EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 6th October 2020 commencing at 10:30 via MS Teams Live

	AGENDA		Lead:	Time:
1.	1.1 Chair's opening remarks 1.2 Apologies for absence 1.3 Trust award winners	A	Chair	1030 - 1100
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 4th August 2020	B		
4.	Matters Arising	C		
5.	Board Committee Chair's Feedback		Committee Chairs	
6.	Board Assurance Framework	D	DCA	
7.	Chief Executive's Report		CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
8.	Integrated Performance Report Month 5 (August) – 1. Quality and Safety 2. Access, Delivery & Activity 3. Leadership and Culture 4. Finance	Assurance	E	DDN MD COO HRD DF	1100 - 1145

BREAK

STRATEGY

					Time:
9.	ICS Collaborative Workstream	Assurance	F	DS	1200 - 1210

GOVERNANCE AND ASSURANCE

					Time:
10.	Winter Preparedness	Assurance	G	COO	1210 - 1245
11.	NHS Charities Together	Assurance	H	DCA	
12.	Workforce Equality	Assurance	I	HRD	

13.	Papers for review and noting: • Learning from deaths Q4 • Health & Safety Annual Report • Organ Donation Annual Report	Assurance	J		
14.	Board Sub Committee Minutes	Assurance	K	Chair	

ITEMS FOR INFORMATION

				Time:
15.	Use of Trust Seal	L	Chair	1245 - 1300
16.	Questions from members of the public (15 minutes maximum)		Chair	
17.	Date of Next Meeting: Tuesday 1st December 2020		Chair	

Chairman

Steve Phoenix

Key:	
Chair	Trust Chairman
CEO	Chief Executive
COO	Chief Operating Officer
DCA	Director of Corporate Affairs
DS	Director of Strategy
DF	Director of Finance
DDN	Deputy Director of Nursing
HRD	Director of Human Resources
MD	Medical Director

3rd September 2020

Annual Trust Award Winners

Meeting information:			
Date of Meeting:	6th October 2020	Agenda Item:	1.3
Meeting:	Trust Board	Reporting Officer:	Steve Phoenix

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

As a result of the pandemic, we were sadly not able to undertake our annual Trust awards in the usual manner. The achievements of members of staff at the Trust were celebrated at three separate socially distanced award ceremonies, with three awards given. Fifteen awards would have been made in a normal year.

People's Choice Award

This was awarded to Dr Graham Whincup, Consultant Paediatrician, who retired in May 2020 but stayed on and undertook work throughout the pandemic. The award was voted for by patients and Dr Whincup was the unanimous choice of the judging panel (conducted virtually this year) of local MPs and representatives from Healthwatch.

Dr Whincup retired in May 2020 but stayed on and undertook work throughout Covid. Nominations praised his professionalism, care, willingness to go the extra mile and approachability. One patient wrote: "Dr Whincup has 100's of patients but he always make you feel you are the important one. There will never be another Dr Whincup, he's a wonderful man."

The People's Choice Award runner-up was Pevensey Day Unit, who provide chemotherapy treatment for patients with cancer.

The Chairman's Award

This was awarded to the Bexhill Irvine Unit. During the pandemic, the Unit had to change from being a "green" area to "red" in the space of 48 hours, due to a number of patients and staff contracting Covid. They responded magnificently, adopting new practices, changing rotas, implementing Covid preventive measures, dealing with families and relatives. They continue to provide active support to the acute hospitals increasing discharge flow rates.

The Unit maintained its consistently high standards of care while meeting these challenges, earning plaudits from patients, families, and colleagues in the acute hospitals alike. They exemplified the Trust's values – working together across the organisation, showing rapid improvement in response to Covid, working with compassion for their patients and respect for families and each other, being engaged and involved in the planning of care. In a year in which people and teams across the organisation rose to a once-in-a-generation

challenge Bexhill Irvine Unit exemplified the resilience, courage, and commitment to care to which we all aspire."

40 years long service award

Six members of staff were presented with 40 years' long service awards:

Lesley Carter	Matron in Ophthalmic Day Surgery
Beverley Chui	Ophthalmic Nurse
Amanda Edwards	Theatre Practitioner
Wendy Elfick	Site Team, Urgent Care
Louise Gausden	Paediatrics
Janice Whiteman	Healthcare Assistant

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 4th August 2020 at 10:30 video conference via Microsoft Teams

Present:
Mr Steve Phoenix, Chairman
Dr Adrian Bull, Chief Executive
Ms Vikki Carruth, Director of Nursing
Mrs Joe Chadwick-Bell, Deputy Chief Executive
Mrs Jackie Churchward-Cardiff, Vice Chair
Mrs Miranda Kavanagh, Non-Executive Director
Mrs Karen Manson, Non-Executive Director
Mr Damian Reid, Director of Finance
Mrs Nicola Webber, Non-Executive Director
Dr David Walker, Medical Director

Non-Voting Directors:
Mr Imran Devji, Interim Chief Operating Officer
Mrs Amanda Fadero, Associate Non-Executive Director
Ms Monica Green, Director of Human Resources
Mr Richard Milner, Director of Strategy Innovation & Planning
Ms Lynette Wells, Director of Corporate Affairs
Ms Carys Williams, Associate Non-Executive Director

In attendance:
Mr Peter Palmer, Assistant Company Secretary (minutes)

041/2020 **Welcome**

1. Chair's Opening Remarks
Mr Phoenix welcomed everyone to the meeting. He noted that Mrs Fadero and Mr Devji were attending their first meetings of the Board and welcomed them. He also noted that this was Dr Bull's final Board meeting in public. He thanked him on behalf of the Board for the outstanding work that he had done for the Trust, noting that it was appreciated throughout the organisation. He would be greatly missed. Dr Bull explained that he had been proud to be part of the Board, the organisation and the successful journey that the Trust had been on.

2. Apologies for Absence
Mr Phoenix advised that apologies for absence had been received from:

Mr Paresh Patel, Associate Non-Executive Director

042/2020 **Declarations of Interest**
In accordance with the Trust's Standing Orders that directors should formally disclose any interests in items of business at the meeting, the Chairman noted that no potential conflicts of interest had been declared.

043/2020 **Minutes**
The minutes of the Trust Board meeting held on 2nd June2020 were considered and were agreed as an accurate record. The minutes were signed by the Chairman and would be lodged in the Register of Minutes.

044/2020 **Matters Arising**

There were no matters arising from the previous meeting.

045/2020 **Board Assurance Framework**

Mrs Wells reported that the Board Assurance Framework (BAF) was being presented in a new format for the first time at the Board. It had already been presented to the Board's sub-Committees. Feedback from the Committees had been positive, and the BAF and Trust Risk Register would be reviewed at the Board seminar in September. She reported that BAF5, the risk associated with Covid risk assessments for staff, had progressed greatly since being added to the BAF.

Mrs Kavanagh praised the clarity of the new format, but queried whether the risk ratings included on the BAF reflected how staff felt about working in the organisation. Dr Bull explained that, particularly at the current time in facing Covid, the BAF was an accurate reflection of the Trust, noting that it set out the likelihood of particular risks occurring, and the impact that it would have should this happen. The likelihood of occurrence was an accurate reflection, and work continued to mitigate the risks detailed. A further review of the BAF would be undertaken by the Executive Team following feedback from the Board and Committees.

Mrs Churchward-Cardiff noted that the BAF had been reviewed by the Quality and Safety (Q&S) Committee and suggested that BAF2, the ongoing impact of Covid, should be part of the remit of that Committee as well as the Strategy Committee. She praised the new format, and hoped that similar update of the Trust's Risk Register could be undertaken.

Mr Phoenix thanked Mrs Wells for her work on revising the BAF.

The Board noted the revised Board Assurance Framework which covered the main risks and appropriate actions to manage them. The Board agreed with the revised Green rating for 7 day working and that the Covid risk would be redrafted.

046/2020 **Chief Executive's Report**

Dr Bull presented his report, explaining that it struck a balance between the Trust's response to Covid and business as usual within the organisation. He reported that visiting arrangements within the Trust continued to be flexed based on the specific circumstances on wards. The Trust was very aware of the importance of visiting to patients and their families, and arrangements were being put in place to allow visiting to take place remotely wherever possible.

He reported on other areas of focus within the Trust, including on transition of patients from paediatric to adult services, improving discharge arrangements, safeguarding work and the looked after children team. Transformation programmes were being relaunched, including the Trust's programme to become the best at frailty, with a new consultant having been appointed to the frailty team.

Dr Bull reported that the education steering group had met the previous day and had discussed how continued education was being managed during the pandemic. Objective Structured Clinical Examinations (OSCEs), part of the registration process for overseas nurses, would be restarted in September. A cohort of medical students had joined the Trust to provide support during the pandemic just prior to graduating and had now joined as foundation year

doctors. A programme with Henley Business School had commenced; 40 members of staff would be commencing a senior masters training programme in November. Successful recent recruitment had been made in specialities which had previously been difficult to recruit to including A&E, ITU, Occupational Therapy and Physical Therapy teams.

Dr Bull highlighted how important communications and engagement had been during the pandemic, praising the Trust's Communications Team for their work. He explained that feedback received had demonstrated the value of the clear messages that had been put out by the Trust had been both to staff and to patients.

He reported that the Trust had been successful in bidding for a number of additional capital streams during the previous and current financial years. Further capital opportunities were being explored by the finance and estates teams. He reported that key priorities for the organisation had been agreed by Executives ahead of lockdown, which would shape the strategy for the Trust over the next five years.

Mrs Churchward-Cardiff congratulated the Trust and Executives on what had been achieved during the pandemic. She asked for an update on winter flu vaccinations and on plans to restart Board Walks. Dr Bull explained that the Trust had been amongst the best in the country for vaccinating staff in 2019/20 and plans for the coming winter were being developed. Board Walks would be reintroduced when possible, with a balance needed between supporting teams in person while respecting the need to socially distance. Mrs Carruth explained that she was very keen for Non-Executive Directors (NEDs) to come back into the organisation as soon as possible to enable them to see all the changes that had taken place since the start of the pandemic. She explained that she would be happy to liaise with NEDs to ensure that visits could be undertaken in a safe manner. Mr Phoenix agreed to speak to Mrs Carruth outside the meeting about how Board Walks could be safely resumed. **SP/VC**

Mrs Kavanagh congratulated the Executive team on their performance in the first phase of the pandemic. She asked for more information about the contribution of junior doctors during the pandemic, as well the take up of counselling for staff. Dr Bull explained that 13-14 junior doctors had joined the Trust prior to completing their training to help with the response to the pandemic. He praised them for the support that they had offered to the Trust, noting that they had fedback that the experience they had gained from working on wards had been beneficial. Mrs Green explained that Trust staff had been offered a comprehensive suite of counselling interventions. Time to Talk had been used by hundreds of staff, and the Employee Assistance Programme and psychological support sessions were also well used by staff. Managers were also being supported and virtual Schwartz rounds continued.

Mrs Manson added her congratulations to Executives and Trust staff for their management during the pandemic, as well as their management of the hospital at same time. She asked what preparations were being made for a potential second wave of the pandemic, asking about any collaboration with care homes. Dr Bull explained that while a second wave of the pandemic was not inevitable, the Trust continued to prepare for the possibility. Critical care capacity had been a key issue at the start of the pandemic and capacity had been increased from 19 beds to 24. This could be increased further to 40 if required. A lot of effort had been made to enhance relationships with care homes, with every nursing home in the county having a registered nursing contact in the Trust.

Mrs Chadwick-Bell noted that the Trust's Recovery Board was monitoring recovery and restoration within the Trust, alongside planning for a second wave. The Trust's Winter Plan included plans for managing a resurgence of Covid and bids had been submitted to NHSE/I for additional funding to build Trust and system capacity.

Dr Walker explained that red and green streaming for patients with Covid and suspected Covid, enhanced doctors rotas and other measures had been stood down, but could be reintroduced if there was a second wave. Clinicians now had considerable experience of treating patients with Covid. Mrs Carruth noted that learning from the pandemic was discussed regularly within the organisation, ensuring that the Trust would be well prepared for a second wave. If there was a second wave, ensuring the wellbeing of staff would continue to be crucial.

Mrs Manson noted that routine business case processes had been suspended due to the pandemic and asked when it was anticipated that these would resume. Mr Reid explained that Covid related business cases continued to be approved. Current national guidance allowed for the approval of business cases for specific areas only.

Mrs Fadero applauded the work undertaken by the organisation, noting that it was refreshing to see the progress that was being made. She asked for further information about children in care and with learning difficulties. Dr Bull explained that around 100 children were being looked after by the safeguarding team, who had continued to provide care during the pandemic. Health visitor teams had changed the way they worked, with remote follow up work being undertaken to maintain contact with families. This had proved to be very effective. Mrs Carruth praised the team for the extraordinary job they had done in the circumstances, and noted that the Trust was working hard to re-establish full safeguarding services for children.

The Board noted the Chief Executive's Report.

047/2020 **Integrated Performance Report Month 3 (June)**

i. Quality & Safety

Mrs Carruth reported that the Trust's complaints process had been paused in line with national guidance during the pandemic, but had resumed on 1st July. The Trust had worked hard during the pandemic to maintain its position, with a small number of complaints received about visiting restrictions which had been reduced in line with national guidance. Restrictions continued to be reviewed on a weekly basis, and would be reduced when it was safe to do so. She thanked all staff, particularly those at the main entrances of hospitals, who had been talking to visitors about visting restrictions, and handing out masks and sanitiser.

Incident reporting had returned to expected levels as activity in the organisation had increased. A deep dive into medication incidents was being undertaken and would be presented to the Patient Safety and Quality Group and the Q&S Committee when complete. Two falls with harm had taken place in June, both of which would be subject to Root Cause Analysis (RCA). There had been one category four pressure ulcer in June which would also be subject to an RCA. Significant work was being undertaken to reduce falls in the Trust, and a report on this work would be presented to Q&S.

Mrs Carruth reported no specific concerns about clostridium difficile rates in the Trust, noting that 10 cases had been reported in the year to date against an annual limit of 22. Four MSSA cases had been reported in June; three were found to be from an unknown source and the fourth had been deemed to be not avoidable since the report had been written. Nursing fill rates were stabilising as normal activity resumed in many areas, although the need for red and green streaming meant that there was increased complexity in managing services. Two periods of increased Covid incidents had been seen in mid-June and July, with some asymptomatic spread between patients and staff. The Trust had seen a total of 337 confirmed positive patients, 249 patients who had tested negative but been treated as positive. 441 patients had been treated and discharged and sadly 128 had died. Testing turnaround time continued to be problematic, and the possibility of in-house testing was being explored.

Dr Walker explained that the next Summary Hospital-level Mortality Indicator (SHMI) would be published the following week and would be 97 for the Trust. A couple of months previously the SHMI had been 94. As ESHT was an integrated trust, deaths in community hospitals were included; the Trust was compared with acute only hospitals, leading to a higher score comparatively. The reasons for the increase were being investigated, and included a slight increase in excess deaths during the winter period and a reduction in coding levels. Measures had been introduced to increase coding levels.

In April, the Trust's Risk Adjusted Mortality Indicator (RAMI), which had included data from the pandemic, had risen from 80 to 142. The comparative score for peer organisations had been 238, demonstrating how well the Trust had managed during the pandemic. In May the RAMI had been 91, compared to an average score of 140 for peer organisations. Dr Walker explained that when covid deaths were excluded from the RAMI, the Trust's score for April had been 101 and 74 in May. The Trust was trying to understand why the score was high in April; this could have been due to undiagnosed deaths as a result of Covid, or delays in patients attending hospital as a result of Covid.

ii. <u>Access and Delivery</u>

Mr Devji praised the organisation's response to the pandemic, explaining that he had found the focus on patient safety, care and colleague wellbeing to be palpable within the organisation since he had joined the Trust. The Trust continued to have red and green areas for Covid management; there were occasions when this caused delays for patients, particularly during busy times and out of hours. Patient flow was being well managed in the Trust and underwent regular review. Patient safety remained a priority.

A&E performance in the Trust had been 95.2% during June, with the Trust ranked 36th nationally out of 114 Trusts. The Trust's performance for July had been 93.2%, with A&E attendances beginning to return to pre-Covid levels. Work was being undertaken with the South East Coast Ambulance Service to review ambulance handover times.

Frailty would play role in the Trust's improvement programme. Planned improvements included a focus on the start of patient pathways at the Conquest Hospital and strengthened discharge processes. Work was being undertaken to reduce variation in patient care at EDGH, along with work with partner organisations to consistently strengthen discharge processes. Best practice would be shared across the organisation, ensuring standardisation of working practices.

Mr Devji reported that patient flow was being reviewed throughout the organisation as part of the patient flow programme which would lead to an integrated approach being taken throughout the Trust. Reviews of length of stay, winter plans and escalation procedures were also being undertaken.

The Trust had been 6th in the country for Referral to Treatment (RTT) performance during June, with performance of 68.6% against the 18 week target. Work was being undertaken to address the backlog of patients that had built up during the pandemic, with 170 patients waiting for longer than 52 weeks to start treatment; the Trust had never previously had a patient who had breached 52 weeks. All long waiting patients had been clinically reviewed and were being prioritised based on clinical urgency. During July, RTT performance had reduced to 59.4%, with patients being added to waiting lists faster than they could be removed. Activity levels were around 60% of those seen pre-covid. Diagnostic performance in June had seen 32.8% of patients not being see within six weeks, against a target of 1% and work to improve this position was being undertaken.

Outpatient performance was around 60% of contracted levels, with an expectation that performance would return to close to pre-Covid levels by October. Mr Devji explained that around 60% of follow-up appointments would take place virtually, and clinical pathways would be strengthened to support this change.

Elective care performance was around 9% below the recovery plan, and at around 53% against contracted levels. Restrictions around patient proximity remained, and turnaround times in theatre were increased due to donning and doffing of PPE. Additional challenges were anticipated in winter and were being planned for, including a second wave.

Mrs Churchward-Cardiff noted that the Trust had continued to perform well given the pandemic. She explained that she was concerned about increasing numbers of stranded patients, the deteriorating RTT and diagnostic positions, the increasing waiting list and A&E breaches being reported. She asked about the biggest change that was needed to get performance under control. Mrs Chadwick-Bell highlighted some of the difficulties of returning to pre-Covid levels of work. A Sussex wide plan was being developed to look at delivery of services in a more innovative manner across the county. The Trust would focus on improving productivity, and whether services could be delivered differently. Full resumption of elective work would be a key challenge for the organisation.

Mrs Chadwick-Bell reported that the Trust would become a ‘fast follower’ for 111 First, a new A&E model which was being piloted in Portsmouth. This would see patients being required to phone 111 prior to attending A&E in most circumstances. Urgent cases would continue to attend A&E via 999 calls. The change would allow patients to be booked into alternative pathways to A&E on a planned basis where appropriate and would represent a large cultural change for local populations. Changing to the new system would take time, but represented an exciting opportunity to change the way urgent care was delivered.

Mrs Kavanagh welcomed the level of detail given in the IPR. She asked whether an update was available on any changes to national standards. Mrs Chadwick-Bell explained that the proposed changes had been trialled in a number of NHS organisations during the previous 18 months, but had not been widely introduced. Changes to how performance was monitored would be

required when they were introduced, so Trusts would need some notice before a change could be implemented.

Mrs Fadero thanked Mrs Chadwick-Bell for her update on 111 services, noting that this would require a behavioural change for the system and the Trust. She asked how the changes would be communicated to the public, patients and primary care colleagues. Mrs Chadwick-Bell explained that planning for communications was still in development, noting that a 50% reduction in walk-in patients had been seen during the early stages of Covid. The Trust would learn from what Portsmouth were doing, and would develop plans over the coming weeks with NHS communications teams across Sussex.

iii. Leadership and Culture

Miss Green noted that the figures included within the IPR were those for Month 2. Updated data for Month 3 had been circulated to the Board prior to the meeting.

The Trust had seen a reduction in staff usage during Month 3, with costs slightly lower than in previous months due to a decrease in the number of temporary staff used. The vacancy rate had reduced to 9% during the month, with good recruitment experienced despite Covid, particularly for medical and dental staff with new consultants recruited in some difficult to recruit areas. Visa restrictions had made recruiting overseas staff difficult but 12 radiographers and a number of nurses would be joining the Trust.

Turnover remained unchanged at 9.8% and compared positively to other Trusts. Sickness had reduced by 0.7% to 3.9% during the month, having been 5.4% in April. A reduction in cough, cold and stress related sickness had been seen and health and wellbeing support offered to staff. Both appraisal and mandatory training rates had increased during the month. 120 new doctors were being inducted into the Trust; the induction programme had been adapted to allow for social distancing.

87% of consultants had an up to date job plan, and 75% of doctors of other grades had completed job plans. Speciality based workforce plans were being developed with divisions. The “We are the NHS: People Plan for 2020/2021” had been launched the previous week. The plan set out what NHS staff could expect from their leaders and each other, examining a number of different aspects including growing the NHS’ future workforce. A response paper would be presented to the People and Organisational Development (POD) Committee in September.

A national requirement for health and safety assessments to be undertaken for all staff, and particularly those with a vulnerability to Covid had been introduced. Over 5,000 of the Trust’s workforce were classified as vulnerable, and 87% of those had been assessed. 61% of the total workforce had been assessed, and 77% of BAME staff.

Mrs Webber praised the Trust for the progress in completing risk assessments for staff She asked whether would be redeployed again if there was a second wave of Covid. Miss Green explained that some staff were still unable to return to their substantive roles, and the possibility of working from home or alternate roles were being explored. She anticipated that the Trust’s workforce would be more agile and flexible following the pandemic, with technology helping to facilitate this. Changes were being made within hospitals to ensure that staff remained safe.

Mrs Fadero thanked Miss Green for her report, praising the work that she and the HR team were doing. She asked how long the additional support for staff would remain in place, and how the impact of this support would be assessed to enable the Trust to ensure it was best targeted moving forward. Miss Green explained that the decision to invest in organisational health and wellbeing had been made a number of years before, so support for staff had been well established prior to the pandemic. A lot of consideration had been given to how the impact of support would be monitored, and measures would include sickness rates, engagement scores from the annual staff survey and feedback to the Speak Up Guardians. A report would be presented to POD about the impact of the support offered to staff.

Mrs Carruth noted that some staff had experienced anxiety and post-traumatic stress during the pandemic, and the Trust was actively supporting staff. She praised the work of the occupational health and wellbeing teams.

iv. Finance

Mr Reid highlighted a slight difference in the financial figures reported in the CEO's report and in the IPR. He reported that the Trust had had a £9m financial deficit over the first three months of the year. £5.3m of this deficit was related to Covid and would therefore be funded by NHSI. The remaining £3.7m would be centrally funded to enable the Trust to reach a break-even position. He anticipated that the national regime giving payments to Trusts to reach break-even positions would continue during months five and six, and anticipated that more detailed information about financial arrangements would be received in the coming weeks.

The Trust would be focussing on its run rate throughout 2020/21 to ensure that when the pandemic financial regime ended the Trust would be in the best financial position possible. The Trust's financial performance in 2019/20 had been excellent and it was vital that this progress was not compromised during the pandemic. Dr Bull noted that the Trust had reduced its monthly run rate to around £2m by the end of the previous financial year. There had been confidence that this would be further reduced during 2020/21, and that the Trust would meet its control total for the year, but this had been complicated by Covid. Internal financial control mechanisms continued to be reinforced with the ambition of emerging from the interim financial regime in a month to month operational position better than a £2m monthly deficit.

Mr Reid reported that the Trust was working on capital plans for the year, which would include internal funding, funding from the local healthcare system and an early release of funds for preparation work for the government's Health Infrastructure Plan (HIP2).

Mrs Kavanagh asked why variances against budgets for all of the divisions were shown as £0 within the IPR. Mr Reid explained that the Trust's shortfalls were being shown against the corporate budget only. He would look at how the shortfall could be reported without Covid related costs in order to present the true divisional position. Work had begun with divisions to forecast what their financial position would be through to the end of the financial year. Issues in some areas had been identified and the finance team would work closely with divisions to develop updated financial plans for 2020/21.

Dr Bull noted that discussions about how divisional performance should be presented had taken place and a decision had been taken to alleviate pressure

on divisions to allow them to focus on responding to the pandemic by presenting shortfalls against the corporate budget. Work to restate divisional budgets in the second half of the year would continue and financial reports would accurately reflect divisional financial performance once completed.

The Board noted the IPR Report for Month 3 and actions in place

048/2020 **Restoration and Recovery Update**

Mr Milner updated that a number of external changes had taken place since the report had been written; these largely reinforced work that had already been undertaken. He reported that the Trust had received detailed information about national priorities for the NHS which had set out the requirements for returning to a near normal level of activity prior to winter. The Trust was developing a winter plan which included any potential second wave of Covid. He noted the importance of ensuring that any organisational improvements realised during the pandemic were sustained.

A draft submission of anticipated progress in returning to pre-pandemic inpatient, day case and outpatient work would be submitted to the Integrated Care System on 1st September, with the final submission due on 25th September. Expected activity levels, capacity, workforce availability and financial implications were all being assessed prior to the final submission data. The final version of the submission would be shared with the Board.

Mrs Churchward-Cardiff asked for further information about paediatrics, which had been rated as red in the report due to space issues. Dr Bull explained that Friston Ward at EDGH had been utilised for additional critical care capacity during the pandemic, leading to a concomitant reduction in Short Stay Paediatric Assessment Unit (SSPAU) activity. Friston Ward continued to be utilised by Critical Care, so outpatient SSPAU activity continued to be constrained.

Mrs Churchward-Cardiff asked how the Trust was managing clinical reviews of the growing numbers of patients on paediatric waiting lists. Mrs Chadwick-Bell explained that all waiting lists were clinically reviewed with treatment given to patients who required urgent care. It was planned that Scott Unit and the area previously occupied by Electronics and Medical Engineering (EME) would be redeveloped and would become a paediatric assessment unit. A suitable off-site location had been identified which would allow community paediatrics to safely restart. Paediatric surgery had restarted at Conquest Hospital.

The Board noted the Restoration and Recovery Update.

049/2020 **Papers for Noting**

i. <u>South East Regional Chair's Briefing</u>

Mr Phoenix presented the briefing, explaining that it had been written a couple of months previously. He noted that matters had progressed significantly since the report had been written.

The Board noted the South East Regional Chair's briefing.

050/2020 **Board and Committee Meetings**

2019/20 Annual reports from the Audit and Finance and Investment Committees were reviewed and approved by the Board. Minutes from the following meetings were noted:

- Audit Committee, 30th January 2020
- Audit Committee 3rd April 2020
- POD Committee Summary, May 2020

The Board noted the Committee Annual Reports and Minutes.

051/2020 **Questions from Members of the Public**

Members of the public submitted questions to the Board in advance of the meeting. Trust responses were prepared in advance of the meeting and are shown in italics.

i. Why is the Trust not holding 'live' virtual meetings that will enable members of public to view proceedings as they happen, and to submit questions to the Board?

The Trust hopes to start broadcasting its Board meetings in public from October, using MS Teams Live. Small scale test events have taken place which have demonstrated the complexity of broadcasting meetings live, and we want be assured that any broadcast will work smoothly before attempting to hold a 'live' Board meeting. In the meantime, a recording of the meeting will be put on to the Trust's website to enable members of public and staff to view the meeting.

Members of public can submit questions to the Board in advance of the meeting.

052/2020 **Date of Next Meeting**

Tuesday 6th October 2020

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 4th August 2020 Trust Board Meeting

Agenda item	Action	Lead	Progress
046/2020 – Chief Executive's Report	Mr Phoenix and Mrs Carruth to meet to discuss the safe resumption of Board Walks	**SP/VC**	Meeting has taken place. Event held on 29.09 to set out changes within the Trust since the pandemic, and whether Board Walks could safely resume.

Board Assurance Framework

Meeting information:			
Date of Meeting:	6th October 2020	Agenda Item:	6
Meeting:	Trust Board	Reporting Officer:	Lynette Wells, Director of Corporate Affairs

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

There were no new risks added to the Board Assurance Framework (BAF) this quarter and all existing risks have been reviewed and updated as appropriate.

The level of risk for BAF 2 in respect of access standards has increased to 16; this is due to the increased backlog and longer waiting times.

The levels of risk for BAF 7 and BAF 8 have reduced from 16 to 12 due to increased capital and bids for capital respectively.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

People and Organisational Development Committee, 17th September 2020
Quality and Safety Committee, 17th September 2020
Audit Committee, 24th September 2020

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board are asked to review and note the Board Assurance Framework and consider whether the main inherent/residual risks have been identified and that actions are appropriate to manage the risks.

East Sussex Healthcare NHS Trust

Board Assurance Framework (BAF)

Quarter 2 2020/21

Overview

The Board Assurance Framework (BAF) supports the Board in focussing on the key risks which might compromise the achievement of the organisation's Strategic Objectives. The BAF maps out the key controls which are in place to support delivery of the Objectives and to mitigate risk and provide a framework of assurance which the Board can draw upon when considering the effectiveness of those controls. These assurances have been set out in line with the '3 lines of defence' model (appendix 2), aiding the identification of areas of weakness.

Each principal risk is owned by an Executive Director and rated in accordance with the grading matrix (Appendix 1). The Executive lead ensures the controls, assurance, gaps and risk score reflect the management of the risk. A Board sub-committee is also nominated to have oversight of the risk.

There are no new risks added to the BAF this quarter and all existing risks have been reviewed and updated as appropriate.

- BAF 2 relating to access standards and BAF 3 restoration and recovery are closely linked. The level of risk for BAF 2 in respect of access standards has increased to 16 this is due to the increased backlog and longer waits as a result of the impact of Covid-19 pandemic,

- BAF 7 and BAF 8 have reduced from 16 to 12 due to increased capital/bids for capital

BOARD ASSURANCE FRAMEWORK - SUMMARY PAGE

NHS East Sussex Healthcare NHS Trust

Ref	RISK SUMMARY	Monitoring Committee	Objectives Impacted					Inherent risk	Current position (Residual risk)								Change	Risk appetite	Target rating	Target date
									2020/21				2021/22							
									Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
BAF 1	Safe care - sustained and continuous improvement	Q&S	✔					20	9	9							◄►	Low	6	Mar-21
BAF 2	Restoration and Recovery - ongoing impact of Covid19	F&S	✔	✔	✔	✔	✔	20	16	16							◄►	Low	6	Dec-20
BAF 3	The Trust's performance against access standards is inconsistent	Q&S	✔	✔				20	12	16							▲	Low	6	Mar-21
BAF 4	Sustainable Workforce	POD	✔	✔	✔		✔	20	16	16							◄►	Moderate	9	Mar-21
BAF 5	Protecting our staff	POD			✔				12	12							◄►	Low	4	Jul-20
BAF 6	Financial Sustainability	F&S				✔	✔	16	12	12							◄►	Moderate	8	Dec-20
BAF 7	Investment required for IT, medical equipment and other capital items	F&S	✔				✔	20	16	12							▼	Moderate	8	Mar-21
BAF 8	Investment required for estate infrastructure – buildings and environment	F&S	✔				✔	20	16	12							▼	Moderate	8	Mar-21
BAF 9	Cyber Security	Audit	✔	✔			✔	20	16	16							◄►	Low	8	Mar-21

- Inherent - (gross) assessment (before current controls) of the risk
- Residual - (net) assessment (after current controls) of the risk

BAF Action Plans – Key to Progress Ratings		
B	Complete / Business as Usual	Completed: Improvement / action delivered with sustainability assured.
G	On Track or not yet due	Improvement on trajectory
A	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement
R	Delayed	Off track / trajectory – milestone / timescales breached. Recovery plan required.

RESIDUAL RISK MATRIX

	Safe and excellent patient care, high quality clinical services	Operate, efficiently and effectively in a timely way	Value, respect and involve employees	Work closely with partners to prevent ill health and deliver services to meet needs	Use resources efficiently and effectively to ensure clinical. operational and financial sustainability
BAF 1 – Safe care - sustained and continuous improvement	**9**				
BAF 2 – Restoration and recovery Ongoing impact of Covid19	**16**	**16**	**16**	**16**	**16**
BAF 3 - The Trust's performance against key access standards is inconsistent	**16**	**16**			
BAF 4 - Sustainable Workforce	**16**	**16**	**16**		**16**
BAF 5 – Protecting our Staff	**12**				
BAF 6 - Financial Sustainability				**12**	**12**
BAF 7 - Investment required for IT, medical equipment and other capital items	**12**				**12**
BAF 8 – Investment required for estate infrastructure – buildings and environment	**12**				**12**
BAF 9 - Cyber Security	**16**	**16**			**16**

Risk Summary						
BAF Reference and Summary Title:	**BAF 1: Safe care – sustained and continuous improvement**				**Strategic Objectives Impacted** ✓	
Risk Description:	**There is a risk that we will not provide sustained and continuous improvement in patient safety and quality of care**					
Lead Director:	Director of Nursing/ Medical Director	**Lead Committee:**	Quality and Safety Committee	**Date of last Committee review:**	Sept-20	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	22/05/14	1187	Ophthalmology follow up waiting list	20	16	◄►
	25/09/15	1360	Cardiology catheter labs breakdowns	16	16	◄►
	16/01/20	1858	Reduced medicine supply due to national shortages	20	Risk closed	▼
	19/02/16	1458	Non-Compliance with NICE guidance NG19 (Diabetic Foot)	20	16	◄►
	10/03/18	1785	Ambulance transfers/capacity	20	12	▼
	17/06/20	1891	Increased backlog of patients	20	15	◄►
	12/06/20	1884	Delayed surgical treatment	20	16	◄►
	06/08/20	1906	Insufficient resource to maintain Mortality database	16	16	**New**
	13/08/20	1907	Insufficient isolation areas and testing kits for Covid-19	16	16	**New**

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**			Despite some individual risks, the Trust has a robust quality and governance framework in place to manage and monitor quality and safety metrics. The Covid 19 pandemic has resulted in some services being suspended/additional pressures. Therefore, likelihood has been scored as 'possible' as patient harm might happen despite implementation of controls and assurance; consequence scored as 'moderate' due to the potential implications on patient safety and experience if controls are not fully implemented.	**Likelihood:**	**2**	Mar-21
Consequence:	**3**	**3**				**Consequence:**	**3**	
Risk Level:	**9**	**9**				**Risk Level:**	**6**	

Cause of risk:	• Covid-19 recovery may impact the Trust's continued quality improvement • Clinical governance systems and systems for learning from incidents and other quality metrics may not be consistently applied and effective	**Impact:**	Failure to provide safe and effective care may result in: • Sub-optimum patient outcomes and experience • impact on our registration and compliance with regulatory bodies

Current methods of management (controls)	A. Robust governance process, to support quality improvement and risk management; including undertaking Root Cause Analysis where there are incidents and sharing learning, B. Audit programme in place and reviewed by clinical effectiveness C. Mortality reviews to share learning D. Independent medical examiner scrutinising deaths to identify any quality concerns E. Quality Improvement strategy in place and improvement hub established QSIR improvement utilised and training programme in place F. 'Excellence in Care' audit and reporting programme rolled out to in-patient areas to facilitate clinical areas in assessing themselves against Trust wide standards of care G. Patient tracking lists and MDT meetings in place

Assurance Framework – 3 Lines of Defence – linked to controls (A-G)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Oversight of excellence in care at ward and service level (F) • Health Assure being utilised by wards and services as depository for CQC evidence (A) • Divisional management of risk and control framework (A) • Quality improvement champions in place and projects in train (E)	• Divisional IPR meetings cover quality and safety (A) • Weekly patient safety summit (A) • Clinical Outcomes and effectiveness group (B) • Integrated Performance Report and incident reporting to Quality and Safety Committee and Trust Board (A) (B) • Improved quality in a number of areas for example sepsis, falls resulting in harm and reduced mortality (A) (C) (D) • Getting it Right First Time (GIRFT) in place has improved learning and actions to improve quality of care (A) (B) • Mortality review group meeting (C) (D) • MDT meetings to manage patient pathways (G)	• CQC inspection regime – Trust rated Good overall and Outstanding at Conquest and Community Services (A) • CCG review of incidents prior to closure (A) • Internal audit conduct annual audit of quality account indictors (A) (B) • External accreditation and quality surveillance such as JAG, audiology (B) • Nationally mandated audits and benchmarking (B)
Gaps in control/assurance:			
• CQC identified some "should do" requirements • Refer to BAF 2 for other gaps • Improvements required in discharge particularly around information and communication to care homes			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Action plan required and monitoring to address CQC should do requirement	Director of Corporate Affairs	End Dec 2020	Action plan developed and review by Quality and Safety Committee. Ongoing monitoring to ensure actions are complete and embedded	
2.	Programme of work require to improve discharge pathway and quality of discharge	COO/DoN	End Oct 2020	Patient Flow – Safe Discharge Workstream in place and multi-disciplinary improvement group focussing on quality being established	

Risk Summary						
BAF Reference and Summary Title:	**BAF 2: Restoration and Recovery**				**Strategic Objectives Impacted**	
Risk Description:	**There is a risk that the historical and ongoing impact of Covid 19 will mean that services are not delivered in a timely and effective way, the trust cannot operate effectively, and that clinical outcomes are not optimised and patient needs are not met.**					
Lead Director:	Director of Strategy	**Lead Committee:**	Finance and Strategy Committee Quality and Safety Committee	**Date of last review by Committee:**	Sept 2020	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	19/03/20	1862	Covid-19 Pandemic Risk	25	16	▼
	17/06/20	1891	Increased backlog of patients	20	15	◄►
	12/06/20	1884	Delayed surgical treatment	20	16	◄►
	12/06/20	1888	Staff shortages due to Covid-19	20	16	◄►
	11/06/20	1887	Use of Anaesthetic machines off-label during COVID-19	20	15	▼
	11/06/20	1885	Insufficient oxygen supplies	20	16	◄►
	12/06/20	1886	Insufficient medical equipment	20	16	◄►
	01/07/20	1894	COVID-19: Diabetic Eye Screening Restoration (scoring to be reviewed)	20	20	**New**

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4			Moved to recovery phase and robust programme in place. Consequence reduced as there is a lower risk of patient harm due to assessments that have taken place. However, there are risks to achieving the Level 3 letter national priorities to restore services by September.	**Likelihood:**	2	Dec-20
Consequence:	4	4				**Consequence:**	3	
Risk Level:	16	16				**Risk Level:**	6	

Cause of risk:	A number of actions were implemented to support the Trust in effectively responding to the Covid-19 pandemic whilst maintaining patient safety. Measures included cancelling all non-urgent surgery, relocating services, redeployment of staff and managing reduction in staffing due to self-isolation, suspension of some meetings and move to virtual meetings.	**Impact:**	Failure to establish a robust restoration and recovery programme gives rise to risk of • patient harm • impaired patient and staff experience • failure to meet constitutional and contractual standards • damage to Trust's stakeholder relationships and reputation

Current methods of management (controls)	A. Recovery workstreams in place aligned to patient, people, process, finance, digital and estates B. NHSEI Guidance on priorities for Restoration and Recovery – 'Trilogy' of correspondence issued C. Activity Tracker being developed – focussing on restoration and to track actual pts vs expected capacity D. Estates space utilisation being reviewed taking account of requirements for recovery of safe services whilst maintaining social distancing E. Identifying areas where improvements have been made eg such as virtual out-patient appointments and maximising these opportunities F. Staff track and trace in place G. Utilisation of capacity in private providers H. Development of harm review process

Assurance Framework – 3 Lines of Defence - linked to controls (A-H)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Risk and Recovery Board meeting weekly, chaired by Deputy Chief Executive (A) (B) • Workstreams and associated governance arrangements in place (A) (C) (D) (E) (G) (H) • Weekly update report covering concerns / key actions / positive assurance and decisions presented to Executive Team (A) (B)	• Report on Restoration and Recovery presented to Trust Board in June 2020 and standing item on Board agenda (A) • Linking into system wide recovery approach (B) • Digital infrastructure improved; hardware available to facilitate home working (D) • HR Support for staff related Covid-19 issues including risk assessment and track and trace (F) • Establishing divisional tracking meeting	• Internal audit plan will include aspects of the management of Covid-19 (A) • Oversight by NHS Improvement through submission of sitrep information and oversight meetings (B) • ICP/ICS risk and recovery group (B)
Gaps in control/assurance:			
• A small number of specialities are recording concerns that patients are unwilling to engage with treatment plans as a result of concerns about Covid-19 • Limited space to meet social distancing requirements has an impact on ability to fully restore clinical activity			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Reviewing staff redeployments with aim of all staff returning to substantive posts	Director of HR	End July 2020	Reviewed weekly as part of the Trust governance of R&R. There are minimal staff without active plans and these are being addressed at divisional level	**Complete**
2.	Programme of work in place to return relocated and suspended services – including EMU, oncology, ophthalmology and cardiology	COO	End August 2020	This is addressed by the Estates/Space workstream and is ongoing. All services have been restored; recovery plans in place but not fully complete Community paediatrics to be relocated but plans in place to reach a sustainable for all service	
4.	Further work on implementing elective activity tracker with an initial focus on restoration and then moving to recovery	COO	End July 2020	Tracker in place and performance reviewed weekly. Updates by specialty (to YE) will be complete by end of July to enable calculation of RTT/18 weeks impact and resulting support required	**Complete**
5.	First draft phase 3 recovery submission being developed for submission to NHSI	DCS/COO	1st Sept 2020	Submission complete	**Complete**
6.	Robust process required to ensure we are able to respond to the challenges highlighted in the Trust's NHSI recovery submission. This will include tracking performance against target	DCS/COO	31st October 2020	Process being developed.	

Risk Summary						
BAF Reference and Summary Title:	**BAF 3: Inconsistent performance against key access standards**				**Strategic Objectives Impacted** ✓ ✓	
Risk Description:	**There is a risk that we will not fully and consistently meet mandated access standards**					
Lead Director:	Chief Operating Officer	**Lead Committee:**	Quality and Safety Committee	**Date of last review by Committee:**	Sept 2020	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	15/04/13	999	Cancer 62 day compliance	16	12	◄►
	01/07/20	1897	Urology follow up database – insufficient slots	20	16	**New**

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**4**	**4**			The limited capacity focusing on clinically urgent and long waits during COVID-19 has resulted in a number of 52 week breaches (232 on 10/9/2020), RTT position of 69.2%, cancer 62 day position of 76% and 104 day delays of 67 (reduced to 48 on 10/9/2020). The 4 hour emergency care patient access standard whilst above 90% is also fragile especially at EDGH where the number of discharge delays causes limited bed availability. Therefore, the overall likelihood of risk is high and the consequence increased due to long delays in pathways.	**Likelihood:**	**2**	Mar-21
Consequence:	**3**	**4**				**Consequence:**	**3**	
Risk Level:	**12**	**16**				**Risk Level:**	**6**	

Cause of risk:	Increased demand for services and diagnostics year on year and a reduction in capacity during Covid-19. This has been further impacted in patient presentations to GPs during the pandemic, leading to a growing backlog of currently unidentified need, and to reluctance on the part of some patients to engage with treatment plans during the pandemic period.	**Impact:**	Failure to meet access standards consistently gives rise to risk of • patient harm • impaired patient experience • failure to meet constitutional and contractual standards • damage to Trust's regulatory and contractual relationships and public reputation

Current methods of management (controls)	A. Urgent care programme of work in place B. ESHT has been allocated a Cancer Alliance Relationship manager who is working in partnership with the Trust. This work focuses on best practice timed pathways along with partnership working with other providers to learn and share best practice. C. Pathway improvements and monitoring for A&E, Cancer and Diagnostics - pathway review in line with 28/62 days - identifying digital opportunities to proactively manage cancer - Alliance decision to be confirmed re AI digital tracking - Contact with individual patient and agreeing individual approaches to mitigating concerns - Contact with GPs / CCGs / Primary Care Networks etc D. Working closely with the Cancer Alliance on improvement actions such as: - Recruitment of sonographers - Addressing inconsistent reporting times in Radiology - Implementation of Breast Triple Assessment clinics - Campaign to support seeing all referred patients by day 7 E. Addressing Histology turnaround times and implementation of the Faster Diagnostic Standard

Assurance Framework – 3 Lines of Defence – mapped to controls A-E			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Clinical oversight and review of cancer PTL throughout pandemic and recovery period. (B) (C) (D) • Day to day oversight of A&E performance (A)	• Specialist support and feedback from Cancer Alliance (D) • Policy and procedures for MDT reviews strengthened early 2020 (C) • Divisional IPR meetings in place (A) (C) • Cancer Board, Urgent Care and Elective Care Boards with oversight of metrics (A) (C) (D) (E) • Review by Quality and Safety Committee (A) (C) • IPR reports to Trust Board (A) (C) • Flow transformation project in place (A)	• Oversight by NHS Improvement through submission of sitrep information and oversight meetings (C)
Gaps in control/assurance:			
• Small number of patients unwilling to engage with treatment plans as a result of concerns about safety in the pandemic period • A&E 4 hour performance is inconsistent, 62 day referral to treatment and 31 day diagnosis standards breached and 52 week waits in excess of 200			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Trust and system recovery programme (R&R) is being finalised and will be implemented with an agreed trajectory as per the phase 3 requirements.	COO	End Mar 2021	Plan being developed for ICS sign off.	
2.	Restoration of services	COO	End Mar 2010	Aligning capacity with demand for the recovery programme. This includes maximising utilisation of the available capacity including the independent sector.	
3.	Refresh and implement the revised patient flow programme	COO	End Dec 2020	Project milestones finalised and workstream leads and implementation planning taking place	

Risk Summary							
BAF Reference and Summary Title:	**BAF 4: Sustainable Workforce**					**Strategic Objectives Impacted**	
						✓	✓ ✓ ✓ ✓
Risk Description:	**There is a risk that the Trust will be unable to attract, develop and retain its workforce to deliver outstanding services within its financial envelope**						
Lead Director:	Director of Human Resources		**Lead Committee:**	People and Organisational Development		**Date of last review by Committee:**	Sept 2020
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**	
	23/02/12	767	Workforce Plan and Capacity	20	16	◀▶	
	23/08/16	1538	Nursing Recruitment	20	16	◀▶	
	23/08/16	1540	AHP/Technical Recruitment	20	16	◀▶	
	03/05/17	1616	Consultant Vacancies	20	16	◀▶	
	21/12/18	1772	Insufficient intensive care consultants	20	16	◀▶	
	21/04/15	1289	Histopathology consultant vacancies	20	16	◀▶	

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4			There are pockets of specialities where recruitment is challenged, although these largely reflect national difficulties. Ongoing success with recruiting into some 'Hard to Recruit' substantive posts, particularly Consultant posts.	**Likelihood:**	3	Mar-21
Consequence:	4	4				**Consequence:**	3	
Risk Level:	16	16				**Risk Level:**	9	

Cause of risk:	• Recognised national shortages in some staff groups • Geographical location • Continued pressure in a number of clinical areas • Uncertainty about the effect of exit from the EU impacting recruitment and retention • Lack of opportunity for career development	**Impact:**	Failure to maintain workforce stability gives rise to risk of: • Increased workforce expenditure due to agency requirements • Detrimental impact on patient care and experience • Failure to comply with regulatory requirements and constitutional standards • Detriment to staff health and well-being

Current methods of management (controls)	A. Ongoing monitoring of Recruitment and Retention Strategy and developing wide range of recruitment methodologies (events, social media, recruitment consultancies, targeted recruitment activity, including a significant overseas recruitment plan) B. Talent management, appraisals and development programmes C. Developing new roles and "growing our own" D. Workforce metrics in place and monitored E. Quarterly CU Reviews in place to determine workforce planning requirements. F. Review of nursing establishment 6 monthly as per Developing Workforce Safeguards G. Full participation in HEKSS Education commissioning process x H. Exit interview programme I. Use of bank and agency if required with authorisation process in place

Assurance Framework – 3 Lines of Defence – mapped to controls A-I			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Monthly reviews of vacancies together with vacancy and turnover rates (A)(H) (D) • Twice yearly establishment reviews (F) • Success with some hard to recruit areas eg consultants in A&E, histopathology, stroke and acute medicine.(A) (C) • Introduction of Certificate of Eligibility of Specialist Registration (CESR) programme in A&E Sept 2020 (C) • In house Temporary Workforce Service to facilitate bank and agency requirement (I)	• Workforce strategy aligned with workforce plans, strategic direction and other delivery plans and metrics reviewed by POD and Trust Board (A) (B) (D) (E) (F) (G) • 3 year Recruitment Strategy refreshed (A) • Overall Time to hire 82 days Sept 2020. (inc advertising/notice period). An increase of 10 days since last update due to Covid 19 travel restrictions (D) • Trust net vacancy trending at 9.9% in July 2020 a .6% decrease on July 2019. Predicted year end finish 9.5% (D) • Temporary workforce costs scrutinised by Finance and Strategy Committee (I)	• National Staff Friends and Family Test (A) (G) (H) • Clinical Commissioning Group Quarterly Workforce meetings (D) • Internal audits of workforce policies and processes (A) (D) (E)
Gaps in control/assurance:			
• Covid travel restrictions has impacted some overseas recruitment/new starters			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Continue with recruitment initiatives and international sourcing of medical candidates, including Radiographers and Sonographers	DHR	End Dec 2020	45 international nurses recruited. Planned monthly interviews for 2020/2021 targeting, specialist roles. Target of 100 nurse candidates and 10 radiographers	
2.	Establishment of local networks with BAME groups and organisations to increase diversity and talent.	DHR	End Nov 2020		

Risk Summary						
BAF Reference and Summary Title:	**BAF 5: Protecting our Staff**				**Strategic Objectives Impacted**	
Risk Description:	**There is a risk to staff welfare and morale if we do not undertake and act upon risk assessments to ensure a safe working environment**					
Lead Director:	Director of Human Resources	**Lead Committee:**	People and Organisational Development	**Date of last review by Committee:**	Sept 2020	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	16/08/20	1908	Protecting our Staff	16	12	◄►
	07/07/20	1900	Availability and use of Personal Protective Equipment	16	16	**New**
	18/11/19	1849	Impact of Violence and Aggression on staff wellbeing	16	16	◄►

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**			Significant work has been undertaken in conducting and acting upon risk assessments for Covid-19. There is also a robust programme of work in place to support wellbeing of staff and manage violence and aggression and the rating will reduce when the revised policy has been rolled out.	**Likelihood:**	**1**	end Dec-20
Consequence:	**4**	**4**				**Consequence:**	**4**	
Risk Level:	**12**	**12**				**Risk Level:**	4	

Cause of risk:	Failure to ensure that we provide a safe working environment for staff where they is adequate protection and support from a number of risks eg Covid-19 and violence and aggression	**Impact:**	Adverse impact on staff health and wellbeing. Risk of increased absences and therefore inability to deliver on services; possible closure of services and adverse impact on patient experience and reputational risks.

Current methods of management (controls)

A. Systems and processes in place to risk assess staff to reduce the risk from infection of COVID 19. Managers are required to complete a risk assessment to identify measures that need to be put in place to enable a member of staff to remain safe at work. If this cannot be achieved managers need to consider deploying their staff member to a different area or working from home if need be.
B. Training for managers to have compassionate conversations about risk assessments with vulnerable staff
C. Daily compliance reviews take place at the Risk Assessment Task and Finish Group to identify targeted actions
D. Systems and processes in place both reactive and proactive to manage violence and aggression – including conflict resolution training, OH support, risk assessments and security support. Trialling revised policy and red and yellow letters.

	E. Improved de-brief process and package of support for staff involved in violence and aggression or distressing situations at work. F. Reviewing and implementing best practice from other areas

Assurance Framework – 3 Lines of Defence			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Covid risk assessment process implemented to be undertaken by line manager and retained on personnel file. Risk assessment compliance now 83.3% for all staff, 99.2% for at risk staff and 99.9% for BAME staff. (A) (C) • Completion of risk assessments to be recorded on ESR. (A) • Appropriate PPE provided (A)	• Occupational Health support and audit of risk assessments and datix incidents (A) (B) (D) • Occupational and staff wellbeing support to staff (E) • Metrics reported to executive team, POD and Trust Board – increased compliance with completion of risk assessments (A) • Weekly COVID19 Workforce Group (A) (C) • Local Security Management Specialist advice and support (D) • Oversight by Violence and Aggression Task Group and monitoring by Health and Safety Steering Group (D)	• CCG undertaking assurance reviews (A) • Sussex network meeting in place and liaising with SECAMB on Trauma Risk Management (F) • Health and Safety Executive review of violence and aggression (D) • Collaboration with ESCC on lone working (F)
Gaps in control/assurance:			
• Although a process is in place, there needs to be greater pace in completing and acting upon Covid risk assessments and ensuring that these are recorded on ESR • The Covid-19 pandemic has impacted some of the progress in supporting staff with incidence of violence and aggression • Need to develop a single software solution to support staff who are lone/community working			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Focus on ensuring that Covid risk assessment outcomes are implemented with ongoing assurance provided to staff about their safety at work	DHR	End Dec 2020	Compliance improved ongoing focus to manage safety at work	
2.	Progressing introduction of Critical Incident Stress Management (CISM) or Trauma Risk Management (TRiM) within the Trust	DHR	End Dec 2020		
3.	Agreed business case for lone worker alert software and this is to be procured and rolled out	DHR	End Dec 2020	Business case approved and exploring options for joint working with ESCC	
4.	Revised V&A policy to be published and communicated to staff	DN	End Sept 2020	On track with oversight from Violence and Aggression Task and Finish Group	

Risk Summary						
BAF Reference and Summary Title:	**BAF 6: Financial Sustainability**				**Strategic Objectives Impacted**	
Risk Description:	**There is a risk that the Trust will fail to operate within available resources leading to a financially unsustainable run-rate at the end of 20/21 or not complying with Covid financial guidance and audit breaches**					
Lead Director:	Director of Finance	**Lead Committee:**	Finance and Strategy Committee	**Date of last review by Committee:**	August 2020	
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	20/05/20	1878	Delivery of 20/21 Financial Plan	**20**	12	◄►

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**			NHSE/I commitment to ensure NHS organisations break even during 20/21. Funded on the basis of last year actuals plus Covid costs (no allowance for business cases). The Trust has had 6 months with a focus on responding to Covid but will need to deliver recovery of activity within a financial envelope and with a refreshed efficiency plan. The risk may increase depending on funding rules that will be notified in Sept/Oct.	**Likelihood:**	**2**	Dec-20
Consequence:	**4**	**4**				**Consequence:**	**4**	
Risk Level:	**12**	**12**				**Risk Level:**	**8**	

Cause of risk:	Controls for financial delivery are established and robust, but the CIP challenge and financial plan for 2020/21 need continual monitoring and support. It will be harder to maintain efficiency as service delivery transforms and PbR is harder to track during the block contract period.	**Impact:**	Failure to maintain financial sustainability gives rise to risk of • Unviable services and increased cost improvement programme • failure to meet contractual standards and possible regulatory action • damage to Trust's stakeholder relationships and reputation
Current methods of management (controls)	A. Risk adjusted CIP programme in place and PID produced for each scheme. B. Transformation programmes in place to realise benefits of cost effectiveness C. Reviewing approved business cases for realisations of benefits and un D. Restatement of budgets in 2021 issued in September E. Process in place for setting and managing budgets "grip and control" F. Developed financial 'solution' for non-recurrent component of CIP delivery driven by delayed investment The finance team are combining a forecast update on the budget with the planners producing a revised activity plan as part of recovery Key areas of focus include: - A refresh of the efficiency plans working with divisions; - Cost pressures arising from service developments/ recruitment; - How to strengthen the controls and accountability frameworks		

Assurance Framework – 3 Lines of Defence - aligned to controls A-F			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Work continues through divisional meetings to both maintain contingency and to strengthen recurrent delivery of the programme. (A) (E) • Covid related costs captured and reimbursed to date (D)	• Oversight by Transformation and Efficiency Committee and Finance and Strategy Committee (A) (B) (C) G. Robust leadership of CIP programme, with strong link to Model Hospital and GIRFT established. (B) (C) (F)	• ICS Capital Programme in place in Line with Capital Resource Limit (CRL) (C) • Internal audit reviewing controls and Covid management (A) (D) • External audit programme in place (A) (D) (F)
Gaps in control/assurance:			
• None identified but need to ensure that the system of internal financial control remains robust and that there is effective governance in place to manage the re-establishment of services			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Maintain system of Internal Financial control and due governance as services step back up	DF	End July 2020	TIAA reviewed Covid incident governance and Reasonable Assurance given Project group to validated coding of Covid claim. Now business as usual	**Closed**
2.	Ensure the emerging financial regime post end of October is fully understood and risks identified	DF	End Oct-20	Awaiting confirmation from NHSI on financial enveloped post Covid	**Amber**
3.	Develop processes to manage the Capital resource limit within the Trust	DF	End July 2020	Tracked within Capital Planning Group	**Closed**
4.	Update financial reporting pack to support board oversight and scrutiny of financial performance	DF	End Dec 2020	Being reviewed as reporting is more difficult during the Covid recovery phase	

Risk Summary						
BAF Reference and Summary Title:	**BAF 7: Infrastructure**				**Strategic Objectives Impacted**	✓
Risk Description:	**There is a risk that the Trust will not have the necessary investment required for IT, medical equipment and other capital items**					
Lead Director:	Director of Finance	**Lead Committee:**	Finance and Strategy Committee	**Date of last review by Committee:**	August 2020	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	27/05/20	1879	Capital sustainability	20	12	◄►
	12/02/14	1152	Obsolete medical devices	20	15	◄►
	25/09/15	1360	Cardiac catheter lab breakdowns	16	16	◄►

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**4**	**3**			Capital plan was delivered in 19/20, with elements continuing in the 20/21 capital plan. However, the 2020/21 capital programme is fully subscribed with a reserve list however, £9m of business cases being progressed to the ICS	**Likelihood:**	**2**	Mar-21
Consequence:	**4**	**4**				**Consequence:**	**4**	
Risk Level:	**16**	**12**				**Risk Level:**	**8**	

Cause of risk:	The historic financial performance of the Trust has led to a restricted internally generated capital budget for many years. Although the Trust has successfully bid for emergency capital funding from NHSE/I the demand for capital outstrips the supply.	**Impact:**	Lack of capital for investing in the future sustainability of the Trust Failure gives rise to risk of a significant impact on the Trust's ability to meet its requirements to provide safe, modern and efficient patient care.
Current methods of management (controls)	A. 2020/21 capital plan is being reprioritised to ensure that it is fit for purpose post COVID-19. B. Continuous prioritisation of spending and active management of capital resource limit through capital programme work-streams Capital bids being prioritised and prepared for submission to ICS. C. Essential work prioritised with estates, IT and medical equipment D. Lease/Managed Equipment Service options will be considered during 2021/22		

Assurance Framework – 3 Lines of Defence - linked to controls A-D			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Day to day management of infrastructure requirements and prioritisation by services (A) (C) • Electronics and Medical Engineering (EME) in close liaison with divisions (C) (D) • Full inventory of medical devices and life cycle maintenance (C)	• Oversight by Finance and Strategy Committee (A) • Estates and Facilities IPR (A) (B) (C) • Digital IPR (A) (B) (C) • Clinical procurement group in place (B) (D)	• Capital business cases reviewed by ICS (B)
Gaps in control/assurance:			
• Longer term capital programme required to identify pressures and requirements			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	10 year capital programme has been developed covering key areas of pressure and investment, aimed at supporting the Trust in delivery of the strategic plan.	Director of Finance	End Mar 2021	Will be utilised to support management of Capital £9m of business cases being progressed to the ICS	

Risk Summary						
BAF Reference and Summary Title:	**BAF 8: Infrastructure**				**Strategic Objectives Impacted**	✓
Risk Description:	**There is a risk that the Trust estates infrastructure, buildings and environment, will not be fit for purpose**					
Lead Director:	Director of Estates	**Lead Committee:**	Finance and Strategy Committee	**Date of last review by Committee:**	August 2020	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	27/05/20	1879	Capital Sustainability	20	12	◄►
	25/02/02	19	Preventing legionella in hot and cold water systems	20	12	▼
	26/06/03	79	Limiting asbestos exposure	20	15	◄►
	11/11/15	1397	Clinical environment maintenance and refurbishment	20	15	◄►
	12/11/15	1410	Inability to manage and control a fire event	20	16	◄►
	03/08/20	1904	Bleep system (intermittent) – Bleeps will not activate during an emergency due to an intermittent fault.	20	20	**New**

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**4**	**3**			Capital plan was delivered in 19/20, with elements continuing in the 20/21 capital plan. However, the 2020/21 capital programme is fully subscribed with a reserve list. Six facet survey indicates significant backlog maintenance. As our total expected CRL for ESHT is £54.3m, the in-year Capital position is improving significantly which has led to a revised risk scoring.	**Likelihood:**	**2**	Mar-21
Consequence:	**4**	**4**				**Consequence:**	**4**	
Risk Level:	**16**	**12**				**Risk Level:**	**8**	

Cause of risk:	The historic financial performance of the Trust has led to a restricted internally generated capital budget for many years. Although the Trust has successfully bid for HIP2 seed funding to develop the Strategic Outline Case (SOC) there is an immediate need for capital which outstrips the available capital.	**Impact:**	Lack of capital for investing in the future sustainability of the Trust Failure gives rise to risk of a significant impact on the Trust's ability to meet its requirements to provide safe, modern and efficient patient care.

Current methods of management (controls)	A. 2020/21 capital plan is being reprioritised to ensure that it is fit for purpose post COVID-19. B. Continuous prioritisation of spending and active management of capital resource limit through capital programme work-streams Capital bids being prioritised and prepared for submission to ICS. C. Essential work prioritised with estates, IT and medical equipment D. Maintenance of active fire precautions eg automatic fire detection. emergency lighting and firefighting equipment

Assurance Framework – 3 Lines of Defence- linked to controls A-D			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Day to day management of infrastructure requirements and prioritisation by services (B) (C) (D)	• Oversight by Finance and Strategy Committee (A) (B) • Simulated patient safety exercise undertaken on Seaford ward in June 2019 - will support refinement of evacuation plans (D) • Estates and Facilities IPR (A) (B) (C)	• Capital business cases reviewed by ICS (A) (C) • The Trust has been named as part of the HIP Programme (Phase 2) and has commenced dialogue with NHSI/E colleagues on next steps to secure significant funding over the next 3-5 years. £5m seed funding to develop the SOC has been approved by DHSC (A) • NHSI funding confirmed Sept-19 in order to facilitate additional fire compartmentation works (D). • Oversight of Fire requirements by East Sussex Fire and Rescue Service (D). • Six Facet Survey (A)
Gaps in control/assurance:			
• Longer term capital programme required to identify pressures and requirements • Need to recommence fire infrastructure work impacted by Covid-19 • Building works delayed to impact of Covid-19			

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

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Developing "Building for Our Future" full business case and project board being established – first phase develop Strategic Outline Case	Chief Executive	End Mar 2021	Programme Director recruited and progressing developing Strategic Outline Case	
2.	Aiming to resume fire compartmentation works at DGH in Autumn 2020	Director of Estates	End Mar-2021	Now that the Maternity Day Unit has become available the 1st phase of the refurbishment plan has commenced	

Risk Summary						
BAF Reference and Summary Title:	**BAF 9: Infrastructure**				**Strategic Objectives Impacted**	
					✓	✓			✓
Risk Description:	A large-scale cyber-attack could shut down the IT network and severely limits the availability of essential information and access to systems for a prolonged period which would impact the Trust's ability to deliver its strategic objectives					
Lead Director:	Director of Finance	**Lead Committee:**	Audit Committee		**Date of last review by Committee**	Sept 2020
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	23/08/17	1660	Cyber Security	**20**	16	◄►

BAF Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**		**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	**4**	**4**			There are a number of robust controls in place but further mitigation can be achieved by implementing a formal programme of work that addresses the wider information security agenda.	**Likelihood:**	**4**	Mar-21
Consequence:	**4**	**4**				**Consequence:**	**2**	
Risk Level:	**16**	**16**				**Risk Level:**	**8**	
Cause of risk:	Global malware attacks infecting computers and server operating systems. The most common type of cyber-attack are phishing attacks, through fraudulent emails or being directed to a fraudulent website,				**Impact:**	A shut down of key IT systems could have a detrimental impact on patient care and access. They can lead to a loss of money and data as well as access to files, networks or system damage.		
Current methods of management (controls)	A. Advanced Threat Protection (ATP) solution implemented to defend against hacking /malware. Regular scanning for vulnerability. B. Anti-virus and Anti-malware software in place with programme of ongoing monitoring. Client and server patching programme in place and monitored C. Process in place to review and respond to national NHS Digital CareCert notifications D. Self-assessment against Cyber Essential Plus Framework to support development of actions for protection against threats E. Education campaign to raise staff awareness - training ongoing with cyber security awareness campaign commenced October 2019 F. System patching programme in place and upgrade of client and server operating systems G. Wider engagement including NHS Secure Boundary and signed up to implementing it at ESHT							

Assurance Framework – 3 Lines of Defence – linked to controls A-G			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Cyber Essential Plus Framework assessment reviewed by division (D) • Day to day systems in place and support provided by cyber security team with increased capacity (A) (B) (C) (F)	• Policies, process and awareness in place to support data security and protection and evidence submitted to the DSPToolkit (D) • Information sharing and development with SESCSG Sussex and East Surrey Cyber Security Group (G) • Regular quarterly security status report to IG Steering Group and Audit Committee (D)	• Cyber security testing and exercises eg senior leaders participated in IT / Cyber exercise delivered by Police South-East Regional Police Organised Crime Unit (Nov-19) (E) • Trust was resilient to WannaCry ransomware attack (May 2017) (A) (B) (C) • Whilst noting the progress made internal audit gave "Limited Assurance" on 19/20 cyber security audit. (D)
Gaps in control/assurance:			
Obtain ISO27001 to provide assurance on reliability and security of systems and information. Continue with patching programme and address points raised by internal audit			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Pursuing ISO27001 certification and engaging with national funded resources to assess and report on our current position against the Cyber Essential Plus framework.	Director of Finance	End March 2021	Ongoing	
2.	Further investment in monitoring solutions and to increase compliance with server patching will be addressed as part of digital programme.	Director of Finance	End March 2021	Tool being introduced	
3.	SOP for the network security administration will be created to ensure a standard approach	Director of Finance	End Dec 2020	SOP being developed	

Appendix One: Risk Matrix

LIKELIHOOD RISK RATING - Likelihood Rating is a matter of collective judgement; the table below provides some structure to aid thinking.

Likelihood	Descriptor	Score
Certain	This type of event will happen or certain to occur in the future, (and frequently)	5
High probability	This type of event may happen or there is a 50/50 chance of it happening again	4
Possible	This type of event may happen again, or it is possible for this event to happen (occasionally)	3
Unlikely	This type of event is unlikely occur or it is unlikely to happen again (remote chance)	2
Rare	Cannot believe this type of event will occur or happen again (in the foreseeable future)	1

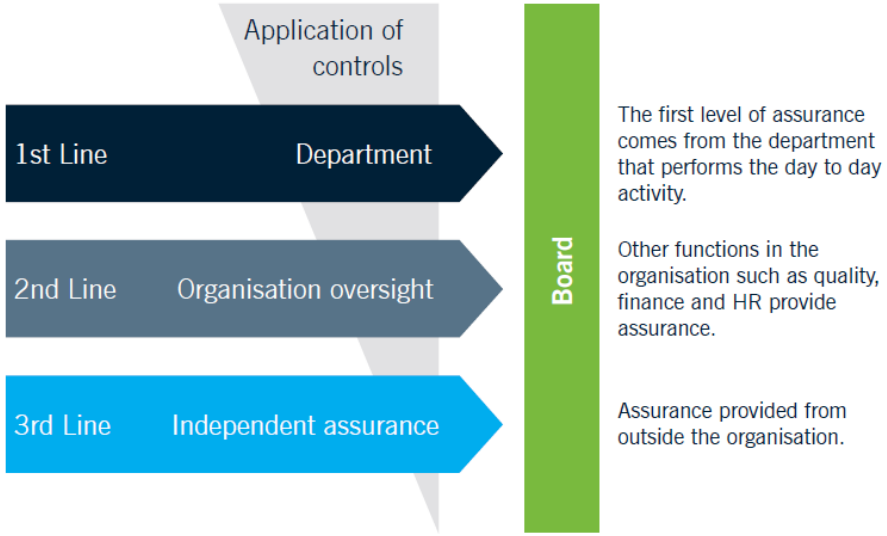
Table LIKELIHOOD X CONSEQUENCE/IMPACT = RISK RATING

		CONSEQUENCES / IMPACT				
		Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
LIKELIHOOD	Certain (5)	5	10	15	20	25
	High probability (4)	4	8	12	16	20
	Possible (3)	3	6	9	12	15
	Unlikely (2)	2	4	6	8	10
	Rare (1)	1	2	3	4	5

Low	Moderate	High	Extreme
1 – 3	4 – 6	8 – 12	15 – 25

Appendix Two – Three Lines of Defence Assurance Model

This model helps to provide a clearer picture of where the organisation receives assurance and whether it has too much, is duplicated, or has none at all, and whether the coverage of assurances is set at the right level to provide confidence to the Board. It is also important to consider the independence of any assurance provided in terms of how much reliance or comfort can be taken from it. The assurances that an organisation receives can be broken down into the three lines model as illustrated below:



- **1st Line** – provides assurance that performance is monitored, risks identified and addressed and objectives are being achieved However, may lack objectivity but it is valued that it comes from those who know the business, culture and day to day challenges.
- **2nd Line** – provides insight into how well work is being carried out in line with set expectations and policy or regulatory considerations. It is distinct from and more objective than the first line of assurance
- **3rd Line** – Independent of the first and second lines of defence. Includes internal and external auditors.

Sources: Baker Tilly: Board Assurance: A toolkit for health sector organisations/BAF University Hospitals of North Midlands

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

For the Period August 2020 (Month 5)

Content

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust

About our IPR

- Our IPR reflects how the Trust is currently working and how the on-going journey of improvement and excellence, reflected within our Strategy and Operational Plan (2019/20), is being delivered.
- Throughout our work we remain committed to delivering and improving on:
  - Care Quality Commission Standards
    - Are we safe?
    - Are we effective?
    - Are we caring?
    - Are we responsive?
    - Are we well-led?
  - Constitutional Standards
  - Financial Sustainability in the long term plan
- Our IPR, therefore, aims to narrate the story of how we are doing and more importantly how we will be doing as we look towards the future.
- Detailed data can be found within the IPR Data Detail (appendix A).

Our AMBITION is to be an outstanding organisation that is always improving
Our VISION is to combine community and hospital services to provide safe, compassionate and high quality care to improve the health and well-being of the people of East Sussex

East Sussex Healthcare NHS Trust

Performance Summary

Safe	Target	Jul-20	Aug-20	Variation	Assurance
Serious Incidents	<>	5	8		
Never Events	0	0	1		
Falls, per 1000 Beddays	< 5.5	6.6	5.1		
Pressure Ulcers, grade 3 to 4	0	0	2		

Infection Control	Target	Jul-20	Aug-20	Variation	Assurance
MRSA Cases	0	1	1		
Cdiff cases	< 5	3	6		
MSSA cases	<>	2	1		

Mortality	Target	Prev	Latest	Variation	Assurance
RAMI	<>	82	83		
SHMI (NHS Digital)	<>	0.97	0.97		

Caring	Target	Jul-20	Aug-20	Variation	Assurance
Complaints received	<>	38	37		
A&E FFT Score	> 96%				
Inpatient FFT Score	> 96%				
Out of Hospital FFT Score	> 96%				
Maternity FFT Score	> 96%				
Out of Hospital FFT Score	> 96%				
Outpatient FFT Score	> 96%				

Operational Performance (Responsive)	Target	Jul-20	Aug-20	Variation	Assurance
A&E 4 hour target	> 95%	92.5%	89.6%		
12 Hour DTAs	0	0	0		
Acute Non Elective LoS	3.9	3.4	3.6		
Community LoS	25	22.0	23.4		
RTT under 18 weeks	> 92%	63.9%	71.4%		
RTT 52 week wait	0	110	151		
Out of Hospital within target wait time	<>	91.6%	87.0%		
Diagnosic under 6 week	< 1%	26.5%	28.1%		
Cancer 2 week wait	> 93%	97.3%			
Cancer 62 day	> 85%	76.0%			

Organisational Health	Target	Jul-20	Aug-20	Variation	Assurance
Trust Level Sickness Rate	<>	4.6%	4.6%		
Trust Turnover Rate	10.4%	9.9%	10.1%		
Vacancy Rate	9.3%	9.9%	9.5%		
Mandatory Training	90%	86.6%	86.9%		
Appraisal Rate (%) 12 months	85%	76.1%	75.9%		

Exceptions in month	Target	Jul-20	Aug-20	Variation	Assurance
VTE Assessment compliance	95%	92.9%	92.8%		

FFT suspended mid March 2020

Variation			Assurance		
Common Cause - No Significant change	Special Cause of concerning nature or higher pressure	Special Cause of improving nature or lower pressure	Variation indicates continued inconsistancy in meeting target	Variation indicates consistantly falling short of Target	Variation indicates consistantly meeting or exceeding Target

Quality and Safety

Delivering safe care for our patients
What patients are telling us?
Delivering effective care for our patients
Challenges and risks

Safe patient care is our highest priority

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

Summary

East Sussex Healthcare NHS Trust

Quality and Safety

Quality and Safety

August 2020 Data

Complaints received
Rate of complaints was highest in DAS and this will be reviewed and discussed at their Div IPRM by the COO and DoN. No specific themes or trends otherwise.

Falls
Overall the rate of falls is relatively stable and within expected control limits. A deep dive into falls resulting in severity 4 or 5 harm during 2019/20 is being undertaken and will report to Q&SC soon.

Infection Control
Mandatory reporting of healthcare associated infections continues with all non Covid infections within limits previously set. Incidence is increasing in line with activity and occupancy as expected.

Mortality
Our current SHMI is 97. NHS Digital have informed us that all Covid-19 deaths will be excluded from SHMI calculation which is unfortunate as we have had very few. RAMI results suggest there has been an increase in mortality, over and above any coding issues and we are looking into this. We still remain better than average, however.

COVID-19
In August COVID-19 admissions and deaths were low. Sept inpatient numbers remain low so far at time of writing but there has been a sustained and steady increase in cases in the local community in early September, and this is being kept under close review. We continue to work closely with PHE and system colleagues. Staff testing is an increasing challenge (locally and nationally) but plans are underway at ESHT in an attempt to improve this

Serious incidents
There was one recent Never Event relating to a patient receiving air instead of oxygen. There was no harm to the patient and a full investigation is underway but cause was likely human error. Immediate actions have been taken locally and scoping is underway trust wide. This was discussed in detail at Q&SC and PSQG and will report back to both when complete.

Infection Control
The recently refreshed national IPC guidance has been reviewed by our CAG and services continue to try to restore in line with national mandate. This continues to prove challenging as is maintaining some flexibility to ensure timely response to increases in local prevalence of COVID and seasonal influenza and related admissions.

Pressure Ulcers
Rates remains within the expected range with common cause variation.
The increase in category 2 damage amongst acute inpatients is subject to close surveillance by the PURG with one category 4 ulcer reported in a patient's own home.

Staffing
Workforce challenges continue with considerable escalation capacity open recently at EDGH and many areas continuing to need to run low and med/high risk areas for IPC reasons (previously Red and Green).

Author

Vikki Carruth
Director of Nursing and Director of Infection Prevention and Control

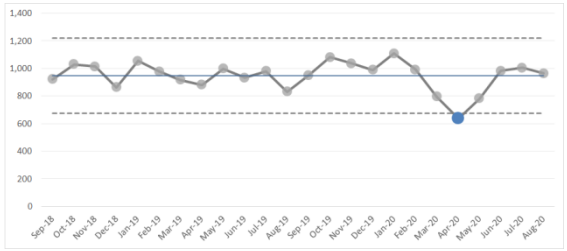
David Walker
Medical Director

Safe Care – Incidents

East Sussex Healthcare NHS Trust

Quality and Safety

Patient Safety Incidents
(Total Incidents ESHT and Non ESHT)



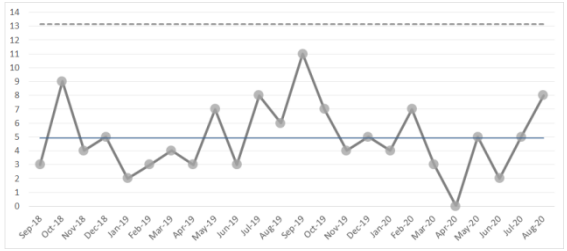
Target: monitor
Variation normal
Current Month: 964

The number of patient safety incidents reported is now stable and at a level of reporting pre Covid-19.

Top 3 categories for ESHT **safety incidents** are:

- Slips, Trips and Falls (105) – Falls Steering Group reviews all moderate and serious incidents. Ongoing work re revised assessment and training/awareness
- Antenatal, Maternity and Postnatal care (105) – prev discussed and no concerns noted
- Medication-related incidents (96) – deep dive is underway & outcome due imminently.

Serious Incidents
(Incidents recorded on Datix)

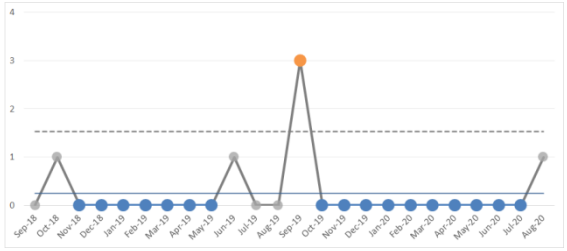


Target: monitor
Variation: normal
Current Month: 8

Serious Incident Management and Duty of Candour:
There were 8 **serious incidents** reported during August 2020:

- 1 x missed diagnosis of appendicitis
- 1 x Covid-19 outbreak (2 or more pts)
- 1 x Thermal injury to bowel
- 3 x women developed abdominal infection post caesarean section investigating as a cluster.
- 1 x delay in surveillance diagnostic resulting in a delayed diagnosis of cancer
- 1 x **Never Event**: patient received air instead of oxygen.
- 1 x delay in an MDT meeting to discuss results which led to delayed cancer diagnosis
- 1 x delay in diagnosis of oesophageal cancer

Never Events
(Incidents recorded on Datix)



Target: 0
Variation: run (improvement)
Current Month: 1

At the end of Aug there were 32 Serious Incidents open in the system; 21 under investigation and within timescales, 2 kept open by the CCG, 7 with CCG for closure and there are 2 incidents with the HSIB.

For Aug verbal DoC was 73%, written was 81% and exceptions 10%. This is a rolling 12 month figure and is discussed at the Weekly Patient Safety Summit, Senior Leaders Forum and the Quality & Safety Committee.

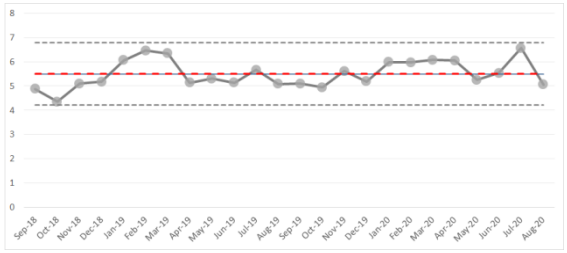
Safe Care - Falls

East Sussex Healthcare NHS Trust

Quality and Safety

Total Falls Per 1000 bed days

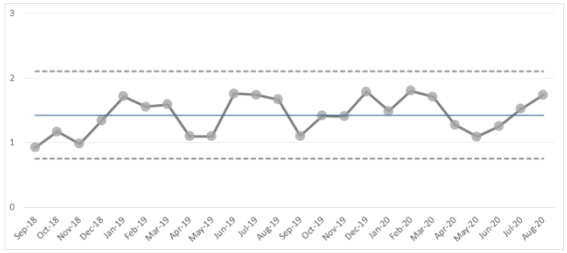
Target: 5.5
Variation: Normal
Current Month: 5.1



Rates are still within control limits and continue to show common cause variation.

Falls with Harm Per 1000 beddays

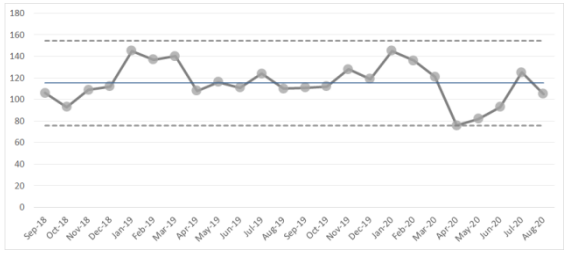
Target: monitor
Variation: Normal
Current Month: 1.7



A deep dive for the falls with harm reported in 2019/20 is being undertaken by the Falls Steering Group and is reporting to Q&SC.

Total Falls

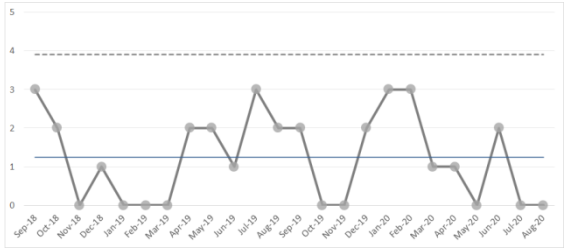
Target: monitor
Variation: normal
Current Month: 105



Work is underway redesigning the risk assessment tool with plans to pilot as soon as possible in Medicine. In addition a review of training and education is underway in terms of more simply assessing risk and the impact of falling for very high risk pts. A risk assessment of patient toilets is also underway to determine if anything can be done to reduce risk. Face to face training has been difficult due to Covid but plans to develop video clips are underway as is a review of patient information. Numbers of patients who have more than one fall remains very low with twice weekly reporting to the DoN.

Major or Catastrophic Falls

Target: monitor
Variation: normal
Current Month: 0



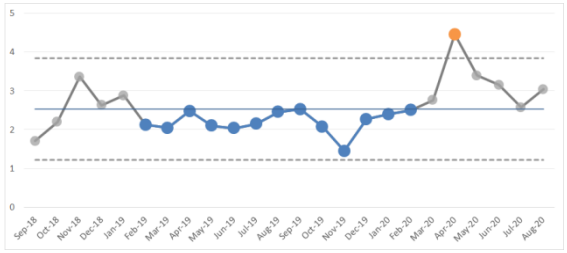
Safe Care - Pressure Ulcers

East Sussex Healthcare NHS Trust

Quality and Safety

Pressure Ulcers Per 1000 bed days (Grade 2,3,4)

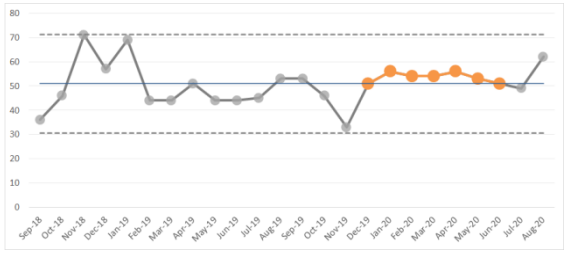
Target: monitor
Variation: normal
Current Month: 3.0



Incidence is returning to pre Covid levels as activity and acuity return to more usual levels and in some cases higher than usual. Rates remains within control limits with common cause variation.

Pressure Ulcers Category 2 (inpatient and community)

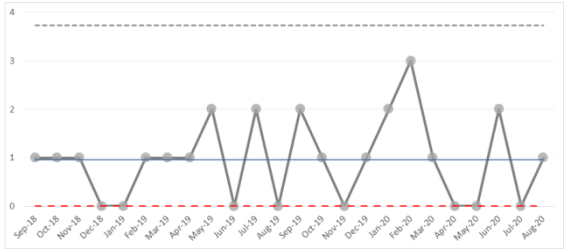
Target: monitor
Variation: normal
Current Month: 62



Improvement work regarding patient seating continues with close surveillance of category 2 damage by the Pressure Ulcer Review Group and TVNs. No specific themes or trends to report.

Pressure Ulcers Category 3&4

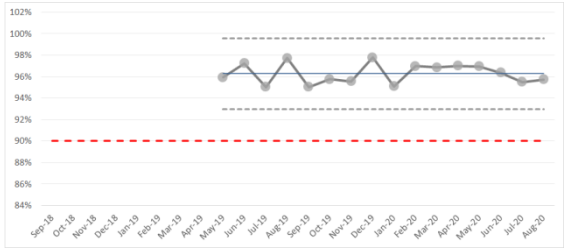
Target: zero
Variation: normal
Current Month: 1



The one category 4 pressure ulcer reported in August 2020 was in a patient's home with full RCA underway.

Pressure Ulcers Assessment Compliance

Target: 90%
Variation: normal
Current Month: 96%



Consistently achieved since May 2019.

Safe Care - Infection Control (non Covid)

East Sussex Healthcare NHS Trust

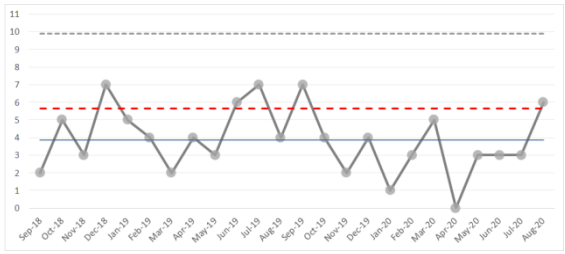
Quality and Safety

MRSA cases

Target: zero
Variation: outlier (concern)
Current Month: 1

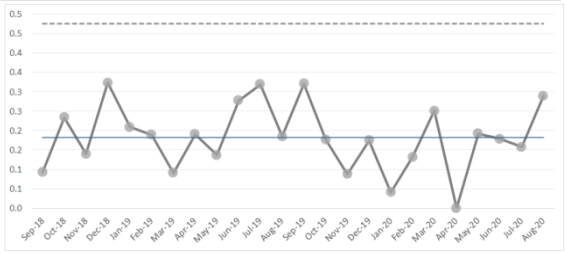
CDIFF cases

Target: 5.66
Variation: normal
Current Month: 6



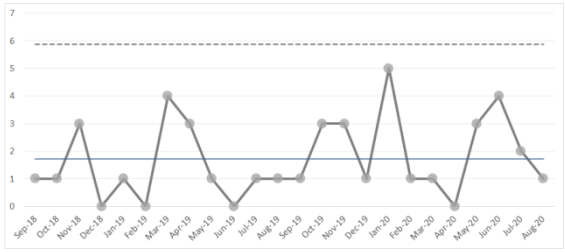
CDIFF per 1000 bed days

Target: monitor
Variation: normal
Current Month: 0.29



MSSA

Target: monitor
Variation: normal
Current Month: 1



MRSA bacteraemia – There has been one Healthcare Associated Infection (HAI) in August related to a patient with complex medical history. Post infection review (PIR) did not confirm the source of infection and could not assess if the infection was avoidable. There was a delay in screening for MRSA and when screened the patient was positive. Education and audit of compliance with MRSA policy is being undertaken.

Clostridium Difficile – Six cases attributable to ESHT were reported for August. The monthly limit of 5 was exceeded but ESHT remains within limit for the quarter and year to date. Five cases were HOHA (Hospital Onset Healthcare Associated) relating to patients on different wards with no common link. One case was a COHA (community onset healthcare associated) infection from a GP sample in a patient treated within the previous 28 days on Cuckmere ward. Post Infection Reviews (PIRs) are underway and report to TIPCG.

We have still not yet been notified of the trust CDI limit for 2020/21. Publication of annual data and commentary for mandatory reportable healthcare associated infections 2019/20 has been postponed until November 2020.

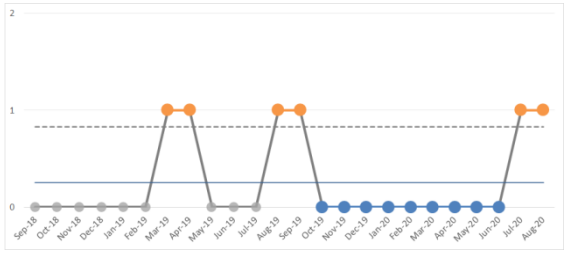
MSSA bacteraemia – There was one HAI related to a patient with heart failure who had cellulitis of the lower limbs. Unavoidable infection.

Safe Care - Infection Control (non Covid)

East Sussex Healthcare NHS Trust

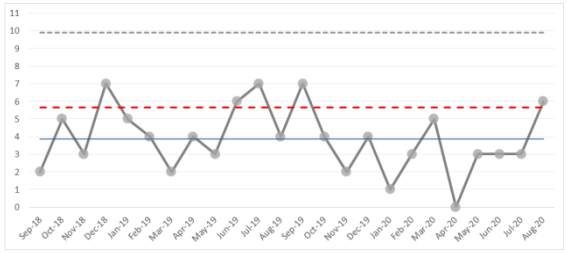
MRSA cases

Target: zero
Variation: outlier (concern)
Current Month: 1



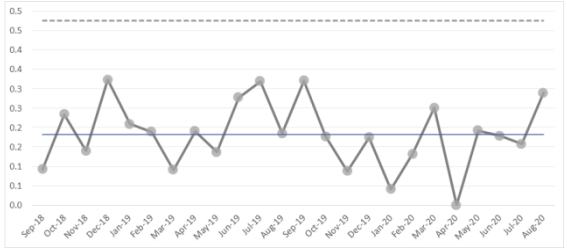
CDIFF cases

Target: 5.66
Variation: normal
Current Month: 6



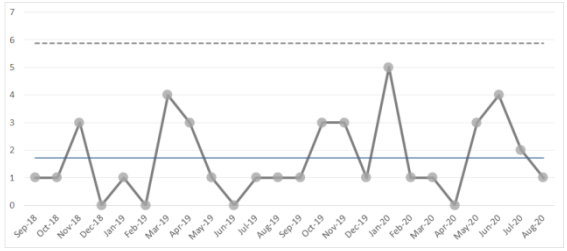
CDIFF per 1000 bed days

Target: monitor
Variation: normal
Current Month: 0.29



MSSA

Target: monitor
Variation: normal
Current Month: 1



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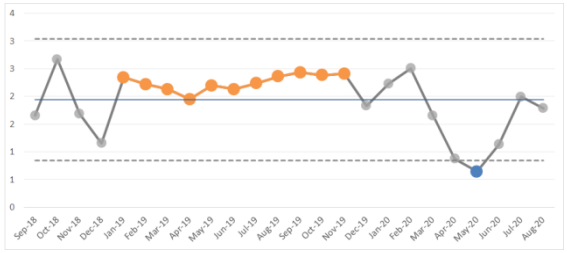
MSSA bacteraemia – There was one HAI related to a patient with heart failure who had cellulitis of the lower limbs. Unavoidable infection.

What patients are telling us?

East Sussex Healthcare NHS Trust

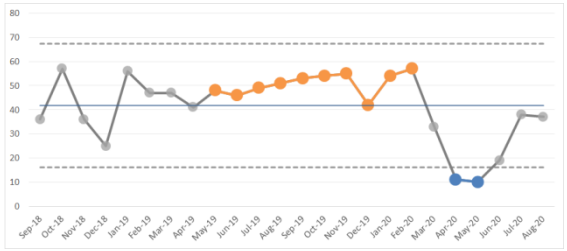
Complaints Received per 1000 bed days



Target: Monitor
Variation: normal
Current Month: 1.8

Themes continue to be about standard of care and patient pathway with issues relating to lack of confidence in delivery of care and missed diagnosis. Work is ongoing with divisions to address themes.

Complaints Received

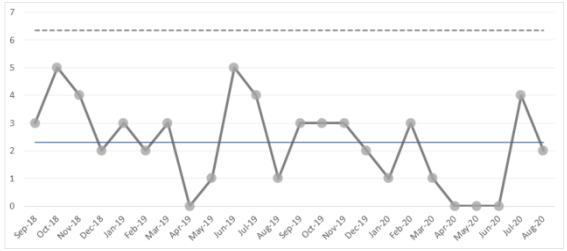


Target: Monitor
Variation: normal
Current Month: 37

- Medicine - 10 complaints - 0.6 per 1000 bed days
- Urgent Care - 6 complaints
- DAS - 14 complaints – 1.9 per 1000 bed days
- Out of Hospital - 2 complaints
- WC&SH – 2 complaints – 1.7 per 1000 bed days

- The DoN and COO will review DAS position and progress in Div IPRMs

PHSO contacts



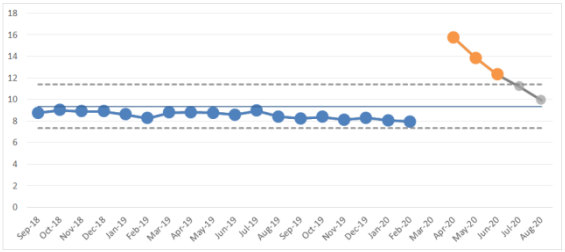
Target: Monitor
Variation: normal
Current Month: 2

In Aug 2 contacts made. One was an enquiry and one was an outcome where the PHSO have decided not to investigate a case of alleged assault.

Effective Care – Nursing & Midwifery Workforce

East Sussex Healthcare NHS Trust

CHPPD
(Trust)

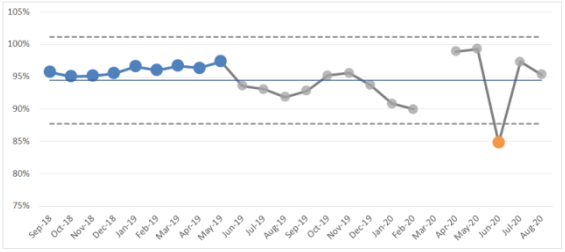


Target: monitor
Variation: normal
Current Month: 9.9

Care Hours Per Patient Day (CHPPD):
As activity resumes CHPPD is consistently returning to an expected level. The Model Hospital data has now been updated for *February* and ESHT CHPPD at that time was 7.9 in line with the national acute and integrated peer medians which were 8.0 and 7.8 respectively.

Staff fill rate – planned vs actual:
As anticipated, the overall fill rate has returned to expected level as planned and unplanned activity has continued to increase. Because of that, workforce challenges exist compounded by considerable escalation capacity open recently at EDGH and some areas continuing to need to run low and med/high risk areas for IPC reasons (previously Red and Green).

Staff Fill Rate
(total)



Target: 100%
Variation: normal
Current Month: 95.3%

As always, it is important to note that these fill rates only relate to inpatient areas and additional escalation capacity is largely staffed/supported by our substantive nursing workforce so often creates gaps or pressure elsewhere. In phase 1 surge this was less of an issue due to reduced occupancy/acuity but now activity has increased it is becoming a pressure once again exacerbated by the need to augment staffing in some areas due to Covid requirements.

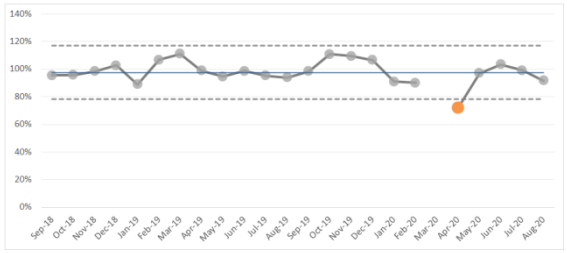
Safety remains a top priority and clinical and operational staff work closely every day to ensure best and safest care for patients in all areas.

Effective Care – Nursing Workforce

East Sussex Healthcare NHS Trust

Staff Fill Rate (Bexhill)

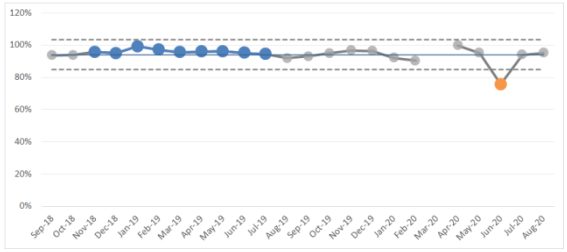
Target: 100%
Variation: normal
Current Month: 91.6%



Bexhill remains largely stable in August with no concerns or exceptions to note.

Staff Fill Rate (Conquest)

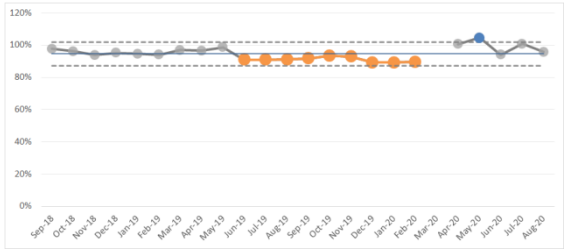
Target: 100%
Variation: normal
Current Month: 95.2%



As predicted the fill rate at Conquest has returned to expected levels as planned and unplanned activity is increasing. There are still some gaps across the trust due to sickness (especially last minute short term) and some vacancies. This is managed carefully and closely on a daily basis with some staff redeployed in shift to support safety albeit this is understandably not popular with staff who are keen to stay in their speciality and teams.

Staff Fill Rate (Eastbourne DGH)

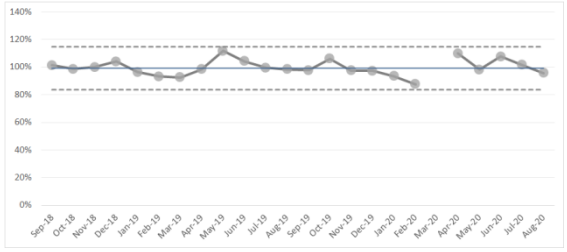
Target: 100%
Variation: normal
Current Month: 95.8%



There has been a greater incidence of patients with confirmed and suspected COVID19 in Eastbourne during July and August which is reflected in the increased fill rates in staffing at Eastbourne District General Hospital. This is because more staff are needed to care for patients who are suspected or confirmed COVID with the additional challenge of needing full PPE in high risk areas.

Staff Fill Rate (Rye Memorial)

Target: 100%
Variation: normal
Current Month: 95.8%



Rye remains largely stable with no concerns or exceptions to note .

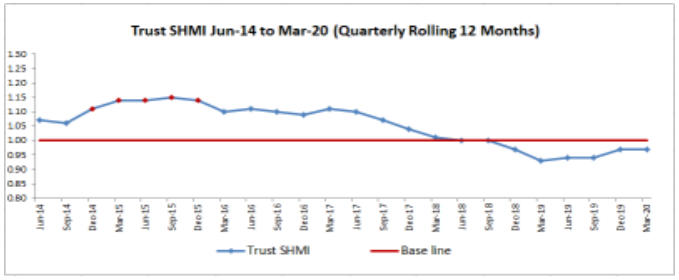
Effective Care - Mortality

East Sussex Healthcare NHS Trust

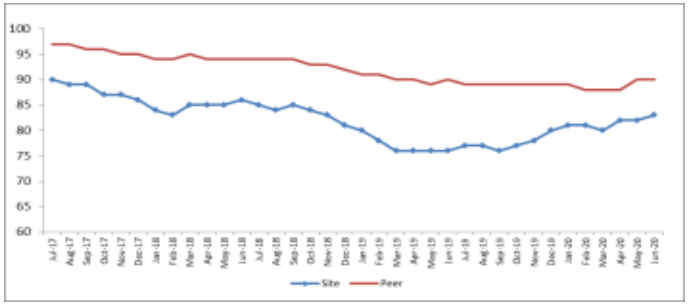
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

Summary Hospital Mortality Indicator (SHMI)

Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures

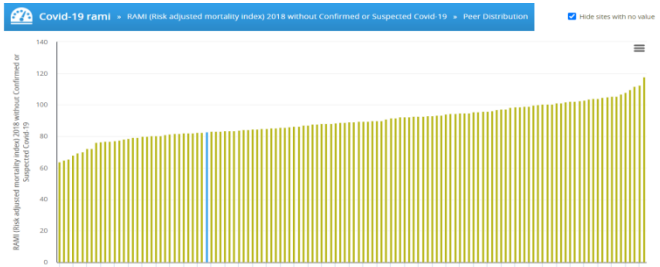


Risk Adjusted Mortality Index (RAMI) – without confirmed or suspected Covid-19



- SHMI – April 2019 to March 2020 is showing an index of 0.97.
- RAMI 18 without confirmed or suspected Covid-19 – July 2019 to June 2020 (rolling 12 months) is 83 compared to 76 for the same period last year. June 2019 to May 2020 was 82.
- RAMI 18 including Covid-19 was 91 for the month of May and also 91 for June with a peer position of 137 and 100 respectively. As with SHMI, RAMI is not designed for this type of pandemic activity, so RAMI without Covid-19 has been provided for consistency.
- Crude mortality shows July 2019 to June 2020 at 1.70%, compared to 1.44% for the same period last year. Crude mortality without confirmed or suspected covid-19 was 1.59%
- The percentage of deaths reviewed within 3 months was 88% in May 2020, April 2020 was 87%.

RAMI Peer Distribution without confirmed or suspected covid-19



RAMI v Peer

This shows our position nationally against other acute trusts - currently 33/128

August 2020 Main Cause of In-Hospital Death Groups (ESHT)

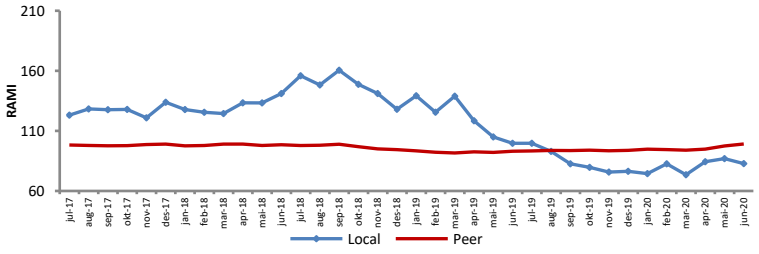
Pneumonia	33
Sepsis/Septicaemia	15
Cancer	12
Heart Failure	7
Cerebro-vascular Incident	5
Chronic Obstructive Pulmonary Disease (COPD)	4
Liver Disease	3
Urinary Tract Infection (UTI)	3
Acute Kidney Injury (AKI)	2
Atrial Fibrillation (AF)	2
Myocardial Infarction (MI)	2
Community-acquired Pneumonia	1
COVID-19	1
Dementia	1

COVID has dropped to 13th position in August with 1 death. There were 7 deaths in July.

There are:

- 28 cases which did not fall into these groups and have been entered as 'other not specified'.
- 13 cases for which no CoD has been entered on the database and therefore no main cause of death group selected.

RAMI Jul 2017 to Jun 2020 - without confirmed or suspected covid-19 CCS Group Liver Disease, Alcohol related



RAMI for Alcoholic liver disease has been consistently below the average peer for the past few months, having previously been a significant cause for concern.

Workforce

Delivering safe care for our patients
What patients are telling us?
Delivering effective care for our patients
Challenges and risks

Safe patient care is our highest priority

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

Summary

East Sussex Healthcare NHS Trust

	Positives	Challenges & Risks	Author
Responsive	The **Trust vacancy rate** has reduced by 0.4% to 9.5% Current vacancies are 691.6 fte, a reduction of 28.8 ftes this month. **Monthly sickness** is unchanged at 4.1% whilst the overall **annual sickness** rate is unchanged at 4.6% **Mandatory Training** compliance rate has increased by 0.3% to 86.9%	**Annual turnover** has increased by 0.2% to 10.1% unchanged reflecting 614.9 FTE leavers in the rolling 12 months **Appraisal** compliance has reduced by 0.2% to 75.9%	 **Monica Green** Director of Human Resources

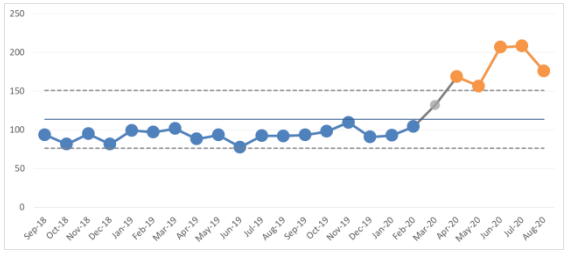
Actions:

- In response to recent guidance and compliance requirements from NHSI/E a task and finish group has been established to ensure that the COVID-19 risk assessment for vulnerable & 'at risk' staff has been completed. As at 17 September 7,152 (95.7%) total risk assessments have been completed with 100% of 'at risk' & 100% BAME staff covered. The Trust has taken the approach to offer all staff a COVID-19 risk assessment to ensure that all staff are supported and adjustments put in place where needed.
- A new Psychological Wellbeing intervention, delivered by suitably qualified therapists has been implemented with an aim to reduce the likelihood of PTSD and burnout in staff. To date 16 teams have engaged in this, with more requests being received weekly.
- Occ Health provided 7 day cover for staff to access COVID testing and support with enquiries, fielding over 200 contacts a day at the height of the pandemic. The COVID hub is being re-established to meet the demands and needs of staff during the expected second wave, utilising learning from processes and approaches that worked well and those that required amendment during the first wave.
- Recruitment continues despite ongoing delays to visas caused by Covid-19. This year, 41 International nurses have received offers with further planned monthly interviews for the rest of the year to address specific nurse vacancies. Planned October cohort of 25 nurses to join the Trust, with a further 50 over the next 4-5 months. Medacs, our medical recruitment partner, have 5 candidates in the pipeline to join the Trust.
- An update to the OSCE (Objective Structured Clinical Examination for overseas nurses) programme is underway to involve a more interactive approach to support the new cohort of OSCE nurses due to arrive in October, The programme will use a range of digital solutions to ensure engagement and allow them to start their programme whilst they are in quarantine for 14 days.
- Joint meetings involving Education, Recruitment and Staff Engagement /Health & Wellbeing with Divisional Managers/ and Assistant Directors of Nursing are being organised to occur over the next 2 weeks to inform Divisional Workforce Plans.
- Core Skills Compliance continues to be a focus and trajectory plans are being revised monthly to ensure that we meet 90%. Dedicated Moving and Handling Sessions are in place thrice weekly with 12 per cohort (for social distancing). These are all fully booked until the end of October.
- Specialty based workforce plans have been produced in conjunction with the Divisions to support recovery & restoration as well as medium and long-term business planning. These are being discussed in the monthly IPRs.
- The National staff survey will be distributed to all our staff during September 2020. The survey is important to us as those organisations that high level of engagement have better patient outcomes and performance, staff satisfaction and overall better financial performance.

Workforce – Contract type

East Sussex Healthcare NHS Trust

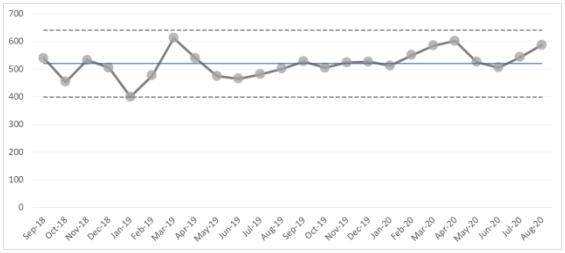
Agency FTE Usage



Current Month: 176.1

- Agency fte usage has reduced by 32.3 ftes to 176.1 ftes. This includes a decrease of -7.6 ftes in nursing agency usage, a decrease of -2.6 ftes medical agency usage and a decrease of -10.0 fte in ancillary usage.

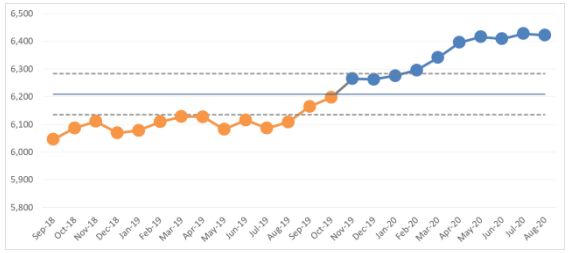
Bank FTE Usage



Current Month: 586.8

- Bank & locum fte usage has increased this month by 44.3 fte overall. Within this total, locum usage has reduced by -3.0 ftes but nursing usage increased by 20.6 ftes and ancillary usage by 20.1 ftes. As such, there has been a switch from agency to bank usage this month.

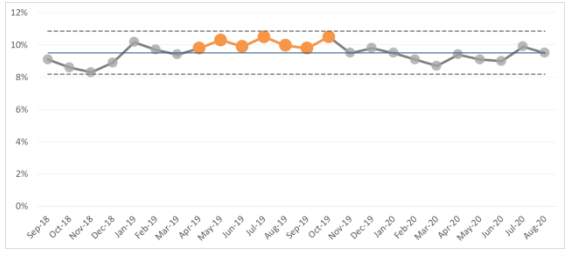
Substantive FTE Usage



Current Month: 6421.9

- Although substantive fte usage has slightly decreased this month by 5.7 ftes to 6,421.9 ftes, due to a reduction in nursing usage, the long term trend shows an increase of 313.5 fte usage over the last 12 months as the budgeted fte establishment has grown and posts have continued to be successfully recruited to.

Vacancy Rate



Current Month: 9.5%

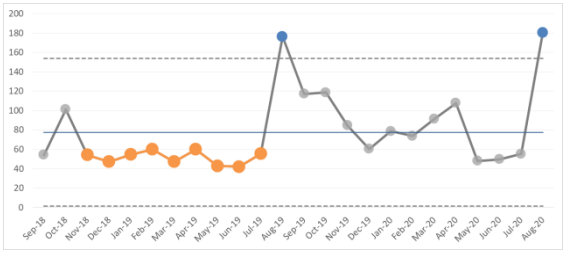
- The vacancy rate has reduced by 0.4% to 9.5%, Current Trust vacancies are 691.6 ftes. Medical & Dental staff have the highest vacancy rate at 17.8% (142.2 fte vacancies), though there has been a reduction of 33.9 fte vacancies in this staff group since July. There are 117.5 medical ftes currently in the recruitment pipeline (not including the junior doctor rotation).

(vacancies are calculated against the initial budgeted fte for August, though budgets are being amended in month)

Workforce - Churn

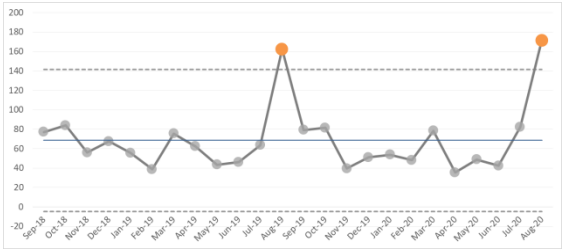
East Sussex Healthcare NHS Trust

Starters FTE



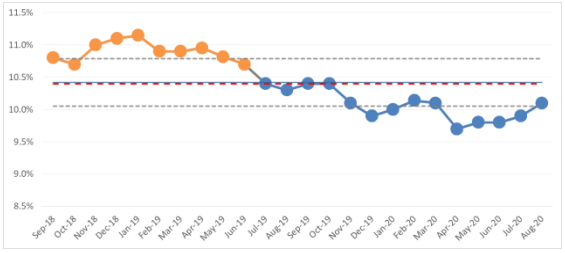
Current Month: 180.3

Leavers FTE



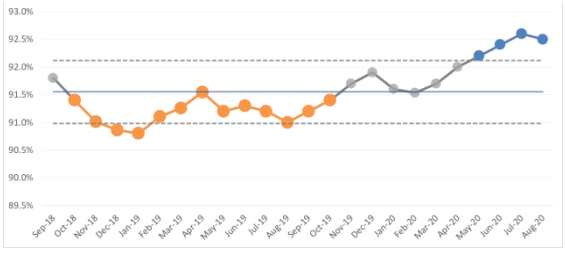
Current Month: 171.4

Annual Turnover Rate



Current Month: 10.1%

Retention Rate



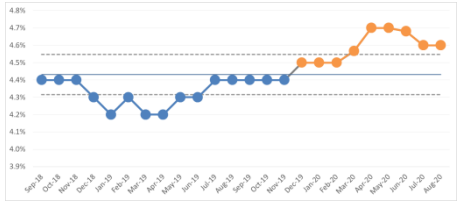
Current Month: 92.5%

- 180.3 ftes joined the Trust this month but 171.4 ftes left (numbers are higher this month due to junior doctors rotation). Over the last 12 months there has been a net increase of 248.6 fte staff. This includes a net increase of 47.8 fte Medical & Dental staff, 22.6 fte Registered Nurses & Midwives and 17.3 fte Allied Health Profs.
- Covid travel restrictions continue to impact on Time to Hire for medical & nursing international candidates. 5 candidates are in the pipeline to start via Medacs (international recruitment agency) including Consultants in Histopathology, Cardiology and Acute Medicine. International nurse recruitment also slowed due to border closures. 8 nurses awaiting arrival from India. Monthly Skype interviews conducted, with 26 potential further offers. Cohort of 25 international nurses due to arrive at the Trust on 2 & 23 October, with a further 25 planned for November.
- Trust turnover has increased by 0.2% to 10.1% (614.9 fte leavers) 8.7% of leavers relate to end of fixed term contracts (not including junior doctors rotation), 11.9% are leaving for career advancement and 18.8% are retiring. Turnover is highest for Addit Prof Scientific & Tech staff at 15.6% (21.5 fte leavers) and Healthcare Scientists at 14.8% (21.6 fte leavers). Medical & Dental turnover is 11.2% and for Registered Nursing & Midwifery it is 10.4%. Overall turnover has reduced by 0.9% in the last two years.
- The retention rate (i.e. % of staff with more than 1 year's service with ESHT) has slightly reduced by 0.1% to 92.5%.

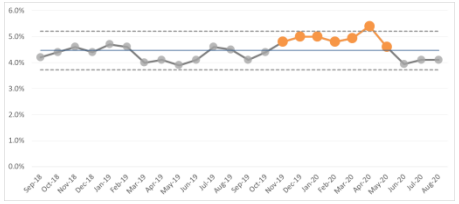
Workforce - Sickness

East Sussex Healthcare NHS Trust

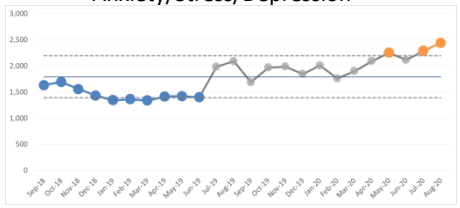
Annual Sickness Current Month:4.6%



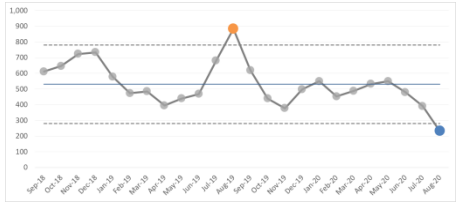
Monthly Sickness Current Month: 4.1%



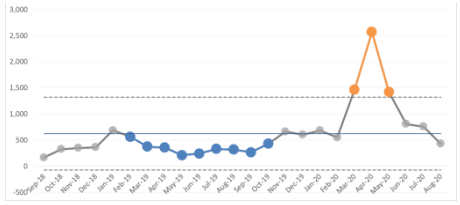
Anxiety/Stress/Depression



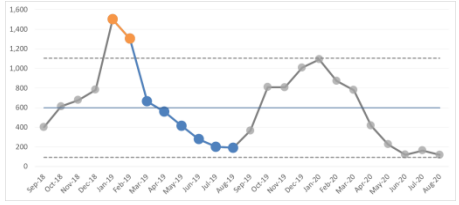
Back Problems



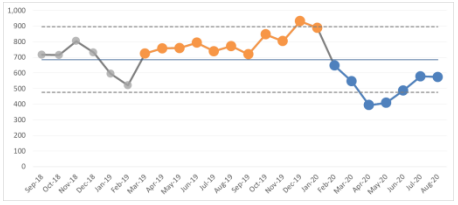
Chest & Respiratory Problems



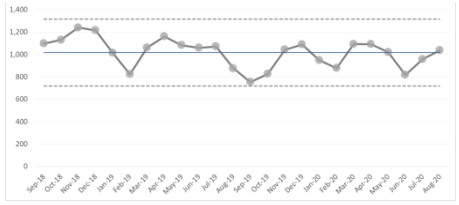
Cough, Cold & Flu



Gastro-intestinal Problems



Other MSK problems



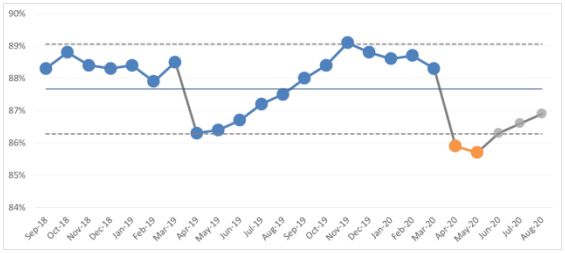
- Annual sickness has remained unchanged at 4.6% this month, as has monthly sickness, remaining at 4.1%.
- This month, sickness has been highest amongst Estates & Ancillary staff at 5.6% and Additional Clinical Services (mostly unregistered nurses and therapy assistants) at 5.5%. Registered Nurses & Midwives sickness was 4.4%, down 0.3% since July.
- Overall there has been a marginal increase of 49 fte days lost to sickness this month. Anxiety/stress/depression fte days lost have increased by 151 fte days lost and other musculoskeletal problems by 80 fte days lost. Chest & respiratory illnesses have continued to fall, however, down by 327 fte days lost and back problems have reduced by 157 fte days lost.
- All staff off for reasons of stress /anxiety and depression are passed to our Staff Welfare team for support and HR are working with the managers as soon as this is identified to offer targeted support such as Occ. Health, Care First and individual and team stress risk assessment. There has been continued focus on support for staff under stress, including targeted interventions across Estates & Facilities with all cases being managed closely with Occ. Health and the “Care first” employee support programme. In Women's and Children's, preventative work has been undertaken to avoid stress absence. They offer a ‘Care and Share’ daily session, where there will be a Head of Nursing or Matron available to listen and offer support
- Risk assessment compliance monitoring in place to ensure staff are adequately protected

Workforce - Compliance

East Sussex Healthcare NHS Trust

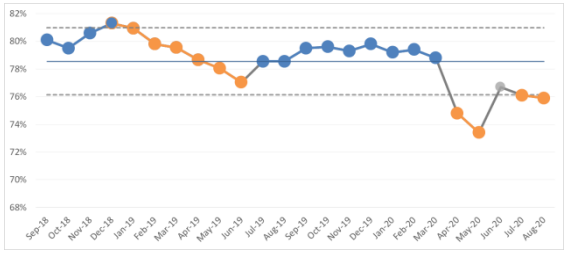
Mandatory Training Compliance

Current Month: 86.9%



Appraisal Rate

Current Month: 75.9%



- The overall mandatory training compliance rate has increased by another 0.3% to 86.9% as compliance rates in most of the mandatory training modules have improved.
- Induction compliance has increased by 2.9%, and there are significant increases again this month for Safeguarding, MCA and DoLs which highlights the drive to support divisions with eLearning in these areas. Attention will also be focussed on driving up compliance for Fire, Infection Control and Information Governance all of which have seen a slight drop in compliance this month.
- As reported last month, Moving and Handling Practical sessions have just restarted during August and should improve over the coming months as staff return to training and we transition to a twice yearly requirement for clinical staff.
- Appraisal compliance rate decreased by -0.2% to 75.9% overall but these figures are monitored monthly via IPR meetings to drive improvement in compliance.

This month:

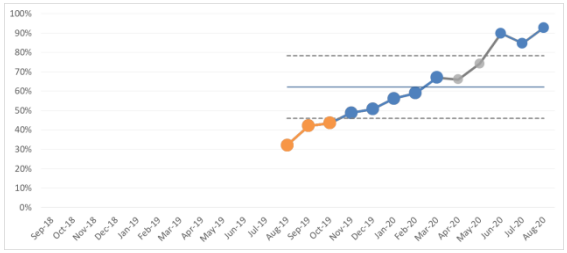
- Urgent Care, compliance rate increased by 2.9% to 83.2%
- Medicine, compliance rate increased by 0.4% to 69.2%
- Out of Hospital Care, compliance rate decreased by -0.9% to 70.8%
- Diagnostics Anaes & Surgery, compliance rate decreased by -3.4% to 80.4%
- Women & Children, compliance rate increased by 1.5% to 80.2%
- Estates & Facilities, compliance rate increased by 2.4% to 74.3%

Workforce – Job Planning

East Sussex Healthcare NHS Trust

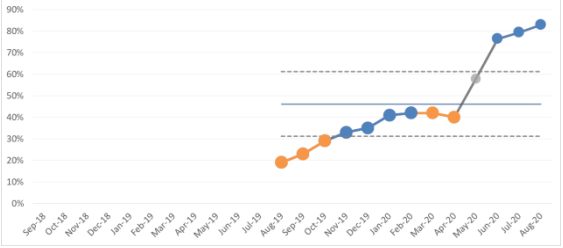
Consultant eJob-Planning Fully Approved Rate

Current Month: 92.7%



SAS Grades eJob-Planning Fully Approved Rate

Current Month: 82.9%



- The associated graph reflects a 24 month view as data is only available from July 2019, when progress reporting was first started.
- As of 8th September 2020, 228 of 246 consultants (92.7%) and 87 of 105 SAS grades (82.9%) had fully approved job plans.
- The target to reach 90% fully completed job plan by the end of August, was achieved. Accomplishing this target means that the Trust has attained Level 2 of NHS Improvement e-job planning levels of attainment and we are one of the few Trusts to complete this.

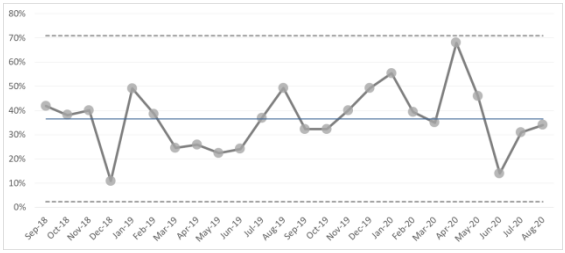
Workforce – Roster Completion & Salary Overpayments

East Sussex Healthcare NHS Trust

Quality and Safety

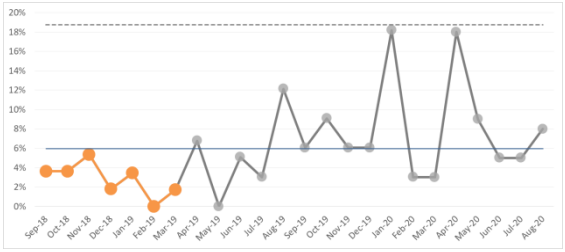
6 week Nursing Management Roster Approval Rate

Current Month: 34.0%



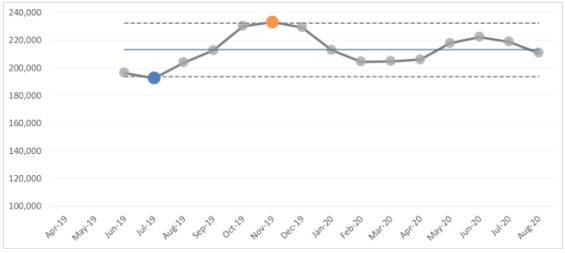
8 week Nursing Management Roster Approval Rate

Current Month: 8.0%



Salary Overpayments

Current Month: 210891



- The following charts show the % of approved rosters as at 6 & 8 weeks prior to commencement.
- For the period commencing 13th July '20, 34% of rosters had been approved at 6 weeks before commencement and 8% had been approved at 8 weeks prior to commencement.
- Monthly reports are produced and sent to Assistant Directors of Nursing and compliance is monitored at the Safer Staffing meeting. During the pandemic, some rostering has been shorter term due to the changing ward footprint.
- The Trust has appointed a Safe Care Lead Nurse who will work with services to address Safe Care compliance as well as to improve roster sign off compliance. It is anticipated that this will alleviate pressures and reduce costs of bank and agency.
- Outstanding debts as of Aug 20 totalled £210,891 against a 12 month average of £217,003. New debt added in July equated to £9,736, from 20 new cases
- There are currently 254 overpayment cases in all; 56 relating to current staff and 198 for leavers. DAS has the highest number of cases at 52 outstanding.
- The most common reason for debts is late notification of leaving (34% of cases i.e. 87 instances). This data is now being monitored via IPR meetings in order to reduce recurrence.

Access and Responsiveness

Delivering the NHS Constitutional Standards

Our front door - Urgent Care

How our patients flow through the hospital

Our Cancer Services

Our Out of Hospital Services

We will operate efficiently & effectively

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

Summary

East Sussex Healthcare NHS Trust

Access and Responsiveness

Positives	Challenges & Risks	Author
Our response to the Covid-19 pandemic has led to significant changes in the way non-elective and elective care is being delivered. This has been driven by our clinical colleagues ensuring safety, maintaining patient experience within the context of change whilst delivering effective outcomes of care. Diagnostic services continue to recover at pace although there is a huge challenge of clearing the backlogs due to activity displacement as a result of prioritising clinically urgent and Covid-19 preparedness. The Trust has recently run a Cancer Recovery focus week with all services in order to review all patients on the waiting list. This has assisted in the continued reduction of the 62 day backlog in August and into September whilst patient pathways over 104 days has also continued to come down during the past month. It has also helped the services to date patients based on clinical urgency and in order of the wait time. However, the current risks around the backlog clearance as part of our recovery programme remain and will continue to be mitigated. Reporting metrics for elective restoration and recovery are being finalised for assurance on delivery. The priority is to continue to treat patients based on clinical urgency and chronological waits within all of the available capacity. Over the past 6 months the Trust has reported patients waiting longer than 52 weeks for elective surgery. This is now starting to stabilise as we treat our long waiting patients. The Trust's new Harm review policy and process is in place for any patient waiting longer than 62/104 days (Cancer) and 52 weeks (RTT).	The Trust started to demonstrate positive recovery from April of it's A&E Performance through to June. However, August has seen performance drop below 90% to 89.6%. This was against a national average of 89.3% and positioned ESHT, 51st out of 114 reporting organisations. The key driver was an increasing level of attendances across both our sites amidst workforce gaps that could not be backfilled (especially at Eastbourne site). ED attendances are now back up to pre-COVID 19 levels. Our bed occupancy levels also increased to above 92% with a corresponding increase in the Long Length of Stay and Medically Ready for Discharge patients. The Trust priority is to ensure patients are managed safely and in a timely manner by the system partners with supported discharge as appropriate. There is a strong focus around reviewing every patient that no longer requires acute care and that a plan is in place for their safe discharge from the hospital. A rapid improvement week is planned from the 14th September 2020 for System Discharge improvement. Our DM01 (Diagnostic 6 week standard) services have been negatively affected during the pandemic as a result of displaced activity prioritising clinically urgent and Covid-19 activity. This is part of our recovery plan covering key diagnostic areas. As part of our continued recovery, we are anticipating and planning for the winter period ensuring the best possible flow for our elective and Urgent Care services. However, the risk remains as we consolidate our resilience planning to include a potential 2nd peak of COVID-19 as the East Sussex ICP and the wider Sussex ICS.	 **Imran Devji** Interim Chief Operating Officer

Restoration & Recovery

East Sussex Healthcare NHS Trust

Access and Responsiveness

In response to the NHSE Phase 3 recovery objectives, the Trust submitted a 'stretch but realistic' trajectory along side the requirements for delivering these targets. A full in-depth review with the senior Executive team and each individual service was carried out in order to complete the required submission and associated trajectory for delivery.

The final submission demonstrates that ESHT will not fully deliver the requirements set out in the Phase 3 (Sir Simon Steven's letter). The key headlines are as follows:

- Daycase – 90% delivered by November 2020 (against the target of 90% for October 2020)
- Elective – 90% delivered by February 2021 (against target of 90% for October 2020)
- Outpatients (New) – 100% delivered by February 2021 (against target of 100% for October 2020)
- Outpatients (Follow up) – 100% delivered by November 2020 (against target of 100% for October 2020)
- Diagnostics (Target 100% from October):
    - MRI – 95% March 2021
    - CT – 100% September 2020
    - Non-obstetric ultrasound – 100% September 2020
    - Colonoscopy – 100% September 2020
    - Flexi Sigmoidoscopy – 100% September 2020
    - Gastroscopy – 100% November

The four main area of challenge against the 90/90/100 delivery are:

1. Anaesthetic cover :
    - Theatre Capacity
    - ITU – needing to maintain Green/Amber capacity
    - Independent sector delivery
2. Ring fenced Elective Bed capacity
3. Workforce (vacancy factor and isolation restrictions) and agency/locum capacity
4. Inability to count Independent Sector activity that would have previously been assigned to the Trust

Restoration & Recovery

East Sussex Healthcare NHS Trust

Current SitRep position

As part of the Phase Three recovery letter from Sir Simon Stevens, the ask of providers was: ***In September at least 80% of last years activity for both overnight electives and day case procedures, rising to 90% in October.***

The data provided below presents the Trusts 4 week average position for mid-September 2020 against the Trust September planned trajectory and in turn the NHSE September target.

In future reports, a month end comparison will be provided which can be tracked against trajectories for the remainder of 20/21.

POD	4 Week Average (as of 13/09/20)	September Planned Trajectory	September NHSE Phase 3 Target
Day Case	74%	80%	80%
Elective Inpatient	63%	75%	80%
Outpatient (New)	82%	83%	100%
Outpatient (FU)	85%	82%	100%

Restoration & Recovery

East Sussex Healthcare NHS Trust

RTT / Elective Recovery

Access and Responsiveness

WHERE WE ARE BEING REQUESTED TO BE

Activity by POD	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	Actuals	Third phase requirement						
Day case	75%	80%	90%	90%	90%	90%	90%	90%
Elective inpatient	71%	80%	90%	90%	90%	90%	90%	90%
Outpatient (new)	78%	100%	100%	100%	100%	100%	100%	100%
Outpatient (follow up)	83%	100%	100%	100%	100%	100%	100%	100%

WHERE WE BELIEVE THAT WE WILL BE

Activity by POD	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	Actuals	ESHT Final Submission						
Day case	75%	80%	86%	90%	90%	90%	90%	90%
Elective inpatient	71%	65%	75%	78%	80%	75%	90%	90%
Outpatient (new)	78%	83%	90%	92%	93%	93%	100%	100%
Outpatient (follow up)	83%	82%	96%	100%	100%	100%	100%	100%

WHAT THE SIZE OF THE GAP TO THE REQUEST IS

Activity by POD	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	Actuals	ESHT Monthly gap to requirement						
Day case		0%	-4%	0%	0%	0%	0%	0%
Elective inpatient		-15%	-15%	-12%	-10%	-15%	0%	0%
Outpatient (new)		-17%	-10%	-8%	-7%	-7%	0%	0%
Outpatient (follow up)		-18%	-4%%	0%	0%	0%	0%	0%

Restoration & Recovery

East Sussex Healthcare NHS Trust

Diagnostics

Access and Responsiveness

WHERE WE ARE BEING REQUESTED TO BE

Activity by POD	August Actuals	Sept	Oct	Nov	Dec	Jan	Feb	Mar
		Third phase requirement						
MRI		90%	100%	100%	100%	100%	100%	100%
CT		90%	100%	100%	100%	100%	100%	100%
Non-Obstetric Ultrasound		90%	100%	100%	100%	100%	100%	100%
Colonoscopy		90%	100%	100%	100%	100%	100%	100%
Flexi Sigmoidoscopy		90%	100%	100%	100%	100%	100%	100%
Gastroscopy		90%	100%	100%	100%	100%	100%	100%

WHERE WE BELIEVE THAT WE WILL BE

Activity by POD	August Actuals	Sept	Oct	Nov	Dec	Jan	Feb	Mar
		ESHT Final Submission						
MRI		92%	95%	95%	95%	95%	95%	95%
CT		100%	100%	100%	100%	100%	100%	100%
Non-Obstetric Ultrasound		100%	100%	100%	100%	100%	100%	100%
Colonoscopy		100%	100%	100%	100%	100%	100%	100%
Flexi Sigmoidoscopy		100%	100%	100%	100%	100%	100%	100%
Gastroscopy		80%	90%	100%	100%	100%	100%	100%

WHAT THE SIZE OF THE GAP TO THE REQUEST IS

Activity by POD	August Actuals	Sept	Oct	Nov	Dec	Jan	Feb	Mar
		ESHT Monthly gap to requirement						
MRI		-8%	-5%	-5%	-5%	-5%	-5%	-5%
CT		0%	0%	0%	0%	0%	0%	0%
Non-Obstetric Ultrasound		0%	0%	0%	0%	0%	0%	0%
Colonoscopy		0%	0%	0%	0%	0%	0%	0%
Flexi Sigmoidoscopy		0%	0%	0%	0%	0%	0%	0%
Gastroscopy		-20%	-10%	0%	0%	0%	0%	0%

NHS Constitutional Standards

East Sussex Healthcare NHS Trust

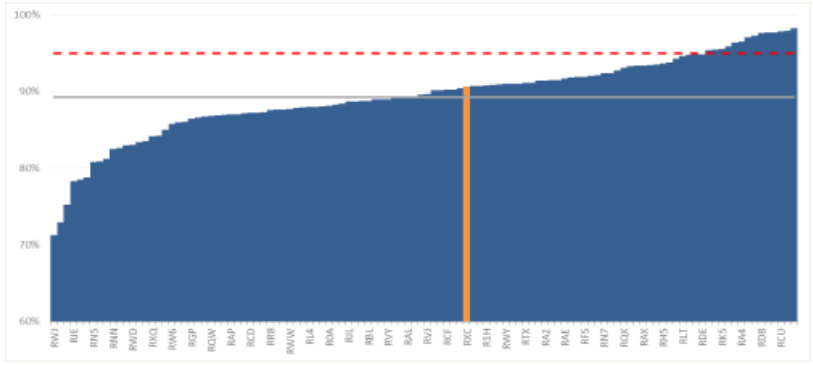
*NHS England has yet to publish all August 2020 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

August 2020 Peer Review

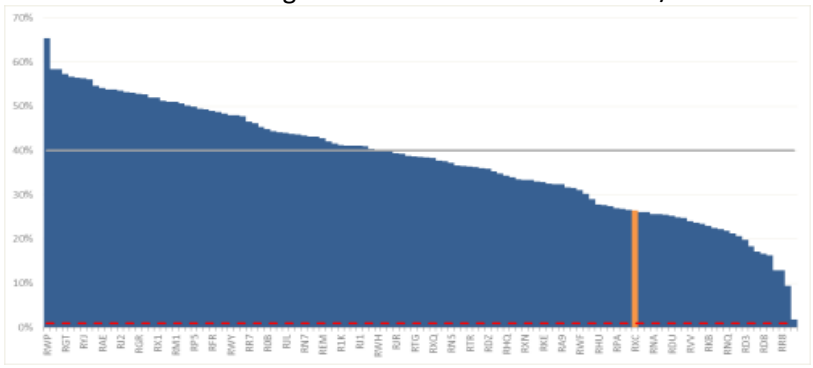
National Average: 89.3% ESHT Rank: 51/114



Planned Care – Diagnostic Waiting Times

July 2020 Peer Review*

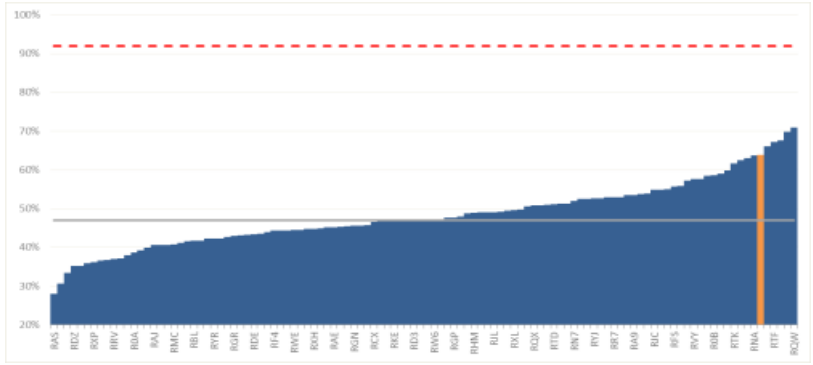
National Average: 40.1% ESHT Rank: 27/123



Planned Care – Referral to Treatment

July 2020 Peer Review*

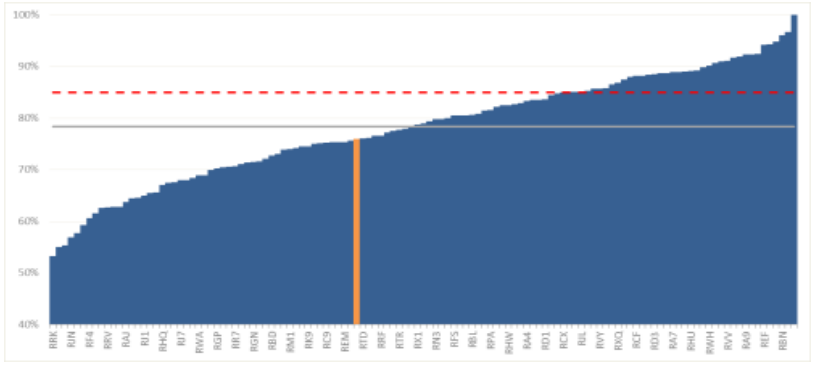
National Average: 47.0% ESHT Rank: 6/112



Cancer Treatment – 62 Day Wait for First Treatment

July 2020 Peer Review*

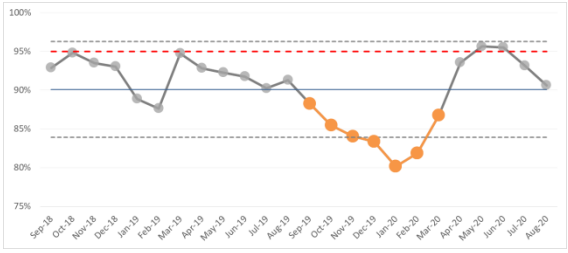
National Average: 78.3% ESHT Rank: 73/123



Urgent Care – Front Door

East Sussex Healthcare NHS Trust

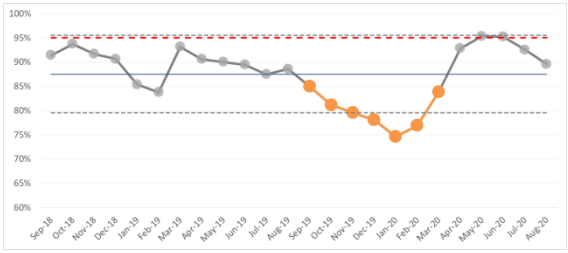
A&E Performance
(Local System)



Target: 95%
Current Month: 90.7%

From 1st August to the 31st August, the A&E Performances (including Walk in Centre Numbers) were:
Trust 90.7% – CQ 92.3% – EDGH 88.9%
ED has an Improving Performance Action plan in place along with weekly meetings to discuss patient safety issues, recruitment and improvements to process.

A&E Performance
(ESHT Total Type 1 & 3)

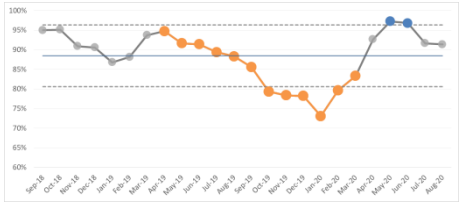


Target: 95%
Current Month: 89.6%

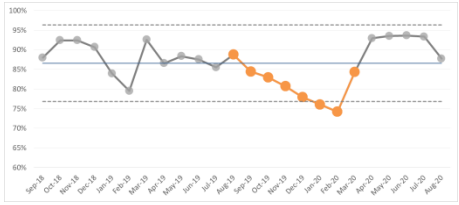
From 1st August to the 31st August, the A&E Performances (Type 1 and Type 3 only) were:

Trust 89.6% – CQ 91.4% – EDGH 87.8%

CONQ

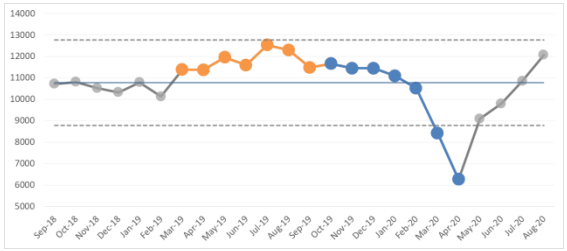


EDGH



For Conquest, the highest breach reason in August was “ED Assessment” with 148 breaches.
For EDGH, the highest breach reason in August was “MAU Bed” with 233 breaches.

A&E Attendances
(ESHT Total Type 1 & 3)



Target: Monitor
Current Month: 12,068

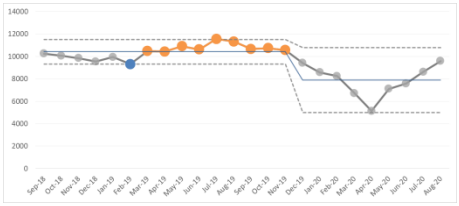
On average, there were 389 attendances a day in August for the Trust, 192 attendances for Conquest and 197 attendances for EDGH.

ESHT is now the a fast follower organisation for the ‘Talk before you Walk’ government initiative to reduce unplanned walk- ins to ED.

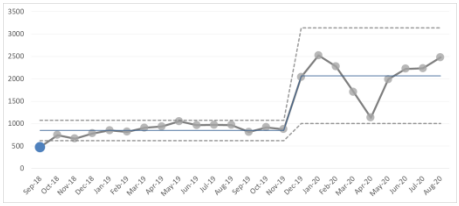
Urgent Care – Front Door

East Sussex Healthcare NHS Trust

ESHT Total Type 1



ESHT Total Type 3

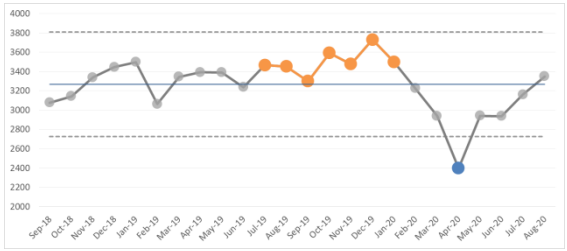


Types of A&E service:
Type 1: Consultant led 24 hour service with full resus facilities.
Type 3: Other type of A&E/minor injury units/Walk-in-Centres/Urgent Care Centre.

In August 2020, on average there were 309 Type 1 attendances and 80 Type 3 attendances.

Conveyances
(ESHT – CQ and EDGH)

Target: Monitor
Current Month: 3,348

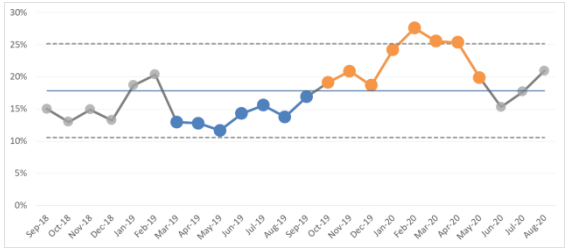


In August 2020, on average there were 108 conveyances a day.

In August 2020, on average there were 54 conveyances at Conquest and 54 conveyances at EDGH a day.

Conveyance Handover >30
(ESHT – CQ and EDGH)

Source: SECAmb
Target: Monitor
Current Month: 20.9%

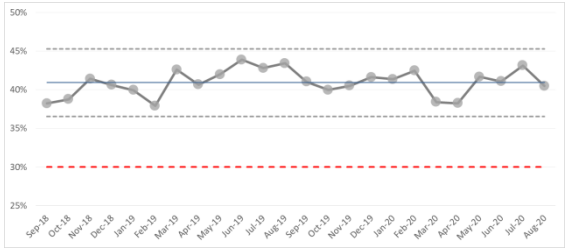


The departments are facing the challenges of redeployed staff being moved back to their original departments and services.

Medical recruitment at Conquest & EDGH has been difficult due to COVID-19 and the challenges in overseas staff travelling/gaining visas etc/competitive other offers.

Same Day Emergency Care
(ESHT – CQ and EDGH)

Target: 30%
Current Month: 40.5%



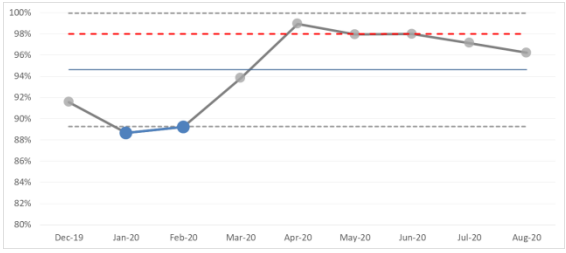
From 1st August to the 31st August, the SDEC Performances were:

Trust 40.5% – CONQ 41.5% – EDGH 39.2%

Urgent Care – UTC

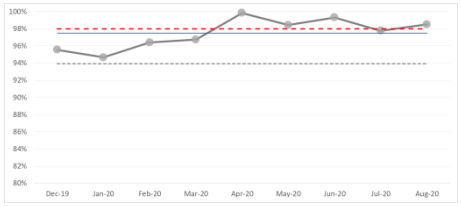
East Sussex Healthcare NHS Trust

UTC 2 Hour Standard
(Treatment start within 2 hrs)

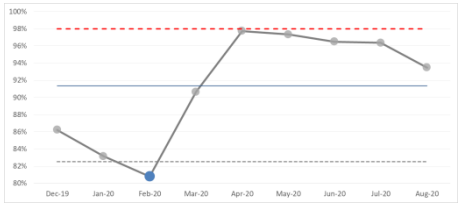


Target: 98%
Current Month: 96.2%

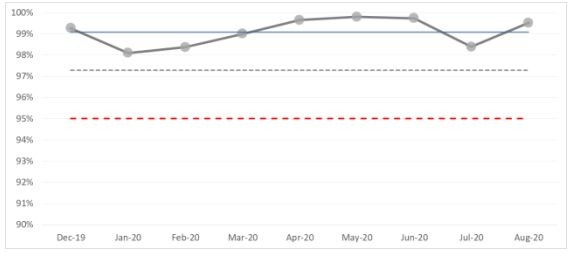
CONQ



EDGH

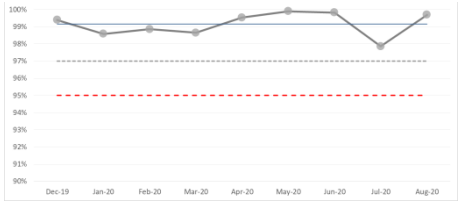


UTC 4 hour standard
(Visit complete within 4 hours)

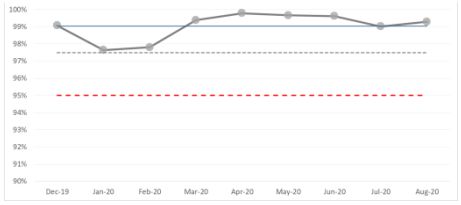


Target: 95%
Current Month: 99.5%

CONQ



EDGH



UTC GP Front Door Model agreed.

Processes are now in place to report UTC attendances.

Continuing to receive high numbers of referrals from 111 especially OOHs. Deep dive completed work continues with 111 to ensure other non-ED pathways are sign-posted to rather then ED first priory option unless ED appropriate or Bookable appointments.

From July to August Comparison.

2 Hour
TRUST – 0.9% decrease (97.1% to 96.2%)
CONQ – 0.7% increase (97.8% to 98.5%)
EDGH – 2.9% decrease (96.4% to 93.5%)

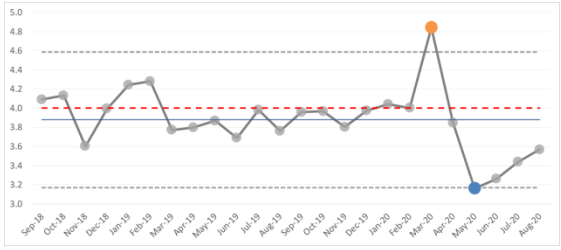
4 Hour
TRUST – 1.1% increase (98.4% to 99.5%)
CONQ – 1.8% increase (97.9% to 99.7%)
EDGH – 0.3% increase (99.0% to 99.3%)

Urgent Care - Flow

East Sussex Healthcare NHS Trust

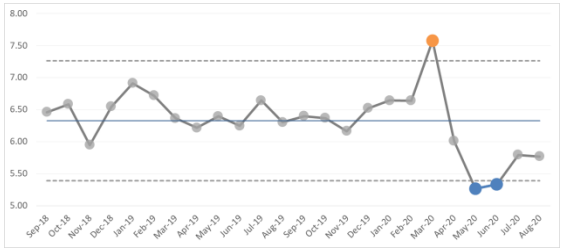
Non-elective Length of Stay (Acute)

Target: 4.0
Current Month: 3.6



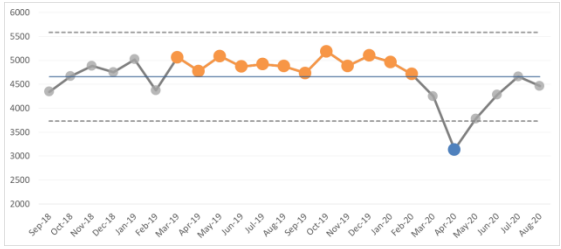
Non-elective Length of Stay, excluding zero LoS (Acute)

Target: Monitor
Current Month: 5.8



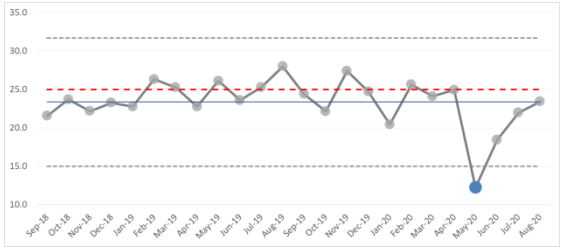
Non-elective Spells

Target: Monitor
Current Month: 4,463



Intermediate Care Units Average LoS (Community)

Target: 25.0
Current Month: 23.4



Rapid improvement week commenced at EDGH 14th September, a de-brief has been held and learning to be shared with Divisional teams. An improvement action plan will be confirmed and implemented.

Discharge Hub working 7 days per week on all medically fit patients on pathways 0 – 3. Out of hospital staff are supporting the hub due to redeployed staff returning to substantive roles. A plan is in place and key posts will be recruited to in the Hub to enable both Acute site Hubs to continue to function 7 days / week.

NEL length of stay increased by 0.2 of a day from July to August. The excluding zero length of stay was unchanged at 5.8 days.

Increased discharges occurred and actions are being taken through the daily discharge leadership meeting. Further actions are being taken through the Patient Flow Programme Board. All available community capacity is being utilised. Spot purchase placements continue to be made. A plan is underway to ensure ESHT meets the new guidance for the remobilisation of services within health and care settings – as of Sept '20.

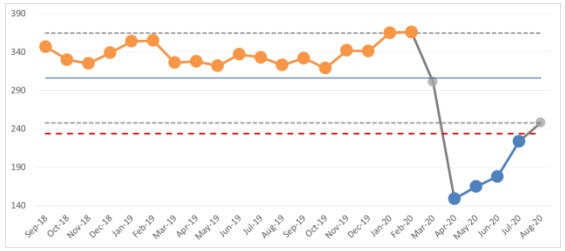
Nervecentre is progressing well – nearly all wards are using this consistently. The site teams are uilising this to enable timely patient transfers.

Urgent Care - Flow

East Sussex Healthcare NHS Trust

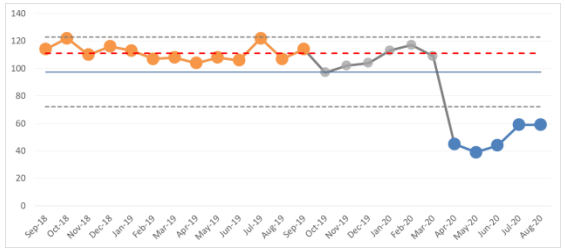
Adult inpatients in hospital for 7+ days (Acute)

Target: 234
Current Month: 248 (Daily Avg.)



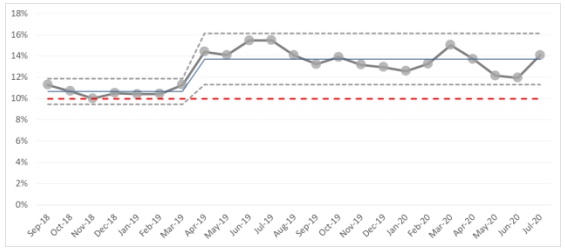
Adult inpatients in hospital for 21+ days (Acute)

Target: 111
Current Month: 59 (Daily Avg.)



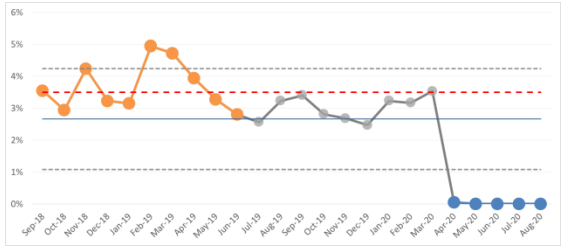
Emergency Re-Admissions within 30 days

Target: 10%
Current Month: 14.1% (Jul-20)



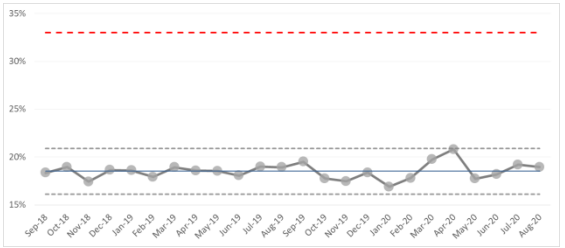
Delayed transfer of care (National Standard)

Target: 3.5%
Current Month: 0.0%



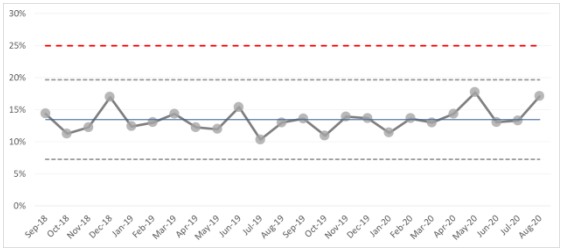
Patients discharged before midday %

Target: 33%
Current Month: 18.9%



Patients discharged on weekend day

Target: 25%
Current Month: 17.1%



The stranded patient number has seen a further increase to 248 across both acute sites, previously 224. 21 day (LLOS) patients has remained at 59 in August.

August has seen a small decrease in patients discharged before midday although the percentage of weekend discharges has fallen back to previous levels after a positive spike in May.

The established emergency readmission rate metric uses finance flags to exclude readmissions in cases where either the initial admission or readmission was an ambulatory tariff. The tariff was discontinued for 19/20, so there has been a step change in the readmission rate because ambulatory admissions are no longer identified as exclusions.

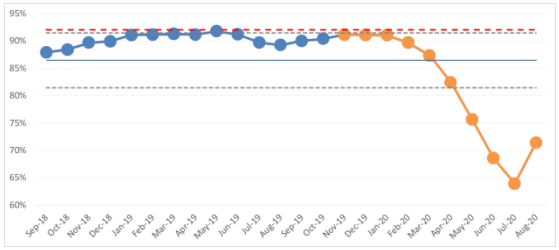
Planned Care – Waiting Times

East Sussex Healthcare NHS Trust

Access and Responsiveness

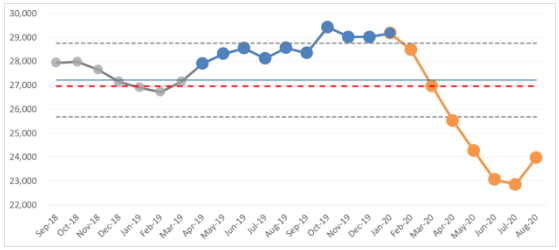
RTT Incomplete Standard

Target: 92%
Current Month: 71.4%



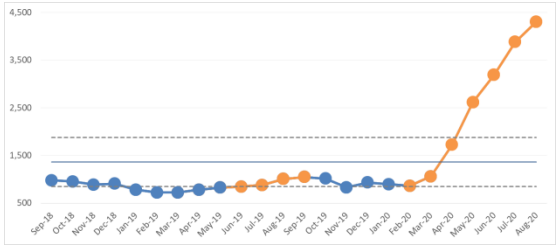
RTT Total Waiting List Size

Target: 26,965
Current Month: 23,980



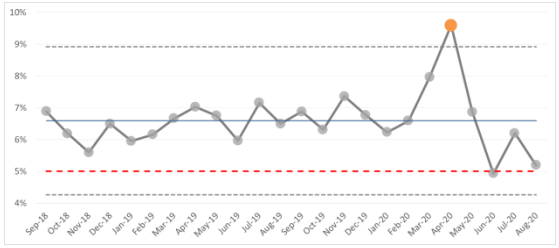
RTT 26 Week Waiters

Target: Monitor
Current Month: 4,301



Cancellations On The Day (Activity %)

Target: 5%
Current Month: 5.2%



Following a number of months where we have seen a continued decline in performance, August is the first month to demonstrate a recovering position with a 7.5% improvement compared to July. N early forward view of September would suggest that we will see further improvement of this standard.

August has seen the first increase in the total waiting list size since the start of the pandemic.

Although we continue to see an increase in the number of patients waiting over 26 weeks, August has shown a decline in patients waiting over 18 weeks. Down by 1397 to 6857.

Medicine as a Division continues to deliver RTT although some services were unable to achieve 92% (Gastro, and Cardiology). Gastro is heavily reliant on Endoscopy to diagnose patients but has a sizable backlog to address. Cardiology has also suffered with limited diagnostics (echos) taking place.

Surgical specialities along with Gynaecology continue to face the challenge of achieving the 92% standard due to the size of the backlog that has built up over the past 6 months.

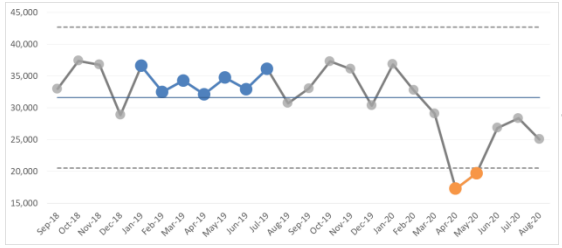
Utilisation of the Independent Sector has continued throughout August and into September with Radiology, T&O and Gynae all using Spire.
The Trust is also using theatre capacity at the Horder Centre for T&O along with some limited usage of Benson ward for Urology services.

Planned Care – Outpatient Delivery

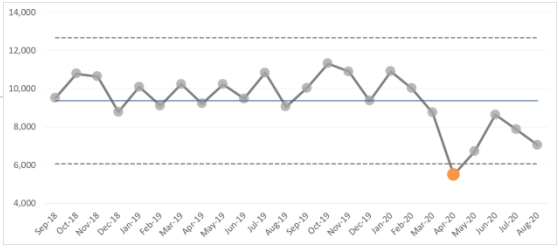
East Sussex Healthcare NHS Trust

Outpatient Total Activity
(New and Follow-up)

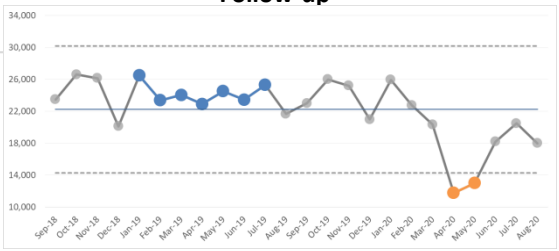
Target: Monitor
Current Month: 25,053



New

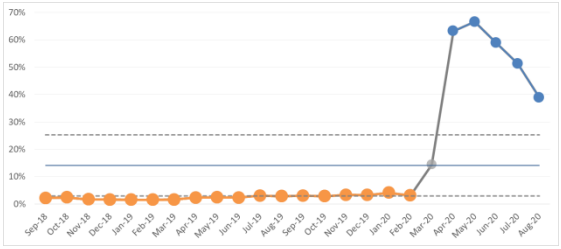


Follow-up



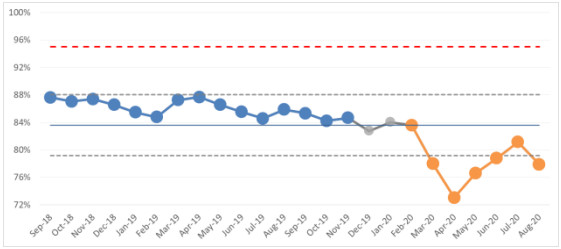
Non Face to Face Outpatients Activity
(Activity %)

Target: Monitor
Current Month: 38.9%



Outpatient Utilisation
(XX1 and Non XX1 Clinics)

Target: 95%
Current Month: 77.9%



Clinic utilisation and Outpatient activity has started to recover over the past three months although there has been a downturn in August due to peak holiday period.

Plans in place to reduce turn around times between patient facing appointments and increase virtual clinics so that we are at pre-Covid levels of activity by October 2020.

Referrals dropped off in April and May by over 50% but have steadily increased month on month to over 80% (compared to last year) in August and look set to be closer to 90% for September.

Through our recovery & transformation programmes we are looking to maintain a high level of virtual activity (25% new OPAs & 60% FU is target). In key specialties there are a range of rapid improvement initiatives to support the requirements of Phase 3

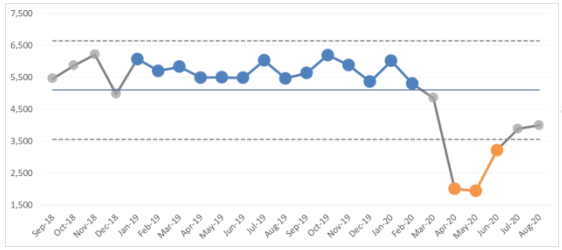
Planned Care – Admitted Delivery

East Sussex Healthcare NHS Trust

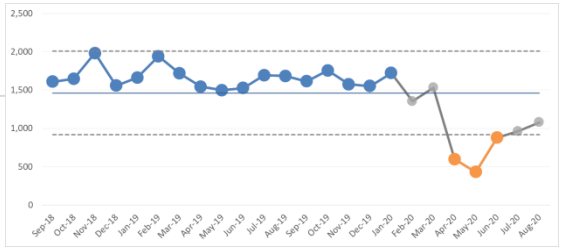
Access and Responsiveness

Elective Spells
(Day case and Elective IP)

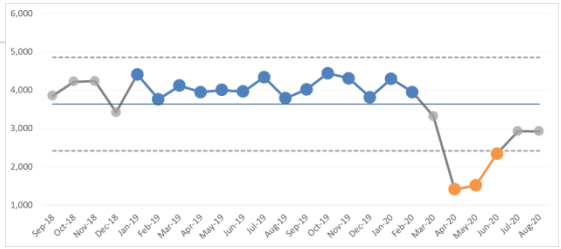
Target: Monitor
Current Month: 3,998



Elective IP

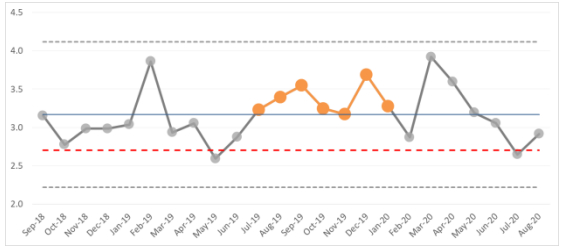


Day case



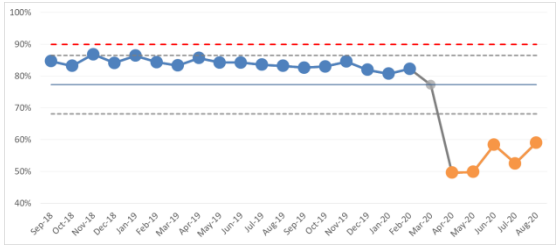
Elective Average LoS
(Acute)

Target: 2.7
Current Month: 2.9



Theatre Utilisation

Target: 90%
Current Month: 59.0%



August has seen a gradual continuous recovery of elective activity although there is still a way to go to reach pre-covid levels. The theatre activity taking place continues work to restrictions in terms of utilisation time due to theatre deep cleans and staff PPE 'Donning & Doffing' times.

Over the past three months, the Trust has seen an increase in utilisation and activity as part of the Restore & Recovery programme. The 6-4-2 theatre utilisation meetings have been reinstated in order to ensure all theatres are working at full capacity.

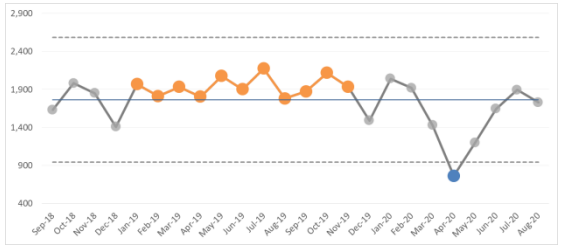
Elective Length of Stay (LoS) has seen a slight increase in August. This is the first increase for a number of months. This could be contributed to by the acuity of cases and focus on clinical priority 2 & 3 patients.

Cancer Pathway

East Sussex Healthcare NHS Trust

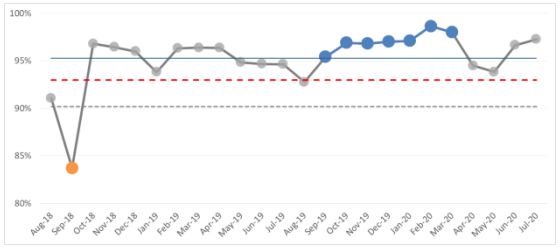
Two Week Wait Referrals

Target: Monitor
Current Month: 1,728



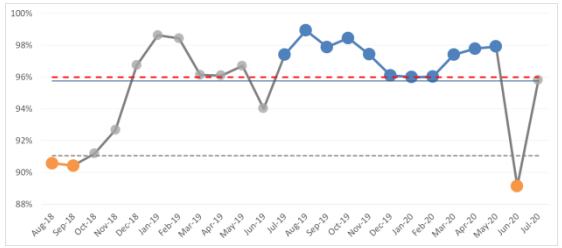
Cancer 2WW Standard

Target: 93%
Current Month: 97.3%



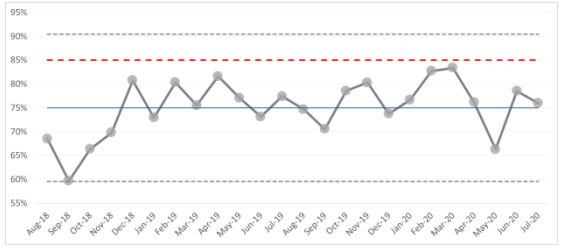
Cancer 31 Day Standard

Target: 96%
Current Month: 95.8%



Cancer 62 Day Standard

Target: 85%
Current Month: 76.0%



The Trust has continued meet the 2 week wait cancer standard in July and will report compliance in August. As predicted, the impact of pandemic led to the Trust not achieving the 31 day standard in June (89.1%) and again in July (95.8%).

The Trust continues to face the challenge of treating the number of patients waiting over 62 days and 104 days which in turn impacts on performance. July has seen a decline of 2.5% with a 76% final position. This was against a national average of 78.3% and placed ESHT 73rd out of 123 reporting organisations.
Validation of August's data will not be available until early October but early intelligence suggests a position between high 70's to low 80's.
It should be noted that due to the focus on clearing the backlog, the forward view for the coming months is a continued challenge on performance with a reduction in performance that will see the percentage drop into the 60's.

Two week wait referral levels reached pre-covid levels and although August number are down on July, there are in line with August 2019.

The Waiting list size has remained static in August at Circa 1700.

- 2WW Standard: 43 breaches out of 1577 patients first seen.
- 31 Day Standard: 6 breaches out of 143 treatments.
- 62 Day Standard: 27.5 breaches out of 114.5 treatments.
- 13 out of the 27.5 breaches for July were impacted in some way by Covid-19, either through surgical restrictions, diagnostic restrictions e.g. endoscopy, consideration of the risk of specific treatment type or cancelled/delayed clinics .

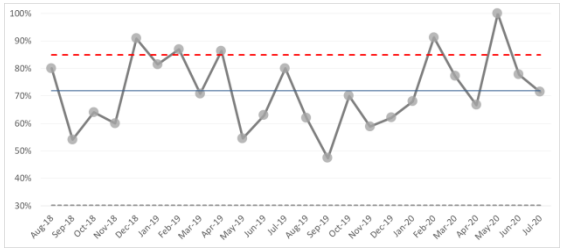
The Trust reported 12 treatments on or over 104 days, 3 of these was shared treatments with other Trusts (Brighton, MTW & QVH) and there were 15 individual patients in total.

The 28 Day Faster Diagnostic Standard (FDS) for July was 68.8%

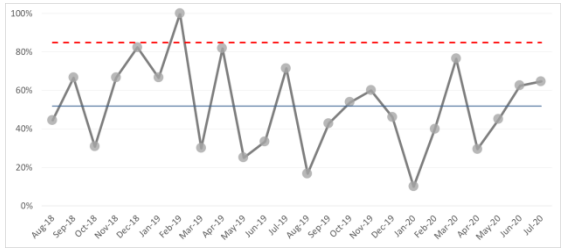
2WW Referral to First Treatment 62 Days

East Sussex Healthcare NHS Trust

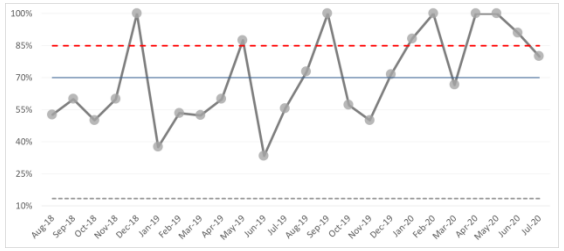
Breast



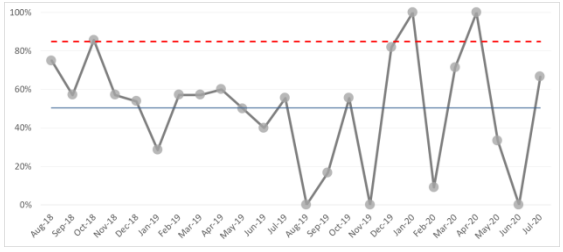
Gynaecology



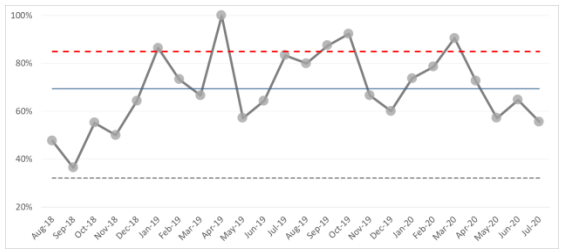
Haematology



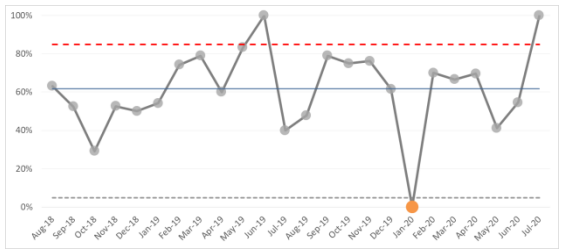
Head & Neck



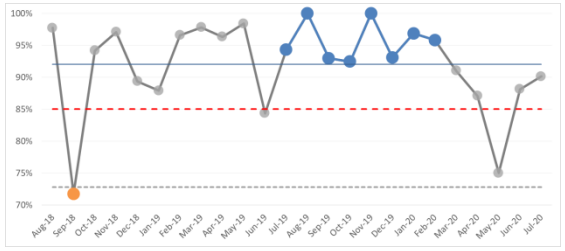
Colorectal



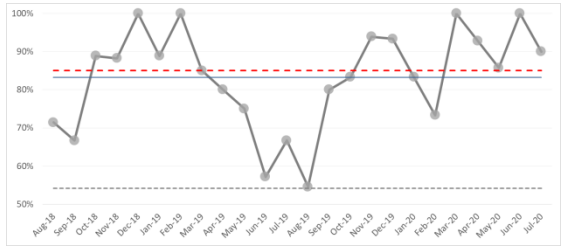
Lung



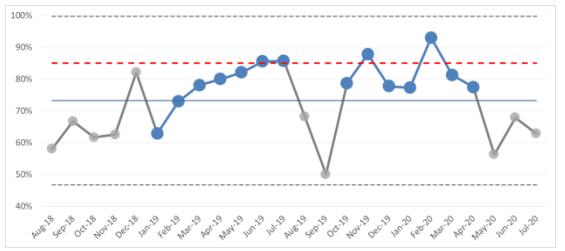
Skin



Upper GI



Urology



Financial Performance

Trust Financial Performance

Statement of Financial Position

Workforce Expenditure

Non Pay Expenditure, Efficiencies & Capital

Receivables, Payables & Cash

Divisional Financial Performance

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

Finance Report Summary - Month 5

Income YTD

	Pr Year Actual £k	19/20 M8-10 Average	Actual £k	Variance £k
Contract/Block Income	156,839	166,020	166,409	389
Divisional Income	17,146	16,181	9,738	(6,444)
Pre Top-Up Income	**173,984**	**182,201**	**176,146**	(6,055)
FRF/Block Top-up	6,969	12,464	14,573	2,109
COVID-19 Expense Claim	0	0	9,114	9,114
COVID-19 Income Claim	0	0	6,177	6,177
Top-up Income	**6,969**	**12,464**	**29,864**	17,400
Total Income	**180,953**	**194,665**	**206,010**	11,345

The Trust's income is above the 19/20 M8-M10 planning average income by £11.3m YTD. This is mainly due to the block top up and retrospective true-up of £17.4m. Without these element the Trust's income would be £6.1m below the 19/20 M8-M10 planning average.

Operational Deficit YTD

	Pr Year Actual £k	19/20 Mth 8-10 Average £	Actual £k	Variance £k
Permanent	(108,792)	(110,796)	(119,363)	(8,567)
Temporary	(14,181)	(15,906)	(20,037)	(4,131)
Total Pay	**(122,974)**	**(126,703)**	**(139,400)**	(12,697)
Non Pay Costs	(65,025)	(65,255)	(66,377)	(1,122)
Operating Costs	**(187,998)**	**(191,958)**	**(205,777)**	(13,819)
Operational Deficit	**(7,045)**	**2,707**	**233**	**(2,474)**

The Trust has achieved breakeven YTD due to the financial regime. The Trust has spent £13.8m YTD more than the NHSE/I planning average of which £12.7m is a pay overspend. The 19/20 M8-M10 planning assumption expected the Trust to be better than break even by £2.4m YTD.

COVID-19 Claim YTD

	Qtr 1	Qtr 2	Qtr 3	YTD
Pay	3,285	2,685	0	5,971
Non-pay	2,234	909	0	3,143
Planning Assumption	3,589	2,416	0	6,004
Loss of Income	135	37	0	173
Surplus Adjustment	(229)	(5)	0	(234)
Total	**9,015**	**6,043**	**0**	**15,057**
Amounts Validated	8,761	3,215	0	11,976
Residual Risk	**(254)**	**(2,828)**	**0**	**(3,081)**

The Trust's retrospective COVID-19 true-up claim of £15m covers increased operating costs due to COVID, a planning assumption gap and non-patient care income losses. The YTD surplus of £0.2m reduces the claim. £3m of this is yet to be paid.

Workforce

	Pr Year Actual WTE	19/20 M8-10 Average	Actual Average WTE	Variance WTE
Permanent	6,038	6,195	6,331	(136)
Temporary	582	633	605	28
Total Pay	**6,620**	**6,828**	**6,936**	(108)

The Trust has used on an average basis 108 FTE above the 19/20 M8-M10 planning average. The Trust has recruited 136 FTE above the planning assumption. Many of these related to pre-COVID-19 service developments and the need to run Red & Green areas of care. These are mitigated against by reduced temporary workforce staff numbers.

Agency Spend YTD

	Pr Year Actual £k	19/20 M8-10 Average £	Actual £k	Variance £k
Medical	1,749	1,901	1,868	32
Nursing	860	1,017	1,806	(790)
AHP's	505	851	791	60
Admin	302	321	292	29
Other	157	48	291	(243)
Total	**3,573**	**4,136**	**5,047**	(911)

Agency spend is above the 19/20 M8-M10 planning average by 22% with Nursing having the highest spend. This is mainly due to the Trust's response to pre-COVID-19 service developments and the requirement for additional staffing for Red & Green areas of care delivery.

Non-pay Spend YTD

	Pr Year Actual £k	19/20 Mth 8-10 Average £	Actual £k	Variance £k
Drugs	18,690	21,887	18,752	3,134
Clinical Supplies	14,898	15,251	12,543	2,708
Purchased Services	4,288	4,004	4,091	(87)
Other	18,042	12,615	17,836	(5,221)
Finance Costs	9,107	11,499	10,021	1,478
Total	**65,025**	**65,255**	**63,244**	2,012

Non-pay spend is below the M8-M10 planning average by 3%. This is largely due to the impact of the Trust's response to COVID-19 limiting planned care activities and the resultant reduction of spend on clinical supplies & drugs.

Cash

	Pr Year Actual £k	Plan £k	Actual £k	Variance £k
Current Balance	2,100	2,100	77,766	75,666
Year End Forecast	2,100	2,100	2,100	0

As a result of the current financial regime, funding has been received in advance of the period it relates to causing a higher than usual cash balance.

Capital Plan

	Plan £k	Actual £k	Variance £k
Year to Date	7,739	8,456	(717)
Year End Forecast	45,106	46,784	(1,678)

At M5 the year end forecast for CRL is £45.106m as bids of £9m need formal approval from NHSE/I and COVID funding is awaiting approval. With the £9m of business cases the forecast CRL is £55.174k. This consists of internally generated depreciation of £13.384k, year 2 of fire compartmentation £6m, Building For Our Future (HIP2) £10.375k, bids for medical equipment £4m, integrated theatres £250k, Scan4Safety £1.5m and cath labs £3.250k, critical infrastructure funds (CIF) £8.220k, Local Health and Care Record £373k and A&E winter £3.7m.

The Trust has an overplanning margin of £1.7m which will be monitored and reviewed monthly by the CRG. The Trust is currently ahead of plan YTD as actual phasing of schemes has materialised at a different pace to the plan set in March.

BPPC

	Month Volume	Month Value	YTD Volume	YTD Value
Trade Invoices	77.46%	88.34%	77.26%	89.77%
NHS Invoices	93.66%	99.17%	85.96%	96.06%

77% of trade invoices were paid within 28 days which equates to 88% of the total value paid in month. This is an 8% improvement in month in invoices paid within the target of 28 days.

94% of NHS invoices were paid within contract or within 28 days of receipt which was 99% of the total NHS invoices paid. This is a 16% improvement in NHS invoices that were paid within the 28 day target.

Divisional Performance

Division	In the Month: 19/20 M8-10 Average	Actual FTE	Variance FTE	Year to Date: 19/20 M8-10 Average £	Actual £k	Variance £k	19/20 M8-10 Average £k	Actual £k	Variance £k	Forecast Outturn: Plan £k	Actual £k	Variance £k
Diagnostics, Anaesthetics & Surgery	1,734.64	1,687.67	46.97	(623)	(49,066)	(48,443)	(3,117)	147,734	3,264	(119,830)	(119,830)	0
Medicine	1,486.75	1,440.51	46.24	4,031	(32,835)	(36,866)	20,154	167,515	(19,986)	(77,469)	(77,469)	0
Urgent Care	330.15	368.66	(38.51)	753	(10,119)	(10,872)	3,766	0	(3,766)	(20,585)	(20,585)	0
Out of Hospital Care	1,019.54	1,053.16	(33.62)	(493)	(21,451)	(20,958)	(2,466)	(21,451)	(18,985)	(51,435)	(51,435)	0
Women's, Children's & Sexual Health	694.75	692.15	2.60	1,065	(15,601)	(16,666)	5,323	(15,605)	(20,927)	(38,795)	(38,795)	0
Estates & Facilities	703.17	723.85	(20.68)	(2,128)	(2,464)	(336)	(10,641)	(13,015)	(2,374)	(28,676)	(28,676)	0
Corporate	916.30	1,032.28	(115.98)	(3,611)	(4,781)	(1,170)	(18,057)	(23,272)	(5,215)	(56,429)	(56,429)	0
Central	0.31	164.73	(164.42)	1,259	136,258	134,999	6,297	72,866	66,569	393,220	393,220	0
Total	**6,885.61**	**7,163.01**	**(277.39)**	**252**	**(59)**	**(311)**	**1,259**	**(161)**	**(1,420)**	**0**	**0**	**0**

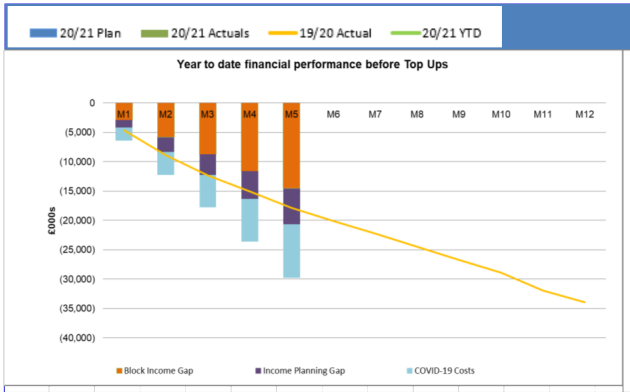
Key Risks

Key Risk 1	The amended financial regime is based on the average income for months 8 to 10 plus a 3.2% inflator. This has the potential to create cost pressures as the block contract is based on a period of time and not on forecast outturn.
Key Risk 2	Continued recruitment to vacant posts and service developments which commenced prior to the amended financial regime could lead to expenditure commitments higher than the funding allows in the block funding for 2020/21.
Key Risk 3	The Trust is required to submit plans to deliver 90% or 100% activity levels. This will incur additional costs. Should we not achieve these activity trajectories then there is a potential for reductions to our block contract even if the system were to achieve a breakeven position.
Key Risk 4	The Trust will receive a revised block value. It is unclear at this stage whether or not this will resolve our block income gap or the income planning gap identified in the current financial regime.

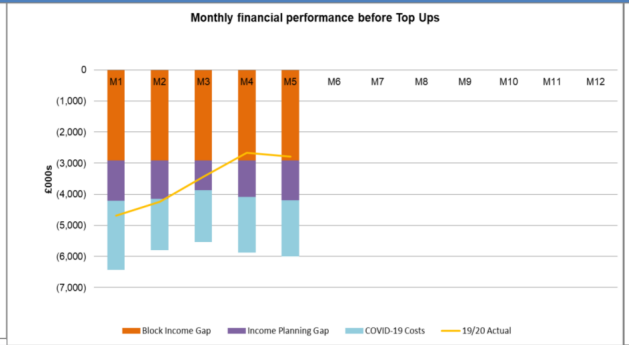
Mitigations

Mitigation 1	An expenditure forecast will be undertaken to understand both the financial opportunities and challenges and put in place early mitigation for the challenges.
Mitigation 2	An update of the Trust's financial plan is being undertaken based on month 1 as a benchmark to monitor pay spend and permanent recruitment
Mitigation 3	The focus will continue to be on productivity and efficiencies to ensure that we meet the required activity trajectories, manage our costs to avoid the risk of a reduced block contract.
Mitigation 4	We have been advising our NHSE/I team of the issues with our block income contract and are hopeful that they will take this feedback on board.

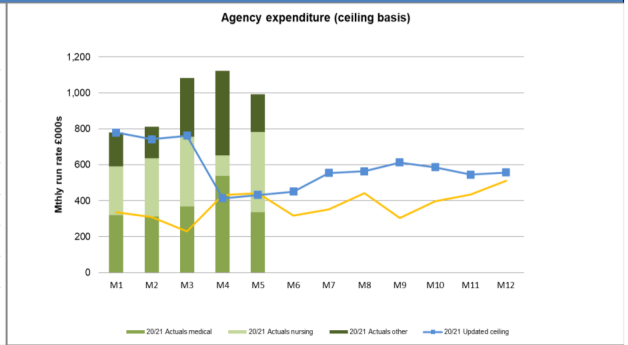
Finance Analysis



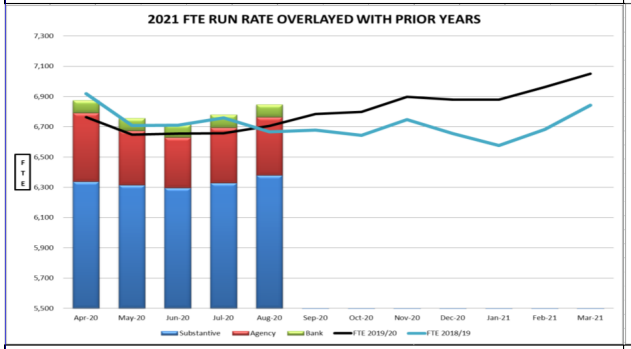
As at M5 the Trust is reporting a deficit pre-top up and True up of £29.8m. This is currently due to a block income gap of £14.5m, an income planning gap of £6.2m and COVID-19 related expenditure of £9.1m.



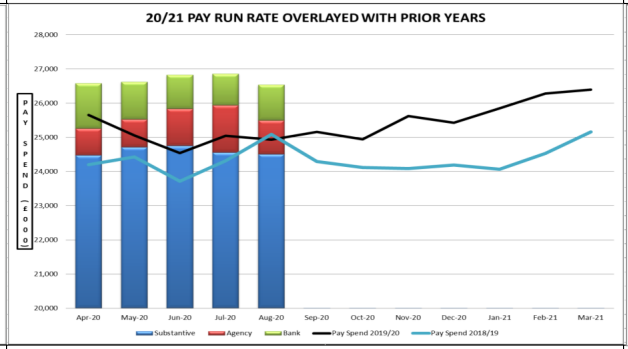
In the month the Trust is reporting a deficit pre-top up and true up of £5.9m. This is currently due to the block income gap of £2.9m, an income planning gap of £1.2m and COVID-19 related expenditure of £1.8m. The increased deficit run rate is due to increased COVID-19 related expenditure and also as a result of restoring 'normal' activity levels.



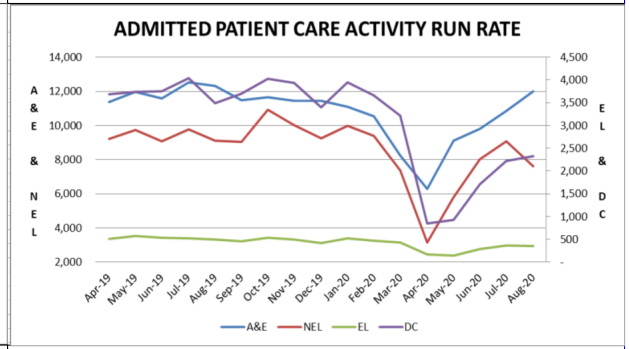
It is key that the Trust continues to focus on cost control as it has a block contract in place during September and probably for the remainder of this financial year. There is little opportunity for non-patient care income due to the wider effects of the COVID-19 amended regime.



The FTE run rate for 2020/21 is higher than both 18/19 and 19/20. This demontrates the Trust's investments prior to the COVID-19 amended financial regime and its response during the pandemic. The trend appears to represent an increase as activity recovers.

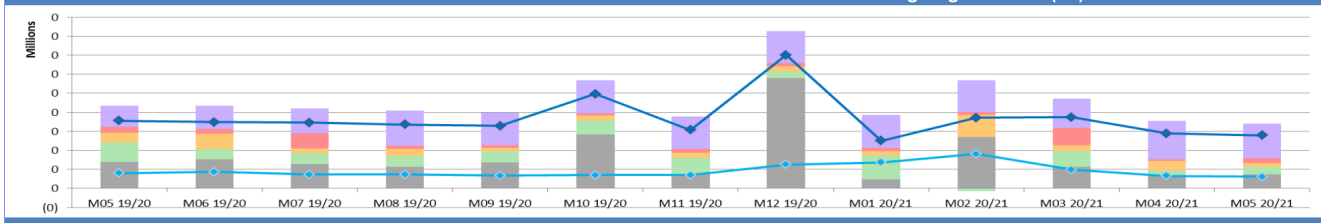


The pay spend is above the run rate of prior years and reflects the increased cost of operating set against a backdrop of COVID-19 (i.e. running 'Red & Green' areas) as well as the impact of service developments which commenced prior to the amended NHSE/I financial regime. The small decrease in run relates to the reduced need for additional and backfill of staff as the pandemic impact is currently reduced.



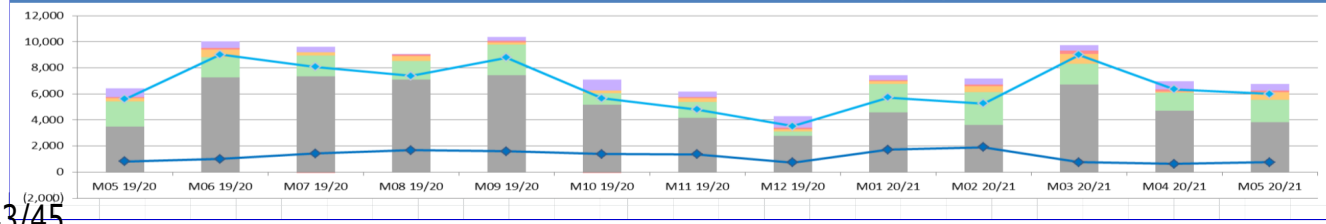
Admitted patient care (excluding critical care) shows a steep decline in April due to COVID and a consistent recovery thereafter. A&E leads the way with 87% of prior year activity followed by NEL at 73%. Both Elective & Daycases are 64% of prior year levels of activity. The expectation is all these are to reach 90% by October

Receivables Ageing Run rate (£k)



The sales ledger balance at the end of August is £6.8m which is a reduction on the previous month of £0.3m despite there being an increase of 96 invoices on the system.
The overall reduction is seeing an improvement in aged debt (invoices > 30 days) of £0.5m. 78% of the total debt owed to the Trust is due and is aged over 30 days. Most of the debt owed to the Trust is from other NHS bodies and therefore there is a low risk of non-recovery.
There are NHS invoices currently being disputed relating to; prior year market rent recharge from NHSPS £0.955m; SLA year-end settlement 2018/19 £0.281m and delayed discharges £0.092m.

Payables Ageing Run rate (£k)



A slight reduction in month of £0.2m on the creditor position reducing the purchase ledger total to £6.8m. The number of invoices on the system also fell by 388. Whilst the total purchase ledger position improved, the value of debt owed to suppliers (aged > 30 days) increased by £0.7m. Balances that are aged and not ready for payment reflect invoices that are awaiting authorisation or the receipting of the goods/services received.
89% of the outstanding invoices are payable to trade suppliers and the balance to NHS providers. The Trust processes weekly payment runs and forecasts to pay £3.5m per week.
Actual payment runs depend on the level of invoices on the system that are system ready to be paid.

Statement of Financial Position - Month 5

	Year to date				Forecast Outturn			
	19/20 Actual (£m)	20/21 Plan (£m)	20/21 Actual (£m)	Variance (£m)	20/21 Plan (£m)	20/21 Outturn (£m)	Variance (£m)	
Non Current Assets								
Property, Plant and Equipment	229.5	232.3	231.9	(0.4)	252.6	252.6	0.0	
Intangible Assets	2.4	1.8	2.5	0.6	2.3	2.3	0.0	
Other Assets	3.0	10.7	3.1	(7.7)	8.8	8.8	0.0	
Total Non Current Assets	**234.9**	**244.9**	**237.4**	**(7.5)**	**263.7**	**263.7**	**0.0**	
Current Assets								
Inventories	7.3	6.6	5.8	(0.8)	6.6	6.6	0.0	
Trade and Other Receivables	47.3	36.4	24.0	(12.5)	37.6	37.6	0.0	
Cash and Cash Equivalents	2.1	4.5	77.8	73.3	2.1	2.1	0.0	
Non Current Assets Held for Sale	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Total Current Assets	**56.8**	**47.5**	**107.6**	**60.0**	**47.5**	**46.3**	**0.0**	
Current Liabilities								
Trade and Other Payables	(28.8)	(35.1)	(44.5)	(9.5)	(32.5)	(32.5)	0.0	
Borrowings	(234.1)	(4.3)	(232.9)	(228.6)	(5.3)	(5.3)	0.0	
Other Financial Liabilities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Provisions	(0.4)	(0.4)	(0.3)	0.1	(0.4)	(0.4)	0.0	
Other Liabilities	(1.4)	(2.2)	(37.4)	(35.2)	(2.2)	(2.2)	0.0	
Total Current Liabilities	**(264.6)**	**(41.9)**	**(315.1)**	**(273.2)**	**(41.9)**	**(40.4)**	**0.0**	
Non-Current Liabilities								
Borrowings	(1.8)	(18.1)	(1.8)	16.3	(27.1)	(27.1)	0.0	
Trade and Other Payables	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Provisions	(2.8)	(2.0)	(2.8)	(0.8)	(1.8)	(1.8)	0.0	
Total Non Current Liabilities	**(4.6)**	**(20.1)**	**(4.6)**	**15.5**	**(28.9)**	**(28.9)**	**0.0**	
Total Assets Employed	**22.4**	**230.4**	**25.2**	**(205.2)**	**240.4**	**240.7**	**0.0**	
Financed By								
Public Dividend Capital	162.6	384.4	165.9	(218.5)	388.6	388.6	0.0	
Income & Expenditure Reserve	(230.5)	(251.7)	(230.9)	20.8	(245.6)	(245.6)	0.0	
Revaluation Reserve	90.2	97.7	90.2	(7.5)	97.7	97.7	0.0	
Total Tax Payers Equity	**22.4**	**230.4**	**25.2**	**(205.2)**	**240.7**	**240.7**	**0.0**	

Summary & Next Steps

1. On 2 April 2020, the Department of Health and Social Care (DHSC) announced reforms to the NHS cash regime for the 2020/21 financial year which included that all interim revenue and capital loans as at 31 March 2020 would be extinguished and replaced with the issue of Public Dividend Capital (PDC). In addition, the Trust was moved to block contract payments as part of the NHS response to COVID-19.
2. The effective date for the extinguishing of debt is 30 September 2020, at the time the plan was generated, the assumed debt conversion was April 2020 hence the variance.
3. All outstanding interim loans totalling £234m have been classified as current as they will be repayable within 12 months.
4. Due to the financial regime changes the Trust has been moved on to block contract payments. Funding is being received in advance causing a higher than usual cash balance at the end of month.

Capital Programme Summary - Month 5

YTD Capital Programme Performance	Original Plan £000	Revised Plan £000	CRG Plan £000	YTD Plan £000	Actual Expenditure £000	Variance to YTD Plan £000
Brought Forward	-	-	250	-	-	-
Estates	3,559	3,559	6,752	200	679	479
Backlog Maintenance	2,783	2,783	2,196	400	915	515
Digital	1,975	1,975	2,522	350	448	98
Medical Equipment	3,667	3,667	3,415	1,598	295	(1,303)
Finance	1,500	1,500	1,500	375	625	250
Unplanned urgents	545	350	334	400	412	12
Fire compartmentalisation	6,020	6,020	4,000	2,190	1,952	(238)
Medical Equipment Bid	4,000	4,000	4,000	-	-	-
Building For Our Future (HIP2)	4,230	10,375	10,375	1,085	1,237	152
Integrated Theatres	250	250	300	-	-	-
Track4Safety barcode implementatio	1,500	1,500	1,500	-	-	-
General Provision	301	-	1,076	-	-	-
Cardiology Cath Labs	3,250	3,250	2,687	-	4	4
Local Health Care Record	-	373	373	-	-	-
Breast Screening Mobile Units	-	26	26	-	-	-
Clinical Ward Internal Courtyards	-	1,800	1,800	-	-	-
Energy Centre Conquest	-	450	450	-	-	-
Energy Centre EDGH	-	720	720	-	-	-
Helipad area	-	2,143	2,143	-	-	-
Temporary Accommodation	-	3,107	3,107	-	87	87
COVID-19	-	1,115	1,115	1,141	1,141	-
CYBER SIEM Solution	-	100	100	-	-	-
A&E Winter	-	3,700	3,700	-	237	237
Oxygen	-	1,024	1,024	-	349	349
Perkin Elmer	-	319	319	-	-	-
COVID-19 (2020/21)	-	1,068	1,068	-	75	75
Total Owned	**33,580**	**55,174**	**56,852**	**7,739**	**8,456**	**717**
Donated	1,000	1,000	1,000	100	22	(78)
Less donated Income	(1,000)	(1,000)	(1,000)	(100)	(22)	78
Total	**33,580**	**55,174**	**56,852**	**7,739**	**8,456**	**717**

Capital Resource Limit (CRL)	£k
Planning CRL	**34,580**
2020/21 Opening CRL	**13,834**
Fire Compartmentation	6,020
Building For Our Future (HIP2)	10,375
Local Health Care Record (LHCRE)	373
Breast Screening Mobile Units	26
COVID-19 reimbursement	1,115
Critical Infrastructure Funds (CIF)	8,220
A&E Winter	3,700
Cyber SIEM solution	100
Closing Working CRL	**43,763**
Business cases (yet to be approved)	**9,000**
COVID-19 (2020/21 to be approved)	**1,068**
Oxygen (awaiting MOU)	**1,024**
Perkin Elmer (awaiting MOU)	**319**
Forecast CRL	**55,174**
Overplanning margin	**1,678**

Capital Commentary

1. At M5 the year end forecast for CRL is £45.106m as bids of £9m need formal approval from NHSE/I and COVID funding is awaiting approval. With the £9m of business cases the forecast CRL is £55,174k. This consists of internally generated depreciation of £13,384k, year 2 of fire compartmentation £6m, Building For Our Future (HIP2) £10,375k, bids for medical equipment £4m, integrated theatres £250k, Scan4Safety £1.5m and cath labs £3,250k, critical infrastructure funds (CIF) £8,220k, Local Health and Care Record £373k and A&E winter £3.7m.
2. CRL is the maximum that can be spent on capital purchases in year however actual permitted expenditure is determined by the capital departmental expenditure limit (CDEL) and this is based on actual depreciation in year, loan repayments and asset disposals.
3. The Trust has a £1.7m overplanning margin which will be reviewed and monitored on a monthly basis by the CRG.

ICS Collaborative Workstreams

Meeting information:			
Date of Meeting:	6th October 2020	Agenda Item:	9
Meeting:	Trust Board	Reporting Officer: Director of Strategy, Improvement & Innovation	

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

This report is for information, and covers the recently-established Integrated Care System (ICS) Collaboratives:

- The three core ICS collaboratives cover the main functional aspects of NHS work across Sussex (acute, mental health and primary/community care). These are supported by enabling workstreams
- These collaboratives are increasingly the mechanisms through which ICS initiatives/requirements will be shared and delivery tracked
- Attendance by relevant senior staff is therefore essential if we are to ensure we can demonstrate both delivery and commitment as partners in the ICS

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

None

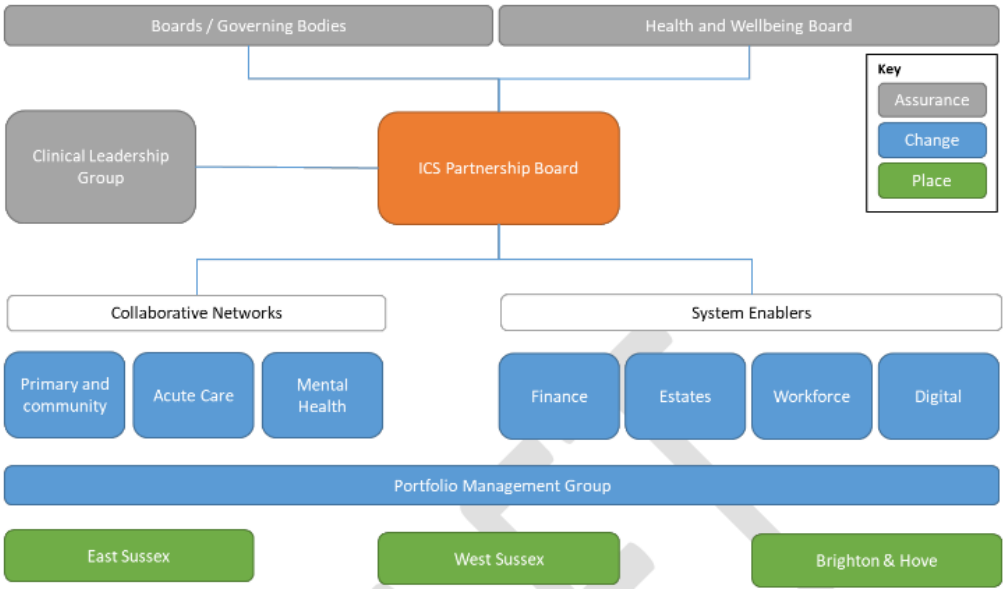
3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board is asked to note the development of the ICS collaboratives and their function.

OVERVIEW

1.1 The Sussex Health and Care Partnership is an integrated care system (ICS) involving all NHS organisations and the local councils that look after public health and social care. The Partnership takes collective action to improve the health of local people, to improve the quality of health and care services and to ensure the most efficient use of our resources.

1.2 Following the decision to formalise the ICS status in April, a governance review was undertaken over the Summer and the Collaborative Networks and System Enablers were set up to provide this oversight and the these groups are shown in the reporting structure below (blue boxes).



1.3 The collaborative networks and system enablers are responsible for the delivery of commitments agreed in response to the Long Term Plan. They also hold the strategic oversight of Sussex scale developments in their area, so our participation is important as these forums evolve.

1.4 Our attendance at the acute care Network includes Chief Executive, Chief Operating Officer (COO), Director of Strategy and Chief Financial Officer (CFO). The CFO also attends the Finance system group and the COO attends the primary and community network. Our Estates Director attends the estates session. As these forums establish and work-plans develop we will need to ensure that our internal governance functions cover any matters and actions of relevance to the Trust.

1.5 In summary, the role of these groups is to:

- Design, co-ordinate, oversee strategies & programmes required to deliver LTP requirements and the development of Sussex ICS
- Provide the strategic direction to programme groups and sign off programme outputs
- Monitor and manage the outcomes and risks across the range of programmes
- Foster coordination and coherence across networks and with place
- Allocate network level resources to the programmes
- Report monthly to the Partnership Executive including escalation of risks and issues that cannot be resolved at programme or Network level

1.6 Although moving at different speeds, these new structures are developing well with evident commitment and support from partners across the system. All met under their new structures in the last month and the

bulk of the business of the Networks has been to consider their response to the Phase 3 planning letter, which has been discussed at each of the most recent meetings.

1.7 Many of the responses to the Phase 3 letter are focused on acute and mental health but further detail was provided on the specific requirements for the roles and responsibilities of the Primary and Community Collaborative. Further work is being undertaken in order to determine the level of oversight from each networks to discharge their responsibilities.

1.8 This is particularly important where work undertaken in one network could impact another. For example, virtual outpatient activity within the planned care programme under the Primary and Community Network to ensure that an appropriate level of representation formed part of pertinent programmes of work under the acute care collaborative and digital programme structures.

1.9 The Sussex Health and Care Partnership Project Management Office (PMO) have streamlined the reporting routine and new templates have been developed to support this. Programme reports now flow through Networks for development in line with the oversight requirements. The new reports meet the needs of the Partnership Executive, Collaborative Network Boards, Clinical Commission Group PMO teams and the restoration programme. It can be adapted for other audiences as required, which will reduce some of the duplication and confusion of the previous reporting structures.

1.10 The Board will receive updates in year as the Networks evolve and delivery against relevant workstream areas progresses.

Winter Planning 2020/21

Meeting information:			
Date of Meeting:	6 October 2020	Agenda Item:	10
Meeting:	Trust Board	Reporting Executive Officer: Imran Devji - COO Author: Shane Morrison-McCabe – Deputy COO – Urgent Care	

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☐
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state: East Sussex Health and Social Care Organisations			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register?	yes

Summary:

1. BACKGROUND, OBJECTIVES, KEY POINTS, RISKS & ISSUES RAISED BY THE REPORT

The East Sussex Integrated Care Partnership has now completed and signed off the winter plan for 2020/21. The plan is informed by a detailed acute and community demand and capacity analysis with an agreed system resource to mitigate the bed gaps ensuring effective winter resilience.

The plan also includes the potential COVID-19 impact over the winter, the phase 3 expectations for restoration and recovery as well as emergency care growth assumptions. These are challenging as well as competing priorities that require a strong system response ensuring timely, safe and consistent response to care needs of the local population during this winter. Further detail is covered in the sections below providing assurance on progress to-date for the board.

1.1 Key elements of the winter plan:

- System and organisational learning from last winter (2019/20)
- Learning and preparation from the first wave of COVID-19
- To avoid ambulance delays of over 30 minutes
- No 60 minute ambulance handover delays
- Detailed capacity and demand modelling of the expected winter pressure with 2% growth and minimum to peak COVID 19 impact
- The agreed restoration and recovery phase 3 plan in alignment with the Sussex ICS and organisational submissions
- Service impact of the latest national guidance including hospital discharge, supporting care homes, infection prevention and control (COVID-19 and flu planning) and adult social care

1.2 Main objectives of the winter plan:

- To maintain patient safety at all times
- To prepare for and respond to periods of increased demand including the impact of COVID-19
- To achieve an acute bed occupancy of no more than 90% and to maintain bed occupancy below 92% throughout Winter
- To ensure that all community bed capacity is fully utilised

- To ensure delivery of the elective care recovery and restoration trajectory
- Strengthen Same Day Emergency Care (SDEC), Ambulatory Emergency Care model and the Acute Frailty model across both sites
- Deliver capacity to manage any COVID-19 demands including critical care capacity
- Manage any flu or other infection control challenges safely & effectively
- Maintain on average green escalation status for Medically Ready for Discharge (MRD) and amber as a maximum tolerance level
- Stranded numbers (over 6 day LOS) to be managed *below 105 (33% bed base per site) and >21 days LoS at a maximum of 30 per site (10% of bed base)*
- *Increase* discharge pathways 1 (Home First model) and 2 (Time limited care home/rehabilitation support)
- *Maximise* out of hospital assessments for discharge pathway 3 (long term care support)

1.3 East Sussex System risks for winter 2020/21:

- A total bed gap of 111 beds (92 acute and 19 community beds) against demand
- Impact of further COVID-19 peak (creating a further gap of 93 beds)
- Increased Critical Care capacity due to COVID-19 peak
- Further delivery of Medically Ready for Discharge (MRD) gains
- The fragility of the care home sector
- The recovery of elective care within a 2nd peak of COVID-19
- Workforce variations including availability of temporary cover

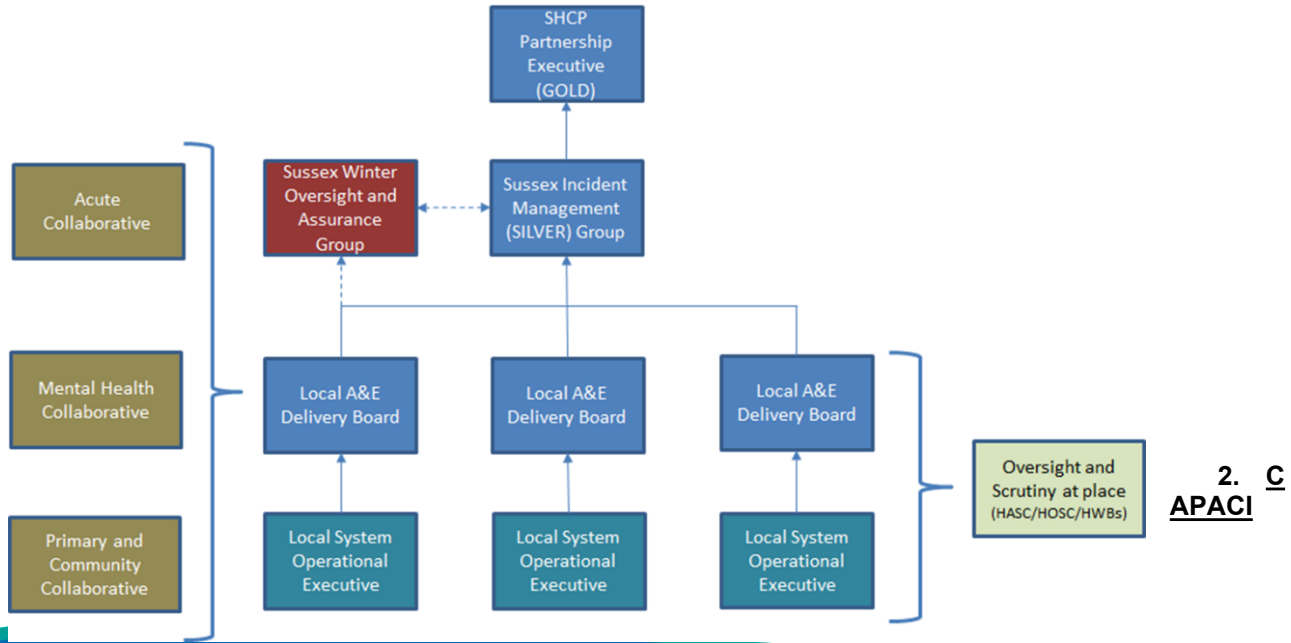
1.4 The KPIs monitored as part of assurance delivery of this winter plan are:

- A&E 4 hour waiting times – over 90%
- 12 hour decision to admit breaches – 0
- Ambulance handovers over 60 minutes – 0
- Sustain (as a minimum) the reductions in the MRD achieved during COVID-19 wave 1 in acute care
- Community MRD levels should remain amber / green as per escalation framework
- Delivery System recovery phase 3 planning including bed occupancy
- Activity against operational modelling:
    - A&E activity
    - Acute demand
    - Community demand
    - Elective activity (including outpatients)

These KPIs and objectives will be a part of the integrated emergency care dashboard monitored through the system multiagency Operational Executive Group and the LAEDB.

1.5 System Winter Plan Governance

The Sussex ICS and the East Sussex ICP have clear governance structures in place ensuring strong alignment between ICS and place based approach as outlined below.



2. C
APACI

TY & DEMAND

The system demand and capacity planning included a combined position between the CCG, Local authority, community and acute leads. Table 1 sets out the capacity gap at site level and table 2 the mitigation to close the gap.

Table 1: Acute and Community bed capacity gap

Care Setting	Provider	Bed capacity gap with minimum COVID-19 surge
Acute	EDGH	40
	CQ	52
Community	All providers	19
Total system capacity gap		**111**

Table 2: System mitigation to reduce the bed gap

Mitigations	Lead	Bed capacity
Improved step up capacity and MRD position	ESHT	34
SCFT escalation beds (Crowborough / Uckfield)	SCFT	6
Glynde ward (escalation capacity)	CCG	24
step down beds	ESCC	47
Total system bed capacity	**ICP**	**111**

The acute bed capacity gap of 92 included 2% growth, 65 ring fenced elective recovery beds and 56 dedicated COVID-19 beds. The site level gap at EDGH is 40 beds and CQ at 52 beds. The community bed gap of 19 was mainly driven by pathway 3 beds (care home) resulting in a total bed gap as a system of 111 beds. All the bed gaps have plans in place for mitigation as follows:

- Step down bed arrangements will build upon the current services, ensuring capacity and type of bed available is maximised to meet requirements of patients (47 ESCC and 6 SCFT beds)
- Medically Ready for Discharge (MRD) improvement plan as per the patient flow programme is in progress within the system. Step down community beds are outlined within adult social care plans. Further discussion in relation to the delivery of 10 additional EMI / bariatric beds is in progress (Total of 34)
- Acute escalation capacity for time limited periods to accommodate surge (24 beds on Glynde by January 21)

Further work in progress to firm up the following schemes listed in table 2:

- Step up capacity and MRD (demand management and earlier discharge)
- Pathways for SCFT beds to be confirmed to ensure capacity is maximised
- Glynde escalation capacity – currently 10 beds in place; capital works in progress to extend to additional 14 beds. Staffing resource to be funded

2.1 Demand and capacity – key enablers (consolidated list including new schemes in Table 2):

Initiative	Owner	Additional capacity	Continuing for Winter 2020-21
Winter escalation beds at Bexhill Irvine Unit	ESCCG	12 beds	Yes
Winter escalation beds at Rye Memorial Care Centre	ESCCG	4 beds	Yes
Continuation of winter escalation home care block hours	ESCC		Yes
Additional community step down beds including 10 EMI/mental health beds	ESCC	47 beds	Yes
Care home spot purchase beds	ESCC	As required	Yes
In Pulse patient transport service	ESCCG	Additional capacity including overnight to support timely discharge	Yes
Wealden ambulance patient transport service	ESCCG	Additional capacity including overnight to support timely discharge	Yes
Improved step up capacity	CCG	34	To be developed
SCFT escalation beds (Crowborough / Uckfield)	SCFT	6	Pathways to be confirmed
Glynde ward (escalation capacity)	CCG	24	Subject to further capital investment
Improved acute MRD position	ESHT	34	Delivery in line with Acute Patient Flow Programme

3 DISCHARGE HUB AND MRD REDUCTION

In line with the March 2020 Covid-19 Discharge Guidance, Discharge Hubs were established in each system. These hubs have had a significant impact on reducing the number of medically ready for discharge (MRD) patients by enabling a multi-agency approach to support patient discharge to the most appropriate location for their current needs. Hubs aim to discharge patients 'home first' (pathway 1) wherever possible and as clinically appropriate.

Hubs are supported by a single coordinator - appointed on behalf of all system partners to secure timely discharge on the appropriate pathway, oversee coordination of discharge arrangements on pathways 1-3 and escalate relevant issues to the Executive Lead. The sustainability and further improvement in MRD performance is key to winter resilience and is identified as a key mitigation to address the acute demand and capacity gap. Discharge Hubs have set out an action plan to further embed Discharge to Assess (D2A) processes and to achieve an MRD position of <3% of occupied G&A beds.

The action plans include:

- Improvement in Discharge Hub systems and processes to reduce the time patients spend waiting to be discharged
- Further development of the Trusted Assessment model to ensure assessments do not take place in the acute setting in line with the national discharge policy
- Embedding a practice of continuous improvement and data driven approach to the development of the Hubs that recognises and addresses the demand profile

A weekly Executive Oversight Task and Finish Group is established to oversee and drive this programme of work, led by the system community Executive Leads.

4 PRIMARY CARE JOINT COMMUNITY WORKING

To support practices going into winter, particularly in the event of a resurgence of COVID-19, final arrangements for Hot sites and zoning have been agreed, all claims reviewed and (subject to appeal on a small number) finalised on 11th September.

Fifteen practices have been identified to pilot the Primary Care Data work to illuminate capacity and demand in Primary Care. This aims to extract data in support of LCS validation, reducing the administrative burden on Practices; and offer real time activity data to contribute to system wide understanding of pressures in the system as we enter the winter period. With regard to the latter, the aim is to develop a similar level of real time data as that represented on the SHREWD systems, though this presents a significant challenge given the number and variety of GP appointment systems and IMT platforms across the county. In the short to medium term however, this pilot will give a proxy rating measure of daily pressures in General Practice.

Notice has been served on a range of LCSs for frail and Care home patients specific to the previous CCG footprints, to be replaced by Sussex wide arrangements, which recognise and complement the PCN DES, on 1 December 2020. This will ensure a comprehensive and consistent level of support for these patients across the county.

The Additional Roles Reimbursement Scheme (ARRS) workforce plans 20/21, and PCN plans for addressing the 19/20 underspend haver been received and the outcome communicated to PCNs. This will provide an additional workforce in each PCN to increase access. Where possible, this recruitment is being fast-tracked in time for winter.

Planned and community Care leads are attending the weekly PCN Clinical Director meetings to identify opportunities for joint working and management of patients.

5 NHS 111 WINTER PLAN

Initiative / Target	Area / provider	Delivery Date	Risks	Mitigations
Implementation of CAS in NHS111	NHS111	October 2020	• Covid-19 second wave • Digital • Workforce	• Workforce Project Manager in post • National workforce blueprint • Ongoing provider input with NHSE/I • National fail-over
Implementation of 111 First	NHS111	December 2020 (October 2020 fast followers)	• Digital • Unknown demand on redirected services • Recruitment • Communications and engagement	• Sussex wude task and finish group established • Bidding opportunities for additional funding available for staffing (for 111 providers only) • Ongoing provider input with NHSE/I
Development and expansion of direct booking and GP Connect	NHS111	TBC	• Primary Care engagement • Roll-out capacity	• KMS digital roadmap in place • Prioritised roll-out plan being progressed across commissioners and providers
Development and expansion of DoS profiling	NHS111	Ongoing	• Provider engagement and commissioner understanding • Volume of changes required	• Support from regional DoS lead • Development of prioritisation plan
Development of Mental Health CAS	NHS111 / SPFT	Winter 2020	• Workforce	• SPFT recruitment in progress
Development and implementation of Starline	NHS111	Pilot commencing 1st Sept 2020 (Kent) which will inform Sussex roll-out	• Delivery slippage	• Engagement with key stakeholders

6. ACUTE HOSPITAL AND COMMUNITY WINTER PLANS

Initiative / Target	Delivery Date	Risks	Mitigations
HOT clinics: Cardiology and Gastroenterology feasibility and plans underway. Other speciality HOT clinics will be explored and proposals put forward.	Tbc, target Oct 2020	• Workforce • Location • Processes – within the acute and with primary care	Medicine division exploring how to establish these clinics
ED expansion plan – majors cubicles at Conquest, CDU capacity at EDGH Further ED expansion by Jan 2021 creating 21 additional spaces at EDGH (13 fit2sit) and 10 extra spaces at CQ	EDGH CDU work completed July 2020 Conquest – Oct 20 Dec 2020/Jan 2021	• CDU remains too small • Additional Majors cubicles are insufficient	Ongoing review as part of the space utilisation board.
Covid19 testing: Currently 40 in-house tests available for both sites and these are prioritised in conjunction with the CAG. Other swabs are being tested off site at Southampton (up to 48hrs turnaround time). POCT trial underway July 2020. If proven efficacy then 3 machines will be available for both sites and give capacity for 18 tests to be processes per hour. Bid put in for additional in-house testing capacity	Ongoing. Pilot evaluation – early Aug 20. Outcome of bid for more in-house testing – Early Aug 20	• Further reduction in available in-house tests (due to national reliance). • Pilot fails to show efficacy • Bid for more in-house tests is declined	• Prioritisation will continue through CAG
Elective programme: Continuation of the restoration, recovery to meet the RTT trajectory. Cancer recovery programme to continue. Ongoing utilisation of available private sector capacity.	Recommenced from June – ongoing and monitored through the Elective Care Board	• Second Covid19 wave leads to an increase in bed occupancy and prevents the elective programme from continuing.	• Outflow and bed occupancy to be maintained. • Utilisation of private elective capacity options.

Initiative / Target	Delivery Date	Risks	Mitigations
Hospital and Home: Model is being explored. Case to be prepared	Oct-Nov 20	• Insufficient funds to afford this model	• Fully utilise BCC, BIU and work to implement the Seacole Centre
Flu: Support from ESHT to ensure proactive immunisation programme is in place, uptake is high and incidents low	Sept 2020 – Dec 2020	• Low uptake	Communications programme though
MRD and stranded patients: Focused daily actions through the Divisions and OOH team (including the Discharge Hub) to fully utilise available non-acute capacity	Ongoing & monitored through the monthly Patient Flow Programme Board	• MRD numbers do not reduce as per trajectory • Revised Hub model is unaffordable. • Insufficient workforce for the proposed Hub model	• Length of stay meetings – weekly • Stranded patient daily review by the wards
Implementation of Live Bed state (Nerve Centre) Sept 2019 to reinforce red/green and patient flow at board rounds. Pilot carried out on wards and full roll out	October 2020	• Slippage on implementation date.	• Project implementation group, project plan, milestones in place.
Monthly week of improvement focus around inflow, flow and outflow – 3 key improvement actions per phase	August 2020	• Lack of preparation to get maximum benefit • Lack of understanding of outputs	• Clear leadership at divisional level to drive improvements • Clinically led and operationally facilitated model

7. INFECTION CONTROL PLAN

- A Sussex wide Influenza Programme Board has been established from June 2020 with task and finish groups focusing on the following areas:
- Prevention of Winter viral illnesses including RSV, Norovirus, Flu and Covid-19
- Outbreak management across all Providers
- Communication strategy to include lessons learnt from 2019/20 – a particular emphasis on prevention of RSV
- Delivery of vaccination programmes such as pneumococcal, shingles and Influenza
- Delivery of staff vaccination programmes
- Delivery models for vaccination programmes
- Expansion of national vaccination programme

8. COMMUNICATION PLAN

To support the NHS response to COVID-19, NHSE and PHE are working together to deliver a single national campaign, with three phases, under the 'Help Us Help You' brand, to help address the impact of the pandemic on people accessing services, with activity running throughout the winter. A clear process is agreed within the system led by the communications team.

9. WINTER PLAN RISKS

Identified Risk	Mitigations
Delivery of MRD reductions: delivery of the MRD gains achieved through early implementation of the discharge hub and response to Covid which underpin demand and capacity modeling	• ESHT patient flow programme in place to inform improvement actions • Monitoring dashboard to be developed • Substantive model for the discharge hub to be agreed
Flu Vaccination Programme: There is a risk that there will be insufficient capacity and vaccine supply to deliver the extended national flu vaccination programme for 2020-21 at 75% for all eligible cohorts..	• Appointment of Mass Vaccination and Testing Programme Director • Primary Care and Community Pharmacy Demand Modelling Completed and gap identified. • Engagement with providers to develop mass vaccination delivery • National financial support to be confirmed. • Access to additional National Influenza Vaccination supply to be confirmed • Active Communication and engagement plan to include the development of Community Influenza Champions • workforce – regional and local workforce modelling underway to support gaps in capacity that are identified and the increase in the vaccination Cohort
Staff Key Worker Testing: There is a significant risk that, due to the current national pillar 2 capacity and demand challenges, that key NHS and non NHS key workers will not be able to access testing, which will extend periods of staff absence related to Covid-19	• Sussex ICS Testing Prioritisation Framework developed. • Pillar 1 capacity and demand modelling developed to inform the above. • Re-establishment of provider in house staff testing capacity. • Sussex Central Booking Hub to facilitate and prioritise access for key workers. • Targeted deployment of mobile testing units (capacity capped due to pillar 2 issues)

9.1 Next steps around risk management and delivery:

- Further ratification of each scheme and monitoring of delivery on a weekly basis
- Further work up on the step up capacity and MRD reduction including funding to deliver 34 bed mitigation
- Develop and finalise the Integrated risk register for winter covering East Sussex place
- Progress update on the winter plan and the integrated risk management to the LAEDB
- Weekly update by the COO at executive group meetings
- Monthly Board updates via the performance section on the winter plan

10. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

The LAEDB has considered the plan and will be monitoring further development of it. There is a fortnightly ICS assurance Group for Winter Planning to ensure alignment across the ICPs.

11. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The paper is submitted to provide the board with an update on progress so far and for assurance on the winter plan.

Update on NHS Charities Together Funding

Meeting information:			
Date of Meeting:	6th October 2020	Agenda Item:	11
Meeting:	Trust Board	Reporting Officer:	Lynette Wells

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☐
Staff	☒	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state: NHS Charities Together, East Sussex Healthcare NHS Charitable Funds……			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

NHS Charities Together (NHSCT) is a national charity providing support and guidance for NHS charities across the country. The charity came to national prominence during the pandemic as the preferred medium for donations to the NHS, including the money raised by Captain Tom. The total raised through NHSCT in response to the pandemic now stands at over £130million.

NHSCT have around 240 member charities, including East Sussex Healthcare NHS Charitable Fund (ESHCT). The money raised is being distributed to member charities in three stages.

Stage One Funding

An initial distribution was made to member charities to meet the urgent needs of the NHS during the initial response to the pandemic. Prior to the receipt of this distribution, the Friends of our Hospitals provided outstanding support to the Trust to support staff and patients in rapidly responding to the initial stages of the pandemic. This included the purchase of items to support separate streaming of covid positive patients, including white goods for a second staff room in theatres, refreshments for staff and iPads to allow patients to communicate with relatives. We are incredibly grateful for the support of our Friends during this time.

ESHCT received stage one funding of £84.5k from NHSCT in late April. Once received ESHCT took over from the Friends in funding the support of staff in the organisation. Money was also used to:

- Fund nurses and matrons in receiving virtual leadership support from the Nightingale Foundation.
- Fund ‘Our ESHT Story’, where staff from across the Trust have been invited to tell their stories about working at ESHT, including how they have coped with the challenge of the pandemic. We hope that sharing stories will prove to be therapeutic for staff.

- A 'What Matters to You' fund where staff from across the organisation could bid for up to £1k for non-essential items that would make a big difference to their place of work. The most popular items requested were white goods, such as fridges and kettles and outside seating.
- A proportion of the initial distribution has been set aside to provide support to staff in the event of a second wave of the pandemic.

NHSCT opened up additional Stage One funding for further bids, particularly for groups who had been disproportionately affected by Covid-19. The Trust successfully applied for an additional grant at this stage, to develop an App to help support our d/Deaf community, providing information in an accessible fashion. If this is successful locally then we hope to share this with the wider NHS.

Stage Two Funding

The second phase of funding was released in early September. This money is to be used to support communities through partnership with social and health care organisations, and has been distributed on a regional basis. Eight NHS Charities from across Sussex have formed a Programme Board to manage the £802k distribution for Sussex. This money has been granted to NHS Charities and not NHS organisations, and the management of the distribution will be led by Heads On, the charity for Sussex Partnership NHS Foundation Trust.

At the end of August, Sussex Health & Care Partnership Executive Leads agreed the following priorities for Stage 2 funding:

- Overarching priority: Health Inequalities including people with a learning disability and BAME communities
- Mental Health priority: Suicide Prevention
- Physical Health priority: Supportive hospital discharge

The recommended priorities were approved by the Programme Board in September.

Grants will be made to third sector and independent charities to support these priorities across the Sussex footprint. The final decision on how the money will be spent lies with the 8 NHS Sussex Charities.

Stage Three Funding

The full details of the third phase of funding were announced in September. This allocation is to be used to support recovery plans within NHS Trusts and the wider community, with money allocated to Trusts at £22 per member of staff. The Trust has been allocated a total of £165k under Stage Three. Unlike previous distributions, the Trust has to make bids to NHSCT in order for money to be released. These funds cannot be used to provide core services, but to add value to and enhance existing work or introduce innovation. The Trust is developing plans for how to best utilise this funding; bids will need to be submitted to NHSCT by the end of the 2020/21 financial year. These bids will be reviewed by the Trust's Charitable Funds Committee, which is chaired by Karen Manson, prior to submission to NHSCT.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

This report is for the Board's information.

Workforce Equality Diversity & Inclusion

Meeting information:	
Date of Meeting: 6th October 2020	Agenda Item: 12
Meeting: Trust Board	Reporting Officer: Monica Green / Cassandra Blowers

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

This report provides an update on the Workforce Equality, Diversity & Inclusion (EDI) agenda including recent activities. It asks the committee to discuss the national requirements and approve the newly proposed governance structure that supports workforce equality and inclusion at the Trust.

The paper also highlights the findings in the 2020 workforce disability & race equality standards with a supporting action plan for approval for the forthcoming year and beyond.

In addition, with the forthcoming retirements of the Chairs of the BAME and Disability staff network, this report provides a proposed new structure for discussion and approval in the next steps leading to the networks becoming self-governing and independent groups. It is proposed that the networks will be seen as critical groups to help transform ESHT diversity agenda.

2. REVIEW BY OTHER COMMITTEES

The paper has been presented to Executive Directors Team on 26 August 2020 and POD Committee on 03 September 2020.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

This paper seeks the Board to:

Approve the proposals for:
- New governance structure for workforce EDI
- Proposal for the future of staff networks

Accept the data and commitment to the 2020/21 Action Plans for
- 2020 Workforce Disability Equality Standard Report
- 2020 Workforce Race Equality Standard

1. Proposed governance structure for workforce Equality Diversity & Inclusion (EDI):

There is a need to ensure that the workforce national requirements have a good governance framework to meet its duties set out in the Public Sector Equality Duties (PSED) alongside the NHS People Plan.

The following proposal has used the 4Ps methodology of People, Purpose, Processes and Performance to provide an EDI governance framework at ESHT.

People
The right stakeholders are at the relevant meetings to ensure that information and work streams are triangulated between the Staff Networks, the newly established 'Task and Finish' groups and the Workforce Equality group.

Purpose
Its main purpose is to ensure that our workforce PSED and national reporting are scrutinised and have deliverable outcomes. Its additional purpose is to align all equality work streams to the National NHS People Plan.

Process
A strong management and staff framework with transparency and accountability to include SMART Objectives

Performance
Provide assurance on measurable outcomes to the POD committee, Executive Directors Committee and Board of Directors on our PSED.

Our current national statutory requirements include:

- EDS2 (workforce element that will link closely to patients) - The Equality Delivery System -EDS2- is a toolkit which has been designed to help NHS Organisations in assessing and grading their equality performance each year relating to patients and workforce.

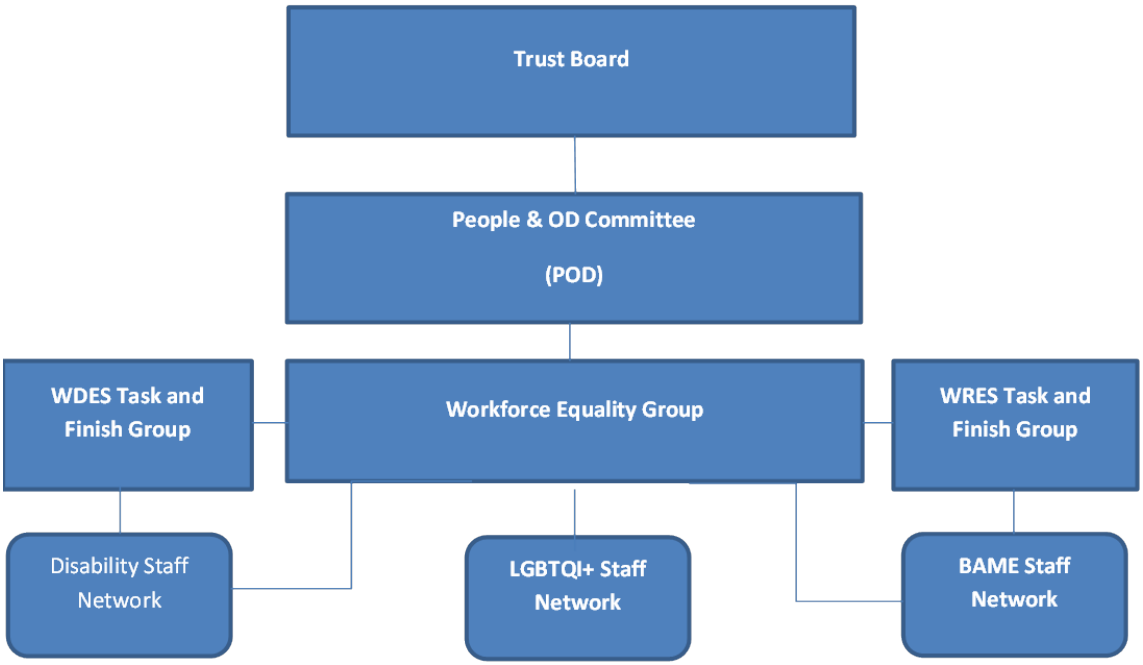
- Gender Pay Gap- all organisations with more than 250 employees in the UK have to publish their gender pay gap.

- Workforce Disability Equality Standard (WDES) - the Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of Disabled and non-disabled staff.

- Workforce Race Equality Standard (WRES) - the workforce Race Equality Standard is a set of 9 metric which enables NHS organisations to compare workplace and career experience of BAME staff and White staff.

- NHS People Plan where Health and Wellbeing of staff has been identified as a priority.

Table1: Proposed Governance Structure



2. Staff Networks a fresh approach

Staff networks at ESHT have been historically chaired by a Board Member that has played a pivotal role in raising the profile of minority groups within the Trust. The networks have also been the driving force in all national requirements such as WRES & WDES and the PSED. With the appointment of the new Workforce Equalities Lead and forthcoming retirement of Dr Adrian Bull & Monica Green it is timely to review the role of our three main staff networks - BAME, Disability & LGBT. Our LGBT Network has operated as a virtual network and there is an appetite to reignite the network into becoming more operational and visible at ESHT.

It is worth noting that the Trust has a number of micro staff networks that operate informally these include: Filipino and Indian nurses and two Neuro Divergent Networks. Early discussions are in place to establish a Consultants Women's network that will look at closing the Gender Pay Gap through Clinical Excellence Awards. The Workforce Equality Lead is in discussions of how these networks can link into current networks or become independent support groups.

The proposal for the future includes: celebrating difference, inspiring staff, help transform the organisation with the inclusion agenda and a strong governance structure to support the voices of staff with lived experience at all levels of the Trust.

The main proposals are:

- Staff Networks become a self-governing group with elected Chairs and Vice Chairs.
- Continue to have a Board Sponsor that will chair two meetings a year.
- Support from the Workforce Equalities team for one day a month per network.

.

The next steps to include:

- Engagement events with all current staff networks at ESHT with the proposed structure.
- The Executive Team to identify a sponsor for each of the three staff networks (BAME, Disability and LGBTQI+).
- The Board to endorse the new structure of staff networks.

3. WRES & WDES 'Task and Finish' groups

The purpose of these groups will be to develop SMART objectives against the action plans from the findings in the current year's report. The group's membership will be determined by the actions deriving from the plans but should include those that can actively drive the actions. Meetings will take place monthly.

Quarterly Business Performance reports will be reviewed at these meetings to measure progress against actions and terms of reference for the group are to be developed.

4. Workforce Equality Group

The Group will reform and act as a Strategic group in addition to its current role of providing support to delivery of actions and gaining assurance on all the national reporting and inclusion initiatives. Tabled agenda items will include the Gender Pay Gap, WDES & WRES, Staff Networks Update, and the Equality Leads up-dates.

This Group will continue to be chaired by the Deputy Director of HR and membership will be reviewed. Meetings will take place bi-monthly and Terms of Reference will also be reviewed to align with the changes being proposed in this paper.

5. WDES 2020 Report

This is the second report since the standard became mandatory for all NHS organisations in 2019. Findings from this year's report include:

- 4% of staff have disclosed a disability.
- Disabled staff are underrepresented across all bandings both clinical and non-clinical against the population mean.
- Disabled staff are 1.25 times less likely to be employed from shortlisting to appointment in 2020 compared to 1.34 times in 2019.
- There are no disabled staff recorded in a formal capability process in 2020 which is an improvement from 2019 where disabled staff were 7.40 times more likely to enter the process. Significant work has been undertaken by the Employee Relations team to ensure early interventions resulted in a Just Culture approach to formal cases.
- There are no voting Board members with a disclosed disability.

N.B: The data should be interpreted with care as 34% of staff have not disclosed or preferred not to disclose their disability status.

Staff survey results reveal a difference in around 690 staff with a disability that answered questions as opposed to 269 members of staff that have disclosed a disability on ESR. The most significant improvement seen is that staff have felt that adequate adjustments have been made for disabled staff to carry out their roles in 2019 survey results.

Whilst improvements have been made in the Staff survey results there is significant work to be done to create an inclusive culture for disabled staff in the workplace.

A 'Task and Finish group' will be set up to establish and ensure that SMART objectives from the action plans will drive areas of improvement into positive outcomes for this staff group.

6. WRES 2020 Report

The Trust will be able to report that it has made improvements across all the nine indicators. Highlights from this year's report include:

- The improvement of disclosure data on ethnicity from 8.5% - 6.3% non-declaration rates.
- The likelihood of BAME staff being appointed from shortlisting improved from 1.26 in 2019 to 1.01in 2020.
- The likelihood of BAME staff entering a formal disciplinary improved from 0.98 in 201 to – 0.94.
- The likelihood of staff accessing non-mandatory training 1.43 in 2019 to 1.17in 2020.
- Voting Board representation increased from 0% in 2019 to 10% in 2020.

Our staff survey results are heading in the right direction however there is more work to improve on civility, culture, engagement with BAME staff and progression within the organisation.

As with WDES a separate 'Task and Finish group' will be established to ensure that SMART objectives from the action plan that will drive areas of improvement into positive outcomes for BAME staff working at ESHT.

7. Staff Engagement Survey COVID 19 Support for BAME colleagues update

A report with recommendations has been produced from the staff engagement survey for BAME colleagues which was presented at an Executive meeting in June 2020. The main areas that participants outlined to be improved were divided in 4: areas Actions for Managers, better education of the problem and training for managers on how to support BAME colleagues, better engagement with BAME staff, a review of risks assessment and its follow up actions; and further COVID related Support.

There have been two informal engagement events in August 2020 chaired by CEO Dr Adrian Bull with the Chairman Steve Phoenix in attendance to listen to the experiences and concerns of BAME staff during this period. The sessions were well attended and concerns and suggestions will be taken into consideration in developing future plans. These will include more clinical information for BAME staff relating to COVID-19 and ensuring that future engagement events will be provided at different times so that more clinical staff can attend.

Our OD department has delivered a "Courageous Conversations" session in August 2020 for managers having compassionate conversations in completing COVID -19 Risk Assessments. The event was well attended with over 30 managers across the Trust. Areas of topic included the national picture, health and wellbeing support and occupational health support

The Trust is expecting around 25 overseas nurses from India that will have to self-isolate for two weeks in Eastbourne. The recruitment team has set up a number of meetings to ensure the needs of the nurses will be met during this period. In addition to looking after the social needs during self-isolation, the working group will be providing written resources and 3 Teams learning sessions to managers on cultural difference before the nurses are placed on wards.

8. Conclusion

Whilst the WRES has made many improvements over 2019/2020 there is more work to be done with the three main themes of Recruitment, Retention and Leadership. Health & Wellbeing will be a priority for BAME staff during COVID 19- and beyond. Through Risk Assessments and engagement events we will put listening into action to address concerns wherever possible for all BAME staff so they feel safe and supported to carry out their roles

The WDES findings will need a targeted focus for 2020/21 to create a culture of psychological safety and an inclusive culture to disclose any disabilities. Due to the high undisclosed disability status of staff, the data does not draw to credible conclusions of the workplace experience for disabled staff. The focus going forward will need a detailed Smart Objectives plan that will sit in the WDES task and finish group to ensure progress is made for this staffing group. Main themes will be to introduce a Health Passport for all staff and work towards the Trust gaining a Disability Confident employer status.

It is envisaged that the new governance model will provide assurance to the Board that engagement with staff and performance indicators in PSED move towards civility, inclusivity and equal treatment for all staff working at ESHT.

9. Next steps

1. To implement the new governance structure and agree frequency on Workforce Equality reporting to POD committee and Board of Directors.
2. Review membership and terms of reference for the Workforce Equality Group.
3. To set up Task and Finish groups and create a terms of reference for both WDES & WRES.
4. Ensure Actions from both the WDES and WRES findings for 2020 are put into Smart objectives.
5. In partnership with colleagues leading on patient inclusion, to develop a platform where workforce inclusion links to patient inclusion.
6. Continue to ensure that the PSED related to workforce are being met.

Appendices List:
Appendix 1 –WRES Report
Appendix 2 - WRES Action Plan
Appendix 3- WRES Infographic
Appendix 4 - WDES Report
Appendix 5 - WDES Action Plan

East Sussex Healthcare NHS
NHS Trust

The Workforce Race Equality Standard (WRES)

2020

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The Workforce Race Equality Standard

1. Introduction

In 2014 the NHS Equality and Diversity Council had agreed action to ensure from employees Black and Minority Ethnic (BAME) backgrounds have equal staff receive equal opportunity to career opportunities and fair treatment in the workplace. In 2015 the Workforce Race Equality Standard (WRES) was mandated for all Trusts and forms part of the Care Quality Commission inspection framework under the Well Led domain.

WRES also offers NHS organisations tools through nine progress indicators to understand their race equality performance, including the BAME representation at senior management and board level. It helps ESHT to focus on where we are right now, where we need to be and how to get there.

East Sussex Healthcare NHS Trust (ESHT) welcomed the new standard which has provided the opportunity to demonstrate our commitment to advancing equality of opportunity for the diverse workforce it employs. The Trust continues to explore and take action to improve the experience and working lives of their BAME staff and ensuring they have fair opportunities to progression.

The 2020 report shows progress in many areas where improvements are made and the highlights for 2019/2020. The report also highlights our aspirational goals in leadership and ensuring we link the WRES Indicators to the NHS Peoples Plan 2020/21 where it states that: "for the future, the NHS needs more people, working differently, in a compassionate and inclusive culture".

2. Data Collection and Monitoring

The first WRES report (2015) highlighted the importance of having processes for collecting robust data. Through the use of the WRES metrics the Trust has identified ways to improve the way data is collected and reported.

The 2011 Census continues to remain the most up to date information we have available to identify Ethnicity in the local areas. As highlighted in previous reports, using East Sussex in Figures, East Sussex, is less ethnically diverse than the South East region or nationally" (ESiF 2012). The local BAME populations are around 10.5% which is lower than the South East (14%) and England (17%). Eastbourne and Hastings have the highest percentage of BAME groups at 13%. BAME groups include:

ESHT calculations are formulated according to the WRES technical guidance where White Irish and White Other are not included in the BAME calculations.

3. Workforce Race Equality Standard Metrics 2019/20

The data relates to all staff captured on the Electronic Staff Records as of 31 March 2020 that were on permanent, fixed term and seconded contracts.

Workforce metrics For each of these four workforce indicators, the Standard compares the metrics for White and BAME staff.	
1.	**Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce as of 31 March 2020** **Note: Calculations Organisations should undertake this calculation separately for non-clinical and for clinical staff**

	Clinical			Non-Clinical		
Pay Band	White B/I/O (%)	BAME (%)	Unidentified (%)	White B/I/O (%)	BAME (%)	Unidentified (%)
Band 1	100.00%	0.00%	0.00%	83.33%	16.67%	0.00%
Band 2	73.30%	21.80%	4.89%	85.87%	7.34%	6.77%
Band 3	79.56%	14.82%	5.61%	90.75%	7.48%	4.76%
Band 4	91.93%	2.68%	5.37%	92.53%	2.68%	4.77%
Band 5	64.86%	27.78%	7.34%	89.52%	6.28%	4.18%
Band 6	81.73%	11.87%	6.39%	90.42%	4.25%	5.31%
Band 7	88.90%	8.55%	2.53%	89.28%	3.57%	7.14%
Band 8a	83.17%	12.14%	4.67%	85.36%	7.31%	7.31%
Band 8b	94.59%	5.40%	0.00%	92.00%	4.00%	4.00%
Band 8c	93.75%	6.25%	0.00%	77.27%	13.63%	9.09%
Band 8d	0.00%	0.00%	N/A	87.50%	12.50%	0.00%
Band 9	100.00%	0.00%	0.00%	60.00%	20.00%	20.00%
Consultant	63.34%	30.67%	5.97%			
Med. Trainee	39.40%	45.36%	15.23%			
NCCG	30.70%	52.63%	16.66%			
Very Senior Manager/Exec	100.00%	0.00%	0.00%	100.00%	0.00%	0.00%
Grand Total	**74%**	**20%**	**6%**	**88%**	**6%**	**6%**

What the data tells us:

Clinical

- 20.0% of all clinical staff identified as BAME
- 74.0% of all clinical staff identified as White British, White Irish or White Other
- There is a Band 5 celling for BAME Clinical staff
- Medical Dental professions are overrepresented over the workforce mean of 13.5%

Non-clinical

- 6.0% of all non-clinical staff identified as BAME
- 88.0% of all non-clinical staff identified as White British, White Irish or White Other
- There is strong representation of BAME leadership at Band 8c – Band 9 leadership roles

There were no BAME representation at VSM roles or at Executive level as of 31 March 2020

Percentage of BAME and White staff in each clinical and non-clinical pay band
Key: White B/I/O = White British/Irish/White Other. **BAME:** Black & Minority Ethnic

2.	**Relative likelihood of BAME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.**
	2019/20 The relative likelihood of white staff being appointed from shortlisting compared to BAME staff was 1.01 times greater.

		White	BAME	Unknown
	No. Shortlisted Applicants	9297	2629	189
	Appointed from Shortlisting	1004	280	103
	relative likelihood appointment from shortlisting	10.80%	10.65%	54.50%

2018/19
The relative likelihood of white staff being appointed from shortlisting compared to BAME staff was 1.26 times greater

The Trust has made an improvement of 0.15 which demonstrates that that there is no barrier in BAME candidates being appointed from shortlisting.

3.	**Relative likelihood of BAME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*** ***Note: this indicator will be based on data from a two year rolling average of the current year and the previous year**

2018/19 – 2019/20
Staff identified as BAME were **0.94** times more likely to enter the formal disciplinary process compared to staff identified as White British, White Irish or White other.

Note
2017/18 – 2018/19 reported BAME staff were 1.81 times more likely to enter the formal disciplinary process compared to staff identified as White British, White Irish or White other, however there was an error in the way the data was recorded and the actual figure was **0.98** times more likely.

Our data tells that we have met our targets with the NHS Peoples Plan, ' A fair experience for all Closing the ethnicity gap in rates of disciplinary action across the NHS workforce' where BAME staff are not over represented in the formal disciplinary process.

4.	**Relative likelihood of BAME staff accessing non-mandatory training and CPD as compared to White staff**

2019/2020
Available figures demonstrate White staff were **1.17** times more likely to access non-mandatory training compared to BAME staff.

2018/2019
Available figures show that White staff were 1.43 times more likely to access non-mandatory training compared to BAME staff.

National NHS Staff Survey findings
For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for white and BAME staff

5.	**KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**
	2019/20 results

	❖ 26.5% of White respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. National Average was 25.4%. ❖ 29.9% of BAME respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. National Average was 28.7%. **2018/19 results** ❖ 26.3% of White respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. National Average was 25.9%. ❖ 32.3% of BAME respondents reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. National Average was 25.9%
6.	**KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**
	2019 results ❖ 25.0% of White respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. National Average was 23.5%. ❖ 29.7% of BAME respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. National Average was 27.9%. **2018results** ❖ 25% of White respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. National Average was 23.5%. ❖ 29.3% of BAME respondents reported experiencing harassment, bullying or abuse from staff in last 12 months. National Average was 28.9%.
7.	**KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion**
	2019 results ❖ 86.3% of White respondents believed they were provided with equal opportunities for career progression or promotion. National Average was 87.4%. ❖ 77.9% of BAME respondents believed they were provided with equal opportunities for career progression or promotion. National Average was 72.9%. **2018 results** ❖ 86.2% of White respondents believed they were provided with equal opportunities for career progression or promotion. National Average was 87.2%. ❖ 74.5% of BAME respondents believed they were provided with equal opportunities for career progression or promotion. National Average was 74.2%.
8.	**Q 17b. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues**
	2019 results ❖ 5.8% of White staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. National Average was 5.5%. ❖ 12.8% of BAME staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. National Average was 14.8%. **2018 results** ❖ 6% of White staff reported they had experienced discrimination at work from their manager or team leader on the grounds of Ethnic background. National Average was 5.6%. ❖ 17.1% of BAME staff reported they had experienced discrimination at work from their manager or

	team leader on the grounds of Ethnic background. National Average was 15.4%.
Boards Does the Board meet the requirement on Board membership in 9?	
9.	**Percentage difference between the organisations' Board voting membership and its overall workforce**
	Total Board members has increased from 0% in 2019 to 7.1% in 2020 Voting Board members have also seen a significant increase from 0% in 2019 to 10% in 2020 In 2020 the Percentage difference between the organisations' Board voting membership and its overall workforce was -13.8%

5. Conclusion

The Equality agenda at ESHT continues to grow and make progress. In order to continue making progress at pace, a new post for a Workforce Equality Lead was created. The newly appointed Equality Workforce Lead will focus on: improving the engagement with the BAME staff community, which has proven challenging during the COVID-19 outbreak, a review of the role for the network groups, developing a task and finish group with SMART objectives to deliver on the WRES indicators action plans during 2020/21 and beyond, review the workforce governance and reporting structures, improve our ethnicity data, and develop a plan to provide a listening space and improve engagement with our medical workforce who have the highest proportion of BAME staff.

In early 2020 a global pandemic emerged and it quickly became evident there was an overrepresentation of BAME individuals and communities affected by the pandemic. With the introduction of the NHS Peoples Plan we aim to ensure that the health and wellbeing of BAME staff will be a priority during the forthcoming year.

5.1 Aspirational Leadership Goals

The table below demonstrates our targets with our aspirations goals in leadership positions for 2020/21 and beyond.

The table above shows the 10-year trajectory to reach equality by 2028 for AfC bands 8a to VSM.

	2018	2019	2020	2021	2022	2023	2024	2028	2026	2027	2028
Band 8A	19	19	20	20	21	21	21	22	22	22	23
8a Actual	19	17	19								
Band 8B	0	1	1	2	3	3	4	5	5	6	7
8b Actual	0	2	3								
Band 8C	1	1	2	2	2	2	3	3	3	3	4
8C Actual	1	3	4								
Band 8D	1	1	1	1	1	1	1	1	1	2	2
8D Actual	1	2	1								
Band 9	0	0	0	0	0	0	0	0	0	0	0
9 Actual	0	0	1								
VSM	0	0	0	0	0	0	0	0	1	1	1
VSM Actual	0	0	0								

The numbers show the required staff in post for each year. Progress against the data in the above table will be looked at by the WRES team and national regulators, and therefore should also be focussed upon on an annual basis.

5.2 National NHS Staff Survey findings

The Key Findings (KF) 25, 26, 21 and Q17 are questions specific for helping identify race inequality in the NHS workforce.

KF 25 – The percentage gap between White and BAME respondents experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. There was no change from 2018 to 2019 for White staff whilst BAME staff report a decrease from 32.3% to 29.9% reducing the gap from 6% to 3.4%.

KF 26 – The percentage gap between White and BAME respondents in 2018 in experiencing harassment, bullying or abuse from staff in last 12 months was 4%. There was no reported change in white staff experience and a 4% reduction in BAME staff suggesting there is not difference in reported experience between white staff and BAME staff.

KF 21 – In 2018/19 the percentage gap between BAME and white staff reporting they believe they were provided with equal opportunities for career progression or promotion was 11.7%. 2019/20 staff survey highlights a 3.4% increase in BAME staff reporting equal opportunities for career progression or promotion with was no change for white staff. The percentage gap between BAME staff and white staff has reduced from 11.7% to 8.4%.

Q 17b – 12.8% of BAME respondents reported experiencing discrimination at work from their manager or team leader on the grounds of Ethnic background. This is a 4.3% decrease from 2018 survey. The National Average was 14.8% which demonstrates a shift in culture in the organisation .

The findings of the survey will be considered during the development of the new action plan to continue ensuring BAME staff have equal access to career progression and promotion and safety in the workplace

5.3 Health and Wellbeing

Clinics were established for all staff that are in the vulnerable category including staff from (BAME) backgrounds. The clinics provided a safe space for staff to discuss their physical and emotional wellbeing. The assessments included BMI with waist, height, Blood pressure checks and discussion focused on Vitamin D, diet, exercise and alcohol intake. Staff were also given space to discuss emotional and psychological impact of COVID-19 and were signposted to additional counselling services as appropriate. The wellbeing team are also provided with expert advice from specialist medical personnel as and when required. Staff can also be referred to One You East Sussex free and accessible service. They are able to offer ongoing support with healthy lifestyle needs. Additional support is focused on stop smoking, weight loss, eating healthier, drinking less and move more. Evaluation will be carried out with everyone attending the clinics 4 weeks after attending in order to ascertain on-going actions taken by staff to enhance their wellbeing.

Staff Engagement -Scoping Psychological and Health & Wellbeing Support for BAME staff

Staff Engagement & OD together with the Equalities team invited staff from the BAME network to take part of an engagement exercise to scope psychological and health and wellbeing support and a sample representative received invites to participate.

BAME Listening events: WRES data has been used to create a series of conversations designed to promote a safe and inclusive platform for staff to express and explore views, and for the organisation to gain a deeper understanding of the lived experiences of BAME staff in the Trust. Staff feedback from these events will be used to positively influence and shape organisational actions to improve the experiences of our current and future BAME staff as measured by the annual NHS Staff Survey and Workplace Race Equality Standard action plan

The data from the Listening conversations has enabled the organisation to:

- Identify the gaps in treatment and experiences between White and BAME staff
- Make comparisons with similar organisations on progress over time
- Take remedial action on causes of ethnic disparities in indicator outcomes

5.4 Staff Networks
The East Sussex Healthcare NHS Trust (ESHT) BAME Staff Network continues to strengthen and grow in members. The network continues to be chaired by Dr Adrian Bull (CEO) and attended by the Equality Lead, union representatives, Human Resource Managers, Leadership Managers, Staff Health & Wellbeing and Engagement Leads. The Network aims to provide a safe place for BAME staff to raise concerns, support one another and identify best practice. The Network also aims to identify training and development opportunities for staff as well support career development and promote inclusive practices. A fresh look at how the network will operate will take place in autumn of 2020

5.4 Improving Data Collection
On 23rd March 2020 the United Kingdom went into lockdown due to COVID-19 pandemic. Shortly after lockdown, evidence began to emerge that Black and Asian people were disproportionately impacted by COVID-19. As a result, BAME staff and staff with unknown ethnicity were asked to complete additional risk assessments and to ensure their ethnicity
A snapshot of unknown ethnicity was taken on 28/7/2020 and has reduced from 6.3% to 5.4%, an improvement of 0.9%

Towards the end of 2019, staff payslips became available online. During this change staff were encouraged and supported to update their equality information on ‘MyESR’ which may have contributed to the slight decrease is in ethnicity unknown/undeclared.

Other initiatives to increase declaration rates included the BAME Network writing to staff with no recorded ethnicity to encourage them to update their information.

We continue to look at innovative ways to capture our staffs ethnicity other than electronically.

5.5 Training
The Trust has 8 members of aspiring leaders in training on the Stepping Up programme aimed at band 5 – 7. ESHT had the highest accepted candidates across the Sussex ICS region

Five members of staff have been successful at gaining a place at the Henley Business Centre to complete a Master’s in Business Administration Leadership Programme. The MBA will commence in Autumn 2020.

Career progression workshops have been developed in-house by our Organisational Development team; we have 30 staff enrolled on the programme that will commence in the Autumn.

Data collection methods of staff attending non-mandatory training has continued to prove challenging. However the way in which the data has been reported has remained consistent. Managers continue to be reminded of the importance of ensuring accurate and detailed recording of staff attending non-mandatory training; however caution must still be used when forming judgements on the outcomes. The Trust will continue to include reminders for managers using Trust communication methods and will continue to explore further options to improve this data.

6 Recommendations

Whilst ESHT is made improvements across the indicators, it is recommended that the focus in going forward must be around:

- Improving the collection of ethnicity data.
- Review the role and function of the BAME staff network group.
- Set up a Task and Finish group to deliver on our workforc race equality action plan.
- Improving the engagement with the BAME staff community especially medics which has proven challenging during the COVID-19 outbreak.
- Covid -19 Risk Assessments for all BAME staff.
- Ensure managers have the necessary skills to identify and tackle discrimination and foster good relations amongst their teams.
- Incidents reported on Datix involving racial discrimination, harassment or victimisation increases.
- Progression and Leadership training and opportunities

This Report is available in alternative formats upon request. Alternative formats include (but not limited to) Large Print, Braille, Audio, Alternative Community Languages. Please contact the Equality, Diversity & Human Rights Team by emailing esh-tr.accessibleinformation@nhs.net or Telephone 01424 755255.

East Sussex Healthcare NHS
NHS Trust

Workforce Disability Equality Standard Action Plan 2020/21

WDES Indicator 1: **Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce**				
Index	Action	Lead	Timescale	Update
1.1	Improve the data from 34 % to 10 % for Disabled staff	Cassandra Blowers	January 2010	
1.2	Improve understanding of the benefits to declaring a disability on employment records. Comms campaign and leaflet	Cassandra Blowers	January 2020	
1.3	Produce the National Benchmarking tool against WDES	Lorraine Mason	Quarterly	
1.3	Produce quarterly report on BI ESR to monitor movement in AFC bandings	David Moulder	Quarterly	
WDES Indicator 2: **Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts**				
Index	Action	Lead	Timescale	Update
2.1	Apply for Disability Confident employer status	Grieg Woodfield	October 2020	
2.2	Full review of the recruitment process from advertising to appointment to identify gaps for Disabled staff	Grieg Woodfield	October 2020	
2.2	Undertake an audit of the disclosure of disability on application forms and guaranteed Interview	Grieg Woodfield	Jan 2020	
2.3	Interview score sheets to be reviewed for better feedback	Grieg Woodfield	Sept 2020	
	Quarterly reports to be produced from Trac to monitor progress	Grieg Woodfield	Quarterly	
WDES Indicator 3: **Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure**				
Index	Action	Lead	Timescale	Update
3.1	Improved processes around adequate/reasonable adjustments	Jo Gahan	On going	
3.2	Training for managers on implementing 3.1	Jo Gahan	On going	
WDES Indicator 4: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: Patients/service users, their relatives or other members of the public, managers or other staff				
Index	Action	Lead	Timescale	Update

4.1	Use the work that is being done on Violence and Aggression to clarify the Trusts approach to dealing with this (separate action plan)	Lorraine Mason/Liz Lipsham	Ongoing	
4.2	Increased reporting on Datix incidents through a comms campaign	Comms Department Workforce Equality Lead	Dec 2020	
4.3	Identify areas from 2019/20 staff survey where we know we have real issues/triangulate with Speak Up Guardian/HR	Speak up Guardian and OD Engagement Group	Nov 2020	
4.3				
WDES Indicator 5: Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.				
5.1	Ensure robust processes are in place to record promotions of Disabled staff attending development programmes/ courses identified via CPD or other career linked training	Dawn Urquhar/ David Moulder	Dec 2020	
WDES Indicator 6: Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties				
Index	Action	Lead	Timescale	Update
6.1	Introduce a Health passport for all staff at ESHT	Liz Lipsham/Janette Williams	Nov 20	
WDES Indicator 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.				
Index	Action	Lead	Timescale	Update
7.1	Re-establish the Disability Staff network so that they become a self-running group with a strong governance structure	Workforce Equality Lead	Nov 2020	
WDES Indicator 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work				
Index	Action	Lead	Timescale	Update
8.1	Create an assets list of all equipment available for reasonable adjustments	Estates and Facilities Workforce Equality Lead Occupational	Nov 2020	

		Health department		
9: Trust Engagement score with its disabled staff				
Index	Action	Lead	Timescale	Update
9.1	Ensure that there is at least monthly meetings for Disabled staff Compassionate Check ins	Workforce Equality Lead and Disability Network Chair	Monthly	
WDES Indicator 10 Board representation.				
Index	Action	Lead	Timescale	Update
10.1	100% declaration rates	Chair & CEO	January 2021	
10.2	Making future vacant Trust Board posts appealing and accessible to applicants. Consider targeting Disabled staff	Monica Green	As and when vacancies Arise	

Mortality Report – Learning from Deaths 1st April 2017 to 31st March 2020

Meeting information:			
Date of Meeting:	6th October 2020	Agenda Item:	13
Meeting:	Trust Board	Reporting Officer:	David Walker

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSI/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register? No	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The attached report on "Learning from Deaths" follows the requirements set out in the Care Quality Commission review. The mortality database is designed to reflect this process and has also been updated to incorporate the new Medical Examiner review process which commenced at the Trust on September 1st.

The Medical Examiners will ensure compliance with the legal and procedural requirements associated with current and proposed reformed processes of certification, investigation by coroners and registration of deaths.

The current "Learning from Deaths" report details the April 2017 – March 2020 deaths recorded and reviewed on the mortality database. The Mortality Review Audit Group continues to review the deaths with a higher likelihood of avoidability on a quarterly basis, to ensure accuracy in reporting.

Learning disability deaths are being reviewed externally against the LeDeR (learning disability mortality review) programme, however, feedback to individual Trusts from these external reviews is extremely slow. Internal reviews therefore continue, in order to mitigate any risk.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

N/A

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board are requested to note the report. "Learning from Deaths" reports are required on a quarterly basis.

EAST SUSSEX HEALTHCARE TRUST: Learning from Deaths Dashboard March 2019-20

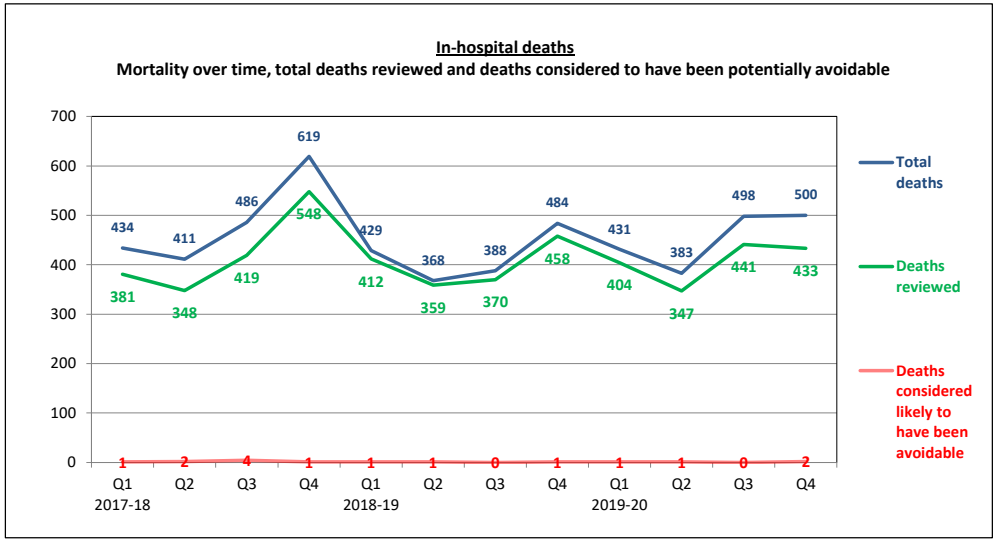
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 14/09/2020)

Total number of in-hospital deaths, deaths reviewed and deaths deemed avoidable (does not include patients with identified learning disabilities)

Time Series:	Start date	2017-18	Q1	End date	2019-20	Q4

Total number of deaths in scope		Total deaths reviewed		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
157	150	135	130	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
500	498	433	441	2	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1812	1669	1625	1599	4	3



Total deaths reviewed by RCP methodology score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	66.7%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	33.3%	This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%	This Year (YTD)	1	12.5%	This Year (YTD)	3	37.5%	This Year (YTD)	2	25.0%	This Year (YTD)	2	25.0%	This Year (YTD)	0	0.0%

Data above is as at 14/09/2020 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were 5 care concerns expressed to the Trust Bereavement team relating to Quarter 4 2019/20 deaths, none of which were subsequently raised as a complaint.
Complaints - Of the complaints closed during Quarter 4 2019/20 which were relating to 'bereavement', none have overall care ratings of 'poor care' on the mortality database.
Serious incidents - There was one severity 5 incident reported in Quarter 4 2019/20. This case was discussed at the Mortality Review Audit Group where an avoidability rating of 3 - probably avoidable (more than 50:50) was agreed.
As at 14/09/2020 there are 509 April 2017 - March 2020 deaths still outstanding for review on the Mortality database.

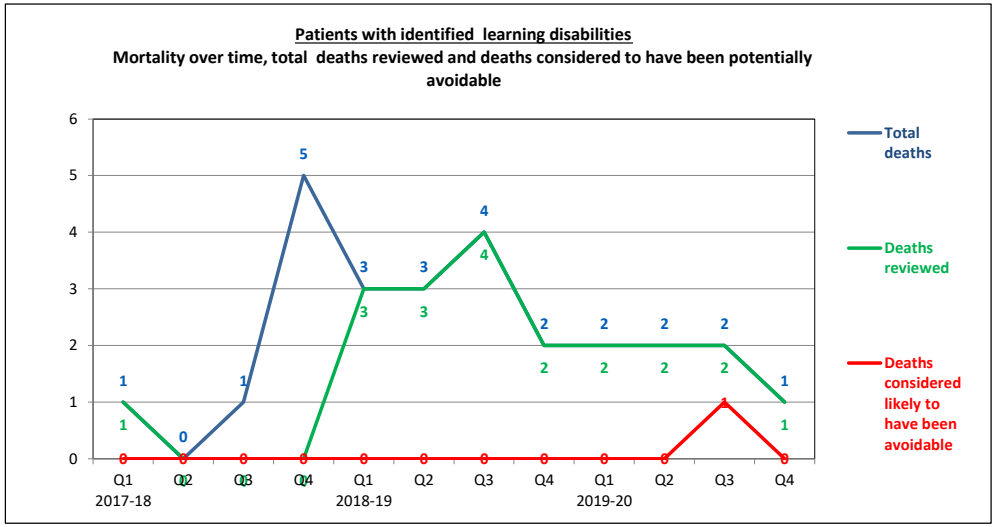
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 14/09/2020)

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

Time Series:	Start date	2017-18	Q1

End date	2019-20	Q4

Total number of deaths in scope		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	2	1	2	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
7	12	7	12	1	0



The LeDeR (learning disability mortality review) programme is now in place and the learning disability deaths are being reviewed against the new criteria externally. Feedback from these external reviews will be received by the Trust in due course. Prior to the national requirement to review learning disability deaths using the national LeDeR methodology, the deaths were reviewed by the learning disability nurse and Head of nursing for safeguarding who entered their review findings on the mortality database.
As feedback from the wider external LeDeR has not yet been received, the internal reviews are being continued in order to mitigate against any risk.

Overarching Health and Safety Annual Report 2019/2020

Meeting information:			
Date of Meeting:	6th October 2020	Agenda Item:	13
Meeting:	Trust Board	Reporting Officer:	Vikki Carruth

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

This overarching report brings together the information on issues and activity related to health and safety and the services provided during 2019/2020 from the Trust's departments, divisions and the specialties (Health and Safety, Medical Devices and Moving and Handling).
An overview of the key achievements and risks are outlined in the Executive Summary with the strategic position in the Executive Statement below, and on pages 3 and 4 of the report. It should be noted that Covid-19 is mentioned minimally as the impact and effects began at the end of the financial year.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Health and Safety Steering Group – 17th August 2020
Quality and Safety Committee – 17th September 2020

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

To review the report and seek assurance around health and safety monitoring, compliance and the actions the organisation is taking.

Executive Summary

The aim of the programme of work that was delivered by the specialties (Health and Safety, Medical Devices, and Moving & Handling) within Health and Safety was to ensure that the Trust was compliant with Health and Safety legislation. These three core functions contribute to the overall management of health and safety within the organisation.

The key achievements for 2019/2020 were:

- The Trust was inspected in July 2019 by the Health and Safety Executive and although the Trust was served with an Improvement Notice and a fine was levied specifically on the management of violence and aggression, the organisation established the Violence and Aggression Group led by the Director of Nursing as the Executive Lead for Health and Safety and was able to demonstrate through its Improvement Plan a significant response and progress on the actions required, resulting in the Notice being lifted in October 2019.
- During the HSE inspection the inspectors provided positive feedback on the Moving and Handling Team and the overall management of manual handling in the Trust, stating that the Team had a very good approach, they were engaged, and involved staff with the procurement of equipment process.
- Review and revision of incident categorisation and sub-categorisation has taken place across all three Specialties. This has produced more accurate and reliable data. A similar review has occurred for the security, violence and aggression categories and will be implemented from 1st April 2020.
- The Health and Safety incidents graded as a severity 3 or above have decreased significantly as total percentage for the year to 3.58% from a previous high of 5.82%. The decrease may be due an increase in reporting following the HSE inspection particularly those of a lower severity. However the latter part of quarter 4 saw significant reduced number of severity 1 and 2 incidents reported which may have been due to the evolving pandemic.
- Reporting of Medical Devices incidents was quite consistent between June and February but there was a significant decrease in March which again may be attributed to the change in practices arising from Covid-19. There was one moderate incident reported in year which concerned the use of equipment in theatres resulting in a member of sustaining injury whilst preventing a patient from falling.
- The number of Moving and Handling incidents reported has decreased compared to previous years. There was an increase in severity 3 incidents in quarters 2 and 4 with no identifying themes. The Team continue to encourage reporting including near miss/no harm incidents.
- Each Specialty worked diligently to provide essential training throughout the year overcoming difficulties such as vacancies, sickness and the impact of the Covid-19. However they were able to demonstrate significant compliance with key performance indicators for training. In addition, the Health and Safety Department facilitated and supported Institution of Occupational Safety and Health (IOSH) training for Senior Executives in February and March; the Medical Devices facilitated training for clinical staff from the external providers of new equipment which has been rolled out across the Trust; and the Moving and Handling team were able to deliver training at the Disability Learning Foundation conference and also supported training on equipment and handling of patients with a high BMI.

The Key Risks Identified for 2020/21:

- It had been agreed by the Health & Safety Steering that the HSSG Work Plan would be closed with areas of concern or risks devolved to divisions/directorates with their reports to the HSSG reflecting the management of the key risks, and trend analysis with the promotion of more accurate information for the areas.

  Risks to be included in the divisional/directorate reports include:
  - Work related musculo-skeletal disorders
  - Security, violence and aggression
  - Needlestick and clinical sharps.
- The HSSG would continue to administrate the action log for areas of risk impacting across the Trust and monitor concerns such as the purchasing and management of COSHH substances, the initiatives being taken forward for work related stress, the management of heatwave preparedness and Covid-19.

- The management of violence and aggression was identified as a key risk following the HSE inspection in quarter 2, and it was agreed that the Violence and Aggression Group would provide reports to the HSSG at every meeting on the elements within the Improvement Plan

Executive Statement
This annual report is presented to demonstrate the progress made over the year 2019/2020. It is well recognised that health and safety is central in the delivery of safer services for staff, patients, carers and visitors.

The Trust Health and Safety Steering Group (HSSG) have been established to plan, organise and monitor organisational compliance with its statutory health and safety obligations and duties. The role of the HSSG is to ensure compliance with external body requirements such as the Health and Safety Executive, NHSE/I, Care Quality Commission etc. This annual report reflects that work over the period of 2019/2020.

The nature of our activities means that a wide range of risks exist, but through the implementation of related policies, directors, managers and staff continue to ensure that all significant risks to health, safety and wellbeing are reduced so as far as is reasonable and practicable.

This report demonstrates the progress made, acknowledges areas of development and this report is intended to assure the Board that suitable and sufficient health and safety arrangements are in place and that health and safety is being effectively managed across the organisation.

Vikki Carruth,
Chief Nurse (Director Infection Prevention and Control) – Trust Executive Lead for Health and Safety.

East Sussex Healthcare NHS Trust

Overarching Health and Safety Annual Report

2019 - 2020

Overarching Health and Safety Annual Report 2019 - 2020

Executive Summary

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- Needlestick and clinical sharps.

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This report demonstrates the progress made, acknowledges areas of development and this report is intended to assure the Board that suitable and sufficient health and safety arrangements are in place and that health and safety is being effectively managed across the organisation.

Vikki Carruth,

Chief Nurse (Director Infection Prevention and Control) – Trust Executive Lead for Health and Safety.

Overarching Health and Safety Annual Report

1. Introduction – Background and Context

The purpose of this report is to provide an overview of activity and outcomes relating to the positive management of health and safety within East Sussex Healthcare NHS Trust. The reporting period is 1st April 2019 – 31st March 2020.

This report addresses the management of Health and Safety within the Trust incorporating the Health and Safety Department, Medical Devices Educators and the Moving and Handling Team in three distinct sections. Annual reports for the management of Fire Safety and Security are presented as separate items to the Board.

The management of health and safety in the organisation is underpinned by the overarching Trust Health and Safety at Work Policy, May 2018.

As at 31st March 2019 the permanent staff headcount was 7133 staff. The head count of permanent staff as at 31st March 2020 was 7482. The average head count for 2019/20 was 7279 (this is taken across the 12 months). (Source: ESHT Workforce Planning)

Trust Health and Safety Steering Group

The Trust Health and Safety Steering Group (HSSG), is chaired by the Chief Nurse and Governance who is the named Executive Lead for Health and Safety. The Group receives reports from Trust wide services including Fire Safety, Radiology, Medical Gas, Security, Waste and Asbestos as identified in the HSSG terms of reference. Staff Side Health and Safety have a standing item on the agenda, and health and safety related risk register entries are monitored on a cyclical basis at every meeting.
All organisations have a legal duty to put in place suitable arrangements to manage health and safety (H&S). Ideally, this should be recognised as being a part of the everyday process of conducting business and /or providing a service, and an integral part of workplace behaviours and attitudes. Notwithstanding a comprehensive legislative framework exists, within which the main duties placed on employers are defined and enforced.

The HSSG provides reports to the Quality and Safety Committee and the People and Organisational Development Group.

2. Legislation and Guidance

2.1 There are an excess of 200 pieces of Health and Safety Legislation however the key pieces relevant to the entirety of the Trust are:

- **The Health and Safety at Work etc. Act 1974 -** This statutory instrument describes the overarching principles of health and safety and duties are placed on employers, employees, people in control of work premises, suppliers and manufacturers. The principles of the Act are overarching and generalise and they are supported by other Regulations that specify an outcome - these are noted below.
- **The Management of Health and Safety at Work Regulation 1999 -** There is an explicit requirement for risk assessment particularly for hazardous activities, the employment of young people and new or expectant mothers. The regulations state ‘Principles of Prevention’ and require systematic identification and management of risks identified through the Trusts risk assessments. There is an absolute requirement for training and information and access to competent health and safety advice relevant to the size and undertaking of an organisation.

- **The Reporting of Incidents Diseases and Dangerous Occurrences Regulations 2005 (as amended) -** These Regulations state the requirements for reporting specific accidents, dangerous occurrences and work related diseases to the HSE and the group of people affected; including staff, patients and members of public.
- **Manual Handling Operations Regulations 1992 (as amended 2002) –** The regulations set out clear measures for dealing with risks from manual handling (transporting or supporting of a load including lifting, putting down, pulling, carrying or moving) by hand or bodily force. By avoiding the hazard if reasonably practical, assessment if the operation cannot be avoided and reducing the risk of injury so far as is reasonably practicable.
- **The Medicines and Healthcare products Regulatory Agency –** The MHRA regulates medicines, medical devices and blood components for transfusion in the United Kingdom. It ensures that all devices and products meet applicable standards of safety, quality and efficacy.
- **Leading health and safety at work (INDG 417) -** This guidance sets out an agenda for the effective leadership of health and safety; it is designed for use by all directors, governors, trustees, officers and their equivalents in the private, public and third sectors. It applies to organisations of all sizes. Protecting the health and safety of employees or members of the public who may be affected by an organisations activity is an essential part of risk management and must be led by the board.

2.2 **Working together with Trade Unions**

Staff-side is made up from members of East Sussex Healthcare NHS Trust staff who are members of a Trade Union or Society, recognised by the Trust. The staff side members have been elected and/or appointed into their role of Health & Safety representatives through the trust recognised organisations and they are governed by **The Safety Representatives and Safety Committees Regulations 1977.** Staff Side Health & Safety representatives are part of the consultation process into Health & Safety policies written by the management side of the Trust. They are involved in investigations, and may be consulted by the Health and Safety Executive (HSE) during Site inspections, and when necessary they also have a legal duty to consult with the HSE.

2.3 **Health and Safety Executive (HSE)**

The Health and Safety Executive are responsible for the encouragement, regulation and enforcement of workplace health, safety and welfare, and for research into occupational risks in Great Britain. They have key formal interventional powers including prosecution.

2.3.1 **Memoranda**

The Memorandum of Understanding (MOU) between the Health and Safety Executive (HSE) and the Care Quality Commission (CQC)) was updated in February 2018. The MOU clarifies the arrangements for enforcement within healthcare regulated activities and the authority who will lead on investigation. This MOU does not alter the requirement to report specific incidents affecting patients to the HSE as a RIDDOR event.

The purpose of the MOU is to help ensure that there is effective, co-ordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public visiting these premises.

2.3.2 **Health and Safety Executive Work Plan**

2019/2020 marked the third year that the HSE focus was on tackling the major causes of work-related ill-health which included musculoskeletal disorders (MSDs) and work-related stress. As part of their forward work plan they undertook a programme of inspections. The Trust underwent a formal inspection in July 2019 with the focus on musculoskeletal disorders and the management of violence and aggression.

2.3.3 Enforcements: Notices of Contravention and Corporate Fines.

The Trust was inspected on 9th and 10th July 2019 as part of the HSE work plan: to undertake a planned schedule of all NHS premises from 2018. The inspection was focussed on the management of violence and aggression and musculoskeletal disorders. The inspectors visited multiple departments in Conquest and Bexhill Hospital sites and interviewed staff and members of the Board. Key findings were favourable in terms of moving and handling training and conflict resolution training however concerns were noted around the level of incident reporting. The deficit was determined by the inspectors to be one of the factors in the inability to provide more relevant training for staff. They stated that there were good robust processes for more extreme cases of violence and aggression, but also that we need to develop our response to cases of violence and aggression that can result from a patient's illness or treatment, such as dementia or recovery from anaesthetic. The inspection reinforced the findings of the 2018 staff survey and also recognised the progress the Trust had made.

As a result of the visit, the Trust was served an improvement notice and a fine was levied. The Trust established the Violence and Aggression Group led by the Director of Nursing to take forward specific actions.

In October 2019, the Notice was lifted by the HSE and the work identified in the Improvement Plan continues to be undertaken by the Group and is monitored by the Health and Safety Steering Group.

3. Claims

There were eleven claims closed during 2019/20 specifically related to health and safety which was a decrease on the fourteen claims settled in 2018/19. Of these eleven incidents which were settled in the financial year, three dated back to 2014/15, one was from 2015, one from 2016, two from 2017, three from 2018 and one from 2019.

- 3 members of staff suffered injuries due to defective wheels on trolleys and a bed
- 2 members of staff slipped on water
- 1 member of staff tripped on uneven ground in the car park
- 1 member of staff sustained eye injuries from loose powder whilst changing a bin
- 1 member of staff tripped up a staircase
- 1 member of staff sustained burn injuries
- The spouse of a member of staff sustained injury when the pavement collapsed
- A member of the ambulance service received injury when stepping into a pothole

Liability type:

- 9 incidents of Employers Liability
- 2 incidents of Public Liability

HEALTH AND SAFETY DEPARTMENT

1. Introduction

The Health and Safety Department's annual report covers the period 1st April 2019 to 31st March 2020 and outlines principle developments as well as activity undertaken relating to the promotion and management of health and safety. The report also summarises incidents and the progress of Occupational Health and Safety Management (OHSMS) audits within East Sussex Healthcare NHS Trust.

2. Regulation of Health and Safety

The Health and Safety Executive (HSE) are the regulatory body with responsibility for enforcing health and safety legislation within the UK. The HSE also provides advice on health and safety issues, and practical guidance on the interpretation and application of the provisions of the legislative framework. Managing for Health and Safety – HSG65 is published by the HSE and gives guidance on the implementation of health and safety and indicates a cyclic approach to health and safety with an emphasis on continual improvement. The guidance indicates the 4 stage approach which is not mutually exclusive. All stages interrelate and the key components are:

- **Plan**: Defining and communicating acceptable standards of health and safety performance through policy and the allocation of resources;
- **Do**: Identification of key risks and the monitoring of control measures including maintain and inspection;
- **Check**: Measurement of health and safety performance including leading and lagging indicators, proactive and reactive methods, audits and incident investigation;
- **Ac**t: Review of performance to inform improvement, implement lessons from incident investigations and identifying areas for improvement.

3. Management of Health and Safety

During the first quarter of the reporting period whilst recruitment was being undertaken the department comprised of 2.6 WTE to deliver the service including: competent health and safety advice; administration of the health and safety and risk assessment software Assure©; specialist and core training and to support key groups on a corporate, divisional and local basis. The lead for the Health and Safety Department is the Deputy Trust Lead for Health and Safety.

Key members of the department hold qualifications in general and specific health and safety subjects and undertake peer review, reflective practice, continuing, specialist and individual professional development with relevant professional bodies. The post of Chair of the South-East based regional network, Healthcare Risk Management Group is also held.

3.1 Trust Board / Directors

Health and Safety Guidance 65 states the role of Trust Board and directors in relation to Health and Safety and is summarised in the Leadership Checklist published by the HSE.
The Board is collectively responsible for providing leadership and direction and should set the direction for Health and Safety with ownership of key issues and risks with health and safety as a standing item on Board agendas

3.2 Divisional and Directorate Level Responsibilities

Division and directorate responsibilities are identified in the Health and Safety at Work Policy. With the exception of Corporate all divisions have a governance representative who report into the Trust Health and Safety Steering Group (HSSG). The expectations of the group are stated in the HSSG terms of reference and include defined parameters of reporting incidents and risks to expedite escalation and also feedback mechanisms as appropriate. All members of the group are expected to facilitate communication: both escalation to and dissemination from HSSG through their divisional and departmental management structure.

3.3 Health and Safety Link Staff

An effective network of link staff willing to undertake and support key health and safety functions throughout all levels of the Trust has been progressing since 2014. Link staff receive regular communication from the Health and Safety department including newsletters, updated policies, ad hoc visits, targeted support 'surgeries' and information 'broadcasts'. The link staff have variable duties which are negotiated locally with the manager in charge of their area. Their duties may include undertaking workplace inspections, risk assessments and working with the ward/department manager on the implementation of recommendations following an Occupational Health and Safety Management Systems audit.

4. Health and Safety Work Plan

The decision was agreed by HSSG in May 2019 to devolve the groups 2018/19 objectives to the divisions and relevant specialities to incorporate into specific work plans relevant to the divisions operations and risk profiles. A Health and Safety Department work plan was subsequently developed structured around and informed by Occupational Health and Safety Management audit, incident trends, national priorities and forthcoming initiatives set by the key regulator of Health and Safety: the Health and Safety Executive.

5. Incidents reported

The information for this report was extracted from the incident reporting system: DatixWeb on 14th April 2020. Incidents involving Moving and Handling and Medical Devices will be discussed in the applicable sections of this overarching Trust Health and Safety Annual Report.

5.1 Incident Classification and Categories

This report summarises Health and Safety related incidents as reported during the financial year, a full report on incidents is reported each financial quarter to the HSSG. Patient Safety incidents are not included in this report which focuses on staff and others who may be affected by the work activity, unless an incident has occurred to a patient resulting in an event categorised by the Reporting of Incidents, Diseases and Dangerous Regulations 2015 (as amended).

A full breakdown of incidents relating to security, violence and aggression and Fire are reported on to the HSSG by the relevant departments. Moving and Handling and Medical Devices incidents are presented as separate reports in the Overarching Trust Health & Safety Annual Report.

- Health and Safety related incidents
- Slips trips and falls
- Violence and Aggression
- Needle stick

5.2 New incidents

The chart below indicates 3 years of new incidents on the date they were reported.

New incidents reported	Number	Month average	Severity 3+	% of total incidents
2017/ 18	1130	94.17	54	4.78%
2018/ 19	1116	93	65	5.82%
2019/ 20	1286	107.17	46	3.58%

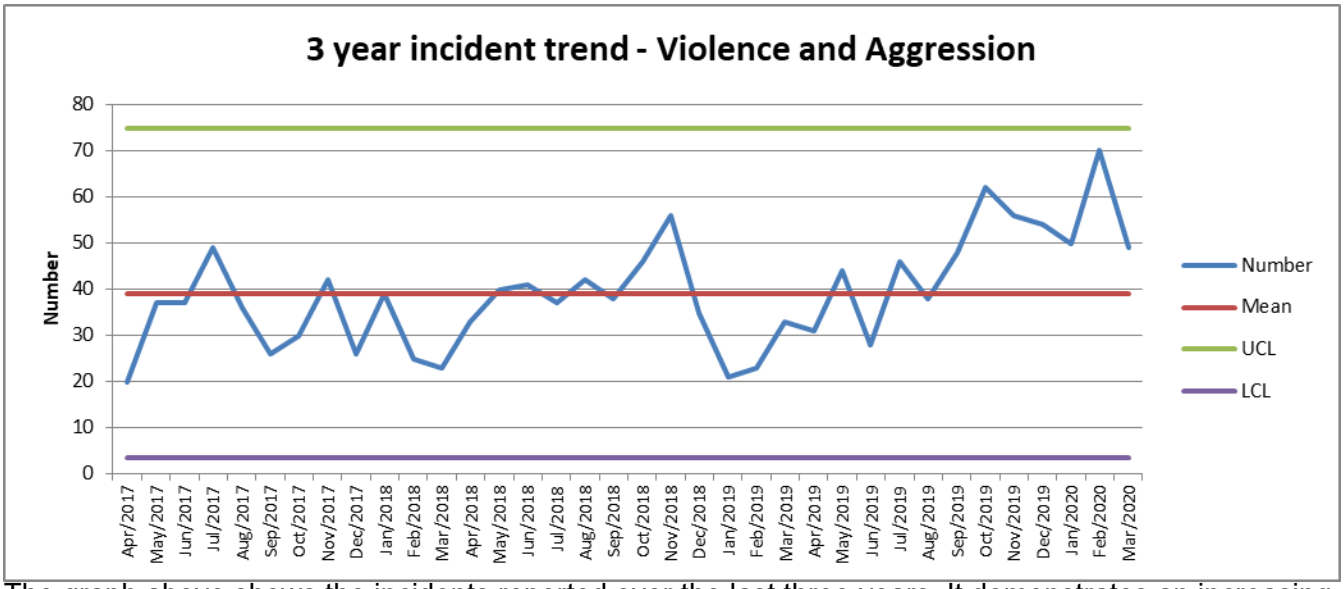
The severity of incidents graded as a severity 3 or above has decreased significantly as a total percentage of the incidents for the year to 3.58% from a previous high of 5.82%. This decrease was potentially influenced by 2 factors:

1. During quarter 2, the Trust was inspected by the Health and Safety Executive. At the same time; a noticeable trend in the increased reporting of incidents particularly those with a lower level of severity and where violence or aggression may have occurred, this continued through quarter 3;
2. The latter part of quarter 4 had a significantly reduced level of grade 1 and 2 incidents reported; this exception may have occurred due the internationally evolving health crisis.

5.3 Analysis of Type of Incident

The top three reported incident categories were Security, Violence and Aggression; Slips, Trips and Falls; and Needle stick and Other Sharps

5.3.1 Security, Violence and Aggression.



The graph above shows the incidents reported over the last three years. It demonstrates an increasing trend. Further analysis indicates increased reporting since raising awareness following the HSE inspection.

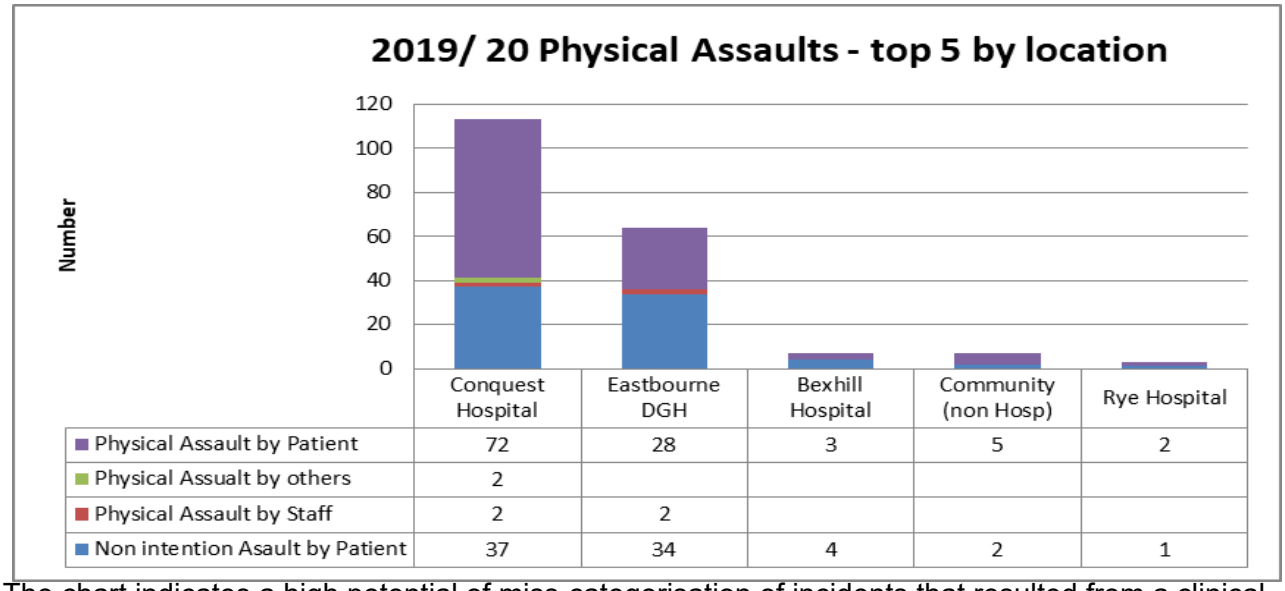
Violence and Aggression	Number	Month average	Severity 1	Severity 2	Severity 3	Number of all Physical	% of total incidents
2017/ 18	446	37.17	72.87%	22.65%	1.57%	180	38.63%
2018/ 19	407	33.92	79.36%	23.34%	1.97%	139	34.15%
2019/ 20	576	48	66.49%	32.46%	1.42%	194	33.68%

Whilst further details of this category is provided in the Trust Security Departmental report, a brief analysis of incidents is given below in respect of physical and intentional violence and compares against clinical violence or aggression as reported.

The number of all incidents reported increased from August as noted in 5.2 and the drive by the Trust on the reporting of these incidents resulted in an overall increase of 41.52% on the previous year. Reported physical incidents both clinical and non-clinically related increased by 39.56%,

It was highlighted throughout 2018/19 that there was an issue with the categorisation of incidents. Revised categories and sub-categories were drafted in quarter 4 that will enable greater accuracy of reporting from 1st April 2020 and this will allow the Trust to interrogate reliable data and determine subsequent priorities from this.

The chart below indicates the top 5 sites by the highest number of physical assault incidents as reported on DatixWeb.



	Conquest Hospital	Eastbourne DGH	Bexhill Hospital	Community (non Hosp)	Rye Hospital
Physical Assault by Patient	72	28	3	5	2
Physical Assualt by others	2				
Physical Assault by Staff	2	2			
Non intention Asault by Patient	37	34	4	2	1

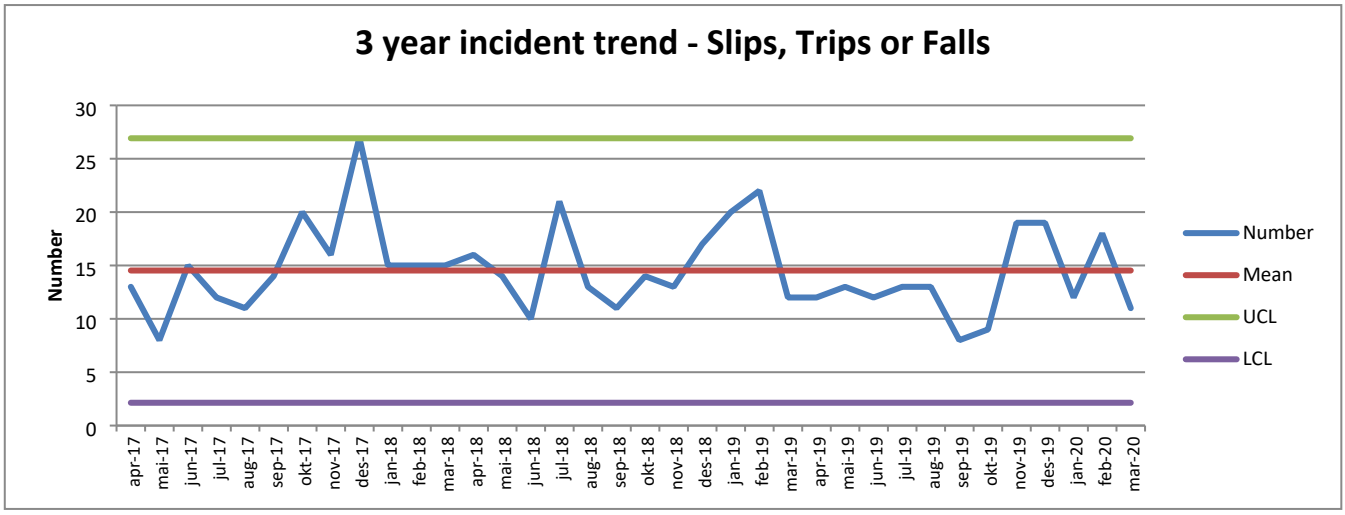
The chart indicates a high potential of miss-categorisation of incidents that resulted from a clinical condition for example; Frailty service reported 28 incidents 10 of which were sub-categorised as non-intentional. Reporting incidents particularly in Emergency Departments where the prevalence of violence or aggressions is nationally higher in comparison to other departments on acute sites. Regardless of the accuracy of the category, measures do need to be identified to reduce the risk to staff and others as a result of physical aggression so that this is not perceived as part of the job.
Following the outcome of the HSE visit, the Violence and Aggression Group was established chaired by the Director of Nursing and Governance with five key work streams:

1. Improvement of Violence and Aggression incident reporting;
2. Assessing risks of violence and aggression including elements of environment and design;

3. Training relevant to the level and type of risk presented by Violence and Aggression
4. Communications and Staff Engagement and Well being
5. Violence and Aggression Policy

5.3.2 Slips, Trips and Falls

The graph below shows the non-patient incidents over the last three years. It shows normal variation since early 2017



There were two concerns highlighted via DatixWeb in previous reports which were readily identifiable as slippery surfaces caused by inclement weather; primarily ice. Peak incidents occurred in February (22) with varied causes although this resulted in 7 incidents graded as a severity of 3.

New incidents reported	Number	Month average	% Severity 1	% Severity 2	% Severity 3	% Severity 4	Severity 3+	% of total incidents
2017/ 18	172	14.33	37.79%	52.91%	8.14%	1.16%	16	9.30%
2018/ 19	171	14.25	27.49%	60.82%	11.11%	0.58%	20	11.69%
2019/ 20	159	13.25	27.04%	60.38%	10.06%	2.52%	20	12.58%

Of a total 159 incidents reported across the year, 20 were graded 3 and above. Trips and falls over objects or structures were the most commonly reported incident (64) and storage of items was often identified as the causal factor, along with environmental issues including holes in floor and uneven surfaces. The lack of storage and the increased complexity of treatment for patient's means that additional medical devices are required to support patient care.

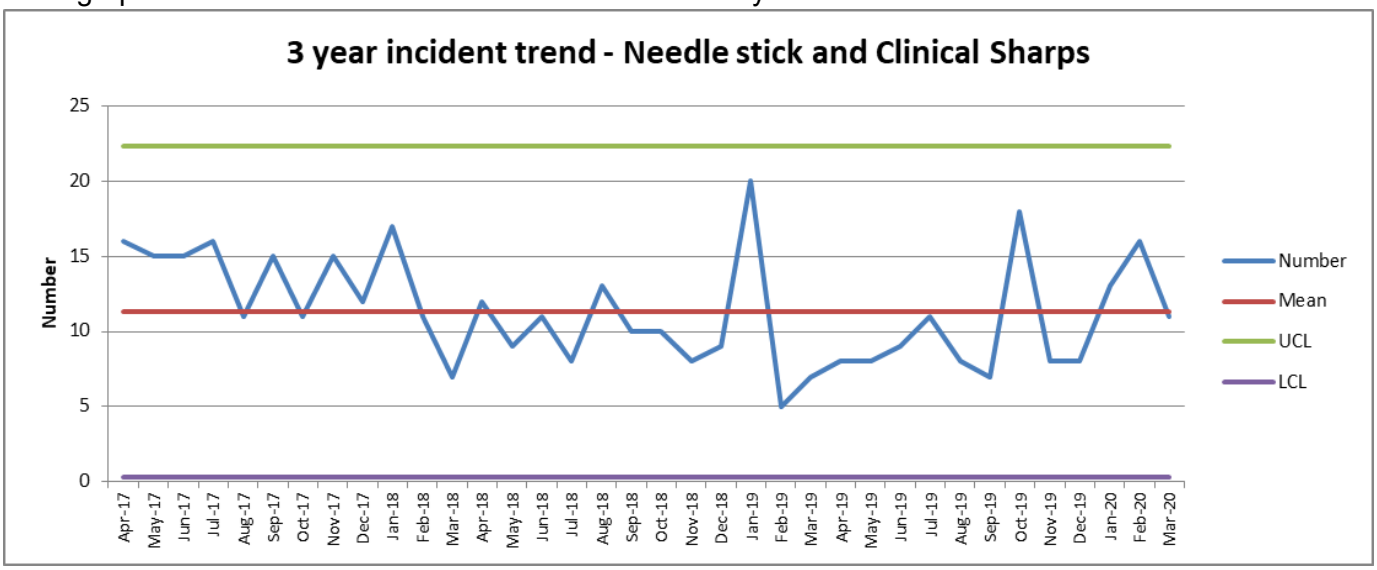
The second most reported category was as a result of slipping on liquids or slippery surfaces (33). Primary causes were during housekeeping activities: wet floors, spillages and environmental: leaks and uneven surfaces. It is recognised that the Trust has improved practices considerably to prevent slips and falls however, the aging estate along with behaviours of staff continue to present a risk.

Due to the decrease in reporting of lower severity incidents and the increase of incidents were harm resulted, the Health and Safety departments work plan for 2020/ 21 will be to further raise awareness of

slips, trips or falls with aim to reducing the frequency and severity. Extremes of temperature were thought to be a factor in some reports.

5.3.3 Needle stick incidents

The graph below shows the incidents over the last three years and demonstrates normal variation.



New incidents reported	Number	Month average	Disposal/ Environment	Clean Injuries	Dirty Injuries	% of Dirty Injuries
2017/ 18	183	15.25	86	6	91	49.73%
2018/ 19	122	10.17	45	5	72	59.02%
2019/ 20	125	10.42	28	21	76	60.80%

An analysis of data identifies that behaviours and systems leading to issues around disposal of waste generated by clinical sharps post use has improved and has led to a 67.4% decrease from those reported in 2017/ 18 (86) to 2019/ 20 (28).

The sub-categories were redefined for the beginning of the reporting year to give greater accuracy in the categorisation of incidents and assist in determining priority measures to reduce the incidence. This work has identified that the overall number of incidents involving injuries from dirty needles and other clinical sharps has increased slightly this year and further work is needed to reduce the frequency of these incidents: injuries form dirty needles accounted for 64 incidents reported and a further 12 were categorised as other clinical sharps including scalpels.

As stated in the previous annual report a 7 year review and analysis across the Trust was undertaken to determine factors affecting the efficacy of the implementation of the Sharps Directive and causative factors in June 2018/19 and led by the Health and Safety Department. The interim report identifying key findings was discussed at HSSG and provided to Infection Control to follow-up on the key findings, and to take further action as required and to work with Waste Management and Health & Safety with regards to the disposal issues.
A Sharps Working Group was set up to determine further measures needed as a result of the 7 year analysis however additional priorities were determined by the pandemic and the group will be meeting at the beginning of 2020/ 21.

6. RIDDOR events – Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 2005 (as amended 2013)

A total 24 incidents were categorised as a RIDDOR event and were reported to the Health and Safety Executive in 2019/ 20.

	2016/17	2017/18	2018/19	2019/20
+ 7 Day	29	16	16	17
Specified /Major	7	4	6	6
Dangerous Occurrences	0	2	4	1
Total	26	22	26	24

Staff: 21
Visitors/ Public: 2
Patients: 1

6.1 Staff RIDDOR events

There were a total of 21 staff related incidents reported as RIDDOR event during the reporting year for the categories of incident identified within this report. The details of the incident statistics have been reported in to the Trust Health and Safety Steering Group which includes:

- Over 7 day injuries: (17 reported) 14 staff were absent for a minimum of 7 days due to environmental conditions and behaviours, slips on floors, falling from stairs or tripping over obstacles. In addition, 1 member of staff had equipment roll over their foot and 1 member of staff walked into a trolley. A road traffic accident also occurred resulting in absence of more than 7 days and this was reported in error as a RIDDOR event due to the requirement to reporting these to the Police.
- Specified/ Major Injuries: (3 reported) 3 members of staff received a fracture due to: Damaged equipment which was awaiting replacement, limited storage and the service demand causing momentary distraction and a further caused by excessive traction between a member of staffs footwear and the floor: a mechanical fall.
- In addition, a contractor fell in a loading bay resulting in a fracture which is required to be reported by the employing company. The area was subject to a multi-disciplinary review and remedial measures and mitigation of future events were rapidly implemented with the assistance of Facilities.
- Dangerous Occurrences: (1 reported) 1 high risk needle-stick injury in the emergency department when a member of staff received a sharps injury when providing assistance to a patient.

6.2 Public/ Visitor RIDDOR events

There were 2 incidents involving members of the public:

- Whilst visiting a patient, the visitor fell out of their chair when asleep and fractured their jaw. Although this was required to be reported as a RIDDOR event, despite investigation, there was no identifiable issues with the environment or equipment and it was determined that the visitor behaviours and age were the causal factors of the incident.
- A mechanical fall and potential pre-existing health condition were deemed to be the cause of a member of the public falling on ESHT controlled premises whilst attending a GP appointment.

Neither incident was identified to have been preventable.

6.3 Patient RIDDOR events

There was 1 incident reported. A patient with dementia made an error of judgement and mistook a curtain for a wall when leaning which caused her to fall. The investigation found that the root cause was that the patient did not have a Falls Risk Assessment completed and therefore potentially avoidable risks were not identified and managed with appropriate strategies.

The decision to report patient events as a RIDDOR is taken after scrutiny of the incident investigation presented to the Weekly Patient Safety Summit. The Memorandum of Understanding (MOU) between the Care Quality Commission and the HSE state their responsibility in the sharing of information and who is the lead body for prosecution where required, Internal Operational circulars also state which regulatory authority will investigate: in all cases the reporting requirements that determine which incidents fall within the criteria of reporting to the HSE are encompassed within the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 2005 (as amended 2013).

More than 70% of staff RIDDOR events were reported outside of the reporting time frames required by RIDDOR which is 15 days for incidents defined as +7 days and 10 days for specified injuries. The primary reason for this is where the information required to complete the report to the HSE was not forthcoming or clarification around length of absence was difficult to ascertain. A number of occasions occurred where a member of staff was absent prior to going on annual leave therefore the categorisation as a RIDDOR event could only be clarified on their return and this is a significant issue where the RIDDOR is an absence of 7 or more days. Cause and effect does need to be demonstrated prior to reporting the incident and a medical diagnosis must be given for all specified injuries.

7. Audits

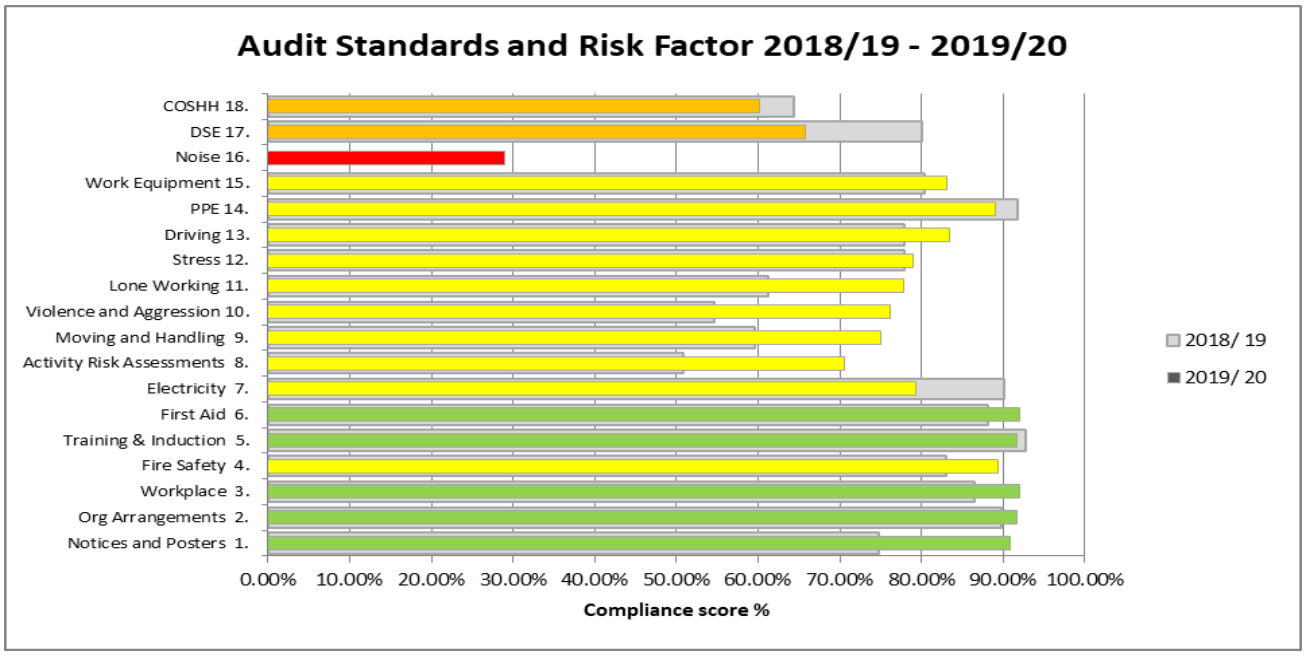
7.1 Rationale

Audits are a leading indicator of the health and safety performance of health and safety management at a local level. The audits have 18 specific standards that are based on legal compliance and adherence to Trust policy. Division of the 18 standards enables an overview of compliance in specific risk factors. Evidence is looked for in all cases that risks have an escalation and feedback process where measures are required as a result of incident or risk assessment are not able to be undertaken at a local level and that there is engagement and communication around risks and safe working practices.

The department has a Key Performance Indicator (KPI) of completing a minimum of 100 audits per year and is a key method of determining the local management of health and safety enabling any deficits or areas of improvement to be identified and action or advice as needed. It was stated in 2018/ 19 report that this was not achieved due to multiple reasons and resulted in 29 audits on the forward programme as significantly overdue at year end. It was a 2019/ 20 priority for the department once trained staffing levels were achieved to address the deficit. The achievement of the year end KPI of 100 audits was impacted during Q4 by the evolving health crisis resulting in 69% completed.
It is important to bear in mind that the audit represents findings at the time of the audit and is reliant on evidence being able to be produced including embedding. Proportionate risk assessments and mitigation measures are actively encouraged. The table on the following page indicates Trust average for 2018/ 19 and 2019/ 20 and the resulting movements in each standard between the years.

7.2. Improvements Achieved

There is an overall increase in compliance by 0.26%.
There are now 5 standards that have moved into a low risk category (2018/19) which were evidenced in the majority of cases by stronger health and safety management in those areas. There are 10 standards that are rated as moderate risk which is the same as the previous year.
There was significant progress in the undertaking of risk assessment and application of proportionate measures to mitigate risk at a local level with escalation as required. The assessments were also evidenced to include lone working and violence and aggression as a factor where the risks were significant.



7.3 Further improvements required

3 standards were audited as higher risk factors which were not adequately evidenced or addressed:

7.3.1 Display Screen Equipment Checklists

- The Policy is under revision to incorporate changes to the frequency of the checklists to make sure that this is meaningful and relevant process.
- A refocus on the need to undertake training on workstation set up to mitigate the risk of musculoskeletal disorders;
- Streamlining of the procurement of equipment needed for safe working.

7.3.2 Control of Substances Hazardous to Health (COSHH)
Stringent control over the majority of substances purchased via Trust central procurement has been achieved through effective working partnerships and consistent messages around hazardous substances. This has enabled oversight in many areas. Improvements are required in some departments and this will remain on the Health and Safety work plan for 2020/ 21.

7.3.3. Noise at work
There were 4 departments where the noise at work as defined by the Regulations was a significant risk. In these areas there were no documented risk assessments or checklists. Specific recommendations were made at the time of the audit and discussed with the relevant lead.

8. Training

Training figures during the last 12 months show marked improvement in compliance through all months; starting the year at 88.8% and closing at 93.3; achieving significant compliance.

Mid way through the year Level 1 training moved to e-Learning only for all staff, did not adversely affect the climb in figures.
When undertaking our Training Needs Analysis for the next financial year, we were able to reduce the number of class based places provided by the department by 50%.

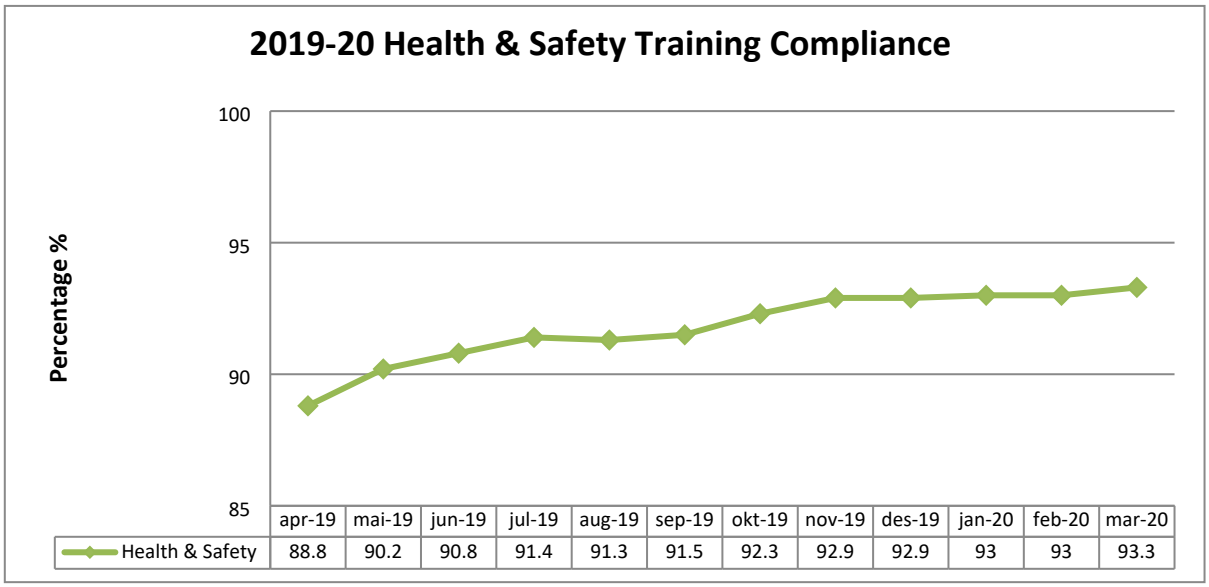
8.1 Training Needs 2020/ 21

From the 1st of April 2020 as agreed by the Education Steering Group, all members of staff will need to undertake Level 1 training as mandatory.

Health and Safety Level 2 course for Supervisors, Team Leads and Managers has been reduced to ½ day; these changes are agreed with the following objectives in mind:

- Greater monitoring of level 1
- The ability to refocus on delivering Trust objectives and priorities with level 2
- A reduction in clinical hours required away from the workplace

The undertaking of training in addition to level 1 will be monitored locally via appraisal and through OHSMS audits.



	apr-19	mai-19	jun-19	jul-19	aug-19	sep-19	okt-19	nov-19	des-19	jan-20	feb-20	mar-20
Health & Safety	88.8	90.2	90.8	91.4	91.3	91.5	92.3	92.9	92.9	93	93	93.3

During Q2 2020/21, level 3 Health and Safety will be reinvigorated further enabling a comprehensive and tailored structure to the course specifically for the Trust.

9. Assure – Health and Safety risk assessment and audit software

9.1 Improvements in Assure

- Collaboration with Occupational Health and Wellbeing Department to update Display Screen Equipment (DSE) Checklist template and highlighting the need for training;
- Security Assessment template revised in conjunction with Security Department to support the Trust Violence and Aggression work plan

- Report templates developed for Governance Lead use, i.e. identifying mandatory document compliance, and risks rated as 12 or above
- Multiple automated daily reminder emails replaced by a single Summary Email to users, ensuring email volume drastically reduced and value of reminder emails is retained:
- OHSMS Audit template updated to reflect integration of Assure into Trust Health and Safety culture
- Assure Steering Group continues to be well-attended by risk assessors and senior Governance representatives, who provide input into key decisions around Assure, escalate user-raised issues, and review key pieces of documentation;

9.2 Key Risks of Assure

- **Limited Reporting Capability**: the reporting functions on Assure remain limited in their sophistication and require time and considerable formatting to produce usable data, however regular reports are now sent out on a monthly and quarterly basis to Governance Leads and other key stakeholders.
- **Confidentiality Permissions not meeting ESHT Requirements**: resulting in confidential assessments completed in a separate risk assessment template and not uploaded to the Assure system.
- **Governance Oversight:** The level of engagement by Governance Leads with Assure is increasing, particularly now that regular reports (as above) are being sent out to them for review and action. However, while risk assessments are being initiated, they are not always being submitted by users, or approved by the relevant line manager when submitted. As such, there needs to be a continued focus by the Governance Leads on the monitoring of documents and their completion, and further discussions are planned for Q1 2020/21 with Governance Leads to resolve these issues,

10. Health and Safety key risks and assurances

10.1 Significant risk: Violence and Aggression

The Trust has a good reporting culture for patient safety incidents however health and safety incidents particularly those involving violence and aggression may be less likely to be reported. This has been impacted by under reporting of incidents and errors in the sub-categorisation of incidents reducing the ability to identify specific problems. This has impacted on the ability to prioritise the level and type of training required to mitigate risk. Additional factors reported nationally are an increase in violence and aggression against healthcare staff. Reporting incidents will remain a high priority for 2020/ 21 and Board support is required to drive improvements needed. The risk is Trust wide and is supported by a risk register entry.

There is an active Violence and Aggression Group with key work streams led by the Chief Nurse that address all elements of the work needed to drive improvement. A project for the procurement of Lone Worker Devices was launched in Q4 although the evolving COVID-19 crisis had a negative impact; an accelerated trial is planned with a business case supporting it for Q1 2020/21 .

10.2 Injuries from Sharps

Incidents involving penetrating sharps injuries increased as a total percentage of all needle stick incidents reported; the 7 year analysis of incidents involving needles and sharps report was discussed at HSSG and requires further action by divisional teams;

10.3 Control of Substances Hazardous to Health

In 2018/19 a significant risk was identified through audit that the Trust may be in breach of the Control of Substances Hazardous to Health Regulations 2002. It was caused by uncontrolled purchasing and the lack of assessment to ensure that risks are identified and mitigated; in addition the organisation did not have a trust wide inventory of hazardous substances.

Moderate to significant assurance is given through work with Procurement to identify all purchasing routes to control the purchases of all substances. Ad hoc inventories were undertaken and a stringent control process is in place. This remains on the departments work plan through 2020/ 21 until significant assurance is achieved.

11. Health and Safety Department
2019/20 Work plan

Performance Standard	Key Measure (summary)	Outcome Summary	%
Policy	All policies remain in date and are relevant. Key points are auditable. All policies have a summary sheet	Display Screen Equipment Policy deferred to 2020/ 21	93%
Competent and Capable Workforce	A relevant training needs analysis Health and Safety competency framework Training delivery mandatory and specific Training compliance		93%
Engagement and Communication	Health and Safety Link forums Health and Safety newsletters Ad hoc and scheduled welfare checks Intuitive Health and Safety extranet	Awaiting upload on new extranet	70%
Accessible service	Health and Safety surgeries, 1:1 schedules and support sessions		94%
Risk Assessments	Activity assessments: Monthly quality assurance, proportionality and mitigation		100%
Risk Assessments - COSHH	Monthly quality assurance, proportionality and mitigation Bi-monthly Trust inventory reconciliation against purchases	Bi-monthly reconciliation slippage	80%
Incident Reporting	Incident triage within 24 hours of receipt Active follow up of all 3+ incidents RIDDORs reported within schedule	70% of RIDDOR's were reported outside of schedule	45%
Occupational Health and Safety Management Audit	Achieve 25 per quarter/ 100 per financial year	Significant loss due to Q1 staffing, Q2 HSE, Q4 COVID-19	69%

The Health and Safety Department will ensure that for 2020/21:

- The Occupational Health and Safety Management audit tool will remain the principle tool to monitor performance and highlight deficiencies;
- The department will continue to work on the management of COSHH Trust wide to ensure resilience within the organisation and to ensure that systems introduced by the Deputy Trust Lead for Health and Safety for controlling purchases become firmly embedded;
- All levels of the organisation are regularly informed of forthcoming local and national health and safety targets and incentives;
- The department continues to support the divisional and directorate Governance and Health and Safety Leads to ensure and be assured of compliance and any gaps have been identified.

12. Introduction

This report summarises the management of medical devices during 1st April 2019 to 31st March 2020 and provides analysis of the data on incidents reported on DatixWeb. It also includes training compliance for mandatory medical devices i.e. Infusion devices, the safe use of oxygen, nebulisers and oxygen saturation training.

The role of the Medical Devices Educators (MDE) team links into all departments throughout the Trust. They are responsible for training Registered Nurses and Midwives and Registered Healthcare Practitioners on the safe use of High Risk medical devices across all sites within ESHT. Training is delivered to ensure compliance with CQC fundamental standards and regulations set out by the Medicines and Healthcare products Regulation Agency (MHRA). Training includes usage, storage, cleaning and maintenance of low, medium and high risk medical devices.

All registered practitioners are required to keep their knowledge, training and competencies up to date to ensure high standards of care and patient safety at all times. Therefore the MDE team offers regular mandatory training sessions and ad hoc updates across all sites.
Part of the role requires the team to investigate and advise, where possible, with incidents involving medical devices that are reported via DatixWeb throughout the Trust.

13. Review of the Year/Work Plan 2019/2020

For the first half of the financial year the Team consisted of 1.0 whole time equivalent (WTE) staff which following successful recruitment was increased by 1 WTE in October 2019. Over the past year the Team has accomplished many tasks and are working together with other teams to improve services across the Trust for the coming year.

13.1 Incidents

The consistency of data that has been retrieved during this period has been varied and it has been difficult to determine for trends, nonetheless, medical devices have not seen any serious incidents reported for the 2019/2020 period. Going forward this has been addressed with specific criteria identified to monitor the incidents report. However there are still incidents occurring in relation to oxygen and training that is an ongoing concern which the team are endeavouring to resolve and will hopefully be able to clarify and formalise this year.

13.2 Training

Throughout the year training compliance figures have improved in part due to filling the whole time vacancy in the team in October 2019; and with the Covid 19 pandemic there has been an increase in the number of staff who received training in preparation for redeployment in the Trust. During the early part of the year a spread sheet for compliance tracking was devised and ward based training sessions were offered to increase training numbers. It has been identified that there is a need to establish a robust system for obtaining compliance data and for tracking staff/departments that require updates.

During the second half of the year an auto enrolment scheme was set up in collaboration with Integrated Education which allows newly appointed staff who attend the Trust induction sessions to be automatically enrolled onto one of the future mandatory training sessions at either hospital site. Ideally this would be within a maximum of eight weeks since starting, however this system initially saw a large number of staff needing to attend this course and classes were oversubscribed which created a a backlog. This system ensures compliance with mandatory training where newly appointed staff are concerned and has been working well and it is hoped that the system will be able to be re-instated once there is more stability re the Covid-19 pandemic

13.3 Medical Device Alert/Patient Safety Alert (PSA)

A move to using the Clinell Economy wipes for all medical devices was made in response to a Field Safety Notice (FSN) followed by a Medical Device Alert (MDA) regarding fluid ingress into the T34 ambulatory syringe driver.
A flyer was produced in response to a request from the Medical Gases Steering Group regarding the use of air compressors for the delivery of nebuliser therapy across the Trust. This practice followed an NHS PSA (2016) and a further incident in another Trust in relation to the accidental supply of Air instead of Oxygen from piped flow meters nationally.
There has also been an MDA for the T34 regarding debris from the actuator building up on the lead screw causing the pump to malfunction. The Alert was cascaded to all clinical areas and highlighted during mandatory training advising staff to visually inspect pumps specifically for this defect.
The actions taken and precautions required in the safety and device alerts have also been included in the newsletters distributed across the organisation.

13.4 Equipment

The project to install 400 Welch Allyn Connex Spot Monitors into the Trust has been achieved despite disruption during March with Covid planning. The Hillrom trainers were able to come to the hospital education centres to facilitate training for clinical staff cross site with support from the Medical Devices team.
The installation and training on the new Baxter EVO IQ volumetric pumps acquired to replace aging stock is due to start in early summer with a view to completion in the autumn.

13.5 Resource Pages

The MDEs were able to work with Simulation to help set up resource pages which can be accessed by staff via the Extranet. These pages contain a mixture of training videos, e learning and user manuals on various devices used throughout the Trust and have been sourced from company websites, company trainers and National Association of Medical Device Educators and Trainers (NAMDET). The information has been gathered together in one place as a compendium to help staff during the crisis to become familiar with various types of equipment when training is unavailable.
This was an improvement that the MDEs were working on prior to the pandemic but now that the foundation has been laid the team would like to continue to build and expand on this to create a valuable resource.

13.6 Areas for Improvement

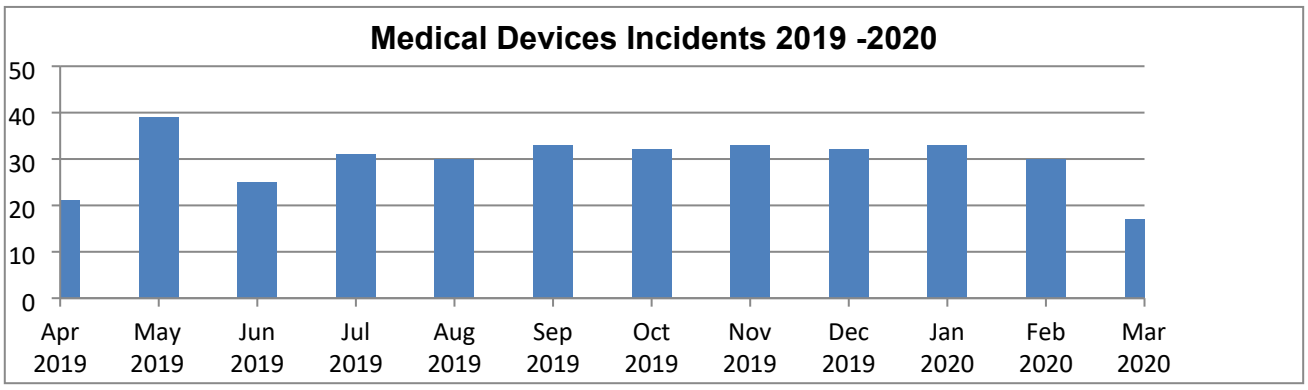
The Team have identified three areas that require review and improvement, and these are;

- Clarification of the need for Oxygen training for all nursing staff and which department is responsible for delivering such training.
- A system to obtain accurate training figures and track compliance for mandatory training in the Trust
- The auditing process for the medical devices green folders

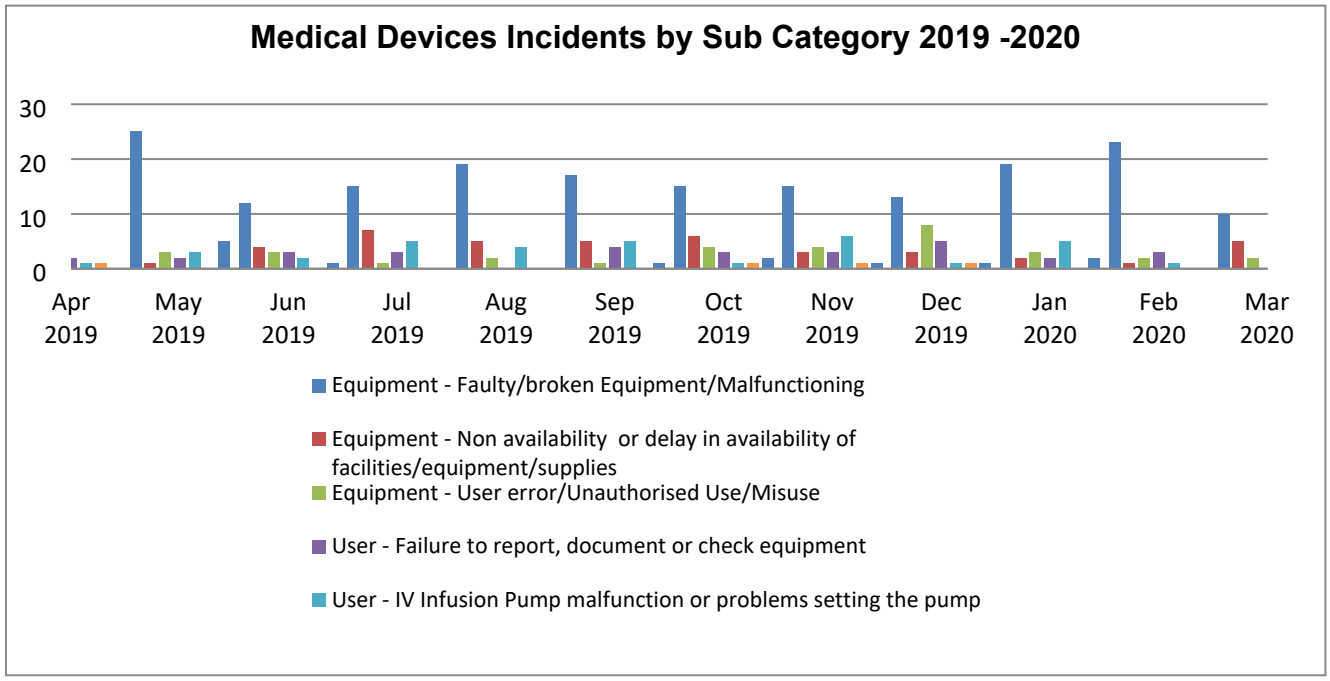
During the next year the team will be working to resolve these issues by working in collaboration with other teams to find solutions.

14. Incidents Reported

Over the last year there has been much variation in the set of standard data being examined for the purpose of reporting. However, overall figures appear to have remained fairly stable over the last two quarters with the biggest decrease seen in March. This decrease could be due to a decline in reporting of incidents due to the increased demand on staff during the initial phase of Covid 19 and reduced activity trust wide. Due to the inconsistency of data being pulled for each quarter report the bar chart below does not accurately replicate the figures drawn for each report but gives an overall picture of the general trend for 2019/2020.



The chart below shows the general trend of incidents when broken down into subcategories.



This set of data has varied over the year but the five subcategories shown above will be the standards used for future quarterly reports. This will allow comparison of trends more accurately and evaluate where further training needs to be applied or problems with supply or function of equipment is an issue.

Infusion Devices Incidents	
Incident	**Outcome**
Furosemide infusion infused to quickly (Alaris GH)	User error. Training provided
Blood transfusion infused to quickly (Baxter)	Incorrect rate set. Should use VTBI/Time as calculation to reduce this error. Included in Med Device mandatory training
Furosemide infusion set at wrong rate. Infusing too slowly	On discovering wrong rate Furosemide was changed to a continuous infusion to be commenced as soon as possible. User error.
Noradrenaline was being double pumped; the BP was dropping quite considerably despite rate being increased. Pump alarming. It was found that the giving set was faulty as when off the syringe driver, it would still not work.	Practice Educator for ICU concluded that incident was due to cross threading of the extension set. Pump taken out of service sent to EME was not the pump in question. The pump cannot be located as the asset number was not documented at the time.
I patient transfer using CD Oxygen cylinder – flow rate set at 2LPM via nasal cannula but the valve was closed.	MDE more training on the safe administration of oxygen. Also Mandatory safe use of oxygen training can be booked via L&D training brochure delivered by

	the MDE's cross site. HCA's are invited to attend to ensure they are aware of Trust policy and amendments.
Registered nurse unable to use oxygen & humidification equipment correctly	Mandatory safe use of O2, nebs & SpO2 offered through L&D for All staff including bank workers
Patient prescribed low flow oxygen (2L/min) but nursing staff discovered that the cylinder was not turned on.	Training provided on opening and closing CD size oxygen cylinders. Training includes highlighting the risk of not delivering low flow oxygen and making sure cylinders are turned on

The three incidents listed under Oxygen clearly highlight the need to clarify the situation with oxygen training and the urgency to adopt a more formal approach to this essential and fundamental training. There was one moderate incident reported in year which concerned the faulty use of equipment in Theatres resulting in a member of staff sustaining injury whilst preventing a patient from falling.

15. Training

This report looks at the compliance figures for mandatory medical devices training which covers the high risk category infusion devices as well as oxygen delivery devices used in the trust. This training is mandatory for all registered nurses and midwives and Allied Healthcare Professional across site and updates are provided on a three yearly basis to ensure compliance with the Medical Devices Training Policy and Procedure.

Training is reviewed yearly as part of the Training Needs Analysis and in conjunction with incident reports to ensure that we are providing training on the most relevant High risk devices. Having identified the need to formalise oxygen training for Healthcare Assistants we are consulting with Integrated Education on how this will be provided.

The tables below represent an approximate percentage of the training compliance for qualified staff across the Trust over the whole year. The team are currently looking at a system to improve the accuracy of staff training records for Medical Devices as currently we do not receive a monthly report based on the information held on ESR. We are hopeful that over the next year we will be able to confirm with Learning and Development a process which will provide the data to accurately analyse training compliance; this will also assist the team in identifying departments which are noncompliant.

EDGH MANDATORY MEDICAL DEVICES

Device	Q1	Q2	Q3	Q4
Alaris GH	72%	76%	78%	81%
Baxter	70%	76%	78%	81%
CME Medical	75%	78%	78%	81%
O2 devices	75%	80%	82%	85%

CONQUEST MANDATORY MEDICAL DEVICES

Device	Q1	Q2	Q3	Q4
Alaris GH	70%	76%	83%	85%
Baxter	72%	76%	83%	85%
CME Medical	75%	80%	83%	87%
O2 devices	74%	82%	84%	87%

Training compliance continues to improve steadily towards achieving the goal of having 90% training compliance in the Trust.
From March 2020 the MDEs were engaged in training redeployed nurses throughout the trust in preparation for the Covid-19 pandemic. We anticipate that this increased activity will boost the number of staff undergoing mandatory training for the first quarter of 2020/21.

Training and installation of Welch Allyn Connex Spot Monitors is almost complete on both sites. 300 out of the 400 units purchased for the Trust have been implemented into their clinical areas. The Hillrom trainers have continued to support the Trust with training during the Covid 19 crisis by facilitating training in the education centres rather than visiting clinical areas. The training schedule has been hindered by Covid 19 but the Medical Devices Team in conjunction with Hillrom have been able to train at least one member of staff from each clinical area (Train the Trainer) in order that they can then cascade training to other staff in their department.

16. Covid-19 Pandemic

March 2020 saw the emergence of Covid 19 which has impacted on the general daily activities in every department in the hospital including medical devices. Due to the social distancing regulations many of the non-essential mandatory training sessions have been cancelled, however, medical devices mandatory training has continued to run along with extra upskilling sessions provided by the MDEs to redeployed staff across the Trust.

Many of the companies within the healthcare industries have temporarily stopped their trainers and representatives from coming to the hospital which has increased the workload for the MDEs as we were, and are, in the process of implementing new equipment into the Trust. However, the trainers have supported us with virtual training and have provided us with many resources to assist us with our training throughout this time of crisis.

One of the team members has also been on shielded leave since the beginning of March having to work from home in an administrative capacity. This has seen a reduction to a 1.5 whole time equivalent of staff providing a physically present service on the hospital sites

17. Medical Devices Department Objectives 2020/2021

- Oxygen Training: The team will establish with Integrated Education the requirements for oxygen training for HCA's. It will also be useful to ascertain where this training comes in to student nurse and newly qualified curriculums. The team are happy to provide this training on a more formal basis

- Monthly training figures and compliance: The team will work with Integrated Education to identify the requirements for a monthly training compliance report so that we can accurately review percentages trained on a monthly basis. The team will also need to look at how other departments configure training records to monitor when training is becoming out of date. This may also be helped by the introduction of a medical devices self-audit (see item below) which can be carried out at ward level.

- Medical Devices Audit: Prior to the pandemic the team were looking into an electronic self-auditing process that can be carried out at ward level and can be accessed by the MDEs to see where there are areas that require training. This would shift some of the responsibility to the wards to establish their own ward inventories, training needs and for individuals to maintain up to date knowledge and training. This system is working for other departments but could be initiated for medical devices possibly for the latter part of the year for a trial period.

MOVING AND HANDLING DEPARTMENT

18. Introduction

The Moving and Handling Team (MHT) annual report for the 2019/2020 financial year provides an overview of incidents, work completed, challenges, team focus and planned actions for 2020/2021. For the majority of the financial year the MHT consisted of 3 whole time equivalent staff who work Trustwide in the acute and community settings. However there was a reduction in staffing from February 2020 by 1 whole time equivalent and the vacancy is anticipated to be filled in 2020/21.

19. Key Performance Indicators 2019/2020

- The team were unable to achieve the target of 92% compliance in delivering moving and handling training for the year due to reduced attendance on sessions for specific groups in January 2020; and reduced numbers on session in March 2020 due to Covid-19. However 91.3% compliance was achieved by the end of quarter 4 2020.
- The MHT were able to deliver manual handling training for all Induction sessions and all of the additional sessions required for Overseas Nurses and Newly Qualified Nurses.
- The team were able to identify and implement opportunities to ensure moving and handling equipment is streamlined with details of products being available – User guides for moving and handling equipment used within the organisation are available on the Moving and Handling pages on the Extranet.
- The Moving and Handling Extranet pages have been developed to include equipment being trained by the Team, competencies for staff; the required moving and handling risk assessments are available on the Assure Database.
- The Moving and Handling Team facilitated and supported a Back Care Awareness promotional event in October 2019.
- The Team have worked with Estates and Facilities, wards and departments to ensure that all patient passive hoists are fit for purpose or have been identified for repair, enabling clinical access at all times, which has continued to be monitored via LOLER meetings and the incident reporting system.

20. Incidents reported

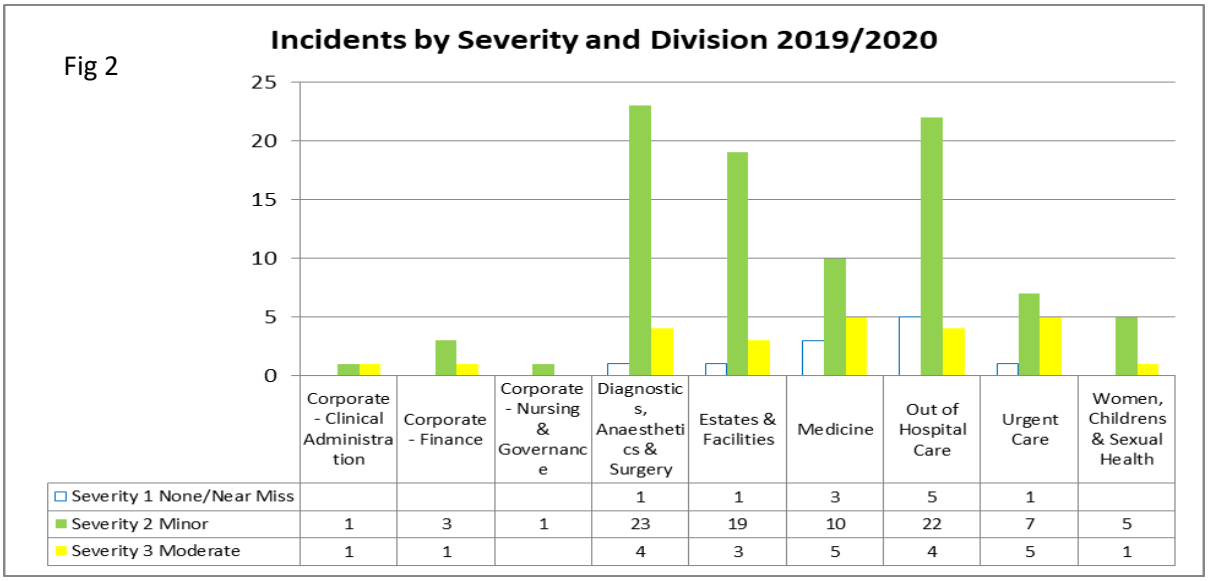
The figures in this summary look at incidents by date reported submitted between 1st April 2019 and 31st March 2020.
There were 126 staff moving and handling (M&H) incidents and Figure 1 shows the rolling total by sub category and financial quarter. Moving a Patient, Moving an Object and Operating/using machinery incidents have decreased compared to last year but with an increase for Equipment – Non availability or delay; and Staff injured due to patient falls and accumulative injury.

Figure 1. Moving & Handling Incidents by Sub Category 2019/2020	Q1	Q2	Q3	Q4
Accident - Moving a patient	10	8	7	14
Accident - Moving an object	7	4	4	7
Accident - Patient fell while mobilising with Trust staff	3	6	3	4
Accumulative injury (work related)	6	11	3	6
Equipment - Inappropriate techniques/equipment used to move pts or objects	2	8	3	2
Equipment - Non availability or delay	1	1	0	1
Equipment - Operating/Using Machinery or Equipment	1	1	2	0
Resources - Training needs identified or inadequate training available	0	1	1	0
Total	30	40	23	34

20.1 Incidents by Division and Severity

On review of incidents in Figure 2, there has been an increase of incidents within DAS and Urgent care in 2019/20 compared to 2018/19. Incident data relates to a wide range of scenarios including positioning/turning patients, patient transfers, Moving equipment with/without patients and equipment availability.

Fig 2

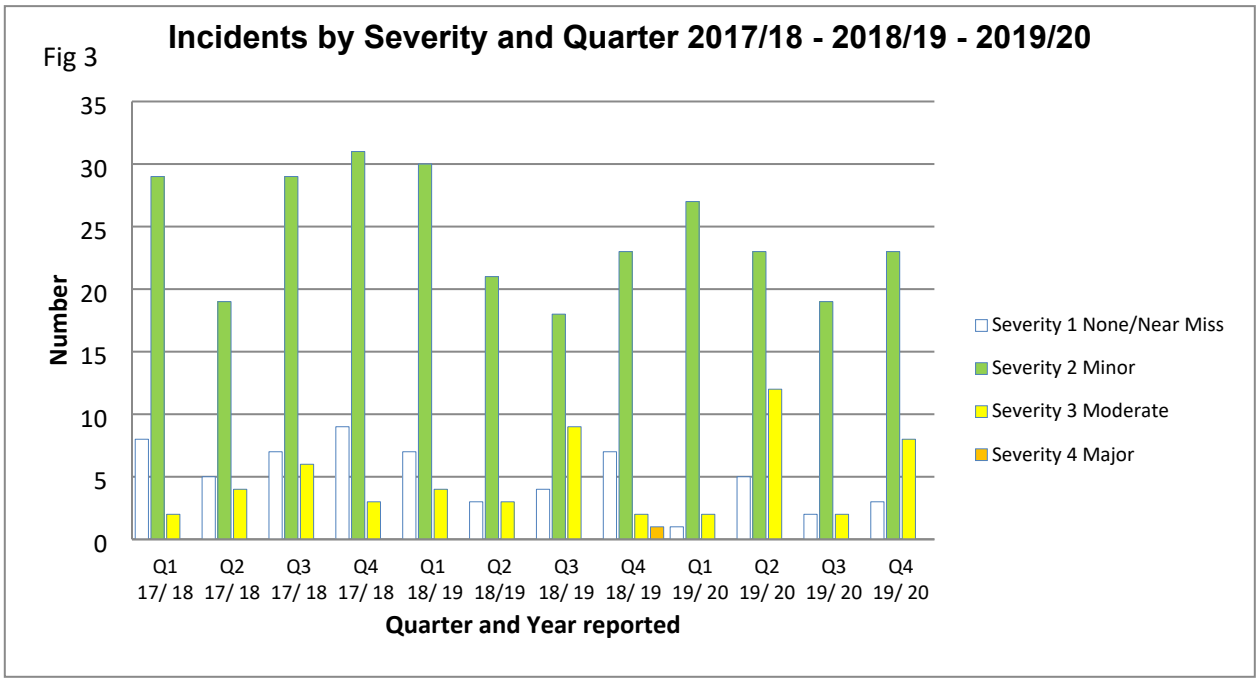


	Corporate - Clinical Administration	Corporate - Finance	Corporate - Nursing & Governance	Diagnostics, Anaesthetics & Surgery	Estates & Facilities	Medicine	Out of Hospital Care	Urgent Care	Women, Childrens & Sexual Health
Severity 1 None/Near Miss				1	1	3	5	1	
Severity 2 Minor	1	3	1	23	19	10	22	7	5
Severity 3 Moderate	1	1		4	3	5	4	5	1

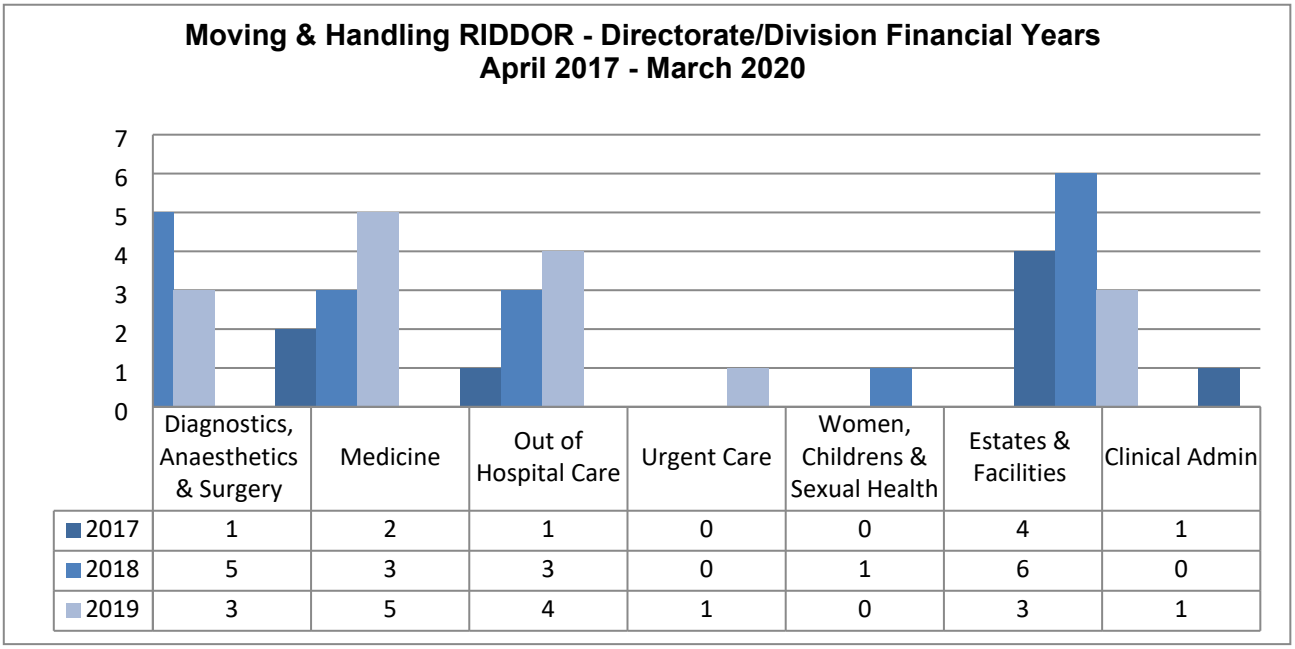
20.2 Incidents by Severity and Quarter for the last 3 financial years

The total number of reported incidents has fallen compared to 2017/18 and 2018/19. Although there has been a rise in severity 3 incidents in Quarters 2 & 4 there are no identifying theme or trend to these incidents. M&H continue to encourage reporting of near misses.

Fig 3



21. RIDDOR Reports



	Diagnostics, Anaesthetics & Surgery	Medicine	Out of Hospital Care	Urgent Care	Women, Childrens & Sexual Health	Estates & Facilities	Clinical Admin
2017	1	2	1	0	0	4	1
2018	5	3	3	0	1	6	0
2019	3	5	4	1	0	3	1

There were 17 M&H related incidents reported as RIDDORs in 2019/2020, in the following Divisions: (Staffing numbers taken 31/03/2020).

Division	Staffing Numbers	Number of RIDDOR's
Diagnostics Anaesthetics & Surgery (DAS)	768	3
Medicine	1404	5
Out of Hospital (OOH)	1121	4
Urgent care	301	1
Estates & Facilities (E&F)	730	3
Corporate (Clinical Administration)	338	1

- 5 incidents related to unexpected patient movements including overbalancing/falling whilst moving
- 4 concerned non-clinical activities including moving objects and trolley movements
- 3 incidents identified that inappropriate techniques were used
- 3 incidents were the accumulative work related injury
- 1 was as a result of a delay in availability of equipment in the community
- 1 incident identified that a review and update or an individual risk assessment was required
- Following investigation the incidents were confirmed as 1 incident at severity 2 and 16 at severity 3

A review of tasks undertaken, training and equipment available has been completed by the M&H Team with key stakeholders. From these recommendations for change in practice and support for the procurement of equipment has been provided.
There have been no incidents relating to the handling of patients who may exhibit aggressive behaviour.

22. Key Achievements

- Continued to highlight M&H incidents in all our training sessions and to encourage staff to complete Datix's including near misses that are under reported.
- Delivered a Staff training compliance mean of 91.3%.
- Refreshed all training materials, in line with the National Back Exchange (NBE) recommendations.
- Launched the M&H Extranet page.
- Promoted ESHT and the M&H Team by delivering a risk assessment workshop at the Disability Living Foundation conference.
- Continued to complete and publish M&H risk assessments to the assure portal.
- Facilitated product reviews and trials of equipment where a need has been identified and current practice has been reviewed.
- Liaised with suppliers to facilitate the above product review and trials.
- Facilitated the back care awareness study day at Conquest as part of back care awareness week.
- M&H Link roles have been encouraged within all Wards & Departments (Acute and Community) this has enabled improved two way communications between M&H and the Wards/Departments.
- M&H issue bimonthly the Hot Topics newsletter in conjunction with the Medical Device Educators delivered through Trust Communications.
- Team twitter account now has over 300 followers @ESHT_MHT
- Delivered Bariatric training at Bexhill Irvine unit, Conquest and EDGH alongside our Bariatric equipment supplier Arjo/1st call.
- The Health & Safety Executive undertook a formal inspection of the Trust in July 2019 and highlighted the good practice particularly in relation to the management of moving and handling within the Trust. It was identified that that Trust staff were very pleased with the delivery of training and felt involved and able to participate. In addition staff stated that they were engaged with the process of procurement of equipment and due to this approach were able to make better use of the equipment rather than having it imposed on them.
- The Moving and Handling Team won the Trust Award 2019 for "Supporting development and learning in the workplace". They received the award for achieving 90% compliance and for delivering a more blended approach in how the team delivers training with an increased amount of ward based training.

23. Moving and Handling Objectives for 2020/2021

Actions:

- Continue to provide competent, suitable and sufficient advice and training.
- Increase team visibility and ensure the M&H team are accessible for training and advice through link meetings, ward/department visits (Acute and Community), e-mail, telephone and Microsoft teams.
- Ensure a flexible approach to ensure the team can deliver Trust priorities.
- Ensure that team members adhere to Trust values.
- Increase joint working with other teams to deliver training sessions i.e. medical devices, tissue viability.
- Promote Back Care Awareness through training delivery and health promotion.
- Promote incident reporting at every opportunity with an emphasis on the under reported severity 1's i.e. near misses.

Reporting and documentation:

- Monitor, report and escalate incident, equipment and staff incidents.
- Attend applicable meetings as available and required.
- Continue to develop the Assure M&H inventory of risk assessments. Review risk assessments by the review date or sooner if applicable following any M&H incidents.
- Develop and complete an M&H audit programme for the Patient Mobility assessment in the IPD.

- Develop competencies for new equipment purchased if M&H team has been involved in the review and purchase.

Training:

- To work with Learning and Development when Mandatory training is re-instated to increase the number of spaces available through extra training sessions as appropriate.
- To deliver bespoke Moving & Handling training sessions wherever possible.
- Explore how to increase compliance in specific areas with targeted interventions. This will be reported and monitored through the Health and Safety Steering Group (HSSG) and the Education Steering Group.
- Deliver competency based training in all Link meetings and support the M&H Links to disseminate the competency training if relevant to their area of work.
- To work alongside our Bariatric equipment supplier to deliver plus size/larger person handling training.
- To deliver suitable and sufficient training for any new M&H equipment brought into the Trust.

Organ Donation Annual Report

Meeting information:			
Date of Meeting:	6th October 2020	Agenda Item:	14
Meeting:	Trust Board	Reporting Officer:	Dr David Walker

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☒	Equality, diversity and human rights	☒
Staff	☒	Regulation (CQC, NHSi/CCG)	☒
		Legal frameworks (NHS Constitution/HSE)	☒
Other stakeholders please state:			
Have any risks been identified ☒ *(Please highlight these in the narrative below)*		On the risk register?	No

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

Key Discussion Points:

Actual & Potential Donors: Within ESHT, between 1st April 19 & 29th February 20, there were 11 families who consented to donation. Eight patients proceeded as solid organ donors leading to 13 patients receiving transplants. This was an increase on the previous year activity. Areas of good practice remain the referral of patients and involvement of the Specialist Nurse for Organ Donation (SN-OD) following neurological death. Areas that remain potential for improvement include referral of patients following circulatory death, neurological testing of patients with potential brainstem death and improved consent rates although it is worth noting that all of these areas have improved since the previous report.

Impact of COVID 19: The COVID-19 pandemic has had a significant impact on organ donation & transplantation. Patients who die from or who are suspected of having COVID-19 are currently precluded from organ donation. In addition, there has been a significant impact on ICU staff work intensity with the resulting potential for an increased missed referral rate. The report issued by NHS Blood & Transplant (NHSBT) covers the period to 29th February 2020 and therefore excludes the start of the most severely affected period.

Changes to donation consent: The Organ Donation (Deemed Consent) Act 2019, also known as “Max & Keira’s law”, became law in England on the 20nd May 2020. The change means that adults with capacity who have been freely resident in the UK for over 1 year can be considered to be in agreement with organ donation unless they have made a written or verbal statement not to donate. The system still allows people to make a free choice and family members will continue to be consulted to ensure that the views of the patient are respected.

Staffing: From July 2019 there has been no Specialist nurse for Organ donation (SN-OD) allocated to the trust. This is due in part to the low numbers of donations

within ESHT. The local SNOD cover has been provided by the SN-OD for Brighton & Sussex University Hospitals Trust.

Benefits of Implementation: Raised awareness of organ donation within ESHT and East Sussex.

Improved End of Life Care that respects the wishes of patients and their families.

Improved transplantation rates across the UK - improving the health of patients awaiting transplants & reducing deaths of patients while on transplant list.

Risk & Implications: Missed referrals - potential for end of life care that does not respect patient's wishes surrounding organ donation.

COVID 19 pandemic has had a significant impact on Intensive Care capacity and staff work intensity – potential for increased missed referrals.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Quality & Safety Committee, 17th September 2020

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

Public awareness: It is very likely that with current restrictions in place national campaigns such as Organ Donation Week, held in September, will need to remain within the virtual domain. Ongoing communications support with appropriate social media content during these events would be advantageous.

Training: Focus for this year should be on the dissemination of information and training on deemed consent law for staff members. Training should initially focus on key areas including Emergency Departments, Acute Medical Units & Intensive Care which was delayed from the previous period due to COVID-19.

Wi-Fi access: Ongoing reports have been received from transplant teams and organ donation staff regarding lack of telephone signal and Wi-Fi in theatres especially at Eastbourne. This has the potential to significantly impact the donation process. Access to a trust Wi-Fi enabled device for the use by organ donation & transplant staff while on site would prevent further issues. This was reviewed last year but with the upgrade to the telephone system this has been delayed.

EXECUTIVE SUMMARY

1. Introduction

1.1. Recognition of a patient's wishes regarding organ donation and discussion with nominated representatives was highlighted as part of End of Life Care Pathways in the Department of Health End of Life Care Strategy, published in 2008.

1.2. The ESHT organ donation committee oversees policy, education and publicity to educate and support organ donation within ESHT and East Sussex.

2. Background

2.1. On the 29th February 2020 there were 6138 people on the active transplant list in the UK. Over the last year 394 patients in the UK have died whilst waiting for a transplant; 22 across the South East Coast.

2.2. In 2008 the Organ Donation Taskforce published 'Organs for Transplants' which set recommendations with the target of increasing deceased donor rates. By 2013 donation rates had increased by 50% with a 30.5% increase in transplants.

2.3. In 2013 The 'Taking Organ Transplantation to 2020 UK Strategy' was published. This built on the changes initiated in 2008. The aim of the strategy was to 'pursue consistently excellent practice in the care of every potential donor and maximise the use of every available organ'. The strategy was aimed at raising awareness of donation, increasing discussion with family members, consideration of organ donation as part of routine end of life care and improved transplantation processes including more sustainable training and development.

2.4. In England 80% of people support donation but only 38% have registered their wishes and this means families are often left with a difficult decision when a loved one dies. Following public consultation, the Organ Donation (Deemed Consent) Bill received Royal Assent on the 15th March 2019 and was passed in to law on the 20th May 2020. This means that all competent adults who are freely resident in England for >1 year will be considered as potential donors unless they specifically chose to opt out or are excluded. Under the law donation will still be discussed with families to ensure that the most up to date individual wishes are known and respected.

3. Main content

3.1. NHS Blood & Transplant Report 1st April 2019 to 29th February 2020:

During the report period, there were 11 families who consented to donation at East Sussex Healthcare NHS Trust. This resulted in 8 solid organ donors and lead to 13 patients receiving transplants. Of the 3 patients whose family kindly agreed to donation but in whom donation did not proceed, 1 was due to coroner refusal, 1 because of a prolonged time to death from withdrawal of treatment and 1 as they were subsequently deemed medically unsuitable by the recipient centres.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2019 - 29 February 2020

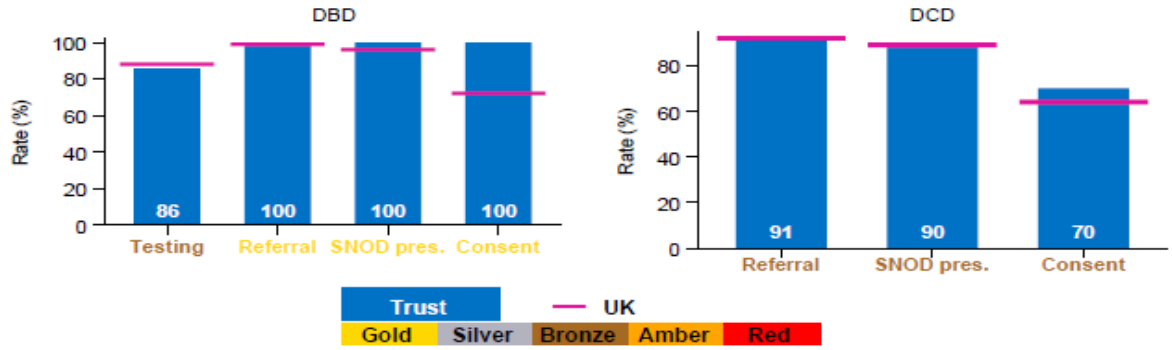


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2015 - 29 February 2020

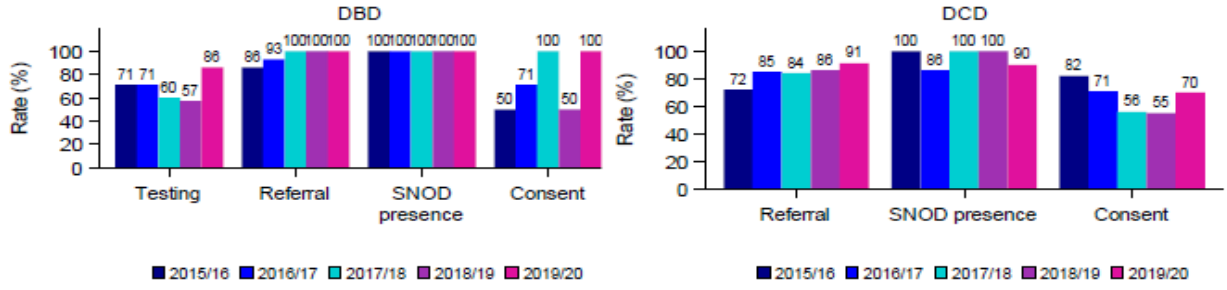


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2019 - 29 February 2020

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	7	1645	33	5676	39	7324
Referred to Organ Donation Service	7	1628	30	5235	36	6876
Referral rate %	G 100%	99%	B 91%	92%	B 92%	94%
Neurological death tested	6	1615				
Testing rate %	B 86%	88%				
Eligible donors[2]	5	1542	29	3985	34	5527
Family approached	4	1368	10	1712	14	3080
Family approached and SNOD present	4	1315	9	1528	13	2843
% of approaches where SNOD present	G 100%	96%	B 90%	89%	B 93%	92%
Consent ascertained	4	983	7	1099	11	2062
Consent rate %	G 100%	72%	B 70%	64%	B 79%	68%
Actual donors (PDA data)	4	876	4	598	8	1475
% of consented donors that became actual donors	100%	89%	57%	54%	73%	71%

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

3.2. Referrals & Missed Opportunities:

3.2.1. Referrals:

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135 and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors.

Of 7 potential Donation after Brainstem Death (DBD) donors, all patients were referred to the Specialist Nurse for Organ Donation (SN-OD). Of these patients 4 proceeded to donation. Of 33 potential Donation after Circulatory Death (DCD) donors, 30 patients were referred to the SN-OD and 4 patients proceeded to donation.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2015 - 29 February 2020

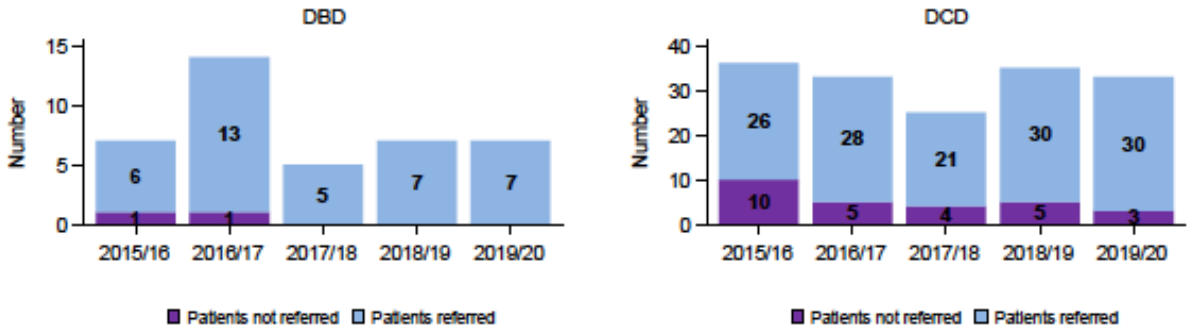


Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2019 - 29 February 2020

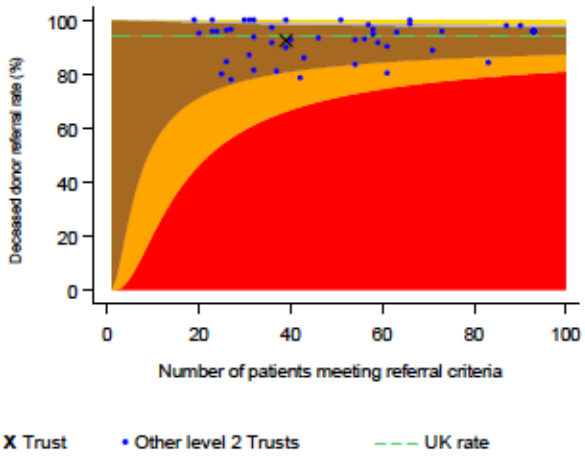
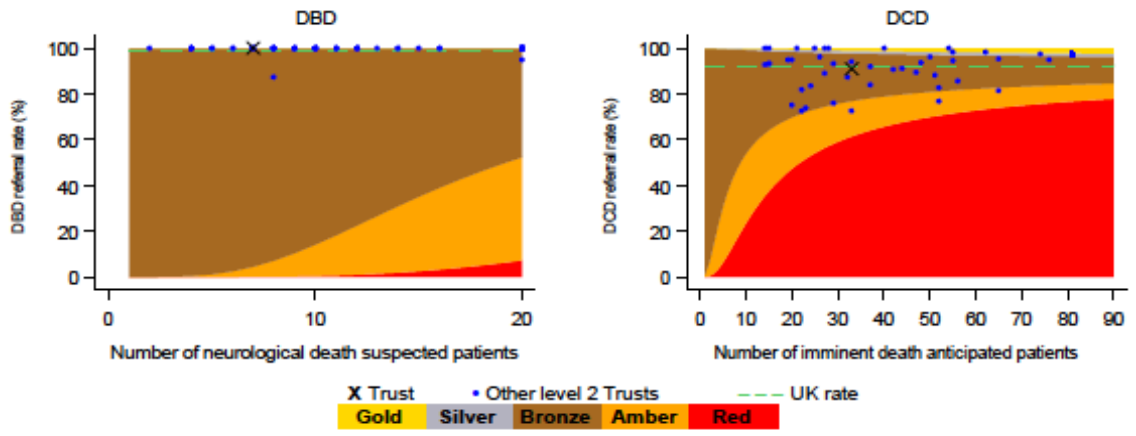


Figure 7.1 Funnel plots of referral rates, 1 April 2019 - 29 February 2020



The reasons for not referring patients have been explored. Only 1 patient was not considered for referral by the ICU team. Of the other 2 patients, 1 patient was referred but due to patient instability the complete details were not passed to the organ donation team and 1 was not referred due to previously expressed family wishes. Of the 3 missed referrals, only 1 patient would have been eligible to proceed to donation.

The number of patients not referred from ESHT has decreased from 5 in 2018-19 to 3 in this year. Changes made on ICU to reduce missed referrals include consideration of Specialist nurse referral and End of Life Care in the daily ICU safety huddle and increased awareness of the whole multidisciplinary team of the process of early notification.

3.2.2.Neurological Testing:

Goal: Neurological death tests are performed wherever possible.

Of 7 potential patients with suspected neurological death and potential for Donation after Brainstem Death, 1 patient did not have neurological death tests performed due to haemodynamic instability - this precludes testing.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2015 - 29 February 2020

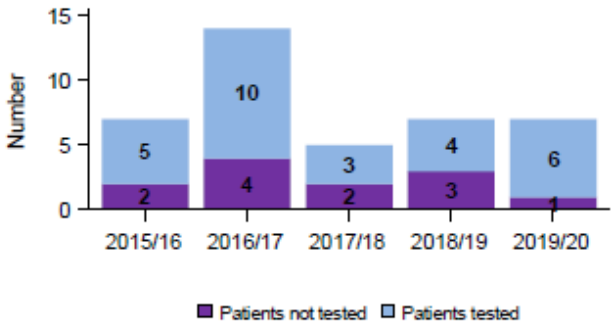
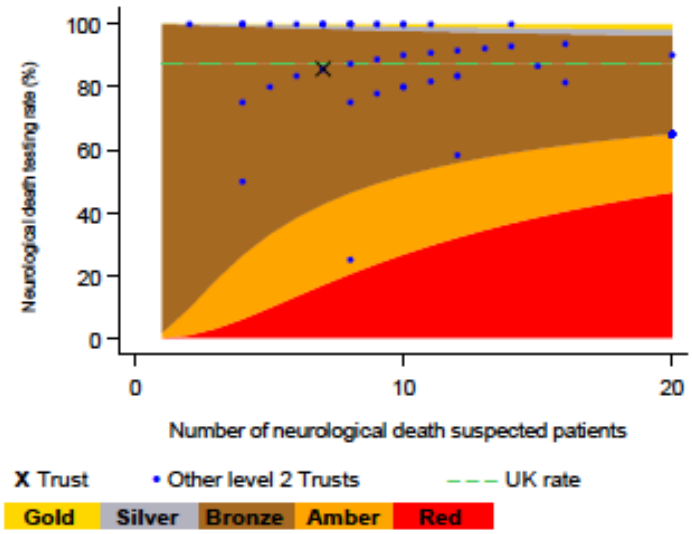


Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2019 - 29 February 2020



3.2.3.Specialist Nurse For Organ Donation presence:

Goal: A SNOD should be present during the formal family approach as per NICE CG135 and NHSBT Best Practice Guidance.

East Sussex Healthcare Trust had 100% SN-OD presence during formal family approaches to discuss donation following Neurological death. SN-OD presence was 90% during family approaches for donation after circulatory death. This represented a single family who due to personal circumstances actually approached the ICU team directly prior to the arrival of the SN-OD. The Specialist Nurse was involved in the case and discussed with the family at a separate time.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2015 - 29 February 2020

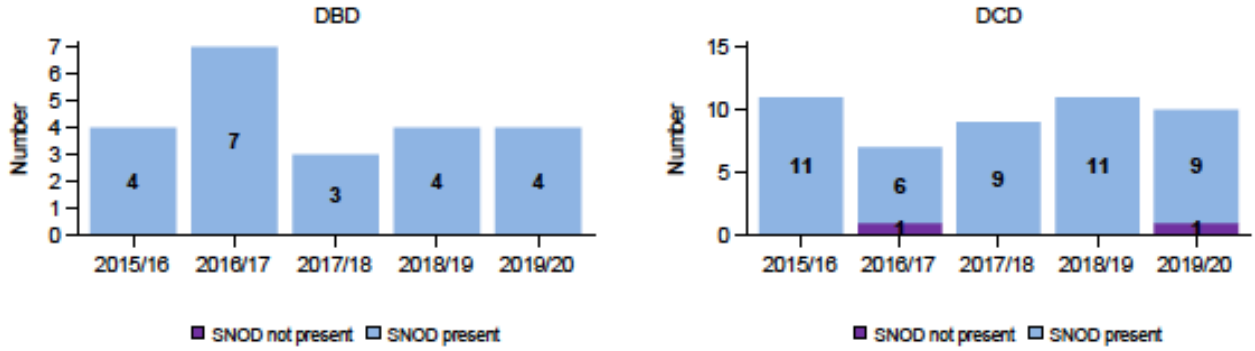


Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2019 - 29 February 2020

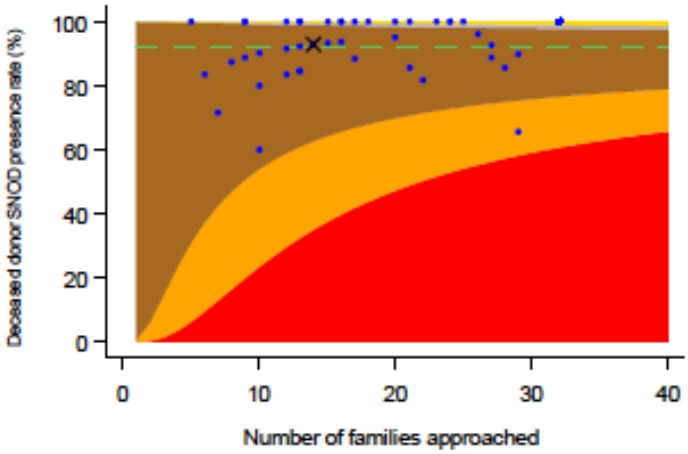
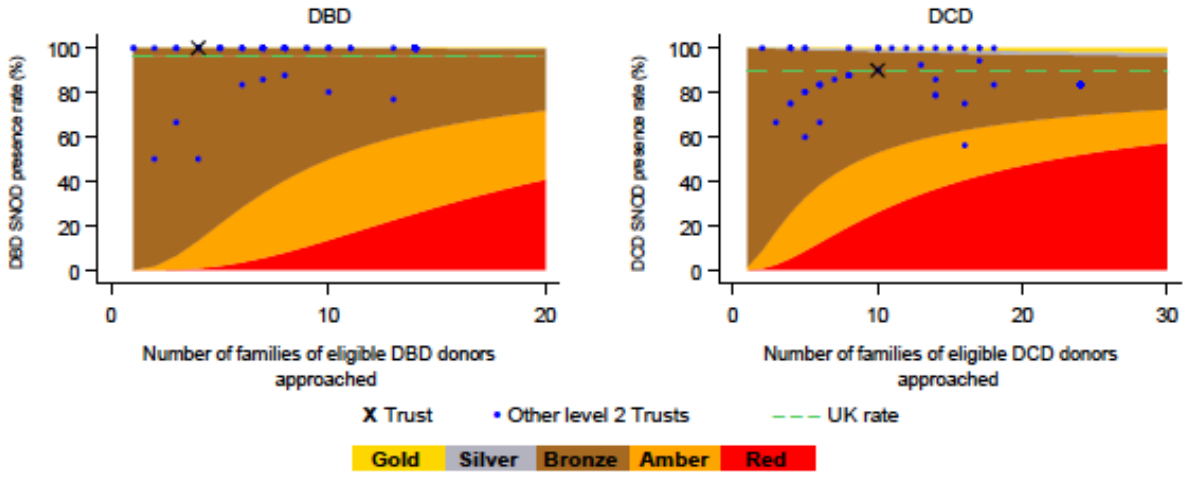


Figure 7.2 Funnel plots of SNOD presence rates, 1 April 2019 - 29 February 2020



3.2.4.Consent:

Goal: Agreed 2019-20 national targets for DBD & DCD consent/ authorisation rates are 83% & 77% respectively.

The DCD consent rate in ESHT was 70% with 7 families consenting to donation out of 10 approached. While this is lower than the national target, it is higher than the national average. The DBD consent rate was 100% with 4 all families consenting. The reasons for families to decline donation included being unsure if their relative would have agreed to donation, the process of donation taking too long and a previously expressed wish not to donate.

Figure 3.4 Number of families approached, 1 April 2015 - 29 February 2020

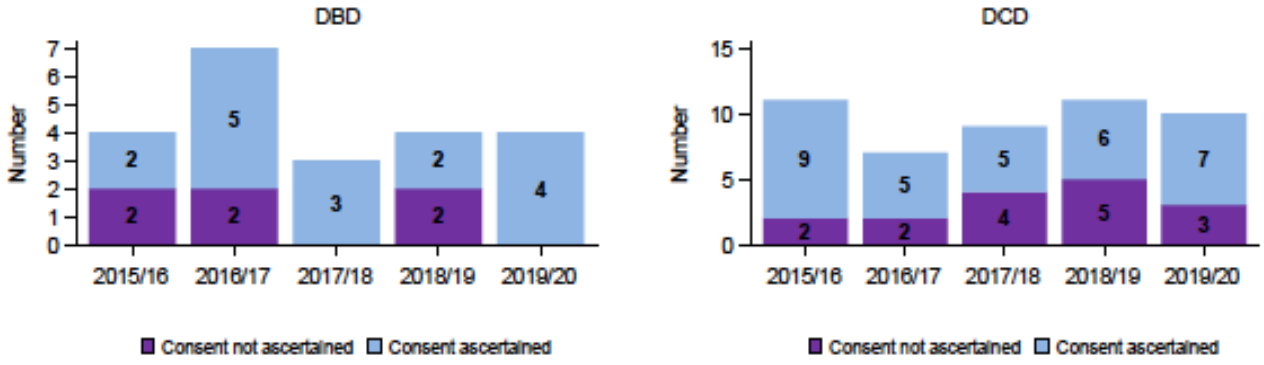


Figure 4.4 Funnel plot of consent rate, 1 April 2019 - 29 February 2020

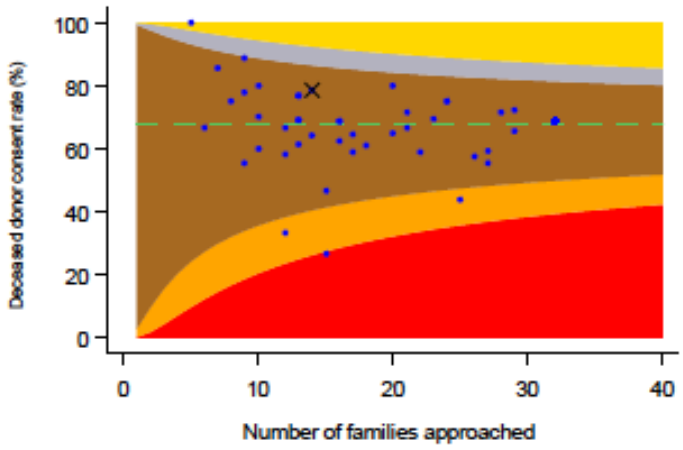
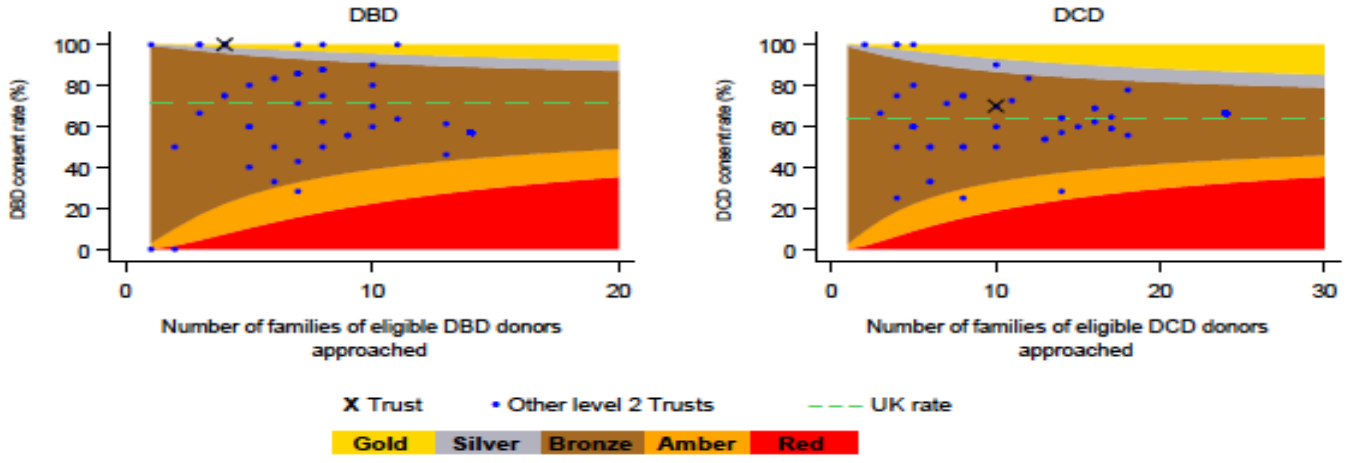


Figure 7.3 Funnel plots of consent rates, 1 April 2019 - 29 February 2020



3.2.5.Emergency Department:
Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.

In 2019-20 there were no patients referred from Emergency Departments and no recorded missed opportunities.

3.3. Training:
Training for Foundation Year doctors & the anaesthetic department in this financial year was arranged for February & March. Unfortunately due to the COVID 19 pandemic this training had to be postponed. Training has now been rearranged for the anaesthetic department & Foundation Doctors and will be carried out between September & December. This training will cover the changes to the law introduced in May 2020.

3.4. Finances:
NHSBT pays the trust 1PA for the Clinical Lead who is appointed following a joint interview process between the trust & NHSBT representatives and appraised annually by the regional CL-OD. The SN-OD position is also appointed by NHSBT. For each donation the trust receives funding from NHSBT to cover the costs of donation with residual funds used to improve the donor families experience, assist with education & publicity. The donor recognition funding has been calculated for 2019-2020 and the trust has been allocated £10,286 for the next financial year.

3.5. Publicity:
Over the last year the Organ Donation Committee has arranged local publicity to raise awareness of organ donation and the need for family members to discuss their wishes with Next of Kin. Events have included a stand at Eastbourne Airborne and in the foyer of the trust during National Organ Donation week in September – covered in the Eastbourne Herald. The planned NHS Blood & Transplant (NHSBT) national campaign to raise public awareness of the change in consent law has been scaled back since the outbreak of Covid-19. It is anticipated that further publicity will be possible during the next financial year but will need to be largely in the virtual domain and the local committee will guided by NHSBT.

4. Conclusions & Recommendations

4.1. ESHT has been categorised as a level 2 trust by NHS Blood & Transplant (NHSBT). This is based on the average number of donors proceeding each year and remains unchanged from the previous years.

4.2. Across the majority of domains there has been improvement in performance when compared to the previous year activity. The exception to this was specialist nurse presence for family discussions regarding potential for donation after circulatory death. This resulted from a family who approached the consultant directly. With the change in law and increased publicity this is an area where there may be more family led approaches in the future.

4.3. The number of missed referrals fell to 3, with 1 of these referrals initiated but not completed. With the involvement in the whole multidisciplinary team in End of Life care planning and Specialist Nurse notification it is hoped that these numbers will continue to fall.

4.4. Covid-19 has led to significant changes across the hospital. Notably organ donation has not been an available option for patients who died with confirmed or suspected coronavirus. The pressure on the organ donation teams & local clinical leads has led to a reduction in capacity for training.

5. References:

5.1. End of life care strategy (2008) Department of Health

5.2. Organs for Transplant – a report from the Organ Donation Taskforce (2008) Department of Health.

5.3. Taking Organ Transplantation to 2020. A UK strategy (2013) NHS Blood & Transplant & Department of Health.

5.4. NICE Clinical Guidelines CG135, 2011

5.5. www.nhsbt.nhs.uk

EAST SUSSEX HEALTHCARE NHS TRUST

AUDIT COMMITTEE

Minutes of the Audit Committee meeting held on Thursday 30th July 2020 at 1300 via Microsoft Teams

Present:
Mrs Nicola Webber, Non-Executive Director (Chair)
Mrs Jackie Churchward-Cardiff, Non-Executive Director
Mrs Karen Manson, Non-Executive Director
Mr Paresh Patel, Non-Executive Director

In attendance:
Dr Adrian Bull, Chief Executive Officer
Mr Damian Reid, Finance Director
Ms Saba Sadiq, Deputy Director of Finance
Mr Kevin Claxton, Head of EPRR
Mr Andy Conlan, Engagement Manager, Grant Thornton
Mrs Lisa Forward, Head of Governance
Mr David Kenealy, Fraud Manager, TiAA
Mr Giles Parratt, Audit Manager, TiAA
Mr Darren Wells, Engagement Lead, Grant Thornton
Mrs Hilary White, Head of Compliance
Mr Pete Palmer, Assistant Company Secretary (minutes)

Action

030/20 Welcome and Apologies for Absence

Mrs Webber opened the meeting. Apologies for absence had been received from:

Mrs Vikki Carruth, Director of Nursing
Mrs Lynette Wells, Director of Corporate Affairs
Mrs Emma Moore, Clinical Effectiveness Lead

031/20 Minutes of the meeting held on 23rd June 2020

The minutes of the meeting held on 23rd June 2020 were considered. Mrs Webber noted that Ms Williams had sent through a number of minor amendments which would be included.

Mrs Webber asked for clarification about a couple of issues in the minutes and asked that changes be made on page 2 and page 3. She noted that it would like the Trust's performance objectives to be tracked and presented to the Audit Committee in the same format as was found in the Annual Report. Mr Reid suggested that the Director of Strategy be asked to present a method for tracking corporate objectives which would allow the Board and its sub-Committees to fully understand how responsibility for doing this was delegated within the organisation. He noted that this was currently a responsibility set out in the Audit Committees' terms of reference, noting that these could be updated if this was being monitored elsewhere. **RM**

032/20 Matters Arising

Tenders and Waivers
This item was on the agenda for the meeting.

Data Quality
Mrs Webber asked about progress in arranging for a paper on data quality to be presented to the Committee. The description of what had been described on paper was not clear and it was suggested that it should be reworded for clarity due to this, and the amount of time that it had remained as a matter arising. It was noted that the matter was not related to the Quality Account, but instead related to assurance about the quality of data within the Trust.

Mr Parrott explained that an internal audit of data quality had previously been undertaken, with a further audit being discussed with Garry East. A framework looking at the risks associated with data had been developed and high priority areas for review would be identified. Mrs Webber noted that the outcome of the original audit had not been presented to the Committee and asked that Mr East and Mr Parrott present this at the next Audit Committee. **GE/GP**

033/20 Board Assurance Framework and High Level Risk Register
Mr Palmer presented the Board Assurance Framework (BAF) explaining that a new version had been developed following feedback from the Audit Committee and from internal auditors. Mrs Wells had reviewed over 30 BAFs from NHS organisations across the country and had discovered that there was no consistent approach being taken. The new style BAF included high level overviews of each risk, tracking how ratings changed over time and whether mitigations were effective. It also included the residual risk for each objective and enhanced detail of actions, timescales and details of associated risks on the Trust's risk register.

Each risk on the BAF included information about the lead director responsible for the risk, and the Committee at which monitoring of the risk would take place. Mr Palmer noted that the BAF had been discussed at that morning's Finance and Investment Committee where issues of how information would flow between the Committees and Board had been raised, as well as the form of presentation of risks on the BAF. Executives had agreed to review the risks and consider including higher level actions associated with the risks on the BAF. Mr Palmer noted that risk number nine, concerning cyber security was being monitored by the Audit Committee.

Mr Patel thanked Mrs Wells for her work in updating the BAF. He explained that a challenge remained in ensuring that updates about how risks were being managed were added to the BAF in a timely manner. Mr Palmer explained the process for updating the BAF, noting that the Executive responsible for each risk on the BAF provided updates on progress. The BAF underwent review by the Executive Team prior to being presented to Board Committees. Mr Patel suggested that it would be helpful if any updates to the BAF were highlighted, and explanations about why any targets might have been missed included.

Mrs Manson praised the new format, explain that she found it to be much

improved. She asked how the target risk level and risk appetite were assessed. Mr Palmer explained that the Board undertook a review of the BAF on an annual basis; this was due to take place at September's Board seminar. Dr Walker noted that many of the risks seen in the NHS were inherent to the business of the organisation and could only be mitigated. Many financial and staffing risks could not be eliminated and therefore had to be managed. Mr Reid noted that some of the target risks might be rated optimistically, as it was unlikely in some cases that the Trust would be able to achieve the levels set.

Mr Parrott reported that the new BAF had been shared with internal audit who had considered it be very encouraging. Feedback had been sent to Mrs Wells, and a formal first part review of the new document was planned in August.

Mrs Churchward-Cardiff noted that the risks included on the BAF were strategic in nature and would not be expected to change much over time. She explained that it would be helpful to discuss the process of escalating items from the Trust's high level risk register to the BAF at September's Board Seminar. Mrs Webber agreed that this would be useful. She suggested that the Risk Register might benefit from being updated in a similar manner to the BAF, as it could be hard to follow without good organisational knowledge, and some of the most recent updates to risks dated back a number of years.

Mr Patel agreed that refreshing the risk register would be helpful and asked whether it was possible to automate the process. Mrs Forward explained that the risk register underwent review by each division during the governance meetings. Historical risks where no new update was available were not updated until there was an update available. The entire risk register also underwent review at the Senior Leader's Forum. She agreed that older actions should be refreshed and agreed to meet with Mrs Wells and the Trust's risk lead to discuss the matter. She would also discuss whether the register could be simplified.

Mrs Webber asked the Committee if they were happy with the assurances set out for the cyber security risk on the BAF, noting that this was the only risk on the BAF for which the Audit Committee led. Mrs Churchward-Cardiff explained that she had a high level of assurance about actions taken recently, and was happy about how they were described on the BAF. Mrs Webber reported that the Committee had previously received reassuring reports about cybersecurity measures from the Digital team. She noted that Internal Audit had raised some concerns about gaps which should be incorporated as actions on the BAF. She explained that if the lead Executive for the risk was happy that actions detailed on the BAF would address issues raised by Internal Audit then this would be sufficient.

034/20 Clinical Audit Update

Mrs Forward explained that many national audits had been suspended during the pandemic. The only exceptions to this were the Child death database, MBRRACE-UK perinatal surveillance and ICNARC (adult intensive care) which were not paused. The Trust had continued to submit data to these studies during the pandemic. Information about when other national audits would restart was awaited. She explained that the clinical audit forward plan for 2020/21 had been completed prior to the pandemic,

but had not yet been implemented. The clinical audit team had been redeployed during the pandemic and were only just returning to their audit roles.

Mrs Webber asked for confirmation that items marked as overdue were not overdue as the programme had been paused. Mrs Forward confirmed that this was correct.

035/20 Declarations of Interest Update

Mrs White presented an update on declarations of interest. She explained that she had taken over looking after the process at the start of 2020 from Mr Palmer. The Trust had taken the decision not to renew its contract with MES in June and had instead moved to using ESR to manage declarations of interest. The new system had launched in June and had already seen 41.5% of staff having made a declaration or nil declaration by July. The total using the previous system for 2019/20 had only been 58%. Feedback indicated that staff were finding the new system easier. All positive declarations received would be reviewed once a month, with any issues escalated to the Executive Team. Local Counterfraud Services (LCFS) had undertaken a review of declarations of interest within the Trust and their report had just been received.

Mrs Webber praised the fantastic progress, noting that it was comforting that the new system was working well. She thanked Mrs White for her hard work. The Committee agreed that future reports on declarations of interest should come to the Committee by exception.

Mrs Sadiq asked whether managers received reports on compliance within teams and asked that guidance for how this could be checked within ESR be added to the intranet. Mrs White agreed to investigate whether this was possible. **HW**

036/20 Emergency Preparedness, Resilience & Response

Mr Claxton presented an update on Emergency Preparedness, Resilience & Response (EPRR) to the Committee. He explained that the pandemic had had a huge impact on EPRR within the organisation. The longevity of the pandemic meant that it was a very unusual incident, and it was still not clear what the long term effect would be on the organisation, particularly if a second wave of covid was seen. A debrief on the first wave had just been concluded and would be presented to the Trust's Recovery Board. EPRR training and exercises had largely been suspended during the pandemic, and the team was looking at how these could be reintroduced from September.

Mrs Churchward-Cardiff thanked Mr Caxton for the report, asking whether stopping incident training could be problematic if the Trust experienced a large scale incident. Mr Claxton explained that new members of staff continued to receive EPRR training, by video. It was hoped that major incident training would resume in September. He explained that the pandemic had highlighted issues with incident alerts and business continuity plans within the organisation and actions were being taken to address these areas.

Mrs Churchward-Cardiff asked whether business continuity should be linked to the Restoration and recovery programme within the Trust. Mr

Claxton explained that issues were discussed with divisions during IPRs. Some services did not have service level business continuity plans in place and this had been raised as a risk. The EPRR had planned to help teams address the issue, but had recently been focussed on the pandemic. Funding had been agreed for a new role to support divisions in developing business continuity plans, and business continuity champions would be nominated for each service.

Mrs Manson explained that she was pleased to see gaps in business continuity plans recognised, and asked whether an action plan had been developed to identify which areas should be prioritised, along with timescales for completion. Mr Claxton explained that the key areas had been identified as A&E and community services, and the target for completion of plans for these areas was within three months.

Mrs Webber acknowledged that progress that had been made, noting the importance of restoring training to previous levels as soon as possible. She explained that she was concerned about the way that Covid had prevented other EPRR issues being addressed, explaining the importance of robust business continuity plans, particularly as staff were redeployed around the organisation as a result of the pandemic. She explained that the Audit Committee was fully supportive of proposals to ensure that business continuity plans were in place throughout the organisation.

Mrs Churchward-Cardiff asked whether climate change issues would be embedded within Building for our Future (BFF) plans for the Trust. Mr Claxton explained that a new sustainability plan was being developed for the organisation; the current plan had been written in 2014. Aspects of this plan would be included within BFF.

037/20 Internal Audit

i. Progress Report

Mr Parratt reported that a number of final audit reports had been issued since the previous meeting, including three with limited assurance for cybersecurity, the BAF and business continuity. Actions from these audits were not included on the tracker as they were too recent. The audit plan for 2020/21 was presented, showing work in progress and in planning. Mr Parratt noted that auditors had been asked not to undertake the planned fire safety audit due to current pressures being experienced by the states team. He asked for suggestions for an audit to replace this and proposals for alternative audits were made, including the ESHT 2025 processes and BFF governance. Mr Parratt agreed to meet with Mr Reid to discuss the matter. **GP/DR**

Mrs Manson asked about the development of a data quality framework within the Trust and Mr Parratt explained that this had been developed in 2019, mapping key metrics particularly those included within Board reporting. These were risk assessed by reviewing the process for collating the data, and then assigned a risk process used to inform the internal audit plan. The other data quality audits looked at the integrity of the data in terms of completeness and accuracy.

Mrs Webber asked about the follow up appointment audit, noting that one of the findings had been that it could be difficult to identify from the existing

database whether triage of patients was taking place. Mr Parratt noted that the audit had been undertaken a few months previously, so the issue may have been resolved. Dr Walker acknowledged the issue raised by internal auditors about the follow –up database. He explained that throughout the pandemic period, clinicians had attended all patient tracking meetings to prioritise patients and assess when they required treatment. He felt that the process was working well, minimising the risks to patients. He explained that the lack of capacity to see patients in a timely manner due to the pandemic was a key issue; the majority of new patients needed to be reviewed in person and therefore virtual appointments only resolved some of the issues. He hoped that ongoing changes to how outpatient appointment were managed would resolve the issues.

ii. Status of Internal Audit Recommendations

Mr Parratt presented the audit recommendation tracker. The committee approved the items on the tracker marked for closure.

038/20 Local Counter Fraud Service Progress Report

Mr Kenealy presented the LCFS report. He explained that in the previous year 882 new starts in the Trust had received fraud training. Following feedback from the Audit Committee, the process for recoding this training was being amended to ensure more accurate records of the number of staff being trained could be maintained.

He explained that a lot of recent LCFS work had been related to the pandemic, with the team working remotely. This had caused issues with progressing investigations to the point of interview, but plans had been introduced to hold these remotely of in a safe face-to-face manner, ensuring that they remained admissible if necessary. Eight new referrals had been received since the previous meeting, and a large number of fraud alerts had been issued, with a number related to the pandemic.

Mr Patel asked about the eight new referrals and Mr Kenealy explained that more details would be provided to the Committee as investigations progressed. Mr Patel asked if there was a timeline and Mr Kenealy explained that reports were made once investigations progressed or closed. In some cases this would be a quick process, while in others the investigation could take a lot of time.

Mrs Churchward-Cardiff noted that concern had been raised within the NHS that there had not been value for money during the pandemic in procuring items. She anticipated that the Trust would be asked questions about their processes in the future. Mr Kenealy explained that LCFS had reviewed procurement processes as part of a thematic review, both during the pandemic and in the long term. Specific issues could be investigated if required. Mr Reid noted that prices for Personal Protective Equipment had risen during the pandemic, but no specific issues had been raised about fraud. Procurement processes had returned to normal in May 2020.

Mrs Webber asked for additional information about a referral received by LCFS concerning pre-employment checks, and Mr Kenealy provided an update to the Committee.

039/20 External Audit Progress Report

Mr Conlan presented the annual audit letter to the Committee, explaining that this was a prescribed process under the National Audit Office. The letter would be published on the Trust's website alongside the annual report. He noted that the deadlines for completing the annual audit of the Trust's accounts had been extended as a result of the pandemic. Teams had worked from home and alternative testing arrangements agreed. Grant Thornton had absorbed most of the cost of this change, but a small fee variation of £3,000 had been discussed and approved with the Trust. No increase to the fee for the audit of charitable fund accounts was anticipated.

040/20 Information Governance

Update

Mrs Webber praised and thanked the Information Governance (IG) team for their report, commenting that she had found it clearer than previous reports. She commended the IG team for continuing to pursue Data Protection and Security Toolkit standards even whilst these were not required due to the pandemic.

She asked about further information about a couple of incidents mentioned in the report, and Mr Reid agreed to asked the IG team for more information and circulate this by email to the Committee. **DR**

041/20 Tenders and Waivers

Mr Reid reported that reducing the number of tenders and waivers issued had been an area of focus over the previous couple of months. The Trust saw a higher level of tenders and waivers than local counterparts and was working to address this. Enhanced challenge from the procurement team was being seen, and the team was ensuring that tenders and waivers were only issued in line with the Trust's Standing Financial Instructions. Spot checks would be undertaken on waivers issued during May and June to ensure that alternative quotes were being sought whenever appropriate. Waivers issued where alternative quotes had been sought unsuccessfully would be clearly marked in future reports.

Mrs Webber explained that the Committee would ratify waivers that had been issued during month one, as these could not be thoroughly checked due to the retirement of the head of procurement. Those issued in months two and three should be presented in greater detail to the Committee before they would be ratified. Mr Reid reported that a full review of the waivers issued had already been started by the new head of procurement.

Mr Patel agreed with the suggested approach. He noted that the number of incidences where only one provider of goods or services was given as the reason for issuing a waiver seemed quite high. Mr Reid explained that this would be checked when the waivers were issued, noting that in some cases this would be due to only a single quote being received despite multiple companies being asked to provide quotes. He explained that there were occasions when only a single supplier offered consumables or servicing for existing medical equipment. Mrs Webber suggested that it would also be helpful to review waivers issued where clinical or technical preference was given as the reason for issue, to ensure that the reasons were valid.

Mr Patel asked what process had been undertaken for advisors for the Building for Our Future project. Mr Reid explained that the advisors had been selected using a tender process and agreed to provide full details of the process to the next Audit Committee. **DR**

042/20 Date of Next Meeting

The next meeting of the Audit Committee would be held on Thursday 24th September 2020 at 1300.

Signed: ……..

Date: ……

EAST SUSSEX HEALTHCARE NHS TRUST

PEOPLE & ORGANISATIONAL DEVELOPMENT (POD) COMMITTEE

Minutes of the People & Organisational Development (POD) Committee

Thursday 23 July 2020
10:00 – 11:00
Microsoft Teams

Present:
Miranda Kavanagh, Non-Executive Director (MK) – Chair
Monica Green, Director of HR (MG)
Dr Adrian Bull, Chief Executive (AB)
Dr David Walker, Medical Director (DW)
Mr Jamal Zaidi, Associate Medical Director – Workforce (JZ)
Mr Pravin Sangle, Associate Specialist (PS)
Dawn Urquhart, Assistant Director HR, Education (DU)
Penny Wright, Head of Workforce Planning (PW)
Lorraine Mason, Assistant Director of HR - OD (LM)
Jo Gahan, Head of Operational HR (JG)
Kim Novis, Equality & Human Rights Lead (KN)
Hazel Tonge, Deputy Director of Nursing (HT)
Sue Esser, Deputy Director of HR (SE)
Amanda Fadero, Non-Executive Director (AF)
Carys Williams, Non-Executive Director (CW)
Cassandra Blowers, Equality lead (EB)
Emma Chambers, Head of Midwifery (EC)
Imran Devji, Interim Chief Operating Officer (ID)
Joe Chadwick-Bell, Deputy Chief Executive / CEO (Elect) (JCB)
Mr Mark Whitehead, Director of Medical Education (MW)
Dominique Holliman, Speak Up Guardian (DH)
Richard Milner, Director of Strategy, Planning & Innovation (RM)
Liz Lipsham, Specialist Nurse, Occupational Health (LL)
Angela Collosi, Assistant Director of Nursing (AC)
Mr Waleed Yousef, Guardian of Safe Working (WY)
Lesley Houston, Deputy GM, Medicine (LH)

In Attendance:
Mrs Nicky Hughes, EA to Director of HR (NH) (minutes)

No	Item	Action
1	**Welcome, introductions and apologies for absence** The Chair welcomed all to the meeting and noted a quorum was present. Apologies for absence were received from: Jan Humber, Staff Side Chair Brenda Lynes, Associate Director of Operations (W&C) Damian Reid, Chief Financial Officer Lynette Wells, Director of Corporate Affairs Michelle Elphick, Associate Director of Operations (DAS) Vikki Carruth, Director of Nursing (VC)	

2.	**Minutes and Matters Arising**	
2.1	**Summaries of POD meetings for March and May 2020** The written summaries of the meetings scheduled for March and May 2020 were noted.	
3.	**Engagement and Culture update**	
3.1	LM provided a verbal summary of the revised approach to the Trust awards, a detailed update on the MA in Leadership Apprenticeship programme and an update on the Trusts approach to provide psychological support to colleagues following COVID-19. **Trust Awards** The plans for the Trust awards to be held in June 2020 have been postponed due to the COVID-19 pandemic. It was agreed that all staff that had been nominated for an award would be written to personally by the CEO to acknowledge their nomination. The staff member will also be invited to tell their story as part of the Chronicler project. AB referred to the Chronicler project that is currently being developed and reported that 18 Chroniclers had been trained in appreciative inquiry and were all developing stories for ESHT. The Chroniclers would each gather 10 narratives from members of staff pre-COVID-19 and their experience during COVID-19. This project would enable ESHT to have a documented legacy on how it responded, how it was set up to respond and the experience that people went through during COVID-19; the sharing of this information will be part of the appreciation events. Each division will have the opportunity of using the funding for the Trust Awards to hold their own event, which must adhere to Trust guidelines. JCB referred to corporate team staff who had been redeployed going over and above and asked if they had been included with the divisions where they have been redeployed. LM confirmed this to be the case. MK highlighted the importance of giving a personal touch and stated that she would be happy to be involved in any socially distanced events. LM confirmed that she would look at these opportunities and involve MK. All staff will receive a “Thank you” card signed by the Trust Board members along with a commemorative badge; a small gesture to thank staff for their contribution made during the COVID-19 pandemic; to be issued early September 2020. **MA through Henley Business School** The MA in Leadership programme with Henley Business School scheduled to commence in June 2020 has been postponed to November 2020 due to the COVID-19 pandemic. There are currently 44 members of staff signed up for the programme from a range of different professions. The programme has 3 key aspects: • Developing yourself as a leader • Leadership of the team • Leadership in the organisation	

The programme will include a range of different levels:

- The growth of the individual – academic progress to be tracked monthly
- The impact on the service and team they manage; a 360 review pre and post programme
- The impact on the Trust CQC well led domain

MK referred to the 44 cohort and asked whether there would be the opportunity for all leaders to undertake this programme when appropriate to do so. LM replied that 44 staff members each year would be considered if funding was available from the apprenticeship levy. In the future there will be a more systematic approach to identify staff members through the talent management process.

MK referred to Module 2, approach to business problems, and asked how business problems were chosen and if they are real life problems of the Trust. LM confirmed that the business problems would be linked to Trust initiatives; a small group would be convened to discuss and identify the approach to what those business problems will be.

Psychological Support for staff

LL provided a verbal summary of the Psychological Wellbeing of Staff Implementation Plan 2020.

Psychological Support

Therapists had been employed by Temporary Workforce to offer psychological support to teams; rationale behind it to prevent PSTD and burnout. Depression and anxiety scores are decreasing and resilience scores are increasing; scoring to be repeated in 6 months' time to ensure sustainability.

Mental Health First Aid Training

Two staff members have been trained to provide First Aid programmes in person and virtually. These programmes will be rolled out across the Trust from September 2020.

Formal Infrastructure around critical incident debrief

IT system for incident debriefs to be agreed for the Trust; it will take 6 months to embed this.

The main risks for the above interventions:

- Releasing teams and staff to have access to these interventions
- Funding IT systems will take some considerable investment
- IT and space

EC stated that the maternity department would be very interested in being involved and take part in the piloting of the IT system.

SE stated that divisional colleagues were being asked to ensure that all staff can access these interventions.

MK referred to the report and asked for further information regarding the psychological impact on NHS staff being one of the unknowns. LL provided an explanation that at Eastbourne DGH there has been a different experience; for one of the departments it has had quite a traumatic experience and staff are personally affected as well as being in red and green zones intermittently.

	AB highlighted the need to achieve the right balance providing support without triggering any anxieties. Debrief sessions as well as interventions are taking place in the most heavily affected areas of the Trust. There is also a need to ensure that everybody has the opportunity to reflect on their experience and decide for themselves and recognise that they need further support.	
4.	**Workforce Management**	
4.1	**Review of Workforce Response to COVID-19** SE provided a verbal summary of the COVID-19 actions, changes and achievements during the pandemic. HR, corporate areas and divisions have worked well together during this pandemic. SE offered her thanks to all the team that had contributed towards this paper. As a team there have been changes in roles undertaken; HR service continue with business as usual but have changed the way in which they have been working following the guidance from the government. Highlights of the report: • Questions and Answers prepared for staff; very proud of the comprehensive work undertaken • Redeployment office; over 600 staff redeployed rapidly at the beginning of the pandemic MK stated that the whole organisation had stepped up and HR had done a brilliant job in very difficult circumstances. MK asked how staff had reacted when moved back into their substantive roles. PW reported that many staff had really enjoyed the new roles with many wanting to stay. This opens the opportunity for divisions to re-shape their service. Once staff members had returned to their substantive jobs, a survey was sent to them asking for feedback. Good feedback was received stating that the support was comprehensive and fantastic; very positive. AB stated that there had been many letters from staff thanking the team to which they were redeployed to, the way they had been treated and welcomed into the teams. The redeployment was a positive experience for many staff members. JZ referred to the GMC survey for doctors, which asks about experience regarding training. JZ highlighted that many of the juniors had lost opportunities in terms of elective work due to the COVID-19 pandemic; the Deanery are aware that it has affected their training. AB reported that many doctors had asked to have an intercalated year with ESHT to make up their training experience and ESHT could offer this to the cohort of senior doctors in training to mutual benefit.	
5.	**Education and Development**	
5.1	**Education Strategy** DU provided a verbal summary of the Education Strategy, which sets out priorities for the next 5 years. The initial education milestone plan is for 1 year to be revised regularly; a dynamic document to incorporate future changes in education. The priorities will be measured; milestones for year 1 with additional external governance measures. DU referred the group to the key points and principle objectives of the plan.	

	DU highlighted the risks: • Inconsistent and outdated technology across both Education Centres. A bid had been submitted to support the upgrade for facilities. • There has been a significant number of changes to the funding of education; discussions underway. • Workforce challenges – introduction of new roles, securing a sustainable workforce, upskilling existing staff, new ways of working and creating compassionate and inclusive leadership. DU referred to the appendices at the end of the strategy and explained that they reflect career pathways and journeys. MK asked if the Executive Team had been part of the process in drafting this strategy. DU replied that she had been liaising with MG and an update briefing regarding funding challenges would be presented to the Executive Team. AB stated that last year the governance for the whole education and training regime had been reviewed enabling Executive input and oversight through the governance. AB stated that this was a really comprehensive, good and detailed document but did not set out the way that the new governance arrangements would ensure delivery. DU stated that improvements and addendums would be made to the strategy to ensure education governance was covered. MG thanked DU for the report and the comprehensive, important strategy, which will include identifying new roles to match the services requirements hence the commissioning of education to support those new roles. Description of career pathways and looking closer at retention in order that staff can develop and follow a career pathway. MK stated that the strategy was very comprehensive but felt there were too many priorities and asked if these needed to be scaled down or to be phased over time. DU recognised that there were quite a few priorities and agreed to reduce them further. MK stated that ESHT were lucky to have such a committed and enthusiastic team.	
6.	**Guardian of Safe Working Quarterly Report**	
	WY provided a verbal summary of the Guardian of Safe Working quarterly report for February to April 2020. WY explained that the report provides an update following the new intake of Doctors in Training since August 2019 to the Trust. There are 244 doctors at different grades of training for February, March and April. WY highly commended the Doctors in Training and all doctors across the Trust for their professionalism during the COVID-19 pandemic. Many doctors were faced with rotations cancelled, study leave cancelled, adjustment to their annual leave and redeployment to other areas of the Trust. Some opted to increase their hours of work and worked 1 in 2 weekends.	

	WY referred to the risks and stated that there had been some issues with communication from some departments in terms of letting the Doctors in Training know about changes to their contract and also change from surge rota to normal rota seeing an individual working 72 hours over a 168 hours period; the Guardians have taken this concern into consideration. WY highlighted that over all during the COVID-19 pandemic it had been a positive period. MK asked if the GOSW was flexible enough to allow for a completely unprecedented event on a scale of a pandemic with staff working extra hours and if so would it need any amendment. WY confirmed that contracts had been changed i.e. one of the areas was working weekends not more frequent than 1 in 3 but as a result of the pandemic some doctors were working 1 in 2 weekends. DW confirmed that whenever there is a level 4 major incident nationally, the organisation is able to make relevant amendments to staff working arrangements. DW stated that the doctors had all worked above and beyond the call of duty for people to keep safe and to keep the hospital running efficiently. DW confirmed that MW had written to all Doctors in Training to thank them for their effort during this time. MW highlighted that the Doctors in Training had enjoyed the experience and many wished to remain with ESHT. DU highlighted that 2 interim early FYIs doctors had appeared on BBC News and had stated that they received valued experience from ESHT.	
7.	**Items for Information:**	
7.1	**Workforce Board Report** MG referred the group to page 11 section 4 regarding risk assessments, which are required to be undertaken nationally for a certain group of staff that are listed vulnerable because of COVID-19. The process is being monitoring daily as well as the submission of figures, which is proving challenging to managers at the moment. These risk assessments are important around the safety and wellbeing of staff ensuring that ESHT is providing a safe working environment for everyone. MK asked what is done with the risk assessments. MG replied that appropriate workplace adjustments are made, discussion to take place between manager and member of staff, occupational health can offer specialist advice and adaptations to working pattern environment can be made. MK asked how long staff have to be undertaking risk assessments. MG stated that these are being undertaken to protect staff and are mandatory for staff that fall under the protected characteristics or are in any of the risk groups have a risk assessment. Risk assessments would also be undertaken or reviewed if there was any change to the working environment or individual circumstances. AB highlighted that ESHT were an outlier against other Trusts in terms of numbers recorded. SE stated that the criteria had changed, which made us an outlier but lots of work is being undertaken to increase compliance.	

8.	**Any other business**	
	MK asked for any feedback on the format of this meeting to be reported back to herself or MG.	
9.	**Next meeting of the POD Committee**	
	The next meeting of the POD Committee will take place on: **Thursday 03 September 2020** **10:00 – 11:00** **Microsoft Teams**	

Use of Trust Seal

Meeting information:			
Date of Meeting:	6th October 2020	Agenda Item:	15
Meeting:	Trust Board	Reporting Officer:	Chair

Purpose of paper: (Please tick)			
Assurance	☒	Decision	☐

Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☐
Staff	☐	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:			
Have any risks been identified ☐ *(Please highlight these in the narrative below)*		On the risk register?	

Summary:

1. ANALYSIS OF KEY DISCUSSION POINTS, RISKS & ISSUES RAISED BY THE REPORT

The purpose of this paper is to provide an overview of the use of the Trust Seal since the last Board meeting.

Sealing 52 – East Sussex County Council, 6th August 2020
Partnership Agreement for Health Visiting Services for 3 years.

Sealing 53 – Aramark Limited on 18th August 2020
Licence to carry out works on Ground Floor Café at EDGH

Sealing 54 – East Sussex County Council, 1st September 2020
Deed of Extension for Mortuary services until 31st March 2020

Sealing 55 – Wilmott Dixon Ltd, 15th September 2020
Construction delivery agreement for fire compartmentation at EDGH

Sealing 56 – Phoenix Software on 16th September 2020
Contract for provision of N365 digital licenses for 3 years +1 year +1year

Sealing 57 – H&A Munro, 25th September 2020
Lease of Unit 10, Wheel Farm Business Park, for provision of district nursing services for 6 years.

2. REVIEW BY OTHER COMMITTEES (PLEASE STATE NAME AND DATE)

Not applicable.

3. RECOMMENDATIONS (WHAT ARE YOU SEEKING FROM THE BOARD/COMMITTEE)

The Board is asked to note the use of the Trust Seal since the last Board meeting.