EAST SUSSEX HEALTHCARE NHS TRUST

BOARD OF DIRECTORS

TRUST BOARD MEETING IN PUBLIC

LECTURE THEATRE, EDUCATION CENTRE, CONQUEST HOSPITAL

24TH JUNE 2025, 09:30 – 12:45

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Board Agenda

Date: Tuesday 24th June 2025

Time: 09:30 – 12:45

Venue: Lecture Theatre, Conquest Hospital, The Ridge, St Leonards-on-Sea TN37 7RD

	Opening Business	Lead	Action	Time	Paper
1.	Welcome and apologies	Chair	Information	09:30	
2.	Colleague Recognition	Chair	Information	09:35	Yes
3.	Trauma Informed Care in ESHT	Charlotte Bright / Jacqui Fuller	Information		No
4.	Declarations of Interest	Chair	Information		
5.	Minutes of Trust Board Meeting in public 29.04.25	Chair	Approval	09:50	Yes
6.	Matters Arising	Chair	Approval		Yes
7.	Chief Executive's Report	CEO	Information	10:00	Yes
8.	Board Committees Chairs' Reports	Committee Chairs	Assurance	10:10	Yes
Quality, Safety and Performance					
9.	Delivery Plan 2025/26	CEO / DCEO	Assurance	10:15	Yes
10.	Integrated Performance Report, Month 1 (April) (i) Chief Executive Summary (ii) Quality & Safety (iii) Our People (iv) Access and Responsiveness (v) Financial Control and Capital Development	CEO CNO/CMO DCEO COO ICFO	Assurance	10:25	Yes
11.	Maternity Update Q4	DOM	Assurance	11:10	Yes

Break – 10 minutes

Governance and Assurance					
12.	Speak Up Guardian's Update	DCEO	Assurance	11:30	Yes
13.	Delegation of Approval of Quality Account	CNO	Approval	11:45	No
For Information					
14.	Use of Trust Seal	Chair	Information	12:15	Yes

15.	Questions from members of the public	Chair		12:15	No
16.	Agenda Forward Plan	-	Information	12:30	Yes
17.	Date of Next Meeting: 26th August 2025	Chair	Information		
18.	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
DCEO	Deputy Chief Executive
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
26th August 2025	St Mary's Boardroom, EDGH	0930- 1245	
23rd September 2025 (**AGM**)	Relais Cooden Beach Hotel	1400-1600	Annual General Meeting
14th 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**	June 2025
Report Title:	Colleague Recognition		
Key question	How does the Trust recognise and thank colleagues for their contribution, effort and loyalty?		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐		
Report Sponsor:	Jacquie Fuller, Assistant Director of HR – People Engagement	**Presenter(s):**	Steve Phoenix, Chair
Outcome/Action requested:	The Board is asked to receive this report for information and for assurance about the formal recognition of our people over the last two months		
Executive Summary	East Sussex Healthcare NHS Trust recognises that the high standard of care and quality of service it provides is dependent on the contribution, effort and loyalty of its people. This is an opportunity for the Trust to acknowledge the exceptional performance, behaviour, achievements and contribution that our colleagues and volunteers have made to the organisation.		
Regulatory/legal requirement:	Not applicable		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration		
Resource Implication/VFM Statement:	Not applicable		
Risk:	Not applicable		
No of Pages	5	**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. From 1 April we have increased opportunities for colleagues to be recognised for their continuous long service. A key change to policy is to recognise NHS continuous long service, rather than limiting recognition to service only within the Trust.

However, we are aware that in some cases service information from previous NHS employers on some systems does not automatically transfer across to the Trust. This is understandably frustrating for colleagues when we are unable to verify their longstanding continuous service.

We are investigating the cause of this issue and are working towards a reliable process for verifying NHS continuous service. In the meantime, we will continue to recognise continuous service at our Trust only.

2. Trust Awards

There has been a slight delay in confirming the date for this year's Trust Awards event. In the interim, we have taken the opportunity to review the Awards model, incorporating feedback from the Partnership Forum, which asked for a more inclusive approach. As part of this review the award categories have also been updated to better reflect the different roles and contributions across the Trust. Award nominations will go live on the extranet in the near future.

3. Celebrating our people

3.1 Hero of the Month

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

February 2025 – Housekeeping team – Bexhill Irvine Unit, Estates & Facilities Division

'I would like to nominate the Bexhill Irvine unit House Keeping Team for the Hero of the Month Award. In-hospital infection rates seem to increase in the winter months. This leads to implementation of various infection control measures at short notice. These measures are often very labour intensive and have to be done repeatedly over the weeks and months. Our house keeping team work tirelessly to maintain high standards and support the clinical staff with an attitude of positivity and attention to detail.

Their work does not go unnoticed; they are a central part of the work we do at the Irvine unit and we greatly appreciate their adaptability and ability to work well under pressure.'

March 2025 – Leah Falla & Kayleigh Clark – Maternity, Conquest Hospital – Women's and Children's Division

'On the 13th February Leah visited a family with a 3-week-old baby for a final check for the mother as she is on the incentive scheme for stop smoking and had been successful in quitting. Leah went to do the visit as normal and confirm the final quit when she identified an extremely and abnormally high CO reading. Leah acted very quickly in asking her colleague Kayleigh Clark for support and they contacted the ambulance service and fire brigade.

The family (mother and 5 children including the newborn baby) were transferred to Conquest Hospital emergency department for medical assessment. The fire brigade condemned the boiler. The family are being supported by social services and were able to return home later in the day.

We just want to thank Leah and Kayleigh together, as their Tobacco Dependency Advisor roles have supported this family and the mother to quit smoking. The continuity of Leah's care and knowledge of the family alerted her to them feeling unwell, with headaches on her arrival, and this gave her the professional assertiveness to take immediate action to ensure this family were safe and able to go home at the end of that day without tragedy having occurred.'

April 2025 – Garry East – Deputy Chief Operating Officer – Corporate Division

'On Friday 28th March there was an incident that occurred at the Conquest main reception desk. A receptionist was trying to help the patient who became very quickly agitated and extremely aggressive. Garry who was passing Reception immediately stepped in and asked if he could help the patient. Things escalated very quickly. The staff on reception really feel grateful for Garry's quick action. Garry put himself in danger to protect the reception team . Garry stood between the patient and the reception team so he created a barrier, putting himself in the firing line.

The team feel through his bravery he stopped one of the receptionists from becoming harmed. Garry deserves recognition for his actions and bravery.'

3.2 Long Service Awards issued: April - May 2025

Long service recognition issued											
Month	5 years	10 years	15 years	20 years	25 years	30 years	35 Years	40 years	45 years	50 years	Total
Apr-25	50	18	21	13	21	2	2	3	1	0	**131**
May-25	32	18	22	10	20	3	3	3	0	0	**111**

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 some of our colleagues receiving their Retirement celebration certificates from Steve Phoenix, Chairman, and Steve Aumayer, Deputy Chief Executive and Chief People Officer.

Peter Rimington

Xanthe Knowles

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.'

6. Celebrating Long Service

Ancuta-Maria Mihai- 5 years

Sarah Baker – 5 years

Nicky Greenwood – 20 years

Sandy Butler – 20 years

Mel Adams – 25 years

Slobodan Antonijevic – 25 years

Rachel Mckie - 5 years

Rebecca Baker - 10 years

Catherine Stringer - 20 years

Loren Bishop – 15 years &
Keran Purser – 5 years

East Sussex Healthcare NHS Trust Board Minutes

Date: 29th April 2025

Time: 09:30 – 12:45

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

		Actions
	Attendance: Steve Phoenix, Chair and Non Executive Director Jayne Black, Chief Executive (CEO) Vikki Carruth, Chief Nurse & Director of Infection, Prevention and Control (CN) Simon Merritt, Chief Medical Officer (CMO) Ian O'Connor, Interim Chief Finance Officer (ICFO) Paresh Patel, Vice Chair and Senior Independent Director Frank Sims, Non-Executive Director Nicki Webber, Non-Executive Director <u>Non-Voting Directors</u> Ama Agbeze, Associate Non-Executive Director Jenny Darwood, Director of People (DOP) Amber Lee, Associate Non-Executive Director Richard Milner, Chief of Staff (COS) <u>In Attendance</u> Andy Bailey, Deputy Chief Operating Officer (Planned Care) (DCOO) Claire Bishop, Deputy Director of Nursing (DDN) Steven Fong, Consultant Gastroenterologist (CG) (for item 23/25 only) Mia Wareham-Storr, Alcohol Care Team Administrator (ACTA) (for item 23/25 only) Brenda Lynes, Director of Maternity Services (DOM) Pete Palmer, Board Secretary (BS) (minutes) Four members of the public were in attendance at the meeting.	
	Apologies: Steve Aumayer, Deputy Chief Executive (DCEO) Amanda Fadero, Non-Executive Director Charlotte O'Brien, Chief Operating Officer (COO) Carys Williams, Non-Executive Director	
21/25	**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. He welcomed Jayne to her first Board meeting in public since joining as Chief Executive and thanked Steve Aumayer for his stewardship of the Trust during his time as Interim CEO, which had been a challenging time for the organisation. He welcomed Ian as Interim Finance Director and thanked Damian Reid for all of his work during his five years with the Trust, wishing him the best for the future. He noted that Andy Bailey was deputising for Charlotte O'Brien, and welcomed members of the Alcohol Care Team.	

22/25	**Colleague Recognition** Steve, Chair reported that December's Hero of the Month had been Matthew Ades, a member of the Catering Team at the Conquest Hospital and that January's winner had been Maria Frost, a housekeeper in A&E at EDGH.	
23/25	**Alcohol Care Team - a success story for building a sustainable future** Steven, CG explained that the Alcohol Care Team was a very small team based at the Conquest Hospital and was probably the smallest such team in the country. East Sussex sat close to the top of a number of national alcohol metrics, including for alcohol related admissions and the number of licenced premises that sold alcohol per square km. The Trust had received seed funding from the Integrated Care System (ICS) to introduce a team to address alcohol related issues. Since the introduction of the team, huge improvements had been realised to the journeys of patients with Alcohol Use Disorder (AUD); doctors were now trained in the treatment of AUD and assessed patients to ensure that they were placed on the most appropriate care pathway which had led to reduced alcohol related admissions, lengths of stay and episodes of care following discharge as care had been moved to the community. The team had also provided education sessions for colleagues, improved data collection and facilitated greater integration between primary and secondary care with MDT meetings taking place every two weeks to ensure that patients received the correct care when they returned home. East Sussex Public Care had reviewed the service provided by the Alcohol Care Team and had assessed that it had saved 696 bed days since being introduced with a total financial saving of around £280k. Work was now being undertaken to better understand local demographics to prevent patients with AUD from needing hospital treatment. This data could be used to better inform other services provided by the Trust and public health agencies. The team was also developing nurse link practitioners and alcohol champion doctors in the Trust and looking at areas, such as obstetrics and pre-surgery, where more focussed work could be undertaken. They would look to replicate the service in Eastbourne and were developing a business case for this expansion. Frank, NED thanked the team for the interesting presentation. He noted that the connection between community and primary care was extremely important when looking after patients with AUD and asked how training and information sharing was being undertaken. Steven, CG explained that a number of workshops had taken place with East Sussex public health colleagues. The team were trying to share their expertise about how to improve the treatment of patients outside of an acute setting; terms of reference and information sharing guidance had been developed which ensured early awareness when known AUD patients were admitted to the Trust. The CEO thanked the team for their presentation and asked what feedback had been received about the service from patients. Mia, ACTA explained that the nurses gave out feedback forms to patients at the end of their assessments and that the feedback that had been received had been very positive. The CMO praised the work of the whole team noting that Steven, CG deserved particular credit as he had fought hard to set up the service. He explained that a team had presented a compelling case for expanding the service to Eastbourne and looked forward to seeing the business case. Paresh, NED thanked the team for their presentation and asked whether further investment into the team would be required at the Conquest. Steven, CG explained that the team were working hard to manage their service within their current resource. He welcomed a business case for expanding the service to EDGH.	

	Ama, NED asked whether there was a mechanism for patients to be referred to the service without attending A&E. Steven, CG explained that patients attended A&E in extremis; the service liaised with community partners who were able to directly refer patients which helped to support integration between different services. Members of the Alcohol Care Team also visited A&E every day to identify patients who would benefit from the service. Nicki, NED asked whether there was an increased focus on the small number of patients who had multiple contacts with the service. Steven, CG explained that the role of Mia, ACTA in looking at data in order to identify patient trends was crucial and helped to support interventional work for specific patients. Frequent attenders had a range of issues that were not just related to alcohol, so the team linked up with other support mechanisms such as safeguarding when necessary. Getting the treatment programmes right for these patients would reduce the amount of resource required to care for them. Steve, Chair thanked the team for the presentation, noting that this provided an outstanding example of how taking a public health approach could make a real impact at ward level if done correctly. He looked forward to seeing the business case for expanding the service to Eastbourne.	
24/25	**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.	
25/25	**Minutes** The minutes of the Trust Board meeting held on 25th February 2025 were reviewed and agreed as a correct and accurate record of the meeting.	
26/25	**Matters Arising** • *Martha's Law Presentation* On the agenda for the meeting. **Closed**. • *Parking Update* Due to be presented at June's Board meeting • *Community Services data in the IPR* Improved data is expected to be included within the monthly Trust IPR from November 2025 as part a the wider review of information flows and reporting which will lead to a revised approach to IPRs in the organisation. • *Improved Board Reporting* This was also being considered as part of the review of information and reporting and improvements were expected from November 2025.	
27/25	**Chief Executive's Report** The CEO presented her report, thanking colleagues for the genuinely warm welcome that she had received from everyone that she had met during her first couple of weeks in the Trust. She had undertaken visits across the Trust and had found the organisation to be extremely friendly. While it was a challenging time for the Trust, and for the wider NHS, she was very proud to have been given the opportunity to lead, she encouraged departments and colleagues to get in touch with her. She praised the work that Steve Aumayer had done during his time as Interim CEO, noting that this had been a particularly challenging time for the organisation. She reported that Steve would now return to his role as Deputy CEO and would take on leadership of digital, performance assurance and business intelligence functions.	

	She also thanked Damian Reid for all his work during his time at the Trust, noting that Ian O'Connor would be stepping into the Chief Financial Officer role on an interim basis while the Trust looked to recruit to the permanent position. The COS would be taking information governance as part of his portfolio. She noted the continued importance of working collaboratively with the system, explaining that the Trust would continue to work closely with the Sussex Integrated Care Board (ICB) while fundamental changes to how it operated took place. The Trust had achieved its biggest ever efficiency savings in 2024/25 with a total of £38m. The work of divisional teams and other colleagues to support this had been very impressive and this would be built upon in the coming year in order to deliver the 6.3% efficiency programme that was required. Nicki, NED noted that the CEO's report mentioned a task and finish group that would enhance leadership accountability when staff spoke up, and asked for more detail about what this would mean for staff. The CEO explained that the Trust was trying to foster an environment where staff felt respected and encouraged to speak up; recent feedback from the annual staff survey and 'Too Hot to Handle' had highlighted areas where improvements could be made. It was important that colleagues, and particularly middle managers, were given the confidence and support to discuss with staff and make changes when things were not going well. Accountability would be introduced over time as these skills were developed. Steve, Chair agreed, noting that the current NHS environment could make it more challenging to make changes. It was important that managers treated feedback from colleagues as a gift. The DOP explained that work was also being undertaken to recognise and address inappropriate behaviours, wherever they occurred in the Trust. Ama, ANED noted that the CEO's report included information about a pioneering stroke rehabilitation pilot programme at Bexhill Irvine Unit which had looked at how services worked with non-NHS partners in NHS environments. She asked how the learning from the programme could be used elsewhere. The CEO explained that the programme had seen really good outcomes; work was being undertaken with system partners to identify other areas where learning could be used to improve patient care. ***The Board noted the CEO's report.***	
28/25	**Board Committees Chairs' Upwards Reports** <u>Audit Committee</u> Paresh, Vice Chair presented the Audit Committee's report. The updated Terms of Reference for the Committee were presented for the Board's approval, having been updated following the publication of the new NHS Audit Committee Handbook in December 2024 to ensure that they reflected best practice. **The Board approved the updated Audit Committee Terms of Reference.** <u>Finance and Productivity Committee</u> Nicki, NED presented the Finance and Productivity (F&P) Committee's report. <u>Inequalities Committee</u> Steve, Chair presented the Inequalities Committee report. <u>People and Organisational Development Committee</u> Frank, NED presented the People and Organisational Development (POD) Committee report. He explained that he had recently become Chair of the Committee and thanked Carys, NED for her work.	

	Quality and Safety Committee Vikki, CNO presented the Quality and Safety Committee (Q&S) report. ***The Board noted the Committees Chairs' upward reports.***	
29/25	**Integrated Performance Report (IPR) for Month 11 (February)** The IPR was jointly reported by the CNO, CMO, DCEO, ICFO and DCOO. The CEO explained that the key priorities for the Trust in 2025/26 were front door performance, reducing length of stay and discharge; improvements in these areas would result in a positive impact across the organisation. Quality and Safety The CNO presented the update. Highlights from this section included: • Quality metrics had remained stable; work was being undertaken to develop spotlight reporting that would provide additional assurance for gateway areas and other areas not currently included in the main IPR. • The Trust had exceed its annual limit for clostridium difficile (c.diff) infections, but had improved on the previous year. Ongoing infection control challenges included high bed occupancy and the necessity of utilising additional capacity. The Trust was working hard to maintain meticulous standards while under high pressure, but there was little margin for error in infection control practices. The CNO thanked colleagues from the estates and housekeeping teams for their ongoing hard work to keep patients safe. • A small number of likely linked infections had been identified during the year. • Sustained performance against complaint response time targets continued to be achieved. A huge increase in Friends and Family Test (FFT) survey responses were being received following a change to how these were collected. 11,500 responses were received in February, the vast majority of which were positive. • The recently recruited Head of Nursing for Mental Health continued to recruit to the Trust's Mental Health Outreach team. The positive impact from this role for both staff and patients was already being seen. • The CNO thanked therapy colleagues, having recently spent time with them. She explained that during her visit a patient had asked her to feedback to the Board about the incredible care that she had received following a devastating stroke, noting in particular the personal level of care that she had experienced. Nicki, NED acknowledged the many positives that were included within the report. She asked about the three harm events mentioned in the IPR that had taken place in February. The CNO explained that further details would be provided in the private meeting to ensure that the patients involved could not be identified. She noted that a validation process for incidents was undertaken at Weekly Patient Safety Summit (WPSS) meetings; once reviewed and the severity was adjusted either up or down if appropriate. The ratings for the three harm events were pre-validation. Paresh, NED reported that he had recently visited Bexhill Irvine Unit and praised the amazing work that the team did and the level of care that they provided to patients. He noted that it could be challenging to read some of the graphics in the IPR and asked whether in-year trend data could be included along with longer term data trends. The CEO explained that improvement work was ongoing to improve both divisional and the Trust IPR and part of this work would include the presentation of metrics which she anticipated would improve as the work progressed. The CMO reported that a deep dive was being undertaken into mortality metrics which would be presented at the next private Board meeting. There was a widening gap between the Summary Hospital-level Mortality Indicator (SHMI) at Conquest and EDGH which was not reflected in the Risk Adjusted Mortality Indictor (RAMI). This was likely due to the relatively small Acute Medical Unit (AMU) at Conquest; the SHMI utilised the	

diagnosis from the first two completed consultant episodes which took place more quickly at Conquest as patients passed through AMU relatively quickly compared to EDGH. Work was being undertaken to identify what could be done to address this discrepancy.

The Trust remained comfortably with normal ranges for mortality metrics and had tracked below other integrated trusts during the last three years. Crude morality was lower than it had been at the same time in 2024. The variety of reporting metrics that were used were helpful in verifying and sense checking the Trust's performance. Work was being undertaken to separate community data from reporting to see if this provided any further insight.

Ama, ANED noted that comparison with other trusts was not always helpful as this was not always made with other integrated trusts. She suggested it might be more helpful to look at different data to ensure that the Trust continued to perform well. The CMO noted that SHMI was a nationally recognised metric and provided a more helpful indicator of the Trust's performance compared to other organisations than RAMI.

Frank, NED asked whether work was being undertaken to ascertain why there was a gap between SHMI performance between Conquest and EDGH. The CMO explained that this was being analysed; he was confident that there was no underlying issue as the Trust's crude mortality continued to reduce. The CEO suggested that it could be helpful to look at the data for patients with different diagnoses so that targeted work on pathways could be undertaken. The CMO agreed, noting that deep dives were already undertaken as part of the work of the mortality review group. Nikki, NED noted that the various metrics helped to identify the right questions to ask about mortality, and where to look for assurance that there was no problem.

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

- Metrics had remained stable across most domains during February. Workforce usage increased during the month in support of escalation areas, and a reduction in the use of temporary staff had been maintained.
- Agency staffing had reduced to its lowest level of the year, at 49.9 whole time equivalents (WTE). This represented a reduction of 60WTE from the start of the year, with many members of this workforce becoming substantive.
- Training and appraisal rates continued to slowly improve. Reporting of appraisals was being moved from ESR to MyLearn and this transition was being closely monitored to ensure that the good progress was not lost.
- Sickness, and particularly unknown reasons for sickness, was an area of focus. It had been identified that the recording of the reason for sickness at the start of illness could be improved and work was being undertaken with managers.
- Support was being given to areas which were outliers for mandatory training. Discussions were also taking place with the national team to ensure that mandatory training remained useful and impactful.
- The Trust was preparing for the challengers of having a reduced workforce in 2025/26. Targeted leadership training and wellbeing resources were being introduced in areas where change was anticipated.

Amber, ANED asked about the recent reduction in appraisal rates, noting that good appraisal rates had a positive effect on culture and accountability. The DOP agreed and explained that support had been put in place in areas where the transition to digital appraisals would be most challenging. Appraisal rates were discussed in detail at each POD Committee and the reasons for the slight reduction were understood.

Access and Responsiveness

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

- Emergency Department (ED) performance had been significantly challenged in recent months with high attendances and high acuity of patients. February's performance against the four hour standard had been 72.1% against the 78% target, but this had improved in April to around 76.9%.
- A recent Multi-Agency Discharge Event (MADE) had successfully taken place which had led to a reduction in length of stay, identified improvements to discharge pathways and ended the use of super surge capacity.
- The Trust took an additional 1,600 elective patients during 2024/25 to help improve waiting times across the system. 41 patients had waited for more than 65 weeks for elective treatment at the end of February and more than half of these were transfers from another Sussex provider. This position had improved greatly by the end of April; support was in place for challenged specialities with an ambition of having no patients waiting for more than 65 weeks.
- The number of patients on the Trust's waiting list would increase in March as musculoskeletal (MSK) patients were included in reporting for the first time. This had led to an improvement in overall performance.
- Cancer performance had been maintained moving into April; performance targets would increase in March 2026 and the Trust was working to ensure that it met these further challenges.
- Diagnostic performance was above 90% and the Trust was working towards meeting the national 95% target.
- A plan had been submitted to the system setting out how performance risks and challenges would be mitigated and addressed in 2025/26. Proactive contact was being made with patients to mitigate and reduce delays as a result of patient choice.
- Improvements were being made in the Trust which would lead to increased outpatient productivity and theatre utilisation.

Steve, Chair noted that there had been a lot of good work undertaken during the last year and was encouraged about the further progress that had been made. The Trust was now tantalisingly close to meeting the four hour ED target. The DCOO agree, explaining that colleagues across the organisation had worked extremely hard to improve performance. Steve, Chair explained that he hoped that the Trust would continue to improve so that 78% became the floor for performance and that exceeding this was normalised.

Steve, Chair asked what substantive changes would be made following the MADE event. The CEO explained that the event had been important for bringing organisations together to evaluate existing patient pathways and identify any improvements. Learning from the event would be used to look at other pathways and would be monitored to ensure that the improvements were sustained in the long term.

Nicki, NED noted that the Trust's Referral to Treatment (RTT) performance was slowly declining; the Trust had moved from 70th in the country to 88th. She asked whether this was an area of focus. The DCOO explained that performance had improved from 55% to 59% in March when MSK patients had been included in reporting for the first time. RTT would be a key area of focus on 2025/26 and recent revalidation work had led to an improved position. The ICFO confirmed that the activity plan was triangulated with financial and workforce planning, but noted that the Trust would need to keep on improving performance to improve its position as other Trusts were also likely to improve. Nicki, NED suggested that reporting could be changed to highlight the Trust's performance, rather than how it was performing relative to other organisations, so that improvement could be more easily identified. Steve, Chair, noted that the Trust's RTT position would be much better if it had not taken on an the additional 1,600 patients.

	The CEO noted the impressive performance of the Trust against the urgent community response standard, at 82.4% against the 70% standard. She thanks community colleagues for the help and support that they gave to the organisation. <u>Financial Control and Capital Development</u> The ICFO presented the update. Highlights from this section included: • The Trust had forecast a deficit of £9m for 2024/25 and had submitted draft accounts for the year which showed an £8.9m deficit for the year. • The ICFO paid tribute to the work of operational, corporate and clinical teams for their support in how spending had been controlled in the Trust during the year. Steve, Chair asked the extent to which excess inflation, unfunded pay rises and industrial action contributed to the Trust's overall deficit position in 2024/25. The ICFO explained that factors outside of the Trust's control accounted for around £5m of the deficit. Steve, Chair, noted that despite delivering the largest Cost Improvement Programme (CIP) ever the Trust had still overspent and that there had been extensive conversations and scrutiny from members of the Board about the Trust's financial position in recent months. ***The Board noted the Integrated Performance report.***	
30/25	**Avoidability of Inpatient Deaths Q2** The CMO presented the report, explaining that all deaths in hospital were subject to review by the Trust's team of medical examiners; cases that required additional scrutiny were discussed at speciality morality and morbidity meetings. In addition, quarterly meetings of the mortality review group were held to review the deaths of patients who had been identified as having any avoidability of death. Cases were reviewed individually and given a subjective rating about avoidability. The group also reviewed all learning disability deaths once independent reviews from the learning disability mortality review (LeDeR) programme had been reviewed. The CMO noted that these external reviews could sometimes take up to a year to be received by the Trust. Nicki, NED asked about the 15 cases dating back over two years which had not been discussed by the group. The CMO explained that nine of these outstanding cases had now been reviewed by the mortality review group, but all had already been subject to review through other Trust processes as avoidability reviews were an additional process on top of Trust processes. Most of these cases had been delayed due to the significant delays in receiving LeDeR reviews. ***The Board noted the Q2 Avoidability of Inpatient Deaths report.***	
31/25	**Maternity Overview Q3** The DOM presented the Q3 maternity overview, explaining that this had previously been presented to Q&S. She reported that maternity services continued to be provided by the Trust in line with national requirements, with clinical safety being maintained. When incidents occurred, appropriate action was taken. Perinatal mortality continued to show significant improvement. The Trust worked closely with service users through the Maternity and Neonatal Voices Partnership (MNVP), and had co-produced an action plan for 2025/26 based on service user feedback. The MBRRACE-UK report had been published in October 2024, which included a number of recommendations for NHS maternity services relating to the improving health inequalities in order to reduce maternal deaths. The Trust had been working with primary care providers to develop a risk assessment of thromboembolism to ensure that appropriate treatment was prescribed, and was also looking at targeted support for patients in areas of deprivation.	

The service had recently welcomed new senior operational leaders and had commenced a leadership programme focussed on ensuring that middle managers fully understood their roles and responsibilities. Work was also being undertaken to strengthen the interface between maternity services and other divisions. Actions from the recent independent investigation were being undertaken with progress being fed back to staff.

A no harm Never Event had taken place in July 2024 which had been discussed extensively by Q&S. Action had been taken which would greatly reduce the risk of any recurrence. A review of the midwifery workforce was progressing, which had demonstrated that the neonatal and medical workforce met recommended levels.

Steve, Chair explained that he was impressed by the work that was being undertaken to reduce health inequalities and asked how this compared to other NHS trusts. The DOM explained that the programme at ESHT was similar to other organisations as it was part of the three year maternity delivery plan.

Steve, Chair asked what the outcome of a recent assurance meeting with NHS England (NHSE) had been. The DON explained that the Trust had not yet received a report following the visit, but had received informal feedback which had praised the Trust's relationship with the MNVP. While she expected that the report would include some areas of focus for the Trust, there had been no surprises and the maternity team had been asked to share good practice with other trusts and had requested learning from other organisations in return.

Steve, Chair reported that his wife was a NED Maternity Champion at another trust and had recently been a birthing partner at the Conquest. He explained that she could not have spoken more positively about the team, service, level of care and attention that she had seen during a non-routine delivery and would be writing to the team to thank them.

Paresh, NED asked about timescales for the leadership training. The DOM explained that divisional leaders had received training in February. Between April and August, band 8 colleagues would receive training and during the same period one to one meetings and training would take place for band 7 staff. She expected that the programme would be completed by October.

Amber, ANED asked how the impact of improvement work would be measured. The DOM explained that annual appraisal compliance had greatly increased over the last year and that this provided an opportunity for colleagues to feedback about improvements; the recent introduction of an electronic appraisal system had been well received. The results of annual staff surveys would be used to receive further assurance about the progress that was being made.

Nicki, NED noted that it was hard to see the positive progress made by the maternity team on smoking cessation from the report, suggesting that reporting could be changed to highlight this more clearly. She asked whether she should be concerned about stillbirths as the report made it unclear whether the number of stillbirths that had occurred was within expected parameters. The DOM explained that sadly a number of stillbirths would always occur and that the reported numbers where within expected levels. All stillbirths were subject to a detailed review to look at any areas of concern and identify any learning.

Frank, NED noted that a lot of good work had been undertaken by the maternity team to address inequalities and asked whether the team worked with system partners to care for patients attending with mental health issues. The DOM explained that every patient who used the service received a mental health risk assessment; if they were considered low risk they were offered community support, medium risk patients were supported by midwives and high risk patients received escalated support. The maternity team linked with the Trust's safeguarding team as well as notifying the system of any patients at risk.

	Ama, ANED noted that despite good staffing levels the report mentioned that staff felt tired towards the end of their shifts, asking whether this feedback had been acted on. The DOM explained that there was an ongoing piece of work taking place to ensure that all staff took breaks when they should; staff found it hard to leave patients and managers were supporting colleagues to ensure that they took breaks. The DON noted that discussions had taken place in the past about whether 12 hour shifts were too long, but feedback from staff was that most preferred longer shifts as they helped them to balance busy lives and responsibilities outside of work. ***The Board noted the Q3 Maternity Update***	
32/25	**EmPoweR Electronic Patient Record Update** The CMO presented an update on the introduction of Electronic Patient Records (EPR) into the Trust. He explained that following a vigorous procurement exercise the Trust has signed a contract for EPR in March with NerveCentre; there would be a two year implementation programme for the system which would replace a number of existing systems including patient administration, orders and results, clinical coding, theatre management and portering. Work to migrate to the cloud was expected to be completed by the end of 2025 with the EPR system beginning to be used in 2026. Further functionality would be added during the course of the two year implementation programme. Steve, Chair noted that a question had been received from a member of the public asking what would happen if the connection to the cloud failed. The CMO explained that the system would connect in multiple ways so had a lot of inbuilt redundancies, which would be supported by business continuity plans should the connection ever fail completely. Nicki, NED noted that the Audit Committee had recently discussed that robust business continuity plans were not in place in all areas of the organisation, recognising that this was a governance gap for the Trust. She noted that the Emergency Preparedness, Resilience and Response (EPRR) team were working hard to address the issue and asked whether business continuity plans for EPR would be prioritised given its importance to the organisation. The CMO confirmed that developing the plans would be a priority and noted that ESHT was benefitting from working and learning from NHS trusts in the midlands who had introduced the NerveCentre EPR system a couple of years before. Amber, ANED asked about the level of change that would be experienced by colleagues on an individual level when EPR was introduced and whether change management plans were robust enough to account for this. The CMO explained that the introduction of EPR would change how almost everyone in the Trust worked. It had been recognised that in the past the Trust had not introduced new systems particularly well and had learnt from this, engaging with colleagues across the organisation at an early stage. Engagement would continue throughout the implementation programme, supported by training programmes, ensuring staff were prepared when the system went live. Once colleagues were used to the system, patient safety would improve as it would provide more granular information that would be used to identify deteriorating patients. The CNO noted that it was important to recognise that initially work would be slower even though it would be safer. Paresh, NED noted that it was unclear from the paper whether clinical processes and pathways were being redesigned for the introduction of EPR and whether clinical staff would be involved in this process. The CMO explained that clinical teams would be redesigning clinical pathways with test environments made available to test these in a safe manner as well as for training purposes. The DOP reported that staff networks had already engaged with the EPR team to discuss accessibility and had been included in procurement processes to ensure that accessibility was considered throughout the introduction of EPR. ***The Board noted the EmPoweR Electronic Patient Record Update***	

33/25 **Trust Financial Plans 2025/26 – Revenue and Capital**

The ICFO reported that there had been a fundamental change to how financial planning and budget setting for 2025/26 had been undertaken with a focus on the run rate and ensuring that financial and operational plans were fully aligned. Divisional leaders had embraced this approach, with outstanding engagement seen across the organisation.

The Trust needed to deliver a 6.3% Cost Improvement Programme (CIP), totalling £49.6m, in 2025/26 in order to reach a breakeven position. £38m of CIPs had been delivered in 2024/25 so delivering the 2025/26 programme would be a significant challenge for the organisation. Half of the 2025/26 CIP programme had already been delivered or was in delivery and the Trust hoped to surpass the CIP target. There were no unidentified schemes in the programme; a further 66 schemes with no current financial value associated with them had not been included emphasising the additional opportunities that existed.

Steve, Chair noted that the Board had already discussed the financial plan on a number of occasions, including in detail at F&P the previous week. He felt that, despite the huge challenges ahead, the Trust was better prepared for the new financial year than it had ever been during his time at the Trust. He explained that this was due to the hard work of executives and clinical and operational teams who had been crucial in pulling the plans together and he thanked them for all that they had done.

Nicki, NED reported that she had discussed how progress against plans would be tracked during the year with the CEO, ensuring the reporting joined operational and financial performance in a way that had never been done before to enable the impact of strategic decisions on performance to be closely monitored. Steve, Chair agreed, explaining that this was a gap in the Trust's governance processes that would be closed.

Frank, NED noted that he felt that the 2025/26 financial plan was robust and was pleased that this was closely linked to divisional plans, included reasonable assumptions and was not reliant on the other organisations undertaking work that would save the Trust money. He asked about early warning systems which would identify deviation from the plan as quickly as possible so that this could be addressed. The ICFO explained that work was being undertaken to look at soft intelligence, including current delivery of CIPs and expectations over the coming weeks. Once this work was completed, metrics would be developed which would provide assurance about whether targets were being met. A key focus would be on income and the reduction in the use of temporary staff. The CEO explained that it had been agreed that weekly monitoring would take place, led by Executives alongside divisions. This monitoring would be used to quickly identify and address issues.

Steve, Chair noted that the Trust would also need to make corporate savings in 2025/26 and asked what approach would be taken in realising these. The CEO explained that the Trust had committed to finalising corporate savings plans by the end of May; these would then be shared with NHSE. Plans would be reviewed by Executives to ensure that they were deliverable, sustainable and had a minimal impact on services.

The ICFO reported that capital plans for 2025/26 were not as advanced as financial plans but were expected to be finalised in the next 4-5 weeks. The Trust had underspent against its capital allocation by £606k in 2024/25, due to not being able to get a vesting certificate from a supplier. Much of the 2025/26 capital allocation would be used for existing commitments, including funding for the Sussex Surgical Centre and the Digestive Diseases Centre. A three year capital plan would be developed which would be refreshed on a quarterly basis.

Paresh, NED noted that depreciation had not been factored into capital planning, which represented a big risk for the organisation. He noted the importance of identifying equipment that was coming to the end of its lifespan at an early stage so that this could be planned for appropriately. The CEO agreed, explaining that this had been identified

	by Executives who would be reviewing the capital prioritisation matrix to address the issue. Steve, Chair noted that the Trust had planned for funding to be received through the New Hospital Programme to address depreciation, but as this had been delayed it would now need to make short and medium term plans. The matter was outside of the Trust's control and had been escalated both regionally and nationally. Steve, Chair thanked the ICFO for his leadership in developing the 2025/26 financial plan. ***The Board endorsed the Trust's revenue and capital plans for 2025/26 and the proposed approach to future financial planning.***	
34/25	**Ward Nursing Establishment Review** The DDN presented the outcomes of the 2024/25 ward nursing establishment review (NER) explaining that she was seeking the Board's formal approval for the paper which had been endorsed by Executives and F&P. A review was undertaken twice a year comparing the Trust's nursing to national standards. The review had concluded with no recommendations to change nursing templates and had set out opportunities for reviews of some services which were being led by ward teams. A review of community nursing had commenced to identify any opportunities or deficiencies in nursing levels. Reviews of outpatient and specialist nursing were due to finish the following day, providing assurance about non-ward areas. The CNO thanked the DDN for her work on the NER. She explained that a bottom up approach was taken with high levels of engagement with services; while this was time consuming she felt that it provided extremely robust data and assurance. The ICFO noted that the outcomes of the NER were fully aligned to the 2025/26 financial plan. ***The Board noted and approved the Ward Nursing Establishment review 2024/25***	
35/25	**NHS Staff Survey - Results 2024** The DOP presented the Trust's results from the annual NHS Staff Survey. She reported that response rates for substantive staff had fallen to 47% and were below the national rate; the response rate for bank staff was 24% and had been one of the highest nationally. There were a number of positives from the survey results, but there was also a lot of work that needed to be done in response. There had been a decline in engagement and positive feedback indicators, with colleagues reporting that they felt less engaged, concerns about being treated with compassion and recognition and about having a voice that counted compared to the previous year. Key priorities for 2025/26 had already been discussed in a number of forums and were included in the report along with associated actions. Divisional dashboards had been developed which would allow divisions to look at their data in detail in order to develop their own action plans. There were also trustwide issues where central actions plans would be developed. A Staff Survey Steering Group would be set up with key stakeholders contributing and ensuring that actions were in place and effective. Governance processes would be strengthened, with a greater focus on discussions with divisions at monthly IPR meetings. The plan had been discussed in detail at POD, and the Board had previously received a presentation on the results. Progress would be overseen by POD. ***The Board noted the 2024 Staff Survey Results.***	
36/25	**Martha's Rule Implementation Update** The CNO presented an update on the implementation of 'Martha's Rule' in the Trust, explaining that this was called 'Call for Concern' locally and that it ensured that rapid reviews of care by an independent critical care team could be requested.	

	20 calls had been received in total since the scheme had been introduced, only five of which had related to concerns about medical care. Work continued to ensure that colleagues were aware of the scheme and the Trust had successfully applied for additional funding which would be used to enhance publicity for the scheme and provide digital devices. Work was being undertaken nationally to develop a digital solution for recording patient conditions. Nicki, NED asked what good looked like and whether 20 calls to the service was good. The CNO explained that she was unsure as national comparators were not available. She hoped that there would not be large numbers of calls as this would mean that people were not happy with the care that they received, but expected that there would be some concerns raised. She explained that the Trust was part of a network of organisations which would allow for comparisons in the future. She noted that work being undertaken to publicise the service might not lead to an increase in contacts. ***The Board noted the update on the Implementation of Martha's Rule in the Trust and approved future updates being presented to the Quality and Safety Committee.***	
37/25	**Q4 Board Assurance Framework** The COS presented the Quarter 4 Board Assurance Framework (BAF) which set out the strategic risks to the organisation. The risk ratings for four of the strategic risks had increased for Q4, while the ratings for three risks had decreased. He explained that the risks for 2025/26 had been devolved to the Board's Committees, with Executive leads and Chairs considering the relevance of existing BAF risks and whether these needed to be changed. Strategic and in-year objectives would also be considered when updating the BAF; recommendations would be presented to the Board at the Development Day in May. Work had commenced on improving the Corporate Risk Register with risks allocated to appropriate Board Committees. Quarterly BAF updates would be more forward focussed in 2025/26 rather than looking back at the previous quarter. Steve, Chair noted that conversations about the BAF were often focussed on how it should be used, and he felt that making this a forward look would be helpful. He asked if EPR should be a strategic risk for 2025/26. The COS noted that EPR was covered under the existing digital strategic risk; he expected that there would be a specific risk added to risk registers about EPRR which would escalate to the Corporate Risk Register if it was scored at 15 mor more. ***The Board noted the Update on the Q4 Board Assurance Framework***	
38/25	**Delegation of Approval of Annual Report and Accounts** The COS asked the Board for their approval of delegation of the annual report and the accounts to the Audit Committee. The Board would receive the final annual report and accounts at the Annual General Meeting in September. ***The Board delegated authority for the approval of the Annual Report and Accounts for 2024/25 to the Audit Committee.***	
39/25	**Car Parking Charges** The DOP provided a verbal update on recent changes to parking charges. She reported that public tariffs were currently being reviewed and noted that the reinstatement of patient drop off periods was being considered as part of this review. From April, the Trust had moved to a tiered system of charges for staff parking that was based on salary banding. This replaced the previous flat rate model to ensure a fairer and more progressive approach, with lower paid staff paying less than £1 a week. Night staff were now charged at the same rate as other staff. Reviews of staff parking charges in counterpart organisations had demonstrated that parking charges were significantly lower at ESHT. The revenue would be used to support parking operations and	

	sustainable travel initiatives for colleagues and to ensure that appropriate parking management controls and enforcement were in place. Steve, Chair noted that when he had first joined the Trust staff parking cost £1.50 a day, so the updated rates represented a significant reduction. Nicki, NED noted that historically staff had not been asked to pay for parking at night; part of the reason for charging staff for parking was to encourage the use of public transport and other sustainable travel options which were not available at night and there were also increased safety concerns when travelling at night. She asked why the Trust was now charging for night time parking. The DOP explained that there were very few staff who only worked at night; the introduction of the charge ensured that there was parity between all staff. The CNO noted that staff who only worked at night earned a third more than other colleagues on the same banding. Nicki, NED noted the importance of ensuring that there were no safety implications for night staff who chose to no longer drive to work due to change to parking charges. ***The Board noted the update on Car Parking Charges***	
40/25	**Use of Trust Seal** Three uses of the Trust Seal since the last Board meeting were noted.	
41/25	**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 and that many of these had been answered as part of presentations. Mr Campbell asked whether the MADE exercise had resulted in higher levels of readmissions than usual, noting that as a volunteer he had encountered a patient who had been discharged and readmitted twice over a weekend following the exercise. The DCOO was unsure and agreed to reply directly to Mr Campbell following the meeting. The DDON explained that it was too early to tell whether there had been readmissions as a result, but that there had not been any initial rise. She noted that the focus of the exercise had been on the resolving the reasons why patients were staying in hospital. Mr Campbell asked why the EPR project required a two year rationalisation period, whether the Trust had sufficient internet capacity for EPR and whether there would be a user change request process introduced during the EPR rollout. The CMO explained that the two year period was in place as part of the contract with the EPR provider and ensured that the system was fully embedded within the organisation before NerveCentre would stop supporting the initial implementation. The Trust's network capacity had been scoped as part of preparation for EPR and would soon be updated to provide greater capacity. He was unsure whether there would initially be a user change process, but explained that changes would be requested as required as the system was embedded within the Trust. Mr Campbell asked whether the Trust had considered surveying patients who self-discharged in order to better understand why they did this. The CNO explained that when staff were aware of the reasons for self-discharging, then this was recorded. There No formal surveying undertaken of these patients, but it would be considered. Mr Campbell asked whether any further changes to the Executive team were anticipated. The CEO explained that a substantive Chief Finance Officer was being sought, but did not anticipate any further changes. Mr Campbell asked whether the CEO was planning to meet with Trust volunteers. The CEO confirmed that she would be delighted to meet with them at any time and would be attending a volunteer celebration event in June. Mr Campbell asked whether the Trust's balanced scorecard would be updated to reflect	

	National Priorities for 2025/26. The CEO explained that work was ongoing to review the balanced scorecard; it was hoped that this would be completed by May. Mr Campbell asked about the experience of patients following the recent change of contract to Non-Emergency patient transport services. The DCOO explained that there had been a number of teething problems when the service had been changed, which had been mitigated through the use of the Trust's own transport service. Issues had been addressed with the new provider as they arose and a improvements in the service had been seen in recent weeks. Ms Burt explained that she had enjoyed the Alcohol Care team's presentation and noted that further savings might be able to be attributed to the service if put into the context of the benefit to patient's families and their legacies. She asked whether the Trust would pay for a service in the community which might support other trusts in the region. The Chair explained that discussions about expanding the service would take place and hoped that this would lead to improved care for patients, along with unanticipated benefits for other organisations. Ms Burt asked whether there was only one acute liaison colleague for LeDeR reviews in the Trust. The CMO explained that LeDeR reviews were undertaken externally to the Trust and confirmed that there was a single person in the liaison service.	
42/25	**Agenda Forward Plan** The Board's forward plan was noted.	
43/25	**Date of Next Trust Board Public Meeting** Tuesday 4th June 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					
10.10.23	73/23	Consider how to increase the focus on community services data within the Trust IPR	Richard Milner	November 2025	29.04.25 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	29.04.25 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					
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	While the annual review of parking has not yet concluded, it has been confirmed that a grace period will be reintroduced.

Agenda Item: 7

Report To/Meeting	Trust Board	**Date of Meeting**	24th June 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

Earlier this month I had the opportunity to attend to NHS Confederation conference and hear from the Health Secretary and other senior figures in the NHS about the direction of travel of the health system.

As an integrated trust that provides both hospital- and community-based care, we are in a strong position to align our services with the national aspirations of the 'left shift' of preventative care and in-reach into our communities to keep them out of hospital, as well as deliver increasing amounts of patient care out of hospital and in patients' homes.

This direction of travel provides us with a real opportunity to provide care that is more patient-centred and more responsive to the needs of our community – an opportunity which we are already working to act on.

Refreshing our organisational strategy

With these changes in mind, and with the announcement earlier this year about the delay to the trust's funding from the New Hospital Programme until 2037, we have started a refresh of the trust's organisational strategy. This is essential to making sure that we can continue to provide the care that our communities need over the next few challenging years.

To be fully effective, the refresh needs to have the support and buy-in from colleagues working in all areas and at all levels, and this week Simon Dowse (our Director of Transformation, strategy and Improvement) and I met with the trust's Partnership Forum to discuss how we could ensure colleagues are empowered and involved in this process. The Forum had some helpful, practical ideas for how we can make this happen and will make sure that our colleagues have a chance to help shape our strategy for the next three to five years. We will be developing these over the coming months.

Patient Safety Week – 'Safety First'

No matter the model, there are fundamental principles of delivering patient care that are universal – and patient safety is one of the most important. This month we are launching 'Safety First', an ongoing campaign to ensure that patient safety is at the forefront of how we work and how we deliver care.

Safety First is being launched as part of the trust's first Patient Safety Week at the end of June. Led by our Chief Medical Officer, Dr Simon Merritt, and Chief Nurse, Vikki Carruth, this month's core theme will be the importance of effective communication in safe patient care. We will be repeating Patient Safety Week a number of times throughout the year, focusing on a range of issues that can contribute to patient care being safe and effective.

NHS England launches of Urgent and Emergency Care plan

Earlier this month NHS England published its Urgent and Emergency Care plan, which sets out how the national NHS and DHSC are looking to work going forward, what their priorities will be and what their expectations are of providers in the coming year and into our busy winter period.

Much of the focus is along the lines that we would anticipate – focusing on core aspects of performance such as the four-hour standard, long ED waits and ambulance turnaround times – but they are no less challenging for that and we are working through how we can make sure we deliver what is expected from us.

Our new Chief Financial Officer

I'm really pleased to share that Andrew Strevens is now our permanent CFO. Andrew joined us a few weeks ago as our interim and threw his hat into the ring for the permanent role. There was some strong competition for the role but Andrew was the strongest candidate and I'm pleased to welcome him aboard.

Launching Gemba walks

A few weeks ago I launched Gemba walks at the trust. Gemba is an initiative that worked well at Medway, and involves me and other members of our executive team visiting teams across the trust to understand their work and the challenges they face.

Gemba walks aren't a way for the executive team to look over people's shoulders or a fluffy PR exercise – they are a way for us to understand the real challenges our colleagues face in their day-to-day work, to recognise the efforts they put in every day and for us to come away with a better understanding of the realities of delivering care and other functions.

The Gemba walks will be happening every week, and we are intending to visit colleagues not just involved in delivering care but in other functions that we can't do without in the trust. The feedback I've had from these teams about the visits has been positive so far, and the insights we've had from these visits will help us in our work to refresh our organisational strategy.

One year of robotic surgery at Conquest

This month marks one year on from when our surgery and gynaecology teams started using undertaking robotic surgery at Conquest.

The teams have used the robot for 165 robotic operations so far, and it already has a couple of firsts; it's use in both colorectal and gynaecology surgery was a first in the region and they used it to carry out the first robotic colorectal operation in Sussex.

	The teams collaborated across divisional lines to secure this robot for the trust, and their achievements show not only what we can do if we have the right equipment, but how working together gives us the chance to make those achievements possible. Recognition by British Cardiac Society Earlier this month our colleagues in cardiology and stroke presented to the board of the British Cardiac Society on the electrophysiology work led by Rick Veasey. The project has been highlighted as one of the top 10 international trials and the design of the trial has been recognised as a 'gold standard' for future interventional trials. Our arrhythmia nurse, Jackie Hunt, was also selected as an emerging leader, and showcased our work on stroke. A timely reminder that we have some truly exceptional staff at the trust, whose efforts aren't just helping our patients but helping patients and colleagues across the NHS.
Regulatory/legal requirement:	Not applicable.
Business Plan Link:	Quality ☐ People ☐ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI issues have been taken into consideration
Resource Implication/VFM Statement:	Not applicable.
Risk:	Not applicable.
No of Pages	3 **Appendixes** None.
Governance and Engagement pathway to date:	Not applicable.
What happens next?	Not applicable.
Publication	Report is for publication.

East Sussex Healthcare NHS Trust

Report to:	Trust Board	Agenda Item:	8.1
Date of Meeting	24 June 2025		

Title of Report:	**Finance & Productivity (F&P) Committee**
Status:	For Discussion
Sponsor:	Steve Phoenix, on behalf of Chair of F&P Committee
Author:	Steve Phoenix, on behalf of Chair of F&P Committee
Appendices:	None

Purpose

This report summarises the discussions, recommendations and approvals made by the Finance & Productivity Committee on 29 May 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

Art of the Possible Phase Two - Draft Business Case

The Committee endorsed the Art of the Possible Phase Two draft business case for approval by the Trust Board. The business case set out proposed investments into community teams which would deliver significant benefits and associated savings from 2025/26. The successful implementation of Phase One of the programme was noted, which had involved the closure of two wards (42 beds) in 2024/25 and led to associated investments in Home First and Acute Therapies.

Alert, Advise and Assure

Proposed Terms of Reference

The Committee agreed the proposed changes to the F&P Committee Terms of Reference which would more closely align operational performance with financial delivery. The Committee would be renamed the Finance & Performance Committee. The Trust Board is asked to approve the updated Terms of Reference.

Month 1 Financial Performance

The Committee noted that the Trust had delivered the planned deficit of £1.7m; the underlying deficit had been driven through expected lower activity compared to the level of fixed costs within the Trust. Payroll savings were ahead of plan partly due to some of the controls that had been put in place. There was still some work to be done around the phasing of some of the budgets to ensure that the plans were aligned. In terms of Use of Resources, the Trust was almost £500k ahead of plan, primarily due to the pay position, and this good performance was expected to continue into the next few months. A capital plan for this year had been developed but required further detailed work to ensure that resource was focused on areas where there was most risk. The Committee noted that the ICB had been very complimentary in terms of the organisation overachieving its savings schemes and its ability to be on track in month 1. The Interim CFO acknowledged that what the team had done so far was quite an achievement, and the Committee congratulated the team. The information being received was now making it a lot easier to make operational decisions, and this had made a huge difference operationally.

System Update
The Committee noted that the following key issues were currently being discussed across the system:

- Available funds at the ICB to support Elective Recovery
- Available cash to offset deficits as they arose
- Costs shifting

Dynamic Budgetary Control
The Committee noted the dynamic budgetary control process which created a more controlled reporting process and would allow finance business partners to work closely with the divisions but also generate more ability to foresee how the month results would be impacted and as the metrics were developed.

2024/25 National Cost Collection Pre-Submission
The Finance Improvement Director presented an overview of the National Cost Collection process and described the process in place to complete the mandated costing submission for 2024/25. Within the approved costing guidance, Boards were being asked to satisfy themselves that the processes in place were adequate.

Workforce Performance Report – Month 1
The Director of People reported a positive month one workforce update, with 152.5 WTE under plan, and a reduction in sickness.

Key Risks or Opportunities and their impact on the Trust

Geothermal Proposal – update
The Committee noted that funding had not become apparent and risks were noted. The Director of Estates & Facilities recommended holding the current position and waiting for potential central funding development

Key Decisions

Exceptions and Challenges

Recommendations

The Board is asked to note this report.

Finance and Performance Committee ("the Committee")
-Terms of Reference

1. Constitution

The Trust Board has resolved to establish a committee of the Board to be known as the Finance and Performance Committee ("the Committee"). The Committee is a committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Purpose

The Finance and Performance Committee is designed to oversee the effectiveness and efficiency of our financial and operational performance within the context of providing safe care for patients. It should provide recommendations and assurance to the Board relating to:

- ***Financial planning, strategy and development***:
  - Development and oversight of the Trust's financial and capital plans and strategies
  - The process for business case assessments and scrutiny including a review of future financial challenges and opportunities
  - Approve/recommend to Board business cases in line with Standing Financial Instructions (SFIs) and tracking of associated benefits.
  - Understanding the financial risk environment in which the Trust operates including reviewing relevant Board Assurance Framework (BAF) risks, providing assurance on mitigations (requesting plans where relevant) and helping the Board to set the financial risk appetite for the Trust
  - The effectiveness and robustness of financial planning
  - Understanding the financial (revenue and capital) and performance environments in which the Trust operates

- ***Financial monitoring and assurance***
  - Tracking monthly financial and capital performance against budget, and reviewing and approving changes to forecast if required
  - Monitoring balance sheet risks and the cash position
  - Reviewing productivity and efficiency delivery
  - Undertaking substantial reviews of issues and areas of concern
  - Tracking performance against planned productivity improvement trajectories
  - Considering any impact resolving financial compliance might have on the Trusts performance metrics

- **Operational performance**
  - Reviewing Trust performance against local (NHS Sussex) and national (NHS England) priorities and operating guidance; incorporating and not exclusively reviewing planned care waiting

times, cancer performance, diagnostic performance and performance against the 4 hour emergency clinical care standard
  - Understanding all-type activity against plan income expectations and its contribution to improvements or deterioration to performance standards
  - Escalating issues of non-delivery to the Board
  - Considering any impact resolving performance standards might have on the Trusts financial sustainability

Membership and attendance

The Committee membership shall comprise of:

- at least three non-executives
- Chief Executive
- Chief Finance Officer
- Chief Operating Officer
- Director of Transformation and Improvement
- Chief Nursing Officer/Chief Medical Officer

To ensure that non-executive directors hold the majority of votes on the Committee, only the Chief Financial Officer and Chief Operating Officer shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.

Where executive directors are in attendance at a Committee meeting, attendance of their deputies is optional, other than where such deputies are presenting an agenda item. Other members of staff including members of the divisional leadership and the finance teams will attend by invitation.

4. Quorum

Quorum of the Committee shall be four members which must include at least two non-executive director and the Chief Financial Officer (or deputy). Nominated deputies will count towards the quorum.

5. Frequency

Meetings shall meet at least ten times a year. Additional meetings may be arranged as required.

6. Duties

The Committee shall review and monitor the longer-term financial health of the Trust. In particular its duties include:

- Reviewing the financial and performance environment in which the Trust operates, and supporting the Board to ensure that its focus on financial and performance issues continually improve
- Monitoring the productivity of the Trust, scrutinising the opportunities for improvement and challenging the organisation to increase efficiency

as appropriate with reference to the Trust's broader strategy and values as well as performance against agreed metrics
- Supporting the Board to understand and secure the financial, fiscal, productivity and operational performance data and reporting it needs to discharge its duties
- Understanding the market and business environment in which the Trust operates and ensuring the capacity and capability of the Trust to respond to the demands of the market under review
- Understanding the business risk environment within which the organisation operates, providing assurance on mitigations (requesting plans where relevant) and helping the Board to agree an appropriate risk appetite for the Trust
- Supporting the Board to agree an annual capital and financial plan
- Supporting the Board to agree an integrated business plan
- Approving or recommending to the Board business cases according to the SFIs. In 2024 this included approving business cases between £500k-£2.5m and recommending cases above £2.5m to the board.
- Ensuring that business cases submitted for approval are in line with the priorities identified in the Trust's strategy
- Receiving assurance and scrutinise the effectiveness of demand and capacity planning. Ensuring that the overall financial strategy of the ICS, and any decisions relating to finance made by the ICB, are considered
- Escalating material deviation from planned financial and operating performance to the Board.

The Board may from time to time delegate to the Committee the authority to agree specific investment decisions over and above the annual financial plan provided that the amended plans:

- Do not compromise the Standing Orders and Standing Financial Instructions
- Do not adversely affect the strategic risk facing the Trust
- Do not adversely affect the organisation's ability to deliver its operational plans and delivery against constitutional standards

The Committee may as appropriate review the work of other Committees within the organisation whose work can provide relevant assurance to the Finance and Performance Committee's own scope of work.

7. Decision making

Every decision put to a vote at a Committee meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding, (i.e. Chair of the Committee) shall have a second and casting vote.

8. Reporting arrangements

The Chair of the Finance and Performance Committee will provide an upward report on key items for escalation to the Board which will be issued at the next

Public Board meeting. However, in some instances including commercial, sensitive and confidential issues and early discussions on the forecast a report will be presented at the Private Board.

The Chair of the Committee shall make recommendations to the Board deemed appropriate by the Committee to be (on any area within the Committee's remit where disclosure, action or improvement are needed). The Committee shall undertake a self-assessment of its effectiveness on at least an annual basis. In collaboration with the Chair of the Committee the CFO, COO the EA to the CFO will support the Committee to develop and implement an annual work programme

These terms of reference shall be reviewed by the Board of directors at least annually.

Terms of Reference approved by the Finance & Performance Committee on 29th May 2025

Ratified by the Board of Directors on 24th June 2025

Report to:	**Trust Board**	**Agenda Item:**	8.2
Date of Meeting	**24 June 2025**		

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

Purpose

This report summarises the discussions, recommendations and approvals made by the People & Organisational Development (POD) Committee on 29 May 2025 to provide the Board with an update of the Committee's activities. The May meeting mainly focussed on workforce assurance for the Trust.

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

The Workforce Insight report for April 2025 data had been circulated and taken as read. It was highlighted that workforce use in month one was 45.7 whole time equivalents below plan and £0.6 million under budget. There was a continued reduction in temporary workforce use and vacancies had increased to 2.1%, driven by business cases for the Sussex Surgical Centre and the Digestive Diseases Centre. Sickness had decreased for the third consecutive month to 5.1%, while appraisal compliance had dropped to 80%. HR was conducting a deep dive to ensure early warnings were addressed.

Alert, Advise and Assure

Freedom to Speak Up Guardian Report

The Freedom to Speak Up Guardian report for Quarters 3 and 4 highlighted key themes raised by staff. In Q3, concerns focused on inappropriate behaviours and their impact on wellbeing. In Q4, patient safety concerns increased, but assurance was provided that these were escalated promptly. Staff wellbeing and safety remained central to reporting, with an emphasis on managing incivility and ensuring timely, appropriate conduct management. There was agreement on the need for better responses to concerns, with a noted shift from bullying to incivility and environmental issues. "Listen Up" training was seen as a positive step, though implementation needed strengthening.

Key Risks or Opportunities and their impact on the Trust

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

Key Decisions

Workforce Assurance

The Workforce Assurance presentation was shared and discussed in detail. The plan outlined key elements and the approach to a break-even plan, highlighting the reduction in whole time equivalents, the focus on productivity and the detailed plans behind each division to ensure safe levels and quality standards.

The main goal was to gain assurance about the workforce plan and its progress throughout the year. The group received strong assurance that the workforce plan was well-aligned with finances and activity, more so than previously, and had divisional support, which was commendable. There were no objections, indicating broad agreement that the plans were in place and being delivered. Early signs from month one showed the plan was generally on track, supported by early warning systems. Additionally, the group heard about the extensive support available for the workforce, especially during periods of change. Overall, the presentation and discussion were excellent.

Exceptions and Challenges
N/A
Recommendations
The Board is asked to note this report.

Report to:	Board of Directors	Agenda Item:	8.3
Date of Meeting	28th May 2025		

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 28th May 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

IGM: Concerns remain around low compliance with blood transfusion training and variable recognition of dying patients; these, along with end-of-life medication issues, are being monitored through the End-of-Life Steering Group. No escalation required at this stage, but ongoing cultural focus is essential.

Maternity Dashboard & Ockenden Perinatal Quality Surveillance Report: The maternity service shows improving morale and strong performance, though the stillbirth rate remains just above threshold. A deep dive is in progress and will return in July; no immediate escalation required.

Governance Quality Report: Incident reporting culture is strong; recurrent falls and equipment availability are being addressed through ongoing reconditioning work. No escalation required but continued monitoring recommended.

Quality Dashboard: Mortality rates remain comfortably within expected range; the Power BI dashboard provides strong visibility of trends. No escalation required.

Maternity and Neonatal Overview Board Report: A repeat Never Event highlights the need for better embedding of learning from incidents.

Quality Impact Assessments Report: The divisional sign-off process is now embedded, but concerns around informal project implementation remain. No immediate escalation but a reminder for divisional accountability is advised.

Research: The Research Team continues to exceed expectations significantly; escalation to Board is recommended to formally recognise performance and prioritise space for continued success.

Quality Account: The Quality Account is on track for submission with priorities clearly defined—no escalation required.

Premature Births Report (Deep Dive): Preterm birth rates are improving, with root causes understood; continued monitoring through maternity reports is in place.No escalation required.

Alert, Advise and Assure

Alert

None.

Advise/Inform/Update

Assurances

Significant and sustained improvements within maternity and community paediatrics.

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.

Agenda Item: 9

Report To/Meeting	Trust Board	**Date of Meeting**	24th June 2025
Report Title:	2025/26 Delivery Plan		
Key question	What is our business plan for 2025/26 and how we assure ourselves of its delivery?		
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☐		
Report Sponsor:	Jayne Black - CEO	**Presenter(s):**	Jayne Black and Steve Aumayer
Report Author:	Steve Aumayer		
Outcome/Action requested:	To note and take assurance from the plan and approach.		
Executive Summary	This is a short presentation summarising our plan for the year 2025/26. Key points to note are: • The Trust's 2025/26 plan is the output of work led by the Executive team over a period of months. • It is in line with the national requirements and will support the delivery of high-quality care to the local population. • The plan supports delivery of all key constitutional standards. • It also supports delivery of a *breakeven* financial plan. We have our normal assurance processes to monitor delivery of the plan, coupled with weekly assurance to the Executive team, a refreshed PSO process and an Executive-Led focus on five key delivery priorities.		
Regulatory/legal requirement:	None		
Business Plan Link:	Quality ☒ People ☒ Sustainability ☒		
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI factors and impact assessments are embedded in the planning process.		
Resource Implication/VFM Statement:	As set out in the plan		
Risk:	No risk specifically set out in this document. The BAF risks already cover key risks of non-delivery.		
No of Pages	14	**Appendixes**	n/a
Governance and Engagement pathway to date:	Extensively discussed by the Executive team, Executive committee and at various Board/sub-committee meetings		
What happens next?	Ongoing assurance of plan delivery		
Publication	For Publication		

NHS
East Sussex Healthcare
NHS Trust

2025/26 Delivery Plan

Our plan and how we assure ourselves of its delivery

June 2025

KINDNESS

INCLUSIVITY

INTEGRITY

Introduction

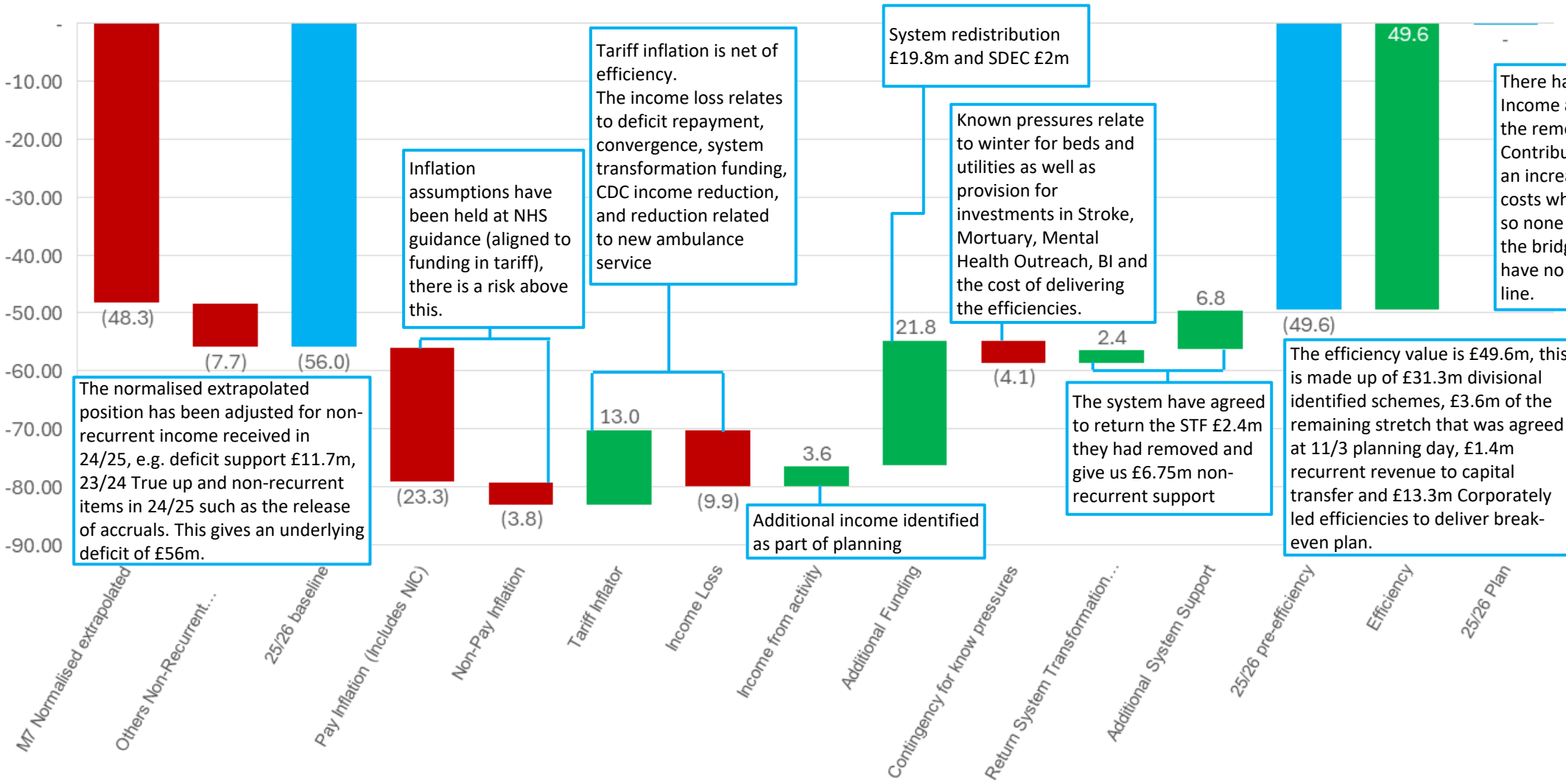
East Sussex Healthcare NHS Trust

The Trust's 2025/26 business plan supports the organisation to meet key constitutional standards, provide high quality care and deliver a financial break-even position. To achieve this the Trust will need to deliver a cost improvement programme equating to circa £50m (6.3%).

- Our business plan triangulates activity, performance workforce and finance.
- The plan is underpinned by detailed plans, enabling progress to be monitored daily, weekly and monthly. This will enable the organisation to identify risks, and any appropriate mitigations at the earliest opportunity.
- This brief presentation aims to provide assurance to the board that the plan is robust and that there are appropriate systems and processes in place to monitor and oversee delivery.
- It will:
  - Describe the key operational and strategic drivers within the plan;
  - Describe how the plan was developed;
  - Describe the plan detail at a high level;
  - Explain how we will monitor progress against the plan; and
  - Describe how the board will receive assurance of progress.

Why was the ask so big?

East Sussex Healthcare NHS Trust



The normalised extrapolated position has been adjusted for non-recurrent income received in 24/25, e.g. deficit support £11.7m, 23/24 True up and non-recurrent items in 24/25 such as the release of accruals. This gives an underlying deficit of £56m.

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

Tariff inflation is net of efficiency.
The income loss relates to deficit repayment, convergence, system transformation funding, CDC income reduction, and reduction related to new ambulance service

Additional income identified as part of planning

System redistribution £19.8m and SDEC £2m

Known pressures relate to winter for beds and utilities as well as provision for investments in Stroke, Mortuary, Mental Health Outreach, BI and the cost of delivering the efficiencies.

The system have agreed to return the STF £2.4m they had removed and give us £6.75m non-recurrent support

The efficiency value is £49.6m, this is made up of £31.3m divisional identified schemes, £3.6m of the remaining stretch that was agreed at 11/3 planning day, £1.4m recurrent revenue to capital transfer and £13.3m Corporately led efficiencies to deliver break-even plan.

There has been reduction Income and Pay relating to the removal of the Pension Contributions and there was an increase to depreciation costs which is match funded so none of entries appear on the bridge as they offset and have no impact to the bottom line.

Key Drivers for our Plan

East Sussex Healthcare NHS Trust

To progress toward our Vision "High Quality Care and Experience for our colleagues and our communities" we set a 3-year goal last year to "restore *timely* access to care and create a financially sustainable position"; that goal still applies

QUALITY

- Quality in 2025/26 will support improvement in waiting times and meeting the key nationally set aims:
  - exceeding 78% against the 4-hour Emergency Department clinical standard by March 2026;
  - reduce the number of people waiting over 52 weeks to complete a treatment pathway from referral to 1%;
  - to improve the percentage of people waiting under 18 weeks for a first outpatient appointment to 67%; and
  - to improve the number of people waiting less that 62 days to start treatment for a confirmed cancer diagnosis to 75%.
- Spending more time than necessary in a hospital bed leads to worse outcomes. There is a challenge in East Sussex to optimise "length of stay" in bedded care and to ensure alternatives are provided.

PEOPLE

- There will be a focus on addressing the issues demonstrated in the staff survey this year and improve engagement.
- One of the key mechanisms we will prioritise this year is to develop our leaders' skills and behaviours as well as push forward (at greater scale than before) our Continuous Quality Improvement system.

SUSTAINABILITY

- The financial challenge is very large. To have the biggest impact we must focus on:
  - Reducing the demand for acute beds to an appropriate level and increase community-based delivery of care ('left-shift');
  - Controlling our pay spend and focus resources into clinical areas and substantive staff;
  - Maximise how productively we use our capacity and achieve the most planned care income we can; and
  - Reducing 'corporate' costs.

Wider Context

East Sussex Healthcare NHS Trust

- The Trust's plan aligns with the Government, the broader NHS and our local ICB priorities and requirements.
- This includes the continued development of out of hospital capacity, improving waiting times, 'integrating' care at a neighbourhood level and maximising the potential of digital technology to increase quality and productivity.
- The organisation has received capital funding to support the development of the Sussex Surgical Centre, this will provide additional capacity in a purpose build facility, and the opportunity to drive towards achieving best practice elective daycase pathways for Sussex residents.
- New Hospital Programme has been delayed and for ESHT until 2037, and therefore the organisation must continue to find opportunities to address the backlog maintenance issues.
- The Trust will need to deliver key constitutional standards, high quality care and a financial breakeven position.
- There will be significant changes to the NHS architecture in 2025/26 with a reduction in the number of ICBs and the role of NHSE.
- Sussex has been identified as a health systems in England that has previously received 'excess' funding per head of population, and this is likely to result in further financial savings in future years.

Plan Development

East Sussex Healthcare NHS Trust

The approach to developing the 2025/26 operating plan differed significantly from that in other years.

- For 2025/26:
  - The plan was created through a bottom-up approach with services and divisions (including corporate) based on strategic intent, demand and national target requirements;
  - The plan focused on activity, workforce and finance (costs and revenue) to ensure full triangulation;
  - Divisions focused on national benchmarking and other data sets to ensure that the plans to deliver services are as productive and efficient as possible;
  - All service changes are supported by Quality Impact Assessments to ensure that there are no unintended consequences in implementing them; and
  - Divisional plans were aligned with each other.

Performance Plan (Key Metrics)

East Sussex Healthcare NHS Trust

- The plan reflects national improvement priorities (see key objectives below).
- Monthly trajectories are in place for all performance standards and have been developed at granular service level.
- All performance objectives 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.

Performance 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 Plan

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 improvements 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	**152,651**	**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 try to improve access and waiting times for patients whilst achieving the financial plan

Workforce Plan

East Sussex Healthcare NHS Trust

- 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.
- Improved analysis of trends and patterns makes it easier for Divisions to make choices about to where to invest, where to protect capacity and where there is less efficiency.
- There are robust pay spend controls, closing any process loop-holes, to help budget holders and senior managers work to the plan.

Outturn by Contract Type	24/25 Outturn	25/26 March	Var	Var%
Substantive	7,614.1	7,410.5	(203.6)	-2.7%
Bank	602.3	397.1	(205.3)	-34%
Agency	58.4	41.3	(17.1)	-29%
Total	**8,274.8**	**7,848.9**	**(425.9)**	**-5%**

Monthly Plan by Contract Type	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	7,553.0	7,585.7	7,536.2	7,557.9	7,493.9	7,465.6	7,377.2	7,369.6	7,360.4	7,372.1	7,410.5
Bank	602.3	520.4	505.4	502.5	486.9	488.4	469.7	465.9	461.9	417	416.9	401.5	397.1
Agency	58.4	42.0	44.8	44.1	43.4	42	42	40.6	41.3	39.2	42.7	40.6	41.3
Total	**8,274.8**	**8,235.7**	**8,103.2**	**8,132.3**	**8,066.4**	**8,088.3**	**8,005.6**	**7,972.1**	**7,880.4**	**7,825.8**	**7,820.0**	**7,814.2**	**7,848.9**

Financial Plan

East Sussex Healthcare NHS Trust

- As has already been described, the plan for 2025/26 is to break even which includes £49.6m (6.3%) of efficiencies to be delivered in year.
- The efficiencies are phased over the year. As plans are delivered it is possible the financial outcome or phasing will change; to mitigate additional potential opportunities will be under constant review.

Financial Plan by 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	59,764	59,043	59,776	61,353	59,889	61,371	63,303	61,115	61,844	61,917	61,197	62,651	**733,223**
Pay	(40,398)	(39,719)	(39,722)	(39,702)	(39,949)	(39,708)	(39,677)	(39,642)	(39,967)	(39,941)	(39,929)	(39,584)	**(477,938)**
Non-Pay	(20,352)	(20,332)	(20,308)	(20,210)	(20,449)	(20,396)	(20,624)	(20,939)	(20,448)	(20,881)	(20,881)	(20,504)	**(246,324)**
Operating Surplus/(Deficit)	**(986)**	**(1,008)**	**(254)**	**1,441**	**(509)**	**1,267**	**3,002**	**534**	**1,429**	**1,095**	**387**	**2,563**	**8,961**
Non-Operating costs	(746)	(746)	(746)	(746)	(746)	(746)	(746)	(746)	(746)	(746)	(746)	(755)	**(8,961)**
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	1,802	2,623	2,778	3,431	3,680	3,996	4,987	5,043	5,537	5,208	5,234	5,293	**49,612**

Supporting Delivery

East Sussex Healthcare NHS Trust

To support delivery of the plan there are 5 areas of focus. Each area is led by a named Executive, supported by the Programme Support Office.

‘Length of Stay’	Workforce	Income	Optimising ‘business cases’	Digitally enabled Change
Focus on reducing clinical length of stay and the number of NCTR patients across the organisation Clear link to the ‘Art of the Possible’ programme	Focuses on reducing dependence on temporary staff requirements and focusing our substantive capacity on clinical service delivery	Improving access, through productivity and efficiency	Business case realisation for key areas of investment such as the Sussex Surgical Centre	This will focus on a selected, prioritised set of changes, driven by new digital technologies including AI, to support improved outcomes
Value c.£7.2m	Value c.£15.1m	Value c.£11.5m	Value £7.6m	Value £0.8

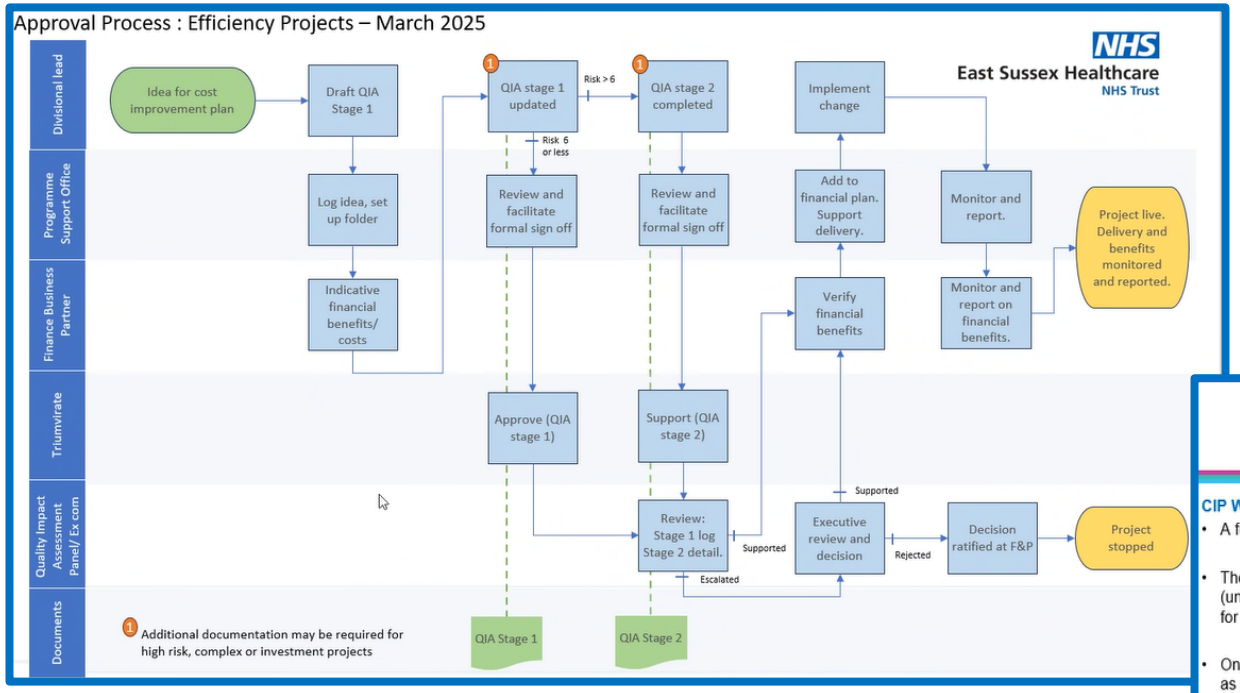
Core enablers

Multiple workstreams link to robust business disciplines in key functions, e.g. procurement, and some technical elements within Divisions (such as CNST rebates)

Value c.£7.4m

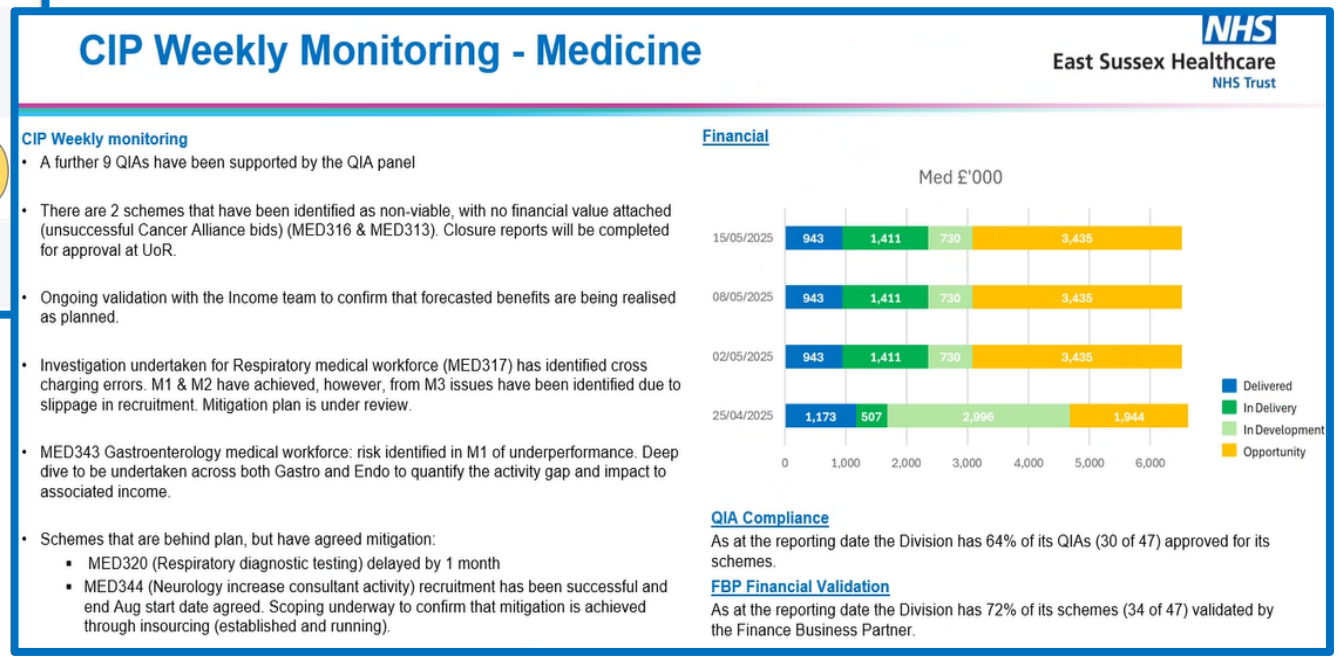
The Lead Executive will coordinate a weekly review of progress to ensure delivery.

Monitoring progress



- The Programme Support Office (PSO) provide Weekly Monitoring to the Executive Leadership Team (ELT).
- Divisions put forward appropriate narrative to provide assurance of delivery against their plan and raise risks where delivery against agreed initiatives are challenging.

- PSO provide support to colleagues developing new initiatives, ensuring proposals meet organisational requirements in terms of quality, safety, financial sustainability and practicality of implementation i.e. include Quality Impact Assessment (QIA), Finance Approval and Use of Resource Committee.
- Initiatives are reported to the Executive team weekly, to Executive Committee and to the Board via Finance & Performance Board Sub-Committee.



Board Assurance

East Sussex Healthcare NHS Trust

The Board can expect to gain assurance of progress against the delivery plan through its normal performance review processes and sub-committees.

- These include:
  - **Updates on progress against the priority programmes of work (informed by weekly Executive-led reviews):**
    - Length of Stay;
    - Workforce;
    - Income;
    - Business cases/Optimising clinical infrastructure; and
    - Digital and Artificial Intelligence (AI).
  - **Board review of the Integrated Performance Report ("IPR"):**
    - Quality and Safety;
    - Patient Experience;
    - Workforce;
    - Activity; and
    - Finance.
  - **The approach to integrated performance reporting will be enhanced and Divisional IPRs will be more focused.**
  - **Other board reports will be made available as necessary.**

Summary

East Sussex Healthcare NHS Trust

- The Trust's 2025/26 plan is the output of work led by the Executive team over a period of months.
- It is in line with the national requirements and will support the delivery of high-quality care to the local population.
- Supports delivery of all key constitutional standards.
- Supports delivery of a breakeven financial plan.
- Mechanisms to monitor delivery are in place and will ensure visibility of performance on a weekly and monthly basis.

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

KINDNESS

INCLUSIVITY

For the Period April 2025 (Month 1)

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 2025/26 Operational Plan 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**

KINDNESS
INCLUSIVITY
INTEGRITY

Chief Executive Summary

East Sussex Healthcare NHS Trust

The Trust's 2025/26 business plan supports the organisation to meet key constitutional standards, provide high quality care and deliver a financial break-even position. A detailed Cost Improvement Programme is in place to deliver financial balance, supported by recovery plans to improve operational performance.

Multi Agency Discharge Events (MADE) continued in April, proving to be successful in increasing the number of discharges and improving flow in the hospital. In addition to the improvement in ED 4-hour performance, there was a marked reduction of patients waiting more than 12 hours in the department as well as reductions in non-criteria to reside patients and a positive bed state on both sites during the MADE event.

Key Areas of Success

- In April, the Trust achieved 77.5% for it's 4-hour Emergency Access Clinical Standard, placing the Trust in the second quartile of national performance. The national target is 78%.
- In March (cancer is reported two months in arrears nationally), the Trust achieved 74.2% against a trajectory 70.2% for the 62-day cancer standard and 82.9% against a national target of 77% for the Faster Diagnostic Standard
- The Trust reported a small number of patients who waited more than 65 weeks
- Sustainably delivering above target for our 2-hour urgent community response, despite a rise in demand for this service. 84.8% of patients were seen within 2 hours, against a target of 70%
- A&E FFT satisfaction score and response rate continue to show strong performance
- The overall number of reportable infections was low in April compared with previous months.

Key Areas of Focus

- Deliver the ED improvement plan to meet the Trust's trajectories in 2025/26
- The Trust has reported a deficit of £1.7m, which is in line with M01 plan
- The Use of Resources plan delivered a significant over achievement of £475K
- Patient Safety week scheduled in June
- The Harm Review process is being reviewed to ensure consistency and clarity across all services, aiming to have an agreed process in August 25.

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)		983	942	493	Common Cause	Target required
Number of Patient safety events (severity 3)		13	38	6	Concern	Target required
Number of Patient safety events (severity 4 ...		3	3	2	Common Cause	Target required
Never Events		2	0	0	Common Cause	Target required
Inpatient Falls per 1,000 Bed days		4.45	4.22	5.79	Common Cause	Target required
Cat 3 ESHT Acq. PU (rate) per 1,000 bed days		0.0374	0.0402	0	Common Cause	Target required
Cat 4 ESHT Acq. PU (rate) per 1,000 bed days		0	0	0	Common Cause	Target required
Healthcare Associated MRSA Bacteraemia (r...		0	0	0	Improvement	Target required
Healthcare Associated C Diff Infections (rate)...		0.112	0	0	Common Cause	Target required
Healthcare Associated MSSA Bacteraemia (r...		0.0748	0.241	0	Common Cause	Target required
RAMI	100	86.4	85.4		Improvement	Achieving
SHMI (NHS Digital monthly)	100	104	103		Concern	Inconsistent
Nursing Fill Rate (IP - RN, RNA and HCA)		94.7%	92.9%	98.9%	Improvement	Target required

Patient Experience	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Complaints received		37	41	11	Common Cause	Target required
Complaints Response Compliance (60 w...		87.9%	73.7%	55.8%	Common Cause	Target required
Reopened Complaints		7	5	1	Common Cause	Target required
A&E FFT Score		78.8%	83.8%		Improvement	Target required
A&E FFT Response Rate		13.9%	15.1%		Improvement	Target required
Inpatient FFT Score		97.2%	97.4%		Concern	Target required
Maternity FFT Score		100%	94.1%		Common Cause	Target required
Outpatient FFT Score		95.5%	95.2%		Concern	Target required

Our People	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Establishment (WTE) All		8,039	8,424	7,343	Improvement	Target required
Agency Rate		0.750%	0.496%	2.37%	Improvement	Target required
Vacancy Rate		1.3%	2.1%	10.1%	Improvement	Target required
Staff Turnover		10.5%	10.4%	9.75%	Common Cause	Target required
Retention Rate		92.3%	92.0%	92.0%	Common Cause	Target required
Monthly Sickness - Absence %		5.2%	5.14%	5.4%	Common Cause	Target required
Sickness - Average Days Lost per Fte		19.8	19.8	17	Concern	Target required
Staff Appraisals		82.3%	80.5%	74.6%	Concern	Target required
Statutory & Mandatory Training		91.6%	91.5%	86.0%	Improvement	Target required

Our Performance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
4 hour standard	78%	71.1%	77.5%	92.8%	Common Cause	Inconsistent
A&E > 12 hours from arrival to discharge	0	1169	741	13	Concern	Not Met
A&E waits over 12 hours from DTA	0	92	7		Common Cause	Inconsistent
Conveyance handover >60 mins	0%	1.88%	0.893%	0.705%	Common Cause	Inconsistent
Non Elective Length of Stay		5.75	5.25	3.85	Concern	Target required
Average daily NCTR		226	198		Common Cause	Target required
Cancer 62 Day	70.2%	72.9%	74.2%		Improvement	Inconsistent
Cancer 31 Day Combined		98.5%	95.0%		Common Cause	Target required
28 Day General FDS	77.0%	86.5%	82.9%		Improvement	Inconsistent
104 day Backlog		49	41	23	Common Cause	Target required
Elective Activity (ELIP,DC,OPFA, OPFUP P...		117%	102%		Common Cause	Target required
RTT under 18 weeks	67%	59.5%	60.0%	82.4%	Improvement	Not Met
RTT 65 week wait	0	2	10	1	Improvement	Not Met
RTT Total Waiting List Size	60521	64102	63185	25526	Concern	Achieving
Diagnostic <6 weeks	1%	9.94%	14.8%	48.2%	Common Cause	Not Met
Urgent Community Response within 2 h...	70%	85.3%	86.6%		Improvement	Achieving
CHIC wait times < 13 weeks	80%	85.4%	84.8%	54.2%	Improvement	Inconsistent
Intermediate Care Length of Stay	30	39.8	34.1	22.7	Common Cause	Inconsistent
% Discharges delayed 1+ days		24.6%	22.7%		Concern	Target required
Total delay days from monthly Discharges	5245	4999	4931		Common Cause	Inconsistent
Number of Deferred visits/ care plans		8669	8402	1356	Concern	Target required
1+ Non Elective LoS (Acute)	8.8	7.99	7.60	6.01	Common Cause	Inconsistent
RTT proportion waiting over 52 weeks	1%	1.69%	1.60%	0.0235%	Improvement	Not Met

Finance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Surplus/(deficit) (£'000) - in month	(1,732)	n/a	(1,730)	n/a	n/a	Achieving
Surplus/(deficit) (£'000) - YTD	(1,732)	n/a	(1,730)	n/a	n/a	Achieving
ERF (£'000) - in month	10,887	n/a	11,702	n/a	n/a	Achieving
ERF (£'000) - YTD	10,887	n/a	11,702	n/a	n/a	Achieving
Efficiency (£'000) - in month	1,812	n/a	2,287	n/a	n/a	Achieving
Efficiency (£'000) - YTD	1,812	n/a	2,287	n/a	n/a	Achieving
Capital (£'000) - YTD	1,177	n/a	765	n/a	n/a	Achieving
Capital (£'000) - FOT	40,061	n/a	40,061	n/a	n/a	Achieving

Constitutional Standards | Benchmarking

East Sussex Healthcare NHS Trust

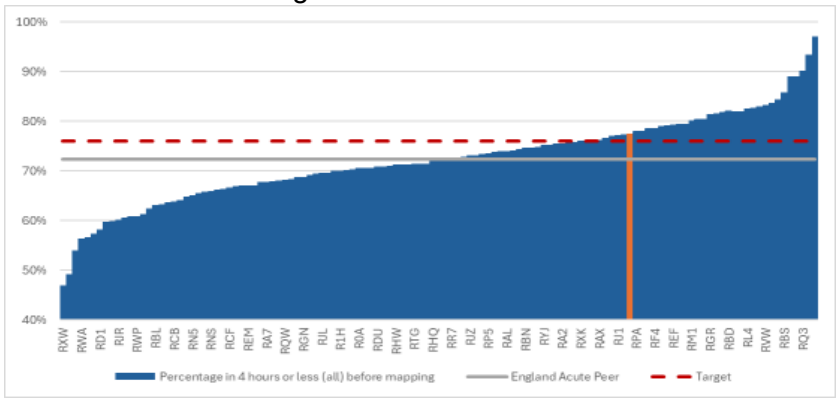
*NHS England has yet to publish all April 2025 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

April 2025 Peer Review

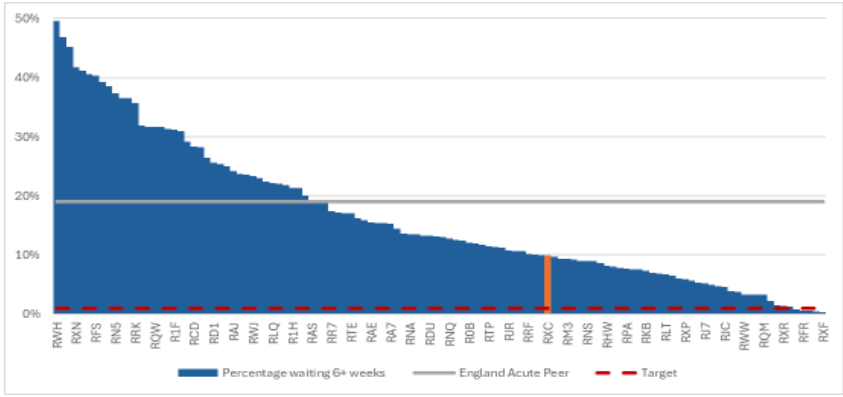
National Average: 72.3% ESHT Rank: 31/123



Planned Care – Diagnostic Waiting Times

March 2025 Peer Review*

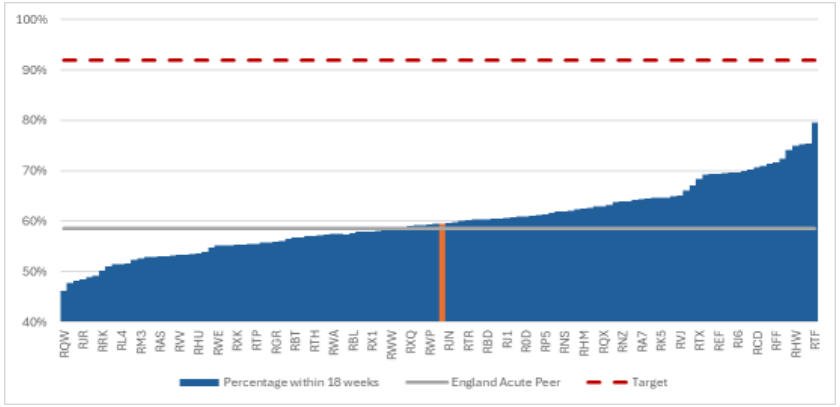
National Average: 19.0% ESHT Rank: 43/118



Planned Care – Referral to Treatment

March 2025 Peer Review*

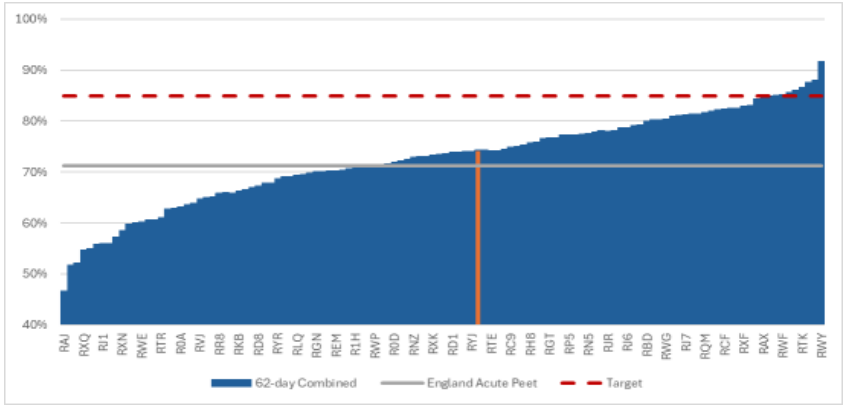
National Average: 58.6% ESHT Rank: 59/118



Cancer Treatment – 62 Day Combined Standard

March 2025 Peer Review*

National Average: 71.2% ESHT Rank: 54/118



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 not yet been set by NHSE for 2025/26. The overall number of reportable infections was low in April compared with previous months.

For April, the Trust reported no cases of CDI or MRSA bacteraemia. There were seven MSSA bacteraemias, of which six HOHA cases due to skin/soft tissue infection (2), Central venous catheter associated, endocarditis, UTI and one unknown source. None of the infections were considered avoidable. The COHA case is of skin/soft tissue infection source and was assessed as unavoidable.
Seasonal influenza (n= 75) and Respiratory Syncytial Virus (n= 9) prevalence continued to decline as prevalence returned to baseline levels.

Safety Events

942 incidents were reported in April 2025, comparable with the average numbers reported for ESHT only incidents. 94% of the total patient events were no / low harm/near miss, which is comparable with the National average (96%), indicative of a good reporting culture at ESHT. Detailed reports are discussed at Integrated Governance Meeting (IGM) regarding Medication Safety and a Falls deep dive is coming to the June Quality & Safety Committee. The Chief Nursing Officer has requested a regular Falls and PU deep dive for IGM.

The top three categories for April 2025 remain consistent as last reported in March: None were Severe / Fatal harm.

1. Slips, Trips and Falls – 140 reported incidents, all were No / Minor harm except one Moderate harm incident in ED EDGH.
2. Medication Errors and other Medication Related Incidents – 111 incidents reported, with none resulting in Severe / Fatal harm.
3. Patient Discharges and Transfers (ESHT Acute only) – 101 incidents were reported, which is less than the average numbers reported for ESHT

Harm

Five Severe and above harms were reported in April 2025 - One was classified as Fatal harm (Severity 5) while four were as severe harm (Severity 4). The Fatal harm incident (Severity 5) is undergoing a chronology review by the Division to determine contributory factors and lessons to learn.
Three of the four incidents have been confirmed as No / Low harm following review as there were no lapses in care or service delivery. The fourth is under review to confirm level of harm caused.

Safeguarding

Compliance for Think Family level 3 remains an ongoing challenge despite additional capacity within the virtual sessions accommodating up to 70, with take up nearer 50. Current compliance is 64%. The team are planning a safeguarding week of bite size training in July which will be advertised via communications.

The Trust has raised two PREVENT referrals in the last couple of months, the Head of Safeguarding and the Trust Security lead have met to review joint working going forward.

An Individual Management Review for a joint safeguarding adults review and domestic homicide related death review is currently being progressed.

The service specification for Children In Care (2023) suggests the service provision would require a Specialist Nurse per 100 children. There are currently 690 East Sussex Children in Care, however including children placed from other areas, the figure rises to 1043. The team currently comprises 6.87 wte, all of whom are part-time. Currently the statistics show that the review health assessments are within the required KPI with 94% recorded in March 2025, this figure considers exception reporting of circumstances outside of ESHT control. However, a waiting list has now been implemented for those children funded from other areas and the wait times are increasing from 3 to 5 months.

The Mental Health Outreach team recruitment is going well, and the growing team 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 46 new complaints, an increase of 9 vs. March. Against our internal target (60 working days) 74% were completed in time (March =81%), 8 complaints were overdue at the end of April. Reviewing the monthly risk rating of all complaints, most were 'moderate' in common with the general pattern: 3 High (March =5), 1 case was previously an SI, 2 cases have been discussed at Weekly Patient Safet Summit and will continue to follow the complaints process, 35 moderate risk (March =20) where aspects of clinical care appear suboptimal and 8 low risk (March =13) where clinical quality does not form part of the complaint. Of the 41 complaints received in April 41% came from one category: Clinical Treatment =19 (missed or incorrect diagnosis)

5 complaints were reopened (March =7), 4 for Medicine and 1 for W&C. 3 were unhappy with the responses and 2 were meeting requests.

Top complaint locations in April were Emergency Department =10 (EDGH =5 and CQ =5) and Outpatients Department =8 (EDGH =5 and CQ=3). This does not necessarily relate to care provided in April as not all are raised in real time.

607 contacts were recorded by PALS in April, which is a decrease of 57 when compared to March (=664). Of these contacts, 337 PALS contacts were recorded as "concerns" (March =352).

The top three primary PALS subjects recorded as a "concern" were as follows:
Appointments =79 - of these 57% related to long waiting times and cancelled appointments.
Communication =66 - of these 50% related to communication with patients/relatives.
Clinical Treatment =65 - of these 34% related to delay in treatment and 20% related to diagnosis issues.

Top 3 locations of PALS concerns: Outpatients Department (=49, CQ =32 and EDGH =17), Emergency Department (=32, EDGH =17 and CQ =15) and Richard Ticehurst Surgical Assessment Unit (=7).

5% of PALS concerns (=18) were escalated to formal complaints.

The Trust received 11,213 FFT responses, which sits just below the last three-month average of 12,068 FFT responses.

The Trust-wide positive FFT feedback rate was 93.72%, which is in line with the last three-month average of 93.59%.

The comments patients provide as to why they gave their rating generate word-based themes; this month, the top positive theme was Staff Attitude (5,617 positive comments), followed by Implementation of Care (2,986) and Environment (1,763).
Conversely, the top negative theme was Staff Attitude (313 negative comments), followed by Environment (230) and Waiting Time (216).

7,989 plaudits were received, the majority of these were from FFT comments.

Workforce

We have 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 April remained stretched to cover the additional requirements.

The focus continues on Healthroster efficiency, use of temporary nursing 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 for Workforce.

Author(s)

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

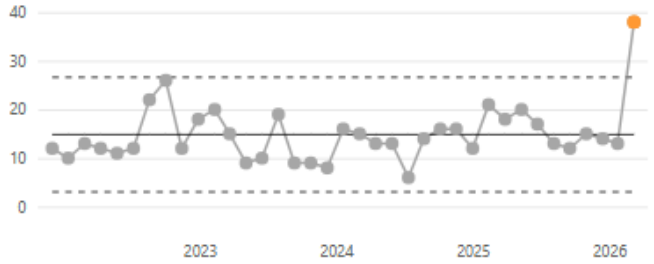
Simon Merritt
Chief Medical Officer

Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

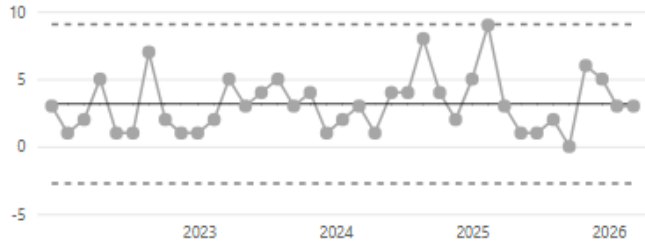
Number of Patient safety events (severity 3): Total, Safety

Target required	Concern	38



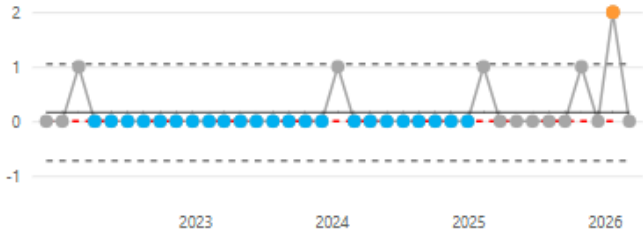
Number of Patient safety events (severity 4 and 5): Total, Sa...

Target required	Common Cause	3



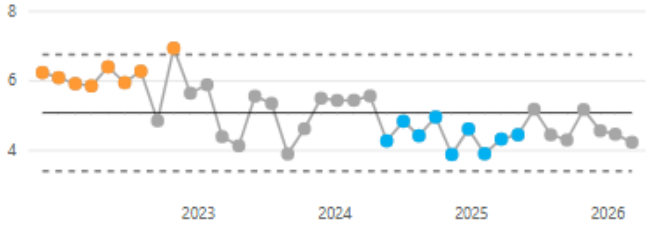
Never Events: Total, Safety

Target required	Common Cause	0



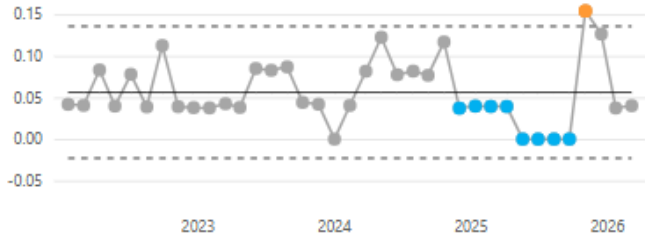
Inpatient Falls per 1,000 Bed days: Total, Safety

Target required	Common Cause	4.22



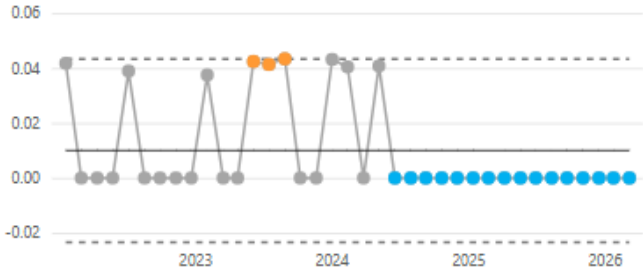
Cat 3 and 4 ESHT Acq. PU (rate) per 1,000 bed days: Total, S...

Target required	Common Cause	0.0402



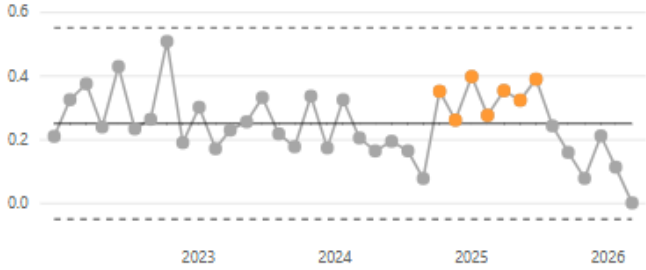
Healthcare Associated MRSA Bacteraemia (rate) per 1,000 ...

Target required	Improvement	0



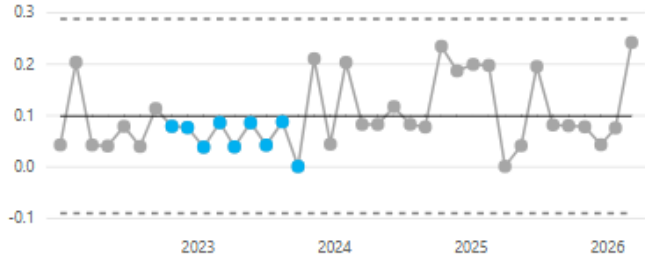
Healthcare Associated C Diff Infections (rate) per 1,000 Bed ...

Target required	Common Cause	0



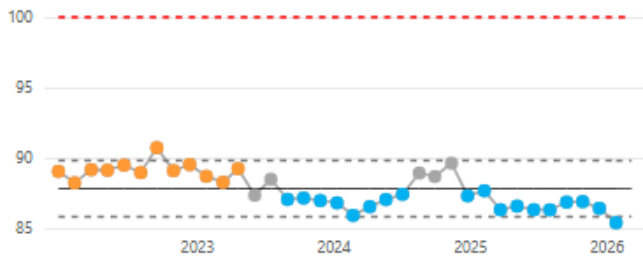
Healthcare Associated MSSA Bacteraemia (rate) per 1,000 ...

Target required	Common Cause	0.241



RAMI: Total, Safety

Achieving	Improvement	85.4

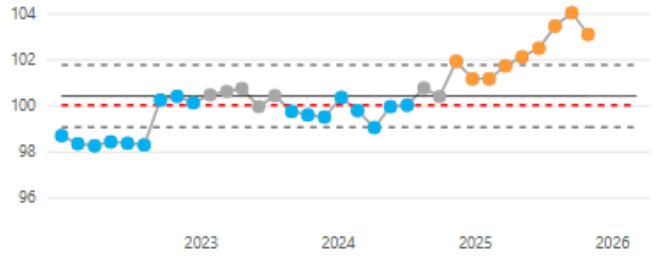


Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

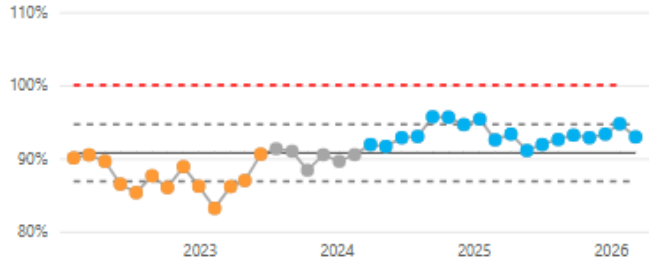
SHMI (NHS Digital monthly): Total, Safety

Inconsistent	Concern	103



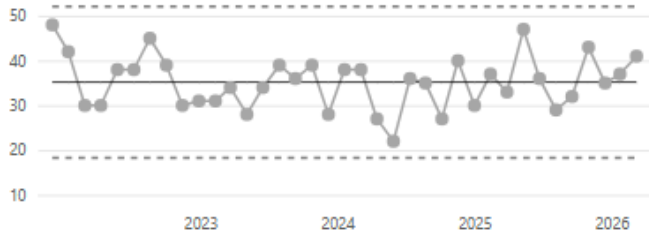
Nursing Fill Rate (IP - RN, RNA and HCA): Total, Safety

Target required	Improvement	92.9%



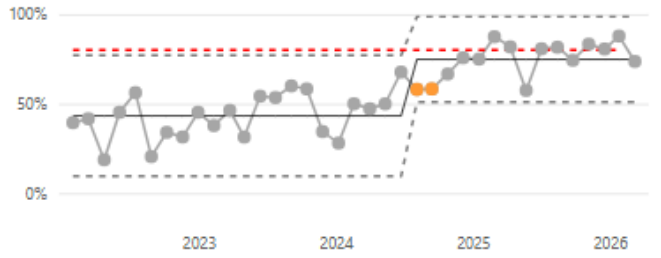
Complaints received: Total, Patient Experience

Target required	Common Cause	41



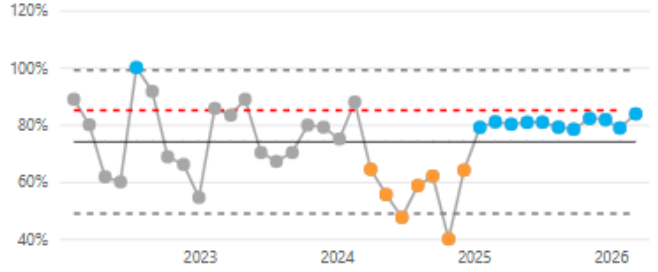
Complaints Response Compliance (60 working days as of 1...

Target required	Common Cause	73.7%



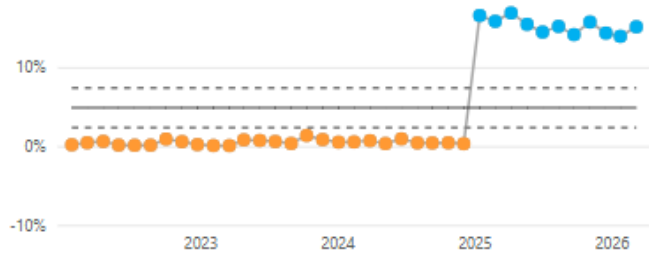
A&E FFT Score: Total, Patient Experience

Target required	Improvement	83.8%



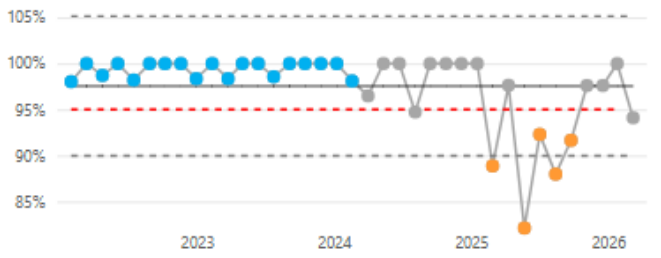
A&E FFT Response Rate: Total, Patient Experience

Target required	Improvement	15.1%



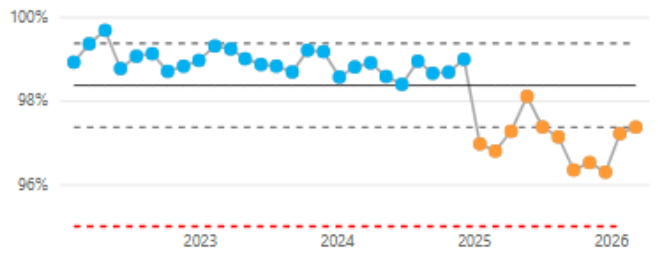
Maternity FFT Score: Total, Patient Experience

Target required	Common Cause	94.1%



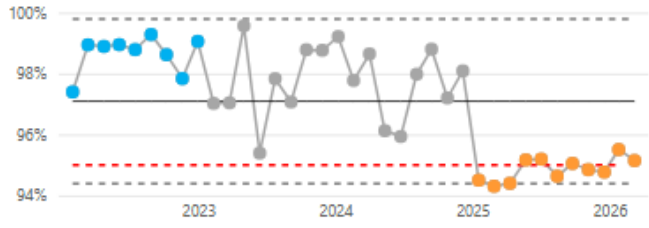
Inpatient FFT Score: Total, Patient Experience

Target required	Concern	97.4%



Outpatient FFT Score: Total, Patient Experience

Target required	Concern	95.2%



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 April 2025, reviewing applicable incidents in a rolling 12-month period, 65% were confirmed to have had verbal DoC completed, and 67% 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 across services and Divisions, where appropriate. The terms of reference for this group is being reviewed • The Patient Safety Team are updating the PSIRF Plan and Policy and reviewing the PSIRF templates; The Chronology template has been fully reviewed. Processes are being reviewed with the aim to move from paper to digital documentation, through collaboration with the Datix team • Weekly meetings chaired by the CNO with the Divisional Governance Leads & Senior Nursing Leadership teams within the Divisions to monitor PSIRF template compliance continues with more work to do • Uptake of Training for All Staff Level 1 PSIRF training remains positive. The data for February is 94.4%, based on compliance figures by department.
Nursing & Midwifery Workforce	During April, occupancy remained very high with ongoing use of additional super surge beds, pre-emptive boarding in corridors 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 nurse staffing. Ward nursing CHPPD overall was 8.3 for April (noting distortion by specialist areas) which is a small improvement most likely due to a slight reduction in the escalation bed numbers. Nursing fill rates for day shifts = RN 91% and HCSW 86%. Nursing fill for night shifts = 96% for RN and 104%.	• For the annual Nursing Establishment Review (NER) for 2025, the first data collection for acute and community has been completed • A review of non ward nursing posts has commenced with a programme of work to look at non-medical job planning, education and supervision frameworks • Recruitment to the Mental Health Outreach team continues and a review of training for staff as part of the MH Strategy is also underway. The pilot in our Emergency Department at EB to offer enhanced assessment and initial care plans for those patients who present with an acute mental illness crisis commenced in May with a trail of body worn cameras for nursing staff starting soon • Nursing/Midwifery monthly Roster Compliance sessions continue, led by the Deputy Chief Nurse to ensure effective/efficient nursing rosters. The fortnightly roster assurance panel continues, to support working within budget and review of temporary staffing requests. There is evidence of good controls to support enhanced observations and requests for additional staff. The focus is now on reducing reliance on Agency staffing • Analysis of the job specific skills and leadership training needs in ongoing and we are working with NHS Elect to identify the skills gap and plan an education framework to ensure training meets the needs of our people • We continuing to offer training and support in the clinical areas with the restorative supervision programme and are reviewing the role of practice educators and current resources.

Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

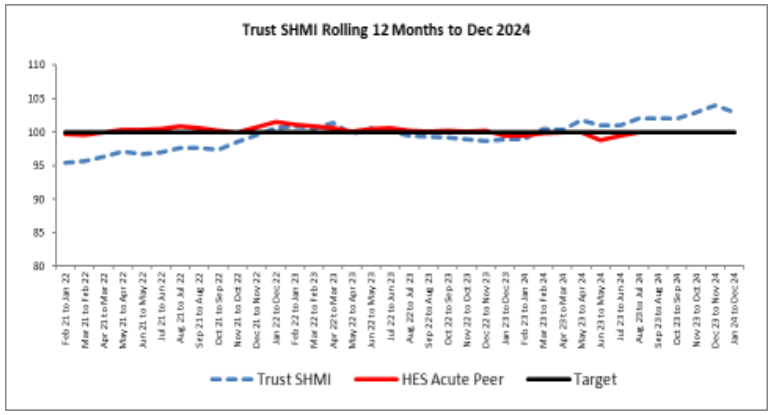
Title	Summary	Actions
Inpatient Falls	Slips, Trips and Falls - The inpatient falls rate for ESHT per 1000 bed days was 4.22 in April 2025. This remains within the control limits with common cause variation. All incidents reported were No or Low harm except one Moderate harm incident for which a SWARM review is being undertaken to determine whether there were any lapses in care delivery in line with the PSIRF policy. 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. Falls incidents by the service are discussed at the Trust Falls group bi-monthly.	• SWARM Forms is planned to be reviewed. Completed forms continue to be monitored, and peer reviewed by the PSIRF Review Group • Divisional themes and trends are reported to the Falls Steering Group for oversight and consideration for quality improvement activities • Deep Dive report of Falls incidents is being undertaken.
Patient Experience	23% (79) of PALS concerns came from the category "appointments". This category includes, waiting times, appointments cancelled and follow up arrangements from an appointment. The main specialities were ENT, Cardiology, Gynaecology and Radiology Our FFT provider Envoy will no longer be providing a transcribing service for paper FFT from October 2025.	This theme has been feedback to the specific areas. Paper surveys account for approx. 14% off FFT responses per month. The suggestion is that paper is available but also promote the completion of FFT via weblink or notify patients that they will receive an SMS and recruit volunteers to support the input of paper surveys.
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 in April. However, on investigation by one of the Tissue Viability Nurses it has been confirmed as a deep tissue injury (DTI). This was caused by the patient having to lay in a supine position following trauma, due to suspected spinal injury. The patient was nursed on an appropriate mattress: it's surmised that the damage was sustained during the long lie the patient suffered prior to being brought to hospital. The initial DTI evolved to category 2 damage and has subsequently been recoded on Datix.	• New Pressure Ulcer & Wound care training produced by the National Wound Care Strategy Programme, approved by the Education Steering Group in 2024 requires implementation by the trust Learning & Development team • The PUSG is due to finalise its annual work plan for 2025-26. This includes the introduction of new audit tool in line with CQUIN 12 and a QI project to improve compliance with PU assessments in gateway areas to promote early introduction of preventative care plans.

Effective Care - Mortality

East Sussex Healthcare NHS Trust

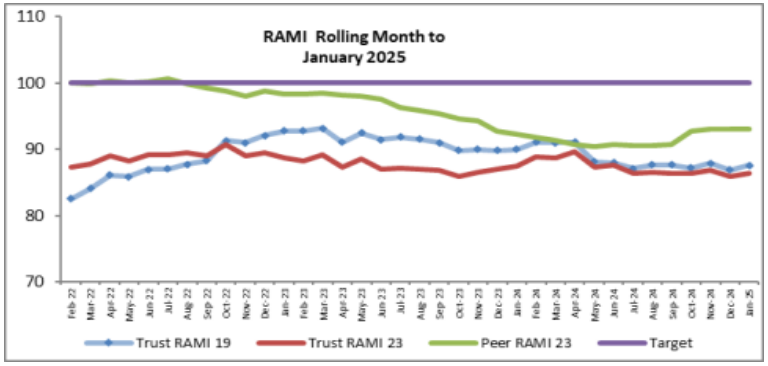
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

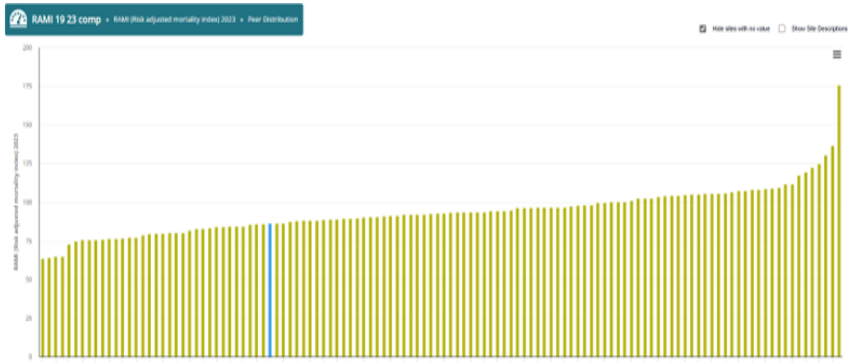
Summary Hospital Mortality Indicator (SHMI)
Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures



- SHMI – January 2024 to December 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 100
- 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 – Feb 2024 to Jan 2025 (rolling 12 months) is 86, and 87 for the same period last year. Peer RAMI was 93 for this period
- The line graph below shows the rolling 12 month figure
- Crude mortality shows Feb 2024 to Jan 2025 at 1.58% compared to 1.65% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 66% for February 2025 deaths compared to 65% for January 2025 deaths.

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





This shows our position nationally against other acute trusts – currently 35/120

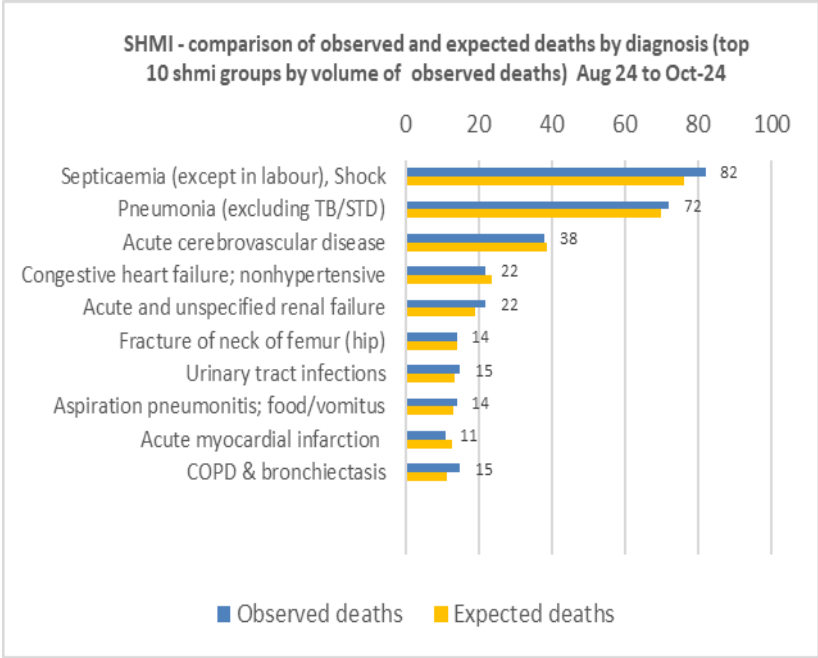
Effective Care - Mortality

East Sussex Healthcare NHS Trust

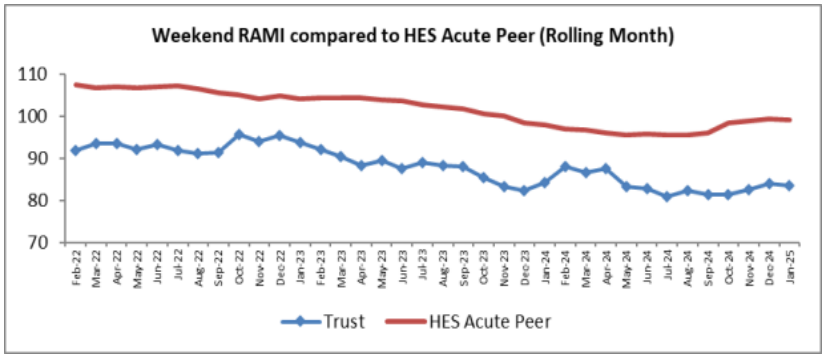
April 2025 Main Cause of In-Hospital Death Groups

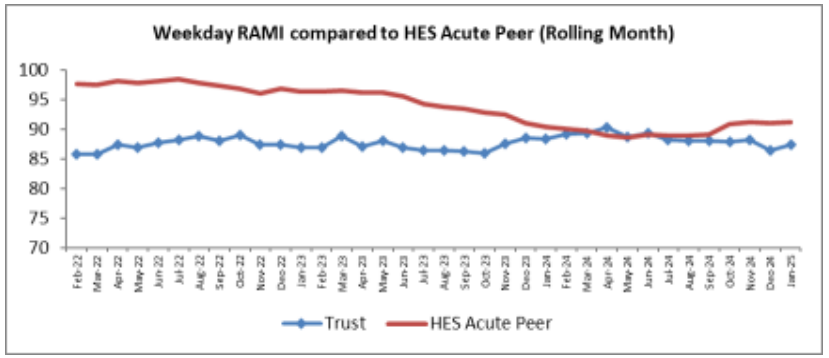
Description	Deaths Apr 24 - Mar 25	Deaths Apr 25
Cancer	198	15
Sepsis/Septicaemia	182	13
Pneumonia	146	13
Heart Failure	111	10
Frailty of Old Age	108	6
Community-acquired Pneumonia	101	8
Hospital-acquired Pneumonia	89	11
Stroke	72	4
Aspiration Pneumonia	59	10
Chronic Obstructive Pulmonary Disease	56	6
Myocardial Infarction (MI)	36	3
Urosepsis	33	2
Atrial Fibrillation (AF)	28	1
COVID-19	28	
Acute Kidney Injury (AKI)	19	1
Dementia	19	2
Liver Disease	19	4
Bowel Obstruction	15	1
Multiple Organ Failure	9	5
Pulmonary Embolism	6	1
Bronchopneumonia	5	1
Type 2 Respiratory Failure	4	1
Bowel Perforation	3	
Congestive Cardiac Failure	2	4
Intersitial lung/pulmonary disease	2	
Spontaneous Upper Gastrointestinal Haem	2	1
Cerebrovascular Accident	1	
Alcoholic liver disease		1
Cellulitis		1
Spontaneous Intracerebral Haemorrhage		2
Ischaemic Bowel		1
Type 1 Respiratory Failure		1
[Uncertified]	124	14
Other not specified	495	7
Total	**1972**	**150**

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:	Challenges and Risks:	Author
	Turnover remains stable and within target. Vacancy rates increased by 0.8% to 2.1%, following budget setting for the new financial year, but well within 7.5% target. Monthly sickness rate reduced by 0.1% to 5.1%. Mandatory Training reduced by 0.1%, but still above target at 91.5%.	Appraisal rate dropped again by 1.8% to 80.5% and is below target.	

Overview:

Budgets were reset for the 25/26 financial year, with an increase of 245 wte in the establishment but with a sliding scale of reductions, in line with Divisional Plans in the forthcoming months. There was a reduction in workforce usage comparison by 74 whole time equivalent (wte) primarily in bank, agency and locum wte. Following the budget reset for 25/26, the Trust vacancy rate increased by 0.8% to 2.1% (170.1 wte vacancies), which is still historically low and compares to a rate of 4.9% at the start of 24/25. The increase in the rate is due to budget changes, with the substantive establishment increasing by 53 wte in April.

Turnover rate remains stable at 10.4% and has been consistent, remaining within the range 10.3% - 10.8%, for the last 13 months. The April figure correlates to 750.5 wte leavers in the last twelve months. A certain amount of churn is desirable to help the Trust to achieve the workforce reductions required by the Business Plan, through natural wastage.

There has been a small reduction in the monthly sickness rate by 0.1% to 5.1%, the third consecutive monthly reduction. Cold, cough & flu absences continue to fall (down by 151 wte days lost) to their lowest level since Sept 24. Anxiety, stress & depression illnesses, however, continue on a slight upward trend (up by 46 wte days lost this month to 2,596 wte days, days lost at their highest level since Dec 24). Annual sickness remains unchanged at 5.4%. Monthly sickness rates remain highest for Additional Clinical Services staff at 6.7% (-0.2% since last month) and Estates & Ancillary staff at 6.5% (-0.3%).

The mandatory training rate remains 1.5% above target at 91.5%. Basic Life Support still has the lowest compliance at 71.1% (-1.3%). DNAs remain an issue for this training, with 108 no shows without given reason, this month (the equivalent of 1.5 days of training). The majority of DNAs were for staff in nursing roles across all divisions. The only other module below the 90% target is Information Governance at 88.3% (+0.1%) as Fire Safety has matched the 90% target as of this month (+0.5%).

The appraisal rate reduced again this month by 1.8% to 80.5%, 4.5% below target so HR Business Partners will be encouraging colleagues to improve this in their respective Divisional IPR's. 1,587 staff currently have outstanding appraisals. The reduction does appear to be, in part, due to the transition to the new online system on MyLearn, as managers adjust to this system. Appraisal rates are lowest for Healthcare Scientists at 71.5% (+5.1%) and Additional Clinical Services staff at 77.2% (-3.5%).

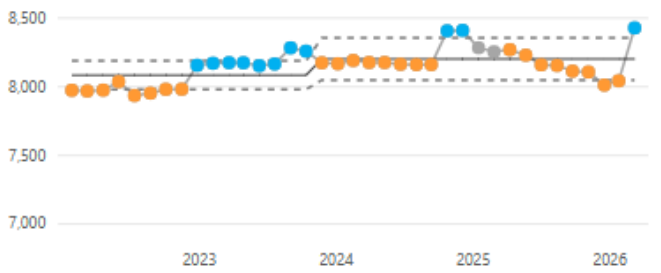
Steve Aumayer
Chief People Officer

Our People Core Metrics

East Sussex Healthcare NHS Trust

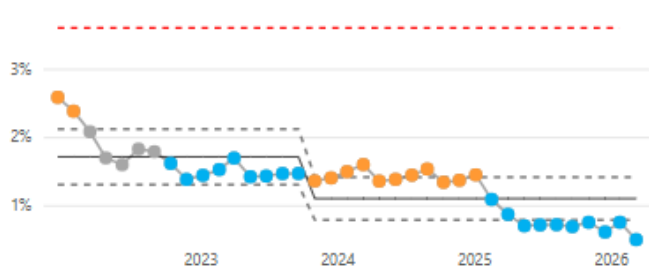
Establishment (WTE) All: Total, Our People

Target required	Improvement	8,424



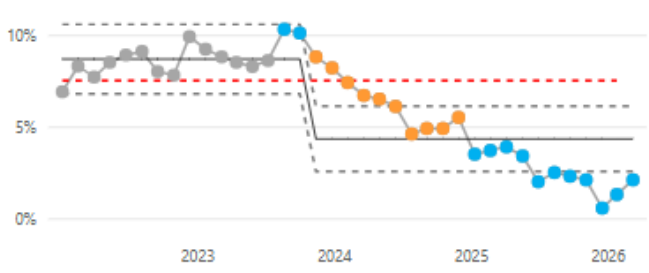
Agency Rate: Total, Our People

Target required	Improvement	0.496%



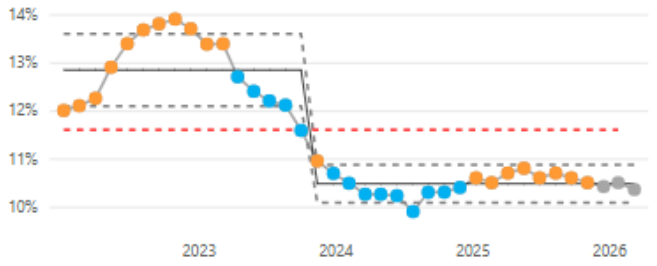
Vacancy Rate: Total, Our People

Target required	Improvement	2.1%



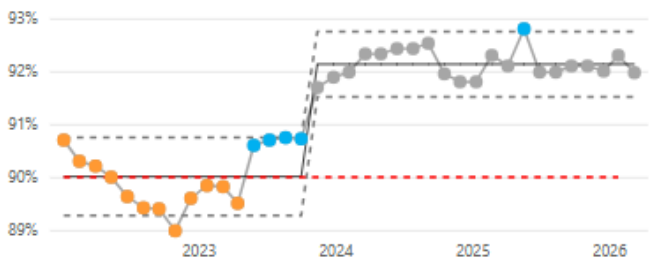
Staff Turnover: Total, Our People

Target required	Common Cause	10.4%



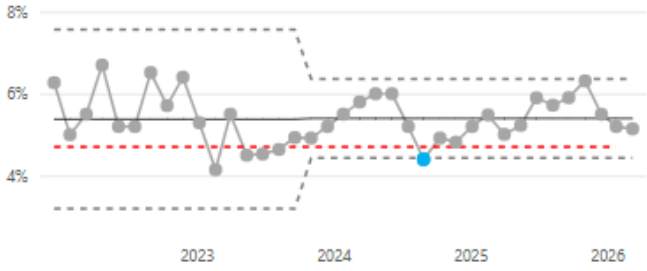
Retention Rate: Total, Our People

Target required	Common Cause	92.0%



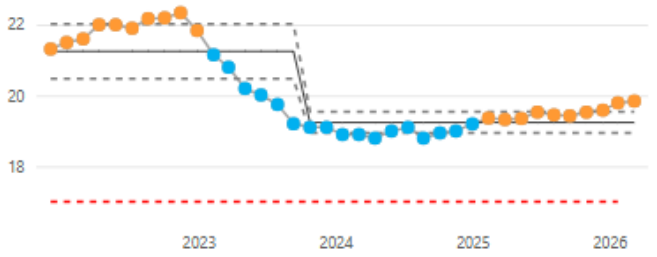
Monthly Sickness - Absence %: Total, Our People

Target required	Common Cause	5.14%



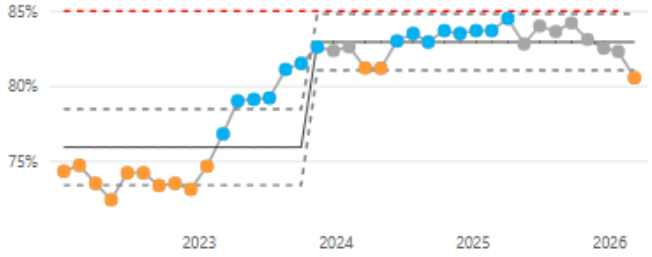
Sickness - Average Days Lost per Fte: Total, Our People

Target required	Concern	19.8



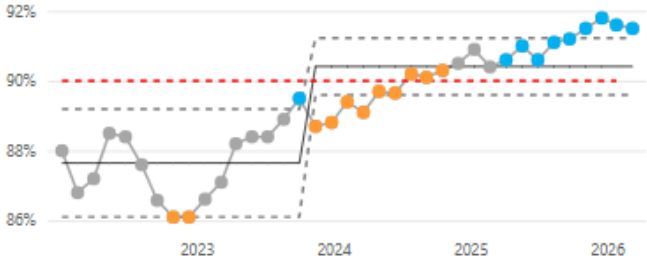
Staff Appraisals: Total, Our People

Target required	Concern	80.5%



Statutory & Mandatory Training: Total, Our People

Target required	Improvement	91.5%



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 0.3% to 92.0%.	• Action Learning Sets have been piloted with the Heads of Nursing in DAS and Matrons in Urgent Care & Frailty. These have been very well received and evaluated with participants requesting for them to continue. The proposed model for the Action Learning Sets is for the People Engagement Team to support by facilitating for a further 4 – 6 months post pilot, whilst the set members become more skilled and competent at leading and facilitating the sets themselves, becoming self sufficient and sustainable • The Legacy Mentoring pilot is continuing with mentors supporting colleagues in a variety of roles and areas including: DAS, Urgent Care, CHIC, Core, WAC, Estates & Facilities • Phase 2 of the Restorative Supervision programme has commenced with cohort 5 starting their training this month, (12 colleagues from across the Trust). Initial feedback from attendees is overwhelmingly positive as it is recognised how this approach will provide tangible support to colleagues who are feeling overwhelmed with competing and complex work-related challenges • Continuing to support the Early Resolution Facilitators to ensure that the Trust has a cohort who are able to deliver this intervention to colleagues in conflict. Exploring options to improve the Trust's in-house mediation service but this is likely to require some investment to upskill existing mediators or train new ones.
Vacancy Rate	Vacancy rate increased by 0.8% to 2.1% (170.1 wte vacancies).	• Focussed recruitment activity to address hard to recruit posts with recruitment activity around Medics,and Allied Health Professionals • Continued activity with temporary workforce agencies for Community and Escalation areas across the Trust • Medical recruitment activity to address hard to recruit posts is ongoing, with specific hard to recruit posts e.g. Dermatology/Stroke with Headhunters • Increased direct applicants for posts across the Trust • Activity to support recruitment for 'Art of the Possible posts' within Community areas • Continued support with redeployment activity and support for both line managers and colleagues affected.

Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Sickness	Monthly sickness reduced by 0.1% to 5.1% whilst annual sickness was unchanged at 5.4% Average sick days per WTE unchanged at 19.8	The Sickness Reduction Focus group continues to meet regularly, reviewing interventions and processes which will support sickness management and identify areas of improvement. This will better aid managers in reporting and supporting absence in their areas. One area of concern has been an increase in the use of the 'Unknown' sickness reason. It has been determined that colleagues reporting in sick often do not wish to share details with the initial contact but wait until they can share with the line manager. The absence is logged on first call and where this is near the finalisation date on Healthroster, any changes made after this date do not update ESR unless manually adjusted. This highlights the importance of accurately inputting the correct reason code before finalising sickness episodes. With the correct detail input, this will allow for easier identification of themes or concerns regarding absence. Long term sickness is monitored on a regular basis, ensuring the health and wellbeing conversations are taking place and, where required, moved onto the first formal ill health meeting whilst all available support is explored.
Statutory & Mandatory Training	Trust compliance reduced slightly by 0.2% to 91.6%, 1.6% above target.	Basic Life Support compliance reduced for the second month running, to 71.1% a further reduction of 1.3%. Five areas are reporting a compliance of below 70%, including Chief Operating Officer, which, for the third month, remains at 42.3%,(15 staff non-compliant), Medical Director BLS compliance has reduced to 11.1% (8 staff are non-compliant), Nursing and Governance compliance was 58.1% (18 staff non-compliant), Core Services Division was 69.2% (121 staff non-compliant) , Urgent Care compliance rate was 63.9% (276 staff non-compliant) and Medicine was 65.2% (340 staff non-compliant). A total of 108 no shows without any reason for our Basic Life support sessions this month (which is the equivalent of 9 sessions wasted). The majority were staff in nursing roles across all divisional areas. The national review of the Core Skills Training Framework (CSTF) Statutory and Mandatory training, remains ongoing. The work to review all essential skills and CSTF delivered training to be completed by the end of June 2025. Announced by the National Team that work on the Staff Digital Passport has been cancelled. The Trust Local Oversight Group first meeting was end of April 2025. National Statutory and Mandatory Policy circulated to all Trusts and is a mandated document for all Trusts.
Appraisal	Compliance rate reduced by 1.8% to 80.5%, 4.5% below target	Appraisal rates reduced slightly for the fourth consecutive month. With the implementation of the new Trust appraisal reporting process, it is anticipated that appraisal compliance rates will continue to reduce slightly for the next 1-2 months whilst the new process embedded.

Access and Responsiveness

Delivering the NHS Constitutional Standards

Urgent Care – Front Door

Urgent Care – Flow

Planned Care

Our Cancer services

We will operate efficiently & effectively

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

Access and Responsiveness | Executive Summary

East Sussex Healthcare NHS Trust

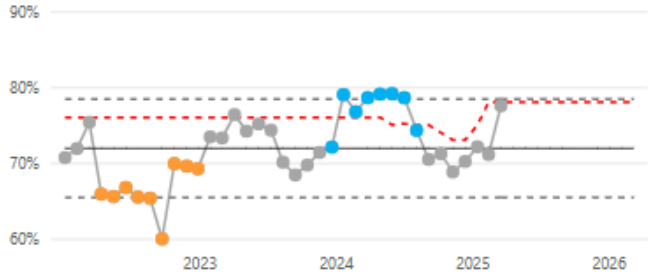
	Positives	Challenges & Risks	Author
Responsive	**Cancer** The Trust delivered 82.9% against the Faster Diagnosis Standard in March (national standard 77%). Performance against the 62-day standard achieved 74.2% versus a trajectory of 70.2% and met the 70% national standard. The 31-day pathway achieved 95% against a standard of 96%. **Urgent Community Response (UCR)** The UCR standard of 70% has been achieved consistently in the Trust, with 86% of patients seen within the 2-hour response window in April. **Elective long waits (RTT)** The Trust reported a small number of patients who waited more than 65 weeks in April.	**4 Hour Emergency Access Clinical Standard** In April, 77.5% of patients were seen and discharged or treated and admitted within 4 hours. To have met the standard an additional 67 patients needed to have been seen and discharged or seen admitted within 4 hours. The Trust continues to work collaboratively with system partners to address high bed occupancy, increasing length of stay and limited ability to discharge patients to their onward care destination. **Cancer** The backlog of patients waiting over 62 days at the end of March was 239 against a trajectory of 85. 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 Apil was 5.25 days. Reducing the pressure on hospital bed capacity is a recognised challenge. Reducing length of hospital stay with a particular focus on clinical length of 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 • Focus on eliminating >65 week waits across Sussex and sustainably reducing elective waiting times.		

Our People Core Metrics

East Sussex Healthcare NHS Trust

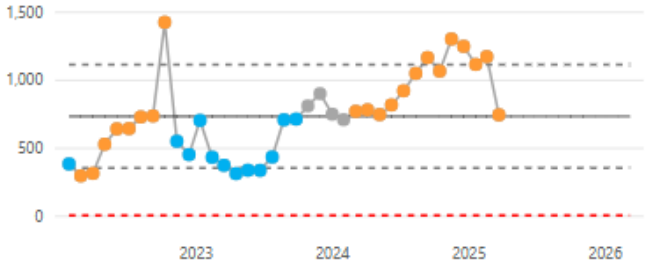
4 hour standard: Total, Our Performance

Inconsistent	Common Cause	77.5%



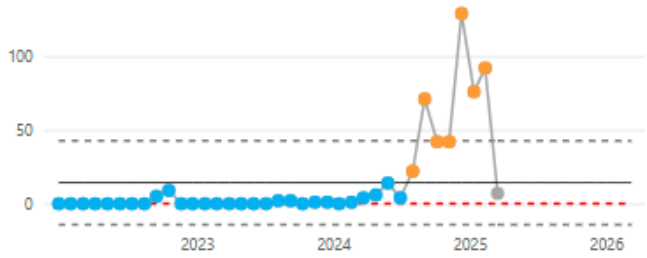
A&E > 12 hours from arrival to discharge: Total, Our Perfor...

Not Met	Concern	741



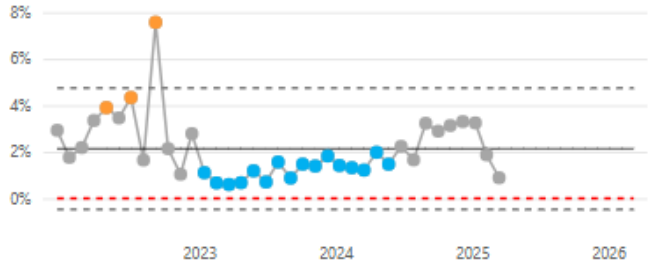
A&E waits over 12 hours from DTA: Total, Our Performance

Inconsistent	Common Cause	7



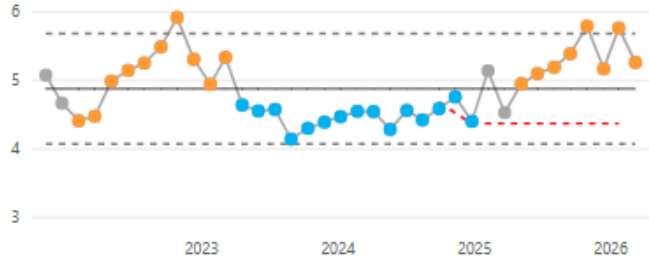
Conveyance handover >60 mins: Total, Our Performance

Inconsistent	Common Cause	0.893%



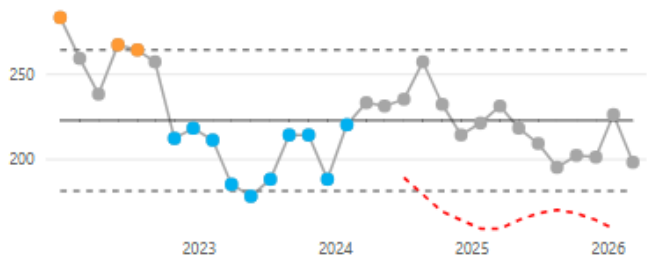
Non Elective Length of Stay: Total, Our Performance

Target required	Concern	5.25



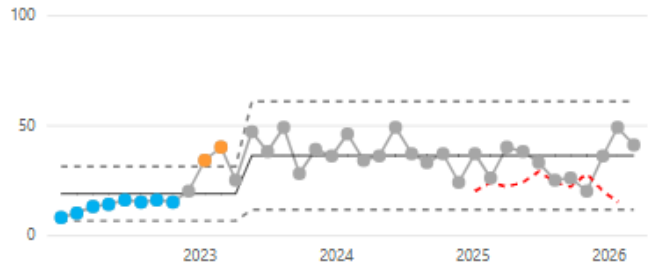
Average daily NCTR: Total, Our Performance

Target required	Common Cause	198



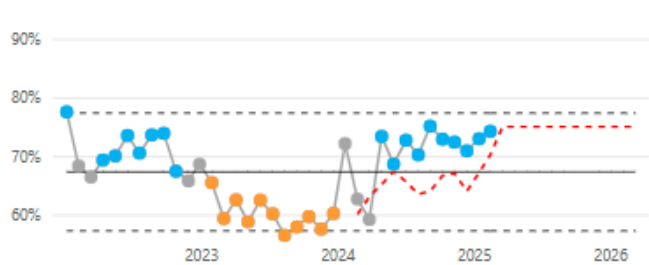
104 day Backlog: Total, Our Performance

Target required	Common Cause	41



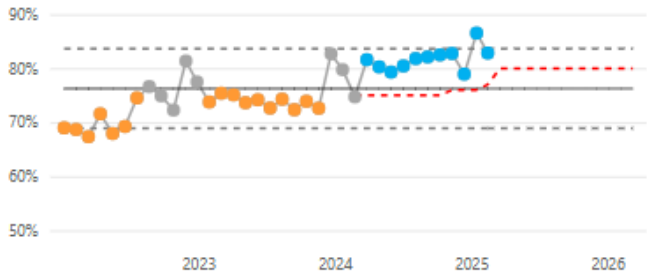
Cancer 62 Day: Total, Our Performance

Inconsistent	Improvement	74.2%



28 Day General FDS: Total, Our Performance

Inconsistent	Improvement	82.9%

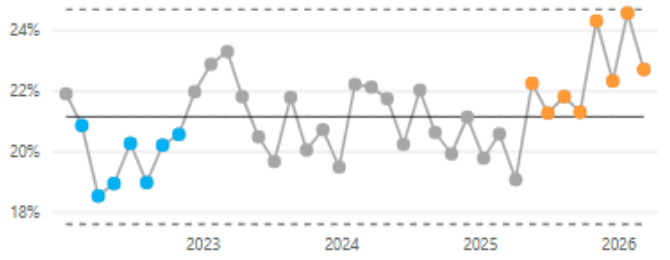


Our People Core Metrics

East Sussex Healthcare NHS Trust

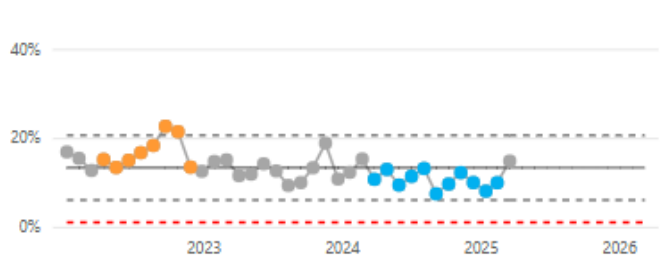
% Discharges delayed 1+ days: Total, Our Performance

Target required	Concern	22.7%



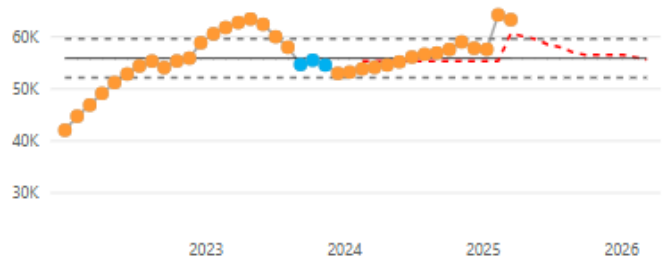
Diagnostic <6 weeks: Total, Our Performance

Not Met	Common Cause	14.8%



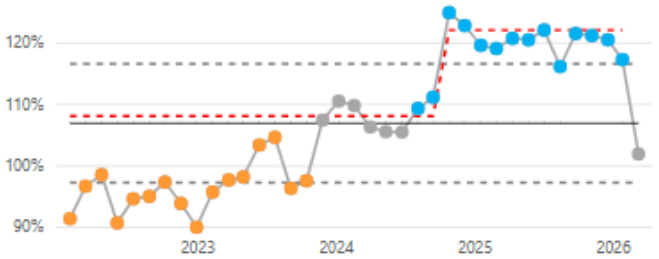
RTT Total Waiting List Size: Total, Our Performance

Achieving	Concern	63185



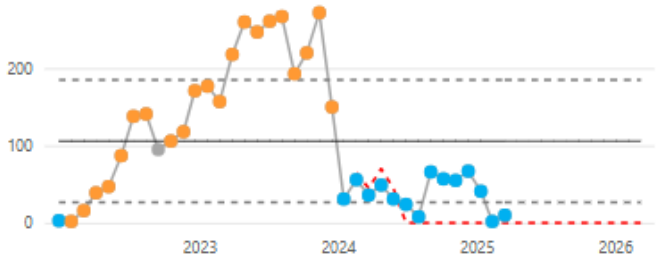
Elective Activity (ELIP,DC,OPFA, OPFUP Proc): Total, Our Perf...

Target required	Common Cause	102%



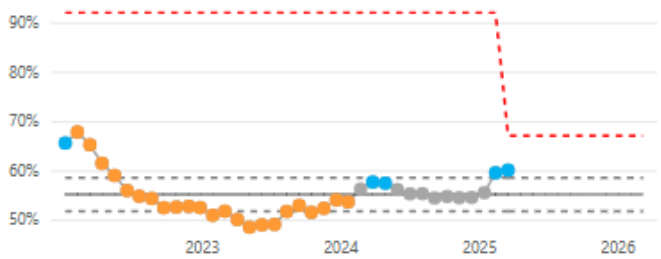
RTT 65 week wait: Total, Our Performance

Not Met	Improvement	10



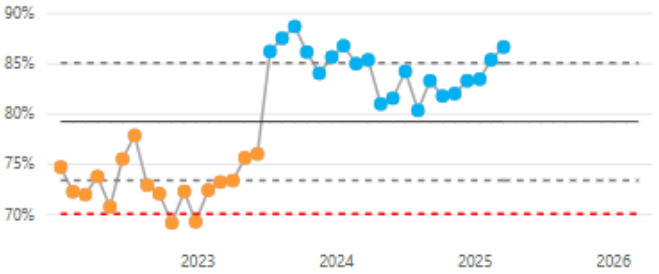
RTT under 18 weeks: Total, Our Performance

Not Met	Improvement	60.0%



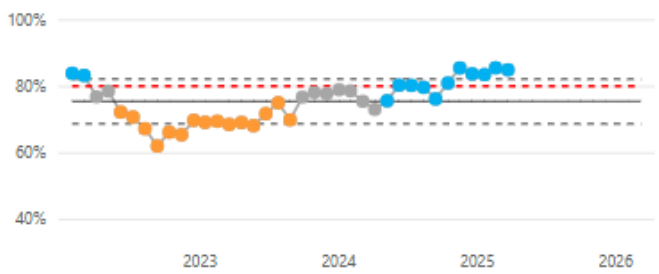
Urgent Community Response within 2 hours: Total, Our Perf...

Achieving	Improvement	86.6%



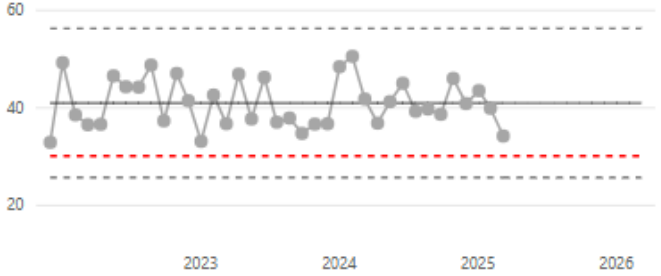
CHIC wait times < 13 weeks: Total, Our Performance

Inconsistent	Improvement	84.8%



Intermediate Care Length of Stay: Total, Our Performance

Inconsistent	Common Cause	34.1



Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Emergency Access Clinical Standard	In April, 77.5 % of patients were seen and discharged or treated and admitted within 4 hours, against the 78% standard. This places the Trust at 31 out of 123 Trusts nationally, in the second quartile for performance. To achieve 78%, the Trust needed to treat an additional 67 patients within 4 hours.	• 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. • Introduction of AI tool to support improvements in timely patients' pathways • Focus on re-direction for T3 patients and overnight appointment allocation.
Patients in department over 12 hours from arrival to discharge	The number of patients waiting over 12 hours from arrival to discharge reduced to 741 patients, compared to 1169 in March. Patients waiting over 12 hours following a decision to admit, for allocation of ward bed reduced to 7, compared to 92 in March.	• 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 • Multi Agency Discharge Events (MADE) to continue in EDGH through May.
Conveyance Handover >60 mins	The percentage of patients handed over >60 mins was 0.89 % in April. This represents a reduction in the number of patients the Trust were not able to offload within 60 minutes compared with March (1.88 %).	• Continued 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 for 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 reduced in April to 5.25 days. Reducing the pressure on hospital bed capacity is a recognised challenge.	• Focus on reducing clinical LOS and embedding Safer on wards – through learning from MADE events and refresh of improvement programme • 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 • Working with system partners to agree key enablers to support a reduction in the number of patients not meeting the criteria to reside.
Community Waiting Times (Paediatric)	Outsourcing to an independent sector provider has supported improvements in community paediatric waiting times over last 18 months. The service has been temporarily paused to enable a full procurement exercise to take place. The number of children waiting for a first outpatient appointment is 2502. There were zero >104 weeks at the end of March (compared to 29 in April 24). There were 6 children waiting over 78 weeks (compared to 83 in April 2024) and 603 children waiting over 52 weeks (compared to 568 in April 2024).	• 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 pathways and streamline processes.
Community Waiting Times (Adult)	Urgent Community 2-hour response achieved 86% in April, against the national target of 70%. Patients waiting to be seen within 13 weeks – 80% target achieved for the last six months despite increase in demand.	• Clinically prioritising patients, ensuring that the most urgent patients are prioritised to be seen.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Cancer	The Trust delivered 82.9% in March against the 77% Faster Diagnosis Standard. The Trust delivered 95% against the 96% 31-Day diagnosis to treatment standard. Performance against the 62 Day standard in March was 74.2% against a trajectory of 70.2%. The backlog of patients waiting over 62 days at the end of March 2025 was 239 against an internal trajectory of 85. The Trust continues to receive high number of GP urgent suspected cancer referrals and in March 2025 received 2949 referrals, an increase of 18% when compared to March 2024. Cancer pathways remain a Trust priority, with continued 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. • 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. • Focus on long waiting patients to reduce the overall backlog however some patients are being treated at tertiary centres, and some have been treated and waiting histology. Partnership working with tertiary centres to support patient treatments. • Cancer Week planned in June to expedite pathways further where possible.
Elective Activity	Currently the Trust has achieved 100% of baseline activity levels in April, compared to 117% the previous month. This is expected to improve once the April activity has been verified.	• Improve outpatient clinic utilisation to maximise delivery of outpatient activity • Outpatient 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 and waiting list size	In April, there were a small number of patients (circa 10) who waited >65 weeks on an elective RTT pathway. One of these pathways was a patient at 78 weeks, who has now been treated and discharged. The Trust intend to have 0 patients waiting greater than 65 weeks at the end of June. In April, the Trust commenced the National Validation Sprint, taking a targeted approach to validate key areas of the PTL. This targeted validation has had a positive impact. In April 1.55% of patients on the RTT waiting list waited >52weeks, against a trajectory of 2.23%. The Trust is confident, that by March 2026 less than 1% patients on the waiting list will be waiting more than 52 weeks. The Trust has also seen a decrease in the total waiting list from 64,102 in March to 63,185 in April. The Trust has also delivered a second month of improvement in RTT compliance. An improvement from 55.5% in February to 59.5% in March and 60.04% in April. The improvement is due to the inclusion of MSK RTT pathways and the result of initiatives to improve both validation and elective capacity.	• 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 April • Daily monitoring of the longest waiting patients to ensure pathways are progressing • Monitoring of 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 • Continue targeted validation at key points in the PTL to improve RTT performance • Ongoing education sessions to support RTT understanding and improve compliance • Progress workstreams to improve elective utilisation.
Diagnostic DMO1	In April, the number of patients waiting more than 6 weeks increased to 1,679 from 1,120 in March. • 85.18% performance in April, against national standard of 95% • The overall size of the DM01 waiting list remained stable at 11,331 patients with increased demand for MRI and Audiology • Cardiac Echo waiting list increased from 742 in March to 1,463 in April due to a change in the way patients are counted. The number of patients waiting more than 6 weeks also increased to 371 for April • Audiology waiting list decreased slightly in April with breaches decreasing from 211 in March to 142 in April. This was in part due to mutual aid patients from UHSX requiring a new audiology test prior to outpatient appointment and an increase in paediatric audiology demand.	• Recovery plans in place in key modalities (MRI, Echo, Audiology) • Radiology are working with Medical Imaging Partnership (MIP) to mitigate the risk of lost activity due to equipment failure. Also working closely with InHealth to address MRI demand. Detailed action plan currently being agreed to • Audiology continue to work through the backlog created following the transfer of long waiting ENT outpatients from UHSX. Further work being agreed to meet paediatric demand • Intensive Support Team due to work with ESHT to support improvements and a return to delivery of >90% against this standard by the end of June.

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	• M1 deficit of £1.7m in line with plan • Capital plan for 25-26 £40.0m. Spend in Month 1 £0.8m • Pay Run rate once normalised for NI changes in April and minimum wage adjustments is similar to Month 12. Underspent against budget by £0.5m, contributing to CIP in month • Non Pay run rate similar to Q4 24-25 with allowance made for inflationary pressures in budget • Use of Resources finished £0.5m over plan in Month 1 • Budget setting process for 18 months from Jan 25 to June 26 in train • New Interim CFO in role and Use of Resources meetings on going for challenge and review.	In 25-26, a rigorous planning cycle has resulted in an agreed breakeven plan for 25-26. This includes an efficiency target of £49.6m and has involved detailed plans worked up with Divisions over Q4. Some of these schemes have enablers so robust monitoring and reporting alongside proactive recovery planning is essential. The budget is phased over the year according to factors such as CIPs starting up in later months. The budget aligns the Operational Plan with the Financial Plan and enables budget and business planning to be an ongoing piece of work rather than once a year. This will help identify potential issues earlier and implement mitigating actions.	 **Andrew Strevens** Interim Chief Financial Officer

Overview:

I&E: Month 1 saw the Trust deliver the planned deficit of £1.7m. Underlying deficit driven through expected lower activity compared to the level of fixed costs within the Trust.

UoR: M1 delivery of £2.3m against plan of £1.8m, an over-delivery of £0.5m.

Workforce predominant workstream delivering improvement over plan as expected benefits were delivered ahead of schedule.

Risk: Budget phasing to be reviewed, although not identified as a risk to the full year result, improved phasing will support more accurate analysis

Capital: Capital expenditure at month 1 was £0.8, £0.4m below plan.

Cash: Cash position concluded at £22.9m, well above the £2.1m minimum permitted balance and is likely to remain above target in 2025/26.

Trust Summary

East Sussex Healthcare NHS Trust

Income and Expenditure

At month 1, the Trust has reported a deficit of £1.7m, which is in line with plan. Key areas to highlight are:

- An income deficit
- A better than expected position on pay
- Some large non-pay variances

The **Use of Resources** plan shows significant over achievement at £475k

The **income** plan has proven difficult to validate based on the activity declared in April and analysis is underway. Initial investigation has shown that while the Trust is comfortable that the actuals are prudent overall, the output in month 1 showed significant variances between divisions that need understanding.

For **pay**, the Committee will recall that when setting the plan, a £5.8 million improvement against plan for vacancy and establishment control was set. This was expected to impact in May. In actuality and probably resulting from human factors in setting detailed budgets, this has been delivered early and without significant further intervention.

Non pay costs while on plan also have some anomalies. Utilities costs in April were higher than planned as heating continued into the Spring. A budgeted contingent exists for these costs although planned towards the end of the year. This upside has not been recognised. In addition, a significant variation in other operating expenses is declared (£600k).

Overall while on plan there is most likely an upside still to be found against the significant variations identified.

Overall the position is positive with some significant refinement of understanding and reporting still required.

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Plan	Act	Var	Plan	Act	Var
Income						
Contract income	41,519	40,882	(636)	41,519	40,882	(636)
Divisional	7,460	6,697	(764)	7,460	6,697	(764)
ERF	10,887	11,702	814	10,887	11,702	814
Total Income	**59,866**	**59,281**	**(585)**	**59,866**	**59,281**	**(585)**
Operating Expense						
Pay						
Permanent	(37,330)	(36,375)	956	(37,330)	(36,375)	956
Temporary	(3,068)	(3,465)	(397)	(3,068)	(3,465)	(397)
Total pay	**(40,398)**	**(39,840)**	**558**	**(40,398)**	**(39,840)**	**558**
Non-pay						
Drugs	(1,531)	(1,558)	(27)	(1,531)	(1,558)	(27)
TEDD	(3,899)	(3,703)	196	(3,899)	(3,703)	196
Clinical supplies	(4,639)	(4,461)	178	(4,639)	(4,461)	178
Purchased service	(2,364)	(2,266)	98	(2,364)	(2,266)	98
Finance costs	(3,026)	(2,895)	131	(3,026)	(2,895)	131
Other	(5,741)	(6,287)	(546)	(5,741)	(6,287)	(546)
Total non-pay	**(21,200)**	**(21,171)**	**29**	**(21,200)**	**(21,171)**	**29**
Total Expense	**(61,598)**	**(61,011)**	**587**	**(61,598)**	**(61,011)**	**587**
Surplus/(Deficit)	**(1,732)**	**(1,730)**	**2**	**(1,732)**	**(1,730)**	**2**

Finance - Income

East Sussex Healthcare NHS Trust

	M1 £'000 Plan	M1 £'000 Actual	M1 £'000 Var
Contract Income	41,519	40,882	(636)
Divisional Income	7,460	6.697	(764)
ERF	10,887	11,702	814
Grand Total	**59,866**	**59,281**	**(585)**

When completing the month 1 reporting process, a £0.6 million deficit was identified that was not readily explainable. As part of a deep dive into the performance a couple of anomalies were identified. Specifically, issues with the phasing of the plan and some omitted income. Both of these adjustments will provide upside in future months.

Divisional Income is reported £0.8m behind plan, with £0.7m of this linked to the phasing of the plan. Further validation is underway.
The remaining £0.1m is in Estates and Facilities and is due to lower income in a number of areas including catering income being lower due to a lower footfall during the Easter period, accommodation and service level agreement income behind plan and further review is also underway.

As a result of these anomalies and further analysis on the phasing of the plan, a detailed assessment of performance by Division (as opposed to Trust wide is not possible). The income team are working diligently to resolve the position.

Further updates will be provided

Finance - Capital

East Sussex Healthcare NHS Trust

The Board signed up to a plan totalling £40.0 million at its meeting in April according to the table below

	Baseline Plan £'000
Backlog Maintenance	2,000
Ward Fire Compartmentation - EDGH	2,750
Sussex Surgical Centre	1,250
Business Cases to support productivity	1,000
Endoscopy	7,500
Cardiology	4,000
Systems	900
EPR/Transformation	1,500
Equipment	900
Infrastructure	950
Minor Capital	500
Our Care Connected	2,500
EME Medical Equipment Replacements	0
EPR matched (external)	2,800
Diagnostics Digital Capability (LIMs)	1,038
Diagnostics Digital Capability (OCS)	297
Conquest Decant Space creation	2,114
Maternity & SCBU Refurbishment	1,000
Replacement of Sub 4 switchgear	450
Replacement of distribution boards	525
Replacement of Fire Doors	1,131
Replacement of Fire Doors	1,131
Replacement of old macerators	210
Replacement of sub station tripping batteries	55
UEC	3,000
Diagnostics	560
Total Programme	40,061

As at month 1, expenditure against this plan was £765k

When setting the plan, further work was needed to prioritise expenditure to allow investment in medical equipment that had exceeded its depreciated life and was difficult to continue to maintain.

This work is largely complete and will follow the Trust's Governance processes over the course of May in order to bring an updated plan for approval at the June Committee.

Since the original plan, a further £1.9 million of system strategic capital has been secured to support the ICB sponsored safety plan. This will be represented in the updated plan

Monthly phasing will be worked through to avoid the significant excess expenditure position experienced in 2024/25.

Use of Resources

East Sussex Healthcare NHS Trust

Division	M1 Plan	M1 Act	M1 Var
	£'000	£'000	£'000
CHIC	14	14	0
Core Services	280	225	(55)
DAS	112	107	(6)
Medicine	325	244	(81)
Urgent Care	14	0	(14)
WAC	94	77	(17)
SPH	0	0	0
Estates & Factilties	94	90	(3)
Corporate Services	237	208	(29)
Central	815	1,495	679
Investment	(173)	(173)	0
Total	**1,812**	**2,287**	**475**

Priority Area	M1 Plan	M1 Act	M1 Var
	£'000	£'000	£'000
Length of Stay	37	0	(37)
Workforce	328	763	435
Income	614	644	29
Business Cases	328	338	9
Digitally Enabled Change	20	1	(19)
Other	485	541	56
Total	**1,812**	**2,287**	**475**

Recurrent/ Non-Recurrent	M1 Plan	M1 Act	M1 Var
	£'000	£'000	£'000
Recurrent	1,548	1,485	(64)
Non-Recurrent	263	802	538
Total	**1,812**	**2,287**	**475**

Category	M1 Plan	M1 Act	M1 Var
	£'000	£'000	£'000
Pay	400	713	313
Non-Pay	702	961	259
Income	710	613	(97)
Total	**1,812**	**2,287**	**475**

The tables above show the month 1 and full year delivery by Division, Priority area, recurrent/non-recurrent split and by category.

There is under delivery in the Divisions, primarily this is due to Medicine and Urgent care delayed implementation compared to financial plan. The divisions are working up plans to recover any under delivery in month 1 and to take action to bring plans for delivery later in the year forward. The over-delivery on central is due to:

- The internal recruitment scheme phased from May, but there has been delivery in month one, we expect this to even out over the year.
- Technical items such as interest receivable being higher than planned

There are 68 items of opportunity that are being worked up that do not currently have a financial value.

Through the establishment of the executive's priorities, performance against each can be monitored as shown above. "Other" relates to non-pay and other improvements that do not fall naturally into the defined groupings. It is expected through the improvement process now being put in place that further upside will be identified to both mitigate pressure and develop plans ahead of the 2026/27 planning round.

Agenda Item: 11

Report To/Meeting	Trust Board in Public	**Date of Meeting**	24 June 2025

Report Title:	Maternity Services Overview Board Report Q4 2024/25
Key question	As part of National reporting findings and Maternity Incentive Scheme (MIS) requirements all NHS Trusts are required to update Boards quarterly on the quality and safety aspects of our 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 provides assurance that ESHT 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 overall of the delivery of high-quality services and ongoing compliance against all 10 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 4 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. Our feature presentation showcases and celebrates the achievements of our Maternity and Neonatal services as aligned with our Maternity Strategy and 3-year Delivery Plan.
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 is progressing, which supports the safe delivery of services in line with the three-year delivery plan. One area we have asked for particular focus on is leadership and accountability at every level; this work is progressing and has been well received. The conclusion of the external independent investigation into Maternity included recommendations as described above. A peer review of clinical practices is currently underway. A no harm event took place in July 2024 which met the Never Event criteria. 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 (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. A further no harm Never Event occurred in March 2025 and similarities were identified. As a result of significant joint working between the patient safety team and the maternity department, a robust plan and audit process is now in place; full reporting of this will be discussed in the Q1 25/26 report. To support delivery of safe services and to identify risk, the Board Safety Champions and the Maternity and Neonatal Voices (MNVP) Chair meet regularly with the Perinatal leadership team. The MNVP are fully funded through the LMNS. Terms of Reference for the Women and Children's safety and governance meetings, show the MNVP Lead as a quorate member, quality, and safety meetings at speciality/divisional/directorate level including, Safety Champion and MatNeo Governance and Accountability meetings.

No of Pages	2	**Appendixes**	33 slides

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 28/05/25 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 1 2025/26 overview report is scheduled for presentation October 2025.
Publication	The report can be published.

East Sussex Healthcare NHS Trust

MatNeo Overview Board Report

Q4 2024/25 (January to March 2025)

KINDNESS

INCLUSIVITY

INTEGRITY

Author: Brenda Lynes, Director of Maternity Services

QSC 28/05/25 & Trust Board in Public 24/06/25

Contents

East Sussex Healthcare NHS Trust

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

East Sussex Healthcare NHS Trust

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 Q4 we closed the 2023 action plan, the outstanding action of the Induction of Labour Pathway is progressing, the 2024 plan is now in place and progressing in line with the National CQC Service User audit, including continuous improvement of our maternity website, progress to support partners in line with our 24-hour visiting, including an easy read poster for all and recliner chairs for birth supporters. 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, an MNVP "Open Space" event took place in May 25, with action planning progressing. There has been a year of focus on personalised care planning from both the maternity staff and empowering service users, this includes ensuring sufficient information is provided at discharge. A discharge video is currently in production, plans for a discharge lounge are underway. 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 low sensory feeding pods are now available on our postnatal ward. We have 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.

The Board Safety Champion(s) and the Maternity and neonatal Voices lead meet regularly with the Perinatal leadership team. The MNVP are fully funded through the LMNS. Terms of Reference for the Women and Children's safety and governance meetings, show the MNVP Lead as a quorate member, quality, and safety meetings at speciality/divisional/directorate level including the following;

- Safety champion meetings
- MatNeo Governance and Accountability meetings

Cover: Theme 2
Growing, retaining and supporting our workforce

East Sussex Healthcare NHS Trust

During Quarter 4 Maternity Services have remained stable, vacancy rate (6%), mainly due to staff retiring, sickness overall has improved, with fill rates remaining static. There were zero red flags that resulted in clinical concern.

Our budgeted establishment is in line with Birthrate+ (2022 analysis) and we have recently completed a new review which is being processed.

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

Our 2024 staff survey actions include supporting staff to Speak Up and seek support if they feel discriminated against and to report adverse interactions. Work continues in-regards to flexible working and self-rostering. Challenges continue in filling vacancy due to short term sickness which impacts on staff working additional hours on occasions.

The external independent investigation in Maternity (October 24) recommendations are progressing including a focus on leadership, with an external company supporting the leadership team. A clinical review is currently underway

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 and our Professional Midwifery Advocates (PMA's) and our Trauma Risk Management (TRIM) team, continue to focus on staff wellbeing. Listening events are a regular part of the Mat Neo process for staff.

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

East Sussex Healthcare NHS Trust

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

Rolling 12 month stillbirth rate

- Stillbirth rates for March 25 shows significant deterioration, the rate of 3.81 per 1000 births equates to 10 stillbirths from April 24 to March 25 (latest rolling 12 months) an audit of all stillbirths during 24/25 is currently underway.
- Currently there is no assurance for stillbirths that ESHT will achieve the target reduction rate of 1.81 (red target line) per 1000 births without further improvement.
- Average days in between each event is 46.7

Rolling 12 month Neonatal Death rate

- Performance continues to show a significant improvement since November 2024
- The latest rolling 12 months April 24 to March 2025 is 0.00 per 1000 births (there have been no neonatal deaths in the latest rolling 12 months). The last neonatal death was reported in March 2024.

HIE Grade 2/3

- Performance is showing no significant change since September 2022, Assurance is showing the Trust will consistently meet the target if nothing changes.

Overall PMR

- No significant change since January 2024

Improvements include a maintained high compliance in all areas of our Saving babies Lives V3.2 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 ICB and LMNS and have met CNST requirements for year 6. We continue to make good progress with the aim for full implementation.

Our identified risks are lack of scanning capacity for growth and uterine 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. The department are working towards holding a stand-alone diabetic clinic for those with a pre-existing condition. 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.

Avoiding Term admissions to SCBU are below national average for Q3 (3.8), 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).

Work continues to reduce health inequalities include targeted smoking cessation support, vaccine uptake and healthy weight management, whilst ESHT do not follow national trends for inequalities relating to Black and Asian women and birthing people (see slides 11-14), numbers are very small and focussed work continues, specifically to ensure use of translation services at every contact where required. Currently across the LMNS cases are monitored in real time so we have an accurate picture of activity, we can currently see when these infrequent events are happening, further analysis will continue as data collection increases.

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

East Sussex Healthcare NHS Trust

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

At a local level, with regards to our Claims, Complaints and Risk scorecard and Perinatal mortality reviews, our data is evidencing that we are a learning organisation and for Q4 there were no avoidable perinatal deaths. Actions include improving verbal communication , ensuring advice is sought from tertiary centres were applicable – a recent visit from the maternal medicine network evidenced good working practice, work continues with the neonatal network.

4 MDT cases closed during Q4, actions include a system review of guidance for the management of raised blood pressure in line with NICE Guidance NG133. Consistent management of Did Not Attend (DNA) appointments within the department – appropriate action to manage this has been taken. Zero MNSI cases closed.

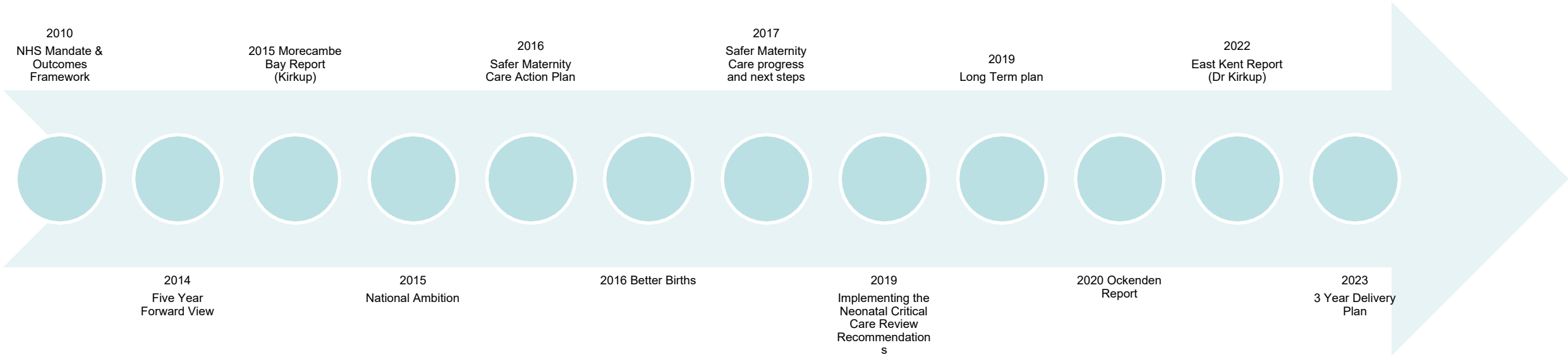
A no harm event took place which met the never event criteria in July 2024. This has been discussed extensively at the Quality and Safety Committee. Action was taken at the time and since to reduce the risk of a reoccurrence. It is important to note that this was the first Never Event reviewed under 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. A second similar no harm event took place in March 2025, significant work continues to reduce the risk of reoccurrence, a full plan of action will be presented in the Q1 25/26 report.

Transitional Care pathway work is ongoing. Across the network main reason for admissions are respiratory. ESHT follows this pattern. A Quality Improvement project underway to reduce admissions to Special Care Baby Unit (SCBU) for respiratory reasons, this has been shared with the LMNS, who are keen for us to share any learning. The project has had a positive impact on reducing the number of respiratory admissions in the first 6 months, the main action has been to review the gestation for elective caesarean sections.

The CQC action plan to achieve 90% for Trust mandatory training, currently averaging at 86% during Q4 (The Quality and Safety committee have seen and agreed key actions to improve overall percentages, with target dates 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

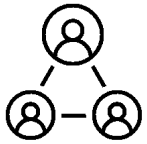
- Objective 1: Care that is personalised .....
- Objective 2: Improve equity for mothers and babies .....
- Objective 3: Work with service users to improve care.....

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 (Q4)

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 Maternity, Early Pregnancy Unit and Special care baby unit, Open Space event scheduled
- 99 individual members of Maternity and Neonatal staff thanked by service users for going above and beyond
- Specific Neonatal and Early Pregnancy 15 steps completed – delivery of actions underway
- Coproduced ESHT and MNVP annual action plan from service user themes. Area with ongoing work: Induction of Labour pathway
- Coproduced ESHT and MNVP action plan following the national CQC maternity survey

Our Service User Voice	
You Said	**We Did**
Improve communication around Induction of Labour	• Worked with the MNVP to provide system –wide service user information regarding IOL, worked with staff to ensure personalised advice and support is provided at all times
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
Provide meals for parents on SCBU	• Worked with the MNVP/ Neonatal unit to ensure provision for all parents

Celebrations & Plaudits

81 individual staff members were named as going 'Above and Beyond' along with lots more general positive comments. We pass on as many of those as possible to staff and create quarterly posters for display on the units.

"Id like to thank the team on SCBU for all of the amazing work they do, they make me feel comfortable, and helped out so much with my little girl. Being in special care is such a hard thing with a preterm baby but they make the experience a bit more better. I'D like to thank Aimee, Jaya, Toni and Anna and all of the amazing ladies that work on that work for looking after my little girl and finally getting us home after 2 long weeks".

Listening to and working with women & families with compassion

East Sussex Healthcare NHS Trust

Improving Equity & Equality

- Improved data collection (18 months of data)
- Monthly equity and equality group
- Robust Public Health services within maternity
- Compliant with Saving Babies Lives (SBL) v3
- Vaccination programme in progress (pertussis, seasonal flu, RSV program commenced 01/09/24)
- Preterm clinic established
- 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

- 4 stillbirths since June 23 – average days in between stillbirths is currently 69 days (139 days in Q 3) – thematic review currently underway of all Stillbirths during 24/25
- 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 levels 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 levels of variation we would expect to see from the process.

20% most deprived outcome measures

6 stillbirths since June 23- thematic review currently underway of all Stillbirths during 24/25

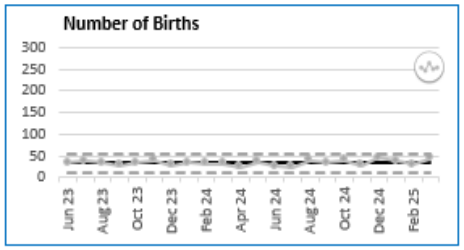
- 1 neonatal death in March 24, since April has shown significant improvement
- 1 HIE grade 1 June 24
- All other outcome measures are showing no significant change and are showing natural levels of variation we would expect to see from the process.

Health Inequalities: BME Population

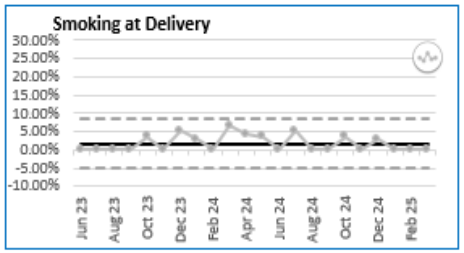
NHS
East Sussex Healthcare

Maternity overview ESHT BME

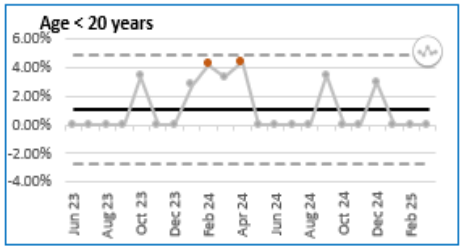
Latest month 01/03/25
Number of Births 43
No significant change



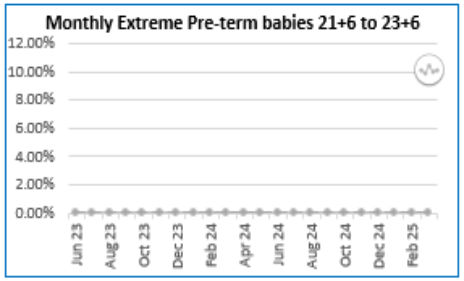
Latest month 01/03/25
Smoking at Delivery 0.0%
No significant change



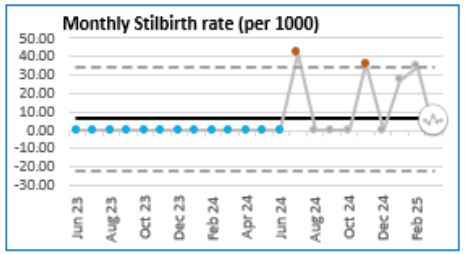
Latest month 01/03/25
Age < 20 years 0.0%
No significant change



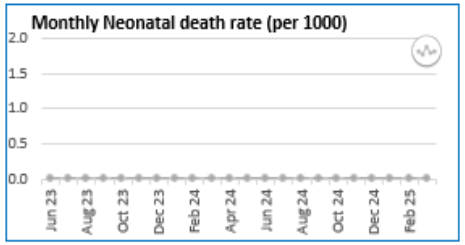
Latest month 01/03/25
Monthly Extreme Pre-term babies 21+6 to 23+6 0.0%
No significant change



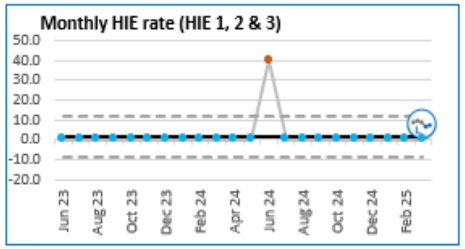
Latest month 01/03/25
Monthly Stilbirth rate (per 1000) 0.00
No significant change



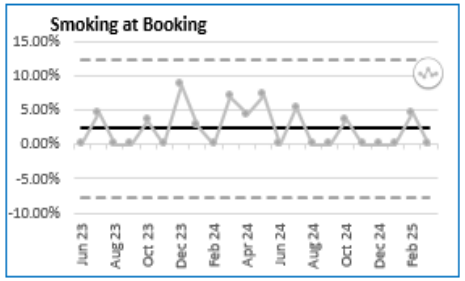
Latest month 01/03/25
Monthly Neonatal death rate (per 1000) 0.00
No significant change



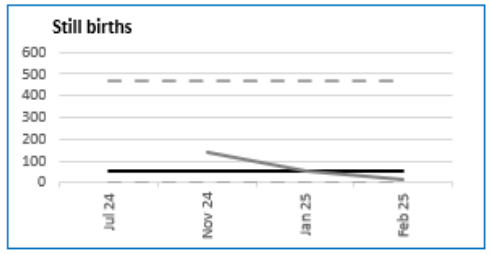
Latest month 01/03/25
Monthly HIE rate (HIE 1, 2 & 3) 0.00
Significant Improvement



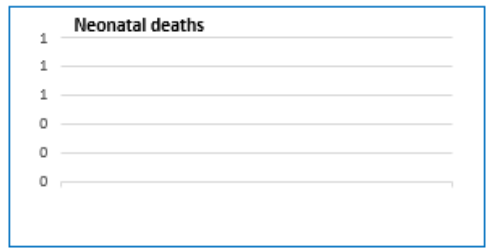
Latest month 01/03/25
Smoking at Booking 0.0%
No significant change



Date of last stillbirth 03/02/25
Average days between stillbirths 68.0
No significant change

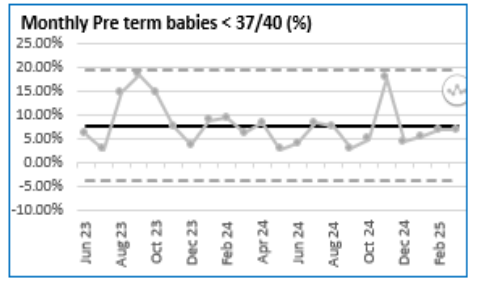


Date of last neonatal death
Average days between deaths
No significant change



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

Latest month 01/03/25
Monthly Pre term babies < 37/40 (%) 7.0%
No significant change



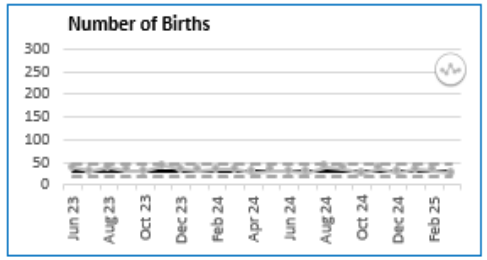
Health Inequalities: 10% most deprived

Maternity overview | ESHT 10% most deprived

Latest month 01/03/25

Number of Births 26

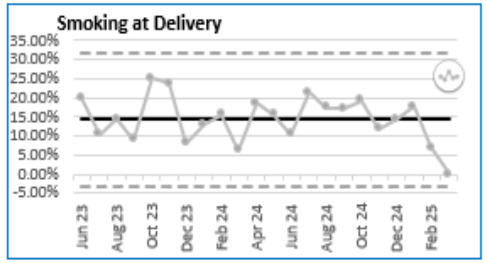
No significant change



Latest month 01/03/25

Smoking at Delivery 0.0%

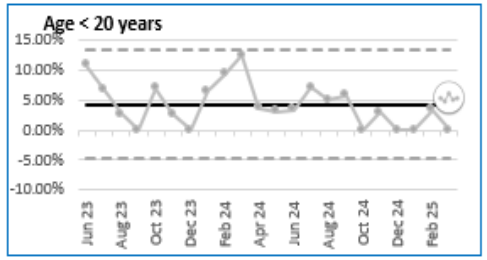
No significant change



Latest month 01/03/25

Age < 20 years 0.0%

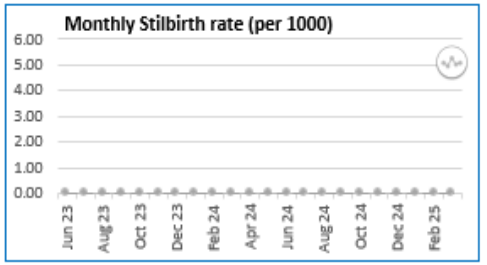
No significant change



Latest month 01/03/25

Monthly Stilbirth rate (per 1000) 0.00

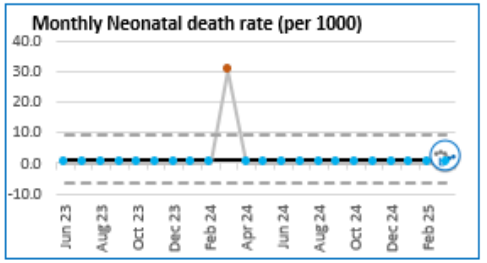
No significant change



Latest month 01/03/25

Monthly Neonatal death rate (per 1000) 0.00

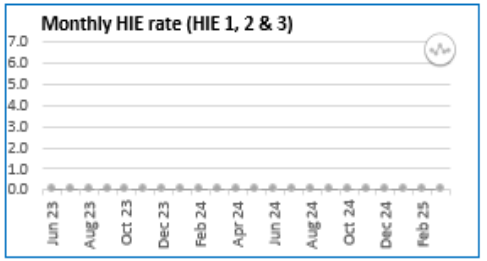
Significant Improvement



Latest month 01/03/25

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

No significant change



Date of last stillbirth

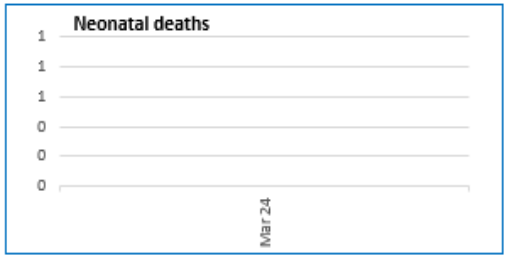
Average days between stillbirths

No significant change

Date of last neonatal death 18/03/24

Average days between deaths

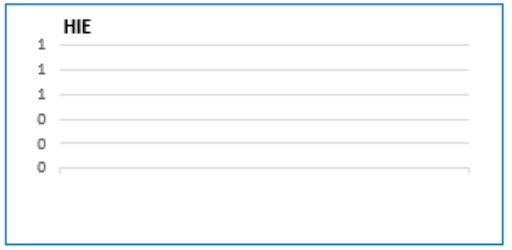
No significant change



Date of last HIE

Average days between HIE

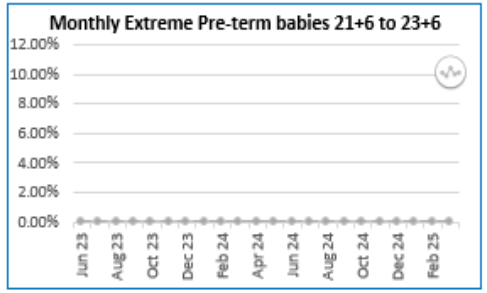
No significant change



Latest month 01/03/25

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

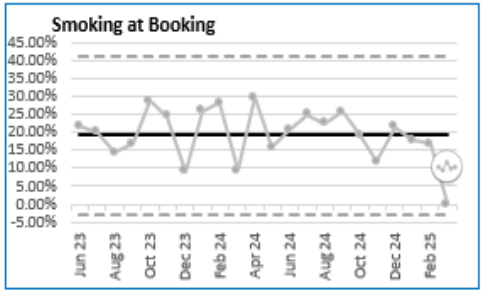
No significant change



Latest month 01/03/25

Smoking at Booking 0.0%

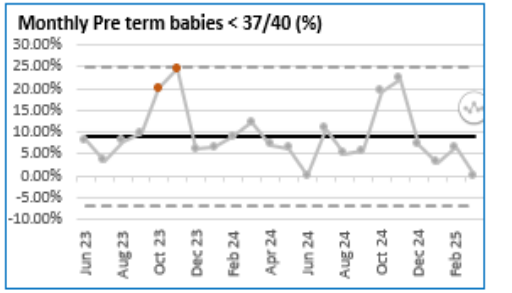
No significant change



Latest month 01/03/25

Monthly Pre term babies < 37/40 (%) 0.0%

No significant change



Health Inequalities: 20% most deprived

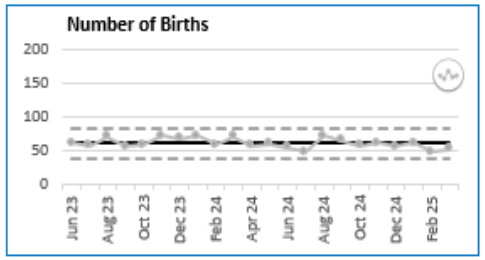
Maternity overview

ESHT 20% most deprived

Latest month 01/03/25

Number of Births 53

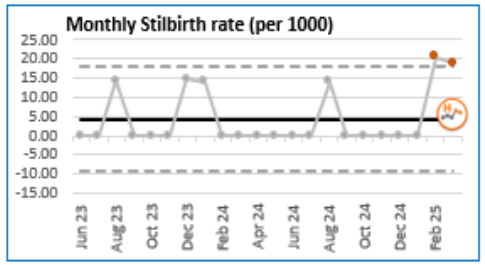
No significant change



Latest month 01/03/25

Monthly Stilbirth rate (per 1000) 18.86

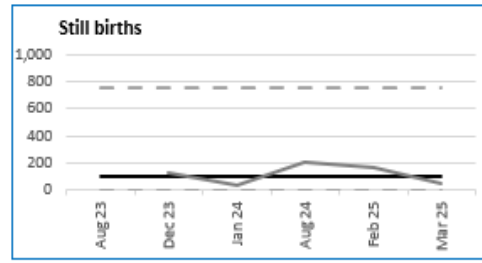
Significant deterioration



Date of last stillbirth 31/03/25

Average days between stillbirths 121.4

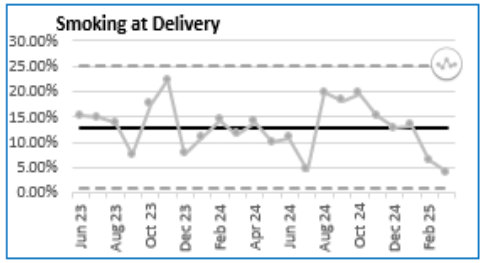
No significant change



Latest month 01/03/25

Smoking at Delivery 4.0%

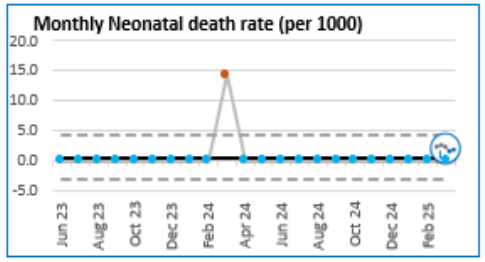
No significant change



Latest month 01/03/25

Monthly Neonatal death rate (per 1000) 0.00

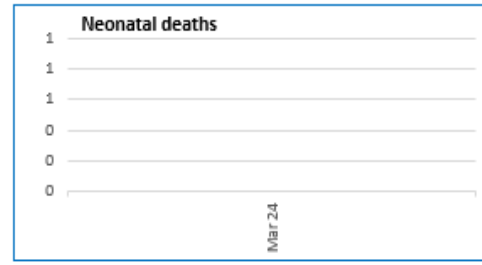
Significant Improvement



Date of last neonatal death 18/03/24

Average days between deaths

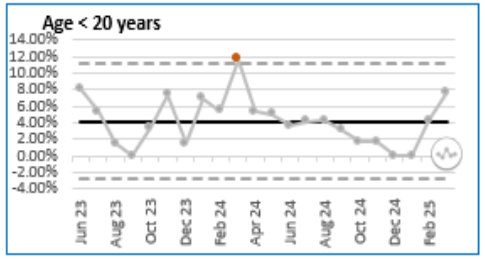
No significant change



Latest month 01/03/25

Age < 20 years 7.7%

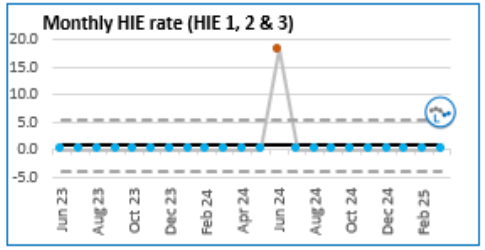
No significant change



Latest month 01/03/25

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

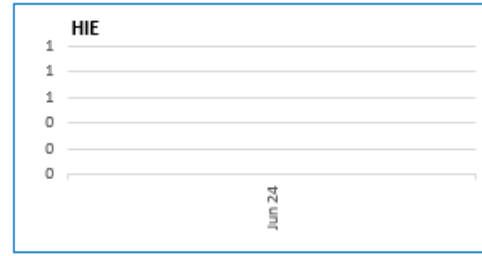
Significant Improvement



Date of last HIE 08/06/24

Average days between HIE

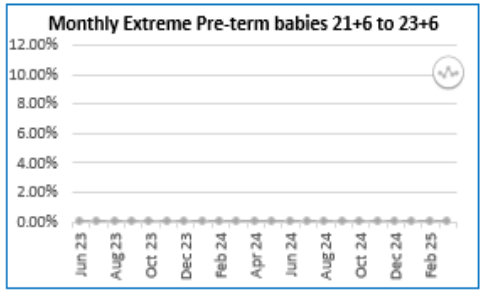
No significant change



Latest month 01/03/25

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

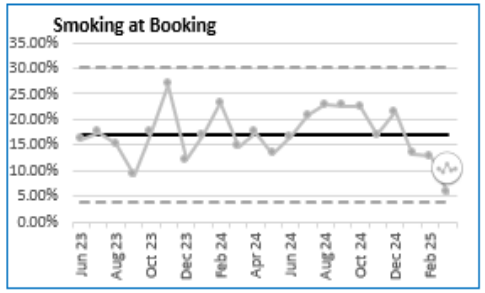
No significant change



Latest month 01/03/25

Smoking at Booking 5.8%

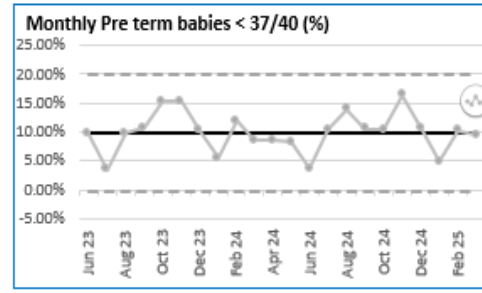
No significant change



Latest month 01/03/25

Monthly Pre term babies < 37/40 (%) 9.4%

No significant change



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%	5.06%
Maternity Leave	4.7%	4.23%	4.1%	4.16%
Vacancy rate	1.6%	0.66%	5.0%	6.6%
Midwifery total fill rates	89.2%	86.7%	86.8%	92.7%

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

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

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

Three Year Delivery Plan: Theme 2

Growing, retaining and supporting our workforce

Our workforce

East Sussex Healthcare NHS Trust

Medical workforce: Obstetrics

- Consultants: 96% compliance with RCOG Roles and Responsibilities (audited quarterly)
- Consultants: Compensatory rest, compliant with RCOG guidance
- Middle grades: full compliance with RCOG guidance on employing short and long term locums

Neonatal staffing: Medical

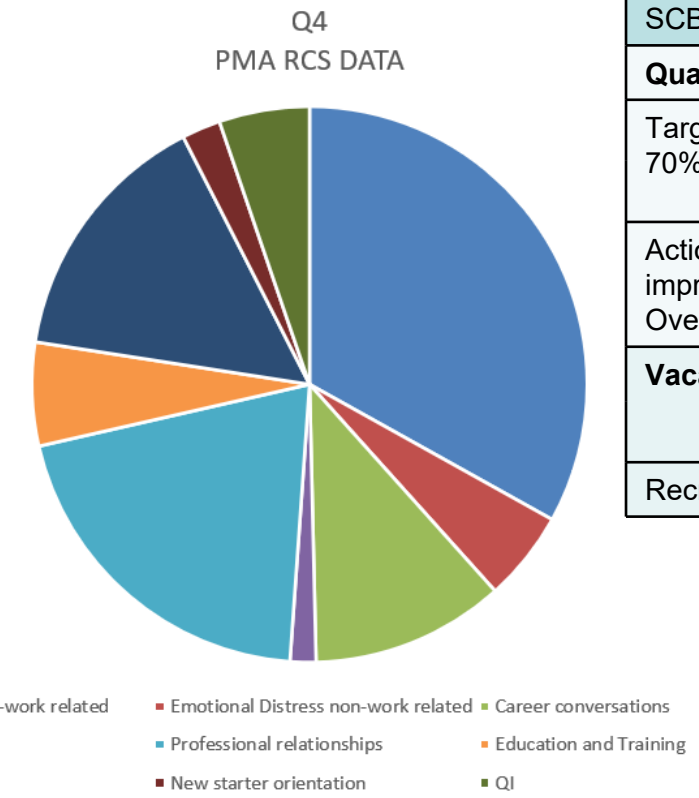
Meets the British Association of Prenatal Medicine (BAPM) national standards of neonatal medical staffing

Clinical Maternity Red Flags Q4

No Red flags which led to clinical concern

Staff Feedback Themes Q4

- Support provided to 556 Individuals
- Emotional distress, work related remains the biggest reason for support (33% Q4 – 37% Q3). Main themes, missed breaks due to short term sickness
- Actions include: Self-Rostering (QI project - ongoing)
- Review of Maternity footprint to improve flow
- Improved management of breaks



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%	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%	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

East Sussex Healthcare NHS Trust

Training Needs Analysis (TNA)

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

MatNeo Staff Survey Score report/ Staff Survey (2024)

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

- Improvements surrounding managing reasonable adjustments/flexible working
- Empowering staff to speak up and report adverse interactions/physical violence/unkind behaviour
- Support staff to speak |up where they feel discriminated against
- Challenges in filling some shifts due to sickness/absence/vacancy

Actions

- Staff listening events in place and ongoing – targeted events planned for 2025
- Staff encouraged to report any adverse incidents/concerns – listening events to understand what mat get in the way of this process
- Additional input from managers to support the management of reasonable adjustments

Recruitment & Retention 3 year plan

Programme Aims

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

Key risks & mitigations

Responding to recommendations from the Independent maternity review:

- Harnessing full engagement from colleagues at all levels, Trust investment to supporting strong leadership investment at all levels
- Tighter controls for recruitment,
- 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

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 Benchmark 5%

	Q1	Q2	Q3	Q4
Rate	5.2	3.8	3.7	3.8

Key actions:
- Quality Improvement project for Respiratory Distress Syndrome(RDS) progressing, 2 RDS cases Q4 (improvement noted)
- Continued downward trend in caesarean section rates at 37 weeks
- Order further equipment for transitional care (hot cot equipment)

(below the national average rate for Q4)
- 22 cases reviewed
- 3 potential avoidable timing of LSCS/GA

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	Transient tachypnea of the Newborn (TTN)
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	Review of LSCS

Saving Babies Lives (SBL) V3 Q4 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

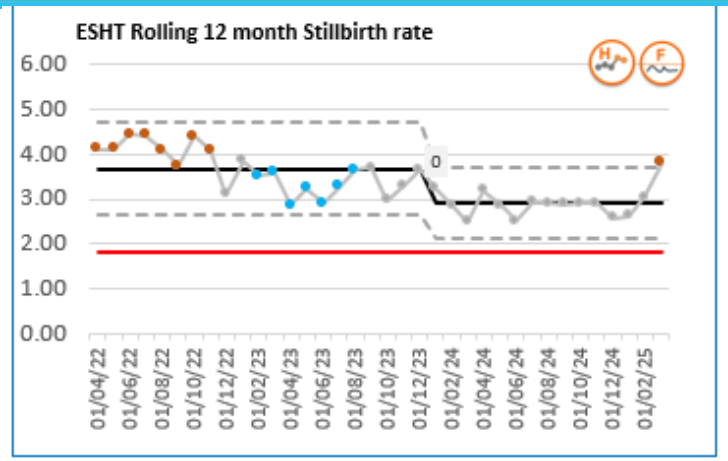
MDT Training target >90% at year end

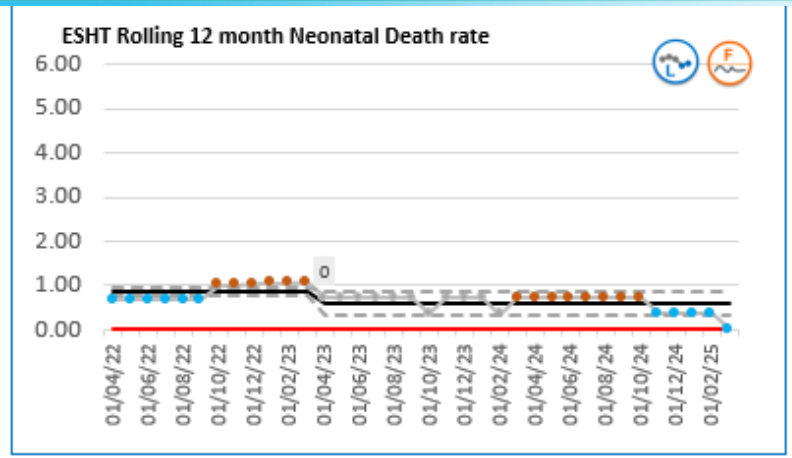
CTG & fetal monitoring training competency	Q1	Q2	Q3	Q4
Combined Medic & Midwives	98%	94%	97%	98%
PROMPT compliance	**Q1**	**Q2**	**Q3**	**Q4**
Combined Medic & Midwives	90%	97%	93%	90%

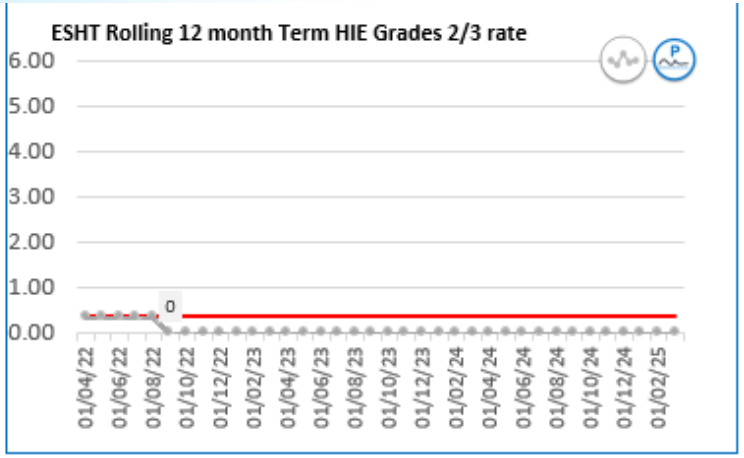
Developing and sustaining a culture of safety, learning and support

Perinatal Quality & Safety

East Sussex Healthcare NHS Trust







Rolling 12 month stillbirth rate

- Stillbirth rates for March 25 show significant deterioration, the rate of 3.81 per 1000 births equates to 10 stillbirths from April 24 to March 25 (latest rolling 12 months)
- Currently there is no assurance for stillbirths that ESHT will achieve the target reduction rate of 1.81 (red target line) per 1000 births without further improvement.
- Average days in between each event is 46.7

Rolling 12 month Neonatal Death rate

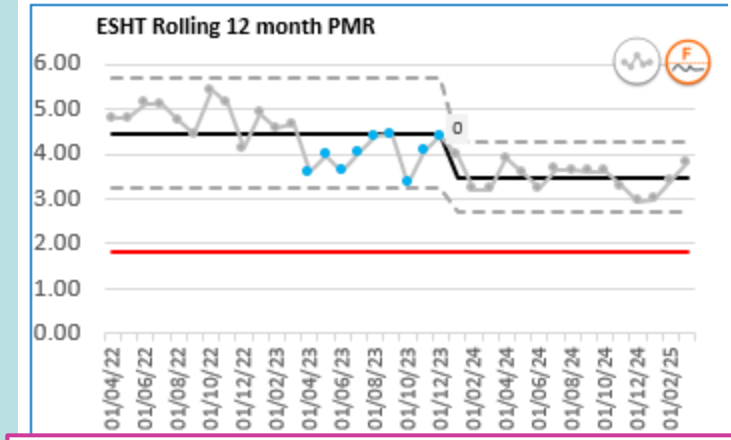
- Performance continues to show a significant improvement since November 2024
- The latest rolling 12 months April 24 to March 2025 is 0.00 per 1000 births (there have been no neonatal deaths in the latest rolling 12 months). The last neonatal death was reported in March 2024.

HIE Grade 2/3

- Performance is showing no significant change since September 2022, Assurance is showing the Trust will consistently meet the target if nothing changes.

Overall PMR

- No significant change since January 2024



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

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)

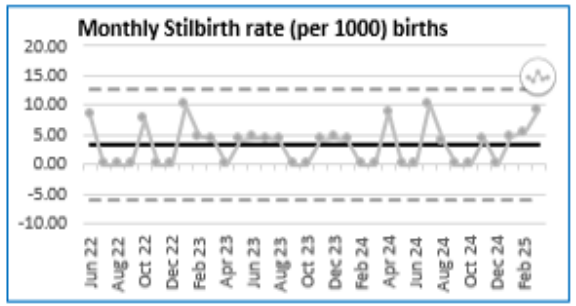
Developing and sustaining a culture of safety, learning and support

Perinatal Quality & Safety

East Sussex Healthcare NHS Trust

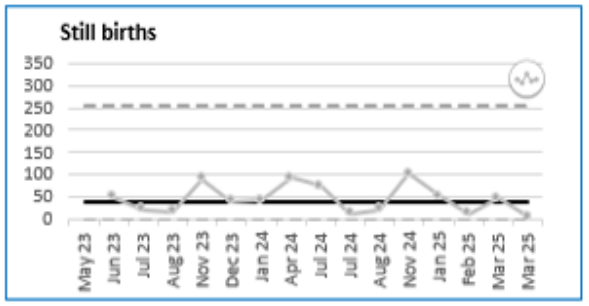
Latest month	01/03/25
Still birth rate/1000	9.09

No significant change



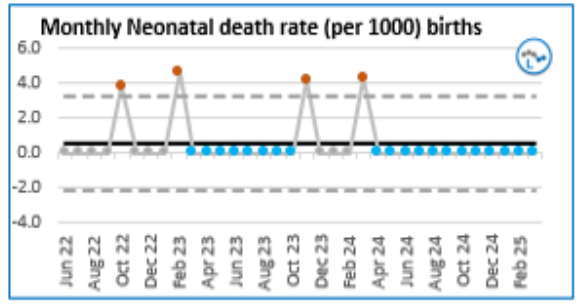
Date of last stillbirth	31/03/25
Average days between stillbirths	46.7

No significant change



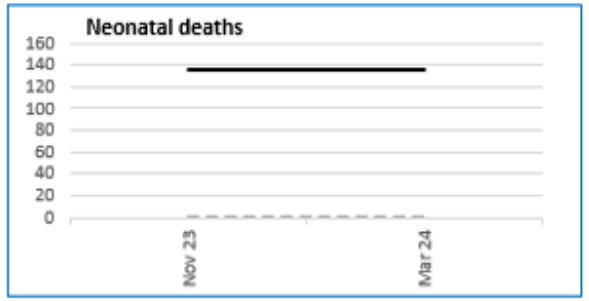
Latest month	01/03/25
Neonatal Death rate/1000	0.00

Significant Improvement



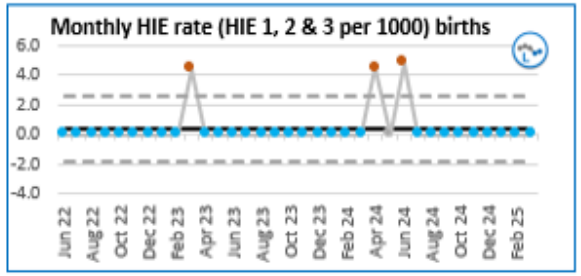
Date of last neonatal death	18/03/24
Average days between deaths	136.0

No significant change



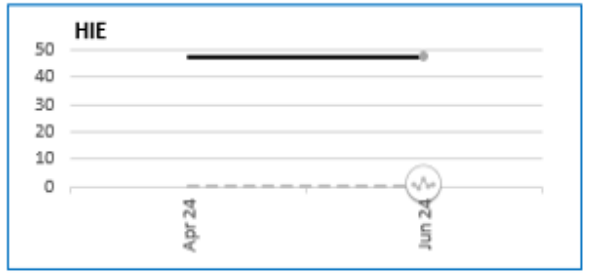
Latest month	01/03/25
HIE rate/1000	0.00

Significant Improvement



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

No significant change



Rare event charts are updated in real time and show the average days between stillbirths, neonatal deaths, and HIE (all diagnosis), further analysis will be possible as we increase this data collection. Stillbirth audit currently underway

Step changes have 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

Perinatal Quality & Safety

East Sussex Healthcare NHS Trust

Closed Incidents	
Incident type	**Recommendations/ actions**
Closed MDT Cases WEB164339 (2024 case)	• Review of consistency for managing service users who DNA appointments, improvement of liaison with external drug and alcohol services
WEB166904 (2024 case)	• Ensure RCOG guidance is followed in regard to consultant presence (audit ongoing quarterly) • Reminder to staff regarding contemporaneous documentation
WEB150180 (2023 case)	• Raised Blood Pressure to consistently be managed in line with NICE Guidance NG133 (new network guidance released late 2024) review of local policy in progress, included in MDT mandatory training program • Home monitoring of Blood Pressure is good practice – local guidelines reviewed
INC388 (2024) (Neonatal)	• Use of teleconferencing to tertiary units for unusual situations explored. Review of EPALS training for paediatric consultants completed
INC5219 (2024)	• Sterilisation guidelines reviewed. Senior clinicians encouraged to seek a second opinion in exceptional circumstances
Closed MNSI/PSII Nil	

Developing and sustaining a culture of safety, learning and support

East Sussex Healthcare NHS Trust

Maternity Incentive Scheme (MIS)

YEAR 7:
- Full MIS year 7 document and accompanying resources published 02/04/25
- No key risks identified against compliance for MIS year 7 to date

Year 6 Fully compliant against all 10 safety actions
Maternity Incentive Scheme year 6 results have been published and can be accessed on their website

Year 7 Safety Actions	
SA1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?
SA2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
SA3	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?
SA4	Can you demonstrate an effective system of clinical workforce planning to the required standard? a) Obstetric medical workforce b) Anaesthetic medical workforce c) Neonatal medical workforce d) Neonatal nursing workforce
SA5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?
SA6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?
SA7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.
SA8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
SA9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?
SA10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Three Year Delivery Plan: Theme 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

3 closed claims during Q4, 5 closed complaints, 5 closed severity 3,4,5 incidents
Learning themes from closed claims, complaints & Severity 3,4 & 5 Incidents

- Improve verbal communication between service users and staff, use of MDT for complex cases
- Improve written documentation, clear instruction documented within electronic records
- Review within acute and community services to ensure service users are advised regarding seeking and self –administration of pain relief
- Review of guidelines to ensure they are written in line with latest NICE Guidance

Perinatal Mortality Review Tool (PMRT)

- 100% compliant with all standards (MIS Yr7)
- 100% compliant for standard of 50% of the deaths reviewed, with an external member present at the multi-disciplinary review panel meeting

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 (m12 average 86%)

All other actions complete

Preview for Q1

M1/April 2025 data

- Appraisal: 85%
- Think Family L3: 87%
- Basic Life Support: 88%
- Blood Transfusion: 88%

NHSE/CQC Self Assessment Tool

- Red item: Patient Story
- Amber item: PDR rates ≥ 90%
- Green items: all other areas

Demonstrating transitional care (TC) services quality improvement to minimise separation of parents and their babies – good progress, reduction in respiratory distress admissions

NHS
East Sussex Healthcare
NHS Trust

2024/25 ESHT MatNeo Services

Celebration of achievements against the three-year delivery plan during 2024/25

Theme 1: Work with Service Users to improve care (Coproduction)

East Sussex Healthcare NHS Trust

24/7 visiting (supporter of choice)

Daily Senior walkabout

Improved discharge process

Dedicated infant feeding pods

Personalised Care and Support Plan relaunch

MatNeo website review

Annual MNVP plan delivered in line with 3 year delivery plan

Annual triangulation of feedback

Quarterly MNVP Meetings (very well attended by MDT)

Funding approved to refurbish pregnancy loss clinical room

Changes to mandatory training such as inclusion of new video scenarios using our SU's voice with input from MNVP (lived experience films), SU experience included in training such as CTG/PCSP

Coproduced work to provide meals for parents while admitted in SCBU

Bespoke Bereavement Suite with 7 day per week specialist support

Open Space event (Neonatal – May 25)

Refurbished SCBU parent room

Monthly parent support group (Tesco community room) facilitated by the neonatal team

unicef UNITED KINGDOM

THE BABY FRIENDLY INITIATIVE

Full BFI Stage 2 assessment

22 & 23 October 2025

ESHT Maternal Medicine for 2025

- Preconception clinics commenced for pregnant people with pre-existing medical conditions.
- Continuing to improve MDT working with other specialities- Joint gastroenterology clinics.
- Part of the EPISAFE National Audit of Care for Pregnant People with Epilepsy in the United Kingdom, ongoing through 2025

Continuity of Carer

- Lighthouse Team: Young parents under 20 years working cross-site
- Ivy team: Birth at home; support for parents with enduring Mental Health concerns; Level 3-4 safeguarding; women & birthing people who's first language is not English; those from ethnic minority backgrounds and most deprived areas. Plan to recruit specialist MH care coordinator (midwife) for both continuity teams
- Provide care for 15% of ESHT birthing population.
- BR+ Review (2025 review) additional information includes the additional staff required should the Trust consider 2 further continuity teams.

Theme 2: Workforce: Sufficient staff across the whole MatNeo service (including trainees), who feel valued and supported; Local plans to reduce workforce

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Consultants

x15, 10 on the on-call rota 2 of whom are pure Obstetricians, 70 hours Consultant presence on the delivery suite per week, Weekend Ockenden evening ward round job planned.

- SCBU specific study days six monthly
- Unit meetings held every 8-10 weeks where positive achievements and improvement requirements are discussed.
- Annual PDR is 99% (SCBU)
- Neonatal preceptorship training facilitated by the neonatal network
- Multicultural training/workshop available for all staff
- Funded neonatal training module

10 student midwives (8 internal; 2 external) requesting jobs

2 apprentice midwives due to finish September 2025 (hours allocated)

Flexible Working/Career Breaks/Secondments supported where possible (5 career breaks supported to date)

Majority of staff have some sort of flexible working agreement

Currently reviewing team-rostering

Reasonable adjustments implemented where required

- Temporary staffing update – In line with RCOG guidance (compliant with MIS yr 6)
- Positive GMC survey, no red flags, 2 green flags for Study Leave and Regional teaching
- Weekly Obstetric Education programme
- Quarterly LFG MDT meetings
- Good support for students GMC surveys (Nov 2024) Neonatal – zero red flags. Obstetric – overall positive, work includes USS capacity for training – teaching/supervision sessions have now moved to face to face

- Robust Recruitment and Retention strategy
- 6 monthly workforce review incudes Medical, Midwifery, Nursing, Anaesthetic, Neonatal - quarterly update to Trust Board/LMNS workforce meeting.
- Engagement with National, Regional, local workforce programmes i.e. MSW programme
- Excellent co-production with the LMNS (e.g. local legal awareness, CTG training)
- Medical MatNeo workforce, compliant processes in line with GMC, BAPM
- Midwifery workforce; compliant with BR+ (MIS compliant year 6), A-Equip model fully implemented within services
- Excellent Education programmes for MatNeo staff
- Commenced implementation of LWC framework

Theme 2: Workforce

Immersive film project
Produced a film of a pregnant person's journey through maternity services, to pilot a new initiative, learning through story telling. Feedback so far overwhelmingly positive with 100% of participants finding this more interactive and 97% of participants preferring this style of teaching. Learning demonstrated with knowledge increasing by over 50% on every session.

Role specific study day developed for Maternity Support workers and Nursery nurses
After much feedback that typical mandatory study days for maternity do not always have relevance to these roles, we have launched a specific day for them based on this feedback – so far really well evaluated

Maternity Prompt & Fetal Monitoring Mandatory training
Consistently above 90%

T Level placements
Introduced into maternity – supporting the promotion of midwifery to contribute to retention and recruitment

LMNS & SECAMB collaborative training developed
Learning themes identified in home birth emergency scenarios – training days developed in response to this that allow community midwives and ambulance staff to train together

Regular skills drills
Supported in all areas, not just the acute – including community and the midwife led unit

NHS
East Sussex Healthcare
NHS Trust

PETALS QI project continues to be successful
With OASI rates remaining lower than the national average

Education faculty members NLS qualification
Achieved (or in the process). One faculty member has been 'instructor potential'd' and will complete her instructor course, providing us with the necessary requirements for MIS.

Opportunities for development
Over the last 1-2 years we have supported over 30 members of staff with applications for funding for external learning – supporting their professional development as well as intending to support retention of staff

Supporting students in Maternity

- Robust, welcoming Induction process (includes paramedics, student midwives, medical students, T-Level students
- Practice-based support to students. All are supernumerary with named practice supervisor on each shift.
- 2 named Practice Assessors (PA) for each academic year for support
- Access to named Professional Midwifery Advocate
- PEF provides monthly staff updates; NMCs Standards for Supervision and Assessment, NHSE Safe Learning Environment Charter (SLEC), information on PA training and all practice related information/themes/updates
- Workshops (feedback through evaluation forms), placement evaluations – feedback disseminated
- OSCE practice sessions with the 2nd year student midwives.
- Monthly Student Forums, Interview preparation sessions
- The Link Lecturer site visits monthly
- 3-yearly clinical placement audit - provide assurance regarding the quality of the practical learning environment

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In addition to our mandatory and statutory training, we have supported staff to complete the following training courses

- Maternity Enhanced Care Unit (MECU) training 17.61 wte (incl. 3.98 labour ward coordinators, 15.08 in acute unit). Working with Healthroster to identify staff easily and ensure one on each shift.
- Newborn and Infant Physical Examinationn (NIPE) training
- Antenatal Results and Choices (ARC)
- Maternity Support Workers (MSW) framework training/conference in Birmingham
- Professional Midwifery Advocate (PMA) training
- TRiM training – PMA's
- Birth Rights Study day
- Florence Nightingale Sustainable Leaders Programme
- SE Neonatal Conference

- Obstetric Immediate Life Support (OILS) – in-house
- Postnatal Contraception
- Optimal Birth
- SECAMB pre-hospital emergencies
- SECAMB homebirth emergencies
- NLS/ALS courses
- Mock Coroner's court
- Courageous conversations
- Jaundice Study day
- Perinatal Mental Health Simulation
- Maternal Medicine Network Event

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

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Research focussed

Praised for outstanding contributions to research study

In early 2024 ESHT were selected as 1 of 40 NHS trusts across England, Wales, Scotland and Northern Ireland to implement a new childbirth care bundle that helps to recognise bleeding early and to standardise the treatment of heavy bleeding during childbirth.

The aim of the OBS UK study is to improve care of pregnant people who bleed during childbirth

ESHT's OBS UK delivery team were 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.

"the progress you have made in adopting all aspects of the bundle at this stage in your implementation period is nothing short of outstanding."

Theme 4: Data Informing Learning

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- Ongoing use of Equity and Equality dashboard to inform services
- MSDS data submitted in line with monthly requirement (MIS yr 6 compliant)
- Regular meeting with MNSI
- Fully compliant with MBRRACE and PMRT reporting

Better use of digital technology

- Digital Strategy in place (2022)
- Trust Digital lead in post (2023)
- Perinatal digital lead – In post (2023)
- Senior Quality and Safety manager in Post
- Developed Neonatal Scorecard (standardised across LMNS 2024)
- Badgernet fully embedded (continuous improvement cycle)

Translation services : Computer on wheels, ongoing training. Audit May 2024. 80% aware of interpretation service, 97% aware of language line compliance. Re-audit due imminently. Top ten languages added to Badgernet. Website supports alternative language choice.

SCBU: successful BLISS accredited in 2022 -2025, ongoing audits and data collection to support 2026 review.

Managing IOL delays: Main indication for delay relates to labour ward transfer for ongoing process due to workforce or acuity. Risk assessment by Obstetrician (twice daily). Plan made with service user. Identify on BR+ acuity app as red flag as per definition. Raise as risk(datix). Ongoing communication with parents, new IOL leaflet explaining process. All delays shared with NHSE regional team fortnightly.

Managing the increase in C/Sections (demand and capacity): overall increase noted. Four elective c/s lists per week – up to three on each list. Recommendation for second theatre to manage emergency cases – footprint review.

Successful service change (QI Project)

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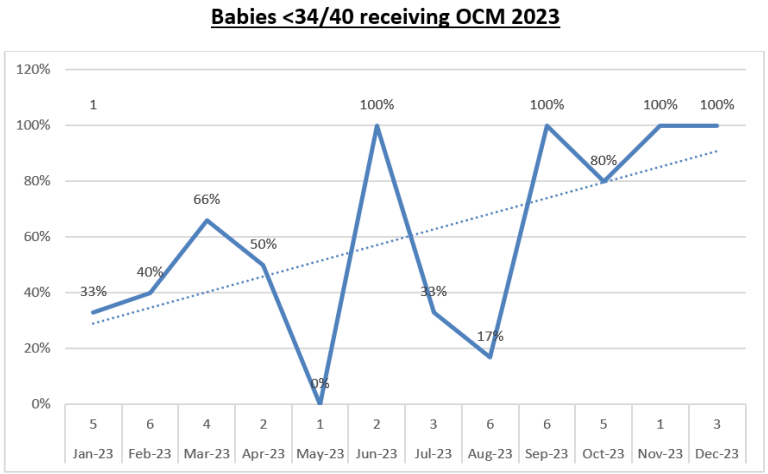
Optimal Cord Management (OCM) is a simple, evidence-based practice that improves newborn outcomes, especially in preterm babies. Delaying cord clamping by at least 60 seconds enhances placental transfusion, reducing mortality by 28% in babies ≤32 weeks gestation. OCM also lowers the need for blood transfusions by 10% and improves blood pressure, reducing the need for inotropes. The World Health Organization recommends delaying cord clamping for at least 60 seconds in preterm babies, except in specific medical situations.

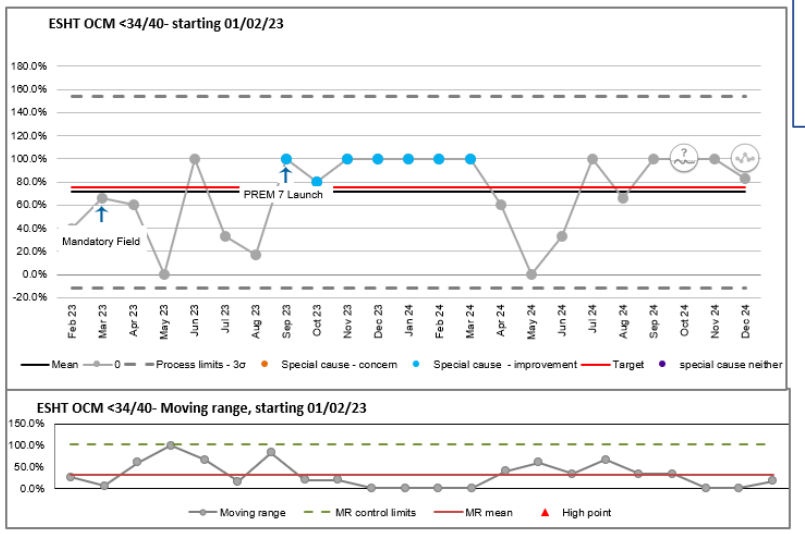
Aims
All babies born <34 weeks gestation should have their umbilical cord clamped at least 60 seconds or more after birth, except when there are specific documented maternal or fetal conditions.

Methods
QI working group
MDT Education, guidelines, study days.

British Association of Perinatal Medicine

Results
Following our launch we have increased OCM compliance from 33% to 80% for our babies born ≤34 weeks.





Conclusions
We have increased OCM compliance for babies born under 34 weeks from 33% to over 80%. Our findings indicate that non-compliance primarily occurs in babies born in theatre requiring resuscitation. To address this, we are procuring necessary equipment and launching MDT-led SIMS training to enhance compliance further.

What is really driving UK Preterm birth rates?

A real-world deep dive beyond the metrics

Authors: Watson H A, Englefield M, Johnson M

East Sussex Healthcare

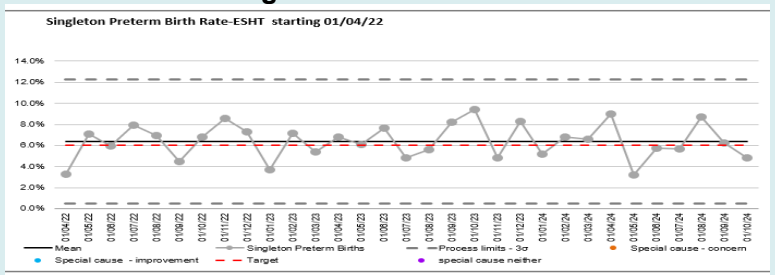
PREM 7+

1.Introduction

The Saving Babies Lives Care Bundle has provided a national focus on reducing preterm birth (PTB) and its associated morbidity and mortality. Reporting preterm and antenatal optimisation rates aims to raise standards, ensure equity and identify outliers. However, these standards overlook the diversity of preterm birth causes and the role of iatrogenic (medically-indicated) deliveries. Failing to investigate the causes of preterm birth limits clinicians' ability to improve outcomes and may misdirect resources.

This deep dive of preterm births < 37 weeks in our deprived coastal community, seeks to better understand our population and practices.

SPC chart showing ESHT singleton preterm birth rate mean average over 31 months = 6.36%

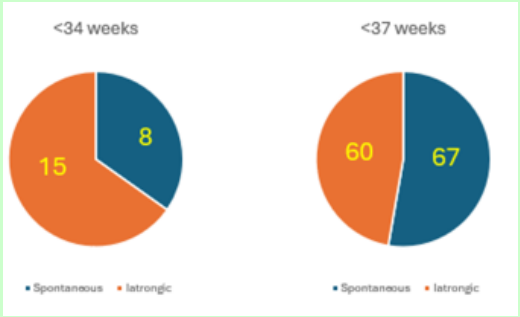


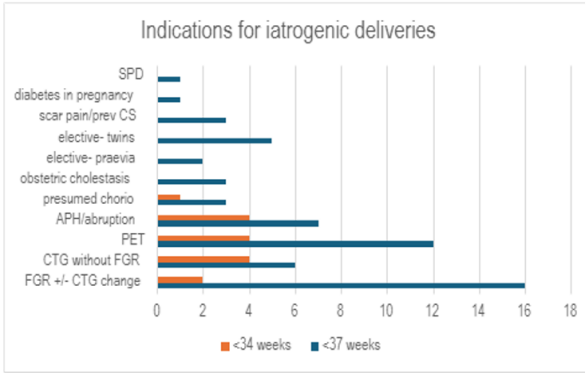
2. Methods

A prospective audit of all births < 37 weeks in our maternity unit from January 1st to August 31st 2024, was conducted. Eligible women were identified from digital records, and data was collected on demographics, preterm birth risk factors, prophylactic interventions, preterm presentation characteristics (e.g. vaginal bleeding, PPROM, contractions) reason for iatrogenic delivery, antenatal optimisation and neonatal outcomes. Each case was reviewed by a a specialist consultant and midwife to determine the leading cause before analysis.

3. Results

In the 8-month time period, 127 women delivered < 37 weeks (145 babies due to twins), representing 7.12% of the population.

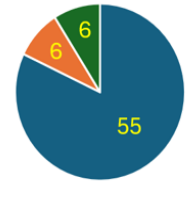




47% of preterm births were iatrogenic, 65% of births < 34 weeks were iatrogenic. 71% (48/65) of iatrogenic deliveries followed national guidelines. Iatrogenic causes varied by gestation, with obstetric emergencies like antepartum haemorrhage, pre-eclampsia, and abnormal CTG leading to early preterm births, Elective deliveries for twins and placenta praevia occurred at late preterm gestation.

Among spontaneous preterm births, 82% had no risk factors, though 53% had recorded mental health or learning difficulties. PPROM was the most common presentation, followed by vaginal bleeding, leaving only 17% eligible for predictive tests like fetal fibronectin or Actim Partus.

Spontaneous preterm birth risk factors



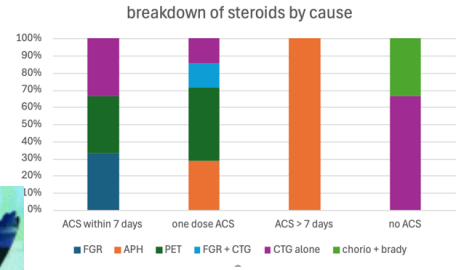
- All seen appropriately – no treatment required.
- 21% smokers
- 5% non-English speakers
- 37% had social flags
- 53% mental health/ learning difficulties

4. Conclusion

This analysis of preterm births in a typical UK maternity unit highlights the significant role of iatrogenic delivery. To prevent preterm births, it is crucial to first identify and exclude those that should not be prevented before comparing crude rates. Our deep dive has also identified key areas for improvement, such as PPROM diagnosis, scar pain, and social deprivation. If these findings are reflected in larger datasets, they could guide future research and have a meaningful real-world impact.

Trends in steroid delivery by iatrogenic cause

- small numbers
- Delivery for FGR anticipated so we are getting it right
- APH unpredictable and recurrent- correct management adhered to
- Always worth one shot?



Achievements

Key achievements in our preterm clinic

- The introduction of a robust triage system has significantly improved compliance – (July 2023) e.g. cervical length (CL) measurements for women with previous FDCS—rising from 10% in 2022 to 100% in 2024.
- Reduced unnecessary appointments. In 2024 following preterm triage more than 80 appointments were not appropriate for preterm clinic, allowing us to offer cervical length scans for twins in line with NICE guidelines.
- Piloting enhanced midwifery care for women who have undergone a cervical suture. We also share high risk preterm “alerts” at the perinatal meeting.
- As part of work towards IUT improvement- Ellie Watson is attending the monthly LMNS preterm network meeting where they share learning and co-producing guidance.

Summary

East Sussex Healthcare NHS Trust

- ESHT provides a high-quality safe service for pregnant people and their families
- We continue to embed the 3 Year delivery plan within MatNeo Services
- We welcome scrutiny of our services
- Ongoing assurance via Perinatal Quality Surveillance Model & Neonatal Dashboard
- We continue to learn and improve through education, audit, data analysis and feedback from our service users and staff
- Importance placed on Service User feedback (continuous improvement cycle) – Excellent relationships as an MNVP
- Importance placed on staff health and wellbeing who in turn provide high quality supportive care to our service users
- Good relationship with Trust Board and key Stakeholders with robust reporting and escalation processes

Agenda Item: [12]

Report To/Meeting	Trust Board Public Paper	**Date of Meeting**	24th June 2025

Report Title:	Freedom to Speak Up Guardian Report Quarter 3 (October-December 2024) Quarter 4 (January to March 2025)
Key question	What assurance can the Freedom to Speak Up Guardians provide to colleagues of ESHT to feel able to speak up safely?
Decision Action:	For approval ☐ For Assurance ☒ For Information ☒ For Discussion ☒

Report Sponsor:	Steve Aumayer Deputy CEO & CPO	**Presenter(s):**	Ruth Agg Dominique Holliman
Outcome/Action requested:	The Board is asked to receive assurance about the activities of the Freedom to Speak Up Guardians from the attached report.		

Executive Summary

The FTSUG's are required to report to Trust board twice a year. This report was presented to the People and Organisational Development Committee (POD) prior to Board on 29th May 2025. This paper is for the Public Board meeting.

This report seeks to provide assurance on the proactive and reactive activities of the Freedom to Speak Up (FTSU) Guardians and insight into the themes raised from cases. It also provides assurance that the FTSU Guardians respond effectively to workers who speak up. They ensure that people are thanked, the issues they raise are responded to and that the person speaking up receives feedback on the actions taken. Recognition of the learning opportunities from staff who speak up can only improve patient safety, staff wellbeing and culture.

The Guardians have been compliant with submitting anonymised quarterly data to the National Guardians Office (NGO), which is a mandatory requirement.

- This report provides an overview of the activity of the Freedom to Speak Up Guardians for quarters 3 and 4 in 2024/2025. It gives the recorded concerns raised by staff groups and the key categories of concerns.
- The majority of concerns were raised by registered nurses and midwives, followed by administrative and clerical staff.
- Inappropriate attitudes and behaviours remain the leading reason for speaking up. Incidents of incivility feature prominently and it is notable that many colleagues have tried to raise concerns through their line management.
- Improvement in mandatory training to support speaking up and listening up to support continued emphasis on ensuring managers and leads are equipped to respond appropriately and effectively to concerns.
- National Guardian Office updates including new detriment guidance, the findings of the overseas trained workers report, the annual report a new Job Description for FTSUG's

	• Seeking to improve the sharing of learning from Speaking up and the communication to staff.
Regulatory/legal requirement:	Compliance with CQC Well-Led Framework, requiring organisations to foster a culture of openness and learning.
Business Plan Link:	Quality ☒ People ☒ Sustainability ☐
Equality, Diversity, and Inclusion Impact Assessment/Comment	EDI considerations are core to the Freedom to Speak Up service. Reports of discrimination and concerns raised by underrepresented groups were addressed sensitively and signposted to appropriate support. FTSUG's work in partnership with a number of staff networks.
Resource Implication/VFM Statement:	*n/a*
Risk:	Risks include potential harm to staff or patients if concerns are not identified early and responded to proportionately. This report provides assurance that processes to mitigate this risk are in place.

No of Pages	10	**Appendixes**	0
Governance and Engagement pathway to date:	Presented at POD prior to Trust Board.		
What happens next?	Update of paper for any points raised and presentation to Board.		
Publication	Can be published.		

Introduction

This report provides a summary of data from Quarter 3 (October 2024 to December 2024) and Quarter 4 (January to March 2025) from the combined case load. The Trust has 2 FTSUG's, both of whom are part time, but covering a WTE post. The FTSUG's work with every ward, department and worker within the organisation regardless of profession, banding or grade and the caseloads reflect assurance of staff speaking up across all groups and designations. The Freedom to Speak Up Guardian role is complex, and the landscape in which guardians operate is constantly evolving. The network has grown from just two hundred guardians in NHS Trusts in 2017 to more than 1,300 guardians supporting a wide range of organisations. The National Guardian's Office, funded by the CQC and NHS England, continues to support and train the growing network of guardians.

Freedom to speak up means creating a culture in which everyone can speak up, regardless of their background, band, role, age, gender identity, sexual orientation, disability, or ethnicity. Speaking up is about anything and everything which gets in the way of patient care or affects the experience of workers in healthcare. It can refer to ideas for improvement, as well as raising concerns, complaints, and issues.

Caseload data and overview of key themes

Key concerns staff at ESHT are raising include inappropriate attitudes and behaviours/incivility and impact on staff wellbeing in Quarter 3. This is a report from the old database, and these are the reportable metrics to the NGO and do not reflect all 64 contact concerns.

Quarter 3

Speak Up – National Report Metrics

Anonymous	Detriment	Bullying	Patient Safety	Worker Safety / Wellbeing	Attitude Behaviour	Total Issues Logged
1	3	4	3	19	34	**64**

During this quarter there were a significant number of concerns in relation to inappropriate attitudes and behaviours. A number of colleagues were not assured with some of the options of resolution meetings (perceived delay in the facilitation of these with some staff advising of further conflict whilst waiting). Concern that perceived conduct issues such as aggression and swearing were managed through this route. Staff wellbeing was cited in several cases with some of the contacts off sick and advising that this was attributable to work-related distress.

In 2023-2024 Quarter 3 we had 45 concerns with inappropriate behaviours and staff wellbeing also being the highest scoring. This has increased to 64 cases for Quarter 3 in 2024-2025. Incidents of incivility feature prominently and it is notable that many colleagues have tried to raise concerns through their line management, but incidents of poor behaviour have been overlooked or perceived to be trivialised. In a number of cases, dynamics have broken down to the point where poor behaviours are perceived to be tolerated and colleagues report persistently negative impact upon wellbeing which too often results in workplace absence.

New database

The new database was launched in January 2025. This was needed to replace the previous caseload management system which was eight years old. The new database provides improved functionality; it

enables greater capacity for more detailed caseload notes and easier data retrieval for our submissions to the National Office. The systems analyst continues to support with some early troubleshooting, but the new system is already capturing some valuable intelligence around average case handling times and will also track how many cases result in a formal process and how many are referred back through the divisions.

On the old database RA had 42 contacts but significant delays in closing the cases. The FTSUG's are obligated to seek assurance and feedback prior to closing a case. Some intelligence for the delays below included:

- 13 on caseload suspended but regular wellbeing and follow up. The reasons for the delays for the 13 cases are below:
    - 7 in a formal process or awaiting resolution meetings.
    - 2 long term sickness
    - 1 bereavement leave
    - 3 concerns went to senior staff so arm's length waiting for assurance and feedback from staff.

Quarter 4 narrative

There was an increase in patient safety concerns and assurance is given they were escalated in a timely way to ensure timely review and support. Both Guardians are Registered Nurses and NMC registered. This reflects an extremely pressured time in A&E with attendance and flow and admissions. Corridor care was discussed nationally. The FTSUG's supported a number of trained staff to share the concerns in partnership. Several solutions and initiatives were already in place by the Leadership team to support this This included support of patients in the waiting room in A&E to ensure safe and effective care during long wait times. There has been a real commitment to support staff from senior leads which is valued and enables partnership working. Managers have facilitated meetings to listen to Band 7 staff to look at solutions and improve communication. This will also support reducing any inappropriate behaviours or attitudes to enable learning and improvement. This was a remarkably busy period of activity with new contacts and existing contacts.

During quarters 3 and 4 in 2024/25, 118 cases were raised to the Guardians, compared with 123 in the same period last year. Over the six-month period, only two concerns were received anonymously and the majority of cases were either resolved to the speaker's satisfaction or were referred back through their division, The average caseload handling time was 77 days in Q3 and 25 days in Q4.

8% of cases received were referred to the Speak Up Guardians by their line manager and 37% had used the Guardian service in the past.

The FTSUG's strive to ensure timely follow up and wellbeing support and resolution of concerns where possible. With a significant caseload this can be a challenge and both Guardians are part time. They do work together providing a WTE post which has been recently recommend by the NGO for Trusts with Banding from a Band 7 for Deputy Speak up Guardians and an 8a for Guardians. We will review the JD with Steve Aumayer alongside the current Job Description was from 8 years ago.

The National Guardian's office has published a framework to support leaders, organisations, and Guardians to clarify expectations, standardise recruitment and ensure that the role is understood, supported and effective. It includes clarity on the Job Description, role, recruitment, banding training and education.

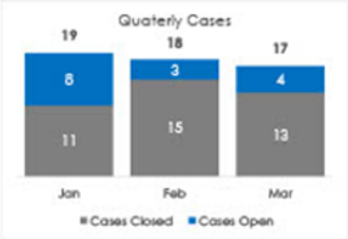
Freedom to speak up requirements and principles

While a clinical qualification or background in patient safety may be beneficial, it is not essential for a Freedom to Speak Up Guardian in the new requirements.

Speak Up Guardian Dashboard

Count: Count of cases in quarter
Closed: Count of closed cases in quarter
Open: Count of open cases in quarter
Avg Days: Average number of days from open date to close date
Quoted: The number of times the items have been used in multiple choices

Source: Speak Up Guardian Database as at May 25



Primary Speak Up Reasons	Count
other inappropriate attitudes or behaviours	16
patient safety/quality	12
system/process	12
bullying or harassment	5
worker safety or wellbeing	5
demeaning treatment as a result of speaking up	2
Missing Data	1
discrimination	1
Grand Total	54

Primary Referral Method	Count
Self referral	28
Recommended by colleague	9
Have used the service before	6
Recommended by manager	5
Seen promotional materials	3
Seen on staff extranet	1
Missing Data	1
Recommended by HR	1
Grand Total	54

Case Load Information	
Total Case Count in Quarter	54
Cases Closed in Quarter	39
Cases Open in Quarter	15
Cases Open Outside of Quarter	19
Current Total Open Case Load	34
Cases Closed in Quarter Avg Days	27

Primary & Secondary Speak Up Reasons	Quoted
other inappropriate attitudes or behaviours	25
worker safety or wellbeing	19
system/process	18
patient safety/quality	14
bullying or harassment	8
demeaning treatment as a result of speaking up	3
Missing Data	1
discrimination	1

Confidentially / Anonymously	Count
Confidentially	53
Anonymous	1
Grand Total	54

Staff Groups	Count
Nursing and Midwifery Registered	19
Administrative and Clerical	13
Medical and Dental	6
Additional Clinical Services	6
Estates and Ancillary	3
Healthcare Scientists	2
Add Prof Scientific and Technic	2
Missing Data	2
Allied Health Professionals	1
Grand Total	54

Used Service Before	Count
No	33
Yes	20
Missing Data	1
Grand Total	54

Primary Outcomes	Count
Missing Data	14
Resolved to speaker's satisfaction	14
Referred back through division	11
Referred to HR solutions	5
Soft intelligence used for escalation to senior lead	4
Disengaged	3
Declined to pursue further	1
Dismissal	1
Proceeded to formal process	1
Grand Total	54

Would Speak Up Again	Count
No Feedback Given	18
Don't Know	4
Yes	32
Grand Total	54

Resulted Formal Process	Count
No	36
Missing Data	11
Yes	7
Grand Total	54

Divisions	Count
Urgent Care	9
Diagnostic, Anaes & Surgery	9
Core Services	6
Medicine	5
Women & Children	5
Finance & IT	5
Community Health & Integrated Care	4
Missing Data	3
Estates & Facilities	3
Nursing & Governance	2
Strategy	1
Transformation	1
Human Resources	1
Grand Total	54

Primary & Secondary Outcomes	Quoted
Missing Data	14
Declined to pursue further	3
Disengaged	3
Dismissal	1
Individuals' expectations could not be reasonably	1
Proceeded to formal process	1
Referred back through division	22
Referred to HR solutions	14
Resolved to speaker's satisfaction	18
Signposted for wellbeing support	21
Soft intelligence used for escalation to senior lead	6

The Freedom to Speak Up Guardians (FTSUGs) continue to support and promote local resolution, learning, and improvement but have relayed ongoing staff concerns about systemic issues, particularly delays in resolution and lack of assurance. In collaboration with HR, staff have been encouraged to escalate concerns that fall under Disciplinary standards or codes of conduct. While bullying and harassment reports have declined, concerns remain around the effectiveness of informal processes, especially regarding behaviour/conduct Datix incidents, where staff often feel there is no feedback or learning. Previous reviews and staff engagement efforts have addressed some of these concerns, but staff still seek more timely and supportive responses. There is planned work with staff engagement to review this further. There is strong interest in Board-level support for oversight of continuing to seek to improve the handling of conduct issues, reduce sickness absence and promote a culture of openness. A key barrier remains the perception of futility, which discourages staff from raising concerns and negatively affects patient safety, staff wellbeing, and organisational culture. Improving feedback to staff will also improve staff survey results where ESHT has deteriorated 2024 data.

National data

The National data correlates with ESHT categories. Worker safety/wellbeing and inappropriate attitudes and behaviours are the highest cause of concerns. ESHT have undertaken significant workstreams to support and address these concerns including support for Managers and leaders with the launch of the new toolkit in 2024. Significant wellbeing support is available for staff and the FTSUG's signpost and support all contacts. TRIM is also utilised by a number of contacts with reassuring feedback and improvement in staff wellbeing.

- One in every three cases raised (32.3%) involved an element of **worker safety or wellbeing**. An increase from one in every four cases (27.6%) in 2022/23.
- Two in every five cases raised (38.5%) involved an element of **inappropriate behaviours and attitudes**. The most reported theme in 2023/24.
- 19.8% of cases reported included an element of **bullying or harassment**. A 2-percentage point fall compared to 2022/23.
- 18.7% of cases raised included an element of **patient safety/quality**, a marginal drop compared to 2022/23 (19.4%)

Staff survey results

This year's National staff survey posed four questions under the heading of raising concerns. The questions ask whether staff would feel secure raising concerns about *unsafe clinical practice* and whether they are confident that the organisation would address their concern. The survey then asks if staff feel safe to speak up about *anything* that concerns them in the organisation and again seeks to explore levels of confidence in the organisations ability to address any issues of concern.

The ESHT score for feeling secure in raising concerns about unsafe clinical practice remained close to our score last year - 69.2% agreed or strongly agreed in 2024, compared with 69.4% in 2023. This was just 0.8% below sector.

Confidence in feeling that the organisation would address concerns related to unsafe clinical practice has decreased by 1.1%, placing us 2.9% below sector.

This year, we see a reduction in feeling safe to speak up about anything but a much larger drop in confidence that the organisation would address concerns.

When asked "If I spoke up about something that concerned me, I am confident my organisation would address my concerns," 44.9% of respondents agreed or strongly agreed **– a reduction of 2.4% from our score in 2023. This places ESHT 4.1% below sector**. This is a disappointing reflection and, whilst we note that staff feel able to speak up, it is concerning that confidence in the Trust addressing their concerns has fallen.

Creating a culture were speaking up is business as usual is essential. However, this is of little value if there are perceptions that concerns will not be addressed. If staff consider that their concerns are diminished, overlooked, or not responded to in a timely and proportionate manner, this is likely to lead to futility in speaking up which could compromise patient and staff safety and wellbeing. The Freedom to Speak Up

Guardians will be regularly meeting with the People Engagement Team to look at themes and hot spot areas to enable enhanced levels of support and more proactive involvements.

It is pleasing to note from the national staff survey that minority ethnic staff has seen a steady increase in confidence that their organisations will act, rising from 54.5% in 2023 to 55.2% in 2024. Additionally, internationally recruited workers report higher trust in organisational action that UK recruits.

An overview of the national staff survey results highlights that, while some staff feel able to raise concerns, many do not trust that those concerns will lead to change. This action gap remains a key challenge for the system.

- Nationally, 71.5% of staff feel safe raising concerns about unsafe clinical practices (unchanged from 2023). Yet only 56.8% believe their organisation will act on patient safety concerns.
- 61.8% feel safe raising concerns about anything in their organisation (slightly down from 62.3% in 2023), but fewer than half (49.5%) trust their organisation to act on concerns more generally.
- Longer-serving staff report lower confidence in speaking up than newer employees, raising concerns about disengagement over time.

Reflecting upon these findings, The National Office have expressed concern that a speak up culture without action risks creating disillusionment, distrust, and disengagement.

NGO publications and guidance

Detriment Guidance

In 23/24 data submitted by Freedom to Speak Up guardians, 4% (1285) of cases indicated workers believed they experienced some form of disadvantageous and/or demeaning treatment as a result of speaking up.

It takes courage to speak up, and there are many barriers preventing workers from raising concerns. Those barriers range from fear about career impact, through to lack of confidence that anything will be done to address issues raised. It is therefore vitally important to clearly communicate how to raise concerns, what workers can expect if they do speak up, and how they will be protected from detrimental treatment as a result of speaking up.

Following a collaborative piece of work with Freedom to Speak Up Guardians, Protect, and the Head of Speak Up at NatWest Group, detriment guidance has now been published for organisations.

The guidance discusses the benefit of completing a detriment risk assessment. Protect has given Freedom to Speak Up Guardians access to its risk assessment which can support those responding to reports of detriment following speaking up. They recommend these are shared with the NED and the Executive lead for Freedom to speaking up. The assessment tool can be used by the Trust but not shared externally. It has been shared with key staff.

In Quarter 3, 3 staff cited detriment an increase from previous quarters. This guidance will support the ongoing discussion in partnership with HR re: managing any raised cases of detriment. In Quarter 4, 2 staff have cited detriment.

National Guardian's Office Annual report

The annual report 2023/24 from the National Guardian's Office has been laid before Parliament. The report highlights the work of Freedom to Speak Up guardians and the National Guardian's Office. The report also shares learning which indicates that more work is needed for speaking up to be described as business as

usual in the healthcare sector in England. A link to the full report can be found here: Making Speaking Up business as usual

Amplifying the voices of overseas-trained Workers

National Guardians Office Review

Overseas-trained workers make up a significant and growing portion of the healthcare workforce in England. However, national data and intelligence have raised concerns about the extent to which these workers feel free to speak up. Last year, the National Guardians office began a Speak Up Review to understand the speaking up experiences of overseas trained workers, identify barriers and highlight examples of good and innovative practices. The aim was to develop actionable recommendations out of this review to improve policies and practices, fostering a more inclusive and supportive Speak Up culture throughout healthcare. Opportunities to contribute to the review through questionnaires and interviews to capture the feedback and experiences of our overseas trained workers were widely shared and promoted in ESHT.

The review was published in early May and Dominique will be meeting with the EDI lead and the People Experience manager to explore how this might inform our proactive work and underpin the People Promise of 'we each have a voice that counts.' A full copy of the report can be found here:

NGO-Overseas-trained-workers-report_May-2025.pdf

Themes and learning from recent cases.

Issue: Lack of timescales in progressing a formal process, the employee had no keeping in touch arrangements during a long-term absence and then no return-to-work interview when a first return was attempted. This return to work failed and the individual felt isolated and suffered a deterioration in their emotional health. Lack of clarity in roles and responsibilities caused drift and this heightened anxiety which led to a further period of absence. The wider team were unsettled in the absence of their colleague and lacked a sense of direction or suitable cover arrangements to help them to meet deadlines and prioritise work.

Following involvement from the FTSUG: Mutually agreeable keeping in touch arrangements were established, a colleague was identified to accompany the individual to meetings, a referral was made to Occupational Health and support given to facilitate a phased return on the second attempted return. This was successful and a return-to-work meeting scheduled with a clear plan formulated for wellbeing support and counselling. The FTSUG maintained weekly contact with the individual and supported them to access and understand relevant policies. The regular check-ins helped to maintain their emotional wellbeing and sustained their engagement with the formal process.

Offers of support were extended to the wider team and the FTSUG liaised with divisional leads to secure appropriate interim management for them. The FTSUG facilitated more effective discussions to ensure that the team understood the timelines for project work and that any delegated work was allocated with consideration for skills, availability and capacity alongside other commitments. FTSUG supported mangers to develop a plan to aid a smooth transition back to the team after the extended absence of their colleague.

Sexual safety: The addition of sexual safety to the Dignity at work policy has been well received. Whilst recognising the sensitivity and reluctance to report concerns, there have already been 2 cases reported. This has enabled looking at how to improve managing such cases and the understanding of the policy application. The reference to "banter" referenced by both cases. Further promotion and communication on this can support improved reporting and confidence that the Trust has zero tolerance and will enable learning

and improvement. Within incivility and inappropriate attitudes “banter” has been a repeated word. A communication plan for the FTSUG’s for the year can look at key points.

Improving feedback to provide assurance: There is ongoing discussion in partnership with HR and key staff to improve feedback to staff following investigations. Noting also external reviews which have been well received, staff still are often raising that the feedback was not assuring. Whilst it is recognised there must be confidentiality and sensitivity, further communication regarding speaking up and learning from it needs to be a focus,

Guardian mentoring: Dominique continues to act as a national guardian mentor, facilitating reflective conversations and providing guidance and support for guardians that are new to post. To date, Dominique has supported over 25 new Guardians across all sectors including integrated care systems, hospices, primary care, regulators, Foundation Trusts and independent healthcare providers. There are quarterly mentor meetings facilitated by the National Guardian Support and Policy Team providing an opportunity to discuss challenges and successes. This February, as a thank you to mentors, the CQC funded a two-day development workshop in London and invited Dominique to attend. This was a valuable opportunity to share practice with other trained mentor colleagues from around the country and to engage in development activities to further enhance the role of the Guardian mentor.

Training and proactive involvements

Face to face speak up training continues to form part of the preceptorship module and this has recently been extended to a Multi-Professional Preceptorship Programme, where we will be delivering the session to all the newly qualified nursing and AHP staff. The Guardians have delivered sessions to first year T Level students as part of their three-week induction prior to commencing block placements at ESHT.

Dominique has also been working alongside a newly appointed nursing lead to support their interventions in tackling a rise in inappropriate behaviours and incidents of incivility reported in one area. Work is now underway to improve team dynamics and the joint working to achieve resolution and build better working relationships is already receiving positive feedback.

The Guardians continue to be present at as many staff network groups as possible and Dominique has attended meetings on sexual misconduct in the workplace and use of the new detriment guidance, both delivered by the National Guardians Office. Dominique undertook a walkabout visit to EMU with the Acting CEO and the staff side representative to meet with staff and explore their challenges and successes. The walkabout was well received and further opportunities at Rye and Winchelsea Hospital, the Conquest and Bexhill Hospitals are scheduled. Dominique has also undertaken joint walkabouts with the pastoral fellows at both sites to ED, AMU, SDEC and Michelham Ward.

Ruth has supported two study days for Devonshire ward and continues to attend and support team meetings to discuss speaking up and listening. DAS Heads of Nursing meeting was attended and supported with the discussion of as leads how they listen up using “A guide for leaders in the NHS and organisations delivering NHS services.” Sessions were delivered at Brighton university in the school of Nursing to a significant number of student Nursing staff in general nursing Paediatric and Mental health. The feedback was incredibly positive and a further 2 days are planned for 2025.

Ruth has met this year again with Howard Lewis from the GMC liaison service to look at partnership supporting of training and discussing speaking up.

Visits to the Bowel and bladder teams in the community and to the Diagnostic unit at Bexhill to take posters and discuss speaking up.

Freedom to speak up training figures for ESHT for April show slight improvement.

Apr-25	Running Total
Speak up - 10	Speak up - 764
Listen up - 19	Listen up - 826
Follow up - 1	Follow up - 53

Ongoing work

- The current anonymous feedback survey supported by JISC has now ended and we need to set up the new survey options. The Guardians have also been utilising an EDI anonymous questionnaire, but response has been extremely low. It does give evidence of supporting staff in minority groups.
- Both Guardians have met and welcomed Jayne Black the new Chief Executive who has oversight of our work here to date.
- Ongoing meetings with Paresh Patel and Frank Sims and their ongoing support and engagement can only enhance supporting Speaking up.
- Planning of objectives for 2025 and appraisals have been supported by Steve Aumayer and we extend significant thanks for his expert guidance and support of the Guardians.
- Planning communications for the year on Freedom to speak up.

Consequences for not taking action.

Failure to act on Freedom to Speak Up feedback risks staff disengagement, unresolved safety issues, and reputational damage, as well as non-compliance with national guidance.

Conclusion

The Freedom to Speak Up service at ESHT continues to provide a trusted mechanism for staff to raise concerns. Q4 figures show sustained engagement and responsiveness. Ongoing improvements in visibility and leadership support remain key to strengthening the culture of speaking up.

Agenda Item: 16

Report To/Meeting	Trust Board	**Date of Meeting**	24th June 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:	Andrew Strevens, Chief Finance Officer	**Presenter(s):**	Steve Phoenix, Trust Chair
Report Author:	Pete Palmer, Board Secretary		
Outcome/Action requested:	The Board is asked to noted the use 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 four documents between 11th April 2025 and 16th June 2025:

Sealing 119
Deed of variation with Sussex Partnership Foundation Trust relating to land in Bexhill.

Sealing 120
Advanced payment bond executed as a deed with Integrated Health Projects and Allianz Trade relating to ongoing works for the Sussex Surgical Centre and first floor endoscopy unit, EDGH.

Sealing 121
Contract with Bauvill Ltd for rapid response buildings framework at Conquest Hospital.

Sealing 122
This sealing is awaiting finalisation. Details will be reported to the Board once this has been concluded.

Sealing 123
Revisionary lease renewal with Salisbury Trading Ltd. for laundry room at EDGH.

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	26th August 2025	23rd September 2025	14th October 2025	16th December 2025
Location	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) 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: Gastro GIRFT (Arun Jeevagan - presented to Execs 01.04.25 - confirmed 22.04.25) Board Committee Annual Reviews and Annual Reports **Kate Murray observing**		**Justin Harris observing**	
Quality, Safety and Performance	Learning From Deaths Q3 Autumn/Winter 2025/2026		Maternity Overview Q1 Learning From Deaths Q4 Medical Revalidation Group Report Urgent and Emergency Care Survey Results	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	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	BAF Q1 Guardian of Safe Working hours - report Annual Review of Trust Governing Documents (from February)	AGM	BAF Q2 Winter Preparedness	Speak Up Guardian Update Guardian of Safe Working hours
Annual Reports	Medical Revalidation Complaints Annual Report (CNO)		Equality annual report Patient Exeprience Annual Report Organ Donation (as per SM's email 11.06.25)	Infection Control Safeguarding Annual Report
Items for Information				Meeting Dates for 2026