East Sussex Healthcare NHS Trust Board Agenda

Date: Tuesday 25th February 2025

Time: 09:30 – 12:45

Venue: St Mary's Boardroom, Eastbourne District General Hospital

	Opening Business	Lead	Action	Time	Paper
1.	Welcome and apologies	Chair	Information	09:30	
2.	Colleague Recognition	Chair	Information		Yes
3.	Art of the Possible	Abi Turner / Anne Canby	Information	09:30	
4.	Declarations of Interest	Chair	Information		
5.	Minutes of Trust Board Meeting in public 10.12.24	Chair	Approval	09:45	Yes
6.	Matters Arising	Chair	Approval		Yes
7.	Chair's Update	Chair	Information	09:50	No
8.	Chief Executive's Report	Acting CEO	Information	09:55	Yes
9.	Board Committees Chairs' Reports	Committee Chairs	Assurance	10:05	Yes
Quality, Safety and Performance					
10.	Integrated Performance Report, Month 9 (December) (i) Chief Executive Summary (ii) Quality & Safety (iii) Our People (iv) Access and Responsiveness (v) Financial Control and Capital Development	Acting CEO CNO/CMO Acting CPO COO CFO	Assurance	10:10	Yes
11.	Avoidability of Inpatient Deaths	CMO	Assurance	10:55	Yes

Break – 10 minutes

Strategy					
12.	Update on the New Hospital Programme following the Government's review and conclusions	Acting CEO	Information	11:10	Yes
13.	Sussex Surgical Centre	COO	Information	11:30	No
14.	Fire Enforcement Notice Update	DEF	Information	11:40	Yes

Governance and Assurance					
15.	Q3 Board Assurance Framework	COS	Assurance	11:50	Yes
16.	Annual Reports: 16.1 Emergency Preparedness, Resilience and Response 16.2 ESHT Charity Annual Report and Accounts	COO Paresh Patel	Assurance	12:00	Yes
For Information					
17.	Use of Trust Seal	Chair	Information	12:15	Yes
18.	Questions from members of the public	Chair		12:15	
19.	Agenda Forward Plan	-	Information	12:30	Yes
20.	Date of Next Meeting 29th April 2025	Chair	Information		
21.	Close	Chair			

Steve Phoenix
Chairman

Key:	
Chair	Trust Chair
Acting CEO	Acting Chief Executive
CNO	Chief Nurse and DIPC
COO	Chief Operating Officer
CFO	Chief Finance Officer
COS	Chief of Staff
CMO	Chief Medical Officer
Acting CPO	Acting Chief People Officer
DEF	Director of Estates and Facilities
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: 2025

Month	Location	Timing	Any other information
29th April 2025	Relais Cooden Beach Hotel	0930-1245	
24th June 2025	Lecture Theatre, Conquest Hospital	0930-1245	
26th August 2025	St Mary's Boardroom, EDGH	0930-1245	
23rd September 2025 (**AGM**)	Relais Cooden Beach Hotel	1400-1600	Annual General Meeting
28th October 2025	Relais Cooden Beach Hotel	0930-1245	
16th December 2025	Lecture Theatre, Conquest Hospital	0930-1245	

Agenda Item: 2

Report To/Meeting	Trust Board	**Date of Meeting**	25 February 2025
Report Title:	Colleague Recognition		
Key question	How does the Trust recognise and thank colleagues for their contribution, effort and loyalty?		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐		
Report Sponsor:	Jacquie Fuller, Assistant Director of HR – People Engagement	**Presenter(s):**	Steve Phoenix, Chair
Outcome/Action requested:	The Board is asked to receive this report for information and for assurance about the formal recognition of our people over the last two months		
Executive Summary	East Sussex Healthcare NHS Trust recognises that the high standard of care and quality of service it provides is dependent on the contribution, effort and loyalty of its people. This is an opportunity for the Trust to acknowledge the exceptional performance, behaviour, achievements and contribution that our colleagues and volunteers have made to the organisation.		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	7	**Appendixes**	No
Governance and Engagement pathway to date:	None		
What happens next?	Prepare to launch the new Colleague Recognition programme		
Publication	Yes		

1. Festive refreshment events

In December festive refreshment events were held for colleagues across the trust. The events, hosted by the People Engagement team, with support from the Chaplaincy and networks, were on behalf of the Board to thank colleagues for their contribution and effort over the year.

Refreshments were provided at the Conquest, EDGH, Rye Hospital, Bexhill Irvine Unit and Bexhill Hospital Ophthalmology outpatients, with over 4,500 mince pies being handed out, as well as other festive treats.

For colleagues unable to leave their area of work multiple deliveries were made to busy patient-facing areas at EDGH and the Conquest over the two days. We delivered 128 token vouchers to community based colleagues so that they could enjoy a festive treat at a time to suit, delivered with the support of our Wellbeing and CHIC colleagues.

This year we welcomed the Rock Choir to the EDGH and it was fantastic to see colleagues popping in to hear the festive singing.

We know that colleagues really appreciated the events, along with those taking delivery of refreshments, and the fact we had so many colleagues come along demonstrates how valuable they are to raising morale at such a busy time of the year.

A round up of the events was shared in Connected in January, along with photos from the events.






2. Changes to long service recognition

From 1 April we will recognise long service at five yearly intervals, starting at five years. Colleagues will receive a certificate and badge for each five years, which will include all NHS service, rather than ESHT service only. A suite of new certificates and badges have been developed in conjunction with the Communications team, which are aligned with the values. Badges include the colours NHS blue and silver up to 30 years' service, with NHS blue and gold from 35 years up to 50+ years' service.

New Long Service badges

New Long Service certificate

3. Hero of the Month

The Hero of the Month award offer has been updated with a refreshed nomination form where colleagues are asked to consider which value their nomination is best aligned to. In conjunction with the Communications team a new suite of certificates have been developed to reflect this which are aligned with the Trust values.

New Hero of the Month certificates

4. Trust Awards

The Partnership Forum was asked to consider the current annual Trust awards model and gain feedback from across the organisation on whether it meets the needs of the trust. Results have been fed back and these are being reviewed and considered, with a recommendation to be made in February to the Executive Leadership team.

Taking on board feedback received about creating a more inclusive awards event, where more colleagues can attend to support and share in the celebrations, we are hoping to move towards a graduation style ceremony.

The current award categories will be reviewed by the Partnership Forum in February to ensure they remain reflective of the organisation and are fully aligned to the values.

A communications bulletin in March will notify our colleagues of the improvements, why it is important and how they can get involved.

5. COVID-19 certificates

Following colleagues' requests for a mark of recognition for the part they played during the COVID-19 pandemic a certificate was created in conjunction with the Communications team in recognition of the hard work and dedication during that difficult period in 2020 and 2021. Colleagues were invited to complete a simple online form if they wished to receive a certificate.

This certificate is in addition to the thank you recognition letter and pin badge which was sent to colleagues' home addresses at the time. Over 400 certificates have now been issued to a variety of staff groups and this initiative has now closed.

Covid-19 certificate

6.

7. Celebrating our people

Hero of the Month

November and December 2024 – due to be announced

Long Service Awards

Nov-24					
10 Years' Service			**25 Years' Service**		**40 Years' Service**
Jazmin	Andrews		Muhannad	Al Hashim	
David	Baker		Julie	Boydell	
Stefanie	Bond		Nida	Castro	
Samantha	Bull		Debra	East	
Paul	Coleman		Jennifer	Lewis-Johns	
Natasha	Csobonas		Susan	Penfold	
Natasha	Done		Armi	Ras	**50 Years' Service**
Vanessa	Evans		Juthamat	Seymour	
Judith	Galloway		Myleen	Spry	
Melanie	Jones		Keith	Talbott	
Christy	Jose		Michael	Todd	
Kathleen	Longley		Mary	Tungul	
Barbora	O'Neill		Angela	Whiteman	
Lynsey	Sadler		Minika	Wray	
Emma	Williams				
Amy	Woodleigh				
Malgorzata	Wronecka				

Congratulations to our People

Esperanza San Juan - 25 years' service

Melanie Jones - 10 years' service

East Sussex Healthcare NHS Trust Board Minutes

Date: 10th December 2024

Time: 09:30 – 12:45

Venue: Lecture Theatre, Education Centre, Conquest Hospital

		Actions
	Attendance: Paresh Patel, Vice Chair and Senior Independent Director (Chairing) Steve Phoenix, Chairman and Non Executive Director (via MS Teams) Steve Aumayer, Acting Chief Executive (ACEO) Vikki Carruth, Chief Nurse & Director of Infection, Prevention and Control (CN) Amanda Fadero, Non-Executive Director (via MS Teams) Karen Manson, Non-Executive Director Simon Merritt, Chief Medical Officer (CMO) Charlotte O'Brien, Chief Operating Officer (COO) Damian Reid, Chief Finance Officer (CFO) Frank Sims, Non-Executive Director Nicki Webber, Non-Executive Director (via MS Teams) Carys Williams, Non-Executive Director <u>Non-Voting Directors</u> Ama Agbeze, Associate Non-Executive Director Jenny Darwood, Acting Chief People Officer (ACPO) Amber Lee, Associate Non-Executive Director Richard Milner, Chief of Staff (COS) <u>In Attendance</u> Dan Asamoah, Associate Director of Corporate Governance and Compliance (ADCG) Garry East, Deputy Chief Operating Officer (DCOO) (for item 86/024 only) Sarah Feather, Equality, Diversity and Inclusion Lead (EDIL) (for item 86/024 only) Brenda Lynes, Director of Maternity Services (DOM) Pete Palmer, Board Secretary (BS) (minutes) <u>Observing</u> Mark Standen, Associate Director Nursing	
	Apologies: None received	
84/024	**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. The meeting was quorate according to the Constitution of the Trust. Paresh, Vice Chair welcomed everyone to the meeting. He reported that this was Steve Aumayer's first meeting as Acting Chief Executive, having taken over the role in November. It was also Jenny Darwood's first meeting as Acting Chief People Officer. He welcomed Sarah Feather and Garry East. He noted that Steve Phoenix, Nicki Webber and Amanda Fadero were attending the meeting via MS Teams.	

85/024	**Staff Recognition** The Chair reported that August's winner had been Kelly Death, a Clinical Research Midwife. She had received the award for her tireless and inclusive work in setting up the Obstetric Bleeding Study UK in the Trust.	
86/024	**Veteran Awareness** Sarah, EDIL and Garry, DCOO, made a presentation to the Board about the work that had been undertaken to help the Trust achieve veteran aware accreditation. An initiative had been launched to become accredited in September 2023; the Trust had signed the Armed Forces Covenant in November 2023 demonstrating the organisation's commitment to supporting people and patients who were members of the armed forces community. In February 2024 the Trust had received Bronze Defence Employer Recognition Scheme (ERS) status, and had been officially accredited as a Veteran Aware organisation in March 2024. Colleagues from across the organisation had been trained to understand the support that was available for the armed forces community within the Trust and from charities. Training was part of the Trust induction highlighting support that was available and a policy had been developed for managers. In June an armed forces celebration event had been held by the Trust, supported by a large number of charities. The Trust had then achieved Silver ERS status in September 2024, and had been supporting other NHS trusts in achieving their accreditation along with providing support for local charities. The Trust had also been involved in an event on Armistice Day and had taken part in a medical endeavour day, as well as forging close links with armed forces charities such as ssafa, the Armed Forces charity. Garry, DCOO noted that veteran awareness was vital as it supported colleagues in the Trust, the local population and patients; everyone involved in the project had volunteered to help and new forums were being initiated within the Trust and locally to share learning. The Board noted that there were a wide range of actions that could be taken to support the armed forces community and their families, and the Trust was taking a flexible approach to employing people who were in armed forces families, recognising that they might need to move around at short notice. Next steps would be to continue to work with reservists, identifying how the Trust could support patients in the armed forces with additional support, work with cadets, the introduction of a Sussex wide and national armed forces champions network and main aim is to go for gold defence employee recognition scheme. The Board were asked to raise awareness of the scheme and support available within the Trust, to champion veteran friendly practices and proposed that the Board included veteran awareness progress within its workplans. The ACEO explained some of the challenges that were faced by members of the armed forces and explained that the Trust was proactively looking for opportunities to provide support. He praised the passion, drive and desire seen in the Trust to support members of the armed forces explaining that it was one of the most proactive groups that he had worked without during his career. He thanked Sarah, EDIL, Garry, DCOO and Henry Alexander for the support and leadership for the project. He noted that it normally took organisations three years to move from bronze to sliver ERS status; the Trust had achieved this in three months and was now being recognised regionally as an exemplar organisation. Frank, NED remarked that the progress made in such a short time was exceptional. He asked if there was any learning from the work that had been undertaken that could be applied beyond armed forces veterans. Garry, DCOO explained that more would be undertaken by working closely with SSAFA, the Armed Forces charity who had good links within the community and to other charities who may be aware of resources that the Trust was not aware of that could be helpful.	

	The CMO praised the amazing work that had been done and asked whether the Trust had formal links which would allow people to be signposted to the Trust when they left the armed forces, noting that they may have skills that would benefit the Trust. Garry, DCOO explained GPs recorded information about whether their patients were serving members, veterans or member of serving family, and work was being undertaken to see if this could be shared with the Trust. Sarah, Equality, Diversity and Inclusion Lead explained that the Trust had a profile on its website for jobs for people leaving the Armed Forces and was working with an organisation called Step into Health to support members of the armed forces transitioning into healthcare.	
87/024	**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.	
88/024	**Minutes** The minutes of the Trust Board meeting held on 8th October 2024 were reviewed. Two amendments were noted: The following changes were noted: • *76/024 - Winter Preparedness 2024/25*: the CN had committed to bringing updates on the delivery of plans to improve discharge to the People and Organisational Development (POD) and Quality and Safety (Q&S) Committees and to the Board. • *78/024 - Board Assurance Framework Q2*: POD have agreed that BAF2 should remain on the BAF and would be subject to review in Q3. They were otherwise agreed as a correct and accurate record of the meeting. Carys, NED suggested that it would be helpful to review the Board meeting dates for 2025 as once was scheduled for 23rd December. It was agreed that this date would be reviewed.	**ADCG**
89/024	**Matters Arising** The Chair led discussion on the Matters Arising and the following was noted: • *72/024 – reporting to the Board*: the CEO explained that a proposal would be brought to the Board in the new year about how the quality and consistency of reporting to the Board would be improved. He noted that this had been discussed at the recent Board Development Day and was an ongoing improvement process that would take some time. **Action Closed.** • *73/024 – Learning from Deaths reporting:* The CN explained that quarterly reporting would be presented to the Board in February and would include additional information. **Action Closed.** Carys, NED reported that she would be meeting with the Board Secretary to review outstanding actions from previous Board meetings.	**CW/BS**
90/024	**Acting Chief Executive's Report** The ACEO presented his report and the following points were noted: • NHSE recognition of the Trust's support to the system in tackling long waits for elective procedures, supported by a letter from NHSE. • Work that was being undertaken in the Trust and as a system to prepare for winter pressures. • Changes to the way that musculo-skeletal (MSK) services would be delivered by the Trust moving forward as the Trust had recently won a contract, in partnership with Horder Healthcare, to deliver community MSK services in East Sussex.	

- A recent joint training emergency response exercise at Eastbourne DGH.
- Strengthening of clinical research in the Trust through participation in the TICH-3 study.
- The introduction of a new therapy programme, Speak Out!, for patients with Parkinson's.
- The Trust had recently been awarded with the Silver Award in the Defence Employer Recognition Scheme (ERS) by the Lord-Lieutenant of Hampshire, Sir Neil Atkinson.

The Acting CEO thanked the Board and other colleagues for the support that they had given to him during his challenging start in his new role. He explained that while the recent budget had spoken about significant investment in the NHS during 2025/26 there was an expectation that Trusts would reach a breakeven financial position for the year. Planning guidance for NHS organisations for 2025/26 had not yet been released, but he anticipated that it would be an extremely challenging year for the Trust; planning for 2025/26 had already commenced. A further update would be presented to the Board once planning guidance was released. He explained that announcements about the New Hospital Programme were expected in January.

He reported that winter pressures were already affecting the Trust and the NHS; across the country flu rates had doubled and were expected to double again. In addition, there were unusually high levels of vomiting and diarrhoea and a new strain of Norovirus with peaks expected in January and potentially in March 2025. The Trust had seen its second highest ever number of attendees in Emergency Departments (EDs) the previous week and beds were already full with additional beds and corridor care in place.

The Trust had agreed to take on the care of 2,081 patients in Sussex who had waited for more than 65 weeks for elective care and about a third of the patients had now been transferred to the Trust. This had impacted on the Trust's 65 week performance, which had been recognised at national level; a letter from NHSE recognising the support that the Trust was giving to the system was included within the meeting papers.

A six month pilot for consolidating day surgery services from Uckfield to Eastbourne had commenced and progress would be closely monitored. Proposals would be developed once the six month period had ended. An unscheduled care hub had been opened in Polegate, in collaboration with SECAmb, which ensured that emergency calls were dealt with in the best possible manner. The hub had already resulted in a number of occasions where patients were not sent to hospital when this was unnecessary and was helping to ensure that patients received the right care as quickly as possible in the right place.

The Acting CEO explained that he had been delighted to include good news stories within his report about MSK services, clinical research and the Speak Out! Therapy programme for patients with Parkinson's.

Carys, NED explained that she was impressed by the work that was being undertaken for patient with early Parkinson's. She noted that East Sussex County Council (ESCC) had recently proposed a number of cuts, including to day centres and support to people with addiction; in addition local charities were talking about their need to reduce services over the next year. She was concerned about the impact that this would have on the local population and the Trust and asked whether this had been included within the Trust's plans for 2025/26. The Acting CEO explained that the council had an obligation to reach a break even position and were in challenging position. He had recently spoken to the CEO of ESCC who was very aware of the potential impact of the changes being proposed; the council would work with the Trust and other partners to mitigate any impact once proposals had been finalised as much as possible. The Trust would include this within planning for 2025/26.

	Frank, NED asked whether plans to address the organisational pressures seen within the Trust were being developed as these were only likely to get worse as winter progressed. The Acting CEO explained that capacity and demand models had been developed demonstrating the gap to where the Trust wanted to be. The Trust was working with GP confederations and the system to address the issue. The COO reported that the systemwide discharge workstream continued with challenging targets set of reducing the number of patients with no criteria to reside by 30% by the end of March 2025. ***The Board noted the Acting CEO's report.***	
91/024	**Committee in Common update** Paresh, Vice Chair reported that the NHS Sussex Committee in Common (CiC) was due to meet the following day. The CiC would be reviewing data which provided an overview of services across Sussex and how they should evolve over the next ten years.	
92/024	**Board Committees Chairs' Upwards Reports** Audit Committee Paresh, Vice Chair presented his report. He explained that the Committee had discussed the marked increase in levels of violence and aggression in hospitals during the last year, driven in part by an increase in patients with mental health needs. Ensuring the safety of staff and patients had placed additional operational and financial pressures on the Trust. He reported that the CN and Trust security teams were doing a lot of work to help staff to identify situations at an early stage and giving them de-escalation strategies. Finance and Productivity Committee The Board noted the F&P Chair's upward report. People and Organisational Development Committee Carys, NED presented her report. She reported that POD had also discussed security in the Trust and had invited the team to return to the Committee as concerns remained. She praised and thanked the security team for all the additional work that they had done to keep staff and patients safe. POD remained concerned about staff attendance and the attendance management processes, which caused a lot of additional work for managers. The Board noted that updates on progress to address both areas would be presented to the Committee during 2025. Quality and Safety Committee The Board noted the Q&S Chair's upward report. ***The Board noted the Committees Chairs' upward reports.***	
93/024	**Integrated Performance Report (IPR) for Month 7 (October)** The IPR was jointly reported by the Acting CEO, CN, CMO, Acting CPO, CFO and COO. The Acting CEO explained that the document presented to the Board included a year end financial projection for the Trust of a £14.9m deficit position. Subsequent to the papers being published, this figure had reduced and the Trust now expected to end the year in a deficit position of between £11-13m, with work continuing to reduce this further. Quality and Safety The CN presented the update, she highlighted the following points: • There was a slight increase in severity three events, a potential link to high bed occupancy were being explored. • The Trust was hoping to improve Duty of Candour compliance following recent national changes and had asked for additional focus from colleagues. • A positive improvement in complaint response times was reported, along with improved maternity and Friends and Family test response rates.	

- SAFER work continued with a focus on discharge and deconditioning; positive improvements had been seen in ward and pre-no criteria to reside (NCTR) lengths of stay.

The CN praised the work of the Trust's incredible staff, noting that the last couple of weeks had been exceptionally busy and planned ward moves had been successfully undertaken in a single day despite this. She thanked all the staff involved. The CN had spent time in the Acute Medical Unit and in the ED at EDGH the previous day and thanked the colleagues there for their commitment, compassion and professionalism.

Carys, NED asked how community staff were faring, and the CN reported that community teams were also under a great deal of pressure, although this could be harder to see. Community colleagues were hugely supportive in trying to avoid unnecessary admissions to hospital and to support discharge. She explained that everyone in the organisation was feeling pressured. Carys, NED asked whether it would be possible to invite a community team to present to the Board so that there was greater visibility for all they did, and so that the Board could thank them. The CN explained that the Community team would be delighted to do this. **BS**

Nicki, NED asked whether she should be concerned by the increase in patient safety concerns. The CN explained that the number of events had not changed, but there had been a slight increase in severity three events which was being analysed. No obvious reasons for this increase had been identified, but further work was being undertaken to understand if this was related to the increase in bed occupancy. Paresh, Vice Chair asked whether it was possible to break down data by site to more clearly understand the reasons for the increase. The CN explained that this was already done, and a more detailed breakdown was being considered for inclusion in future IPRs.

The CMO presented the mortality report to the Board, noting that the Summary Hospital-level Mortality Indicator (SHMI) look at patient comorbidities and corrected for these; the Risk-Adjusted Mortality Index (RAMI) looked at people who had died during their hospital stay. The SHMI figure remained within control limits; it was rebased every time it was released, so the Trust's stable position meant that this metric was generally improving. The RAMI had not been rebased for some time, but the Trust was rated as 44th out of 120 acute trusts. Crude mortality, which had been 1.78% in 2023 had reduced to 1.57% in August 2024. He reported that weekend mortality in the Trust was lower than the weekday rate.

<u>Our People – Our Staff</u>
The Acting CPO presented the update. The Board noted the following points:

- Workforce usage in October was 58 whole time equivalents (wte) above plan, mainly driven by the use of escalation areas, nursing requirements for patients with mental health needs and hosted roles within the organisation.
- Workforce expenditure had increased due to the pay award implemented in October, with an improvement of £200k.
- Workforce metrics continued to be positive, although there had been an increase in sickness in October, predominantly due to coughs, colds, anxiety and stress.
- The rise in turnover reported during recent months had reduced in October and would continue to be monitored.
- The Trust's vacancy rate had been at its lowest ever level at 2%, and applications being received for hard to fill roles were increasing.
- Appraisal and mandatory training rates remained stable. Deep dives were being undertaken to look at whether Basic Life Support (BLS) and blood transfusion training could be delivered differently as they remained lower than other mandatory training.

Paresh, Vice Chair asked what the reasons were for staff leaving the Trust. The Acting CPO explained that the primary reasons were retirement and staff leaving the area. Many of the staff who retired chose to come back and work for the Trust on the staff bank. Carys, NED noted that a large amount of work had been undertaken to support retiring staff to come back on the bank and praised the team for this.

Access and Responsiveness

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

- Performance against the 4 hour emergency access standard in October had been 70.5%. While was a reduction in delivery levels the Trust continued to be well placed nationally. An improvement had been seen in November.
- 71 patients had waited in ED for more than 12 hours following a decision to admit in October and improving this was an area of focus for the organisation.
- There had been high bed occupancy during the month, with large numbers of patients with NCTR. The impact of SAFER and work with system partners to reduce the numbers of NCTR patients was beginning to be seen.
- 22 patients had been in the Trust for more than 100 days and was also an area of focus.
- The Trust had delivered 81.9% against the Faster Diagnosis cancer standard in September, and performance against the 62 day standard had also improved to 70.2%.
- Reviews of breast, lung and skin cancer pathways had commenced.
- The Trust's diagnostic (DM01) performance had significantly improved during the months to 92.5%.
- The Urgent Community Response (UCR) standard of 70% had been consistently achieved during 2024, virtual ward occupancy was above 80% and the Trust had performed well for ambulance handover but was focussing on improving further.
- The Trust had reported 120% elective activity against 2019/20 performance during October.
- No children had waited for more than 104 weeks for community paediatric appointments; 14 children had waited over 78 weeks and 166 over 52 weeks, greatly reduced from 655 in November 2023.

Carys, NED asked how staff were doing, given the recent pressures on the organisation, and whether there was anything the Board could do to support them. The COO explained that it had been an extremely challenging, relentless period for colleagues who were nonetheless remaining positive. The CN explained that colleagues always appreciated being visited by members of the Board, which could make a big difference to morale.

Frank, NED noted the improvement seen in unurgent community response times, given the pressures on the organisation. He asked how the Trust was ensuring that patients remained safe in EDs during long waits and how staff were supported in caring for those patients. The CN explained that safety huddles took place throughout the day, with staff very aware that all patients who had waited for a long time were checked on regularly. Long ED waits were not good for patients of staff and staff worked incredibly hard to minimise these. The COO explained that meetings that took place throughout the day focussed on ensuring that patients were moved out of ED as soon as possible.

Amanda, NED explained that she was pleased that performance remained encouraging, particularly the recent improvements to cancer performance, despite the current pressures on the organisation. Paresh, Vice Chair agreed, noting the importance of ensuring that patient safety was prioritised ahead of financial considerations. He thanked the Trust's staff for all that they did.

Financial Control and Capital Development

The CFO presented the update. The Board noted the following points:

	• The Trust had reported an in month deficit in October of £1.4m which was £1.7m adverse to the planned monthly position. • The Trust's was projecting a £14.9m deficit position for the year. • The Trust was delivering against its Cost Improvement Plan (CIP) target for the year, but much of this was on a non-recurrent basis which would impact on plans for 2025/26. • A reset of the Use of Resources programme for the second half of the year had been completed, which had shown under delivery at month seven of £0.03m. The Trust was now focussing on its run rate, looking to improve this for every division on a monthly basis. Reporting would be changed the following month with a focus on run rate improvement, rather than against budgets to provide greater understanding about how the Trust would meet its financial targets. • The Trust was ahead of its capital plan as of month seven and was forecasting a breakeven capital position for the year. The Trust's capital position continued to be monitored with regular reporting presented to F&P. The Acting CEO reported that it was important that the Trust focussed on planning for 2025/26 as continuing to do the same things would not enable the Trust to reach a breakeven position. There would be some difficult challenges for the Trust including conversations about what activity the Trust did and how and where it was done. The only way that the Trust would be able to deliver a breakeven position would be to deliver care in the best possible and most efficient manner, and only delivering to contract and not above this. Structural changes would also be required to achieve this. Paresh, Vice Chair asked whether assumptions about planning for 2025/26 were being made prior to the planning guidance being released. The CFO confirmed that planning had commenced with divisions a month before. Tentative planning guidance had been set by Executives with a minimum of 5% savings for divisions and a suggested additional 1% to mitigate winter pressures and other contingencies for the year. This would be updated once national planning guidance was released. He anticipated that 2025/26 would be extremely challenging for the organisation. Paresh, Vice Chair commended the estates team on delivering the capital programme for the year, noting that they had done this in very challenging circumstances. **The Board noted the Integrated Performance report.**	
94/024	**Maternity Overview Q2** The DOM presented the maternity update for Q2 2023/24 which confirmed that: • The Neonatal medical workforce met the relevant British Association of Perinatal Medicine (BAPM) recommendations • The Trust was compliant with BAPM nurse staffing standards as per the Neonatal Nursing Workforce Calculator • The midwifery workforce funded establishment was compliant with outcomes of BirthRate+. • Trust Board safety champions met bimonthly with the perinatal leadership team at the MatNeo Clinical Board). • Progress with the MatNeo culture improvement was monitored quarterly. The commissioned external independent investigation within Maternity had reached its conclusion and a range of recommendations have been made, with a robust and detailed action plan being finalised to respond to the recommendations. • There was a recruitment and retention strategy and plans were progressing well. Active listening events continue across maternity services. • The CNST MIS year six reporting period had concluded and ESHT had confirmed full compliance in all areas. The compliance audit of evidence against minimum requirements was completed by RSM UK Risk Assurance Services and demonstrated full compliance against all ten safety actions.	

	Carys, NED noted that there had been a lot of research into the mental health of women after giving birth and about the treatment of minority groups; she asked for assurance that the Trust was providing the best service possible for all groups. The DOM reported that the Trust collected a lot of data, including data on ethnicity, perinatal mental health and other risks factors. This was used to identify whether services could be offered differently to reduce any inequalities of care. An example of learning from the data was that some service users had not being using translation services effectively as they were not comfortable using male translators. The newly commissioned translation service had a larger pool of female translators to address the issue. There was a significant pathway supporting mothers with perinatal mental health needs. Ama, ANED asked whether data was reviewed while people were in the Trust's care. The DOM explained that reviews took place through a multi-disciplinary team when there was an emergency or an event outside of expectations. When patients were identified as having particular needs during their stay then they would be placed onto an appropriate pathway. The DON reported that discussions had recently taken place about how the robust learning places that had been put in place in maternity could be applied to other services. Ama, ANED noted the Trust's charity might be able to provide some additional support to services. Paresh, Vice Chair noted that sickness levels had significantly increased. The DOM explained that this was partially related to the concerns that had been raised by maternity colleagues, and also due to an increase in coughs and colds as winter approached. Paresh, Vice Chair asked about the increase in patients who smoked when booked into services. The DOM explained that further work was required alongside public health colleagues to address the issue; patients were directed to smoking cessation services when they came into the Trust, but the Trust was not involved in smoking cessation in the general population. She noted that smoking rates in East Sussex were much higher than national averages due to the level of deprivation that was seen. The Acting CEO noted that smoking had been identified to the CiC as a particular challenge in the region and would be a focus for integrated care teams moving forward. **The Board noted the Maternity Overview Q2 report.**	
95/024	**1. Freedom to Speak Up Guardian Update** The Acting CEO presented the report, explaining that it had been written independently by the Freedom to Speak Up Guardians. They would be presenting to the Board meeting in private later in the day. The number of contacts with the Guardians had increased from Q1 to Q2 in line with national increases. The two most common reasons for speaking up were worker safety and attitudes and behaviours. He explained that the numbers in the tables in the report did not appear to add up as the report was produced in accordance with national guidance; some of the contacts with the Guardians in the Trust did not fit into these prescribed categories. A database had been developed in the Trust which would allow for more detailed reporting moving forward, as well as supporting year on year comparisons. The Trust had always seen contacts with Guardians at a higher level than the national average, reflecting the confidence of staff in raising concerns. The majority of contacts were made from the largest staffing groups in the Trust. An example of this was for ED staff who were reporting more cases of abuse and violence and the Trust was working hard to address this and support staff. The Guardians were praised for their work in supporting colleagues; their work	

was greatly appreciated and made a real difference. The Guardian's services were fully compliant with national standards.

Paresh, Vice Chair explained that he had recently attended an event at Sussex Premier Health and the feedback he had received about the support given by the Guardians had been excellent.

2. **Trust Response**
The Acting CPO thanked the Guardians for their report and explained that that it was welcomed and fully accepted by the Trust. She noted that nationally, following a number of high profile cases, contacts with Guardians had increased, which had not been seen in the Trust. The Guardians were well embedded and respected within the organisation and the work that they do had helped to shape training for managers. A toolkit had recently been developed to help support managers and encouraged colleagues to undertake Speak Up and Listen up training. Civility training had also been launched in the organisation the previous day. She reported that a bullying and intimidating behaviours report was discussed by the violence and aggression group.

Carys, NED reiterated the importance of managers undertaking Listen Up training and asked what support the Board could give to ensure that compliance increased. The Acting CPO explained that work was being undertaken to increase awareness in the Trust of training that was available, including Speak Up, Listen Up and civility training. If the first contact with colleagues raising concerns was done correctly then it increased the chances of issues being resolved and resolution being achieved. She hoped that this raised awareness would encourage managers and all staff to complete the training as training rates were not currently where the Trust wanted them to be. Managers were also receiving training emphasising their responsibilities towards speaking up.

Paresh, Vice Chair noted that the amount of work that the Guardians undertook was remarkable and thanked them for all they did.

The Board noted the Freedom to Speak Up Guardian Update and Trust Response

96/024 **Annual Reports:**

1. **Infection Control**
The CN presented the report, explaining that it had previously been discussed by Q&S. Carys, NED asked what she should be most concerned about. The CN explained that operational pressures meant that it was not possible to isolate patients as quickly as it would have been preferred and when it was very busy it was more challenging for everyone to do the right thing all the time. It was important that the Trust continued to do what it was doing as the margin for error was small.

Carys, NED asked whether she should be concerned that the water safety risk assessment had been deferred to 2025. The CN explained that the Trust has a proactive Water Safety Group who meet three times a year; infection control and estates teams monitored safety with great engagement and water safety was subject to external scrutiny so she was not concerned by the deferment.

Paresh, Vice Chair asked about the significant reduction in the number of mask fit appointments for staff during the year. The CN reported that encouraging colleagues to attend appointments had been challenging, although there was no evidence that the reduction had translated into a detrimental impact for staff. It was important to keep on encouraging staff to do the right thing to keep themselves safe.

	2. Safeguarding The CN presented the report, explaining that it had also previously been discussed by Q&S. She explained that work would be undertaken moving forward to produce shorter reports. It had been a busy year for the safeguarding team, with an increased complexity of both adult and young patients being seen. Positive collaborative work with system partners had taken place during the year. **3. Organ Donation** The CMO presented the report noting that it had previously been discussed by Q&S. He explained that of all the meetings he attended, he found the Organ Donation Committee to be the most uplifting. The Committee benefitted from having a very involved lay member who had a family member who had donated organs. The CMO reported that 16 patients had received donated organs during 2023/24, from seven donors. Eight patients had received donated corneas from four patients. There had been improvements in specialist nurse availability during conversations about organ donation during the year, and he praised the work of the organ donation team. Nicki, NED praised the achievement of the Trust in being above the national average for receiving consent from families for organ donations. Paresh, Vice Chair asked if the Board could do more to support organ donation in the Trust. The CMO explained that he did not think that the Board could do more. He noted that a bench and trees had been put in place at Conquest, which was dedicated to organ donors, with plans to do the same at EDGH and encouraged Board members to visit these peaceful places. **4. Guardian of Safe Working Hours** The CMO presented the report, noting that it had previously been discussed by POD. There had been a significant increase in exception reporting during the past year and therefore an increase in additional pay. One of the reasons for the increase was that non-training doctors in the Trust now utilised the safe working hours mechanism when they had worked beyond their allotted shifts. The Guardians had issued a fine to the medicine division during the year as a result of two resident doctors working significantly above the 48 hours allowed. This was the first fine issued since 2022 and reflected how busy medicine had been during the year. A number of exception reports had been submitted in August due to concerns about low numbers of doctors on admission units, again reflecting the pressure on the organisation. The CMO anticipated that more exception reports would be submitted during the winter period. The CFO asked how normal it was for fines to be issued and whether there was action that should be taken as a result. The CMO reported that the issuing of a fine did not make the Trust stand out when compared to other organisations. Since 2016 when the Safe Working Hours process had been introduced, just under £24k of fines had been issued so it was unusual that more had not been issued recently.. Carys, NED, thanked Drs Wiggins and Yousef, the Trust's Guardians of Safe Working Hours, for the work that they did in support of colleagues.	
97/027	**Use of Trust Seal** One use of the Trust seal since the last Board meeting were noted.	
98/024	**Questions from members of the public** Paresh, Vice Chair reported that Mr Campbell had submitted a number of questions for the Board prior to the meeting.	

1. *The entries in the assurance column of the Balanced Scorecard are Not Met 14, Inconsistent 23, Target Required 8 and Achieving 14. Would it be possible to increase the viability of this report by adding an action plan that states how the assurance entries other than Achieving are to be improved and for those action plans to be reviewed by the appropriate Board Committees.*

   The CEO explained that the IPR presented to the Board was a summary of a number of more detailed reports that were presented to the Board's subcommittees. The Committees reviewed these reports, identifying any areas of concern. He was reluctant to increase the level of detail provided in the Board IPR as he was confident that the level of scrutiny provided by the Board's commitment was robust and appropriate.

   Mr Cambell explained that he felt that the balanced scorecard included within the IPR presented a negative reflection of the Trust's activities due to the included assurance column. The CEO explained that a review of how performance was being presented to the Board was being undertaken; he anticipated that this would lead to a different, more informative front page for the IPR in the future.

2. *Has the Trust achieved delivery of the Trajectories that were published as part of the 2024/25 Financial Plan in the Board papers of the 13th August 2024?*

   The CFO reported that the Trust was not delivering against its target deficit, but was delivering against its use of resources target and on cash and capital. Mr Cambell explained that he felt that it would be helpful if the review of the IPR included consideration about the inclusion of how the Trust was delivering against performance trajectories as well as financial. Paresh, Vice Chair thanked Mr Campbell for the suggestion.

3. *According to the NHS Sussex Board papers of the 27th November 2024 a letter was sent by NHS Sussex to Acute Providers outlining the NHS Sussex commissioning intentions. Can the Trust say if they submitted a response to that letter and what the Board considers to be the impact of the proposed Strategic Commissioning strategy on the Trust?*

   The Acting CEO reported that the Trust had received the letter from NHS Sussex which was very broad, touching on the strategic approach to commissioning, clinical outcomes and other areas. The Trust had submitted a response which acknowledged the financial pressures on NHS and raised concerns about the recent increase in workload in ED areas.

4. *Given the current public consultation being undertaken by the NHS for its 10 Year Plan has the Trust considered conducting a similar consultation with all staff to identify current operational issues that staff believe may be impacting productivity or quality of service and should be addressed?*

   The CEO reported that the Trust engaged and sought feedback from staff through a number of routes, including the annual staff survey, listening events, reach out events and the staff partnership forum. A major piece of involvement work would take place around the next stages of the New Hospital Programme no matter what the outcome of announcements expected in January.

   Mr. Campbell asked whether the Trust has a suggestion scheme, as it could generate ideas for potential savings from staff. The Acting CEO confirmed that a suggestion scheme was still running, explaining that a 'Small Change Challenge' had also commenced which allowed colleagues to make suggestions about small things that they felt could make a big difference to staff and patients.

	5. *Given that it is likely that current appointments are being made for dates after the commencement of the new contract for Non-emergency Patient Transport services, does the Trust have a new contact number for patients to use to register for eligibility and use of the service?* The COO explained that the new contract was being led by the ICS. Mobilisation was due to take place in March, with contact numbers being sent to patients in February to minimise any potential confusion. Paresh, Vice Chair reported that questions had also been received prior to the meeting from Liz Walke. She had requested updates on the following: 1. *The recruitment of the new Chief Executive Officer and if there were any changes in senior management or the Board.* Paresh, Vice Chair reported that a competitive recruitment process had commenced for the new Chief Executive of the Trust and would conclude in January 2025. He anticipated that an update would be provided at the next Board meeting. He explained that there had been no changes to the Board apart from the acting roles for the CEO and CPO. 2. *The new Sussex Surgical Centre* Paresh, Vice Chair explained that the building was expected to open in 2025 and remained on track. 3. *The New Hospital Programme* Paresh, Vice Chair noted that an update had been given during the Acting Chief Executive's report, presented earlier in the meeting.	
99/024	**Agenda Forward Plan** The Board's forward plan was noted.	
100/024	**Date of Next Trust Board Public Meeting** Tuesday 25th February 2025	

Matters Arising from Public Board meetings

Please note that a review of historic actions arising from Board meetings in public over the last 18 months was undertaken to identify any that were not considered to be fully discharged. Original updates provided to the Board can be found below in italics.

MEETING DATE	MINUTE NO:	ACTION	BY WHOM	BY WHEN	COMMENTS – INCLUDING ANY UPDATES
OPEN ACTIONS					
10.10.23	73/23	Consider how to increase the focus on community services data within the Trust IPR	Richard Milner	January 2024	*12.12.23* *Verbal update to be given in meeting* 25.02.25 We are looking at what goes into the Board IPR more generally as a result of the insightful board work and this will get picked up as part of March's Board Development Day.
10.10.23	73/23	Query about whether community paediatric hub in Bexhill was running at full capacity.	Charlotte O'Brien	January 2024	*12.12.23* *The clinical workforce at the Paediatric Hub is fully utilised. A further review is underway to support increased utilisation of the available clinic space this includes a review of all clinical job plans to enable this. Review will have been completed by January 2024 and results will be fed back to the Board.* 25.02.25 Work has progressed over the last year to review productivity within the service. Despite workforce challenges the service are now at the point where detailed demand and capacity analysis (alongside a review of the service and workforce model), is underway. This is likely to take around six months to complete, supported by the recruitment of a new Service Manager who will help lead this focussed piece of work.
12.12.23	92/23	Update on the impact of improved culture on recruitment for community maternity services to be given.	Brenda Lynes	February 2024	*13.02.24* *Verbal update to be given in meeting* 25.02.25 Community services carried out a three month review following the restructure; overall staff note this has been an extremely positive change, there remain a couple of areas which continue to be reviewed and tweaked (for example the day on call

					process). However overall the service is functioning well, recruitment has been highly successful with a less than 1% vacancy rate in that area (Feb 2025). Both staff and service users are highly complementary and positive of the service change.
08.10.24	72/24	Executives were asked to reflect on how reporting to the Board could be improved moving forward.	Execs	December 2024	*12.12.24* *Execs are reviewing the measures proposed by the Insightful Provider Board Guidance at the Exec away day on 04/12/2024. In addition, a summary page showing performance across domains will be introduced in the board IPR. Disaggregated granular data will be available off links to self-service reports.* 25.02.25 Verbal update to be given in meeting.
08.10.24	73/024	The CMO to consider how more detailed information about avoidability of deaths and learning arising from the Learning from Deaths process could be shared through the Quality and Safety Committee.	Simon Merritt	December 2024	*12.12.24* *Verbal update to be given in meeting* 25.02.25 Verbal update to be given in meeting.
NOT YET DUE					
09.04.24	26/24	Updated on Martha's Law implementation to be presented to the Board	Vikki Carruth	April 2025	Scheduled for April 2025
ACTIONS COMPLETED					
10.12.25	89/24	Carys, NED to meet with the Board Secretary to review outstanding actions from previous Board meetings.	Carys Williams / Pete Palmer	February 2025	Meeting took place on 3rd February 2025. Actions reviewed and those considered to have not been fully closed have been updated.
10.12.25	93/24	Community team to be invited to present to the Trust Board	Pete Palmer	February 2025	Presentation to take place at February's meeting
10.12.25	88/24	Review December's Trust Board meeting date and reschedule from 23rd December	Pete Palmer	February 2025	Meeting rescheduled to Tuesday 16th December 2024.

Agenda Item: 8

Report To/Meeting	Trust Board	**Date of Meeting**	25th February 2025
Report Title:	Chief Executive's Report		
Key question	What key news from the Trust does the Chief Executive want to highlight to the Board?		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐		
Report Sponsor:	Steve Aumayer, Acting Chief Executive	**Presenter(s):**	Steve Aumayer, Acting Chief Executive
Outcome/Action requested:	The Board is asked to note the Chief Executive's report.		

Executive Summary

Chief Executive's report

As anticipated, the period between December and February was impacted by significant seasonal challenges, this year including a *quademic (Flu, Covid, Norovirus and RSV),* and these were reflected in the level of front door activity and workforce availability over the period. Despite significant supply-side and demand pressures, we remain within the second quartile for our performance on the ED clinical standard (4-hrs) and we continue to support local partners in reducing long waits in elective care.

The 2025/6 planning guidance was announced in late January, with a focused set of priorities that echoed the widely trailed government aims. The headlines that are most directly relevant to this trust include 65% of elective patients waiting no longer than 18 weeks from referral to treatment by year end, 75% of patients with a 62-day cancer referral to treatment, 80% of patients receiving a diagnosis within 28 days and 78% of ED patients seen within 4hrs.

Achieving these standards within a tight financial allocation, is a challenge and one which requires this Trust and partners to achieve cost improvement levels that have not been seen previously. We are working alongside ICB colleagues and provider partners to ensure that plans for this coming financial year are ambitious and realistic, while placing safety at the core of our decision making.

Announcement of new CEO for ESHT

After a competitive and open recruitment process, Jayne Black has been appointed as our trust's new Chief Executive.

Jayne will join us later this year from Medway NHS Foundation Trust in Gillingham, Kent, where she is currently Chief Executive. Jayne brings a wealth of experience from her previous leadership positions across operations and transformation within London, Kent and Sussex, spanning acute and community service provision and strategic commissioning.

These include Chief Operating Officer at University Hospitals Sussex Foundation Trust from 2018 and, before this, Chief Operating Officer and Deputy Chief Executive at Croydon Health Services NHS Trust. Jayne has also worked as Director of Strategy and Transformation for Maidstone and Tunbridge Wells NHS Trust and West Kent Clinical Commissioning Group, and had worked previously with us here at the trust.

I will be continuing as Acting Chief Executive until she joins us, currently likely to be the early summer, when I will then return to my Deputy Chief Executive and Chief People Officer role.

Discharge Choice Policy

Alongside other NHS providers last year we have formally agreed the discharge choice policy, ensuring an aligned Sussex-wide approach in terms of supporting patients with discharge from the hospital. In short, this provides guidance to staff on how to ensure that patients who are ready for discharge do not remain indefinitely in a hospital bed whilst choosing a care home or alternative care provider. It also explains that interim accommodation should be secured for patients whose preferred choice of care home or care provider are not available within the discharge planning period.

New Hospitals Programme review

Towards the end of January, we received an official communication from the Department of Health and Social Care on the future of our bid for investment under the New Hospitals Programme (NHP).

It has been confirmed that we will be receiving between £1.5bn and £2bn in funds for new facilities from the Programme – however we will receive this money much later than we had thought; construction is not now expected to start until 2037 at the earliest, some ten years later than we had expected.

This disappointing news will mean that certain plans and assumptions on the timescales for replacing parts of our hospitals will have to be revisited and we will have to look carefully at how we can extend the lifespan of essential parts our estate and infrastructure before our NHP scheme begins – and how we will fund that work.

The extensive work from the teams who have worked on our bid will not be wasted and their commitment and creativity will be incorporated into our ongoing plans for improvement. We are very grateful to our dedicated team who have got us to this point and are committed working with them to ensure that they are looked after as the programme is closed down for an extended period.

Welcoming the Chair of NHSE

Earlier this month we welcomed Richard Meddings, the Chair of NHS England, to Eastbourne DGH. An East Sussex resident himself with a particular interest in frailty, we had the opportunity to showcase an extensive range of the work that we undertake at the trust to support care of frail patients – as well as discuss the impact of the NHP announcement.

Led by our clinical lead for frailty, Dr Henry Alexander, we walked through the experience of care a frail patient would have at the trust from their initial attendance in our Emergency Department through Same Day Emergency Care, the Acute Medical Unit and onto Seaford ward, one of our elderly care wards. We also had a working lunch attended by members of both our acute and community teams to discuss the opportunities that being an integrated trust presented to actively manage frail patients in the community and avoid admission to hospital, as well as our work with the ambulance service and local care homes to support the care of frail patients and Henry's work with other acute specialties to support the imbedding of the principles of frailty care into their work.

	The visit concluded with a trip around the soon-to-be completed Sussex Surgical Centre. Feedback from Richard on the visit was very positive, and he thanked us for the comprehensive insight into the realities and possibilities of frailty care. Celebrating our apprentices This month we have been celebrating National Apprenticeship week, sharing information with colleagues and with our communities about the importance of modern apprenticeships. With skilled staff in short supply in many technical and clinical disciplines, apprenticeships give us the opportunity to 'grow our own' skilled staff in many sectors and bring people into the NHS to learn an essential trade. Apprenticeships also offer many existing staff the opportunity to upskill and develop their careers within the NHS – either in their current disciplines, or in new ones. Evolving vascular access With an expanding network of Vascular Access Champions at the trust, we are driving real change across the organisation – enhancing staff development, improving patient outcomes, and setting new standards in vascular access excellence. Led by Sajini Davidson – vascular access specialist nurse and champion lead – the team have been working with colleagues across the trust to help deliver training, standardise practices and reduce infections and contamination. With over 90% of acute hospital patients requiring a vascular access device or other vascular procedure, getting this aspect of care right can make a significant difference to the care outcomes of our patients.

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	3	**Appendixes**	None.

Governance and Engagement pathway to date:	Not applicable.
What happens next?	Not applicable.
Publication	Report is for publication.

East Sussex Healthcare NHS Trust

Report to:	Trust Board	**Agenda Item:**	9.1
Date of Meeting	25th February 2025		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the Audit Committee on 30 January 2025 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

Tenders and Waivers

It was noted that several pieces of high value equipment would need to be procured before year-end. The largest waiver of note was on behalf of Our Care Connected (OCC) West Sussex Partners in Care and to cover pass through payments of grants to care homes. This approach had been signed off by the ICB's Chief Financial Officer. The Chair of the Audit Committee had oversight of all waivers over tender value.

Counter-Fraud Specialist Service Report

The Committee received confirmation that two new referrals had been received during the reporting period and seven had been closed. RSM had reviewed the Procurement, Freedom to Speak Up, and Risk Management policies. Recommendations were made to the relevant key staff to review from a counter fraud perspective.

Review of Losses and Special Payments

The Committee approved a proposed write-off totalling £215,398. Most of this amount related to pharmacy stock. A discussion took place about ensuring invoices to insurance providers for Sussex Premier Health patients were issued in a timely manner to prevent further losses because of expiry periods having passed.

Board Assurance Framework (BAF) & Corporate Risk Register (CRR)

It was acknowledged that the BAF still required some improvement to maximise its effectiveness as a live document to inform decision making. More work was also needed to align CRR risks with the BAF. However, reassurance was given that Trust executives were monitoring high-level risks extremely closely. BAF risks for 2025/26 would be discussed in detail at the Board Development Day taking place in March 2025.

Alert, Advise and Assure

Alert

None.

Advise/Inform/Update

Cybersecurity Update

Server client patching levels continued to steadily improve. One key outstanding action from NHSE would be challenging to implement because some clinical systems would need downtime for work to occur.

There had been a 50% reduction in ESHT staff who erroneously engaged with an internal phishing exercise when compared to the previous year. Colleagues who clicked on the phishing link were redirected to training materials.

Some software used by ESHT was not yet multifactor authorisation compliant but suppliers and affected teams had been given time-based ultimatums to rectify this shortcoming. There was a potential impact on patient safety if these systems were withdrawn without continuity planning, so a one-year grace period had been agreed. All systems which needed administrator access could be blocked by the Digital team, pending audit.

Assure

Internal Audit Report

The following final reports had been issued:

1) **Medicines Management – 'Partial Assurance'.** Two 'high' priority actions derived from the audit. The first of these linked to the reconciliation of stock values between stock systems and the financial ledger. The second related to improving the daily rolling stock date process to cover all essential stocks at least once per year.
2) **Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Return: Internal Audit Validation - Advisory review**. Auditors took assurance that there was a good body of evidence to support EHST's self-assessment in this area.
3) **Resident Doctors – 'Reasonable Assurance'.** The processes considered during this review were found to be generally well designed and operating effectively. Four 'medium' priority actions were recommended.

Key Risks or Opportunities and their impact on the Trust

Emergency Preparedness, Resilience and Response (EPRR) Annual Report

It was noted that Business Continuity Plans (BCP) were not yet comprehensive across the Trust. One potential route to improve visibility and senior oversight of this work would be asking divisions to update on their BCPs as part of integrated performance reporting (IPR). There were plans for IPRs to be more focused on risk, but details had not yet been finalised. A roadmap of milestones towards full BCP compliance was requested in time for the next Audit Committee.

Key Decisions

None.

Exceptions and Challenges

None.

Recommendations

The Board is asked to note this report.

East Sussex Healthcare NHS Trust

Report to:	Trust Board	**Agenda Item:**	9.2
Date of Meeting	25th February 2025		

Title of Report:	Finance & Productivity Committee Chair's Report
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 (F&P) Committee on 31st January 2025.

Background

The 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

Bed Strategy/Art of the Possible

The Committee received an update on the Bed Strategy /Art of the Possible investment in Acute Therapist and HomeFirst UCR capacity. The investment had been approved on the basis that it would enable acute beds to be closed. The Committee noted the success of closing Littlington ward in July, with this closure having been sustained until recently. Murray Ward was also successfully closed at the end of September, and despite having to be opened for a brief period of time had been closed again in October. Both areas were opened between Christmas and New Year, as a result of operational pressures and an increase in the number of patients presenting with flu. Furthermore, there had been a reduction in P1 patients waiting for discharge. From a financial perspective it was noted that while the original savings target had not been fully achieved due to organisational pressures and recruitment delays (resulting in the use of an external bridging provider), the net benefit realised had been £260k at the point when the document was written with further benefits expected once fully recruited.

Alert, Advise and Assure

2025/26 Business Planning Process & Outline Plan

The Committee received an update on the 2025/26 Business Planning process and 2025/26 financial planning. Divisions had received their baseline budget and were working to agree plans. National planning guidance had only just been received and assumptions and modelling would be updated to reflect this. Considerable engagement from divisional leadership, and support from finance and executive teams is required in order to ensure that financial and operational plans which meet central targets and requirements are agreed by 1 April.

The Trust's interim planning submission for workforce was required by 12th February 2025, with an activity and finance submission by 14th February. A second submission was due towards the end of March. The Committee noted the challenges in bringing together the various planning requirements in a short time frame.

System Update

The Committee received the 25/26 Financial Planning, Commissioning intentions and principles for information.

Capital
The Committee received an update on the Trust's month 9 capital position noting an increase in funding to £70m for the year. The Director of Operational Finance confirmed that he was confident that the Trust would deliver the capital plan by the end of the year, noting that there would be slippage of some of the schemes into 2025/26.

Workforce
The Committee received a workforce report for month 9 which highlighted that the key drivers of workforce costs were:

- Unfunded posts in the Emergency Department & Medicine
- Vacancy factor in Emergency Departments
- A planned increase in CHIC aligned to 'Art of the Possible'.
- Short notice sickness

The Committee noted the continued reduction around the use of temporary workforce compared with 1 April 2024. Controls had been put in place through the Use of Resources programme which had reduced agency usage significantly. Continued agency costs were being seen in areas that were experiencing significant continued operational pressures such as ED and theatres. Deviation from forecast headcount reductions continues to drive high workforce costs.

Key Risks or Opportunities and their impact on the Trust

M9 Financial Performance
The Committee noted an actual loss year to date of £12.8m with an in-month loss of £2.3m in month 9. December had been quite challenging as income was slightly down; some of the loss of income had been factored into the budget. Pay costs for the month were down.

The Trust would need to continue to closely manage its balance sheet as well as incurred costs in order to achieve its expected deficit position for the year. The Trust had agreed a deficit target of £16m for the year, although was working hard to identify actions which could help to improve this position. There is pressure from the region to achieve £14m and risk associated with agreeing to this position which has been discussed at our extraordinary board meeting.

The Use of Resources programme was considered. Most KPIs are off-target. It is critical that 25/26 operational and financial plans are agreed early to support achievement of these metrics as we move forward. As yet, the committee is not assured that these will improve.

Key Decisions

Board Assurance Framework Q3
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.
The Committee recommended to the Audit Committee that the rating for this risk should be increased from 16 to 20.

24/25 Outturn
Agreement of the anticipated outturn budget was escalated to an extraordinary board meeting.

Exceptions and Challenges

See above

Recommendations

The Board is asked to note this report.

Report to:	Board of Directors	**Agenda Item:**	9.3
Date of Meeting	30 January 2025		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the People & Organisational Development (POD) Committee on 30 January 2025 to provide the Board with an update of the Committee's activities.

Background

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

Business Undertaken

POD Workforce Insight Report

Key highlights of the workforce data for December 2024:

- Sickness levels continued to be a challenge, particularly due to widespread coughs and colds. This had affected various departments especially Emergency Care, Eastbourne.
- Financially the organisation continued to adhere to the control total for month seven with plans in place to sustain cost improvement programmes (CIPs) until year-end to start the next year in a stronger position.
- The National Guidance for business planning had been delayed, shortening the preparation timeframe. Despite this, there had been a strong focus on ensuring a fully triangulated plan. Feedback was being provided to the ICB regarding the staggered submission deadlines for workforce, finance, and activity data, emphasising the need for a more streamlined approach.

The Chair asked about staff wellbeing, leading to a lengthy discussion. It was acknowledged that staff were extremely tired and that both staff and patients were facing difficult conditions. Key highlights:

- Board level action required to support staff.
- Importance of training and education essential for staff to perform their roles effectively.
- Concerns raised about the high percentage of staff nearing retirement and the need for strategies to retain experienced staff or ensure a smooth transition.

It was noted that a major issue was the high number of stranded patients and those without criteria to reside, which continued to affect occupancy and escalation.

Alert, Advise and Assure

Schwartz Rounds Report

The report highlighted the success of Schwartz Rounds and the need for more storytellers from diverse roles within the Trust; she emphasised the importance of ensuring a completely safe and comfortable environment for storytellers, the audience and everyone involved.

The report highlighted successes and ongoing challenges with a focus on sustaining quality and expanding the reach of rounds across different sectors of the Trust, including virtual, face to face and pop-up sessions for frontline staff.

The key aim for the year was to increase attendance from underrepresented staff groups, ensuring that all staff members had access to the reflective space. Continued support in engaging senior staff and identifying storytellers to share their stories was sought.

The POD Committee accepted the report for assurance.

Violence & Aggression Update
A national review of the Violence, Prevention and Reduction Standard had been undertaking, and feedback received from NHS Trusts across the country had resulted in an update to the National Standard. Peer reviews had been carried out in January 2025 as part of the governance process.

A full review of the red and yellow card sanction scheme would be conducted, including an assessment of their effectiveness and the processes behind them. This review would involve engagement sessions with staff, particularly in gateway and hotspot areas, to gather feedback on their effectiveness and communication.

The POD Committee accepted the report for assurance.

Staff Survey update with HRBP Division – Women & Children
The Staff Survey presentation for Women & Children division was shared and included updates on the staff survey action plan, including feedback sessions, signposting and initiatives to address discrimination and wellbeing conversations. Key highlights:

- The team use the opportunity to signpost resources related to staff survey responses; taking breaks, reasonable adjustments, self-care and raising awareness of initiatives like Freedom to Speak Up.
- The team had focused on improving feedback on Friends and Family Test (FFT) within their governance process. They considered using a newsletter to share governance updates, including FFTR to enhance staff oversight.
- Effectiveness of alternative communication methods for reaching staff and sharing lessons learned.
- Maternity staff survey scoring highlighted concerns around discrimination. In response they had introduced an LGBT and EDI champion within maternity and were considering expanding this initiative across the division.
- Identified challenges with wellbeing conversations, particularly for staff in bands 2 to 6, who represent the bulk of the workforce. Shift patterns had made it difficult to engage with these staff members consistently. However, they had planned a focus on improving the Personal Development Review (PDR) cycle, aiming to make wellbeing a more integral and ongoing part of the process.

The POD Committee accepted the report for assurance.

Leadership Development
An update was provided on the new leadership training programme emphasising the integration of national competencies, practical management training and the importance of continuous improvement and cultural awareness. A new set of national competencies and provisions had been introduced, along with the possibility of manager regulation. The roadmap for leadership development was adaptive and designed to respond to these changes. Progress had been made

on several modules throughout the year, and the five-year timeline allowed for a reset, especially considering the impact of the pandemic.

The coaching culture initiative was highlighted, which focused on sustainability. Rather than relying on large funding, they were implementing a train the trainer programme. It was confirmed that the coaching cohort had commenced and they had found it exceptional.

The Chair expressed that the five-year plan should focus on cultural awareness and continuous improvement, areas where the trust could make significant progress. Many managers would appreciate support in these areas, based on her observations during boardwalks. It was confirmed that the programme included both leadership and practical management training. As well as toolkits available for managers, there was budget management, recruitment selection and appraisals, which would be offered both in person on online. The programme aims to address both initial learning needs and ongoing development, ensuring managers remain skilled and effective in their roles.

The POD Committee accepted the report for assurance.

Appraisal Compliance monthly update

The Appraisal data for August 2024 was shared for information.

Apprenticeship update

The Apprenticeship paper 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 Q4

The BAF Q4 had been circulated and taken as read. The Chair reported that Q4 of the BAF appeared unchanged, with just some minor adjustments. The Chair referred to the introduction of the "Extreme Risk Register" detailing risk scores of 15+, risks that cannot be managed or controlled locally within the division, service of department and require the attention or assistance of Executive Directors.

The Committee highlighted the need to establish principles for managing shared risks between the POD Committee and the Quality and Safety Committee. It was agreed to schedule a meeting to map out the process and ensure proper oversight about which risks should be overseen by which Committee.

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:**	9.4
Date of Meeting	25th February 2025		

Title of Report:	Quality & Safety Committee 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 Quality & Safety Committee (QSC) on 29th January 2025 to provide the Board with an update of the Committee's activities. This was an agreed reduced senior membership meeting.

Background

The QSC holds delegated responsibility from the Board of Directors as set out in Terms of Reference; this report provides assurance to the Board that the monitoring required to meet those responsibilities is being carried out and or escalation of any significant issue or concerns.

Business Undertaken

Maternity Dashboard & Ockenden Perinatal Quality Surveillance Report: The Committee noted the report with positive comments and no areas for escalation.

Board Assurance Framework and High Level Risk Register: The Committee was responsible for two strategic risks on the Board Assurance Framework (BAF). The scoring of the risks remained at 16 for Q3, reflecting extreme pressures the Trust was facing with ongoing requirements for significant additional capacity including boarding patients on wards.

Quality KPI's & Monthly Report: The Committee noted the pressures faced by staff, including the high acuity of patients and the challenges of managing significant additional capacity. The Chair emphasised the need to support staff during these difficult times. The Committee noted the increase in staff sickness relating to stress and anxiety, and concerns about staff wellbeing given the on going pressures being experienced.

Infection Prevention & Control BAF: The Committee noted the Infection Prevention and Control Board Assurance Framework which highlighted that the organisation was compliant with 46 out of 54 key lines of inquiry. Nothing to escalate.

Alert, Advise and Assure

Alert

None.

Advise/Inform/Update

Extreme pressures for the Trust were expected to continue; staff were thanked for all that they were doing to ensure that patients remained safe during the difficult times.

Assurances

Significant and sustained improvements within the cancer services performance.

Key Risks or Opportunities and their impact on the Trust
None.
Key Decisions
None required for this meeting.
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 December 2024 (Month 9)

INTEGRITY

Content

East Sussex Healthcare NHS Trust

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

About our IPR

East Sussex Healthcare NHS Trust

Our IPR reflects how the Trust is currently working and how the on-going journey of improvement and excellence, reflected within our Strategy and Operational Plan (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 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. The delivery of the priorities are against significant financial pressures faced by the Trust for the remainder of 2024/25 and going into 2025/26.

Delivery of the Trust's 4-hour Emergency Access Clinical Standard has been a challenge for the Trust. In December 2024, 68.8% of patients were seen and discharged or treated and admitted within 4 hours, against the 78% target. The Trust is working collaboratively with system partners to bring down non-Criteria to Reside patients, which affects admitted performance. The Emergency Department is implementing an improvement plan to increase non-admitted performance.

Key Areas of Success

- Cancer 62-day pathway and Faster Diagnostic Standard (FDS) have been meeting their trajectories each month, over the last seven months. In December, the Trust achieved 72.9% against a target 66.7% for the 62-day standard and 82.5% against a national target of 77% for the Faster Diagnostic Standard
- Elective recovery fund activity targets are being achieved
- The Trust continues to support system partners in reducing long waits in elective care. The number of patients waiting 65 weeks or more for treatment reduced for the second consecutive month, from 57 in November to 55 in December (this includes circa 1430 long waiting patients being transferred from another Sussex provider)
- Sustainably delivering above target for our 2-hour urgent community response, despite a rise in demand for this service.

Key Areas of Focus

- ED improvement plan to recover performance to 78% by March 25
- The trust is planning to deliver a year end forecast deficit of £14m. This includes a drive to improve elective activity in the final quarter through fully utilised outpatient and theatre lists, and working to a target of 10% improvement in temporary staffing
- The Trust has been set a target of breakeven in 2025/26.

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	929	892	849	Common Cause	Not Met
Number of Patient safety events (severity 3)	0	15	19	10	Common Cause	Not Met
Number of Patient safety events (severity 4 ...	0	3	0	4	Common Cause	Inconsistent
Never Events	0	0	0	0	Common Cause	Inconsistent
Inpatient Falls per 1,000 Bed days		4.42	4.28	4.30	Common Cause	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	0.0438	Common Cause	Inconsistent
Healthcare Associated MRSA Bacteraemia (r...	0	0	0	0	Improvement	Inconsistent
Healthcare Associated C Diff Infections (rate)...	0	0.241	0.198	0.175	Common Cause	Inconsistent
Healthcare Associated MSSA Bacteraemia (r...	0	0.0804	0.158	0.0438	Common Cause	Inconsistent
RAMI	100	86.3	86.3		Improvement	Achieving
SHMI (NHS Digital monthly)	100	102	102	94.7	Concern	Inconsistent
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	92.6%	93.2%	93.7%	Improvement	Not Met

Patient Experience	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Complaints received		29	32	42	Common Cause	Target required
Complaints Response Compliance (60 w...		81.6%	74.4%		Common Cause	Target required
Reopened Complaints		5	3	5	Common Cause	Target required
A&E FFT Score	85%	79.1%	78.4%	94.9%	Improvement	Inconsistent
A&E FFT Response Rate		15.2%	14.1%	6.13%	Improvement	Target required
Inpatient FFT Score	95%	97.1%	96.3%	97.9%	Concern	Achieving
Maternity FFT Score	95%	88%	91.7%	100%	Concern	Inconsistent
Outpatient FFT Score	95%	94.6%	95.1%	97.0%	Concern	Inconsistent
Post Covid19 Assessment FFT Score	95%	100%	0%		Common Cause	Inconsistent

Our People	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Establishment (WTE) All		8,151	8,109	7,228	Common Cause	Target required
Agency Rate	3.6%	0.715%	0.687%	1.34%	Improvement	Achieving
Vacancy Rate	7.5%	2.5%	2.3%	10.5%	Improvement	Achieving
Staff Turnover	11.6%	10.7%	10.6%	10.0%	Concern	Achieving
Retention Rate	90%	92.0%	92.1%	91.9%	Common Cause	Achieving
Monthly Sickness - Absence %	4.7%	5.72%	5.90%	5%	Common Cause	Inconsistent
Sickness - Average Days Lost per Fte	17	19.5	19.4	16.3	Concern	Not Met
Staff Appraisals	85%	83.6%	84.2%	79.8%	Common Cause	Not Met
Statutory & Mandatory Training	90%	91.1%	91.2%	88.8%	Improvement	Inconsistent

Our Performance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
4 hour standard	73%	71.2%	68.8%	78.0%	Common Cause	Inconsistent
A&E > 12 hours from arrival to discharge	0	1063	1299	223	Concern	Not Met
A&E waits over 12 hours from DTA	0	42	42		Concern	Inconsistent
Conveyance handover >60 mins	0%	2.90%	3.14%	2.11%	Common Cause	Inconsistent
Non Elective Length of Stay	4.36	5.18	5.39	3.97	Common Cause	Inconsistent
Average daily NCTR	170	209	195		Common Cause	Not Met
Cancer 62 Day	66.7%	75.1%	72.9%	77.8%	Common Cause	Inconsistent
Cancer 31 Day Combined		95.7%	92.8%	97.8%	Common Cause	Target required
28 Day General FDS	75%	82.1%	82.5%	69.4%	Improvement	Inconsistent
104 day Backlog	22	19	14	27	Common Cause	Inconsistent
Elective Activity (ELIP,DC,OPFA, OPFUP P...	122%	116%	121%		Improvement	Not Met
RTT under 18 weeks	92%	54.7%	54.5%	91.1%	Common Cause	Not Met
RTT 65 week wait	0	57	55	0	Improvement	Not Met
RTT Total Waiting List Size	55250	57465	58907	29019	Concern	Inconsistent
Diagnostic <6 weeks	1%	9.65%	12.2%	0.597%	Improvement	Not Met
Urgent Community Response within 2 h...	70%	81.7%	82.0%		Improvement	Achieving
CHIC wait times < 13 weeks	75%	81.8%	84.7%	52.4%	Improvement	Inconsistent
Intermediate Care Length of Stay	30	38.6	44.6	22.9	Common Cause	Inconsistent
% Discharges delayed 1+ days		21.8%	21.3%		Common Cause	Target required
Total delay days from monthly Discharges		5048	5237		Common Cause	Target required
Number of Deferred visits/ care plans	0	7565	7493	1219	Concern	Not Met

Finance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Surplus/(deficit) (£'000) - in month	(932)	(1,321)	(2,327)	n/a	n/a	Not met
Surplus/(deficit) (£'000) - YTD	(2,533)	(10,520)	(12,847)	n/a	n/a	Not met
ERF (£'000) - in month	11,241	12,330	11,179	n/a	n/a	Achieving
ERF (£'000) - YTD	101,111	93,522	104,701	n/a	n/a	Achieving
Efficiency (£'000) - in month	3,915	4,183	3,576	n/a	n/a	Achieving
Efficiency (£'000) - YTD	21,013	20,317	23,893	n/a	n/a	Achieving
Capital (£'000) - YTD	17,446	26,444	30,185	n/a	n/a	Achieving
Capital (£'000) - FOT	70,638	67,088	72,054	n/a	n/a	Achieving

Constitutional Standards | Benchmarking

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

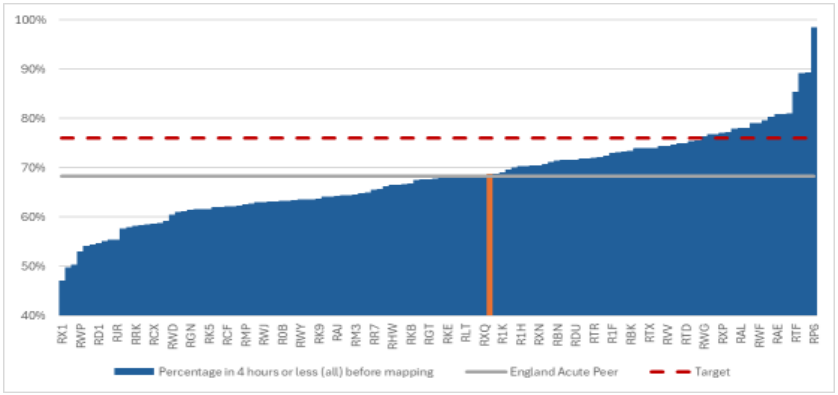
East Sussex Healthcare NHS Trust

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

December 2024 Peer Review

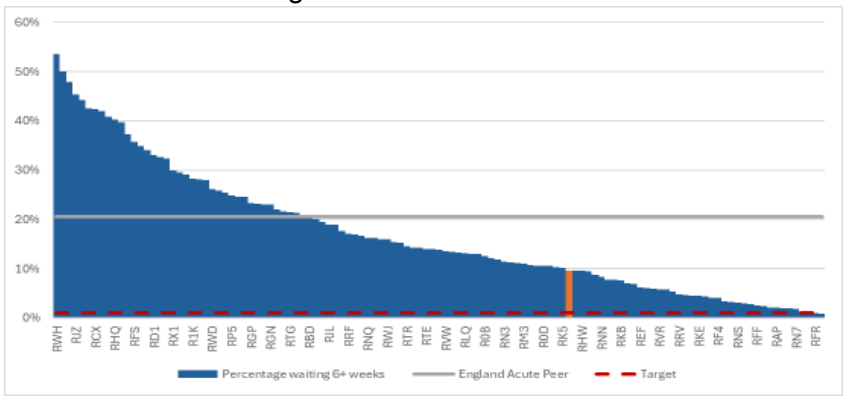
National Average: 68.4% ESHT Rank: 54/124



Planned Care – Diagnostic Waiting Times

November 2024 Peer Review*

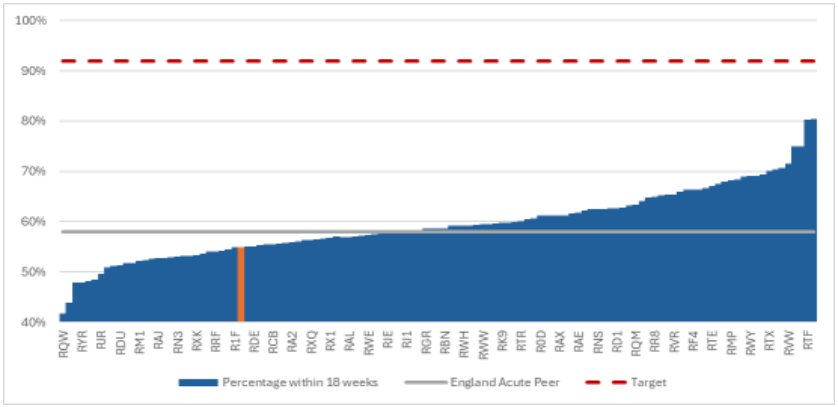
National Average: 20.5% ESHT Rank: 40/119



Planned Care – Referral to Treatment

November 2024 Peer Review*

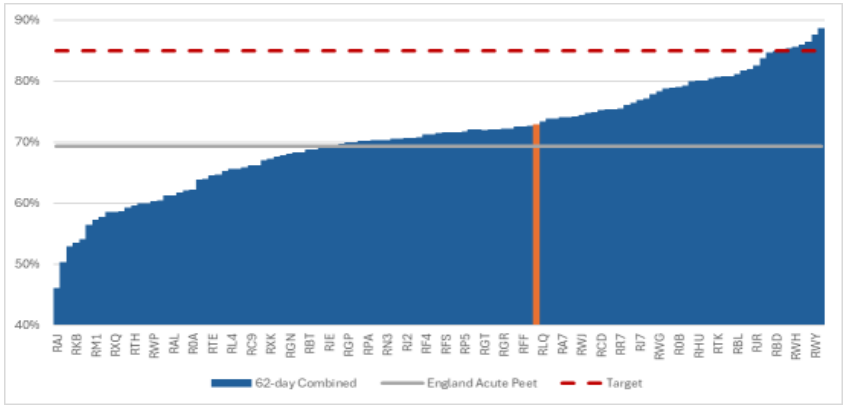
National Average: 57.9% ESHT Rank: 91/119



Cancer Treatment – 62 Day Combined Standard

November 2024 Peer Review*

National Average: 69.3% ESHT Rank: 45/119



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 been set by NHSE for 2024/25. ESHT limits are: C. difficile 67; E. coli 109; P. aeruginosa 19; Klebsiella sp. 47. There have been no limits set for MSSA and the expectation for MRSA is zero avoidable bloodstream infections.

As previously advised, ESHT has exceeded the CDI threshold, reporting 76 cases with discussions at Quality Safety Committee (QSC) in relation to causes and mitigations. This is multifactorial due to very high occupancy, frailty, antibiotic stewardship and transmission. National CDI incidence has also increased, and the reason is not fully understood yet.

For December, the Trust reported five cases of CDI. Two HOHA and three COHA. One further case of 002 ribotype was identified at EDGH. There were no MRSA bacteraemias for December and four MSSA; 2 COHA due to vascular access devices in oncology patients, successfully treated and 2 HOHA due to prosthetic joint infections for review as surgical site infection MDT. High prevalence of seasonal influenza and Respiratory Syncytial Virus (RSV) was evident during December.

Safety Events
906 incidents were reported in December comparable to the 944 reported in November (ESHT only and filtered for duplicates). 96% of the total patient events were no harm/near miss, which is comparable with the National average (96%), indicative of a good reporting culture at ESHT.

The top three categories for December were:
1. Diagnosis and Diagnostic Services (134) - All were near miss / no harm and low severity.
2. Slip, Trips and Falls (132) – Falls rate remains within normal variation with no cause for concern. 6 moderate harm incidents were reported and reviewed via the SWARM PSIRF process. These incidents are monitored via the Trust Falls Steering Group.
3. Medication Errors and other Medication Related incidents (114) – A decrease from 136 in November. These are monitored and reviewed by the Trust Medication Safety Officer and overseen by the Medicine Safety Group and Medicine Optimisation Group.

Harm Levels
There was 0 Fatal / Catastrophic events (Severity 5) and 0 Severe harm (severity 4) reported in December.

Safeguarding
The trend in compliance for Think Family level 3 training has continued, with the latest statistics showing 58.% of staff marked as compliant. Some other topics are also seeing variable non-compliance across the divisions with discussion at QSC and POD about actions with trajectories and timelines for improvement.

Previous concern regarding the data reporting platform on NHSE has been solved and quarter 3 PREVENT data successfully submitted, data for Children in Care is due in February via the same platform.

The predominant themes in adult safeguarding continue to be neglect (the biggest and most wide-ranging category), self-neglect, and domestic abuse while in the Children's area, mental ill health continues to feature. There is an emerging trend with neuro divergence seen as part of the picture in all age groups. Workstreams on complexity and self-neglect were paused in the last month due to the operational situation, these are being progressed in the coming weeks.

Mortality
RAMI indices of mortality rolling 12 months is 88 for the current period and positioned at 44 out of 120 Acute Peer Trusts. SHMI is showing a value of 101 and is within the expected range. EDGH has an index of 100 and Conquest 102.
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 concerns remain negligible. The Trust received 32 new complaints, an increase of 3 vs. November. 6 complaints were overdue at the end of December (the oldest being 20 working days over). Of the complaints closed in-month against the timeframe of 60 working days, 74% were completed in time (November was 82%).

Reviewing the monthly risk rating of all complaints, most were 'moderate' in common with the general pattern: 22 moderate risk (November =21) where aspects of clinical care appear suboptimal and 10 low risk (November =7) where clinical quality does not form part of the complaint.

3 complaints were reopened (November had 5), 1 for Urgent Care, 1 for Medicine, and 1 for Diagnostic, Anaesthetic and Surgery (2 were meeting requests and 1 was unhappy with the Trust's response). The Trust received no contacts from the Parliamentary and Health Service Ombudsman in December.

Of the 32 complaints in December, 44% came from 1 category: Clinical Treatment =14. Top complaint locations in December were: Outpatient Departments =5 (EDGH=3 and CQ =2) and Emergency Department CQ =2.

550 contacts were recorded by PALS in December, a decrease of 36 when compared to November with 586. Of these contacts, 321 PALS contacts were recorded as "concerns" (November was 328).

The top three primary PALS subjects recorded as a "concern" were as follows: Communication =96 (of these 65% related to communication with patients, or incorrect/no information given). MSK accounting for 35, where enquirers raised concern over an EDS poster displayed at CQ, as it is felt this contains inaccurate information. Appointments =63 (of these 51% related to long waiting times and cancelled appointments) and Clinical Treatment =47 (of these 40% related to delay in treatment and 21% related to diagnosis issues).

In December, the Trust received 9,669 FFT responses; this was a further drop on the two preceding months (October =12,414, November =11,148) however, the drop will also reflect seasonal trends. The Trust wide positive feedback rate was 92.42%, which is in line with the last three-month average of 92.85%. In December, positive FFT comments (=6,933) accounted for 99% of all plaudits (=7,028) received in the month.

86% of all FFT responses were received in a digital format. There was a drop in completion of online FFT's which is primarily attributed to the Phlebotomy service, and this is being investigated locally.

The comments patients provide as to why they gave the score generate word-based themes; in December, the top positive theme was Staff Attitude (4,603 positive comments), followed by Implementation of Care (2,503) and Environment (1,612). Conversely, the top negative theme was Staff Attitude (309 negative comments), followed by Environment (263) and Waiting Time (240).

Workforce

We have continued to see a high level of attendances to the Emergency Departments and continued high occupancy, despite a consistent focus on discharge, successful use of Minerva to support packages of care 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, especially at EDGH.

Ward and Community staffing in October 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 clinical 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 in use of agency and additional shifts through roster efficiency and fortnightly oversight from the Chief Nursing Officer and Deputy Chief Nurse. 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)

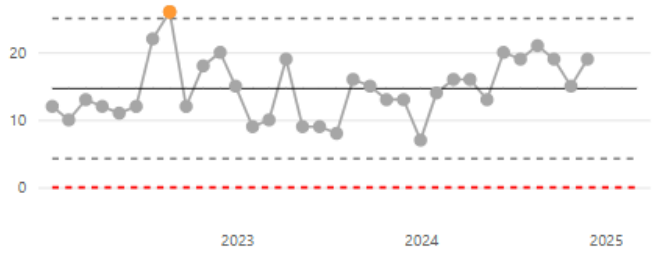
Simon Merritt
Chief Medical Officer

Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

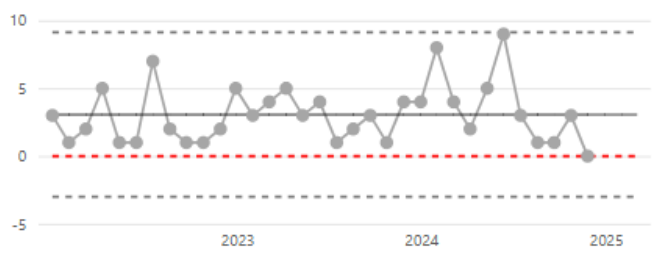
Number of Patient safety events (severity 3): Total, Safety

Not Met	Common Cause	19



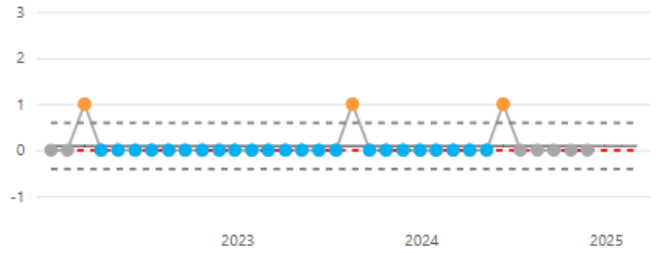
Number of Patient safety events (severity 4 and 5): Total, Sa...

Inconsistent	Common Cause	0



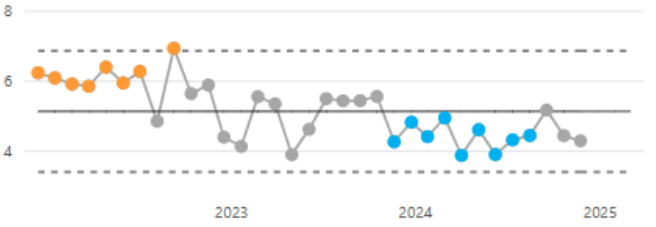
Never Events: Total, Safety

Inconsistent	Common Cause	0



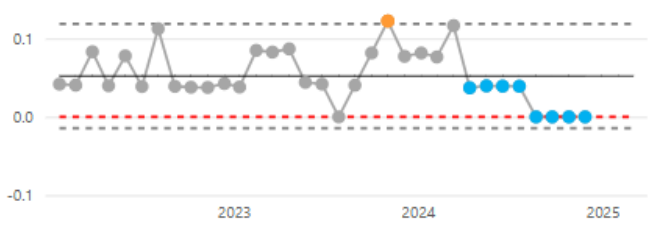
Inpatient Falls per 1,000 Bed days: Total, Safety

Target required	Common Cause	4.28



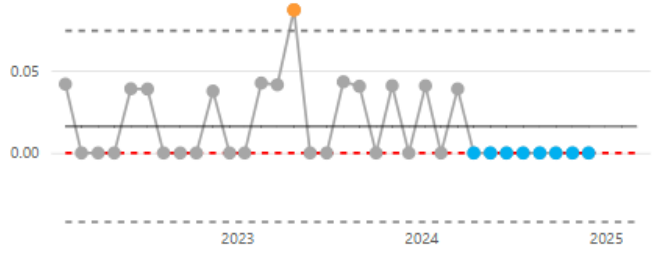
Cat 3 and 4 ESHT Acq. PU (rate) per 1,000 bed days: Total, S...

Inconsistent	Improvement	0



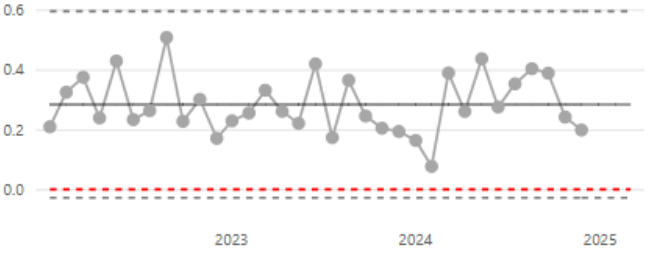
Healthcare Associated MRSA Bacteraemia (rate) per 1,000 ...

Inconsistent	Improvement	0



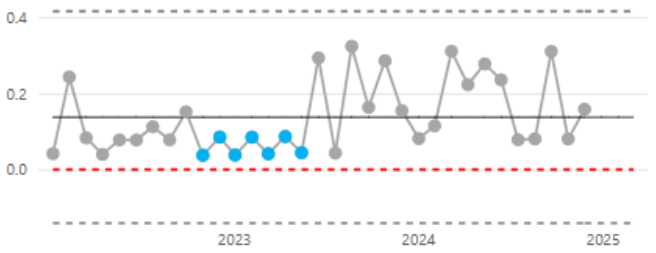
Healthcare Associated C Diff Infections (rate) per 1,000 Bed ...

Inconsistent	Common Cause	0.198



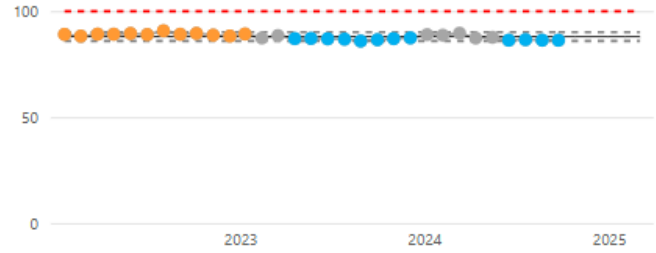
Healthcare Associated MSSA Bacteraemia (rate) per 1,000 ...

Inconsistent	Common Cause	0.158



RAMI: Total, Safety

Achieving	Improvement	86.3

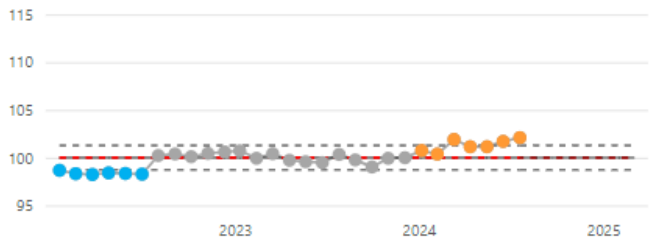


Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

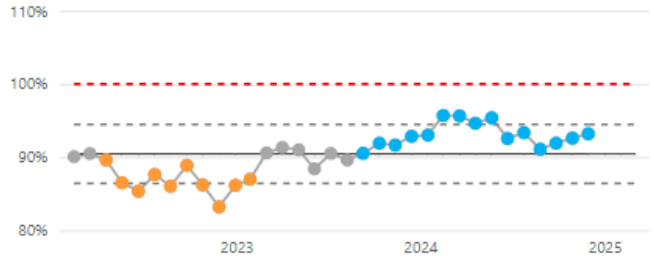
SHMI (NHS Digital monthly): Total, Safety

Inconsistent	Concern	102



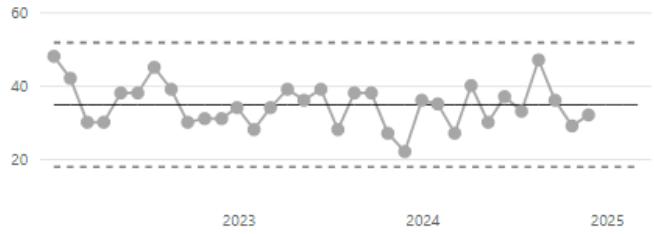
Nursing Fill Rate (IP - RN, RNA and HCA): Total, Safety

Not Met	Improvement	93.2%



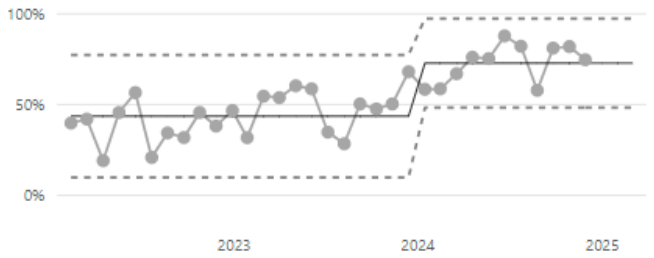
Complaints received: Total, Patient Experience

Target required	Common Cause	32



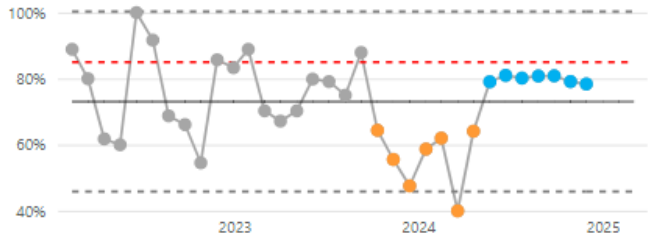
Complaints Response Compliance (60 working days as of 1...

Target required	Common Cause	74.4%



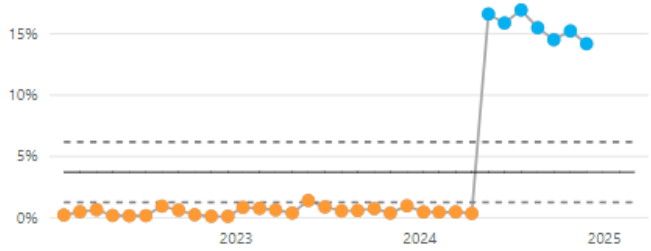
A&E FFT Score: Total, Patient Experience

Inconsistent	Improvement	78.4%



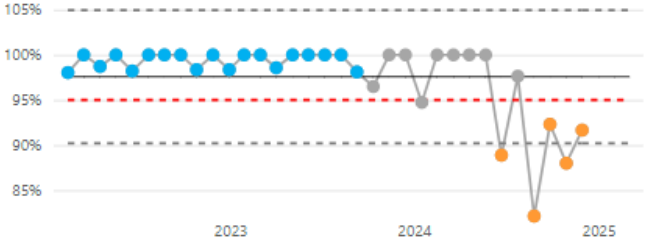
A&E FFT Response Rate: Total, Patient Experience

Target required	Improvement	14.1%



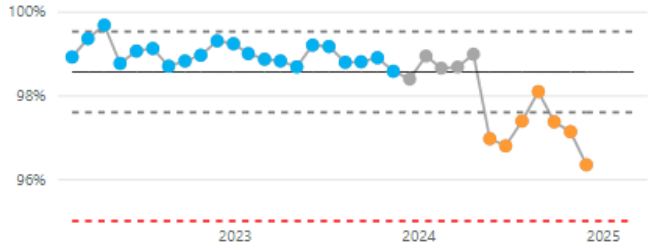
Maternity FFT Score: Total, Patient Experience

Inconsistent	Concern	91.7%



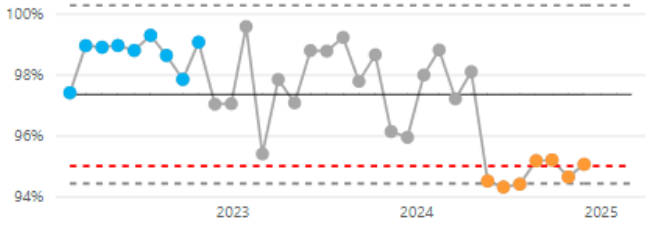
Inpatient FFT Score: Total, Patient Experience

Achieving	Concern	96.3%



Outpatient FFT Score: Total, Patient Experience

Inconsistent	Concern	95.1%



Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Patient Safety Incident Response Framework (PSIRF)	The Duty of Candour compliance improved slightly from 37% to 47% for verbal, and from 34% to 40% for written. This continues to be monitored and Divisions supported to complete in a timely manner. The PSIRF process remains in place for reporting, triaging and deciding on level of harm of events. The PSIRF Working group will be reviewing the processes and collaborating closely with DCIQ, to leverage the digital capability of the system to support the documentation of compliance, which ultimately positively impacts oversight, benchmarking, reporting and analysis overall. The "Safety Learnings" Module in DCIQ is still undergoing review by key stakeholders and we are awaiting a demo session to drive a decision for next steps.	• The PSIRF Working Group is now focusing on sharing learning from PSIRF reviews across clinical services and Divisions, where appropriate. • The Patient Safety Team are updating the PSIRF Plan and Policy and reviewing the PSIRF templates. • Processes are being reviewed with the aim to move from paper to digital documentation, through collaboration with the Datix team. • Weekly meetings with the Divisional Governance Leads & Senior Nursing Leadership within the Divisions to monitor PSIRF template compliance continues. • Uptake of Training for All Staff Level 1 PSIRF training has been good. The data for December 2024 is approximately 92%, based on compliance figures by department.
Nursing & Midwifery Workforce	During December, occupancy remained very high with ongoing use of additional super surge beds, pre-emptive boarding and significant numbers of patients requiring enhanced observation in relation to high risk of falls or patients with challenging/violent behaviour. Controls remain in place to ensure staffing continues to meet the needs of our patients and there is an overall reduction in the reliance on agency staffing in our inpatient areas. Ward nursing CHPPD overall was 8.2 for Oct (noting distortion by specialist areas). Nursing fill rates for day shifts = RN 90% and HCSW 88%. Nursing fill for night shifts = 94% for RN and 100%.	• Data collection to inform the annual Nursing Establishment Review (NER) is complete using the new national tool piloted/tested, with analysis underway. • 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 progress. • Nursing/Midwifery monthly Roster Compliance sessions continue, led by the Deputy Chief Nurse to ensure effective/efficient nursing rosters. There is a fortnightly roster assurance panel in place with the Chief Nursing Officer, 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

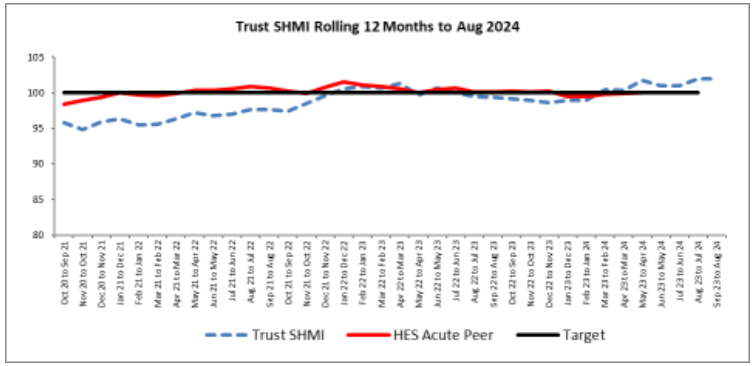
Title	Summary	Actions
Inpatient Falls	Slips, Trips and Falls (132) with no Catastrophic or Severe harm incidents. There were 6 Moderate incidents. SWARM falls templates are completed for all Moderate harm and above Falls incidents by the service and discussed at the Trust Falls group bi-monthly. One Moderate harm Falls incident was re-graded as a No harm incident following review. The inpatient falls rate for ESHT per 1000 bed days was 4.28 in December 2024; this remains within the control limits with common cause variation. The top sub-category continues to be 'patient fall whilst mobilising independently' majority resulting in No harm. The main locations for patient falls were Irvine Unit – CHIC (9), Benson and Egerton Trauma ward – DAS (8), ED EDGH – Urgent care (8) and Tressel ward – Urgent care (7).	• SWARM Forms have been updated and continue to be monitored and peer reviewed by the PSIRF Review Group. • There is an ongoing Falls QI project looking to reduce inpatient falls by 20% within the BIU (Bexhill Irvine Unit). • Divisional themes and trends are reported to the Falls Steering Group for oversight and consideration for quality improvement activities.
Patient Experience	FFT- Following an ongoing review of patient eligibility data, it has been noted that a further batch of data extract files were not processed by Healthcare Communications, resulting in a further number of patients not being sent an SMS FFT.	There are ongoing discussions between Healthcare Communications and ESHT to resolve this. Explore how the learning from complaints, PALS and FFT can be used to make changes.
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 Divisional Integrated Performance Report and summary overview to Integrated Governance Meeting. • A formal overview of Harm Reviews is being prepared for • On completion of this first review, methodology and reporting will be further developed to ensure consistency and clarity across all services
Pressure Damage	There had been no Cat 3 or 4 PUs reported amongst inpatients in the last 3 months. One new category 3 PU was reported in December in a patient in their own home. A further Cat 3 was identified in a patient with pressure damage originally reported as unstageable in August in the community. On admission to hospital the damage was reassessed and recoded to Cat 3 due to deterioration.	• 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 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

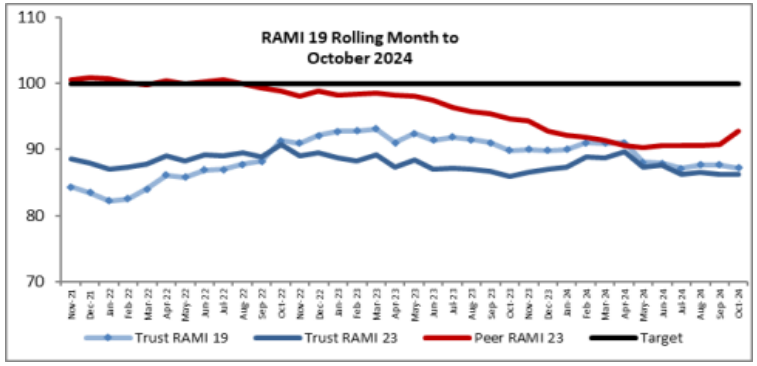
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

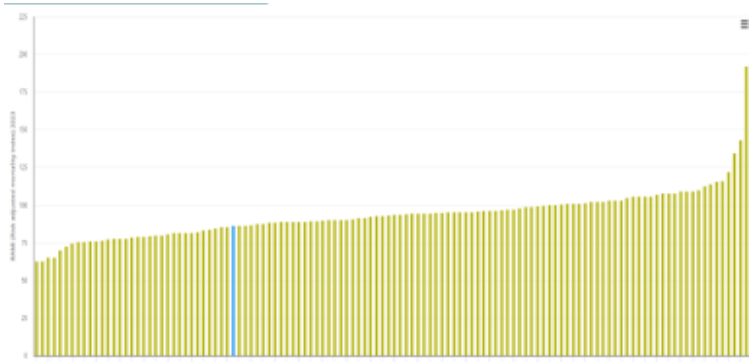
Summary Hospital Mortality Indicator (SHMI)
Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures



- SHMI – September 2023 to August 2024 is showing an index of 102 and is within the expected range. EDGH is showing 99 and Conquest is 106. Peer SHMI for the latest period is not yet available.
- SHMI is rebased each time it is published whereas RAMI is not. RAMI has recently been rebased however, and the new RAMI 23 is now available.
- RAMI 23 – Nov 2023 to Oct 2024 (rolling 12 months) is 86, and 86 for the same period last year. Peer RAMI was 93 for this period
- RAMI 23 was 87 for the month of October only and 81 for September. The line graph below shows the rolling 12 month figure
- Crude mortality shows Nov 2023 to Oct 2024 at 1.55% compared to 1.72% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 70% for October 2024 deaths compared to 70% for September 2024 deaths.

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





This shows our position nationally against other acute trusts – currently 34/120

Effective Care - Mortality

East Sussex Healthcare NHS Trust

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

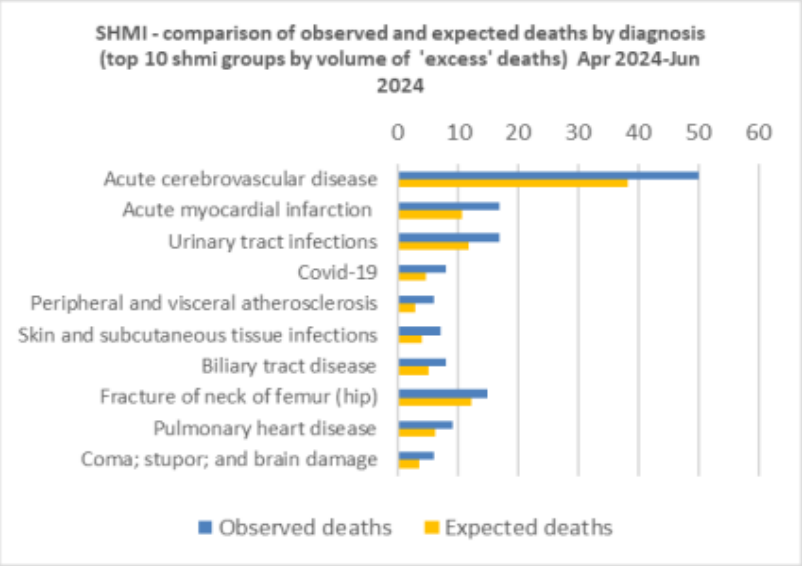
Description	Deaths
Frailty of old age	16
Pneumonia	13
Sepsis/Septicaemia	13
Cancer	12
Heart Failure	9
Community-acquired Pneumonia	8
Atrial Fibrillation (AF)	6
Hospital-acquired Pneumonia	6
Acute Kidney Injury (AKI)	4
Bowel Obstruction	3
Chronic Obstructive Pulmonary Disease (COPD)	3
Urosepsis	3
Aspiration Pneumonia	2
COVID-19	2
Stroke	2
Myocardial Infarction (MI)	1

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

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

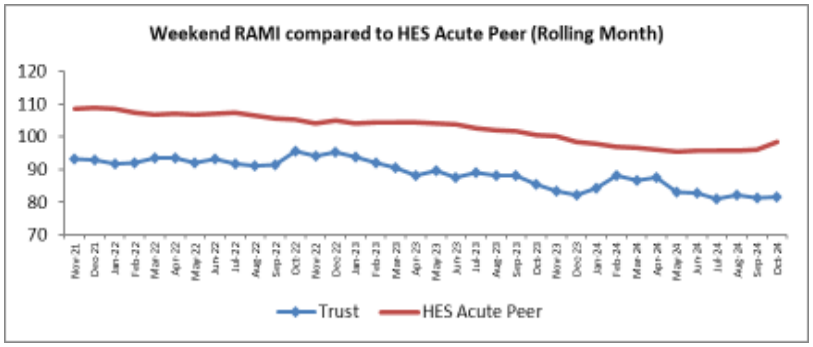
NB: Delays in recording cause of death can be due to awaiting results from an inquest, post-mortem or other reasons.

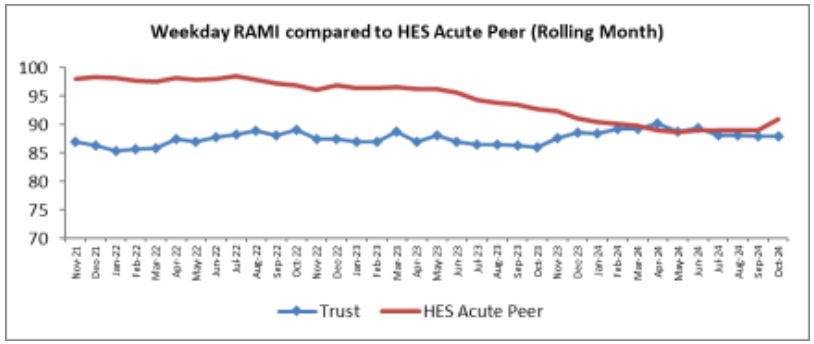
SHMI Diagnosis Main Groups



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

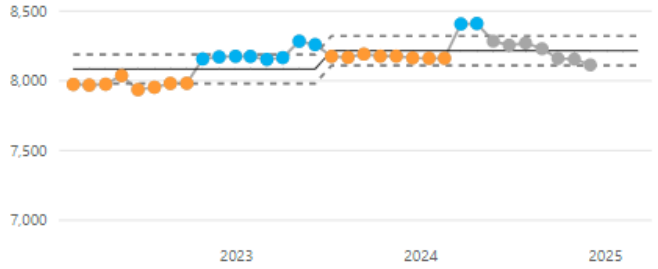
Responsive	**Positives:** Turnover reduced by 0.1% to 10.6% and within target. Vacancy rates reduced by 0.2% to 2.3%, well within 7.5% target. Mandatory Training rate hit a new high of 91.2%, above target.	**Challenges and Risks:** Monthly sickness increased by 0.2% to 5.9% with a marked increase in Cold, Cough Flu illnesses. Appraisal rate increased by 0.6% to 84.2% but 0.8% below target.	**Author** 
Overview:	Overall usage dropped by 83.4 whole time equivalent (wte), reducing the gap between usage and budget. This includes bank & locum wte usage reducing by 45.9 wte. There may have been some slight under reporting due to the holiday period. Agency usage reduced to 56.1 wte but there remains a residual need for agency in Theatres and Emergency Care. Over the past 12 months there has been 762.3 wte leavers (10.6%). The rate has stabilised within the range 10.5% - 10.8% within the last six months which is an improvement compared to two years ago where the rate was 13.7%. Medical & Dental staff turnover showed the largest reduction (-0.6% to 8.6%), whilst Healthcare Scientists showed the largest increase (1.3% to 6.4%; an increase of 2.0 wte leavers). Turnover rates fell for Registered Nurses & Midwives (-0.1% to 9.3%), Additional Clinical Services (-0.2 to 12.2%) and Admin & Clerical staff (-0.2% to 10.6%). The Trust vacancy rate, at 2.3%, equals 177.2 wte vacancies, the reduction largely due to the changes in substantive budgeted establishment in respect of the Cost Improvement Programme. This outweighs a small reduction in contracted staff in post this month of 5.3 wte. The monthly sickness rate increased by 0.2% to 5.9% whilst the annual sickness rate remains unchanged at 5.3%. Wte days lost in month increased by 859. The increase was most marked in December for Cold, Cough & Flu which increased by 674 wte days lost in month to 2,124. Gastro illnesses dropped by 56 wte days lost, despite reports of norovirus outbreaks but this may well impact more in January. Anxiety/Stress absences remain the highest identified cause of sickness but did drop this month by 84 wte days lost to 2,931, as these cases continue to be managed. The mandatory training rate increased slightly by 0.1% to 91.2% and is 1.2% above target. All courses are at over 90% compliant, with the exception of Information Governance at 88.0% (+0.3%), Fire Safety at 89.3% (+0.3%) and Basic Life Support (BLS) which remains the outlier at 72.9% (+0.7%). BLS compliance is lowest for Healthcare Scientists at 48.2%, Prof & Tech staff at 59.5% and Medical & Dental staff at 68.3%. The appraisal rate increased by 0.6% to 84.2%. All staff group rates improved, except for Medical & Dental which was slightly down, by 0.2% to 91.3% (though still has the highest compliance rate of all staff groups) and Additional Clinical Services which reduced by 0.5% to 83.4%. The largest increase was for Healthcare Scientists, up by 1.5% to 74.4% (though this is the lowest staff group rate).	**Jenny Darwood** Acting Chief People Officer

Our People Core Metrics

East Sussex Healthcare NHS Trust

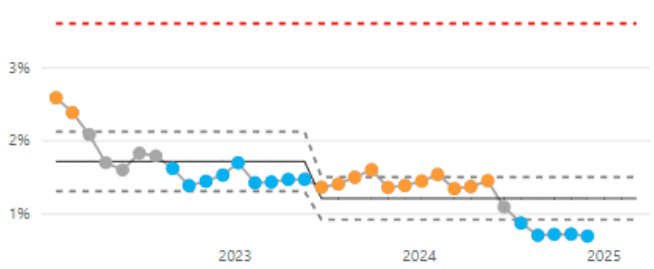
Establishment (WTE) All: Total, Our People

Target required	Common Cause	8,109



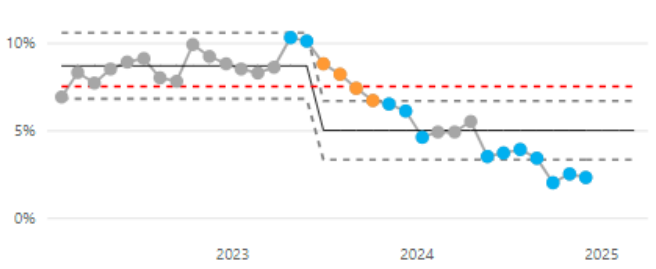
Agency Rate: Total, Our People

Achieving	Improvement	0.687%



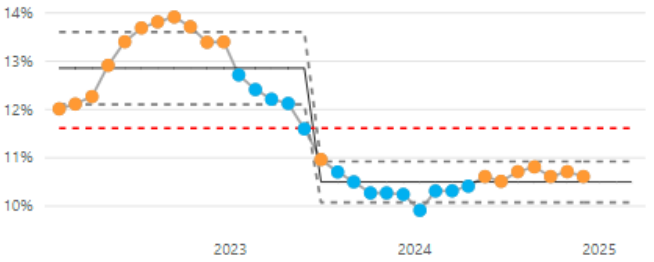
Vacancy Rate: Total, Our People

Achieving	Improvement	2.3%



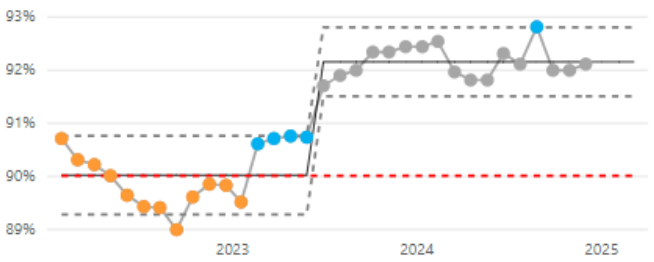
Staff Turnover: Total, Our People

Achieving	Concern	10.6%



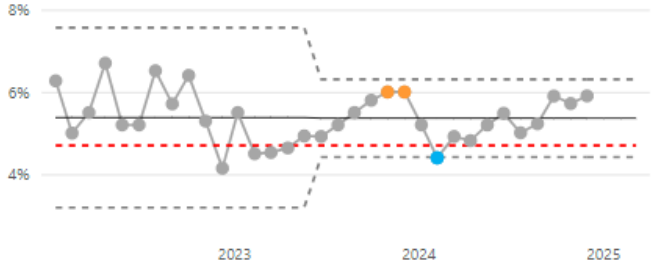
Retention Rate: Total, Our People

Achieving	Common Cause	92.1%



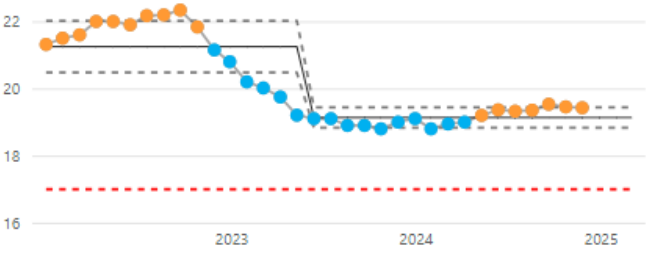
Monthly Sickness - Absence %: Total, Our People

Inconsistent	Common Cause	5.90%



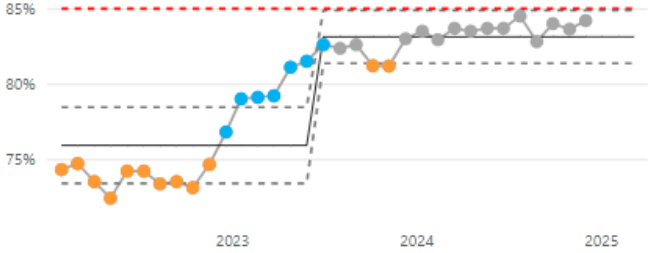
Sickness - Average Days Lost per Fte: Total, Our People

Not Met	Concern	19.4



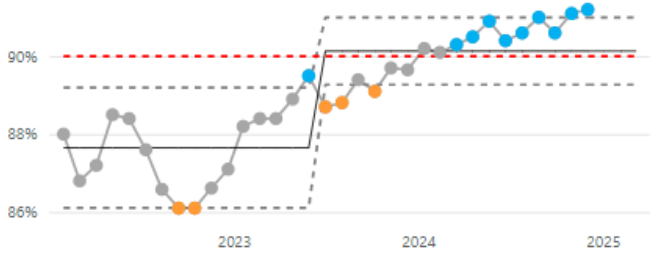
Staff Appraisals: Total, Our People

Not Met	Common Cause	84.2%



Statutory & Mandatory Training: Total, Our People

Inconsistent	Improvement	91.2%



Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Turnover & Retention	Turnover rate slightly reduced by 0.1% to 10.6%. The stability rate increased by 0.1% to 92.1%.	Workstreams and programmes to support retention of our people continue to progress as summarised below: • Continuing to make preparations for the Legacy Mentoring training pilot, starting in Jan 2025. We now have 13 participants from a range of disciplines and areas signed up to undertake the training. Linking up with areas of high turnover (defined as colleagues leaving the trust within the first 12 months of starting), to offer legacy mentoring input to new starters in an attempt to improve retention. • Mapping out Action Learning Set (ALS) dates for teams who have expressed an interest in trialling this approach. Most likely to start from March onwards to avoid winter pressures. Training scheduled for the end of January for members of the ESHT Henley Leadership Graduate cohort, to become ALS facilitators. • In collaboration with HR colleagues, we have now agreed the process templates for Exit Interviews. The Ending Employment policy will now be updated to reflect these changes and will go through necessary consultation and ratification before being finalised. • Early review of responses from the Exit & Stay surveys shows that 9.5% of colleagues remaining with the Trust but moving to a new role, completed the Staying with the Trust survey. The Trust is exploring ways to increase this response rate. 24% of colleagues leaving the Trust over this first period, responded to the Exit survey. Further thematic analysis of colleagues' reasons for leaving and staying with the Trust to be undertaken this month. • Development of an Appraisal Task and Finish group in preparation for electronic appraisal launch at the end of Jan 2025 • Working closely with key stakeholders to develop and shape the leadership strategy for ESHT for the next five years. • Working with HR solutions to make minor improvements to the electronic Flexible Working Request process. • Reviewing the feedback process for the team stress questionnaire and agreeing reporting requirements through HSSG.
Vacancy Rate	Vacancy rate reduced by 0.2% to 2.3% (177.2 wte vacancies). This is due to change in substantive budgeted establishment. in respect of the Cost Improvement programme	• Ongoing recruitment activity to address hard to recruit posts including Medacs Agency / Allied Health Professionals and Community. Retained headhunter activity underway to tackle Consultant hard to recruit posts i.e. Microbiology and Dermatology. • Ongoing social media activity to promote both the Trust and hard to recruit posts. Specific online job boards also being engaged to support activity. • Continued success with direct applicants has assisted the reduction in overall vacancies i.e. number of OT applicants.

Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Sickness	Monthly sickness increased by 0.2% to 5.9% whilst annual sickness was unchanged at 5.3% Average sick days per fte have reduced by 0.1 to 19.4	There has been a general increase in sickness across the Trust due to seasonal colds, cough and flu; with symptoms lasting longer. Colleagues are being encouraged to take up the offer of a flu vaccine and the period of availability has been extended to support this. HR business partners are continuing to review sickness in particular hotspot areas to consider potential interventions. It has been noted that there is an increase in the use of the 'Unknown' reason. Managers are being asked to review these to ensure all appropriate support can be offered. Work continues in partnership with Occupational Health to focus on long term sickness, particularly those of 100 days plus, ensuring that a plan to facilitate a return to work is in place where appropriate
Statutory & Mandatory Training	Trust compliance increased by 0.1% to 91.2%, above target and a new high. .	Compliance for BLS has increased again for the second month in a row (from 72.2% to 72.9%). The initial review of audiences did result in some amendments, however, BLS compliance remains below 70% for Medicine Division, Urgent Care and Corporate Services. The Subject Matter Expert for Resuscitation is reviewing all those who are non-compliant and will follow up. Did Not Attend (DNA) rates continue to be a factor which is compounded by the overwhelming service pressures on front line services which has impacted on attendance. The national work is also being implemented as the action plans have been agreed. Current work is mapping provision to the CSTF. The meeting of the Education Steering Group has been rescheduled to Feb in response to Business Continuity implemented w/c 6/1/25. Safeguarding Level 3 compliance remains poor across all areas, at 60.4%. Resident Doctors on placement, or due to go on placement, have been contacted and a number have confirmed they are compliant so data will be amended. Remaining list of non- compliant staff will be sent to senior managers. Additional dates have been added to MyLearn platform.
Appraisal	Compliance rate increased by 0.6% to 84.2%.	Despite significant operational pressures, appraisal rates Increased by 0.6% to 84.2% compliance in Dec 24.

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

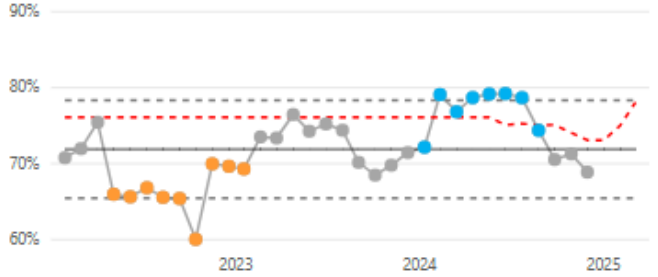
	Positives	Challenges & Risks	Author
Responsive	**Cancer** The Trust delivered 82.5% against the Faster Diagnosis Standard in November (national standard 77%). Performance against the 62-day standard also improved to 72.9% versus a trajectory of 66.7%. **Urgent Community Response (UCR)** The UCR standard of 70% has been consistently achieved year to date, with 82.0% of patients seen within the 2-hour response window in December. **Elective long waits (RTT)** The Trust continues to support system partners in reducing long waits in elective care. The number of patients waiting 65 weeks or more for treatment reduced for the second consecutive month, from 57 in November to 55 in December (this includes circa 1430 long waiting patients being transferred from another Sussex provider).	**4 Hour Emergency Access Clinical Standard** In December 2024, 68.8% of patients were seen and discharged or treated and admitted within 4 hours, against the 78% target. During December, the Trust has seen high bed occupancy, increasing length of stay and our limited ability to discharge patients to their onward care destination. We continue to work collaboratively with system partners in an attempt to address these issues. **Cancer** The backlog of patients waiting over 62 days at the end of December 2024 was 201 against a trajectory of 143. A backlog trajectory is in place for each tumour site, and this is monitored weekly. **Length of Stay (LoS)** Non-elective LoS has continued to increase, increasing from 5.18 days in November to 5.39 in December. Reducing the pressure on hospital bed capacity is a recognised challenge. Reducing length of hospital stay continues to be an area of focus for the Trust.	 **Charlotte O'Brien** Chief Operating Officer
Actions:	• Focus on reducing non admitted breaches and overnight waiting times in ED to support delivery of the 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 across Sussex by the end of March 2025 and sustainably reducing elective waiting times.		

Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

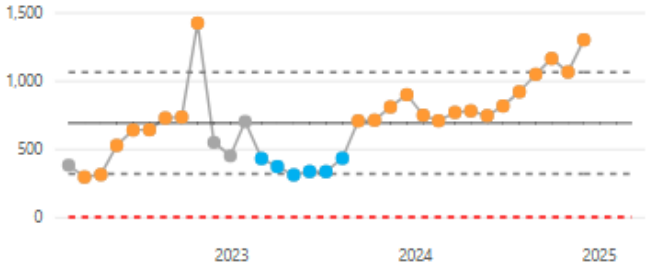
4 hour standard: Total, Our Performance

Inconsistent	Common Cause	68.8%



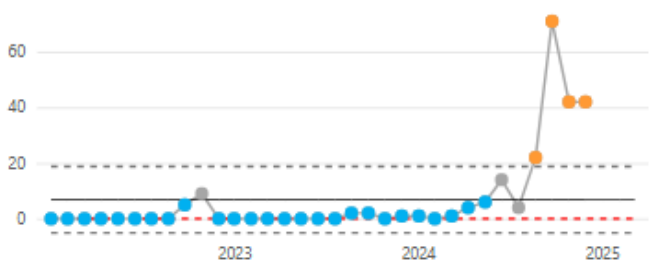
A&E > 12 hours from arrival to discharge: Total, Our Perfor...

Not Met	Concern	1299



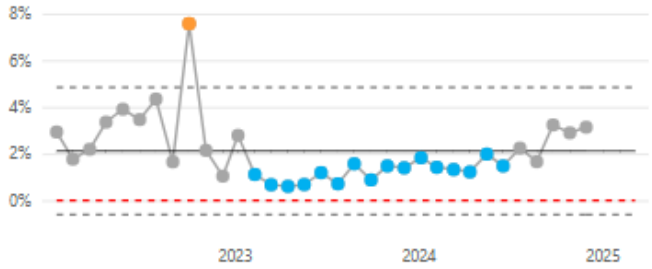
A&E waits over 12 hours from DTA: Total, Our Performance

Inconsistent	Concern	42



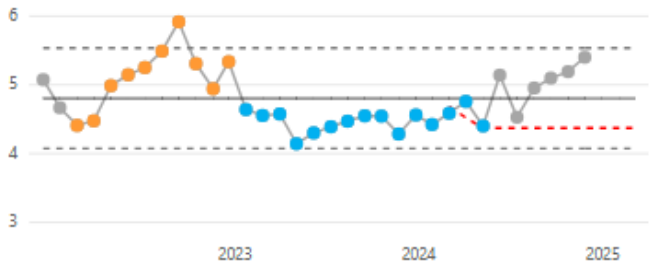
Conveyance handover >60 mins: Total, Our Performance

Inconsistent	Common Cause	3.14%



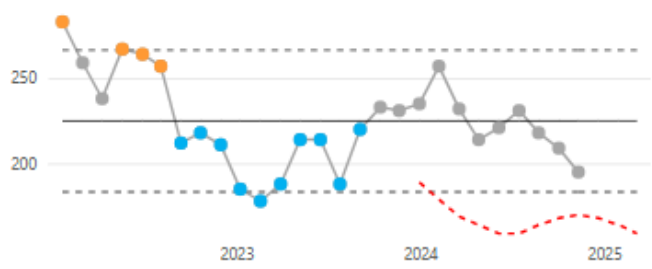
Non Elective Length of Stay: Total, Our Performance

Inconsistent	Common Cause	5.39



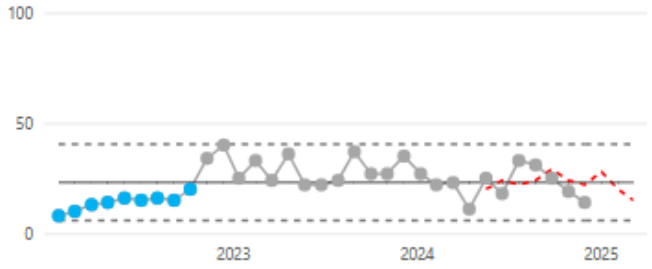
Average daily NCTR: Total, Our Performance

Not Met	Common Cause	195



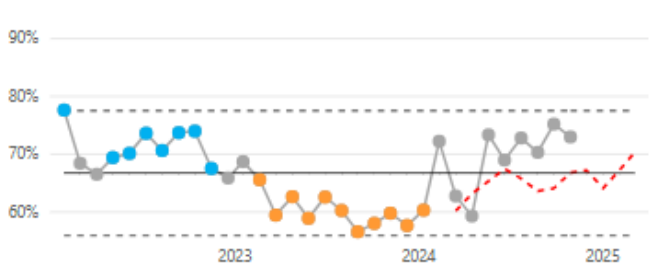
104 day Backlog: Total, Our Performance

Inconsistent	Common Cause	14



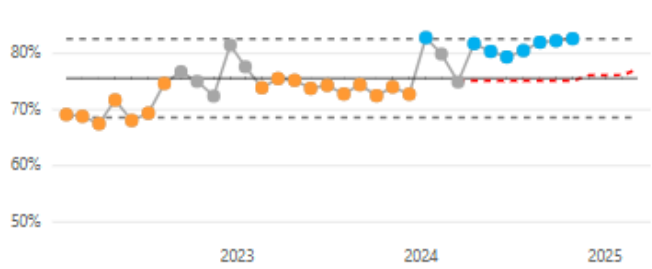
Cancer 62 Day: Total, Our Performance

Inconsistent	Common Cause	72.9%



28 Day General FDS: Total, Our Performance

Inconsistent	Improvement	82.5%

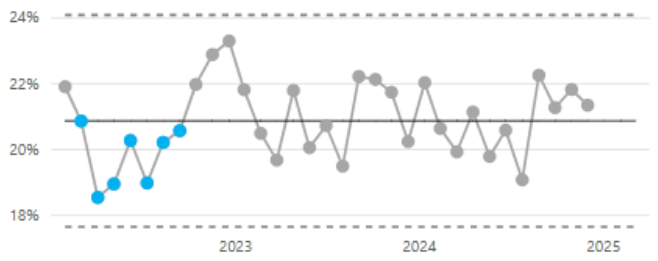


Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

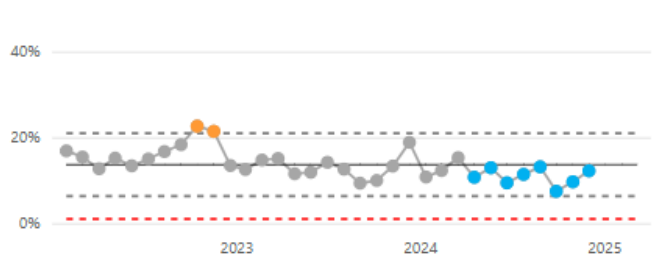
% Discharges delayed 1+ days: Total, Our Performance

Target required	Common Cause	21.3%



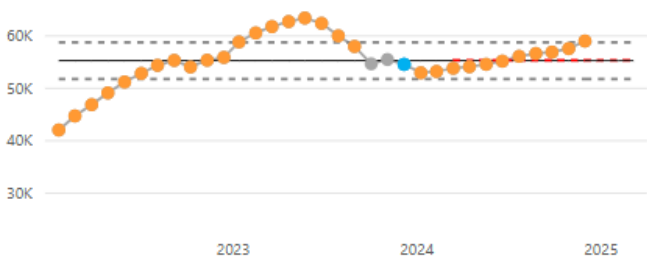
Diagnostic <6 weeks: Total, Our Performance

Not Met	Improvement	12.2%



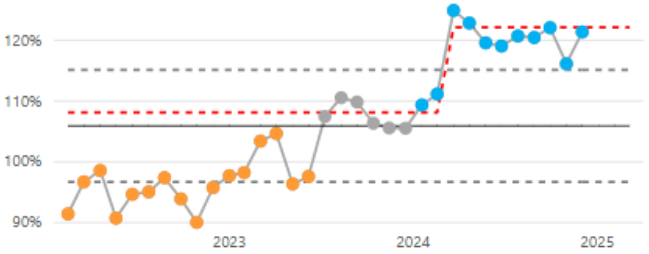
RTT Total Waiting List Size: Total, Our Performance

Inconsistent	Concern	58907



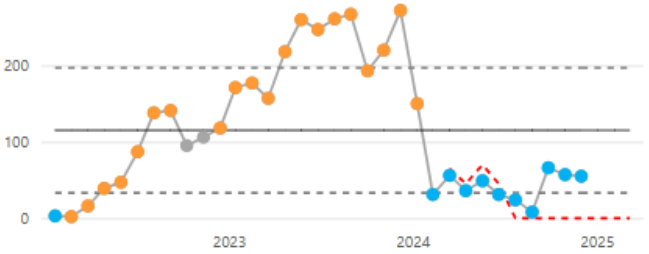
Elective Activity (ELIP,DC,OPFA, OPFUP Proc): Total, Our Perf...

Not Met	Improvement	121%



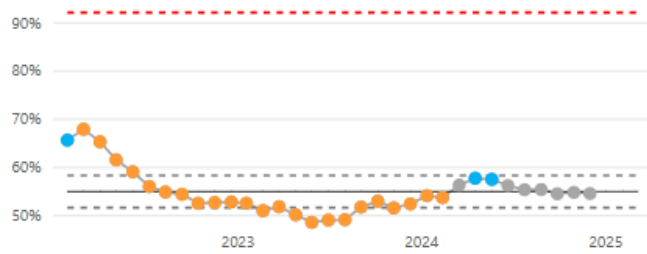
RTT 65 week wait: Total, Our Performance

Not Met	Improvement	55



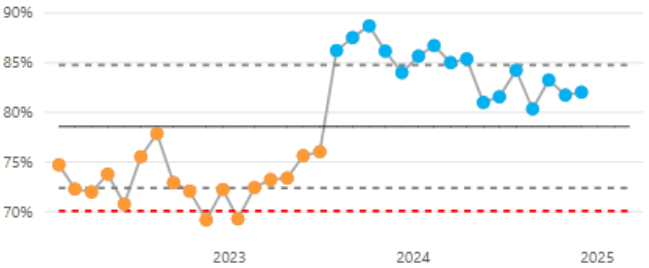
RTT under 18 weeks: Total, Our Performance

Not Met	Common Cause	54.5%



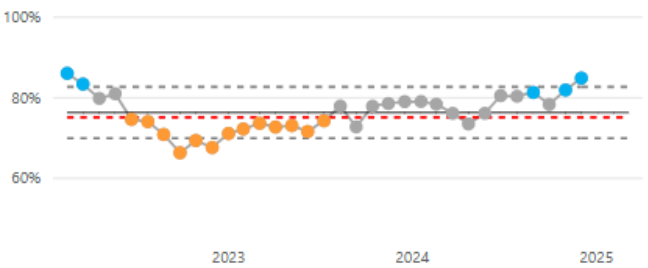
Urgent Community Response within 2 hours: Total, Our Perf...

Achieving	Improvement	82.0%



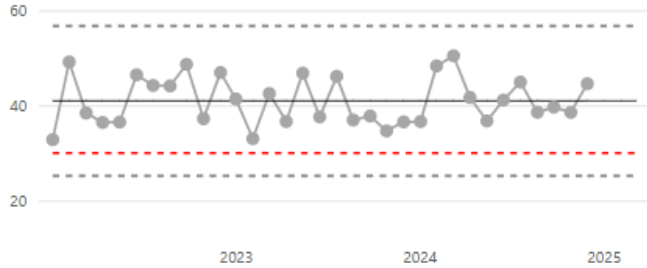
CHIC wait times < 13 weeks: Total, Our Performance

Inconsistent	Improvement	84.7%



Intermediate Care Length of Stay: Total, Our Performance

Inconsistent	Common Cause	44.6



Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Emergency Access Clinical Standard	In December 2024, 68.8% of patients were seen and discharged or treated and admitted within 4 hours, against the 78% standard. This places our Trust at 54 out of 124 trusts nationally, ranking us in the second quartile. To achieve 78%, the Trust would require a daily breach reduction of 37 less breaches a day across the two sites.	• Escalation of delays and pathways that are not optimised with support of all divisions and site teams. • Trust wide focus to achieve 78 % 4-hour clinical standard. • Focus on roles and responsibilities to support overnight resilience. • Ringfence CDU for Emergency Department.
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 1063 in October to 1299 in December. 42 patients remained in ED for >12 hours following a decision to admit in both November and December.	• Detailed review of each patient who remained in ED for more than 12 hours following a decision to admit, including an assessment of clinical harm and lessons learnt are being taken forward. • Timely escalation within the ED department when at full capacity to majors, RAT and Resus, to enable ED and cross divisional plans to create space. Escalations to site managers and ED operational leadership team where there are inbound conveyances with no plans. • 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 3.14% in December. This represents an increase in the number of patients the Trust were not able to offload within 60 minutes compared with November at 2.90%	• Increase focus on ambulance handover times, early escalations and actions to mitigate delays and support decompressing the department • Improve staffing and flow through RAT to allow for improved RAT process and model. • Continue to work with SeCAMB to ensure crews are not waiting longer than 15 minutes to offload.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Non elective Length of Stay (LOS)	The Trusts non-elective length of stay increased from 5.18 days in M8 to 5.39 days in M9. This is linked to the change in 0-day LOS reporting with SDEC attendances being recorded as T5 attendances rather than admissions (the reduced denominator impacts LOS for the remaining inpatients). The increase in capacity for both Pathway 1 and 2 patients has supported a reduction in the number of patients who do not meet the criteria to reside within our acute beds.	Discharge Improvement workstreams: • Embedding Safer on wards • Planning discharge from point of admission. • Reconditioning and rehabilitation on wards, including trialling a mobility volunteer role, pilot wards reviewing mobility assessments, undertaking harm reviews and getting patients up and dressed to be active. • Optimising the Transfer of care Hub • Increased P1 capacity to support same day/ next day discharges, 7 days week • Additional System Funding to support a further increase in P1 capacity and a night sitting service for the winter period.
Community Waiting Times (Paediatric)	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 Dec was 0 (compared to 65 in Dec 23). There are 9 children waiting over 78 weeks and 314 children waiting over 52 weeks compared to 641 in Dec 2023.	• On going recruitment to both clinical & administrative roles in Community Paediatrics. • Redesign of service continues to be explored including a digital opportunities to optimise the patient pathway.
Community Waiting Times (Adult)	Urgent Community 2-hour response achieved 82.0% against the national target of 70%. There has been a reduction in the overall waiting times for new patients in planned care community services, This is despite demand for services increasing in Dietetics, District Nursing, Joint Community Rehabilitation, Podiatry and Speech and Language Therapy.	• Capacity demand modelling and services review for community services with longer waiting times for planned new and follow up care

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Cancer	The Trust delivered 82.5% in November against the 77% Faster Diagnosis Standard. The Trust delivered 92.8% against the 31-Day national standard of 96%. Performance against the 62 Day standard in December was 72.9% against a trajectory of 66.7%. The backlog of patients waiting over 62 days at the end of December 2024 was 201 against a trajectory of 143. This was 5.9% of the total Cancer Patient Tracking List. The Sussex position is 7.4% and the national position is 7.9%. The Trust continues to receive high number of urgent suspected cancer referrals and in November received 2577 GP referrals. Cancer pathways remain a Trust priority, and we continue to focus on all elements of the patient journey to ensure patients are seen, diagnosed and treated in a timely way.	• Detailed Divisional Cancer Action Plans underpinned by improvement trajectories in place to support improvement and sustainability. • National Best Practice Timed Cancer Pathways and SSCA Optimal Pathways shared with Cancer Clinical Leads and being reviewed by Trust Cancer Clinical Lead and Lead Cancer Nurse to support improvements in local pathways. (Skin and Lung). • Enhanced focus on patients early in the pathway to improve transfer dates to tertiary providers by Day 38. • Tumour site predictions of performance for in month and future month to ensure performance is aligned to the trajectory, reviewed weekly. • Implementation of a Tiering approach to challenged tumour sites to provide senior support to expedite pathways. • Chief Operating Officer Led Recovery meetings for challenged specialties.
Elective Activity	In December, the Trust delivered 121% of 2019/20 baseline activity levels, an improvement of 5% from the previous month with the Trust delivering improvements in all areas.	• Outpatient productivity programme progressing well, includes 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 expected in H2 as a result of supporting system partners recover the long wait position in Sussex.

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 Trust remains on target to delivering zero 65-week breaches by 31/03/25. In December, the Trust reported 55 patients who had waited >65 weeks. This was a reduction of 2 from the previous month and significantly below the trajectory of 73 that the Trust had set for December. 38 of these long waiting patients had recently been transferred from another Sussex provider as part of ESHT's support to reduce the number of long waiting patients across Sussex. The Trust reported 3 patients who waited for more than 78weeks. The patients have all been treated in January. The increase in the total waiting list (increase from 56798 to 58907), is a result of contracting and reporting changes to the MSK pathway. This change has had no impact on the 65-week risk cohort numbers and RTT compliance has remained largely unchanged at 54.5%.	• Progressing mutual aid requests from neighbouring providers to support a reduction in waiting times for patients in Sussex continues. The Trust has supported the transfer of circa 1600 patients year to date. Insourcing/Outsourcing continues to support the more challenged specialties, including Neurology, Vascular, ENT and Gynaecology. • Daily monitoring of the longest waiting patients to ensure pathways are progressing. • Increasing First Out-patient appointment (FOPA) attendances to reduce FOPA waits across all specialities. • Focus on validation at diagnostic and follow-up stage to improve RTT performance.
Diagnostic DMO1	In December the overall size of the DM01 waiting list rose to 9,103 patients. This increase was as a result of the transfer of the MSK service and patients being added to the waiting list. There were also smaller increases in Audiology and Urodynamics. The number of breaches increased from 784 in November to 1,112 in December. These were mostly in Radiology and linked to the MSK service transfer. Performance reduced from 90.35% in November to 87.78% in December.	• Continued focus to support modality level recovery plans and to sustain delivery of 95% at year end in line with national requirement. • Monitor the impact of supporting system partners reduce long waits is having on diagnostic waiting lists and DMO1 performance.

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 (£2.3m) compared to a deficit plan of (£0.9m), resulting in a (£1.4m) deficit to plan in month. This takes the year to date (YTD) deficit to (£12.8m) which is an adverse variance of (£10.3m). • Elective Recovery Fund (ERF) on plan in month with actual of £11.179m (excluding prior month catch up) compared to plan of £11.241m. Overachieved by £3.6m ytd. • Capital overspent by £12.739m, the plan is materially back phased. The Trust is currently rephasing to better align to expected profile, and forecast out-turn shows slightly over plan • Pay Run rate similar to M9. Overall view positive and temporary workforce staff costs still lower, with agency half of what it was in M3 and lowest M9 ytd. • Non Pay run rate higher than M8 due to one off costs for contract catch ups and Legal. • Use of Resources over plan YTD at £23.893m and forecast to slightly overachieve. • Financial Recovery Director in post and helping ESHT find more initiatives to improve position. • Drive to keep costs within M7 levels in order to achieve the Trust Forecast Outturn. • Budget setting process for 18 months from Jan 25 to June 26 on going.	Current projection of year end (£14m) deficit with risks including winter pressures. In order to achieve this, the Trust is controlling monthly spend over the next three months and deliver agreed monthly efficiencies (the Use of Resources), and also increase ERF by £1m through Out-patient booking and Theatre Utilisation and a further £1m decrease on temporary spend.	 **Damian Reid** Chief Financial Officer
Overview:	**I&E**: The Trust plan was for a deficit of (£0.9m) in month. Actual performance was a deficit of (£2.3m) so (£1.4m) deficit to plan in month. YTD adverse variance of (£10.3m). 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, Security for MH patients, partly offset by realised old year income (catch up and contracts) ERF performance, and one-off benefits from the balance sheet and Integrated Care Board. **UoR**: FY24/25 full year efficiency requirement is £36.7m. Total YTD delivery at month 9 of £23.9m against plan of £23.5m, an over-delivery of £378k. Workstreams operational productivity, elective capacity, procurement and non-pay, grip and control are delivering well overall. Full year efficiency delivery forecast for FY24/25 is £37.4m against efficiency requirement of £36.7m, a positive forecast variance of £733K. Capital: Capital expenditure in month 9 was £30.2m, £12.7m above plan. Forecast outturn is to be on plan and Capital Resource Group will identify options to mitigate any risk and ensure allocation is maximised but not breached. **Cash**: Cash position is above the £2.1m minimum, likely to remain above target throughout 2024/25 and at least up until June. Partner Trusts are being requested to pay their OCC share.		

Finance | Income and Expenditure

East Sussex Healthcare NHS Trust

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Plan	Act	Var	Plan	Act	Var
Income						
Contract income	38,057	37,911	*(146)*	350,890	351,220	*330*
Divisional	6,361	7,359	*998*	60,157	66,156	*5,999*
ERF	11,035	11,179	*144*	101,489	104,701	*3,212*
Total Income	**55,453**	**56,449**	***996***	**512,536**	**522,077**	***9,541***
Operating Expense						
Pay						
Permanent	(37,363)	(35,561)	*1,802*	(336,982)	(318,339)	*18,644*
Temporary	(1,288)	(3,710)	*(2,422)*	(11,682)	(37,467)	*(25,784)*
Total pay	**(38,651)**	**(39,271)**	***(620)***	**(348,665)**	**(355,806)**	***(7,141)***
Non-pay						
Drugs	(1,369)	(689)	*681*	(12,470)	(13,021)	*(551)*
TEDD	(3,691)	(4,091)	*(401)*	(33,799)	(35,542)	*(1,743)*
Clinical supplies	(4,525)	(4,887)	*(362)*	(40,737)	(43,875)	*(3,138)*
Purchased services	(1,200)	(1,958)	*(758)*	(10,805)	(11,878)	*(1,073)*
Finance costs	(2,677)	(2,737)	*(59)*	(24,095)	(23,907)	*188*
Other	(4,272)	(5,144)	*(871)*	(44,499)	(50,894)	*(6,395)*
Total non-pay	**(17,734)**	**(19,505)**	***(1,771)***	**(166,405)**	**(179,117)**	***(12,712)***
Total Expense	**(56,386)**	**(58,776)**	**(2,390)**	**(515,070)**	**(534,923)**	**(19,853)**
Surplus/(Deficit)	**(932)**	**(2,327)**	***(1,394)***	**(2,534)**	**(12,846)**	***(10,312)***

I&E position

- In M9 there is a deficit of (£2.3m) compared to a deficit plan of (£0.9m) resulting in a deficit of (£1.4m) in month. YTD the Trust is adverse to a (£2.5m) plan by (£10.3m). A bridge of the current variance is set out on the next page.
- The £2.3m deficit is still aligned to the same themes overall, premium cost of staff mainly in Theatres and urgent Care, added to inflationary pressures on non and support for MH patients. Also in M9 ERF was lower as expected, this was built into the overall plan hence a deficit plan of (£0.9m) in month.
- M9 Note – The in month position was supported by £1.6m of balance sheet adjustments in month.

Income

- Contract income
  - New MSK contract £0.7m included in actual.
- Divisional income
  - SPH overachieved against plan £0.2m, driven predominantly through higher surgical activity than planned
  - Consistent with run rate.
- ERF
  - On plan, however run rate lower than M8 due to Christmas period.
- YTD £9.5m surplus, driven predominantly by;
  - 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 £3.6m (detail on slide 6)
  - £1.0m C&V Drugs in M1-9
  - £1.4m ERF 23-24 true up
  - TEDDS £1.0m, this is offset by non pay costs of £2.6m versus drugs.
  - £1.3m Pay Award extra funding (FYE £1.680m)
  - £1.0m A&E Recovery funding

Expense

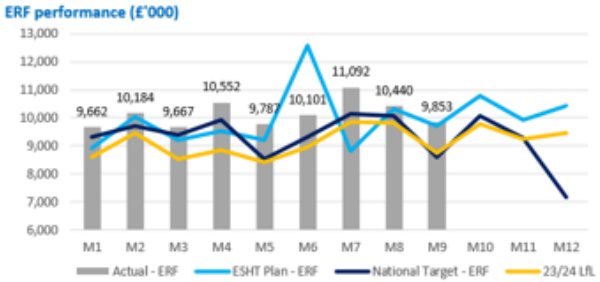
- M9 Pay was impacted by continued Escalation costs in month, mainly in UC (£0.15m) and Medicine (£0.04m). The cost of premium staffing due to higher staffing leave (sick leave approx. 5.9% and total staff unavailability of 27.6%). UC and Theatre predominantly driving higher overall agency usage. FTE above current budgeted levels, driven by unachieved CIP, previously mentioned staffing leave and supporting MH patients.
- M9 Non pay was impact by higher costs within Pathology/Radiology for quarterly catch ups (approx. £0.3m) on activity related invoices and unexpected on off legal costs (approx. £0.1m). The variance in month contains (£0.7m) of MSK costs from the new tender, (offset within contract income). Other drivers are in month CIP targets not being achieved against plan and general inflation.
- Balance Sheet releases included GRNI adjustments (£0.6m) and a VAT adjustment against pharmacy stock (£1.0m)

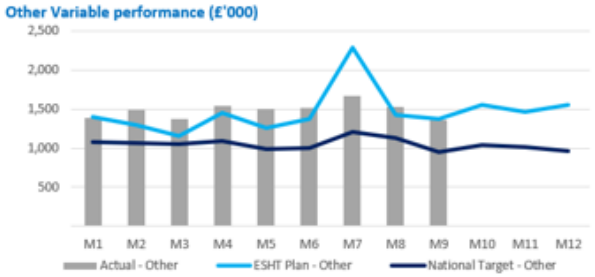
Finance | Variable income

East Sussex Healthcare NHS Trust

ERF performance

- ERF YTD over-performance of £2.2m. We expect this performance to increase as we report flex and freeze for previous months. Other variable activity over-performed by £177k in month and £1.4m over performance YTD.





	In Month				YTD			
	Plan	Actual	Var		Plan	Actual	Var	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Daycase	3,533	3,616	82	2.3%	30,390	33,054	2,664	8.8%
Elective	2,182	1,787	(395)	(18.1%)	18,356	16,835	(1,520)	(8.3%)
Outpatients - First	2,040	1,889	(151)	(7.4%)	17,758	17,438	(320)	(1.8%)
Outpatients - Procedures	1,770	1,902	132	7.4%	17,714	18,311	597	3.4%
Ward Attenders	135	147	12	9.1%	1,430	1,524	94	6.6%
ERS	52	103	50	96.9%	605	911	305	50.4%
SPH	257	410	153	59.5%	2,875	3,263	388	13.5%
Prior month catch up	-	(122)	(122)	n/a	n/a	n/a	n/a	n/a
ERF activity	**9,970**	**9,731**	**(239)**	**(2.4%)**	**89,128**	**91,337**	**2,208**	**2.5%**
Other Variable	**1,271**	**1,448**	**177**	**14.0%**	**11,983**	**13,364**	**1,381**	**11.5%**
Total	**11,241**	**11,179**	**(62)**	**(0.6%)**	**101,111**	**104,701**	**3,590**	**3.6%**

	In Month			YTD		
	Plan	Actual	Var	Plan	Actual	Var
	£'000	£'000	£'000	£'000	£'000	£'000
Endoscopy service	685	400	(285)	6,006	5,684	(322)
Ear Nose and Throat Service	526	443	(83)	3,898	3,962	65
Ophthalmology Service	1,259	1,185	(74)	11,252	11,504	252
Respiratory Physiology Service	77	11	(65)	505	564	59
Acute Internal Medicine Service	81	18	(63)	732	529	(203)
Cardiology Service	731	674	(57)	6,209	6,373	164
Clinical Oncology Service	143	95	(49)	1,539	1,306	(233)
Breast Surgery Service	247	202	(45)	2,278	2,317	39
Respiratory Medicine Service	182	149	(33)	1,486	1,180	(306)
Diabetes Service	66	38	(28)	471	404	(68)
Rheumatology Service	313	285	(28)	2,603	2,598	(5)
Paediatric Service	163	135	(27)	1,456	1,306	(150)
General Internal Medicine Service	61	45	(15)	580	517	(63)
Stroke Medicine Service	17	2	(15)	96	101	6
Vascular Surgery Service	79	65	(13)	502	602	100
Interventional Radiology Service	56	45	(11)	358	528	170
Transient Ischaemic Attack Service	40	30	(10)	395	366	(29)
Neurology Service	197	188	(10)	1,579	1,492	(86)
Anaesthetic Service	18	11	(8)	170	169	(2)
Paediatric Surgery Service	12	6	(6)	98	82	(16)
BCSP	30	27	(3)	354	349	(5)
Paediatric Epilepsy Service	7	4	(3)	68	47	(20)
Palliative Medicine Service	4	1	(3)	17	9	(8)
Chemical Pathology Service	16	14	(2)	181	155	(26)
Diagnostic Imaging Service	0	-	(0)	52	0	(51)
Paediatric Dermatology Service	6	6	(0)	56	54	(2)
Emergency Medicine Service	-	-	-	-	3	3
Physiotherapy Service	-	-	-	-	-	-
Plastic Surgery Service	-	-	-	6	-	(6)
Paediatric Trauma and Orthopaedic	4	5	0	53	45	(8)
Hepatology Service	0	1	0	3	11	8
Elderly Medicine Service	29	31	3	268	283	15
Orthodontic Service	22	32	10	275	265	(10)
Cardiac Rehabilitation Service	-	10	10	0	68	68
Urology Service	878	891	13	8,615	8,960	345
Maxillofacial Surgery Service	127	145	18	1,306	1,235	(71)
Clinical Haematology Service	257	283	25	2,405	2,304	(100)
Gynaecology Service	499	525	26	4,893	5,118	225
Gastroenterology Service	341	374	34	2,674	3,021	348
Endocrinology Service	42	81	38	537	698	161
Dermatology Service	219	267	48	2,204	2,429	225
Sleep Medicine Service	-	109	109	-	789	789
SPH	257	410	153	2,875	3,263	388
Trauma and Orthopaedic Service	1,444	1,651	207	13,831	14,441	610
General Surgery Service	586	961	375	5,481	6,207	727

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	Full Year Fcast Risk	Full Year Variance £'000
	Original										
DIG	Digital Programmes	208	216	8	1,138	1,019	(119)	4,682	3,800	Low	(882)
DIG	Our Care Connected	-	1,875	1,875	-	1,875	1,875	2,500	2,500	Low	-
	Total Digital	**208**	**2,091**	**1,883**	**1,138**	**2,894**	**1,756**	**7,182**	**6,300**		**(882)**
EME	Diagnostic Equipment	326	303	(23)	978	726	(252)	2,000	1,820	Med	(180)
EME	MSC Implementation	-	-	-	476	-	(476)	476	-	Low	(476)
EME	Medical Equipment	47	-	(47)	427	296	(131)	2,200	2,200	Low	0
EME	Endoscopy (Internal)	-	-	-	-	-	-	2,500	2,500	Low	-
	Total Medical Equipment	**373**	**303**	**(71)**	**1,881**	**1,022**	**(859)**	**7,176**	**6,520**		**(656)**
EST	Fire	166	204	38	1,494	1,456	(38)	2,000	2,200	Med	200
EST	Backlog	212	117	(94)	1,418	3,534	2,116	3,100	4,322	High	1,222
EST	EDGH Cat 3 Labs	12	0	(12)	98	9	(89)	125	80	Low	(45)
EST	ICU adaptations (Phase 1)	12	11	(1)	98	496	398	125	500	Med	375
EST	Clinical Priorities - Prior Year	24	8	(16)	195	442	246	250	480	Med	230
EST	Endoscopy (Internal)	39	-	(39)	313	-	(313)	400	400	Low	-
EST	Sussex Surgical Centre (Trust Funded)	946	-	(946)	6,031	3,119	(2,912)	16,000	14,500	Low	(1,500)
EST	Ward Refurbishment	42	13	(29)	108	375	267	250	500	Med	250
EST	Ophthalmology Business Case	-	8	8	-	619	619	1,766	750	Low	(1,016)
EST	Cardiology business case	648	53	(594)	648	2,212	1,564	3,500	3,608	Med	108
EST	Emergency Department - WIS	84	-	(84)	251	-	(251)	500	250	Low	(250)
	Total Estates	**2,184**	**415**	**(1,769)**	**10,652**	**12,260**	**1,608**	**28,016**	**27,590**		**(426)**
FIN	Divisional Small Works	12	0	(11)	105	20	(85)	175	76	Low	(99)
FIN	Minor Capital	130	59	(70)	389	185	(204)	500	247	Low	(253)
FIN	Planned slippage/prioritisation	(497)	-	497	(2,430)	-	2,430	(6,439)	(500)	High	5,939
FIN	IFRS16 Lease Schemes	-	-	-	-	-	-	1,000	1,043	Low	43
FIN	ICB Brokerage	-	-	-	-	-	-	2,250	-	Low	(2,250)
	Total Finance	**(356)**	**60**	**415**	**(1,936)**	**205**	**2,141**	**(2,514)**	**866**	**-**	**3,380**
	System Capital	**2,409**	**2,868**	**459**	**11,735**	**16,382**	**4,646**	**39,860**	**41,276**		**1,416**
	New										
EST	Building For Our Future	150	192	42	1,035	844	(191)	1,859	1,859	Low	0
EST	Sussex Surgical Centre (TIF Funded)	500	2,005	1,506	999	11,276	10,277	9,271	9,271	Low	-
DIG	Diagnostics Digital Capability (LIMS)	49	140	92	146	350	204	607	607	Low	-
DIG	Diagnostics Digital Capability (OCS)	44	-	(44)	131	-	(131)	547	547	Low	-
DIG	Diagnostics Digital Capability (Image Sharing)	120	-	(120)	360	(66)	(426)	1,500	1,500	Low	(0)
DIG	Frontline Digitalisation (EPR)	-	816	816	-	1,128	1,128	6,484	6,484	Low	0
EST	Endoscopy (External)	500	(14)	(514)	3,000	244	(2,756)	10,000	10,000	Low	0
DIG	AI Diagnostics	13	-	(13)	40	28	(11)	165	165	Low	-
DIG	CoIN Network	345	-	(345)	345	-	(345)	345	345	Low	-
	Total Additional Capital	**1,375**	**3,140**	**1,765**	**5,711**	**13,804**	**8,093**	**30,778**	**30,778**	**0**	**0**
	Total Capital	**3,784**	**6,008**	**2,224**	**17,446**	**30,185**	**12,739**	**70,638**	**72,054**	**0**	**1,416**
FIN	Donated Expenditure	85	1	(84)	765	112	(653)	1,000	1,000	Low	-
FIN	Donated Income	(85)	480	565	(765)	(112)	653	(1,000)	(1,000)	Low	-
	Total Donated Capital	**-**	**481**	**481**	**-**	**-**	**-**	**-**	**-**		**-**
	Total Capital	**3,784**	**6,489**	**2,705**	**17,446**	**30,185**	**12,739**	**70,638**	**72,054**		**1,416**

Capital

- The planned capital allocation for 2024/25 is £70.6m.
- The capital expenditure incurred at month 9 totals £30.2m.
- Capital expenditure was largely driven by the following schemes:
  - Sussex Surgical Centre £14.4m.
  - Medical equipment £1.0m, including diagnostic equipment.
  - Estates works of £12.3m, the main schemes being, backlog maintenance (£3.5m), fire safety (£1.5m), cardiology services at EDGH (£2.2m), and ophthalmology (0.6m).
  - Building for Our Future £0.8m.
  - Digital £2.9m.
  - Frontline Digitalisation £1.1m.
- The Sussex Surgical Centre (Elective Care Hub) is scheduled to complete in March 2025 and is split funded in 2024/25 partly from system funding (£16.0m) and national PDC schemes (£9.3m). The project has incurred costs of £14.4m in year.
- The Sussex Surgical Centre is in delay. There are a range of potential outcomes and are actively working to mitigate the 4 main risks (vacuum, UCV theatres, NETB2024/3 and Plant Room 9 water systems).
- The Endoscopy Suite is scheduled to complete in 2025/26 and is split funded between system funding (£0.4m) and PDC funding (£10.0m). The suite will be incorporated into the new Sussex Surgical Centre building and in year costs to date total £0.2m.
- The Trust has an increase allocation of £6.7m from system strategic funding which has been made available from the system wide underspend on planned IFRS 16.
- Overall, the capital allocation to the Trust has increased by £5.5m in month because of the additional strategic funds, an increase in Building For Our Future allocation of £340k and a decrease in Frontline Digitalisation of £1.5m.
- The Government have announced that the NHP for EDGH will be delayed until 2037.
- CRG will identify options to mitigate any expenditure risk and ensure allocation is maximised but not breached.

Agenda Item: 11

Report To/Meeting	Trust Board	**Date of Meeting**	25 February 2025
Report Title:	Avoidability of Inpatient Deaths		
Key question	Was there any element of avoidability in any of the inpatient deaths that occurred in hospital?		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐		
Report Sponsor:	Dr Simon Merritt Chief Medical Officer	**Presenter(s):**	Dr Simon Merritt Chief Medical Officer
Outcome/Action requested:	The Board is asked to note the report. "Avoidability of Inpatient Deaths"; reports are presented to the Board on a quarterly basis.		
Executive Summary	The current "Avoidability of Inpatient Deaths" report details the April 2017 – June 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. There are two reasons as to why we are behind with regard to learning disability deaths; Firstly, we recently discovered that 15 cases dating back over 2 years had not been discussed, we have now discussed 9 of them. Four were found to have a learning difficulty rather than learning disability. The remaining two are due to be reviewed at the next meeting, if the LeDeR report has been completed., There is also a considerable time lag from death to external completion of the LeDeR report, without which we cannot proceed.		
Regulatory/legal requirement:	The reporting of "Learning from Deaths" to the Trust Board is a requirement in the Care Quality Commission review.		
Business Plan Link:	Quality ☒ People ☐ Sustainability ☐		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:			
No of Pages	2	**Appendixes**	1
Governance and Engagement pathway to date:	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		

What happens next?	The Mortality Review Audit Group continues to review deaths identified as having 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 also reviewed for completeness

Publication	Published

Avoidability of Inpatient Deaths Dashboard April 2017-June 2024 (Data as at 23/12/2024)

Department of Health

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

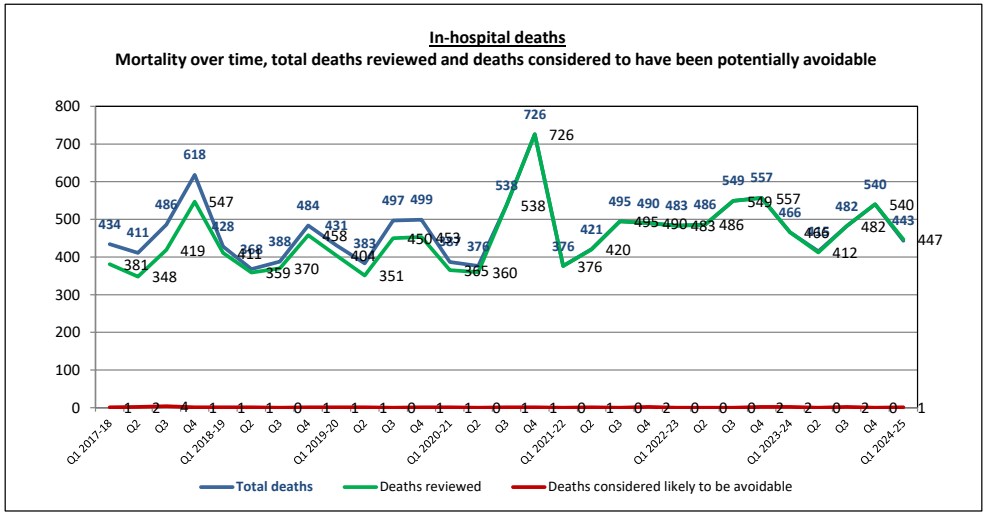
EAST SUSSEX HEALTHCARE TRUST: Avoidability of Inpatient Deaths Dashboard June 2024-25

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

Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 23/12/2024)

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

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
139	144	139	148	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
443	540	447	540	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
443	1903	447	1900	1	4



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	0	0.0%	This Month	4	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	7.1%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	13	92.9%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	7.1%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	13	92.9%

Data above is as at 23/12/2024 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 1 2024/25 deaths.This was not taken forward as a formal complaint.
Complaints - Of the complaints closed during Quarter 1 2024/25 which related to to bereavement in hospital, all had an overall care rating of 'good care' .
There were two patients with an overall rating of 1 or 2, poor care. These cases have been reviewed and the deaths were found to be definitely not avoidable.
Serious incidents - There were 3 severity 5 serious incidents raised in Q1 2024/2025.
As at 23/12/2024 there are 38 April 2020 - June 2024 deaths outstanding for review on the Mortality database.

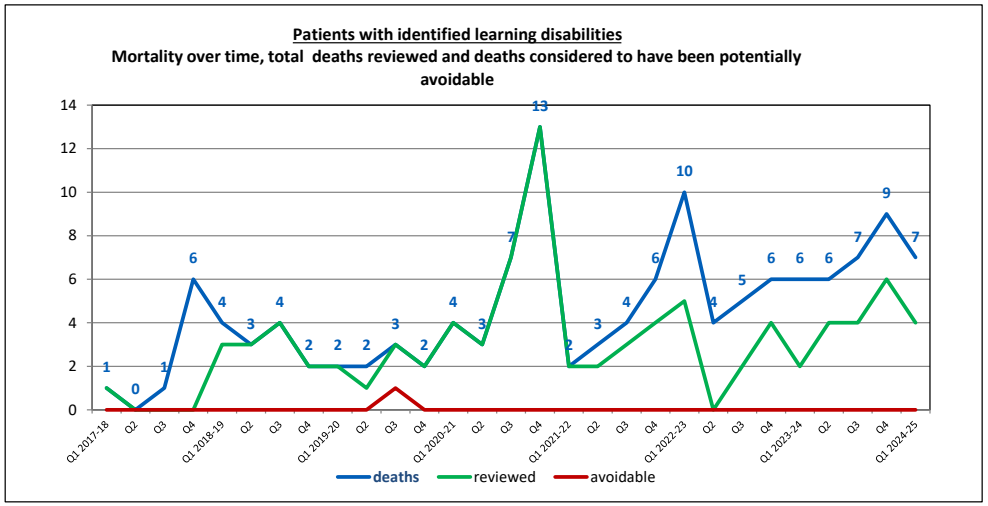
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 23/12/2024)

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	2024-25	Q1

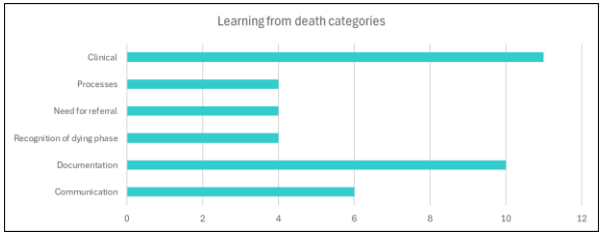
Total number of deaths recorded in the mortality database - Learning Disability		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	4	0	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
7	9	4	6	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
7	28	4	16	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.

Summary of Learning from Deaths and Action Points - Q1 24/25

Category	Learning	Actions
Communication	There were six cases where communication was mentioned in the learning. Communication to patients and family regarding prognosis and expectations, and also between staff members. The three cases discussed at the Mortality Review Audit Group (MRAG) were considered to be definitely not avoidable. There was an action point arising from a Mortality & Morbidity meeting (M&M) where a communication session was arranged for junior doctors.	Action 1: Communication training session to be organised with Junior Doctors
Documentation	There were ten cases found where the documentation could have been better. The MRAG learning was that the completion of a MUST score should be documented and the importance of documenting important health decisions was also noted. M&M learning mentioned the correct completion of RESPECT forms and ensuring death certificates were discussed and accurately recorded. Additionally, the importance of documenting observations, treatments and prescriptions. The two cases discussed at MRAG were found to be definitely not avoidable.	Action 1: Discuss with the Bereavement Team and liaise with the Haematology consultant before completing the death certificate. Action 2: To discuss the case with team caring for the patient in the previous admission. Action 3: Feedback regarding gap in observations to ward.
Recognition of dying phase	There were four cases in this category, one of which was discussed at MRAG. In one case it was found there was inadequate recognition of dying and in another it was to involve the palliative care team earlier. There was also an observation that increasingly patients may be in the wrong setting and perhaps it would have been better if they had stayed in their nursing home. The patient discussed at MRAG was found to be definitely not avoidable.	
Need for referral	There were four cases coming out of M&M meetings. Observations included referrals that should have been made to specialist clinics and also a reminder of involving the Learning Disability Team for this particular group of patients.	Action 1: Refer patients with Learning Disabilities to adult social care team for this specific group of patients. Action 2: Discussion with Radiology to have alert on report of CT where new ILD is found
Processes	There was one case discussed at MRAG. The patient was lost in the system to follow up appointments. This case was found to be probably avoidable: more than 50/50. Three cases discussed at M&M, covering the importance of chest x-rays for a specific cohort, timeliness of diagnosis and guidelines for cath lab arrests.	Action: To create local guidelines/education for ITU colleagues and Med Regs with regard to being called to Cath lab arrests. Aiming to look at the roles of the attending team colleagues during arrest calls.
Clinical	In the clinical category, learning was gathered from eleven cases discussed at M&M meetings. Each noted observations on specific conditions, awareness was raised, and revision of guidelines and protocols for given scenarios was discussed.	Action: Teaching session will be arranged with case discussion for junior doctors for early recognition of bowel ischaemia.



Agenda Item: 12

Report To/Meeting	Trust Board	**Date of Meeting**	25 February 2025
Report Title:	Update on the New Hospital Programme following the Government's review and conclusions		
Key question	What does the Trust need to consider given the announcement the ESHT should not expect to benefit from investment via the New Hospital Programme until 2037-2039?		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☒		
Report Sponsor:	Steve Aumayer – CEO	**Presenter(s):**	Steve Aumayer
Outcome/Action requested:	To note the risks this decision creates and support the steps being taken by the Executive team in response		
Executive Summary	The Government's review of the New Hospital Programme ("NHP") increases the indicative envelope for ESHT to £1.5-2bn, but pushes the expected investment back to 2037-2039 (the end of the programme). This creates significant risk and we must rethink our future plans: a) how will we sustain services and meet growing demand for much longer than expected within an out-of-date and constrained estate; and b) how will we mitigate critical infrastructure risk and manage backlog maintenance long-term without the prospect of a significant, medium term capital investment opportunity. We have raised these issues with the Integrated Care Board ("ICB") and NHS England and we must now rapidly review the impact on the Trusts priorities and plans.		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	Not been reviewed in detail as yet. However, this could leave East Sussex with an increasing quality and access gap driven by failing estate relative to surrounding areas.		
Resource Implication/VFM Statement:	Beyond the infrastructure risk impact and cost of mitigation, this has a negative impact on Trust strategy and change capacity and capability.		
Risk:	This changes the risks and mitigations associated with critical infrastructure and estates backlog. It also adds a risk about transformation capacity and impetus which the presence of the NHP supported. All relevant registers will be updated to reflect the risk.		
No of Pages	4	**Appendixes**	1
Governance and Engagement pathway to date:	Not this report specifically, but the issues have been discussed at the New Hospital Programme Board and Executive Leadership Team meeting		
What happens next?	Next steps outlined in the paper. Follow up at Trust Board.		
Publication	Published		

Update on the New Hospital Programme ("NHP") following the Government's review and conclusions

Context

This is a short, summary-only paper to update the board following the conclusion of the government's review into the New Hospital Programme ("NHP") and announced findings in January 2025.

The outcome of that review moves ESHT's prospective investment from the programme to 2037-2039 (a delay) and indicates a financial envelope of £1.5 - 2.0bn (an increased envelope).

We were part of the programme because we have, across our estate, one of the most significant backlog maintenance and critical infrastructure risks of any acute provider in the NHS, by value. We saw the NHP both providing a means of mitigating that risk within the foreseeable future, whilst upgrading digital infrastructure, AND as a primary enabler for transforming and modernising services and facilities; ultimately a major opportunity to improve care for the people of East Sussex and the day to day experience of our staff.

We have been working hard and have fully, positively engaged with the programme since the beginning in 2019/20. We have met all their requirements, progressive assurance steps and milestones; we have supported the development of the Demand and Capacity modelling and have been held up as an exemplar in some key aspects of our work. We have also been clear that our preferred options did not require any public consultation processes and so we could move to a development phase more quickly.

The original expectation was that substantial capital investment would become accessible from c.2025. This was pushed back, under the previous government, after multiple programme changes to an uncertain "post-2030" indicative timeframe, albeit with an invitation to bid for 'enabling works' ahead of the main building phase. We had several enabling business cases prepared and our refreshed "Strategic Outline Case" was on track to be submitted, as requested by the programme, in June 2025.

The review by the new government offers more certainty and a significantly larger capital envelope to work with, but a 2037-2039 anticipated date for major investment is much further away that we had hoped. We are told there is no prospect of challenging the decision.

Impact

This delay creates substantial challenges for the Trust, hampers our ability to improve care for the people we serve in East Sussex in the long term and in turn has implications for the sustainability of the wider Sussex health and care system.

Significant issues and risks for ESHT:

- We lose our primary, long-term mitigation for backlog maintenance (c.£410m) and critical infrastructure risk (£160m incl. fees/contingency etc) – both of which are growing risks.
- Some critical risks we may have deferred solving in anticipation of NHP funding, will now potentially consume most of any annual local capital allocation – e.g. electrical sub-station at Eastbourne District General Hospital is over 45 years old vs. a life-span of 15 years; that alone would be over £15m to replace
- We lose the potential for NHP funded enabling works to mitigate risk
- NHP funding would have allowed us to reprioritise our normal capital allocation to address unsustainable operating and clinical footprints not covered by the NHP envelope
- We risk losing the momentum and a key driver behind clinical engagement on our target operating model and transformation
- NHP funded Trust resources, both our own and external advisory resource, offered a 'double benefit' – i.e. the work that supported the Strategic Outline Case ("SOC"), enabling business case, Target Operating Model ("TOM") development, clinical environment redesign for the NHP are just

as relevant for the Trust anyway. Closure of the NHP creates a deficit in resources for strategy, transformation and major business cases.
- We risk disengagement and disappointment for multiple colleagues who were engaged with the NHP as well as the team who have dedicated so many years to the programme. More broadly morale across the Trust is likely to be negatively affected as we face one of the most financially challenging periods in the Trust's history.
- This puts a highly skilled and experienced core NHP team at risk, who currently provide benefit beyond the scope of the programme and as individuals represent some capabilities and knowledge that we do not hold elsewhere.

Actions and Next Steps

We must now review short and medium-term critical infrastructure priorities, medium-term (5 year) transformation and strategic priorities and how we retain and fund the capacity and capability to deliver them.

Immediate actions taken:

- High level communications response have been prepared, all-staff briefing has taken place
- Written to the Integrated Care Board ("ICB") CEO expressing the risks
- Met with NHP leaders at the most senior level and again at local level:
    - Expressed disappointment, outlined the risks this creates, and made a clear point about the impact on our team dedicated to this task for the last 5 years
    - Outlined the backlog and Critical Infrastructure Risk ("CIR") this decision leaves the Trust with – making it clear that is an NHS England risk as much as a Trust risk now
    - Made it clear that a sudden programme closure is unreasonable and asked how much transition time they will support.

We have also asked NHP and NHSE some key practical questions (as have all the affected Trusts, we believe):

- Funding to manage programme closure processes, commitments to external advisers, HR consultation processes that will not be not covered by the Memorandum of Understanding ("MoU") with the Secretary of State that covered funding and output expectations for 2024/25.
- Treatment of the capital costs incurred to date (£16.9m) and how we ensure they do not adversely impacting our Trust deficit because of a programme decision
- Redundancy exposure – how will they mitigate either with funding or with redeployment prospects for our team
- Confirmation, in writing, that the outputs our funding MOU required are no longer expected – such as the SOC
- Confirmation that we can retain access to key tools and content developed by the NHP – like the demand and capacity model

We await responses on the above points.

Further work is ongoing to understand more fully the impact of the NHP review and the delay in our timetable. We now need to:

- Confirm future plans and consult with colleagues in our NHP team with respect to their roles as soon as we reasonably can
- Review CIR and understand what to prioritise. Work with the ICB and NHSE region on how to mitigate the risks
- Review our transformation plan and overall master plan in light of the above
- Prepare business cases we know will be required for critical works
- Work out how to retain the energy and imperative around transformation

- Understand how to retain, replace or manage without the highly skilled resources that were driving the NHP programme
- Review corporate and Trust risk registers

We have been asked by NHS England Estates lead to share what developmental works are required to keep us safe and operational and to submit a summary of these so that consideration can be given to funding them separately. That summary will range from critical infrastructure to fit for purpose clinical footprints like emergency floors.

Once we have worked through that we will come back to Trust Board with the implications, risks and proposed mitigations.

Appendix

We have appended a timeline of headline outputs and milestones over the last 5 years for information and, in a small way, to recognise the enormous amount of work, skill and contribution made by our colleagues in the NHP team.

Agenda Item: 12

APPENDIX – Summary Timeline of work on the NHP – known at ESHT as the "Building For our Future" programme

BFF programme roadmap

Building Our Future

Sep-19: ESHT in HIP2
ESHT announced as part of Government's Health Infrastructure Plan (HIP2)

Sep-20: Public engagement
Engagement of public to inform programme spending objectives and quality impact assessment for the SOC

Mar-21: SOC Submission
Original Strategic Outline Case (SOC) submitted to NHS England identifying three preferred way forward options depending on financial allocation

May-23: Secretary of State announcement
Trust scheme placed in post 2030 delivery cohort

Aug-23: NHP Target Cost Model Review:
Trust scheme refined to prioritise new builds over refurbishment and incorporate H2.0 parameters

Mar 2023: Improvements to staff facilities
Improvements implemented at EDGH and Conquest staff restaurants, corridor areas and HSDU staff area

Oct-23: Enabling works proposals
Proposals started up for Conquest site and feasibility studies undertaken for new build options at EDGH to test deliverability of H2.0 requirements and update cost estimates

2020 2021 2022 2023

Jun-20: Case for Change
Workshops held with key stakeholders to agree spending objectives, existing arrangements, business needs and programme scope

Jan-21: D&C Modelling
Healthcare planning to confirm demand and capacity, confirm functional content and schedules of accommodation

Jun-21: Workscape survey
Survey of Trust staff completed to identify improvements to staff facilities

Oct-22: Elective Hub OBC
OBC for standalone elective hub facility at EDGH submitted to NHS England

Apr-21 to Jan-23: Models of Care
Engagement with clinical and operational teams to develop and refine clinical models for unscheduled care, elective care, maternity and paediatrics, integrated care, corporate support services and core services.

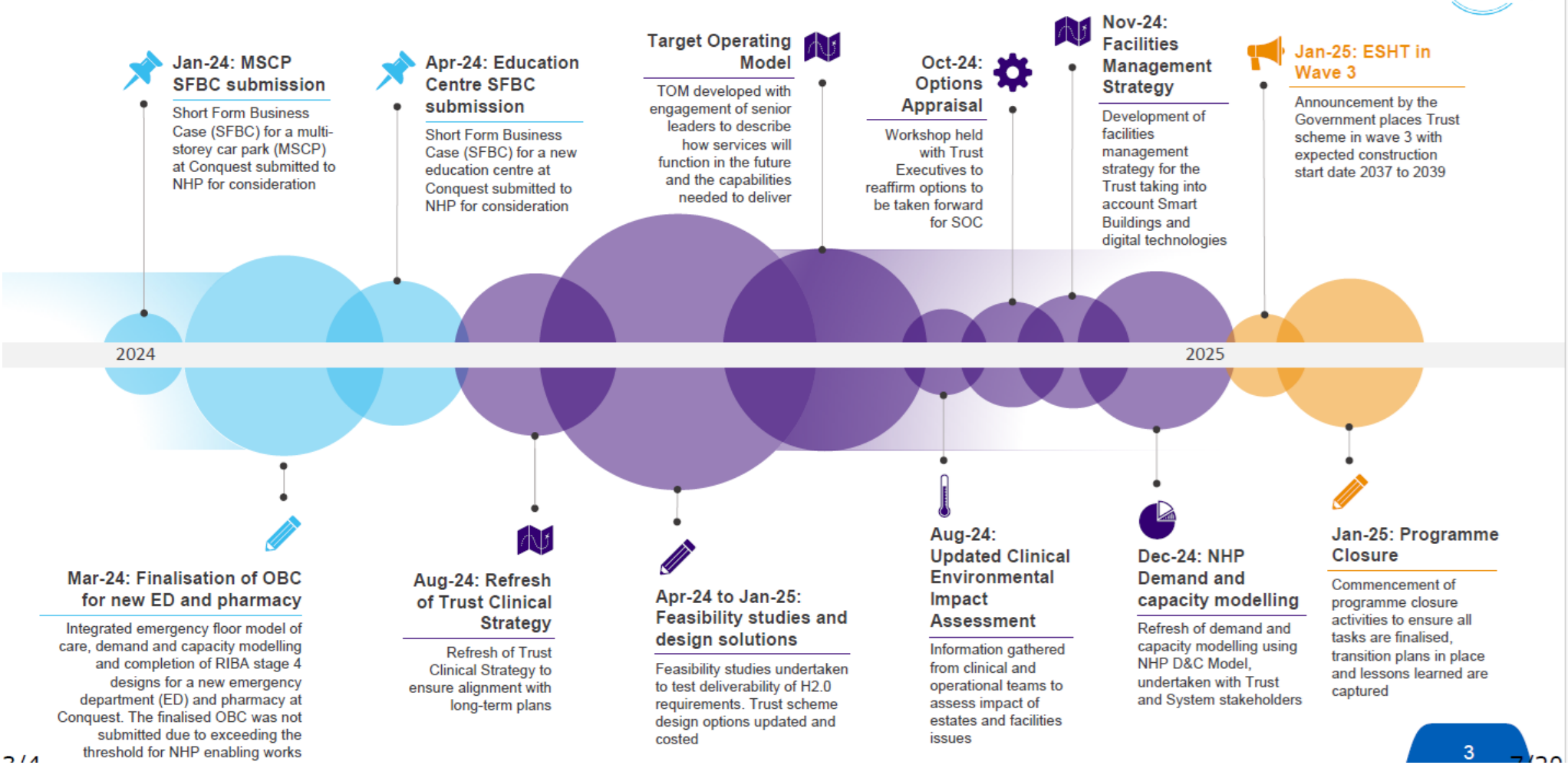
Nov-22: NHP Clinical Environmental Impact Assessment
Information gathered from clinical and operational teams to assess impact of estates and facilities issues

Jun-23: Elective Hub FBC
FBC for standalone elective hub facility at EDGH submitted to NHS England

Nov-23: Case for change
Workshops held with Trust Executives to reaffirm the strategic context for the Trust's scheme and refresh the spending objectives and scope

2

BFF programme roadmap



Agenda Item: 14

Report To/Meeting	Trust Board	**Date of Meeting**	25th February 2025
Report Title:	Fire Enforcement Notice Update		
Key question	What progress has the Trust made in meeting the requirements of the Enforcement Notice issued by East Sussex Fire and Rescue Service?		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☐ For Discussion ☐		
Report Sponsor:	Steve Aumayer Acting Chief Executive	**Presenter(s):**	Chris Hodgson Director of Estates and Facilities
Outcome/Action requested:	This report provides information on the outcome of the recent East Sussex Fire and Rescue (ESF&RS) Fire Officer visit following the Enforcement Notice served on the Trust in April 2024 and progress of the work completed to comply with the notice.		
Executive Summary	To update the Board on the Enforcement Notice arising from the ESF&RS visit on 3rd April 2024 and subsequent visits, to review progress against the Enforcement Notice. The level of co-operation between all teams involved has been extremely high and is a major factor in the progress achieved so far. The lack of decant space in the Trust is a significant problem as full and free availability of decant space at both sites is crucial to maintaining progress. The Fire Officer was satisfied with progress to date and as a result, an agreement to extend the Enforcement Notice for three years until March 2028 has been reached. This period must not be exceeded as a further extension is extremely unlikely. Regular update visits and "advice & guidance" sessions have been agreed with the Fire Officer to ensure progress is maintained and to keep him appraised of progress.		
Regulatory/legal requirement:	Compliance with The Regulatory Reform (Fire Safety) Order 2005		
Business Plan Link:	Quality ☒ People ☐ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Current resource levels are sufficient to meet the planned timelines of the required works. Planned spend is c£3.5m per annum for three years. It is assumed that this will be funded via our current capital backlog plan. Given the extended timeline for the NHP programme this raises significant issues and puts considerable pressure on our ability to resolve the current critical infrastructure risks within our Estate.		

Risk:	1. Work is delayed or not completed due to the lack of decant space at Conquest and EDGH. 2. Safety of patients' visitors and staff in the event of a significant fire event. 3. Further, non-compliance may result in progressive punitive measures taken by the Fire Service, up to and including prosecution. 4. Risk to reputation of ESHT These risks will be managed on a dynamic basis.

No of Pages	4	**Appendixes**	None

Governance and Engagement pathway to date:	Regular progress updates are provided to Executive Directors and, as and when requested, to Committees.
What happens next?	Progress monitored against the remedial works plan at the Fire Remedials Oversight Group and Executive Directors as required.
Publication	Present and publish report at public session of Trust Board

1.0 Context – Background

An Enforcement Notice was issued on 8th April 2024 by East Sussex Fire and Rescue Service (ESF&RS) following a visit to the Conquest site. The Notice applies Trustwide and covers the following:

1. Review of fire risk assessments to consider the compartmentation survey outcomes (Art 9)
2. Implement a procedure to monitor and maintain fire doors (Art 17)
3. Identify adequate numbers of staff to carry out the emergency procedures at all times (Art 15)
4. Train adequate numbers of staff in the roles required to effectively implement the emergency procedures. This includes fire wardens, duty managers and the fire response team (Art 21)
5. Ensure the compartment lines are agreed and understood and that the dampers complement the compartmentation and facilitate the PHE procedure. This includes the need to review what dampers are in place and to upgrade those on compartment lines to fire and smoke (Art 8).

Five matters covered in the Enforcement Notice were raised and all were required to be resolved by 7th January 2025 (within nine months). ESF&RS initially asked that the work was completed within six months, but the Trust asked for an extension to nine months based upon the amount of fire compartmentation and fire/smoke dampers that were required, all of which are intrusive works in occupied wards/departments. The revised deadline was always challenging.

No other significant issues were identified during visits to other sites within our estate in April 2024. A number of minor items were identified and resulting actions have been completed to resolve these. They mainly relate to storage of items and signage improvements.

2.0 Fire Officer Follow up Visit (January 2025)

ESF&RS visited for a progress review on 14th January 2025. A folder containing details of completed work to date, programmes for completion and drawings was handed over by the Trust Projects team and detailed discussions followed covering the work completed to date and the challenges identified. A realistic timeframe of completion for all works by 31st March 2028 was agreed with ESF&RS, with regular reviews of progress to take place.

The outcome of the visit was an unofficial caution for the Trust as we had not met the original completion date; this is the minimum level of sanction available to ESF&RS. It is understood that this caution will have no impact unless we fail to comply with the revised deadline for completing the work.

ESF&RS commended us for the progress made to date and acknowledged that we have taken timely actions on the enforcement notice. Furthermore they acknowledged that we had fully complied with section 1, item 1, and that our fire risk assessments now fully reflect the surveys and that these are up to date.

3.0 Programme

As noted within section 2.0 of this report, we provided a high-level summary of the planned remedial works programme for the completion of the works necessary to comply with the Enforcement Notice. This remedial works programme is predicated on full and free access to a full decant ward on both acute sites. The level of co-operation between all teams involved has been extremely high and is a major factor in progress achieved so far.

Current resource levels are sufficient to meet the planned timelines of the required works. Planned spend is estimated to be in the region of c£3.5m per annum for each of the next three years.

Progress is monitored against the remedial works plan at the Fire Remedials Oversight Group and shared with Executive Directors and Board Committees as required.

Notwithstanding the comments above on collaboration between teams, due to the high clinical activity levels across all sites access for works continues to be an issue on all sites and needs to be resolved as progress has slowed as a result of these high levels of clinical activity.

4.0 Issues and Consequences for not taking action

It is assumed that this improvement work will be funded via our current capital backlog plan. Given the extended timeline for the NHP programme to 2037 and beyond, this raises significant cost and risk issues and puts considerable pressure on our ability to resolve the current critical infrastructure risks within our Estate.

Progress has only been maintained during the winter pressure period, where decant space has been unavailable, by addressing issues in other areas. The permanent availability of decant space is crucial to achieving compliance and supporting the planned programme of works. Therefore, we require the creation of a full decant ward at both acute sites and this must be maintained for the majority of time within each of the calendar years to keep pace with the remedial program of work.

Without this we will not meet the agreed timelines and will be in breach of the agreed extension with ESF&RS, which could render the Trust liable to further and more severe sanctions, up to and including prosecution.

4.0 Conclusion

Good progress has been made since the initial visit which was held in April 2024 and a full implementation plan has been worked up and shared with the appropriate teams.

Progress will only continue to be made with a decant ward being made available on the Conquest and Eastbourne sites.

Financial resource for the fire remedial works is being met in the first instance, via capital resource within the Trust capital plan.

We will continue to allocate capital resource of c£3.5m for each of the next three years, noting that this places a burden on other pressing and current critical infrastructure risks within our Estate. We will seek external funding opportunities where possible to ease the burden on the capital resources, so we can look to address the other pressing current critical infrastructure risks within our Estate.

5.0 Recommendations

The Trust board is asked to note the revised deadline for complying with the Fire Enforcement Notice, and the good progress that has been made to date.

Agenda Item: 15

Report To/Meeting	Trust Board	**Meeting date**	25th February 2025
Report Title:	Q3 Board Assurance Framework Update		
Key question	To ensure that the Board Assurance Framework (BAF) risks are coherent, and that the Trust is managing the controls of the risks in a dynamic way, with a forward view to YE and alternative mitigations if the risk trajectories are not moving in the anticipated direction.		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☐ For Discussion ☒		
Report Sponsor:	Richard Milner, Chief of Staff	**Presenter(s):**	Richard Milner, Chief of Staff
Purpose/Outcome/Action requested:	The Board is asked to consider, discuss and note the report.		
Executive Summary	This report provides outlines the BAF risks for Q3. It provides an update on progress since Q2, highlighting areas of success, future opportunities, current challenges, and potential future risks, along with the actions being taken to manage them.		
Regulatory/legal requirement:	a) The Code of Governance requires the board of directors to establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the trust is willing to take to achieve its long-term strategic objectives. b) The Board 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:	Failure to monitor risks may result in the Trust failing to achieve its annual objectives or risk stalling progress on strategic aims		
No of Pages	8	**Appendixes**	1 - BAF

Governance and Engagement pathway to date:	The report has been presented to each relevant Committee with responsibility for overseeing each strategic risk and mitigations have been reviewed by each of the relevant executive directors
What happens next?	The BAF will be updated for Q4.
Publication	Yes

Introduction/Background

The report provides an update on the BAF. We note that, in the preparation of this report for Q3, there was significant discussion about the focus of this report and how we ensure that it reflects the corporate thinking around a number of points:

- That the risks remain aligned with annual objectives and the business-critical aspects of our work
- That the assessment of the risk includes a forward-looking aspect, and the BAF avoids being solely a retrospective risk management tool
- That, beyond this report, we are able to show in a consistent way how risk management informs our decision-making at executive level

All of these elements will inform our plans for the 2025/6 BAF and we have also engaged with our internal auditors to consider how our current approach fits with sector good practice and whether there are therefore improvement actions that we need to consider in terms of presentation, content and frequency/location of reporting of Board-level risks.

As colleagues would expect, we have already begun to prepare for the 2025/6 BAF and will be exploring this in our Board Development session in March 2025.

Board Assurance Framework (BAF) at Q3

The BAF is a Board-level log of Strategic Risks. These comprise risks that are of strategic nature and which if not mitigated effectively will directly impact the Trust's ambitions of achieving its objectives and thus strategy. There are currently 12 risks on the BAF.

Strategic risks are unlikely to shift their scores on a monthly basis and so we currently provide updates quarterly to the Trust Board. The strategic risks linked to the BAF are reviewed monthly and presented to the Executive Committee (ExCom) at its meetings. The BAF risks have recently been reviewed and updated by their respective risk owners for this quarter and have been evaluated through the relevant assurance committees.

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	12		▲	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	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	16		◄►	Cautious/ Open	16
4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery	F&P			X	20	20	20	20		◄►	Cautious	20
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	20		▲	Cautious	20
6	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack	Audit	X	X	X	16	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	16		◄►	Open	12
8	Failure to transform digitally and deliver associated improvements to patient care	F&P			X	16	12	12	12		◄►	Significant	8
9	Failure to maintain focus on improvement	ExCom		X		16	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	16		◄►	Open/Seek	16
11	Failure to demonstrate fair and equal access to our services	Ineq	X			16	12	12	12		◄►	Cautious/ Open	8
12	Failure to meet the four-hour standard	Q&S	X	X	X	20	16	16	16		◄►	Cautious	12

In Q3, 10 of the strategic risks have remained at the same score as in Q2. The risk rating for BAF 1 (concerning capacity constraints associated with supporting the collaborative infrastructure) increased from 8 to 12, while the risk rating for BAF 5 (concerning the Trust's aging estate and capital allowance limiting the way in which services and equipment can be provided in a safe manner for patients and staff) increased from 16 to 20.

We have summarised below our view on the Q2 to Q3 moves for each of our BAF risks.

BAF 1
The risk rating for BAF 1 has increased from 8 in Q2 to 12 in Q3, due to the likelihood score having increased from 2 to 3. This recognises that the increased pressure on the organisation as a result of the immediate need to address financial recovery, which increases demand on the organisation and senior leaders as they engage with the NHS Sussex collaborative infrastructure. This is likely to continue over Q4 to YE.

BAF 2
The risk rating for BAF 2 has remained at 12 in Q3. The Trust has an overall low vacancy rate, with lots of applicants to historic hard to fill posts but the risk rating reflects that there are still key pockets of higher vacancy rates in the organisation.

BAF 3
The risk rating for BAF 3 has remained at 16 in Q3. This sustained position reflects the risks associated with ongoing financial pressures, increased activity and a reduction in our 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 Q3. There is a continued high level of risk associated with the delivery of the Trust's financial plan for 2024/25. As per the Trust's reporting to F&P committee, ongoing mitigations are in place to support the delivery of our YE position, but we do not anticipate this changing significantly over Q4, given existing operational challenges.

BAF 5
The risk rating for BAF 5 has increased to 20 for Q3. The risk rating has increased reflecting the scale of the capital backlog and, given the extended timeframes of the New Hospital Programme there is a need to manage the risk of maintaining an aging estate. Although we are managing our capital to budget, we are not sufficiently able to address the scale of backlog issues. The anticipated year end risk has also been increased from 16 to 20.

BAF 6
The risk rating for BAF 6 remained at 20 in Q3. While significant work has been undertaken to increase the robustness of the Trust's cybersecurity posture, and Trust's current security risk status has reduced, the overall cyber threat level to the NHS has increased. Improvements have been released in the number of end-of-life systems in the Trust as well as improved patching across servers and client devices. We do not expect a change in Q4.

BAF 7
The risk rating for BAF 7 has remained at 16 in Q3. Significant progress has been made in agreeing restructuring of the Business Intelligence (BI) team and with the development of a BI strategy. A couple of rounds of recruitment have been held which has not led to any increase in WTEs in the team and other recruitment avenues are now being explored.

BAF 8
The risk rating for BAF 8 has remained at 12 in Q3. Digital awareness continues to improve in the Trust 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 hoped that the implementation of EPR, LIMS and OCS Order Comms will lead to a reduction in the risk rating.

BAF 9

The risk rating for BAF 9 has remained at 16 for Q3. The trust is resource constrained and has had to prioritise rapid recovery action over the development of a CQI culture.

BAF 10

The risk rating for BAF 10 has remained at 16 in Q3. This reflects the continued impact of more than 200 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. In addition, due to huge operational pressures experienced in December and January ongoing pressures on the hospital it has been necessary to pre-emptively place additional patients on wards until bed space is available.

BAF 11

The risk rating for BAF 11 has remained at 12 for Q3 as progress remains on track. The Health Inequalities Steering Group is now an established group, monitoring performance and service delivery in key areas. The YE aim is a risk rating of 8, and we recognise that this will broadly be dependent on prioritising support for the teams and delivery of HI strategy priorities at YE. With the ongoing focus on operational performance standards and financial management, we recognise that the focus required to achieve risk rating of 8 will be a challenge to achieve against these other pressing priorities for teams.

BAF 12

The risk rating for BAF 12 has also remained at 16 for Q3. 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 demand on services is decreasing along with the need to close additional beds.

The full BAF is set in Appendix 1.

Board Assurance Framework (BAF)

East Sussex Healthcare NHS Trust

Quarter 3 Update 2024/25 Overview

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 aiding the identification of areas of weakness.

Each principal risk is owned by an Executive Director. 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) 2024/25				Change	Risk Appetite	Anticipated Risk
							Q1	Q2	Q3	Q4			
1	Capacity constraints associated with supporting the collaborative infrastructure	ExCom	X			9	6	8	12		▲	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	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	16		◄►	Cautious/ Open	16
4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery	F&P			X	20	20	20	20		◄►	Cautious	20
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	20		▲	Cautious	20
6	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack	Audit	X	X	X	16	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	16		◄►	Open	12
8	Failure to transform digitally and deliver associated improvements to patient care	F&P			X	16	12	12	12		◄►	Significant	8
9	Failure to maintain focus on improvement	ExCom		X		16	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	16		◄►	Open/Seek	16
11	Failure to demonstrate fair and equal access to our services	Ineq	X			16	12	12	12		◄►	Cautious/ Open	8
12	Failure to meet the four-hour standard	Q&S	X	X	X	20	16	16	16		◄►	Cautious	12

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:	24/09/2024	

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	3		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 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. The combination of the collaboratives, Committee in Common, system planning and major service review and our own immediate need to address financial recovery has increased the likelihood from 3 to 4.	Likelihood:	2
	Consequence:	3	4	4			Consequence:	3
	Risk Level:	6	8	12			Risk Level:	6

Cause of risk:	• New/evolving governance forums and programmes of work 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 • Ability to engage in system programmes is compromised
Current methods of management (controls)	A. Escalation process to ICB when required B. Controlled 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	Green

Progress		
What is going well/future opportunities	What are the current challenges including future risks?	How are these challenges being managed?
• We remain closely engaged through Director of TSI, CMO and CEO attendance at relevant collaborative meetings • The collaborative is clarifying, the Committee in Common also	• More demand on these structures to resolve system challenges, including financial challenges and as yet no clear redistribution of resources from providers or from the ICB to support that. • It is still not clear what the priorities and focus will be	• Trust is well engaged with the process and flagging concerns and risks at all the relevant system meetings.

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:	Acting Chief People Officer	Lead Committee:	People and Organisational Development Committee	Date of last Committee review:	30/01/2025	

	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	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. The vacancy rate has reduced further to 2.4% (November 2024). However there are still key pockets of higher vacancy levels which drives the risk level.	Likelihood:	4
	Consequence:	3	3	3			Consequence:	3
	Risk Level:	15	12	12			Risk Level:	12

Cause of risk:	• 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 • Age profile of workforce particularly for registered nurses, clinical groups and additional clinical services.	Impact:	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

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 develop apprenticeship programmes 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			
	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 3 Progress Report**	**BRAG**
1.	Continue with recruitment initiatives and international sourcing of medical candidates, including Radiographers, Sonographers.	Acting 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	Green
2.	Local outreach initiatives	Acting 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	Green
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	Acting 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.	Green

Progress		
What is going well/future opportunities	What are the current challenges including future risks?	How are these challenges being managed?
• Recruitment, with a low vacancy rate • Lots of direct applicants for historic hard to fill posts • Focus on managed recruitment for key consultant positions • Apprenticeships, with apprenticeship levy utilised	• National guidance for reduction in workforce • Aligning retirement attrition and recruitment	• Through the Use of Resources and working with divisional teams on workforce reduction plans. • Developing attrition reports to enhance our workforce metrics

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	07/02/2013	74	Delays in reporting for Radiological Investigations- - on F&P CRR	15	16	◀▶
	03/12/2018	16	Emergency Department nursing vacancies - on Q&S CRR	12	16	◀▶
	01/07/2020	79	Unchaperoned ultrasound examinations	16	16	◀▶
	12/08/2021	7	Inadequate staffing levels to provide consistent Lipid Clinic service	20	15	◀▶
	28/06/2022	10	Delays in out of hours patient assessment times on Q&S CRR	20	16	◀▶
	29/07/2022	110	Vacancy rate of Occupational Therapists	20	12	▲
	01/06/2023	73	Radiology Physics Service Staffing - on F&P CRR	20	15	◀▶
	18/08/2023	97	Delays to Paediatric Dietetic Appointments on Q&S CRR	20	20	◀▶
	25/09/2023	72	Histopathology consultant vacancies a *chronic issue*	20	16	◀▶
	08/07/2024	264	Insourcing contracts on Audit Committee CRR	25	15	◀▶

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:	Acting Chief People Officer	Lead Committee:	People and Organisational Development Committee	Date of last Committee review:	30/01/2025

	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	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 our engagement with staff surveys has remained static. 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	4			Consequence:	4
	Risk Level:	16	16	16			Risk Level:	16

Cause of risk:	Ongoing operational instability and pressures, alongside workforce availability and financial constraints.	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; planned pilots completed and amendments to self-rostering made 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 W. Reasonable adjustments for staff

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 3 Progress Report	BRAG
1.	People Strategy	Acting 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 on a quarterly basis	Green
Progress					

What is going well/future opportunities	What are the current challenges including future risks?	How are these challenges being managed?
• Engagement team offering a wide expanse of support mechanisms for all teams • Commenced online offering of line management and leadership training • Developed a leadership strategy • Introduction of sexual safety charter for workforce	• Workforce engagement during a time of high operational activity and financial constraints • No reduction in violence and aggression incidents	• Engaging within divisions to support personal and team development • Progressing with the violence and aggression reduction • Engagement with staff following staff survey results and development of bespoke divisional plans in response to the staff survey.

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	12	◀▶
	14/12/2017	18	Violence and Aggression in Emergency Departments	9	15	◀▶
	03/12/2018	16	Emergency Department nursing vacancies on Q&S CRR	12	16	◀▶
	11/11/2022	159	Violence and Aggression to colleagues working in Intermediate Care	12	16	◀▶
	01/06/2023	73	Radiology Physics Service Staffing on F&P CRR	20	15	◀▶

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 an updated forecast for 24/25 of a £14m deficit. This is in addition to the original position of £11.7m, which has since been funded. This deficit included a CIP delivery of £36.7m; however there have been additional cost pressures incurred during 2024/25.**				
Lead Director:	**Chief Financial Officer**	**Lead Committee:**	**Finance and Productivity Committee**	**Date of last Committee review:**	**30/01/2025**

	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**	**5**		**Likelihood**: At M8 the Trust deficit was £10.5m, a negative variance of £8.9m. This deficit was after receipt of funding for the original £11.7m deficit. The £36.7m CIP is being overdelivered but does not cover additional unplanned cost pressures. **Consequences**: There is risk to not delivering the budget and consequent reputational impact.	**Likelihood:**	**5**
	Consequence:	**4**	**4**	**4**			**Consequence:**	**4**
20	**Risk Level:**	**20**	**20**	**20**			**Risk Level:**	**20**

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 • While strike actions have been resolved, national funding covered direct pay consequences but there was also an impact on delivery of elective recovery • Inflation pressures resulting from recent contract awards • A&E pressure from additional attendances	**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 • The Trust is currently engaged through the ICB to region in formally reviewing its forecast outturn

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 Acting CEO or Acting Chief People Officer 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 Recovery Director has been appointed by the Trust

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 3 Progress Report**	**BRAG**
1.	Finalise CIP plan for year with an emphasis on controlling costs as well as delivering increased activity	Chief Financial Officer	Complete	• The Trust is likely to overdeliver on CIP; however this will be partly on a nonrecurrent basis. • We are overdelivering on income • ERF activity is above plan year to date • Total pay is in adverse variance of £6.5m year to date • Industrial action has been resolved for the year and direct costs have been funded. However, the Trust could have driven additional activity to help cover additional inflationary pressure which has not been covered by the direct funding • A revised forecast has been agreed with the ICS and region	Green
2.	Use of Resources meetings are now supported by the Financial Recovery Director	Chief Executive	Ongoing	• Use of resources plan is being delivered • In addition, enhanced controls have been implemented to help to manage cost pressures	Green

3.	Work is beginning on identifying recurrent solutions as it will be challenging to deliver a break even position in 2025/26.	Chief Financial Officer	March 2025	• The final budget is due for submission by the end of March 2025.	**Red**

Progress		
What is going well/future opportunities	What are the current challenges including future risks?	How are these challenges being managed?
• Focus on run rate controls	• Scale of requirement to deliver against plan in 2024/25 and additional pressure to get to breakeven by the end of 2025/26	• Through the identification of transformational improvements

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:	30/01/2025

	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	5		The risk rating has increased reflecting the scale of the capital backlog and, given the extended timeframes of the New Hospital Programme there is a need to manage the risk of maintaining an aging estate. Although we are managing our capital to budget, we are not sufficiently able to address the scale of backlog issues. The Trust's capital budget for 2024/25 is £71m, which includes ICS CRL of £40.2m and national programmes including £10m digestive diseases; £9.3m Sussex Surgical Centre; £6.5m for digitalisation; digital image sharing of £1.5m and £1.9m New Hospital Programme. The majority of the balance remaining is digital related. 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. A bid for capital funding for medical equipment has been submitted to the ICS to help address 25/26 and 26/27. A report has been presented to ELT and ExCom to highlight the challenges in the next five years. We continue to work with Friends to support addressing the equipment gap.	Likelihood:	5
	Consequence:	4	4	4			Consequence:	4
	Risk Level:	16	16	20			Risk Level:	20

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 • Capital Resource Group (CRG) in place • Prioritisation decisions about capital expenditure are made by CRG and F&P	• Significant capital business cases reviewed by ICS and region • 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 3 Progress Report	BRAG
1.	ICS will undertake a medium term financial plan, which addresses a plan to break even and capital allocation.	Chief Finance Officer	Ongoing	• Expenditure monitored • Progress reported regularly to Finance and Productivity Committee	Amber
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	Ongoing	• Priorities to be developed into the New Hospital Programme Case, Building for our Future (BFF) Business Case • There are likely to be opportunities for staged investment through the NHP programme to offset the longer timeframe that is anticipated for the rebuild.	Amber

Progress		
What is going well/future opportunities	What are the current challenges including future risks?	How are these challenges being managed?
• A bid for capital funding for medical equipment has been submitted to the ICS to help address 25/26 and 26/27. A report had been presented to ELT and ExCom to highlight the challenges in the next 5 years. • The E&F team are working on a 5 year critical estate infrastructure backlog • We are working with the fire service and we have demonstrated progress in backlog fire issues. We are currently working on a three year plan to fully address the backlog issues.	• The funding required for the backlog exceeds the capital envelope available (ICS/ESHT capital) • We carry the risk of unplanned infrastructural failures occurring more frequently and it is challenging to rectify those critical failures.	• We are prioritising both medical and estate backlog which is included in the 5 year plan • Bidding for external funding where we can (ICS, Friends, National Funding pots etc)

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	07/02/2013	74	Delays in reporting for Radiological Investigations	15	16	◀▶
	10/12/2013	68	Aging Building Management System (BMS)	15	15	◀▶
	11/11/2015	64	Clinical Environment Maintenance & Refurbishment	20	15	◀▶
	12/11/2015	65	External Cladding/Façade at EDGH	20	15	◀▶
	12/11/2015	8	Potential non-compliance with Fire Safety Legislation EDGH	15	15	◀▶
	12/11/2015	67	Potential non-compliance with Fire Safety Legislation Conquest	15	15	◀▶
	12/11/2015	263	Potential non-compliance with Fire Safety Legislation Bexhill	15	15	◀▶
	12/11/2015	60	Failure of lifts	16	16	◀▶
	09/05/2017	61	Loss of Electrical Services to Critical Clinical Areas	16	16	◀▶
	03/08/2017	75	Containment Level 3 Laboratory - on POD CRR	15	15	◀▶
	27/06/2019	62	Insufficient Ward decant accommodation on Audit CRR	12	16	◀▶
	27/06/2019	63	Insufficient isolation facilities to meet demand on Q&S CRR	12	16	◀▶
	27/05/2020	14	Capital - Sustainability	12	20	◀▶
	02/07/2021	84	Clinical Space on Frank Shaw Ward - on Q&S CRR	20	15	◀▶
	30/05/2023	70	Effect of Business Continuity & Critical or Major incidents on Audit CRR	16	16	◀▶
	22/08/2023	5	Conquest CT Scanner installation on Q&S CRR	25	20	◀▶
	02/10/2023	87	Environment for children and young people with complex psycho-social challenges on Q&S CRR	20	16	◀▶

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:	30/01/2025	

	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	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. The vulnerability of the IT network will improve with the introduction of EPR, assuming this is signed off nationally in February.	Likelihood:	3
	Consequence:	4	4	4			Consequence:	4
	Risk Level:	16	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 3 Progress Report**	**BRAG**
1.	Cyber Assurance Framework	Chief Finance Officer	Ongoing	• Internal DSPT self-assessment completed which 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	Green
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	Amber
3.	LAN Refresh EDGH	Chief Finance Officer	Q1 2025	• Migration of Edge network over the course of Q4 2024/Q1 2025	Green
4.	LAN Refresh Conquest	Chief Finance Officer	Q4 2024/25	• Replace the Core Network and Fibre connections to the Edge Switches • Equipment delivered • Fibre network now being installed	Amber
5.	Active directory migration	Chief Finance Officer	2025	• Migration of users and devices has started • Migration of services during 2025	Amber

Progress

What is going well/future opportunities	What are the current challenges including future risks?	How are these challenges being managed?
• We have further reduced end of life systems • Improved patching across Servers and Client devices • Working with the ICB system to reduce / identify risks in the supply chain	• Capacity in the physical Estate to improve network capacity as part of refresh • Funding to replace Legacy clinical systems • Resource are limited due to EPR	• Identified areas of challenge and working with Estates on identifying new locations • Identifying Regional and National funding to support change • Working on prioritising resources

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	06/06/2023	13	Unable to update Network Infrastructure Devices	16	16	◀▶
	21/03/2022	15	Unmitigated Software Vulnerabilities	16	16	◀▶
	23/08/2017	17	Cyber Attack	20	15	▲
	25/01/2021	53	Unsupported Server Vulnerability	12	16	◀▶
	21/03/2022	54	Data Centre Segregation	20	15	◀▶
	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	◀▶
	09/07/2024	270	Reduced pathology testing capacity following cyberattack	20	16	NEW

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 organisation 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:	Chief Operating Officer	Lead Committee:	Finance and Productivity Committee		Date of last Committee review:	30/01/2025	

	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	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	4			Consequence:	4
	Risk Level:	16	16	16			Risk Level:	12

Cause of risk:	• 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.	Impact:	• 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. C. Investment in BI Tools: Implementation of modern BI platforms (e.g., Power BI,) to enhance data analysis and reporting capabilities.

management (controls)	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 3 Progress Report	BRAG

1.	Enhance BI Structure and Investment	COO	May 2024	• BI Structure that meets the organisation's needs and investment agreed • Create recruitment plan • Have led a couple of rounds of recruitment; have internally promoted but have had no increase in WTEs • Now looking at other recruitment avenues	Green
2.	Clarify Roles and Responsibilities:	COO	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	COO	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. • Development of the new power BI online service and SharePoint front end is ongoing	Green
4.	Enhance BI Training Programs:	COO	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. • Have utilised and been proactive on Microsoft and NHS training modules, with significant uptake form team to develop power BI skills and continue to push this out on a regular basis	Amber
5.	Improve Reporting Mechanism, Automation First and Self Service	COO	Ongoing	• Develop Automated Reporting Workflows • Set Up Scheduled Report Generation • Deploy Self-Service BI Tool • Create Predefined Reporting Templates • Consolidate Data from Multiple Sources • New developments are being done on a web front automated first approach; including elective programme utilisation reporting, A&E , flow, quality and safety and theatre reporting	Amber

6.	Engage External Partners:	COO	Ongoing	• Collaborate with BI consultants and data visualisation experts to support timelines in development of key reports and self-service tools. • Utilise external expertise to address complex challenges and drive continuous improvement. • Working closely with Northdoor, developing self service tools, finalising completion of theatres and commencing outpatient dashboard.	Amber
7.	Design and Implement a New Data Warehouse:	COO	Ongoing	• Assess and Select Technology • Develop new reporting tables • Migrate Data Effectively	Red

Progress		
What is going well/future opportunities	What are the current challenges including future risks?	How are these challenges being managed?

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:	30/01/2025

	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	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	4			Consequence:	4
	Risk Level:	12	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.	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

	• Inconsistent processes in relation to be purchase & implementation of new systems, which results in additional steps and handoffs in the process for patient care. • Potential organisational unwillingness to embrace change. • 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 3 Progress Report**	**BRAG**
1.	EPR implementation	Chief Medical Officer	July 2027	• Full business case and specification complete • FBC being reviewed by National SMEs and will go to signoff by the national EPRIB Board on the 26th Feb • Contract negotiation with the preferred supplier underway with Contract Signature due in early March • A large number of posts will need to be recruited to support implementation • Start of implementation in May 2025 • End date of implementation will be July 2027	Green
2.	Digital transformation roadmap based on supporting the digital strategy	Chief Finance Officer	March 2025	• Moorhouse engaged to rewrite the Digital Strategy with a detail 12 month plan and a high level 5 year roadmap. Delivery due end of March 25 to then go through Trust governance.	Green
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	Amber
4.	Increase digital culture	Chief Finance Officer	Ongoing	• Communications strategy and engagement • Multidisciplinary team working • Appointment of digital delivery partners now complete • Developing links with education teams to embed digital literacy into workforce descriptions • Identifying a new Non-Executive Digital Champion	Green

Progress		
What is going well/future opportunities	What are the current challenges including future risks?	How are these challenges being managed?
• EPR Implementation planning and governance • Engagement with Moorhouse	• Cultural Change and Communication	• Work with Strategy team and Communication team

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	07/02/2013	74	Delays in reporting for Radiological Investigations	15	16	◀▶
	18/04/2019	78	Limited functionality of follow up appointment database	16	16	◀▶
	28/06/2023	85	Subject Access Requests / Redaction Software on Audit CRR	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:	24/09/2024	

	BAF Risk Scoring							
Inherent Risk	Quarter	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Rationale for Risk Level	Anticipated Risk	
(4x4) 16	Likelihood:	4	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 have initiated a programme to develop stronger leadership behaviours and culture for CQI.	Likelihood:	3
	Consequence:	4	4	4			Consequence:	4
	Risk Level:	16	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			
	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 3 Progress Report	BRAG
1	Recruit to CQI lead within TSI team	Dir of TSI	Completed	• CQI Lead recruited in March 2024	Green
2	Reprioritise TSI team work programme to specify CQI support		Completed	• Completed in August 2024	Green
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	Red
4	Identify and launch CQI leadership, culture and behaviour programme		September 2024	• Phase one completed	Green

Progress		
What is going well/future opportunities	What are the current challenges including future risks?	How are these challenges being managed?
• Leadership, culture and behaviour programme is progressing well and identifying critical gaps that we need to focus on • The development of our QI 'network' in the region • The Trust is maintaining active capacity for frontline training and support through the clinical effectiveness team	• Lack of resources to drive an accelerated programme • Financial recovery is a top imperative	• Within the limited resources available we are prioritising around leadership, culture and behaviour programme which is moving into phase two and maintaining active capacity for frontline training

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:**	**29/01/2025**

	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**	**4**		Evidence on a daily basis of the impact of greater than 200 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 Q4.	**Likelihood:**	**4**
	Consequence:	**4**	**4**	**4**			**Consequence:**	**4**
	Risk Level:	**16**	**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 • Still some delays with discharge planning and process given the significant numbers of additional and/or complex patients

	• 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 Recover and Assess (D2RA) 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		• 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 • Residual safeguarding concerns given the huge numbers of vulnerable patients, many of whom are resistant to care and have a very considerable length of stay • Ongoing incidents of violence and aggression • Successful recruitment to therapy posts. Data to understand impact on internal delays being collated.
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. New process for harm reviews of NCTR and long length of stay patients in place and due to report shortly 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 Transfer of Care Hub J. Recent addition using NerveCentre to enable accurate monitoring of waiting times for therapy, social services and mental health input K. Head of Nursing for Mental Health now in place and will be recruiting, onboarding and training additional Outreach staff.		

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:	• Robust management of all capacity • Thrice daily reviews of staffing • Redeployment of staff as required • Safety huddles in all clinical areas • Real time bed state/information available	• Use of any additional specialist advice or support, including visits to ESHT and ESHT staff visiting other locations • Daily patient pathway review for all P1-P3 patients with system partners	• Scheduled meetings with CQC to discuss data, intelligence and KPIs • Challenge at Trust Board • Provider assurance meetings and system clinical quality review meetings

Assurance Framework – 3 Lines of Defence			
	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)*
	• 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.	• Clear oversight and responsibility for operational delivery, and of quality and safety • Monitoring of patients admitted over establishment and their location in the Trust using NerveCentre • System wide discharge improvement workstream focussed on improving discharge processes and reducing length of stay in acute hospital and community hospital beds	

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
- Lack of Nursing Home capacity
- Accuracy and timeliness of data on NerveCentre albeit improving
- Stranded patients requiring mental health support and those with Significant Mental Illness (SMI)

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 3 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 HoN now in post and recruitment and onboarding of rest of team underway • Agreement to invest in therapy resource for inpatients with recruitment well underway and all posts recruited to.	Amber
2.	Ensure 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.	Amber
3.	Ensure high risk patients are assessed and flagged appropriately	COO/CNO/CMO	Ongoing	• Divisional long length of stay meetings • As required on a case by case basis, divisions escalate particularly complex patients	Green
4.	Need to roll out and embed process for capturing and reporting on the impact of deconditioning	COO/CNO/CMO	Ongoing	• Process now in place with first report almost complete	Amber

Progress		
What is going well/future opportunities	What are the current challenges including future risks?	How are these challenges being managed?
• Recruitment of Head of Nursing for Mental Health and ongoing recruitment of team • SAFER and reconditioning work has started to show some benefits.	• Risk of not recruiting into mental health outreach team • Huge operational pressures have stalled some of this work in December and January	• Close monitoring of recruitment into the team to be maintained. • Expectation is that work will resume in February as pressures hopefully ease

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	◄►

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:**	**08/10/2024**	

	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**	**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**	**4**			**Consequence:**	**4**
	Risk Level:	**12**	**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	• 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

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)*
		• Regular reports to Inequalities Committee	vision, scale and the difference made to patient outcomes • Deloitte well led report

Gaps in control/assurance:

- Health Inequalities Steering Group (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 3 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 is well established, with good attendance and conversations are underway with our new AD for Performance regarding a data refresh for YE 24/5. Actions 2, 3 and 4 are either completed or are ongoing as expected. There has been a delay on action 6, with reporting templates not anticipated until YE, with the aim to include updates in the revised IPRs Any additional variation or deviation will be provided on an exception-based approach	Amber
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		Sept-24		

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)*
	Divisions will receive means we can hold them accountable for progress via the IPRs				
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		

Progress		
What is going well/future opportunities	What are the current challenges including future risks?	How are these challenges being managed?
• HISG is now an established group that monitors performance and service delivery across the areas set out in action 1	• Generally the greatest challenge is focusing on how we can move consideration of inequalities into how we develop clinical pathways and services	• The work across divisions on the quality of data reporting means that inequalities lenses remain an item that the Trust is required to report upon. • We expect to roll out our campaign "It's OK to ask" early next year that supports staff to engage with patients and families from groups where we know greater inequalities to access are seen, in order that we can learn more about them and how they will best engage with our teams

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	19/09/2024	284	Management of Transgender Records	20	16	**NEW**

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 remain around 200 patients with No Criteria to Reside), there is a risk that patients spend longer than they need to in the emergency department once they are clinically ready to proceed. This is due to a number of factors and also affects those patients who wait longer than they should to access the emergency department. There is evidence to suggest that patients who spend more than six hours in emergency departments are more likely to suffer harm.**				
Lead Directors:	**Chief Operating Officer, Chief Medical Officer and Chief Nurse**	**Lead Committee:**	**Quality and Safety Committee**	**Date of last Committee review:**	**29/01/2025**

	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**	**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 Q3. Non-admitted performance has improved, but no sustained improvement has been seen in length of stay, or in the overall number of patients with no criteria to reside.	**Likelihood:**	**3**
	Consequence:	**4**	**4**	**4**			**Consequence:**	**4**
	Risk Level:	**16**	**16**	**16**			**Risk Level:**	**12**

Cause of risk:	• High numbers of patients who do not meet CTR and are Discharge Ready circa 200 or 25% of bed stock • Bed occupancy in excess of 98%/100% • Lengthy times to assessment in ED, leading to high numbers of non-admitted breaches. • Insufficient bedded capacity immediately available to decompress ED • Insufficient Local Authority assessment capacity • Insufficient community capacity (care homes and discharge to assess)	**Impact:**	• Patients spending longer than they need to in the emergency department • Delays for patients being able to access the emergency department in a timely way • At times increased handover times for ambulance crews • Overcrowding of the emergency departments affecting the experience of patients and staff as is boarding (corridor care) on wards and use of supersurge capacity

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			
	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	• 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:

- 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 affecting the experience of patients and staff as is boarding (corridor care) on wards and use of supersurge capacity

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 3 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	**Green**
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	**Blue**
3.	Still working on KPIs and dashboard to support work on Length of Stay and internal/external processes e.g. wait times for therapies, ASC and MH.	CNO	Ongoing	• Some progress but not yet complete with new ask in late Dec on NerveCentre for digital data.	**Amber**

Progress		
What is going well/future opportunities	What are the current challenges including future risks?	How are these challenges being managed?
• The roll out of SAFER and work on Reconditioning well received with good engagement.	• Work on SAFER and Reconditioning stalled and also impeded by very high occupancy and corridor care affecting workforce and physical space for mobilising and activities. • Little change in NCTR numbers (circa 200).	• Trying to decompress wards but still have patients in additional areas/corridors daily.

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	◀▶

Agenda Item: 16.1

Report To/Meeting	Trust Board	**Date of Meeting**	10th February 2025
Report Title:	Emergency Preparedness, Resilience & Response (EPRR) Annual Update to Trust Board		
Key question	What is the current position of ESHT in terms of EPRR?		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☐ For Discussion ☐		
Report Sponsor:	Charlotte O'Brien, Chief Operating Officer	**Presenter(s):**	Charlotte O'Brien, Chief Operating Officer
Outcome/Action requested:	The Board is asked to note and approve this report.		

Executive Summary	The EPRR annual report is presented to the Trust Board, as required by the NHS Emergency Preparedness, Resilience & Response framework, and as set out in the Trust EPRR policy. The report details the current EPRR agenda on key issues of Trust performance over the period October 23 to date, on behalf of the Chief Operating Officer (COO) as 'Accountable Emergency Officer'. This report also presents the outcome of the 2024 EPRR Assurance process, which confirms that the Trust have demonstrated improvement from a 'Substantially Compliant' position in 2023, to gaining 'Full Compliance' status for 2024 for the EPRR Core Standards Assessment. The following report includes an overview of the following: 1. EPRR training and exercises undertaken by the organisation. 2. Progress with business continuity across the organisation. 3. Summary of any business continuity, critical and major incidents experienced by the organisation. 4. Lessons identified from incidents and exercises. 5. The organisation's compliance position in relation to the latest NHS England EPRR assurance process
Regulatory/legal requirement:	The NHS EPRR Core Standards for assurance require that: "The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements".
Business Plan Link:	Quality ☐ People ☐ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration.
Resource Implication/VFM Statement:	N/A
Risk:	The Trust EPRR risk register is aligned to ESHT risk systems, links to the Local Health Resilience Partnership (LHRP) and the Sussex Resilience Forum (SRF) Community Risk registers and is reviewed monthly. The

	EPPR Team have the same three risks which were presented to the Audit Committee and Board last year. These three risks are: • 2190 (score 16) Effect on ESHT from Business Continuity, Critical or Major Incidents • 2189 (score 12) Ability to respond to Mass Casualty Event. • 2191 (score 8) Effect on HEMMS patient transfers at Conquest Hospital The plan for 2025 is to look to reduce risk 2190 by completing more in-depth Business Continuity work with the services, with an increased focus on digital aspects

No of Pages	5	**Appendixes**	0

Governance and Engagement pathway to date:	This report is submitted on behalf of the Trust's EPRR Steering Group (5th December 2024) and tabled for assurance and approval at Audit Committee on 30th January 2025.
What happens next?	This annual report, along with minutes from Trust Board, will be submitted as evidence towards this coming years level of compliance of the NHSE Core Standards for EPRR.
Publication	Yes

Introduction/Background

The Trust continues to recognise & comply with its duties as a 'Category 1 responder' under the Civil Contingencies Act 2004, and the requirements of the NHS EPRR Framework, (which has been updated in 2022). Core tasks within the CCA2004 are:

- Assess the risk of emergencies occurring and use the assessments to inform planning.
- Confirm emergency plans for external incidents.
- Implement further Business Continuity Management arrangements (for internal incidents).
- Embed arrangements to warn / inform the public about civil protection matters.
- Share information and co-operate with other local responders.

Following successful recruitment to the positions of Head of EPRR, EPRR Manager and Business Support Officer the EPRR team is now fully established, given the current staffing model, as outlined in the paper below there still work required to ensure the Trust improves its overall resilience and preparedness for untoward events and incidents. A project plan for short term, midterm and long-term goals has been developed and progressed during the forthcoming year.

EPRR Training and Exercises

Throughout the past year, work has taken place to develop a comprehensive training package for the On-Call Managers. Currently there is a total of 111 On Call Managers/Directors and Clinical Site Team members.

On-Call Manager & Director Training; Currently 65 'Silver' and 'Gold' on-call staff have completed this course (59%). From February 2025 these courses will run face to face on a monthly basis across the remainder of the year to support 100% training compliance.

As of December 2024, two E-Learning modules were added to 'MyLearn' for the On-Call Managers to complete, these include NHS Principles in Health Command (PHIC) and Joint Emergency Services Interoperability Programme (JESIP).

Throughout the year the EPRR team will monitor training compliance and will report this at quarterly governance meetings.

CBRN Training figures

Since 2023 we have trained 137 staff as Chemical, Biological, Radiological, and Nuclear (CBRN) responders with the vast majority being from our Emergency Departments. We have several further dates planned and we will be increasing that number throughout 2025.

ESHT has a record of commitment to both internal & external EPRR exercises.

- The Trust participated in Exercise Cire, which was a digital exercise run by NHS England Digital team.
- The EPRR Team supported in an internal Digital exercise in June 2024.
- The EPRR Team facilitated an Infection Prevention Control (IPC) exercise to test the Trust Viral haemorrhagic fever (VHF).
- The EPRR team held several CBRN training sessions across both our acute sites and further work is being done to develop the package further and look at options to get more areas with trained responders so we can ensure we have a resilient 24/7 cover to CBRN response.
- The EPRR Team were part of the planning group for Exercise Fallout which took place in September 2024 at the EDGH. This was a live multi agency SRF CBRN exercise.
- The EPRR Team alongside the Deputy Divisional Director Capacity and Flow have produced a new Senior on Call (SOC) and Director on Call (DOC) training package which has been running throughout 2024.
- The EPRR Team planned and ran a live Marauding Terror Attack (MTA) /Lockdown exercise in Conquest in October 2024.

- The EPRR Team facilitated two Estates & Facilities Business Continuity tabletop exercises in April and May 2024.

Business Continuity

The Trust are yet to achieve full Business Continuity Plans (BCP) compliance across all services. There have been many contributing factors as to why we have not progressed to the levels that we had anticipated.

Following an in-depth review of the BCP objectives, it became clear that some services required far more detailed plans whilst others were simply out of date or not meeting current guidelines. Resources and pressures on staffing levels being a contributing factor.

It should still be noted that as we moved through the year, we did still make progress with business continuity, and there was encouraging engagement from many services.

The EPRR team is currently introducing measures via the EPRR Steering Group to confirm the responsible senior managers from each division who will work on EPRR related issues, specifically taking oversight for their divisional Business Continuity.

The team is focused on ensuring that the Business Continuity project is prioritised in 2025, and the team have identified how it can spread it resources to cover differing elements of the process: Completion of Business Impact Assessment, completion of Business Continuity Plan and Exercising the plan once complete.

It is important to highlight that the time frame for this project could take up to 24 months to fully complete as every division, service & digital system will require plans which have been produced and tested via an exercise.

Whilst this is not the position we wanted to be in at the end of 2024, we are confident that we now have the complete picture of where we are currently, and what is required to achieve the full compliance.

Incidents and Lessons identified

Incidents since the last report are:

- Lewes Prison (March 2024)
- Hastings Water Outage (May 2024)
- Sussex Priemer Health Fire (June 2024)
- Industrial Action (June 2024)
- Heatwave Response (July, August, September 2024)
- Digital downtime BCI (November 2024)

The key lessons identified from incidents and exercises are listed below:

- The EPRR team continues to support services to develop their Business Continuity plans where possible. However, a number of these incidents and other Digital issues have highlighted that to effectively deliver on a more robust project plan, a comprehensive road map is required to support the timeliness of succinct and effective Business Continuity Plans
- Another theme that has arisen from a number of these incidents is the initial alerting process of Incidents. Firstly, how we as a Trust are alerted of Incidents that may impact us. Work has continued to develop this year, and the Sussex Resilience Forum are close to brining in an altering system Sussex wide.
- The need to further embed an effective Trust ‘incident alerting’ and ‘staff briefing’ system is a recurring theme highlighted in all recent Trust de-briefing processes. This was raised last year and remains an issue which we are yet to resolve.
- The need for more robust training packages covering a wide range of EPRR topics to ensure more resilience. The decision has been made for the EPRR Manager to be released to solely focus on training & exercising which will help to make a huge difference.
- We continue to identify lessons learnt from all exercise and incidents regarding communication.

Notable Successes and Challenges

Successes include:

- The successful recruitment to the Head of EPRR, EPRR Manager & joint Business Support Officer Posts.
- Successful planning and facilitation of a live CBRN exercise at the EDGH in September 2024 followed by an MTA live exercise at Conquest in October 2024.
- The ongoing work to support services to continue to develop their Business Continuity Plans.
- Development of new CBRN training package.
- Supporting the delivery of the new SOC/DOC face to face training.
- The work on the annual EPRR core standards with improvements made since 2023 which led to gaining full compliance in 2024.
- The improved working relationships between the EPRR Team and both internal services and external organisations.
- The continual management of the Trust Operational Centre.
- New Command & Control Framework and Major Incident Plan.
- Future proofing the department to cope with the increasing demands of emergency and resilience planning.

Compliance: NHS England EPRR assurance Process

The Audit Committee and Board have previously been provided with a letter from the ICB which confirms that in the 2023 assurance process, the Trust is ‘Substantially Compliant’ with the EPRR Core Standards Assessment.

The EPRR Team has completed the 2024 assurance process and can report the Trust achieved ‘Full Compliance’.

Recommendations

The Trust Board is asked to:

1. Note the EPRR annual update
2. Note the continued importance of the delivery of the EPRR programme of work
3. Note of the Trust’s level of compliance with the NHS E/I Core Standards for EPRR.

Agenda Item: 16.2

Report To/Meeting	Trust Board	**Date of Meeting**	25th February 2025
Report Title:	East Sussex Healthcare NHS Charity Annual Report and Accounts 2023/24		
Key question	What activity did the Trust's Charity undertake during 2023/24?		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☐ For Discussion ☐		
Report Sponsor:	Ama Agbeze, NED and Charity Chair	**Presenter(s):**	Paresh Patel, NED and Charity Committee Member
Outcome/Action requested:	The Board is asked to note the Charity's Annual Report and Accounts for 2023/24		

Executive Summary

East Sussex Healthcare NHS Charity is the Charity of East Sussex Healthcare NHS Trust.

The Charity's aims are to:

1. Enhance the patient experience throughout their time with the Trust
2. Expand East Sussex Healthcare NHS Trust's capacity to provide care and improve health outcomes
3. Support staff wellbeing in our hospitals and community services

We rely on the generosity of our donors to be able to enhance the care that is provided by the Trust and everything that the Charity does is only possible due to the generosity and support of the public. More information about the Charity can be found on its website: https://eastsussexhealthcarenhs.charity/

Karen Manson retired as Chair of the Charity in August 2024, and was succeeded by Ama Agbeze. The Charity's income for 2023/24 was £161,000; £325,000 was spent funding charitable activities during the year.

The annual report and accounts attached as an appendix to the Board papers were approved at the meeting of the Charity's Corporate Trustee on 28th January 2025 and were submitted to the Charity Commission on 30th January 2025.

Regulatory/legal requirement:	East Sussex Healthcare NHS Trust (ESHT) is the sole Trustee of the Charity, with members of the Board acting on the Trust's behalf.
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:	The major risks to which the Charity is exposed have been identified and reviewed with systems established to mitigate them. The Charity relies on and benefits from the financial controls framework of ESHT. The most significant risks identified were: 1. possible losses from a fall in the value of the investments; 2. possible lack of growth related to the investment strategy adopted; and 3. reputational damage leading to a sudden and dramatic fall in donations.

No of Pages	2	**Appendixes**	1

Governance and Engagement pathway to date:	The annual report and accounts were subject to, and approved by, external audit. They were approved by the Charity's Corporate Trustees on 28th January 2025.
What happens next?	The Charity will continue to raise money to provide support the Trust in delivering the highest quality care to patients.
Publication	Yes

Agenda Item: 17

Report To/Meeting	Trust Board	**Date of Meeting**	25th February 2025
Report Title:	Use of Trust Seal		
Key question	Has the Trust Seal been used since the last Trust Board meeting?		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐		
Report Sponsor:	Damian Reid, Chief Financial Officer	**Presenter(s):**	Steve Phoenix, Trust Chair
Outcome/Action requested:	The Board is asked to noted the usage of the Trust Seal.		
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 4th December 2024 and 13th February 2025: **Sealing 115** Curtins Consulting Limited, 16th December 2024. Duty of Care Deed providing 12 year warranty for EDGH Phase 1 and 2 cladding		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☐ People ☐ Sustainability ☐		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	1	**Appendixes**	None
Governance and Engagement pathway to date:	Not applicable		
What happens next?	Not applicable		
Publication	Report is for publication		

Trust Board Meeting in Public 12-month forward plan

Agenda sections	29th April 2025	24th June 2025	26th August 2025	23rd September 2025	28th October 2025	16th December 2025
Location	Bexhill	Conquest	Eastbourne	TBC	Bexhill	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)	Staff Recognition Board Committee Reports CEO's Update (verbal) IPR Shared Delivery Plan Use of Trust Seal Questions from members of the public (15 mins)	Staff Recognition Board Committee Reports CEO's Update (verbal) IPR Shared Delivery Plan Use of Trust Seal Questions from members of the public (15 mins) Patient story or staff story		Staff Recognition Board Committee Reports CEO's Update (verbal) IPR Shared Delivery Plan Use of Trust Seal Questions from members of the public (15 mins)	Staff Recognition Board Committee Reports CEO's Update (verbal) IPR Shared Delivery Plan Use of Trust Seal Questions from members of the public (15 mins)
General	Presentation: Alcohol Team (from RM, 22.01.25) - confirmed with Steven Fong 27.01.25	Presentation: Trauma Informed Care (Jacquie Fuller) - TBC as of 12.02.25	Board Committee Annual Reviews and Annual Reports			
Quality, Safety and Performance	Maternity Overview Q3 Learning From Deaths Q2 Cancer Patient Experience Survey Results Martha's Rule Implementation Update National Adult Inpatient and Urgent Care Survey National Maternity Survey Results	Maternity Overview Q4 Patient Experience Report Q4	Learning From Deaths Q3 Autumn/Winter 2025/2026		Maternity Overview Q1 Learning From Deaths Q4 Patient Experience Report Q1 Tissue viability annual report Medical Revalidation Group Report Urgent and Emergency Care Survey Results	Maternity Overview Q2
Annual Reports	Annual Post Graduate Medical Education Report	Annual Director of Infection Prevention & Control Report CNO	Complaints Annual Report (CNO) Childrens Safeguarding Annual Report (CNO) Adults Safeguarding Annual Report (CNO)			
Human Resources incorporating workforce targets and staff survey			Health & Wellbeing Report CPO Workforce Race Equality Standard Report Workforce Disability Equality Standard Report		Equality & Diversity Bi annual report Gender Pay Gap Report	
Strategy	ESHT CiC - Items for Information, Items for Decision, Minutes	SDP and Transformation Workstreams ESHT CiC - Items for Information, Items for Decision, Minutes	ESHT CiC - Items for Information, Items for Decision, Minutes		SDP and Transformation Workstreams ESHT CiC - Items for Information, Items for Decision, Minutes	ESHT CiC - Items for Information, Items for Decision, Minutes
Other monitoring	Estates & Facilities Sustainability		Estates & Facilities Sustainability			
Governance and Assurance	Trust Annual plan, budget and capital plan 2024/25 (final) EPRR Update BAF Q4 Delegation of approval of Annual Report and Accounts 2023/24 NHS Provider Licence	Nursing Establishment Review Violence Prevention and Reduction Standard Speak Up Guardian Update	BAF Q1 Guardian of Safe Working hours - report	AGM	BAF Q2 Winter Preparedness	Speak Up Guardian Update Violence Prevention and Reduction Standard Guardian of Safe Working hours
Annual Reports			Medical Revalidation		Equality annual report	Infection Control Safeguarding Organ Donation
Items for Information						Meeting Dates for 2026