EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 12th October 2021 commencing at 09:30 via MS Teams

	AGENDA		**Lead:**	**Time:**
1.	1.1 Chair's opening remarks 1.2 Apologies for absence		Chair	0930 - 1015
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 10th August 2021	A		
4.	Matters Arising	B		
5.	Board Committee Chair's Feedback	C	Committee Chairs	
6.	Board Assurance Framework	D	ACS	
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	CND MD COO CPO CFO	1015 – 1130
9.	Winter Plans	Assurance	F	COO	
10.	Learning from Deaths Q4	Assurance	G	MD	

BREAK

GOVERNANCE AND ASSURANCE

					Time:
11.	Annual Reports for noting: • Health and Safety • Infection Control • Organ Donation	Assurance	H	Various	

ITEMS FOR INFORMATION

				Time:
12.	Use of Trust Seal	I	Chair	1215 - 1230
13.	Questions from members of the public (15 minutes maximum)		Chair	
14.	Date of Next Meeting: Tuesday 9th December 2021		Chair	

Steve Phoenix

Chairman 16th September 2021

Key:	
Chair	Trust Chair
CEO	Chief Executive
ACS	Acting Company Secretary
CND	Chief Nurse and DIPC
COO	Chief Operating Officer
DCA	Director of Corporate Affairs
DEF	Director of Estates and Facilities
DS	Director of Strategy
CFO	Chief Financial Officer
CPO	Chief People Officer
MD	Medical Director

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 10th August 2021 at 09:30 video conference via Microsoft Teams

Present: Mr Steve Phoenix, Chairman
Mrs Jackie Churchward-Cardiff, Vice Chair
Mrs Joe Chadwick-Bell, Chief Executive
Mrs Tara Argent, Chief Operating Officer
Mrs Vikki Carruth, Chief Nurse & DIPC
Mrs Karen Manson, Non-Executive Director
Mr Paresh Patel, Non-Executive Director
Mr Damian Reid, Chief Finance Officer
Mrs Nicola Webber, Non-Executive Director

Non-Voting Directors:
Mr Steve Aumayer, Chief People Officer
Mrs Amanda Fadero, Associate Non-Executive Director
Mr Chris Hodgson, Director of Estates and Facilities
Mr Richard Milner, Director of Strategy, Inequalities & Partnerships
Ms Carys Williams, Associate Non-Executive Director

In attendance:
Mrs Kim Novis, Head of Equality, Diversity & Inclusion (Patients), Kent Community Health Foundation Trust (for item 053/2021 only)
Dr James Wilkinson, Deputy Medical Director
Mr Peter Palmer, Acting Company Secretary (minutes)

047/2021 **Welcome**

1. Chair's Opening Remarks
Mr Phoenix welcomed everyone to the meeting, noting that Dr Wilkinson was attending in place of Dr David Walker.

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

Mrs Miranda Kavanagh, Non-Executive Director
Dr David Walker, Medical Director
Ms Lynette Wells, Director of Corporate Affairs

048/2021 **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 Chair noted that no potential conflicts of interest had been declared.

049/2021 **Minutes**

The minutes of the Trust Board meeting held on 8th June 2021 were considered and agreed as an accurate record. The minutes were signed by the Chair and would be lodged in the Register of Minutes.

050/2021 **Matters Arising**

There was one matter arising from the meeting on 8th June, for the Trust's recovery plan to be presented to the Board. This was included on the meeting's agenda.

051/2021 **Board Committee Chair's Feedback**

i. Audit Committee

Mrs Webber reported that the Audit Committee had met on 29th July 2021, as well as in June, where the annual accounts and annual report had been approved. July's meeting had received an update on cybersecurity in the Trust, where progress on cyber-maturity in the Trust had been discussed. An Emergency Preparedness, Resilience and Response (EPRR) update had been presented, and an update would be brought to the Board in the future. Mrs Argent noted that a peer review of EPRR was due to take place on 19th August, and resources would be considered following this.

An update on tenders and waivers, the BAF and High Level Risk Register and updates from external and internal auditors had been presents. The counterfraud update had been received and the Committee had asked for the resumption of training in areas of high risk.

The Board noted the report.

ii. Finance and Investment Committee

Mr Phoenix reported that the Finance and Investment (F&I) Committee had met on 29th July 2021, where financial performance highlights had been reviewed. The Trust had remained on track to meet its financial targets in month 2, but there were some significant risks noted. The five year strategic plan had been discussed and was on the agenda for the Board meeting. Division's business plans on a page had also been reviewed, along with a number of business cases.

The Board noted the report.

iii. People and Organisational Development Committee

Mr Aumayer reported that there had been two meetings of the People and Organisational Development (POD) Committee since the last Board meeting, with the last having taken place on 22nd July 2021. The introduction of new workforce analytics and planning tools, ensuring that future workforce decisions in the Trust were supported by data, was reviewed. The ongoing organisational focus on the health and wellbeing of staff was discussed, including agile working and space utilisation. The results of a workforce survey were presented

to the Committee, ensuring that the views of staff on different ways of working were considered in future plans, and an update on the Trust's People Strategy was received. The Committee discussed the national changes to the education contract with the Health Education England, noting that the matter was being managed at ICS level.

The terms of reference for the Committee had been reviewed and the Committee would be meeting on a bi-monthly basis moving forward with an alternating focus on performance and strategic issues.

The Board noted the report.

iv. Quality and Safety Committee

Mrs Churchward-Cardiff reported that that there had been two meetings of the Quality and Safety (Q&S) Committee since the last Board meeting, with the last having taken place on 22nd July 2021. She explained that falls had been an area of focus for the Committee for some time, and an update on progress had been presented. The story of a patient who had suffered a brain injury had been presented, and the Committee had endorsed a region wide approach to the management of Acute Brain Injuries. The Infection Control Board Assurance Framework had been received, and the operational pressures of managing small numbers of patients with Covid patients had been discussed. A pharmacy review of integrated care received, and the Committee was assured that issues raised were being addressed.

The Board noted the report.

Mr Phoenix noted that a refresh of Chairs of the Board's sub-committees was taking place. He thanked Non-Executive colleagues for the hard work they had done in chairing the Committees, and those who were taking on the chair of committees.

052/2021 **Board Assurance Framework**

Mr Reid presented the Quarter One update to the Board Assurance Framework (BAF) explaining that it had been reviewed by Executives and at each of the Board's sub-committees. Five risks had been added to the BAF during the quarter, and the scores of three of the areas had been adjusted, recognising that the risks associated with Covid had decreased, and increased concern about the Trust's H2 financial position.

Mrs Webber asked whether, following discussion by the F&I Committee, the financial risk included on the BAF had been adjusted. Mr Reid explained that the rating remained the same, but as further information about the available funding became available the rating would be reviewed and discussed with F&I. Mrs Webber asked whether the Trust's Cost Improvement Plan (CIP) for 2021/22 had been agreed. Mr Reid explained that robust CIPs had been identified to date, but that this would be harder moving into H2. Good engagement was being seen with divisions and corporate services to further develop plans for the remainder of the year. Mrs Webber noted that BAF9,

concerning cybersecurity, had been discussed by the Audit Committee and noted that the risk rating was unlikely to materially reduce before 2023.

Mrs Fadero noted that BAF5, concerning protecting staff, had been discussed by POD and asked about how violence and aggression (V&A) issues were being managed in the Trust. Mr Aumayer explained that V&A was a key area for both himself and Mrs Carruth, and they had reviewed the focus of the Trust's V&A workgroup to ensure that it was correct. A sub-group was being set up focussing on V&A against staff, as it was recognised that there were issues that needed to be addressed. He noted that the results of the recent staff survey had highlighted some issues. Work was being undertaken with staff networks to identify mechanisms of support for staff with protected characterises, and any areas of concern were identified and work undertaken to address concerns and provide support for staff. Work was also being undertaken in conjunction with the Trust's Speak Up Guardians, and the issue would remain high on the Trust's agenda.

Mrs Churchward-Cardiff asked about whether BAF6 should include a risk highlighting the emerging cost pressures being seen in the Trust. Mr Reid explained that costs pressures were a major concern moving into H2. The recent quality review of staffing had included a 2% increase, and work to return the Trust to a full establishment had further increased financial pressures against a baseline that had been set two years before. The Trust was looking to achieve 2% savings through CIPs in H1, and 3% in H2 in order to address these pressures, which would be reflected in the BAF moving forward.

Mrs Churchward-Cardiff asked whether a decision had been made about top-up Covid vaccines. Mr Aumayer explained that an announcement was anticipated soon at system level setting out the approach that would be taken to top up vaccines. He anticipated that a program might begin in September, and would share details when available.

Mr Patel asked whether any additional information had been received about the funding that would be available to the Trust in H2 2021/22. Mr Reid explained that limited guidance had been published, which included increased performance targets expected for months 4-6 of the year. The continued management of Covid in the organisation meant that delivery of these targets was challenging. He anticipated that the draft H2 allocation for the Trust would be published at the end of August.

Mr Patel asked whether the lack of information was affecting CIP targets. Mr Reid explained that the organisation had set a challenging 3% organisational CIP target in anticipation of the potential funding that would be made available. £3m of CIPs had been identified, against a total of £10m for the year, with work ongoing with divisions to identify the remainder. Additional work, including benchmarking, would be used to identify areas of focus for the organisation. The ICS would be monitoring delivery of savings across the system.

053/2021 **Chief Executive's Report**

Mrs Chadwick-Bell presented a verbal update, noting how busy the organisation was and explaining that the Trust continued to prioritise recovery or performance and the treatment of patients with Covid. Urgent care services were particularly busy, but the Trust was ensuring that that staff were able to take annual leave. Reducing numbers of patients with Covid were being seen in the Trust with 17 patients currently in hospital, and continuing daily admissions. During the first wave the peak had been around 75 patients, in the second wave 225, while the peak in the third wave had been 30 patients. The Trust continued to maintain red, amber and elective pathways separating patients out; this caused operational, financial and staffing pressures, but maintained the safety of patients.

She thanked the Trust's staff for their continued hard work, noting that teams throughout the organisation, including back office, support and leadership teams were working above and beyond their duties during the pandemic. It was important to continue balancing the delivery of services with ensuring that the organisation remained sustainable moving forward, and organisational objectives had been developed which would be discussed at the AGM that afternoon.

Mrs Fadero asked how measures to support staff were being utilised and Mrs Chadwick-Bell explained that different staff wanted to be supported in different ways, so the Trust had a variety of initiatives in place. It was important that staff took their annual leave; the wellbeing of staff was a key priority for the organisation, and would lead to better care for patients. Mr Aumayer noted that a number of interventions were being offered for staff that were closer to their time of need. A large number of mental health first aiders had been trained to recognise signs of stress in colleagues, stress assessments were being undertaken in areas of high pressures and TRiM was being delivered across the organisation. Executives were buddying with some high risk areas to allow informal conversations and support to take place. The introduction of health and wellbeing champions to act as role models was also being discussed.

Mrs Chadwick-Bell explained that there would be an increased focus at ESHT, and across the NHS, on eliminating health inequalities and ensuring that patients were not disadvantaged in how they could access health care. She introduced Mrs Novis, who had previously worked as Head of Equality and Diversity at ESHT. While working for the Trust, Mrs Novis had begun development of an innovative British Sign Language (BSL) app, and had continued supporting this since moving to a new organisation.

Mrs Novis explained that Covid had exacerbated existing health inequalities, and deaf people had been particularly affected by this, experiencing issues with virtual and phone appointments, and miscommunication of information. BSL was very different language from English and there was a common misconception that they were the same; it could be challenging for deaf people to find understandable information, and the app had been developed to provide a library of reliable information for deaf patients. A grant to allow the app to be

developed had been received from NHS Charities Together.

The app provided a variety of information in BSL, including covid information, patient leaflets, a medicine and healthcare terminology (which had been provided by Great Ormond Street Hospital), the ability for users to provide feedback, and for users to subscribe in order to receive urgent information and updates. The second phase of development would include video subtitles, and the ability to leave feedback in BSL, and it was hoped would also allow patients to change appointments and book interpreters in the future.

The development of the app had been undertaken by Amazon Web Services, who had been very supportive. They had invited Mrs Novis, colleagues and some deaf users to visit them to film a vlog to further promote the app. Mrs Novis hoped that other Trusts would use the app moving forward, allowing costs and resources to be pooled. A steering group was being put introduced to oversee future development of the app, to quality check the information included and to identify future funding opportunities. There was lots of national interest in supporting the app. She thanked Lynette Wells, Pete Palmer and Shanice Novis for their support during the development of the app.

Mrs Churchward-Cardiff praised the innovative app, noting that it would be beneficial for deaf patients and for outpatient services in the Trust. Ms Williams agreed, thanking Mrs Novis and explaining that she liked the digital patient first approach that had been taken in developing the app. Mrs Chadwick-Bell thanked Mrs Novis for all her hard work on the app, explaining that it was a incredibly exciting project which would look to reduce inequalities and ensure that more patients could access the Trust's services in an equal manner.

Mr Phoenix explained that he thought that the project was fantastic. He asked that Mrs Novis present an update on the app to the Board in the future, and thanked Mrs Novis for her work on the project.

The Board noted the Chief Executive's Report.

054/2021 **Integrated Performance Report Month 3 (June)**

i. Quality & Safety

Mrs Carruth reported that hospital Covid numbers had reduced since the time of writing the report, with numbers in Eastbourne and Hastings below national rates. It was anticipated that small, steady numbers of inpatients would continue to be seen for some time, which would create clinical and operational challenges for the Trust.

An increase in the number of clostridium difficile infections had been seen in May and June, before numbers stabilised in July and August. There was no clear reason for the increase, but this was being closely monitored. A slight increase in the rate of falls had been seen in June, but quality improvement work continued and Q&S had received an excellent presentation from matrons about work taking place in the Trust to address falls.

A review of response times to complaints had been requested as the team was not fully staffed and there was a post-Covid backlog that was being addressed. Fill rates for nursing staff had remained largely stable in June, but the Trust continued to have significant amounts of escalation capacity open which created pressure on staffing.

Mrs Webber asked whether there were any risks to the commencement of the Patient Safety Incident Response Framework (PSIRF). Mrs Carruth explained that the PSIRF formed part of the NHS Patient Safety Strategy and an update would be presented at the next Q&S Committee. This represented a significant change to incident investigation and the approach to patient safety in the NHS, with a greater focus on human factors, culture and how lessons were learned. It was a big piece of work for the Trust, and it was possible that additional resource would be required to implement it.

Mrs Webber noted that the Care Hours per Patient Day (CHPPD) data reported ESHT at ten hours compared to a peer figure of nine hours per day. Mrs Carruth explained that the data being reported was from April, where the after-effects of Covid were still being seen. ESHT had had a very different experience to other local Trusts during the second wave of the pandemic, and this had had a longer impact on the workforce. The comparative figures would be monitored moving forward. Mrs Webber suggested that it would be helpful to include a peer benchmark line in future IPRs to enable this to be easily monitored.

JW – mortality indicies, apart from in Jan and Feb when in peak of covid, have remained significantly better than national average, although they rose substantially. RAMI in November was 86, December 102. Subsequently declined and now back in best quartile in the country for RAMI, SHMI and HSMR. SHMI had reduced further to 96%, despite the pandemic. A lookback exercise to identify what lessons could be learned from second wave of covid was being undertaken. Overall care given by the Trust was good, reflected in rapid normalisation of mortality indices.

ii <u>Access and Responsiveness</u>

Mrs Argent reported the Trust had over-delivered against its elective recovery trajectory during the first quarter of 2021/22. The Trust had been one of the top three in the region for patients with a 40+ week TCI. Emergency Departments remained very busy and an increase in the acuity of presentations had been seen. Despite this, the Trust had delivered 86.2% performance against A&E targets and remained in the upper quartile of performing trusts nationally.

The Trust was working with system partners to promote the Urgent Treatment Centre (UTC) as an alternative for patients to receive treatment, alongside other options for patients including pharmacies and opticians. A recent peer review of EDs had been impressed by the enthusiasm of staff was, the openness of the organisation and the willingness to embrace service change. Work to improve patient flow in order to improve throughput continued.

Achieving the DM01 diagnostic recovery target remained a challenge, with activity now returned to pre-pandemic levels. The Trust had funded additional endoscopy capacity which would lead to reduced waiting times for patients, and therefore improved diagnostic and cancer performance. There would be a focus on patient discharge over the coming weeks, with bed availability impacting on the length of stay for patients.

Mrs Churchward-Cardiff noted that the work being done to look at non-admitted and non-elective patients and cancer performance was commendable. She was concerned about elective performance, given the size of the waiting list, staffing and winter pressures and the need for additional beds due to Covid. Once winter arrived, delivery of elective performance would become even hard, and she noted the threat of the Trust's theatre staff being recruited by private practices offering higher salaries and other incentives. Mrs Argent explained that the Trust had recently seen an increase in trauma patients, leading to a reduction in the amount of elective activity that could be undertaken. The Trust was working with the independent sector to get support, and was looking at how waiting lists could be managed innovatively, alongside work on theatre productivity. Issues with community capacity could lead to post-operative rehabilitation pressures, so it was important to look at the complete patient pathway.

Mrs Churchward-Cardiff when it was anticipated that waiting lists for diagnostics would reduce to pre-pandemic levels and Mrs Argent anticipated that this would take 32 weeks, although the timescale was different for different modalities. Diagnostic patients were being prioritised based on clinical need. She explained that it would take at least 18 months to for performance to recover fully, and further waves of Covid could extend this.

Ms Williams asked about the impact of e-job planning and roster completion rates on performance. Mr Aumayer explained that the rosters were planned six to eight weeks in advance, but the Trust was dealing with rapidly changing capacity and delivery requirements. Site teams monitored staffing on a daily basis and did a wonderful job in ensuring that the demands of additional capacity were met when required, but this meant that approving rosters at an early stage was challenging. Medical staff were also working flexibly to meet demand. Mrs Carruth acknowledged the importance of completing rosters in a timely manner to give the best possible chance of identifying and filling gaps where they appeared, noting the importance to staff to know when they would be working.

Dr Wilkinson explained that the trainees and other non-consultant medical staff had worked incredibly hard during the pandemic to maintain staffing levels while absences due to sickness or isolation had taken place. There had been an enormous amount of adjustment required, but acute medical coverage had been maintained without interfering with elective performance.

Mrs Fadero noted that it had been a phenomenally busy time for the Trust, and

recognised the difficulties of managing the pressures being seen in the NHS. She asked about the benefits and risks of partnership working to the Trust's recovery plans. Mrs Argent explained the oversight systems in place across the system that provided confidence that plans made by the Trust that involved other providers (including discharge to assess beds, GP provision for UTCs and the 111 service) would be protected. The risks involved were shared by all of the partners in the local healthcare system.

Mrs Webber asked that consideration be given when compiling the IPR making it more accessible to readers with a non-NHS and clinical background. She explained that highlighting key headlines from the report would be very beneficial as it was difficult to identify key risks and achievements from the large amount of data being presented. Mrs Chadwick-Bell explained that process changes for the IPR were planned, which would include improving the narrative provided in the document.

iii Leadership and Culture

Mr Aumayer reported that staffing pressures were no longer predominantly due to Covid, with only 11 staff 'pinged' in the previous week. Vacancy rates had increased slightly to 5.5%, but had been 9.9% at the same time the previous year. Turnover was 10.1%, compared to 10.7% the previous year but had increased slightly and was being monitored. Sickness rates remained consistent, but were up slightly compared to the previous year. Long term sickness, particularly as a result of Musculoskeletal issues was an area of particular concern and work was being undertaken with the Occupational Health, Physiotherapy and Moving and Handling teams to address this. Anxiety and stress were other key areas where additional support for staff was in place. Refreshments and food for staff who continued to have to wear PPE had been reintroduced.

New junior doctors had been welcomed to the Trust in the last couple of weeks, and good interest was being seen in nursing and medical roles in the Trust. Recruitment challenges remained in some areas, both locally and nationally. He thanked the Trust's amazing staff for the way in which they continued to deliver services in a difficult time.

Mrs Churchward-Cardiff asked whether anything could be done to shorten the time taken to recruit staff. Mr Aumayer explained that there was an ongoing piece of work to look at this issue. The recruitment process was relatively efficient, but a large part of the time was due to the notice period new starters had to give. The recruitment team worked with candidates to shorten this and proactively identified any other issues which might hold up the process. Mrs Churchward-Cardiff noted the importance of being aware of what the independent sector might be offering to tempt staff to leave the Trust; Mr Aumayer agreed, explaining that it was important that NHS organisations worked with each other to recruit to challenging areas.

Mrs Manson asked whether more could be done to support and motivate staff ahead of winter. Mr Aumayer explained that staff would be thanked for their

efforts in a number of different ways. The pressure being seen was the new reality for the NHS and would not be over soon, so conversations were taking place about different ways of working that would allow the Trust to adapt. Plans included looking at the way leave was planned to smooth this out across the year, looking at operational excellence in rostering and ensuring that teams felt well supported, with the right number of staff at the right time.

iv Finance

Mr Reid presented the month three financial results, which showed that the Trust had exceeded its planned income by £2.3m, mainly due to additional Elective Recovery Fund (ERF) income due to over-delivery in the first two months of the year. Over-delivery against targets would become more challenging as the year progressed. The previous year's claim for Covid expenses was being scrutinised, and he anticipated that a further claim of around £6m would be submitted for Covid costs.

The Trust's cash position remained good. The Trust's capital plan for 2021/22 was £10m tighter due to ca number of capital plans not having been delivered at the end of the previous year. A revised Trust two year capital plan had been developed which would be shared with the ICS. Divisional financial results had been affected by the Trust's plans to hold recovery funding centrally, but it had been agreed that from month four this funding would be transferred to divisions to allow them to accurately monitor progress. A small element of funding was indirectly driving individual recovery work, and this would continue to be held centrally.

Mr Reid anticipated that the Trust's financial position would become more challenging as the year progressed. Returning to a full establishment, and the management of cost pressures would need to be carefully managed, alongside the full delivery of a CIP plan of £10m for the year. Plans would be finalised once the budget for the second half of the year was known.

Mrs Webber noted that the Trust's run rate was reliant on Covid funding to break even, and asked whether there was a risk of a gap emerging as Covid funding reduced. Mr Reid explained that restructuring was taking place that would reduce the number of staff related to Covid in April; costs would be carefully tracked moving forward. The region was carefully monitoring Covid related claims, so it was important that the Trust maintained an accurate and consistent approach to submitting costs.

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

055/2021 **Trust Elective Recovery Plan**

Mrs Argent presented the Trust elective recovery plan, noting that the system recovery plan had been presented at the previous Board meeting. The Trust had received planning guidance for recovery it's elective position and had agreed recovery trajectories, which had been submitted via the ICS. Significant progress had been made in meeting these targets, and the Trust was ahead of its trajectory for cancer recovery. There were no patients waiting for more that

78 weeks for treatment, and significant progress was being made with the 104 week target. Plans for the recovery of cancer performance had been made in order to achieve this in a sustainable manner; some reluctance was being seen in patients for starting treatment, particularly if they had a holiday booked, which could affect performance.

The Trust had over-delivered against the national elective trajectory in the first quarter. As a result of this performance, the Trust's target had been changed to 95 moving forward, and it was important that the Trust and the system continued to deliver against targets. 90 patients had waited for more than 52 weeks for treatment, with 56 now having a date set to come to hospital.

Mrs Chadwick-Bell explained that recovery trajectories had been submitted based on information available at the time. Recovery plans continued to be updated as circumstances changed. The Trust was doing incredibly well when compared to other organisations nationally, and she commended Mrs Argent and the operational teams for how well they were managing a very difficult environment.

Mrs Churchward-Cardiff commended the performance of the Trust, and asked if there were any services where there was particular pressure on waiting times due to the pandemic. Mrs Argent explained that trauma and orthopaedic waiting times were being managed with the help of the independent sector, ENT was being managed with a single waiting list across the system, and work was being undertaken to manage high volume low complexity workstreams which would allow day case procedures in large numbers to be quickly addressed. Breast surgery was being managed by the system, as staff sickness was contributing to waiting times. Chief Operating Officers across Sussex were working closely to identify and address issues as a system as they arose.

Mrs Manson thanked TA for the assurance and praised the progress being made. She asked whether changes to clinical models were taking place reactively or proactively, and whether this would help patient flow at the front door. Mrs Argent reported that patient flow was being looked at on a system wide basis, as it was important that patients received timely advice and care, so that they would not require secondary care. Primary care would need support to be able to do this in an effective and timely manner. Mrs Chadwick-Bell noted that this whole system approach was a national model that had been in place for a number of years. Sometimes GPs needed specialist advice and guidance to help manage patients in community settings, which would reduce the number of outpatient appointments in hospital.

The Board noted the Trust Elective Recovery Plan

056/2021 **Better Care Together for East Sussex – ESHT Strategy**

Mrs Chadwick-Bell presented ESHT's updated strategy, noting the importance following the pandemic of continuing to look at the future and at how the Trust would look moving forward. The Trust's new strategy was interim as it

recognised that the NHS was in a state of change at present. This overarching trust strategy, which had been seen by the Board on a number of previous occasions, was underpinned by a number of supporting strategies.

Mr Milner explained that the process of writing that strategy had begun around 11 months before, and had been the first piece of work undertaken by Non-Executives and Executives in conjunction. He explained that there had been an excellent response to the strategy both within and externally to the Trust, including good feedback from ICS and primary care colleagues.

Mrs Churchward-Cardiff explained that she was pleased to see the Trust's four strategic pillars set out at the front of the document, as this explicitly emphasised the Trust's intention to collaborate. She noted that it was a very good strategy.

Mrs Fadero explained that she felt that the strategy represented all of the conversations between the Board that had previously taken place; she liked the way that it simply set out the future direction of the organisation and the health need of the population of Cast Sussex. She explained that the strategy was only the beginning and looked forward to seeing progress being brought before the Board in the future. Healthcare would need to be delivered differently post Covid and the strategy would allow the Trust to work in partnership, while supporting staff who remained the organisation's greatest asset.

Mrs Chadwick-Bell explained that the four underpinning strategies would be shared with Board Committees before Christmas, and would then be shared publically. The strategy would be formally launched at the AGM that afternoon, and would be supported by engagement and communication within the Trust.

057/2021 **Maternity Lookback**

Mrs Chadwick-Bell explained that Board members had already discussed the maternity lookback at a recent meeting in private; the paper had subsequently been updated to reflect their feedback. She explained that the Trust had received a request from a section of the community to look at whether maternity services with obstetrics should return to Eastbourne or whether the current model of care remained appropriate.

A lookback had been undertaken to review whether the anything had changed since the original decision had been made. This had looked at six key areas, as well as new models of care, and had concluded that the Trust provided a good range of care, with obstetric care consolidated at Conquest. There had been a significant improvement in quality since the change to services. Workforce issues that had led to the change remained, and would be exacerbated by the increased workforce requirements following the Ockenden review. The lookback had concluded that the current model of care was both safe and effective, and continued to be supported by consultants and midwives who did not want to see it change. It recommended continuation of the current model of care, and the Trust had no intention of revisiting this decision.

Mrs Churchward-Cardiff explained that a midwifery led service should not be considered to be a second class maternity service, as it was now the optimum place to have a child. She noted that improvements could be made to the environment in the midwifery unit, but that the service provided by the Trust was excellent. Mrs Chadwick-Bell explained that the Trust was exploring the possibility of a maternity hub in Eastbourne, providing antenatal and postnatal care for patients who chose or needed this.

Mrs Fadero explained that midwifery led units were essential to providing a good choice in maternity services. She explained that she had had met with maternity leaders in the Trust and was assured that maternity services had improved significantly for staff and patients, with improved outcomes. There was a lot of potential for improvement in the future through working in a more integrated manner.

The Trust Board endorsed the recommendation for maternity services to remain as they were.

058/2021 **Workforce Race Equality Standard (WRES)**

Mr Aumayer presented the WRES reports, noting that this had previously been discussed in detail at POD. He explained that the report was very encouraging and positive, but also identified some areas of focus for the organisation.

Mrs Churchward-Cardiff noted that it was good to see an improving picture in the organisation, but was concerned about vaccination reluctance in some staff groups. Mr Aumayer explained that the Trust's BAME network played a crucial role in providing access and support for staff. A range of information about vaccination myths and realities had been provided to staff through the network, along with, open sessions for staff to ask questions and to look at the science and data for vaccinations, allowing them to make informed decisions.

Mrs Webber asked why the Trust employing a higher percentage of BAME staff than was representative of the local community was considered a success. Mr Aumayer explained that national targets were set where workforces should be representative of local communities. The Trust had exceed this target, and was delighted to be a Trust where people from all backgrounds and ethnicities want to work. Mr Phoenix noted that the Trust was also representative in numbers of senior members of BAME staff.

Mr Patel explained that it was encouraging to see an improving picture compared to the previous report. He noted that a higher percentage of BAME staff reported being harassed at work than no-BAME staff and asked what action was being taken to address this. Mr Aumayer explained that action was being taken to address violence and aggression across the organisation. The Trust was working with each of the protected characteristic networks to identify how staff felt, their lived experience and what could be done to support them. Updates progress and on actions being taken would be reported to the POD Committee. Staff were encouraged to report any issues, with incidents investigated and addressed when necessary.

Mrs Webber noted that presentation of analysis of staff reporting on Datix, alongside the indicators seen in the report, would allow the Trust to track improvement over time as areas of concern were targeted. Mr Aumayer agreed, and explained that this would be included in reporting to POD. He noted that less tolerance was being seen from patients, as treatments were delayed and waiting times increased due to the pandemic. He anticipated that reporting would reflect this moving forward.

059/2021 **Questions from Members of the Public**

Mr Phoenix reported that one written question had been received from Mrs Liz Walke, who had asked about the model of care being offered at South Lakes Birth Centre. She noted that this demonstrated that it was possible to provide maternity services in units with under 2,000 births a year, and had asked that this should be considered by the Trust as it could be established for a relatively low cost of under £20m.

Mrs Chadwick-Bell agreed that the the birthing numbers were less of an issue than they had once been, and accepted that it was possible to have a maternity unit with under 2,000 births a year. However, this did not change any of the other factors in maternity, including maintaining a sustainable workforce, ensuring safe and sustainable services in place and that the model was supported by consultants who needed to be confident that they could deliver safe care. Mr Phoenix noted that the issues had been previously discussed in a face to face meeting with Mrs Walke and her colleagues.

060/2021 **Date of Next Meeting**

Tuesday 12th October 2021

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 10th August 2021 Trust Board Meeting

Agenda item	Action	Lead	Progress

There were no matters arising from the Trust Board Meeting held on 10th August 2021.

Audit Committee Report – 23rd September 2021

The Audit Committee last met on the 23rd September.

- The results of a self-assessment of the Trust's Emergency Preparedness, Resilience and Response (EPRR) team were presented to the Committee. These demonstrated that the Trust was substantially compliant with the national EPRR Assurance framework. This represented a a significant achievement for the organisation, as it had been nationally recognised that compliance during the pandemic would be challenging.

- The digital team presented an update on progress on completing actions that emerged from four internal audits relater to Information Technology and Digital. A number of actions had been completed, but some remained in progress and an update was requested by the Committee in January 2022.

- A report on the use of single tender waivers was received. In line with the Trust's Standing Orders, single tender waivers are only be permitted if supported by a detailed explanation of why a single tender waiver is appropriate, and with the express written authority of the Chief Executive, or designated deputy. Numbers of single tender waivers issued in Q2 2021/22 had reduced in comparison to 2020/21. The procurement team was working to continue to reduce the use of single tender waivers with proactive challenge of prospective use to ensure value for money.

- The Committee reviewed the Business Assurance Framework (BAF) & Risk Register and noted that:

    - There were 64 risks on the corporate section of risk register. Of these risks, 55 have been reviewed in the last month (in line with policy). The remaining 9 were reviewed in June. Clinical governance, risk and specialist group meetings were held in mid-September. Of the 64 risks:

        - 7 have a current rating of severity 20 – an increase of 2 since July
        - 41 have a current rating of severity 16 – this is a reduction of 3 from July
        - 16 have a current rating of severity 15 – a reduction of 2 from July

    - The BAF would be presented to the Trust Board in October.

- The Committee received an Information Governance (IG) update, and the 2020/21 IG Annual Report. Work had started on evidencing compliance with the newly issued 2021/22 Data Security and Protection Toolkit, with a year-end return due in June 2022. Good compliance against standards could already be demonstrated and the team would work closely with internal auditors to evidence full compliance by the submission deadline.

- Internal Audit presented an update to the Committee, reporting that three draft reports had been issued:

    - Covid Risk Assessment: Reasonable Assurance
    - Overseas Recruitment: Reasonable Assurance
    - Workforce Strategy - Remote Working: Limited Assurance.

12th October 2021 - Finance and Investment Committee Summary

1. Introduction

A Finance & Investment Committee was held on 23 September 2021. A summary of the items discussed is set out below.

2. Board Assurance Framework (BAF)

BAF risks 6, 7 and 8 were considered. A reduction in the capital available for 21/22 had resulted in the risk for BAF 7 increasing from 12 to 16. Additionally impacting BAF 7 were new risks added to the Trust's risk register relating to the aging radiology equipment at both Conquest and Bexhill. It was noted that this risk would be mitigated by additional funding which was discussed later in the meeting.

The committee agreed that the Executive would consider whether a separate risk relating to the estates team's ability to undertake improvements whilst the Trust was operating at close to full capacity should be added to the risk register.

Finally, the committee agreed to escalate to Board that there was a risk that the risk of 16 for BAF 8 may change when the six-facet survey update is concluded later in the year. BAF 6 remains under review by the executive whilst H2 funding continues to be uncertain.

3. Month 5 Financial Performance

An update on Month 5 Financial Performance was given. The Trust had delivered a breakeven position year to date, and expected to do so for H1. ERF funding was higher than originally anticipated for M1-2, but delivery during H2 was less certain and the Trust may be exposed to risk of non-delivery by ICS partner organisations. There is currently a gap of £4.9m to full year CIP target, and the committee has asked for a deep dive on this risk and mitigations at this month's meeting. The committee requested additional information on workforce spend.

4. Elective Recovery Update

The Committee noted that the Trust had delivered activity above the Elective Recovery targets for April, May and June. For July the Trust was very slightly below target and for August, the Trust is achieving against the 95% target. The committee received a detailed explanation of the preconditions and it was agreed that future reports would include tracking of Trust performance against these metrics. It was anticipated that achieving recovery targets would be more challenging during H2.

5. Capital Update

A final 21/22 capital plan was presented which included the phasing over the 21/22 period. The committee requested that this be updated each month to allow tracking of performance against plan (both budget and timing), and to monitor how slippage was mitigated well in advance of year end. The Trust is in discussion with the ICS about additional funding for the proposed Day Surgery Unit. Additional capital items funded outside of the capital envelope (via PDC) include the Community Diagnostic Hub, Radiology and Pathology, and IT. The committee discussed the multi-storey car park proposed at the Conquest, and it was agreed that this would not be progressed until there was clearer visibility on funding and clinical priorities. The committee noted that the processes for approvals of large capital projects were being clarified by the Executive team, acknowledging the need for timely sign off in order to ensure value for money could be achieved via tender or other due process.

6. 21/22 H2 Budget Setting

Financial guidance on H2 has not yet been issued. This is likely to be issued in the next few weeks.

7. Building for the Future (BFF) Procurement

An update was given on the BFF procurement process. The Committee approved the recommendation to award the contracts for provision of specialist advisory services for the BFF programme to the preferred bidders subject to the New Hospital Programme confirming funding and next steps for the BFF programme.

8. **Letters of Agreement**

Letters of Agreement were provided for assurance for the Community Diagnostic Hub and also the Digital Imaging Network.

Nicki Webber
Chair of Finance & Investment Committee

06 October 2021

Quality and Safety Committee Report – 16 September 2021 Meeting

The Quality and Safety Committee last met on the 16th September 2021.

- Core Services Division Report – Confirmation that complaints and PALS contacts attributed to the Outpatient Department Service mostly relate to specialties operating in the Department. A regular report will be developed to ensure these contacts are monitored through the Integrated Performance meetings of the relevant Divisions. Risks relating to obsolete equipment and to staffing (specialised roles) were discussed and assurance provided that both were being managed. Significant achievements noted were implementation of new testing for Covid-19 and management of high level of cancer referrals post surge.

- Infection Prevention & Control Board Assurance Framework – continuing dynamic situation but progress positive with a very small number of areas remaining to mitigate.

- Maternity – main issues are medical and midwifery staffing but both improving. Successful launch of Badgernet system with further packages to launch in November 2021. TIAA Assurance Review of Maternity Services presented and 'reasonable assurance' gained. 24/7 twice daily consultant-led ward rounds, 7 days per week deemed the area of greatest weakness.

- Quality Account Priorities Progress Report Progress in all three priorities. Confirmation that the discharge project is aligned with the 'Let's Get You Home' stream of work. Long list of priorities for next year being developed and due to be reduced to a short list for consultation later in the year.

- Getting it Right First Time – programme relaunched post Covid-19 surges and now linked to CQC assessment. Steady progress across the majority of specialties and good clinical engagement. 29 surgical pathways being reviewed with a view to becoming day cases. Medical pathways due to be reviewed once this work has completed. Visits have been reinstated and the next visit to the Trust will be Urology.
- Excellence in Care – the Committee received a report outlining the benefits of Excellence in Care and agreed that given the lack of an appropriate, off the shelf, alternative, this programme should continue. Amanda Fadero agreed to raise the challenges relating to dedicated resource for the programme and the urgent need for a more user friendly dashboard to be developed.

- Safer Staffing – significant challenges over the past few months. Consistent additional escalation capacity at EDGH impacting substantive areas.

- CQC Self-Assessment – progress being monitored through the Division Integrated Performance Review meetings. 9 of the 'should dos' remaining to be closed. The chair requested that the programme of assessments and action plans are brought back to the committee.

- Annual Reports – Health & Safety, Infection Prevention & Control and Legal and Claims were presented and approved.

Amanda Fadero, Chair
4 October 2021

Board Assurance Framework

Meeting information:			
Date of Meeting:	12th October 2021	Agenda Item: 6	
Meeting:	Trust Board	Reporting Officer: Pete Palmer	

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

Five new risks have been added to the BAF this quarter:

- 2055 and 2056: Potential failure of aging radiology equipment
- 2059: The impact of violence and aggression on staff wellbeing
- 2065: Lack of availability of community midwifery hubs
- 2066: Staffing levels for the lipid clinic service

The reduction in the amount of capital available during 2021/22 has led to an increased score for BAF 7 from 12 to 16. Target risk levels and target dates for all areas of the BAF have been updated to reflect the Trust's current position.

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

Quality and Safety Committee	16th September 2021
Finance and Investment Committee	23rd September 2021
Audit Committee	23rd September 2021

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

The Board is asked to review and note the Corporate Risk Register and Board Assurance Framework and consider whether the mean inherent/residual risk have been identified and that actions are appropriate to manage the risks.

Board Assurance Framework (BAF)

Quarter 2 2021/22

East Sussex Healthcare NHS Trust

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.

Target risk levels for each area of the BAF have been reviewed and updated to ensure that these are realistic and potentially achievable, and the target dates for achievement have also been updated. The overall risk rating for BAF 7 has increased from 12 to 16 due to a reduction in the amount of capital available to the Trust in 2021/22.

Five new risks have been added for Quarter 2 2021/22. All existing risks on the BAF have been reviewed and progress updated:

BAF 1 – SAFE CARE

- 2055 and 2056, which are the risks that radiology equipment at Bexhill and Conquest has the potential to fail due to the equipment's age (also included under BAF 7)
- 2066, which is the risk associated with staffing levels for the Lipid Clinic Service (also included under BAF 4)

BAF 4 – SUSTAINABLE WORKFORCE

- 2066, which is the risk associated with staffing levels for the Lipid Clinic Service (also included under BAF 1)

BAF 5 – PROTECTING OUR STAFF

- 2059, which concerns the impact of violence and aggression on staff wellbeing. This replaces 1947 and has been extended to a wider scope, and includes actions to identify any potential hotspots.

BAF 7 – CAPITAL INVESTMENT

- 2055 and 2056, which are the risks that radiology equipment at Bexhill and Conquest has the potential to fail due to the equipment's age (also included under BAF 1)

BAF 8 - INFRASTRUCTURE

- 2065, which expands on and replaces risk 1877. The original risk concerned premises for community midwifery services in a single location in St. Leonards, while the replacement highlights the wider lack of availability of community midwifery hubs.

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	12	16	12	12			◄►	Low	6	Mar 22
BAF 2	Restoration and Recovery - ongoing impact of Covid19	Q&S	✔	✔	✔	✔	✔	20	16	16	20	20	16	16			◄►	Low	8	Mar 22
BAF 3	The Trust's performance against access standards is inconsistent	Q&S	✔	✔				20	12	16	20	20	16	16			◄►	Low	6	Mar-22
BAF 4	Sustainable Workforce	POD	✔	✔	✔		✔	20	16	16	16	16	16	16			◄►	Moderate	12	Mar-22
BAF 5	Protecting our staff	POD			✔			16	12	12	12	12	12	12			◄►	Low	9	Mar 22
BAF 6	Financial Sustainability	F&S				✔	✔	16	12	12	12	4	12	12			◄►	Moderate	8	Mar-22
BAF 7	Investment required for IT, medical equipment and other capital items	F&S	✔				✔	20	16	16	12	12	12	16			▲	Moderate	12	Mar-22
BAF 8	Investment required for estate infrastructure – buildings and environment	F&S	✔				✔	20	16	16	12	12	16	16			▲	Moderate	8	Mar-22
BAF 9	Cyber Security	Audit	✔	✔			✔	20	16	16	16	16	16	16			◄►	Low	12	Mar-22

- 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	12				
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	16				16
BAF 8 – Investment required for estate infrastructure – buildings and environment	16				16
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:	Chief Nurse & DIPC/ Medical Director	**Lead Committee:**	Quality and Safety Committee	**Date of last Committee review:**	Jul-21	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	25/09/15	1360	Cardiology catheter labs breakdowns	16	16	◄►
	19/02/16	1458	Non-Compliance with NICE guidance NG19 (Diabetic Foot)	20	16	◄►
	12/06/20	1884	Delayed surgical treatment	20	16	◄►
	13/08/20	1907	Insufficient isolation areas and testing kits for Covid-19	16	16	◄►
	24/09/20	1913	Increased waiting times due to cancellations as a result of Covid-19	16	16	◄►
	03/12/20	1942	Risk of insufficient acute beds during winter	20	16	◄►
	11/03/21	2035	Nervecentre recording error for patient alerts	16	16	◄►
	12/07/21	2055 & 2056	Radiology equipment breakdowns	20	15	**New**

BAF Risk Scoring								
Quarter	**20/21 Q3**	**20/21 Q4**	**21/22 Q1**	**21/22 Q2**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4	4	4	ESHT has now entered the next phase of Covid, presenting different challenges to those seen in the second wave. Infection control requirements are impacting both clinically and operationally, even with the small numbers of covid positive patients, impacting on capacity, staffing, flow and performance. Challenges are likely to be sustained in the medium to longer term. A surge in paediatric respiratory illnesses is anticipated over the next few months	**Likelihood:**	2	Mar-22
Consequence:	3	4	3	3		**Consequence:**	3	
Risk Level:	**12**	**16**	**12**	**12**		**Risk Level:**	**6**	

Cause of risk:	**Impact:**
• Covid-19 impacting the Trust's ability to provide safe and effective care • Impact of significant additional capacity being required and subsequent effect on workforce • Clinical governance systems and systems for learning from incidents and other quality metrics may not be consistently applied and effective	Failure to provide safe and effective care may result in: • Sub-optimal 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, use of nerve centre and MDT meetings in place H. Daily safe staffing monitoring and establishment reviews to ensure safe, effective and efficient skill mix

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) • Daily clinical review of patients on waiting list (G) • Nerve centre in use for monitoring real time bed state (G) • Daily monitoring of staffing levels (H)	• 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
- Improvements required in discharge particularly around information and communication to care homes
- Refer to BAF 2 for other gaps related to Covid-19 pandemic

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	Programme of work in place to improve discharge pathway and quality of discharge	COO/CN	Ongoing	• Multi-professional Discharge Improvement Group paused during wave 3 and now restarted. • Workstreams in place to Perfect Discharge which is a Quality Account priority.	
2.	Mitigating actions to minimise the risk to patients of safety alerts not being visible to staff accessing Nerve Centre	COO/CFO	Ongoing	• Staff are checking patient alerts on alternate system • Matter raised with Head of Digital who has escalated to software provider • Interface from PAS to Nerve Centre is built. • Formal Testing is underway and then the interface will be put into live. • Need to backload the historical warnings	
	Refer to BAF 2 for additional actions related to Covid-19 pandemic				

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 be detrimental to the trust's ability to operate effectively, which could impact service delivery, clinical outcomes and patient experience.**					
Lead Director:	Chief Operating Officer	**Lead Committee:**	Quality and Safety Committee Finance and Strategy Committee	**Date of last review by Committee:**	July -21	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	12/06/20	1884	Delayed surgical treatment	20	16	◄►
	27/11/20	1937	EMU birth centre environment	15	15	◄►
	03/12/20	1942	Insufficient acute beds during winter	20	16	◄►

BAF Risk Scoring								
Quarter	**20/21 Q3**	**20/21 Q4**	**21/22 Q1**	**21/22 Q2**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	5	5	4	4	Risk level decreased due to the lessening impact of Covid-19 on the delivery, restoration and recovery of services. Likelihood of further wave reduced from 'certain' to 'high probability'.	**Likelihood:**	2	Mar 22
Consequence:	4	4	4	4		**Consequence:**	4	
Risk Level:	20	20	16	16		**Risk Level:**	8	

Cause of risk:	2021 recovery (H1) is being overseen at an ICS level against the national 2021/22 priorities and operational planning guidance. There is an expectation that ESHT will deliver the national ask of 95% in H2. Risks for Q3/4 are a further Covid surge and workforce availability in key roles such as ODPs, which is being managed by the Divisions. Significant progress has been made with D Codes, and we are now awaiting guidance O codes (outpatients). The risk will be reviewed in line with National ask for H2.	**Impact:**	Failure to effectively manage the pandemic and 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. Compliance with 95% in H2 B. Working to national guidance on activity requirements C. Estates space utilisation being reviewed taking account of requirements for recovery of safe services whilst maintaining social distancing ongoing D. Identifying areas where improvements have been made e.g. such as virtual out-patient appointments and maximising these opportunities E. Utilisation of capacity in private providers where available during H2 F. Elective Care Board oversight of long waiting patients & harm reviews; G. Trust Recovery Board established, linked to System Recovery Board H. The Trust is being asked to support system partners to smooth the Sussex waiting list profile and the number of patient waiting over 78 week

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:	• Weekly system operations and surge group meeting in place and all decisions logged and risks monitored (F) (G) • Elective, Urgent and Community Care Boards and associated governance arrangements in place (A) (B) (C) (D) (E) (F) (G) • Update report covering concerns/ key actions / positive assurance and decisions presented to Executive Team (A) • Weekly Elective Care Board overseeing re-starting of services and interdependencies (E) (F) • Performance against National Standards (A) (B)	• Reporting on Restoration and Recovery presented to Trust Board in IPR (A) • Linking into system wide recovery approach, via System Recovery Board (B) (G) (H) • Digital infrastructure improved; hardware available to facilitate home working (C) • HR Support for staff related Covid-19 issues including risk assessment and track and trace (G) • Divisional tracking through Elective Care Board against trajectories that are in development (A) (F)	• Internal audit plan will include aspects of the management of Covid-19 (G) • Oversight by NHS Improvement through submission of sitrep information and oversight meetings (A) • ICP/ICS risk and recovery group (A)(G) • Planned Care Board (B)
Gaps in control/assurance:			
• Further controls and assurances will be required to restore and recover services post the current second wave			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	Winter bed modelling in progress and mitigations being identified	COO	End Sept-21	• Presented to Executives on 06.09.21 • To be presented to Quality and Safety Committee on 16th September	

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 national operating guidance KPIs**					
Lead Director:	Chief Operating Officer	**Lead Committee:**	Quality and Safety Committee	**Date of last review by Committee:**	July-21	
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	◄►
	24/09/20	1915	Outpatient follow up backlog – particularly ENT, Ophthalmology and Urology.	20	16	◄►

BAF Risk Scoring								
Quarter	**20/21 Q3**	**20/21 Q4**	**21/22 Q1**	**21/22 Q2**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	5	5	4	4	Risk level reduced due to the impact of the second wave of Covid-19 had on restoration and recovery of services. Impact moved to "highly probable" and consequence "major". Additional capacity for endoscopy introduced in August which will help address the diagnostic backlog for routine and cancer patients.	**Likelihood:**	2	Mar-22
Consequence:	4	4	4	4		**Consequence:**	3	
Risk Level:	20	20	16	16		**Risk Level:**	6	

Cause of risk:	Increased demand for services and diagnostics year on year. This has been further impacted by the reduction of patient presentations to GPs during the pandemic, leading to a growing 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, diagnostics and RTT - pathway review in line with 28/62 days - identifying digital opportunities to proactively manage patient care - 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: - Straight to test pathway - Faster diagnostic standard 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 RTT and cancer PTL weekly (B) (C) (D) • Day to day oversight of A&E performance (A) • Ongoing 'Cancer Week' focussed MDT PTL meetings on six week basis (E) (D) (B)	• Policy and procedures for MDT reviews strengthened and continually reviewed (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 & Safety Committee (A) (C) • IPR reports to Trust Board (A) (C) • Cancer Access Meeting (weekly) (C) (D) (E) • System Access Policy and PTL meetings being established (A) (B) (C) (D)	• Oversight by NHS Improvement through submission of sitrep information and oversight meetings (C) • System Recovery Board (A) (C) (E) • Admin and clinical validation of DM01 PTL and diagnostic codes to prioritise patients (A) (C)
Gaps in control/assurance:			
• Further controls and assurance will be required to restore and recover services post the current second wave			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	System and Trust recovery trajectories for DM01 / Admitted / Non-admitted for H1	COO	End Mar 2022	• Elective care Board and Cancer Access Meetings oversee performance • Trust cancer Board	

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:	Chief People Officer	**Lead Committee:**	People and Organisational Development	**Date of last review by Committee:**	July-21	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	21/04/15	1289	Histopathology consultant vacancies	20	16	◄►
	03/05/17	1616	Consultant Vacancies	20	20	▲
	21/12/18	1772	Insufficient intensive care consultants	20	16	◄►
	05/10/20	1919	Shortage of staffing in chemistry	15	15	◄►
	15/02/21	2030	Impact of covid-19 pressures on staff retention	20	16	◄►
	07/07/21	2054	Recruitment to Trust Vacancies (substantive)	16	12	◄►

BAF Risk Scoring								
Quarter	**20/21 Q3**	**20/21 Q4**	**21/22 Q1**	**21/22 Q2**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4	4	4	There are pockets of specialities where recruitment is challenged, although these largely reflect national difficulties. Ongoing success with recruiting into some 'Hard to Recruit' substantive posts, particularly Consultant posts. Retention likely to be a risk especially following Covid-19 pressures.	**Likelihood:**	4	Mar-22
Consequence:	4	4	4	4		**Consequence:**	3	
Risk Level:	16	16	16	16		**Risk Level:**	12	

Cause of risk:	• Recognised national shortages in some staff groups • Geographical location • Continued pressure in a number of clinical areas • Lack of opportunity for career development • Pandemic may have a detrimental impact on staff retention.	**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 efficiency 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 H. Exit interview programme I. Use of bank and agency if required with authorisation process in place J. Managing impact of EU exit K. Range of wellbeing support available and being further developed

Assurance Framework – 3 Lines of Defence – mapped to controls A-K			
	1st Line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control*
Assurance:	• Monthly reviews of vacancies together with vacancy/turnover rates (A)(H)(D) • Twice yearly establishment reviews (F) • Success with some hard to recruit areas eg consultants in Histopathology, Radiology, Neurology and Acute medicine.(A) (C) • Introduction of Certificate of Eligibility of Specialist Registration (CESR) programme in A&E Sept 2020.Proposed roll out across other areas Qtr 1 2021. (C) • In house Temporary Workforce Service to facilitate bank and agency requirement (I) • Direct communication to all EU staff re settled status. Task and finish group established. Direct communication to all EU Nationals (J) • Workforce efficiency metrics (D) • Alignment of volunteers under Temporary Workforce Services (A)(C)(D)	• 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 and Attraction Strategy refreshed (A) • Improvements to Applicant Tracking system (Trac) have led to reduced time to hire for new staff (not including Medical & Dental staff). (D) • Trust vacancy rate increased to 6.9% in August 2021. (D) • Temporary workforce costs scrutinised by Finance and Strategy Committee (I) • Wellbeing offering enhance and reviewed by POD (K) • People Strategy being developed (A)(B)(C)(D)(E)(F)(I)(K)	• 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 have continued to impact on 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 2 Progress Report**	**BRAG**
1.	Continue with recruitment initiatives and international sourcing of medical candidates, including Radiographers and Sonographers	CPO	Dec 2021	125 international nurses and 9 radiographers recruited to date (July 2021). Further 7 Nurses due to arrive July 2021 with planned c25 every other month during 2021/22.	
2.	Establishment of local networks with protected characteristic groups and organisations to increase diversity and talent.	CPO	June 2021	Networks established and operational, with active engagement and support from the Trust.	**Completed**
3.	Kickstarter and other local outreach initiatives	CPO	Ongoing	Programmes established, and cohorts being identified (Covid has led to a reduction of areas cohorts can work in)	
4.	People Strategy	CPO	Dec 2021	Stakeholder meetings arranged, prior to presentation of strategy at Trust Board Seminar in Sept '21. Final strategy will be presented to POD and then Trust Board for approval.	

Risk Summary						
BAF Reference and Summary Title:	**BAF 5: Protecting our Staff**				**Strategic Objectives Impacted**	
Risk Description:	**There is a risk to staff health, welfare and morale if we do not undertake and act upon risk assessments to ensure a safe working environment and effective support for wellbeing**					
Lead Director:	Chief People Officer	**Lead Committee:**	People and Organisational Development	**Date of last review by Committee:**	July-21	

Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	07/07/20	1900	Availability and use of Personal Protective Equipment	16	8	◄►
	16/08/20	1908	Protecting our Staff	16	6	◄►
	15/02/21	2030	Impact of covid-19 pressures on staff retention	20	16	◄►
	16/07/21	2059	Impact of Violence and Aggression on staff wellbeing	16	12	**New**

BAF Risk Scoring								
Quarter	**20/21 Q3**	**20/21 Q4**	**21/22 Q1**	**21/22 Q2**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**	**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 however there is still more that can be done. As Covid levels reduce, pressures are being replaced by recovery and other emerging operational challenges.	**Likelihood:**	**3**	End Mar-22
Consequence:	**4**	**4**	**4**	**4**		**Consequence:**	**3**	
Risk Level:	**12**	**12**	**12**	**12**		**Risk Level:**	9	

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, violence and aggression and work related stress.	**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. 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. D. Improved de-brief process and package of support for staff involved in violence and aggression or distressing situations at work. E. Reviewing and implementing best practice from other areas (e.g. TRiM, MHFA) F. Range of wellbeing support available and being further developed G. Violence and Aggression action plans developed following the 2020/21 staff survey results H. Ongoing National vaccination programmes I. Workforce Efficiency and Availability Reviews J. Workforce Strategy

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:	• Covid risk assessment process implemented to be undertaken by line manager and retained on personnel file. (A) (C) • Completion of risk assessments to be recorded on ESR. (A) • Appropriate PPE provided (A) • Promoting wellbeing support available and training to line managers (G) • Workforce efficiency and availability reviews considering registered and unregistered nurses, and AHPs (I)	• Occupational Health and Health and Safety Team support and audit of risk assessments and datix incidents (A) (B) (D) • Occupational and staff wellbeing support to staff (E) (H) (I) • Metrics reported to executive team, POD and Trust Board – increased compliance with completion of risk assessments (A) • Local Security Management Specialist advice and support (D) • Oversight 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) • Audit of Covid-19 staff risk assessments undertaken by TIAA, providing reasonable assurance (A)

Gaps in control/assurance:

- The Covid-19 pandemic and recovery 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
- Need to ensure that staff have access to appropriate well-being support during and following the Covid-19 pandemic

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	Managers and staff to review existing covid risk assessments to ensure they reflect latest risk profiles and ensure appropriate mitigations are in place in line with Trust/national guidance.	CPO	Ongoing	Audit completed by internal auditors, providing assurance about compliance and completion of staff risk assessments. Good compliance with completion but need to ensure assessments are reviewed and updated, including reviewing and implementing effective mitigation if required. Providing guidance regarding vaccination.	
2.	Agreed business case for lone worker alert software and this is to be procured and rolled out	Associate. Director for Digital	Jun 2021	• Business case approved and exploring options for joint working with ESCC. • Lone worker alert software rolled out in Trust.	**Complete**
3.	People Strategy	CPO	Dec 2021	Stakeholder meetings arranged, prior to presentation of strategy at Trust Board Seminar in Sept '21. Final strategy will be presented to POD and then Trust Board for approval.	

Risk Summary						
BAF Reference and Summary Title:	**BAF 6: Financial Sustainability**				**Strategic Objectives Impacted**	
					SO4 ✓	SO5 ✓
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 21/22 or not complying with Covid financial guidance and audit breaches**					
Lead Director:	Director of Finance	**Lead Committee:**	Finance and Investment Committee		**Date of last review by Committee:**	July-21
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	22/07/21	2060	Delivery of 21/22 Financial Plan	**20**	12	◄►

BAF Risk Scoring								
Quarter	**20/21 Q3**	**20/21 Q4**	**21/22 Q1**	**21/22 Q2**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	3	1	3	3	The financial position for H1 of 2021/22 is reasonably assured, with an agreed H1 settlement despite ERF targets increasing. In H2 there will be increased risk against ERF funding and we will need to develop further CIP schemes for the year. To be reviewed following Month 6 and the H2 forecast, and risk level could potentially be increased following this.	**Likelihood:**	2	Mar-22
Consequence:	4	4	4	4		**Consequence:**	4	
Risk Level:	**12**	**4**	**12**	**12**		**Risk Level:**	**8**	

Cause of risk:	The Trust has agreed a block contract and agreed Covid payments for the first half of 2021/22. The financial envelope and position for H2 has not yet been finalised. Additional cost pressures for H2 are beginning to be identified, including escalation wards, discharge costs, crisis response and echo capacity.	**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 process of being updated with divisions B. Transformation programmes in place to realise benefits of cost effectiveness C. Reviewing approved business cases for realisations of benefits D. 21/22 budgets are being updated to reflect nursing establishment changes. There is a further review underway to reflect 21/22 nursing establishment changes. E. There will be an ongoing review of process following the previous year of IMT covid controls. F. Monthly benchmarking of covid costs within ICS and agreement to only charge excess costs to Covid reclaim system		

Assurance Framework – 3 Lines of Defence - aligned 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:	• 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 Efficiency Committee and Finance & Investment Committee (A) (B) (C) • 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 2 Progress Report**	**BRAG**
1.	Agree CIP plan for 2021/22: 2% in H1 and 3% in H2	Chief Finance Officer	Ongoing	£5m identified from a £10m 2021/22 target, and work is progressing on mitigating cost pressures.	
2.	Monitor delivery of any activity above the elective threshold to maintain this within additional ERF funding	Chief Finance Officer	Ongoing	No penalties have applied up to month 4 and the finance performance is break even to date.	
3.	Maintain staffing controls through establishment control, including vacancy panel	Chief People Officer	Ongoing	Workforce efficiency metrics in place and regularly monitored	
4.	Capital controls: • Agree and manage within an updated capital plan for the year • Develop controls to forecast and deliver capital projects in line with Trust agreed limits	Chief Finance Officer	Sept 21	A cash flow of the capital plan is being developed and shared with the ICS.	
5.	Capital funding: • Bids for additional discharge and crisis response costs are being raised with the ICS • Potentially costs of echo might be funded under the Community Diagnostic Hub	Chief Finance Officer	Mar 22		**New**

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 Investment Committee	**Date of last review by Committee:**	July-2021	

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Inherent Risk Score	Current Risk Score	Change
	12/02/14	1152	Obsolete medical devices	20	12	▼
	25/09/15	1360	Cardiac catheter lab breakdowns	16	16	◄►
	27/05/20	1879	Capital sustainability	20	20	◄►
	01/02/21	2027	Trust Compute Resources for the Virtual infrastructure	20	15	◄►
	02/07/21	2051	Potential failure of digital backup hardware components	16	16	◄►
	12/07/21	2055 & 2056	Radiology equipment breakdowns	20	15	**New**

BAF Risk Scoring								
Quarter	**20/21 Q3**	**20/21 Q4**	**21/22 Q1**	**21/22 Q2**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**	**3**	**4**	Due to in year controls, currently expecting to limit IT and medical equipment spending to £4.5m for the year.	**Likelihood:**	**3**	Mar-22
Consequence :	**4**	**4**	**4**	**4**		**Consequence:**	**4**	
Risk Level:	**12**	**12**	**12**	**16**		**Risk Level:**	**12**	

Cause of risk:	Insufficient capital to meet significant backlog maintenance	**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. clearer reporting of any slippage against plan. Annual capital for digital is limited to £3.5m, plus £1m for equipment, so some risk to demonstrating matched funding for an EPR project, with a potential impact on achieving digital maturity over next five years if the capital position does not return to £4.5m for digital and £1m for equipment in 2022/23.
Current methods of management (controls)	A. Significant work was undertaken to deliver the capital plan. However in future there will be clearer reporting of any slippage against plan. B. Essential work prioritised with estates, IT and medical equipment		

Assurance Framework – 3 Lines of Defence - linked to controls A-B			
	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) (B) • Electronics and Medical Engineering (EME) in close liaison with divisions (B) • Full inventory of medical devices and life cycle maintenance (B)	• Oversight by Finance and Strategy Committee (A) • Estates and Facilities IPR (A) (B) • Digital IPR (A) (B) • Clinical procurement group in place (A) (B)	• Capital business cases reviewed by ICS (A)
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 2 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.	Chief Finance Officer	End Mar 2021	Completed	**Complete**
2.	To develop clearing escalation and reporting of slippage of capital plans	Chief Finance Officer	End Sept 2022	By September 2022 a two year capital plan will have been developed and shared with the ICS.	
3.	Radiology equipment: Bexhill Friends / potential funding over the next year with phasing to be agreed. Also potential funding through the Community Diagnostic Hub	Chief Finance Officer Director of Strategy, Inequalities & Partnerships	End Mar 2022 Oct 2022	£1m ring-fenced from capital budget for equipment. Prioritisation through Sim Beaumont. Activity plan by modality in development for discussion with NHSE	**New**

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 Investment Committee	**Date of last review by Committee:**	July-21	

Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**
	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	◄►
	09/05/17	1621	Loss of Electrical Services (Power and Lighting) to Critical Clinical Areas	20	16	◄►
	27/11/20	1937	EMU birth centre environment	15	15	◄►
	29/12/20	1949	Insufficient air ventilation could contribute to Covid-19 cross infection	16	16	◄►
	03/08/21	2065	Lack of suitable premises for community midwifery service	15	15	**New**

BAF Risk Scoring								
Quarter	**20/21 Q3**	**20/21 Q4**	**21/22 Q1**	**21/22 Q2**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	3	3	4	4	The Six facet survey indicates significant backlog maintenance. Whilst £12m of backlog was eradicated in 20/21 with external capital support, the backlog inflationary pressures are outstripping the available internal capital .	**Likelihood:**	2	Mar-22
Consequence:	4	4	4	4		**Consequence:**	4	
Risk Level:	12	12	16	16		**Risk Level:**	8	

Cause of risk:	The Trust's historic financial performance has led to a restricted internally generated capital budget for many years. Despite a successful bid for HIP2 seed funding to develop the Strategic Outline Case there is an immediate need for capital which outstrips availability.	**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	A. 2020/21 capital plan 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		

management (controls)	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 e.g. 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 to 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 developing strategic outline case to secure significant funding over the next 5-10 years (A) • NHSI funding confirmed in order to facilitate additional fire compartmentation works, but is being delayed by Covid-19 bed pressures (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
- Some areas inadequately ventilated

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

No.	Action Required	Executive Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	Developing "Building for Our Future" full business case and project board being established	Chief Executive	End Mar 2021	• Programme Director in place. • Governance structure in place. • SOC submitted late March 21 – awaiting DH/NHP review	
2.	Aiming to resume fire compartmentation works at DGH in Autumn 2020	Director of Estates	End Mar-2024	• Now that the Maternity Day Unit has become available the 1st phase of the refurbishment plan has now been completed Sept '21 (SDEC). • Winter escalation plan delayed works scheduled for the rest of FY21/22, so now limited fire compartmentation works have been agreed to be undertaken in EDGH AMU over Oct-Dec' 21.	

3.	Comprehensive trust-wide plans for improving ventilation being developed	Director of Estates	End Mar-2022	• Draft report sent to TIPCG in April 2021 and progress updated being reported bi-monthly as appropriate. • Can only be fully mitigated upon completion of BFF programme due to the significant level of investment required to minimise the risk	

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**	July-2021
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	**20/21 Q3**	**20/21 Q4**	**21/22 Q1**	**21/22 Q2**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4	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-22
Consequence:	4	4	4	4		**Consequence:**	3	
Risk Level:	16	16	16	16		**Risk Level:**	12	
Cause of risk:	Global malware attacks infecting computers and server operating systems. The most common type of cyber-attack are phishing attacks, through fraudulent emails or being directed to a fraudulent website,				**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. Ongoing Education campaign to raise staff awareness F. System patching programme in place and upgrade of client and server operating systems G. Wider engagement including NHS Secure Boundary							

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 organisations within the Sussex ICS (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 2 Progress Report**	**BRAG**
1.	Cyber Essential Plus framework.	Director of Finance	End March 2022	Greatly improved and aiming to achieve Cyber Essentials Plus early in Q4 21/22,	
2.	Pursuing ISO27001	Director of Finance	End March 2023	Set up initial conversations with auditors	
3	Implement a Privileged access management (PAM) solution	Director of Finance	Dec 2022	Order placed for PAM	
4	New Cyber awareness Campaign	Director of Finance	End Oct 2021	• Campaign is under development and now anticipated to take place in October 2021 • Malware email campaign carried out August 2021 with good results	

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

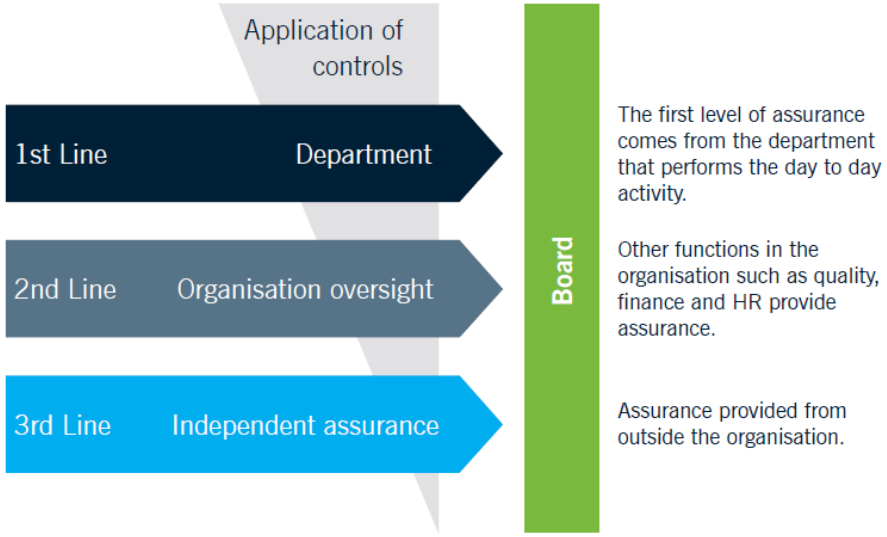
Table LIKELIHOOD X CONSEQUENCE/IMPACT = RISK RATING

		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 2021 (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 (2021/22), 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

Balanced Scorecard

East Sussex Healthcare NHS Trust

Key Metrics

Safety	Target / Limit	Last month	This Month	Variation	Assurance
Patient Safety Incidents	M	1074	1004	Common Cause	
Serious Incidents	M	5	2	Common Cause	
Never Events	M	0	0	Common Cause	
Falls per 1,000 bed days	5.5	6.8	6.0	Common Cause	Inconsistent
Pressure Ulcers, grade 3 to 4	0	2	1	Common Cause	Inconsistent
MRSA Cases	0	0	0	Improvement	Consistently Hit
Cdiff cases	<5	2	6	Common Cause	Inconsistent
MSSA cases	M	3	4	Common Cause	
RAMI	M	87.0	85.3	Concern	
SHMI (NHS Digital monthly)	M	0.96	0.96	Common Cause	
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	93%	87%	Common Cause	Consistently Missed

Patient Experience	Target / Limit	Last month	This Month	Variation	Assurance
Complaints received	M	39	35	Common Cause	
A&E FFT Score	M	96%	89%	Common Cause	
Inpatient FFT Score	M	99%	99%	Improvement	
Maternity FFT Score	M	96%	98%	Common Cause	
Out of Hospital FFT Score	M	98%	99%	Common Cause	
Outpatient FFT Score	M	99%	100%	Common Cause	

Our Performance	Target / Limit	Last month	This Month	Variation	Assurance
A&E 4 hour target	>95%	83.4%	78.1%	Common Cause	Consistently Missed
A&E Non Admitted	M	88.2%	84.5%	Concern	
A%E 12 hour from Arrival	M	115	275	Common Cause	
UTC 2 hour	>98%	85.5%	79.9%	Concern	Consistently Missed
Cancer 2ww	>93%	96.1%	94.4%	Common Cause	Consistently Hit
Cancer 62 Day	>85%	72.7%	72.2%	Common Cause	Inconsistent
62 day Backlog	M	154	149	Common Cause	
104 day Backlog	M	21	33	Common Cause	
RTT under 18 weeks	>92%	79.7%	78.6%	Concern	Consistently Missed
RTT 52 week wait	0	73	75	Common Cause	Consistently Missed
RTT Total Waiting List Size	26,965	35,521	36,147	Concern	Consistently Missed
Overdue P2	M	249	198	Concern	
CHIC within target wait time	M	87.5%	85.6%	Common Cause	
Diagnostic <6 weeks	<1%	20.5%	19.8%	Common Cause	Consistently Missed

Our People	Target	Last month	This Month	Variation	Assurance
Establishment (WTE)	M	7,532.9	7,520.0		
Vacancy Rate	<5%	6.9%	6.1%	Common Cause	Inconsistent
Staff Turnover	<9.9%	10.1%	10.2%	Common Cause	Inconsistent
Retention Rate	>92%	92.7%	92.3%	Improvement	Consistently Hit
Sickness - Absence % (rolling 12 mths)	<4.5%	4.9%	5.0%	Concern	Consistently Missed
Sickness - Average Days Lost per Fte	<16	17.8	18.2	Concern	Consistently Missed
Staff Appraisals	>85%	73.0%	73.5%	Concern	Consistently Missed
Statutory & Mandatory Training	>90%	88.7%	89.9%	Improvement	Consistently Missed

Our Recovery	%19/20 Agreed	Last month	Var	%19/20 Agreed	This Month	Var
Total Outpatients	95%	100%	5%	95%	107%	12%
New Outpatients	95%	99%	4%	95%	110%	15%
Follow UP Outpatients	95%	107%	12%	95%	116%	21%
Elective Daycase	95%	95%	0%	95%	106%	11%
Elective Inpatients	95%	86%	-9%	95%	74%	-21%
Non Elective Activity	95%	102%	7%	98%	94%	-4%
A&E Attendances	104%	108%	4%	104%	109%	5%

Our Productivity	Target	Last month	This Month	Variation	Assurance
4 hour theatre sessions	M	480	449	Common Cause	
Average Cases per 4 hour session	M	2.6	2.5	Improvement	
Clinic run rate	M	80.3%	80.9%	Common Cause	
Non Face to Face Outpatients	>25%	31.7%	29.9%	Concern	Consistently Hit
Elective Length of Stay	2.7	2.5	2.6	Common Cause	Inconsistent
Non Elective Length of Stay	3.6	3.8	3.9	Common Cause	Inconsistent

Executive Summary

- The month of August has been an exceptionally challenging time not just for the Trust but for the region.
- Specific key areas of challenge have been the demand on our Emergency Departments, bed occupancy and patient flow. Which in turn has put some additional pressure on maintaining our elective activity levels.
- Our system partners such as SECAMB, SCFT, SPFT (eg. Care homes, nursing homes, rehabilitation beds etc) have all been experiencing high levels of demand and workforce challenges . These issues have impacted on delivery of services to support the acute, which compromises our LoS and ability to discharge patients who are medically fit and no longer meet the criteria to reside in an acute bed.
- Workforce has seen an increase in staff absence due to sickness which has put the whole system under stress. But this is being mitigated with the use of temporary workforce and reassignment of substantive staff to make wards safe. Our workforce fill rates have dipped in month. This is due to a rise in demand for staffing because of the requirement to open escalation areas .
- The balance scorecard shows that the UTC measure is a concern. The Trust continues not to focus on the two hour standard but on flow and increased throughput of the UTCs to support the overarching four hour standard.
- Although not achieving the 4 hour standard, we are 43rd in the country. We have a comprehensive action plan and are working with commissioners that the UTC is appropriately commissioned which will support our ability to adapt our capacity to meet the change in demand acuity.
- Despite the challenges to our elective recovery, the Trust have exceed the target (95% of 19/20 baseline activity) in August. With outpatients (new and follow up appointments)and daycase procedures over 100% of target. With the fewest number of patients waiting over 52 weeks in the region. We are also currently carrying out in excess of 100% of 19/20 baseline activity for all of our reportable diagnostic departments putting us above target for this measure. The national standard for Referral to Treatment (RTT) is 92%. However it remains challenged as a result of the national suspension of elective activity due to Covid
- Our quality of care has continued to be delivered at a high standard with falls, incidents- and pressure ulcer numbers all within normal control limits

Quality and Safety

Delivering safe care for our patients

What our patients are telling us?

Delivering effective care for our patients

Safe patient care is our highest priority

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

Summary

East Sussex Healthcare NHS Trust

Quality and Safety

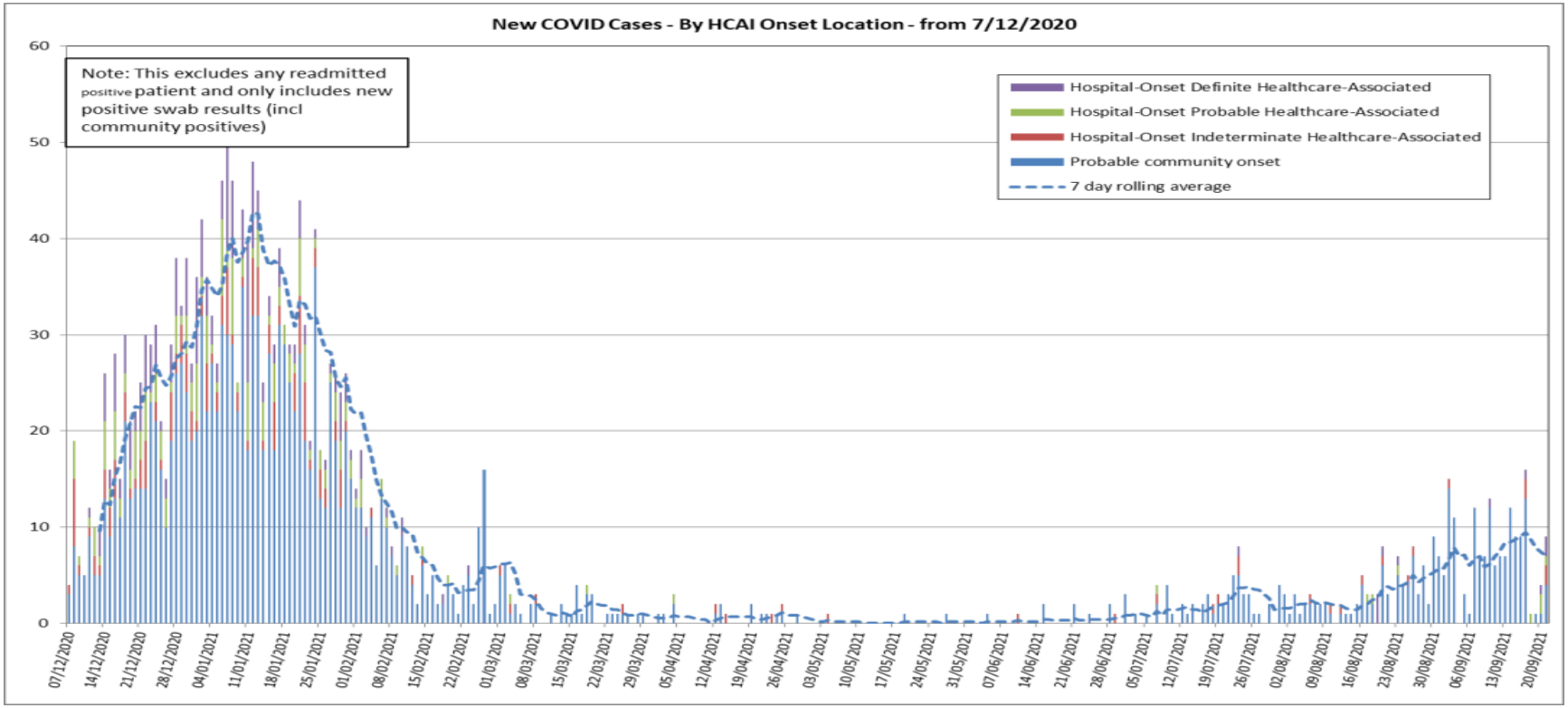
			Author(s)
Quality and Safety **August 2021 data**	**COVID - 19** The number of people testing positive is reducing in E. Sussex and in August was 292 per 100,000 population compared to the England rate of 311 per 100,000. Hastings had a higher rate than England at 376/100,000 but this has since fallen in Sept. Inpatient numbers averaged 30 with double the number at Conquest compared to EDGH. The IPC team continues to work with clinical teams to advise on patient pathways and guidelines in consultation with the members of the Clinical Advisory Group. **Infection Control** The revised limits for the alert organisms were published in August and the DIPC and the Head of Infection Control are reviewing them. For the month of August, ESHT reported 9 cases of CDI against a monthly limit of 4. Of these 9 cases, 7 were reported as a HOHA (Hospital Onset Healthcare Associated), and 2 were reported as a COHA (Community Onset Healthcare Associated). **Incidents** • Total patient safety incidents consistent and remain within normal variation • 2 SIs were reported in August and incidence remains within normal variation **Pressure Ulcers** Overall rates remain within control limits with common cause variation. One category 3 pressure ulcer was reported but has since been validated as a category 2. **Falls** The rate of falls has returned to within expected limits for the last six months with collaborative work ongoing and Falls Awareness Week 20th – 26th Sept 2021 sharing key learning so far.	**Patient Experience - Complaints/Friends & Family Test (FFT)** Teams continue to work through the backlog of complaints from wave 2 with improving response times. FFT submissions remain lower than pre-COVID but with recommendation rates ranging between 88.94% and 98.76 % for A&E, Inpatient areas and Maternity. **Nursing & Midwifery Workforce** The continued requirement for significant amounts of additional (escalation) areas has continued through August (and Sept) and has impacted on nurse staffing levels on a daily basis. Absences due to annual leave, study leave, extended maternity leave, reduced temp staff cover and staff isolation has also contributed to the challenge. Maternity and acute/community Paediatric activity has increased, placing significant pressure on staff resource. This is reviewed on a twice daily basis to ensure risks are identified and mitigating actions are in place. EMU and home births are now reinstated but staffing remains challenged. System benchmarking and sharing of safer staffing methodology for nursing to ensure consistency across Sussex has commenced. The inpatient Nurse Establishment Review is complete and will be submitted in due course.	 **Vikki Carruth** Chief Nurse and Director of Infection Prevention & Control (DIPC)  **David Walker** Medical Director
Actions:	• Work ongoing by divisions to improve complaints response times.		

COVID-19

East Sussex Healthcare NHS Trust

Prevalence

The rate of COVID in parts of East Sussex was greater than the England rate for much of August. Hastings has persistently been higher with people aged 10-19 accounting for the highest proportion of cases. The Delta variant continues to be the cause of most infections. 99 positive patients were admitted during August with double the number at Conquest compared to EDGH as per previous months.



Outbreaks and Serious Incident Investigations

There was an outbreak of COVID on Tressell ward involving 6 patients in August. The index case was identified from a day 3 positive result with the patient having tested negative on admission. One member of staff also tested positive when all the staff were screened as part of the outbreak control plan. The ward was closed to admissions and discharges and was reopened on 29th August following deep cleaning. A SI investigation is underway.

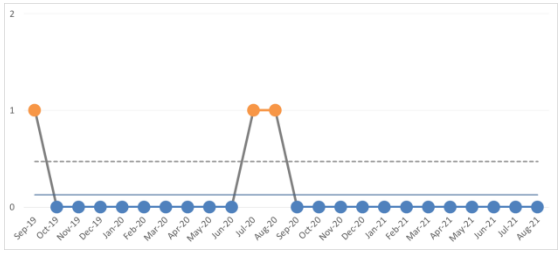
Safe Care - Infection Control (non COVID)

East Sussex Healthcare NHS Trust

Quality and Safety

MRSA cases

Target: 0
Variation: Normal
Current Month: 0

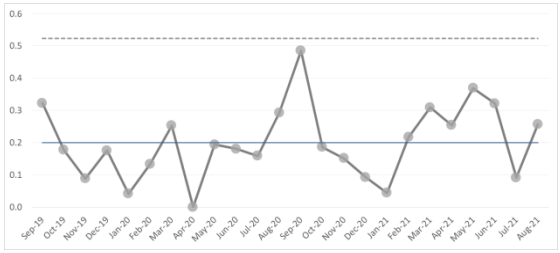


CDIFF cases

Limit: 5.66
Variation: Normal
Current Month: 9

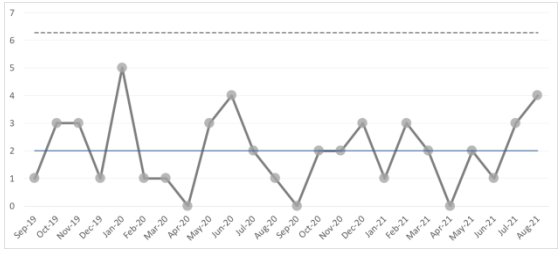
CDIFF per 1000 bed days

Monitoring
Variation: Normal
Current Month: 0.26



MSSA

Monitoring
Variation: Normal
Current Month: 4



Author: Lisa Redmond – Head of Infection Control & Deputy DIPC

MRSA bacteraemia (MRSA)
There were no attributable MRSA bacteraemias reported in August.

Clostridium Difficile Infection (CDI)
For the month of August, ESHT reported 9 cases of CDI against a monthly limit of 4. Of these 9 cases, 7 were reported as a HOHA (Hospital Onset Healthcare Associated), and two cases were reported as a COHA (Community Onset Healthcare Associated). Post infection reviews are underway. There is no evidence that cases are related in time and place, or represent an outbreak.

MSSA bacteraemia -
In August the trust reported 4 hospital attributable MSSA bacteraemias. All cases were assessed as Unavoidable.

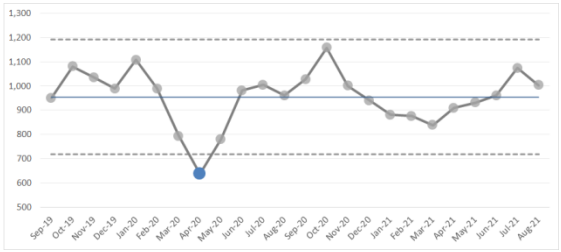
Safe Care – Incidents

East Sussex Healthcare NHS Trust

Quality and Safety

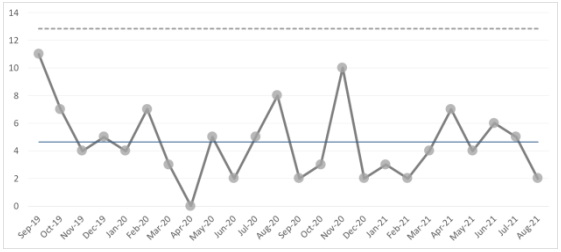
Patient Safety Incidents
(Total Incidents ESHT *and Non ESHT*)

Monitoring
Variation Normal
Current Month: 1,003



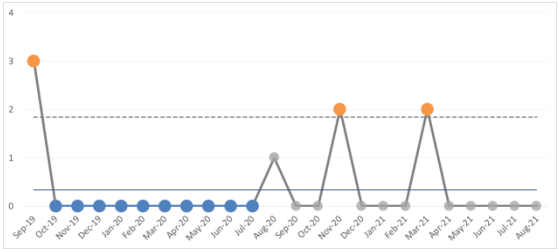
Serious Incidents
(Incidents recorded on Datix)

Monitoring
Variation: Normal
Current Month: 2



Never Events
(Incidents recorded on Datix)

Monitoring
Variation: Normal
Current Month: 0



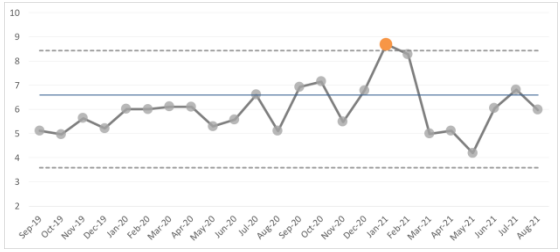
Author:	**Lisa Forward – Head of Governance**
Status Report	Patient Safety incidents remain consistent and within normal variation. Top category remains Slips/Trips/Falls with 140 incidents, followed by Diagnosis and Diagnostic Services with 108 . Both have seen a slight reduction. Third top category is Medication incidents with 87. There were 2 SIs reported in August: • 1 x Failure to follow up a possible cancer diagnosis • 1 x Intrauterine death (HSIB investigation)
Challenge & Risk:	There continues to be a challenge in completing SI RCA investigations within the expected 60 days. This is due to the Patient Safety Team being at capacity for investigations and the impact of business continuity on the divisions to provide responses. The Datix system requires an upgrade to iCloud in order to be compatible with the new Learning From Patient Safety Events (LFPSE) system which will be replacing the NRLS and StEIS. A business case was declined at the Business Development Group in August and will be resubmitted with additional information in October. Some progress is being made with the implementation of the Patient Safety Incident Response Framework (PSIRF) , but will become more challenging with increasing activities required by Q4 21/22.
Actions:	A Patient Safety Incident Response Plan is being drafted that will inform the thematic reviews the Trust may wish to take forward as part of PSIRF in 21/22. Paper on the National Patient Safety Strategy and PSIRF was presented to Quality and Safety Committee in August and presentations are being given to Divisional Governance leads

Safe Care – Falls

East Sussex Healthcare NHS Trust

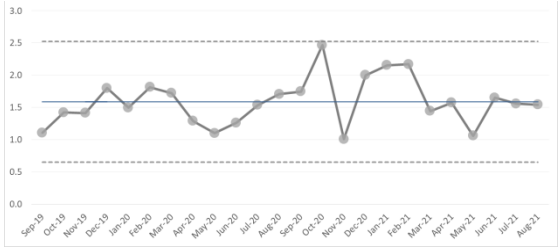
Total Falls Per 1000 bed days

RCP National Average: 6.6
(RCP – Royal College of Physicians)
Internal Stretch: <5.5
Variation: Normal
Current Month: 6.0



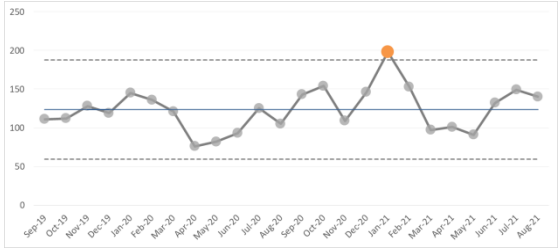
Falls with Harm Per 1000 bed days

Monitoring
Variation: Normal
Current Month: 1.5



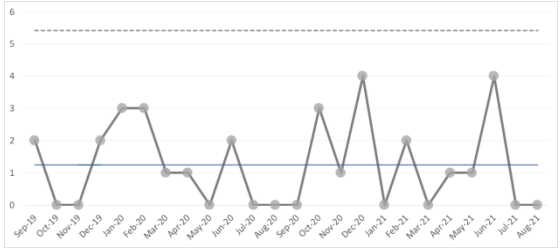
Total Falls

Monitoring
Variation: Normal
Current Month: 140



Major or Catastrophic Falls

Monitoring
Variation: Normal
Current Month: 0



Author: **Hazel Tonge – Deputy Director of Nursing**

Status Report: The rate of falls per 1,000 bed days has returned to within expected limits for the last six months.

The COO will provide more detail in her report but recent months have been very challenging due to ongoing operational challenges with significant additional capacity open of circa 70 beds. To ensure safety and support continuity, substantive areas are deploying staff to escalation areas and it has not always been possible to backfill leaving gaps at times in many areas.

Challenge & Risk: As above, the significant additional capacity is impacting on staff which is likely to have an impact on wards and falls especially in higher risk patients who may require enhanced observation.

Actions:

- Activities and events being delivered for Falls Awareness Week 20th – 26th Sept 2021

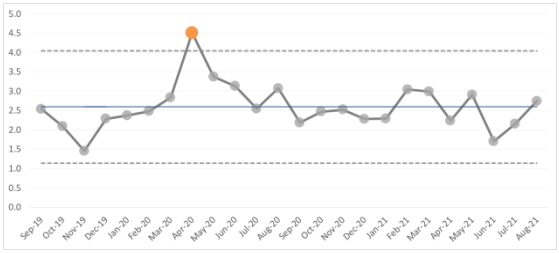
Safe Care - Pressure Ulcers

East Sussex Healthcare NHS Trust

Quality and Safety

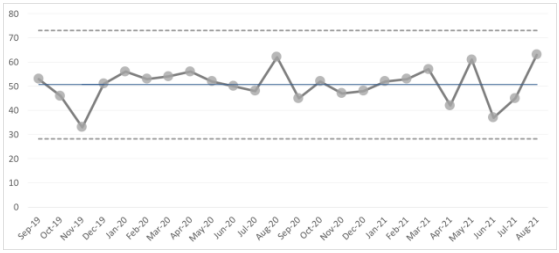
Pressure Ulcers Per 1000 bed days (Grade 2,3,4)

Monitoring
Variation: Normal
Current Month: 2.7



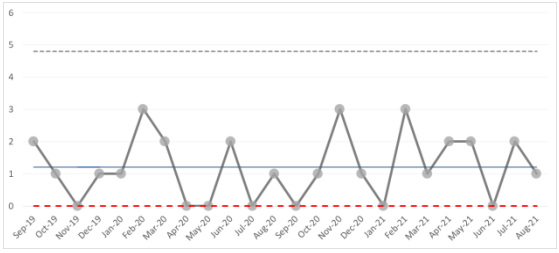
Pressure Ulcers Category 2 (inpatient and community)

Monitoring
Variation: Normal
Current Month: 63



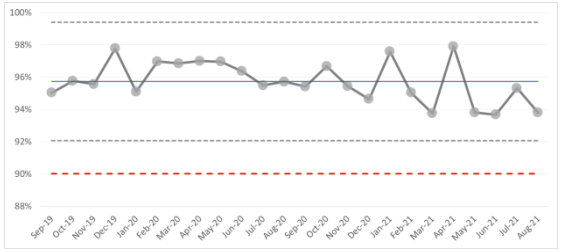
Pressure Ulcers Category 3&4

Monitoring
Variation: Normal
Current Month: 1



Pressure Ulcers Assessment Compliance

Target: 90%
Variation: Normal
Current Month: 93.8%



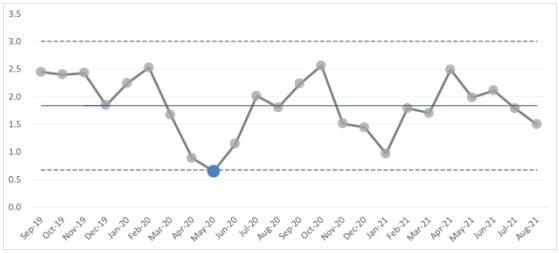
Author:	**Tina Lloyd, Assistant Director of Nursing - Corporate**
Status Report	The overall rate of Pressure Ulcers (PUs) reported remains within control limits. A total of 63 category 2 PUs were reported August 2021. One category 3 PU was reported in month but now clinically validated as category 2. Of those audited, the compliance of patients with completed PU assessments remains high/good at 94%.
Challenge & Risk:	A slight upward trend in category 2 damage is apparent which may be as a result on the ongoing staffing challenges being exacerbated by the significant additional capacity open affecting substantive staffing. Due to reassessment/validation of damage that may deteriorate/change after the reports are extracted each month this report may alter in future. This occurs because the Datix system is live and subject to change as damage is subject to ongoing clinical review and validation.
Actions:	The Pressure Ulcer Review Group (PURG) continues to review the root cause analyses relating to pressure ulceration.

What patients are telling us?

East Sussex Healthcare NHS Trust

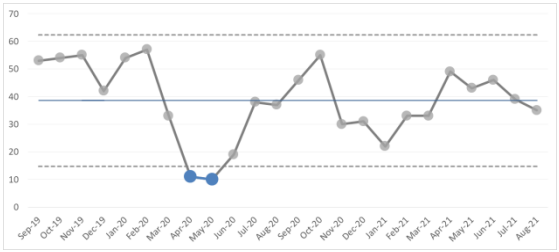
Quality and Safety

Complaints Received per 1000 bed days



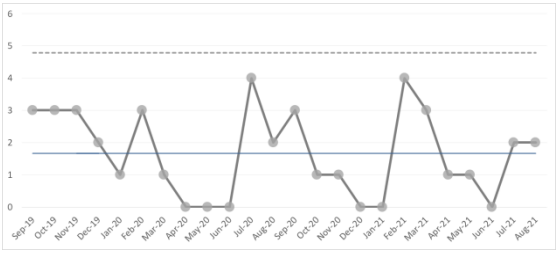
Monitoring
Variation: Normal
Current Month: 1.5

Complaints Received



Monitoring
Variation: Normal
Current Month: 35

PHSO contacts



Monitoring
Variation: Normal
Current Month: 2

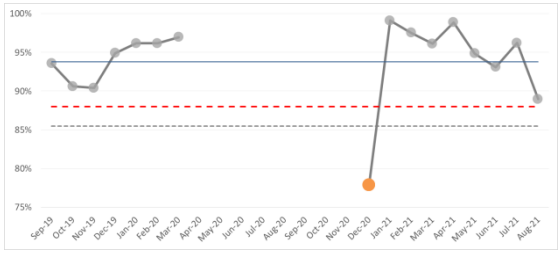
Author:	**Amy Pain- Patient Experience Lead**
Status Report	There were 117 open complaints at the end of August, a reduction from July when there were 151 with an apparent downward trend recently. In August, there were two contacts made with the Trust by the PHSO; both were enquiries into cases the PHSO were considering for investigation (DAS and CHIC) . In August there was 100% compliance, with new complaints being acknowledged within 3 working days and there were no reopened complaints. Complaint response times were distorted due to the pandemic, with a considerable backlog of complaints caused by wave 2. This is slowly improving and it is hoped that there will be a gradual restoration going forward albeit services remain under considerable pressure with recovery and restoration of services.
Challenge & Risk:	There remains a large caseload of overdue, open complaints as a result of wave 2 and the ongoing pressures.
Actions:	Ongoing monitoring and discussion in divisional IPRMs and at Q&SC.

What patients are telling us?

East Sussex Healthcare NHS Trust

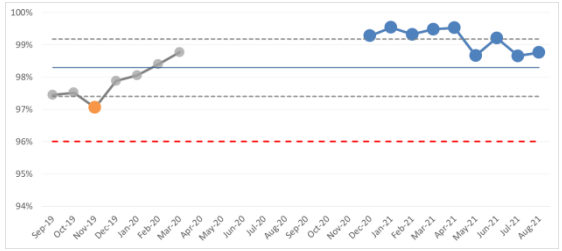
Quality and Safety

F&FT – A&E Score



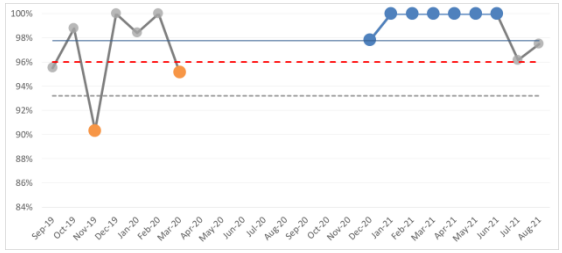
Target: 88%
Variation: Normal
Current Month: 88.9%

F&FT – Inpatient Score



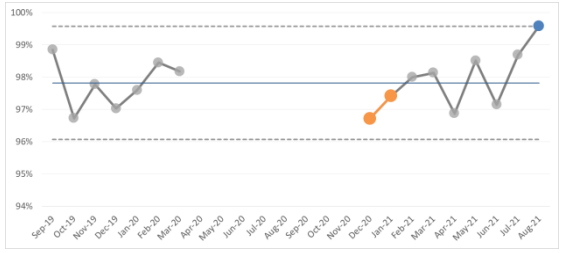
Target: 96%
Variation: Improvement
Current Month: 98.8%

F&FT – Maternity Score



Target: 100%
Variation: Normal
Current Month: 97.5%

F&FT – Outpatient Score



Monitoring
Variation: Normal
Current Month: 99.6%

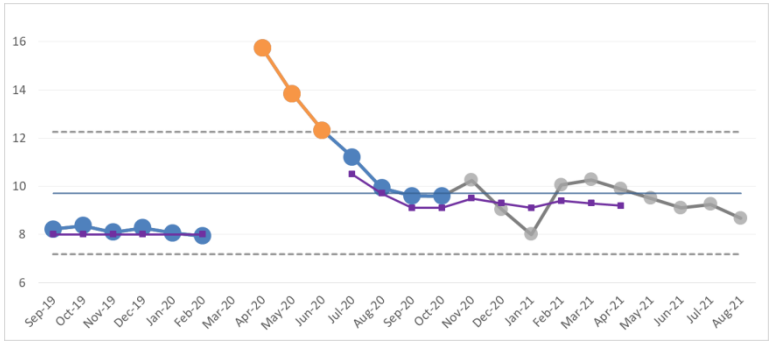
Author:	**Amy Pain - Patient Experience Lead**
Status Report	Following the pause (indicated by the gap in reporting) FFT was relaunched on 1 December 2020 at the request of NHS England. However, response rates have remained low due to the pressures of wave 2 and ongoing challenges. Whilst FFT response rates remain below pre-COVID levels, recommendation rates in July for A&E, Inpatient, and Maternity FFTs were between 88.94% and 98.76% (national average ranges between 76% and 94% for these areas). The monthly Patient Experience report (to PS&QG) contains more analysis and information regarding FFT recommendation rates and top and bottom scoring questions. The Emergency Depts scores do seem to be falling recently and may be due perhaps to the considerable pressures they are under with crowding at times and longer waits that the trust would wish for. On a positive note there has been a notable improvement in Outpatient scores with much work ongoing by the teams.
Challenge & Risk:	The focus on FFT was reduced during COVID and in wave 2 due to operational pressures and reduced staffing levels.
Actions:	Greater discussion in divisional IPRMs regarding feedback and actions/lessons learned. To support those clinical services with poor response rates in encouraging patient feedback via FFT.

Effective Care – Nursing & Midwifery Workforce

East Sussex Healthcare NHS Trust

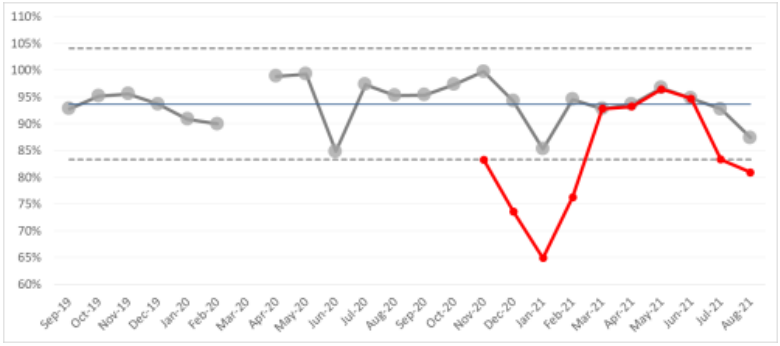
Quality and Safety

CHPPD
(Trust)



Care Hrs Per Patient Day National Median: 9.2 (April 2021)
Variation: Normal
Current Month: 8.67

Staff Fill Rate
(total)



Target: 100%
Variation: Normal
Current Month: 87.4%
Incl. escalation: 80.9%

Author:	**Angela Colosi, Assistant Director of Nursing - Corporate**
Status Report	**Care Hours per Patient Day (CHPPD*)** May's Model Hospital benchmark data shows peers at 8.9 and national median at 9.1 with ESHT at 9.5 with a return to common cause variation after the second wave of COVID. ESHT's CHPPD shows a decreasing trend with overall rate of 8.67 in August. Ward level breakdown will be discussed in the Safe Staffing report at Q&SC. *CHPPD is calculated by dividing the actual hours worked by the number of patients in beds at midnight **Staff Fill Rate** 80.9% was August's fill rate against the budgeted establishment for nursing. Escalation areas were opened for medical patients on Devonshire, Glynde, Polegate, Egerton and Murray. The fill rate including the escalation areas was 80.9% (red line), indicating that substantive nurse staffing levels were stretched to care for a greater number of medical patients. Some shifts were filled with temporary staff where available. The red line shows the wave 2 impact of COVID including additional capacity and the additional staff required to care for patients with COVID. In July it shows the increased demand for medical beds, and the increased number of staff required to safely care for those patients.
Actions:	• Health and well-being initiatives continue for staff. • Funding for substantive positions on Glynde and Devonshire is being explored to aid recruitment. • International Nurse recruitment in the community setting is planned.

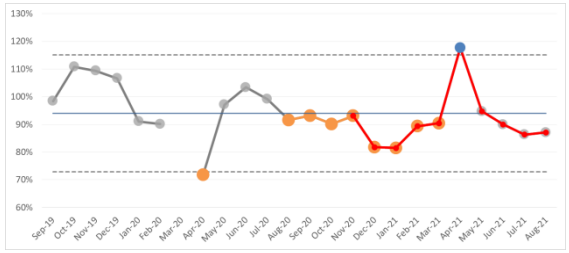
Effective Care – Nursing Workforce

East Sussex Healthcare NHS Trust

Quality and Safety

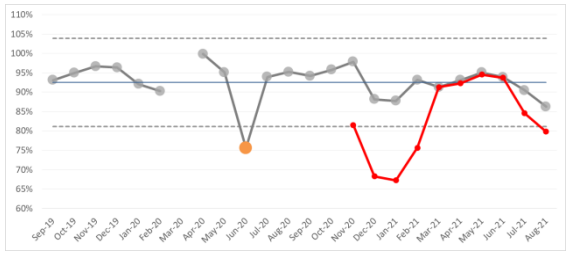
Staff Fill Rate (Bexhill)

Target: 100%
Variation: Normal
Current Month: 87.1%
Incl. escalation: 87.1%



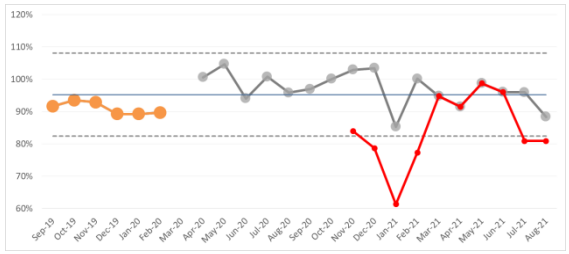
Staff Fill Rate (Conquest)

Target: 100%
Variation: Normal
Current Month 86.3%
Incl. escalation: 79.8%



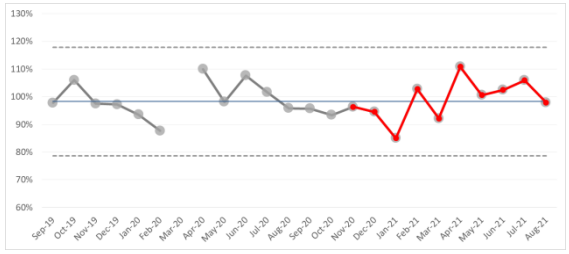
Staff Fill Rate (Eastbourne DGH)

Target: 100%
Variation: Normal
Current Month: 88.3%
Incl. escalation: 80.9%



Staff Fill Rate (Rye Memorial)

Target: 100%
Variation: Normal
Current Month: 97.9%
Incl. escalation: 97.9%



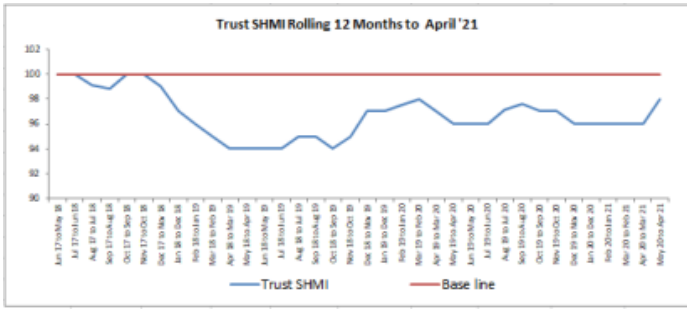
Author:	**Angela Colosi, Assistant Director of Nursing - Corporate**
Status Report	Following the significant impact of wave 2, fill rates had returned to expected levels, however over the Summer, the increase in additional escalation areas in the acute sites has impacted on the fill rate. EDGH and Conquest acute hospitals therefore show a reduced fill rate (red line) against the established template as staff are distributed to safely care for those patients in escalation areas. Common cause variation is shown in the Bexhill and Rye Hospital data. There are no longer escalation areas as all 54 and 19 beds respectively are utilised for rehabilitation and patients who are unable to weight bear.
Challenge & Risk:	The daily deployment of nurses to other wards is having an impact on morale and willingness of some staff to work extra shifts as they are moved from their base ward. Paediatrics and Maternity continue to have high activity levels and bed occupancy.
Actions:	• Health and Wellbeing initiatives continue to support staff • The twice daily staffing meetings continue in order to ensure safe care and service delivery, and shared risk management and decision making across the divisions. • Winter planning to reduce daily redeployment underway • EMU and home births have been reinstated at time of reporting

Effective Care - Mortality

East Sussex Healthcare NHS Trust

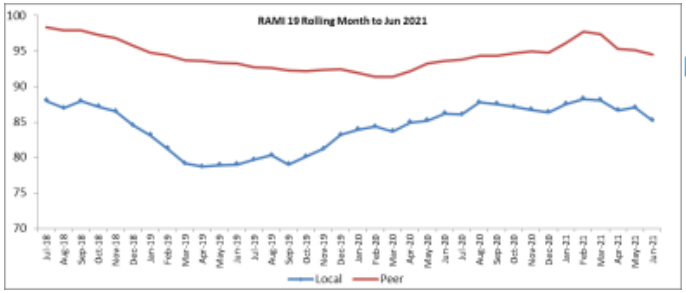
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

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

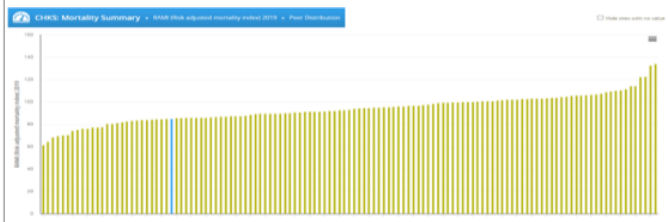


- SHMI – May 2020 to April 2021 is showing an index of 0.98
- RAMI 19 without confirmed or suspected Covid-19 – July 2020 to June 2021 (rolling 12 months) is 85 compared to 86 for the same period last year. June 2020 to May 2021 was 87.
- RAMI 19 was 72 for the month of June and 84 for May with a peer value of 95 and 91 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 without confirmed or suspected covid-19 shows July 2020 to June 2021 at 1.38% compared to 1.59% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 68% for July 2021 deaths compared to 95% for June 2021 deaths.

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



RAMI Peer Distribution without confirmed or suspected covid-19



RAMI v Peer

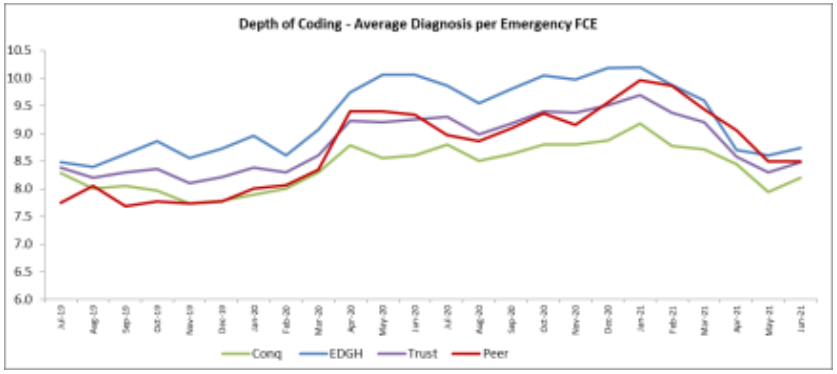
This shows our position nationally against other acute trusts - currently 27/125

August 2021 Main Cause of In-Hospital Death Groups (ESHT)

Pneumonia	20
Sepsis/Septicaemia	19
Cancer	13
Community-acquired Pneumonia	5
COVID-19	5
Cerebro-vascular Incident	4
Heart Failure	4
Myocardial Infarction (MI)	4
Chronic Obstructive Pulmonary Disease (COPD)	2
Hospital-acquired Pneumonia	2
Urinary Tract Infection (UTI)	2
Dementia	1
Liver Disease	1

There were 5 COVID -19 related deaths in August and 4 in July.

There are:
41 cases which did not fall into these groups and have been entered as 'Other not specified'.
6 cases for which no CoD has been entered on the database and therefore no main cause of death group selected.



Work is ongoing to understand the differences between the sites and why depth of coding has declined in recent months

Our People – Our Staff

Recruitment and retention
Staff turnover / sickness
Our quality workforce
What our staff are telling us?

Safe patient care is our highest priority

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

Summary

East Sussex Healthcare NHS Trust

	Positives	Challenges & Risks	Author
Responsive	**Vacancy rate** has reduced by 0.8% to 6.1%. **Current vacancies** are showing as 434.2 ftes **Mandatory Training** rate has increased by 1.2% to 89.9% **Appraisal** compliance has increased by 0.5% to 73.5%	**Annual turnover** has increased by 0.1% to 10.2%, reflecting 642.0 fte leavers in the rolling 12 months **Annual sickness** has increased by 0.1% to 5.0% but **Monthly sickness** is unchanged at 5.3%.	 **Steve Aumayer** Chief People Officer

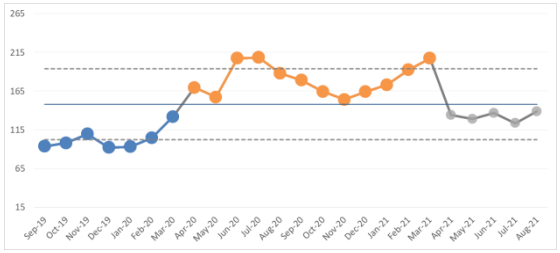
Actions:

- The Trust welcomes a further 25 International Nurses in September with further cohorts planned for November and December 2021. This brings the total to 152 since Oct 20. Medical recruitment has remained strong with locum consultants being appointed to some hard to recruit posts.
- The Pride of ESHT awards have been launched with nominations for a range of different categories. Local award ceremonies will be held later in the year.
- Following the allocation of £30K from the Friends of Eastbourne & Hastings as well as charitable trust funds, wards and departments have been allocated key items that they identified will support their Health and Wellbeing, In addition, outdoor furniture for each of the main 3 sites including the restaurant at Conquest has been purchased. There is also a new rest /eating area at Bexhill hospital that has been designed by staff and supported by the friends of Bexhill.
- Thank You & Recognition postcards have started to be delivered to teams.
- The National staff survey will be launched in Sept 2021. Over 500 colleagues completed our last Pulse survey and results will be published later this month
- Planning how we will be celebrating Black History Month in October . There will be a range of activities including key note speakers, stories from individuals who work at the Trust and our restaurants providing food from around the world
- Core Skills training compliance has improved and is at 89.9%, - 0.1 % below the required CQC set target of 90%. HRBPs will work with the divisions to drive and maintain the rate at over 90%. Integrated Education to undertake an analysis of the data and will continue to work with the Divisional Governance Leads and HRBP to lead on securing and maintaining a compliance target of 90% .
- Appraisal compliance increased slightly on last month. There was a delay in implementing the new template but the concerns have been addressed and the new template has been launched. The new training programme and additional resources have also been introduced.
- The Education Centre on the Conquest site will again be supporting the booster vaccination of all substantive and bank staff through allocation of two rooms, and space to enable staff to book in. This will be for period of no more than 12 weeks- although deadline to complete is 8 weeks.
- The IE Governance and Development Teams will continue to build a record and monitor Covid RA of all new and existing staff (where appropriate) This is a technology based solution, an initial iteration of a possible solution is being evaluated by Occupational Health.
- Refreshed Appraisal Template launched through weekly Education Communications with links to revised support learning resources and guidance.
- The Community Assets Programme at ESHT has really gathered traction in the last couple of weeks and we are proud to confirm that we will be hosting 60 placements for Kickstart at ESHT
- HR Reporting & Analytics team are starting to move towards the Blue Lab ethos which draws in analytical talent to focus on innovative delivery. We will be reaching out to ESHT colleagues to create a support network so skills and experience can enhance our insight and technical capability at the Trust
- We have designed and launched a new EDI insight tool to support the tracking of progress against our ambitious people plan as well as identify areas that need additional support
- Rostering Optimisation Programme continues to deliver tangible benefits with Roster Perform Insight for nursing, review and refresh of the Working Time Directive configuration. We are moving training bite size modules to the self-serve education platform to ensure easy access to training materials
- People Review analysis has been delayed due to increase focus on operational Business Continuity support however this process is iterative and will support strategic planning for the longer term linking with BFF and the Strategy Team
- Vaccine workforce planning is currently being scoped

Workforce – Contract type

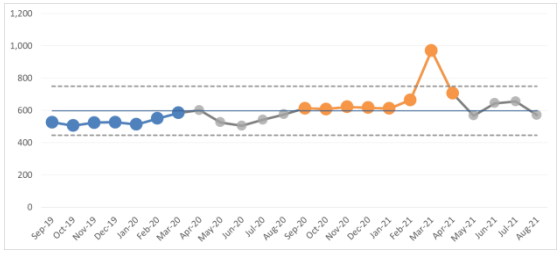
East Sussex Healthcare NHS Trust

Agency FTE Usage



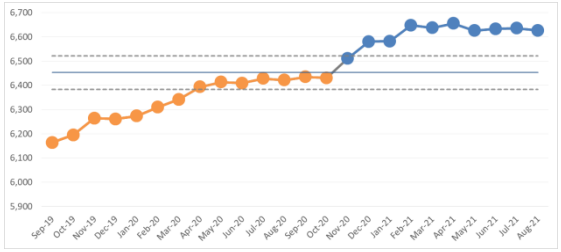
Current Month: 138.6

Bank FTE Usage



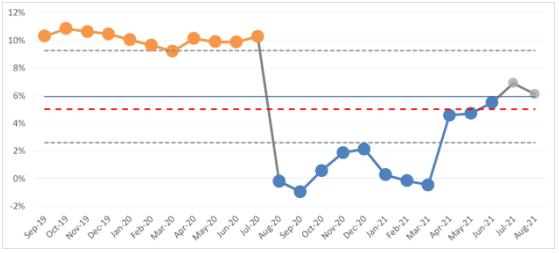
Current Month: 571.3

Substantive FTE Usage



Current Month: 6626.7

Vacancy Rate



Target: 5%
Current Month: 6.1%

Author: Penny Wright & Jenny Darwood

Status Report

Substantive usage reduced by 9.0 fte , Bank usage reduced by 83.7 ftes whilst agency fte usage increased by 15.1 ftes. Vacancy rate has reduced by 0.8% to 6.1%.
Whilst we are seeing a rise in applicants to the Trust, there is in demand for staffing due to opening escalation areas and a higher than usual absence due to sickness for this time of year.
Bank remains our main supplier of temporary staffing fulfilling 84% of filled shifts. Fill rate has reduced by 4% to 60% this dip is driven by the increase in demand as temporary supply continues to be unable to respond to the surge in requests. Although agency supply remains lower than normal months it is in line with the seasonal trend.
TWS demand increased by a further 10% compared to July , a rise for the 5th consecutive month.

Staff group	Vacancies ftes	Recruitment Process (ftes)	Offers & Start Dates (ftes)	Time to Hire (days)
Med & Dental	66.8	61	37.6 (+50 Jr Dr in Oct)	89
Reg Nurse	142.2	185.2	94.2	79
Addit Clin Serv	191.6	72.9	83.2	58
AHP	10.1	47.4	53	68
Prof, Sci, Tech	-2.6	4	7.8	76
Healthcare Scs	8.1	29.2	13.8	72
A&C	0.8	88.7	47.3	47
Est & Ancillary	10.5	35	15.5	62
Trust	**434.2**	**523.4**	**352.4**	**68.9**

Challenge & Risk:

Financial risk due to an increasing reliance on Tier 2 suppliers (above NHSI capped rates) and the requirement to source agency HCA.

Patient Safety & Quality - insufficient agency supply to meet request demand will reduce % fill.

Actions:

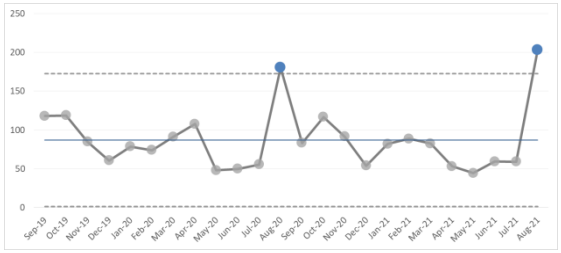
TWS, Recruitment & Workforce Planning engage with operational managers in areas of high vacancy and/or high temporary staffing reliance. Community Assets launched to support the Trust
Key stakeholder across ICS and national programmes for both temporary and volunteer workforce ensuring ESHT is spearheading key programmes such as collaborative bank across our CCG partners

Workforce - Churn

East Sussex Healthcare NHS Trust

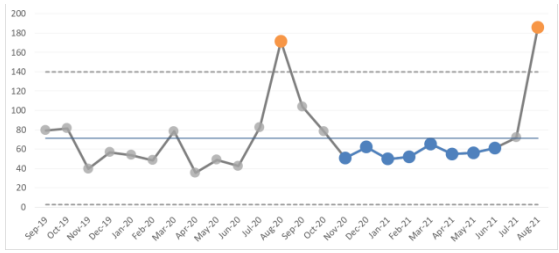
Starters FTE

Current Month: 203.3



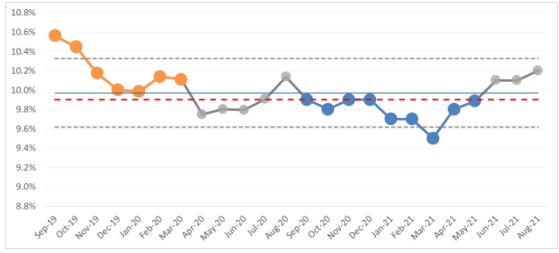
Leavers FTE

Current Month: 185.5



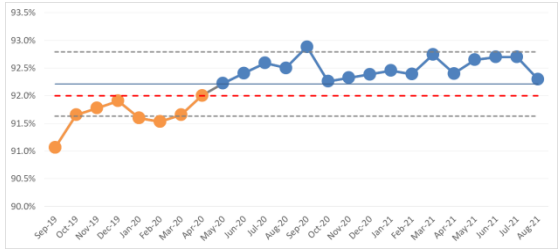
Annual Turnover Rate

Target: 9.90%
Current Month: 10.2%



Retention Rate

Target: 92%
Current Month: 92.3%

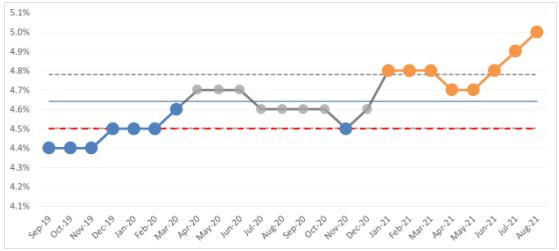


Author:	Penny Wright & Greig Woodfield
Status Report	The Trust starters & leavers monthly net total as at Aug 2021 is +17.8 with 203.3 starters fte and-185.5 leavers fte (figures are higher this month due to junior doctor rotation). Over the last 12 months there was 1016.4 Starters fte & -890.6 leavers fte giving a net increase of 125.8. The Trust turnover rate has risen slightly by 0.1% to 10.2%. There were 642.0 fte leavers in the previous 12 months. The Trust Retention rate (i.e. % of staff with at least one year's service) was down by 0.4% to 92.3%.
Challenge & Risk:	Covid travel restrictions are monitored to reduce impact on the Trust Time To Hire. Delays with Visa/TB checks at source countries is impacting on overall Trust Time To Hire. Despite success with continued targeting of "hard to recruit" posts, areas of focus remain eg Consultants for Care of the Elderly Theatre ODPs. Sonographers, Dietitians and Community Nurses.
Actions:	There is a strong pipeline of international nurses, 127 arrived since Oct 20. Next cohort of 25 Nurses due end of Sept 21.Planned intakes for remainder of 2021/22. Continued campaigns with external recruitment agencies to provide Sonographers and Theatre ODPs (6 offers to date).4 offers made to International Radiographer candidates following recent interviews. Hard to recruit medical posts with Medacs and other additional agencies, as required. Targeted phased approach to filling medical posts has proved successful. 2 Gastro Consultants, Respiratory Consultant, 2Neurological Consultants and an A &E Consultant New Recruitment Attraction webpage on target to be launched end of Sept 21.

Workforce - Sickness

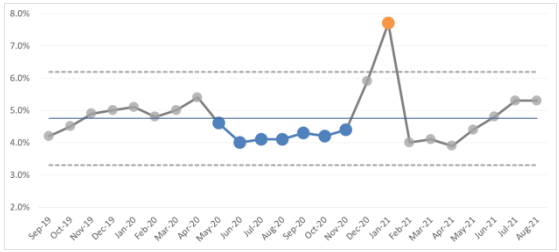
East Sussex Healthcare NHS Trust

Annual Sickness



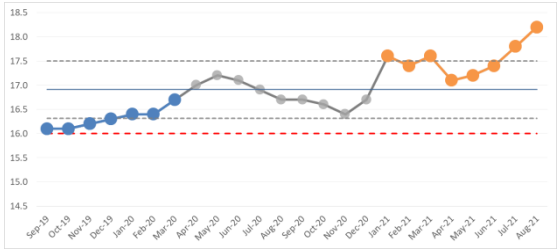
Target: 4.5%
Current Month: 5.0%

Monthly Sickness



Current Month: 5.3%

Average sickness Days per FTE



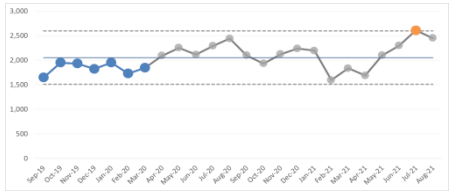
Target: 16
Current Month: 18.2

Author:	David Moulder, Julie Hales
Status Report	Annual sickness rate has increased slightly again by 0.1% to 5.0%; monthly sickness is unchanged at 5.3%. Total staff reported as absent due to Covid sickness as at 10th Sept was 26 (compared to a peak of 237 on 22nd Jan and 33 a month ago). Overall, there were 343 staff absent due to all types of sickness, compared to a peak of 540 (also on 22nd Jan, and 337 a month ago). There were 54 staff absent on isolation, (of which 21 are able to work), This figure peaked on 15th Jan at 378 staff absent. Average sickness days per fte 18.2 days per fte, up by 0.4 since last month. The average over the last two years was 16.9.
Challenge & Risk:	Monthly sickness rate remains at its highest since pandemic peak in Jan 21. It is 1.2% higher than rate for Aug 20 and 0.7% higher than rate for Aug 19. Annual sickness rate is the highest it has been for the last 2 years. With no change to national guidelines for management of Long Covid, the affected staff remain supported by managers and, where relevant, referrals to PCAS are made to ensure all appropriate support and adjustments are considered.
Actions:	HR are working with managers and Occ Health, HWLB and Divisional Leads on preventative measures, ensuring all relevant wellbeing interventions are available to staff. Revised risk assessments have either been carried out or planned to help identify lower level anxieties and concerns that allow for immediate review, in particular environmental, which may impact on staff health and wellbeing. Well being conversations have been undertaken in some areas, with good feedback.

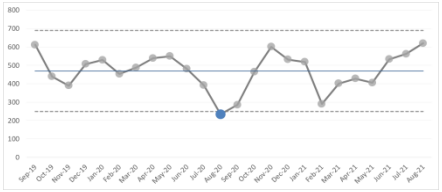
Workforce - Sickness

East Sussex Healthcare NHS Trust

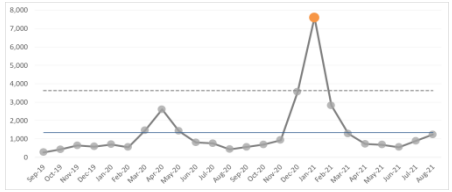
Anxiety/Stress/Depression



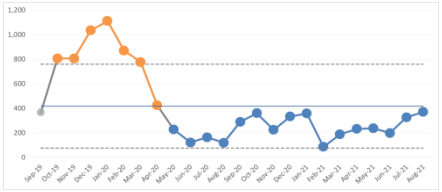
Back Problems



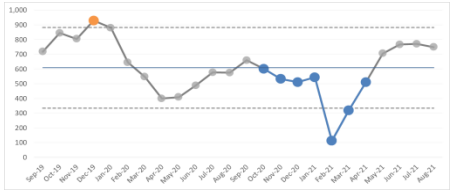
Chest & Respiratory Problems



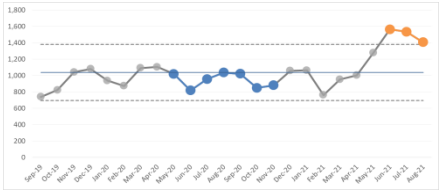
Cough, Cold & Flu



Gastro-intestinal Problems



Other MSK problems



Author: David Moulder

Status Report

Reason		fte Days Lost +/-	Total fte Days Lost
Anxiety, stress & depression	▼	-157.6	2,449.9
Back problems	▲	+57.1	619.3
Chest & respiratory	▲	+352.1	1,239.2
Cold, cough & flu	▲	+42.8	369.6
Gastrointestinal	▼	-21.5	748.6
Other MSK problems	▼	-127.3	1,407.2
Other reasons	▼	-208.5	4.211.0
All reasons	▼	-62.9	11,044.8

Challenge & Risk:

Increases in Chest & Respiratory illnesses , which are at their highest level since Mar 21, although there has not been a huge upsurge in staff off sick with Covid.

Anxiety, stress & depression sickness has fallen this month, but it is still the highest reason for sickness , accounting for 22.2% of total monthly sickness. .

Actions:

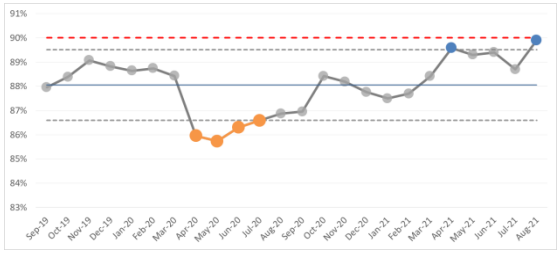
The Operational HR team continues to work with managers and staff to understand the reasons for anxiety/stress absence , which include personal reasons as well as work related stressors. Targeted piece of work underway focussing on the effectiveness of psychological interventions.

Workforce - Compliance

East Sussex Healthcare NHS Trust

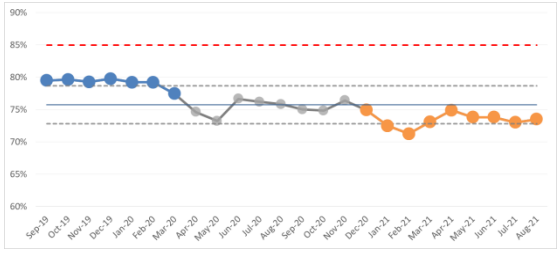
Mandatory Training Compliance

Target: 90%
Current Month: 89.9%



Appraisal Rate

Target: 85%
Current Month: 73.5%



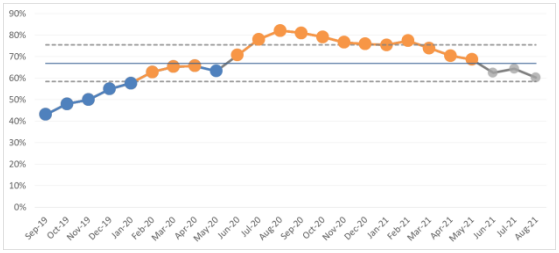
Author:	Dawn Urquhart
Status Report	Core Skills Training compliance increased by 1.2% to 89.9% just 0.1 off 90% . An excellent achievement against a backdrop of significant Trust pressures, aided by the close working relationships developed with the Divisional Governance Leads to enable the Trust to almost reach the CQC 90% target.. Appraisal compliance increased slightly on last month. There was a delay in implementing the new template but the concerns have been addressed and it has now been launched. The new training programme and additional resources have also been introduced. The Education Centre on the Conquest site will again be supporting the booster vaccination of all substantive and bank staff through allocation of two rooms, and space to enable staff to book in. This will be for period of no more than 12 weeks, although deadline to complete is 8 weeks.
Challenge & Risk:	We need to finalise new modules and ascribe the relevant competency to roles in the Trust dependent on subject matter Work is due to be completed by the end of Oct on finalising competencies for Looked After Training and Oxygen . We continue to provide additional Induction capacity to support recruitment initiatives. Operational status of the Trust (including future Covid outbreaks) with the subsequent pressures on service infrastructures and care pathways could impact negatively on future compliance capability.
Actions:	In response to possible future waves of Covid, the Training Directory has been kept up to date. The spreadsheet of trained competent vaccinators has been shared with Occ Health Working with the HR Business Partners we will be undertaking an analysis of data to understand where there are variable compliance ratios to ensure that services work to improve on their compliance. The IE Governance and Development Teams will continue to build a record and monitor Covid RA of all new and existing staff (where appropriate). An initial iteration of a possible solution is being evaluated by Occupational Health.

Workforce – Job Planning

East Sussex Healthcare NHS Trust

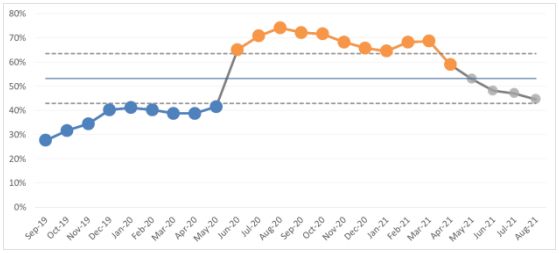
Consultant eJob-Planning Fully Approved Rate

Current Month: 60.2%



SAS Grades eJob-Planning Fully Approved Rate

Current Month: 44.6%



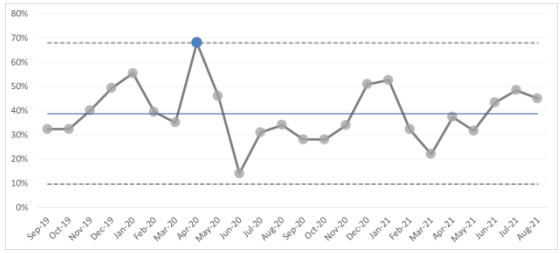
Author:	Penny Wright
Status Report	This equates to an overall approval rate of 55.7%. 151 of 251 Consultants have a completed eJob Plan (60.2%) and 45 of 101 SAS Doctors have a completed eJob Plan (44.6%).
Challenge & Risk:	The sign off rate has dropped due to job plans being reviewed and returning back to discussion to reflect the changing demands on the services for 2021. Operational pressures are also impacting on Service Managers, Specialty Leads and Medics having the time to review job plans.
Actions:	Of the 156 not yet signed off, 84 are in discussion and 72 are within the sign-off stage. The eJP team are actively working with Consultants, Clinical Leads and Service Managers to assist job plans to completion. There will be a detailed report provided to David Walker and Jamal Zaidi in their capacity as Medical Director and Deputy Medical Director to support specific areas struggling to process the job plans. It is expected there will also be a number of eJP's that will require formal mediation to resolve ongoing debates regarding the detail within some plans. This will significantly improve the quality of all job plans and ensure that there is an increase in fully approved JP's. Whilst the fully approved rate has reduced, the job plans have improved in quality of content. Feedback has confirmed that they are more reflective of the day to day medics role/activities. The Trust is aiming for a 90% compliance rate by the 30th Sept 21 and will need the full support of all Clinical Leads to achieve this. facilitated by the Service Managers.

Workforce – Roster Completion

East Sussex Healthcare NHS Trust

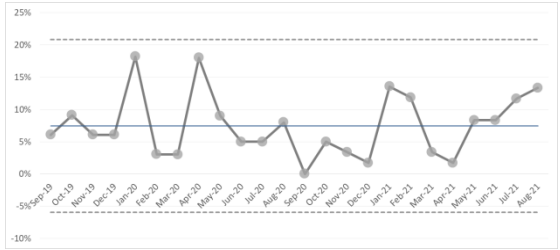
6 week Nursing Management Roster Approval Rate

Current Month: 45%



8 week Nursing Management Roster Approval Rate

Current Month: 13%



Author:	Penny Wright
Status Report	For the roster starting on 9th August, 45% of rosters had been approved at 6 weeks before the go live date which is a 3% reduction on the previous month, whilst 13% had been approved at 8 weeks prior to commencement which is a 1% improvement on the previous month.
Challenge & Risk:	There are opportunities to improve effective planning to in turn drive efficient deployment of staff. Lower roster approval rates are linked with late requests for TWS support. This means probability for filling shifts becomes lower and has implications for patient safety and staff morale.
Actions:	New workforce planning tools have been designed to support effective planning of rosters in a timely manner. These will be embedded in the divisional IPR reviews and supported by Corporate Nursing and HR. Further self-serve bite size training modules are currently being piloted in the operations to ensure that we improve the quality of roster planning with practical guidance. There will also be a programme designed to link effective planning and efficiently deploying rosters with staff wellbeing due in Oct/Nov. Whilst this initially starts with nursing, the intention will be to roll out to all areas and staff groups so the Trust has sight of short to medium term planning capability & opportunities to enhance through education. Further details for Roster Performance in Chief of Nurse section.

Access and Responsiveness

Delivering the NHS Constitutional Standards

Urgent Care – Front Door

Urgent Care – Flow

Planned Care

Our Cancer services

We will operate efficiently & effectively

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

Summary

East Sussex Healthcare NHS Trust

Access and Responsiveness

	Positives	Challenges & Risks	Author
Responsive	**Elective Recovery:** To maintain our H1 recovery, we had to deliver >95% of 19/20 baseline activity in August. The Trust delivered across 3 of the 4 points of delivery with • Daycase at 107%, • Follow up appointments 111% • Total outpatient appointments 111% Diagnostics similarly, achieved above the target (>100% 19/20 baseline activity) in August • Radiology: 117% • Endoscopy: 134% **Cancer 62 day trajectories:** We have remained ahead of trajectory for the number of patients waiting over 62 days on a cancer pathway. Finishing with 149 patients against a trajectory of 154. And were the only provider within our system to sustainably deliver this.	**ED Performance:** The Trust delivered 80.5% against a target of 95% in August putting the Trust @ 43st in the country. Similar to elective inpatients, the challenges remain with high bed occupancy, escalation wards open, workforce challenges and an increased overall LoS which is due to the current pressures in the social care market limiting our ability to discharge medically fit patients. **Elective Recovery:** Although we have in the main delivered the activity targets, there does remain the non-elective challenge which will compromise future delivery. With limited patient flow and high bed occupancy numbers, our elective bed footprint is frequently compromised. Workforce challenges remain a key factor in our ability to improve our elective activity numbers **Community Capacity:** East Sussex Health and Care Partnership are working to reduce the unwarranted variation in access to rehab services and high demand on intermediate care beds to understand how community services can support the reduction in LoS which will support improved patient flow, ED performance and elective recovery **Cancer 28 day FDS and 62 day standards:** Although we achieved our trajectory targets in Cancer, the Trust remains challenged to deliver the 28 day FDS and 62 day standards. This is in the main, due to our ability to deliver timely diagnostics. As well as a reliance on tertiary centres for some diagnostics and treatments, we have our own internal challenges which we are working to address around the timely turnaround of suspected cancer diagnostics	 **Tara Argent** Chief Operating Officer
Actions:	• Increase UTC throughput • Re-direction to other services including signposting patients towards NHS111, pharmacies and other healthcare providers • Finalisation of the Winter plan to understand the demand and mitigating actions /system partner requirements • Contributing to the re-imagining of community health services in South East England • Work with the CCG to deliver Community Diagnostic Hub (CDH) . Specifically for cardiology and radiology capacity • Hold an East Sussex Same Day Access Rapid Improvement away day with providers and local GPs		

NHS Constitutional Standards

East Sussex Healthcare NHS Trust

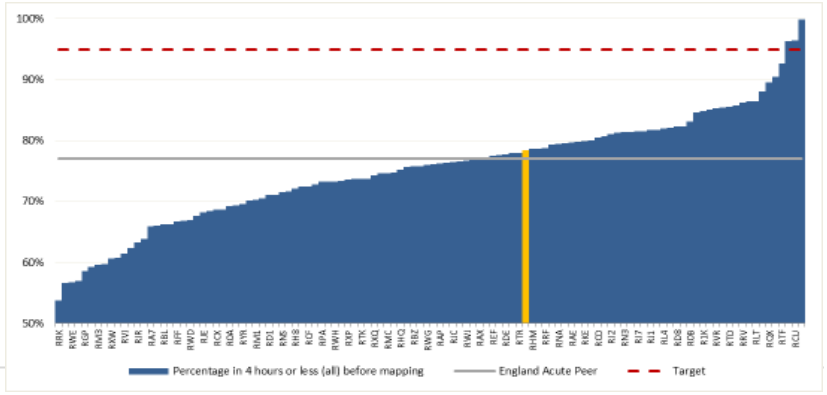
*NHS England has yet to publish all August 2021 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

August 2021 Peer Review

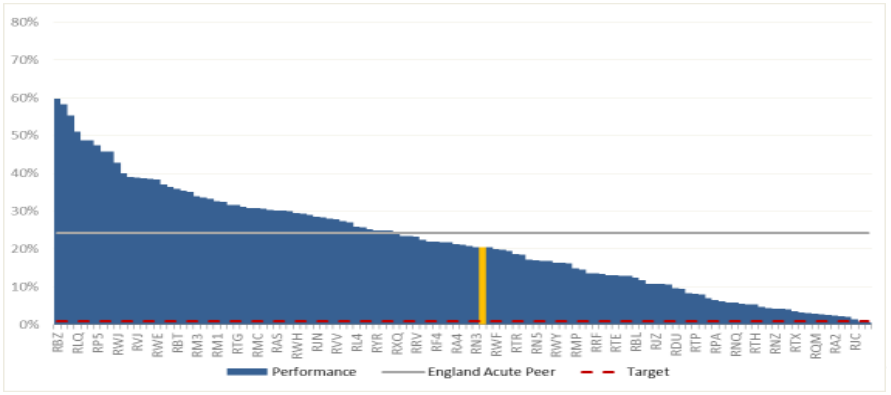
National Average: 77.01% ESHT Rank: 43/114



Planned Care – Diagnostic Waiting Times

July 2021 Peer Review*

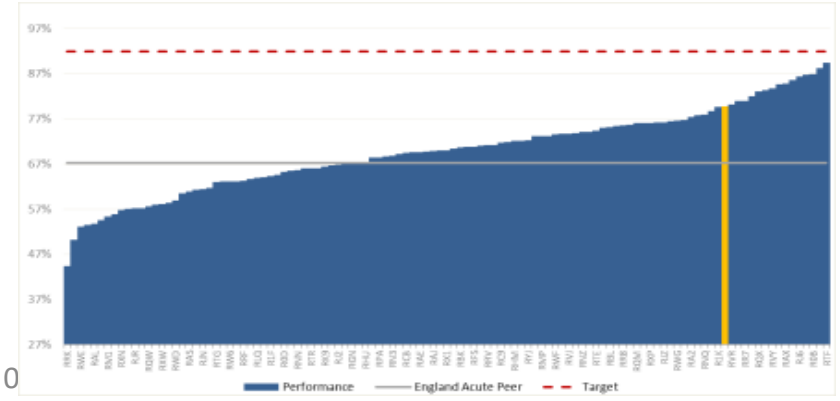
National Average: 24.2% ESHT Rank: 59/123



Planned Care – Referral to Treatment

July 2021 Peer Review*

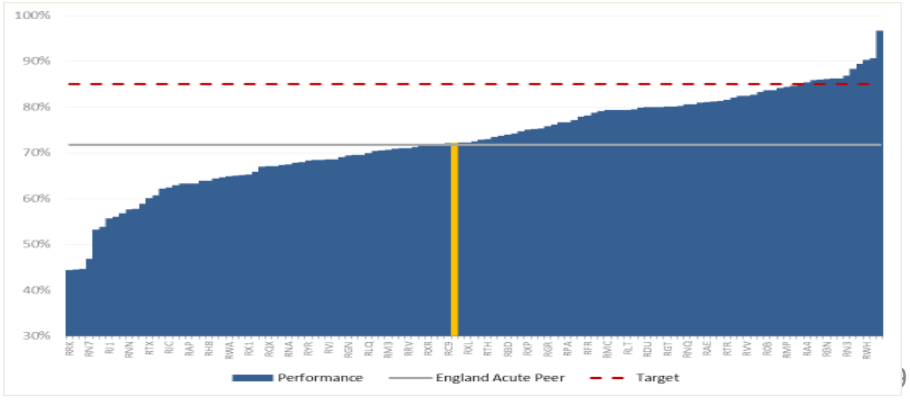
National Average: 67.3% ESHT Rank: 16/113



Cancer Treatment – 62 Day Wait for First Treatment

July 2021 Peer Review*

National Average: 71.8% ESHT Rank: 65/123

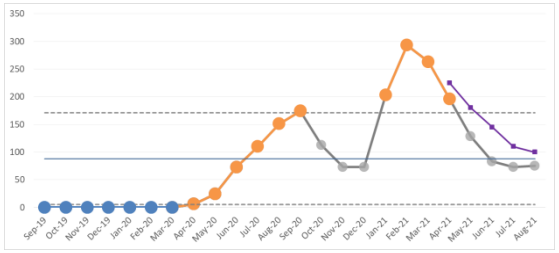


Planned Care – H1 Recovery KPIs

East Sussex Healthcare NHS Trust

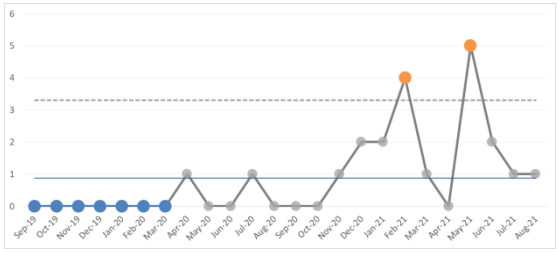
Access and Responsiveness

RTT 52 Week Waiters



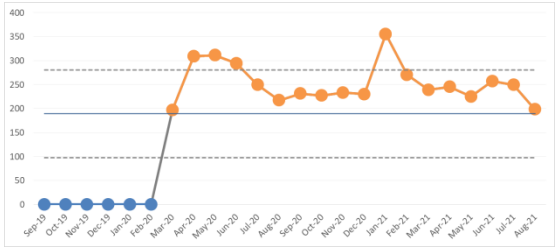
Target: 0
Trajectory: 100
Current Month: 75

RTT 78 Week Waiters



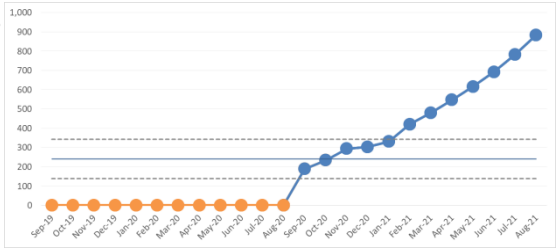
Target: 0
Current Month: 1

P2 Overdue (> 35 Days)



Target: Monitor
Current Month: 198

PIFU Pathways



Target: Monitor
Current Month: 883

The Trust continues to manage its long waiting patients effectively. With the waiting list age profile increasing, this can be more challenging for divisions but the trend is a positive one and the number of patients waiting >78 weeks still remains 0. We have the lowest number of patients waiting >52 weeks in the region.

P2 patients waiting >5 weeks continue to be monitored and booked effectively through weekly PTL meetings and safe monitoring.
The number of patients on a Patient Initiated Follow-Up (PIFU) pathway continues to increase and all specialties are working through their pathways to determine if any are PIFU suited, in an effort to try and drive this number up further. We do have the highest number of patients on PIFU plan in the region currently. Although there is further work needed to ensure we meet the target for H2

TRUST

					Forecast	
Total Elective Admissions - Daycase	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
National Target	70%	75%	80%	95%	95%	95%
ESHT Threshold Target	81%	86%	92%	94%	92%	93%
Actual	93%	102%	93%	95%	99%	
Total Elective Admissions - Ordinary						
National Target	70%	75%	80%	95%	95%	95%
ESHT Threshold Target	70%	78%	85%	87%	87%	87%
Actual	79%	97%	84%	87%	76%	
Consultant led first outpatient attendances (Spec Acute)						
National Target	70%	75%	80%	95%	95%	95%
ESHT Threshold Target	86%	88%	95%	95%	96%	96%
Actual	94%	93%	95%	86%	92%	
Consultant led follow-up attendances (Spec Acute)						
National Target	70%	75%	80%	95%	95%	95%
ESHT Threshold Target	84%	86%	93%	93%	94%	94%
Actual	107%	107%	102%	99%	105%	
Total Outpatient attendance (All TFC, cons and non cons led)						
National Target	70%	75%	80%	95%	95%	95%
ESHT Threshold Target	85%	87%	94%	94%	95%	95%
Actual	104%	108%	105%	100%	102%	

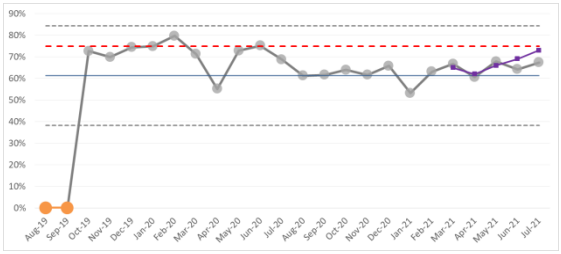
Planned Care – H1 Recovery KPIs

East Sussex Healthcare NHS Trust

Access and Responsiveness

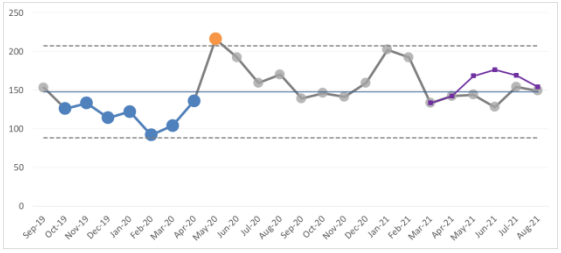
28 Day FDS(Faster Diagnosis Standard)

Target: 75%
Trajectory: 73%
Current Month: 67.4%



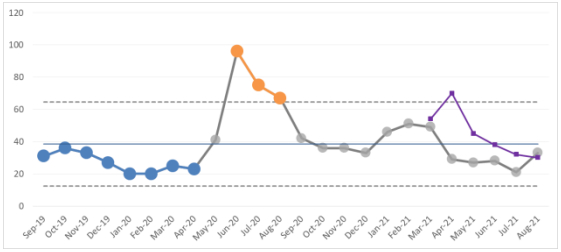
Cancer 62 Day Breach

Target: Monitor
Trajectory: 154
Current Month: 149



Cancer 104 Day Breach

Target: Monitor
Trajectory: 30
Current Month: 33



We have seen an improvement in our 28 day FDS standard this month although not yet compliant with the national target of 75%.

To address this, divisions are working to reduce the number of days wait for a patient's first appointment to 4 days, to allow for time to complete full diagnostics and inform the patient by day 28, of their diagnosis.
The introduction of insourcing in Endoscopy supports an improved turnaround time for patients waiting scope procedures. The primary focus is for those patients on a colorectal pathway as this represents the highest volume of referrals received.

We remained below trajectory for our number of patients waiting more than 62 days. However, the number of patients waiting over 104 days is currently 3 above trajectory and this is due to patient choice and complex pathways. These patients will continue to be closely monitored.

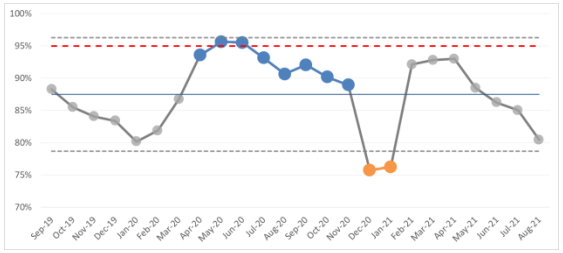
Urgent Care – Front Door

East Sussex Healthcare NHS Trust

Access and Responsiveness

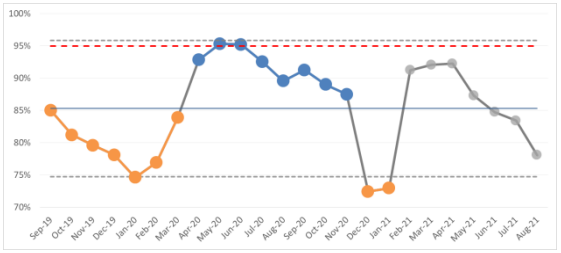
A&E Performance
(Local System)

Target: 95%
Current Month: 80.5%

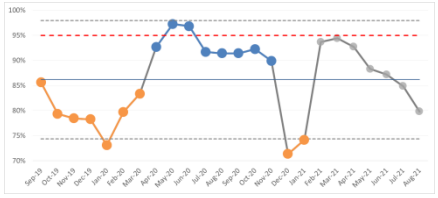


A&E Performance
(ESHT Total Type 1 & 3)

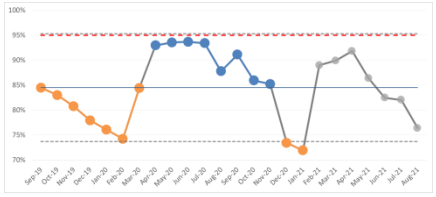
Target: 95%
Current Month: 78.1%



CONQ

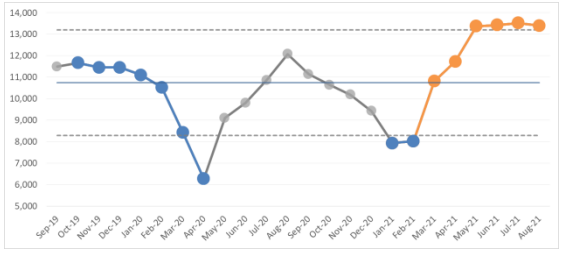


EDGH



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

Target: Monitor
Current Month: 13,397



Urgent Care demand appears to have now stabilised, with a plateau in the rise in demand however, this new level of demand is now higher than pre-covid demand with a change in acuity of patients.

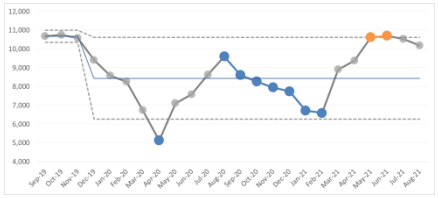
Despite Trust performance remaining below the 95% target, the Trust does continue to be a higher performing Trust within the region and in the upper quartile nationally.

Managing flow and admission avoidance to the emergency departments is essential to recover performance and work has started across urgent care to explore how best to support the new level of demand and increased utilisation of the Urgent Treatment Centre (UTC) to stem the flow into the main emergency department.

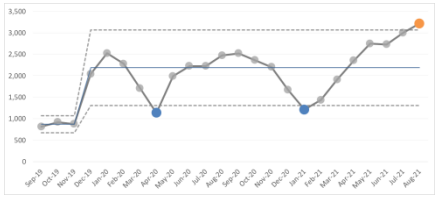
Urgent Care – Front Door

East Sussex Healthcare NHS Trust

ESHT Total Type 1

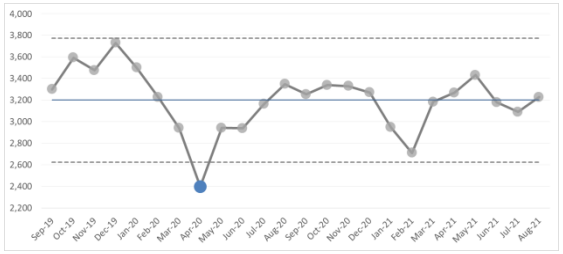


ESHT Total Type 3



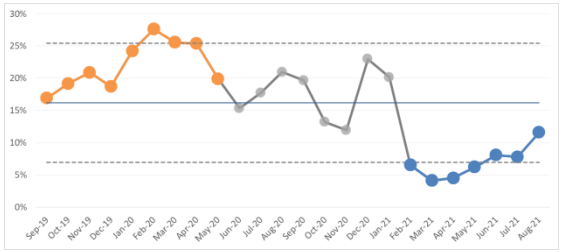
Conveyances
(ESHT – CQ and EDGH)

Target: Monitor
Current Month: 3,227



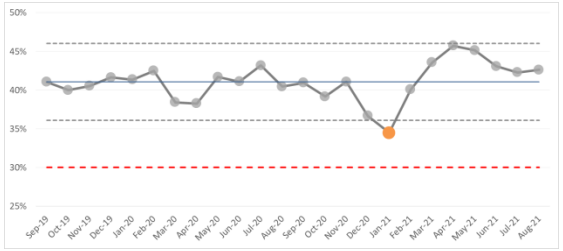
Conveyance Handover >30
(ESHT – CQ and EDGH)

Source: SECAmb
Target: Monitor
Current Month: 11.6%



Same Day Emergency Care
(ESHT – CQ and EDGH)

Target: 30%
Current Month: 42.6%



Extensive work is being undertaken across urgent care to ensure patients are seen by the clinician with the most suitable skills for their condition, with an emphasis on focusing on discharging back to community care where possible – this work will lead to a renewed front door model but the initial stage of change in models is reflected in the increase in type 3 attendances.

Re-direction to other services to be launched in September including signposting patients towards NHS111, pharmacies and other healthcare providers and it is expected that this will lead to a further increase in type 3 being recorded and a continued downward trend of type 1.

Daily reviews of conveyances remains a focus for the urgent care team, with some progress made with system partners on understanding alternative pathways however the continued increase in handover delays remains difficult to manage mainly due to constraints in flow as a result of the demand for medical beds.

As a Trust we continue to work towards increased usage of SDEC and have now gone live with NHS111 referrals into our medical SDEC with the next focus on direct Ambulance referrals.

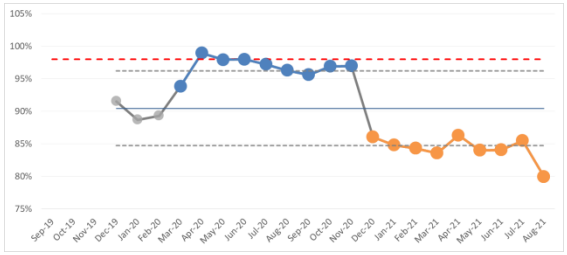
We have improved our communication to patients via social media and poster campaign to increase awareness of healthcare through alternate provision.

Urgent Care – UTC

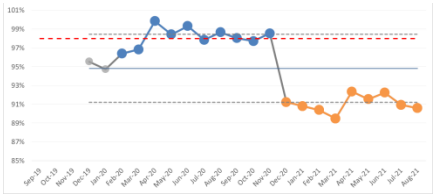
East Sussex Healthcare NHS Trust

UTC 2 Hour Standard
(Treatment start within 2 hrs)

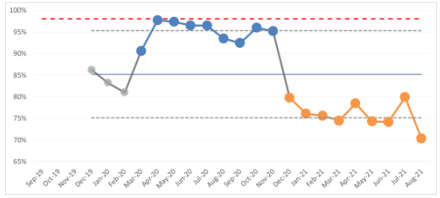
Target: 98%
Current Month: 79.9%



CONQ

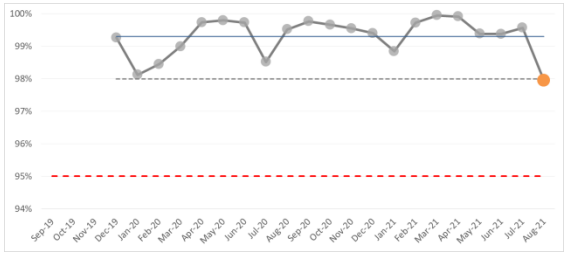


EDGH

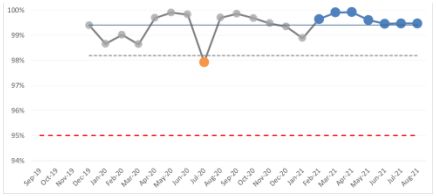


UTC 4 hour standard
(Visit complete within 4 hours)

Target: 95%
Current Month: 97.9%



CONQ



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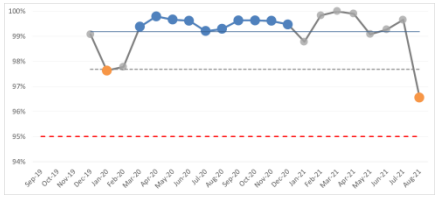


The Trust continues not to focus on the two hour standard but on flow and increased throughput of the UTCs to support the overarching four hour standard, the decrease in performance against the two hour standard is related to the increase workload being applied to the UTCs. A review of the operating model of the UTCs and the clinical staffing is currently being developed with system partners.

UTC Performance is reported at each sites bed meeting, three times per day with a noted increase in attendance numbers.

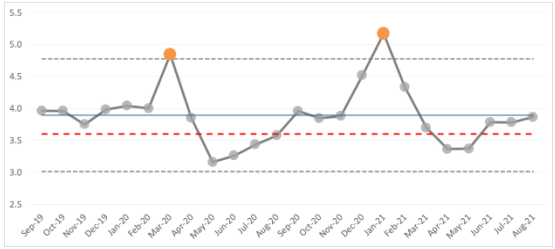
Patient Care- Flow

East Sussex Healthcare NHS Trust

Access and Responsiveness

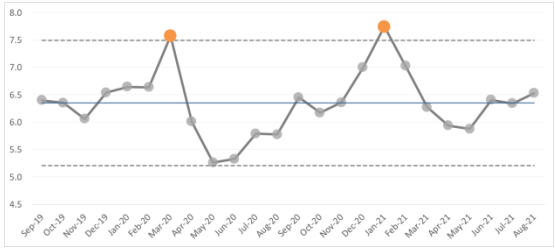
Non-elective Length of Stay (Acute)

Target: 3.6
Current Month: 3.9



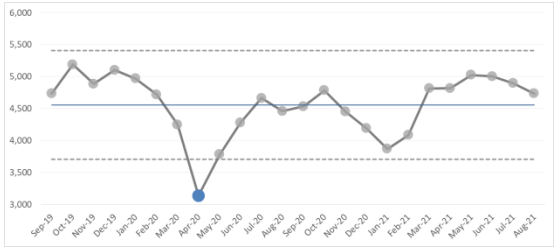
Non-elective Length of Stay, excluding zero LoS (Acute)

Target: Monitor
Current Month: 6.5



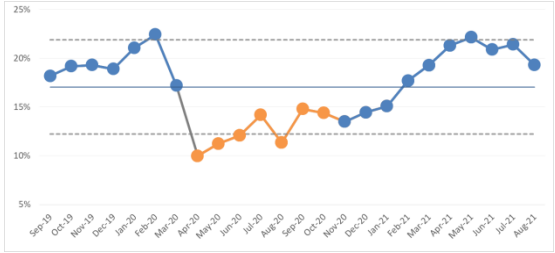
Non Elective Spells

Target: Monitor
Current Month: 4,732



Medical Non Elective Admissions (% SDEC)

Target: Monitor
Current Month: 19.3%



Non-elective LoS has seen a slight increase from trajectory at 3.9 days

The Trust continues to see an increased pressure on acute admissions and patient flow.
Resourcing challenges in the care market with availability of packages of care capacity, is having a direct impact on the Trust's overall average LoS.

Actions for ED / UTC Gateway:

- Working with the system on strategies to prevent admission and reduce foot fall in A&E/UTCs and redirecting patients to other UTC's
- UTC front door total triage call-back model
- Continue to drive a LOS reduction across all pathways with increased utilisation of SDEC
- - Direct access to gateways and availability of specialist advice to GPs to prevent admission
- - Bookable access to GPs for plain film imaging
- Financial submission to ICS to access SDF funds to support community 2 hour responses to prevent admissions-investment signed off; CHIC to share model once finalised.

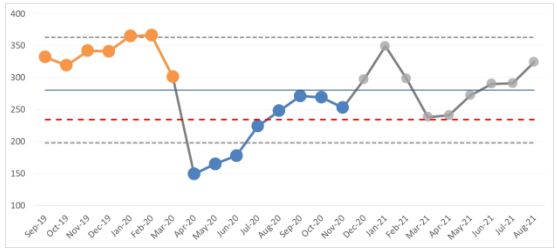
Patient Care - Flow

East Sussex Healthcare NHS Trust

Access and Responsiveness

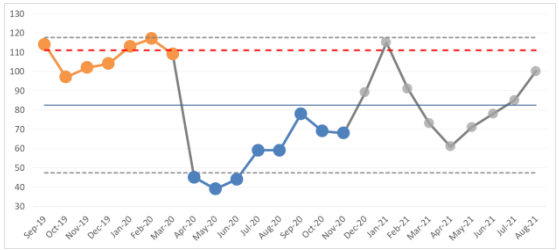
Adult inpatients in hospital for 7+ days (Acute)

Target: Monitor
Current Month: 324



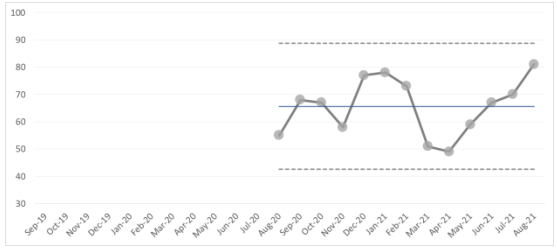
Adult inpatients in hospital for 21+ days (Acute)

Target: Monitor
Current Month: 100



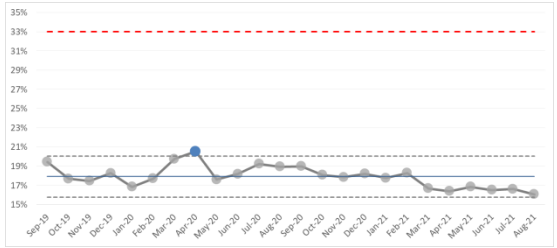
MRD on Pathways 1-3

Target: Monitor
Current Month: 81



Patients discharged before midday %

Target: 33%
Current Month: 16.1%



There has been a continued increase in LoS for patients waiting over 7 and 21 days

Patients on Pathway 1 are taking longer to be discharged from the point that they no longer meet the criteria to reside this is due to both the time for the screening to occur to allow them to access the services they require outside hospital and also the current pressures on the care market limiting capacity for discharges.

Patients on Pathway 2 discharge are being delayed into community rehabilitation beds due to the increase in volume of patients who are requiring bedded rehabilitation and also the complexity of those cases e.g. we have seen a significant increase in patients who have suffered from strokes.

Patients on Pathway 3 requiring care home placements have remained a similar LoS as August.

Increase in LoS from point that a person doesn't meet the criteria to reside to discharge increases pressure on beds, can lead to further deconditioning of that patient supporting them to return home in a safe and timely way.

Actions under consideration :

- Full Implementation of Discharge to Assess and trusted assessor model across the system
- Clarity of roles and responsibilities for system partners- gap analysis in progress.
- Increasing same day discharge by supporting the increase in capacity for Crisis Response service
- System wide review on community rehabilitation beds to ensure capacity meets both volume and complexity of demand-In progress.
- Planning discharge at point of admission-model in development.
- Working with the system partners on winter and 12- 18 month Discharge Plan to support current pressures.
- Process map the P1's from Pre-MRD to MRD recommending streamlined pathway.

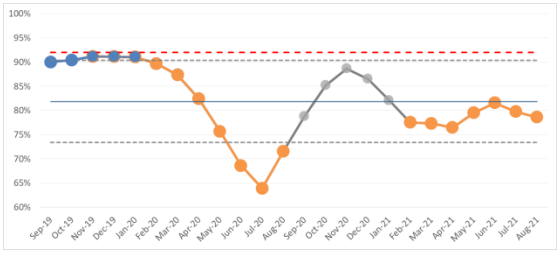
Planned Care – Waiting Times

East Sussex Healthcare NHS Trust

Access and Responsiveness

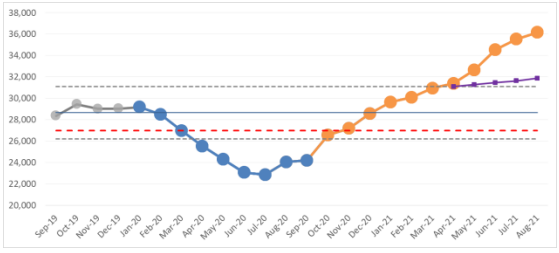
RTT Incomplete Standard

Target: 92%
Current Month: 78.6%



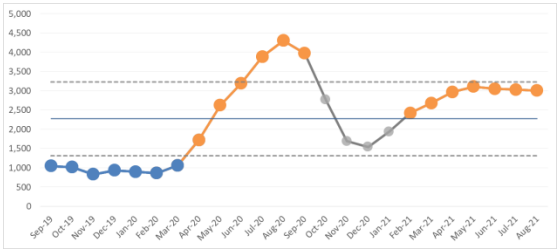
RTT Total Waiting List Size

Target: 26,965 (Mar-20)
Trajectory: 31,870
Current Month: 36,147



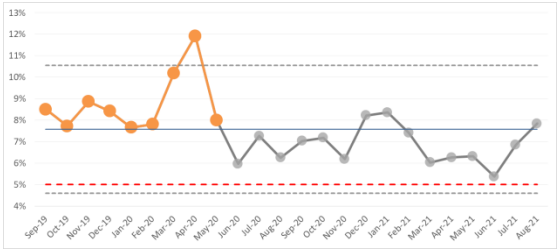
RTT 26 Week Waiters

Target: Monitor
Current Month: 3,000



Cancellations On The Day (Activity %)

Target: 5%
Current Month: 7.8%



The national standard for Referral to Treatment (RTT) is 92%. However it remains challenged as a result of the national suspension of elective activity due to Covid. The Trust is working to the national guidance for recovery and operational standards and as such, we are still treating almost 80% of our patients within 18 weeks.
The age profile of our waiting list has grown, we are seeing higher numbers of patients waiting in the 18-26 week bracket. Activity numbers do remain high however and divisions are not only working to reduce their waiting time for a first appointment but also managing their long waiting patients effectively.

We should begin to see our overall waiting list size reduce with an increase in Advice & Guidance and PIFU.

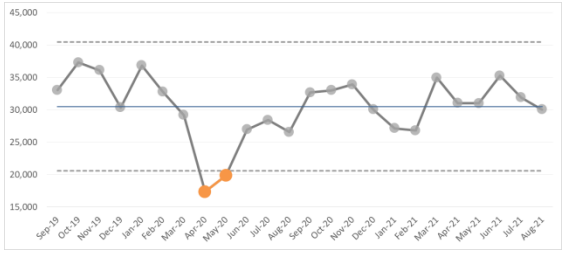
Cancellations on the day increased in August and this is largely due to workforce challenges resulting in reduced theatre capacity meaning we had to prioritise our theatre staff to accommodate trauma and CEPOD, as well as cancer and urgent cases. Lists were clinically reviewed to ascertain what patients were the safest to postpone.

Planned Care – Outpatient Delivery

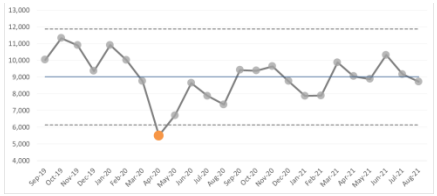
East Sussex Healthcare NHS Trust

Outpatient Total Activity
(New and Follow-up)

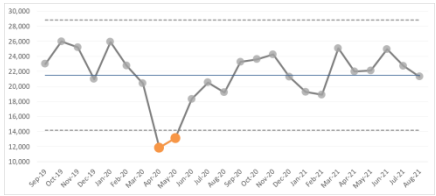
Target: Monitor
Current Month: 30,037



New

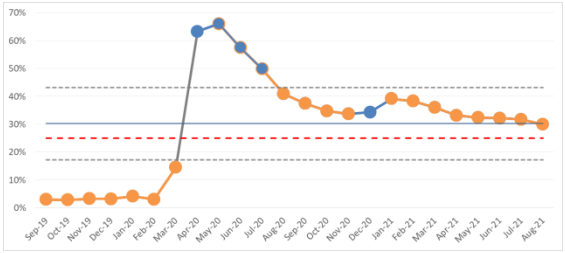


Follow-up



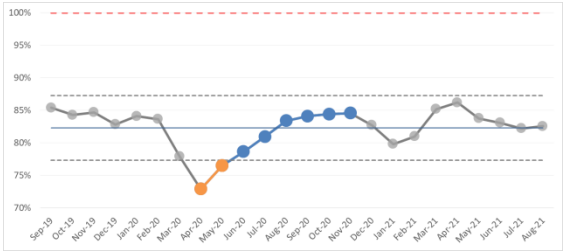
Non Face to Face Outpatients Activity
(Activity %)

Target: 25%
Current Month: 29.9%



Outpatient Utilisation
(Consultant and nurse led Clinics)

Target: 100%
Current Month: 82.5%



August saw a decrease in the number of patients seen, due to annual leave and staff sickness. We had planned for a reduction in activity however, as a result of an increase in non-elective activity and bed occupancy, some outpatient clinics had to be rescheduled to release clinicians to cover ward rounds and support patient flow.
However ESHT did deliver 103% against 19/20 activity and over delivered against the 95% Elective Recovery Fund Target.

We remain above the ERF target of 25% of activity being delivered virtually.

Utilisation is constantly reviewed and the administrative teams are working to ensure that the "available" clinics on our PAS system are accurate to reduce the number of hospital initiated cancellations. This is taking time to clear but is a priority for the team.

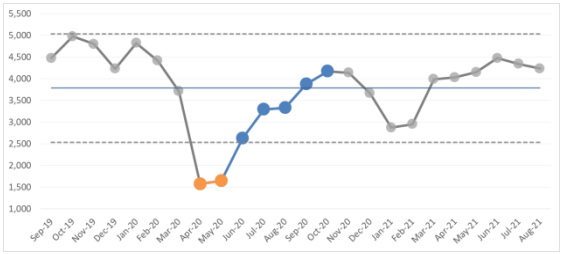
Planned Care – Admitted Delivery

East Sussex Healthcare NHS Trust

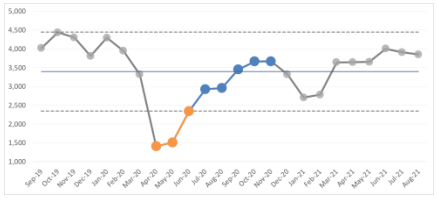
Access and Responsiveness

Elective Spells
(Day case and Elective IP)

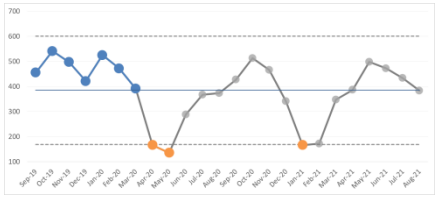
Target: Monitor
Current Month: 4,233



Day case

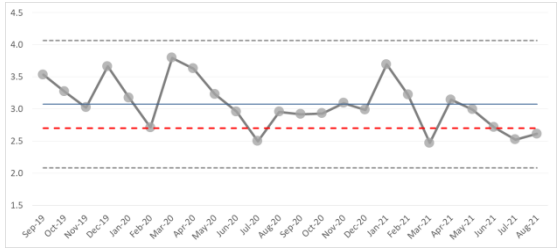


Elective IP



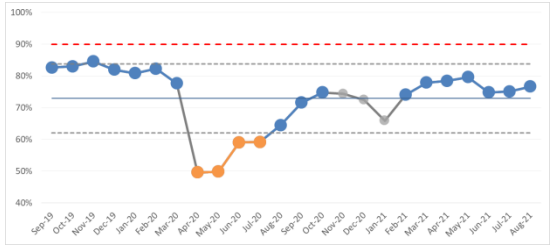
Elective Average LoS
(Acute)

Target: 2.7
Current Month: 2.6



Theatre Utilisation

Target: 90%
Current Month: 76.7%



August was a challenging month for our admitted delivery as we dealt with an increase in bed pressures and non-elective demand.

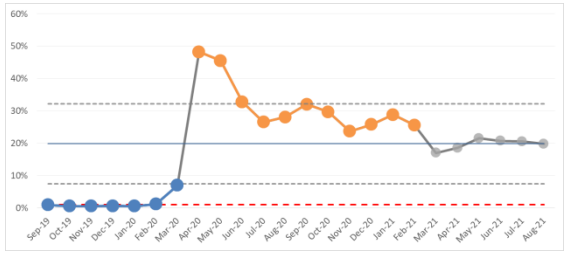
The Trust still managed to deliver above the 95% of 19/20 baseline activity ask, collectively delivering 103% of inpatient activity.

The LoS was compromised by the limited ability to discharge and a backlog of packages of care in social care

Planned Care – Diagnostic

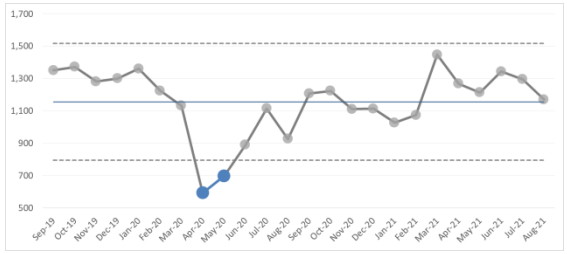
East Sussex Healthcare NHS Trust

Diagnostic Standard



Target: < 1.0%
Current Month: 19.8%

Endoscopy Demand
(Waiting List Additions)



Target: Monitor
Current Month: 1,170

The DM01 position is slowly improving as modalities address their backlog whilst trying to maintain provision for suspected cancer and urgent patients.
Insourcing for Endoscopy commenced on August 14th and we are already seeing the benefits of this with a reduction in overall waiting list size to include reduced waiting times for patients on a suspected cancer pathway and reduction in the number of patients waiting >6 weeks for a diagnostic.

Radiology has reduced its overall waiting list size with MR and CT. Non Obstetric Ultrasound (NOUS) does remain a challenge. Although the waiting list size is being maintained, the modality have to prioritise urgent scans and as a result, the waits for routine scans are increasing. Radiology are looking to increase their outsourcing capacity to tackle this.

Cardiology are working on a plan to insource in order to address their backlog.

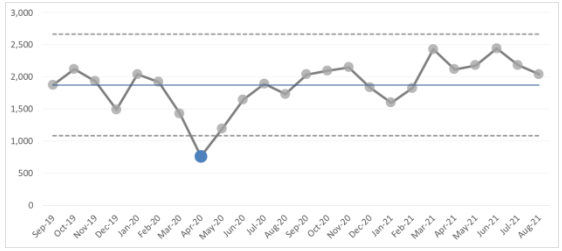
Audiology continues to deliver diagnostic tests within 6 weeks. As does cystoscopy and urodynamics.

Cancer Pathway

East Sussex Healthcare NHS Trust

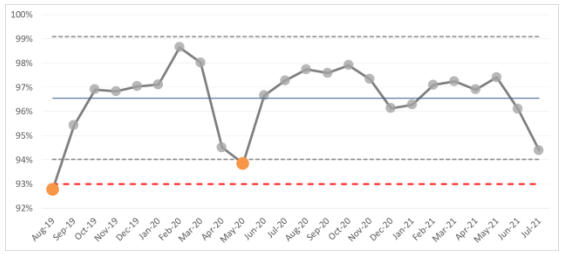
Two Week Wait Referrals

Target: Monitor
Current Month: 2,040



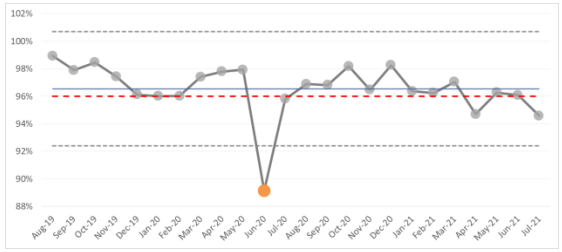
Cancer 2WW Standard

Target: 93%
Current Month: 94.4%



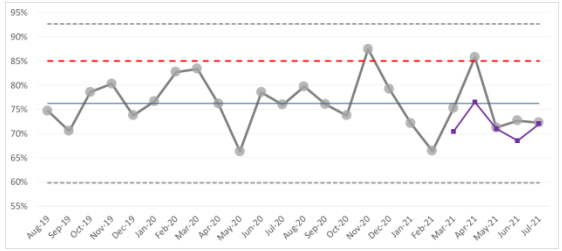
Cancer 31 Day Standard

Target: 96%
Current Month: 94.6%



Cancer 62 Day Standard

Target: 85%
Trajectory: 72.0%
Current Month: 72.2%



We continue to work to reduce the backlog and are currently achieving the trajectory .

Focused “cancer weeks” continue to support tumour stream specific PTL meetings ensuring patients are treated in a timely manner.

We are still working to deliver a sustained 62 day performance and performance is improving. The focused work on achieving the 28 day FDS standard will be pivotal to us achieving the 62 day standard for our patients.

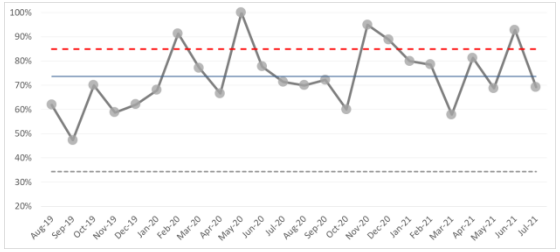
The risks to delivery remain

- Increased 2ww referrals
- Histology capacity and turnaround times
- Radiology and Endoscopy capacity
- Tertiary / Specialist capacity
- Impact of Covid
- Patient engagement

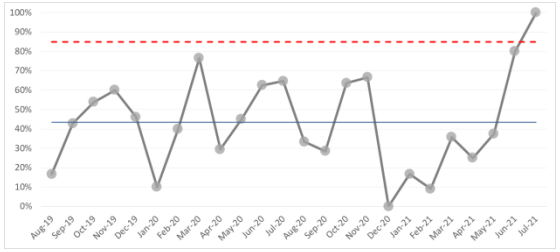
2WW Referral to First Treatment 62 Days

East Sussex Healthcare NHS Trust

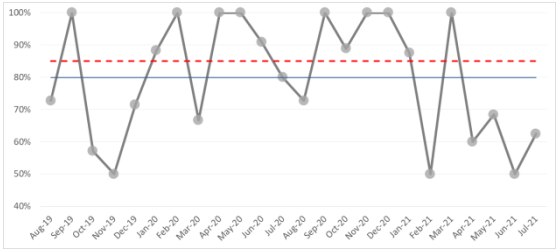
Breast



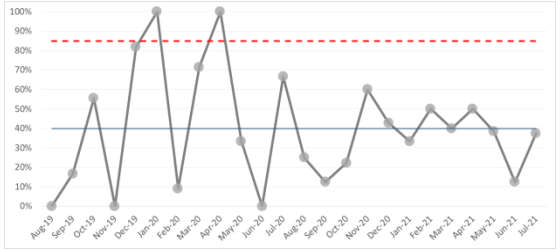
Gynaecology



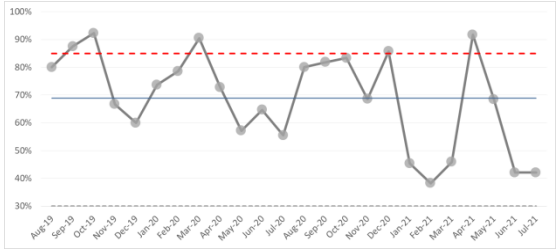
Haematology



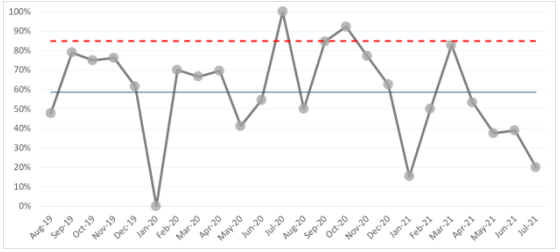
Head & Neck



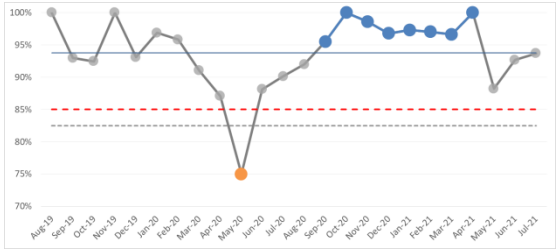
Colorectal



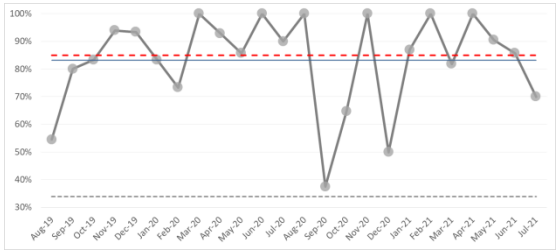
Lung



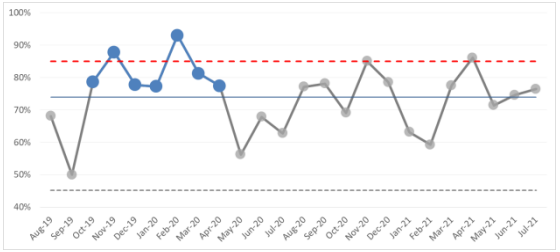
Skin



Upper GI



Urology



Rolling monthly reported positions by Tumour Site, Target: 85%

Financial Control and Capital Development

Our Income and Expenditure

Our Income and Activity

Our Expenditure and Workforce, including temporary workforce

Cost Improvement Plans

Divisional Summaries

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

Contents

East Sussex Healthcare NHS Trust

(1) Due to the reallocation of covid costs and into core spend in M5 as well as some other significant one-offs in the last couple of months as well as backdated pay award expected to occur in M6 the run rate analysis is not considered helpful at present in the absence of a detailed forecast. We will re-introduce this analysis alongside a forecast in coming months when the position is more stable.

Exec summary

East Sussex Healthcare NHS Trust

	RAG	YTD actual (£m)	YTD var (£m)	Commentary
Income	A	225.1	4.5	• Income is broadly in line with plan, variance is driven by ERF (see below)
ERF (inc above)	G	8.7	5.6	• ERF income if £5.6m ahead of plan, this is a material increase from M4 due to receiving confirmation from NHSE/I as to M1-2 and we have now replicated the calculation which was a material under-reporting.
Pay	R	(140.5)	(4.0)	• Pay costs are £4.0m worse than plan, this has increased from £1.4m last month due to an exercise around what was reported to covid costs compared to in the main position. • Temporary costs are £18.6m (excluding Covid) compared to £15.1m in 2019/20
Non-pay	A	(77.8)	(4.9)	• Non-pay costs now exceed budget mainly driven by drugs costs above plan by £2.9m, some of this is offset by higher tariff drug income. Other variances are being investigated.
Covid	G	(3.0)	7.4	• Covid position continues to support the trusts overall financial position with an effective YTD contribution of £8.7m (£11.7m income) .
Surplus/deficit	G	-	-	• The Trust has delivered a breakeven position YTD (and in month) and is forecast to do so for H1.
Efficiency	R	2.8	-	• Full year identified efficiency is £5.2m against an indicative plan of £10.1m (recently communicated based on expectation of ask from NHSE/I). This represents a significant gap and as a result we have RAG rated as Red.
Capex	A	6.9	0.1	• We have revised the capital plan following the audit adjustment, phasing has now been updated, note however this does vary from the original plan. • The current indicative plan is £4.5m above the allocation (separate paper to F&I on capital plan)
Risk & Mits	A	n/a	n/a	• As financial guidance on H2 has not yet been issued and this has the biggest impact on current risk and mitigations we have not amended the position from the previous month as there has been limited new information or change in the underlying position. • We have identified £8.7m of net risk (after probability weighting) against mitigations of £8.7m suggesting that based on current information the Trust expects to be able to deliver a balanced financial position however this will be very stretching to deliver and will require action to deliver the mitigations.

Income and Expenditure

East Sussex Healthcare NHS Trust

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Act	Plan	Var	Act	Plan	Var
Income						
Contract income	37,374	37,056	317	186,093	185,281	812
Divisional	2,132	3,339	(1,207)	14,794	16,694	(1,899)
ERF	4,956	437	4,519	8,675	3,073	5,602
Covid - block	2,342	2,342	-	11,708	11,708	-
Covid - variable	762	762	-	3,874	3,874	-
Total Income	**47,565**	**43,936**	**3,629**	**225,145**	**220,631**	**4,515**
Operating Expense						
Pay						
Permanent	(25,660)	(26,687)	1,026	(121,862)	(128,434)	6,572
Temporary	(5,332)	(1,722)	(3,610)	(18,595)	(8,015)	(10,580)
Total pay	**(30,992)**	**(28,409)**	**(2,583)**	**(140,458)**	**(136,449)**	**(4,008)**
Non-pay						
Drugs	(1,007)	(939)	(69)	(5,204)	(4,693)	(512)
TEDD	(4,274)	(3,263)	(1,011)	(19,185)	(16,316)	(2,869)
Clinical supplies	(2,721)	(2,870)	150	(14,558)	(14,313)	(244)
Purchased services	(1,075)	(757)	(318)	(4,843)	(4,016)	(827)
Finance costs	(1,894)	(2,078)	184	(9,470)	(10,389)	919
Other	(7,138)	(4,488)	(2,650)	(24,514)	(23,133)	(1,380)
Total non-pay	**(18,109)**	**(14,395)**	**(3,714)**	**(77,775)**	**(72,862)**	**(4,913)**
Covid exp - block	2,299	(370)	2,669	(3,035)	(7,445)	4,410
Covid exp - variable	(762)	(762)	-	(3,874)	(3,874)	-
Total Expense	**(47,565)**	**(43,936)**	**(3,629)**	**(225,142)**	**(220,631)**	**(4,511)**
Surplus/(Deficit)	**0**	**-**	**0**	**3**	**-**	**3**
Memo:						
WTE (worked)	7,232	7,520	(288)	7,237	7,437	(200)

I&E position

The Trust continues to deliver to plan at a global level and expects to do so for H1.

Income

- YTD favourable income position £4.5m driven by of ERF from months 1 to 5 being £5.6m ahead of plan.
- As noted in the M4 report we have now received indicative figures from NHSE/I for M1-2 and have been able to replicate
- Income is ahead of plan by £0.9m YTD, this is driven by ERF income ahead of plan by £1.1m as a result of relevant activity in excess of plan.
- M4 income is ahead of plan by £1.6m however this is largely driven by catching up covid income that had not been recognised in previous months and the variable covid element.

Expense

- The Trusts £4.0m adverse Pay position is due to the Trusts reliance on temporary staffing solutions to deliver the elective recovery and increased emergency care levels that are currently being delivered
- The £4.9m adverse non-pay variance is due to the increased effort in delivering the elective recovery, increased emergency care activity and the costs of delivering health care under a COVID regime.
- Covid expenditure £3.0m YTD (prior month £5.3m, changed due to realignment to pay and non-pay of some items) which is £4.4m better than plan. Income recognised is £11.7m meaning there has been an effective contribution of c£8.7m YTD.
- The Trust is showing using 288 WTE less than planned due to a one-off reporting timing difference which will be rectified in Month 6 which will hold the additional days of labour not yet reported. The corrected position would indicate a FTE usage of 110 WTE below plan.

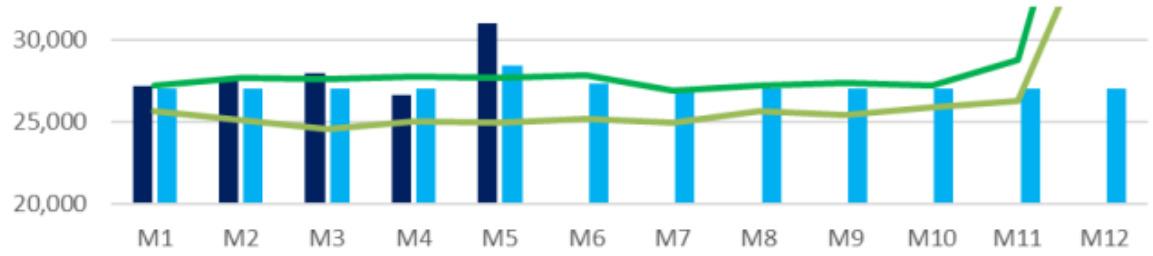
Pay costs

East Sussex Healthcare NHS Trust

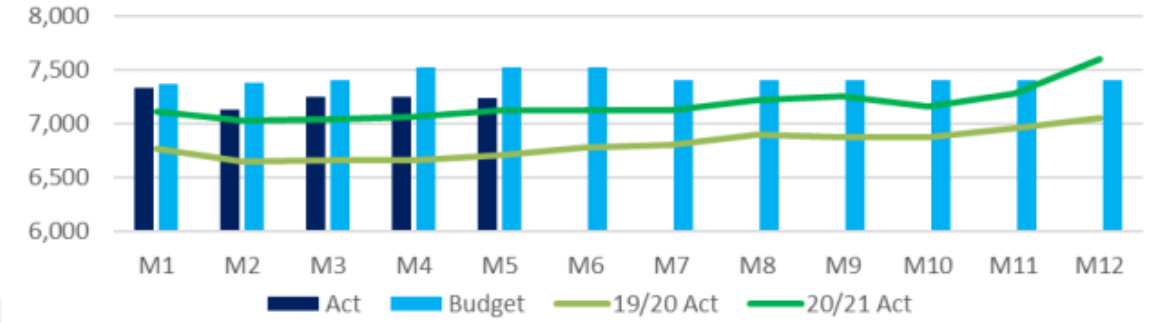
Pay analysis

	Pay costs (£'000)					WTE				
	Jun	Jul	Aug	PY	YTD	Jun	Jul	Aug	PY	YTD Ave
Permanent	(24,403)	(23,512)	(25,660)	*(21,727)*	(121,862)	6,549	6,555	6,566	*6,094*	6,566
Temporary	(3,517)	(3,142)	(5,332)	*(3,201)*	(18,595)	698	692	666	*611*	671
Total	**(27,920)**	**(26,654)**	**(30,992)**	***(24,927)***	**(140,458)**	**7,248**	**7,247**	**7,232**	***6,705***	**7,237**
Budget Var	(910)	356	(2,583)		(4,008)	(151)	(271)	(288)		(200)
Temporary analysis										
Bank	**(1,285)**	**(1,256)**	**(2,006)**	***(1,196)***	**(6,943)**	**462**	**455**	**407**	***422***	**428**
Medical	(1,495)	(1,177)	(2,416)	*(1,437)*	(7,908)	118	127	140	*103*	132
Nursing	(270)	(211)	(554)	*(174)*	(1,341)	55	49	66	*37*	54
AHP	(116)	(83)	(97)	*(145)*	(491)	20	16	16	*24*	19
Admin	(50)	(133)	5	*(48)*	(563)	16	16	14	*4*	16
Other	(18)	-	(4)	*(20)*	(4)	-	(1)	(2)	*4*	(4)
Agency & locum	**(1,948)**	**(1,604)**	**(3,065)**	***(1,825)***	**(10,307)**	**209**	**207**	**235**	***172***	**217**
WLI	**(284)**	**(282)**	**(260)**	***(180)***	**(1,345)**	**27**	**31**	**25**	***17***	**26**
Total Temp	**(3,517)**	**(3,142)**	**(5,332)**	***(3,201)***	**(18,595)**	**698**	**692**	**666**	***611***	**671**

Pay Costs (£'000)



WTEs



Note: Due to the impact of Covid, the 19/20 equivalent has been used as the prior year comparator

Pay analysis

- Note the costs and WTE's exclude those included in covid costs.
- Pay costs in M5 were £31.0m, this represents a significant increase on the month before, however this is driven by the reallocation of Covid which accounts for around £3.2m of the £4.4m increase, the rest is driven by an increase in temporary staffing costs.
- YTD all staffing groups other than nursing are overspending. Nursing underspending due to the significant increase in the budget for H1 and recruitment lagging behind this.
- Whilst WTEs are below budget, cost are above. This is driven by use of temporary workforce which is more expensive. A more detailed analysis is set out in appendix 1.

PY comparison

- Pay (£) is overall in line with the 20/21 comparator although the underlying related activity trends are quite dissimilar (covid and non-covid). The spike in month five is caused by the reallocation of covid costs.
- They do however exceed the 19/20 comparator but do so due to COVID related spend and the existence of new service developments that have occurred since.

Sub-divisional Performance

East Sussex Healthcare NHS Trust

Divisional position

Division	Aug	Vs Budget	Change from Jul	YTD - Aug	Vs Budget	Run rate analysis		
						Jun	Jul	Aug
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Community Health & Integrated Care	(3,172)	193	206 ▲	(16,096)	642	(3,189)	(3,279)	(3,172) ▲
Core Services	(5,735)	100	158 ▲	(28,928)	(994)	(5,994)	(5,776)	(5,735) ▲
Estates & Facilities	(2,022)	625	(16) ▼	(12,802)	(261)	(2,847)	(2,689)	(2,022) ▲
Medicine	(8,065)	(1,332)	(2,627) ▼	(34,230)	(626)	(6,800)	(6,097)	(8,065) ▼
Surgery, Anaesthetics & Theatres	(7,225)	(96)	(62) ▼	(36,129)	(472)	(7,141)	(7,347)	(7,225) ▲
Urgent Care	(3,482)	(851)	(1,535) ▼	(9,711)	(899)	(1,697)	(1,299)	(3,482) ▼
Women's, Children's & Sexual Health	(2,764)	(63)	(238) ▼	(13,582)	(79)	(1,882)	(2,755)	(2,764) ▼
Corporate Services	(4,641)	(893)	(984) ▼	(18,439)	246	(3,551)	(3,684)	(4,641) ▼
Central/Trust wide	37,105	2,317	5,093 ▲	169,920	2,446	33,099	32,930	37,105 ▲
ESHT	**0**	**0**	**(4)** ▼	**3**	**3**	**(0)**	**4**	**0** ▼

Sub-divisional Performance

With the exception of CHIC (and Core in month), the operational services are operating above planned funding levels, although it should be noted that ERF income has been held centrally and this is therefore not showing as a benefit within the divisions. We will explore the possibility to report ERF at a more granular level in future months.

The overspends are driven by the services most affected by emergency activity and include Urgent Care, Medicine and Core services divisions. These divisions have higher than funded pay positions and these are mostly Medical staff & AHP's where temporary staffing solutions are proving expensive.

Efficiency

East Sussex Healthcare NHS Trust

Division	In Month			Ytd -M5			Full Year					Schemes
	Plan	Actual	Var	Plan	Actual	Var	Target	Rec	NR	Total	Gap	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	#
Medicine & Emergency Care	1	1	-	393	393	-	2,486	15	387	402	(2,084)	2
DAS	28	32	4	455	473	18	2,273	143	672	815	(1,458)	6
Core Services	20	15	(5)	107	123	16	1,695	654	46	700	(994)	8
CHIC	44	44	-	345	345	-	1,056	362	213	576	(480)	3
WCSH	6	6	-	239	239	-	997	13	1,032	1,046	49	4
Estates & Facilities	14	14	-	886	886	-	823	164	817	981	159	2
Corporate	26	60	34	252	303	51	806	216	438	655	(151)	23
Total	**138**	**172**	**34**	**2,677**	**2,761**	**84**	**10,135**	**1,569**	**3,606**	**5,175**	**(4,959)**	**48**
Movement from last month	*(1,465)*	*(1,421)*	*44*	*138*	*172*	*34*	*-*	*175*	*498*	*673*	*673*	*48*

Overview

- The Divisions have delivered £0.2m in month 5 and £2.8m YTD, (including the ERF Q1 over-performance)
- There in month variance is positive overall, for DAS this is due to the increased SEES activity, Core is related to Pharmacy drugs which fluctuates each month and Corporate is due to vacancy slippage.
- The YTD variance is largely due to the vacancy slippage in Corporate and SEES increased activity.
- The target for the year is £10.1m, £5.2m has been identified. The remaining gaps stands at £4.9m, £0.7m of this is in H1 and the remaining £4.2m is in H2.
- There is a high proportion (70%) of non-recurrent schemes, this is expected during a transition back to BAU working patterns, with budgeting and the funding regime making it hard to recognise items (such as the ERF Q1 over-performance) as recurrent.

Risks

The main risks to delivery are:

- Impact on delivery of a further wave of COVID-19; and
- Sufficient time and capacity for division to develop and implement savings plan in an uncertain environment; and
- Less than 7 months left to identify and deliver the £4.9m gap.

Next Steps

- Work with the divisions to develop robust plans for the second half of the year;
- Incorporate and maximise benefits from previously agreed business cases that have resumed (Nerve Centre, Badgernet); and
- Exploit benefits using Model Hospital and Model Health System and GIRFT benchmarking, including Gateway documents and MH highlight reports as well as Corporate benchmarking which is due to be published Q3/Q4.

Capital

East Sussex Healthcare NHS Trust

YTD Capital Programme Performance	Original Plan £000	CRG Plan £000	YTD Plan £000	Actual Expenditure £000	Variance
CIR/Backlog Maintenance	*7,970*	4,446	175	447	272
Clinical	*6,765*	3,900	141	288	147
Divisional Priorities	*1,000*	1,025	48	7	(42)
Digital	*4,050*	3,600	1,020	622	(398)
BFF Enabling/Transformation	*6,625*	2,800	897	639	(258)
Other	*2,250*	2,150	609	672	63
2020/21 Accruals	-	10,836	3,944	4,084	140
Diagnostics	*313*	-	-	-	-
Assumed Slippage	*(4,574)*		-	-	-
Total Owned	**24,399**	**28,757**	**6,834**	**6,760**	**(74)**
Donated	1,000	1,000	400	675	275
Less donated Income	(1,000)	(1,000)	(400)	(520)	(120)
Total	**24,399**	**28,757**	**6,834**	**6,916**	**82**
Original plan phasing			*8,996*	*6,916*	*(2,080)*

Capital Resource Limit (CRL)	Planning CRL £k	Forecast CRL £k
2020/21 Opening CRL		
Internal Depreciation	16,671	16,671
Closing Working CRL	**16,671**	**16,671**
Fire Compartmentalisation (Year 3 of 3)	3,790	3,790
HIP2 (Year 2 of 2)	625	625
HIP2 (brought forward - Car Parking)	2,000	2,000
Seed (brought forward)	1,000	775
Diagnostics	313	313
Expected CRL	**24,399**	**24,174**
Digital Aspirant/Digital Transformation		1,600
Seed Aspirant		250
Digital Pathology - PathNetwork 7		2,075
Possible Additional Funding		**3,925**
Target CRL		**28,099**
Overplanning/(underplanning) margin		**4,583**

Capital notes

- *Following the audit adjustment there was a requirement to revise the capital plan. This revised plan is being submitted to the September F&I committee and has been included here in the "CRG plan". As this is approved we will update the reporting to reflect that. Suggested new phasing has been include in the analysis above.*
- *Further to the above, and the outcome of the capital controls and process review we will revise the capital reporting reflecting any recommendations and including as a minimum addition to the current format a forecast for year end.*

Capital

- The total allocation to the Trust is £24.4m and is made up of the Trust's allocation from the overall capital funding allocated to the ICS plus £3.4m of funding for HIP2 which is funded separately. The total allocation may increase to £28.1m if the Trust is successful with bids relating to Digital Aspirant, Seed Aspirant and Digital Pathology.
- Year to date capital spend amounts to £6.9m, the majority relating to the impact of schemes already in train in the prior year. The YTD spend represents a relatively low proportion of spend. However a number of schemes are now progressing with a bit of a hiatus as the implications of the audit have played through.
- The forecast capital programme totals £28.8m which is £4.6m above planned funding, this position will need to be carefully monitored to ensure the Trust delivers it's capital programme and does not breach CRL.

Balance Sheet

East Sussex Healthcare NHS Trust

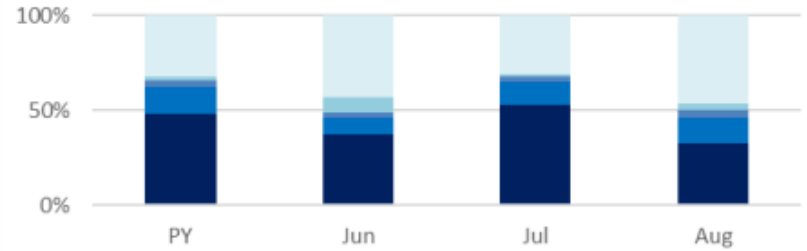
Trust Balance Sheet

	Jun	Jul	Aug	Change
	£'000	£'000	£'000	£'000
Non-current assets	**247,739**	**256,345**	**256,813**	**468**
Inventories	6,177	4,068	6,651	2,583
Trade and other receivables	21,149	27,453	25,707	(1,746)
Cash and Cash equivalents	51,778	48,317	53,072	4,755
Current Assets	**79,104**	**79,838**	**85,430**	**5,592**
Trade and other payables	(40,313)	(41,041)	(48,549)	(7,508)
Other liabilities	(6,557)	(4,754)	(3,399)	1,355
Current Liabilities	**(46,870)**	**(45,795)**	**(51,948)**	**(6,153)**
Non-current liabilities	**(2,939)**	**(5,226)**	**(5,226)**	**0**
Total assets employed	**277,033**	**285,161**	**285,069**	**(92)**

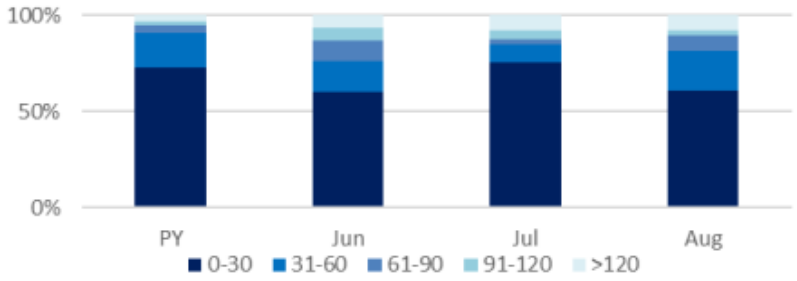
BPPC

Trade	88.4%	89.9%	90.7%	0.7%
NHS	99.1%	99.2%	99.4%	0.1%

Trade receivables Ageing



Trade Payables Ageing



Balance sheet

- The balance sheet shows a consistent position overall with the previous month (as would be expected with a break even I&E position).
- There have been a number of movements relating to timing of payments (eg trade payables and receivables).
- In M4 (July) the balance sheet showed an increase in non-current assets of £8.6m, however this was due to the audit adjustment on capital being incorrectly applied in Month 3 (around whether the reduction in additions impacted the overall site valuation – which was concluded in the audit it did not but this was not in time for Month 3 ledger close).
- The Trust continues to hold very significant cash balances.

Trade Receivables and Better Payment Practice Code (BPPC)

- BPPC performance has improved in August and has now exceeded 90% for Trade and NHS payables.
- The sales ledger balance at the end of June is £6.0m which is an decrease on the previous month of £2.8m (offsetting an increase from the previous month of £3.2m).
- The number of invoices on the sales ledger at the end of the month has also decreased by 52 to a total of 1,403. The position reflects a decrease in aged debt (invoices > 30 days) of £0.1m
- 67% of the total debt owed to the Trust is due and is aged over 30 days. This is a big increase on the previous month however that was largely as a result of some large invoices raised in M4 in the less that 30 days which have now been paid. In addition most of the debt owed to the Trust is from other NHS bodies and therefore there is a low risk of non-recovery.

Trade Payables

- A decrease in month of £1.8m on the creditor position reducing the purchase ledger total to £8.3m. This was reflected in a decrease in the number of invoices on the purchase ledger system to 5,770. Despite the decrease, the value of debt owed to suppliers (aged > 30 days) increased by £0.8m. Balances that are aged and not ready for payment reflect invoices that are awaiting authorisation or the receipting of the goods/services received.
- 87% of the outstanding invoices are payable to trade (Non NHS) suppliers and the balance to NHS providers. The Trust processes weekly payment runs.

Risks and mitigations

East Sussex Healthcare NHS Trust

	Gross value £'000	Risk adjusted %	Net value £'000	Description
ERF	4,800	40%	1,920	Clawback of funding where baseline is not met plus costs incurred to deliver activity exceed amounts recovered, estimated risk at c£0.6m per month
Covid H2 Funding	6,000	40%	2,400	Guidance has not been issued on H2, we expect covid funding to be reduced, net value represents a quarter of current funding representing that it is likely some of this might be offset with additional income streams
Agency premium	2,000	20%	400	Very limited agency premium has been included in the budget, however the current run rate includes current levels of agency spend
Escalation wards	2,000	60%	1,200	The Trust currently has a number of escalation wards being utilised which are not funded in the core budget. Costs are above the amount shown but a the majority of this cost is included in the run rate
CIP slippage against H2 ask	4,000	40%	1,600	The Trust is likely to need to deliver around £6m CIP in the second half of the year to offset efficiency applied to the tarigg, around £2m has already been identified
WTE utilisation	3,000	40%	1,200	Excluding covid there are c400 budgeted WTE above used, if these are filled then it will increase costs faced
Divisional risks	tbc	Varied	tbc	Aggregate of divisional risks not included above
Total Risk	**21,800**		**8,720**	
ERF estimation	3,000	80%	2,400	The indicative NHSE/I figures for the ERF have come in materially above the Trust figures which should result in additional income being paid, work is ongoing to reconcile this figure
ERF contribution	2,000	20%	400	ERF income may contribute to financial resources of the trust if income exceeds costs incurred
CIP H2 delivery	6,000	40%	2,400	The H2 CIP programme has not been reflected in the run rate and we would expect this to contribute against the financial pressures
NHSPS negotiation	1,500	40%	600	There is an ongoing dispute with NHSPS with regards to historical estate costs, potential that a negotiated settlement is reached reducing below the level invoiced
CCG funding agreement	6,400	20%	1,280	There are significant values relating to amounts that the CCG historically paid, or agreed to pay that were impacted by Covid (and have been efffectively funded via Covif). We have been seeking resolution with the CCG around payment for these
Reserves	2,000	80%	1,600	The Trust has a number of prudent accruals and general reserves where final amounts may be lower than estimates made at the time. These may result in financial benefit to the Trust
Divisional mitigations	tbc	Varied	tbc	Aggregate of divisional mitigations not included above
Total mitigation	**20,900**		**8,680**	

Appendices

Appendix 1: Pay and drug costs

East Sussex Healthcare NHS Trust

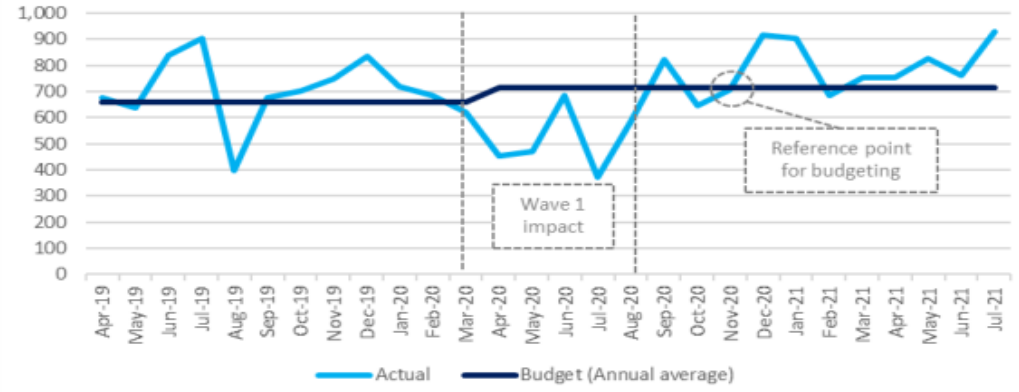
Pay analysis

	Bud FTE	Act FTE	Bud £	Act £	Bud unit cost	Act Unit cost	WTE impact	Unit impact
	Ave FTE	Ave FTE	£'000	£'000	£'000	£'000	£'000	£'000
Agency	32	48	551	1,270	41.0	62.9	448	270
Locum	73	102	3,928	5,859	129.7	138.0	1,447	484
Permanent	7,058	6,537	129,163	119,995	43.9	44.1	(9,060)	(107)
Bank	259	395	3,204	6,347	29.7	38.6	1,693	1,451
Direct comparable	**7,421**	**7,082**	**136,846**	**133,471**	**44.3**	**45.2**	**(5,472)**	**2,098**
Waiting List	-	26	-	1,346	n/a	125.4	1,346	
No budget	-	108	-	3,635	n/a	81.0	3,635	
No actual	11	-	324	-	73.9	n/a	(324)	
Indirect comparable	**11**	**134**	**324**	**4,981**	**73.9**	**89.5**	**4,657**	
Total comparable	**7,432**	**7,216**	**137,169**	**138,452**	**44.3**	**46.1**	**(815)**	**2,098**
Uncomparable	**5**	**22**	**(720)**	**2,005**				
M5 Total ex Covid	**7,437**	**7,237**	**136,449**	**140,458**				

Pay analysis

- At last months F&I it was noted that ESHT was using less WTE's than budget but pay costs exceeded budget, the table left analyses the impact between a WTE and Unit cost (unit cost is annual, impacts are YTD).
- For permanent staff the unit cost is very comparable with only £0.1m variance on £120.0m spend. However there are more significant variances in bank agency and locum.
- The higher overall unit cost in actual is driven by:
  - Variances in unit costs in the temporary side, possible explained by less granularity (eg only has registered and unregistered nurses – permanent has by band).
  - Using relatively more bank, agency and locum than budget which have a higher unit cost
  - WLIs which attract a very high unit cost
  - Lines where we have spend where there is no budget seem to be high unit cost (over 80% of this spend is temporary workforce)
  - Some budgets and spend which are not directly comparable, such as any reserves, CIPs etc

Tariff Drug spend (£'000)



Drug analysis

- The total variance in M4 for drugs was £1.9m, of this £1.5m related to tariff excluded drugs which have offsetting income. The main I&E statement has been updated to include a split of drugs (and tariff excluded devices have now been incorporated).
- Tariff drug spend was £0.4m above budget in 21/22, this was based (like the majority of non-pay) on M8 20/21. M8 was used as non-covid activity was at its peak for 20/21 and therefore likely the most comparable to what we were expecting to see in 21/22.
- Current trend is above the budget noting that no inflation has been incorporated and therefore the budget is potentially too low. This will be considered for H2.

Trust Winter Plan 21/22

Meeting information:		
Date of Meeting:	12th October 2021	Agenda Item: 9
Meeting:	Trust Board	Reporting Officer: Tara Argent

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?	

Summary:

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

The Winter plan for the East Sussex system outlines the actions being undertaken to address the expected challenging Winter for 2021/22; including addressing the expected demand and additional capacity requirements, mitigating risk in relation to quality and performance and ensuring that systems continue to deliver the quarter 3 and 4 (H2) elective recovery ask. The plan has been developed through the Operational Executive (OPEX) and Local A&E Delivery Board (LAEDB) and developed in line with regional guidance, the operating model, and published Key Lines of Enquiry (KLOES) for 21-22 which notes vaccination and protecting the elective programme as key considerations.

The 2021/22 plan is underpinned by learning from Winter 2020-21 and the Covid incident response, capacity and demand modelling, delivery of latest national guidance including hospital discharge, supporting care homes, infection prevention and control (Covid-19 and flu planning), nationally mandated UEC recovery actions and locally agreed UEC transformation plans.

A number of schemes within this plan are subject to ICS funding approval and will be integral to ensuring sufficient community capacity to reduce Medically Ready for Discharge (MRD).

The Winter plan is a live document and subject to the work underway in relation to discharge plans submissions and financial allocations, and will be updated to include any further MRD and discharge capacity once finalised.

<u>Demand and Capacity Modelling</u>
A standardised 12-month system-wide demand and capacity tool has been developed as part of the Hospital Discharge Programme which tracks the expected impact of Planned Care recovery, Winter demand and specific point surges from Covid, Respiratory Syncytial Virus (RSV), Norovirus and Flu - this is a dynamic tool which will allow for adjustment throughout Winter.

The acute bed model assumes that 19/20 G&A escalation capacity continues for 21/22, elective recovery continues as planned, there is no change to the current MRD position and there will be no significant Covid

increase over and above 20/21. Demand is based on the 2-3 year pre-Covid position and adjusted for YTD actuals.

Plans

Place-specific actions for East Sussex include provider plans and supplementary local actions to Sussex-wide initiatives.

Plans are in place to protect the elective programme which includes some use of the independent sector and additional diagnostic capacity via Community Diagnostic Hubs. As part of planning for H2, the East Sussex system is developing discharge plans which includes forecast capacity requirements to deliver agreed Medically Ready for Discharge (MRD) trajectories and ensure long-term funded capacity is in place to meet demand surges. These plans are pending funding approval and have not been included in this iteration of the Winter plan.

The Trust has developed mitigations to reduce the forecast peak acute bed gap; however there remains a significant gap in both the local system and the Sussex wide system. Acute bed modelling assumes MRD remains at current levels, therefore reducing the MRD delivers an opportunity to further reduce the acute bed gap, and however this opportunity is subject to discharge funding and workforce/care market capacity.

The ESHT starting bed gap was 94 for EDGH and 47 for Conquest. The ESHT plan identifies additional escalation capacity and a reduced bed requirement from Crisis Response and care bridging services which leaves a gap of 37 beds at EDGH and 30 at Conquest – this leave a total residual acute bed gap of 67 for the East Sussex system.

Risks and mitigations

The highest scoring risks for the East Sussex system this Winter are in relation to:

- Workforce – noting current workforce challenges there is a risk that this will continue and/or be exacerbated during the Winter period
- Care market capacity and responsiveness
- IPC – there is a risk of high levels of Noro/Flu/Covid this Winter which will impact on available capacity, performance and quality
- Hospital discharge and flow – this is in light of workforce, care market fragility and risk in relation to Red/Green pathways
- Elective programme delivery in the event of significant pressure there is a risk that elective delivery will be compromised
- Mental Health demand and capacity for both Adults and Children's and Adolescent Mental Health (CAMHs) services remains high
- Paediatric capacity, noting the potential RSV surge later in Winter and high CAMHs demand, there is a paediatric capacity risk

Mitigations have been identified to reduce the overall risk score however there remains substantial risk for the Winter period. Risks will be reviewed regularly at OPEXs and LAEDBs, with oversight by the System Operations and Surge Group (SOSG).

Testing & Assurance

A Sussex-wide stress testing session will be delivered in early October to test the Winter plan and enable cross-pollination of good practice between systems. In light of the current system pressure, this session will also include a coordinated debrief of the current ICS OPEL 4 escalation status to identify learning and additionally required actions.

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

The East LAEDB meeting in September was cancelled due to operational pressures across the Sussex system and so a separate Winter Plan meeting has been arranged for 18 October 2021. This is to allow for any feedback from NHSE who are sighted on a draft version ahead of any sign off of the final version.

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

The paper is submitted for assurance.

Sussex
Health and Care Partnership

3c: East Sussex Place Modelling and Actions

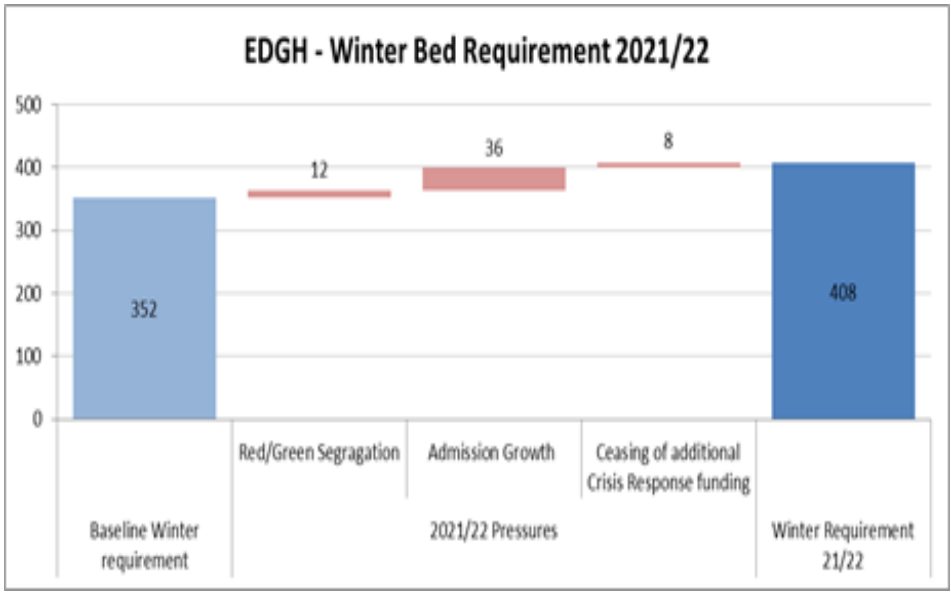
Sussex Acute Demand and Capacity Model - G&A Bed Capacity levels

Demand modelling

- A baseline bed requirement is produced based on the following assumptions:
  - 19/20 demand
  - 19/20 Length of Stay
    - The trust will track the LOS monitoring the variation and impact on the bed gap – this will also need to be monitored at a system level
    - Risk of increased demand in the 1+LOS admissions
  - Continued availability of community beds and crisis response

- The variation in demand by day for each cohort of beds is assessed in the formation of this baseline. The level of beds required is set to allow a balance between occupancy and flow through the system. This is set at 85th percentile for the majority of the year and 95th percentile in winter.

- IPC measure impact initially based on ability to segregate by bay which is being reviewed. If this does not fall in line with IPC requirements there will be a much greater impact on beds required for red/green segregation.

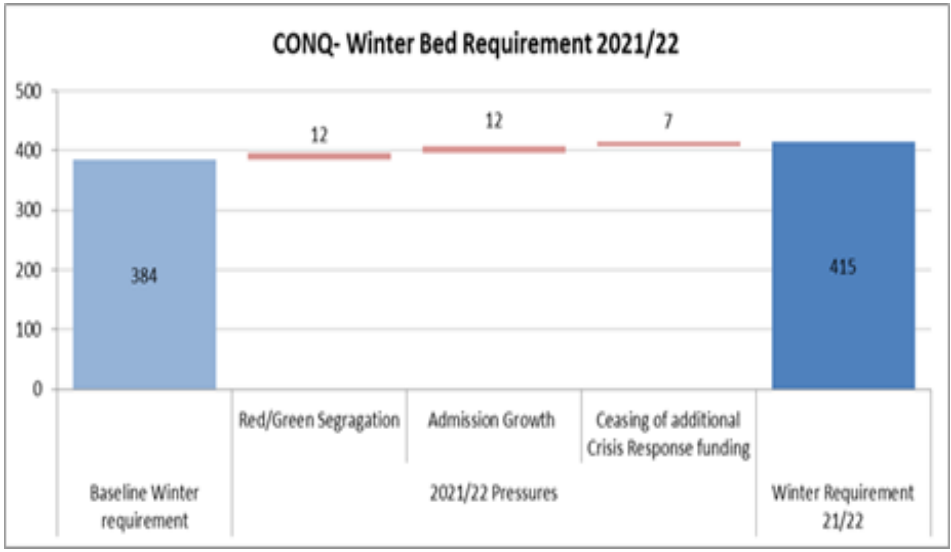


EDGH

Assessment of current demand and performance against 19/20 leads to the adjustments in the waterfall.

Total winter requirement = 408 beds

Length of stay has fallen to pre-covid levels and continues to sit just under 19/20.



Conquest

Assessment of current demand and performance against 19/20 leads to the adjustments in the waterfall.

Total winter requirement = 415 beds

Length of stay has fallen to pre-covid levels and continues to sit just under 19/20.

ESHT Acute Demand and Capacity Model - G&A Bed Demand levels

Capacity vs Demand

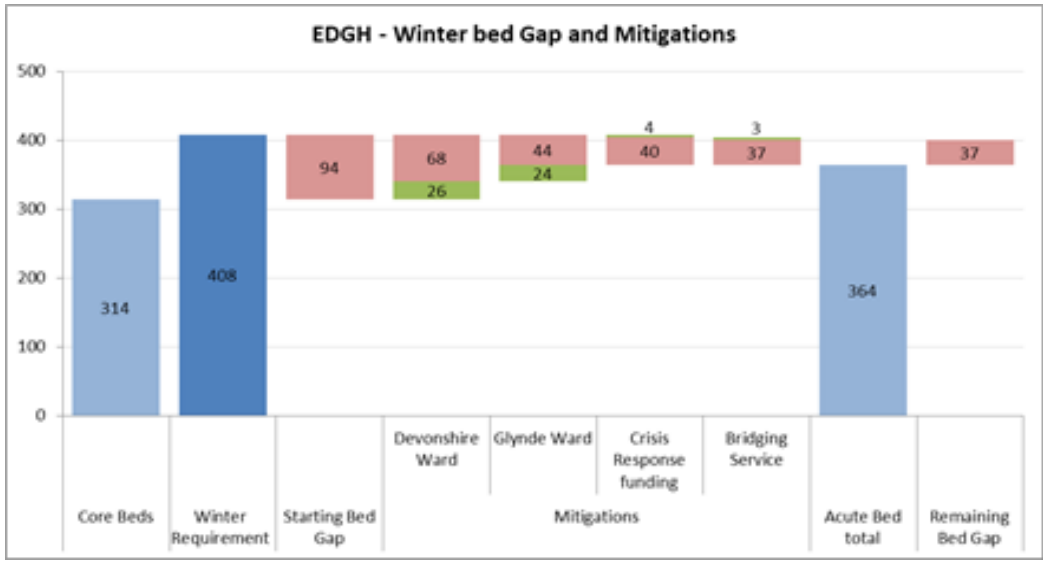
EDGH

Core Funded beds = 314

50 Escalated beds continue to be staffed and run = 364

Reduction in requirement through continuing crisis response and implementation of bridging service

Winter bed gap remaining = 37 beds



CONQ

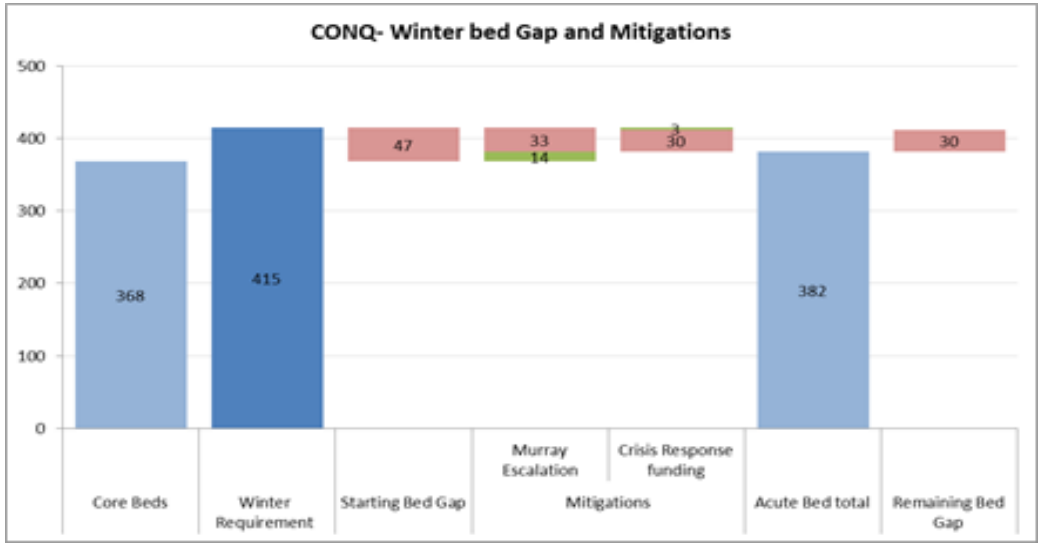
Core Funded beds = 368

Open and staff 14 escalation beds on Murray = 382

Reduce requirement by through continuing crisis response

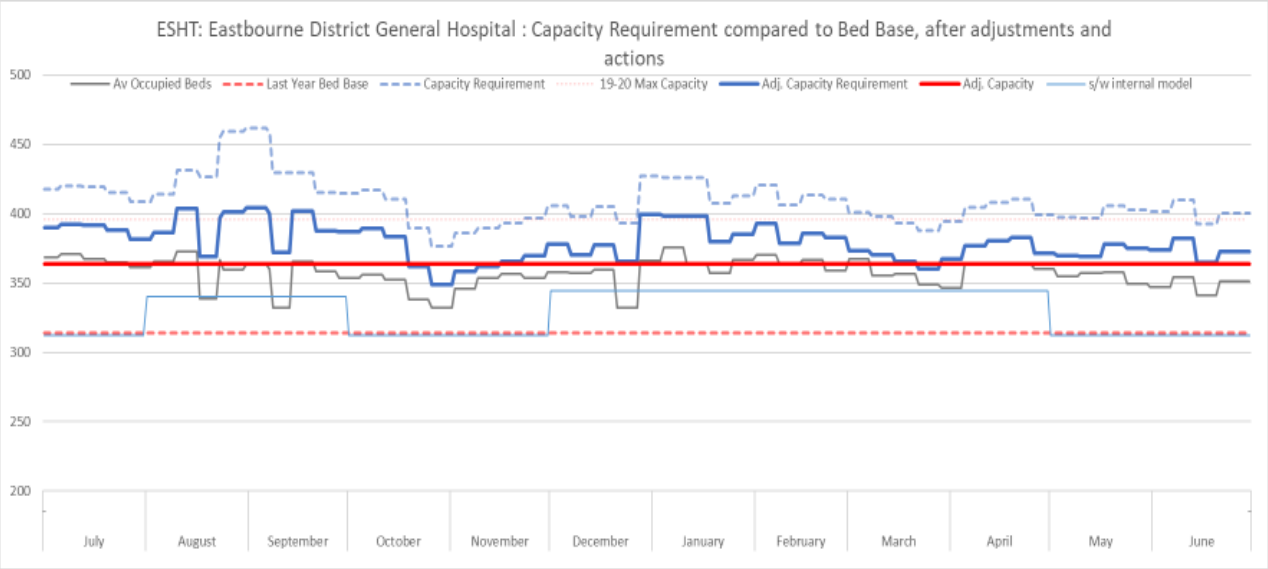
Reduction in requirement from crisis response

Winter bed gap remaining = 30 beds



Acute Demand and Capacity Model – EDGH

- Covid Scenario: Observed/Delayed Scenario A
- Devonshire Escalation added (26 beds)
- Glynde Ward Escalation added (24 beds)
- Crisis Response funding impact included (-4 bed demand)
- Bridging Service impact added (-3 bed demand)
- Demand adjusted from historical precedent to observed bed occupancy
- Assumes Elective Recovery and full use of Elective beds
- Assumes MRD levels continue at current level
- This leaves **a bed gap to 95th centile or 30-40 during Winter**
- This compares to the ESHT internal model showing a 37 bed gap

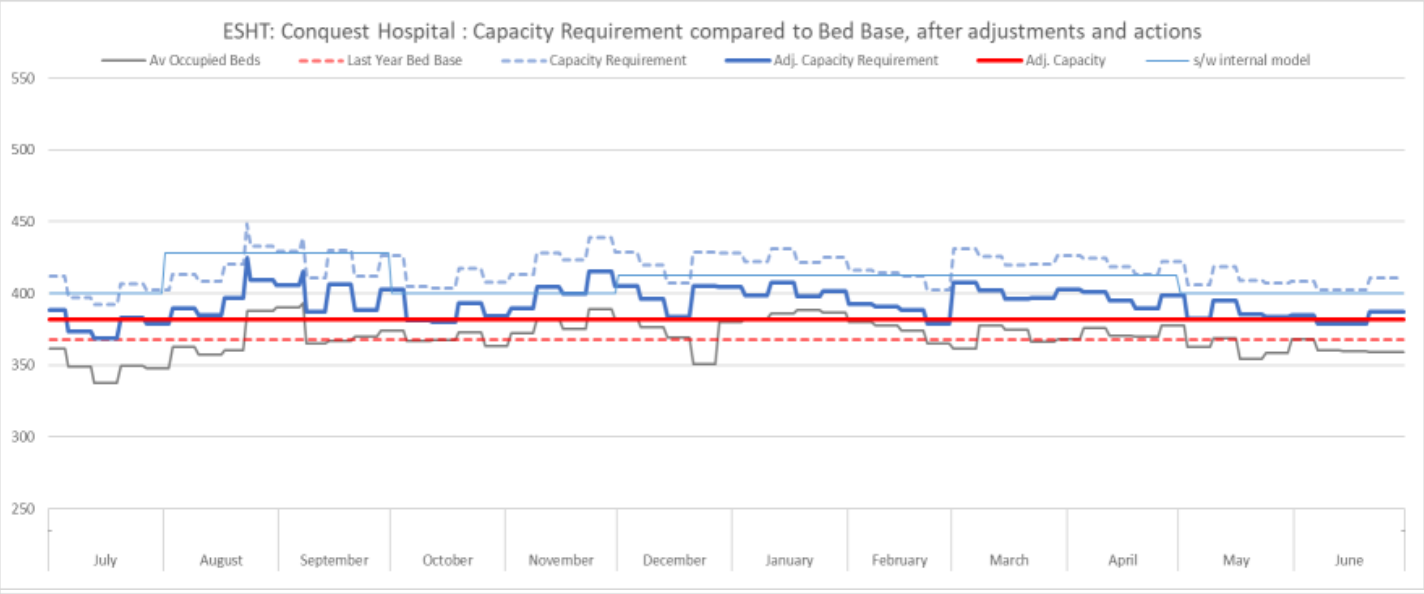


ESHT : EDGH	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
min Planned Capacity	364	364	364	364	364	364	364	364	364	364	364	364
max Capacity Requirement	393	404	404	389	369	378	400	393	383	383	378	382
Remaining gap to CR	29	40	**40**	**25**	**5**	**14**	**36**	**29**	**19**	**19**	**14**	**18**

Acute Demand and Capacity Model – Conquest

- Covid Scenario: Observed/Delayed Scenario A
- Murray Escalation added (14 beds)
- Crisis Response funding impact included (-3 bed demand)

- Demand adjusted from historical precedent to observed bed occupancy
- Assumes Elective Recovery and full use of Elective beds
- Assumes MRD levels continue at current level
- This leaves **a bed gap to 95th centile of 25-35** during winter peaking for a single week at 33 beds at the beginning of November.
- This compares to the ESHT internal model showing a 30 bed gap



ESHT : Conquest	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
min Planned Capacity	382	382	382	382	382	382	382	382	382	382	382	382
max Capacity Requirement	389	425	409	403	415	405	407	402	408	402	399	387
Remaining gap to CR	7	43	27	21	**33**	**23**	**25**	**20**	**26**	20	17	5

East Sussex Local Authority Discharges

- Average Daily Discharges Projected through till the end of 22/23.
- Including Sussex Acutes, SaSH and post-pathway 2 discharges
- Split by Pathway 0, 1, 2 & 3
- Complex Discharges includes likely demand at the 90th centile. This should give an indication of the likely additional capacity required to cope with Surge levels of activity
- Pathway 1 supply varies considerably and is crudely split in the lowest table
- Note: whilst this shows average discharges per day, discharges at weekends can be 40% lower than discharges on a weekday

Total Discharges	2021						2022												2023		
projected daily discharges	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
RSCH	20.1	20.4	20.9	20.7	20.2	19.8	20.0	21.3	20.3	20.3	20.0	19.9	20.2	20.5	20.7	20.9	20.4	20.3	21.5	21.3	21.2
PRH	11.7	12.0	12.1	11.7	11.9	12.1	12.5	13.2	12.7	11.7	11.7	11.7	11.9	12.1	12.1	12.2	12.0	12.0	12.4	12.3	12.3
EDGH	57.2	58.4	57.5	55.6	52.5	53.0	56.3	59.8	56.4	55.7	55.3	53.6	55.1	56.2	56.9	57.7	56.0	55.5	59.7	59.1	58.6
Conquest	71.0	71.9	73.5	74.1	74.9	74.9	74.6	77.5	73.5	73.1	73.5	71.7	73.0	74.0	74.6	75.3	73.8	73.3	77.1	76.5	76.1
StRichard's	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Worthing	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
SaSH	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
After pathway 2	5.3	5.8	6.3	6.3	5.6	5.3	5.3	5.7	5.4	5.3	5.3	5.2	5.3	5.4	5.4	5.5	5.3	5.3	5.6	5.6	5.5
Total	165	169	170	169	165	165	169	178	168	166	166	162	165	168	170	172	168	166	176	175	174

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Pathway 0: Total	146	147	148	147	146	146	149	157	149	147	147	143	146	149	150	152	148	147	156	155	154
Pathway 1: Total	11.5	12.0	12.4	12.3	11.6	11.4	11.6	12.3	11.6	11.4	11.4	11.2	11.4	11.6	11.7	11.8	11.5	11.4	12.1	12.0	12.0
90th Centile Surge	15	15	16	16	15	14	15	16	15	15	14	14	14	15	15	15	15	15	15	15	15
Pathway 2: Total	5.5	5.9	6.3	6.1	5.4	5.3	5.4	5.7	5.4	5.3	5.3	5.2	5.3	5.4	5.4	5.5	5.3	5.3	5.6	5.6	5.5
90th Centile Surge	7	8	8	8	7	7	7	8	7	7	7	7	7	7	7	7	7	7	8	8	7
Pathway 3: Total	7.6	8.0	8.4	8.3	7.9	7.8	7.9	8.1	7.6	7.5	7.5	7.3	7.5	7.7	7.7	7.8	7.6	7.6	8.0	8.0	7.9
90th Centile Surge	9	9	10	10	9	9	9	10	9	9	9	9	9	9	9	9	9	9	10	9	9

projected daily discharges	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Eastbourne	4.6	4.8	4.8	4.7	4.4	4.3	4.5	4.8	4.5	4.5	4.5	4.3	4.4	4.5	4.6	4.6	4.5	4.5	4.7	4.7	4.7
Hastings	4.0	4.2	4.4	4.4	4.3	4.2	4.2	4.4	4.1	4.1	4.1	4.0	4.1	4.2	4.2	4.2	4.1	4.1	4.4	4.3	4.3
HWLH	2.8	3.0	3.2	3.1	2.9	2.8	2.9	3.0	2.9	2.8	2.8	2.8	2.8	2.9	2.9	2.9	2.9	2.8	3.0	3.0	3.0

In the above 90% of EDGH flows to Eastbourne, 90% of Conquest to Hastings and the remainder to HWLH

East Sussex Place Specific Actions – ESHT Acute

- Trust have already open the escalation beds available (Glynde/Devonshire to meet demand)
- The escalation beds are currently unfunded and therefore there is considerable pressure on workforce to cover the additional beds funding has been requested to allow for recruitment initiatives to take place
    - Planned essential estates works will result in the Cath Lab at CQ closing and activity transferring to EDGH
    - Planned Fire Compartmentalisation works at EDGH result in a 6 bed reduction in AMU over the winter period

Ref.	Action	Lead Organisation	Delivery Date	Expected Impact
EA 1.1	UTC front door total triage call-back model	ESHT/System	In progress	• Admission avoidance – improved ED performance
EA 1.2	Continue to drive a LOS reduction across all pathways with increased utilisation of SDEC - Direct access to gateways and availability of specialist advice to GPs to prevent admission - Bookable access to GPs for plain film imaging	ESHT with PCN support	On going	• Admission avoidance – increased flow and reduction in LOS
EA 1.3	Glynde open at 24 beds ESHT Already open and including in modelling mitigation Funded (been requested)	ESHT	Already open to met the current demand – the winter plan includes that these beds remain open	• A reduction of the EDGH 105 winter bed gap by 26 (to 79)
EA 1.4	Devonshire at 26 beds ESHT Already open and included in modelling mitigation. Funded (been requested).	ESHT	Already open to met the current demand – the winter plan includes that these beds remain open	• A reduction of the EDGH 105 winter bed gap by 24 (to 55)
EA 1.5	Murray at 14 ESHT – currently unfunded, funding requested	ESHT	Already open to met the current demand – the winter plan includes that these beds remain open	• A reduction of the CQ 51 winter bed gap by 14 (to 37)
EA 1.6	ESHT at Home Pulse Oximetry In November 2020, clinical commissioning groups (CCGs) were recommended to put in place a 'COVID Oximetry @home' model as rapidly as possible. CCGs should ensure that COVID Oximetry @home services remain available to support COVID-19 patients	ESHT	Awaiting engagement with Primary care via CCG to confirm that this will be a primary care lead service in the community and re-establish the service at home	• Admission avoidance
EA 1.7	Commission cross site ambulance ESHT Starts end September-January support PCI/ED flow and performance /Trauma.	ESHT	Unfunded – would need commissioning discussions	Support ED and patient flow and ensure that patient care is being delivered on the correct site

The full provider plan can be found in the appendix

East Sussex Place Specific Actions – Community (ESHT)

- No escalation beds available in Bexhill Irvine Unit or Rye for this winter as beds fully utilised
- No financial agreement for actions below
- Ability to recruit into posts describes below
- Secure temporary workforce to support Winter pressures

Ref.	Action	Lead Organisation	Delivery Date	Expected Impact
EA 1.8	Review presentation of HSCC activity list (waiting list to describe patient as needs based rather than specific unit).	ESHT CHIC division	December 2021	• Reduce wait time for Pathway 2 beds by 0.5 days
EA 1.9	Approval to recruit additional capacity for Crisis Response to support the Homefirst pathway 1. This equates to 35 WTE which would support approx. 20-25 patients per day. (£83k/per month)	ESHT CHIC division	Dependent on finance agreement (12-18 month plan)	• Reduce bed deficit by approx. 20 beds
EA 2.0	Approval to recruit 8WTE to provide rehabilitation and reablement to support 7 day discharges (£28k/month)	ESHT CHIC division	Dependent on finance agreement (12-18 month plan)	• Pre MRD – MRD data for screening patient for discharge (Feb-April acute therapy teams were supported by MSK staff and could offer 7 day service) • **Feb-April 2021 (7 day service)** • P1 on average 2.17 days • P2 on average 0.85 days • **June-August 2021 (5 day service)** • P1 on average 2.96 days • P2 on average 1.47 days • Approx. 0.5 day increase in length of stay for each pathway when therapy covers a 5 day service
EA 2.1	Approval to recruit rehabilitation and reablement to support discharges from Pathway 3 beds (7 WTE; £66k/month)	ESHT CHIC Division	Dependent on finance agreement (12-18 month plan)	• Sustain and reduce length of stay in Pathway 3 bed

The full provider plan can be found in the appendix

East Sussex Place Specific Actions – Community (SCFT)

- To ensure operational resilience for winter 2021/22 the SCFT plan sets out the organisational arrangements for the winter period, in recognition of the increase in pressure due to demand, both in acuity of patients and capacity demands
- In addition, Winter often results in untoward events such as widespread infectious diseases, including norovirus and influenza
- The SCFT plan includes on call arrangements over the Christmas and New Year period, 20th December 2021 to 3rd January 2022, and a current synopsis of the Trust flu vaccination programme and trajectory aims for 2021/22, given the potential impact of flu on staffing and capacity

Ref	Action	Lead Organisation	Delivery Date	Expected Impact
CE 1.1	Escalation beds in HWLH - opening 4 beds at Crowborough and 2 beds at Uckfield community hospitals will help provide additional P2 capacity this Winter	SCFT	Tbc – workforce dependent	• Reduction in number of P2 MRDs at RSCH/PRH/ESHT
CE 1.2	Expansion of Urgent Response Services across Brighton and Hove, West Sussex, and High Weald, Lewes and Havens	SCFT	TBC- pending finance review	• Facilitate reduction in MRD and increase same day discharge rates
CE 1.3	Discharge Hubs implemented and co-ordinated by community services- longer term resourcing plan	SCFT	Commenced and ongoing	• enhanced integrated working across providers, with shared understanding of flow and capacity and timely escalation
CE 1.4	Extending hours for System Capacity and Flow service to increase in-reach capacity and support to discharge hubs	SCFT	TBC- pending finance review	• Reduction in delayed transfers
CE 1.5	SCFT will work closely with Operations and Medicines Management Team to support vaccination of high risk patients. All in-patients will be vaccinated against flu if they have not already been vaccinated	SCFT	Commenced and ongoing	• Increase in number of inpatients vaccinated against flu
CE 1.6	Daily MRD MST conference calls in place to prevent an increase in % of MRD's and escalation process followed	SCFT	Commenced and ongoing	• Prevent increase in % of MRDs
CE 1.7	Review of risk within teams to identify potential deployment of staff to higher risk areas. Staff Direct in place – internally facing supply of bank and agency workers primarily to inpatient units	SCFT	TBC	• Higher risk areas are staffed through mutual aid process
CE 1.8	Access to 4x4 vehicles available for Community teams in the case of adverse weather conditions	SCFT	In place	• Service resilience in the event of adverse weather

East Sussex Place Specific Actions – Adult Social Care (ESCC)

Ref.	Action	Lead Organisation	Delivery Date	Expected Impact
ES 1.1	Procure, on behalf of the East Sussex system agreed block contract D2A beds and homecare hours	ESCC	1st October 2021	• Manage MRD patients within performance target.
ES 1.2	Use JCR capacity to facilitate discharge of "red" patients from hospital.	ESCC	1 September 2021	• Reduce LoS for COVID+ patients
ES 1.3	Brokerage to prioritise hospital discharges over and above all other work	ESCC	1 September 2021	• This will help to expedite discharges but with increasing number of community referrals this could create even more delays and inequity of allocations
ES 1.4	Use Care Management resources flexible to meet demand across the whole county and neighbouring systems	ESCC	1 September 2021	• Assessment commenced within target timescales
ES 1.5	Work with CCG and SCFT to develop a home first service in HWLH Continue with the Rapid Response Team Project in the East of the County with ESHT	CCG ASC/ESHT/CCG	2022 Summer 2022	• Increase use of Pathway 1 and manage MRD patients within performance targets • This has been agreed through COB and positive impacts identified through the Project Brief
ES 1.6	Milton Grange to use it's beds flexibly if required to admit "red" patients from acute sites and BIU	ESCC	1 September 2021	• Reduce LoS for COVID+ patients

East Sussex Place Specific Actions – Voluntary Sector

Ref	Action	Lead Organisation	Delivery Date	Expected Impact
VS1.1	**Assisted Discharge Service** • Safe car transport home • Initial settling-in support in the home • Signposting/referrals to ongoing help Undertaking risk assessments in the home to reduce the risk of falls/further hospital admission to the patient • Ensuring vulnerable older people are settled back in at home: deliver, set-up, explain aids and equipment • Developing a personal support plan with the patient; • Provision of telephone support as required during first 48 hours post discharge and referrals to health, social care, housing, East Sussex Fire and Rescue and/or other services where required • Reporting back to appropriate ward or team regarding concerns about patients • Practical support: light shopping/housework; snack preparation; disposal of perishable foods/other household rubbish; assist with bedding; check/turn on heating; assist with paperwork etc • Assistance with medications management • Help to access local activities/support; Follow-up telephone check within seven days	**British Red Cross**	Ongoing	Facilitating safe and timely discharge Reducing hospital readmissions
VS1.2	**Home from Hospital service** Short-term support for a person who has had a recent stay in hospital (within the last four weeks) to smooth the process of settling back into a normal routine and enabling people to regain confidence and independence.	**British Red Cross**	Ongoing	Reducing hospital readmissions
VS1.3	**Street Pastors**: Refuges for vulnerable people in central Hastings and Eastbourne. Safe Space will operate at weekends in the night-time economy to provide support and advice to vulnerable people including: • basic first aid, including mental health first aid • pastoral care raising awareness of the risks associated with substance and alcohol misuse	Safe Space	Ongoing	Admissions avoidance Reducing demand on the ambulance service

East Sussex Place Specific Actions – MRD

This slide sets out the plans in relation to Medically Ready for Discharge (MRD) :

Actions:

- Gap analysis for hospital discharge action cards including roles and responsibilities for staff in acute, community and system partners
- Final approval of NHSE/I patient and family leaflets (and other patient comms) to support discharge processes
- Process map discharge pathways 1-3 to explore further opportunity to reduce length of stay

Reporting and data:

- 3 safety huddles each day to review escalations from the discharge hub which are discussed at Sub OPEX and raised with OPEX as appropriate
- There is an established programme of work to deliver discharge pathway transformation and improvement which is reported via the East Sussex OPEX and LAEDB
- Criteria to Reside Project – daily reporting of patients who meet / do not meet the clinical criteria to reside (against national criteria)
- MRD reporting will be fully automated via nervecentre from October 2021 which will replace the daily snap shot email

Outcomes:

- The expected impact of this work is to sustain delivery of the agreed trajectory of 41 MRDs (pre - Easter target)
- In addition, the following operational mechanisms are in place to underpin MRD delivery:
  - Tracking and monitoring via performance report discussed a OPEX
  - Twice daily updates from the Discharge Hub - start of the day and close of play
  - Tracking and escalation of discharges over 72hrs
- This should be noted alongside the risk relating to care market fragility

Title of Report: Mortality Report – Learning from Deaths 1st April 2017 to 31st March 2021

Meeting information:			
Date of Meeting:	12th October 2021	Agenda Item: 10	
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 Medical Examiner review process which commenced at the Trust on September 1st 2020. All cases referred by the Medical Examiners for further scrutiny, are highlighted to divisions and are discussed at specialty Mortality and Morbidity meetings.

The current "Learning from Deaths" report details the April 2017 – March 2021 deaths, recorded and reviewed on the mortality database. It should be noted that there has been an increase in deaths due to the Covid-19 pandemic, particularly during the second wave from December 2020 to March 2021.

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. This process has been particularly difficult with regard to the deaths related to nosocomial Covid-19 infection as these have largely involved an elderly, frail, multi-comorbid group of patients.

Learning disability deaths are being reviewed externally against the LeDeR (learning disability mortality review) programme. Trusts are now receiving feedback from these reviews, although the process is slow. We continue to review deaths of patients with learning disabilities internally due to the delays in the external process, in order to mitigate any risk.

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 2020-21

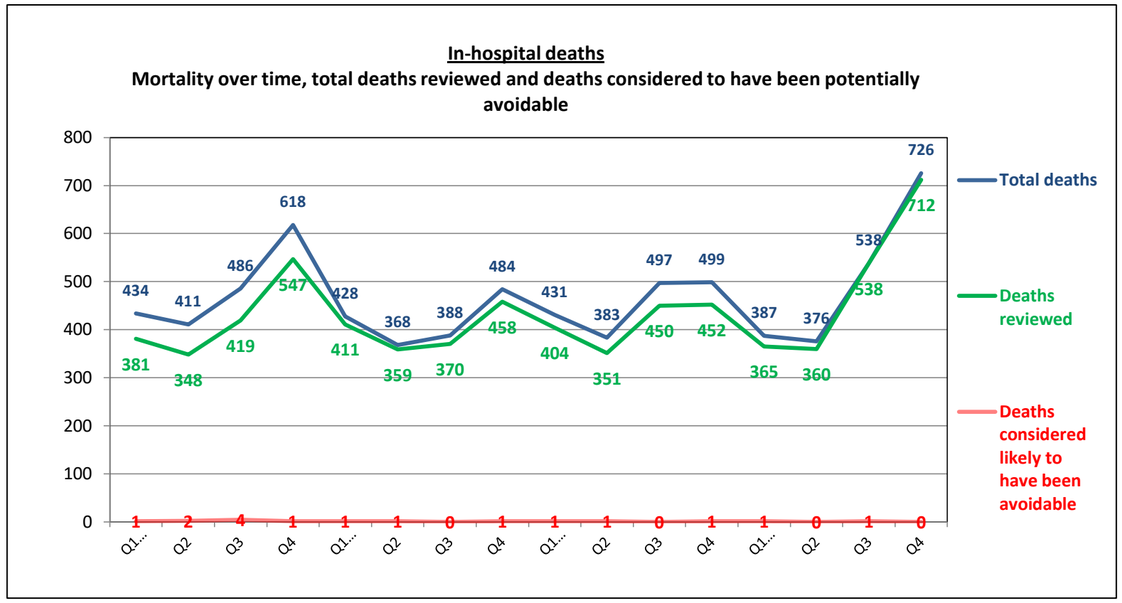
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 19/08/2021)

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	2020-21	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
105	197	105	197	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
726	538	712	538	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2027	1810	1975	1657	2	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)	0	0.0%	This Quarter (QTD)	3	100.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%
This Year (YTD)	0	0.0%	This Year (YTD)	1	8.3%	This Year (YTD)	1	8.3%	This Year (YTD)	8	66.7%	This Year (YTD)	1	8.3%	This Year (YTD)	1	8.3%

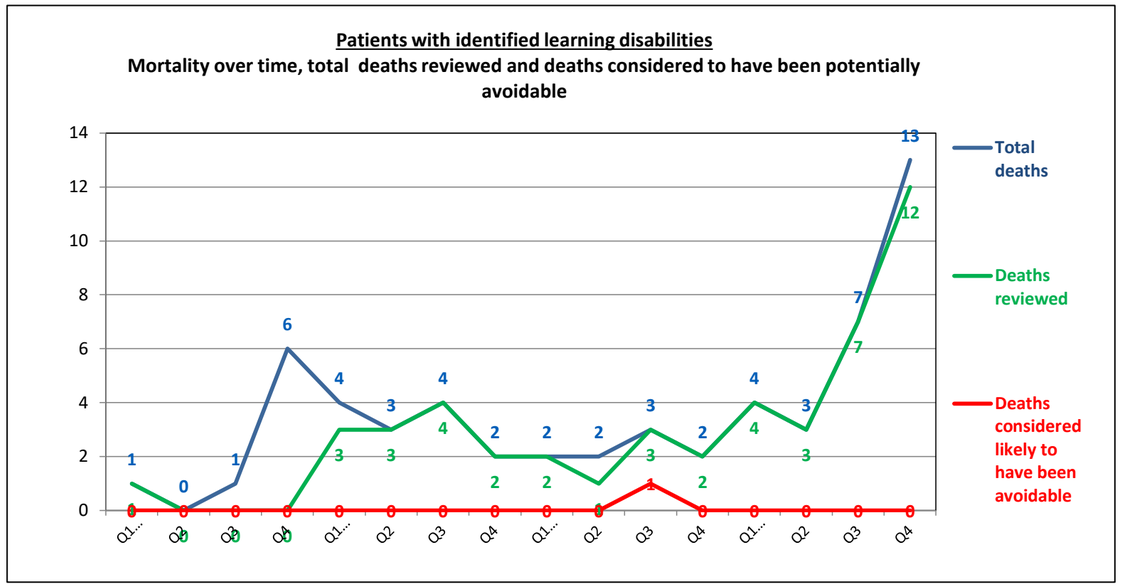
Data above is as at 19/08/2021 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were 4 care concerns expressed to the Trust Bereavement team relating to Quarter 4 2020/21 deaths, one of which was taken forward as a complaint.
Complaints - Of the complaints closed during Quarter 4 2020/21 which related to to 'bereavement', one has an overall care rating of 'poor care' and an avoidability rating of 'possibly avoidable' was agreed at the Mortality Review Audit Group.
Serious incidents - There was one severity 5 Serious incident in Q4 2020/2021. This related to in-hospital COVID deaths on 7 wards.
As at 19/08/2021 there are 529 April 2017 - March 2021 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 19/08/2021)

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	2020-21	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
2	2	1	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
13	7	12	7	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
27	9	26	8	0	1



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

Overarching Health and Safety Annual Report

Meeting information:			
Date of Meeting:	12th October 2021	Agenda Item:	11.1
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 2020/2021 from the Trust's departments, divisions and the specialties (Health and Safety, Medical Devices and Moving and Handling).

The aim of the programme of work that was delivered by the specialties (Health and Safety, Medical Devices, and Moving and 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.

This annual report is presented to demonstrate the progress made over the year 2020/2021. It is well recognised that health and safety is central in the delivery of safer services for patients, and for carers, visitors and staff.

The key achievements for 2020/2021 were:

The core function's response to the impact of the Covid-19 pandemic on the organisation and management of health and safety was exemplary and is identified throughout the report in the relevant sections.

The Health and Safety Department, led by the Trust Deputy Lead for Health and Safety, had essential and central responsibilities in the organisation's response to the Covid-19 pandemic. This was achieved by developing, driving and supporting the implementation of measures to ensure that the Trust, the staff, and patients were compliant with Health and Safety Executive and national directives. Full details are provided within the body of the report.

Although impacted by reduced staffing levels, both the Medical Devices and the Moving and Handling Teams were able to provide essential upskilling training for all re-deployed staff and staff returning or new to healthcare during the initial months of the pandemic. Mandatory training was suspended from March through to September but where needed, the teams provided ad hoc sessions.

The review and revision of incident categorisation and sub-categorisation undertaken in 2019/2020 for the three specialties (Health and Safety, Medical Devices, and Moving & Handling) and for security, violence and aggression has produced more accurate and reliable data. While the Trust continues to have a strong reporting culture, the number of incidents reported was impacted by the pandemic, particularly during the lockdown periods. Initially there was significantly reduced activity within acute areas, and as clinical and service delivery priorities increased dramatically, staff may not have been reporting near misses or incidents of a lower severity.

The Health and Safety department developed a successful business case and a programme for the procurement implementation of Lone Worker Devices for the better protection of domiciliary based staff. The devices enable staff to summon discreet and rapid assistance in the event of an emergency. ESHT Digital is supporting the implementation programme during 2021/2022.

Following a review of incidents in response to safety issues, the Medical Devices Educator Team initiated oxygen training for a broader range of staff. This training has been well received by all staff groups and has had a significant impact on ensuring greater safety for those patients receiving oxygen therapy in the Trust.

Each Specialty worked diligently to provide essential training throughout the year. Difficulties such as vacancies, sickness and the impact of the Covid-19 were overcome and they were able to demonstrate significant compliance with key performance indicators for training. In addition, the Medical Devices Team facilitated training when external providers were not able to attend the Trust. This allowed training on new equipment which had been rolled out across the Trust. The Moving and Handling team adapted their delivery of training when the Moving and Handling training room was requisitioned for the Vaccination Hub at the Conquest site.

Key objectives identified for 2021/2022:

Violence and Aggression – There is now an ongoing Violence and Aggression Group that has a workplan to implement the actions that arose from the Health and Safety Executive (HSE) inspection in July 2019, and other areas of focus to reduce the burden on staff of violence and aggression. Although progress has been slow due to the pandemic, there remains a commitment to the programme of work around a training needs analysis which will inform an education programme, development of guidance for staff on how to manage patients who lack capacity, ongoing engagement with and support for staff and ongoing support with the implementation of the sanctions policy. There is an overarching risk on the Trust Risk Register.

Implementation of new Lone Worker Devices - Although the Lone Devices project is part of the V&A group work programme, it is a separate priority due to the current high risk relating to lone working staff. ESHT Digital is supporting on the roll out of new devices and uptake by staff will be monitored. The risk is on the Trust Risk Register.

Covid-19 risk assessments – All staff must have up to date individual Covid-19 risk assessment. The COVID-19 risk assessment provides managers with the opportunity to have a conversation with their staff member to check on their wellbeing and ensure any required adjustments are in place. Environmental risk assessments are essential and all managers are required to complete one for their relevant areas. Ongoing support and advice is being given to managers and the assessments are regularly reviewed to ensure they meet current guidance. Exposure risks are on the Trust Risk Register.

Staff wellbeing - The focus on staff wellbeing has remained throughout the pandemic but with significant additional input in recognition of the impact it had, and continues to have. Significant measures have/are being put in place to provide support and training for staff. This risk is on the Trust Risk Register.

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

Health and Safety Steering Group – 16th August 2021
Quality and Safety Committee – 16th September 2021

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

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

East Sussex Healthcare NHS Trust

Overarching Health and Safety Annual Report

2020 - 2021

Executive Summary

One of the Trust's core responsibilities and the role of the key services/specialities (Health and Safety, Medical Devices, and Moving & Handling) is to ensure that the Trust is compliant with Health and Safety legislation. For the purposes of this report, this refers to the time period outlined from April 2020 to March 2021. Those three core functions contributed to the overall management of health and safety within the organisation and in particular to the trust's response to the impact of the Covid-19 pandemic on the organisation. In addition, the collaborative working with Infection Control (IPC), Emergency Planning (EPRR) colleagues and many others across the trust and the system was key given the nature of the challenges and the ongoing response to the "incident".

The management of health and safety was felt to be exemplary and is identified throughout the report in the relevant sections. In a year like no other with unprecedented challenges and changes, the trust has continued to maintain focus on the overall Health & Safety agenda and ensured that safe systems of work were in place for patients and staff.

The key achievements for 2020/2021 were:

The Health and Safety Department, led by the Trust Deputy Lead for Health and Safety, had essential and central responsibilities in the organisation's response to the Covid-19 pandemic. This was achieved by developing, driving and supporting the implementation of measures to ensure that the Trust, it's staff, and patients were compliant with Health and Safety Executive and national directives. Full details are provided within the body of the report.

Although impacted by reduced staffing levels, both the Medical Devices Team and the Moving and Handling Team were able to provide essential upskilling training for all re-deployed staff and staff returning or new to healthcare during the initial months of the pandemic. Mandatory training was suspended from March through to September but where needed, the teams provided ad hoc sessions.

The review and revision of incident categorisation and sub-categorisation undertaken in 2019/2020 for the three specialties (Health and Safety, Medical Devices, and Moving & Handling) and for security, violence and aggression has produced more accurate and reliable data. While the Trust continues to have a strong reporting culture, the number of incidents reported was impacted by the pandemic, particularly during the lockdown periods. Initially there was significantly reduced activity within acute areas, and as clinical and service delivery priorities increased dramatically, staff may not have been reporting near misses or incidents of a lower severity.

The Health and Safety department developed a successful business case and a programme for the procurement of Lone Worker Devices for the better protection of domiciliary based staff.
The devices enable staff to summon discreet and rapid assistance in the event of an emergency. ESHT Digital are supporting the implementation programme during 2021/2022.

Following a review of incidents in response to safety issues, the Medical Devices Educator Team initiated oxygen training for a broader range of staff. This training has been well received by all staff groups and has had a significant impact on ensuring greater safety for those patients receiving oxygen therapy in the Trust.

During the first lockdown, the Moving and Handling Team supported the external inspections of moving and handling equipment as per the Provision and Use of Work Equipment Regulations 1998 (PUWER) and Lifting Operations and Lifting Equipment Regularities 1998 (LOLER). This ensured that all safety measures were in place and that Trust equipment was fit for purpose.

Each Specialty worked diligently to provide essential training throughout the year. Difficulties such as vacancies, sickness and the impact of the Covid-19 were overcome and they were able to demonstrate significant compliance with key performance indicators for training. In addition, the Medical Devices Team facilitated training when external providers were not able to attend the Trust. This allowed training on new equipment which had been rolled out across the Trust. The Moving and Handling team adapted their delivery of training when the Moving and Handling training room was requisitioned for the Vaccination Hub at the Conquest site.

The Key Risks Identified for 2021/2022:

Violence and Aggression - Following an inspection by the Health and Safety Executive (HSE) in July 2019, and the issuing of a contravention notice, violence and aggression (V&A) has remained a key priority within the organisation. The V&A Task and Finish Group was established to implement an improvement programme to address the concerns raised by the HSE. The improvement programme provided assurance and led to the closure of the contravention notice in October 2019. Although some progress had been made with the improvement programme, the Covid-19 pandemic caused a delay to some elements. The task and finish group has, therefore, become a permanent forum through which to complete the programme and also take forward further actions that have been identified. The overarching risk is on the Trust Risk Register.

Implementation of new Lone Worker Devices - Although the Lone Devices project is part of the V&A group work programme, it is a separate priority due to the current high risk relating to lone working staff. ESHT Digital is supporting on the roll out of new devices and uptake by staff will be monitored. The risk is on the Trust Risk Register

Covid-19 risk assessments – All staff must have up to date individual Covid-19 risk assessment. The COVID-19 risk assessment provides managers with the opportunity to have a conversation with their staff member to check on their wellbeing and ensure any required adjustments are in place. Environmental risk assessments are essential and all managers must ensure that they are completed for their relevant areas. Exposure risks are on the Trust Risk Register

Staff wellbeing - The focus on staff wellbeing has remained throughout the pandemic but with significant additional input in recognition of the impact it had, and continues to have. Significant measures have/are being put in place to provide support and training for staff. This risk is on the Trust Risk Register

Executive Statement

This annual report is presented to demonstrate the progress made over the year 2020/2021. It is well recognised that health and safety is central in the delivery of safer services for patients, and for carers, visitors and staff.

The Trust Health and Safety Steering Group (HSSG) is in place to organise and monitor organisational compliance with 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 2020/2021.

The nature of Trust activities means that a wide range of risks exist, but through the implementation of related policies, Trust 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, acknowledging areas of development. This report is intended to assure the Trust Board that appropriate and adequate health and safety arrangements are in place and that health and safety is being effectively managed across the organisation.

Vikki Carruth,

Chief Nurse and 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 2020 – 31st March 2021.

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.

The head count of permanent staff was 7,482 as at 31st March 2020 and 7,725 as at 31st March 2021. The average head count for 2020/21 was 7,571 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 (Director Infection Prevention and Control) 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 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. Nevertheless 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 Committee.

2. Legislation and Guidance

2.1 There are in excess of 200 pieces of Health and Safety Legislation. The key legislation 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. Duties are placed on employers, employees, and those in control of work premises, suppliers and manufacturers. The principles of the Act are overarching and general 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. This includes staff, patients and members of the 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. This is 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 and applies to all organisations of all sizes. It is designed for use by all directors, governors, trustees, officers (and their equivalents) in the private, public and third sectors. 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 comprises members of East Sussex Healthcare NHS Trust staff who are members of a Trade Union or Society that is 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 regarding 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. 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 and is scheduled for review in February 2022. 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**

2020/2021 marked the fourth year that the HSE focus was on tackling the major causes of work-related ill-health. This included musculoskeletal disorders (MSDs) and work-related stress. Following the

outbreak of the Coronavirus pandemic, the HSE has had a pivotal role in the national response, helping to reduce the level of transmission as well as supporting the country's economic recovery following lockdown.

3. Claims

There were thirteen claims closed during 2020/21 specifically related to health and safety which was a increase on the eleven claims settled in 2019/20. Of these thirteen incidents which were settled in the financial year, two dated back to 2015, one was from 2016, three from 2018, four from 2019, three from 2020. Two patient falls have been included as meeting the health and safety criteria.

Claim Date	Claim Closed	Description
February 2015	July 2020	Assault by patient
December 2015	July 2020	Injury due to equipment malfunction
December 2016	August 2020	Electric shock from equipment
May 2018	June 2020	Tripped on pothole
November 2018	June 2020	Patient fall
November 2018	February 2021	Trip on carpet tile
April 2019	April 2020	Alleged assault by member of staff
June 2019	June 2020	Injury caused by defective trolley wheels
June 2019	February 2021	Patient fall
September 2019	May 2020	Metal hook became detached causing soft tissue injury
February 2020	August 2020	Facial injuries from falling box
February 2020	August 2020	Soft tissue injury to head from door opening
August 2020	February 2021	Slip on plastic manhole cover

Liability type:

- Employers Liability - 11 incidents
- Clinical Negligence Scheme - 2 incidents

HEALTH AND SAFETY DEPARTMENT

1. Introduction

The Health and Safety Department's annual report covers the period 1st April 2020 to 31st March 2021 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 Systems (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** (published by the HSE) 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 are interrelated 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 maintenance 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 identify areas for improvement.

2.1 Regulatory visits and contacts

Health and Safety Executive. November 2020
The HSE made contact with the Trust in November 2020 regarding the Covid-19 related death of a member of staff, employed by a neighbouring Trust, who had worked to support mental health patients within the Emergency department at Eastbourne Hospital. The HSE required evidence of risk mitigation for the department held by ESHT to protect members of staff and others who may be affected. A comprehensive evidence base of the historic and current measures to mitigate the risk of Covid-19 including Covid-19 Secure checklists and risk assessments was collected and sent to the HSE.

Outcome: The HSE were satisfied with the evidence and no further information was required.

Health and Safety Executive. February 2021.
The principal inspector of the HSE telephoned the department requesting further information about the circumstances leading to the death of a member of staff from Covid-19. An extensive investigation was undertaken by Health and Safety to examine all factors including work patterns, risks and mitigation and this also encompassed community infection rates. The investigation and evidence was presented to the HSE for senior panel review in April 2021. The Coroner opened a case for potential inquest in tandem with their investigation and a copy of the Trust's investigation was sent to the Coroner to assist with their enquiries.

Outcome: The HSE concluded their enquiries and agreed that there was no work related factor involved.
An inquest was not held by the Coroner who was satisfied the death was non-work related.

3. Management of Health and Safety

During the last 2 quarters of the reporting period it should be noted that recruitment was being undertaken and the department comprised 2.6 Full Time Equivalents (FTE) to deliver the following services:

- competent health and safety advice;
- administration of the health and safety and risk assessment software Assure ©;
- specialist and core training and
- support for key groups on a corporate, divisional and local basis.

Key members of the department hold qualifications in general and specific health and safety subjects. They undertake peer review, reflective practice, continuing, specialist and individual professional development with relevant professional bodies. A member of the team holds the post of Chair of the national network, Healthcare Risk Management Group.

3.1 Trust Board / Directors

Health and Safety Guidance 65 outlines 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, setting the direction for Health and Safety and retaining ownership of key issues and risks as part of the quality section presented by the Chief Nurse and Medical Director.

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 reports into the Trust Health and Safety Steering Group (HSSG). The expectations of the group are outlined in the HSSG terms of reference. These include defined parameters for reporting incidents and risks to expedite escalation, and also feedback mechanisms as appropriate. All members of the group are expected to escalate to, and disseminate 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. 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.

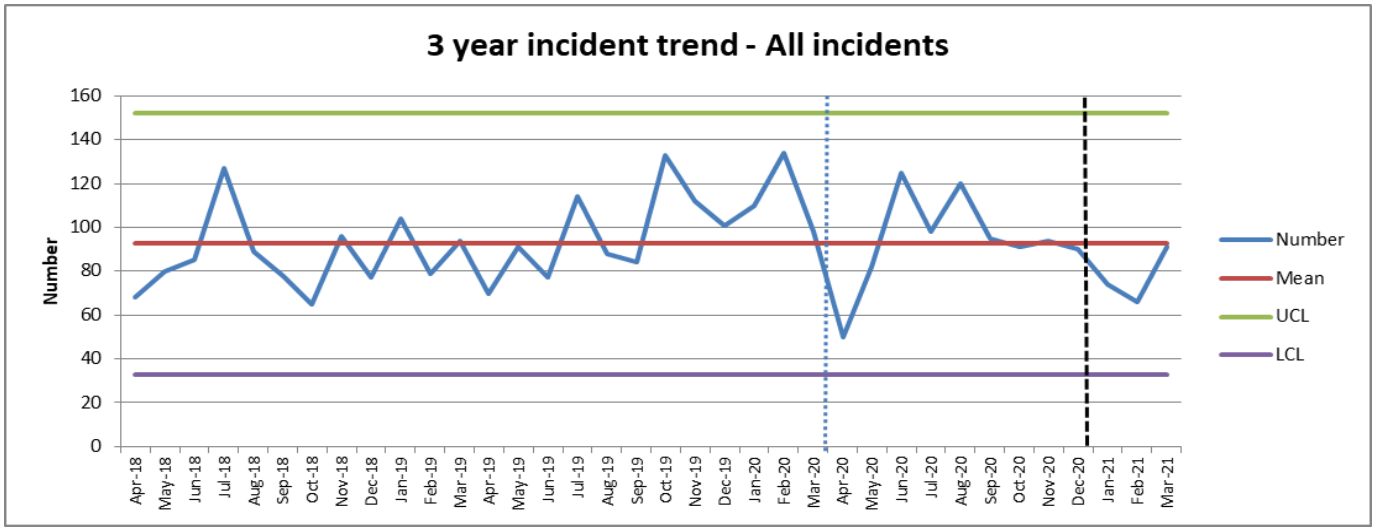
4.1 Incident Classification and Categories

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 unless an incident has occurred to a patient resulting in an event categorised by the Reporting of Incidents, Diseases and Dangerous Regulations 2015. Otherwise this report focuses on staff and others who may be affected by work related activity.

A full breakdown of incidents relating to security, violence and aggression and fire are reported 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.

4.2 New incidents

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



Key to this chart and highlighted in the date markers is the effect of incidents reported using the timelines of:

- 11th March 2020 – World Health Organisation declared the Covid-19 health crisis to be a pandemic,
- Mid-December 2020 to mid-January 2021 in East Sussex there was a rapid increase in infection rates moving from East to West of East Sussex impacting at different times within this period. A significant amount of work was undertaken by the Trust to reduce footfall. This included visiting restrictions, the implementation of virtual appointments and additional Security guards on the acute sites. This wave was the most significant to date, involving a new variant of concern.

The impact of the Covid-19 pandemic had an effect on incident reporting as indicated in the table below. Staff may not have been reporting incidents of lower severity or near misses due to clinical and service delivery priorities. The Trust has a strong reporting culture but the examination of historic incident reports has identified that throughout Q4 2020/21, the actual numbers of incidents may have

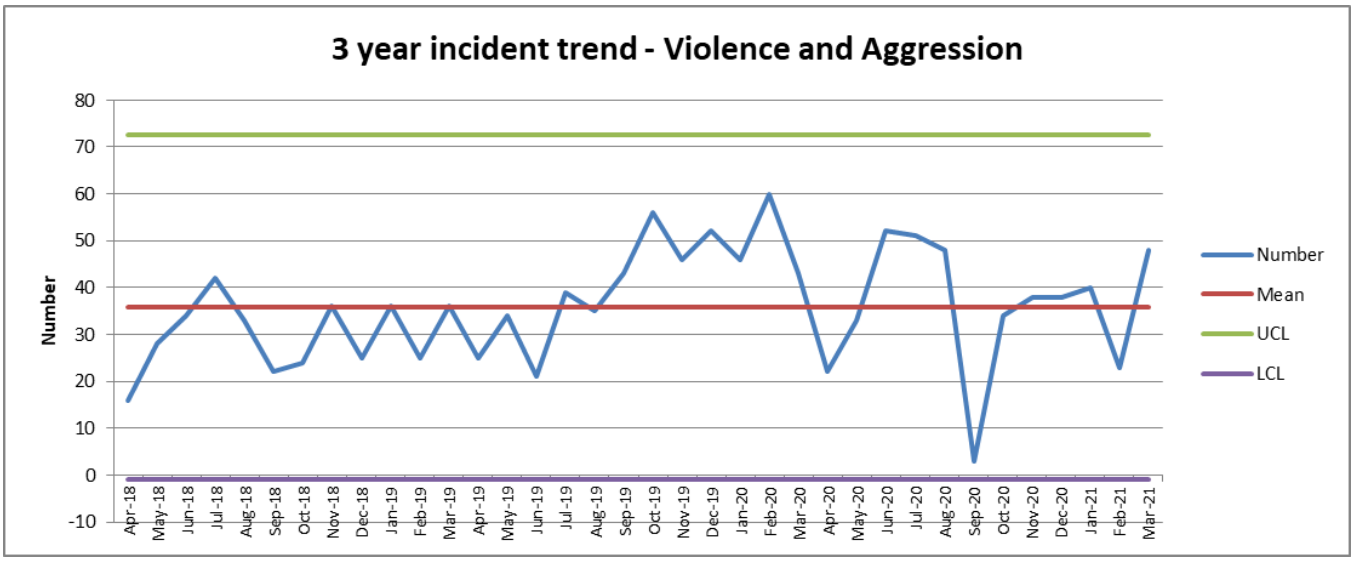
been higher if all incidents including severity 1/near misses had been reported. Overall there was an 11% reduction in incidents compared to the previous year.

All incidents	Total Number	Month average	Severity 1	Severity 2	Severity 3	Severity 4
2018/ 19	1042	86.83	51.44%	43.67%	4.70%	0.20%
2019/ 20	1212	101.00	50.67%	46.37%	2.64%	0.33%
2020/ 21	1076	89.67	37.08%	59.67%	3.07%	0.19%

4.3 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 incidents.

4.3.1 Security, Violence and Aggression.



Work was undertaken by the Trust to reduce footfall and infection risk. This included visiting restrictions and the implementation of virtual appointments. A greater reduction of incidents was anticipated due to the additional Security guards on the acute sites.

The table below indicates that the level (severity) of violence and aggression may have been much greater as staff were not reporting lower level incidents. The monthly averages are similar to the previous year, however the much reduced level of lower severity reporting should be noted. An increase in actual harm incidents (severity 2) may indicate that the effect on staff of the incidents that were reported was more serious. It is also of concern to note that 46.58% of incidents involved physical violence to staff, an increase on the previous two years.

Violence and Aggression	Total Number	Month average	Severity 1	Severity 2	Severity 3	Number of all Physical	% of total incidents
2018/ 19	357	29.75	71.15%	26.05%	2.80%	140	39.22%
2019/ 20	500	41.66	62.20%	37.20%	0.60%	195	39.00%
2020/ 21	483	40.25	36.23%	62.94%	0.83%	225	46.58%

Work was undertaken in March 2020 which enabled those reporting incidents to include the factors relating to the incident. From the increased data intelligence, it has been identified that 160 incidents involved a clinical component such as mental health issues, capacity or treatment (including anaesthesia).

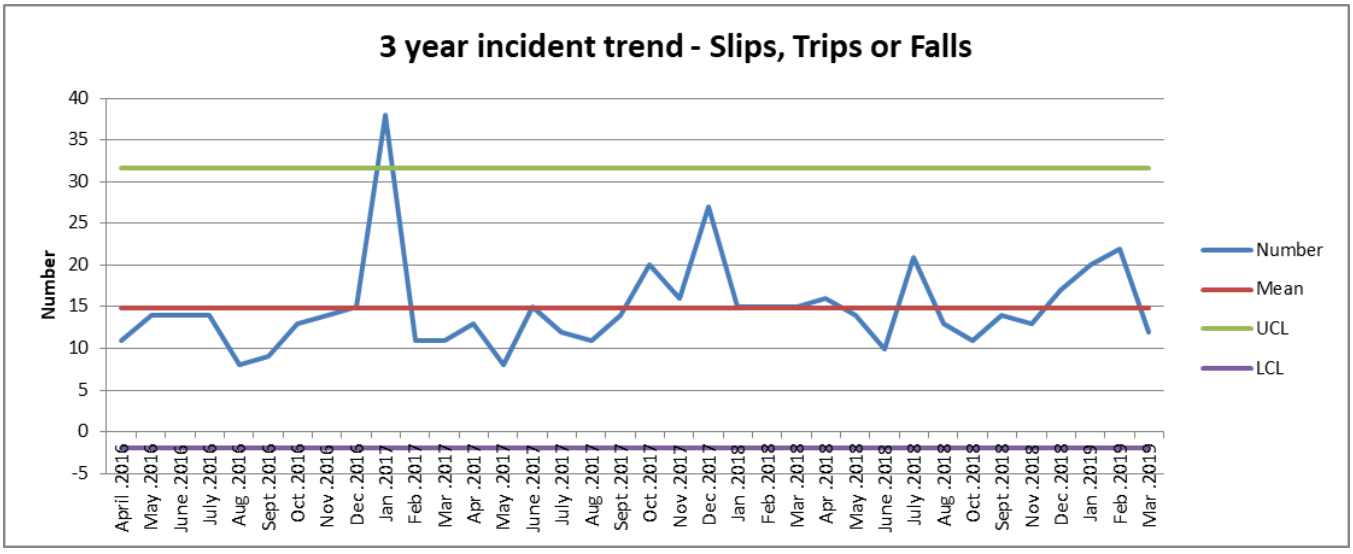
The Trust is a member of the Health and Care Partnership (HCP) Sussex a specific forum set up to address the requirements of the Violence Prevention and Reduction Standards (Appendix 1) published and mandated by NHS England in December 2020. The group has acknowledged the work already undertaken by ESHT which is noted as being at an advanced stage compared to the majority of Trusts.

Information from the HCP also informs the ESHT Violence and Aggression Steering Group which was set up to address specific actions from the July 2019 inspection undertaken by the Health and Safety Executive, and to improve further on staff experiences.
The group, chaired by the Head of Governance, had key work streams which were then developed during the year into a work plan which includes:

- Training Needs Analysis
- Guidance on managing patients who are violent or aggressive and lack capacity
- Violence and Aggression Policy
- Implementation of the Lone Worker Devices
- Staff Wellbeing and Engagement
- Communications
- Access to information

There are specific leads for the components of the work plan and the group reports to the Trust Health and Safety Steering Group on a quarterly basis.

4.3.2 Slips, Trips or Falls



The above graph maps the three year trend of slip, trip and fall incidents of staff and others e.g. visitors, contractors.

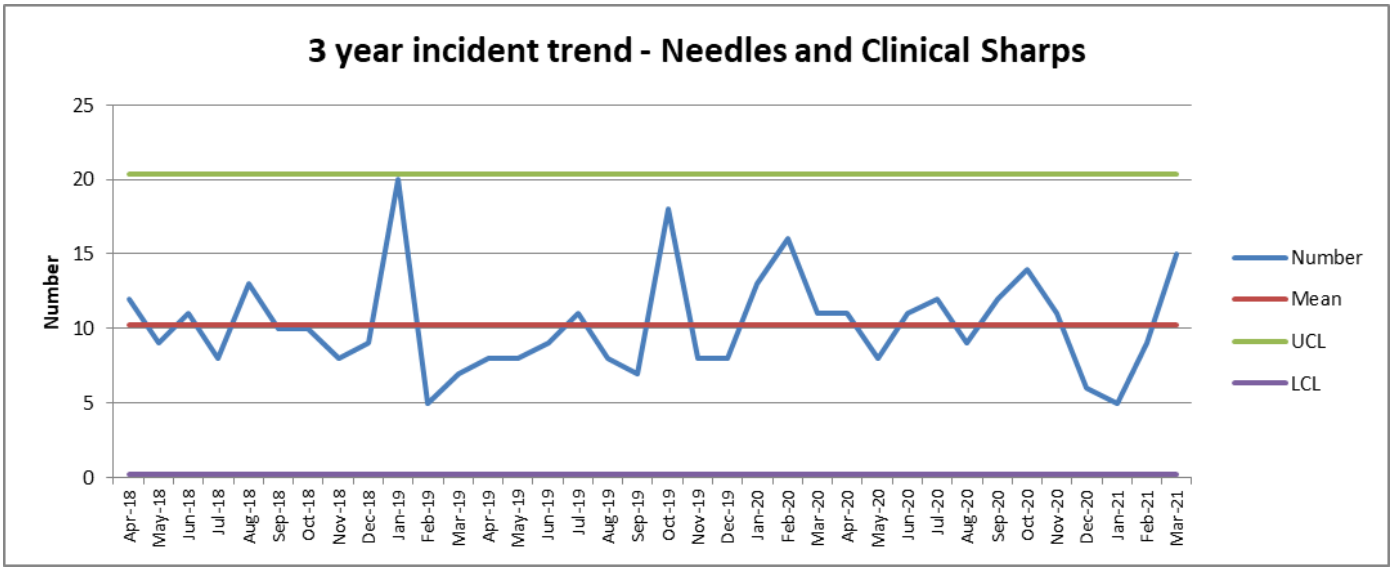
New incidents reported	Number	Month average	% Severity 1	% Severity 2	% Severity 3	% Severity 4	Severity 3+	% of total incidents
2018/19	171	14.25	27.85%	60.82%	11.11%	0.58%	20	11.70%
2019/20	160	13.33	27.50%	60.62%	10.63%	1.25%	19	11.87%
2020/21	151	13.25	24.50%	64.24%	9.93%	1.32%	17	11.26%

A total of 151 incidents reported across the year, 17 resulted in an incident graded severity 3 and above in comparison to 20 in 2019/20. Trips and falls over objects or structures were the most commonly reported incident (58) and storage of items was often identified as the causal factor, along with environmental issues including holes in floor and uneven surfaces. The increased complexity of treatment for patients means that additional medical devices are required to support patient care. This impacted on storage and ability to keep equipment away from walkways.

The second most reported category was as a result of slipping on liquids or slippery surfaces (44). Primary causes were wet floors during housekeeping activities as well as spillages and environmental (leaks and uneven surfaces). It is recognised that the Trust has improved practices considerably to prevent slips and falls but the aging estate, along with behaviours of staff, continues to present a risk.

4.3.3 Needle stick incidents

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%
2020/ 21	123	10.25	30	4	89	72.36%



The above graph maps the three year trend of incidents reported. There was a reduction in incidents during the peak of the second wave of Covid-19 in East Sussex (December 2020/January 2021) consistent with reduced footfall and activity in some areas.

An analysis of data identifies that behaviours such as re-sheathing of needles, walking with used sharps and departing from the Trust policy of using safe needles were causal factors.
A Sharps Working Group was set up to determine further measures needed as a result of the 7 year analysis and review of Sharps Safety in the Trust. The group had scheduled to meet at the beginning of 2020/21 but this was delayed due to the evolving health crisis and the need to prioritise other activities. The incidents occurring through 2020/21 gave rise to a recommendation that the Sharps Working Group should be re-established with senior leadership and attended by specialists responsible for the training and education of staff and for the implementation of safe sharps within the Trust.

5. RIDDOR events – Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 2005 (as amended 2013)
There were a total of 31 incidents reported as RIDDOR events to the Health and Safety Executive that fall with the standardised incident reporting criteria of:

- Health and Safety
- Violence and Aggression
- Slips, trips and falls
- Needle-stick injuries including those defined as a dangerous occurrence

5.1 Staff RIDDOR events

	2016/17	2017/18	2018/19	2019/20	2020/ 21
+ 7 Day	29	16	16	17	21
Specified /Major	7	4	6	6	7
Dangerous Occurrences	0	2	4	1	1
Total	**26**	**22**	**26**	**24**	**29**

A total of 29 incidents affecting staff were categorised as a RIDDOR event and were then reported to the Health and Safety Executive in 2020/21. This is an increase on previous years. The details of the incident statistics have been reported in to the Trust Health and Safety Steering Group and included:

5.1.1 Dangerous Occurrence
1 incident caused by a departure from Trust policy in relation to the use of a safety engineered device. A standard needle was used to undertake blood glucose testing. The injury exposed the member of staff to a risk of a blood borne virus and they were seen immediately by the Emergency department. The incident was investigated and retraining arranged for the member of staff.

5.1.2 Over 7 day injuries
21 incidents affecting staff and incurring an excess of 7 days absence from work. The incidents were due to environmental conditions and behaviours, slips on floors, falling from stairs or tripping over obstacles and faulty trolley wheels. In addition, 2 members of staff sustained injury from patients who lacked capacity, 3 staff had hand or finger injuries during moving procedures and 1 member of staff sustained a scald when a kettle slipped from their hand.

5.1.3 Specified/ Major Injuries
7 incidents, all related to slips trips and falls. 6 members of staff received a fracture due to:

- 3 miss-step incidents on stairs due to non-uniform steps with poor lighting, vision obstructed by face mask, and using a mobile phone;
- Sunken drain combined with poor lighting in the car park;
- Staff member tripped on their shoe laces and

- Uneven paving the causal factor of a staff member falling (East Sussex County Council have been contacted).
  Additionally a member of staff tripped over a door step, a long term neurological condition causing mobility difficulties was determined to be a factor for which a risk assessment was in place.

5.2 Public/ Visitor RIDDOR events
There were no (0) incidents involving members of the public.

5.3 Patient RIDDOR events
There were 2 patient RIDDOR events both, relating to trips and falls.

- A patient experiencing temporary hallucinogenic episodes went from their ward to another area and jumped through a window after breaking the glass sustaining injury to their back. The subsequent investigation identified that the patient was awaiting a specialist assessment by the psychiatric team to support the patient, but prior to the incident was not deemed to be a risk to either themselves or others. It was determined that this was not an avoidable event.
- A patient tripped and fell on an external contractor generator cable outside the hospital building on their way to an outpatient appointment and sustained a minor injury. The subsequent investigation determined immediate actions for the contractors and very specific learning to be taken forward by the Project Management department.

More than 58% of staff RIDDOR events were reported outside of the reporting time frames required by RIDDOR (15 days for incidents defined as +7 days, and 10 days for specified injuries). This occurred due to the following reasons:

- An incident is not reported on the Datix system by the member of staff or, by their manager if the member of staff is absent,
- Health and Safety is not notified of the incident by the manager,
- There is insufficient investigation detail in the incident to prevent recurrence of the incident which is required for the report,
- A delay in obtaining staff details to populate the RIDDOR report form.

The Health and Safety department has notified the HSE that it will no longer give personal details such as staff address and date of birth as this has previously introduced delays. The absence of investigation undertaken for a large proportion of incidents is of concern to the Trust as it may prevent future mitigation and learning from incidents. The population of this field for staff related incidents and the undertaking of proportionate incident investigations is a 2021/22 objective for the Health and Safety department.

6. Health and Safety Department Activity

6.1 Occupational Health and Safety Management System - audit and performance

Audits are a leading indicator of the health and safety performance of health and safety management at a local level, and assist in informing strategic health and safety priorities.

The audits have 18 specific standards that are based on legal compliance and adherence to Trust policy. Division of 18 standards enables an overview of compliance in specific risk areas. In all cases, evidence is sought where measures required as a result of incident or risk assessment and not able to be undertaken at a local level that risks have an escalation and feedback process. There should be good engagement and communication regarding risks and safe working practices.

The department has a KPI of completing a minimum of 100 audits per year. It was a 2020/21 priority for the department, once trained staffing levels were achieved, to address the deficit and remain on track at year end. Audits were undertaken during Quarter 1 but due to the Covid-19 pandemic and notwithstanding a trial of desk-top audits, only 11% of audits were undertaken and the year end KPI was not achieved.
A rapid shift in priorities was needed to focus on the immediate risk presented by the Covid-19 pandemic to ensure that measures were in place to reduce the risk of transmission. This presented a risk in terms of monitoring, and a backlog for the department for the longer term. As the department supports services to return to business as usual, in line with revised guidance anticipated in 2021/22, an objective will be to restore occupational health and safety management audits and all additional core services, including communications networks.

6.2 Covid – 19

Until mid-Quarter 1 there was an absence of guidance from regulatory and advisory bodies regarding the measures needed to be taken by NHS organisations in relation to Covid-19. When this guidance was issued it was found to be both general and non-specific, or the guidance conflicted between the advisory and regulatory bodies. This conflict extended to the guidance relating to RIDDOR reporting where there was a possibility that a member of staff may have contracted Covid-19 as the result of a work related exposure.

6.2.1 Covid-19 Secure checklists
Due to the lack of specific information, the department worked with a national network to develop information based on the mandate issued by the Health and Safety Executive in May 2021. A risk checklist was then developed by the department, with comments from Trust specialists, which would serve to guide managers giving them direction to reliable and contemporaneous information. The checklist required positive confirmation that all aspects of the HSE mandate had been considered. Any response to the negative was targeted for further assistance and a monthly report was forwarded to the governance leads for information and further action.
This methodology gave a balanced and proportionate approach to the assessment of risk specifically:

1. ESHT Covid-19 risk assessment. A risk assessment for the workforce and published to the Assure system
2. Working from home
3. Cleaning, handwashing and hygiene procedures
4. Maintaining safe social distancing
5. Managing transmission risk

6.2.2 Covid-19 Secure risk reviews
The Health and Safety department completed over 120 visits across all areas of the Trust in both community and acute hospital sites with an objective review undertaken of 385 rooms, services and full sites. In each instance, clear guidance was given during the visits, including discussion with the matron or manager on the areas reviewed, followed by a summary report outlining the findings and any recommendations or actions identified. The visits also provided reassurance to staff and an opportunity for them to ask questions and a chance to highlight good practice.

Key findings
Whilst good practice, a clear understanding of what Covid Secure means and a strong sense of personal responsibility was seen, there were also areas of concern. Many of the factors in place to

become Covid Safe during Quarters 1 and 2 were not in place, or had eroded over the year and this was reported on to the Trust Health and Safety Steering Group for discussion and action.

6.2.3 General Covid-19 response

- A major proportion of the department's activity was in the response to Covid-19. This involved leading on incident investigation and assisting in the rapid development of policy, including supporting the Home and Mobile Working Policy and a specific Home Working checklist for staff needing to work from home.
- Close co-ordination with Infection Control and Occupational Health and Wellbeing teams was also required to ensure that the incidents involving staff infections remained under review and considered for further reporting.
- A review was undertaken of purified air powered respiratory (PAPR) hoods to determine the availability of the equipment, with the aim of reducing variation in type and the adequacy of training. A Standard Operating Procedure was developed and included specification criteria with the aim of moving to management of these devices in the same way as a medical device, including asset marking and a competency framework.
- The control provided through a revised procedure and as a result of a close working relationship with the Procurement department, resulted in rapid assessment of substances required to supplement existing hand hygiene stocks. Many alternative substances were purchased (and some declined) due to the lack of assurance from non-standard manufacturers.
- Services were supported and timely advice was provided for departments that needed to rapidly identify alternative ways of working (or from different premises) in order to continue patient care. Guidance and collaboration with other departments included Infection Control, Fire and Waste to ensure services were covered and that any delay in service delivery was kept to a minimum,

6.3 Lone Working Devices

The Health and Safety department developed a successful business case and programme for the procurement of Lone Worker Devices for the better protection of domiciliary based staff.
The devices enable staff to summon discreet and rapid assistance in the event of an emergency. The risk to domiciliary based staff remains under review in light of the local and nationally reported increasing levels of violence and aggression. Implementation of the programme is supported in 2021/22 by ESHT Digital.

6.4 Training

Training figures during the last 12 months show marked improvement in compliance through all months with year-end indicating significant compliance at 93.5%

Mid-way through the year, Level 1 training moved to e-Learning (only) for all staff. This has allowed the team to factor in a Training Needs Analysis for the next financial year with a reduction, (50%) of the number of class-based places provided by the department.

6.4.1 Training Needs 2020/2021

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

Health and Safety Level 2 course for Supervisors, Team Leads and Managers was reduced to half a day; these changes have been 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.

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

7.1 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 for discussion at risk meetings and Integrated Performance Reviews.
- Multiple, automated, daily reminder emails replaced by a single Summary Weekly 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.

7.2 Key Risks of Assure

- **Limited Reporting Capability**: Although the reporting functions on Assure remain limited in their sophistication and require time and considerable formatting to produce usable data, a number of regular reports are now sent out by the Health and Safety Department on a monthly and quarterly basis to Governance Leads and other key stakeholders.
- **Confidentiality Permissions not meeting ESHT Requirements**: This results in confidential assessments being 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.

8. Health and Safety key risks and assurances

8.1 Significant risk - Violence and Aggression

The Trust has a good reporting culture for patient safety incidents but health and safety incidents relating to staff, particularly those involving violence and aggression, remain less likely to be reported. The reduction in reporting of lower severity incidents was particularly noted to correlate with the peak of Covid-19 infection rates and the corresponding higher levels of activity in the Trust.

Violence Prevention and Reduction standards were drafted by NHSE/I and published in December 2020 with a resultant pilot programme of key actions in which all Trusts are required to participate. The

programme is led by NHSE/I and co-ordinated by Health and Care Partnership Sussex. The standards will be monitored, via the Sussex ICS framework, for incident reporting after the pilot phase.

8.2 Significant risk - Lone Workers; Domiciliary staff

The Health and Safety department developed a business case and programme for the procurement of Lone Worker Devices for the better protection of domiciliary based staff. The devices enable staff to summon discreet and rapid assistance in the event of an emergency. The risk to domiciliary based staff remains under review in light of the local and nationally reported increasing levels of violence and aggression. Implementation of the programme will be supported in 2021/22 by ESHT Digital. Assurances sought in order to reduce the risk in 2021/ 22 will be qualitative and quantitative through incidents, ad-hoc reviews, audits and risk assessments.

8.3 Moderate assurance - 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 non-controlled 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. This is a risk register entry.
Moderate assurance is provided through working with Procurement to identify procurement routes in order to control and assess substances and has resulted in a Trust wide inventory. This working relationship and level of control was tested and noted to be particularly effective during the Covid-19 pandemic as new substances needed to be rapidly sourced to supplement depleted national stocks for hand hygiene. Rapid multi-disciplinary COSHH assessments were undertaken prior to purchase, purchasing recommendations were then made or declined. The need for further assurance remains on the department's work plan through 2021/22 until greater evidence is achieved for all purchasing routes, including Estates, through audit and reconciliation of purchase histories with the Trust inventory.

8.4 Moderate risk – Space and storage

Trips and falls over objects or structures were the most commonly reported incident (58) and storage of items was often identified as the causal factor. The lack of storage and the increased complexity of treatment for patients mean that additional medical devices are required to support patient care. Further clinical spaces are planned.

8.5 Moderate risk - Monitoring and investigation of Health and Safety Incidents

The content and quality of incident investigations was identified as a concern throughout 2020/21, with incidents failing to identify causal factors, including those that had high potential to have a more serious outcome. The H&S department is currently examining each incident received via triage and making immediate recommendations to managers. Further to this, incident investigation will be incorporated into the training programme and aligned with Root Cause Analysis training to provide rigour to all levels of incident investigation, expediting consistency and reducing duplication.

9. Health and Safety Department 2020/2021 Work plan

The decision was agreed by HSSG in May 2019 to devolve the group's 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. This was 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.

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	Driving at Work Policy deferred to 2020/ 21. Lone Worker Policy Nov 2020.	93%
Competent and Capable Workforce	A relevant training needs analysis Health and Safety competency framework Training delivery mandatory and specific Training compliance, Coaching	Specialist content not delivered	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 of 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	58% of RIDDOR's were reported outside of schedule	45%
Health and Safety Management Audit	Achieve 25 per quarter/ 100 per financial year	Significant loss due to staffing and Covid priorities	11%

Due to the impact of the pandemic, compliance of 100% for above indicators was not achieved and they are included in the 2021/202 work plan.

10. The Health and Safety Department Objectives for 2021/2022:

- Ensure there are effective Health and Safety policies in place that are subject to full consultation and worker involvement
- Identify emerging risks and assess these against the organisations operating profile
- Enable a competent workforce to deliver health and safety throughout the structure of the organisation
- Engage and communicate with all Trust staff to improve health and safety standards and to ensure that all staff feel valued and are supported to deliver health and safety within their role
- Improve the level of incident investigation ensuring that incidents have proportionate investigation, and appropriate feedback to members of staff involved, so that staff feel valued and able to report incidents
- Increase the level of low severity incident reporting and to reduce H&S and Moving and Handling RIDDOR reports by 25% to 35 by the end of 2021/22
- Work collaboratively with internal and external stakeholders to support health and safety agendas, specifically the reduction and management of violence and aggression
- Undertake a risk based programme of scheduled audits and inspections

MEDICAL DEVICES DEPARTMENT

11. Introduction

This report summarises the management of medical devices during the period 1st April 2020 to 31st March 2021 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. The Team are responsible for facilitating training and providing highly specialised, clinical and technical advice and support to staff groups, in the use of basic and highly complex medical devices. Training is delivered to ensure compliance with CQC Fundamental Standards, and regulations set out by the Medicines & Healthcare products Regulation Agency (MHRA). Training includes usage, storage, cleaning and maintenance of low, medium and high risk medical devices.

In line with the Nursing & Midwifery Code of Professional Conduct and the Healthcare Professionals Council all Registered Nurses and Midwives and Healthcare 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 updates cross site to these groups and also to medical students, doctors in training and healthcare assistants.

A requirement of the MDE role is to investigate and advise, where possible, on incidents involving medical devices which are reported via DatixWeb throughout the Trust.

12. Summary

From the beginning of the pandemic, the onsite working capacity of the Medical Devices Team was reduced from 2 FTE to 1.6 FTE as one member of staff was required to shield and work from home This presented a number of challenges to the team including the need for training provision to be rationalised in order to maximise the amount of training provided. This was done by utilising key trainers in clinical areas and providing dedicated face to face training sessions in the education centres cross site. This training strategy allowed the Team to provide upskilling training for Registered Nurses during the first wave of the pandemic; and to complete the training on the new Baxter Evo IQ volumetric pumps which were put into service in the Trust in autumn 2020.

During this period the MDEs also initiated oxygen training for a broader staff audience in response to safety issues surrounding oxygen delivery and a Never Event which occurred in the summer of 2020. This training received an overwhelming response and has had a significant impact on ensuring greater safety for those patients receiving oxygen therapy in the Trust.

Training compliance remains satisfactory, despite the disturbance that the pandemic has caused during this period. However, the team are looking at ways to improve the service, including the training, so that staff in the Trust can access, the relevant training and resources (readily available on specific webpages.

Incident reporting for medical devices saw an increase in numbers in November 2020 but in general the MDEs have not dealt with any incidents that were classed above severity 2. All risks and medical device safety alerts have either been resolved or are being rectified by the individual companies.

12.1 Medical Device Alert/Patient Safety Alert (PSA)

There have been a number of medical devices and patient safety alerts which have required involvement by the Team.

- **BD T34 End of Life Care syringe drivers** – battery life. It was identified as a national problem which led to the company agreeing to replace specific editions of the pump.
- **Intersurgical Cirrus 2 Nebuliser** – faulty face masks, this only affected one clinical area
- **BD Extension sets Alaris Pumps** – Potential of incomplete sterilisation by a third party company. A limited number of ESHT pumps were affected and remedial actions were immediately implemented.
- **Baxter Multiple extension sets** - multiple extension sets being used on Covid-19 patients to allow for infusion pumps to be situated outside of patient rooms may lead to under or over infusion, disconnection of lines and risk of infection. To date there have been no reports of this practice being implemented in ESHT.

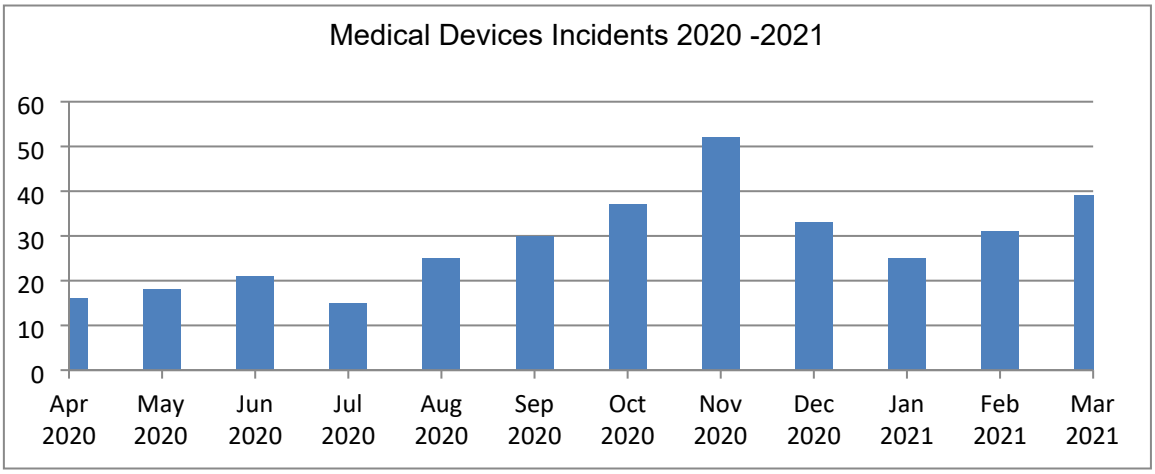
12.2 Areas for Improvement

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

- Integrate training in the Trust to support the learning by combining topics such as infusion devices and vascular access.
- Secure connectivity of the Hillron Connex spot Monitors to the patient electronic records system.
- Develop a training resource web page which staff can have continuous access to.
- Establish a dedicated training area for medical devices.

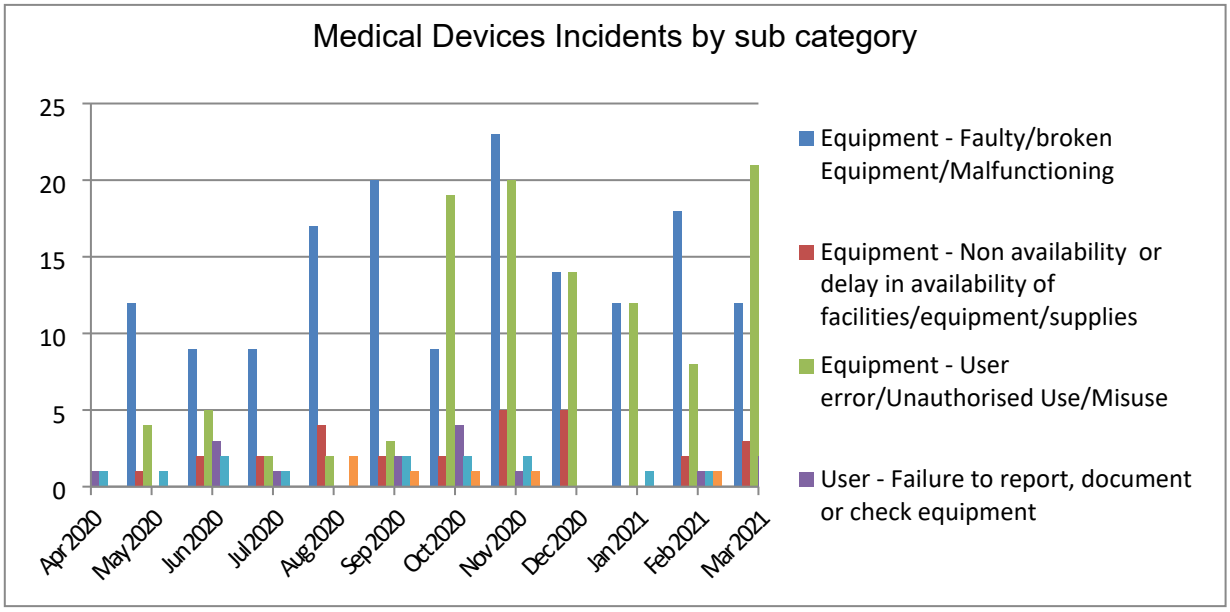
During the next year the team will be working to resolve these issues by working in collaboration with other teams to find solutions.

13. Incidents Reported



This report looks at the general trend of incidents in the Trust relating to medical devices overall. Numbers remained fairly low until the autumn when a gradual increase was seen with a spike in November 2020. This could be attributed to the new Baxter Evo IQ pumps being put into service in clinical areas in October/November with a majority of the old Baxter pumps being removed. As there is now a consistency in data recorded, a SPC chart will be utilised for the 2022/2023 report.

The table below, which is further broken down into sub categories, clearly reflects this pattern but also shows that the majority of the reported incidents fall into the category of faulty/broken/malfunctioning equipment and user error/unauthorised/misuse of equipment. Review of incidents related to oxygen identified the need to adopt a formal and robust approach to training staff in the safe administration of oxygen.



Throughout the reporting period there have not been any incidents for the medical devices category classed above severity 2. However, there was one moderate incident (severity 3) reported during wave one of the pandemic in Critical Care which had surge capacity open which concerned the unintentional connection of a patient requiring oxygen to an airflow meter. This was categorised as a medication incident but at the same time being attributed to the incorrect use of medical equipment. The patient did not suffer any harm from this but as a Never Event a serious incident investigation was undertaken with immediate actions taken by Critical Care. The actions identified to mitigate the risks continue to be monitored by the Trust Medical Gases Group, and ongoing audit of air outlet caps is included in the MDE Annual Programme of Work.

14. Training

From March 2020 the MDEs delivered a significant amount of training to redeployed staff in preparation for them returning to clinical areas to provide extra support during the first wave of the pandemic. However during the past year the focus has mainly centred on training staff on the new Baxter volumetric pump and the introduction of oxygen training to an extended target group as well as facilitating the mandatory infusion device training cross site

The report provides the compliance figures for mandatory medical devices training (tables below) which cover 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 Allied Healthcare Professionals cross site and updates are provided on a three yearly basis to ensure compliance with the Medical Devices Training policy. Training is reviewed yearly as part of the Training Needs Analysis and in conjunction with incident reports to ensure that the Trust is providing training on the most relevant high risk devices.

EDGH MANDATORY MEDICAL DEVICES

Device	Q1	Q2	Q3	Q4
Baxter	88%	90%	No longer used	No longer used
Alaris GH	88%	90%	90%	88%
CME Medical	88%	90%	90%	88%
Baxter EVO IQ	40%	70%	95%	95%
O2 devices	80%	82%	*New training	*New training

CONQUEST MANDATORY MEDICAL DEVICES

Device	Q1	Q2	Q3	Q4
Baxter	91%	93%	No longer used	No longer used
Alaris GH	91%	93%	93%	89%
CME Medical	91%	93%	93%	89%
Baxter EVO IQ	55%	74%	95%	95%
O2 devices	82%	84%	*New training	*New training

* Since October 2020 the MDEs have been providing Oxygen training to include a wider group of staff and the table above shows the total numbers of staff trained in each group which is correct for this reporting period.

Training compliance figures at the end of the year remain satisfactory. During this year the MDEs have worked collaboratively with Integrated Education to devise a system which monitors the compliance of mandatory medical devices training. The new system will require a slight change to the way that infusion device training is booked and delivered but in the longer term will ensure better staff compliance, more accurate percentages trained and a more efficient and focused way of delivering infusion device training. This is still a work in progress but the goal is to have this system in place and implemented by May 2021.

In 2020, the Baxter Colleague volumetric pumps were replaced by the new Baxter Evo IQ as the pumps had reached the end of their serviceable life and are no longer supported in the Trust. The MDEs delivered training cross site with the help of key trainers in clinical areas as the manufacturer trainers were unable to provide onsite training during the pandemic.

As stated the MDEs initiated oxygen training for a broader staff group in response to safety issues regarding oxygen delivery. A review of the incidents demonstrated a variety of staff were involved and suggested that they occurred through a lack of awareness, education and human factors. To address this, since the end of October 2020, the format for the delivery of oxygen training in the Trust has changed and the staff groups have been re assessed to include Health Care Assistants and all Allied Healthcare Practitioners. The MDEs have been delivering four one hour face to face training sessions cross site per week which have been arranged in conjunction with Integrated Education and dates for these have been secured until March 2022.
The response to this training has been very positive and feedback has highlighted the need to reinforce this training as a mandatory requirement for staff to promote patient safety throughout the Trust. Despite interruptions to training from the Covid-19 pandemic, in light of the number of incidents reported and oxygen being an essential element in the treatment of Covid, this training was deemed key to patient safety and remained face to face with relatively good attendance throughout. During these sessions, the MDEs also provided instruction on the use of oxygen concentrators which were

deployed in the Trust during the pandemic to ensure a continuous supply of oxygen was available to patients when required.

The table below shows that over 300 staff received oxygen training from the end of October 2020 to March 31st 2021. An approximation of the percentage trained on the new course is < 20% for registered nurse and <16% for healthcare assistants (about a fifth of the staff in those groups).

Staff Cohort	Number Trained
Registered Nurses	171
Healthcare Assistants	96
Occupational Therapy	20
Physiotherapist	25
Other	10
Total	**312**

A review and update of training competencies has also been undertaken along with the provision of new and relevant training resources being made accessible to all staff in the Trust.

15. Covid-19 Pandemic

During the initial stages of the pandemic the Medical Devices Team faced workforce challenges resulting in reduced capacity but was able to provide upskilling training to redeployed staff and to staff returning to work to support the Trust during the first wave of the pandemic.

Class sizes were reduced to a maximum of eight at Eastbourne and ten at Conquest to comply with social distancing requirements. This introduced the problem of the need for more training sessions to get through the number of staff needing to be trained, not only with the upskilling training but also with all other face to face training that the MDEs provide. In order to continue to provide training on high risk medical devices there was a revision of the services provided by the Team and any non-mandatory training was suspended during this period. Training remained as face to face sessions throughout the year but with an obvious variation in attendance figures which reflected the activity in the Trust during the peaks of the pandemic.

16. Equipment

During the period May to December 2020 the Trust procured 460 new Baxter volumetric pumps to replace the older Baxter pumps which had reached the end of serviceable life. The MDE's initiated a training programme to all relevant staff cross site in preparation for the new pumps being put into service in the autumn as the Baxter trainers were unable to attend the Trust. To ensure compliance Train the Trainer sessions were offered to key trainers cross site to coordinate staff training in their clinical areas. When the pumps went into service there was approximately 80% compliance with staff training and a dedicated team of key trainers to support staff in clinical areas.

The Trust purchased 80 new Alaris GH syringe pumps in February 2021 and these were commissioned on the Conquest site to replace some of the older Alaris pumps. This did not require any additional training as these were just a newer version of the same pumps.

17. Medical Devices Department Objectives 2021/2022

1. Integrate training in the Trust to support the learning by combining topics such as infusion devices and vascular access or Oxygen training and RESPS team.
2. To increase flexibility of training in clinical areas, establish a merged team of key trainers who can provide departmental training.
3. Secure connectivity of the Hillrom Connex spot Monitors to the patient electronic records system (Nerve Centre) to ensure timely and accurate recording of patient observations to increase patient safety and faster escalation of care.
4. Develop a training resource in the form of a web page which staff can have continuous access to. The page will allow staff to book onto courses, access training videos and find user manuals for relevant equipment.
5. Establish a dedicated training area for medical devices where equipment can be stored without the need to transport it around the hospital sites.

MOVING AND HANDLING DEPARTMENT

18. Introduction

The Moving and Handling Team (MHT) annual report for the 2020/2021 financial year provides an overview of incidents, work completed, challenges, and objectives for 2021/2022. The MHT is established for 3 FTE members of staff. The Moving and Handling (M&H) Lead Adviser was seconded from February 2020 to support the Pandemic response which resulted in the MHT establishment temporarily reduced to 2 FTE staff until September 2020 when the vacancy was filled with a seconded member of staff.

19. Key Achievements

- Continued to highlight M&H incidents in all training sessions and to encourage staff to report incidents including near misses which are under reported.
- Completed published and updated M&H risk assessments on the Assure portal.
- Delivered workshops at Bexhill Hospital, Conquest Hospital and EDGH looking at equipment and techniques to support staff undertaking leg dressings and foot care such as Community nurses and Podiatrists. Staff were made aware of techniques and equipment readily available through Millbrook Healthcare (community equipment supplier) that can assist with leg dressings. Leg stools were also distributed at the sessions at EDGH and Bexhill (purchased by the Friends of these two Hospitals).
- Team Twitter account now has over 338 followers @ESHT_MHT.
- Added to and updated the competencies as required for moving and handling equipment used within ESHT. This is available for all staff on the M&H Extranet page.
- Provided Moving & Handling Equipment User guides/instructional manuals on the M&H Extranet page to ensure these are available for all staff to access.
- Supported Estates and the LOLER inspectors (Zurich engineering) to ensure lifting equipment in wards and departments was able to be inspected as per schedule.
- Supported Estates and the Hoist service engineers (Caretech) that hoists were serviced and inspected under PUWER as per schedule.
- Advice and support given to clinical areas re: equipment purchase such as Bexhill Irvine Unit, Bexhill Hospital and Uckfield DSU (Stryker chairs), Dowling unit (Vela move+ ophthalmic chairs), Coronary Care EDGH (Stryker Stretcher chair).

20. Training 2020/2021

- Delivered Staff training compliance of 91.3%.
- All Mandatory training was cancelled as the 2020/2021 financial year began due to Covid-19.
- Adhoc Mandatory training sessions delivered from Mid-June 2020 before training recommenced at the end of August 2020.
- M&H upskilling workshops were run for staff who were being redeployed due to Covid-19.
- Extra induction sessions were delivered at Conquest and EDGH due to the increased numbers of staff. More sessions were then required as capacity was reduced in the training rooms.
- The MH Team with Integrated Education reviewed the frequency for mandatory updates and it was agreed that refresh training for those staff who had annual updates would move to every two years.

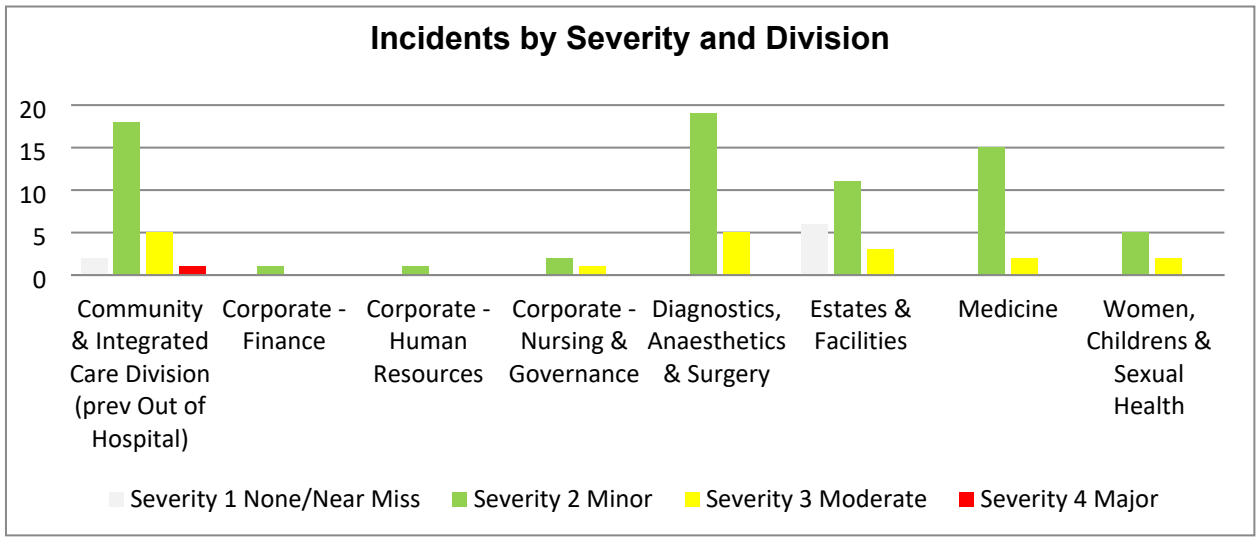
21. Incidents reported

The Figures reported in this summary were obtained 12th April 2021. In the last 12 months there were 98 staff M&H incidents, a decrease from 127 in 2019/20. Despite the decrease, an increase overall has occurred in the top 2 reported areas by sub-category. These were *Moving a Patient* and *Accident – Moving an object.*

Figure 1. Moving & Handling Incidents by Sub Category 2020/2021	**Q1**	**Q2**	**Q3**	**Q4**
Accident - Moving a patient	8	14	12	12
Accident - Moving an object	11	3	6	4
Accident - Patient fell while mobilising with Trust staff	3	2	0	0
Accumulative injury (work related)	8	5	3	2
Equipment - Inappropriate techniques/equipment used to move pts or objects	1	0	2	0
Equipment - Non availability or delay	0	0	0	1
Equipment - Operating/Using Machinery or Equipment	0	1	0	0
Resources - Training needs identified or inadequate training available	0	0	0	0
Totals	**31**	**25**	**23**	**19**

21.1 Incidents by Division and Severity

On review of incidents by division, Diagnostic Anaesthetics and Surgery (DAS), Out of Hospital (OOH) and Estates and Facilities (E&F) continue to be the top 3 Divisions for M&H incidents reported. Incident data relates to a wide range of scenarios including positioning/turning patients, patient transfers, Moving equipment with/without patients and using the correct techniques. The incidents in DAS occurred in a number of locations with no common theme or trend.

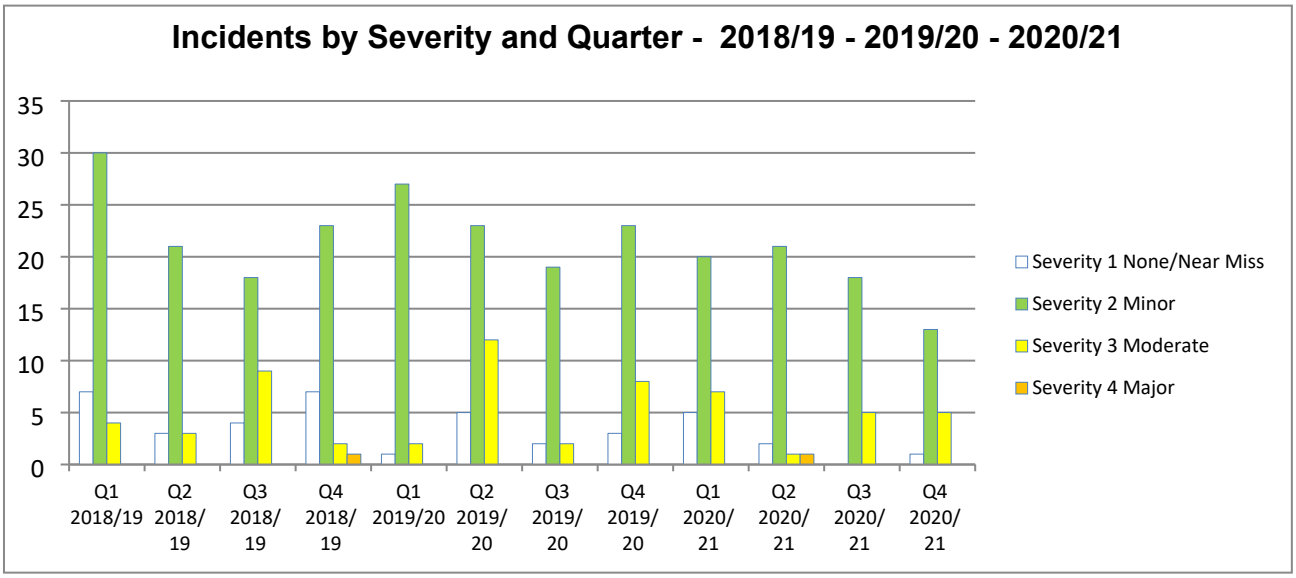


The severity 4 incident was a RIDDOR incident and is included in Section 22.

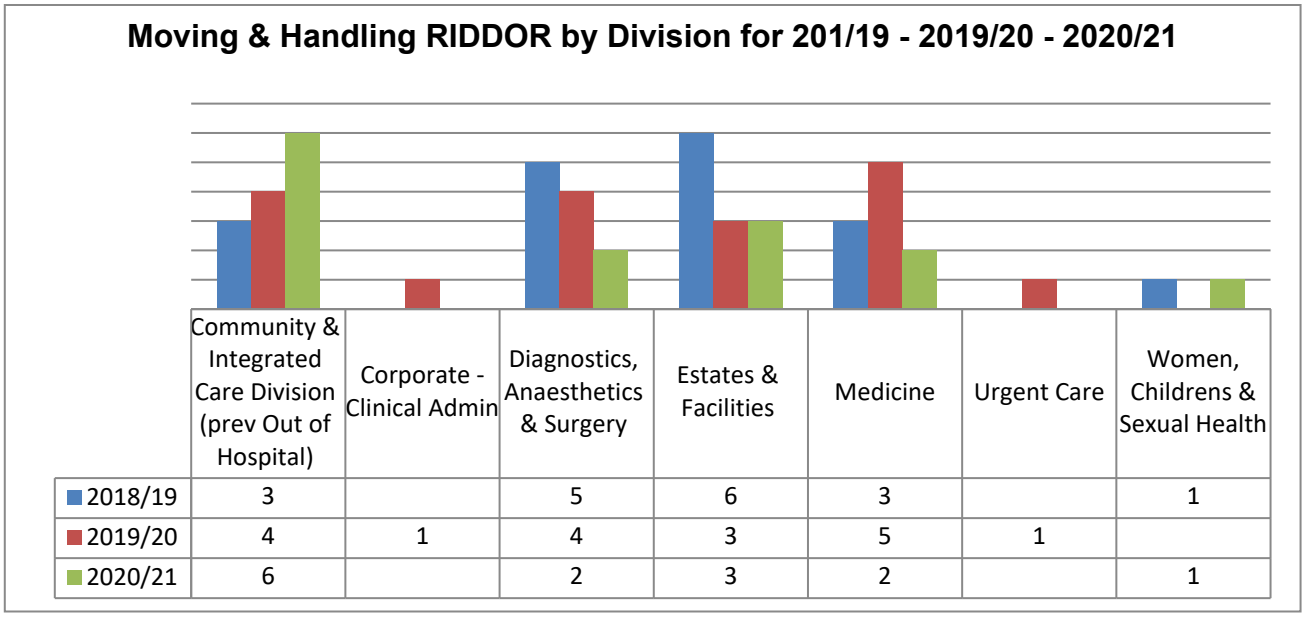
21.2 Incidents by Severity and Quarter for the last 3 financial years

The total number of reported incidents has fallen compared to 2018/19 and 2019/20. This may be due to the reduced activity in quarter 1 of the pandemic. The majority of incidents reported which occurr whilst undertaking moving and handling procedures usually result in minor harm.

The MHT continue to encourage reporting of Incidents, accidents and near misses. There are no identified themes or trends.



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



	Community & Integrated Care Division (prev Out of Hospital)	Corporate - Clinical Admin	Diagnostics, Anaesthetics & Surgery	Estates & Facilities	Medicine	Urgent Care	Women, Childrens & Sexual Health
2018/19	3		5	6	3		1
2019/20	4	1	4	3	5	1	
2020/21	6		2	3	2		1

There were 14 M&H related incidents reported as RIDDORs in 2020/21 in the following Divisions.

Division	***Staffing Numbers**	**Number of RIDDOR's**
Diagnostics Anaesthetics & Surgery (DAS)	1776	2
Medicine	1348	2
Community Health & Intermediate care division (Previously Out of Hospital)	1180	6
Estates & Facilities (E&F)	717	3
Women's, Childrens and sexual Health	773	1

*Staffing numbers as per the Mandatory Training Matrix 31/03/2021

- 3 incidents related to unexpected patient movements including overbalancing/falling whilst moving.
- 3 incidents were non-clinical activities including moving objects and trolley movements.
- 4 incidents identified that inappropriate techniques were used indicating training is required
- 2 incidents were cumulative work related injuries.
- 1 incident occurred when a patient's own bariatric wheelchair affected manoeuvrability. Measures have been put in place to ensure more time and help is available when bariatric patients attend the unit.
- 1 incident identified that a review and update of an individual risk assessment was required.
- Following investigation there were a total of 1 incident at severity 2 and 12 incidents at severity 3.
- The severity 4 incident occurred whilst assisting a patient with a controlled fall and the staff member suffered exacerbation of a long term back problem.

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

23. Covid-19 Pandemic

The onset of Covid-19 led to the initial cancellation of mandatory training. Additional induction sessions and upskilling training were required for staff returning to support the NHS or those redeployed during the commencement of the pandemic. Due to the combination of these issues with the workforce challenges in the team a risk was raised on the Trust risk register with mitigating actions to reduce the risks to staff and patient safety.

Following the successful appointment of a Secondee to the team, further support, training and advice was provided on equipment and safe procedures to clinical areas as they changed their use due to Covid-19. The MH Team also supported the clinical teams following the opening of inpatient beds at Firwood House to assist with patient flow and the opening of Devonshire Ward.

The Moving and Handling Training room at the Conquest Hospital was requisitioned for one of the Vaccination Hubs which impacted on the delivery of mandatory and induction training and the knowledge checks on both acute sites. The team arranged re-scheduled and relocated training sessions to ensure the staff continued to be safe when undertaking moving and handling procedures. Some training was delivered at Conquest Hospital in areas that could accommodate the team i.e. Theatres, Radiology and Physiotherapy.

24. Moving and Handling Team Objectives for 2021/2022

24.1 Actions

- Increase team presence in departments and clinical areas and ensure the Moving and Handling team are accessible for training and advice through link meetings, ward/department visits (Acute and Community), e-mail, telephone and Microsoft teams.
- Complete an M&H audit of compliance of the Patient Mobility assessment in the Integrated Patient Documentation (IPD).
- Liaise with Community teams to support with the completion of the Patients Individual Handling Plan on SystmOne.
- To work flexibly to ensure the Moving and Handling Team delivers Trust priorities.
- Promote incident reporting at every opportunity with an emphasis on the importance of reporting no harm/near miss incidents.

- Review the use of electric stand aids within in-patient settings to ascertain if there are sufficient numbers and the correct type for the patient's needs.
- To look into working with other teams to deliver joint training sessions i.e. Medical Devices Educators, Tissue Viability Team.
- Promote Back Care Awareness through training delivery and health promotion.

24.2 Reporting and documentation

- Monitor, report and escalate equipment and staff incidents.
- Continue to develop the Assure M&H inventory of risk assessments.
- Review all risk assessments by the review date or sooner if applicable following any M&H incidents.
- Produce hoist resources for staff with a range of images to support training needs.
- Update the Moving & Handling Assure User Guide for inclusion on the Assure portal and M&H Extranet page.

24.3 Training:

- To Liaise with Integrated Education to ensure that sufficient training places are available for staff to attend mandatory training, and induction training and increase the number of staff trained through extra training sessions as appropriate.
- To deliver bespoke team M&H training sessions wherever possible.
- Deliver specific training sessions as applicable such as Hoverjack, Raizer, slide sheets, etc.
- Training compliance will be monitored monthly via the training matrix and identification of divisions with low compliance with the aim of a targeted approach to increase compliance. The results will be reported to the Health and Safety Steering Group (HSSG) and the Education Steering Group.
- Re-start the face to face M&H Link meetings as safe to do so.
- Deliver competency based training in all Link meetings and support the M&H Links to disseminate competency training to their area of work.
- Deliver Plus size/Larger person training in-conjunction with the Trust's Bariatric equipment provider.
- Produce training videos i.e. Equipment and techniques for addition to the MHT Extranet page to complement the M&H training that is delivered.
- Deliver combined sessions for Porters on the two acute sites to include Portering specific Mandatory training and Porters Mortuary training.

Infection Prevention & Control Annual Report – 2020/2021

Meeting information:		
Date of Meeting:	12th October 2021	Agenda Item: 11.2
Meeting:	Trust Board	Reporting Officer: Vikki Carruth, Chief Nurse and DIPC

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 ☒ *The main report describes challenges and limitations with regard to IPC and Covid in particular and also the availability of isolation for patients.*		On the risk register? Yes	

Summary:

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

This report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare NHS Trust (ESHT) for the financial year 2020/21. Arrangements made by ESHT to allow the early identification of patients with infections, measures taken to reduce the spread of infections to others, audit, surveillance, achievements and challenges are presented.

The prevention of avoidable infections is fundamental to safe patient care. Prevention and control of healthcare associated infections (HCAIs) remains a priority for ESHT and with a programme of activities to implement national initiatives and reduce infection rates. ESHT employs a team of specialist nurses and support staff to advise and co-ordinate activities to prevent and control infection but it is the responsibility of all staff in the organisation to comply with Trust policies and implement these. The Trust reports performance and activities related to IPC regularly throughout the year to the local clinical commissioning groups (CCGs).

Key points during 2020/21 an extraordinary year:-

- A new infectious disease caused by SARS-CoV-2 (a new form of coronavirus) emerged and spread worldwide resulting in a global pandemic. The first cases identified at ESHT occurred in March 2020. This highly infectious virus dominated the work of the IPCT in 2020/21 as the full support of the IPCT was required with the emergency response.
- ESHT has treated over 2,500 patients with COVID. The associated mortality is 30%. The second surge in cases in December and January were the most challenging due to the emergence of a new Alpha variant which was more easily transmitted to others. 27 outbreaks of infection were reported and 19% of all cases were assessed as healthcare associated. Serious incident reports are being prepared to outline contributory factors and lessons learnt.

Structured judgment reviews have been undertaken for patients who died with COVID that was considered to be healthcare associated.

- The number of MRSA bacteraemia cases reported was 2 potentially avoidable infections. Testing and decolonisation required improvement and the clinical teams have been supported with this.
- Peripheral inserted central venous catheters (PICCs) were identified as a common source of avoidable MSSA bacteraemias and the support of the Vascular Access Team has been sought to understand if this increase relates to higher numbers of PICC insertions or an actual increase in the risk of infection.
- *Clostridium difficile* infections (CDI) were within limits. The trust reported 47 cases down from 51 patients the previous year, against a limit of 68. There were five lapses in care likely to have contributed to the development of CDI that were primarily related to antimicrobial prescribing.
- The mandatory orthopaedic surgical site infections surveillance scheme data indicates that the incidence of infection with orthopaedic hip and knee surgery has improved and is lower than the national limits for the year 2019/20 (most current report).
- The Trust now has a well established and embedded IPC BAF which is monitored by the TIPCG and reports to the Q&SC.

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

Monthly reports are presented to TICPG and PQSG.
Trust Infection Prevention & Control Group - 18 Aug 2021
Quality & Safety Committee – 16 Sep 2021

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

For assurance and support.

East Sussex Healthcare NHS
NHS Trust

Infection Prevention & Control

Annual Report
2020 - 2021

"A Year Like No Other"

NHS
ESHT
Infection Prevention and Control

CONTENTS

Executive Summary

This report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare NHS Trust (ESHT) for the financial year 2020/21. Arrangements made by ESHT to allow the early identification of patients with infections, measures taken to reduce the spread of infections to others, audit, surveillance, achievements and challenges are presented.

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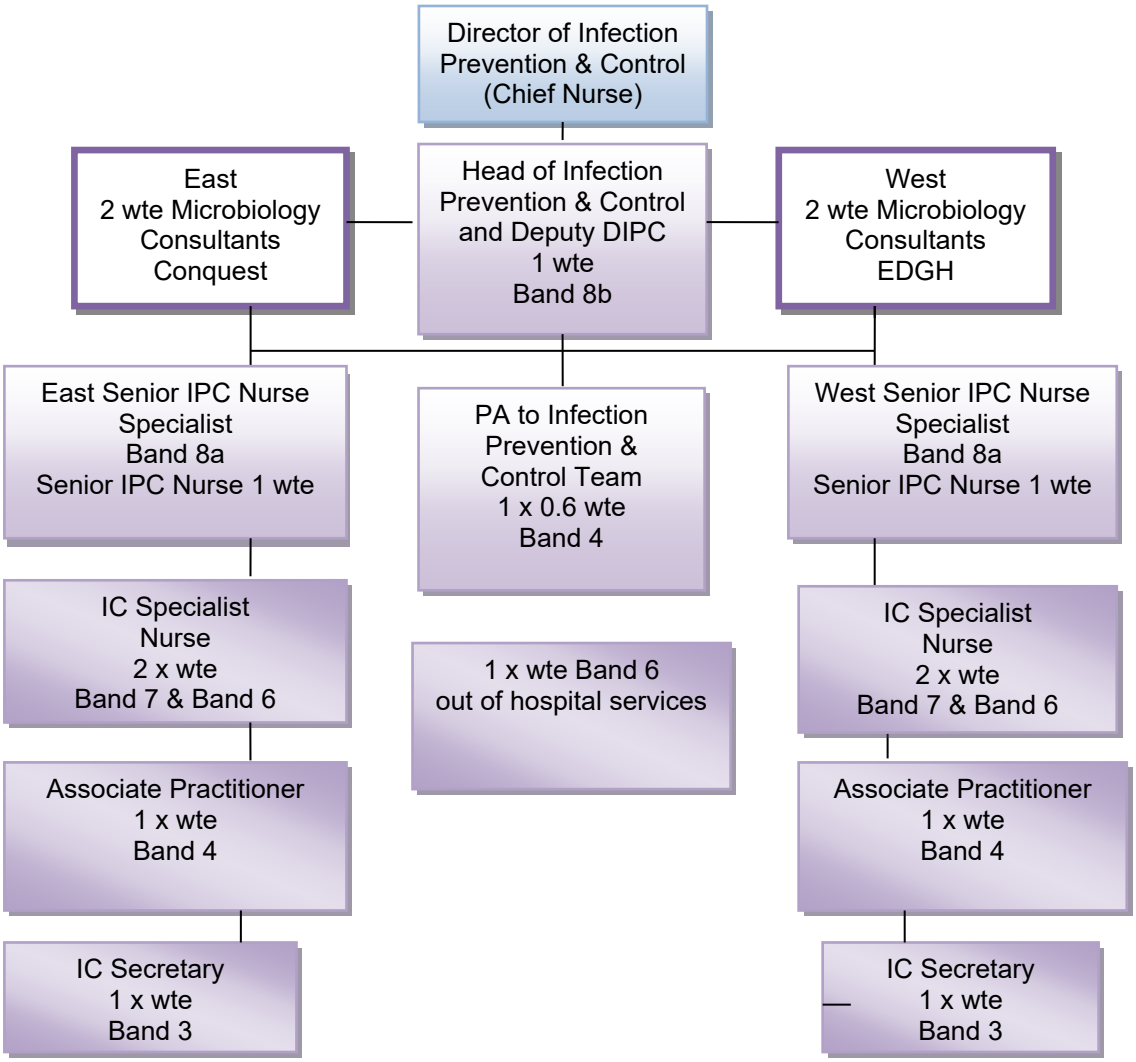
Lisa Redmond
Head of Infection Prevention and Control & Deputy DIPC

1. Structure

The Chief Nurse is the Executive Lead and Director of Infection Prevention and Control (DIPC), within the Trust and sits on the Trust Board.



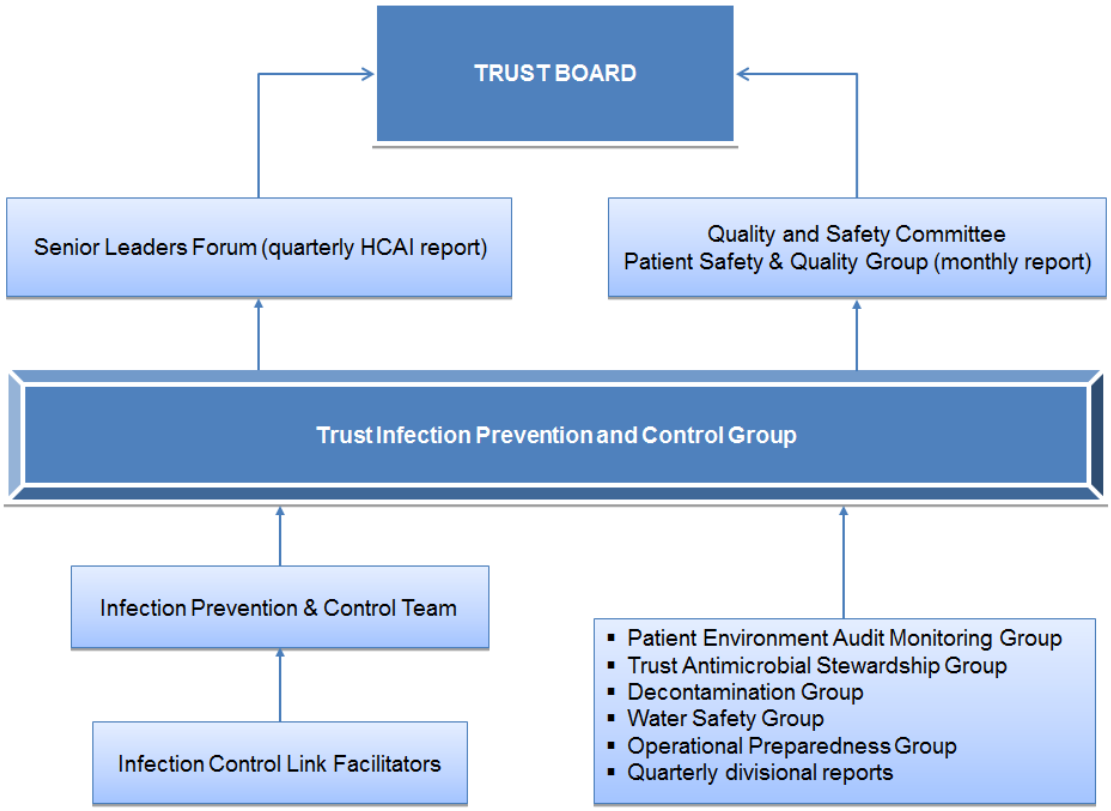
Infection Prevention & Control Team Structure

The IPCT comprises of specialist Infection Prevention and Control nurses and administrative staff. Two area teams (East and West) based in each of the acute hospital sites provide Infection Prevention and Control support to all ESHT services in their local area (acute, community, inpatient and domiciliary).

In addition to the IPCT, the Trust also funds 4 x wte Consultant Microbiologist posts (2 on each acute site) based within the Diagnostics Anaesthetics and Surgery Division who work with the IPCT, one of whom undertakes the role of Infection Prevention and Control Doctor. Two of these posts are currently fulfilled by locum staff and a remaining post is covered part time.

An Orthopaedic Surgical Site Infection Surveillance Nurse is appointed within the Diagnostics Anaesthetics and Surgery Division and an Antimicrobial Prescribing Lead post is appointed within the Core Services Division.

1.1 Infection Prevention & Control internal reporting arrangements



The Trust Infection Prevention and Control Group (TIPCG) are chaired by the DIPC/ Chief Nurse. The Group meets monthly and has wide representation from throughout the Trust including from Divisions, Occupational Health, Pharmacy, CCG and external membership from the local department of Public Health England (PHE). The TIPCG reports monthly to Patient Safety and Quality Group regarding performance and operational issues and also compliance against Outcome 8 Regulation 12 "Cleanliness and Infection Control" Health & Social Care Act 2008. (See reporting structure in 1.1)

Each of the Division report directly to the TIPCG on compliance with regulatory standards for IP&C. Matrons and Managers have the responsibility for the prevention and control of infection in their local area in line with national and local policies and guidelines. Each clinical department has appointed an Infection Control Link Facilitator (ICLF) who, with educational support and guidance from the IPCT, is responsible for cascading and monitoring compliance with Infection Prevention and Control practices at local level.

1.2 Infection Prevention & Control external reporting arrangements

External reporting arrangements have been subject to change in the past year due to reorganisation of the CCGs. The DIPC and Head of IPC discuss any significant IPC issues with the CCG Head of Quality and Nursing and the Southeast Lead for NHSE/I. There has been a new requirement for a daily external report relating to COVID and additional outbreak reporting processes in relation to COVID outbreaks. ESHT has been compliant with reporting requirements throughout the year.

1.3 Infection Control Link Facilitators

There are approximately 80 Link Facilitators across the Trust. Each new ICLF is provided with an induction programme provided by the IPCT. With the educational support and guidance from the IPCT, they are responsible for cascading and monitoring compliance with infection prevention and control practices at clinical level. The IPCT hold monthly ICLF meetings on each acute site.

The ICLF role has been limited by severe staffing shortages during the year, primary focus remains on hand hygiene and sharing good practice and disseminating guidance relating to COVID.

1.4 Joint working across the local system

The Trust IPCT continues to work with the Clinical Commissioning Group (CCG) and Public Health England (PHE) colleagues towards joint strategies for the reduction of healthcare associated infections which can lead to hospital admission.

The IPC specialist nurses are members of the Infection Prevention Specialists Regional Network Meeting who share and discuss local initiatives, innovations and work towards common goals across Sussex.

The IPCT in collaboration with PHE, East Sussex County Council and the Network Group have worked together tirelessly on the emerging threat of the new disease SARS CoV2 and its associated infection COVID-19. The challenge with the global pandemic has required the IPC programme of work to change priorities in order to support the safe provision of care to patients with this new disease and ensure that staff is equipped to deliver care using the necessary infection control precautions to prevent transmission to themselves and others.

Surveillance of community acquired Clostridium difficile infections and Gram-negative bacteraemias has continued to be undertaken by the ESHT IPC team on behalf of the local CCGs under a service level agreement (SLA).

2. Compliance with Outcome 8 Regulation 12 “Cleanliness and Infection Control” Health & Social Care Act 2008 and the new NHS IPC Board Assurance Framework.

The Trust has been required to undertake self-assessment against Care Quality Commission (CQC) standards and regulations, develop action plans for improvement if required and provide evidence of compliance, including against Outcome 8 which specifically relates to cleanliness and infection control. The CQC re-inspection in 2018 which assessed the trust overall as Good and Outstanding for caring; reported that “*Infection prevention and control was now a real strength”.*

A new Board Assurance Framework has been published as a consequence of the COVID pandemic. The framework is structured around the 10 criteria set out in the Code of Practice on the Prevention and Control of Infection linked to Regulation 12 of the Health and Social Care Act 2008.

The Trust performance against framework standards is discussed at the Trust Infection Prevention and Control Group (TICPG) which also receives reports from Divisions as evidence of local compliance and assurance. Compliance with the BAF is then reported to the Quality and Safety Committee who receive monthly updates on performance,

agree actions and report/requirements escalate to the Trust Board as required. It should be noted that the IPC BAF is iterative and has changed over time.

Key Lines of Enquiry	Compliance Status	Continuous improvement / Actions
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users	**Partial**	• Robust process to record decisions to move patients is required. • Improve recording of PPE training and audit of compliance.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	**Compliant**	
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	**Partial**	• Antimicrobial audits need to increase. • Implement ePMA.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion	**Compliant**	
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	**Compliant**	
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	**Partial**	• Improve recording and auditing of PPE training.
7. Provide or secure adequate isolation facilities	**Partial**	• Insufficient isolation (on risk register). The risk is managed by IPC with clinical site team.
8. Secure adequate access to laboratory support as appropriate	**Compliant**	
9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections	**Compliant**	
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	**Compliant**	

The clinical governance team is introducing a new electronic system to support clinical audit and IPC are hopeful that IPC audit standards can be incorporated into the new system to make it easier for auditing of IPC practice to gain assurance.

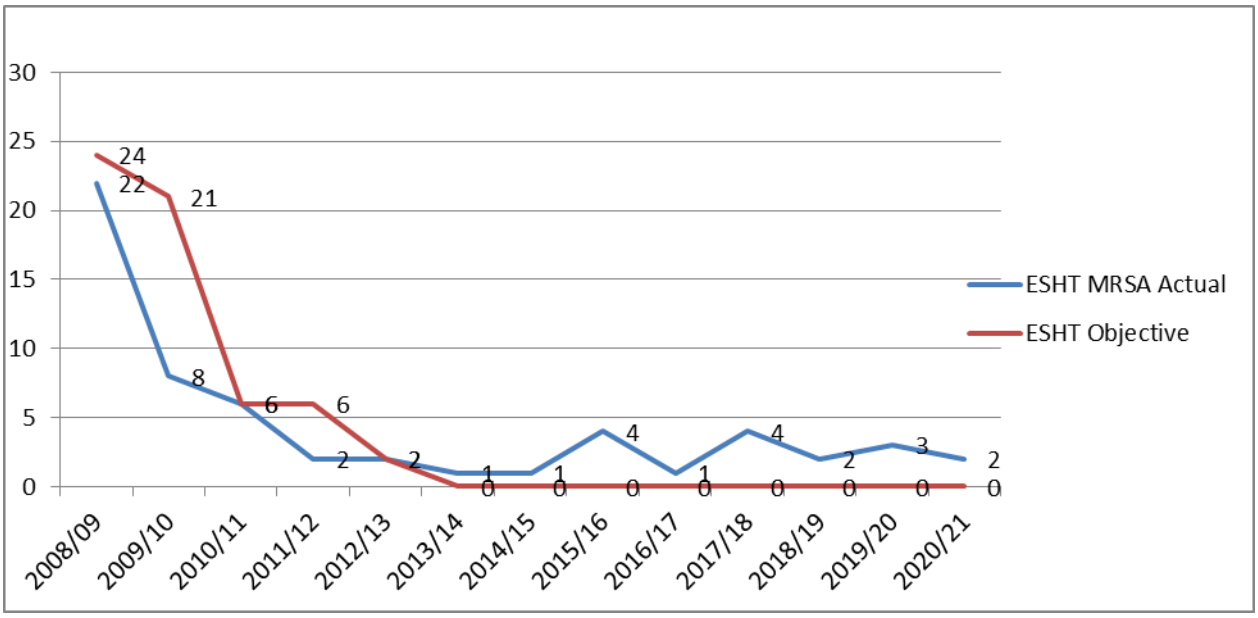
3. Mandatory Surveillance

The Department of Health (DH) requires NHS Trusts to take part in a national mandatory and voluntary surveillance programme. This involves providing information about a number of specific infections including bloodstream infections due to Methicillin resistant S*taphylococcus aureus* (MRSA bacteraemia) and diarrhoea due to *Clostridium difficile* infection (CDI).

Each Trust is set an annual objective for numbers of MRSA bacteraemias and CDI. Not all cases of CDI or bacteraemias are avoidable or due to lapses and therefore the focus are on the concept of preventing avoidable harm. The number of MRSA bacteraemias has reduced significantly therefore the tolerance is now zero avoidable infections. All MRSA bacteraemia and CDI diagnosed and attributed to the Trust are investigated with a post infection review (PIR) conducted by a multi-disciplinary team to ensure any potential lessons learnt are acted upon and shared across the organisation.

3.1 MRSA bacteraemia

ESHT continues to have a zero tolerance to cases of MRSA bacteraemia which could potentially be avoidable. ESHT reported 2 cases of Healthcare associated MRSA bacteraemia in 2020/21 compared to 3 cases in 2019/20.



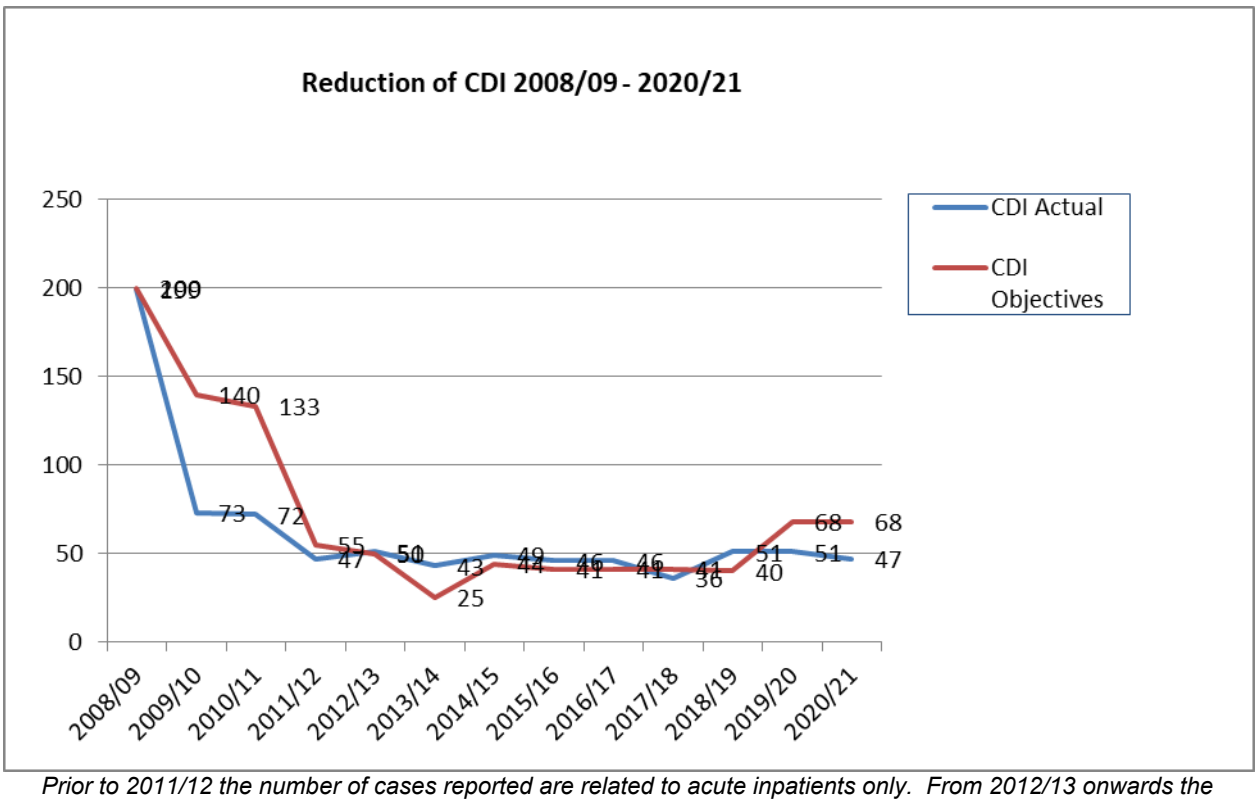
- Case 1, July 2020. The patient was identified as MRSA carrier for the first time on admission screening. The result was known on 21/07/20 but decolonisation was delayed. The first blood culture taken was on day 5 of admission and was positive for MRSA. The source has been considered and not identified although consideration was given to a skin source. The patient was appropriately treated before being discharged.

- Case 2, August 2020. The PIR has not identified a source of the bacteraemia therefore it is not known if this could have been avoided. However, the patient was not screened for MRSA on admission and was only screened when the blood culture result was received. Patient found to be MRSA carrier therefore

had they been screened and given decolonisation as per ESHT policy the positive blood culture may have been avoided.

3.2 *Clostridium difficile* infection (CDI)

The annual limit set for 2020/21 was 68 cases for ESHT to take account of prior healthcare exposure within 28 days. In total 47 cases were attributed to ESHT for 2020/21. 12 cases were community onset healthcare associated because the CDI diagnosis was made within 28 days of a patient's previous treatment in hospital rather than related to a current admission. The number of *C.difficile* infections reported annually within ESHT is shown in the chart below.



Prior to 2011/12 the number of cases reported are related to acute inpatients only. From 2012/13 onwards the number of cases also includes cases reported from the additional community inpatient beds following integration.

Each case of CDI diagnosed beyond 48 hours of admission undergoes a multi-professional post infection review (PIR) investigation. Findings of these PIRs are considered to assess if each case constitutes a lapse of care likely to have resulted in CDI, a lapse of care unlikely to have resulted in CDI or no lapse of care.

>72hrs CDI	2020/21
No Lapse in Care	**8**
Lapse in Care likely to have contributed to outcome	**5**
Lapse in Care unlikely to have contributed to outcome	**31**
Community Onset Healthcare associated (PIR not undertaken)	**3**
TOTAL cases	**47**

It was considerably more challenging during the pandemic to arrange the multi-professional post infection review (PIR) but with perseverance each case has been assessed with involvement of the relevant clinical teams. Most of cases were considered unavoidable or did not have contributory lapses. Most of the non-contributory lapses were related to lack of documentation of loose stools and delay in sending stool samples. It is acknowledged that this has been a transitional year for clinical teams who need to familiarise themselves with the Nerve centre system re: clinical assessment. Further development of Nervecentre is required to improve staff's ability to document bowel actions for all patients.

Lapses in Care
The year ended with 5 cases thought to have been lapses in care. Three of the 5 cases were assessed as lapses in the context of patients who were known C. difficile carriers and it was felt that more care was required in relation to antimicrobial prescribing in these patients. The remaining two lapses were identified as due to antimicrobial prescribing that was not compliant with ESHT policy or clearly clinically reasonable. One of the lapses was a Community onset case. The Consultant microbiologists and antimicrobial pharmacists have agreed to provide increased support to medical teams in relation to antimicrobial prescribing. It was acknowledged that there has been reduced frequency of antimicrobial audit and antimicrobial stewardship rounds due to the impact of the pandemic on staffing levels and workload.

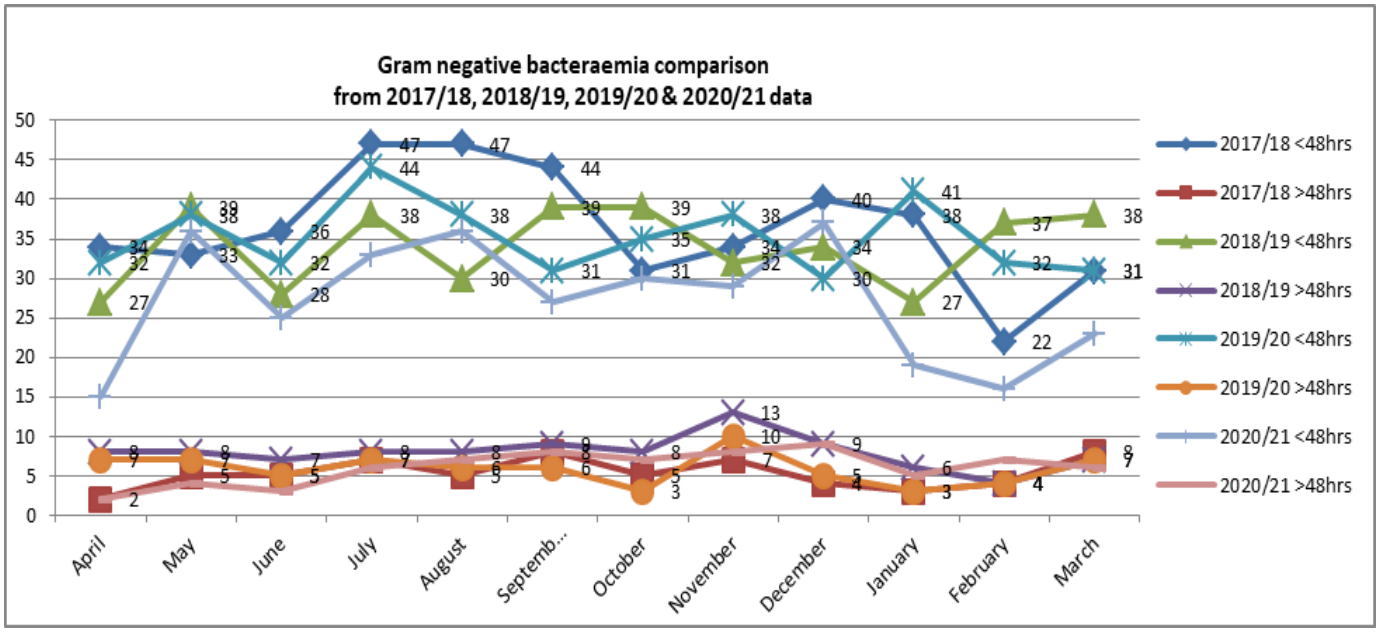
Outbreaks and Periods of Increased Incidence (PIIs)
In line with national guidelines, if there are two or more cases of CDI identified on the same ward within 28 days of each other these are investigated as a PII. Further tests are performed at a specialist reference laboratory to compare the *C. difficile* bacteria and to see if they are the same type (known as ribotyping). Any found to be the same ribotype are considered to be outbreaks. All CDIs related to ESHT as sent routinely for ribotyping to help detect outbreaks.

There were three incidences when two cases were considered to be possibly related on three different wards. These were fully investigated by the IPC team and occurred on in August and September. The Ribotyping later confirmed that each incidence was not related to each other and therefore not an outbreak.

3.3 *E.coli* Bacteraemias

The reporting of *E.coli* bacteraemia is mandatory for all provider Trusts. The Government announced its plan to reduce healthcare associated Gram-negative bloodstream infections in England by 50% by 2021. *E.coli* bacteraemia generally represent 55% of all Gram negative infections therefore the initial focus is expected to be for Trusts to demonstrate a 10% reduction in both pre and post 48 hour cases with baseline data collected from January 2016 to December 2016. During this period ESHT reported 67 cases of E. coli bacteraemia which was set as baseline for reduction. Focused improvement work was being led by the IPC team with clinical teams and in 2019/20 ESHT achieved a 26% reduction by reporting 46 cases. The Trust has been unable to sustain this work during the pandemic. This year there has been 44 cases showing the incidence is stable but no significant reduction has been achieved.

The IPC team is also currently undertaking the *E.coli* bacteraemia primary care data collection on behalf of the CCG under a service level agreement (SLA).

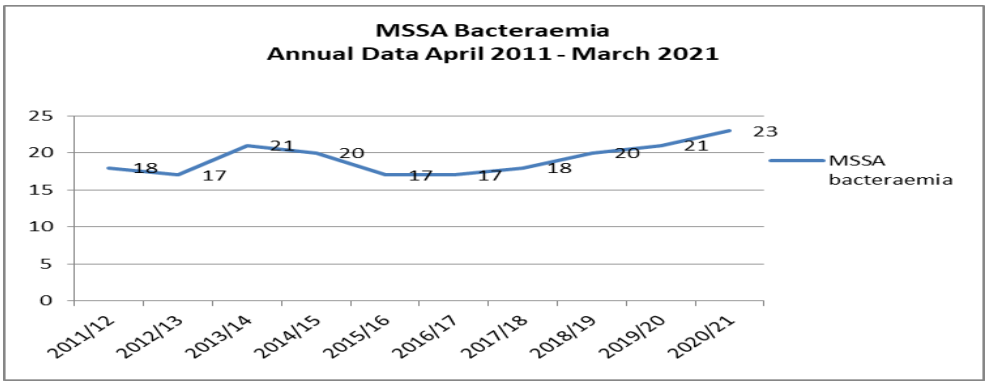


E. coli remains the most common cause of GNBs. The national surveillance reports are yet to be published for 2020/21 to fully understand if the changes to healthcare and society as a result of the global pandemic have impacted on gram negative infections.

Organism	Total	UTI source	CAUTI source	Biliary	Other	Unknown
E. coli	44	11	7	8	9	16
Klebsiella sp.	18	4	3	0	9	5
Pseudomonas	10	4	3	1	5	3
Total (%)	72	20	13	9	23	24

28% of GNBs were assessed as related to urinary tract infection (UTI) with 65% of these associated with an indwelling catheter. While the number of UTI related bacteraemias appears reduced many cases did not have a source identified and may have been UTI. When the IPCT undertake the surveillance of each case, every effort is made to identify the source and this includes discussion with the consultant microbiologist. There has been less time to spend on each investigation this year which may account for the 33% of cases that did not have a source identified.

3.4 Mandatory reporting of Methicillin sensitive Staphylococcus aureus (MSSA)



The number of MSSA bacteraemias at ESHT has increased by 10% this year. Five cases were assessed during post infection review, as potentially avoidable during the

year. Two cases were related to PICC lines in patients receiving total parenteral nutrition (TPN) and another PICC line associated infection from a neutropenic patient receiving oncology treatment. The infections were treated successfully with antibiotics. A further patient was treated for a bacteraemia related to a peripheral cannula and the remaining case was due to hip surgery. The Vascular Access Team is contacted when a bacteraemia is considered line related to ensure staff is aware of the correct management of intravascular lines and vessel health preservation.

3.5 Mandatory Surgical Site Infection Surveillance Scheme

Since 2004, all NHS Trusts undertaking orthopaedic surgery are required to complete the mandatory surveillance study program devised by the Surgical Site Infection Surveillance Service (SSISS) Public Health England (PHE) for a minimum of three consecutive months per year. ESHT have maintained this recommended gold standard since January 2010 and practiced a continuous study to establish any patterns or trends over time. A standardised set of demographic and operation-related details are submitted for every patient undergoing Hip and Knee Prosthetic Replacement Surgery including re-surfacing and revision (excluding 1st stage revision where spacer implant is used) as well as the surgical procedure, inpatient stay, post discharge reports and complete relevant data of any case readmitted with a SSI during the first post-operative year.

Please note: PHE SSISS studies are undertaken prospectively and submitted quarterly but results are published 12 months retrospectively as infection rates are influenced by performance and readmissions within the audit population over each 12 month surveillance period. Finalised results are therefore only available up until the end of March 2020 although data from April 2020 onwards is within the surveillance system and continues to be analysed and officially reported by PHE at the end of the following year. ESHT submitted data for the four quarters of the year (April 19 – March 2020).

Core data 1st April 2019 – 31st March 2020

Category of surgery	Number of procedures	Number of infections	Infection rate	Mean infection rate for all participating Trusts (data April 2015 -March 2020)
Total hip replacement	357	1	0.3%	0.5%
Total knee replacement	449	0	0.0%*	0.5%

Surgical site infection rates for prosthetic hip and knee surgery were below the national five year average which stands at 0.5%.

ESHT reported a high rate of surgical site infection in orthopaedic hip and knee surgery in 2017 and the service agreed an action plan and have actively worked to ensure compliance with NICE standards for reducing surgical site infection. The process for agreeing cases that meet the definition for reporting to PHE has been strengthened. A multi-professional group chaired by the Chief Nurse (DIPC) is in place to assess cases prior to submission to PHE.

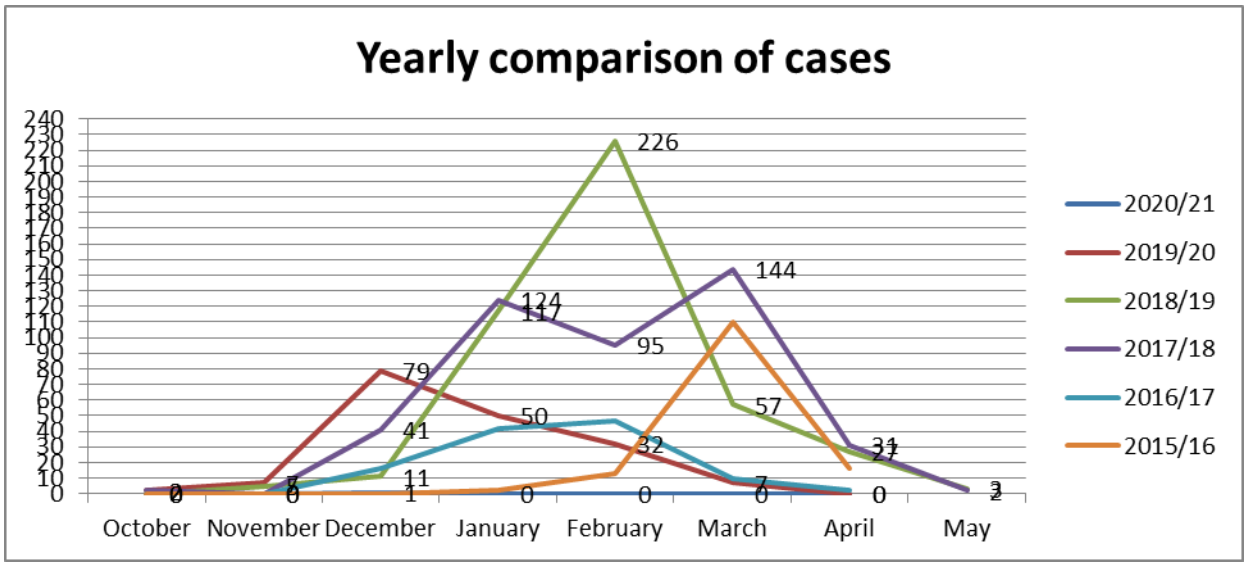
ESHT has taken part in a national study “Quality Improvement in Surgical Teams (QIST)” which intends to halve the rate of orthopaedic surgical site infection through the use of nasal and skin decolonisation of patients to prevent carriage of MSSA causing infection. Patients having planned primary hip and knee replacement surgery were

invited to take part in the study which was led by the orthopaedic team with collaboration from pharmacy, research, information management and IPC. The team has received national recognition for the benefits of the improvement project and the orthopaedic department are reviewing how the learning from this can be used to benefit patients in other surgical specialities. A meeting held during 2020/21 to consider the preliminary findings of the study agreed that the trust would continue with this practice until the formal report is received and findings fully considered. The report is still pending.

Discussions are underway regarding the need for additional resource re: SSISS as it currently consists of one specialist nurse looking at one speciality. Resources would enable inclusion of other surgical specialities/services including maternity.

3.6 Influenza

All acute trusts are required to report (on a weekly basis during the Influenza season) the number of cases of Influenza requiring admission to intensive care to determine the national “burden” on critical care units.



There was only one case of influenza diagnosed at ESHT during 2020/21 and this very low prevalence reflects that seen nationally. The patient had chronic pulmonary disease and was diagnosed during routine COVID testing at a time when the Trust had commenced testing of all patients for COVID and seasonal influenza on the same new testing platform.

Over 85% of ESHT frontline clinical staff was vaccinated against seasonal influenza. Achieved as a result of the campaign managed by Occupational Health and Wellbeing and successful utilisation of a peer vaccination scheme.

3.7 Norovirus

During the winter months Norovirus is often circulating in the community and the risk of outbreaks in the in-patient setting related to Norovirus increases. There were no outbreaks of Norovirus in 2020/21 which is most unusual and thought to be a reflection of increased social distancing, national lockdowns and mask wearing in healthcare settings and the wider community.

4. Emerging Threats and Operational Preparedness

- The Trusts 'Emergency Preparedness , Resilience & Response' (EPRR) Team is charged with ensuring that the Trusts fulfils its roles under the Civil Contingencies Act 2004 and the NHS EPRR Framework, in ensuring the Trust is prepared to meet internal and external Threats, and can respond to a range of risk-assed incidents as when they occur.
- The EPRR Team remains fully linked to the Infection Prevention & Control Team, and as part of its remit, provides a horizon-scanning service, and is heavily engaged in risk-assessing identified threats and challenges.
- 2020 and 2021 have been dominated by preparedness for, and the response to the on-going Covid-19 pandemic. NHS E/I mandated that the NHS pandemic response would be coordinated in line with EPRR principles, and this has resulted in the Trusts EPRR Team being totally engaged in the Trusts response, which heavily engaged the IPC Team, over this period.
- The winter 2021 coordination of the 2nd wave was also combined with response and reporting arrangements for both NHS winter 20-21 planning and also EU Exit arrangements.
- From the 1st wave through to the on-going 3rd wave, the Trust's arrangements have included:
    - A command and control structure with identified Strategic, Tactical and Operational leads
    - An staffed 'Incident Coordination Centre' (managing information flow and reporting)
    - Regular 'Incident Management Team' meetings (with frequency varied according to need).
- The EPRR team have been heavily supporting all 3 of the above with on-going EPRR advice and support, as well as managing EPRR actions relate to the pandemic. The IPC Team have been fully engaged in this work and in tasks mentioned throughout this report. Team managers have attended IMT meetings as operational leads for the service.
- Other 'usual' EPRR activity has had to take a back seat due to the pandemic. To ensure the Trust is fully prepared requires activities across a range of areas, many of which have bene curtailed over this period. Significantly:
    - External liaison (with the Sussex Resilience Forum and Sussex Local Health Resilience Partnership has been on-going but at a reduced level.
    - Training and exercising was halted during the peaks of the first 2 waves, but has now re-commenced with social-distancing arrangements.
    - The Team have worked to progress Business Continuity planning arrangements at service-level across the Trust, so that services are resilient to the internal impacts of business challenges such as shortages of staff or utilities etc, (which has been recognised as being of importance throughout the pandemic).
    - The Team also planned and ran a further de-brief process for COVID-19 after the 2nd wave.
- During the pandemic response the Trust has been also subject to unrelated but simultaneous BC incidents, which have required incident management arrangements to be implemented. These have included the recurring loss of key digital platforms and also an electrical failure which closed the Conquest

Mortuary for several weeks. (The latter also required management input from the IPC Team).

- At the time of writing the current 3rd wave is on-going, and both the EPRR and the IPC Teams remain heavily involved in the ongoing response.

4.1 SARS-CoV-2, COVID-19

On 31st of December 2019 the World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei province in the Republic of China. On 12th of January 2020 it was confirmed as a novel coronavirus. This respiratory virus is highly contagious and has been named SARS-CoV-2 and the associated disease as COVID-19. Public Health England first published information for healthcare on 15th January 2020. WHO declared pandemic status on 11th of March 2020 and National prevalence increased and the UK government took the unprecedented decision to lockdown the country on 23rd March 2020. By 4th of April 2020, 1 million cases had been confirmed worldwide. By 30th March 2021 WHO was reporting 3.8million cases each week with Europe and America accounting for 80% of cases.

The chart below shows local prevalence in East Sussex. Increases in COVID in the local population subsequently result in more patients with COVID in inpatient services.

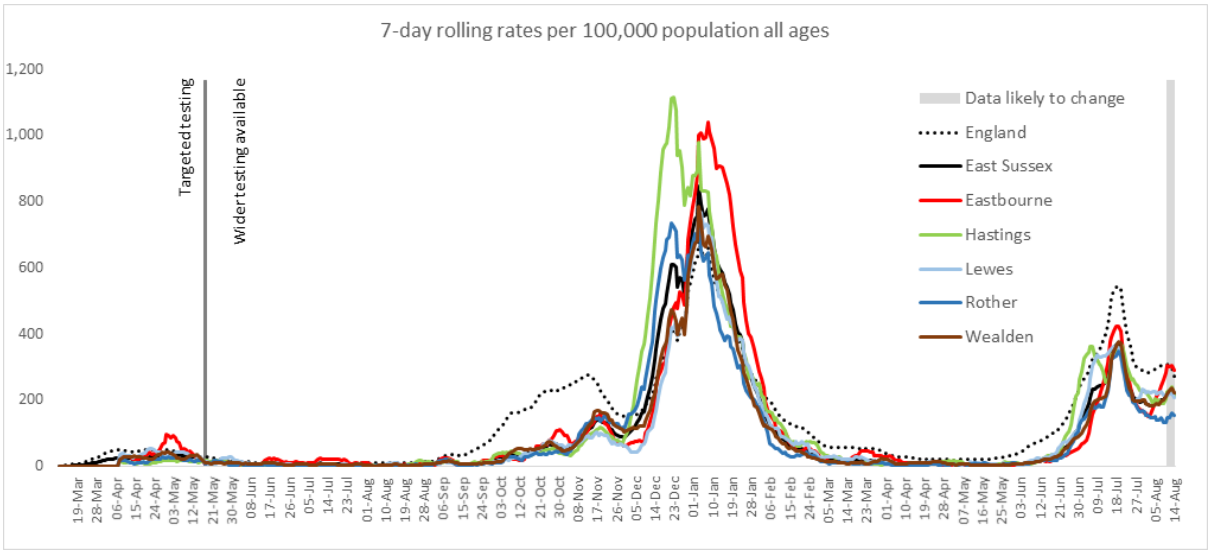


Figure 1. East Sussex COVID prevalence (Source: East Sussex County Council).

The first case in ESHT was identified on 11th of March 2020. Initial diagnosis relied heavily on recognition of symptoms as laboratory testing was initially only undertaken in specific external laboratories and results took up to 72hrs to be received.

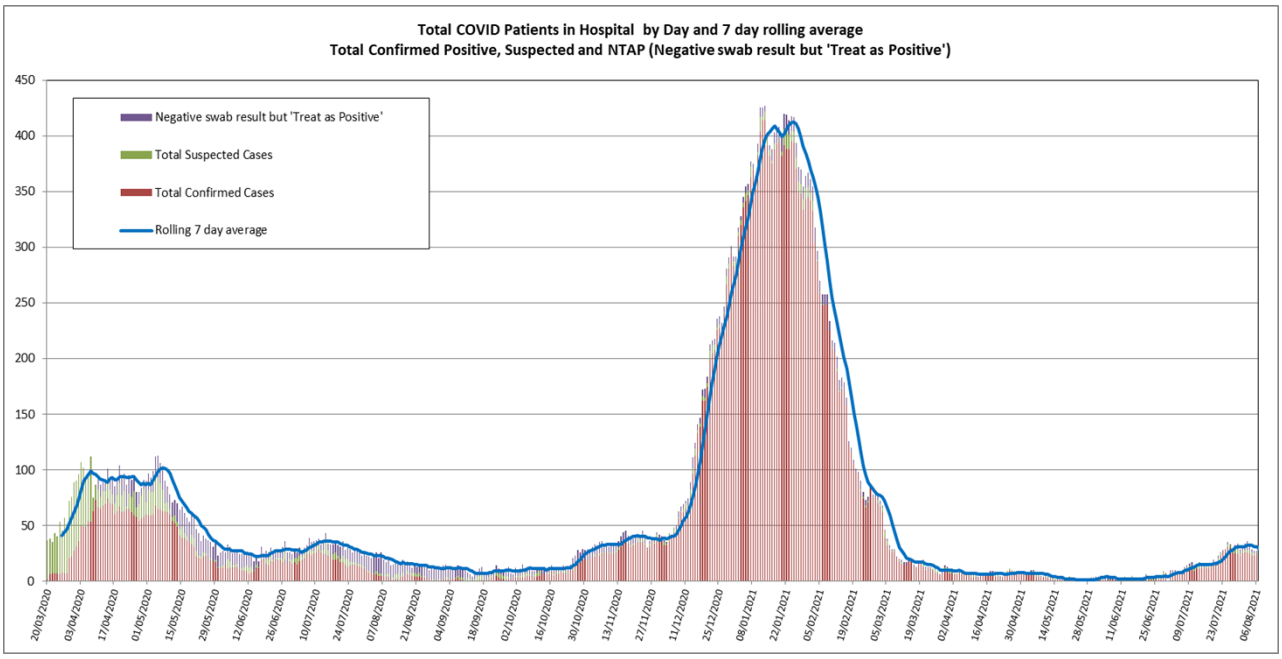


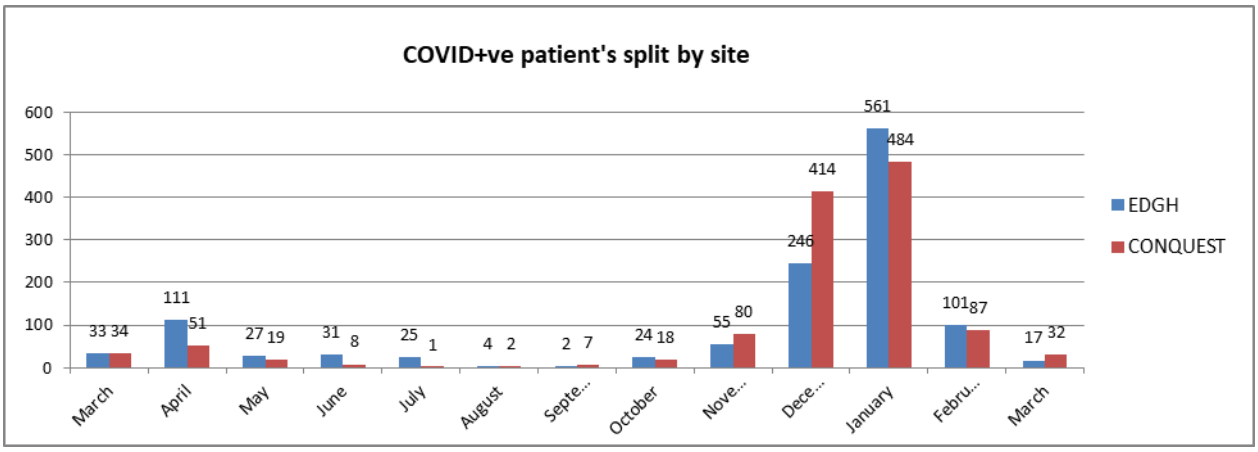
Figure 2: ESHT in-patient COVID positives.

Over 2,500 cases have since been diagnosed as at the end of March 2021 of which over 1,700 occurred during December 2020 and January 2021. At the peak, 45 new cases were being diagnosed daily and over 50% of ESHT inpatient beds were occupied by patients with COVID at peak.

The surge in cases is attributed to the emergence of a new variant that the UK reported to WHO in December 2020. This variant, now known as Alpha or Kent variant, is considered to be 70% more infectious and was first detected in Kent and Sussex where there was a rapid surge in cases in the local population and ultimately the hospital.

Week Ending	16-Jan-21	23-Jan-21	Growth between Weeks
West Sussex	503.9	345.0	-31.5%
Brighton and Hove	477.9	294.6	-38.4%
East Sussex	559.0	395.5	-29.2%
England	485.5	373.2	-23.1%
Sussex	517.4	352.8	-31.8%

The emergence of the Alpha variant required national lockdown In January in order to try to contain its spread.



Admissions continued to increase and the increase in admissions to EDGH reflects the fact that the variant reached this part of Sussex later as the virus spread East to West and these local authorities went into more significant restrictions later.

4.2 Role of the IPC team in the COVID pandemic

Developing patient pathways
From the onset of COVID-19 planning, the trust approach has been to follow national guidance. The Trust put in place patient pathways to stream patients according to the risk of COVID-19 and to clinical need. Pathways have been developed to reflect PHE guidance and advice from professional bodies such as the Royal College of Surgeons and the British Thoracic Society have been approved by the ESHT Clinical Advisory Group to review emerging clinical and scientific evidence and guidance and advise the Incident Management Team (IMT).

Surveillance and Contact Tracing
The IPC team has undertaken surveillance on every COVID case identified in ESHT. Each of the 2,500 patients was reviewed by the IPC team, to identify potential contacts that needed to isolate to try to prevent onward transmission of the disease in the hospital and wider community. Each contact received verbal or written information on the correct action to take to protect themselves and the wider community. The surveillance also captured important epidemiological data to inform knowledge of the disease.

An electronic log of all positive in-patients and their contacts was maintained by the IPCT. This was a laborious process that required manual inputting of patient information to ensure that patients were isolated or cohorted together to protect others from exposure.

The IPCT also initiated data capture of HCAI COVID infections by location to assist with early outbreak detection. The information was shared with operational teams daily or more frequently during surges of cases. At the height of the pandemic in December and January it became clear that manual recording of COVID patient data was unsustainable. Working with the Nerve centre team there is now a robust electronic process to record COVID positive or suspected patients from onset and the system also support updating COVID status as the patient improves and the ICP can record key information for clinical teams regarding repeat testing, isolation and level of cleaning required for each patient stay. Most recently the COVID vaccination status of patients has been added which affords the opportunity to offer the vaccine to those who have

not had it and ensure that unvaccinated patients are not admitted to wards that may have COVID positive patients.

Transmission based precautions
This respiratory infection is considered to be mainly spread by droplet and contact transmission but there is also aerosol transmission. Close contact in crowded places is an important contributing factor to SARS-CoV-2 transmission. There is now increasing evidence that good ventilation can significantly reduce transmission.

The recommended distance to reduce droplet transmission is 2metres. Inpatient beds at ESHT are not more that 2metres apart therefor Perspex screens were installed between all bed spaces and are disinfected when the bed space is vacated. Patients and Staff are required to wear surgical face masks to reduce droplet transmission and additional respiratory protection if aerosol generating procedures are taking place as such procedures can contaminate the air for up to 1hour depending on the ventilation in the area. The virus will then drop onto surfaces and contact with these surfaces can lead to cross infection. Surfaces therefore need to be cleaned frequently, gloves changed and hands washed between patients.

PPE and fit testing
Initially the IPC prepared early response kits for staff that contained the essential personal protective equipment (PPE) required to safely care for a patient with confirmed or suspect COVID. Fit testing of staff to provide the correct filtering respiratory facemasks (FFP3 masks) was an essential role for IPC in the early preparation for COVID-19 along with training on the correct donning and doffing procedures for PPE. Training materials and large posters were produced by the IPC team and distributed to all clinical settings in acute and community services. The initial fit testing was a qualitative procedure taking up to 30minutes per person.

Staff who did not pass the fit test required powered respiratory hoods. The use of this equipment in healthcare was a relatively new concept. The IPC team produced practical guidance for clinical teams on the use and decontamination of the different makes of powered respiratory hoods, accessible via the electronic COVID staff resource. A working group was established by the Chief Nurse to manage PPE and ensure that appropriate standards and sufficient stock of PPE was available to staff at all times. A specific fit testing team was also established to provide a consistent trained workforce to undertake this assessment and the best available quantitative equipment was procured to improve the reliability of testing. This is now a requirement going forward for the Trust.

Patient and Staff engagement and information
Information leaflets are provided to all patients who are diagnosed with COVID while in hospital. In the absence of national material the IPC team have produced information for patients, staff and visitors and worked with the communications team to disseminate in electronic and paper format. Whenever possible the IPC team visit wards and talk to exposed patients, providing written guidance on the period of isolation required, symptoms to observe for and actions to take to protect the wider public health. Daily support during outbreaks of infection is provided.

Outbreak Management
Outbreaks are managed as per public health (PHE) and NHS improvement guidance. On detection of an outbreak multidisciplinary outbreak control meetings are arranged to agree key actions with DIPC involvement. Daily reporting to PHE and CCGs of COVID

outbreaks has been undertaken by the IPC team to provide information about number of patients and escalation or closure of outbreaks. The IPC team liaise with operational site team three times daily to agree how to contain outbreaks and provide safest bed capacity for those accessing services.

Staff outbreaks and Occupational health
There is a robust system in place for staff to report sickness due to COVID. This includes a contact tracing process to enable managers to identify work related contacts who would be required to isolate due to COVID exposure. Numbers of staff testing positive are reported electronically to the IPC team to assist with early detection of outbreaks.

5 Incidents related to infection

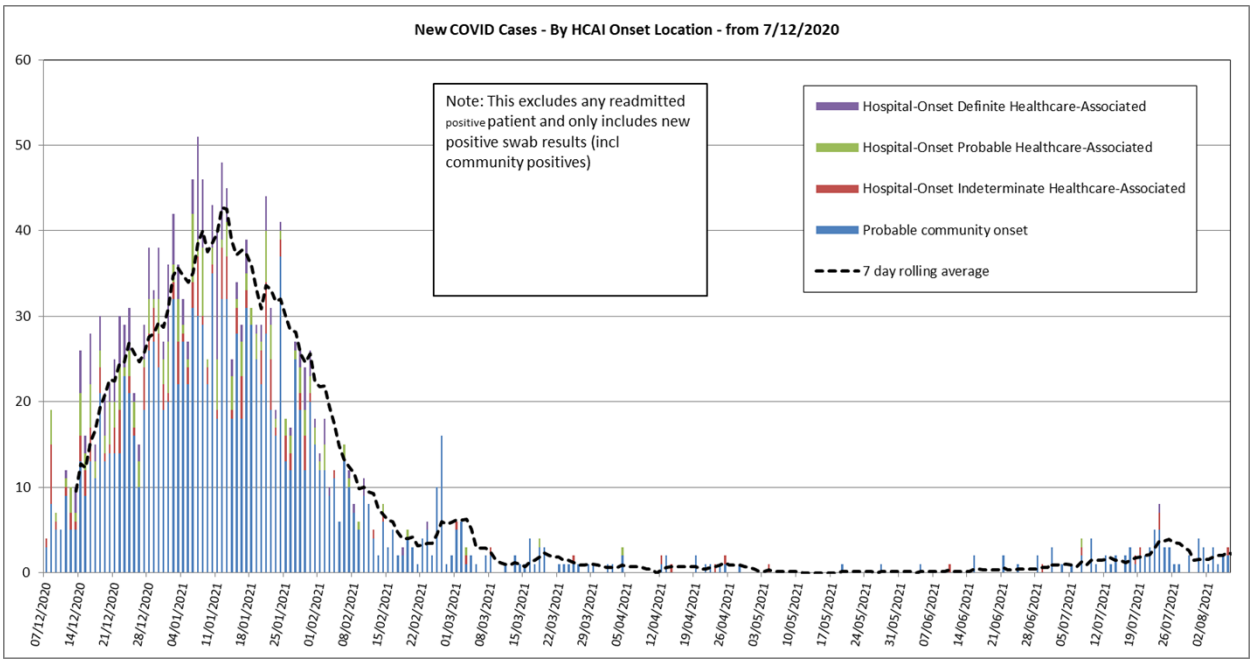
5.1 Serious Incidents (SIs) and risks managed by the Infection Prevention & Control Team

ESHT reports outbreaks of infection as possible serious incidents to the Weekly Patient Safety Summit (WPSS) who discuss and agreed approach required. These include incidents where there has been a significant impact on the running of the Trust's services (ward closures for example), or where there has been a severe impact on patient outcome. In addition to this, the team undertake risk assessments in response to organisms that could pose a risk to patients and/or staff in order to ensure they were safely managed. The PIR/RCA investigations and subsequent recommendations and completion of actions are monitored by the TIPCG.

5.2 Serious Incident related to outbreaks of COVID

In total 27 outbreaks of COVID occurred in in-patient areas during the year, 18 of these occurred the second very significant wave in December and January when there was very high prevalence in the community and very high bed occupancy in our hospitals. SI reports have been submitted in relation to outbreaks for wave one that are pending sign off. Lessons learnt to date from early outbreaks both at local and national level are:

- COVID can be transmitted by a person who does not have symptoms of the infection.
- The list of COVID symptoms has increased as our knowledge of the disease improves and now includes headaches, abdominal pains and diarrhoea that can be attributed to other illnesses.
- COVID positive people may not have clear clinical symptoms of COVID therefore testing is required at the point of admission and while an in-patient and always prior to planned interventions or transfer to other healthcare settings.
- Visitors should be limited during periods of high community prevalence and must wear face masks without exceptions and wash hands to limit transmission.
- Staff may have COVID and be asymptomatic therefore face masks are required and regular staff testing.
- Patient movement to other wards increases the number of patients potentially exposed and subsequently infected if a patient proves to be COVID positive.
- Ventilation is very important to reduce the level of transmission. Guidance in relation to role of good ventilation in reducing transmission was only published in June 2021 although ESHT had already taken remedial measures in 2020 to improve ventilation in the absence of national guidance.
- Decant facilities are required to assist with deep cleaning.



As the burden of COVID inpatient numbers increased the number of HCAI infections increased. It was apparent something had changed with the virus early in December when one patient was diagnosed with COVID in a bay on Tressell ward and within three days 27 of the 28 patients on the ward had tested positive with staff testing positive also. A similar experience soon followed on Newington ward. This was unlike any level of transmission the Trust had experienced, up to then if one person was positive for COVID in a bay a further one or two people would likely acquire the infection. The change could not be attributed to lapses in IPC precautions and the team raised our concerns with the IPC lead at NHSEI. We now know this was the beginning or our experience with the new Alpha (Kent) variant. 19% of COVID infections have been assessed as meeting the definition of Healthcare associated. The full impact of the second wave Alpha variant of COVID will be addressed in the serious incident reports. Four SI reports are in progress to detail the outbreaks that occurred during the second surge in COVID cases and relate to Conquest hospital, EDGH, Bexhill Irvine Unit and Memorial Care Centre Rye reports have already been provided by the DIPC and the Medical Director and discussed at Trust Board.

5.3 Non- COVID related outbreaks

- <u>SCBU two babies with MRSA</u>

  Two babies on SCBU at the same time in October 2020, but not in same place, found to have MRSA, both in incubators. (Meeting held to discuss).
  Patient One had a history of MRSA and was admitted from another non ESHT hospital, however this was not handed over to staff on SCBU. The baby was put into Nursery 2. This was deep cleaned once the baby transferred to the side room.

  Baby Two was negative for MRSA on admission and positive for MRSA from a swab taken in October 2020. This was 10 days following admission. The baby's mother visited occasionally and tested negative for MRSA.
  (This baby was in Nursery 1 in an incubator initially then transferred to Nursery 2 before transferring to the side room with the first baby)
  Results for both babies showed the same sensitivities. Unfortunately we are unable to send the samples for typing. This is due to the laboratory that they are

sent to being unable to carry out typing at this time due to COVID. IPC precautions were in place.

- Maternity MRSA C-sections

  Seven patients were found to have MRSA from abdominal wounds during the period of August 2019 to June 2020. One of these patients was found to have MRSA from a left eye swab taken, this was a child of one of the other patients (mother was positive) so had probably acquired it from their mother.
  Meetings were held to discuss the cases and IPC precautions required.
  It was discussed that a program of deep cleaning of Delivery Theatre be put in place and the plan is to deep clean it every couple of months.
  There is now an Orderly who is cleaning the theatre floor daily. No housekeeping issues were raised by staff at the meeting.

6. Promoting Standard Infection Prevention Precautions

6.1 Hand Hygiene Promotion

The Trust IPCT continues to co-ordinate an annual programme to promote effective hand hygiene throughout the Trust including;

- Monitoring of compliance by clinical staff with monthly audits.
- Monthly hand hygiene promotional posters
- Training of ICLFs to undertake practical hand hygiene training of clinical staff.
- Providing training of all staff on induction (joining the organisation) and at regular mandatory updates.
- Ad-hoc training when indicated for focused improvement.
- Series of focussed hand hygiene promotion events for staff and patients including participation in the International World Hand Hygiene Day during May 2019.
- The IPCT supported this even in COVID with huge support from Clinical areas.

6.1.2 Hand Hygiene Compliance

Monthly hand hygiene audits are undertaken by Infection Control Link Facilitators (ICLFs) measuring compliance by healthcare staff in direct contact with patients. Observations are made in each clinical area and feedback is given at the time of audit by the Infection Control Link Facilitator, staff responses are noted as part of the audit. Results are monitored to detect trends and act where frequent non-compliance occurs.

The ICLFs should complete and submit 10 observations every month. If an area doesn't return an audit for one month the matron is contacted, if for two consecutive months the Head of Nursing for that area is contacted and if there is no audit for three consecutive months it is escalated to the Chief Nurse (DIPC).

A "Fit to Care" hand hygiene compliance check list has been introduced for clinical teams who are working in environments such as clinical and community settings and cannot be easily audited, to provide assurance that staff have undergone the correct IPC training and have the right equipment to be compliant with IPC policies.

In April 2018 the Trust's recording system (Meridian) for hand hygiene compliance was discontinued. To facilitate the transition from Meridian to Allocate's My Assure system the ICLFs were asked to submit paper copies of their hand hygiene audits.

The chart below provides details of the overall Trust compliance. Since the introduction of Allocate for the submission of hand hygiene audits it has been much more difficult to obtain data and analyse on a trustwide level. We are able to obtain information on each ward's compliance but the system does not collate this into a format to provide a view of overall compliance, instead IPCT has to calculate the compliance data for each hospital. Members of the IPC team have worked with staff in the Allocate team to try to address this but a satisfactory solution has not been achieved yet.

Inpatient Areas

Average data												
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Totals	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Overall ESHT Totals	332	367	331	376	364	392	484	457	400	184	299	350
Quarterly #	1030			1132			1341			833		
HH Before %	100%	99%	99%	100%	99%	100%	98%	98%	100%	100%	97%	100%
Quarterly HH Before	100%			100%			99%			99%		
HH After %	100%	99%	100%	100%	100%	99%	100%	99%	100%	100%	98%	100%
Quarterly HH After	100%			100%			99%			99%		
BBE %	99%	100%	99%	96%	99%	100%	100%	98%	98%	99%	99%	99%
Quarterly BBE	99%			98%			99%			99%		
Total areas Submitting audit	33	34	33	32	502	36	34	36	30	18	26	33
Average for the quarter	33			190			33			26		

Breakdown By Site												
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Totals	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
EDGH total number of audits submitted	148	150	169	194	168	184	242	215	218	81	149	181
Compliance before contact	100%	98%	99%	100%	98%	100%	99%	100%	100%	100%	93%	100%
Compliance after contact	100%	99%	100%	99%	99%	100%	99%	99%	100%	100%	95%	99%
Bare below Elbow	99%	99%	100%	91%	99%	99%	100%	99%	95%	100%	98%	96%
Conquest total number of audits submitted	145	185	132	145	166	181	218	212	153	63	119	149
Compliance before contact	100%	100%	99%	100%	99%	99%	95%	98%	99%	100%	99%	99%
Compliance after contact	100%	99%	100%	100%	100%	99%	99%	98%	99%	99%	99%	100%
Bare below Elbow	99%	100%	100%	97%	100%	100%	100%	99%	98%	97%	99%	99%
OOH total number of audits submitted	39	32	30	37	30	27	24	30	29	40	31	20
Compliance before contact	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%
Compliance after contact	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Bare below Elbow	100%	100%	97%	100%	97%	100%	100%	97%	100%	100%	100%	100%

Outpatient Areas

Average data												
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Totals	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Overall ESHT Totals	57	46	60	48	57	69	67	69	93	51	30	59
Quarterly #	163			174			229			140		
BBE %	98%	100%	100%	100%	100%	97%	100%	100%	99%	100%	100%	99%
Quarterly BBE	99%			99%			100%			100%		
Glow Box training %	92%	94%	91%	93%	86%	76%	89%	81%	73%	78%	95%	77%
Quarterly Glow Box training	92%			85%			81%			83%		
Total areas Submitting audit	6	6	7	5	7	8	8	8	11	6	3	6

Breakdown By Site												
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Totals	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
EDGH total number of audits submitted	17	10	14	10	24	26	38	30	48	22	0	24
Bare below Elbow	93%	100%	100%	100%	100%	90%	100%	100%	98%	100%	n/a	96%
Glow box training	79%	100%	100%	100%	82%	79%	85%	61%	53%	92%	n/a	93%
Conquest total number of audits submitted	30	21	27	19	18	32	13	21	20	20	20	25
Bare below Elbow	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Glow box training	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	67%
OOH total number of audits submitted	10	15	19	19	15	11	16	18	25	9	10	10
Bare below Elbow	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Glow box training	100%	83%	72%	78%	75%	50%	83%	81%	66%	43%	90%	70%
Average for the quarter	6			7			9			5		

Community Areas

Average data												
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Totals	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Overall ESHT Totals	15	11	30	22	21	9	20	23	3	14	19	30
Quarterly #	56			52			46			63		
BBE %	100%	100%	100%	97%	98%	100%	100%	98%	100%	100%	100%	85%
Quarterly BBE	100%			98%			99%			95%		
HH Kit available %	100%	100%	86%	97%	92%	100%	100%	100%	100%	100%	100%	97%
Quarterly HH kit available %	95%			96%			100%			99%		
Aware of replenishment process %	100%	100%	99%	98%	100%	100%	100%	100%	100%	100%	100%	100%
Quarterly awareness of replenishment process %	100%			99%			100%			100%		
Gel/Foam attached %	100%	100%	52%	63%	67%	67%	100%	93%	100%	100%	100%	98%

Quarterly Gel/Foam attached %	84%			66%			98%			99%		
Total areas Submitting audit	2	2	6	6	5	4	7	7	1	2	3	4
Average for the quarter	3			5			5			3		

Totals	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
EDGH total number of audits submitted	10	0	4	0	3	0	1	7	0	0	6	16
Bare below Elbow	100%	n/a	100%	n/a	100%	n/a	100%	100%	n/a	n/a	100%	65%
HH kit available	100%	n/a	75%	n/a	100%	n/a	100%	100%	n/a	n/a	100%	100%
Aware of replenishment process	100%	n/a	100%	n/a	100%	n/a	100%	100%	n/a	n/a	100%	100%
Gel/foam attached	100%	n/a	75%	n/a	100%	n/a	100%	100%	n/a	n/a	100%	95%
Conquest total number of audits submitted	5	7	22	17	13	3	3	3	0	14	10	11
Bare below Elbow	100%	100%	100%	93%	95%	100%	100%	100%	n/a	100%	100%	91%
HH kit available	100%	100%	83%	93%	75%	100%	100%	100%	n/a	100%	100%	91%
Aware of replenishment process	100%	100%	97%	97%	100%	100%	100%	100%	n/a	100%	100%	100%
Gel/foam attached	100%	100%	80%	93%	100%	100%	100%	100%	n/a	100%	100%	100%
Cross Site total number of audits submitted	0	4	4	5	5	6	16	13	3	0	3	3
Bare below Elbow	n/a	100%	100%	100%	100%	100%	100%	93%	100%	n/a	100%	100%
HH kit available	n/a	100%	100%	100%	100%	100%	100%	100%	100%	n/a	100%	100%
Aware of replenishment process	n/a	100%	100%	100%	100%	100%	100%	100%	100%	n/a	100%	100%
Gel/foam attached	n/a	100%	0%	33%	0%	33%	100%	80%	100%	n/a	100%	100%

The overall compliance is very good and most of the areas continued to complete their Hand Hygiene audits, and submit on the Allocate system. However, as a result of the COVID19 pandemic, there is a significant reduction in the audits submitted by a number of clinical areas during Quarter 1 and Quarter 4. In order to validate this data, and provide assurance regarding its accuracy, the Associate Practitioners in the IPC Team audited compliance with Hand Hygiene (overall compliance 86%) and "bare below the elbows" (overall compliance 98.2%) standards. Their audits evidence that overall there is good compliance among Trust staff.

Once again, Clinical Teams showed their support for World Hand Hygiene Day on 5th May by promoting the importance of hand hygiene for everyone.

6.2 Infection Prevention & Control Compliance Monitoring Programme

(Please see Appendix 1 for overview of results).

The common themes of non-compliance for MRSA audit are staff not documenting the application of the antimicrobial body wash and hair wash. Hand hygiene and bare below the elbow audits identified that staff failed to perform hand hygiene before and/or after patient contact as per Trust Policy and some are wearing wrist watches and rings with stones in clinical areas. Personal Protective Equipment (PPE) audits showed some staff not using appropriate PPE as advised in the national and Trust guidelines and failure to perform hand hygiene before donning and after doffing. For the Commode audit, the common theme of non-compliance was contamination. The common themes of non-compliance for the Sharps Audit were container lids left open rather than availing of the temporary closure mechanism and not all containers being dated/signed when they are required to have documentation. During Quarter 1 and Quarter 4 as a result of higher incidence of COVID cases in the Trust, more support was provided with training re: hand hygiene, PPE and updating the wards on COVID guidelines. A huge effort was made towards completing the surveillance so that the contacts of every COVID positive patient could be identified promptly in order to prevent further outbreaks.

6.3 Training and Education

The IP&C specialist nurses provide a comprehensive training and education programme for all Trust staff and volunteers related to all aspects of infection prevention and control, both planned and as required. This includes;

- Mandatory training and induction for all staff and volunteers is provided via e-learning platforms.
- Annual updates for clinical staff, patient facing staff, food handlers and other high risk groups
- 3-yearly mandatory training for non-clinical, non-patient facing staff.

Compliance with attendance at mandatory induction and update sessions remains above 85% and is monitored by the Trust along with other mandatory components of the Trust mandatory training programme.

Since January 2020 the main focus of the IPCT training has been on the safe appropriate use of personal protective equipment for use during the COVID-19 pandemic to provide safe care for patients and staff. This has involved considerable resource using online and practical demonstrations and development of training material and printed visual instruction and guidance.

The IPCT held training days on both acute sites in February 2020 with ICLF staff from all areas invited to attend. The focus was on preparedness for the COVID-19 pandemic particularly wave 1 surge with presentations and practical application of PPE so that this information could be disseminated to clinical teams.

This work has continued throughout the pandemic and has been very challenging at times as the national IPC guidance changed so frequently and rapidly.

6.4 Audit activity

The IPCT co-ordinates a number of planned and unplanned audits throughout each year to monitor compliance with core infection prevention and control standards and any areas of risk or concern which may arise as a result of incidents. Completion of audits has been interrupted at times during the COVID pandemic when staffing or access to departments was reduced.

The following audits were undertaken:

- Monthly staff hand hygiene audits
- National Specification of Cleanliness audits.
- The One Together audit of compliance with best practice across the surgical pathway was paused. Work with women's health with a focus on good practice in caesarean section and hysterectomy surgery recommenced in Spring 2021 and continues.
- Audit of compliance with COVID IPC Checklist (report pending)
- Re-audit of compliance with best practise guidelines to minimise risk of Pseudomonas aeruginosa and legionella contamination in Augmented care.

6.5 Professional Development

All specialist nurses within the team maintain professional competence and attend relevant study and training. Networking with other clinical specialists is supported through attendance at regional meetings.

Our associate practitioners have both now completed the foundation degree in Health and Social Care.

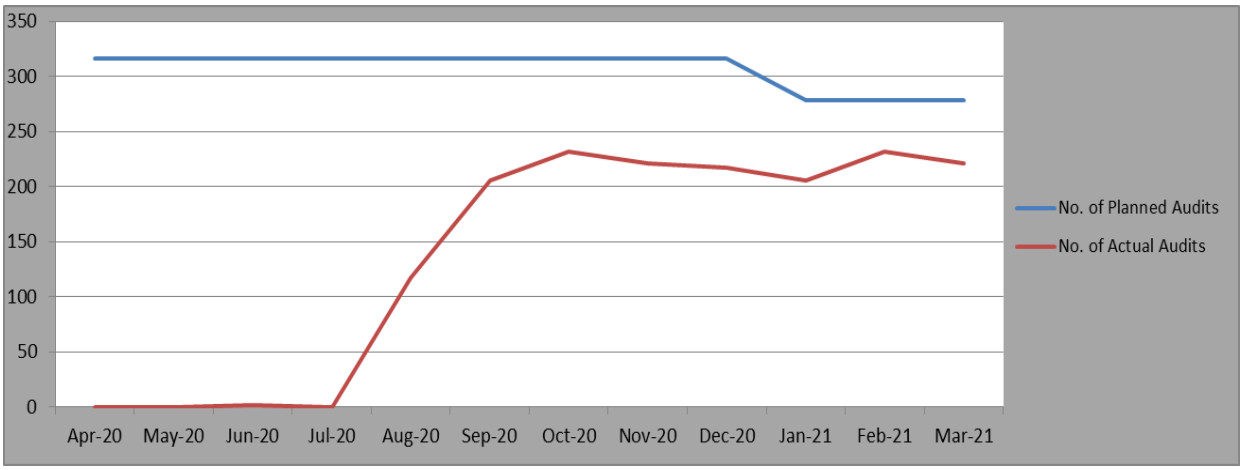
The team have accessed online training and seminars to gain knowledge of COVID as new information became available. We have collaborated with other specialists via regional and local network meetings to contribute to the development of national guidance on the IPC management of COVID.

7. Maintaining a clean environment that facilitates the prevention and control of infection

The National Specification of Cleanliness (NSC) audits continue to be monitored via the TIPCG and the Divisional Integrated Performance Reviews. (See table below for planned versus actual numbers of audits).

Number of NSC Audits Planned vs Number Completed

Month	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
No. of Planned Audits	316	316	316	316	316	316	316	316	316	278	278	278
No. of Actual Audits	0	0	2	0	117	206	232	221	217	206	232	221



The Trust NSC target score for Clinical equipment and Housekeeping was assessed as >92%, overall this was achieved although there were some low scoring areas. Where an area has consistently low scores they are asked to attend the Patient Environmental Audit Meeting (PEAM) to provide assurance of the actions being taken to address the low compliance and this is discussed at the TIPCG which is chained by the DIPC.

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
House Keeping			98.08		92.27	98.04	97.68	98.49	98.57	96.69	95.39	98.66
Clinical Staffing			95.65		85.09	94.71	96.49	95.62	95.89	91.25	89.82	92.84
Estates			97.06		90.91	96.55	95.44	95.27	95.18	95.28	93.97	97.79

The introduction of the Clinical Orderly role to support cleaning of clinical equipment has significantly improved compliance scores. Vacancies and absence can cause lower compliance. Lower estates scores relate to aging infrastructure which requires investment, works are prioritised by risk; the average annual score for estates (92%) is compliant with NSC. It is anticipated that forthcoming “Building for Our Future” project work being led by our Estates and Facilities team, will significantly improve the standards of the estate.

7.1 Housekeeping

The Housekeeping services for ESHT continue to be provided by the in-house team within Estates and Facilities. Housekeeping resources are matched to each area in line with the National Specification for Cleanliness (NSC) guidelines and the associated risk ratings – Very high Risk, High Risk, Significant and low.

New National Standards of Cleanliness have now been released and one of the significant changes is the risk rating categories have increased from 4 to 6, which are:

- FR1 – 98%; FR2 – 95%; FR3 – 90%; FR4 – 85%; FR5 – 80%; FR6 – 75%

The new standards are expected to be operational by the end of the year.

The Trusts Housekeeping service were under intense pressure during the peaks of the COVID Pandemic, however staff worked tirelessly to ensure all areas were covered and cleanliness standards achieved. The daily task sheets were redesigned to reflect areas that were classed as ‘red’ to ensure extra cleans were carried out per day in

toilets/bathrooms. Personal COVID Risk Assessments were completed and staff were assessed and moved to different areas to support those who were vulnerable.

Test and Trace was completed for staff with Occupational Health to support Infection Control procedures.

Heightened touch point cleaning was introduced on all sites and Housekeeping staff supported areas to ensure there were sufficient masks and hand gel available at all times at all entrances.

During January 2021 Housekeeping services suffered significant staff shortages and were supported with TWS Staff, Agency and Army personnel. Within the Estates and Facilities Management team, rotas were developed to support staff with on site management cover every weekend.

Staff also moved areas and times of work to support the service including working at alternative sites to support oncology patients.

Community: Bexhill Irvine Unit was particularly affected with the Covid Pandemic from March 2020. Additional cleaning regimes were put in place to allow for 2 full cleans per day and additional continuous touch point cleaning. Staff were aligned to work in Red and Amber Zones, with very few beds remaining Green.

Additional Staff were required at all times to maintain the cleaning standards required, as well as the Deep Cleaning and HPV Cleaning as needed, including at Rye Hospital.

Outbreaks of Covid occurred within other buildings at the Bexhill Site, and at Arthur Blackman Clinic, which also required an emergency cleaning response.

Bexhill Hospital Outpatients, Renal, Physiotherapy and Day Surgery all continued as normal with staff dedicated to those areas (not used at the Irvine Unit), the implementation of a day cleaner was introduced at the Hospital (a new position) continual cleaning to all areas during the day commenced and is still ongoing. Deep cleaning is carried out every evening.

7.2 Deep clean programme

The Rapid Response team provide cover 24/7 and during the pandemic have been an integral part of Housekeeping. They were supported with additional staff to ensure that the increase in deep cleaning was achieved and standards maintained.

7.3 Activity

Housekeeping continued to receive demands from all areas for cleaning support from the Rapid Response Team including single rooms, bed space cleans, and others. This averages at about 200+ calls per month per acute site. To meet this demand calls for cleans are prioritised and communication and support is structured from the IPCT and clinical site teams and clear plans are in place at all levels to ensure disruption is minimised.

During the pandemic Rapid Response had a 50% increase in deep cleans at Conquest and a 75% increase in deep cleans at EDGH.

7.4 Service Development

The Housekeeping department continues to use HPV (Hydrogen Peroxide Vaporisation) units to support the reduction of infections by destroying organisms, this process is undertaken by the rapid response team who are on site 24hrs and can be deployed to any site if called upon. This will be sustained in the modernisation plan.

To support IPCT working practices and water safety staff undertake refresher training in sink cleaning procedures. Standard operating procedures have been revised and training rolled out to all Housekeeping personnel, including annual Refresher training.

Recently Housekeeping has procured a new company to supply HPV Units and will be looking into the new UV-C Decontamination as an additional support for smaller areas and for quicker turnaround times.

8. Antimicrobial Stewardship Activities and Innovation

The Trust has an established Antimicrobial Stewardship Group (ASG) with a core membership of a consultant microbiologist, medical consultant, Clinical Pharmacy Manager, Lead Antimicrobial pharmacist and a CCG representative. The purpose of the ASG is to support the prudent use of antimicrobials to reduce the development and spread of antimicrobial resistance. This is achieved by:

- Developing and maintaining evidence based antimicrobial policies and guidelines for use in secondary and primary care
- Developing a strategic plan with the aim to continuously improve the use of antimicrobial with ESHT and the local community
- Ensuring safe and cost effective use of antimicrobials taking local, national and international bacterial resistance rates into account.
- Monitoring antimicrobial usage (reviewing daily divided doses, antimicrobial expenditure data and compliance to guidelines using a point prevalence audit) and addressing any issues that may arise.
- Undertaking audits on antimicrobial prescribing practice and providing feedback to TIPCG, ASG and MOG
- Providing advice to other specialist groups/committees on use of antimicrobials
- Providing education to staff on all matters relating to prescribing and administration of antimicrobials.
- Educating patients and members of the public on antimicrobial stewardship
- The lead antimicrobial pharmacist providing feedback from lesson learnt, following a Post Infection Reviews to the pharmacy team.

8.1 Antimicrobial Prescribing Policy and Guidelines

The purpose of the ASG is to support the prudent use of antimicrobials to help support patient care and reduce the development and spread of antimicrobial resistance.

This is achieved by:

- Developing and maintaining evidence based antimicrobial policies and guidelines for use in secondary and primary care
- Developing a strategic plan with the aim to continuously improve the use of antimicrobial with ESHT and the local community

- Ensuring safe and cost effective use of antimicrobials taking local, national and international bacterial resistance rates into account
- Monitoring antimicrobial usage (reviewing daily divided doses, antimicrobial expenditure data and compliance to guidelines using a point prevalence audit) and addressing any issues that may arise
- Undertaking a monthly antimicrobial audit the focusses prescribing practice and providing feedback to TIPCG, ASG and MOG
- Providing advice to other specialist groups and committees on use of antimicrobials
- Providing education to staff on all matters relating to prescribing and administration of antimicrobials
- Educating patients and members of the public on antimicrobial stewardship

The Adult and Paediatric antimicrobial guidelines are reviewed, on a regular basis, by the Antimicrobial Stewardship Group (ASG). The guidance is evidence based and specialist Consultants and/or Allied Health professional (AHP) are consulted for advice. Any major change to the Trust antimicrobial guidance is submitted, prior to publication, to the Medicines Optimisation Group (MOG) for consideration - a major change in guidance should only be published after receiving approval from MOG.

8.2 Multi-disciplinary team (MDT) Ward Rounds

The aim of MDT ward rounds are to reduce the inappropriate prescribing of antibiotics, reduce the risk of treatment failure and the development of antimicrobial resistance, and provide support to the prescribing team with specialist input into the highest risk and/ or most critical patients in the hospitals.

The impact of the COVID-19 pandemic affected how pharmacy provided support to MDT wards rounds during 2020/21. The AMS ward rounds were temporarily switched to virtual ward rounds - to reduce the risk of transmission and spread of COVID-19.

During 2020/21 the following weekly multi-disciplinary ward rounds were initiated;

1. Diabetic Foot Management
2. Orthopaedics

The Consultant Microbiologists (CMM) and antimicrobial or an Intensive Care Pharmacist continue to participate in daily Intensive Care Multi-disciplinary team ward rounds, weekly Clostridium *difficile* infection and immunocompromised haematology-oncology ward rounds.

In addition, the AMS wards rounds are targeted to a ward or area with a concern, for example a ward with an unexpected high use of broad spectrum antibiotics. The review of antimicrobial prescribing follows standards outlined in the PHE “Start Smart then Focus” document (March 2015).

The AMS ward round has made a number of interventions that include;

1. Stopping treatment.
2. Escalating / de-escalating treatment.
3. Switching administration route from an intravenous to oral treatment.
4. Continuing current treatment and providing advice on duration/review date.

5. Providing advice to the medical or surgical team on the prescribing of antibiotics for a CDI antigen or toxin positive patient.

8.3 Training

An in-house on-line replacement e-module was development and approved for use by the Antimicrobial Stewardship Group. As part of the Trust Induction programme prescribers and nursing staff are required to complete the e-module and at least every three years of employment at ESHT. In addition to the e-module, the FY1/FY2 Trust Induction programme includes a Consultant Microbiologist and Pharmacist face-to-face teaching on antimicrobial stewardship.

An antibiotic training pack is available to help support the development of rotational pharmacists in antimicrobial use and prescribing. The training pack is based on the Royal Pharmaceutical Society antimicrobial training guidance.

8.4 Antibiotic Incident reports

The lead antimicrobial pharmacist is involved in reviewing of incidents reported on Datix involving antimicrobials. An Antimicrobial and Ward Pharmacist, where possible, should attend Post Infection Reviews (for example CDI) and provide feedback, where appropriate, to the pharmacy team.

8.5 Audit of antimicrobial usage

Improving Antimicrobial Stewardship standards at ESHT forms part of the quality improvement strategy for patient safety, to help to reduce inappropriate prescribing and optimise antibiotic use. The Trust total antimicrobial consumption rate is monitored by a review of pharmacy and admission data (via Define), and Public Health England (PHE) published reports.

To help provide assurance on AMS practice, pharmacy undertakes a monthly antimicrobial stewardship audit. The audit should help identify AMS issues and highlight possible areas for improvement. Any inappropriate prescribing practice, highlighted by the antimicrobial audit, is reviewed and investigated. If needed, the concern will be escalated to the Antimicrobial Stewardship and Infection Prevention and Control Groups

Due to the COVID-19 pandemic, the monthly audit was temporally placed on hold to help pharmacy focus on the provision of the pharmacy clinical service, for example medicines reconciliation and optimisation, and medication supply.

The electronic prescribing and medication administration system (ePMA) is planned to be rolled-out, in a phased manner, in 2021/22. The ePMA system should reduce the inappropriate prescribing of antibiotics and enable pharmacy and microbiology to review live antimicrobial prescribing information. This data will assist microbiology and pharmacy to prioritise and improve the efficiency of AMS ward rounds to review the use of broad spectrum antibiotics and antifungals. The ePMA system should improve AMS practice.

8.6 Antibiotic CQUIN 2020/21

Due to COVID-19 pandemic, the CQUIN 2020/21 measures were withdrawn.

9. Water Safety Incidents

9.1 *Legionella* species:

Legionella pneumophila serogroup 1 is the most virulent strain causing the majority of infections. The remaining non-pneumophila species (found in water and soil) are considered non-pathogenic until shown to cause disease, mainly associated with severely immunosuppressed patients.

Legionella pneumophila was isolated from water samples at Bexhill hospital, Urology Investigation Suite and Nuclear Medicine this year. Remedial measures were taken and the repeat result show further reduction in the level isolated. Non-pneumophila legionella has been isolated in water samples in several clinical areas at the Conquest hospital. IPC inform the clinical matron and check that there is recorded evidence of flushing and cleaning of outlets. Estates and Facilities team are supporting regular flushing of water outlets. The risk was managed and monitored by the water safety group.

There has been no known hospital acquired cases of *Legionella* to date. Legionella species has not been identified at EDGH this year.

9.2 *Pseudomonas aeruginosa*

Pseudomonas species has been detected in routine water sampling in several clinical areas and has been well managed by the Estates and Facilities team.
An outbreak investigation relating to Pseudomonas on Critical Care at the Conquest hospital was undertaken. Four patients were found to have *Pseudomonas aeruginosa* between January and March 2021. One patient may have been colonised prior to coming into hospital. Two patients sputum had different sensitivities however this does not confirm or rule out the same strain. Patient 3 was not in ITU at the same time as Patient 1 and 2. Patient 3 had previously been in Critical care at EDGH prior to Conquest. One patient was on Meropenem which can select out Pseudomonas species. Patient 1 and 2 were located in bed spaces next to each other as were patient 3 and 4. All four patients were ventilated and were long term patients. ITU/HDU were having new taps/sinks installed at this time. Water safety precautions were in place. Staff were unable to send the samples for typing to determine if they were the same strain as laboratories were not undertaking this work due to COVID.

Appendix 1

Infection Prevention & Control Compliance Monitoring Programme results table

AUDIT	Quarter 1				Quarter 2				Quarter 3				Quarter 4			
	EB	CQ	Total Compliance		EB	CQ	Total Compliance		EB	CQ	Total Compliance		EB	CQ	Total Compliance	
			#	%			#	%			#	%			#	%
MRSA compliance monitoring																
Total audits	77	75	**152**		140	190	**330**		101	88	**189**		73	40	**133**	
Complied	73	73	**146**	**96.0526**	126	181	**307**	**95.2632**	92	77	**169**	**89.418**	63	39	**102**	**90.2655**
Hand Hygiene Audit																
Total audits	10	70	**80**		75	144	**219**		31	116	**147**		7	110	**117**	
Complied	7	60	**67**	**83.75**	63	122	**185**	**0.84475**	38	108	**146**	**99.3197**	3	84	**87**	**74.359**
Audit of universal precautions																
Total audits	37	45	**82**		80	118	**198**		60	102	**162**		41	102	**143**	
Complied	30	39	**69**	**84.1463**	62	97	**159**	**82.2034**	48	87	**135**	**83.3333**	29	71	**100**	**69.9301**
Bare Below Elbow Audit																
Total audits	37	52	**89**		336	147	**483**		152	146	**298**		61	69	**130**	
Complied	30	51	**81**	**91.0112**	332	144	**476**	**98.5507**	150	146	**296**	**99.3289**	60	69	**129**	**99.2308**
Commode Audit																
Total audits	31	37	**68**		109	61	**170**		83	20	**103**		85	37	**122**	
Complied	28	37	**65**	**95.5882**	91	53	**144**	**84.7059**	72	18	**90**	**87.3786**	67	35	**102**	**83.6066**
Sharps audit																
Total audits	38	125	**163**		137	163	**300**		20	107	**127**		7	121	**128**	
Complied	32	92	**124**	**76.0736**	114	129	**243**	**81**	18	88	**106**	**83.4646**	6	97	**103**	**80.4688**

Organ Donation Annual Report

Meeting information:		
Date of Meeting:	12th October 2021	Agenda Item: 11.3
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 20 & 31st March 21, there were 7 families who consented to donation. Four patients proceeded as solid organ donors leading to 7 patients receiving transplants. This was a decrease on the previous year activity but occurred during the COVID-19 pandemic, during which COVID-19 infection has remained a contraindication to donation. The trust has achieved 100% compliance with neurological death testing and involvement of specialist nurses. Additionally, of the families approached, 100% consent rates were achieved. When compared to UK performance this means that ESHT has been rated as exceptional for these areas of care. As with previous years, referral of patients following circulatory death continues to be an area for improvement. While the trust achieved only 69% referral rate, all of the patients who were not referred had contraindications to donation (88% due to current COVID infection).

Funding:

Since 2018, trusts have received financial support from NHS blood & transplant in 3 ways:

- Donor recognition funding: which is based on the number of proceeding donors in the previous financial year and is intended to support future donation activity
- Funding for the clinical lead position: to provide clinical leadership for donation
- Clinical Lead & Organ donation committee expenses.

Donor recognition funding is provided with the specific purpose of supporting future donations. As the funding can potentially vary significantly between each financial year it makes future planning & budgeting extremely difficult,

especially if remaining funds are not rolled over from each financial year. It also makes larger areas of financial support or purchases impossible.

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.

Research: ESHT has been requested by NHSBT to participate in a national research study – SIGNET. The study aim is to examine the effect of a single dose of simvastatin given to consented, proceeding donors following neurological death on the outcome in cardiac recipients. This work has been agreed with the ESHT research and development team, is supported by the National Institute for Health Research and will require minimal interventions locally once set up.

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.

Ongoing COVID 19 cases with possibility of further case surges has the potential to impact on Intensive Care work intensity– potential for increased missed referrals.

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

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

Public awareness: With ongoing potential for restrictions on large scale public occasions and the cancellation of local events such as Eastbourne Airbourne, raising public awareness of organ donation is going to remain largely in the virtual domain. Ongoing communications support with appropriate social media content during events such as Organ Donation Week in September, would be advantageous.

Finances: The Organ Donation committee requests that the board reviews the allocation of donor recognition funds at the end of each financial year. To allow the organ donation committee to support larger scale projects within the trust, the committee requests that these funds are routinely rolled over, leaving any remaining funds available to support organ donation activity within the trust.

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 31st March 2021 there were 4256 people on the active transplant list in the UK. Over the last year 497 patients in the UK have died whilst waiting for a transplant; 29 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'.

2.4. In England 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 are now 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. People are still able to register their decision – either to donate their organs or to decline donation, via the NHS organ donor register. On the 31st March 2021, 26,746,406 people had registered their decision across the UK.

2.5. Roll out of the next NHSBT strategy – "Meeting the need – A ten year vision", has been delayed due to the COVID-19 pandemic and is awaiting formal agreement by the UK health departments & the government.

3. Main content

3.1. NHS Blood & Transplant Report 1st April 2020 to 31st March 2021:

During the report period, there were 7 families who consented to donation at East Sussex Healthcare NHS Trust. This resulted in 4 proceeding solid organ donors and lead to 7 patients receiving transplants. Of the 3 patients whose family kindly agreed to donation but in whom donation did not proceed, 2 were subsequently found to have a contraindication during the screening process and 1 deteriorated and died prior to donation.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2020 - 31 March 2021

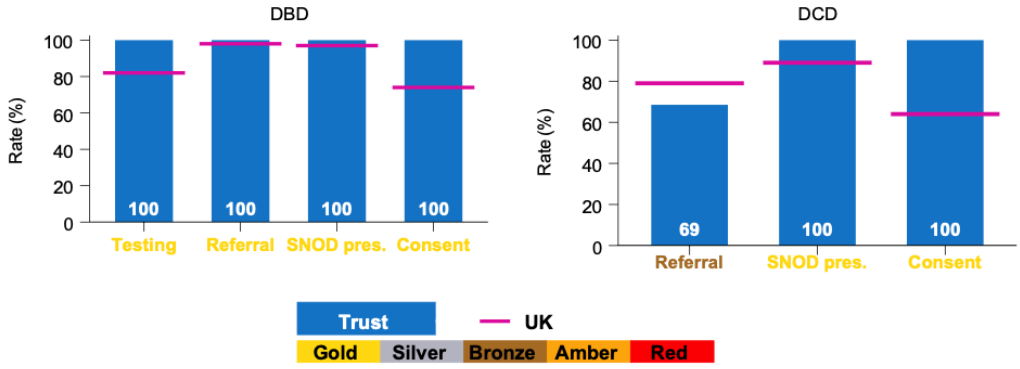


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2016 - 31 March 2021

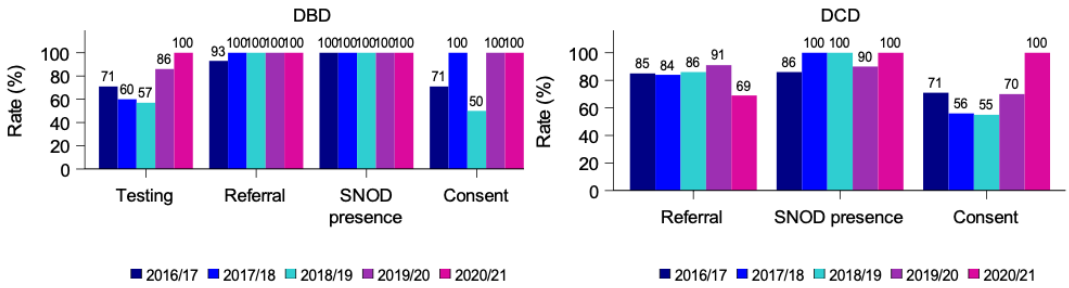


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2020 - 31 March 2021

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	4	1810	54	6027	58	7551
Referred to Organ Donation Service	4	1777	37	4770	41	6282
Referral rate %	G *100%*	*98%*	B *69%*	*79%*	A *71%*	*83%*
Neurological death tested	4	1490				
Testing rate %	G *100%*	*82%*				
Eligible donors[2]	4	1353	17	2860	21	4207
Family approached	4	1210	3	1042	7	2248
Family approached and SNOD present	4	1168	3	925	7	2089
% of approaches where SNOD present	G *100%*	*97%*	G *100%*	*89%*	G *100%*	*93%*
Consent ascertained	4	891	3	665	7	1553
Consent rate %	G *100%*	*74%*	G *100%*	*64%*	G *100%*	*69%*
Actual donors (PDA data)	2	777	2	404	4	1180
% of consented donors that became actual donors	*50%*	*87%*	*67%*	*61%*	*57%*	*76%*

[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 4 potential Donation after Brainstem Death (DBD) donors, all patients were referred to the Specialist Nurse for Organ Donation (SN-OD). Of these patients all 4 families consented to donation. Of 54 potential Donation after Circulatory Death (DCD) donors, 37 patients were referred to the SN-OD, 34 patients had contraindications to donation and 3 families were approached and consented to donation.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2016 - 31 March 2021

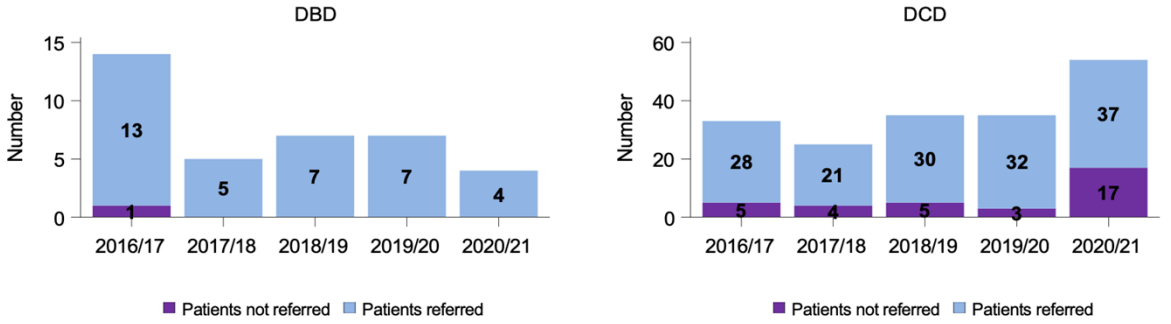


Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2020 - 31 March 2021

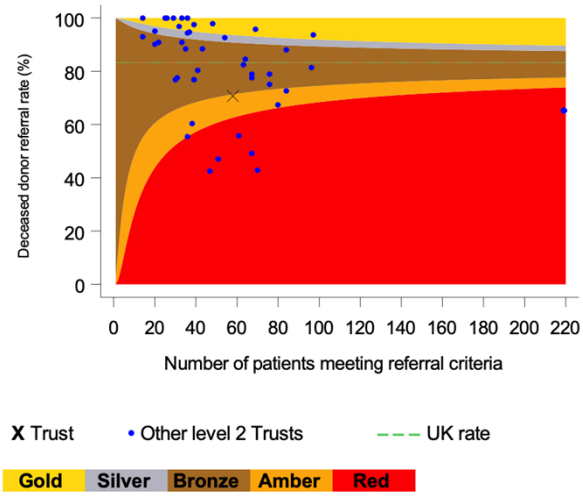
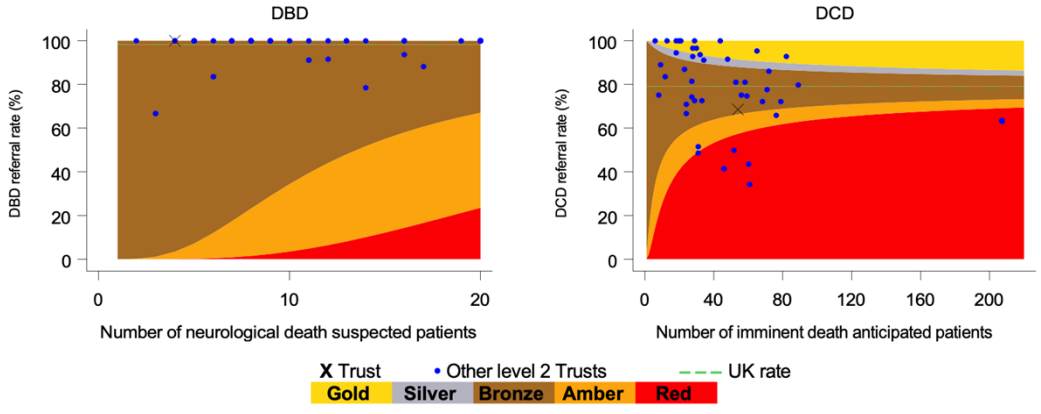


Figure 7.1 Funnel plots of referral rates, 1 April 2020 - 31 March 2021



ESHT has been rated as below average for referrals. However, of the patients not referred for consideration of donation, *all* had a medical contraindication to donation and therefore their families would not have been approached even if referred as donation would not have been clinically possible for these patients. The main reason for medical contraindication was a positive COVID-19 result (88% of cases). Additionally, the majority of "missed" referrals occurred during both COVID-19 surge peaks which represented a time of significant increased clinical workload for the entire critical care team.

This year has seen a significant drop in the DCD referral rate for the reasons outlined above. Alongside the ongoing consideration of Specialist nurse referral and End of Life Care in the daily ICU safety huddle, the organ donation team have also worked with the critical care teams to increase awareness amongst new and redeployed staff by the inclusion of an update in the ICU newsletter – so far included twice since December.

3.2.2.Neurological Testing:

Goal: Neurological death tests are performed wherever possible.

Of 4 potential patients with suspected neurological death and potential for Donation after Brainstem Death, all patients underwent neurological testing. This is a local goal of the South East Organ donation collaborative and ESHT has been rated as exceptional when compared to UK performance.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2016 - 31 March 2021

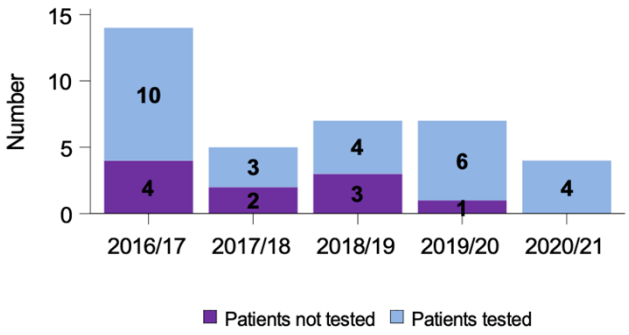
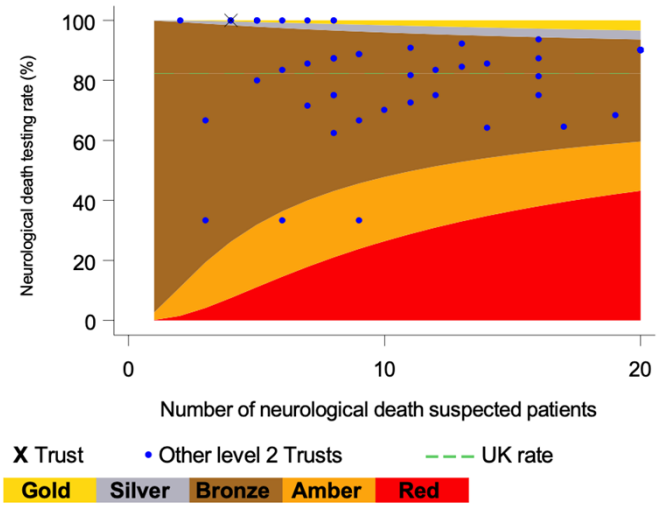


Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2020 - 31 March 2021



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 both Neurological death and for donation after circulatory death. When compared to UK performance this means that ESHT was rated as exceptional.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2016 - 31 March 2021

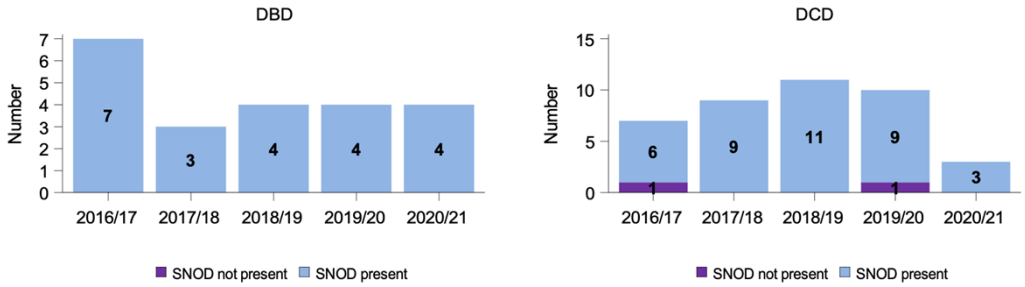
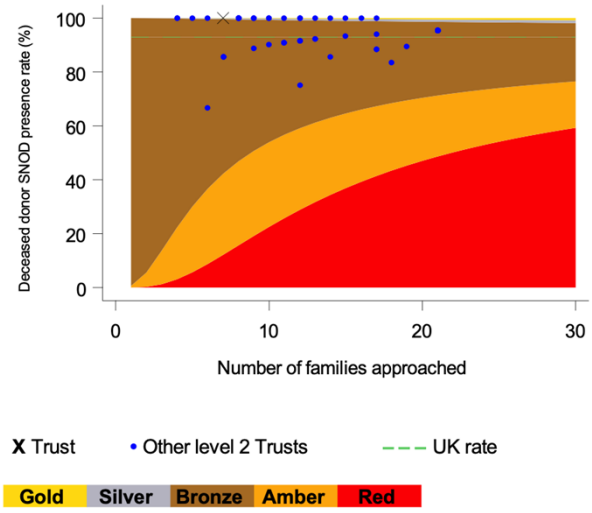


Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2020 - 31 March 2021



3.2.4.Consent:

The consent rate for families agreeing to organ donation at ESHT this year was 100% - rated as exceptional when compared to UK performance.

Figure 3.4 Number of families approached, 1 April 2016 - 31 March 2021

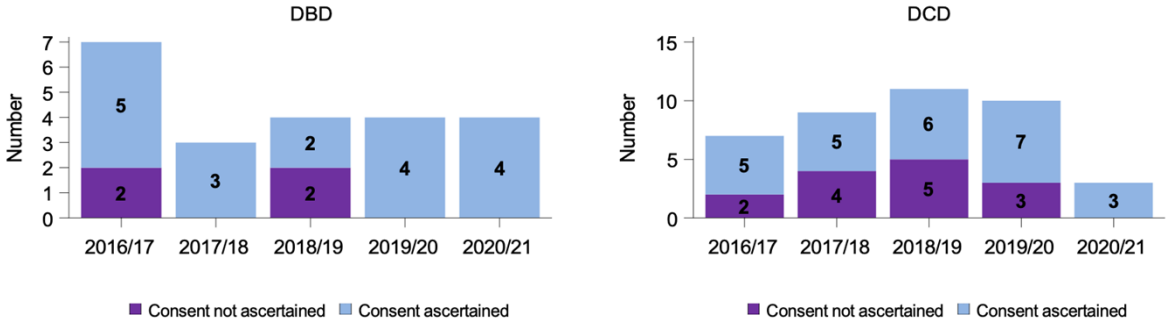
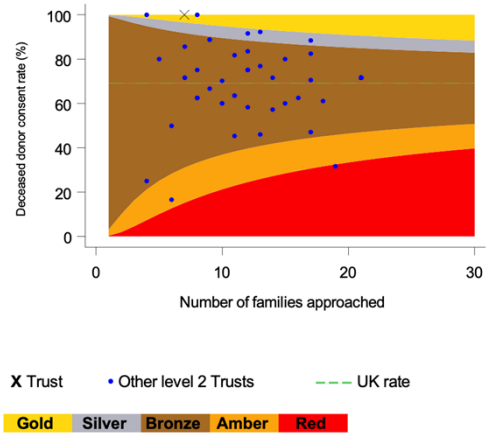


Figure 4.4 Funnel plot of consent rate, 1 April 2020 - 31 March 2021



3.2.5.Emergency Department:

Goal: No one dies in ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.

In 2020-21 there was 1 patient referred from the Emergency Departments at ESHT but this patient's family were not approached as the patient had a medical contraindication to donation. There were no recorded missed opportunities.

3.3. Training:

Since the last trust report, the organ donation team (SNOD & CLOD) have undertaken teaching sessions for the Foundation Year 1 & 2 doctors, anaesthetic trainees & consultants, ICU trainees & consultants & the theatre team at Conquest Hospital. Training covered organ donation, the role of the organ donation committee and the changes to the law surrounding organ donation, introduced in May 2020. The training was well received and it is planned to repeat this training and also expand it to cover groups not included this year.

3.4. Finances:

Hospital trusts receive financial support from NHS blood & transplant to support the work of organ donation and this covers funding for the clinical lead position (1PA) and organ donation committee expenses. The main proportion of the funding is allocated according to the number of proceeding donors in the trust for the previous year. The donor recognition funding is intended with the specific purpose of supporting future donation activity and how the funds are used is overseen by the organ donation committee. Examples of how the funds can be used include to support the development of critical care & ED family rooms, equipment purchases for the departments and artwork or memorials for proceeding donors. However, as the funding can potentially vary significantly between each financial year it makes future planning & budgeting extremely difficult, especially if remaining funds are not rolled over from each financial year. It also makes larger areas of financial support such as the development of relative's rooms or higher value purchases impossible.

In order for the Organ Donation committee to have greater flexibility and a degree of financial planning that extends over 1 year, the committee requests that the board reviews the allocation of donor recognition funds at the end of each financial year. To allow the organ donation committee to support larger scale projects within the trust, the committee requests that these funds are routinely rolled over, leaving any remaining funds available to support organ donation activity within the trust.

3.5. Publicity:

The COVID-19 pandemic has significantly impacted on publicity for organ donation across the UK. At the height of the first peak of infections, a decision was taken to limit publicity around the role out of the Deemed consent law in order that the public health messaging for COVID-19 was not impacted. Locally the organ donation committee, especially our volunteer member, has been working with the hospital communications team around social media content. The trust social media platforms hosted information during National Organ donation week and the team have been liaising with other organisations to tell the story of local donor families.

3.6. Tissue donation:

Unlike solid organs, the body's tissues do not deteriorate immediately after death, meaning that tissue donation can occur up to 48 hours after death. Tissue donation is therefore a way for a greater number of patients who would wish to donate after their death to have their wishes fulfilled. All families of deceased patients should be offered information on tissue donation as it may be possible for donation to proceed regardless of donor age and the general contraindications for donation can be screened for by the tissue donation team. In an effort to increase tissue donation rates within ESHT, the organ donation team have been liaising with the team in the bereavement office who have kindly agreed to include an information leaflet in each bereavement pack given to relatives following a patient's death. The team will monitor the effect on tissue donations locally over the next year.

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 and in a number of domains ESHT is now rated as exceptional when compared to UK performance. The exception to this is referrals for consideration of donation after circulatory death where the rate has dropped significantly due to the covid-19 pandemic.

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

Use of Trust Seal

Meeting information:			
Date of Meeting:	12th October 2021	Agenda Item:	12
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 between 1st June 2021 and 4th October 2021.

Sealing 72 – East Sussex County Council, 4th August 2021
Lease agreement for building at Egerton Park, Bexhill.

Sealing 73 – Cheesmur Building Contractors, 13th September 2021
Agreement for construction of First Steps Nursery, Conquest Hospital.

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.