A meeting of the Board of Directors will be held in Public on
Thursday 8 January 2026, 9:30 am – 1:00 pm
Joshua & Genesis Room, Kingsland Church, 86 London Road, Lexden, Colchester, C03 9DW

AGENDA

Quorum: Standing Order 4.11, no business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and Directors (including at least one Non-Executive Director and one Executive) is present (five voting members)

No.	Item	Purpose	Lead		Approx Time
Section 1 – Chair's Business					
1.1	Welcome and Apologies for Absence • Mr John Humpston, Deputy Chair and Senior Independent Director • Ms Alex Duffety, Associate Non- Executive Director • Ms Karen Lough, Chief Operating Officer Elective and Cancer Care	To note	Interim Chair		9:30
1.2	Declarations of Interest	To note	Interim Chair		
1.3	Patient Experience – Tammy Shepherd, Morven Hurding, Amanda Price-Davey	Information	Chief Nurse	Attachment	
1.4	Minutes of the meeting held on 6 November 2025	Approval	Interim Chair	Attachment	9:50
1.5	Matters Arising from the minutes and action log	To note	Associate Director of Risk, Governance and Compliance	Attachment	
1.6	Report from the Trust Chair	To note	Interim Chair		
1.7	Report from the Chief Executive • Integrated Care Board update	To note	Interim Chief Executive	Attachment	
Section 2 – Integrated Performance					
2.1	Key Issues reports - Performance and Finance Committee Nov/Dec	Assurance	Committee Chair and Executive Lead	Attachment	10:00
2.2	Key Issues report - People and Organisational Development Committee	Assurance		Attachment	
2.3	Key Issues report – Quality and People Safety Committee	Assurance		Attachment	
2.4	Integrated Performance Report	Assurance	Executive Leadership Team Chief Medical Officer	Attachment	
Refreshment break 10.30am					
Section 3 – Quality and Patient Safety					
3.1	Maternity Incentive Scheme (CNST) submission	Approval	Chief Nurse Director of Midwifery	Attachment	11:00

No.	Item	Purpose	Lead		Approx Time
3.2	Key Issues report - Maternity and Neonatal Improvement Board	Assurance	Board Chair	Attachment	
3.3	Care Quality Commission	Assurance	Chief Nurse	Verbal update	
Section 4 – Strategy and Transformation					
4.1	ESNEFT Delivery Plan	Assurance	Strategy Programme Director	Attachment	12:00
Section 5: Finance and Performance					
	There are no items for consideration				
Section 6: People					
6.1	Sexual Safety Charter Assurance Framework	To note	Chief People Officer	Attachment	12:10
6.2	UNISON Anti Racism Charter	To note	Chief People Officer	Attachment	
Section 7: Governance					
7.1	Board Assurance Framework	Approval	Associate Director of Governance, Risk and Compliance	Attachment	12:25
7.2	Key Issues Report – Audit and Risk Committee	Assurance	Committee Chair	Attachment	
7.3	Emergency Preparedness, Resilience and Response (EPRR) Framework Annual Submission	Assurance	Managing Director	Attachment	
Section 8 – Questions from the public					
8.1	Public Questions	Discussion	Chair		12:45
Section 9 – Urgent business					
9.1	Any Other Urgent Business	Information	Chair		
9.2	Date of next meeting in Public & Private 9.30am, Thursday 5 March 2026, Conference Centre, Kesgrave War Memorial, Twelve Acre Approach, Kesgrave, Ipswich IP5 1JF	Information	Chair		1:00

EXCLUSION OF THE PRESS AND PUBLIC

The Chair to move those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Contact information:
All papers are published on the Trust website a few days before each meeting https://www.esneft.nhs.uk/about-us/how-we-work/board-of-directors-meetings/

For further information, please contact the Board and Committee Secretary, Tina Terry, tina.terry@esneft.nhs.uk, 07745 746072, during office hours

Wifi Code: Guest Wifi code requiring no password

First Name	Last Name	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	Col Date From	Col Date To	Last Updated Date
Sarah	Boulton	With effect from 1/11/25 - undergoing Board induction							
David	Eagles	Y	Financial interests	Shareholdings and other ownership interests	Equity Partner of Pannells LLP (the residual, non-trading partnership of PKF)	Pannells LLP is being wound down and is not trading	05/01/2025		05/01/2025
Michael	Gogarty	Y	Non-financial personal interests	Loyalty interests	Partner is employed by Shaw Trust as a social prescriber		12/02/2024	28/02/2026	23/01/2025
John	Humpston	Y	Non-financial personal interests	Loyalty interests	Trustee, Victor Batte Lay Foundation		31/01/2025	31/01/2028	31/01/2025
Hussein	Khatib	Y	Non-financial personal interests	Loyalty interests	My partner is a Health Visitor and employed part-time at the HCRG Group Limited in Essex, covering the Basildon and Brentwood areas.		03/06/2024	28/03/2025	30/04/2025
Hussein	Khatib	Y	Non-financial professional interest	Outside employment	I have been appionted as the Registrant Council Member of the Nursing & Midwifery Council		13/10/2025	31/03/2029	16/10/2025
Paul	Little	N					25/10/2024		25/10/2024
Karen	Livingstone	With effect from 1/11/25 - undergoing Board induction							
Karen	Lough	Y	Financial interests	Shareholdings and other ownership interests	Director of Pekal Ltd		10/07/2022		31/01/2025
Adrian	Marr	Y	Non-financial personal interests	Loyalty interests	My Daughter, Amy Marr, works for East Suffolk District Council as a Health promotion manager. She has links with ESNEFT and the SNEE ICB as part of this role.	This needs to be declared as part of my interests at Board level.	31/12/2021	01/12/2026	25/02/2025
Michael	Meers	Y	Indirect interests	Loyalty interests	Daughter is part of the Medical Apprenticeship Degree (partneship scheme between ARU and ESNEFT)		21/01/2025	31/08/2029	22/01/2025
Mark	Millar	Y	Non-financial personal interests	Outside employment	Finance Director, Woodbridge Golf Club		07/03/2025		03/03/2025
Catherine	Morgan	Y	Non-financial professional interest	Outside employment	Trustee St Helena Hospice		03/02/2025		03/02/2025
Katherine	Read	N	I have no interests to declare				23/01/2024		03/04/2025
Alexandra	Rutterford-Duffety	Y	Financial interests	Outside employment	Director of Finance and Operations (employee) of The Royal College of Psychiatrists		24/04/2025		24/04/2025
Karen	Sinnott	Y	Non-financial personal interests	Outside employment	Santander Bank UK		24/01/2025		03/07/2025
Doug	Ward	Y	Non-financial personal interests	Loyalty interests	Member of the Australian Institution of Engineers European Chapter Committee	I serve on the European Chapter of the Institution of Engineers Australia as a Fellow of the Chapter. The appointment is by peer vote and is not renumerated	07/01/2023	28/11/2025	07/10/2025
Doug	Ward	Y	Indirect interests	Outside employment	Visiting Lecturer in the Department of Power & Propulsion Cranfield University College Road , Cranfield Bedfordshire , Milton Keynes MK43 0AL	Visiting lecturer in the Department of Power & Propulsion at Cranfield University lecturing UK and international engineering master's degree and doctoral students on gas turbine engineering operations & maintenance.	07/01/2023	17/11/2025	07/10/2025

Trust Board Meeting in public

Report Summary

<table>
<tr><td colspan="2">Date of meeting: Thursday 08 January 2026</td></tr>
<tr><td colspan="2">Title of Document: Public Board of Directors Patient Story</td></tr>
<tr><td>To be presented by:
Catherine Morgan, Chief Nurse</td><td>Author:
Tammy Shepherd, Head of Patient Experience
Amanda Price-Davey, Director of Midwifery
Morven Hurding, Macmillan Lead Cancer Nurse</td></tr>
<tr><td colspan="2">1. Status: For Approval/<u>Discussion</u>/Assurance/Noting/Information</td></tr>
<tr><td colspan="2">2. Purpose:
To receive an update following the presentation at the Trust Public Board meeting in November 2025.
To hear of a patient’s experience, and the learning undertaken following the feedback.</td></tr>
<tr><td colspan="2">Relates to:</td></tr>
<tr><td>Strategic Objective</td><td>Keep people in control of their health;
Develop our centres of excellence;
Drive technology enabled care</td></tr>
<tr><td>Operational performance</td><td>N/A</td></tr>
<tr><td>Quality and equality impact</td><td>The 2025/26 priorities and operational planning guidance refers to the difficult decisions that will be required in prioritising resources. To proactively manage quality, mitigate, manage, and escalate risks and concerns, a robust quality and equality impact assessment process is required as part of financial and operational decision-making, including cost improvement plans.
To comply with the Equality Delivery System 2022 framework, Board responsibilities, Domain 3 - Board/ Committee papers (including minutes), to identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.
Delivering a positive patient and relative experience is a key part of ensuring high quality clinical care. It is key that Board is sighted on direct experience of care, which are both positive and negative; to gain assurance that when a poor experience occurs action is taken to improve.</td></tr>
<tr><td>Legal, Regulatory, Audit</td><td>Oversight of patient experience forms part of the Trust’s requirements in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 16: Receiving and acting on complaints, and Regulation 17: Good governance.</td></tr>
<tr><td>Finance</td><td>By ensuring a positive patient experience, the risk of ongoing escalation of concerns towards legal claim and financial remedy is reduced.</td></tr>
<tr><td>Governance</td><td>As part of a well-led organisation, it is important that the Board is sighted on patient experience stories, in order to connect back information regarding quality and operational performance to patients and families.</td></tr>
<tr><td>NHS policy/public consultation</td><td>N/A</td></tr>
<tr><td>Accreditation/ Inspection</td><td>Regulatory frameworks expect Trusts to have a programme of continuous improvement</td></tr>
</table>

Anchor institutions	The Trust is committed to being an inclusive purchaser, employer and service provider and regularly reviews its accessibility for all cohorts of people for both employment opportunities and service provision.
ICS/ICB/Alliance	We ensure there is transparency in terms of availability of our ED&I data and work collaboratively with the wider health and care system (Suffolk & North East Essex Integrated Care System, etc.) to share best practices relating to patient and staff experience improvement initiatives.
Board Assurance Framework (BAF) Risk	BAF Risk 4: If ESNEFT does not have the correct quality assurance mechanisms in place, then it may fail to maintain or improve the quality and safety of patient services, resulting in poor patient care, increased health inequalities, experience, and potential harm.
Other	

3. Summary:

At the Public Board meeting held Thursday 06 November, Amanda Price Davey, Director of Midwifery shared a video hosted by Joyce McIntyre, Community Ambassador – African Families in the UK in relation to care within maternity.

Since this public board meeting, further work has been undertaken which includes:

- The “It’s ok to ask” videos have been shared more widely following significant interest.
- Further scoping for Midwifery Continuity of Carer teams for our most vulnerable groups is underway.
- The development of a specialist team in Colchester community to replicate that now in place on the Ipswich site is in development with plans to roll out in the summer of 2026.
- New research study has been launched by consultant Midwife Patience Gyampeh (nee Pounds)

Today, the Board will hear from Morven Hurding, Macmillan Lead Cancer Nurse and Natalie Wheatley, Neuro-Oncology & Teenage and Young Adult Clinical Nurse Specialist who are both supporting Mr Bateman to share his experience of care.

Mr Bateman’s care experience began in 2017 when he was diagnosed with a tumour in his spinal cord. Mr Bateman had an initial operation to try to remove the tumour, however, it was embedded and it could not be removed.

Mr Bateman was told the tumour was an ependymoma, characteristically slow growing with no spread and regular MRI scans would be carried out to monitor the tumour. Unfortunately, on 06 March 2023, David woke up to discover he had suddenly become completely paralysed from the chest down. This was believed to have been due to the tumour reacting to chemotherapy, changing shape and tearing at the spinal cord in the process.

Mr Bateman was referred to Stoke Mandeville and whilst chasing up an appointment with them, the secretary asked if he had been in touch with SIA (Spinal Injuries Association). Mr and Mrs Bateman immediately got in touch with SIA at which point their lives begin to change for the better some 16 months after the initial paralysis.

Key issues identified

Lack of joined up communication, treating symptoms in silos rather than adopting a holistic approach – no single point of contact to reach out to for support

Due to a lack of coordinated support from healthcare teams, alternative resources were called upon unnecessarily i.e. hospice, paramedics, emergency department staff

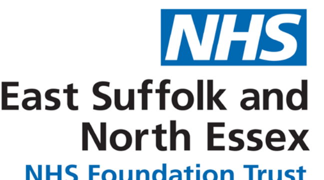
Multiple opportunities were missed throughout a prolonged period by various healthcare professionals to signpost the Mr Bateman to SIA (Spinal Injuries Association) for support

Learning opportunities

Patient Experience to be shared at a number of forums to increase staff awareness of SIA
Posters to be placed in outpatient clinics, wards areas, waiting areas signposting SIA
Patient Experience noticeboards to include SIA awareness
PALS office to be briefed on SIA so they can signpost to them when necessary/appropriate
Information on SIA shared with the cancer wellbeing centres

4. Recommendations / Actions

That the Board of Directors note the continued improvements following the November Public Board meeting and the work undertaken to improve patient and family experience within Cancer for our patients, carers and loved ones.



Minutes of the Trust Board of Directors' Meeting held in public
on Thursday 6 November 2025, 9:30 am – 1:30 pm,
Conference Centre, Kesgrave War Memorial, Twelve Acre Approach, Kesgrave, Ipswich IP5 1JF

Present:

Mr Mark Millar	Interim Chair
Mr David Eagles	Non-Executive Director
Dr Michael Gogarty	Non-Executive Director
Mr John Humpston	Non-Executive Director, Senior Independent Director and Deputy Chair
Mr Hussein Khatib	Non-Executive Director
Ms Karen Sinnott	Non-Executive Director
Ms Sarah Boulton	Non-Executive Director
Ms Karen Livingstone	Associate Non-Executive
Mr Nick Hulme	Chief Executive
Mr Adrian Marr	Director of Finance and Deputy Chief Executive
Mr George Chalkias	Director of Governance
Dr Angela Tillett	Chief Medical Officer
Mr Mike Meers	Director of Digital, Logistics and Operations - Ipswich
Ms Catherine Morgan	Chief Nurse
Ms Kate Read	Director of People and Organisational Development

In attendance:

Ms Karen Lough	Director of Operations - Elective Care
Mr Doug Ward	Interim Director of Estates and Facilities
Ms Ann Filby	Trust Secretary
Amanda Price Davey	Director of Midwifery – item 1.3
Jamie Hanson	Associate Professor/Consultant Midwife – item 1.3
Patience Gyampeh	Consultant Midwife/Associate Midwifery Professor – item 1.3
Sally Barber	Associate Director, Health Inequalities & QI
Helen Green	Clinical Lead for Health Inequalities
Andy Higby	Strategy Programme Director – item 4.1

Apologies for absence:

Ms Alex Duffety	Associate Non-Executive Director
Mr Paul Little	Strategic Director for Service Development

There were no governors attended to observe the meeting.

Section 1 – Chair's Business		**Action**
P130/25	**1.1 Welcome and Apologies for Absence**	
	The Chair welcomed members and attendees and apologies for absence were noted. Ms Sarah Boulton and Ms Karen Livingstone were welcomed to their first Board meetings and Dr Tillett was welcomed back into the role of Chief Medical Officer.	
P131/25	**1.2 Declarations of Interest**	
	The declarations of interest were **noted.** Mr Khatib reported on his appointment to Norfolk and Suffolk NHS Foundation Trust. He was congratulated on his appointment as a Registrant Council Member at the Nursing and Midwifery Council.	
P132/25	**1.3 Patient Experience** • **Key Issues Report – Maternity and Neonatal Improvement Board**	
	The Chief Nurse referred to the Key Issues Report and the attendance of the National Maternity improvement Adviser who reported on the progress made and the recommendation for the Trust to exit from the Maternity Safety Support Programme (MSSP), with confidence in the plans developed and that improvements had been embedded. Formal confirmation was received from the national team yesterday. The team	

	was congratulated on the work undertaken to enable the Trust to exit the programme. A detailed paper on the future strategy for the Ipswich ODR would be considered at the Executive Management Committee prior to presentation to the Board. An update was also provided on CNST progress and a more consistent and sustained programme over the 12-month period. The Chief Executive congratulated the Director of Midwifery and her team and acknowledged that when improvement was required this was recognised, a plan was prepared, and the work was undertaken. The Director has had a pivotal role; the Chief Nurse was thanked for her leadership and Mr Khatib was thanked for his support as the maternity safety champion. Mr Khatib confirmed that this was achieved against a background of challenges including the lifts not working and moving from seven CNST standards to 10. The Maternity Voices Partnership had also supported effective oversight. The MSSP letter presented demonstrated the level of scrutiny experienced. The full report would be circulated. The Chief Nurse referred to the report updating a previous Board story. Today's film related to maternity care as the Board is required to understand what is happening within the service, with reference made to a letter received earlier this year from the NHS England Chief Executive regarding the Board's responsibilities. The Director of Midwifery advised it was difficult to confirm someone from our harder to reach services to attend the Board. Significant work had been undertaken on Its Ok to Ask, collaboration with the Local Maternity and Neonatal System (LMNS) and the context was described, including access to services and that people often engage much later in a pregnancy. The film highlighted the challenges faced by African women, described the cultural issues and the support they need. Additional information was given regarding personalised support plans, a document that women complete with their midwife, the universal offers and individualised work for communities, listening events, the Roma advocate and work with local voluntary groups. Patience Gyampeh, a Consultant Midwife in ESNEFT and a shared role with the University of Suffolk, talked about her research and the central strategies implemented. Women often feel they haven't been heard and listened to, and we are committed to continuing to improve their experience. Her work is looking at the continuity of care model, the care that builds trust between midwives and families, and exploring patient feedback using a validated tool. The findings may guide leadership and policy makers to identify where we are doing well and where improvement is required. Continuity, choice and control are the three concepts highlighted in multiple reports and if we get these right women will have safer, more equitable personalised care. Jamie Hanson, a midwife for 30 years, referred to the study involving African women and advised of the importance of acting on the barriers and enablers to them accessing services. He had located a black African community and had been working with them prior to starting data collection. The women are very shy but with the support of the Equality, Diversity and Inclusion strategic and operational groups, 24 women had been recruited with extensive data to analyse. There is stigma, they don't feel safe to talk about their mental health within their culture, and we may need to rethink some of the words we use as we consider how services can be improved. Mr Khatib questioned the work being done to support Asian women. It isn't the focus of research currently, although the service would be part of a Partner trial pilot. The Chief Medical Officer referred to obstetric care and asked whether there was any learning so far or if this was to be included in the next stage. Patience advised that the same questions were being used with obstetricians with the aim of understanding all views. The Chief Executive thanked Patience and Jamie for the work they were doing, he was supportive of continuity of care and questioned how we share this great work to support the wider care of the global majority, which the Board needs to consider.	**AF**

	The Chair reflected on the importance of partnerships, not being passive, and investing time and energy in furthering the debate to support better decisions about the care being provided.	
P133/25	**1.4 Minutes of the meeting held on 4 September 2025**	
	RESOLVED: That the minutes of the meeting held on 4 September 2025 were received and approved.	
P134/25	**1.5 Matters Arising – Action Log**	
	The action log was noted as complete.	
P135/25	**1.6 Report from the Trust Chair**	
	The Chair acknowledged the period of challenge since the previous Board meeting held in public. Epic had been implemented, and these issues would frame much of today's discussion. The Chief Executive had referred to 'bouncability'. The Trust was adept at assessing issues and agreeing a plan to resolve them, and the energy required to do so should not be under-estimated. The Chair advised that this will be the Chief Executive's last Board meeting in public following his announcement that he planned to retire, and the people of Ipswich, East Suffolk, Colchester and North East Essex owed him a great debt for what has been achieved over the last 13 years. He was thanked and wished well for the future. This was also the last Board meeting in public for the Trust Secretary and the Director of Governance. Their influence has been positive and their support to the Board and to the Chair was acknowledged.	
P136/25	**1.7 Report from the Chief Executive** • **Integrated Care Board update**	
	The Chief Executive referred to other Trusts' experience of implementing an Electronic Patient Record, which is regarded as the most difficult to deliver in your career. This Trust's experience had been more positive, the system did not fail, we have not returned to paper, and we reported in the first week post go-live. The Chief Executive put on record his praise for each member of staff who had undertaken their training, the divisions' provision of ambassadors, to the Epic team, to the implementation team and its leaders, to the extraordinary work done by the training teams, and to the Director of Digital, Logistics and Operations for his vision and leadership. Epic will improve every patient and staff experience every day. The Board took a leap of faith in investing in this system and the courage of members, both past and present, was acknowledged. The Chief Executive expressed his immense pride in the transformation of care for the next generation. The Chair endorsed the comments made on behalf of the Board. The Board was invited to note the summary of key matters considered at the meetings of the Essex ICB held on 18 September and 16 October 2025.	
Section 2 – Integrated Performance Report		
P137/25	**2.1 Key Issues Report: Quality and Patient Safety Committee** • **BAF4, Quality assurance mechanisms regarding the quality and safety of patient services**	
	Mr Khatib presented two reports from the meetings held on 25 September and 30 October 2025, with a focus on the most recent meeting, highlighting the following: • BAF4, and a recommendation to increase the risk rating to 12 – presented for approval • Ambulance offload delays/capacity from a quality and patient perspective and the assurance received that patients were not affected by the delays • A Fundamentals of Care Board Assurance Report, with this Board leading and monitoring the improvements • Assurance was received on the confidence in the Seasonal Variation Plan, whilst there will be challenges • The Infection Prevention and Control Annual Report was received. The Chief Nurse referred to there being no incidents to date in relation to patients and the offload delays and provided more detail about the thematic review to provide that wider	

	assurance. The Chief Medical Officer referred to the enhanced data available through Epic and looking ahead to that next phase. The Chair asked how concerned the Board should be about being an outlier in relation to infection prevention and control. The Chief Nurse advised that on mandatory surveillance infections the Trust was above trajectory, and more detail on the benchmarking was provided. It is multi-factorial, with good plans in place. There is concern that overcrowding impacts on our ability to reduce transmission although there are good governance processes and improvement plans in place with multi professional input. **RESOLVED: That the Board received and noted the two Key Issues Reports and approved the revised BAF4.**	
P138/25	**2.2 Key issues Report – Performance and Finance Committee**	
	Mr Humpston reported on two meetings of the Committee held on 24 September and 29 October 2025. The latter was much more reassuring, setting out recovery plans across urgent and emergency care, cancer and elective care. The Committee took delegated authority from the Board to review and endorse the winter plans and was assured by the rigour, and the synergies between the Committee and the Quality and Patient Safety Committee (QPS) were demonstrated. The diligence and grip were clear, ensuring that the benefits of Epic are demonstrated in real time. There has been an increase in demand for community services, cost improvement (CIP) progress is disappointing whilst there are plans in place for this year and a continuing grip to incorporate learning into next year's requirements. A review of ESOEC is in train to ensure its productivity is as high as it can be. The ability of the Executive Directors to recover the position has been demonstrated. The Director of Finance and Deputy Chief Executive reported on an adverse variance of £4.2m, divisional financial recovery plans have been received with some good solutions and recurrent benefits. A series of additional controls have been implemented, authorisation limits have been raised as agreed at the previous meeting, and proactive rather than reactive bank and agency controls are in place. CIP is £6.1m behind plan, the cash position is relatively stable, capital is underspent by £13m but forecasting break even at year end. Business planning has begun. All aspects of performance were reviewed with regional NHS England on 31 October, discussing each of the quadrants and recovery plans. Assurance was sought on delivery on key metrics by year-end and quarterly meetings are likely. The Chief Executive provided his reflections, recognised the challenge for the second half of the year, and the appointment of one person responsible for flow will be positive. Financial support is being discussed with the ICB. The Director of Operations – Elective Care briefed the Board on management of elective pathways, the elective roadshows to support teams post Epic go live, and from next week daily tactical meetings will focus on elective and weekly meetings will ensure sufficient activity. The report to Committee outlined months 1-4 performance and the deterioration from month 5. The diagnostics recovery has begun, the new Endoscopy Unit opened on 2 October, and this will be a huge asset in terms of capacity and improving pathways, particularly for cancer patients. Four taskforces have been implemented including elective optimisation and improving cancer care, and we are starting to see the benefits. Whilst there is a clear deterioration from plan, confidence was expressed that the deliverables at the end of March 2026 would be achieved. The Chief Executive was clear that there is no difference between performance and quality, as such delays have a significant impact on patients and their quality of life. The Director of Digital, Logistics and Operations advised of the adjusted planning trajectories set at the beginning of the year for urgent and emergency care to reflect the Epic implementation. We will be above the 68% plan for October, and further improvement has been seen in November. Meetings have taken place with the East of England Ambulance Service with some positive feedback and confidence regarding the Ipswich site. His absolute focus is on long patient waits, with a taskforce set up on patient flow and TTOs (To Take Out medicines) which cause significant delays, evidenced by the data now available within Epic. The final taskforce led by clinicians is frailty, admission avoidance	

	and the ESNEFT-wide offer. Each taskforce has a small team supporting delivery. There remains work to do on length of stay work across both sites. The Chair confirmed that the information pack for the regional meeting had been shared with all Board members, which enabled calibration with our own performance reports. Ms Boulton referred to the grip and control issue and the scale of the pressures, the cancellation of accountability reviews due to such pressures, and whether this was unusual. It was confirmed that these meetings are only cancelled in exceptional circumstances and had been held this week. The Chief People Officer briefed the Board on the industrial planning meetings, the robust plans for cover that were being produced by divisions, the communication to be sent to staff, and the redoubling of efforts to ensure data collection was robust as it can be. During the previous action, the Trust was successful in maintaining a high proportion of activity and there was high confidence in the provision of emergency care and ensuring we treat urgent cases. The Trust had been notified there will be no picket line. **RESOLVED: That the Board received and noted the reports.**	
P139/25	**2.3 Key Issues Report – People and Organisational Development Committee**	
	Ms Sinnott reported on the meetings held on 11 and 15 September 2025. The agenda is full, reports were good, lessons learned played out into actions, the staff survey went live, the Workforce Race Equality and Workforce Disability Equality Scheme data and Freedom to Speak Up reports were also considered. The efforts to support leadership development enabled reflection in the Non-Executive focus group with the Care Quality Commission. Ms Sinnott referred to the ability for members to cover for one another in presenting reports, which was important when making change happen. The extraordinary meeting considered the people domain of the Provider Capability Assessment. The Chief People Officer confirmed the strong workforce pipeline and highlighted the work with education providers and recruitment as part of the academy, management of sickness, current statistics regarding the staff survey, and confirmed that the flu vaccination rate was currently ahead in comparison with the same time last year. **RESOLVED: That the Board received and noted the reports.**	
P140/25	**2.4 Integrated Performance Report**	
	RESOLVED: That the Board received and noted the Integrated Performance Report.	
Section 3 – Quality and Patient Safety		
P141/25	**3.1 Infection Prevention and Control Annual Report 2024/25**	
	The Chief Nurse and Director of Infection Prevention and Control (DIPC) described the strengthened governance arrangements, next steps for the improvement plan, the trajectories achieved in a number of areas and the breaches in other areas, and a changing picture towards the end of the year with several outbreaks including CPE. With robust management there had been a significant improvement this year in terms of the numbers of CPE cases and a strengthened screening programme, largely related to community prevalence with some transmission in hospital. National expertise and estates work led to a much better position following samples of aspergillus which were colonised in critical care. There had been no cases for some months, showing that surveillance is important in preventing such infections. The Group A Streptococcus outbreak in the community had been stood down. A range of improvements were described with further work to do to strengthen assurance around cleaning standards. Operational pressures will impact with point of care testing to be in place for early identification going into the winter. The Infection Prevention and Control Board Assurance Framework will be given better visibility at QPS and then to Board. We are starting to see higher cases of flu, earlier than last year, demonstrating the importance of the vaccine. Our preparedness is critical.	

	The Chief Executive referred to the number of variables and whether genotyping has advanced to enable our efforts to be focussed in the right areas. This has been used to provide some generic information regarding transmission. Universal precautions remain the tightest method of prevention, whilst acknowledging that our estate and the environment are critical factors. In response to a question regarding the flu variant and increased mortality the Seasonal Variation Plan will require review, particularly with a more acute strain. Mr Khatib acknowledged the contribution from pathology and estates in supporting the DIPC and highlighted the importance of hand washing. The Chair queried if the introduction of Sodexo had increased cleaning standards to contribute to infection prevention and control improvement. It was difficult to say due to the multi factorial nature. The DIPC referenced good working relationships with Sodexo, and the additional scrutiny of an external contractor was now identifying risks. Some challenges remain. **RESOLVED: That the Board received and noted the Infection Prevention and Control Annual Report for 2024/25.**	
P142/25	**3.1 Clinical Presentation**	
	The Chief Medical Officer set the context prior to a presentation focussed on addressing health inequalities and the importance of reaching out to those in our communities that are not so well served. Helen Green and Sally Barber talked through the current strategy and areas of work including reviewing whether there are any inequalities created by delivering healthcare. The CORE20Plus5 approach was described and the key clinical areas of health inequalities and impact on health outcomes. A summary of the achievements from 2024/25 covered tobacco treatment and the quit rate, Making Every Contact Count, community outreach, asthma outreach, and health inequalities awareness sessions to divisions. The presentation focused on three projects in particular: • Children and young people asthma project in North East Essex.118 patients were identified, and early data described an 87-88% reduction in inhaler or steroid use. • Tobacco treatment inpatient services have been established for two years, working closely with smoking cessation services in the community, with a smoking quit rate from 2022-25 of 54%. Since Epic implementation, data confirms that of 160 patients visited in hospital 50% want to give up smoking. Smoke free generation funding has been secured to support intervention in the UEC. • System wide health literacy, a new project and a large programme of work, with data provided on literacy in our communities which impacts in a number of ways. The aim is for consistency wherever patients are in the system, looking at standardised tools. In terms of quality improvement, we will be working with the podiatry team to talk to their patients to confirm what they need to enable access to the care they require. Sally advised that this programme has been running since 2022, and the main risk is substantive funding to ensure benefits can be maximised. Concern was expressed about the changes to ICB boundaries and how this will impact commissioning. There is also more work to do with our vulnerable and inclusion groups and financial support for expansion of the programme will be needed. The 10-year NHS health plan was referenced, and the next steps were described. The Chair welcomed the positivity and enthusiasm demonstrated and the depth of work undertaken. There were several questions raised by members: • Mr Khatib fully supported this work and reflected on the impact of tobacco treatment in reducing perinatal mortality. Health literacy will change people's lives. • Ms Boulton questioned how success was demonstrated with partners. This work reports through a range of system-wide meetings and the strategy is aligned to system plans.	

	• The Chief Nurse attended a regional presentation yesterday with some stark data on health post-retirement. Frailty cannot be cured but it can be delayed, and this work is pivotal. • Dr Gogarty advised that the quit rates were phenomenal. We must focus on those activities that will preserve wellbeing in older people. • The Director of Operations – Elective Care found the literacy project exciting and asked what success looks like and how impact would be tracked. The team would be talking to patients to see what good looks like for them. This may affect DNA and medication rates. • Mr Humpston questioned how patients who don't understand health systems were being supported. The work undertaken in Jaywick was described and the importance of increasing the opportunities to speak to our patients. • The Director of Finance and Deputy Chief Executive fully endorsed this work and questioned some of the ICB funding choices. The ICB changes will be a challenge, and he offered his support in navigating this and encouraging ICBs to make the right decisions for the best return for local people. The Chief Medical Officer concluded that the Board had supported this programme, recognising that the Trust may not see the direct benefits. To stop this work now would be fundamentally wrong for patients and would negatively impact the connections made with our communities and our partners. Other measures we could take may need to be considered. The Freedom to Speak Up report and the Strategy update were taken at this point in the meeting.	
P143/25	**3.3 Nursing and Midwifery Skill Mix Review: six-monthly update**	
	The Chief Nurse referred to the comprehensive annual review and this report provides a progress update. It has been reviewed at the People and Organisational Development Committee (POD) and at QPS from a quality and patient safety perspective. Essentially, good progress is being made in delivering the recommendations whilst there have been challenges in consistently meeting fill rates. Roles have been offered to all newly qualified nurses and midwives, in effect over-establishing, and reducing impact on temporary spend. The Board was briefed on the changes being made for the next review, to be a joint report with the Director of Finance. The funding implications of the changes in older people's services have been met by divisions. Mr Khatib advised that QPS had supported the review, and the use of nursing associates and multi-professional working was highlighted. The Chief Nurse referred to the Epic benefits realisation and the use of a teamwork tool in Epic is being considered **RESOLVED: That the Board approved the outcome of the six-monthly review and supported the recommended actions to optimise achievement of the right staff with the right skills in the right place.**	
P144/25	**3.4 Care Quality Commission**	
	The Chief Nurse referred to previous discussions at the Board and the publication of the report following the inspection at Colchester Hospital in April, with the safe domain rated as inadequate. Work is ongoing to address the concerns raised by the CQC, tackling the root cause through five clinically led work streams reporting to the Fundamentals of Care Board, a holistic approach to quality improvement. A shorter inspection had now taken place at the Ipswich site, and the feedback letter outlined the positive elements from that visit and some concerns. A Trust-wide approach is being taken for this long-term improvement programme and a recent meeting with stakeholders enabled progress to be described. We are working closely with the CQC. The Chair thanked the Chief Nurse for her report to the Council of Governors last week, which governors found helpful. The CQC's view of progress was questioned. The CQC acknowledges the Trust's honesty regarding current progress, the risks and operational	

	pressures, and are confident in the regular dialogue. The CQC will wish to re-visit and undertake a comprehensive assessment. As a new Board member Ms Livingstone was surprised at the end-of-life element which felt at odds with some of the pressures in the service. The Chief Medical Officer referred to use of the ReSPECT tool and understanding patients' wishes, a medical task. The cycle of audits was showing improvement, and we want to get this right for patients. A full briefing would be provided outside the meeting. The Director of Governance referred to the CQC Well-led inspection taking place from 25-27 November, a presentation led by the Chief Executive and a series of interviews reflecting the new format of inspections assessing the Trust across the eight quality statements. The CQC will be on site the day prior to the inspection for a document review and the inspection team has just been confirmed. External support is in place, a Board seminar is being held on 11 November, the documentation request has been complied with in full, and a smaller request has been received. 24 different staff focus groups have been requested ahead of the visit including Non-Executive Directors. Frequently Asked Questions have been published following a review of best practice. The CQC has advised of the list of meetings they wish to observe, and weekly Executive planning meetings are continuing. **RESOLVED: That the Board reviewed the outcome of the inspections and noted the planning for the well-led inspection.**	
Section 4 – Strategy and Transformation		
P145/25	**4.1 Strategy update: NHS Medium Term Planning** The Strategy Programme Director assured the Board that work is progressing to meet the national requirements. The Chief Medical Officer and Deputy Chief Medical Officer are overseeing revisions to the Clinical Strategy with clinicians. The planning instructions were recently published with some technical documents not yet available. The first submission for years 1-3 is due on 17 or 18 December and NHS England will review and provide their comments. The second submission is potentially required in the first week of February to include revised years 1-3 and years 4-5. The Director of Finance and Deputy Chief Executive advised of the work to confirm two Board Seminar dates for discussion with Non-Executive Directors. The timeframe for the first submission will be tight. The Chair recognised the challenges, and the Board would be as flexible as possible under the constraints within which we are operating. **RESOLVED: That the Board endorsed the approach for the phase two work set out in the report.**	
P146/25	**4.2 ESNEFT as an Anchor Organisation**	
	The Director of Finance and Deputy Chief Executive provided an update on progress, highlighting that over 2,600 students had engaged in career events, over 700 students had completed work experience, three schools have launched new facilities in 2025/26, the second cohort of the medical doctor degree apprentices has started, all to support the future pipeline of staff. As purchasers, social value criteria were applied to 181 tender exercises with a contract value of £26m, progressing sustainable opportunities. The Chief People Officer confirmed the progress being made and that 87% of our staff live within five miles of our acute hospital sites, so our anchor responsibilities are important. Further detail was provided on the educational links, coaching for teachers and future workforce opportunities, with a range of programmes to support students from year 9 and above. There are 500 apprenticeships and £1.2m of levy transfers funding new employment opportunities for those outside the NHS, with people volunteering as part of their programme. The Interim Director of Estates and Facilities highlighted the work regarding solar panels and in providing business for micro/local firms within the very strict procurement rules.	

	Ms Livingstone felt health inequalities was missing from this report and it should be integrated. **RESOLVED: That the Board received the presentation.**	
P147/25	**4.3 Property and Estate Strategy**	
	The Interim Director of Estates and Facilities set out the programme of work the Trust is seeking to achieve to develop a safe, functional, sustainable and value for money estate to benefit the patient environment, to be fit for the future and to comply with the law. The estate will be developed to enhance our built environment, to eradicate backlog maintenance by 2034 and to make best possible use of our estate. Buildings need to be modern and flexible to enable ease of change, to reduce energy and our carbon footprint, working with partners. Mr Khatib questioned how the clinical strategy review would impact. Should changes be required, the strategy would be modified and re-presented to the Board. The Chief Executive highlighted the importance of the Board continuing to lobby nationally regarding NHS ownership of property to support that flexibility, particularly regarding Clacton Hospital, the maternity block at Ipswich and additional beds at Colchester Hospital. The Director of Finance and Deputy Chief Executive welcomed the easy-to-read document and added to the point regarding NHS property ownership, with some major strategic decisions to be considered at Committees and Board. The Board was advised of the new national process, NESTA, which will be topical for ESNEFT. 22 Museum Street Ipswich is progressing positively, and a meeting of the Business Case Oversight and Scrutiny Group will be required shortly. Ms Sinnott highlighted that the success of property can make a difference to the patient environment, and it would be important to bring that out in the communications plan. **RESOLVED: That the Board approved the Property and Estates Strategy 2025-30 with the caveat that this would be revised should it be required.**	
Section 5 – Finance & Performance		
P148/25	There were no items for consideration.	
Section 6 - People and Organisational Development		
P149/25	**6.1 Freedom to Seak Up: six-monthly update** • **Annual review of Board self-reflection tool**	
	The Freedom to Speak Up Guardian presented the quarter 2 figures and confirmed receipt of 61 cases, consisting of nine anonymised, 23 relating to patient safety and 31 to worker safety. This represented a significant increase from the previous quarter and already within quarter 3 there have been an increased number of concerns raised. It is positive that people are recognising and utilising the service, but it may indicate a significant number of concerns. Some of these are time-consuming and important to resolve, others are less serious. The Speak up wheel has been updated to include QR codes to ensure ease of access to the support that staff need. A raising concerns toolkit is being prepared to support managers to respond well and to answer concerns raised. The Chief People Officer supported the launch of the toolkit and the revised poster campaign. The analysis has been compared with the staff survey data and there are some notable differences, such as community staff flagging highly in the latter in terms of raising concerns, providing assurance that we are reviewing this. The Lead Guardian has done some exceptional training with our wellbeing ambassadors who are now signposting people. The training for our leaders to respond to a member of staff who has had the courage to raise a concern includes how to respond in the moment, within our civility and respect and just and learning culture. This was included in the self-assessment, and our bite sized training and the 1,000 fresh eyes conversations that retention partners have had feeds into our triangulation.	

	Mr Khatib was interested in the themes relating to the line manager's role, which has been raised previously, and questioned when changes in behaviours of line managers would be evident. The Chief People Officer advised that the broad data set tells us that staff feel confident to raise concerns. If concerns are raised with the Guardian, this is likely due to the response received not being sufficient. The Guardian referred to the case studies presented monthly, provided an example and referenced the additional support to managers who may not always know how to deal with a concern. We will continue to focus on improvement. Ms Sinnott proposed that POD reviews the data in six months and the impact of the training to see if managers feel more confident to deal with concerns. The Chief Medical Officer questioned the feedback loop and wider learning and if more work was required. The Guardian reflected on what can be difficult feedback to individuals if the outcome is not what they hoped for, and this can be even more difficult for issues raised by a group of staff. Mr Humpston, the Lead Non-Executive Director, referred to the importance of some humility when issues are raised, and how powerful it would be if we could celebrate a concern raised and the outcome with that manager. This is a difficult area which would be considered over the next six months. The Chair questioned if there was a perception of insufficient visible consequences and repeat offenders, recognising the complexity of issues and confidentiality. The Chief Executive reminded the Board that FTSU was originally about quality and safety, and the importance of getting the balance right and not overly focussing on staff. This was supported by the Guardian, although a patient safety concern is underpinned by other issues that could cause a safety issue, and concerns are not singular. The Guardian thanked the Board for the support offered to the role which makes a significant difference and is not replicated in all Trusts. **RESOLVED: That the Board noted the report for information and approved the annual review of the FTSU reflection and planning tool.**	KR
P150/25	**6.2 Workforce Race Equality Standard (WRES) Annual Report**	
	The Chief People Officer confirmed this had been considered in detail at Committee and highlighted the following: • A focus on responding to concerns • Education, experience and reverse mentoring and appraisal training commitment, the Springboard programme, My Career Matters • A deep dive into recruitment and selection. Mr Khatib confirmed that in terms of Board representation this would change when his term of office comes to an end. It was recognised that some trends are disappointing, with action being taken. **RESOLVED: That the Board approved the WRES 2024/25 Annual Report for publication on the Trust's website.**	
P151/25	**6.3 Workforce Disability Race Equality Standard (WDES) Annual Report**	
	The Chief People Officer highlighted: • The focus on what we are already doing in relation to employee relations cases • Our relationship with Essex Carers Limited and the Memorandum of Understanding in place to support the provision of meaningful and appropriate work for colleagues with learning disabilities and autism, work that has been recognised nationally • The reasonable adjustments passport is working well • A focus on inclusive recruitment. **RESOLVED: That the Board approved the WDES 2024/25 Annual Report for publication on the Trust's website.**	

Section 7 – Governance		
P152/25	**7.1 Key Issues Report – Audit and Risk Committee**	
	Mr Eagles reported on the meeting held on 16 September 2025 and highlighted: • Private meetings held with both internal and external audit with no issues of concern • Sufficient evidence was received to close the referral to QPS regarding quality improvement and clinical outcomes • A partial assurance internal audit report on safeguarding (16-17 year olds). Two further reports were received at the Committee held this week • The RSM contract was extended by one year • The EY final audit report • A cyber security controls update • Counter fraud and the new corporate offence of failing to prevent fraud, Section 199 of Economic Crime and Corporate Transparency Act 2023 from 1 September • A 10% increase in decision makers' declarations since 31 March, with the local counter fraud service providing additional support. **RESOLVED: That the Board noted the report.**	
P153/25	**7.2 Provider Capability Assessment**	
	The Director of Governance advised that this was approved in private in October and is presented in public. **RESOLVED: That the Board noted the assessment process completed for each of the domains and the detailed evidence and approved the assessment.**	
P154/25	**7.3 Trust Seal**	
	The Trust Secretary advised that the seal had been used on 16 occasions since the previous report to the Board in July. **RESOLVED: That the Board noted the report.**	
Section 8 – Questions from the public		
P155/25	**8.1 Public Questions**	
	There were no questions.	
Section 9 – Other Urgent Business		
P156/25	**9.1 Any Other Urgent Business**	
	No further business was raised.	
P157/25	**9.2 Date of next meeting**	
	The next meeting in public would be held on Thursday 8 January 2026, 9.30 am, Kingsland Church, Colchester.	

Approved: 8 January 2026 TBC

Chair: Mark Millar, Interim Trust Chair

Disclaimer: The minutes do not necessarily reflect the order of business as it was considered.

Action Points - Board of Directors in PUBLIC

Key:

Blue	Action Completed
Green	Action On Track
Amber	Action At risk of slippage
Red	Action Overdue

Action #	Minute/ Action Reference	Agenda item/subject	Action	Accountable Officer	Target Completion Date	Status Update/Date of completion	BRAG
06 November 2025							
14	P132/25	Patient Experience: Key Issues Report, Maternity and Neonatal Improvement Board	Full MSSP report to be circulated	Catherine Morgan		Circulated to members 10/11/25	B
15	P149/25	Freedom to Speak Up: six monthly update	POD to review data in six to nine months and impact of training to see if managers feel more confident to deal with concerns	Kate Read		**7/11/25:** Added to POD work programme	B

Trust Board of Directors

Report Summary

Date of Meeting: 8 January 2026	
Title of Document: Board Briefing – covering Mid and South Essex Integrated Care Board (ICB) and Suffolk and North East Essex ICB.	
To be presented by: Mr Adrian Marr, Interim Chief Executive	**Author:** Anthony May, Associate Director – Governance, Risk and Compliance
1. Status: For Information and Assurance	
2. **Purpose:** This report provides a summary of recent Board meetings of the local ICBs. Commencing 2 November 2025, this standing report was expanded to provide a summary of Mid and South Essex (MSE) ICB Board meetings, in addition to a summary of Suffolk and North East Essex (SNEE) ICB Board meetings. This enables the Trust Board to consider the work of both systems ahead of formal ICB boundary reorganisation. From 1 April 2026, these organisations are due to be reorganised and become part of the larger, newly established ICBs: Essex ICB, and Norfolk and Suffolk ICB, respectively. The Trust Board is invited to note that the following ICB Board meetings have taken place: • MSE ICB met on 20 November 2025. • SNEE ICB met on 25 November 2025. Key matters discussed at those meetings are summarised within the body of this report.	
Relates to:	
Strategic Objective	All
Operational performance	
Quality and equality impact	No quality or equality impacts have been identified specifically arising from this report; it reports on local ICB Board meetings.
Legal/Regulatory/Audit	
Finance	
Governance	
NHS policy/public consultation	

Accreditation/inspection	
Anchor institutions	
ICS/ICB/Alliance	Provides a summary of local ICB Board meetings
Board Assurance Framework (BAF) Risk	BAF1: Partnership working
Other	

3. Summary:

The Board is invited to note the following summary of key matters considered at the meeting of the MSE ICB Board held on 20 November 2025:

- Standing Items:
  - Chief Executive's Report, a written report provided an update on key issues, progress and priorities.
  - Quality Report, providing assurance through presentation of a summary of the key issues in relation to regulatory oversight of providers, and national changes to the provision of ICB-led services in maternity/neonatal care and statutory functions following the publication of national guidance.
  - Finance & Performance Report, providing an overview of the financial performance of the ICB and broader partners in the MSE system (at month 6), and the current position against NHS constitutional standards.
  - Primary Care and Alliance Report, an update on the development of services by the Alliance teams including the Primary Care Team.
- General Governance: ICB Board Assurance Framework – providing ICB strategic risks and a summary of risks from their main provider's (MSE FT and EPUT) Board Assurance Frameworks; New and Revised Policies; Approved Committee minutes.

The Board is invited to note the following summary of key matters considered at the meeting of the SNEE ICB held on 25 November 2025:

- Heart of Greenstead Project Update – a verbal presentation providing an update to the Board on this Colchester based regeneration programme. This followed a detailed presentation provided to the ICB Board in May 2025.
- National Neighbourhood Health Implementation Programme – a report updating the Board on the priorities of the National Neighbourhood Health Implementation Programme and outlining the next steps in its scoping and implementation.
- Winter Plan Update – a report providing an update on winter preparedness following approval and assurance of the System's Winter Plan.
- Suffolk and North East Essex Learning from Lives and Deaths (LeDeR) of people with a learning disability and autistic people Annual Report 2024-2025
- ICB Work and Health Strategic Plan – Fit for Work, Fit for Life – presented to the Board for approval. The strategy outlines how the ICB will lead the system to:

- improve population health, by addressing the root causes of the health needs that impact a person’s ability to work; increasing healthy life expectancy and reducing the future number of people who could become economically inactive
  - Support people who are currently facing health barriers to being employed, providing personalised support programmes
  - Support employers and employees where a person is disabled or has a health need which impacts them at work, so that they can be well and remain employed.

- 2025 ICB Cost Reduction and Transition Programme Update – providing a summary of progress against the cost reduction and transition programme. Includes reference to the transition to three ICBs within the East of England region:
  - Norfolk and Suffolk ICB
  - Central East ICB
  - Essex ICB

- Research in Primary Care – providing an update on primary care research activity in SNEE, as well as the current support provided by Norfolk and Waveney ICB for primary care research.

- Green Plan – presented for approval, to meet the national requirement for all Trusts and systems to have a green plan published by end of November 2025.

- Emergency Preparedness, Resilience, and Response Core Standards – provided for approval a summary of the individual provider self-assessments. All providers reported full compliance with the exception of Norfolk and Suffolk FT which reported ‘partially compliant’.

- Freedom to Speak Up (FTSU) Report – Q1 & Q2 2025-26 – providing an update on the FTSU arrangements for ICB and Primary care providers, and detailing the number of referrals made.

- Medium Term Planning update – 2026/27 – requesting the Board endorse the approach being taken to develop the Integrated Needs Assessment, Population Health and Commissioning Strategy; and the Population Health Improvement Plan.

- SNEE ICB Performance Report November 2025

- Finance Report

- Integrated Care Partnership Committee Update

- General Governance: Governance Handbook and Constitution – requesting support to seek approval from NHS England regarding the changes to required to these key governance documents to support ICB transition arrangements; Board Assurance Framework; Committee minutes and highlight reports.

4. Recommendations / Actions

The Board is invited to receive and note this report.

Key Issues Report

Issues for referral

Originating Committee/Group and meeting date:	Performance and Finance Committee, 26 November 2025
Chair:	John Humpston, Non-Executive Director
Lead Executive (as appropriate):	Adrian Marr, Director of Finance and Deputy Chief Executive

Subject	Details of Issue	Action*
Chair's Business Board Assurance Framework (BAF) Month 6 NHS England Performance Review meeting	The report provided an update on the six strategic risks and the corporate risks relevant to the committee. A reduction in the risk rating for BAF7, Estates Development and Capital Equipment, was re-presented with the likelihood reduced. Further information was provided on development of the strategy and discussion with clinical leads prior to Board approval, the capital funding received and maximising external funding opportunities, the Board approved Green Plan and the master development plan to take this work forward. The risk rating reduction was **recommended to the Board for approval**. The Director of Finance provided the feedback from the meeting to assess the likely position at the end of the financial year. NHS England (NHSE) advised there was a clear understanding of the Trust's position, with a further meeting to be held in three months' time. The information shared with NHSE had been discussed at this committee previously. This formal process is supplemented by more informal discussions, including the national team requesting a meeting with the Chief Operating Officer regarding the cancer and elective recovery.	Escalation – January Board
Operational Performance Report (Acute)	The Trust was working through the data stabilisation phase following implementation of the Epic Electronic Patient Record and there was the potential of data incompleteness and/or data quality impacts in some metrics. **Urgent and Emergency Care:** September saw a reduction in performance with an improving trend demonstrated across all UEC metrics. One of the challenges in October was ambulance handovers and flow, with a business continuity incident called. A week-on-week improvement was now being seen,12-hour waits have improved and particularly for non-admitted patients. The UEC plan is to be adopted from 1 December. Quality and safety is being reviewed to ensure effective triangulation and to identify further ways to minimise the use of Temporary Escalation Spaces, whilst delivering on recovery plans. The Chief Medical Officer referenced the added focus on risk assessment and infection prevention and control, Datix reporting is in place and the process for harm reviews was described. With EEAST, patient pathways are being reviewed particularly for our frail patients, as the hospital is not necessarily the best option for their care. At Colchester concerns remain regarding bed capacity and Same Day Emergency Care (SDEC) is now open 24/7. In summary, the Trust delivered above its planned four-hour performance trajectory.	Assurance

Subject	Details of Issue	Action*
	Elective, Cancer and Diagnostics: There has been significant work in educating teams, launching roadshows in the first week of November, specialty deep dives, twice weekly tactical meetings and 'turbo rooms' for elective validation, focussing on specific elements of pathways. In bringing teams together in the same location, there is education and learning whilst there remains work to do with clinicians' elements of the work. The waiting list size has reduced by just over 3,000, there has been a continued reduction over the last two months in the number of patients waiting over 52 weeks, and over 85% of the patient cohort that need to be treated have been seen, treated or dated, reducing from over 90,000 to nearly 13,000, demonstrating amazing progress. Weekly meetings review specialty plans, with further work to do. Cancer performance is being validated with improvements due to be seen in November, particularly in the higher volume specialities. The diagnostic waiting list has grown significantly as expected, with a slight reduction seen in the last week. Long waiting patients from other Trusts are to be treated through ESEOC and added to the Trust's waiting list which will increase our overall PTL and those waiting longer. The impressive recovery was recognised, and the remaining areas of concern were questioned. The biggest risk remains 18-weeks delivery due to the impact of PACS. Members sought further clarity on admissions data (type 5), delays with identifying medically fit for discharge patients and the recovery plans. The Trust was now compliant with reporting of Type 5 activity. Reporting for fit for discharge has been enhanced and data now enables both sites to be observed and improvements are anticipated. Recovery is more difficult than anticipated in some specialties with plans in place to resolve this by the end of December. Triaging and outcoming of referrals also require additional work. Just under 97% of elective activity was delivered during the recent period of industrial action, and the divisional and executive teams were congratulated on this achievement.	
Operational Performance Report Community	In Ipswich and East Suffolk (IES) community nursing referrals and face to face activity continue to increase, a positive position resulting from the deliberate move to providing activity within the community. North East Essex (NEE) activity remains stable overall with RTT above the 75% target. Non-Consultant RTT performance has fallen sharply in IES and is beneath target. This is currently being assessed and may reflect a data quality issue rather than a true change in performance. UCRS performance remains positive and discussions are continuing with EEAST and the ICB about how to collectively invest to provide urgent activity in the community. The Neighbourhood Test and Learn programme launches in December across Ranworth and Abbeyfield PCNs, creating multi-disciplinary teams to support the highest-need residents. Assessing how this impacts acute care will be a key factor. Clarity was sought on virtual wards (hospital at home) and occupancy, noting the concerns around frailty. There was confidence that utilisation would improve with frailty at the centre of the hospital at home delivery model.	Assurance
Workforce Performance	The Chief People Officer confirmed the WTE variance to plan, highlighted the additional controls implemented, the management of bank and agency staffing and sickness, turnover, compliance on appraisals and progress with flu vaccinations, with more detail provided to the People and Organisational Development Committee. Agency staffing remains above plan linked to hard to recruit roles and a line-by-line review is underway with divisions. From Monday, the vacancy control panel will consider all agency requirements. The bridge analysis between planned staffing and budget was helpful, with further work required to describe the full position.	Assurance

Subject	Details of Issue	Action*
Patient safety and quality	The Chief Nurse referred to the Quality and Patient Safety Committee deep dive on PACS with a focus on the safety aspects and what this means for patients. There was good oversight of patient pathways and appropriate escalation in place to ensure patient harm was mitigated to the lowest level, with a clear impact on pathways, elective care and screening programmes. Operational pressures continue to be a challenge, we are still operating outside of funded establishment and experiencing high pressures in our assessment areas. A review is underway of the workforce requirements to meet current needs in Colchester SDEC to ensure delays aren't encountered due to senior nursing decision makers, with some minor capital works also required. The conversion of administration space is on track to open at the end of December, and the revenue implications will be clarified. The pressures at Ipswich are not experienced to the same extent. The peripatetic team are working on the case for enhanced therapeutic care, with a recent national publication to support this work.	Assurance
Finance Report Month 7	A year-to-date deficit of £10.1m was reported, £5.7m behind plan. The impact of MARS (the Mutually Agreed Resignation Scheme) was described with the financial benefit due in the coming months. The current adjusted forecast deficit is £10.7m, with proactive and positive discussions with the ICB regarding additional income to enable break-even. Divisional financial recovery plans and additional controls will continue. The full monthly position was described, and the system wide forecast is to break even. Members questioned the forecast and whether there was clarity on the impact of improved controls and the profiling of the Cost Improvement Plans (CIP) was discussed. This was a more encouraging position. Reference was made to the briefing held the previous week and the risks for the new financial year. The cumulative effect of the number of technical changes to be made was significant, including deficit support funding which will affect the Essex system. For capital, it was more positive with additional resource available to support NHS constitutional standards.	Assurance
Business planning update 2025-26 Quarter 2	The plan is divided into four quadrants, service delivery, quality, workforce and finance. Out of 33 Trust objectives, one was complete, 19 are on track to deliver and 13 are progressing but may miss the deadline. This was judged to be a fair reflection of the current position. The committee welcomed the helpful way this was presented.	Assurance
Medium Term Planning Framework (MTP): National Guidance and progress update	The Director of Finance summarised the published documents and the submission requirements. This had been discussed in detail at a Board briefing held on 18 November and the Key Issues Report was presented. The 17 December submission is likely to be a first draft for years 1 and 2. The process regarding ICB host commissioner arrangements was described, with further work required regarding the consequences of performance trajectories, for discussion at the next Board briefing on 8 December. Further nuanced guidance on Community Diagnostic Centres will be important in relation to Ipswich CDC. The second submission will link more directly to the narrative of the MTP and a revised Clinical Strategy. Templates and submission requirements have been confirmed, and the MTP requires the evidence base and the strategic approach for improving performance to meet the needs of our population and an implementation plan. A refresh of our Clinical Strategy is required with some potential changes to strategic objectives and an explicit link to the MTP to help frontline staff to understand the direction of travel and how we plan to get there. Members welcomed the wide-ranging and detailed update, felt reassured by the process with reference to the briefing sessions, but questioned the tight timetable for delivery. It would be positive to discuss this with the governors, and this was already scheduled for Council on 10 December.	Assurance

Subject	Details of Issue	Action*
Productivity and Efficiency	The month 7 report confirmed £15.1m CIP delivery against a target of £22.4m and a full year target of £43.9m. In relation to implied productivity and the national 2% improvement requirement, the Trust was now 6.3% ahead, driven by increased patient output and reduction in costs and was ranked positively nationally and regionally. The headline metrics measured nationally and plans for 2026/27 were discussed, including maximising the gains from recent investments. Further clarity was requested on the Model Health system. The reporting and timeframe for the ESEOC post-delivery review was questioned, with presentation to this committee and to Board in February. The Green Surgical Hub accreditation was confirmed; a recovery plan has been submitted and dates for committee and Board review were to be scheduled. The importance of including achievable activity levels was highlighted.	Assurance
Seasonal Variation Plan Forum	A Key Issues Report provided assurance that divisions are reviewing their schemes for discussion later today, a review of the projected bed base at Colchester had been requested, and exploration of the enabling functions around discharge and admission avoidance. This will report to the Operational Delivery and Oversight Group and on to the Executive Management Committee. The meeting later today would be helpful to understand the scale of the gap and our ability to fill it (corridor care).	Assurance
Epic Benefits Realisation	This has been a four-year journey prior to go live on 2 October 2025. The planned financial benefits were set out within the Full Business Case, divided into cash releasing, non-cash releasing, societal including reduced carbon emissions and improved compliance, and unmonetisable through improving staff and patient experience. Examples of live dashboards demonstrated how benefits will report. Divisional plans are reviewed monthly and through working with Epic additional benefits have arisen, with examples provided. There are 3,050 average concurrent users, 54,000 MyChart users, and significant clinical benefits so far from the number of patient records shared with other healthcare partners. For cash releasing benefits, the decommissioning of legacy systems and contracts, reduction in the time used for admin and clerical tasks, and areas of likely over-delivery were set out. There will be a huge reduction in printing, thereby reducing our carbon footprint. A summary confirmed the financial savings delivered to date, forecast delivery for 2025/26 and a summary of benefits for 2026/27. Regular reports would be provided to this committee and to the Quality and Patient Safety Committee in relation to patient benefits. Members questioned whether there had been any surprises. The pace at which patients are signing up to MyChart and their engagement with it was much more positive than anticipated and within most specialties there are individuals who are championing Epic. The ease of communication between clinical teams and patients has been impressive. The need for continued behavioural change was raised with reference to driving the changes in process in the first six months which was key to delivering the long-term benefits. The committee was impressed with the dashboards and the progress made so far. This had only been possible through executive and divisional involvement, and the ambition for delivery was applauded.	Assurance
Reports by Consent	The Accountability Framework month 6 report was received. Reference was made to Audit and Risk Committee discussion regarding the difference between IES and NEE in terms of the number of policy documents and corporate risks.	Assurance

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Key Issues Report

Issues for referral

Originating Committee/Group and meeting date:	Performance and Finance Committee, 19 December 2025
Chair:	John Humpston, Non-Executive Director
Lead Executive (as appropriate):	Adrian Marr, Director of Finance and Deputy Chief Executive

Subject	Details of Issue	Action*
Chair's Business Board Assurance Framework (BAF)	At the Chair's request, the Director of Finance summarised the initial Medium Term Plan submission, which had been approved at the extraordinary Board meeting held immediately prior to the committee meeting, and confirmed that it would be submitted to the NHSE Region to meet the midday deadline. The BAF report provided an update on the six strategic risks aligned to the committee, alongside the risks on the corporate risk register aligned to the committee due to their impact category. There were no proposed changes to the rating of strategic risks, however updates to controls / assurances / actions were provided across all six risks. The committee recognised the assurance provided through regular updates of the BAF. In terms of the corporate risks, members raised queries regarding the two most significant risks, relating to microbiology recruitment and pharmacy robots. Assurance was provided regarding ongoing recruitment and inclusion on the capital programme respectively.	Escalation – January Board
Operational Performance Report (Acute)	**Urgent and Emergency Care**: Performance improved in November, and further improvements have been seen in December – with similar performance across both sites. Ambulance handovers have been improving, although particularly challenging last week due to a number of closed beds related to flu. Position now improving and 4-hour wait performance continues to improve – by around 6% since last month. Across both sites non admitted ED performance has improved. There is a continued focus on patient flow task force to reduce long waits. Additional capacity to improve flow and reduce ambulance hand-over delays, as part of the Seasonal Variation Plan (SVP), is due to open at Colchester Hospital later in December. **Elective, Cancer and Diagnostics:** Work continues on resolving the PACS backlog – this is now at levels consistent with pre-Epic implementation. In terms of national reporting, weekly and monthly league tables are being shared. Improvements are being seen in 18-week and 52-week percentage, but it is not yet sufficient to move ESNEFT up the table. There are 8,799 patients to date and treat by end of March 2026. 92% of the PTL (Patient Tracking List) has been completed. The regional and national teams are being updated regularly, with discussions	Assurance

Subject	Details of Issue	Action*
	focused on cancer performance, noting slower recovery compared to other areas. Turbo rooms (combining Epic experts with operational experts (waiting list managers, etc.) have been implemented to support elective validation and improve cancer treatment timelines. The committee noted that Medically Fit for Discharge performance has not improved for some time. It was recognised that this was a snapshot figure, and that a more meaningful measure would be a process delay time from a patient being ready to discharge, to them being discharged. Following the implementation of Epic, data is more comprehensive. There is a focus on improving this internally alongside working with community colleagues to support flow.	
Operational Performance Report Community	Work in Leiston, one of the Ipswich neighbourhood teams is progressing, supporting the shift of care into communities. Early indications suggest this may be reducing ED attendances in Ipswich compared to West Suffolk, despite Ipswich having a larger, older population which typically drives higher demand. Discharge and deferred visits: Challenges remain with patient discharge across communities. In North East Essex, the focus on reducing deferred community nursing visits (as cancellations affect care stability and patient experience) is showing sustained improvements. Slow but positive progress on MSK and pain management waiting times were noted; future reports will provide better visibility on specialist and community service waits. Ongoing issues with housebound phlebotomy referrals were noted, which were impacted by QOF. A new report format is due to be presented to the committee from January 2026 – there had been a delay in implementing this due to needing to collate data from different sources – both internally and externally. The report will continue to be refined from January.	Assurance
SVP Forum update	A series of meetings have been arranged to discuss additional capacity for winter, with a particular focus on extra bed space. While the proposed plan is considered unaffordable, the priority is ensuring a safe winter given the challenges posed by flu and other pressures. Urgent decisions are needed to maintain patient flow and safety.	Alert
Workforce Performance	A slight increase in sickness was reported (to 5.11%), and voluntary turnover is stable at 5.5%. Mandatory training compliance was at 92%, but appraisals have reduced to 82%. There will be a re-focus on mandatory training and appraisal compliance now Epic training has completed. Staff in post vs planned, good. Positive position reported regarding agency and bank usage – supported by controls being exercised. It was however noted that whilst vacancy rates look positive, the actual available clinical workforce remains a challenge – with additional bed capacity compounding this. A significant proportion of wards are not currently achieving the 95% fill rate against funded establishment. To support capacity, the Trust over-recruited in September and maintained international recruitment.	Assurance

Subject	Details of Issue	Action*
Patient safety and quality	The Chief Nurse alerted committee members to updated guidance from NHSE regarding corridor care. References to 'treatment escalation space' (TES) should no-longer be used: it is now referred to as 'corridor care' to accurately reflect where people are being cared for. The guidance places an emphasis on ensuring senior and board level visibility. Use of corridors within wards is currently more easily reportable than corridor use within ED, but this is being addressed. A clear aspiration should be to reduce the use of corridors as these are currently routinely used. Additional capacity at Colchester should address. A gap analysis is being undertaken against current Standard Operating Procedures – the outcome will be reported to the Quality and Patient Safety Committee.	Assurance
Finance Report Month 8	A year-to-date deficit of £11.6m was reported, £7.8m behind plan. £300K related to unfunded costs for industrial action (not funded nationally). Current forecast outturn £16m. Continue to meet with ICB re. additional funding – Epic mobilisation, winter, etc. Receptive but not conclusive, recognise end point required for January 2026. The Trust has funded Epic £9m internally, and will be seeking support from the ICB . Within monthly cap for bank and agency. Routine elective surgery overspend £400K in month to maintain position against 52 week position. Drugs feeder – reporting from Epic into the general ledger – due to resolved by January, currently accruing value based on historic trends for that month. Cash value stable at £27.5m. Capital £18m underspent. Currently reviewing potential projects to be brought forward to reduce risk profile associated with medical equipment. SVP would create additional pressure against outturn position but continue to discuss with ICB. The committee discussed Surgery division recovery due to substantial variation from plan, a lot of work remains.	Assurance
NHS Oversight Framework	NOF Q2 published last week, Trust remained in sector 3, improved position by 4 places. Actual score moved to 2.47 from 2.48 (lower better). Not many changes in quartile. NHSE are continuously evolving the NOF. Vast majority (78%) Acute Trusts are in segments 3 and 4. Trusts within segments 1 and 2 are mostly single speciality or community providers. Nationally recognised as a trial year for NOF, may be changes in future.	Assurance
Productivity and Efficiency	The month 8 report confirmed £18.4m CIP delivery against a target of £26.8m and a full year target of £43.9m. The current focus is on delivery for remainder of year as well as planning for 2026/27. The Trust benchmarks well within the region. Productivity has improved, with figures showing a 6.3% increase year-to-date compared to the same point last year, although 2024–25 was less productive at -1.8%. Elective activity is progressing in line with expectations and links to the new elective regime. National cost collection data shows ESNEFT at 96, indicating slightly better than average efficiency. Early planning for 2026–27 is required, aligned with the wider strategy and medium-term	Assurance

Subject	Details of Issue	Action*
	financial plan. The key themes for the next two years will be stabilisation, consolidation and maximising existing assets such as Epic, Green Surgical Hubs, UTCs, and Endoscopy units. Looking to 2026/27, there is a need to understand whether the Trust is too ambitious with CIP targets: there is a need to focus on what has been delivered historically to ensure the target is realistic.	
Reports by Consent	The Accountability Framework month 7 report was received. Reference was made to the 2026/27 review of the AF, which is commencing. This will be include improved information from Epic, alignment to the NOF and additional quality metrics.	Assurance

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Key Issues Report
Issues for referral to reporting Committee/Group

Originating Committee/Group and meeting date:	People and Organisational Development Committee – 13 November 2025
Chair:	Karen Sinnott, Non-Executive Director
Lead Executive Director (as appropriate):	Kate Read, Chief People Officer

Subject	Details of Issue	Action*
Assurance Reports	The **Board Assurance Framework** was received with a new gap in assurance in relation to Epic go live and the impact on staff survey results. Given the fluidity of the wider NHS labour market and the push for corporate cost reduction, the risk and opportunity would be reconsidered as part of the ongoing review. The Chief People Officer provided an update on the medium-term planning framework as it relates to workforce, highlighting resident doctors' working lives and the appointment of a resident doctor champion; reducing sickness absence rates; the framework for eliminating agency workers; the focus on burn out and staff wellbeing and the work being undertaken. There is a focus on AI, digital and apprenticeships with Trust presentations at regional meetings to share our work, and the Department of Health and Social Care due to visit to particularly look at the work we have been doing to support those staff who are neurodiverse. Wider pay reforms and planning for industrial action were also discussed. The Committee recognised the importance of sharing the great work we are doing and the boost this provides to Trust teams. Further clarity was requested regarding agency workers, and the importance of ensuring all elements of the people agenda were highlighted during the CQC Well-led inspection. The importance of flexibility in staffing was discussed. The Director highlighted key elements of the **month 6 workforce performance report** under each of the strategic pillars. The vacancy rate was below the 4% target, overall turnover had been slowly reducing and for healthcare support workers the selection centre approach and connecting with our higher and further education institutions was working well. The strong apprenticeship programme and work experience placements, the range of measures in place to support staff wellbeing and the training of additional Cultural Ambassadors were highlighted. There was further progress to be made in relation to the Staff Survey to meet our ambitions. The plans on a page are updated on a quarterly basis and these set out achievements and next steps. Members questioned the sharing of information with West Suffolk NHS Foundation Trust and highlighted the importance of reigniting work in January and questioned the impact of Epic on the whole workforce agenda and whether there had been any surprises. Further detail was provided regarding changing roles and the work to support	Assurance

Subject	Details of Issue	Action*
	staff. The continued focus around agency and bank staffing was described in more detail, and a more aggressive target is set for the next three years due to the national assessment at month 6. The **Workforce Safeguards Report** assessed compliance with the national toolkit to ensure there are appropriate safeguards in place that support NHS boards to make informed, safe and sustainable workforce decisions. The Chief Medical Officer, Chief Nurse and Chief People Officer had undertaken an assessment which demonstrated that the Trust continues to progress the work required to triangulate all of the data available, supporting a clearer view on determining whether all aspects of the workforce are achieving maximum productivity and efficiency. They were satisfied with the outcome of the assessment that staffing is safe, effective and sustainable for 2025/26. There was discussion on the plans to revise reporting in 2026, to bring it to life from a ward to Board perspective. There are opportunities in Epic which will take time to explore and to strengthen in the medium term how well sighted the Board is on those outlying areas. The Committee recognised the challenges and welcomed the comprehensive set of assurances presented.	 Alert
Fair and Inclusive Workplace	The Trust signed up to the **Sexual Safety Charter** in March 2024. Information was provided on the review of policies and training, the concerning results of prevalence and the significant difference when reviewing the number of cases reported. This raised concern regarding behaviours and culture and the impact on staff who may be suffering in silence. The Trust was not an outlier, but 49 additional actions and the self-assessment had enabled a thorough review of current processes, most of which had been embedded. The gap analysis has given some focus for the next 12 months. The Chief People Officer referenced the training and whether it should be mandatory or a core competency. The Executive Management Committee (EMC) at its meeting the previous day had suggested it was a core competency. Members welcomed the report demonstrating that this issue is being taken seriously and comes from a position of care, there is a desire for transparency and to tackle the issues although some of these cases are not easy. There is an NHS England review of mandatory training, and this would form part of that review. **Recommended to the Board.** The **Guardians of Safe Working Hours** presented their annual report which outlined the importance of Exception Reports on Resident Doctors working hours and the feedback received via the Resident Doctor Forums which provide intelligence on the issues affecting them and their recommendations for how to improve the work environment. A separate presentation of the issues was provided, and the Committee was advised that exception reporting is working, it enables challenges to be addressed but this can take some time. Bringing together Datix incident reporting and exception reporting works well. Concern was expressed regarding ENT, wider challenges in the GMC survey and with recruitment, and the Deputy Chief Medical Officer was arranging a meeting to discuss this with the Divisional Directors. The BMA negotiated changes to the exception reporting process have been delayed until February 2026 and the Guardians and the HR department feel ready to implement these. This may lead to an increase in reporting once exception reports are anonymised. The Guardians advised that consultants generally support them in their role but there is a tension between what can be achieved and what can be managed financially. Members welcomed the candid report, referred to the areas of concern, questioned the pressures on medical staffing and whether these had increased. The Chief People Officer reflected on the trust and confidence that the Guardians have with this group of staff and questioned the	Escalation Alert

Subject	Details of Issue	Action*
	connections with the education team and medical staffing, and the opportunity for triangulation with the GMC survey. A new committee member commended the level of reporting and the level of challenge provided. A **presentation was received from the Chair of the LGBTQ+ Network**, highlighting the increasing challenges being experienced by this group of staff. The progress made over the last two years included awareness sessions, staff pronoun badges, support to Transgender staff and patients, active bystander training, work with our library to provide resources, LGBTQ+ History Month with a focus on intersectionality, education through conversation and 'cake and chat', and participation in Colchester Pride. The action plan for 2025/26 was progressing with closer links to other networks, significant work to support Epic implementation, signposting, network social events and providing support and advice for staff who reach out. The current climate and the national and international rise in discrimination against transgender people was highlighted and the issues that have arisen following the Supreme Court ruling which redefines equality through biology not lived identity, eroding the protection the Equality Act 2010 was meant to uphold. The Trust's policy is person centred care where we possibly can, going by gender and how individuals present. We await an official stance from the UK Government to enable the Trust's policy to be reviewed, and clear staff communication and training with an emphasis on zero toleration of discrimination. Reference was made to the Network Chair's attendance at Board, the discussion regarding social media, and the increasing online discrimination. The Staff Network had requested input into the review of the policy as many staff members are reporting discriminatory comments. The Committee welcomed the superb presentation capturing the joy of the network and its outreach activities to create a sense of safety, as well as raising the challenges that some individuals face every day. The support available to the network was reiterated. The Board should consider very seriously how these issues are to be addressed, and the Quality and Patient Safety Committee should also be sighted on this. The extent of cross-Trust working was questioned in seeking to assess what others are doing as we await revised legislation. The Network Chair was thanked for all they were doing to celebrate the community and to raise the issues to support a zero-tolerance approach. Assurance was provided that the social media policy was being reviewed with the involvement of the network.	 Alert
Executive Group Reports	The Faculty of Education Steering Group Key Issues Report was received. Additional information was provided on the work to development a Clinical School, enhancing the Trust's relationship with Anglia Ruskin University, our Next-Medic programme, placements for medics, and the medical employment programme. Having inspiring medics, senior nurses and AHPs attracted and developed locally will support provision of the very best care for our patients. The Equality, Diversity and Inclusion Strategic Reference Group Key Issues Report summarised the meeting held this week. The Fairness Framework was discussed at length and would be presented to this Committee and the Executive Management Committee. The EDI roadmap and the key issues to progress relating to the WRES/WDES reports were also described, demonstrating continued improvement and progress. It was proposed that Mr Khatib, as the Chair of the Group, presents to this meeting prior to his departure.	Assurance

Subject	Details of Issue	Action*
	Progress updates had previously been provided on the work on anti-racism. UNISON has asked the Trust to introduce the **Anti-Racism Charter** which had been reviewed. **Approved**. A presentation focussed on the **communications strategy** and operational plan and described the key achievements, the vision and purpose for the team, the strategic context in the NHS and the strong encouragement to adopt the recently published national strategy as an integral part of what we do. This focussed on three core themes, reassurance, progress and connection. The principles will be adopted - being patient and staff centred, locally driven, inclusive and representative, responsive, to reflect the full range of services, to be realistic, optimistic, rooted in the NHS values, flexible and set within the context of delivering the 10 Year Plan. The team provides strategic advice, responds to daily media requests, provides proactive communications and stakeholder engagement, brand and content management. They are at the heart of building our culture in setting the tone and voice for the organisation to build a motivated clinical and operational team, to promote equality and inclusion to ensure people's voices are heard and building pride in Team ESNEFT. The approach was described, including regular reviews of the right channels to communicate the messages to effect change, putting patients at the front of everything we are doing and involving people in that change. The priorities for the next six months were set out. The clarity of the presentation was welcomed in describing the breadth of the work undertaken.	Escalation

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Key Issues Report - Issues for referral

Originating Committee/Group and meeting date:	Quality and Patient Safety Committee – 18 December 2025	
Chair:	Hussein Khatib, Non-Executive Director	
Lead Executive (as appropriate):	Catherine Morgan, Chief Nurse, and Angela Tillett, Chief Medical Officer	

Agenda Item	**Details of Issue**	**Approval Escalation Alert Assurance Information**
Board Assurance Framework	The BAF report provided an update on the two strategic risks aligned to the committee (BAF4, quality assurance mechanisms regarding the quality and safety of patient services and BAF8 regarding the implementation and benefits realisation related to the Epic Electronic Patient Record) alongside the risks on the corporate risk register aligned to the committee. Amendments to the BAF related to controls / assurances and actions. No amendments to ratings were proposed. In relation to BAF8, the committee requested that consideration be given to digital literacy amongst patients. In terms of corporate risks, a new risk regarding meeting Human Tissue Authority requirements had been added to the register. This had been presented to the Risk Oversight Committee (ROC) in November 2025, including details of immediate actions. The risk will be presented in full to the January 2026 ROC.	Assurance
Assurance reports	The Chief Nurse highlighted: NHSE have published updated guidance for providing care for patients in corridors. References to 'treatment escalation space' (TES) should no longer be used: it is now referred to as 'corridor care' to accurately reflect where people are being cared for. The principles are being reviewed against our current SOPs and practices to identify any gaps. The organisation recognises it is an unacceptable practice but an ongoing challenge, specifically on the Colchester Hospital site. The new guidance includes recommended exclusion criteria, which will be reviewed against current practice. Handover45 process has been reviewed and updated; there have been some external communication concerns now resolved. Appropriate triage/initial assessment is essential. Protocols have been communicated to ambulance teams.	Assurance

	The Chief Medical Officer highlighted: Five days of industrial action (amongst resident doctors) had commenced. Ongoing monitoring of industrial action continues; at this time the teams are coping well. Elective pathways: focused Triage referral work is underway for non-cancer patients, with significant backlogs in some areas, with delays of up to 33 days in non-cancer services. The Epic team is supporting clinical teams with processes and training. **Integrated Patient Safety and Experience Report:** A key focus this month was infection prevention and control (IPC). Audit data and other quality reviews highlight the need to reinforce core IPC principles while addressing operational challenges related to patient numbers and complexity. There is a focus on empowering clinical staff to apply IPC principles flexibly. A pilot at Colchester, expanding to Ipswich, focuses on the top 15 audit interventions such as hand hygiene, equipment cleaning, decluttering, and isolation practices. Measures include redesigned isolation posters, quick teaching sessions, and prioritisation of single-room isolation in line with NHS England standards. A baseline audit revealed knowledge gaps, and ESNEFT remains an outlier in regional surveillance. Four key work-streams have been identified: C. difficile: Thematic reviews highlight delays in isolation and sample collection; CPE: Cases have risen but are stabilising with monthly IMTs and UKHSA support; IV-line management: Collaboration with procurement for quality equipment and online ANTT guidance; Surgical site infections: Deep-dives at Ipswich Hospital show no major concerns or themes. Additional actions include environmental refurbishments at Ipswich to reduce drainage-related risks, rapid POCT in ED for Flu, RSV, and Covid, and monitoring flu trends (peak at Ipswich now declining, but another surge expected per NHS England/UKHSA forecasts). The committee discussed learning in relation to case studies presented, in particular in relation to the use of gloves, and how there can be a misconception that these offer full protection. There had been a significant increase in PALS and complaints during October/November, however improvement is now being seen. Similar organisations have seen the same trend around the implementation of an EPR. There have also been a number of incidents raised, although none have led to harm. Continued improvement is being seen in pressure ulcers and falls overall with a reduction in restrictive practice and chemical restraint. The committee raised a query regarding a rise in still births; assurance was provided that a small cluster of cases had been observed but this had not continued into this month. Work to ensure data accuracy was referenced, as at least five of the fourteen cases reported in the IPSE report were late miscarriages incorrectly recorded. All stillbirth cases have been reviewed, and no common themes identified. Data now validated and updated. **CNST submission** The committee had established a CNST group to review the detailed data regarding compliance with each safety action. Evidence had been reviewed by the group, which included both the Chief Nurse and Chief Medical Officer as members. Following review, the group concluded that full compliance had been achieved, and a summary report was provided to the committee detailing this. The quality of the evidence presented was praised and the Committee recommended the CNST submission to the Board for approval.	Escalation

	Fundamentals of Care Board Assurance Report: The CKI report from the most recent FoCB was presented, and it was noted that the Board was due to meet again later that afternoon. The committee noted that improvements are beginning to be evidenced, but documentary evidence regarding compliance with the Mental Capacity Act (MCA) throughout care and treatment is challenging. Changes within Epic are supporting this, and the Bures Ward model is working effectively however there is significant unmet need and the next phase for the model needs to be considered for scale up. Epic has supported improvements with NEWS compliance. It was noted that a detailed update was provided to the CQC on 2 December detailing progress against actions in relation to the Improvement notice for Ipswich Hospital, and that a final update was due on 2 January 2026. The formal reports following the CQC Ipswich clinical inspections and the CQC Trust wide well-led review had not yet been received. Progress following the improvement notices (arising from the clinical inspections) was queried, and it was noted that there remains a risk against two key areas – improvements in the use of MCA and Deprivation of Liberty Standards have not yet translated into consistently strong practice – despite better awareness and escalation – and at Colchester Hospital there continue to be challenges maintaining appropriate nursing fill rates across 24/7 coverage, particularly when additional capacity is opened. **Quality Improvement and Clinical Outcome Report:** The committee received a presentation on clinical audit and quality improvement (QI) initiatives, detailing the activity from April to September 2025. The committee noted that completed audits had improved from 55 to 78% and recognised the many strong examples of QI initiatives. The committee heard that QI methodology is becoming more widely understood, with many projects being undertaken across multidisciplinary teams. **Inequalities Programme Update** The programme's impact on the communities the Trust serve remains significant, aligning with priorities set out in the NHS Long Term Plan. The strategy is approaching its scheduled review, with a key focus on exploring options for sustainable funding in the context of changes being made at ICB level. Key achievements presented, included the tobacco treatment services (reporting a 54% quit rate), and the impact of Epic on improving the referral rate. Other achievements highlighted included the asthma outreach project, and the Health Literacy project supporting people with lower reading ages. The unique opportunity the Trust has to offer personal support to patients when they need it most and continue that support beyond admission is a key element to driving success. **Internal Professional Standards:** The report provided an update on 7 day hospital services clinical standards. The standard set reasonable expectations around 'timeliness of response and turnaround times' for expected interventions with ED, assessment units and wards. Task forces are using clinical standards as a foundation for improvement. Improvements in the accuracy of the Expected Discharge Date (EDD) and Clinical ready to proceed data following implementation of Epic were emphasised. **Learning from Death Quarterly Report:** Presented for consideration prior to presentation to the Board, the report highlighted that deaths within same day emergency care (SDEC) are now included within ED reporting, rather than being included within admitted patient data. This change was made following implementation of Epic and reflects	

	national reporting requirements. The report highlighted that lower death numbers than the seasonal average are still being seen, both locally and nationally; rolling 12-month extended perinatal mortality rates suggest that the Trust may be an outlier in MBRRACE data for 2025 in the metric where congenital abnormalities are included in the algorithm; the latest national hip fracture report indicates that both sites now have crude and risk-adjusted mortality below the national average; new Structured Judgement Review (SJR) categories have been introduced to support shared learning at all points in the patient pathway – the reviewer is asked to identify specific learning and the team with which it should be shared. **Patient Safety Partners Report:** The Patient Safety Partners Annual report was presented, summarising activity undertaken during the year and highlighting challenges. Future priorities include balancing attendance at governance meetings with patient-facing activities, and ensuring the Patient Safety Partner role is clarified. The committee noted that this was currently being reviewed by the Deputy Chief Nurse, and that additional sources of patient voice – such as carer engagement and partnerships – will be integrated. **Research Six-Monthly verbal update:** The 2026/27 plan on a page for the Research department, within the Faculty of Education, was shared with the committee. Key highlights of the plan include opening a Clinical Trials Unity at Colchester, delivering commissioned and NIHR-funded studies, advancing strategic research priorities such as neurodiversity, dementia, maternity, and orthopaedics, and building in-house capability through dedicated research groups and academic partnerships. The aim is to increase interventional studies that benefit patients, identify and support staff with research expertise, meet RDN funding requirements, and maintain robust governance through regular Board-level review **Seasonal Variation Plan (Urgent and Emergency Care): Following** approval of the SVP in September, a series of meetings have been held to monitor interventions, chaired by the Director of People and Organisational Development. Due to recent flu surge, there have been increased attendances and admissions with earlier than usual pressures. Pressures are slowly decreasing, but a second peak is expected. The Trust has continued to remain above 100% bed occupancy. The SVP contains a number of schemes, including increasing capacity at both Colchester and Ipswich Hospitals, revised Hospital at Home model and discharge support from pharmacy. The committee noted it was important to evaluate the impact of each scheme to inform future planning.	
Annual Reports	**Patient Services Roadmap** The EDI Roadmap was presented, outlining the Trust's strategic approach to an inclusive culture where fairness and diversity is valued. It includes the long-term objectives and short-term actions to improve equality, diversity and inclusion, and will provide the framework for a set of clear goals, actions and accountability measures. Committee members were invited to provide feedback directly to the author.	Assurance
Executive Group reports	Reports were received from: The EPR Programme Board The Infection Control Committee The Patient Safety and Clinical Effectiveness Group	Assurance

	The Maternity and Neonatal Improvement Board Medical Devices Management Group. The Health and Safety Committee. The Safeguarding Families and Complex Health Committee.	
Governance	**Horizon Scanning** The committee noted that the CQC is in the process of reviewing the implementation of the single assessment framework and has established advisory groups which the Trust provides input to. **ICB Quality and Safety Update** A verbal update regarding the staff consultation launched by the ICB was provided. Significant changes to quality and safety teams have been indicated, with both the IPC and Safeguarding teams within the ICB expected to function considerably differently. The Trust is working closely with the ICB Chief Nurse to understand the impact on providers and mitigations that may be required. **Legal** An overview of recent learning from claims and inquests was presented. The national increase in the number of Regulation 28 Prevention of Future Death (PFD) reports being issued by coroners was noted, alongside the duty of the coroner to highlight concerns (where appropriate), and an organisation's right to respond.	Assurance

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Trust Board of Directors

Report Summary

<table>
<tr><td colspan="2">Date of meeting: Thursday 8th January 2026</td></tr>
<tr><td colspan="2">Title of Document: Integrated Performance Report (IPR) Month 8 (November) 2025/26</td></tr>
<tr><td>To be presented by:
Director of Finance</td><td>Author:
Deputy Finance Manager with relevant Executive Directors</td></tr>
<tr><td colspan="2">1. Status: For Approval/Assurance/<u>Discussion</u>/Information</td></tr>
<tr><td colspan="2">2. Purpose:
This report provides an overview of the Trust's performance in November 2025 across the domains of Quality, Performance, Finance and Workforce.</td></tr>
<tr><td colspan="2">Relates to:</td></tr>
<tr><td>Strategic Objective</td><td>Keep people in control of their health;
Lead the integration of care;
Develop our centers of excellence;
Support and develop our staff;
Drive technology enabled care</td></tr>
<tr><td>Operational performance</td><td>The report provides oversight of the Trust's progress in delivering operational performance objectives for 25/26. National objectives and priorities are set out in the 25/26 priorities and operational planning guidance.
Oversight is provided for acute performance in urgent care, inpatients, cancer, diagnostics, RTT & recovery. Through this monitoring, areas of excellence and those that require improvement are highlighted (allowing action to be taken where appropriate), supporting overall delivery and performance.</td></tr>
<tr><td>Quality and equality impact</td><td>The report provides an overview of the Trusts quality objectives and key actions for 25/26. Equality impacts are considered across all Quality areas, and Health Inequalities are reported through this report on a regular basis.
Quality: The board is cautious when it comes to quality and places the principle of "no harm" at the heart of the decision. It is prepared to accept some risk if the benefits are justifiable and the potential for mitigation is strong.</td></tr>
<tr><td>Legal, Regulatory, Audit</td><td>The report outlines how the Trust intends to meet or surpass the national NHS objectives confirmed by NHS England for 2025/26. Currently, through the NHS Oversight Framework the performance of providers is reviewed and monitored by SNEE ICB and ultimately NHS England.</td></tr>
<tr><td>Finance</td><td>Living within the budget allocated, reducing waste and improving productivity is one of the national priorities for 25/26.
This report sets out how the Trust is working to deliver a balanced net system financial position for 2025/26, reducing agency expenditure as far as possible (minimum reduction of 30% to current spending) and to close the activity / WTE</td></tr>
</table>

	gap against pre-Covid levels.
Governance	The report confirms the key performance indicators and targets that the Trust will monitor and measure to ensure delivery of its objectives as well as highlighting performance in reported domains. It also confirms the actions and governance that exists to monitor and maintain high performance.
NHS policy/public consultation	The report has been formulated with reference to all national guidance for 2025/26, such as national NHS objectives confirmed in the 25/26 priorities and operational planning guidance published by NHS England and the NHS Oversight Framework.
Accreditation/Inspection	Many aspects of the performance covered by the report are subject to wider scrutiny and review: such as internal and external audit of the Trust's financial performance and controls and systems, and the report subject matter is reviewed with each Executive SRO on a monthly basis.
Anchor institutions	N/A
ICS/ICB/Alliance	The Trust's performance ultimately feeds into the wider SNEE ICS reported performance (across all domains quality, workforce, finance and operations). During 2025/26 NHS England will assess performance at a system level in the first instance as part of the NHS Oversight Framework (NOF).
Board Assurance Framework (BAF) Risk	BAF2 - Financial performance – value and sustainability. BAF3 - Insufficient capital resources to progress investments. BAF4 - Quality assurance mechanisms regarding the quality and safety of patient services. BAF5 - Workforce – recruitment and retention. BAF6 - Sustainable delivery of elective performance. BAF6A - Sustainable delivery of emergency care performance targets. BAF7 - Estates development and capital equipment. BAF9 - Transformation.
Other	N/A

3. Summary:

This Integrated Performance Report (IPR) for month 8 (November) outlines the Trust's key performance indicators for Quality, Operational, Finance and Workforce domains and provides analysis at primarily an overall organisational level, though for some areas there is discussion of performance by site (notably mortality and A&E access). The Trust's post COVID-19 recovery progress is included as part of the operational commentary and analysis.

The report contains summary slides for each of the reports' key domains. This includes "trends and hotspots", along with commentary on areas that have shown improvement in June and those that require further focus and attention.

The report also summarises key performance headlines, for divisions and corporate CDGs against the Accountability Framework. Divisional Accountability Meetings to discuss Divisional Accountability to review November took place on the 2nd and 3rd of December. Corporate divisions AF meetings were cancelled.

Key points to note this month include:

NHS Oversight Framework (national Q2 publication):

- **ESNEFTs overall segment has remained at a 3.** The average metric score has improved marginally from 2.48 to 2.47.
- The Trust's rank has improved to **82 (86) out of 134 acute providers** nationally (both in terms of segment and average metric score)
- The financial override is now applicable, meaning that the Trust was not able to score higher than a 3.
- Domain scores do not inform the overall average score/segment per se. They are for information and provide an aggregated assessment of how an organisation is performing in those individual areas. Acknowledging this, the poorest performing domains are: Access to services & Patient Safety.

Quality & Patient Safety:

- ESNEFT 12-mth HSMR+ to August 2025 was 108.7, 'higher than expected'. Colchester reported 113.4 and Ipswich reported 107.1.
- ESNEFT SHMI to June 2025 was 1.07 'as expected'
- Serious harm falls. There were 5 serious harm falls in November on ESNEFT sites.
- There were 69 reportable pressure ulcers in November. There were 35 (53) grade 2 occurrences, 34 (18) grade 3 cases, and 0 (1) grade 4 cases.
- Complaints. There were 88 (133) complaints in November. This was below the monthly target of 100.
- Infection control. There has been 0 onset healthcare associated MRSA bacteraemia cases reported in November.
- There have been a total of 9 C.difficile cases during November 2025 (the total number of HOHA and COHA cases).
- There have been a total of 5 Klebsiella cases during November 2025 (the total number of HOHA and COHA cases).
- There have been a total of 0 Pseudomonas Aeruginosa cases during November 2025 (the total number of HOHA and COHA cases).
- There have been a total of 9 E.coli cases during November 2025 (the total number of HOHA and COHA cases).

Operational:

- The Trust is currently working through the activity stabilisation period of EpicEPR development. As such, there may be elements of data incompleteness and/or data quality impacts in some metrics. Where possible these have been reviewed and corrected, but some issues may remain.
- A&E 4-hour standard performance for the economy in November was 73.3%, which did not meet the national target of 78% (the Trust internal trajectory of 73.2% was met). NEE delivered a position of 74.6% whilst IES achieved 70.9% (there was a marked improved in performance in Ipswich compared to October).
- November's current RTT position is 54.23%. This is behind the internal trajectory of 57.3%
- 62-day cancer waits for first treatment remain below the internal trajectory of 79.6% at 61.3% (not validated) for November.

- Diagnostic performance for patients waiting over 6 weeks was 26.3% in November; this remains above the national target of 1%. The Trust is working to a target of less than 5% for 2025/2026.
- In terms of recovery, elective inpatient activity decreased by 0.9% in month, with day case activity increasing by 5.2%. Outpatient first attendances decreased by 0.6% while follow-ups decreased by 21.1%.
- The ESNEFT RTT waiting list decreased by 4.0%, and is above the trajectory set for the month by 5,887. Patients waiting 65 weeks or more decreased by 5 to 0. At Ipswich the 65+ cohort decreased by 1 patients, while at Colchester the cohort decreased by 4 patients. The number of patients waiting 52 or more weeks decreased by 209 to 3,044. At Ipswich, the number of 52+ week waiters decreased by 91 and at Colchester the number decreased by 9.
- Excluding OPAT, virtual ward occupancy increased by 8.0% compared to the month before. Average length of stay increased by 0.7 days and the assumed bed saving on ESNEFT acute sites decreased by 3.0 to 13.9.
- Including OPAT, in month Virtual Ward occupancy in North East Essex decreased by 48.8% compared to the previous month, and in Suffolk occupancy decreased by 42.1%. Overall, in ESNEFT, Virtual Ward occupancy decreased by 45.8%.

Finance:

- The Trust incurred a deficit of £1.5m for November, £2m adverse to plan.
- The cumulative position has moved to an actual deficit of £11.6m. This is behind plan by £7.8m.
- Agency expenditure accounted for 1.7% of all pay costs (YTD). Consultants are the staff group most reliant on agency with agency making up 6.3% of consultant costs.
- Bank expenditure accounted for 7.2% of all pay costs (year to date). Nursing are the staff group most reliant on bank with bank making up 10.2% of nursing costs.
- £3.3m of cost improvement plans were delivered in November against a target of £4.3m.
- £18.4m year to date of cost improvement plans have been delivered for the year, against a target of £26.8m.
- The Trust held cash of £27.5m at the end of November, which was £1.1m less than projected in the plan.
- Capital expenditure was underspent against CDEL cumulatively by £18.9m at the end of November, with £23.1m spent against a £43.8m plan. The main programme variances in relate to Building for Better Care (underspend is £12.1m) including Clacton STAR; and Estates & Facilities (underspend of £5.5m); in particular, the backlog programme was £2.1m underspent. Additionally, a business case for new funding of electrical elements (£2.4m) is still awaited.

People & Organisational Development:

- The vacancy rate across the Trust decreased to 3% in November from 3.4% in October.
- Voluntary turnover (rolling 12 months) marginally increased in November from 5.46% to 5.54%.
- Mandatory training compliance was 91.7% in November and has consistently been above target for 30 consecutive months.

- Sickness absence increased in November to 5.11% from 5.1% in October and was just above the Trust target of 4%. There has been an decrease this month in Cold, Cough, Flu - Influenza from 1.01% to 0.79% of the workforce. Staff absence due to anxiety, stress and depression has also increased this month from 1.32% to 1.31% of the workforce. The continued work being undertaken by colleagues in employee relations and well-being teams in supporting staff back to work and addressing early interventions with managers is recognised.
- Equality, Diversity and Inclusion training has restarted however numbers are relatively low.
- There has been an increase in concerns reported to FTSU guardian, ER and EDI teams. As well as the individuals being supported, themes are being discussed at with HR OD leads to explore interventional work.
- The Sexual Safety Charter Framework Self-assessment was completed on the 49 additional actions added to the framework. A report providing the current status of the actions, gap analysis and further actions to take forward to close the gap was shared with EDI operational groups, PODC and EMC where assurance was given. The new NHSE e-learning module on sexual safety will be added to OLM in the near future and will be in addition to the current face to face in-house training provided by ER.
- The Trust has adopted the UNISON Anti-Racism Charter and the associated recommendations will be taken forward as part of the EDI work plan.
- 52 formal ER cases (6 of which have been paused) continue to be carefully managed with 17 opened in month and with 8 cases closed.

4. Recommendations / Actions

The Board is asked to note the Trust's performance

Integrated Performance Report

East Suffolk and North Essex NHS Foundation Trust

Board of Directors

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Glossary

November 2025

ACE	Accreditation of Care at ESNEFT	FINN	Finn Clinic (Physiotherapy)	PACS	Picture Archiving Communications System
ADOS	Autism Diagnostic Observation Schedule	FOT	Forecast Outturn	PIL	Patient Information Leaflet
AECU	Ambulatory Emergency Care Unit	FYE	Full Year Effect	POD	People & Organisational Development Committee
AF	Accountability Framework	HCAI	Health Care Associated Infections	PSII	Patient Safety Incident Investigation
AMD	Associate Medical Director	HCSW	Health Care Support Worker	PSR	Patient Safety Response
AMSDEC	Acute Medical Same Day Emergency Care	HOHA	Healthcare Onset Healthcare Associated	PTL	Patient Tracking List
APC	Admitted Patient Care	HQIP	Healthcare Quality Improvement Partnership	QEH	Queen Elizabeth Hospital
ASD	Autism Spectrum Disorder	HRBP	HR Business Partner	QI	Quality Improvement
C&D	Cancer & Diagnostics	HSMR	Hospital Standardised Mortality Ratio	QIP	Quality Improvement Project
CAD	Computer Aided Dispatch	I&ES	Ipswich & East Suffolk	QTD	Quarter To Date
CAELR	Cardiac Arrest	IA	Industrial Action	R2G	Red 2 Green
CDEL	Capital Departmental Expenditure Limit	ICB	Integrated Care Board	RAG	Red Amber Green
CDG	Clinical Delivery Group	ICU	Intensive Care Unit	RES	Routine Elective Services
CHPPD	Care hours per patient day	IPC	Infection Prevention & Control	RhD	Rhesus D antigen
CIP	Cost Improvement Plan	IV	Intravenous	RI	Risk Indicator
CNS	Clinical Nurse Specialist	KPI	Key Performance Indicator	RM	Registered Midwife
CNST	Clinical Negligence Scheme for Trusts	LD	Learning Disabilities	RN	Registered Nurse
CO	Clinical Outcome	LFPSE	Learn from Patient Safety Events	RSV	Respiratory Syncytial Virus
COHA	Community Onset Healthcare Associated	LLOS	Long length of stay	RTT	Referral to Treatment
COPD	Chronic obstructive pulmonary disease	LMNS	Local Maternity and Neonatal System	SB	St Barnabas
CUSUM	Cumulative Sum	LoS	Length of Stay	SBL	Saving Babies Lives
DAM	Divisional Accountability Meeting	MACIES	Medicine and Community - IES	SDEC	Same Day Emergency Care
DCIQ	Datix Cloud IQ	MACNEE	Medicine and Community - NEE	SGA	Surgery, Gastroenterology & Anaesthetics
DM01	Diagnostics Waiting Times and Activity	MBRRACE	Mothers & Babies: Reducing Risk Audits & Confidential Enquiries	SHMI	Summary Hospital Mortality Indicator
DQ	Data Quality	MCCD	Medical Certificate Cause of Death	SJR	Structured Judgement Review
EAU	Emergency Assessment Unit	MCI	Marie Curie	SMR	Standardised Mortality Ratio
ECDS	Emergency Care Data Set	MDT	Multidisciplinary Team	SNCT	Safer Nursing Care Tool
ED	Emergency Department	MHLT	Mental Health Liaison Team	SOP	Standard Operating Procedure
EDD	Expected Date of Discharge	MNSI	Maternity & Newborn Safety Investigations	Turbo rooms	Rapid solutions to problems team
EDI	Equality, Diversity & Inclusion	MSE	Mid and South Essex Foundation Trust	UCR	Urgent Community Response
EEAST	East of England Ambulance Service	MSK	Musculoskeletal	UEC	Urgent & Emergency Care
ELR	Early Learning Review	NDD	Neurodevelopmental disorder	UECC	Urgent & Emergency Care Centre
EMC	Executive Management Committee	NEE	North East Essex	VTE	Venous thromboembolism
ENT	Ear Nose & Throat	NHSE	NHS England	VTELR	Venous thromboembolism
EoE	East of England	NMAAC	Nursing, Midwifery & Allied Health Prof Advisory Committee	W&C	Women's & Children's
EPUT	Essex Partnership University NHS Foundation Trust	NOF	NHS Oversight Framework	WDES	Workforce Disability Equality Standard
ER	Employee Relations	NQM	Newly Qualified Midwife	WRES	Workforce Race Equality Standard
ESDEC	East Suffolk Same Day Emergency	NSFT	Norfolk & Suffolk NHS Foundation Trust	WTB	Working Towards Bronze
ETOC	Enhanced therapeutic observations	NSS	National Staff Survey	WTE	Whole Time Equivalent
F&F	Friends and Family Test	OH	Occupational Health	YTD	Year to Date
F/U	Follow Up	OLM	Oracle Learning Management		
fDNA testing	Fetal DNA testing	OPAT	Outpatient Parenteral Antimicrobial Therapy		

Introduction

November 2025

This month's performance report provides detail of the November performance for East Suffolk and North Essex NHS Foundation Trust (ESNEFT).

The NHS Oversight Framework (NOF) for 2025/26 was published in June 2025 following a 3-month period of consultation. The framework describes a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

A range of agreed metrics that promote improvement and help to quickly identify where support is required fall under the following five themes:

- **Access to Services**
- **Effectiveness and Experience of Care**
- **Patient Safety**
- **People and Workforce**
- **Finance and Productivity**

The NOF is a one-year framework, which will be reviewed in 2026/27 to incorporate the ICB operating model and to reflect the 10 Year Health Plan. A focused set of national priorities, including those set out in the planning guidance for 2025/26, underpin the framework aiming to strengthen local autonomy. These are presented alongside wider contextual metrics that reflect medium term goals in areas such as inequalities and outcomes. The contextual metrics do not constitute part of the score but will inform how NHS England responds to segmentation

Every ICB and provider will be allocated a segment (ICBs will though not be subject to segmentation until 2026/27). This indicates its level of delivery from 1 (high performing) to 4 (poorly performing) with an additional segment 5 to indicate the most intensive support requirement. To reflect the importance of the NHS living within the budget it is allocated, reduce waste and increase productivity to deliver growth against demand, a financial override is in place that will mean that unless providers are delivering a surplus or breakeven position, their segmentation will be limited to no better than 3.

The Trust is considering how the recent release of the NOF, including its scope and scoring methodology, should potentially impact on its own performance management tool (the AF) and its wider reporting. Q2 data has now been published (11 December 2025). This is only the second set of national data published. Overall, the Trust's rank has improved to 82 (86) out of 134 acute providers. Further detail about this publication and the Trust's performance is detailed in subsequent slides.

As part of the Trust's 2023 Well Led Review, a redesign of the Integrated Performance Report (IPR) was agreed. The format that follows in this report now includes a slide that highlights high level trends and hotspots that broadly cover the five national themes as well as local priorities. The trends and hotspots highlighted are shown as areas that have seen improvement in the month and areas that require further work.

Before each section of the report a more detailed trends and hotspots update is also provided showing metrics which highlight performance in key areas of the domain and include more detail on the issues raised in the high-level trends and hotspots. Spotlight reports are also included to provide more detail on performance across each domain, and where necessary, corrective actions that are being implemented.

Information on elective recovery, including comparison to 19/20 performance, is now included as part of the slides detailing performance. Detailed commentary is provided about RTT recovery.

The Accountability Framework (AF) is the mechanism by which the Trust holds both Clinical and Corporate Divisions to account for their performance. The AF is the primary performance management regime to cover all aspects of divisional business plans. As a consequence, its purpose is to ensure that the Trust delivers its promises to patients and stakeholders. The domains covered in the AF broadly cover the five national themes laid out above and a review is held at the end of each financial year to consider metrics included, their weights and their targets. Divisional Accountability Meetings to discuss Divisional Accountability to review October took place on the 2nd and 3rd of December. Corporate divisions AF meetings were cancelled.

NHS Oversight Framework (NOF) 2025/26 – Overall Position (Detailed)

November 2025

NOF Publication						
REF	Metric	Data period - Q2	Metric Score - Q2	Provider rank - Q2	Provider value - Q2	Q1 - Q2 value movement
Access to Services						
AS1	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Sep-25	3.52	109/131	56.46%	↓
AS2	Difference between planned and actual 18 weeks performance	Sep-25	1.00	49/131	0.91%	↓
AS3	Percentage of patients waiting over 52 weeks for elective treatment	Sep-25	3.43	103/131	3.23%	↓
AS4	Percentage of patients waiting over 52 weeks for community services	Sep-25	3.07	83/120	4.90%	↓
AS5	Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Sep-25	3.32	88/118	72.62%	↓
AS6	Percentage of patients treated for cancer within 62 days of referral	Sep-25	2.67	63/118	68.75%	↑
AS7	Percentage of emergency department attendances admitted, transferred or discharged within 4 hours	Sep-25	2.74	73/123	74.00%	↓
AS8	Percentage of emergency department attendances spending over 12 hours in the department	Sep-25	3.06	82/119	10.23%	↓
Effectiveness and experience of care						
EE1	Urgent Community Response 2-hour performance	Sep-25	2.1	45/89	85.86%	↓
EE2	Summary Hospital Level Mortality Indicator		2.00			
EE3	Average number of days from discharge ready date to actual discharge date (including zero days)	Sep-25	1.63	27/125	0.42	↑
EE4	CQC inpatient survey satisfaction rate		2.00			
Patient Safety						
PS1	NHS Staff Survey – raising concerns sub-score	2024	2.89			→
PS2	CQC safe inspection score (if awarded within the preceding 2 years)					
PS3	Number of MRSA bacteraemia cases (12 months)	Sep-25	3.40	100/134	6.00	↑
PS4	Proportion of C. difficile infections versus threshold (12 months)	Sep-25	3.40	99/134	1.34	↑
PS5	Proportion of E. coli bacteraemia versus threshold (12 months)	Sep-25	3.30	96/134	1.27	↑
People and workforce						
PW1	Sickness absence rate	Jun-25	1.38	27/205	4.1%	↓
PW2	NHS staff survey engagement theme score	Jun-25	2.85			→
Finance and productivity						
FP1	Planned surplus/deficit		1.00			→
FP2	Variance year-to-date to financial plan	Sep-25	3.00	158/205	-0.69	↓
FP3	Implied productivity level	Jun-25	1.52	23/134	5.83%	↑
		Total metric score	**53.28**			

- **ESNEFTs overall segment has remained at a 3.** The average metric score has improved marginally from 2.48 to 2.47.
- The Trust's rank has improved to **82 (86) out of 134 acute providers** nationally.
- The financial override is now applicable, meaning that the Trust was not able to score higher than a 3.
- Domain scores do not inform the overall average score/segment per se. They are for information and provide an aggregated assessment of how an organisation is performing in those individual areas. Acknowledging this, the poorest performing domains are: **Access to services** and **Patient Safety**.

NHS Oversight Framework (NOF) Q2 publication: East of England providers (published externally) November 2025

Below is the summary position for **East of England providers**:

Total 134 Acute Providers

Region	Trust Type	Trust Subtype	Trust Code	Trust Name	Quarter	Average metric score	Average metric rank score	Adjusted segment (after financial override)	Adjusted Segment Rank	Financial Override
East	Acute trust	Acute - Specialist	RGM	Royal Papworth Hospital NHS Foundation Trust	Q2 2025/26	1.33	1	1	1	No
East	Acute trust	Acute - Large	RWH	East and North Hertfordshire Teaching NHS Trust	Q2 2025/26	2.1	35	2	21	No
East	Acute trust	Acute - Teaching	RWG	West Hertfordshire Teaching Hospitals NHS Trust	Q2 2025/26	1.83	17	3	31	Yes
East	Acute trust	Acute - Small	RGR	West Suffolk NHS Foundation Trust	Q2 2025/26	2.27	55	3	57	Yes
East	Acute trust	Acute - Medium	RC9	Bedfordshire Hospitals NHS Foundation Trust	Q2 2025/26	2.34	66	3	66	Yes
East	Acute trust	Acute - Teaching	RGT	Cambridge University Hospitals NHS Foundation Trust	Q2 2025/26	2.37	71	3	71	No
East	Acute trust	Acute - Large	RGN	North-West Anglia NHS Foundation Trust	Q2 2025/26	2.46	81	3	81	Yes
East	Acute trust	Acute - Large	RDE	East Suffolk and North Essex NHS Foundation Trust	Q2 2025/26	2.47	82	3	82	Yes
East	Acute trust	Acute - Teaching	RD8	Milton Keynes University Hospital NHS Foundation Trust	Q2 2025/26	2.55	90	3	90	Yes
East	Acute trust	Acute - Teaching	RM1	Norfolk and Norwich University Hospitals NHS Foundation Trust	Q2 2025/26	2.74	108	4	108	Yes
East	Acute trust	Acute - Small	RQW	The Princess Alexandra Hospital NHS Trust	Q2 2025/26	2.86	119	4	119	Yes
East	Acute trust	Acute - Large	RAJ	Mid and South Essex NHS Foundation Trust	Q2 2025/26	2.93	126	4	126	Yes
East	Acute trust	Acute - Teaching	RGP	James Paget University Hospitals NHS Foundation Trust	Q2 2025/26	3.08	129	4	129	Yes
East	Acute trust	Acute - Small	RCX	The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	Q2 2025/26	3.29	134	4	134	Yes

Total national ranks in terms of adjusted segments, including the East of England provider performance:

Segment	Q1	Q2	Q1	Q2	Q1	Q2
	Total number of providers		Rank		Number of EoE providers	
1 (Best)	16	20	1 - 16	1 - 20	1	1
2	11	8	17 - 27	21 - 29	1	1
3	76	76	28 - 102	30 - 103	6	7
4 (Worst)	31	30	103 - 134	104 - 134	6	5
	134	134				

Of the 134 providers, only 29 (27) have achieved segment 1 or 2 (approximately 22%) including only 2 East of England organisations. The **vast majority of providers are in segments 3 and 4 (approximately 78%).** The **East of England does have a disproportionately higher amount of segment 4 providers** (EoE 36% compared to 22% nationally).

Summary Performance: Trends & Hotspots

November 2025

	Areas of Improvement	Areas requiring further work
QUALITY	**Mortality** • Rolling 12-month crude mortality rates in HSMR and SMR continue to indicate downward trends **Quality** • Continued reduction in the rate of falls across the Trust at 5.2 per 100 bed days	**Mortality** • Rolling 12-month crude mortality rates in HSMR and SMR continue to indicate downward trends • NHSE Digital has reversed its decision to record same day emergency care in the emergency care data set. Although the aim is to include data in the admitted patient care data set spring 2026, it will be many months before trust informatics teams nationally will be able to adjust clinical systems **Quality** There has been a review of the ACE programme during the pause for Epic implementation including how data sets will be utilised from the Epic dashboards. Going forward the number of follow up visits for wards achieving Bronze will increase to support assessment of impact of quality improvement plans. Visits will restart in February 2026. Patient safety reporting is under review to strengthen an outcome and learning focus rather than process reporting. This report will be enhanced to reflect the developments made.
PERFORMANCE	• Both sites saw improvement across the UEC metrics as stabilisation from Epic improvement with a 10.6% improvement on 4-hour performance in Ipswich and ESNEFT above plan submitted for November, with improvements in 12 hour waits also. • No patients over 65 weeks for any reason and improvement in those patients waiting over 52 weeks. • Improvement in Activity levels following the planned reductions – still some areas where improvements are slower to return. • Improvement month on month for Cancer • Elective Focus throughout November with Elective Roadshows, speciality Deep Dives, tactical weekly and Turbo rooms all to support validation and education with a dedicated focus on data quality i.e. duplicate referrals, appts with no next steps and DNA appts. This supported the reduction of the total waiting list size.	• The Trust achieved 73.3% performance against the A&E 4-hour standard in November. • Both sites are working towards approved recovery plans with good progress seen in non admitted pathways and December performance on track to improve over November. • Taskforce workstreams inpatient flow and frailty admission prevention will supplement and enable the improvements required for our patients waiting longer than 12 hours. • Time to care week planned week commencing 15th December across both sites to support further improvements to Handover 45 and LOS. • Turbo rooms and focus for Cancer as per Elective approach • Resolution of PACS issues to support the improvement in all pathways in Cancer, DM01 and RTT. • Focus is on the 62-day backlog with additional capacity planning underway for November onwards. • Returning to pre-go live activity levels for those areas still not back to plan

Summary Performance: Trends & Hotspots

November 2025

	Areas of Improvement	Areas requiring further work
FINANCE	• Bank costs in November were £4.1m which is the lowest it has been all year and on the ceiling target for the month. Cumulatively the Trust has exceeded the bank ceiling by £2.9m (£35.5m v £32.6m). • Agency costs in November were £0.7m. Reported monthly costs have dipped under the 25/26 ceiling set for the first time this year (£0.1m). Cumulatively the Trust has exceeded the agency ceiling by £1.9m (£8.4m v £6.5m). • £3.3m of cost improvement plans were delivered in November which was an improvement on the £3.1m delivered in October.	• The Trust reported an actual deficit of £1.5m in November, £2m adverse to plan. This means that the cumulative position has moved to a deficit £11.6m. This is behind plan by £7.8m. Renewed energy needs to go into the Trust's recovery plans (both central schemes and those locally developed by divisions). • While the in-month delivery of CIP improved on the prior month by £0.2m, this was still below the target delivery by £0.9m (target £4.3m). • £18.4m year to date of cost improvement plans have been delivered for the year, against a target of £26.8m. • Capital expenditure cumulatively underspent against CDEL by £18.9m at the end of November. The main drivers of this underspend were Building for Better Care (£12.1m) and Estates & Facilities (£5.5m).
WORKFORCE	• The Trust is -1.3WTE at variance to plan across all workforce (across agency, bank and substantive workforce) • The Trust is reporting 5.11% sickness absence, which is above target of 4%. Wellbeing calls alongside supportive absence management processes are in place to support colleagues to return to work safely. • The Trust is reporting a 5.54% voluntary turnover rate. • **National Staff Survey (NSS)** – The survey closed on 28 November with a response rate of 50.3% this year, reaching the 2025 target of 50%. Results are due to be released in March 2026. • Various leads have supported the Sexual Safety Charter Framework Self-assessment on the 49 additional actions within the framework. This provides the current status of the actions, gap analysis and further actions to take forward to close the gap. A self-assessment has been undertaken to review our progress against the additional 49 actions, the outcomes will be reported to the EMC/POD/Board in due course.	• The Retention Team is currently working closely with two departments holding listening sessions to gather information about staff experience that feeds into a report for the commissioning management team. Feedback sessions for staff have been arranged for Jan 2026. • New Staff are invited to 1, 3 and 6 month review meetings as part of new starter programme gaining insight into their early experience working at the Trust. Feedback is shared with HRBP's to support with divisional improvements. • EDI Training has restarted post implementation of Epic system, although numbers of participants are low. The EDI team is continuing to support on EDI related concerns. • Further work to complete the gap analysis actions from the Sexual Safety Charter Framework. • October saw the launch of freedom to speak up month, revising our training, speak-up guide and speaking to staff about the importance of raising concerns

Summary Performance - Accountability Framework and DAMs

November 2025

The Accountability Framework (AF) is the Trust's principal performance management tool.

The AF is the mechanism used to hold both Clinical and Corporate divisions to account for their performance and to ensure that Trust resources are converted into the best possible outcomes, for both the quality of services and treatment, as well as the value for money of the work performed.

The AF therefore encapsulates the Trust's vision and more detailed objectives, resourcing, delivery, monitoring performance, course correction and evaluation.

Changes to the AF are agreed on a monthly basis through the Informatics Programme Board and actioned the following month. The AF policy was updated and agreed through the Executive Management Committee in October 2022.

Aggregated AF Score Classification Explained

Domain Scores	Aggregated AF Score	
Two or more domains scoring '1'	1	Inadequate
Three or more domains scoring '2' or below, with / or any domain score of '1' occuring once only	2	Requires Improvement
Other combinations of domain scores between an overall domain score of '2' and '4'	3	Good
Two or more domains scoring '4' and no domain scoring below a '3'	4	Outstanding

2025/26 reporting – Month 7

This report summarises the month 7 (2025/2026) performance reported in the Accountability Framework (AF). The October performance accountability meetings took place on the 2nd and 3rd of December.

Clinical divisions performance

	Cancer and			Medicine and			Medicine and			Surgical Division			Women and Children		
Caring	4	3	↓	3	3	→	3	3	→	2	2	→	3	3	→
Responsive	2	2	→	2	2	→	2	1	↓	1	1	→	1	1	→
Safe	3	2	↓	2	2	→	2	2	→	2	3	↑	3	3	→
Effective	3	4	↑	3	3	→	4	3	↓	2	1	↓	3	4	↑
Well-Led	2	2	→	1	1	→	2	2	→	2	2	→	3	2	↓
Use of Resources	1	1	→	1	2	↑	1	1	→	1	1	→	1	1	→
Aggregated AF Score	2	2	→	1	2	↑	2	1	↓	1	1	→	1	1	→

Summary Divisional Performance

- Cancer and Diagnostics maintained a score of 2 and Medicine & Community IES improved from a 1 to a 2.
- Medicine and Community NEE declined from a score of 2 to a score of 1 in month.
- Women and Children and Surgical Division maintained a score of 1 in month.

Corporate performance

The October Corporate performance accountability meetings were cancelled due to operational pressures.

	Communications			Estates & Facilities			Faculty of Education			Finance & Information Services			Governance		
Well-Led	3	3	→	3	2	↓	3	3	→	3	3	→	2	3	↑
Use of Resources	4	4	→	2	1	↓	4	4	→	1	3	↑	3	3	→
Aggregated AF Score	3	3	→	3	2	↓	3	3	→	2	3	↑	3	3	→

	Human Resources			ICT			Medical Director			Nursing			Operations			Research & Innovation		
Well-Led	3	3	→	3	3	→	3	2	↓	3	4	↑	3	3	→	3	3	→
Use of Resources	3	3	→	2	2	→	2	3	↑	2	1	↓	2	3	↑	3	3	→
Aggregated AF Score	3	3	→	3	3	→	3	3	→	3	2	↓	3	3	→	3	3	→

Summary Corporate Services Performance

- Finance & Information improved from a 2 to a score of 3 (Good).
- Estates & Facilities and Nursing declined from a 3 to a 2 in month.
- All other corporate CDGs maintained a score of 3 (Good).

Score Rating	1 Inadequate	2 Requires Improvement	3 Good	4 Outstanding

Quality: Trends & Hotspots

November 2025

Mortality	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
12-mth rolling HSMR	100	122.1	113.0	111.5	110.0	108.6	108.7
SHMI	1	1.09	1.08	1.07	1.07	TBC	TBC

Incidents & Complaints	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Total incidents reported	-	3,231	3,402	3,042	3,058	3,003	3,252
Never Events	0	1	1	0	1	0	0
Mixed Sex Accommodation Breaches	0	305	267	206	206	70	44
Total complaints reported	-	117	116	97	110	133	88
Overdue Complaints	0	0	0	1	1	7	10
Complaint Response Compliance	95%	95.4%	97.5%	97.2%	100.0%	98.1%	93.0%
Total PALs Enquiries	-	349	319	366	567	815	633
Duty of Candour (Initial)	100%	86.4%	95.5%	91.2%	85.1%	90.5%	87.3%

Infection Control	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
C.Diff	0	17	11	16	17	12	9
MRSA	0	1	0	0	2	0	0
MSSA	0	4	8	4	6	3	10
E.Coli	0	13	14	16	7	11	9

Harm Free Care	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
VTE Risk Assessments	95%	68.75%	75.64%	65.71%	63.30%	N/R	94.74%
Total falls (acute)	-	185	196	199	203	186	178
Serious Harm falls	0	3	4	0	3	3	5
Category 3 Pressure Ulcers	0	17	17	16	10	18	34
Category 4 Pressure Ulcers	0	1	0	0	0	1	0

FFT	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
F&F: Inpatients % Recommending	90%	92.9%	94.8%	93.2%	90.5%	N/R	93.9%
F&F: A&E % Recommending	90%	87.4%	86.6%	87.5%	85.4%	78.6%	73.7%
F&F: Day Case % Recommending	90%	96.0%	97.6%	97.4%	95.3%	97.4%	83.3%
F&F: Birth % Recommending	90%	100.0%	100.0%	90.0%	83.3%	N/R	100.0%
F&F: Post Natal Ward % Recommending	90%	88.9%	100.0%	80.0%	100.0%	50.0%	N/R
F&F: Antenatal % Recommending	90%	50.0%	84.6%	85.7%	100.0%	100.0%	100.0%

Areas of Improvement

Mortality

- Rolling 12-month crude mortality rates in HSMR and SMR continue to indicate downward trends.

Quality

Infection Prevention and control

Continued reduction trend for C Difficle infection over past 3 months however continued work through the improvement programme required to sustain this.

Significant improvement seen in compliance with VTE risk assessment which is marginally under the Trust target for the first time in the year.

Sustained reduction in MSA breaches following implementation of new pathway at the Ipswich site.

Areas requiring further work

Mortality

- NHSE Digital has reversed its decision to record same day emergency care in the emergency care data set. Although the aim is to include data in the admitted patient care data set spring 2026, it will be many months before trust informatics teams nationally will be able to adjust clinical systems.

Quality

It is anticipated that the complaint response compliance will improve in Q4 following delays encountered during the period of EPIC mobilisation where there was a rise in the number of complaints and workload prioritisation. The number of complaints raised in month has significantly reduced following the rise seen alongside Epic implementation as anticipated.

PALS enquires remain higher than the monthly average, but a downward trend is being seen.

Spotlight Report

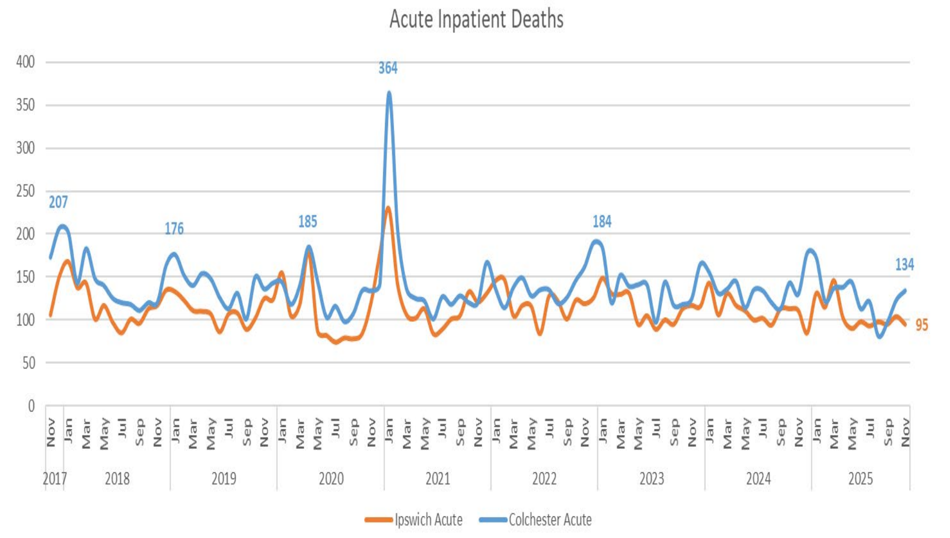
November 2025

Mortality Trend Data – All inpatients and ED attenders

November 2025

229 acute inpatient deaths (227 in October):

- **Ipswich 95 – below seasonal ‘norm’**
- **Colchester 134 – lower end of seasonal ‘norm’**
- **29 deaths in SDEC (31 in October)**

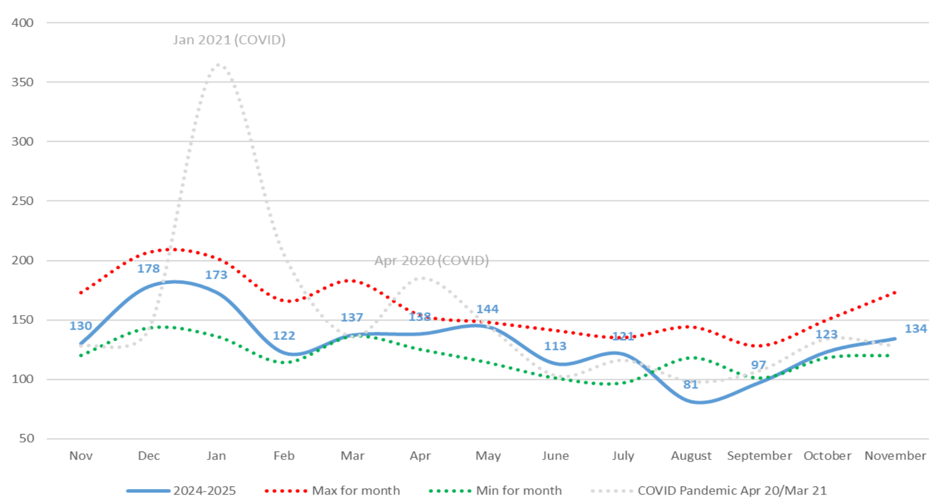


IP = inpatient SDEC=same day emergency care	Nov 2025 No. Deaths	Nov 2024 No. deaths	Rolling 12 mths avg
Ips acute IP	95 (104)	111	106
Col acute IP	134 (123)	130	130
Ips SDEC	13 (13)	ED 11	ED 11
Col SDEC	16 (18)	ED 15	ED 14
E Suffolk Comm	0 (4)		
NE Essex Comm	9 (5)		
Virtual ward	1 (2)		

Figure in brackets = previous month

Ipswich Hospital Mortality Trend - Inpatient Deaths 2017 - 2025
(Max & Min exclude COVID-19 pandemic months)

Jan 2021 (COVID)
Apr 2020 (COVID)
111, 85, 131, 115, 146, 103, 90, 98, 93, 98, 95, 104, 95
Nov, Dec, Jan, Feb, Mar, Apr, May, June, July, August, September, October, November
2024-2025 · Max for month · Min for month · COVID Pandemic Apr 20/Mar 21



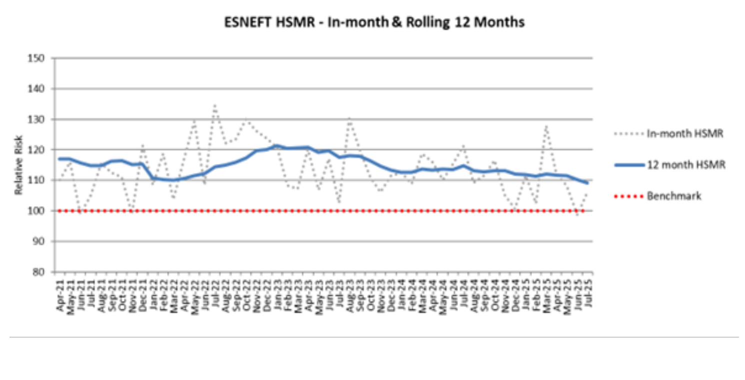
Spotlight Report

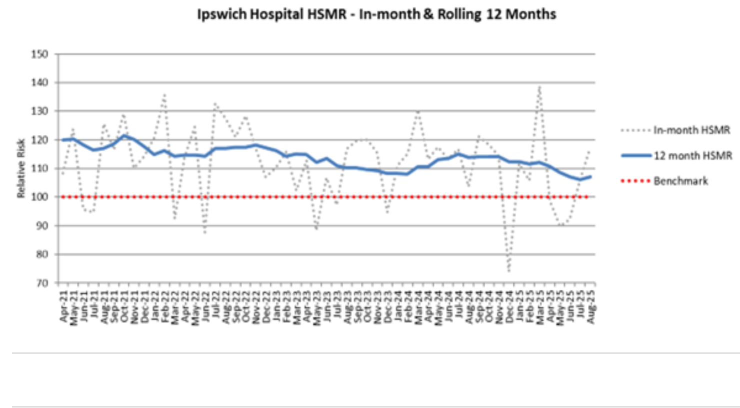
November 2025

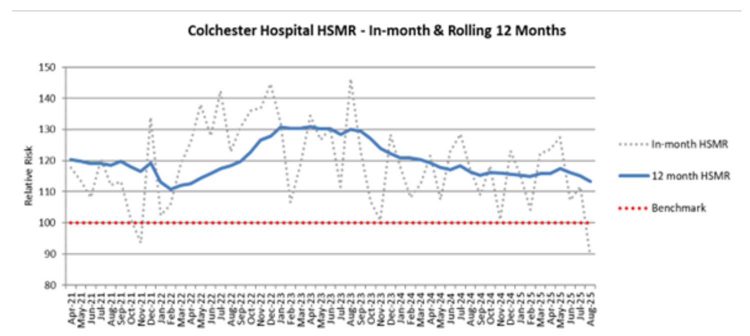
Mortality Ratios - Data Source DF Intelligence (Telstra Health)

Summary

- **ESNEFT 12-mth HSMR+ to August 2025, 108.7, ‘higher than expected’**
- **ESNEFT 12-mth all-diagnoses (SMR+) to August 2025, 108.1, ‘higher than expected’**
- **ESNEFT has the sixth highest crude mortality rate in the peer group (ordinary admissions)**



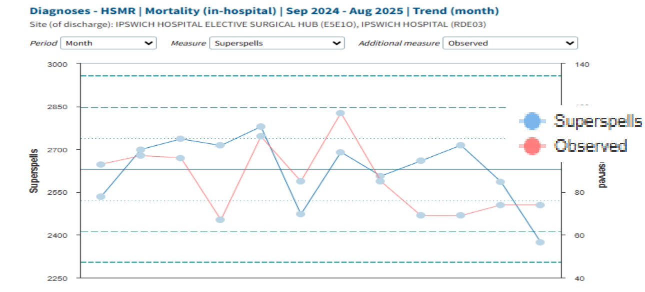




Dr Foster Summary – 12 months to August 2025

Aug 2025 - 12 month rolling data except where specified	ESNEFT	IPS	COL
HSMR+ in-month	101.0	117.1	89.4
HSMR+	▲ 108.7	▲ 107.1	▼ 113.4
HSMR+ Lower confidence limit	▲ 104.4 Outlier	▲ 100.7 Outlier	▼ 107.4 Outlier
HSMR+ with emergency cases removed	▲ 109.8 Outlier	▲ 107.1 Outlier	▼ 115.4 Outlier
HSMR+ Death rate (nat. ➤3.7%) (emergency cases removed)	➤ 3.6%	▲ 3.3%	➤ 4.4%
All diagnosis groups (SMR)	▲ 108.1	▲ 106.7	▼ 110.6
Lower confidence limit (all)	▲ 104.3 Outlier	▲ 101.0 Outlier	▼ 105.4 Outlier
SMR+ with emergency cases removed	▲ 109.4 Outlier	▲ 106.7 Outlier	▼ 113.2 Outlier

Increasing HSMR+ rates over the last few months at Ipswich Hospital are being driven by a reduction in the number of HSMR+ discharges, coupled with a stable mortality rate.

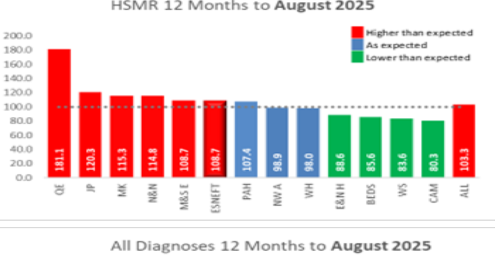


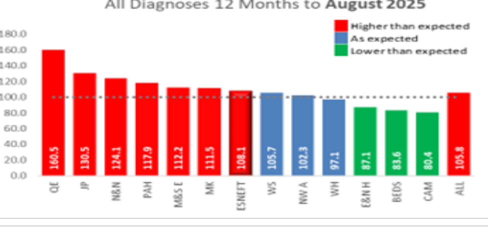
Weekend/Weekday HSMR Admissions

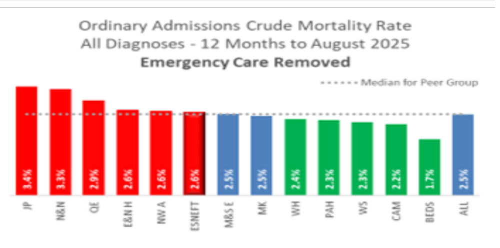
In the 12 months to August 2025, both weekday and weekend ESNEFT HSMR emergency admissions were ‘higher than expected’. Only Ipswich Hospital weekday admissions were ‘as expected’.

National & Regional Peer Group

The Trust’s mortality ratios are currently ‘higher than expected’. The region is currently regarded as being ‘higher than expected’. Many peer trusts have significant volumes of uncoded spells, particularly West Suffolk (30% discharges) and QEH (19% discharges), so the data should be used with caution. QEH has seen a drop in the number of discharges over the last two years coupled with a drop in the ‘expected’ % deaths.





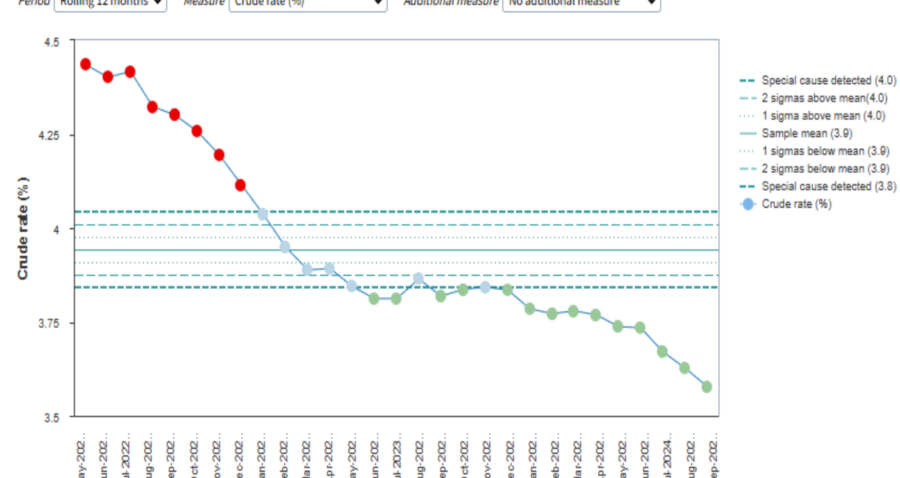


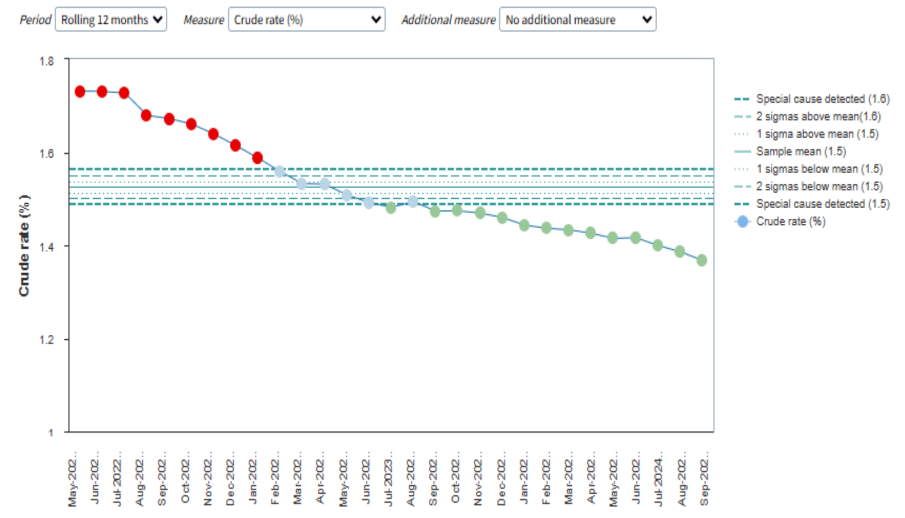
Crude Mortality Rates

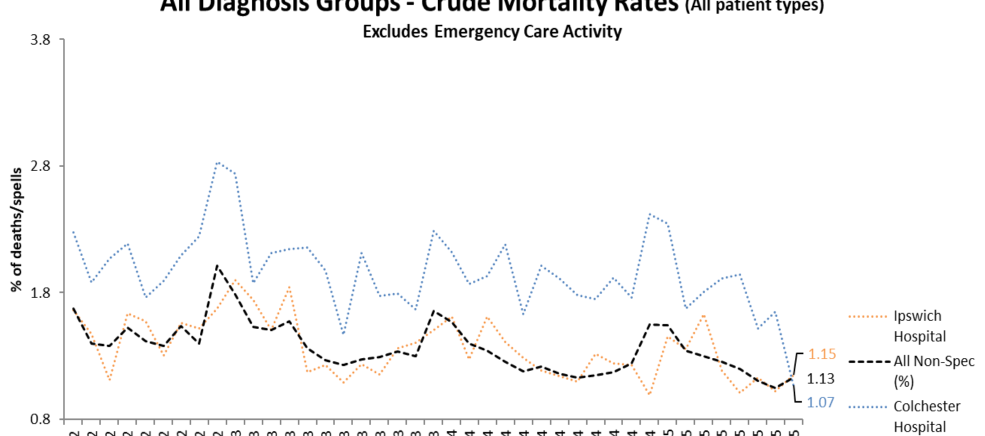
ESNEFT rolling 12-month trend data for crude mortality rates in HSMR+ and SMR+ (emergency cases removed) indicate a downward trend between April 2023 and August 2025.

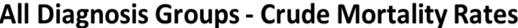
For August 2025, ESNEFT mortality for ordinary admissions were 2.1% compared to a national rate of 2.1%

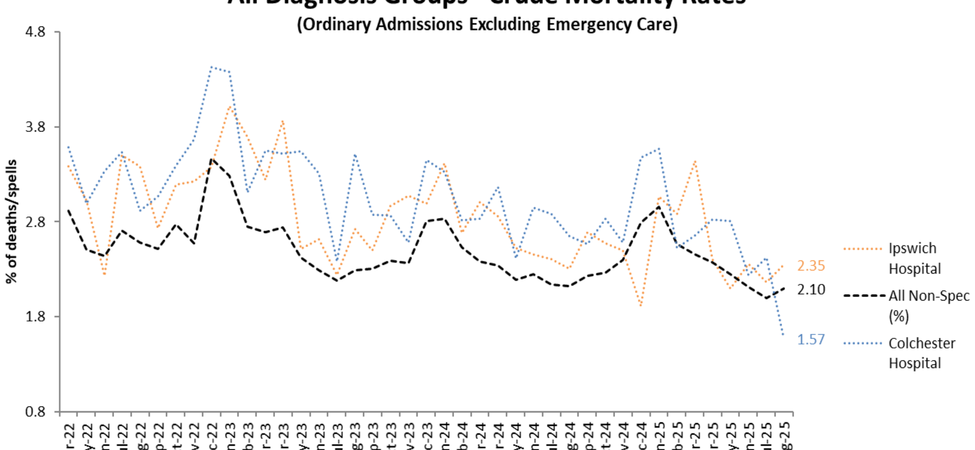
- **Colchester 1.6%**
- **Ipswich 2.4%**











Spotlight Report

November 2025

Risk-Adjusted Mortality: High Risk Conditions – Source Dr Foster: Results to August 2025

3 of the 4 high risk groups are showing 'higher than expected'.

Pneumonia Ranking by Relative Risk

Rank 88/118 trusts, HIGHER THAN EXPECTED

ESNEFT, 115.2

250
200
150
100
50
0

UNIVERSITY… COUNTY… EAST CHESHIRE… GATESHEAD… SALISBURY NHS… SOUTH TYNESIDE… BRADFORD… SOMERSET NHS… NOTTINGHAM… WEST… ESNEFT CALDERDALE… THE… THE… UNIVERSITY… LEEDS TEACHING… WORCESTERSHIR… EAST AND… SURREY AND… NORFOLK AND… HOMERTON… NORTHAMPTON… UNIVERSITY… SOUTH TEES… BARNSLEY… EAST SUSSEX… BARTS HEALTH… MAIDSTONE… ISLE OF WIGHT… NORTH BRISTOL… LIVERPOOL… MID CHESHIRE… THE NEWCASTLE… UNIVERSITY… MANCHESTER… ROYAL DEVON… NORTH TEES… WEST SUFFOLK… ST GEORGE'S… CAMBRIDGE…

Sepsis Ranking by Relative Risk

Rank 72/118 trusts, AS EXPECTED

ESNEFT, 110.4

250
200
150
100
50
0

UNIVERSITY… NORFOLK AND… TORBAY AND… WIRRAL… SOUTH… NORTHERN… SOUTH TYNESIDE… CHESTERFIELD… PORTSMOUTH… UNIVERSITY… THE… BOLTON NHS… GUY'S AND ST… THE NEWCASTLE… MID AND SOUTH… EAST SUSSEX… UNIVERSITY… MILTON KEYNES… LEEDS TEACHING… BARKING… ROYAL SURREY… UNIVERSITY… NOTTINGHAM… BLACKPOOL… SHERWOOD… WEST SUFFOLK… CALDERDALE… UNITED… HAMPSHIRE… ISLE OF WIGHT… FRIMLEY HEALTH… LONDON NORTH… CAMBRIDGE… LEWISHAM AND… KING'S COLLEGE… MERSEY AND… COUNTESS OF… LANCASHIRE… THE HILLINGDON… WEST…

COPD Ranking by Relative Risk

Rank 95/118 trusts, HIGHER THAN EXPECTED

ESNEFT, 128.8

250
200
150
100
50
0

UNIVERSITY… COUNTY… THE QUEEN… EAST… ROYAL UNITED… GLOUCESTERSHI… NORTHAMPTON… ROYAL… CALDERDALE… MID AND… UNIVERSITY… JAMES PAGET… MEDWAY NHS… CROYDON… EAST KENT… AIREDALE NHS… EPSOM AND ST… UNIVERSITY… DORSET… WEST SUFFOLK… SOUTH… KING'S COLLEGE… WARRINGTON… WIRRAL… BRADFORD… HAMPSHIRE… UNIVERSITY… WALSALL… CAMBRIDGE… ROYAL DEVON… SHERWOOD… BARTS HEALTH… THE… UNIVERSITY… MANCHESTER… NORTHUMBRIA… BOLTON NHS… NOTTINGHAM… MERSEY AND… ROYAL SURREY… COUNTESS OF… UNIVERSITY… SURREY AND… OXFORD… ROYAL FREE… THE DUDLEY… BARKING… WEST… KETTERING… THE… TORBAY AND… SANDWELL AND… UNIVERSITY… THE… UNIVERSITY… LANCASHIRE… GUY'S AND ST…

Acute Bronchitis Ranking by Relative Risk

Rank 109/118 trusts, HIGHER THAN EXPECTED

ESNEFT, 163.2

300
250
200
150
100
50
0

UNIVERSITY… THE QUEEN… COUNTY… GUY'S AND ST… JAMES PAGET… THE PRINCESS… GEORGE ELIOT… CALDERDALE… GATESHEAD… UNIVERSITY… PORTSMOUTH… ROYAL DEVON… THE… MERSEY AND… EAST CHESHIRE… EPSOM AND ST… NOTTINGHAM… SOUTH… THE DUDLEY… ROYAL… MANCHESTER… NORTH… MID AND… SOUTH… UNIVERSITY… SANDWELL… NORFOLK AND… YORK AND… NORTH… EAST KENT… SHERWOOD… TAMESIDE AND… THE… THE ROYAL… ASHFORD AND… WEST SUFFOLK… LEWISHAM… UNIVERSITY… LONDON… BARNSLEY… BARKING… NORTHERN… UNIVERSITY… EAST AND… NORTH TEES… STOCKPORT… KETTERING…

A review this year of pneumonia cases overseen by the AMD for Patient Safety did not identify any significant issues in care.

Each month, Deteriorating Patient CNSs/Resus Officers screen all deaths where the patient died with sepsis/septic shock on the death certificate. Cases are highlighted for review if care deficits are identified.

Performance within the COPD group has slipped since 2023/4. The crude mortality rate has increased from 4.4% to 4.9%. The CUSUM chart indicates that a peak in activity in Jan/Feb 2025 resolved without triggering. This group has always struggled with diagnostic accuracy on admission. Analysis from the 12 months to September 2025 indicates that 48/75 patients had COPD on their death certificate - 21 in part 1A and 15 with infective exacerbation. Other deaths in this group had a wide range of other conditions, not all of them respiratory.

Analysis of the acute bronchitis group indicates that other acute trusts do not code as many cases to this this group as ESNEFT. This may account for poor benchmarked performance.

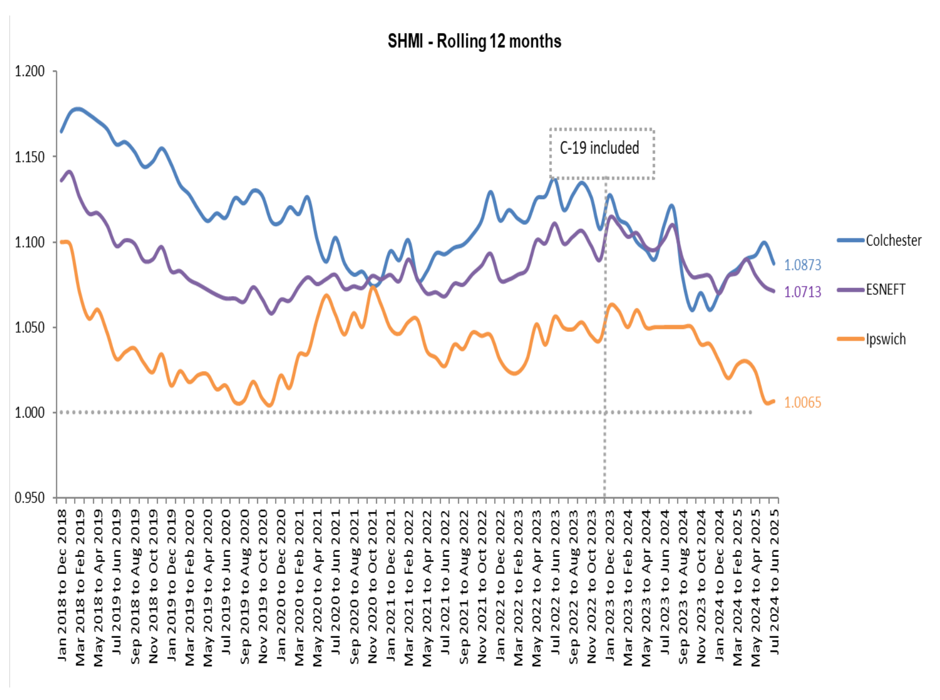
SHMI (includes deaths within 30 days of discharge)

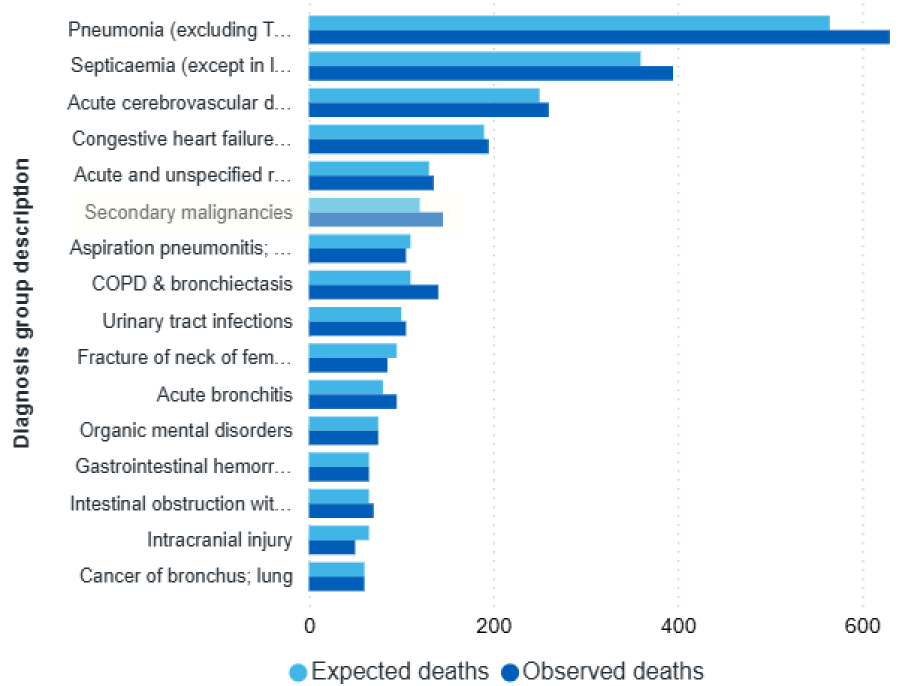
Office for Health Improvement and Disparities

All SHMI diagnosis groups are 'as expected' with the exception of secondary malignancies which are 'higher than expected' – performance has deteriorated since September 2024.

ESNEFT SHMI to June 2025 was 1.07 'as expected'.

Colchester 1.09 as expected
Ipswich 1.00 as expected.





SDEC Update

NHSE Digital posted 25/11/2025 that: *"A decision has been taken to change the reporting approach to speciality Same Day Emergency Care (SDEC) activity from the Emergency Care Data Set (ECDS) as specified in version 4.0 of the ECDS Information Standard Notice to the Admitted Patient Care (APC) data set, with the expectation this is implemented from Spring 2026. We will provide guidance on updated recording and reporting expectations by early 2026 but in the meantime, we ask providers in the process of shifting SDEC reporting into ECDS to pause and retain their current status quo."*

ESNEFT recently migrated SDEC to the ECDS with the roll-out of Epic.

Spotlight Report

November 2025

Mortality Review Dashboard

ESNEFT (Colchester Apr 17 - Jun 18, Ipswich & Colchester from Jul 18): Learning from Deaths Dashboard - October 2025-26

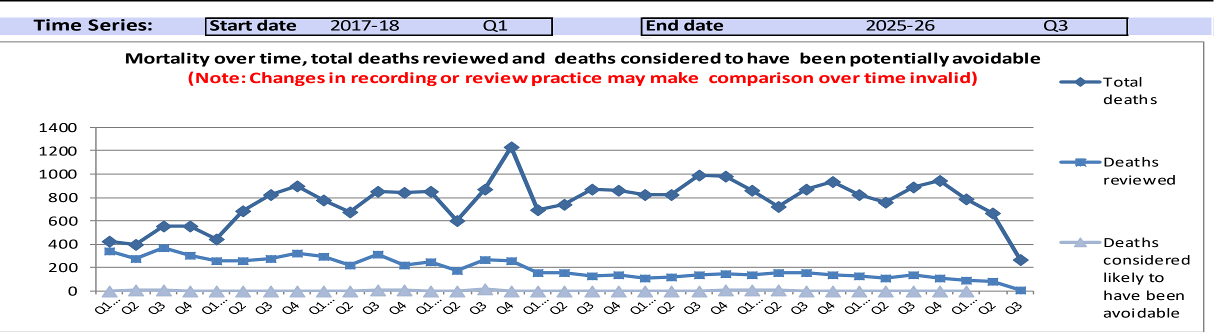
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Potentially Due to Problems in Healthcare (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total No. of deaths considered to have been possibly due to problems in healthcare (Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
268	215	9	29	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
268	667	9	84	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1725	3423	184	488	1	9

Time Series:	Start date	2017-18	Q1	End date	2025-26	Q3



Total Deaths Reviewed by Mortality Methodology Score

Score 1 Definitely due to problems in healthcare		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%

Score 2 Strong evidence there were problems in healthcare		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	1	0.6%

Score 3 Probably due to problems in healthcare (more than 50:50)		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%

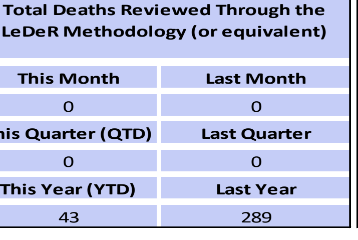
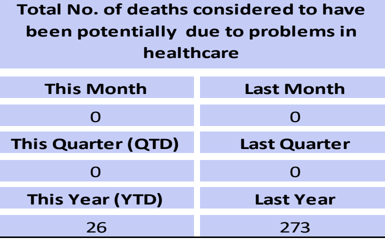
Score 4 Probably due to problems in healthcare but not very likely		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	5	3.0%

Score 5 Slight evidence that death was due to problems in healthcare		
This Month	1	12.5%
This Quarter (QTD)	1	12.5%
This Year (YTD)	15	9.0%

Score 6 Death was definitely not due to problems in healthcare		
This Month	7	87.5%
This Quarter (QTL	7	87.5%
This Year (YTD)	145	87.3%

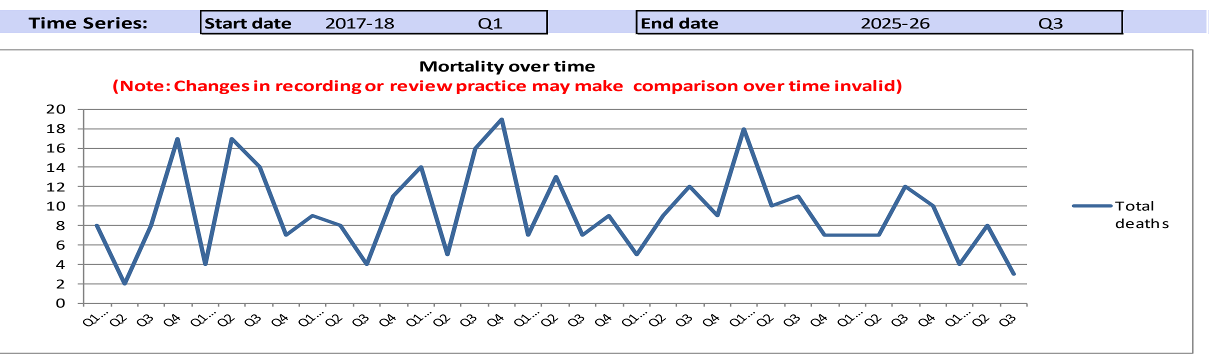
Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Due to Problems in Healthcare for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total No. of deaths considered to have been potentially due to problems in healthcare	
This Month	Last Month	This Month	Last Month	This Month	Last Month
3	3	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	8	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
15	36	43	289	26	273

Time Series:	Start date	2017-18	Q1	End date	2025-26	Q3



Spotlight Report

November 2025

Mortality Review Dashboard

- **April 2023 to March 2025, 19 SJR-reviewed deaths where issues in healthcare may have contributed to death – see next slides for detail.**

Trust	ESNEFT (Colchester Apr 17 - Jun 18, Ipswich & Colchester from Jul 18)
Org Code	432
Month	October
Year	2025-26

Total deaths include inpatients, paediatrics, maternity, ED
Total deaths also includes patients with LD reviewed under SJR criteria by local team - additional LeDeR death reviews are shown separately

Please note, where it is indicated that care contributed to death (score 1, 2 or 3), the case is escalated to the Patient Safety Team for PSR/PSII - this result may be revised following MDT review. The results shown below are for SJRs only.

Not all deaths are subject to mandatory review.												Review of mandatory case records			
Financial Year	Month	Total Deaths	Total Deaths Reviewed	Deaths likelihood > 50% contributed to death	Deaths judged to have been due to problems in healthcare: Defin 1	Evidnc 2	>50/50 3	<50/50 4	Slight 5	Deaths judged not due to problems in care 6	LD Deaths	No. deaths subject to case record review	No. reviews returned	% Case record reviews completed	No. case record reviews outstanding
2024-25	April	284	39	1	0	0	1	0	2	36	1	24	23	96%	1
2024-25	May	270	47	1	0	0	1	0	4	41	4	31	30	97%	1
2024-25	June	267	40	1	0	1	0	1	3	35	2	23	23	100%	0
2024-25	July	264	41	0	0	0	0	0	3	37	3	25	24	96%	1
2024-25	August	236	35	0	0	0	0	1	2	32	1	18	17	94%	1
2024-25	September	263	38	2	0	1	1	1	2	33	3	20	20	100%	0
2024-25	October	299	54	2	0	1	1	3	7	42	0	30	30	100%	0
2024-25	November	275	41	0	0	0	0	1	3	37	4	22	22	100%	0
2024-25	December	316	41	1	0	1	0	0	4	36	8	25	24	96%	1
2024-25	January	358	47	1	0	0	1	1	5	40	4	31	31	100%	0
2024-25	February	269	30	0	0	0	0	2	1	27	5	18	18	100%	0
2024-25	March	322	35	0	0	0	0	0	1	35	1	24	22	92%	2
2025-26	April	278	36	1	0	1	0	0	4	31	1	26	21	81%	5
2025-26	May	274	27	0	0	0	0	2	3	21	0	16	13	81%	3
2025-26	June	238	28	0	0	0	0	1	2	25	3	20	17	85%	3
2025-26	July	244	31	0	0	0	0	0	1	29	1	22	18	82%	4
2025-26	August	208	24	0	0	0	0	1	2	16	4	19	14	74%	5
2025-26	September	215	29	0	0	0	0	1	2	16	3	15	8	53%	7
2025-26	October	268	9	0	0	0	0	0	1	7	3	23	8	35%	15

Spotlight Report

November 2025

Learning from Deaths meeting 5 December 2025 – meeting limited to one presentation owing to clinical pressures

- **Coroner has stated that all deaths of children aged 0-17 must be referred to the coroner.**
- **SOP from Coroner will outline visiting rights for bereaved parents.**
- **Thematic review underway for paediatric emergency transfers to tertiary surgical centres.**
- **Actions taken following the death of a patient who experienced a massive haemorrhage.**

Biannual Update – Women's and Children's Services

Meetings are ongoing between the division and mortuary staff to facilitate parental viewing. Training/competencies are being rolled out across the Children's Band 7 nursing teams. The ADN advised that guidance had recently been revised to ensure that all deaths of children aged 0 to 17 years of age are referred to the coroner. A coroner's SOP, developed in conjunction with the police, will be issued shortly.

Paediatrics are undertaking a thematic review of deaths following transfer to tertiary surgical units. A local SOP is to be drafted for paediatrics (acute abdomen pathway). Addenbrooke's are working on a regional acute abdomen pathway, which will include important information to communicate to the tertiary unit for transfer (PEWS). Early themes include the effective communication of case-urgency between ESNEFT, the PaNDR team (Paediatric and Neonatal Decision Support and Retrieval Service) and the tertiary centre.

There has been issues in EpicEPR with regard to sudden and unexpected death in infancy and childhood (SUDIC) – bereavement documentation and processes are not yet built – this has been raised with the relevant RDG.

A case study involved the very sad death of a young Gynae patient.

Summary of findings, areas for improvement and safety actions

Recognition of critical blood loss and timely escalation to a consultant: All staff should understand the signs and symptoms of hypovolaemia and ensure early recognition, management and escalation. Training sessions for the gynaecology team (medical and nursing) for deteriorating gynaecology patients are planned to commence in February 2026 and will be undertaken twice per year going forwards for continued learning.

Transfer to theatre in a timely fashion as per NCEPOD recommended standards: The NCEPOD recommended standards must be incorporated into standard practice in gynaecology to ensure there is no similar delay in transfer to theatre in the future. A local audit of transfer to theatre intervals compared to NCEPOD standards should be undertaken. A SOP for categorisation of gynaecology patients requiring surgery is in development, aimed to be approved in January 2026 to aid the team with decision making and timely transfer to theatre depending on condition, in line with NCEPOD recommendations.

Measuring and Recording Blood Loss and Fluid Balance: The ward needs to implement more robust processes of measuring, recording and escalation of fluid balance, including timely measured blood loss. This must include full details of estimated blood loss within the 24-hour period. Further training has been undertaken across the nursing team to ensure that blood loss is measured (not estimated) wherever possible. Fluid balance charts are now in EpicEPR, and training and audit of compliance is ongoing.

Review of the Massive Haemorrhage Protocol to ensure an anaesthetist is included in the protocol (completed October 2024).

Prostap Clinic Referrals Review: The team will review the referral process into the Prostap clinic to ensure that referrals are clear and streamlined, thereby reducing potential confusion or delays. The referral process is under review to reduce delays wherever possible. The Prostap guideline has recently been reviewed and updated to ensure the criteria for use is clear.

Spotlight Report

November 2025

Cases where care may have contributed to death

Where an investigation identified that care may have contributed to death:

6 SJRs/Datixes

1 ELR* (different grading to SJR)

1 PST Review (TBC)

SJR Summary – where care may have contributed to death (separate to PSIRF outcomes) – final assessment to be agreed		
Sep 2024	Datix	Suspicion that a tubogram (procedure using contrast to determine if a drain/tube is blocked) introduced bacteria into the patient's abdominal cavity resulting in spontaneous bacterial peritonitis, sepsis and death.
Sep 2024	ELR	Patient discharged on Dexamethasone with no PPI cover, which may have caused duodenal perforation. When attended A&E, CT appropriately requested but the report wasn't escalated by radiology and no one checked the report. When deteriorated overnight, no escalation and no TEP. Action - HotSpot
Oct 2024	Datix	Early management of sepsis in this patient could have led to avoidance of death. Needed early recognition of gas gangrene and escalation to specialist teams including diabetes foot and vascular surgery.
Oct 2024 (NEW)	TBC – PST review required	Raised by ME central line should have been removed promptly at first suspicion of line infection and MRI was delayed (Datix 16688) – graded as 'probably avoidable' but supporting narrative advises 'Patient was frail with multiple comorbidities. Death was not preventable despite best medical management. Line sepsis, osteomyelitis of the metal work in the vertebra contributed to the death.'
Dec 2024	Datix	Patient presented to ED with chest pain and should have had an urgent ECG within 15 minutes of arrival. This would have resulted in an immediate transfer to Papworth Hospital. Follow-up now with Patient Safety Team.
Jan 2025	Datix	Prolonged wait outside ED owing to lack of beds, delays in treating signs of sepsis on arrival, delay in the delivery of acute coronary syndrome treatment, failure to monitor according to trust protocols, delays to escalation to ITU - clinical opinion requested by Patient Safety team.
Apr 2025 (Not currently included)	*Datix*	*Awaiting post mortem examination results – young patient admitted with vertigo. Her death was likely a result of Neuroleptic Malignant Syndrome with exposure to Quetiapine shortly before death - lethal hyperthermia (with resultant DIC). The root cause of her presentation might well have been an autoimmune encephalitis (and most probably Anti-NMDA-R Encephalitis from an abrupt immunological recognition/response to an existing ovarian teratoma/dermoid cyst containing neuronal tissue) – TBC*
April 2025	Datixes	Self-harm – the patient safety team and the divisional director of nursing have chased investigators for their final report. The ELR identified that the patient was reviewed daily by the pain team owing to chronic abdominal pain, but had declined analgesia other than paracetamol and amitriptyline as she had found medication to be ineffective. Staff noted a new confusion with agitation and insomnia. DOLS, MCA and BI were completed as the patient was declining treatment. The patient's son expressed concern and was advised that a mental health review had been requested. EPUT identified low mood but 'no concerns' and the patient was deemed to be 'low risk'. Early learning points note that there was no evidence that 1:1 enhanced support was requested when the patient's mood worsened. Safety-netting advice from EPUT would have been helpful. Although the behaviour chart was completed inconsistently, what was documented indicated limited restlessness and agitation. The patient should have been re-escalated when she became more delusional and expressed hopelessness.

Accrediting Care at ESNEFT (ACE)

Summary

Care Accreditation provides us with the tools to undertake a comprehensive assessment of quality of care at ward, unit and team levels. It does this by bringing together key measures into a single, overarching framework, from across nursing and clinical care, as relevant to us and to our patients.

Percentage of grading across all standards for the twenty-four wards included:

Bronze – 38%

Silver - 31%

Gold – 4%

Working towards Bronze – 27%

Focus EpicEPR: Accrediting Care at ESNEFT (ACE) results for wards visited in Q2;

	Ward	D'Arcy	Waldgringfield	Somersham	ED CH	ED IH	Aldham
Standards	Individualised Care	Silver	Bronze	Silver	Silver	Bronze	WTB
	Dignity and Respect	Silver	Silver	Silver	WTB	Silver	WTB
	Safeguarding, Complex Health and Consent	Silver	WTB	Silver	Gold	Silver	WTB
	Leadership , Education and People	Bronze	Bronze	Bronze	Silver	Silver	Silver
	Harm Free Care	WTB	Bronze	WTB	Bronze	WTB	Bronze
	Delivering Safe Care	WTB	Silver	Bronze	Silver	Bronze	Silver
	Nutrition and Hydration	WTB	Silver	Silver	Bronze	Silver	Bronze
	Clinical Governance	Bronze	Silver	Silver	Bronze	WTB	WTB
	Infection Prevention and Control & Environment Safety	Bronze	Bronze	Silver	WTB	WTB	WTB
Overall		Bronze	Bronze	Silver	Bronze	Bronze	Bronze

Spotlight Report

November 2025

Accrediting Care at ESNEFT (ACE)

Summary

Care Accreditation provides us with the tools to undertake a comprehensive assessment of quality of care at ward, unit and team levels. It does this by bringing together key measures into a single, overarching framework, from across nursing and clinical care, as relevant to us and to our patients.

The ACE programme recommenced in December, meaning next month's report will include EAU Ipswich and Birch ward's return visit

The nursing audit programme recommenced in November with changes made due to EpicEPR

Data from all wards since inception of programme

Standards / Ward→	Haughley	EAU	Peldon	Washbrook	Martlesham	Brightlingsea	West Bergholt	Shotley	Stanway	Stow upland	Layer Marney	Birch	Grundisburgh	Needham	Stour	Easthorpe	Debenham	Nayland	D'Arcy	Waldgringfield	Somersham	ED CH	ED IH	Aldham
Individualised Care	Bronze	Bronze	Bronze	Silver	Silver	Bronze	Silver	Gold	Silver	Silver	Bronze	WTB	WTB	Bronze	Silver	Gold	Silver	Bronze	Silver	Bronze	Silver	Silver	Bronze	WTB
Dignity and Respect	WTB	WTB	WTB	Bronze	Silver	Silver	Silver	Silver	Bronze	Bronze	WTB	WTB	Bronze	Bronze	Bronze	WTB	WTB	WTB	Silver	Silver	Silver	WTB	Silver	WTB
Safeguarding, Complex Health and Consent	Silver	Gold	WTB	Silver	WTB	Silver	WTB	Bronze	WTB	Gold	Gold	Bronze	Silver	Silver	Gold	WTB	Silver	Silver	Silver	WTB	Silver	Gold	Silver	WTB
Leadership , Education and People	Silver	Bronze	Bronze	Silver	Silver	WTB	Bronze	Silver	Bronze	Bronze	Silver	Bronze	WTB	Bronze	Silver	Silver	Bronze	Silver	Bronze	Bronze	Bronze	Silver	Silver	Silver
Harm Free Care	Silver	WTB	WTB	WTB	Bronze	Bronze	WTB	Silver	Bronze	WTB	Bronze	Bronze	WTB	WTB	WTB	Bronze	WTB	WTB	WTB	Bronze	WTB	Bronze	WTB	Bronze
Delivering Safe Care	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Silver	Bronze	Bronze	WTB	Bronze	Bronze	Bronze	Silver	Bronze	Bronze	Bronze	WTB	Silver	Bronze	Silver	Bronze	Silver
Nutrition and Hydration	Gold	WTB	WTB	Silver	WTB	WTB	WTB	Silver	Bronze	Bronze	WTB	WTB	Bronze	WTB	Bronze	WTB	Bronze	WTB	WTB	Silver	Silver	Bronze	Silver	Bronze
Clinical Governance	Silver	Bronze	Silver	Silver	WTB	Bronze	WTB	Silver	Silver	Bronze	Silver	Bronze	WTB	WTB	Bronze	Silver	Silver	Bronze	Bronze	Silver	Silver	Bronze	WTB	WTB
Infection Prevention and Control & Environment Safety	Silver	Silver	Bronze	Bronze	Silver	Bronze	Gold	Silver	Bronze	WTB	Bronze	Bronze	WTB	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Silver	WTB	WTB	WTB
Overall	Silver	Bronze	Bronze	Bronze	Bronze	Bronze	Bronze	Silver	Bronze	Bronze	Bronze	WTB	Bronze	Bronze	Bronze	Bronze	Silver	Bronze	Bronze	Bronze	Silver	Bronze	Bronze	Bronze

Standard	Most common grading achieved from data so far
Individualised care	Silver
Dignity and Respect	Working towards Bronze
Safeguarding, Complex Health and Consent	Silver
Leadership , Education and People	Tied Bronze and Silver
Harm Free Care	Working towards Bronze
Delivering Safe Care	Bronze
Nutrition and Hydration	Working towards Bronze
Clinical Governance	Silver
Infection Prevention and Control & Environment Safety	Bronze

Spotlight Report

November 2025

Clinical Outcome (Audit)

Progress Against Planned Audits – Snapshot Mid Nov

Planned Audits 2025-26: Split by Division

Division	Proposed	Registered	In Progress	Complete	Complete - With Actions	Overdue	On Hold	Agreed to Discontinue
C&D	55	1	10	8	6	12	0	0
Corporate	3	0	0	0	0	0	0	0
MaCIES	5	0	1	1	3	1	0	2
MaCNEE	19	0	4	0	0	2	0	6
MSK SS	43	0	9	4	7	5	0	0
SGA	17	0	8	0	6	16	0	0
W&Cs	41	0	6	2	1	0	0	3

Key Focus Tasks for Nov/Dec/Jan

1: Review Planned audits & highlight any of 'risk if not completed'

2: Register & start planned audits starting with higher risk first

3: Prepare for audit planning discussions 2026-27 with Audit team in Dec/Jan

Planned Audits Completed in November from 2025-26 Plan

* **CD24-088**: Audit of Adherence to Management of the RhD Negative Mother using fDNA testing and Anti D Immunoglobulin in Pregnancy
* **IP25-001**: QI Polypharamacy - Post fall medication review - any fall patients admitted from virtual fraility ward/UCR/Cleric
* **MACIES25-001**: Audit of the use of prolonged-release opioids and transdermal patches following fracture of humerus, neck of femur and/or pubic rami on discharge from acute and community hospitals.
* **MACNEE**: – 0
* **MSK SS**: – 0
* **SGA25-061**: To measure infection control practices against local and national standards
* **SGA24-081**: Retrospective review of mortality and morbidity during first 12 months after discharge from ICU.
* **WC25-024**: Open Access - Service Evaluation
* **WC25-033**: Audit of the Hyponatraemia Pathway in Labour

Updates from RSM Audit Actions

- New Audit & Improvement SOP live & shared across divisions
- New KPIs x2 introduced & baseline measured from 2024-25 & shared across divisions
- New KPIs monitored on new dashboard & reported first time in Nov across Divisions
- CO team & governance managers collaborating on improving audit action tracking

Supporting QI

13 QI projects supported by audit team to collect baseline data

3 still in progress

Clinical Audit Awards

Moving towards HQIP Best Practice

Developing access to central records via excel for visibility, transparency & shared learning

Planned Audits Completed in November from 2024-25 plan that were carried over

***C&D:** 1 of 26 Adherence To Guidelines In Stopping Anticoagulation Prior To Interventional Radiology Procedures CD24-102

* **MACIES:** Cleared all 11 (4 discontinued)
* **MACNEE:** 1 of 9 Pneumonia MEDCOL24-031
* **MSK SS:** 0 of 13
* **SGA:** - 0 of 34
* **W&C:** - 0 of 2

Spotlight Report

November 2025

QI Project Benefits – 8 projects completed in November

QIP23-446
Developing parent / carer knowledge and confidence to support childrens' sensory needs .

Co-design with 71 families
Sensory workshops
Community based

Parent confidence ⇧ 99% in understanding sensory needs of autistic child
More able to self-manage dysregulation & avoid professional intervention

Adopted elsewhere & Spreading across Essex

QIP25-571B
Bridging the gap between discharge from critical care and attending a face-to-face follow-up appointment

Co-design with 28 CCU patients with Faster follow up for improved recovery

Patient satisfaction ⇧ 20%
Improved recovery
Early identification of referral
Waiting list ⇩ 57%
Less travel & parking

Explore MyChart function for self-referrals

QIP25-597
Reducing the carbon footprint with electronic ENT Patient Information

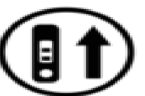
Collaboration between ENT & the Green Team
QR codes for patient info

Less paper & printing costs
⇩ Carbon footprint 2500 kgCO2e
Time saved on admin & paper stock management

Share across ESNEFT via Green Champion Network

QIP25-638
Review of CT and Ultrasound Sensitivity in the Diagnosis of Suspected Appendicitis

Correlation of sensitivity between ultrasound & histopathology results
Monitoring, education & reinforcing protocols



Correlation sensitivity ⇧ 34%
Improved diagnostic accuracy of suspected appendicitis

QIP25-640
Hot Swollen Joints – optimising treatment & plan of care

Education, communication & surveys with T&O colleagues
Visual aids & prompts

Diagnostic investigations moved towards best practice
ESR ⇧ 53% LFT ⇧ 14%
Blood Culture ⇧ 15%
Radiographs ⇧ 13%

Expand to medical team and ED clinicians

QIP25-643
Assessing smoke exposure in paediatric patients

Awareness posters, proforma, education & communication for Drs

More children under 5 with asthma/wheeze having smoking exposure assessed ⇧ 29%

Area to improve : 44% of the children were readmitted with worsening symptoms with only 19% of their parents given smoking cessation advice

QIP25-648
Communication & Swallowing Education for Carers of People with Dementia

Co-design with family members & carers
Dementia friendly, eating & drinking educational sessions
Community based

Increased confidence for carers in communicating, planning activities and addressing eating & drinking difficulties
Continue sessions with more support for advertising them
Develop videos & info packs to share

QIP25-649
Time Matters: Sculpting a Dynamic SOP for Returner's Clinic Excellence

Service user feedback
Developed new SOP
Awareness campaign

Appropriate referrals ⇧ 44%
Quality of referrals improved
New referral cap to 20 per day

Opportunity to build into Epic
Better able to mesaure demand & capacity

Spotlight Report

November 2025

Patient Safety – Incident Reporting

There was an increase in Datix submitted for November. Highest patient related incidents reported continue to be pressure ulcers and falls.

There were a total of 3,252 (3,003) incidents reported in November. 1,647 of these incidents were Patient Safety related. There were 41,398 (44,137) admissions resulting in 73.5 incidents per 1,000 bed days across ESNEFT.

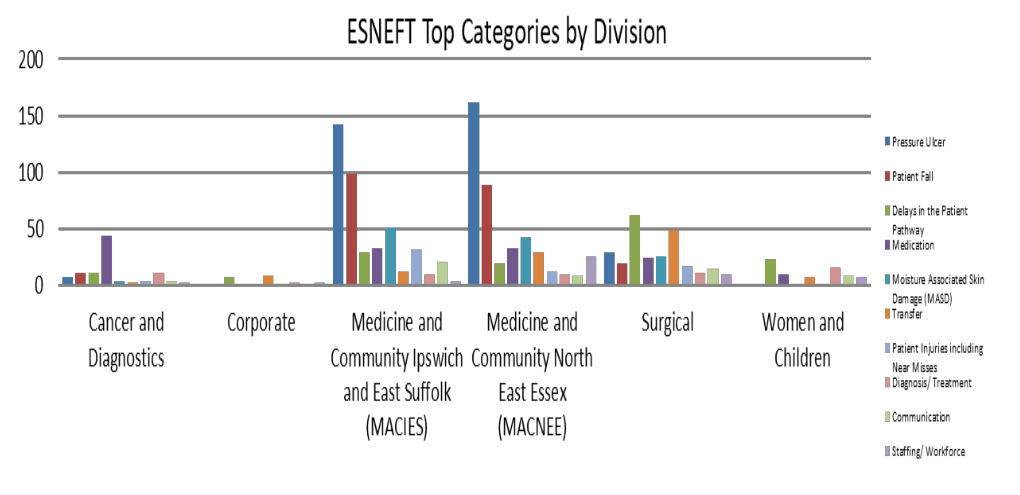
The highest reported category was Pressure Ulcer damage with 340 (279) incidents reported, 9 of which were severe harm, with 7 being within both Suffolk and NEE Community, 1 recorded on Brightlingsea Ward and 1 other recorded on Birch Ward. There were 93 moderate harm incidents.

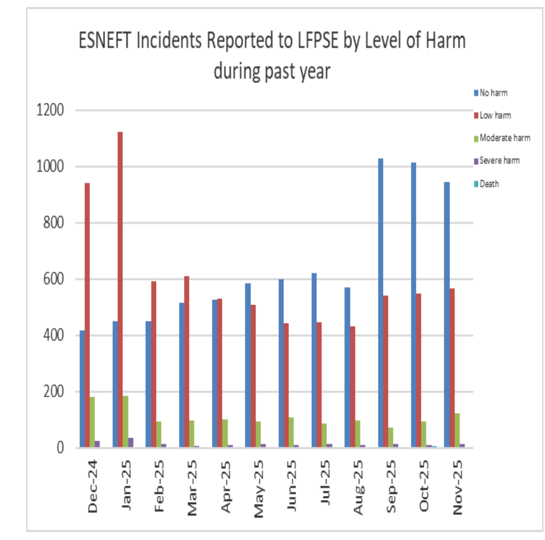
The 2nd highest reported category was Patient Falls with there being 218 (232) incidents reported with 3 reported as severe harm on Nayland Ward, Bramford Ward and Ipswich Emergency Department, all were unwitnessed. A further 6 were reported as moderate of which 5 were unwitnessed.

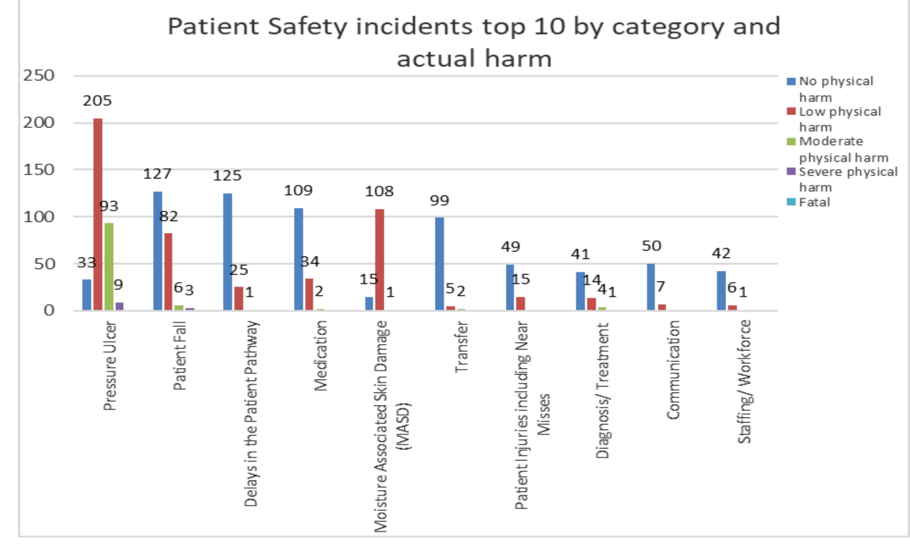
The 3rd highest reported category was Delays in the Patient Pathway with 151 (170) incidents. 1 was reported as moderate harm with the remainder being low and no harm.

Division	DatixWeb	DCIQ	Total
Surgical	3	421	424 ↑
Corporate	44	225	269 ↑
MACIES	4	206	210 ↑
MACNEE	3	177	180 ↑
Cancer and Diagnostics	1	96	97 ↑
Women & Children	0	31	31 →
Total	55	1156	1211 ↑

The Surgical division have the highest number of overdue incidents with 424.







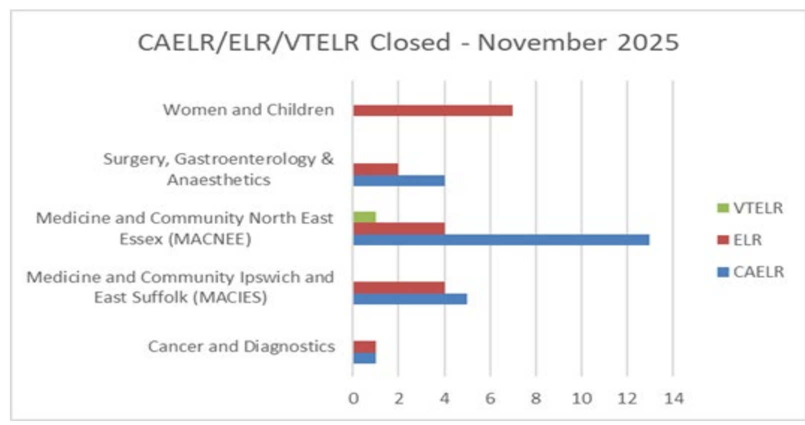
Spotlight Report

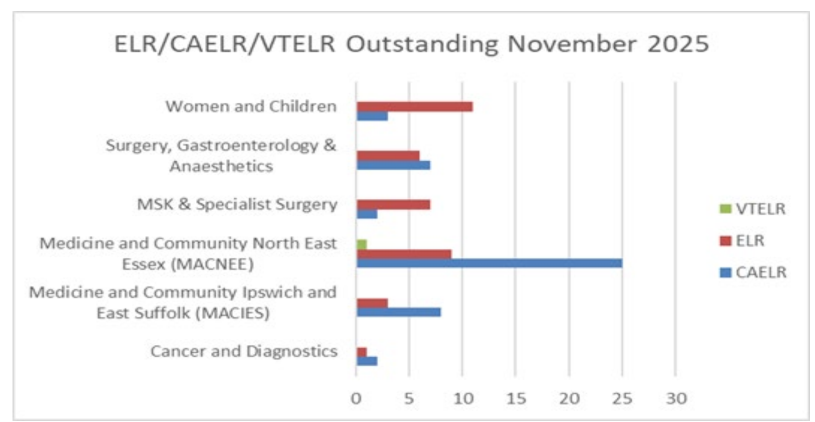
November 2025

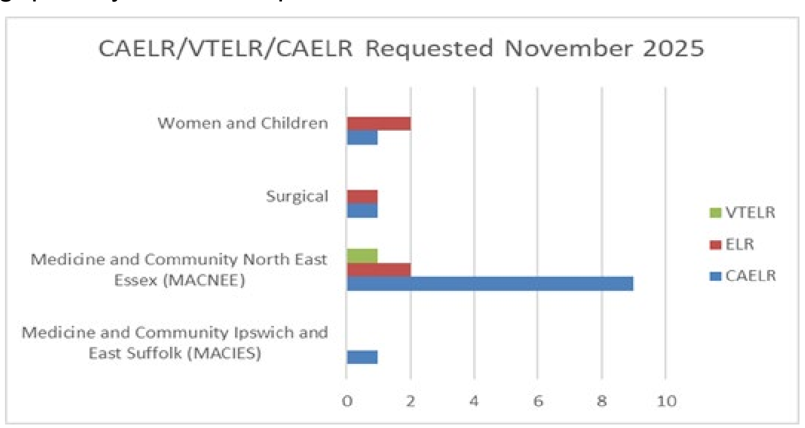
Patient Safety – Early Learning Reviews, Never Events, Patient Safety Reviews & Patient Safety Incident Investigations

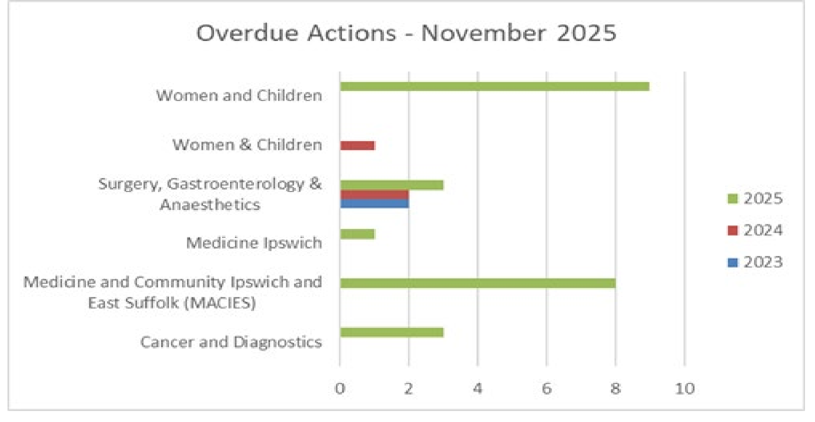
Early Learning Review (ELR), Cardiac Arrest (CAELR), Venous thromboembolism (VTELR), Patient Safety Review (PSR), Patient Safety Incident Investigations (PSII)

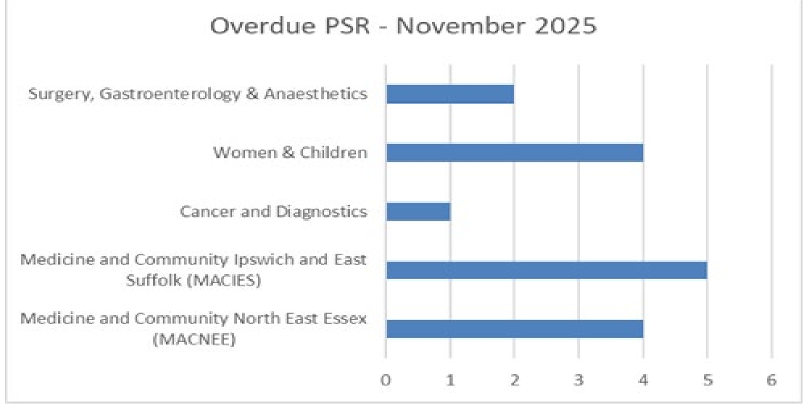
- 12 CAELR's, 5 ELR's and 1 VTELR were closed in November 2025.
- 47 CAELR's, 37 ELR's and 1 VTELR are currently outstanding in November 2025.
- 23 CAELR's, 18 ELR's and 1 VTELR were closed in November 2025.
- 2 PSR's were requested in November 2025. Both were for Medicine & Community Ipswich and East Suffolk (MACIES) Diagnosis – Wrong/missed and Delay in clinical assessment being performed.
- 6 PSR's were completed in November 2025. 5 for Women & Children and 1 for Surgery, Gastroenterology & Anaesthetics.
- One PSII was declared in November 2025. 2025-PSII003 (62,641) This PSII was declared to look at the organisational learning for boarding and escalation Trust wide.
- 96 Incidents of ESNEFT acquired pressure damage at moderate harm or above where reporting in November 2025. 4 full gap analysis were requested in November 2025











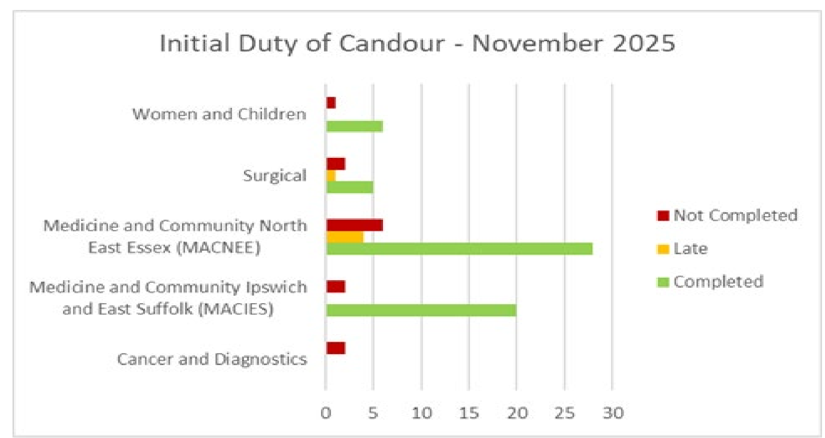
Type	Current Reports	Declaration	3 Month Due date	Status update - September 2025
Maternity Escalation	2025-PSII003	November		

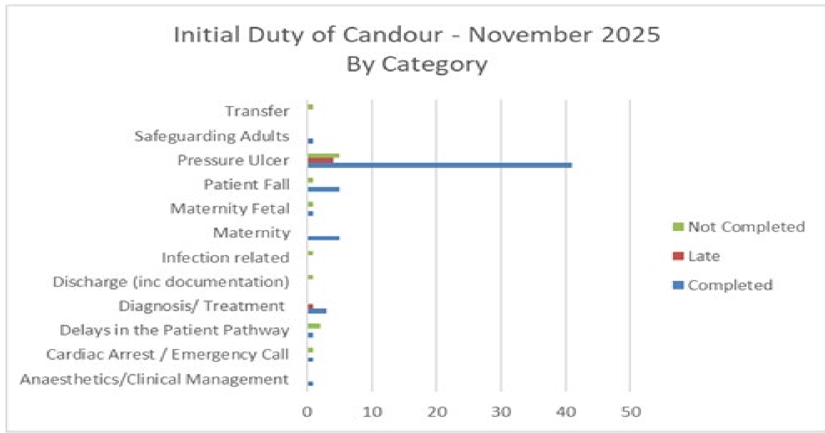
Patient Safety – Duty of Candour

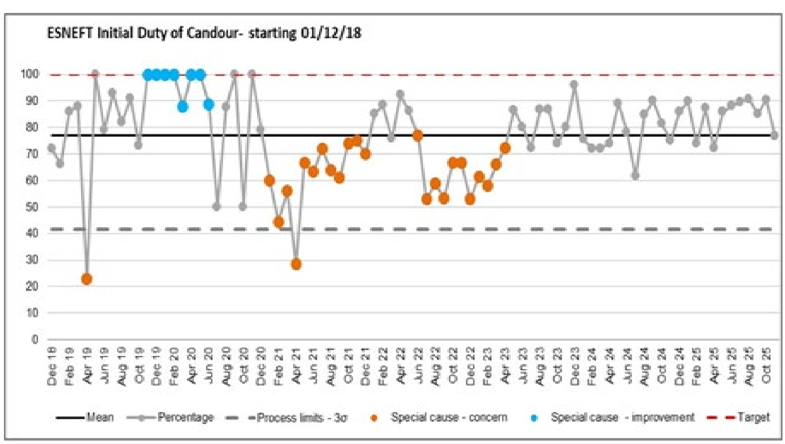
There was a decrease in initial Duty of Candour compliance. Improvements though are still to be made with post Duty of Candour

Initial Duty of Candour

Initial Duty of Candour compliance for November 2025 is 76.6% (90.5%)

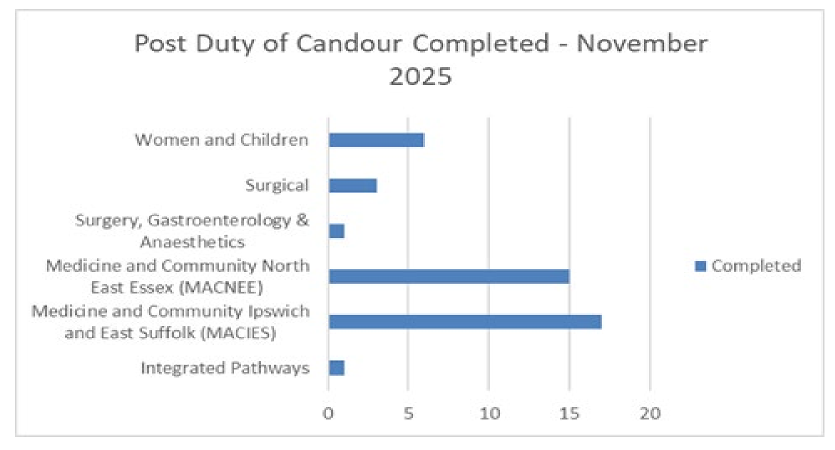


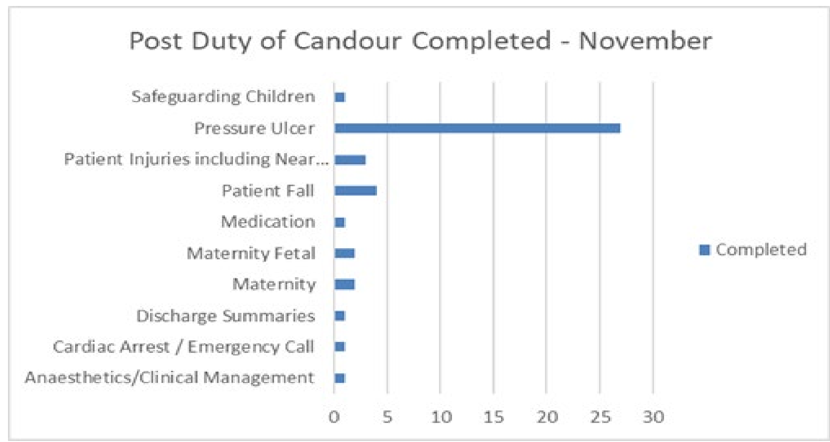


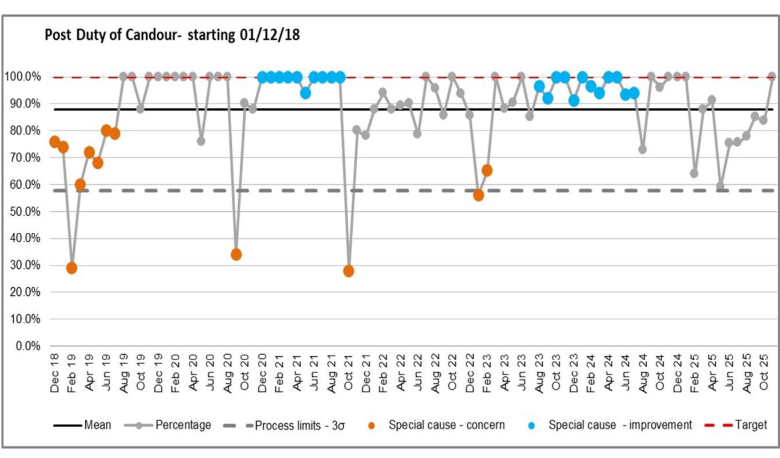


Post Duty of Candour

Post Duty of Candour compliance for November 2025 is 100% (83.7%)



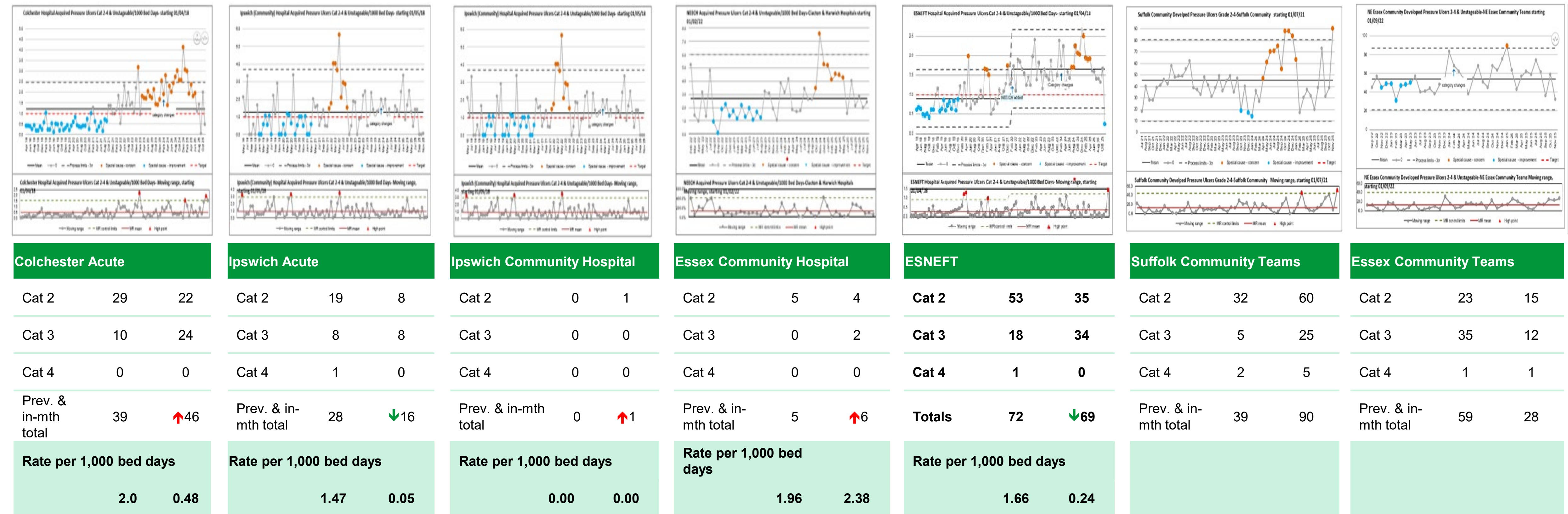




Spotlight Report

November 2025

Patient Safety – Tissue Viability



Colchester Acute		
Cat 2	29	22
Cat 3	10	24
Cat 4	0	0
Prev. & in-mth total	39	↑46
Rate per 1,000 bed days	**2.0**	**0.48**

Ipswich Acute		
Cat 2	19	8
Cat 3	8	8
Cat 4	1	0
Prev. & in-mth total	28	↓16
Rate per 1,000 bed days	**1.47**	**0.05**

Ipswich Community Hospital		
Cat 2	0	1
Cat 3	0	0
Cat 4	0	0
Prev. & in-mth total	0	↑1
Rate per 1,000 bed days	**0.00**	**0.00**

Essex Community Hospital		
Cat 2	5	4
Cat 3	0	2
Cat 4	0	0
Prev. & in-mth total	5	↑6
Rate per 1,000 bed days	**1.96**	**2.38**

ESNEFT		
Cat 2	**53**	**35**
Cat 3	**18**	**34**
Cat 4	**1**	**0**
Totals	**72**	**↓69**
Rate per 1,000 bed days	**1.66**	**0.24**

Suffolk Community Teams		
Cat 2	32	60
Cat 3	5	25
Cat 4	2	5
Prev. & in-mth total	39	90

Essex Community Teams		
Cat 2	23	15
Cat 3	35	12
Cat 4	1	1
Prev. & in-mth total	59	28

Service Commentary

We have seen a decline in category 2 Pressure Ulcers in our acute hospitals, which was our yearly aim.

There has been an increase in pressure ulcers in Suffolk Community, which may link in with the increase of infected wounds also present.

Community Matron, Safeguard Lead and Tissue Viability Nurse Lead are aware and have formulated an action plan around recognition of infection and early intervention.

Spotlight Report

November 2025

Patient Safety – Falls

Falls Monthly Numbers

	CH	IH	Suffolk	NEECS	Acute Total	Community Total	ESNEFT Total
Nov-23	99	96	12	8	195	20	215
Nov -24	84	80	18	8	164	26	190
Nov -25	89	89	21	9	178	30	208

Falls per 1,000 Bed Days (Acute)

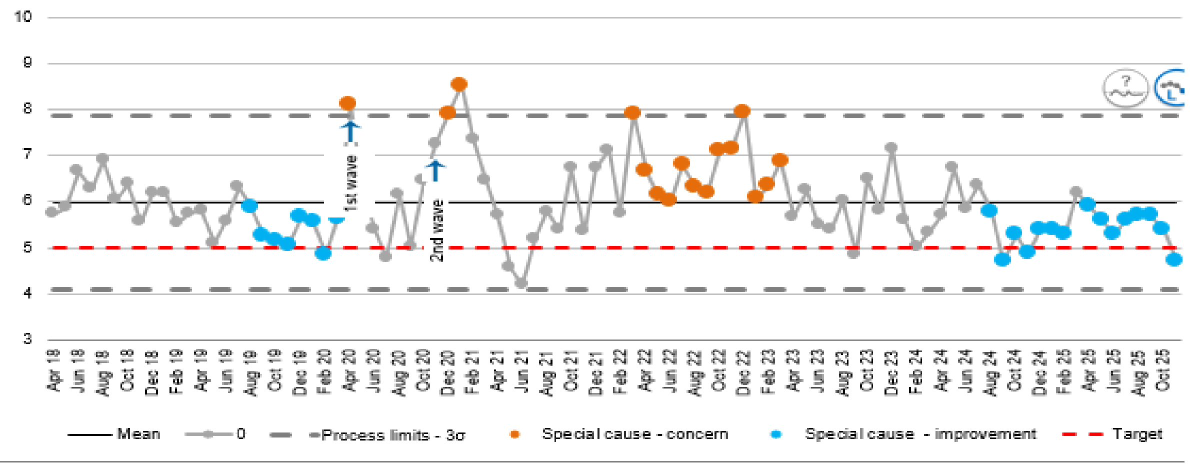
Falls/1,000 Bed Days								
	Colchester Acute	Ipswich Acute	Ipswich Community	NEECS	ESNEFT	ESNEFT Acute Bed Days	YTD Acute Falls/Bed Days	YTD Comm Falls/Bed Days
Nov-24	5.0	4.6	9.5	3.5	5.0	4.8	5.6	6.9
Aug-25	6.3	5.2	3.5	2.9	5.4	5.7	5.6	4.6
Sep-25	5.7	5.6	5.6	6.4	5.7	5.6	5.6	4.8
Oct-25	5.5	5.2	7.9	7.5	5.6	5.4	5.6	5.2
Nov-25	5.2	5.2	10.1	3.4	5.3	5.2	5.5	5.4

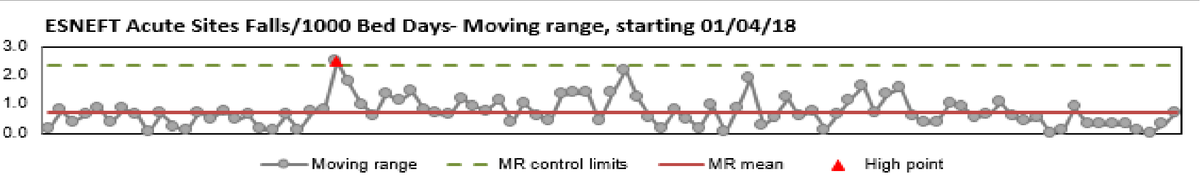
In November there was a reduction in falls in both acute hospitals, meeting the national falls per 1,000 bed days target. There has also been a reduction in serious harm incidents. One of these incidents is due a collapse of medical reasons, rather than a direct fall.

Ipswich were on target to see less than 70 falls, but in the later part of November, there were increased falls in ED and Haughley.

The Falls team, along with the wards continue to embrace Epic and the opportunities it provides. There have been noted improvements in post falls medical reviews, which is encouraging .

With regards to the QI project for the Yellow Falls Prevention Kits, there was not a reduction in falls, but the teams in the UEC felt the benefit of using the kit, due to the visibility it provides. The base wards also felt the benefit as the kit provided better visibility of patients. This will be explored, taking into consideration the green agenda, and discussing the opportunities for yellow blankets with the new laundry provider.

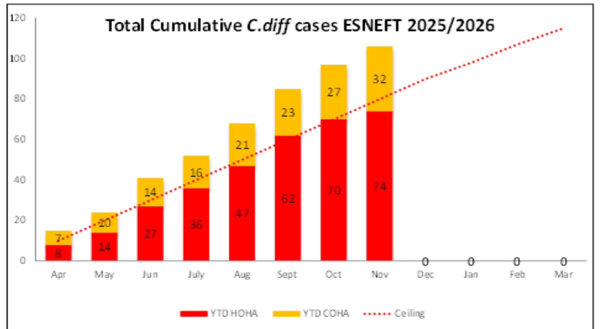


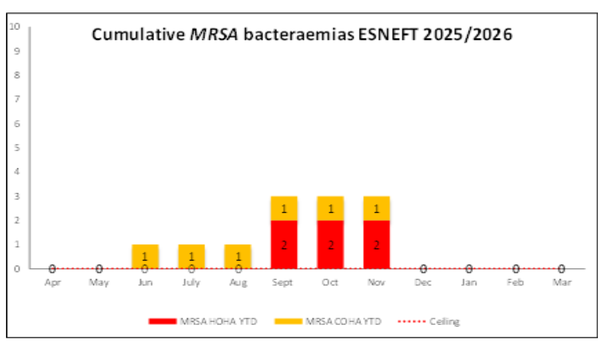


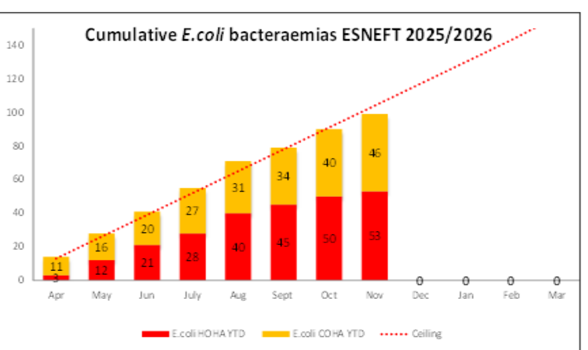
Spotlight Report

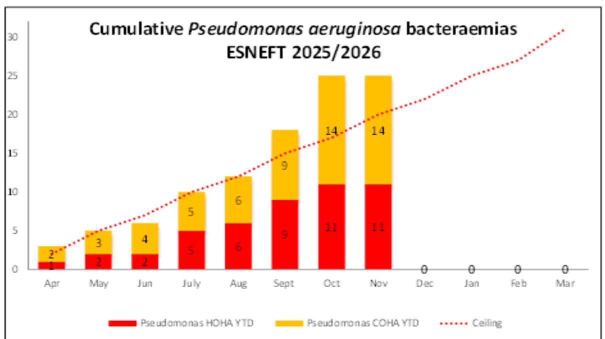
November 2025

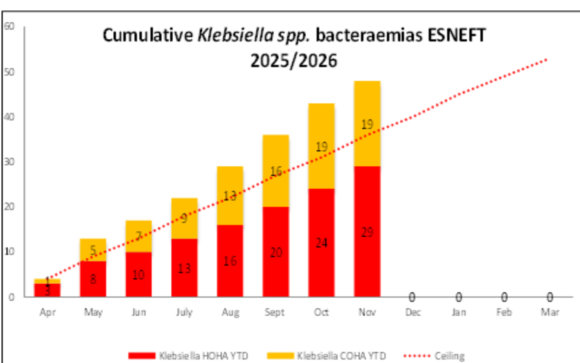
Patient Safety – Infection Prevention and Control - October 2025 figures – HCAI figures











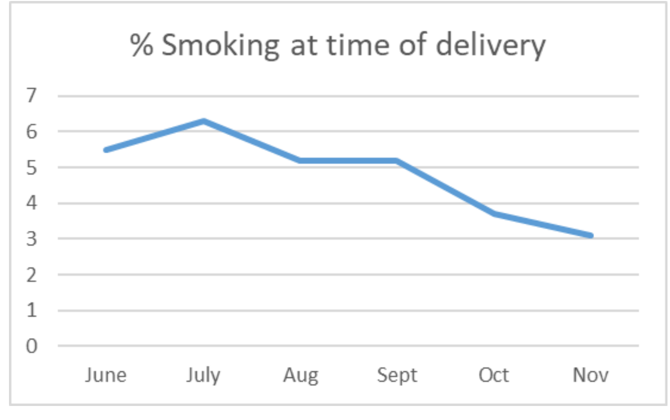
Infection	ESNEFT Total for month	Category	Trajectory	Total for year HOHA/COHA to end Oct Not inc Nov	Total for year total HCAI not inc Nov	EoE performance/benchmark (Upward arrows indicate a ESNEFT is above the benchmark, and are therefore an outlier)
C diff	9	4 HOHA	115	74	106	
		5 COHA		32		
MRSAb	0	0 HOHA	0	2	3	
		0 COHA		1		
E coli	9	3 HOHA	124	53	99	
		6 COHA		46		
Kleb spp	5	5 HOHA	47	29	48	
		0 COHA		19		
Pseudo A	0	0 HOHA	29	11	25	
		0 COHA		14		
MSSAb	10	9 HOHA	N/A	34	46	
		1 COHA		12		

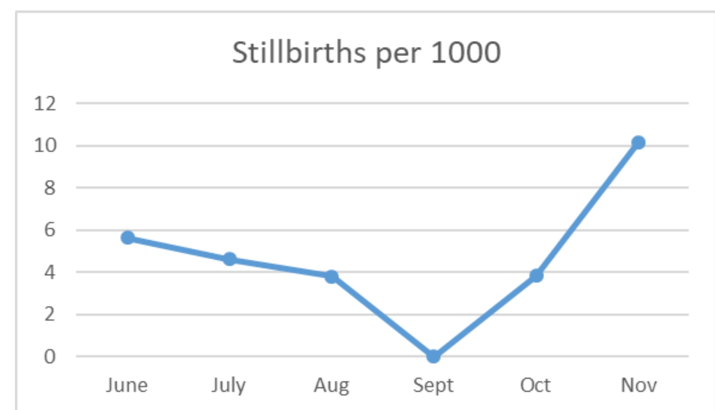
↑	Above (worse) than region average
↔	Equal with region average
↓	Below (better) than region average

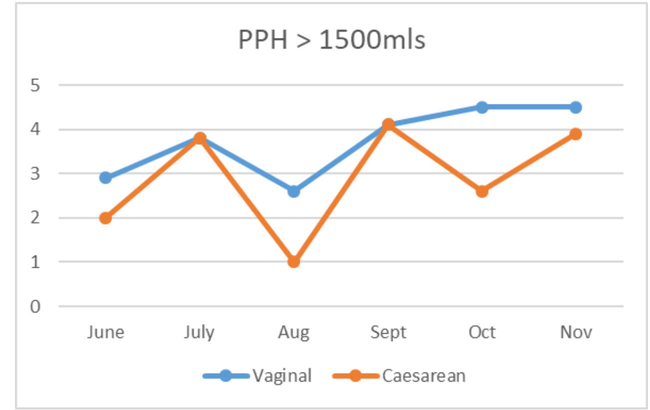
Spotlight Report

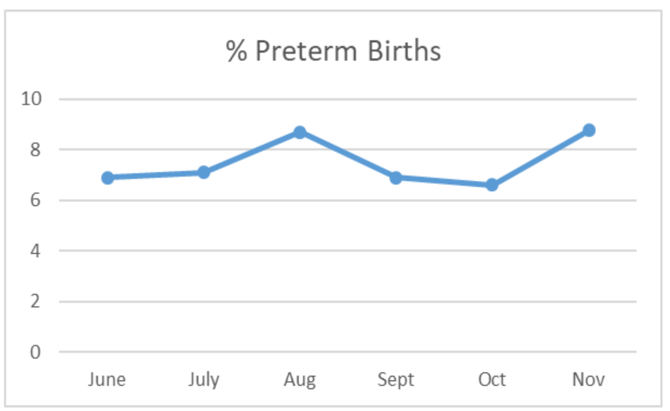
November 2025

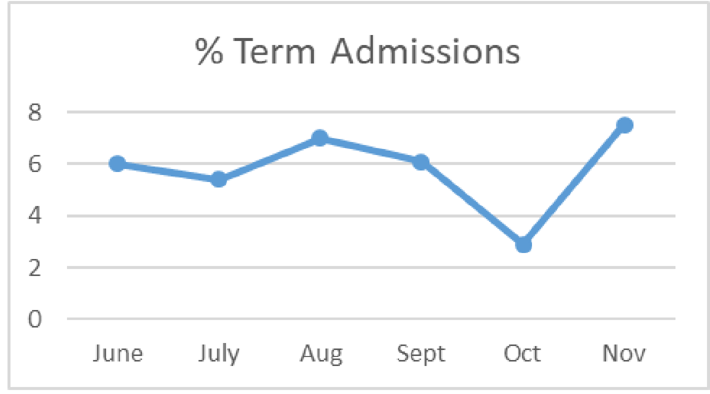
Patient Safety – Maternity Dashboard, SBL and CNST updates











Data has been pulled from EpicEPR which is still being tested for data quality. There remains some inaccuracies in the data, which are being worked through.

Stillbirth rates have increased in November at 10.14 (this equates to 5 cases), the rolling rate is 3.74, above the national average at 3.54. All of the cases are being reviewed through MIRG and the PMRT process. This will continue to be monitored closely with any identified learning shared through appropriate forums. A more detailed report will be provided to MNIB.

Preterm births are over the national aim of 6%, which the PARTNER trial aims to improve.

ATAIN continues to fluctuate each month. A deep dive is currently underway to develop a QI project.

Spotlight Report

November 2025

Patient Safety – Maternity Dashboard, SBL and CNST updates

Risk and Governance Update for Maternity

PSII
Number of new declared – 0
Currently open – 1

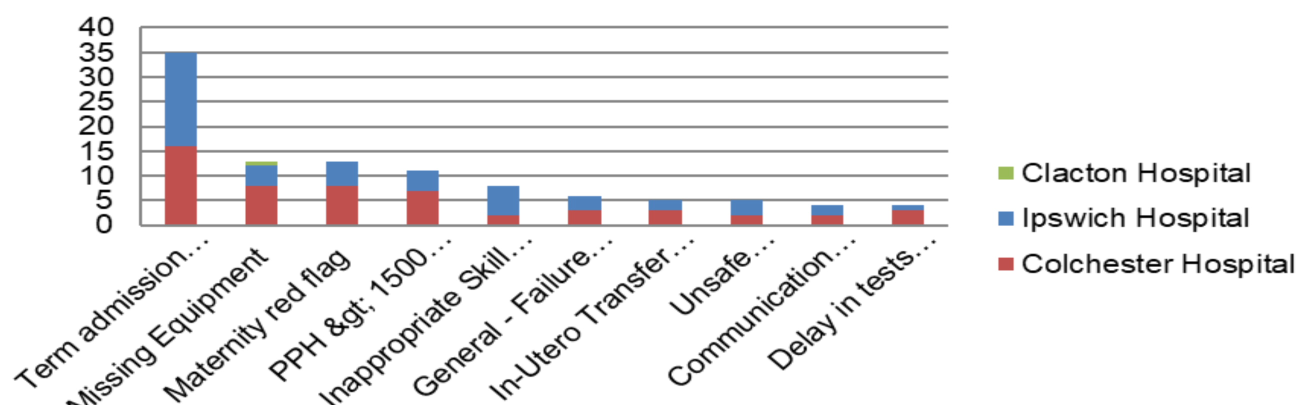
PSR
Number of new declared – 1
Currently open -4

ELR
Number of new declared – 8

MNSI
Number of new declared – 0
Currently open – 0
Completed -0

Complaints
New –9
Call back compliance – 4 out of 5 completed.
Response compliance – 100%

Risk Register
New risks – 0
Closed risks – 0



Learning from complaints

ID	Location - Ward / Dept / Team	Description	Subject (primary)	Outcome code	Lessons learned
9852	Delivery Suite (Col)	Concerns raised regarding delays to be seen and complications following stitches.	Admission and discharges	Partially upheld	Delay in patient being seen and transferred out of Triage due to Epic being implemented which affected the effectiveness. Right sided labial tear was not visualised and identified and repaired during the first examination.
10331	Lexden Ward (Col)	Complications following IV drip flushing.	Patient care	Upheld	Debrief regarding use of Ferinject was not documented. New combined consent form being developed, alongside increasing the awareness amongst our clinical staff of our patient information leaflet (PIL) to be given to patients.
11022	Orwell Ward (Ips)	Referral to FINN clinic was not made, staff have been unable to use the new EPR system which has directly impacted the patients care, and there has been an overall lack of communication.	Appointments	Upheld	Staff did not take the appropriate action when patient contacted Orwell Ward and identified they had not received an appointment. Issues with new computer system and not understanding how to proceed. Patient was able to follow up themselves to get the correct referral.

Spotlight Report

November 2025

Patient Safety – Maternity Dashboard, SBL and CNST updates

SA1 - On track	SA2 - Complete	SA3- On track	SA4 - Complete	SA5 - Complete
• Compliant • Paper drafted for Trust CNST meeting Dec 25	• Compliant • Approved at Trust CNST meeting Nov 25	• Compliant • Paper drafted for Trust CNST meeting Dec 25	• Compliant • Action plan in place for Tiers 1&3 neonatal workforce and monitored through risk register • Paper approved at Trust CNST meeting Nov 25	• Compliant • Paper approved at Trust CNST meeting Nov 25
SA6 - Complete	**SA7 - Complete**	**SA8 – On track**	**SA9 - On track**	**SA10 - On track**
• Compliant • Q1 report submitted Aug 91% implementation • Paper approved at Trust CNST meeting Nov 25	• Compliant • Paper approved at Trust CNST meeting Nov 25	• Compliant • Paper drafted for Trust CNST meeting Dec 25	• Compliant • Paper drafted for Trust CNST meeting Dec 25	• Compliant • Paper drafted for Trust CNST meeting Dec 25

Patient Safety – Maternity Dashboard, SBL and workforce updates

SBLv3.2

91% implemented on Q1 data. Awaiting Q2 validation from LMNS

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)
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	90%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Partially implemented	60%
Element 5	Preterm birth	Partially implemented	96%	Partially implemented	92%
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%
All Elements	TOTAL	Partially implemented	96%	Partially implemented	91%

Workforce

- 2025 nil incidents cross site of coordinator losing supernumerary status or 1-2-1 in labour not being provided.
- Sickness rate remains above Trust average and high for the region. Daily sickness meetings in place at Colchester, with twice weekly meetings for staffing reviews.
- Fully recruited cross site – recruited above template to allow for preceptors. First wave started with additional preceptor recruitment planned for January 2026
- Over establishment of RMs with NQM starting in Trust in October and more to commence in early 2026

Spotlight Report

November 2025

Patient Experience

Executive Summary

The Trust received a much lower number of new complaints in November 2025, with 88 new complaints - a significant reduction from 133 in October 2025. The compliance rate for courtesy call completion remained high at 98%, but 8 late replies in one Division has caused the complaint response compliance to drop from 98% to 93%.

The total number of complaints completed in November was 106 and coupled with the reduced number of new complaints for November, this has seen the overall number of open complaints reduce in total. After seeing a new high number of PALS enquires logged for October (815), the Trust has seen that number drop to 633 in November 2025. This total comprised of 240 enquiries for the Surgical Division and 122 for the Women's & Children Division and all Divisions saw a reduction in the total number of new PALS received.

Learning from Complaints

Complaint about communication from Sexual Health Centre

- Staff member repeatedly misgendered the patient and their partner. Learning taken from the complaint and shared in the complaint reply– To be discussed with staff member at next 1:1. Staff have been reminded of the 'Supporting transgender service users and staff policy'. Concerns raised by the patient were discussed in departmental meeting to raise awareness and reinforce best practice. A "Do's and Don'ts: Supporting Transgender, Non-Binary, and Gender Questioning People" grab sheet was shared with all staff, and they attended an additional refresher training session on inclusivity.

Ombudsman Update

Update for November 2025

- The Trust is still seeing regular communication from the Ombudsman's office, and during November 2025 this has resulted in three formal communications. One of these communications from the Ombudsman was requesting copies of the patients' medical records and the Trust's complaint file. The other two were in relation to ongoing complaints where the Ombudsman was asking for the Trusts comments on the ongoing cases, including a draft report they have completed.

Reopened Complaints

No complaints needed to be formally reopened

- No complaints needed to be formally reopened in November 2025. The Trust had 13 complaints that have been subject to a further review, and the reasons for those additional reviews are that six complainants requested to meet with the investigating teams. Three other complainants supplied additional concerns to be reviewed, three complainants disputed our information, and the final reopened complaint resulted from feedback being received from the PHSO.

PALS update

Only 1 PALS needed to be converted to a complaint in November 2025

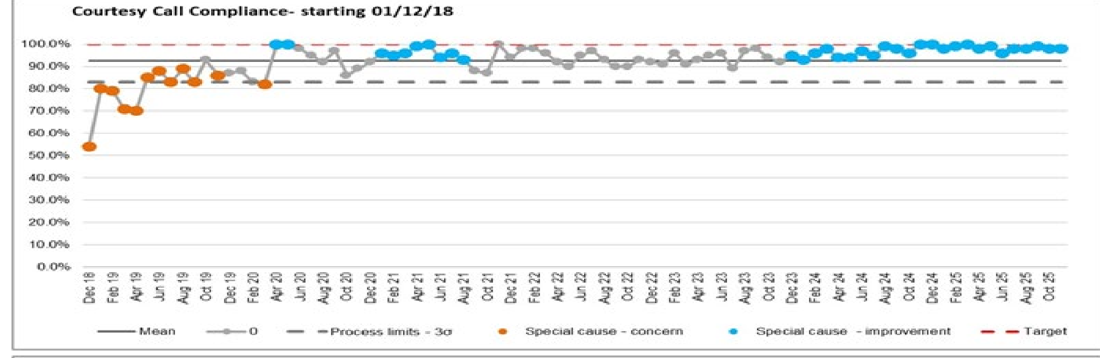
- The total number of PALS enquiries has reduced from the high in October, and the monthly total for November 2025 was 633. It is hoped that this drop is linked to the implementation of the new EpicEPR system, and PALS are continuing to direct patients towards the use of MyChart, explaining the benefits for patients. There has been a reduction in the number of waiting list and appointment-based concerns, and hopefully more people are able to get updates through MyChart and are not needing to contact PALS around this type of issue.

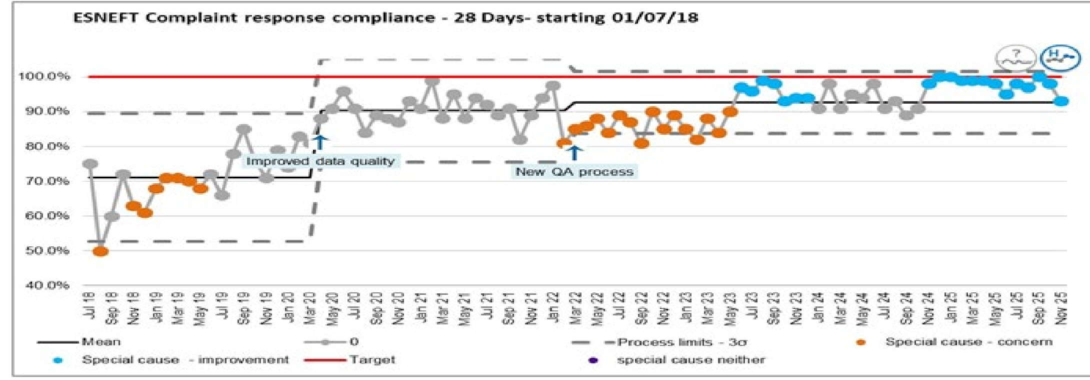
Spotlight Report

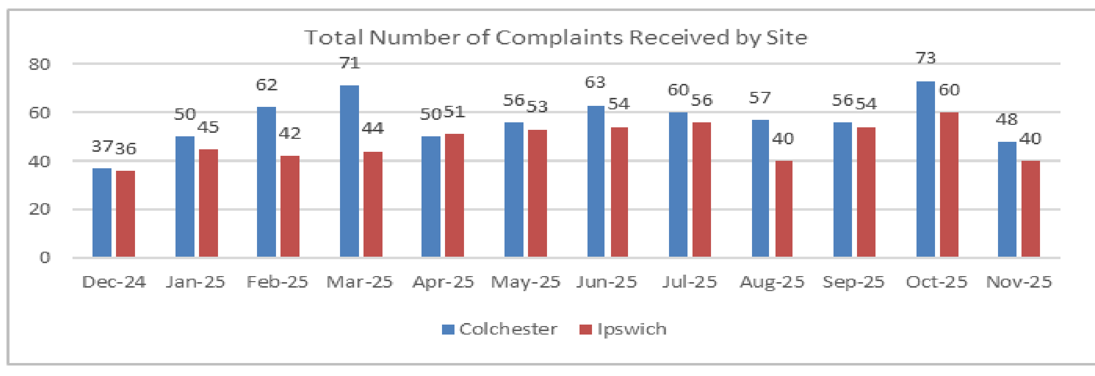
November 2025

Patient Experience

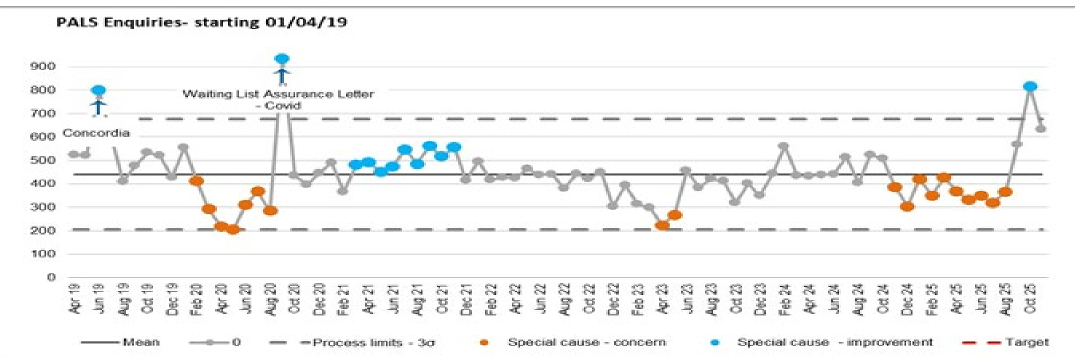
Complaints

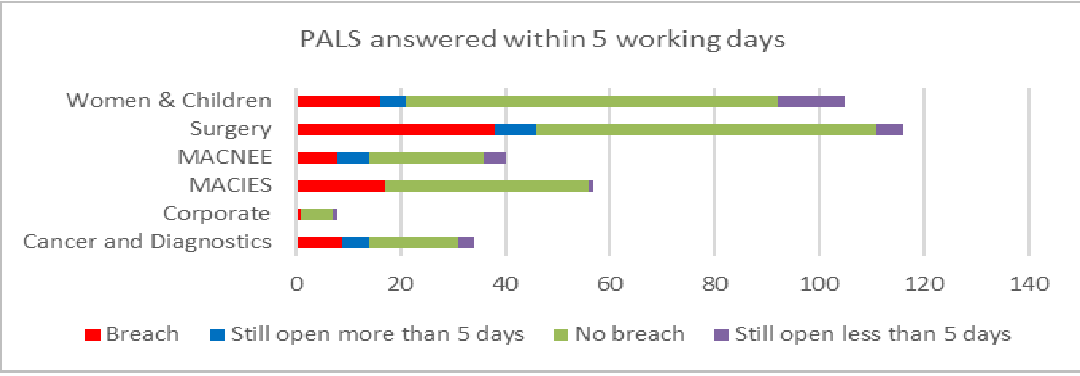


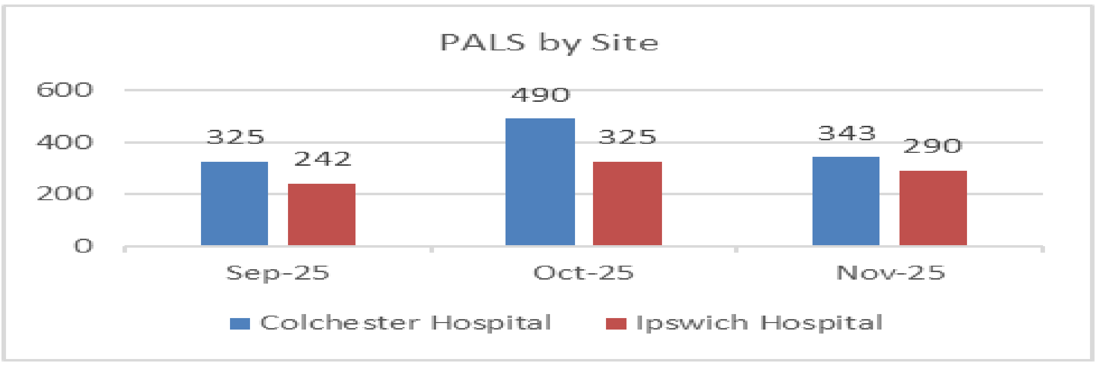




PALS



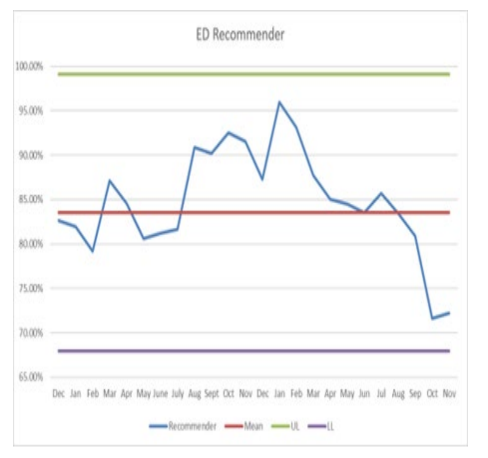


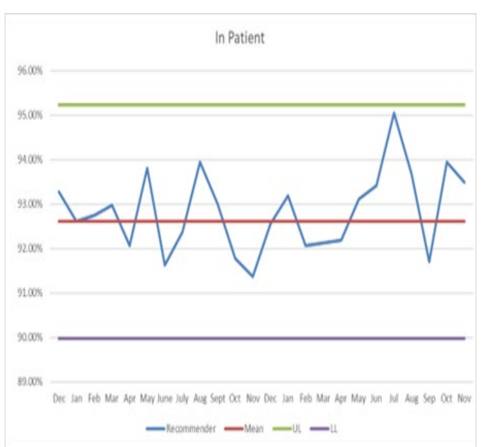


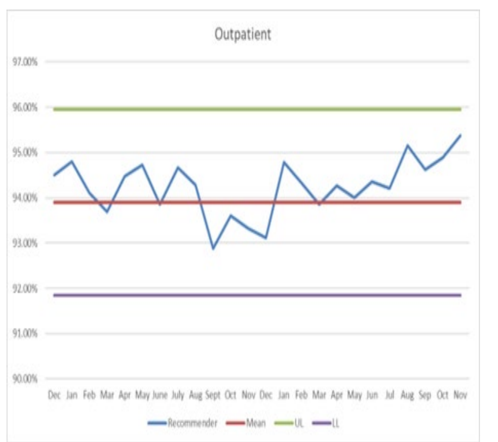
Spotlight Report

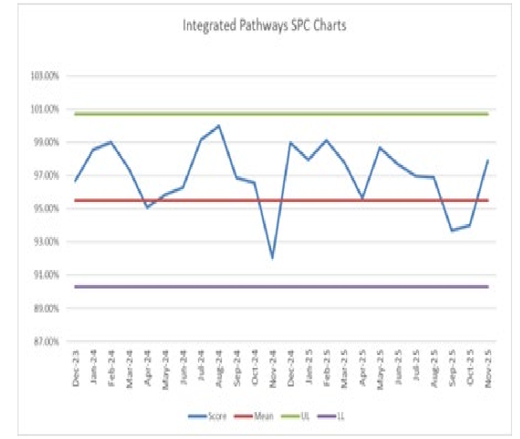
November 2025

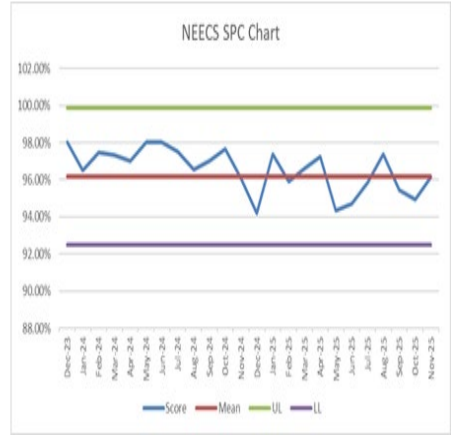
Patient Experience – Friends & Family



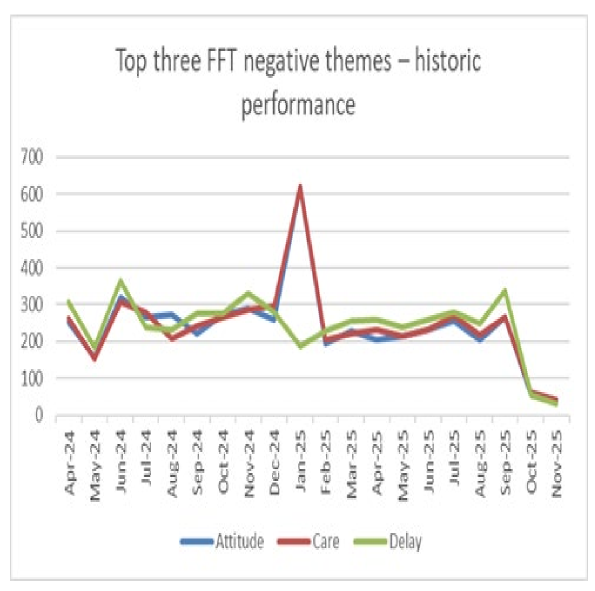


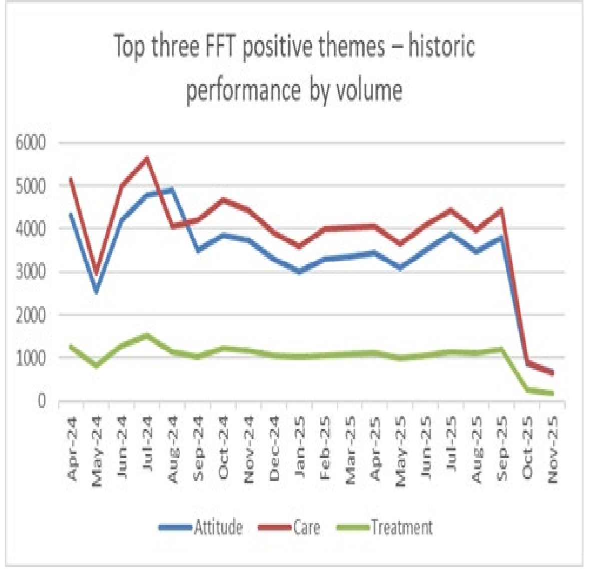




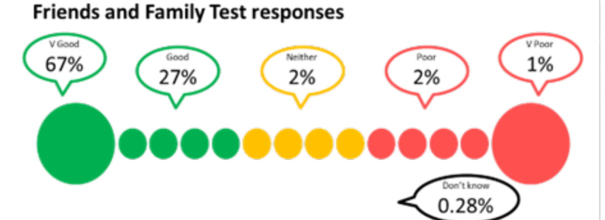


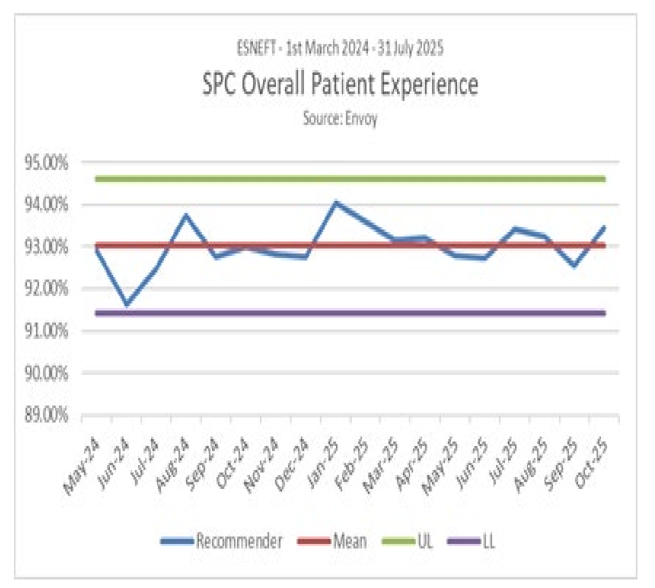
Top themes from Friends and Family for negative and positive comments for the month





FFT Response	Ipswich	Colchester
Very good/Good	94.8%	93.4%
Poor/Very poor	2.0%	4.5%
Neither good nor poor	3.3%	2.1%

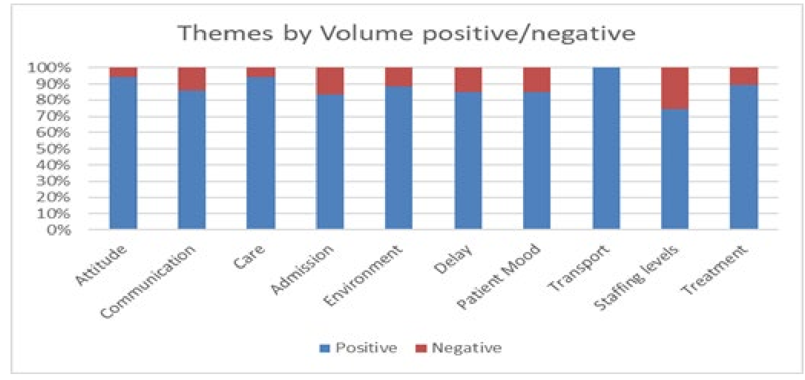


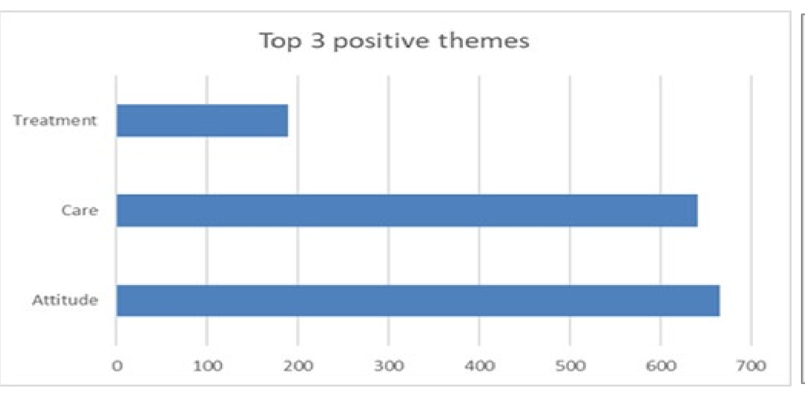


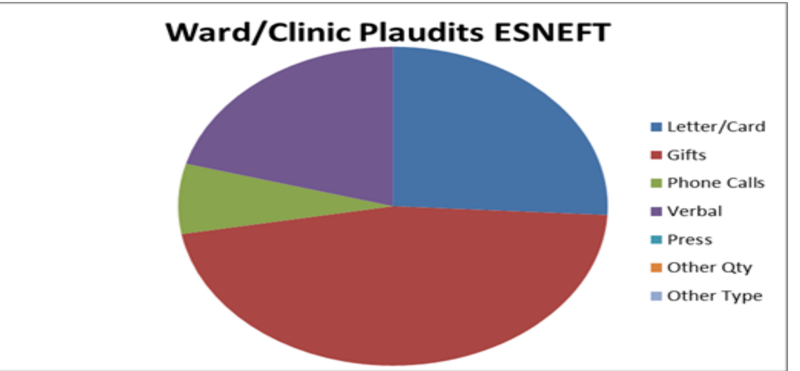
Spotlight Report

November 2025

Patient Experience – Friends & Family







There were **367** plaudits sent in to wards and clinics for ESNEFT.

Top 3 negative themes in November and contributors

Delay – Patients commenting on waiting for tests and test results along with being forgotten about while waiting for care.

Attitude – Patients feeling that staff are abrupt and telling them to “get on with it” while others have commented on lacking compassion.

Care – Triage area in Colchester close to doors with people coming and going and patient notes not being referred to.

Online Feedback

Ipswich Paediatric ED - I just wanted to email to say a huge thank you to your paediatric A&E and children's assessment unit teams. On Saturday my toddler, was brought in with RSV. The teams made us feel so well cared for and really listened to our concerns- we felt like we were the only ones in the hospital, thanks to their care. A special shout out to a nurse, you remembered us from your earlier shift in the morning and were therefore able to advocate for her when her presentation changed later in the evening, we appreciated you being there.

Colchester Maternity - I hope you are well today. I wanted to get in touch to pass on my thanks and praise for the medical team who looked after me at Colchester Hospital last week.

MACCIES Cardia Rehab - 'Suffolk Cardiac Rehab is brilliant. The Suffolk Cardiac Rehab based at the hospital is brilliant, they saw me for 6-8 weeks after my heart attack, I felt very cared for by them.

ENT Ipswich - Just visited ENT, went in 1 hour early and the lady who treated me ,I can’t thank her enough , Been deaf for a week and hard of hearing for few years, this lady has not just got my hearing back, but hearing is the best its been, Really hope this lady at ENT gets my compliment, made such a difference to my life now to have hearing back but 100% better than been for years

Palliative Care – Feedback from relative - Thank you to MCI and SB Palliative Care CNS's, for your kindness giving hearts and blankets somehow this made a difference

Performance: Trends & Hotspots

November 2025

Emergency Care	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
A&E: Total Wait - 4 Hour Performance	78.4%	76.5%	75.6%	75.0%	71.8%	70.1%	73.3%
A&E: Time to initial assessment	-	83.7%	85.1%	81.0%	76.4%	29.8%	34.6%
ESNEFT Mental health Attendances	-	421	383	387	342	368	369

Inpatients	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
ESNEFT Total Spells	-	19,547	20,378	18,452	19,841	13,950	15,354
ESNEFT Daily average LLOS patients	-	151	159	176	177	187	259

Cancer	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Cancer: 62-day wait performance	81.2%	66.1%	70.2%	65.1%	70.7%	58.7%	61.3%
Cancer: 28 Day Faster Diagnosis Standard	83.5%	72.5%	73.9%	74.9%	72.3%	66.2%	65.4%

Diagnostics	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Diagnostics: % Patients waiting 6 weeks or longer	5%	6.9%	6.1%	12.4%	13.1%	23.1%	26.3%

RTT	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
RTT: Incomplete pathway >65 weeks	0%	0.01%	0.02%	0.01%	0.01%	0.01%	0.00%
RTT: Incomplete pathway >52 weeks	3.5%	3.44%	3.17%	3.19%	3.23%	3.33%	3.25%

Areas of Improvement

- Improvements in 4 hours standard and 12 hours waits seen.
- Colchester focus on SDEC model which will operate 24/7, workforce to be reviewed.
- Challenges to offload ambulances continued, however improvement in month seen. Additional capacity to come online end of December.
- No patients over 65 weeks for any reason and improvement in those patients waiting over 52 weeks.
- Improvement in Activity levels following the planned reductions – still some areas where improvements are slower to return.
- Improvement month on month for Cancer
- Elective Focus throughout November with Elective Roadshows, speciality Deep Dives, tactical weekly and Turbo rooms all to support validation and education with a dedicated focus on data quality i.e. duplicate referrals, appts with no next steps and DNA appts. This supported the reduction of the total waiting list size.

Areas requiring further work

- The Trust achieved 73.3% performance against the A&E 4-hour standard in October.
- Inpatient and frailty taskforce to implement recommended changes.
- SDEC models to improve the 'offer' on both sites
- Additional capacity to be in place for Colchester end of December
- Time to care week in December will have a multi-disciplinary approach to reduce delays and safe patient discharge.
- Continued focus on reducing the 62-day backlog and improving the diagnostic element of the pathways timelines.
- Returning to pre go live activity and recovering overall positions for Cancer, Elective and Diagnostics throughout the 60 day stabilisation programme.
- Validation of PTLs and key work queues
- Focus with clinical colleagues on reducing both the triaging referrals and outcoming work queues to get to doing todays work today.

** The target is the Trust's local target and trajectory submitted to NHSE, as identified for May 2025.*

Performance: Executive Summary

November 2025

	Performance Measure	Trust Agreed plan	Reporting Month ESNEFT	Reporting Month Col	Reporting Month Ips	Trend ESNEFT	Trend Col	Trend Ips
Emergency Department	Four hour standard (Whole Economy)	73.2%	73.3%	74.6%	70.9%	3.2%	(1.9%)	10.6%
	Time to initial assessment - 95th pct	Not in Trust Submitted plan	92	115	42	(41)	(39)	(15)
	Time to initial assessment- percentage within 15 minutes (new measures)	Not in Trust Submitted plan	34.6%	36.9%	32.5%	4.8%	8.2%	1.5%
	Time to treatment - median time in department	Not in Trust Submitted plan	48	30	119	(8)	(7)	(18)
	Average (mean) time in department- non-admitted patients (new measure)	Not in Trust Submitted plan	233	260	237	(14)	9	(41)
	Average (mean) time in department- admitted patients (new measure)	Not in Trust Submitted plan	767	751	787	(9)	5	(37)
	Patients spending more than 12 hours in A&E	963	1,695	1,001	694	(373)	(124)	(249)
	Proportion of ambulance handovers within 15 minutes (new measure)	Not in Trust Submitted plan	8.6%	6.8%	10.7%	3.7%	3.3%	4.1%
Cancer	% Patients seen within 2 weeks from urgent GP referral	Not in Trust Submitted plan	58.5%			9.2%		
	% patients meeting 28 day faster diagnosis	81.1%	65.4%			(0.9%)		
	% patients waiting no more than 62 days for treatment	79.6%	61.3%			2.6%		
Diagnostics	% patients waiting 6 weeks or more for a diagnostic test	Not in Trust Submitted plan	26.3%			3.1%		
	Diagnostic waiting list	Not in Trust Submitted plan	20,645			1,500		
RTT	% of incomplete pathways within 18 weeks	57.3%	54.2%			(1.8%)		
	Total RTT waiting list (open pathways)	87,850	93,737			(3,915)		
	Total 52+ weeks waiters	1,723	3,044			(209)		
	% of RTT waiting list at 52+ weeks	2.0%	3.2%			(0.1%)		
	Total 65+ weeks waiters	0	-			(5)		
	% of RTT waiting list at 65+ weeks	0.0%	0.00%			(0.01%)		

The Trust is currently working through the activity stabilisation period of EpicEPR development. As such, there may be elements of data incompleteness and/or data quality impacts in some metrics. Where possible these have been reviewed and corrected, but some issues may remain.

UEC: November saw improvements with both sites with Emergency care metrics. ESNEFT is over its plan for the month, with a 10.6% improvement at the Ipswich site with further improvements made across both sites in ambulance handovers – despite this they remain too long. Focus remains on sustaining improvement despite the expected seasonal variation with focus remaining on the UECC improvement plan supported by the patient flow taskforce.

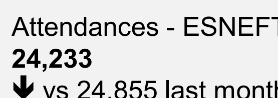
Elective – Cancer, Elective and Diagnostics: Improvements were seen across most of the metrics compared to October and there was a focus in November on activity stabilisation from EpicEPR Go Live. Activity levels in some specialities were off track against plans before Go Live. There was a significant reduction in the overall waiting lists and no patients for the first month this year, waiting over 65 weeks.

Whole Economy performance for ESNEFT in month improved by 3.18%, but was below the national standard of 78% in November 25. Local performance was below both National and Regional average for October (Nov national not yet available). Colchester performance declined by 1.9% and Ipswich performance improved by 10.6%. Overall, ESNEFT attendances decreased by 622 (2.5%) with Colchester attendances increasing by 3.8% and Ipswich attendances decreasing by 12.1%.

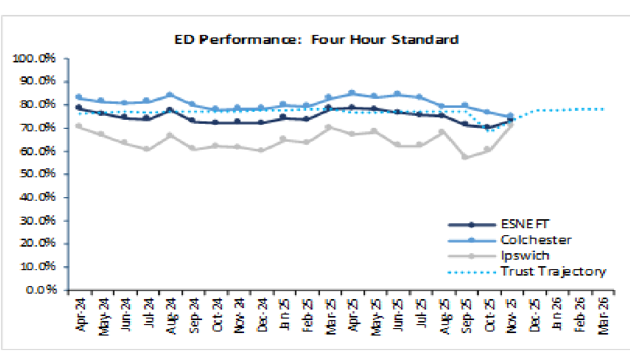
4-hour standard- ESNEFT whole economy
73.3%
vs 70.13% last month
*includes Clacton and Harwich

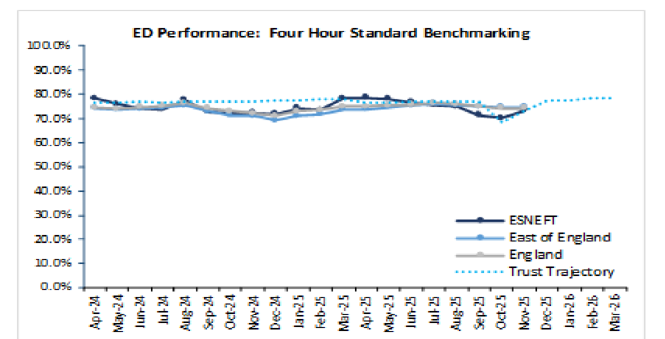
4-hour standard- Colchester
74.6%
vs 76.5% last month

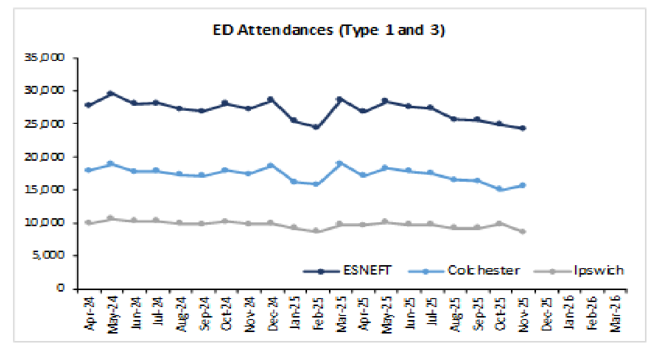
4-hour standard- Ipswich
70.9%
vs 60.4% last month

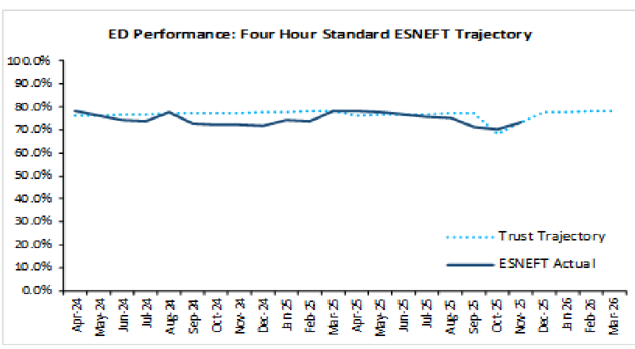


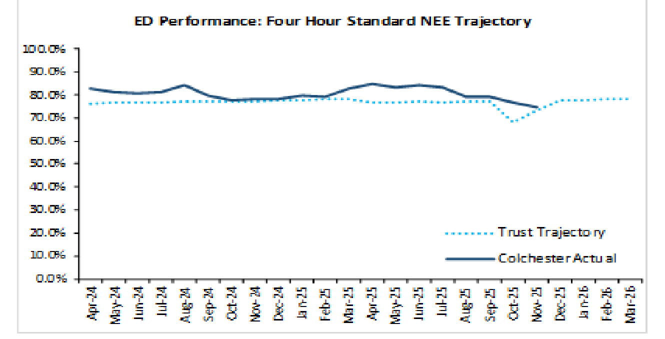
Attendances - ESNEFT
24,233
vs 24,855 last month

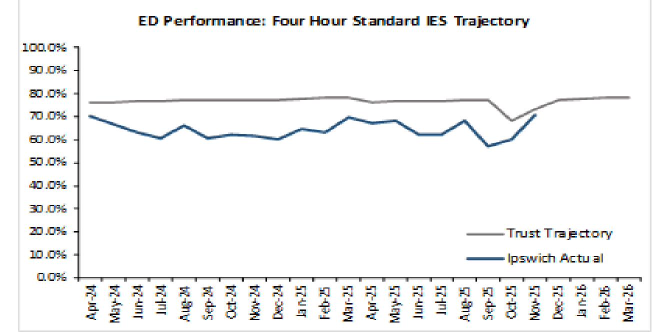












Colchester

November saw the site challenged with significant exit block, and increased attendances to the department. This has contributed to a decrease in the 4-hour standard. To ensure recovery to the 4-hour standard being achieved, a recovery plan is in place against all agreed trajectories.

Ipswich

During the month of November, some of the anticipated improvements of EpicEPR have started and will support departments in relation to productivity, visibility and more accurate reporting.

Although Ipswich did not meet the national target of 78% or the Trust trajectory of 72% an improvement of over 10% in the 4-hour standard performance was reported in November. This was the highest achievement this year. Type 1 data has shown particular improvement in line with opening the SDEC area 24/7.

Performance: Urgent Care - Ambulances

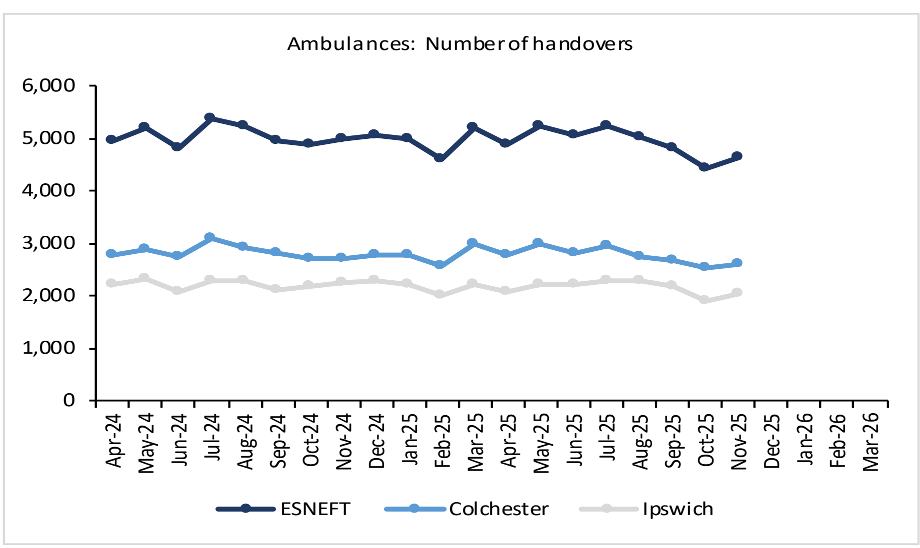
November 2025

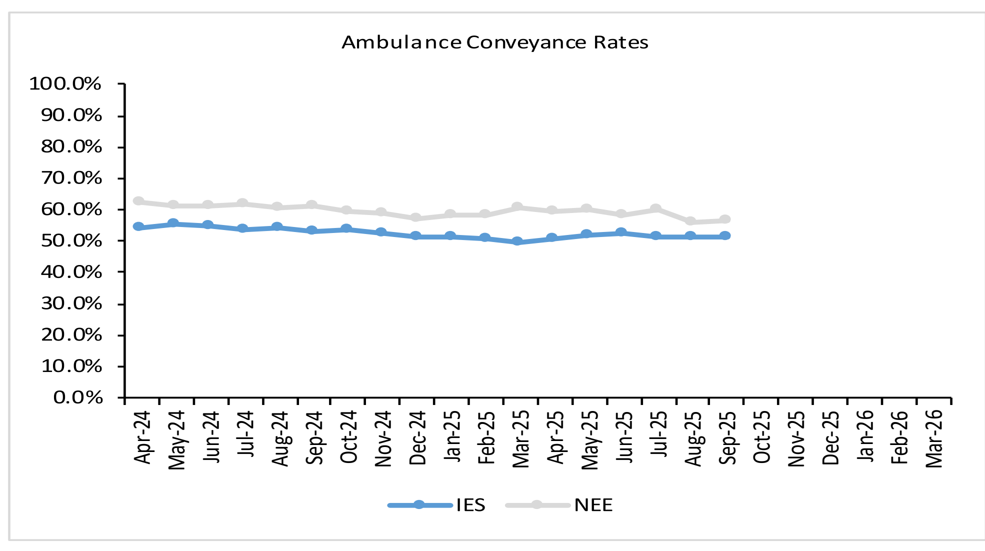
The number of ambulance handovers increased in November for ESNEFT by 5.2%, with the number at Colchester increasing by 2.8% and increasing by 8.3% at Ipswich.

Number of handovers - ESNEFT
4,654
↑ vs 4,425 last month

Number of handovers - Colchester
2,598
↑ vs 2,527 last month

Number of handovers - Ipswich
2,056
↑ vs 1,898 last month





**Ambulance conveyance rates not received for October/November

Colchester

There was notable increase in demand for the Emergency Department in November, particularly with demand for Resus. There is regular liaison and communication with the Ambulance Service to ensure that they are using Same Day Emergency Care and the Urgent Treatment Centre, where possible. This is to ensure the Emergency Department is protected for life and limb. There has been good direct utilisation of Same Day Emergency Care services averaging 5 conveyances there per day.

Ipswich

Due to changes in the CAD system last month, it is expected the 8.3% increase reported in ambulance handovers is due to accurate reporting in line with usual levels of demand.

With the pressure currently being experienced in the Emergency Department and wider hospital, there is a need for reviewing conveyance avoidance pathways and working with EEAST colleagues to identify any other alternative ways of working to reduce conveyance for suitable patients.

Performance: Urgent Care - Ambulances

November 2025

ESNEFT performance for handovers within 15 minutes increased by 3.7% in month. At Colchester, the proportion of patients handed over within 15 mins increased by 3.3% and at Ipswich it increased by 4.1%. Overall, the number of handovers between 15 and 30 minutes increased by 9.3%, between 30 and 60 minutes decreased by 1.8%, and the number handed over after 60 minutes decreased by 11.2%.

Handovers within 15 minutes - **ESNEFT**
8.6%
vs 13.4% last month

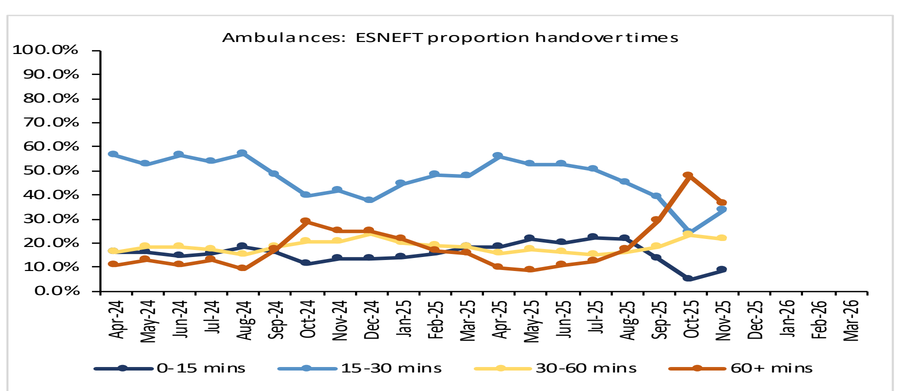
Handovers within 15 minutes – **Colchester**
6.8%
vs 3.6% last month

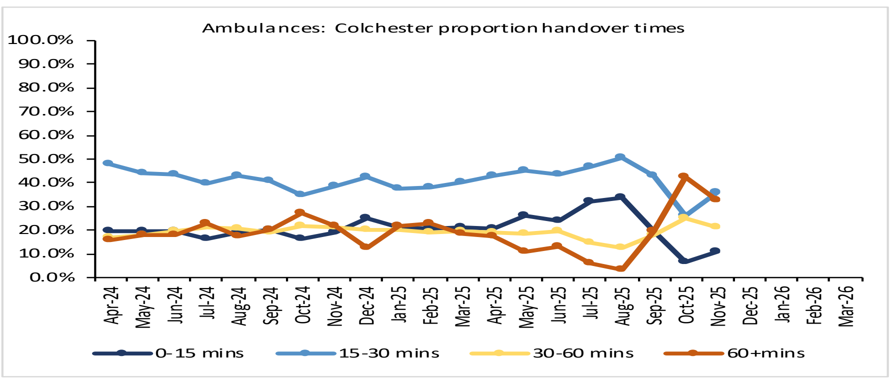
Handovers within 15 minutes - **Ipswich**
10.7%
vs 6.6% last month

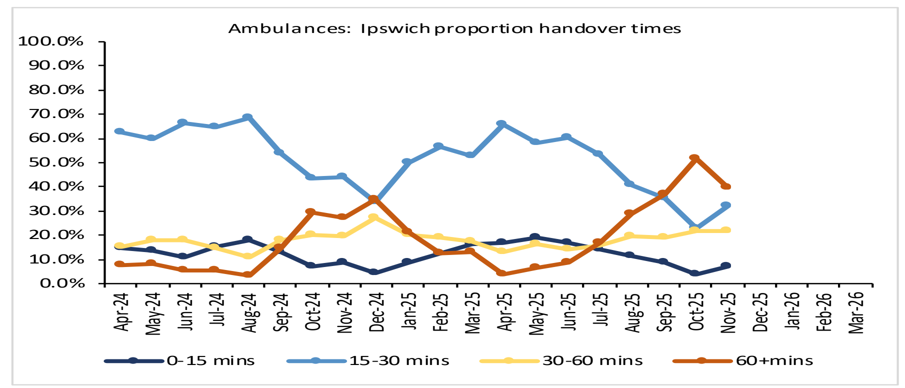
Handovers within 15 – 30 minutes - **ESNEFT**
33.5%
vs 24.2% last month

Handovers within 30 – 60 minutes - **ESNEFT**
21.5%
vs 23.3% last month

Handovers over 60 minutes - **ESNEFT**
36.4%
vs 47.6% last month







Colchester

November saw significant challenges with exit block. However, teams are assured that normal Initial Assessment processes were followed. Those people who are fit to sit and those able to utilise alternative internal pathways did so. In turn this has improved the 15-minute handover performance. The site continues to ensure that where possible, all alternative pathways are utilised to enable timely ambulance handover performance.

Ipswich

Familiarisation with EpicEPR has improved levels of productivity for clinicians and administrative staff which has positively impacted ambulance offloads. Teams are also using a secure chat function between majors and the initial assessment area to expedite moves when beds are ready. Currently teams are working with EEAST colleagues on escalation plans at times of increased pressure to maintain patient safety and experience. Work is ongoing with acute medical colleagues to plan a trial of direct access to AMSDEC to align with regional offers.

Performance: Urgent Care – Time in Department

November 2025

Overall, the time to initial assessment in ED improved, with the number of patients assessed within 15 minutes increasing by 4.8%. Colchester increased by 8.2% and Ipswich increased by 1.5%. Average time in department for admitted patients decreased by 9 minutes, and decreased by 14 minutes for non-admitted patients. The number of patients staying in the department for 12 hours decreased by 18.0% compared to the previous month.

Time to initial assessment (% patients within 15 mins)
34.6%
↑ vs 29.8% last month

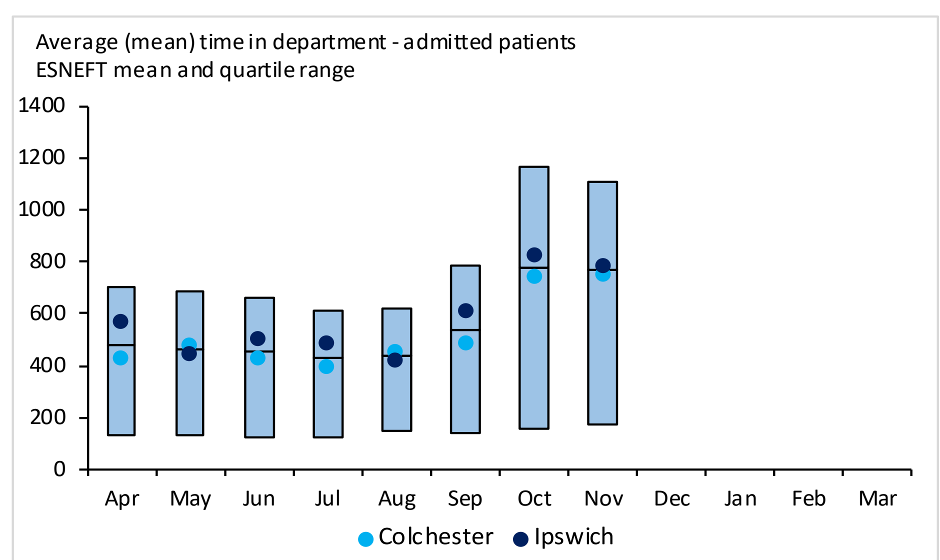
Time to initial assessment: (95pct)
92 min
↓ vs 133 min last month

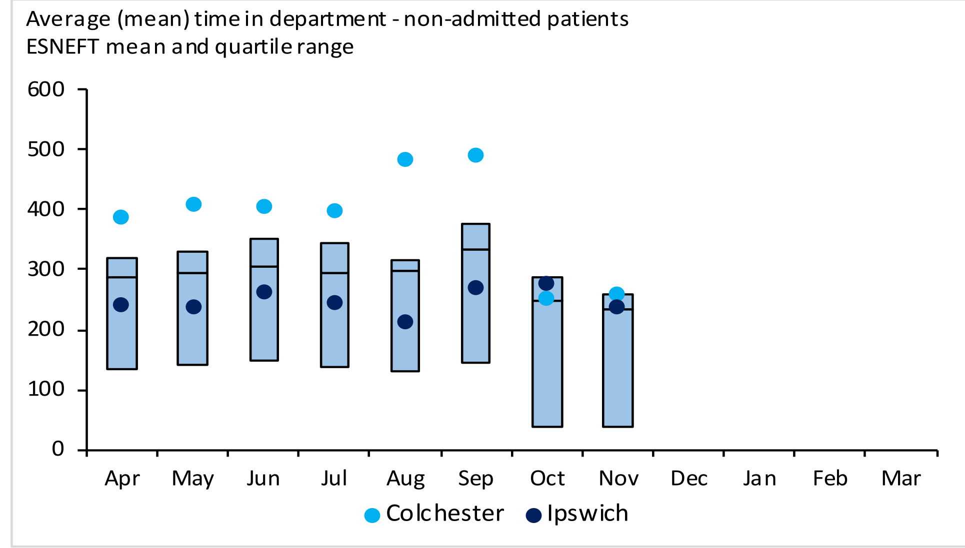
Average time in dept – non-admitted
233 min
↓ vs 247 min last month

Average time in dept – admitted
767 min
↓ vs 776 min last month

Time to treatment – median time in dept. (60 mins)
48 min
↓ vs 56 min last month

12-hour patients
1,695
↓ vs 2,068 last month





Colchester

Proficiency with EpicEPR in times of extremis is improving in line with following normal operational protocols. This is resulting in improvements in a number of metrics. However, 12-hour performance remains challenged. To ensure that there is a whole site focus to this improvement this is being led by the inpatient flow management team.

Ipswich

Similarly to other areas of UEC performance, improvements have been seen compared to October, aligned to the familiarisation of EpicEPR.

The ED recovery plan actions focused on time in department, and teams have seen an improvement in both admitted and non admitted time in department. Continued work with specialities to ensure community heralded patients are moved to the right place on arrival to the department. Furthermore, during December's Time to Care week, there will be a focus on accurate streaming at the front door and empowering clinicians to implement the ED transfer standards of care.

Performance: Urgent Care – Mental Health

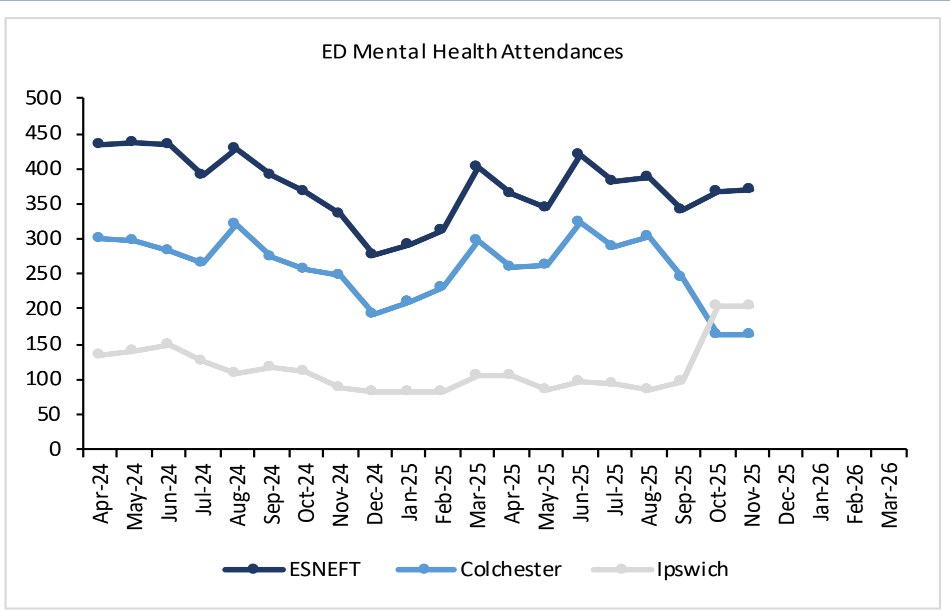
November 2025

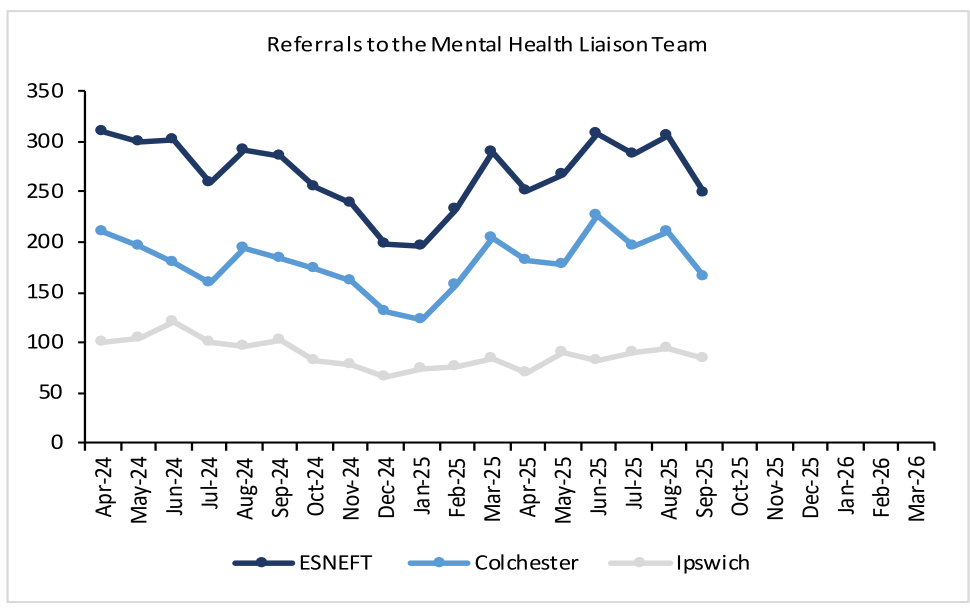
Mental Health ED attendances increased by 0.3% across ESNEFT compared with last month. In Colchester attendances increased by 0.6% and in Ipswich attendances decreased by 0.0%.

Mental Health referral data post EpicEPR Go-Live is currently not available.

MH attendances - Colchester
164
↑ vs 163 last month

MH attendances - Ipswich
205
→ Vs 205 last month





**Reporting post Epic is currently being developed.

An area of concern has been highlighted due to NSFT and EPUT engaging late on in the EpicEPR process which has resulted in difficulties in accessing referrals, as well as staff not always referring to the MHLT due to confusion regarding the new EPR. This has resulted in some patients not being assessed within required timeframes and increased risks for those individuals as a result. Work is ongoing to address this.

Colchester in particular has experienced high numbers of patients experiencing delays in accessing Mental Health beds from ED. System communication and support is in place to ensure escalation.

There has been a slight increase on both sites in the application of the Mental Health Act, use of Risk Indicator (RI) and Enhanced therapeutic observations (EToC).

Performance: Admissions

November 2025

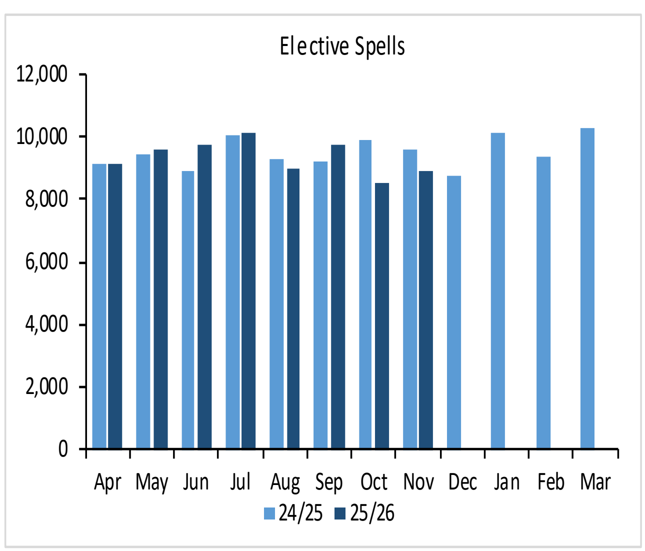
Total spells increased by 5.8% in month for ESNEFT. Emergencies increased by 11.9% and non-electives decreased by 6.8%. Elective spells increased by 4.2% relative to October. Compared with the same period 24/25, elective activity has decreased by 7.3%, emergencies have decreased by 40.4% and non-electives have increased by 2.4%. However, the growth in emergencies is a reflection of a number of significant service changes, including the introduction of the Ambulatory Emergency Care Unit (AECU).

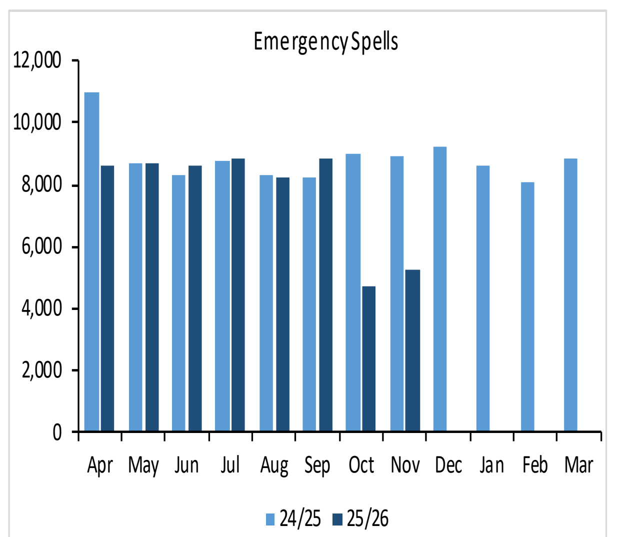
Elective spells
8,886
↑ vs 8,525 last month

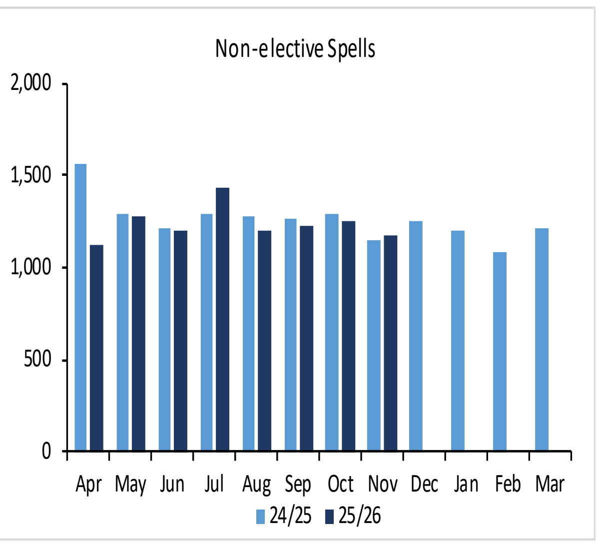
Emergency spells
5,298
↑ vs 4,734 last month

Non-elective spells
1,170
↓ vs 1,255 last month

Total spells
15,354
↑ vs 14,514 last month







Note, Same Day Emergency Care (SDEC) recording in EpicEPR has reduced the number of Emergency Admissions (effective from October).

Colchester

Contingency beds remain open as well as bedding in the frailty end of ESNEFT Same Day Emergency Care (ESDEC) to manage demand. RAG patient review meetings continue across all wards with a number of complex patients with extended LOS. Time to Care week will take place in the week before Christmas with collaboration from system partners to support patients getting home, or to an alternative care setting ahead of the festive period. Acuity has been high, with flu and respiratory admissions.

Ipswich

Ipswich, continued to utilise temporary escalation beds. These opened in October including the Stroke gym and 9 additional beds in Aldeburgh Hospital. At the end of the month, Waveney was opened as a medical escalation ward which now has 27 patients.

Another Time to Care week will run in December to focus on alleviating delays within the hospital and working with system partners to support discharges.

Performance: Inpatients

November 2025

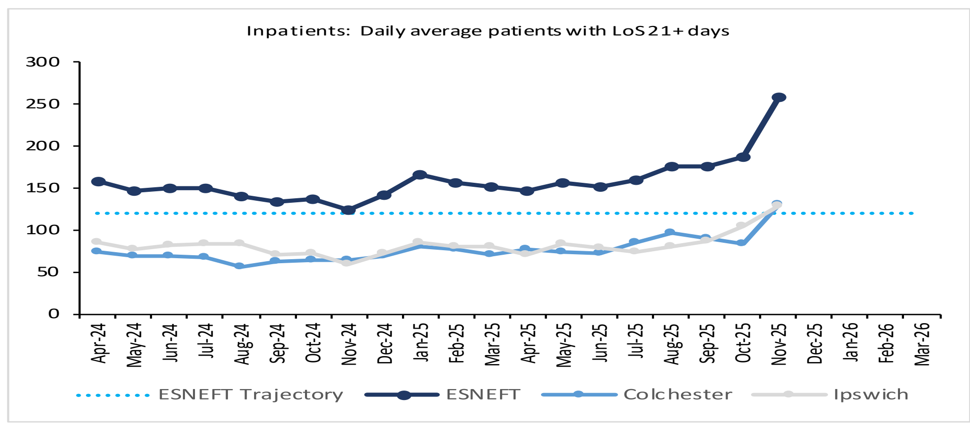
The average number of long length of stay (21+ days) patients across ESNEFT increased by 72 in month and is 139 patients above the trajectory. Colchester increased by 47 patients and Ipswich increased by 25 patients.

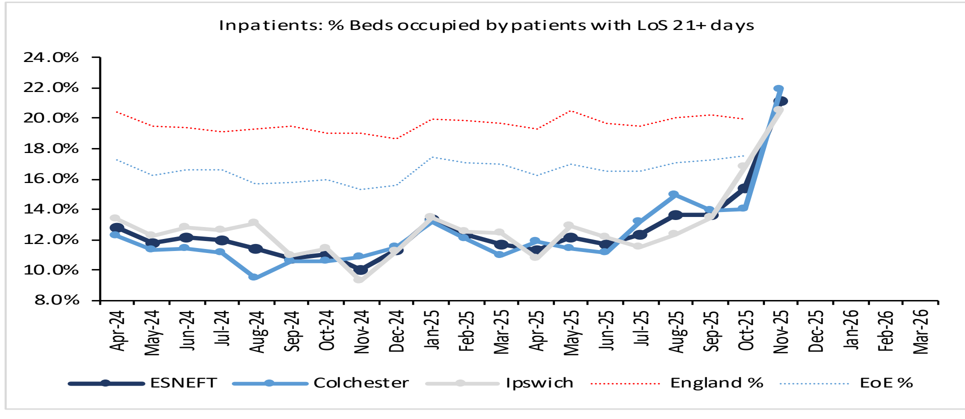
ESNEFT – Daily average LLOS patients
259
↑ vs 187 last month

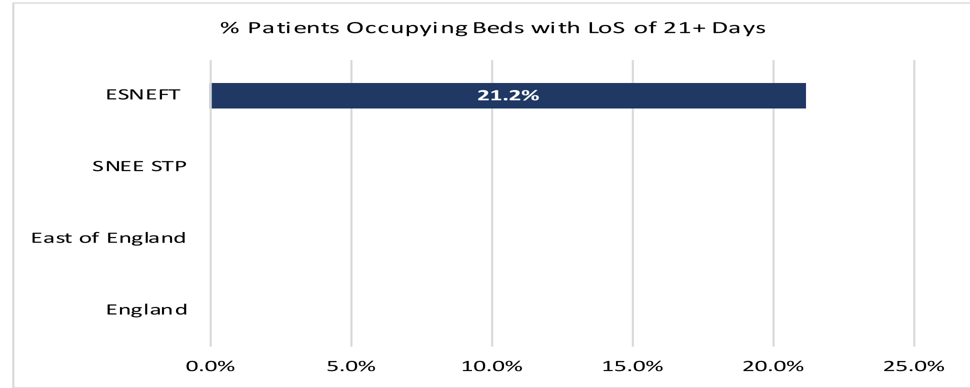
Colchester – Daily average LLOS patients
130
↓ vs 83 last month

Ipswich – Daily average LLOS patients
129
↑ vs 104 last month

***National/Regional data for November was not available at time of submission.*







Note It is possible that due to the recent implementation of EpicEPR in Community Hospitals, the inclusion of these figures in the overall patient Length of Stay (LoS) is contributing to increase seen in month. This will require further review to ensure accurate reporting and alignment with organisational standards.

Colchester

There has been an increase in complex patients which has led to more patients waiting over 21 days. There have been significant challenges with mental health patients throughout November, both at the front door and on the deeper wards which was impacting on this increase.

Daily complex meetings have been stood up and the MH patients are discussed daily on the Sit Rep call and escalated accordingly. A Time to Care week is planned for the 15th December.

Ipswich

The Trust set up an ESNEFT focus group looking at Patient Flow in late October. This task group is being held weekly led by the Transformation team to look across both Colchester and Ipswich sites, to ensure uniformity and promote change to improve length of stay. Targeted work on the wards this month was to focus on Expected Date of Discharge (EDD) to improve the accuracy of ward discharges.

Teams continue to run weekly Time to care, MDT's on each medical ward reviewing our complex and long length of stay patients. There is a continued drive on Time to Care initiatives implementing the revised Board round Standard Operating Procedure (SOP) and preparing for the next event in December to prepare the Trust for the festive bank holiday

Performance: Medically Fit for Discharge (MFFD)

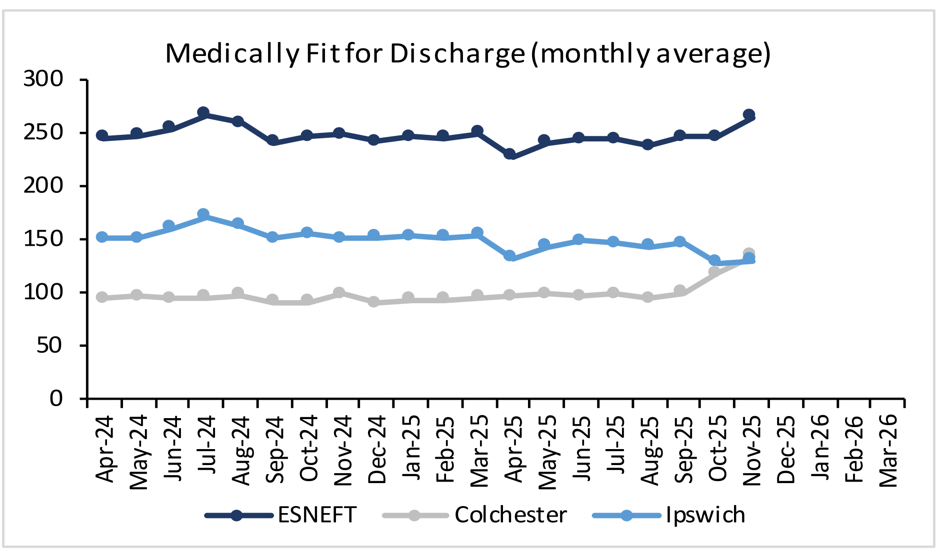
November 2025

The average number of medically fit for discharge patients has increased by 7.3% in month for ESNEFT. Colchester increased by 13.6% and Ipswich increased by 1.6%.

Medically fit discharges - ESNEFT
264
↑ vs 246 last month

Medically fit discharges - Colchester
134
↑ vs 118 last month

Medically fit discharges - Ipswich
130
↓ vs 146 last month



Colchester

The discharge data is being monitored closely. An increase in admissions is creating strain on the system which is contributing to the growth in MFFD patients. Complex patients, as described on the previous slide, are medically fit but cannot move. The winter period has set in, and this is reflected in the number of patients in the hospital. Lack of discharges over a weekend create further pressure, particularly on a Monday and Tuesday as the hospital catches up. The changes in EpicEPR have also made it easier to record a patient as medically fit, so this is being reviewed daily to ensure accurate data capture.

Ipswich

Medically fit for discharge patients remained static in November. Discharge to assess meetings were re-launched to drive improvements in discharges across Community Hospitals, to drive down length of stay for our medically fit for discharge patients. As part of the new Patient Flow Focus group, teams are specifically looking at medically ready patients and identifying these patients in EpicEPR to reduce delays in discharge planning and decision making, alongside system partners.

Performance: Cancer

November 2025

ESNEFT performance in month improved by 9.2% for two week waits and improved by 2.6% for 62 day first treatments. The 28 day faster diagnosis rate declined by 0.9% compared to the month before and is below ESNEFT's internal trajectory to meet 81.1% in month.

62-day wait performance
61.3%
vs 58.7% last month

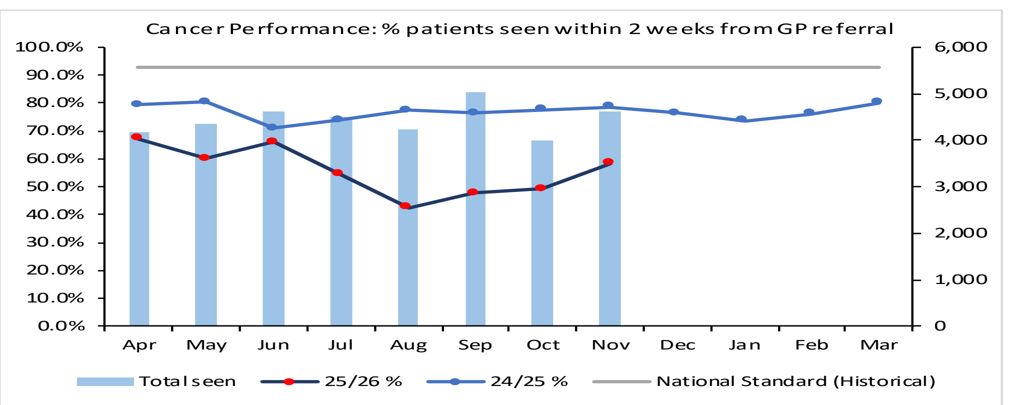
Two week wait performance
58.5%
vs 49.2% last month

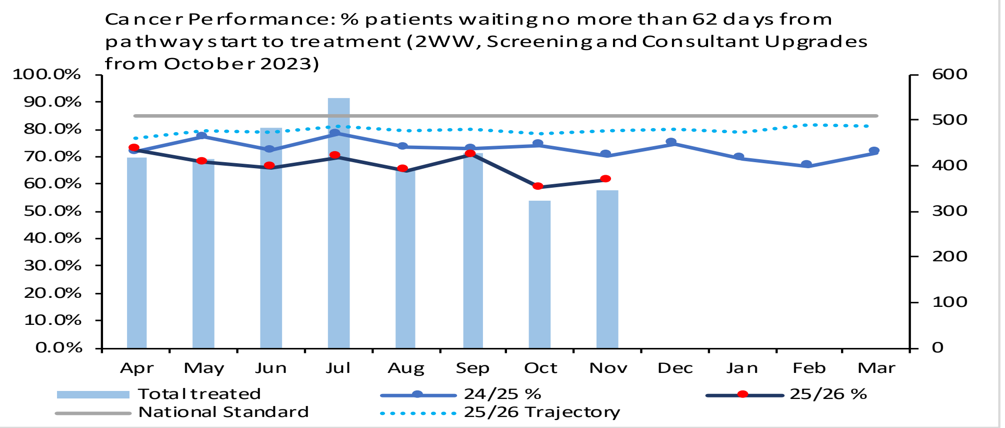
28-day faster day diagnosis performance
65.4%
vs 66.2% last month

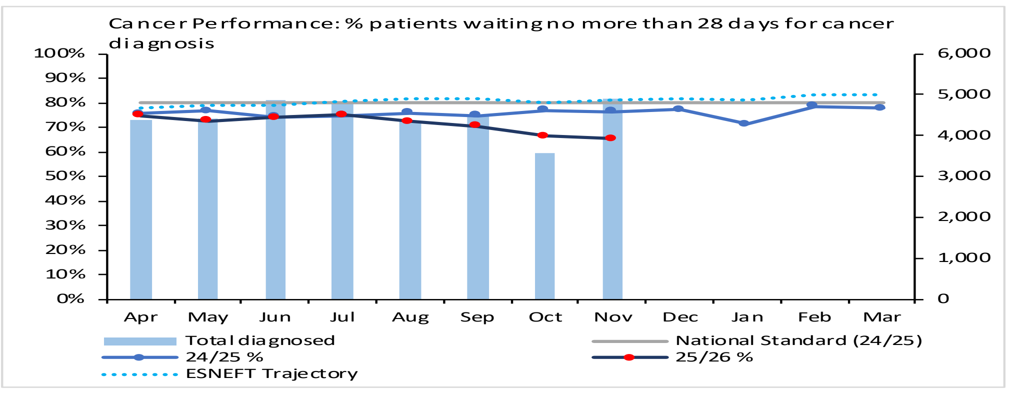
Patients treated at 63+ days
1,141
vs 1,117 last month

Patients treated at 104+ days
54
vs 44 last month

62-day PTL size
6,365
vs 7,010 last month







Service Commentary

Data Quality (DQ) issues continue to impact overall numbers in the PTL, but work continues at pace to resolve these. EpicEPR are reviewing where changes can be made in the system to resolve data capture inaccuracies and additional training for the MDT tracking teams will support to ensure any changes are relayed to ensure tracking quality continues to improve.

The Cancer Task Force and associated programme of works as well as daily Red to Green for colorectal and urology are having a positive impact on PTL numbers. A more focused piece of work next week as part of cancer turbo rooms will look at validation of the backlog, work up and booking of patients with a confirmed diagnosis. In the lead up to the holidays, as always, additional service team and CNS support will be calling patients with benign results to ensure they have the news before Christmas. This not only means a much better Christmas for those patients, but this will also have a positive impact on 28 FDS performance.

From when the data shown was run, there have been further improvements:

- The overall PTL size is now 5,661, down a further 704 patients.
- The backlog is now 1,013, down by a further 128 patients. 100 patients in the total backlog are waiting next steps with a tertiary provider.

Performance: Diagnostics

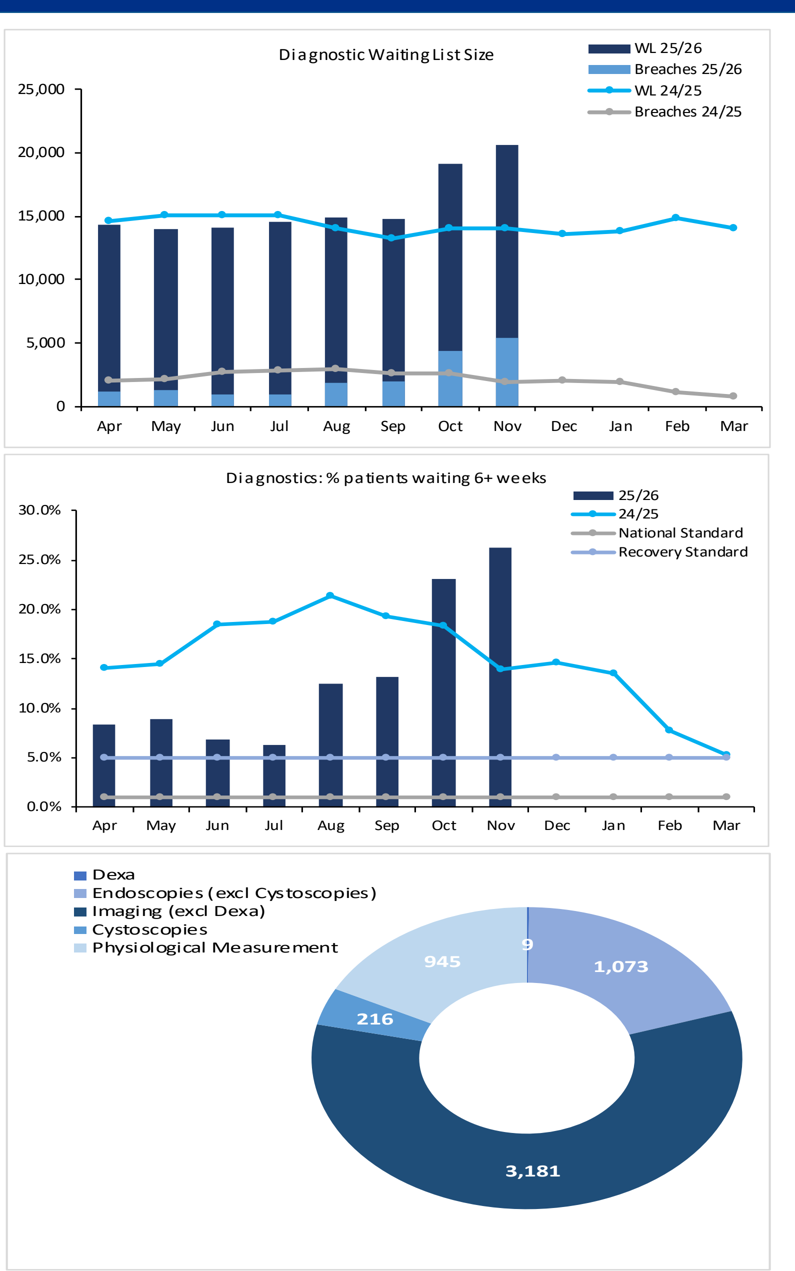
November 2025

6 week performance declined by 3.1% in month. The number of 6 week breaches increased by 997 with the waiting list increasing by 1,500 (7.8%). Ipswich currently holds the greatest proportion of the breaches at 62.8%. Of the Ipswich breaches, non-obstetric ultrasound constitute 48.2% of the site total. At Colchester non-obstetric ultrasound account for the greatest proportion of breaches (29.3%).

% patients waiting > 6 weeks
26.3%
↑ vs 23.1% last month

DM01 6-week breaches
5,424
↑ vs 4,427 last month

DM01 Waiting List
20,645
↑ vs 19,145 last month



Service Commentary

DM01 performance declined in November with growth in the waiting list and the backlog.

The DM01 PTL grew over and above expected levels at Go Live. Focused Turbo rooms in November have supported additional training around user error which is seeing the waiting list reduce.

DM01 patents waiting have been impacted through August to November by the known PACs issue. The division continue to work through these issues.

At present the proportion of the population waiting at ESNEFT is in line with national rates but with less patients waiting 13+ weeks.

All services remain committed to returning to upper quartile performance within the financial year.

Performance: RTT

November 2025

Performance against the 18-week standard declined by 1.76% in month. Performance is below the national average and below the regional average for September. The proportion of patients waiting 65 weeks or more has reduced by 0.01% and the proportion of patients waiting 52 weeks or more has decreased by 0.08%.**

Open pathways within 18 weeks - ESNEFT
54.23%
vs 56.0% last month

*Open pathways within 18 weeks – National ***

60.7%

65+ week waits - ESNEFT
0.00%
vs 0.01% last month

65+ week waits - National

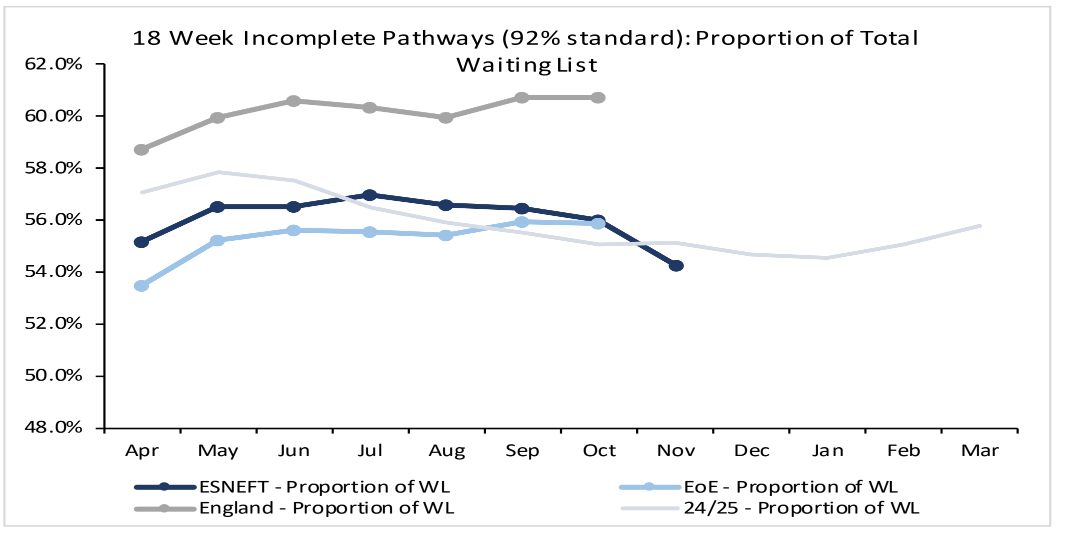
0.2%

52+ week waits - ESNEFT
3.25%
vs 3.33% last month

52+ week waits - National

2.5%

**National reporting is one month in arrears with only September's available at time of this submission.



**November 25 is not fully validated and will be updated accordingly.

Service Commentary

ESNEFT performance deteriorated against the October position. However, performance is ahead of plan (including the plan factoring in the Go-Live impact).

The Trust remains on track to meet the national priority target of a 5% improvement from baseline; however, it is noted the coming months require steep improvement, against an uncertain period of industrial action.

The 52+ week wait % reduced from October to November. ESNEFT are above trajectory for to clear the waiting list.

Following agreement for mutual aid support to MSE, the Trust anticipates a steep increase in patients over 52 and 65 weeks on the PTL. This is being closely monitored and supported by NHSE, and teams are working to identify patients in this cohort as they will sit on the ESNEFT PTL.

Performance: Recovery

Elective inpatient activity decreased by 0.9% in month, with day case activity increasing by 5.2%.

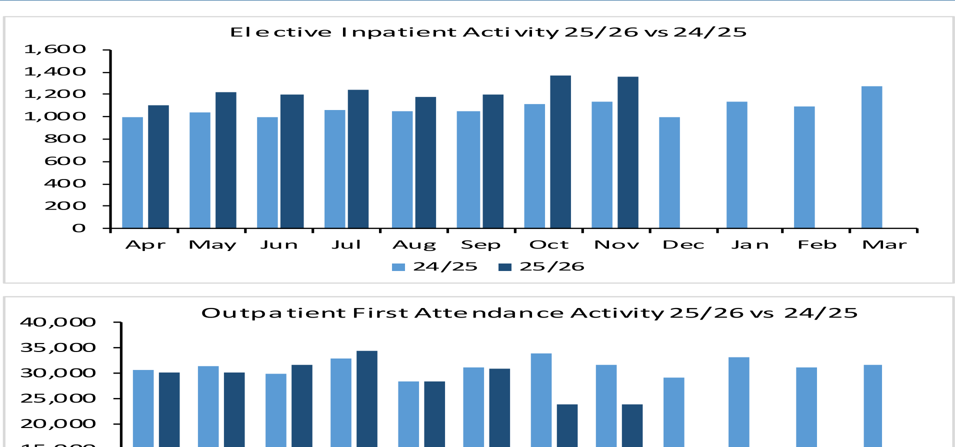
Outpatient first attendances decreased by 0.6% while follow-ups decreased by 21.1%.

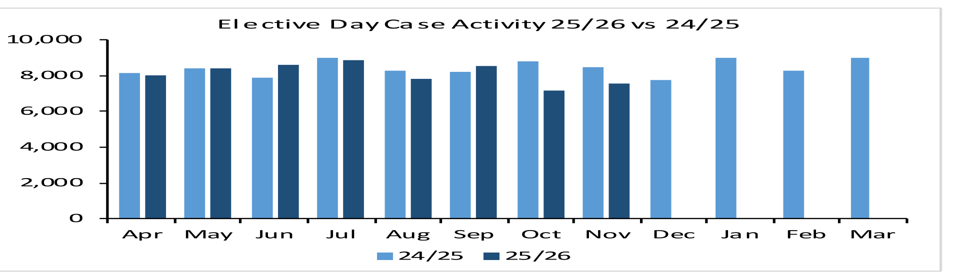
Elective inpatients
1,357
↓vs 1,369 last month

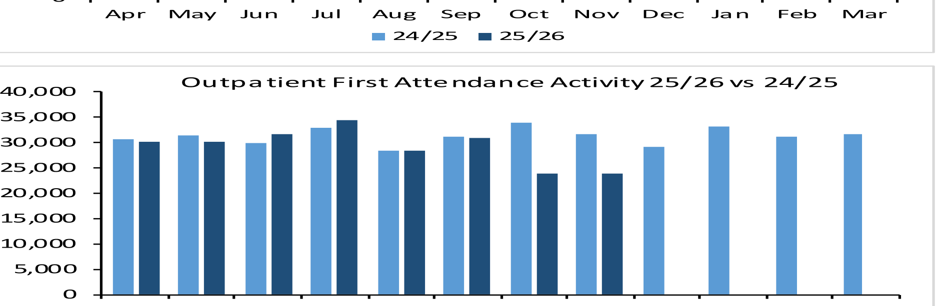
Elective daycase
7,529
↑ vs 7,156 last month

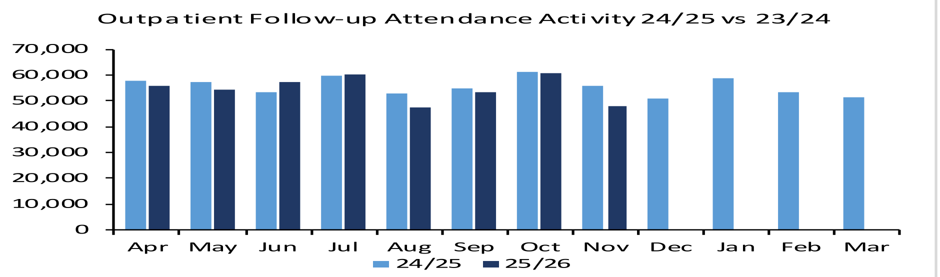
Outpatient First Appt
23,874
↓ vs 24,021 last month

Outpatient F/U Appt
47,781
↓ vs 60,522 last month









Outpatients

As part of Epic Stabilisation, clinic activity was reduced with services increasing through November. Services identified that activity was behind plan in terms of increasing to pre-EpicEPR levels. This is being monitored through centralised stabilisation reviews.

MyChart

In November, the Trust relaunched "Validation contact" with patients, this was previously delivered through text message, however November moved to using MyChart (EpicEPR). Since commencing in November 27,651 patients have been contacted via MyChart with some patients confirming they no longer need an appointment.

Theatres

Whilst down on the previous month, inpatient activity increased compared to the November 24/25 position.

Daycase activity

Activity increased in November compared to October; but was down against the same time last year. The levels are being tracked against services plans with actions in place to recover to expected levels.

Performance: RTT Recovery

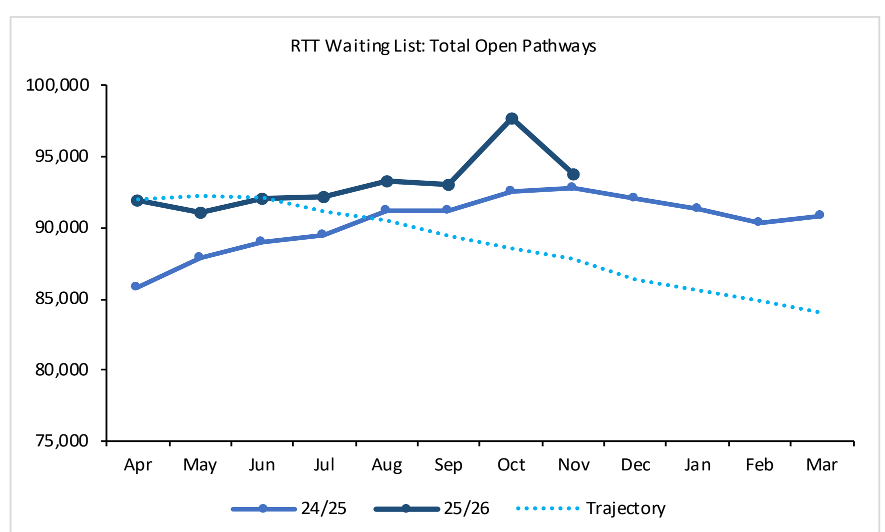
November 2025

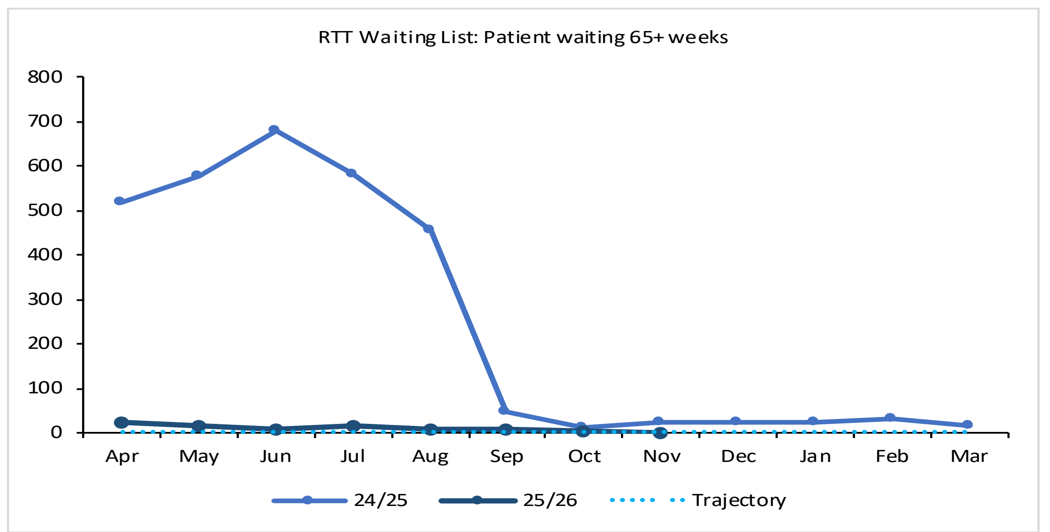
The ESNEFT RTT waiting list has decreased by 4.0%, but is above the trajectory set for the month by 5,887. Patients waiting 65 weeks or more decreased by 5 to 0. At Ipswich the 65+ cohort decreased by 1 patient, while at Colchester the cohort decreased by 4 patients. The number of patients waiting 52 or more weeks decreased by 209 to 3,044. At Ipswich, the number of 52+ week waiters decreased by 91 and at Colchester the number decreased by 9.

RTT open pathways
93,737
↓ vs 97,652 last month

65+ week waiters
0
↓ vs 5 last month

52+ week waiters
3,044
↓ vs 3,044 last month





Service Commentary

November saw the completion of the planned ‘Activity Stabilisation’ period post Go Live of Epic EPR. At the end of September, prior to Go Live, ESNEFT had 89,958 patients waiting internally, 93,053 including Oaks RES patients. A total of 116.1 per 1k of the population.

Growth in October was over and above anticipated figures due to migration and user challenges. Following focused support using ‘Turbo Rooms’, peer to peer training and increased PTL support, there has been a reduction at the end of November to 93,737. As at the end of October there were no patients over 65 weeks with confidence this will be maintained month on month and focus moving to 52+ week reduction.

November saw a reduction in patients waiting over 52 week waits versus the previous month. 52 week wait cohorts are reducing however, are above current trajectory. All services continue to work to the national expectation of 52+ week patients being a maximum of 1% of total PTL size.

Industrial Action (IA) is a continued risk to elective provision. In November, the risk was able to be minimised, and teams are currently assessing the December impact which is anticipated to be more challenging given increased leave alongside increased emergency activity.

Performance: Virtual Wards – excluding OPAT

November 2025

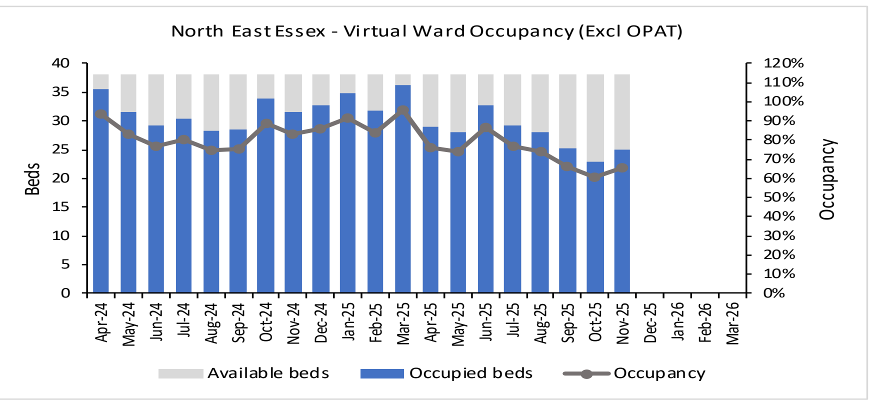
Excluding OPAT, virtual ward occupancy increased by 8.0% compared to the month before. Average length of stay increased by 0.7 days and the assumed bed saving on ESNEFT acute sites increased by 3.0 to 13.9.

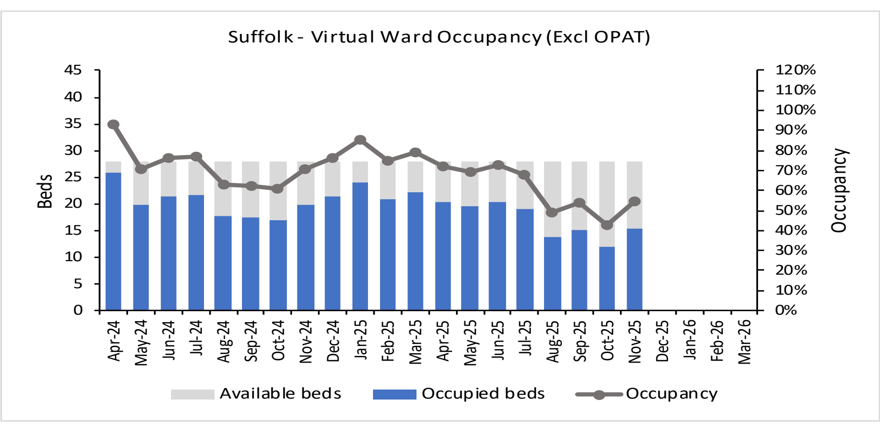
Virtual Ward occupancy
61.1%
vs 53.0% last month

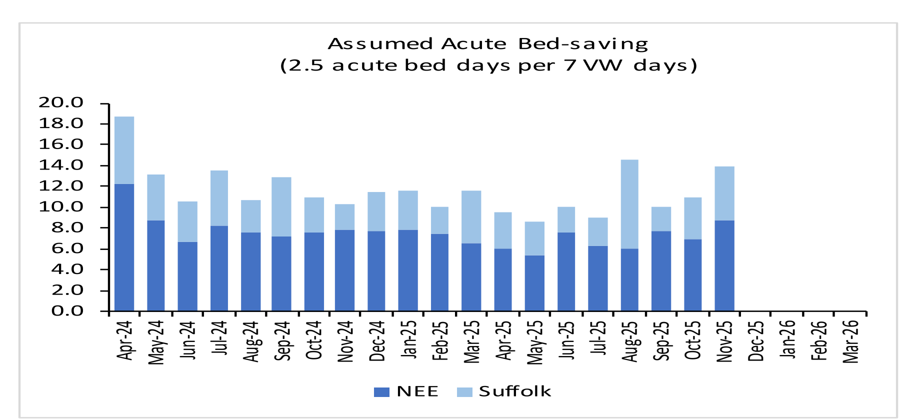
Virtual Ward ALoS
5.50
vs 4.80 last month

Virtual Ward – assumed acute bed saving**
13.9
vs 10. last month

**Acute bed saving assumes a reduction of 2.5 bed days in an acute setting for every 7 days in the virtual ward, further to the analysis performed by the Advanced Analytics Team in December 2023.







Service Commentary

The percentage utilisation figures are still subject to adjustment and checking of accuracy, as the Trust transitions from the 'Virtual Ward' model to a 'Hospital at Home' approach with a primary focus on avoiding admissions to base wards.

The new model in based on frailty pathways and continues to perform well. Divisional oversight on capacity shows utilisation often above the stated maximum capacity.

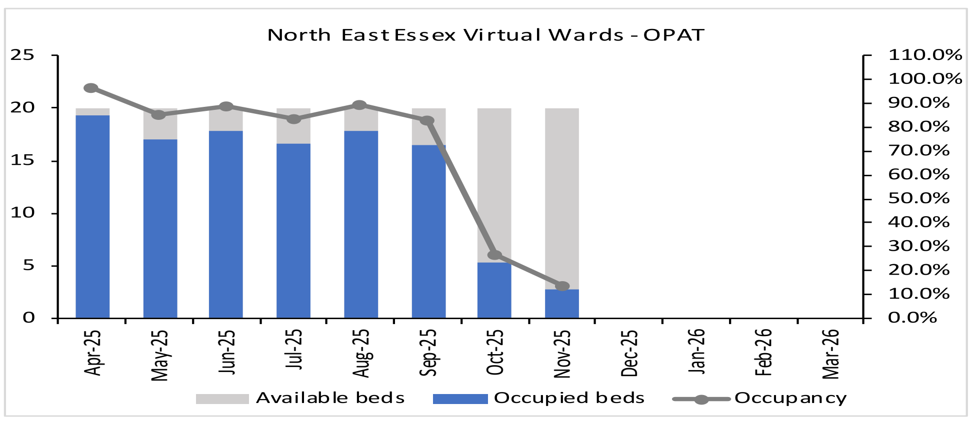
Full delivery of the transition to hospital at home is dependent on a number of staffing moves which are not expected to be fully completed until January.

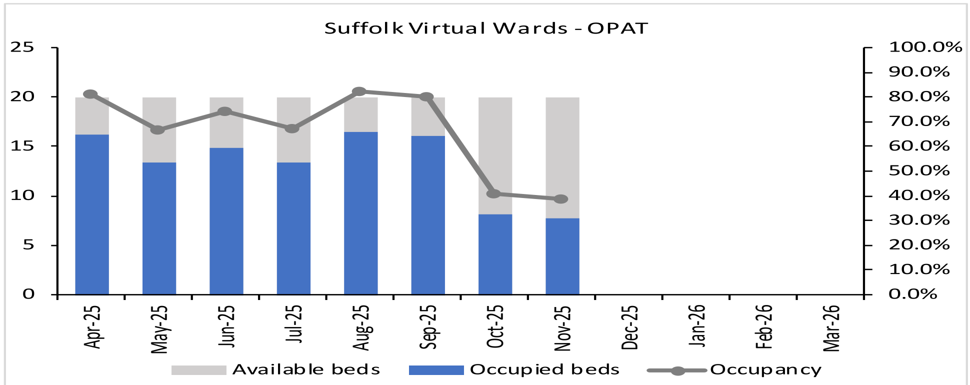
Performance: Virtual Wards – including OPAT

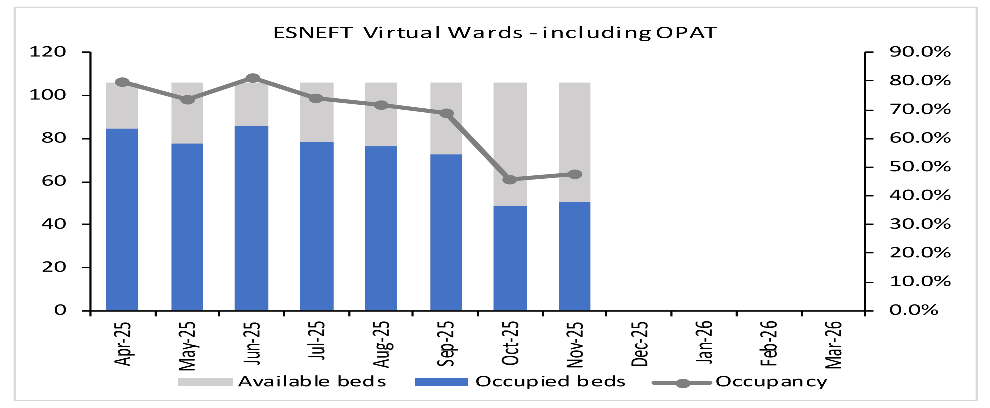
November 2025

Including OPAT, in month Virtual Ward occupancy in North East Essex decreased by 48.8% compared to the previous month, and in Suffolk occupancy decreased by 42.1%.

Overall, in ESNEFT, Virtual Ward occupancy decreased by 45.8%.







Performance: Community Paediatric Patients

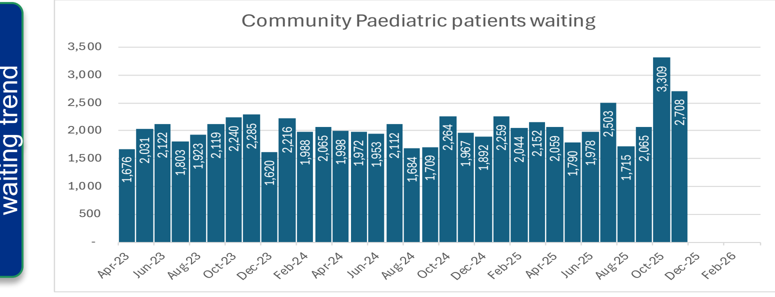
November 2025

There are 2,708 Community Paediatric patients, including Paediatric Neurology. Following a significant rise in patients waiting around Go-Live, the number of patients waiting has declined following much work to cleanse the impacts of Go-Live and new ways of working, as well as treatments provided to patients. The number of patients waiting remains higher than it was before Go-Live.

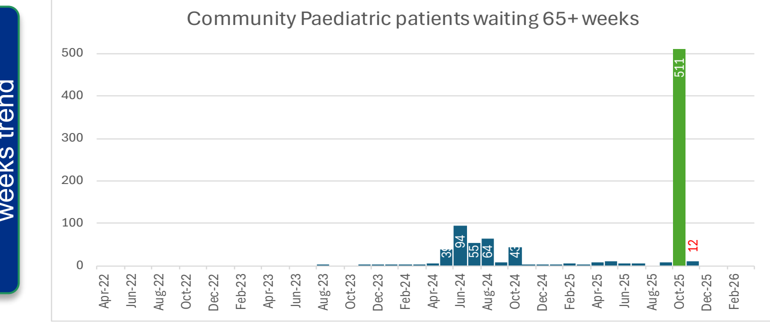
Excluding admin events, the number of treatments provided in November was high at 502, compared to a previous high of 439.

Community Paediatrics has a dedicated patients waiting dashboard to support.

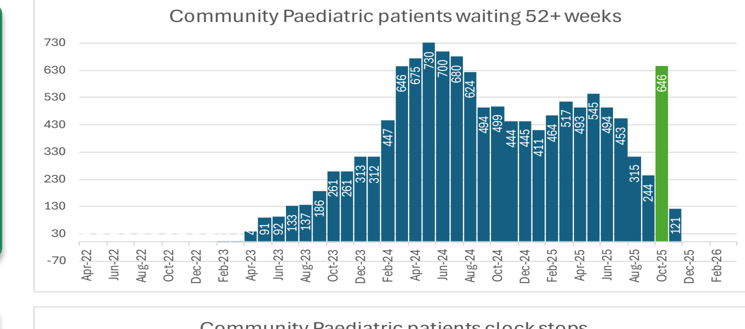
Total patients waiting trend



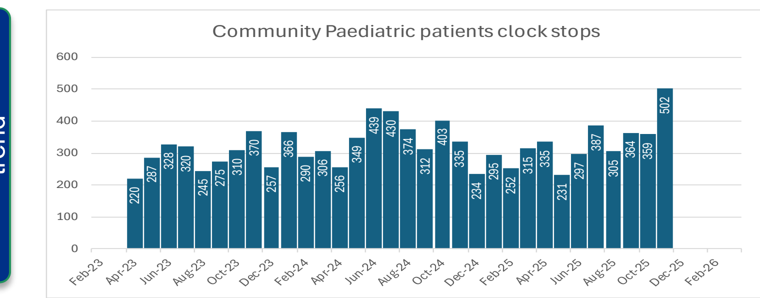
Patients waiting 65+ weeks trend



Patients waiting 52+ weeks trend



Patient treatments trend



There are 2,708 patients on the ESNEFT NDD pathway. The current waiting time is 47 weeks for a 1st appointment, 52 weeks for a subsequent ADOS assessment (1,455 patients waiting) and 8-10 weeks for an outcome diagnosis.

Referral demand

Average over last 12 months is 234 per month.

The service is in discussion to increase ADOS capacity by February 2026 by reviewing job plans and training an ASD nurse and clinical psychologist. This will not be enough to manage incoming referrals or backlog.

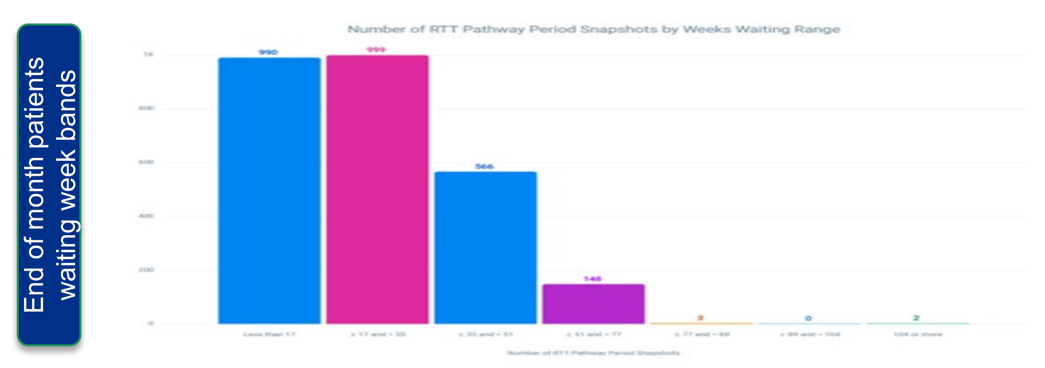
As part of Commissioning intentions, there is a plan to submit an updated business case requesting funding for insourcing or additional sessions from April 2026.

Follow up capacity reduced by 30% in October due to the EpicEPR rollout and clinic reduction. This has increased back to normal templates from November. There was further reduction in capacity from October due to two doctor retirements and an ADHD Nurse specialist resignation.

Community Paediatrics is now recorded as non-RTT. However, teams are still aiming for 65% 18-week compliance by March 2026.

Current clock stops are an average of 250.

End of month patients waiting week bands



Finance and Use of Resources: Trends & Hotspots

November 2025

Revenue	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Performance Against Control Total (YTD)	0	32	(357)	(1,743)	(4,173)	(5,770)	(7,796)
FOT Variance to Plan	0	-	-	-	-	-	-
YTD CIP variance to plan	0	(3,448)	(5,468)	(6,696)	(6,105)	(7,322)	(8,340)
Forecast CIP FYE Variance to Plan	0	(17,121)	(16,828)	(16,441)	(14,348)	(13,822)	(10,980)

Capital	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Capital variance (in month)		1,188	1,946	1,332	(248)	(30)	5,839
Capital variance (YTD)		10,012	11,958	13,290	13,042	13,012	18,851

***(Overspend)/Underspend**

Balance Sheet	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Cash YTD		23,522	31,007	27,906	20,453	28,066	27,537

Areas of Improvement

- Bank costs in November were £4.1m which is the lowest it has been all year and on the ceiling target for the month. Cumulatively the Trust has exceeded the bank ceiling by £2.9m (£35.5m v £32.6m).
- Agency costs in November were £0.7m. Reported monthly costs have dipped under the 25/26 ceiling set for the first time this year (£0.1m). Cumulatively the Trust has exceeded the agency ceiling by £1.9m (£8.4m v £6.5m).
- £3.3m of cost improvement plans were delivered in November which was an improvement on the £3.1m delivered in October.

Areas requiring further work

- The Trust reported an actual deficit of £1.5m in November, £2m adverse to plan. This means that the cumulative position has moved to a deficit £11.6m. This is behind plan by £7.8m. Renewed energy needs to go into the Trust's recovery plans (both central schemes and those locally developed by divisions).
- While the in-month delivery of CIP improved on the prior month by £0.2m, this was still below the target delivery by £0.9m (target £4.3m).
- £18.4m year to date of cost improvement plans have been delivered for the year, against a target of £26.8m.
- Capital expenditure cumulatively underspent against CDEL by £18.9m at the end of November. The main drivers of this underspend were Building for Better Care (£12.1m) and Estates & Facilities (£5.5m).

Finance and Use of Resources

November 2025

Performance against Control Total

Deficit

£11.6m

Performance against CT for the year to date

Behind Plan

£7.8m

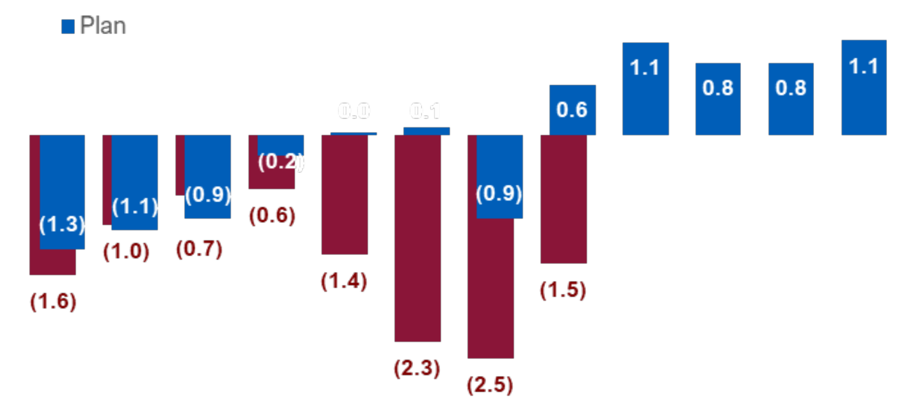
Deterioration of £2.0m in the month

Monthly Performance against Control Total

The Trust has a financial control total (CT) set by NHSE which informs the Trust financial plan for the year. For 2025/26 the target is to achieve a break-even position or better. The planned delivery of this target is not profiled evenly across the year. Deficits have been planned in early months as CIP schemes are expected to deliver more as the year progresses (including EPIC efficiencies).

When measuring financial performance against this control total certain items are excluded, e.g. capital donations, impact of PFI UK GAAP and impairments.

After adjusting for these items, the Trust's plan for November was a surplus of £0.6m. The Trust failed to meet this CT for the month incurring a deficit of £1.5m (an adverse variance of £2.0m).



In Month

The Trust incurred a deficit of £1.5m for November. Overspends on expenditure have been partly mitigated by increases in income. IA impacted in the month amounting to £0.3m.

I&E Overview (November)	Plan £000	Actual £000	Fav/(Adv) £000
Income	99,669	102,525	**2,856**
Pay	(58,974)	(61,653)	**(2,679)**
Non Pay	(38,499)	(39,784)	**(1,285)**
Non Operating	(1,434)	(1,386)	**48**
Surplus / (Deficit)	**762**	**(298)**	**(1,060)**
Less: Other Non CT Items	(188)	(1,153)	(965)
Adjusted financial performance	**574**	**(1,451)**	**(2,025)**

Year to Date

The cumulative position has moved to a deficit £11.6m. This is behind plan by £7.8m. £0.7m related to IA action.

I&E Overview (YTD)	Plan £000	Actual £000	Fav/(Adv) £000
Income	799,497	816,215	**16,718**
Pay	(477,593)	(494,325)	**(16,732)**
Non Pay	(310,488)	(319,727)	**(9,239)**
Non Operating	(12,357)	(12,407)	**(50)**
Surplus / (Deficit)	**(941)**	**(10,244)**	**(9,303)**
Less: Other Non CT Items	(2,827)	(1,320)	1,507
Adjusted financial performance	**(3,768)**	**(11,564)**	**(7,796)**

Temporary Pay Expenditure

November 2025

Bank Above Ceiling

£2.9m

Bank is cumulatively over the ceiling

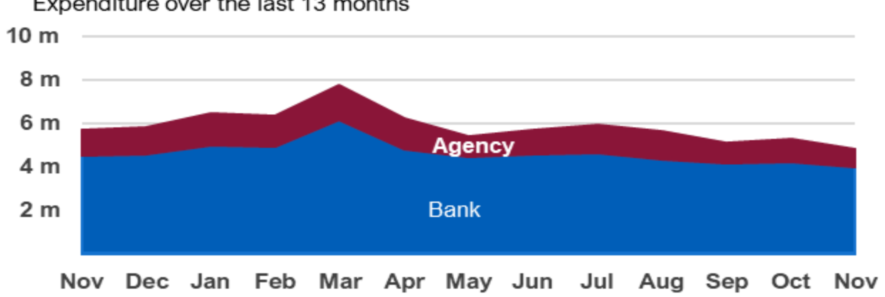
Agency Above Ceiling

£1.9m

Agency is cumulatively over the ceiling

Temporary Pay Expenditure

Bank expenditure is the most significant element of temporary pay expenditure.

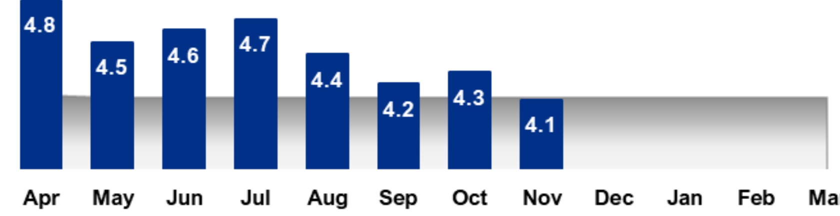


Bank Expenditure

Bank expenditure accounted for 7.2% of all pay costs (year to date). Nursing are the staff group most reliant on bank, with bank making up 10.2% of nursing costs.

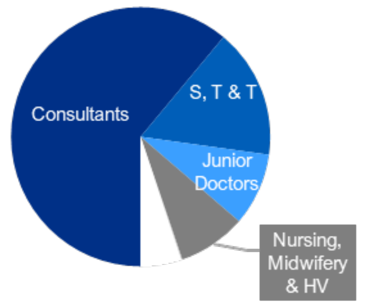
Bank Ceiling

Bank costs in November were £4.1m which is the lowest it has been all year and on the ceiling target for the month. Cumulatively the Trust has exceeded the bank ceiling by £2.9m (£35.5m v £32.6m).



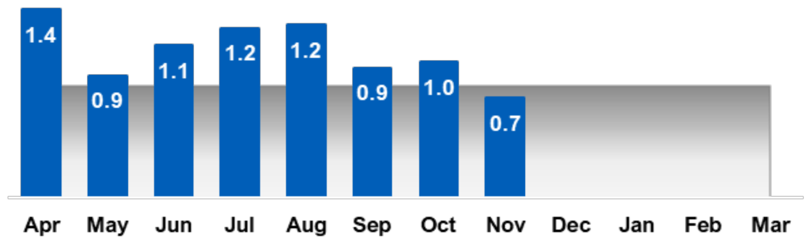
Agency Expenditure

Agency expenditure accounted for 1.7% of all pay costs (year to date). Consultants are the staff group most reliant on agency with agency making up 6.3% of consultant costs



Agency Ceiling

Agency costs in November were £0.7m. Reported monthly costs have dipped under the 25/26 ceiling set for the first time this year (£0.1m). Cumulatively the Trust has exceeded the agency ceiling by £1.9m (£8.4m v £6.5m).



Cost Improvement Programme (CIP)

Under Delivery

£8.3m

Actual delivery of £3.3m in the month against a plan of £4.3m

In Month

£3.3m of cost improvement plans were delivered in November against a target of £4.3m.

Year To Date

£18.4m year to date of cost improvement plans have been delivered for the year, against a target of £26.8m.

CIP Delivery (YTD)	Plan £000	Actual £000	Over/(Under) £000	%
Cancer and Diagnostics	4,229	2,136	(2,093)	(49%)
Medicine and Community IES	4,020	2,469	(1,550)	(39%)
Medicine and Community NEE	3,849	1,883	(1,966)	(51%)
Surgical Services	6,341	2,946	(3,395)	(54%)
Women's and Children's Services	2,834	640	(2,194)	(77%)
Total Operations	**21,273**	**10,074**	**(11,199)**	**(53%)**
Estates & Facilities	3,005	1,569	(1,436)	(48%)
Corporate Services	2,477	2,076	(402)	(16%)
Other Non Divisional	-	4,696	4,696	100%
Total Trust	**26,756**	**18,415**	**(8,340)**	**(31%)**

Finance and Use of Resources

November 2025

Cash Flow

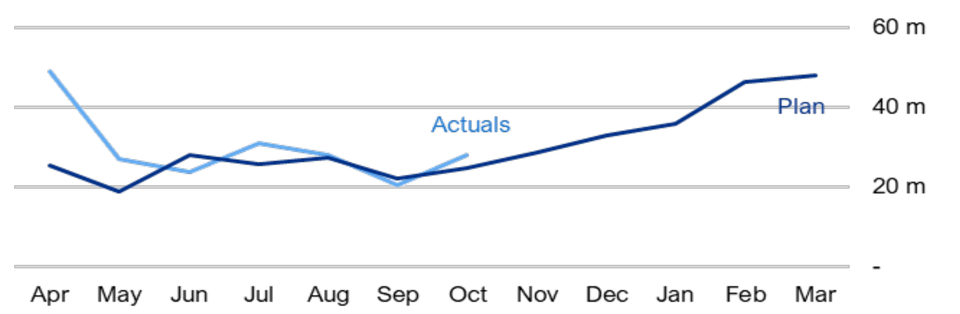
Cash Balance

£27.5m

Less than plan by £1.1m

Cash Balance

The Trust held cash of £27.5m at the end of November; which was £1.1m less than projected in the plan. Although the Trust is incurring a deficit the expected cash shortfall has not yet been realised because of underspends on the capital programme. When the capital programme recovers to plan, a cash shortfall will occur and potentially necessitate tighter payment controls and the seeking of cash support from NHSE. This is likely to be exacerbated by the Trust's plan profile which expects higher surpluses in later months.



Opening Balance v Movement in Receivables

In the Trust plan it was assumed that ERF owing to the Trust for 24/25 would not be paid until later in the new year (as had happened in prior years). However, ERF was fully paid in March (£18.3m). At the point of payment it was too late to adjust the Trust plan and therefore two lines in the cashflow have material underlying variances which effectively offset each other. These lines are 'Cash at start of period' and 'Movement in Receivables'.

Cash Management Actions

The Trust's cash balance requires more active management of creditor payments to ensure liquidity is maintained throughout the month. This is because during the month at its nadir the cash level is as low as circa £4m.

Statement of Cash Flows (Summary)	Plan £000	Actual £000	Fav/(Adv) £000
Cash Flows from Operating Actvities			
Surplus/(deficit) from operations	11,416	2,163	**(9,253)**
Non-cash items in operating surplus/(deficit)			
Depreciation and amortisation	27,804	23,592	**(4,212)**
Impairment losses/(reversals)	-	-	**-**
Capital donations (cash and non-cash)	(2,261)	(1,055)	**1,206**
Movement in Receivables	11,505	(16,696)	**(28,201)**
Movement in Inventories	-	(1,294)	**(1,294)**
Movement in Payables	1,941	(585)	**(2,526)**
Movement in Other liabilities	3	11,982	**11,979**
Movement in Provisions	(188)	(1,262)	**(1,074)**
Tax (paid) / received	-	1,488	**1,488**
Net Cash (Outflow) from operating	**50,220**	**18,332**	**(31,888)**
Cash Flows from Investing Activities			
Interest received	864	1,506	**642**
Purchase of Capital Assets	(67,499)	(44,485)	**23,014**
Proceeds from Sales of Assets	-	137	**137**
Donations to purchase Assets	2,261	1,000	**(1,261)**
PFI lifecycle prepayments	(1,112)	(1,114)	**(2)**
Net Cash (Outflow) from investing	**(65,486)**	**(42,956)**	**22,530**
Cash Flows from Financing Activities			
Public dividend capital received	11,565	5,662	**(5,903)**
Loans repayments	(631)	(638)	**(7)**
Capital lease and PFI payments	(6,983)	(6,269)	**714**
Interest paid including leases and PFI	(1,413)	(1,471)	**(58)**
PDC dividend (paid)/refunded	(7,781)	(7,300)	**481**
Net Cash (Outflow) from financing	**(5,243)**	**(10,016)**	**(4,773)**
Net increase / (decrease) in cash	**(20,509)**	**(34,640)**	**(14,131)**
Cash at start of period	49,136	62,176	13,040
Cash at end of period	**28,627**	**27,537**	**(1,090)**

Capital Expenditure

Behind CDEL

£18.9m

An increase to the cumulative underspend of £5.9m compared to last month

Underspends on a range of schemes, the most significant being Building for Better Care projects (£12.1m)

Year To Date

Capital expenditure has cumulatively underspent against CDEL by £18.9m at the end of November, with £23.1m spent against a £43.8m plan

Capital Expenditure (YTD)	Plan £000	Actual £000	Fav / (adv) £000
Medical Equipment	1,599	1,288	**311**
ICT	3,488	1,849	**1,639**
Estates & Facilities	8,637	3,137	**5,500**
Building for Better Care	21,968	9,853	**12,115**
Schemes	5,713	6,628	**(915)**
Financing (PFI, ROU and leases)	2,354	1,434	**920**
Total Capital Programme	**43,759**	**24,189**	**19,570**
Other Adjustments			
PFI Lifecycle Costs	-	-	**-**
PFI Residual Interest	504	504	**-**
Disposals	-	(488)	**488**
Donated	(2,261)	(1,054)	**(1,207)**
Capital Expenditure	42,002	23,151	18,851
CDEL	42,002	42,002	-
Performance against CDEL	**-**	**18,851**	**18,851**

Drivers of Underspend

The capital programme is underspent across a range of schemes including:

Building for Better Care (underspend £12.1m); most material being Clacton STAR with a £8.4m underspend. There was minimal spend in November and the most recent valuation has not been received. There continues to be a struggle to evidence a catch-up on programme.

Estates & Facilities (underspend £5.5m); in particular, the backlog programme is £2.1m underspent, while a business case for new funding of electrical elements (£2.4m) is still awaited.

Forecast

The current forecast is to achieve plan but there is a significant amount of delivery required to fulfil our capital programme in the remainder of the year, and this carries a significant risk of underspending against our CDEL.

Workforce: Trends & Hotspots

November 2025

Workforce Metrics	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Vacancy (excluding Agency)	3.50%	4.9%	4.8%	4.0%	3.6%	3.4%	3.0%
Proportion of temporary staff (Bank & Agency)	-	9.3%	9.6%	8.9%	8.8%	7.9%	7.7%
Sickness	4%	4.1%	4.4%	4.4%	4.6%	5.1%	5.1%
Mandatory Training	90%	93.7%	93.6%	92.8%	92.1%	91.9%	91.7%

Areas of Improvement

- The vacancy rate has decreased to 3% in November from 3.4% in October. Time to hire parameters have been amended nationally and is now reported from advert live to employment checks complete based on a 3-month rolling basis. The Time to Hire for month 6 based on the new parameters is 52 days [average 2 days below model hospital comparator Trusts].
- Bitesize training sessions focussed on absence are continuing and the sickness review group continues to meet on a monthly basis and is making good progress. There is a focus on those who have been absent over 3 months as well as complex cases by the ER Team who are targeting progress with OH and managers.
- The Absence Policy has been updated, and training sessions have been adjusted accordingly. Targeted work focussing on the management of short-term sickness absence is underway. A SOP is being developed in relation to automated processes for informing and guiding managers in relation to both Long term and short-term sickness with a view to minimise short term persistent absence and encourage earlier intervention for Long term absence.
- Mandatory Training has remained above target for 30 consecutive months.
- Individual meetings held by Retention Partner for each cohort of the HCSW Apprenticeship Academy to offer support and promote hub. Meetings for October cohort on the Ipswich site took place in November. Meetings with November cohort to take place in Colchester in December. Feedback from this staff group is reported to the Internal Delivery Strategy & Performance Group.

Areas requiring further work

- There is continued focus on hard to recruit consultant vacancies utilising head-hunters and international recruitment drives.
- 178 HCSW's appointed via the assessment centre – 106 will commence on the apprenticeship pathway. Monthly assessment centres take place at alternate sites.
- Consultant vacancies are currently at 31 WTE. 8 consultants are going through on-boarding with recent appointments to Obstetrics & Gynaecology, Histopathology, & Acute Medicine.
- Retention Partners continue to hold the 8 week individual meetings with HCSW Level 2 Apprentices. Feedback from this staff group is reported to the Internal Delivery Strategy & Performance Group. Meetings for November cohort on Colchester site to take place in December.
- International Nurse pipeline continues. The next cohort is in January. For the International Nurse upskilling programme, the final cohort of 8 is to commenced in September (37).
- Sickness absence has increased this month to 5.11% and was above the target of 4%. The main reasons for absence were Anxiety, Stress and Depression which is 1.31% of the workforce, followed by Cold, Cough, Flu - Influenza at 0.79%. The total number of employees who have been absent for 3-6 months, and over 6 months, remains steady and on-going targeted work continues by the ER & OH teams, including regular joint meetings discussing ongoing cases.

Workforce: Trends & Hotspots

November 2025

Workforce Metrics	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Appraisals	90%	88.8%	86.1%	85.7%	84.2%	81.2%	81.9%
Voluntary Turnover	7%	5.8%	5.6%	5.7%	5.5%	5.5%	5.5%
Ward Fill Rates (ESNEFT)	95%	90.9%	91.2%	89.7%	91.5%	88.3%	91.4%
Care Hours Per Patient Day (ESNEFT)	-	7.13	7.27	7.02	6.89	7.09	7.19
Executive team turnover	-	0	1	0	0	1	1

Areas of Improvement

- Leadership Development training: 1,795 completed/103 soon to complete, plus a further 2,112 attending management bitesize training. Along with 3,745 staff engaging in the suite of EDI training in the last year.
- National Staff Survey (NSS) – The survey close on 28 November with a 50.3% response rate. Results due March 2026.
- Ad hoc requests from leaders as part of their development journey will still be run and aligned to one of the experienced facilitators in the Trust to provide feedback. The Trust is proposing to teach another cohort of facilitators within the next few months and have asked the current team to recommend any colleagues before they launch a recruitment campaign.
- 'My Career Matters: The number of career conversations taking place across the Trust has grown to 1,179 from 1,134 conversations since the previous report. The results of career conversations can now be linked to recruitment opportunities so we can target those that are ready soon and ready now with career options. We also have data available for our WRES and WDES reporting for conversations that have taken place to monitor opportunity for all staff. Targeted contact with apprenticeship opportunities delivered both internally and externally will commence as well as targeting employees for leadership development and masterclass signposting.

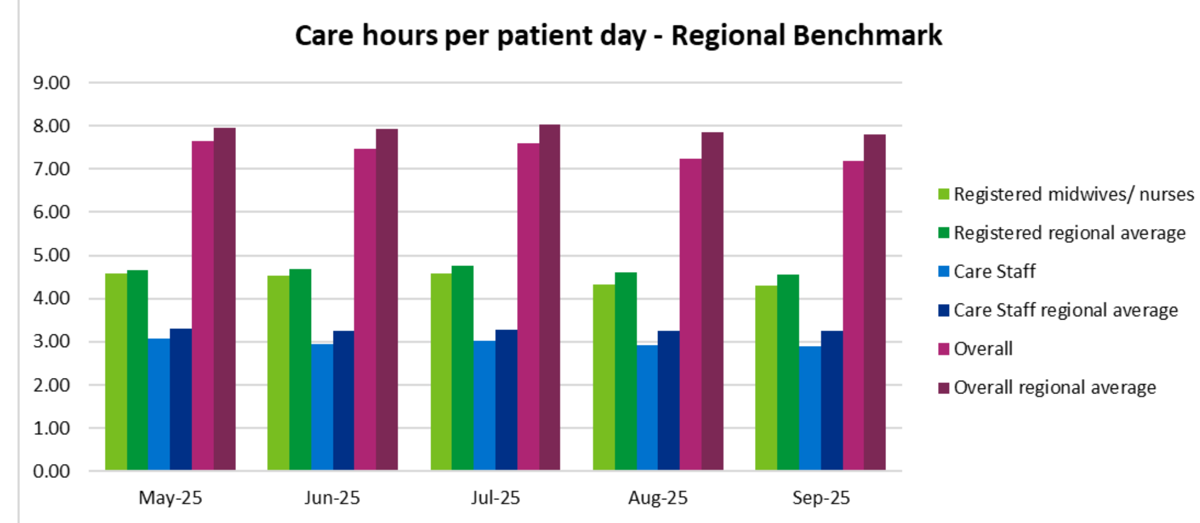
Areas requiring further work

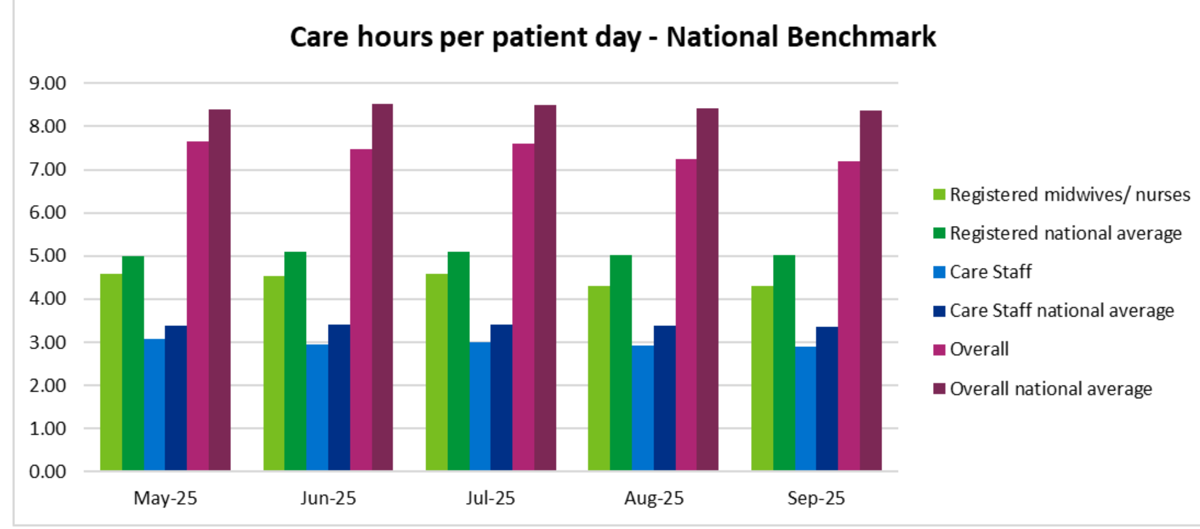
- Voluntary turnover rate is 5.54% (a marginal increase from previous month 5.46%). Nursing & Midwifery voluntary turnover is 4.20%, an increase from 3.98% in October and a substantial decrease from 5.80% in November 2025.
- Management of 52 formal employee relations cases (including disciplinary and grievance) as well as informal cases is ongoing. 17 opened in month and with 8 cases closed.
- November's Appraisal compliance rate increased to 81.9% from 81.2%. The Trust is under target for Appraisals. Bitesize training for appraisals is now being delivered through the Management Masterclasses. Improvements to the offer of career conversations, management masterclasses have been a focus for the divisions and HR, OD support to improve the quality of the conversations during appraisals.
- A range of measures to support staff wellbeing continues.
- As a continuation of the work to promote flexible working, a refresh of the flexible working offering was emailed to senior managers on 4th September. It highlights access to training and promotes the team rostering programme. This is to precede the flexible working case studies piece to be published at the beginning of October.
- Supportive 360 Leadership reviews: There are currently no open 360 projects and as EpicEPR is introduced, the launch of any new ones is being paused until the New Year. A project is lined up for then with the MACNEE division. This will be run as three cohorts with a total of 337 staff being invited to participate.

Well-Led - Nursing, Midwifery and AHP Workforce Update - CHPPD

November 2025

Care hours per patient day	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Registered midwives/ nurses	4.58	4.54	4.58	4.32	4.37
Care Staff	3.07	2.94	3.01	2.91	2.92
Overall	**7.66**	**7.48**	**7.59**	**7.23**	**7.29**





Care Hours Per patient Day (CHPPD) **

CHPPD is an NHS England metric calculated by combining the hours of staff on duty in a month in a department and dividing by the average number of patients occupying beds in the department at midnight. It is a key indicator of staffing levels in an NHS organisation but does not directly show whether care is safe, effective or responsive.

ESNEFT'S Registered Nursing & Midwifery, Care Staff (HCSWs) and overall CHPPD consistently falls under both the regional and national average (regional/national data for October is not yet available).

Safer Staffing

The Annual Staffing Review is almost complete utilising the Safer Nursing Care Tool (SNCT) audit data triangulated against patient outcomes and professional judgement. 96 wards/departments have participated in individual meetings to review their nursing budgeted establishments with a recommendations expected to be provided to Board in the next few months.

A Safer Staffing benchmarking self-assessment exercise was been submitted to NHSE for review. There was consensus on the majority of metrics which scored “green”. A very small number of elements were deemed by NHSE as “amber” who recommended changes to this monthly Board Integrated Performance report. A revaluation will take place in quarter 4.

International recruitment

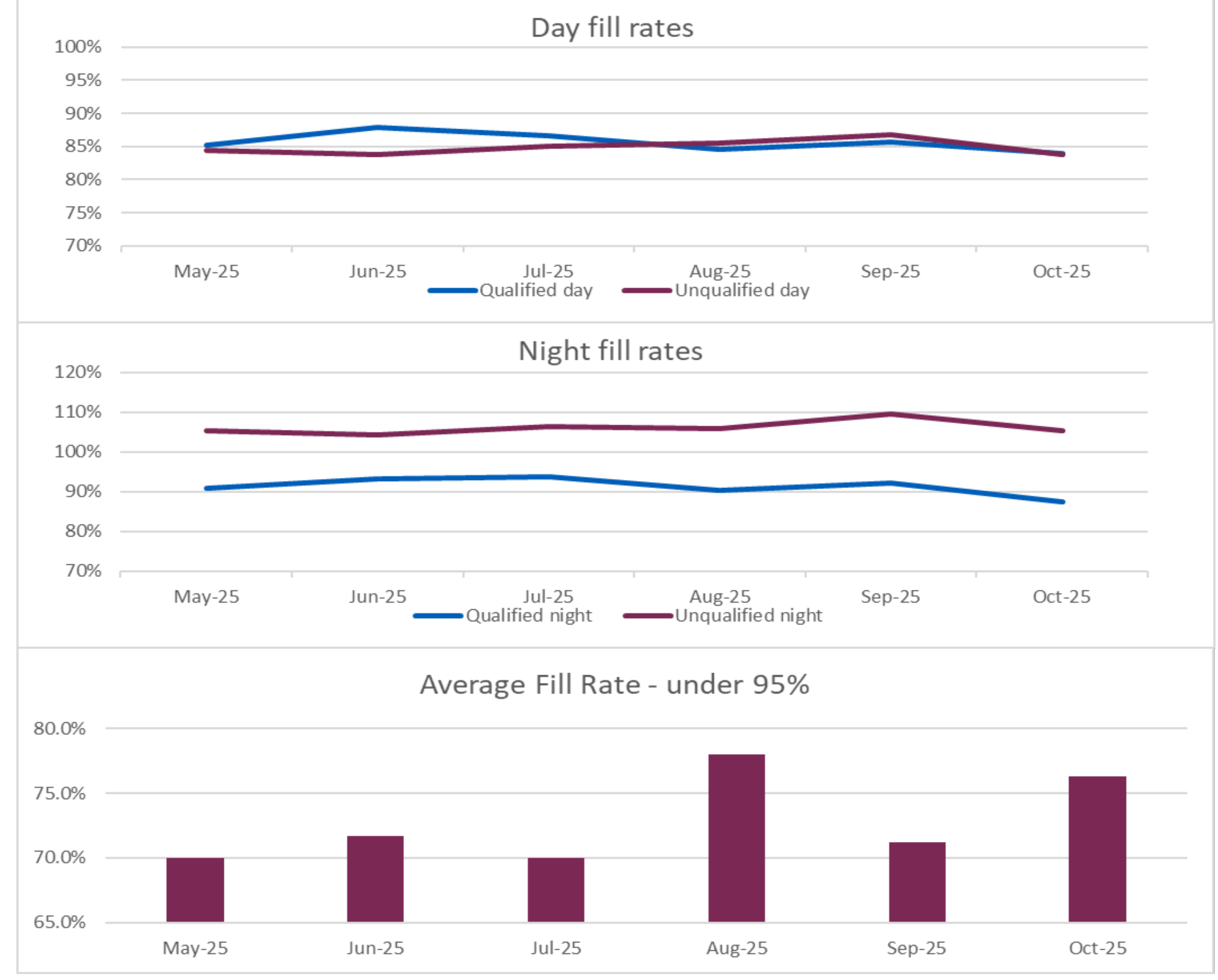
There have been significant challenges in placing a number of international nurses into clinical areas at Ipswich hospital. These nurses are being transported to Colchester site to support the newly opened Boxted ward.

*** The care hours data presented is currently under review: both the Trust's own calculations (ensuring that they are consistent with national guidance; and all appropriate nursing areas are captured). Benchmarking data (both regional and national) is also being scrutinised. The analysis currently excludes Specialist and Mental Health Trusts, but the treatment of community provision / trusts needs further consideration. National data is only available up to August 2025.*

Well-Led - Nursing, Midwifery and AHP Workforce Update – Fill Rates

November 2025

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Qualified day	85.3%	87.9%	86.5%	84.5%	85.7%	84.0%
Qualified night	90.8%	93.1%	93.6%	90.4%	92.1%	87.5%
Unqualified day	84.4%	83.8%	85.0%	85.5%	86.8%	83.7%
Unqualified night	105.2%	104.2%	106.3%	105.8%	109.6%	105.2%
Overall (average) fill	89.7%	90.9%	91.2%	89.7%	91.5%	88.3%



Fill rates

NHS providers are required to submit data (Nursing, Midwifery and care Staff Staffing Fill Rate Indicator) on staffing levels on a monthly basis via the UNIFY return. The data shows actual vs planned hours (budgeted template vs actual hours worked). This data is published on the ESNEFT website and appears on the NHS Choices website.

A target of 95% fill is set by the majority of NHS trusts. ESNEFT consistently falls under this target due to several reasons;

- In November the Registered Nursing & Midwifery sickness rate was 5.49% against a target of 4%. The sickness rate for HCSWs was 7.03% against a target of 4%.
- Vacancy rate for RN/RMs stands at 3.6% and 5.11% for HCSWs.

Bures model

A decision is awaited regarding expansion of the Bures model at Colchester- expanding the RN pool to fill staffing gaps as well as expansion of the ETOC Service in response to patient demand for 1 to 1 care. The proposal also includes launching an RN pool and ETOC service at Ipswich site.

Retention

43 wards are now participating in team rostering. Data indicates that there is a reduction in unfilled shifts at the point of roster approval (reducing the number of shifts sent to bank) particularly at weekends. Feedback from staff and managers has been very positive. A 12-month review report will be presented to NMAAC in December with the view to roll out Team rostering across all nursing teams.

Work will be undertaken to compare a number of roster metrics such as net hours, annual leave distribution, additional shifts and unavailability in team rostering wards compared to non team rostering wards/departments.

RAG rules: Less than 80% : Red; 80 - 95%: Amber; 95%+: Green

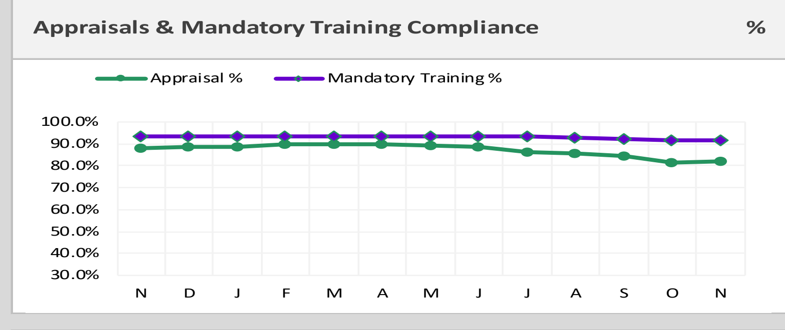
Workforce Dashboard

November 2025

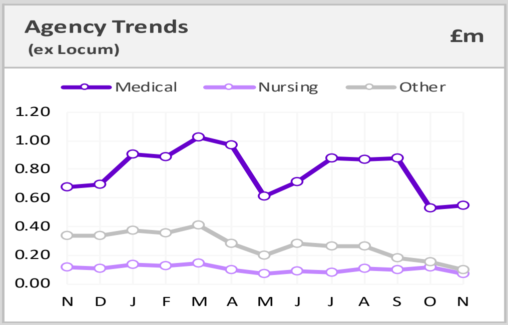
Trust Level

Key Metrics	Vacancy (Ex Agency)	Pay (YTD)	Sickness	Mandatory Training	Appraisal	Voluntary Turnover	Agency Ceiling	Ward Fill Rate
Performance	3.0%	£4.4m	5.1%	91.7%	81.9%	5.5%	(£1.97m)	91.4%
Target	Budget 11659wte	Budget £490.1m	4.0%	90%	90%	8%	(£6.48m)	95%
Achieved	Contracted 11304wte	Spend £494.5m	5.1%	View portal for detail	81.9 out of 100 staff		(£8.45m)	
Vs Prior Month	↓	↑	↑	↓	↑	↑	↑	↑
Prior Month	3.4%	£4.56m	5.1%	91.8%	81.2%	5.5%	(£2.07m)	88.3%

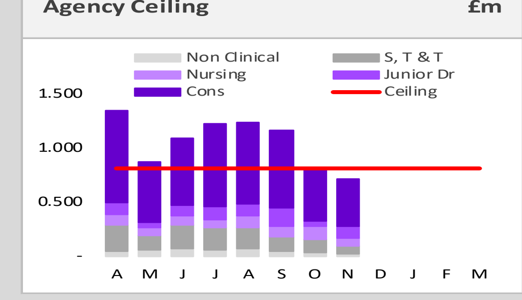
Appraisals & Mandatory Training Compliance %



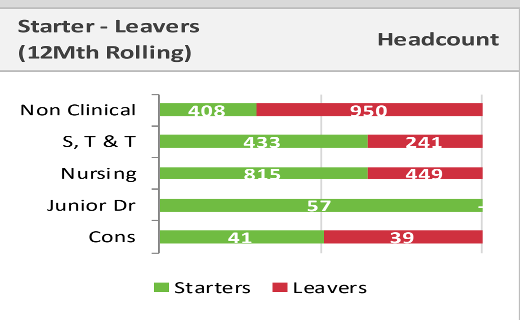
Agency Trends (ex Locum) £m



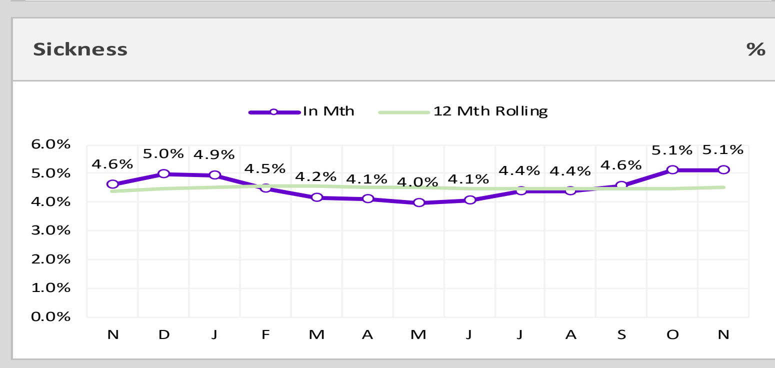
Agency Ceiling £m



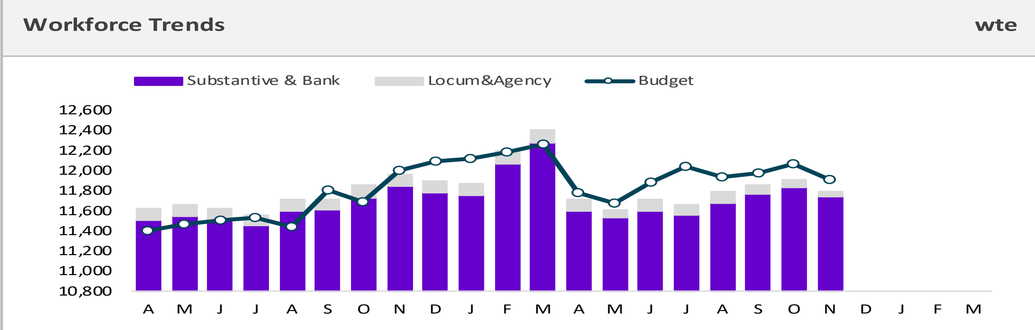
Starter - Leavers (12Mth Rolling) Headcount



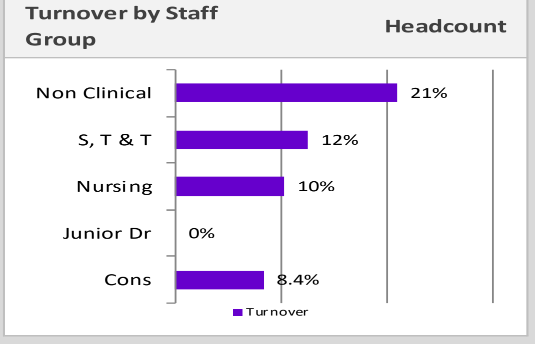
Sickness %



Workforce Trends wte



Turnover by Staff Group Headcount



Well-Led

November 2025

	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25
All Staff													
Headcount	12,760	12,782	12,872	12,932	12,991	12,589	12,491	12,568	12,579	12,641	12,765	12,734	12,791
Establishment (including agency)	11,805	11,877	11,895	11,971	12,042	11,566	11,533	11,591	11,629	11,623	11,684	11,696	11,659
In post	11,214	11,223	11,261	11,409	11,413	11,004	11,007	11,024	11,076	11,154	11,262	11,302	11,304
Vacancy	592	654	634	562	628	562	526	567	554	468	422	394	355
Vacancy %	5.0%	5.5%	5.3%	4.7%	5.2%	4.9%	4.6%	4.9%	4.8%	4.0%	3.6%	3.4%	3.0%
Establishment (excluding agency)	11,805	11,877	11,895	11,971	12,042	11,566	11,533	11,591	11,629	11,623	11,684	11,696	11,659
Vacancy (excluding agency)	592	654	634	562	628	562	526	567	554	468	422	394	355
Vacancy % (excluding agency)	5.0%	5.5%	5.3%	4.7%	5.2%	4.9%	4.6%	4.9%	4.8%	4.0%	3.6%	3.4%	3.0%
Turnover													
[1] Turnover (12 Month)	9.2%	9.0%	8.9%	8.9%	12.0%	12.7%	13.2%	12.4%	12.4%	12.4%	12.2%	12.6%	12.8%
[1] Voluntary Turnover (12 Month)	6.6%	6.5%	6.3%	6.4%	6.1%	6.0%	6.2%	5.8%	5.6%	5.7%	5.5%	5.5%	5.5%
[1] Starters (to Trust)	171	105	174	147	119	132	201	141	116	93	233	158	135
[1] Leavers (from Trust)	116	113	107	83	147	187	168	80	93	92	87	131	97
Sickness													
% In Mth	4.6%	5.0%	4.9%	4.5%	4.2%	4.1%	4.0%	4.1%	4.4%	4.4%	4.6%	5.1%	5.1%
WTE Days Absent In Mth	15,366	17,267	17,207	14,115	14,667	13,485	13,565	13,468	14,987	14,982	15,321	17,714	17,225
Mandatory Training & Appraisal Compliance													
Mandatory Training	93.5%	93.4%	93.2%	93.5%	93.2%	93.3%	93.2%	93.7%	93.6%	92.8%	92.1%	91.8%	91.7%
Appraisal	87.8%	88.8%	88.4%	90.0%	89.7%	89.6%	89.1%	88.8%	86.1%	85.7%	84.2%	81.2%	81.9%
Temporary staffing as a % of spend													
Substantive Pay Spend	53,024	52,373	52,986	53,036	92,922	55,052	54,843	55,088	55,370	57,306	56,786	57,978	56,627
Overtime Pay Spend	148	170	134	146	158	201	183	167	137	153	169	173	250
Bank Pay Spend	4,564	4,636	5,001	4,969	6,167	4,830	4,499	4,599	4,683	4,409	4,339	4,159	4,053
Agency Pay Spend	1,124	1,134	1,419	1,369	1,580	1,350	875	1,090	1,218	1,238	1,162	802	714
Total Pay Spend	58,859	58,314	59,539	59,520	100,828	61,433	60,401	60,943	61,407	63,106	62,455	63,112	61,644
Agency & Bank %	9.7%	9.9%	10.8%	10.6%	7.7%	10.1%	8.9%	9.3%	9.6%	8.9%	8.8%	7.9%	7.7%
Agency %	1.9%	1.9%	2.4%	2.3%	1.6%	2.2%	1.4%	1.8%	2.0%	2.0%	1.9%	1.3%	1.2%
Nurse staffing fill rate													
% Filled	87.7%	85.0%	86.6%	86.2%	86.0%	88.7%	89.7%	90.9%	91.2%	89.7%	91.5%	88.3%	91.4%

[1] Excludes training grade junior doctors

Well-Led

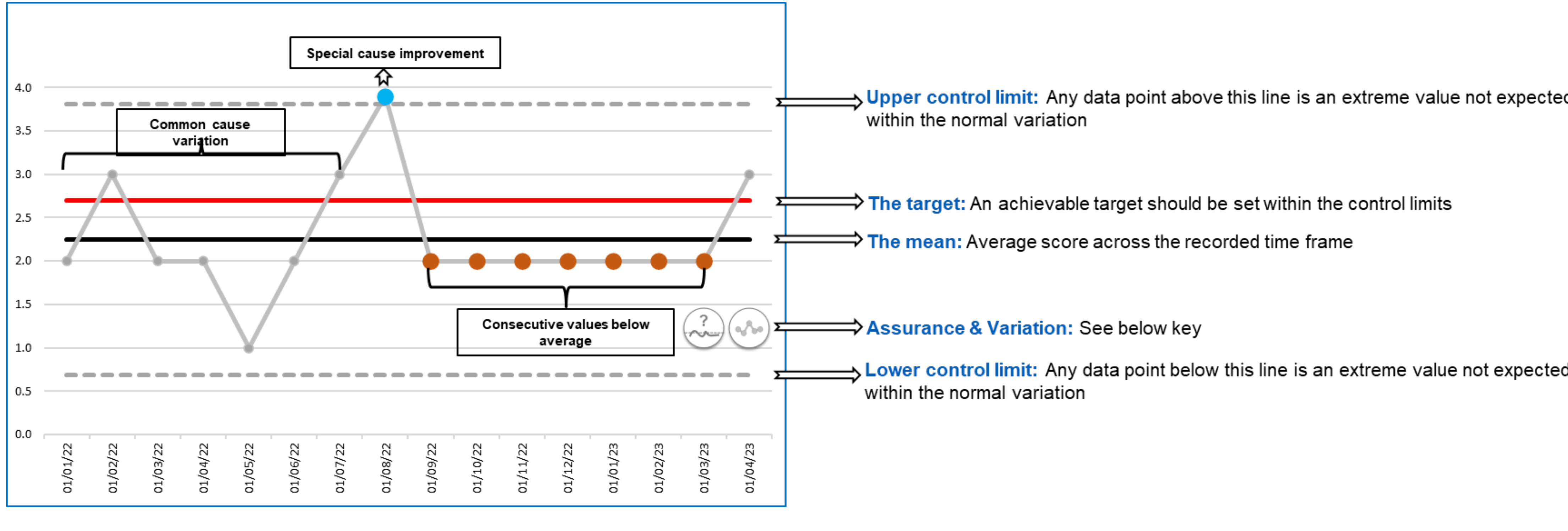
November 2025

	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25
Nursing (Qualified) - excluding Midwives													
Establishment (including agency)	3,439	3,496	3,502	3,540	3,541	3,546	3,555	3,598	3,581	3,572	3,575	3,588	3,573
In post	3,258	3,267	3,268	3,310	3,309	3,280	3,305	3,297	3,305	3,310	3,351	3,379	3,413
Vacancy	182	229	235	230	232	266	249	301	277	262	224	209	160
Vacancy %	5.3%	6.5%	6.7%	6.5%	6.5%	7.5%	7.0%	8.4%	7.7%	7.3%	6.3%	5.8%	4.5%
Nursing (Band 5) - excluding Midwives													
Establishment (including agency)	1,604	1,629	1,628	1,646	1,646	1,671	1,679	1,698	1,703	1,701	1,688	1,683	1,667
In post	1,520	1,522	1,526	1,552	1,552	1,541	1,554	1,545	1,550	1,558	1,599	1,614	1,648
Vacancy	84	107	102	94	94	130	125	153	153	143	89	69	19
Vacancy %	5.2%	6.6%	6.2%	5.7%	5.7%	7.8%	7.4%	9.0%	9.0%	8.4%	5.3%	4.1%	1.1%
Nursing (Band 4)													
In post Band 4	-	-	-	-	-	-	-	-	-	-	-	-	-
In post Band 4 Pre Reg	-	-	-	-	-	-	-	-	-	-	-	-	-
Nursing (Apprentice, B2 & B3)													
Establishment (including agency)	1,466	1,461	1,465	1,475	1,465	1,477	1,458	1,478	1,471	1,457	1,495	1,492	1,470
In post	1,285	1,296	1,305	1,318	1,323	1,328	1,330	1,336	1,328	1,321	1,346	1,376	1,403
Vacancy	182	165	159	157	142	149	128	142	144	135	149	116	67
Vacancy %	12.4%	11.3%	10.9%	10.6%	9.7%	10.1%	8.8%	9.6%	9.8%	9.3%	9.9%	7.8%	4.5%
Consultants													
Establishment (including agency)	558	554	556	559	571	565	556	547	555	555	560	567	567
In post	498	497	502	506	503	500	505	502	504	505	512	517	515
Vacancy	60	57	54	53	68	65	51	44	51	49	48	50	51
Vacancy %	10.8%	10.2%	9.8%	9.5%	11.9%	11.5%	9.2%	8.1%	9.2%	8.9%	8.6%	8.9%	9.1%
Junior Medical													
Establishment (including agency)	847	854	857	860	862	858	842	882	914	900	905	915	922
In post	844	829	835	858	842	812	827	828	825	998	895	872	861
Vacancy	3	25	22	2	20	46	15	54	89	(98)	10	43	61
Vacancy %	0.4%	2.9%	2.6%	0.2%	2.3%	5.4%	1.8%	6.1%	9.7%	-10.9%	1.1%	4.7%	6.6%
Scientific, Technical and Therapeutic													
Establishment (including agency)	2,363	2,376	2,365	2,379	2,384	2,389	2,373	2,414	2,461	2,451	2,436	2,483	2,497
In post	2,144	2,151	2,162	2,198	2,206	2,201	2,197	2,205	2,214	2,230	2,289	2,290	2,315
Vacancy	219	225	203	181	179	189	176	209	248	220	147	194	182
Vacancy %	9.3%	9.5%	8.6%	7.6%	7.5%	7.9%	7.4%	8.7%	10.1%	9.0%	6.0%	7.8%	7.3%

[1] Excludes training grade junior doctors

How to read a Statistical Process Control (SPC) Chart

November 2025



Variation			Assurance		
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values.	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Common cause with no significant changes	Metric has (F)ailed to meet the target for the last 6 (or more) data points.	Metric has (P)assed the target for the last 6 (or more) data points.	Inconsistent performance against target

Trust Board of Directors Meeting

Report Summary

<table>
<tr><td colspan="2">Date of Meeting: 8th January 2026</td></tr>
<tr><td colspan="2">Title of Document: Maternity Incentive Scheme Compliance Report (CNST year 7)</td></tr>
<tr><td>To be presented by:
Amanda Price-Davey, Director of Midwifery</td><td>Author:
Amanda Price-Davey, Director of Midwifery</td></tr>
<tr><td colspan="2">1. Status: For Approval/Discussion/Assurance/Noting/Information</td></tr>
<tr><td colspan="2">2. Purpose: This paper provides assurance to the Trust Board of Directors that ESNEFT has met all requirements of the Maternity Incentive Scheme (CNST Year 7) and seeks their support to recommend the signed declaration by the Trust CEO</td></tr>
<tr><td colspan="2">Relates to:</td></tr>
<tr><td>Strategic Objective</td><td>Lead the integration of care; Full compliance with the Maternity Incentive Scheme (MIS) supports safer, more integrated maternity pathways across the LMNS. The evidence submitted demonstrates that our maternity service is consistently applying national safety standards, enabling seamless collaboration with local partners and improving continuity of care for women and families.

Develop our centers of excellence; Achieving 100% compliance reinforces the Trust's position as a centre of excellence for maternity care. The work undertaken—including robust clinical governance, multidisciplinary training, and adherence to evidence-based practice—strengthens our clinical leadership and supports the delivery of high-quality, safe maternity services.

Support and develop our staff; Compliance has been achieved through strong staff engagement, targeted training programmes, and improvements in workforce planning. This process has enabled staff to develop skills in incident investigation, risk management, and safety improvement, embedding a culture of continuous learning and professional development.</td></tr>
<tr><td>Operational performance</td><td>Operational performance will impact positively on patient safety and patient experience.
The requirements of CNST Year 7 have driven improvements in key operational areas, such as timely risk assessments, improved documentation standards, escalation processes, and multidisciplinary training compliance. These outputs contribute directly to safer day-to-day operational decision-making and enhance the overall experience for women, birthing people, and families.</td></tr>
<tr><td>Quality and equality impact</td><td>The Board is cautious when it comes to quality and places the principle of "no harm" at the heart of all decisions.
The evidence submitted for CNST Year 7 demonstrates strong alignment with this principle. Compliance indicates that the Trust has robust systems in place to prevent avoidable harm, respond effectively to incidents, and apply learning. While some residual risks remain inherent in maternity care, the Board can take assurance that mitigation strategies are strong, monitored, and continuously improved.</td></tr>
</table>

Legal/Regulatory/Audit	Compliance with MIS supports the Trust in meeting its statutory obligations around safe maternity care and clinical governance. The structured audit and validation processes undertaken for CNST Year 7 contribute to demonstrable regulatory compliance, enhance CQC assurance, and reduce exposure to medico-legal risk.
Finance	**Significant financial implications.** For a large organisation such as ESNEFT, MIS compliance has a material financial impact: • **Avoidance of the increased maternity insurance premium**: Non-compliance would result in a substantial financial penalty, in excess of a million pounds for an organisation with ESNEFT's scale of maternity activity. • **Receipt of the CNST incentive**: Full compliance allows the Trust to access the financial benefit associated with the maternity safety incentive scheme. • **Strengthening long-term financial sustainability**: By reducing avoidable harm, improving incident management, and embedding learning, compliance helps decrease the likelihood of future clinical negligence claims, which carry significant long-term financial risk. This Board paper therefore presents compliance not only as a clinical priority, but as a key financial risk-mitigation achievement.
Governance	MIS Year 7 requirements are embedded within the Trust's maternity governance framework, including the Maternity Assurance Group, Safety Champions meetings, and internal audit processes. The submission has undergone internal review, Executive oversight, and cross-checking against national guidance to provide the Board with high confidence in the robustness of the evidence. All evidence has also been reviewed by the Local Maternity and Neonatal System within the ICB as the declaration also requires a signature of the ICB CEO
NHS policy/public consultation	The NHS Impact framework emphasises continuous improvement and learning cultures. Full compliance demonstrates alignment with key national policy drivers, including Ockenden, Kirkup, East Kent, and the NHS Long Term Plan's focus on maternity safety.
Accreditation/inspection	Compliance demonstrates that ESNEFT is meeting regulatory expectations for safe maternity care. This supports positive CQC assessments and evidences a culture of continuous improvement aligned with NHS Resolution's requirements.
Anchor institutions	While there is no direct anchor institution obligation, the improvements made through MIS have a positive impact on the wider community by enhancing safety, staff development, and trust in local maternity services.
ICS/ICB/Alliance	ESNEFT continues to work closely with LMNS colleagues within the ICB to support continuous improvement of maternity services. MIS compliance reflects effective system working, shared learning, and a coordinated approach to delivering safe maternity care across the region.
Board Assurance Framework (BAF) Risk	This paper provides Board-level assurance against the maternity safety risk on the Board Assurance Framework by confirming full compliance with the NHS Resolution Maternity Incentive Scheme (MIS) Year 7 safety actions.
Other	

3. Summary:

This paper provides the Trust Executive Board with assurance regarding ESNEFT's final position against the **NHS Resolution Maternity Incentive Scheme (MIS) – CNST Year 7 Safety Actions**.

A comprehensive programme of work has been delivered throughout the year to achieve compliance with all ten MIS Year 7 safety actions. Early delivery risks were identified, particularly in the context of significant organisational change associated with the implementation of the Trust's Electronic Patient Record (EPR), Epic. These risks were actively managed through coordinated multidisciplinary working to ensure that all required standards were met.

All supporting evidence has now been fully reviewed and approved by the Executive CNST Sub-Board Committee, which holds delegated authority for scrutiny of the MIS submission. This review has included detailed consideration of audit outcomes, training compliance, risk assessments, governance outputs, and assurance documentation. The Sub-Committee has confirmed that all ten safety actions have been met in full.

The paper was previously considered by the Quality and Patient Safety Committee (QPS), which received summary compliance information and took assurance from the Sub-Board Committee's detailed scrutiny of the full evidence pack. In line with the Trust's agreed governance framework, the extensive technical evidence has therefore not been reproduced for Board-level review.

To support transparency and assurance, ten appendices accompany this paper. Each appendix contains a summary compliance sheet for one MIS Year 7 safety action, detailing the requirements of the standard and listing the evidence collated to demonstrate compliance. These summaries reflect the evidence already scrutinised and approved through the Trust's delegated governance process.

In addition, the Local Maternity and Neonatal System (LMNS) has reviewed the full evidence set and has confirmed its support for the submission. The LMNS will be recommending that the Integrated Care Board (ICB) Chief Executive, signs the MIS declaration, in accordance with NHS Resolution requirements.

The Trust Board is asked to take assurance that:

- All ten MIS Year 7 safety actions have been met in full
- Robust maternity governance arrangements are in place and operating effectively
- Risks have been identified, managed, and mitigated appropriately throughout the year
- The remaining formal sign-off process is progressing in line with national requirements

Full compliance with MIS Year 7 demonstrates ESNEFT's continued commitment to maternity safety, learning from national reviews including Ockenden, Kirkup and East Kent, and alignment with the NHS Impact framework. It also secures the CNST financial incentive for 2024/25 and avoids a potentially significant financial penalty, which is material to the Trust.

4. Recommendations / Actions

The Trust Board is asked to:

- Note the outcome of ESNEFT's assessment against the NHS Resolution Maternity Incentive Scheme (MIS) – CNST Year 7 Safety Actions.

- Take assurance that all ten MIS Year 7 safety actions have been met in full and that the evidence collated has been reviewed and approved through the Trust's delegated governance arrangements, including the Executive CNST Sub-Board Committee and the Quality and Patient Safety Committee..

- Recommend that the Chief Executive Officer signs the NHS Resolution MIS declaration, confirming that the Trust has met all ten Year 7 safety actions in full and that the evidence submitted is complete and accurate, in accordance with NHS Resolution requirements.

- Note that the Local Maternity and Neonatal System (LMNS) has reviewed the evidence and will recommend that the Integrated Care Board (ICB) Chief Executive signs the MIS declaration, in line with NHS Resolution requirements

- Note that ten appendices accompany this paper, each containing a summary compliance sheet for each of the ten safety actions, detailing the requirements of the standard and the evidence collated to demonstrate compliance

CNST sub Board approvals Committee

Report Title:	Compliance with CNST Maternity Safety Standard 1
Executive/NED Lead:	Catherine Morgan, Chief Nurse Hussein Khatib, NED
Report author(s):	Alana Hunt, Quality Safety and Governance Lead Midwife
Previously considered by:	

☑ **Approval** ☐ **Discussion** ☐ **Information** ☐ **Assurance**

Executive summary

Compliance Statement – Safety Action 1

CNST Maternity Incentive Scheme (Reporting period: 1 December 2024 – 30 November 2025)

In order to meet the requirements of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, NHS Trusts must demonstrate compliance with ten safety actions. Safety Action 1 requires assurance that the National Perinatal Mortality Review Tool (PMRT) is being used to review perinatal deaths to the required standard.

Safety Action 1 asks:
"Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?"

Required Standards

The Trust is required to demonstrate compliance with the following elements:

A) All eligible perinatal deaths from 1 December 2024 onwards have been notified to MBRRACE-UK within seven working days.
B) For at least 95% of all deaths of babies who died in the Trust from 1 December 2024, parents' perspectives of care were sought and they were given the opportunity to raise questions.
C) A PMRT review of at least 95% of all deaths suitable for review from 1 December 2024 was started within two months of each death, including deaths following home births where care was provided by the Trust.
D) At least 75% of all reports were completed and published within six months of death.
E) For a minimum of 50% of reviewed deaths, an external member was present at the multidisciplinary review panel meeting and this was documented within the PMRT.
F) Quarterly reports were submitted on an ongoing basis to the Trust Executive Board (or a sub-Board with formally delegated authority).
G) Quarterly reports were discussed with Trust Maternity Safety and Board-level Safety Champions.

Minimum Requirements

Notifications have been made, and surveillance forms completed, using the NHS SPEN system. The PMRT has been used to review individual eligible perinatal deaths, with reports generated directly from the PMRT.

Quarterly reports have been produced on an ongoing basis from 1 December 2024. These reports include details of all perinatal deaths reviewed, themes identified, and resulting action plans. The reports provide assurance that PMRT has been used appropriately and that the required standards have been met.

Board Oversight and Delegated Authority

Safety Action 1 requires that quarterly reports are received by the Trust Executive Board. CNST guidance clarifies that where the term *Trust Board* is used, this requirement may also be met through a **sub-Board with formally delegated authority**.

Within this Trust, delegated oversight for maternity safety sits with the **Maternity and Neonatal Improvement Board**, which operates as a formal sub-Board with delegated authority from the Trust Executive Board. This Board provides executive-level oversight of maternity safety, receives quarterly PMRT reports, and includes representation from Trust Maternity Safety and Board-level Safety Champions.

Quarterly PMRT reports for Q4 and Q1 were formally presented to and discussed at the Maternity and Neonatal Improvement Board. Agendas, minutes, and reports evidencing this are provided in files 0.2–1.5.
The Q2 report is scheduled for presentation in December; however, assurance was also provided via discussion at the Divisional Board meeting in November, attended by maternity and Board-level Safety Champions. It is acknowledged that the third report is likely to fall outside the reporting period.

Evidence and Assurance

Safety Action 1 is externally verifiable via MBRRACE-UK. Evidence is provided in file 0.1, which confirms:

- 100% compliance with Standards A–D
- 82% compliance with Standard E, exceeding the minimum requirement of 50%

Compliance with Standards F and G is demonstrated through documented evidence of quarterly reporting and discussion at a sub-Board with delegated authority, fulfilling CNST requirements.

Conclusion

This report provides the final assurance position for Safety Action 1. The Trust has met all required standards, including Board-level oversight through a formally delegated sub-Board.

The Trust has therefore achieved Safety Action 1, and full compliance is recommended for declaration.

Action Required of the Board/Committee
The Committee is requested to receive and note this report as evidence that ESNEFT meets all of the requirements of safety action 1 of the CNST maternity incentive scheme for year 7, and recommend to the Trust Board that full compliance with this safety action is confirmed within the CNST Maternity Incentive Scheme submission.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☐
SO2	Lead the integration of care	☑
SO3	Develop our centres of excellence	☑
SO4	Support and develop our staff	☐
SO4	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	If we do not have effective safety standards and assurance mechanisms in place, we cannot demonstrate learning from perinatal loss and provide assurance to parents and families that we have responded to any concerns.
Trust Risk Appetite	Quality: The board will take minimal risks when it comes to patient safety, patient experience or clinical outcomes. Its tolerance for risk taking will be limited to decisions where the impact is low and the potential mitigations are strong

Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc.)*	Requirement to complete reviews on all perinatal losses, assessing the care against the national standards to enable learning to be identified at local and national levels. This will enable the Trust to provide safer care and provide patients with the best possible experience.
Financial Implications	Risk to reputation and subsequent financial loss by not meeting the incentive scheme standards
Equality and Diversity	No E&D implications identified

1. EVIDENCE submitted to demonstrate full compliance	
0.1	Report from MBRRACE evidencing compliance with the standards A-D
0.2	Q4 24/25 PMRT report
0.3	Q1 25/26 PMRT report
0.4	Q2 25/26 PMRT report
0.5	MNIB Agenda May 2025
0.6	MNIB Agenda July 2025

0.7	Maternity Governance and Risk Report to MNIB July 2025
0.8	Maternity Governance and Risk Report to Divisional Board Nov 2025
0.9	Divisional Board Maternity CDG Transcript Nov 25 (p16)
1.0	Mat Neo Improvement Board CKI May 2025
1.1	Mat Neo Improvement Board CKI July 2025
1.2	MNIB Minutes May 2025
1.3	MNIB Minutes July 2025
1.4	SNIP of MNIB Papers in Teams channel May & July 2025

CNST Sub Board Approvals Committee

Report Title:	Compliance with CNST Maternity Safety Standard 2
Executive/NED Lead:	Catherine Morgan, Chief Nurse Hussein Khatib, NED
Report author(s):	Alana Hunt, Quality, Safety and Governance Lead Midwife
Previously considered by:	

☑ **Approval** ☐ **Discussion** ☐ **Information** ☐ **Assurance**

Executive summary

In order to meet the requirements of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, NHS Trusts are required to meet 10 standards.

This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.

1. Did July 2025's data contain valid birthweight information for at least 80% of the babies born in the month? This requires the recorded weight to be accompanied by a valid unit entry (relevant data tables include MSD401; MSD405).
2. Did July 2025 data contain a valid ethnic category (mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances (MSD001).

Minimal Requirements

The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria, which is significantly lower than in MIS year 6 with only two data points required, compared with the previous eleven. The Score Card with July 2025 data is submitted as evidence and demonstrates full compliance with the above requirements.

Select organisation	Select reporting month
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	July 2025

Note: This edition of the dashboard now contains the final July data on which Trusts are assessed. It is expected that the dashboard will be refreshed less frequently following this assessment edition.

CNST: Safety Action 2 results for EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST for July 2025

1.

Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	630	640	98.4	Passed

Pass rate: 80%

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	645	665	97.0	Passed

Pass rate: 90%

The above report was taken from NHS digital CNST MIS Scorecard Dashboard found at: Microsoft Power BI which demonstrates full compliance.

Action Required of the Board/Committee

The Committee is requested to receive and note this report as evidence that ESNEFT meets all of the requirements of safety action 2 of the CNST maternity incentive scheme for year 7, and recommend to the Trust Board that full compliance with this safety action is confirmed within the CNST Maternity Incentive Scheme submission.

Link to Strategic Objectives (SO)		Please tick
SO1	Keep people in control of their health	☑
SO2	Lead the integration of care	☐
SO3	Develop our centres of excellence	☑
SO4	Support and develop our staff	☐
SO4	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	If we are unable to meet this safety standard around data submissions, we cannot confidently demonstrate an understanding of the data we are using. There are financial penalties to the Trust for being no complaint with CNST
Trust Risk Appetite	Compliance/Regulatory: The Board has a minimal risk appetite when it comes to compliance with regulatory issues. It will meet laws, regulations and standards unless there is strong evidence or argument to challenge them.
Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits,*	MIS applies to all trusts that deliver maternity services and are members of

etc.)	CNST. If ESNEFT is unable to meet the requirements of the MIS then there is an increased risk of breaches to the Fundamental Standards and associated Regulations as outlined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015.
Financial Implications	Risk to reputation and subsequent financial loss by not meeting the incentive scheme standards
Equality and Diversity	No E&D implications identified

CNST sub Board Approvals Committee

Tuesday, 16 December 2025

Report Title:	Transitional Care services report CNST safety action 3
Executive/NED Lead:	Catherine Morgan, Chief Nurse Hussein Khatib, NED
Report author(s):	Alana Hunt, Quality, Safety and Governance Lead Midwife
Previously considered by:	

☑ **Approval** ☐ **Discussion** ☐ **Information** ☐ **Assurance**

Executive summary

NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

Required standard:

a) Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice or be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards

b) Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of mother/infant separation. For units commencing a new QI project, it must be registered with the Trust QI team by 2nd Sept and an update presented to the Safety Champions and LMNS by 30th November.

Evidence for standard A

ESNEFT has successfully implemented TC pathways at each site which are BAPM compliant; Ipswich launched in May and Colchester June 2025. Bi monthly reports have been shared with MNIB within the evidence file and an update provided at the LMNS Safety Forum in November. ESNEFT Standard Operating Procedure has been approved to support the new pathways and monthly audits have commenced against the BAPM standards to ensure continued compliance, shared monthly through CDG meetings.

Standard A is complaint.

Evidence for standard B

A new QI project was registered with the trust QI team on the 26th August and presented at MNIB and the LMNS Safety Forum in September and November 2025.

The new project aims to improve breastfeeding initiation rates within the first hour of life, as it is associated with improved neonatal outcomes, including stabilisation of blood glucose, improved breastfeeding success, and reduced morbidity. Current data at ESNEFT shows that only 50% of babies' ≥34 weeks are fed within 1 hour of birth. Having reviewed the data and themes from the units ATAIN data it was highlighted that hypoglycaemia was responsible for some of the avoidable admissions, on deeper analysis a link was found between low blood sugar and time of feeding post-delivery- feeding delay causes a drop in blood sugar. This is an avoidable complication which often results in other medical interventions and increases length of stay in hospital thus separation from mothers. The BAPM Framework for Practice (2022) emphasises early skin-to-skin contact, recognition

of feeding cues, and the use of colostrum (by hand expression if needed) to ensure babies receive milk early. This QIP seeks to bridge the gap between current practice and best practice. **Standard B is compliant.**
Action Required of the Board/Committee
The Board is requested to receive and note this report as evidence that ESNEFT meets all of the requirements of safety action 3 of the CNST maternity incentive scheme for year 7, and recommend to the Trust Board that compliance with this safety action is confirmed within the CNST Maternity Incentive Scheme submission.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☐
SO2	Lead the integration of care	☐
SO3	Develop our centres of excellence	☐
SO4	Support and develop our staff	☐
SO4	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	A failure to achieve all 10 of the CNST Maternity Safety Actions, to which this programme of work contributes, will mean the Trust cannot recoup additional contributions already made to the Maternity premium, nor claim a share of unallocated funds (altogether circa £1.1m)
Trust Risk Appetite	Workforce: the board is prepared to take decisions that would have an effect on staff morale if there are compelling arguments supporting change, including some decisions with a high inherent risk if there is a potential higher reward

Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc)*	Implementation of the Saving Babies Lives care bundle is required by NHS England.
Financial Implications	A failure to achieve all 10 of the CNST Maternity Safety Actions, to which this programme of work contributes, will mean the Trust cannot recoup additional contributions already made to the Maternity premium, nor claim a share of unallocated funds (altogether circa £1m)
Equality and Diversity	No equality and diversity implications

1. EVIDENCE submitted to demonstrate full compliance	
0.1	ESNEFT Transitional care SOP
0.2	MNIB Neonatal Update May 2025
0.3	MNIB Neonatal Update July 2025
0.4	MNIB Neonatal Update Sept 2025

0.5	Agenda – Safety Forum (Evidence of TC and QI update)
0.6	Maternity Report CDG Nov (Oct data)
0.7	MNIB QI Update Aug 25 (evidence of newly registered QI project)

CNST Sub Board Approvals Committee

Report Summary

Title of Document: Medical workforce planning in Maternity – report in line with CNST safety action 4	
To be presented by: Andrea Turner – Divisional Director, Women's and Children's Services	**Authors:** Chloe Catling, Rachel Pyman, Emma Hart
1. Status: For Approval/Assurance/Discussion	
2. As part of Year 6 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, Trusts must demonstrate an effective system of clinical workforce planning to the required standard.	

Relates to:	
Strategic Objective	Develop our centres of excellence Support and develop our staff Lead the integration of care
Operational performance	Operational performance will impact positively on patient safety and patient experience
Quality	Quality: The board is cautious when it comes to quality and places the principle of "no harm" at the heart of the decision. It is prepared to accept some risk if the benefits are justifiable and the potential for mitigation is strong.
Legal, Regulatory, Audit	A failure to ensure that the Trust meets the necessary standards of safety and quality may bring into question maternity services compliance with the Fundamental Standards of Care which are outlined in the Health and Social Care Act 2008 Regulated Activities (Regulations) 2015
Equality and diversity	No Equality and Diversity implications are identified as part of the completion of this report.
Finance	Failure to achieve all 10 of the CNST Maternity Safety Actions, to which this programme of work contributes, will mean the Trust cannot recoup additional contributions already made to the Maternity premium, nor claim a share of unallocated funds (altogether circa £1m)
Governance	Continuous improvements to patient safety to ensure quality care is being provided
NHS policy/public consultation	CNST required standard
Accreditation/ Inspection	Regulatory frameworks expect Trusts to have a programme of continuous improvement
Anchor institutions	N/A
ICS/ICB/Alliance	LMNS
Board Assurance Framework (BAF) Risk	BAF Risk 4: If ESNEFT does not have the correct quality assurance mechanisms in place, then it may fail to maintain or improve the quality and safety of patient services, resulting in poor patient care, increased health inequalities, experience and potential harm.
Other	N/A

3. **Summary:**

. As part of Year 7 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, Trusts must demonstrate an effective system of clinical workforce planning to the required standard.

As evidence of an effective planning system, Trust Boards must be sighted on the following indicators:

a) Obstetric medical workforce

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a) *currently work in their unit on the tier 2 or 3 rota*
   or
b) *have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)*
   or
c) *Hold a certificate of eligibility (CEL) to undertake short-term locums.*

Compliant - A 6-month audit of short-term locums has been undertaken from 01/02/25 to 31/07/25 and demonstrates that 100% of shifts met the above standard.

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings

Compliant – An audit of compliance with the requirements showed full compliance.

3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.

Compliant – An audit of compensatory rest has been carried out from 01/02/25 to 31/07/25. This shows one occasion where the consultant supervised a clinic after being on call.

4) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service, when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

Compliant – An audit of consultant attendance at the required emergency situations is recorded on both sites daily in the morning safety huddle. There were no occasions where the consultant was required to attend and did not.

b) Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients.

Colchester – compliant

On the Colchester site there is a resident duty anaesthetist for delivery suite, 24 hours a day, 7 days a week who holds bleep 400. In addition to this there is a dedicated obstetric anaesthetic consultant on delivery suite from 8am to 6pm Monday – Friday. Both are responsible for covering delivery suite emergencies, epidural requests, follow ups, multidisciplinary ward rounds and any other emergency delivery suite duties. From 5pm there is an on call consultant who covers main theatres and delivery suite out of hours. They are resident in the hospital until 10pm on weekdays and 8am-8pm at weekends and bank holidays. Between 10pm and 8am weekdays and 8pm and 8am weekend nights they become non-

resident but available to be contacted via telephone and are able to attend within 30 minutes in an emergency.

Ipswich - compliant

On the Ipswich site, there is a dedicated duty anaesthetist available for the obstetric unit 24 hours a day, 7 days a week. They hold the emergency bleep (066) and have the responsibility for covering the labour ward as well as the emergency obstetric theatre. They are also expected to participate in the multidisciplinary ward rounds on labour ward.

The duty anaesthetist is clearly displayed on the rota, as are the anaesthetists covering the late and night shifts for obstetrics. The daytime emergency obstetric lists are covered by consultants, senior trainees or staff grade anaesthetists (with a named supervising consultant with overall responsibility).

Out of hours the duty anaesthetist is a senior trainee or staff grade and they are resident within the hospital, supported by a consultant anaesthetist on call for both obstetrics and general emergencies from home.

c) Neonatal medical workforce

The neonatal unit meets the relevant BAPM national standards of medical staffing. or the standards are not met but there is an action plan with progress against any previously developed action plans and monitored via a risk register. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

Compliant – The BAPM recommendations for the neonatal workforce are detailed within the document, *The BAPM Service and Quality Standards for Provision of Neonatal Care in the UK, November 2022*, which differs from the guidance for benchmarking in CNST MIS year 5 (*Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice 2018*). Our compliance with these standards has therefore changed in CNST MIS year 6 and 7 compared to previously.

Both sites have a **non-compliant** Tier 1 rota, as although these are EWTD compliant and provide a resident tier 1 practitioner dedicated to the Neonatal Unit 24/7, the rotas are not comprised of a minimum of 8 WTE staff who do not cover general paediatrics in addition. This is addressed in the attached action plan.

The Tier 2 rota is **compliant** with BAPM recommendations on both sites.

The Tier 3 rota is **not compliant** on either site, as not all consultants have the equivalent neonatal intensive care experience to be the equivalent of the current Neonatal SPIN (special interest module). Colchester has 8 consultants with neonatal expertise and Ipswich has 5. Both units undertake an active programme of education to maintain the skills of the non-neonatal consultants

There has been some progress against last year’s action plan for both Tier 2 and Tier 3 medical staff, enabling compliance overall against this CNST MIS standard. The action plan has been revised, and will be submitted to the LMNS and shared with the Neonatal ODN following approval by Trust Board.

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards. or the standards are not met but there is an action plan with progress against any previously developed action plans and monitored via a risk register. Any action plans should be shared with the LMNS and Neonatal ODN..

Compliant -

Both neonatal units undertake an acuity review in line with the ESNEFT process as well as the submission of the workforce calculator to the ODN and LMNS on a quarterly basis.

Ipswich is compliant for QIS (qualified in speciality) against the required standard of 70% at 71.8%. The previous action plan has been closed and will be submitted to the LMNS and shared with the Neonatal ODN following approval by trust board. Colchester remains compliant against the required standard at 76.8%.

The supernumerary nurse in charge role is maintained on both sites.

Both units have recruited into the additional quality nursing roles (Infant Feeding and Family Integrated Care) to support the required quality in practice protected time. Outreach services runs 7 days a week on the Ipswich site and 6 days a week on the Colchester site.
4. Recommendations / Actions Note and approve the contents of the report. Note and approve the embedded action plans for Neonatal Medical and Neonatal Nursing Workforce

Compliance with year 6

a) Obstetric Medical Workforce

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a) *currently work in their unit on the tier 2 or 3 rota*
or
b) *have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)*
or
c) *Hold a certificate of eligibility (CEL) to undertake short-term locums.*

Compliant - A 6-month audit of short-term locums has been undertaken from 01/02/25 to 31/07/25 and demonstrates that 100% of shifts met the above standard.

Over this time period, short-term locum shifts were used with breakdown as follows –

Count of Session	24 hour on call	Afternoon	Evening	Long Day	Morning	Night	NWD	Grand Total
Feb	1	3	6	9	4	13	5	41
Mar	1	2	8	9	7	7	17	51
Apr		4	1	14	18	9	9	55
May	2	1	3	11	12	11	6	46
Jun	1	2	4	6	4	13	8	38
Jul		2	9	12	11	16	5	55
Grand Total	**5**	**14**	**31**	**61**	**56**	**69**	**50**	**286**

The position of the locum doctors against the standard is as follows –

Count of Type of Locum	Currently in unit	Holds CEL	Worked in last 5 years
Feb	25		16
Mar	33	3	15
May	31		15
Jun	26	3	9
Jul	17		17
Grand Total	**167**	**7**	**91**

Count of Deanery	Deanery	LED	Previous Deanery	Research Fellow	Grand Total
Feb	23	9	4	5	41
Mar	31	7	12	1	51
Apr	32	10	10	3	55
May	25	10	11		46
Jun	19	10	9		38
Jul	15	8	8	3	34
Grand Total	**145**	**54**	**54**	**12**	**265**

There were no shifts that were not compliant with this standard.

Actions

1. Litmus now include Certificate of Eligibility on checklist for locums
2. Medical workforce and maternity management teams to continue to ensure no short-term locums are employed unless standards met

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings

Compliant - An audit of compliance with the requirements showed full compliance.

A summary of audit data is as follows –

Month	Locums commencing in month		
	Consultant	All checklist elements completed	Registrar
Feb-25	0	10/02/25	1
Mar-25	0	NA	0
Apr-25	0	NA	0
May-25	0	NA	0
Jun-25	1	02/06/2025	0
Jul-25	1	28/07/2025	0

Actions

Ongoing audit to ensure checklist and processes underpinning this completed for all long-term (>2 weeks) locums

3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.

Compliant - An audit of compensatory rest has been carried out from 01/02/25 to 31/07/25.

A summary of audit data is as follows -

Month	Colchester			Ipswich		
	Activity stood down	Activity covered	Activity not impacted	Activity stood down	Activity covered	Activity not impacted
Feb-25	0	5	23	0	0	28
Mar-25	0	3	28	0	0	31
Apr-25	0	3	27	0	0	30
May-25	0	2	29	0	2	29
Jun-25	0	3	27	0	1	29
Jul-25	0	2	29	0	2	29

4) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

Compliant – An audit of consultant attendance at the required emergency situations is recorded on both sites daily in the morning safety huddle. There were no occasion where the consultant needed to attended and did not.

Consultant attendance overnight

	Colchester			**Ipswich**		
Month	**Calls**	**Attended**	**Not required**	**Calls**	**Attended**	**Not required**
Feb-25	9	8	1	8	3	5
Mar-25	9	9	0	15	9	6
Apr-25	11	10	1	14	11	3
May-25	16	13	3	12	8	4
Jun-25	14	14	0	11	8	3
Jul-25	9	9	0	17	14	3
Total	68	63	5	77	53	24

b) Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients.

Colchester – compliant

On the Colchester site there is a resident duty anaesthetist for delivery suite, 24 hours a day, 7 days a week who holds bleep 400. In addition to this there is a dedicated obstetric anaesthetic consultant on delivery suite from 8am to 6pm Monday – Friday. Both are responsible for covering delivery suite emergencies, epidural requests, follow ups, multidisciplinary ward rounds and any other emergency delivery suite duties. From 5pm there is an on call consultant who covers main theatres and delivery suite out of hours. They are resident in the hospital until 10pm on weekdays and 8am-8pm at weekends and bank holidays. Between 10pm and 8am weekday and 8pm and 8am weekend nights they become non-resident but available to contact via telephone and to attend within 30 minutes in an emergency

Ipswich - compliant

On the Ipswich site, there is a dedicated duty anaesthetist available for the obstetric unit 24 hours a day, 7 days a week. They hold the emergency bleep (066) and have a responsibility for covering the labour ward as well as the emergency obstetric theatre. They are also expected to participate in the multidisciplinary ward rounds on labour ward.

The duty anaesthetist is clearly displayed on the rota, as are the anaesthetists covering the late and night shifts for obstetrics. The daytime emergency obstetric lists are covered by consultants, senior trainee or staff grade anaesthetists (with a named supervising consultant with overall responsibility).

Out of hours the duty anaesthetist is a senior trainee or staff grade and they are resident within the hospital, supported by a consultant anaesthetist on call for both obstetrics and general emergencies from home.

c) Neonatal Medical Workforce

The neonatal unit meets the relevant BAPM national standards of medical staffing or the standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN). The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

Compliant with CNST MIS Y7 requirements

The BAPM recommendations for the neonatal workforce are detailed within the document, *The BAPM Service and Quality Standards for Provision of Neonatal Care in the UK, November 2022*, which differs from the guidance recommended in CNST MIS year 6 (*Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice 2018*). Our compliance with these standards has therefore changed.

Tier 1: Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general paediatrics in addition.

Both sites have a **non-compliant** Tier 1 rota, as although these are EWTD compliant and provide a resident tier 1 practitioner dedicated to the Neonatal Unit 24/7, the rotas are not comprised of a minimum of 8 WTE staff not covering general paediatrics in addition.

The Ipswich rota comprises 14 staff (junior doctors, ANNPs and ANPs), who will have some shifts covering paediatrics and some shifts covering the neonatal unit. The Colchester rota comprises six staff purely dedicated to the neonatal unit. These staffing arrangements were compliant with the 2018 standards

required in CNST MIS Year 5. An action plan has been formulated to monitor and improve compliance with this standard.

Tier 2: Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff.

The Tier 2 rota is compliant with BAPM recommendations on both sites.

Colchester - separate middle grade cover 0900-2200 7 days per week. Overnight cover is shared with the paediatric service. The cover is provided by a rota that is compliant with the 2016 contract. The rota is staffed by paediatric trainees ST4+, locally employed doctors, a speciality doctor and an ANNP who provides day time cover. All are NLS providers and several of the middle grade team are also NLS instructors or course directors.

Ipswich - improved staffing over the last year with additional ANNP and overseas senior resident. Now offers 0900-21.30 7day a week dedicated neonatal cover (in line with BAPM 2018 framework).

Tier 3: A minimum of 7 WTE neonatal paediatricians/neonatal consultants on the on-call rota. Minimum of 1 consultant with a designated lead interest in neonatology. Tier 3 consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification and substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN. At least one LNU Tier 3 consultant should have either a CCT in neonatal medicine or neonatal SPIN module*. All consultants covering the service must demonstrate expertise in neonatal care (based on training, experience, CPD and on-going appraisal).

Colchester has a total of 12 WTE consultants, eight of whom have a neonatal interest, and one of whom is the neonatal lead. This number has increased over the last year. There is a high level of neonatal expertise amongst these eight consultants, including five Neonatal Life Support instructors and several course directors. However, not all consultants have had substantial exposure to tertiary neonatal practice, at least to the equivalent of neonatal SPIN, meaning that the BAPM standard is not met.

The neonatal unit is covered by a 'consultant of the week model' 0900-1300 by one of the eight consultants with a neonatal interest. In the afternoon, the paediatric consultant of the week provides cover, supported by the neonatal consultant on an informal basis. The unit meets RCPCH facing the future standards with consultant presence 0900-2200, and then on call.

Four of the consultants do not cover neonatal consultant of the week, but continue on the on call rota. In order to maintain their skills, we organise and run regular update days covering a variety of neonatal topics and practical skills, for all members of the MDT.

Ipswich has appointed three additional consultants making the total 11.5 WTE, five of which have a neonatal interest. However, not all consultants have substantial exposure to tertiary neonatal practice, at least to the equivalent of neonatal SPIN, meaning that the BAPM standard is not met.

There is now Monday to Friday daily consultant cover for the neonatal unit 9-1 (consultant of the week) in which all consultants participate. Consultants with a neonatal interest undertake 6 weeks per year, with other consultants undertaking 3 weeks. Regular simulation and airway training is being undertaken to help all staff maintain skills.

Whilst the Tier 3 rota is not compliant with BAPM standards progress has been made against the action plan, and this has been further updated.

Summary of Tier 3 medical staffing

	Consultants with neonatal interest	Consultants on rota	Weeks of consultant of week NNU
Colchester	8	13	6.5
Ipswich	7	13	5 undertake 6 weeks 8 undertake 3 weeks

Training provided to Tier 3 Staff

Both units currently provide:

- Simulation training
- Joint skills days
- Airways skills sessions
- Neonatal life support yearly update
- NLS certification up to date

The action plan proposes that all consultants complete a practical skills log e.g. the BAPM skills log,

https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/2588/Appendix_I_-_Neonatal_Unit_Staff_Airway_Assessment.xlsx and the BAPM framework self-assessment

https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/2587/Appendix_H_-_Individual_Airway_Competency_Assessment_Log.xlsx in order to maintain and demonstrate neonatal expertise.

Action No.	Date action agreed	Area of Practice for Review	Aim	Smart Action	Proposed completion date	Comments/progress	BRAG status	Other areas	Date closed	Assurance	Supporting Documents
1	27/11/2023	BAPM Requirement for Medical Workforce in Local Neonatal Unit	At least one resident tier 1 practitioner immediately available dedicated to providing emergency care for the neonatal service 24/7	No action required on either site					27/11/2023	Rota demonstraes compliance with Tier 1 cover 24/7 for NNU	Example of Tier 1 rota CGH Tier 1 rota for IH on medirota (awaiting screenshot)
	30/11/2024			Review structure of Tier 1 rota on each site with split between paediatrics and neonatal cover (8WTE required for neonatal rota)	Jul-25						
2	27/11/2023	BAPM Requirement for Medical Workforce in Local Neonatal Unit	An immediately available resident tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00 - 22.00, seven days a week. Colchester compliant Ipswich non-compliant	Application to Neonatal ODN for additional funding for further Trust registrar / ANP	May-24	NHSE have awarded funding for an ANNP 8b to support this rota. Recruited and filled role.			27/11/2023	Post filled and part of Tier 2 rota	Tier 2 rota (includes ANNP)
				Ongoing recruitment to vacancy and use of locums to achieve compliance on Ipswich site	May-24	Vacancy filled / gaps covered and rota now compliant			29/10/2024	No use of locums at present as no vacancies	
				Audit to be undertaken to monitor % of uncovered shifts	May-24	Review completed for Aug/Sept 2024 for Ipswich. There was separate neonatal and paediatric cover on middle grade rota everyday, which includes the use of locum staff where required (x 4) plus one consultant step down to cover sickness. Everyday there was cover till 21:30				Review completed evidencing service cover until 21:30hrs.	
3	27/11/2023	BAPM Requirement for Medical Workforce in Local Neonatal Unit	All LNUs should ensure that all Consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system and no consultant should undertake fewer than 4 'consultant of the week' service weeks annually. No on-call rota should be more onerous than one in six and all new appointments to units with separate rotas should either have a SCCT in neonatal medicine or be a general paediatrician with a special interest in neonatology or have equivalent neonatal experience and training Neither site currently compliant	All paediatricians to maintain neonatal CPD (at least 10 points per year) as mitigation, with skills days	May-24	Action in progress - Skills days taking place on Colchester site, and consultants encouraged to keep a procedure log. Airway skills and simulation sessions regularly in place on Ipswich site. Cross-site monthly Neonatal M&M held Amongst the consultant body there are 5 NLS instructors and some are also course directors. All paediatricians are responsible for maintaining own CPD Skills log to be shared within team				Need further assurance as currently no formal record of training outside of individual appraisal process Live tracker available to ensure training dates are booked	
				Options review to be undertaken to decide whether to change the rota with the current workforce (will result in less expertise on the units, significant change in job plans, reduction in other specialty work) or to work towards separate neonatal on call.	May-24	Completed May 24. It is not felt at present that a change to all consultants doing neonatal consultant of the week to the required frequency would be beneficial for the units as this would dilute the neonatal skill available (neonatal consultants would spend less time covering the NNU)			22/05/2024	Options appraisal presented to W&C Divisional Board 22/05/24	Medical workforce options appraisal
				To explore the feasibility of a cross site neonatal on call rota.	May-24	A separate rota would require an expansion in consultant numbers which is not possible at present. This will be kept under review					
	30/10/2024			All consultants to complete a practical skills log e.g. the BAPM skills log	31/10/2025						https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/2588/Appendix_I_-_Neonatal_Unit_Staff_Airway_Assessment.xlsx
	30/10/2024			All consultants to complete the BAPM framework self-assessment	31/10/2025						https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/2587/Appendix_H_-_Individual_Airway_Competency_Assessment_Log.xlsx i
	30/10/2024			CDG to keep a record of consultant neonatal training, and monitor CPD, NLS compliance annually	01/04/2025	Ongoing					

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards or the standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal ODN. The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal ODN.

Compliant –

The Neonatal Unit at Ipswich has made significant progress against the QIS action plan and is now compliant for QIS (qualified in speciality) against the required standard of 70% at 71.8% as of the June 2025 nursing workforce submission. The previous action plan has been closed and will be submitted to the LMNS and shared with the Neonatal ODN following approval by trust board, evidence 0.2. The ODN continue to support this position with funding to secure additional spaces on the QIS training programme. This has allowed 5 members of staff to enrol on the 25/26 training programme from Ipswich including opportunities within the neonatal outreach team.

Neonatal Nursing Workforce Tool (2020): Ipswich

Unit details					
Trust	East Suffolk And North Essex NHS Foundation Trust				
Unit	Ipswich				
Designation	LNU				
Completed by	Danielle Mitchell				
Date completed	25.07.25				
Activity period	01/04/24	to	31/03/25	365	days

Activity (HRG 2016)		
	Activity	Commissioned cot
HRG 1 (IC)	324	2
HRG 2 (HD)	954	3
HRG 3 - 5 (SC)	3,051	13
Total	**4,329**	**18**

Staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	17.64	23.83
Total Non QIS	17.64	9.35
Total Non Reg	5.04	5.83
Total	**40.32**	**39.01**

Activity calculations (HRG 2016)							
	Activity	*For calculations* 80% of daily activity	*WTE (6.07 / BAPM)*	Commissioned cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
HRG 1	324	*1.1*	*6.07*	2	44.38%	2	0
HRG 2	954	*3.3*	*3.04*	3	87.12%	3	0
HRG 3	3,051	*10.4*	*1.52*	13	64.30%	10	3
Total	**4,329**			**18**	**65.89%**	**15**	**3**

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 47.04, of which 32.93 (70%) should be QIS					
	Current position: Budget	Current position: In post	Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
Total nursing staff	40.32	39.01	38.58	1.74	0.43
Total reg nurses	35.28	33.18	33.82	1.46	-0.64
Total QIS	17.64	23.83	23.67	-6.03	0.16
Total non-QIS	17.64	9.35	10.15	7.49	-0.80
Total non-reg	5.04	5.83	4.76	0.28	1.07
Reg nurses as % nursing staff	87.5%	85.1%	87.7%		
QIS as % reg nurses	50.0%	71.8%	70.0%		

Supernumerary shift coordinator, BAPM minimum nurse to baby and registered to non-registered ratios met on the Ipswich site.

Neonatal Nursing Workforce Tool (2020): Colchester

Unit details						
Trust	East Suffolk And North Essex NHS Foundation Trust					
Unit	Colchester					
Designation	LNU					
Completed by	Emma Hart					
Date completed	30.07.2025					
Activity period	01/04/24	to	31/03/25		365	days

Activity (HRG 2016)		
	Activity	Commissioned cots
HRG 1 (IC)	236	1
HRG 2 (HD)	923	4
HRG 3 - 5 (SC)	2,490	12
Total	**3,649**	**17**

Staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	15.12	22.34
Total Non QIS	15.12	6.75
Total Non Reg	5.04	4.90
Total	**35.28**	**33.99**

Activity calculations (HRG 2016)							
	Activity	*For calculations*		Commissioned cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	236	*0.8*	*6.07*	1	64.66%	1	0
HRG 2	923	*3.2*	*3.04*	4	63.22%	3	1
HRG 3	2,490	*8.5*	*1.52*	12	56.85%	9	3
Total	**3,649**			**17**	**58.81%**	**13**	**4**

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 42.49, of which 29.74 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	35.28	33.99	33.51	1.77	0.48
Total reg nurses	30.24	29.09	29.63	0.61	-0.54
Total QIS	15.12	22.34	20.74	-5.62	1.60
Total non-QIS	15.12	6.75	8.89	6.23	-2.14
Total non-reg	5.04	4.90	3.88	1.16	1.02
Reg nurses as % nursing staff	85.7%	85.6%	88.4%		
QIS as % reg nurses	50.0%	76.8%	70.0%		

Supernumerary shift coordinator, BAPM minimum nurse to baby and registered to non-registered ratios met on the Colchester site.

Additional nursing roles. The following areas have allocated staff dedicated to improvement work as per ODN/BAPM requirements:

Infant Feeding, Family Care, Developmental Care, QI in Perinatal Optimisation, Safeguarding Children, Bereavement support and palliative Care, Risk, governance and patient safety, Infection Control, Education and Practice development. In addition to this both units have an embedded 6/7 day outreach service ensuring safe timely discharge with community support in their own homes.

An increasing number of these roles are now funded. Both units have recruited into the additional funded quality nursing roles (Infant Feeding and Family Integrated Care) to allow for the quality of practice to be supported. Those with dedicated WTE budget are included within the units nursing workforce calculator. Nursing workforce calculator submitted to quarterly to the ODN and LMNS.

Ipswich

NON DIRECT PATIENT CARE - *DO NOT INCLUDE ANY DIRECT PATIENT CARE WTE*					COMMENTS
Role Title	**Band**	**WTE Budget**	**WTE in post**	**Head Count in post**	*e.g. no dedicated hours, date*
LEADERSHIP ROLES					
Consultant Nurse					
Senior/Lead Nurse					
Matron	8a	0.5	0.5	1	
Ward Manager	7	1	0.92	1	
Recruitment & Retention Lead					
Other Senior role (please specify)					
Subtotal - Leadership roles		**1.5**	**1.42**	**2**	
QUALITY ROLES					
Governance Lead Nurse	7	0.4	0.4	1	
Practice Development / Education Lead	7	1	1	1	
Clinical Educator					
Infant Feeding Lead	6	0.2	0	0	
Family Integrated Care Lead / equivalent	6	0.2	0.2	1	
Family Integrated care Nurse / equivalent	4	0.3	0.3	1	
Family Integrated Care Link Nurse					
Other Family Care (please specify)					
Bereavement Lead					
Palliative Care Lead					
Professional nurse advocate (PNA)	6				no dedicated hours
Other (please specify)	5				PNA - no dedicated hours
Other (please specify)	4	0.3	0.3	1	Infant Feeding Support
Other (please specify)					
Subtotal - Quality roles		**2.4**	**2.2**	**5**	

OUTREACH NURSING STAFF					
Outreach Lead					
Outreach Registered Nurse - Band 6	6	0.6	0.6	1	
Outreach Registered Nurse - Band 5	5	1.4	1.4	3	
Outreach Nursery Nurse	4		0.16	1	not funded. Taken from NNU budget
Outreach Non-Reg (please specify)					
Subtotal - Outreach Nursing staff		**2**	**2.16**	**5**	

Infant Feeding Lead currently seconded into B7 Transitional Care Lead, continues to cover elements of this role.

Colchester

NON DIRECT PATIENT CARE - *DO NOT INCLUDE ANY DIRECT PATIENT CARE WTE*					COMMENTS
Role Title	**Band**	**WTE Budget**	**WTE in post**	**Head Count in post**	*e.g. no dedicated hours, data n*
LEADERSHIP ROLES					
Consultant Nurse					
Senior/Lead Nurse					
Matron	8a	0.5	0.5	1	
Ward Manager	7	1	1	1	
Recruitment & Retention Lead					
Other Senior role (please specify)					
Subtotal - Leadership roles		**1.5**	**1.5**	**2**	
QUALITY ROLES					
Governance Lead Nurse	7	0.4	0.4	1	
Practice Development / Education Lead	7	1	1	1	
Clinical Educator					
Infant Feeding Lead	6	0.2	0.2	1	
Family Integrated Care Lead / equivalent	6	0.2	0.2	2	
Family Integrated care Nurse / equivalent	4	0.3	0.3	1	
Family Integrated Care Link Nurse					
Other Family Care (please specify)					
Bereavement Lead					
Palliative Care Lead					
Professional nurse advocate (PNA)	6				no dedicated hours 2 qualified
Other (please specify)	4	0.3	0	0	Infant Feeding Support
Other (please specify)					
Other (please specify)					
Subtotal - Quality roles		**2.4**	**2.1**	**6**	
TOTAL NON DIRECT PATIENT CARE		**3.9**	**3.6**	**8**	

OUTREACH NURSING STAFF					
Outreach Lead					
Outreach Registered Nurse - Band 6	6	1	1	1	
Outreach Registered Nurse - Band 5	5	1	1	1	
Outreach Nursery Nurse	4				
Outreach Non-Reg (please specify)					

B4 Infant Feeding support interested staff member currently on maternity leave.

Evidence in addition to that supplied in body of document

0.1	**Anaesthetics rota**
0.2	**QIS action plan**

CNST sub Board Approvals Committee

Report Title:	Maternity Workforce Report
Executive/NED Lead:	Catherine Morgan, Chief Nurse Hussein Khatib, NED
Report author(s):	Alana Hunt, Quality, Safety and Governance Lead Midwife
Previously considered by:	

☑ Approval ☐ Discussion ☐ Information ☐ Assurance

Executive summary
The purpose of this report is to demonstrate compliance with Safety Action 5 of the Maternity Incentive Scheme. The Maternity incentive Scheme run by NHS Resolution (MIS) supports the delivery of safer maternity care through an incentive element to trust contributions to the CNST and rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity services. **SA5 Requirements**; a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed within the last three years? b) Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the board every 6 months (in line with the NICE midwifery staffing guidance) on an ongoing basis? Every report should include an update on all of the points below: • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing shortfall • The midwife to birth ratio • Evidence from an acuity tool (may be locally developed) local audit and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift • Evidence from an acuity tool, local audit and/or local dashboard figures demonstrating 100% compliance with the provision of one to one care in active labour • Is a plan in place for mitigation/escalation to cover any shortfalls in the points above? c) We recommend that Trusts continue to monitor and include NICE safe staffing red flags in this report, **however this is not currently mandated**. d) Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: • Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations • The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in the clinical numbers. This includes those in management positions and specialist midwives. For an organisation the size of ESNEFT with the complexity of working over two acute sites, our BR report stipulates this figure at 12% e) Where trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls

f) Where deficits in staffing levels have been identified, these must be shared with local commissioners

Evidence of meeting these standards is detailed below;

Part A - Evidence of a systematic, evidence-based process to calculate midwifery staffing establishment

A systematic midwifery workforce review was undertaken utilising the Birthrate Plus (BR+) tool endorsed by NICE. The final report was received by the Trust on 28th November 2023.

The BR+ report suggests a midwifery workforce totalling just under 300 WTE

	Ipswich	Colchester	Total wte
Total Clinical, Specialist and Management wte	141.40	158.37wte	299.77wte

Total Clinical, Specialist and Management wte Table 10

The recommended skill mix requirements for the larger maternity units, such as ESNEFT, is 90/10 within clinical staffing. This equates to 270 WTE RMs and 30 WTE Support Staff delivering postnatal care. At ESNEFT this would also include our Registered Nursing team who also deliver postnatal care. **The findings of this review were received and approved by the Trust Board and remain current until the next scheduled review in 2026.**

Internal acuity reviews have been undertaken to validate and update workforce assumptions. These reviews compared real-time acuity data against the BR+ findings and resulted in a fully funded establishment in excess of the BR+ recommendations, ensuring adequate cover for the introduction of the `telephone triage service and compliance with Ockenden requirements (which are now part of the baseline establishment from 2025).

Part B – Six-monthly midwifery staffing oversight reports submitted to the Board

ESNEFT continues to meet the requirement for biannual midwifery workforce reports to the Trust Board, aligning with NICE and CNST guidance. Reports were presented in January and July 2025, covering workforce establishment, acuity, fill rates, and red flag trends.

Both reports were designed to demonstrate compliance with Safety Action 5 and were received and discussed at Board level. Board minutes (January 2025, and July 2025) evidence active oversight of maternity staffing, assurance against BR+ recommendations, and review of escalation and mitigation plans.

Additionally, bi-monthly Red Flag Reports (incorporating the monthly Essence of Care audits) are submitted to the Maternity and Neonatal Improvement Board (MNIB). These provide triangulated assurance of staffing safety and key points are escalated to the Trust Board for oversight and assurance.

Part C – Supernumerary Labour Ward Coordinator

The supernumerary status of the Labour Ward Coordinator is fully compliant with CNST requirements.

Both the December 2024 and June 2025 workforce reports confirm that:

- The coordinator is rostered and remains supernumerary at the start of every shift, as defined by NHS Resolution.

- A revised Maternity Escalation Policy (v3.0) was implemented in November 2024, detailing the process for ensuring cover where a coordinator is unavailable at the start of a shift. This includes the use of a second Band 7 “bleep holder” and Manager on Call to act as substitutes when required.
- Supernumerary compliance is monitored continuously via the BR+ acuity tool, Red Flag reports, and Essence of Care audits.

Between December 2024 and May 2025, there were six instances on the Colchester site where the tool indicated loss of supernumerary status. Subsequent review confirmed that coordinators were not providing direct patient care, and therefore supernumerary status was retained. Ipswich remained 100% compliant throughout the period.

This provides robust evidence of oversight, audit, and action against any potential breaches, meeting CNST expectations.

Part D – Evidence of one-to-one care in labour

Provision of 1:1 midwifery care in active labour is a key safety indicator and is monitored monthly through:

- The Divisional Dashboard,
- Red Flag reporting to the MNIB, and
- The Regional Perinatal Quality Surveillance Model (PQSM) reports submitted to LMNS and NHS England.

Evidence from the Efficiency of Care audits confirms that on the Ipswich site, 1:1 care has been delivered consistently without exception during the reporting period.

At Colchester, data inaccuracies in the Medway Maternity Information System led to some false non-compliance flags in April and May 2025. Review of clinical notes confirmed 1:1 care was in fact delivered, and additional staff training has been provided to ensure accurate data entry going forward.

Both sites have therefore maintained full compliance with 1:1 care standards, supported by ongoing data validation and governance monitoring.

Part E – Staffing establishment and budget alignment

Board-approved workforce reports (presented January and July 2025) **demonstrate compliance** in that ESNEFT’s funded midwifery establishment fully aligns with the BR+ recommendations. Furthermore, the next 6 monthly report is scheduled to be brought to Trust Board in January 2026. It is recognised by NHS Resolution that the second report may fall outside of the reporting period, therefore this evidence will contribute to next year’s evidence.

The Trust Board minutes from January and July 2025 confirm that the midwifery staffing budget reflects the calculated establishment, and the Division’s workforce plan is fully funded.
This includes additional posts funded to meet Ockenden recommendations, now incorporated into baseline budgets, ensuring sustainability. Regular workforce monitoring through Finance and HR oversight meetings ensures budget alignment remains under active review.

Part F – Ongoing monitoring and escalation

ESNEFT continues to **demonstrate compliance** through effective governance oversight of maternity safety and workforce risks through:

- Bi-monthly Red Flag reports to the MNIB, including incidents of supernumerary breaches, 1:1 care, and acuity trends.
- Six-monthly workforce reports to the Trust Board for assurance and transparency.

Where staffing shortfalls or risks are identified, these are escalated through the Maternity Escalation Policy, shared with commissioners via LMNS Strategic Group, and reviewed at the Maternity and Neonatal Safety Improvement Board.

The above evidence demonstrates full compliance with all elements of Safety Action 5 (CNST Year 7)

- A systematic workforce planning process has been completed and reviewed.
- Midwifery staffing establishment is aligned with national tools and fully funded.
- Supernumerary coordinator and 1:1 care standards are consistently met and monitored.
- Governance structures ensure transparent reporting to both Divisional and Trust Board levels.

The Trust is therefore compliant with Safety Action 5 and maintains robust systems for ongoing monitoring, assurance, and improvement.

Action requested of the Committee

The Committee is requested to review this paper as evidence of compliance with Safety Action 5 of the Maternity Incentive Scheme.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☐
SO2	Lead the integration of care	☑
SO3	Develop our centres of excellence	☑
SO4	Support and develop our staff	☑
SO5	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	If the Trust is unable to meet the requirements of the Maternity incentive Scheme then there is the potential that pregnant people and their babies will be placed at increased risk of poor outcomes and experience and an associated impact on staff morale and retention within the Trust.

	If the Trust does not meet the CNST required standards then it will have a significant impact on the Trust financially where the CNST contribution will not be refunded to the Trust. This equates to over £1m There is a risk to the Trusts reputation if it were not to meet the required standards again this year.
Trust Risk Appetite	Compliance/Regulatory: The Board has a minimal risk appetite when it comes to compliance with regulatory issues. It will meet laws, regulations and standards unless there is strong evidence or argument to challenge them.
Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc)*	If ESNEFT is unable to meet the requirements of the MIS then there is an increased risk of breaches to the Fundamental Standards and associated Regulations as outlined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015.
Financial Implications	As well as the risk detailed above, if ESNEFT does not have effective process in place for regulatory requirements then it may not make best use of its resources; failure to deliver improvements in maternity and neonatal services may lead to an increased exposure to potential litigation costs and regulatory sanctions.
Equality and Diversity	The report recognises that there are particular protected characteristics which are at a greater risk of maternal and neonatal complications

1. EVIDENCE submitted to demonstrate full compliance	
0.1	ESNEFT Midwifery Workforce Report to Trust Board July 2025
0.2	ESNEFT Midwifery Workforce Report to Trust Board Jan 2025
0.3	Maternity Escalation Policy v3.0 - ESNEFT
0.4	ESNEFT Birth rate plus red flag report presented to MNIB Sept 2025
0.5	ESNEFT Birth rate plus red flag report presented to MNIB May 2025

CNST sub Board approvals Committee

Report Title:	Compliance with CNST Maternity Safety Standard 6
Executive/NED Lead:	Catherine Morgan, Chief Nurse Hussein Khatib, NED
Report author(s):	Alana Hunt, Quality, Safety and Governance Lead Midwife
Previously considered by:	

☑ **Approval** ☐ **Discussion** ☐ **Information** ☐ **Assurance**

Executive summary

In order to meet the requirements of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, NHS Trusts are required to meet 10 standards.

Within this scheme, Safety Action 6 asks, **"Can you demonstrate that you are on track for compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?"**

The Reporting period 2nd April 2025 to 30th November 2025

As evidence of this, Trust must demonstrate compliance with the following elements –

Required Standards

1. Trusts should have agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment?
2. Trusts should have continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in year 7 to track compliance with the care bundle. These meetings must include:
   - Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory.
   - Details of element specific improvement working being undertaken including the evidence of generating and using the process and outcome metrics for each element.
   - Evidence of sustained improvement where high levels of reliability have already been achieved.
   - Regular review of local themes and trends with regard to potential harms in each of the six elements.
   - Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.

3. Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?

4. If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been

provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.

Evidence of Compliance

1. Trust and ICB agreement and Board oversight

   East Suffolk and North Essex NHS Foundation Trust (ESNEFT) confirms that the Saving Babies' Lives Care Bundle Version 3.2 (SBLCBv3.2) is implemented and monitored, with an overall LMNS validated compliance rate of 91%. The Board Report (07 October 2025) and Assurance Template demonstrate oversight by the Trust Board and alignment with the Suffolk and North East Essex ICB. Accountability is clearly established through Amanda Price-Davey (Director of Midwifery, ESNEFT) and Lisa Nobes (Executive Chief Nurse, SNEE ICB), confirming joint ownership and governance of the improvement trajectory.

2. Quarterly quality improvement discussions with LMNS/ICB

   Quarterly Saving Babies' Lives meetings held on 11 June and 25 September 2025 provided structured oversight and progress review against the agreed trajectory. The discussions covered all six SBLCBv3.2 elements, highlighting sustained improvement in fully implemented areas (Elements 2 and 3) and targeted QI work for partially implemented areas. Key actions included improving CO monitoring, fetal monitoring competencies, and preterm birth optimisation. Local trends, risks, and learning were reviewed collaboratively, and shared across the LMNS and MNVP to ensure consistent system-wide improvement.

3. LMNS determination of progress against improvement trajectory

   The LMNS validated substantial and sustained progress toward full implementation of SBLCBv3.2, confirming ESNEFT's position against the agreed improvement trajectory. Elements 2 and 3 achieved full compliance, with all other elements demonstrating active progress through focused QIPs. LMNS commentary recognised effective governance, timely resubmissions, and continuous improvement planning, confirming that ESNEFT is on track to achieve full implementation during 2025–26.

4. Use of Implementation Tool or signed declaration

   Evidence of compliance was recorded and validated using the national SBLSBv3 Implementation Tool for the August and September 2025 submissions. As the tool provided comprehensive and validated evidence across all elements, a separate declaration from the Executive Medical Director was not required. This approach has been accepted by both the LMNS and the ICB as the formal mechanism for demonstrating compliance and progress.

Overall Statement of Assurance

ESNEFT demonstrates strong governance, consistent LMNS engagement, and validated progress toward full implementation of the Saving Babies' Lives Care Bundle Version 3.2. With 91% overall compliance and robust quality improvement processes in place, the Trust continues to show commitment to improving outcomes, sustaining progress, and meeting national expectations under the Three-Year Delivery Plan for Maternity and Neonatal Services.

Action Required of the Board/Committee

The Committee is requested to receive and note this report as evidence that ESNEFT meets all of the requirements of safety action 6 of the CNST maternity incentive scheme for year 7, and recommend to the Trust Board that full compliance with this safety action is confirmed within the CNST Maternity Incentive Scheme submission.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☑
SO2	Lead the integration of care	☐
SO3	Develop our centres of excellence	☑
SO4	Support and develop our staff	☐
SO4	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	If the Trust is unable to meet the requirements of the Maternity incentive Scheme then there is the potential that pregnant people and their babies will be placed at increased risk of poor outcomes and experience and an associated impact on staff morale and retention within the Trust.
Trust Risk Appetite	Quality: The board will take minimal risks when it comes to patient safety, patient experience or clinical outcomes. Its tolerance for risk taking will be limited to decisions where the impact is low and the potential mitigations are strong
Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc.)*	If ESNEFT is unable to meet the requirements of the MIS then there is an increased risk of breaches to the Fundamental Standards and associated Regulations as outlined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015.
Financial Implications	If the Trust does not meet the CNST required standards then it will have a significant impact on the Trust financially where the CNST contribution will not be refunded to the Trust. This equates to over £1m There is a risk to the Trusts reputation if it were not to meet the required standards again this year.
Equality and Diversity	The report recognises that there are particular protected characteristics which are at a greater risk of maternal and neonatal complications

1. EVIDENCE submitted to demonstrate full compliance	
0.1	SNEE ICB Board Report and Action Plan on Implementation of the SBLCBv3 Oct 2025
0.2	Maternity Governance & Risk report to MNIB Sept 2025
0.3	Saving Babies Lives Update MNIB Sept 2025
0.4	Maternity Governance & Risk report to MNIB July 2025
0.5	Saving Babies Lives update to MNIB July 2025
0.6	Mat Neo Maternity update MNIB May 2025

CNST sub Board Approvals Committee

Report Title:	Compliance with CNST Maternity Safety Standard 7
Executive/NED Lead:	Catherine Morgan, Chief Nurse Hussein Khatib, NED
Report author(s):	Alana Hunt, Quality, Safety and Governance Lead Midwife
Previously considered by:	Women's and Children's Divisional Management Team

☑ **Approval** ☐ **Discussion** ☐ **Information** ☐ **Assurance**

Executive summary

NHS Resolution is operating year seven of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

The Trust is required to evidence listening to women, parents and families using maternity and neonatal services and coproduce services with service users.

Through strong collaboration with the LMNS, ICB, and MNVP, the Trust has ensured that feedback from families directly informs improvement planning, governance discussions, and equitable service design.

Requirements and Demonstration of Compliance

1. ***Evidence of an action plan co-produced following joint review of the annual CQC Maternity Survey free-text data, with progress shared with safety champions and the LMNS***

The Trust is compliant with this requirement as the CQC Maternity Survey free-text feedback has been reviewed collaboratively with the MNVP and LMNS. A co-produced action plan has been developed, focusing on themes identified by service users including facilitating partners staying overnight on the postnatal ward and improving information and choice.

Progress against the plan is monitored through the Maternity and Neonatal Improvement Board through a single Maternity and Neonatal Improvement Plan, shared with the Maternity and Neonatal Safety Champions and LMNS. The MNVP also presented a progress update at the LMNS Strategic Group in March and September 2025.

2. ***Evidence of MNVP infrastructure being in place from your LMNS/ICB, including all of the following:***

- Job description for MNVP Lead
- Contracts for service or grant agreements
- Budget with allocated funds for IT, comms, engagement, training and administrative support

- Local service user volunteer expenses policy including out of pocket expenses and childcare cost

The LMNS confirms a commissioned MNVP in place, aligned with NHS England guidance with a current job description for the MNVP lead and MNVP engagement officer. The MNVP lead is in place however the engagement officer has been unable to be recruited due to the present recruitment freeze.

The MNVP operates under a formal service agreement with the ICB, providing financial and administrative infrastructure to support activity.

The evidence attached shows a defined budget for the MNVP which covers IT, communication, engagement events, training, and admin support. A volunteer expenses policy is also in place, ensuring reimbursement for travel, subsistence, and childcare to promote inclusive participation.

The Trust is compliant with this requirement.

3. ***If the above evidence of an MNVP, commissioned and functioning as per national guidance is unobtainable, there should be evidence that this has been escalated via the PQSM at Trust, ICB, and regional level.***

The Trust is compliant with this requirement - full MNVP evidence is available; therefore, escalation was not required.

Should the service or commissioning changes arise, escalation processes are understood and embedded within Perinatal Quality Surveillance Model reporting to ensure sustained assurance.

4. ***Terms of Reference for Trust safety and governance meetings must show the MNVP Lead as a quorate member of trust governance, quality and safety meetings at speciality/divisional/directorate level, including all of the following:***

- Safety Champion meetings
- Maternity business and governance
- Neonatal business and governance
- PMRT review meeting
- Patient safety meeting
- Guideline committee

The MNVP Lead is a quorate member of Maternity and Neonatal Improvement Board, PMRT, guideline, maternity and children’s Quality and Risk meetings which cover governance and patient safety. Attendance and contributions are recorded in meeting minutes and attendance logs ensuring service user voice representation in decision-making.

The Trust is compliant with this requirement.

5. ***Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality Plan.***

In line with the LMNS Equity and Equality Plan, the MNVP has demonstrated proactive engagement with local community groups and charities, prioritising the perspectives of women and families most affected by inequitable outcomes. This collaborative approach supports continuous listening, targeted action, and sustained learning. Activities include outreach weeks and iMatter forums evidenced through the MNVP work plan, annual update and through the equity and equality action plan, which is detailed within the evidence folders.

The Trust is compliant with this requirement.

Action Required of the Performance Committee
To consider and approve the contents of the report.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☑
SO2	Lead the integration of care	☑
SO3	Develop our centres of excellence	☐
SO4	Support and develop our staff	☐
SO4	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	If the Trust is unable to meet the expectations of the CNST SA7 the risk is non-compliance against the standards. Services won't be designed collaboratively with service users and could potentially not meet the requirements of the population. There is also a reputational and financial risk to not meeting the 10 Safety Actions for CNST
Trust Risk Appetite	Quality: The board will take minimal risks when it comes to patient safety, patient experience or clinical outcomes. Its tolerance for risk taking will be limited to

	decisions where the impact is low and the potential mitigations are strong
Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc)*	MIS applies to all trusts that deliver maternity services and are members of CNST. If ESNEFT is unable to meet the requirements of the MIS then there is an increased risk of breaches to the Fundamental Standards and associated Regulations as outlined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015.
Financial Implications	Risk to reputation and subsequent financial loss by not meeting the incentive scheme standards
Equality and Diversity	MNVPs listens to the experiences of women, birthing people, and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. They are pivotal in ensuring the voices of women from all communities, backgrounds, religions and ethnicities are heard and play an integral role in designing services to meet their needs.

Action

The CNST sub Board approvals Committee is asked to review the evidence and confirm compliance with this standard.

1. Evidence	
1.1	CQC Survey Action Plan Nov 2025
1.2	CQC Action Plan August 2025
1.3	LMNS SG September 2025 Agenda
1.4	LMNS SG September 2025 Minutes
1.5	ESNEFT Maternity and Neonatal Governance Update report Sept 2025
2.1	MNVP Lead JD SNEE
2.2	SNEE LMNS MNVP Engagement Officer JD
2.3	New MNVP role for SNEE – Job matching email
2.4	SNEE Contract Agreement for Joint LMNS and MNVP Working Final
2.5	LMNS B3 Admin JD and PS
2.6	SNEE Maternity – M6 Finance update

2.7	NHSE Policy on working in partnership with people and communities
2.8	SNEE ICB Reimbursement of expenses and recognition for non-staff
3.0	NA
4.1	MNIB TOR July 2025
4.2	Maternity Quality and Risk Group TOR
4.3	ESNEFT Acute Children’s Quality and Risk Group TOR
4.4	Review process for PMRT cases (TOR appendix 3)
4.5	Guideline Group TOR
5.1	SNEE MNVP 24/25 Annual Update
5.2	MNVP Work plan 25/26
5.3	LMNS SG August 2025 Agenda
5.4	LMNS SG August 2025 Minutes
5.5	Outreach weeks proposed groups
5.6	iMatter tracker 24/25
5.7	LMNS Equity and Equality Action Plan

CNST sub Board approvals Committee

Report Title:	Compliance with CNST MIS 7 Maternity Safety Action 8 December 2025
Executive/NED Lead:	Catherine Morgan, Chief Nurse Hussein Khatib, NED
Report author(s):	Alana Hunt, Quality Safety and Governance Lead Midwife
Previously considered by:	

☑ **Approval** ☐ **Discussion** ☐ **Information** ☐ **Assurance**

Executive summary

In order to meet the requirements of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme 7, NHS Trusts are required to meet 10 standards.

Within this scheme this year, Safety Action 8 asks:

PART A
Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

90% of attendance in each relevant staff group at:
1. Fetal monitoring and surveillance (in antenatal and intrapartum period) training
2. Multi-professional maternity emergencies training
3. Neonatal resuscitation training

PART B
In addition, can you demonstrate that at least one multidisciplinary (MDT) emergency scenario is conducted in any clinical area or at a point of care during the whole MIS reporting period?

The Reporting period runs from 1 December 2024 to 30th November 2025

Training updates have been submitted through the CDG reports to Divisional Board on a monthly basis and Maternity and Neonatal Improvement Board meetings bi-monthly.

For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. As long as a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust. **We are pleased to confirm that this wasn't required and we achieved full compliance within all staff groups including rotational doctors.**

Evidence
PART A
1. Fetal monitoring and surveillance training is broken down below by site and staff group. Overall ESNEFT compliance is 97.66%, with each staff group compliance above 90%:

Ipswich Fetal Monitoring Study Day		
Overall	**98.06%**	
Midwives + Bank Midwives	176	98.88%
Consultants and SAS Doctors	10	90.91%
Doctors	16	94.12%

Colchester Fetal Monitoring Study Day		
Overall	**97.26%**	
Midwives + Bank Midwives	186	98.94%
Consultants and SAS Doctors	12	100%
Doctors	13	92.86%

2. Multi-professional maternity emergencies training is also broken down by site and staff groups, with an overall compliance for ESNEFT of 92.73%.

Ipswich PROMPT		
Overall	**98.24%**	
Midwives + Bank Midwives	175	98.31%
Nurses	4	100.00%
Support Workers	36	97.30%
Consultants	11	100.00%
Doctors	21	100.00%
Anaesthetic Consultant	14	93.33%
Anaesthetic Doctor	18	100.00%

Colchester PROMPT		
Overall	**97.23%**	
Midwives + Bank Midwives	182	98.38%
Nurses	4	100.00%
Support Workers	45	93.75%
Consultants	12	100.00%
Doctors	24	96.00%
Anaesthetic Consultant	25	96.15%
Anaesthetic Doctor	29	93.55%

3. Neonatal resuscitation training is broken down by staff groups, with an overall compliance for ESNEFT of 97.59%.

ESNEFT Neonatal Resuscitation training			
90% of neonatal Consultants or Paediatric consultants covering neonatal units	26	26	100%
90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births	47	46	97.87%
90% of neonatal nurses (Band 5 and above who attend any births)	83	80	96.38%
90% of maternity support workers, health care assistants and nursery nurses *dependant on their roles within the service - for local policy to determine.	87	83	95.40%
90% of advanced Neonatal Nurse Practitioner (ANNP)	4	4	100%
90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	365	346	94.79%
In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance. **Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.**	77	76	98.70%

PART B

ESNEFT runs MDT emergency scenarios as standard in the clinical areas (unless acuity does not allow) within PROMPT training days but also on an adhoc basis. PROMPT generally take place within birthing rooms setting - Juno in Colchester and Brook in Ipswich. Emergency scenarios have also taken place outside of training days within clinical areas within the reporting period – please see evidence files attached.

ESNEFT is compliant for safety action 8.

Action Required of the Board/Committee

The Committee is requested to receive and note this report as evidence that ESNEFT meets all of the requirements of safety action 8 of the CNST maternity incentive scheme for year 7, and recommend to the Trust Board that full compliance with this safety action is confirmed within the CNST Maternity Incentive Scheme submission.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☐
SO2	Lead the integration of care	☑
SO3	Develop our centres of excellence	☑
SO4	Support and develop our staff	☐
SO4	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	High risk if we do not have compliance across mandatory training standards, supported by robust implementations programmes. Without these we cannot ensure safety or professional develop across our staff, it is imperative we ensure we are meeting the minimum safety standards with maternity.
Trust Risk Appetite	Quality: The board will take minimal risks when it comes to patient safety, patient experience or clinical outcomes. Its tolerance for risk taking will be limited to decisions where the impact is low and the potential mitigations are strong

Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc.)*	Requirement to meet our training compliance to enable ESNEFT maternity are provide the safest and best care possible for those under our charge. This will enable the Trust to provide safer care and provide patients with the best possible experience.
Financial Implications	Risk to reputation and subsequent financial loss by not meeting the incentive scheme standards
Equality and Diversity	No E&D implications identified

1. Additional evidence submitted to demonstrate full compliance	
0.1	MatNeo May 2025 Education update
0.2	MatNeo Education update July 2025
0.3	MatNeo Education update September 2025
0.4	Skills and Drills Ipswich
0.5	Skills and Drills Colchester

CNST sub Board Approvals Committee

Report Title:	Compliance with CNST Maternity Safety Standard 9, MIS 7
Executive/NED Lead:	Catherine Morgan, Chief Nurse Hussein Khatib, NED
Report author(s):	Alana Hunt – Quality, Safety and Governance Lead Midwife
Previously considered by:	Women's and Children's Divisional Management Team

☑ **Approval** ☐ **Discussion** ☐ **Information** ☐ **Assurance**

Executive summary
NHS Resolution is operating year 7 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. **This paper sets out the Trust's current position on Safety Action 9 which asks can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues, including:** a) All Trust requirements of the PQSM must be fully embedded with evidence of working towards the revised Perinatal Quality Oversight Model (PQOM) when published in 2025. b) Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)? c) Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context. d) Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent? e) Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM. f) Ongoing engagement sessions with staff as per previous years of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025. g) Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?

h) Evidence in the Trust Board minutes that Board Safety Champion(s) and the MNVP lead (where infrastructure is in place as per SA7) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented. I) Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.
Action Required of the Performance Committee
To consider and approve the contents of the report.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☑
SO2	Lead the integration of care	☑
SO3	Develop our centres of excellence	☐
SO4	Support and develop our staff	☐
SO4	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	If the Trust is unable to meet the expectations of the CNST SA9 the risk is non-compliance against the standards.
Trust Risk Appetite	Quality: The board will take minimal risks when it comes to patient safety, patient experience or clinical outcomes. Its tolerance for risk taking will be limited to decisions where the impact is low and the potential mitigations are strong
Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc)*	MIS applies to all trusts that deliver maternity services and are members of CNST. If ESNEFT is unable to meet the requirements of the MIS then there is an increased risk of breaches to the Fundamental Standards and associated Regulations as outlined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015.

Financial Implications	Risk to reputation and subsequent financial loss by not meeting the incentive scheme standards
Equality and Diversity	No specific E & D risks identified

1. Narrative summary

Evidence

a) All Trust requirements of the PQSM must be fully embedded with evidence of working towards the revised Perinatal Quality Oversight Model (PQOM) when published in 2025.

A review of the PQSM evidence is reported through LMNS 6 monthly, which has now converted to align with PQOM requirements which is evidenced in file 0.1 and 0.2.

b) Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?

Information shared as part of MIS 5, this is ongoing with no change in personnel at this time. This is evidenced through the MNIB TOR's and CKI's to trust board within files 0.3, 0.4, 0.5 and 0.6.

c) Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context.

d) Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?

Bi-monthly reports are shared at MNIB, which are enclosed in evidence files and detail all requirements within 0.7 – 1.4.

e) Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.

Shared learning with the LMNS, ODN and ICB is evidenced through safety forum and strategic groups meeting minutes contained within files 1.5, 1.6, 1.7, 2.3, 2.4 and 2.5.

f) Ongoing engagement sessions with staff as per previous years of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025.

Bi-monthly reports to MNIB evidence the ongoing engagement with staff, feedback and progress within files 1.0, 1.1, 1.2 and 1.8.

g) Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?

Evidence for this is included in files 0.9, 1.9, 2.2 and 2.6 within the maternity governance and risk reports for Sept and November. The September report was shared through MNIB, the November report was shared at divisional board with maternity neonatal and trust level safety champions present.

h) Evidence in the Trust Board minutes that Board Safety Champion(s) and the MNVP lead (where infrastructure is in place as per SA7) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.

Evidenced through MNIB meeting minutes with files 2.0, 2.1 and 2.2.

i) Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.

Evidenced through MNIB meeting minutes with files 2.0, 2.1 and 2.2.

Conclusions

The Trust is compliant with safety action 9 within CNST Year 6.

Evidence	
0.1	PQSM ESNEFT June 2025
0.2	PQOM ESNEFT Nov 2025
0.3	Mat Neo Improvement Board TOR’s
0.4	Mat Neo Improvement Board CKI’s May 25
0.5	Mat Neo Improvement Board CKI’s July 25
0.6	Mat Neo Improvement Board CKI’s Sept 25
0.7	Maternity governance and risk report to MNIB May 25
0.8	Maternity governance and risk report to MNIB July 25
0.9	Maternity governance and risk report to MNIB Sept 25
1.0	Mat Neo Maternity Update May 25
1.1	Safety Surveillance update July 25
1.2	Mat Neo Maternity Update Sept 25
1.3	ESNEFT Birth rate plus red flag report MNIB Sept 25
1.4	ESNEFT Perinatal Culture Programme Update Sept 25
1.5	LMNS SG Minutes May 25
1.6	LMNS SG Minutes Aug 25
1.7	LMNS SG Minutes Sept 25
1.8	Safety Champions Walkabouts email
1.9	Maternity governance and risk report to Divisional Board Nov 25

2.0	MNIB minutes May 25
2.1	MNIB minutes July 25
2.2	MNIB minutes Sept 25
2.3	Safety Forum minutes May 25
2.4	Safety Forum minutes July 25
2.5	Safety Forum minutes August 25
2.6	Divisional Board Maternity CDG Transcript Nov 25

Quality and Patient Safety Committee

Report Title:	Maternity and Newborn Safety Investigations (MNSI) programme and NHS Resolution's Early Notification (EN) Scheme – report on compliance, in line with CNST (Safety Action #10) for Year 7.
Executive/NED Lead:	Catherine Morgan, Chief Nurse Hussein Khatib, NED
Report author(s):	Sarah Carter – Maternity Governance Manager
Previously considered by:	Women's and Children's Divisional Management Team

☐ **Approval** ☐ **Discussion** ☐ **Information** ☑ **Assurance**

Executive summary
NHS Resolution is operating year seven of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. This paper sets out the Trust's current position on Safety Action 10: **"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 1 December 2024 to 30 November 2025?"** Giving assurance of the compliance against the standard for reporting relevant incidents of meeting the MNSI and / or NHSR EN referral criteria within the required timeframe. As part of a Maternity Safety Action required, Trusts must demonstrate that they have reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) and (if applicable) subsequently reported to NHS Resolution's Early Notification (EN) scheme once confirmation has been declared that an investigation will be undertaken. This report gives an overview of the compliance against the standard for reporting relevant incidents of suspected severe brain injury to MNSI and NHSR EN within the required timeframe.
Action Required of the Performance Committee
To consider and approve the contents of the report.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☐
SO2	Lead the integration of care	☑

SO3	Develop our centres of excellence	☐
SO4	Support and develop our staff	☐
SO4	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	If we do not have effective safety standards and assurance mechanisms in place, we cannot demonstrate that cases of severe brain injury at birth are reported to NHSR EN or MNSI and there will be early resolution of cases.
Trust Risk Appetite	Quality: The board will take minimal risks when it comes to patient safety, patient experience or clinical outcomes. Its tolerance for risk taking will be limited to decisions where the impact is low and the potential mitigations are strong
Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc)*	Requirement to report all relevant cases of severe brain injury at birth to NHSR after gaining consent from the parent(s) of the baby.
Financial Implications	Risk to reputation and subsequent financial loss by not meeting the incentive scheme standards
Equality and Diversity	There are no E&D implications

1. Introductions

NHS Resolution is operating year seven of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

The scheme incentivises ten maternity safety actions ("the standards"). Trusts that can demonstrate they have achieved all of the ten standards will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

As with SA1 and SA2 this SA is also verified externally as well as the self-declaration that is required of the Board.

2. Requirements for SA10

A. Reporting of all qualifying cases to MNSI from 1 December 2024 to 30 November 2025.

B. Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 1 December 2024 until 30 November 2025.

C. For all qualifying cases which have occurred during the period 1 December 2024 to 30 November 2025, the Trust Board are assured that:
   i. the family have received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them; and

ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

D. Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.
E. Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this.
F. Has Trust Board had sight of evidence of compliance with the statutory duty of candour?
G. Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.

3. ESNEFT Qualifying Cases

Evidence

Parts A, B, C and G

Between 01 December 2024 and 30 November 2025 there were 5 cases that initially met the referral criteria for MNSI; only 1 of which met the criteria for NHSR EN and was subsequently referred:

- **Incident date: 22/01/2025 Referral date: 04/02/2025 MNSI Ref: MI-039558 Category = HIE/Cooling – family concerns only.**
  Case accepted by MNSI based on family concerns (normal MRI findings). Status = Complete.

- **Incident date: 20/01/2025 Referral date: 10/02/2025 MNSI Ref: MI-039687 Category = Intrapartum stillbirth.**
  Case rejected as no consent for MNSI to investigate received from family. Status = Rejected.

- **Incident date: 03/02/2025 Referral date: 10/02/2025 MNSI Ref: MI-039688 Category = HIE/Cooling – family concerns only.**
  Case accepted by MNSI based on family concerns (normal MRI findings). The family later withdrew participation with the investigation resulting it not including their perception of events. English was noted as not being the patient's first language however, translated documents were offered but declined due to her speaking and reading English fluently. Status = Complete.

- **Incident date: 09/02/2025 Referral date: 11/02/2025 MNSI Ref: MI-039720 Category = HIE/Cooling - potential severe brain injury.**
  NHSr EN Ref: 183344 (CMS number)
  Case initially accepted by MNSI based on family concerns (normal MRI findings) but the trust was updated on 12/06/2025 that their expert had identified some changes on MRI images, therefore they have had changed their acceptance criteria to 'potential severe brain injury'.

Referral made 16/06/2025 to NHSr EN. Status = Complete.

- **Incident date: 15/02/2025 Referral date: 28/02/2025 MNSI Ref: MI-040160 Category = HIE/Cooling – family concerns only.**
  Case accepted by MNSI based on family concerns (normal MRI findings). Status = Complete.

All cases received verbal duty of candour in line with regulation 20, followed by written confirmation which included relevant patient information signposting to MNSI and/or NHS resolutions early notification scheme (if applicable).

Case Ref	Case type	Incident Date	Verbal DoC*	Written DoC**	Information on MNSI and / or NHSR EN
MI-039558	HIE/Cooling	22/01/2025	28/01/2025	28/01/2025	✓
MI-039687	Intrapartum stillbirth	20/01/2025	20/01/2025	N/A	N/A
MI-039688	HIE/Cooling	03/02/2025	03/02/2025	18/02/2025	✓ Translation offered but declined as not required.
MI-039720	HIE/Cooling	09/02/2025	10/02/2025	18/02/2025	✓
MI-040160	HIE/Cooling	15/02/2025	28/02/2025	03/03/2025	✓

** Verbal discussion re MNSI & EN scheme (if applicable) between staff and patient/family.*
*** Written letter including information and/or signposting to further information regarding MNSI & EN scheme (if applicable) sent by Governance Team.*

Parts D, E and F

Qualifying cases identified were included within the maternity section submitted for the Trust's Integrated Patient Safety and Experience Report, which also monitors statutory duty of candour for the division and has been fully compliant within the reporting period. These reports are fed up to Trust board for oversight.

4. Conclusions

The Trust is 100% compliant with all requirements relating to safety action 10 within CNST Year 7.

5. Action Required

The Committee is ask to review the details and confirm compliance with Safety Action 10

6. ADDITIONAL EVIDENCE submitted to demonstrate compliance	
0.1	MNSI family information summary
0.2	Copy of DOC template letter
0.3	October 2025 IPSE report
0.4	November 2025 IPSE report

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 1 December 2024 to 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose N/A)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes

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Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No)
1	Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month? This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	Yes
2	Did July 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

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Safety action No. 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	Yes
2	**Or** Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards?	N/A
Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.		
For units commencing a new QI project		
3	By 2 September 2025, register the QI project with local Trust quality/service improvement team.	Yes
4	By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.	Yes
Or **For units continuing a QI project from the previous year**		
5	Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions.	N/A
6	By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period	N/A

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Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board (select N/A if no short-term locum doctors were employed in this period): Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust ensured that the RCOG guidance on engagement of long-term locums has been implemented in full for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025 (select N/A if no long-term locum doctors were employed in this period)	Yes
3	**For information only:** RCOG compensatory rest (not reportable in MIS year 7) Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	Yes
4	Is the Trust compliant with the Consultant attendance in person to the clinical situations guidance, listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	Yes
5	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Yes
6	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Yes
7	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	No
10	Is this formally recorded in Trust Board minutes?	Yes
11	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	Yes
12	Was the above action plan shared with the LMNS?	Yes
13	Was the above action plan shared with the Neonatal ODN?	Yes
d) Neonatal nursing workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	Yes
15	Is this formally recorded in Trust Board minutes?	Yes
16	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	N/A
17	Was the above action plan shared with the LMNS?	N/A
18	Was the above action plan shared with the Neonatal ODN?	N/A

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Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, you can declare compliance but evidence of communication with the BirthRate+ organisation (or equivalent) MUST demonstrate this.)	Yes
2	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. This must include at least one report in the MIS period 2 April - 30 November. Every report must include an update on all of the points below: ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour ● Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?	Yes
3	**For Information Only:** We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: •Redeployment of staff to other services/sites/wards based on acuity. •Delayed or cancelled time critical activity. •Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). •Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). •Delay of more than 30 minutes in providing pain relief. •Delay of 30 minutes or more between presentation and triage. •Full clinical examination not carried out when presenting in labour. •Delay of two hours or more between admission for induction and beginning of process. •Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). •Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally.	Yes
4	Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
5	Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	N/A
6	Where deficits in staffing levels have been identified must be shared with the local commissioners.	N/A
7	Evidence from an acuity tool (may be locally developed) that the Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
8	**For Information Only:** A workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement.**	N/A
9	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
10	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the improvement plan will enable the Trust to declare compliance with this sub-requirement. This improvement plan does not need to be submitted to NHS Resolution**	N/A

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Safety action No. 6

Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3.2 is fully in place, and can you evidence that the Trust Board have oversight of this assessment?	Yes
2	Where full implementation is not in place, has the ICB been assured that all best endeavours and sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectory?	N/A
3	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include: ● Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory. ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes
4	Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?	Yes
5	If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB	N/A

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Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of an action plan co-produced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge	Yes
2	● Has progress on the co-produced action above been shared with Safety Champions?	Yes
3	● Has progress on the co-produced action above been shared with the LMNS?	Yes
4	**Do you have evidence of MNVP infrastructure being in place from your LMNS/ICB, in full as per national guidance, and including all of the following:** • Job description for MNVP lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Yes
5	**If MNVP infrastructure is not in place and evidence of an MNVP, commissioned and functioning in full as per national guidance, is unobtainable (and you have answered N to Q4):** Has this has been escalated via the Perinatal Quality Oversight Model (PQOM) at trust, ICB and regional level? In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below to meet compliance for MIS for this safety action.	N/A
6	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Terms of Reference for Trust safety and governance meetings, showing the MNVP lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	Yes
7	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes

Return to Guidance Sheet

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12 month period using a training certificate or correspondence from the previous maternity unit.		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota? (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank midwives employed by Trust and maternity theatre midwives who also work outside of theatres)?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants?	Yes
6	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota?	Yes
7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust?	Yes
9	90% of maternity support workers and health care assistants? (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors?	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA?	Yes
12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	Yes
	Neonatal resuscitation training	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births?	Yes
16	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
17	90% of neonatal nurses? (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
19	**For Information Only:** 90% of maternity support workers, health care assistants and nursery nurses? (dependant on their roles within the service - for local policy to determine)	N/A
20	90% of midwives? (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust)	Yes
21	In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance? Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.	Yes

Safety action No. 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the Perinatal Quality Oversight Model (PQOM)?	Yes
2	Has a non-executive director (NED) been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM/PQOM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context?	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM/PQOM?	Yes
6	Ongoing engagement sessions should be being held with staff as per previous years of the scheme. Is progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025?	Yes
7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period 2 April - 30 November)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period 2 April - 30 November) and that any support required of the Trust Board has been identified and is being implemented? **Where the infrastructure is in place, this should also include the MNVP lead as per SA7.**	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented?	Yes

Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025?	Yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	Yes
4	For any occasions where it has not been possible to provide a format that is accesible for eligible families, has a SMART plan been developed to address this for the future?	N/A
5	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
6	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	Yes
7	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this?	Yes
8	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
9	When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored, and externally validated.	Yes

Return to Guidance Sheet

Section A : Maternity safety actions - East Suffolk North Essex NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes

Section B : Action plan details for East Suffolk North Essex NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Please refer to the guidance sheet to ensure correct entries into the action plan: Return to Guidance Sheet

Action plan 1

Safety action | **To be met by**

Work to meet action

Does this action plan have executive level sign off | **Action plan agreed by head of midwifery/clinical director?**

Action plan owner

Lead executive director

Amount requested from the incentive fund, if required

Reason for not meeting action

Rationale

Benefits

Risk assessment

	How?	Who?	When?
Monitoring			

Action plan 2

Safety action | | **To be met by** |

Work to meet action

Brief description of the work planned to meet the required progress.

Does this action plan have executive level sign off

Action plan agreed by head of midwifery/clinical director?

Action plan owner

Who is responsible for delivering the action plan?

Lead executive director

Does the action plan have executive sponsorship?

Amount requested from the incentive fund, if required

Reason for not meeting action

Please explain why the trust did not meet this safety action

Rationale

Please explain why this action plan will ensure the trust meets the safety action.

Benefits

Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.

Risk assessment

What are the risks of not meeting the safety action?

	How?	Who?	When?
Monitoring			

Action plan 3

Safety action

To be met by

Work to meet action

Brief description of the work planned to meet the required progress.

Does this action plan have executive level sign off

Action plan agreed by head of midwifery/clinical director?

Action plan owner

Who is responsible for delivering the action plan?

Lead executive director

Does the action plan have executive sponsorship?

Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 4

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

Monitoring	How?	Who?	When?

Action plan 5

Safety action | **To be met by**

Work to meet action: *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off

Action plan agreed by head of midwifery/clinical director?

Action plan owner: *Who is responsible for delivering the action plan?*

Lead executive director: *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action: *Please explain why the trust did not meet this safety action*

Rationale: *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits: *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*

Risk assessment: *What are the risks of not meeting the safety action?*

Monitoring	How?	Who?	When?

Action plan 6

Safety action | **To be met by**

Work to meet action: *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off	
Action plan agreed by head of midwifery/clinical director?	
Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 7

Safety action	
To be met by	
Work to meet action	*Brief description of the work planned to meet the required progress.*
Does this action plan have executive level sign off	
Action plan agreed by head of midwifery/clinical director?	
Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*

Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 8

Safety action [ ] **To be met by** [ ]

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off [ ] **Action plan agreed by head of midwifery/clinical director?** [ ]

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required [ ]

Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 9

Safety action | | **To be met by** |

Work to meet action
Brief description of the work planned to meet the required progress.

Does this action plan have executive level sign off | | **Action plan agreed by head of midwifery/clinical director?** |

Action plan owner
Who is responsible for delivering the action plan?

Lead executive director
Does the action plan have executive sponsorship?

Amount requested from the incentive fund, if required

Reason for not meeting action
Please explain why the trust did not meet this safety action

Rationale
Please explain why this action plan will ensure the trust meets the safety action.

Benefits
Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.

Risk assessment
What are the risks of not meeting the safety action?

	How?	Who?	When?
Monitoring			

Action plan 10

Safety action | | **To be met by** |

Work to meet action
Brief description of the work planned to meet the required progress.

Does this action plan have executive level sign off | | **Action plan agreed by head of midwifery/clinical director?** |

Action plan owner
Who is responsible for delivering the action plan?

Lead executive director | *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Maternity Incentive Scheme - Year 7 Board declaration form

Trust name	**East Suffolk North Essex NHS Foundation Trust**
Trust code	**T690**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.
* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2025/26) or the previous financial year (2024/25)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	East Suffolk North Essex NHS Foundation Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	East Suffolk North Essex NHS Foundation Trust
Name:	
Position:	
Date:	

CHAIR'S KEY ISSUES

ISSUES FOR REFERRING / ESCALATING TO BOARD / COMMITTEE / TASK & FINISH GROUP

ORIGINATING BOARD / COMMITTEE / TASK & FINISH GROUP AND DATE:	Maternity and Neonatal Improvement Board – 9th December 2025
CHAIR:	Hussein Khatib, Non-Executive Director
LEAD EXECUTIVE DIRECTOR:	Catherine Morgan, Chief Nurse

Agenda Item	Details of Issue	Approval Escalation Alert Assurance Information
Matters Arising	Mat Neo Improvement Board was quorate and had representation from all staff groups.	Information
Assurance Report	The Chair reported that good progress continues to be made across maternity services and thanked all teams for their ongoing efforts. Very early findings from the Baroness Amos report were discussed. These initial findings are not positive, and further work will be required once the full report is available to understand the implications and to align the findings with the work already undertaken by the maternity teams at ESNEFT. Benchmarking against the Safe Home Birthing Services review in relation to the prevention of deaths has been completed. This data will be analysed and presented at the next MNIB meeting. It was reported positively that CNST standards are currently compliant. However, the introduction of the new BAPM standards will present challenges for the medical workforce. A proposal outlining management and resolution options will be brought to a future Board meeting. The maternity services culture review is ongoing, and a formal communications strategy will be developed and presented at the next MNIB.	Information Information Information Information Information

	The PPH review has been completed and confirmed ESNEFT compliance, although further work is required to strengthen compliance in some areas. The education update was well received, as were updates from the LMNS and MNVP regarding the CQC action plan and partner charters. Some initial issues have been experienced with the Epic system, which have affected data collection and reporting. As a result, incomplete triage data was reported for October. Meetings with the Epic team have taken place, and they have been responsive, with plans in place to resolve the issues.	Information Information Information

Escalation	Support/decision required by reporting committee to resolve an issue within its remit	**Alert**	Proactive notification of subject matter/risk that reporting committee is currently dealing with or mitigating which may require future action/decision
Assurance	Evidence or information to demonstrate that appropriate action is being taken within a reporting committee's remit	**Information**	No action required. Reporting to update on discussion within a reporting committee's remit

Trust Board of Directors

Report Summary

<table>
<tr><td colspan="2">Date of meeting: 08 January 2026</td></tr>
<tr><td colspan="2">Title of Document: ESNEFT Delivery Plan – Update for Trust Board of Directors as at end Q2 FY2025-2026</td></tr>
<tr><td>To be presented by:

Andy Higby
Strategy Programme Director</td><td>Author:

Andy Higby
Strategy Programme Director</td></tr>
<tr><td colspan="2">1. Status: For Approval/Discussion/<u>Assurance</u>/Noting/<u>Information</u></td></tr>
<tr><td colspan="2">2. Purpose:
This report is being presented to Trust Board members to provide assurance on progress with the schemes that comprise the Delivery Plan.</td></tr>
<tr><td colspan="2">Relates to:</td></tr>
<tr><td>Strategic Objective</td><td>This report covers all the director-led programmes which deliver across the Trust’s Strategic Objectives:
• Keep people in control of their health;
• Lead the integration of care;
• Develop our centres of excellence;
• Support and develop our staff;
• Drive technology enabled care</td></tr>
<tr><td>Operational performance</td><td>The report references elements of operational performance e.g., schemes 01 - Elective, 02a – Urgent & Emergency Care (COL) and 02b – Urgent & Emergency Care (IPS)</td></tr>
<tr><td>Quality and equality impact</td><td>The report includes elements of the Quality Strategy e.g., schemes 03 – Quality Improvement and 04 – Quality Priorities.</td></tr>
<tr><td>Legal, Regulatory, Audit</td><td>N/A</td></tr>
<tr><td>Finance</td><td>This report includes finance elements i.e., scheme 05 – Financial Sustainability</td></tr>
<tr><td>Governance</td><td>This report provides the Trust Board of Directors with assurance of progress across all schemes – with measures identified at baseline and quarter end; as well as target for year-end</td></tr>
<tr><td>NHS policy/public consultation</td><td>N/A</td></tr>
</table>

Accreditation/ Inspection	Scheme updates are not subject to review by an accreditation body; or by the Trust's Internal Audit provider
Anchor institutions	N/A
ICS/ICB/Alliance	N/A
Board Assurance Framework (BAF) Risk	This report does not provide material additional assurance in relation to BAF risks. However, scheme updates are included for: • Financial Sustainability (BAF2 Financial performance – value and sustainability). • Workforce (BAF5 Workforce – recruitment and retention) • Elective (BAF6 Sustainable delivery of elective performance.), • U&EC (COL) and U&EC (IPS) (BAF6a - Sustainable delivery of emergency care performance targets.), • Digital (BAF8 - Digital maturity and major disruptive outage)
Other	N/A

3. **Summary:**

This report provides a summary for Board members on the progress across the range of programmes that make up the ESNEFT Delivery Plan.

Two programmes are not reporting as at end Q2 - Digital (EpicEPR implementation and Stabilisation) and ESNEFT Capital Schemes (temporary moratorium on reporting agreed with ELT).

4. Recommendations / Actions

Board members are invited to note the update reports below, and seek any clarification required.

Scheme name:	**Elective Care**
SRO / Support	**Karen Lough / Carolyn Tester**
Period ending	**30 September 2025**

Intended change to be delivered by scheme: -

- Reduction in overall Waiting List size
- Reduction in the number of patients waiting 65+ weeks
- Deliver against overall DM01 performance trajectory
- Increase Theatre productivity
- Implement Transformative change to increase uptake of PIFU and A&G and decrease DNA's

Measure	**Baseline (as at 31st March)**	**In month position (as at 30th September '25)**	**Year-end target**
Total waiting list size	91,895	**93,643** *(deteriorated by 1748 from baseline)*	83,999
Total patients waiting 65+ weeks	23	**9** *(improved by 14 from baseline)* *Taken from internal data source (AF)*	0
DM01 Overall Performance against trajectory	8.4%	**13.3%** *(deteriorated by 4.9 baseline)* *Taken from internal data source (AF)*	5%

Theatre Productivity: Average cases per list	2.1	**2.3** *(Improved by 0.2 from baseline)* *Data reported until 21/09 in MHS.*	2.3
Theatre Productivity: In-session usage	76.6%	***80.2%*** *(Improved by 3.6 from baseline)* *Data reported until 21/09 in MHS.*	85%
Outpatient Transformation: PIFU against 5% target	4.1% *(Including SUS data e.g. Oaks etc)*	**6%** *(Including SUS data e.g. Oaks etc)* *(Improved by 1.9% from baseline)* *MHS data*	5%
Outpatient Transformation: Advice & Guidance against 16% target	19.5%	**26.6%** *(Improved by 7.1% from baseline)* *EROC data*	16%

Key points from this reporting period:

- 5 out of 7 strategic metrics have improved since 31st March baseline, with the exception of total waiting size and DM01
- No breaches for 65+ weeks for capacity reasons, with a month end position of 9 breaches, these were related to complexity and choice.
- **EpicEPR –** Trust wide planning and preparation was undertaken towards a Go-Live on 2nd October. Intensive focus was given to application builds and test, wait list validation, work queues, clinic templates, activity stabilisation planning, automatic and manual data migration, cutover planning, training and practice/personalisation and overall organisational readiness for the implementation.

PIFU

- PIFU performance continued to improve significantly across many of our specialties in September; leading to 6**%** overall as a trust, achieving highest quartile nationally as per Model Health System data and places us top nationally when compared with peers.

RTT 65% Performance

- RTT Performance was 56.8% in Sept, a reduction from previous quarterly reporting from 57.5.%

- Areas with the largest gap include ENT, Gynae and Urology. All services have increased monitoring in place to support plans for recovery, with ENT having reached out and met with GIRFT colleagues for recovery advice and support.
- We have met with Newcastle-upon-Tyne and Torbay in relation to their RTT performance as similar-sized trusts, with a view to learning and sharing best practices to support continuous improvement. Key themes from this learning included focus on text validation campaigns, increasing clinical engagement and strengthened governance and drumbeat meetings and escalations.

DNA's:-

- Continued improvements underway for our DNA's, now showing in the lowest (best) quartile nationally at **5.7%** as per Model Health System data for September.

Theatre productivity:-

ESEOC

- Capped utilisation in ESEOC is in the top national benchmarking quartile in August at 84.6%, following good work to achieve reduced start delays and turnaround times. Completed activity increasing each month as shown below. However, available weekly list capacity is not where it needs to be, hence intense focused plans underway to increase lists per week *(from current 33 towards the original business case of 44).*

Delivery	November 2024	December 2024	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025	July 2025	August 2025	September 2025
Elective	218	274	433	431	467	425	393	466	463	429	516
Total	**218**	**274**	**433**	**431**	**467**	**425**	**393**	**466**	**463**	**429**	**516**

Green Surgical hub:

- Accreditation visit completed on 3rd September 2025. Clear expectations set on the requirement to increase number of patients through the GSH and utilisation to reach 85% ASAP.
- Establishment of a Surgical Command Centre underway; centrally overseeing day to day management of theatres, to ensure capacity optimisation and productivity achievements

Diagnostics:-

- DM01 performance for September was 87.6%, impacted primarily by Ultrasound capacity.
- The Clacton Community Diagnostic Centre (CDC) continues to exceed planned activity levels, currently delivering 110% of target throughput.

Clinic Templates:-

- 13,000 additional appointments were identified across 6 surgical specialties as part of a national GIRFT review process and for loading into EpicEPR to increase our outpatient capacity. Current work underway to ensure these have all been loaded and every slot optimised.

Examples of key focus areas over the next period include:

- Benefits realisation of EpicEPR (including MyChart application) as enabler to drive elective care metrics, with particular focus on DNA, PIFU and reduced appointment demand
- Activity stabilisation intense period, following EpicEPR go-live
- 'Optimising elective care' taskforce group; 30 and 60 day workstream plans, via weekly taskforce reporting
- Focus efforts on those specialty areas identified as biggest opportunities as part of five year planning national peer benchmarking activities through Model Health System
- Establishment of a Surgical Command Centre; centrally overseeing day to day management of theatres, to ensure capacity optimisation and productivity achievements

Programme title:	Urgent and Emergency Care (COL)
SRO / Support	Shume Begum/ Renee Ward/ Ben Page
Period ending	31 October 2025

Intended improvement to be delivered by scheme

- Patients are seen, treated and discharged from our Emergency Departments within 4 hours.
- Maximum 92% Bed occupancy at all times, (i.e., maximum 92% of 'available' beds occupied at any one time)
- Average LOS per specialty, (per patient, per specialty)

Measures	Baseline	In month position	Year-end target
Preventative: ED attendances (excluding UTC): patients aged 65 and over	**April 2023:** 2,518	**Sept 2025:** 2,519	
Front door focus: admissions discharged on the day of attendance (move from 1/5 to 1/3)	**April 2023:** 29.4%	**Sept 2025:** 35%	33%
Flow: Virtual ward pathways are maximised to at least 80% capacity available	**April 2023:** 61.9%	**Sept 2025** (*please note September data has been used due to Epic migration*): **60.88%**	95% *(Q1 80%, Q2 85%, Q3 90%)*

Available, Occupied, Capacity Utilised %

BY ORGANISATION NAME, SERVICE

Organisation Name	Available	Occupied	Capacity Utilised %
North East Essex Virtual Wards	**1,140**	**694**	**60.88%**
Acute Frailty	540	428	79.26%
Acute Medical	300	189	63.00%
Acute Respiratory	180	24	13.33%
Community Heart Failure	120	53	44.17%
Total	**1,140**	**694**	**60.88%**

Key milestones met from this reporting period:

- The launch of the 24-hour SDEC was successful, with an average of 120 patients being seen in the unit each day.
- The launch of Epic has been successful throughout Medicine and Community Services
- Emergency Assessment Unit continues to deliver required share of discharges as part of Quality Discharge Initiative
- Additional medical beds brought online to support with exit block from Emergency department
- Additional clinical frailty resource brought into Colchester to support with front door demand

Off track actions – and remediation for the same:

- Colchester 12-hour performance has not shown significant improvement. However, with additional winter beds now being brought online, we are likely to see improvement in this.

Key milestones expected in next reporting period:

- Expecting to see increases in Type-1 non-admitted performance now that SDEC is 24-hours a day
- Improvement in Emergency Department LoS
- Improvement in 12-hour performance

Top three risks

- Due to lack of flow within the department patients are having extended length of stays above 24 hours at times, this is poor patient experience and there is an increased risk of patient harm.
- Internal Professional Standards – there is a concern regarding the delay in specialty response

Scheme name:	**Urgent and Emergency Care (IPS)**
SRO / Support	**Mike Meers / Rebecca Walker & Hannah Armes**
Period ending	**30 September 2025**

Intended improvement to be delivered by scheme

1. Patients are seen, treated and discharged from our Emergency Departments within 4 hours
2. Maximum 92% Bed occupancy at all times, *(i.e. maximum 92% of 'available' beds occupied at any one time)*
3. Average LOS per specialty, *(per patient, per specialty)*

<table>
<tr><th>Measures (from EMC reporting)</th><th>Baseline</th><th>End quarter position</th><th>Year-end target</th></tr>
<tr><td>Preventative: ED attendances patients aged 65 and over</td><td>April 2023: 2,209</td><td>July 2025 – 2466
August 2025 – 2570
September 2025 - 2530</td><td></td></tr>
<tr><td>Front door focus: Admissions discharged on the day of attendance</td><td>April 2023:
19.5%</td><td>July – September: 39%</td><td>33%</td></tr>
<tr><td>Flow: Virtual ward pathways are maximised to at least 80% capacity</td><td>0%</td><td><table><tr><td></td><td>Frailty</td><td>Resp</td><td>Medical</td></tr><tr><td>July</td><td>89%</td><td>32%</td><td>65%</td></tr><tr><td>Aug</td><td>80%</td><td>20%</td><td>23%</td></tr><tr><td>Sept</td><td>95%</td><td>46%</td><td>20%</td></tr></table></td><td>95%</td></tr>
</table>

Key points from this reporting period:

- Completion of the Emergency Department recovery plan which was developed collaboratively and under-pinned by real-time data. It outlines immediate actions, medium-term improvements and long term transformation goals to ensure our ED is equipped to meet demands.
- Advanced analytics to understand current demand and capacity including attendance patterns, workforce mapping, and performance tipping points, cohort specific breaches and identification of delays.
- The front door assessment team identify patients seen by a community clinician and refer them directly to the relevant assessment unit.
- ED display screen updated to provide earlier triggers for breaches (to be mirrored in Epic)
- Nursing review – removal of 3rd RATS team overnight to support increased activity in AECU.
- EEAST and ESNEFT lean mapping process to improve Handover 45.

- UEC team demonstrated significant improvements in key metrics including 4 hour standard, 12 hour journeys and Handover 45 in July and August. September introduced multifaceted challenges including daily bed waits, untimely speciality input and staffing challenges due to Epic training.

	July	August	September
4 hour standard	62.39%	68.03%	59%
12 hour journey	8.16%	5.17%	13.4%
HO45	88.9%	93.5%	73%

- Reconfiguration of EAU to ensure same sex requirements are not breached.
- Increased utilisation of AMSDEC including the waiting area.
- Front door frailty has pulled through an average of 87 patients/month during Q2 compared to 68 patients/month in Q1 - supporting treating the right patient in the right place.

Scheme name:	Quality Improvement		
SRO / Support	Angela Tillett and Sally Barber / Marie Elliott		
Period ending	30 September 2025		
Intended change to be delivered by scheme • End of Life Care - To improve the care of patients who are in the last days or weeks of life and those close to them, wherever they are cared for in the Trust, including rapidly deteriorating patients reaching their preferred place of care, in a timely manner. • Inequalities - Tobacco Treatment. NHS Long Term Plan – by 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.			
Measures	**Baseline**	**End quarter position**	**Year-end target**
1. End of Life Care - Fast Track time to discharge – data covers last 12 months Data for Colchester up to July only	Patients discharged to own home – 7 days Patients discharged to care home – 10.2 days	Patients discharged to own home Colchester Hospital – 4.7 days Ipswich Hospital – 4.7 days Patients discharged to care home Colchester Hospital – 9.3 days Ipswich hospital – 7.9 days	Patients discharged to own home – 5 days Patients discharged to care home – 8.5 days
2. Tobacco treatment Number of patients taking up support Number of patients referred	70% 63 90	Q2 2025 data – 64% 81 126 Q1 2025 data - 65% Q4 2024 data - 62% Q3 2024 data - 60% Q2 2024 data - 68%	80%

Key points from this reporting period:

End of Life Care - Fast Track time to discharge Average days to discharge end of life patients to all destinations continue to decrease, although fluctuations relating to time of year and acuity are apparent. Both Colchester and Ipswich sites positively exceed the target for discharging patients to their own home (4.7 days - compared to a 5.0-day

target). Ipswich positively exceeds the target for discharging patients to care home (7.9-day average, compared to an 8.5-day target). These figures show significant positive decrease from baseline.

Colchester hospital data for discharge to care home remains above target. Capacity challenges with data collation have caused delays, particularly with Colchester data. Difficult set of data to refine, but reporting is now robust – data tool updated in April 2025. Site specific reporting necessary, due to practical differences at each site. End of Life steering Group oversees data monthly. Collaborative working continues with palliative and end of life teams, working with: North East Essex, Ipswich and East Suffolk, Integrated Care Boards, Primary Care, Compassionate Community UK, Hospices and East of England on national and regional projects.

Inequalities - Tobacco Treatment: Tobacco treatment has now had over 2199 referrals to the service, and the staff support service has over 139 referrals. Recruitment at Ipswich complete. CoSTED running from both EDs and Outpatient departments (although only 1 TDA on each site currently). Stoptober promotion delivered. Animations developed for Ward screens. TTS evaluation report developed showing cost benefits realisation – to be shared with ICB colleagues to support future funding conversations. Following Epic go-live, patient list available each day identifying smokers across the hospital.

Funding for the Tobacco Treatment Service received for Ipswich site only by Public Health, Suffolk, leaving cost pressure for Colchester service. Evaluation report to be socialised with ICB to support future funding conversations. Public Health Suffolk developing business case proposal to support at Ipswich hospital for 26/27. Colchester funding remains a challenge. CoSTEd is running with only 1 TDA on each site due to recruitment challenges.

Scheme name:	Quality Priorities
SRO / Support	**Catherine Morgan, Anne Rutland, Rachael Edwards/ Marie Elliott**
Period ending	**30 September 2025**

Intended change to be delivered by scheme

- Mental Health - To improve clinical outcomes for patients with mental health conditions and transform Mental Health provision across ESNEFT
- Dementia - To improve the care and management of patients who have Dementia, their families and their carers, wherever they are cared for in the Trust.

Measures (from EMC reporting)	Baseline	End quarter position	Year-end target
1. Mental Health Reduce the use of non-specialist security observations through increasing use of clinical assessment and therapeutic interventions. This will include use of Bures Ward staff (began end March 2025) to undertake therapeutic observations and a reduction in the unnecessary use of 1:1 observations.	5399 hours per month average October 2024 – March 2025	Madigan Gill and Bures ward - hours provided per month (7000, 6000, 5000, 4000, 3000, 2000, 1000, 0; Apr-25, May-25, Jun-25, Jul-25, Aug-25, Sep-25; Bures hours, Madigan Gill hours) 21% decrease in use of non-specialist security observations since April 2025 (April = 6084, September = 4779) 246% increase in Bures ward hours provided since April 2025 (April = 671, September = 2323)	10% reduction in the use of security observations in the first 6 months
2. Dementia – use of 'This is Me' booklet for all patients with Dementia and Delirium. *The audit process was refined in April. At each acute site, 25 patients on the older*	<20%	Q2 – 43% Colchester – 42% (fewer patients audited than usual) Ipswich – 44% (significant increase from Q1)	50%

person's service's wards and 10 patients on the orthopaedic wards are audited monthly – this is a change from previous auditing which covered most inpatient wards – where staffing allowed.		Q1 – 45.5% (Colchester - 74% Ipswich – 15%) Q4 = 22% (Colchester 30% Ipswich 14%) 2024-2025 annual average = 36% 2023-24 annual average = 22%	

Key points from this reporting period:

Measure 1 – Significant decrease in the use of non-specialist security observations. This percentage may be larger than reported, due to difficulty separating some of the data – disaggregation is being worked on. Data shows a reduction in agency hours; in Colchester - the vast number of agency hours for 1:1 has been security use and some hours have been attributed to an agency which provides staff who are trained to support patients with eating disorders or those with mental health needs who may require frequent restraint, therefore the overall reduction in security use is potentially higher. This data, alongside the reduction in overall hours required for 1:1 observations, demonstrates there is improved therapeutic assessment and intervention. Bures Ward became operational at the end of March 2025. There were some quite complex long stay patients in the summer months which impacted the data. Monitoring of data, to evidence reduction in use of security observations and reduction of unnecessary 1:1 observations overall, continues.

Measure 2: Overall percentage has risen significantly since Q4 – being close to target of 50% and eclipsing the previous two years of percentages. Ipswich wards have seen a significant increase in 'This is Me' usage in quarter two, compared to previous quarters.

Colchester audited fewer patients in quarter two due to pressures on the service. Small teams at both acute sites (one Dementia specialist and one part time Dementia specialist support worker on each site) impacts auditing capability, this can be further exacerbated by sickness and position vacancies. There is an inherent difficulty meeting the target due to the 'This is Me' booklet being an external document produced by The Alzheimer's Society and Royal College of Nursing, for patients and carers to choose to complete. At Colchester teams are able to refer into the care home liaison team for follow up support post discharge for complex patients, this will be investigated for parity across sites. Daily Huddles with Bures virtual ward, to identify patients with complex needs at Colchester is improving the oversight of the dementia nurse. Teaching sessions completed in Ipswich regarding development of staff competencies in Dementia and Enhanced Therapeutic Observations of Care - awaiting new members of staff to complete this in Colchester.
Essex University Research Team Service Improvement project 'Dementia: Fundamentals of Care in Acute Hospital Settings', joint working is in progress. The Accrediting Care at ESNEFT (ACE) process will encourage greater focus on dementia and delirium care at ward level.

Scheme name:	Financial Sustainability
SRO / Support	Adrian Marr / James Rowe
Period ending	30 September 2025

Intended improvement to be delivered by scheme:

- Financial sustainability comprises a combination of long term planning, annual planning and in-year monitoring
- 2025/26 Trust plan submitted and Divisional business plans in place, including productivity targets and plans
- 2025/26 CIP intention; i) CIP target of £43.9m; built from Brought forward divisional surplus / deficit, 3% new CIP, and EpicEPR benefit realisation, and ii) Implied productivity compared to rolling previous year / periods baseline (2% improvement)
- Translation of guidance and completion of appropriate returns for medium term and Annual planning

Measures (from EMC reporting)	Baseline	End quarter position	Year-end target
1. Local Cost per WAU	107.8 (Mar 23)	109.8 (Trust September 25 index)	
2. Implied Productivity	2024/25 (Q1)	+3.7% (Q1 25/26, national / regional information, MHS tbc)	+2.0%
3. CIP		£12.0m ytd as at September 25, compared to £18.2m target	£43.9m
4. Recurrent CIP	N/A	£29.7m currently identified recurrently (not risk rated)	£43.9m

Key points from this reporting period:

- 2025/26 Trust internal and external planning completed, with agreement of Trust Contracts with host and associated Commissioners
- EpicEPR analytics implementation, reporting and information system – in stabilisation stage
- Focus on CIP scheme delivery via AF / DAM reporting. Divisional Financial Recovery Plans submitted and being progressed, with enhanced Cost Controls agreed. Internal Trust governance in place, with accountability framework / oversight reporting and tracking. Additional specific executive meetings held, acknowledging concurrent material developments progressing such as EpicEPR
- EpicEPR benefit realisation group in place, and benefit plan for H2 25/26 and onwards
- SNEE system sustainability review follow up as part of Joint Productivity Board

- Reporting of Q2 progress compared to business plan objectives – to occur via DAM cycle. This ensuring reference to the Trust Strategy, whilst looking to align Quality, Activity / performance, Workforce, and Finance
- National Oversight Framework Q2 metric publication expected at the end of November (tbc)

- Medium Term Financial Plan continually under review for refresh. NHSE delivering change together 26/27 to 28/29 published 24th October. This confirming organisational requirement to submit 3-year numerical plans covering workforce, finance and performance trajectories, as well as Board assurance statements 'before Christmas' and then final plans (covering 5 years and including the narrative plans) to be submitted in early February. Exact dates tbc
- 2026/27 Trust internal and external planning processes underway and to be accelerated in Q3 for all four domains of; Service Delivery, Quality, Workforce & OD, and Finance, Capital & Charity. Whilst a priority, this process mindful and acknowledging concurrent Trust wide work streams and requirements
- Related Financial Board Assurance Frameworks reviewed and updated as appropriate

Scheme name:	Workforce
SRO / Support	Kate Read – Director of People & OD / Sam Thorne
Period ending	30 September 2025

Intended improvement to be delivered by scheme

- **Vacancies –** To reduce vacancy rate to below 3.5%. Time to hire parameters have been amended nationally and is now reported from advert live to employment checks complete based on a 3 month rolling basis. Average for model hospital comparator Trusts is 54 days. The Time to Hire for month 6 based on the new parameters is 48 days. [ave. 6 days below model hospital comparator Trusts]. Dedicated recruitment campaigns for hard to fill roles, increased apprenticeships, increase talent pool will support the maintenance of low vacancy rate and time to hire. Continuing improved applicant communications and review of pre-employment processes will also assist with maintaining time to hire.
- **Sickness Absence –** To reduce absence rate to under 4%. Continued focus on bitesize training sessions to support managers dealing with short and long term sickness absence. Ongoing sickness review groups held on a monthly basis to focus on staff who have been absent over 3 months which includes complex cases. Absence Policy has been reviewed and strengthened to provide a more robust clearer framework for managing short term and long term absence.
- **Leadership Development** – paused until February 2026.

Measures (from EMC reporting)	Baseline	In month position	Year-end target
5. Vacancy Rate	3%	3.6%	<3.5%
6. Sickness Rate	4.23%	4.57%	<4%
7. Attended Leadership Development	53.26%	61.05%	70%

Key points from this reporting period:

- **Vacancies**
  - Vacancy rate has marginally decreased this quarter to 3.6% (September 2025) from 4.8% (May 2025). We have 519.8 WTE vacancies across the Trust, with 357 WTE successful candidates in the pipeline.

Staff Group	Vac WTE	Pipeline	Remaining
A&C	105.2	28	77.2
N&M	115.9	200	-84.1
Support to nursing	123.6	56	67.6
AHP	69.5	27	42.5
Support to AHP	17.4	7	10.4
Healthcare Scientist	16.2	12	4.2

Support to clinical	43.8	14	29.8
Medical & Dental	28.2	13	15.2

- Consultant vacancies are currently 28.2 WTE. 13 consultants are going through on-boarding with recent appointments to Obstetrics & Gynaecology, Anaesthetics, Gastroenterology & Breast Surgery.

- AAC's to be set up for Obstetrics & Gynaecology, Urology, Breast Surgery & Radiology.

- Dedicated recruitment campaigns for hard to fill roles, including use of social media campaign; and highly targeted advertising (e.g. Royal College of Pathologist of Australasia). This work is augmented by some agreed incentives as well as increased apprenticeships, increase talent pool will support the maintenance of low vacancy rate and time to hire.

- Time to hire parameters have been amended nationally and is now reported from advert live to employment checks complete based on a 3 month rolling basis. The Time to Hire for month 6 based on the new parameters is 48 days. [ave. 6 days below model hospital comparator Trusts].

- Establishment increased by 150.9 WTE in quarter to 11,684 WTE with a headcount of 11,261.8 WTE (11,533.1wte establishment, headcount 11,006.8wte in May).

- The Trust continues to have significantly more starters than leavers overall and is 32.73wte ahead of plan in respect of our workforce trajectory.

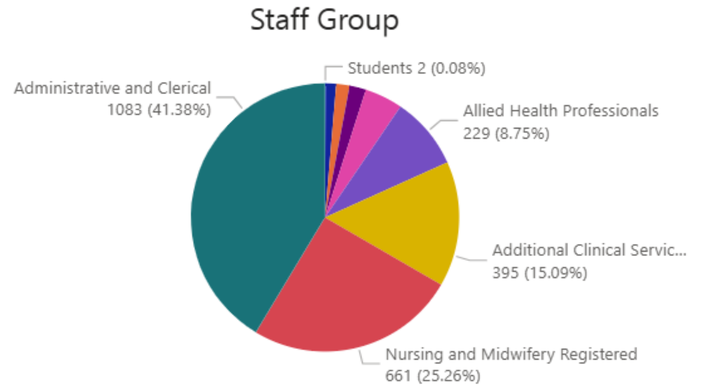
- Voluntary turnover (rolling 12 months) decreased this quarter to 5.45% (September 2025) from 5.77% (May 2025). The Retention team are continuing to raise the profile of flexible working and its economic value in improving work life balance and retaining staff. Triangulation of staff survey results and retention data/trends are shared with HRBPs to support with divisional planning and make improvements.

Division	Leavers	FTE	Avg LoS (Yrs)	12 Mth Leavers	12 Mth Leavers (Vol)	Avg . 12 Month SIP	Turnover %	Vol. Turnover %	12mth Movers
Estates & Facilities	1	1.00	32.50	572	30	450	127.11%	6.67%	29
Cancer and Diagnostics	11	9.16	10.16	165	119	1817	9.08%	6.55%	138
Corporate Services	16	13.59	4.67	119	80	1297	9.18%	6.17%	107
Medicine & Community IES	15	12.58	5.07	192	129	2156	8.91%	5.98%	235
Medicine & Community NEE	11	8.09	4.22	146	113	2085	7.00%	5.42%	267
Faculty of Education	3	2.80	5.19	27	16	306	8.82%	5.23%	81
Women's and Children's Service	11	8.50	3.67	88	62	1282	6.86%	4.84%	294
MSK and Specialist Surgery	12	8.14	7.13	87	53	1186	7.34%	4.47%	132
Surgery, Gastro & Anaesthetics	7	5.01	9.43	98	69	1736	5.65%	3.97%	221
Non Divisional				7		4	175.00%		
Total	**87**	**68.87**	**6.31**	**1500**	**671**	**12317**	**12.18%**	**5.45%**	**1504**

Leaving Reason	Leavers	FTE
Resignation - Voluntary	52	42.85
Retirement	14	9.73
	11	8.95
Dismissal	5	3.76
Retirement - Voluntary	3	1.58
End of Fixed Term	2	2.00
Death in Service		
Employee Transfer		
Not worked		
Pregnancy		
Redundancy		
Total	**87**	**68.87**

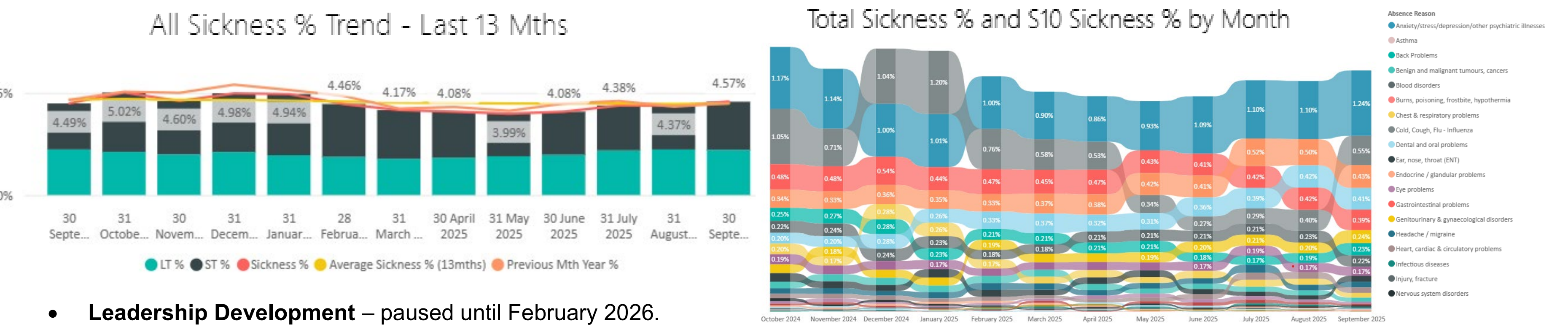
- **National Staff Survey 2025 –** The survey launched on 22 September, and the fieldwork period remains open until 28 November. This year 78% of surveys have been issued as electronic copies. As a thank you for taking the time to complete a survey staff will be issued with a hot drink voucher. As of 17 October, the response rate stood at 21.1%.

Division	Completed	Total	Response Rate
Cancer and Diagnostics	206	1819	11.3%
Corporate Services	782	1830	42.7%
Medicine & Community IES	403	2180	18.5%
Medicine & Community NEE	461	2171	21.2%
Surgical Services	554	3134	17.7%
Women's and Children's Service	211	1297	16.3%
Total	**2617**	**12431**	**21.1%**



- **Sickness Absence**

- Sickness absence remains just above target and has increased compared to the previous quarter from 3.99% (May 2025) to 4.57% (September 2025). This is likely to the increase in anxiety, stress and depression absence during the quarter which has increased to 1.24% (September 2025) from 0.93% (May 2025) of the workforce. This cohort is offered support from the Wellbeing Hub. Cold, Cough, Flu – Influenza has also seen an increase this quarter from 0.34% (May 2025) to 0.40% (September 2025).
- Opening sessions are continuing for Managers Wellbeing training.
- The ER, Wellbeing and O/H teams are continuing to support divisions with sickness absence.
- Ongoing psychological support for staff and consultation for managers.
- Launch of NHS Health checks at Colchester via Essex Provide and Suffolk GP Federation for Ipswich is available. We are also exploring use of mobile machines that do a 5 minute health check at Colchester.
- From the Staff Survey we have identified areas with burn out rates and are working with HRBP's to look at support options for these areas.
- The Wellbeing team created a safe space for staff to have a break during the go-live for Epic throughout October.
- Bite size training sessions focussed on sickness absence are continuing and the sickness review group continues to meet on a monthly basis and is making good progress with a focus on staff who have been absent over 3 months as well as complex cases.
- The Menopause Information service is continuing and training for managers is available.
- Work around support for staff experiencing violence and aggression in the work place is also underway, including submitting a bid to the NHS charity Together and NHS England joint grant for TRiM, which was resubmitted in October due to unsuccessful submission in June.
- The ESNEFT Carers Network has launched, and a creation of a dedicated intranet page is being planned and a Carers support plan.



- **Leadership Development** – paused until February 2026.

Scheme name:	**Logistics**
SRO / Support	**Michael Fuller**
Period ending	**Q2 2025/26**

Intended improvement to be delivered by scheme

- **ALLCAS (Ipswich) reduction**: With the transition to Epic E-referral services transferred on 30.9.25, no further ALLCAS referrals will be received.
- **Workplace Management Solution**: Project on space optimisation has transferred to Estates and Facilities, however, the room booking element remains with Logistics.
- **Synertec**: Transition our letter communication to patients from in-house postage & franking to Synertec resulting in a reduction in costs of postage and franking across the Trust.

Measures (from EMC reporting)	Baseline	End quarter position	Year-end target
8. Progress towards elimination of "ghost bookings". Target = zero ghost bookings by 31 March 2024.	17,042	0	0
9. Percentage utilisation of monitored Trust space.	Data no longer being collated by Logistics for space optimisation but room booking element of project continues.		
10. Synertec and Inhouse Franking – reduction in postage costs.	Cost saving projections continue to indicate a consistent reduction in internal postage costs across the Trust as a result of the initiative to remove the red 1st class post bags from various Colchester locations.		

Key points from this reporting period:

ALLCAS reduction:-

- With the transition to Epic – all services transferred and no further ALLCAS referrals will be received.

Workplace Management Solution:-

- **Current sensor stock** –Remaining stock returned on the 11th September.
- **Programming of Sensors and Placement** – Estates have now taken over this part of the project. The sensors that we currently have in place around the Trust could be redeployed and used to monitor areas of interest to Estates. The Estates Team have further training scheduled with FMSystems to fully utilise the assets

- **Current Project Plan** – Phase 3 has yet to be implemented. This involved monitoring rooms in outpatients and further community sites. Due to previous programme support. Hopefully, this will be achieved now that Estates have taken over this part of the project.
- **FMSystems Contract** - the current FMsystems contract for room booking will cease on the 31st December 2025 and our intention is not to renew the contract and replace with an in-house solution, developed by the Trust's Data Automation and Integration Team. It is anticipated that this solution will be developed in two phases, initially to incorporate the outpatient generic clinic areas, which has been achieved. The next phase is to develop a room and hot desk booking platform across the Trust.

Synertec:-

- Transitioning our letter communication to patients from in-house postage & franking to Synertec is ongoing and wherever possible utilise Epic for sending letters. We will be able to report on the impact that this is having at the next quarter report.
- The full benefits realisation of Epic's MyChart is already starting to see a benefit with the number of patients signed up and letters going via this route, rather than posting letters to patients, therefore representing a saving to the Trust.
- Regular Contract Review meetings continue to take place and are extremely constructive in terms of managing expectations of delivering the postal service, which includes regular monitoring of contractual KPIs.
- Further onboarding work with specialities will continue post go-live.

In-House Franking

- Initial reporting has shown a decrease in in-house franked post due to Epic go live. The next quarter report we will be able to demonstrate the fuller impact of this.
- In-house franking is under review in terms of onboarding to Synertec to make use of the Synertec 20% discount across all postal classes.
- The red 1st class post bags have been removed from all locations on the Colchester site, including Clacton, Harwich, and Kennedy House.
- A SOP has been written to describe a new process for post to be sent 2nd class by default with a robust authorisation procedure for exemptions (e.g. cancer 2-week wait patients).
- We have seen a reduction in internal postage costs across the Trust as a result of this initiative.
- We will be reviewing our current franking machine equipment which is more appropriate for the new volume throughput that we are seeing.

Scheme name:	**Community services - IES**		
SRO / Support	**John Tobin / Rebecca Walker & John Mallett**		
Period ending	**30 September 2025**		

Intended improvement to be delivered by scheme

- Provide responsive support to patients in a timely fashion, allowing them to receive care in their own home, promoting admission avoidance.
- Ensuring that patients receive preventative, enabling, and holistic care, to reduce demands on services due to avoidable admissions and future system demand.
- Ensuring that patients at community hospitals receive reablement care which maximises their opportunity to return home where able.

Measures (from EMC reporting)	**Baseline**	**End quarter position**	**Year-end target**
11. % utilisation rates for Virtual Ward	Q4 23/24 Frailty = 73.6% Respiratory = 76.24%	Q2 25/26 Frailty = 87.2% Respiratory = 37.6%	92%
12. Virtual Ward Length of Stay	Frailty = 6.73 days Respiratory = 3.63 days	Frailty = 4.4 days Respiratory = 6.4 days	
13. UCRS - % of calls receiving a 2-hour response	70%	78.1%	70%
14. % acceptance rates for UCRS (CLERIC)	485/604 = 80%	836/977 = 85.6%	70%

Key points from this reporting period:

MAC-IES continues to prioritise care closer to home, with a sustained focus on admission avoidance, timely response, and maximising community capacity while managing cost. Key developments in Q2 include:

- **Frailty Virtual Ward (VW):** Average length of stay (ALOS) reduced further in Q2, improving throughput. All CLERIC referrals requiring ongoing clinical input are now admitted to the Frailty VW within REACT, ensuring continuity of care and optimal use of capacity. The ward admitted 8 fewer patients than in Q1, but 91 more than in Q2 2024. Despite this increase, the VW did not meet the 92% occupancy target due to the significantly reduced ALOS. However, September shows 95% utilisation with July 25 achieving 89% utilisation above the target. This demonstrates the demand, improved productivity and effective utilisation of available capacity and virtual ward for admission prevention and step-down. Relatively low numbers/scale also causes fluctuation in the % utilisation metric, but it remains consistently high.

  Productivity gains due to the reduced average length of stay and improved utilisation vs Q2 24/25 resulted in reduced cost per VW bed day (£102.9 vs £136.3), additional 83 avoided admissions due to high acuity of patients seen on Frailty VW (when accounted for 7 and 30 day readmissions) with approximate £164,962.5 cost avoided based on the below figures (7.95 avg. LoS on Older People's Services wards at Ipswich hospital and approx. £250 cost per bed day at Ipswich Hospital):

	Q2 24/25	Q2 25/26	Difference
Discharges	90	187	↑ 97
Avg. LoS (days)	6.9	4.4	↓ 2.5
Bed Days	621	822.8	↑ 201.8
Readmissions *(7 & 30 days)*	15	34	↑19
Total avoided admissions	75	153	↑ 83
Cost per bed day **@ £338,870 / 4** (per quarter) running cost budget	£136.4	£102.9	**+£33.5** gain per bed day

- **Respiratory Virtual Ward (VW):** Admissions fell by 14 compared to Q1, and by 26 compared to Q2 2024, reflecting the seasonal decline in respiratory illness. This contributed to a reduction in occupancy levels.
- **REACT Rapid Optimisation Pilot:** Operational changes, including vehicle tracking via WebFleet, enabled dynamic deployment. During the pilot, the two-hour response rate exceeded 80%, with a notable increase in patients seen within target. After the free trial ended, performance dipped to 75% in September, indicating a positive impact from the technology. CLERIC call acceptance also improved to 85.6%, up from a baseline of 80%.
- **Community Operations and Resilience Team (CORT):** Now operating with a structured daily, weekly, and monthly rhythm, CORT leads escalation management, resource reallocation across East Suffolk, and system-wide communication. Development of near-live data flows is progressing to support a Common Operational Picture (COP). CORT is also leading process automation within the Community Delivery Group (CDG) using Microsoft Power Platform.
- **Technology and Equipment Investment:** A business case has been submitted to self-fund WebFleet and secure capital for additional clinical equipment. These investments are expected to enhance operational effectiveness and contribute to the Cost Improvement Plan (CIP).

- **Community Input to Time to Care:** East Suffolk community teams are actively supporting discharge flow through Time to Care events. A project is underway to explore how Integrated Neighbourhood Teams (INTs) can mobilise statutory and non-statutory community assets to support post-discharge recovery and reduce re-admissions, with a current focus on respiratory and cardiac pathways.

Scheme name:	**NE Essex Community Services (NEECS)**
SRO / Support	**Simba Chandiwana / Tom Booth**
Period ending	**30 September 2025**

Intended improvement to be delivered by scheme:

- Increase support to people to stay healthy without the need of community services, focussing our efforts to tackle health inequalities and increasing resource to the areas that need it most.
- Ensuring that patients receive preventative, enabling and holistic care, to reduce severity of frailty and reduce demands on services due to avoidable admissions.

Measures (from EMC reporting)	Baseline	End quarter position	Year-end target
15. % utilisation rates for Virtual Ward	83% (2023/24)	94.85% (Q2)	92%
16. Virtual Ward Length of Stay	8.1 days (Apr 23)	5.5 days (Q2)	tbc
17. UCRS - % of calls receiving a 2-hour response	55.01% (Apr 23)	89.98% (Q2)	90%
18. % acceptance rates for UCRS (CLERIC)	87% (Apr 23)	89.54% (Q2)	90%

Key points from this reporting period:

The Divisional priority to enhance the Community Offer, such that it supports Future (Left) Shift, providing patients with effective services closer to home (including alternatives to admission and attendance), is gaining pace, including:

- UCRS (Cleric) Acceptance Rate for the quarter increased slightly to 89.98%, against a regional average of 79.64%. The overall number of referrals increased slightly in Q2 to 1,215. The number of patients seen within 2hours has reduced to just below 90%. Discussions with ICB have started regards 26/27 funding which will include maintaining 90% target.
- NEECS Virtual Ward utilisation in Q2 was above target at a total of 98.83%, with July seeing the highest utilisation at 99.3%. There was a LOS reduction of nearly 1 day to from 6.4 days in Q1 to 5.5 days in Q2. Work is underway across the division to agree the most effective future model for virtual wards, with clinical leads prioritising this ahead of winter to stabilise utilisation and sustain capacity.
- In Q3 the focus will be on improving capacity and flow over winter, with the following initiatives being implemented over October and November:
    - **12 Additional Winter Beds** to be opened across Aldham, Fordham, and Stanway wards to increase downstream capacity and support ED flow. This has been facilitated by opening beds on Mistley ward to support T&O capacity.

  - **Frailty resources expansion** within Colchester to enhance early senior review, rapid assessment, and streaming to appropriate pathways.
  - **Acute to Community Pull Model:** The Proactive Neighbourhood Based Care CDG is implementing an acute-to-community pull model that is effectively improving hospital discharge flow and ensuring better continuity of care.
- Following completion of the system diagnostic in Q1, discussions are continuing about the next steps for a neighbourhood model in NEE. Early discussions with Adult Social Care and system partners have proposed that the initial focus should be on establishing two neighbourhood sites in Colchester and Tendring, operating on a co-located, face-to-face model of care. A provisional workforce plan has been developed for each site, recognising that the precise operational model and MDT requirements will need to evolve through trial and refinement.
- Recovery of waiting times: **Podiatry** has seen reduction in long waiters as the Provide Outsource was live for first full month from July. The service also continues to use positive response letters. A quote is pending from Steeper group for orthotist time to target waits in biomechanics patients, which are not covered by Provide. **HOS** over 18 week waits continue to improve with dedicated slots increased whilst COPD is seasonally less activity. Bank and agency is in use but is kept under review by the service lead. Additional staff costs are covered within budget with vacancy and allocated ERF. **PR** service continues to improve waits as part of their QI project. This has included several initiatives. The service still has some fixed term vacancies which we are working to fill. However, without investment long term, when the current non recurrent funds end March 2026 the service will see increased waits. The service currently aims to eliminate all over 18 week waits by end December 2025. **Respiratory Physio** has now recovered with no waiters over 18 weeks in September.

Trust Board of Directors Meeting

Report Summary

Date of meeting: **8 January 2026**	
Title of Document: Sexual Safety Charter Assurance Framework – Self Assessment	
To be presented by: Kate Read, Chief People Officer	**Author:** Clare Harper, HR Business Manager – Staff Experience & Culture
1. Status: **For Approval**	
2. Purpose: To provide assurance that the Trust is compliant with the Sexual Safety Charter Assurance Framework	
Relates to:	
Strategic Objective	Keep people in control of their health Support and develop our staff
Operational performance	The framework aims to ensure a safe environment is provided for our staff to work in and our patients and service users to receive treatment and care.
Quality and equality impact	The Worker Protection (Amendment of Equality Act 2010) Act 2023 creates a duty on employers to take reasonable steps to stop sexual harassment in the workplace from colleagues and third parties.
Legal, Regulatory, Audit	Requirement for all Trusts to sign up to the sexual safety in healthcare organisational charter and implement the Sexual Safety Charter Assurance Framework. Using this framework will support the Board and leaders at ESNEFT to assure themselves against this legal duty.
Finance	Whilst there are no costs associated to the actions stated in this report, there may be potential payouts/costs from any legal cases against the Trust if it was found that preventative steps were not taken to protect staff, patients and service users.
Governance	Annual review of progress reported to the EMC and POD Committee.
NHS policy/public consultation	NHS England » Sexual safety charter assurance framework
Accreditation/Inspection	None currently
Anchor institutions	As a key anchor organisation, the Trust should be leading by example by implementing and promoting preventative steps to protect its staff, patients and service users from any sexual harassment or assault.
ICS/ICB/Alliance	Updates provided to the SNEE EDI Meetings
Board Assurance Framework (BAF) Risk	-
Other	

3. **Summary:**

The Sexual Safety in Healthcare Organisational Charter was developed by NHS England in collaboration with healthcare partners and published in 2023. All NHS trusts and ICBs have signed the charter.

The Sexual Safety Charter Assurance Framework was updated in August 2025 to reflect a new set of actions which aim to safeguard staff and patients against sexual misconduct. All Trusts have been asked to review these new actions and complete a self-assessment.

This report provides the outcome of the self-assessment review and our progress against the NHS England » Sexual safety charter assurance framework including current status for each action, gap analysis and further actions proposed to address the gaps (Appendix 1).

This report has been considered at the Executive Management Committee and at the People and Organisational Development Committee and is recommended to the Board for approval.

4. Recommendations / Actions

The Board is invited to note that the Sexual Safety Charter Assurance Framework gap analysis and proposed actions to take forward were approved at the private Board meeting in December 2025, and to receive this report for information.

SEXUAL SAFETY CHARTER ASSURANCE FRAMEWORK

Background

The Trust signed up to the Sexual Safety in Healthcare Charter in March 2024, which was submitted to the EMC and Board as well as promoted trust wide to raise awareness and proactive actions required to prevent sexual harassment or assault in the workplace.

A key programme of works was then undertaken which included strengthening the Bullying and Harassment Policy with a Sexual Safety Toolkit which provides reporting mechanisms and support available to individuals who experience any unwanted, inappropriate and/or harmful sexual behaviours within the workplace. In addition, Sexual Safety Training sessions were rolled out earlier this year and are held monthly, as well as bespoke sessions for teams upon request, and an inclusion of sexual safety awareness in corporate induction and EDI bitesize training.

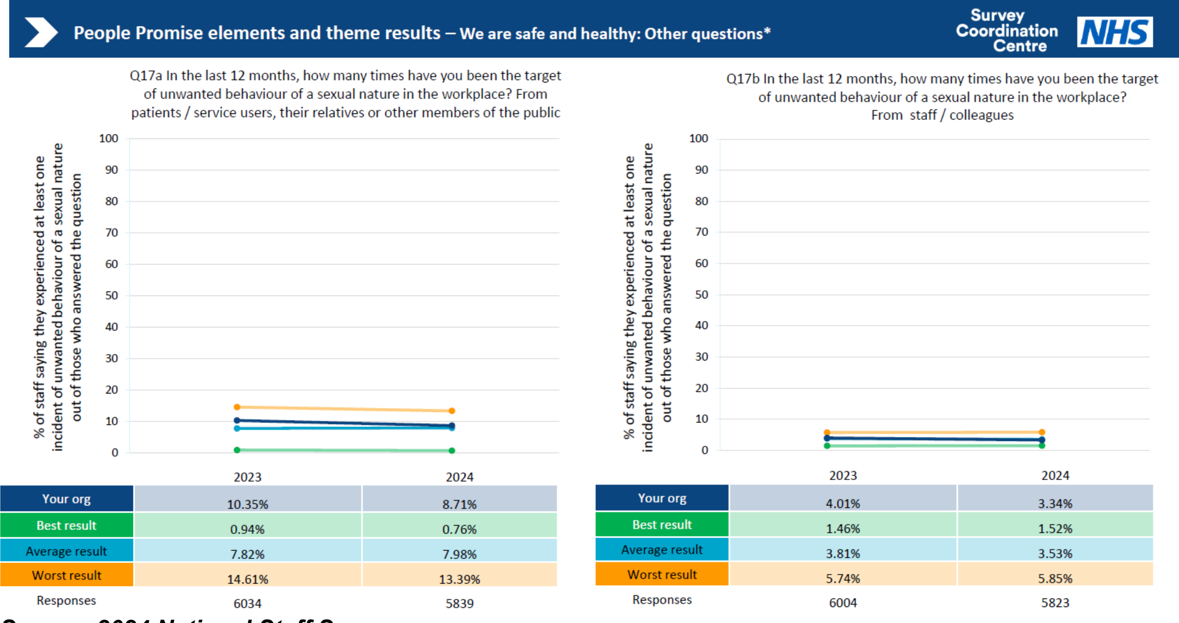
NHSE wrote to all Trusts in August 2025 to advise of an additional 49 actions which have been added to the NHS England » Sexual safety charter assurance framework and the requirement for a self-assessment against these actions to be undertaken, including a gap analysis and any further actions needed to be completed in order to evidence that preventative steps are being taken to safeguard anyone who works or receives care at this Trust.

Prevalence

Over the past year, the prevalence of sexual harassment in the Trust appeared to be relatively low given that only 2 cases were reported in the last year:

- Case 1 – Bullying and sexual harassment proceeded to investigation and letter of behavioural expectations issued
- Case 2 – Sexual harassment - proceeded to investigation and disciplinary hearing and Dismissal

However, when we reviewed the 2024 national staff survey results, the number of responders who answered yes to experiencing at least one incident of unwanted behaviour of a sexual nature from patients was 8.71% (511) and from colleagues this was 3.34% (196):



Source: 2024 National Staff Survey

We also cross referenced this against the number of incidents reported on Datix:

Incidents reported from 1st Nov 24 to 30th Sep 25 with sub category or wording in description of sexual abuse												
	2024		2025									
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total
Patient to staff ??										1		1
Patient to staff physical	1		1			1		7	1	1	1	13
Patient to staff verbal	2	3	3	1		3	1	1		1		15
Patient to staff verbal and physical					1							1
Relative to staff physical	1											1
Staff (security) to patient		1										1
staff to patient physical				3								3
Staff to staff verbal				1								1
Total	4	4	4	5	1	4	1	8	1	3	1	36

Both sets of statistics would indicate a significantly higher number of occurrence than the number of cases reported to ER and is a real concern around behaviours and culture within the organisation. Urgent action needs to be taken to with regard to accountability in addressing these behaviours and creating a safe environment for staff, patients and service users, particularly around reporting incidents.

The Charter Principles and New Actions – Self Assessment

The outcome of the framework self-assessment shows that of the 49 actions recommended:

- 17 were already embedded into trust wide processes or BAU with no gaps identified;
- 31 were fully or partly implemented and the self-assessment identified some gaps in analysis and further work required; and
- 1 outstanding action awaiting national guidance (Action 49)

Appendix 1 provides the 10 principles within the charter and the new recommended actions which underpin each principle, the Trust's current status update, and details of the gaps identified and proposed actions to address these.

Gap Analysis Summary

A summary of the themes of gaps in assurance are shown below:

- Requirement to increase frequency of communications to ensure all managers and staff are fully informed of:
    - the sexual safety charter principles and Trust's obligations to take proactive steps to prevent sexual harassment
    - how to identify sexual harassment/assault
    - how to report an incident and the support available to staff
    - where to seek support
    - promoting Allyship/active bystander principles

- Trust provides in-house Sexual Safety Awareness training however this is not mandatory and uptake has been relatively low. There is an e-Learning training module provided by the NHSE which is being explored for staff to access via OLM – this would enable monitoring of compliance.
  Committee Action: Once implemented, Committee to consider if the e-learning training should be made mandatory for all staff?

- Further assurance needed around triangulation of incident reporting/information sharing between organisations from a patient safety lens and gaining views from senior clinical colleagues for consideration.

- Lack of assurance reporting:

- Sexual misconduct cases are clearly identified as such within regular ER Case reporting to Board;
- Clear response time targets on cases reported to be defined by Employee Relations team;
- Clear guidance and training to be provided relating to escalation thresholds; and
- Establish regular thematic reviews to support learning and continuous improvement.
- Trust wide reporting of feedback from national staff survey and learnings

APPENDIX 1: SEXUAL SAFETY CHARTER ASSURANCE FRAMEWORK

Charter principles 1 to 10: Actions and implementation updates for assurance

Principle 1: we will actively work to eradicate sexual harassment and abuse in the workplace
Principle 2: we will promote a culture that fosters openness and transparency and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours

Outcome:

- sexual misconduct, its prevalence, impact and how to eradicate it is discussed openly and appropriately within the organisation
- the executive board has agreed a suitable governance process to understand prevalence rates, staff experience and the outcomes of cases in their organisation
- data about prevalence, actions taken and learning from cases is shared across the organisation
- reduction in cases (recognising likely to be an initial increase due to increased confidence in reporting)
- reduction in staff saying in annual staff survey they have experienced sexual misconduct in the workplace
- the Board proactively governs and escalates emerging sexual misconduct risks, ensuring accountability, oversight, and early intervention across the organisation
- increased confidence in the organisation at tackling sexual misconduct and improving safety for all staff

Framework Actions	Current Status	Gap Analysis	Actions to address gaps	RAG
1. have clear plans to focus the organisation on prevention and culture change	Trust sign up to Charter in March 2024 with action plan of commitment presented to PODC and EMC in March 2024 who were assured by the plan.	Additional actions added to framework in August 2025 highlighted to respective leads to take forward.	N/A	
2. set clear standards of behaviour in policies and enforce them	Reviewed our B&H policy and created enhanced tool-kits one of which focusses purely on Sexual Harassment: Safe Workplace - Tackling Sexual Harassment Guides and toolkit. This provides clear examples of behaviours such as harassment and assault that will not be tolerated and explains the process for reporting an incident together with how the individual will be supported.	Whilst clear examples of behaviour expectations are included in B&H policy, further work to ensure **all** staff are aware.	Regular reminders in ESNEFT News, EDI Updates and SS posters to be erected across all sites	
3. core training for all staff and specialist training for those who need it	Sexual Safety Training provided in-house by ER team (c. 230 attendance to date) and bespoke sessions for teams available upon request. Monthly sessions promoted in monthly EDI Update SWAY and advertised on SS and EDI intranet pages.	New NHSE Sexual Safety e-learning module not currently implemented.	Working with Education Team to have this added to OLM	
4. communications campaign shared with all staff	Charter principles and Trust's commitment to preventing sexual harassment promoted to all staff via ESNEFT News and new page created on staff intranet: Sexual Safety in Healthcare Charter. Policy updated on intranet, promoted via ESNEFT News and linked within the dedicated Sexual Safety intranet page.	N/A	Regular reminders of charter/behavioural expectations to be communicated to all staff	
5. establish a structured risk management and escalation process for sexual misconduct, including defined risk thresholds for escalation to executive and board levels	All allegations of sexual misconduct are subject to a detailed fact-finding process and, where appropriate, a formal investigation. Each case undergoes risk assessment and ongoing review to identify and manage any safeguarding, workforce, or reputational risks. All cases are reported at the weekly Complex Case MDT and included as high-profile cases on the POD report, which is submitted to the Board on a bi-monthly basis. Clear escalation thresholds are in place to ensure cases with significant risk or impact are appropriately managed and, where necessary, escalated to Executive and Board level for oversight.	Current processes for managing and escalating sexual misconduct cases are robust, but some gaps remain. The timeliness of initial fact-finding can vary. Escalation criteria may not be uniformly understood, and there is limited trend analysis or formal feedback from completed cases.	To address these gaps, the organisation could set clear response time targets, provide guidance and training on escalation thresholds, and establish regular thematic reviews to support learning and continuous improvement.	

6. board-level ownership and accountability for cultural issues, prevention strategies, and oversight	Charter sign up reported to PODC/EMC/Board in 2024 which was approved.	Regular reporting not currently scheduled	Annual and where necessary more regular reporting to PODC proposed (see action above) with support from staff network leads and ER, to identify any cultural issues, prevention strategies.	
7. embed tackling sexual misconduct and protecting the sexual safety of our workforce into all relevant business as usual areas – for example, training, contracts, induction and equality, diversity and inclusion (EDI) improvement plans	B&H Policy, training provision and induction content embedded as BAU	Not currently reporting Sexual Harassment case numbers to determine the level of prevalence.	ER/OD Leads to provide regular reporting of case numbers and work with relevant leads to identify any areas of concern for interventional work	
8. clear signposting to policies and support services, which are easily accessible to all staff	Sexual Safety toolkit easily located within B&H Policy via search mechanism on intranet as well as a dedicated intranet page. B&H Policy and intranet page includes signposting to in-house and external support available.	N/A	N/A	
9. visible, senior leadership	The Charter was shared with the EMC in 2024 and subsequent updates have been included in the monthly EDI update report which was emailed to senior leads.	Further work required to ensure that all senior staff have completed the sexual safety training and are aware of the reporting process, signposting staff to support available.	Comms to be drafted	
10. appoint domestic abuse and sexual violence lead	Safeguarding Adult Leads in place which includes domestic abuse and sexual violence. 3 yearly review of the following policies: • Domestic Abuse Policy reviewed in 2025. • Domestic Abuse (Employees) Policy and Toolkit completed in Sep 2025 and will be promoted with policy at the Sexual Safety training sessions. • Care and Treatment of Adults and Children Who Have Been Victims of Sexual Assault Policy. Review undertaken in 2024 - Next due 2027.	Trust has considered whether a specific lead for domestic abuse and sexual violence is required. Given domestic abuse and sexual violence is included in the Safeguarding Adults Lead roles, who meet weekly with ER, Deputy Chief Medical Officer and Deputy Chief Nurse, the Trust does not feel an additional lead role is required at this time.	Review situation in 1 year.	

Principle 3: we will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate. For example, women, black, ethnic minority, disabled and LGBTQ+ groups

Outcome

- a clear understanding of the prevalence of sexual misconduct within different workforce groups
- support is tailored, appropriate and effective in tackling intersectional experience of sexual misconduct

Framework Actions	Current Status	Gap Analysis	Actions to address gaps	RAG
11. complete equality impact assessment of sexual safety and misconduct work (including policies)	EIA completed on revised Bullying and Harassment policy.	Further EIA planned on effectiveness of in-house training, reporting process and wellbeing support.	When reporting of case numbers commences, the EDI lead will monitor the demographics and work with the OD/ER/FTSU leads to determine whether additional support or reporting mechanisms plus any targeted interventional work is required	
12. engage through staff networks, EDI officials and experts by	Sexual safety has been promoted to all network members including location of the policy and toolkit, sexual safety training sessions,	Frequency of engagement to increase.	Regular reminders to all staff of behavioural expectations and how to	

experience to ensure all cohorts of our staff are represented appropriately and robustly as part of this work	process for reporting an incident and what support is available. All relevant leads within the Speaking Up wheel are aware of the process to follow should a member of staff report an incident. They have also been signposted to attend the in-house sexual safety training.		report incidents of sexual harassment or assault, training and wellbeing support available.	
13. use data from NHS staff surveys, cut by EDI metrics, to understand staff experience and inform iterative development of key products	The WRES/WDES/Speaking Up questions from the NSS were reviewed and findings shared with network/senior/Executive leads but the Sexual Harassment question was not included.	Requirement to include the Sexual Harassment questions in the EDI metrics going forward.	Added to the 2025 NSS results work plan.	
14. tailor responses to ensure they are appropriate for groups that experience sexual misconduct at a disproportionate rate	As per Q13 above, this question was not included in the review and sharing of data analysis.	Review and identify any cohorts that disproportionately experience sexual misconduct.	Work with respective network leads to provide targeted support work for any specific cohorts identified	

Principle 4: we will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours

Outcome

- staff have knowledge of and access to a range of support tools and mechanisms that are iteratively reviewed and based on a growing evidence base
- specific and specialist support for those who experience sexual misconduct is embedded into organisational staff support structures

Framework Actions	Current Status	Gap Analysis	Actions to address gaps	RAG
15. confidential information and resources are available on the intranet and staff are signposted to them regularly	Dedicated intranet page including link to Policy, toolkit and training sessions.	Not regularly promoted	Regular promotion of resources to be scheduled	
16. staff support structures, like the Employee Assistance Programme, have guidance on sexual misconduct processes and pathways to specialist support	We have both in-house psychological services who provide 1:1 psychological support as well as out of hours counselling provided by our Employee Assistance Programme. Our toolkit outlines the processes and pathways to specialist support. This is also listed on Wellbeing Hub intranet page.	-	-	
17. the support offer is monitored to inform continuous improvement and ensure appropriateness. Offsite support can be offered	We use outcome measures and feedback forms to evaluate the individual psychological support we provide. Staff can be seen off site or can access counselling via our EAP completely externally to the organisation.	Possibly some cases are not being recorded as sexual misconduct	Review recording of incidents presenting to the Wellbeing Team.	
18. relevant policies are evidence based and informed by data and subject matter expertise	Due to the low cases reported our policy was drafted based on best practices and from other Trusts. However the in-house training we provide highlights our staff survey results and how the Trust dealt with the cases.	Due to low number of cases it has not been possible to review the policy via evidence based information.	Review in 1 year.	

Principle 5: we will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour				
Outcome • staff are clear about the standards of behaviour required in the organisation • the organisation adheres to policies and applies them consistently • staff feel empowered to take action should they witness or experience unwanted and/or harmful sexual behaviour				
Framework Actions	**Current Status**	**Gap Analysis**	**Actions to address gaps**	**RAG**
19. sexual misconduct policy is clear on standards of behaviour, the role of those who witness inappropriate behaviour, and any interactions with other relevant policies	Clear examples of harassment and assault are included in the B&H policy together with expectations in terms of behaviour and conduct.	N/A	-	
20. roll out communications campaign to all staff	Completed in March 2024 and sexual safety training sessions promoted in EDI monthly update SWAY.	No specific comms relating to sexual safety since 2024.	Consider quarterly updates in ESNEFT News with number of cases for transparency and prevalence	
21. sexual safety and misconduct are comprehensively addressed in induction and all staff training	Mentioned in Corporate Induction under EDI slot and sexual safety training sessions available for all staff to attend	N/A	-	

Principle 6: we will ensure appropriate, specific, clear policies are in place. They will include appropriate and timely action against alleged perpetrators				
Outcome • action is always taken against perpetrators, and in line with policies • clear, evidence-based and trauma-informed processes are documented in policies • all staff are clear on roles and responsibilities • line managers are clear on their responsibility to escalate potential sexual misconduct issues and the processes for doing so • HR and people professionals are clear on the necessary steps required to take timely action against alleged perpetrators and this is part of their induction and ongoing training • HR and people professionals are clear about when information needs to be shared with future employers relating to sexual misconduct complaints and investigations				
Framework Actions	**Current Status**	**Gap Analysis**	**Actions to address gaps**	**RAG**
22. publish a policy on sexual misconduct in line with the NHS national policy framework	See Framework Action 2 above. Policy will be reviewed against NHS national policy framework as part of the 3 yearly review process.	N/A	-	
23. sexual misconduct policy is supported by flowchart and easy-read version and is easily accessible to all staff	6 page toolkit provides examples of misconduct and process to follow when witnessing or experiencing an incident of sexual harassment.	Currently no flow chart	Consider this within next review process.	
24. conduct/competence policies should take account of complexities in cases where it may initially be unclear whether behaviours and actions should be considered as conduct or capability	These type of concerns are treated as a conduct matter, not capability. Any concerns would go via a fact finding process first, this is then triaged in line with the Trust Just & Learning culture by senior ER members. If it is found that policies have been breached we would then investigate and take actions in line with the Trust Disciplinary Policy. There may be odd occasions where a training element is	-	-	

	found and in which case we would deal with it informally, but normally they are all investigated under conduct as per Disciplinary Policy.			
25. policies set out roles and responsibilities of people in the organisation, for example, HR and people professionals, safeguarding teams, freedom to speak up guardians, mental health first aiders, leadership, line managers	The policy sits within the framework of the Disciplinary Policy which clearly highlights roles and responsibilities and signposts to wellbeing support.	-	-	
26. provide tools and support for line managers to understand their responsibilities and how to follow escalation processes consistently	Specific section within the policy and toolkit relating to line managers responsibilities and escalation process.	-	-	
27. policies are clear about action that needs to be taken against perpetrators, by whom, when and how	This is clearly stated within the disciplinary policy Sexual Harassment toolkit	-	-	
28. policies are clear about investigation processes and standards	This is clearly stated within the disciplinary policy Sexual Harassment toolkit	-	-	
29. policies are clear about the circumstances in which complaints and investigations about staff should be shared with future employers and police	Section 2.2 of the policy discusses that sexual assault is a crime but there is no further guidance on when/if a case will be referred to the Police. However the Safeguarding Adults Policy state that: • *If it is suspected a crime has been committed, the on-call Manager must be informed and a decision taken to contact the police.* • *The Care Act 2014 requires organisations to make safeguarding personal. ESNEFT will work together with other agencies within Suffolk & Essex such as Safeguarding Adult Boards for Suffolk & Essex, Social Services and the Police to achieve our aim. No single agency can act in isolation to ensure the welfare and protection of adults at risk.*	Policy does not currently state that details of complaints or investigations will be shared with Police.	To address this we will develop clear guidance on the escalation thresholds i.e. when a case should be escalated to the Police.	

Principle 7: we will ensure appropriate, specific, clear training is in place

Outcome

- training on sexual misconduct and sexual safety is accessible to all staff
- specialist training is accessible to those who need it
- staff knowledge and awareness of issues relating to sexual misconduct increases

Framework Actions	Current Status	Gap Analysis	Actions to address gaps	RAG
30. training is available for all staff to recognise and report sexual misconduct and to understand	Sexual Safety Training provided once per month for any staff to attend. Within the training content is a section on how to report an incident and practical things a witness can do if they witness sexual	-	-	

Framework Actions	Current Status	Gap Analysis	Actions to address gaps	RAG
how to support colleagues (victims and witnesses)	harassment and want to support. In addition, the ER team provide bespoke sessions for Teams upon request.			
31. specialist training is available for those who need it to ensure effective support, reporting and investigations (for case managers, investigators and responsible officers)	There is no specialist training as such other than the normal support for Investigating officers and from the case handler.	This is a gap and a measure that could be put in place to address.	Explore use of trained investigators who are skilled in; trauma informed interviewing, bias awareness, sexual harassment, sensitivity, etc.	
32 training is developed for managers to support culture change	The in-house training sessions highlight that some protected characteristics can prevent some staff to report to seek support when an incident occurs. It provides tips that supports managers on how to handle situations and provide support.	The number of responders to the National Staff Survey who stated they had experienced sexual harassment in the workplace compared to the number who reported a case to understand the culture.	Review to be undertaken	
33. all staff have undertaken national e-learning on sexual misconduct	Not yet actioned	Not currently promoted to staff	Working with Training Team to have this added to OLM. Roll out a.s.a.p.	

Principle 8: we will ensure appropriate reporting mechanisms are in place

Outcome

- staff can report an instance of alleged sexual misconduct through multiple routes, including anonymously
- staff have confidence their disclosure will be treated confidentially (and understand where it might need to be shared for safeguarding reasons) and escalated appropriately
- disproportionate and inappropriate use of patient records is picked up earlier

Framework Actions	Current Status	Gap Analysis	Actions to address gaps	RAG
34. policy outlines sexual misconduct reporting mechanisms, including anonymous reporting	Reporting mechanisms are clearly defined in the policy. Any concern can be raised confidentially or anonymously with the FTSU Guardian and it remains a fundamental principle of the process and is referred to in our policy. However, issues of confidentiality invariably limit the ability to follow anonymous reporting through	-	-	
35. reporting mechanisms are widely communicated to ensure awareness	Originally promoted in ESNEFT News in March 2024 and Sexual Safety Training promoted in the monthly EDI update report included in the ESNEFT Comms.	Requirement for specific regular promotion of sexual safety and reporting mechanisms/policies etc.	Action 20 above. Consider quarterly updates in ESNEFT News with number of cases for transparency and prevalence	
36. Freedom to Speak Up infrastructure and training for guardians updated to include sexual misconduct	This is included within FTSU Training	-	-	
37. there is a clear safeguarding process for identifying unusual patterns of patient record access (where an electronic patient record is in place)	The IG team run weekly audits on Classified Records in Epic for any unusual access. They can also audit for any queries from patients who may be concerned that their records have been inappropriately accessed. If inappropriate access is found this is dealt with under the Trust's Disciplinary Policy which starts with a fact finding meeting and if there has been unauthorised access we take formal action as per the policy due to this being an IG breach.	-	-	

Principle 9: we will take all reports of sexual misconduct seriously, and appropriate and timely action will be taken in all cases				
Outcome • sexual misconduct is identified in a timely way, all reports are actioned following organisational policies, and incidents are escalated appropriately • staff have increased confidence to report concerns • complex cases have Board and executive scrutiny, aiding the identification of systemic and organisation-wide issues				
Framework Actions	**Current Status**	**Gap Analysis**	**Actions to address gaps**	**RAG**
38. clear actions and action-owners set out in the sexual misconduct policy	See status of Action 5 above. Current processes for managing and escalating sexual misconduct cases are defined within the policy and toolkit and are considered robust.	Some gaps remain regarding the timeliness of initial fact-finding which can vary and escalation criteria may not be uniformly understood for those not routinely experienced in such cases.	To address these gaps, the organisation could set clear response time targets, provide guidance and training on escalation thresholds, and establish regular thematic reviews to support learning and continuous improvement.	
39. timeframes for action set out in sexual misconduct policy	As per gap analysis in question 37, these are not defined within the policy as fact finding timeframes can differ depending on the complexity of the case and people/agencies involved.	As per Q37 above	As per Q37 above	
40. ensure access to external subject matter experts	We engage with our Safeguarding leads who will be our contact with the police however the majority of cases will only have police involvement if the complainant wishes to report the alleged Sexual Misconduct – we obtain assistance and guidance from our in-house Legal team where required and they also act as a link with the police where necessary.	-	-	
41. executive/board reporting, including on relevant data and learning from surveys, reports and investigations of sexual misconduct, FTSU, complaints	SM cases are currently included in Bullying & Harassment or Disciplinary data which is reported to Board monthly. Individual cases reported to FTSU Guardian are not taken to Board but would be discussed on a limited basis with key executives.	Staff cases, surveys, investigations or complaints of sexual misconduct are not clearly identified within regular reporting and nor are the learnings from surveys.	ER team to work with OD lead, FTSU, Complaints team to commence reporting of specific case numbers and learnings from investigations/surveys/ complaints a.s.a.p.	
42. establish a governance and risk oversight process for serious and complex sexual misconduct cases, with defined escalation thresholds for executive and Board review	Patients: Are discussed at Staff Serious Allegation (SSA) panel, once per month. Panel consists of: Safeguarding Leads, Medical Directors, Head HR, DCN (Chair). Presentation of SSA to Board annually. Some staff cases are also discussed at SSA if they meet the threshold. Medical Staff: Serious and complex sexual misconduct cases are escalated to the HR Matters decision-making group for their consideration and decision on next steps. There are close working links with safeguarding colleagues, and the Responsible Officer (Martin Mansfield) attends the monthly SSA meetings. For resident doctors we also work closely with the faculty of Medical Education and HEE, including Medical schools (for FY1 doctors). The MHPS (Maintaining High Professional Standards) policy provides the framework for managing concerns about doctors and dentists in conjunction with local disciplinary and bullying and harassment policies and toolkits The membership of HR Matters includes Deputy Chief Medical Officer/s, Responsible Officer, Deputy Responsible Officer and Director of People and Organisational Development, Associate	-	-	

	Director of Medical Workforce and the Medical ER team which ensures immediate executive level oversight. The reporting structure includes bi-monthly reporting of all formal MHPS cases via the People and Organisational Development Committee (POD), where the Designated Board Members have oversight. Non-Medical Staff cases: are managed by the ER team and a Suspension/Risk matrix completed where Suspension/Restrictions are identified as necessary taken to weekly Complex Case MDT for agreement as to appropriate next steps. The membership of this group includes Director of People and organisational Development, Associate Director of ER and Organisational change and Heads of Employee Relations.			
43. there are timely routes to share with HR concerns raised through professional and clinical avenues that could have a sexual component plus data from FTSU and sexual misconduct reporting is triangulated to support	See Action 40 above re Staff on Patients allegations. FTSU - This would normally be reported through the Workforce ODM depending on confidentiality issues.	-	-	

Principle 10: we will transparently capture and share data on the prevalence of sexual misconduct and staff experience of sexual misconduct

Outcome

- executive board understands prevalence rates, staff experience and the outcomes of cases in their organisation, including impacts and any differences between different groups of staff and required actions
- staff have access to data on sexual misconduct prevalence in their organisation

Framework Actions	Current Status	Gap Analysis	Actions to address gaps	RAG
44. staff survey results are published and shared, with actions taken/to be taken to address issues and risks raised in the results	The National Staff Survey results are shared with Board and senior leaders and are available on the national survey website. HRBPs share the results with their respective divisional MDTs.	To date we have not pulled through the specific questions relating to sexual harassment to Board. However each HRBP reviews the results for their division and raises any anomalies at their respective DMT.	We will ensure this is added to the annual reporting of EDI questions (WRES/WDES/Speaking Up) going forward.	
45. executive/board reporting on cases, including relevant data and learning	The ER Case Tracker is still work in progress and does not enable confidence in data accuracy in terms of specific categories.	See Q5 above. Not currently reporting specific SM cases to Board.	As per Q5 above. In addition we will look into transparency in our reporting by stating the number of cases on the Sexual Safety Charter page on the Staff intranet.	

Additional considerations….

Actions	Current Status	Gap Analysis	Actions to address gaps	RAG
46. Review staff policies and processes to ensure appropriate sharing of concerns about healthcare professionals with future employers and host organisations. (see next page….	All DBS checks are reviewed by Head of Recruitment and Associate Director – Organisational Change & ER and a decision made based on when the incident occurred, what are circumstances around the incident, what role they have been offered and if there are any further convictions/cautions/safety concerns.			

• this should include investigation findings, relevant DBS information, and reflect cumulative patterns of behaviour • Sexual misconduct should be considered through a patient safety lens as well as through HR processes	As mentioned in Action 42, there is a robust process in place within the Safeguarding policy, specifically the requirement to liaise with LADO and POT when allegations are made regarding staff to support multi-agency risk review. Within our SSA process we have introduced a risk assessment process to consider risks to patients, visitors, staff and the organisation.	Further assurance needed around triangulation of incident reporting/information sharing between organisations from a patient safety lens.	Multidisciplinary discussion to be arranged.	
47. Ensure that ESR (where an organisation uses this to record employee relations issues) is up to date with ongoing and complete investigations into staff: • inter-authority transfers (IATs) may reveal where there are ongoing investigations, and should be built into onboarding processes	IAT do not hold any information relating to investigations.	Potential risk if not informed by individual of investigations that are ongoing.	Explore process to provide assurance	
48. Review chaperoning policies to ensure they empower chaperones and lead to the creation of auditable records	The Trust's Chaperone policy provides clear definition of the role and the process to be followed when a patient is chaperoned including documenting within patient's notes (see Appendix 3)	Whilst the Trust's Chaperone Policy is widely known across the Trust, for further assurance it is recommended that the policy is circulated within future communications planned to highlight the patient element of sexual safety.	Circulate Chaperone Policy with Charter Comms	
49. Sharing of information that could protect patients or staff.	Process to be agreed once new guidance is provided by NHSE c. end of 2025 clarifying responsibilities on information sharing v data protection rules.	tbc	tbc	

Trust Board of Directors Meeting

Report Summary

Date of meeting: 4 December 2025	
Title of Document: UNISON Anti-Racism Charter	
To be presented by: Kate Read, Chief People Officer	**Author:** Clare Harper, HR Business Manager – Staff Experience & Culture
1. Status: **For Approval**	
2. Purpose: To review and agree to the adoption of the charter.	
Relates to:	
Strategic Objective	Support and develop our staff
Operational performance	The charter aims to ensure a safe and equitable environment is provided for our diverse staff to work in and patients and service users to receive treatment and care.
Quality and equality impact	The charter will provide a check and balance that our processes, policies and practices are fair and equitable to all cohorts and that any acts of racism or discriminatory behaviours are dealt with in line with our conduct policies.
Legal, Regulatory, Audit	Sign up to this charter will provide a further framework that will support the Trust's aim to be an anti-racist organisation.
Finance	No costs associated to the sign up of this charter
Governance	Annual review of progress of actions within the charter reported to POD Committee.
NHS policy/public consultation	
Accreditation/Inspection	N/A
Anchor institutions	As a key anchor organisation, the Trust should be leading by example by implementing and promoting preventative steps to protect its staff, patients and service users from any acts of racism or race disparities
ICS/ICB/Alliance	-
Board Assurance Framework (BAF) Risk	-
Other	-

3. **Summary:**

The Trust works closely with UNISON, whose main role is to represent and act for members working in a range of public services. They represent members, negotiate and bargain on their behalf, campaign for better working conditions and pay and for public services.

UNISON introduced an Anti-Racism Charter for organisations and leaders to pledge to a number of commitments which aim to accelerate change for ethnically diverse employees by improving the equality of opportunity for staff and drive long-term change to tackle racism and race disparities in the workplace.

UNISON have asked the Trust to consider signing up to the charter and to implement the commitment suggestions within 12 months of sign up. Whilst the majority of the commitments are already implemented into our processes as business as usual, this charter will enable the Trust to report progress on all actions to the People and Organisational Development Committee on a regular basis to provide assurance around our continued commitment to be an anti-racist organisation.

The People and Organisational Development Committee considered and approved the charter at its meeting on 13 November 2025.

4. Recommendations / Actions

The Board is invited to note that sign up to the UNISON Anti-Racism Charter was confirmed at the private Board meeting in December 2025, and to receive this report for information.

Anti-Racism Charter

Our organisation pledges we will introduce the following ongoing commitments within 12 months of signing:

Our leaders will
- Recognise the need and benefit in championing a racially diverse workforce.
- Challenge racism internally and externally wherever it arises in relation to the organisation.
- Recognise the impact of racism upon staff members' wellbeing.
- Set and regularly review strategy to improve racial equality, diversity and inclusion so that the organisation reflects the communities it serves.

Our organisation will
- Have a clear and visible race equality policy championed by leadership.
- Have a clear and visible anti-racism programme of initiatives and actions.
- Undertake equality impact assessments for all strategic-level decisions.
- Undertake ethnicity pay gap recording and publicly publish results.
- Undertake workforce ethnicity recording and publicly publish results.
- Provide unconscious bias and anti-racism training for all staff members.
- Provide a racism reporting process for notifying, investigating and recording outcomes.
- Provide robust equality training for managers involved in recruiting, promotions and investigating allegations.
- Provide a wellbeing support facility for staff experiencing racism in the workplace.
- Will be anti-racist, not just non-racist in all we do.

Our equality auditing process will review
- Recruitment processes to identify and address race disparities in equality of opportunity.
- Exit interview results to identify and address race disparities in retention of staff members.
- Promotional processes to identify and address race disparities in equality of opportunity.
- Discipline and grievance to identify and address race disparity in outcomes of comparable cases.
- Policies and research under a duty or commitment to promote solidarity and tackle racism.
- Our mission, values, and support to removing racial discrimination in all its forms.

Employer

Date

Board of Directors

Date of Meeting: 8 January 2026	
Title of Document: Board Assurance Framework	
To be presented by: Anthony May, Associate Director of Governance – Risk and Compliance, with additional input from relevant Executive risk owners.	**Author:** Anthony May, Associate Director of Governance – Risk and Compliance.
1. Status: For Approval/Discussion/Noting/Information	
2. Purpose: To provide the Board with the latest version of the Board Assurance Framework (BAF), detailing the most significant risks to the organisation. The BAF describes the controls in place to mitigate each risk, together with sources of assurance around their effectiveness. The BAF also details gaps in control or assurance and the actions being taken to address these.	

Relates to:	
Strategic Objective	All
Operational performance	Effective risk management processes support the operational and strategic performance of the Trust by identifying risks and mitigating them as effectively as possible prior to the issue occurring.
Quality and equality impact	Effective risk management processes help to identify where a risk in the organisation will have significant impact on the quality of care provided. No quality or equality impacts have been identified specifically arising from this governance report; it reports on risks to strategy, delivery plans and objectives which have their own equality impact assessments.
Legal/Regulatory/Audit	If ESNEFT does not have an effective risk management process in place for the identification, assessment and control of risk then we will be unable to provide a positive statement within the Annual Governance Statement to that effect, with the potential for impact to our NHS provider license.
Finance	If ESNEFT does not have an effective risk management process in place for the identification, assessment and control of risk then we may not make best use of our resources; be exposed to potential litigation costs and regulatory sanctions.
Governance	The BAF is a key governance tool used to report assurance to the Board regarding mitigation of strategic risks.
NHS policy/public consultation	ESNEFT risk management processes are in line with the Government's Orange book for risk management.
Accreditation/inspection	ESNEFT's risk management processes are subject to internal audit annually.
Anchor institutions	n/a

ICS/ICB/Alliance	The Trust BAF is shared with health and care system colleagues within SNEE ICS to support the development of a system risk management approach.
Board Assurance Framework (BAF) Risk	The full BAF is provided within appendix two of this report.
Other	n/a

3. Summary:

The Board Assurance Framework (BAF) is designed to provide the Board with a simple but comprehensive method for effective and focused review of strategic risk. Within the Trust, strategic risks are aligned to Board committees, as determined by the committee's terms of reference. The BAF therefore enables the Board to receive assurance from its committees that strategic risks are being appropriately managed.

This report provides a summary of key changes made to the content of the BAF since the September 2025 report to the Board. This includes proposed amendments to risk ratings and a minor amendment to the BAF template:

- Following comprehensive review by the Interim Director of Estates, appointed in September 2025, and the completion of substantial actions that strengthened controls - particularly through the Property and Estates Strategy (2025–2030) approved by the Trust Board in November - the Performance and Finance Committee recommends that the rating of BAF7, regarding Estates Development and Capital Equipment is reduced from 4×4=16 to 4×3=12.

- At the November 2025 Board meeting, the Board approved an increase in rating to BAF4, Quality assurance mechanisms regarding the quality and safety of patient services, from 4x2=8 to 4x3=12. This was as a result of the additional gaps in control and assurance highlighted through the CQC inspections of Colchester and Ipswich Hospitals, covering Medical and Urgent and Emergency Care.

- The BAF template has been enhanced to include definitions for the 'impact of planned actions' (low / med / high) – these are now described on the final page of the BAF (appendix 2).

Further details of the changes made to individual risks are provided in the table over page. In addition, the following appendices are provided:

- **Appendix one** provides, for information, a summary of risk ownership – detailing both the lead executive and lead assurance committee.

- **Appendix two** provides the current BAF for review and approval. A summary of key changes is provided later in this report.

4. Recommendations / Actions

The Board is invited to:

1. Note the Executive Lead and Assurance Committee responsible for each risk (appendix one).

2. Approve the reduction in rating to risk BAF7, regarding Estates Development and Capital Equipment from 4x4=16 to 4x3=12, as recommend by the Performance and Finance Committee.

3. Approve the current version of the Board Assurance Framework (appendix two).

Board Assurance Framework report

Summary of key changes made to the BAF since September 2025

Ref.	Risk summary	Rating (Impact x Likelihood)	Executive Lead(s)	Target risk rating (Impact x Likelihood)
BAF1	Partnership Working	4x3 =12	Director of Finance	3x2=6

No changes, actions ongoing

BAF2	Financial performance – value and sustainability	4x4=16	Director of Finance	4x3=12

Assurance regarding key control (a) 'Medium Term Planning' updated to reference the national planning guidance being issued late October (2025).

Action (8) regarding participation in the new commissioning landscape amended to reflect both risks and opportunities this is likely to present as both Norfolk and Essex have significant deficit funding that will reduce over time.

- Additional assurance added to control (b) 'Annual budget setting and CIP' to reference Non-exec briefing sessions regarding development of Medium Term Plan submission
- Control (c) regarding collaborative system financial performance has been removed following national changes that apply from April 2026: ICBs and NHS trusts must each deliver financial breakeven individually. The previous system breakeven duty (aggregate across the ICS) is removed. ICBs and Trusts must work together on aligned plans addressing population health needs and priorities.
- Associated gaps in assurance have been added:
  - The Trust is currently awaiting confirmation of commissioner allocations and working through technical aspects of the planning guidance, such as block disaggregation.
  - Unclear how the shift in accountability, combined with upcoming ICB boundary changes, will influence future relationships and collaboration across the system.
- Control (d) regarding Financial recovering and the National Oversight Framework (NOF) has been added with associated assurance.
- Additional assurance regarding the Implementation of the non-pay oversight group has been added to control (h) 'Effective procurement systems and processes'.

BAF3	Insufficient capital resources to progress investments	3x3=9	Director of Finance	4x2=8

Added additional contextual narrative, relating to the NHS 10 year plan, to the assurance for control (a) '5 year capital plan'. This will be summarised in future versions of the BAF.

BAF4	Quality assurance mechanisms regarding the quality and safety of patient services	4x2=8	Chief Nurse	4x1=4

The risk has been reviewed by the Chief Nurse, QPS Committee Chair, Deputy Chief Medical Officer (Colchester) and Director of Governance, and a number of amendments were considered by the QPS Committee and approved by the Trust Board in November 2025. These include an increase in risk rating – from 4x2=8 to 4x3=12 - as a result of the additional gaps in control and assurance highlighted through the CQC inspections of Colchester and Ipswich Hospitals, covering Medical and Urgent and Emergency Care. A summary of the changes is detailed below.

Amendments to risk description and key controls / assurance:

- "Poorer clinical outcomes" has been added to the 'defined by' part of the risk description.
- Control (f), regarding oversight arrangements for corridor care and boarding within ED has been amended to refer to the revised SOP reducing the capacity for Boarding, and the assurance report provided to the CQC regarding the implementation of this.
- Assurance regarding control (h) 'Fundamentals of Care Board..' has been amended to reference the role of the

<table>
<tr><th>Ref.</th><th>Risk summary</th><th>Rating (Impact x Likelihood)</th><th>Executive Lead(s)</th><th>Target risk rating (Impact x Likelihood)</th></tr>
<tr><td colspan="5">Evidence Assurance Group, and the report provided to the CQC.
• Control (j) regarding the Nursing and Midwifery Skill Mix review (reported via POD and PFC to the Board) has been documented.
• Control (k) regarding Faculty of Education’s role in ensuring an appropriately skilled workforce has been documented, alongside associated assurance reported through POD to the Board.

Amendments to gaps in control/assurance:
• An additional gap in control regarding ‘Processes to fully support the implementation and understanding of the Mental Capacity Act Deprivation of Liberties (DoLs) requirements’ has been added. Action (5) has been enhanced to detail actions in progress to mitigate.
• Reference has been made to the concerns raised following the CQC inspection of Ipswich Hospital (in addition to those previously documented regarding Colchester). Action (5) details actions in progress to mitigate.
• Additional gaps in assurance have been added:
  o Limited assurance that learning from training and development activities is being effectively embedded into practice, with insufficient evidence of sustained impact on service delivery.
  o Lack of assurance regarding the presence of a culture of continuous improvement necessary to consistently deliver high-quality services.
  o Full resolution of PACS implementation issues ongoing, impacting on clinical pathways
    o Increased ambulance handover delays and boarding due to increase in patients attending ED, as a result of flu surge
• The gap in control relating to the ability to report trends and themes accurately on corridor care and boarding at Ipswich Hospital has been remove following the implementation of Epic.

Action (5) has been enhanced as follows:
Implement actions to drive improvements in the quality of care and clinical outcomes, prioritised against external regulator findings, alongside internal clinical audit and ACE programme reporting. Actions overseen by the Fundaments of Care Board, EMC and Quality and Patient Safety Committee. Workstreams focused on: Workforce planning, staff experience and leadership; Environment and Infection Prevention Control; Mental Health, Complex Health, Patient Safety and Experience and Safeguarding; Essential Care; Patient journey. Regular updates on progress of improvements provided to CQC.

Action (4) regarding the implementation of Epic, to improve quality metric reporting, has been amended to note that Epic is now live, and provide a link to BAF8 (Improvements to patient quality, safety and experience through implementation of an EPR).</td></tr>
<tr><td>BAF5</td><td>Workforce – recruitment and retention</td><td>4x2=8</td><td>Director of People & Organisational Development</td><td>4x2=8</td></tr>
<tr><td colspan="5">Additional gap in assurance added in relation to the potential impact of the Epic implementation on staff survey results, recognising that the staff survey window falls within the initial few weeks from go-live.

Action (5),regarding providing an assurance report to the Board in relation to the national Nursing and Midwifery profiles, recorded as complete, and a new action (6) added regarding completing the associated job evaluation.</td></tr>
<tr><td>BAF6</td><td>Sustainable delivery of elective performance targets</td><td>5x3=15</td><td>Chief Operating Officer for Elective Care</td><td>5X2=10</td></tr>
<tr><td colspan="5">Gaps in assurance amended as follows:

• Gap regarding “Divisional risk assessment and review of all PTLs, to ensure all waiting patients are appropriately managed” removed, following completion of associated action (4)
• New gap added in relation to productivity “Comparative analysis suggests that further productivity improvements are achievable in specific areas (e.g. GIRFT best practice areas in outpatients, Daycase rates). Also Productivity gains as per clinical configuration work”. Associated action 8, regarding ‘optimising elective care’ and ‘inpatient flow’ taskforces, to address these gaps.
• Added additional gap in assurance regarding full resolution of PACS implementation issues.

Actions amended as follows:
• Action (4), regarding risk assessment and review of all Patient Treatment Lists, recorded as complete
• Amended action (5) to reference audit, validation of waiting lists and sharing of learning since Epic go-live.</td></tr>
</table>

<table>
<tr><th>Ref.</th><th>Risk summary</th><th>Rating (Impact x Likelihood)</th><th>Executive Lead(s)</th><th>Target risk rating (Impact x Likelihood)</th></tr>
<tr><td>BAF6A</td><td>Sustainable delivery of emergency care performance targets</td><td>5x3=15</td><td>Managing Director</td><td>5X2=10</td></tr>
<tr><td colspan="5">• Gap in assurance regarding CQC inspections amended to reference Ipswich in addition to Colchester – following the September unannounced UEC inspection at Ipswich Hospital.
• Added additional assurance to control (a) referencing the Board Assurance SVP statement approved in September.

• Added additional gap in assurance regarding ambulance handover delays due to increase in patients attending ED as a result of flu surge.</td></tr>
<tr><td>BAF6B</td><td>Timely cancer diagnosis and treatment</td><td>5x3=15</td><td>Chief Operating Officer for Elective Care</td><td>3x2=6</td></tr>
<tr><td colspan="5">Added additional assurance to controls (a) to (e) regarding QPS committee deep dive into PACS implementation.

Gap in control regarding reduced endoscopy capacity (due to building work at Colchester) removed following completion of action (4) – opening of new Endoscopy Unit at Colchester Hospital.

Additional gaps in assurance added regarding:
• the 28 day Faster Diagnosis Standard not being consistently met across some tumour sites.
• the Patient Treatment List size increasing
• full resolution of PACS implementation issues.

• Added two new actions:

Action (7) Achieve productivity improvements through clinically led ‘improving cancer care’ task force
Action (8) Harm review long cancer waits to be reported to QPS in January 2026</td></tr>
<tr><td>BAF7</td><td>Estates Development and Capital Equipment</td><td>4x4=16

Proposed reduction to 4x3=12 – see below</td><td>Interim Director of Estates and Facilities</td><td>3x2=6</td></tr>
<tr><td colspan="5">The risk has been reviewed in detail by the new Interim Director of Estates, following his appointment in early September.

The following amendments have been made to control and assurance gaps:
• Additional gap in assurance added regarding progress with capital maintenance programme, with associated action (7).

Amendments to actions and controls:
• Action (1) regarding development of the property strategy has been recorded as complete following approval at the November 2025 Board. Key control (a) has been updated to reference the new Property and Estates Strategy 2025-2030
• Action (2) regarding review of 2025/26 backlog maintenance programme against clinical priorities and capital availability has been completed.
• Action (6) Develop accurate programme of annual capital expenditure (added in September 2025) has been completed.

The following new actions have been added.
• Action (5) Review of PFI concession within ESNEFT and termination dates by end March 2026
• Action (7) Mutual aid being provided by GSTT to provide new service delivery model for capital construction through financial year – being implemented in conjunction with procurement by end February 2026</td></tr>
</table>

Ref.	Risk summary	Rating (Impact x Likelihood)	Executive Lead(s)	Target risk rating (Impact x Likelihood)
Proposed reduction in risk rating: Following comprehensive review by the Interim Director of Estates, appointed in September 2025, and the completion of substantial actions that strengthened controls - particularly through the Property and Estates Strategy (2025–2030) approved by the Trust Board in November - the Performance and Finance Committee recommends reducing the risk rating from 4×4=16 to 4×3=12.				
BAF8	Improvements to patient quality, safety and experience through implementation of an EPR	4x2=8	Managing Director	4x1=4
Following go-live on 2 October, the actions preceding go-live have been recorded as complete and the related gaps in assurance have been removed. Go-live of Epic EPR does not however mitigate the risk, as that will be achieved through the delivery of the benefits defined within the business plan. Additional assurance has been added to control (c) – to include the Benefits Realisation Group chaired by the Managing Director. New control (f) added to reference the Epic programme continuing beyond go-live into optimisation and business as usual, to support delivery of benefits. The gap in control regarding ‘limited digital literacy’ and associated action regarding ‘digital literacy training programme’ has been removed, following completion of Epic training; all staff that have an Epic login have completed the training and associated assessment. Digital literacy support continues to be available via the Education Team if required. Action (1) describes the main ongoing action regarding delivering and monitoring benefits through the Benefits Realisation Group. The wording has been amended to reference the priorities over the next 6 months. Action (2) has been added to describe the restructure within Digital and Logistics, to support career development and mitigate the gap in assurance regarding demand for Epic trained / experienced delivery teams. This action will provide mitigation to the associated gap in assurance.				
BAF9	Transformation	4x3=12	Director of Finance	4x2=8
Additional assurance added to control (i) regarding submission of initial Medium Term Plan (MTP) submission to NHS England. Action 2, regarding strategic plans, updated to reference Medium Term Plan and requirement to adhere to NHS England timetable. Action 3, regarding implementation of Epic EPR, recorded as complete.				
BAF10	Digital resilience	4x2=8	Managing Director	4x1=4
Action 4, regarding procurement and deployment of a network detection and response (NDR) tool, has been completed. The associated gap in control has been removed.				

The full BAF is provided within appendix two.

Appendix 1: Strategic Risks
- Executive Lead and Assurance Committee

Each strategic risk is allocated an Executive Lead, and reported either to an assurance committee or directly to the Board. The table below provides a summary of the current strategic risks, the associated Executive Lead and where applicable the Board assurance committee.

Reference	Risk summary	Risk rating (Impact x Likelihood) and trend indicator	Executive Lead	Board Assurance Committee	Target Risk rating (Impact x Likelihood)
BAF1	Partnership working	4x3=12 →	Director of Finance	Retained by the Board	3x2=6
BAF2	Financial performance and sustainability – failure to maintain revenue financial balance in future years	4x4=16 →	Director of Finance	Performance and Finance Committee	4x3=12
BAF3	Insufficient capital resources to progress investments	3x3=9 →	Director of Finance	Performance and Finance Committee	3x2=6
BAF4	Quality assurance mechanisms regarding the quality and safety of patient services	4x3=12 ↑	Chief Nurse	Quality and Patient Safety Committee	4x1=4
BAF5	Workforce – recruitment and retention	4x2=8 →	Director of People and Organisational Development	People & Organisational Development Committee	4x2=8
BAF6	Sustainable delivery of elective performance targets	5x3=15 →	Chief Operating Officer for Elective Care	Performance and Finance Committee	5x2=10
BAF6A	Sustainable delivery of emergency care performance targets	5x3=15 →	Managing Director	Performance and Finance Committee	5x2=10
BAF6B	Timely cancer diagnosis and treatment	5x3=15 →	Chief Operating Officer for Elective Care	Performance and Finance Committee	3x2=6
BAF7	Estates Development and Capital Equipment	4x4=16 ↓ *Proposed reduction to 12*	Interim Director of Estates and Facilities	Performance and Finance Committee	3x2=6
BAF8	Improvements to patient quality, safety and experience through implementation of an EPR	4x2=8 →	Managing Director	Quality and Patient Safety Committee	2x2=4
BAF9	Transformation	4x3=12 →	Director of Finance	Retained by the Board	4x2=8
BAF10	Digital resilience	4x2=8 →	Managing Director	Audit and Risk Committee	4x1=4

Updated December 2025

Appendix 2 - ESNEFT Board Assurance Framework (BAF) – for January 2026 Board

BAF1: Partnership Working

Strategic Objectives: 2. Lead the integration of care			
Strategic Risk:			
IF ESNEFT does not develop effective partnerships across place, system and beyond	**Then** it will be unable to respond to the needs of patients and public across Suffolk and North East Essex	**Resulting in** lost opportunities to deliver the right care at the right place and at the right time to address the full range of people's needs in our communities	**Defined by** Lack of continuity of care, poor utilisation of resources, impact on strategic and operational delivery, inequitable access to services

Lead Executive	Director of Finance	**Assurance committee**	Trust Board

	Impact	Likelihood	Score	Risk movement (last 3 quarters)			Risk rating
				Q4 2024/25	Q1 2025/26	Q2 2025/26	
Inherent	4	3	12	4x2=8	4x3=12	4x3=12	12
Residual	**4**	**3**	**12**				
Target	3	2	6				

Key Controls	Assurances reported to Board and committees

a) Formal joint partnership arrangements in place with a number of external partners, including:
• West Suffolk Hospital (WSH)
  ○ Provider collaborative
  ○ Shared PMO
• East of England Ambulance Service Trust (EEAST)
• SNEE ICS
• ESNEFT as an Anchor organisation and Anchor Programme Board
• Mental health collaborative
• Faculty of Education associated with University of Suffolk, University of Essex and Anglia Ruskin University
• Specialised commissioning provider collaborative (East of England)
	Priority areas for joint working are established and identified in the annual plans, strategies, operational plans and business plans.
	
	ICS and ESNEFT plans in line with National Planning Framework.
	
	Joint Forward Plan developed by SNEE ICB
	
	Recommendations and action plans referring to partnership working regularly submitted to the Board, Quality and Patient Safety Committee, People and Organisational Development Committee and Performance and Finance Committee
	
	SNEE SOF rating segment 2

b) Formal partnerships in place to support the delivery of our goal to be a centre of excellence in research, education and innovation • Trust is part of RRDN – Regional Research Delivery Network • Close working with HTE - Health Technology East	Board to Board meetings (ESNEFT/ICB) to establish good relationships and ensure strategic alignment. ICB Research Collaborative Chaired by ICB Medical Director, attended by Director of Strategy
c) Hospital and community health services provided by Trust	Reporting via Integrated Patient Safety Report through 'Performance and Finance Committee' and 'Quality and Safety Committee' to Trust Board
d) Trust is a member of system wide governance including Suffolk and North East Essex (SNEE) ICB Board, SNEE ICP Board, Finance, Medical, Nursing, Workforce and Quality, ICS CQC Assessment Engagement and Coordination Group and System Risk Management Groups. Trust regularly attends Health Overview and Scrutiny Committee (HOSC) meetings.	Updates reported to Trust Committees; SNEE ICB and ICP briefing report provided to Trust Board. NHSE segmentation ratings reported through system governance (both SNEE ICB and the Trust are currently in segment 2)
e) Collaborative Governance agreed between ESNEFT and WSFT (West Suffolk Foundation Trust), consisting of a Joint Productivity Board, established as a consequence of the system commissioned sustainability review.	Monthly Joint Productivity Board, jointly chaired by Trust Chairs with Non-Exec and Exec Director membership (from each Trust); reports to both Trust Boards.

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
Gaps in control: No Integrated Care System (ICS) Clinical Strategy. **Gaps in assurance:** • Limited assurance regarding integration benefits • Resource limitations across system partners – including mental health and social care. • No progress regarding development of ICS Clinical Strategy. • National changes impacting NHSE and ICBs. • Impact of ICB boundary changes - Colchester and North East Essex will be in a different ICB boundary to Ipswich and East Suffolk	1. Continue to develop and enhance partnership working and relationships - ongoing	**High**
	2. Contribute to development of ICS Clinical Strategy for delivery once finalised by ICS (timelines defined by ICS)	**Medium**

BAF2: Financial performance and sustainability – Failure to maintain revenue financial balance in future years

Strategic Objectives: ALL			
Strategic Risk: BAF2			
IF the Trust's approach to value and financial sustainability are not embedded	**Then** we will not be able to fully mitigate the variance and also volatility in financial performance	**Resulting in** an impact on cash flow and long-term financial sustainability	**Defined by** The potential need to reduce services and compromise on future investment to mitigate pressure on finances

Lead Executive	Director of Finance	**Assurance committee**	Performance and Finance Committee (PAF)

	Impact	Likelihood	Score	Risk movement (last 3 quarters)			Risk rating
				Q4 2024/25	Q1 2025/26	Q2 2025/26	
Inherent	4	4	16	4x4=16	4x4=16	4x4=16	16
Residual	4	4	16				
Target	4	3	12				

Key Controls	Assurances reported to Board and committees
a) Medium Term Planning	Medium Term Plan briefings and discussion with Exec Team, NEDs, Governors and Trust Board. Formal approval of Trust Initial MTP submission to be recommended to Board for approval on 17 December 2025.
b) Annual Budget setting and Cost Improvement Programme with QIA process to ensure CIP schemes are reviewed and signed off before implementation decisions	HFMA, One NHS Finance and SDN training available to budget holders in addition to internal courses and support. DAM leadership in developing and monitoring these plans, with escalation through PAF to Trust Board. Non-exec sessions to review the internal position in readiness for initial Medium Term Plan submission to NHS England on 17 December 2025.
c) Financial recovery: The NHS National Oversight Framework (NOF) assigns organisations to segments based on: • Operational performance (e.g. elective recovery, urgent care, cancer targets). • Financial sustainability (balanced or surplus position required for higher segments). • Leadership capability and governance strength.	NHS England will use contextual metrics (e.g., health inequalities, outcomes) to inform improvement support, though these will not directly affect segmentation scores. NHS England retains powers to: • Mandate recovery plans for trusts in lower segments. • Deploy turnaround directors or leadership support. • Apply contractual levers via ICB commissioning. Improvement support will be tailored to segment level, with more intensive oversight for segments 4 and 5 The Trust is in segment 3, has produced a headline financial recovery plan that has been shared with the ICB and NHS England to support the mid-year review. The Trust will use the medium term and annual business planning processes to identify opportunities, review current ways or working and minimise waste in order to maximise resources for care.
d) Delegated accountability to Divisions for planning and delivery of divisional financial plans. Focus on the enablement of recurrent cost improvement schemes, developments and productivity concepts through the Financial Sustainability Group	Divisional Accountability Framework (AF) metrics reviewed annually and approved by EMC and reported to PFC for assurance. Metrics are monitored and managed through monthly through Divisional Accountability Meetings (DAMs) and escalated to EMC/PFC as appropriate. Regular use of the Integrated Finance and HR dashboard by managers and budget holders. Financial Sustainability Group updates to EMC.

	The Trust will be undertaking business planning meetings with Divisions in January 2026
e) Internal Audit Cyclical review of systems and processes and External Audit VFM review	Reporting to Audit Committee and Trust Board.
f) Benchmarking using local WAU, Model system, GIRFT and other relevant datasets.	Reporting to PAF and Trust Board. Trust reviewing national bench marking data with a specific objective to improve productivity. Presentations to EMC, POD and PFC. The Darzi report refers to the need to improve productivity and contains significant data to support its conclusions and recommendations. The Trust can use this data in support of its work to maximise its efficiency and effectiveness.
g) Effective Procurement Systems and process	Monthly Reports to Medical Devices Management Group and Quarterly updates to Clinical Reference Group, Implementation of the Trust non pay oversight group

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
Gaps in control: All appropriate controls currently in place with Divisional Management Board review on a monthly basis. **Gaps in assurance:** Lack of direct influence on resource allocation decisions at a national level - potentially resulting in unfunded inflationary pressures, for example The Trust is currently awaiting confirmation of commissioner allocations and working through technical aspects of the planning guidance, such as block disaggregation. Unclear how the shift in accountability, combined with upcoming ICB boundary changes, will influence future relationships and collaboration across the system.	1. Continue to model different financial scenarios as intelligence becomes available	Medium
	2. Support Divisions to continue identifying strategic change opportunities (e.g. Spec Comm)	High
	3. Support and educate Divisions to understand and implement strong financial governance processes. Implement and embed the additional controls agreed at the September 2025 EMC meeting.	Medium
	4. Review ICB strategy ambition and potential impact on service delivery Review 10 year plan and medium-term clinical strategy to assess the potential impact/opportunities for service efficiency and productivity.	Medium
	5. Implement areas of improvement identified through benchmarking, strengthening processes in relation to budget reporting and monitoring.	High
	6. Use Regional DOF meetings to influence the NHSE Regional DOF who in turn can attempt to influence the NHSE National DOF.	Medium
	7. To tightly manage the revenue consequences of recent and future capital investment to maximise opportunities and avoid the risks of poor implementation	High
	8. To actively participate and influence in the emerging new commissioning landscape of the Suffolk and Norfolk ICB and the Essex ICB, This is likely to present both risks and opportunities as both Norfolk and Essex have significant deficit funding which will reduce over time.	Medium
	All actions above are ongoing.	

BAF3: Insufficient capital resources to progress investments

Strategic Objectives: ALL			
Strategic Risk:			
IF resources (cash and / or Public Dividend Capital) are not available to the Trust in line with its planned capital expenditure.	**Then** there will be insufficient resources to progress capital developments.	**Resulting in** Potential regulatory impact, loss of income generation potential as well as reputational and patient impact	**Defined by** NHSE and DHSC regulatory action, adverse publicity, inability to deliver improved estate

Lead Executive	Director of Finance	**Assurance committee**	Performance and Finance Committee (PAF)

	Impact	Likelihood	Score
Inherent	3	4	12
Residual	**3**	**3**	**9**
Target	3	2	6

Risk movement (last 3 quarters)

Q4 2024/25	Q1 2025/26	Q2 2025/26
4x3=12	3x3=9	3x3=9

Risk rating: 9

Key Controls	Assurances reported to Board and committees
a) Rolling 5 year capital plan	Regularly reviewed and discussed at PAF Committee with escalation to Trust Board as required. The Trust has gained access to constitutional standards capital funding. This amounts to at least £20.2 million in 2025/26 and beyond to assist with urgent care, diagnostics and elective care capacity. This funding is likely to continue in the medium term. However, this source of funding will not cover projects, such as the new maternity block at Ipswich and additional ward capacity at Colchester. *The NHS 10 year plan proposes to increase capital investment to drive improvements including* • *Introduction of multi-year capital budgets, set on a rolling five-year basis.* • *Devolving more control over capital budgets to the frontline with fewer restrictions on what providers can spend their capital on and greater flexibility to spend funding between financial years.* • *Reforming the approvals process with at most three approval levels on the very largest nationally significant schemes (one provider level, one regional/national and one cross government).* • *Greater autonomy for new NHS foundation trusts.* • *Where capital allocations and any associated cash are still required, these will generally flow in line with a fair and transparent formula directly to the accountable organisation best placed to prioritise and deliver value for patients.* • *Funding to tackle maintenance backlogs directly to all providers in line with the extent of their backlogs. This leaves systems to focus on strategic capital.* • *The government will also consult with the NHS on reforms to public dividend capital charges.* • *NHS England guidance caps BAU capital at around 5% of the total capital envelope for each Integrated Care System (ICS) or provider.* *The aim is to prioritise strategic investment (e.g., elective recovery, diagnostics, digital transformation, RAAC remediation, and safety-critical estates) rather than routine spend.*
b) Review and prioritisation of capital schemes c) Monitoring of approved capital schemes under construction to determine position relative to planned values	Capital position against CDEL reported and discussed at ESPG, IG, Finance and Performance Committee and Trust Board. The approval of a new estates strategy will support the prioritisation of new schemes.
d) Business case framework	Divisional Management Board, Investment Group, EMC and Trust Board

e) Monitoring of national, regional and system framework and guidance in relation to capital expenditure. f) SNEE ICB Finance Committee meetings	Planning for the use of capital needs to take into account national impacts on key controls. Reporting of performance will work through sub committees to Trust Board as necessary

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
Gaps in control: All appropriate controls currently in place with Divisional Management Board review on a monthly basis. **Gaps in assurance:** Lack of direct influence on resource allocation decisions at a national level potentially resulting in reduced opportunities for capital investment Mismatch between CDEL availability and cash generated by depreciation may lead to cash shortfalls in future years. – National issue Reliability on suppliers providing goods and services when needed. Project Management agreeing timelines for delivery and ability to manage procurement process and or construction plan.	1. Long term capital programme to be regularly discussed at Performance and Finance Committee and Investment Group	Low
	2. Value for money assessment of schemes to be considered as part of business case development and approvals.	High
	3. Use Regional DoF Meeting to raise CDEL and Cash issues which can be fed back nationally.	Medium
	4. Use of contractual terms where necessary and proactive communications and relationship building to try to mitigate any potential risks of goods and services delays.	Medium
	5. From 2026-27 there will be a new CSR process which may impact on our medium term capital plan.	High
	6. This BAF risk has indirect links to risk BAF7 associated with the ongoing sustainability of the organisation’s estate.	Medium
	All actions above are ongoing	

BAF4: Quality assurance mechanisms regarding the quality and safety of patient services.

Strategic Objectives:

1. Keep people in control of their health
2. Lead the integration of care

Strategic Risk: BAF4

IF ESNEFT does not have the correct quality assurance mechanisms in place	**Then** it may fail to maintain or improve the quality and safety of patient services	**Resulting in** poor patient care, increased health inequalities, experience and potential harm.	**Defined by** Poorer clinical outcomes. Increase in patient incidents, serious incidents and complaints.

Lead Executive	Chief Nurse	**Assurance committee**	Quality and Patient Safety Committee (QPS)

	Impact	Likelihood	Score
Inherent	4	3	12
Residual	**4**	**3**	**12**
Target	4	1	4

Risk movement (last 3 quarters)

Q4 2024/25	Q1 2025/26	Q2 2025/26
4x2=8	4x2=8	4x2=8

Risk rating: 12

	Key Controls	Assurances reported to Board and committees
Patient Safety and Quality	a) Patient Safety Investigation Response Framework (PSIRF) in place to ensure robust investigations are undertaken in order to enhance learning and quality improvement, aligned to the national framework and safety priorities.	Reporting of PSIRF through Integrated Patient Safety and Experience Report to QPS Committee. The Integrated Performance Report (IPR) also contains evidence of PSIRF compliance and is reported to Trust Board.
	b) Quality and Clinical strategy in line with quality priorities	Reporting to QPS Committee, including bi-monthly deep-dives, and quarterly update to committee. November deep dive into PACS implementation.
	c) Divisional Accountability Meetings (DAMs) have robust discussions focused on delivery of the quality governance agenda and quality metrics.	Divisional updates reported through NMAAC, PEG and PSCEG
	d) QI Team and workplan	Twice yearly progress identified through sessions led by Chief Medical Officer and Chief Nurse to seek assurance against delivery, reported through PSCEG to QPS and Trust Board.
	e) Triangulation of quality metrics (including falls, pressure ulcers and maternity) and reporting undertaken with assurance visits to wards and departments.	Reporting of metrics through Integrated Patient Safety and Experience (IPSE) Report to Board. Infection Prevention and Control Board Assurance Framework (IPC BAF) reported to Board biannually through Infection Control Committee and QPS. Infection Control Annual Report 2023/24
	f) Strengthened oversight arrangements for corridor care and boarding within ED: revised SOP with reduced capacity for Boarding (in Colchester ED) from end June 2025	Assurance reporting to Fundamentals of Care Board, through to QPS and Trust Board. Assurance regarding completion of actions provided to CQC.
	g) Appropriate speciality leads engaged with EPIC Rapid Decision Groups regarding patient safety and experience indicators.	Epic reporting (EMC / QPS) CMO and CNO members of Epic Programme Board
	h) Fundamentals of Care Board (FoCB) established to drive and oversee improvements in the quality of care and ensure timely response to CQC findings.	Chaired by Chief Nurse, reporting to EMC, QPS Committee and Trust Board. Separate Evidence Assurance Group established to review evidence in support of the Trust's improvement actions. Assurance regarding completion of actions provided to CQC (September, October and November 2025).
	i) Bures Ward model intervention	Evaluation and progress of the implementation of the Bures ward model is reported through the FoCB and EMC.
	j) Nursing and Midwifery Skill Mix Review/Acuity	Reported through People and Organisational Development Committee and Performance and Finance Committee to Board.
	k) Faculty of Education works to ensure appropriate skilled, educated and trained workforce.	Training compliance reported through People and Organisational Development Committee to Board.
Health Inequaliti	l) ESNEFT Inequalities Strategy and associated governance	Strategy approved by Board and monitored at QPS Committee with reporting to Board. Reporting to SNEE ICS Alliance Boards

	m) Health Inequalities Working Group	Reporting to PSCEG, QPS Committee, Performance and Finance Committee and Trust Board
Perinatal care	n) Compliance with CNST Standards – with detailed action plan to deliver compliance with all 10 standards	Monitoring of programmes and quality/outcome metrics through DAMs, CNST Group, Maternity and Neonatal Improvement Board with reporting through EMC and QPS Committee to Trust Board. Maternity and Neonatal Assurance Report
	o) Maternity and Neonatal Safety Champions and associated governance	Findings reported through LMNS, Maternity and Neonatal Improvement Board, QPS and Trust Board
	p) Learning from deaths group	Perinatal mortality outcomes monitored through Learning from Deaths group reported through LMNS, Maternity and Neonatal Improvement Board, QPS and Trust Board

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
Gaps in control: • Inconsistent triangulation of quality metrics. • Processes to fully support the implementation and understanding of the Mental Capacity Act Deprivation of Liberties (DoLs) requirements **Gaps in assurance:** • Lack of assurance regarding clinical outcomes – including patient experience and effectiveness of clinical interventions. • Lack of visibility of sustained / embedded learning. • Lack of effective reporting of triangulation of quality and outcome measures across performance, workforce and finance. • Concerns regarding quality of care raised by CQC following inspections of medical wards and urgent and emergency care at Colchester and Ipswich Hospitals. • Limited assurance that learning from training and development activities is being effectively embedded into practice, with insufficient • evidence of sustained impact on service delivery. • Lack of assurance regarding the presence of a culture of continuous improvement necessary to consistently deliver high-quality services. • Full resolution of PACS implementation issues ongoing, impacting on clinical pathways • Increased ambulance handover delays and boarding due to increase in patients attending ED, as a result of flu surge	1. Development of a clear overarching Quality Improvement (QI) plan which encompasses; Care Accreditation, focused improvement plan for fundamentals of care (experience, IPC, timely access to treatment and discharge, reducing harm): a. consider how to effectively provide assurance on lessons learned being embedded e.g. forward plan for testing embeddedness/ inclusion in audit plans etc. b. include benchmarking for quality measures where available Actions above are ongoing, with regular reporting to QPS Committee.	Medium
	2. Deliver quality priorities for 2025/26 – ongoing throughout 2025/26: a. Identification and oversight of three highest priority outcomes for each clinical service. b. Continued implementation of the Maternity Single Delivery plan. c. Continue to extend the health inequalities programme, via making every contact count programme. d. Continue to implement our Accrediting Care at ESNEFT (ACE) Programme. e. Embed the use of TEP (Treatment Escalation Plan) and ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) tool. f. Reduction of restrictive practice. g. Continue to improve end of life care via timely transfer to preferred place of care.	High
	3. Implement actions to drive improvements in the quality of care and clinical outcomes, prioritised against external regulator findings, alongside internal clinical audit and ACE programme reporting. Actions overseen by the Fundaments of Care Board, EMC and Quality and Patient Safety Committee. Workstreams focused on: Workforce planning, staff experience and leadership; Environment and Infection Prevention Control; Mental Health, Complex Health, Patient Safety and Experience and Safeguarding; Essential Care; Patient journey. Regular updates on progress of improvements provided to CQC; actions ongoing.	High

BAF5: Workforce – recruitment and retention

Strategic Objectives: **4. Support and develop our staff**			
Strategic Risk: BAF5			
IF ESNEFT is not able to attract and retain its workforce	**Then** it will not be able to deliver high quality patient care.	**Resulting in** reduced organisational resilience, impact on patient care, additional pressure on existing workforce	**Defined by** Increase in sickness, increased agency costs, potential increase in patient safety incidents.

Lead Executive	Director of People and Organisational Development	**Assurance committee**	People and Organisational Development (POD) Committee

	Impact	**Likelihood**	**Score**
Inherent	4	4	16
Residual	**4**	**2**	**8**
Target	4	2	8

Risk movement (last 3 quarters)

Q4 2024/25	**Q1 2025/26**	**Q2 2025/26**
4x3=12	4x2=8	4x2=8

Risk rating: **8**

Key Controls	**Assurances reported to Board and committees**
a) Annual workforce plan b) Recruitment Policy and Procedures	Monitored monthly, reporting via POD Committee. Recruitment pipeline monitored monthly against planned activity, which includes leaver rate.
c) People and OD Strategy and associated calendar; Faculty of Education Strategy 2024-29; EDI Strategy and associated governance; POD Committee; EDI Strategic and EDI Operational Groups d) EDI related awareness sessions (Active Bystander, Race Conversations, Disability and LGBTQ Awareness)	Strategies focus on: approach to equality diversity and inclusion, staff experience including ensuring staff feel confident in speaking up, educating and training our workforce, outreach to schools, supporting staff well-being and providing high quality leadership development opportunities. Staff Experience Committee monitors performance against key controls, reports to POD Committee, POD Committee reporting to Board. EDI Operational Group monitors performance against WRES/WDES/GPG/PSED Data and Annual Reports/Action Plans and reports to EDI Strategic Group and POD Committee
e) People metrics: appraisal compliance, turnover, sickness absence, Workforce Race Equality Standard (WRES) f) Retention strategy g) Talent and succession planning process h) Appraisal process with EDI specific objectives for all staff	Monitored through Performance and Finance Committee or POD Committee and reported to Board. Retention conversations continuing, expanding to moves intra-Trust. Voluntary turnover at 5.98%
i) Active Staff networks	EDI Operational Group and EDI Steering Groups reporting to POD

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**	**Impact of Actions on risk**
Gaps in control: None documented	1. Increase engagement of leaders in leadership development programmes to 75% by end 2025/26	High
Gaps in assurance: • Sickness absence rates • Staff survey results with regard to recommending ESNEFT as a place to work and be treated • EPIC impact on Staff Survey results • Representation from BAME individuals is not balanced across staff groups • Potential impact of immigration white	2. Reduce sickness absence in relation to stress, anxiety and depression from 1% of the total workforce (2024/25) to 0.89% of workforce through early contact with wellbeing services, establishment of carer's network and employee assistance programme (ongoing to end 2028/2029)	Medium
	3. Improve staff survey results in respect of staff recommending ESNEFT as a place to work and be treated – ongoing, upper quartile by 2025 survey	Medium
	4. Work towards proportional representation (amongst ESNEFT staff) from BAME individuals accessing Band 6 and above roles to ensure leaders reflect the diversity of staff in Trust – by increasing representation from 17%	Medium

paper • Potential impact of implementing new national bands 4-9 Nursing and Midwifery Profiles	(2024/25) to 26% by end 2028/29.	
	5. Assurance report to be provided to September Board regarding new national bands 4-9 Nursing and Midwifery profiles. (Complete)	**Medium**
	6. To support national band 4-9 Nursing and Midwifery profiles, bob descriptions to be concluded and evaluation panels to be established, with evaluations to be complete by end December 2025	**Medium**

BAF6: Sustainable delivery of elective performance targets

Strategic Objectives: **1. Keep people in control of their health**			
Strategic Risk:			
IF there is insufficient capacity to match demand and failure to delivery timely patient care (achieve operational performance targets)	**Then** waiting times and delays for treatment will increase	**Resulting in** unintended harm to patients due to longer waiting times which may result in delayed diagnosis, disease progressions and poor outcomes; impact on financial outcomes and ability to deliver annual plan	**Defined by** increasing number and severity of incidents and claims; regulatory action or reputational damage

Lead Executive	Chief Operating Officer for Elective Care	**Assurance committee**	Performance and Finance Committee (PAF)

	Impact	**Likelihood**	**Score**	**Risk movement (last 3 quarters)**			**Risk rating**
				Q4 2024/25	**Q1 2025/26**	**Q2 2025/26**	
Inherent	5	4	20	5x3=15	5x3=15	5x3=15	**15**
Residual	**5**	**3**	**15**				
Target	5	2	10				

Key Controls	**Assurances reported to Board and committees**
a) Elective Care Charter which supports the development of the elective care element of the ESNEFT strategy	Joint Programme Board between ESNEFT and West Suffolk Executive Management Committee (EMC)
b) ESNEFT Elective Medium Term Plan 2025-2027 (2 year plan approved July 2025, based on national priorities)	Performance and Finance Committee (PAF) - Monthly reporting and periodic deep dives. Topic based deep dives presented to Council of Governors and Performance and Finance Committee Regular reporting to Executive Leadership Team and Elective and Emergency care programme boards. Reporting to ICB wide Elective Care Programme Board chaired by ESNEFT Chief Operating Officer for Elective Care
c) SNEE Elective Programmes Strategic and Diagnostic Committee	Reporting to System Oversight Assurance Committee
d) Divisional Accountability Framework	Monthly performance packs to monitor productivity and activity
e) Performance and Finance Committee	Regular reporting to Trust Board including periodic deep dives
f) Quality and Patient Safety Committee	Long wait clinical pathway review monitored through harm reviews.
g) Divisional Management of Patient Tracking Lists (PTLs), supported by data quality reporting	Reporting to DAMs and PAF

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**	**Impact of Actions on risk**
Gaps in control: • Waiting list data cleanse has identified Patient Treatment List (PTL) data quality reports are not always being acted upon. **Gaps in assurance:** • Action plans from divisions to meet national priorities on elective waits. • Comparative analysis suggests that further productivity improvements are achievable in specific areas (e.g. GIRFT best practice areas in outpatients, Daycase rates), as well as productivity gains as per clinical configuration work • Full resolution of PACS implementation issues	1. Deliver the ESNEFT Elective Medium term plan which sets out the objectives and KPI's for 2025 to 2027. (ongoing)	High
	2. 'Further Faster' outpatient transformation work to continue (PIFU and advice and guidance) to reduce demand for key specialities ongoing throughout 2025/26.	Medium
	3. Ongoing monitoring of diagnostic performance through regular review of performance against Patient Treatment Lists along with focused demand and capacity work.	Medium
	4. Ongoing audit, validation of waiting lists and sharing of learning and education events since Epic go live – planned to March 2026	Medium
	5. Patient contact validation for all non-admitted patients at weeks 12, 24, 36 and 48 that are not booked for an appointment and have not had an appointment in the last 12 weeks – contacted to confirm place on waiting list to confirm if appointed still needed – ongoing.	Medium

	6. Organisation undertaking validation sprint as per national mandate – ongoing during 2025/26	**Medium**
	7. Implement 30/60/90 day action plans, for Elective Optimisation (including productivity improvements) as part of ongoing optimising elective care and inpatient flow taskforces initiated post Epic go-live – ongoing from November 2025 to end March 2026.	**Medium**

BAF6A: Sustainable delivery of emergency care performance targets

Strategic Objectives:

1. **Keep people in control of their health**

Strategic Risk:

IF there is insufficient capacity to match demand and inability to deliver timely patient care (achieve operational performance targets)	**Then** waiting times and delays for treatment will increase	**Resulting in** unintended harm to patients due to longer waiting times which may result in delayed diagnosis, disease progressions and poor outcomes; impact on financial outcomes and ability to deliver annual plan	**Defined by** Increased morbidity and excess deaths; increasing number and severity of incidents and claims; regulatory action or reputational damage

Lead Executives	Director Digital Logistics and Operations	**Assurance committee**	Performance and Finance Committee (PAF)

	Impact	**Likelihood**	**Score**
Inherent	5	4	20
Residual	**5**	**3**	**15**
Target	5	2	10

Risk movement (last 3 quarters)

Q4 2024/25	**Q1 2025/26**	**Q2 2025/26**
5x3=15	5x3=15	5x3=15

Risk rating: **15**

Key Controls	**Assurances reported to Board and committees**
a) Executive Management Committee (EMC) overseeing deliverables including admission prevention and avoidance, front door transformation, patient pathways, virtual wards, acute respiratory infection hubs and ED sustainability as detailed within the following plans: Urgent and emergency care medium term plan Community care medium term plan SNEE Joint Forward Plan Seasonal variation plan	Programme risks and issues monitored by Emergency Care Programme Board, and escalated to EMC and Trust Board as appropriate. System Alliance Operational Group undertakes deep-dives, including ambulance handovers, seasonal variation, cancer and diagnostics with reporting through Performance and Finance Committee to Trust Board. Reporting through SNEE Operational Delivery Group reporting to Urgent Emergency Care Alliance Committee (SNEE ICB) NHSE SVP Board Assurance statement approved by Trust Board (Sept 2025)
b) Alliance Operational Group	Highlight report reports up to ICB Strategic Operational Group
c) Emergency Care Programme Board	Performance management reporting arrangements between Divisions, Service Lines and Executive Team.
d) Operational Performance Targets – national and Trust standard monitored through Divisional Accountability Framework	Monthly Divisional Accountability Meetings (DAMs) supported by Executive Director, finance and performance teams. This enables 'confirm and challenge' to Divisional management teams around specialty level recovery plans; and review the progress against detailed divisional plans, with escalation to PAF Committee as necessary.
e) Peer reviews of UEC pathways at Colchester and Ipswich hospitals and associated actions plans	Reporting of outcomes through PAF Committee and System Oversight Assurance Committee.
f) Covid and Flu vaccination programme	Performance and Quality Report to PAF Committee, and onward report to Trust Board.
g) Enhanced Boarding Standard Operating Procedure. Strengthened oversight arrangements on corridor care and boarding; introduction of harm review process and quality and safety action group.	
h) SHREWD (Single Health Resilience Early Warning Database) system resilience dashboard with live data feed to monitor system pressures and support management of clinical risk	
i) Daily Site Capacity and Flow Meeting - Colchester	
j) System Oversight and Assurance Group with representatives from system partners.	

k)	Home for lunch quality initiative to release capacity earlier	
l)	Handover 45 national initiative and associated local protocols to ensure prompt ambulance handover	

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
Gaps in control: • Insufficient bed and staffing capacity at Colchester Hospital • Insufficient bed and staff capacity within ESNEFT to support predicted population growth • Reduced flow through Trust due to high number of medically optimised patients • Insufficient capacity and skills to care for patients with acute mental health conditions • Limited ability to control demand due to challenges in primary care / community providers • Not all services are 7-day, impacting on demand • Insufficient side room capacity	1. Work with partners to influence and gain assurance regarding improving timely patient pathways for medically optimised patients - ongoing	High
	2. Work with partners to influence and gain assurance regarding improving timely care for patients with acute mental health conditions - ongoing	Medium
	3. Internal programme of work to support patient flow and safety – clinically ready to proceed and professional standards – ongoing	Medium
	4. Work with system and primary care partners to support patient care closer to home - ongoing	High
	5. Longer term bed capacity business case being developed to mitigate predicted population growth and bed requirements –ongoing	High
Gaps in assurance: • Limited external care capacity (nursing, residential, social, mental health reablement) impacting length of stay • Significant number of patients waiting over 12 hours in Colchester Hospital ED (therefore ESNEFT is regional outlier) • Significant number of patients waiting over 4 hours in Ipswich Hospital ED (therefore ESNEFT is regional outlier) • Number of patients cared for in corridors within ED and wards. • Concerns regarding quality of care raised by CQC following inspections urgent and emergency care at Colchester and Ipswich Hospital. • Increased ambulance handover delays due to increase in patients attending ED as a result of flu surge	6. Implement Winter 2025/26 SVP plan to support delivery of national UEC 2025/26 priorities (ongoing to end March 2026).	High

BAF6B: Timely cancer diagnosis and treatment

Strategic Objectives: 1. Keep people in control of their health			
Strategic Risk:			
IF there is insufficient capacity to match demand and failure to delivery timely patient care (achieve operational performance targets)	**Then** the Trust will be unable to provide timely cancer diagnosis and treatment	**Resulting in** unintended harm to patients and non-compliance with national standards	**Defined by** delayed diagnosis; increased disease progression; excess deaths; increasing number and severity of incidents and claims; regulatory action; reputational damage

Lead Executives	Chief Operating Officer for Elective Care	**Assurance committee**	Performance and Finance Committee (PAF)

	Impact	**Likelihood**	**Score**
Inherent	5	4	20
Residual	**5**	**3**	**15**
Target	3	2	6

Risk movement (last 3 quarters)

Q4 2024/25	**Q1 2025/26**	**Q2 2025/26**
5x3=15	5x3=15	5x3=15

Risk rating: **15**

Key Controls	**Assurances reported to Board and committees**
a) Monitoring of 62 day performance and 28 Faster Diagnosis national standard (ensuring diagnosed patients are treated as soon as possible)	Reporting through SNEE Operational Delivery Group Reporting through PAF Committee, QPS Committee, Executive Management Committee and Board Clinical outcomes from National Cancer Audits report to QPS Patient experience feedback through National Patient Survey report to QPS QPS Committee deep dive into PACS implementation
b) SNEE-wide Cancer Operational Group and Committee	
c) ESNEFT Trust-wide Cancer Board	
d) Tumour Site specific 'red to green' recovery meetings.	
e) Cancer recovery plans for specific tumour sites	
f) Operational Performance Targets – national and Trust standard monitored through Divisional Accountability Framework	Monthly Divisional Accountability Meetings (DAMs) supported by Executive Director with escalation to EMC and PAF Committee as necessary.
g) Cancer SITREP – 31 day PTL	Reporting to NHS England
h) 104 day long wait patients – Clinical review panel	Reporting through PAF Committee, QPS Committee, Executive Management Committee and Board

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**	**Impact of Actions on risk**
Gaps in control: • Challenges in pathology consultant workforce in combination with increasing demand on service. • Surgical capacity constraints in relation to preference to only undertake robotic procedures. • Colchester bed base challenged • Capacity challenges within tertiary centres (diagnostic and treatment) **Gaps in assurance:** • Challenge with reducing the number of patients waiting over 62 days in colorectal and urology (recovery plans in place) • Robust recovery plans for radiology. • Not meeting 28 day FDS national standard for colorectal. • The 28 day FDS national standard is not being consistently met across some tumour sites • Patient Treatment List size continues to increase • Full resolution of PACS implementation issues	1. Improve performance across all specialties with a retained focus on colorectal to achieve 80% 28 FDS by end 2025/26.	High
	2. Continue working with primary care on appropriate referral pathways for cancer patients – ongoing.	Low
	3. Roll out of Targeted Lung Screening programme to Ipswich and East Suffolk practices – ongoing to 2028/29.	Low
	4. Open new outpatient Endoscopy Unit at Colchester Hospital by Autumn 2025 - Complete	Medium
	5. Consider how pathology recovery plan can be delivered sooner than 2028 -ongoing	Medium
	6. Develop radiology recovery plan by end Q2 2025/26 to achieve 7 day turnaround times.	Medium

	7. Achieve productivity improvements through clinically led ‘improving cancer care’ task force	**Medium**
	8. Harm review long cancer waits to be reported to QPS in January 2026	**Low**

BAF7: Estates Development and Capital Equipment

Strategic Objectives: **5. Drive technology enabled care**			
Strategic Risk:			
IF there is insufficient investment available and made in respect of the Trust's estate,	**Then** the Trust will be unable to maintain, develop and transform the physical estate of the Trust,	**Resulting in** a dilapidated, inconsistent and dated estate leading to an inability of the Trust to provide high-quality care; poor patient, staff and visitor experiences; and potential regulatory action.	**Defined by** Worse care - Cancelled or delayed appointments; Delayed diagnosis; Less modern care; Inconvenient locations Worse experience - Increase in complaints; Greater frequency and severity of incidents; Worse staff retention Worse governance - Increased unforecast reactive spend; Regulatory action; Increased Health and Safety risk Failure to reduce carbon footprint

Lead Executive	Interim Director of Estates and Facilities	**Assurance committee**	Performance and Finance Committee (PAF)

	Impact	**Likelihood**	**Score**	**Risk movement (last 3 quarters)**			**Risk rating**
				Q4 2024/25	**Q1 2025/26**	**Q2 2025/26**	
Inherent	5	4	20	4x4=16	4x4=16	4x4=16	**12***
Residual	**4**	**3**	**12***				
Target	3	2	6				

*proposed reduction in rating (from 4x4=16 to 4x3=12) for Board approval, see summary report for details.

Key Controls	**Assurances reported to Board and committees**
a) Estates and Facilities Division's Strategies and Plans: a. Property and Estates Strategy 2025-2030 b. Property Strategy c. Green Plan 2024-2027 d. Master Control Plan and Development Control Plan for each major site.	Aligned with Clinical Strategy. Each of the strategies is taken through the divisional DMT, Estates Strategy Programme Group (ESPG) one of the Committees (depending on content) and then the Board. Separately, the estates and property strategies are submitted to the ICB Estates Committee to ensure alignment to the wider system strategy. Annual ERIC (Estates Returns Information Collection) return to NHS England
b) Estates and Facilities Plans and Business Cases a. Master Control Plan and Development Control Plan for each major site. b. Annual and Medium Term Backlog Maintenance Plans c. 5 year annual capital and maintenance plan	Six Facet Survey Specific condition reports (when deemed necessary) Each of the plans and business cases are taken through the Investment Group, BFBC Group (Building for Better Care) and/or ESPG with appropriate escalation to Trust Board and ICB Estates Committee
c) Estates and Facilities Performance metrics and KPIs Includes metrics for reactive and PPM works; HTM compliance; National standards of cleanliness; Food hygiene standards; environment standards; nutrition standards; waste segregation requirements; violence prevention and reduction standard; MHRA medical device regulations.	Annual PLACE (Patient Led Assessments of the Care Environment) Survey Annual PAM (Premises Assurance Model) survey HTM sub committees Health and Safety Committee EMC Compliance Report National standards of cleanliness report, cleanliness audits, food hygiene inspections to IPC Committee MHRA Compliance report to Medical Devices Management Group
d) Estates and Facilities financial reports Monthly divisional and Assistant Director level monthly report with performance metrics and forecast analysis. Monthly CIP and monthly departmental financial performance meetings	Monthly Divisional finance SMT meeting Monthly DMT meeting Monthly DAM and then EMC Monthly Capital spend meeting CIP Tracker report to Divisional Management Team and Divisional Accountability Meeting
e) Comprehensive asset register	Reporting to ESP Group, provides recommendations through Investment Group to BFBC Group with appropriate escalation to Trust Board.
f) Authorising Engineer audit reports	HTM Compliance tracker, Report to relevant HTM Groups, reporting to Health and Safety Committee, EMC and on to Trust Board.

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
Gaps in control: • None documented	1. Development of property strategy and annual property plan – complete (approved at November 2025 Board)	High
	2. Review proposed 2025/26 backlog maintenance programme against clinical priorities and capital availability - complete	High
Gaps in assurance: • User satisfaction – hard and soft estate. • Progress with capital maintenance programme • Future PFI concession arrangements	3. Improved internal financial reporting of planned and reactive maintenance expenditure by end Q3 2025/26.	Medium
	4. Monthly review of backlog maintenance plan to ensure timely delivery (ongoing).	High
	5. Review of PFI concession within ESNEFT and termination dates end March 2026	Low-Medium
	6. Develop accurate programme of annual capital expenditure - complete	Medium
	7. Mutual aid being provided by GSTT to provide new service delivery model for capital construction through financial year – being implemented in conjunction with procurement by end February 2026	High

BAF8: Improvements to patient quality, safety and experience through implementation of an EPR

Strategic Objectives: **5. Drive technology enabled care**			
Strategic Risk: BAF8			
IF we are unable to realise the benefits of our Electronic Patient Record (EPR) in accordance with the agreed benefits realisation plan	**Then** we will significantly constrain the delivery of linked digital and strategic goals regarding improvements to patient quality, safety, experience, outcomes and clinical integration	**Resulting in** an inability to standardise clinical processes and mitigate clinical risk associated with the lack of interoperability between legacy systems and processes. Non-compliance with national reporting requirements, reduced workforce satisfaction and workforce inefficiencies	**Defined by** Inefficient service models and patient pathways, characterised by limited visibility of patient information (including history), limited interoperability between acute and community, lack of digital support tools for clinical safety, continued reliance on paper processes and records, inability to fully integrate medical technology into patient pathway. Significant reputational damage, financial impact, regulator scrutiny and reduced workforce retention

Lead Executive	Managing Director	**Assurance committee**	Quality and Patient Safety Committee (QPSC)

	Impact	**Likelihood**	**Score**	**Risk movement (last 3 quarters)**			**Risk rating**
				Q4 2024/25	**Q1 2025/26**	**Q2 2025/26**	
Inherent	4	3	12	4x2=8	4x2=8	4x2=8	**8**
Residual	**4**	**2**	**8**				
Target	2	2	4				

Key Controls	**Assurances reported to Board and committees**
a) Digital, Data and Technology Strategy 2023-26	Approved by Board September 2023, with annual review. Periodic highlight reports to EPR Programme Board and Trust Board.
b) Annual Capital Programme with prioritisation of IT Capital Programme through Investment Group	Reviewed monthly and reported through PAF Committee to Trust Board.
c) EPR Programme Governance and Structure with clinical, operational and patient engagement	Service Line and Speciality Rapid Decision Groups (RDGs), chaired by clinicians and operational leads who are subject matter experts. Patient Experience RDGs include patient representatives, influencing design of patient portal. RDGs report to Advisory Councils and Design Authorities, through the EPR Programme Delivery Group to EPR Programme Board meeting, reporting to EMC, QPS Committee and Trust Board Independent internal audit of EPR programme governance concluded reasonable assurance Benefits Realisation Group, chaired by Managing Director 'Hot topic: Epic Benefits Realisation' presented to November Performance and Finance Committee
d) EPR Full Business Case, contract, implementation plan, benefits realisation and programme delivery team.	Full Business Case approved by Trust Board and NHS England. Benefits Realisation Group tracks benefits, reported through EPR Programme Governance to Trust Board.
e) Digital leadership development, Digital Fellows to support and lead digital health transformation and innovations. Credentialed Trainers (seconded clinicians) training clinical colleagues within nursing and midwifery, AHPs and health sciences	Digital leadership workshops with Trust Board Epic Executive Briefing EPR programme governance
f) Epic programme continues beyond October 2025 go-live into optimisation and business as usual activities.	Focused 'Turbo rooms' supporting operational staff. Reporting through EPR Programme Governance to Trust Board

Gaps in Controls and Assurances	Actions planned to improve controls and assurance	Impact of Actions on risk
Gaps in control: • None documented **Gaps in assurance:** • Demand for Epic trained/experienced workforce from other Trust's creating risk of high turnover within delivery team	1. Delivery and monitoring of benefits realisation. Overseen by Benefits Realisation Group, chaired by Managing Director. Group oversees delivery across divisions, tracking progress against planned outcomes and ensuring alignment with business case targets. Group is focused on delivery of 4 types of benefits; Cash releasing, Non-cash releasing; Societal; Unmonetisable. Key priorities for next 6 months (to June 2026): a. Deep dive into A&C reduction and drug spend reduction benefits b. Clinical informatics benefits c. Societal and unmonetisable benefits	High
	2. Restructure within Digital and Logistics to provide career development opportunities and increase resilience via training across multiple applications, with professional development opportunities – ongoing to April 2026	Medium

BAF9: Transformation

Strategic Objectives:

1. **Keep people in control of their health**
2. **Lead the integration of care**
3. **Develop our centres of excellence**
4. **Support and develop our staff**
5. **Drive technology enabled change**

Strategic Risk:
If we do not transform through strategy and its delivery then we will be unable to achieve long term sustainability leading to regulator intervention

IF we are unable to transform though strategy and adapt to changing NHS requirements	**Then** this will limit the Trust's ability to deliver its strategic goals and achieve long term financial sustainability	**Resulting in** loss of regulator/public confidence and consequent regulator intervention; inability to deliver strategic objectives.	**Defined by** Being unable to meet the needs of our patients, stakeholders and communities; regulatory action

Lead Executive	Director of Finance	**Assurance committee**	Trust Board

	Impact	**Likelihood**	**Score**
Inherent	4	4	16
Residual	**4**	**3**	**12**
Target	4	2	8

Risk movement (last 3 quarters)

Q4 2024/25	Q1 2025/26	Q2 2025/26
4x3=12	4x3=12	4x3=12

Risk rating: **12**

Key Controls	**Assurances reported to Board and committees**
a) People Strategy	Monitored through People and OD Committee and reported to Trust Board
b) Quality Strategy	Monitored through Quality and Patient Safety Committee and reported to Trust Board
c) Digital and Data Strategy	Monthly highlight reports to eHealth Group monitor KPIs. Quarterly reporting to ICS Strategic Digital Investment Assurance Committee
d) Communications and Engagement Strategy	Monitored through People and OD Committee and reported to Trust Board
e) Estates Strategy	Monitored through Estates Strategy Programme Group with regular updates provided to Trust Board
f) Diagnostics Strategy	Monitored through EMC and reported to Trust Board via strategic update.
g) Research and Innovation Strategy	Monthly monitoring through Executive Management Committee, quarterly strategic update report and Research and Innovation annual report to Trust Board
h) Strategic Plan	Quarterly reporting to EMC and then Trust Board
i) ESNEFT 2024-2029 Clinical Strategy	Strategy Endorsed by ICB November 2023 Financial sustainability. Deloitte Well Led review 2022. Performance, quality and finance reporting to NHS England and ICB as required. Quarterly Strategic update to Trust Board reports performance against strategy success measures. Delivery of new operating theatres (Ipswich Hospital), Urgent and Emergency Care Centre (Ipswich Hospital) ESEOC (Colchester Hospital). Approval of business case for Ipswich Community Diagnostic Centre. Trust Board approved Initial Medium Term Plan submission submitted to NHS England, December 2025.

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**	**Impact of Actions on risk**
Gaps in control: None documented **Gaps in assurance:** • Alignment of strategies to NHS 10 year plan • Concerns regarding quality of care raised by CQC following inspections of medical wards and urgent and emergency care at Colchester and Ipswich Hospitals	1. Deliver the Trust 2024 to 2029 strategy – reporting key measures of success to Trust Board quarterly (ongoing)	High
	2. Refresh of strategic plans, following publication of NHS 10 Year Plan, including submission of Medium Term Plan, as per NHS England timetable.	High
	3. Implement Epic EPR to improve quality metric reporting, productivity, access to information, and performance monitoring by end October 2025 - complete	High

BAF10: Digital resilience

Strategic Objectives: **5. Drive technology enabled care**			
Strategic Risk: BAF8			
IF we are underprepared for a cyber-attack and/or have insufficient digital resilience to recover from a digital incident	**Then** there is a risk of significant impact to patients, staff and the organisation due to inaccessibility of information	**Resulting in** disruption to services due to non-availability of clinical and non-clinical information. Potential data loss across key clinical and non-clinical systems.	**Defined by** delays and cancellation of treatment. Inability to accurately report activity Significant reputational damage, financial impact, regulator scrutiny and reduced workforce retention. Delay to delivery of transformation services.

Lead Executive	Director of Digital Logistics and Operations	**Assurance committee**	Audit and Risk Committee

	Impact	**Likelihood**	**Score**
Inherent	4	4	16
Residual	**4**	**2**	**8**
Target	4	1	4

Risk movement (last 3 quarters)

Q4 2024/25	Q1 2025/26	Q2 2025/26
-	new 4x2=8	4x2=8

Risk rating: **8**

Key Controls	**Assurances reported to Board and committees**
g) Digital, Data and Technology Strategy 2023-26 • Cyber security strategy and associated strategic model, aligned to national DSPT and CAF.	Approved by Board September 2023, with annual review. Periodic highlight reports to EPR Programme Board and Trust Board. Monthly ICT Operational Security Controls report provided to Audit and Risk Committee
h) Cyber Security Strategy Covers all hardware, software and data assets – including information technology, operation technology, connected medical devices, network components (both on our premises and in the cloud, including 3rd party managed assets).	Data Security and Protection Toolkit (DSPT) submission and internal audit findings reported to Audit and Risk Committee. Quarterly cyber reports detailing patch compliance, Operating System compliance and threat detection rates, Cyber Assessment Framework (CAF) IT key controls report provided to Audit Committee quarterly. Briefings on cyber security and EPR provided to Trust Board. Annual Penetration Testing, simulated phishing exercises. Participation in cyber security incident exercises
i) Application of cyber security notifications from NHS England and the National Microsoft Defender for Endpoint tenant.	Completed actions are reported back to the NHS England Cyber Responding Service or the NHS England Advanced Threat Protection service.
j) Business continuity and disaster recovery plans	EPRR Working Group - Digital and Cyber Security, reporting to Strategic Oversight Group through to Executive Management Team.
k) ICT Operational Security Team supported by: • NHS England Digital - Cyber Security Operations Centre (SCOC) • Sophos - Central Managed Detection and Response service (MDR) • Rubrik Ransomware Response Team (RTT)	Included in Monthly ICT Operational Security Controls report provided to Audit and Risk Committee.

Gaps in Controls and Assurances	**Actions planned to improve controls and assurance**	**Impact of Actions on risk**
Gaps in control: • Compliance with DSPT requirement regarding server operating systems **Gaps in assurance:** Security governance Board (SecGOV) to be established and onward governance route established.	1. Deployment of Windows 11 / Extended Support to client computers prior to Microsoft ending support for Windows 10.	Medium
	2. Technology refresh programme (per Annum)	Medium

	3. Build a complete view of all assets and define their criticality to our clinical and corporate systems. - ongoing to be completed post EPR go live, by end April 2026.	**High**
	4. Procure and Deploy Network Detection and Response (NDR) tool - complete	**Medium**

Definitions

BAF

The Board Assurance Framework (BAF) is designed to provide the Board with a simple but comprehensive method for effective and focused review of strategic risk. The BAF enables the Board to receive assurance from its committees that strategic risks are being appropriately managed.

Strategic risk

Strategic risks are those that represent major threats to achieving the Trust's strategic objectives or to its continued existence. Strategic risks also include key operational failures. Being clear about strategic risk allows the Board to ensure that the information it receives is pertinent to achievement of objectives and facilitates a clearer starting point for mitigation and control as well as business planning. These risks form the core content of the Board Assurance Framework.

Impact of actions (on controls / assurances)

For each of the actions recorded on the BAF, the impact (on controls / assurances) of completing these actions is indicated as either 'low', 'medium' or 'high'. This supports the effective evaluation of how planned actions are expected to strengthen control or assurance and reduce risk exposure.

High, medium low impact are defined as follows:

HIGH	Action is expected to significantly strengthen controls or close a major assurance gap. Potential residual risk rating reduction on completion.
MEDIUM	Action is expected to partially enhance controls or address a limited aspect of the risk. Improvement in control or assurance is expected but risk level will remain largely stable in the short term.
LOW	Action maintains or reinforces current control or assurance effectiveness; risk position likely unchanged.

Key Issues Report

Issues for referral to reporting Committee/Group

Originating Committee/Group and meeting date:	Audit and Risk Committee, 4 November 2025
Chair:	David Eagles, Non-Executive Director
Lead Executive Director (as appropriate):	Adrian Marr, Director of Finance/Deputy Chief Executive

Subject	**Details of Issue**	**Action***
Chairman's Business and meeting the Terms of Reference	The full Board Assurance Framework (BAF) included the amendments for strategic risk BAF4, quality, following a significant review and the proposal to increase the risk rating from 8 to 12 would be considered by the Board this week. Amendments to BAF7, estates, will be further considered at the Performance and Finance Committee and a revised proposal is to be presented to the Board in January 2026. The BAF had been further enhanced at the request of the Committee to include key questions designed to provide assurance in relation to achievement of the target risk rating. These had been applied to two BAF risks for consideration. Definitions for the impact of planned actions had also been applied. BAF risk 6A is now jointly owned by the Director of Operations – Elective and the Director of Digital, Logistics and Operations. The Committee referred to the helpful enhancements to achieve interim targets, with some changes proposed in the ordering of the new questions to enable an overview of whether the target risk is achievable. The comparatives were included within the corporate risk register, and the two medical divisions are working closely together to understand the disparity. A timeline for those discussions would be presented through the update from the Risk Oversight Committee. A six-monthly contract management report described the processes for managing the 741 income and expenditure contracts through the national Atamis e-commercial system and the development of the Contract Management Framework. The contract management dashboard was shared, which enables clarity on those contracts that are due to expire to ensure action is taken at the appropriate time. The changes being made will enable enhanced oversight and standardisation of relevant processes for best management of supplier delivery. This included strengthening governance and compliance, enabling support to service teams as contract owners, enhancing visibility and control and performance monitoring, value for money, mitigating risks and escalating issues, enabling strategic insight and decision making and building organisational capability. Examples were provided of the contracts being managed, which demonstrated a significant step forward. Members questioned the ICB structural changes and the opportunities to work together on procurement, and whether the Trust could review their data. In the NHS we have not traditionally maximised our buying power and this enables us to be much more courageous. Discussions have already started and there are opportunities to progress for mutual	Assurance

Subject	Details of Issue	Action*
	benefit. Further clarification was sought on whether there was a breakdown of the aims of individual contracts that are due to expire to enable an assessment of the next steps, how risks were highlighted, and the confidence in having sufficient clinical and divisional engagement in these conversations. The process to track this information was described and this would be picked up through the Divisional Accountability Meetings (DAMs). There is also an additional system, and discussions are underway with divisions regarding clinical issues such as surgical consumables. It was agreed that a report would be presented to the Board to review delivery and the benefits realisation following the award of the soft facilities management contract to Sodexo. The Treasury Management Policy was **approved.**	Alert
Internal Audit	Two reports had been finalised, both with Reasonable Assurance, resulting in four positive reports (Reasonable or Substantial) received to date and one Partial Assurance to support the end of year opinion. Two further reports had been issued in draft, and the plan was progressing in accordance with the schedule. In response to a previous Committee action, the audit themes from reviews were confirmed. A first draft of the 2026/27 plan would be presented to the Committee in January following re-evaluation of the risk register and discussion with Executive Directors, prior to a final plan being presented for approval in March 2026. The thematic analysis was welcomed. The management action status progress report confirmed closure of three actions, with a request for one revised implementation date to be agreed in relation to clinical audit, which was dependent on the job planning cycle. The Committee welcomed the positive performance presented and encouraged a focus on those actions that are not yet due. Assurance was provided relating to the discussion with Executive Directors in this regard. In relation to the extension requested, one of the fundamental points raised was that audit leads had not been appointed, and confirmation was sought that such gaps were being addressed. The proposed extension was **approved.** **Payroll, reasonable assurance:** Engagement from the team was strong and they had requested the re-audit to ensure their focus was in the right areas. Generally, the design of the control framework was positive, a User Responsibilities Payroll and Pensions document was in place and was robust and communication was regularly sent to remind line managers of payroll cut off dates and requirements for key forms to be submitted. Some areas of improvement were identified, and these were described. Eight management actions were agreed, two medium and six low priority. Given this was a significant change following the move from external to inhouse provision, such a positive report in the first six months was welcomed. A further review is scheduled in six-eight months to assess consolidation of in-house provision. Further work is required regarding line management arrangements and ensuring these are even more robust and consideration was being given to whether overpayments to staff was to be included in the Accountability Framework for 2026/27 to enhance divisional accountability. **Medicines Management, reasonable assurance:** The Trust demonstrated strong foundations in medicines governance and operational controls, but recurring issues in procedural compliance, documentation and staff training indicate a need for targeted improvements to ensure consistency, safety, and regulatory adherence across both hospital sites. The Trust had a comprehensive and well-governed policy framework in place, controlled drugs were securely stored using approved systems, disposal procedures were compliant with site specific protocols, and incident reporting was timely and well-documented. Governance structures were effective, roles and responsibilities were clearly defined, and disposal processes were consistently followed across both sites. Seven actions were	Assurance

Subject	Details of Issue	Action*
	agreed, four medium and three low priority. The Committee welcomed this helpful report with isolated administration issues to resolve. Members questioned if there was a relationship between this audit and the implementation of Epic and changes to practices, which was confirmed as an area of focus relating to the software interface.	
Counter fraud	A full update included five new referrals, confirming that staff remain vigilant to fraud and bribery risks. A webinar regarding the new failure to prevent fraud offence introduced under the Economic Crime and Corporate Transparency Act 2023 was attended by two members of Trust staff and for international fraud awareness week from 17 November there are multiple sessions available for staff to attend. The training being offered was also described and the revised risk register was presented. The positive progress was welcomed and the plan for 2026/27 was questioned.	Assurance
External audit	The outline audit plan for 2025/26 described the audit scope, the team appointed to ensure continuity from previous years, the audit risks and areas of focus, levels of materiality, the process and areas of focus for reviewing value for money, the fees and the timeline. The implementation of Epic will be included. The detailed work starts in December with enhanced focus from February to the completion of the audit in June 2026. The Committee sought further clarification regarding assessment of new systems, such as payroll, which was not regarded as a significant risk currently due to no data transfer. This would be considered further as more information became available. Any known increases in relation to technology improvements and AI was also questioned, with no issues currently that will change the audit for this year. The plan was received and the efforts made to achieve the best continuity possible were recognised. The Director of Finance referenced the monthly meetings with EY which were useful in ensuring clarity on the position and demonstrated a positive relationship between EY and the Trust.	Assurance
Trust Charity	The final documents relating to the Charity audit were presented for completeness following Board approval. For next year the team will engage with the Audit and Risk Committee earlier in the process. An impact report will also be produced. An internal debrief is scheduled and the timeframe for this would be accelerated. The Committee reflected that the Charity's Annual Report was a positive and uplifting read.	Assurance
Governance	An update on Trust policies confirmed that compliance remains above the 90% threshold for escalation reporting to Committee, at 96%. Members questioned how embedded the performance monitoring was, and how long compliance was expected to remain at this level. Assurance was provided on the process through DAMs. The contrast between the two MAC divisions matches with the risks being tracked (IES being notably higher volume in both elements than NEE). The report was helpful in providing assurance.	Assurance
Reports by Consent	The Committee received the six-monthly detailed update on declarations of interest at its previous meeting. This short report presented all new declarations for decision makers and all Trust staff. It included a declaration referred to in the previous report relating to sponsored research, which had now been received. Money had been bequeathed to a member of staff in a patient's will for donation to the Trust Charity. Assurance was provided that the Associate Director of the Charity was aware and the Trust's legal team was supporting the member of staff. This month the work supported by the LCFS would progress the additional checks of those decision makers who	Assurance

Subject	Details of Issue	Action*
	are non-compliant. The Committee questioned the work required to maintain and to enhance compliance and when additional escalation may be required. The Losses and Special Payments and Tender Waivers were received.	
Closure of meeting	As part of the meeting reflection, it was confirmed that reports were clear and highlighted areas for assurance and where further work was required the Committee has had the opportunity to challenge this. The Chief Executive, Director of Governance and the Trust Secretary were thanked for their contributions to this Committee.	Assurance

*Key:		**Approval**	Positive action required regarding an item of business or support for a decision
Escalation	Support/decision required by reporting committee to resolve an issue within its remit	**Alert**	Proactive notification of subject matter/risk that reporting committee is currently dealing with or mitigating which may require future action/decision
Assurance	Evidence or information to demonstrate that appropriate action is being taken within a reporting committee's remit	**Information**	No action required. Reporting to update on discussion within a reporting committee's remit

Trust Board

Report Summary

Date of meeting: 08/01/2026	
Title of Document: NHS Core Standards for EPRR 2025	
To be presented by: Mike Meers	**Author: Eric Gentry**
1. Status: For Approval/Assurance/Information	
2. Purpose: For approval of Trust Board	
Relates to: EPRR Core Standards annual self-assessment	
Strategic Objective	Include the relevant objective/all – Develop our centers of excellence; Support and develop our staff; Drive technology enabled care
Operational performance	EPRR supports operational performance and departmental business continuity plans to maintain Trust defined critical functions.
Quality	Effective business continuity and EPRR management supports quality metrics and business as usual performance by maintaining critical functions as far as reasonably practical, testing plans and supporting organizational learning to improve quality.
Legal, Regulatory, Audit	Non-compliance with the legal, contractual and statutory requirements has implications for the Trust in relation to reputation impact and financial loss. Individual commanders can be held accountable for their failure to act or to reasonably justify their decision making. Impacts on all service provisions may occur should we fail to appropriately and effectively respond, manage and recover from incidents.
Equality and diversity	There are no impacts on equality and diversity by implementing the work plan or in the assurance process.
Finance	The financial implications from the delivery of the work plan are that the Trust agrees to supply the appropriate resources in relation to material, labour, facilities and time to deliver the plan in order to become compliant.
Governance	This assessment required Board approval and public board declaration, details of the assessment are not for release into the public domain beyond the overall score and classified as Official Sensitive.
NHS policy/public consultation	This assessment aligns with the NHS England Policy for Emergency Preparedness, Resilience and Response Framework and associated policies.
Accreditation/ Inspection	This is a self-assessment of organisation preparedness against a nationally defined assessment criteria, the self-assessment will undergo scrutiny at system level and evidence of compliance will

	be provided to the ICB to fulfill this.
Anchor institutions	
ICS/ICB/Alliance	The annual core standards assessment is submitted to the ICB for collation into the system preparedness return to region. A confirm and challenge of our assessed position took place on 7th November.
Board Assurance Framework (BAF) Risk	This assessment aligns with preparedness and response to BAF risks associated with Industrial Action and infrastructure unavailability
Other	

3. **Summary:**

The Trust is required to undertake an annual core standards assessment in line with the NHSE EPRR Framework and the NHS Standard Contract. This assessment underpins the EPRR activity and enables the Trust to demonstrate its compliance and the discharge of its duties under the Civil Contingencies Act 2004 as a Category 1 responder.

The annual core standards return for Emergency Preparedness, Resilience and Response (EPRR) has been undertaken.

Annual self-assessments are scored against relevant core standards with each standard scored either;

- Non-compliant - Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months.
- Partially compliant - Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.
- Fully compliant - Fully compliant with core standard.

Once each of the standards has been assessed the organisation has an overall score determined by the percentage of standards scoring fully compliant as follow;

Organisational rating	Criteria
Fully compliant	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

This year's assessment required ESNEFT to score ourselves against 62 standards assigned to acute hospital Trusts and Community Health Providers. Of the 62 standards appropriate for our assessment, there have been no changes in the standards for this year. Initially we assessed ourselves as Fully Compliant in 60 out of 62 standards, Following the ICB check and challenge review on the 7th of November, we this has been updated to show Fully Compliant in 59 of the 62 standards with the 3 standards not met included in the work plan for the coming months and

therefore partially compliant. Overall, the score of 59 out of 62 represents a compliance rating of 95.16% therefore the Trust remains at a Substantially Compliant status.

Due to the ongoing changes within NHSE and the impact on ICBs this year's assessment has not included a deep dive question with focus being maintained on the full core standards.

This year's primary work in EPRR has focused on work around embedding governance changes as agreed following last years assurance return with focused working groups around key areas within the core standards covering E&F, Digital and Cyber, CBRN and Mass Casualty, Training and Education and Exercising and Incidents reporting to the Strategic Oversight Group on a quarterly basis. A focus on Business Continuity including creation of a BCP dashboard and an external BCP audit with 2 medium priority actions and 1 low priority action highlighted for improvement with plans in place to implement these recommendations as part of the EPRR work plan, continuing commander competencies particularly to Operational (Bronze) Commanders and Tactical (Silver) Commanders including competency assessments for Tactical colleagues, and training for Loggists. In addition, plans have been tested through industrial action, building utility and ICT outages, System go live challenges with both new PACs and Epic EPR systems being implemented, along with continued blood product supply challenges and continued patient flow and capacity challenges.

ESNEFT continue to be supportive of regional exercising and planning in, supporting and participating in exercises around pandemic response and winter planning, ESNEFT staff have also taken part in multi-agency marauding terrorist exercises as observers.

4. Recommendations / Actions

It is recommended the board acknowledge the score inclusive of the completed confirm and challenge as undertaken with ICB colleagues.

Details of the individual areas of assessment are to remain out of the public domain and subject to classification as Official Sensitive due to the subject nature of the assessment and the response plans summarized.