East Sussex Healthcare NHS Trust

EAST SUSSEX HEALTHCARE NHS TRUST

BOARD OF DIRECTORS

TRUST BOARD MEETING IN PUBLIC

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

29TH APRIL 2025, 09:30-12:45

East Sussex Healthcare NHS Trust Board Agenda

Date: Tuesday 29th April 2025

Time: 09:30 – 12:45

Venue: Elva Room, The Relais Cooden Beach, Cooden Sea Rd, Bexhill-on-Sea TN39 4TT

	Opening Business	Lead	Action	Time	Paper
1.	Welcome and apologies	Chair	Information	09:30	
2.	Colleague Recognition	Chair	Information	09:35	Yes
3.	Alcohol Care Team - a success story for building a sustainable future	Stephen Fong / Alcohol Care Team	Information		No
4.	Declarations of Interest	Chair	Information		
5.	Minutes of Trust Board Meeting in public 25.02.25	Chair	Approval	09:45	Yes
6.	Matters Arising	Chair	Approval		Yes
7.	Chair's Update	Chair	Information		No
8.	Chief Executive's Report	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 11 (February) (i) Chief Executive Summary (ii) Quality & Safety (iii) Our People (iv) Access and Responsiveness (v) Financial Control and Capital Development	CEO CNO/CMO CPO COO ICFO	Assurance	10:10	Yes
11.	Avoidability of Inpatient Deaths Q2	CMO	Assurance	10:55	Yes
12.	Maternity Update Q3	DOM	Assurance	11:00	Yes

Break – 10 minutes

	Strategy				
13.	EmPoweR Electronic Patient Record Update	CMO	Information	11:25	Yes

Governance and Assurance					
14.	Trust Financial Plans 2025/26 – Revenue and Capital	ICFO	Approval	11:35	Yes
15.	Nursing Establishment Review	DCNO	Approval	11:45	Yes
16.	NHS Staff Survey - Results 2024	CPO	Information	11:50	Yes
17.	Martha's Rule Implementation Update	CNO	Information	12:00	Yes
18.	Q4 Board Assurance Framework	COS	Assurance	12:05	Yes
19.	Delegation of Approval of Annual Report and Accounts	COS	Verbal	12:10	No
For Information					
20.	Car Parking Charges	CPO	Verbal	12:10	No
21.	Use of Trust Seal	Chair	Information	12:15	Yes
22.	Questions from members of the public	Chair		12:15	No
23.	Agenda Forward Plan	-	Information	12:30	Yes
24.	Date of Next Meeting 24th June 2025	Chair	Information		
25.	Close	Chair			

Steve Phoenix
Chairman

Key:	
Chair	Trust Chair
CEO	Chief Executive
CNO	Chief Nurse and DIPC
COO	Chief Operating Officer
ICFO	Interim Chief Finance Officer
COS	Chief of Staff
CMO	Chief Medical Officer
CPO	Chief People Officer
DCNO	Deputy Chief Nurse
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
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**	29 April 2025
Report Title:	Colleague Recognition		
Key question	How does the Trust recognise and thank colleagues for their contribution, effort and loyalty?		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐		
Report Sponsor:	Jacquie Fuller, Assistant Director of HR – People Engagement	**Presenter(s):**	Steve Phoenix, Chair
Report Author	Melanie Adams, People Experience Manager		
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	6	**Appendixes**	No
Governance and Engagement pathway to date:	None		
What happens next?	Delivery of the updated colleague recognition programme including planning for the 2025 annual Trust Awards event		
Publication	Yes		

1. Changes to long service recognition

We know how much colleagues value recognition of their contribution to the NHS and organisation. From 1 April we have increased opportunities for colleagues to be recognised for their continuous long service at the Trust and wider NHS. Feedback to date has been positive and further information will be included in the next report.

2. Trust Awards

Planning is underway in preparation for this year's Trust Awards event which, following feedback from the Partnership Forum, will be a more inclusive event and an opportunity for more of our people to attend and share in the celebrations with their colleagues.

3. Celebrating our people

3.1 Hero of the Month

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

December 2024 – Matthew Ades – Catering, Conquest Hospital, Estates and Facilities

'Matthew is a bank member of staff, who happens to have severe autism and has partial deafness. Today a housekeeper completely ignored a blind lady who was struggling to find her way to James ward. Matthew got out of his comfort zone and asked the visitor if he could help. Although he was uncomfortable escorting her to the ward, he recognised my supervisor and asked her if she would be able to assist. Matthew deserves some way of thank you. He has failed interviews because of his conditions and yet as today has proved he has come on so much to assist a member of the public. Small act, but a huge gesture for him.'

January 2025 - Maria Frost – Housekeeper A&E EDGH, Estates and Facilities

Nomination 1

'Maria is hardworking and her cleaning standards are impeccable. Nothing is ever too much trouble for her. She's happy and friendly and an asset to the department in these difficult times. She's much loved by the members of the ED team for her kindness, hard work ethic and willingness to help. She goes above and beyond. Maria is simply the best!'

Nomination 2

'Maria is always friendly and helpful. Her work is exceptional, and our ED is kept spotless through her hard work. She always has a smile and kind word, and nothing is too much trouble for her. She is much loved and valuable part of the ED family.'

3.2 Long Service Awards: December 2024 – March 2025

Dec-24					
10 Years' Service			**25 Years' Service**		**40 Years' Service**
Kamran	Abdullah		Tracy	King	
Charlotte	Barton		Ewa	Tutaj	
Rebecca	Green		Susan	White	
Rhianna	Hanson				
Jency	Jaise				
Paul	Jones				
Norman	Madzivanzira				**50 Years**
Stephen	Price				
Megan	Scrace				
David	Sharp				
Sara	Webb				
Denise	Wood				

Jan-25					
10 Years' Service			**25 Years' Service**		**40 Years' Service**
Leslie	Brown Fumeau		William	Baldry	
Richard	Chapman		Natasha	Ewen	
Tina	Coleman		James	Flaherty	
Matthew	Cox		Susan	Hanmer	
Christopher	Delonnette		Veronica	Hitchman	
Ninette	Hicks		Susan	Loft	
Claudia	Moodley		Pravin	Sangle	**50 Years**
Louise	Orbell		Samantha	Stevens	
Benjamin	Sinden				
Emma	Weir				
Janice	Woolford				

Feb-25					
10 Years' Service			25 Years' Service		40 Years' Service
Susan	Baker		Louise	Brown	
Lauren	Bell		Faith	Makura	
Emily	Botting		Andrew	Slater	
Turina	Crouch				
Samantha	Crozier				
Clare	Evans				
Liudmila	Fleming				50 Years
Manolo	Garcia				
Chrysoulla	Gower				
Vanessa	Irvine				
Jacqueline	Kelly				
Graham	L'Hemeury				
Anita	Lacey				
Lindsey	Lau				
Monika	Lipnicka-Khan				
Lisa	Marosi				
Magdalena	Mazurkiewicz				
Florin	Mutu Bodiu				
Rebecca	O'Farrell				
John	Payne				
Mizue	Payne				
Mark	Taylor				
Steven	Towgood				
Lynn	Wilson				

Mar-24							
10 Years' Service			25 Years' Service			40 Years' Service
Ross	Baxter		Paula	Reed		
Louise	Brine		Nicola	Tester		
Kerri-Anne	Cookson		Iain	Wearne		
Toni	De Freitas					
Lisa	Fuller					
Stephanie	Gill					
Kyra	Harvey					50 Years
Ian	Hawley					
Cheryl	Hollands					
Michail	Klimovskij					
Diego	Outes Rivera					
Billie	Plasted					
Molly	Skelton					
Giles	Smith					
Samantha	Wales					

4 Celebrating our retiring colleagues

We recognise colleagues who are retiring after 20 years' service in the NHS. Colleagues are invited, along with a family member and/or work colleague, to a retirement celebration hosted by the Chairman and executive colleagues. Events are held at alternate sites on a monthly basis.

The event is an opportunity to thank colleagues for their contribution on behalf of the Trust Board and to present them with a framed retirement certificate. Feedback to date has been extremely positive with people saying how much it means to them to have their service acknowledged formally.

Below are photos taken from the March event held at Eastbourne DGH.

Karen Martin, Medical Secretary

Mark Paice, Assistant Director - Commercial Services

Tracey Jenner, Ophthalmic Practitioner

Trevor King, Consultant in Anaesthetics

Xanthe Knowles, Deputy Head of Nursing

5. Hero of the Month presentation

Monica Dabrowska, Housekeeper at EDGH accepting her Trust overall Hero of the Month award from Steve Aumayer, Acting Chief Executive

'Monica comes and cleans the CT department and goes above and beyond doing all extra cleaning duties along the way. She is kind and caring and nothing is ever too much trouble.'

East Sussex Healthcare NHS Trust Board Minutes

Date: 25th February 2025

Time: 09:30 – 12:45

Venue: St Mary's Boardroom, EDGH

		Actions
	Attendance: Steve Phoenix, Chairman and Non Executive Director Steve Aumayer, Acting Chief Executive (ACEO) Vikki Carruth, Chief Nurse & Director of Infection, Prevention and Control (CN) Amanda Fadero, Non-Executive Director Simon Merritt, Chief Medical Officer (CMO) Charlotte O'Brien, Chief Operating Officer (COO) Paresh Patel, Vice Chair and Senior Independent Director Damian Reid, Chief Finance Officer (CFO) Frank Sims, Non-Executive Director Carys Williams, Non-Executive Director <u>Non-Voting Directors</u> Jenny Darwood, Acting Chief People Officer (ACPO) Amber Lee, Associate Non-Executive Director Richard Milner, Chief of Staff (COS) <u>In Attendance</u> Anne Canby, Assistant Director of Allied Health Professions, CHIC (for item 03/025) (ADAHP) Chris Hodgson, Director of Estates and Facilities (for item 14/025) (DEF) Brenda Lynes, Director of Maternity Services (DOM) Abi Turner, Associate Director Community Health and Integrated Care (for item 03/025) (ADCHIC) Pete Palmer, Board Secretary (BS) (minutes) <u>Observing</u> Blessing Manzani, Associate Director Nursing Five members of the public were in attendance at the meeting.	
	Apologies: Ama Agbeze, Associate Non-Executive Director Nicki Webber, Non-Executive Director	
01/25	**Chair's Opening Remarks** Steve, Chair welcomed everybody to the meeting. It was confirmed that the notice of the meeting had been duly issued to the members of the Board entitled to receive notice and attend Board meetings. The meeting was quorate according to the Constitution of the Trust.	
02/25	**Colleague Recognition** Steve, Chair reported that January's Hero of the Month had been Sammi Foy, Occupational Health Manager.	

03/25	**Community Health and Integrated Care – Art of the Possible** Abi, ADCHIC and Anne, ADAHP made a presentation to the Board about the development of community and integrated community services in the Trust. The Community Health and Integrated Care (CHIC) division had been undertaking work to identify what it would mean, in an ideal world, for the division, Trust and patients if community services were 'right sized', with care delivered to patients at the most beneficial point in their pathway, along with how patients could be better supported to return home with the right care and services following a stay in hospital. Getting all these factors right would lead to a reduced dependency on hospitals, higher quality care and improved use of resources. The approach being taken aligned with national, regional and local priorities and the Trust was in strong position to align resources across clinical pathways as it was an integrated organisation. Alongside this, work continued with system partners to deliver improvements. Progress that had been made in year one included managing delayed transfers of care by expanding virtual ward capacity, scaling up discharge to recover and assess care and improving Urgent Community Response performance. Other areas of focus had been on preventing people from needing acute care and supporting patients in returning home, including Home First provision when patients no longer required consultant led care. There had been a focus on keeping people well at home by identifying increasing frailty and need, developing plans and providing care to manage these patients. The complexity and acuity of patients being managed in the community had increased since the pandemic. Work was supported by the introduction of an Unscheduled Care Hub, to support people remaining at home or having a managed pathway into and back out of hospital. This had led to a reduction in unnecessary admissions and in delays in returning home, benefitting frail and complex patients on these pathways. The division's acute therapy teams provided support for people in hospital, supporting their discharge and ongoing care and rehabilitation. Care coordination was led by the transfer of care hub in order to reduce internal delays, utilising intermediate care capacity to step patients down and manage challenges for discharging patients. Discharge planning started at the point when a patient was admitted to hospital, and sometimes before this, which reduced delayed discharges. The work undertaken over the previous year had led to a reduction in acute stays due to proactive discharge planning, reduced delays in providing community services with more patients receiving care at home and had realised financial savings for the Trust which had been reinvested in community services to further enhance care and outcomes for patients. More work needed to be done in integrating clinical pathways where benefits could be realised and in working with system partners to achieve the biggest possible impact, realigning resources from acute to community services. Steve, Chair asked what impact the emerging policy on Integrated Care Teams (ICTs) would have on the Trust's services. Abi, ADCHIC explained that the biggest impact from this work would be from improved coordination of care across the system by working together with partners to deliver better care to local populations. Frank, NED, was pleased to hear about the fantastic work that had taken place, and asked what the next steps would be, particularly in realising benefits from working with partner organisations. Abi, ADCHIC, explained that work was taking place to ensure that resources were aligned at both Trust and system level. The introduction of the Unscheduled Care Hub had helped to identify alternative ways of managing the needs of patients rather than sending them to hospital; resources would need to be aligned to reflect these changing pathways. Amanda, NED, praised the illuminating presentation; she asked what the impact of integration could be if their were no constraints for ICTs and the Trust. Abi, ADCHIC

	explained that modelling had shown that there was a lot more that could theoretically be done, including resolving the issue of around 200 patients who were in hospital at any time who no longer needed to be cared for in an acute environment. Initiatives such as virtual wards and Home First allowed patients to be stepped down from acute care sooner, to go home at an earlier stage with significantly reduced packages of care and to regain independence more quickly. She explained that thinking about the future provision of services considered how the needs of the local population could be met without patients having to be admitted to hospital. Damian, CFO noted that it would be helpful to be able to articulate the benefits that had been realised since the introduction of the Unscheduled Care Hub, both for the Trust and the system. Abi, ADCHIC explained that the impact of Hubs had varied between East and West Sussex; it was important that a consistent approach was taken and work was being undertaken with system partners to improve this. Local variations might be required, but it was important that these did not lead to unintentional health inequalities. Steve, Chair, explained that the Board would be keen to receive an update on the progress that was being made in the future.	
04/25	**Declarations of Interest** There were no interests declared for any item to be considered on the agenda. All declarations of interest were noted as held on the Register of Directors' Interest.	
05/25	**Minutes** The minutes of the Trust Board meeting held on 10th December 2024 were reviewed. One amendment was noted: • Page 7 – 'un urgent' to be changed to 'in urgent' They were otherwise agreed as a correct and accurate record of the meeting.	
06/25	**Matters Arising** The Chair noted that a review of undischarged matters arising had been undertaken by Carys, NED and the BS which had looked at the minutes over the past 18 months. Therefore some historical actions were being revisited and the following progress was noted: • *073/23 –Increased focus on Community Services data within the IPR* This was due to be discussed at an upcoming Board Development day as part of Insightful Board work. • *073/23 – Bexhill Community Paediatric Hub* An update had been provided about productivity at Bexhill Community Paediatric Hub. ***Closed.*** • *92/23 – Recruitment Culture in Community Maternity Services* Update on improved culture in community maternity services provided to the Board. ***Closed.*** • *72/24 – Improving Board reporting* The ACEO explained that Insightful Provider Board guidance had recently been published which included recommendations on key metrics that should be reported to NHS Boards. A review of this guidance was being undertaken alongside the drafting of business objectives for 2025/26 to ensure that performance reporting in the Trust was correctly aligned and reported. • *73/24 – Avoidability of deaths reporting* SM – this has been included within the reporting to the Board. ***Closed.***	

	• *26/24 – Martha's Law Implementation Update* Due to take place in April 2025. • *89/24 – Review of undischarged Board actions* Minutes from the past 18 months had been reviewed, with undischarged actions being revisited. ***Closed.*** • *93/24 – Community team presentation to the Board* The Community Team were presenting to the Board at February's meeting. ***Closed.*** • *88/24 – Change of date for December's Board Meeting* December's Trust Board meeting had been rescheduled to 16th December 2025. ***Closed.***	
07/25	**Chair's Update** Steve, Chair reported that the Board meeting was the first to have been held since the disappointing announcement about the future capital investment for the Trust being delayed until 2037 under the New Hospital Programme (NHP). A more detailed update would be provided to the Board later in the meeting. He reported that the Trust had recently made the substantive appointment of Jayne Black as new Chief Executive, following an extensive recruitment process, following national guidance, which had included involvement from internal and external agencies and stakeholders. Jayne had worked for the Trust in the past, so was already knowledgeable about the organisation and had already visited the Trust to say hello to colleagues prior to her start date in April. He thanked the ACEO for all the work he had done in his acting role, as well as other Executives for their support while the new Chief Executive had been appointed.	
08/25	**Acting Chief Executive's Report** The ACEO presented his report, explaining the challenges that had been experienced in keeping patients isolated during the winter period due to the quademic (flu, Covid, Respiratory syncytial virus (RSV) and Norovirus). Despite this, alongside increased A&E attendances, the Trust had maintained its position in the second quartile for ED performance nationally during December, which was a remarkable achievement and testament to the hard work of colleagues across the organisation. Planning guidance for 2025/26 had been announced which included a focus on improving referral to treatment compliance for elective and cancer patients and for ED patients being seen within 4 hours. Achieving these targets within financial constraints would be challenging and the Trust was looking at how it could do things differently while continuing to ensure that safety was at the core of all decision making. The ACEO noted that there had been a question submitted prior to the meeting about whether patient stakeholders had been included within the appointment process for the new Chief Executive. He explained that they had not been, but that the Trust had worked with a range of stakeholders to ensure an external perspective was heard. He echoed the Chair's disappointment in the news about the delay to NHP. Richard Meddings, the Chair of NHSE, had recently visited the Trust; he had a professional interest in frailty and was keen to look at the work the Trust had been undertaking. Colleagues had walked him through a patient's journey, discussing the challenges that were faced and he had visited the Sussex Surgical Centre (SSC). Following the visit, he had written to the Trust to say that he had been impressed by the work that the Trust was doing and would be reporting this back to the NHSE Board. The	

	Trust was very grateful for the visit and had been pleased to be able show all the good work that was being undertaken. National apprenticeship week had recently taken place; there were around 170 apprentices in the Trust, helping the Trust to grow its own skilled staff in areas where their were staffing challenges. The ACEO explained that a lot of hard work had gone into growing the apprenticeship programme in the Trust and he was very proud of what had been achieved. The Trust was developing an expanding network of Vascular Access Champions; the vast majority of patients who came to hospital required a vascular access device or vascular procedure and the work that was being undertaken was delivering training, standardising practices, reducing infections and leading to an improved service. The success of the network had been celebrated regionally. Carys, NED asked whether there would be an impact on safety and quality following the introduction of discharge choice policies. The CNO explained that conversations with patients and loved ones about discharge options at an early stage were crucial. This could be challenging to do when patients were clinically unwell. The COO reported that an embedding plan was being developed to support the introduction. ***The Board noted the ACEO's report.***	
09/25	**Board Committees Chairs' Upwards Reports** <u>Audit Committee</u> Paresh, Vice Chair presented his report reporting that the finance team were working closely with external auditors to agree processes for the annual year end audit. The Committee would be reviewing the Board Assurance Framework (BAF) to ensure a better alignment with corporate risk with discussions about this due to take place in March. <u>Finance and Productivity Committee</u> The CFO presented the Finance and Productivity Committee's report. He reported that the Committee had discussed the Trust's Bed Strategy and had looked at business planning guidelines for 2025/26. They had also discussed the Trust's confidence that the Trust's capital plan would be fully delivered in year. <u>People and Organisational Development Committee</u> Carys, NED presented her report. <u>Quality and Safety Committee</u> Amanda, NED presented her report. She reported that a consolidated Committee meeting had taken place in January due to the organisational pressures and commended staff on continuing to keep patients safe during this incredibly busy period. ***The Board noted the Committees Chairs' upward reports.***	
10/25	**Integrated Performance Report (IPR) for Month 9 (December)** The IPR was jointly reported by the CNO, CMO, ACPO, CFO and COO. <u>Quality and Safety</u> The CNO presented the update. Highlights from this section included: • Key KPIs had remained stable in December and into January, despite this having been an incredibly busy period and the CNO thanked all of the Trust's staff for all the had done to continue to keep patients safe. • There were concerns about sustaining this good performance due to the continuing pressure on services and colleagues. There were around 180 patients who remained stranded in the Trust. Internal actions to address this	

were being undertaken, but this placed a significant ongoing pressure on the organisation.
- Planned transformation work had slowed due to the challenge of managing significant additional capacity and ward moves. It was hoped that once this pressure eased that colleagues would be able to refocus on transformational work.
- The Trust's new Mental Health Head of Nursing had started in January and was already having an impact. She was recruiting the rest of the Mental Health Outreach team and would be asked to present to the Board in the future about the work that she was doing.

Carys, NED asked whether stranded was the correct term for patients who were not able to be discharged from hospital. The CNO explained that she felt it was a more appropriate description than 'no criteria to reside' as patients remained in hospital through no fault of their own. Carys, NED, asked what support was given to colleagues who were caring for stranded patients and the CNO explained that not being able to discharge patients when they no longer required acute care was frustrating for staff. The Trust recognised that it could do more to support patients, including reconditioning work while they were in hospital. The number of stranded patients had impacted on the Trust's ability to manage recent pressures and had meant that additional capacity had needed to be opened, and some patients had needed to be cared for in corridors, leading to an experience that neither staff nor patients wanted. There were ongoing conversations with system partners to resolve the issue and it was a key priority for all the organisations in the system. The Trust was focusing on preventing unnecessary admissions to hospital as this would help to reduce the number of stranded patients.

Steve, Chair noted that when he had joined the Trust in 2019 there had been around 75 stranded patients, which had seemed high. The number had got as high as 240, but was now consistently around 200. The issue had been exacerbated by the collapse of the social care market during the pandemic and recent action plans and interventions had not made a difference despite the hard work of everyone involved. The situation was not good for patients, families or relatives, was costly for the Trust, disruptive for staff and was not the fault of any of the patients who were stranded in hospital. The COO agreed, explaining that the ICB's discharge group had been reinvigorated to try to help address the issue. It had been nationally recognised that stranded patients were a particular challenge in Sussex. The ACEO reported that the Trust was always looking for ways to improve the situation and was receive national support to do so. The lead for the national discharge team had been invited to visit the Trust to help identify if more could be done.

Amanda, NED noted that while the Trust was not able to solve the problems that were faced by social care it was able to make recommendations that could help; remarkably quick improvements had been seen during the pandemic which had demonstrated that quick change was possible. Stranded patients would continue to be a growing problem until this was resolved. The ACEO agreed, explaining that it was an incredibly difficult challenge to resolve. Further actions that the Trust planned to take included cohorting stranded patients into the same place, with responsibility for their care stepped down from consultants to GPs. The Trust was also working with a local college to look at how apprenticeships could create a more social environment for patients to normalise bringing patients together, with increased therapies to help manage deconditioning. The number of stranded patients equated to eight wards worth of patients, but despite this challenge the Trust continued to work to provide the best possible care in the best possible environment for patients.

Amber, ANED asked whether there was an educational piece of work for system colleagues in preventing people from coming to hospital. The CNO explained that this was a focus of ICTs and of the system's prevention agenda. There were opportunities to reduce admissions for patients with Urinary Tract Infections (UTIs) or who had fallen when they did not need to come to hospital and there needed to be a shift towards

treating patients in the community where this was appropriate. There were 1,000 care homes in Sussex and the Trust and system partners were trying to reach out to them to offer advice and guidance that could prevent admissions.

Frank, NED noted that he was pleased, given the number of patients in hospital, that infection control performance had been maintained. He asked what more could be done to keep staff and patients safe given anticipated pressures in 2025/26. The CNO explained it was not always possible to isolate patients as quickly as the Trust wanted to, but staff worked tirelessly to manage this and good relationships between teams were one reason why the Trust did so well. The COO noted that the Trust had a team who worked with care homes to provide support and the work of CHIC also complemented this approach. Work was being done to look at out of hours and weekend support for patients as not all services were available all the time.

The CMO reported that mortality metrics remained under close scrutiny. The Summary Hospital-level Mortality Indicator (SHMI) had been 102 in August 2024, the last reporting period, and remained comfortably within the expected range. SHMI data was released quarterly and was rebased each time it was published, so Trusts need to continually improve in order to remain within the expected range. The Trust was ranked 34th out of 120 acute trusts nationally for Risk Adjusted Mortality Index (RAMI). A review of the deprivation of patients being admitted against mortality data had been undertaken which had found no increase in mortality for more deprived groups. Excess deaths were looked at on a monthly basis by the Trust's mortality group and clinical outcomes group. Stroke mortality in the Trust was reducing. The Trust's mortality at weekends was lower than on weekdays.

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

- The Trust's vacancy rate remained low at 2.7%. High levels of applications for jobs continued to be seen.
- The Trust was continuing its focus on reducing the use of agency staff, although there would be an increase in January and February due to increased sickness.
- A sickness reduction group was looking at the drivers for long term sickness and interventions that could be offered to keep colleagues well and get people back to work. There were no colleagues absent from work for over 365 days.
- Mental health as a cause of sickness remained high; data was being utilised to put mental health first aiders in the right areas to help address this. Areas with high incidences of violence and aggression were being reviewed to understand the impact this might have on sickness levels.
- Appraisal and mandatory training rates were slowly increasing. Areas which were underperforming were being offered support.

Paresh, NED congratulated the ACPO on the improvement to mandatory training rates, noting that there were the best ever reported. He asked whether the 10% staff turnover rate was considered to be the new normal. The ACPO explained that this was being used as the new baseline figure. Carys, NED explained that POD had discussed staff turnover and was concerned about high turnover in particular areas which were being reviewed. The ACPO explained that pockets of high turnover were monitored by divisions with interventional support provided where appropriate.

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

- Performance against the four hour A&E standard had fallen to 68.8%, reflecting recent operational pressures. There had been 14,566 A&E attendances in the month, with over 10,000 patients treated in under four hours. Performance had subsequently improved and had been 72.7% in February to date.
- 55 patients had waited more than 65 weeks for elective treatment in December, with the Trust remaining on its trajectory of having no patients by the end of March despite transferring 1,600 patients from another provider.

- Improvements in cancer performance were reported and the Trust remained on target to meet all of the cancer standards by the end of the year.

Steve, Chair noted that treating an additional 1,600 patients while maintaining performance was an outstanding achievement. He congratulated and thanked all the colleagues who had been involved in achieving this.

Carys, NED asked what lessons had been learned from the recent winter period which would be taken forward to the following year. The COO explained that a meeting to identify learnings was due to take place shortly; winter was challenging every year and the quademic had been particularly demanding to manage as the Trust had not experienced this before. The ACEO explained that he was proud that, despite the pressures that had been experienced, elective activity had continued throughout the winter period.

Paresh, NED, asked whether there was a way of quantifying numbers of patients who should not have attended A&E so that this insight could be shared with system partners. The COO explained that this information was already collected, and that type three attendances (such as those to the Urgent Treatment Centres (UTC)) had significantly increased. Conversations had taken place with primary care providers who had also seen greatly increased activity and the Trust was looking at how the UTC model could be adapted to reduce the impact of the increased attendances.

Financial Control and Capital Development

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

- Financial performance in December had been driven by organisational pressures, including increased patient numbers, additional bed capacity and increased length of stay.
- The Trust's year to date deficit was £12m, against a deficit target for the year of £14m.
- The Trust had recoded a £2.3m deficit in December, a £1.4m deficit against the planned position for the month. This run rate was not sustainable for the rest of the financial year and the Trust would focus on improving elective capacity and reducing agency and bank spending.
- Capital availability for 2024/25 had increased significantly to £70m which meant that the Trust would need to spend 60% of the annual capital in the final three months of the year. He anticipated that the Trust would fully utilise the capital allowance by the end of the year.

Steve, Chair asked whether the Trust's recent focus on improving the monthly run rate had resulted in improvements. The CFO reporting that the Trust continued to expect to meet the £14m deficit target; some improvement had been achieved to the monthly run rate in January, but further improvements would be required in February and March in order to achieve this.

Amanda, NED noted that a large improvement was required to meet the £14m deficit target and asked what the consequences would be for not achieving this. The CFO reported that the Board had previously discussed recognising a VAT ruling which would provide a £2.5m benefit to help the Trust meeting its annual target, but recognised that there was a risk that the target would not be delivered. The delivery of additional activity and reduction in bank, agency, security and 1:1 nursing costs would help to deliver the position. Steve, Chair noted that it was essential that the Trust delivered against its annual financial target.

Frank, NED asked whether the Trust was doing everything that it could to manage its finances, with grip and control measures fully implemented. The ACEO explained that the Trust was as confident as it could be that it was doing all it could to meet financial targets. Every new recruitment, use of bank and agency staff and use of additional lists

	was reviewed and he was confident that the controls that had been put in place were making a significant difference to financial performance. The Trust was using 277 less whole time equivalents each month as a result of controls, ensuring that the right people were available in the right place at the right time. The COO noted that positive conversations had taken place with divisions about their anticipated end of year financial positions. Paresh, NED noted that some capital invoices were expected in the last quarter of the year; auditors were aware that this was happening. There was always a 'hockey stick' effect as capital was spent in year due to the way that the Trust received this funding. Amanda, NED noted that the Trust had always been clear that safety would not be comprised as a result of financial pressure; she asked for assurance the processes considered money, quality and safety. The ACEO confirmed that this was the case. He explained that the Trust had inevitably had to stop doing some things in order to meet financial targets, but was not willing to compromise on safety in any way. ***The Board noted the Integrated Performance report.***	
11/25	**Avoidability of Inpatient Deaths** The CMO presented the report, explaining that it was a mandatory quarterly report to Board. A selection of deaths under specific criteria were reviewed and discussed by medical examiners who looked at all aspects of the patients' care to identify whether there had been any avoidability. In the last quarter, one patient death had been assessed as probably avoidable; this had been for a patient with significant cancer where the patient's life could have been prolonged. No other avoidability in patient deaths had been identified during the period. Frank, NED, noted that the report mentioned delays in assessing 15 cases dating back over the last two years and asked what had led to these delays. The CMO explained that the Trust's mortality analyst had sadly passed away; no-one had filled the role for some time resulting in delays. A new member of staff had now taken over the role, and processes had been strengthened to ensure that there was no longer a single point of failure. There had also been delays as a result of the lag in receiving independent reviews relating to deaths of patients with learning disabilities. ***The Board noted the Avoidability of Inpatient Deaths report.***	
12/25	**Update on the New Hospital Programme following the Government's review and conclusions** The ACEO reported that the outcome of a review by the new government of the New Hospital Programme (NHP) had been released in January. ESHT had been placed into wave three, delaying the start date for investment to 2037-39, although with a higher than expected financial envelope of £1.5-2 billion. The Trust had a significant backlog of estates and critical infrastructure that needed addressing, including key functions such as the electricity supply. Reprioritising of capital would need to take place to identify how the critical infrastructure backlog would be managed and how services would be developed before 2037. The Trust had written to the Integrated Care Board (ICB) and the region, and had met with NHP leaders, setting out concerns and disappointment about the announcement. The challenges faced by the Trust had also been discussed with three south coast MPs. The Trust had asked for support to address specific challenges, including capital that had been spent in preparation for NHP that could no longer be capitalised and would become revenue; assurance had been received that this would not have an affect on the Trust's financial performance. Areas of critical infrastructure where investment was required as soon as possible had been identified, along with areas where the estate was no longer fit for purpose, including integrated emergency floors and ability to deliver	

	urgent and emergency care. The Trust had outgrown its current estate which had not been built to manage the levels of activity that were currently being experienced. A short impact assessment had been submitted to NHP which would lead to a wider piece of work which would be shared with the Board. Work was ongoing with NHS and NHP partners to identify how the Trust would manage the issues. The ACEO noted that the Trust had benefitted from a fantastic team who had been working on NHP for some time, but had been asked to close this down with immediate effect. The Trust was doing all it could to support and redeploy the team and to utilise their skills to develop services in the organisation. He thanked the team for all that they had done, noting that he felt for them as the work that they had been preparing for would now not be completed within many of their working lives. Carys, NED thanked the team on behalf of the Board, recognising the amount of hard work that they had done in preparing for NHP. She noted that their skills would be very helpful to the organisation moving forward. ***The Board noted the Update on the New Hospital Programme***	
13/25	**Sussex Surgical Centre** The COO presented a verbal update on the Sussex Surgical Centre (SSC). She explained that there would be a slight delay in the handover of the building to the Trust due to construction issues and this was now due to take place at the end of May. Activity was expected to increase moving into June which should ensure that the delay would not affect planned activity. The DEF invited Board members to visit the building as it was practically complete with only some technical commissioning matters awaiting finalisation. ***The Board noted the Update on the Sussex Surgical Centre***	
14/25	**Fire Enforcement Notice Update** The DEF presented an update on the Trust's progress in complying with the Fire Enforcement Notice issued by East Sussex Fire Service (ESFS) in April 2024 where five matters had been identified as needing to be addressed. The Trust had originally been given nine months to complete the work. This timeline had been revised in January 2025 as the original timescale had proved to be extremely challenging due to operational pressures. An updated plan had been approved by ESFS setting out the significant work that would be undertaken in the Trust over three years to address the issues which would lead to the Trust being fully compliant once completed. Steve, Chair noted that it had been beneficial to the Trust to have been given the time to undertake the work in a manner that minimised the impact on patients. The DEF agreed, thanking ESFS for recognising that the Trust needed to continue to care for patients safely while undertaking the work. Paresh, NED, asked whether any further work might be needed in the future. The DEF explained that the review by ESFS had been thorough, although there would inevitably be further issues that would need addressing in the future. The Trust had commissioned external assessments to try to ensure that all aspects of fire safety were being addressed during the programme of work. ***The Board noted the progress on the Fire Enforcement Notice***	
15/25	**Q3 Board Assurance Framework** The COS presented the Quarter 3 Board Assurance Framework (BAF) which set out the strategic risks to the organisation. The risk ratings for ten of the twelve risks had not changed in Q3. Conversations had taken place with Non-Executive colleagues about the 2025/26 BAF, including how to make it easier to read and a more dynamic document with critical risks devolved to Committees. ***The Board noted the Update on the Q3 Board Assurance Framework***	

16/25	**Annual Reports:** **1. Emergency Preparedness, Resilience and Response** The COO presented the Emergency Preparedness, Resilience and Response (EPRR) annual report, explaining that this had been presented to the last meeting of the Audit Committee. The Trust was now fully compliant with the requirements of the NHS EPRR framework, and she thanked the team for their hard work in achieving this. Steve, Chair noted that emergency preparedness was crucial when it was needed and often went under the radar when it was not. He was pleased to see the progress that had been made. Frank, NED praised the work that had been done, and was pleased to see that it had been recognised that more work was required to develop business continuity plans in the organisation and the actions being taken to remedy this. **2. Trust Charity Annual Report and Accounts** Paresh, Vice Chair presented the Trust Charity's annual report and accounts. He explained that these had been approved by the Charity's Trustees and submitted to the Charity Commission ahead of the submission deadline of 31st January. He noted the risk that existed around the investment of the Charity's assets, explaining that these needed to be kept within cash investments due to needs of the business. ***The Board noted the EPRR and Charity Annual Reports***	
17/25	**Use of Trust Seal** One use of the Trust Seal since the last Board meeting was noted.	
18/25	**Questions from members of the public** Steve, Chair reported that there had been a number of questions submitted to the Board prior to the meeting. Questions received from Mrs Walke would be answered by email following the meeting. A number of questions received from Mr Campbell ahead of the meeting had already been answered during the course of the meeting. Steve, Chair apologised to Mr Hardwick that a full response to a question he had asked about car parking at the AGM had not been provided. The DEF explained that the Trust reviewed car parking charges and operations on an annual basis and as part of the most recent reviewed had stopped offering patients 30 minutes of free parking as this had not been widely used. The Trust's parking arrangements were due to be reviewed again in April 2025 and a grace period would be discussed during this review. Mr Hardwick explained that it was possible to attend some appointments within the original 30 minute period; he noted that removing the grace period had also caused issued for the Friends of the hospital as members of the public could no longer easily drop off donations. The DEF thanked Mr Hardwick for his comments and agreed to feedback the results of the annual review of parking to the Board once this had concluded in April. Mr Hardwick asked whether the number members of public in attendance could be added to the minutes of each meeting. Steve, Chair agreed to review and consider this. Mr Campbell asked whether the Trust had seen any concerns raised under Martha's Law. The CNO explained that an update on the implementation of Call 4 Concern in the Trust was due to be presented to the Board in April. Only a tiny number of calls had been received and these had generally been about non-clinical concerns. Mr Campbell asked about the quality measurements that were applied to integrated processes to ensure the happiness of patients and staff remain happy. He asked how patients were asked questions about the service that they received and how staff	**CH**

	feedback was collected. The COO explained that the Trust received standard information from all services and this had been positive. Different questions could be answered if necessary to look at different if alternate assurance was required. Mr Steeples reported that he had undergone a total knee replacement three weeks before. Following his surgery he had been visited by the Joint Community Rehabilitation team; he praised the team explaining that he had had a very positive experience and had been well looked after. Mrs Burt reported that a friend of hers had recently been discharged from the Trust following a terminal cancer diagnosis and had not received support post discharge. She had sadly subsequently passed away. She explained that she felt that the Trust did not want to hear about times when things had not gone well. Steve, Chair passed on his condolences and explained that the Trust always wanted to hear about things that had not gone well as they provided an opportunity to improve. He noted that there was no way to respond to the specific concern that was being raised during the meeting. The COS and CNO explained that they would be happy to receive feedback about any concerns so that this could be investigated with outcomes formally fed back. Mr Brown explained that he had recently raised a concern with the Trust but had found getting answers in response to be very challenging. He asked whether the Board was concerned about this. Steve, Chair explained that the Trust followed a complaints process, which ensured that concerns and complaints were investigated in detail. The Trust always tried to get things right, but mistakes did happen. He recognised that the complaints process was not faultless and that it could sometimes take more time than was ideal, but assured Mr Brown that colleagues always endeavoured to be as engaged and open as possible when dealing with concerns. Mr Hardwick reported that he had recently been on holiday abroad where he had suffered an issue with his eye. He had sought treatment while on holiday but the issue persisted when he returned home. He praised the speed with which he had been given an appointment by the hospital, which had happened within seven days of his return. Steve, Chair explained that he was glad to hear that Mr Hardwick had received efficient service, and hoped that he would have a good outcome.	
19/25	**Agenda Forward Plan** The Board's forward plan was noted.	
20/25	**Date of Next Trust Board Public Meeting** Tuesday 29th April 2025	

Matters Arising from Public Board meetings

MEETING DATE	MINUTE NO:	ACTION	BY WHOM	BY WHEN	COMMENTS – INCLUDING ANY UPDATES
OPEN ACTIONS					
None					
NOT YET DUE					
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
25.02.25	18/25	Update on annual review of parking to be given to the Board following its conclusion in April 2025	Chris Hodgson	June 2025	Scheduled for June 2025
10.10.23	73/23	Consider how to increase the focus on community services data within the Trust IPR	Richard Milner	November 2025	<u>*12.12.23*</u> *Verbal update to be given in meeting* <u>25.02.25</u> *The Trust is 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 an upcoming Board Development Day.* <u>29.04.25</u> As part of the wider review of information flows and reporting, a revised approach to IPRs and data that is subsequently shared with sub-committees and the Board is expected to be in place from November

08.10.24	72/24	Executives were asked to reflect on how reporting to the Board could be improved moving forward.	Execs	November 2025	<u>12.12.24</u> *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.* <u>25.02.25</u> *Insightful Provider Board guidance would be used alongside KPIs and business objectives to ensure that performance reporting was correctly aligned and reported.* <u>29.04.25</u> As part of the wider review of information flows and reporting, a revised approach to IPRs and data that is subsequently shared with sub-committees and the Board is expected to be in place from November
ACTIONS COMPLETED					
None					

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:	Jayne Black, Chief Executive	**Presenter(s):**	Jayne Black, Chief Executive
Outcome/Action requested:	The Board is asked to note the Chief Executive's report.		

Executive Summary

Chief Executive's report

This is my first report to the Board and I wanted to begin by saying a big thank you to everyone that I have had the opportunity to meet – some of whom I'm meeting again after a few years away. I have felt a genuine warmth to my welcome, and particular thanks to Steve Aumayer who has acted into the CEO role since November last year.

I have been out and about in my first few weeks and can say with confidence that ESHT remains the friendly and engaging place that I recall. The resilience and commitment to care that I have seen so far makes me proud to be joining the Trust at this time.

I realise that we can always improve upon what we do, but in a year which promises to be perhaps the most challenging that the NHS has faced, we have a solid set of foundations at the Trust from which we can develop further.

Changes to NHS England and Integrated Care Boards (ICBs)

The announcement of the abolition of NHS England and consolidating its functions within the Department of Health and Social Care (DHSC) made national headlines in March 2025, along with changes more local to us.

Sussex ICB, in common with all 42 ICBs, is required to reduce operating costs by 50% by Q3 of this financial year (Oct-Dec 2025). The scale and pace of these cost savings created an ambitious environment within which all NHS provider trusts have been requested to reach a break-even position in this new financial year 2025/6.

Our financial plan to break even in 2025/6

In 2024/5 we delivered a £38M efficiency saving (the largest ever) but the costs of excess inflation and pay awards resulted in a £9M overspend.

As noted above, the pace and scale of the financial challenge for all NHS trusts is unprecedented and I can report that ESHT has agreed a 25/26 plan that meets the national requirement to break even. This is predicated on a 6.3% efficiency programme, which in absolute numbers is almost £50M.

This is a higher target than ever delivered in East Sussex. The plan uses non-recurrent savings to balance and, despite the challenges ahead for 2025/6, there is considerable optimism that on the basis of our current assumptions and analysis our 25/26 Plan is achievable. Updates on our progress will, of course, feature formally through the Trust Board during the year.

Changes to ESHT leadership team

This month we say farewell to Damian Reid, Chief Financial Officer, who is moving on to focus on new challenges after five years working for the trust. Damian is currently working with University Hospitals Sussex to help support them with their financial performance and will remain in this role until the end of June. We express our gratitude to Damian for the last five years and wish him every success in the future.

Ian O'Connor, who joined the trust last November as Financial Recovery Director, will step into the Chief Financial Officer role on an interim basis while we look to recruit to the permanent position.

Steve Aumayer returns to his role as Deputy Chief Executive, and takes on the leadership of our digital, performance assurance and business intelligence functions.

Richard Milner, our Chief of Staff, takes information governance into his portfolio, alongside his existing corporate governance responsibilities.

The above changes will enable our interim, and new substantive CFO when recruited, to focus on the delivery of our plans and the development of the finance function over what promises to be a challenging year.

Supporting colleagues to Speak Up and Speak Out

The national 'Too Hot to Handle' report last year highlighted that 50% of multicultural colleagues across the NHS felt unable to report discrimination. Recognising the urgency of these concerns, the trust's inequalities board sub-committee initiated work to ensure that every colleague feels safe, supported and empowered to speak up.

Listening events were held at Conquest Hospital and Eastbourne DGH for all staff network members and a total of 173 participants came to an event or completed the anonymous survey. In total we reached 33% of our network membership.

Following the presentation of the outcomes from these events to the Board in December 2024, we established a task and finish group to oversee the implementation of key actions to address the key themes raised. Key areas underway include:

- Ensuring reporting procedures are accessible and clear-to-follow
- Strengthening communications around workplace behaviour expectations
- Supporting staff with training that empowers individuals and teams
- Enhancing leadership accountability to reported issue
- Supporting divisions to align their priorities with insights from our Staff Survey

This work aims to deliver real change over the next six months and foster an environment where all colleagues feel respected, supported and empowered to speak up.

Transforming stroke recovery – a pioneering collaboration in rehabilitation

An innovative pilot programme in the Irvine Unit in Bexhill is revolutionising the way stroke rehabilitation is approached, offering improvements to patient outcomes and healthcare provider collaboration.

Funded by Active Sussex, in partnership with the trust, Active Rother, East Sussex Public Health, and 20/20 Health, this landmark project aimed to address the detrimental effects of inactivity among stroke patients. The first phase of this transformative project was celebrated on 7 March 2025, marking an important milestone in its journey.

The pilot provided 26 weeks of supervised physical activity sessions led by health instructors from 20/20 Health, alongside trust physiotherapists. As well as the activity at the Irvine Unit, the initiative also supported patients in transitioning to community-based exercise programmes to ensure long-term, active lifestyles.

Patients have benefited from four sessions a week in the hospital, as well as community-based provision in Hastings, Bexhill, Lewes and Eastbourne.

The activity groups increased access to physical and social activity for patients recovering at the Irvine Rehabilitation Unit, contributing to their mood, wellbeing and a positive culture across our workforce.

This pilot has also tested how we can work with non-NHS partners in traditional NHS environments, paving the way for greater confidence in this approach. The Active Sussex Reconditioning Pilot serves as an exemplar of what we can achieve working together.

Improving obstetric bleeding research study

We are one of 40 trusts taking part in an OBS UK research study to implement a new childbirth care bundle that helps to recognise bleeding early and to standardise the treatment of heavy bleeding during childbirth.

Patients will be given usual NHS care for bleeding during childbirth but in addition receive the OBS UK care bundle. The bundle adds an assessment of everyone's bleeding risk before and during labour, real-time measurement of blood loss after births, a consistent method of involving more senior doctors and midwives and a bedside test to quickly identify and treat abnormal blood clotting. The use of quality improvement systems will make sure all training is standardised and that the OBS care bundle is being implemented correctly.

The trust's OBS UK delivery team were also highly praised at the recent OBS UK National Symposium held at the Royal College of Surgeons in Birmingham, where the team had a unique opportunity to consolidate the QI methodology, they have undertaken to embed the bundle into the unit and also meet other UK sites that are also in their implementation period.

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.		

Report to:	Trust Board	**Agenda Item:**	9.1
Date of Meeting	29th April 2025		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the Audit Committee on 27 March 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

- £435k had been saved from a waiver in relation to Medtronic.
- A challenge was raised that generator hire should be via call-off arrangements rather than waivers, as this was a common need. It was noted that colleagues in Estates and Facilities had received training about the tendering process to help minimise the need for waivers.

Internal Audit Plan 2025/26

- One area to be explored within the plan was rostering, with focus on the use of agency workers and achieving safe staffing levels whilst maintaining flexibility.
- The Committee advised that an audit of discharges could be valuable, either to find areas for improvement or evidence good practice to the wider system.
- A planned review of the Board Assurance Framework (BAF) could potentially be moved earlier than January 2026 (as drafted), depending on outcomes from related work which would be finalised over the coming weeks.
- The Committee approved the workplan, subject to the revisions discussed.

Counter-Fraud Specialist Service Report Plan 2025/26

- The plan included targeted awareness, training, and proactive reviews. Some areas of proposed focus included Healthroster, as well as compliance benchmarking for tenders and waivers. The plan was approved by the Committee.

External Audit Plan 2024/25

- The plan included consideration of potential risks related to assets under construction, as well as the delay of the Building For our Future programme.
- The materiality threshold for the audit had increased from 1.5% to 19.9%.
- Financial sustainability would be carried forward from the previous year's audit as a possible significant risk
- Discussions would take place about whether certain depreciated assets should be written out of the accounts. The Trust advised that the materiality of these assets was small.

Data Protection and Security Toolkit (DSPT) Update

- The Trust had increased its DSPT compliance from 45% (at the interim submission in December 2024) to 61%.
- Twelve of the assertions made by the Trust would need to be audited by RSM as part of the usual annual process.
- Requirements were more stringent than in previous years and full compliance was unlikely, but ESHT's position would be very common among NHS organisations and was felt to be good overall.

Review of Accounting Policies and Accounting Estimates

- There had been no significant changes to the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) for 2024/25. The Committee noted the accounting estimates and were satisfied that they were appropriate.

Audit Committee Terms of Reference (ToR)

- A draft version of the updated ToR was presented. Proposed amendments were discussed, and an updated version would be circulated for the Committee's approval via email. These would then be submitted for formal approval by the Trust Board in April.

Alert, Advise and Assure

Alert

None.

Advise/Inform/Update

Update to the Standing Financial Instructions

It was highlighted that the Board had agreed to update the SFIs to allow the Trust Chair to sign contracts and tender waivers in addition to the Chief Executive and Chief Finance Officer. Any two of these three roles could sign contracts valued at over £2.5m and tender waivers over £160k. This contingency would remain in place until the SFIs were updated later in the year.

Draft Annual Governance Statement (AGS)

Work has begun on updating the AGS and this would be circulated electronically to Committee members in mid-April for comment.

Assure

Head of Internal Audit Opinion

A positive overall opinion was expected at year-end, with some areas for improvement noted.

External Audit Questionnaire Responses

The Committee noted ESHT's responses to the two key questionnaires provided by external auditors to inform their work:

1. Inquiries of Management and those charged with governance (TCWG)
2. Accounting Estimates

It was noted that achieving better compliance around declaration of interest statements was important to give assurance and further mitigate fraud risk.

Key Risks or Opportunities and their impact on the Trust

None.

Key Decisions

None.

Exceptions and Challenges

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

- The Committee proposed that the focus of BAF 4 should move from in-year finance to continual optimisation so medium-term targets and risks were better reflected.

- There was discussion about whether the relatively low risk-scoring for BAF 11 could be justified based on the available assurance. It was agreed this should be reviewed.
- Given known and potential developments at system and regional level, the scope of BAF 1 would need to be updated for the coming year.
- It was noted that Corporate Risk Register (CRR) risks had not yet been allocated to the various Board subcommittees. This work would be important to developing a more proactive approach to risk.

Recommendations

The Board is asked to note this report and to formally approved the attached updated Committee Terms of Reference.

Audit Committee

Terms of Reference

East Sussex Healthcare NHS Trust

1.	**Constitution**
	The Board hereby resolves to establish a committee of the board to be known as the Audit Committee ("the Committee"). The Committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.
2.	**Purpose**
	The Audit Committee will support the Board with its oversight responsibilities and independently and objectively monitor, review and report to the Board on the adequacy of the processes for governance, assurance, and risk management on which the Board places reliance, and where appropriate, facilitate and or support through its independence, the attainment of effective processes. It will seek assurance that financial reporting and internal control principles are applied, and maintain an appropriate relationship with the organisation's auditors, both internal and external. This includes the power to review other committee's work, including in relation to quality, and to provide assurance to the board with regard to the reliability and robustness of internal controls. The Committee will agree and work to an annual programme that takes into account the need to contribute to the timely sign-off of statutory requirements such as the annual accounts. This programme will be reviewed by the Board. The Committee may be commissioned by the Board to undertake particular studies or investigations, or to focus attention on any matters relating to finance and investment as the Trust Board thinks fit.
3.	**Membership and Quorum**
	The Committee shall be appointed by the board from amongst its independent, non-executive and associate non-executive directors and shall consist of not less than three members. One of the members will be appointed Chair of the Committee by the Trust Board Chair. One member should also be a member of the Quality and Safety Committee and one member a member of the Finance and Productivity Committee. At least one member of the Committee should have recent and relevant financial experience. A quorum shall be two of the three independent members. One of the members will be appointed chair of the committee by the board. The Chair of the Board shall not be a member of the Committee.
4.	**Attendance**
	Attendees to include: - Chief Financial Officer - Chief Nurse - Chief of Staff or their nominee - Representative of Internal and External Auditors - Counter Fraud Specialist shall attend at least two meeting in the year (to be agreed with the Committee Chair) The Chief Executive Officer may be invited to attend meetings and should discuss at least annually with the Audit Committee the process for assurance that supports the Annual Governance Statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts. Other executive directors/ managers may be invited for specific agenda items, particularly of matters of relevance with regard to risk or operation that are the responsibility of that director/ manager.

5. Access

The Heads of or representatives of both internal and external auditors, counter fraud specialist and the security management specialist have a right of direct access to the chair of the Committee.

6. Frequency

Meetings shall be held not less than four times a year and at such other times as The Chair of the Committee, Board, Chief Executive Officer/ Chief Financial Officer, External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

At least once a year the Committee shall meet privately with the internal auditors, external auditors and LCFS either separately or together without the presence of management. Additional meetings may be scheduled to discuss specific issues if required.

To assist in the management of business over the year an annual workplan will be maintained in the light of the frequency of meetings to allow for discharge of all the Committee's responsibilities.

7. Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference and in line with the Committee's prime purpose of providing assurance to the Board.

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

8. Duties

8.1 Governance, Risk Management and Internal control

The Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- the board assurance framework, risk management system, Annual Governance Statement together with an accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible
- the information governance system, including requirements under the Data Security & Protection Toolkit (DSPT) and progress in implementing the General Data Protection Regulations (GDPR)
- the rigour of the processes for producing the quality accounts, in particular whether the information included in the quality account is reported accurately and whether the quality account is representative in its reporting of the services provided and the issues of concern to its stakeholders.
- the underlying assurance processes, the effectiveness of the management of principal risks and the appropriateness of the Annual Governance Statement
- the policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority guidance and Government Functional Standard 013: Counter Fraud.

- Standing Financial Instructions (SFIs) and Standing Orders (SOs) on an annual basis, and will receive reporting of any breaches to the SFIs or SOs as necessary.

- the Committee shall report issues in relation to audit, risk or internal control to the Board of Directors on an exception basis in addition to an annual report focused on the effectiveness of the Committee in exercising these duties.

- the Committee will be responsible for forming a panel to procure and appoint both internal and external auditors

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions.

It will also seek reports and assurances from officers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

8.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards (PSIAS) and provides appropriate independent assurance to the Committee, Chief Executive and Board. The Committee will approve the appointment of any new internal auditor for the Trust. This will be achieved by:

- Consideration of the provision of the Internal Audit Service, the cost of the audit and any questions of resignation and dismissal.

- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that it is consistent with the audit needs of the organisation as identified in the Assurance Framework and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

- Review of the major findings of Internal Audit work, management's response and the implementation of management action

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.

- An annual review of the effectiveness of internal audit.

8.3 External audit

The Committee shall review the work and findings of the External Auditors and consider the implications and management's responses to their work. The Committee will approve the appointment of any new external auditor for the Trust. This will be achieved by:

- consideration of the appointment and performance of the External Auditor as far as the rules governing the appointment permit.

- discussion and agreement with the External Auditor, before the audit commences on the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate with other external and internal auditors in the local health economy.

- discussion with the External Auditors of the local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

- review of all external audit reports including agreement of the annual audit letter before submission to the Board for any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

8.4 Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of Counter Fraud work.

8.5 Other assurance functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include but will not be limited to reviews by:

- Department of Health
- Care Quality Commission
- NHS Resolution
- Other regulators and inspectors
- Professional bodies with responsibility for performance of staff or functions including Royal Colleges and accreditation bodies
- The Trust's internal assurance function

In addition, the Committee will review the work of other Committees within the organisation whose work can provide relevant assurance to the Audit Committee's own scope of work; in particular this will include the Quality and Safety Committee and the Finance and Productivity Committee. In reviewing the work of the Quality and Safety Committee and issues around clinical risk management, the Audit Committee will wish to satisfy itself that appropriate assurance that can be gained from the clinical audit function and to take the advice of the Quality and Safety Committee on how this function should best be utilised. The Audit Committee will also receive and review annual reports from the board's committees in support of the annual governance statement prior to them being submitted to the Board.

The Committee will provide assurance to the Board that the Trust is properly managing its cyber risk including any appropriate risk mitigation strategies. The Committee will receive reports that controls are in place for, protect from, and respond to cyber-attacks including management of the consequences of a cyber-security incident. The Committee will satisfy itself that there is a capable management resource and receive assurance that the Trust has an incident response plan in place to deal with cyber security matters and ensure staff have been duly truly trained about cyber security.

8.6 Hosted arrangements

The Committee will, on an exception basis, review and provide assurance to the Board in respect of any hosted arrangements or services, both those services hosted by the Trust and also those services hosted elsewhere but to which the Trust is a party.

8.7 Management

The Committee shall request and review reports and positive assurances from Directors and Managers on the overall arrangements for governance, risk and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example clinical audit) as they may be relevant to the overall arrangements.

8.8 Financial reporting

The Committee shall monitor the integrity of the financial systems of the Trust and systems of financial control.

The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.

- changes in and compliance with accounting policies and practices.

unadjusted mis-statements in the financial statements. Significant judgments in preparation of the financial statements.

- Significant or proposed adjustments resulting from the audit
- Qualitative aspects of financial reporting; and
- The rigour with which the Auditor has undertaken the audit.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Committee shall maintain responsibility for overseeing and approving tenders and waivers within the Trust. The Committee shall approve any potential writes offs of aged debt when these are not considered to be recoverable.

8.9 System for raising concerns

The Committee shall review the Trust's arrangements for its employees to raise concerns, in confidence, about possible wrongdoing in financial reporting and controls, clinical quality, patient safety or other matters. The Committee shall ensure that the arrangements allow for a proportionate and independent investigation of such matters and appropriate follow ups and reassure individuals raising concerns about protection from any negative repercussions.

8.10 Collaborative Working

The Audit Committee will seek clarity and understanding around what the local arrangements are for collaborative working having regard for the Trust as a sovereign entity. The Committee will seek to understand the clarity around arrangements about shared decision making arrangements, accounting and any proposals to agree on risk appetites and tolerance.

9. Reporting arrangements

Minutes of the Committee meetings shall be formally recorded by the Company Secretary, or their nominee, and submitted to the Board. The Chair of the Committee shall present a short written summary of Committee meetings to the Board in order to draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness of purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and compliance with CQC registration standards.

The Committee shall undertake a self-assessment of its effectiveness on at least an annual basis and this will be timetabled into the schedule of audit committee business.

This assessment will follow best practice as outlined in the NHS Audit Committee Handbook and may be facilitated by independent advisors if the Committee considers this appropriate or necessary. A copy of the self-assessment and any proposed actions will be reviewed by the Trust Board.

These Terms of Reference shall be reviewed by the Committee and Trust Board at least annually.

East Sussex Healthcare NHS Trust

Report to:	Trust Board	**Agenda Item:**	9.2
Date of Meeting	29th April 2025		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the Extraordinary meeting of the Finance & Productivity Committee on 25 March 2025.

Background

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

Business Undertaken

Alert, Advise and Assure

The following were considered:

- A financial update, where performance of a £200k surplus against the plan for month 11 along with an anticipated year end position of a £9m deficit were reported. It should be noted that the surplus is as a result of technical adjustments, but run rate did improve in month 11 over month 10.
- An update on capital spending against the annual £71m plan was received and it was noted that spending was £640k below plan. Significant work has been undertaken to validate this number.
- The Ward Nursing Establishment Review for 2024/25 was presented and approved by the Committee. No increases in nursing budgets were recommended as part of the review. The Committee recommended that the Board should approve the annual Ward Nursing Establishment review.

Key Risks or Opportunities and their impact on the Trust

Key Decisions

Exceptions and Challenges

Recommendations

The Board is asked to note this report.

Report to:	Trust Board	**Agenda Item:**	9.3
Date of Meeting	29th April 2025		

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

Purpose

This report summarises the discussions, recommendations, and approvals made by the Inequalities Sub Board Committee on Thursday, 6th March 2025, to provide the Board with an update of the Committee's activities. The meeting was chaired by Mr Steve Phoenix.

Background

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

Business Undertaken

Patient Experience and Health Inequalities:

The Chief of Staff provided an update on three priority areas: improved ethnicity data collection, analysis of service use linked to deprivation (particularly through the Alcohol Care Team), and progress monitoring in relation to patient-level data and protected characteristics.

Further work was being undertaken with NHS Digital regarding the correlation between deprivation and mortality rates. Early findings are prompting the design of a potential patient questionnaire to gather more granular data. Similar work from cancer services, led by Dee Daly, is being used to explore trends in appointment attendance.

Concerns were raised about the impact of service cuts agreed by the County Council, particularly relating to addiction support services. These changes were expected to disproportionately affect the most deprived communities. An informal meeting has been arranged between the Chief of Staff and Public Health to assess these changes.

The Committee also discussed end-of-life care, and whether patients without familial support may face disadvantage. This will be explored further and reported on at the next meeting.

In response to the Committee's desire for broader awareness and accountability, the Chief of Staff will prepare a public-facing update for the Annual General Meeting to showcase progress in this space.

Workforce Equality:

The Committee received a presentation on the Transforming Workforce Behaviours initiative from the People Experience Manager. This programme is focused on improving staff experience, specifically addressing bullying, harassment and abuse between colleagues. It builds on the "Too Hot to Handle" report and is informed by regular data analysis.

The Committee was updated on HR drop-in sessions, which have been well attended, and on training development timelines. The Chair and Committee members encouraged a review of these timelines to accelerate rollout where possible. The importance of reinforcing that complaints lead to tangible outcomes was noted.

The Committee was briefed on plans for Inclusion Week in September, which will include the launch of an Allyship campaign, supported by video and a toolkit.

Network Updates:
Network leads presented their 2025 priorities. These included:

Women's Network: Growth in membership, educational sessions on menstruation, menopause and maternity, and a "period poverty" project rollout.

DisAbility Network: Increased allyship, new Vice Chair appointment, motivational speaker programme and communications improvements.

LGBTQI+ Network: Plans to relaunch training and events, based on survey feedback.

Neurodiversity Network: To be formally launched during Neurodiversity Celebration Week, following a successful subgroup trial.

The Committee acknowledged communications challenges and committed to exploring new routes including newsletters and digital noticeboards. The Trust's charity was highlighted as a potential source of funding for supporting network initiatives.

Career Progression and Talent Management:
An update was received on embedding inclusive recruitment processes, access to training, and understanding progression disparities. Data from the WRES and WDES indicators is under review. Early findings suggest that TRAC sickness metrics may influence disabled applicants' recruitment outcomes. A deep dive is underway.

Line manager training on inclusive recruitment is being expanded through additional sessions led by the Recruitment Team.

EDI High Impact Actions:

The Trust received positive feedback from NHS England on its response to the "Too Hot to Handle" findings and wider inclusion work. High Impact Action progress remains a priority, with some actions currently rated as amber.

The Ethnicity Pay Gap report has been completed, and a Disability Pay Gap report is in development. NHS England has asked the Trust to ensure all protected characteristics are considered in reporting and actions. A timeline is now in place for delivering the Talent Management strategy.

Black History Month Conference:

The Committee confirmed that the Trust will host the Black History Month Conference on Thursday 9th October at the CQ, in collaboration with the Multicultural Network.

Alert, Advise and Assure

Alert: Potential risk to service accessibility as a result of County Council service cuts.

Advise:

1. Deep dive into end-of-life care access and inequalities to be conducted.
2. Communications plan required to increase visibility of network activities and outcomes from inclusion work.
3. Allyship campaign toolkit and video to be produced for September launch.

Assure:

1. Positive trajectory in Health Inequalities data collection and service-level insight.
2. EDI High Impact Action work well embedded, with clear oversight.
3. Increased network activity and cross-network collaboration noted as a strength.

Key Risks or Opportunities and their impact on the Trust

Loss of County Council-led services risks increased inequality among deprived groups. Opportunity exists to use AGM as platform to visibly demonstrate progress and engage staff/public.

Key Decisions

Agreement to create public-facing update for the AGM.

Exceptions and Challenges

Some High Impact Actions remain amber.
TRAC system metrics may require adjustment to support inclusive recruitment.

Recommendations

The Board is asked to note this report.

Report to:	Trust Board	**Agenda Item:**	9.4
Date of Meeting	29th April 2025		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the People & Organisational Development (POD) Committee on 27 March 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 February 2025:

- **Turnover rate** continued to remain stable and within the parameters expected with a consistent 92% of all substantive colleagues choosing to stay at ESHT for more than 12 months (excluding rotations).
- **The Trust vacancy rate reduced by 1.5% to 0.6%** (43.5 wte vacancies). This was largely due to a significant reduction in the substantive budgeted establishment, in line with the Cost Improvement Programme, whilst contracted staff in post did also increase by 25.1 wtes, compared to January.
- **Monthly Sickness** - There was a significant reduction in the number of absences, although the sickness rate was still a little higher than this time last year (+0.3%), the monthly sickness absence reduced from 6.3% to 5.5% (0.8%).
- **The mandatory training rate increased by 0.3% to 91.8%.** Education continues to work with the Resuscitation Lead to improve BLS compliance but there are continuing issues with DNAs for this training.
- **The appraisal rate saw a small reduction**, which was expected as colleagues familiarised themselves with the online appraisal process launched this month.
- **Planned v's Actual WTE (whole time equivalent)** Overall workforce usage had increased by 81 largely in the escalation areas with temporary workforce slightly higher than substantive.
- **Ongoing efforts in workforce planning**, including aligning workforce plans with operational and financial recovery plans. The importance of making the best use of resources while maintaining patient care and safety

Alert, Advise and Assure

Health and Wellbeing

The Health & Wellbeing report had been circulated. The focus on tailored team support had been crucial, allowing for customised assistance in managing change and resilience rather than a generic approach. Continuing this, along with the wellbeing programme, which prioritised physical and mental health, remained a key priority guided by feedback and evaluation.

Flexible Working
The Flexible Working paper had been circulated. The progress made on flexible working was highlighted, noting the positive impact on staff survey results with staff feeling more comfortable discussing flexible working with their managers.

Neurodivergence
An update was provided on collaborative working for ESHT to become a more neuro-inclusive employer. Initially a workplace assessor had been proposed but this had been paused as it was decided to provide managers with the skills and offer them the opportunity for training to deal with their own workforce.

HRBP Update – Urgent Care
An update was provided on the Urgent Care division. Recent activity involved significant work on business and workforce planning for the upcoming financial year.

CPD Funding
The priorities for the following year included continuing to focus on leadership and management, particularly considering the government's decision to defund level 7 apprenticeships. The plan was also to move the study leave process to "My Learn," working with a new company to transition to an electronic system for better data management. However, there were risks to address, including the abolition of NHS England, whose impact remained uncertain, and funding issues affecting colleagues.

Guardian of Safe Working Hours (GOSWH) Report
Concerns raised about the medical workforce, particularly on the Conquest site, where junior doctors were overworked and unable to take leave, which had led to an increase in exception reporting.

The Committee was assured by the ACPO and the DCMO that immediate actions were being taken to address the medical workforce challenges.

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
BAF 2: Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time.
Risk scoring for BAF 2 had been reduced from 12 in Q3 to 9 in Q4 as a result of the further reduction in vacancies. Rostering Assurance paper to be shared at the next POD Committee.

The POD Committee agreed to the reduction of scoring for BAF 2. Assurance to be provided with a presentation of a Rostering Assurance paper as the next POD Committee.

BAF 3: Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.
The risk scoring for BAF 12 increased from 16 in Q3 to 20 in Q4. This reflected the decrease in engagement emerging from the 2024 staff survey results and the decline in some areas of the staff survey report within the People Promise scores.

The POD Committee agreed to the increase in scoring of BAF 3.

Exceptions and Challenges

N/A

Recommendations

The Board is asked to note this report.

East Sussex Healthcare NHS Trust

Report to:	Board of Directors	Agenda Item:	9.5
Date of Meeting	29.04.25		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the QSC on 26th March 2025 to provide the Board with an update of the Committee's activities.

Background

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

Business Undertaken

Integrated Governance Meeting
Key quality metrics remained largely stable during January and February.

Maternity Dashboard & Ockenden Perinatal Quality Surveillance Report
The report highlighted safe perinatal mortality and morbidity rates which were considerably lower than the national average. The trust is taking part in the OBS UK trial, which measures blood loss more accurately. It was noted that the trust is not an outlier for postpartum haemorrhage and that the rate has dropped in February.

Governance Quality Report
There is no immediate cause for concern from the incident reporting, it is well within the normal limits and encourages incident reporting when there has been no harm.

Infection Prevention & Control BAF (by exception)
The committee acknowledged improvement required with antimicrobial prescribing, education and training.

CQC Key Lines of Enquiry
Positive picture across the divisions with majority scoring good.

Martha's Rule
The Deputy CNO provided an update on Martha's Rule, noting the work done to increase awareness and access to the service. It was mentioned the need for ongoing publicity and the integration of Martha's Rule into the Weekly Patient Safety Summit.

The Committee also had a significant discussion about the impact of the significant high levels of activity on staff health and wellbeing.

Alert, Advise and Assure

Alert

None.

Advise/Inform/Update

Assurances

It was assured that following meetings with the team, the changes for the never event to happen again has been dramatically reduced.

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 February 2025 (Month 11)

INTEGRITY

Content

East Sussex Healthcare NHS Trust

About our IPR

East Sussex Healthcare NHS Trust

Our IPR reflects how the Trust is currently working and how the on-going journey of improvement and excellence, reflected within our Strategy and Operational Plan (2024/25), is being delivered.

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

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

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

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

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

Chief Executive Summary

East Sussex Healthcare NHS Trust

Priority for the Trust is 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.

Against a backdrop of increased demand for Emergency Department services, the Trust was able to achieve 72.1% for it's 4-hour Emergency Access Clinical Standard. The national target is 78% by March 2025.

The Trust has achieved trajectories for cancer 62-day pathway and Faster Diagnostic Standard for the last eight consecutive months.

Key Areas of Success

- In January, the Trust achieved 70.9% against a trajectory 64% for the 62-day cancer standard and 78.9% against a national target of 77% for the Faster Diagnostic Standard
- In February, Elective Recovery Fund activity achieved 121% of 2019/20 baseline, against a target of 123%
- 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 was 41 in February, against a trajectory of 80. More than half of these patients (24) were transfers from another Sussex provider as part of ESHT's support to reduce the number of long waiting patients across Sussex
- Sustainably delivering above target for our 2-hour urgent community response, despite a rise in demand for this service. In January, 82.4% of patients were seen within 2 hours, against a target of 70%.

Key Areas of Focus

- Deliver the ED improvement plan to recover performance
- The trust is planning to deliver a year end forecast deficit of £9m. 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
- Divisional and corporate plans have been worked up to deliver a breakeven position 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)		1014	864	866	Common Cause	Target required
Number of Patient safety events (severity 3)		20	23	10	Common Cause	Target required
Number of Patient safety events (severity 4 ...		6	8	5	Common Cause	Target required
Never Events	0	0	0	0	Improvement	Inconsistent
Inpatient Falls per 1,000 Bed days		5.16	4.55	5.04	Common Cause	Target required
Cat 3 ESHT Acq. PU (rate) per 1,000 bed days		0.0385	0.0421	0.0442	Common Cause	Target required
Cat 4 ESHT Acq. PU (rate) per 1,000 bed days		0.0770	0	0.0442	Common Cause	Target required
Healthcare Associated MRSA Bacteraemia (r...		0	0	0	Improvement	Inconsistent
Healthcare Associated C Diff Infections (rate)...		0.0770	0.211	0.133	Common Cause	Inconsistent
Healthcare Associated MSSA Bacteraemia (r...		0.116	0.126	0.0442	Common Cause	Inconsistent
RAMI	100	86.9	86.9	0	Improvement	Achieving
SHMI (NHS Digital monthly)	100	102	103	95.4	Concern	Inconsistent
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	92.8%	93.3%	90.0%	Improvement	Not Met

Patient Experience	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Complaints received		43	35	57	Common Cause	Target required
Complaints Response Compliance (60 w...		83.3%	80.6%		Common Cause	Target required
Reopened Complaints		9	10	4	Common Cause	Target required
A&E FFT Score	85%	82.2%	81.8%	96.2%	Improvement	Inconsistent
A&E FFT Response Rate		15.7%	14.3%	7.21%	Improvement	Target required
Inpatient FFT Score	95%	96.5%	96.3%	98.4%	Concern	Achieving
Maternity FFT Score	95%	97.6%	97.6%	100%	Common Cause	Inconsistent
Outpatient FFT Score	95%	94.9%	94.8%	98.4%	Concern	Inconsistent
Post Covid19 Assessment FFT Score	95%	0%	0%		Concern	Inconsistent

Our People	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Establishment (WTE) All		8,103	8,007	7,247	Concern	Target required
Agency Rate	3.6%	0.75%	0.607%	1.50%	Improvement	Achieving
Vacancy Rate	7.5%	2.1%	0.562%	9.65%	Improvement	Achieving
Staff Turnover	11.6%	10.5%	10.4%	10.1%	Common Cause	Achieving
Retention Rate	90%	92.1%	92.0%	91.5%	Common Cause	Achieving
Monthly Sickness - Absence %	4.7%	6.31%	5.50%	4.8%	Common Cause	Inconsistent
Sickness - Average Days Lost per Fte	17	19.5	19.6	16.4	Concern	Not Met
Staff Appraisals	85%	83.1%	82.5%	79.2%	Common Cause	Not Met
Statutory & Mandatory Training	90%	91.5%	91.8%	88.7%	Improvement	Inconsistent

Our Performance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
4 hour standard	75%	70.2%	72.1%	76.9%	Common Cause	Inconsistent
A&E > 12 hours from arrival to discharge	0	1245	1112	278	Concern	Not Met
A&E waits over 12 hours from DTA	0	129	76		Concern	Inconsistent
Conveyance handover >60 mins	0%	3.31%	3.25%	4.15%	Common Cause	Inconsistent
Non Elective Length of Stay	4.36	5.78	5.29	4.00	Common Cause	Inconsistent
Average daily NCTR	164	202	201		Common Cause	Not Met
Cancer 62 Day	64%	72.4%	70.9%	76.0%	Improvement	Inconsistent
Cancer 31 Day Combined		96.4%	94.9%	96.3%	Common Cause	Target required
28 Day General FDS	76%	82.8%	78.9%	74.6%	Improvement	Inconsistent
104 day Backlog	20	9	23	20	Common Cause	Inconsistent
Elective Activity (ELIP,DC,OPFA, OPFUP P...	122%	121%	118%		Improvement	Not Met
RTT under 18 weeks	92%	54.5%	55.5%	89.6%	Common Cause	Not Met
RTT 65 week wait	0	67	41	0	Improvement	Not Met
RTT Total Waiting List Size	55250	57698	57483	28485	Concern	Inconsistent
Diagnostic <6 weeks	1%	9.98%	8.06%	1.21%	Improvement	Not Met
Urgent Community Response within 2 h...	70%	82.8%	82.4%		Improvement	Achieving
CHIC wait times < 13 weeks	80%	83.0%	82.9%	64.8%	Improvement	Inconsistent
Intermediate Care Length of Stay	30	40.3	42.3	26.6	Common Cause	Inconsistent
% Discharges delayed 1+ days		24.3%	22.3%		Common Cause	Target required
Total delay days from monthly Discharges		5354	3685		Common Cause	Target required
Number of Deferred visits/ care plans	0	7934	6814	1331	Concern	Not Met

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

Finance	Target/ Limit	Previous Month	Current Month	1920 Same period	Variation	Assurance
Surplus/(deficit) (£'000) - In month	766	(1,334)	173	n/a	n/a	Not met
Surplus/(deficit) (£'000) - YTD	(1,049)	(14,181)	(14,008)	n/a	n/a	Not met
ERF (£'000) - In month	12,027	12,337	11,740	n/a	n/a	Achieving
ERF (£'000) - YTD	125,875	117,038	128,778	n/a	n/a	Achieving
Efficiency (£'000) - In month	5,198	4,991	3,028	n/a	n/a	Achieving
Efficiency (£'000) - YTD	31,009	28,884	31,912	n/a	n/a	Achieving
Capital (£'000) - YTD	40,662	34,978	38,183	n/a	n/a	Achieving
Capital (£'000) - FOT	71,228	71,583	70,836	n/a	n/a	Achieving

Constitutional Standards | Benchmarking

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

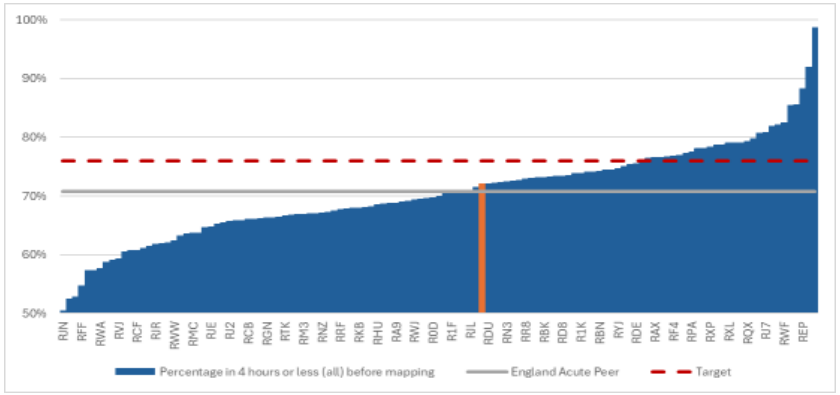
East Sussex Healthcare NHS Trust

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

February 2025 Peer Review

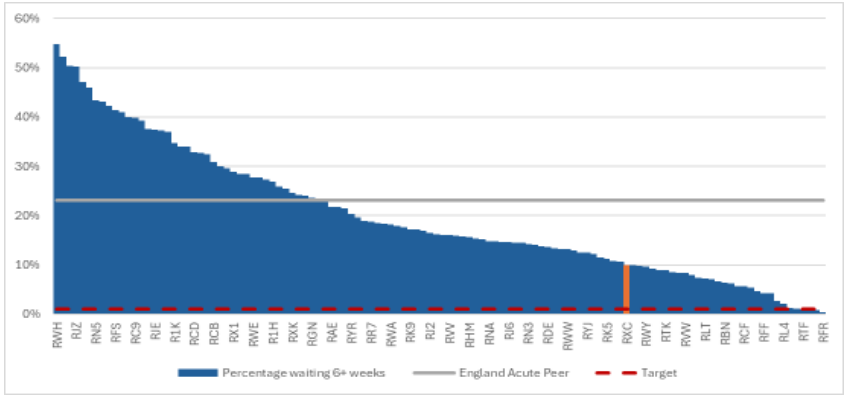
National Average: 70.8% ESHT Rank: 55/123



Planned Care – Diagnostic Waiting Times

January 2025 Peer Review*

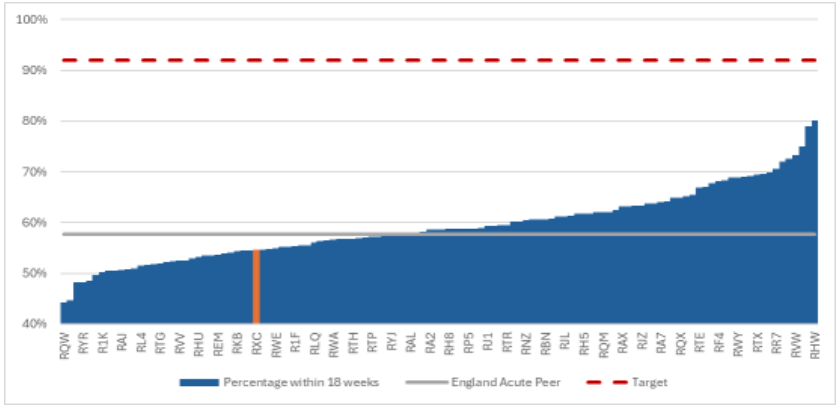
National Average: 23.1% ESHT Rank: 31/118



Planned Care – Referral to Treatment

January 2025 Peer Review*

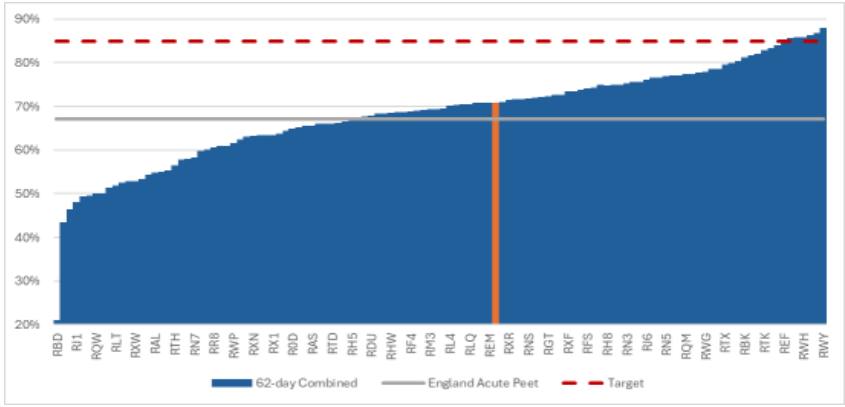
National Average: 57.7% ESHT Rank: 88/118



Cancer Treatment – 62 Day Combined Standard

January 2025 Peer Review*

National Average: 67.2% ESHT Rank: 51/118



Quality and Safety

Delivering safe care for our patients

What our patients are telling us?

Delivering effective care for our patients

Safe patient care is our highest priority

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

Quality and Safety | Executive Summary

East Sussex Healthcare NHS Trust

Infection Control
Healthcare Associated Infection limits have 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 83 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 February, the Trust reported five cases of CDI. Four HOHA and one COHA. One further case of 002 ribotype was identified at EDGH. There were no MRSA bacteraemias and three MSSA which were all community onset with prior healthcare; 2 COHA unavoidable due to pneumonia and endocarditis and one unknown source. Seasonal influenza (n=138) and Respiratory Syncytial Virus (n= 39) prevalence reduced during February. Norovirus circulated at low levels and was mainly confined to a bay on several wards.

Safety Events
968 incidents were reported in February 2025, comparable with the average numbers reported for ESHT only incidents. 96% of the total patient events were no harm/near miss, in line with the National average (96%), indicative of a good reporting culture at ESHT. Detailed reports are discussed at IGM regarding Medication Safety and a Falls deep dive is coming to April Q&SC. The CNO has requested a regular Falls and PU deep dive for IGM.

The top three categories for February 2025 remain the same as last reported in January: None were Severe / Fatal harm.

1. **Slips, Trips and Falls** – 145 reported incidents, all were No / Minor harm except one Moderate harm incident in ED EDGH.
2. **Medication Errors and other Medication Related Incidents** – 101 incidents reported, with none resulting in Severe / Fatal harm.
3. **Pressure Ulcer (ESHT Acute only)** – 81 incidents were reported, which is less than the average numbers reported for ESHT.

Harm
Three events reported in February 2025 - Two as Fatal (Severity 5), one as severe harm (Severity 4). The Major harm (severity 4) was confirmed as having no contributory factors when reviewed at WPSS, thus the level of harm changed to No harm (Severity one). The two reported as Fatal harm are being reviewed to validate level of harm.

Safeguarding
There continues to be challenges regarding compliance for Think Family level 3 training, however the latest data shows a slight increase on the previous month. The team are planning a safeguarding week of bite size training in May which will be advertised via communications.

The data collection processes across all safeguarding specialities is an area of difficulty going forward. One solution could be the use of AI to develop robust data portals, discussions are ongoing. In the meantime, the team can only capture data via spreadsheets which require a manual count and thus could have inaccuracies.

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 areas, mental ill health continues to feature. There is an emerging trend with neuro divergence seen as part of the picture in all age groups, in response to this workstreams on complexity and self-neglect have been developed.
There are an increasing number of Children In Care with monthly data submitted to the ICB regarding health assessments.

The Mental Health Outreach team recruitment is going well, and the new Head of Nursing is already making a very positive difference to patients and staff.

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 numbers were extremely small. The Trust received 35 new complaints, a decrease of 8 vs. January. Against our internal target (60 working days) 81% were completed in time (January =83%), 4 complaints were overdue at the end of February. Reviewing the monthly risk rating of all complaints, most were 'moderate' in common with the general pattern: 5 High (January =3), four cases have been discussed at WPSS and will continue to follow the complaints process, one case due to be discussed at WPSS, 20 moderate risk (January =28) where aspects of clinical care appear suboptimal and 10 low risk (January =12) where clinical quality does not form part of the complaint.

10 complaints were reopened (January =9), 5 in Medicine, 3 to DAS, 1 in Urgent Care and 1 in Corporate Services. Of the 35 complaints received in February 31% came from 2 categories: Clinical Treatment =11 and Patient Care =18.

Complaint locations in February; Emergency Department =10 (EDGH =5 and CQ =5), Baird ward =2, Wellington ward =2, Berwick ward =2, Glynde ward =2 and Westham ward =2.

581 contacts were recorded by PALS in February, which is a decrease of 79 when compared to January (=660). Of these contacts, 294 PALS contacts were recorded as concerns (January =371). 1.2% of PALS cases (n=7) were escalated to formal complaints
The top three primary PALS subjects recorded as a concern were as follows: Communication =77 (of these 44% related to communication with patients/relatives), Appointments =60 (of these 67% related to long waiting times and cancelled appointments) and Clinical Treatment =39 (of these 38% related to diagnosis issues and 26% related to delay in treatment).

Top 3 locations of PALS concerns: Emergency Department (=40) (EDGH =28 and CQ =12),Outpatients Department (=34) (CQ =18 and EDGH =16)
ENT Outpatients (=6).

Top 3 PALS concern themes, patient care only featured in the top 3 in Sept-24.

The Trust received 11,482 FFT responses, which is on a par with January data (=11,545). 85% of all FFT responses were received in a digital format. The previously reported drop in completion of online FFT was due to a fault with the Phlebotomy texting service (which embeds a link to the FFT online) has been rectified, as reflected in the data above.
The Trust wide positive feedback rate was 93.54%, which is in line with the last three-month average of 93.19%.

The comments patients provide as to why they gave their rating generate word-based themes; this month, the top positive theme was Staff Attitude (5,707 positive comments), followed by Implementation of Care (3,013) and Environment (1,833). Conversely, the top negative theme was Staff Attitude (325 negative comments), followed by Environment (258) and Waiting Time (237).

8,246 plaudits were received, the majority of these were from FFT comments.

Workforce

The Trust has continued to see 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 February remained stretched to cover the additional requirements.

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 Workforce. 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)

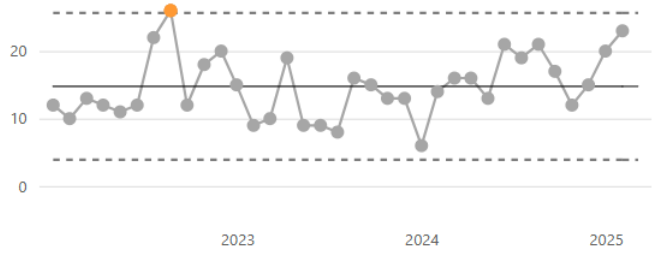
Simon Merritt
Chief Medical Officer

Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

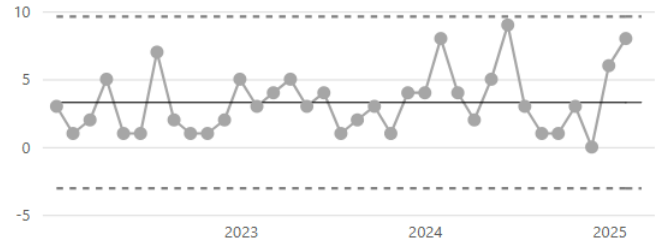
Number of Patient safety events (severity 3): Total, Safety

Target required	Common Cause	23



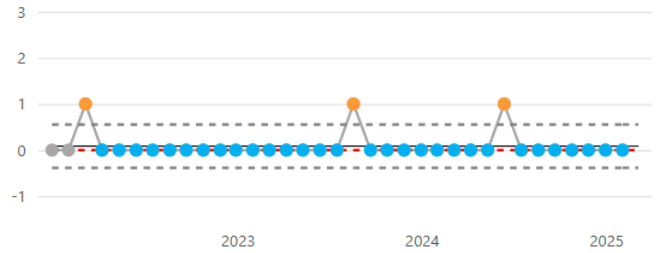
Number of Patient safety events (severity 4 and 5): Total, Sa...

Target required	Common Cause	8



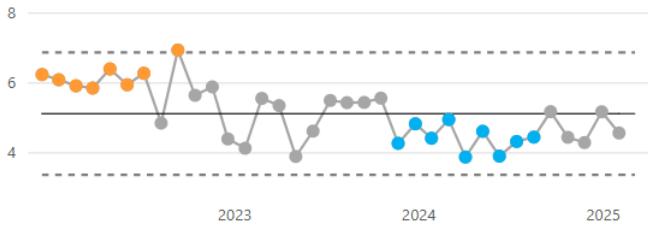
Never Events: Total, Safety

Inconsistent	Improvement	0



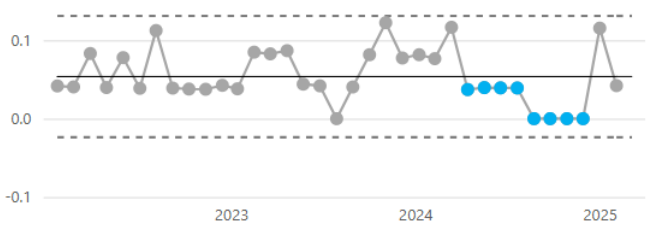
Inpatient Falls per 1,000 Bed days: Total, Safety

Target required	Common Cause	4.55



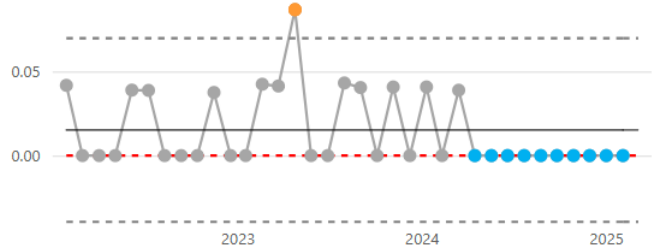
Cat 3 and 4 ESHT Acq. PU (rate) per 1,000 bed days: Total, S...

Target required	Common Cause	0.0421



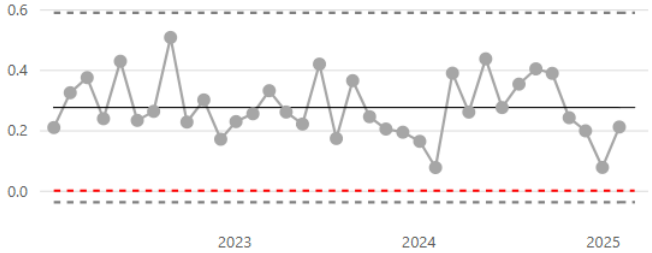
Healthcare Associated MRSA Bacteraemia (rate) per 1,000 ...

Inconsistent	Improvement	0



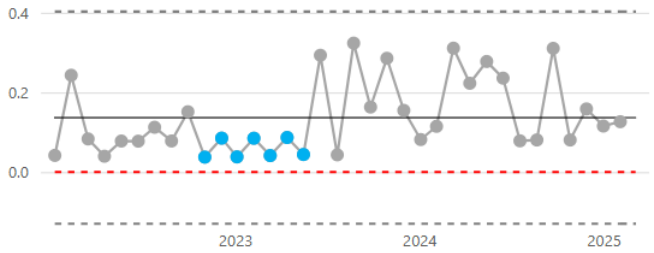
Healthcare Associated C Diff Infections (rate) per 1,000 Bed ...

Inconsistent	Common Cause	0.211



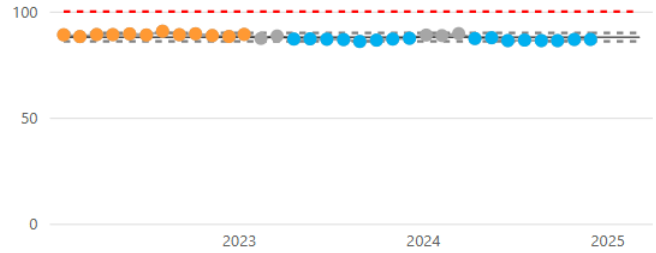
Healthcare Associated MSSA Bacteraemia (rate) per 1,000 ...

Inconsistent	Common Cause	0.126



RAMI: Total, Safety

Achieving	Improvement	86.9

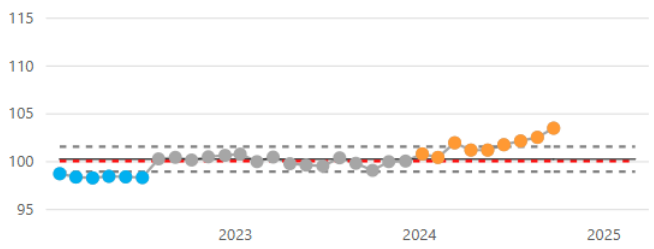


Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

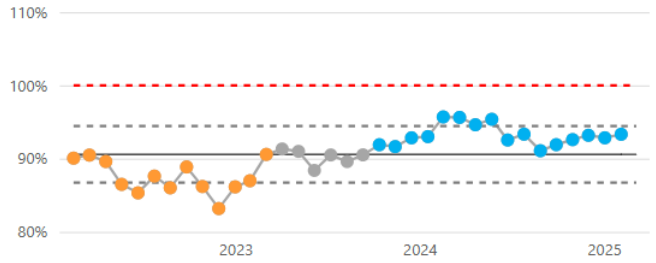
SHMI (NHS Digital monthly): Total, Safety

Inconsistent	Concern	103



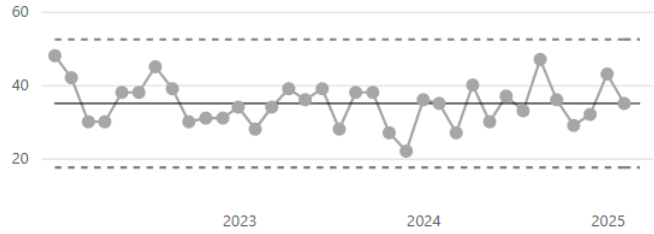
Nursing Fill Rate (IP - RN, RNA and HCA): Total, Safety

Not Met	Improvement	93.3%



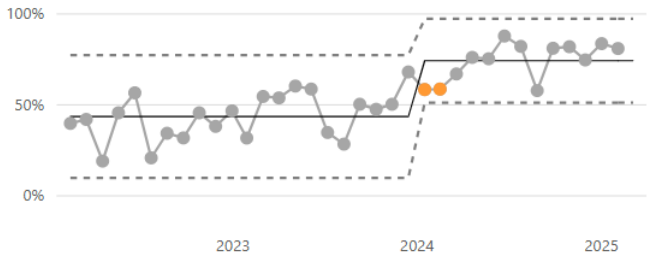
Complaints received: Total, Patient Experience

Target required	Common Cause	35



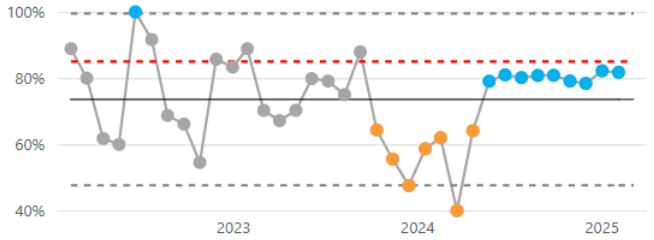
Complaints Response Compliance (60 working days as of 1...

Target required	Common Cause	80.6%



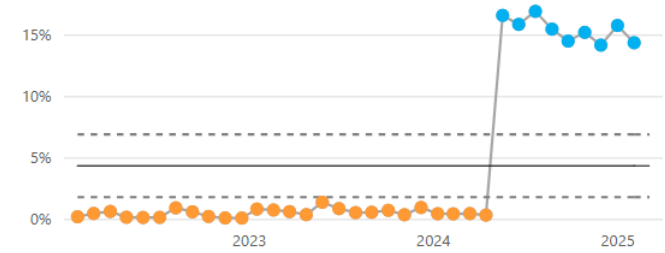
A&E FFT Score: Total, Patient Experience

Inconsistent	Improvement	81.8%



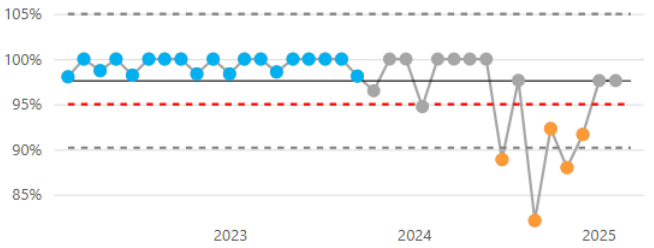
A&E FFT Response Rate: Total, Patient Experience

Target required	Improvement	14.3%



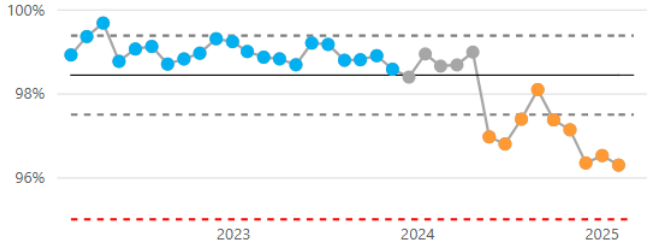
Maternity FFT Score: Total, Patient Experience

Inconsistent	Common Cause	97.6%



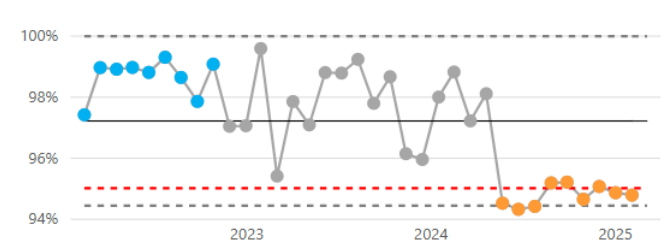
Inpatient FFT Score: Total, Patient Experience

Achieving	Concern	96.3%



Outpatient FFT Score: Total, Patient Experience

Inconsistent	Concern	94.8%



Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Patient Safety Incident Response Framework (PSIRF)	Duty of Candour (DoC) compliance continues to be monitored, and divisions supported to complete in a timely manner. In February, reviewing applicable incidents in a rolling 12-month period, 63% were confirmed to have had verbal DoC completed, and 76% had written completed. The issues identified with recording completion of DoC has been resolved by relocating the DoC fields on DCIQ as a stand-alone section. The DoC policy is being refreshed for clarity and increased awareness. The PSIRF process remains in place for reporting, triaging and deciding on level of harm of events. The PSIRF Working group are reviewing the process 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 undergoing review by key stakeholders.	• The PSIRF Review Group reviews all completed reports, and learning is shared is shared across 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 remains positive. The data for February is approximately 93.6%, based on compliance figures by department.
Nursing & Midwifery Workforce	During February, 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. Ward nursing CHPPD overall was 8.1 for Feb (noting distortion by specialist areas). Nursing fill rates for day shifts = RN 92% and HCSW 86%. Nursing fill for night shifts = 98% for RN and 102%.	• The annual Nursing Establishment Review (NER) for 2024 has been agreed and the 2025 data collection is underway • Recruitment to the Mental Health Outreach team continues and a review of training for staff and the MH Strategy 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 CNO, to support working within budget and review of temporary staffing requests. There is evidence of good controls and work in progress to support enhanced observations and requests for additional staff. The focus is now on reducing our reliance on agency staffing • 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

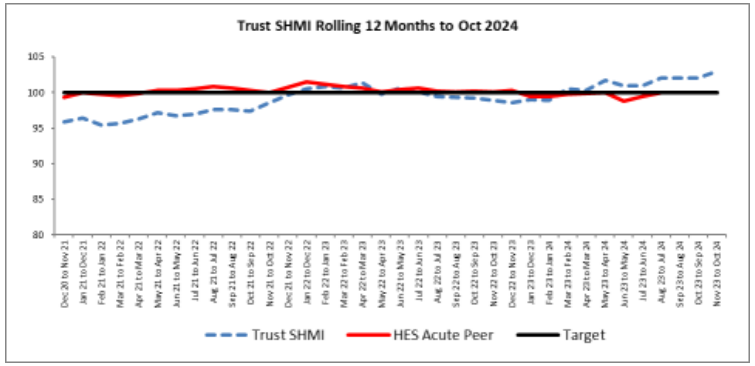
Title	Summary	Actions
Inpatient Falls	Slips, Trips and Falls - The inpatient falls rate for ESHT per 1000 bed days was 4.55 in February 2025. This remains within the control limits with common cause variation. The top sub-category continues to be 'patient fall whilst mobilising independently' majority resulting in No harm. There were no hot spots In relation to location. There were no Catastrophic or Severe harm incidents. SWARM reviews 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.	• 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 • Deep Dive coming to April Q&SC.
Patient Experience	Various inpatient areas featured in the top location for complaints.	This will be monitored and triangulated with other data and metrics noting some complaints received in February relate to care provided in the last 12 months.
Harm reviews	Ensure there is a process of review for patients who experience long waits.	• A formal overview of Harm Reviews was presented at Quality and Safety Committee • Methodology and reporting will be further developed to ensure consistency and clarity across all services, with a renewed review process implemented towards July / August 2025
Pressure Damage	One Category 3 pressure ulcer was reported for an acute hospital inpatient in February 2025. A further two Category 3 pressure ulcers were reported in patients in their own home.	• 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 approved by ESHT Education Steering group for introduction for clinical staff.

Effective Care - Mortality

East Sussex Healthcare NHS Trust

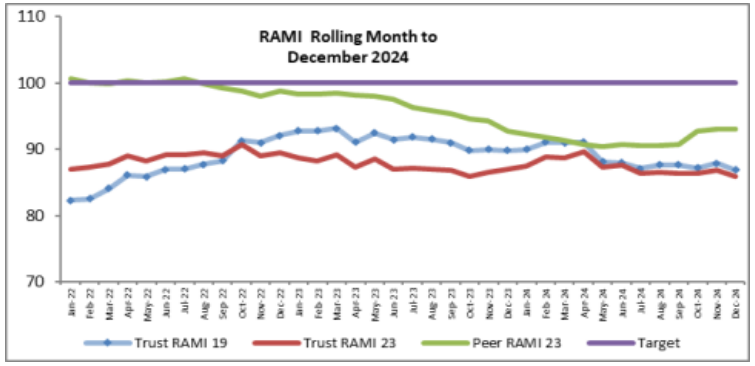
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

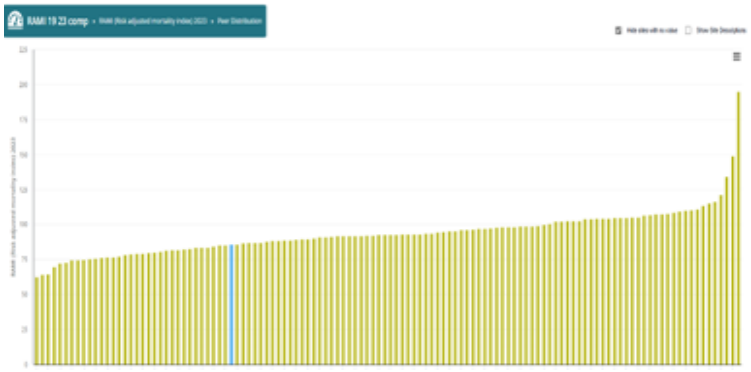
Summary Hospital Mortality Indicator (SHMI)
Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures



- SHMI – November 2023 to October 2024 is showing an index of 103 and is within the expected range. EDGH is showing 100 and Conquest is 108, both also within the expected range. Peer SHMI for the previous period is 99.93
- SHMI is rebased each time it is published whereas RAMI is not. RAMI has recently been rebased, and the new RAMI 23 is now available.
- RAMI 23 – Jan 2024 to Dec 2024 (rolling 12 months) is 86, and 87 for the same period last year. Peer RAMI was 93 for this period
- RAMI 23 was 89 for the month of December and 91 for November. The line graph below shows the rolling 12 month figure
- Crude mortality shows Jan 2024 to Dec 2024 at 1.55% compared to 1.68% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 70% for December 2024 deaths compared to 67% for November 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

February 2025 Main Cause of In-Hospital Death Groups

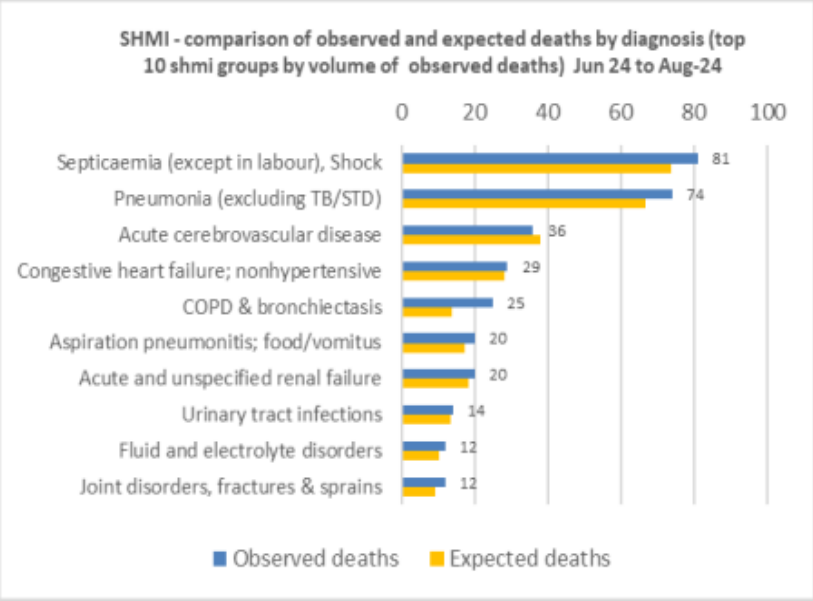
Description	Deaths Apr 24 - Jan 25 (10 months)	Deaths Feb 25
Cancer	172	14
Sepsis/Septicaemia	143	20
Pneumonia	124	14
Frailty of Old Age	87	11
Heart Failure	85	12
Community-acquired Pneumonia	84	11
Hospital-acquired Pneumonia	65	8
Stroke	54	8
Aspiration Pneumonia	53	1
COPD	44	4
Urosepsis	27	4
Myocardial Infarction (MI)	25	2
Atrial Fibrillation (AF)	23	3
COVID-19	23	3
Dementia	18	0
Liver Disease	15	1
Acute Kidney Injury (AKI)	12	1
Bowel Obstruction	11	0
Bowel Perforation	3	0
Multiple Organ Failure		1
Pulmonary Embolism		1
Other not specified	430	40
[Uncertified]	122	6
Total	**1620**	**165**

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

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

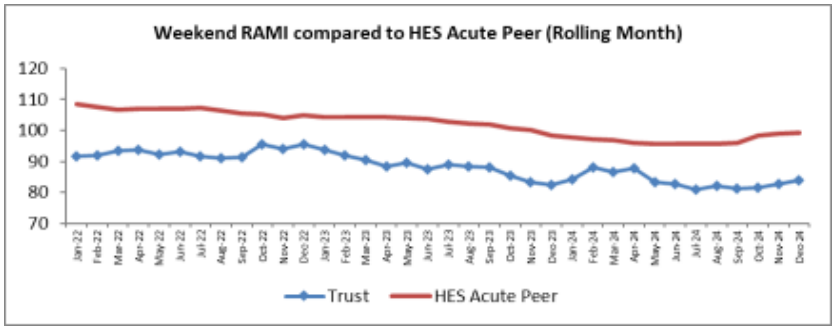
NB: Delays in recording cause of death can be due to awaiting results from an inquest, post-mortem or other reasons.

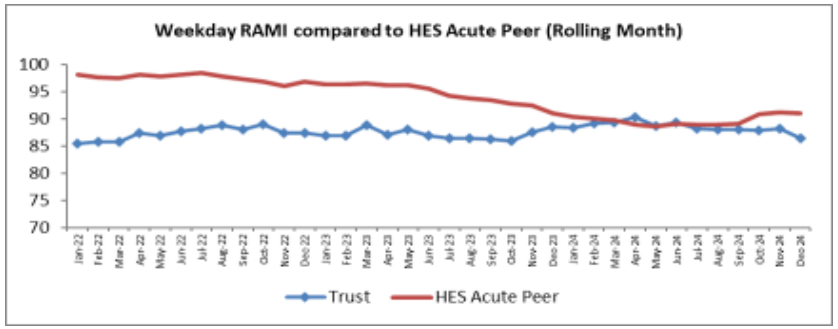
SHMI Diagnosis Main Groups



Risk Adjusted Mortality Index (RAMI)

Weekend and Weekday Mortality Trends





Our People

Recruitment and retention

Staff turnover / sickness

Our quality workforce

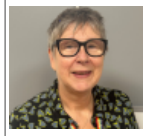
What our staff are telling us?

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

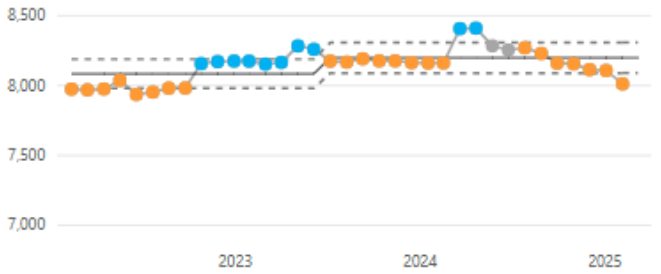
Responsive	**Positives:** Turnover reduced by 0.1% to 10.4% and within target. Vacancy rates reduced by 1.5% to 0.6%, well within 7.5% target. Monthly sickness reduced by 0.8% to 5.5%. Mandatory Training achieved a high of 91.8%, above target.	**Challenges and Risks:** Sickness remains high despite a good reduction this month.	**Author** 
Overview:	Overall workforce usage has increased by 81 largely in the escalation areas with temporary workforce slightly higher than substantive. Agency staffing has reduced to its lowest level this year (49.9 WTE) with reductions in A&E, Theatres and AAU. At the beginning of the year, the monthly workforce average for agency was 112 whole time equivalent (WTE). Turnover continues to remain stable and within the parameters expected with a consistent 92% of all substantive colleagues choosing to stay at ESHT for more than 12 months (excluding rotations). Vacancy rate continues to remain low due to financial adjustments and tighter controls 0.6%. There was a significant reduction in the number of absences due to cough, colds and flu as the Trust comes out of winter period. Although the sickness rate is still higher than this time last year (+0.3%), the monthly sickness absence reduced from 6.3% to 5.5% (0.8%). Actions plans are continuing to support colleagues affected by sickness and leaders are managing sickness with additional focus on areas where 'no specific reason' was provided. The mandatory training rate increased by 0.3% to 91.8%, 1.8% above target with all training modules courses over 90% compliance, with the exception of Information Governance at 88.5% (+0.3%), Fire Safety at 89.5% (+0.1%) and Basic Life Support (BLS) at 74.5% (+0.7%). Education continues to work with the Resuscitation Lead to improve BLS compliance but there are continuing issues with DNAs for this training. Appraisal rate observed a small reduction, however, this is to be expected as colleagues familiarise themselves with the online appraisal process launched this month.		**Jenny Darwood** Acting Chief People Officer

Our People Core Metrics

East Sussex Healthcare NHS Trust

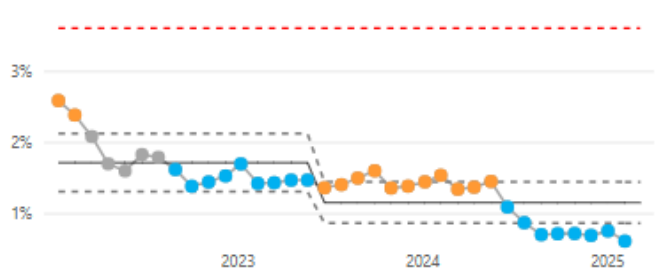
Establishment (WTE) All: Total, Our People

Target required	Concern	8,007



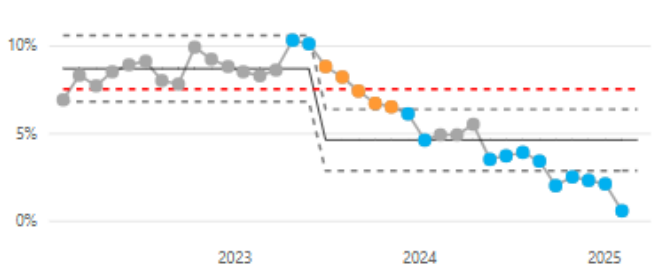
Agency Rate: Total, Our People

Achieving	Improvement	0.607%



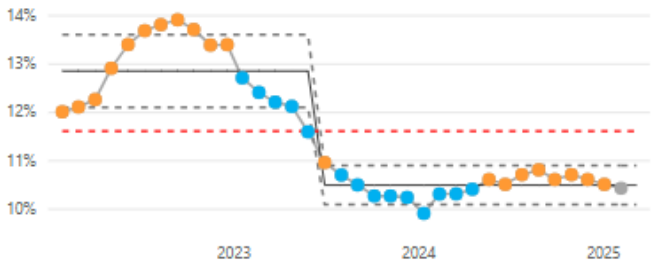
Vacancy Rate: Total, Our People

Achieving	Improvement	0.562%



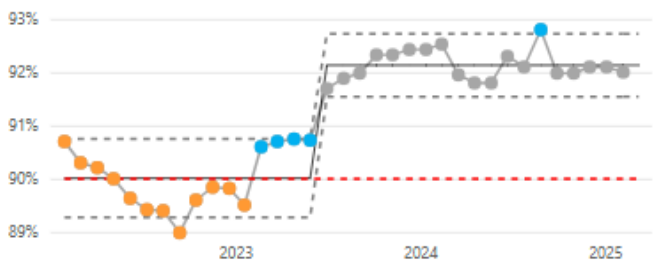
Staff Turnover: Total, Our People

Achieving	Common Cause	10.4%



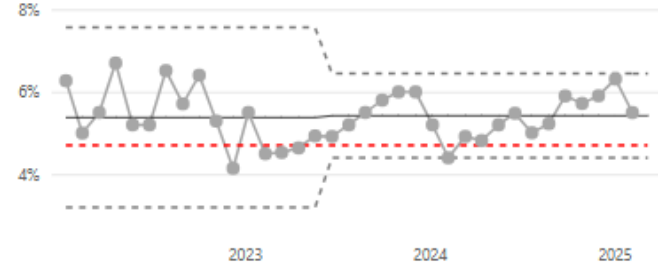
Retention Rate: Total, Our People

Achieving	Common Cause	92.0%



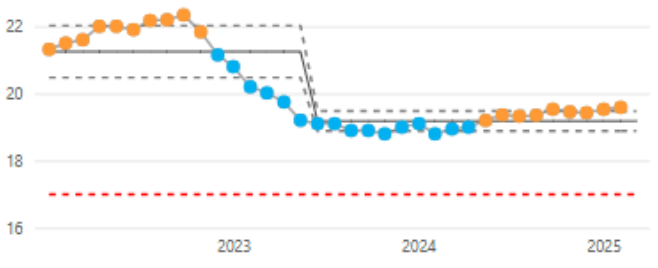
Monthly Sickness - Absence %: Total, Our People

Inconsistent	Common Cause	5.50%



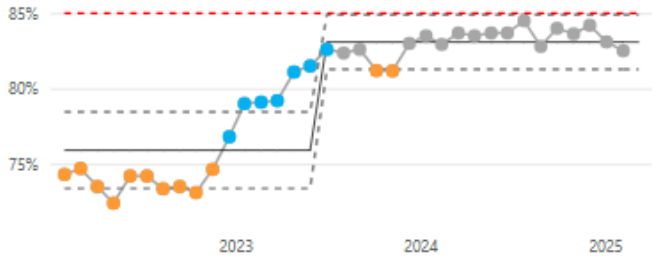
Sickness - Average Days Lost per Fte: Total, Our People

Not Met	Concern	19.6



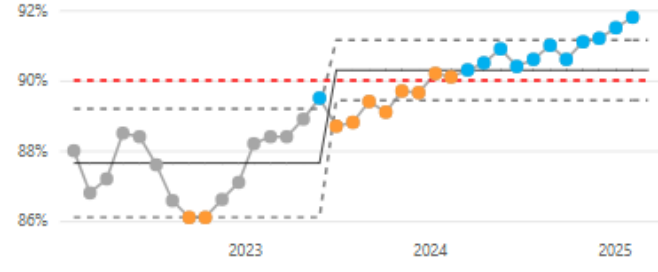
Staff Appraisals: Total, Our People

Not Met	Common Cause	82.5%



Statutory & Mandatory Training: Total, Our People

Inconsistent	Improvement	91.8%



Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Turnover & Retention	Turnover rate reduced by 0.1% to 10.4%. The stability rate reduced by 0.1% to 92.0%.	• Commenced Legacy Mentoring training programme with 12 colleagues from within the Trust and 1 from the ESHT Alumni joining this pilot • Started to review the current provision for early resolution and mediation within the Trust. Exploring how process can be improved and aligned with the workplace behaviours and civility agenda • Bringing the Internationally Recruited Task & Finish group to a close. Ensuring all actions are completed and mechanisms for ongoing monitoring agreed and secured. The group will finish in March at which point the improvements made will be shared by Communications • Continuing to promote Action Learning Sets as a concept for leaders. Many teams were unable to engage due to winter pressures, therefore, the Trust has scheduled sessions from March onwards • Developed content for a flexible working page on the Extranet. This will be expanded as work progresses. Increasingly managers are finding it challenging to agree flexible working requests, particularly if this means a reduction in hours, as they are no longer able to reallocate these hours elsewhere. This has resulted in a number of flexible working requests being declined.
Vacancy Rate	Vacancy rate reduced by 1.5% to 0.6% (43.5 wte vacancies).	• Focussed recruitment activity to address hard to recruit posts with recruitment activity around Medics, Community and AHPs • Continued activity with TWS agencies for Community and to support escalation areas across the Trust • Medical recruitment activity to address hard to recruit posts is ongoing. Increased direct applicants for posts across the Trust • Ongoing retained searches for Stroke, Dermatology and Microbiology Consultants. Additional permanent agencies engaged • Redeployment activity and support has commenced • Hiring Manager upskilling training sessions ongoing to support new managers to the Trust • Volunteers 3-year plan scoped and key areas identified to both improve service delivery and volunteer numbers.

Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Sickness	Monthly sickness reduced by 0.8% to 5.5% whilst annual sickness was unchanged at 5.4% Average sick days per WTE have increased by 0.1 to 19.6	Coming out of seasonal illnesses period, the Trust has observed a reduction in Cold, Cough & Flu and Chest & Respiratory absences. Additionally, the reduction in Anxiety & Stress, this month, will include the return of some colleagues who have been on long term sickness absence. This will have a positive knock-on effect for those staff who have supported the gaps due to sickness absence. HR continues to work with managers to ensure there is a plan in place supporting a return to work where appropriate, reviewing reasonable adjustments and work activities. The proportion of long-term sickness absence to short term has, however, increased this month and is now showing as 43.8% (+3.5%). The HRBPs continue to review all long-term cases to ensure all relevant support and interventions are offered.
Statutory & Mandatory Training	Trust compliance increased by 0.3% to 91.8%, 1.8% above target.	BLS compliance increased slightly across a number of specialities this month, but four areas are reporting a compliance of below 70%; COO at 42.3%,(15 staff non- compliant), Medical Director at 33.3% (6 staff non-compliant), Urgent Care 65% (271 staff non- compliant), Medicine 68% (310 staff non-compliant). There were over 100 DNA across BLS sessions for the last four weeks with no notice being received. In addition, there were 5 DNA for PILS and 3 DNA for ILS. Safeguarding Level 3 also requires a deep dive analysis to understand poor compliance over the last month. Current work on national priorities such as mapping provision to the Core Skills Training Framework which has been completed. Trusts to implement a single national standardised process for approving Stat and Mand training and a mandated template for TOR for a local oversight approval group have been circulated. This was discussed at the Education Steering Group in February and circulated for comment.
Appraisal	Compliance rate reduced by 0.6% to 82.5%, 2.5% below target	Appraisal rates continue to reduce, reflecting service pressures. The launch of the new on-line appraisal process in February may have had a slight impact on compliance, as managers and staff adapt. It is expected that compliance may decrease further over the next month. There are 10 speciality areas that have posted an appraisal compliance score of less than 60%.

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

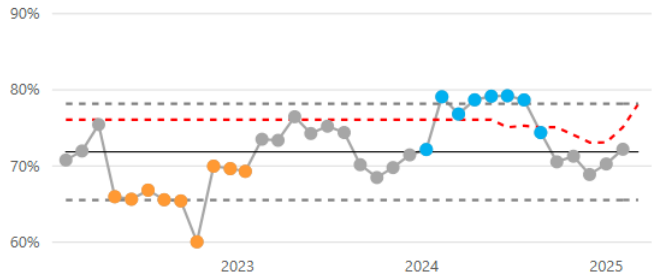
	Positives	Challenges & Risks	Author
Responsive	**Cancer** The Trust delivered 78.9% against the Faster Diagnosis Standard in January (national standard 77%). Performance against the 62-day standard achieved to 70.9% versus a trajectory of 64.0%. **Urgent Community Response (UCR)** The UCR standard of 70% has been consistently achieved year to date, with 82.4% of patients seen within the 2-hour response window in February. **Elective long waits (RTT)** The Trust continues to support system partners in reducing long waits in elective care. In February, the Trust reported 41 patients waiting more than 65 weeks, significantly below the trajectory of 80. More than half of these patients (24) were transfers from another Sussex provider	**4 Hour Emergency Access Clinical Standard** In February, 72.1% of patients were seen and discharged or treated and admitted within 4 hours, against the 78% target. The Trust continues to have a high bed occupancy, increasing length of stay and limited ability to discharge patients to their onward care destination. The Trust is working collaboratively with system partners to address these issues. **Cancer** The backlog of patients waiting over 62 days at the end of January was 194 against a trajectory of 149. A backlog trajectory is in place for each tumour site, and is monitored weekly, alongside action plans where required. **Length of Stay (LoS)** Non-elective LoS for February was 5.29 days. 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

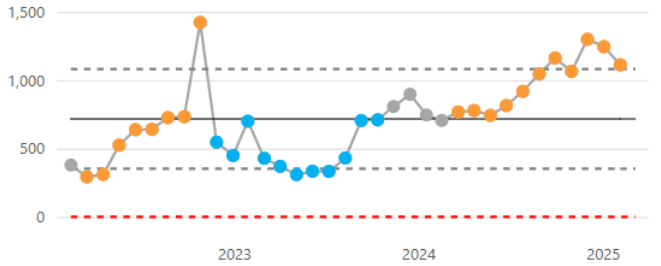
4 hour standard: Total, Our Performance

Inconsistent	Common Cause	72.1%



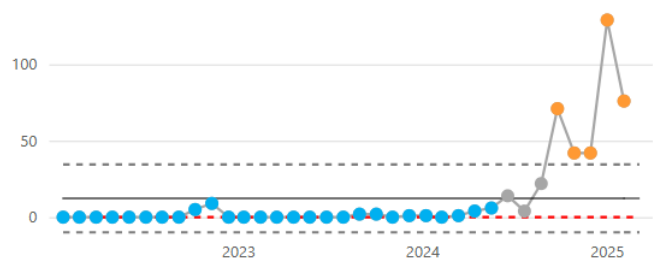
A&E > 12 hours from arrival to discharge: Total, Our Perfor...

Not Met	Concern	1112



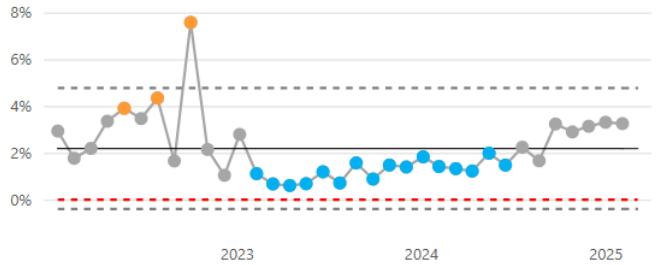
A&E waits over 12 hours from DTA: Total, Our Performance

Inconsistent	Concern	76



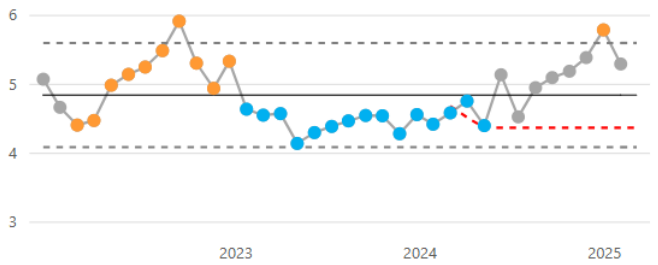
Conveyance handover >60 mins: Total, Our Performance

Inconsistent	Common Cause	3.25%



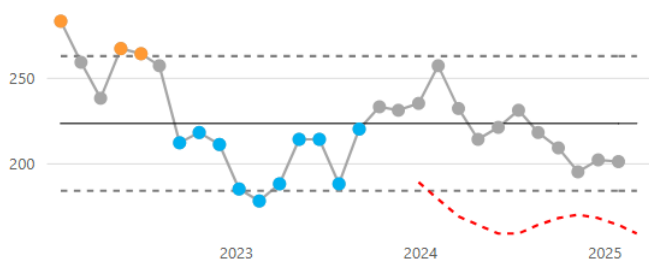
Non Elective Length of Stay: Total, Our Performance

Inconsistent	Common Cause	5.29



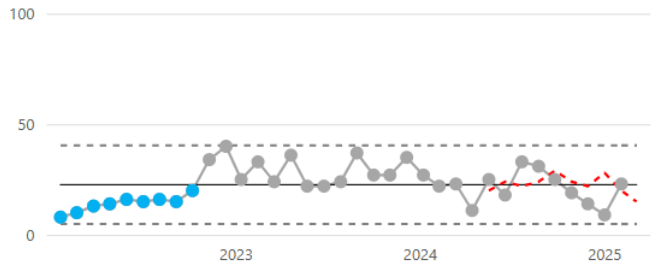
Average daily NCTR: Total, Our Performance

Not Met	Common Cause	201



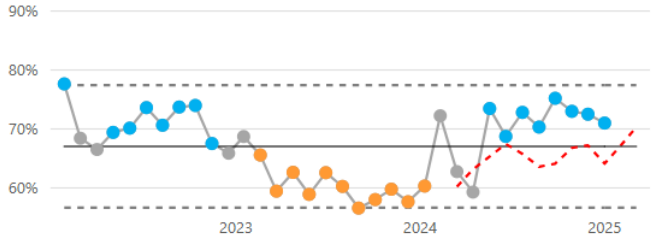
104 day Backlog: Total, Our Performance

Inconsistent	Common Cause	23



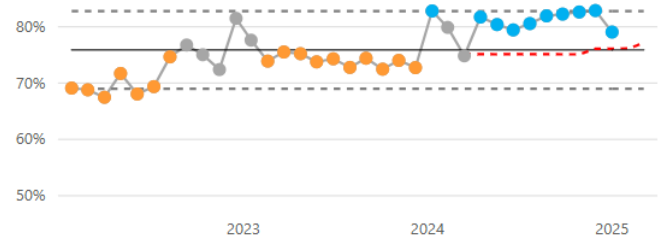
Cancer 62 Day: Total, Our Performance

Inconsistent	Improvement	70.9%



28 Day General FDS: Total, Our Performance

Inconsistent	Improvement	78.9%

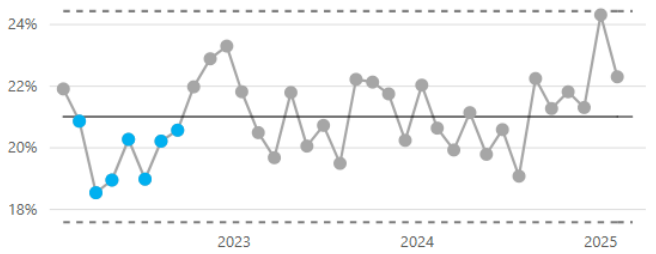


Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

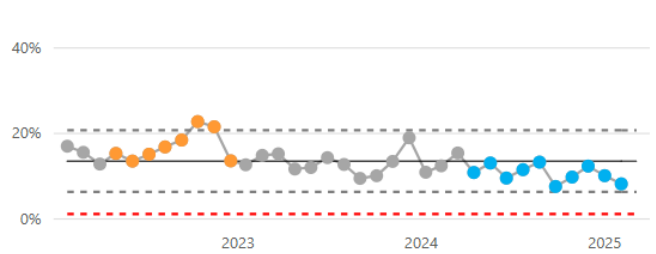
% Discharges delayed 1+ days: Total, Our Performance

Target required	Common Cause	22.3%



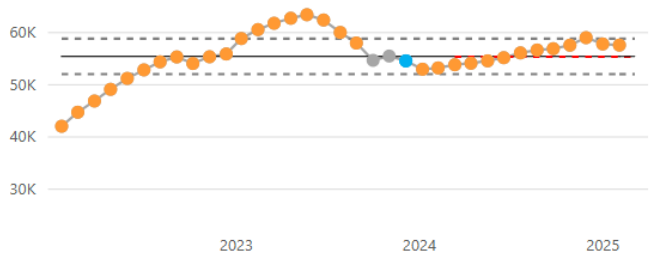
Diagnostic <6 weeks: Total, Our Performance

Not Met	Improvement	8.06%



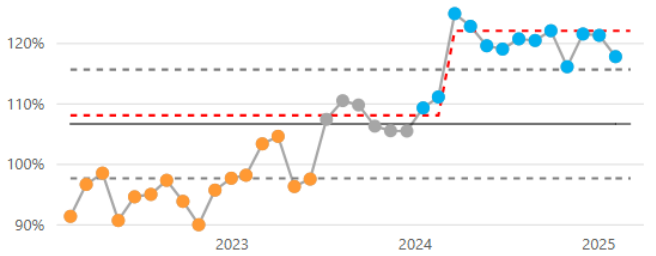
RTT Total Waiting List Size: Total, Our Performance

Inconsistent	Concern	57483



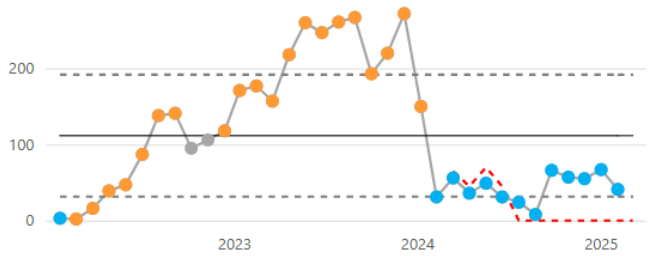
Elective Activity (ELIP,DC,OPFA, OPFUP Proc): Total, Our Perf...

Not Met	Improvement	118%



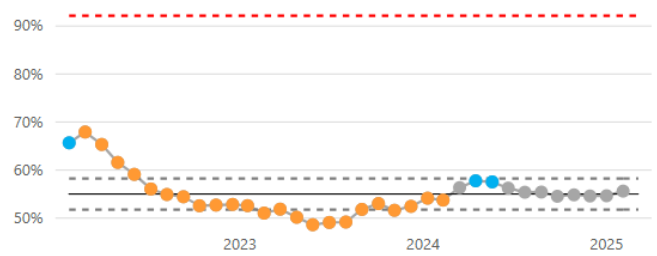
RTT 65 week wait: Total, Our Performance

Not Met	Improvement	41



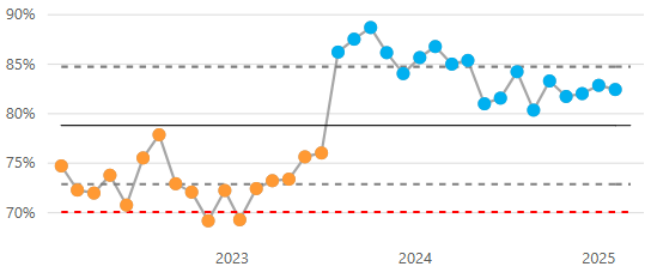
RTT under 18 weeks: Total, Our Performance

Not Met	Common Cause	55.5%



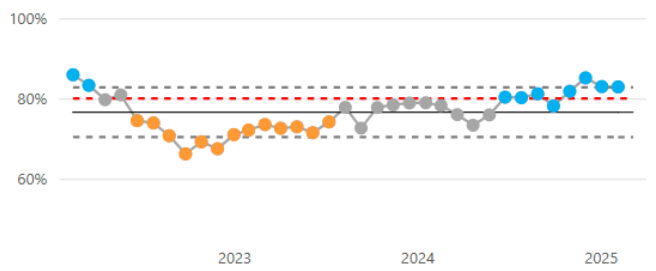
Urgent Community Response within 2 hours: Total, Our Perf...

Achieving	Improvement	82.4%



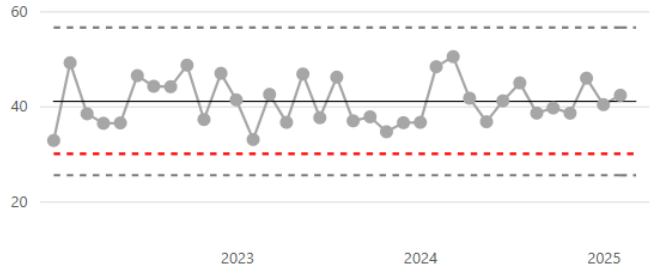
CHIC wait times < 13 weeks: Total, Our Performance

Inconsistent	Improvement	82.9%



Intermediate Care Length of Stay: Total, Our Performance

Inconsistent	Common Cause	42.3



Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Emergency Access Clinical Standard	In February, 72.1% of patients were seen and discharged or treated and admitted within 4 hours, against the 78% standard. This places our Trust at 55 out of 123 trusts nationally, ranking us in the second quartile. To achieve 78%, the Trust would require a reduction of 27 breaches per day.	• 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 a reduction in number of patients waiting over 12 hours from arrival to discharge at 1112 patients, compared to January (1245). 76 patients waited over 12 hours following a decision to admit, for allocation of ward bed. Improvement from January (129).	• 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 ensuring any lessons learnt are being taken forward • Timely escalation within the ED department when at full capacity to enable ED and divisional support to create space. • 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 3.25% in February. This represents a reduction in the number of patients the Trust were not able to offload within 60 minutes compared with January (3.31%).	• Increase focus on ambulance handover times, early escalations and actions to mitigate delays and support decompressing the department • Improve staffing and flow through Rapid Assessment and Triage (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. • Escalations to site managers and ED operational leadership team where there are inbound conveyances with no capacity to support offloading

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Non elective Length of Stay (LOS)	Non-elective LoS was 5.29 in February, remaining above target since June 24. Reducing the pressure on hospital bed capacity is a recognised challenge.	• Focus on reducing clinical LOS and embedding Safer on wards • Support for ward areas to plan discharge from point of admission • Optimising the Transfer of Care Hub and trialling the Multiagency Pull Leadership Model for patients on stroke pathway • Increased P1 capacity to support same day / next day discharges, 7 days a week using a Home First approach • Additional System Funding to support a further increase in P1 capacity, including a trial of a 24-hour care offer 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 February was 0 (compared to 372 in Feb 23). There were 4 children waiting over 78 weeks and 432 children waiting over 52 weeks (compared to 1136 in Feb 2023).	• On going recruitment to both clinical and administrative roles in Community Paediatrics • Redesign of service continues to be explored including digital opportunities to optimise the patient pathway.
Community Waiting Times (Adult)	Urgent Community 2-hour response achieved 82.4% against the national target of 70%. Patients waiting to be seen within 13 weeks – 80% target achieved for the last four months despite increase in demand. February performance was 82.9%. An increase in demand has been observed across rapid response and planned care services.	• Demand and capacity modelling completed and included in the Trust's financial improvement plan.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Cancer	The Trust delivered 78.9% in January against the 77% Faster Diagnosis Standard. The Trust delivered 94.9% against the 96% 31-Day diagnosis to treatment standard. Performance against the 62 Day standard in January was 70.9% against a trajectory of 64.0%. The backlog of patients waiting over 62 days at the end of January 2025 was 194 against a trajectory of 149. This equates to 5.6% of the PTL with Sussex overall being 8.4%. The Trust continues to receive high number of urgent suspected cancer referrals and in January received 2972 referrals. This is the highest number of referrals received in month. 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 tumour site Cancer Action Plans underpinned by improvement trajectories to support improvement and sustainability • Weekly review of in month and future month performance to support delivery of tumour site level trajectories • Enhanced focus on patients early in the pathway to improve transfer dates to tertiary providers by Day 38
Elective Activity	In February the Trust delivered 121% of 2019/20 baseline activity levels, with a small improvement noted in elective inpatient activity.	• Improve outpatient clinic utilisation to maximise delivery of outpatient activity • OP productivity programme; focus on validation; targeted action on DNAs; reducing paper in outpatients; improving governance arrangements for insourced/outsourced clinical services (to maximise efficiency) and improving management of follow-ups • Theatre productivity programme; focus on increased theatre utilisation via management of under runs and additional governance measures to reduce on the day cancellations • Ongoing review of coding to ensure accurate capture of activity.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
RTT long wait position (78 and 65 weeks) and waiting list size	The Trust reported further reductions in the volume of patients who have waited 65+ weeks on an elective RTT pathway, reporting 41 breaches in February (24 of which were patients who had transferred to ESHT from another Sussex provider). This was a reduction of 26 from the previous month and was significantly ahead of trajectory, which was set at 80 65+ week breaches for February. The Trust is expecting to report two 65+ week breaches in March, the lowest volume in Sussex. These are both patients who transferred from another provider as part of mutual aid. Both patients will be treated in April. The Trust reported a small number of patients (<5) who waited more than 78 weeks in February. These patients were all treated in March. The Trust is currently reviewing all overarching operational procedures underpinning patient tracking and waiting list management, to mitigate future risk and ensure all patients are seen and treated in a timely way. The total waiting list remained largely unchanged in size in February with only a small decrease noted (down from 57698 to 57483) RTT compliance improved by 1% in February, up from 54.5% to 55.5%.	• Continue to progress mutual aid requests from neighbouring providers to support a reduction in waiting times for patients in Sussex. The Trust has accepted a further 40 patients in March • Quantify and agree the Trust's mutual aid offer to Sussex system for 2025/26, in line with capacity and acceptable monthly profiling • Daily monitoring of the longest waiting patients to ensure pathways are progressing • Developing trajectories for each speciality to support delivering the 2025/26 national ambition for RTT • 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 February, the number of patients waiting more than 6 weeks reduced to 895 from 970 in January. • Performance improved from 90% in January to 91.7% in February • The overall size of the DM01 waiting list increased to 10,875 patients with increased demand for Radiology modalities including CT, MRI and NOUS. • Cardiac Echo waiting list reduced from 852 in January to 809 and the number of patients waiting >6 weeks also reduced from 269 in January to 122 in February in line with the recovery plan. • Audiology waiting list increased from 666 in January to 768 in February due to Sussex mutual aid patients requiring a new audiology test	• Echo performance in February was 85%. The modality is now moving towards compliance with the DMO1 standard and is expected to deliver the 6-week standard in March 2025 • Radiology are working with Medical Imaging Partnership (MIP) to mitigate the risk of lost activity due to equipment failure.

Financial Control and Capital Development

Our Income and Expenditure

Our Elective Recovery

Our Run Rate

Efficiency

Capital

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

Finance | Executive Summary

East Sussex Healthcare NHS Trust

Finance

	Positives	Challenges & Risks	Author
Responsive	• In month surplus of £0.2m compared to a surplus plan of £0.8m, a £0.6m deficit to plan in month. This takes the year-to-date (YTD) deficit to £14.0m. The trust is planning to deliver a year end deficit of £9m. • Elective Recovery Fund (ERF) on plan in month with actual of £11.6m compared to plan of £11.4m. Overachieved by £3.3m YTD • Capital underspent by £2m, forecast out-turn (FOT) shows slightly under plan by £0.4m • Pay Run rate is similar to M10 aside from one off back pay of £0.9m to Health Care Assistant for national banding adjustment for band 2 and 3. Temporary staffing costs are at their lowest this financial year, with agency cost around 50% of M3 level • Non-pay run rate lower than M10 due to lower contract costs and general supplies • Use of Resources programme is over plan YTD at £31.9m and forecast to slightly overachieve • Drive to maintain costs within M7 levels in order to achieve Trust FOT • Budget setting process for 18 months from Jan 25 to June 26 on going	Current projection of year end is £9m deficit with risks including winter pressures. In order to achieve this, the Trust needs to control monthly spend until Month 12 and deliver agreed monthly efficiencies (the Use of Resources programme). The Trust will increase ERF by £1m through OP booking and Theatre Utilisation and a further £1m decrease on temporary spend. Further SDEC (Same Day Emergency Care) support funding agreed of £2m towards final position. FOT also now including £5m further support from ICB in M12 for NCTR (No criteria to reside) and Mental Health patient support costs.	 **Damian Reid** Chief Financial Officer
Overview:	**I&E**: The Trust plan was for a surplus of £0.8m in month. Actual performance was a surplus of £0.2m so (£0.6m) deficit to plan in month. YTD adverse variance of (£13.0m). Variance YTD is driven by pay premium costs, unfunded escalation, pay Cost Improvement Programme (CIP) and non-pay CIP, old year invoices, higher activity related non pay and drug costs, security for mental health patients. Run rate was £0.2m in month, improving by £1.5m compared to Month 10. **UoR**: FY24/25 full year efficiency requirement is £36.7m. Total YTD delivery at month 11 of £31.9m against plan of £32.2m, an under-delivery of £0.3m. The profiling of the plan saw an increase of £0.8m between M10 and M11. Workstreams in operational productivity, elective capacity, procurement and non-pay are delivering well overall. Full year delivery forecast for FY24/25 is £37.7m against efficiency requirement of £36.7m, a positive forecast variance of £1m. Despite the under-delivery YTD, there is high confidence with delivering the £37.7m. **Capital**: Capital expenditure at month 11 was £38.2m, £1.9m below plan. Capital Resource group (CRG) will try to mitigate any programme risk to ensure allocation is maximised but not breached. **Cash**: Cash position is above the £2.1m minimum permitted balance and is likely to remain above target throughout 2024/25.		

Finance | Income and Expenditure

East Sussex Healthcare NHS Trust

Finance

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Plan	Act	Var	Plan	Act	Var
Income						
Contract income	38,064	37,720	*(344)*	427,038	427,058	*21*
Divisional	6,869	8,029	*1,160*	73,559	81,940	*8,380*
ERF	11,414	11,740	*326*	125,500	128,778	*3,278*
Total Income	**56,347**	**57,489**	***1,142***	**626,097**	**637,776**	***11,679***
Operating Expense						
Pay						
Permanent	(36,905)	(36,542)	*364*	(411,187)	(389,104)	*22,082*
Temporary	(1,304)	(3,431)	*(2,127)*	(14,303)	(44,570)	*(30,267)*
Total pay	**(38,209)**	**(39,972)**	***(1,763)***	**(425,490)**	**(433,675)**	***(8,185)***
Non-pay						
Drugs	(1,369)	(827)	*542*	(15,209)	(14,942)	*267*
TEDD	(3,691)	(3,635)	*56*	(41,180)	(43,035)	*(1,855)*
Clinical supplies	(4,525)	(2,565)	*1,961*	(49,787)	(51,489)	*(1,701)*
Purchased services	(1,195)	(2,384)	*(1,190)*	(13,194)	(17,238)	*(4,044)*
Finance costs	(2,677)	(2,369)	*308*	(29,450)	(28,926)	*524*
Other	(3,915)	(5,563)	*(1,648)*	(52,836)	(62,479)	*(9,643)*
Total non-pay	**(17,372)**	**(17,343)**	***29***	**(201,656)**	**(218,109)**	***(16,453)***
Total Expense	**(55,581)**	**(57,315)**	**(1,734)**	**(627,146)**	**(651,784)**	**(24,637)**
Surplus/(Deficit)	**766**	**173**	***(592)***	**(1,049)**	**(14,008)**	***(12,958)***
Memo:						
WTE (worked)	8,007	8,213	*205*	8,221	8,248	*26*

I&E position

- In M11 there is a surplus of £0.2m compared to a surplus plan of £0.8m resulting in a deficit of (£0.6m) in month. YTD the Trust is adverse to a (£1.0m) plan by (£13.0m). A bridge of the current variance is set out on the next page.
- The £0.2m surplus 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, offset as per M11 note below. In M11 ERF lower due to less working days but budget phased accordingly.
- M11 Note – The in month position was supported by £1.0m of balance sheet adjustments in month, a £2.5m HMRC VAT adjustment and £0.1m of Rev to Cap. Conversely (£0.9m) of HCA back pay was tolerated in the position.

Income

- Contract income
  - New MSK contract £2.1m (M9-11) 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 M11 due to less working days (budget phased accordingly).
- YTD £11.7m 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 £3.2m (detail on slide 6)
  - £1.4m C&V Drugs and Devices in M1-11
  - £1.4m ERF 23-24 true up
  - TEDDS £1.0m, this is offset by non pay costs of £1.9m versus drugs.
  - £1.5m Pay Award extra funding (FYE £1.680m)
  - £1.0m A&E Recovery funding
  - £2.1m MSK new tender (offset in non pay)

Expense

- M11 Pay was impacted by continued Escalation costs in month, mainly in UC (£0.10m) and Medicine (£0.10m), aligned to escalation open in month. TWS costs lower in month. FTE above current budgeted levels, driven by unachieved CIP, TWS for escalation/Theatres and supporting MH patients. M11 also saw HCA Backpay of (£0.9m) for Band 2 – Band 3 salary changes.
- M11 Non pay was lower due to an HMRC adjustment for VAT of £2.5mThe 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 £0.3m and a VAT adjustment Ascribe £0.6m.

Finance | Variable income

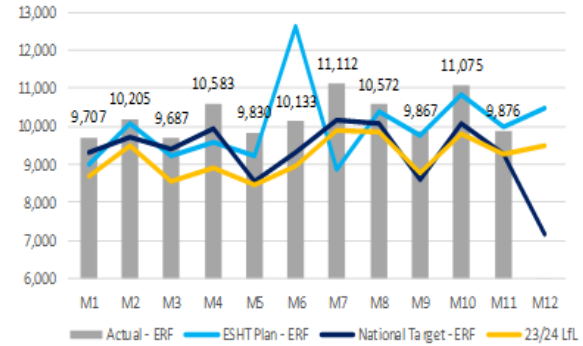
East Sussex Healthcare NHS Trust

Finance

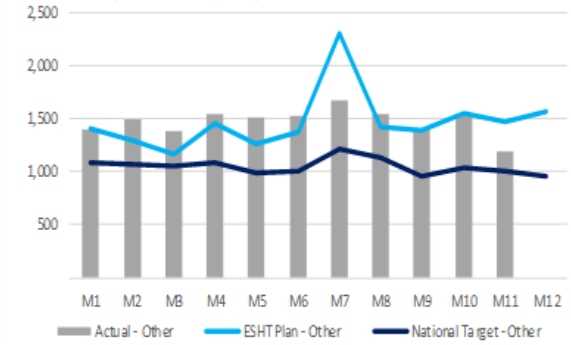
ERF performance

- ERF YTD over-performance of £3.173m. We expect this performance to increase as we report flex and freeze for previous months. Other variable activity under-performed by £285k in month and adjustments to the plan see over performance YTD reduce to £90k.

ERF performance (£'000)



Other Variable performance (£'000)



	In Month				YTD			
	Plan	Actual	Var		Plan	Actual	Var	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Daycase	3,861	3,622	(239)	(6.2%)	38,564	40,673	2,109	5.5%
Elective	2,225	1,818	(408)	(18.3%)	22,742	20,895	(1,847)	(8.1%)
Outpatients - First	2,234	1,895	(340)	(15.2%)	22,485	21,650	(835)	(3.7%)
Outpatients - Procedure	2,009	1,939	(70)	(3.5%)	21,931	22,482	551	2.5%
Ward Attenders	137	166	29	21.0%	1,722	1,845	123	7.2%
ERS	49	101	52	107.2%	705	1,115	410	58.1%
SPH	239	336	97	40.4%	3,466	3,988	522	15.1%
Prior month catch up	-	584	584	n/a	n/a	n/a	n/a	n/a
Plan Adjustment	(784)	-	784	(100.0%)	(2,140)	-	2,140	(100.0%)
ERF activity	**9,970**	**10,460**	**489**	**4.9%**	**109,475**	**112,648**	**3,173**	**2.9%**
Unbundled diagnostics	706	720	15	2.1%	7,848	8,780	933	11.9%
Direct Access	281	247	(35)	(12.3%)	3,240	3,339	99	3.0%
Chemo	316	215	(101)	(32.0%)	3,577	4,011	433	12.1%
Prior month catch up	-	-	-	n/a	n/a	n/a	n/a	n/a
Plan Adjustment	164	-	(164)	(100.0%)	1,375	-	(1,375)	(100.0%)
Other Variable	**1,467**	**1,182**	**(285)**	**(19.4%)**	**16,040**	**16,130**	**90**	**0.6%**
Total	**11,437**	**11,642**	**204**	**1.8%**	**125,515**	**128,778**	**3,263**	**2.6%**

				In Month			YTD		
				Plan	Actual	Var	Plan	Actual	Var
Rank	Unique ra	Division	Service	£'000	£'000	£'000	£'000	£'000	£'000
27	27	CHIC	Physiotherapy Service	-	-	-	-	-	-
9	9	Core	Interventional Radiology Service	24	-	(24)	452	556	104
18	18	Core	Chemical Pathology Service	18	13	(5)	218	180	(39)
24	24	Core	Diagnostic Imaging Service	1	0	(0)	59	1	(58)
20	20	DAS	Anaesthetic Service	19	15	(4)	211	206	(5)
32	32	DAS	Maxillofacial Surgery Service	137	139	2	1,624	1,544	(80)
35	35	DAS	Paediatric Trauma and Orthopaedic Service	4	8	3	64	58	(6)
27	28	DAS	Plastic Surgery Service	-	-	-	6	-	(6)
41	41	DAS	Ear Nose and Throat Service	481	512	31	4,914	5,040	126
8	8	DAS	Breast Surgery Service	294	268	(26)	2,893	2,910	17
45	45	DAS	General Surgery Service	671	838	167	6,892	7,424	531
11	11	DAS	Ophthalmology Service	1,359	1,337	(23)	14,042	14,407	365
14	14	DAS	Orthodontic Service	37	28	(9)	345	342	(3)
16	16	DAS	Vascular Surgery Service	72	63	(9)	639	787	148
38	38	DAS	Urology Service	880	897	17	10,488	10,969	481
37	37	DAS	Trauma and Orthopaedic Service	1,538	1,551	12	17,015	17,960	945
7	7	Med	Gastroenterology Service	336	302	(34)	3,383	3,629	246
1	1	Med	Respiratory Physiology Service	130	25	(105)	741	611	(130)
13	13	Med	Respiratory Medicine Service	129	114	(15)	1,798	1,419	(379)
5	5	Med	Rheumatology Service	313	245	(67)	3,260	3,148	(112)
6	6	Med	Cardiology Service	731	673	(58)	7,741	7,907	166
4	4	Med	Neurology Service	198	131	(67)	1,996	1,778	(219)
22	22	Med	General Internal Medicine Service	61	60	(1)	709	634	(75)
40	40	Med	Clinical Haematology Service	253	282	29	2,969	2,791	(178)
15	15	Med	Stroke Medicine Service	13	4	(9)	127	109	(17)
26	26	Med	Transient Ischaemic Attack Service	44	44	(0)	487	471	(16)
21	21	Med	Palliative Medicine Service	4	0	(3)	25	10	(15)
17	17	Med	Paediatric Dermatology Service	7	-	(7)	70	-	(70)
29	29	Med	Hepatology Service	-	1	1	4	13	9
12	12	Med	Diabetes Service	49	31	(18)	567	477	(90)
39	39	Med	Dermatology Service	217	237	19	2,665	2,914	248
36	36	Med	BCSP	35	44	8	424	432	8
23	23	Med	Cardiac Rehabilitation Service	2	2	(1)	9	85	77
25	25	Med	Endocrinology Service	60	59	(0)	671	845	174
2	2	Med	Endoscopy service	685	587	(98)	7,453	7,233	(219)
42	42	Med	Clinical Oncology Service	145	183	38	1,833	1,742	(92)
44	44	Med	Sleep Medicine Service	-	147	147	-	1,041	1,041
43	43	SPH	SPH	239	336	97	3,466	3,988	522
3	3	UC	Acute Internal Medicine Service	81	7	(75)	905	568	(337)
31	31	UC	Emergency Medicine Service	-	1	1	-	4	4
19	19	UC	Elderly Medicine Service	29	25	(4)	328	363	35
10	10	WAC	Paediatric Service	167	144	(23)	1,808	1,588	(220)
33	33	WAC	Paediatric Surgery Service	6	9	3	114	93	(21)
30	30	WAC	Paediatric Epilepsy Service	4	5	1	83	58	(25)
34	34	WAC	Gynaecology Service	497	501	3	5,976	6,226	250

Finance | Capital

East Sussex Healthcare NHS Trust

Finance

Trust Lead	Capital Scheme	In Month Plan £'000	In Month Actual £'000	In Month Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000	Full Year Plan £'000	Full Year Fcast £'000	Fcast Risk	Full Year Variance £'000
	Original										
DIG	Digital Programmes	1,659	81	(1,577)	4,291	2,101	(2,189)	4,682	3,800	Low	(882)
DIG	Our Care Connected	-	208	208	-	2,292	2,292	2,500	2,500	Low	-
	Total Digital	**1,659**	**289**	**(1,369)**	**4,291**	**4,393**	**103**	**7,182**	**6,300**		**(882)**
EME	Diagnostic Equipment	-	214	214	978	979	1	2,000	1,650	Med	(350)
EME	MSC Implementation	-	-	-	476	-	(476)	476	-	Low	(476)
EME	Medical Equipment	301	227	(73)	775	561	(214)	2,200	2,192	Low	(8)
EME	Endoscopy (Internal)	-	-	-	-	-	-	2,500	1,575	Low	(925)
	Total Medical Equipment	**301**	**441**	**140**	**2,229**	**1,540**	**(689)**	**7,176**	**5,417**		**(1,759)**
EST	Fire	166	221	55	1,826	1,857	31	2,000	2,500	Med	500
EST	Backlog	523	(145)	(668)	2,464	3,691	1,227	3,100	4,467	High	1,367
EST	EDGH Cat 3 Labs	12	1	(11)	122	11	(111)	125	13	Low	(112)
EST	ICU adaptations (Phase 1)	12	(2)	(14)	122	558	435	125	630	Med	505
EST	Clinical Priorities - Prior Year	24	6	(19)	244	450	206	250	480	Med	230
EST	Endoscopy (Internal)	39	-	(39)	391	-	(391)	400	-	Low	(400)
EST	Sussex Surgical Centre (Trust Funded)	3,784	1,091	(2,693)	11,706	7,724	(3,982)	16,000	15,000	Low	(1,000)
EST	Ward Refurbishment	42	4	(37)	191	384	193	250	420	Med	170
EST	Ophthalmology Business Case	440	1	(439)	881	620	(260)	1,766	730	Low	(1,036)
EST	Cardiology business case	648	190	(458)	1,943	2,598	655	3,500	3,401	Med	(99)
EST	Emergency Department - WIS	84	7	(76)	418	24	(394)	500	25	Low	(475)
	Total Estates	**5,774**	**1,375**	**(4,399)**	**20,307**	**17,916**	**(2,391)**	**28,016**	**27,665**		**(351)**
FIN	Divisional Small Works	29	0	(29)	145	19	(126)	175	25	Low	(150)
FIN	Minor Capital	-	-	-	389	202	(188)	500	247	Low	(253)
FIN	Planned slippage/prioritisation	(1,339)	-	1,339	(4,426)	-	4,426	(6,439)	(500)	High	5,939
FIN	IFRS16 Lease Schemes	-	-	-	-	-	-	1,000	493	Low	(507)
FIN	ICB Brokerage	-	-	-	-	-	-	2,250	-	Low	(2,250)
	Total Finance	**(1,310)**	**0**	**1,310**	**(3,891)**	**221**	**4,112**	**(2,514)**	**265**	-	**2,779**
	System Capital	**6,423**	**2,105**	**(4,318)**	**22,936**	**24,070**	**1,135**	**39,860**	**39,647**		**(213)**
	New										
EST	Building For Our Future	150	212	62	1,335	1,195	(140)	1,859	1,859	Low	0
EST	Sussex Surgical Centre (TIF Funded)	1,000	(0)	(1,001)	3,000	9,271	6,271	9,271	9,271	Low	-
DIG	Diagnostics Digital Capability (LIMS)	121	145	23	388	694	306	607	1,154	Low	547
DIG	Diagnostics Digital Capability (OCS)	109	-	(109)	350	-	(350)	547	-	Low	(547)
DIG	Diagnostics Digital Capability (Image Sharing)	300	17	(283)	960	18	(942)	1,500	1,321	Low	(179)
DIG	Frontline Digitalisation (EPR)	3,000	233	(2,767)	4,000	1,511	(2,489)	6,484	6,484	Low	(0)
EST	Endoscopy (External)	2,000	6	(1,994)	7,000	908	(6,092)	10,000	10,000	Low	(0)
DIG	AI Diagnostics	33	102	69	106	131	25	165	165	Low	-
DIG	Connecting Care Records	-	-	-	-	-	-	290	290	Low	-
DIG	Critical Infrastructure Risk	-	-	-	-	-	-	100	100	Low	-
DIG	CoIN Network	-	385	385	-	385	385	345	345	Low	-
DIG	Secure Data Enviroments	-	-	-	-	-	-	200	200	Low	-
	Total Additional Capital	**6,714**	**1,100**	**(5,614)**	**17,139**	**14,112**	**(3,027)**	**31,368**	**31,189**	-	**(179)**
	Total Capital	**13,137**	**3,205**	**(9,932)**	**40,075**	**38,183**	**(1,892)**	**71,228**	**70,836**	-	**(392)**
FIN	Donated Expenditure	85	16	(69)	935	358	(577)	1,000	1,000	Low	-
FIN	Donated Income	(85)	-	85	(935)	(358)	577	(1,000)	(1,000)	Low	-
	Total Donated Capital	-	**16**	**16**	-	-	-	-	-		-
	Total Capital	**13,137**	**3,221**	**(9,916)**	**40,075**	**38,183**	**(1,892)**	**71,228**	**70,836**		**(392)**

Capital

- The planned capital allocation for 2024/25 is £71.2m.
- The capital expenditure incurred at month 11 totals £38.2m.
- Capital expenditure was largely driven by the following schemes:
  - Sussex Surgical Centre (Elective Care Hub) £17.0m.
  - Medical equipment £1.5m, including diagnostic equipment.
  - Estates works of £10.2m, the main schemes being, backlog maintenance (£3.7m), fire safety (£1.9m), cardiology services at EDGH (£2.6m), and ophthalmology (0.6m).
  - Building for Our Future £1.2m.
  - Digital £4.4m.
  - Frontline Digitalisation £1.5m.
- The Sussex Surgical Centre (SSC) has now been revised to complete in June 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 £17.0m to month 11 of 24/25.
- The SSC new build is in delay with completion estimated for June 2025. There are a range of potential outcomes and Estates are actively working to mitigate the 4 main risks (vacuum, UCV theatres, NETB2024/3 and Plant Room 9 water systems).
- The original plan for the SSC was to incur costs of £16m in 2024/25 from internally sourced funds. Following review, the forecast spend for 2024/25 has been revised downwards to £15m with £1.0m being moved into the next financial year. Total costs of the build are anticipated to cost £38.5m.
- The Endoscopy Suite originally planned for Bexhill, is being incorporated into the new Sussex Surgical Centre building. A total spend for the scheme is forecast to be £18.7m. In the first year (2023/24) costs of £3.4m were incurred (which represented an overspend of £0.1m) and funded by additional PDC. The remaining funding is split between system funding (£5.4m) and PDC funding (£9.9m).
- In 2024/25 expenditure is forecast to be £10.0m with £5.0m planned for 2025/26. An additional £2.5m for Endoscopy Scopes has been allocated however scopes will be purchased from the original funds.
- The Trust has an increased allocation of £6.7m from system strategic funding which has been made available from the system wide underspend on planned IFRS 16. This was agreed in January 2025.
- Overall, the capital allocation to the Trust has increased by £0.2m in month because of an additional national programme, Secured Data Environments.
- The Government have announced that the NHP for EDGH will be delayed until 2037, and the Trust has received confirmation that the central budget cover of impairments has been approved at £12.2m.
- 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**	29th April 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
Report Author:	Louise Holmes, Mortality and Learning from Deaths Programme Manager		
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 – September 2024 deaths, recorded and reviewed on the mortality database. 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. Learning disability deaths are subject to external review against the LeDeR (learning disability mortality review) programme. Trusts are now receiving feedback from these reviews, although the process is slow. We continue to review deaths of patients with learning disabilities internally due to the delays in the external process in order to mitigate any risk. There are two reasons as to why we are behind with regard to learning disability deaths; Firstly, we recently discovered that 15 cases dating back over 2 years had not been discussed, we have now discussed 9 of them. Four were found to have a learning difficulty rather than learning disability. The remaining two will be reviewed at the next meeting, if the LeDer report has been completed, but these have not been received yet., There is also a considerable time lag from death to external completion of the LeDeR report, without which we cannot proceed.		
Regulatory/legal requirement:	The reporting of "Learning from Deaths" to the Trust Board is a requirement in the Care Quality Commission review.		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☐		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
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 the deaths with a higher likelihood of avoidability, on a quarterly basis, to ensure accuracy in reporting. Deaths going to inquest, SIs, Amber reports, complaints and “low risk” deaths are all reviewed for completeness
Publication	Appropriate for publication

Avoidability of Inpatient Deaths Dashboard April 2017-September 2024 (Data as at 25/03/2025)

Department of Health

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

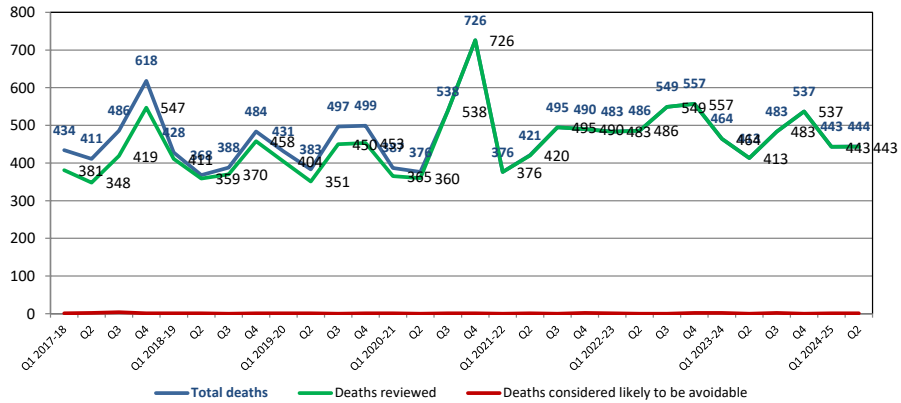
EAST SUSSEX HEALTHCARE TRUST: Avoidability of Inpatient Deaths Dashboard September 2024-25

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 25/03/2025)

Time Series:	Start date	2017-18	Q1	End date	2024-25	Q2

In-hospital deaths
Mortality over time, total deaths reviewed and deaths considered to have been potentially avoidable



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**
140	158	139	158	0	1
This Quarter (QTD)	**Last Quarter**	**This Quarter (QTD)**	**Last Quarter**	**This Quarter (QTD)**	**Last Quarter**
444	443	443	443	1	1
This Year (YTD)	**Last Year**	**This Year (YTD)**	**Last Year**	**This Year (YTD)**	**Last Year**
887	1897	886	1897	2	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**	1	11.1%	**This Month**	8	88.9%
This Quarter (QTD)	0	0.0%	**This Quarter (QTD)**	0	0.0%	**This Quarter (QTD)**	1	5.0%	**This Quarter (QTD)**	0	0.0%	**This Quarter (QTD)**	1	5.0%	**This Quarter (QTD)**	18	90.0%
This Year (YTD)	0	0.0%	**This Year (YTD)**	0	0.0%	**This Year (YTD)**	2	5.9%	**This Year (YTD)**	0	0.0%	**This Year (YTD)**	1	2.9%	**This Year (YTD)**	31	91.2%

Data above is as at 25/03/2025 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were three care concerns expressed to the Trust Bereavement team relating to Quarter 2 2024/25 deaths. One was taken forward as a complaint.
Complaints - Of the complaints closed during Quarter 2 2024/25 which related to to bereavement in hospital, all had an overall care rating of 'good care' or 'excellent care'.
There was one patient with an overall rating of 1 or 2, poor care. This case has been reviewed and was found to have a 50:50 probability of avoidability.
Serious incidents - There were 3 severity 5 patient safety incidents raised in Q2 2024/2025.
As at 25/03/2025 there are two September 2020 - September 2024 deaths outstanding for review on the Mortality database.

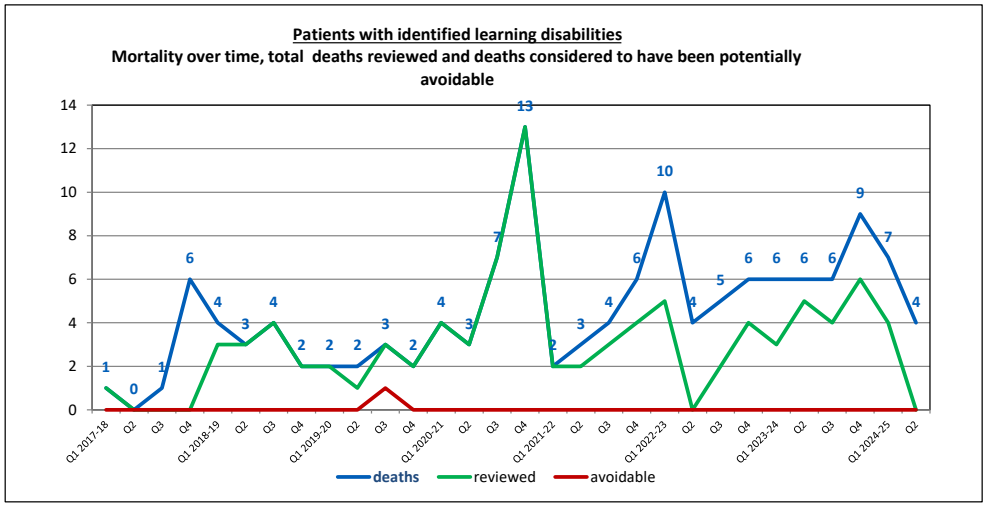
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 25/03/2025)

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

Time Series:	Start date	2017-18	Q1

End date	2024-25	Q2

Total number of deaths recorded in the mortality database - Learning Disability		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	7	0	4	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
11	27	4	18	0	0



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

Agenda Item: 12

Report To/Meeting	Trust Board	**Date of Meeting**	29th April 2025
Report Title:	MatNeo Overview Board Report Q3 2024/25		
Key question	As part of National reporting findings and Maternity Incentive Scheme (MIS) requirements all NHS Trusts are required to provide quarterly updates to their Boards about the quality and safety of maternity and neonatal services. This report is presented for approval and assurance following presentation to the Quality and Safety Committee. • Are ESHT Maternity services managed and monitored effectively? • Is overall safety maintained clinically? • Where concerns/incidents have been raised, has appropriate action been taken which is effective?		
Decision Action:	For approval ☒ For Assurance ☒ For Information ☐ For Discussion ☐		
Report Sponsor:	Vikki Carruth, Chief Nurse & Executive Maternity Safety Champion	**Presenter(s):**	Brenda Lynes
Report Author:	Brenda Lynes, Director of Maternity Services		
Outcome/Action requested:	This report is presented for approval. It provides assurance that the trust's Maternity services are managed and monitored effectively, overall safety is maintained clinically and where concerns/incidents have been raised, appropriate effective action has been taken. Information within this report provides evidence of the delivery of high-quality services and of ongoing compliance against all ten safety actions in line with MIS and the three-year delivery plan and action to mitigate where required.		
Executive Summary	This paper provides an overview of maternity and neonatal planning, progress and activity during quarter 3 2024/25 and assurance of the quality and safety of our perinatal services, including an overview of progress in meeting the perinatal clinical quality surveillance standards and action taken to proactively identify and mitigate any quality and safety concerns or risks. Updates have been included about the Three-Year delivery plan for maternity and neonatal services, the National CQC Maternity Survey 2024 and The MBRRACE Report 2022-2024 (Mothers and babies: Reducing Risk through Audits and Confidential Enquiries across the UK. Published October 2024.		
Regulatory/legal requirement:	NHSE compliance requires the Board to review and approve this report		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		

Resource Implication/VFM Statement:	Not applicable

Risk:	Local risk: The senior operational leads are a new team (other than the Head of Midwifery). Following the difficult period from Sept 23 – October 24, the new team are extremely positive and keen to move forward. An agreed programme of leadership/culture improvement has now commenced, to support the safe delivery of services in line with the three-year delivery plan. This will have a particular focus on leadership at Band 8 and 7 level to ensure that these colleagues fully understand both their role and accountability within that role and the process for providing assurance. Work is underway to strengthen the interface between the maternity department and the divisional governance team, both the Head of Midwifery and the Divisional Director are working on this process and recognise this as an area for action. The external independent investigation in Maternity has now reached its conclusion and a range of recommendations have been made. A detailed action plan is now being progressed. Key delivery to date includes; • Feedback to staff • A program of leadership development and training to secure psychological wellbeing and safety for leaders at every level • Tighter controls for recruitment have been agreed • A review of Maternity Leadership structure • A Peer review of clinical practices has been commissioned A no harm event took place in July 2024 which met the Never Event criteria. This has been discussed extensively at the Quality and Safety Committee. Action was taken at the time and since to reduce the risk of a reoccurrence. It is important to note that this was the first Never Event reviewed (as a Patient Safety Incident Investigation) under the new PSIRF process and it has highlighted that there is work to be done to ensure divisional teams and the central Patient Safety Team work cohesively to agree and embed actions required in a timely way.

No of Pages	2	**Appendixes**	1

Governance and Engagement pathway to date:	Prior to this overview report being presented at Public Trust Board, this report and supporting informing reports were reviewed and approved via the Quality and Safety Committee 23/04/25 on behalf of Trust Board. Areas covered in this report were addressed in MatNeo Governance and Accountability monthly meetings, MatNeo Assurance Meetings and MatNeo Clinical Board.

What happens next?	This report is for assurance and information. The subsequent quarter 4 2024/25 overview report is scheduled for presentation June 2025.

Publication	The report can be published.

East Sussex Healthcare NHS Trust

MatNeo Overview Board Report

Q3 2024/25 (October to December 2024)

Author: Brenda Lynes, Director of Maternity Services

Trust Board in Public 29/04/25

Contents

East Sussex Healthcare NHS Trust

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

The Maternity and Neonatal department have substantial evidence demonstrating effective co-production and collaborative working to proactively and positively improve services for our women and birthing people. During Q3 we have made good progress in line with the National CQC Service User audit action plan, including continuous improvement of our maternity website and progress to support partners in line with our 24-hour visiting. Work continues to improve our Induction of labour pathway and align processes across Sussex. Service users commented on the range of good quality information available throughout pregnancy

We are working to improve Service User experience, specifically around communication as to a baby's wellbeing when straddling the postnatal ward and our Special Care Baby Unit. Breastfeeding support is another area where improvements are required to ensure consistent advice is given. We have recently recruited two support workers who offer increased consistent support on the ward area, two feeding pods are now available on our postnatal ward. We have also recruited a discharge coordinator and have started an improvement journey in this area.

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

We reviewed the first three months of the newly Integrated Eastbourne Maternity Unit; overall the feedback is positive from both staff and service users.

Theme 2 - Growing, retaining and supporting our workforce

Quarter 3 has seen an expected increase in vacancy rates (5%), mainly because of staff retirement. Sickness overall has improved, with fill rates remaining static. Red flags for Q3 reflect that short term sickness has led to an increase in the use of escalation processes.
Our budgeted establishment is in line with Birthrate+ (2022 analysis) and we have recently completed a new review with data currently being analysed.

Neonatal nursing and medical services and obstetric medical services are all commissioned and delivered in line with national requirement.

Our staff survey actions have included focussed work on improving Personal Development Review compliance, ensuring staff understand their role and have clear annual Key Performance Indicators. We are analysing the latest survey results. Work is ongoing in-regards to flexible working and self-rostering.

The external independent investigation in Maternity concluded in October 2024. A detailed action plan in line with recommendations is currently being worked through. Leadership at every level is a key focus, external delivery is underway. Rebuilding the best aspects of the department's culture in line with our trust values is also a key focus.

We have an active Score Survey action plan this has evolved to include actions from the external review including pulse surveys (or similar). Cultural coaches, Professional Midwifery Advocates and our Trauma Risk Management (TRIM) team continue to focus on staff wellbeing

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

Overall perinatal mortality rate (PMR) Stillbirth & Neonatal deaths (NND) and Hypoxic ischaemic encephalopathy (HIE) grade 2&3 are all showing significant improvement with continued low numbers.

The stillbirth rate has continued to move in the right direction despite not having shown significant improvement since Aug 2023. The Trust is unlikely to meet the year end target of 1.81 per 1000 births. The neonatal death rate has shown significant improvement since November 2024 and overall perinatal mortality rates since Jan 24 and Hypoxic-ischaemic encephalopathy (HIE) grades 2&3 since March 2023. Improvements include a maintained high compliance in all areas of our Saving Babies Lives (SBL) V3 care bundle, we continue to embed our regional preterm optimisation quality Improvement initiative Prem 7. We are 99% compliant with the SBL toolkit verified by the Integrated Care Board and the local maternity and neonatal system (LMNS) and have met CNST requirements for year 6. We continue to make good progress with the aim for full implementation.

Our identified issue is lack of scanning capacity for both growth scans to meet the national required timeframes and uterine artery doppler compliance; the department is working to review provision of all scans to enable focussed work on essential scans.

Avoiding term admissions to the Special Care Baby Unit (SCBU) are below national average for Q3 (3.7), a Quality Improvement project is underway to review admissions for respiratory distress syndrome. We continue an ongoing review of caesarean section rates which have risen (as is the case nationally).

Focussed work to reduce health inequalities includes targeted smoking cessation support, vaccine uptake and healthy weight management. While ESHT do not follow national trends for inequalities relating to Black and Asian women and birthing people (see slides 11-14), numbers are very small and focussed work continues, specifically to ensure use of translation services at every contact where required.

Assurance is confirmed through the LMNS quarterly assurance group and our annual internal audit that full CNST compliance across all 10 safety actions has been achieved for year 6.

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

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

At a local level, with regards to our Claims, Complaints and Risk scorecard and Perinatal mortality reviews, our data is evidencing that we are a learning organisation and for Q3 there were no avoidable perinatal deaths. Actions include improving verbal communication and ensuring advice is sought from tertiary centres were applicable. A recent visit from the maternal medicine network evidenced good working practice and work continues with the neonatal network.

Five multi-disciplinary team (MDT) cases were closed during Q3 (two of which were over a year old). Identified actions included a review of guidance for the management of raised blood pressure and use of the bereavement suite. A cluster review moved the department to cease use of Monofer and move to a new line of treatment for iron deficiency during the perinatal period. One MNSI review was closed which required ESHT to review and confirm its placenta pathology process was in line with national guidance; this is now audited regularly.

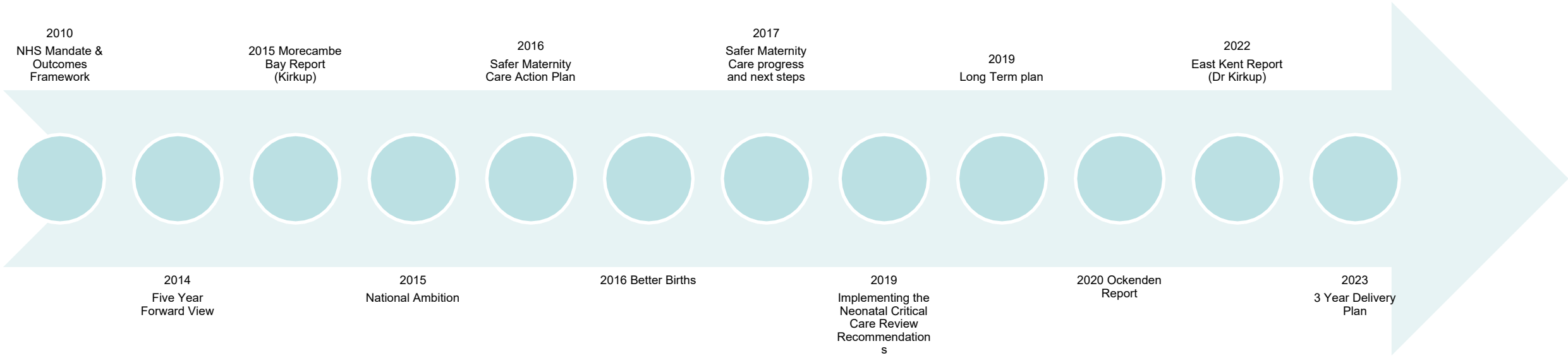
A no harm event took place which met the Never Event criteria in July 2024. This has been discussed extensively at the Quality and Safety Committee. Action was taken at the time and subsequently to reduce the risk of a reoccurrence. It is important to note that this was the first Never Event reviewed under the new PSIRF process and it has highlighted that there is work to be done to ensure divisions and the central Patient Safety team work cohesively to agree and embed actions required in a timely way.

TC pathway work is doing well. Across the network the main reason for admissions are respiratory and ESHT is not an outlier in this regard. An ESHT Quality Improvement project is underway which has been shared with the LMNS, who are keen for us to share any learning. In the last 10 months there were no avoidable term admissions to the neonatal unit which is positive.

The CQC action plan set a target of achieving 90% for Trust mandatory training and MatNeo averaged 88% during Q3. Q&S have seen and agreed key actions to improve overall percentages, with a target date of the end of April 2024 agreed.

East Sussex Healthcare NHS Trust

The Journey to a national Maternity and Neonatal Safety Ambition



The 3 Year Delivery Plan

East Sussex Healthcare NHS Trust

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

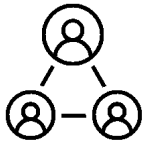
- Objective 1: Care that is personalised
- Objective 2: Improve equity for mothers and babies
- Objective 3: Work with service users to improve care

Theme 2: Growing, retaining, and supporting our workforce

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

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

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



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

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

Three Year Delivery Plan: Theme 1

Listening to and working with women & families with compassion (Q2)

East Sussex Healthcare NHS Trust

Work with Service Users to Improve Care

- Regular on-site walkabouts with our Maternity and Neonatal Voices partners; 15 steps completed for Early Pregnancy Unit and Special care baby unit
- 30 individual members of staff thanked by service users for going above and beyond
- Specific Neonatal and Early Pregnancy workstreams underway
- Coproduced ESHT and MNVP annual action plan from service user themes
- Coproduced ESHT and MNVP action plan following the national CQC maternity survey

Our Service User Voice	
You Said	**We Did**
Improve discharge processes	• Discharge coordinator in post, continue to work on a discharge lounge
Consider how we can improve Infant feeding support	• Improved website information (link to tongue tie and community feeding support). Current review of the entire pathway • Neuro divergence training introduced for all staff • New feeding pods available on the postnatal ward • Infant feeding supporters available daily on the postnatal ward

Three Year Delivery Plan: Theme 1

Listening to and working with women & families with compassion

East Sussex Healthcare NHS Trust

Improving Equity & Equality

- Improved data collection (13 months of data)
- Monthly equity and equality group
- Robust Public Health services within maternity
- Compliant with SBL v3
- Vaccination programme in progress (pertussis, seasonal flu, RSV program commenced 01/09/24)
- Targeted work on Folic Acid
- Targeted smoking cessation activity
- Established Maternal Medicine service across Sussex
- Robust Pelvic Health and Perinatal Mental Health Services
- Targeted work following NND as an immediate action surrounding the management of raised Blood Pressure (skills drills and medical teaching session)
- Black & Asian data does not follow national trends
- Areas of deprivation requires ongoing focussed work

Health Inequalities – Key themes

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

BME Population outcome measures

- 2 stillbirths since June 23 – average days in between stillbirths is currently 139 days
- There have been no neonatal deaths since June 23
- I HIE grade 1 (normal MRI) since June 23.
- All other outcome measures are showing no significant change and are showing natural level of variation we would expect to see from the process.

10% most deprived outcome measures

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

20% most deprived outcome measures

4 stillbirths since June 23

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

Health Inequalities: BME Population

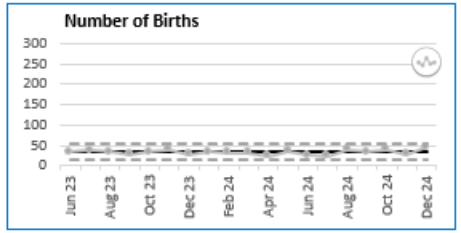
East Sussex Healthcare NHS Trust

Maternity overview | **ESHT BME**

Latest month 01/12/24

Number of Births 46

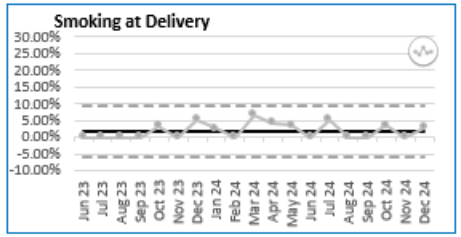
No significant change



Latest month 01/12/24

Smoking at Delivery 2.9%

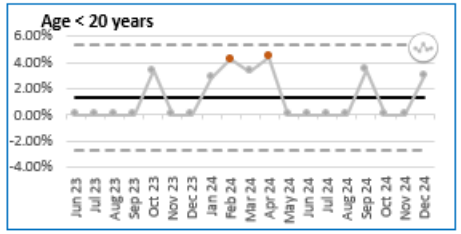
No significant change



Latest month 01/12/24

Age < 20 years 2.9%

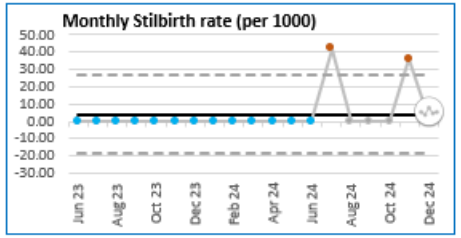
No significant change



Latest month 01/12/24

Monthly Stilbirth rate (per 1000) 0.00

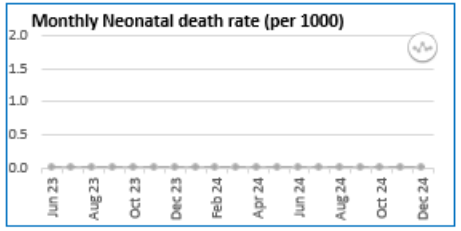
No significant change



Latest month 01/12/24

Monthly Neonatal death rate (per 1000) 0.00

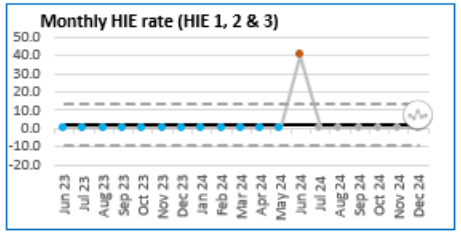
No significant change



Latest month 01/12/24

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

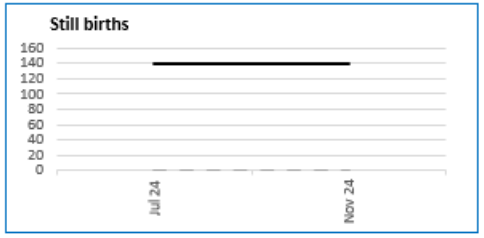
No significant change



Date of last stillbirth 30/11/24

Average days between stillbirths 139.0

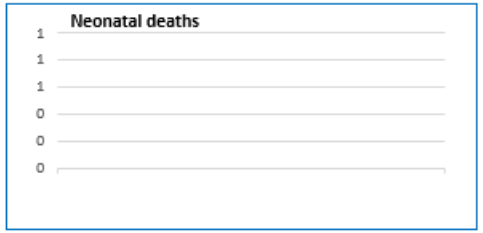
No significant change



Date of last neonatal death

Average days between deaths

No significant change



Date of last HIE 08/06/24

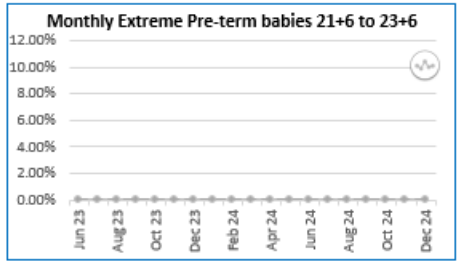
Average days between HIE

No significant change

Latest month 01/12/24

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

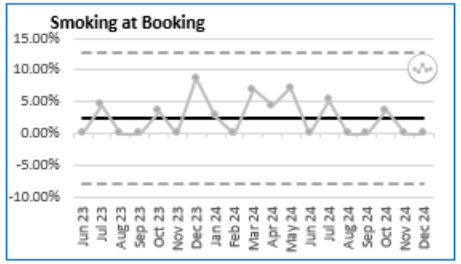
No significant change



Latest month 01/12/24

Smoking at Booking 0.0%

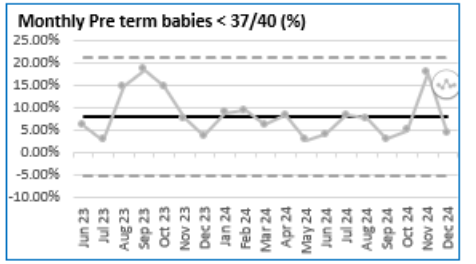
No significant change



Latest month 01/12/24

Monthly Pre term babies < 37/40 (%) 4.4%

No significant change

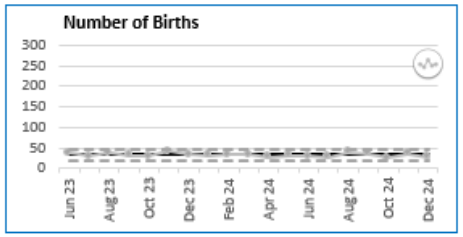


Health Inequalities: 10% most deprived

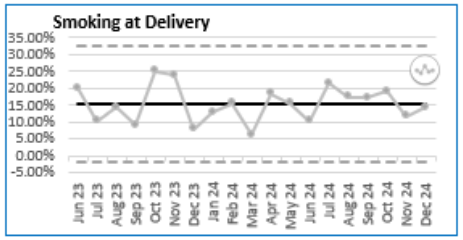
NHS East Sussex Healthcare

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

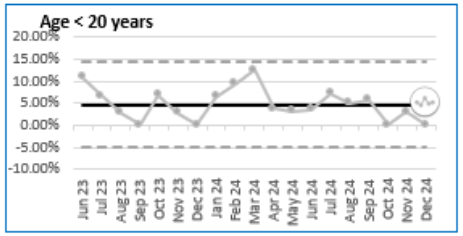
Latest month 01/12/24
Number of Births 28
No significant change



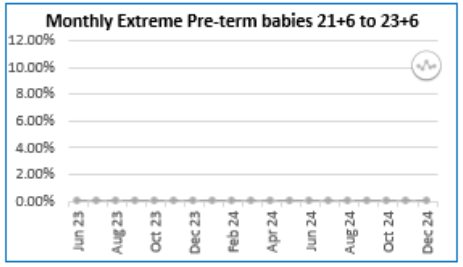
Latest month 01/12/24
Smoking at Delivery 14.3%
No significant change



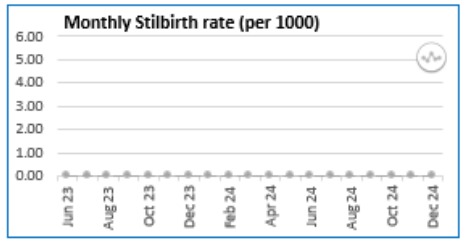
Latest month 01/12/24
Age < 20 years 0.0%
No significant change



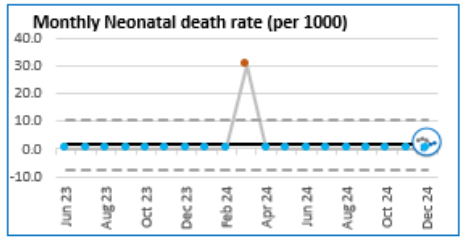
Latest month 01/12/24
Monthly Extreme Pre-term babies 21+6 to 23+6 0.0
No significant change



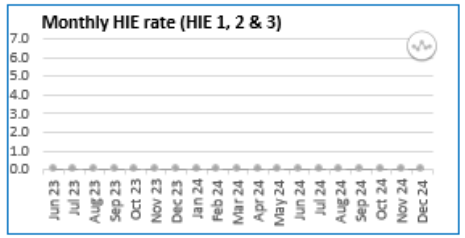
Latest month 01/12/24
Monthly Stilbirth rate (per 1000) 0.00
No significant change



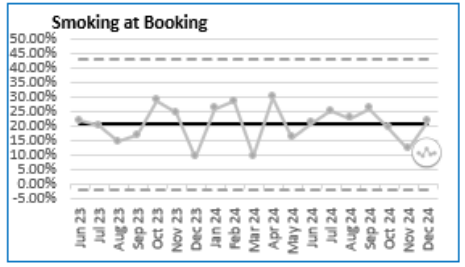
Latest month 01/12/24
Monthly Neonatal death rate (per 1000) 0.00
Significant Improvement



Latest month 01/12/24
Monthly HIE rate (HIE 1, 2 & 3) 0.00
No significant change

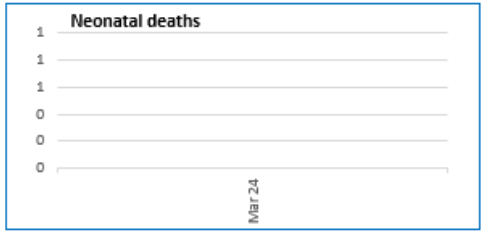


Latest month 01/12/24
Smoking at Booking 21.4%
No significant change



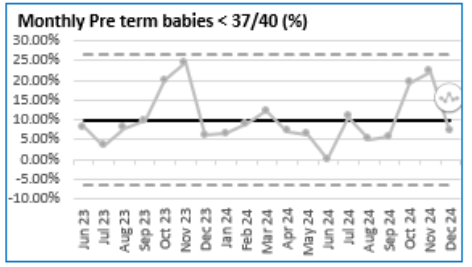
Date of last stillbirth
Average days between stillbirths
No significant change

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



Date of last HIE
Average days between HIE
No significant change

Latest month 01/12/24
Monthly Pre term babies < 37/40 (%) 7.1%
No significant change

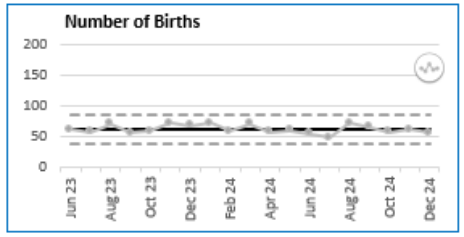


Health Inequalities: 20% most deprived

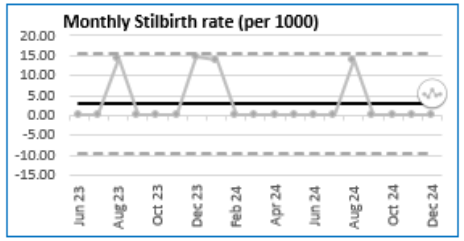
East Sussex Healthcare NHS Trust

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

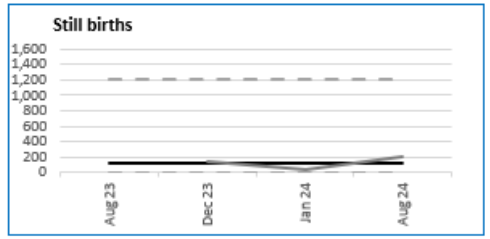
Latest month 01/12/24
Number of Births 56
No significant change



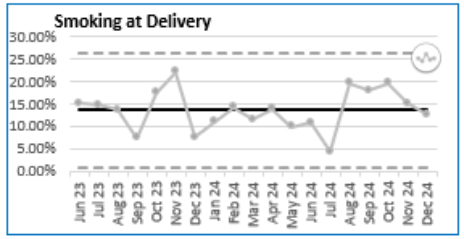
Latest month 01/12/24
Monthly Stilbirth rate (per 1000) 0.00
No significant change



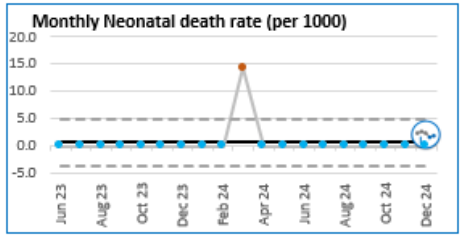
Date of last stillbirth 20/08/24
Average days between stillbirths 128.0
No significant change



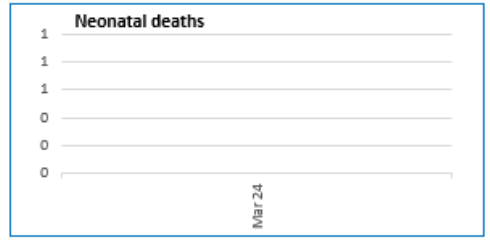
Latest month 01/12/24
Smoking at Delivery 12.7%
No significant change



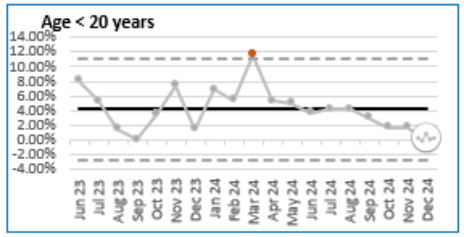
Latest month 01/12/24
Monthly Neonatal death rate (per 1000) 0.00
Significant Improvement



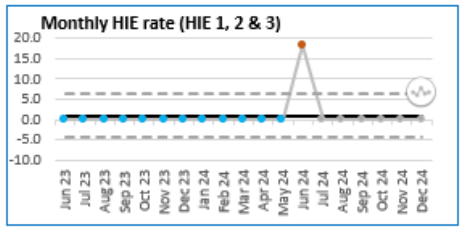
Date of last neonatal death 18/03/24
Average days between deaths
No significant change



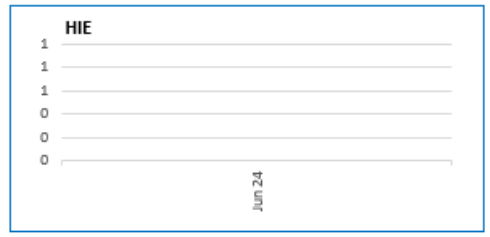
Latest month 01/12/24
Age < 20 years 0.0%
No significant change



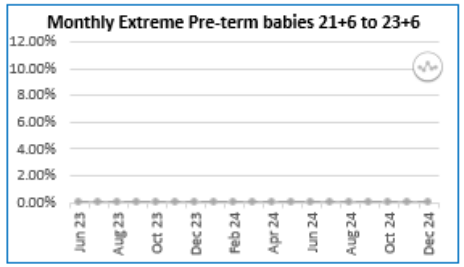
Latest month 01/12/24
Monthly HIE rate (HIE 1, 2 & 3) 0.00
No significant change



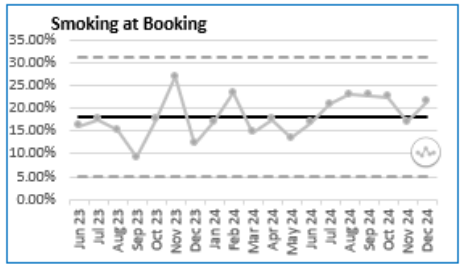
Date of last HIE 08/06/24
Average days between HIE
No significant change



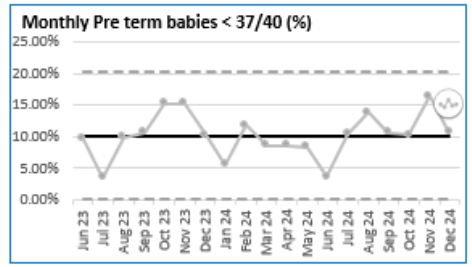
Latest month 01/12/24
Monthly Extreme Pre-term babies 21+6 to 23+6 0.0
No significant change



Latest month 01/12/24
Smoking at Booking 21.4%
No significant change



Latest month 01/12/24
Monthly Pre term babies < 37/40 (%) 10.7%
No significant change



Three Year Delivery Plan: Theme 2

Growing, retaining and supporting our workforce

Our workforce

East Sussex Healthcare NHS Trust

Maternity Workforce

Data Source	Q1	Q2	Q3	Q4
Sickness	1.9%	7.5%	6.3%	
Maternity Leave	4.7%	4.23%	4.1%	
Vacancy rate	1.6%	0.66%	5.0%	
Midwifery total fill rates	89.2%	86.7%	86.8%	

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

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

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

Three Year Delivery Plan: Theme 2

Growing, retaining and supporting our workforce

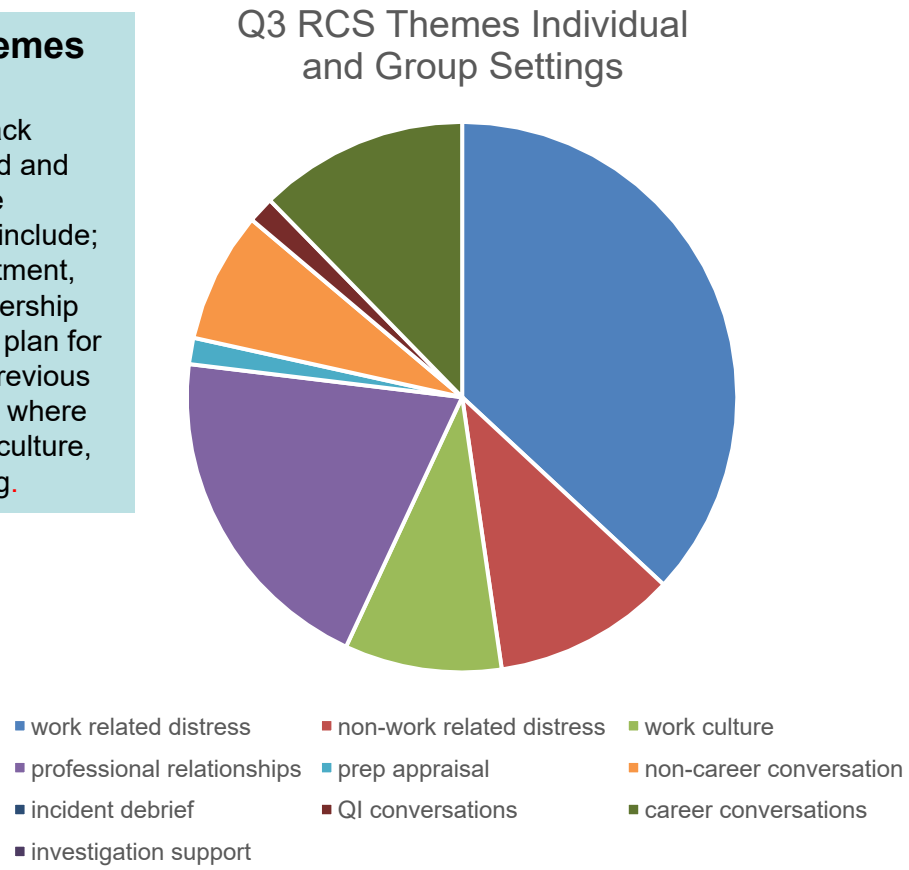
Our workforce

NHS East Sussex Healthcare NHS Trust

Clinical Maternity Red Flags Q3	Action
• Inability to take rest breaks	HoM working with team to review and plan/ escalation called where required
• Delayed commencement of Induction of labour	All cases are clinically risk assessment by the medical team prior to agreeing a delay

Staff Feedback Themes Q3

Themes from staff feedback reflect the concerns raised and investigated as part of the External review. Actions include; Tighter controls for recruitment, Review of Maternity Leadership structure, communication plan for all staff, work to restore previous good culture and improve where there were areas of poor culture, all actions are progressing.



Medical workforce: Obstetrics

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

Neonatal staffing: Medical

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

Neonatal staffing: Nursing

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

Qualified in Speciality (QIS)

Target 70%	Q1	Q2	Q3	Q4
	57.4%	50.2%	48%	

Action Plan in place with staff currently on training programme, expect to improve by August 25 (training program 18-24 months)
Over the past quarter 0 shifts fell short for QIS trained staff per shift

Vacancy rate	Q1	Q2	Q3	Q4
	7%	2.2%	7%	

Recruitment ongoing

Anaesthetic staffing

100% compliance Anaesthesia Clinical Services Accreditation (ACSA)

Three Year Delivery Plan: Theme 2

Growing, retaining and supporting our workforce

Our workforce

NHS East Sussex Healthcare NHS Trust

Training Needs Analysis (TNA)

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

Recruitment & Retention 3-year plan

Programme Aims

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

Key risks & mitigations

- Maternity leadership and culture review concluded. Key actions include:
  - Feedback to staff (completed),
  - A commitment to investing in leadership development and training to secure psychological wellbeing and safety provided. A programme is underway – informed by the external review
  - Harnessing full engagement from colleagues at all levels continues to be a key focus
  - Tighter controls for recruitment, Review of Maternity Leadership structure (completed)
  - work to restore previous good culture and improve where there were areas of poor culture – ongoing with positive results to date
  - Peer review of clinical practices (progressing)
  - Alignment of Professional Midwifery Advocates (PMA) with Trust Restorative Supervision approach to improve the quality of monitoring and evaluation – in progress

MatNeo Staff Survey Score report

Positives

- Good focus on Incidents
- Increased PDR compliance (and increased career conversations)
- Less people considering leaving the division
- Noted increased focus on wellbeing(trust –wide)
- Ongoing engagement sessions
- Vacancy rate is low

Learning Points

- Staff want to really know and understand their individual responsibilities
- Increasing MSK problems at work
- Staff feel worn out at the end of their shift
- Increased work-related stress (related to specific issues)

Actions

- Staff listening events in place and ongoing
- Results discussed with staff, who have been asked for their ideas for improvement
- Additional OH support to allow earlier return to work where possible
- OD work to be confirmed following external review

Three Year Delivery Plan: Theme 3

Developing and sustaining a culture of safety, learning and support

East Sussex Healthcare NHS Trust

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

	Q1	Q2	Q3	Q4
Rate	5.2	3.8	3.7	

Key actions:
- Quality Improvement project for Respiratory Distress Syndrome(RDS) in progress
- Ongoing review of caesarean section rates – noted decrease in LSCS at 37 weeks
- Order further equipment for transitional care (hot cot equipment) (below the national average rate for Q3)
- 86% were appropriate admissions
- 3 avoidable for social or increased TC facilities

Transitional Care (TC)

	Q1	Q2	Q3	Q4
No	73	47	27	
Main treatments	• IV antibiotics • Treatment for Hypoglycaemia	• IV antibiotics • Temperature support	• IV antibiotics • Phototherapy for Jaundice	
Actions	*Nil – 0 inappropriate admissions to SCBU*	*1– 1 inappropriate admission to SCBU – could have been managed through transitional care*	*1- 1 inappropriate admission to SCBU – feeding support*	

Saving Babies Lives (SBL) V3 Q3 2023/24

Implementation Progress

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

MDT Training target >90% at year end

CTG & fetal monitoring training competency	Q1	Q2	Q3	Q4
Combined Medic & Midwives	98%	94%	97%	

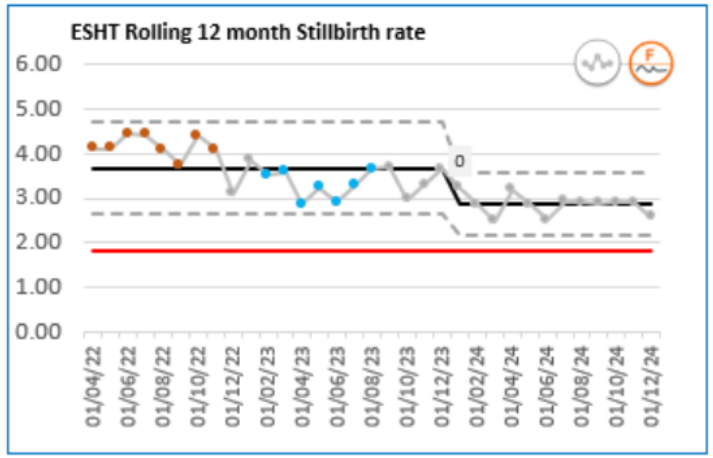
PROMPT compliance	Q1	Q2	Q3	Q4
Combined Medic & Midwives	90%	97%	93%	

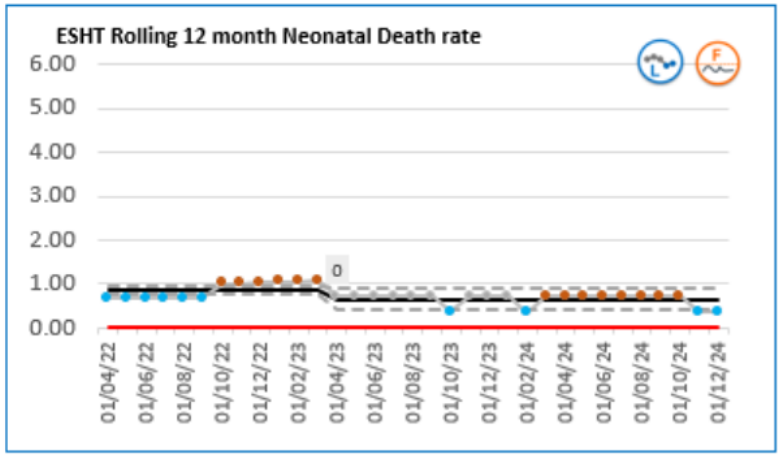
Developing and sustaining a culture of safety, learning and support

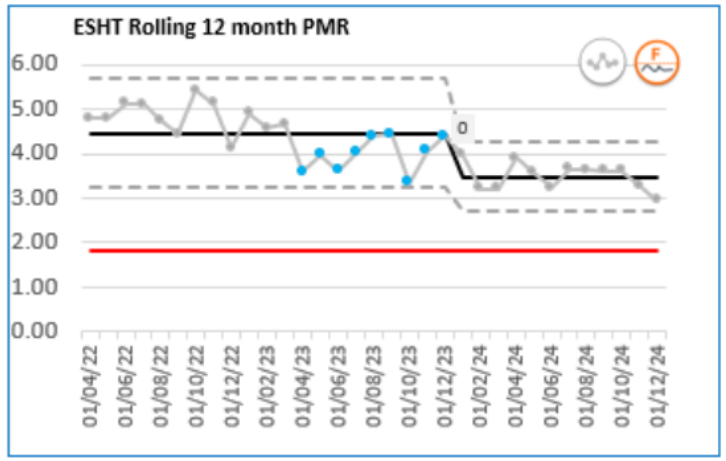
East Sussex Healthcare NHS Trust

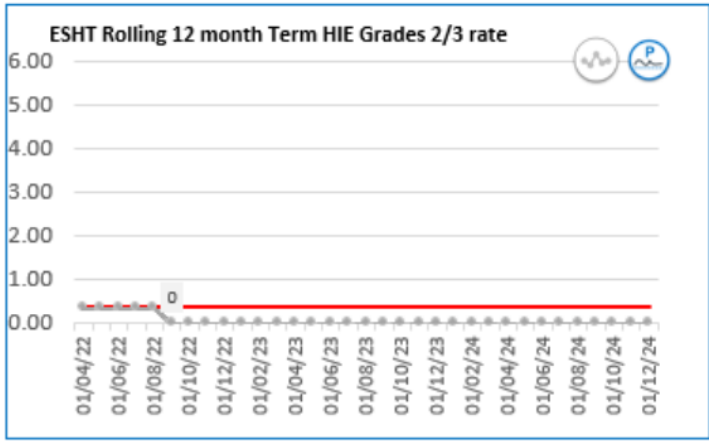
Perinatal Quality & Safety

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









Significant improvements

•Stillbirth rates no significant change since August 2023.

•Stillbirth rates ESHT unlikely to achieve the target reduction rate of 1.81 (red target line) per 1000 births without further improvement, noting this is a year-end target. However, the rates are continuing to move in the right direction.

Rolling 12-month Neonatal Death rate

•Significant improvement, since November 2024

•Neonatal deaths that ESHT unlikely to achieve the target reduction rate of 0.00 per 1000 births (red target line), noting this is a year-end target. However, the rates are continuing to move in the right direction.

HIE Grade 2/3

•Significant change since March 2023, assurance is showing the Trust will consistently meet the target if nothing changes.

Overall PMR

•No significant change since January 2024

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

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

Developing and sustaining a culture of safety, learning and support

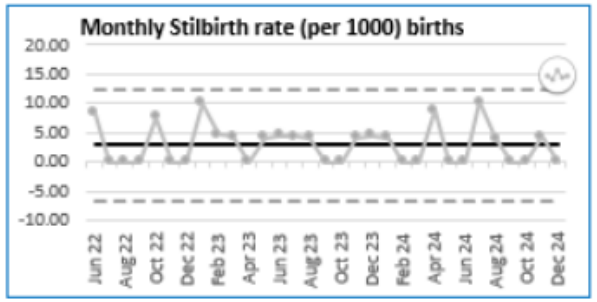
East Sussex Healthcare NHS Trust

Perinatal Quality & Safety

Rare event charts: are updated in real time and show the average days between stillbirths, neonatal deaths, and HIE (all diagnosis)

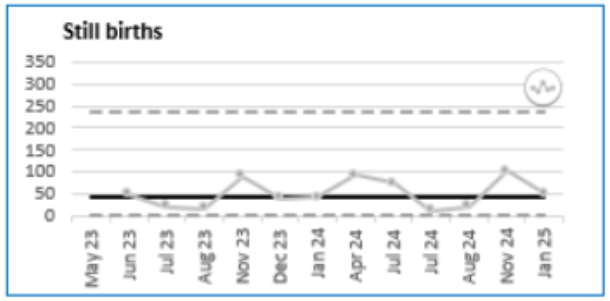
Latest month	01/12/24
Still birth rate/1000	0.00

No significant change



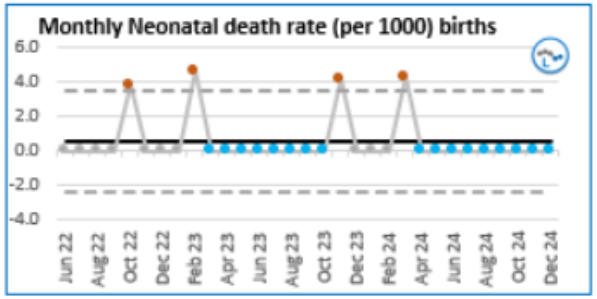
Date of last stillbirth	21/01/25
Average days between stillbirths	52.6

No significant change



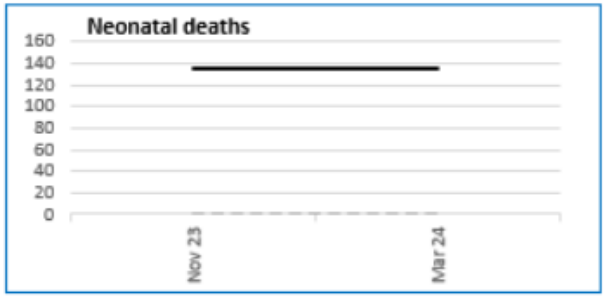
Latest month	01/12/24
Neonatal Death rate/1000	0.00

Significant Improvement



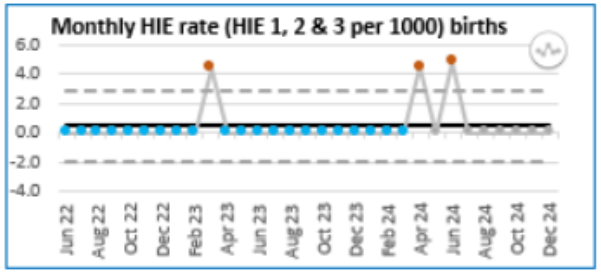
Date of last neonatal death	18/03/24
Average days between deaths	136.0

No significant change



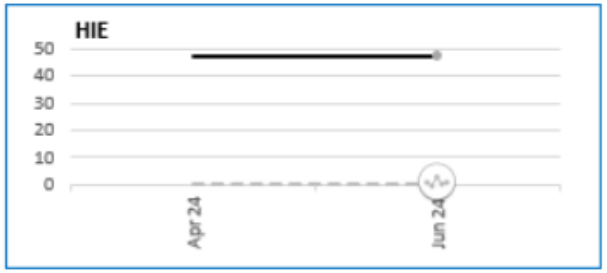
Latest month	01/12/24
HIE rate/1000	0.00

No significant change



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

No significant change



- **Significant improvements**
- Stillbirths: No significant change since August 23, neonatal deaths, overall PMR and HIE grade 2 & 3 no significant improvement due to continued shift of low numbers.
- Neonatal deaths: Significant improvement since November 2024. HIE, no significant change since March 2023

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

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

Developing and sustaining a culture of safety, learning and support

East Sussex Healthcare NHS Trust

Perinatal Quality & Safety

Closed Incidents	
Incident type	**Recommendations/ actions**
Closed MDT Cases **W**EB153797 (2023 case) **WEB142821(2022 case)**	• EMU staff to follow guidelines for raised Blood pressure during intrapartum period & maintain a written record of FH every 5 minutes • SOP written for the Bereavement suite to ensure SU's are medically fit for discharge prior to usage • Updated Guideline for management of Severe Hypertension/Eclampsia
WEB165848 (2024 case) WEB166902 (2024)	• Consider obtaining advice from a tertiary centre when managing unusual clinical presentations • Review LSCS process and role of MSW in breastfeeding support/ clarity of role & training where required. Review Midwife's role for breastfeeding support in theatre
Cluster Review (2024)	• Cease use of Monofer – FerrInject infusion as first line treatment
Closed MNSI/PSII MI-035595	• To ensure placentas are sent for pathological examination including histology in line with local and national guidance (Evans et al 2022).

Three Year Delivery Plan: Theme 4

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

East Sussex Healthcare NHS Trust

MatNeo Claims, Complaints, Incident Scorecard

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

No closed claims during Q3
Learning from closed complaints & Severity 3,4 & 5 Incidents

- no avoidable deaths
- Improve verbal communication with service users and between staff
- Ensure advice and guidance is sought from tertiary centres where applicable
- Review of caesarean section pathway underway
- Current pause on use of Monofer. Ferrinject to be first line iron infusion

Perinatal Mortality Review Tool (PMRT)

- 100% compliant with all standards

Key actions:

- MD & CNO meeting to discuss parity of Intra Uterine transfers across Sussex
- Communication to staff regarding the importance of using Translation services (where it is clinically safe to do so)

CQC Inspection action plan

Outstanding action: Mandatory training

- Achieve 90% for Trust mandatory training as listed in report (currently average 88.5%)
- Plan to achieve above 90% by end April 2025

All other actions complete

CNST Maternity Incentive Scheme (MIS)

- ESHT Board Notification form for Year 6 of the MIS submitted declared full compliance
- Once all submissions have been reviewed Trusts will be contacted directly to confirm final MIS year 6 results in late March, working towards making payments to all from end of April 2025 following the external publication of all results.
- Full MIS year 7 document and accompanying resources published 02/04/25

Feature Report: CQC national maternity survey 2024

East Sussex Healthcare NHS Trust

Who took part at ESHT

The population of maternity service users who took part in the survey for ESHT: 300 pregnant women and birthing people were invited to participate, 131 responded (45%), a slight decrease (1%) from 2023. This is above the average response rate for all trusts (41%).

- 49% of respondents gave birth to their first baby; 94% were heterosexual/straight, 4% bisexual, 2% prefer not to say, 0% other, 0% gay/lesbian
- Ethnicity: 84% white, 7% Asian or Asian British, 4% not known, 3% mixed, 2% Black or Black British, 1% Arab or other ethnic group
- Age: 35% 35 and over, 35% 30-34, 17% 25-29, 13% 19-24, 0% 16-18, English as main language 88%, 2% easy read materials, 98% no communication needs 1% Translation/interpreter and 0% sign language/Braille materials, large print or other.
- Religion: 55% no religion, 38% Christian, 2% Hindu, 2% Muslim, 2% other, 2% prefer not to say and 0% Buddhist, Jewish or Sikh.. LTC: 29% physical or mental health condition or illness
- Pregnancy-related health conditions: 28% pelvic health problems, 27% another pregnancy related health conditions, 54% none of the above and 1% prefer not to say.
- Baby received neonatal care: 30%

ESHT Headline Report: Summary of findings

Overall, ESHT remained about the same, slight progress was made for slightly, better than and much better than expected

Section 1: Antenatal Care

- Antenatal check-ups (score 8.8) - about the same
- During your pregnancy (score 8.9) - about the same
- Triage: Assessment and Evaluation (score 8.4) - about the same

Section 2: Labour & Birth

- Your labour and birth (no score due to low response numbers); Staff caring for you (score 8.5) – about the same

Section 3: Postnatal care

- Care in the ward after birth (score 8.1) – somewhat better than expected ; Feeding your baby (score 8.2) – about the same ; Care at home after birth (score 7.7) – about the same

Section 4: Complaints

- Complaints (score 6.8) – about the same

Benchmarking against self

ESHT results from the 2024 survey showed no significant change from 2023 results (which were excellent). There was no difference in 41 questions, 1 question scored significantly better, no questions were significantly worse from the previous year, there was a slight deterioration on 3 questions as shown in the below table. Two of those 3 still score well, the other (F13) has been considered within the action plan.

Feature Report MMBRACE report, published Oct 24

Sadly, an increase in the maternal death rate nationally. This increase is muti factorial with birthing people having multiple co morbidities in pregnancy. Many of the deaths were of women older than 35 years of age and the majority being overweight or obese, (64%).

Key drivers of maternity death are:

Thrombosis & thromboembolism are the leading cause of maternal death followed by Covid-19 & cardiac disease

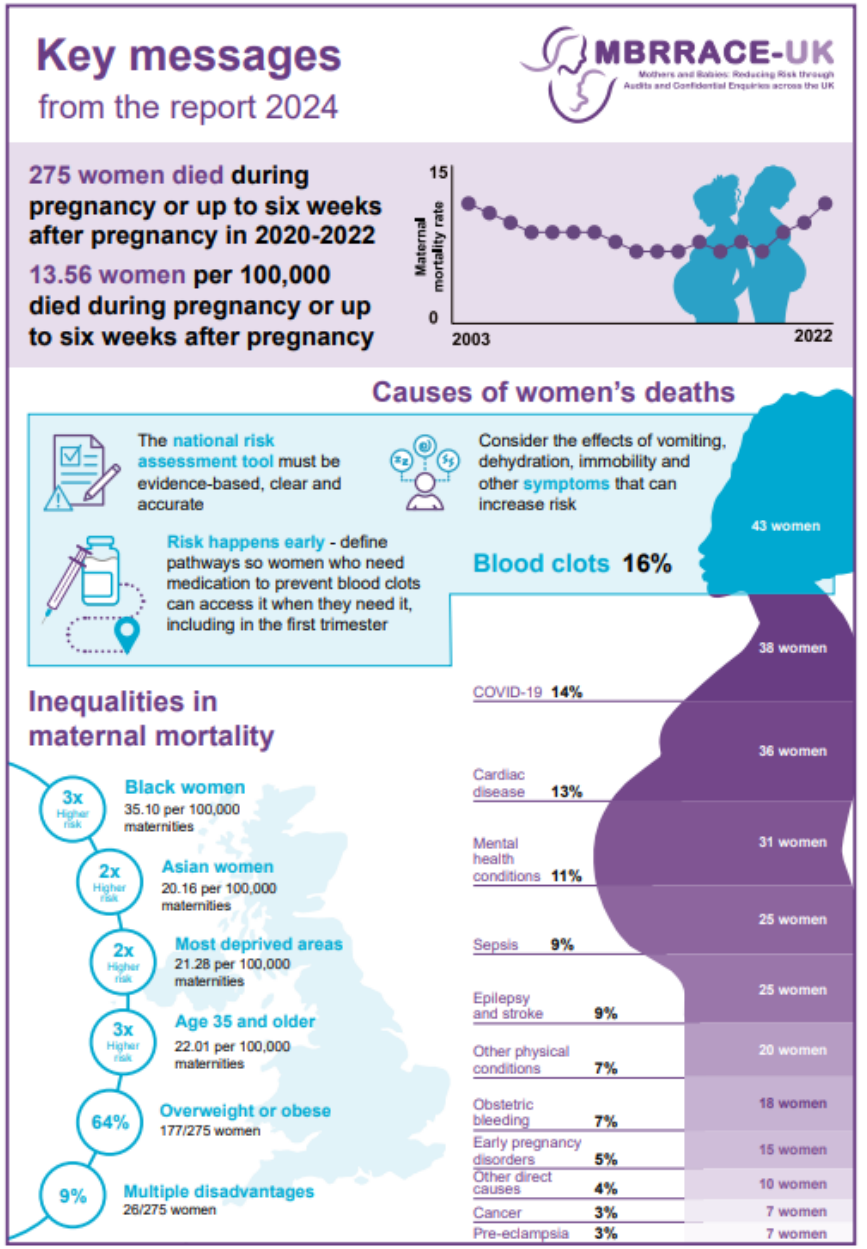
- Mental health related causes (34%) with suicide being the highest cause of maternal death between 6 weeks and 12 months after the end of pregnancy.
- Living in the most deprived area increased the mortality rate by twice than those living in the least deprived decile.
- Mortality rate 3 times higher in black ethnic background, and almost twice as high from Asian backgrounds compared to white women.

Local picture is not totally reflective of the national picture in terms of health inequalities regarding ethnicity and deprivation, but commonalities do exist with other themes, for example weight management.. Actions locally are underway

Recommendations:

- Continue to report on outcomes using a health inequalities lens ensuring early oversight & appropriate actions are in place.
- To work with Primary care to address the issues of VTE deaths (predominately during the first trimester or postnatally)
- Collaborate with public health teams to ensure maternity is considered when promoting a healthy lifestyle including weight management.
- Ongoing work through the Sussex LMNS Workforce and Education Forum (WEF) on translation, culture and cultural competency.
- Work is underway locally to address the MBRRACE findings

[Saving Lives, Improving Mothers' Care 2024 - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22]



MBRRACE-UK - Saving Lives, Improving Mothers' Care 2024 - Compiled Report

Agenda Item: 13

Report To/Meeting	Trust Board	**Date of Meeting**	29th April 2025

Report Title:	EmPoweR Electronic Patient Record Update
Key question	What is the current position of the EmPoweR Electronic Patient Record (EPR) programme ahead of the commencement of the formal implementation phase?
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐

Report Sponsor:	Dr Simon Merritt Chief Medical Officer EmPoweR EPR SRO	**Presenter(s):**	Dr Simon Merritt
Report Author:	Duncan Robinson, EPR Programme Director		
Outcome/Action requested:	The Board is asked to note the contents of the report for information and assurance.		

Executive Summary	In March 2025, following more than three years of dedicated, focussed work including a rigorous tender process, a contract to replace certain existing and now legacy clinical systems with a new EPR solution was signed. The Trust Board and the Executive Team were kept updated as to progress, risks, issues, costs and benefits throughout, with the Full Business Case (FBC) being approved locally within the Trust in late October 2024. This was followed by approval by the ICB in December, Region in January and the national Frontline Digitisation EPR Investment Board (EPRIB) in February 2025. The EPR Programme – branded locally as EmPoweR – is poised to commence a two-year implementation phase to deliver the Nervecentre EPR solution. This will be followed by a period of optimisation ahead of standard business as usual (BAU) running. The Trust has been supported throughout by the national Frontline Digitisation team and is also working closely with peer Trusts both within the Integrated Care System and from further afield.
Regulatory/legal requirement:	None – this paper provides an update to the Board.
Business Plan Link:	Quality ☐ People ☐ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration

Resource Implication/VFM Statement:	The EPR cost envelope (to include the cost of the solution itself together with the supplier and Trust implementation costs) was capped at £30m over the lifetime of the contract, and the FBC demonstrated affordability over this period through a combination of central and match-funded Trust capital and revenue. Detailed benefits realisation work identified a Benefits Cost Ratio (BCR) of 3.91 and the highest Net Present Social Value (NPSV) of the options discussed, demonstrating excellent value for money.

Risk:	High level risks, as contained within the EPR FBC, are presented within the report for information. All risks are owned and will be managed by the programme's Risk Review Group, with significant risks being escalated to the EPR Programme Board.

No of Pages	11	**Appendixes**	2

Governance and Engagement pathway to date:	The EPR Programme Board is responsible for oversight of the EPR programme deliverables and associated costs, risks and benefits. It reports up through Transformation Board to the Finance & Productivity Committee.

What happens next?	EPR implementation will commence in May 2025 and run for approximately two years. Pre-implementation planning continues to take place.

Publication	The update may be presented as part of the public Board session

Introduction/Background

In March 2025, following more than three years of dedicated, focussed work including a rigorous tender process, a contract to replace certain existing and now legacy clinical systems with a new Electronic Patient Record (EPR) solution was signed. Trust Board and the Executive Team was kept updated as to progress, risks, issues, costs and benefits throughout, with the Full Business Case (FBC) being approved locally within the Trust in late October 2024. This was followed by approval by the ICB in December, Region in January and the national Frontline Digitisation EPR Investment Board (EPRIB) in February 2025.

The preferred supplier is Nervecentre whose software we already use within ED and other targeted areas across the Trust, and will replace the following clinical and operational systems:

- PAS
- Theatres
- EPMA
- Orders & Results
- Clinical Coding, via a third-party solution embedded into the Nervecentre product
- eSearcher in-house developed clinical information system
- Portering
- Casenote Tracking

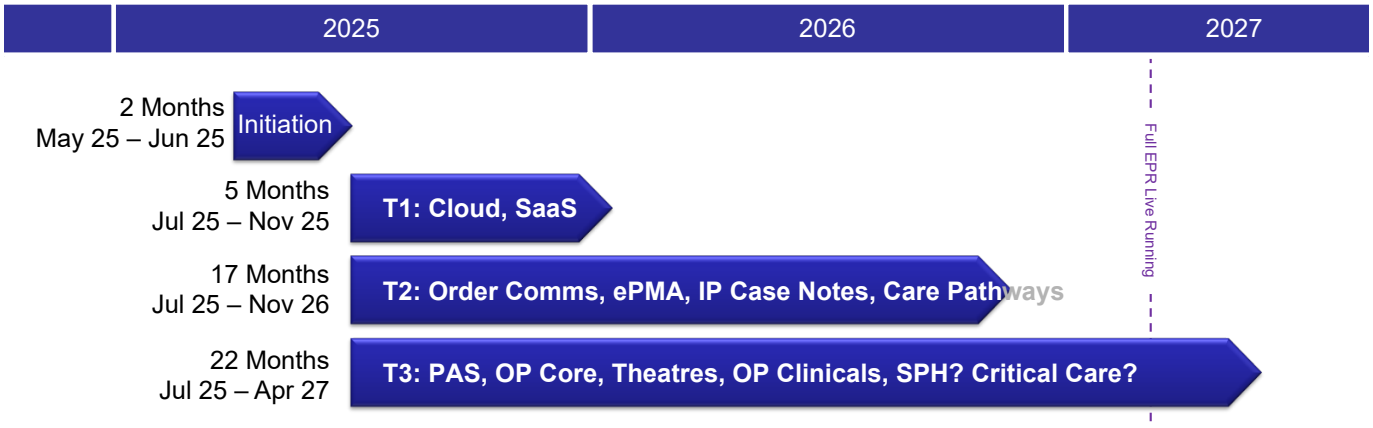
Allied to this we are also replacing the Kainos Evolve electronic document management system (EDMS) with an ICS-wide alternative (Mizaic Mediviewer) and this will be embedded within the new EPR to provide clinicians with seamless access to patient information on demand at the point of care.

Included within the Nervecentre bid but currently out of scope were Critical Care and a patient app although critical care has its own mature clinical solution and the patient app (Patients Know Best [PKB]) has been chosen at an ICS level to provide all Sussex patients with a consistent experience.

High Level Timeline

The EPR implementation is planned to commence within the initiation phase in May 2025 and take two years to complete. Resource plans were developed and included within the FBC covering this two-year implementation plus a period of up to a further two years for optimisation prior to full BAU operation.

The implementation comprises an initiation/discovery phase followed by three parallel tranches; the first migrating the existing on premise Nervecentre solution to the cloud followed by two more clinically focussed tranches, as follows:



A full breakdown of the above is presented at Appendix A below.

Issues and Risks

The FBC has demonstrated affordability over the lifetime of the contract however, as with all clinical system implementations aiming to deliver transformation, risks have been identified, captured and are being managed.

Within the programme governance structure a dedicated Risk Review Group has been established, co-chaired by the Chief Nursing Information Officer (CNIO) and the EPR Programme Director. Meeting bi-monthly, this forum ensures all programme risks are captured, owned and managed, with significant risks escalated to the EPR Programme Board.

A full risk register is maintained as part of the programme and the key risks, broken down thematically, were presented within the FBC, with risk categories including:

- Resources
- Infrastructure
- Implementation
- Engagement
- Configuration
- Commercial
- Change

The risks captured within the FBC are presented at Appendix B below.

Benefits

Significant benefits capture work has taken place to identify, detail, manage and track benefits associated with the implementation of the new EPR. These break down into cash releasing (CRB), non-cash releasing (NCRB), societal (SB) and unmonetizable (UB) benefits, and these have been mapped to the strategic and investment objectives of the Trust, recognising some benefits deliver against multiple investment objectives. Each benefit has an owner, SMART metrics, a realisation timeline and all CRBs also link to planned CIPs delivered by their respective benefit owners.

The table below presents the benefits assessed both within the much-reduced OBC scope and the far more comprehensive FBC scope. From a value for money perspective the preferred Enterprise EPR option provided a Benefits Cost Ratio (BCR) of 3.91 and the highest Net Present Social Value (NPSV) of the options discussed.

£	Option 0 BAU	Option 1 Do Minimum	Option 2 Enterprise EPR
Discounted CRBs	-	4,133,871	14,669,029
Discounted NCRBs	-	656,588	45,121,855
Discounted SBs	-	1,714,383	5,183,467
Total	**-**	**6,504,842**	**64,974,351**
Total (OBC)	**-**	**4,783,908**	**38,966,414**

Support

The national Frontline Digitisation team continues to provide detailed and comprehensive support across all areas of EPR procurement, deployment, transformational change and ongoing management. Specific procurement support was provided by NHS LPP, who are now assisting the Trust with supplementary EPR contract management support as part of a central agreement. We are working closely with ICS partner organisations and have also recently reached out to the East Midlands Acute Provider (EMAP) Digital Design Collaborative (DDC), which is a group of Trusts within the East Midlands who have procured Nervecentre and who are sharing learning and best practice.

Conclusion

The Trust is set to commence its EPR implementation following rigorous business case, tender and contract finalisation processes. Resources have been identified and a programme governance structure put in place which builds on existing governance forums, existing Trust programme delivery experience plus advice and guidance from peers local, regional and national peers and from the supplier. Risks, issues and benefits are being continuously reviewed and managed,

Recommendations

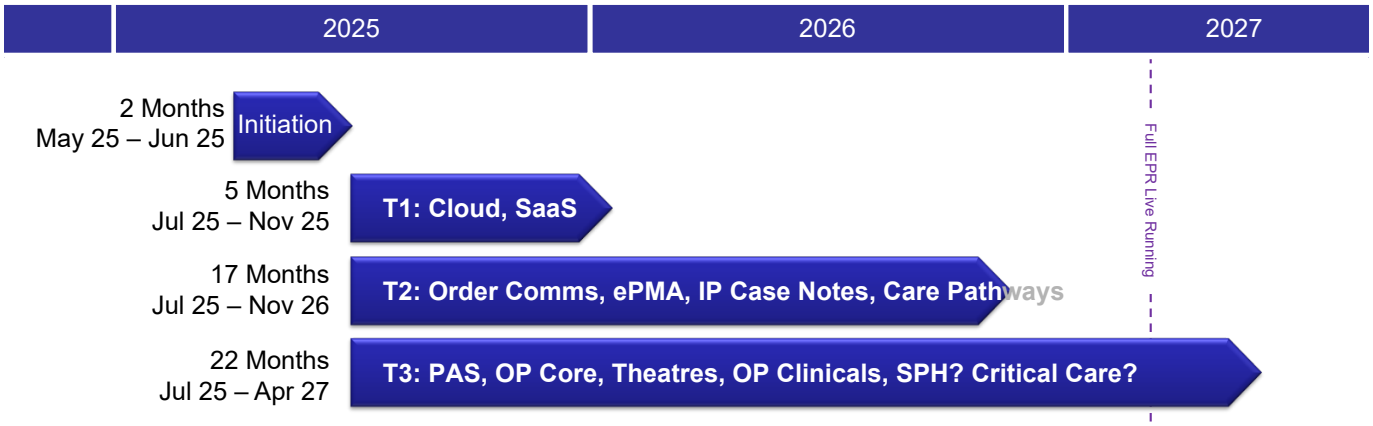
Trust Board is asked to note the contents of this update.

Appendix A – EmPoweR EPR Implementation Plan – Overview and Key Milestones

The current implementation plan is based on the plan submitted by Nervecentre as part of their tender bid back in May 2024. During the contract finalisation process several small changes were made to this plan as a result of contact between supplier and the Trust being permitted, however one key output following that contract finalisation process is the need for both parties to agree a detailed implementation plan. This is to be produced, agreed and published within 60 working days of contract signature, which is on/around 20th June 2025.

As such this briefing paper is based on the original plan and the milestones contained therein.

The high-level timeline is as follows:



The plan also includes currently out of scope modules including Critical Care and the Nervecentre Patient App, both of which can be assessed at a later date. We are also looking to implement elements of the solution within Sussex Premier Health although they will also retain the existing Compucare solution for billing purposes.

The tranches are broken down within the following sections.

Initiation
(6th May '25 – 2nd July '25)

This phase runs from early May to early July and covers Programme Mobilisation and Programme Definition (PID) and Planning

Item	Dates
Programme Mobilisation • Team Assignment & Kick Off Meetings • Mobilisation Plan • Initial Comms activities • Programme Team Knowledge Transfer • EPR Governance Structure Confirmed	**06/05/25 – 02/07/25**
Programme Definition • Review Benefits & Business Case • Information Discovery • Programme Strategy Development & Review • Develop Programme Timeline • Tranche 1 Project Briefs • Produce, Agree, Sign-Off Project Definition Document (PID) and Programme Plan	**08/05/25 – 02/07/25**

Tranche 1 – Migration to the Cloud
(3rd July '25 – 14th November '25)

Immediately following on from the Initiation Phase is the migration of the current "on premise" Nervecentre software to the cloud and on to the Software as a Service (SaaS) platform. To realise this there is some pre-work required which involves an upgrade to the current version from v8.2 up to v9.2 which is the SaaS compatible version. While this is being tested the supplier will be building the SaaS environments (Test, Train and Production) for the ESHT instance to occupy, before populating it and making it available for pre-cutover testing.

Item	Dates
Build SaaS Environments	**03/07/25 – 09/09/25**
Nervecentre version 9.2 Upgrade	**15/07/25 – 12/09/25**
Trust Infrastructure Planning for SaaS • Firewall & Connectivity Management • Mobile Device Management • Web/Workstation Management • BCP Approach • IG Review & DPIA	**10/07/25 – 25/08/25**
Migrate Data & Services to SaaS • DEV/SANDPIT(s) for Cloud Testing • UAT for Cloud Testing • PROD/TRAIN for Cloud Testing • Freeze "On Prem" PROD config updates • Final Data Migration, Testing and Sign-Off • "On Prem" decommissioning able to commence	**17/09/25 – 14/11/25**

Tranche 2 – IP Medical Systems, EPMA, Orders/Results, Escalations, AKI & Sepsis, Care Plans, PSB Optimisation
(3rd July ’25 – 30th November ‘26)

Starting in parallel with Tranches 1 and 3, Tranche 2 focusses on Inpatient-related modules and functionality. Similar to Tranche 3, all key project resources will participate in an initial training and knowledge transfer exercise to ensure they have the skills and knowledge to enable targeted configuration of the modules being deployed within this tranche.

Go lives will take place between September ’26 and November ’26 with a 3-month period of service stability following this before the milestone is deemed delivered.

Item	Dates
Training & Knowledge Transfer	**03/07/25 – 26/09/25**
Tranche Mobilisation – PIDs, Plans, Resources	**04/07/25 – 26/09/25**
Service Discovery & Config Build / Optimise • ED Discharge and PAS IP Admission Automation • Live Bed State (Patient Flow) • IP Case Notes • EPMA • Order Communications • Care Pathways • IP Clinical Documentation: Sepsis & AKI • Hospital @ Night	**26/09/25 – 08/04/26**
Integration & Interoperability Design & Build	**11/12/25 – 24/04/26**
Data Migration Design	**17/02/26 – 24/04/26**
Testing Cycles	**19/03/26 – 27/08/26**
Training & Go Live Planning	**03/06/26 – 20/11/26**
Go Live Cutovers • IP Case Notes • Care Pathways • EPMA • Order Communications	**08/09/26 – 30/11/26**

Tranche 3 – PAS, Theatres, Advanced Scheduling, OP Core, OP Clinicals
(3rd July '25 – 26th February '27)

Starting in parallel with Tranches 1 and 2, Tranche 3 focusses on Outpatients, PAS and Theatres functionality. Similar to Tranche 2, all key project resources will participate in an initial training and knowledge transfer exercise to ensure they have the skills and knowledge to enable targeted configuration of the modules being deployed within this tranche.

Go lives will take place between February '27 and March '27 with a 3-month period of service stability following this before the final implementation programme milestone (M7) is deemed delivered.

Item	Dates
Training & Knowledge Transfer	**03/07/25 – 06/11/25**
Tranche Mobilisation – PIDs, Plans, Resources	**14/07/25 – 04/11/25**
Service Discovery & Config Build / Optimise • PAS and 'As Is' Benefits/Issues • OP Clinicals • Critical Care *(this is currently out of scope)* • Theatres • Advanced Scheduling • Patient App *(this is currently out of scope)*	**21/08/25 – 21/05/26**
Integration & Interoperability Design & Build	**17/02/26 – 19/08/26**
Data Migration Design	**11/03/26 – 26/08/26**
Testing Cycles	**12/06/26 – 29/01/27**
Training & Go Live Planning	**05/10/26 – 08/03/27**
Go Live Cutovers • IP Case Notes • Care Pathways • EPMA • Order Communications	**12/02/27 – 18/03/27**

Appendix B – Key Risks presented within the FBC

Risk ID	Key Risk	Mitigation
R - 011	**Engagement** - There is a risk, the Engagement and Cultural Change required to support the strategy will not happen as quickly as needed or expected.	Development of a change approach and communications plan, attendance at operational management meetings. Support of the staff engagement team. Looking at the process and procedures within the Digital Change Team to support greater engagement.
R - 002	**Resources** - There is a risk, the resources within Digital do not have the capability or capacity to support the design and implementation of the strategy or EPR.	Investigate the option of third-party support via partnership with suppliers to reinforce the internal resources. Upskill the teams based on the roadmaps. Review the organisational structure of the Digital team with a view to having a dedicated Transformation team.
R - 008	**Commercial** - There is a risk that the procured EPR needs to link to a greater number of other solutions/systems. This will impact on the timescales for delivery and usability.	The FBC will set out the detailed investment required to implement a new EPR. It will include reference to those additional requirements outside of the core EPR that will require additional investment. Integration costs from suppliers of the other solutions will be quoted and included in the FBC costs.
R - 011	**Configuration -** There is a risk that the solution cannot be configured to meet the Trust's specific processes.	Detailed demonstrations and dialogue will aim to identify issues and seek out solution's pre-contract. There is an awareness that some processes will need to change as a result of moving away from paper-based processes. The FBC will additionally identify those areas where the core EPR functionality does not meet all requirements. Routine risk monitoring will allow for escalation of missing/inflexible functionality that may need to be addressed.
R - 014	**Implementation** - There is a risk that the Trust will be unable to resource the implementation sufficiently resulting in programme delays and/or rework.	Resources to support implementation and adoption will be included in the OBC and refined in the FBC, developed based on experience from other organisations and with input from key operational and clinical stakeholders in the Trust. Supporting the HR Strategy will ensure that adequate resource is released in support of all phases of the EPR Programme.

Risk ID	Key Risk	Mitigation
R - 015	**Infrastructure** - There is a risk that additional infrastructure will be required to support the solution.	Detailed infrastructure requirements will be reviewed in the production of the FBC. Alignment of programme timeframes with the infrastructure improvement programme currently being scoped in the Trust. Hosting costs are included as part of the overall enterprise EPR solution costs.
R - 017	**Change** - There is a risk that the solution will require substantial change post-live to properly support Trust workflows.	Ensure substantial 'content' provided as part of initial deployment. Detailed milestone plan as part of contract outlining development of non-core functionality and supporting payment milestones. Workflow changes will be supported by the Transformation team and existing change team which will work on continuous improvement as part of an MDT with the training, clinical config, Digital Engagement leads and EPR Nurses.
R - 018	**Change -** There is a risk that substantial additional change activity will be needed to enable the business to use the solution.	Plan for post go-live optimisation. Business Change will constitute an essential function with the EPR Implementation Team. The Change Management strategy will be included in the FBC submission. Design work and ongoing liaison with Trust's clinical, operational and management communities as part of the FBC process will help to initiate areas of concerns that will need to be addressed early. Support for users, clear leadership and an effective training and communications campaign to highlight users' roles and responsibilities and benefits of use of the system will be required.
R - 019	**Change -** Key stakeholders such as staff may not support the EPR implementation and hence not make full use of it. This will result in the Trust not realising the full benefits of the EPR.	The Trust will undertake a structured programme of stakeholder engagement activities to communicate the benefits of the EPR Programme and encourage buy-in. Change champions from across the Trust will be identified and engaged early in the process. User centre design principles will be used when working with stakeholders to ensure their needs are being fully considered and met. External consultants will be procured to work with the Trust on this process. We will encourage the users to use a continuous cycle of change methodology to maximise the efficiencies in the processes to ensure the system procured is fit for propose. We have also completed requirement workshops and have a comprehensive requirements catalogue using MOSCOW categorisation.

Agenda Item: 14

Report To/Meeting	Trust Board	**Date of Meeting**	29th April 2025
Report Title:	Trust Financial Plans 2025/26 – Revenue and Capital		
Key question	What are the Trusts financial plans that support and allow for strategic and operational delivery?		
Decision Action:	For approval ☒ For Assurance ☐ For Information ☐ For Discussion ☐		
Report Sponsor:	Ian O'Connor Chief Finance Officer	**Presenter(s):**	Ian O'Connor Chief Finance Officer
Report Author:	Ian O'Connor, Chief Finance Officer		
Outcome/Action requested:	The Trust Board is asked to: • Formally endorse the Trusts revenue and capital and revenue plans • Endorse the approach taken to financial planning and in particular the need for a rolling 18 month plan updated twice a year		
Executive Summary	Revenue financial plans have been set against a backdrop of aligning operational plans within the financial resource. A balanced financial plan has been set and this expects a challenging yet deliverable expectation of a 6.3% financial improvement in 2025/26. The Capital plan is at present overcommitted and further work is needed with stakeholders to address some risks and strategic objectives.		
Regulatory/legal requirement:	None 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:	None		
Risk:	A 6.3% financial improvement programme is a challenging ask, however plans exist for every element of the plan and there are likely to be upsides both in the timeliness of delivery and other schemes that are currently in progress and under review		
No of Pages	1	**Appendixes**	One
Governance and Engagement pathway to date:	Elements of this report have been discussed in variety of forums including Use of Resources Committee, the Executive Leadership Team, Finance and Productivity Committee and the Board Development Day		
What happens next?	The Executive will enact the plans through their teams		
Publication	Yes		

East Sussex Healthcare NHS Trust

Trust Financial Plans 2025/26
Revenue and Capital

Contents	Page

Ian O'Connor
Chief Finance Officer
April 2025

Revenue Plan

East Sussex Healthcare NHS Trust

Context and Approach

The financial year ended with the Trust reporting a draft deficit of £8.9 million in its draft accounts.

In its drive to secure a more sustainable financial future the Trust at all levels engaged in a change to the way in which it approached both the monitoring of its budgets and the setting of budgets as we approached 2025/26.

Key changes were:

- to recognise areas of continuous variance from plan and seek to establish a financial plan that was recognised and agreed across the Trust as reflecting Divisional operational plans for the year
- to reflect non recurrent support and non recurrent solutions to the delivery of the 2024/25 position in the plan for the year though analysis and consistency of Divisional run rate monitoring
- to ensure resources would be available to cover the nationally predicted costs of pay awards and inflation
- to ensure we have some resource over winter to cover the excess costs of escalation capacity and utilities
- to ensure the cost of delivery of improvement programmes are included in the plan
- to begin the process of setting regular 18-month plans, updated twice a year in order to
    - keep financial and operational plans aligned
    - manage any variation from plan in a structured way
    - Improve the timeliness of plans for future 2026/27
    - Allow for the development of medium and longer term financial plans (MTFP and LTFP)

The development of the plan according to the principals established in the approach proved challenging and resulted in the financial plan agreed by the Board at its development day on 25th March.

This paper serves to give a summary of the agreement reached and highlight some key issues.

Summary

The Trust has established a balanced plan for 2025/26 in line with many healthcare organisations. In setting this balanced plan the following items are agreed

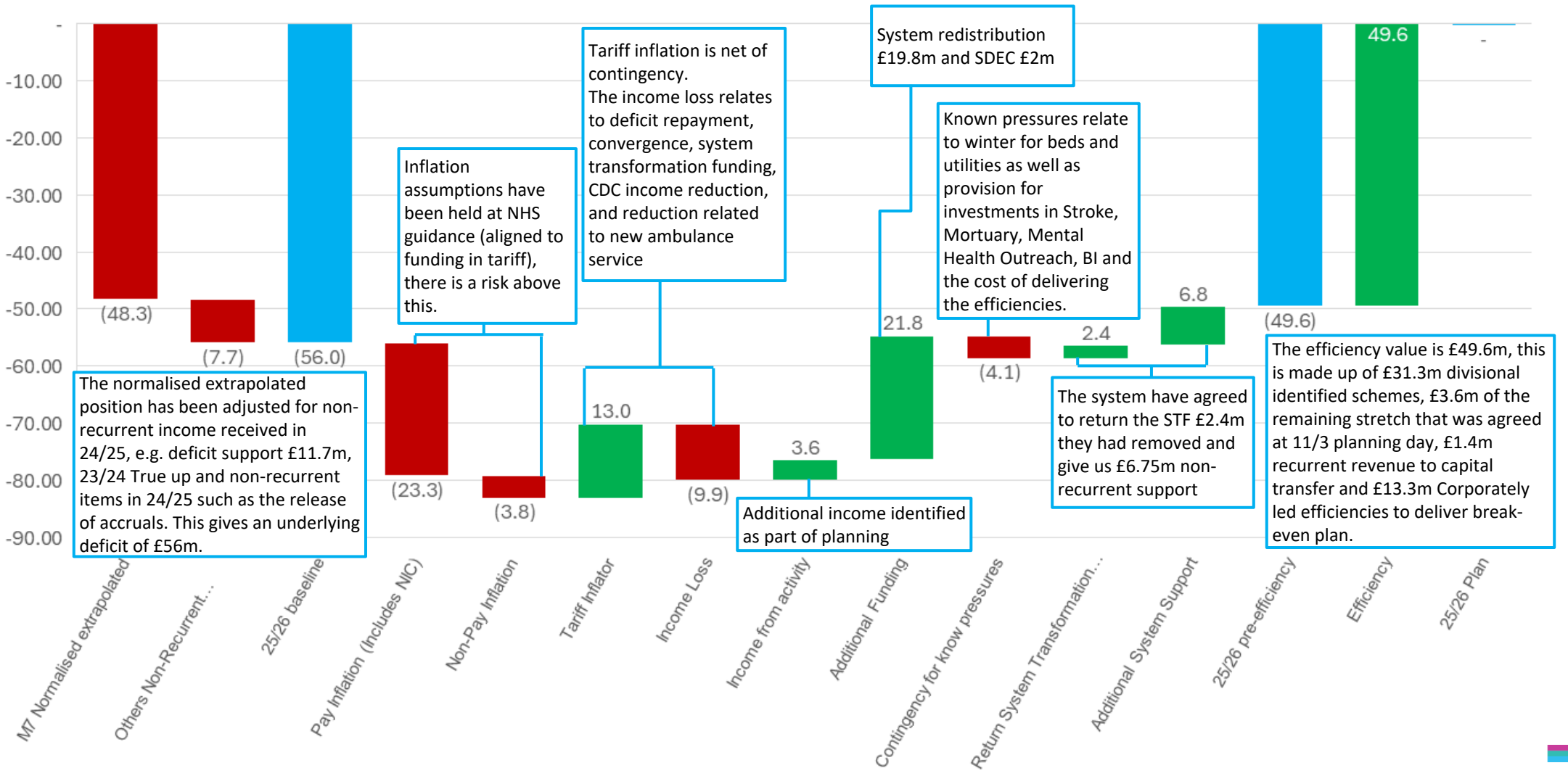
- £29.4 million of support from the ICB
- The Trust to deliver a 6.3% cost improvement programme totalling £49.6 million

It is recognised that a 6.3% improvement plan is a significant requirement to deliver the balanced position however there are specific plans in place for each element of the plan and an expectation that further plans to address any shortfall and potential upsides particularly for charges against the elective recovery fund will be possible.

In achieving this balanced position the Trust has developed a bridge of its plan from its normalised financial position in 2024/24 to the plan for 2025/25. This bridge is set out in this report.

Finance bridge 24/25-25/26

East Sussex Healthcare NHS Trust



Key Performance Trajectories by Month

East Sussex Healthcare NHS Trust

In compiling the annual plan along with the financial plan and as set out in the planning approach cognisance has been taken of the expectations for trajectories against national standards. For completeness these are set out in the table below

Monthly trajectories are in place for all performance standards, and have been developed internally at granular service level.

All performance trajectories have been agreed with operational teams and NHS Sussex colleagues.

A&E performance trajectories are underpinned by key actions focussing on streaming, UTC and CDU ring fencing. The Trust strategy to reduce LOS and improve flow is also expected to have a significant impact.

Elective performance trajectories are underpinned by improved and sustained validation, expansion of PIFU, launch of Sussex Surgical centre and redeveloped productivity programmes in outpatients and theatres.

Cancer trajectories are underpinned by implementation of best practice pathways, development of one-stop pathways, additional surgical capacity and expansion of PSFU.

OBJECTIVE	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Percentage of attendances at Type 1, 2, 3 A&E departments, excluding planned follow-up attendances, departing in less than 4 hours	72%	73%	74%	75%	76%	76%	75%	74%	72%	72%	74%	78%
Percentage of patients waiting for first attendance who have been waiting less than 18 weeks	57%	57%	58%	59%	60%	61%	63%	63%	64%	65%	65%	67%
% of patients waiting less than 31 days for Cancer Diagnosis (Faster Diagnosis Standard)	93%	93%	93%	93%	94%	93%	94%	94%	94%	95%	95%	97%
% of patients seen within 62 days for Cancer treatment	70%	70%	70%	70%	70%	70%	70%	70%	70%	71%	72%	75%
% of patients of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 52 weeks or more	2%	2%	2%	2%	2%	2%	1%	1%	1%	1%	1%	1%

Activity Trajectories

East Sussex Healthcare NHS Trust

The activity submission reflects the expected activity levels for 25/26 and the elective change from 24/25 represents the productivity changes that form part of the Use of Resources Programme and opening of the Sussex Surgical Centre.

Elective Activity	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	25/26 Total	% change from 24/25
Elective Daycase Spells	4,438	4,438	4,659	5,290	4,762	5,238	5,476	4,762	5,000	5,000	4,762	5,238	**59,063**	**7.6%**
Elective Ordinary Spells	366	366	384	460	433	477	498	433	455	455	433	477	**5,237**	**17.1%**
Total Elective Spells	**4,804**	**4,804**	**5,043**	**5,750**	**5,195**	**5,715**	**5,974**	**5,195**	**5,455**	**5,455**	**5,195**	**5,715**	**64,300**	**8.4%**
First Outpatient Attendances	12,029	12,029	12,640	13,862	12,029	13,251	13,922	12,089	12,700	12,700	12,089	13,311	**12,029**	**6.1%**
Follow Up Outpatient Attendances	21,762	21,762	22,850	24,745	21,517	23,669	24,481	21,291	22,354	22,097	21,046	23,149	**270,723**	**(1%)**

Non-Elective Activity	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	25/26 Total	% change from 24/25
Type 1,2 and 3 Attendances	13,901	14,365	13,901	14,365	14,365	13,901	14,365	13,901	14,365	14,365	12,975	14,365	**169,134**	**0%**
Non-Elective Spells	3,743	3,827	3,626	3,701	3,615	3,583	3,910	3,734	3,831	3,928	3,548	3,928	**44,974**	**(8.2%)**
Diagnostics	14,899	14,899	15,644	17,135	14,899	16,388	17,135	14,899	15,644	15,644	14,899	16,388	**188,473**	**3.1%**

Productive use of the Trust's resources is critical to achieving these targets especially as we concurrently try to reduce temporary/ad hoc pay expenditure
This will be achieved with strong focus and progress will be monitored closely with each Division

Workforce Trajectories

East Sussex Healthcare NHS Trust

Key Headlines

An extensive training, upskilling and cultural programme for any member of staff able to make decisions that impact workforce 'usage' has been established. This is designed to encourage better planning and less ad-hoc decision making and focus on getting things right first time a key component in any quality system

Trends and growth in workforce in each area to help teams identify where pay spend may have become inefficient have been identified along with understanding why. This rigour allows choices as to where to invest and where we must protect capacity more carefully to be made

We are implementing appropriate and robust pay spend controls and closing any process loop-holes to support budget holders and senior managers in working to their budgets

This is a significant challenge and has therefore been one of the top priorities for the Trust in 24/25 and will continue to be into 25/26

Table 1.1 – Year on Year Outturn by Contract Type

Annual Change	24/25 Outturn	25/26 March	Var	Var%
Substantive	7,614.1	7,165.6	(448.5)	-6%
Bank	602.3	397.1	(205.3)	-34%
Agency	58.4	41.3	(17.1)	-29%
Total	**8,274.8**	**7,604.0**	**(670.8)**	**-8%**

Table 1.2 – Monthly Trajectory by Contract Type

Monthly Trajectory	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Substantive	7,614.1	7,673.3	7,546.0	7,578.7	7,515.2	7,472.7	7,390.7	7,348.7	7,242.6	7,224.3	7,203.4	7,204.4	7,165.6
Bank	602.3	520.4	505.4	502.5	486.9	488.4	469.7	465.9	461.9	417.0	416.9	401.5	397.1
Agency	58.4	42.0	44.8	44.1	43.4	42.0	42.0	40.6	41.3	39.2	42.7	40.6	41.3
Total	**8,274.8**	**8,235.7**	**8,096.2**	**8,125.3**	**8,045.4**	**8,003.1**	**7,902.4**	**7,855.2**	**7,745.8**	**7,680.5**	**7,663.0**	**7,646.5**	**7,604.0**

Financial Trajectories

East Sussex Healthcare NHS Trust

As has already been described, the plan for 2025/26 is to break even and this includes £49.6m (6.3%) of efficiencies to be delivered in year.

The efficiencies ramp up over the year to allow for the development of the plans that are in progress, but the bulk of these are in delivery from the start of Q3. There is a degree of optimism that these might be delivered ahead of plan thus mitigating any pressure of non delivery in some areas and other pressures that may arise during the year.

Category	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	25/26
Income	61,050	60,327	61,060	62,533	61,069	62,551	64,258	62,070	62,799	62,872	62,152	63,614	**746,355**
Pay	(41,700)	(41,019)	(41,022)	(40,898)	(41,145)	(40,904)	(40,648)	(40,613)	(40,938)	(40,912)	(40,900)	(40,555)	**(491,254)**
Non Pay	(20,350)	(20,330)	(20,306)	(20,208)	(20,447)	(20,394)	(20,622)	(20,937)	(20,446)	(20,879)	(20,879)	(20,527)	**(246,325)**
Operating Surplus/(Deficit)	**(1,000)**	**(1,022)**	**(268)**	**1,427**	**(523)**	**1,253**	**2,988**	**520**	**1,415**	**1,081**	**373**	**2,532**	**8,776**
Non-Operating costs	(732)	(732)	(732)	(732)	(732)	(732)	(732)	(732)	(732)	(732)	(732)	(724)	**(8,776)**
Surplus/(Deficit)	**(1,732)**	**(1,754)**	**(1,000)**	**695**	**(1,255)**	**521**	**2,256**	**(212)**	**683**	**349**	**(359)**	**1,808**	**0**

£'000	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	25/26
Efficiencies	1,811	2,622	2,785	3,434	3,684	3,995	4,992	5,042	5,537	5,204	5,228	5,283	**49,617**

Capital Plan

East Sussex Healthcare NHS Trust

Context

Capital Planning for 2025/26 is not in as advanced state as the revenue plan and further review will be needed by the Executive and subsequently the Finance and Productivity Committee.

The plan is set against a backdrop of a £71 million programme in 2024/25 that included the Sussex Surgical Centre and progress against the endoscopy development. This plan resulted in a £434k underspend against the capital resource limit.

This report seeks to establish an interim plan while further work is undertaken both to assess risks and ensure compliance of the capital programme with the Trust's strategic objectives and operational delivery requirements. It sets out the unavoidable costs both of existing commitments and funding secured from other NHS sources for schemes contributing towards the Trusts objectives.

Available Resource

Resources available at the beginning of 2025/26 are set out in the table below

Available Resource	Total £'000
Block Capital	23,682
National Funding (Digital)	4,135
ICB Safety Fund	6,615
ICB Funding Constitutional Standards	3,560
	37,992

Commitments

In considering the plan for 2025/26, the Executive have considered things across three categories

1. Existing and unavoidable commitments
   - Sussex Surgical Centre
   - Endoscopy Unit
   - Our Care Connected
   - Other ICB funded schemes
   - Other nationally funded schemes
2. Known Risks / Priorities
   - Fire compartmentalisation and safety
   - Business cases driving productivity gain
3. Other issues
   - Medical Equipment
   - Minor Works
   - Other

As can be seen in the table overleaf the programme is significantly over-committed and further work is required by the Executive to both ensure the spending of capital addresses its strategic goals along with perceived risk factors. Further work is also being undertaken to secure more system and / or regional funding to support the shortfall,

Capital Programme

East Sussex Healthcare NHS Trust

	Totals £'000	Core Funding £'000	Strategic Capital £'000	Regional Safety Fund £'000	National Funding £'000	Constitutional Standards £'000
Sussex Surgical Centre	(1,250)	(1,250)				
Endoscopy (Digestive Diseases)	(7,500)	(7,500)				
Our Care Connected	(2,500)		(2,500)			
Constitutional Standards	(3,560)					(3,560)
Cardiology	(4,000)	1,000	(5,000)			
Fire / Safety	(9,365)	(2,750)		(6,615)		
Digital	(8,385)	(4,250)			(4,135)	
Total Existing Commitments	**(36,560)**	**(14,750)**	**(7,500)**	**(6,615)**	**(4,135)**	**(3,560)**
Minimum level Statutory Compliance	**(2,000)**	(2,000)				
Minor Capital	**(500)**	(500)				
Business Cases to support financial improvement	**(1,000)**	(1,000)				
Total Safety and Productivity	**(3,500)**	**(3,500)**	**0**	**0**	**0**	**0**
Total Committed	**(40,060)**	**(18,250)**	**(7,500)**	**(6,615)**	**(4,135)**	**(3,560)**
Available Resource						
Baseline	42,156	**20,346**	7,500	6,615	4,135	3,560
Return of Brokerage	(4,164)	**(4,164)**				
Total Resource	**37,992**	**16,182**	**7,500**	**6,615**	**4,135**	**3,560**
(Over) / Under Commitment	**(2,068)**	**(2,068)**	**0**	**0**	**0**	**0**

Next Steps for the Capital Programme

In order to address the current overcommitment there is further work requires as set out below

- to seek support from the ICB and other stakeholders to support an expansion of the capital programme as a result of emerging risks and the impact of the delay for the Trust within the New Hospital Programme
- consider the likelihood of spending the capital schemes as proposed in the 2025/26 financial year
- once the plan for 2025/26 is complete to develop a longer-term plan that returns the Trust to a sustainable programme of work to support its risks, strategy and delivery objectives.

Next Steps, Conclusions and Recommendations

East Sussex Healthcare NHS Trust

Conclusions

Notwithstanding the 6.3% financial improvement programme required for 2025/26 is challenging and not without risk, the Executive consider that the revenue plan for 2025/26 is robust and timely

Additional work is required on the likelihood of spending the resource included in the capital programme and further work is needed with stakeholders in an attempt to secure addition resource to address other risks and strategic intentions

Recommendations

The Board is asked to :

- Formally endorse the revenue plan discussed at the development day in March
- Notwithstanding the further work that is required for the capital plan the Board is asked to endorse the plan as set and receive updates through the Finance and Productivity Committee
- Endorse the approach taken to financial plan and in particular the need for a rolling 18 month plan updated twice a year

Agenda Item: 15

Report To/Meeting	Trust Board Meeting in Public	**Date of Meeting**	29th April 2025

Report Title:	Ward Nursing Establishment Review Summary 2024/25
Key question	Do the ward establishments for inpatient areas have safe levels of nurse staffing (minimum safe staffing levels) and is there any investment or opportunities based on the Nursing Establishment Review that took place during 2024.
Decision Action:	For approval ☒ For Assurance ☒ For Information ☐ For Discussion ☐

Report Sponsor:	Vikki Carruth CNO	**Presenter(s):**	Vikki Carruth CNO
Report Author:	Claire Bishop, Deputy Chief Nurse		

Outcome/Action requested:	The Board is asked to: 1. Note the contents of the review for assurance and recommendations for inclusion in the NER in 2025. 2. Formally approve the Ward Nursing Establishment Review 2024/25
Executive Summary	The new Shelford Safer Nursing Care Tool (SNCT) was used to collect patient needs and staffing data over a 30-day period in February 2024 and September 2024. This data was then triangulated with professional and clinical judgement and patient safety data. The ward NER demonstrated that all inpatient areas, except for, our elderly care wards and the Irvine Rehabilitation Unit at Bexhill have the recommended minimum nurse staffing to meet the planned care needs of our patients. This recommended minimum staffing template is reflected in the agreed NER for 2023/24 and budgeted FTE prior to the Month 7 run rate changes. The enhanced needs of our more complex patients require staffing in addition to the current nurse templates. For most areas this is achievable within the existing nurse staffing templates and the impact of the mental health outreach team will need to be considered. There are no recommendations for an increase in budgets or staffing templates for our inpatient areas. Opportunities for a staffing review against the SNCT results for 2024 are recommended in: • Murray Gynaecology • Paediatrics • Elective surgical wards due to changing service demands and the Sussex Surgical Centre project • Elderly care ward reconfigurations will include a review of the staffing templates • Irvine Unit to review admission criteria against staffing model to ensure safe levels of enhanced care can be provided.

	The NER for the Emergency Departments suggests no change to the staffing template however it does not consider the patients who are in the department for 12hrs or more. The NER for Community Nursing was paused nationally for 2024, whilst the tool was adjusted. In conclusion, there are no recommended changes from the 2024 NER to staffing budgets or templates.* It is important to note that the uplift/headroom applied to all areas except maternity is 21% which for specialist areas such as ITU, CCU, SCBU, ED is not enough due to the required training which increases the planned absence. Maternity is the only area that has more than 21% (it is 26.4%) and this was increased and agreed as part of Ockenden recommendations in recognition of that. In addition, since Covid the average days absence for WTE has increased and remains at 19 day per annum and the 21% uplift has not changed to reflect that. If uplift is not sufficient (especially for training in specialist areas) it is likely that some areas will overspend and a ward by ward review is underway. The 2025 safer staffing NER should include: • Additional capacity open in our inpatient areas and emergency departments. • Community Nursing planned care needs • A review of the outpatient and specialist/advanced nurse resources. • A review of the nursing workforce in specialist service areas against service needs and national guidance. Due to the transformation projects in Cardiology and Elective Surgery these areas will be excluded in the 2025 NER as workforce adjustments are already in progress for the predicted service changes but reviewed against service requirements. Opportunities to review staffing levels in the areas identified will be worked through by the Divisions as part of the Use of Resources programme of work. It should be noted that although there is a request to ensure all areas have the required FTE as approved in the NER 2024, there is work already underway to go live with the first of a number of Intermediate Care Wards which will effectively change the skill mix and reduce the overall nursing FTE for bedded areas. This summary was presented to the Extraordinary Meeting of the Finance and Productivity Committee on 25th March 2025, where it was recommended for approval by the Trust Board.
Regulatory/legal requirement:	The Royal College of Nursing Workforce Standards (July 2021) The Royal College of Emergency Medicine guidance (2018) The Nursing and Midwifery Council (NMC) recognises that safe staffing must be matched to patients' needs and is about skill-mix as well as numbers of staff, including all staff groups not just nursing to ensure trusts are delivering safe and effective healthcare.

	Developing Workforce Safeguards (DWS) (NHSI 2018) details the accountability framework for NHS organisations in relation to the delivery of best practice standards for workforce deployment and planning. It recommends that Trusts must ensure three components are used in their safe staffing processes: • Evidence-based tools (where they exist) • Professional Judgement • Outcomes CQC fundamental standards for Person Centred Care, Safety and Fit and Proper Staffing
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration
Resource Implication/VFM Statement:	The planned nursing needs should reflect the patient care requirements and nurse staffing levels to reduce reliance on temporary workforce. There are quality and safety benefits to ensuring our nurse staffing requirements match the patient acuity needs. The current workforce costs and recommendations were all included within the budgeted establishment prior to the M7 run rate changes.
Risk:	*There has been an (unintended) impact with the M7 run rate budget approach that vacancies within the agreed ward nurse staffing establishments have not been recruited to as vacancies were removed with an additional impact with the ask not to use temporary staff to support. This has not been suggested or agreed by the board and the existing minimum safe staffing templates must be covered with recruitment and if required temporarily by additional staff until this is remedied. Grip and control is in place with a reduction of over 200 wte in usage by nursing in recent months on a background of an increase in circa 100 beds over time due to significant additional capacity still open and a relatively constant circa 200 NCTR patients in acute beds resulting in super surge capacity and corridor care. There are financial risks and additional staffing requirements with the ongoing levels of enhanced care requirements and extra capacity open that need to be quantified in the NER for 2025.

No of Pages	6	**Appendixes**	0
Governance and Engagement pathway to date:	Executive Leadership Meeting Extraordinary Finance and Productivity Committee		
What happens next?	The proposal asks that all inpatient area budgets are rechecked against the M7 run rate and previously board agreed minimum ward nurse staffing templates and budgeted establishments are in place. The NER for 2025 will capture the additional capacity open and is planned for February/March and September/October 2025.		
Publication	Appropriate for publication		

Introduction

The new Shelford Safer Nursing Care Tool (SNCT) was used to collect patient needs and staffing data over a 30-day period in February 2024 and September 2024. This data is then triangulated with professional and clinical judgement and patient safety data.

Three senior nursing staff were identified in each area to be involved in the data collection and have undergone relevant training from the Trust Safe Care Lead Nurse and random validation checks were performed by Team CNO and Divisional Heads of Nursing during the review.

Scope (inpatients)

*All In patient areas were included in the scope of practice. Exceptions to be noted:

- Nursing includes Registered Nursing Associates/Assistant Practitioners not Allied Health Professionals (AHP) or other professional groups. Matrons are supervisory and excluded from the safe care calculations.
- Specialist areas such as ITU, CCU, SCBU etc have no suggested changes as there have been no changes to services or footprints. These will be considered again in the next review using
- national guidance recommendations for level 2 and level 3 care.
- Acute Cardiac Units are currently excluded whilst the Trust completes the Cardiology Transformation Programme and workforce will be reviewed as part of the business case.
- Maternity is excluded and covered elsewhere and has a robust and separate review process in place using the National Birthrate Plus Tool, which is externally facilitated every 3 years, due to report shortly.
- Emergency Department and Community Nursing Establishment reviews have conducted a pilot during September 2024 and will be updated for the 2025 NER but has been included for information (see Appendix 3)
- Theatres are currently excluded whilst the Trust completes the Sussex Surgical Centre Transformation programme and workforce will be reviewed as part of the business case.
- Outpatient areas are undergoing a separate skill mix review which will be completed during 2025.

Escalation areas and boarding (pre-emptively placing/corridor care) patients are excluded from the establishment review recommendations as they are not planned within establishment and are above agreed substantive bed numbers. In the last year this has been true on most wards on most days with occupancy in gateways areas at 111% at times. Most wards typically have one extra and at times 2 extra patients depending on ward layout and fire requirements.

Scope (Emergency Department)

Collect *patient dependency/acuity data in the department twice daily for a minimum of 12 days to determine the specific dependency/acuity mix for the Trust. *Linked to attendances so each patient is only scored once.

If in the department for longer than 12 hours, then that information needs to be part of the professional judgement factor

Uplift/headroom

Although the Shelford SNCT recommends 22% uplift (for a degree of planned and unplanned absence) 21% is allocated at ESHT other than in Maternity which is 26.4%. Work is underway to review uplift by ward/unit and especially for all specialist areas once the new national training requirements for statutory and mandatory training are received in June 2025.

Royal College of Emergency Medicine recommends an uplift of 27% for staffing templates in the Emergency Departments.

Additional Considerations Used in Professional Judgement and Triangulation of Data

NICE guidance (2014) refers to Registered Nurse to patient levels. This was duly considered and recommendations for Registered Nurse to patient ratios during the day reflected this at 1:8. Professional judgement was applied to draw conclusions for the 1:10 Registered Nurse/Patient ratio at night. National guidance within the SNCT recognise there are some additional nursing requirements due to complex care needs that may require a Patient Registered Nurse ratio outside of the tool and include:

- The provision of Non-invasive Ventilation (NIV) on Baird and Westham Wards are recognised as needing 1:2 Registered Nurse to Patient ratio for acuity and safety reasons. In some other trusts, these patients may be cared for on a level 2 Critical Care or High Dependency Unit (HDU).
- The Hyper Acute Stroke Unit (HASU) on East Dean Ward requires a 1:2 Registered Nurse to patient ratio for the first 24 hours. This is captured in the Level 2 acuity data capture and there is a Specialist Nurse for Stroke available 24/7 as additional workforce support which is in addition to the establishment template. The average admissions to the hyper acute stroke unit per 24 hours is 6, recognising this is variable.
- Pevensey Ward provides acute inpatient haematology services and complex chemotherapy treatments and support to Neutropenic patients with Sepsis. This is captured in the level 2 acuity data capture and requires a 1:2 Registered Nurse to patient ratio.
- Our patients with significant mental illness or cognitive impairment. This is captured in the 1c and 1d data but will not identify the specific need for a Registered Mental Health Nurse in addition to the general nursing requirement.

Bed occupancy, Ward Layout, Complaints and Patient Safety Incidents (PSI's) during the data collection period were also considered as part of the triangulation of data and application of professional judgement.

For the Emergency Departments it is important to consider admission data over the 12-hour period, identifying those times for increased demands.

Costings

Based on the agreed NER nurse staffing templates for 24/25 compared to the M7 adjusted run rate position budgets and FTE.

Division	FTE 24/25 NER
Urgent Care	384.63
Medicine	564.67
DAS	342.47
CHIC	112.09
W and C	66.67
Total NER 24/25 FTE position	**1470.54 (804 beds) 1:8 ratio**
Less adjustments for the agreed changes	Litlington -42.56 Murray -21.78 Elective wards -12.74
Net NER for 25/26	**1393.46**
FTE in Post M7 Annualised	**1377.88**
FTE Difference	**-15.58**

Division	Annual Budget 24/25	Month 7 Annualised Budget	Difference
Urgent Care	17,125,051	17,441,616	
Medicine	22,690,883	22,958,832	
DAS	14,824,448	14,085,024	
CHIC	4,753,095	5,120,544	
W and C	3,454,853	3,285,072	
Total	**62,848,330**	**62,891,088**	**+42,758**

Emergency Departments	FTE adjustment NER v M7	Annual Budget 24/25	M7 Annualised Budget
ED CQ	-0.13 FTE	5,031,727	5,146,931
ED EB	-2.15 FTE	5,182,347	5,485,700
Total	**-2.28 FTE**	**+418,557**	

Conclusion and Recommendations

The NER demonstrated that all inpatient areas, except for, our elderly care wards and the Irvine Rehabilitation Unit at Bexhill have the recommended nurse staffing to meet the planned care needs of our patients noting the point about uplift.

This recommended staffing template is reflected in the agreed NER for 2024/5 and budgeted FTE prior to the Month 7 run rate changes. The difference in inpatient ward areas FTE is -15.58 however the annualised M7 budget costs have £42,758 over the previously set budget. Similarly with the Emergency Departments the M7 adjusted position is -2.28 FTE but with a budget adjustment of £412,557 over the previously set budget, therefore it is an FTE correction not a budget cost pressure.

The enhanced needs of our more complex patients require staffing in addition to the current nurse templates. For most areas this is achievable within the existing nurse staffing templates and the impact of the mental health outreach team will need to be considered.

There are no recommendations for an increase in budgets or staffing templates for our inpatient areas noting uplift work required.

Opportunities for a staffing review against the SNCT results for 2024 are recommended in:

- Murray Gynaecology
- Paediatrics
- Elective surgical wards due to changing service demands and the Sussex Surgical Centre project
- Elderly care ward reconfigurations will include a review of the staffing templates
- Irvine Unit to review admission criteria against staffing model to ensure safe levels of enhanced care can be provided.
- Intermediate care ward staffing model for our low acuity patients

The NER for the Emergency Departments suggests no change to the staffing template however does not consider the patients who are in the department for 12hrs or more and will be included in the 2025 NER. The NER for Community Nursing was paused nationally for 2024, whilst the tool was adjusted.

In conclusion, there are no recommended changes from the 2024 NER to staffing budgets or templates apart from a review of uplift however the 17.86 FTE should be reinstated to correct the staffing template vacancies.

The 2025 safer staffing NER should include:

- Additional capacity open in our inpatient areas and emergency departments.
- Community Nursing planned care needs
- A review of the outpatient and specialist/advanced nurse resources.
- A review of the nursing workforce in specialist service areas against service needs and national guidance.

Due to the transformation projects in Cardiology and Elective Surgery these areas will be excluded in the 2025 NER as workforce adjustments are already in progress for the predicted service changes.

Opportunities to review staffing levels in the areas identified will be worked through by the Divisions as part of the Use of Resources programme of work. So, although there is a request to ensure all areas have the required FTE as approved in the NER 2024, there is work underway to create the intermediate wards which will effectively reduce the overall nursing FTE requirements.

Agenda Item: 16

Report To/Meeting	Trust Board	**Date of Meeting**	29th April 2025
Report Title:	NHS Staff Survey – Results 2024		
Key question	How can we improve engagement with the NHS Staff Survey and collaborate effectively to show that we are listening to feedback and taking action?		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☒		
Report Sponsor:	Steve Aumayer – CPO/ Deputy CEO	**Presenter(s):**	Steve Aumayer
Report Author:	Jacquie Fuller- Assistant Director of HR - People Engagement Melanie Adams - People Experience Manager		
Outcome/Action requested:	The Board is asked to review this report which summarises the 2024 NHS Staff Survey results, providing assurance of a revised approach for divisions to demonstrate actions on their improvement priorities for this year.		

Executive Summary

Each autumn NHS staff in England are invited to take part in the NHS Staff Survey, capturing a snapshot of how people experience their working lives.

To promote participation for the duration of the live survey, the People Engagement team held daily pop-up events and virtual sessions to engage with colleagues, addressing concerns such as confidentiality and highlighting the benefits of the survey. Regular updates were shared through the 'Connected' weekly bulletin and information on the extranet was increased explaining what happens to staff feedback and the important role divisions play in implementing changes.

In 2024 survey questionnaires were sent to 8,657 staff members, with 4,046 responses received. This resulted in a 47% response rate for substantive staff, and a 24% response rate for Bank staff which was amongst the highest in the country. However, the substantive staff response rate decreased by 1.5% from the previous year, slightly below the national average of 52%.

The 2024 survey results were initially shared with the Executive Leadership Team and with the Trust Board under embargo in February 2025, prior to their public release on 13th March 2025, accompanied by a Chief Executive blog.

This year, we aim to increase engagement by enhancing the divisional staff survey assurance framework and establishing a Trust staff survey steering group to support improvements and to hold divisions accountable.

Regulatory/legal requirement:	NHS England
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration

Resource Implication/VFM Statement:	None identified		
Risk:	Failure to demonstrate and communicate actions and improvements regularly may lead to decreased staff morale and lower engagement in the annual survey.		
No of Pages	7	**Appendixes**	2
Governance and Engagement pathway to date:	Executive Leadership Team / POD		
What happens next?	To establish the Staff Survey Steering Group and create supporting task and finish groups to progress the identified Trust priorities.		
Publication	Yes		

Introduction/Background

The annual NHS Staff Survey results provide us with valuable insight into colleague experience at the Trust including the areas in which we excel, as well as those where we can do better. The results provide the basis for our annual Trust priorities and a comprehensive programme of improvement workstreams.

Colleagues with a permanent or fixed term contract, who joined the Trust by 1 September 2024 received an invite to take part in the survey, which ran from the 23rd September to the 29th November. Since 2023 eligible Bank only workers, which includes those who have been paid for Bank shifts within the six months to 1 September and who do not have a substantive or fixed term contract, have received a tailored version of the survey which is relevant to the experience of Bank only workers.

In 2024 survey questionnaires were sent to 8,657 staff members. Out of these 4,046 surveys were returned, resulting in a 47% response rate for substantive staff and a 24% response rate for Bank staff, which was amongst the highest in the country. The substantive staff response rate decreased by 1.5% compared to the previous year, slightly below the national average of 52%.

The 2024 survey results were shared with the Executive Leadership Team under embargo in February 2025 and with the Trust board in March, prior to the embargo being lifted on 13th March when the results were released across the Trust.

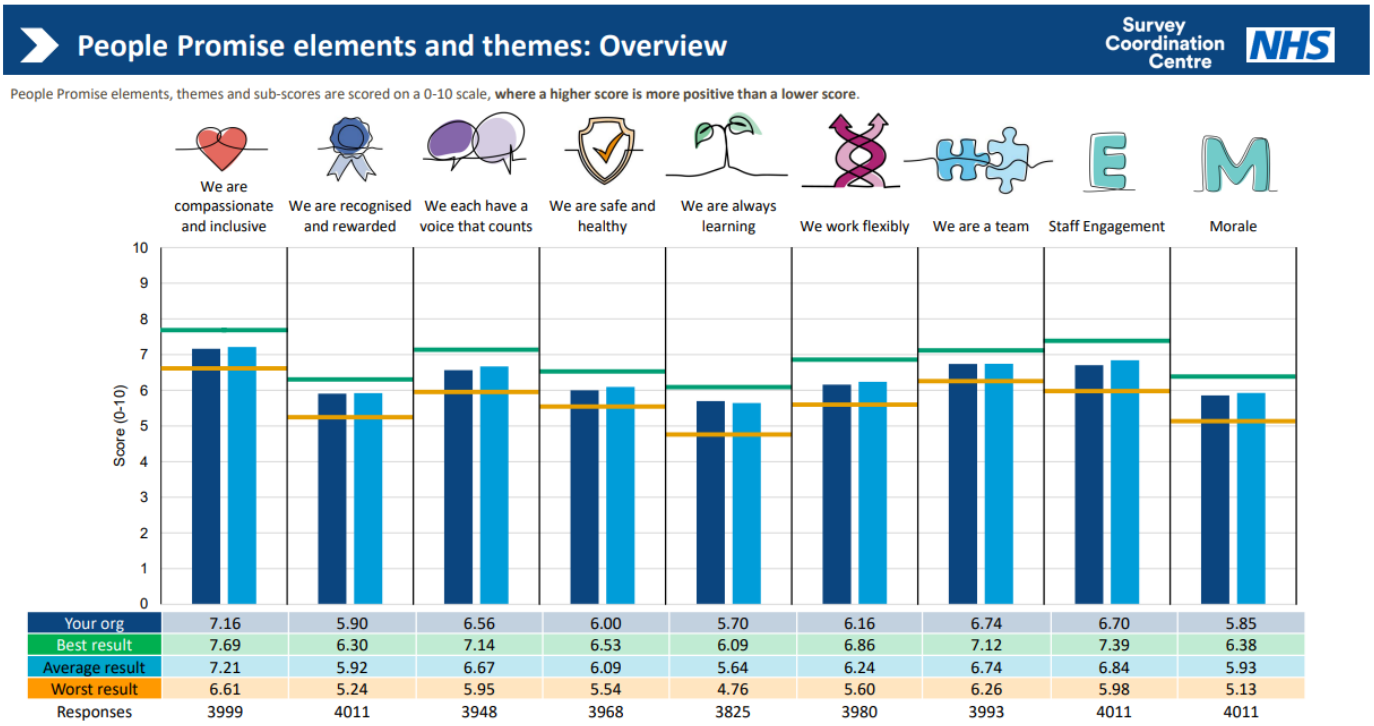
In 2024 we launched a divisional assurance framework to support divisional leadership teams to identify and progress improvement priorities and associated actions from their divisional results in a timely way. There is a requirement within the framework that colleagues receive regular communication about the results, how their feedback will be taken forward and awareness of what the focus will be for the year ahead. Divisions are invited to attend the People and Organisation Development Committee (POD) throughout the year to provide assurance to the non-executive directors that improvement action is underway within the division.

The People Engagement team and HR colleagues work closely with divisional and departmental leads and provide insight and support as they identify key survey priorities and progress action plans. Regular meetings are an opportunity to talk through potential barriers and identify solutions, particularly where there are operational constraints. A range of tools are available to support managers to communicate and engage with their staff at different points throughout the year; these include ‘You said, Together we will’ and ‘You said, Together we did’ posters to communicate action required, and where there have been successes that these are celebrated with colleagues.

It is acknowledged that while some divisions are proactive in their approach towards the survey results and regularly progress the required action and communication with their teams, this is not consistent across the Trust. Colleagues regularly provide feedback that they don’t see the value in completing the annual staff survey as they ‘never hear back’ and ‘nothing ever changes’.

NHS Staff Survey 2024 results

The NHS Staff Survey is aligned with the nine elements of the NHS People Promise, allowing for easy tracking of progress for each element. The graph below illustrates the Trust’s position for each element, alongside the best, average and worst comparator results.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.16	5.90	6.56	6.00	5.70	6.16	6.74	6.70	5.85
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	3999	4011	3948	3968	3825	3980	3993	4011	4011

This year's results tell us that:

- We are compassionate and inclusive – 87% of our people feel their role makes a different to patients and service users
- We are a team – 81% of our people enjoy working with the colleagues in their team
- We each have a voice that counts – 90% of our people feel trusted to do their job

For the majority of people (over 80%) who fed back this is how they feel, this is great news. However, we are conscious that these figures indicate a decline in the number of people reporting this compared to in 2023/24.

Overall there are many positives to take from this year's results. Nearly 80% of colleagues reported that the Trust has made reasonable adjustments to support them in their work, demonstrating our commitment to helping them stay in work if they have a physical or mental health condition or disability.

However, alongside the positives the results show a picture of decline in positive feedback received.

On the themes of colleague engagement, compassion, recognition and having a voice that counts, this year's results show an overall drop in morale. It is recognised by the Trust leadership team that more needs to be done to improve the experience for colleagues working across the Trust. Each colleague is a valued member of the workforce and in areas where it does not feel that way, we must work harder to ensure our Trust is a place that supports colleagues to be safe and healthy, to work flexibly and to feel valued.

Delivering the results to divisions and to our people

Building on last year's work to support the divisions, this year we have introduced divisional staff survey dashboards in response to previous feedback from divisions about how their results are presented. The dashboards, built in collaboration with the HR Workforce team, can be filtered to enable teams to access all survey questions across their division to easily identify where improvement is needed and to improve benchmarking. A video tutorial was developed to demonstrate how to navigate the dashboard, along with a number of different resources to encourage divisions to become more self-sufficient and inquisitive about all their results.

All colleagues have been encouraged through Trust communication to be curious and seek out their division and service level improvement action plans. It is important that they feel empowered to get involved and understand that we all play a role in the improvement journey.

Throughout the year the People Engagement Team, supported by the HR business partners, will continue to meet regularly with divisional leadership teams, guiding them towards identifying their own improvement priorities and taking appropriate action, in addition to the overarching Trust improvement priorities.

The People Engagement Team will be looking to hear from our colleagues on a range of different issues identified via listening events, making use of the colleague networks and where we know there is a requirement to understand challenges faced. We will visit a wide range of clinical and non-clinical areas listening to colleagues and working to identify solutions. This feedback will support actions being established to address specific issues within a set timeframe.

We recognise that some divisions and services consistently receive lower scores which are below the Trust average. In these cases we would plan to work more proactively with divisions to deliver interventional support to these areas and this approach should be seen as a necessary intervention, rather than an optional measure.

Interventional support would include a more targeted approach for these areas, tailored to divisional need. Examples may include:- listening events to understand the issues in more detail so that appropriate support can be identified; more regular monitoring to track progress and identify barriers to reduce unnecessary delay; regular check ins to assess the impact of interventions to maintain momentum and ensure continuous improvement and increasing accountability for divisional leads to provide regular reports on action taken which could be at divisional IPR.
By adopting these interventional measures we can address the persistent issues in divisions with lower scores, and lower overall engagement in the annual survey.

Trust Staff Survey Priorities

'A different response to the NHS Staff Survey'
Following the presentation of this year's results to the Executive, they have agreed a set of Trust priorities and identified the need to establish a Staff Survey Steering Group. The group will have executive sponsorship and attendance and will oversee and drive forward the identified and agreed NHS Staff Survey Trust priorities.

The objectives will be:

- To increase engagement with the annual NHS Staff Survey by increasing the survey response rate and ensuring divisions and services are accountable for progressing improvement actions identified from their divisional survey results
- To have an appreciation of areas of success and have greater visibility of the outputs
- To increase governance in areas where there has been little or no traction in results
- To provide oversight for task and finish groups established in response to agreed Trust priorities in response to staff survey results

Divisional attendance at POD will continue on a twice yearly basis for each division to provide ongoing assurance to the Board.

Four Trust priorities agreed by Executive Leadership team will be divided into task and finish groups and report into the Staff Survey Steering Group. The priorities are:

1) **People Promise 1 'We are compassionate and inclusive' – Ensuring the best care and treatment of our patients**

- Ensuring patient safety remains our top priority

- Delivering high-quality care is central to everything we do

2) People Promise 3 'We each have a voice that counts' - That our colleagues feel confident that when they speak up that their concern will be managed in a timely and consistent way

- We will work with divisional leadership teams and managers to ensure that when people raise a concern on DCIQ (Datix) that are assured that it will be investigated in a timely way and that they will receive appropriate feedback

3) People Promise 4 'We are safe and healthy' - That all our colleagues feel safe at work

- We will bring the Trust values of kindness, inclusivity and integrity to life and deliver a Values and Behaviours Charter which will include examples of behaviours that we expect at work supporting a culture where our values are standard.
- We will continue to embed the values across all our People policies and processes which will include recruitment, induction, career progression, recognition and appraisal and we will work with medical colleagues to embed the values and behaviours into medical, nursing and Allied Health Professions appraisals.
- We will launch an Allyship programme where allies, or individuals, can champion underrepresented groups and incorporate this into policies and procedures.
- We will continue our focus to eliminate sexually inappropriate behaviour in the workplace and ensure our framework is aligned with the NHS England Sexual Safety Charter assurance framework.
- We will continue to engage with and listen to our colleagues about their experiences at work through regular listening events, identifying solutions and making recommendations to take forward as part of the Violence and Aggression Reduction steering group and Transforming Workplace Behaviours group and discrete task and finish groups.

4) People Promise 4 – Reducing Stress and Burnout of our colleagues

- We will continue to provide comprehensive Wellbeing support to our people to include self-care wellness, Compassion without Burnout, action learning sets and Restorative Supervision for teams and individuals
- We will update the Team Stress process to strengthen the manager's engagement with teams in finding solutions or ways to alleviate work related stress

Issues

It is acknowledged that while some divisions are proactive in their approach towards the survey results and regularly progress the required action and communication with their teams, this is not consistent across the Trust. Colleagues regularly provide feedback that they don't see the value in completing the annual staff survey as they never hear back and nothing ever changes.

To drive forward agreed divisional and service level priorities divisions should look to increase the number of service leads involved in supporting the identified action required.

Consequences for not taking action

Failure to demonstrate and communicate actions and improvements regularly will contribute to decreased staff morale and lower engagement in the annual survey.

Conclusion

Our efforts to deliver results to divisions have been significantly enhanced this year through the introduction of divisional staff survey dashboards. These dashboards provide a comprehensive and user-friendly tool for divisions and services to take ownership of their results, identify areas for improvement, benchmark their progress and drive meaningful and sustainable change.

Encouraging curiosity and engagement amongst our colleagues is key to the Trust's improvement journey and by driving a culture of improvement and understanding everyone has a role to play.

The People Engagement team, supported by the HR business partners, will continue to provide guidance and support to divisional leadership teams, helping them prioritise and act on their improvement priorities, as well as celebrating success against previous improvement actions.

The establishment of the Staff Survey Steering Group with executive sponsorship demonstrates our commitment to moving forward with this year's Trust priorities. This group will oversee task and finish groups focussing on the identified priorities, ensuring clear accountability and assurance that progress is being made.

The four Trust priorities, which align with the NHS People Promise, focus on safety, compassion, inclusivity and the wellbeing of our colleagues. By embedding these values into our policies and practices we aim to create an enhanced experience for everyone at ESHT.

Recommendations

We ask the Board to consider this report and welcome your feedback.

Appendix A - NHS Staff Survey – Substantive staff results highlights

We are compassionate and inclusive
87% of our people feel their role makes a difference to patients and service users

We are always learning
87% of our people have had an appraisal in the last 12 months

We are recognised and rewarded
72% of our people feel their immediate manager values their work

We are a team
81% of our people enjoy working with the colleagues in their team

We each have a voice that counts
90% of our people feel trusted to do their job

We are safe and healthy
68% of our people reported that the last time they experienced physical violence at work, they or a colleague reported it

We work flexibly

69% of our people feel they can approach their immediate manager to talk openly about flexible working

Staff Engagement

72% of our people say there are frequent opportunities for them to show initiative in their role

Morale

55% of our people reported they have adequate materials, supplies and equipment to do their work

Appendix B - NHS Staff Survey – Bank staff results highlights

Bank colleagues also took part in the annual NHS Staff Survey. This is really important as it ensures that all our people have the opportunity to tell us about their experience at work.

We are compassionate and inclusive
88% of our people feel their role makes a difference to patients and service users

We are always learning
52% of our people have had an appraisal in the last 12 months

We are recognised and rewarded
73% of our people feel their immediate manager values their work

We are a team
83% of our people enjoy working with the colleagues in their team

We each have a voice that counts
66% of our people feel trusted to do their job

We are safe and healthy
75% of our people reported that the last time they experienced physical violence at work, they or a colleague reported it

We work flexibly
69% of our people feel they can approach their immediate manager to talk openly about flexible working

Agenda Item: 17

Report To/Meeting	Trust Board	**Date of Meeting**	29th April 2025
Report Title:	Martha's Rule Update		
Key question	What progress has been made with the Martha's Rule programme and what is the plan for the months ahead?		
Decision Action:	For approval ☐ For Assurance ☐ For Information ☒ For Discussion ☐		
Report Sponsor:	Vikki Carruth, Chief Nurse	**Presenter(s):**	Vikki Carruth, Chief Nurse
Report Author:	Paul Smith, Deputy Chief Nurse		
Outcome/Action requested:	The Board is asked to continue to support and drive the implementation of Martha's Rule in the Trust.		

Executive Summary	Martha's Rule was implemented nationally following the death of Martha Mills from sepsis: the coroner ruled that her death was probably preventable had she been moved to ICU earlier. Martha's family felt that their concerns had not been heard. In February 2024 the right to a rapid review from an independent critical care team was announced, under the auspices of 'Martha's Rule'. 143 sites submitted successful expressions of interest to be included in the pilot, and ESHT was one of these. The responsibility for implementing the trial was placed with Cheryl Sparkes, Critical Care Outreach Lead Nurse, and Dr Judith Highgate. A mobile phone specific for the purposes of Martha's Rule was identified, and the trial publicised to the Trust. Utilising the name 'Call4Concern', work began in July 2024: data has been gathered on the number and type of calls since October 2024. The decision was taken to run the trial in all adult in-patient wards: Paediatrics, Maternity and A&E would require additional planning, although had calls come from these areas they would not be redirected. There were four calls in the first two weeks: none were regarding clinical deterioration. There have been 16 further calls: the cause for the call varied, but five were regarding concerns around the medical plan of care. Martha's Rule processes are embedded in the organisation and there has been some uptake by members of the public. However, there is an assumption that more activity can still be generated, and more can be done to raise both awareness and understanding of Martha's Rule.

Regulatory/legal requirement:	Martha's Rule was introduced in all English NHS hospitals in April 2024.
Business Plan Link:	Quality ☒ People ☒ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration

Resource Implication/VFM Statement:	Costs associated with improving awareness and understanding of Martha's Rule are included within budgets.
Risk:	None identified.
No of Pages	2 **Appendixes** None
Governance and Engagement pathway to date:	Quality and Safety Committee
What happens next?	To increase awareness and understanding, the team is putting in place: 1. A seconded member of staff from the Critical Care Outreach Team for six months to solely focus on staff education and awareness raising of the purpose and process of Martha's Rule 2. Work is actively underway between the Paediatric team and the Critical Care Team to introduce a bespoke variation of Martha's Rule to the paediatric areas 3. A greatly enhanced publicity campaign of new posters, banners and other materials to ensure that both public and staff are aware of the scheme and how to access it 4. The purchase of new phones and digital devices to make the team more readily accessible and to allow the team to more accurately record their interactions and activity The implementation of phase three of Martha's Rule, that the 'NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily', will require a digital solution. This has been designed, an adaptation of a system currently used in Bradford NHS Trust, and is with our Digital Team for introduction onto NerveCentre. Future updates on Martha's Rule will be presented to the Quality and Safety Committee.
Publication	This report can be published.

Agenda Item: 18

Report To/Meeting	Trust Board	**Meeting date**	29th April 2025
Report Title:	Q4 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):**	Pete Palmer, Board Secretary
Report Authors:	Richard Milner, Chief Of Staff and Pete Palmer, Board Secretary		
Purpose/Outcome/Action requested:	The Board is asked to consider, discuss and note the report.		
Executive Summary	This report provides outlines the BAF risks for Q4, an update on progress since Q3, 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	4	**Appendixes**	1
Governance and Engagement pathway to date:	The report was presented to the relevant Committees with responsibility for overseeing each strategic risk in March and mitigations have been reviewed by each of the relevant executive directors		
What happens next?	Discussions will take place with the Board and Committee to agree the trust's key strategic risks for 2025/6. The 2025/6 Q1 BAF will be presented to Committees in July, and to the Board in August 2025.		
Publication	Yes		

Introduction/Background

The report provides an update on the BAF. There has continued to be helpful 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.

Board Assurance Framework (BAF)

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 change on a monthly basis; therefore, updates are provided quarterly. 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			16	6	8	12	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	9	▼	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	20	▲	Cautious/ Open	16
4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery	F&P			X	20	20	20	20	16	▼	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	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	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	16	◄►	Open	12
8	Failure to transform digitally and deliver associated improvements to patient care	F&P			X	16	12	12	12	12	◄►	Significant	8
9	Failure to maintain focus on improvement	ExCom		X		16	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	20	▲	Open/Seek	16
11	Failure to demonstrate fair and equal access to our services	Ineq	X			16	12	12	12	8	▼	Cautious/ Open	8
12	Failure to meet the four-hour standard	Q&S	X	X	X	20	16	16	16	20	▲	Cautious	12

In Q4 only five of the 12 strategic risks have remained at the same score as they were in Q3. The scoring for four risks has increased and has decreased for the remaining three risks. We have summarised below our view on the Q3 to Q4 moves for each of our BAF risks.

BAF 1: Capacity constraints associated with supporting the collaborative infrastructure
The risk scoring for BAF 1 remained at 12 from Q3 to Q4. The Trust continues to engage closely with the ICS through collaborative meetings and the Committee in Common. However, demand on these structures to resolve system challenges continues and will be exacerbated by additional financial, workforce and other challenges anticipated moving into 2025/26. Greater clarity on the scale of this risk is likely to come from the focus of the NHS ten-year plan and detail on the future status/role for ICBs moving forward.

BAF 2: Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time.
The risk scoring for BAF 2 has been reduced from 12 in Q3 to 9 in Q4 as a result of the further reduction in vacancies seen in the Trust in historically hard to fill post, supported by a buoyant recruitment market and planned apprenticeship pathways. In addition, targeted recruitment in areas where there are national consultant shortages have proved to be successful for the Trust.

BAF 3: Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.
The risk scoring for BAF 12 increased from 16 in Q3 to 20 in Q4. This reflects the decrease in engagement emerging from the 2024 staff survey results and the decline in some areas of the staff survey report within the People Promise scores. The increase in score also reflects the challenges that will be faced in realising improvement while also managing ongoing financial pressures, increased activity and a reduction in workforce over the coming year.

BAF 4: Failure to deliver income levels/manage cost/expenditure impacts savings delivery.
The risk score for this strategic risk has reduced from 20 in Q3 to 16 in Q4 reflecting the increased confidence that the Trust will deliver against the end of year financial target. However, the financial climate in 25/26 promises to bring equal, if not even greater, risk to this area and will require even more robust management over the coming twelve months.

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 risk score for this strategic risk has increased from 16 in Q3 to 20 in Q4 as a result of the announcement that the New Hospital Programme will be delayed in the Trust until 2037. Mitigations are underway, including a major review of our capital programme, to address the risk into 25/26.

BAF 6: Vulnerability of IT network and infrastructure weakens insightful and timely analysis to support decisions
The risk rating for BAF 6 has remained at 16 in Q4. 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. An ICB Cyber Strategy and Action Plan have been agreed for 2025/26.

BAF 7: Failure to develop business intelligence weakens insightful and timely analysis to support decisions.
The scoring for this strategic risk is unchanged from Q3 to Q4 at 16. While Band 7 recruitment to the team has begun, with an internal appointment made, this continues to be challenging with roles that are hard to fill. Development of a self-service power Business Intelligence (BI) platform and reporting and tools that will support operational flow continues. Planning has commenced for 2025/26 to ensure that the Trust continues to meet national reporting requirements.

BAF 8: Failure to transform digitally and deliver associated improvements to patient care
Scoring for this strategic risk is also unchanged from Q3 to Q4 and remains at 12. Planning and governance for the new Electronic Patient Record (EPR) system continues to progress well and positive engagement has been seen with colleagues around the development of a new digital strategy for the organisation, in partnership with Moorhouse.

BAF 9: Failure to maintain focus on improvement

The risk scoring for BAF 9 has also not changed from Q3 to Q4, remaining at 16 in recognition that during 24/25 the Trust remained resource constrained and has been unable to make the anticipated progress in becoming a CQI mature organisation. Some progress has been made making use of available Trust and system resources and the expectation for 25/26 is that the status of this risk will move significantly.

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.

The risk scoring for BAF 10 has been increased from 16 in Q3 to 20 in Q4, due to the additional impact during the winter period of significant infection control challenges, including norovirus, RSV, Covid and flu. This created significant operational challenge with a corresponding negative impact on workforce attendance and required significant and sustained additional capacity including 'supersurge' and 'boarding' of patients (corridor care).

BAF 11: Failure to demonstrate fair and equal access to our services.

The risk rating for BAF 11 has reduced to from 12 in Q3 to 8 in Q4, reflecting the improvements that have been achieved during the year. The Health Inequalities Steering Group is now an established group, monitoring performance and service delivery in key areas; the Inequalities Committee is also now well established. The Trust has been recognised as having made significant improvements in ethnicity data recording in 2024/25 and the in-year successes regarding the establishment of the Inpatient Smoking Team, as well as the continuation of the Alcohol Care team are expected to contribute significant benefit to more vulnerable members of our East Sussex communities.

BAF 12: Failure to meet the four-hour standard.

The risk scoring for BAF 12 also increased from 16 in Q3 to 20 in Q4 due to the deterioration in overall performance that was seen during the winter period. While non-admitted performance improved, there was no sustained improvement seen in length of stay or a reduction in numbers of patients with no criteria to reside. This will evidently be a key area of focus for 25/26.

The full BAF can be found in Appendix 1.

Board Assurance Framework (BAF)

Quarter 4 Update 2024/25 Overview

East Sussex Healthcare NHS Trust

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

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

BOARD ASSURANCE FRAMEWORK - SUMMARY PAGE

NHS
East Sussex Healthcare
NHS Trust

BAF Ref	Risk Summary	Monitoring Committee				Inherent Risk	Current position (Residual risk)				Change	Risk Appetite	Anticipated Risk
							2024/25						
							Q1	Q2	Q3	Q4			
1	Capacity constraints associated with supporting the collaborative infrastructure	ExCom	X			16	6	8	12	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	9	▼	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	20	▲	Cautious/ Open	16
4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery	F&P			X	20	20	20	20	16	▼	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	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	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	16	◄►	Open	12
8	Failure to transform digitally and deliver associated improvements to patient care	F&P			X	16	12	12	12	12	◄►	Significant	8
9	Failure to maintain focus on improvement	ExCom		X		16	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	20	▲	Open/Seek	16
11	Failure to demonstrate fair and equal access to our services	Ineq	X			16	12	12	12	8	▼	Cautious/ Open	8
12	Failure to meet the four-hour standard	Q&S	X	X	X	20	16	16	16	20	▲	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:	01/04/25	

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	
(4x4) 16	Likelihood:	2	2	3	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 remained at 4. The combination of the collaboratives, Committee in Common, system planning and major service review and our own immediate need to address financial recovery means that the likelihood remains as a 3, although there are signs of clarity.	Likelihood:	2
	Consequence:	3	4	4	4		Consequence:	3
	Risk Level:	6	8	12	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 4 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:	27/03/25	

	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	3	There are pockets of specialities where there are national shortages which increases the reliance of high cost temporary staff to maintain services. The Trust's age profile presents a specific requirement for career succession planning and talent management, with around 20% of our workforce at a point where they are technically able to retire. The vacancy rate has reduced further to 2% (February 2025). Due to a buoyant recruitment market and planned apprenticeship pathways we have seen further reduction in vacancies including historic hard to fill posts. Retained targeted recruitment for small pockets of national consultant shortages have proved successful. As a result the overall risk rating has been reduced to 9 for Q4.	Likelihood:	4
	Consequence:	3	3	3	3		Consequence:	3
	Risk Level:	15	12	12	9		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 • Age profile of workforce particularly for registered nurses, clinical groups and additional clinical services. • Lack of maturity of career succession and talent management workplans	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 in accordance with service developments 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. Supportive to flexible working patterns H. Proactively building our positive reputation as an employer I. Ongoing responses to key themes from staff survey J. Continued targeted international recruitment for medical and AHP posts K. Additional headhunter agencies engaged for hard to recruit medical posts L. Job plans in place for all doctors M. People Strategy is in place and is being delivered in line with NHS Workforce/People Plan N. Agreement with East Sussex College to establish academy working

Assurance Framework – 3 Lines of Defence			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• 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 4 Progress Report**	**BRAG**
1.	Continue with recruitment initiatives and international sourcing of candidates as required	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 e.g. 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 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 • Designated as academy with East Sussex College	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	• Monitored through the DDOs and their aligned HR Business Partner specialist • Developing attrition reports to enhance our workforce metrics • Through divisional IPRs

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	◀▶
	03/12/2018	16	Emergency Department nursing vacancies	12	16	◀▶
	12/08/2021	7	Inadequate staffing levels to provide consistent Lipid Clinic service	20	15	◀▶
	29/09/2021	171	Mortuary Service Staffing	16	16	▲
	28/06/2022	10	Delays in out of hours patient assessment times	20	16	◀▶
	01/06/2023	73	Radiology Physics Service Staffing	20	15	◀▶
	18/08/2023	97	Delays to Paediatric Dietetic Appointments	20	20	◀▶
	25/09/2023	72	Histopathology consultant vacancies	20	16	◀▶
	08/07/2024	264	Insourcing contracts	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:	27/03/25	

	BAF Risk Scoring							
Inherent Risk	Quarter	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Rationale for Risk Level	Anticipated Risk	
	Likelihood:	4	4	4	5	Data is showing that engagement levels across the NHS and locally have reduced over the past three years. There has been a decrease in our engagement with staff survey results for 2024 and a decline in some areas of the staff survey report within the People Promise scores. The Q4 risk has increased, reflecting the improvement required within this area aligned with the ongoing financial pressures, increased activity and reduction in our workforce.	Likelihood:	4
	Consequence:	4	4	4	4		Consequence:	4
(5x4) 20	Risk Level:	16	16	16	20		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. Leadership training for managers to support compassionate conversations with all staff
B. Development of a five year leadership pathway
C. Development of behavioural framework
D. 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.
E. Embedding the system wide strategy and policy on violence prevention
F. Improved debrief process and package of support for staff involved in violence and aggression or distressing situations at work.
G. Continuous reviewing and implementing best practice from other areas (e.g. TRiM, MHFA)
H. Targeted support for areas with high levels Datix linked to violence and aggression
I. Embedded range of wellbeing/pastoral support available for all professional groups
J. Wellbeing Conversations for all colleagues
K. Ongoing focus on Violence and Aggression with ambition to become upper quartile organisation
L. Ongoing National vaccination programmes
M. Workforce Strategy
N. Admission avoidance and discharge activity through operational teams

	O. Working with the entire system, third sector and independent health and social care organisations to assist them with recruitment and training. P. Effective rostering and leave management; planned pilots completed and amendments to self-rostering made Q. Undertaking deep dive cultural reviews in areas where there is particular concern regarding colleague engagement and morale R. Increased listening events focusing on culture and behaviours S. Promoting wellbeing support available and training to line managers T. Occupational Health and Health and Safety Team support and audit of risk assessments and Datix incidents U. Occupational and staff wellbeing support to staff V. Local Security Management Specialist advice and support W. Sussex network meeting in place and liaising with SECAMB on Trauma Risk Management X. 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 • Development of task and finish focus groups to support key remedial actions in response to staff survey	• Workforce metrics reported to executive team, POD and Trust Board – increased compliance with completion of risk assessments • Oversight and monitoring by Health and Safety Steering Group • Deep dive cultural reviews	• Health and Safety Executive review of violence and aggression • GMC outcomes have action plans with quality virtual visits in place to provide assurance to HEEKSS/Trust
Gaps in control/assurance:			
• None identified			

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

No.	Action Required	Executive Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	People Strategy	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

2.	Development of actions plans associated with staff survey	Acting Chief People Officer	End of April 2025	• Staff survey results are being analysed to identify key actions	**Red**

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	• Workforce engagement during a time of high operational activity and financial constraints • No reduction in violence and aggression incidents • Change in patient engagement team members which may delay some pieces of work • Implementing a leadership strategy	• 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. • Implementing task and finish groups to support delivery of action plans associated with staff survey

Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Initial Risk Score**	**Current Risk Score**	**Change**
	14/12/2017	18	Violence and Aggression in Emergency Departments	9	15	◀▶
	03/12/2018	16	Emergency Department nursing vacancies	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	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:	27/03/25

	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:	5	5	5	4	**Likelihood**: At month 10 the Trust's deficit was close to £14m, near to the full year forecast. 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. There is a plan to deliver the year end £14m target, but partly through non-recurrent measures. Therefore the total risk score is reduced slightly as we assume that we will deliver the revised forecast. **Consequences**: There is risk to not delivering the budget and consequent reputational impact.	Likelihood:	5
	Consequence:	4	4	4	4		Consequence:	4
	Risk Level:	20	20	20	16		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 Improvement 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 4 Progress Report	BRAG
1.	Finalise CIP plan for year with an emphasis on controlling costs as well as delivering increased activity	Chief Financial Officer	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 £6.4m 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	**Red**
2.	Use of Resources meetings are now supported by the Financial Improvement 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**

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:	27/03/25

	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	5	The Trust's capital budget for 2024/25 is £23.1m but this could increase up to £77.5m with national schemes. The core capital in the Trust budget is not sufficient to support the current EME medical equipment replacement priorities and is also insufficient to address the estates maintenance backlog. A bid for capital funding for medical equipment and critical infrastructure risk (CIR) has been submitted to the ICS to help address 25/26 and 26/27. A report had been presented to ELT and ExCom to highlight the challenges in the next 5 years. We continue to work with Friends to support to address the equipment gap. A report on estates backlog maintenance was submitted to the ELT and F&P Committee in May 2024; an update on medical equipment was presented to ELT in October and December 2024 and was then presented to the Executive Committee in January 2025. The BAF risk score has been increased to 20 for Q4 due to due to the delays in the New Hospital Programme (NHP) in the Trust to 2037. We are compiling a ten year investment backlog programme, which is due to be completed in Q1 2025/26. We have committed to supporting capital projects during 2024/25 which will exceed the available capital budget. Therefore our ability to spend on our backlog will be reduced, apart from fire compartmentation work and replacement of essential equipment as required.	Likelihood:	5
	Consequence:	4	4	4	4		Consequence:	4
	Risk Level:	16	16	16	20		Risk Level:	20

Cause of risk:	• Insufficient capital to meet maintenance backlog (high and significant backlog) • Delay to NHP in the Trust	**Impact:**	Lack of capital for investing in the future sustainability of the Trust gives rise to risk of a significant impact on the Trust's ability to meet its requirements to provide safe, modern and efficient patient care.
Current methods of management (controls)	A. Annual capital plan and five year capital plan in place B. Essential work prioritised with estates, IT and medical equipment in light of patient safety and health and safety C. Day to day management of infrastructure requirements and prioritisation by services D. Electronics and Medical Engineering (EME) in close liaison with divisions E. Full inventory of medical devices and life cycle maintenance		

Assurance Framework – 3 Lines of Defence

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

Gaps in control/assurance:

- Longer term capital programme has been produced; however, significantly more capital is required to address this than is available to the Trust.
- New Hospital Programme/BFF funding envelope delayed until 2037 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 4 Progress Report	BRAG
1.	ICS will undertake a medium term financial plan	Chief Finance Officer	Ongoing	• Expenditure monitored • Progress reported regularly to Finance and Productivity Committee	Amber
2.	Development of ten year investment backlog programme	Chief Finance Officer	Q1 2025/26	• Plans are being developed within the Estates team	Amber
3.	External funding opportunities	Director of Estates and Facilities	Ongoing	• The Trust will continue to bid for funding through ICS and national programmes as and when opportunities occur	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 ten year critical estate infrastructure backlog	• The funding required for the backlog exceeds the capital envelope available (ICS/ESHT capital) • We carry the risk of unplanned infrastructural failures occurring more frequency and it is challenging to rectify those critical failures.	• We are prioritising both medical and estate backlog which is included in the ten 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
	10/12/2013	68	Aging Building Management System (BMS)	15	15	◀▶
	11/11/2015	64	Clinical Environment Maintenance & Refurbishment	20	15	◀▶
	12/11/2015	8	Potential non-compliance with Fire Safety Legislation EDGH	15	15	◀▶
	12/11/2015	67	Potential non-compliance with Fire Safety Legislation Conquest	15	15	◀▶
	12/11/2015	263	Potential non-compliance with Fire Safety Legislation Bexhill	15	15	◀▶
	12/11/2015	60	Failure of lifts	16	16	◀▶
	09/05/2017	61	Loss of Electrical Services to Critical Clinical Areas	16	16	◀▶
	03/08/2017	75	Containment Level 3 Laboratory	15	15	◀▶
	17/05/2018	163	Aging Physiotherapy environment	12	16	▲
	27/06/2019	62	Insufficient Ward decant accommodation	12	16	◀▶
	27/06/2019	63	Insufficient isolation facilities to meet demand	12	16	◀▶
	27/05/2020	14	Capital - Sustainability	12	20	◀▶
	02/07/2021	84	Clinical Space on Frank Shaw Ward	20	15	◀▶
	30/05/2023	70	Effect of Business Continuity & Critical or Major incidents	16	16	◀▶
	22/08/2023	5	Conquest CT Scanner installation	25	15	◀▶
	02/10/2023	87	Environment for children and young people with complex psycho-social challenges	20	16	◀▶
	24/10/2024	292	Unauthorised access to roofs	15	15	**NEW**
	29/01/2025	302	Equipment obsolescence in Diabetic Eye Screening	16	16	**NEW**

Risk Summary					
BAF Reference and Summary Title:	BAF 6: Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack			Strategic Aims Impacted	
				x	x x
Risk Description:	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack				
Lead Director:	Chief Financial Officer	Lead Committee:	Audit Committee	Date of last Committee review:	27/03/25

	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	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. 10 risks on the trust risk register Two of the key actions to achieve the anticipated risk level of 12 will be to deliver the active directory migration and a further reduction in unsupported legacy systems along with the Conquest core LAN migration.	Likelihood: 3
	Consequence:	4	4	4	4		Consequence: 4
	Risk Level:	16	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. 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. Day to day systems in place and support provided by cyber security team with increased capacity M. Policies, process and awareness in place to support data security and protection and evidence submitted to CAF N. Information sharing and development with organisations within the Sussex ICS O. Development of ICS Cyber Strategy and working in regional cyber user group P. Rollout of MFA; progressing with work 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 • We have run in-house email phishing campaigns	• Regular quarterly security status report to IG Steering Group and every six months to Audit Committee	• RSM internal audits reports • Feedback from NHS Digital on Cyber Exposure score • Advice and guidance provided by third party security operation centre

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 4 Progress Report**	**BRAG**
1.	Cyber Assurance Framework	Chief Finance Officer	Ongoing	• Internal CAF 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	2025/26	• 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	Green
3.	LAN Refresh EDGH	Chief Finance Officer	2025	• Migration of Edge network over the course of 2025 • Delayed due to winter pressures and fire compartmentalisation work	Amber
4.	LAN Refresh Conquest	Chief Finance Officer	2025	• Replace the Core Network and Fibre connections to the Edge Switches • Equipment delivered • Fibre network now being installed and should be complete by end of March	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 • Have agreed an ICB cyber strategy with an action plan for 2025/26 • Reduced the top 12 risks by two • We have signed of the Full Business Case and national funding has been agreed for the preferred supplier for EPR implementation • Development of new digital and data strategy which will encompass cybersecurity	• Capacity in the physical Estate to improve network capacity as part of refresh • Funding to replace Legacy clinical systems • Resources 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
	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	◀▶
	09/07/2024	270	Reduced pathology testing capacity following cyberattack	20	16	◀▶

BAF Reference and Summary Title:	BAF 7: Failure to attract and develop business intelligence limits insightful and timely analysis to support decisions				Strategic Aims Impacted		
						x	x
Risk Description:	It is likely there will continue to be delayed, inaccurate, or incomplete data analysis due to a failure to attract/recruit/develop business intelligence resource. The impact of this is significant/major, ultimately leading to poor decision-making or missed opportunities not meeting objectives and efficiency goals. Mitigating actions described will reducing the risk likelihood.						
Lead Director:	Chief Operating Officer	Lead Committee:	Finance and Productivity Committee		Date of last Committee review:	27/03/25	

	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	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	4		Consequence: 4
	Risk Level:	16	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 management (controls)	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. 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 integrating data from disparate clinical systems/sources into a central data warehouse, resulting in incomplete or inaccurate insights.
- Insufficient Data Governance: Weak data governance practices that fail to ensure data quality, consistency, and security across systems.
- Outdated BI Tools: Use of outdated or incompatible BI tools that do not support advanced data analytics or real-time reporting.
- Fragmented Reporting: Ineffective reporting mechanisms that do not provide timely, accurate, or actionable insights to decision-makers.
- Inadequate BI Training Programs: Insufficient or outdated training for staff on BI tools and data management, leading to skill gaps and ineffective use of BI systems.
- Clear national guidance reduces the risk of inaccurate data being reported and is not available for all metrics.
- Level of automation. Significant manual intervention increases the risk of human input errors.
- Complexity of rules, where the rules set out in national guidance are highly complicated and risk misinterpretation.

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

No.	Action Required	Executive Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	Enhance BI Structure and Investment	COO	Complete	• BI Structure that meets the organisation's needs and investment agreed • Create recruitment plan • Recruitment efforts have resulted in some internal promotions but no overarching increase in WTEs • Other recruitment avenues actively being explored	Green
2.	Clarify Roles and Responsibilities:	COO	April 2025	• 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	April 2025	• 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. • Significant progress with uptake of Microsoft and NHS training modules, and development of power BI skills within team	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.	Green
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?
• Continued development of self-service Power BI platform, continuing relationship with external partners • Continued development of reports and tools to support operational flow • Training opportunities identified and attended by staff in Quarter. • B7 recruitment started – internal appointment • Improvement in monthly reporting processes with structured timeframes for delivery	• Recruitment Challenges – Hard to fill roles • Legacy systems, data warehouse structure and agreed future platform and structure • National reporting requirements- 25/26 planning • Resource requirements to support transition to new EPR	• Expanding recruitment campaigns for key roles plus continuing external partnerships in 25/26 and continued investment in internal upskilling • Automation-First Approach – Prioritizing automation to streamline processes, reduce manual workload, and improve efficiency. • Collaborative Working Across the System – Strengthened partnerships with NHS trusts, ICSs to align data strategies and share best practices.

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:	27/03/25

	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	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 as well as 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	4		Consequence: 4
	Risk Level:	12	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 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 • Challenges of communicating to wider trust • Understanding the organisation's digital literacy		

Current methods of management (controls)	A. Digital Steering Group established to monitor, support, approve any Trust wide digital initiative and improve governance relating 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 digital project / programmes developed J. Benefits Strategy in place K. Improved engagement and awareness through the development of the digital strategy L. Survey the level of digital literacy across the organisation

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
- We need a training plan to increase digital literacy and add digital into all job descriptions

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	EPR implementation	Chief Medical Officer	July 2027	• Full business case and specification complete • FBC signed off by 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, with recruitment commenced • 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 • Developing links with education teams to embed digital literacy into workforce descriptions	Amber
4.	Increase digital culture	Chief Finance Officer	Ongoing	• Communications strategy and engagement • Multidisciplinary team working • Appointment of digital delivery partners now complete • 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 on the digital strategy	• 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 for change and 'Continuous Quality Improvement'				Strategic Aims Impacted	
						x
Risk Description:	Insufficient focus and resources leading to a failure to drive necessary changes and embed a CQI 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:	01/04/25	

	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	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	4		Consequence:	4
	Risk Level:	16	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 4 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	Amber
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 phase one completed and we now need to agree what phase two will look like. • The development of our QI 'network' in the region continues and we expect to leverage it to help with our quality management system development • Our new CEO comes from a Trust with mature CQI • 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 • The requirements of the collaborative infrastructure and major services review may draw on current resource further	• Within the limited resources available we are prioritising around leadership, culture and behaviour programme which has moved 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:**	**26/03/25**

	BAF Risk Scoring							
Inherent Risk	**Quarter**	**24/25 Q1**	**24/25 Q2**	**24/25 Q3**	**24/25 Q4**	**Rationale for Risk Level**	**Anticipated Risk**	
	Likelihood:	**4**	**4**	**4**	**5**	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 not all of the challenges are internal to ESHT. The likelihood score has been increased to 5 in Q4 as there has been an additional impact in December, January and February of significant infection control challenges, including norovirus, RSV, Covid and flu. This created significant operational challenge with a corresponding negative impact on workforce attendance. This has required significant and sustained additional capacity including 'supersurge' and 'boarding' of patients (corridor care).	**Likelihood:**	**4**
	Consequence:	**4**	**4**	**4**	**4**		**Consequence:**	**4**
(5x4) 20	**Risk Level:**	**16**	**16**	**16**	**20**		**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	**Impact:**	• Delays for some patients in being able to access care • Delays to assessment and treatment • Patients in inappropriate locations

	• Pressures on primary care • Lack of sufficient suitable alternative pathways for patients • Lack of sufficient assessment and treatment capacity in mental health • Recent sustained increase in patients whose primary need is mental health and/or housing • Increase in assaults and aggressive behaviour from patients and/or members of the public • Lack of sufficient capacity for urgent placement of children at risk • 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 system 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		• 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 • 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 discussions at ICB level to identify solutions E. New process for harm reviews of NCTR and long length of stay patients in development and due to report shortly F. Full capacity protocol, and escalation actions updated in line with new OPEL framework G. Several pieces of work as described in the Use Of Resources programme looking at the internal discharge process (SAFER) and focus on reconditioning H. Plans underway for new volunteer and activity roles to support reconditioning and the Transfer of Care Hub I. Recent addition using NerveCentre to enable accurate monitoring of waiting times for therapy, social services and mental health input J. 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 • 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	• Use of any additional specialist advice or support, including visits to ESHT and ESHT staff visiting other locations • Daily patient pathway review for all P1-P3 patients with system partners • Clear oversight and responsibility for operational delivery, and of quality and safety • Monitoring of patients admitted over establishment and their location in the Trust using NerveCentre • System wide discharge improvement workstream focussed on improving discharge processes and reducing length of stay in acute hospital and community hospital beds	• Scheduled meetings with CQC to discuss data, intelligence and KPIs • Challenge at Quality and Safety Committee and Trust Board • Provider assurance meetings and system clinical quality review meetings

Gaps in control/assurance:
• Workforce demand outstripping supply due to significant additional capacity required • Lack of suitable physical space for surge capacity and boarding • Lack of sufficient equipment for surge capacity and boarding • 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 4 Progress Report**	**BRAG**
1.	Ensure clinical areas are staffed as safely as possible	COO/CNO/CMO	Ongoing	• 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 boarding 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, January and February	• Close monitoring of recruitment into the team to be maintained. • Expectation is that work will resume in March 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	16	Emergency Department nursing vacancies	12	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	◀▶
	10/02/2025	310	Safety of clinical environment due to boarding	15	15	**NEW**

Risk Summary						
BAF Reference and Summary Title:	BAF 11: Failure to demonstrate fair and equal access to our services				Strategic Aims Impacted	
					x	
Risk Description:	Operational and financial pressures means that the Trust resource and time required to identify and implement change is diverted by other urgent and important priorities					
Lead Director:	Chief of Staff	Lead Committee:	Inequalities Committee	Date of Committee review:	06/03/25	

	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	2	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	4		Consequence:	4
	Risk Level:	12	12	12	8		Risk Level:	8

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

Assurance Framework – 3 Lines of Defence			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Review of outcomes from Friends and Family Tests • Reviews and triangulation of patient complaints and feedback	• Routine data-led reports reviewed by divisional leadership teams • Regular reporting of health inequalities by divisions at Executive led IPRs • Regular reports to Inequalities Committee	• Internal audit review reports of our governance, planning and delivery against inequalities • Peer review and challenge with local trusts and/or noted peer high performers – especially around vision, scale and the difference made to patient outcomes • Deloitte well led report

Gaps in control/assurance:
• 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 4 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	Of the six actions set out, 1-4 have been completed. 5 is in discussion and 6 has yet to be concluded. Overall, this represents a strong degree of assurance across most of the actions designed to reduce the risk (of not being able to demonstrate fair and equal access). Moreover, considering the range of services that has presented to the HISG over the year (alcohol, inpatient tobacco, smoking in maternity, cancer services) and the noted improvement in inequalities data monitoring, we are confident that the inherent risk has been mitigated to the level expected at YE.	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 Divisions will receive means we can hold them accountable for progress via the IPRs		Sept-24		
6.	Develop a standard framework for divisions to complete regarding health inequalities updates and monitor reporting – and, following on from 5, if we also build Divisions a template, it supports their focus solely on the initiatives/content		Nov-24		

Progress		
What is going well/future opportunities	What are the current challenges including future risks?	How are these challenges being managed?
• HISG and the inequalities committee are functioning well in terms of bringing services and measuring of inequalities to light. • ESHT has been recognised as having made significant improvements in ethnicity data recording this year • Services where inequalities are addressed as part of performance management has increased	• The single greatest issue currently remains routine reporting of waiting times by protected characteristic - and ensuring that this aspect plays a role in the clinical decisions made around PTL management	• The allocation of BI resource to this task remains under discussion • We are in discussion with divisions and other Trusts to understand lessons we can learn to strengthen clinical buy-in to this wider approach to waiting times (that supports a focus on inequalities)

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	◄►

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:**	**27/03/25**

	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**	**5**	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 increased to 20 for Q4 due to a deterioration in overall performance. Non-admitted performance has improved, but no sustained improvement has been seen in length of stay, or in the overall number of patients with no criteria to reside.	**Likelihood:**	**3**
	Consequence:	**4**	**4**	**4**	**4**		**Consequence:**	**4**
	Risk Level:	**16**	**16**	**16**	**20**		**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. Workforce demand outstripping supply due to significant additional capacity required B. Lack of suitable physical space for surge capacity and boarding C. Lack of sufficient equipment for surge capacity and boarding D. Overcrowding due to additional beds and equipment impacting on mobilising patients E. Unable to completely avoid all inappropriate attendances/admissions F. Lack of Adult Social Care capacity G. Lack of Nursing Home capacity H. Accuracy and timeliness of data on NerveCentre albeit improving I. Stranded patients requiring mental health support and those with Significant Mental Illness (SMI)

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 presented 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 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 4 Progress Report**	**BRAG**
1.	Ongoing recruitment for Transfer of Care Hub	COO	Complete	• Successfully recruited to all leadership roles and ongoing success with nursing and DISCO roles	**Blue**
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 due to capacity of senior leaders and also impeded by very high occupancy and boarding affecting workforce and physical space for mobilising and activities. • Little change in NCTR numbers (circa 200).	• Trying to decompress wards but still have patients boarding daily.

	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
Links to Corporate Risk Register:	06/06/2016	108	Demand exceeding capacity of District Nursing service	15	16	◀▶
	03/12/2018	9	Inpatient flow impacting on delivery of care in the Emergency Department	12	20	◀▶
	03/12/2018	16	Emergency Department nursing vacancies	12	16	◀▶
	03/12/2020	69	Risk of insufficient beds during winter	16	16	◀▶
	28/06/2022	10	Delays in out of hours patient assessment times	20	16	◀▶
	10/02/2025	310	Safety of clinical environment due to boarding	15	15	**NEW**

Agenda Item: 21

Report To/Meeting	Trust Board	**Date of Meeting**	29th April 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:	Ian O'Connor, Interim Finance Director	**Presenter(s):**	Steve Phoenix, Trust Chair
Report Author:	Pete Palmer, Board Secretary		
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 three documents between 13th February 2025 and 10th April 2025: **Sealing 116** Insight Direct (UK) Ltd, 25th March 2025. Provision of Electronic Patient Record (EPR) contract via Nervecentre Ltd for seven + three years. **Sealing 117** P.D. Harris (Henfield) Limited, 8th March 2025. Award of rapid response buildings work framework for four years. **Sealing 118** Siemens Healthcare Ltd, 8th March 2025. Refurbishment of Gamma Camera control room and installation of Gamma Camera.		
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	24th June 2025	26th August 2025	23rd September 2025	28th October 2025	16th December 2025
Location	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) 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: Trauma Informed Care	Presentation: Gastro GIRFT Board Committee Annual Reviews and Annual Reports			
Quality, Safety and Performance	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 Medical Revalidation Annual Report	Maternity Overview Q2
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	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					
Governance and Assurance	Violence Prevention and Reduction Standard Speak Up Guardian Update Annual Review of Trust Governing Documents (from February)	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 Complaints Annual Report (CNO)		Equality annual report	Infection Control Childrens Safeguarding Annual Report (CNO) Adults Safeguarding Annual Report (CNO) Organ Donation
Items for Information					Meeting Dates for 2026