EAST SUSSEX HEALTHCARE NHS TRUST

BOARD OF DIRECTORS

TRUST BOARD MEETING IN PUBLIC

ST MARK'S CHURCH HALL, GREEN LANE, BEXHILL-ON-SEA TN39 4BZ

8th OCTOBER 2024, 09:30-12:45

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Board Agenda

Date: Tuesday 8th October 2024

Time: 09:30 – 12:45

Venue: St Mark's Church Hall, Green Lane, Bexhill-on-Sea, TN39 4BZ

	Opening Business	Lead	Action	Time	Enc.
1.	Welcome and apologies	Chair	Information	09:30	
2.	Colleague Recognition	Chair	Information	09:30	Yes
3.	ESHT Clinical Research 2024-2025	Jo-Anne Taylor & Dr. Rick Veasey	Information		Yes
4.	Declarations of Interest	Chair	Information		
5.	Minutes of Trust Board Meeting in public 13.08.24	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 5 (August) (i) Chief Executive Summary (ii) Quality & Safety (iii) Our People (iv) Access and Responsiveness (v) Financial Control and Capital Development	CEO CNO/CMO DCEO COO CFO	Assurance	10.10	Yes
10.	Learning From Deaths Q4	CMO	Assurance	10:55	Yes
11.	Maternity Overview Q1	DOM	Assurance	11:05	Yes

Break – 10 minutes

Strategy					
12.	Health Inequalities Strategy	COS	Approval		
Governance and Assurance					
13.	Winter Preparedness 2024/25	COO	Assurance		Yes
14.	Discharge Update	COO/CNO	Assurance		Yes
15.	Board Assurance Framework Q2	COS	Assurance		Yes

16.	Annual Equality Report	DCEO			Yes
For Information					
17.	Use of Trust Seal	Chair	Information		Yes
18.	Questions from members of the public	Chair		12:15	
19.	Agenda Forward Plan	-	Information		Yes
20.	Date of Next Meeting Tuesday 10th December 2024	Chair	Information		
21.	Close	Chair			

Steve Phoenix
Chairman

Key:	
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
DCEO	Deputy Chief Executive and Chief People Officer
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 December	Conquest – Lecture Theatre, Education Centre	09.30 – 12.30	

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	Trust Board	**Date of Meeting**	8 October 2024
Report Title:	Colleague Recognition		
Purpose of the Report/Outcome/ action requested:	The Board is asked to receive this report for information and to receive assurance about: 1. the Trust's formal recognition of our people over the last two months and; 2. the changes made to the Trust Colleague Recognition and Reward Policy		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐		
Authority for Decision:	Not applicable		
Executive Summary	East Sussex Healthcare NHS Trust recognises that the high standard of care and quality of service it provides is dependent on the contribution, effort and loyalty of its people. This is an opportunity for the Trust to acknowledge the exceptional performance, behaviour, achievements and contribution that our colleagues and volunteers have made to the organisation.		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☐ People ☒ Sustainability ☐		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	4	**Appendixes**	No
Name, position and contact details of author:	Melanie Adams, People Experience Manager Melanieadams1@nhs.net		
Report Sponsor	Jacquie Fuller, Assistant Director of HR – People Engagement	**Presenter:**	Steve Phoenix, Chair
Governance and Engagement pathway to date:	Executive Leadership Team Workforce Policies Partnership Group Staff Side		
What happens next?	Changes made to policy will be communicated across the organisation		
Publication	Yes		

The Colleague Recognition and Reward policy was recently updated to reflect changes made to the recognition programme. We know that expressing thanks and service recognition connects people to the organisation, elevates their performance, boosts morale and assists with retention. We also know from regular feedback that it is extremely important to our colleagues and, as a result, we have increased opportunities for colleagues to be celebrated for their contribution and commitment to the trust and the NHS.

Long service recognition has been increased from 10, 25 and 40+ years to five yearly intervals. Colleagues will receive a signed certificate of appreciation from the Chief Executive at these five yearly intervals. 10, 25 and 40+ years' long service will receive a certificate, together with a token voucher to acknowledge their contribution in service.

As a trust we have moved to recognising continuous NHS service, rather than service specific to East Sussex Healthcare only. This has been welcomed by colleagues.

We are also changing the way we recognise colleagues retiring from the organisation after 20+ years' service. In future, colleagues, together with a supporting family member or colleague of their choice, will be invited to a retirement celebration event closest to their retirement date. They will be presented with a framed certificate of thanks by the Chairman or Chief Executive. This is again a welcomed improvement which will improve the experience of valued colleagues who have dedicated many years of service to the NHS.

These changes were approved by the Executive Leadership Team prior to approval by the Workplace Policies Partnership Group and Staff Side.

Hero of the Month

June 2024

Winner – Lucy Bates, Histopathology - Conquest Hospital, Core Services Division

'Lucy has gone above and beyond to make it her mission to complete our backlog on placentae cutup. In a matter of days, she managed to fully process a backlog that had been setting the department back for months. She decided under her own will that she would dedicate her spare time to complete them all, to help the entire histology team and the patients awaiting their results. Lucy worked super efficiently and incredibly hard and managed to dissect and dictate all the placentae in just a few days. Lucy fully deserves to be recognised for her amazing work and dedication to providing the best service to our patients.'

Winner - Lincy Issac – Ward - Sussex Premier Health

Nomination 1
'On Friday 7th June SPH was already short staffed and Lincy a junior staff nurse was the Nurse in charge. When the fire happened at SPH and it was a confirmed fire she calmly helped the evacuation of all the patients off the ward.

Lincy has not been with us long and she is not often in charge on the ward, but on this day, under the most stressful circumstances, she stood up to the challenge and was amazing. She took charge of the safety of the patients at the time and for the rest of the shift. She quickly recognised she was missing a patient whilst in the corridor and calmly reported this and the patient was found safety. Lincy transferred all the patients to the Conquest hospital ward and stayed with them for the rest of the day. Lincy liaised with site managers and HOD and was clear and informative about all the patients. The feedback from every single patient was how amazing she was. I am not sure Lincy even

had a break Friday and yet she returned Saturday and did it all again. I am so proud to work with her - she is an asset to SPH, ESHT and the whole of Nursing.

So many people worked over and beyond during this incident but Lincy, quietly in the background, stood out for me, keeping her focus solely on keeping our inpatients safe and well looked after.'

Nomination 2
'Lincy demonstrates the Trust values every day but over the last month has been exceptional. She has been involved in two very unusual events on the ward. Firstly, the rapid deterioration of a patient post-surgery, and secondly when she was co-ordinating the ward a small fire happened in the basement resulting in patient evacuation. In both instances Lincy was responsive and calm, organised and kind, and always puts her patient's safety first. She is an inspiration to the team.'

Winner - John Hinkley- Estates and Facilities, Conquest Hospital - Estates and Facilities Division

'John was invaluable in leading on specialist advice and knowledge of the Conquest and SPH sites in response to the water shortage incident in Hastings/St Leonards in May and again in response to the fire at SPH in June.'

July 2024

Winner – Matthew Bilton – Acute Stroke Physiotherapy – Community Health & Integrated Care Division

'Matt has been a marvellous team player. Within the multidisciplinary team he listens to his colleagues and always works as an advocate for his patients. Acute Stroke patients often lack the capacity to make decisions, but he works tirelessly with families and patients to enable and advocate for them. Carers and families often are grateful for his consistent clear communication and joint working.

Due to staffing issues Matt has taken on extra responsibility and a higher more complex caseload for a protracted period of time. He has done all this with professionalism and a positive attitude. During a period of extreme stress, Matt has provided stability for staff and patients alike. He is reliable, caring and works extremely hard at all times. He is a model staff member and a credit to the profession and he deserves some recognition in this award.'

Long Service Awards

August 2024		
10 Years' Service	**25 Years' Service**	**40 Years' Service**
John Anderson	Rebecca Barrar	
Michael Dickins	Judy Bettley	
Tayla Dinmore	Anna Clarke	
Audrey Haffenden	Tracey Dougan	
Ciara Joyce	Samantha Knowles	
Caroline Panama	Katrina Luck	
Monika Partridge	Max Porter	
Claire Robus-Bolton	Jacqueline Rhodes	
Mini Saiju		
Mary Ssewannyana		
Chloe Stonham		
Liana Tavares		
Kerry Tosun		
September 2024		
10 Years' Service	**25 Years' Service**	**40 Years' Service**
James Bowers	Russul Abdul Ghani	
Nicola Clevett	Jane Barton	
Nadia Gawler	Sharon Felson	
Victoria Machen	Samantha Haynes	
Simon Pugh	Monique Lynch	
Alexander Trimmings		
Hannah Wake		
Margaret Walker		
Eleanor Weale		
Carl Wilkinson		

Rachel Swift – 10 years' long service award

Leanne Wood – 10 years' long service award

Jacquie Rhodes – 25 years' long service award

East Sussex Healthcare NHS Trust Board Minutes

Date: 12th August 2024

Time: 09:30 – 12:45

Venue: St Mary's Boardroom, Eastbourne District General 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) Amanda Fadero, Non-Executive Director 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 Non-Voting Directors Ama Agbeze, Associate Non-Executive Director Steve Aumayer, Deputy Chief Executive and Chief People Officer (DCE) Richard Milner, Chief of Staff (CoS) In Attendance Dan Asamoah, Associate Director of Corporate Governance and Compliance (ADCG) Chris Faulkes, Pathology Stores, EDGH (for item 44/024 only) Jacquie Fuller, Assistant Director HR - Engagement & Wellbeing (for item 44/024 only) Brenda Lynes, Director of Midwifery (DoM) Abi Turner, Deputy COO/Divisional Director of Operations - Community (DDO CHIC) Peter Palmer, Board Secretary (minutes) Observing Sue Allen, Assistant Director of Nursing, Medicine Division	
	Apologies: Carys Williams, Non-Executive Director Charlotte O'Brien, Chief Operating Officer (COO) Frank Sims, Associate Non-Executive Director	
42/024	**Chair's Opening Remarks** 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, Charlotte O'Brien, COO and and Frank Sims, ANED The meeting was quorate according to the Constitution of the Trust. The Chair welcomed everyone to the meeting. Sue Allen, Assistant Director of Nursing, Medicine Division was observing the Board as part of her professional development.	

	He noted that this meeting would be Karen Manson's, (NED) final Board meeting in the Trust after serving a six year term. The Trust had been on a journey of improvement during this time and Karen had made a huge contribution to this. She had chaired Board Committees, had been chair of the Trust's Chairty and a champion for Community Services and Digital during her time with the organisation. He praised her valuable contributions in meetings, thanking her for all that she had done and wishing her the best for the future. Karen, NED explained that she had had an amazing six years with the Trust. She had not come from an NHS background and had experienced a steep learning curve, however over the period of serving ESHT; she had found the Trust to be amazing and noted that colleagues were critical to the success of the organisation. She thanked the Board for their support and explained that she would continue to support the Trust from a distance.	
43/024	**Staff Recognition** The Chair reported that April's Hero of the Month winner had been Oliver Smith from the Pharmacy team at the Conquest. May's winner had been Callum Mead, from the Estates and Facilities Team He reported that Debra Cranfield, Amelia Pamplin, Vivien Cox and Gilberto Da Silva had all completed 40 years of NHS service since the last Board meeting.	
44/024	**Project Search** Jacquie Fuller, Assistant Director HR - Engagement & Wellbeing presented the report, she explained that she was thrilled to be presenting to the Board about Project Search, a programme which supported internships for young people aged 18-25 who had an education, health or care plan. Project Search allowed young people to learn workplace behaviours, and helped the Trust to break down barriers for accessing work. Since 2014 the Trust had facilitated 105 interns, 24 of whom had subsequently been employed by the Trust. The programme was hosted by Sussex College and East Sussex County Council also hosted interns. A celebration event marking 10 years of partnership between the Trust and Project Search took place in June. The programme was only possible thanks to the support of colleagues who hosted interns during their placements. She praised the Estates and Facilities, Pathology and Pharmacy teams who regularly hosted interns. She noted that the support of Sussex College, along with the leadership for Project Search from Stacey Beard were key factors in its success. Chris Faulkes from Pathology, explained that Pathology Stores had hosted interns throughout the ten years of the programme. He had found this to be an extremely rewarding experience, and took great pleasure in helping young people to develop new skills that would help them to gain employment either within or outside of the Trust. He encouraged colleagues to embrace the programme. The CNO noted that Project Search was a fantastic project, explaining that people who had a learning disability only had a 10% chance of securing employment. It was important to match interns with placements that were appropriate for them, and the feedback that was received from the parents of interns emphasised how well received the project was. She thanked colleagues who supported the programme, explaining that it helped the Trust to think differently about working with people with disabilities. The CMO asked what more the Board could do to support Project Search. The Assistant Director HR - Engagement & Wellbeing explained that it would be helpful to identify other departments and areas in the Trust where there may be opportunities for placements. Colleagues who took on interns would receive support from the Project Search team. She encouraged the Board to promote the programme when speaking to members of staff. Nicki, NED explained that she had been pleased to hear about the journey that the Trust had gone on over the previous ten years of Project Search and how it had improved the	

	experience for both colleagues and interns. She was pleased that the programme allowed the Trust to learn and to do better for a more diverse workforce, as well as giving a better perspective about the people that the Trust served. The Chair noted that it would be helpful to identify whether there were any corporate functions that could support an intern in the future. The Board noted the presentation.	
45/024	**Declarations of Interest** There were no interests declared for any item to be considered on the agenda. All declarations of interest were noted as held on the Register of Directors' Interest.	
46/024	**Minutes** The minutes of the Trust Board meeting held on 11th June 2024 were reviewed and approved as a correct and accurate record of the meeting subject to adding Amanda Fadero, NED in the attendance list.	
47/024	**Matters Arising** The Chair led discussion on the Matters Arising and Action Log and the following was noted: • 32/024 – Freedom to Speak Up Guardian Self Reflection – the Action was noted as complete as the document had been circulated to the Board on 5th July 2024 and was included on the agenda for this meeting	
48/024	**Chief Executive's Report** The CEO presented her report and the following points were noted: • Thanked staff for their support during recent industrial actions • A recent clinically led patient experience event by the Community Health and Integrated Care (CHIC) division • The launch of the Prototype Pottery Project for people with cancer, and the support of the Trust for the Cancer Vaccine Launch Pad (CVLP) • Joe acknowledged the successful elections and congratulated the newly elected and re-elected local MPs. The CEO reported that work would be undertaken to build up relationships with the new and re-elected MPs over the coming months; regular meetings would be organised and they would be invited to undertake site visits. She thanked colleagues for their continued support in managing industrial actions, noting that the most recent of these had taken place at the end of June. The Midwifery Led Unit at Eastbourne would reopen on 2nd September. She reported that the annual Trust Awards had been a really proud night for her and for the organisation, where the contributions of colleagues throughout the year were recognised. She praised the winners and nominees, and thanked Assistant Director HR - Engagement & Wellbeing and her team for organising the evening. The Chair agreed, noting that it had been a great evening which had meant a great deal to those who had attended. She noted that a number of trusts in London had been impacted during the recent Synnovis data leak. ESHT had not seen a significant impact from the leak although there had been a minimal effect on cancer pathways; it was unclear whether any confidential data was being held in relation to the leak, but if this turned out to be the case in the future then the Trust would inform anyone affected. The Board noted the CEO report.	

49/024	**Board Committees Chairs' Reports** Audit Committee Paresh, NED presented his report and thanked the finance team for their hard work in finalising the annual audit of Trust accounts in good time. Finance and Productivity Committee Nicki, NED presented her report and reported that the Board had virtually approved an extraordinary process for approving additional cash from the centre. Inequalities Committee The Chair presented the Inequalities Committee Chair's report. People and Organisational Development Committee The DCE presented the Chair's report in the absence of Carys, NED the Committee's Chair. Quality and Safety Committee Amanda, NED presented her report and reported that the Patient Safety Incident Response Framework (PSIRF) remained high on the Committee's agenda. A deep dive was due to be presented in September to give assurance about the process. The Board noted the Committees Chairs' upward reports.	
50/024	**Integrated Performance Report (IPR)for Month 3 (June)** The IPR was jointly reported by the CEO, CNO, CMO, DCE and CPO, CFO and the AD for CHIC. The CEO reported that the Trust's continued with its success against the four hour ED standard. The Trust had undertaken care of around 110 patients from elsewhere in Sussex in support of the system's ongoing work to reduce the number of patients waiting for more than 65 weeks for elective care. This had led to a slight increase in the number of patients waiting for more than 65 weeks at ESHT. Quality and Safety Highlights from this section included: • The transfer of DatixWeb to DCIQ in the Trust continued. • Reporting of incidents in June had reduced, with 73% of reported events resulting in no harm or near miss. Two catastrophic events (severity 5) and two Major events (severity 4) were reported in June • Work continued to improve patient discharge, particularly for patients who do not meet the criteria to reside • Eleven cases of clostridium difficile (CDI) and eleven cases of MSSA bacteraemia were reported in the Trust in June. One confirmed case of measles was reported at EDGH during the month. • Covid outbreaks continued during June, with most patients requiring no additional treatment. The CNO reported that there had been an outbreak of CDI in the Trust, with six cases of common origin identified. The CNO thanked clinical and site teams for their support in ensuring that those affected areas had been subject to deep cleaning despite high occupancy rates. An investigation had been undertaken with no clear links between the affected wards identified; a paper setting out the findings of the investigation was due to be presented to the Executive Leadership Team (ELT). A new digital approach to Friends and Family Testing had been successfully introduced with over 10,000 survey responses captured in Emergency Departments during June. The Trust continued to focus on the reconditioning of patients and improving internal discharge processes. The CNO thanks colleagues for their continued hard work, noting that they did an amazing job in challenging circumstances.	

Nicki, NED asked how the CDI investigation and associated actions were being concluded. The CNO explained that while there was a clear link between the cases as they had the same origin, it had not been possible to definitively establish why the outbreak had taken place. The need for meticulous infection control and hand hygiene practices were being reinforced with colleagues, although the challenge of doing this in a very busy organisation was recognised. She noted that the management of patients who were not always concordant with infection control advice and guidance was also an area of focus.

Nicki, NED asked whether follow up visits took place to the affected areas to reinforce messaging. The CNO explained that training took place regularly, supported by audits of infection control practices. The infection control team was focussing on the effect that environmental factors could have on the most vulnerable patients, and on long length of stay patients.

Paresh, NED asked whether challenges being experienced with the embedding of the Patient Safety Incident Response Framework (PSIRF) into the organisation were of concern. The CNO explained that she was not concerned about the Trust's reporting culture. The number of incidents reported in the Trust had remained consistent at around 1,000 a month over the last five years, with the vast majority being no harm or near miss.

Karen, NED noted that recruitment for mental health practitioners had commenced and asked about the impact this team was anticipated to have once fully operational. The CNO explained that once recruitment had been completed, colleagues would receive training, including in mental health first aid, conflict resolution and de-escalation to ensure that they had the skills that were required to support patients with poor mental ill health. The Trust was doing all it could as a non-mental health Trust to support patients as it had a duty of care while the patients were being cared for at the Trust.

The CMO reported that the Trust's mortality metrics provided one marker of the care that was being provided to patients. The Summary Hospital-level Mortality Indicator (SHMI) figures were rebased on a quarterly basis against acute peers. The Risk Adjusted Mortality Indicator (RAMI) was subject to annual rebasing; he anticipated that this would significantly change the figures being reported. He explained that the Trust's position against peer organisations would be reviewed once the rebasing had been completed.

The CEO stated that the Trust was an outlier for stroke mortality; she noted that high level assurance about mortality was given to the Board and asked how any areas of concern were monitored within the organisation. The CMO explained that detailed reviews of heart failure, acute myocardial infarction, and fractured neck of femur mortality had been undertaken in the past with results reported to Q&S. The Trust was currently undertaking a deep dive of stroke mortality with the help of NHSE and the National Stroke Lead; no issues had been identified. He hoped that actions from research published following improvements at Salford Trust would be applied at ESHT. He added that an action plan would be developed and presented to Q&S. The Trust had not been identified as an outlier for stroke mortality by CHKS, but had chosen to undertaken a deep dive based on mortality data.

<u>Our People – Our Staff</u>
Highlights from this section included:

- Positive changes in the Trust's vacancy and mandatory training rates and with appraisal compliance.
- Increased turnover and monthly and annual sickness

The DCE and CPO reported that June had been a relatively stable month for workforce metrics. A recruitment freeze had been instigated in the Trust, but offers that had been made to new starters prior to the freeze had been honoured. A high level of Covid sickness had led to increased use of temporary workforce during the month and he expected this to continue into May.

Staff turnover had increased to 10.6% in June, although this was 25% lower than it had been in 2022; the increase was being monitored. The Trust's vacancy rate had dropped significantly in June due to a technical adjustment associated with the application of Cost Improvement Plan (CIP) to roles. A focus was continuing on improving both long- and short-term sickness rates.

The Chair noted that the Trust's mandatory training and appraisal levels were both the highest they had ever been.

Access and Responsiveness

Highlights from this section included:

- Continued delivery against the 4 hour emergency access standard, with work ongoing to embed this sustained improvement within the Trust.
- A decline in DM01 performance in June, with work taking place to recover performance against for the faster diagnosis standard
- A reduction in long waits for cancer and routine elective pathways

The DDO for Community Health and Integrated Care (CHIC) reported that performance against the four hour ED standard had been 79.1% during June and placing the Trust in the upper quartile of organisations nationally. The number of attendances to EDs continued to increase. The Trust was working with system partners to ensure that patients were treated in the right place. Work was being undertaken on an unscheduled care hub and on improving primary care access. There had been a slight reduction in patient length of stay to 4.41 days in June, but challenges with patients who had no criteria to reside continued with a daily average of 261 patients across the Trust's acute sites during the month.

A system improvement plan continued to be developed, which also included internal measures such as increased recruitment of Allied Healthcare Professionals, ensuring that the Trust had the correct capacity and that patients could access care from within care homes in the community. Support for patients returning home under Homecare was being increased enabling patients to return home from hospital more quickly. Work was being undertaken with Adult Social Care (ASC) to reduce the number of patients with no criteria to reside and in intermediate care units. Work was also taking place with ICS and ASC colleagues to increase assessment capacity in order to minimise waiting times for patients and improve more rapid access to packages of care.

49 patients (nine of whom had come from University Hospitals Sussex NHS Trust) had waited for more than 65 weeks for elective care at the end of June. Weekly meetings focussed on reducing 65 week waits across all specialties were held.

Performance for the Faster Diagnostic Standard had improved to 73% in June but remained an area of focus. DM01 performance had declined in June to 87.1%, with a focus on improving MRI utilisation. Elective activity in June had been at 114% of the 2019/20 baseline level. The total Trust waiting list had increased between May and June and a slight deterioration in the Referral to Treatment position had been seen during the same period. Plans to improve this trajectory had been developed. Improvements in community waiting times and urgent community responses continued to be seen and good occupancy of virtual wards continued.

The Chair noted that the Trust's position of 20th out of 124 NHS Trusts for the four hour ED standard was impressive, particularly when considering the context of increased attendances; he thanked colleagues for their hard work in achieving this. He asked how the rise in non-elective lengths of stay was being addressed. The DDO for CHIC reported that there had been a slight reduction in numbers of patients who met the criteria to reside in June, but managing this issue remained challenging.

The CFO noted that Trust's elective performance plan for the year included a trajectory which saw elective patient numbers increase from 9,000 a month in August to 12,000 a month in November. He noted that a lot of additional activity would need to be undertaken in order to meet this trajectory. The CEO assured the Board that the Trust's Use of Resources (UoR) programme included a clear productivity plan focussing on the utilisation and the amount of activity that was undertaken and was being overseen by the COO.

Karen, NED praised the progress that was being made. She noted that the Trust had been performing below the national average for 62 day cancer performance during the last 18 months and asked what the drivers for this had been. The CEO explained that the Trust was struggling to perform consistently well against the standard. One of the reasons for this was the need to outsource some diagnostic tests to other organisations, which added to delays in pathways. There was also insufficient dermatology and breast capacity in the system to meet demand. Work was being undertaken to develop plans to address the issues that were found in very specific areas.

Amanda, NED asked how mutual aid between organisations in the system was agreed. The CEO explained that different specialities took differing approaches to agreeing mutual aid. Decisions were taken through the elective co-ordination centre to ensure that the correct balance was maintained.

Amanda, NED asked whether the increases in elective and non-elective patient numbers would be reflected in planning for 2024/25. The CEO explained that planning for the next financial year had not yet commenced, but that capacity would form part of the business planning process. She noted that while attendances had increased many of these were primary care type presentations and admissions had only increased by 1%. The Trust was working with system partners to look at how demand could be better managed, including by offering community services differently and through admission avoidance.

Financial Control and Capital Development

Highlights from this section included:

- Performance against plan during June for Emergency Recovery Funding (ERF)
- An overspend on capital during the month, with the annual capital plan being rephased to ensure it is aligned with the additional spend.
- A deficit of £2.6m during June, and a year to date deficit variance against plan of £4.9m
- Underdeliver of the UoR programme in month of £65k.
- Concern about the Trust's cash position which was being closely monitored.

The CFO reported that the Trust's income had increased in June, with increasing activity over leading to increased income. Additional expenditure had been required in order to fund escalation wards, high cost temporary staffing and no-pay costs associated with inflation. The Trust continued the development of the full year £36.7m CIP programme, which would be embedded with a clear plan for each scheme. The CIP plan had delivered against its trajectory to date, but increasing savings would be required as the year progressed in order to meet the full year target.

He added that the Trust had overcommitted capital spending for the year by £9m, a position that would need to be carefully managed by only spending on the most urgent issues, such as fire and patient safety. He anticipated that the capital position would remain challenging for a number of years. The Trust's cash position was being closely monitored, and any issues identified would be quickly escalated if necessary.

The Chair noted that the Trust's financial position had been discussed in detail at the recent F&P Committee as well as at a recent Board Seminar. Paresh, NED noted that the HSJ had reported on national concerns about the cash position of NHS organisations, so the Trust was not alone in being concerned about this.

The Board noted the Integrated Performance report.

51/024	**Learning From Deaths Q3** The CMO reported that there had been around 2,100 deaths in the Trust in 2023/24 and each of these had been subject to review by Medical Examiners. This review process was separate from the learning from deaths process where between 30-50 patients who met certain criteria were reviewed each month to ascertain if there had been any avoidability of death associated with their care. Any learning identified through these processes was shared with colleagues throughout the organisation. The Board noted the Learning from Deaths Q3 report	
52/024	**Martha's Rule Implementation** The CNO gave a verbal update on the implementation of Martha's Rule in the Trust reporting that the process had now gone live in all adult inpatient areas of the Trust. Four calls had been received, none of which had been about clinical deterioration and all of which had been responded to. Pathways were being developed for Maternity and Paediatric services. The Trust was an active member of the Martha's Rule network. A further update on implementation was due to be presented to the Board at the end of the year. The Board noted the Matha's rule implementation update.	
53/024	**Financial Plan 2024/25** Highlights of the report were: • The final agreed deficit position for the Trust was £11.7m for 2024/25 • The Trust's efficiency target for the year was £36.7m (5.2%) • The Trust was supporting University Hospitals Sussex NHS Foundation Trust in reducing their 65 week backlog, but this would delay the reduction of the Trust's 65 week backlog to zero. • A shift from elective inpatient to day case activity was proposed in order for the financial plan to be aligned, The CFO explained that the paper being presented to the Board represented the end of the process of approval for the Trust's annual financial plan. The plan had gone through a number of iterations due to challenges that had been received from the centre to improve recovery of the productivity gap that had developed following the pandemic. The plan set out a 5.2% efficiency target for the Trust which would result in a deficit position for the year of 11.7m deficit forecast. Nicki, NED noted that there were a number of trajectories included in the plan and noted the importance of ensuring that these were explicitly tracked during the year. She asked where these would be reported. The CEO agreed about the importance of tracking the trajectories and suggested that these should be presented to the Board. She noted that a new Director of Performance would be joining the Trust the following week who would be responsible for manging the trajectories. Following further discussions, the Board resolved to approve the 2024/25 Financial Plan	
54/024	**Freedom to Speak Up Guardian Update** Highlights of the report were: • Continued assurance provided that the Freedom to Speak Up arrangements in the Trust were effective and compliant with national guidance. • The most commonly cited reasons for speaking up continued to be inappropriate behaviours (incivility) and worker safety The DCE and CPO presented the Freedom to Speak Up Guardian (FTSUG) update. He explained that the report included three sections: the FTSUG report, a management response and a reflection and planning tool. The FTSUG report had been written by the Trust's Speak Up Guardians, one of whom would be attending the private Board meeting	

that afternoon. The report provided assurance that colleagues were supported in speaking up and raising their concerns in the Trust and highlighted that providing a timely response to concerns that were raised could be challenging. The Trust was fully compliant with FTSUG national guidance and continued to work to promote that work that was done by the Guardians.

Bullying and harassment concerns had previously been the primary category of concerns raised in the Trust; these had now been split up to provide more useful data. The predominant reasons for speaking up were now worker safety and attitude and behaviour. When areas of concern were identified, deep dives were undertaken. The recent staff survey had shown a small but significant increase in the confidence of staff that the organisation would address concerns if they were raised. The Trust continued to work to improve this.

The DCE and CPO explained that the Trust's management welcomed the FTSUG report and agreed with its content. An Executive attended every new stater induction to promote the service, and pastoral support was made available for trainee clinical staff. Action was taken to address concerns raised whenever this was required.

The reflection and planning tool had been circulated to the Board following the last meeting and was included in the report. The self-assessment concluded that the speak up service in the Trust was in a good place, but that there were opportunities for improvement in a couple of areas. The full action plan would be presented to the Board in December and would be monitored by POD.

The Chair praised the FTSU culture in the Trust, noting that the FTSUGs provided excellent continuity and were well known throughout the organisation. They had direct access to the Chair, CEO and DCE and CPO whenever they required and regularly reported to the Board. He was pleased to see that staff survey results reflected the focusses work that had been undertaken and noted that work to ensure that colleagues felt comfortable in speaking up was a continuous focus for the Trust. Paresh, NED praised the work that the FTSUGs did, noting that they do an incredible job.

Karen, NED noted that there were a number of concerns raised by nursing and midwifery teams and asked if the responses were broken down for the relevant managers. The CNO explained that she did not receive a detailed breakdown, but was unsurprised that nurses raised concerns as they were the biggest staff group and this was a key part of the nursing culture. She noted that the FTSUG were happy to raise concerns directly with her when required. The DoM reported that she met regularly with the FTSUGs and was briefed about any concerns raised in her Division, which allowed these to be addressed appropriately.

Nicki, NED noted that discussions that took place with the FTSUG in private Board allowed the Board to hear more details about concerns that were raised to the FTSUGs and to provide challenge that was not possible during the public conversation.

Ama, Associate NED noted that the number of anonymous concerns raised to the FTSUGs was very low and asked whether enough was being done to ensure that colleagues knew that raising concerns anonymously was possible. The DCE and CPO explained that national guidance was that anonymous reporting should be minimised. When colleagues wanted to raise concerns anonymously they were supported and given encouragement to engage with processes that would allow them to raise their concerns and ensure that they were addressed. Some colleagues chose to raise concerns directly with himself or with the CEO. He noted that a department had recently been identified as an area of concern despite no colleagues raising concerns; in response an action plan had been developed and had been shared with all staff in the department.

The Board noted Freedom to Speak Up Guardian Update.

55/024	**Mortuary Assurance** Highlights of the report were: • Updates on the actions that had been agreed for mortuary services at ESHT following the Phase 1 report of the Fuller Inquiry The CMO explained that a number of recommendations had come out of the Phase 1 report into mortuary services at Maidstone and Tunbridge Wells NHS Trust (MTW) from the Fuller Inquiry. The Trust had taken the decision to assess itself against these recommendations ahead of the publication of national recommendations which were anticipated from the Phase 2 report from the Inquiry. He noted that he had been interviewed by the Inquiry as part of their evidence gathering earlier in the week, and the Inquiry had been pleased with the progress being made by the Trust and the proactive approach being taken in providing updates to the Board. Nicki, NED noted that discussions when the previous report had been presented to the Board included conversation about CCTV coverage in the mortuary. One of the recommendations from the Inquiry for MTW had been that there should be CCTV coverage within the post mortem room. The previous update to the Board had reported that this recommendation had not been accepted by ESHT at the time and she asked for an update. The CMO explained that as the recommendation had been made to MTW and not to ESHT it was not mandatory. ESHT had taken the view that it would be appropriate to wait for national recommendations from the Phase 2 report before making a decision about CCTV in the post mortem room. It was not possible to access the post mortem rooms without being captured by CCTV, but the Trust was concerned about the privacy and dignity of patients if CCTV was installed in the room. If this was a requirement in the Phase 2 report then the Trust would comply. The Board noted the Mortuary Assurance report and the discussions.	
56/024	**Board Assurance Framework Q1** Highlights of the report were: • A review of the Q1 Board Assurance Framework (BAF) position. • Scoring for seven of the twelve strategic risks had remained consistent since Q4 2023/24, and had increased for five of the risks. The CoS explained that the BAF had been updated following feedback received from Committees. The Board had previously discussed and agreed the strategic risks included within the report; the Q1 update had been discussed with Committees with helpful suggestions received from the Audit Committee about improvements that could be made to the BAF. It was important that the BAF was an exhaustive document, but a template would be developed to ensure that issues within the document could be quickly identified. There would be a focus on evidence and ensuring that the BAF was a dynamic document, both looking back at the previous quarter and giving foresight about what issues might be coming through the remainder of the year and the impact that they might have on the strategic risks. The Chair asked how foresight would be achieved and the CoS explained that this would take place through conversations with Committees, where assurance would be provided about directions of travel, and any factors which might affect the risk position moving forward. Nicki, NED explained that she felt that the BAF should be almost entirely forward looking as it dealt with how the organisation managed risk moving forward. She noted that there had been an update to the BAF had been discussed by the Audit Committees and commented that she was pleased that the new version provided an improved reflection of current risks for the Board. The CEO suggested that it would be helpful for the Board to spend some time reviewing the strategic risks included on the BAF at a future Board Development session to ensure	

	that these remained correct. The discussion would include what the Board wanted from the BAF. **Action**: to be added to a future Board Development Day agenda. The Chair noted that there were a range of views amongst members of the Board about the purpose of the BAF. He welcomed the chance for the Board to discuss and come to agreement about how it would best be utilised by the organisation. The Board noted the Q1 BAF report and the discussions.	**PP**
57/024	**Medical Revalidation Annual Report** Highlights of the report were: • The Trust had maintained its 100% appraisal rate for doctors • Concerns about the number of appraisers remained and an action plan was being developed to address this The CMO explained that he was the responsible officer for medical revalidation in the Trust. He was delighted to report that the Trust continued to be 100% complaint with medical revalidation. Once approved by the Board the preformatted report would be signed by the CEO and submitted to the Secretary of State. The Chair praised the continued excellent performance. Following further discussion the Board noted the Medical Revalidation Annual Report.	
58/027	**NHS Provider Licence** The report set out the evidence to demonstrate the Trust's compliance with the annual NHS provider licence. The CoS reported that the Trust self-certified against relevant licencing conditions on an annual basis. The reported included a summary of the evidence that was used to ensure compliance with the Provider Licence. The Board approved the NHS Provider Licence agreement as recommended by the Audit Committee.	
59/024	**Use of Trust Seal** Two uses of the Trust seal since the last Board meeting were noted.	
60/024	**Questions from members of the public** <u>Eastbourne Maternity Led Unit</u> Mrs Walke explained that she was pleased to hear about the reopening of the Maternity Led Unit (MLU) in Eastbourne. She asked for assurance that it would remain open in the future. The DOM explained that the MLU was now fully recruited and staff were very excited about the new integrated service, which would make the service more sustainable. The Chair noted that it was not possible to say that the MLU would never need to be closed again, but the new model ensured that the service was more resilient and would reduce the likelihood of the service being unavailable. Mrs Walke praised the impact that Project Search had had in the Trust over the past ten years. Mrs Walke reported that her mother had recently been unwell and had been treated at Eastbourne District General Hospital before moving to Milton Grange; her mother had subsequently made a full recovery. She praised staff for the encouraging and supportive care, noting that her mother's experience had been fantastic and thanked staff on the frailty unit for the care that they had provided. She explained that she had helped to feed her mother during protected mealtimes and suggested that the families and friends of other patients might also like to do that. The CNO explained that protected mealtimes on	

	wards were to remind colleagues to ensure that patients could eat without being disturbed. She would be delighted if friends and relatives visited as this cheered up patients and meant that they were more likely to eat. She would speak to colleagues about how this could be communicated better throughout the organisation. Mortuary Services Ms Burt reported that she had drafted an email to the Trust following the Board meeting in December 2023 where she had highlighted concerns about the robustness of the Trust's response to the Phase 1 Fuller Report. She read out the email to the Board. In response, the CMO gave assurance that: • Mortuary registers were no longer kept by the Trust since the introduction of EDEN electronic register in 2020. Records continued to be GDPR compliant. • It was not possible to access the mortuary without being seen by CCTV cameras. • Monthly audits of swipe card access were undertaken, cross referenced against CCTV footage to ensure that there was no unauthorised access. • Mortuary staff only worked in the mortuary in pairs. Colleagues from elsewhere in the division provided cover if there was any staff sickness. • Bodies were not stored outside of fridges and freezers. • When the mortuary reached capacity, the Trust worked with the system to ensure that appropriate storage was found in different mortuaries. Freedom to Speak Up Guardians Mr Hardwick asked whether the FTSUGs were permanent roles. The Chair explained that FTSUGs permanent staff members who job share and work across Trust sites as required to fulfil their role as FTSUGs. Board Walks Mr Hardwick noted that reports of ward visits by Board members used to be presented to the Board and asked why these had been stopped. The Chair explained that he had stopped this reporting as it was unduly bureaucratic. The Trust had other mechanisms for collating feedback from visits. Patient Safety Mr Steeples asked how potential cross-contamination between patients was managed by the Trust. The CNO explained that this was sometimes managed through the use of side rooms, either to isolate patients with infections or to stop a patient from being exposed. It was important to balance the needs of patients to ensure that they did feel isolated, encouraging visits from friends and relatives. Visting was only stopped when it was necessary to do so. This could be challenging as understandably members of the public wanted to visit, but they did no always conform with infection control best practices.	
61/024	**Agenda Forward Plan** The Board's forward plan was noted.	
63/024	**Date of Next Trust Board Public Meeting** Tuesday 10th September 2024 (AGM)	

East Sussex Healthcare NHS Trust

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				
13.08.24	56/024	Board Assurance Framework to be added to planner for future Board Development Day to enable the Board to discuss what they wanted from the BAF and the included strategic risks.	Board Secretary	Following August's Board meeting	Added to planner.

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	Trust Board	**Date of Meeting**	8th October 2024

Report Title:	Chief Executive's Report
Purpose of the Report/Outcome/ action requested:	To update on key items of information which are relevant but not covered in the performance report or other papers
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐
Authority for Decision:	Not applicable

Executive Summary

Change remains a constant in the NHS and since my last report to the Board in August, we have witnessed renewed interest in direction-setting for the next decade of the NHS, some positive movement in our industrial relations landscape and, closer to home, continued service developments and a real-time training exercise for a public health emergency.

Lord Darzi Report

Colleagues will no doubt be aware of the review and findings from Lord Darzi's *Independent Investigation into the NHS in England*, commissioned by the Secretary of State for Health & Social Care, which we broadly welcome.

More than merely a precursor to the NHS 10-year plan, expected in April 2025, it included three key themes that we have already sought to address in our new strategy, annual objectives and Use of Resources programme. These are:

1) Working on further innovation around care in community settings;
2) Enhancing the focus on preventative care; and
3) Exploring how digital transformation can drive further improvements in care

Industrial Action update

Members of the British Medical Association (BMA) voted to support the government's offer, with 66% of members voting in favour of the 22% increase spread over two years. This brings to an end the 18-month dispute, which saw junior doctors take part in 11 separate strikes. Colleagues may have also seen that the Royal College of Nursing (RCN) voted against accepting the pay award of 5.5% announced by the chancellor at the end of July. We understand that the RCN is, however, not currently planning to ballot its members on strike action, and we welcome a return to a more stable workforce environment.

Sussex-wide ambitions for service improvement

The system strategy *Improving Lives Together* envisages more responsive services within our communities and shifting our efforts from reactive to proactive care. To achieve this will require whole scale system clinical change, and improved collaboration across providers of services, to work with our communities and workforce in a fundamentally different

way. We envisage that this new model of care will shift current NHS resources away from acute hospitals to a service offering closer to where people live. This will be community focused, provider agnostic and over time will support people to live well for longer.

Central to the delivery of this community model of care will be the implementation of sixteen Integrated Community Teams across Sussex. These teams will deliver a core service offer which is consistent across different geographies and is focused on delivering the triple integration aim. This will be supplemented by a local offer to reflect variations in what different communities across Sussex require to 'level up' improvements in experience and outcomes.

There is a recognition across our Sussex Health and Care system partners that we need to move at pace to deliver the improvements required for patients in Sussex. These extend beyond the individual changes within organisations or delivery areas. As a result, our NHS system leaders have agreed that a major service review needs to be conducted for all NHS services across Sussex over the next 30 months. The ICB and providers will seek the support of an independent organisation to work with, bringing both a level of independence and experience from undertaking similar reviews across the country.

Eastbourne Midwifery Unit reopens on plan

I am pleased to report that the Eastbourne Maternity Unit (EMU) resumed births from the beginning of September, as we anticipated. The pausing of births at the unit since last December was so we could ensure safe staffing of our community maternity services but has attracted some media attention

Since April colleagues have been working to implement a new way of delivering maternity care in Eastbourne by combining community and EMU rotas. The new ways of working not only allows us to resume births at the EMU, but also gives us the opportunity to provide a safer joined up maternity service throughout pregnancy and during postnatal care

I would like to thank the whole EMU team who have worked so hard over the last few months to achieve this.

A first for robotics in Sussex

The first robotic colorectal operation in Sussex has been performed at Conquest Hospital, following the installation of a £2 million da Vinci robotic surgical system.

The new system offers some key advantages over conventional surgery and have proved to be less invasive with less blood loss and resulting in lower amounts of pain for patients.

Strengthening our stroke service through partnership working

We have partnered with Active Sussex to keep stroke patients moving to improve their health while at hospital and when they go home.

The partnership is designed to ensure stroke patients do not suffer from deconditioning and involves our stroke rehabilitation team and Active Sussex, who work to increase physical activity for people across Sussex. This unique project will test out the impact of delivering additional activity

	sessions in an inpatient unit to reduce the risk of harm from deconditioning and enhance the opportunity for older people to participate in activity sessions when they return home. A visit from the Chief Nurse for NHS England In September, nursing staff at Eastbourne District General Hospital hosted a visit from Duncan Barton, the new Chief Nursing Officer at NHS England, and Andrea Lewis, the Chief Nursing Officer for NHS England's South East Region. Duncan and Andrea visited Michelham ward, the hospital's gastroenterology ward, which cares for many of our patients who have the most complex clinical needs, as well as the hospital's busy emergency department. The visit concluded with a round table, where Duncan and Andrea met with senior nurses from across the trust to discuss the day-to-day challenges of delivering high quality nursing care in the NHS. Operation Fallout Eastbourne District General Hospital was the site of a joint training exercise with colleagues from NHS Sussex, East Sussex Fire and Rescue, Sussex Police and South East Coast Ambulance Services to test the emergency response plans in the event of a hazardous materials incident such as a chemical, biological, or radiological release. As part of the 2-hour exercise, a large tent was set up outside the entrance to ED and volunteers were made up to look as though they had injuries from a chemical incident. The volunteers were from Casualties Union, a registered charity and voluntary organisation who provide acting and reacting casualties and patients for training sessions such as this. Colleagues from ED, along with those in the other emergency services, then went through the process of 'casualties' arriving at the hospital, being decontaminated and showered before being treated. A big thank you to all staff and volunteers involved. Training sessions like these are crucial to ensuring all services are fully prepared in the event of a public health emergency. Goodbye and Happy Retirement to Angela Colosi We bid a fond farewell to Angela Colosi our Deputy Chief Nurse for Quality and Policy who retired from the trust in September after an incredible 42 years with the NHS - clearly no doubt that she has earned a break! Angela began her training in 1983 at the Hastings School of Nursing. During her time with the trust, she has held a number of senior roles and received the prestigious Florence Nightingale Leadership Scholarship. We wish Angela the very best for her retirement.

Regulatory/legal requirement:	Not applicable

Business Plan Link:	Quality ☒	People ☒	Sustainability ☒

Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	4	**Appendixes**	None
Name, position and contact details of author:	Joe Chadwick-Bell, Chief Executive		
Report Sponsor	Not applicable	**Presenter:**	Joe Chadwick-Bell
Governance and Engagement pathway to date:	Not applicable		
What happens next?	Not applicable		
Publication	Report is for publication		

East Sussex Healthcare NHS Trust

Report to:	Board of Directors	**Agenda Item:**	8.1
Date of Meeting	08 October 2024		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the Audit Committee on 26 September 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

Trust Policy Annual Report: It was noted that the number of policy and procedural documents had grown over time and an exercise would be needed whereby each would be assessed to determine whether they remained necessary. The Committee also agreed that outdated policies should be addressed in order of importance rather than length of time since previous review. The new InPhase module which was being used to monitor policy and procedural documents had a flagging toll which would support with this approach.

Tenders and Waivers: The Committee was assured that waivers were being managed effectively but highlighted that a more proactive approach should be developed around sole-supplier contracts and continuity of service planning.

Board Assurance Framework (BAF) Q1 & Corporate Risk Register (CRR): Discussion focused primarily on BAFs 6 and 8.

The risk rating for BAF 6 remained at 16 in Q2. While significant work has been undertaken to increase the robustness of the Trust's cybersecurity posture, and the Trust's current security risk status has reduced, the overall cyber threat level to the NHS has increased. It was hoped that the delivery of active directory migration, Conquest core LAN migration and a reduction in unsupported legacy systems moving through the year could result in the lowering of the risk rating to 12 as a realistic target. The Committee received assurance that the Clinical Engineering team was aware of cybersecurity requirements and all network devices procured were compliant for these purposes.

The risk rating for BAF 8 remained at 12 in Q2. Digital awareness in the Trust had greatly improved, and the benefits of embedding clinical and operational staff within the digital system delivery were being realised with divisions working to embed digital processes. Work in preparation for the introduction of EPR continued.

It was noted that some CRR entries linked to BAF 8 should be updated as wording was no longer aligned to the evolving digital landscape. Across the CRR, it was recognised that risks were being flagged effectively but more focus would be given to developing robust mitigations and drawing distinction between 'risks' and 'issues'.

Alert, Advise and Assure

Alert

None.

Advise/Inform/Update

Information Governance Toolkit Update

The updated version of the Daat Security and Protection Toolkit (DSPT) had recently been issued and was more closely aligned with the cyber assurance framework. A mid-year submission against the DSPT was due in December and it had been identified that a wider cross-section of colleagues across ESHT would need to be involved with providing evidence.

Assure

Recruitment and Onboarding (Internal Audit Report) - Reasonable Assurance

Internal controls for recruitment and onboarding were found to be appropriate. It was noted that the Recruitment and Selection policy was being updated to ensure it remained a robust and effective document. Time to hire was identified as an area where improvements could be made.

Green Plan (Internal Audit Report) – Reasonable Assurance

Internal auditors concluded that Green Plan controls were well-designed and operating effectively. Those involved in the production and delivery of the Plan were found to have depth of experience in sustainability project management. Some recommendations from the report included updating the Corporate Risk Register to include climate-related risks, as well as the identification of an Evolving Care workstream lead.

Key Risks or Opportunities and their impact on the Trust

None.

Key Decisions

None.

Exceptions and Challenges

None.

Recommendations

The Board is asked to note this report.

East Sussex Healthcare NHS Trust

Report to:	**Board of Directors**	**Agenda Item:**	8.2
Date of Meeting	**8th October 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 26 September 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

Acute EPR Contract Award Recommendation Report

The Committee received a report providing assurance that an appropriate procurement process had been undertaken to identify a preferred provider of an Acute EPR system, and that appropriate rigour had been applied to ensure value for money. The preferred supplier will be notified, subject to the full business case sign off by the Finance & Productivity Committee and the Board in due course. This report followed the outline business case previously presented and approved.

Alert, Advise and Assure

Workforce plans

The Committee received a presentation on workforce data and trends, with analysis of plan vs budget. This followed a request made to provide additional assurance on the trajectories. It was noted that trends were in the right direction but at a rate which does not yet provide assurance that full year delivery of workforce plans is deliverable.

Q4 Service Line Reporting (SLR)

The Committee received a paper on the Q4 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 within the Trust, with in-depth reviews of these specialities being undertaken. Focused action plans and support are being developed to improve performance in these areas.

Capital

The Committee received a report on the capital position, noting delivery to date and expected forecast. Unlike previous years the main risk is an overspend of budget. The Committee was advised that the ICB may balance forecast positions across Sussex, and that there may be an opportunity for the Trust to increase its allocation in year with an equal and opposite reduction next year. Whilst this would make 2025/26 more challenging it would allow the Trust to mitigate the likely in-year 2024/25 overspend.

Key Risks or Opportunities and their impact on the Trust

M5 Financial Performance

The main part of the meeting focused on a discussion around the M5 year to date performance and likely year end position. The Committee noted that in month the Trust delivered to plan of £2.1m deficit, however this was only achieved through deploying one-off mitigations (as occurred in M4) and that this could not be repeated at this level going forward, meaning that the variance to plan was likely to worsen in M6.

The paper presented a best-case scenario of a deficit of £21.4m, a base case of a deficit of £25.7m and a downside case of a deficit of £42.7m. The Committee queried the range in these assumptions and it was noted that the straight-line extrapolation of the underlying run rate was a £45.9m deficit and therefore the downside did not seem overly pessimistic. The upside case was noted as aligning to the ICBs expectation of the Trust delivering no worse that £20m (plus HCA band 2 to band 3) and represented the Trust's ambition for the year. Consistent and meaningful month-on-month run rate improvements are yet to be demonstrated.

Key Decisions

Board Assurance Framework Q2

BAF 4: Failure to deliver income levels/manage cost/expenditure impacts savings delivery
It was agreed that the risk rating should remain at 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.
Risk was proposed to remain at 16, the committee noted that the backlog paper was due to be presented to the Board. It was noted that pressure in this area is increasing.

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. The supporting information was to be updated to be clear this was a people and system risk.

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

None of note

Recommendations

The Board is asked to note this report.

Report to:	Board of Directors	**Agenda Item:**	8.3
Date of Meeting:	8th October 2024		

Title of Report:	Inequalities Sub Board Committee – Chair's Report
Status:	For Discussion
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, 19th September 2024, to provide the Board with an update of the Committee's activities. The meeting was chaired by Mr Paresh Patel.

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

Health Inequalities Strategy: The Chief of Staff provided with an update on several areas related to health inequalities. The Committee remains focused on the development and implementation of the Health Inequalities Strategy. Collaboration with Public Health teams is ongoing, and their feedback is crucial for refining the strategic approach. Progress continues to be made, with focus areas including the use of inequalities data and collaboration with Integrated Care Board (ICB) colleagues. Discussions also included a review of maternal health data, which continues to highlight the links between deprivation and poor birth outcomes. Efforts are underway to tackle these inequalities by addressing high-risk factors such as high BMI and smoking rates in expectant mothers. It is anticipated that the finalized strategy will be presented to the Board at a future meeting, following incorporation of feedback and further refinement.

AccessAble Pilot: The Committee was briefed by the Chair of the Disability Network on the "Access Able" pilot, which aims to improve accessibility for patients and staff across the Trust. This pilot has received strong support and, pending its success, a wider rollout across the Trust is planned. The Facilities team is already using data from a previous report from AccessAble on accessible toilet facilities to drive improvements in accessibility infrastructure.

Ethnicity and Gender Pay Gaps: The Equality, Diversity and Inclusion Lead provided the Committee with updates on the Ethnicity and Gender Pay Gap Reports, which are directly linked to High Impact Action 3. The Ethnicity Pay Gap Report, while delayed, has now been completed. The Committee acknowledged that this was a new requirement, and not all partner organisations are at the same stage in producing this report. Benchmarking will be undertaken in the future where possible.

In terms of the Gender Pay Gap Report, there have been slight improvements favouring women in the Agenda for Change roles. Additionally, Clinical Excellence Awards (which historically favoured men and certain ethnic groups) are being phased out to create a more equitable reward system. The Committee discussed the need for improved mentorship and culturally relevant talent management for ethnic minority staff, which will be integrated into the Trust's leadership and development programs.

EDI High Impact Actions: The Committee reviewed the progress on High Impact Actions (HIA) related to addressing pay gaps and improving talent management. High Impact Action #3, which involved producing the additional pay gap reports, remains a focus area as a disability pay gap

report will be required from March 2025. The Committee acknowledged that while the Ethnicity Pay Gap Report has been completed, there is ongoing work related to talent management and leadership training that needs to be fully developed before the next phase can be rolled out.

The Committee emphasised the importance of not rushing the work on talent management and leadership development, as it is crucial to ensure that these frameworks are fit for purpose. High Impact Action areas will receive more attention in future meetings as the work progresses.

ESHT Network Visibility: The Women's Network has been actively gathering feedback from staff on key areas affecting women in the Trust, such as misogyny, menopause, estates, and flexible working. Feedback was collected through physical boxes and digital forms, and meetings with relevant service managers are underway to develop action plans. The network seeks to collaborate with other teams to address these areas cohesively.

Board Assurance Framework (BAF) Update: The Committee reviewed BAF 11, which addresses the risk of failing to demonstrate fair and equal access to services. For Q2, the risk rating remains at a Likelihood of 3 and a Consequence of 4. Current controls in place (outlined in four areas within the BAF) were deemed effective, with no major gaps in assurance identified at this time. The discussion also highlighted that the Q3 risk rating will be influenced by how well divisions are able to act on inequalities data, demonstrating that they have clear plans in place to mitigate disparities. Specific actions to improve clarity and detail in reporting will be refined in the next quarter.

Alert, Advise and Assure

Alert: None

Advise:

1. Action plan to be circulated in advance of the December meeting to ensure all activities captured.
2. Ongoing work on the talent management strategy and health inequalities strategy.
3. The Committee has agreed to review its progress in the next meeting, with the Chief of Staff leading the effort to create a feedback survey for members.

Assure:

1. Gender and Ethnicity Pay Gap requirements met and will now be published.
2. Successful implementation of EDI actions and ongoing collaborations but will be developed further for next meeting.
3. The BAF #11 risk rating reflects the Trust's commitment to addressing potential inequalities. Controls in place are providing an adequate assurance and that further action plans are being developed to enhance this work.

Key Risks or Opportunities and their impact on the Trust

Collaboration with External Partners: The opportunity to collaborate with University Hospital Sussex on joint projects around workplace inequalities was highlighted. This presents a chance to leverage shared expertise and make a more substantial impact.

Key Decisions

Board Assurance Framework: The Committee approved the Q2 BAF 11 risk rating and will review specific action points offline to enhance clarity and focus for Q3.

Exceptions and Challenges

Delayed Progress on Talent Management and Leadership Programs: While the Ethnicity Pay Gap Report has been completed, the development of the Talent Management and Leadership Program, a crucial part of High Impact Actions is not yet finalised.
Divisional Analysis of Inequalities Data: The Committee discussed the importance of incorporating inequalities data into divisional reports as part of the Board Assurance Framework (BAF). However, progress in regularising this analysis across all service areas has been slower than anticipated.

Recommendations

The Board is asked to note this report.

East Sussex Healthcare NHS Trust

Report to:	Board of Directors	**Agenda Item:**	8.4
Date of Meeting:	8th October 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 POD Committee on 19 September 2024, providing the Board with an update of the Committee's activities.

Background

The POD Committee holds delegated responsibility from the Board of Directors as set out in 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 August 2024:

- WTE Planned v Usage (wte) in August, budget wte and usage wte came into line at 8,266, having previously been in deficit for the first four months of the financial year.
- WTE Planned v Usage (£'s) Total workforce expenditure reduced by £369k compared to July, whilst budget to usage variance had reduced by £450k to £145k.
- The monthly sickness rate had reduced by 0.5% to 5.% whilst the annual sickness rate was unchanged at 5.3%. Long term sickness in Aug made up 54.2% of the total (up by 5.6% from last month).
- The mandatory training rate increased by 0.2% to 90.6%, despite the recent expansion in the courses included in this metric.
- The appraisal rate increased by 0.8% to 84.5%, the highest rate in the last five years.
- The Turnover rate had increased by 0.2% to 10.7%, equating to 762.2 wte leavers, an increase of 9.4 wte leavers.
- The Trust vacancy rate increased by 0.2% to 3.9% (311.3 wte vacancies).

A discussion took place regarding mandatory training and it was noted that the IPRs contained a different breakdown to include specific training. It was suggested to report into the Patient Safety and Quality Group, which could summarise the findings for the Quality Committee to escalate or provide assurance. Therefore an action was taken for this information to be taken to the Quality Committee, linking it to risks and incidents.

Alert, Advise and Assure

Guardian of safe Working Hours (GOSWH) Report

The GOSWH Annual report to include May/Jun/July was shared and it was highlighted that there had been a significant increase in exception reports over the past year. This rise was attributed to efforts encouraging junior doctors to file exception reports, especially due to breaches in working hours. Increased support from guardians and pastoral fellows also contributed to the rise, along with more locum doctors now able to submit these reports.

The POD Committee accepted the report for assurance.

Health & Wellbeing Report

The Health & Wellbeing report was shared providing a brief update on the work, actions and progress in relation to supporting the wellbeing of our people.

A conversation took place regarding Mental Health First Aider (MHFA) training and the importance of linking in with physical health training. The benefits of MHFA training supports the workplace culture and wellbeing beyond just patient care. Therefore an action was taken to consider this as mandatory or suitable level of training.

The POD Committee accepted the report for assurance.

Equality, Diversity & Inclusion

The Neurodivergence report was shared and it was highlighted that there was a growing trend of people being diagnosed with conditions such as ADHD later in life. ADHD had often been viewed as a childhood condition rather than a lifelong one. There was a reported 30 to 44 week wait for diagnoses and information was scarce.

A proposal was submitted to train an Accredited Workplace Assessor to enhance support for Neurodiverse colleagues at ESHT; a cost effective and sustainable approach reducing reliance on external assessments.

After a lengthy comprehensive conversation and many questions the POD Committee agreed the proposal.

The POD Committee agreed the proposal.

Appraisal Compliance monthly update

The Appraisal data for August 2024 was shared for information.

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 – recommendation to reduce risk to 12 from 15.

An improvement had been seen in filling difficult positions and whilst some roles still required head-hunters, the need was decreasing.

It was noted that this risk was too general as it was created during a period of significant recruitment difficulties. the need to address specific risks related to retirement and planning, suggesting that these issues should be more clearly highlighted in the risk assessment.

It was agreed to amend the risk to reflect the reality of what we are now facing rather than the generalist view of hard to recruit and to reduce the risk to 12.

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.

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

Exceptions and Challenges

N/A

Recommendations

The Board is asked to note this report.

East Sussex Healthcare NHS Trust

Report to:	Trust Board	Agenda Item:	8.5
Date of Meeting	08 October 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 25 September 2024 to provide the Board with an update of the Committee's activities.

Background

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

Business Undertaken

Division Report – Medicine

The Assistant Director of Nursing for Medicine advised that falls numbers and rates (including harm) were being maintained below average levels. Work is underway regarding recording pressure damage as it is not always appropriately allocated and at times is shown as acquired on the ward that documented it but this is not always the case. Some patients arrive with harm or may experience deterioration/damage before arrival on a downstream ward. Pressure Ulcer Risk assessment compliance is also a focus. Responding to National Inflammatory Arthritis Audit was flagged as an area of challenge; a registrar had been allocated specific time for data entry so this could be addressed.

Governance Quality Report

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

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

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

Alert, Advise and Assure

Alert

None.

Advise/Inform/Update

Quality Dashboard (August data)

Data not reviewed by PS&QG as not received in time.

Rates of clostridium difficile remained slightly elevated with an exceedance of internally set limits. National limits have now finally been shared. A multifactorial response was in place and a paper has bene to ExCom, with two of the key strands being the continued reduction of hospital occupancy and renewed focus on antimicrobial stewardship as well as adherence to meticulous IPC standards and HPV cleaning. Collaboration with regional and national teams was ongoing.

Expected paper from BI regarding process/governance of data anticipated for October meeting. All other watch metrics were stable in August noting ongoing and significant operational pressures with additional/surge/pre-emptive capacity still open.

End of Life Care (EOLC) Update

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

Assurances

Patient Safety & Quality Group - Escalation and Assurance

• Huge reduction in incidents in the holding area. Overdue Patient Safety Incident Response Framework (PSIRF) templates continued to be monitored closely and were prioritised for completion with an improving picture. Ongoing focus required for overdue actions.
• The PSIRF Implementation Tool has been presented to senior colleagues as part of a cascading approach to embedding new practices
• Divisions were being encouraged to use a variety of PSIRF templates.
• The Pressure Ulcer Review Group has begun using the PSIRF compliant After-Action Review template. This was a new national tool to review how this damage occurs and is investigated

Key Risks or Opportunities and their impact on the Trust

None.

Key Decisions

Perinatal Quality Surveillance (PQS) Operating Model

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

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

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

Exceptions and Challenges

None.

Recommendations

The Board is asked to note this report.

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

KINDNESS

INCLUSIVITY

For the Period August 2024 (Month 5)

INTEGRITY

Content

East Sussex Healthcare NHS Trust

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 (2024/25), 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 continues to perform strongly against the NHS constitutional standards.

The Trust remains in the upper quartile for performance against the 4-hour Emergency Access Clinical Standard, having met consecutive trajectories over the last six months. Improvements were also seen in June for cancer performance and RTT long waits continue to reduce ahead of trajectory.

The Trust is working towards delivering the 2024/25 operational planning guidance and is focused on continuing to improve several 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. In addition, the Trust is committed to improving elective recovery, especially in critical areas including cancer treatment, diagnostics, routine long waits and supporting system partners with reducing the number of long waiting patients.

Key Areas of Success

- ESHT is compliant against the 4-hour standard (78.6% in August). The Trust is the fifth best performer in the region
- The Trust is showing a positive position over the last six months against Faster Diagnosis Standard. At 79.3% in July, it has met the Trust trajectory and the new national standard to achieve 77% by March 25
- Cancer 62 Day pathway is performing at above national average. The Trust delivered 68.9% for the 62 Day referral to treatment standard against an agreed trajectory of 67.3%
- The Trust is sustainably delivering above target for our 2-hour urgent community response
- Financial Improvement Director in post, working with ESHT on financial recovery.

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
- Deliver on the workstreams in our Use of Resources programme
- Average length of stay in our acute, community beds and overall bed occupancy rates – the Trust is working with the ICS to support patients receiving rehabilitation and reablement in their homes
- 62 day cancer performance - an enhanced focus at tumour site level has been implemented, to ensure sustainable achievement of trajectories to meet the national ambition of 70% by March 25
- 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	958	823	709	Common Cause	Not Met
Number of Patient safety events (severity 3)	0	24	19	5	Common Cause	Not Met
Number of Patient safety events (severity 4 ...	0	10	3	5	Common Cause	Inconsistent
Never Events	0	1	0	0	Common Cause	Inconsistent
Inpatient Falls per 1,000 Bed days		3.81	4.24	4.27	Improvement	Target required
Cat 3 ESHT Acq. PU (rate) per 1,000 bed days	0	0	0	0	Common Cause	Inconsistent
Cat 4 ESHT Acq. PU (rate) per 1,000 bed days	0	0	0	0	Common Cause	Inconsistent
Healthcare Associated MRSA Bacteraemia (r...	0	0	0	0.0464	Common Cause	Inconsistent
Healthcare Associated C Diff Infections (rate)...	0	0.272	0.347	0.186	Common Cause	Inconsistent
Healthcare Associated MSSA Bacteraemia (r...	0	0.233	0.0771	0.0464	Common Cause	Inconsistent
RAMI	100	88.1	88	79.0	Improvement	Achieving
SHMI (NHS Digital monthly)	100	100	102	116	Concern	Inconsistent
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	92.5%	93.3%	91.8%	Improvement	Not Met

Patient Experience	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Complaints received		37	33	51	Common Cause	Target required
Complaints Response Compliance (60 w...		87.5%	81.8%		Common Cause	Target required
Reopened Complaints		14	4	3	Common Cause	Target required
A&E FFT Score	85%	81.0%	80.2%	92.9%	Common Cause	Inconsistent
A&E FFT Response Rate		15.8%	16.9%	4.47%	Improvement	Target required
Inpatient FFT Score	95%	96.8%	97.4%	97.3%	Concern	Achieving
Maternity FFT Score	95%	88.9%	97.6%	97.8%	Common Cause	Inconsistent
Outpatient FFT Score	95%	94.3%	94.4%	97.1%	Concern	Inconsistent
Post Covid19 Assessment FFT Score	95%	60%	100%		Common Cause	Inconsistent

Our People	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Establishment (WTE) All		8,251	8,266	7,136	Common Cause	Target required
Agency Rate	3.6%	1.09%	0.866%	1.38%	Improvement	Achieving
Vacancy Rate	7.5%	3.7%	3.9%	10.5%	Improvement	Achieving
Staff Turnover	11.6%	10.5%	10.7%	10.6%	Common Cause	Achieving
Retention Rate	90%	92.3%	92.1%	91.7%	Common Cause	Achieving
Monthly Sickness - Absence %	4.7%	5.48%	5.01%	4.6%	Common Cause	Inconsistent
Sickness - Average Days Lost per Fte	17	19.4	19.3	16.1	Concern	Not Met
Staff Appraisals	85%	83.7%	84.5%	78.6%	Improvement	Not Met
Statutory & Mandatory Training	90%	90.4%	90.6%	88.1%	Improvement	Inconsistent

Our Performance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
4 hour standard	75.2%	79.1%	78.6%	88.6%	Improvement	Inconsistent
A&E > 12 hours from arrival to discharge	0	813	917	73	Concern	Not Met
A&E waits over 12 hours from DTA	0	14	4		Common Cause	Inconsistent
Conveyance handover >60 mins	0%	1.48%	2.24%	0.678%	Common Cause	Inconsistent
Non Elective Length of Stay	4.36	5.14	4.53	3.76	Common Cause	Inconsistent
Average daily NCTR	159	214	221		Common Cause	Not Met
Cancer 62 Day	67.3%	73.2%	68.9%	79.2%	Common Cause	Inconsistent
28 Day General FDS	75.0%	80.2%	79.3%		Common Cause	Inconsistent
104 day Backlog	22	18	33	34	Common Cause	Inconsistent
Elective Activity (ELIP,DC,OPFA, OPFUP P...	122%	119%	119%		Improvement	Not Met
RTT under 18 weeks	92%	56.0%	55.1%	89.2%	Common Cause	Not Met
RTT 65 week wait	0	31	24	0	Improvement	Not Met
RTT Total Waiting List Size	55250	55072	55992	28567	Concern	Inconsistent
Diagnostic <6 weeks	1%	9.42%	11.4%	1.61%	Common Cause	Not Met
Urgent Community Response within 2 h...	70%	81.5%	84.2%		Improvement	Achieving
CHIC wait times < 13 weeks	75%	80.6%	81.0%	84.1%	Common Cause	Achieving
Intermediate Care Length of Stay	30	40.8	42.3	27.2	Common Cause	Inconsistent
% Discharges delayed 1+ days		20.5%	19.1%		Common Cause	Target required
Total delay days from monthly Discharges		4758	4261		Common Cause	Target required
Number of Deferred visits/ care plans	0	7248	7510	1235	Concern	Not Met

Finance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Surplus/(deficit) (£'000) - in month	(2,112)	(1,806)	(2,112)	n/a	n/a	Not met
Surplus/(deficit) (£'000) - YTD	(12,672)	(15,382)	(17,494)	n/a	n/a	Not met
ERF (£'000) - in month	8,936	9,493	9,585	n/a	n/a	Achieving
ERF (£'000) - YTD	45,542	37,767	47,352	n/a	n/a	Achieving
Efficiency (£'000) - in month	2,224	1,021	2,208	n/a	n/a	Not met
Efficiency (£'000) - YTD	7,836	4,813	7,021	n/a	n/a	Not met
Capital (£'000) - YTD	5,687	10,196	11,706	n/a	n/a	Achieving
Capital (£'000) - FOT	73,045	82,724	78,123	n/a	n/a	Not met

Constitutional Standards | Benchmarking

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

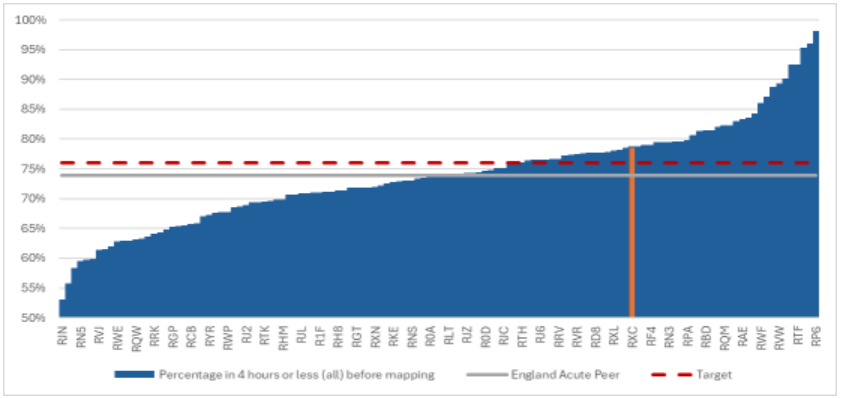
East Sussex Healthcare NHS Trust

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

August 2024 Peer Review

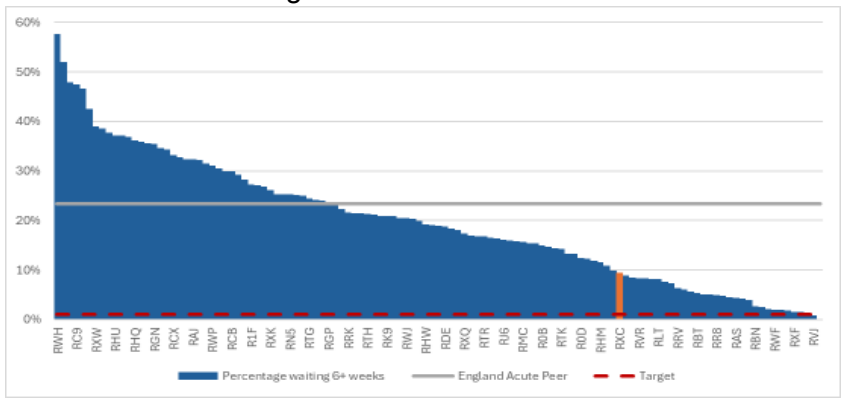
National Average: 73.8% ESHT Rank: 31/124



Planned Care – Diagnostic Waiting Times

July 2024 Peer Review*

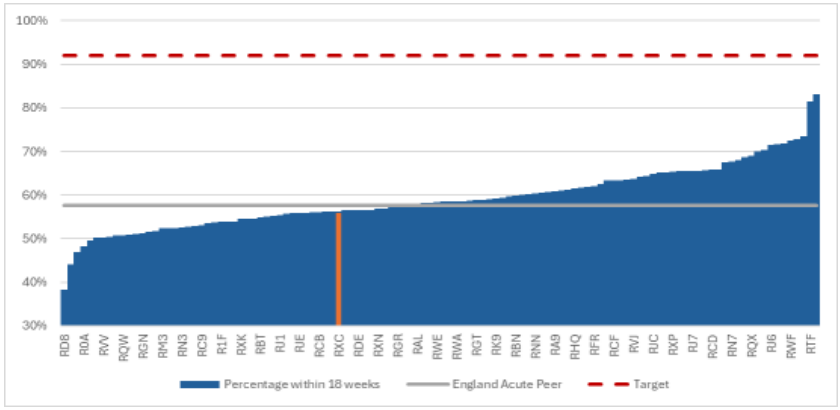
National Average: 23.4% ESHT Rank: 32/119



Planned Care – Referral to Treatment

July 2024 Peer Review*

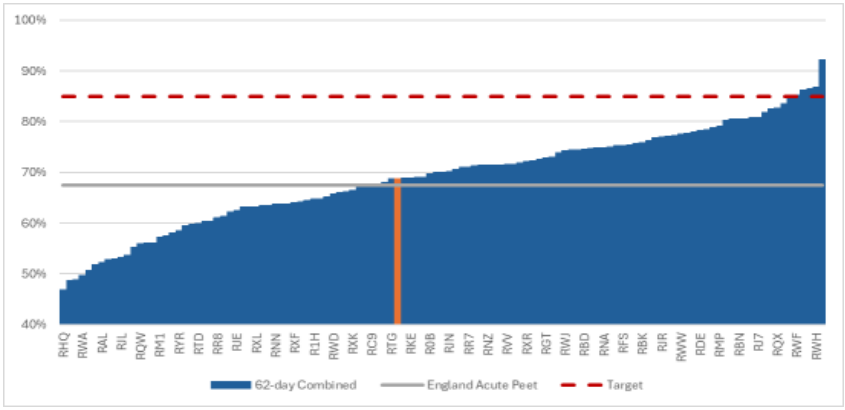
National Average: 57.6% ESHT Rank: 74/116



Cancer Treatment – 62 Day Combined Standard

July 2024 Peer Review*

National Average: 67.5% ESHT Rank: 67/119



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

Infection Control

Healthcare Associated Infection limits have now been set by NHSE for this year. ESHT is exceeding the CDI threshold with discussions at TIPCG and QSC in relation to causes and mitigations. This is multifactorial due to very high occupancy with ongoing surge capacity open and boarding crowding wards, antibiotic stewardship and essential IPC practice as well as some non-concordance with confused patients.

For the month of August, we reported nine cases of CDI. Seven were HOHA and two COHA. A further case of 002 has been identified on Frailty ward and is being subtyped to identify if related to the other cases. Michelham ward was supported for a period of increased incidents due to two cases of ribotype 005. Subtyping has shown these are not related.

There have been no MRSA bacteraemia infections reported. 2 MSSA bacteraemia were reported in August, both community onset and assessed as unavoidable due to pneumonia and pleural effusion. COVID outbreaks are still being detected and managed to minimise impact to care and service delivery.

UKHSA issued a CAS alert on 15/08/2024, requiring healthcare providers to prepare for possible case(s) of Clade 1 Mpox which is considered a high consequence infectious disease (HCID), although the risk in the UK remains low. HCID preparedness tabletop event had been undertaken at ESHT earlier in August and formed the foundation for planning preparedness actions. A preparedness meeting was booked for 11/09/24 to confirm pathways. Additional training will be required.

Safety Events

Reporting on DCIQ has decreased for the month of August 2024 and is 823 (ESHT only and filtered for duplicates). 72% of the total patient events were no harm/near miss, with the national average at 71%. We have a good reporting culture at ESHT, and it is noted that this (holiday) period is predicted to be lower on reporting and we may encounter balancing over the next two months; this will be monitored. Harm level is based on reporting date & current severity.

The themes of the top three categories for August 2024 were:

Slips, Trips and Falls (133) - an increase from July 2024 (125).
Diagnosis & Diagnostic Services (120) – an increase from July 2024 (96)
Medication Related Events (89) – a decrease from July 2024 (123).

There was 1 event (Severity 5) reported in August 2024 in Urgent Care. This was an increase from severity 4 through the WPSS step in the process (13/08/2024). This has been declared as a PSII (PSII2024/6939): Apparent/actual/suspected self-inflicted harm, which met the PSII criteria under the PSIRF Plan criteria. Also, there have been 2 events (Severity 4). One was reported by Core Services and the other Urgent Care, all with planned review at the WPSS at the beginning of September 2024 (report dates for all are in the final days of August 2024). July had one never event which will be discussed in part 2.

Safeguarding

As a result of Right Care Right Person, ESHT developed a missing person's meeting to scrutinise cases both in terms of risk and any learning. The meetings are multiagency and initially led by the Head of Safeguarding and more recently the Named Lead. The work has received plaudits within external RCPC forums.

Multi-agency work to establish a Children's Neglect forum has occurred over the last year, the first meeting in which practitioners can bring cases for discussion occurs in October. Similarly, a task and finish group has commenced to establish a multi-agency forum for self-neglect cases.

Specialised one-stop clinics for unaccompanied asylum seekers commenced in July, to ensure that the young people receive their appropriate blood screening alongside their initial health assessments.

Mortality

RAMI indices of mortality rolling 12 months is 88 for the current period and positioned at 47 out of 120 Acute Peer Trusts. SHMI is showing a value of 102 and is within the expected range. EDGH has an index of 100 and Conquest 104.

Weekend RAMI continues to show a value below the national average for HES Acute peers. SHMI contextual data is not yet available for the period.

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
As a percentage of total PE feedback, complaints and PALS contacts remain negligible. We received 33 new complaints, a decrease of 4 vs. July's number
Against our internal target of 60 days (changed in Nov '23), 7 complaints were overdue at the end of August the oldest being 21 working days over. The notable step change on the SPC chart corresponds with the change to 60 days in Nov. Different trusts apply different internal timescales depending on complexity, ranging from 25 to 60 days.

Of the complaints closed in-month: Against the local **timeframe** of 60 working days, 82% were completed in time (July =88%).
Reviewing the monthly risk rating of all complaints, most were 'moderate' in common with the general pattern: 2 high risk (July =1), 19 moderate risk (July =21) and 12 low risk (July =15).

We take **re-opened complaints/PHSO contacts** as proxies for where we may have learning. 4 complaints were reopened (July =14), 3 to Medicine, and 1 to Urgent Care - 2 were seeking further clarification, 1 was unhappy with the Trust's response and 1 was a meeting request. The Trust received no enquiries from the PHSO in August.

Of the 33 complaints in August, 76% came from **four categories**: Clinical Treatment =8, Patient Care =7, Communications =5, Admissions and Discharges =5.

Top complaint locations in August: ED =6 (EDGH =3 and CQ =3)
MRI Scanning =2, Gynaecology Investigation Suite =2, SDEC =2.
562 contacts were recorded by PALS in June (July =618) of these, 309 PALS contacts were recorded as "concerns" (July =326).

The top three primary PALS subjects recorded as a "concern" were:
Appointments =82 (66% related to long waiting times and cancelled appointments)
Communication =71 (48% related to communication with patients, relatives/ carers)
Clinical Treatment =32 (47% related to delay in treatment/care, acting on test results.

FFT transitioned to Healthcare Communications (HCC) in June with completion in August. We have continued to identify some areas where the Trust hierarchy doesn't match clinical activity and the Deputy Patient Experience Manager continues to work with BI and HCC to resolve these issues.

8,946 surveys were returned in August, a decrease when compared to July= 12,724 surveys (June= 9806, May= 2474). Due to the system hierarchy issues and paper survey names not aligning within Community services activity, SMS FFT was suspended for this area, resulting in only 1 survey returned for Community in August (July = 2784).
The number of SMS surveys returned decreased by 4,298, Community accounts for many of these surveys and there was also a reduction in SMS Inpatient surveys returned.
In line with the reduction of surveys returned we also noted a reduction in plaudits received, August= 6,563 (July =9,370).

Workforce
We have continued to see a high level of attendances to the Emergency Departments and continued high occupancy, despite a continued focus on discharge and our improvement programmes regarding 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 esp at EDGH. The new Mental Health outreach team recruitment is well underway. Ward and Community staffing in August remained stretched to cover the additional requirements. In all areas this is likely to have had an impact on key quality KPIs. This is also impacting on compliance with some training and at times staff wellbeing. Overall, however, there continues to be an improvement in appraisals and mandatory training (all staff) compliance. The focus continues on Healthroster efficiency, use of temporary workforce, authorisation of additional shifts and supernumerary time. There are significant improvements noted regarding the reduction use of additional shifts through roster efficiency and fortnightly oversight from the CNO and DCN. This needs to include other staff groups/rosters going forward applying the same methodology.

Author(s)

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

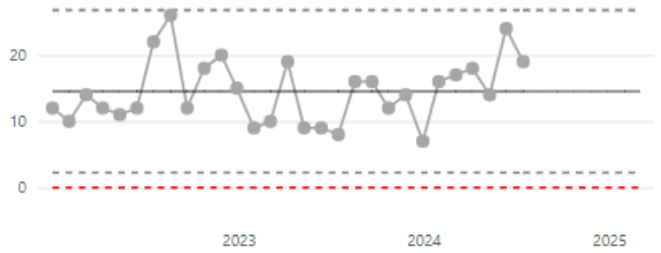
Simon Merritt
Chief Medical Officer

Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

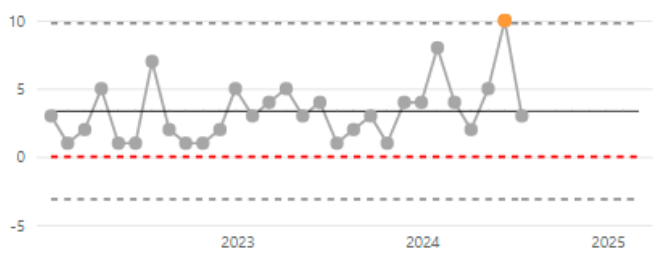
Number of Patient safety events (severity 3): Total, Safety

Not Met	Common Cause	19



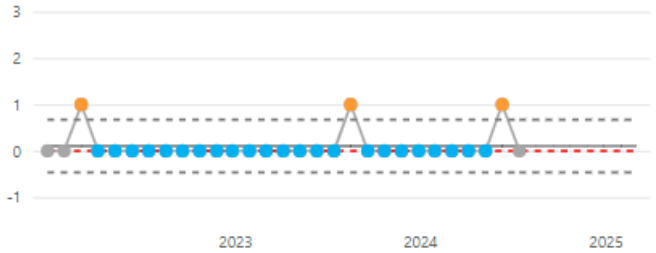
Number of Patient safety events (severity 4 and 5): Total, Sa...

Inconsistent	Common Cause	3



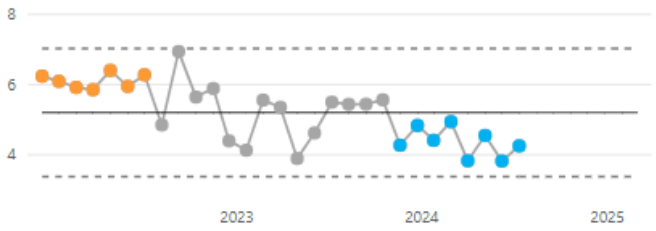
Never Events: Total, Safety

Inconsistent	Common Cause	0



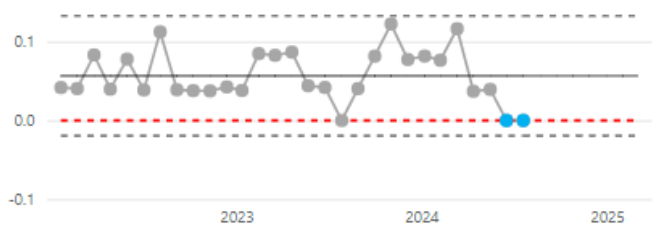
Inpatient Falls per 1,000 Bed days: Total, Safety

Target required	Improvement	4.24



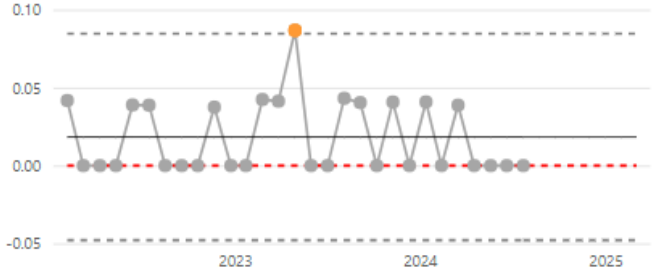
Cat 3 and 4 ESHT Acq. PU (rate) per 1,000 bed days: Total, S...

Inconsistent	Improvement	0



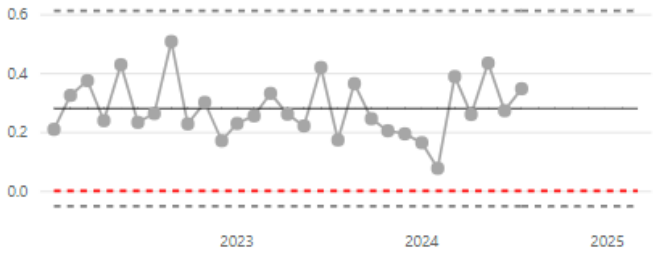
Healthcare Associated MRSA Bacteraemia (rate) per 1,000 ...

Inconsistent	Common Cause	0



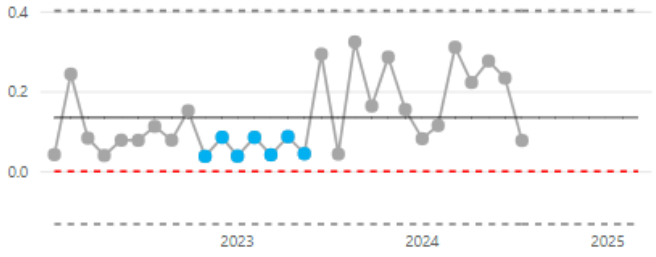
Healthcare Associated C Diff Infections (rate) per 1,000 Bed ...

Inconsistent	Common Cause	0.347



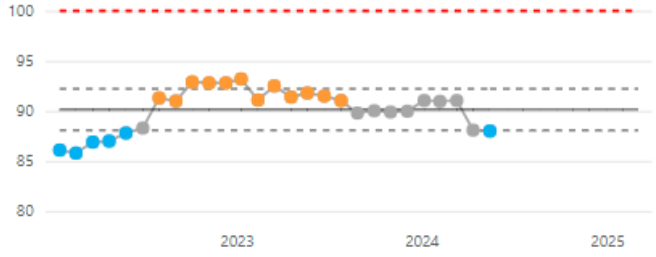
Healthcare Associated MSSA Bacteraemia (rate) per 1,000 ...

Inconsistent	Common Cause	0.0771



RAMI: Total, Safety

Achieving	Improvement	88

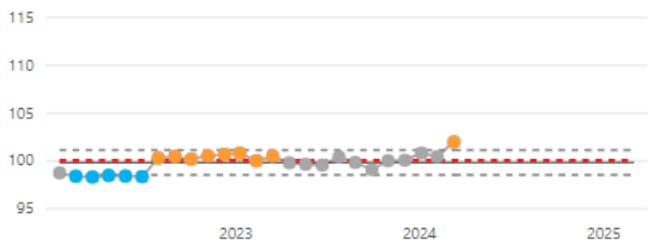


Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

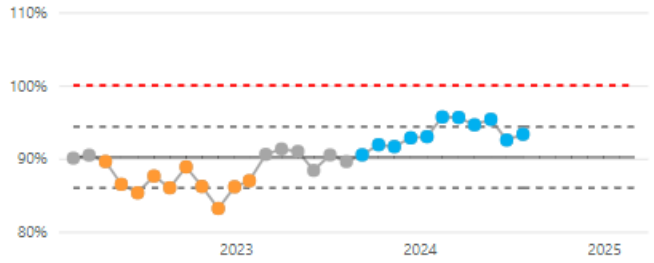
SHMI (NHS Digital monthly): Total, Safety

Inconsistent	Concern	102



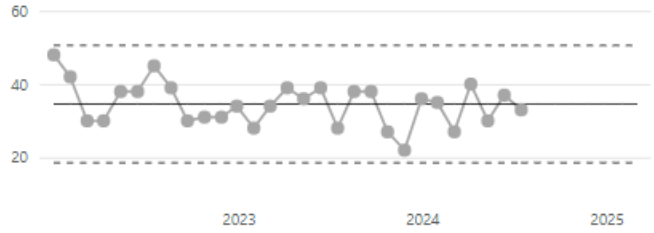
Nursing Fill Rate (IP - RN, RNA and HCA): Total, Safety

Not Met	Improvement	93.3%



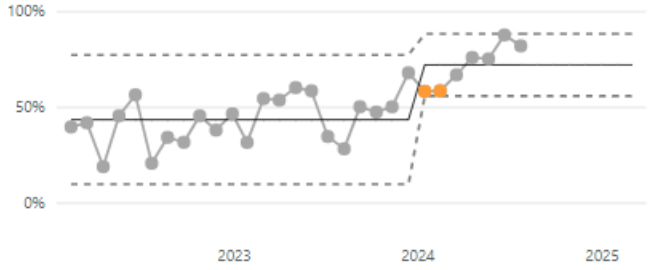
Complaints received: Total, Patient Experience

Target required	Common Cause	33



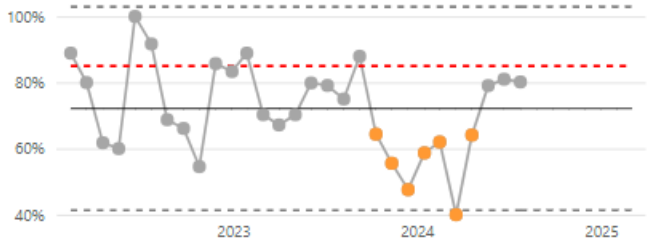
Complaints Response Compliance (60 working days as of 1...

Target required	Common Cause	81.8%



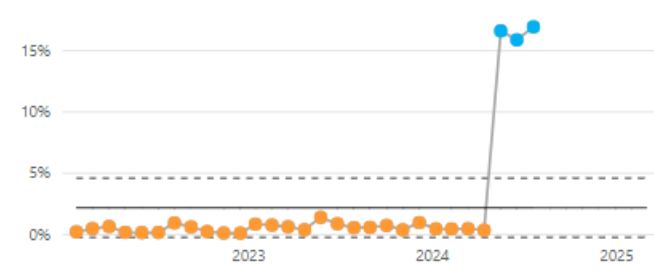
A&E FFT Score: Total, Patient Experience

Inconsistent	Common Cause	80.2%



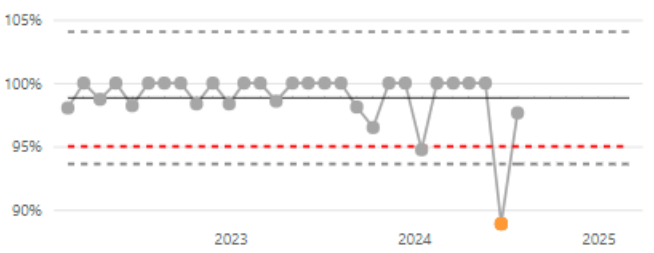
A&E FFT Response Rate: Total, Patient Experience

Target required	Improvement	16.9%



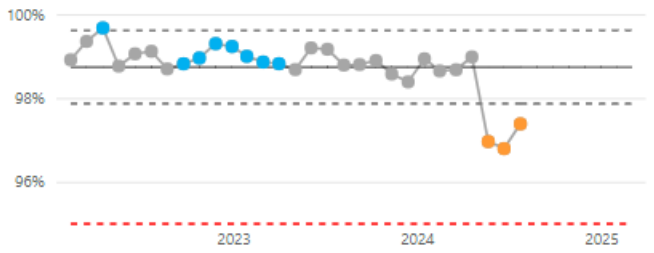
Maternity FFT Score: Total, Patient Experience

Inconsistent	Common Cause	97.6%



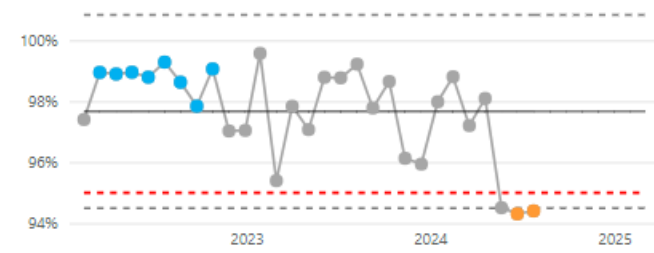
Inpatient FFT Score: Total, Patient Experience

Achieving	Concern	97.4%



Outpatient FFT Score: Total, Patient Experience

Inconsistent	Concern	94.4%



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 considerably reduced for this month as the position for verbal is at 56% (86% in the previous month), and written has moved to being higher than verbal and is at 63% although this is also a decline in compliance on the previous month. This reduction overall, may be due to the reduced activity aligned with reporting overall for this period, as mentioned previously. 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, which has been a recent anomaly with the system which is now resolved. 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 Working group are reviewing the processes and will be collaborating closely with DCIQ to leverage the digital capability of the system to facilitate both process and documentation, which ultimately positively impacts oversight, benchmarking, reporting and analysis overall.	• The Patient Safety Team, with the Divisions continue to close cases under the previous SI framework. • The PSIRF Working Group focus continues and the draft PSIRP and PSIRF Policy are moving through internal governance in readiness for sharing with the ICB. This is an update from the November 2023 go-live with the framework the frequency will then revert to 3 yearly. • Processes are being reviewed with a digital lens to move from paper to digital documentation, which is being achieved through collaboration with the Datix team. • Weekly meetings with Senior Nursing Leadership within the Divisions and the CNO continue, to monitor PSIRF template compliance continues with good effect. • Quality Summits and bespoke Matrons meetings have been used as a vehicle to engage colleagues about PSIRF and the link with Quality Improvement. • Uptake of Training for All Staff Level 1 PSIRF training continues to improve month on month with the reporting at 87.7% for July 2024
Nursing & Midwifery Workforce	During August, occupancy remained very high with ongoing use of additional super surge beds, pre-emptive boarding and significant numbers of patients requiring enhanced observation re high risk of falls or patients with challenging/violent behaviour. Ward nursing CHPPD overall was 8.4 for August (noting distortion by specialist areas). Nursing fill rates for day shifts = RN 90% and HCSW 91%. Nursing fill for night shifts = 95% for RN and 102%. National reprofiling of Band 2 to 3 Clinical Support workers project has commenced.	• Data collection to inform the annual Nursing Establishment Review (NER) is underway using the new national tool piloted/tested in the Spring. • Recruitment to the Mental Health Outreach team has commenced and a review of training for staff and a review of the estate in high-risk areas is also in train. • Nursing/Midwifery Monthly Roster Compliance sessions continue, led by the DCN to ensure effective/efficient nursing rosters. There is a fortnightly roster assurance panel in place with the CNO, to support working within budget and review of temporary staffing requests. There is evidence of good controls and work in progress to support enhanced observations and requests for additional staff. The focus is now on reducing our reliance on Agency staffing. Other roles now need to follow the same methodology. • 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 and current resources.

Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

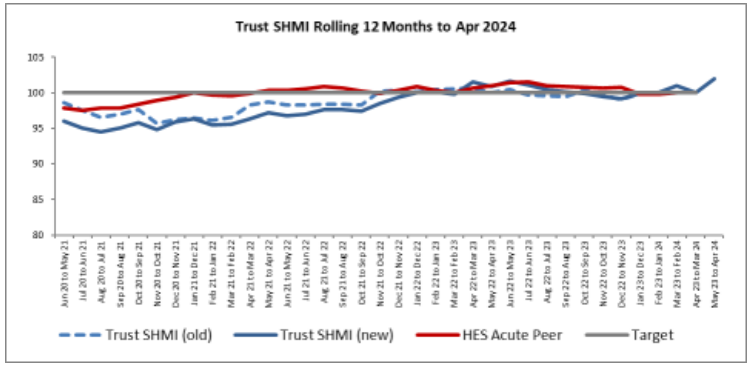
Title	Summary	Actions
Inpatient Falls	There were no catastrophic or major events/incidents in this category for August. The falls rate for ESHT per 1000 bed days was 4.24. The top three sub-categories were Patient found on the floor suspected of falling, fall whilst mobilising independently, fall from a bed or trolley or couch. The top 3 falls by location being Devonshire Ward, Frailty Unit and James Ward.	• The Quality Improvement Lead Nurse is working with ward areas and teams to close the loop in responding to the learning outcomes identified. • There is an ongoing Falls QI project looking to reduce inpatient falls by 20% within the BIU. • SWARM Forms have been updated and there will be a report from the Divisions going to the Falls Steering group to review themes and trends as well as consider further quality improvement potential.
Patient Experience	Huge increase in responses and overwhelmingly positive feedback. Some reporting issues for new digital FFT- activity not matching Trust hierarchy. Increase in the number of reopened complaints.	• Work with CHIC and new FFT platform provider underway to match the clinical activity to the Trust hierarchy to ensure patient feedback is captured in line with the service provided to the patient. Continue to encourage the completion of surveys for the BIU and Rye Intermediate Care Beds. • Monitor the themes for reopened complaints and consider any learning/changes needed.
Harm reviews	Ensure there is a process of review for patients who experience long waits and/or who have domiciliary visits deferred.	• Systems now in place for snapshot reviews of patients with a LLoS and who have community/domiciliary visits deferred with results going to relevant Div IPR.
Pressure Damage	There have been no Cat 3 or 4 PUs reported amongst inpatients in the last 2 months. During August, Four Category 3 pressure ulcers (PU) were reported in the community setting which are being explored for potential learning/themes: • 1 Category 3 PU in a patient residing in a nursing home. • 3 Category 3 PUs were reported in patient's own homes.	• The Pressure Ulcer Steering Group (PUSG) is working with the Trust Patient Safety Lead, to ensure a PSIRF approach to pressure ulcer prevention going forward. • A new national PU categorisation tool was published in June 2024 and is under review by the PUSG for implementation. • New Pressure Ulcer & Wound care training has been produced by the National Wound Care Strategy Programme and has been added to training for clinical staff to complete.

Effective Care - Mortality

East Sussex Healthcare NHS Trust

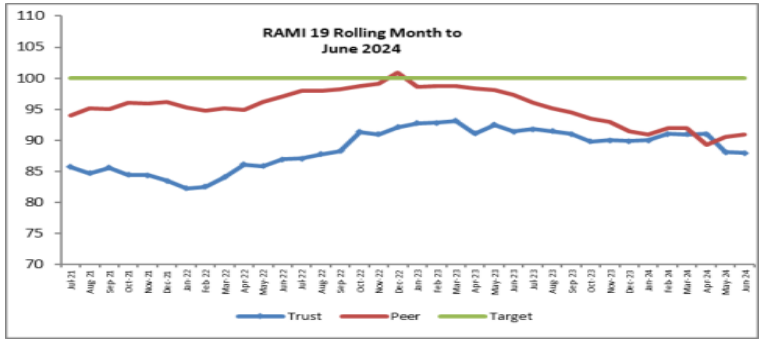
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

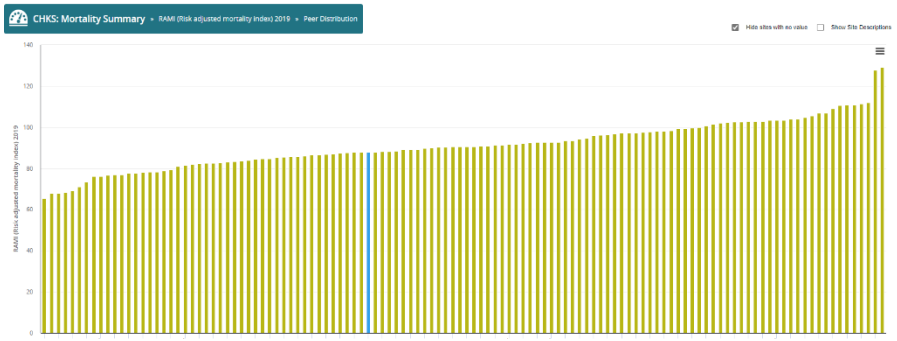
Summary Hospital Mortality Indicator (SHMI)
Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures



- SHMI – May 2023 to April 2024 is showing an index of 102 and is within the expected range. EDGH is showing 100 and Conquest is 104. 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 – Jul 2023 to Jun 2024 (rolling 12 months) is 88, and 91 for the same period last year. Jun 2023 to May 2024 was also 88.
- RAMI 19 was 72 for the month of June only and 66 for May. Peer value was 114 for June only. The line graph below shows the rolling 12 month figure
- Crude mortality shows Jul 2023 to Jun 2024 at 1.57% compared to 1.85% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 69% for June 2024 deaths compared to 72% for May 2024 deaths.

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





This shows our position nationally against other acute trusts – currently 47/120

Effective Care - Mortality

East Sussex Healthcare NHS Trust

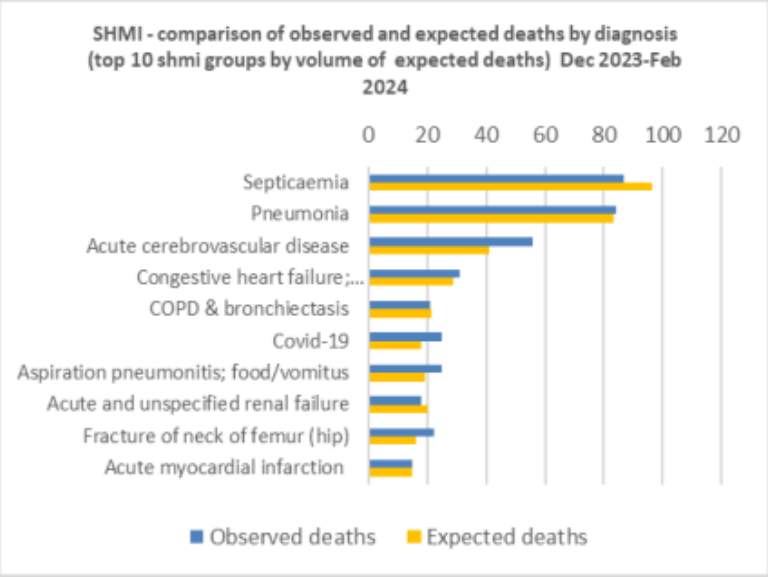
August 2024 Main Cause of In-Hospital Death Groups (ESHT)

Description	Deaths
Cancer	26
Sepsis/Septicaemia	12
Chronic Obstructive Pulmonary Disease (COPD)	9
Community-acquired Pneumonia	9
Heart Failure	8
Pneumonia	8
Frailty of old age	7
Hospital-acquired Pneumonia	7
Aspiration Pneumonia	4
Acute Kidney Injury (AKI)	3
Atrial Fibrillation (AF)	2
Dementia	2
Liver Disease	2
Urosepsis	2
Bowel Obstruction	1
Stroke	1

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

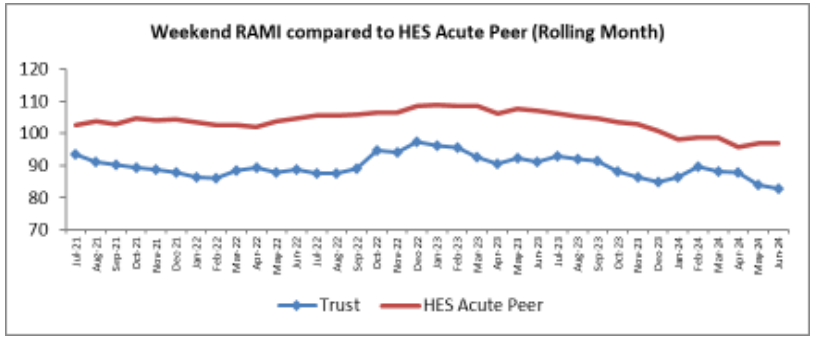
19 cases for which no CoD has been entered on the database and therefore no main cause of death group selected.

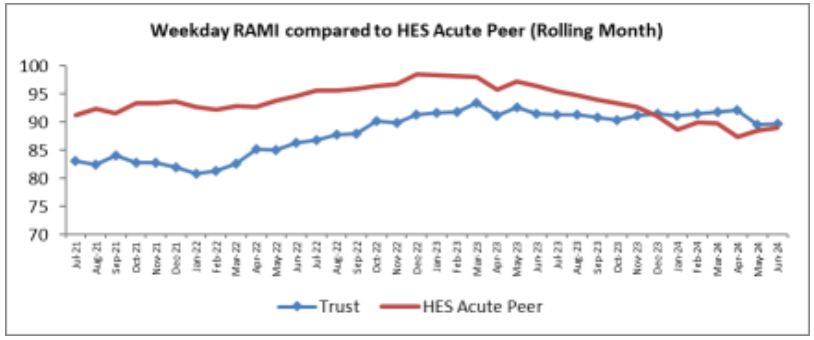
SHMI Diagnosis Main Groups



Risk Adjusted Mortality Index (RAMI)

Weekend and Weekday Mortality 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

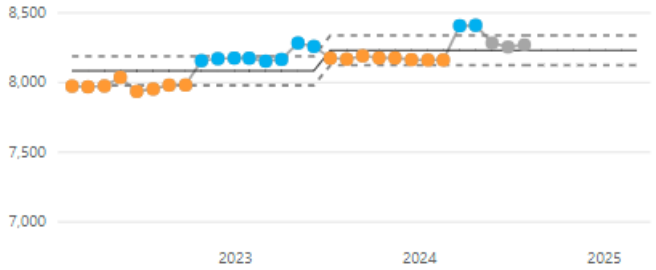
Responsive	**Positives:** Mandatory Training rate is compliant with the 90% standard. Appraisals are showing an upward trajectory for the last six months. Vacancy rates has consistently improved and is meeting the 7.5% target.	**Challenges and Risks:** The Trust has reduced the variation in monthly sickness and is now working towards achieving the sickness target of 4.7% on a regular basis.	**Author** 
Overview:	In Aug, budget wte and usage wte came into line at 8,266, having previously been in deficit for the first four months of the financial year. Total workforce expenditure reduced by £369k compared to July, whilst budget to usage variance has reduced by £450k to £145k. The Turnover rate has increased by 0.2% to 10.7%, which equates to 762.2 wte leavers (an increase of 9.4 wte leavers). Within reasonable parameters, an increase in turnover can be helpful in enabling the Trust to achieve reductions in workforce to meet financial targets. The Vacancy Control Panel continues to review requests for replacements to ensure a balance between operational needs and cost reduction. The Trust vacancy rate increased by 0.2% to 3.9% (311.3 wte vacancies). This is largely due to an increase in the substantive budgeted establishment, following achievement of a Cost Improvement project (CIP) related to bed strategy for the "Art of the Possible" scheme. As a result, the negative wte factor applied to budgets for CIP targets has reduced, increasing the substantive budget. Staff in post also fell slightly by 4 wtes due to vacancy controls. The monthly sickness rate has reduced by 0.5% to 5.0% whilst the annual sickness rate was unchanged at 5.3%. Long term sickness in Aug made up 54.2% of the total (up by 5.6% from last month). Wte days lost in month reduced by 1,138. There were significant reductions in Cold/Cough/Flu absence (-505 wte days) and Chest & Respiratory illnesses (-424) which, as noted last month, had seen an unseasonal surge in July due to a Covid outbreak. This month, AHP sickness reduced by 1.0% to 3.1%, A&C reduced by 0.8% to 3.9%, Medical & Dental reduced by 0.7% to 1.3%, Estates & Ancillary reduced by 0.4% to 7.5% and Reg. Nursing & Midwifery reduced by 0.3% to 5.4%. The mandatory training rate increased by 0.2% to 90.6%, despite the recent expansion in the courses included in this metric. All courses are over 90% compliance with the exception of Info Gov at 87.6%, Fire at 88.6%, Infec Ctrl at 89.8% and Basic Life Support which remains an outlier at 72.4% (though increased by 3.1% in the last month). The appraisal rate increased by 0.8% to 84.5%, the highest rate in the last five years. Registered Nursing & Midwifery compliance increased by 2.0% to 84.4%, Additional Clinical Services increased by 1.0% to 85.9%, but Medical & Dental compliance reduced by 0.4% to 89.0%, AHP reduced by 0.5% to 84.7%, whilst A&C was slightly down by 0.1% to 81.9%.	**Steve Aumayer** Chief People Officer

Our People Core Metrics

East Sussex Healthcare NHS Trust

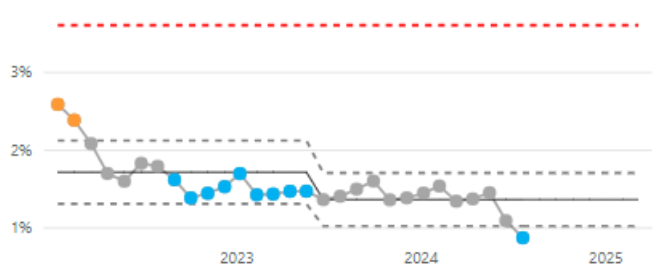
Establishment (WTE) All: Total, Our People

Target required	Common Cause	8,266



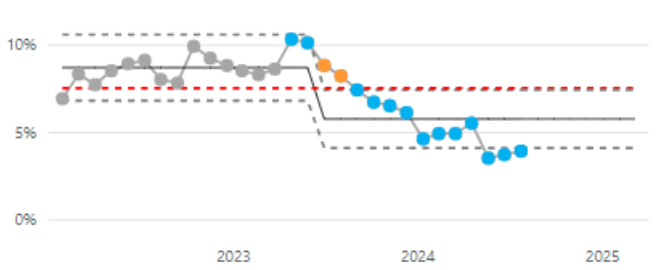
Agency Rate: Total, Our People

Achieving	Improvement	0.866%



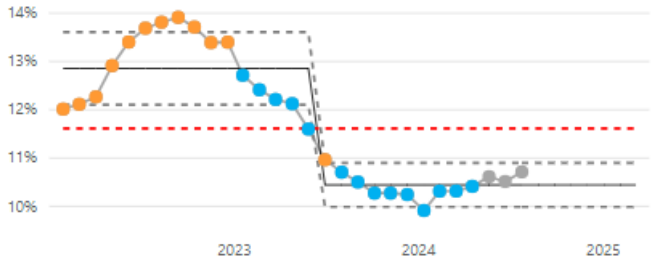
Vacancy Rate: Total, Our People

Achieving	Improvement	3.9%



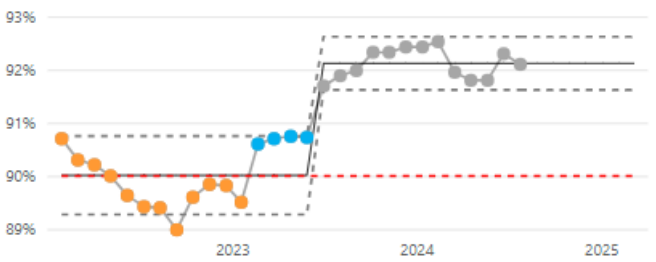
Staff Turnover: Total, Our People

Achieving	Common Cause	10.7%



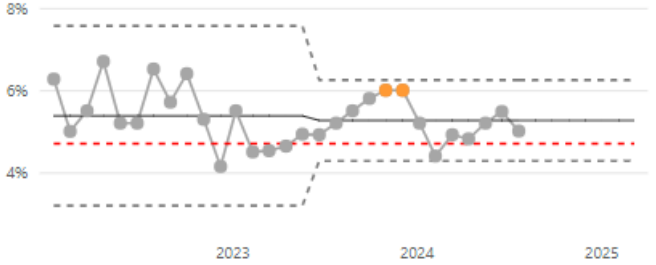
Retention Rate: Total, Our People

Achieving	Common Cause	92.1%



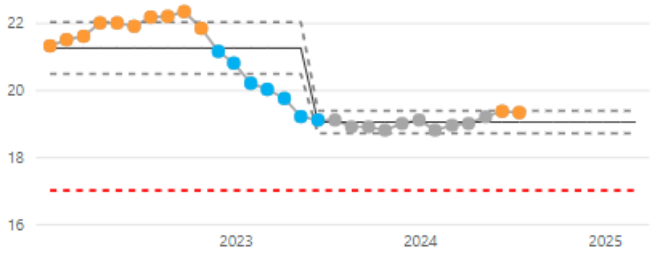
Monthly Sickness - Absence %: Total, Our People

Inconsistent	Common Cause	5.01%



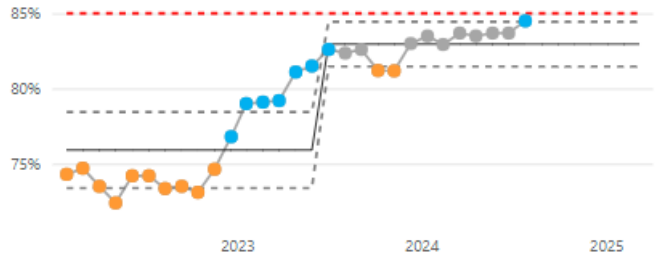
Sickness - Average Days Lost per Fte: Total, Our People

Not Met	Concern	19.3



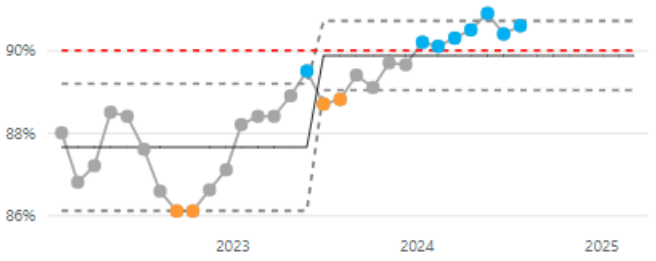
Staff Appraisals: Total, Our People

Not Met	Improvement	84.5%



Statutory & Mandatory Training: Total, Our People

Inconsistent	Improvement	90.6%



Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Turnover & Retention	Turnover rate increased by 0.2% to 10.7%	• **Exit process** 1. Exit & Staying with the Trust Phase one of the exit process review was implemented with the introduction of two new surveys (exit and staying), with the aim that this new approach will bring greater insights and a higher response rate from colleagues in relation to why people leave or move within the Trust. 2. Thrive & Grow Conversations and Exit Interviews Phase two of the exit process review involves the ending of the Thrive and Grow pilots. Templates and reporting process being finalised. Drafted new templates for the Exit Interview. Process to be agreed with HR. Aim to launch both of these initiatives at the end of December. **Legacy Mentoring Pilots** Currently developing a Legacy Mentoring programme for ESHT, based on a module delivered successfully within Nottingham NHS Trust. Recruiting legacy mentors to participate in this programme which is due to commence mid-autumn. **Psychological Wellbeing** We were able to respond quickly to an urgent and potential threat to the psychological wellbeing of our people due to pending social unrest. Fortunately, our plans did not need to be implemented, but we are aware of the longer-term effect this has had on many of our colleagues and are working with EDI to determine how best to reassure and support them. Retention team working intensely with the following teams: Maternity, Pharmacy, ED, Community Nursing, Pre-op Assessment
Vacancy Rate	Vacancy rate increased by 0.2% to 3.9% (311.3 wte vacancies).	• Focussed activity to address hard to recruit posts with recruitment activity around Medics, Community and AHPs. • Continued activity with TWS agencies to improve candidate pipeline. • Medical recruitment continues to target hard to recruit posts • Additional Agencies engaged(perm) to target hard to recruit posts • Increased branding and social media activity continues to support increase in direct candidates eg OTs. • Activity to support Clinical Support Worker (regrading from Band 2 to 3) ongoing. • Recruitment metrics report being finalised to highlight areas to improve TTH.

Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Sickness	Monthly sickness reduced by 0.5% to 5.0% whilst annual sickness was unchanged at 5.3% Average sickness days per fte have reduced by 0.1 to 19.3 Reductions in seasonal illnesses after Covid spike in July. Chest & Respiratory illnesses reduced by 424 wte days lost in month and Cold/Cough/Flu absences by 505 wte days lost.	Sickness levels remain under review across the Trust; the HRBP's are looking to triangulate the data with the impact absence has on service delivery and staff morale. This may affect bank usage, gaps in rota, appraisal and mandatory training compliance. Whilst it is acknowledged that by the nature of a long-term absence. the recovery and support may take an unknown period of time, ensuring that managers are fully engaged with their teams and understanding impact of absence may prevent future absences. Additionally, carrying out the appropriate meetings and reviews will support a potential earlier return, albeit in a temporary placement whilst continuing to recover. A Sickness Reduction Task and Finish Group is now in place looking at interventions to support maintaining a regular attendance at work and an earlier return to work In areas where there has been an increase in MSK absences, a deep dive will be carried out to ensure all appropriate preventative and support plans are in place.
Statutory & Mandatory Training	Trust compliance increased by 0.2% to 90.6%.) .	Divisional IPR information has also been amended to highlight other Essential Skills training, such as Blood Transfusion, Falls Prevention, Wound Care Level 1 etc. Basic Life Support will remain a focus, although there was an increase in compliance reaching 72.4% and increase of 3.1% over the last month , however, all new doctors who joined the organisation in August had BLS training and are compliant. Oliver McGowan eLearning Programme continues to improve, up by 3.8% this month to 77.6%.
Appraisal	Compliance rate increased by 0.8% to 84.5%. .	Whilst the appraisal tool remains ready for launch, there is likely to be a delay as a result of the remit for appraisal delivery being transferred to the People Engagement team from the end of Sept 2024.

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

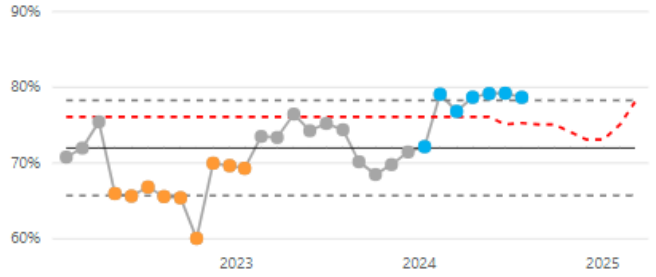
	Positives	Challenges & Risks	Author
Responsive	**4 Hour Emergency Access Clinical Standard** The Trust is committed to reducing the amount of time it takes to assess and treat patients within our emergency departments. The Trust delivered 78.6% against the revised Emergency Access Clinical Standard of 78% and remains in the upper quartile nationally for performance. **Elective long waits (RTT)** The Trust continues to have the lowest number of long waiting patients in the region, reporting only 24 patients waiting over 65 weeks in August. **Cancer** The 28 Day FDS standard was achieved in August with compliance reported at 79.3%, higher than the Trust trajectory of 75% and the new national standard of 77% (by March 2025). The Trust delivered 68.9% for the 62 Day referral to treatment standard against an agreed trajectory of 67.3%. **Urgent Community Response (UCR)** UCR has again achieved target, seeing 84.2% of patients within the 2 hour response window with national target of 70%.	**Cancer** Despite improvements in cancer standards performance the ESHT backlog of patients waiting over 62 days as at 30.06.2024 is 7.5% (211 patients). The national position is 8.5%. A monthly backlog reduction trajectory has been developed for each tumour site to ensure the overall backlog has reduced by March 2025. **Elective waiting list** The waiting list has continued to increase. Reducing the number of patients waiting more than 65 weeks for elective treatment continues to be an area of focus. The Trust anticipate having no patients waiting >65 weeks by the end of September 2024. **DMO1** DM01 performance reduced in August, down from 90.6% in July to 88.6% in August 2024 and the Trust continues to work through the action plans that are in place to support improvements in DMO1 compliance.	 **Charlotte O'Brien** Chief Operating Officer
Actions:	• Supporting system partners to reduce waiting times across the Sussex ICB. • Improving and sustaining the progress made to deliver the revised 78% Emergency Access Clinical Standard • 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. • Focus on eliminating >65 week waits and sustainably reducing elective waiting times. • 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

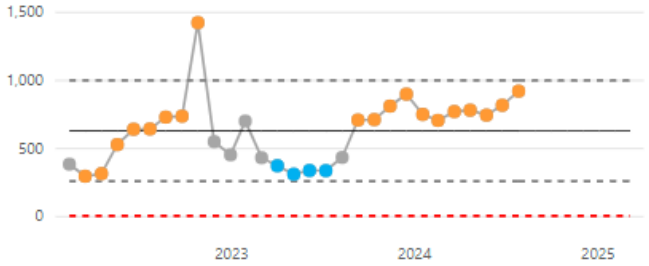
4 hour standard: Total, Our Performance

Inconsistent	Improvement	78.6%



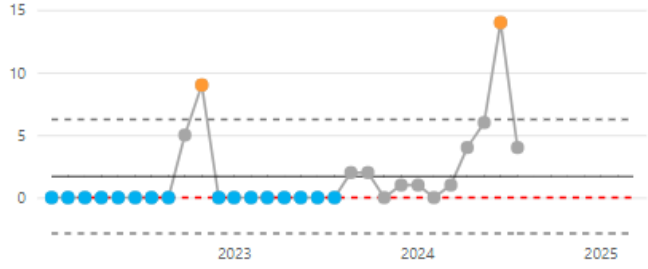
A&E > 12 hours from arrival to discharge: Total, Our Perfor...

Not Met	Concern	917



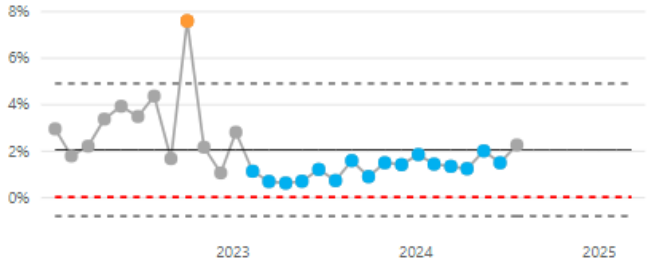
A&E waits over 12 hours from DTA: Total, Our Performance

Inconsistent	Common Cause	4



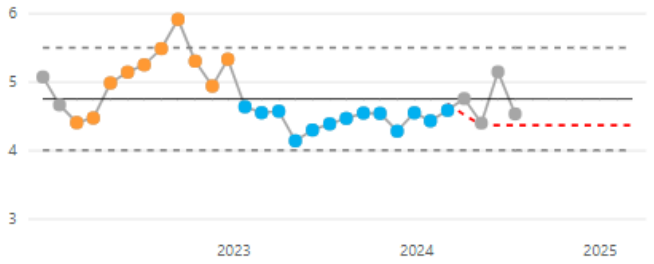
Conveyance handover >60 mins: Total, Our Performance

Inconsistent	Common Cause	2.24%



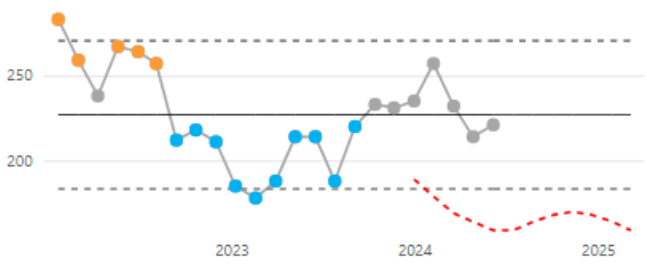
Non Elective Length of Stay: Total, Our Performance

Inconsistent	Common Cause	4.53



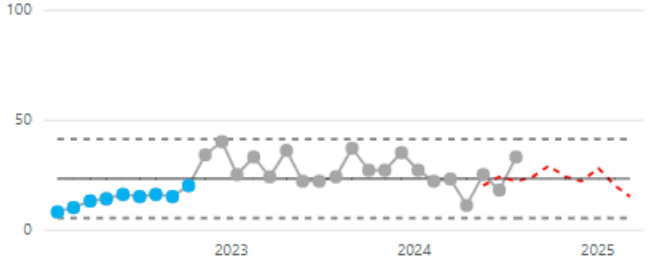
Average daily NCTR: Total, Our Performance

Not Met	Common Cause	221



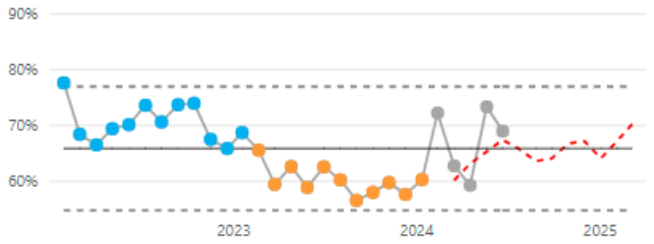
104 day Backlog: Total, Our Performance

Inconsistent	Common Cause	33



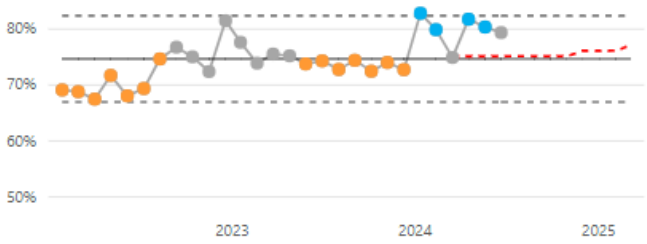
Cancer 62 Day: Total, Our Performance

Inconsistent	Common Cause	68.9%



28 Day General FDS: Total, Our Performance

Inconsistent	Common Cause	79.3%

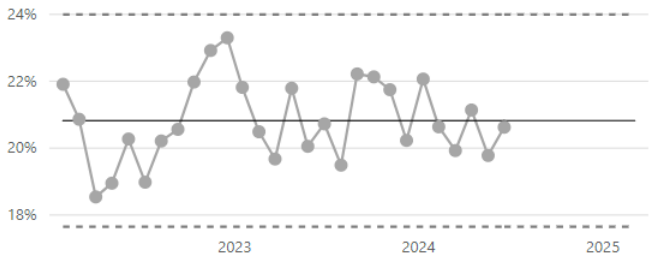


Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

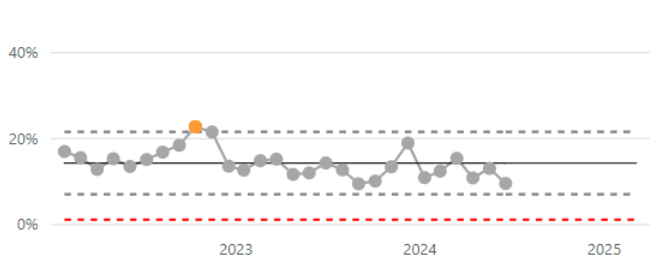
% Discharges delayed 1+ days: Total, Our Performance

Target required	Common Cause	20.6%



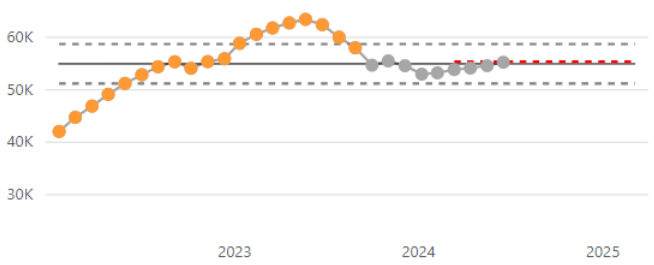
Diagnostic <6 weeks: Total, Our Performance

Not Met	Common Cause	9.42%



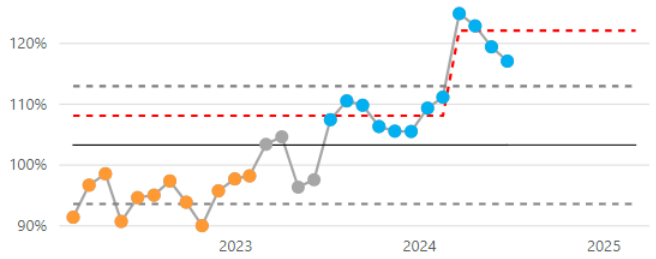
RTT Total Waiting List Size: Total, Our Performance

Inconsistent	Common Cause	55124



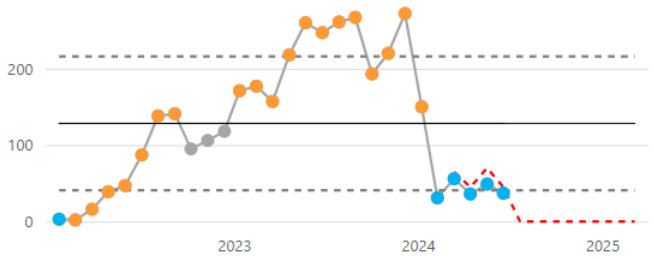
Elective Activity (ELIP,DC,OPFA, OPFUP Proc): Total, Our Perf...

Not Met	Improvement	117%



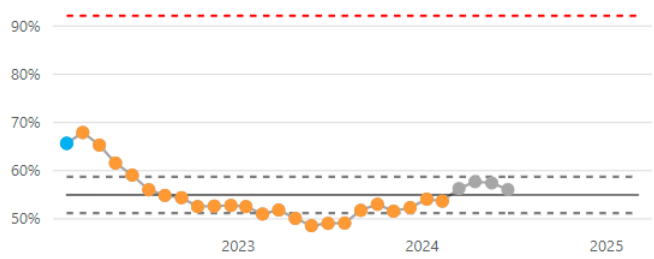
RTT 65 week wait: Total, Our Performance

Inconsistent	Improvement	37



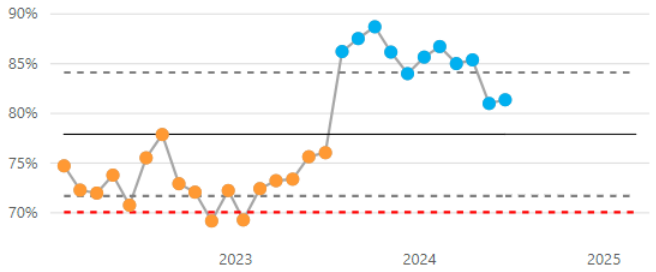
RTT under 18 weeks: Total, Our Performance

Not Met	Common Cause	55.9%



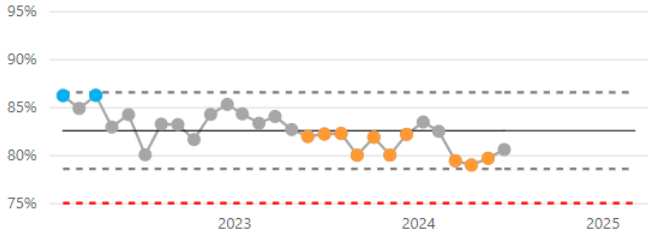
Urgent Community Response within 2 hours: Total, Our Perf...

Achieving	Improvement	81.3%



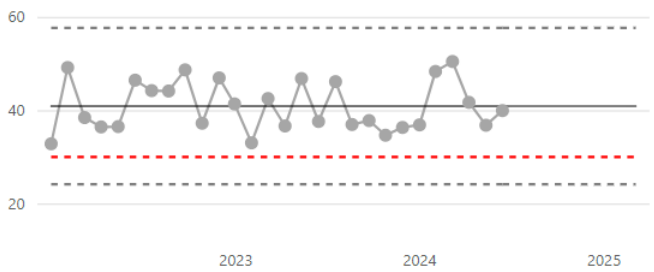
CHIC wait times < 13 weeks: Total, Our Performance

Achieving	Common Cause	80.6%



Intermediate Care Length of Stay: Total, Our Performance

Inconsistent	Common Cause	39.9



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, or treated and admitted within 4 hours; the Trust achieved 78.6 % against the standard in August 2024. Our national ranking was 31 of 124 trusts, putting us in the upper quartile.	• Continue to work with SeCAMB to ensure crews are not waiting longer than 15 minutes to offload • Focus on reducing time to triage and time to treatment. • Escalation of delays and pathways that are not working well with support of all divisions and site teams.
Patients in department over 12 hours from arrival to discharge	There was an increase in number of patients waiting over 12 hours from arrival to discharge, from 813 in July to 917 in August. 4 patients remained in ED for >12 hours following a decision to admit in August, an improvement on the July position.	• 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. • Continued 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 2.2 % in August, a deterioration from July.	• Maintain improvements in Ambulance handover recovery over 60 minutes whilst focusing on reducing over 45 minutes.
Non elective Length of Stay (LOS)	The Trusts non-elective LOS decreased from 5.14 days in in July to 4.53 days in August.	• Transfer of care – trialling eligibility criteria P2 pathway (community rehabilitation bed stay) • Choice policy to be relaunched • ICS developing model to move patients from P2 pathway to P1 where patients receive rehabilitation and reablement in their homes. The shift will be supported by setting up of a night visiting service • System development of 'TOC Pentagon Model' to be trialled to ensure all patients have a destination pathway assigned • Daily Discharge Ready reviews with senior MDT and partners for patients in the Acute Hospitals now implemented • East Sussex LLOS (long length of stay) over 30 days escalation call weekly with partners now implemented.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Cancer	The Trust delivered 79.3% against the Faster Diagnosis Standard in July versus a trajectory of 75% and the national target of 77% (by March 2025). We delivered 92.1% against the 31-Day standard versus the national target of 96% and 68.9% against the 62 day standard (versus a trajectory of 67.3%). The ESHT backlog of patients waiting over 62 days at the end of July was 7.5% of the total Cancer Patient Tracking List against Fair Shares target of 6.0%. The national position is 8.5%. The Trust continues to receive high number of urgent suspected cancer referrals and in July received 2751 referrals via the GP referral route. This is the highest number of monthly referrals recorded. The continuation of high numbers of referrals creates pressure on all phases of the patient pathway. Cancer pathways remain a Trust priority, and the clinical and operational teams continue to focus on all elements of the patient journey to ensure timely diagnosis and treatment for our patients.	• Detailed Divisional Cancer Action Plans underpinned by recovery trajectories in place • Regular Breach Analysis Reports circulated to identify bottlenecks in pathways. • Enhanced focus on patients early in the pathway to improve transfer dates to tertiary providers by Day 38. • Predictions of performance for in month and future month to ensure performance is aligned to the trajectory. • Implementation of a Tiering approach to challenged tumour sites to provide senior support to expedite pathways. • Root cause analysis to be completed for all 104+ patients to identify cause for delays, identifying trends and develop a plan to mitigate.
Elective Activity	In August the Trust delivered 118% of 2019/20 baseline activity levels.	• Outpatient productivity programme progressing with good progress reported • New initiatives in 24/25 include a focus on validation; 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 • Additional activity as a result of supporting system partners due to increase from September.

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 55992 patients on the PTL in August. This is an increase of 868 patients from July. The Trust has seen an increase in the PTL size over the last six consecutive months. RTT compliance reduced from 56% in July to 55.1% in August. Focus on reducing long waits continues. In August the Trust reported 24 patients who had waited > 65 weeks. Focus continues on eliminating 65 week waits and the Trust is expecting to report zero 65-week waits in 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. • Daily monitoring of the longest waiting patients to ensure pathways are progressing. • Exploring mutual aid, both via the ICS and the Digital Mutual Aid System, including PIDMAS with patients transferring to Independent sector providers on admitted and non-admitted pathways. • Increasing FOPA attendances to reduce FOPA waits.
Diagnostic DMO1	Although August DM01 performance reduced from 90.6% in July% to 88.6% THE overall waiting list size reduced (despite increasing referrals) from 9,597 in July to 8,362 in August. Significant improvement observed in MRI with the waiting list reducing from 2,657 in July to 1,842 in August. Breaches also reduced, from 410 in July to 122 in August.	• Cardiac Echo Waiting list size increased by 200, breaches increased from 211 to 542 in August as a result of WLIs being paused. Action plan in place to recover position and will include WLIs (mostly through CDC) and continued training of additional staff. • MRI position still the focus for improvement. Detailed action plan in place focussing on (a) utilisation (b) extended days (c) extra sessions • Further MRI placed at EDGH in September to relieve pressure (funded by NHS Sussex). Mobile CT in place at Conquest. • NOUS improving overall, but pressure remains on specialist scanning related to cancer diagnostics. • Endoscopy continue to deliver excellent performance. Surveillance patients being booked within recall month. • Audiology recovery ongoing. Steady at around 80-81% compliance.
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 Aug was 0 (compared to 94 in Sept 23). The number over 52 weeks is 135 (compared to 863 in Sept 23)	• On going recruitment to both clinical & administrative roles in Community Paediatrics. • Redesign of service continues to be explored including a digital overhaul of waiting lists.

East Sussex Healthcare NHS Trust

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

	Positives	Challenges & Risks	Author
Responsive	• In month deficit of £2,112k compared to budget of £2,121k, resulting performance aligned to plan in month. This takes the YTD deficit to £17,496k which is an adverse variance of £4,824k. On plan for second month in a row albeit with one off adjustments in both months. • ERF underperformance in month with actual of £8,717k excluding prior month catch up) compared to plan of £8,914k – however likely to exceed plan once we have freeze data for the month • Capital overspent by £561k, 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. • Pay Run rate reduction of £400k in month showing workforce initiatives having an effect. Second month in a row that sees reduction. (Agency down to £0.6m from £1m in Month 3) • Non Pay run rate returned to previous trend after one offs benefitted Month 4. • Overall Forecast lowered in this month due to M4-5 improved performance. • Financial Improvement Director in post and helping ESHT find more initiatives to improve position.	Risk adjusted forecast ranges from £43.6m (downside) to £14.9m (upside) deficit with a base case of £23.5m. For reference a straight-line extrapolation of the Month 5 run-rate would result in deficit of £46.2m which would be £34.5m 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 (£1.9m) in month 4 (noted the plan is phased based on CIP delivery and working days from a variable income perspective). Actual performance was a deficit of (£1.8m) or a favourable variance of £0.1m. YTD adverse variance of (£4.8m). Variance ytd is driven by Pay premium costs, unfunded escalation, Pay CIP and non-pay CIP, old year invoices, higher activity related non pay and Drug costs. **UoR:** Total YTD delivery of £4,680k against plan of £5,385k, an under-delivery of £705k. Largest variance is in operational productivity. External plan is phased more front loaded so external reported variance is £2.7m **Capital:** Capital expenditure in month 4 was £10.2m, £3.3m above plan. **Cash:** The timing of the receipt of cash has switched to the first of the month and this has eased the immediate pressure on the cash balance. 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

	Month (£'000)			YTD (£'000)		
	Plan	Act	Var	Plan	Act	Var
Income						
Contract income	36,492	36,394	*(98)*	180,727	181,193	*466*
Divisional	6,418	9,325	*2,906*	34,121	38,000	*3,879*
ERF	10,133	10,548	*415*	51,828	54,333	*2,506*
Total Income	**53,044**	**56,267**	***3,223***	**266,676**	**273,526**	***6,850***
Operating Expense						
Pay						
Permanent	(36,019)	(33,324)	*2,696*	(180,830)	(168,802)	*12,029*
Temporary	(1,309)	(4,149)	*(2,840)*	(6,746)	(22,011)	*(15,264)*
Total pay	**(37,328)**	**(37,473)**	***(145)***	**(187,577)**	**(190,812)**	***(3,236)***
Non-pay						
Drugs	(1,394)	(1,719)	*(326)*	(6,968)	(7,778)	*(810)*
TEDD	(3,788)	(4,389)	*(601)*	(18,939)	(20,323)	*(1,383)*
Clinical supplies	(4,539)	(5,379)	*(840)*	(22,793)	(24,963)	*(2,170)*
Purchased services	(987)	(706)	*281*	(6,026)	(5,323)	*703*
Finance costs	(2,677)	(2,717)	*(40)*	(13,386)	(13,472)	*(85)*
Other	(4,443)	(6,004)	*(1,561)*	(23,658)	(28,352)	*(4,694)*
Total non-pay	**(17,828)**	**(20,915)**	***(3,088)***	**(91,771)**	**(100,210)**	***(8,439)***
Total Expense	**(55,156)**	**(58,388)**	**(3,232)**	**(279,347)**	**(291,022)**	**(11,675)**
Surplus/(Deficit)	**(2,112)**	**(2,121)**	***(10)***	**(12,672)**	**(17,496)**	***(4,824)***
Memo:						
WTE (worked)	8,266	8,266	*0*	8,331	8,247	*(84)*

I&E position

In M5 there is a deficit of £2.1m compared to a deficit plan of £2.1m resulting in a breakeven position in month. YTD the Trust is adverse to a £12.7m plan by (£4.8m). A bridge of the current variance is set out on the next page.

M5 Note - In order to hit the deficit target of £2.1m year to date adjustments related to ERF/Direct Access and Baseline income were realised totalling £1.7m:

- Direct access/unbundled baseline (£0.5m) catch-up M1-5
- ERF Sussex baseline (£0.3m) catch-up M1-5
- ERF true up (£0.5m) one-off
- ERF prior year closing (£0.4m) One-off

Income

The position is surplus by (£6.9m) 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 £3.0m
- £0.5m C&V Drugs in M4
- £1m MSK M4 adjustment for Retained earnings.
- £1.7m Adjustments M5 (as above)
- TEDDS (tariff excluded drugs and devices) £0.8m

Expense

The Trust has a (£3.2m) adverse pay position ytd. This is driven by £1.0m unfunded Escalation costs in Litlington Ward/BIU, £0.8m Premium costs for EC staffing (Medical), and £0.4m Premium staffing costs in Theatres (ODPs), Medicine pressures £0.4 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 (£8.4m) 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 £0.4m, Theatre activity £0.9m, £0.3m WAC outsourcing (offset in income), Drugs £1.9m and CIP centrally held in M4 of £4.6m.

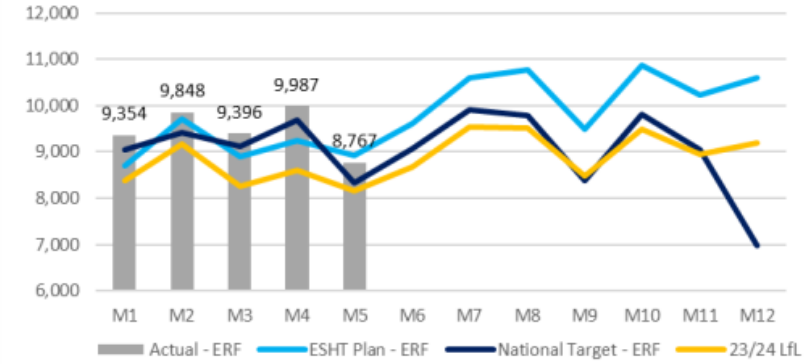
Finance | Variable income

East Sussex Healthcare NHS Trust

ERF performance

- The Trust over-performed its ERF plan by £0.2m in month with YTD over-performance of £1.9m. We expect this performance to increase as we report flex and freeze for previous months.
- Outside of this Ophthalmology (known coding issue in YTD) and general surgery have underperformed significantly.
- Other variable activity over-performed by £0.2m in month taking the total variable delivery to on plan in month and £0.6m over YTD.

ERF performance (£'000)



	In Month				YTD			
	Plan	Actual	Var		Plan	Actual	Var	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Daycase	3,176	3,105	(71)	(2.2%)	15,560	17,346	1,786	11.5%
Elective	1,684	1,726	43	2.5%	9,612	8,767	(845)	(8.8%)
Outpatients - First	1,722	1,579	(143)	(8.3%)	8,446	8,989	543	6.4%
Outpatients - Procedure	1,811	1,723	(88)	(4.9%)	9,140	9,305	165	1.8%
Ward Attenders	145	150	5	3.6%	820	744	(77)	(9.3%)
ERS	82	105	23	27.6%	396	523	128	32.3%
SPH	295	329	34	11.6%	1,504	1,678	174	11.5%
Prior month catch up	-	393	393	n/a	n/a	n/a	n/a	n/a
ERF activity	**8,914**	**9,110**	**196**	**2.2%**	**45,478**	**47,352**	**1,874**	**4.1%**
Unbundled diagnostics	642	786	143	22.3%	3,349	3,749	400	12.0%
Direct Access	263	301	38	14.4%	1,465	1,520	55	3.7%
Chemo	313	276	(38)	(12.0%)	1,535	1,712	178	11.6%
Prior month catch up	-	76	76	n/a	n/a	n/a	n/a	n/a
Other Variable	**1,219**	**1,438**	**220**	**18.0%**	**6,348**	**6,981**	**633**	**10.0%**
Total	**10,133**	**10,548**	**415**	**4.1%**	**51,826**	**54,333**	**2,507**	**4.8%**

	In Month			YTD		
	Plan	Actual	Var	Plan	Actual	Var
	£'000	£'000	£'000	£'000	£'000	£'000
General Surgery Service	658	560	(97)	3,407	2,988	(419)
Clinical Oncology Service	105	43	(62)	615	527	(88)
Ophthalmology Service	1,198	1,143	(54)	6,348	6,045	(303)
Clinical Haematology Service	228	175	(52)	1,213	1,086	(127)
Endoscopy service	615	565	(50)	3,190	3,129	(61)
Gynaecology Service	575	526	(50)	2,934	2,779	(155)
Neurology Service	149	110	(39)	661	752	91
Gastroenterology Service	258	226	(32)	1,094	1,389	295
Paediatric Service	155	124	(31)	962	692	(270)
Elderly Medicine Service	39	19	(20)	132	97	(35)
Maxillofacial Surgery Service	140	123	(17)	741	701	(40)
Transient Ischaemic Attack Ser	42	27	(16)	212	122	(89)
Cardiology Service	609	597	(12)	2,984	3,455	471
Diagnostic Imaging Service	8	0	(8)	27	0	(27)
Paediatric Surgery Service	10	2	(7)	52	46	(5)
Respiratory Physiology Service	46	39	(7)	159	509	350
Interventional Radiology Servi	6	0	(6)	175	229	54
Paediatric Trauma and Orthop	7	2	(5)	29	23	(6)
Orthodontic Service	37	34	(3)	144	146	2
Chemical Pathology Service	15	12	(2)	88	82	(6)
Paediatric Epilepsy Service	4	3	(1)	29	15	(14)
Acute Internal Medicine Servic	70	68	(1)	279	408	129
Hepatology Service	1	0	(0)	2	5	3
Trauma and Orthopaedic Servi	1,377	1,377	(0)	7,221	7,610	389
Plastic Surgery Service	-	-	-	6	-	(6)
Palliative Medicine Service	-	1	1	2	4	2
Paediatric Dermatology Servic	5	6	1	30	32	2
Cardiac Rehabilitation Service	-	1	1	-	24	24
Stroke Medicine Service	4	7	3	20	65	45
Rheumatology Service	237	240	3	1,088	1,160	73
Endocrinology Service	53	59	5	317	349	32
Anaesthetic Service	12	20	8	57	95	38
Vascular Surgery Service	35	46	11	243	250	8
BCSP	41	52	12	198	205	8
Dermatology Service	294	307	13	1,200	1,475	276
Respiratory Medicine Service	90	111	21	753	504	(249)
Diabetes Service	12	35	23	71	209	138
Ear Nose and Throat Service	353	384	31	1,673	2,013	340
SPH	295	329	34	1,504	1,678	174
Breast Surgery Service	204	250	45	1,073	1,228	155
General Internal Medicine Ser	14	81	67	122	376	253
Urology Service	916	1,012	95	4,426	4,845	419
Prior month catch-up	-	393	393	-	-	-
Sub total	**8,914**	**9,109**	**195**	**45,478**	**47,351**	**1,872**

Finance | Divisional summary

East Sussex Healthcare NHS Trust

Divisional position

Division	Variance to budget - M5							YTD overall Variance
	Contract Income	Divisional income	Pay	Non pay	Overall Variance	M4 Variance	WTE	
	£'000	£'000	£'000	£'000	£'000	£'000	WTE	£'000
CHIC	-	1	25	34	60	60	(8)	214
Core Services	52	93	203	(285)	64	(342)	(21)	(90)
Estates & Facilities	-	(31)	71	135	174	623	(2)	1,277
Medicine	504	(10)	86	(318)	262	(416)	+5	1,285
DAS	687	28	124	(156)	683	893	+3	(427)
Urgent Care	(61)	2	8	(98)	(149)	21	+13	(1,068)
WCSH	(119)	10	105	(76)	(80)	(22)	(34)	(297)
Corporate Services	-	13	(245)	(379)	(611)	(237)	(7)	(818)
SPH	-	9	54	(50)	13	188	(15)	131
Central/Trust wide	228	1,818	(576)	(1,896)	(426)	(723)	(17)	(5,031)
ESHT	**1,291**	**1,932**	**(145)**	**(3,088)**	**(10)**	**45**	(84)	**(4,824)**

- CHIC within plan and has mobilised Virtual Ward and Art of the possible.
- CORE Vacancies across most areas, especially Pharmacy. Drugs pressure in Month 4-5, analysis underway to determine inflation vs activity influence.
- E&F lower than planned Utilities costs in month and on going Hotel Services vacancies, also reflected in ytd position.
- Medicine Gastro activity in month offset partly by non pay Endoscopy activity and security costs overspent ytd. Overall pay on target, non pay security pressures, while Endoscopy/Gastro income underachieved ytd.
- DAS Theatre premium staffing costs for ODP's/Nurses lower in month but still £0.5m pressure ytd. Non pay theatres activity increased in month, ytd £0.8m. CI overachieving in month across all areas bar General and Breast with a ytd adjustment in Ophthalmology. Ytd overachieved by £1.0m.
- Urgent Care pressure in month against Security costs but pay in line with budget. Biggest driver of ytd £1m overspend is medical workforce in ED (premium costs), plus security costs.
- WAC vacancies offset by general non pay and CI off plan in month. YTD CI lower than plan.
- Corporate Pay overspent £0.3m due to Escalation costs. NP pressure of £0.4m due to IT contracts/liaison/SBS invoicing ytd.
- SPH slightly above plan ytd. Fire incident M3 result in £0.3m loss of income with partial recovery during rest of 24-25 forecast.
- Central is overspent on non pay due to holding the unallocated CIP circa £11.1m. Income over achieved due to M1-5 ERF/DA/Baseline income adjustment in month.

Finance | Capital

East Sussex Healthcare NHS Trust

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	Full Year Variance £'000
	Original										
DIG	Digital Programmes	108	153	45	465	321	(144)	3,182	3,000	Low	(182)
DIG	Our Care Connected	-	-	-	-	-	-	2,500	2,500	Low	-
	Total Digital	**108**	**153**	**45**	**465**	**321**	**(144)**	**5,682**	**5,500**		**(182)**
EME	Diagnostic Equipment	-	31	31	326	243	(83)	2,000	2,005	Med	5
EME	MSC Implementation	83	-	(83)	415	-	(415)	476	-	Low	(476)
EME	Medical Equipment	47	-	(47)	237	231	(6)	500	500	Low	0
	Total Medical Equipment	**131**	**31**	**(99)**	**979**	**474**	**(504)**	**2,976**	**2,505**		**(471)**
EST	Fire	166	327	161	830	536	(294)	2,000	2,000	Med	(0)
EST	Backlog	120	358	238	685	2,544	1,859	3,100	3,712	High	612
EST	EDGH Cat 3 Labs	12	1	(12)	49	1	(48)	125	125	Low	-
EST	ICU adaptations (Phase 1)	12	71	59	49	207	158	125	216	Low	91
EST	Clinical Priorities - Prior Year	24	43	19	98	363	265	250	480	Med	230
EST	Endoscopy (Internal)	39	-	(39)	156	-	(156)	400	400	Low	-
EST	Sussex Surgical Centre (Trust Funded)	189	-	(189)	4,519	-	(4,519)	16,000	16,000	Low	0
EST	Ward Refurbishment	8	(0)	(9)	17	340	323	250	500	Med	250
EST	Ophthalmology Business Case	-	151	151	-	444	444	1,766	451	Low	(1,315)
EST	Cardiology business case	-	149	149	-	1,260	1,260	3,500	3,608	Med	108
EST	Emergency Department - WIS	-	-	-	-	-	-	500	500	Low	-
	Total Estates	**571**	**1,100**	**528**	**6,402**	**5,695**	**(707)**	**28,016**	**27,992**		**(24)**
FIN	Divisional Small Works	12	(0)	(12)	58	5	(53)	175	175	Low	-
FIN	Minor Capital	-	141	141	130	141	11	500	432	Low	(68)
FIN	Planned slippage/prioritisation	(183)	-	183	(1,235)	-	1,235	(6,439)	(500)	High	5,939
FIN	IFRS16 Lease Schemes	-	-	-	-	-	-	-	43	Low	43
	Total Finance	**(172)**	**141**	**312**	**(1,047)**	**145**	**1,192**	**(5,764)**	**150**	-	**5,914**
	System Capital	**638**	**1,425**	**787**	**6,799**	**6,636**	**(163)**	**30,910**	**36,148**		**5,238**
	New										
EST	Building For Our Future	150	94	(56)	435	285	(150)	1,500	1,497	Low	(3)
EST	Sussex Surgical Centre (TIF Funded)	-	23	23	-	4,027	4,027	9,271	9,271	Low	-
DIG	Diagnostics Digital Capability (LIMS)	-	12	12	-	54	54	607	781	Low	174
DIG	Diagnostics Digital Capability (OCS)	-	-	-	-	-	-	547	216	Low	(331)
DIG	Diagnostics Digital Capability (Image Sharing)	-	-	-	-	(66)	(66)	1,500	1,500	Low	-
DIG	Frontline Digitalisation (EPR)	-	326	326	-	573	573	8,000	8,000	Low	(0)
EST	NHP - Enabling Fees	16	23	6	16	(9)	(25)	10,200	10,200	Low	(0)
EST	Endoscopy (External)	500	4	(496)	1,000	184	(816)	10,000	10,000	Low	0
DIG	AI Diagnostics	-	24	24	-	24	24	165	165	Low	-
DIG	CoIN Network	-	-	-	-	-	-	345	345	Low	-
	Total Additional Capital	**666**	**505**	**(161)**	**1,451**	**5,071**	**3,620**	**42,135**	**41,975**	**(160)**	**(160)**
	Total Capital	**1,305**	**1,930**	**626**	**8,250**	**11,706**	**3,456**	**73,045**	**78,123**	**(160)**	**5,078**
FIN	Donated Expenditure	85	24	(61)	425	89	(336)	1,000	1,000	Low	-
FIN	Donated Income	(85)	(89)	(4)	(425)	(89)	336	(1,000)	(1,000)	Low	-
	Total Donated Capital	**-**	**(65)**	**(65)**	**-**	**-**	**-**	**-**	**-**		**-**
	Total Capital	**1,305**	**1,865**	**561**	**8,250**	**11,706**	**3,456**	**73,045**	**78,123**		**5,078**

Capital

The planned capital allocation for 2024/25 is £73.0m.

The capital expenditure incurred at month 5 totals £11.7m.

Capital expenditure was largely driven by the following schemes:

- Medical equipment £0.5m, including diagnostic equipment.
- Estates works of £5.7m, the main schemes being, backlog maintenance (£2.5m), ward refurbishments (£0.3m), and cardiology services at EDGH (£1.3m).
- Building for Our Future £285k.
- Frontline Digitalisation £573k

The Elective Care Hub is scheduled to complete in February 2025 and is split funded in 2024/25 partly from system funding (£16.0m) 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 (£0.4m) and PDC funding (£10.0m). In year costs total £184k. In 23/24 £5m (national funded) was drawn down and spent.

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. The plan has been reviewed and the slippage reduced to £6.4m.

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	Trust Board	**Date of Meeting**	8 October 2024

Report Title:	Learning from Deaths
Purpose of the Report/Outcome/ action requested:	The Board is asked to note the Learning from Deaths update.
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐
Authority for Decision:	*N/A*
Executive Summary	The current "Learning from Deaths" report details the April 2017 – March 2024 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. 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. There are two reasons why we are behind with regard to learning disability deaths; firstly we recently discovered that 15 cases dating back over two years had not been discussed, we have now discussed six of them, with the remainder to review at the next meeting, there is also a considerable time lag from death to external completion of the LeDeR report, without which we cannot proceed.
Regulatory/legal requirement:	The reporting of "Learning from Deaths" to the Trust Board is a requirement in the Care Quality Commission review.
Business Plan Link:	Quality ☒ People ☐ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration
Resource Implication/VFM Statement:	N/A
Risk:	.

No of Pages	3	**Appendixes**	

Name, position and contact details of author:	Dr Simon Merritt Chief Medical Officer

Report Sponsor		**Presenter:**	Dr Simon Merritt

Governance and Engagement pathway to date:	N/A

What happens next?	The Mortality Review Audit Group continues to review the deaths with a higher likelihood of avoidability, on a quarterly basis, to ensure accuracy in reporting. Deaths going to inquest, SIs, Amber reports, complaints and “low risk” deaths are all reviewed for completeness The Board are requested to note the report. “Learning from Deaths” reports are presented on a quarterly basis

Publication	Published

Learning from Deaths Dashboard April 2017-March 2024 (Data as at 19/09/2024)

Department of Health

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

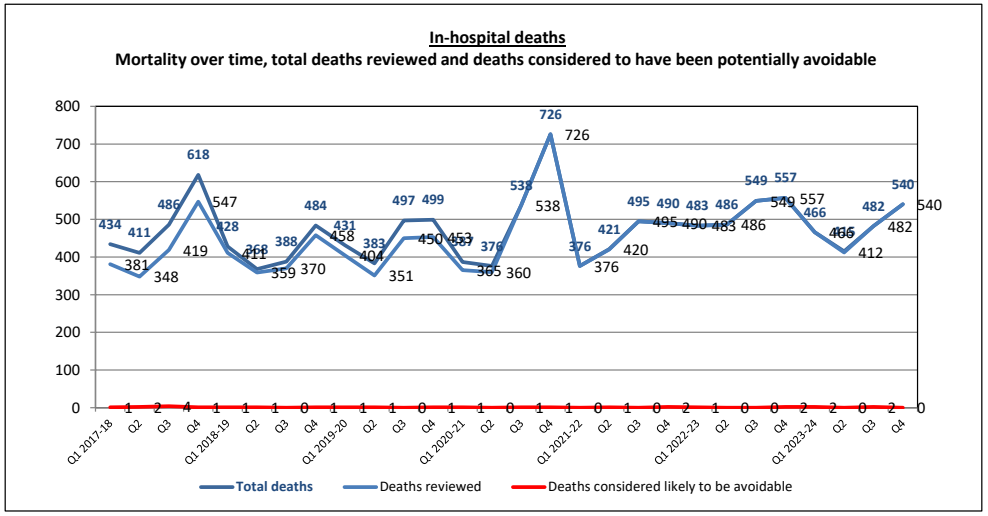
EAST SUSSEX HEALTHCARE TRUST: Learning from Deaths Dashboard March 2023-24

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 19/09/2024)

Time Series:	Start date	2017-18	Q1	End date	2023-24	Q4

Total number of deaths recorded in the mortality database - excluding Learning Disability		Total deaths reviewed by Medical Examiner		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
166	193	166	193	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
540	482	540	482	0	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1903	2075	1900	2075	4	3



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

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	14.3%	This Month	6	85.7%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	10.0%	This Quarter (QTD)	1	5.0%	This Quarter (QTD)	17	85.0%
This Year (YTD)	0	0.0%	This Year (YTD)	1	1.1%	This Year (YTD)	3	3.3%	This Year (YTD)	7	7.7%	This Year (YTD)	8	8.8%	This Year (YTD)	72	79.1%

Data above is as at 19/09/2024 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There was one care concern expressed to the Trust Bereavement team relating to Quarter 4 2023/24 deaths.This was not taken forward as a formal complaint.
Complaints - Of the complaints closed during Quarter 4 2023/24 which related to to bereavement in hospital, all had an overall care rating of 'good care' '.
There was one patient with an overall rating of 1 or 2, poor care. This case has been reviewed and the death was found to be definitely not avoidable.
Serious incidents - There were no severity 5 serious incidents raised in Q4 2023/2024.
As at 19/09/2024 there are 42 April 2020 - March 2024 deaths, still outstanding for review on the Mortality database.

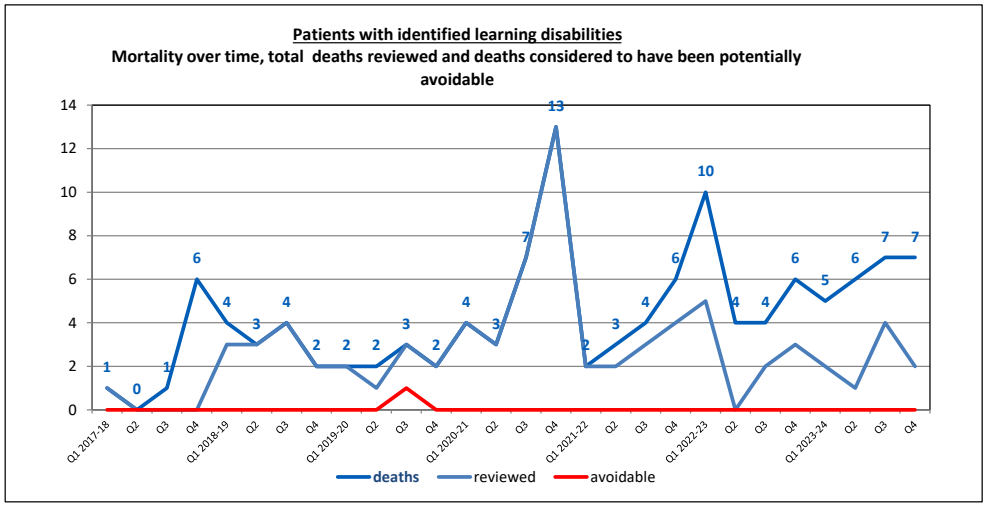
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 19/09/2024)

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	Q4

Total number of deaths recorded in the mortality database - Learning Disability		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	3	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
7	7	2	4	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
25	24	9	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.

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	Public Trust Board	**Date of Meeting**	8th October 2024

Report Title:	Maternity Services Overview Report – Q1 2024/25
Purpose of the Report/Outcome/ action requested:	The Trust Board is asked to receive assurance from the report about the quality and safety of our perinatal services; the report incudes an overview of progress in meeting the perinatal clinical quality surveillance standards and actions taken to proactively identify and mitigate any quality and safety concerns or risks.
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐
Authority for Decision:	As part of the National reporting findings and Clinical negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) requirement, all NHS Trusts are required to update Boards on the quality and safety aspects of our maternity services.
Executive Summary	This report provides an overview of Maternity planning, progress and activity during quarter 1 2024/25. ESHT Maternity and Neonatal services are managed effectively, and safety is maintained clinically. At minimum, a daily review of staffing levels takes place and our escalation plan is activated when required to ensure we maintain safe services. Recruitment and retention planning is an ongoing key part of service planning. Focus continues on reducing maternal and neonatal morbidity, we have seen an increase in women/people presenting with Mental Health and Safeguarding concerns and are currently reviewing service provision in line with the recent Birth Trauma report. Our three-year delivery plan includes targeted services in line with requirements within the Birth Trauma report. Focus continues to reduce health inequalities locally through our public health team and our Equity and Equality leads, supported by our Local Maternity and Neonatal System (LMNS), to ensure seamless service delivery between primary and secondary care. Perinatal mortality data shows normal variation and no cause for concern.
Regulatory/legal requirement:	NHSE compliance requires the Board to review and approve this report
Business Plan Link:	Quality ☐ People ☐ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration and identified within this report

Resource Implication/VFM Statement:	Not applicable

Risk:	During Q1, our main concern has been around staff raising concerns through the Speak Up Guardian regarding some aspects of poor culture and behaviours within acute services. Considerable action has been taken including listening events through the senior and executive teams, support has been offered and accepted through our OD and OH services and a commissioned external review is currently underway.

No of Pages	22 slides	**Appendixes**	Nil

Name, position and contact details of author:	Brenda Lynes, Director of Maternity Services brenda.lynes@nhs.net

Report Sponsor	Vikki Carruth, Chief Nurse & Executive Maternity Safety Champion	**Presenter:**	Brenda Lynes

Governance and Engagement pathway to date:	Ahead of this overview report being presented at Public Trust Board, this report and supporting informing reports were reviewed and approved via the Quality and Safety Committee 25/09/24 on behalf of Trust Board. Areas covered in this report were addressed in MatNeo Governance and Accountability monthly meetings, MatNeo Assurance Meetings and MatNeo Clinical Board.

What happens next?	This report is for assurance information. The subsequent quarter 2 2024/25 maternity services overview report is scheduled for presentation December 2024.

Publication	The report can be published.

Background

The Three-Year delivery plan for maternity and neonatal services sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families.

There was clear agreement from all key stakeholders on what the plan's focus should be, services are asked to concentrate on four themes:

- Listening to and working with women and families, with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support
- Standards and structures that underpin safer, more personalised, and more equitable care.

Delivering this plan requires the dedication of everyone working in NHS maternity and neonatal services in England who are working tirelessly to support women and families and improve care.

Issues

Workforce can still prove a challenge within maternity services during high activity/acuity and increasing numbers of cases where medical and social complexities means that despite staffing improvements the clinical floor can feel increasingly busy, a full midwifery workforce review (Birthrate+) commenced in March 2024. The maternity team continue to focus on improving the workplace culture, following considerable concerns raised by staff, with subsequent and extensive listening events held (including the executive team and safety Champions) a decision was made to commission an external cultural review which is currently underway.

A robust plan of action is underway to ensure Trust targets are met with regards to trust mandatory training with rates currently above 80% and a focus to reach our 90% target.

Consequences for not taking action

Not applicable, this report is for information and assurance.

Conclusion

There is good evidence to support that our services are managed effectively on a day-to-day basis as confirmed following the CQC visit in October 2022, staff compliance in line with national requirement for maternity specific training has been maintained.

Robust governance process has been maintained in line with our Perinatal Quality Surveillance process during the reporting period. Any risks are escalated through robust Trust process to confirm that ESHT Maternity services are managed and monitored effectively and safety is maintained clinically.

Recommendations

This report is for information and assurance and makes no recommendations.

East Sussex Healthcare NHS Trust

MatNeo Overview Board Report

Q1 2024/25 (April to June 2024)

KINDNESS

INCLUSIVITY

INTEGRITY

Author: Brenda Lynes, Director of Maternity Services

Trust Board in Public 08/10/24

Contents

Cover

East Sussex Healthcare NHS Trust

Theme 1 - Listening to and working with women & families with compassion

The Maternity and Neonatal department have substantial evidence demonstrating highly effective co-production and collaborative working to proactively and positively improve services for our women and birthing people. During Q1 we have launched our new maternity website and continued to work to improve our 24-hour visiting. Work continues to improve our Induction of labour pathway and ensure our staff listen and respond effectively to all our service users.

We are actively working to improve our Equity and Equality data and have resourced targeted services to support stopping smoking for pregnant people and their families, with robust surveillance services for those people at greater risk during pregnancy. A recent local review has identified a need to improve our weight management services, which will be a targeted approach in line with findings. We are also reviewing our pelvic Health and Perinatal mental Health services which supports our response to the Birth trauma review.
Finally, staff and service users are delighted that we reopened our Eastbourne Maternity Unit to intrapartum care on 2/9/24.

Service Evaluation of Stillbirths 2020 – 2024 – Findings:

- Rates equate to national rates for 25-29 yrs – Increased rates in distribution for under 25yrs, Lower rates than national group for over 35yrs
- 62.9% classed as overweight, with 42.8% with a BMI>30
- 37.8% smokers
- 24.3 lived in 10% most deprived area, 18.9% in 20% most deprived area (43.2% in bottom two deciles of multiple deprivation)
- Identified risk concerns Deprivation and Obesity
- Actions include focussed preventative work on healthy lifestyle education needs with targeted groups for those under 25yrs and those with raised BMI
- There is consideration for combining our vaccination program with Healthy lifestyle support in the future

Cover

East Sussex Healthcare NHS Trust

Theme 2 - Growing, retaining and supporting our workforce

Quarter 1 has seen a reduction in vacancy rate and increase in fill rates across services, providing good evidence that our recruitment and retention plan is effectively being delivered. Sickness has remained of concern, this is being actively managed. Red flags reflect our sickness rates with appropriate mitigation in place to manage services and mitigate risk for service users.

Our budgeted establishment is in line with Birthrate + (2022 analysis) and we have currently commissioned a further review (completion expected November 24)
Neonatal nursing and medical services and Obstetric medical services are all commissioned and delivered in line with national requirement. Our staff survey actions have included focussed work on improving PDR compliance, ensuring staff understand their role and have clear annual KPI's.

Continued recruitment and retention work to provide wellbeing services for staff includes the training of a further 10 midwifery staff to provide Trauma Risk Management support to staff (TRIM), further work is ongoing in regards to flexible working and self-rostering, with a current 1% vacancy rate focus continues on reducing time to hire, this has improved from 43.9days (May 2022) to 32.3 days (May 2024) within maternity.

Following a considerable number of staff raising concerns through the Speak Up Guardians regarding areas of poor culture within the maternity unit, a large number of listening events were held for all staff (including executive and Safety Champion listening events). A decision was taken to externally commission a review of culture within maternity services, this extensive piece of work has spanned over several months and is ongoing currently. Support systems have been and continue to be offered and provided to our staff during this time.

Cover

East Sussex Healthcare NHS Trust

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

Overall perinatal mortality rate (Stillbirth & Neonatal deaths(NND) and Hypoxic ischaemic encephalopathy (HIE) grade 2&3 are all showing significant improvement (continued low numbers). Stillbirth rate, significant improvement since Jan 24, NND since April 23, overall PMR since Jan 24 and HIE grades 2&3 since Sept 22. Improvements to care include high compliance with Saving babies Lives V3 care bundle.

Avoiding Term admissions to SCBU are just above national average for Q1 – a quality Improvement project to review admissions for respiratory distress is underway, plus an ongoing review of caesarean section rates. Focussed work to reduce health inequalities include targeted smoking cessation support, vaccine uptake and healthy weight management, whilst ESHT do not follow national trends for inequalities relating to Black and Asian women and birthing people, numbers are very small and focussed work continues.

Assurance is confirmed through the LMNS quarterly assurance group that full CNST compliance across all 10 safety actions for Q1

Main actions from MNSI and Serious Incident closures in Q1 are work to improve the process for non-attenders to ultrasound appointments, improved support to staff who require support following traumatic events and a full review of the pre-term guidance has been completed and disseminated to all relevant staff groups

Cover

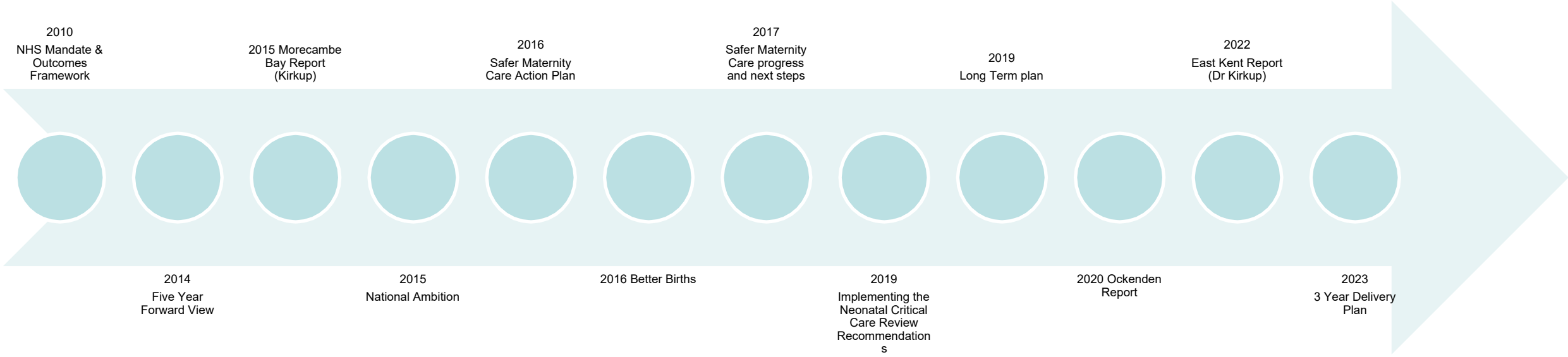
East Sussex Healthcare NHS Trust

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

There has been significant improvement across our partnership (Local Maternity and Neonatal System (LMNS) with improving oversight and assurance, driving significant joint working, data quality improvement, oversight of quality and safety and identifying areas to standardise and improve as a system through our Perinatal Quality Surveillance (PQS) Operating model, with significant work to improve our local dashboard.
At a local level, with regards to our Claims, Complaints and Risk scorecard and Perinatal mortality reviews, our data is evidencing that we are a learning organisation and for Q1 there were no avoidable perinatal deaths, there has been discussion through our annual training program (Prompt) to improve written communication within management plans for birthing people and that when a risk assessment takes place, previous history is taken into consideration. Part of this improvement is a continued quality Improvement process surrounding or electronic patient record system, Badgernet.
Considerable work has been undertaken during Q1 to ensure the appropriate use of translation services within maternity services.
A key action is for the CQC action plan to achieve 90% for Trust mandatory training, currently averaging at 75% during Q1, targeted work is ongoing.

East Sussex Healthcare NHS Trust

The Journey to a national Maternity and Neonatal Safety Ambition



The 3 Year Delivery Plan

East Sussex Healthcare NHS Trust

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

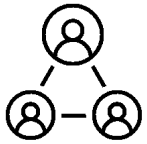
- Objective 1: Care that is personalised .....
- Objective 2: Improve equity for mothers and babies .....
- Objective 3: Work with service users to improve care.....

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

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

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

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



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

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

Three Year Delivery Plan: Theme 1

Listening to and working with women & families with compassion (Q1)

East Sussex Healthcare NHS Trust

Work with Service Users to Improve Care

- Regular on-site walkabouts with our Maternity voices partners
- Service user support surrounding the reconfiguration of Eastbourne Maternity Unit (EMU) –reopen to Intrapartum care 2/9/24
- Coproduced ESHT and MNVP action plan from service user themes
- Coproduced ESHT and MNVP action plan following the national CQC maternity survey – all actions progressing and to scheduled targets Agreed MNVP annual workplan 37 individual members of staff thanked by service users for going above and beyond

Our Service User Voice

You Said	We Did
• Provide clearer information on the induction of labour process	• We reviewed and updated our leaflets and added these to BadgerNet
• Clearer information on the discharge process	• Employed a Discharge Coordinator 5 days a week to support service users and advise staff
• Improve Communication	• We have totally revamped our maternity website • Spoken with staff about clear communication to our service users • Continuous review of our electronic records system to ensure clarity for service users • Increased our provision for infant feeding support • Clearer signposting to additional services

MatNeo CQC Survey (Outstanding actions)

Outstanding action to introduce our new Induction of Labour Pathway
Current work ongoing to standardised care across the LMNS including information to service users

Listening to and working with women & families with compassion

East Sussex Healthcare NHS Trust

Improving Equity & Equality

- Improved data collection
- Monthly equity and equality group
- Robust Public Health services within maternity
- Compliant with Saving Babies Lives (SBL) v3
- Vaccination programme in progress (pertussis, seasonal flu, RSV to commence 01/09/24)
- Targeted work on Folic Acid
- Targeted smoking cessation activity

Equity & Equality	10% most deprived				20% most deprived			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BME stillbirth rate Rate per 1000 births	0				0			
BME neonatal deaths Rate per 1000 births	0				0			
BME maternal death rate Rate per 1000 births	0				0			
BME Neonatal HIE diagnosis (brain injury) Rate per 1000 births	0				18.2 (1 baby)			
Smoking at booking National average 9.9% (2023/24)	21.98%				15.85%			
Smoking at delivery National average 7.4% (2023/24)	14.83%				11.65%			

2022/23 data

For the UK in 2022: Adult smokers: 12.9% total approx. 6.4 million (England: 12.7%)

7.4% of women were known to be smokers at time of delivery in 2023-24 as shown below:

East Sussex Healthcare NHS Trust

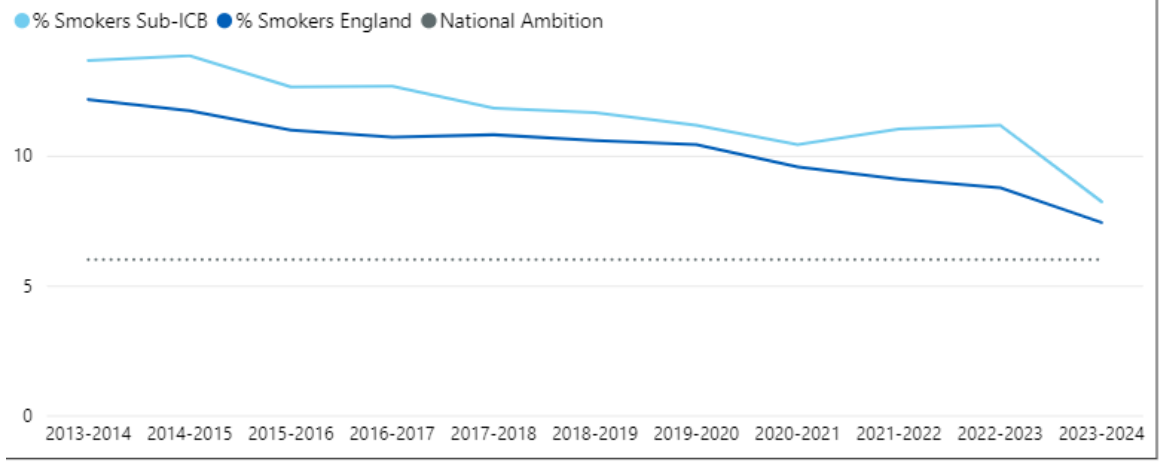
Statistics on women's smoking status at time of delivery, England, 2023-2024

NHS England

Select a Sub-ICB: NHS Sussex ICB - 97R

Select a Time Period: Annual

Percent of women that were smokers by year (for all years) | View by financial year | View by quarter

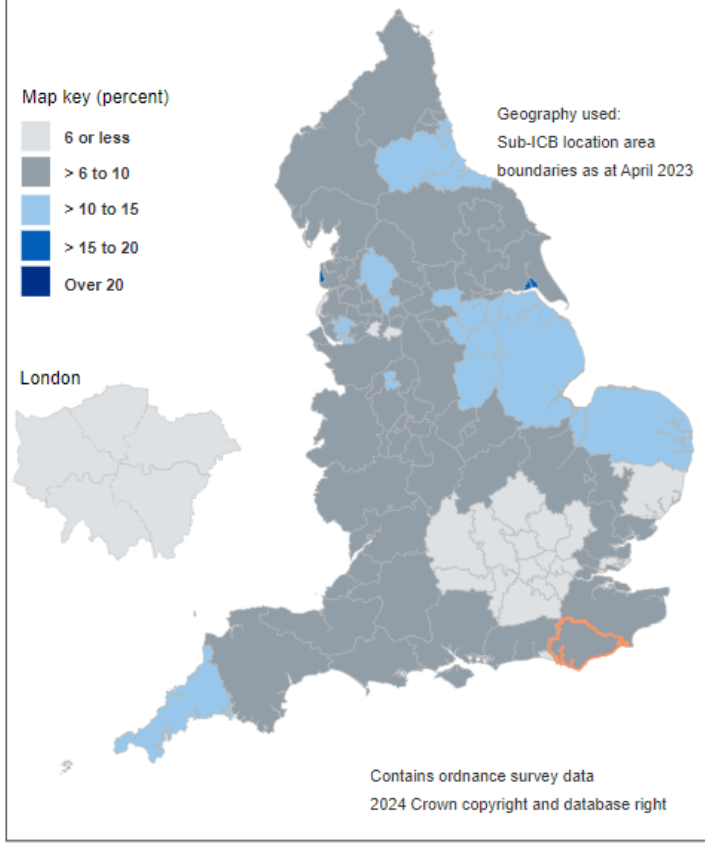


Sub-ICB Location, ICB and National comparisons (for selected period)

	Maternities	Smokers	% Smokers	% Unknown
NHS Sussex ICB - 97R	4,286	326	8.2	7.5
NHS Sussex Integrated Care Board	13,939	902	6.6	2.4
England	536,053	38,884	7.4	2.3

Source: Clinical Indicators and Outcomes, NHS England.

Percent of women that were smokers by Sub-ICB (for selected period)



Three Year Delivery Plan: Theme 2

Growing, retaining and supporting our workforce

Our workforce

East Sussex Healthcare NHS Trust

Maternity Workforce

	Q1	Q2	Q3	Q4
Birthrate Plus Acuity Compliance (National recommendation 85%)	83%			
Data Source	**Q1**	Q2	Q3	Q4
Birth to midwife ratio (National recommendation 1:21)	1:28			
Planned staffing levels	89.2%			
Sickness	1.9%			
Maternity Leave	4.7%			
Vacancy rate	1.6%			
Fill Rates	89.2%			

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

The BR+ workforce assessment was presented to the Board in June 2022. The Board agreed with the workforce assessment, with a headroom uplift of 26.4%. This is reflected in current midwifery workforce budgets as demonstrated in the extraction below.

	Q1	Q2	Q3	Q4
1-2-1 Care in Labour	100 %			
Supernumerary labour ward coordinator	100 %			

Three Year Delivery Plan: Theme 2

Growing, retaining and supporting our workforce

Our workforce

East Sussex Healthcare NHS Trust

Medical workforce: Obstetrics
- Consultants: Full compliance with RCOG Roles and Responsibilities (audited quarterly)
- Consultants: Compensatory rest, fully compliant with RCOG guidance
- Middle grades: full compliance with RCOG guidance on employing short and long term locums

Anaesthetic staffing
- 100% compliance Anaesthesia Clinical Services Accreditation (ACSA)

Neonatal staffing: Nursing
- Levels meet Operating Delivery network (ODN) levels (ESHT has a 12 cot SCBU)

Qualified in Speciality (QIS)				
Target 70%	Q1	Q2	Q3	Q4
	57.4%			
Action Plan in place with staff currently on training programme, expect to achieve by Q2 2025				
Vacancy rate				
	Q1	Q2	Q3	Q4
	7%			
Recruitment progressing				

Neonatal staffing: Medical
- Meet British Association of Prenatal Medicine (BAPM) national standards of neonatal medical staffing

Clinical Maternity Red Flags Q1	Action
• Unable to fill vacant shifts, unexpected absence/ sickness	Mitigated by use of escalation process and Bank usage
• Delayed commencement of Induction of labour	All cases are clinically risk assessment by the medical team prior to agreeing a delay

Three Year Delivery Plan: Theme 2

Growing, retaining and supporting our workforce

East Sussex Healthcare NHS Trust

Recruitment & Retention 3 year plan

Programme Aims
- Retention
- Psychological wellbeing and safety
- Recruitment
- Career mapping

Key risks & mitigations
- A review within maternity into leadership and culture has commenced (considerable concern raised by staff)
- Early intelligence indicated a gap in leadership skills at senior operational level impacting on the wider service within maternity
- Currently being explored via independent review and a series of listening evens during Q2 & Q3
- A commitment to investing in leadership development and training to secure psychological wellbeing and safety provided. To be informed by outcomes of independent review
- Significant support has been offered to our staff

Our workforce

Training Needs Analysis (TNA)

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

MatNeo Staff Survey Score report Positives

- Good focus on Incidents
- Increased PDR compliance
- Less people considering leaving the division
- Less work related stress
- Noted increased focus on wellbeing
- Ongoing engagement sessions

Learning Points
- Staff want to really know and understand their individual responsibilities
- Increasing MSK problems at work
- Staff feel worn out at the end of their shift

Actions
- Staff listening events held
- Results discussed with staff, who have been asked for their ideas for improvement

Three Year Delivery Plan: Theme 3

Developing and sustaining a culture of safety, learning and support

East Sussex Healthcare NHS Trust

CNST Maternity Incentive Scheme Safety Action		Compliance Q1
SA1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?	
SA2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	
SA3	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?	
SA4	Can you demonstrate an effective system of clinical workforce planning to the required standard? a) Obstetric medical workforce b) Anaesthetic medical workforce c) Neonatal medical workforce d) Neonatal nursing workforce	
SA5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
SA6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	
SA7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	
SA8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	
SA9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	
SA10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	

Three Year Delivery Plan: Theme 3

Developing and sustaining a culture of safety, learning and support

East Sussex Healthcare NHS Trust

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

	Q1	Q2	Q3	Q4
Rate	5.27			

Key action:
- Quality Improvement project for Respiratory Distress Syndrome(RDS) in progress
- Ongoing review of caesarean section rates – noted decrease in LSCS at 37 weeks

(above the national average rate for Q1)
- 94% were appropriate admissions – potentially with enhanced TC facilities

Transitional Care (TC)

	Q1	Q2	Q3	Q4
No	73			
Main treatments	• IV antibiotics • Treatment for Hypoglycaemia			
Actions	*Nil – 0 inappropriate admissions to SCBU*			

MDT Training target >90% at year end

CTG & fetal monitoring training competency	**Q1**	Q2	Q3	Q4
Combined Medic & Midwives	**98%**			
PROMPT compliance	**Q1**	Q2	Q3	Q4
Combined Medic & Midwives	90%			

Saving Babies Lives (SBL) V3 Q1 2023/24

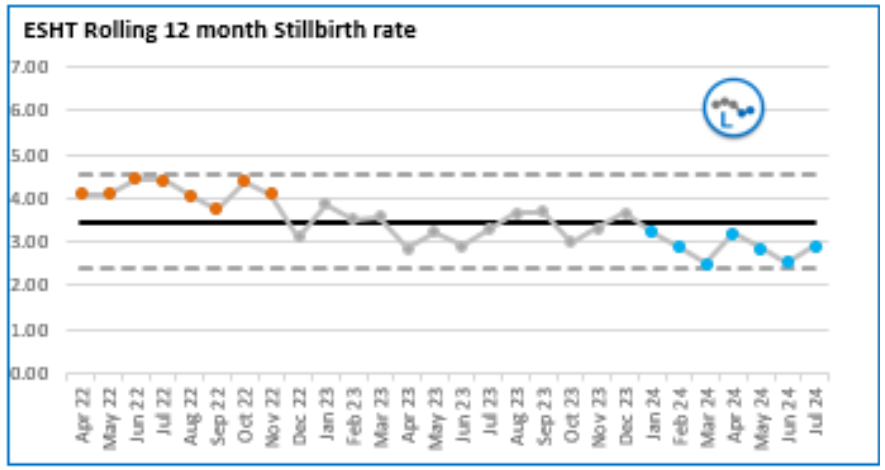
Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	93%	Partially implemented	93%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	96%	Partially implemented	96%	CNST Met

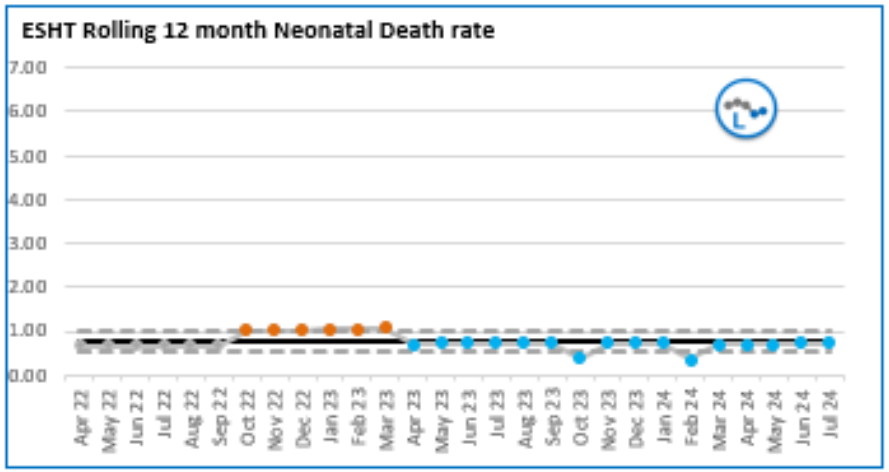
Three Year Delivery Plan: Theme 3

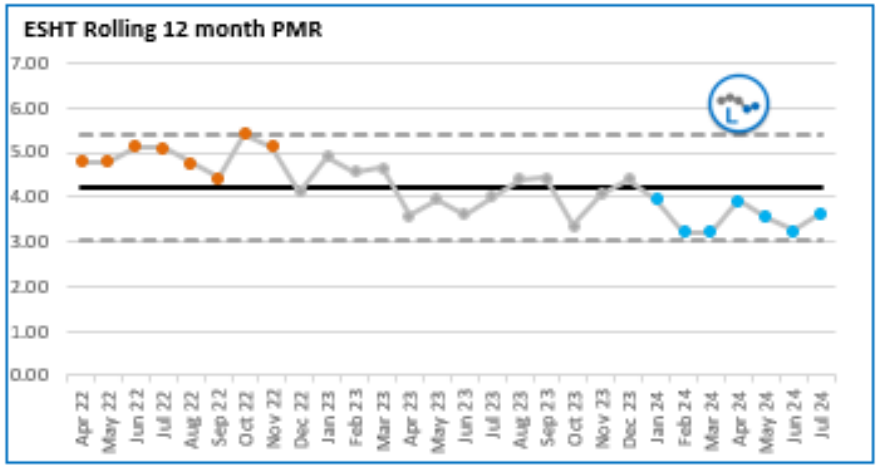
Developing and sustaining a culture of safety, learning and support

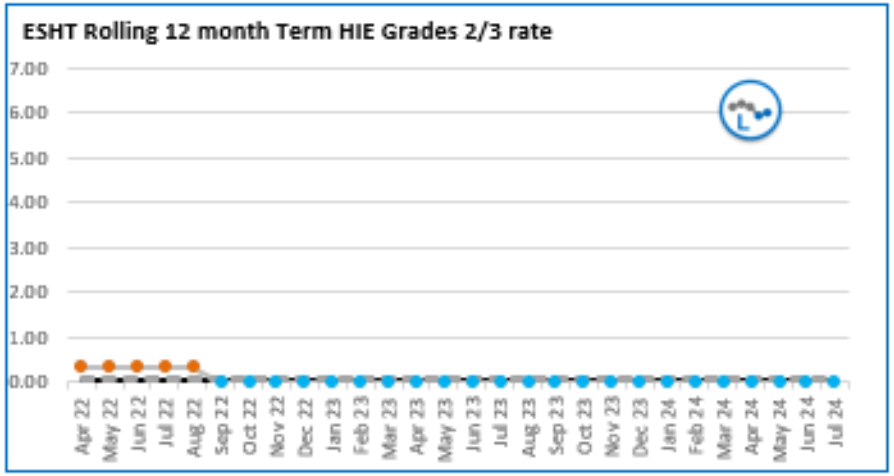
East Sussex Healthcare NHS Trust

Perinatal Quality & Safety









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

Significant improvements
Stillbirths, neonatal deaths, overall PMR and HIE grade 2 & 3 all show significant improvement due to continued shift of low numbers.

Stillbirth rates have shown a significant improvement since Jan 24, Neonatal deaths since April 23, overall PMR since Jan 24 & HIE grades 2/3 since Sept 22.

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

Developing and sustaining a culture of safety, learning and support

East Sussex Healthcare NHS Trust

Perinatal Quality & Safety

Closed Incidents		
Incident type	**Case detail**	**Recommendations/ actions**
Closed SI 143584 (2022)	Stillbirth 22+6	Work completed with MDT regarding DNA follow up for USS Increased staff trained to provide Trauma Risk management for MatNeo teams Preterm birth guidance reviewed, and staff updated to changes
154770 (2023)	Listeria monocytogenesis	Improved documentation for routine cleaning checklists in Obstetric theatres Refresher cleaning and disinfection refresher training for key staff Non-essential equipment removed from obstetric theatres Shared information and learning regarding the use of the deep clean rapid response team Increased staff trained to provide Trauma Risk management for MatNeo teams
142821 (2023)	Neonatal death; Maternal venous Infarct	Bereavement suite guideline review/ MDT update Eclampsia guideline review and MDT training Preterm birth guidance reviewed
Closed MNSI/PSII	Shoulder Dystocia at term (potential HIE case)	Coincidental finding to remind staff regarding guidance for managing reduced fetal movements No Safety recommendations : This case was managed in line with expected outcomes, MRI concluded no evidence of HIE

Three Year Delivery Plan: Theme 4

East Sussex Healthcare NHS Trust

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

MatNeo Claims, Complaints, Incident Scorecard
- Provides volume value and cause of claims over 10 years
- August 2023 = 51 claims made to value of £86,127,373

- Learning in Q1:
- no avoidable deaths
- Improve written communication for management plans.
- Ensure when risk assessing, previous history is taken into consideration.

PMRT
- 100% compliant with all standards

Key actions:
- Kliehauer rest added to departmental guidelines
- Improve MDT process for high-risk cases
- Reviewed pathway completed for a third episode of reduced fetal movements

CQC Inspection action plan
- Outstanding action:
- Achieve 90% for Trust mandatory training as listed in report (currently average 83%)

Birth Trauma Report: Ending the Postcode Lottery on Perinatal Care

- Report published by the All-Party Parliamentary Group (APPG) (13/5/24)
- NHSE highlighted that the implementation of the 3-year delivery plan for MatNeo Services was a requirement of the operational planning guidance for 2024/2025, NHSE requested Trust Boards review commissioning and Implementation of existing commitments which address recommendations within the report
- 17/5/24 NHSE recommended that Boards the review the commissioning and implementation of existing services in line with the 3-year delivery plan for Maternity and neonatal services (operational planning services 24/25), specifically services which address recommendations within the Birth Trauma report

Inquiry Objectives

1. Identify common features in maternity care (antenatally, during birth and postnatally) that contribute to birth trauma
2. Highlight examples of good practice, both in the quality of maternity care and in providing support to women/birthing people who have had traumatic birth experiences
3. Look at the impact of birth trauma on relationships, ability to bond with their baby and future decision making (e.g. having another baby/returning to work)
4. Find out whether current postnatal services to diagnose and treat women's physical and mental health problems are up to scratch. This would include, looking at whether severe obstetric tears are being diagnosed promptly, whether mental health problems are being identified at the 6-8 week check, whether perinatal mental health teams are accepting and treating women within an appropriate time frame
5. Develop parameters for understanding the possible economic cost of birth trauma, with a view to informing future research
6. Influence government policy by identifying areas where maternity care could be improved to minimise birth trauma and by highlighting ways in which postnatal support can be optimised to meet women's physical and psychological needs after traumatic birth

Key themes included:

- Failure to listen, Lack of consent, Poor communication, Lack of pain relief, Lack of kindness, Breastfeeding problems, Postnatal care, The impact of Covid, complaints and medical negligence

ESHT's commitments in line with the 3-year Delivery Plan include the provision of:

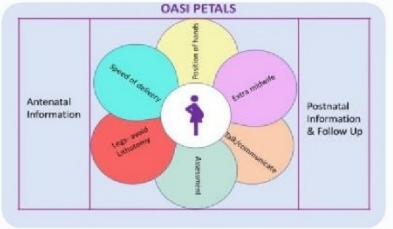
- Perinatal mental Health services
- Maternal mental health Services
- Availability of bereavement services 7 days per week
- Delivery in line with our LMNS Equity and Equality action plans, working across organisational boundaries

Current achievement and ongoing actions include:

- A pelvic Health service, including improved access to physiotherapy, early access to a specialist midwive and Urogynae clinics a robust training programme for staff, ongoing quality improvement which has seen year on year reduction of Obstetric anal sphincter injury (OASI). Further work is currently underway to ensure a one stop clinic provision in line with commissioning requirements.
- An established Perinatal Mental Health service has been established for 4 years within ESHT, this includes psychiatric, specialist obstetric and specialist midwifery input, nationally we have seen on overall 25% increase in demand for services over the past 2 years, as a result ESHT are currently reviewing the capacity and demand of current services.
- Bereavement services have been reviewed and an increase in capacity has enabled training of all operational clinical leaders within maternity, a core service is available Monday to Friday with Champions trained to manage bereavement services out of hours
- LMNS and local Equity and Equality action plans, allow for working across organisational boundaries with the support of our Maternity and Neonatal Voices Partnership, a quarterly progress report is available.

Work continues in collaboration with the LMNS and in line with our 3-year delivery plan to ensure full implementation. Please find a gap analysis of all areas within ESHT and wider system working either in progress or within a planning phase.

Annual PETALS Review August 2024



Headline news

- Lowest year since the launch in 2020
- Lowest rates in the LMNS
- Nearly 90 staff attended Episiotomy and suturing workshops over the past year
- Correct episiotomy scissors introduced last year.

2018 / 2019 67 OASI

July 2024 35 OASI

The Stats

Aug 2023 – Jul 2024 - Year 4 PETALS		
35 OASI for ESHT = 2.2% (National Average 3.2% - NMPA)	**18 Midwife led care** = 1.4% (National Average 2.5% - NMPA)	**17 Assisted births** = 5.2 (National Average 6.3% - NMPA)
LMNS rates	*12 month rolling – Under 32 / 1000*	This is amazing to see how well we are protecting our women and people against OASI. Don't take your foot of the pedal keep supporting them in Labour with the protective features
ESHT CQ and EMU	*11.15/ 1000*	
UHSx Worthing and st Richards	*39.54 / 1000*	
UHSx Royal Sussex County and Haywards Heath	*29.66 / 1000*	

Type of tear

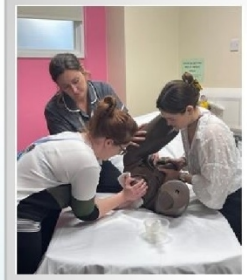
3a = 17 - SVD = 8
Assisted = 9

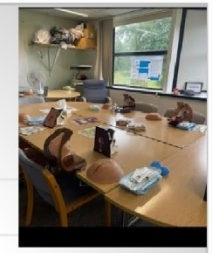
3b = 16 - SVD = 9
Assisted = 7

3C = 1 = SVD

4 = 1 = Ventouse.

4 Years of PETALS





	PETALS YR 1	PETALS YR 2	PETALS YR 3	PETALS YR 4
ESHT TOTAL	52	39	45	35
SVD	36	26	31	18
ASSISTED	16	13	14	17

Annual PETALS Review 30 August, 2024. Thank you to all staff for making best practice happen.

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	Trust Board	**Date of Meeting**	08 October 2024

Report Title:	Draft Health Inequalities Strategy 2024-27
Purpose of the Report/Outcome/ action requested:	The Board is asked to approve this strategy, the first of its kind for the organisation, in principle and subject to the final comments from members of the Trust's Inequalities Committee
Decision Action:	For approval ☒ For Assurance ☐ For Information ☐ For Discussion ☐
Authority for Decision:	Delegated authority for this paper sits with the Trust's Inequalities Committee (as a sub-committee of the Board)
Executive Summary	The Trust has sought to develop a strategy that, over the coming three years, sets out where we will seek to prioritise our efforts to tackle health inequalities among our patients. We recognise that, like many Trusts, we are starting from a low base, and our intention is to revisit and refresh this strategy over each of the three years to provide the detail for the coming 12 month monitoring period, using relevant data that reflects our evolving maturity in this area. To this extent, our aims for year 1 are ambitious while remaining realistic and reflect a range of areas from 'start up' (tobacco dependency, data quality improvement) to 'evolving' (smoking support in maternity). We include the additional areas for focus in years 2 and 3, and these will be developed as we refresh our approach annually and bring the updated strategy to Inequalities Committee, as noted above.
Regulatory/legal requirement:	We are required to have due regard to NHSE guidance on health inequalities data recording, and this is addressed within the strategy from year 1. There is no requirement for Trusts to have an inequalities strategy, but this is and increasingly common way in which Trusts are framing their ambitions.
Business Plan Link:	Quality ☒ People ☐ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration
Resource Implication/VFM Statement:	There are no additional pay or non-pay costs associated with the delivery of this strategy in year 1.
Risk:	Key risks include the ongoing operational priorities 'crowding out' capacity to develop several of the embryonic services/schemes included in the strategy. This risk is recognised in our Board Assurance Framework along with the requisite mitigations.

No of Pages		**Appendixes**	

Name, position and contact details of author:	Richard Milner, Chief of Staff richard.milner5@nhs.net

Report Sponsor	Chief of Staff	**Presenter:**	Chief of Staff

Governance and Engagement pathway to date:	Earlier versions of this paper have been shared with the Inequalities Committee, the Executive Leadership Team, the Trust's partnership forum and we have discussed its focus and remit with senior members of NHS Sussex.
What happens next?	Should the Board approve this paper it will be presented to the Inequalities Committee for final sign-off. This committee includes members of the Trust's staff network groups (Women's, (dis)Ability, Multicultural, Faith & Belief, LGBTQI+ and the East Sussex County Council Director of Public Health
Publication	This report is for publication on the Trust's website

Background

NHS trusts play a vital role in addressing health inequalities (HI) by focusing on providing equitable access to services and consistent levels of care. Taking a strategic approach is identified as a key enabler to making progress; it can provide a focused way to achieve longer term objectives aligned with the Trust's overall strategy and identify the opportunities and risks to making progress.

Equally, we recognise that the Trust is facing a year already replete with challenges, and so any strategy must seek to support operational effectiveness, rather than divert resource and focus from the 'core business' of the Trust. This strategy recognises the position from which we are beginning this journey and is therefore consciously light touch in this first year and reflects areas already underway.

Issues

We recognise that other Trusts have undertaken HI strategies and in preparing ours, have sought inspiration from others. As noted in the frontsheet we have engaged with a range of internal and external stakeholders, not just to share our thinking for their comments but also to raise awareness more widely that this is an issue of importance for the Trust.

In preparing this strategy, we have also had regard to the NHS Providers '*Review of NHS Trust strategies for addressing health inequalities*' (August 2024) as part of the development and have considered the good practice points contained therein. NHS Providers reviewed 40 NHS Trusts and noted that the most developed health inequalities strategies were characterised by:

1. Clear leadership and board buy-in
2. Being integrated in the wider context of the trust and system
3. Prioritised with clear measurable outcomes identified
4. Underpinned by data
5. Realistic with well-defined implementation plans
6. Patient centred
7. Focus on the need for a cultural shift

Taken in the round, we feel that this first year strategy addresses 1, 2 and 6, and partly addresses 3 and 5 (we can improve on the initial set of measurable outcomes in the strategy and the implementation plans are sitting with the teams). Addressing 4 and 7 more explicitly will come as our information improves and as divisional teams engage with this agenda, which we are driving through our performance meetings (HI steering group and divisional performance reviews) and our Inequalities Committee.

Consequences for not taking action

The two immediate negative consequences for not taking this forward are:

A failure to support NHSE and Sussex priorities, which means the Trust would not be adhering to our duty to engage as a constructive collaborative partner.

More significantly, we risk failing to provide inclusive services for our patients, a risk we have shared as one of the most important to the Trust (through our Board Assurance Framework). It is also one which has recently been articulated in Lord Darzi's report (in that vulnerable communities are disproportionately affected by health issues that has led to them not being in work) and Sir Chris Whitty's evidence to the Covid-19 enquiry, in which he noted the importance of tackling health inequalities in order to be better able to manage a pandemic on a similar scale. It is also worth noting here the Health Foundation impact enquiry of 2022, that reported inequalities in COVID-19 mortality persist with mortality rates 3 to 4 times higher in the most deprived areas.

Conclusion

That this report is approved as a practical and pragmatic strategy that starts the Trust on its journey to embed HI into the business of the Trust.

Recommendations

Board members are asked to consider and approve the final draft of the HI strategy 2024-27. Consistent with our approach around engagement with relevant stakeholders as regards this strategy, final sign off prior to publication will be through the Inequalities Committee.

NHS
East Sussex Healthcare
NHS Trust

Addressing Health Inequalities in East Sussex

2024-2027

Making a difference where it matters

Contents

Executive Summary

Our Addressing Health Inequalities Strategy sets out our vision to tackle the health inequity gap for our patients and communities across East Sussex over the next three years, with the emphasis on year one.

Health inequalities are “unfair and avoidable differences in health between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies[1].”

These inequalities influence opportunities for good health and how people think, feel and act, which subsequently determines the risk of people getting ill and influences the ability to prevent sickness or opportunities to take action and access treatment when ill health occurs.

They arise because of the conditions in which we are born, grow, live, work and age. They can manifest as longer waiting times, Do Not Attend (DNA) rates increasing and mortality rates rising in our communities. We know that this has been so unequally, for example in our catchment area, residents experiencing the most complex deprivation wait longer for some specialties (such as general surgery) than those less deprived.

[1]Kings Fund, What Are Health Inequalities? June 2022

As part of addressing these challenges, we will work alongside our communities to understand what matters to them and their experience of the services we provide.

Our ambition outlined in this strategy is to “ensure equitable access to our services and improve health outcomes for all our patients”.

It recognises that we are part of a complex system of health, care and wellbeing services and that we have a key role in ensuring health inequalities are reduced. This strategy is aligned with national and local strategies, including the NHS Sussex strategy Improving Lives Together and the trust’s strategic objectives namely:

- Improve health and health outcomes for local people, especially the most disadvantaged
- Tackling the health inequalities we have
- Working better and smarter and getting the most value out of funding we have
- Doing more to support our communities to develop socially and economically

This strategy sets out our immediate year 1 and medium-term aims over year two and three to guide our approach to delivery between 2024 and 2027. This is supported by four key objectives:

1. Make equity in health everyone's business at the trust
2. Identify and monitor health inequalities using data
3. Understand the causes of inequities and barriers resulting in them
4. Create change together with our partners and communities and measure its impact

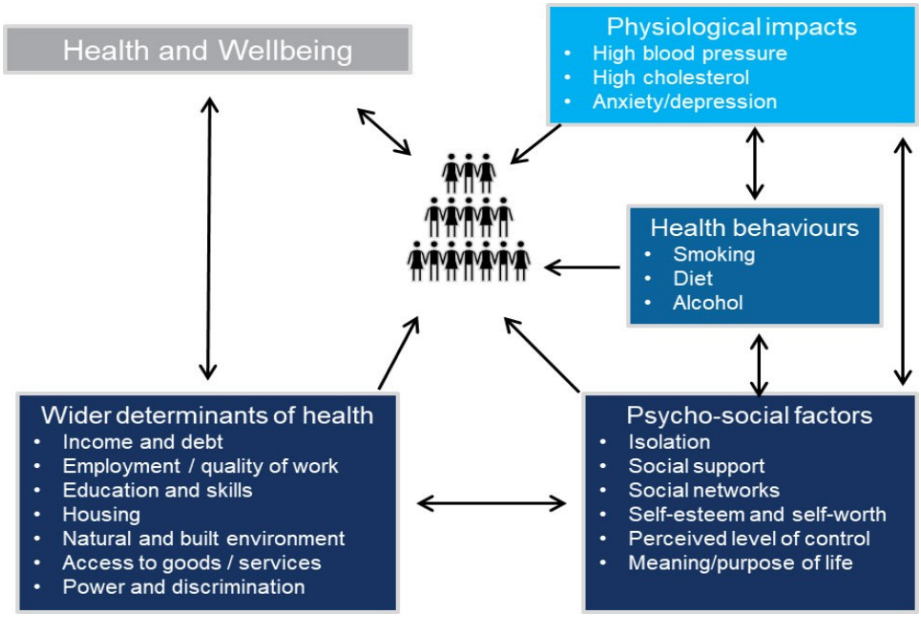
Programmes of work at the trust to address our ambition over the first year of this strategy include:

- The implementation of a tobacco treatment service for our inpatients
- The continued development of tobacco reduction service for maternity service users
- Review/analysis of DNA rates leading to identification of barriers that are driving these rates
- Review/analysis of cancer referrals, by tumour sites in our most deprived areas
- Review of the waiting lists by ethnicity and socio-economic deprivation
- Consider other areas for prioritisation re: elective waiting lists

Introduction

Inequalities (in terms of access and outcomes) to health are multifactorial, will rely on collaboration to resolve and are inherently linked to life expectancy.

Health inequalities nationally were already significant and widening pre-pandemic. COVID-19 has shone a light on health inequalities, replicating existing ones and in some cases further increasing them. Life expectancy has been observed as stalling and the gap between population groups growing, in East Sussex the gap in healthy life expectancy is around 10 years between the most and least deprived areas of the county[2].



Source: Public Health England, Place-based Approaches for Reducing Health Inequalities (2022)

The extra costs to the NHS of health inequalities have been estimated as around £5 billion a year from the greater use of hospitals by people in deprived areas alone, almost 20% of the total hospital budget[3].

Action on reducing health inequalities requires identifying those with or at risk of the worst health and improving their lives, fastest. Health inequalities are not caused by one single issue, but a complex mix of environmental and social factors which play out in a local area, or place[4].

A conceptual model is provided to the left of the causes of health inequalities.

There is, therefore, a critical role for local areas to play in reducing health inequalities across the life course, by taking a joined-up place-based approach. However, individual organisations also have a role to play in reducing health inequalities, and that is what this document is designed to set out.

From a healthcare provider perspective, there can be healthcare inequalities impacting on health outcome inequalities through, for example, inequities in terms of either access/availability of services (typically “When can I be seen?” or ease of engaging with services) and the experience of services (typically “What was the quality of service provided in the interaction?”).

[2]Improving Lives Together, NHS Sussex, 2023
[3]Public Health England, Place-based Approaches for Reducing Health Inequalities, 2022
[4]The New Statesman, ‘As inequality rises, life expectancy falls’ Feb 2024

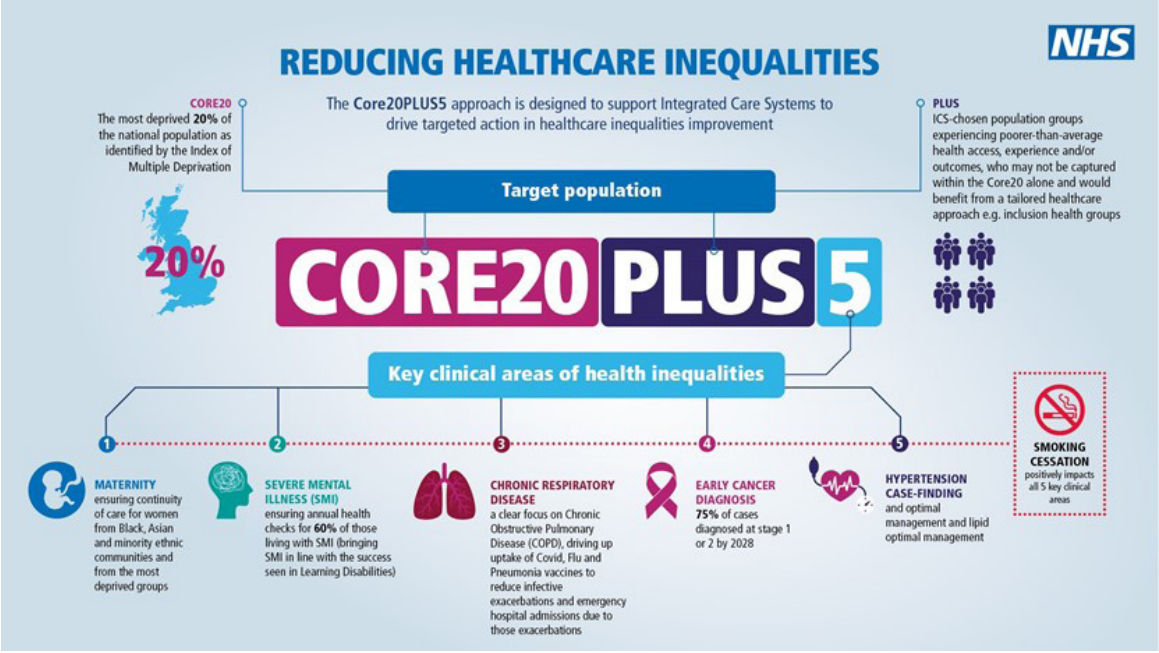
NHS Policy guidance on inequalities has been in development since the NHS Long Term Plan of 2019 and has regularly been included in the annual planning guidance.

The NHS Long Term Plan acknowledged the case for acting to reduce health inequalities and set out the key commitments to accelerate action. Subsequently commitments to health inequalities appeared in annual planning guidance as a key delivery area from 2022/23 onward. This sustained focus set the context for the development of the Core20PLUS5 approach to support the reduction of health inequalities at both the national and integrated care system (ICS) level.

A key strategic purpose of all ICSs is to tackle inequities in outcomes, experience and access.

As regards NHS Sussex, health inequalities has featured as a key element of System Delivery Plan in 2023/24. Following further developments in system management and governance, health inequalities and health improvements will be tracked at place (East Sussex) level.

The approach defines target population cohorts as outlined in the infographic below.



Inequalities in East Sussex

Our county skews older than the national average for England and Wales, but the typical picture of East Sussex as rolling countryside, relative affluence and a broadly homogenous population is an oversimplification of a far more complex socio-demographic and ethnic mix.

We have a good picture of our local health challenges. East Sussex is commonly seen as “older” than the England average and, while true, is far from a representative summary of the county. East Sussex certainly skews older than the UK average age distribution - and over the coming 15 years that gap is predicted to increase. The fastest-growing group will be the over 65s, whereas the forecasts suggest that children and young people and working-age groups will see comparatively low growth.

In terms of the distribution of this older population, it is spread widely across the county, and not always in areas of higher population density - areas around Crowborough, Uckfield and Heathfield have a higher percentage of over 65s, but significantly lower population density. The same is true for a stretch of the county around from Bexhill (higher density and higher over 65s) through to Battle and onto Rye (where the density is much lower, but there are higher over 65s in place).

Poverty and complex deprivation are greatest (both in scale/depth/extent and in absolute numbers affected) in Eastbourne, Bexhill and particularly in Hastings. There are pockets of ‘rural poverty’ linked to complex deprivation (notably toward the east of Rye, around Camber) but these do not come close to levels seen in the three largest towns in East Sussex.

Hastings has two wards where the level of complex deprivation is greater than Toxteth in Liverpool or Broadwater Farm in Tottenham. The ability to review patients attending by deprivation is therefore potentially as beneficial as a review of protected characteristics in terms of seeking to address inequalities experienced by our most vulnerable groups. This becomes evident when we consider other aspects of diversity in East Sussex.

Considering our population for other aspects of diversity, across the four district/borough council areas (Eastbourne, Wealden, Hastings and Rother) the data shows that, as perhaps we would anticipate, the greatest range of differences are seen in more urban areas:

- More residents stated they were veterans (between 3.9% and 5.3%) than those who stated they were members of the LGBT+ community (2.3% - 4.7%). The UK average for both is 3.8% and 3%, respectively so, overall, East Sussex is more diverse than the UK average. Both the Eastbourne (3.9%) and Hastings (4.6%) LGBT+ numbers were significantly higher than the UK average of 3%
- Fewer residents than the UK average of 9% said that English was not their first language. This was 7.3% in Eastbourne and 5.2% in Hastings (Wealden and Rother were 2.0% and 1.9% respectively)
- Trans community numbers were very close to the national average (0.5%) and varied between 0.2% and 0.5% of the East Sussex population

Our approach in ESHT

We have developed a governance approach to identify and track improvements in HI programmes line with our four objectives and are focusing on practical areas in year 1 where we can show the difference we are making through our services where it matters most.

We have established a Health Inequalities Steering Group (HISG) and Committee of the Board (the Inequalities Committee) to identify local inequalities priorities and to review and develop our service-led responses to these. The HISG meets bimonthly with a purpose to:

- Provide oversight and assurance to the trust's ExCom and Inequality Committee on action to address health inequalities, meet Trust Equality Duties and to embed delivery against the Trusts prevention and population health priorities across the Trust
- Support delivery of NHS Long Term Plan, Equality Act, Contractual and System priorities addressing health inequalities associated with CORE20PLUS5 and/or Planning Guidance
- Ensure that Trust action to address health inequalities recognises and addresses the factors which influence our ability to be healthy

It brings operational teams together to consider responses to the insights generated from our inequalities data[5] and to receive updates from teams covering inequalities priorities consiste with our 2024/5 contract (tobacco prevention in inpatients and maternity services and alcohol prevention services).

Considering year 2 priorities and beyond, we will work with community teams and NHS Sussex colleagues to ensure that we continue to identify areas relevant to both the trust and Sussex-wide ambitions.

Through the HISG we are focusing on **health behaviours** as well as **access to services**. Our approach aims to support managing the risk factors of patients and how we structure our services to address health issues across those categories where we know we can see inequalities manifest.

This approach is consistent with our contractual obligations and NHS Sussex priorities.

[5]The ESHT business intelligence team provide bi-annual updates of waiting time analysis by specialty, by site according to four criteria: gender, age, deprivation, and ethnicity

Our approach in year 1 considers:

- Examining maternal outcomes for economically disadvantaged women (vs national disparities)
- Reviewing the collection rates for information on ethnicity
- Creating and implementing a Tobacco Treatment Service for inpatients, as outlined in the NHS Long Term Plan
- Establishing a patient-focused hydration and nutrition improvement group
- Reviewing cancer referrals by tumour site and areas of deprivation
- Reviewing patient waiting times by site and specialty and tracking actions as appropriate
- Consolidating our approach to supporting veterans in the county needing access to our services

A targeted selection of these issues is shared with the Inequalities Committee over the course of the year.

Additionally, we are aware of position of one of the largest employers in the county and, supportive of the aims of East Sussex County Council we are addressing the need to attract and maintain local people within our organisation through an innovative approach to health-based apprenticeships, working alongside the Director of Public Health.

We already provide extensive data to operational teams and are looking to develop key performance indicators that monitor both qualitative and quantitative approaches.

Looking at our year one objectives, a basket of qualitative and quantitative KPIs that support our services and align with system priorities will include:

Quantitative 'hard' measures:

- 70% of inpatients referred to tobacco dependency team by Q4 2024/5
- Reduction in the "not known/shared" category when looking at patient ethnicity
- Reduction in the waiting times of the most deprived population (vs. average time over all cohorts)

Patient-focused outcomes and quality improvement:

- Improvements in patient outcomes from the tobacco programmes (maternity/inpatient)
- Increase in self-esteem (e.g. via Rosenberg Tool) for patients in the hydration/nutrition group

Our longer-term ambitions for inequalities

We want this strategy to be able to demonstrate progress from the first year, but also recognise the complexity of the issues we aim to address means we can do it neither alone nor in one year. It is important that we share how we see this strategy will make a difference over the next 2-3 years.

When we think of the impact that a strategy can make, one way of framing this is to ask, “So what will be different for residents in three years’ time”. In keeping with the overarching theme of this strategy to have a pragmatic and realistic set of ambitions, we identified three areas as worthy, deliverable and also ambitious aims around health inequalities.

We feel that these three, if we can deliver with partners, will genuinely make a difference for those local people who need us the most.

These areas will drive the year 2 and 3 iterations of this strategy, with our focus in year one being to establish the basics of a distinct approach to health inequalities that fits within our trust strategy and supports system priorities.

We will...		By...
1	Embed an inclusive approach across our core services	• *Ensuring clinical decisions have regard to wider health drivers* • *Showing outcome improvements as part of our regular KPI set*
2	Integrate Care around local communities through Place partnerships	• *Developing integrated care teams in the community as part of our stronger focus on care outside of an acute setting* • *Teams & pathways that reflect the lives of patients we care for*
3	Enhance our impact as one of East Sussex’s largest employers	• *Recruiting locally from a range of locations* • *Expanding apprenticeships to diversify our workforce* • *Building on our success in Project Search*

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	ESHT Trust Board	**Date of Meeting**	8th October 2024

Report Title:	Winter Preparedness 2024/25

Purpose of the Report/Outcome/ action requested:	The Board is asked to: • Note the work undertaken to date to develop the winter plan and the further work required to finalise the plan. • Note the plan is a live document and will be updated on an ongoing basis to reflect emerging changes throughout the winter. • Note the bed model to understand the impact of admissions avoidance, LOS reductions and demand management schemes is under continual review

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

Authority for Decision:	NHSE has asked Acute Trust Boards, through its Winter and H2 priorities Letter 2024, to review and receive assurance about general and acute core and escalation bed capacity plans for the peak winter period.

Executive Summary	This paper provides an update on the development of the Trust's Winter Plan for 2024/25. It sets out key areas of focus and draws on learning from last year. The Trust are working as part of the broader Sussex system to develop the 2024/25 Winter Plan which covers the requirements of the NHS England Winter letter and considers the specific needs of the Sussex system. As a Trust we have undertaken comprehensive demand and capacity modelling which enables us to quantify predicted bed requirements (including that required to maintain our elective activity) throughout the year and considers the impact of work focused on both reducing length of stay and the number of patients not meeting the criteria to reside in our hospital beds. The modelling includes assumptions in relation to covid, flu and respiratory syncytial virus (RSV) that are likely to adversely affect demand through the winter and the positive impact of proposed schemes to close the capacity shortfall. This winter the Trust will have the added complexity of ensuring the Fire Remedial works on both acute sites continue at pace. To facilitate these works a decant ward is required on both sites and means there is not the physical space to create an escalation ward. An 'Initial Winter Guidance and Preparation' letter was received on 23 August 2023 from NHSE South East which set out the initial areas of

	focus and highlighted the expected national areas of priority. Key focus areas from the initial guidance include: • Safety, quality of care and patient experience • Utilising the revised OPEL Framework • Reducing hospital handover delays • Capacity management review • Reducing inappropriate mental health placements. Additional guidance was received from NHS England on 16 September (available at: https://www.england.nhs.uk/long-read/winter-and- h2-priorities/) and this will be incorporated into the final plan. Over the next month we will continue to develop and finalise plans to support rapid access to health and care services over the winter period.
Regulatory/legal requirement:	N/A
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration
Resource Implication/VFM Statement:	N/A
Risk:	Initial modelling for winter indicates the Trust should be able to manage demand over the winter months within the existing bed base (including surge and super surge areas) providing the internal transformation schemes deliver. It should be noted the known challenges linked to length of stay and the number of NCTR patients continues to present an ongoing risk to the organisations plans.

No of Pages	4	**Appendixes**	None
Name, position and contact details of author:	Garry East, Deputy COO Tom Bayston, Programme Manager, Bed Strategy		
Report Sponsor	Charlotte O'Brien	**Presenter:**	Charlotte O'Brien

Governance and Engagement pathway to date:	Executive Leadership Team meeting on 2nd October 2024
What happens next?	Plan to be reviewed and updated on an ongoing basis (reflecting emerging changes over the winter months).
Publication	Public Board 8th October 2024

1. Introduction – Winter 2024/25

Each year, providers and systems are required to develop a shared Winter Plan as a means for coordinating system wide efforts and available resources, to support timely access for patients requiring emergency care during the winter months.

Over the past year, the Sussex system, like other systems across the country, has continued to see a sustained increase in demand for urgent and emergency care services. Performance at the Trust has continued to improve over the past 18 months and for the year to date, the organisation has delivered the 78% 4-hour emergency clinical access standard. For the winter period ahead, the Trust anticipates a challenging position driven by increased demand across primary, secondary, community and mental health services, increased acuity of patients presenting to our Emergency Departments, increased length of stay (LOS), high numbers of patients not meeting the criteria reside (NCTR) in the acute bed base, workforce challenges and financial viability.

These challenges will continue over the winter months and will as in other years be compounded by additional factors such as seasonally driven increases in illness (respiratory, norovirus etc), cold weather and the ongoing impact from the cost-of-living crisis.

ESHT is currently working to define a wider strategic journey which includes a 3-year ambition to reduce acute core bed stock with associated further investments in community services to support patients in the optimal place for their care. This document reflects the short-term operational plan for the coming winter 2024/25.

2. System approach to developing the Winter Plan

The approach to developing the winter plan has been driven by two key influences; national and local requirements.

Each year, national requirements for Winter planning are published, reflecting a response to the trends in operational pressures observed at a national level and the actions required to deliver national policy objectives. This year the guidance *'PRN01454 – Letter - Winter and H2 priorities'* was issued on 16 September 2024.

NHS England have set out several key requirements and expectations with NHS Trusts being asked to: review all general and acute escalation bed capacity plans, test 'full capacity' plans, ensure that fundamental standards of care are in place particularly in periods of full capacity and ensure that plans are in place to maximise patient flow throughout the hospital.

In addition to the national requirements, consideration has been given to specific priorities that best meet the needs of our local population (based on locally observed demand and capacity) and the governance arrangements required to ensure all parts of the system are working together to best mitigate risks thereby providing access to high quality, timely care for patients presenting to our services.

3. Trust Approach

As previously referenced, a robust demand and capacity modelling exercise has been undertaken. This modelling evidences the baseline bed requirement and is based on several assumptions including:

- Elective activity agreed for 2024/25 planning up to 123% of 2019/20 actual
- Non-Elective 2023/24 demand reviewed up to September 2024 plus additional growth at 3%
- Length of stay reviewed up to September 2024 as a baseline

3.1 Summary of bed Modelling

Conquest	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Bed gap based on 96% occupancy before any mitigation is applied	-41	-51	-56	-56	-42
Additional capacity created via use of 'Surge ' or 'super surge' spaces	18	18	18	18	18
Virtual Ward (increasing utilisation within existing capacity)	1	1	1	1	1
Unscheduled Care Navigation Hubs (into UCR)	1	1	1	1	1
SAFER Discharge	1	1	4	4	4
Rehabilitation and Reconditioning	0	1	4	4	4
Art of the Possible (investment in Acute Therapies and Home First teams)	14	15	15	15	15
Final Bed Gap	-6	-14	-13	-13	+1

At the height of our winter pressures the Trust assumption is that there will be a capacity gap of 14 beds at the Conquest site. The requirement for additional medical bed capacity will need to be achieved by using and implementing the length of stay opportunities in Geriatric Medicine, General Medicine and Gastroenterology.

EDGH	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Bed gap based on 96% occupancy before any mitigation is applied	-55	-70	-74	-74	-60
Additional capacity created via use of 'Surge ' areas	26	26	26	26	26
Virtual Ward (increasing utilisation within existing capacity)	2	3	3	3	3
Unscheduled Care Navigation Hubs (into UCR)	2	2	2	2	2
SAFER Discharge	2	2	7	7	7
Rehabilitation and Reconditioning	0	2	6	6	6
Art of the Possible (investment in Acute Therapies and Home First teams)	29	29	29	29	29
Final Bed Gap	+6	-6	-1	-1	+13

The bed modelling predicts the Eastbourne site will see its height in demand between December and February. Current modelling indicates the capacity gap will be mitigated providing the impact of the planned schemes is realised.

ESHT is continuing to pursue further plans to reduce inappropriate admissions, reduce LOS and to discharge patients on lower pathways (left shift) combined with working across the system to reduce the numbers of patients not meeting the criteria to reside (NCTR). The NCTR numbers in the Trust are frequently in excess of 200 making up more than 25% of the total occupancy of General and Acute beds.

The number of Discharge to Assess beds available to ESHT reduced to 50 from 83 on 1st April, this together with the closure of Litlington Ward at the EDGH site in July and the escalation beds on Murray Ward at Conquest from October (required for the fire safety works) have added to the pressures. The increase in capacity within the Acute Therapies and Home First teams associated with the closure of the two wards (Art of the Possible) is starting to impact in October as we see people arriving into post.

ESHT has put in place several projects which will impact the number of beds required. These include:

1. Working to implement an Unscheduled Care Navigation Hub as part of the Sussex wide work
2. Further work to develop Integrated Community Teams (ICTs)
3. Re-implementing SAFER Discharge practices within the wards across the two acute sites
4. Focus on Rehabilitation and Reconditioning aimed at maintaining patients on lower discharge pathways to reduce the numbers of NCTR patients currently being cared for in the Trust
5. Implementing a control centre to support management of our sites based on live data
6. Focus on reducing overcrowding in our Emergency Departments, and ensuring we are able to offload ambulances within 45 minutes.

ESHT plans align well to the proposed refresh of the NHS Sussex Discharge Programme expected in mid-October 2024. NHS Sussex will lead the Sussex Health and Care system in accelerating work in four key areas, in parallel. These are:

1. Following the national SAFER patient flow bundle across all hospital sites;
2. Supporting patients (anyone who is ‘at risk of deconditioning’) to stay active whilst an inpatient in a hospital (all settings) and developing a plan for how we can do better at reablement;
3. Optimising the three Transfer of Care Hubs we have in each Local Authority Area; and
4. Developing a needs-based demand and capacity model that is sensitive to population projections

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	ESHT Trust Board	**Date of Meeting**	8th October 2024

Report Title:	Discharge Update
Purpose of the Report/Outcome/ action requested:	The Board is asked to: 1. note the work undertaken to date to improve the flow of patients through their period of acute care in line with wider system priorities 2. note that this is work in progress at pilot stage currently and so some of the final details of the approaches are still in development
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☒
Authority for Decision:	The Board requested an update on discharge in the Trust following discussions at the Board Development Day in May 2024.
Executive Summary	This report summarises the Trust's approach to improving discharge processes across the organisation and alignment with the wider System plans. These approaches form part of the wider Bed Strategy and include: • The refresh and re-implementation of the SAFER NHS Bundle to improve discharge processes • Rehabilitation & Reconditioning approaches to maintain patient's independence and reduce risk/harm during their period of acute care • The Transfer of Care Hubs (TOCH), which aim to build capacity and competencies for discharge improvement and to align to the nine priorities for Care Transfer Hubs NHSE & DHSE, the Sussex wide discharge strategies and the internal ESHT Bed Strategy to assist in faster discharges on lower pathways. The East TOCH (hosted by ESHT) works with System partners to facilitate patients' discharge on appropriate discharge pathways. The re-implementation of SAFER and launch of the Rehabilitation and Reconditioning work is focussed on four pilot wards across both acute hospital sites during September with a planned wider roll out from October.
Regulatory/legal requirement:	N/A
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒

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

Resource Implication/VFM Statement:	N/A

Risk:	This work supports the wider work on the ESHT 3-year Bed Strategy and the operational plans for Winter Preparedness in helping to achieve the length of stay reductions required to manage within the existing bed stock. It should be noted that known challenges linked to the higher-than-expected number of NCTR patients continues to present an ongoing risk to the Trust's plans.

No of Pages	9	**Appendixes**	0

Name, position and contact details of author:	Tom Bayston, Programme Manager, Bed Strategy

Report Sponsors	Charlotte O'Brien COO Vikki Carruth CNO	**Presenters:**	Charlotte O'Brien COO Vikki Carruth CNO

Governance and Engagement pathway to date:	Executive Leadership Team meeting on 2nd October 2024

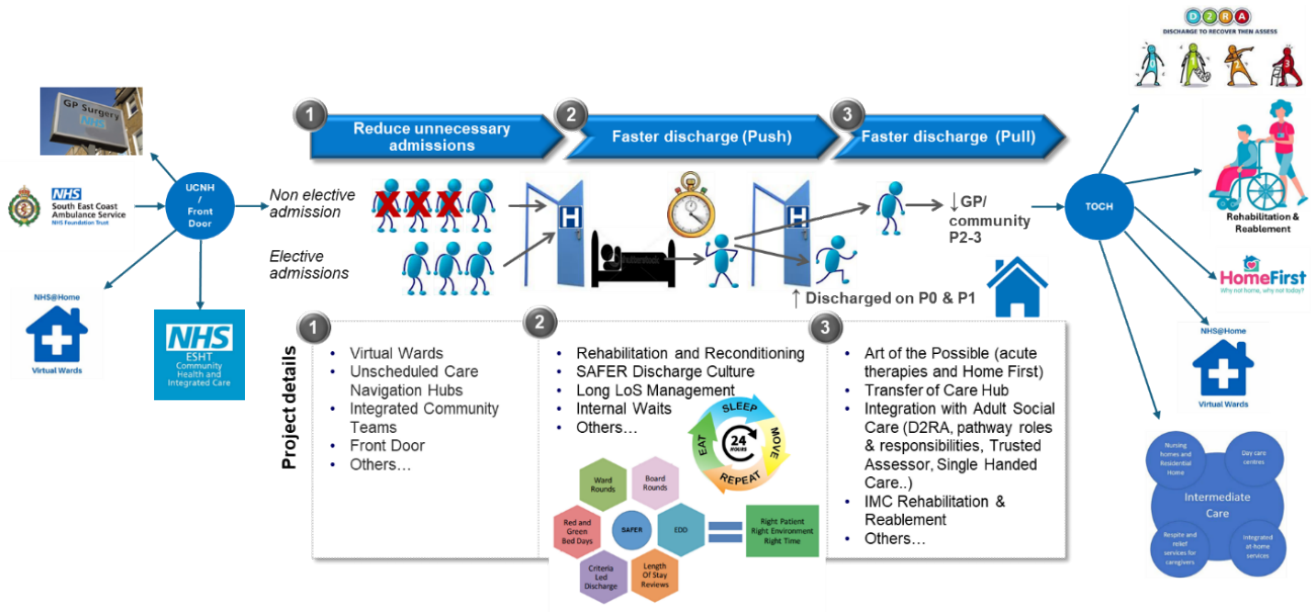
What happens next?	Plans continue to be developed with wider roll out of SAFER NHS Bundle and Rehabilitation and Reconditioning approaches across all wards

Publication	Trust Board (public) 8th October 2024

Overview

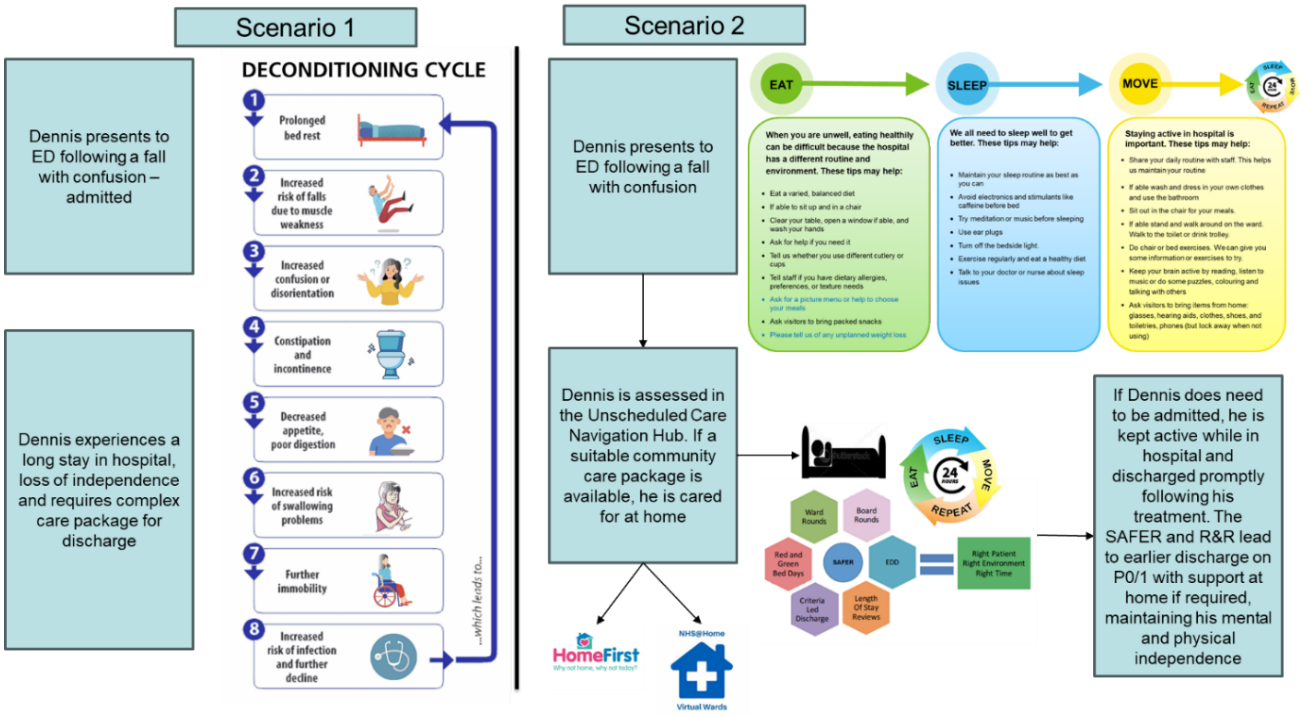
ESHT has put in place a renewed Bed Strategy which includes a structured portfolio of programmes and projects to make sure that:

- Patients are navigated to the most appropriate place for their care and clinically inappropriate hospital admissions are avoided
- Patients move seamlessly through their period of essential acute care with minimal waits and/or harm
- Patients are discharged as soon as it is clinically appropriate, on the right pathway and that there is capacity in the system to meet demand



The diagram above shows the overview of the bed strategy including the programmes and projects that have been designed to avoid clinically inappropriate admissions, navigate patients smoothly through their required period of acute care and support early clinically appropriate discharge to the right place to support any ongoing care requirements.

This paper focusses on ESHT approach to improving discharge for patients once admitted. We aim to streamline the management of patients during their period of acute hospital stay, focussing on improved discharge processes through the implementation of the NHS SAFER Bundle and to reduce deconditioning through our approach to Rehabilitation and Reconditioning, then discharge them appropriately to the most right/best place following their acute care utilising the Transfer of Care Hub where appropriate. We aim to move away from Scenario 1 (as set out overleaf) towards Scenario 2:



SAFER

For admitted patients, ESHT is in the process of re-launching the NHS SAFER Bundle to support the flow of patients and to improve discharge processes together with our Rehabilitation and Reconditioning approach to keep patients from deconditioning and reduce risk/harm while they are in their necessary period of acute care.

The NHS **SAFER** Bundle includes:

1. **S - Senior Review**. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
2. **A – All** patients will have an Expected Discharge Date and Clinical Criteria for Discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.
3. **F - Flow** of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.
4. **E – Early discharge**. 33% of patients will be discharged from base inpatient wards before midday.
5. **R – Review**. A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded patients') with a clear 'home first' mind set.

ESHT has relaunched pilots for the SAFER and Rehabilitation & Reconditioning work on four Care of the Elderly/Frailty and Gastroenterology wards across the two acute sites from September 2024 as these specialties showed higher than expected length of stay. (Wellington, Michelham, Seaford, MacDonald).

The SAFER work, led by Sue Allen, Assistant Director of Nursing for Medicine, has included workshops at both acute sites with Matrons and Heads of Nursing from the pilot wards. The following gaps were identified by the group in relation to the SAFER Care Bundle Standards as seen above.

1. **Senior Review**. Completing the Senior Review before midday and the challenges of the wards being able to do this at weekends. There is a need to standardised agenda for Ward Round and agreed terminology for the rounds e.g.
    - 09.00 – Board Round – quick meeting focussed on discharges
    - 12.00 – Ward Round – in-depth MDT meeting
    - 15.00 – Board Round – 'mop up' meeting

There is a need to agree processes for weekends – no senior consultant review and need better clarity and communication for what Virtual Wards can do. Solution could be criteria led discharge agreed on Fridays.

2. **Expected Discharge Date and Clinical Criteria for Discharge**, Patients are at times clerked by Junior Doctors which can slow the process. Supportive challenge needed for the Expected Date of Discharge (EDD) in gateway areas. Need NerveCentre to record the rationale for why the EDD is not met and the extended timeframe. Definitions required for EDD, Medically Safe for Discharge (MSFD), Medically Fit for Discharge (MFFD). Do we enact the “Choice” policy? Are we too risk averse? Do we involve the patient enough?
3. **Flow**. The Discharge Lounges are frequently required/used overnight for bedded care which reduces flow the next morning and there are a significant number of patients who do Not meet the Criteria To Reside (NCTR).
4. **Early Discharge**. Discharge letters and to-take-out drugs (TTOs). Awareness of the discharge lounge and what they do. Transcribing training being more accessible but may not be needed with Electronic Prescribing and Medicines Administration (ePMA).
5. **Review**. Minimal gaps identified as ESHT already has good MDT meetings in place supported by the Transfer of Care Hub (TOCH)
6. **Red2Green Days**. There is a need for clarification of purpose and consistency of application.

The following Standards were agreed by the group in correlation with the Care Bundle gaps.

1. **Senior Review**. All board and ward rounds will have a senior registrar or consultant undertaking the patient review, with a quick board round am and pm led/supported by the Matron or Senior Nurse on the ward. Aim is to keep the morning Board round and afternoon mop up Board Round to 15 minutes with a particular focus on discharge and Red2Green.
2. **Expected Discharge Date/Medically Safe for Discharge Date**. The EDD will be set within 24 hours of admission to the gateway areas and revised again on the downstream/speciality ward. The EDD/ (maybe MFFD) should be agreed by a senior and the EDD time will be a set as standard after the ward review.
3. **Clinical Criteria for Discharge**. First patients will arrive on the ward at 11:00 am. The discharge lounge will be ring fenced overnight.
4. **Flow**. 33% of patients will be discharged before Midday.
5. **Early Discharge**. This standard could be linked to the work being undertaken by the Internal Waits group who are looking at reducing delays due to TTOs and imaging and diagnostics.
6. **Review and Red2Green Days**. These will be recorded at the Board Rounds and reviewed at a ‘wrap up’ board round by 4:00pm.

Measuring the success of the SAFER NHS bundle implementation involves tracking several key metrics to ensure that the intended improvements in patient flow and discharge processes are being achieved. Below are some effective ways to measure success:

- **Length of Stay (LOS)**: Monitor the average length of stay for patients. A reduction in LOS indicates that patients are being discharged more efficiently.
- **Discharge Before Midday**: Track the percentage of patients discharged before midday. The target is to have at least 33% of discharges occur before noon.
- **Readmission Rates**: Measure the rate of (related) patient readmissions within 30 days of discharge. A stable or reduced readmission rate suggests that patients are being discharged appropriately.
- **Senior Review Compliance**: Ensure that all patients receive a senior review before midday. High compliance rates with this practice are crucial for timely decision-making.
- **Red2Green Days**: Use the Red2Green days tool to identify and reduce delays in patient care. Track the number of red days (days when patients are not receiving active treatment) and aim to convert them to green days (days when patients are receiving active treatment).
- **Patient Flow Metrics**: Monitor the flow of patients from assessment units to inpatient wards, ensuring that the first patient arrives on the ward by 11 am.

- **Multidisciplinary Team (MDT) Reviews**: Conduct regular MDT reviews for patients with extended lengths of stay (more than 7 days) and track the outcomes of these reviews.
- **Patient and Staff Feedback**: Collect feedback from patients and staff to identify areas for improvement and to gauge the overall effectiveness of the SAFER bundle implementation.

By consistently measuring these metrics, ESHT can identify areas of success and opportunities for further improvement, ultimately enhancing patient care and operational efficiency.

We aim to finalise the approach through the work on the pilot wards during September and early October and develop the roll out plan to further wards from October. Early feedback from the wards suggests that senior registrar or consultant input into the morning ward rounds is vital for decision making but attendance at the morning board rounds is variable across the wards, with some having very good engagement and attendance at all 3 ward and board rounds each day. Escalation processes are in place and the ward rounds are included in consultant job plans. In gastroenterology the consultants rotate every 2 weeks which causes some issues around consistency. Where we have had good engagement, we have already seen the impact on ward length of stay reducing.

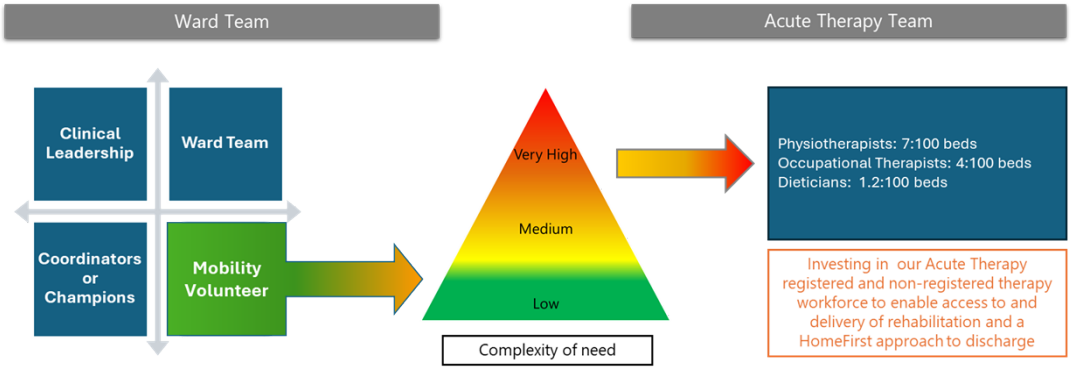
There are also high numbers of patients not meeting the criteria to reside (NCTR) especially in the Frailty wards, which impacts on the Red2Green measure as these patients will almost always be red. There is still further work required to develop the criteria led discharge approaches as there needs to be absolute support from all clinicians.

There is a cultural change required to embed this approach. Coaching to Matrons and Senior Nurses in leading the Board Rounds effectively to maximise the use of time, Senior Medical input, criteria led discharge especially over the weekends, use of discharge lounge and places for referral such as Virtual Wards and Home First.

Once the pilots are completed the aim is to roll out to further wards during October including Tressell, Glynde, Decham and Jevington wards.

Rehabilitation & Reconditioning

This work is jointly led by Claire Bishop, Deputy Chief Nurse and Anne Canby, Assistant Director of Allied Health Professionals, aim of this work is to ensure delivery of proportionate tiered matched model of rehabilitation and reablement for patients whilst in acute beds.



Needs based model of care: ***'Deconditioning Prevention is Everybody's business'***

Rehabilitation aims to increase access to timely, appropriate quality rehabilitation and increase dosage based on need to improve outcomes for patients, maximise recovery and minimise ongoing needs on discharge.

Reconditioning approaches are to ensure all patients in acute bedded care have a personalised activity/mobility plan that is being met through a tier matched model of care - supported by therapy for complex patients and the ward team for less complex patients supported by a volunteer workforce.

The scope of this work currently is to pilot for SAFER and Reconditioning will be 4 wards initially (Wellington, Michelham, Seaford, MacDonald). Followed by a phase 2 roll out on 5 additional wards (DeCham, Baird, Westham, Jevington, Devonshire). All patients on these wards will be included, as there has been no reason to

identify patient exclusion criteria for reconditioning. The pilot will last for 1 month with a view to rolling out activity further if deemed successful. Pilot launched 02/09/2024 (Reconditioning). Rehabilitation focus will be across all wards in the acute setting.

KPIs have been identified to monitor and record progress with this work. These include:

- % of patients discharged on pathway 0/1 (left shift)
- % of patients dressed by lunchtime
- Ward activity levels, including number of patients sitting out of bed for meals
- Harms relating to deconditioning (tools now in place)
- Time waiting for pathway 2 (target 2 days max)
- Therapy response times

Benefits of this work include:

- Patients will be less likely to experience detrimental deconditioning whilst in hospital for their care, because of improvements in their activity levels.
- Patients and staff will understand the importance of maintaining activity levels whilst in hospital to avoid risks/impacts of deconditioning.
- Patients will access rehabilitation assessment and intervention in a timelier way which will improve their health outcomes and onward patient journey.

The programme will be delivered in 2 phases. The initial pilot will begin in September (02/09) on 4 wards and will last for approximately 1 month. Following a feedback and evaluation process, the second phase will begin for a further 1-month period, rolled out onto an additional 5 wards. Rehabilitation is focussed across all wards in the acute setting. There are 2 separate working groups delivering the project (Rehabilitation and Reconditioning). The working groups will report into the Rehab and Reconditioning Steering Group fortnightly. The Rehab and Reconditioning Steering Group will provide reports to the Faster Discharge (PUSH) lead. Should the pilot phases be considered successful (see success criteria measures), the aim will be to roll out the principles of rehab and reconditioning across the Trust.

Transfer of Care Hub

The TOCH aims to build capacity and competencies for discharge improvement and is developing plans to align to the 9 priorities for Care Transfer Hubs NHSE & DHSE, the Sussex wide discharge strategies and the internal ESHT Bed Strategy to assist in faster discharges on lower pathways. The TOCH works with system partners to facilitate patients discharge on appropriate discharge pathways.

Transfer of Care Hubs are designed to streamline the discharge process from hospitals and ensure patients receive the necessary support and care once they leave the hospital. These hubs act as a central point where various services such as acute care, community care, primary care, social care, housing, and voluntary services are coordinated to facilitate smooth transitions for patients.

Key features of Transfer of Care Hubs include:

- Multidisciplinary Teams: The hub is designed to work with health and social care professionals, therapists, discharge coordinators, and third-sector agencies working together with an on-site acute presence.
- Early Discharge Planning: Planning for discharge begins early, from the point of admission, to ensure that patients and their families are well-informed and prepared. Implementing and refining Rhythm of the Day process, weekly escalations and complex case reviews with daily system-level NCTR reviews, including Divisional focus, weekly LLoS escalation, and ESHT complex case reviews.
- Coordination of Services and strengthening of place-based relationships, escalation and governance requirements: The hubs link all relevant services to support patients during and after discharge, aiming to prevent unnecessary hospital readmissions linking with UCR and VWs.

These hubs are part of a broader strategy to improve patient outcomes and efficiency within the healthcare system.

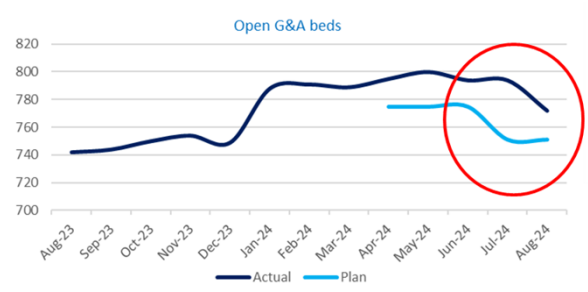
Work is also underway to align our approaches with the wider East Sussex System plans (East Sussex Discharge Improvement Plan 2024/25 and the NHS Sussex Discharge Transformation Plan 2024/25 including:

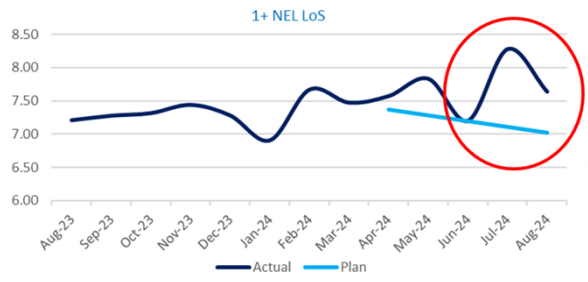
- Move to a full **Home First Discharge to Recover and then Assess** discharge model and refocus existing assessment resources to support our intermediate care pathways (P1 and P2)
- Rehabilitation and Reconditioning approaches to enable earlier and consistent mobilisation of patients in acute hospital beds to reduce deconditioning and increase Home First demand
- Supporting clinical teams to make recovery discharge planning decisions on a consistent needs-based risk stratified basis with a focus on maximising the number of people who can be discharged to their normal place of residence with minimal support
- Continuing to develop and embed our Care Transfer Hub model to ensure we optimise how our operational teams work together and to streamline our discharge systems and processes and deliver on the national Intermediate Care Framework care transfer priorities
- Develop and agree a Discharge to Recover operating model glossary of terms to ensure that all parties are using consistent and understood language when describing elements of our discharge pathways and intermediate care services

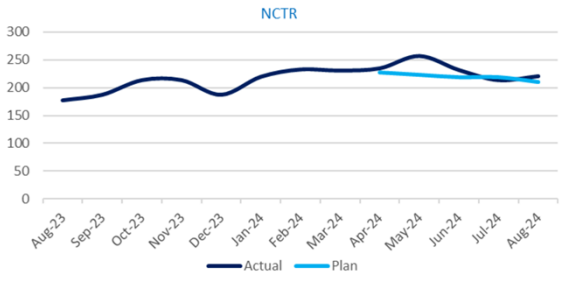
Key Performance Indicators (KPIs)

We have identified a set of KPIs and created a dashboard to track the progress of the Bed Strategy. These include (not exhaustive):

- Number of open General & Acute (G&A) beds
- Non elective Length of Stay (NELOS)
- Number of patients who do not meet the criteria to reside (NCTR)
- Number of patients discharged on pathways 0, 1, 2 & 3 with the aim of increasing the number of P0 and P1 pathway discharges







The Excellence in Care Dashboard provides us with Ward level data to enable us to see and record metrics and a specific dashboard is in development to support this and the wider Bed Strategy work. This is the Access and Delivery tab as there are other measures including quality which the Divisions use in their IPR's.

Wellington Ward

Access & Delivery

Indicator Description	Source	Measure	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Trend
Access and Delivery															
Discharged on or before their Expected Date of Discharge (Excludes Patients Who Died)	PAS	80%	37.7%	23.3%	28.9%	42.4%	35.7%	27.9%	34.9%	34.0%	55.8%	37.5%	22.9%	46.7%	
Discharged before Midday (Excludes Patients Who Died)	PAS	33%	9.4%	10.0%	13.2%	11.9%	10.7%	9.3%	20.9%	13.2%	16.3%	12.5%	18.8%	6.7%	
Average Length of Stay (Includes 0 Length of Stay)	PAS	-	9.17	11.05	12.75	8.21	8.46	18.73	12.85	10.79	10.88	9.02	14.34	10.23	
Stranded Patients > 6 (Month End Snapshot)	PAS	-	10	11	18	9	14	13	14	14	14	14	14	11	
Stranded Patients > 20 (Month End Snapshot)	PAS	-	2	8	8	4	10	7	7	7	7	7	7	6	
Number of Emergency Readmission Within 30 Days of Discharge	PAS	-	8.8%	21.6%	10.4%	11.0%	35.1%	11.9%	10.0%	18.2%	3.9%	6.7%	13.4%	8.1%	
Patient seen by Consultant (not including A&E Consultant) within 14 hours of admission (if elective admission record as N/A)	My Assurance	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.5%	90.0%	94.7%	95.0%	
A working diagnosis and management plan discussed with patient and or carer (within 48 hours of admission) is clearly documented in the notes (should be on post take ward round document)	My Assurance	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Number of patients admitted at a weekend (Saturday/Sunday) that are seen by a Consultant within 14 hours of unplanned admission	My Assurance	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.0%	80.0%	80.0%	75.0%	

A Bed Strategy Dashboard is in development and includes a wider set of KPIs to track the impact of the entire portfolio of programmes and projects.

Category	Bed Strategy Draft KPIs	Data source
Quality	NEL LoS	PAS Oasis
Quality	Community social LoS within UCR	SystemOne
Quality	LoS from NCTR Date	Nervecentre linked to PAS Oasis
Quality	LoS from NCTR P0	Nervecentre linked to PAS Oasis
Quality	LoS from NCTR P1	Nervecentre linked to PAS Oasis
Quality	LoS from NCTR P2	Nervecentre linked to PAS Oasis
Quality	LoS from NCTR P3	Nervecentre linked to PAS Oasis
Quality	NCTR numbers	Nervecentre linked to PAS Oasis
Quality	# of patients with LoS >21 Days	PAS Oasis
Quality	% patients discharged on P0 (all)	Nervecentre
Quality	% patients discharged on P0 (NCTR)	Nervecentre
Quality	% patients discharged on P1 (all)	Nervecentre
Quality	% patients discharged on P1 (NCTR)	Nervecentre
Quality	# patients discharged same day from NCTR date	Nervecentre linked to PAS Oasis
Quality	# patients discharged next day from NCTR date	Nervecentre linked to PAS Oasis
Quality	% variation between weekday and weekend discharges	PAS
Quality	# patients delayed discharge waiting for therapy	Nervecentre (? Validation)
Quality	Missed acute therapy appointments (monthly)	OPEL report
Quality	# patients discharged by UCR via Home First	SystemOne
Quality	% of patients who have reduction in UCR care needs	SystemOne
Quality	UCR care needs on referral to no care required on assessment	SystemOne
People	Home First additional FTEs recruited	Finance (Donna Taylor)
People	AHP additional FTEs recruited	Finance (Donna Taylor)
People	VW additional FTEs recruited	Finance (Donna Taylor)
People	# people recruited into posts vacated by internal candidates	Finance (Donna Taylor)
Sustainability	Reduction in acute FTEs	Workforce (David Mulder)
Sustainability	# Acute beds open (established and actual)	Live bed state model
Sustainability	Financial impact (£'000)	Finance (Kirsty Watts)

Going forward the plan is to report progress monthly through the Bed Strategy Governance into the Use of Resources Committee and to the Board. ESHT will complete the evaluation of the pilots and roll these programmes out to all wards and track appropriate KPIs to monitor the impact.

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	Board of Directors (Board)	**Date of Meeting**	8 October 2024

Report Title:	BAF Q2
Purpose of the Report/Outcome/ action requested:	The Board is asked to review, discuss and note the Board Assurance Framework and note a) the rationale for the Q2 position and b) the forward look as regards the progress of the risk score over the remaining half of 24/25.
Decision Action:	For approval ☐ For Assurance ☒ For Information ☐ For Discussion ☒
Authority for Decision:	The Board has the ultimate authority for management of Risk within the Trust
Executive Summary	This report provides an update on progress on the Q2 BAF. This report sets out the BAF risks for Q2. Considering the movements since Q1, 10 of the 12 strategic risk scores have remained the same. Each Executive director has provided updates to their respective BAF risks. Below are updates to the two BAF risks where movement has occurred: BAF1 (concerning capacity constraints associated with supporting the collaborative infrastructure) The risk rating for BAF 1 has increased from 6 in Q1 to 8 in Q2, due to the change in the risk scoring having increased from 3 to 4. This recognises the collaborative infrastructure of NHS Sussex as not fully settled, but is required to drive initiatives that could be material for ESHT. BAF 2 (concerning failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time) The risk rating for BAF 2 has reduced from 15 to 12 in Q2. This reduction reflects the reduced risk of industrial action and the Trust's ongoing success in recruiting to 'hard to recruit' substantive posts. The anticipated risk score has also been reduced to from 15 to 12. Based on our continuing reduction in vacancies, it is anticipated that we may be able to remove this risk by YE from the BAF if performance continues to be sustained. Following interviews with BAF risk leads, we have also included single-page summaries within the BAF that help colleagues see the controls and evidence of their effectiveness. This articulates more clearly how/why leads are able to take assurance on the risk scores and potential progress over the remainder of the year. **Appendices:** Appendix 1 – Trust Board Assurance Framework 2024-25
Regulatory/legal requirement:	The Board of Directors is required to have a Board Assurance Framework in place as it is one of the key sources of evidence to support for the preparation of the Annual Governance Statement.

Business Plan Link:	Quality ☒ People ☒ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Outcomes focus: achieving the best sustainable outcomes for patients and service users by encouraging continuous improvement, clinical excellence and value for money		
Risk:	The full version the BAF reflects specific significant risks for each BAF risk		
No of Pages	4	**Appendixes:**	1 - BAF
Name, position and contact details of author:	Pete Palmer, Board Secretary and Dan Asamoah, Associate Director of Corporate Governance and Compliance		
Report Sponsor	Richard Milner, Chief of Staff	**Presenter:**	Richard Milner, Chief of Staff
Governance and Engagement pathway to date:	The allocated BAF risks have been presented to their respective Board Committees, and the entire BAF presented to the Audit Committee in September 2024.		
What happens next?	The BAF will be updated accordingly		
Publication	Yes		

Introduction

The report provides an update on the BAF.

Board Assurance Framework (BAF)

The BAF is a log of strategic risks which could prevent the Board from achieving its strategic objectives. There are 12 risk on the BAF.

The strategic risks (CRR) associated with the BAF are reviewed monthly and present to the Executive Committee (ExCom) at its monthly meetings. Executive directors have recently provided updates to their respective BAF risks.

Board Committees continue to monitor their allocated BAF risks. The Audit Committee continues to monitor its allocated risks and maintain oversight of the overall effectiveness of the risk management arrangements within the Trust. The Audit Committee undertook a deep dive into BAF 6 and BAF 8 at its most recent meeting on 26th September.

We have reviewed all 12 risks and provided a summary of the Q2 assessment for each:

BAF 1

The risk rating for BAF 1 has increased from 6 in Q1 to 8 in Q2, due to the change in the risk scoring having increased from 3 to 4. This recognises the collaborative infrastructure of NHS Sussex as not fully settled but is required to drive initiatives that could be material for ESHT.

BAF 2

The risk rating for BAF 2 has reduced from 15 to 12 in Q2. This reduction reflects the reduced risk of industrial action and the Trust's ongoing success in recruiting to 'hard to recruit' substantive posts. The anticipated risk score has also been reduced to from 15 to 12. Based on our continuing reduction in vacancies, it is anticipated that we may be able to remove this risk by YE from the BAF if performance continues to improve.

Despite a reduction in overall vacancies to 3.7% (July 2024) it is anticipated that the risk will remain at 12 moving forward to enable the review of activities to reduce the hard to recruit posts to be completed. Based on our continuing reduction in vacancies, it is anticipated that we may be able to remove this risk from the BAF if performance continues to be sustained for the rest of the year.

BAF 3

The risk rating for BAF 3 has remained at 16 in Q2. This sustained position reflects the continued risks associated with industrial action as well as the ongoing financial pressures, increased activity and reduction in the Trust's workforce. The ongoing and sustained improvements in other workforce metrics, including turnover and vacancy rates are recognised.

BAF 4

The risk rating for BAF 4 has remained at 20 in Q2. There is a continued high level of risk associated with the delivery of the Trust's financial plan for 2024/25.

BAF 5

The risk rating for BAF 5 has remained at 16 for Q2. The Trust's 2024/25 capital plan commits to supporting capital projects which exceed the available capital; this reduces the Trust's ability to spend on its backlog, apart from for fire maintenance and the replacement of essential equipment. It is anticipated that the risk rating may increase to 20 following the presentation of a report on the estates backlog maintenance position to the Trust Board in December.

BAF 6

The risk rating for BAF 6 has remained at 16 in Q2. While significant work has been undertaken to increase the robustness of the Trust's cybersecurity position, and Trust's current security risk status has reduced, the overall cyber threat level to the NHS has increased. It is hoped that the delivery of

active directory migration, Conquest core LAN migration and a reduction in unsupported legacy systems moving through the year could result in the lowering of the risk rating to 12.

BAF 7

The risk rating for BAF 7 has remained at 16 in Q2. Significant progress has been made with restructuring the Business Intelligence (BI) team and with the development of a BI strategy. It is hoped that the rating will be lowered later in the year once recruitment to the team has been completed and the benefits of current actions being undertaken are fully realised.

BAF 8

The risk rating for BAF 8 has remained at 12 in Q2. Digital awareness in the Trust has greatly improved, and the benefits of embedding clinical and operational staff within the digital system delivery are being realised with divisions working to embed digital processes. Work in preparation for the introduction of EPR continues. It is expected that once EPR, LIMS and OCS Order Comms are implemented in the Trust that the risk rating will be able to be reduced although funding has not yet been identified for completing this work in 25/26.

BAF 9

The risk rating for BAF 9 has remained at 16 for Q2. The trust is resource constrained and has had to prioritise rapid recovery action over the development of a CQI culture. It is anticipated that the initiation of a programme supporting CQI behaviours and cultures could lead to a reduction in the likelihood score to 3 as the year progresses.

BAF 10

The risk rating for BAF 10 has remained at 16 in Q2. This reflects the continued impact of more than 150 patients who are discharge ready each day within the Trust, which has an ongoing effect on patient flow increasing the risk to patients and staff. It is not felt likely that the risk rating will significantly reduce through the rest of the year despite significant work that is being undertaken to address the issue as not all of the challenges are internal to ESHT.

BAF 11

The risk rating for BAF 11 has remained at 12 for Q2 as progress remains on track. While it is hoped that the rating may reduce to 8 as the year progresses, with divisional analysis of inequalities information and reporting through IRs becoming regularised, it is recognised that the availability of data may be a constraint in achieving this reduction.

BAF 12

The risk rating for BAF 12 has also remained at 16 for Q2. While non-admitted performance has improved, no sustained improvement has been seen in length of stay and there has not been a reduction in the number of patients with no criteria to reside. This score is expected to remain at 16 moving into winter as there is no indication that service demand is decreasing along with the need to close additional beds.

The BAF is set out in Appendix 1

Board Assurance Framework (BAF)

Quarter 2 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	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	ExCom	X			9	6	8			▲	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	15	15	12			▼	Open	12
3	Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.	POD		X	X	20	16	16			◄►	Cautious/ Open	16
4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery	F&P			X	20	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	20	16	16			◄►	Cautious	16
6	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack	Audit	X	X	X	16	16	16			◄►	Minimal	12
7	Failure to develop business intelligence weakens insightful and timely analysis to support decisions	F&P		X	X	16	16	16			◄►	Open	12
8	Failure to transform digitally and deliver associated improvements to patient care	F&P			X	16	12	12			◄►	Significant	8
9	Failure to maintain focus on improvement	ExCom		X		16	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	20	16	16			◄►	Open/Seek	16
11	Failure to demonstrate fair and equal access to our services	Ineq	X			15	12	12			◄►	Cautious/ Open	8
12	Failure to meet the four-hour standard	Q&S	X	X	X	20	16	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 NHS Sussex collaborative infrastructure			Strategic Aims Impacted		
				x		
Risk Description:	Resourcing pressure arising from support/presence at partnership initiatives diverts leadership resource from internal ESHT priorities					
Lead Director:	Director of Transformation Strategy and Improvement	Lead Committee:	Executive Committee	Date of last Committee review:	06/08/2024	

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	
(3x3) 9	Likelihood:	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. The NHS Sussex collaborative infrastructure is not fully settled in practice but is being expected to drive initiatives that could be material for ESHT. Therefore the consequences of not being able to engage fully has increased to 4.	Likelihood:	2
	Consequence:	3	4				Consequence:	3
	Risk Level:	6	8				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. Escalation process to ICB when required B. Attendance at collaborative meetings C. Managing director of provider collaboratives regularly attends ESHT Executive Committee D. Provider collaborative executive with the ESHT Chief Executive as a core member		

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:	• Robust monitoring process by Executive Directors at IPRs enabling teams to flag where pressures arises • Executive management processes	• Regular reporting to Executive Committee • Regular reporting to Trust Board and relevant Committees	• Regular reporting to System Oversight Board • Regular reporting to East Sussex Health and Social Care Partnership Board

Gaps in control/assurance:
• Gaps in assurance arise from parallel system governance arrangements

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 2 Progress Report**	**BRAG**
1.	Ensuring that NHS Sussex and collaborative partners are sighted on the risks and how we are engaging.	Dir TSI	Ongoing	• Risks are escalated to NHS Sussex and collaborative partners as required	G

BAF 1 - Capacity constraints associated with supporting the NHS Sussex 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	-	-	-

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
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:	18/07/2024

	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	4			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. Despite a reduction in overall vacancies to 3.7% (July 2024) it is anticipated that the risk will remain at 12 moving forward to enable the review of activities to reduce the hard to recruit posts to be completed. Based on our continuing reduction in vacancies, it is anticipated that we may be able to remove this risk from the BAF if performance continues to be sustained for the rest of the year.	Likelihood:	4
	Consequence:	3	3				Consequence:	3
	Risk Level:	15	12				Risk Level:	12

Cause of risk:	Impact:
• Recognised national shortages in some staff groups i.e. AHPs, Consultants • Geographical location, demographics and age profile of workforce • Continued operational pressure in several 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)	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

			• 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) B. Talent management, succession planning, appraisals and development programmes C. Developing new roles D. Workforce efficiency metrics in place E. Stay interview and exit interview programmes F. In house Temporary Workforce Service to facilitate bank and agency requirement G. Focus on retention particularly on understanding why people may want to leave the Trust. H. Working in partnership with DWPP and local colleges to attract and pipeline candidates I. Review flexible working where appropriate J. More flexible use of retire and return K. Proactively building our positive reputation as an employer L. Ongoing responses to key themes from staff survey M. Continued targeted International recruitment for medical and AHP posts N. Additional headhunter agencies engaged for hard to recruit medical posts O. Job plans in place for all doctors P. People Strategy is in place and is being delivered in line with NHS Workforce/People Plan

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 • Review of nursing establishment six monthly as per Developing Workforce Safeguards • Workforce efficiency metrics and monitored • Regular meetings with Regional Post Graduate Deans for Acute and Primary care • Quarterly reviews in place to determine workforce planning requirements.	• Workforce strategy aligned with workforce plans, strategic direction and other delivery plans and metrics reviewed by POD and Trust Board • Temporary workforce costs scrutinised and reviewed weekly at TAP meetings with DDOs • Wellbeing offering enhanced (includes Pastoral Fellows support) and reviewed by POD	• Triangulation of National Staff Friends and Family Test reports, reviewed by POD • ICB Quarterly Workforce meetings • Internal audit review reports on effectiveness of workforce policies and processes • NHS Staff Surveys and Pulse Surveys and benchmarking data

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 2 Progress Report**	**BRAG**
1.	Continue with recruitment initiatives and international sourcing of medical candidates, including Radiographers, Sonographers.	Chief People Officer	Ongoing	• Continued recruitment campaigns with existing RPO Agencies, as well as partnering with new agencies to source candidates for hard to recruit posts. • Additional Recruitment agencies engaged to support with hard to recruit posts where necessary. • Local and UK recruitment campaigns continue.eg Veterans Events • Recruitment merchandise and on line presence to assist with Trust branding • . 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. • Trust working with other ICB organisations with regards local recruitment activities and initiatives • Trust involved with both Little Gate Farm and Project Search initiatives. • Campaign to increase volunteer numbers across the Trust. • Targeted campaigns with Eastbourne College to support candidate pipelines	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.	G

				• 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.	

BAF 2 - Failure to attract, develop & retain a workforce that delivers the right care, right setting, right time						
	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
Links to Corporate Risk Register:	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	◀▶
	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	◀▶
	08/07/2024	264	Insourcing contracts	25	15	NEW

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
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:**	**18/07/2024**

	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**	**4**			Data is showing that engagement levels across the NHS and locally have reduced over the past three years. Whilst we saw an increased level of engagement through the NHS Staff Survey in 2023 and an increased % uptake we saw very little movement and marginal increases with the positive scoring. We have seen a decline in engagement with pulse surveys The anticipated year end risk has remained the same to acknowledge the ongoing financial pressures, increased activity and reduction in our workforce. However it is recognised there is ongoing and sustained improvement in other metrics (e.g. turnover, vacancy rate)	**Likelihood:**	**4**
	Consequence:	**4**	**4**				**Consequence:**	**4**
	Risk Level:	**16**	**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. Embedding the system wide strategy and policy on violence prevention
D. Improved debrief process and package of support for staff involved in violence and aggression or distressing situations at work.
E. Continuous reviewing and implementing best practice from other areas (e.g. TRiM, MHFA)
F. Targeted support for areas with high levels Datix linked to violence and aggression
G. Embedded range of wellbeing/pastoral support available for all professional groups
H. 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 Strategy L. Admission avoidance and discharge activity through operational teams M. Working with the entire system, third sector and independent health and social care organisations to assist them with recruitment and training. N. Effective rostering and leave management with planned pilots in place to develop further self-rostering best practice O. Undertaking deep dive cultural reviews in areas where there is particular concern regarding colleague engagement and morale P. Increased listening events focusing on culture and behaviours Q. Promoting wellbeing support available and training to line managers R. Occupational Health and Health and Safety Team support and audit of risk assessments and Datix incidents S. Occupational and staff wellbeing support to staff T. Local Security Management Specialist advice and support U. Sussex network meeting in place and liaising with SECAMB on Trauma Risk Management V. Collaboration with ESCC on lone working

Assurance Framework – 3 Lines of Defence			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Ongoing monitoring of, and response to, key workforce metrics/staff survey • DME monitors and reviews 'trainees in difficulty' register • Workforce efficiency and availability reviews considering registered and unregistered nurses, and AHPs • Ongoing reviews of effectiveness and efficiency of rostering	• Workforce metrics reported to executive team, POD and Trust Board – increased compliance with completion of risk assessments • Oversight and monitoring by Health and Safety Steering Group • Deep dive cultural reviews	• ICS undertaking assurance reviews and reporting outcomes to the Trust • Health and Safety Executive review of violence and aggression • GMC outcomes have action plans with quality virtual visits in place to provide assurance to HEEKSS/Trust
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 2 Progress Report	BRAG
1.	People Strategy	Chief People Officer	Ongoing	• People Promise Manager role (funded) in place and responsible for People Strategy Year 3 focus and priorities / workstreams underway and this is an established programme of works and has reported to POD. • Further updates will continue a quarterly basis	G

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	12	16	◀▶
	01/06/2023	73	Radiology Physics Service Staffing	20	15	◀▶
	15/05/2024	131	Account payable staffing	20	16	NEW

Risk Summary						
BAF Reference and Summary Title:	BAF 4: Failure to deliver income levels/manage cost/expenditure impacts savings delivery			Strategic Aims Impacted		
						x
Risk Description:	The Trust agreed budget for 24/25 is a £11.7m deficit including a CIP target of £36.7m					
Lead Director:	Chief Financial Officer	Lead Committee:	Finance and Productivity Committee	Date of last Committee review:	25/07/2024	

	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	5			**Likelihood**: At M4 the Trust deficit was £4.9m worse than plan. £35m of the CIP target has been allocated but there is a need to finalise agreement to supporting PIDs **Consequences**: There is risk to delivering the plan and without being able to demonstrate supporting PIDs there is a risk of loss of confidence in the controls.	Likelihood:	4
	Consequence:	4	4				Consequence:	4
20	Risk Level:	20	20				Risk Level:	16

Cause of risk:	• Income continues to be delivered above 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, increases in costs 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 results in: • 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. • Centrally managed staffing control

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 managing their financial performance with budgets agreed through the Divisions and Executive. C. Finance actions are reinforced through a separate Use of Resources (DRUM) meeting D. Scheme of Delegation (SoD) and Standing Financial Instructions (SFIs) in place to manage expenditure across pay and non-pay. E. All recruitment is directly reviewed by the CEO or Deputy CEO on a weekly basis through a Vacancy Panel. F. All non pay spend above £5k is being referred to a Non-Pay panel review, and all spend above £50k is being referred to a triple lock process requiring sign off from Trust, ICS and Region. G. A Financial Improvement Director has been appointed by the ICS

Assurance Framework – 3 Lines of Defence			
	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:	• Procurement, Temporary Workforce Services and vacancy panel all monitor compliance with controls that have been introduced	• Oversight by Use of Resources Programme • Regular reporting to Trust Board and relevant committees • Divisions held to account for overall financial performance through IPR process based on budgets agreed through the Divisions and Executive. Finance actions are reinforced through a separate Use of Resources (DRUM) meeting.	• Internal audit review reports • ICS Oversight
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 2 Progress Report**	**BRAG**
1.	Finalise CIP plan for year with an emphasis on controlling costs as well as delivering increased activity	Chief Financial Officer	30/09/2024	• There are plans being developed for the full £36.7m CIP, with £4.7m delivered to date. • ERF activity is 3.3% above plan year to date • Pay costs are £3.1m above plan year to date • The current Use of Resources plan is for £36.7m; however, the risk adjusted value is currently £25m resulting in a potential shortfall of £11.7m, 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 took place in August 2024, involving presentations by workstream leads and commitment to full year target.	G

3.	Develop DRUM meeting to improve accountability for the UoR programme chaired by COO and CFO	Chief Financial Officer	Ongoing	• Finance and Assurance meetings have been taking place for a number of months.	G

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	◄►

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
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:	25/07/2024

	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	4			The Trust's capital budget for 2023/24 is £23.1m but this could increase up to £77.5m 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 F&P Committee in May 2024. We anticipate that this will be presented to the Trust Board in December when consideration should also be given about whether this risk rating should be increased to 20. We have committed to supporting capital projects during 2024/25 which will exceed the available capital budget. Therefore our ability to spend on our backlog will be reduced, apart from fire compartmentation work and replacement of essential equipment as required. During Q4 of this financial year we will start to identify our backlog priorities for 2025/26.	Likelihood:	4
	Consequence:	4	4				Consequence:	4
	Risk Level:	16	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. Annual capital plan and five year capital plan in place B. Essential work prioritised with estates, IT and medical equipment in light of patient safety and health and safety C. Day to day management of infrastructure requirements and prioritisation by services D. Electronics and Medical Engineering (EME) in close liaison with divisions							

	E. Full inventory of medical devices and life cycle maintenance

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

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

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 2 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, Building for our Future (BFF) Business Case process and associated enabling business cases, Trust will be addressing solutions for backlog maintenance	Chief Finance Officer	Q3 2024	• Priorities to be developed into the New Hospital Programme Case, Building for our Future (BFF) Business Case	A
3.	Options appraisal for Building for our Future (BFF) to be undertaken	Programme Director BFF	Q3 2024	• NHP will inform us when the revised SOC should be submitted, anticipated in 2024/25	A

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						
	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
Links to Corporate Risk Register:	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	◀▶
	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	◀▶
	26/07/2024	272	End of life operating system in use in cardiac cath lab	16	16	NEW

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
Risk Description:	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack					
Lead Director:	Chief Financial Officer	Lead Committee:	Audit Committee	Date of last Committee review:	25/07/2024	

	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	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 which has been a great achievement. But the threat level in the NHS has increased with a number of attacks on NHS Trusts or provider organisations. Cyber maturity has improved over the last six months, which has reduced the Trust from a high to a medium risk status. We are no longer looking to deliver Cyber Essentials as this has now been incorporated into a new version of the Data Security Protection Toolkit (DSPT) called Cyber Assurance Framework (CAF). The cyber action plan, which is presented to the Audit Committee, has four elements: 1. Internal Audit recommendation 2. CAF Self Assessment 3. External Penetration Test recommendations 4. 12 Risks on the trust risk register Two of the key actions to achieve the anticipated risk level of 12 will be to deliver the active directory migration and further reduction in unsupported legacy systems along with the Conquest core LAN migration.	Likelihood:	3
	Consequence:	4	4				Consequence:	4
	Risk Level:	16	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. • Infrastructure Hardware failure, due to unsupported systems or lack of Capital Refresh.	**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.
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. Ongoing education campaign to raise staff awareness. E. System patching programme in place and upgrade of client and server operating systems F. Wider engagement including NHS Secure Boundary G. Continual network monitoring for abnormal activity / behaviour H. Vulnerability scanning, to identify vulnerabilities and remediate I. Migration of clinical systems to the Cloud J. Strategy of Cloud first, so 'software as a service' or 'platform as a service' on any new procurement K. Rolling refresh of infrastructure Hardware, LAN, Wi-Fi, Servers, and Client Devices. L. Working in regional cyber user group and developing ICS cyber strategy M. Day to day systems in place and support provided by cyber security team with increased capacity N. Policies, process and awareness in place to support data security and protection and evidence submitted to CAF O. Information sharing and development with organisations within the Sussex ICS P. Development of ICS Cyber Strategy and working in regional cyber user group Q. Rollout of MFA to key users, plan to minimise non-supported software and contain software that cannot currently be removed, and ensure offsite backup.		

Assurance Framework – 3 Lines of Defence			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Self-assessment against CAF to support development of actions for protection against threats, reviewed by division • Cyber security testing and exercises e.g. ICB cyber simulation event with all NHS organisations in Sussex, and two internal events at ESHT with senior leaders	• Regular quarterly security status report to IG Steering Group and every six months to Audit Committee	• RSM internal audits reports • Outcome, following submission of DSPT in June 2024 • Feedback from NHS Digital on Cyber Exposure score

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

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 2 Progress Report**	**BRAG**
1.	Cyber Assurance Framework	Chief Finance Officer	Ongoing	• Internal DSPT 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 • Refreshed cyber five year strategy and awaiting approval	*G*
2.	Medical devices with network connectivity asset list	Chief Finance Officer	Q4 24/25	• 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 March 2025 • Conquest delivery anticipated in 2025	*A*
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 complete • Migration of Edge network over the course of Q4 2024/Q1 2025	*G*
4.	LAN Refresh Conquest	Chief Finance Officer	Q4 2024	• Replace the Core Network and Fibre connections to the Edge Switches • Orders are being placed. • Core network estates work now complete	*A*
5.	Active directory migration	Chief Finance Officer	2025	• New domain has been built • Migration of users and devices has started • Migration of services during 2025	*A*

BAF 6 - Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack						
	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
Links to Corporate Risk Register:	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 Reference and Summary Title:	BAF 7: Failure to attract and develop business intelligence limits insightful and timely analysis to support decisions				Strategic Aims Impacted		
						x	x
Risk Description:	There is a risk that the organization suffers from delayed, inaccurate, or incomplete data analysis, ultimately leading to poor decision-making or missed opportunities not meeting objectives and efficiency goals						
Lead Director:	Deputy CEO & Chief People Officer	Lead Committee:	Finance and Productivity Committee	Date of last Committee review:	25/07/2024		

	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	4			This risk has the potential to severely impact strategic decision-making and operational efficiency, as the failure to develop robust business intelligence capabilities can hinder timely and accurate insights. Such limitations are likely to have a high impact on both financial performance and patient outcomes. The likelihood of this risk materializing is considerable, given the rapid advancements in BI technologies and the growing demand for specialized talent, making it increasingly challenging to attract and retain the necessary expertise. Significant progress has been made in agreeing restructuring and a strategy; however the risk rating is expected to remain at 16 until recruitment is completed and the benefit of actions currently being taken is fully realised. It is hoped that the rating may be lowered later in the year.	Likelihood:	3
	Consequence:	4	4				Consequence:	4
	Risk Level:	16	16				Risk Level:	12

Cause of risk:		Impact:	
	• Data Warehouse complexity and Integration Issues • Talent Acquisition Challenges • Inadequate Training and Development • Budgetary Constraints • Technological Change - Rapid evolution of BI technologies, • Technological Limitations: Outdated BI tools, poor system integration.		• Delayed Decision-Making • Increased Compliance Risks • Diminished Stakeholder Confidence • Staff Burnout – Health and wellbeing of team • Higher Employee Turnover: Skilled employees may leave • Negative Impact on Financial Performance • Reduced Patient Care Quality • Operational Inefficiency • Missed Market Opportunities..

Current methods of	
	A. Daily prioritisation of reporting and development needs B. Cross-Functional BI Teams: Establishment of BI teams across departments to ensure alignment between business needs and data-driven solutions.

management (controls)	C. Investment in BI Tools: Implementation of modern BI platforms (e.g., Power BI,) to enhance data analysis and reporting capabilities. D. Leadership Oversight: Senior management actively supports and oversees BI initiatives, ensuring resources and focus on BI development. E. Developing new roles and "growing our own" F. Automation first approach where data and technology allows G. Consulting with BI Experts: Engaging external consultants or firms to improve BI strategies and train internal teams. Responsibilities of all staff groups involved in the process are clearly defined and documented. H. Integration of Clinical Systems: Ongoing efforts to standardise and integrate clinical data systems into a centralised data warehouse for better analysis. I. System Validation: automated checking (such as reasonableness, completeness) of data prior to reporting. J. BI Governance Framework: Establishing and overseeing policies and procedures related to data governance, ensuring data integrity and compliance with regulations. K. Training and Development Oversight: Ensuring that training programs for BI tools and data management are in place and aligned with organisational needs and regulatory requirements.

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

Gaps in control/assurance:

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

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 2 Progress Report	BRAG
1.	Enhance BI Structure and Investment	Chief People Officer	May 2024	• Develop a BI Structure that meets the organisations needs • Create recruitment plan	Green
2.	Clarify Roles and Responsibilities:	Chief People Officer	December 2024	• Define and communicate clear roles and responsibilities for BI management, data governance, and risk oversight. Ensure accountability through regular performance reviews and role assessments.	Amber
3.	Update BI Tools	Chief People Officer	May 2024	• Assess and upgrade outdated BI tools to incorporate modern features that support advanced analytics and real-time reporting. • Evaluate and select BI platforms that best meet the organization's data analysis needs.	Green
4.	Enhance BI Training Programs:	Chief People Officer	Ongoing	• Develop and implement comprehensive training programs for staff on BI tools, data management, and analytics techniques. • Regularly update training materials and sessions to keep pace with advancements in BI technology and best practices.	Red
5.	Improve Reporting Mechanism, Automation First and Self Service	Chief People Officer	Ongoing	• Develop Automated Reporting Workflows • Set Up Scheduled Report Generation • Deploy Self-Service BI Tool • Create Predefined Reporting Templates • Consolidate Data from Multiple Sources	Amber
6.	Engage External Partners:	Chief People Officer	Ongoing	• Collaborate with BI consultants and data visualisation experts to support timelines in development of key reports and self-service tools. • Utilize external expertise to address complex challenges and drive continuous improvement.	Amber
7.	Design and Implement a New Data Warehouse:	Chief Finance Officer	Ongoing	• Assess and Select Technology • Develop new reporting tables • Migrate Data Effectively	Red

BAF 7 - Failure to attract and develop business intelligence limits 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	-	-	-

Risk Summary					
BAF Reference and Summary Title:	BAF 8: Failure to transform digitally and deliver associated improvements to patient care			Strategic Aims Impacted	
					x
Risk Description:	Failure to transform digitally and deliver associated improvements to patient care and develop a digital culture				
Lead Director:	Chief Financial Officer	Lead Committee:	Finance and Productivity Committee	Date of last Committee review:	25/07/2024

	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	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. Embedding clinical and operational staff within the digital system delivery is greatly supporting the digital culture across the organisation. Digital awareness across the organisation has greatly improved; divisions are looking to embed digital processes. EPR readiness work is underway to improve digital maturity across the organisation. The implementation of EPR/LIMS/OCS order comms should lead to a reduction of this risk rating.	Likelihood:	2
	Consequence:	4	4				Consequence:	4
	Risk Level:	12	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.	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

	• Potential organisational unwillingness to embrace change. • Trust-wide digital transformation programme requires significantly enhanced capacity and capability to manage change		
Current methods of management (controls)	A. Digital Steering Group established to monitor, support, and approve any Trust wide digital initiative and alignment to digital strategy B. Project Prioritisation Matrix in place 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 in place F. Transformation programmes to be put in place to realise benefits of cost effectiveness G. Longer term capital plan to support delivery of sustainable services H. Operational Management Group established to ensure integrated governance I. Process relating to the prioritisation of project / programmes with digital developed J. Benefits Strategy in place		

Assurance Framework – 3 Lines of Defence			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Project Prioritisation Matrix used to track and manage priorities for digital • Process Mapping utilised to monitor and facilitate change acceptance and benefits management	• Regular reports to Executive and Finance and Productivity Committee and Trust Board • Regular presentation to Digital IPR • Regular reports to Transformation Board (monthly) • Regular reports to Operational Management Group • Regular reports to Digital Steering Group	• Capital Business cases reviewed by ICS • Internal audit review reports

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

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 2 Progress Report**	**BRAG**
1.	EPR implementation	Chief Medical Officer	July 2027	• Full business case and specification in development • OBC was signed off by the national EPRIB Board with some conditions; these are being reviewed by the regional team • Tender process has been completed with a preferred supplier selected • A large number of posts will need to be recruited to support implementation • Contract award in March 2025 • Start of implementation in May 2025 End date of implementation will be July 2027	G
2.	Digital transformation roadmap based on supporting the digital strategy	Chief Finance Officer	Nov 2024	• Roadmap is in development	A
3.	Digital Literacy Assessment	Chief Finance Officer	May 2025	• Digital literacy assessment has started to be rolled out across clinical wards • Development of a plan to increase digital literacy	A
4.	Increase digital culture	Chief Finance Officer	Ongoing	• Communications strategy and engagement • Multidisciplinary team working • Appointment of operational programme manager, EPR • Appointment of digital delivery partners • Developing links with education teams to embedding digital literacy into workforce descriptions • Identifying a new Non-Executive Digital Champion	G

BAF 8 - Failure to transform digitally and deliver associated improvements to patient care						
	Date:	**Risk Register Number**	**Title**	**Initial Risk Score**	**Current Risk Score**	**Change**
Links to Corporate Risk Register:	07/02/2013	74	Delays in reporting for Radiological Investigations	15	16	◀▶
	31/10/2022	77	Conquest Radiology Imaging Equipment	20	16	◀▶
	18/04/2019	78	Limited functionality of follow up appointment database	16	16	◀▶
	28/06/2023	85	Subject Access Requests / Redaction Software	15	15	◀▶

Risk Summary						
BAF Reference and Summary Title:	BAF 9: Failure to build a culture and system of 'Continuous Quality Improvement'				Strategic Aims Impacted	
						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:	Executive Committee	Date of last Committee review:	06/08/2024	

	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	4			The current risk position recognises that we are resource constrained and have no option but to prioritise rapid recovery actions, both operational and financial. In this context addressing our plan to become a mature CQI organisation is more challenging in the short term despite the development of a CQI culture being a Trust priority. However, the risk is not a 20 as we have a plan to use some resources to move this forward and we have an active frontline QI programme run through the clinical effectiveness team. We are initiating a programme to develop stronger leadership behaviours and culture for CQI. During Q1 and Q2 the risk was higher as we haven't implemented this programme. We anticipate that the likelihood will reduce to 3 as the year progresses	Likelihood:	3
	Consequence:	4	4				Consequence:	4
	Risk Level:	16	16				Risk Level:	12

Cause of risk:	• People trained under previous model have been inactive • Substantial turnover in leadership over the last five years • Financial constraints do not allow us to prioritise this for investment in the short term	Impact:	• Fail to embed a CQI management system across planning and operational mechanisms • Persistence of a capability gap across the Trust • Fail to derive the recognised benefit to staff engagement from CQI systems

Current methods of management (controls)	A. Encouraging a CQI leadership and culture behavioural programme B. Developing local network of relationships with trusts with mature CQI systems C. Directly learning from other organisations how best to acquire support, apply policy and procedure D. Supporting and aligning the work of the QI manager within the clinical effectiveness team E. Working with development centre to optimise the use of corporate capacity to support the 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:	• Dedicated senior lead in TSI team monitors day to day activity of TSI team. • Regular reviews of status reports by Director of TSI	• Regular reports to Ex Comm • Regular transformation updates to Board	• Potential for peer review, especially with strategic partner and their experiences elsewhere • Peer review, exchanges and leader to leader interaction with the network

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 2 Progress Report**	**BRAG**
1	Recruit to CQI lead within TSI team	Dir of TSI	Completed	• CQI Lead recruited in March 2024	G
2	Reprioritise TSI team work programme to specify CQI support		Completed	• Completed in August 2024	G
3	Agree first phase of 'Management System' component through Business Planning Round using internal resource		Q4 24/25	• Being reviewed as an action • New director of performance has joined the Trust • Revising progress for 2025/26 business planning round	A
4	Identify and launch CQI leadership, culture and behaviour programme		September 2024	• Plan in place	G

BAF 9 - Failure to build a culture and system of 'Continuous Quality 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	-	-	-

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
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:**	**18/07/2024**

	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**	**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. Significant work is underway and is being monitored as part of the use of resources programme, but as not all of the challenges are internal to ESHT it is not felt likely that the consequence and score will reduce significantly in Q3 and Q4.	**Likelihood:**	**4**
	Consequence:	**4**	**4**				**Consequence:**	**4**
	Risk Level:	**16**	**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	**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

Strategic Aim 1: Quality - Delivering safe care; always improving outcomes and experience for patients

Strategic Aim 2: People - Fostering a positive culture; living our values; helping our teams feel equipped to deliver

Strategic Aim 3: Sustainability - Always searching for the best way to use our resources for clinical, workforce and financial outcomes

	• 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 • 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 (although improving with investment and recruitment) • 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		• 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 • 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 (although improving with recent additional investment and recruitment)

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. Snapshot audits of LLoS 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. Several pieces of work as described in the Use Of resources programme looking at the internal Discharge process (SAFER) and focus on Reconditioning. I. Plans underway for new volunteer and activity 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	• Use of any additional specialist advice or support, including visits to ESHT and ESHT staff visiting other locations	• Scheduled meetings with CQC to discuss data, intelligence and KPIs • Challenge at Trust Board

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)*
	• Real time bed state/information available • Monitoring of quality and safety KPIs • Daily capture and monitoring of escalation and supersurge capacity • System escalation calls to discuss the number of Super Surge patients being cared for at the Trust and the number of patients not meeting the criteria to reside.	• 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 • System wide discharge improvement workstream focussed on improving discharge processes and reducing length of stay in acute hospital and community hospital beds • Maintaining Focus on Care Quality and Experience report submitted to Quality and Safety Committee September 2024	• Provider assurance meetings and system clinical quality review meetings

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 impacting on mobilising patients
- 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, snapshots underway but manual process and time consuming
- 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 constrained by BI resources

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 2 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, have appointed to new HoN post • Agreement to invest in therapy resource for inpatients with recruitment underway and staff coming into post now	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 roll out and embed 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.	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. HoN post appointed to and this will oversee recruitment and induction of new MH CSW roles.	G

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.						
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	◀▶

Risk Summary						
BAF Reference and Summary Title:	BAF 11: Failure to demonstrate fair and equal access to our services				Strategic Aims Impacted	
					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:	06/08/2024	

	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	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	4				Consequence:	4
	Risk Level:	12	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 for monitoring D. Inequalities Committee established		

Assurance Framework – 3 Lines of Defence			
	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:	• Review of outcomes from Friends and Family Tests • Reviews and triangulation of patient complaints and feedback	• Routine data-led reports reviewed by divisional leadership teams • Regular reporting of health inequalities by divisions at Executive led IPRs • Regular reports to Inequalities Committee	• Internal audit review reports of our governance, planning and delivery against inequalities • Peer review and challenge with local trusts and/or noted peer high performers – especially around vision, scale and the difference made to patient outcomes • Deloitte well led report

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 2 progress report**	**BRAG**
1.	Refocusing the TOR and attendance at HISG to drive a more productive and focussed meeting. This meeting will systematically review progress against: • Data reviews within Division • Tobacco Dependency Team (planning & delivery) • Maternity smoking • Ethnicity data recording	Chief of Staff	Sept-24	Action 1 is now complete and action 5 is ongoing, the revised HISG having met in August (next meeting in October) and conversations are underway with our new AD for Performance. All remaining five action areas are on plan to deliver to the due dates shown, noted that all are dated from October 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. This gives a clear platform for health inequalities and enables us to share progress and challenge divisional leadership teams/raise issues as needed		Oct-24		
3.	Publish health inequalities strategy with aims and KPIs for the year and review 6-monthly progress – enables us to check in (twice a year) against our trajectory vs. the aims for the year		Oct-24 & Mar-25		
4.	Provide progress update to provider Quarterly Assurance Meeting with ICB to ensure we are tracking delivery against the ICB priorities (tobacco and alcohol)		Oct-24 & Jan -25		
5.	Agree with BI team the resources needed and regularity of inequalities reporting – having clarity around what Divisions will receive means we can hold them accountable for progress via the IPRs		Sept-24		
6.	Develop a standard framework for divisions to complete regarding health inequalities updates and monitor reporting – and, following on from 5, if we also build Divisions a template, it supports their focus solely on the initiatives/content		Nov-24		

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	◄►

Risk Summary					
BAF Reference and Summary Title:	BAF 12: Failure to meet the four-hour clinical standard			Strategic Aims Impacted	
				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:	18/07/2024

	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	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. The risk rating remains at 16 for Q2. Non-admitted performance has improved, but no sustained improvement has been seen in length of stay, in the overall number of patients with no criteria to reside. It is not anticipated that this score will reduce moving in to winter as more beds need to be closed and there is no indication that demand is decreasing.	Likelihood:	3
	Consequence:	4	4				Consequence:	4
	Risk Level:	16	16				Risk Level:	12

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) • Planning to reduce substantive bed stock	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 as is boarding on wards and supersurge

Current methods of management (controls)	A. Eliminate reliance on escalation, super surge areas and boarding 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 E. Decompressing our Emergency Departments by treating patients who do not require admission in a timely way F. SAFER and reconditioning work in pilot areas G. Virtual ward (community staffing) increase in capacity H. Focus on improving weekend discharges

Assurance Framework – 3 Lines of Defence – linked to controls			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Live bed state provides accurate information regarding occupancy and available bedded capacity • Breach compliance assurance across divisions • Long length of stay reviews across divisions • Complex patient reviews escalated to CMO/CNO/COO	• Maintaining Focus on Care Quality and Experience report submitted to Quality and Safety Committee September 2024 • Bed strategy programme reporting through Use of Resources, with programme of work to reduce LOS in addition to areas described above • IPR reports to Quality and Safety Committee and Trust Board	• Internal Audit Reports • Healthwatch feedback following visits • Family and Friends Testing Feedback from ED patients
Gaps in control/assurance:			
• Consistent and embedded (SAFER) Discharge 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 2 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.	Priority actions identified and include work regarding culture, education and roles and responsibilities. (SAFER and Reconditioning work)	COO	Complete	• Programmes of work clear and work underway on pilot areas re SAFER and Reconditioning • Likely a requirement for programme management – now in place	B

BAF 12 – Failure to meet the four hour standard						
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	◀▶
	03/12/2018	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	◀▶

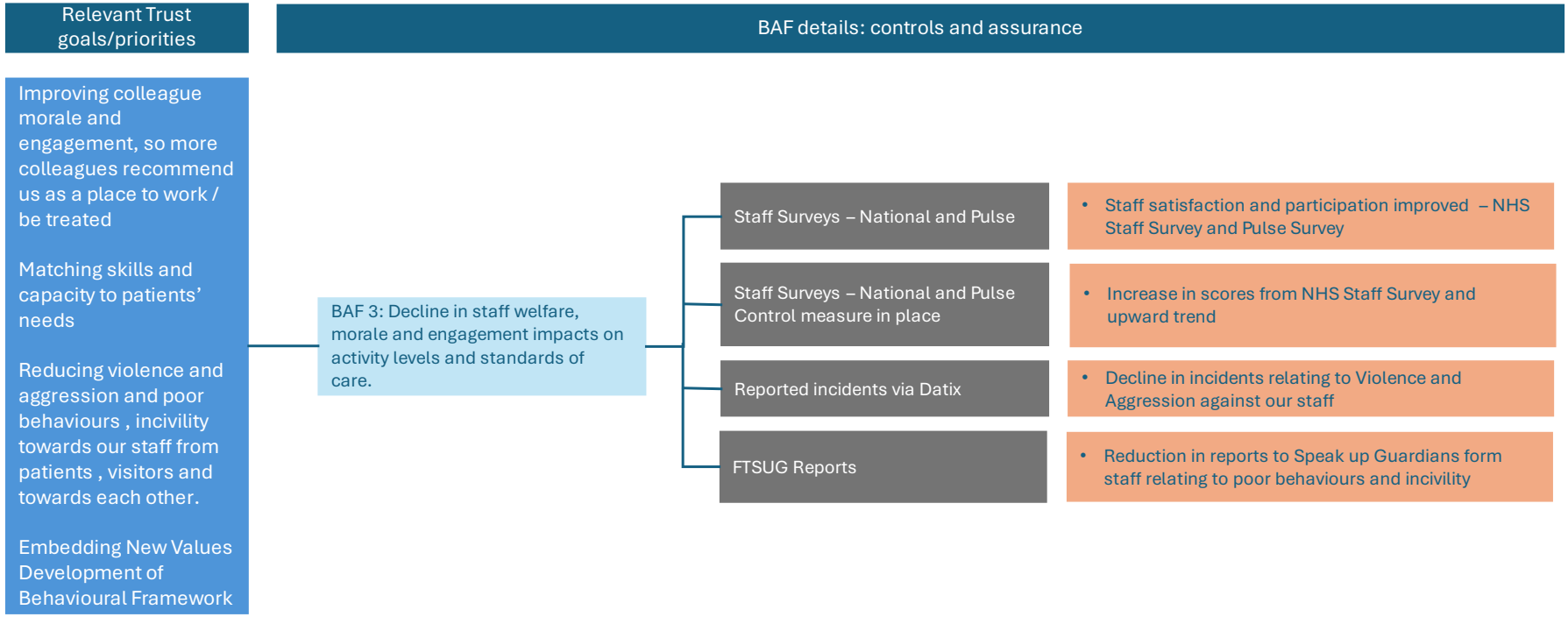
BAF summary by committee: Executive Committee

Relevant Trust goals/priorities	BAF details: controls and assurance		
Understand where any inequalities in planned care exist Initiate CQI programme Optimise balance of hospital vs 'community' based delivery (phase 1) Improvement & sustainability plans for 'ten priority services' (according to SLR)	BAF 1: Capacity constraints associated with supporting the collaborative infrastructure.	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	• IPRs • Executive management processes • Attendance at collaborative meetings • Executive Committee • Trust Board • East Sussex Health and Social Care Partnership Board • Managing director of provider collaboratives regularly attends ESHT Executive Committee • Provider collaborative executive with the ESHT Chief Executive as a core member • System Oversight Board • Escalation process to ICB when required

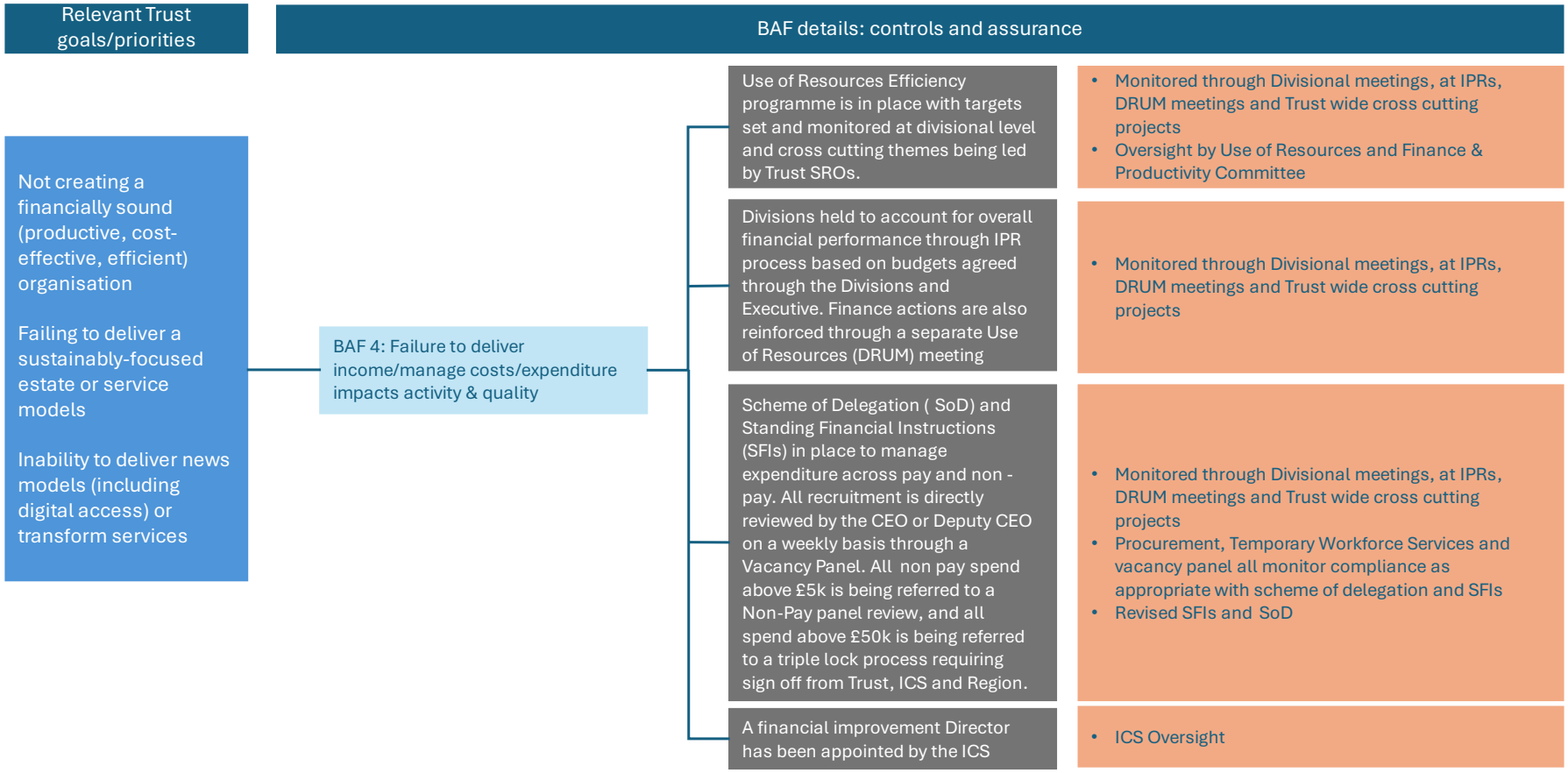
BAF summary by committee: People and Organisational Development Committee

Relevant Trust goals/priorities	BAF details: controls and assurance		
Improving colleague morale and engagement, so more colleagues recommend us as a place to work / be treated Matching skills and capacity to patients' needs Reducing violence and aggression and poor behaviours , incivility towards our staff from patients , visitors and towards each other. Embedding New Values Development of Behavioural Framework	BAF 2: Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time	Workforce Metrics reviewed monthly with associated action plans	• Improving workforce metrics i.e. retention and vacancy rate
		Talent Management and succession planning	• Staff satisfaction and participation improved NHS Staff Survey and Pulse Survey. • Internal promotions • Access to training and the right training and support for our managers and leaders
		Attraction & Recruitment Strategy	• Applicant satisfaction survey. Vacancy rate
		Flexible Working Opportunities	• Retire & Return to both bank and substantive roles increase. Flexible working requests and outcomes are documented

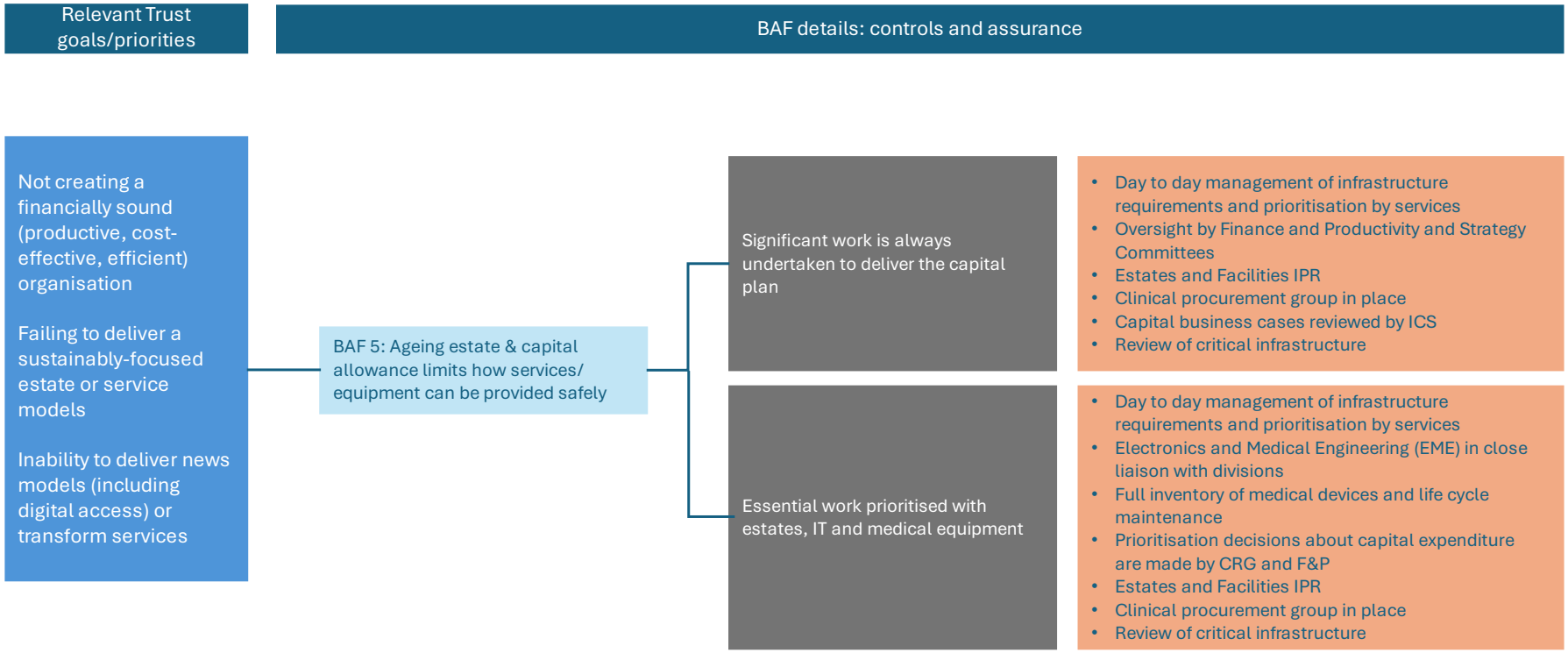
BAF summary by committee: People and Organisational Development Committee



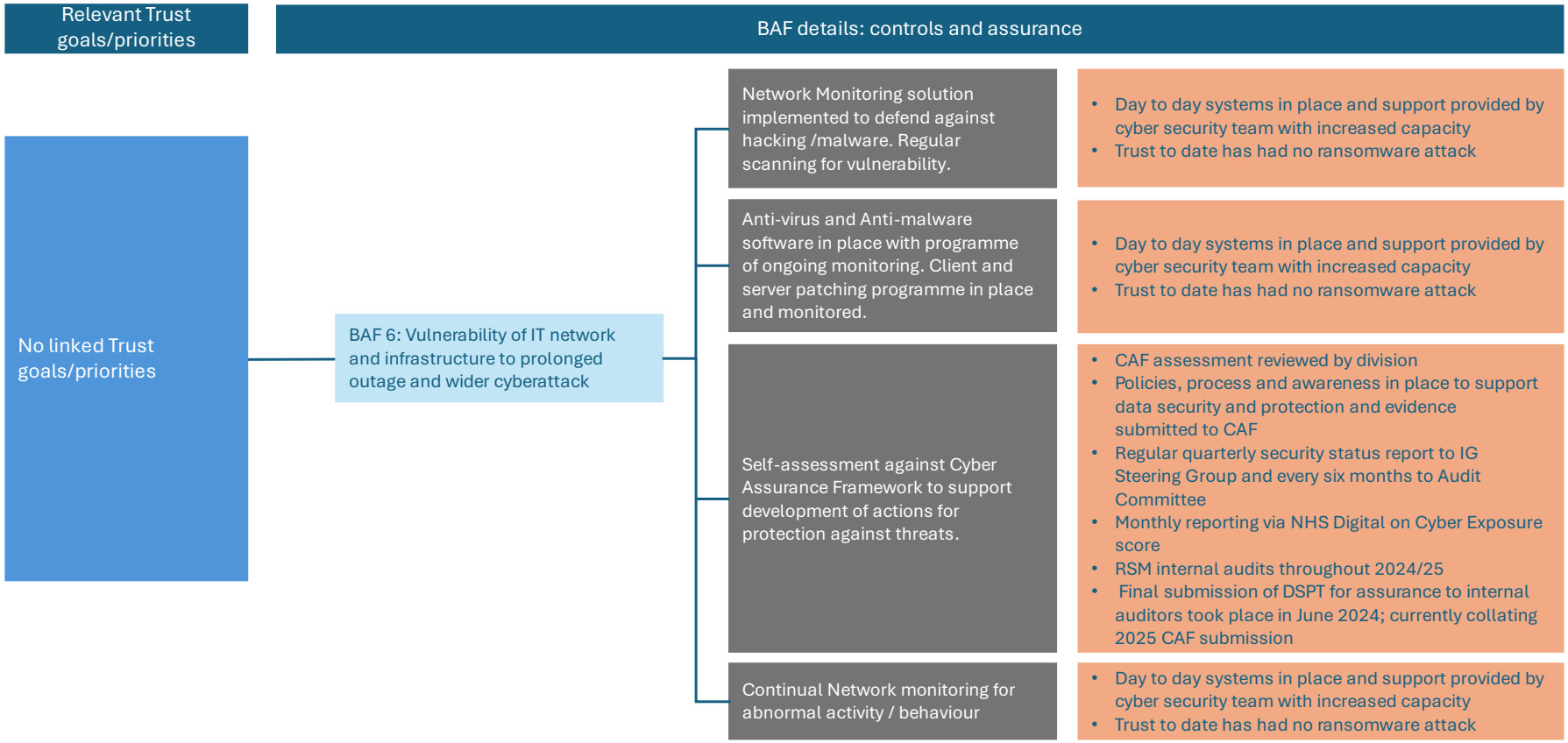
BAF summary by committee: Finance and Productivity Committee



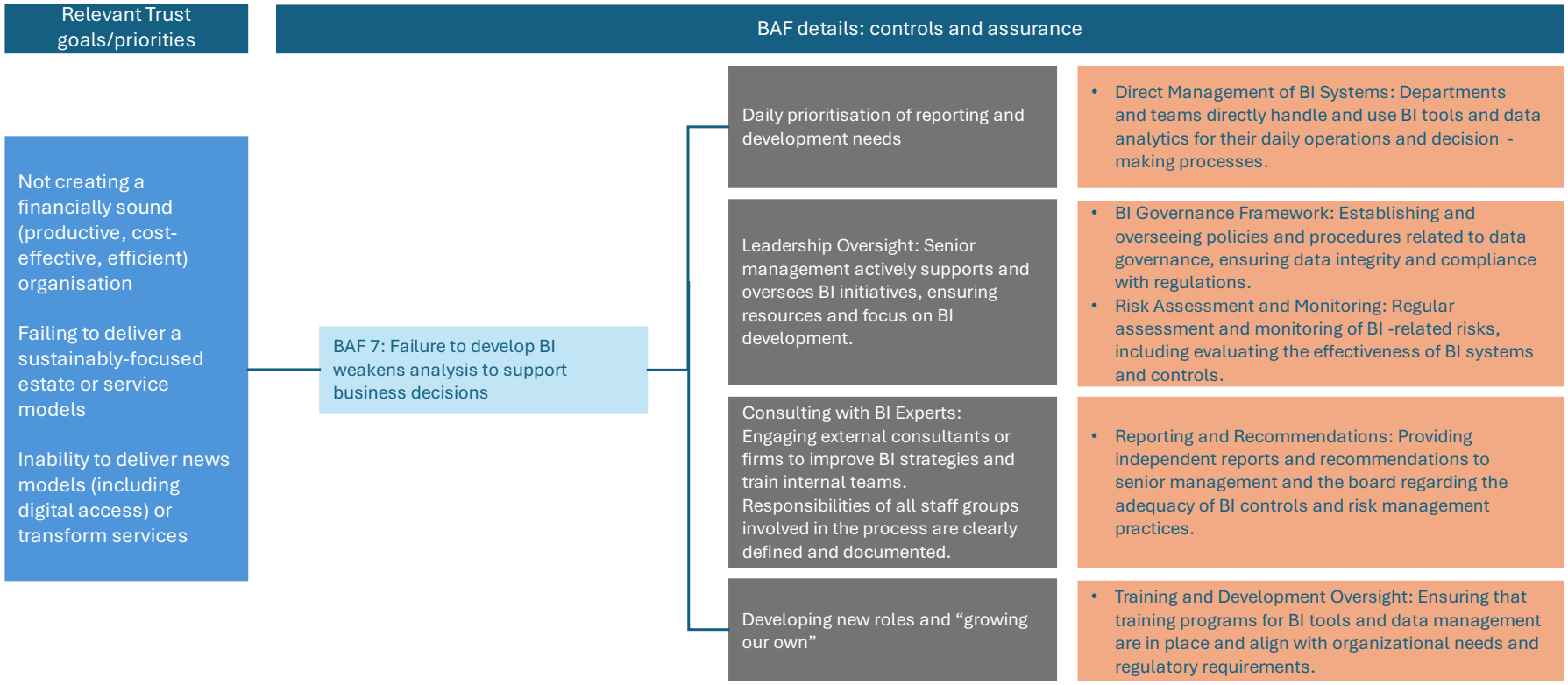
BAF summary by committee: Finance and Productivity Committee



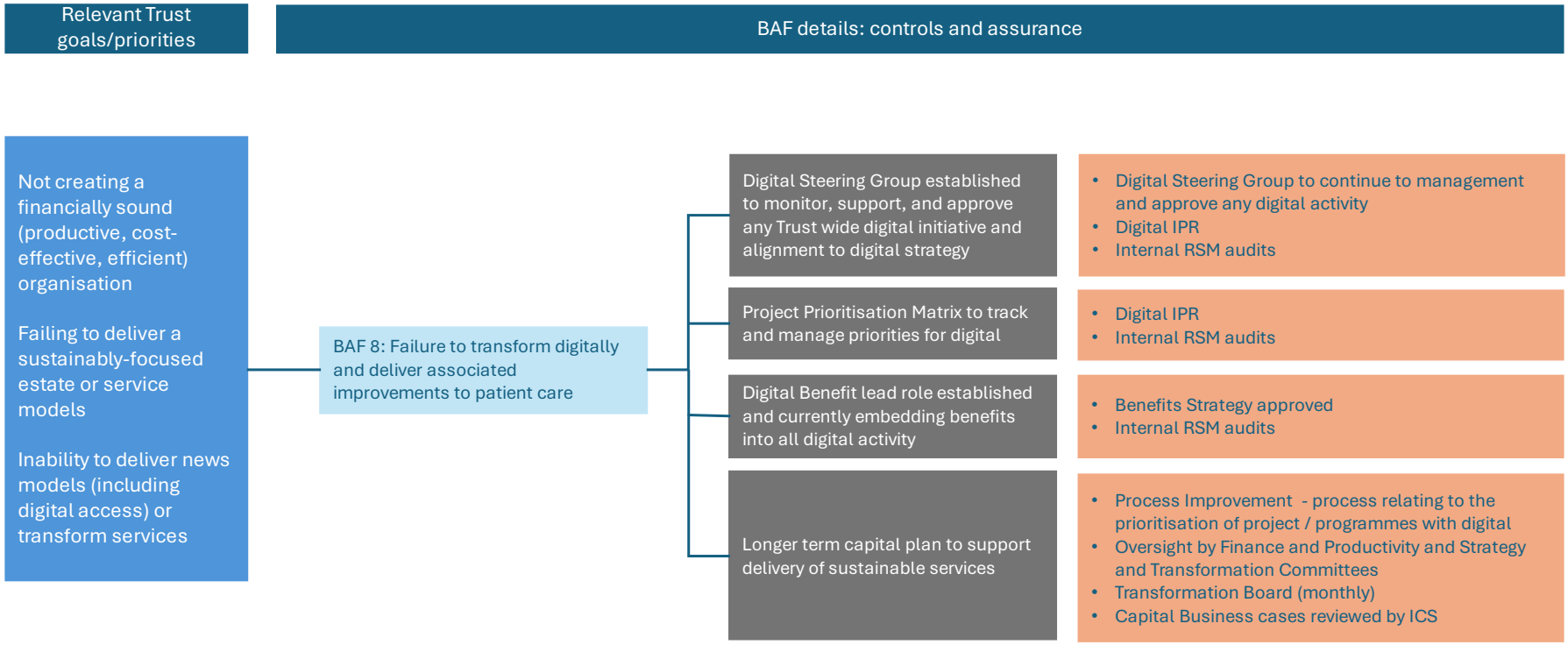
BAF summary by committee: Audit Committee



BAF summary by committee: Finance and Productivity Committee



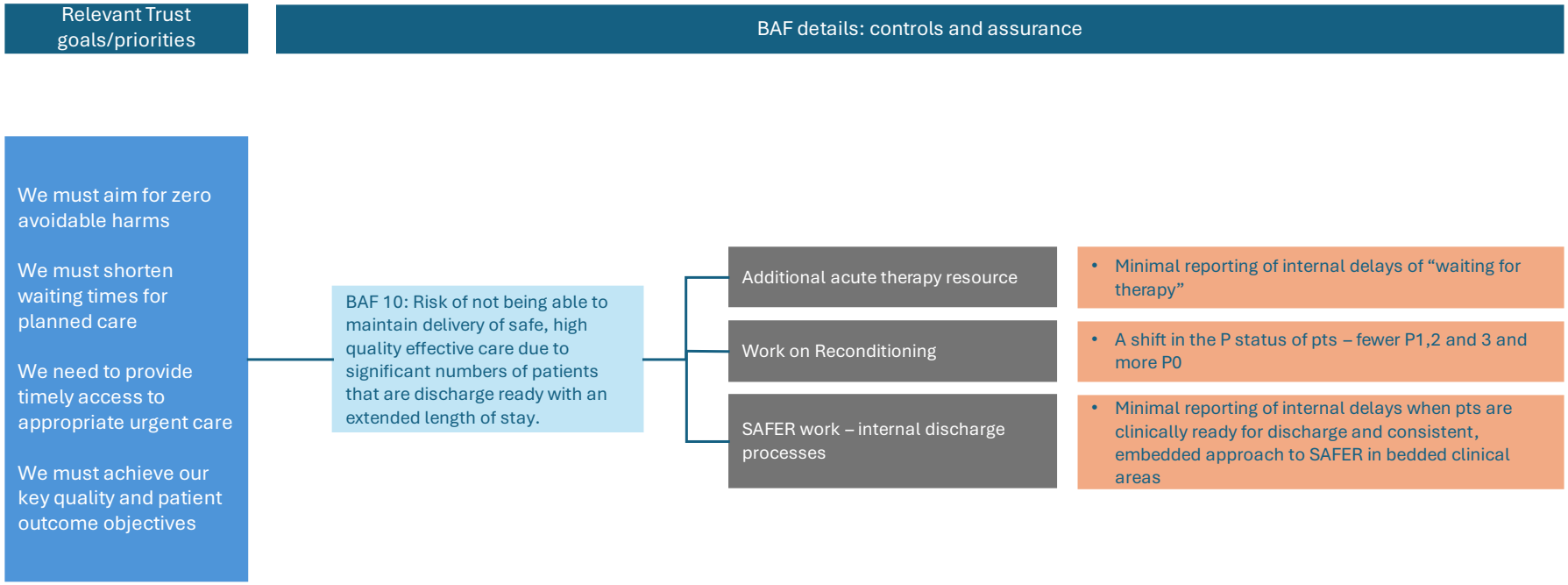
BAF summary by committee: Finance and Productivity Committee



BAF summary by committee: Executive Committee

Relevant Trust goals/priorities	BAF details: controls and assurance		
Understand where any inequalities in planned care exist Initiate CQI programme Optimise balance of hospital vs 'community' based delivery (phase 1) Improvement & sustainability plans for 'ten priority services' (according to SLR)	BAF 9: Failure to maintain focus on improvement.	Instigating a CQI leadership and culture behavioural programme	• Dedicated senior lead identified in TSI team • Regular transformation updates to Board • Reporting to Ex Comm
		Developing local network of relationships with trusts with mature CQI systems	• Peer review, exchanges and leader to leader interaction with the network
		Supporting and aligning the work of the QI manager within the clinical effectiveness team	• Dedicated senior lead identified in TSI team • Regular updates to Director of TSI
		Working with development centre to optimise the use of corporate capacity to support the programme	• Potential for peer review, especially with strategic partner and their experiences elsewhere • Directly learning from other organisations how best to acquire support, apply policy and procedure

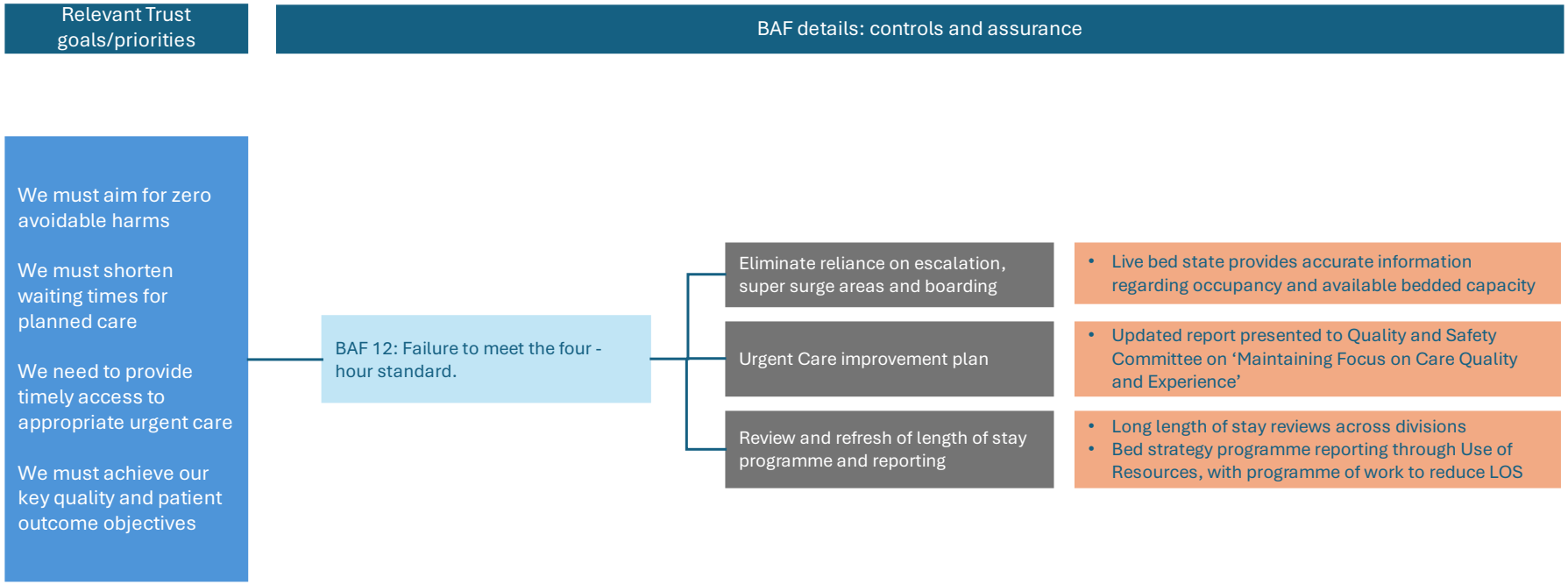
BAF summary by committee: Quality and Safety Committee



BAF summary by committee: Inequalities Committee

Relevant Trust goals/priorities	BAF details: controls and assurance		
Understand where any inequalities in planned care exist Initiate CQI programme Optimise balance of hospital vs 'community' based delivery (phase 1) Improvement & sustainability plans for 'ten priority services' (according to SLR)	BAF 11: Failure to demonstrate fair and equal access to our services	Adhering to existing governance process (performance & assurance) via the Health Inequalities Steering Group (HISG)	• Through existing controls (and increasing their focus/effectiveness) • Internal audit review of our governance, planning and delivery against inequalities
		Reporting progress updates through our Quarterly Assurance Meetings with the ICB	• 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
		Routine data-led reports shared with divisional leadership teams	• Through existing controls (and increasing their focus/effectiveness) • Internal audit review of our governance, planning and delivery against inequalities
		Divisional teams to report on how their services are considering health inequalities as a standing item at IPRs	• Through existing controls (and increasing their focus/effectiveness) • Internal audit review of our governance, planning and delivery against inequalities

BAF summary by committee: Quality and Safety Committee



EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	Trust Board meeting in public	**Date of Meeting**	8th October 2024

Report Title:	Annual Equality Report
Purpose of the Report/Outcome/ action requested:	The Board is asked to: 1. consider and approve the final draft of the Annual Equality Report 2024; 2. endorse the proposed action plans for addressing identified gaps in race, disability, and gender equality; 3. support ongoing initiatives to promote an inclusive and diverse workforce.
Decision Action:	For approval ☒ For Assurance ☒ For Information ☐ For Discussion ☐
Authority for Decision:	NHS Trust Boards review annual equality reports to ensure compliance with the Equality Act 2010 and the Public Sector Equality Duty (PSED). The report helps us to understand how our policies and services impact different groups, ensuring they are accessible and meet the needs of all individuals.
Executive Summary	This report provides an overview of the Trust's performance in promoting equality, diversity, and inclusion. It covers the period between April 2023-March 2024. Key areas of focus include the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and Gender Pay Gap analysis.
Regulatory/legal requirement:	Compliance with the Equality Act 2010, the duty to publish gender pay gap information, and obligations under the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).
Business Plan Link:	Quality ☐ People ☒ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration
Resource Implication/VFM Statement:	This includes provisions within the current year's budget for ongoing EDI initiatives.
Risk:	Identified risks include potential non-compliance with statutory requirements and ongoing challenges in achieving EDI targets. The report provides assurance on addressing these risks through strategic initiatives and action plans.

No of Pages	25	**Appendixes**	

Name, position and contact details of author:	Sarah Feather, Equality, Diversity and Inclusion Lead for Workforce s.feather@nhs.net

Report Sponsor	Steve Aumayer, Deputy Chief Executive Execuitve and Chief People Officer	**Presenter:**	Steve Aumayer, Deputy Chief Executive Execuitve and Chief People Officer

Governance and Engagement pathway to date:	This paper has presented to staff network meetings, the Workforce Equality Meeting and the People and Organisational Development Committee.
What happens next?	Post-approval the report will be published on the Trust website. The report's findings and recommendations will be implemented, with ongoing monitoring and evaluation to ensure continued progress towards EDI goals.
Publication	The report will be published as a legal and statutory requirement to report on the WRES, WDES and Gender Pay Gap and to publish action proposed actions. It does not contain confidential information.

1 Background

1.1 The Annual Equality Report 2023/2024 of the East Sussex Healthcare NHS Trust provides an in-depth review of the Trust's efforts to promote equality, diversity, and inclusion within its workforce. It covers the period between April 2023-April 2024. It aligns with statutory requirements and outlines the Trust's compliance with the Equality Act 2010, the Gender Pay Gap reporting obligations, and the Workforce Race and Disability Equality Standards.

1.2 Key measures within the annual include a traffic light system of progress, illustrated by either a red (R), an amber (A) or a green (G) point. The WRES and WDES consider any score of 0.80-1.20 as an acceptable threshold for parity of outcome or experience.

1.3 Green indicates any gaps between groups which are within accepted thresholds, and do not indicate concerns. Amber indicates work in progress and red indicates a decline beyond acceptable thresholds. This summary sets out the key measures that are either red or amber.

2 Issues

2.1 Workforce Race Equality Standard (WRES) (page 7)

2.1.1 Workforce ethnicity representation (WRES 1):

- 21.9% of the workforce are multicultural, growing by over 4% in three years.
- Medical and dental colleagues: 52.9%, Clinical staff: 24.8%.
- AfC 8c-9 and VSMs: 88.3% White British, 10.3% multicultural.

2.1.2 Ethnicity shortlisting-to-appointment likelihood (WRES 2): White applicants were 1.39 times more likely to be appointed than multicultural applicants, an improvement from 2.2 of the previous year.

2.1.3 Non-mandatory training (WRES 4): White people were 0.39 times less likely to access non-mandatory training compared to multicultural colleagues.

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

- 30.6% of multicultural colleagues reported harassment from patients, 28.6% from colleagues.
- Both figures are above the provider benchmarks and targets.

2.1.5 Equality of opportunity for promotions (WRES 7): 50.5% of multicultural colleagues felt the Trust provides equal promotion opportunities compared to 56.1% of white colleagues.

2.1.6 Staff work discrimination by ethnicity (WRES 8): 14.81% of multicultural colleagues experienced discrimination from managers, higher than their white counterparts.

2.1.7 Board ethnicity membership (WRES 9): The Board is 86% white, 6.75% multicultural, and 6.75% unknown, showing a -15.2% difference from workforce diversity.

2.2 Workforce Disability Equality Standard (WDES) (page 16)

2.2.1 Workforce disability representation (WDES 1):

- 5.9% of the workforce identify as disabled, an increase of 0.7% over the previous 12 months.
- 15.1% chose not to disclose their disability status, a decrease of 3%.
- However, 24.5% of staff survey respondents identified as disabled, nearly double those that share their status on ESR.

2.2.2 Shortlisting-to-appointment by disability (WDES 2): People without a disability were 1.3 times more likely to be appointed from shortlisting than people with a disability, aligning with regional and sector averages.

2.2.3 Harassment, bullying, or abuse by disability (WDES 4):

- 29.8% of disabled employees experienced harassment from patients, relatives, or the public, which is a 4.2% decrease from the previous year but still higher than the 23.8% reported by non-disabled employees.
- 15.2% of disabled employees reported harassment from managers, nearly double the rate for non-disabled employees.
- 24.9% of disabled employees faced harassment from other colleagues, which is 8 percentage points higher than for non-disabled employees.

2.2.4 Disability equal opportunities for promotion (WDES 5): 51.02% of disabled colleagues felt the Trust provided equal promotion opportunities, consistent over three years but 5 points lower than for non-disabled staff.

2.2.5 Pressure to work when unwell by disability (WDES 6): 27.6% of disabled colleagues felt pressured to work when unwell, nearly 10 points higher than for non-disabled colleagues, a deterioration over the previous 12 months.

2.2.6 Trust values their work by disability (WDES 7): 35.66% of disabled colleagues felt valued by the Trust, nearly 12 points lower than non-disabled colleagues.

2.2.7 Adequate adjustments for disabled people (WDES 8): 74.1% of disabled colleagues felt the Trust made adequate adjustments to enable them to work, a 2.6% decrease from the previous year.

2.2.8 Board disability membership (WDES 10): The Board is 66.7% non-disabled and 33.3% undeclared.

2.3 Gender Pay Gap (page 11): Published information on the government website for the snapshot date of 31st March 2024. Analysis of the pay gap across specific staff groups within the Trust.

2.3.1 Workforce Distribution: The workforce is 76% female and 24% male, with a slight increase of 0.3% in male employees over the past two years. Representation data for Trans or non-binary individuals remains unavailable.

2.3.2 Women earned £0.95 for every £1 earned by men in median hourly wages, a slight improvement over previous years. However, women's mean hourly pay is 18.3% lower than men's. Women occupy 69.3% of the highest-paid positions and 77.1% of the lowest-paid positions.

2.3.3 Bonus Pay Gap: Women earn £0.68 for every £1 that men earn in terms of median bonus pay, indicating a gender pay gap of 29.8%. Only 0.3% of women received bonus pay compared to 3% of men, with a significant disparity in bonus distribution among consultant staff (68% male and 32% female). The percentage of female staff receiving bonus payments in 2023-2024 decreased by 4.4%. These bonuses are Clinical Excellence awards, primarily for consultant-level medical staff and will not be awarded next year.

2.3.4 With a focus on pay - As part of NHS England's High Impact Actions, the Trust will report on both the ethnicity pay gap and the disability pay gap over the next 12 months.

3 Consequences for not taking action

3.1 Failure to address these issues could result in non-compliance with statutory requirements, decreased staff morale, and a less inclusive workplace, impacting overall service delivery and patient care.

4 Conclusion

4.1 The report indicates progress in some areas of equality, diversity, and inclusion while highlighting the need for continued efforts to address existing gaps. The Trust remains committed to fostering a diverse and inclusive environment, aligning with the NHS England High Impact Actions.

5 Recommendations

5.1 Board members are asked to consider and approve the final draft of the Annual Equality Report 2024.

5.2 Endorse the proposed action plans for addressing identified gaps in race, disability, and gender equality.

5.3 Support ongoing initiatives to promote an inclusive and diverse workforce.

East Sussex Healthcare NHS Trust

Annual Equality Report 2023/2024

KINDNESS INCLUSIVITY INTEGRITY

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

CONTENTS

FOREWORD

Welcome to the East Sussex Healthcare NHS Trust (ESHT) Annual Equality Report for 2023-24. This document serves as a comprehensive review of our ongoing commitment and progress toward fostering equality, diversity, and inclusion within our Trust and covers the period between April 2023-April 2024.

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

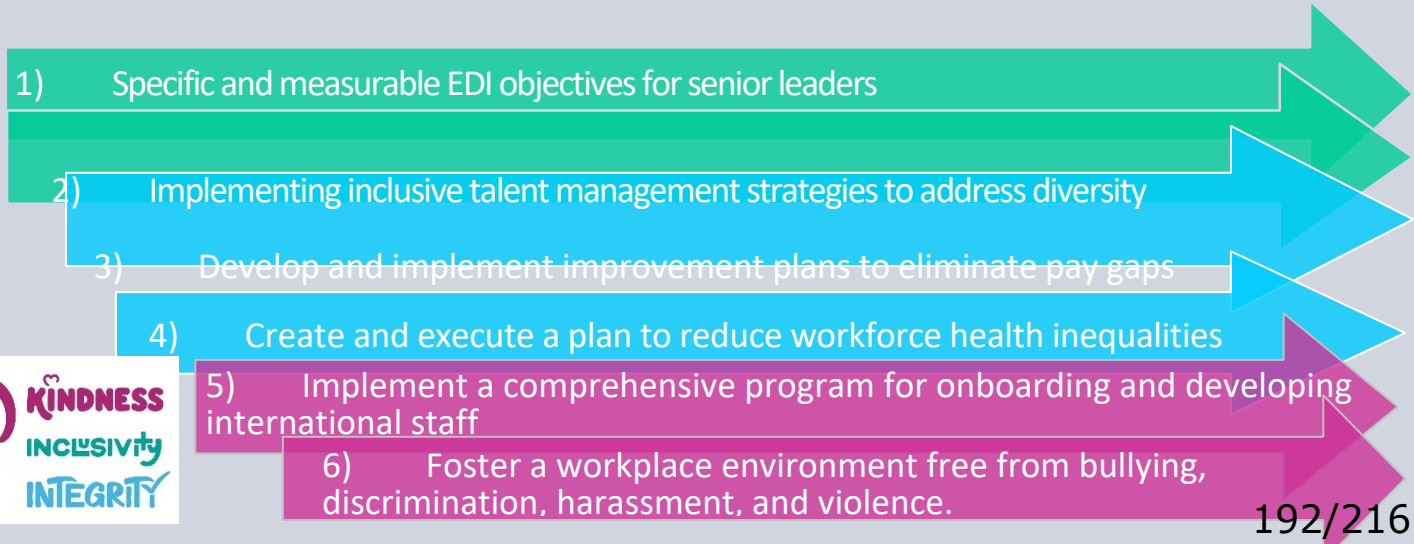
We recognise that true equality goes beyond mere compliance with standards and regulations. It requires continuous reflection, learning, and action to address the diverse needs of our workforce and the communities we serve. This report not only documents our achievements but also identifies areas where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

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

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

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

FIG. 1 NHS England High Impact Actions (summarised)



KINDNESS INCLUSIVITY INTEGRITY

SUMMARY

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

RACE (page 7)

i. Increased Representation and Appointment Likelihood: Multicultural colleagues make up 21.9% of the workforce, with Board representation growing to 6.67%. White applicants are 1.39 times more likely to be appointed from shortlisting compared to multicultural applicants, showing improvement from the previous year.

ii. Training and Disciplinary Processes**:** White people are less likely to access non-mandatory training compared to multicultural colleagues. Multicultural individuals are slightly more likely than white individuals to enter the formal disciplinary process this is within as the non-adverse likelihood range.

iii. Harassment and Discrimination**:** 30.6% of multicultural colleagues reported experiencing harassment from patients, and 28.6% from colleagues. Additionally, 14.81% experienced discrimination at work from their manager, which is higher than their white counterparts.

iv. Promotion Opportunities and Board Representation: 50.5% of multicultural colleagues believe the Trust provides equal opportunities for promotion, which is lower than the 56.07% reported by white staff. The new ethnicity pay gap will support in identifying any areas for improvement.

v. The Board's composition includes 86% white, 6.7% multicultural, and 6.7% unknown backgrounds, indicating a -15.2% difference in multicultural representation compared to the overall workforce.

RELIGION AND BELIEF (page 9)

vi. Increased Disclosure: The proportion of colleagues sharing their beliefs grew to 76.9%, a 3.9% increase over the past two years. However, 23.1% of colleagues still choose not to disclose their religion.

vii. Faith and Belief Network Growth: The Faith and Belief Network doubled in size, creating a larger multifaith room at EDGH and hosting events like the Hastings and Rother Multifaith Forum.

viii. Harassment and Discrimination: There has been a decrease in reported incidents of harassment and bullying from patients or their carers among all belief groups except for Jewish colleagues and those who prefer not to disclose their religion.

ix. Career Progression Opportunities: On average, 55% of colleagues felt ESHT provides fair treatment in promotions. The lowest proportion was among those who prefer not to disclose their religion (35.1%), while Muslim colleagues showed the largest increase in positive perception regarding career progression opportunities.

GENDER (page 11)

x. Workforce Distribution: The workforce is 76% female and 24% male, with a slight increase of 0.3% in male employees over the past two years. Representation data for Trans or non-binary individuals remains unavailable.

xi. Bullying and Discrimination: Female employees were slightly more likely than males to report instances of bullying from patients or discrimination from colleagues. Both genders experienced a decline in reports of discrimination from patients, with those preferring to self-describe reporting the highest incidence.

xii. Gender Pay Gap: Women earned £0.95 for every £1 earned by men in median hourly wages, a slight improvement over previous years. However, women's mean hourly pay is 18.3% lower than men's. Women occupy 69.3% of the highest-paid positions but have lower representation in medical and dental roles (45.3%) and executive team positions (37.5%).

xiii. Bonus Pay Gap: Women earn £0.68 for every £1 that men earn in terms of median bonus pay, indicating a gender pay gap of 29.8%. Only 0.3% of women received bonus pay compared to 3% of men, with a significant disparity in bonus distribution among consultant staff (68% male and 32% female).

SEXUAL ORIENTATION (page 13)

xiv. LGB Representation: Just over 4.5% of the workforce identified as lesbian, gay, or bisexual (LGB), marking a 0.5% increase from the previous year. The highest representation is in Agenda for Change (AfC) pay bands 5-7.

xv. Discrimination and Harassment: Colleagues identifying as bisexual or those preferring not to share their sexual orientation reported higher rates of discrimination and harassment compared to their heterosexual counterparts. Bisexual individuals experienced the highest incidence of harassment from colleagues (33.3%).

xvi. Career Progression: On average, 55% of colleagues felt ESHT provides fair treatment in promotions. Colleagues preferring not to share their sexual orientation had the lowest perception of fair treatment (35.9%), while gay or lesbian colleagues had the highest (64.6%).

xvii. Inclusivity Initiatives: Key initiatives include the growth of the LGBTQ+ network, diversity dialogues conducted by the ESHT sexual health team, participation in Hastings Pride, and an audit on the availability of gender-neutral facilities.

DISABILITY (page 15)

xviii. Disability Representation: 5.19% of the workforce shared that they identify as disabled on their electronic staff record, with 15.1% choosing not to share their disability status. This represents a 0.7% increase in disclosed disabilities over the past 12 months.

xix. Appointment Likelihood: People with disabilities were 1.3 times less likely to be appointed from shortlisting than non-disabled individuals, aligning with regional and sector averages.

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

xxi. Workplace Adjustments and Promotion: 74.1% of disabled colleagues felt that ESHT made adequate adjustments to enable them to work, a slight decrease from the previous year. 51.02% of disabled colleagues felt ESHT provided equal opportunities for promotion, which is similar to the disabled colleague provider benchmark compared to 73.9% nationally.

AGE (page 17)

xxi. Workforce Distribution and Aging Workforce: A significant portion of the workforce (one-third) is aged 45-55 years old, indicating an aging workforce comparable to national data. The age distribution across other groups has remained stable over the past year.

xxii. Career Progression and Young Workforce Satisfaction: Younger employees, particularly those in the 16-20 and 21-30 age groups, reported the highest positive responses regarding fair treatment in career progression (68.4% and 59.5%, respectively). This indicates that younger staff feel more supported in their career advancement within the Trust.

Equality Delivery System (EDS) (page 19)

xxii. Providing the position of ESHT in relation to demonstrating implementation of the EDS 2023.

ORGANISATIONAL INCLUSION (page 20)

xxiii. In addition to the progress highlighted in each section, across 2023-24 ESHT continued certain trust-wide initiatives to advance equality of opportunity, eliminate discrimination and foster good relations.

Conclusion

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

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

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

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

INTRODUCTION

Welcome to our annual equality report 2023-24

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

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

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

- Each section begins with our key achievements to advance equality, including fostering good relations.
- There are then key findings including measures of workforce equality, in particular representation and recruitment rates
- There are measures of our work to eliminate discrimination, including harassment.
- Each section then ends with next steps to address the findings that underpin the 2024/25 equality, diversity and inclusion action plans and links to the NHS England high impact actions for equality, diversity and inclusion.

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

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

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

This report evidences compliance with our specific equality duty (Equality Act 2010), our duty to publish gender pay gap information (*on page 11*) and our obligations to publish information relating to the workforce race equality standard (WRES; on page 7) and the workforce disability equality standard (WDES; on page 15).
It also provides the progress on our Equality, Diversity and Inclusion objectives 2024-2026 that are centered on the NHS England High Impact Actions.

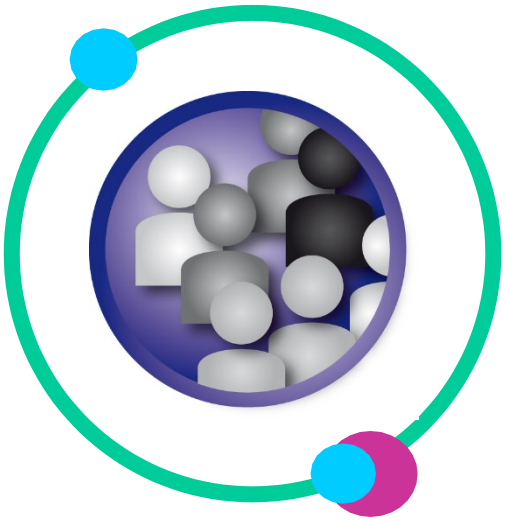
RACE

The proportion of our multicultural colleagues grew by 4% over three years across ESHT. Representation at Board level grew to 6.75%, the first increase since 2019.

Across three years there was a two-point increase in multicultural colleagues reporting the Trust takes positive action on health and wellbeing, coinciding with the engagement of the Multicultural Network to disseminate health and wellbeing opportunities.

1.1. Across 2023-24 ESHT's Multicultural Network brought people together from different backgrounds committed to valuing individuality, supporting inclusion and promoting diversity. Key achievements include:

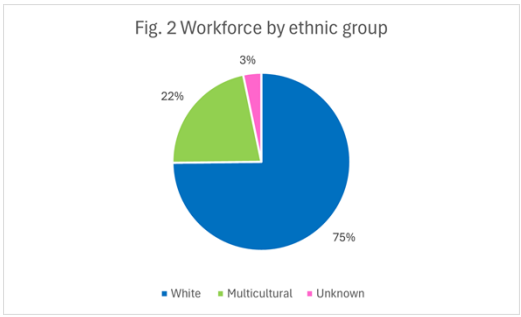
- Events were held to promote intercultural learning, culminating in the Trust's first South Asian Heritage Month celebrations.
- ESHT adopted the system-wide race equality strategy.
- The multicultural network membership grew to 143, representing approximately 1.6% of the total Trust workforce.



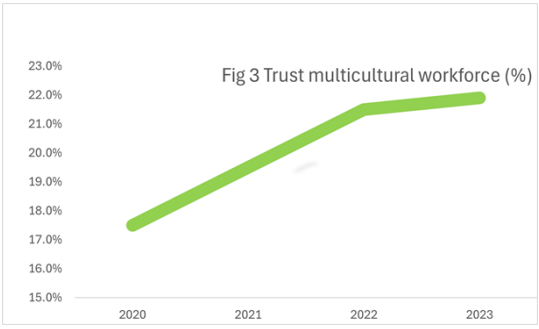
KEY FINDINGS: RACE

Workforce ethnicity representation (WRES 1)

1.2. The number of multicultural people in the workforce at 31 March 2024 was 1904, or 21.9% of the workforce overall. The Trust's multicultural workforce has grown by over 4% over the past three years.



1.3. Medical and dental colleagues was 52.9% (n.424). Clinical staff was 24.8% (n. 1329). Agenda for Change (AfC) pay band 5 had the largest proportion of any AfC pay band at 47.8% (n.601), followed by band 6 at 21.9% (n.264), then band 8d at 21.05% (n.4).



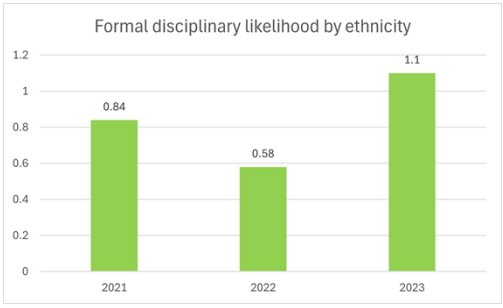
1.4. By comparison the average multicultural workforce was 26.4% in the whole NHS South Region.

1.5. AfC 8c-9 and very senior managers (VSMs) is made up of 88.3 % White British, 10.3% people from multicultural backgrounds. 1.4% is made up of those where ethnicity is unknown.

Ethnicity shortlisting-to-appointment likelihood (WRES 2)

1.6. In 2023-24, 338 individuals from a multicultural background and 983 white individuals were appointed. White applicants were 1.39 times more likely to be appointed from shortlisting compared to those from a multicultural background, aligning with regional and sector averages. This represents a positive trend from the previous year, when white individuals were 2.11 times more likely to be appointed. Last year's higher ratio was identified as a reporting anomaly and has been corrected. However, the current ratio is amber, as

the non-adverse likelihood range set by the NHS WRES strategy team is 0.80-1.25. The new ethnicity pay gap, as part of NHSE HIA will examine pay across bandings.

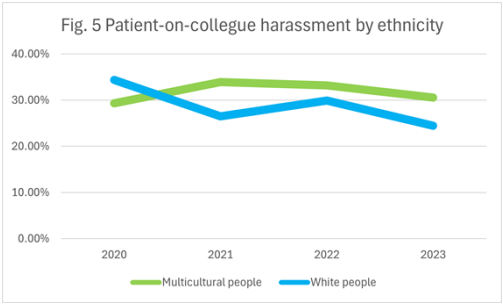


Formal disciplinary likelihood by ethnicity (WRES 3)

1.7. Multicultural individuals were slightly more likely than white individuals to enter the formal disciplinary process. Ratio score of 1.1 but this within the non-adverse likelihood range set by the NHS WRES strategy team. In 2023-24, 0.58% (n.51) of the total workforce underwent the formal disciplinary process.

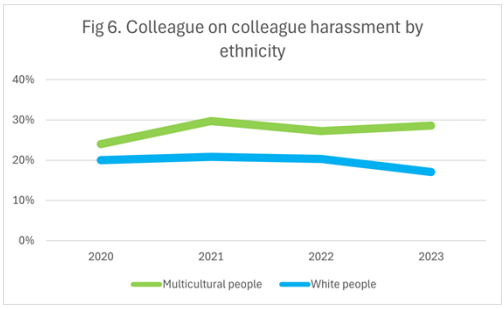
Non-mandatory training (WRES 4)

1.8. White people (n. 763) were 0.39 times less likely to access non-mandatory training and development compared to multicultural people (n. 316).



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

1.9. In the past 12 months, 30.6% of multicultural colleagues reported experiencing harassment, bullying, or abuse from patients, relatives, or the public, marking a decrease of 2.6 percentage points from 2022 and a 3.3-point decrease over the last two years. ESHT's figure is 3 points higher than the provider benchmark of 27.6%, and despite efforts, the target of reducing this percentage to 26.5% over the last two years was not met. Consequently, this target will b[illegible] maintained for the next two years.



1.10. In the past 12 months, 28.6% of multicultural colleagues experienced harassment, bullying, or abuse from other colleagues, which is 2.2 points higher than the provider benchmark and 2.7 points above ESHT's target of reducing this to 25.9% over two years. Addressing this issue will remain a priority for ESHT.

Racial equality of opportunity for promotions (WRES 7)

1.11. 50.5% of multicultural colleagues reported that the Trust provides equal opportunities for promotion, showing a positive trend over the past three years. This is 1% higher than the provider benchmark average for multicultural colleagues. However, with 56.07% of white staff reporting equal opportunities for promotion, the rating remains amber.

Staff work discrimination by ethnicity (WRES 8)

1.12. In 2023, 14.81% of multicultural colleagues (n.103) experienced discrimination at work from their manager or team leader. This represents an 8.07-point difference compared to the 6.74% of white colleagues reporting the same experience. However, it is 1.3 points lower than the provider benchmark of 16.7% for multicultural colleagues.

Board ethnicity membership (WRES 9)

1.13. The Board, including voting and executive members, was composed of 86% white, 6.75% multicultural, and 6.75% with unknown backgrounds. This results in a -15.2% difference between the multicultural representation in the overall workforce and on the Board.

NEXT STEPS FOR RACE EQUALITY 2024-26

- Review and strengthen procedures for reporting and addressing discrimination and harassment. Ensure that all reports are handled promptly and effectively. (HIA6)
- Examine ethnicity pay gap and diversity across pay bandings. (HIA3)
- Implement mentorship and sponsorship programmes to support career progression for multicultural staff. (HIA 2)
- Ensure those in middle management are prepared for senior roles. (HIA 6)

RELIGION AND BELIEF

The proportion of colleagues (76.9%) sharing their beliefs has grown by 3.9% over the past 2 years.

Discrimination rates from patients or the public towards our colleagues remain higher towards our Buddhist, and colleagues preferring not to state their religion.

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

- Creating a new, larger multifaith room at EDGH.
- Hosting the Hastings and Rother Multifaith Forum, featuring an evening talk on healthcare and faith.

KEY FINDINGS: RELIGION AND BELIEF

Workforce religion and belief representation 

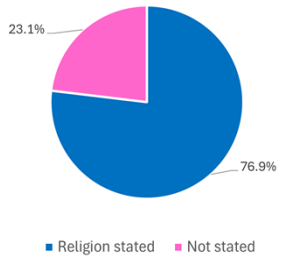
2.2. The number of people sharing their religion or belief with the Trust at 31 March 2024 was 6,691, or 76.9% of the workforce. Colleagues in agenda for change (AfC) pay band 5 had the largest proportion identifying as religious at 79.5%. Over 12 months the proportion of colleagues sharing their belief information increased by 1.4% a positive trend over the last two years.

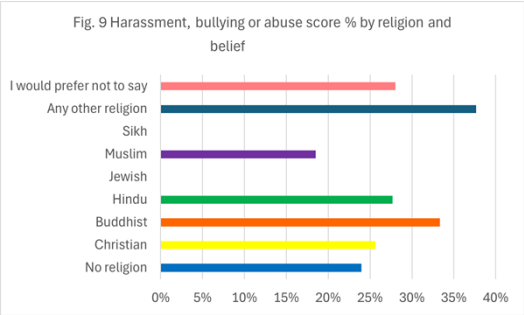
2.3. Colleagues sharing, they were Christian was the largest belief group at 44.7% (n.3889.), followed by the non-religious group at 23.1% (n. 2010) and then followed by the group sharing that described themselves as Atheist at 16.7% (n.1453).

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

2.5. The proportion sharing that they identify as non-religious decreased by 1.4% (n. 121) overall, over 12 months. The score is rated amber because 23.1% of colleagues do not wish to share their religion with us.

Fig. 8 Workforce by belief group



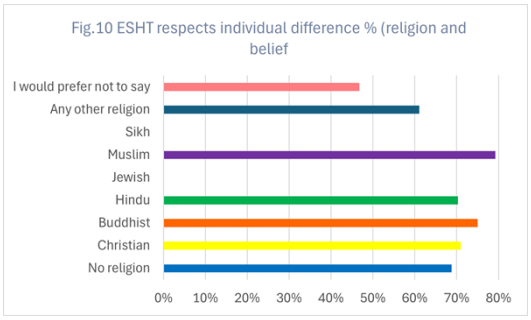


Religion and belief: We are safe and healthy by religion and belief.

2.6 In the past year, "We are safe and healthy" measured responses from the staff survey 2023 concerning personal experiences of harassment, bullying, or abuse from patients, relatives, members of the public, managers, and colleagues through nine specific questions. There has been a decrease in reported incidents of bullying and harassment from patients or their carers among all belief groups, except for Jewish colleagues and those who 'prefer not to disclose' their religion. It's important to note that the analysis considers the relatively low response rates to this particular question.

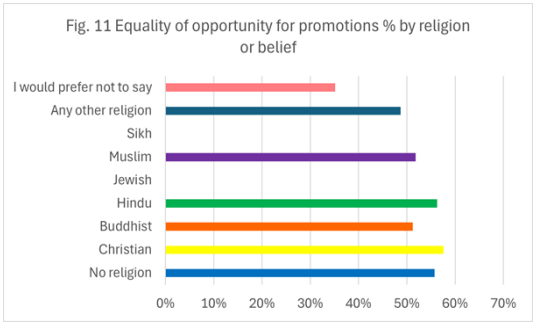
Religion and belief: We are compassionate and inclusive.

2.7. "We are compassionate and inclusive" pertains to a series of eight questions drawn from the staff survey 2023 that address equal opportunities in career advancement, workplace discrimination, and the recognition of individual differences.



2.8. ESHT's commitment to respecting individual differences reveals that colleagues who choose not to disclose their religion recorded the lowest score at 46.79%, with colleagues of 'Any other religion' following at 61.04%. Conversely, Muslim colleagues achieved the highest score at 79.3% (n. 82), marking the most significant percentage increase among all belief groups over the past 12 months.

Religion and belief equality of opportunity for career progression/promotions



2.9 On average, 55% of colleagues indicated that ESHT provides fair treatment in promotions compared to benchmark standards. The group with the lowest proportion was those who preferred not to disclose their preference, at 35.1% (n. 108), marking a 3% increase over the last 12 months but lagging nearly 21 points behind the highest score held by Christian colleagues at 57.5% (n. 1000). Among other faith groups within the Trust, those identifying with Any other religion reported 48.6% (n. 37). The largest percentage increase of 3.4% was observed among Muslim colleagues, reaching 51.8% (n. 42).

NEXT STEPS FOR RELIGION AND BELIEF EQUALITY 2024-26

- Continue to grow the Faith and Belief Network and increase engagement through regular meetings and events that cater to diverse religious and non-religious groups. (HIA5/6)
- Organise and host multifaith events to promote understanding and inclusivity among employees of different faiths and beliefs. (HIA4)
- Support the rollout and integration of the Sussex Religion and Belief guide (when available) to ensure all staff are informed about the diverse religious and belief practices within the workforce. (HIA4)
- Increase support available for people of all faiths and beliefs by exploring the requirement of a multifaith room at the Conquest hospital, providing resources for spiritual care, and ensuring respectful acknowledgment of various religious practices and observance. (HIA4)

GENDER (SEX)

Over the past two years, the male workforce has seen a slight increase of 0.3%, resulting in a current distribution of 76% female and 24% male employees. Representation data for Trans or non-binary individuals remains unavailable.

Female employees were slightly more likely than their male counterparts to report instances of bullying from patients or discrimination from colleagues.

Regarding pay equity, for every £1 earned by men, women earned £0.95, reflecting a 2p increase for women compared to the previous year. In terms of job distribution, women occupy 69.3% of the highest-paid positions (8a-9). However, their representation is lower in medical and dental roles at 45.3% and executive team positions at 37.5%.

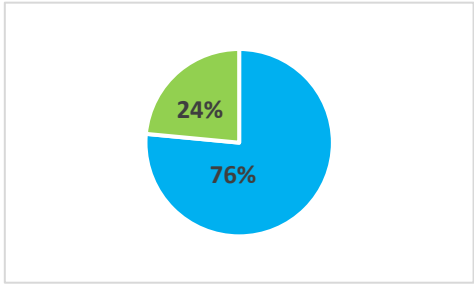
3.1. Across 2023-24 ESHT continued its work to promote gender equality between men, women, non-binary people and trans people. Key achievements include:

- Launching a Women's Network aimed at fostering support and development opportunities for female employees. This is the fastest growing network.
- Successfully organising and hosting an engaging event in celebration of International Women's Day.
- Commemorating South Asian Heritage Month with a thought-provoking presentation by Jaspreet Kaur, highlighting her experiences growing up as a South Asian female in the UK.
- Introducing a comprehensive policy to provide support for colleagues undergoing transition in the workplace.

KEY FINDINGS: GENDER (SEX)

Workforce gender representation

3.2. Out of 8,702 staff, 76% (n. 6613) were recorded as female and 24% (n. 2088) as male on their Electronic Staff Records (ESR). The proportion of the male workforce grew by 0.3%.

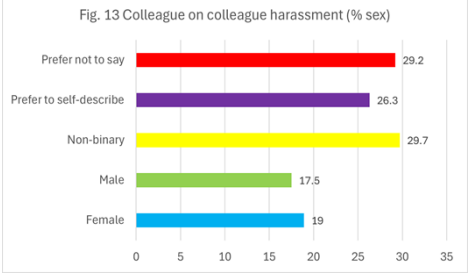


3.3. The female workforce in Agenda for Change pay bands was 78.2% (n. 5,445) compared to 41.8% (n. 298) of females with medical and dental contracts.

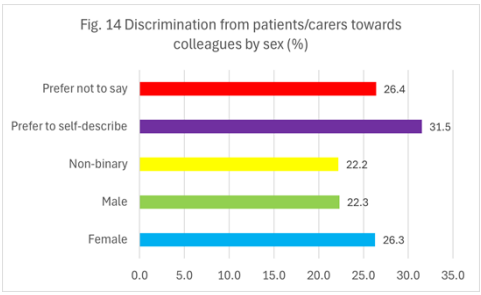
3.4. At present the national ESR system cannot record staff members who do not identify with a specific binary sex or who prefer to self-describe, hence this measure is rated amber. The staff survey now provides this detail and so is reported below.

Harassment, bullying or abuse from staff by gender

3.5. In the past twelve months, there was a 1.4-point distinction between the percentage of female employees (18.9%) and male employees (17.5%) who reported instances of harassment, bullying, or abuse from colleagues. Individuals identifying as non-binary reported the highest incidence at 29.7%.



Discrimination from patients, relatives, or membersof the public by gender



3.6. There was a four-point disparity between the percentage of males (22.3%) and females (26.3%) reporting discrimination from patients, relatives, or members of the public in the last twelve months, marking a declining trend for both genders. Those who prefer to self-describe reported the highest incidence of discrimination.

Gender Pay

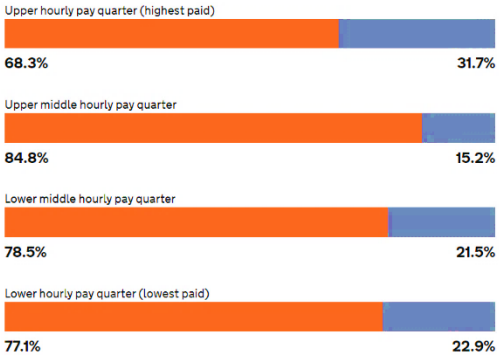
3.7. In ESHT, women earned £0.95 for every £1 than men earned when comparing median hourly wages (a change of £0.02 on the previous two years). Their median hourly pay is 6.9% lower than men's.

3.8. When comparing mean hourly wages, women's mean hourly pay is 18.3% lower than men's. This has reduced by 1.6% over the previous two years and is a decreasing trend.

3.9. The below table shows a breakdown of the mean pay rates split for Agenda for Change & Executive and Medical & Dental staff across the last 3 years. The % difference for Medical & Dental staff has reduced by 2.1% in 23/24 whilst the difference for Agenda for Change & Executive staff, where female mean pay is higher than male, has been constant across the three years, reducing by 0.5% since last year.

Agenda for Change and Medical & Dental	Male	Female	% diff
Agenda for Change - Mean hrly rate 31/3/22	£15.70	£15.89	**-1.2%**
Agenda for Change - Mean hrly rate 31/3/23	£16.42	£16.70	**-1.7%**
Agenda for Change - Mean hrly rate 31/3/24	£16.40	£16.62	**-1.2%**
Medical & Dental - Mean hrly rate 31/3/22	£39.43	£32.27	**18.2%**
Medical & Dental - Mean hrly rate 31/3/23	£40.83	£32.78	**19.7%**
Medical & Dental - Mean hrly rate 31/3/24	£37.98	£31.31	**17.6%**

Fig. 16 Pay quarters as of 31st March 2024



Proportion of women in each pay quarter

3.10. Pay quarters are determined by dividing all employees into four equal groups based on their pay. Analysing the representation of women in each quartile provides insight into their distribution across different levels within ESHT. Currently, women hold 68.3% of the highest paid positions and 77.1% of the lowest paid positions within the organisation.

Gender bonus gap

Fig. 17 Bonus Pay Gap

3.11. In ESHT, women earn £0.68 for every £1 that men earn in terms of median bonus pay, indicating a gender pay gap of 29.8%. Similarly, women's mean bonus pay is 25.3% lower than men's. Only 0.3% of women received bonus pay, whereas 3% of men received bonus pay.

3.12.The percentage of female staff receiving bonus payments in 2023-2024 decreased by 4.4%. These bonuses, which are Clinical Excellence awards, specifically pertain to medical staff, particularly consultant-level medical staff who are eligible for these awards. As of March 31, 2024, the gender breakdown among consultant staff was 68.0% male and 32.0% female, highlighting a significant disparity in bonus distribution.

3.13. The Clinical Excellence awards will no longer be awarded so there is no action to address this. The awards were considered exclusionary, as applicants had to have evidence of management and research activity. It was seen as contributing to the gender and ethnicity pay gaps and lacking value for money.

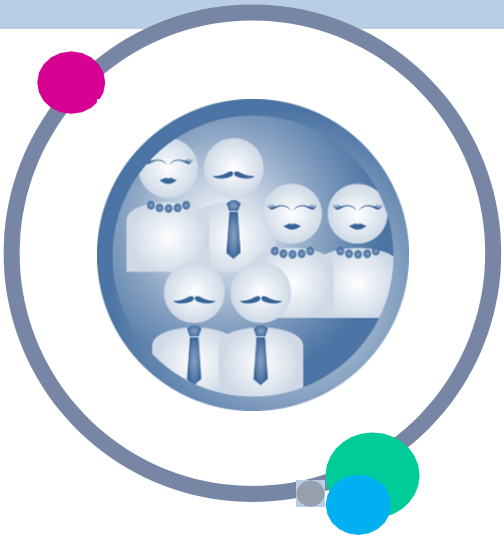
NEXT STEPS FOR GENDER EQUALITY 2024-26

- The focus on pay will expand to cover both the ethnicity pay gap and the disability pay gap over the next 12 months. (HIA 3)
- Ensure women as well as men sit on the SAS doctors group meetings. (HIA 3)
- Investigate leaver rate between men and women. (HIA 2)
- Strengthen support systems to reduce harassment and discrimination against all genders, with particular focus on those identifying as non-binary and women, who report higher rates of abuse. Regularly review and update training programmes to foster a safe and inclusive work environment. (HIA 6)
- Explore shared parental leave, monitoring uptake. (HIA 3)
- Explore the capability of systems to record and report on the representation and experiences of non-binary and trans staff. (HIA 6)
- Host regular events and workshops to promote gender inclusivity and raise awareness about gender equality issues. (HIA 3)

SEXUAL ORIENTATION

Four and a half percent of the workforce identified themselves as lesbian, gay, or bisexual (LGB), marking a 0.5% increase from the previous year. Employees at bands 5-7 showed a higher likelihood of identifying as LGB compared to other bands.

Those identifying as gay or lesbian scored five points higher than the ESHT average in their perception of the organisation's fairness in career progression, irrespective of diversity factors. Currently, there are 76 registered members in the LGBTQ++ network.



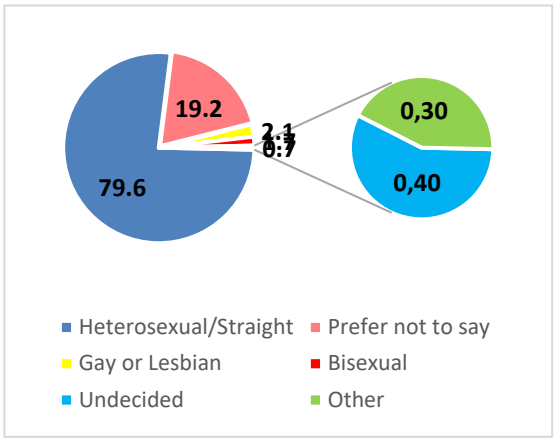
4.1. Across 2023-24 ESHT continued its work to promote equality between people of all sexual orientations, including lesbian, gay, bisexual (LGB) and straight people. Key achievements include:

- The ESHT sexual health team conducted diversity dialogues, sharing how they maintained dignity and respect while working with LGBTQ+ patients and creating openness to improve health outcomes for this community.
- An audit was conducted on the availability of gender-neutral facilities.
- ESHT participated for the first time in Hastings Pride with other NHS colleagues in August 2023.
- A session on Lived Experience was delivered to Health Care Assistants.

KEY FINDINGS: SEXUAL ORIENTATION

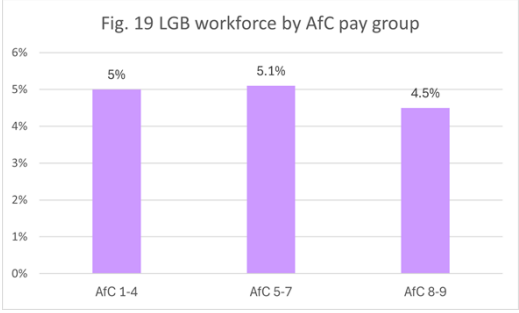
Workforce sexual orientation representation

4.2. The number of people sharing their sexual orientation with the Trust at 31 March 2024 was 7,204 or 82.5% of the workforce an increase of 2.5% on the previous year.



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

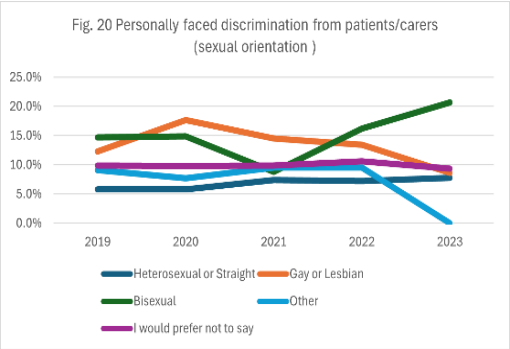
- Heterosexual: The largest group comprising 79.6% (n = 6,930) of
- colleagues.
- Prefer not to share: Constituting 19.2% (n = 1,678) of the workforce.
- Gay or lesbian: Representing 2.1% (n = 149) of colleagues.
- Bisexual: Making up 1.7% (n = 123) of the workforce.
- Undecided: Comprising 0.4% (n = 34) of colleagues.
- Other: Accounting for 0.3% (n = 26) of individuals who selected their sexual orientation as "other".



4.4. Colleagues in Agenda for Change (AfC) pay group 5-7 had the largest proportion identifying as LGB on their staff record at 5.1% each, compared to 3.9% in the workforce overall.

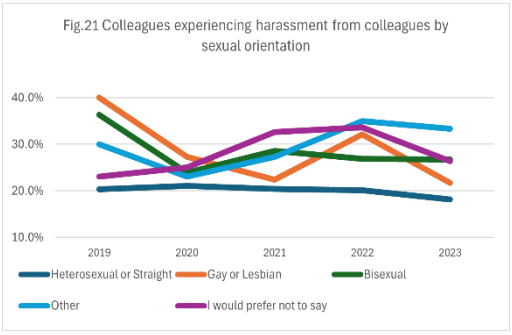
4.5. Correspondingly the lowest proportion of LGB on ESR was in Agenda for Change pay bands 8a-9 at 4.5.% (n.<10). With almost 20% of the workforce not wishing to share their sexual orientation an amber rating is given.

Safe environment (bullying and harassment) by sexual orientation



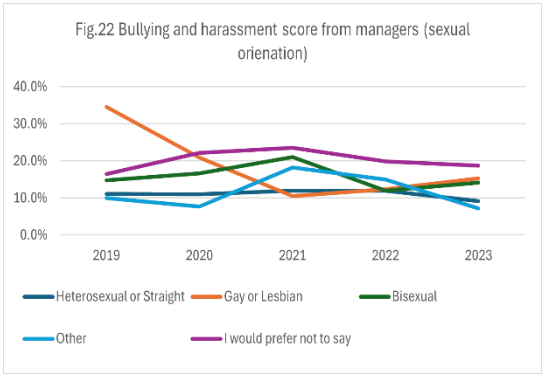
4.6. ESHT response to colleagues who have personally experienced discrimination from patients/services users, their relatives or other members of the public in the *preceding twelve months* was 26.3% of 4025 responding to the staff survey. The group with the lowest score was those colleagues describing their sexual orientation as Other at 0% (n.28) a reduction of over 9% on the previous year. Colleagues sharing that they were Bisexual were the highest at 20.69% (n.18) a decrease of 4%, followed those 'Preferring not to say' 9.33% (n.28) a decrease of nearly five points.

Colleagues experiencing harassment from colleagues by sexual orientation



4.7. In ESHT 33.3% (n.<10) of employees who identified as "Other" in terms of sexual orientation reported experiencing at least one incident of bullying, harassment, or abuse from colleagues. The next highest group was bisexual employees, with 26.7% (n.23) reporting such incidents, followed closely by those who 'Preferred not to Share' their sexual orientation, at 26.3% (n.77). Notably, there were overall decreases in harassment incidents reported across all sexual orientations.

Colleagues experiencing harassment from managers by sexual orientation



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

Equality of opportunity for career progression/promotions by sexual orientation

4.9. On average, 55% of colleagues reported ESHT acts fairly with promotions in line with the benchmark group. The group with the lowest proportion were colleagues 'Preferring not to share' their sexual orientation at 35.6% (n.106); nearly 25 points behind the highest score 60.4% colleagues sharing that they were Gay or Lesbian (n.55).

4.10 LGBTQ+ Rainbow Scheme

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

Despite the programme's closure, the initiative is evolving into a new iteration. Over the coming months, the Rainbow Badge Scheme will engage with NHS Trusts to outline the details of this new phase and ESHT will then determine how it will be involved.

NEXT STEPS FOR SEXUAL ORIENTATION EQUALITY 2024-26

- Continue to grow the LGBTQ+ network and enhance engagement through regular meetings, support groups, and social events. Encourage more staff to share their sexual orientation by fostering a safe and inclusive environment. (HIA 6)
- Review external webpages to ensure inclusivity for LGBTQ+ patients and colleagues. (HIA 4)
- Focus on reducing the incidence of discrimination and bullying, particularly for bisexual and "Other" identified colleagues who report higher rates of these issues. (HIA 6)

DISABILITY

According to electronic staff records, 5.9% of the NHS workforce identifies as disabled, while 15.1% chose not to disclose their disability status. Disabled individuals were slightly less likely to be appointed from shortlisting compared to their non-disabled counterparts, according to a key national Workplace Disability Equality Standard (WDES) measure.

In terms of workplace accommodations, 74.1% of disabled colleagues felt that adequate adjustments were made to enable them to work, marking a decrease of 2.6% from the previous year. The disAbility network has 77 registered members, and the A-Typical sub-network has 39 registered members.

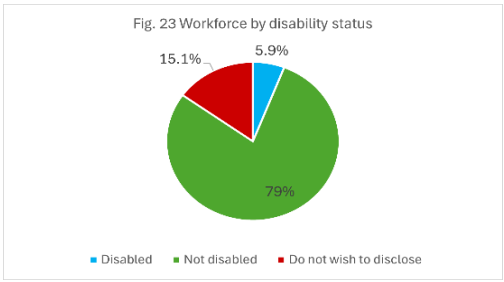
5.1. Across 2023-24 ESHT continued to advance disability equality and make reasonable adjustments for disabled people in our workplaces and to facilitate that their voices be heard (WDES 9). Key achievements include:

- Centralised the reasonable adjustments process (HIA 6)
- Produced a handbook for managers in accessing the right information to support their neurodiverse colleagues (HIA 4)
- ESHT Estates team completed a project with AccessAble to map all our toilet facilities and identify those that are accessible or gender neutral.

KEY FINDINGS: DISABILITY

Workforce disability representation (WDES 1) 

5.2. The number of people sharing their disability with the Trust at 31 March 2024 on their staff record was 513, or 5.9% of the workforce an increase of 0.7% on the previous 12 months.The group not wishing to share their disability status is at 15.1%, although a decrease of 3% over the preceding 12 months. There were 24.5% (n.1001) of 4,071 who answered the staff survey and selected they were disabled hence the amber rating remains.



5.3. Colleagues in agenda for change (AfC) pay band 8a-9 had the largest proportion of disabled colleagues declaring a disability at 6.1% (n. 25), with the lowest also being colleagues AfC band 1-4 with just 5.7% (n. 178) sharing they have a disability.

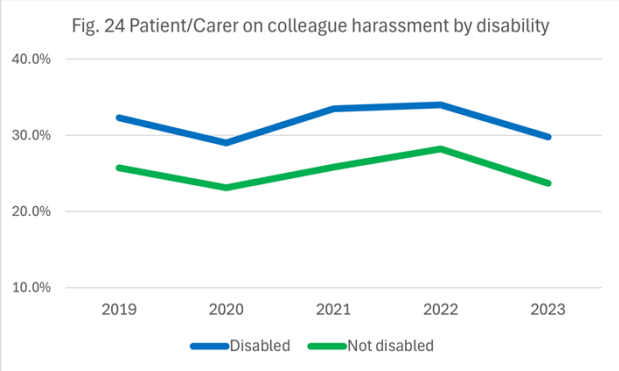
5.4. Over the last year the number of colleagues sharing their disability status grew by 0.74% overall, this is an increasing trend.

Shortlisting-to-appointment by disability (WDES 2) 

5.5. People without a disability were 1.3 times more likely to be appointed from shortlisting than people with a disability, the same as the regional and the sector averages. This is a decline from last year's score of 1.0. However, it is amber because 0.80-1.25 is the non-adverse likelihood range set by the NHS WDES strategy team.

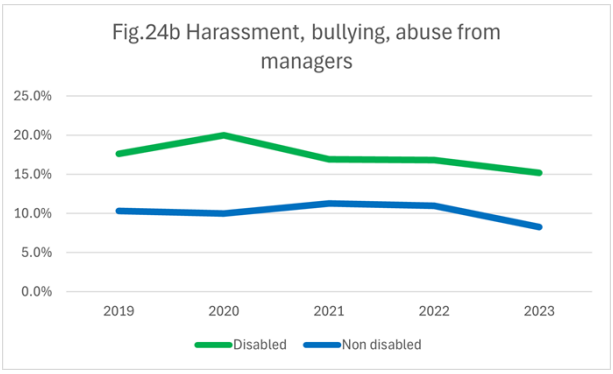
Formal capability likelihood by disability (WDES 3) 

5.6. People with a disability were 1.1 times (10%) more likely to enter the formal disciplinary process than people without a disability, much lower than the regional and the sector averages. This is an improvement from last year's score of 0.3 less likely to enter the formal disciplinary process if you were disabled. However, the WDES national team regard the score as not statistically significant.



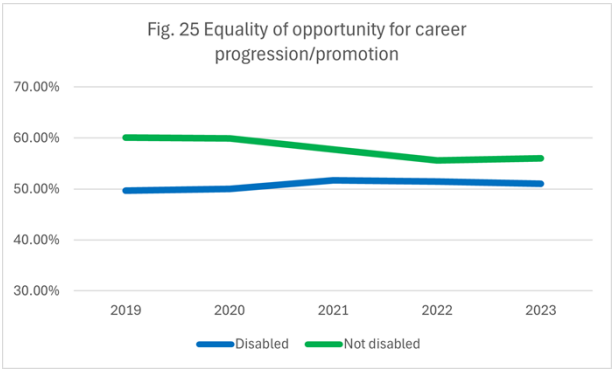
Harassment, bullying or abuse by disability (WDES 4) A

5.7. In the 2023 staff survey, 29.8% (n.295) of disabled colleagues reported experiencing harassment, bullying, or abuse from patients, relatives, or the public in the past 12 months. This figure represents a 6% difference compared to the 23.8% (n.696) of non-disabled colleagues who reported similar experiences. However, it also marks a 4.2% decrease from the previous year, aligning with the benchmark for disabled colleagues, which stands at 29.8%. R



5.8. The survey showed that 15.2% (n.150) of disabled colleagues reported experiencing harassment, bullying, or abuse from managers, nearly double the 8.25% (n.239) reported by non-disabled colleagues.

5.9. Additionally, 24.9% (n.245) of disabled colleagues faced similar issues from other colleagues, an 8-point difference compared to the 17% (n.494) of non-disabled colleagues. Although these figures are the lowest in the past five years and align with benchmark providers, addressing this issue remains a priority for ESHT.



Disability equal opportunities for promotion (WDES 5) A

5.10. 51.02% of disabled colleagues felt ESHT provided equal opportunities for promotion, with a static trend over three years, a 5-point difference from the 56.02% of non-disabled staff, hence the amber rating. ESHT disabled colleague figure is the same as the disabled colleague provider benchmark.

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

5.11. 27.6% of disabled colleagues felt management pressure to come to work when not feeling well enough, nearly a 10-point difference from the 17.5% of non-disabled colleagues. This is a 5-point deterioration on the previous twelve months but below the disabled colleague provider benchmark.

Trust values their work by disability (WDES 7) R

5.12. 35.66% of disabled colleagues felt the Trust valued their work, nearly a 12-point difference from the 54.62% of non-disabled staff but both these scores are equal to that of the disabled provider benchmark.

Adequate adjustments for disabled people (WDES 8) A

5.13. 74.1% of disabled colleagues felt ESHT made adequate adjustment(s) to enable them to carry out their work. A 2.6% decrease on those disabled staff completing the staff survey in the previous twelve months.

Board disability membership (WDES 10)

5.14. The Board, including voting and executive, was 66.7% non-disabled and 33.3% undeclared. A

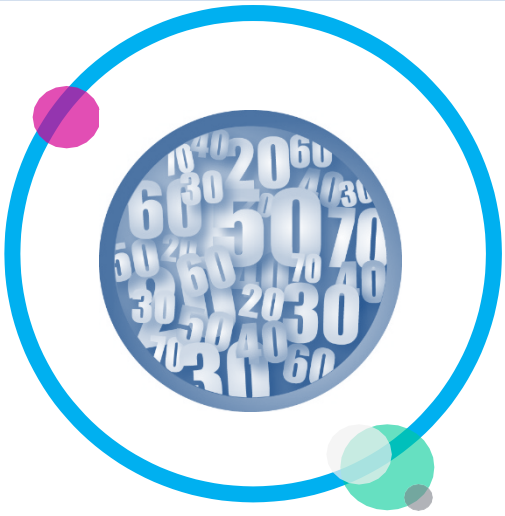
NEXT STEPS FOR DISABILITY EQUALITY 2024-26

- Increase efforts to encourage colleagues to disclose their disability status through assurance of confidentiality and reduce the percentage of colleagues who prefer not to disclose their status. (HIA 6)
- Develop strategies to support neurodiverse colleagues in the workplace. (HIA 4)
- Examine disability pay gap and across pay bandings and solutions through talent management. (HIA 3)
- Explore continued collaboration with AccessAble for the accessible environment of sites. (HIA 4)
- Work towards increasing the visibility of disabled individuals in leadership positions, including the Board. (HIA 2)

AGE

Colleagues in the 16-21 age group have a higher perception of equality of opportunity compared to the average provider sector benchmark, with a score of 68.4%.

Conversely, colleagues in the 51-65 age group report lower perceptions of equality of opportunity compared to all other age groups, yet their score remains higher than the benchmark provider score.



6.1. Across 2023-24 the Trust continued its work to promote age equality between people of different ages. Key achievements include:

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

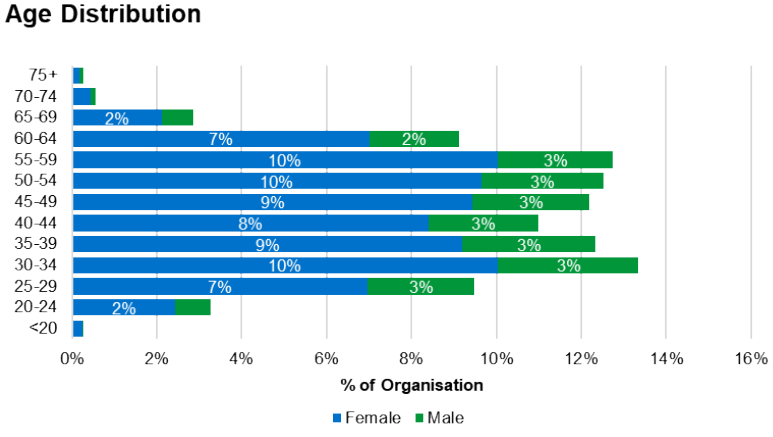
KEY FINDINGS: AGE

Workforce age representation

6.2. ESHT Colleagues in post changed over twelve months from 8778 in April 2023 to 8702 in April 2024.

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

Fig. 26 Workforce age groups by %

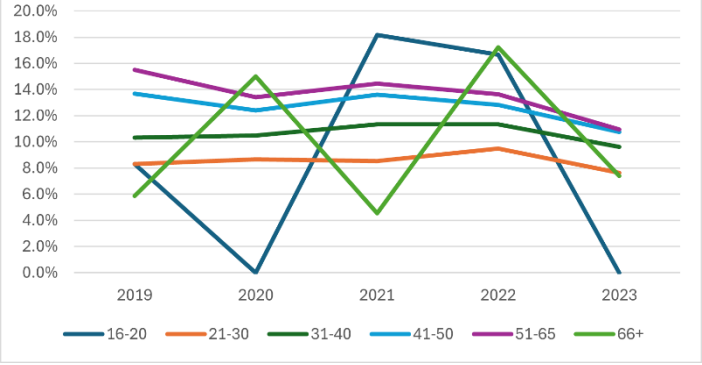


We are safe and healthy (bullying and harassment) by age.

6.4. The 21–30-year age group reported the lowest negative response rate at 24.9% (n. 120) regarding experiences of bullying and harassment from patients, service users, their relatives, or other members of the public. Similarly, the 66+ years age group reported a rate of 25% (n. 21). Comparatively, the provider benchmark for all age groups stood at 24.7%, while ESHT averaged 26.3%.

6.5. The 21-30 years age group reported the lowest score for taking positive action on health and wellbeing at ESHT, with 24.9% (n. 120). Meanwhile, the 16-20 years age group saw the largest increase, with an 11.8% rise compared to the previous twelve months. Conversely, the 41-50 years age group experienced the largest decline, decreasing by 5.5%. No other age groups showed such a significant decrease in this regard.

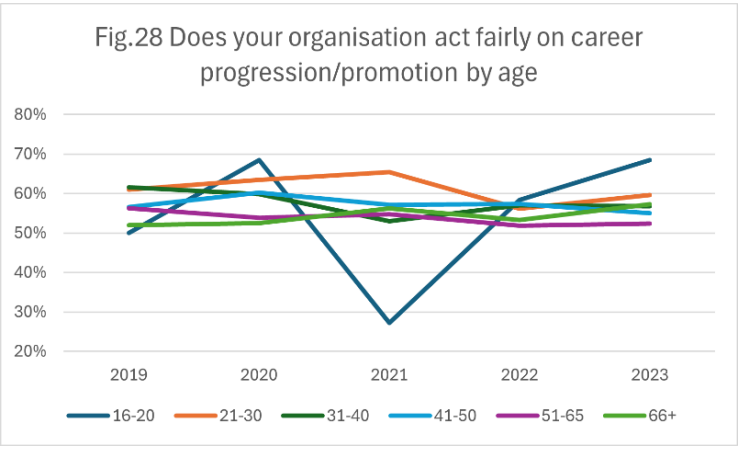
Fig.27 Discrimination from manager by age



6.6. The 16–20-year age group had the lowest positive response regarding experiencing discrimination from a manager or team leader, with 0% (n. 19). In contrast, the highest response came from the 51–65-year age group, at 10.96%, compared to the organisational average of 10.25% (n. 408).

Age equality, we are compassionate and inclusive.

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



6.7. The 16-20 and 21-30-year age groups provided the highest positive responses regarding ESHT's fairness in career progression, with rates of 68.4% and 59.5% respectively. In contrast, the lowest score was recorded in the 51-65-year age group, at 52.5%.

6.8. The 16-20 age group showed the largest increase in positive responses to the career progression question, with a 10% rise, representing a 41% increase over the past two years.

NEXT STEPS FOR AGE EQUALITY 2024-26

- Where possible support social mobility and improve employment opportunities across healthcare through education programmes. (HIA 4)
- Review support systems available for colleagues specifically with a focus on vulnerable age groups. (HIA 6)
- Increase the awareness of age discrimination across the ESHT.

EQUALITY DELIVERY SYSTEM (EDS)

The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

7.1 ESHT reviewed EDS 2022 in creating equality objectives in October 2023. However, the reporting template was not completed for two reasons:

- The standards are extremely broad (e.g., 'Individual patients (service users) health needs are met'), so at this stage every question would be scored 1 'Developing Activity'. As everything would score the same, there was little benefit in writing up the scoring exercise in addition to the equality objectives.

- The supporting technical guidance emphasises application of EDS 2022 at 'regional or ICS footprint'. And the Sussex ICS has said it remains in the position that it cannot lead on implementation at present.

7.2 In addition to this as the Trust began to implement the actions set out in the NHS EDI HIA. Work to implement these actions further supports ESHT in demonstrating compliance with the EDS.

High Impact Actions (HIAs)

	High Impact Action (HIA)
HIA1	Chief executives, chairs and board members must have **specific and measurable EDI objectives** to which they will be individually and collectively accountable.
HIA2	**Embed fair and inclusive recruitment processes and talent management strategies** that target under-representation and lack of diversity.
HIA3	Develop an **improvement plan to eliminate pay gaps.**
HIA4	Develop an improvement plan to **address health inequalities** within their workforce.
HIA5	Develop a **comprehensive induction, onboarding and development programme for internationally recruited staff.**
HIA6	Create an environment which **eliminates the conditions in which bullying, discrimination, harassment and physical violence at work** occurs.

NEXT STEPS FOR NHSE HIA 2024-25

- Continue to monitor demonstration of compliance with EDS 2022 and work with the ICS when they begin to lead on implementation.

- Continue with the programme of evidence-based action to meet the requirements of the NHS England high impact actions for EDI.

ORGANISATIONAL INCLUSION

ESHT put the Armed Forces Act obligations into practice by signing the armed forces covenant, achieving Veteran Aware Accreditation and the bronze award of the Ministry of Defence (MoD) Employer Recognition Scheme. Equality, Diversity and Inclusion policy and equality and health inequalities impact assessment process have both been reviewed.

Diversity dialogues were held month about a variety of topics, hearing from those with lived experiences.

8.1 In addition to the progress highlighted in each section, across 2023-24 ESHT continued certain trust-wide initiatives to advance equality of opportunity eliminate discrimination and foster good relations. Key achievements include:

- Establishment of the Inequalities Sub Board Committee
- Revision and update of the Equality, Diversity and Inclusion policy and the Equality and Health Inequality Impact Assessment (EHIA)
- Creation of the centralised reasonable adjustment process
- A monthly diversity dialogue with a different topic for each month.
- Establishment of the Armed Forces steering group and have 28 colleagues trained as Armed Forces Champions across various departments.

KEY FINDINGS: INCLUSION

We are compassionate and inclusive: diversity and equality

8.2 ESHT overall score for colleagues believing that ESHT respects individual differences was 68.3%. This was just below the average provider benchmark of 70.3%.

We are compassionate and inclusive: Inclusion

8.3 ESHT overall score for colleagues feeling a strong personal attachment to their team was 63.9%, this is similar to the provider benchmark of 64.3%.

NEXT STEPS FOR ORGANISATIONAL INCLUSION 2024-26

- Continue to implement the NHS England high impact actions, with progress overseen by the Inequalities Sub Board Committee.
- Provide opportunities for allies and for role models to develop cultural competence by increasing support for leaders to identify bias, to reduce prejudice and to eliminate systemic barriers.
- Pursue further achievement in the Defence Employer Recognition Scheme.
- Align systems to strengthen the conditions for change; embedding inclusion within talent management.

Summary of Actions for Equality, Diversity, and Inclusion 2024-2026

This action plan outlines the specific steps and initiatives to advance equality, diversity, and inclusion across the organisation for the period 2024-2026, ensuring alignment with the NHS England High Impact Actions and organisational goals.

Objective	Actions
Race (Aligns with HIA 2,3 and 6)	
1. **Strengthen Reporting and Addressing Discrimination**	Review and enhance procedures for reporting and addressing discrimination and harassment. Ensure all reports are handled promptly and effectively.
2. **Examine Ethnicity Pay Gap**	Analyse and address ethnicity pay gaps across different pay bandings.
3. **Mentorship and Sponsorship Programmes**	Implement programmes to support career progression for multicultural staff.
4. **Middle Management Preparation**	Ensure those in middle management are prepared for senior roles.
Religion and Belief (Aligns with HIA 4, 5 and 6)	
1. **Grow Faith and Belief Network**	Increase engagement through regular meetings and events catering to diverse religious and non-religious groups.
2. **Organise Multifaith Events**	Promote understanding and inclusivity among employees of different faiths and beliefs.
3. Rollout Sussex Religion and Belief Guide	Support the rollout and integration of the ICB guide (when available) to ensure staff are informed about diverse religious and belief practices.
4. **Enhance Spiritual Care Resources**	Explore the requirement of a multifaith room at the Conquest Hospital and provide resources for spiritual care.

Objective	Actions
Gender (Sex) (Aligns with HIA 2,3 and 6)	
1. Ensure Equal Representation in SAS Doctors Group	Ensure women as well as men sit on the SAS doctors group meetings.
2. Investigate Gender-based Leaver Rates	Investigate the leaver rate between men and women.
3. Strengthen Support Systems	Reduce harassment and discrimination against all genders, with a focus on non-binary individuals and women. Regularly review and update training programme to foster a safe and inclusive work environment.
4. Explore Shared Parental Leave	Explore shared parental leave and monitor its uptake.
Sexual Orientation (Aligns with HIA 4 and 6)	
1. **Enhance LGBTQ+ Network Engagement**	Regularly conduct meetings, support groups, and social events to encourage staff to share their sexual orientation. Foster a safe and inclusive environment.
2. **Review Inclusivity of Webpages**	Ensure external webpages are inclusive for LGBTQ+ patients and colleagues.
3. **Reduce Discrimination and Bullying**	Focus on reducing discrimination and bullying, especially for bisexual and "Other" identified colleagues.

Objective	Actions
Disability (aligns with HIA 1,2,3,4 and 6)	
1. **Encourage Disability Disclosure**	Increase efforts to assure confidentiality and reduce the percentage of colleagues who prefer not to disclose their status.
2. **Support Neurodiverse Colleagues**	Develop strategies to support neurodiverse colleagues in the workplace.
3. **Examine Disability Pay Gap**	Analyse and address the disability pay gap across different pay bandings through talent management solutions.
4. **Collaboration with AccessAble**	Continue exploring collaboration for accessible environments across sites.
5. **Increase Visibility in Leadership**	Work towards increasing the visibility of disabled individuals in leadership positions, including the Board.
Age (Aligns with HIA 4, 5 and 6)	
1. **Support Social Mobility and Employment Opportunities**	Improve employment opportunities through education programmes.
2. **Review Support Systems**	Focus on support systems for vulnerable age groups.
3. **Increase Awareness of Age Discrimination**	Enhance awareness to reduce age discrimination within ESHT.
Organisational Inclusion (Aligns with HIA 1, 4 and 5)	
1. **Implement NHS England High Impact Actions**	Progress overseen by the Inequalities Sub Board Committee. Align systems to embed inclusion within talent management.
1. **Develop Cultural Competence**	Provide opportunities for allies and role models to develop cultural competence, reduce bias, and eliminate systemic barriers.
2. **Pursue Defence Employer Recognition Scheme**	Work towards further achievements in the Defence Employer Recognition Scheme.

EAST SUSSEX HEALTHCARE NHS TRUST (ESHT)

Report To/Meeting	Trust Board	**Date of Meeting**	8th October 2024
Report Title:	Use of Trust Seal		
Purpose of the Report/Outcome/ action requested:	The Board is asked to noted the usage of the Trust Seal.		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐		
Authority for Decision:	East Sussex Healthcare NHS Trust Standing Financial Instructions		
Executive Summary	This report informs the Board of the use of the Trust Seal since the last Board meeting in public. The Trust Seal was used to seal one document between 1st August 2024 and 26th September 2024: **Sealing 113** Currie & Brown, 16th September 2024. Agreement for design and build of x-ray room one, Eastbourne District General Hospital.		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☐ People ☐ Sustainability ☐		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues had been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	1	**Appendixes**	None
Name, position and contact details of author:	Pete Palmer, Board Secretary		
Report Sponsor	Damian Reid, Chief Financial Officer	**Presenter:**	Steve Phoenix, Trust Chair
Governance and Engagement pathway to date:	Not applicable		
What happens next?	Not applicable		
Publication	Report is for publication		

Trust Board Meeting in Public forward plan 2024

Agenda sections	10th December 2024
Location	Conquest
Standing Items	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	Veteran Awareness Presentation
Quality, Safety and Performance	Maternity Overview Q2 Patient Survey Martha's Law Implementation Update (paper)
Strategy	ESHT CiC - Items for Information, Items for Decision, Minutes
Governance and Assurance	Speak Up Guardian Update Violence Prevention and Reduction Standard
Annual Reports	Infection Control Safeguarding Patient Experience Guardian of Safe Working Hours Organ Donation
Items for Information	Meeting Dates for 2025