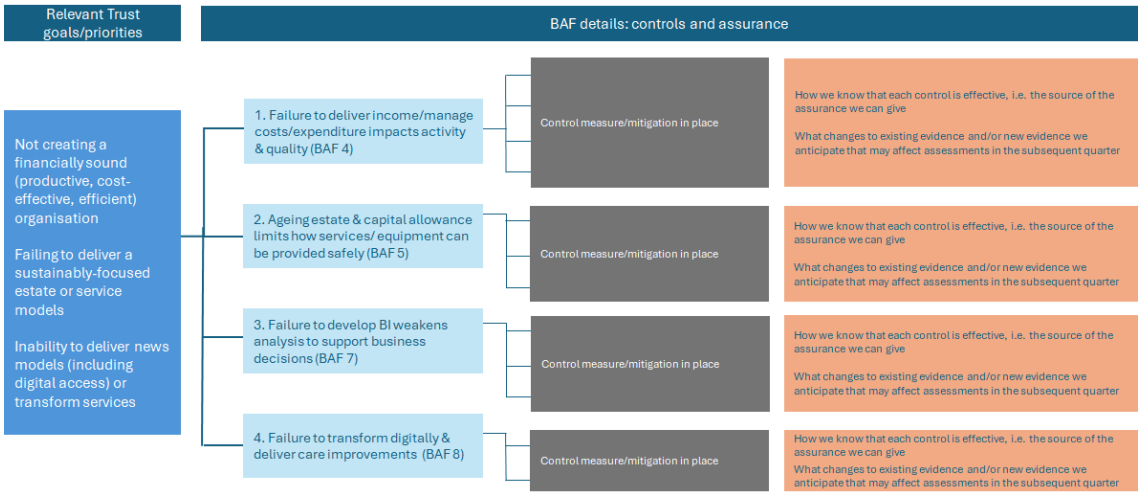
Forward look into the next quarter – our current BAF review process involves the Board Secretary/AD for Corporate Governance meeting with executives to review and amend as needed the details of the BAF risks. We recognise that this is necessarily a 'look-back' approach and that this does not obviously lend itself to demonstrating how the BAF is a dynamic document.

As part of this process, we will include consideration of a 'forward look', with the position of the current quarter including comment on the quarter to come (e.g. whether there is likely to be any evidence that we would anticipate leading to a movement in an existing BAF risk score and why, and/or how we would propose to manage a new material risk).

Clarity of assurance taken – the BAF is a comprehensive document and has previously been acknowledged positively by our internal auditors, but we recognise that there is room for improvement, specifically around articulating how we have reached the quarterly position, and the supporting evidence for it.

The illustrative schematic below (using the BAF risks for F&P as an example) will be completed for the Q2 reviews for each sub-Committee in order to make it easier to see how the scoring has been arrived at, and assurance been taken.

Figure 3: Committee-level summary of BAF risks and controls/assurance (template)



4. Next steps

4.1 As per the front sheet, we have begun the process of preparing the actions required to ensure that this revised approach is ready for the Q2 reporting period.

Board Assurance Framework (BAF)

Quarter 1 Update 2024/25 Overview

East Sussex Healthcare NHS Trust

The Board Assurance Framework (BAF) supports the Board in focussing on the key risks which might compromise the achievement of the organisation's Strategic Objectives. The BAF maps out the key controls which are in place to support delivery of the Objectives and to mitigate risk and provide a framework of assurance which the Board can draw upon when considering the effectiveness of those controls. These assurances have been set out in line with the '3 lines of defence' model (Appendix Five), aiding the identification of areas of weakness.

Each principal risk is owned by an Executive Director and rated in accordance with the grading matrix (Appendix Four). The Executive lead ensures the controls, assurance, gaps and risk score reflect the management of the risk. A Board sub-committee is also nominated to have oversight of the risk.

BOARD ASSURANCE FRAMEWORK - SUMMARY PAGE

NHS East Sussex Healthcare NHS Trust

BAF Ref	RISK SUMMARY	Monitoring Committee	Strategic Aims Impacted				Inherent Risk	Current position (Residual risk)				Change	Risk Appetite	Anticipated Risk
								2024/25						
								Q1	Q2	Q3	Q4			
1	Capacity constraints associated with supporting the collaborative infrastructure	Strat	X			X	9	6				◄►	Seek/ Significant	6
2	Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time.	POD		X	X	X	15	15				◄►	Open	15
3	Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.	POD		X	X	X	20	16				◄►	Cautious/ Open	16
4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery	F&P			X	X	20	20				▲	Cautious	16
5	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		X	X	X	20	16				◄►	Cautious	16
6	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack	Audit	X	X	X	X	16	16				▲	Minimal	12
7	Failure to develop business intelligence weakens insightful and timely analysis to support decisions	F&P			X	X	16	16				◄►	Open	12
8	Failure to transform digitally and deliver associated improvements to patient care	F&P			X	X	16	12				▲	Significant	8
9	Failure to maintain focus on improvement	Strat		X		X	16	16				▲	Open	12
10	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	X	X	X	X	20	16				◄►	Open/Seek	16
11	Failure to demonstrate fair and equal access to our services	Strat	X			X	15	12				▲	Cautious/ Open	8
12	Failure to meet the four-hour standard	Q&S	X	X	X	X	20	16				◄►	Cautious	16

BAF Action Plans – Key to Progress Ratings		
B	Complete / Business as Usual	Completed: Improvement / action delivered with sustainability assured.
G	On Track or not yet due	Improvement on trajectory
A	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement
R	Delayed	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Key to Risk Appetite Ratings		
0	None	Avoidance of risk is a key organisational objective
1	Minimal	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential
2	Cautious	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential
3	Open	Willing to consider all potential deliver option and choose while also providing an acceptable level of reward
4	Seek	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)
5	Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust

Key to Risk Rating Types	
Inherent Risk Rating	The amount of risk that exists in the absence of controls
Residual Risk Rating	The amount of risk that remains after controls are accounted for.
Target Risk Rating	The desired optimal level of risk.

Risk Summary								
BAF Reference and Summary Title:	BAF 1: Capacity constraints associated with supporting the collaborative infrastructure				Strategic Aims Impacted			
					x			x
Risk Description:	Resourcing pressure arising from support/presence at partnership initiatives diverts leadership resource from internal ESHT priorities							
Lead Director:	Chief of Staff	Lead Committee:	Strategy & Transformation Committee		Date of last Committee review:	07/12/2023		

BAF Risk Scoring								
Inherent Risk	Residual Risk	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Rationale for Risk Level	Anticipated Risk	
(3x3) 9	Likelihood:	2	2	2	2	The synergy between System-level success and organisation-led delivery to achieve this aligns Sussex-wide goals with what Trusts are doing. However, this risk reflects the potential disadvantage of this tie-up; namely that key senior leaders' capacity is stretched across external meetings as well as internal ones. To date, the Trust has managed within its existing resources and we intend to do so (hence the risk score for Q1) but – especially in certain areas – there is a recognition that ICB resource is well-provided for and, with this, comes a commensurate range of ambitions and scale of workload.	Likelihood:	2
	Consequence:	3	3	3	3		Consequence:	3
	Risk Level:	6					Risk Level:	6

Cause of risk:	• New/evolving governance forums leading to the time commitment of ESHT senior leaders being compromised	Impact:	• Internal priorities focused on delivery of ESHT 24/25 objectives may be compromised by relevant senior leaders being at other meetings
Current methods of management (controls)	A. Robust monitoring process via EDs, IPRs enabling teams to flag where pressures arise – either on external commitments or internal presence being compromised to the point where senior leaders' grip on internal priorities is suboptimal		

Assurance Framework – 3 Lines of Defence – linked to control (above)			
	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:	• Teams to consider alternative options/resources to ensure ESHT collaboration is maintained at an appropriate level	• Teams able to escalate to EDs for review/support/mitigation options • EDs to consider alternative resource and appropriateness to the responsibility levels	• EDs to raise with external partners as required where no alternative resource is available

Gaps in control/assurance:
• None seen currently

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**

The YE position remains at 6, the expected YE target. Continued proactive management and ongoing ICB review of meeting commitments means that we are confident of this risk not being realised despite the not insignificant meeting burden that comes with the transition to the new system infrastructure. We maintain good, open relations with ICB colleagues and are comfortable escalating where we feel requirements stretch internal resource in order to support ongoing ICB areas. Attendance issues are flagged via Executive Directors meeting and/or Divisional IPRs and our discussions with the relevant partners to seek to manage expectations on attendance have so far been extremely positive.

Risk Summary								
BAF Reference and Summary Title:	BAF 2: Failure to attract, develop & retain a workforce that delivers the right care, right setting, right time				Strategic Aims Impacted			
						x	x	x
Risk Description:	There is a risk that the available workforce does not meet the organisation's resource requirements in the short, medium and long term							
Lead Director:	Chief People Officer	Lead Committee:	People and Organisational Development Committee	Date of last Committee review:	21/03/2024			

	BAF Risk Scoring							
Inherent Risk	Residual Risk	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Rationale for Risk Level	Anticipated Risk	
(5x3) 15	Likelihood:	5				There are pockets of specialities where recruitment is challenged, although these largely reflect national difficulties. Ongoing success with recruiting into some 'Hard to Recruit' substantive posts, particularly Consultant posts. Retention is a clear risk given the ongoing operational pressures being experienced locally and across the NHS. The Trust's age profile presents a specific risk to longer term retention with around 20% of our workforce are at a point where they are technically able to retire. Industrial action relating to the BMA continues to present short term workforce issues and disquiet in the workforce. The risk rating remains as for Q1 2024/25 based on the nature of the industrial action. The anticipated year end risk reflects the ongoing threat of industrial action.	Likelihood:	5
	Consequence:	3					Consequence:	3
	Risk Level:	15					Risk Level:	15

Cause of risk:	Impact:
• Industrial action • Recognised national shortages in some staff groups • Geographical location, demographics and age profile of workforce • Continued operational pressure in a number of clinical areas • Lack of opportunity for career development • Working pressures over the last three years have had a detrimental impact on staff retention (although turnover rates for the last nine months have been reducing) • Withdrawal of Brighton University from East Sussex may impact on the number of trainees choosing to base themselves in East Sussex during their training, which may reduce the number of potential employees seeing the Trust as a natural first choice for post training employment	Failure to maintain workforce stability gives rise to risk of: • Not being able to deliver activity in line with operational needs • Detrimental impact on patient care and experience • Detriment to staff health and well-being • Detriment to staff development as result of reduced ability for staff wanting to attend education/training due to staff shortages in key areas • Failure to comply with regulatory requirements and constitutional standards • Detriment to performance and productivity • Increased workforce expenditure due to agency requirements

	• Withdrawal of funding for registered nurses associates to undertake two year degree to become fully registered nurses		• Inability to ensure 'great place to work' culture and climate thus frustrating strategies and efforts to attract, recruit, retain, deploy, and develop staff

Current methods of management (controls)	A. Ongoing monitoring of Attraction, Recruitment and Retention Strategy and developing wide range of recruitment methodologies (events, social media, recruitment consultancies, targeted recruitment activity, including a significant overseas recruitment plan) B. Talent management, succession planning, appraisals and development programmes C. Developing new roles and "growing our own" e.g. New to Care D. Workforce efficiency metrics in place and monitored E. Quarterly reviews in place to determine workforce planning requirements. F. Review of nursing establishment 6 monthly as per Developing Workforce Safeguards G. Full participation in HEKSS Education commissioning process and regional medical role expansion programme – Foundation and some Speciality Training programmes H. Stay interview and exit interview programmes I. Use of bank and agency where required J. Focus on retention particularly on understanding why people may want to leave the Trust. K. Use of government initiatives e.g. Kickstart L. Flexible working M. More flexible use of retire and return N. Proactively building our positive reputation as an employer O. Implementation of an industrial action project to mitigate the impact of colleagues taking industrial action P. Assurance is being provided re industrial action preparedness to system and region via self-assessment checklist Q. Ongoing responses to key themes from staff survey

Assurance Framework – 3 Lines of Defence – linked to controls (A-P)			
	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:	• Monthly reviews of vacancies together with vacancy/turnover rates (A)(H)(D) • Twice yearly establishment reviews (F) • Success with some hard to recruit areas e.g. consultants in Histopathology, Radiology, Neurology, Orthopaedics and Acute medicine.(A) (C) • In house Temporary Workforce Service to facilitate bank and agency requirement (I) • Workforce efficiency metrics (D) • New AHP /HCSW initiatives (C) • Continued International Nurse recruitment. c70 in total for 2023/24 (A)	• Workforce strategy aligned with workforce plans, strategic direction and other delivery plans and metrics reviewed by POD and Trust Board (A) (B) (D) (E) (F) (G) • Three-year Attraction and Recruitment Strategy refreshed (A) • Improvements to Applicant Tracking system (Trac) have led to reduced time to hire for new staff (not including Medical & Dental staff). (D) • Temporary workforce costs scrutinised by Finance and Productivity Committee (I)	• National Staff Friends and Family Test (A) (G) (H) • Clinical Commissioning Group Quarterly Workforce meetings (D) • Internal audits of workforce policies and processes (A) (D) (E) • NHS Staff Surveys and Pulse Surveys and benchmarking data (A) (B) (C)

Assurance Framework – 3 Lines of Defence – linked to controls (A-P)			
	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)*
	• Additional Headhunter Agencies engaged for hard to recruit Medical Posts (A) • Regular meetings with Regional Post Graduate Deans for Acute and Primary care (C)(J)(N) • Job plans in place for all doctors (B) • Industrial Action working group and daily resource meetings attached to site meetings (O)(P) • In the event of industrial action, reduction in services to ensure all urgent and derogated services are delivered (O)(P)	• Wellbeing offering enhance (includes Pastoral Fellowes support) and reviewed by POD (K) • People Strategy is being delivered (A)(B)(C)(D)(E)(F)(I)(K) • Ongoing recruitment campaigns for hard to fill roles (A) • Delivery of an employee value proposition (EVP) in 2023/24 • NHS Workforce long term plan implementation	
Gaps in control/assurance:			
• None identified			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	Continue with recruitment initiatives and international sourcing of medical candidates, including Radiographers, Sonographers, Gastro and Endoscopy	Chief People Officer	Ongoing	• Continued recruitment campaigns with existing RPO Agencies including Medacs and MSI to source International Nurses, AHPs and Medics. • Additional Recruitment agencies engaged to support with hard to recruit posts where necessary. • Local and UK recruitment campaigns continue. Trust main sponsor for recruitment event in Bexhill. • Recruitment merchandise ordered for 2024/25 to assist with Trust branding • Trust continues to work with external recruitment agencies to assist with recruiting 'hard to fill posts'. Number of initiatives in place to support recruitment e.g. assistance with relocation/onboarding of new colleagues • Increased number of direct applicants to hard to recruit posts continues	G

2.	Local outreach initiatives	Chief People Officer	Ongoing	• Trust working with DWP and Princes Trust. To date c60 young adults supported with Prince Trust initiative. Recruitment events attended in conjunction with DWP. Planned events for 2024/25 • Trust working with other ICB organisations with regards local recruitment activities and initiatives e.g. 'Recruitment Hub' which is due to go live Feb/March 2024 • Trust involved with both Little Gate Farm and Project Search initiatives. • Campaign to increase volunteer numbers across the Trust.	G
3.	Focus on Advanced Practitioner role and roles that support medicine such as Physician Assistants, Surgical Care Practitioners, Anaesthesia Associates (new national curriculum due soon), increase number of Doctors Assistants	Chief People Officer	Ongoing	• SCP :We continue to have two SCP on programme at Anglia Ruskin University the course is for 2 years part time. Meeting scheduled to discuss future SCP development for 23/24 to 27/28 for the NHS England Workforce Training and Education commissioning process. • PA Role : Conversations to formalise the lead PA appointment. There is a one off payment of 20k funding from the ICB to support this role, with additional funding for a Band 7/8a to support the. A meeting, in collaboration with UHSx is scheduled to discuss support to take the role forward in light of new NHS Workforce Plan released this week. • Education Steering Group: ToRs are currently being reviewed. The new Deputy Chief Medical Office – Workforce will co-chair the group. • Anaesthetic Associates: Recent meetings held with clinical lead and division, as well as with the GMC's lead for anaesthetic associates. NHS England announced pump prime funding to support development of the role in Trusts. Business case to be written for development of x2 anaesthetic associate roles in the service with funding from NHS England.	G

Risk Summary							
BAF Reference and Summary Title:	BAF 3: Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.				Strategic Aims Impacted		
						x	x	x
Risk 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.						
Lead Director:	Chief People Officer	Lead Committee:	People and Organisational Development Committee	Date of last Committee review:	21/03/2024		

	BAF Risk Scoring							
Inherent Risk	Quarter	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Rationale for Risk Level	Anticipated Risk	
(5x4) 20	Likelihood:	4				Data is showing that engagement levels across the NHS and locally have reduced over the past three years Elongated industrial action without resolution may further impact on the motivation and morale of colleagues taking industrial action and those directly impacted by it, and our ability to deliver services in a timely and efficient way. The anticipated year end risk has been increased to acknowledge the ongoing industrial action. However it is recognised there is ongoing and sustained improvement in other metrics (e.g. turnover, vacancy rate)	Likelihood:	4
	Consequence:	4					Consequence:	4
	Risk Level:	16					Risk Level:	16

Cause of risk:	Ongoing operational instability and pressures, alongside workforce availability and industrial action.	Impact:	Adverse impact on staff engagement, health and wellbeing could lead to increased absences and turnover, and an associated inability to deliver services, possible closure of services and adverse impact on patient experience and reputational risk.

Current methods of management (controls)	A. Training for managers to have compassionate conversations about risk assessments with vulnerable staff B. Systems and processes in place both reactive and proactive to manage violence and aggression – including conflict resolution training, OH support, risk assessments and security support. C. Working with the ICS to develop a system wide strategy and policy on violence prevention D. Improved de-brief process and package of support for staff involved in violence and aggression or distressing situations at work. E. Reviewing and implementing best practice from other areas (e.g. TRiM, MHFA) F. Targeted support for implementing TRiM in ED departments through a dedicated resource for a period of three months G. Range of wellbeing/pastoral support available and being further developed across all professional groups H. Development of Health and Wellbeing Conversations for all colleagues I. Ongoing focus on Violence and Aggression with ambition to become upper quartile organisation J. Ongoing National vaccination programmes

	K. Workforce Efficiency and Availability Reviews L. Workforce Strategy M. Admission avoidance and discharge activity through operational teams N. Working with the entire system, third sector and independent health and social care organisations to assist them with recruitment and training. O. Effective rostering and leave management P. Undertaking deep dive cultural reviews in areas where there is particular concern regarding colleague engagement and morale

Assurance Framework – 3 Lines of Defence – linked to controls (A-P)			
	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 • Completion of risk assessments to be recorded on ESR. (A) • Promoting wellbeing support available and training to line managers (G) • DME monitor/reviews confidential trainees in difficulty register • Workforce efficiency and availability reviews considering registered and unregistered nurses, and AHPs (I) • Appropriate PPE provided (A) • Ongoing reviews of effectiveness and efficiency of rostering to deliver the required staffing levels	• Occupational Health and Health and Safety Team support and audit of risk assessments and Datix incidents (A) (B) (D) • Occupational and staff wellbeing support to staff (E) (H) (I) • Metrics reported to executive team, POD and Trust Board – increased compliance with completion of risk assessments (A) • Local Security Management Specialist advice and support (D) • Oversight and monitoring by Health and Safety Steering Group (D) • Deep dive cultural Reviews (P) • Implementation of NHS Long term workforce plan	• ICS undertaking assurance reviews (A) • Sussex network meeting in place and liaising with SECAMB on Trauma Risk Management (F) • Health and Safety Executive review of violence and aggression (D) • Collaboration with ESCC on lone working (F) • GMC outcomes have action plans with quality virtual visits in place to provide assurance to HEEKSS/Trust (H)(L)
Gaps in control/assurance:			
• *None identified*			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	People Strategy	Chief People Officer	Ongoing	• People Strategy has undergone year 2 refresh and this established programme of works and has reported to POD. • Further updates will continue on a quarterly basis	G

Risk Summary							
BAF Reference and Summary Title:	BAF 4: Failure to deliver income levels/manage cost/expenditure impacts savings delivery				Strategic Aims Impacted		
							x	x
Risk Description:	The Trust agreed budget for 24/25 is a £11.7m deficit including a CIP target of £37.6m						
Lead Director:	Chief Financial Officer	Lead Committee:	Finance and Productivity Committee		Date of last Committee review:	28/03/2024	

	BAF Risk Scoring							
Inherent Risk	Quarter	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Rationale for Risk Level	Anticipated Risk	
(5x4)	Likelihood:	5				**Likelihood**: At M3 the Trust deficit is £4.9m worse than plan. £35m of the CIP target has been allocated but there is a need to develop supporting PIDs	Likelihood:	4
	Consequence:	4					Consequence:	4
20	Risk Level:	20				**Consequences**: There is risk to delivering the plan.	Risk Level:	16

Cause of risk:	• ERF activity continues to be delivered close to plan; however, pay and non-pay costs have also risen. • Patients not meeting the criteria to reside continues to be an issue. • As discussed at F&P, increased in cost since 19/20 and a loss of non-recurrent income have resulted in a productivity challenge • Ongoing lack of resolution of strike actions • Inflation pressures resulting from recent contract awards	Impact:	Failure to maintain financial sustainability gives rise to risk of: • A need to deliver improved productivity • Reduction in staff levels to the average of 23/24 • Unviable services and increased cost improvement programme; • Additional controls will be imposed by the national team. There is a risk of the System being included in risk level 4 with triple lock controls. • Damage to Trust's stakeholder relationships and reputation..

Current methods of management (controls)	A. Use of Resources Efficiency programme is in place with targets set and monitored at divisional level and cross cutting themes being led by Trust SROs. B. Divisions held to account for overall financial performance through IPR process based on budgets agreed through the Divisions and Executive. Finance actions are also reinforced through a separate Use of Resources (DRUM) meeting C. Scheme of Delegation (SoD) and Standing Financial Instructions (SFIs) in place to manage expenditure across pay and non-pay. All pay to be managed through a Vacancy Panel and all non pay spend above £5k is being referred to a Non-Pay review, and all spend above £10k will be referred to a triple lock process requiring sign off from Trust, ICS and Region. D. A financial improvement Director has been appointed by the ICS with a focus on ESHT and UHS

Assurance Framework – 3 Lines of Defence – linked to controls (A-D)			
	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:	• Work continues through divisional meetings, at IPRs, DRUM meetings and Trust wide cross cutting projects . (A) (B) (C) • Procurement, Temporary Workforce Services and vacancy panel all monitor compliance as appropriate with scheme of delegation and SFIs (C)	• Oversight by Use of Resources and Finance & Productivity Committee (A) • Revised SFIs and SoD (C)	• Internal audit reviews • ICS Oversight (D)
Gaps in control/assurance:			
None identified but need to ensure that the system of internal financial control remains robust.			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	Finalise CIP plan for year with an emphasis on controlling costs as well as delivering increased activity	Chief Financial Officer	05/08/2024	• There are plans being developed for the full £36.7m CIP, with £3m delivered to date. • The current developed list of PIDs is £25m delivery, resulting in a shortfall of £11.6m, but additional schemes are being developed. • Industrial action and the need to reduce the waiting list remains a risk. • There is an expectation that the Trust will deliver the full efficiency requirement of £36.7m.	R
2.	Use of Resources meetings chaired by Chief Executive and coordinated by Use of Resources Director	Chief Executive	Ongoing	• Meetings commenced in 2024/25 • Extraordinary private Board meeting scheduled for August 2024, involving presentation by workstream leads and commitment to full year target.	A
3.	Develop DRUM meeting to improve accountability for the UoR programme chaired by COO and CFO	Chief Financial Officer	31/05/2024	• Finance and Assurance meetings have been taking place for a number of months.	A

Risk Summary							
BAF Reference and Summary Title:	BAF 5: 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				Strategic Aims Impacted		
						x	x	x
Risk Description:	There is a risk that there may be unplanned outages in equipment, buildings and facilities not being available for clinical purposes						
Lead Director:	Chief Financial Officer	Lead Committee:	Finance and Productivity Committee		Date of last Committee review:	28/03/2024	

	BAF Risk Scoring							
Inherent Risk	Quarter	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Rationale for Risk Level	Anticipated Risk	
(5x4) 20	Likelihood:	4				The Trust's capital budget for 2023/24 is £23.1m but this could increase up to £77m with national schemes. The core capital in the Trust budget is not sufficient to support the current EME medical equipment replacement priorities and is also insufficient to address the estates maintenance backlog. The Trust is working with the Friends to bridge the EME medical equipment gap and is also highlighting the need to review capital prioritisation for 25/26 with the ICB. A report on estates backlog maintenance was submitted to the Committee in May 2024. Consideration to be given on increasing this risk to 20.	Likelihood:	4
	Consequence:	4					Consequence:	4
	Risk Level:	16					Risk Level:	16
Cause of risk:	Insufficient capital to meet maintenance backlog (high and significant backlog)					Impact:	Lack of capital for investing in the future sustainability of the Trust gives rise to risk of a significant impact on the Trust's ability to meet its requirements to provide safe, modern and efficient patient care.	
Current methods of management (controls)	A. Significant work is always undertaken to deliver the capital plan B. Essential work prioritised with estates, IT and medical equipment							

Assurance Framework – 3 Lines of Defence – linked to controls (A-B)			
	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 requirements and prioritisation by services (A) (B) • Electronics and Medical Engineering (EME) in close liaison with divisions (B) • Full inventory of medical devices and life cycle maintenance (B)	• Oversight by Finance and Productivity and Strategy Committees (A) • Estates and Facilities IPR (A) (B) • Clinical procurement group in place (A) (B)	• Capital business cases reviewed by ICS (A) • Review of critical infrastructure (A) (B)

Gaps in control/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 and timeframe and scope/extent of work against the funding allocation is not clear at present
- Availability of project managers to deliver the backlog programme

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	ICS will undertake a medium term financial plan	Chief Finance Officer	Ongoing	• Expenditure monitored • Progress reported regularly to Finance and Productivity Committee	A
2.	Through New Hospital Programme business case process and associated enabling business cases, Trust will be addressing solutions for backlog maintenance	Chief Finance Officer	September 2024	• Priorities to be developed into the New Hospital Programme Case	A
3.	Options appraisal for Building for our Future (BFF) to be undertaken	Programme Director BFF	September 2024	• NHP will inform us when the revised SOC should be submitted, anticipated in 2024/25	A
4.	Work to be undertaken with consultancy to review critical infrastructure and clinical activity/risk in order to clarify the level of capital backlog and how this will affect future capital spend.	Director of Estates and Facilities	Complete	• Work with consultancy commenced in December 2023 and report summarised in the May 24 Committee report	G

Risk Summary

Risk Summary							
BAF Reference and Summary Title:	BAF 6: Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack				Strategic Aims Impacted		
					x	x	x	x
Risk Description:	Current mitigations include rollout of MFA to key users, plan to minimise non-supported software and contain software that cannot currently be removed, and ensure offsite backup.						
Lead Director:	Chief Financial Officer	Lead Committee:	Audit Committee	Date of last Committee review:	28/03/2024		

	BAF Risk Scoring							
Inherent Risk	Quarter	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Rationale for Risk Level	Anticipated Risk	
(4x4) 16	Likelihood:	4				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 to which has been a great achievement. But the threat level in the NHS has increased with a number of attacks on NHS Trusts or provider organisations. We have created a Cyber Action Plan, which has got the Trust to medium risk status, which has resulted in the risk rating being reduced to 12. We continue to work towards receiving Cyber Essentials Plus accreditation. The action plan has four elements: 1. Internal Audit recommendation 2. Cyber Essentials Self-assessment recommendations 3. External Penetration Test recommendations 4. 12 Risks on the trust risk register	Likelihood:	3
	Consequence:	4					Consequence:	4
	Risk Level:	16					Risk Level:	12

Cause of risk:	• Global malware attacks infecting computers and server operating systems. The most common type of cyber-attack are phishing attacks, through fraudulent emails or being directed to a fraudulent website.	Impact:	• A shut down of key IT systems could have a detrimental impact on patient care and access. They can lead to a loss of money and data as well as access to files, networks or system damage.

	• Infrastructure Hardware failure, due to unsupported systems or lack of Capital Refresh.		
Current methods of management (controls)	A. Network Monitoring solution implemented to defend against hacking /malware. Regular scanning for vulnerability. B. Anti-virus and Anti-malware software in place with programme of ongoing monitoring. Client and server patching programme in place and monitored. C. Process in place to review and respond to national NHS Digital CareCert notifications. D. Self-assessment against Cyber Essential Plus Framework to support development of actions for protection against threats. E. Ongoing Education campaign to raise staff awareness. F. System patching programme in place and upgrade of client and server operating systems G. Wider engagement including NHS Secure Boundary H. Continual Network monitoring for abnormal activity / behaviour I. Vulnerability scanning, to identify vulnerabilities and remediate J. Migration of Clinical Systems to the Cloud K. Strategy of Cloud first, so Software as a service or platform as a service on any new procurements L. Rolling refresh of infrastructure Hardware, LAN, Wi-Fi, Servers, and Client Devices.		

Assurance Framework – 3 Lines of Defence – linked to controls (A-L)			
	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:	• Cyber Essential Plus Framework assessment reviewed by division (D) • Day to day systems in place and support provided by cyber security team with increased capacity (A) (B) (C) (F) (H) (I)	• Policies, process and awareness in place to support data security and protection and evidence submitted to the DSPToolkit (D) • Information sharing and development with organisations within the Sussex ICS (G) • Regular quarterly security status report to IG Steering Group and every six months to Audit Committee (D) • Monthly reporting via NHS Digital on Cyber Exposure score (D)	• Cyber security testing and exercises e.g. ICB cyber simulation event with all NHS organisations in Sussex, and two internal events at ESHT with senior leaders (E) • Trust to date has had no ransomware attack (A) (B) (C)(H)(I) • RSM internal audits throughout 2024/25 (D) • Final submission of DSPT for assurance to internal auditors took place in June 2023; currently collating 2024 submission (D)
Gaps in control/assurance:			
• Obtain Cyber Essentials Plus 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			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	Cyber Essentials framework.	Chief Finance Officer	Ongoing	• Internal Cyber Essentials self-assessment completed with identifies gaps in compliance • Gaps have been used to create the cyber action plan • Next step is to mitigate gaps in compliance • Refreshing cyber five year strategy	*G*
2.	Medical devices with network connectivity asset list	Chief Finance Officer	2024	• Celera, an auditing tool, has been installed and is now running network audit. Further work required to enable greater visibility • Anticipate that full visibility will be delivered at EDGH by end of April 2024 • Conquest delivery anticipated in 2024	*G*
3.	LAN Refresh EDGH	Chief Finance Officer	2024	• Replace the Core Network and Fibre connections to the Edge Switches • Eastbourne core network is now live and migration will be completed during March 2024 • Migration of Edge network over the course of 2024	*G*
4.	LAN Refresh Conquest	Chief Finance Officer	2024	• Replace the Core Network and Fibre connections to the Edge Switches • Orders are being placed. • Core network estates work now complete	*A*
5.	24/7 Cyber Operations Centre	Chief Finance Officer	Complete	• In place and Complete	*G*
6.	Active directory migration	Chief Finance Officer	2024	• New domain has been built • Migration of users April 2024 • Migration of devices June 2024 • Migration of services December 2024	*G*

BAF Reference and Summary Title:	BAF 7: Failure to develop business intelligence weakens insightful and timely analysis to support decisions				Strategic Aims Impacted			
							x	x
Risk Description:	Currently developing daily, weekly and monthly dashboard. Aim to develop self-serve as a second stage.							
Lead Director:	Deputy CEO & Chief People Officer	Lead Committee:	Finance and Productivity Committee		Date of last Committee review:	28/03/2024		

	BAF Risk Scoring							
Inherent Risk	Quarter	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Rationale for Risk Level	Anticipated Risk	
(4x4) 16	Likelihood:	4				A large number of clinical systems and complex data structures, along with a variety of reporting methods and a lack of controls around the data quality leads to a lack of confidence in the data that we produce.	Likelihood:	3
	Consequence:	4					Consequence:	4
	Risk Level:	16					Risk Level:	12

Cause of risk:	• There are a large number of complex clinical systems used across the Trust. • Variable quality of data input into systems • Number of systems can lead to duplication of data entry • Limited assurance available about the data reported outside of the organisation	Impact:	• Inability to make clinical decisions. • Impact of potentially incorrect data on business planning • Impact of using potentially incorrect data when reporting nationally.

Current methods of management (controls)	A. Local data management policy which includes clear reference to performance data collection, collation and reporting processes; offers a localised point of reference that can provide more clarity to Trust officers than relying solely on national guidance. B. Standard Operating Procedures which assist in ensuring a consistent approach in line with policy by all involved in processes. C. Awareness Training D. Process Mapping E. Responsibilities of all staff groups involved in the process are clearly defined and documented. F. Manual Validation of collected data prior to reporting. G. System Validation – automated checking (such as reasonableness, completeness) of data prior to reporting.

Assurance Framework – 3 Lines of Defence – linked to controls (A-G)			
	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:	• Incidents – there have been incidents (or no incidents) relating to the accuracy of data in this metric. (A)(B)(C)(D)(E) • Process Improvement – processes relating to the collection/collation/reporting of data have been subject to improvement. (A)(B)(C)(D)(E)(G) • Recruitment of Data Quality lead (A)(B)	• Observation/Feels Right – the executive and/or operational lead considers that the reported figures feel correct and are consistent with observations and frontline feedback. (F) • Benchmarking – reported figures for the Trust are comparable with similar organisations. (F) • Business Intelligence Team View – Business Intelligence/Knowledge Management opinion on the accuracy of the data being reported. (F)	• External Review – external organisations (e.g. CQC) have recently reviewed the data and/or data collection processes. (F) • Internal Audit/Granularity – Internal Audit (or another assurance function) has conducted a recent, detailed review of the current process. (A)(B)(F)

Gaps in control/assurance:

- 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.
- System set-up. Nationally validated systems tend to assist in providing consistency in application of rules and reported data across multiple organisations, providing a greater source of confidence than locally developed systems.
- Weakest link, where there may be a single point in the process where data quality could be compromised, such as an individual making a process error that impacts on reportable figures.
- Sensitivity, where small reportable numbers mean any error is exacerbated.
- Dependency on external bodies to validate data prior to reporting.
- Opportunity for manipulation if there is any point within the process whereby any individual (or group) can alter reportable figures so that the data is no longer true or accurate.

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	Recruitment of replacement Data Quality and Assurance Lead	Chief People Officer	April 2024	• Data Quality and Assurance Lead has been recruited and starts on 1st April 2024 • Continue data quality steering group and further development of framework	G
2.	Electronic Patient Record (EPR) procurement	Chief Medical Officer	March 2024	• Outline business case and specification completed, and review of invitation to tender being completed. • OBC has been signed off by the national EPRIB Board • Procurement will start in 25th March 2024 • A large number of posts have been recruited to support procurement and implementation.	G
3.	Development of Power Business Intelligence (BI) Reporting	Chief People Officer	Ongoing	• Daily, weekly, and monthly dashboards have been completed • Development of divisional reporting • Development of updated Board IPR	G
4.	Upskilling the Business Intelligence team	Chief People Officer	Ongoing	• Provision of suitable training in the development of Power BI	A
5.	Development of new data warehouse	Chief Finance Officer	December 2024	• Move Systm One to Azure Modern Data Platform (MDP) • Move NerveCentre to MDP • Integration of new EPR into MDP	A

Risk Summary					
BAF Reference and Summary Title:	BAF 8: Failure to transform digitally and deliver associated improvements to patient care			Strategic Aims Impacted	
					x x
Risk Description:	Currently targeted investment in LIMS Pathology, Sectra Radiology, and virtual wards. Full Business Case for Electronic Patient Records to be developed in 23/24.				
Lead Director:	Chief Financial Officer	Lead Committee:	Finance and Productivity Committee	Date of last Committee review:	28/03/2024

	BAF Risk Scoring							
Inherent Risk	Quarter	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Rationale for Risk Level	Anticipated Risk	
(4x4) 16	Likelihood:	3				**Likelihood**: To enable to Trust to transform digitally and develop a culture which embraces significant change there is a dependency on investment and resources however, currently the Trust is reliant on non-recurrent funding making it challenging to plan for large scale changes or recruit to roles. **Consequence**: 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 and the need for digital and structured data. We have reduced the risk rating associated with this strategic risk because digital awareness across the organisation has greatly improved; divisions are looking to embed digital processes. EPR readiness work is underway to improve digital maturity across the organisation.	Likelihood:	2
	Consequence:	4					Consequence:	4
	Risk Level:	12					Risk Level:	8

Cause of risk:	• Lack of capital and digital funding to deliver improved digital maturity. • Lack of staff and capability to deliver, support and manage transformative digital solutions. • Lack of time, Business as Usual activity and operational pressures reduce the time required and available to support the change required for digital transformation. • Inconsistent processes in relation to be purchase & implementation of new systems, which results in additional steps and handoffs in the process for patient care. • Potential organisational unwillingness to embrace change.	Impact:	• Acceptance of change needed to support new and innovative solutions is disparate across the Trust • Lack of capital for investing in the future sustainability of the Trust • Loss of key staff • Digital solutions developed in silos and unsupported by the Digital team, impacting on the management of patient pathways due to increase in process steps

	• Trust-wide digital transformation programme requires significantly enhanced capacity and capability to manage change		

Current methods of management (controls)	A. Digital Steering Group setup and established to monitor, support, and approve any Trust wide digital initiative and alignment to digital strategy B. Project Prioritisation Matrix to track and manage priorities for digital C. Working with the ICS to develop a system wide strategy for digital innovation D. Digital Benefit lead role established and currently embedding benefits into all digital activity E. Process Mapping to facilitate change acceptance and benefits management F. Transformation programmes to be put place to realise benefits of cost effectiveness G. Longer term capital plan to support delivery of sustainable services

Assurance Framework – 3 Lines of Defence – linked to controls (A-G)			
	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:	• Digital Steering Group to continue to management and approve any digital activity (A) • Process Improvement - process relating to the prioritisation of project / programmes with digital (C) (E) (F) (G) • Benefits Strategy approved (D)	• Oversight by Finance and Productivity and Strategy and Transformation Committees (G) • Digital IPR (A) (B) (F) (G) • Transformation Board (monthly) (F) (G)	• Capital Business cases reviewed by ICS (G) • Internal RSM audits (A) (B) (D)

Gaps in control/assurance:
• Level of automation. Significant manual intervention impacts on the acceptance of change within the Trust • Complexity and changes to national guidance retain to the patient pathways

Risk Summary						
BAF Reference and Summary Title:	**BAF 9: Failure to maintain focus on improvement**			**Strategic Aims Impacted**		
					X	X
Risk Description:	**Insufficient focus leads to a failure to embed a QI culture as "the ESHT way" of securing change and the expected improvement outcomes/benefits are therefore not realised**					
Lead Director:	**Director of Transformation Strategy and Improvement**	**Lead Committee:**	**Strategy and Transformation Committee**	**Date of last Committee review:**	**07/12/2023**	

	BAF Risk Scoring							
Inherent Risk	**Quarter**	**24/25 Q1**	**24/25 Q2**	**24/25 Q3**	**24/25 Q4**	**Rationale for Risk Level**	**Anticipated Risk**	
(4x4) 16	**Likelihood:**	**4**				The current risk position recognises the challenge of delivering the improvements. The improvement in the Q3 scoring is driven by greater confidence in our revised approach, which prioritises skills development internally, supplemented by additional resources in the interim. Over the medium term we are confident that additional resources will be made available to continue the support for our CQI programme. The associated actions are set out in the 'further actions' section.	**Likelihood:**	**3**
	Consequence:	**4**					**Consequence:**	**4**
	Risk Level:	**16**					**Risk Level:**	**12**

Cause of risk:	• People trained under previous model have been inactive • Need to build capacity & training infrastructure of new model • Challenge of delivering improvement aims in an operationally/ financially challenged environment	**Impact:**	• No current systemic approach to delivering improvements • Persistence of training gaps esp. with senior leaders across the Trust
Current methods of management (controls)	A. Stocktake via the creation of ED Transformation Improvement B. Provide regular reporting via EDs/StratCom as regards the current transformation programme		

Assurance Framework – 3 Lines of Defence – linked to controls (A-B)			
	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:	• Through reporting to EDs	• Engage strategic partners to capacity build within our teams and clarify approach	• Potential for peer review, especially with strategic partner and their experiences elsewhere

Gaps in control/assurance:
• None seen currently

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1	Recruit to clear CQI lead within TSI team	Dir of TSI	Apr 24	• On track	G
2	Relaunch Exec CQI steering group		Dec 23	• Began on time	B
3	Reprioritise TSI team work programme to increase CQI support		Dec 23	• Began in Dec 23 but not yet complete	A
4	Drive first phase of 'Management System' component through Business Planning Round using internal resource		Apr 24	• On track	A
5	Develop 'Plan B' to continue programme through internal team development and expansion (jointly with HR)		Mar 25	• Not yet due. Will be a key action over 24/25	A
6	Identify and launch with strategic partner (pending financial commitment)		During 24/25	• Not yet due. Remains an intended action over 24/25. High risk relates to the expectation of a challenged resource environment over 24/25	R

Risk Summary							
BAF Reference and Summary Title:	BAF 10: 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.				Strategic Aims Impacted		
					x	x	x	x
Risk Description:	The Trust has large numbers of patients who do not need the specialist inpatient care provided by ESHT (discharge ready) resulting in a requirement for significant additional capacity and staffing. There is an impact on flow of patients and an increased risk of deconditioning and harms (both physical and mental health) due to the very extended length of stay of some of these patients. In addition, there is a negative impact on patient experience as a result.						
Lead Director:	Chief Operating Officer / Chief Nursing Officer / Chief Medical Officer	Lead Committee:	Quality and Safety Committee		Date of last Committee review:	21/03/2024	

	BAF Risk Scoring							
Inherent Risk	Quarter	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Rationale for Risk Level	Anticipated Risk	
(5x4) 20	Likelihood:	4				Evidence on a daily basis of the impact of greater than 150 patients who are discharge ready and the impact that this has on flow and increasing risk to patients and staff. Situation continues with large numbers of patients who are discharge ready and significant extra bedded capacity open including "supersurge" capacity. In addition, it is necessary to pre-emptively place (board) additional patients on wards until a bed space is available.	Likelihood:	4
	Consequence:	4					Consequence:	4
	Risk Level:	16					Risk Level:	16

Cause of risk:	• Sustained pressure on care home sector resulting in reduced staffing, capacity and acceptance criteria • Closure of care homes across Sussex • Pressures on primary care • Lack of sufficient suitable alternative pathways for patients • Lack of sufficient assessment and treatment capacity in mental health • Recent sustained increase in patients whose primary need is mental health and/or housing • Increase in assaults and aggressive behaviour from patients and/or members of the public • Lack of sufficient capacity for urgent placement of children at risk	Impact:	• Delays for some patients in being able to access care • Delays to assessment and treatment • Patients in inappropriate locations • Poor experience for patients and staff • Delays with discharge planning and process given the significant numbers of additional and/or complex patients • Risk of harm to patients, e.g. self-harm, harm to others, risk of absconding, violence and aggression • Some patients are deconditioning due to length of stay once discharge ready

	• Lack of sufficient suitably trained staff for all capacity that is in use • National removal of discharge to assess funding • Insufficient ESHT therapy resource for inpatients • Insufficient Discharge to Assess capacity • Insufficient ASC practitioner to undertake discharge to assess reviews • Increased length of stay in the acute and onward care settings • Ongoing negative impact of the pandemic e.g. elective backlog of patients, impact on non-elective patients who have not accessed healthcare as a result of the pandemic • Ongoing industrial action by various staff groups		• Increase in safeguarding concerns given the huge numbers of vulnerable patients, many of whom are resistant to care and have a very considerable length of stay • Increasing incidents of violence and aggression • Lack of therapy input leading to some internal delays
Current methods of management (controls)	A. Significant variable additional capacity remains open B. Significant attempts to safely staff all capacity C. Systems in place to identify and escalate NCTR/discharge ready patients D. Ongoing collaborative system working to identify solutions, with discussion at ICB level E. Audit of stranded patients to investigate risks and/or harms F. Weekly long length of stay panel meeting to support expediting discharge of patients with the longest length of stay G. Full capacity protocol, and escalation actions being updated. H. Ongoing workshops to ensure whole Trust approach in supporting this work. Future work ongoing with plans in place. I. Plans underway for new volunteer roles to support reconditioning and the ToCH		

Assurance Framework – 3 Lines of Defence – linked to controls (A-H)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Robust management of all capacity • Thrice daily reviews of staffing • Redeployment of staff as required • Safety huddles in all clinical areas • Real time bed state/information available • Monitoring of quality and safety KPIs • Daily capture and monitoring of escalation and supersurge capacity • System escalation calls to discuss the number of Super Surge patients being cared	• Use of any additional specialist advice or support, including visits to ESHT and ESHT staff visiting other locations • Daily patient pathway review for all P1-P3 patients with system partners • Clear oversight and responsibility for operational delivery, and of quality and safety • Work being undertaken with Nervecentre to develop capture and monitor patients who are pre-emptively placed	• Scheduled meetings with CQC to discuss data, intelligence and KPIs • Challenge at Trust Board • Provider assurance meetings and system clinical quality review meetings

Assurance Framework – 3 Lines of Defence – linked to controls (A-H)			
	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)*
	for at the Trust and the number of patients not meeting the criteria to reside.	• System wide discharge improvement workstream focussed on improving discharge processes and reducing length of stay in acute hospital and community hospital beds	

Gaps in control/assurance:

- Workforce demand outstripping supply due to significant additional capacity required
- Lack of suitable physical space for surge capacity and pre emptive placement
- Lack of sufficient equipment for surge capacity and pre emptive placement
- Overcrowding due to additional beds and equipment
- Unable to completely avoid all inappropriate attendances/admissions
- Lack of Adult Social Care capacity
- Currently unable to easily/accurately describe the impact or harm from reconditioning
- Accuracy and timeliness of data on NerveCentre albeit improving
- Stranded patients requiring mental health support or housing (the housing challenge is increasing)
- Work still required regarding more detailed quality dashboard

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Ensure clinical areas are staffed as safely as possible	COO/CNO/CMO	Ongoing	• Additional capacity is open as anticipated. • Workforce pressures remain • Clear escalation and de-escalation processes in place. • MH Outreach business case approved to support more complex inpatients who often have a LLoS • Agreement to invest in therapy resource for inpatients	A
2.	Ensure as far as possible that patients are placed as safely and appropriately as conditions permit	COO/CNO/CMO	Ongoing	• All escalation areas remain open with additional supersurge capacity remaining open and pre-emptive placement of patients.	A

3.	Ensure high risk patients are assessed and flagged appropriately	COO/CNO/CMO	Ongoing	• Divisional long length of stay meetings • Weekly high risk/complex patient panel to be established.	G
4.	Need to design process for capturing and reporting on the impact of deconditioning	COO/CNO/CMO	Ongoing	• Work continues on this in terms of harm reviews, but it is a manual clinical review process which is labour intensive with no nationally agreed/recognised metrics that we can easily report on. Suggestion of using increase in P) patients as a proxy.	A
5.	Write and present a case for new mental health outreach team at ESHT to support high risk patients whose primary need is mental health (many often have a LLoS)	CNO	April 2024	• Case agreed and recruitment plan and induction/educational programme being enacted.	G

Risk Summary							
BAF Reference and Summary Title:	BAF 11: Failure to demonstrate fair and equal access to our services				Strategic Aims Impacted		
					X		X
Risk Description:	Operational and financial pressures means that the Trust resource and time required to identify and implement change is diverted by other urgent and important priorities						
Lead Director:	Chief of Staff	Lead Committee:	Inequalities Committee	Date of Committee review:	09/2024		

	BAF Risk Scoring							
Inherent Risk	Quarter	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Rationale for Risk Level	Anticipated Risk	
(4x4) 16	Likelihood:	3				This risk has been scored at 16 (inherent risk). Should we be unable to demonstrate fair and equal access to our services, the **consequences** for our most vulnerable groups of patients may be potentially severe – hence the score of 4. The **likelihood** of this risk is scored at a 4 because we believe the potential for the risk event(s) to occur that would give rise to the consequence materialising is high.	Likelihood:	2
	Consequence:	4					Consequence:	4
	Risk Level:	12					Risk Level:	8

Cause of risk:	• Senior leadership **time commitment** available to track implementation (operational and executive) • Reputational **consequences and implications** for the trust given the local and national focus on inequalities • Available **capacity** within existing BI team to report progress	Impact:	• Delivery on inequalities priorities (within the strategy) is compromised • Intervention and oversight from NHS Sussex and other organisations will intensify • Reporting against nationally recognised data sets (age, gender, deprivation and ethnicity) will not be shared with operational teams
Current methods of management (controls)	A. Adhering to existing governance process (performance & assurance) via the Health Inequalities Steering Group (HISG) B. Reporting progress updates through our Quarterly Assurance Meetings with the ICB C. Routine data-led reports shared with divisional leadership teams D. Divisional teams to report on how their services are considering health inequalities as a standing item at IPRs		

Assurance Framework – 3 Lines of Defence – linked to controls (A-D)			
	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:	• Through existing controls (and increasing their focus/effectiveness) as set out in controls A to F on previous page	• Peer support/review and challenge with either local trusts and/or noted peer high performers – especially around vision, scale and the difference made to patient outcomes	• Internal audit review of our governance, planning and delivery against inequalities

Gaps in control/assurance:
• HISG effectiveness (meeting attendance levels are variable, and topics covered are not standardised)
• HISG reporting line does not include accountability challenge through ExCom
• No clear set of aims and KPIs for the year around health inequalities
• Regularise inequalities data reporting from BI team as a standing priority
• IPRs to include a section on inequalities update as part of common template

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve anticipated YE risk score in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 progress report**	**BRAG**
1.	Refocusing the TOR and attendance at HISG to drive a more productive and focussed meeting	Chief of Staff	Sept-24	All five action areas remain on plan to deliver to the due dates shown, noted that all are dated from September onward (hence amber, not green BRAG score). Any variation or deviation will be provided on an exception-based approach	A
2.	Change reporting line of HISG into ExCom to drive accountability for actions/delivery/KPIs		Oct-24		
3.	Publish health inequalities strategy with aims and KPIs for the year and review 6-monthly progress		Oct-24 & Mar-25		
4.	Provide progress update to provider Quarterly Assurance Meeting with ICB		Oct-24 & Jan -25		
5.	Agree with BI team the resources needed and regularity of inequalities reporting		Sept-24		
6.	Develop a standard framework for divisions to complete regarding health inequalities updates and monitor reporting		Nov-24		

Risk Summary					
BAF Reference and Summary Title:	**BAF 12: Failure to meet the four-hour standard**			**Strategic Aims Impacted**	
				X	X	X	X
Risk Description:	**Due to ongoing challenges with patient flow, there is a risk that patients spend longer than they need to in the emergency department once they are clinically ready to proceed. This is due to a number of factors and also affects those patients who wait longer than they should to access the emergency department. There is evidence to suggest that patients who spend more than six hours in emergency departments are more likely to suffer harm.**				
Lead Directors:	**Chief Operating Officer, Chief Medical Officer and Chief Nurse**	**Lead Committee:**	**Quality and Safety Committee**	**Date of last Committee review:**	**21/03/2024**

	BAF Risk Scoring							
Inherent Risk	**Quarter**	**24/25 Q1**	**24/25 Q2**	**24/25 Q3**	**24/25 Q4**	**Rationale for Risk Level**	**Anticipated Risk**	
(5x4) 20	**Likelihood:**	**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.	**Likelihood:**	**4**
	Consequence:	**4**					**Consequence:**	**4**
	Risk Level:	**16**					**Risk Level:**	**16**

Cause of risk:	• Bed occupancy in excess of 98% • Lengthy times to assessment in ED, leading to high numbers of non-admitted breaches. • High numbers of patients who do not meet CTR and are Discharge Ready • Insufficient bedded capacity immediately available • Insufficient community capacity (care homes and discharge to assess)	**Impact:**	• Patients spending longer than they need to in the emergency department • Delays for patients being able to access the emergency department in a timely way • At times increased handover times for ambulance crews • Overcrowding of the emergency departments effecting the experience of patients and staff
Current methods of management (controls)	A. Live bed state provides accurate information regarding occupancy and available bedded capacity B. Urgent Care improvement plan C. Review and refresh of length of stay programme and reporting D. Weekly highlight meetings regarding improvement plan and related KPIs		

Assurance Framework – 3 Lines of Defence – linked to controls (A-B)			
	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:	• Urgent Care improvement plan overseen by Urgent Care Oversight Group • Eliminate reliance on escalation and super surge areas • Focus on non-admitted breaches • Back to basics training for staff on discharge processes • Review and refresh of length of stay programme, governance and reporting •	• Breach compliance assurance across divisions • Long length of stay reviews across divisions • High risk patient reviews	• Virtual ward (community staffing) increase in capacity • Focus on improving weekend discharges via Urgent and Emergency Care Improvement Plan
Gaps in control/assurance:			
• Still embedding processes at ward level e.g. board rounds, referral to Transfer of Care Hub, accurate update of information on NerveCentre • Lack of a clear agreed process at system level to escalate and manage delays for temporary accommodation/housing			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	Ongoing recruitment for Transfer of Care Hub	COO	Q1 2024	• Successfully recruited to all leadership roles and ongoing success with nursing and DISCO roles	G
2.	Review of CHC process	COO	Oct 2023	• Part of discharge front runner workplan	A
3.	Continue three programmes of work reporting to UCOG. Priority actions identified and include work regarding culture, education and roles and responsibilities.	COO	Complete	• Refreshed education/engagement events now scheduled monthly • Likely a requirement for programme management	B

Appendix One – Links to Corporate Risk Register (only risks rated 15 and above appear on the Corporate Risk Register)

BAF 1 - Capacity constraints associated with supporting the collaborative infrastructure						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
			No current risks on the Corporate Risk Register that apply			
BAF 2 - Failure to attract, develop & retain a workforce that delivers the right care, right setting, right time						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	07/02/2013	74	Delays in reporting for Radiological Investigations	15	16	◀▶
	14/11/2017	89	Wait times for routine Child Development clinic referrals >36 months	12	16	◀▶
	17/05/2018	111	Insufficient physiotherapy staffing for neurological outpatient service	15	15	◀▶
	03/12/2018	16	Emergency Department nursing vacancies	12	16	◀▶
	21/12/2018	2	Insufficient intensive care medical consultant staff to deliver 7 day consultant led service	20	16	◀▶
	01/07/2020	79	Unchaperoned ultrasound examinations	16	16	◀▶
	23/10/2020	90	Health Visitor Vacancies	9	20	◀▶
	12/08/2021	7	Inadequate staffing levels to provide consistent Lipid Clinic service	20	15	◀▶
	25/11/2021	58	Construction project manager vacancies	25	16	◀▶
	25/11/2021	59	Statutory compliance and quality assurance in construction activities	20	16	◀▶
	28/06/2022	10	Delays in out of hours patient assessment times	20	16	◀▶
	29/07/2022	110	Vacancy rate of Occupational Therapists	20	15	▲
	01/08/2022	71	Insufficient accommodation for international nurses	16	16	◀▶
	17/08/2022	76	Vacancies in radiology and histopathology increasing diagnostic service waiting times	12	15	◀▶
	01/06/2023	73	Radiology Physics Service Staffing	20	15	◀▶
	28/06/2023	85	Subject Access Requests / Redaction Software	15	15	◀▶
	18/08/2023	97	Delays to Paediatric Dietetic Appointments	20	20	◀▶
	25/09/2023	72	Histopathology consultant vacancies	20	16	◀▶
	30/04/2024	107	Dietetics Gastroenterology Vacancies and Wait Times	16	16	**NEW**

BAF 3 - Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	02/10/2017	109	Risk to community staff from lone working	12	16	◀▶
	14/12/2017	18	Violence and Aggression in Emergency Departments	9	15	◀▶
	03/12/2018	16	Emergency Department nursing vacancies	12	16	◀▶
	21/12/2018	2	Insufficient intensive care medical consultant staff to deliver 7 day consultant led service	20	16	◀▶
	01/08/2022	71	Insufficient accommodation for international nurses	16	16	◀▶
	11/11/2022	159	Access to security at intermediate Care Units	16	16	NEW
	01/06/2023	73	Radiology Physics Service Staffing	20	15	◀▶
BAF 4 - Failure to deliver income levels/manage cost/expenditure impacts savings delivery						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	15/05/2024	130	Delivery of the 2024/25 financial plan	20	20	NEW
BAF 5 - 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						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	07/02/2013	74	Delays in reporting for Radiological Investigations	15	16	◀▶
	10/12/2013	68	Aging Building Management System (BMS)	15	15	◀▶
	11/11/2015	64	Clinical Environment Maintenance & Refurbishment	20	15	◀▶
	12/11/2015	65	External Cladding/Façade at EDGH	20	15	◀▶
	12/11/2015	8	Potential non-compliance with Fire Safety Legislation EDGH	15	15	◀▶
	12/11/2015	67	Potential non-compliance with Fire Safety Legislation Conquest	15	15	◀▶
	12/11/2015	263	Potential non-compliance with Fire Safety Legislation Bexhill	15	15	◀▶
	12/11/2015	60	Failure of lifts	16	16	◀▶
	09/05/2017	61	Loss of Electrical Services to Critical Clinical Areas	16	16	◀▶
	09/05/2017	66	Working at Height	15	15	◀▶
	03/08/2017	75	Containment Level 3 Laboratory	15	15	▼
	27/06/2019	62	Insufficient Ward decant accommodation	12	16	◀▶
	27/06/2019	63	Insufficient isolation facilities to meet demand	12	16	◀▶
	27/05/2020	14	Capital - Sustainability	12	20	◀▶
	02/07/2021	84	Clinical Space on Frank Shaw Ward	20	15	◀▶
	25/11/2021	58	Construction project manager vacancies	25	16	◀▶
	25/11/2021	59	Statutory compliance and quality assurance in construction activities	20	16	◀▶
	31/10/2022	77	Conquest Radiology Imaging Equipment	20	16	◀▶

	30/05/2023	70	Effect of Business Continuity & Critical or Major incidents	16	16	◀▶
	22/08/2023	5	Conquest CT Scanner installation	25	20	◀▶
	02/10/2023	87	Environment for children and young people with complex psycho-social challenges	20	16	◀▶
BAF 6 - Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Initial Risk Score**	**Current Risk Score**	**Change**
	23/08/2017	17	Cyber Security	20	16	◀▶
	21/03/2022	15	Unmitigated Software Vulnerabilities	16	16	◀▶
	30/05/2023	70	Effect of Business Continuity & Critical or Major incidents	16	16	◀▶
	06/06/2023	13	Network infrastructure devices	16	16	◀▶
	18/08/2023	88	Digital booking management for paediatrics	16	16	◀▶
BAF 7 - Failure to develop business intelligence weakens insightful and timely analysis to support decisions						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Initial Risk Score**	**Current Risk Score**	**Change**
			No current risks on the Corporate Risk Register that apply			
BAF 8 - Failure to transform digitally and deliver associated improvements to patient care						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Initial Risk Score**	**Current Risk Score**	**Change**
	07/02/2013	74	Delays in reporting for Radiological Investigations	15	16	◀▶
	31/10/2022	77	Conquest Radiology Imaging Equipment	20	16	◀▶
	28/06/2023	85	Subject Access Requests / Redaction Software	15	15	◀▶
BAF 9 - Failure to maintain focus on improvement						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Initial Risk Score**	**Current Risk Score**	**Change**
			No current risks on the Corporate Risk Register that apply	-	-	-
BAF 10 - Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that no longer meet the criteria to reside.						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Initial Risk Score**	**Current Risk Score**	**Change**
	06/06/2016	108	Demand exceeding capacity of District Nursing service	15	16	◀▶
	03/12/2018	9	Inpatient flow impacting on delivery of care in the Emergency Department	12	20	◀▶
	03/12/2020	69	Risk of insufficient beds during winter	16	16	◀▶
	28/05/2024	11	Delayed discharges from Critical Care	16	16	**NEW**
BAF 11 - Failure to demonstrate fair and equal access to our services						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Initial Risk Score**	**Current Risk Score**	**Change**
	10/01/2022	102	Inadequate psychological support for ESHT patients in the long term condition management and rehab services	20	16	◀▶

BAF 12 – Failure to meet the four hour standard						
	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
Links to Corporate Risk Register:	06/06/2016	108	Demand exceeding capacity of District Nursing service	15	16	◀▶
	03/12/2018	9	Inpatient flow impacting on delivery of care in the Emergency Department	12	20	◀▶
	03/12/2018	16	Emergency Department nursing vacancies	12	16	◀▶
	03/12/2020	69	Risk of insufficient beds during winter	16	16	◀▶
	28/06/2022	10	Delays in out of hours patient assessment times	20	16	◀▶

Appendix Two: Risk Matrix

LIKELIHOOD RISK RATING - Likelihood Rating is a matter of collective judgement; the table below provides some structure to aid thinking.

Likelihood	Descriptor	Score
Certain	This type of event will happen or certain to occur in the future, (and frequently)	5
High probability	This type of event may happen or there is a 50/50 chance of it happening again	4
Possible	This type of event may happen again, or it is possible for this event to happen (occasionally)	3
Unlikely	This type of event is unlikely occur or it is unlikely to happen again (remote chance)	2
Rare	Cannot believe this type of event will occur or happen again (in the foreseeable future)	1

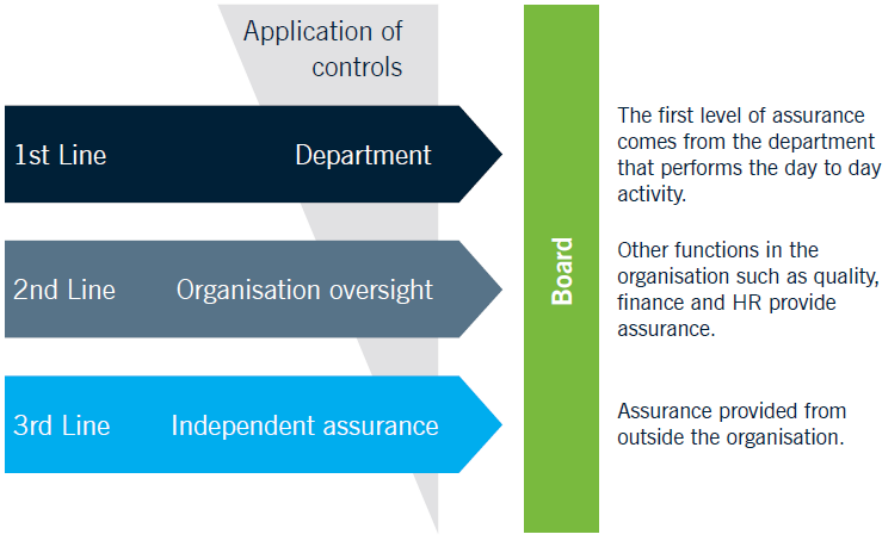
Table LIKELIHOOD X CONSEQUENCE/IMPACT = RISK RATING

		CONSEQUENCES / IMPACT				
		Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
LIKELIHOOD	Certain (5)	5	10	15	20	25
	High probability (4)	4	8	12	16	20
	Possible (3)	3	6	9	12	15
	Unlikely (2)	2	4	6	8	10
	Rare (1)	1	2	3	4	5

Low	Moderate	High	Extreme
1 – 3	4 – 6	8 – 12	15 – 25

Appendix three – Three Lines of Defence Assurance Model

This model helps to provide a clearer picture of where the organisation receives assurance and whether it has too much, is duplicated, or has none at all, and whether the coverage of assurances is set at the right level to provide confidence to the Board. It is also important to consider the independence of any assurance provided in terms of how much reliance or comfort can be taken from it. The assurances that an organisation receives can be broken down into the three lines model as illustrated below:



- **1st Line** – provides assurance that performance is monitored, risks identified and addressed and objectives are being achieved
  However, may lack objectivity but it is valued that it comes from those who know the business, culture and day to day challenges.
- **2nd Line** – provides insight into how well work is being carried out in line with set expectations and policy or regulatory considerations. It is distinct from and more objective than the first line of assurance
- **3rd Line** – Independent of the first and second lines of defence. Includes internal and external auditors.

Sources: Baker Tilly: Board Assurance: A toolkit for health sector organisations/BAF University Hospitals of North Midlands

Medical Revalidation Annual Report 2023-24

Purpose of the paper	This is the Medical Revalidation Annual Report presented in the template required by NHS England. This report needs to be approved and signed off by the CEO and/or the Chair of the Trust Board before it is submitted by the Revalidation team to the Secretary of State for Health by 30 September 2024. The purpose of this report is to demonstrate compliance by ESHT with the regulatory requirements for medical revalidation and to record the achievements of the organisation in meeting these requirements.					
	For decision		For assurance	x	For information	
Sponsor/Author	Shelley Christou Revalidation Team Manager					
Governance overview	**<u>Accountabilities of the Revalidation Team:</u>** The Revalidation team is responsible for co-ordinating the medical appraisal and revalidation process within ESHT including: • Recruiting medical appraisers and monitoring their performance for quality assurance purposes; supporting the process for medical appraisers recruited via the Trust Temporary Workforce Services (TWS) ('Bank') • Maintaining an appraisal and revalidation software system and holding relevant data • Organising and managing the ongoing support for medical appraisers through update communications and training and action learning sets • Allocating a medical appraiser to each doctor annually • Providing general and specific advice and support to doctors regarding appraisal and revalidation • Monitoring and reporting on the progress of the annual appraisal meetings • Auditing any missed or incomplete appraisals annually • Providing regular reports both internally and externally to the organisation • Developing the annual Trust Board reports for medical revalidation in line with NHS England guidance • Administering the Medical Revalidation Advisory Panel meetings including the preparation of documentation for each doctor's recommendation • Assisting doctors with provision of a multisource feedback (360 appraisal) report • administering relevant Responsible Officer Transfer of Information Forms (full scope of practice) for joiners and leavers and those who are additionally employed elsewhere • Providing appropriate communications to doctors and to maintaining the medical revalidation extranet site **<u>Accountabilities of doctors:</u>** Doctors at ESHT are accountable to the Responsible Officer (Dr Simon Merritt) for participating in annual appraisals to prove that they are up to date and fit to practise in line with Trust policies and with NHS England and GMC guidance. Failure to do so may lead to the reporting of non-engagement to the GMC, with a potential removal by the GMC of their licence to practise. Every doctor is expected to provide a nhs.net email address for the transmission of confidential appraisal and revalidation supporting information.					

	Accountabilities of Chiefs of Service: Chiefs of Service are responsible for monitoring the appraisal compliance of doctors within their divisions and ensuring that all doctors have undertaken a medical appraisal within 12 months of their previous appraisal. Appraisal compliance reports are supplied to Divisional Leads by the revalidation team on request.

Strategic objectives	Quality	People	Sustainability
	x	x	x

Our values	Kindness	Inclusivity	Integrity
	x	x	x

Recommendation	The CEO and/or Chair of the Trust Board are asked to approve and sign the Statement of Compliance at the end of this report so that it can be submitted to the Secretary of State for Health. NHS England's Regional Responsible Officer also requests a copy of this report.
Executive summary	During 2023-24 the Trust reported 100% compliance with medical revalidation. There were 87 positive recommendations made and no non-engagement recommendations. There were 14 deferred recommendations made for reasons mostly relating to insufficient information due to sickness absence, maternity/paternity/adoption leave etc. All revalidation recommendations due have been made on time whether a positive recommendation or a deferral as suggested by NHS England. The key risk faced during 2023 - 2024 for medical revalidation and appraisal was the shortage of medical appraisers. Actions are in place to mitigate against the risk of a lack of sufficient medical appraisers.
Next steps	The CEO and/or Chair of the Trust Board are asked to approve and sign the Statement of Compliance at the end of this report so that it can be submitted to the Secretary of State for Health. NHS England's Regional Responsible Officer also requests a copy of this report.

Illustrative Designated Body Annual Board Report and Statement of Compliance

1A – General

The Board/executive management team of East Sussex Healthcare Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	To update the Trust policy Recruitment of medical appraisers
Comments:	Dr Simon Merritt is the Chief Medical Officer and Responsible Officer for ESHT. Dr Gez Gould was appointed as Deputy Chief Medical Officer in May 2023. Shelley Christou was appointed Revalidation Team Manager in June 2023.
Action for next year:	• To update the Trust policy • Recruitment of medical appraisers • A review of the Education Strategy is to commence to link this to the Long Term Workforce Plan and the additional governance requirements as set in the NHSE Funding Agreement for 2024-2027. • To ensure the agreement for funding continues.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	None
Comments:	The Chief Medical Officer has a revalidation team that supports the work for medical revalidation. Funding has been sought and secured for the use of external appraisers to meet the statutory requirements for medical appraisal and revalidation.
Action for next year:	To ensure the agreement for funding continues.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	None
Comments:	The revalidation team maintains an accurate record of all licensed medical practitioners with a prescribed connection. This is monitored daily, and the team has full access to the GMC records of those doctors claiming a prescribed connection. Revalidation and appraisal software is used for doctors, appraisers and administrators. The system assists in the management of records for the doctors.
Action for next year:	None

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	To review and update the Medical appraisal and revalidation policy
Comments:	There is a fully ratified medical revalidation policy which is in the process of being updated to reflect the changes in the appraisal process.
Action for next year:	To update the Trust policy

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	None
Comments:	The last peer review undertaken at ESHT was in November 2014. A further peer review was requested by ESHT in 2022 but NHS England considered it was unnecessary due to the very high standards of medical revalidation compliance and appraisals in ESHT.
Action for next year:	None

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	None
Comments:	ESHT provides support to all doctors with a prescribed connection to the Responsible Officer. The Integrated Education, Governance and Development Team provides additional support for continuing professional development. Doctors without a prescribed connection to ESHT are guided to seek support from their own designated body with appraisal and revalidation. The Responsible Officer an provide governance information via the confidential transfer of information form to support the process for these doctors.
Action for next year	None

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	None
Comments:	The Trust can be proud that the compliance with the Medical Revalidation & Appraisal Policy for medical appraisals and doctors with a prescribed connection is once again 100% for the year. All doctors who were expected to have an appraisal (n=483) had their appraisal. Some doctors were granted an authorised postponed appraisal by the Responsible Officer (n=102) and some were granted an authorised missed appraisal (n=86). Full support is provided to doctors in the form of the provision of complaints and incident reports that include all direct and indirect involvement of doctors in complaints and significant events over the previous year or since their last appraisal, whichever is the longest period of time.
Action for next year:	None

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	None
Comments:	The revalidation team maintains a careful and thorough record of all doctors with a prescribed connection to ESHT including recording any reasons for missing an appraisal and any support or actions provided. In particular agreements for a date for a future appraisal are recorded.
Action for next year:	None

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	To review and update the Medical appraisal and revalidation policy
Comments:	There is a fully ratified medical revalidation policy in place.
Action for next year:	To update the Trust policy to reflect the changes in the appraisal process

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Recruitment
Comments:	ESHT was able to remain compliant with appraisals through requesting our internal appraisers to undertake additional appraisals. The under-capacity of medical appraisers is being addressed by frequent recruitment drives and the engagement of appraisers sourced externally. A recruitment drive was held in the March 2024 with 5 new appointments that will provide additional medical appraisers for the Trust. A further recruitment drive is planned in August 2024. In addition, we continue to use external and bank appraisers to ensure the Trust has sufficient medical appraisers in the Trust.
Action for next year:	Further recruitment

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	None
Comments:	The revalidation team organises two update training sessions for medical appraisers each year and these sessions are generally well attended. In 2023-24, sessions took place on 22nd May 2023 and 1st December 2023. Additional correspondence has been sent by The Revalidation Team Manager to appraisers in relation to the new GMC Good Medical Practice Guidelines and this was addressed in the December update. In addition, appraisers attend software training at times convenient to themselves. The planned sessions have been delivered by the Appraisal Lead and The Revalidation Team Manager, with guest speakers from the appraisal software providers in December 2023. Attendance is fully monitored, and the Appraisal Lead has additionally provided 1-1 support for appraisers who are unable to attend the sessions or for those requiring 1-1 feedback on the quality of their appraisal outputs.
Action for next year:	None

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	None
Comments:	ESHT has a quality assurance tool adapted from the NHS England tool. There is a programme in place to be able to assess systematically all appraisal outputs such as the appraisal summary and personal development plans. Appraisal Lead and Revalidation Team Manager undertakes quality assurance exercises once a year for each appraiser and provides constructive feedback to them. The first three appraisal outputs of new appraisers are reviewed by the Appraisal Lead and feedback is provided to promote continuous improvement. The Appraisal Lead reports on quality assurance of medical to the Medical Revalidation Advisory Panel twice yearly.
Action for next year:	None

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	None
Comments:	ESHT has 100% compliance and has never missed making a revalidation recommendation on time. This can often be a challenge if a new doctor adds themselves without any notice to the GMC list of prescribed connection to ESHT immediately before their revalidation recommendation is due. As the revalidation team is vigilant in checking the GMC list regularly, it has been able to support all doctors to have their revalidation recommendations made in a timely manner. During 2023-24, there were 87 positive recommendations made and no non-engagement recommendations. There were 14 deferred recommendations made for reasons mostly relating to insufficient information due to sickness absence, maternity/paternity/adoption leave etc.
Action for next year:	None

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	None
Comments:	The revalidation team ensures that all recommendations to revalidate are confirmed to the doctor at the time the recommendation is made. If the recommendation is to defer, the reasons for the deferral and actions needed are sent to the doctor via email first, requesting an acknowledgement from the doctor. Full support is always offered by the revalidation team to the doctor if there are any actions required.
Action for next year:	None

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	None
Comments:	ESHT has a formal clinical governance structure and appraisal governance reports are provided to each doctor prior to the appraisal meeting by the Revalidation Team. Appraisal Governance Reports offer each doctor information about any complaints or significant events in which they are directly or indirectly involved over the previous year. These can then be reflected upon and discussed during the appraisal meeting so that learning can be applied and any appropriate actions added to the doctor's personal development plan for the following year. Additionally, CLiP (clinical outcome) reports are provided to the relevant doctors.
Action for next year:	None

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	None
Comments:	Regular meetings are held between the Chief Medical Officer/ Deputy Chief Medical Officer and Human Resource colleagues to monitor the conduct and performance of doctors in ESHT. Where specific actions are required, the doctor is obliged to include these in their appraisal supporting information and is expected to discuss these with their appraiser during the appraisal meeting. Appropriate actions and learning can then be applied to their personal development plan.
Action for next year:	None

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	None
Comments:	The Doctors are provided with an incidents report and a complaints report in the second or third week of the month before their appraisal. This is downloaded straight into the software system and the Doctor is notified when it is ready for review.
Action for next year:	None

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	None
Comments:	The Trust has a regularly reviewed Remediation: Responding to Concerns Policy and formal well tested processes and procedures in place. Regular meetings are held between the Chief Medical Officer, Chief People Officer and the GMC Employment Liaison Advisor.
Action for next year:	None

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	None
Comments:	The Chief Medical Officer ensures that he runs regular and formal monthly medical review meetings. These meetings provide assurance that matters and any arising issues involving concerns about doctors are reviewed and actions are progressed. The meetings are formally minuted.
Action for next year:	None

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	None
Comments:	The revalidation team ensures that all requests from other Responsible Officers are acted upon and provided within ten working days. A Transfer of Information form is requested from a new starter's previous Responsible Officer after the date that the doctor has joined the Trust. Doctors who work in other organisations are required to bring any relevant information from their other employers to their appraisal, for example any involvement in incidents or complaints so that they can be included in the appraisal discussion. Doctors who work elsewhere are expected to be participating fully in the appraisal process of their own organisation and the revalidation team provides confidential information to their organisation's Responsible Officer on request.
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	None
Comments:	The monthly medical review meeting, Chaired by the Chief Medical Officer is attended by the Deputy Chief Medical Officer, Chief People Officer and Head of Operational HR to ensure fair and consistent processes are adhered to. All members of the meeting have attended equality and diversity training.
Action for next year:	None

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	None
Comments:	Our Medical Appraisers are trained and kept regularly updated with relevant reports and information from the HLRO, GMC. NHSE and other organisations. They incorporate this information when aiding and encouraging annual Personal Development Plans that identify educational needs and set development objectives in line with the Trust governance policies, procedures and culture.
Action for next year:	A review of the Education Strategy is to commence to link this to the Long Term Workforce Plan and the additional governance requirements as set in the NHSE Funding Agreement for 2024-2027.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	None
Comments:	The Trust Excellence in Care Standard Operating Procedure is a framework that provides one source of robust data to enable clinical teams to review, analyse and understand their performance against a range of metrics which align with national guidance and local policy. This enable improvement to be identified and the resource to monitor consistency in care delivery with a reduction in unwarranted variation.
Action for next year:	None

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	None
Comments:	The ongoing process is that any Trust doctors who are not recruited via an agency have recruitment checks completed through the Trust applicant tracking system 'TRAC'. This includes checking the candidate's GMC registration. This is countersigned by another member of the recruitment team and filed against the candidate. Interviews take place for the clinicians to ascertain their skills are suitable for the post to which they are applying. Consultants are appointed following an AAC Panel selection process. The above processes are reviewed on a regular basis to ensure compliance, by both the recruitment leads and TIAA auditors.
Action for next year:	None

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	None
Comments:	The accountability framework supports the delivery of trust strategies and processes, ensuring that it is well led with regular monitoring and assurance. Periodically the Trust is required to undertake national initiatives and programmes. The accountability for these is determined at the outset to ensure their implementation is as successful as possible. Currently one such national programme is GIRFT (Getting it Right First Time).
Action for next year:	None

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	None
Comments:	Yes – this is linked into our recruitment process - our trust values- and our policies
Action for next year:	None

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	None
Comments:	Both the Values and Freedom to Speak Up are included in the Trust Welcome sessions by both the Wellbeing Team and Exec welcome slot. This is an overview but makes clear from day 1 the expectations of the Values and the importance of Freedom to Speak Up
Action for next year:	None

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	None
Comments:	Comments, concerns, and complaints are recorded on Datix, which is ESHT's risk management system. As well as a robust complaints policy the Trust is committed to listening and learning from feedback and has a Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy as well as two Freedom to Speak Up Guardians.
Action for next year:	None

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	None
Comments:	The Trust holds a number of policies in relation to equality and diversity and actively seek to eliminate unlawful discrimination and foster good relations between those who share a protected characteristic (age, race religion, gender, gender reassignment, sexual orientation, marriage and civil partnership, pregnancy and maternity and disability – including carers). The last published Annual Equality Report includes the result of a survey for ESHT's multicultural colleague experience. The trust proves a Chaplaincy and Pastoral care team Pastoral, Spiritual and Religious Care to patients, staff and relatives. All staff must undertake mandatory Equality and Diversity training. The end goal remains; thriving and culturally competent staff providing inclusive care to promote positive health outcomes and tackle health inequalities.
Action for next year:	None

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	None
Comments:	The RO, Deputy RO, Appraisal Lead and Revalidation Team Manager attend regular updates organised by: South East High Level Responsible Officers team and The GMC. The Revalidation Team Manager, Appraisal Lead and team members attend regular meetings organised by the National Medical Appraisal and Revalidation Managers Network The last peer review undertaken at ESHT was in November 2014. A further peer review was requested by ESHT in 2022 but NHS England considered it was unnecessary due to the very high standards of medical revalidation compliance and appraisals in ESHT.
Action for next year:	None

Section 2 – metrics

Year covered by this report and statement: 1st April 2023- 31st March 2024

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	586

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	**534**
Total number of appraisals approved missed	**49**
Total number of unapproved missed	**0**

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	87
Total number of late recommendations	0
Total number of positive recommendations	87
Total number of deferrals made	14
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	11
Total number of trained case managers	5
Total number of new concerns registered	0
Total number of concerns processes completed	1 -bfwd from 22-23
Longest duration of concerns process of those open on 31 March	**0**
Median duration of concerns processes closed	1 case – 42.6 weeks
Total number of doctors excluded/suspended	**1**
Total number of doctors referred to GMC	**0**

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	316
Number of new employment checks completed before commencement of employment	316

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
There were two actions from last year's report. Recruitment of medical appraisers is an ongoing action. The second action was to update the Trust Policy for medical revalidation and appraisal, with details of progress set out below.
Actions still outstanding
The only outstanding action from last year is to review and update the Medical appraisal and revalidation policy. There is a fully ratified policy in place, but some organisational changes need to be made to bring it up to date. The delay has been due to internal discussions which are now resolved.
Current issues
The main issue facing medical revalidation currently is that internal medical appraisers are facing challenges in meeting rising clinical demands and conducting medical appraisals and are stepping down. This is causing a shortage of medical appraisers.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
1. To update the Trust policy 2. Recruitment of medical appraisers 3. A review of the Education Strategy is to commence to link this to the Long Term Workforce Plan and the additional governance requirements as set in the NHSE Funding Agreement for 2024-2027. 4. To ensure the agreement for funding continues.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Despite its challenges, the medical revalidation and appraisal process is well established in the Trust and appraisals meet 100% compliance with the Trust's Medical Revalidation Policy. Actions are in place to mitigate against the risk of a lack of sufficient internal medical appraisers.

NHS Provider Licence Self Certification

Purpose of the paper	To present the proposed self-certifications against the Provider Licence conditions for approval by the Board.					
	For decision	x	For assurance		For information	
Sponsor/Author	Sponsor: Richard Milner, Chief of Staff Author: Pete Palmer, Board Secretary					
Governance overview	Discussed by Executive Leadership Team Presented and endorsed by the Audit Committee, 13.06.24					

Strategic objectives	Quality	People	Sustainability
Our values	Kindness	Inclusivity	Integrity

Recommendation	The Board is asked to agree the suggested declarations and responses. Once agreed these will be published on the Trust's website.
Executive summary	The Trust holds a provider licence which forms part of NHS England (NHSE) oversight arrangements for NHS providers. As reported to the Audit Committee, updates to the provider licence were made by NHSE to reflect changes to the statutory and operating environment, including the shift of emphasis from economic regulation and competition to system working and collaboration. These changes came into effect from 1 April 2023. Application of the provider licence was also extended all NHS provider trusts (not just foundation trusts). In updating the licence, the requirement for licensees to self-certify against a number of specific licence conditions and the requirement to prepare a Corporate Governance Statement were removed. The new licence has, however, retained the requirement to self-certify against condition CoS7 (Availability of Resources). According to the new Provider Licence requirement the Board is expected to make a self-certification, not later than two months from the end of the financial year, as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate. The form of this certification must be one of three - (a), (b) or (c) - outlined under CoS7 (refer to appended certificate) and in making this certificate the Board of Directors should detail the main factors taken into account. It is recommended that statement (a) is made to align with conclusions drawn from the going concern assessment process reported within the Trust's 2023/24 Annual Report. (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." The self-certification and supporting references are presented in Appendix A. As in prior years it is proposed that the certificate is signed by the Chair and published on the Trust's website with the supporting references
Next steps	The Board of Directors is asked to:

	a) approve the self-certification against provider licence condition CoS7(Availability of Resources) as set out in Appendix A, in the light of references made on Table A b) (b) agree for sign the self-certification and made available on the Trust website.

NHS Provider Licence - Self-Certification

Appendix A

Details of Condition	1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources*. 2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee. 3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms: a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate." b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources". c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate". ** "Required Resources" means such management resources including clinical leadership / appropriate and accurate information pertinent to the governance of quality / financial resources and financial facilities / personnel / physical and other assets including rights, licences and consents relating to their use / subcontracts / working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable the Licensee at all times to provide the Commissioner Requested Services.*	
Self-certification	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources	Confirmed

	available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	

Table A

Assurance and Evidence	• Going Concern Statement within Annual Report and Accounts 2023/24 agreed by consideration by Audit Committee of Going Concern Concept paper on 13th June 2024 • Financial Plan 2024/25 approved by Board of Directors 13th August 2024 • Annual Governance Statement 2023/24 and Board Terms of Reference and Annual Reports which outlined our governance and reporting structure • External Well-led Review Report 2024 • Integrated management arrangements (Trust Executive Committee, Divisional Management Groups, Clinical Governance, Health and Safety, Executive Integrated Performance Reviews) • Board Assurance Framework • Robust Responsible Officer arrangement for Medical Staff • Mandatory and statutory training compliance reporting to Board • Regular Patients Experience Reports to Board and Quality and Safety committee • Trust Standing Orders, Standing Financial Instructions and Scheme of Delegation

This self-certification is signed by Steve Phoenix, Chair of East Sussex Healthcare NHS Trust on behalf of the Board of Directors

Signed	
Dated	[signed date]

Use of Trust Seal

Purpose of the paper	To inform the Board of the use of the Trust Seal					
	For decision		For assurance		For information	x
Sponsor/Author	Chief of Staff					
Governance overview	Not applicable					

Strategic objectives	Quality	People	Sustainability
Our values	Kindness	Inclusivity	Integrity

Recommendation	The Board is asked to note the use of the Trust Seal since the last Board meeting.
Executive summary	The Trust Seal was used to seal two documents between 31st May 2024 and 31st July 2024: **Sealing 111 – British Telecommunications PLC, 3rd July 2024** Agreement for services in support of Sussex Community of Internet Network. **Sealing 113 – Phoenix Partnership (Leeds) Ltd, 31st July 2024** Agreement for provision of Electronic Patient Record System for Community Services.
Next steps	Not applicable

Trust Board Meeting in Public Forward Plan 2024

Date	**10th September 2024**	**8th October 2024**	**10th December 2024**
Location	**Cooden**	**Bexhill**	**Conquest**
Standing Items	AGM Standard items - Overview of the Year and Presentation of Annual Report and Quality Account	Staff Recognition Board Committee Reports CEO's Update (verbal) IPR Shared Delivery Plan Use of Trust Seal Questions from members of the public (15 mins)	Staff Recognition Board Committee Reports CEO's Update (verbal) IPR Shared Delivery Plan Use of Trust Seal Questions from members of the public (15 mins)
General	AGM	Capital Report (layman's report highlighting developments in Trust)	
Quality, Safety and Performance		Maternity Overview Q1 Learning From Deaths Q4 Martha's Law Update (from Board mtg 09.04.24)	Maternity Overview Q2 Patient Survey (TBC whether going to just Q&S, or Q&S and Board - from JCB email 13.09.23) Martha's Law Implementation Update (paper)
Annual Reports			
Human Resources incorporating workforce targets and staff surv**ey**		Equality & Diversity Bi annual report	
Strategy		SDP and Transformation Workstreams Implications of a failing Estate (backlog maintenance) ESHT CiC - Items for Information, Items for Decision, Minutes	ESHT CiC - Items for Information, Items for Decision, Minutes
Other monitoring			
Governance and Assurance		BAF Q2 Winter Preparedness	Speak Up Guardian Update Violence Prevention and Reduction Standard Guardian of Safe Working hours - Quarterley report
Annual Reports		Equality annual report Guardian of Safe Working Hours	Infection Control Safeguarding Patient Experience
Items for Information			Meeting Dates for 2025