EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on Tuesday, 8th February 2022 commencing at 09:30 via MS Teams

	AGENDA		Lead:	Time:
1.	1.1 Chair's opening remarks 1.2 Apologies for absence 1.3 Hero of the Month Award		Chair	0930 - 1015
2.	Declarations of interests		Chair	
3.	Minutes of the Trust Board Meeting in public held on 14/12/2021	A	Chair	
4.	Matters Arising	B		
5.	Board Committee Chair's Feedback (including written reports from each Committee)	C	Committee Chairs	
6.	Chief Executive's Report	D	CEO	

QUALITY, SAFETY AND PERFORMANCE

					Time:
7.	Integrated Performance Report Month 8 (November) 1. Quality and Safety 2. Our People – Our Staff 3. Access and Responsiveness 4. Financial Control and Capital Development	Assurance	E	CND MD COO CPO CFO	1015 - 1115

BREAK

STRATEGY

					Time:
8.	Board Assurance Framework Update	Assurance	F	DS	1130 - 1140
9.	ESHT Strategic Direction to 2025/26: 9.1 Digital Strategy 9.2 Clinical Strategy 9.3 Estates Strategy 9.4 People Strategy	Information	G	DS	1140 - 1145

10.	ESHT Green Plan	Information	H	DEF	1145 - 1155

GOVERNANCE AND ASSURANCE

					Time:
11.	Speak Up Guardian Report	Assurance	I	CPO	1155 - 1210
12.	Gender Pay Gap	Assurance	J	CPO	
13.	Ockenden Actions – Verbal Update	Assurance		CND	1210 - 1215

ITEMS FOR INFORMATION

				Time:
14.	Charity Annual Report and Accounts	K	CFO	1215 - 1230
15.	Use of Trust Seal	L	Chair	
16.	Questions from members of the public (15 minutes maximum)		Chair	
17.	Date of Next Meeting: Tuesday 12th April 2022		Chair	

Key:	
Chair	Trust Chair
CEO	Chief Executive
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

Steve Phoenix
Chairman

27.01.2022

Hero of the Month Awards

Meeting information:		
Date of Meeting:	8th February 2022	Agenda Item: 1.3
Meeting:	Trust Board	Reporting Officer: Steve Phoenix, Chair

November 2021

Galena Doneva, Surgery Division, Eastbourne DGH

Dr Doneva was nominated by David Jones, ACCS Speciality Doctor, who said:

“Today was an extremely challenging day in resus and we sadly had a death of a 24 year old female from bowl obstruction secondary to a cecal volvulus. The decision was taken, in coordination with the wishes of the patient's parents, not to operate on the basis of her multicomorbidity.”

“Dr Galena Doneva was superb in her support of ED, she 'owned' this patient, spent 5 hours with her, her family, liaising with medics, ICU and eventually palliative care.”

“When a patient dies we have only one chance to 'get it right'. Without Dr Galena Doneva this would have been near impossible.”

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 14th December 2021 at 09:30 video conference via Microsoft Teams

Present:
Mr Steve Phoenix, Chairman
Mrs Joe Chadwick-Bell, Chief Executive
Mrs Tara Argent, Chief Operating Officer
Mrs Vikki Carruth, Chief Nurse & DIPC
Mrs Miranda Kavanagh, Non-Executive Director
Mr Paresh Patel, Non-Executive Director
Mr Damian Reid, Chief Finance Officer
Dr David Walker, Medical Director
Mrs Nicola Webber, Non-Executive Director
Mrs Jackie Churchward-Cardiff, Vice Chair
Mrs Karen Manson, 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:
Mr Peter Palmer, Acting Company Secretary
Mr Josh Graham, Assistant Company Secretary (minutes)
Lucy Upton, CQC

Welcome

075/2021 **Chair's Opening Remarks**
Mr Phoenix welcomed everyone to the meeting.

Apologies for Absence

i. Mr Phoenix advised that apologies for absence had been received from:
Ms Lynette Wells, Director of Corporate Affairs

ii. **Hero of the Month**
Mr Phoenix reported on the winners of the Trust's Hero of the Month Award for August 2021 to September 2021.

076/2021 **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 Dr Walker declared an interest in the cardiology transformation plans.

077/2021 **Minutes**

The minutes of the Trust Board meeting held on 12th October 2021 were considered and agreed as an accurate record. This was subject to Mrs Kavanagh being added to the list of meeting attendees, from which she had been mistakenly omitted. The minutes were signed by the Chair and would be lodged in the Register of Minutes.

078/2021 **Matters Arising**

There were no formal matters arising from the meeting on 12th October 2021.

Mrs Chuchward-Cardiff asked whether there had been progress in extending opening hours for the discharge lounge. Mrs Argent confirmed that proposals were still being explored. Meanwhile, efforts were being made as part of the Winter Sparkle campaign to ensure maximum efficiency within operating hours as they were, and this included measures to recruit and retain staff.

079/2021 **Board Committee Chair's Feedback**

i. Quality and Safety (Q & S) Committee

Mrs Fadero highlighted the revised terms of reference (ToR) for the Q & S Committee which had been submitted for the Board's information.

Mrs Webber noted that clinical audit and research oversight had been transferred from the Audit Committee to Q & S but this was not referenced in the ToR. Mrs Fadero confirmed that clinical audit had been discussed at the Committee and agreed that this new focus would be added as an explicit area of focus within the ToR document.

The Board noted the report and approved the updated terms of reference.

People and Organisational Development (POD) Committee

The report was taken as read. Mrs Kavanagh added that there were some issues linked to operational pressures and staffing that would be detailed in the integrated performance report (IPR).

In response to a question from Mrs Churchward-Cardiff about the number of clinical apprenticeships, Mr Aumayer confirmed there were 84 at the time of the meeting.

The Board noted the report.

ii. Audit Committee

The paper was taken as read. Mr Patel advised that the finance team were entering a period of heavy workload in preparation for the year-end audit.

The Board noted the report.

iii. Strategy Committee

The paper was taken as read. Mrs Churchward-Cardiff advised that the Strategy Committee would next meet on 23rd December 2021. It was confirmed the cardiology and ophthalmology papers, which were on the meeting agenda as a separate item, had been submitted to the East Sussex Health Overview and Scrutiny Committee (HOSC).

The Board noted the report.

iv. Finance and Investment Committee

Mrs Webber reported that the F & I Committee last met on the 25th November. Planning for the second half of the financial year (H2) had been a main focus of discussions. Delivery of this was under considerable pressure for three reasons:

- £9M of Elective Recovery Funding from H1 was not expected to be replicated in H2. This was linked to the basis of calculation changing to clock stops.
- A reduction in block funding.
- Challenges linked to the operation of escalation wards.

The Trust had agreed a breakeven plan with the ICS. Activity was overall in line with or above H1 level and recovery would be an ongoing priority.

Month 7 financial performance was closed prior to finalising discussions with the ICS. The year to date position was a £1.2M loss but the expectation was would be recovered over the subsequent five months.

The Trust's capital allocation for 2021 had increased significantly in year from £24M to over £40M and this was causing pressure to deliver on spend. A significant proportion of programmes were expected to land in the final quarter.

Mrs Webber advised that an ESHT Capital Committee had been formed as a sub-group of F & I. This was to provide specific oversight of capital and delivery of spend. Slippage had been built into the agreed programme but it was expected that the fill allocation would be delivered in year.

Regarding the efficiency programme, a gap remained between the identified capital improvement programmes and target of £3.1M. It was noted that 69% of identified savings were non-recurrent and this presented a significant challenge for 2022/23 delivery.

F & I had also discussed the public sector decarbonisation opportunity and

were supportive of the Estates team pursuing the project.

Mrs Churchward-Cardiff commended the Estates team's efforts to spend capital during the year and the schemes undertaken. She added that the scrutiny provided by F & I offered a high level of assurance to the Board around capital process.

The Board noted the report.

066/2021 **Chief Executive's Report**

Mrs Chadwick-Bell thanked staff for their efforts and noted that balancing urgent care, planned care, good governance and strategic elements within the current climate was challenging.

It was confirmed ESHT would be participating in four pilot schemes. One of these was around data quality and presented an exciting opportunity to develop a robust, self-service model.

ESHT continued to work effectively with system partners and maintained a strong reputation across Sussex. Mrs Chadwick-Bell added that the ICS would develop into an integrated care Board (ICB) from 1st April 2022.

The previously mentioned Winter Sparkle campaign aimed to focus on staff wellbeing and some of the key operational objectives. Patient and staff safety were always the highest priority.

It was reported that that the formal consultation processes for ophthalmology and cardiology transformation plans had begun on 6th December 2021 and would end on 11th March 2022.

In response to the Omicron variant of Covid-19, the NHS as a whole had moved to incident Level 4. NHS Trusts had been asked to prepare for what was anticipated to be a highly challenging period as cases continued to rise.

ESHT was heavily engaged in delivering the Covid vaccination programme and had been asked to open patient-facing hubs. Mr Aumayer explained that two of these would be opened: one at Conquest and another at EDGH. The scale of these hubs was substantial in order to deliver as many booster vaccinations as possible. An area on each site had been identified where those being vaccinated could be kept entirely separate from hospital patients. Operation of the hubs would not interfere with the rest of Trust activity. Both hubs would need national approval and this had already been granted for the Conquest site. It was expected that approval for EDGH would soon follow. Once the two sites were operational, around 16,000 vaccinations could be delivered per week across them.

Waiting times were being well-managed. Only one patient had waited for over 78 weeks and that was for a specific reason.

Discharge was a major focus, with around three to four wards of medically ready for discharge (MRD) patients still within acute sites. Intensive work with system partners was underway but a capacity gap had become apparent. Innovative solutions would therefore be required to address the deficit and this had started with a reset of incident control. Eight work streams had been tasked with improving front door patient discharge.

Mr Phoenix asked what level of staffing would be required for the vaccination hubs and where it would be sourced. Mr Aumayer advised that publicly trained vaccinators would be deployed through the national protocol, meaning ESHT would not need to draw upon its own registered nurses. Allied Health Professions (AHPs) could also be recruited through the bank as required to facilitate the programme and overall there was confidence it could be delivered.

In response to a question from Mr Phoenix about whether the squeeze on Trust finances would impact upon the quality of patient care, Mrs Chadwick-Bell acknowledged the expectation that some elective activity would be scaled back. The risk, therefore, was around the Elective Recovery Funding (ERF) and a number of bids had been received. Any changes to operational plans would be discussed at ICS level. It was explained that most of the strategy was based on reprioritising activity rather than taking on more. Mr Reid noted that an effective system was in place for directly recharging costs linked to Covid and so setting up the vaccination hubs was straightforward in a financial sense. It was difficult so secure income for going above 89% clock stops, however, and this could present challenge.

In response to a question from Mrs Churchward-Cardiff about timescales for the Covid hubs, Mr Aumayer confirmed the expectation that they would be operational until the end of January 2022.

Mrs Churchward-Cardiff asked whether there had been any national level discussions around using Nightingale units for patients who had Covid or were non-acute. Mr Aumayer advised there were national concerns about whether Nightingales could be adequately staffed. Mrs Chadwick-Bell added the possibility of stepping up provision in the community sector to manage these challenges had also been explored but once again workforce was the bottleneck rather than space. As such, working with relatives of patients to support them in caring for people in their own homes (once they were ready for discharge) was important.

Mrs Churchward-Cardiff highlighted the Winter Sparkle section of the report and in particular a stated aim of reducing the need to reduce bed occupancy and asked what that meant in practice. Mrs Chadwick-Bell explained that additional wards would generate higher capacity and this benefit would be compounded by a concerted focus on reducing bed occupancy. She added that readmission rates would also need to be closely tracked. Mrs Argent referred to

the system developed out of the Lightfoot Report of monitoring patients who had a hospital stay of 14 days or more to prevent readmission wherever possible. Mrs Manson commented that from her experiences observed that the Trust was managing well in discharging patients with relatively simple needs but discharging those with complex needs was the challenge and required particular focus. Mrs Argent agreed and reported that work was being done with system partners to support discharge as much as possible. For example, providing training on drug administration to care homes. Mrs Chadwick-Bell added that discharge was an integrated system with a common goal and the Enhanced Care Homes Programmes was a vital facet in addressing the challenges noted.

The Board noted the Chief Executive's Report.

067/2021 **Integrated Performance Report for Month 7 (October)**

i. Quality and Safety

Mrs Carruth reported that October had been a busy month, with winter surge capacity opened on Devonshire, Glynde and Murray wards. Polegate ward at EDGH had been opened consistently to provide 30 extra beds. As such, the workforce had at times been stretched and this was a contributory factor to the increased falls rate.

Covid outbreaks had also caused enhanced levels of pressure and complexity, with staff needing to wear additional PPE to attend to patients.

A decrease in pressure damage was noted and this was a testament to staff working in difficult circumstances.

East Sussex had recently been confirmed as the upper-tier local authority with the highest Covid rate in England (733 compared to the national average of 473). Within that, the Hastings local rate was 803 and for Eastbourne it was 751. Numbers had come down slightly in the previous week to 670 for East Sussex but the national average had risen to 508. Mrs Carruth advised caution, however, as there was typically a lag between local population rates and any impact on services or attendance rates. Covid had overall caused a significant local impact and for the first time there had been a noticeable increase in rates for children under five years old and 10-14 year olds. In the latter group, local rates were twice the national average. A considerable number of patients required non-invasive ventilation and challenges were also being seen in maternity. Dr Walker added that the doubling time for infections stood at two to three days but it was hoped the measures being brought through parliament could increase this to seven days. The likely peak was expected to be 100,000 - 200,000 community cases per day but it remained unclear how this would translate into hospital admissions. ESHT had been asked to prepare for a peak

similar to the one form January 2021, which was the worst wave experienced.

Covid had also affected the workforce, with many staff needing to isolate due to contact with an infected individual or testing positive. Significant efforts were being made to recruit staff to surge areas and to fill other clinical vacancies. Fill rates were in general were challenged.

Patient feedback was generally very positive. Complaint response times for October were particularly low but had improved to 37% overall for November.

Rates of first and second dose vaccinations were generally at or just above the national England average. However, booster dose rates were slightly lower and particularly in the 40-65 year old age range. Most patients falling severely ill with Covid were part of this group. Mrs Carruth reported there was an ongoing effort to promote vaccination to protect against both Covid-19 and the flu.

Mrs Webber noted that staffing rates appeared to be impacting upon various IPR metrics. She asked whether anything else could be done to improve the vacancy rate or alternative solutions could be found to ease pressures on qualified substantive staff. Mrs Carruth agreed that overall performance was being affected but it was reassuring that this had not been reflected in quality of care. Regarding the vacancy rate, Mr Aumayer said this had in part increased because a number of new roles had been created. As well as investment in apprenticeships, work was underway to challenge models of care and bolster efficiency. Colleagues were only being asked to complete work at their highest qualified level to ensure the workforce was being as effective as possible. International recruitment remained essential and ESHT was supporting system partners in hiring staff through this route. This would help to develop flow from acute settings back into the community. Recruitment issues were expected to be long-term and so short-term fixes would not be enough. Mrs Chadwick-Bell added that demand was in many ways the root of the challenges faced and matching it to capacity. Expediting discharge would have a benefit across all areas under pressure. ESHT was focusing on pathway zero patients (those who did not require ongoing care after discharge) and those on long waits to make the maximum impact with available resources.

Mrs Churchward-Cardiff asked whether the plans for diagnostic centres would help to manage inflow volume for day-case patients. Even if there were no need for extra wards, there would still be issues clearing the backlog and achieving diagnostic targets, amongst others. Mrs Chadwick-Bell acknowledged the ongoing challenges in the areas outlined. She added that focusing on pathway zero patients, reducing length of stay and increasing day-cases would reduce pressure on beds.

Dr Walker reported that within the Trust there had been eight Covid deaths in October and 15 in September. These levels had since increased slightly.

The Summary Hospital-level Mortality Indicator (SHMI) had reduced since the previous Board meeting. Furthermore, the Risk Adjusted Mortality Indicator

(RAMI) had continued to improve and ESHT was in the top 20% nationally. Dr Walker explained that the large difference between the two indicators was due to coding differences, including across the two acute sites. This was a structural issue rather than omission and work was being done to achieve consistency. Crude mortality had declined in year and Dr Walker said this indicated that there was not an underlying fundamental mortality issue, despite the increased SHMI.

ii. Our People – Our Staff

The report was taken as read. Mr Aumayer advised that staffing flows had been reviewed to determine where additional roles could be made to support activity. ESHT was improving its proactive planning around workforce needs and shifts were being opened earlier. Drawing in temporary workforce was a potential gateway to recruiting substantively.

Mr Aumayer reported that one of the main staffing challenges was the short-term unavailability of colleagues due to sickness. The Trust had therefore relied on bank and agency staff to fill some roles.

The aforementioned initiatives to reduce bed occupancy and accelerate discharge would in turn lower staffing needs in certain areas. Being unable to place patients where they would ideally go also reduced efficiency of pathways.

It had sometimes been necessary to move staff to different areas where they were not rostered. This was not ideal but having flexibility was vital within such a challenging context to ensure safety. Mr Aumayer praised the commitment and attitude of colleagues who had responded to all that was asked of them.

Substantive staffing numbers had once again increased in the month. However, a greater turnover rate (up 0.4% to 10.5%) meant that despite 110 new starters the net impact was only 12.3 additional whole time equivalent (WTE) staff. A recruitment reset week took place in November to bring forward the start of some new staff. 125 start dates were booked during the week and this was an excellent achievement. 44 internationally recruited nurses were also due to begin employment with ESHT over the coming weeks.

Typically, ESHT held around 900 open recruitment actions on its system at any one time and all these were being delivered within service level agreements. Ongoing success with recruitment of consultants was highly encouraging.

Mr Aumayer noted that although the turnover rate was up, it was only 1% of the March 2021 level and 0.1% of the level a year previously. Around 10% of the turnover was due to the end of fixed term contracts and other Covid roles. Some staff preferred to work on an interim basis but where appropriate the Trust aimed to retain positions.

The vacancy rate had increased by 281 WTE posts, which was a 2.9%

increase for the month. This was largely attributable to increased funding of the emergency care pathway.

Reliance on temporary workers remained high. Significant levels of activity meant around 22,000 shifts were requested each month. This level had decreased slightly for the first time in seven months (except for AHPs and scientific staff). Fill rates were challenging due to the volume of requests but there were around 200 people being processed through the recruitment pipeline as temporary workforce.

Levels of staff sickness continued to be a concern, with sickness rates increasing each month of the previous six. Numbers of staff off with Covid or self-isolating were similar to those over Summer 2021. Mr Aumayer reported that stress, anxiety and depression were the most commonly cited reasons for absence but rates had reduced over the previous three months. This went against the trend for other Trusts in the system.

The announcement of mandatory vaccines had presented a new set of challenges. All staff required to go into a ward or clinic to undertake their role were now required to be fully vaccinated. 6230 ESHT staff were therefore in scope. 86% of staff were already double vaccinated and around 4% had only one vaccination. For around 10% of staff, their vaccination status was unknown. All colleagues within this category had been contacted so their status could be confirmed. Once this data was gathered, supportive measures would be put in place for those who would not be compliant with the new rules once they came into place on 1st April 2022. For those who were unvaccinated, they would need to have their first dose by early February at the latest if they were to become compliant in time. Overall, there was strong confidence that the number of staff impacted would be less than 10%.

Mrs Churchward-Cardiff asked what was in place to support staff in gathering the required evidence of vaccination. Mr Aumayer reported that an online portal had been created. For those with the NHS app, the travel pass provided within was acceptable proof. Vaccination cards were also permissible and work was being done to identify staff who were unable to provide evidence.

Mrs Manson noted that the Trust's staff turnover had risen slightly over the previous six months and asked how the rate compared with ICS and regional partners. Mr Aumayer confirmed that ESHT was at the same level or slightly better than similarly placed organisations. Moreover, the Trust's approaches to workforce health and wellbeing were widely recognised for their quality and innovation. Due to the age profile of the workforce, a degree of guaranteed turnover was inevitable. Continuing to develop outstanding recruitment was a high priority.

iii. Access and Responsiveness

The report was taken as read. Mrs Argent reported that the Trust was rated 12th nationally for its emergency department (ED) performance and this was a testament to the workforce.

Since its implementation the previous week, the Livi digital system had supported in redirecting patients who came in through 111 or the front door to urgent treatment centre (UTC) appointments where needed. The system also accommodated triage and could book GP appointments. On its second day of operation, Livi diverted 17 patients and ESHT was the first in the region to deploy it.

An e-triage system to facilitate patient self-check-in was also under development. This would redirect people to the relevant services, including their local pharmacy if appropriate. The electronic solution used to improve the flow of clinician to patient contact continued to be successful.

An increased establishment to the front door model had been agreed and a substantive recruitment was already seeing uptake. Lots of excellent candidates were showing a desire to work for ESHT.

Exit block had impacted upon performance and so part of the Winter Sparkle campaign focused on streaming patient pathways. Recognising staff for their work and involving them in the process was at the forefront of the planning process.

In the first week of Winter Sparkle, a reduction in patient length of stay had been achieved. Before the campaign, the average period between a patient no longer meeting the criteria to reside and being medically ready for discharge was 8.57 days. It had since reduced to 3.97 days, which was an encouraging outcome.

Elective delivery had been challenging and this was in part due to the previously mentioned workforce absences. A lack of anaesthetists and operating department practitioners (ODPs) was difficult to work around. Lists were frequently rearranged to maximise procedures within limitations.

Mrs Argent explained that theatre planning was reviewed six, four and two weeks in advance. Recently, a one week review was added to the system. Furthermore, patients were being moved to day case or local anaesthetic where this was possible.

Many high volume and low complexity procedures were being delivered in the outpatient arena, which exceeded the target of processing them as day cases. ESHT was still managing to deliver against its H1 trajectory and the Trust also had the lowest rate of over 52 week waits in the region.

A significant increase in diagnostic delivery had been achieved and additional

insourcing for echocardiograms would contribute to further step change. Rollout of the Trust's community diagnostic centre (CDC) was another positive step in this direction and there were benefits to moving this away from an acute site. In October, ESHT delivered against the 28 day faster diagnostic standard for the second month, which would support in achieving standards in areas such as cancer services. A Winter Director had been recruited to further improve day-to-day performance. A reimagined 'yellow form' system for doctors to instruct discharge over weekends had already provided successful outcomes.

Mrs Argent reported that ESHT was a pilot Trust for the Palantir system, which itself was part of the Foundry project. Palantir would sit above all existing clinical systems to provide a single view of activity that was waiting at clinician level and oversee harm reviews. Additionally, there would be notable data quality benefits. The system also offered a clear audit trail for when patients were moved. Mrs Argent explained it was the elective module being trialled but there was likely to have opportunity for leading the community discharge module as well.

Mrs Webber praised the progress made asked what assurance could be given that it would continue once Winter Sparkle ended. Mrs Argent responded that it had provided a framework to evaluate processes and reaffirm core priorities. This culture was sustainable and allowed the best possible use of resources.

Mrs Fadero asked what progress had been made in developing nurse-led discharge. Mrs Argent said some developments had been made but it was still not at the desired level. Recruitment was a major part of the picture as having enough nurses in the right places underpinned the initiative.

Mrs Churchward-Cardiff asked whether anything could be learnt from organisations which were performing strongly in urgent care and diagnostics. Mrs Argent explained that ESHT worked closely with its partners to develop best practice. Cleansing of waiting lists through Palantir would help achieve a marked difference. A company called Source had been commissioned to evaluate around 18,000 Trust pathways. There were likely to be some duplicates within the systems and these would be purged to drive efficiency. Chelsea and Westminster NHS had undergone a similar process to achieve positive results.

068/2021 Financial Control and Capital Development

Mr Reid confirmed that staffing numbers had increased by 498 people against the 2019/20 baseline. The most recent increase in establishment was a step of 282 WTEs. This encompassed recruitment based on the ED Nursing Review, four escalation wards and changes linked to H2 delivery (including enhanced care homes).

Establishments across medicine and ED were now at a level those departments could recognise. Previously, there had been consistent overspend

against a target that had not been fully signed into.

During months 1- 6 ESHT had performed relatively well compared to the national standard in terms of delivering against elective recovery funds; £9M of additional income had been secured. However, the standard had become based on clocks stops and this made delivery much more challenging. As such, the Trust was focused on achieving balance in H2 bids and funding escalation wards within them.

Mr Reid explained that three areas still needed to be addressed:

- £9M gap due to reduced elective income
- £4.5M gap against the escalation wards
- The expected delivery of £4M in efficiencies

ESHT declared a £1.15M loss in month seven and a further £0.4M loss was forecast for month eight. By the end of the year, it was anticipated the Trust would have achieved breakeven. This would require utilising £3M of reserves which had been built up over the first six months.

Mr Reid outlined the following pressures on Trust finances:

- Pay costs had increased, but this had been factored into modelling for the coming four months.
- Covid spending was expected to continue at the same rate, although a clear ceiling for this had been established. A reduction in Covid-related spending was expected from April 2022, but this was not linked to an assumption of infection rates dropping.
- Initial calculations found ESHT was £3.1M short of the full year plan on efficiencies. However, the following month this would fall to a £2.7M gap. This included a local stretch target of £1.4M. Against national reporting, ESHT was only £1.3M short.

Mr Reid reported that the Trust had been awarded extra capital and a plan of just over £40M was being targeted. Identified slippage had been built into the over planning margin. Overall, capital plans remained on track. Close monitoring of when goods would be delivered and when programmes conclude would continue. It was forecast that the target would be delivered during January 2022.

Mrs Kavanagh commended the executive team for their efforts and asked whether other Trusts were experiencing similar financial challenges. Mr Reid responded some areas were expected to be in deficit at year end but the ICS as a whole forecasted breakeven. Mr Reid acknowledged there were some risks to ESHT achieving what it had forecast, though, including Covid. Some difficult decisions would need to be made on holding some of the H2 award to cover gaps in staffing and core spends, but these would be agreed with the ICS.

Mrs Chadwick-Bell added that increases to establishment had been approved in previous years, especially around nursing, but this was not always accounted for in budgets and Covid had exacerbated challenges. Achieving a baseline position was therefore vital.

The Board reviewed the integrated performance report and considered the adequacy of controls and actions.

069/2021 **Learning from Deaths Q1**

Dr Walker reported that only one potentially avoidable death had been identified within the quarter. The number of deaths reviewed fell dramatically from the previous quarter, where a significant amount of Covid deaths sadly occurred.

It was noted that the number of deaths from the previous year (especially the final quarter of the year) would almost certainly need to be revised upwards. The Mortality Review Group routinely reviewed all serious incident (SI) reports where a death occurred to determine how avoidable they were. However, a number of SI reports linked to Covid outbreaks were only just being completed and would take time to assess.

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

070/2021 **Cardiology and Ophthalmology**

Dr Walker left the meeting, having declared an interest in this item.

Mr Phoenix explained that the paper brought to the meeting reaffirmed the Board's support for these proposals, which had been given on 30th November.

Mr Milner added that the East Sussex Health Overview and Scrutiny Committee (HOSC) had reviewed the proposals and determined that they would constitute a substantial variation to service. As such, a formal public consultation begun on 6th December. The Communications department within ESHT were working alongside their ICS counterparts to deliver a strong model of engagement. Once finalised, the consultation meetings would be clinician-led.

Mrs Manson asked whether the increase in Covid cases could cause the consultation process to be extended. Mr Milner said he did not expect they would be as long as it could be demonstrated that the meetings had been made as accessible as possible. ESHT was cognisant of previous judicial review challenges and a robust programme was being drafted, with a mixture of face-to-face and virtual meetings.

The Board:

1) Noted the 30 November Board reaffirmation of support for the transformation proposals
2) Noted the 02 December HOSC decision that the two transformation proposals constituted a "significant variation" from the current operating model
3) Acknowledged the ongoing work with ICS colleagues to determine the consultation roadmap and implications for ESHT during this timeframe

071/2021 **Mortuary Security Assurance**

Dr Walker re-joined the meeting.

It was highlighted by Mrs Carruth that there had been a copying error in the paper and that this would be amended before being resubmitted.

Mrs Carruth explained that recent events at an NHS Trust in Kent had prompted a nationwide review of mortuary access and post-mortem activities against guidance. A review of practises against the Human Tissue Act (HTA) had also been requested and a planned inspection would take place in February 2022. It was noted that this was not in response to any specific concerns.

All NHS Trusts were required to consider access provisions into their mortuary and the adequacy of CCTV provision. Furthermore, scrutiny was to be given as to whether DBS checks were applied consistently.

Mrs Carruth explained that the Board were being asked to review the evidence the Trust had gathered against the areas outlined and confirm whether it was satisfied that the responses were appropriate. Future updates and action plans would be brought to the Q & S Committee, with the Board's approval.

Mrs Churchward-Cardiff took assurance that the Trust did not permit sole-person attendance into the mortuary. She asked whether the swipe card system could determine when cards were used and by whom so this data could be periodically. Mr Hodgson confirmed that this functionality was operational. Additionally, three additional swipe card external doors had been added to the mortuary at EDGH.

Mrs Webber highlighted the statement "Maintenance team to be reminded that there is no access out of hours unless accompanied by a porter or On-Call APT throughout the visit," and that this implied the possibility of them obtaining access on their own. Dr Walker explained that all access was monitored by CCTV which was regularly reviewed. Combined with swipe card data, there would be clear evidence of any access in contravention of policy and disciplinary action would follow.

In response to a question from Mrs Kavanagh about whether staff were

required to hand over electronic devices before entering the mortuary, Mrs Carruth advised she would investigate and provide an update.

The Board:

1. Reviewed the evidence in response to the actions detailed and confirmed that they were satisfied that the appropriate responses had been taken to date;

2. Noted the upcoming HTA inspection visit in February 2022; and

3. Agreed that future updates regarding mortuary and body store processes and guidance should be reported to the Quality & Safety Committee along with an action plan as required.

072/2021 **Annual Reports for Noting**

i. Workforce Disability Equality Standard

The report was taken as read.

Mrs Webber asked how the actions listed in the report had been determined as the most impactful. Mr Aumayer responded that they had been drafted in conjunction with the ESHT Disability staff network. The Trust's health and wellbeing experts, along with the relevant network leads, had also agreed on the final outcomes. The actions encompassed the Trust's values and People Strategy.

In response to a question from Mrs Churchward-Cardiff about whether it was technically possible to include protected characteristic data fields within Datix for incident reporting, Mr Aumayer confirmed this was an adjustment that could and would be made.

The Board noted and accepted the contents of the data for submission.

Assurance was received from the WDES Action Plan that the actions will be progressed and the leads were committed to delivering results within the agreed timescales.

ii. Guardian of Safe Working Hours

The paper was taken as read and Dr Walker confirmed it had been discussed extensively at POD.

The Board gave support to Trainees to submit exception reports in keeping with their Terms and Conditions of Service, and act on any

grievance a trainee might raise with concern following discouragement or unfair denial of authorisation.

The Board provided reassurance that the pathway and procedures for all medical staff would be clear, simple and widely accessible.

iii. Safeguarding

Mrs Carruth advised that the paper had been discussed comprehensively at the Q & S Committee. She thanked all the Trust's named safeguarding doctors and nurses for their work in what had been a very challenging year where cases of domestic violence and child neglect had sadly increased.

It was noted that the Board had recently received updated safeguarding training at a recent seminar.

Mrs Churchward-Cardiff asked how staff felt about potentially reverting to telephone surveillance. She added that previously some health visitors expressed that without face-to-face interaction it was harder to evaluate concerns. Mrs Carruth noted that some families would deliberately put up barriers to entry. This included refusing to wear a face covering, having lots of people in the home or refusing to open windows. In these scenarios, staff had been given capacity to step up their PPE so visits could be safely facilitated.

The Board:

1. Supported the implementation and delivery of the actions outlined in the safeguarding work plan for 2020-2021

2. Supported the Safeguarding Teams contribution to the work undertaken by the Safeguarding Boards and the dissemination of learning and actions from presentations, case reviews and safeguarding audits.

iv. Complaints

Mrs Carruth confirmed this paper had also been discussed at Q & S. The Trust had streamlined and digitised its complaints procedure to ensure maximum efficiency.

Following the distortion to complaint types and rates in certain areas due to the pandemic, a lower baseline was now becoming established. Complaint response times were challenged over the summer and autumn but had improved over the previous few months.

Mrs Churchward-Cardiff asked whether responses from the Parliamentary and Health Service Ombudsman (PHSO) were shared and how lessons were learnt. Mrs Carruth confirmed that relatively few cases went to the ombudsman

and those upheld were shared. Mrs Fadero added that Q & S had oversight of complaints and processes. Complaint feedback to patients was being reviewed as an ongoing priority.

The Board received assurance from the report.

v. Nursing Establishment

Mrs Carruth advised a full discussion of the report had taken place at the F & I Committee. It was noted that the review related to ward areas and not all nursing.

Three options were proposed within the paper and the third was recommended. This entailed funding a small number of posts within an elective area. F & I approved it at a cost of just over £0.5M. It was not certain that the previous review and year were anomalous, which had factored into the decision.

The next establishment review was already underway, with data collected in November being evaluated. System benchmarking had begun and would be fed into the final paper.

Mrs Churchward-Cardiff asked whether the urgent care and cardiology business cases would fall into the budget setting process. Mrs Carruth advised that where considerable change was being proposed to a specialty or an establishment required considerable investment, then that would be brought as a specific and separate business case. Mr Reid added that ward nursing had to go through a formal process that was nationally mandated. He also noted that benchmarking would be key and that some staffing levels could down as well as up. Mrs Webber welcomed a broadening of benchmarking so the Board could be comfortable with overall establishment and staffing spend. Mrs Carruth confirmed a wider process would take place in close consultation with divisions.

The Trust Board acknowledged the contents of the report and noted that the investment request had been approved by the Finance and Investment Committee (28 October 2021). It was also noted that with regard to the other recommendations in the report, these would be taken forward for discussion by the Executive Team.

073/2021 **Disciplinary Procedure**

Mr Aumayer explained that a number of recommendations around disciplinary policies were made to NHS Trusts following a tragic incident in 2015 relating to an employee of Imperial College Healthcare NHS Trust. It was requested that these recommendations were taken through a board committee to provide

assurance of completion. ESHT did this in July 2019 but it transpired some other trusts had not. Resultantly, all trusts needed to reconfirm the process had occurred and ensure their disciplinary policies were published on their website. ESHT had complied with this directive and continued to review its policy periodically.

The Board noted that the ESHT Disciplinary Procedure was now available to the public.

074/2021 **Meeting Dates for 2022**

The Board noted the meeting dates for the Trust Board during 2022.

075/2021 **Use of Trust Seal**

The Board is noted the use of the Trust Seal since the last Board meeting.

076/2021 **Questions from members of the public**

Mr Phoenix confirmed that a number of questions had been received from Mr Campbell and would be responded to in writing.

Ms Walke noted that issues in maternity were highlighted during agenda item seven and asked what these were. Mrs Carruth explained they were linked mainly to Covid. Unfortunately, some pregnant people had fallen critically ill with the virus and a number of these individuals were unvaccinated. Mrs Carruth confirmed that there was now NHS clear guidance to pregnant people that they should receive the vaccine. Dr Walker added that sadly there had been misinformation about getting the vaccine during pregnancy on social media, but evidence in favour of vaccines for pregnant people and their unborn children was overwhelming.

Mrs Walke asked what consideration there was for increased transport costs for patients if certain services would be single-sited .She also asked whether patients who may be impacted by the ophthalmology or cardiology transformation plans had been notified they could participate in the consultation process and would be supported in doing so. Mr Milner responded that a number of ways to engage with those affected by the consultation were being explored and these would not be limited to a digital arena. There was a clear focus on addressing health inequalities and engaging with harder to reach patients. Mr Milner added that potentially higher transport costs for patients would also factored into decision making and support options explored.

077/2021 **Date of Next Trust Board Public Meeting**

The next meeting of the Trust Board would be on Tuesday 8th February 2022 at 0930.

Signed ……

Position ……..

Date ……

East Sussex Healthcare NHS Trust

Progress against Action Items from East Sussex Healthcare NHS Trust 14th December 2021 Trust Board Meeting

Agenda item	Action	Lead	Progress
071/2021	Mrs Carruth to confirm whether staff are required to relinquish electronic devices before entering into the mortuary.	**VC**	There has not been national guidance which advises staff should handover electronic devices before entering the mortuary. There are many other checks such as CCTV to see who is outside the door, rules against solo access and everyone having to sign-in on entry.

Strategy Committee Report to Board

Meeting information:		
Date of Meeting:	8th February 2022	Agenda Item: 5
Meeting:	Trust Board	Reporting Officer: Jackie Churchward-Cardiff

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 Strategy Committee last met on 23rd December 2021.

Key points discussed were:

1. **Community services and integration.**
   As an integrated Trust, ESHT has more opportunity for integration and has been successfully working with local partners to remove organisational barriers and improve access to services. However, since Covid the patient acuity has increased, adding to workloads and as such requires more experienced staff to assess and meet care needs. The committee requested that the vision for community services is articulated through their business plans and includes reimaging the totality of services. The division is also developing KPIs for the services, an implementation plan and a workforce strategy. There will need to be an assessment of risks to services and an investment plan. Overall, the community took assurance on the scale and focus of the community teams.
2. **Clinical Strategy**
   The final clinical strategy was presented and positive feedback given. This is a large piece of work and complex in places. The committee were assured that attention is being given to engaging with stakeholders to articulate key and fixed points.
3. **Digital Strategy**
   The final digital strategy was presented. It was emphasised that digital is a way of working applicable to the whole trust. As such communication and engagement will be key to developing an implementation plan. This will also require board support and investment prioritisation. The next steps will finalise risks which cover time, skills and resource.
4. **Estates Strategy**
   The estates strategy was presented and included timelines for the HIP2 BFF hospital redevelopment. A high-level road map would help staff understand the phases. There will be a need to further understand and rationalise community premises and also respond to changes in work patterns such as agile working. Estates also lead on the Green Plan which will be brought to the committee as a separate item.

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

N/A

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

The board is invited to note the report.

Audit Committee Report – 27th January 2022

The Audit Committee last met on the 27th January 2022.

Update on Outstanding Digital Actions
A significant number of actions recommended by internal auditors had been completed since the previous meeting. These mainly related to business continuity but there had also been developments around cyber maturity and telecoms. Many software suppliers were now providing specific disaster recovery plans as part of the subscription charged to the Trust. Evidence of these plans was requested annually so ESHT could assess their robustness.

Security Annual Report
ESHT was fully compliant with all legislation around security. As across most of the healthcare sector, there had unfortunately been increased levels of assault (both physical and verbal) within the Trust. Various work streams were in place to address the issue in conjunction with staff governance and HR. Renewed efforts to purse sanctions and redress against offenders continued. Increased deployments of body worn cameras meant around 300 incidents per month were now being filmed. ESHT maintained strong relationships with local police.

Information Governance Toolkit Update
85% of staff had completed the information governance e-learning module. Specialist training was being explored for staff whose job role involved processing subject access requests.

Internal Audit Update
It was noted that despite impending plans for the NHS to come out of business continuity measures, this would not mean an immediate return to normal operational conditions. This was in part why several audits had been postponed. However, internal auditors assured they would be able to deliver a meaningful audit opinion by the deadline.

Internal Audit Plan for 22/23
A key focus for the coming year would be evaluating the Trust's data quality framework. A varied mix of discretionary risk based audits would take place, including an assessment of mortality indices coding to determine why there was some disparity between them.

External Audit Report
A report was presented to highlight key deliverables for the upcoming year. Early planning and testing would commence in February. The Trust's charitable fund accounts had been audited and no issues were discovered. They would imminently be submitted to the Charity Commission. Finance staff had been invited to attend the Chief Accountants' Workshop so they could be updated on key changes or issues. This would also support in streamlining the production of final accounts and the audit process.

Anti-Crime Specialist (ACS) Service Update
A number of alerts and publications had been issued since the previous meeting. Many of these related to Covid and they had been circulated within the Trust to staff in key positions. A number of webinars would be offered to ESHT, including one on security management, to ensure implications of current and future legislation were clear.

Paresh Patel
Chair – Audit Committee

Quality and Safety Committee Report – 20 January 2022 Meeting

Due to operational challenges attendance at the meeting on 20 January 2022 was restricted to the Chair, Amanda Fadero, Non-Executive Director – Karen Manson, Medical Director – David Walker, Chief Nurse – Vikki Carruth, Head of Governance – Lisa Forward and those attending to present papers.

- Patient Safety and Quality Group – increase in category 2 pressure ulcers which is being reviewed.
- CQC – 2 contacts relating to Maternity and Infection Prevention and Control. Information sent back to the CQC and further contact/discussion offered.
- Infection Prevention & Control Board Assurance Framework – Quarterly Ventilation Safety Group set up to manage ongoing ventilation concerns. Nervecentre Team developing method of recording decision making on NerveCentre. Advice being sought regarding impact on NHS settings of revised national guidance.
- Quality & Safety Exception Report – Dec 21 data. Commendable performance given workforce challenges with no specific areas of concern and a continuing good reporting culture.
- Maternity – continuing impact of midwifery staffing absences and increase in retirements, resignations and reductions in hours of work. Funding bid submitted for fixed contract role to address workforce issues. Assurance received that despite workforce challenges level of safety and harm had not been seen to deteriorate.
- Maternity - Ockenden Progress Report – 5 Immediate and Essential requirements remaining open but good progress.
- Safer Staffing – staffing noted to be safe but fragile with particular challenges at EDGH. Quality metrics holding steady despite this.
- Covid-19 Recovery – continued downward trend in the numbers of patients waiting. Some challenges in specialties but patients under constant review. 31 January 2022 would see the standing up of some routine elective work that had been stood down in case of surge. New software system (Foundry) being rolled out to improve management of wait lists.
- High Level Risk Register – Balanced position being held despite operational challenges.

Amanda Fadero, Chair – 31 January 2022

Finance and Investment (F & I) Committee Report – 27th January 2022

The F & I Committee last met on the 27th January 2022.

Governance

- The Committee discussed the appropriateness of separating BAF6 to reflect the different challenges associated with delivering 21/22 outturn and thereafter subsequent years (in particular the pressure of convergence). Executives were to consider and propose an approach to the Board.
- BAF 7 and 8 were considered and it was noted that actions could be updated.

Operational financial performance

- Headlines remain consistent month on month, with the Trust forecasting to break even in 21/22.
- Detailed review by the estates, digital and finance team gives confidence that the capital budget will be delivered in year. To allow for unforeseen slippage, ESHT has requested that £1m of funding is deferred to 22/23, giving a buffer to delivery. Undoubtedly delivery remains challenging, with the Committee noting that the run rate of spend needs to increase markedly in the final quarter of the year (from c£2m pcm to c£5m pcm).
- It is expected that the efficiency plan will be delivered in year. The Committee noted that the majority of efficiencies are non-recurrent.

Financial strategy, transformation and sustainability

- The Committee was updated by the finance team on the 22/23 planning guidance
- The key movements between 21/22 and 22/23 were discussed, and the bridge between years was considered. At present there is considerable risk to delivering a break even position next year. Particular areas to note are the challenge to the Trust if it continues to require escalation areas to remain open, and the need to secure additional funding to deliver proposed recovery trajectories.
- The Trust considered the proposed scope of benchmarking work which it is anticipated will help support the Trust in driving future transformation and identification of efficiency opportunities.
- The draft 22/23 capital plan was acknowledged as being materially complete and it is anticipated that an additional committee session will be scheduled during February in order to review this in detail and to recommend a final plan to this Board. It is hoped that additional scrutiny prior to the commencement of financial year 22/23 will facilitate delivery of the plan.
- The Committee acknowledged the estates team's success in successfully receiving an offer of grant funding in relation to the Public sector decarbonisation scheme. This grant will enable the Trust to bring forward significant BFF and backlog works, funded via a non-repayable grant (giving a significant PDC saving when compared to alternate funding options), as well as help deliver the Trust's green agenda. The Board will need to consider the full business case in due course and, if appropriate, approve receipt of these funds.

Business cases, capital and project approvals

- The Committee approved the CRG recommendation that spend of £600k be made on refreshing digital hardware (part of an ongoing cycle of updating hardware, started during 20/21).
- The Committee approved the spend of £850k on Westham Ward. The Committee requested that a paper be presented at a future meeting to set out the relevant process where projects increase in scope from that originally anticipated and new financial thresholds are exceeded (relevant to this project and also the CDC). It was noted that new processes involving clinical representation and leadership earlier in the project should reduce the frequency of this going forwards.

Other

- The work programme was noted, as were the minutes of the FEC, Capital Committee and CRG.

Nicki Webber
Chair – F & I Committee

Chief Executive Report

Meeting information:			
Date of Meeting:	8th February 2022	Agenda Item:	6
Meeting:	Trust Board	Reporting Officer:	Joe Chadwick-Bell, CEO

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:

Introduction

Since the last Trust Board meeting we have managed the Trust through one of our busiest periods and with the expected Omicron surge the teams have been focused on ensuing we had good plans in place should the Covid numbers increase in line or in excess of last year and as you will have heard in the press the expected staff absences. Fortunately the anticipated number of Covid admissions have been more aligned to the first wave in March 2020 and with the benefit of vaccines we have seen a smaller number of patients requiring critical care, although staff absences have been higher and colleagues will touch on this through their performance updates. That said we have been able to maintain most services and ensure safer staffing levels have been achieved.

I'd like to take this opportunity to thank all of our staff who have been working hard to ensure we continue to deliver safe services for our patients. We have worked hard to maintain as much planned care activities as we can and although the Covid numbers remain the highest we have been since last winter we are now planning on resetting ourselves with an increased focus on recovery. I'd also like to thank system partners who have their own challenges, but we have demonstrated our commitment to working together to deliver the best care that we can for our local residents.

I'd like to thank colleagues who have led, set-up and delivered our patient facing vaccination hubs at Eastbourne DGH and Conquest, closely followed by the roving vaccine services. Some staff were redeployed and trained to consent and deliver vaccines and they deserve recognition for they pragmatic approach, meeting the NHSE governance requirements and their dedication to ensure the public were vaccinated before the end of 2021.

I met members of the voluntary team this week at Eastbourne and I'd like to extend my thanks to all of our dedicated volunteers.

Strategy

The Trust with our CCG colleagues are currently consulting on the proposed service changes for Cardiology and Ophthalmology. The consultation is due to finish on 11th March 2022, we would encourage as many people

to look at our website where they can find details of the service options and models of care as well as details on how to provide feedback. We would like to thank those who have attended on of the events so far and those booked into future events, as well as those who have provided feedback, people views are important to us in order to help us make decisions in due course.

As you may recall, the Trust agreed to take ownership of the private Spire Hospital on the Conquest site last year, and we will be formally taking over the running of the hospital from 1st April.

- It'll be run as a ring fenced division called Sussex Premier Health, which will be owned by the Trust, and will continue to deliver outstanding private healthcare to patients.
- Sussex Premier Health will include, not just the services provided by Spire at Hastings, but the existing private services provided by Michelham at Eastbourne and Bexhill. Although it will have a new name, the services, members of staff and consultants at these units will remain the same.
- As part of the Trust, the profits generated by Sussex Premier Health will be reinvested back into the NHS. This is an exciting opportunity for us and allows us to expand the choices available for patients.

Estates

Whilst most of the leadership team have been focused on responding to the winter and pandemic Conquest Cardiology Cath Lab is being refurbished with construction due to finish in early February before the new equipment is installed

- The build for the new catheter lab at Conquest is well underway with an expected completion of February which allows the new lab to be installed with an expectation that it is operational Mid-April.
- The last stages of the extension to the Conquest emergency department is underway with a new modular building due to be completed in early April, this will bring much needed accommodation for clinical teams
- The emergency department at Eastbourne has seen some developments over recent years and there will be some further developments to make best use of the space and these are due to complete in May.
- A new recovery area is being built at EDGH which enables the day surgery theatres to have a dedicated day unit which will allow for an increase in elective capacity, which can be kept separate from the ward areas support the recovery programme, due to complete early May.
- Westham ward is being refurbished to create red and green bays and is due to be finished in early April

The Executive Team and divisional leads are currently working through the three year capital plan which is hoped will take us through to funding which would then be made available through the Hospital Development Programme.

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

For the Period November 2021 (Month 8)

Content

East Sussex Healthcare NHS Trust

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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	1037	1061	Common Cause	
Serious Incidents	M	4	3	Common Cause	
Never Events	M	0	0	Improvement	
Falls per 1,000 bed days	5.5	7.1	6.3	Common Cause	Inconsistent
Pressure Ulcers, grade 3 to 4	0	2	3	Common Cause	Inconsistent
MRSA Cases	0	0	0	Improvement	Consistently Hit
C diff cases	<5	1	5	Common Cause	Inconsistent
MSSA cases	M	2	3	Common Cause	
RAM	94	85.6	84.7	Common Cause	Consistently Hit
SHM (NHS Digital monthly)	0.99	0.99	0.97	Common Cause	Consistently Hit
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	89%	90%	Common Cause	Consistently Missed
Nursing Fill Rate (Including Escalation)	100%	83%	90%	Common Cause	Consistently Missed

Patient Experience	Target / Limit	Last month	This Month	Variation	Assurance
Complaints received	M	38	35	Common Cause	
A&E FFT Score	M	94%	101%	Common Cause	
Inpatient FFT Score	M	99%	99%	Common Cause	
Maternity FFT Score	M	98%	98%	Common Cause	
Out of Hospital FFT Score	M	98%	99%	Common Cause	
Outpatient FFT Score	M	99%	99%	Common Cause	

Our Performance	Target / Limit	Last month	This Month	Variation	Assurance
A&E 4 hour target	>95%	73.9%	73.8%	Concern	Consistently Missed
A&E Non Admitted	M	81.8%	80.9%	Concern	
A%E 12 hour from Arrival	M	330	403	Common Cause	
UTC 2 hour	>98%	62.6%	53.0%	Concern	Consistently Missed
Cancer 2ww	>93%	97.5%	0.0%	Common Cause	Consistently Hit
Cancer 62 Day	>85%	73.3%	0.0%	Common Cause	Consistently Missed
62 day Backlog	M	156	149	Improvement	
104 day Backlog	M	34	27	Improvement	
RTT under 18 weeks	>92%	75.1%	74.3%	Common Cause	Consistently Missed
RTT 52 week wait	0	50	52	Improvement	Inconsistent
RTT Total Waiting List Size	36,833	37,005	36,152	Concern	Inconsistent
Overdue P2	M	252	219	Common Cause	
CHIC within target wait time	M	83.8%	88.6%	Common Cause	
Diagnostic <6 weeks	<1%	17.7%	17.6%	Improvement	Consistently Missed

Our People	Target / Limit	Last month	This Month	Variation	Assurance
Establishment (WTE)	M	7,910.8	7,979.4		
Vacancy Rate	<5%	9.2%	9.4%	Concern	Inconsistent
Staff Turnover	<9.9%	10.5%	10.4%	Concern	Inconsistent
Retention Rate	>92%	92.5%	92.0%	Common Cause	Consistently Hit
Sickness - Absence % (rolling 12 mths)	<4.5%	5.2%	5.3%	Concern	Consistently Missed
Sickness - Average Days Lost per Fte	<16	19.1	19.4	Concern	Consistently Missed
Staff Appraisals	>85%	73.3%	73.8%	Concern	Consistently Missed
Statutory & Mandatory Training	>90%	89.1%	89.4%	Improvement	Consistently Missed

Our Productivity	Target / Limit	Last month	This Month	Variation	Assurance
4 hour theatre sessions	M	461	524	Concern	
Average Cases per 4 hour session	M	2.4	2.3	Common Cause	
Clinic run rate	M	82.3%	85.3%	Common Cause	
Non Face to Face Outpatients	>25%	29.6%	29.0%	Concern	Consistently Hit
Elective Length of Stay	2.7	2.5	2.4	Common Cause	Inconsistent
Non Elective Length of Stay	3.6	4.2	4.4	Common Cause	Consistently Missed

Executive Summary

- 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.
- We are ranked 48th (out of 113 Trusts) in terms of our overall ED performance, in-line the national average of 74.1%. It is acknowledged that this is not where we would want to be but we are continuing to invest in our Emergency Departments and ESHT continues to be one of the highest performing Trusts in the region.
- Cancer performance remains challenged. There continues to be an increase in cancer referrals and managing these referrals is a key focus for the Trust to ensure patients are seen in line with national guidance. Future delivery of the cancer standards is dependant on timely diagnostic tests and procedures as well as the reliance on other tertiary providers to support with consultations, complex diagnostics and procedures which are not undertaken at ESHT
- Whilst not yet achieving the H2 ask for 89% of clock stops against our 19/20 figures there is significant improvement this month within this target; In November we are reporting 85% of clock stops against the 89% ask, compared to 78% in October. Financial and workforce pressures in the coming months are both a risk to the delivery of the elective programme . The Trust will continue to work towards and ensure patients are waiting well, but it should be recognised that the aforementioned are limiting factors to delivery.
- There has been a continued increase in non-elective LoS which is as a result of the current pressures on the care market limiting capacity for discharges. Patients are being delayed into community rehabilitation beds due to the increase demand of patients who are requiring bedded rehabilitation and also the complexity of those cases. We continue to work with our system partners on how we can ensure that we maintain flow and reduce the LoS in the acute setting and get the best for our patients.
- Our recruitment and retention has improved, for both substantive and temporary workforce alike. Although stabilising, the Trust continues to rely on temporary staff to support current activity levels and operational pressures.
- YTD favourable income position of £8m, variance is driven by ERF, the effect of the back dated pay award in H1 and Divisional income under-performing.
- Our pay cost variance has reduced by £0.8m to £8.1, driven by a pay award of £4.3m and use of temporary staff. Temporary staff costs are £30.6m YTD
- Non-pay costs continue to exceed budget, mainly driven by tariff excluded drugs and devices above plan by £2.5m, some of this is offset by higher tariff drug income.
- A net risk of £4.5m has been identified against mitigations of £5.0m, suggesting that based on current information that whilst the Trust will face very significant challenge to deliver a balanced position it should be deliverable.
- The Covid position continues to support the trusts overall financial position with an effective YTD contribution of £13.4m (£17.8m income).

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

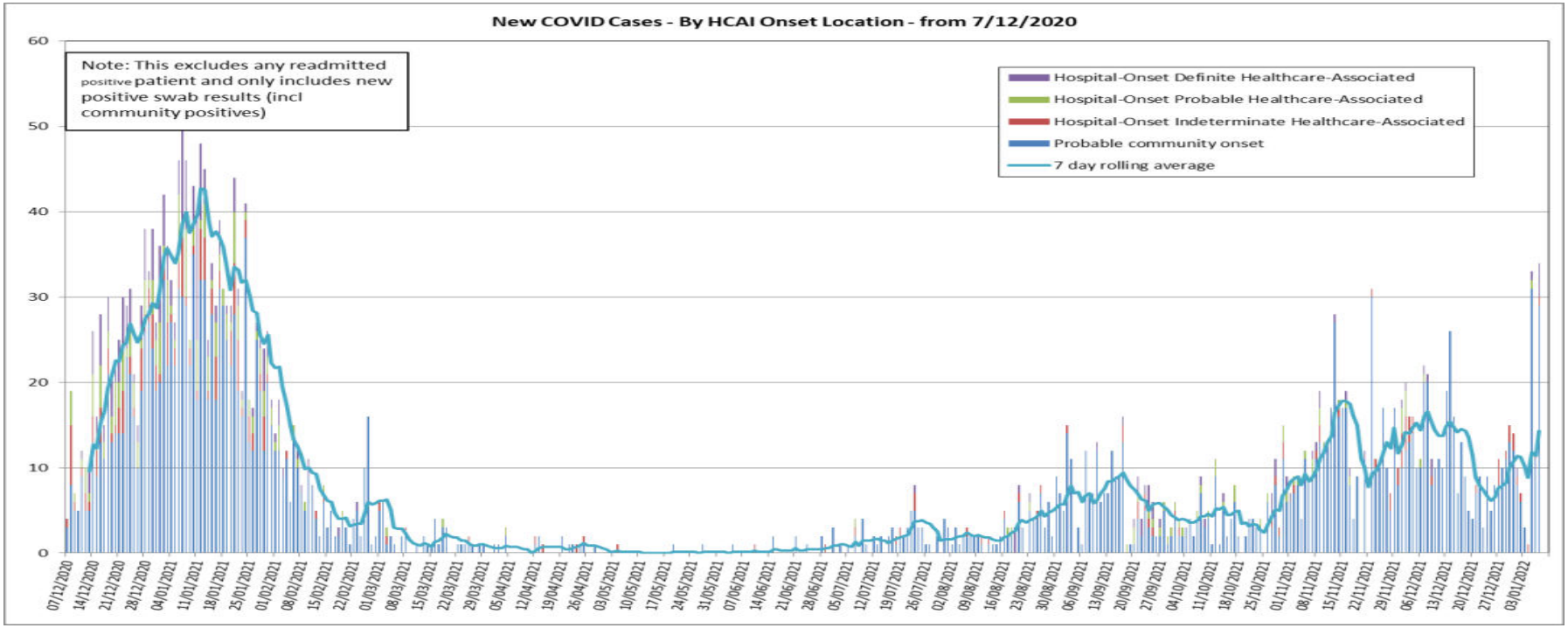
			Author(s)
Quality and Safety **November 2021 data**	**COVID - 19** The prevalence of COVID in the local population was (and is) increasing with a higher rate in all areas of East Sussex. than the national level. The highly infectious Delta variant was still the dominant strain at that time. There were two small outbreaks of COVID during Nov. **Infection Control** The limit of CDI was exceeded in the first two quarters of the year but numbers were back within limits in October and November. At month end, 47 cases had been reported against a limit of 38. All specimens were ribotyped and there is no evidence of an outbreak. **Incidents** • 3 SIs were reported in November and incidence remains within normal variation • Challenges remain for divisions to complete SI investigations and reports within 60 days **Pressure Ulcers** There was a notable increase in the total number of PUs reported in November especially category 2. A deep dive is underway and will feed into the PS&QG. Three category 3 pressure ulcers were reported in Nov. 2021 (1 CQ, 1 BIU & 1 patient's own home). **Falls** November saw a slight reduction in falls with one severity 3. Significant additional/new capacity remained open (avge 90 beds over 5 areas) impacting on nurse staffing levels with resources still very stretched. Recruitment to surge area continues.	**Patient Experience - Complaints/Friends & Family Test (FFT)** Teams continue to work through the backlog of complaints from wave 2 with ongoing challenges to response times albeit with some improvement. FFT submissions still remain lower than pre-COVID but with recommendation rates very high ranging between 98.01% and 99.04% for A&E, Inpatient areas, Maternity and Outpatients. It is hoped that a digital option for FFT will be available soon which will give patients the option to provide feedback in other ways. **Nursing & Midwifery Workforce** The requirement for significant amounts of additional capacity continues. Nurse staffing in November continued to be stretched in most areas which may have had an impact on some of the key quality metrics as well as on staff morale in some areas. System benchmarking and sharing of safer staffing methodology for nursing to ensure consistency across Sussex has been delayed due to increasing operational pressures but will continue. This will support the 2021/2022 Nursing Establishment Review. **Mortality** Both SHMI and RAMI indices of mortality remain better than peers. SHMI has decreased this month and RAMI remains in the top quartile across NHS England Acute Peers. Depth of Coding has improved at Eastbourne.	 **Vikki Carruth** Chief Nurse and Director of Infection Prevention & Control (DIPC)  **David Walker** Medical Director
Actions:	Deep dive into cat 2 PU damage in Nov		

COVID-19

East Sussex Healthcare NHS Trust

Prevalence

The rate of COVID in parts of East Sussex was greater than the England rate. Prevalence of COVID in the local community increased in all areas. At the 29th of November East Sussex had a positivity rate of 640/100,000 compared to the England prevalence of 440/100,000. The prevalence continues to increase.



Outbreaks and Serious Incident Investigations

There was a small outbreak of COVID in maternity relating to a positive person who was unvaccinated with subsequent transmission to two other women in the same bay. Seven other contacts were identified and contacted with advice in line with national guidance. There was also a small outbreak on the gynae ward in the medical escalation bays which was managed within national guidance. Outbreaks are reported nationally and the lessons learnt discussed at the multi-disciplinary outbreak meetings. If an outbreak meets criteria for serious incident this is taken via the patient safety meeting.

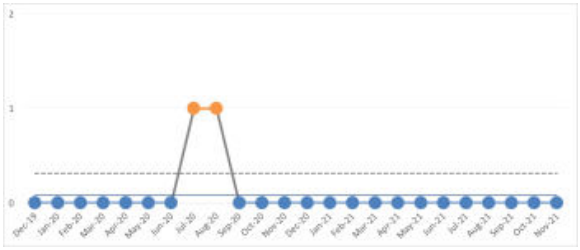
Safe Care - Infection Control (non COVID)

East Sussex Healthcare NHS Trust

Quality and Safety

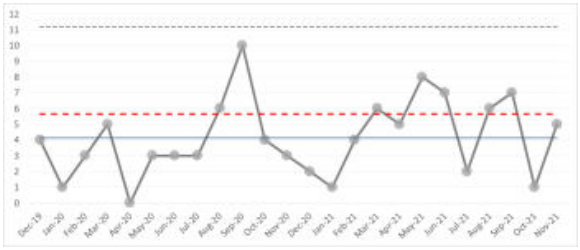
MRSA cases

Target: 0
Variation: Normal
Current Month: 0



CDIFF cases

Limit: 5.66
Variation: Normal
Current Month: 5

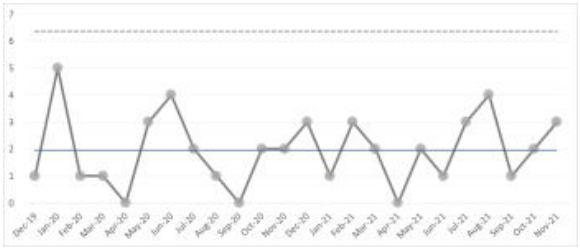


CDIFF per 1000 bed days

Monitoring
Variation: Normal
Current Month: 0.2

MSSA

Monitoring
Variation: Normal
Current Month: 3



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

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

Clostridium Difficile Infection (CDI)
For the month of November, 5 cases of CDI were reported against a monthly limit of 5. Of these 5 cases, 3 were reported as a HOHA (Hospital Onset Healthcare Associated), and 2 cases being reported as a COHA (Community Onset Healthcare Associated). Post infection reviews are being arranged.

National reporting of CDI per 1000 bed days has been suspended to reflect organisations need to flex bed numbers during the pandemic.

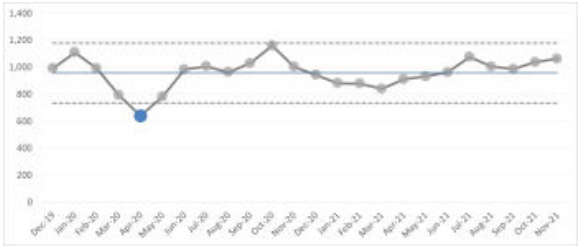
MSSA bacteraemia
In November the trust reported 3 hospital attributable MSSA bacteraemias of which, two were assessed as possibly avoidable. One case was a possible line related infection. Patient had cannula removed and replaced, with twice daily monitoring. Patient also received antibiotic treatment.
The second hospital attributable case was of an unknown source.

Safe Care – Incidents

East Sussex Healthcare NHS Trust

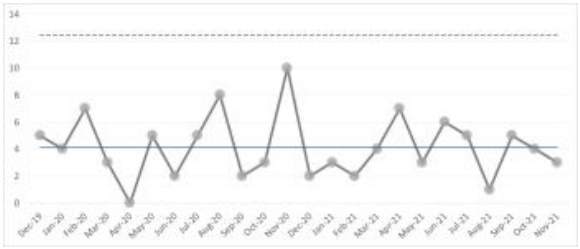
Quality and Safety

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



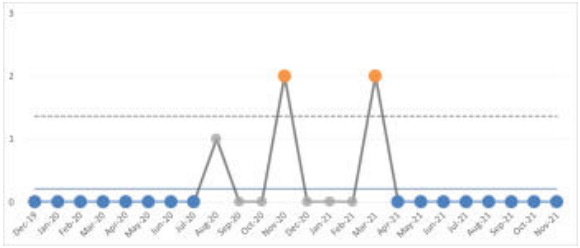
Monitoring
Variation Normal
Current Month: 1061

Serious Incidents (SIs)
(Incidents recorded on Datix)



Monitoring
Variation: Normal
Current Month: 3

Never Events
(Incidents recorded on Datix)



Monitoring
Variation: Normal
Current Month: 0

Author:	**Lisa Forward – Head of Governance**
Status Report	Of the 1061 – 915 are **ESHT only** incidents: 611 x severity one 282 x severity two 20 x severity three 0 x severity four 2 x severity five (both Covid outbreaks) **Top four locations**: • Patient's Home (108) • Emergency Dept CQ (57) • Emergency Dept EDGH (50) • Delivery suite (36) Top categories remain Slips/Trips/Falls with 146 incidents, Diagnostic Services with 82 and Medication incidents with 81. All categories had a decrease in incidents. There were 3 SIs reported in November: • 1 x Delayed cancer diagnosis • 2 x Covid outbreaks
Challenge & Risk:	Completion of SI investigations remains challenging due to workforce shortages and operational pressures, although the number open has reduced slightly. There is slow progress of the Implementation of PSIRF* which remains a concern. Education is the most significant challenge.
Actions:	Previous gap analysis against the short and medium term priorities for PSIRF* have been updated. *Patient safety Incident Response Framework

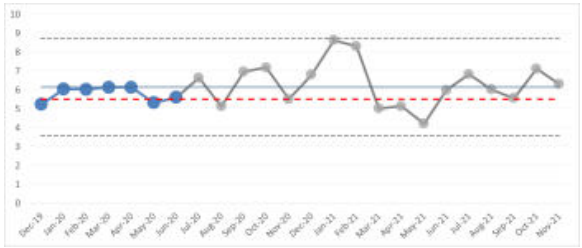
Safe Care – Falls

East Sussex Healthcare NHS Trust

Quality and Safety

Total Falls Per 1000 bed days

RCP National Average: 6.6
(RCP – Royal College of Physicians)
Internal Stretch: <5.5
Variation: Normal
Current Month: 6.3

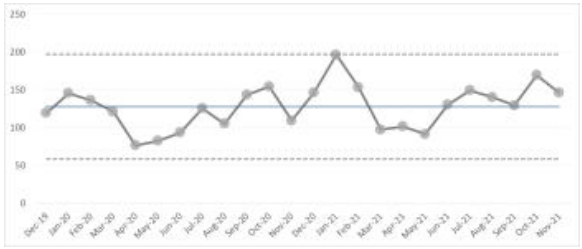


Falls with Harm Per 1000 bed days

Monitoring
Variation: Normal
Current Month: 1.7

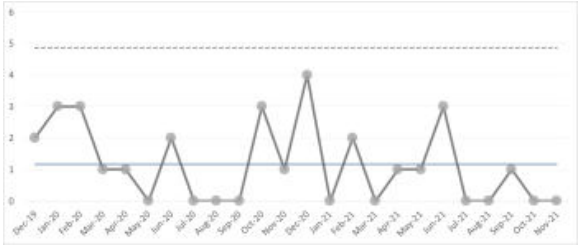
Total Falls

Monitoring
Variation: Normal
Current Month: 146



Major or Catastrophic Falls

Monitoring
Variation: Normal
Current Month: 0



Author: **Lisa Forward – Head of Governance**

Status Report

Recent months have continued to be very challenging due to ongoing pressures with significant new additional and escalation capacity open of circa 70 -100 beds. To ensure safety and support continuity, substantive areas continue to deploy staff to the new areas whilst recruitment continues. Despite best efforts, it is not always possible to backfill, leaving many gaps at times with reduced ratios and skill mix.

1 x severity 3 fall on Baird Ward

Top locations :

- Irvine Unit (15)
- Benson Ward (12)

Challenge & Risk:

The significant additional capacity and impact on nurse staffing is likely to have an impact on falls especially for higher risk patients many of whom require enhanced observation (1:1 care) or two staff to help with mobility and personal care.

Actions:

- Recruitment continues for new surge areas and resulting vacancies on other wards due to internal movement of staff.

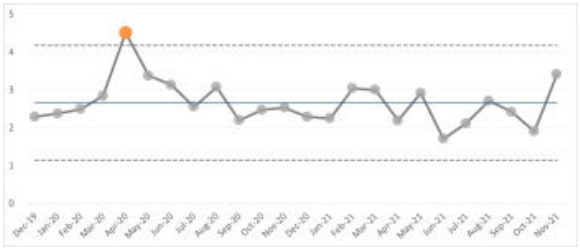
Safe Care - Pressure Ulcers

East Sussex Healthcare NHS Trust

Quality and Safety

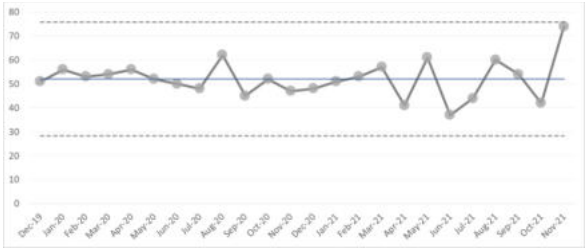
Pressure Ulcers (PUs) Per 1000 bed days (Grade 2,3,4)

Monitoring
Variation: Normal
Current Month: 3.3



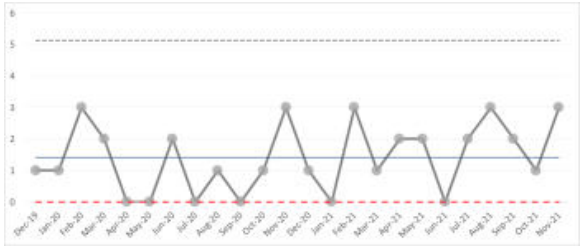
Pressure Ulcers Category 2 (inpatient and community)

Monitoring
Variation: Normal
Current Month: 74



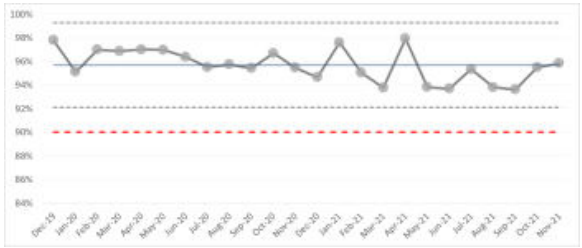
Pressure Ulcers Category 3&4

Monitoring
Variation: Normal
Current Month: 3



Pressure Ulcers Assessment Compliance

Target: 90%
Variation: Normal
Current Month: 95.8%



Author:	**Tina Lloyd, Assistant Director of Nursing - Corporate**
Status Report	There was a notable increase in the total number of Cat 2 PUs reported in Nov 2021 (total of 74 in November compared to 45 in October). A deep dive is underway and will report to PS&QG. Despite the increase in bed numbers and occupancy, the rate of PUs reported remains within expected control limits which is a credit to staff. Three category 3 PUs were reported in Nov. All were previously reported PUs that have been recoded; 1 in ICU CQ, 1 (foot) in patients own home and 1 (back) Bexhill Intermediate Care Unit. Of those audited, the compliance of patients with completed PU assessments is 95.8%. The Pressure Ulcer Review Group continues to oversee incidents to determine if there are any contributory lapses.
Challenge & Risk:	This data may change in the future due to reassessment/validation of damage that may deteriorate/change after the reports are extracted each month. This occurs because the Datix system is live and subject to change as skin damage is subject to ongoing clinical review and validation. Increased operational pressures associated with the opening of surge and escalations wards, new service demands in response to Covid 19 & staff sickness continue to challenge all areas.
Actions:	Deep dive of cat 2 damage in Nov

What patients are telling us?

East Sussex Healthcare NHS Trust

Quality and Safety

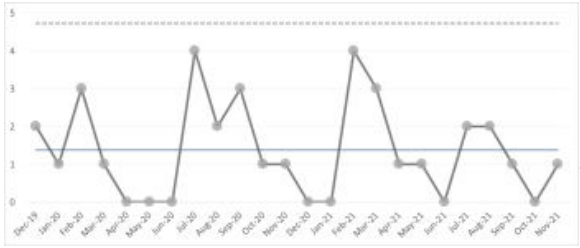
Complaints Received per 1000 bed days

Monitoring
Variation: Normal
Current Month: 1.5

Complaints Received

Monitoring
Variation: Normal
Current Month: 35

PHSO contacts



Monitoring
Variation: Normal
Current Month: 1

Author:	**Amy Pain- Patient Experience Lead**
Status Report	There were 78 open complaints at the end of November, a positive reduction compared to 104 at the end of October. In November, the top three primary complaint subjects were: • 'Standard of Care' (22) • 'Attitude' (7) • 'Communication'(3) Top complaint locations: • Emergency Departments totalled 12 (CQ =7, EDGH =5) • Outpatient Departments combined totalled 7 (EDGH =5, CQ =2) with Ophthalmology x1, Oncology x1, Cardiology x1, Breast x2, Gastro x1 and Radiology x1. • Kipling Ward 2 The remaining complaints were spread over a further 14 different locations. The PHSO made one contact with the Trust in November. 610 PALS contacts received. This is an increase of 5.5% compared to October. In October compliance with the three day acknowledgment standard for new complaints was 100%. November saw the highest compliance rates since October 2020. Compliance with complaint response rates had dropped due to ongoing operational and clinical pressures, with the Trust regularly in Business Continuity. The 35 (working) day rate was at 36% (October=9%), whilst the 50 day rate was 44% (October=17%). The overall response rate for November was 37 % (October= 10%). 4 complaints were reopened in November 2021 as complainants were unhappy and/or had additional questions/concerns. The trust received 2,232 compliments in November versus 35 complaints. This is an increase in compliments compared to October (2,078).
Challenge & Risk:	There remains a caseload of overdue (34 at the end of November), open complaints as a result of wave 2 of Covid and the ongoing operational pressures.
Actions:	Ongoing monitoring and discussions in divisional Integrated Performance Report Meetings and at Quality &Safety Committee.

What patients are telling us?

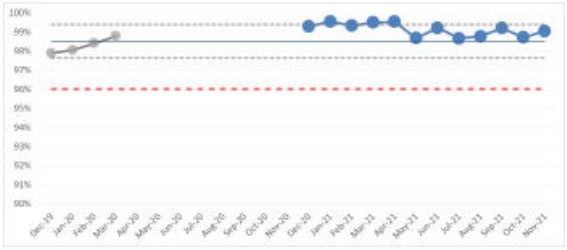
East Sussex Healthcare NHS Trust

Quality and Safety

F&FT – A&E Score

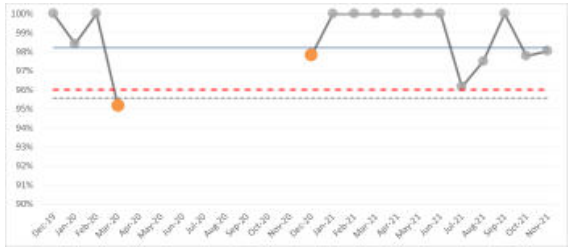
Target: 88%
Variation: Normal
Current Month: 98.0%

F&FT – Inpatient Score



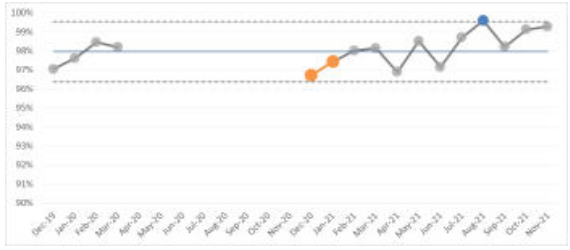
Target: 96%
Variation: Improvement
Current Month: 99.0%

F&FT – Maternity Score



Target: 100%
Variation: Normal
Current Month: 98.0%

F&FT – Outpatient Score



Monitoring
Variation: Normal
Current Month: 99.3%

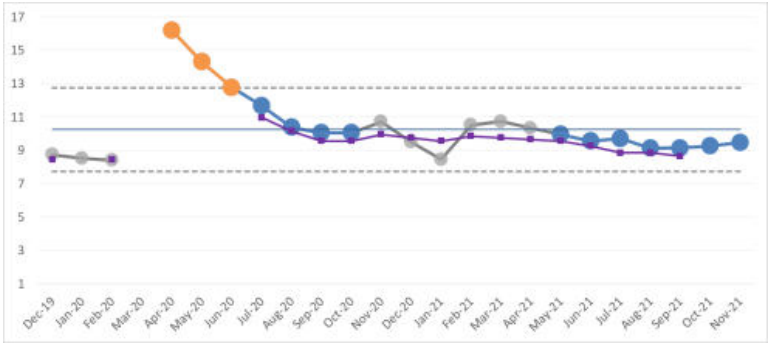
Author:	**Amy Pain - Patient Experience Lead**
Status Report	The total number of FFTs returned in November was 2,634, which was an increase compared to October's 2,322. As with complaints, response rates are challenged by ongoing operational pressures. Response rates for mandated areas were; Inpatients 23.06%, A&E 1.04% and Maternity 21.34%. The positive recommendation rates for November, compared to the most recent data released by NHSE (October) were all higher than the national average as follows: **ESHT** Inpatient - 99.04% (national average in October 94%) A&E – 98.13% (national average in October 75%) Maternity - 98.04 % (national average in October 93%) The top scoring questions were: • Were you always treated with kindness? 99.04% (730 responses) • Did you feel the staff responded appropriately to any questions or concerns you raised? 99.03% (723 responses) • Did you feel your pain was appropriately managed whilst you were in hospital? 98.75% (722 responses) The lower scoring questions were: • Do you know who to contact if your condition deteriorates? 90.86% (678 responses) • Did you feel involved in decisions about your discharge from hospital? 93.82 % (712 responses) • Were you given enough notice about when you were going to be discharged from hospital? 94.77% (707 responses)
Challenge & Risk:	Both A&E's continued to face considerable pressures with crowding and longer waits at times.
Actions:	Continue to work towards offering FFT via a digital platform in addition to paper.

Effective Care – Nursing & Midwifery Workforce

East Sussex Healthcare NHS Trust

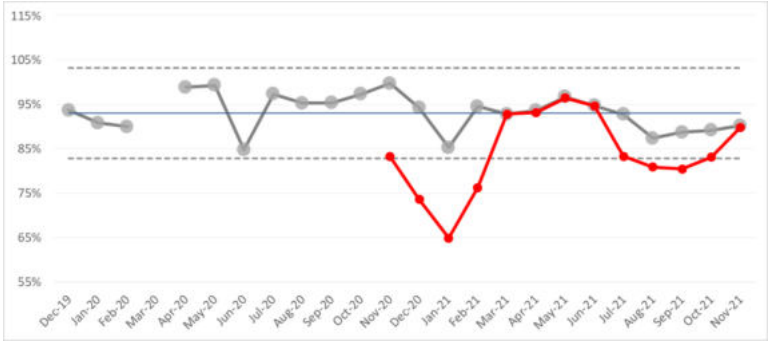
Quality and Safety

CHPPD
(Trust)



Care Hrs Per Patient Day National Median: 8.2 (September 2021)
Variation: Normal
Current Month: 9.0

Staff Fill Rate
(total)



Target: 100%
Variation: Normal
Current Month: 90.2%
Incl. escalation: 89.9%

Author:	**Angela Colosi, Assistant Director of Nursing - Corporate**
Status Report	**Care Hours per Patient Day (CHPPD*)** September's Model Hospital benchmark data shows peers at 8.0 and national median at 8.2 with ESHT at 8.7. ESHT's CHPPD shows a stable trend with overall rate of 9.0 in November 2021. Ward level breakdown is discussed in the Safer Staffing report at PSQG with some significant variation across wards and units. Higher acuity areas skew the overall average, with 15 areas less than 8 CHPDD in November and the lowest area at 5.8. *CHPPD is calculated by dividing the actual hours worked by the number of patients in beds at midnight **Staff Fill Rate** 90.2% was November's fill rate against the budgeted establishment for nursing with 8 areas at less than 80% for RNs. Surge/additional capacity remained open for medical patients on Devonshire, Glynde, Polegate, Egerton, Murray , an extra bay on Seaford and occasionally having to use SDEC at EDGH. The fill rate including the escalation areas was 89.9% (red line) but this only represents the additional unfunded Polegate ward. It is not possible to separate the additional beds used on existing wards such as Murray and Seaford. Additional duties created are also not currently included in this data so does not include the extra IPC requirement for 'red' areas. There is a gap between the grey and red line during the summer months as Devonshire and Glynde were unfunded at that time.
Actions:	• Health and well-being initiatives continue for staff • Recruitment to support community posts and substantive positions on Glynde and Devonshire has begun with a new initiative of those HCAs 'New to Care'. This supports the national HCSW2020 scheme to reduce vacancies in this cohort to zero. • Additional snacks and refreshments have been provided by the Health and Well-Being team for ward staff supported by NHSE/I funding.

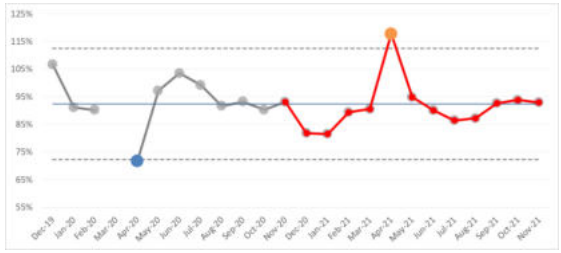
Effective Care – Nursing Workforce

East Sussex Healthcare NHS Trust

Quality and Safety

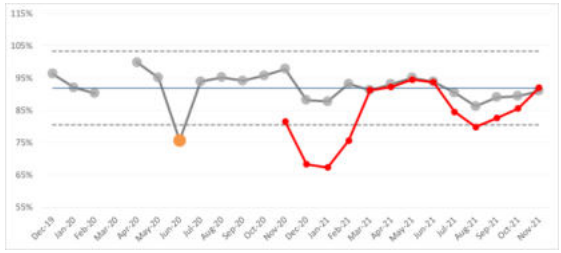
Staff Fill Rate (Bexhill)

Target: 100%
Variation: Normal
Current Month: 92.9%
Incl. escalation: 92.9%



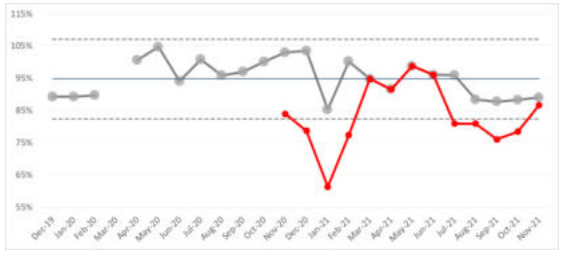
Staff Fill Rate (Conquest)

Target: 100%
Variation: Normal
Current Month 91.0%
Incl. escalation: 92.0%



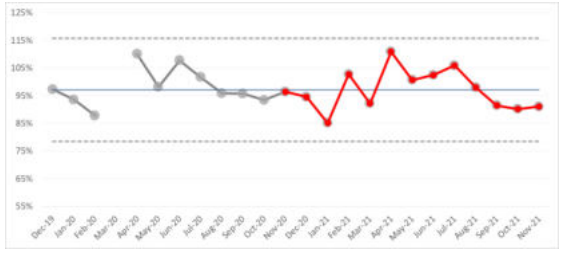
Staff Fill Rate (Eastbourne DGH)

Target: 100%
Variation: Normal
Current Month: 89.0%
Incl. escalation: 86.6%



Staff Fill Rate (Rye Memorial)

Target: 100%
Variation: Normal
Current Month: 91.0%
Incl. escalation: 91.0%



Author:	**Angela Colosi, Assistant Director of Nursing - Corporate**
Status Report	Fill rates at Bexhill have remained stable during November. Rye continues to see a slight decrease but remains relatively stable. There are no escalation beds at either community hospital now as they are funded for the full occupancy of beds (54 and 19 respectively) to facilitate rehabilitation and care of patients who are non weight bearing. EDGH and Conquest acute hospital data does not fully represent the impact of the extra areas that are open as only Polegate at EDGH is captured as an extra unfunded area for November with funding available for Glynde and Devonshire until the end of March 2022.
Challenge & Risk:	As the majority of surge/additional capacity is at EDGH the fill rates are lower there with daily challenges in most areas. With the workforce so stretched, it is very difficult for staff to be able to undertake all of the clinical and non clinical elements of care such as complaints, RCA investigations, some elements of documentation and certain aspects of flow/discharge. The daily deployment of nurses to other wards continues to have an impact on morale and the willingness of some staff to work extra shifts as they are moved from their teams/base ward.
Actions:	• 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.

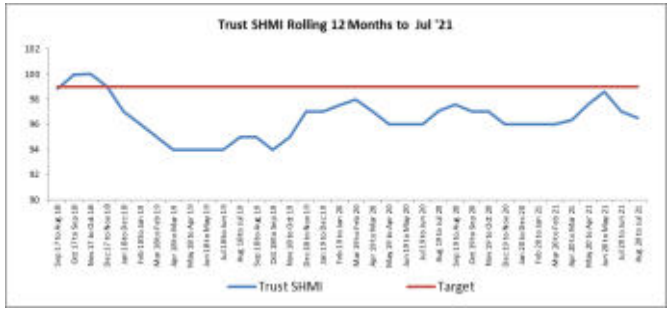
Effective Care - Mortality

East Sussex Healthcare NHS Trust

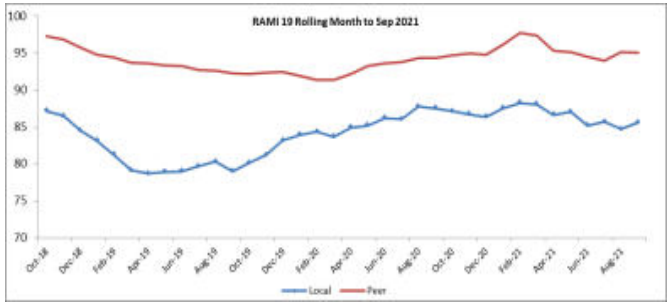
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

Summary Hospital Mortality Indicator (SHMI)

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



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



- SHMI – August 2020 to July 2021 is showing an index of 0.97. SHMI is still higher at Conquest but has fallen slightly. Depth of Coding has improved at Eastbourne.
- RAMI 19 – October 2020 to September 2021 (rolling 12 months) is 86 compared to 88 for the same period last year. September 2020 to August 2021 was 85.
- RAMI 19 was 86 for the month of September and 79 for August. Peer value is 101 for September.
- Crude mortality without confirmed or suspected covid-19 shows October 2020 to September 2021 at 1.39% compared to 1.62% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 64% for October 2021 deaths compared to 65% for September 2021 deaths.

RAMI Peer Distribution without confirmed or suspected covid-19

RAMI v Peer

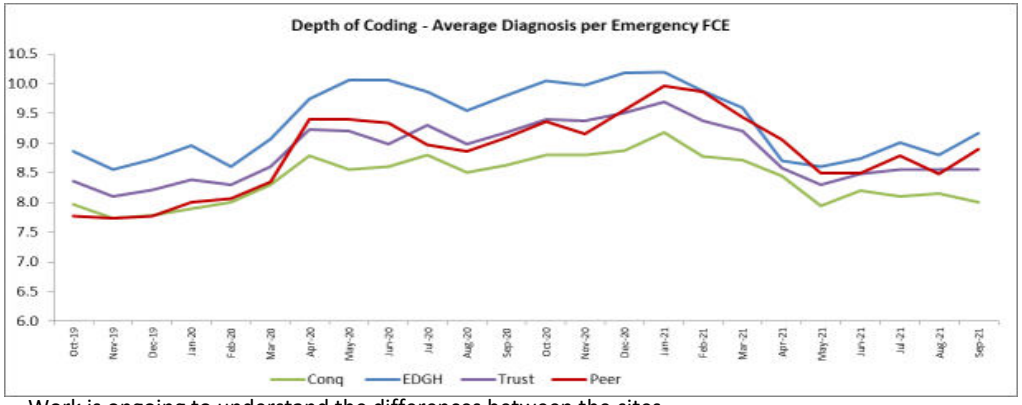
This shows our position nationally against other acute trusts - currently 30/124

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

COVID-19	24
Pneumonia	24
Cancer	18
Sepsis/Septicaemia	16
Chronic Obstructive Pulmonary Disease (COPD)	9
Cerebro-vascular Incident	5
Myocardial Infarction (MI)	5
Heart Failure	4
Hospital-acquired Pneumonia	4
Bowel Obstruction	2
Liver Disease	2
Acute Kidney Injury (AKI)	1
Atrial Fibrillation (AF)	1
Community-acquired Pneumonia	1
Urinary Tract Infection (UTI)	1

There were 24 COVID-19 related deaths in November and 8 in October.

There are:
51 cases which did not fall into these groups and have been entered as 'Other not specified'.
10 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.

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	**Annual turnover** has reduced by 0.1% to 10.4%, reflecting 664.8 fte leavers in the rolling 12 months **Monthly sickness** has decreased by 0.3% to 5.4%. **Mandatory Training** rate has increased by 0.3% to 89.4% **Appraisal** compliance has increased by 0.5% to 73.8%	**Vacancy rate** has increased by 0.2% to 9.4%. **Current vacancies** are showing as 714.1 ftes **Annual sickness** has increased by 0.1% to 5.3% and	 **Steve Aumayer** Chief People Officer

Overview:

- Performance continues to be challenged across the Trust due to levels of Covid and non-Covid activity. This is driven through high levels of ED attendance and multiple "Medically Ready to Discharge" (MRD) patients within the Trust. This additional activity requires an increase in staffing and affects flow and our healthcare partners ability to provide a consistent care pathway. We have an increase in staffing through a range of sources however remain stretched.

- Substantive staff numbers increased once again within the month. There were 105 fte starters and only 48.9 fte leavers, a net impact of +56.1 ftes. The Trust turnover rate in month was slightly down by -0.1% on the previous month at 10.4% (0.5% higher than for Nov 21). One of the noted reasons for leavers is end of fixed term contracts. If we remove those planned leavers our turnover rates reduce to 9.9% for this year. Our vacancy rate has increased in month by 0.2% to 9.4%, which equates to 714.1 fte vacancies, an increase of +22.5 ftes on last month.

- The Trust reliance on temporary workers remains high due to activity demands although in Nov, demand for clinical staff reduced slightly compared to last month. Demand for temporary resource still remains high in Critical Care Areas and Emergency Departments due to increased capacity, leavers and additional funding. Fill rates remain a challenge because of the volume of requests but TWS were able to increase supply to 820 fte in Nov (previously 800 fte).

- Sickness levels remain a concern, though monthly sickness did reduce in Nov by 0.3%, the first reduction in 7 months. The annual trend has increased by 0.1% to 5.3% as the monthly rate is 1.0% higher than this time last year. There were 19.4 average sick days per FTE against pre-Covid rates of an average of 16.4 days lost per fte (18.3% increase). Anxiety, Stress and Depression, the predominant identified reason for absence, continues to fall for the fourth consecutive month, reflecting the interventions that have been put in place to support our colleagues. Seasonal illnesses also dropped slightly this month.

- Our staff vaccination hubs for COVID booster vaccinations closed on 19th Nov but flu vaccinations continue. Work is underway to ensure compliance with mandatory vaccination requirements

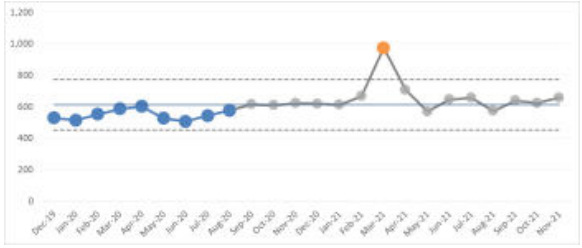
Workforce – Contract type

East Sussex Healthcare NHS Trust

Agency FTE Usage

Current Month: 164.3

Bank FTE Usage



Current Month: 656.4

Substantive FTE Usage

Current Month: 6736.4

Vacancy Rate

Target: 5%
Current Month: 9.4%

Author: Jenny Darwood

Status Report

Substantive usage increased by 19.3 fte, bank usage increased by 34.1 ftes whilst agency fte usage decreased by -13.4 ftes. Vacancy rate has increased by 0.2 to 9.4%.

Demand for temporary workforce has stabilised at c.22,000 shifts equating to 1,681 fte. There has been a slight decrease in demand for clinical staff. There is a particular pressure for temporary resource within Critical Care and Emergency Departments; drivers are increased capacity, leavers and additional funding.

Escalation wards, especially on the EDGH site, remain a significant pressure for TWS.

Staff group	Vacancies ftes	Recruitment Process (ftes)	Offers & Start Dates (ftes)	Time to Hire (days)
Med & Dental	63.4	62.6	59.1	86
Reg Nurse	296.0	209.2	135	62
Addit Clin Serv	307.2	103.8	68.2	56
AHP	20.4	89.2	43.2	54
Prof, Sci, Tech	-4.1	7.4	5.3	75
Healthcare Scs	3.8	13	6	68
A&C	6.0	92	37.4	42
Est & Ancillary	15.4	28.2	22.2	76
Trust	**714.1**	**605.4**	**376.4**	**64.9**

Challenge & Risk:

Supply of staff has increased to 820fte; although there is a fluctuation in fill rates across workgroups. Medical remains at 50%, Registered Nurse & Midwives has increased by 4 % to 46%, Healthcare Support Workers has decreased by 12% to 47%, Admin & Estates decreased by8% to 86% whilst Scientific & AHP stable at 53%

Risk to Patient Safety & Quality as agency & bank supply are unable to respond to the level of demand; neither Tier 1 or Tier 2 agencies have been able to respond. Off-framework supply is minimal. There is also a financial risk due to reliance on high cost framework and off framework agencies

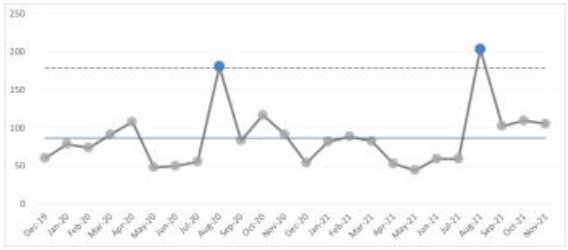
Actions:

An incentive scheme is planned over key Xmas dates. Off framework agencies have been approved for key risk areas; Critical Care, Emergency Department and the Escalation areas

Workforce - Churn

East Sussex Healthcare NHS Trust

Starters FTE

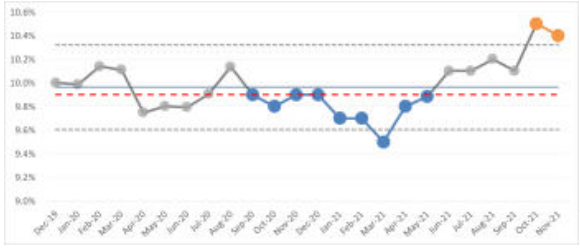


Current Month: 105

Leavers FTE

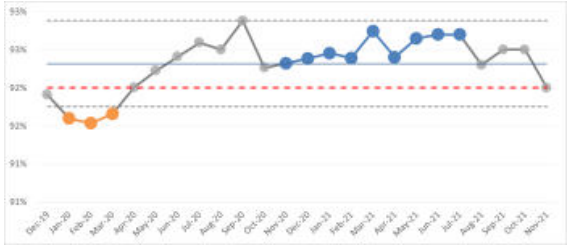
Current Month: 48.9

Annual Turnover Rate



Target: 9.90%
Current Month: 10.4%

Retention Rate



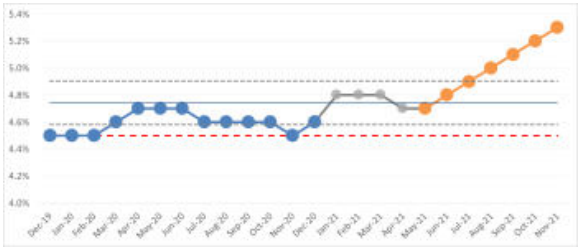
Target: 92%
Current Month: 92.0%

Author:	David Moulder & Greig Woodfield
Status Report	The Trust starters & leavers monthly net total as at Nov 21 is +56.1 with +105 starters fte and -48.9 leavers fte. Over the last 12 months there was 1,041.7 fte starters & -866.9 fte leavers giving a net increase of +174.8 mainly showing in the nursing staff group. The Trust turnover rate has reduced by -0.1% to 10.4%. There were 664.8 fte leavers in the previous 12 months. The Trust Retention rate (i.e. % of staff with at least one year's service) decreased by 0.5% to 92.0%.
Challenge & Risk:	Staff peak retirement usually occurs in Dec or Mar. however we may see an increase in this due to Covid pressures. Recruitment activity remains high year on year with over 900 actions currently underway on TRAC. Covid Travel restrictions continue to effect some international travel which impacts on overall Trust Time To Hire. International candidates still currently required to quarantine for 10 days. Some delays still with visa applications at source countries due to volumes. Despite success with continued targeting of "hard to recruit" posts, areas of focus remain e.g. Consultants for various posts; Cardiology,, Acute Medicine, Respiratory and Care of the Elderly. Recruitment activity focused around Escalation wards, Theatre ODPs. Sonographers, Dietitians and Community Nurses.
Actions:	There is a strong pipeline of international nurses, in place with 171 arrived since Oct 20. A further 27 nurses were welcomed in Nov with an additional 17 due in Dec. Further cohorts are planned for Jan and Feb.. Continued campaigns with external recruitment agencies to provide Sonographers and Theatre ODPs. Hard to recruit medical posts are with Medacs and other additional agencies, as required. Targeted phased approach to filling medical posts continues with direct applications remaining strong year on year . Major campaigns for CHIC UTC and Emergency Medicine underway.

Workforce - Sickness

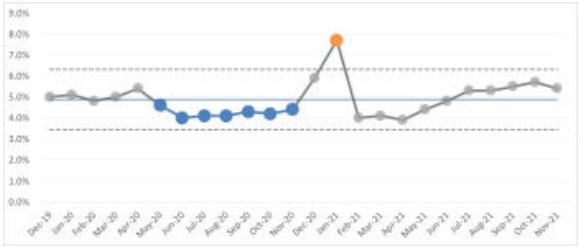
East Sussex Healthcare NHS Trust

Annual Sickness



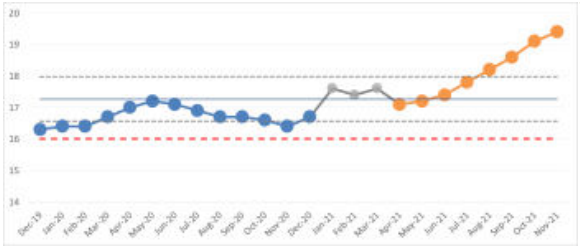
Target: 4.5%
Current Month: 5.3%

Monthly Sickness



Current Month: 5.4%

Average sickness Days per FTE



Target: 16
Current Month: 19.4

Author:	David Moulder, Julie Hales
Status Report	Monthly sickness % has shown the first drop for 7 months, down by -0.3% to 5.4%. It is still 1.0% higher, however, than for Nov 20 and thus annual sickness continues to increase, up a further 0.1% to 5.3%. Total staff reported as absent due to Covid sickness ,as at 10th Dec, was 38 (compared to a peak of 237 on 22nd Jan). Overall, there were 375 staff absent due to all types of sickness, compared to a peak of 540 (also on 22nd Jan). Covid sickness has been trending higher since the start of Dec with an average of 38 staff off sick (a high of 44 on 9th Dec) compared to 26 staff on average in Nov. Sickness average is 19.4 days per fte compared to pre-Covid when it averaged 16.4 absent sick days lost per fte.
Challenge & Risk:	Whilst it is acknowledged that staff are being encouraged to take up the booster and flu vaccine; with the new variant becoming more prevalent, we do anticipate this having an impact on absence and isolation levels.
Actions:	The focus continues on identifying other reasons that absence may increase ,such as annual leave and study leave. Managers will be helped to plan their schedules further in advance, including reporting on all outstanding annual leave still to be booked until end of leave year OD interventions continue in supporting areas of high stress such as key work with teams around values and utilising the TRIM practitioner role along with mental health first aiders. Work continues with understanding the impact of the HWLB interventions and the potential reduction in stress and anxiety

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; Julie Hales

Status Report

Reason	fte Days Lost +/-		Total fte Days Lost
Anxiety, stress & depression	▼	-277.5	1,808.9
Back problems	▼	-1.2	513.6
Chest & respiratory	▼	-97.8	1,468.4
Cold, cough & flu	▼	-135.2	1,182.2
Gastrointestinal	▲	+80.4	728.6
Other MSK problems	▼	-162.9	1,456.9
Other reasons	▼	-358.9	3,949.1
All reasons	▼	-953.1	11,107.7

Challenge & Risk: Sickness reason trends are largely positive this month but national forecasts are for Covid infections to increase which puts additional emphasis on the importance of the booster programme.

Actions: Occupational Health & Wellbeing have provided targeted individual access to trauma therapists for those staff who have been identified as requiring support and are supporting individual stress risk assessments within Divisions

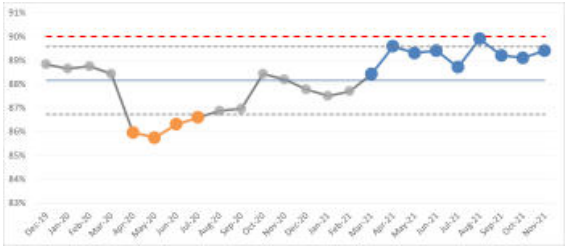
Working in conjunction with OH, Divisions have been provided with details of the MSK resources to support staff. This includes the process to refer to OH as early as possible, especially those staff that are in work with symptoms, or recently signed off for greater than 7 days for MSK conditions.

Workforce - Compliance

East Sussex Healthcare NHS Trust

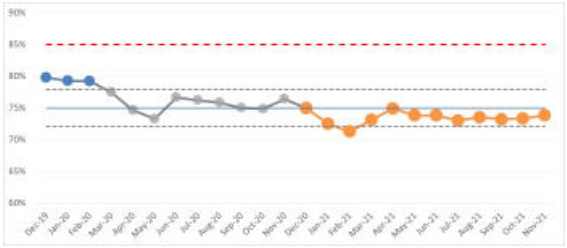
Our People – Our Staff

Mandatory Training Compliance



Target: 90%
Current Month: 89.4%

Appraisal Rate



Target: 85%
Current Month: 73.8%

Author:	Dawn Urquhart
Status Report	Despite significant operational pressures, Core Skills Training compliance increased to 89.4% a tremendous achievement for staff who continue to work incredibly hard to deliver Winter Sparkle Appraisal compliance again increased by 0.5% to 73.8%. Work is ongoing to deliver the agreed project plan for the implementation of the new Educational Learning Management System. Following revised national targets on Covid Booster vaccinations the Education Centre on the Conquest site is to be used again as a vaccination hub for both staff and members of the public. This will commence 3rd week of Dec and last until the end of Jan 22. An educational programme for HCSW new to care has been developed. This will involve a one week "bootcamp" consisting of both Core and Specialist modules, EOLC, etc. This will involve looking for HCSW co-ordinators to support HCSW new to care in a supernumerary way. Funding has been made available by NHSE/I to support HCSW initiatives. Bids to be in by 21st Dec 21.
Challenge & Risk:	Whilst we are continuing to provide additional Induction capacity to support recruitment initiatives, there is a risk that we will not be able to implement more blended approaches to learning as is being advocated by HEE. This is due to the Education Centre being identified as the new vaccination hub for members of the public. The ongoing impacts of the operational status of the Trust (including future Covid outbreaks) will continue to impact on Trust CST/Appraisal compliance for the rest of the year impeding the Trust in achieving 90% target.
Actions:	A number of rooms used for the provision of Induction and Training for all staff have been secured and are not part of the current available COVID Vaccination capacity. This is to ensure that we continue to deliver training to the current and future cohorts of International Nurses.

Workforce – Job Planning

East Sussex Healthcare NHS Trust

Consultant eJob-Planning Fully Approved Rate

Current Month: 58.2%

SAS Grades eJob-Planning Fully Approved Rate

Current Month: 47.6%

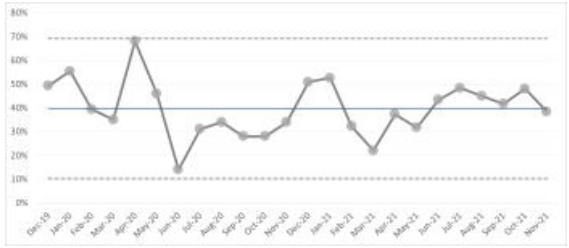
Author:	Joanne Penfold
Status Report	The overall medical job plan approval rate remains at 56%. 149 of 256 Consultants have a completed eJob Plan (58.2%) and 49 of 103 SAS Doctors have a completed eJob Plan (47.6%).
Challenge & Risk:	Operational pressures are impacting on Service Managers, Specialty Leads and Medics having the time to review job plans. Some specialties have progressed job plans to the signed off stage (Haem, Obs & Gynae), but other specialties continue to review and return job plans to discussion (Radiology, Neurology & Trauma & Orthopaedic Surgery).
Actions:	As per policy, the new job planning cycle will begin in Jan 22. Specialties are to set up an initial team job planning meeting, to agree service outputs for the forthcoming year. This is followed up with an individual medic job plan meeting to review and sign off a refreshed job plan in line with the team job planning outputs. As part of the team job planning, Service Managers/Specialty Leads are also asked to review and submit service objectives, as part of the NHSI levels of attainment requirement. The review process should be completed by the 1st Apr 2022.

Workforce – Roster Completion

East Sussex Healthcare NHS Trust

6 week Nursing Management Roster Approval Rate

Current Month: 38.%



8 week Nursing Management Roster Approval Rate

Current Month: 8.%

Author:	Penny Wright
Status Report	Roster approval rates at 6 & 8 weeks have dropped in Nov. For the roster starting on 1st Nov, 38% of rosters had been approved at 6 weeks before the go live date which is a 10% reduction on the previous month, whilst 8% had been approved at 8 weeks prior to commencement which is a reduction of 4%. .
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. The new Nursing Deployment dashboard has been shared with senior nurse leaders and is regularly updated. . 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.

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	2 Theatres closed to upgrade to laminar flow . This will allow the Trust to utilise the theatre capacity differently and adjust the speciality mix / list configuration to meet demand. Winter Sparkle campaign commenced on the 22nd of November focusing on streamlining the patient journey through our services. It's all about making sure that we are providing the right care in the right place at the right time. LIVI implementation planning for December Go Live Type 3 attendances have decreased as a result of patients being re-directed away from the Emergency Department or Urgent Treatment Centre back to their primary care provider, dentist or optician. Created a "Green" infusion suite at the EDGH site in the old social club to ensure patients received treatment against the increased bed pressures and escalating COVID numbers.	ED Performance: The Trust delivered 74.01% against a target of 95% in November placing the Trust 48th in the country. Similar to elective inpatients, the challenges the target are the constraints to inpatient flow: 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; and the acuity of patients continuing to remain higher than pre-covid levels. Elective Recovery: Whilst not yet achieving the H2 ask for 89% of clock stops against our 19/20 figures we have seen a significant improvement within this target in November, reporting 85% of clock stops against the 89%, compared to 78% in October. External validation of the RTT PTL starts in January which should further support delivery of this target. Escalation Wards: November saw continued use of our escalation beds across both sites to support flow which further challenged workforce and had financial challenges in order for us to maintain this level of bed capacity. Cancer 62 day standard: The Trust remains challenged to deliver against the 62 day standard and future delivery of the 62 day standard is reliant on timely diagnostic tests and procedures as well as the reliance on other tertiary providers to support us with consultations, complex diagnostics and procedures which ESHT do not carry out internally Cashing Up: There has been an increased focus on cashing up so as to support the 89% target for clock stops and as a result we have seen a significant decrease in the number of outstanding uncashed appointments. This will be an area that we continue to focus on moving forward.	 **Tara Argent** Chief Operating Officer

Actions:

- Recruit to new urgent care model
- Reinvigorate 642 meetings and manage the closure of 2 theatres on the Conquest site from 22nd November for planned estates works
- Continue with winter pressure and surge planning
- Ensure staff wellbeing with the increasing Omicron prevalence

NHS Constitutional Standards

East Sussex Healthcare NHS Trust

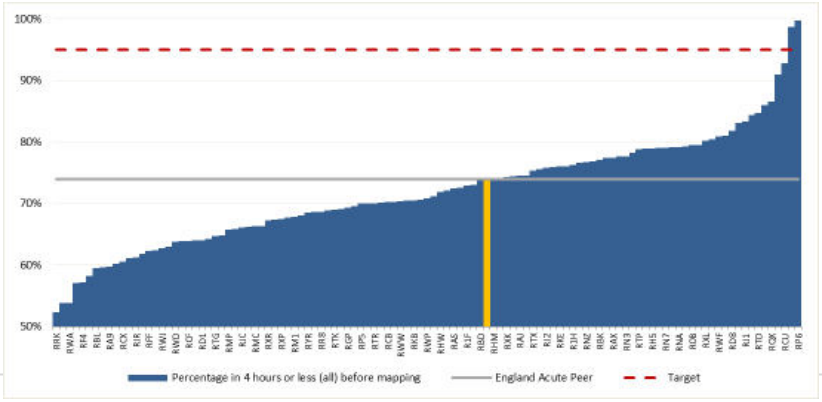
*NHS England has yet to publish all November 2021 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

November 2021 Peer Review

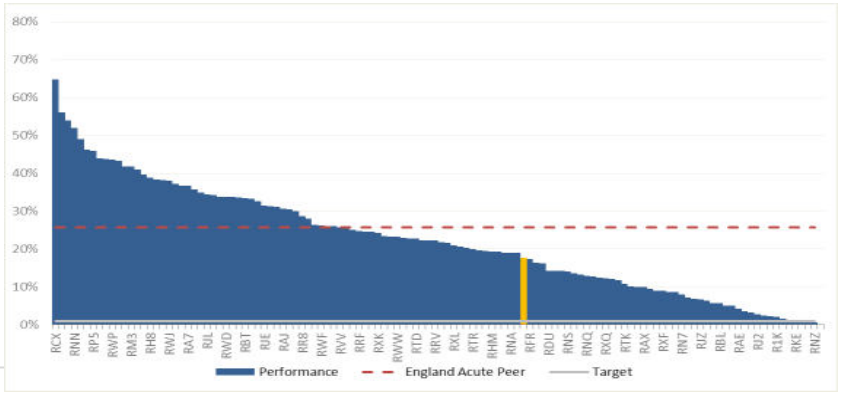
National Average: 74.01% ESHT Rank: 48/113



Planned Care – Diagnostic Waiting Times

October 2021 Peer Review*

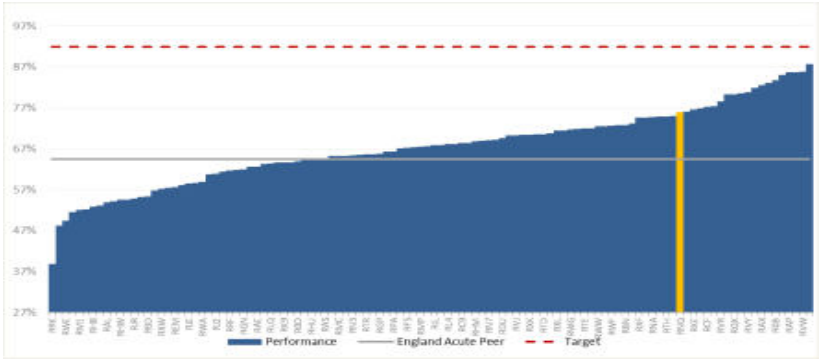
National Average: 25.8% ESHT Rank: 47/121



Planned Care – Referral to Treatment

October 2021 Peer Review*

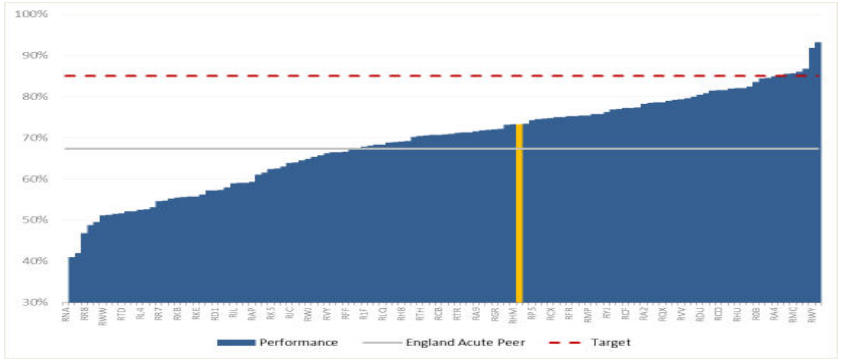
National Average: 64.5% ESHT Rank: 21/112



Cancer Treatment – 62 Day Wait for First Treatment

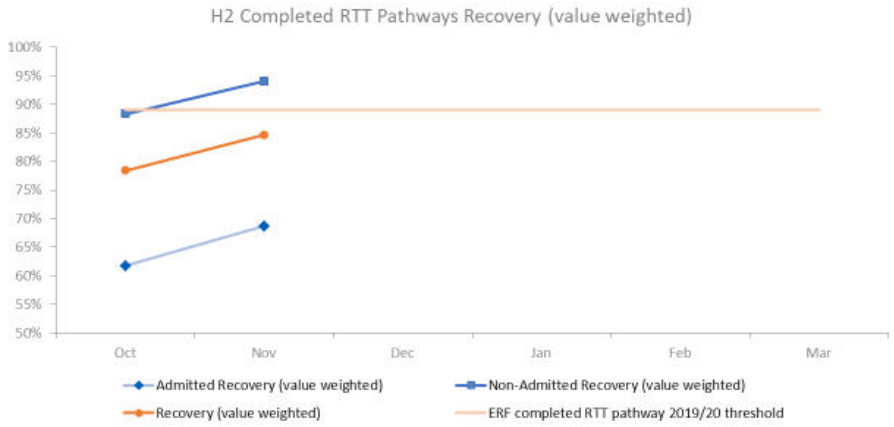
October 2021 Peer Review*

National Average: 67.4% ESHT Rank: 49/122



Planned Care – H2 Recovery KPIs

East Sussex Healthcare NHS Trust



The Trust continues to work towards delivery of the H2 recovery targets although this has been challenged due to the rising non elective demand. Plans are in place for patients waiting over 52 weeks to support continued delivery against trajectory . The Trust had planned/anticipated a change in November and December however regional changes smoothed the delivery over the remaining months of the year which changed the seasonal impact.

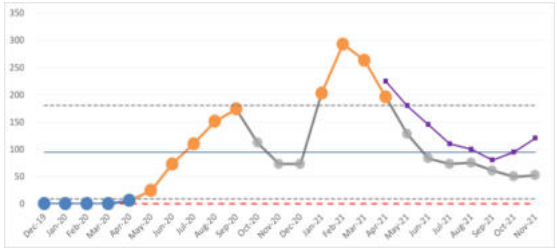
The ask for H2 is to deliver 89% of clock stop activity against a 2019/20 baseline. Whilst we have improved on the previous month we have not delivered 89% of clock stops.

Although Patient Initiated Follow Up (PIFU) numbers remain steady there is more work to be done to ensure PIFU pathways are being routinely adopted to deliver and maintain the required 800 conversions to PIFUs per month.

The Outpatient Transformation team are undertaking target work with specialties to support this.

RTT 52 Week Waiters

Target: 0
Trajectory: 120
Current Month: 52



Access and Responsiveness

Planned Care – H2 Recovery KPIs

East Sussex Healthcare NHS Trust

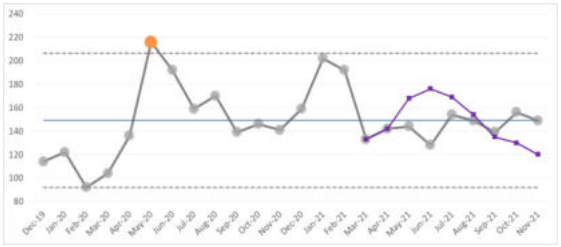
Access and Responsiveness

28 Day FDS(Faster Diagnosis Standard)

Target: 75%
Trajectory: 75%
Current Month: 75.4%

Cancer 62 Day Backlog

Target: Monitor
Trajectory: 120
Current Month: 149



Cancer 104 Day Backlog

Target: Monitor
Trajectory: 25
Current Month: 27

In September the Trust delivered FDS target for the first time since its introduction and this was maintained in October but not sustained in November, this is due to an increased demand in 2WW referrals but limited capacity in ultrasound, especially for the Breast cancer pathway.

Patient choice alongside a reliance on tertiary centres for certain cancer pathways and a continued increase in referrals have impacted on delivering against trajectory.

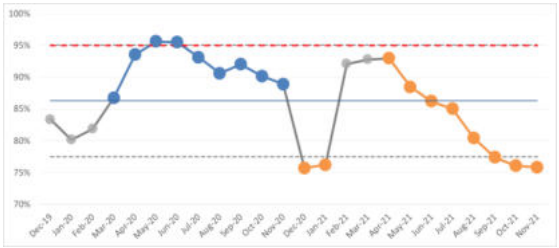
All >104 day waiters are reviewed weekly by the senior leadership team to ensure that actions are taken and these patients will continue to be closely monitored so as to recover our position.

Urgent Care – Front Door

East Sussex Healthcare NHS Trust

A&E Performance
(Local System)

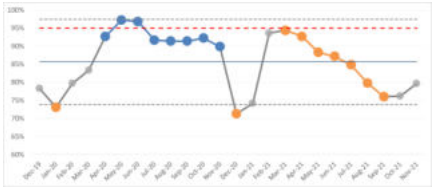
Target: 95%
Current Month: 75.9%



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

Target: 95%
Current Month: 73.8%

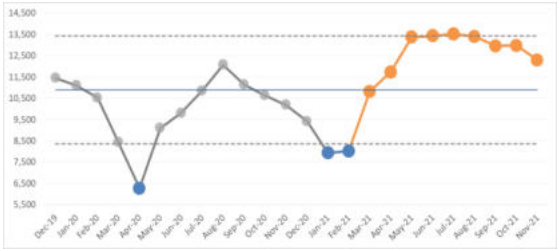
CONQ



EDGH

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

Target: Monitor
Current Month: 12,292



There remains an insufficient number of discharges to meet the urgent care demand which has a direct impact on performance against the national 4 hour urgent care metric. It should be acknowledged that this performance is mirrored across the UK and the region and ESHT continues to be one of the highest performing in the region.

Access to gateways remains difficult and direct access to a gateway from ambulance services has not uniformly been adopted which increases the demand in both the emergency department and the urgent treatment centre. A continued focus is to improve the flow at the front door with improved utilisation of the all gateways continue with further work required to meet the 27 standards for access to gateways from ambulance services.

The slight decrease in attendances is likely as a result of new effort within the Emergency Department and Urgent Treatment Centre to re-direct patients to alternative providers at point of streaming.

Urgent Care – Front Door

East Sussex Healthcare NHS Trust

ESHT Total Type 1

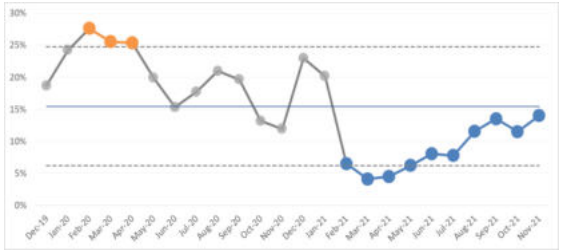
ESHT Total Type 3

Conveyances
(ESHT – CQ and EDGH)

Target: Monitor
Current Month: 3,165

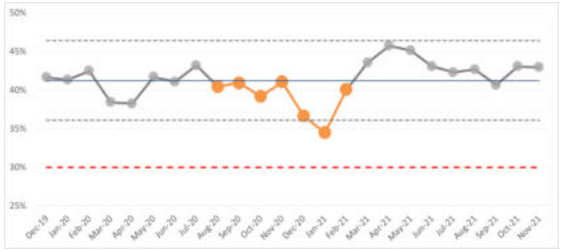
Conveyance Handover >30
(ESHT – CQ and EDGH)

Source: SECAmb
Target: Monitor
Current Month: 14.0%



Same Day Emergency Care
(ESHT – CQ and EDGH)

Target: 30%
Current Month: 43.0%



Type 3 attendances have decreased as a result of patients being re-directed away from the Emergency Department or Urgent Treatment Centre back to their primary care provider, dentist or optician.

Conveyances appear to have stabilised over the last quarter however flow issues are contributing to handover delays which impacts on our ability to achieve the 15 minutes national standard.

To address challenges, the Trust is working on

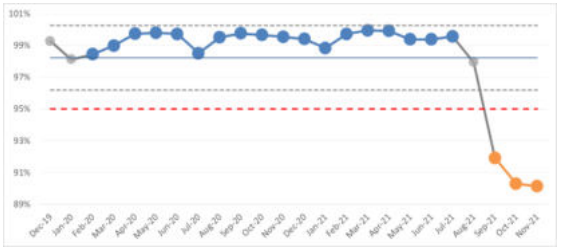
- Estate works to enable rapid assessment areas on both sites
- Recruitment to staff the rapid assessment areas
- Early adoption of new national urgent care metrics in early 2022
- Launch of LIVI in December 2021
- Re-Focus on streaming with the enhanced re-direction

Urgent Care – UTC

East Sussex Healthcare NHS Trust

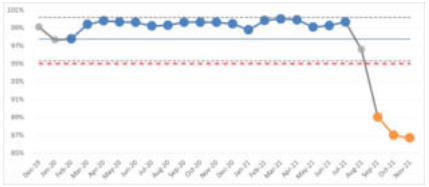
UTC 4 hour standard
(Visit complete within 4 hours)

Target: 95%
Current Month: 90.1%



CONQ

EDGH



The ICS bid was successful and recruitment is now underway in order to improve staffing within the Urgent Treatment Centre. Once recruited, and with the launch of LIVI for remote consultations, it is anticipated that the Trust will be able to increase the number of patients seen in the Urgent Treatment Centre and discharged within the four hour standard.

Further work will then be required to reduce this further to the two hours required as part of the national standards for Urgent Treatment Centres.

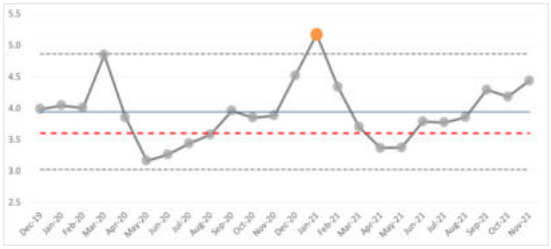
Patient Care- Flow

East Sussex Healthcare NHS Trust

Access and Responsiveness

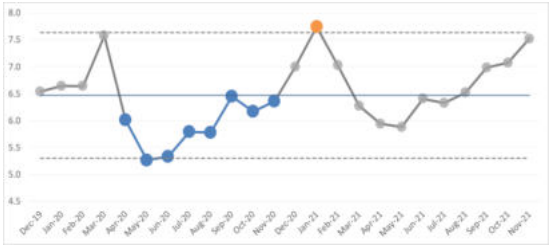
Non-elective Length of Stay (Acute)

Target: 3.6
Current Month: 4.4



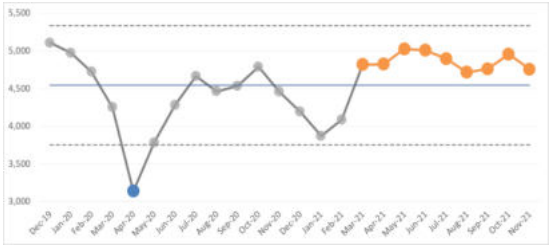
Non-elective Length of Stay, excluding zero LoS (Acute)

Target: Monitor
Current Month: 7.5



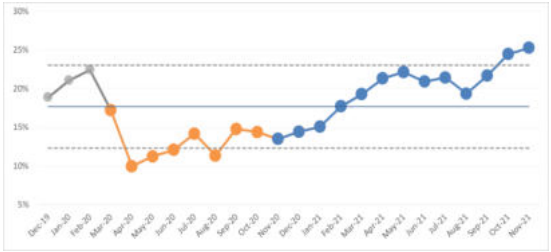
Non Elective Spells

Target: Monitor
Current Month: 4,752



Medical Non Elective Admissions (% SDEC)

Target: Monitor
Current Month: 25.3%



Throughout November, the Trust experienced increased pressure on acute admissions and patient flow, along with patients presenting with a higher acuity.

Additional escalation capacity has been in place on both sites for a number of months. This is to increase the bed base to support the additional activity although it should be noted that this places additional pressure on the workforce and overall patient flow. This in turn is potentially linked to the Trust seeing an increase in its overall length of stay in November.

The Trust has employed more locum Doctors assistants (qualified Drs) to current vacancies to support the clinical teams and discharging of patients. This initiative remains in place with the divisions who continue to review and look to expand.

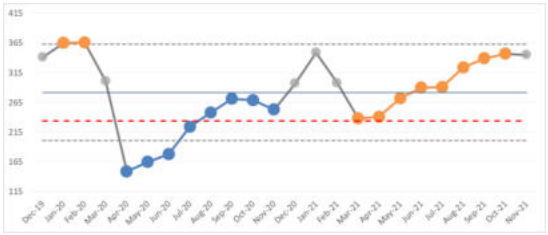
It is not only the Trust that is experiencing these issues and the resourcing challenges as the care market is also continuing to experience challenges with recruitment and retention which is impacting on the availability and timeliness of packages of care (delivery and capacity) . As a result discharges to D2A/Intermediate care beds and nursing homes are being delayed and this is having a direct impact on the Trust's overall average LoS.

Patient Care - Flow

East Sussex Healthcare NHS Trust

Adult inpatients in hospital for 7+ days (Acute)

Target: Monitor
Current Month: 345

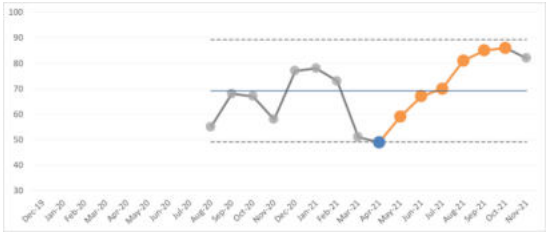


Adult inpatients in hospital for 21+ days (Acute)

Target: Monitor
Current Month: 112

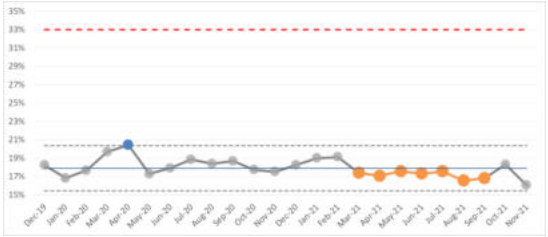
MRD on Pathways 1-3

Target: Monitor
Current Month: 82



Patients discharged before midday %

Target: 33%
Current Month: 16.1%



November has seen the Trusts LoS for patients waiting over 7 and 21 days to plateau. This is an initial area of focus for the Winter Sparkle campaign for December.

Patients on Pathway 1 are generally taking longer to be discharged from the point that they no longer meet the criteria to reside, this is as a result of 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 demand of patients who are requiring bedded rehabilitation and also the complexity of those cases. These delays and lack of flow also impact on delivery of services at the front door.
We continue to work with our system partners to ensure that we maintain flow and reduce the LoS in the acute setting.

Increase in LoS from the point that a person doesn't meet the criteria to reside to actual discharge , places additional pressure on bed capacity and can lead to further deconditioning of the patient.

Actions under consideration :

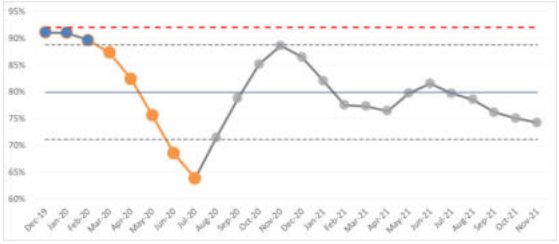
- Winter Sparkle campaign
- Increasing same day discharge by supporting the continued increase in capacity for Crisis Response service
- System wide review on community rehabilitation beds to ensure capacity meets both volume and complexity of demand-In progress.
- Working with the system partners on winter and 12- 18 month Discharge Plan to support current pressures.
- Process map the P1's from Pre-MRD to MRD recommending streamlined pathway.
- Report the number of patients that do not meet the criteria to reside daily – of which MRD will be a subset
- Winter Director in post for Nov-Feb with an option to extend to April if needed

Planned Care – Waiting Times

East Sussex Healthcare NHS Trust

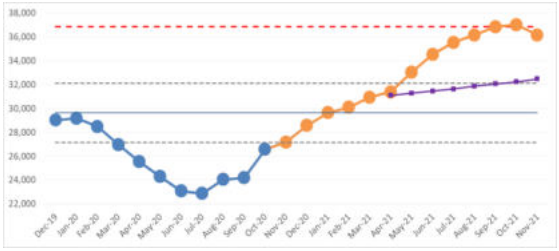
Access and Responsiveness

RTT Incomplete Standard



Target: 92%
Current Month: 74.3%

RTT Total Waiting List Size

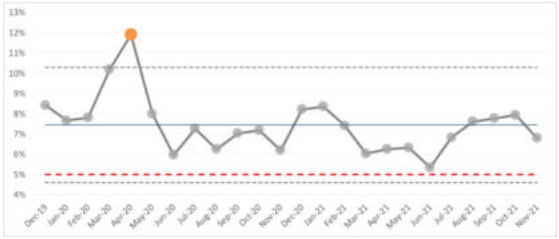


Target: 36,833 (Sep-21)
Trajectory: 32,470
Current Month: 36,152

RTT 26 Week Waiters

Target: Monitor
Current Month: 3,696

Cancellations On The Day (Activity %)



Target: 5%
Current Month: 6.8%

The Trust placed 21st out of 112 against the RTT 18 weeks constitutional standard, however NHS Trusts are not currently being actively measured against this standard but are focusing on recovery as part of H2 priorities.

As was expected our waiting list size has continued to increase above trajectory, this is ahead of the timescales expected by the system. The volume of referrals received, both Cancer and Routine, has increased by 5.14% from 19/20 and 32.24% from 20/21, as GPs become more accessible. Advice & Guidance and PIFU are areas which we are exploring and developing to help address the increase in demand.

Whilst the percentage of cancellations on the day are at the lowest level we have seen since June 2021 the continued increase in covid related cancellations pre-surgery due to patients testing positive, and ongoing workforce challenges with staff having to isolate and bed pressures elective bookings are lower than previous years.

On day cancellations continue to go through a robust escalation process before any decision is made to cancel patients. Patients who are unfortunately cancelled get rebooked within 28 days. We are fully compliant with this.

Planned Care – Outpatient Delivery

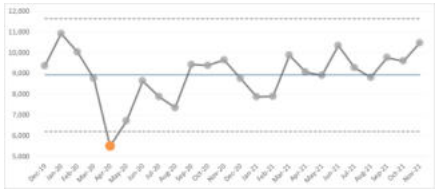
East Sussex Healthcare NHS Trust

Access and Responsiveness

Outpatient Total Activity
(New and Follow-up)

Target: Monitor
Current Month: 36,075

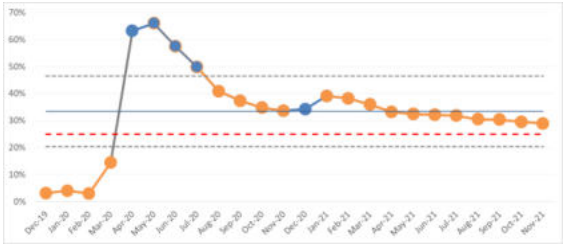
New



Follow-up

Non Face to Face Outpatients Activity
(Activity %)

Target: 25%
Current Month: 29.0%



Outpatient Utilisation
(Consultant and nurse led Clinics)

Target: 100%
Current Month: 82.5%

To enable us to deliver the operational planning guidance for the second half of the year and for the Trust to maximise our capacity, outpatient utilisation remains key, along with the timely cashing up of clinics to ensure 'clock-stops' are identified early.

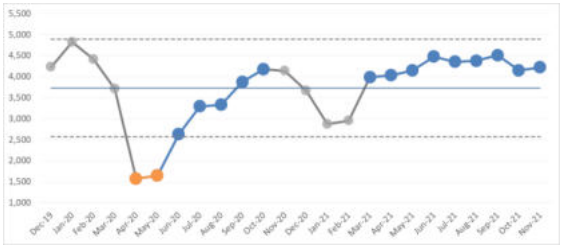
November saw the highest volume of outpatient activity undertaken so far in 2021/22. Clinic utilisation also improved but the increase in short notice cancellations and a higher than target DNA rate continues to have an impact against the delivery of the 95%, further work is needed to address this.

29% of our outpatient appointments were delivered virtually allowing us to comfortably meet the target of 25%. Whilst we continue to deliver a high volume of outpatient appointments virtual we are ensuring we continue to adopt a balanced approach to all outpatient appointments are of value to both patient and clinician.

Planned Care – Admitted Delivery

East Sussex Healthcare NHS Trust

Elective Spells
(Day case and Elective IP)

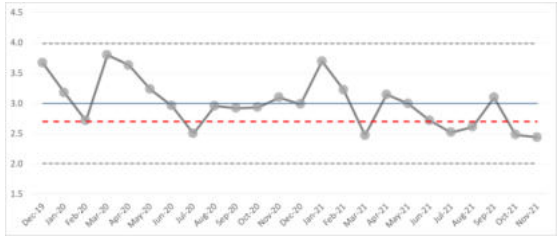


Target: Monitor
Current Month: 4,221

Day case

Elective IP

Elective Average LoS
(Acute)



Target: 2.7
Current Month: 2.4

Theatre Utilisation

Target: 90%
Current Month: 73.8%

The Trust saw an increase in both Daycase and Elective IP however we are still not seeing the volumes of activity we would normally expect.

Ongoing workforce challenges and the continued increase in non elective pressures are all factors that are challenging elective delivery. All Divisions continue to work hard to balance these priorities and ensure elective activity is not severely compromised as a result.

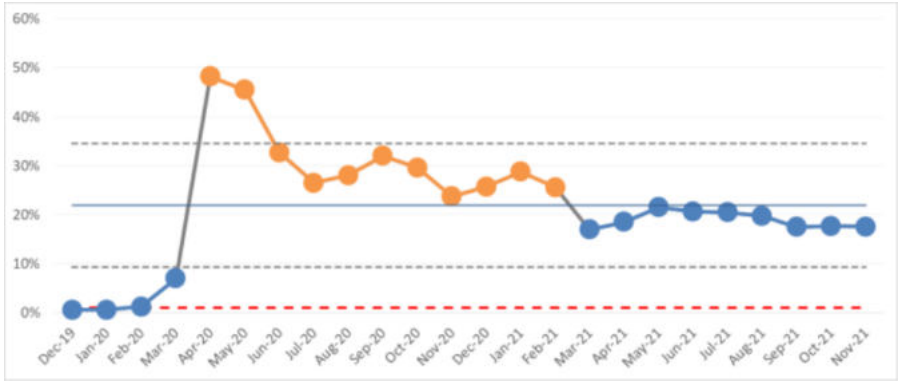
Teams work hard to support timely discharges and this is reflected in our elective average LoS which is inline with target days of 2.7.

Planned Care – Diagnostic

East Sussex Healthcare NHS Trust

Diagnostic Standard

Target: < 1.0%
Current Month: 17.6%



Our DM01 position remained static in November but it is anticipated that we will begin to see improvement from January 2022. Insourcing for echocardiograms starts in December and work has begun on the Community Diagnostic Centre in Bexhill which both will help to address the wait for routine diagnostics. More work is needed though for to reach the 99% compliance target for DM01.

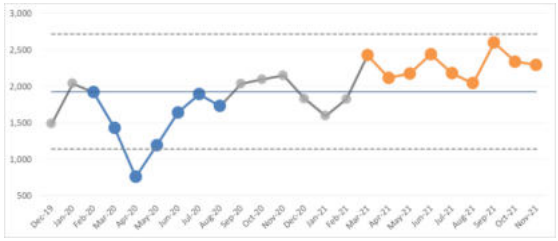
Whilst work is ongoing to provide additional capacity where possible with insourcing lists Non Obstetric Ultrasound remains challenged as a result of increased demand and a shortage of workforce nationally that is impeding substantive recruitment, especially in both Breast and Head and Neck specialisms

Cancer Pathway

East Sussex Healthcare NHS Trust

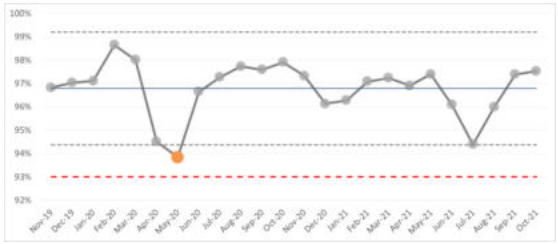
Two Week Wait Referrals

Target: Monitor
Current Month: 2,295



Cancer 2WW Standard

Target: 93%
Current Month: 97.5%

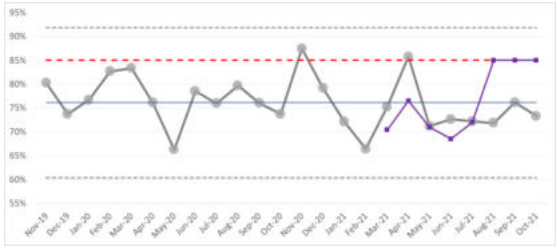


Cancer 31 Day Standard

Target: 96%
Current Month: 92.6%

Cancer 62 Day Standard

Target: 85%
Trajectory: 85%
Current Month: 73.3%



Whilst overall numbers on the cancer PTL have reduced we are still experiencing am increase in the volume of 2ww referrals received compared to 19/20 figures.

The volume of patients waiting over 104 and 62 days has also risen and further work is needed to reduce long waiting patients (> 62 days) to enable us to meet trajectory figures. Factors impacting on the long waiters are: complex pathways, patient choice, increased covid prevalence impacting both staff and patient availability, histology capacity and reporting times and Radiology demand outstripping capacity for some specialties.

Performance against the 62 Day Referral to Treatment standard was maintained at 73% and it is recognised that further work is required to improve on this position.

Focused weekly PTL meetings continue to support and tumour stream specific PTL meetings ensuring patients are treated in a timely manner.

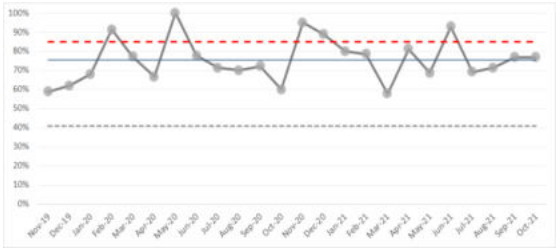
The delivery of the 28 day FDS standard is pivotal in supporting the Trust in achieving the 62 day standard for our patients. The Trust delivered the FDS target for the first time in September and delivered again in October. However in November, the FDS standard was not met due to diagnostic delays mainly related to the breast pathway.

Developments and transformation projects are being progressed to support the pathways and improve performance, for example, FIT –ve pathway and Breast Triple Assessment Service at EDGH.

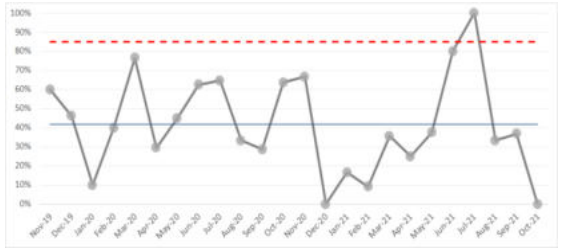
2WW Referral to First Treatment 62 Days

East Sussex Healthcare NHS Trust

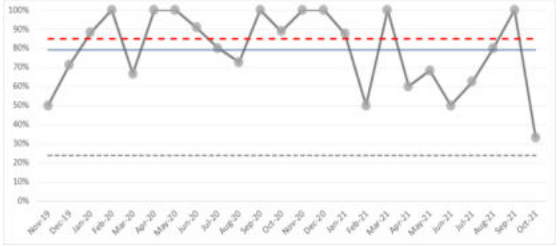
Breast



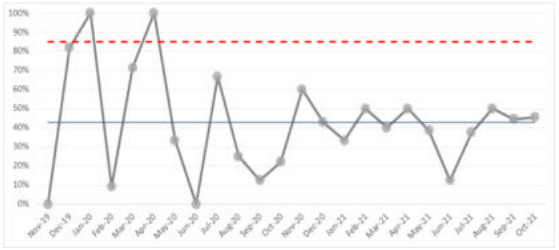
Gynaecology



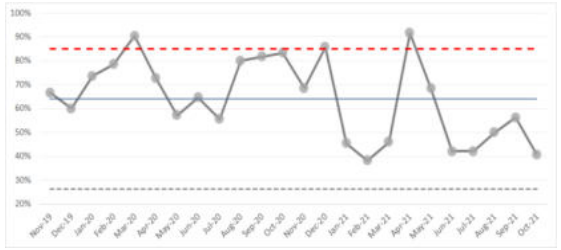
Haematology



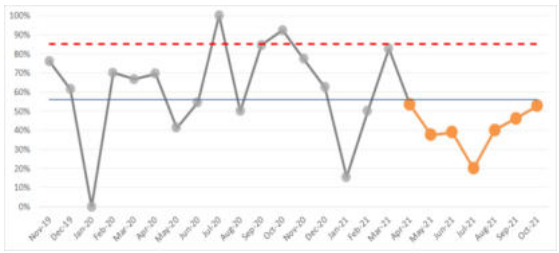
Head & Neck



Colorectal

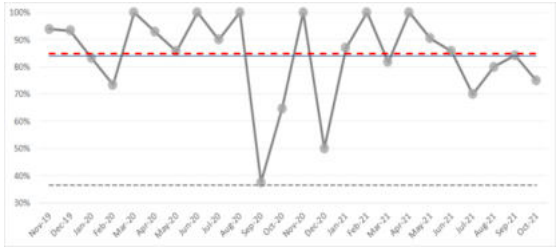


Lung

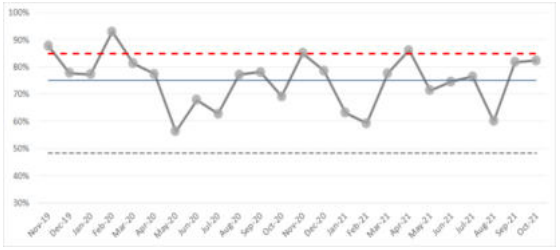


Skin

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	G	363.6	8.0	• YTD favourable of £8.0m driven by H1 pay award (£4.3m), ERF (£6.7m) partially offset by lower divisional income (£3.0m)
Pay	R	(231.6)	(8.1)	• Pay cost variance has reduced by £0.8m to £8.1m, this is driven by pay award of £4.3m and use of temporary staff at higher unit cost partially offset by WTE usage below budget. • Temporary staff costs are £30.6m YTD • The Trust is using 532 (8%) more staff than in 19/20
Non-pay	R	(123.8)	(5.6)	• Non-pay costs now exceed budget mainly driven by tariff excluded drugs and devices above plan by £2.5m, some of this is offset by higher tariff drug income.
Covid	G	(4.3)	5.7	• Covid position continues to support the trusts overall financial position with an effective YTD contribution of £13.4m (£17.8m income).
Surplus/deficit	A	(1.6)	0	• The in-month deficit is £0.4m (improvement from £1.2m last month) taking the cumulative position to £1.6m. The Trust is expected to recover this position over the rest of the half.
Efficiency	R	6.6	0.1	• Full year identified efficiency is £11.6m against an indicative plan of £14.7m. Whilst the gap to year end target has reduced to £2.7m, the H2 requirement is based on run-rate reductions. As such this has been rated as red.
Capital	A	12.4	2.8	• Capex of £12.4m is £2.8m behind plan, this needs to be carefully monitored against the capital allocation. • Current forecast is to spend £39.6m against a plan of £44.0m, a £4.3m slippage against the overplanning margin of £5.4m, leaving a residual overplanning amount of £1.1m
Risk & Mits	R	n/a	n/a	• We have identified £4.5m of net risk (after probability weighting – to present a reasonable worst case) against mitigations of £5.0m suggesting that based on current information that whilst the Trust will face very significant challenge to deliver a balanced position it should be deliverable.

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	39,669	40,483	(815)	305,551	301,220	4,331
Divisional	3,688	3,486	202	24,584	27,618	(3,034)
ERF	1,213	-	1,213	10,223	3,567	6,655
Covid - block	1,826	1,372	454	17,812	17,812	-
Covid - variable	347	347	-	5,419	5,419	-
Total Income	**46,744**	**45,689**	**1,054**	**363,589**	**355,637**	**7,953**
Operating Expense						
Pay						
Permanent	(25,261)	(27,821)	2,560	(200,993)	(209,804)	8,811
Temporary	(3,955)	(2,195)	(1,760)	(30,604)	(13,695)	(16,909)
Total pay	**(29,216)**	**(30,015)**	**799**	**(231,597)**	**(223,500)**	**(8,097)**
Non-pay						
Drugs	(1,014)	(1,087)	72	(8,230)	(7,805)	(425)
TEDD	(3,827)	(3,644)	(183)	(29,375)	(26,868)	(2,508)
Clinical supplies	(3,531)	(4,226)	695	(26,054)	(24,641)	(1,413)
Purchased services	(948)	(809)	(139)	(8,267)	(6,423)	(1,843)
Finance costs	(2,277)	(2,078)	(199)	(15,534)	(16,623)	1,089
Other	(5,564)	(3,369)	(2,195)	(36,326)	(35,869)	(458)
Total non-pay	**(17,161)**	**(15,213)**	**(1,948)**	**(123,787)**	**(118,228)**	**(5,558)**
Covid exp - block	(465)	(603)	137	(4,390)	(10,139)	5,749
Covid exp - variable	(347)	(347)	-	(5,419)	(5,419)	-
Total Expense	**(47,189)**	**(46,178)**	**(1,011)**	**(365,193)**	**(357,287)**	**(7,907)**
Surplus/(Deficit)	**(446)**	**(489)**	**43**	**(1,604)**	**(1,650)**	**46**
Memo:						
WTE (worked)	7,430	7,979	(550)	7,285	7,596	(311)

I&E position

The in-month deficit is £0.4m in line with plan (YTD deficit of £1.6m). The Trust is expected to return to surplus in M9.

Income

- YTD favourable income position £7.9m driven by:
  - of ERF being £6.6m ahead of plan, all driven from H1 performance, there has been a true up to actual activity which was ahead of flex performance of £1.2m in M8;
  - the effect of the back dated pay award for H1 of £4.3m included in contract income; partially offset by
  - Divisional income under-performing due to the impact of COVID on the Trust's ability to bill for third party rents, car parking and other services provided.
- M8 income is above plan by £1.1m this is driven by the ERF catch-up.

Expense

- The Trust has a YTD £8.1m adverse pay position, this has reduced from £8.6m in M6 of which £4.3m driven by the back dated pay award.
- Underlying overspend 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.
- WTE usage is significantly below plan, it is therefore the use of agency and bank is therefore driving the overspend on pay.
- The £5.6m 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 block expenditure is £4.4m which is £5.7m better than plan with Covid Block Income recognised at £17.8m meaning there has been an effective contribution of c£13.4m YTD.

Pay costs

East Sussex Healthcare NHS Trust

Pay analysis

All staff	Pay costs (£'000) - In Month					WTE				
	Act	Var	PY	YTD var	YTD ave	Act	Var	PY	YTD var	YTD Ave
Medical	(7,286)	(323)	*(6,902)*	(3,521)	(7,206)	810	11	*744*	20	793
Nursing	(11,949)	882	*(10,727)*	2,658	(11,798)	3,429	(512)	*3,129*	(302)	3,361
AHP	(4,067)	126	*(3,734)*	285	(4,001)	1,106	(40)	*1,021*	(12)	1,094
Admin	(3,351)	259	*(3,353)*	89	(3,516)	1,299	(4)	*1,223*	3	1,290
Other	(2,563)	(144)	*(2,441)*	(7,609)	(2,429)	786	(5)	*780*	(20)	748
Total	**(29,216)**	**799**	**(27,156)**	***(8,097)***	**(28,950)**	**7,430**	**(550)**	**6,897**	***(311)***	**7,285**

Temporary	Pay costs (£'000)					WTE				
	H1 Ave	Oct	Nov	PY	YTD	H1	Oct	Nov	PY	YTD Ave
Bank	**(1,416)**	**(1,475)**	**(1,654)**	**(1,313)**	**(11,623)**	**424**	**453**	**469**	***434***	**433**
Medical	(385)	(574)	(376)	(442)	(3,258)	30	36	30	*34*	31
Nursing	(281)	(405)	(368)	(224)	(2,456)	57	86	83	*41*	64
AHP	(97)	(112)	(124)	(155)	(818)	18	21	20	*32*	19
Admin	(68)	32	94	(76)	(281)	16	12	12	*2*	15
Other	-	-	-	-	-	-	-	-	-	-
Agency	**(830)**	**(1,059)**	**(775)**	**(897)**	**(6,813)**	**121**	**154**	**146**	***109***	**128**
Locum	**(1,223)**	**(1,410)**	**(1,232)**	**(1,097)**	**(9,980)**	**103**	**106**	**101**	***89***	**103**
WLI	**(264)**	**(298)**	**(293)**	**(147)**	**(2,175)**	**25**	**23**	**28**	***12***	**25**
Total Temp	**(3,732)**	**(4,242)**	**(3,954)**	**(3,454)**	**(30,591)**	**673**	**736**	**744**	***645***	**690**

Pay Costs (£'000)

Pay analysis

- Note the costs and WTE's exclude those included in covid costs.
- M8 pay costs are lower than budget by £0.8m driven largely by recruitment lags on new services. Nursing remains the largest area of underspend at £0.8m in month, this will reduce when the outcome of the ward establishment review is implemented in budgets.
- Overall the in month spend of £29.2m is £2.1m higher than inflation adjusted 19/20 comparator with covid costs over and above that.
- YTD all staffing groups other than nursing & AHP's are overspending. Nursing underspending due to the significant increase in the budget for H1 & H2 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 demonstrating this was included in the M5 finance report.

PY comparison

- Pay (£) is overall is above the inflation adjusted 19/20 and 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 and M6 from pay award.
- When compared to 19/20 in particular costs are materially higher in 21/22.
- WTEs continue to be higher in 21/22 than in 19/20. Nov 21 when compared to 2019 has 8% more WTE (532), driven mainly by nursing (300), AHP (85), Medical (66) & admin (76).

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

Efficiency

East Sussex Healthcare NHS Trust

Division	In Month			Ytd -M8			Full Year					Schemes
	Plan	Actual	Var	Plan	Actual	Var	Rec	NR	Total	Target	Gap	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	#
Medicine	1	1	-	397	397	-	27	387	414	1,948	(1,534)	4
Emergency Care	0	0	0	1	1	0	2	2	4	538	(534)	2
DAS	68	91	23	639	693	54	208	1,282	1,491	2,273	(782)	10
Core Services	52	44	(8)	229	242	14	672	65	737	1,695	(958)	14
CHIC	295	440	146	716	862	146	362	627	989	1,056	(67)	5
WCSH	9	9	-	267	267	-	21	753	774	997	(223)	6
Estates & Facilities	76	76	-	1,008	1,008	-	363	862	1,226	823	403	5
Corporate	59	125	66	531	662	131	222	631	853	806	47	24
ERF	-	-	-	958	958	-	-	958	958	-	958	-
Trustwide	1,359	1,359	-	1,530	1,530	-	1,590	3,000	4,590	4,590	-	2
Total	**1,919**	**2,146**	**227**	**6,275**	**6,620**	**345**	**3,468**	**8,567**	**12,036**	**14,725**	**(2,689)**	**72**
Unidentified	*122*	*-*	*(122)*	*238*	*-*	*(238)*	*-*	*-*	*2,689*	*-*	*2,689*	*-*
Total	**2,041**	**2,146**	**105**	**6,513**	**6,620**	**107**	**3,468**	**8,567**	**14,725**	**14,725**	**-**	**72**
Movement from last month	*1,846*	*1,728*	*(118)*	*1,919*	*2,146*	*227*	*(200)*	*630*	*431*	*(0)*	*430*	*6*

Overview

- There has been £2.1m delivered in month 8 and £6.6m YTD, (including the ERF over-performance)
- The in month and YTD variance is largely due to the increased SEES activity and vacancy slippage in CHIC and Corporate.
- The target for the year is £14.7m, £12m has been identified, including £3m contingency and £1.6m income recovery. The remaining gaps stands at £2.7m.
- There is a high proportion (71%) 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 over-performance) as recurrent.

Risks

The main risks to delivery are:

- Impact on delivery of a further wave of COVID-19; and
- The H2 target needs to be a run-rate reduction; and
- Sufficient time and capacity for division to develop and implement savings plan in an uncertain environment; and
- Less than 4 months left to identify and deliver the £2.7m gap.

Next Steps

- Work with the divisions to develop robust plans for the rest of the year, targeting run-rate reductions;
- Exploit benefits using Model Hospital and Model Health System and GIRFT and other 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

SCHEME	TRUST LEAD	YTD			Full year			RAG
		Plan	Actual	Var	Plan	F'cast	Var	
		£'000	£'000	£'000	£'000	£'000	£'000	
Fire Compartmentalisation	EST	735	606	(129)	1,250	1,250	-	
Backlog Maintenance	EST	3,018	2,486	(532)	6,996	5,098	(1,898)	
Cath Lab Replacement CONQ	EST	485	244	(241)	1,315	1,315	-	
ED and DSU - EDGH	EST	150	8	(142)	2,200	1,750	(450)	
Emergency Department CONQ	EST	1,509	1,935	426	2,549	2,549	-	
Medical Equipment	EME	459	1,001	542	1,527	1,177	(350)	
Paediatrics	EST	135	-	(135)	200	200	-	
Respiratory Ward - Westham	EST	250	8	(242)	250	500	250	
Respiratory Ward - Baird	EST	250	5	(245)	250	50	(200)	
Energy Centre EDGH/CONQ	EST	446	617	171	535	535	-	
BFF Enabling/Transformation	EST	2,312	1,493	(819)	4,694	4,094	(600)	
ICU Covid-19 adaptations	EST	160	2	(158)	400	200	(200)	
Triple Breast	EST	200	113	(87)	200	200	-	
Temporary Accommodation	EST	1,423	1,225	(198)	1,423	1,423	-	
Digital	DIG	2,180	1,076	(1,104)	3,800	3,800	-	
Minor Capital	FIN	770	933	163	1,400	1,400	-	
Reserves and Unplanned Urgents	FIN	413	-	(413)	750	400	(350)	
Other	FIN	218	456	238	218	218	-	
Donated	FIN	-	176	176	-	-	-	
Original planned Capital		**15,112**	**12,384**	**(2,728)**	**29,957**	**26,159**	**(3,798)**	
Digital Aspirant/Transformation	DIG	-	-	-	1,600	1,600	-	
Seed Aspirant - EPR	DIG	-	-	-	250	250	-	
Digital Pathology - PathNetwork 7	DIG	-	-	-	903	903	-	
Community Diagnostics Centre	EST	-	-	-	1,786	1,586	(200)	
Radiology Imaging Network	DIG	89	-	(89)	1,321	1,321	-	
Cyber Security	DIG	-	-	-	250	250	-	
ICS Digital - Shared Care Record	DIG	-	-	-	3,802	3,802	-	
Robotic Process Automation (TIF)	DIG	-	-	-	150	150	-	
E-Triage (TIF)	DIG	-	-	-	407	407	-	
Da Vinci Robot (TIF)	THE	-	-	-	700	700	-	
Upgrade Theatres (TIF)	THE	-	-	-	1,400	1,120	(280)	
CT Scanner (TIF)	RAD	-	-	-	550	550	-	
Diagnostics Equipment (TIF)	RAD	-	-	-	885	885	-	
Additional Capital		**89**	**-**	**(89)**	**14,004**	**13,524**	**(480)**	
Capital Position		**15,201**	**12,384**	**(2,817)**	**43,961**	**39,683**	**(4,278)**	
Headroom/(Overplanning) Margin					**(5,358)**	**(1,080)**		

RED: Reasonable chance of 25% slippage or 250k on individual scheme whichever is smaller
Amber: Reasonable chance of 10% slippage or 100k whichever is smaller
Green: Less than 10% chance of slippage
Blue: Scheme complete

Capital

- The planned Capital resource limit (CRL) for 2021.22 is £23.4m. This is made up of internally generated depreciation of £16.7m and additional external funding expected to be received in year (£6.7m).
- The forecast CRL totals **£38.6m** and includes additional funding of £15.2m (including agreed overspend offset with another ICS provider - £14.0m without).
- The total capital plan is now expected to be £43.9m with an overplanning margin of £5.4m.
- Consideration is being given to deferring the carpark to later in next year due to the commitment on Trust internal capital it would place on next years programme and the likely delay in BFOF means this is less urgent.
- The capital position at the end of month 8 totals £12.4m of actual expenditure. This compares to the revised plan of £15.2m with a slippage of £2.8m.
- 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 current forecast shows a predicted variance of £4.3m underspend against plan, resulting in a £1.1m overspend against capital resource limit. Our expectation is that as we continue the forecasting exercise that this will reduce further, although it is possible with the direction construction costs are moving that this may increase – which will require us to consciously slip the timeline on some projects.
- The biggest risks to delivery of the capital plan relate to some of the recent allocations (CDC and the laminar flow theatres), the DSU and EDGH ED may also be challenging to deliver by 31 March.

Balance Sheet

East Sussex Healthcare NHS Trust

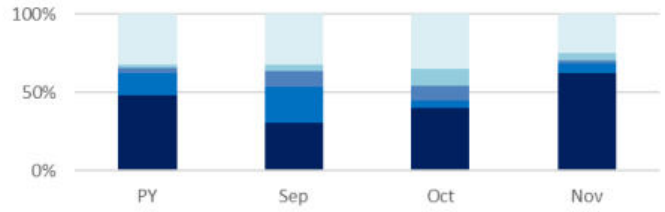
Trust Balance Sheet

	Sep £'000	Oct £'000	Nov £'000	Change £'000
Non-current assets	**257,149**	**258,740**	**258,664**	**(76)**
Inventories	5,291	5,611	5,288	(323)
Trade and other receivables	25,421	17,697	18,460	763
Cash and Cash equivalents	49,420	54,018	53,165	(853)
Current Assets	**80,132**	**77,326**	**76,914**	**(413)**
Trade and other payables	(44,257)	(41,509)	(41,254)	255
Other liabilities	(2,821)	(6,392)	(5,327)	1,065
Current Liabilities	**(47,078)**	**(47,901)**	**(46,581)**	**1,321**
Non-current liabilities	**(5,226)**	**(5,226)**	**(5,226)**	**-**
Total assets employed	**284,977**	**282,939**	**283,771**	**832**

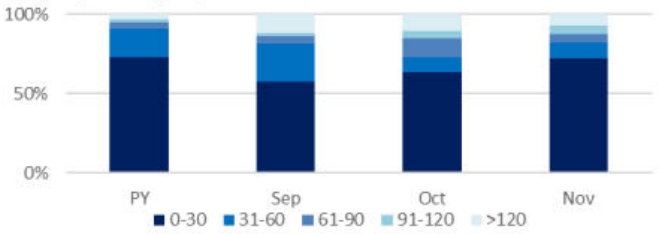
BPPC

Trade	91.0%	91.9%	92.6%	0.7%
NHS	99.4%	99.5%	99.5%	0.1%

Trade receivables Ageing



Trade Payables Ageing



Balance sheet

- The balance sheet shows a broadly consistent position overall with the previous month (as would be expected with a break even I&E position), total assets deployed have reduced driven by the in month deficit.
- There have been a number of movements relating to timing of payments (e.g. trade payables and receivables).
- The Trust continues to hold very significant cash balances.

Trade Receivables

- The sales ledger balance at the end of November is £7.7m which is a large increase on the previous month of £2.9m. This is driven by a large one off invoice raised to the CCG at the end of November for H2 transformation funding and has driven a change in the ageing profile.
- The number of invoices on the sales ledger at the end of the month has decreased by 29 to a total of 1,475.
- With the exception of the invoice noted above the ageing profile remains broadly similar to the previous month. the total debt owed to the Trust aged over 30 days has decreased from 60% to 37%. 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 and Better Payment Practice Code (BPPC)

- BPPC performance has improved again in November and is a result of the on-going work of the financial services team to increase performance, particularly around non-NHS payables.
- An increase in month of £1.3m on the creditor position reducing the purchase ledger total to £7.9m. There has also been an increase in the number of invoices on the purchase ledger system from 5,280 to 6,084.
- 82% 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

The risks and mitigations set out below are aligned to the H2 system planning submission and highlight the very significant level of risk facing the Trust to deliver on the H2 plan of breakeven.

	Gross value £'000	Risk adjusted %	Net value £'000	Prior month £'000	Description
H2 Efficiency Programme	4,736	20%	947	1,894	Trust plan is predicated on delivery of £4.7m of efficiency compared to H1 run rate. Reducing expenditure by that qunatum in four months remaining will be extremely challenging. Further progress has been made and we anticipate being able to deliver broadly in line with plan
CCG income disputes	1,590	80%	1,272	954	The plan includes £1.6m of additional income from CCGs for historical services commissioned outside the block. The CCG has yet to agree to pay for these and refused in H1 on the grounds of affordability. The Trust position is to offer a 50:50 settlement over the year. The CCG is refusing to engage meaningfully
Funding assumptions	9,573	20%	1,915	3,829	Funding has now been confirmed, however there may be some expectation that incremental services are delivered rather than the funding being used to close the financial gap.
Additional cost pressures	2,060	20%	412	824	General risk for 1% of H2 forecast expenditure. The most signficant risk being WTE utilisations as excluding covid are c400-500 budgeted WTE above used, if these are filled then it will increase costs faced. This risk has been lowered due to the Trusts commitment to balance the position.
Total Risk	**17,960**		**4,546**	**7,502**	
Fair Share Capacity Funding	-	n/a	-	2,118	This money has now been allocated
Additional bid funding	1,590	80%	1,272	-	If the CCG refuses the offered positon on the unpaid for services additional bid funding could be diverted
ESHT contingency contribution	3,080	40%	1,232	1,232	ESHT has contributed £3.1m to ICS contingencies which are currently not allocated
ICS contingency	12,232	20%	2,446	2,446	Deployment of residual ICS capacity
Total mitigation	**16,902**		**4,950**	**5,797**	

Board Assurance Framework (BAF) Q3 update

Meeting information:		
Date of Meeting:	8th February 2022	Agenda Item: 8
Meeting:	Trust Board	Reporting Officer: Richard Milner, Director of Strategy

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 is the regular, quarterly update to the Board that reviews those organisational risks (sometimes referred to as "killer risks") that could compromise delivery of Trust strategic objectives or our most important in-year deliverables. The scores in the main body of the paper refer to the position as at December 2021 (end of Q3).

Each of the Executive Directors has reviewed the risks ascribed to them, and has provided updates within the main body of the report. As a reminder, the relevant Executive Directors are as below:

BAF risk	Owner	Board Committee with oversight
1	Chief Nurse/Medical Director	Quality & Safety
2-3	Chief Operating Officer	
4-5	Chief People Officer	People & Organisational Development (POD)
6-8	Chief Finance Officer	Finance & Investment
9		Audit

There are no new risks this Quarter, nor are there proposed changes to the post-control scores.

The report concludes with a brief overview of the approach that we are taking as an Executive Team to ensure that the improvements made to the BAF are consolidated in 22/23 and that we are reflecting adequately in our BAF for the coming year our management of the 'killer risks' that we face over the twelve months ahead from April 2022. Further details will be provided in the Q4 paper as we close out the 21/22 BAF.

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

Board members are well-apprised of the disruption to corporate business caused by the re-emergence of COVID via the Omicron variant during Q3, and the response across the NHS; namely to move to "governance light".

As a consequence there has been some disturbance to the normal course of events; Executive Directors have reviewed the BAF updates but there has been a delay in the formal oversight function of the updates across the Committees at section 1 above.

- Risk 1 was reviewed at Quality & Safety (November 21)
- Risk 2-3 planned for Quality & Safety (February)
- Risks 4-5 reviewed at POD (January)
- Risks 6-9 planned for (January F&I/Audit)

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

The Board is asked to note:

1) The Board Assurance Framework and consider the risk scores and control mechanisms in place for Q3
2) The approach for considering the BAF and its scope in 22/23

Board Assurance Framework (BAF)

Quarter 3 2021/22

East Sussex Healthcare NHS Trust

1. Overview and BAF updates

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. 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	12		◄►	Low	6	Mar 22
BAF 2	Restoration and Recovery - ongoing impact of Covid19	Q&S	✔	✔	✔	✔	✔	20	16	16	20	20	16	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	16		◄►	Low	6	Mar-22
BAF 4	Sustainable Workforce	POD	✔	✔	✔		✔	20	16	16	16	16	16	16	16		◄►	Moderate	12	Mar-22
BAF 5	Protecting our staff	POD			✔			16	12	12	12	12	12	12	12		◄►	Low	9	Mar 22
BAF 6	Financial Sustainability	F&S				✔	✔	16	12	12	12	4	12	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	16		▲	Moderate	12	Mar-22
BAF 8	Investment required for estate infrastructure – buildings and environment	F&S	✔				✔	20	16	16	12	12	16	16	16		▲	Moderate	8	Mar-22
BAF 9	Cyber Security	Audit	✔	✔			✔	20	16	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:**	Nov-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 Q4**	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**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 with a new VOC, 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. The Trust is continuing to see ongoing multiple Covid outbreaks with high local prevalence still at time of writing.	**Likelihood:**	2	Mar-22
Consequence:	4	3	3	3		**Consequence:**	3	
Risk Level:	16	12	12	12		**Risk Level:**	6	

Cause of risk:	• 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	**Impact:**	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

	learning from incidents and other quality metrics may not be consistently applied and effective		
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	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 Committee	**Date of last review by Committee:**	xxx	
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 Q4**	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	5	4	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	16	16	16		**Risk Level:** 8	

Cause of risk:	2021 recovery (H1&2) 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, also that the Trust starts planning against the operational guidance for 22/23, which has been delayed to the end of April due to the current COVID response levels. As expected the Trust has seen an increase in the Omicron variant and this has impacted staffing levels available to deliver elective sessions. There is an additional impact on the increase in the number of beds having to be closed due to contacts/outbreaks – encroaching on the elective bed base as a result. Additional capacity has been opened and the Trust is working as part of the ICS to utilise IS and Cancer capacity at QVH to maintain urgent elective procedures for Skin. It is recognised regionally and nationally that the impact is on the elective programme and the Trust delivered 85% in November for admitted activity. The trust continues to deliver against OP activity and Day Case but along with the rest of the country the inpatient elective programme has been impacted. The trust remains with 0 patients waiting over 104 weeks and 1 patient over 78 weeks which is being planned in conjunction with the patient availability.	**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 Access meeting with oversight of Trust level PTL profile and long waiters including cancer and private patients G. The Trust is 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 Access, Urgent and Community Care Boards and associated governance arrangements in place (A) (B) (C) (D) (E) (F) • Update report covering concerns/ key actions / positive assurance and decisions presented to Executive Team (A) • Weekly Elective Access meeting 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) • 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 (F) • Divisional tracking through Elective Access meeting against trajectories that are in development (A) (F) • ICS Planned Care Leads meeting (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.	Seasonal bed modelling in progress and mitigations being identified	COO	End of April 22	• Escalation waterfall and triggers presented to Execs and NEDS – via board drop in session and IMT – being embedded into EPRR / BC documentation	

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:**	xx	

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**	**21/22 Q3**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	5	5	4	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	4		**Consequence:** 3	
Risk Level:	20	20	16	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 F. Development and implementation of additional diagnostic capacity with the Community Diagnostic Centre roll out in Bexhill

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 Access 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 changes commencing with ENT (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 Access 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:**	Oct -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 Q4**	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**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. • Changes to national educational programmes especially GP training. From August 2022 GP trainees will have to spend 24 months in the community leading to a reduction in the current hospital based posts. This will affect ED, Medicine, Paediatrics, O&G and Psychiatry. • South Thames Foundation School splitting apart new Foundation School being created for HEEKSS; expectation ready for August 2022, could impact on smooth allocation of FY doctors in August 2022. • Staff leave NHS employment as result of mandated vaccinations affect all areas.	**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 • Detriment to staff development as result of reduced ability for staff wanting to attend education/training due to staff shortages in key areas

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 and regional medical role expansion programme – Foundation and some Speciality Training programmes H. Exit interview programme I. Use of bank and agency if required with authorisation process in place J. Range of wellbeing support available and being further developed K. We continue to look for opportunities to thank our colleagues and celebrate the success of the work they do through the Pride of ESHT awards, thank you cards, regular meals, Hero of the Month Awards, Winter Sparkle Campaign L. Real focus on retention particularly on understanding why people may want to leave the trust.

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 e.g. consultants in Histopathology, Radiology, Neurology and Acute medicine.(A) (C) • In house Temporary Workforce Service to facilitate bank and agency requirement (I) • Workforce efficiency metrics (D) • New AHP /HCSW initiatives rolled out Jan 2022(C) • Continued International Nurse recruitment.c30 each month Jan/Feb/March 2022.Cohorts planned for rest of Financial year 2022(A) • Additional Headhunter Agencies engaged for hard to recruit Medical Posts (A) • Regular meetings with Regional Post Graduate Deans for Acute and Primary care • HR develop policies, strategies and support for all staff reference mandated	• 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 (includes Pastoral Fellowes support) and reviewed by POD (K) • People Strategy being developed (A)(B)(C)(D)(E)(F)(I)(K) • Planned 3-6 month recruitment campaign to be scoped and rolled out early March 2022 (A)	• 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)

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*
	vaccinations – through HRBP roles.		
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 ,Sonographers, gastro and endoscopy	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.	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)	
3.	Focus on Advanced Practitioner role and roles that support medicine such as Physician Assistants, Surgical Care Practitioners, Anaesthesia Associates (new national curriculum due soon), increase number of Doctors Assistants	CPO	Ongoing	Review role of Advanced Practitioner roles that support medical teams e.g. only have 3 PA in the Trust, could have more. Task and Finish Group set up to see where could be best improved patient experience.	
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:**	Oct -21
Links to Corporate Risk	**Date:**	**Risk Register**	**Title**	**Inherent Risk Score**	**Current Risk Score**	**Change**

Register:		Number				
	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 Q4	21/22 Q1	21/22 Q2	21/22 Q3	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 e.g. 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. Working with the ICS to develop a system wide strategy and policy on violence prevention
E. Improved de-brief process and package of support for staff involved in violence and aggression or distressing situations at work.
F. Reviewing and implementing best practice from other areas (e.g. TRiM, MHFA)
G. Targeted support for implementing TRIM in ED departments through a dedicated resource for a period of three months
H. Range of wellbeing/pastoral support available and being further developed across all professional groups
I. Development of Health and wellbeing Conversations for all colleagues which will be implemented in April 2022
J. Violence and Aggression action plans developed following the 2020/21 staff survey results
K. Ongoing National vaccination programmes
L. Workforce Efficiency and Availability Reviews
M. 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 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:	• On Line 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) • DME monitor/reviews confidential trainees in difficulty register • 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) • GMC outcomes have action plans with quality virtual visits in place to provide assurance to HEEKSS/Trust

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.	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**	
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:**	Oct -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 Q4**	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**1**	**3**	**3**	**3**	The financial position for H1 of 2021/22 is reasonably assured, with an agreed H1 settlement despite ERF targets increasing. In M8 additional funding was agreed, providing some assurance that H2 should be delivered.	**Likelihood:**	**2**	Mar-22
Consequence:	**4**	**4**	**4**	**4**		**Consequence:**	**4**	
Risk Level:	**4**	**12**	**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 been finalised in M8. Delivery is being closely managed through H2 as the current Covid pressures are adding to the system challenge.				**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:**	Oct -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 Q4**	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**	**4**	**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**	**16**	**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:**	Oct -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 Q4**	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	3	4	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	16	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 management	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 bids being prioritised and prepared for submission to ICS.		

(controls)	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**	Oct -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 Q4**	**21/22 Q1**	**21/22 Q2**	**21/22 Q3**	**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 e.g. 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	

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 e.g. 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			

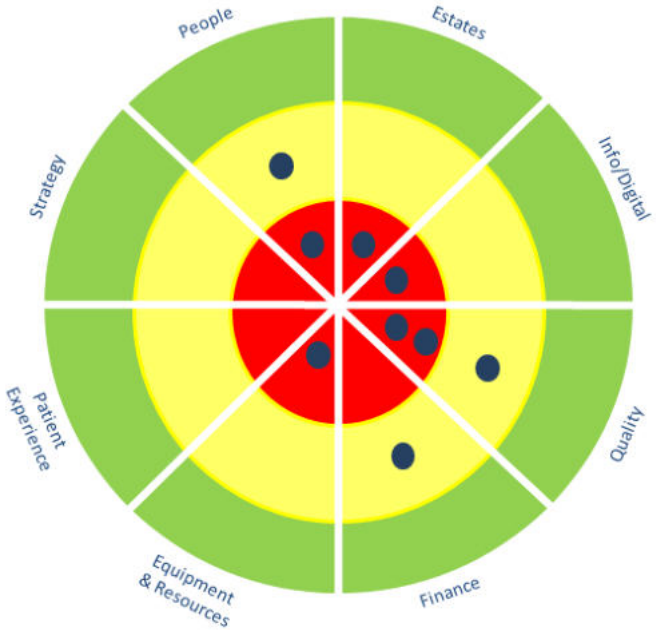
Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	Cyber Essential Plus framework.	Director of Finance	End March 2022	Greatly 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	

2. Planning for FY 22/23 BAF risks

Board members are aware that we have made significant improvements to our BAF and, looking forward, we are keen to continue this mindful that 22/23 brings additional challenges. We now have a clear set of Trust strategies, the aims/objectives of which will drive the Trust's direction over the coming five years at least. These aims/objectives have been shaped by an understanding of our operating context and we also have annual priorities as set out in the Annual Planning Guidance that we need to ensure the Trust aims to deliver this year.

We therefore need to ensure that we have captured adequately all the relevant information on the risks to the delivery of the Trust's aims/objectives and urgent priorities. As we move into the new FY 2022/23 this is a sensible point at which to review and refresh our BAF. The figure below shows an approach known as the "assurance radar" and, as an Executive Team, we are looking to use this to prompt our own thinking about how we shape the 22/23 BAF and this will be coming as part of the Q4 YE summary.

(NB: The figure below shows our current BAF controls and risk parameters covered)



*Baker Tilly: Board Assurance, A Toolkit for Health Sector Organisations

Considering our current BAF using this approach, two immediate questions appear:

1) Are we comfortable that our BAF identifies no Trust-level risks around patient experience or strategy?

2) Given the dots represent our residual risks (i.e. post- controls) are we comfortable with two-thirds of our BAF risks remaining red?

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

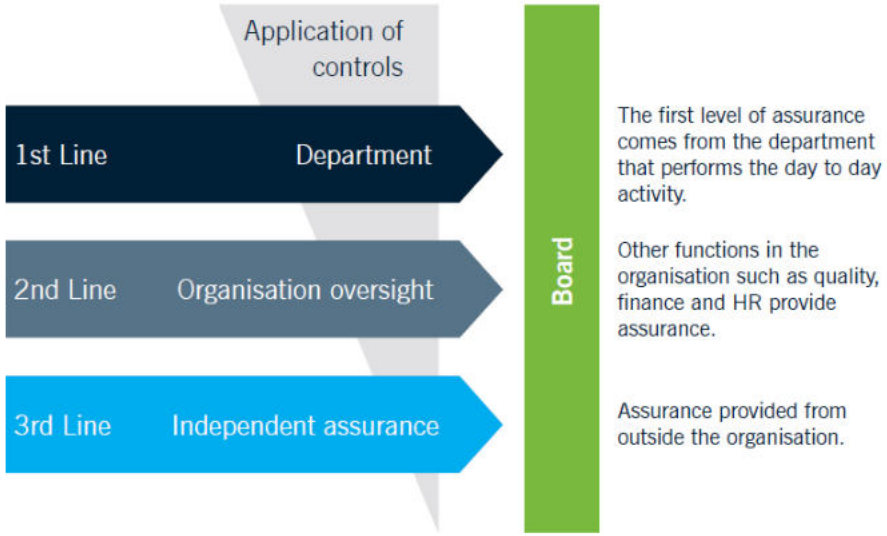
Table LIKELIHOOD X CONSEQUENCE/IMPACT = RISK RATING

		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

ESHT Enabling Strategies

Meeting information:		
Date of Meeting:	8th February 2022	Agenda Item: 9
Meeting:	Trust Board	Reporting Officer: Richard Milner, Director of Strategy

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

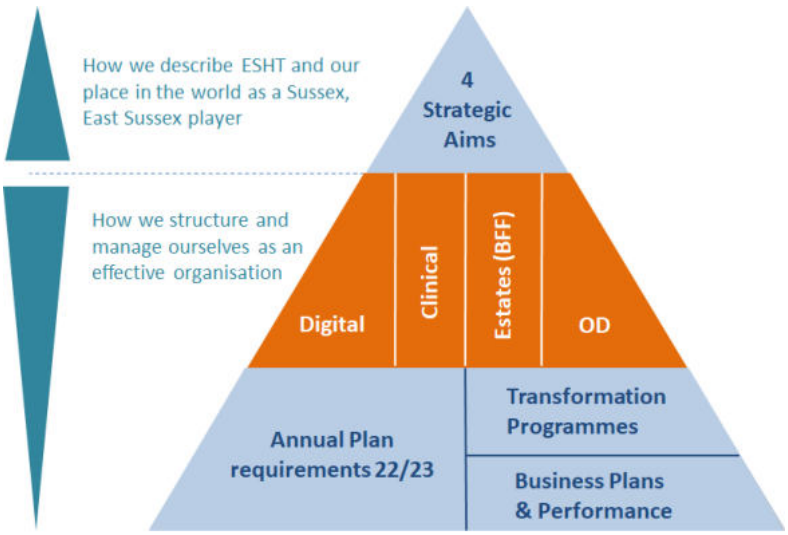
Has this paper considered: (Please tick)			
Key stakeholders:		**Compliance with:**	
Patients	☐	Equality, diversity and human rights	☐
Staff	☒	Regulation (CQC, NHSi/CCG)	☐
		Legal frameworks (NHS Constitution/HSE)	☐
Other stakeholders please state:	Primary Care and Local authority colleagues		
Have any 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

As Board members will be aware, ESHT completed its 5-year forward strategy *Better Health Together for East Sussex* earlier in 2021. This set the four strategic aims for the Trust and included a set of objectives under each aim.

This Trust-wide strategy was underpinned by four enabling strategies (People, Clinical, Digital and Estates – shown in orange in the figure below) that have been taken through the relevant Board Committees to ensure scrutiny of the progress made against each area. These Board Committees have now signed off these enabling strategies and they are brought collectively to this Board for approval.



We should be rightly proud of this work, that has brought together senior clinicians and managers across the organisation, and has been developed with a very clear internal and external perspective; internally we need to ensure that our ambitions are both challenging but also achievable, aligned to our Building for Our Future business case, and externally that our sense of 'what is best for the people we serve in East Sussex' is consistent with the Sussex-wide priorities that are set out in the Sussex Vision 2025 outcomes and the new operating environment presaged by the Health and Care Bill.

We believe that this sets out ESHT's role as an integrated provider, building on strong working relationships with local government colleagues and our leadership role in Sussex co-ordinating digital innovation across organisations in the county.

Our focus on next steps as we bring this together is to ensure we have joined up, programmatic approach to delivery that encompasses financial viability, operational sustainability and a focus on change/transformation so that ESHT is well-placed to make the most of the expected HIP2 monies that we anticipate receiving in 2026/7. The detail of this work will come through the Trust's Strategy Committee, and may include other Board Committees too.

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

- The People Strategy was shared and discussed with full Board at the September seminar
- The Estates, Digital and Clinical Strategies were agreed at Strategy Committee on 23/12/2021

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

Following the recommendation for approval at the Board Committees noted in section 2, above, the Board is asked to approve these four enabling strategies.

NHS
East Sussex Healthcare
NHS Trust

DIGITAL STRATEGY 2021 - 2026

Outstanding care through digital transformation, innovation and data

www.esht.nhs.uk

CONTENTS

Joe Chadwick-Bell
Chief Executive

Damian Reid
Chief Financial Officer

Andy Bissenden
Associate Director of ESHT Digital

Dr Kate Murray
Chief Clinical Information Officer

FOREWORD

Welcome to "Outstanding care through digital transformation, innovation and data," our Digital Strategy for East Sussex Healthcare NHS Trust. This document describes our digital ambitions for the next five years, how we intend to achieve those ambitions and the difference it will make for our patients and staff. It sets out how we will radically change and improve the digital infrastructure and systems we provide to support the delivery of modern, digitally enabled healthcare (digital transformation), using new and emerging technologies (innovation) and the wealth of patient information we have available to us (data) to provide outstanding care.

This strategy is one of four enabling strategies that underpin and support "Better Care Together For East Sussex", the Trust's five year strategic plan which sets the overall direction for our services; enabling our residents to access the best care in the most appropriate place – at home, in the community or when they need to come into hospital.

These are exciting times at ESHT: in recent years we've made significant improvements to the services that we provide and now, as part of the Government's New Hospital Programme, we have the opportunity to improve our hospital infrastructure.

One of the most important components of our success and continued journey of improvement will be how we take full advantage to use digital to support our changing infrastructure. Although we have introduced a number of new innovations in the last few years, we want to go much further, embarking on a programme of digital transformation until we reach our ultimate ambition, which is to become a digitally mature Trust.

We must ensure that we continue to deliver outstanding integrated acute and community services. This will only be possible if we have the digital infrastructure and solutions in place. We want to ensure that our digital systems enable our staff to work more efficiently and that they have the skills and confidence to use them to their full advantage. We also want to give patients the chance to engage more in their care, reducing unnecessary appointments and giving them easy and safe access to information to help them and others to be more involved.

Whilst this strategy is an important step forward, we recognise that it is just the start of our journey - delivering its ambitious vision will require a combined effort from us all, working closely with our staff, patients and partner organisations to realise the benefits of a digital future.

1

INTRODUCTION

In recent years, the way we use technology to deliver healthcare has evolved. We developed ESHT's first Digital Strategy in 2018 and have made good progress on the aims we set out to achieve. We've already introduced a number of new innovations which have changed the way we work and the way we provide care to our patients (more information about some of these is available on page 8).

The pace of change continues to accelerate as we respond to the demands of how we deliver healthcare and so we're taking the opportunity to refresh our Digital Strategy. We want to be more ambitious with what we set out to achieve, maximising the opportunities that are now available to us to digitally transform over the next five years.

Whilst developing this document, we sought the views of our colleagues and patients and have used their feedback to develop four pledges that will underpin everything we do digitally. These are the key things that our colleagues and patients have told us are important and that we must get right if we want to achieve our digital ambitions:

- **We will get the basics right**
- **We will never digitally exclude our patients**
- **We will ensure our colleagues have the knowledge and skills to use the technology available to them**
- **We will continue to engage with our colleagues and patients**

We have also identified eight key objectives which will help us to deliver our overarching ambition to become a truly digital organisation. These aims have been developed to align and support the Trust's four key strategic aims, as outlined in Better Care Together for East Sussex:

- **Give patients electronic access to their records through a Personal Health Record**
- **Introduce a single Electronic Patient Record across all our services**
- **Empower patients by using digital to support personalised care, putting them at the heart of everything we do**
- **Work with partners in the Integrated Care System (ICS) to implement regional priorities and ensure data is used to inform the decisions we make**
- **Maximise opportunities for using Robotic Process Automation, Artificial Intelligence and Machine Learning**
- **Ensure that our infrastructure and all data held in our systems is protected**
- **Ensure the digital infrastructure in our buildings is consistent and resilient**
- **Achieve HIMSS (Healthcare Information and Management Systems Society) Level 7 by 2026**

The table on the next page shows how our pledges and objectives will support the Trust to achieve its key strategic aims. More detail on our pledges and objectives is given from page 12 onwards.

	Improving the health of communities	Collaborating to deliver care better	Empowering our people	Ensuring innovative and sustainable care
ESHT Strategic Aim	We will focus on service improvement to drive better outcomes and address inequalities of access to care	We will actively strengthen partnerships to deliver integrated care for the communities	We will nurture our culture and champion the capabilities of our people	We will embed a culture of innovative, affordable care that meets the changing needs across Sussex
How Digital will support this	We will support "digital by default" across all services, identifying and delivering priority services for fully digital pathways. We will give patients more choice, enabling greater levels of personalised care, with individuals having access to a digital patient record and empowered to manage self-care	We will work with partners across the Integrated Care System to deliver a long-term strategy for a Local Health and Care Record	We will support implementation of digitally enabled flexible working, providing a reliable infrastructure that empowers staff to work remotely. We will support staff to use new technologies to enhance their daily working practices	We will ensure we are innovative in our approach and contribute to sustainable care. We will collaborate with other Trusts to develop digital care partnership working
Our Digital Strategy Objectives	Give patients electronic access to their records through a Personal Health Record. Empower patients by using digital to support personalised care, putting them at the heart of everything we do	Introduce a single Electronic Patient Record across all our services. Work with partners in the Integrated Care System (ICS) to implement regional priorities and ensure data is used to inform the decisions we make	Ensure systems in our buildings are consistent and resilient	Maximise opportunites for using robotics and artificial intelligence. Ensure that our infrastructure and all data held in our systems is secure
	Achieve HIMSS Level 7 by 2026		**Achieve HIMSS Level 7 by 2026**	

Our Digital Strategy Pledges

- We will get the basics right
- We will never digitally exclude patients
- We will ensure our colleagues have the knowledge and skills to use the technology available to them
- We will continue to engage with our colleagues and patients

ABOUT ESHT DIGITAL

Our work in ESHT Digital is far more than just Information Technology, it is about the people and the processes. We have a team of over 100 people and we deliver digital services and systems to all our Trust colleagues, at sites across the county.

We want to provide a friendly and responsive service that works in line with the Trust's values, tailored to meet individual/team/division requirements. We will offer expert advice, dealing with queries quickly and efficiently, supporting colleagues with digital transformation.

A key part of our work is influencing the move towards a digital culture, encouraging colleagues across the Trust to think digital first. We recognise the significant role that digital has in the future of healthcare and it is imperative we get this right if we are to support the Trust in achieving its overall aim to be rated as "outstanding".

In the last ten years, the way we use digital technology to provide care to our patients has changed massively. On the next page are some of the key changes we've already made:

Introduced a digital system across our inpatient wards to monitor patients'observations at the bedside and provide real time data to manage our bed and patient flow

Recruited our first dedicated Cyber Security team

Brought the Digital Service Desk in-house, giving a local first point of contact for help and support for colleagues

Introduced a digital system in our community services, giving teams more time to focus on patient care and reducing duplication of data entry

Started to introduce a Personal Health Record, giving patients access to appointment letters and information online

We also have some exciting developments planned for 2021/22:

Introducing an electronic patient record system to our maternity department, removing the need for pregnant women to carry paper notes

Improving the use of digital technology in our community services through the Digital Aspirant programme, for which we've been awarded £2,450,000 over the next two years

Introducing a new digital patient safety system to ensure robust communication and handover between our clinical teams at night

Implementing an Electronic Prescribing and Medicines Administration (ePMA) system, to improve patient safety and reduce time taken to prescribe, administer and check medicines

OUR ROADMAP

Below is our roadmap which sets out what we plan to achieve and will support delivery of our eight objectives.

In progress · Not started · Business Case · Complete

	2021	2022	2023	2024	2025	2026+
HIMSS level	2	3	4	5	6	7
Clinical Systems	Nervecentre Rollout; Medical Photography; eConsult/eTriage; Hospital@Home; Lab Information Management System; PHR (Phase 1); PHR (Phase 2); PHR (Phase 3, Appointments, Results, Pathways); Maternity System Implementation (Phase 1); Maternity System Implementation (Phase 2); ePMA Pilot; ePMA rapid rollout; Digital Aspirant for CHIC; Remote/Virtual Care/At home monitoring; ICE Upgrade; Maximisation of functionality; ICE for Radiology; PACS, Radiology Imaging Replacement Procurement; PACS, Radiology Imaging Replacement Implementation; CRIS Upgrade; VNA Cardiology; VNA Endoscopy; Private Patients Hastings					
Electronic Patient Record	Options paper; ITT and Tender; Phase 1; Phase 2; Spec & OBC; Award of contract; Phase 3; FBC; Phase 4					
Smart Tech/ Automation	Robotic Automation/AI; Phase 1; Phase 2; Phase 3; Phase 4					
Service Redesign	Audiology booths (DGH); Outpatient Transformation; Relocation of acute/off-site Community Paeds hub; Community Diagnostics Centre; Agile working; Ophthalmology; Cardiology					
Infrastructure	Orchestration Layer/Platform; Migration of Data Centre; Legacy OS Retirement; LAN; WiFi upgrade; VDI					
Cyber		Continuous improvement; Credential Accreditation				
Building Systems		Fire Compartmentation; Building Information System (BIM)				
ICS	SID; Virtual consultation; Plexus/eSearcher integration; Plexus/Nervecentre integration					

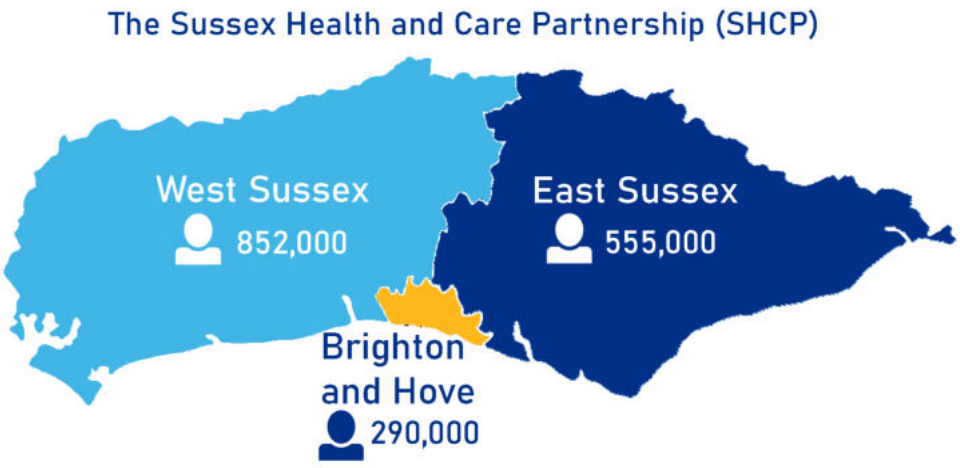
WORKING IN PARTNERSHIP

ESHT is part of the Sussex Health and Care Partnership (SHCP) which brings together 13 organisations into what is known as an Integrated Care System (ICS). The SHCP is sub-divided into three smaller regional zones, of which we are part of the East Sussex partnership.

Across the SHCP, we work collectively to improve the health of local people, ensuring that health and care services are high-quality and make the most efficient use of resources.This should enable local people to stay healthy for longer, to receive more support and treatment at home or in the community and, if they do get ill, to ensure they get the right care in the right place at the right time.

One of the ambitions of the ICS is to improve digital health and care services. The SHCP recognises that there are amazing opportunities to use technology and data to design better ways for services and patients to support each other. For example, population health data is now being shared to inform system wide pathway redesigns and to measure outcomes for patients.

However, it's also recognised that the opportunities technology and data can bring will also bring challenges. Privacy will need to be respected and steps taken to ensure that no one becomes digitally excluded so that inequalities are reduced, not made worse.



Improving population health is one of the key aims within the NHS Long Term Plan. To achieve this, we need higher quality, structured data to understand our patients and population.This links to work across the ICS on the Sussex Integrated Dataset (SID), which features in our objective to implement regional priorities (see page 22 for more information).

As part of the Digital Aspirant Programme, we're working closely with Sussex Community Foundation NHS Trust, to deliver a number of collaborative projects, using data and the latest innovations and technology to transform our community services. We're also benefitting hugely from the shared learning that this collaborative approach brings.

We also recognise that our patients are partners in their own care and want to give them more control over how they interact with our services. We also want to engage with them when we are introducing new digital solutions. As a first step, we will develop a virtual Digital Engagement Group, where ideas can be discussed and feedback given. Over 100 of our Trust members have expressed an interest in being part of this, and we will look to widen the membership and develop this group over time.

> **"We're already seeing great benefits in our collaboration through the Digital Aspirant programme. Sharing our work on key digital projects is helping us to move faster and lead the way in community digital healthcare, building a blueprint for community digital development which can be applied to other Trusts nationally."**
>
> **Diarmaid Crean**
> **Chief Digital and Technology Officer,**
> **Sussex Community Foundation NHS Trust**

2

OUR PLEDGES

From the feedback we received from our colleagues and patients, we have developed the four following pledges, which will underpin everything we do:

Pledge 1: We will get the basics right

When we spoke to colleagues, it was clear that things such as wifi, lack of digital storage space and hardware failures cause them the most frustration. That's why our first step will be a programme of work to ensure that our digital infrastructure can fully support the ever increasing demands being placed on it and that our colleagues can have more confidence in the reliability of the equipment and systems they use.

Pledge 2: We will never digitally exclude our patients

We believe the use of digital tools can enhance the care experience, allowing us to connect with our patients in a flexible and responsive way. We understand though that not everyone wants to use the technology that's now available. Healthcare must be accessible to all and so we will always offer alternative ways to communicate with patients who choose not to use technology. We will also train our staff to be digital health champions who can support patients and their families.

Pledge 3: We will ensure our colleagues have the knowledge and skills to use the technology available to them

Adapting to new technology can be difficult for some of our colleagues. We want to support them to get the most from the technology available, helping them to work more efficiently and ultimately to improve the care they provide patients. We want to extend the training and support we offer. We also want to increase our visibility in clinical areas so that any issues can be dealt with quickly without the need to escalate.

Pledge 4: We will continue to engage with our colleagues and patients about our plans

When asked, colleagues and the public told us they want to be more involved with the digital changes we're making. Starting early conversations with them around our digital ideas will give us a better understanding of what they need. To help with this, we have already introduced new Digital Business Partner roles, who work with our clinical and non-clinical areas to engage and collaborate. For members of the public, we plan to set up a virtual Digital Patient Experience Group to help us achieve this continuing engagement.

We also need to ensure that our digital systems are safe so we can avoid unnecessary harm. We have introduced digital clinical safety processes where both clinicians and technical staff work together to ensure there is a culture of digital safety.

We want to further improve patient safety by understanding 'what good looks like'. We can do this by looking at the benefits and cost savings associated with best practice, equipping staff, patients and partners with the opportunities and skills to improve patient safety throughout the patient pathway. We will also embed digital clinical safety in policy and regulatory documents and look for further opportunities for digital technology to solve patient safety problems. To support this, we will work with NHS Digital and local partners to share insights about what works best and why, and have an open forum for discussing potential digital safety risks and solutions.

See **Maria** and **Bens'** stories on the following two pages, which show the difference that meeting these pledges could make to our colleagues

COLLEAGUE STORY

MARIA

Age: mid 40's
Lives: Hastings
Works: Eastbourne DGH
Digital confidence: Good

Maria works in the digital project team, based at Eastbourne DGH. Although her role is mostly desk-based, she often attends meetings and visits clinical areas as part of her role.

Concerns: Balancing work and home life, access to technology at work that helps rather than hinders

2017

Maria worked full-time, travelling from Hastings to Eastbourne each day. She sometimes had to take her son to school on her way to work or collect him on the way home and felt like she was always rushing from one place to another.

Maria's team enjoyed working together, there was a good atmosphere in the office. Maria often attended meetings in the hospital's designated meeting rooms, but the equipment in each room was different so she didn't always have the right kit, causing unnecessary stress. It was also not unusual for Maria to find the room had been changed with no notice given to attendees. Wifi coverage around the hospital was patchy, making it difficult to access systems when out in clinical areas.

2021

As the pandemic began, Maria started to work from home. She was provided with a laptop and access to systems through a Virtual Private Network (VPN) connection. As working from home became longer term, Maria was provided with a screen, keyboard and mouse to set up a home office.

The introduction of Microsoft Teams completely changed how Maria and her colleagues interact. At a glance, she can see if colleagues are available, send them an instant message and have virtual meetings. Maria and her team have regular virtual catch-ups in the diary to make sure that everyone is doing OK and not feeling isolated.

2026

Maria works two days a week in the hospital and three days at home. She has a much better work-life balance and has agreed a flexible work pattern which she can fit around the school run. Working at home every day felt quite isolating so Maria enjoys seeing colleagues on her office days and feels she has the best of both worlds.

When at work, Maria no longer has a dedicated office but books a desk in one of the agile working spaces. Equipment in the meeting rooms has been standardised and wifi coverage has improved. A smart room booking system has also been introduced, which automatically notifies attendees if the location of their meeting changes.

COLLEAGUE STORY

BEN

Age: early 30's
Works: Conquest Hospital
Digital confidence: High

Ben is a Consultant Interventional Radiologist, performing minimally-invasive procedures guided by medical imaging such as x-rays and scans. This involves looking at very detailed images to make a diagnosis and decision on suitable treatment. Ben works from Conquest Hospital during the day but is part of an on-call rota overnight and at weekends. When on-call, Ben will review scans at home before travelling to the hospital to perform a procedure, for example, an angiogram and embolization for a patient with bleeding from the colon.

2018

At the hospital, Ben used a 32 inch screen to see all the necessary detail of scans. When on-call, he used his laptop which was much smaller, making the job more difficult. The connection to the hospital's systems from home was slow, with no guarantee that the Virtual Private Network (VPN) would connect. Scans are large files, up to a gigabyte in size, and downloading them can take time. From being woken at night, it could take up to 40 minutes for Ben to review a scan and then make the decision to travel to the hospital to perform a procedure.

2020

The radiology team has new equipment for working from home including larger screens, a new VPN and webcams. Almost everyone in the department has the same equipment at home as what they use on site. It can now take as little as 10 minutes from Ben being woken up to reviewing a scan and making the decision to go to the hospital.

The improved equipment gives team members the option to work from home during the day. This has helped productivity as it allows a quiet space to concentrate, rather than being interrupted as happens when in the office. This has also had a positive impact on work/life balance, with Ben able to collect his children from school on the afternoon he works from home. Wherever they are, the team members are always contactable and everyone has set times to be in the hospital each week.

2026

A new Picture Archiving Communication System (PACS) will be introduced in 2022, procured by Trusts across Surrey and Sussex. Ben can now view scans taken at any hospital in the region immediately, rather than sending a request and waiting for them to be sent. Electronic requesting for radiology imaging has also been introduced, replacing the hand-written piece of card previously used to request scans. This has made the requesting process quicker and provides clearer information to clinicians.

OBJECTIVE 1

Give patients electronic access to their records through a Personal Health Record

We are working to introduce a Personal Health Record, giving patients access to their health information through any internet enabled device, such as a laptop, smartphone or tablet. We're still in the early stages of implementation – at the moment most patients can see appointments and clinical letters sent to them online. We will move to a more ambitious roll-out which will include:

- **All appointments, medical correspondence, test results, medication lists and care plans, together in one place and accessible on any device**
- **Notifications when new information is available**
- **Messaging clinicians directly, with the ability to share data, photos, videos and documents**
- **Access to tailored resources designed for the individual patient**
- **Sharing data from wearable devices with clinicians**
- **Keeping a journal and monitoring symptoms**
- **Sharing records with other people such as GP, pharmacist, paramedic, carer or next of kin**

Giving patients access to this information will empower them to be more involved in their healthcare whilst for clinicians, it will give quick and easy access to the most up-to-date information they need to make decisions about their patients' care.

What difference could this make to patients? Read **Lydia's** story to find out

PATIENT STORY

LYDIA

Age: early 20's
Lives: Polegate
Digital confidence: Very high

In summer 2020, Lydia was knocked off her bike by a car. She was taken to Eastbourne DGH and diagnosed with a traumatic brain injury. As a result of her injuries, Lydia was referred to the Neurology team and worked with the Trauma Rehabilitation team and Neuro Physiotherapists, who are amongst the early adopters of the Personal Health Record platform at ESHT.

Concerns: Memory loss and reduced cognitive function due to brain injury

2015

All correspondence was sent in the post – likely that letters wouldn't have arrived in time to attend short notice appointments. Also issues with letters getting lost or being sent to the wrong place.

> "I wouldn't have been able to cope with all the bits of paper, I would have lost and forgotten things and missed appointments."

2020

Lydia could see all her appointments, letters and the information she had been sent in the Personal Health Record app. She also received an email whenever an appointment was booked. Given her memory loss, having all this in one place was a huge help. Lydia also used the app's symptom tracker to record her symptoms, which she could refer back to at appointments. She used a medication tracker which listed her medications and doses, again this was really helpful to have to hand at appointments when coping with memory loss.

Lydia also accessed services to help her recovery online through the links given and her rehab exercises were provided online rather than on paper. This meant any changes to the exercises or information could be given immediately, rather than being printed on paper.

2026

We want to have fully implemented a Personal Health Record across all our services. For Lydia, this will mean having access to all health information in one place. Lydia would be able to send messages, videos or photos securely to clinicians, saving time spent on the telephone or unnecessary appointments. The information could be shared with other clinicians involved in Lydia's care.

OBJECTIVE 2

Introduce a single Electronic Patient Record across all our services

We currently have around 400 different systems within the Trust which all collect information and use it in different ways. Many of these systems are standalone and cannot share the information they hold, which means clinicians have to log in to different systems to find the information they need to provide care. Inconsistencies in the data across these systems places a significant administrative burden on our staff but could also cause safety risks to our patients.

There is also still a large amount of paper in use and patients often have to repeat themselves, giving the same information over and over again to different people.

To overcome this, we want to introduce a single Electronic Patient Record (EPR) which is used across all our services. This would mean all patient information is available electronically, across our acute hospitals and community services and is available at all times.

Doing this will give clinicians more time to spend caring for patients as they will have faster access to information and will save patients having to give the same information to different members of staff.

Our plans have been boosted by the announcement that we have been selected to be part of the Digital Aspirants Plus programme, and will receive national funding and support to implement a full EPR.

This would also be the first step in allowing information to be shared more easily with other NHS organisations, GPs and social care providers across our acute hospitals and community services.

What difference could this make to colleagues? Read **Mark's** story to find out

COLLEAGUE STORY

MARK

Age: mid 40's
Works: Conquest Hospital
Digital confidence: High

Mark has been a nurse for over twenty years and currently works on a ward at Conquest Hospital.

Concerns: Providing best possible care for patients and adapting to new technology

2014

A system that provides bedside observations is introduced on Mark's ward. This records patient observations (such as temperature, pulse and blood pressure) digitally. The information is displayed on mobile devices which Mark and his colleagues carry round with them. The system automatically generates a National Early Warning Score (NEWS) to identify patients who may be deteriorating, improving patient safety by giving an early warning. The information is available 24/7, unlike paper charts which can go missing. The system has also removed any issues around the illegibility of handwriting.

2021

Additional digital functions have been introduced over time, such as the monitoring of patients' fluid balance. Mark and his colleagues were able to co-design other assessments and tools, which have enhanced patient care and improved collaboration between ward colleagues.

> "The new systems make my job much easier, having all the information I need about my patients readily available has given me more time to spend with them and greater confidence in the care we give them."

The new systems save Mark and his colleagues time which is spent with patients and visitors. Although they've had to learn and adapt, having all the information needed readily available has given more confidence when caring for patients, leading to a higher standard of care.

2026

Further developments will see a move towards paperless wards. Colleagues from ESHT Digital visit the ward regularly to deal with questions and further support is provided by eHealth Practitioners. Digital equipment across all wards has been standardised, so Mark can do a shift on a different ward and use the same digital equipment that he is already familiar with.

Mark's role will change as patients start to take greater control of their care, with more information available to them. Data will become more important and Mark will be involved in discussions around the impact of this and how it is used as an additional nursing tool.

OBJECTIVE 3

Empower patients by using digital to support personalised care, putting them at the heart of everything we do

Personalised care is one of the five major changes to the NHS outlined in the NHS Long Term Plan. It means giving people more choice and control over the way their care is planned and delivered, recognising that the complexity of people's needs and expectations for health and care can no longer be met through a one-size-fits-all approach.

We recognise that digital solutions have a significant role to play in moving towards providing personalised care. We want to support people in East Sussex, empowering them to access health and care services via digital solutions to provide care in a way that suits them and their personal needs.

Examples of this include:

- **Choice around how they attend outpatient appointments, with the use of virtual consultations (video or telephone) where appropriate**
- **Access to clinicians and clinical advice or support online, for example, through email or web chats**
- **Using wearable technology (for example, insulin pumps, skin patches, smartwatches) so symptoms can be monitored remotely, giving patients greater knowledge about their condition and reducing the need for unnecessary appointments**

What difference could this make to patients? Read **Aisha's** story to find out

PATIENT STORY

AISHA

Age: early 40's
Lives: Heathfield
Digital confidence: Average

Aisha lives with her husband and two sons. She was generally fit and healthy until, in April 2020, she tested positive for Covid-19. Although Aisha's symptoms were fairly mild, she has struggled since with fatigue, breathlessness and anxiety. She also finds it hard to concentrate, describing a "brain fog". As a result, Aisha hasn't been able to work for over a year. Following a diagnosis of long-Covid, Aisha was referred to the Post-Covid Assessment Service (PCAS).

Concerns: Scared about the future, returning to normal life and to work, the family's finances, will she fully recover?

2015

All outpatient appointments were face-to-face, requiring travel to our hospital sites. All information provided would have been in paper copy.

2021

Aisha completed an online self-assessment form which was used as the basis for her initial assessment, held virtually via video link. All her appointments were held via video or telephone, removing the need to travel and saving time. Aisha was able to email the team directly with any questions in between appointments.

Aisha was signposted to online resources, which she could work through in her own time. Being online, the resources were quickly and easily updated, so she had access to the latest information and research. Virtual support was also given to her family, again without leaving their home. With Aisha's permission, a virtual meeting was held with her employer to discuss phasing her return to work.

The PCAS team could work remotely from different locations and access patient notes digitally wherever they were. The use of technology broke down barriers between organisations, with the team finding it easier to liaise with Aisha's GP and specialists who work for other Trusts.

2026

The PCAS team are now looking to use technology to set up virtual group sessions, where patients can support each other from the comfort of their own homes. These will be attended by other professionals, for example, GPs or specialists from out of area.

As outlined in objective 1 on page 16, the intention is to use a Personal Health Record to give patients electronic access to their records. The use of the app as an engagement and feedback tool is also being investigated.

The model of virtual appointments and the closer working with professionals from other specialties and other geographical locations that this enables is being copied in other areas.

OBJECTIVE 4

Work with partners in the Integrated Care System (ICS) to implement regional priorities and ensure data is used to inform the decisions we make

One of the key programmes being worked on by the Sussex Health and Care Partnership (SHCP) is Our Care Connected, which aims to deliver a single Local Health and Care Record (LHCR) for every person living in Sussex. This would mean that every health and social care practitioner in Sussex would have access to the right information they need at the right time to provide care. This would also remove the need for patients to repeat the same information at every appointment.

Part of this work is the Plexus Care Record which will see systems across GPs, acute, community and mental healthcare services and adult social care connected. In practice, this will mean the same patient data being accessible across organisational boundaries and, as part of the national programme, across geographical boundaries as part of the LHCR.

Sharing data is key to providing the best possible care. Having a more complete picture of a patient's journey across different services will allow clinicians to provide a better patient experience and improve safety and efficiency, ultimately leading to better care and outcomes.

Sharing data is just the first step though, we need to ensure that all data flowing in and out of our systems is correctly coded and structured, in line with NHS Digital's standards e.g. Transfer of Care. The focus is on the digital sharing of structured discharge and clinic attendance documents sent from secondary care to primary care. This will ensure that information follows the patient and continuity of care is maintained because services are better connected.

Not only is ESHT a partner in this work providing and consuming the data, but we are also the technical delivery partner for the Cloud hosted platform, building the infrastructure this sits on.

Intrinsically linked to this is the development of the Sussex Integrated Dataset (SID). This is a population health management system which takes data from all health and care providers. This data is then analysed to help redesign clinical pathways and measure patient outcomes for the population of Sussex.

Raw data sent through to the SID is depersonalised so any patient identifiable information is removed and the data is therefore anonymous. Analysis of the data is used to identify trends in population health and to inform evidence-based decisions around service delivery and reconfiguration and effectively target prevention measures.

What difference could this make to patients? Read **Louise's** story to find out

PATIENT STORY

LOUISE

Age: early 30's
Lives: Rye
Digital confidence: Average

Louise has just found out that she's pregnant with her first baby.

Concerns: Nervousness around her first pregnancy, feels overwhelmed by amount of information available (some of it conflicting)

2015

Louise made an appointment with her GP and was then referred to the Maternity service. At her first midwife appointment, she was given a set of paper notes, which she had to remember to take to every appointment. Sometimes Louise forgot so the clinician seeing her had very little information available to them. Once when visiting family in Kent, Louise was taken to hospital and didn't have her notes, so they only had the information she could give them. These paper notes often became bulky as additional information was stuck in, such as ultrasound scans and blood test results. It wasn't unusual for these pieces of paper, containing highly sensitive information, to become unstuck and lost or for whole sets of notes to be mislaid.

2021

Louise self-refers using the online form on the Trust's website. A bounce back email tells her about an electronic maternity notes system and gives instructions on how to download the app to her smartphone. At all appointments, information about Louise's care is added to this secure system so any clinician she sees can access the information they need, 24 hours a day. This removes the need for Louise to remember to take her notes to appointments. Louise's midwife can send her relevant information, and she receives a notification whenever a new message or appointment is available on the app. During appointments, Louise's midwife inputs information straight in to the system and so doesn't have to spend time after writing or inputting details into other systems.

2026

Information from the electronic maternity notes system feeds in to the Local Health and Care Record. Clinical information about Louise's pregnancy is available whenever she accesses healthcare, regardless of organisational and geographical boundaries.

Anonymised data about Louise is sent through to the Sussex Integrated Dataset (SID). Analysis of data across the local population identifies those at risk of poor health and informs decisions around the services and support that are provided. For example, the data identifies areas where the number of smokers is above average, so smoking cessation services can be focussed where they can have the greatest impact to improve the health of the population. The data is also used to measure patient outcomes, so the success of interventions can be assessed.

OBJECTIVE 5

Maximise opportunites for using robotics and artificial intelligence

Within healthcare, there are a number of processes that currently have to be undertaken manually and are time intensive for staff. We want to maximise opportunities for these repetitive processes to be automated, by using robotics.

For example, all referrals that come in to the organisation have documents attached, which currently have to be downloaded and reloaded in to the system. Using Robotic Process Automation (RPA) would remove the need for this to be a manual process.

There are a number of areas where Artificial Intelligence (AI) could be used, for example, working alongside consultants to help identify and diagnose conditions, leading to improvements in patient care and patient outcomes.

Another example could be in Outpatients, where patients are sent a text message reminder in advance of their appointment.

This would allow patients to be seen quicker and reduce the number of missed appointments, which cost millions of pounds each year.

Increasing our use of RPA and AI would reduce the administrative burden for colleagues, cutting mundane and repetitive tasks in both clinical areas and back office functions. However, this is not aimed at replacing humans or reducing the size of the workforce. The aim is to increase capacity and give colleagues working in support functions more time to devote to other tasks and to give those who work in clinical areas more time to devote to their patients.

What difference could this make to patients? Read **Joan's** story to find out

PATIENT STORY

JOAN

Age: mid 60's
Lives: Battle
Digital confidence: Low

During the summer, Joan was in her garden when she suddenly felt a strange sensation down one side of her body and collapsed. Luckily Joan's husband saw her collapse, recognised the signs of a stroke and called an ambulance, which took Joan to Eastbourne DGH. On arrival and after assessment, Joan was given a brain scan.

2021

Cutting edge software that uses artificial intelligence (AI) technology is being used across Sussex to improve the way people who have suffered strokes are diagnosed and treated.

The software analyses Joan's brain scan, automatically highlights the position of the clot and areas of possible damage and quickly provides an ASPECT (Alberta Stroke Program Early CT) score to show the number of areas of the brain affected. Consultants use this information, alongside the other information they have available to them, to make decisions on the most appropriate treatment for the patient.

In Joan's case, this led to her quickly being transferred to the specialist mechanical thrombectomy centre in Brighton, where she underwent an operation just a couple of hours after being diagnosed with a blood clot on the brain. Two days later, Joan was able to return home and has now made a full recovery.

2026

The stroke team can now use an app on their smartphone to view scans remotely and instant message colleagues in other hospitals. This means decisions around treatment and transfer to other hospitals can be made more quickly, which is crucial when treating stroke patients.

OBJECTIVE 6

Ensure that our infrastructure and all data held in our systems is secure

The patient information held in our systems is a high value target for cyber criminals. Ensuring that information is protected and is secure is paramount to give staff and our patients confidence in us and our work.

In 2020 we recruited a new Information and Cyber Security team who provide and coordinate expertise to influence our information security approach, helping ESHT to achieve its strategic objectives by aligning with local and national strategy and ensuring the availability, confidentiality and integrity of our information.

We have already made some progress in implementing the technical standards recommended by the National Cyber Security Centre (NCSC). The next step is to implement an Information Security Management System (ISMS) which gives a framework for policies and controls that manage security and risks systematically.

We also want to achive accreditation for International Standard ISO/IEC 27001 on managing information security, achieve a high level of compliance with the Data Security Protection Toolkit and Cyber Security Essentials+ certification.

A key component to achieve this objective is recognising that all colleagues across the Trust have a responsibility to ensure that the security of our systems and data is maintained. Our colleagues need to be sufficiently trained and understand what action they need to take to reduce the likelihood of a cyber attack succeeding, and so we will undertake an ongoing education programme to ensure all colleagues have the skills, knowledge and guidance to improve our information security posture.

What difference could this make to patients? Read **Liam's** story to find out

COLLEAGUE STORY

LIAM

Age: mid 30's
Works: Conquest Hospital
Digital confidence: Very high

Liam is a member of our dedicated Information and Cyber Security team.

Concerns: Keeping Trust systems and the data in them secure

2018

There was very little knowledge or resource within the Trust about cyber security. However, realisation about its importance was increasing following the Wannacry attack in 2017.

2021

The team has started to use the latest monitoring software to scan for possible cyber threats. This works in the background, analysing network data generated by users and their devices, looking for activity that the system believes is "not normal". Any alerts generated can then be investigated by the team, who feed their findings back in to the system, which learns from these. So for example, if the team disagree with the system and feel that an alert was not necessary, the system will learn from this and not flag the same concern again. By doing this, the system improves over time and the number of alerts that the team will need to investigate will reduce.

During June 2021, the system saw over 8,000 alerts from 5,355 devices. Although most of these were the result of normal activity, previously they would have needed investigating, which was unmanageable. The introduction of monitoring software means that normal activity is excluded automatically, so Liam and his colleagues can focus on the abnormal alerts that require investigation – in June, this was just 59 alerts across 5 devices.

2026

Further developments in artificial intelligence and automation will increase efficiency in dealing with alerts and allow the Trust to respond in a more timely way to emerging cyber security threats at any time of day or night. This will free up time for Liam and his colleagues to spend on other tasks.

OBJECTIVE 7

Ensure the digital infrastructure in our buildings is consistent and resilient

Our hospital buildings were designed many years ago, long before the start of the digital age in which we now live. New technology has had to be installed within the limitations of these buildings, which has led to a digital infrastructure that is inefficient and unreliable.

The Building for our Future programme gives us an exciting opportunity to transform the environment in which we provide care and ensure that our buildings support technology, both now and in to the future. We want to move towards our hospitals becoming smart buildings, where the technology is fully integrated and enhances the experience of patients, colleagues and visitors.

The first step to achieve this will be to ensure the fabric of our buildings is fit for purpose and able to support the necessary digital infrastructure. We will then look at the many existing systems that we currently have in our buildings and network them so they are joined up, share information and work together to improve the experience of everyone using the buildings.

We will also ensure that the digital infrastructure in our buildings supports the Trust's aims around sustainability, in line with the Estates Strategy. This sets out our commitment to improve our carbon footprint and reduce the environmental impact of our services, to support the national aim for the NHS to become the world's first net zero national health service.

What difference could this make to colleagues? Read **Frank's** story to find out

PATIENT STORY

FRANK

Age: late 70's
Lives: Uckfield
Digital confidence: Low

Frank is attending an outpatient appointment at Eastbourne DGH. Whilst his husband uses technology frequently, Frank is not so keen. However, after persuasion from his children, he has recently got his first smartphone and, with their help, is starting to get to grips with it.

Concerns: Stress of appointment (will it be bad news?), made worse by stress of going to hospital - finding a parking space and finding way around the building

2019

Frank left home in plenty of time to make sure he wasn't late for his appointment. It was fairly busy when he got to the hospital but after driving round the car park for a while, he found a space.

Once in the hospital, Frank queued at the desk to book in for his appointment and was given directions to the clinic. However, he took a wrong turn, got lost and had to ask someone for help. He was almost late for his appointment, stressed and out of breath from rushing.

> "Attending hospital, whether you're a patient or visitor, can be really stressful. Although I'm not a big fan of new technology, if there are simple things that can be introduced to make the experience a bit less stressful, that's got to be a good thing."

2026

The first phase of the re-development of the hospital has seen a new car park built, with more spaces available to patients. Lighting is used to direct people to available spaces so Frank is able to drive directly to a space on level 3 and there is no need to leave home quite so early.

As he walks in to the hospital, scanners pick up the signal from his mobile phone and book Frank in for his appointment automatically. He then gets a text message to tell him that the appointments are running a little behind schedule so he goes and gets a cup of tea from the café. Directions to the clinic are then given on his phone via a way finding app, supported by new digital signage which can be updated immediately when departments or clinics move. Frank arrives for his appointment feeling relaxed and calm.

OBJECTIVE 8

Achieve HIMSS Level 7 by 2026

HIMSS (Healthcare and Information Management Systems Society) is an internationally recognised model used to assess the digital maturity of healthcare organisations.

There are eight stages in the HIMSS model and each stage must be fully met before an organisation is assured as compliant. To reach the highest level, an organisation will have become truly digital, achieving digital maturity resulting in improved patient care, better workforce experience, financial efficiencies and innovation benefits. Only a handful of NHS Trusts have achieved this.

We had a HIMSS assessment in 2020, which rated us at Stage 0. Although it was acknowledged that we were making good progress towards some of the higher stages, we were not yet fully compliant with Stage 0 and so could not be rated any higher.

Our aim is to achieve HIMSS Level 7 by 2026. Achievement of the objectives outlined above will help us to reach this. In particular, we will need to:

- **Ensure that departments who support clinical care, (e.g. pathology laboratories, pharmacy and radiology) are fully digital with requests ordered electronically and all results available digitally and visible across systems**
- **Integrate the Plexus Care Record in to other systems so it is visible at point of care**
- **Implement a new Trust-wide system for digital imaging and for the storage and archive of images**
- **Introduce closed loop systems so that the ordering, prescribing, verification, dispensing and administering of medication and blood is fully electronic**
- **Use data and analytics for decision making around patient care**
- **Integrate data into the Health Information Exchange and the Patient Health Record**
- **Ensure robust business continuity plans for all systems are in place**

What difference could this make to patients? Read **Sophie's** story to find out

COLLEAGUE STORY

SOPHIE

Age: late 20's
Works: Eastbourne DGH
Digital confidence: High

Sophie is a pharmacist working at Eastbourne DGH. The majority of her time is spent out on the wards supporting clinical teams and talking to patients.

2017

Sophie would visit a ward to review patients' medication charts, these were handwritten on paper. If a chart was mislaid, staff would spend valuable time searching, delaying care for the patient. Information on the chart was sometimes illegible and it took Sophie time to read what some of her colleagues had written. Illegible handwriting could also lead to administration errors due to the dose or drug being misread. When any changes were made to a prescription, the process to order new medicines could take over three and a half hours, relying on nurses writing the order in a book, which Sophie checked when she was on the ward.

An Electronic Prescribing and Medicines Administration (ePMA) system has been introduced, so inpatient medication charts can now be updated electronically. Sophie can view medication charts from her office before she visits the ward and can prioritise the patients to review and speak to first. The time colleagues previously spent searching for paper charts is now spent caring for patients.

2022

Sophie accesses online resources through the ePMA software such as the British National Formulary, NICE guidance and Trust guidelines to aid safe, effective and evidence based prescribing. The system is linked to Pharmacy so Sophie can order medicines remotely from the electronic drug chart straight to the dispensary rather than having to check the ward book.

The overall time to order and supply medicines has reduced to approximately 90 minutes. The information in the chart is typed, so there are no issues with illegible handwriting. If, for any reason, the system fails, a robust Business Continuity Plan is in place to ensure patients will continue to receive the treatment and care required.

2026

A complete closed loop system means the ordering, prescribing, verification, dispensing and administering of medicines is fully electronic. Barcode scanning has been introduced so the barcode on any medicine given to a patient is scanned, alongside the barcode on the patient's wristband. The system alerts if a patient is about to be given the wrong medicine and there is a complete audit of the patient's journey through the hospital so if ever there is a recall on a particular product, those patients who may be impacted can be easily traced.

We have a wide range of volunteering opportunities and you don't need previous experience in a health setting to volunteer for us.

For more information visit our website:

esht.nhs.uk/volunteering

4

GLOSSARY

of words used in this document

Artificial Intelligence (AI)

The theory behind and development of computer systems able to perform tasks normally requiring human intelligence such as visual perception, speech recognition, decision-making and translation between languages.

Building for our Future

This is the name of the Trust's programme co-ordinating both the new developments to be funded by the national Health Infrastructure Plan and the Trust-wide transformation initiatives.

Care Quality Commission (CQC)

The Care Quality Commission (CQC) is an executive non-departmental public body of the Department of Health and Social Care. It was established in 2009 as the independent regulator of all health and social care services in England. The CQC monitors, inspects and regulates hospitals, care homes, GP surgeries, dental practices and other care services to make sure they meet fundamental standards of quality and safety and publishes what it finds, including performance ratings to help people choose care.

Digital Aspirant

A national programme which aims to accelerate procurement, deployment and most importantly, uptake of the technology that is needed to underpin digital transformation in NHS Trusts.

Healthcare and Information Management Systems Society (HIMSS)

The Healthcare and Information Management Systems Society (HIMSS) is an internationally recognised model used to assess the digital maturity of healthcare organisations. There are eight stages in the HIMSS model and each stage must be fully met before an organisation can be assured as compliant. To reach the highest level, an organisation will have become truly digital, achieving digital maturity resulting in improved patient care, better workforce experience, financial efficiencies and innovation benefits.

Integrated Care System (ICS)

Integrated Care Systems (ICSs) are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population. The central aim of ICSs is to integrate care across different organisations and settings, joining up hospital and community-based services, physical and mental health, and health and social care. Since April 2021, all parts of England have been covered by one of 42 ICSs.

Place

The term "Place" refers to collaboration at a local level (meaning over a smaller area than an ICS). In Sussex, there are three Places; Brighton and Hove, East Sussex and West Sussex. The collaboration is between sovereign organisations working together to improve population health outcomes. These organisations will include health, social services, third sector and other local networks.

Plexus

A care record which will see systems across GPs, acute, community and mental healthcare services and adult social care connected, allowing practitioners to securely access and update relevant information anywhere anytime.

Sussex Integrated Dataset (SID)

A population health management system which takes data from health and care providers and analyses it to help redesign clinical pathways and measure patient outcomes for the population of Sussex. Raw data sent through to the SID is depersonalised so any patient identifiable information such as name, date of birth or address is removed and the data is therefore anonymous. Analysis of the data is used to identify trends in population health and to inform evidence-based decisions around service delivery and reconfiguration and effectively target prevention measures.

Voice Over Internet Protocol (VOIP)

Technology that allows users to make voice calls using a broadband internet connection rather than a regular phone line.

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NHS
East Sussex Healthcare
NHS Trust

CLINICAL STRATEGY 2021 - 2026

www.esht.nhs.uk

CONTENTS

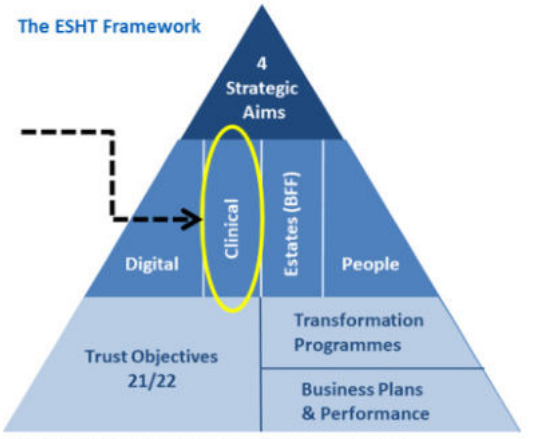
SECTION 1

SUMMARY

1.1 The purpose of the Clinical Strategy

Our Trust Strategy **Better Care Together for East Sussex** sets out the strategic aims for ESHT within the evolving Place and System environment. Our Clinical Service Strategy is one of four enabling strategies (figure 1) through which we plan to deliver our strategic aims.

There is never an "ideal time" to embark upon strategic thinking, not least when NHS Trusts are facing the twin challenges of operational recovery and the emergence of new COVID variants. However, our learning curve has been steep and we are entering a new legislative and policy environment which brings new opportunities and ways for systems to operate that we want to exploit effectively. As our Integrated Care System and Place find their form and set out priorities, it is vital that ESHT is clear in the near-term about how we develop our services to support the delivery of these priorities for local people.

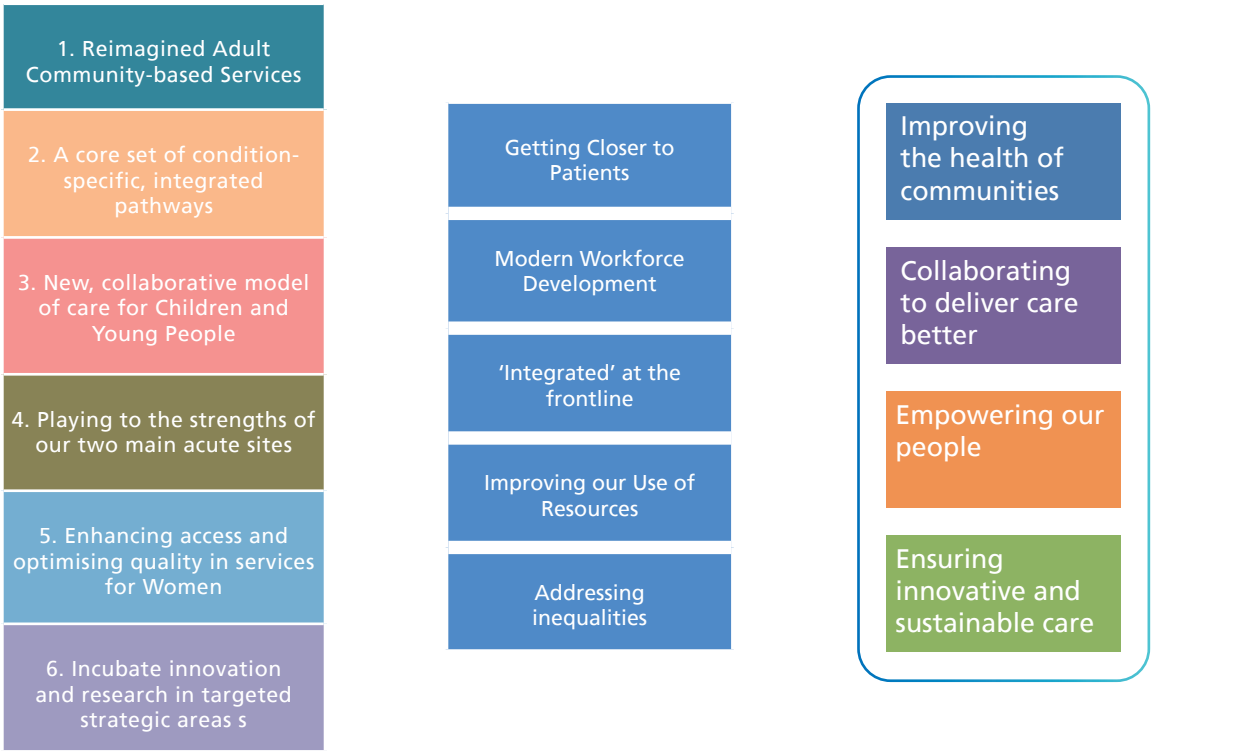


(Figure from "Better Care Together for East Sussex" pg. 22)

This Clinical Strategy also bridges the years into our Building for the Future (BFF) transformation programme and so must be consistent with our longer-term transformative changes envisioned in BFF.

1.2 Six, Five, Four

Working with clinical and operational leaders of individual services, examining together the challenges and opportunities we face over the next 5 to 10 years, our clinical strategy is comprised of **6 core statements,** delivered using **5 key principles** that will allow us to deliver the **4 strategic aims** of our Trust strategy:



These **6 core statements** embody a shift in the way we serve our population. We seek to change the balance and value of our work outside hospitals, allowing us to tackle access issues and inequalities more effectively with an enhanced ability to proactively manage the health of our communities alongside a more sustainable capacity to react to escalating need or ill health with high quality responsive services.

This does not mean no increase in hospital capacity over the years of this strategy, but acute activity would grow at a slower rate because we are able to deliver more to people outside hospital or before they need a hospital, pre-empting and/or preventing an attendance. This is a critical outcome from this strategy because it will allow us to make best use of the expected Health Infrastructure Plan investment in several years' time (part of our BFF programme) and beyond that to exploit the benefits from it more effectively.

Delivering these core statements is a challenge. Success requires all our enabling strategies to come together with adherence to the 5 key principles (see section 2.1) that have emerged from this work to get the benefits we need from it. It also needs our ICS and Place collaborations to work effectively; we can do a lot of this on our own, but not all.

Success will bring benefit for communities in East Sussex. People will experience 'ESHT' in a different way; with simpler, more consistent access, a seamless experience and proactive care that wraps around their needs. They will see ESHT as a key route to wider services and disciplines as our collaborations develop, and as a partner in their care alongside their GP.

For our staff we can empower them by making the day to day work easier to get done; East Sussex will be a more attractive place to work and learn, providing new career opportunities as we modernise the workforce. We will also support them to innovate, particularly in priority areas, to improve what we do and make services more sustainable over time.

Ultimately this strategy will enable ESHT to make its best contribution, as an integrated provider, to our population, Place and ICS priorities.

1.2 The Challenges this strategy seeks to address

As we shaped this strategy with senior operational and clinical leaders our considerations also covered the issues/challenges/risks we expect will impact ESHT over the next 5 to 10 years. We have summarised the 5 critical challenges to which this strategy must respond:

Ensuring Future Pandemic Resilience

Recovering planned care capacity after the COVID waves is an immediate priority across the country - however tor the long-term we have to look at the structure and location of our services to protect planned care capacity and 'green' patient journeys in future. For ESHT it means optimising the way services run across our main sites, designing pandemic resilience into our Building For our Future ("BFF") plans, and doing more outside the hospital.

Adapting urgent services to fit changing demand

Demand through our Emergency Department grew at 6% each year before the pandemic and has come back to that growth rate since; well above demographic trends. Patients want simple access for urgent problems. This was an ongoing trend pre-COVID but has accelerated since. We cannot sustain that rate of growth with our current model. It has also become clear that our two A&Es have quite different demand profiles, so in future we cannot simply adopt the same model and design on both sites.

Caring for an Ageing Population

It is well documented that East Sussex has one of the oldest populations in the country and that the oldest age groups are growing the fastest.

This is not a new challenge and we have been developing our Frailty services in response over recent years. That approach will need to continue. What is new is the context in which we are now working, i.e. we now have our ICS and growing collaborative networks that mean we can be more ambitious collectively to develop something both substantially better for people and more sustainable for the system.

Simplifying access even as delivery models become more complex

Services and professionals have become more specialised over time but day to day disease and risk management has the potential to be more patient-led and less 'medical'. This can make patient journeys more complex when multiple professionals, organisations and processes are needed to deliver the right care. Our large elderly population is more likely to experience multiple problems as well, both social and clinical, which makes offering simple access and a seamless experience harder.

Integration at the frontline is critical to solving this problem (meaning making it easy for multiple professionals to share information and work together) as is building personalised timley but consistent approaches to 'pathways' of care.

Ensuring equitable access and targeting inequalities

We have sought to build in to service strategies the need to consider equitable access and targeting health inequalities. We know there are outcome and service variation across East Sussex that we want to address as a priority. Doing this successfully will mean close collaboration both with colleagues in local networks (i.e. Primary Care Networks).

1.3 The Core Statements

Through our engagement and analysis, we have agreed that 6 core statements capture the critical essence of our strategy and this document sets out the vital elements of each in terms of the context, our ambition and what we will do to deliver against them.

1. We will reimagine Adult Community Services:

a. Delivering faster and serving higher acuity need outside the main hospitals to meet or prevent need before hospital admissions are required

b. Forming local, collaborative networks to enhance access, target inequalities and personalise care

2. We will develop a core set of condition-specific, integrated pathways to support population and patient priorities:

a. For simpler and timely access to the right services for patients & professionals

b. For consistent, equitable services to meet growing need

c. To maximise patient engagement, promote self-management and monitor risk as close to home as possible

3. We create a Place-based, collaborative model of care for Children and Young People:

a. An evolution services? For children and young people - more appropriate locations, earlier interventions and holistic support

b. Collaborating to wrap all the right disciplines around a child's need - and offering that away from the main hospitals unless needed

4. We develop our two main acute sites by playing to their strengths:

a. Developing Eastbounre DGH as a centre of excellence for Day Case surgical interventions, Tertiary Urology and Frailty; continuing to on focus surgical complexity and emergencies at Conquest Hospital

b. Aiming for the best quality, pandemic resilience and fast access

5. We will enhance access and optimise quality in services for Women:

a. Develop a 'hub' approach to services for mothers to improve access and make the choice to use midwife-led care where it is most beneficial more attractive

b. Equitable access to optimum outpatient services on sites, community diagnostics, improved inpatient environments and day case access

6. Incubate innovation and research in targeted strategic areas:

a. To ensure ESHT leads the way in the most critical service areas for our population and our strategy - Frailty, Rehabilitation, Urology and Day Case delivery

b. To attract the workforce we need so we can make our best contribution to an improved and sustainable Place and ICS

1.4 Measuring Success

We already work very closely with Model Health System, Model Hospital and GIRFT which will help us track success, along with multiple internal measures of quality, productivity, outcomes and experience. We will use that capability, as we develop implementation plans, to detail success measures for each service strategy and the Trust overall.

As Place and System thinking evolves, we anticipate that measures, objectives and outcomes will be co-ordinated across organisations and we will reflect this in our implementation plans.

CORE STATEMENT 1:

Reimagined adult community services

The opening statement of our clinical strategy focused on three key community-based services has strong alignment with statement 2. Each of the three service groupings below contain multiple services; this is not solely what our Community Health Integrated Care (CHIC) division does (although that will be a key contributor). These service groups will, over time, bring greater integrated and multi-disciplinary models together, linking closely back into acute hospital services in some cases and working in local, collaborative networks with GP practice, social care, mental health and the voluntary sector. They will provide the connection from a person's home or residence through a Primary Care Network (PCN) and into specialist hospital services.

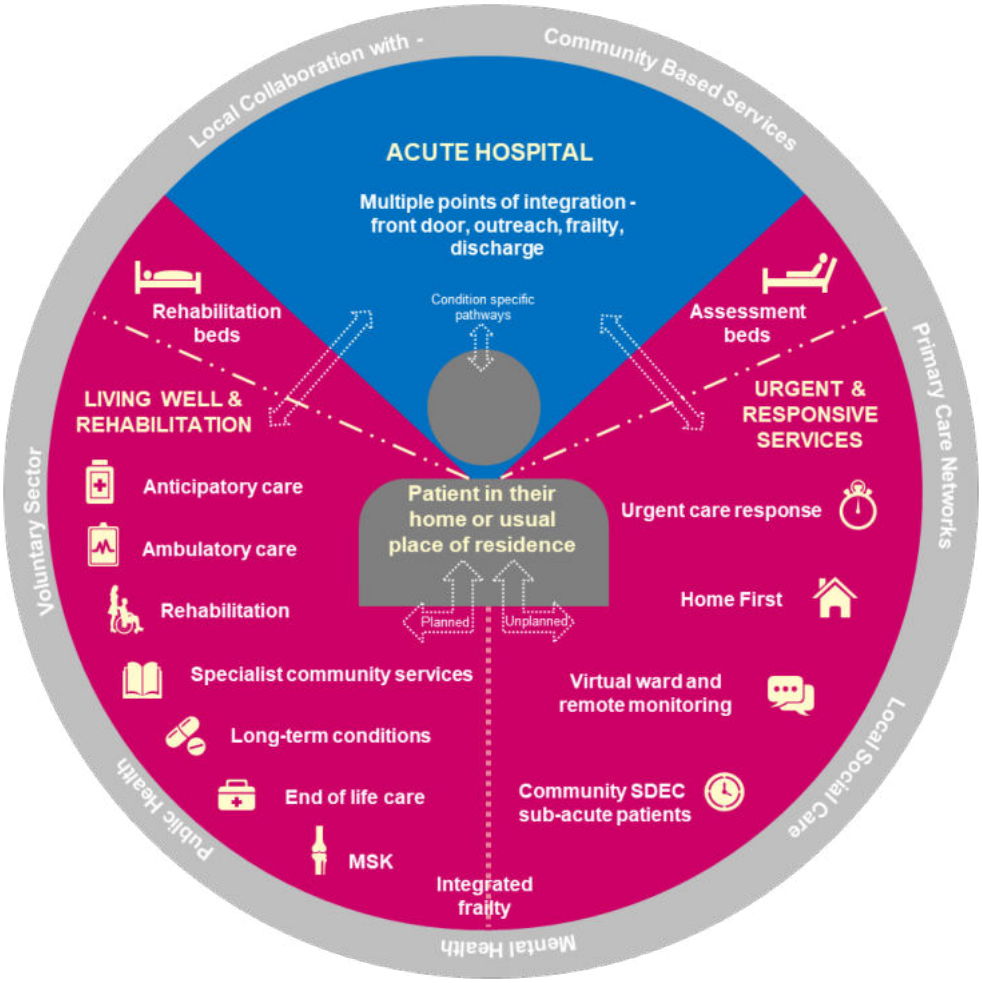
They will embody particular cross-cutting capabilities for our Place in Frailty and End of Life care and will help us improve access and target inequalities. These groups will become critical contributors to the Primary and Community Care Collaborative Network's **Ageing Well and Community Transformation programme** as well as the emerging South East 'Reimaging Community Services' programme.

a. **Living Well - a 'Collaborative Community Offer':** This is about forming local, collaborative networks that wrap around PCN geographies - with co-designed adaptations to address access issues and tackle inequalities.

b. **Urgent & Responsive services:** We need to enhancing our capability to respond very rapidly to escalating need, tackle higher acuity and work closely with acute urgent care and social care.

c. **Rehabilitation:** For our population we need to be excellent at delivering services that assess and improve function and quality of life, whether proactively or reactively, both in the community, in bedded units and in hospitals.

Our ambition is to create a collaborative model that will offer and achieve more outside hospitals through better access to a more proactive, personalised service, providing care in the safest locations, as close as possible to home. This is summarised in the graphic below.



1a.
Living Well - A Collaborative Community Offer

Context

We run traditional community services (including community nursing, wound care, general health support, home assessments, falls services) across East Sussex. Historically, community services have been underinvested nationally which has constrained what we have been able to achieve. However we have been working on pushing the art of the possible forward for many years with our colleagues from social care and the voluntary sector and have made some progress with services like Crisis Response and digital enablers like SystemOne and AttendAnywhere. Our response to COVID-19 also showed us we can adapt more quickly and work more flexibly.

Programmes like the Regional 'Reimagining Community Services' look set to address that and will help systems target investment where clear benefits are achievable. In our ICS we have now established far-reaching priority programmes, like Ageing Well, that will drive community service transformation further forward than ever before.

Our Ambition

We want to fully engage and support local networks so we are not just responding to need after events have occurred, but helping to predict them and respond proactively. We want our core community offer to:

- **Support primary care and other community based colleagues in forming local collaborative models so we can jointly:**

  1. **Understand and track health risk**
  2. **Offer personalised care**
  3. **Reduce the frequency of unexpected or escalating need**

- **Help remove any access variations and make adaptations that will directly target health inequalities**
- **Make it easy for patients and partner professionals to navigate services (any services, not just ESHT services)**
- **Exploit digital capabilities so we can engage and interact more easily with people and colleagues. That is not to say 'digital only' access for people, it means use those tools where appropriate to engage**

Ultimately people get a better experience, a quicker response and need hospitals less often.

What we will do

This is a challenging undertaking and we will not succeed in isolation. Co-design and collaboration will be - principles from the very beginning.

We will co-design a local, collaboration of core services with our emerging Primary Care Networks - addressing the specific needs of a local area with named colleagues, single access, digital access, shared information and care navigation. We will also standardise practice in key areas to best practice models (e.g. wound care).

That core offer will be supported by adapted or enhanced services (such as Enhanced Health in Care Homes (EHCH) or specialist clinics in GP practices) that address inequalities or access gaps.

Within the core offer we will implement key elements of the Ageing Well programme - including Anticipatory Care and work with colleagues to implement population risk stratification and segmentation together.

Our teams will embed Frailty practices and responses, such as Comprehensive Geriatric Assessments (CGA), electronic Rockwood scoring and we will use this information to respond proactively with partners in social care voluntary sector, informal carers, with patients themselves and with other care providers.

Learning from our COVID-19 experiences we will also expand our capability for virtual patient interactions and make widespread use (subject to people's capability and preference) of tools like Patient Knows Best (PKB), AttendAnywhere to give patients control and make access flexible.

Digital and Estates strategies will be key enablers. We will work with the community Digital programme on shared information systems and care plans, patient interaction, making best use of the Sussex Integrated Dataset and progressing opportunities like remote vital sign monitoring. We will review, with our Estates team, our footprint and work with PCN colleagues to map out the best physical distribution for staff and services.

1b. Urgent and Responsive Services

Context

Some people are admitted to hospital or stay in hospital too long because the best alternatives are not always available. To address that issue ESHT has been developing community crisis response capabilities for several years and we have made good progress. Adapting for the COVID-19 pandemic showed that our ability to act flexibly and rapidly was invaluable and we have been able to test our services supporting even higher acuity patients outside hospitals. It has become clear that with the right workforce, the right investment and the right digital tools we can achieve much more.

There is plenty of evidence now that many hospital admissions can be avoided or shortened, to the benefit of patient experience and quality of care, by enhancing services outside the hospital. The PCCCN Ageing Well and Community Transformation Programme Board and the Urgent and Emergency Care Programme board are driving improvements in our ICS and our strategy will contribute directly into those programmes of work.

Succeeding has the potential to improve the use of resources in East Sussex as well, i.e. if we don't need to grow our hospitals as quickly, so East Sussex will get more value for money overall and the room to support innovation.

Our Ambition

Improving urgent and responsive community based services has the potential to improve the use of resources in East Sussex at the same time as improving the experience and quality of care for our population. Our ambition is four-fold:

- **To design services that can meet the new targets for urgent community responses**
- **To embed best-in-class management of Frailty and End of Life across our services**
- **To change the perception across the system that a 'hospital' is by default the best place to deliver the most effective response for people with escalating needs**
- **To implement innovative approaches to community based crisis response**

By increasing what we can offer at home or in care homes, we can avoid unnecessary admissions, reduce hospital length of stay, minimise the hospital population that does not meet the 'criteria to reside' to improve the systems use of resources; more importantly we can improve the quality, experience and outcome of care for people in East Sussex.

What we will do

Several workstreams are already underway that start the journey toward these ambitions, many of which are in support of the PCCCN and Urgent and Emergency care board.

We are implementing an enhanced model for Urgent Community Response with the Community Frailty Response and working on models for Enhancing Health in Care Homes / Care Home In-reach (part of our ICS Ageing Well programme). As those are embedded and rolling out, the collaborative model for our 'core community offer' will be progressing and we will design the access routes into UCR together to make them simple and effective.

All of these services will link to End of Life Care colleagues and the emerging Hub model to build those elements into our urgent and responsive service models, to help people achieve their preferences for dying well. All of these services will also be a point of assessment and interaction for those with Frailty and so we will be implementing our Frailty strategy throughout. We will pull from our planned Frailty, Centre of Excellence, and align to the Trust Frailty strategy to build the right approaches into our practice models, tools and information capture.

Community-based diagnostics and point of care testing to help plan responses and avoid unnecessary admissions or speed up necessary ones will be an essential enabler, so we will work with our core services division, the ICS programme and pathology network to determine the right capacity and model to support the UCR models.

New roles will be critical to making this model effective, productive and affordable (this is not about 100s of Doctors driving round in cars). So our People Strategy is another critical enabler to help us create the career paths, training and roles to attract, motivate and retain a modern workforce.

Digital tools are also critical to success here - as with almost all our plans - primarily those that enable quick and easy information sharing, a shared health and care record, risk stratification tools, remote status monitoring, remote interaction with colleagues and patients – outside hospitals and in patients' homes.

1c. Rehabilitation and prehabilitation

Context

'Rehabilitation' is a critical capability for our population. It is important for all ages, but more so where patients are living with frailty; hence is of particular interest in East Sussex.

Rehabilitation is critical in recovering from acute interventions or events; but we also consider the potential for rehabilitation to improve outcomes and quality of life all along the 'care continuum'. This includes preparing for planned interventions (hence the term 'Prehab') as well as pure functional improvement and support that 're-able' people so they can stay well at home for longer. An example is a surgical operation on a frail patient. It is not only the procedure in the theatre that results in the outcome (although it is critical, of course) but also the pre-operative support/preparation and aftercare within and without the hospital to restore function and quality of life. Collectively all these aspects are the 'intervention' that delivers the desired outcome.

The shift toward collaboration, regional programmes like 'Reimagining Community Services', and our own ICS programmes indicate we are now in a position to pursue a more ambitious plan that will improve health and reduce the risk of sudden ill-health for our population. It will also help us reserve the capacity in hospitals for when it is most needed.

Our Ambition

Combined with our overall plan to Reimagine Community Services we want to achieve a virtuous circle - i.e. healthier, more able people need less of the expensive bits of health and social care, so there will be more to invest in making people healthier and more able. To get there we have 4 main ambitions:

- **To create a centre of excellence for Rehabilitation at ESHT**
- **To be able to provide services 7 days per week - to support a comprehensive Home First approach and 'Discharge to Assess' model and help reduce the number of days people are waiting in hospital beds**
- **To deliver an integrated service - with all the key disciplines engaged regardless of the person's location, so we are focused on the goal for them**
- **To make it far easier for people to self-rehabilitate**

What we will do

Broadly our plans to deliver this ambition align with our ICS programme of work:

Improve **Self-management** - we will help patients to do this by enhancing information we offer, collaboratively and consistently for Place, enhancing the access to information and designing and implementing ambulatory rehabilitation clinics and integrating through local, collaborative networks (i.e. our core community offer)

We will embed **'Home First'** approach and principles and specifically:

- **Work with colleagues in our acute hospitals and integrate digital systems so we can act early (linking to our Urgent Community Response as needed)**
- **Fully implement 'Discharge to Assess' models**
- **Develop tools that help us make quicker decisions and help patients engage - Rehab decision tool, patient access & review tool**

We will increase our **Definitive Rehabilitation** capacity to meet demand and expand it to encompass all the required inputs for prehab and rehab scenarios

- **Rapid access beds**
- **Long Covid support and rehab pathway**
- **Personalised care champions in Community Rehab**
- **Engage psychological service**
- **Planned prehab/reablement packages (e.g. joint schools)**

We will examine new approaches for long term management and implement those that work:

- **Integrated complex management pathway**
- **Developing 'Peer Leaders' to support services**
- **Integrated disability management clinics**

We will also investigate what it would take create a 'Centre of Excellence' for Rehabilitation, in the sense of how do we innovate rehabilitation techniques, models and workforce for demonstrable benefits to a population like ours (see part 6 – Incubating Innovation and Research). To do this will require the right workforce, with advanced roles and new roles.

CORE STATEMENT 2:

A core set of condition-specific, integrated pathways

Context

For a number of conditions (e.g. long term conditions like diabetes, heart failure and chronic respiratory disease) optimal models of care involve integrated pathways operating both in and out of hospitals with multi-disciplinary teams. This is also the case for some groups of conditions (e.g. Musculoskeletal) and complex scenarios (e.g. End of Life care).

Integrating pathways means being able to monitor and treat a specific condition at any point on the care continuum. This may include traditional care settings but could also mean self-managing and monitoring a condition and/or getting specialist advice at home.

We already deliver several services in this way and as a first step we will enhance those. Going further forward we also expect to expand our core set of condition-specific pathways as technology; treatment options and patient engagement improve. These ideas are already emerging for condition sets such as chronic rheumatological, neurological and bowel conditions.

This statement is closely interdependent with core statement 1, connects directly to the Primary and Community Care Network 'Long Term Conditions' programme and links to other strategies like community diagnostics and point of care testing.

Several change drivers make this an imperative and provide the opportunity to improve:

- **The need for pandemic resilience means increasing community-based delivery of services, including acute specialist input**
- **New and widely available digital technology allows us to enhance information sharing, remote condition monitoring and interact with patients differently**
- **Collaboration is more achievable than ever before - by designing improvements with our ICS and East Sussex Place colleagues**
- **The workforce is already evolving and new types of specialists allow for different approaches (e.g. first contact practitioners)**

Working with Divisional leadership teams, we have identified three priority areas:

a. **Musculoskeletal Services ('MSK')** This is about harmonising the model for integrated MSK services across the county and enhancing the offer through new roles and collaboration (NB: This is subject to commissioning arrangements and provider structure)

b. **Long-Term Conditions:** This is about enhancing access to our core-set of condition-specific, integrated pathways, targeting inequalities with adapted offers and expanding that capability over time

c. **End of Life Care ('EOLC')** We have 'Outstanding' rated EOLC services that provide a multi-disciplinary approach to end of life care. This is about moving that service to the next level.

2a. Musculoskeletal Services

Context

MSK' for short, these are integrated services for people with musculoskeletal symptoms. The MSK approach focuses on early diagnosis and assessment followed by selection of a treatment pathway to provide the best outcome. The benefits of the model are speed and access, followed by a defined package for their particular condition and circumstances. This approach is already well established in East Sussex.

The challenge however is that status of MSK pathways is different across East Sussex at the moment. ESHT provides the MSK pathway in the East of the county; a different partnership serves the west of the county. This has led to some variation in services and waiting times.

In addition the role and capability of allied health professionals like Physiotherapists in this pathway has evolved - giving us different options for the future.

Our Ambition

The main aim is to develop a simple and consistent approach to MSK across the county and to modernise the model using digital enablers and new workforce options.

- **Develop an effective, fully integrated model - working from primary care to acute provision to deliver the East Sussex 'Place' vision for MSK pathways**
- **Maximise the use of digital technologies for patient interaction and information sharing**
- **Develop a modern workforce that can bring First Contact Practitioner capability to Primary Care Networks**
- **Ensure consistent/equitable access to the right interventions across the county**

What we will do

An early step will be to review the long term capacity requirement for all points on the MSK pathway – assuming a consistent, equitable, county-wide model so we can deploy capacity by location accordingly.

We will collaborate with primary care and our 'Place' to locate services in the most cost-effective and accessible configuration alongside the plans described above under 'statement 1' which is will drive the Community Estates Strategy (that work is already underway).

We will co-develop/embed a shared decision making model, with MDTs for orthopaedic and rheumatology pathways – to enhance our current pathways and bring consistency.

At the front of that pathway we expect a county-wide implementation of a rapid access, self-referral services, supported First Contact Practitioners and other key roles. This in turn will mean a comprehensive programme, developed in collaboration our ICS, for training, education and career progression.

We will work with our Digital colleagues to expand our use of technology for: Patient interaction, patient held records and Patient Knows Best (PKB):

- **Develop an effective, fully integrated model - working from primary care to acute provision to deliver the East Sussex 'Place' vision for MSK pathways.**
- **Maximise the use of digital technologies for patient interaction and information sharing**
- **Develop a modern workforce that can bring First Contact Practitioner capability to Primary Care Networks**

All future services will link closely into our 'Reimagined' community-based services vision and will integrate back into orthopaedic and rheumatology teams. We need to factor in the future configuration of orthopaedic work (statement 4) and support capacity planning for elective and High Volume Low Complexity (HVLC) orthopaedic delivery.

2b.
Long-term Conditions

Context

ESHT runs several integrated pathways for specific conditions (e.g, diabetes, heart failure, chronic respiratory disease) but there is more to do to fully integrate with our partners in Place and ensure a consistent approach and access across East Sussex. As more conditions lend themselves to integrated pathways operating in a range of settings not just the traditional acute model we will expand our core set.

A key challenge is the variation in relationships, primary care capability and other community services, but as we reimagine community services and design our core community offer (statement 1) the opportunities will grow.

We have divided our ambition and plan into 1) already established set of pathways and 2) the potentially expanded set.

Our Ambition - Established Pathways

Our ambition is to offer consistent access, across the county, to target inequalities and build from what we have now to a fully integrated, seamless condition-specific set of pathways:

- **To ensure uniform access to consistent approaches that build on what we have achieved and what we know works best**
- **To develop the patient as a partner in the care pathway**
- **To make access simple and seamless for the patient**
- **To make interaction across disciplines easy**
- **To deliver more value to the patient outside the hospital**

What we will do - Established Pathways

These services have individual strategies for all aspects of their service. Our plans include:

- **Continuously improving current pathways, e.g. enhancing Pump therapy and CGM for Diabetes**
- **Developing the workforce to fit the best models - from medical to nursing to allied health professionals, e.g. Community-based Consultants, specialist nurses**
- **Using local collaborations for better signposting to holistic support; pointing patients to other services when needed**
- **Using the digital strategy to enhance information sharing and offer digital interaction**
- **Working with our 'core community offer' and the local collaborative networks to enable interventions for higher acuity patients so they are less likely to need hospitals**

Our Ambition - Expanded Set of Pathways

Once we have a clear view of what works well we can expand the set of conditions where an integrated pathway, operating across all settings, offers:

- **A clear benefit for people's experience**
- **Improved outcomes for patients**
- **Use local collaborations for better signposting to holistic support; point patients to other services when needed**
- **Consistency with the System and Place overarching plans**
- **Support for patients to take greater control and responsibility for their condition**

What we will do - Expanded Set of Pathways

As our 'core community offer', community diagnostics and urgent response models bed in - and the digital infrastructure is both installed and familiar we can safely expand the core set.

To do that we will:

- **Prioritise the services and conditions**
- **Use the collaborative community model we will develop to co-design the ideal solutions for Place - recognising the need to tailor it to address inequalities or access gaps**
- **Implement the right pathways - learning from the established pathways**
- **Key areas we will investigate include chronic rheumatological conditions and treatments, oncology services, inflammatory bowel disease and chronic neurological conditions**

2c.
End of Life Care

Context

'End of Life Care' (EoLC) refers to a range of services that support people in their last year of life. It is not therefore 'condition-specific' but is involved with people who have conditions like cancers, respiratory failure, heart failure and renal failure – for which we are enhancing and developing integrated pathways.

It thus lends itself to collaborative, integrated models and, in that sense, has parallels with Frailty models - albeit with a different purpose.

Particular challenges are that funding is often fragmented and so although we have good services and a good reputation in East Sussex access and models can still vary. Given our population, we are ambitious to provide exemplary care.

Our Ambition

The main aim for End of Life care is to embed our best models and best practice across the county, through collaborative working in order to:

- **To ensure uniform access to consistent approaches that build on what we have achieved and what we know works best**
- **To develop the patient as a partner in the care pathway**
- **To make access simple and seamless for the patient**
- **To make interaction across disciplines easy**
- **To deliver more value to the patient outside the hospital**

What we will do

- We will work, through the PCCCN, to design the most effective models for Sussex that will deliver the national strategy through a 'hub' type approach and by developing the workforce so we are effective in the acute setting and have the right skill mix in community settings
- Work in collaboration with colleagues in primary care, social care and hospitals to implement our Gateway Project – to reinforce processes for recognition, support the difficult conversations at the right time and initiate multi-disciplinary support early
- We will link closely into the developing model for our core community offer and condition-specific pathways so we can operate with a 'hub' model supporting local collaborative networks. This will mean working together in terms of digital infrastructure, training, relationship building and shared planning

CORE STATEMENT 3:

A new, collaborative model of care for Children and Young People:

Context

ESHT provides a range of services for Children and Young People at ESHT and because of traditional models, we often refer to the general, hospital-based specialties as 'Acute' Paediatrics and those focused on neurodevelopmental disorders as 'Community' paediatrics, However both services now operate in and outside hospitals.

Paediatrics is a changing field - more can be done in community based settings, there is increasing sub-specialisation, we often have to engage with other professionals and services to deliver the right care, how we work with schools, GPs and mental health is increasingly critical, and the workforce is evolving – with more non-medical specialists input along the various pathways.

As the whole field specialises the role of networks is increasingly important and ESHT has strong relationships with other providers for tertiary services and paediatric surgical services (like the Evelina in London and UHS in Sussex).

Rather like the future for adult services - the simpler challenges are actually to how we arrange acute, hospital-based services; whereas the key to sustainable, high quality services that improves the health of children and young people in our community is about how we operate outside hospitals. So this statement mirrors statements 1 and 2 to some degree.

Whilst our local demography means that the population of Children and Young people is not growing rapidly, in some specialties like neurodevelopmental disorders demand is growing and we see increasing numbers of children attending our A&E. Moreover the nature of demand is changing as capabilities evolve making paediatrics a more multi-disciplinary field.

There are 4 critical strategic challenges we will address over the next 5 years:

- **Recognising each site has a different demand profile. How do we play to their strengths?**
- **What is the best, sustainable model of care for our 'Place'?**
- **How do we create the right capacity and capability for neurodevelopmental paediatrics?**
- **How do we create age-appropriate environments and processes for young people and those in transition to adult services?**

The answer to all of these requires collaboration with multiple services to grow over the coming years – with GPs, schools, Looked After Children (LAC) services, Child and Adolescent Mental Health Service (CAMHS), the voluntary sector, health visitors and other specialists. Earlier identification and intervention needs to be a key practice principle for all services, working together. We also need to look at the design of our locations – and use our BFF opportunity to completely refresh how we think about the physical arrangement of services and we need to be able to develop the modern future workforce – in particular the non-medical specialists.

The services we are addressing in this statement cover a wide range of disciplines, but we group into 2 main areas, based on the type of need:

a. General and Acute Paediatrics:

These are services that respond to the general physical health of children and young people – either in acute hospitals or community settings – encompassing several sub-specialties. We need to develop from a largely reactive, hospital based service to an integrated, collaborative model with a much higher proportion of interactions happening in the community.

b. 'Community' Paediatrics

Traditionally called community paediatrics because much of the work is non-acute (and in apposition to 'acute' paeds as described above), these services are focused mainly on the growing area of Neurodevelopmental disorders. Demand has outgrown its capacity and we need to create enhanced capability that diagnose and support these children and young people earlier.

3a.
General and Acute Paediatrics

Our Ambition

We have three key aims:

- **To ensure that the 'front door' response for urgent care in Paediatrics is modern, age-appropriate, fits with the demand profile at each site**
- **To shift the balance of our work from hospitals/beds toward homes, schools and supported residences enabling early intervention, supporting improved access and targeting outcome inequalities**
- **To focus on age-appropriate settings and services for teenagers/children in transition to adult services**

There are three key enablers to achieving those aims - building a sustainable workforce that will be fit the future of our services, aligning to the digital strategy to exploit the potential that brings and maintaining robust relationships and pathways in our tertiary network.

What we will do

The first aim, in terms of the front door design element, is being taken forward as part of our building for our future (BFF) transformation programme, specifically around how paediatric care fits with our proposed emergency floor.

We will expand range of roles in the workforce, (e.g. Advanced Paediatric Nurse Practitioners (APNPs), to enable new ways of working outside our hospital buildings as well as maintain inpatient paediatrics at the Conquest Hospital and urgent care and short stay capacity at Eastbourne DGH.

The second aim is a bigger transformation requiring wide collaboration:

- **Build the offer around PCNs, ensure named responder, good relationships and capacity designed to jointly identified needs. That will form a collaborative model with primary care, schools and looked after children's services**
- **We will also collaborate with colleagues in our ICS to build the training and career paths - as new roles will be necessary to make this model sustainable**
- **We will examine additional non-medical specialist roles to target inequalities in key locations**
- **Review and enhance transition pathways across a range of services - building on what we have learned in diabetes and respiratory**
- **Design stronger, urgent mental health pathways with CAMHS**
- **Exploit high technological adoption rates amongst young people to offer modern forms of access, monitoring and self-management**

The Third aim also links with BFF plans; we will build age appropriate facilities and examine pathways, transition planning and integration into adult services. Transition and integration means we will seek to agree optimal practice with colleagues in adult services and developing the small number of roles we have already for people to specifically address the challenges children face in transition.

3b.
‘Community’ Paediatrics General

Our Ambition

There are two stages of ambition for community paediatrics to create a step-change in the experience of parents, carers and children and the quality we can offer.

- **In the short term, we aim to address the back log in demand for these services and match capacity to demand sustainably**
- **In the long-term, we want consistent access, to the same, high quality across place and above all to achieve early intervention**
- **We also want to widen our offer beyond Paediatrician input, to include therapies and other professional support right across the county and act as the guide point to a holistic set of services.**
- **As with General and Acute paediatrics we also need to enhance transition to ensure the best outcomes can be achieved**

What we will do

- We will co-develop a collaborative model with key system partners - Schools, CAMHS, LAC and social care. We will also enhance MDT working with a Child Therapy Team so we can address the full set of needs in an equal way across the county
- We will embed integrated neurodevelopmental pathways for all conditions, building on the progress we have made so far
- As with other services, we will support our Digital Strategy to implement shared information systems as these will be critical to a collaborative model
- As the collaboration takes shape we will work with Place partners to develop one-stop approaches, MDT triage, nurse assessments and embed the modernised pathways we are already in the process of developing right across the county

CORE STATEMENT 4:

Playing to the strengths of our two main acute sites

Context

This statement focuses on finding the most effective and sustainable configuration of services across our main acute sites and we have approached this with a key mantra - play to their respective strengths. Our two main acute hospitals have complementary strengths and marked differences in the profile of their patients:

- **At Eastbourne, the age profile is older and so our medical patients tend to be more complex in terms of co-morbidities and frailty. Eastbourne also sees slightly more people attend A&E each day, but a higher proportion of them attend with primary care problems, minor illnesses and ailments alongside the complex medical admissions. Eastbourne is also where we have our tertiary Urology service**

- **At Conquest the particular strengths are in complex, major and emergency surgery, Trauma and Obstetrician-led Maternity, inpatient Paediatrics and the proportion of major illness attending A&E is higher**

This clinical strategy needs to take account of a range of enablers (good practice, digital developments and other technology) and also ensure that we optimise the resources we have. Additionally there are three near-term factors that shape the imperative to ensure we are fit for the future:

1. **Baking in 'Pandemic Resilience' to future planning:** We learnt significant lessons from waves one and two of COVID. Our strategy must minimise the risk of disruption in future by ensuring our configuration protects 'green' or 'super-green' pathways (i.e. patient journeys with minimal to no risk of cross-infection).

2. **Collaborating as an ICS means we have opportunities to improve the way some services are delivered across Sussex:** Cyclical trends in the availability of specialist staff and unwarranted variation in waiting times show us that standalone provision in some specialties will not be sustainable. We already have arrangements in place for many of these situations (such as vascular surgery, plastic surgery). The development of our Sussex Acute Collaborative Network means we can now find better solutions by working together.

3. **Building for our Future transformation programme:** This includes our business case for potential capital funding via the national Health Infrastructure Plan (HIP) to improve our hospital buildings in about 6 years' time (subject to approval). That funding will not be enough to make a single, large new hospital an option nor will it let us do everything we want on our current sites. So we need to use that investment to maximise quality of care.

To respond to these challenges, we have split our priority delivery areas into 3 groups:

a. **Playing to Eastbourne's Strengths**
b. **Playing to Conquest's Strengths**
c. **Optimising key services**

Our Ambition

Our ambitions are to provide safe, productive, high quality services and:

- **A Pandemic resilient configuration to protect planned activity in the future**
- **To deliver top quartile productivity and promote key areas of excellence**
- **Ensure our population has access to the best quality**
- **To be ready with the right configuration to make the best use of the HIP investment**

4a.
Playing to Eastbourne's Strengths

What we will do

Eastbourne will be more ambitious in 3 key areas:

Tertiary Urology:
Over the next 5 to 10 years, robots will become more common, so to retain our Tertiary status we will create a 'Centre of Excellence' for Urology at Eastbourne.

Develop Day Case Excellence:
We will create the facilities, processes and flow to provide best-in-class day case operations at Eastbourne. This will mean initially creating the processes and spaces that enable day case flow. Over time we will review at how day case work is distributed across our two sites to consolidate procedures into Eastbourne where best for quality and where practical, as capacity allows. Longer-term this will build into our BFF transformation programme and factor into the plans for HIP investment. This also helps us develop pandemic resilient pathways, support recovery of planned activity, improves productivity and helps the ICS respond to the national drive to bolster capacity for 'High volume, low complexity' interventions.

Frailty:
We will create a Centre of Excellence for Frailty focused not just on acute care but how we create a common approach to Frailty across all points of care in East Sussex. We want to help drive innovation and best practice across all services in East Sussex, supporting our ICS and ultimately garnering a national reputation for innovation in this area. It suits the population that Eastbourne serves and its inpatient profile, and it is a perfect case for driving our key principles (see 'Delivering our Strategy) and statements 1 and 2.

This will support our Trust's cross-cutting Frailty Strategy, which focuses on 5 primary drivers - Recognise, Respond and Prevent, Personalise, Plan and Innovate.

4b. Maximising Conquest's Strengths

What we will do

Conquest will retain our Trauma, inpatient paediatrics and obstetrician-led Maternity services alongside current acute medical and surgical services. (Paediatrics and Maternity are the subject of statements 3 and 5.)

The critical tasks here relate to the plans for HIP investment and arranging services and facilities ahead of that key milestone to improve those services and sustain quality:

- **We will continue to consolidate complex surgical cases in Conquest as we do now. The HIP investment and nearer term capital developments will help us ensure the facilities to continue with the best quality of care are there. This includes trauma and emergency surgery.**
- **We will seek to protect elective capacity for pandemic resilience and high productivity. We will review, for the Trust as a whole, but particularly for Conquest, the facilities and internal arrangement of services to create and protect the best environments for high quality, high productivity elective surgical services.**
- **We will seek to develop further our CCU at Hastings.The majority of our critical care capability and capacity will continue to be centred at Conquest, with appropriate provision at Eastbourne to support services there.**

4c. Optimising key services

What we will do

Shaping our Urgent and Emergency Departments
Both sites will retain urgent and emergency access at their 'front doors'. Each ED will be redesigned, using a new model of delivery (Manchester model), digital enablers to support streaming and live information sharing, remove paper-based processes and an enhanced non-medical workforce (i.e. specialist nurses, new roles). The aim in both departments is to enable the quickest route to the right clinical decision maker.

Both sites are also designing their Emergency Floor models, which we can partially implement over the next 2 years, but will need the HIP investment to complete the transformation. The design of each will differ to reflect the nature of demand attending the sites (i.e. acute medicine, frailty, urology, urgent paediatrics at Eastbourne DGH vs surgery, inpatient paediatrics, acute medicine at Conquest Hospital). At Eastbourne this will include innovative approaches to the urgent treatment centre and urgent primary care to address the very high rate of growth in demand there.

We already have strategies for our acute medical models (these will inform our Emergency Floor plans) focused on closer integration of pathways out (whether specialist inpatient, hot outpatient, same-day or community based) to get away from the concept of 'referrals'. The precise design and capacity around those models will be adapted to the profile of demand at each site. On both sites we will improve the facilities and experience for patients, staff and visitors over time; the HIP investment will enable a step-change in the quality of ED and Acute environments.

Improving services through collaboration
Across our ICS we will work collaboratively to find solutions for services that are particularly difficult to operate as an individual trust (such as ENT and Dermatology) or to improve services already run using older partnership arrangements (such as vascular surgery and oncology that we deliver with UHS and maxilo-facial surgery that we deliver with QVH). We are already working with the SACN to examine ways to reduce variation in waiting times across high volume services (like ENT and orthopaedics). Collaboration will be essential to improving access and quality for people in East Sussex and Sussex as a whole.

Aligning interdependent services

For critical care a service specific strategy is in development addressing two main ambitions: a) to get the right capacity and distribution of capacity across our two sites, again playing to their respective strengths, that accommodates growth, good practice and the lessons from the COVID-19 response; and b) to develop the workforce and the staffing model to leverage our Consultant Anaesthetist and Intensivists more effectively (e.g. developing Advanced Critical Care Practitioners) and delivers the range of disciplines that now represent good practice in modern critical care. In the short term we need to review the configuration to ensure we can sustain a high quality service and in the longer term we need to enhance facilities and align capacity to the BFF transformation.

The strategy for radiology (and linked diagnostic services from pathology) is three pronged - a) we will need to develop the workforce and may need to collaborate to support growth in radiography and ultrasonography, b) ensure capacity goes into the right places and access is improved; and c) enhancing diagnostics in the community - starting with a Community Diagnostics Centre; the plans for which are already underway.

We will also work with our Pathology Network to develop and implement our strategy for Pathology, focusing on the most productive and cost-effective arrangement of capability and capacity across Sussex and specifying capacity to fit each of our hospital's service profile and strengths. We are also supporting the development of our Network's point of care testing strategy and community diagnostics.

CORE STATEMENT 5:

Enhancing access & optimising quality in services for Women

Context

We are focusing on two specific areas within women's health; firstly maternity services covering a full range of care, with Obstetrician-led care at Conquest and Midwife-led at Eastbourne. Secondly gynaecology where the Conquest provides most of our inpatient and emergency gynaecology, with a smaller inpatient service at Eastbourne.

There are several challenges our strategy needs to address for these services. For Maternity, the service is already developing a detailed long term strategy that aims to create an Outstanding maternity service, and our particular challenges are in fully utilising our midwife-led services when these are best for patients and making best use of our resources across both Obstetrician-led care (at Conquest Hospitial) and Gynaecology.

We know that women benefit from multi-disciplinary support before, during and after a birth but it is a period of a relatively high frequency interaction with health and care services for many women and their partners - and so it is also an opportunity for us to act as an anchor point and signpost to a range of services that we want to capitalise on. As East Sussex's only integrated provider of maternity care, we also recognise that this aspect of our work can support the women we see from more vulnerable groups; it is essential that we ensure all routes into care are available and responsive.

For Gynaecology services we have not yet maximised the potential for day case surgery and we can also improve diagnostic speed and access. The Ockenden report recommendations may offer some opportunities provided we review our configuration for Gynaecology services.

5a. Improving Maternity Services

Our Ambition

- **We want to achieve and sustain top quality maternity services recognised as 'Outstanding', that offer the 4 main options for mothers - Obstetrician-led, 'Alongside Midwife-led Unit', 'Freestanding Midwife-led Unit' and Home births.**
- **This means delivering on our Maternity Strategy (separate document).**
- **We also want to increase the utilisation of midwife-led services when they offer the best outcomes and use that engagement to support better access to a range of service that wrap around or support mothers and their partners.**

What we will do

We will enhance the role, location and content of our midwife-led unit at Eastbourne to create a more attractive, fuller midwife-led "hub" that brings a range of relevant services to women into a welcoming location. That will have a 'Freestanding Midwife Led Unit' (FMU) as a core component and we will work with local stakeholders and women to determine the best location for the FMU.

The 'hub' will also serve as a base or centre to support the home births services and will bring other provider services to women or signpost women to them, such as health visiting, psychological services, voluntary sector partners, advice for expectant Fathers, paediatric support and more. If successful and depending on the preferred location it may also be able to offer social environments (like coffee shops). This will be a key enabler for the delivery of our Maternity Strategy.

It will allow rapid access to advice, have digital access and potentially some diagnostics. We will link it to the development of our Community Diagnostics Centre as and when appropriate (e.g. for ultrasound services), subject to finalising those plans.

We will deliver the Ockenden requirements and examine whether these offer an opportunity to enhance our approach to both Obstetrics and urgent and complex inpatient gynaecology at Conquest Hospital.

5b.
Gynaecology and Breast services

Our Ambition

For both gynaecology and breast services we will maintain outpatient services on both main sites. Virtual interaction will be enhanced and potentially could also operate through the hub and as part of day case plans at Eastbourne we will increase day case flow.

For Breast services we will make triple assessment the standard approach in both Eastbourne DGH and Conquest Hsopital.

What we will do

- **We want to ensure consistent access to early diagnosis and assessment for gynaecological and breast conditions.**
- **We want to increase the availability of day case capacity and the flow of planned care services to minimise waiting times and improve access.**

CORE STATEMENT 6:

Incubate innovation and research

Context

ESHT has, for some time, engaged in innovation and research albeit on a smaller scale than larger acute Trusts.

We nevertheless recognise the benefits of a vibrant approach to clinical innovation and so this statement is focused on the areas where we, as a Trust, want to pursue national recognition for how we innovate, potentially creating 'Centres of Excellence' in fields that represent both our strategic goals and what the population needs.

Choices may need to adapt over time but there are 4 areas that at present need to become a particular focus for innovation and research:

1. **Tertiary Urology**
2. **Day case delivery**
3. **Frailty**
4. **Rehabilitation**

Our Ambition

Each area will set its own specific ambitions and priorities but overall the ambitions are to:

- **Identify best practice and ways to improve services for our population, tackle inequalities, enhance access, improve outcomes and our use of resources**
- **Develop and implement innovations that could improve services for ours and any population and showcase the benefits**
- **Become recognised nationally for excellence in each area**

What we will do

- **Support selected academic posts and research**

  a. **We have some opportunity already to approach this for Frailty**

- **Drive the culture and method for continuous improvement**

  a. **We are developing a 'change network' model for our People Strategy - these services will exploit that to the maximum extent**

  b. **Working with patients and colleagues in our collaborative**

- **Demonstrate the benefits of innovation and improvements for patients and East Sussex**
- **Work with Academic Health Science Centres, support joint working with Universities and Medical Schools in these areas**
- **Pursue strong relationships with the relevant networks, colleges, institutions and the national teams and use the output of these centres to inform our Education and Training capabilities**
- **Work with Health Education England to help lead on designing new roles and capabilities**

SECTION 2

DELIVERING THE STRATEGY

2.1 The Five Key Principles

As we move forward with this Clinical Service Strategy we will be linking into our BFF transformation programmes and working with individual services to develop detailed short term and outline long term implementation plans.

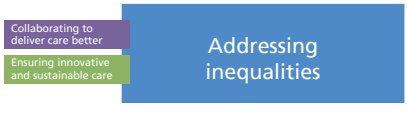
During the development of this strategy we encountered recurrent factors which constitute five principles that we are confident will drive a clinical strategy that is transformative and not merely "more of the same". These are shown in summary below:

This does not necessarily mean physically closer (although it may), but we are well placed to get to know our patients, work with them as partners and use the to inform service design and process. This principle will make our approach more proactive and personalised, it will keep access and equality front of mind and give greater control to patients. We will test implementation steps to ensure this principle is leading our thinking.

New roles, careers and training requirements are emerging in many services. For some these are critical to future sustainability or to implementing new models. This principle means: a) challenging ourselves to think beyond current workforce structures; b) keeping close connection to our People Strategy; and c) identifying where we need to collaborate in the ICS for career progression and training.

Being "integrated" can mean a number of things. Critically though the benefits must be felt at frontline interactions where staff and patients are working or moving across organisational or service boundaries. Achieving it is both cultural and practical. We are uniquely placed to succeed in this, but the ambition in the 6 core statements means we must embed this principle into implementation planning.

This is not a new principle, but it is still paramount for ESHT. This strategy is, in part, geared toward sustainability and improving use of resources as well as delivering the best quality of care we can. We will need to test each step in our progress to ensure we will, overall, improve our systems use of resources and be clear on how and when we will be able to demonstrate that.



Addressing inequalities is a priority for the NHS as a whole. The goals of this strategy will enable us to target them more effectively, partly through improved and optimised access and partly through targeted changes.This principle means we must examine any proposed changes, during implementation to ensure a) they do not risk inequality and b) the reduce inequalities where possible.

As we work on the implementation we will use these principles to inform, test and challenge specific plans. We have tested them against the 4 main aims of our overarching strategy to ensure alignment.

2.2 Mapping principles to the Core Statements

In considering how we ensure that these principles 'come alive' through each of our statements, the summary table articulates the areas in which we would want to focus in order to assess the nature of the progress made.

Critical Connections between statements and principles	Getting Closer to Patients	Modern Workforce Development	Integrated' at the frontline Getting	Improving our Use of Resources	Addressing Inequalities
Reimagined Adult Community-based Services	Central to Living Well – core collaborative offer	Fundamental requirement for Urgent & Responsive and Rehabilitation	Relevant to all areas – both with ESHT colleagues (for rehab & urgent) and collaborative partners	Designed to improve overall for Place and ESHT – need to be able to demonstrate that	Central to the purpose of local collaborative offers (with adapted/ enhanced elements)
A core set of condition-specific, integrated pathways	This is core to service delivery and to improving community health	Essential both for current core set and the future expanded set	Critical success factor to all elements	Designed to improve use of ESHT resources	Targeted adaptations will be used to address inequalities (co-designed in collaboration)
New, collaborative model of care for Children and Young people	Getting this right for the General and Acute strategy is key. Already embedded in Community Paeds services	Critical success factor for General and Acute. For Community Paeds collaboration is the key	Needs to be enabled, for collaborative working and transition age services	Part of the point of these strategies is how to best use resources to meet need	Central to the purpose. We need to be stay alert to this during implementation to target known gaps
Playing to the strengths of our two main acute sites	Important mainly at points of integration	Critical for several services (e.g. critical care, endoscopy, ED)	Essential principle for the link to urgent & responsive services	This will be a key test as we move to implementation. Solutions must be affordable	We will need to test changes to ensure they support access to quality
Enhancing access and optimising quality in services for Women	A central aim of the 'hub' model and also community diagnostics	Critical for maternity in particular	Important for all services – particularly the maternity hub	A challenging test for Maternity but a key driver for Breast and Gynaecology	Particularly important for Breast outpatients and diagnostics generally
Incubate innovation and research in targeted strategic areas	Particularly key for Frailty	Essential for Frailty & Rehabilitation. Potentially for Urology as innovations emerge	Key for all and absolutely critical for Frailty in particular	This will be one of the set tasks for 'Centres for Excellence' and a general purpose for innovation	Strong capabilities in key areas will help us innovate to tackle inequalities

2.3 Alignment with enabling strategies

As part this Clinical Strategy, we developed summary service strategies, and these reflect our other enabling strategies (Digital, People, Estates). We have worked together to ensure a 'golden thread' runs across all the enabling strategies and that, together, these drive the four strategic aims of our Trust-wide strategy Better Care Together for East Sussex.

Digital

The development and effective use of digital infrastructure/tools is essential to almost all our service strategies and therefore to the Clinical Strategy overall. The critical requirements are:

- **The ability to offer modern patient interaction (e.g. virtual face to face contact, information sharing, health data monitoring) is critical**
- **Ensuring access consistent, clear, available anywhere**
- **Common approaches/operating principles for staff and professionals**

Key objectives in our digital strategy will provide the infrastructure to enable this:

- **Electronic access to Personal Health Record**
- **Single EPR**
- **Digital to support personalised care**

We also need to make sure that adding digital functionality does not add work or manual steps over time, nor does it create unintended inequality. This is a challenge for the NHS and requires careful implementation. The digital strategy aligns with our Clinical and overall strategy, the key will be how we execute it and the "pledges" within the strategy are therefore very important.

The pledge to "engage with colleagues and patients" is an absolute requirement for success along with the pledge "not to digitally exclude" - not every person can or will access digital tools.

People

Nearly every service has a strategy that requires the workforce to evolve. Our people strategy has 4 goals that align perfectly to our Clinical Strategy and up to our overarching strategy, namely:

1. **Looking after our People - compassionate leadership, right staffing and right equipment**

2. **Different Ways of Working and New Roles - the Improvement network, planning tools, new role design**

3. **A Culture of Inclusion and Involvement - equality, diversity and engagement with staff**

4. **Growing for the Future - developing career pathways and workforce pipelines, acting as an 'anchor', working across the system**

Most services need new roles for a sustainable future - from ED, Paeds, MSK, Crisis Response, Urology, Endoscopy and more. Much of this we can develop ourselves and this is a central objective of our People strategy. We will also seek to play a lead role where collaboration is required to create careers and training approaches.

Looking after our people and Inclusion and Involvement will drive essential cultural aspects that enable integrated models and joint working where we have a more diverse, distributed workforce with more remote working.

Improvement and change networks will also be key - we are already targeting micro-level changes in areas like the interface between ED, Acute Medicine and our specialties to make 'front door' flow more effective. That approach will be necessary at multiple points as integration and collaboration build. In addition – continuous improvement will be a key principle and we will need our People Strategy to help create the tools and environment to do that well.

Estates

Priority 2 of the Estates strategy is "Support delivery of the Trust Clinical Strategy" in particular it talks about flexible accommodation, infrastructure that enables digitisation and modern environments.

Near term we are developing day case facilities as a first phase, at Eastbourne, we are reviewing the community estate overall in light of this strategy, some reshaping of our Emergency Departments is happening and the Community Diagnostics Centre development is progressing.

In the long term the major element in capital terms of our Estates strategy will be the HIP investment as part of our BFF transformation plans - each transformation workstream within that is linked to the clinical strategy and roughly plans split into two phases - namely being ready to implement the BFF investment successfully and then benefiting from what the redesign of particular areas enables.

Broadly - our plans to shift the balance of work toward 'out of hospital' activity helps limit the acute footprint required in future, which means we can both improve care and make the BFF investment more affordable. They key benefit after these investments will be in improved productivity (for example the design of our emergency floor and enhancing day case delivery), a better environment for patients and staff (including enabling agile working, virtual interactions - as well as modern internal environments), more flexibility (e.g. multi-purpose spaces) and pandemic resilience (e.g. increasing single rooms, protecting elective capacity).

Our Green Plan, a sub-element of our overall estates strategy will benefit from the plans in our clinical strategy. It will result in a small acute footprint than we might have needed without it, it will also mean patients are supported outside the hospital and at home more often which reduces travel and waste.

2.4 Building for our Future and Implementation Planning

Appropriately, the final section of this strategy leads into the Trust's major infrastructure and transformation vehicle, Building for our Future (BFF). As we turn to implementation planning, the strategic process will connect directly into BFF workstreams and the HIP business case to create unified, integrated implementation plans. The outline phasing for delivering the strategy is naturally partly driven by the HIP investment.

Elements of those major workstreams will focus on short term steps, all aligned with our Strategy, such as:

- **The immediate developments in community services within our 'Integrated Care' workstream supporting the ICS Ageing Well programme like developing our Community Frailty Response, Community SDEC, the initial steps to enhance care in care homes and enhanced crisis response (including virtual wards)**
- **Key hospital focused workstreams such as the initial steps in transforming our ED model (e.g. implementing the Manchester Model, e-consult, going paperless), the development of our day case flow and environment at Eastbourne in the short term, creating a near term sustainable configuration for critical care**
- **Working through ongoing consultation processes to improve the quality of Ophthalmology and Cardiology services (these are in progress so are not commented on in this strategy)**
- **Our ICS's SACN is already working on plans for some challenged services and ways to address variation in waiting times (e.g. ENT and high volume/low complexity capacity)**
- **The initial plans for our centres of excellence can also begin now and there are some elements already under review (such as a research opportunity and academic opportunity link to Frailty)**

Other elements focus on longer-term steps in the build up to the key HIP investments and will be interdependent with the other enabling strategies:

In this case our the next step is developing more detailed implementation plans, using this strategy and its principles, that account for / integrate with critical path milestones from the enabling strategies. Some are tied directly into the BFF workstreams and the work to do this has already begun.

For example, some we have begun the process of designing the workstream to deliver on statement 1 (part of BFF's 'integrated care workstream') but longer term details need to be mapped to key digital developments like Electronic Patient Record (EPR), workforce developments (like First Contact Practitioners), our community estates strategy (interdependent with the intended form for the core collaborative offer) and some external drivers that may come from the regional Reimagining Community Services programme as that emerges.

Similarly the implementation for statement 3 can begin now. We can address some short term challenges in our hospital configuration for Paediatrics and begin planning the development of collaborative, community based models, but the longer term implementation plan will connect into the Women's and Children's BFF workstream. The major transformative steps depend on key estates milestones, workforce developments and digital enablers.

As we create these plans, we will build details into the assumptions and content for our HIP business case.

Service specific implementation plans were initiated at a high level during the development of this strategy by considering key actions against their objective, but are not yet complete and outlining the implementation timeline is next step for each service (that will align to business planning)

The success of HIP is dependent on this strategy, but it will also enable some to complete their ambitions. For example completing statement 4 is dependent on the HIP investment as it enables the full realisation of the Emergency Floor model, Day Case excellence, Critical Care configuration and aspects of diagnostics. It will also impact the eventual design of hospital based Paediatric services (e.g. adjacency with ED for urgent care, age appropriate environments) and the Maternity Strategy and so on.

We have a wide range of volunteering opportunities and you don't need previous experience in a health setting to volunteer for us.

For more information visit our website:

esht.nhs.uk/volunteering

Visit, follow and subscribe to East Sussex Healthcare NHS Trust (ESHT)

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0300 131 4500

Conquest Hospital

The Ridge, St Leonards-on-Sea, East Sussex, TN37 7RD
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Eastbourne District General Hospital

Kings Drive, Eastbourne, East Sussex, BN21 2UD
0300 131 4500

East Sussex Healthcare
NHS Trust

ESTATES STRATEGY 2021-2026

Delivering - Better Care Together for East Sussex

www.esht.nhs.uk

Contents

FOREWORD

Chris Hodgson
Director of Estates and Facilities

East Sussex Healthcare NHS Trust (ESHT) places great emphasis on the quality of care and patient safety and in particular privacy and dignity, infection control and the quality of the environment. These underpin the vision for our estate development in the short, medium and long term.

At the time of writing this Estate Strategy the Trust has been dealing with the unprecedented implications of the Covid-19 pandemic. This has had a significant affect upon how the Trust has operated and delivered services. Like other NHS Trusts and care organisations in the UK and worldwide, the pandemic will have a profound and long-lasting impact. The reaction and approach to Covid-19, and any subsequent contagious viral outbreaks, will impact upon the manner in which the estate develops to support the Trust's service delivery.

In developing this strategy, we have drawn upon the lessons learned from Covid-19 to shape the delivery and development of the Trust estate, and we will continue to look towards emerging evidence to adapt our strategy going forward. This Estate Strategy provides a framework to respond to the developing clinical service needs. This includes minimising the risk to patient safety from ageing and obsolete buildings and engineering services infrastructure.

EXECUTIVE SUMMARY

ESHT is committed to a robust approach to developing and maintaining the Trust estate and aims to implement the Building for our Future (BFF) programme as the means to make our estate suitable and relevant to the population we serve for the coming decades.

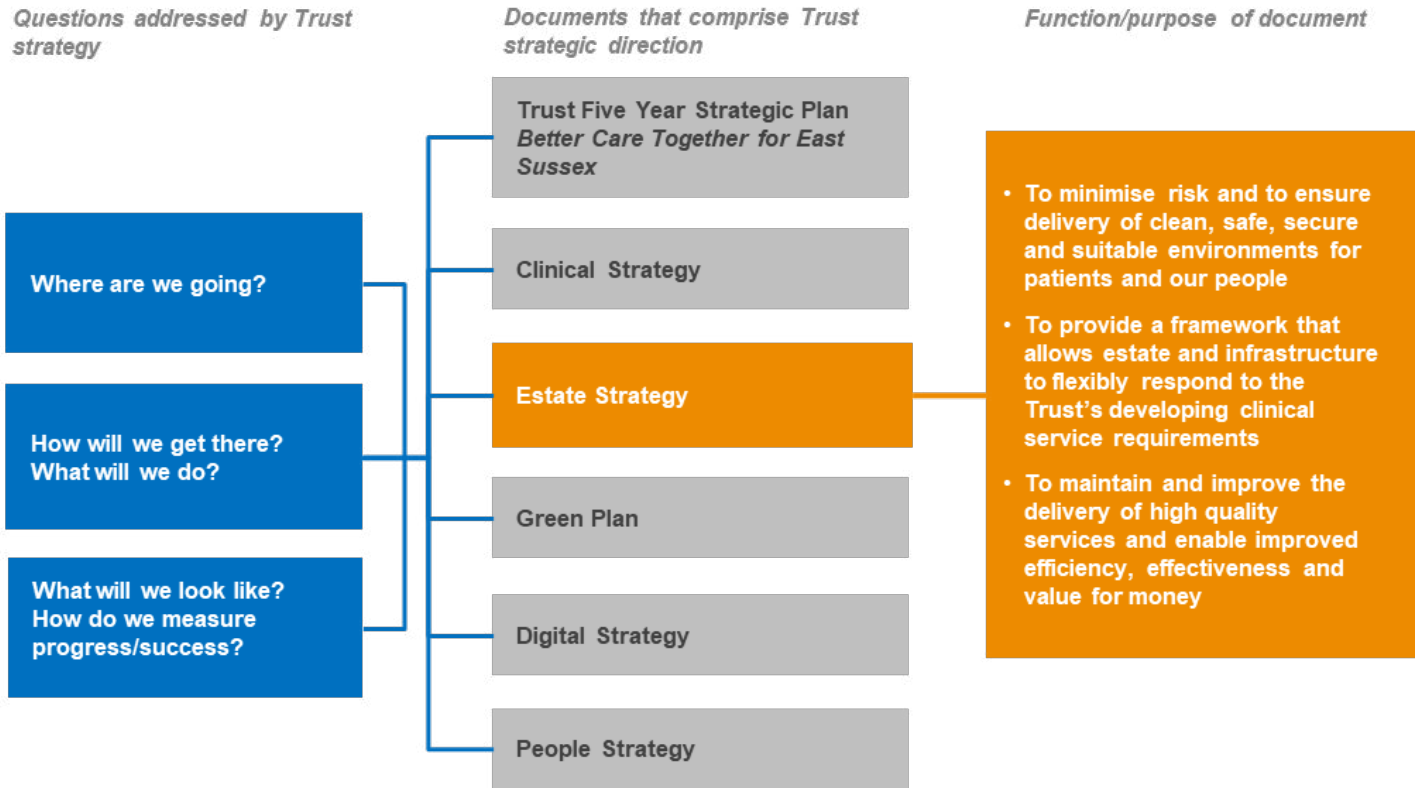
Whilst the BFF programme is still in the early stages of development, the Trust recognises that continued resource and investment will be required to maintain the existing estate over the next five years while the Trust proceeds with the development and approval of the wider hospital redevelopment plans. The Trust Board of Directors are committed to the BFF programme, and will continue to support the direction and development of the BFF plan in relation to the estate, along with meticulous monitoring and management of the programme by the Project team.

The Trust will establish a medium term 2-5 year capital programme and irrespective of the BFF programme, the Trust will prioritise its capital investment in buildings and facilities to ensure it continues to:

- Commit significant funding from its own capital program each year to address/mitigate where possible the estate critical infrastructure backlog risks, thereby managing risk to patient safety
- Bid for external capital funding e.g. ICS sources to improve our resilience and supplement its Estate critical infrastructure risk backlog funding, SALIX to reduce the Trust carbon emissions etc.
- Review and improve where possible with capital funding e.g. operational productivity KPI's such as clinical to non-clinical space indicators
- Increase the clinical utilisation of space
- Develop the ESHT Green Plan and reduce the Trust's carbon emissions
- Consider the associated plans and delivery of investment for those areas that the BFF programme may not be able to deliver on

INTRODUCTION

The Trust has an overarching Strategy "Better Care Together for East Sussex" that is supported by a number of enabling strategies. Collectively these describe the strategic vision for ESHT. This Five Year Estate Strategy complements other Trust strategies and should be read in conjunction with the clinical, digital and people strategies and as we move to implementation planning we will maintain the golden thread between each of them.



This document is set out as follows:

- **Context**
- **Part 1: Where are we now?**
- **Part 2: Where do we want to be?**
- **Part 3: How will we get there?**

CONTEXT

Since 2015, the Trust has embarked upon a series of initiatives to begin to address the physical, compliance and suitability issues that exist across the Trust's estate. This process has been constrained by financial and other resource limitations, and as such the estate still suffers from physical and functional deficiencies which impact upon service delivery and attainment of Trust goals and objectives.

In October 2019, the Trust received the welcome news that it had been included within phase 2 of the Government's Health Infrastructure Programme (HIP) and secured seed funding to develop a business case.

The Trust has put in place the Building for our Future (BFF) programme to transform services and deliver on its ambition to reshape the Trust estate to meet the needs of future generations and address the physical and functional deficiencies.

This Estate Strategy focuses on our ambition to deliver outstanding healthcare enabled through high quality, flexible and future proofed environments that enhance the patient experience and supports our 7,000 staff to deliver high quality care. The immediate priorities emphasise incorporating service improvements to enhance the quality of services and managing and alleviating the risks that currently prevail in relation to the Trust infrastructure and estate. It also includes how we will shape the development of the estate to meet the future needs of our population, taking into account the opportunity offered by the Government's Health Infrastructure Programme.

PART 1: WHERE ARE WE NOW

Description of the Trust Estate

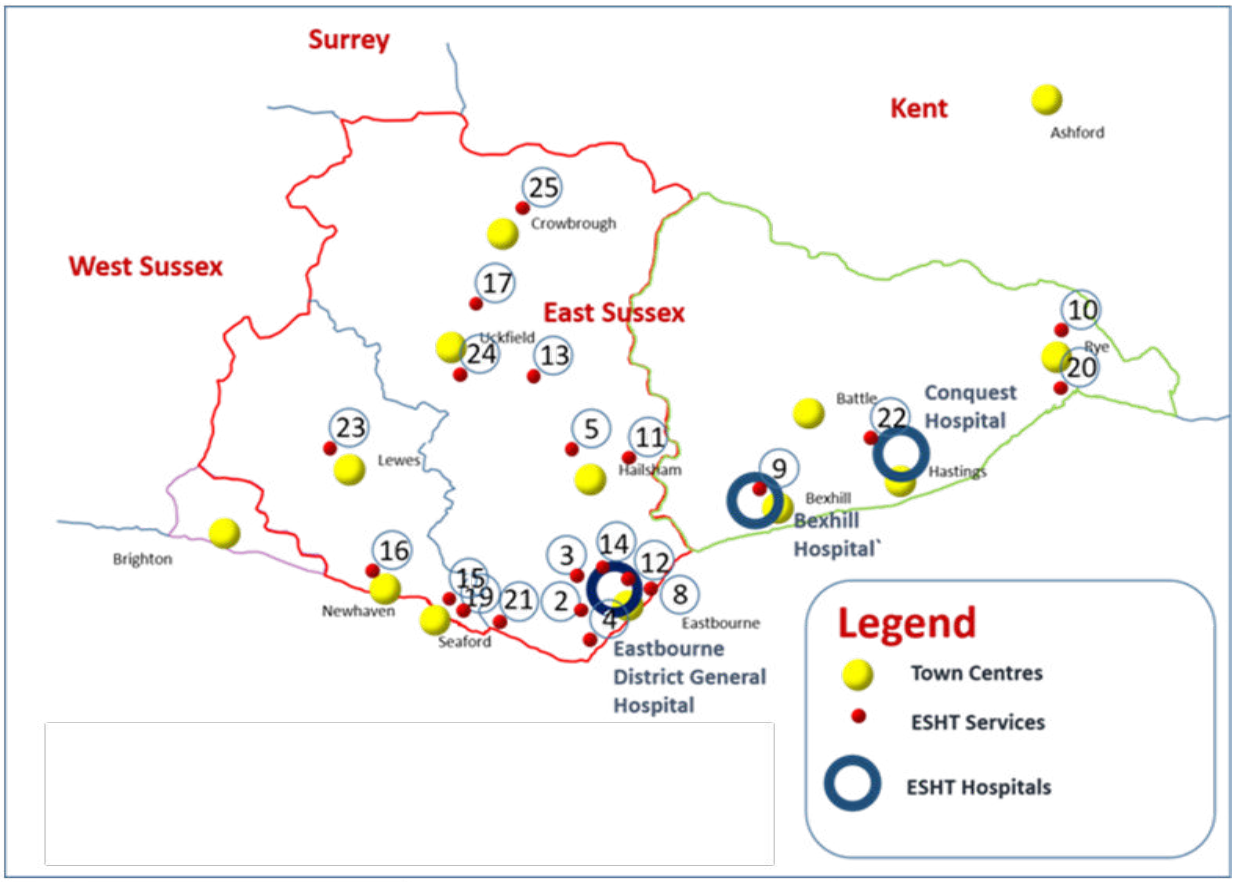
ESHT is a medium sized provider of general acute and community services. The Trust estate comprises two acute and one community hospital.

Conquest Hospital at Hastings and Eastbourne District General Hospital (EDGH) are 20 miles apart, with Bexhill Community Hospital located in-between.

In addition, ESHT also leases Rye Memorial Hospital and has services operating from a further 25 leasehold properties and 71 undocumented properties across East Sussex, including community hospitals, children's centres, community centres and GP surgeries.

ESHT's main sites located at Eastbourne, Hastings and Bexhill, are large sprawling sites, with aged estate at various levels of degradation, and with varying levels of backlog.

Figure 1 – ESHT Service Locations



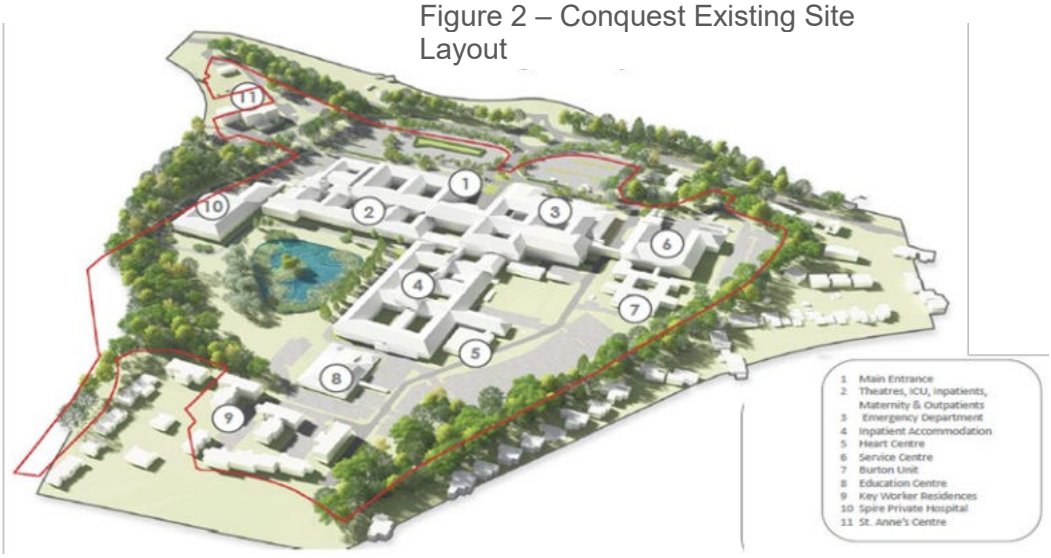
2	St. Mary's House	11	Hailsham Health Centre	19	Peacehaven Childrens's Clinic
3	Avenue House	12	Hampden Park Health Centre	20	Rye Memorial Care Centre
4	Centenary House	13	Heathfield Health Centre	21	Seaford Health Centre
5	Apex Way Units 5 & 6	14	Ian Gow Health Centre	22	Wheel Farm, Unit 10
8	Eastbourne Park Health Centre	15	Newhaven Polyclinic	23	Lewes Victoria Hospital
9	Fellowship of St. Nicholas	16	Newhaven Rehabilitation Centre	24	Uckfield Hospital
10	Ferry Road	17	Newwick Health Centre	25	Crowbrough Hospital

Conquest Hospital sits on a steeply sloping site and the accommodation is split over 4 levels. There are limited development areas for expansion on the site due to the topography and proximity to neighbouring residential areas.

The six facet survey highlighted severe maintenance backlog requiring significant works to almost all of the existing estate. The primary area of concern is the existing tiled pitched roofs which are failing due to perished felt underlay. Temporary local repairs have been undertaken to prevent water ingress, however a replacement roof is required across the whole estate.

- Total land area of 14.02 hectares providing total occupied area of 51,488m^2. The occupied area includes 4,835m^2 of staff residences
- The percentage of non-clinical space is 31% (excludes areas such as residencies etc.)
- Majority of the site (67%) was built between 1985 and 1994, with 29% built between 1995 and 2004, and 3% built before 1964
- In terms of condition, the identified backlog maintenance requirement in 2019/20 is £129.8m

Figure 2 – Conquest Existing Site Layout



Backlog rectification costs as at 2019/20 by category for years 1-10

Element	Conquest Hospital
Physical Condition	£62,032,662
Statutory Compliance	£885,571
Functional Suitability	£45,505,250
Space Utilisation	£16,753,800
Quality of the Environment	£4,281,712
Equality	£380,850
Total	**£129,839,845**

Eastbourne District General Hospital has residential buildings to the West and a college campus to the North. There is green belt open land (flood plain) to the East.

The six facet survey highlighted the need for significant improvement to the current estate which would incur substantial costs to bring the existing buildings up to current standards. The main clinical building is the critical area of the site requiring major intervention. Further intervention is also required for the industrial process area.

The New Eastbourne Local Plan 2018-2038 is currently in preparation by Lewes District Council and Eastbourne Borough Councils. This new plan will look ahead to 2038 and will be the key planning document that will shape, plan and manage growth, regeneration and development across the Borough, based on a vision of what the local authority wants Eastbourne to be like in 20 year's time.

- Total land area of 15.56 hectares providing total occupied area of 65,324m2. The occupied area includes 10,698m2 of staff residences
- The percentage of non-clinical space is 28%. (This excludes areas such as laundry, HSDU, residencies etc.)
- Majority of the site (63%) was built between 1965 and1974, with 28% built between 1985 and 1994, and 8% between 2005 and 2015
- In terms of condition, the identified backlog maintenance requirement in 2019/20 is £162.6m

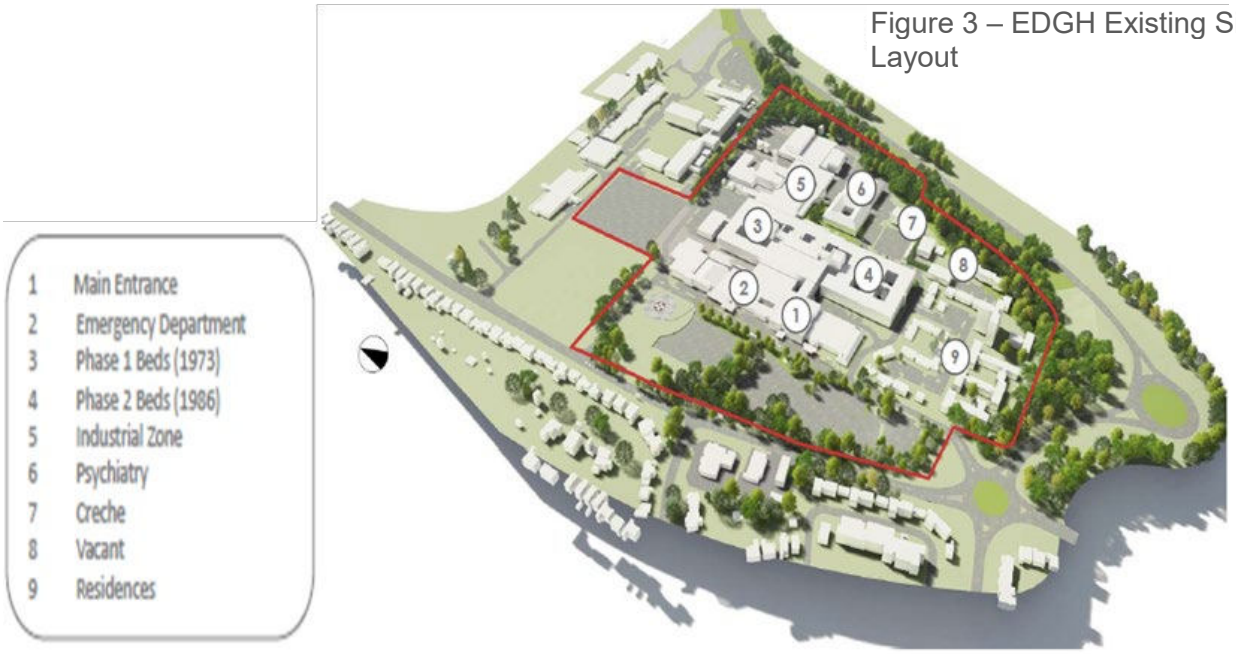


Figure 3 – EDGH Existing Site Layout

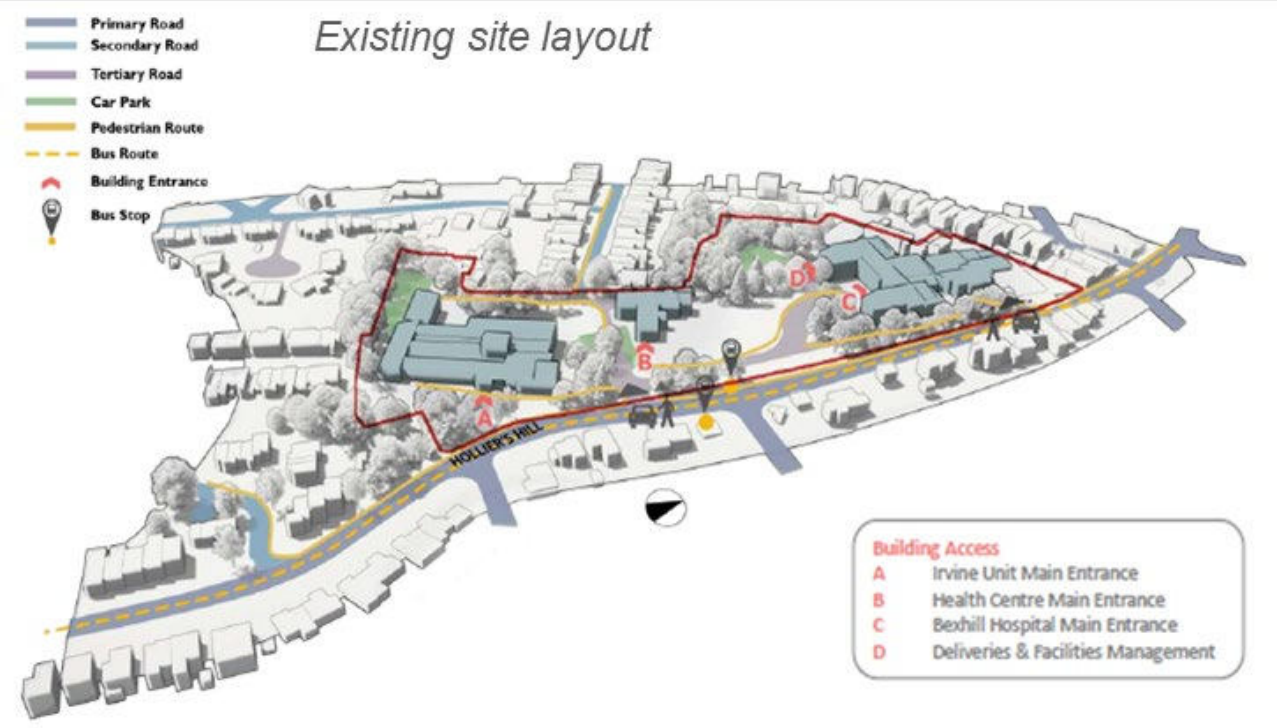
Backlog rectification costs as at 2019/20 by category for years 1-10

Element	EDGH
Physical Condition	£87,115,467
Statutory Compliance	£1,620,819
Functional Suitability	£41,635,888
Space Utilisation	£21,922,300
Quality of the Environment	£9,087,374
Equality	£1,175,900
Total	**£162,557,748**

The site of **Bexhill hospital** is steeply sloping and surrounded by residential housing. There are a number of bus stops in close proximity but on-site parking is limited. The clinical facilities delivered on site are outdated and in need of major alteration works, however the existing buildings are not easily adaptable.

- Total land area of 2.33 hectares providing total occupied area of 5,168m^2
- The percentage of non-clinical space is 61%
- Majority of the site (42.5%) was built between 1975 and1984, with 25% built before 1948, and 16% built between 1995 and 2004
- In terms of condition, the identified backlog maintenance requirement in 2019/20 is £15.1m

Figure 4 – Bexhill Existing Site Layout



Backlog rectification costs as at 2019/20 by category for years 1-10

Element	Bexhill Hospital
Physical Condition	£3,971,889
Statutory Compliance	£388,559
Functional Suitability	£6,429,250
Space Utilisation	£2,553,750
Quality of the Environment	£1,455,090
Equality	£252,000
Total	**£15,050,538**

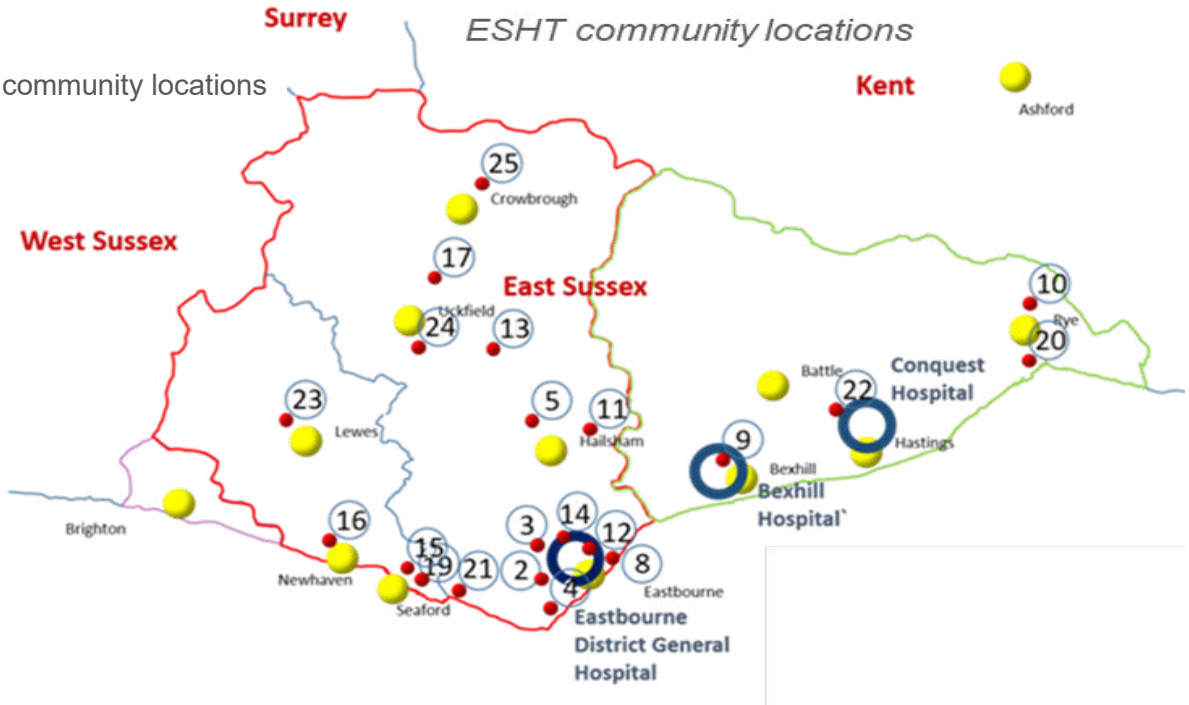
ESHT's occupation of **Community Estate** is complex and has been shaped by specific policies relating to the treatment of property and also tender activities in support of the any qualified provider agenda.

The majority of community estate occupied by the Trust is owned and operated by NHS Property Services. Generally these properties are old and no longer provide compliant accommodation and are deemed to be expensive. There are also properties where the Trust has no documented occupation (e.g. Amberstone).

There are utilisation and efficiency challenges relating to the community estate:

- The pattern of occupation has remained relatively unchanged over 10 years and is no longer best placed to support changing clinical pathways through the formation of Primary Care Networks (PCNs)
- Trust occupation has changed in scale as a result of commissioner tendering activity together with cost efficiency initiatives
- In the area of the former High Weald, Lewes and Havens CCG, the impact of the Musculoskeletal (MSK) Partnership has resulted in a loss of demand and reduced occupation of sites in the area
- The accommodation type reflects historical organisational form and policy, with expensive clinical space used for domiciliary services
- Arrangement of accommodation has not reflected efficiencies resulting from agile working, resulting in inconsistent occupation of buildings

Figure 5 - ESHT community locations



2	St. Mary's House	11	Hailsham Health Centre	19	Peacehaven Childrens's Clinic
3	Avenue House	12	Hampden Park Health Centre	20	Rye Memorial Care Centre
4	Centenary House	13	Heathfield Health Centre	21	Seaford Health Centre
5	Apex Way Units 5 & 6	14	Ian Gow Health Centre	22	Wheel Farm, Unit 10
8	Eastbourne Park Health Centre	15	Newhaven Polyclinic	23	Lewes Victoria Hospital
9	Fellowship of St. Nicholas	16	Newhaven Rehabilitation Centre	24	Uckfield Hospital
10	Ferry Road	17	Newwick Health Centre	25	Crowbrough Hospital

ESHT also has an extensive **Residential stock** at both the Conquest and Eastbourne sites which are key enablers to supporting the Trust's workforce strategy by enhancing staff wellbeing and improving recruitment and retention.

The Trust residential accommodation is a mix of self-contained and shared multi-occupancy units, and ranges in age from the 1970s through to the 1990s.

- There has been very limited investment in the residential accommodation for a number of years
- The condition of the residential accommodation has deteriorated over time and consequently has a high backlog maintenance investment required to bring it up to an appropriate standard
- We need to invest in our residential accommodation portfolio on both sites

Capital Investment 2016-2020

The Trust's capital investment programme invests in projects to improve the patient environment, enable priority service improvements and management of backlog maintenance. The table below illustrates some of the capital schemes that have been completed or are in progress since 2016.

				Site		Outcome			
Ref	Year	Project	Status	EDGH	Conquest	Improved infection control	Improved patient experience	Improved staff experience	Reduction in backlog maintenance
1	2017 – 2018	Provision of new Primary Care Departments adjacent to Emergency Departments	Complete	•	•		✓	✓	✓
2	2017 -	Fire compartmentation works at EDGH clinical buildings	In progress	•					✓
3	2017 – 2018	New fracture clinic	Complete		•		✓	✓	
4	2018 - 2019	Vacated inpatient facility converted into Urology Investigation Suite (UIS)	Complete	•			✓	✓	
5	2018 – 2020	Remodelling of front entrances including new café at EDGH	Complete	•			✓		
6	2018 – 2019	Installation of 2 new CT scanners in refurbished area adjacent to radiology	Complete	•			✓	✓	
7	2018 – 2019	New MRI facility with close links to theatres	Complete		•		✓	✓	
8	2018 - 2019	Refurbishment of 3 theatre anaesthetic rooms	Complete	•		✓	✓	✓	
9	2018 - 2019	Installation of automatic booking terminals for outpatients	Complete	•	•		✓		
10	2018 - 2019	Staff changing room refurbishments	Complete	•	•			✓	
11	2018 - 2019	Maxillofacial Unit (MFU) Orthodontics area refurbishment	Complete	•			✓		
12	2018 - 2019	Infrastructure for the Electronic bed management system	Complete	•	•		✓	✓	
13	2018 - 2019	Reapplying waterproof finishes to roofs	Complete	•	•				✓
14	2018 - 2019	Installation of new medical air plant	Complete	•					✓
15	2018 - 2019	Replacement of main circulatory pumps	Complete	•					✓
16	2018 -	Asbestos removal	In progress	•					✓
17	2019 – 2020	Main entrance refurbishment at Conquest	Complete		•		✓	✓	✓
18	2019 - 2020	External fenestration works on over 1000m^2 of external walls to reduce water leaks	Complete	•	•				✓
19	2020 - 2021	Installation of new VIE to increase medical oxygen capacity	Complete	•	•		✓	✓	✓
20	2020 - 2021	26 bed ward refurbishment (Devonshire) to increase number of side rooms	Complete	•		✓	✓	✓	✓
21	2021 -	Glynde ward refurbishment	Complete	•		✓	✓	✓	✓

Estate Performance

The Trust's key deliverable, as part of the NHS Constitution, is to provide clean, safe, secure and suitable environments for our patients and service users.

We recognise that the quality of the Trust estate is vital for the delivery of safe and efficient healthcare. Quality and fit for purpose elements of the Trust estate are assessed against a set of standards, through:

- Healthcare Technical Memorandum (HTM) which are used to evidence the Trust compliance with legal requirements and standards
- The Trust governance processes which focus on how our managers are directed and how we monitor our engineering activities to comply with statutory requirements

The Trust participates in the annual NHS Estates Return and Information Collection (ERIC) benchmarking process which provides valuable insight into the performance of Estates and Facilities departments nationally by generating key performance indicators (KPIs) and national comparisons.

2018/19 assessment	Unit	Trust Value	Lower Quartile	Median
Estates and Facilities costs per occupied floor area	£/m^2	155.75	101.36	144.78
Hard FM costs per occupied floor area	£/m^2	77.92	84.89	102.21
Soft FM costs per occupied floor area	£/m^2	124.02	127.65	144.23
Hard and Soft FM costs per occupied floor area	£/m^2	201.95	217.89	244.30
Facilities Management costs per occupied floor area	£/m^2	357.70	353.57	374.74

The Trust's estates and facilities services perform well against the national benchmark. In all categories with the exception of finance costs (covered within the facilities management costs per occupied floor area metric) the Trust is at or below the lower quartile cost. Although this is positive in terms of cost control, we are left with no financial headroom for future succession planning/backfill and a training fund,. This will need to be addressed as there is a significant risk arising from not having a full complement of trained engineering/estates team for the next 1-10yrs.

- The Trust finance costs include capital charges and charges for the occupation of buildings operated by NHS Property Services
- As a vertically integrated provider of acute and community services, the Trust is in a minority of comparable Trusts, which has a negative impact on costs compared with our peer group

Benchmarking with other hospital providers through the NHS Model Hospital system also indicates that ESHT is significantly above the benchmark and peer group median for:

- Critical Infrastructure Risk (CIR) – £/m^2
- Total backlog maintenance costs – £/m^2
- Amount of non-clinical space (%)

Condition of the Trust Estate

ESHT has an ageing estate with very significant levels of backlog maintenance: Significant elements of the estate are either condition C or D indicating that "major repair or replacement is needed in the short to medium term or there is serious risk of major failure or breakdown".

It is essential that the physical condition of Trust estate is accurately assessed and maintained to ensure it is fit for purpose and safe for patients and staff. The Department of Health's Estate Code indicates that all buildings should be ranked as condition B or above – sound, operationally safe and exhibits only minor deterioration.

Six Facet Surveys were undertaken across the Trust in 2019, providing an indication of the cost of backlog rectification. The surveys undertaken incorporated 5 facets, with the sixth facet relating to environment undertaken as part of the Trust's Green Plan in partnership with Sussex Community NHS Foundation Trust.

Understanding six facet surveys

Six Facet Surveys allow Condition Categories to be allocated to properties on a facet by facet basis, and provide an indication of the remedial costs required to bring each facet up to a safe and sound condition.

Each facet of the estate is reviewed on the basis of:

- **Physical condition** – condition of the internal, external building fabric, mechanical systems and electrical systems
- **Statutory compliance** – compliance with fire, health and safety, and statutory legislation
- **Functional suitability** – suitability of the internal space, support facilities and location
- **Space utilisation** – assessment of the intensity of use in volume and frequency
- **Quality of the environment** – amenity, comfort and design
- **Environment** – overall efficiency of the estate

Estate Code Physical Condition rankings

Rank	Description
A	As new (that is built within the last 2 years) and can be expected to perform adequately over its expected shelf life.
B	Sound, operationally safe and exhibits only minor deterioration.
B/C	Operationally safe, however falling into Condition C within 1 year.
C	Operational but major repair or replacement will be needed soon, that is within 3 years for building elements and 1 year for engineering elements.
CX	Operational but major repair or replacement will be needed soon, that is within 3 years for building elements and 1 year for engineering elements. Item will require total rebuild or relocation.
D	Runs a serious risk of imminent breakdown
DX	Runs a serious risk of imminent breakdown. Item will require total rebuild or relocation.

ESHT's level of Critical Infrastructure Risk (CIR) is the 10th highest when compared to all Trusts in England.

The Trust employed external consultants to predict the rise in future backlog liability relating to deterioration of physical and statutory risk over the next 10 years assuming there is no investment in backlog eradication in the interim.

The total backlog rectification cost for the Trust for the next 10 years (as identified at August 2019) is over £300 million. For NHS reporting purposes these cost are shown as nett costs and they exclude VAT, fees, decant etc. . The real gross costs are of the order of circa £500million.

Of the total backlog, the nett cost of the Critical Infrastructure Risk (CIR) is over £64 million – this is more than 20 times the Trust's current baseline annual capital programme, which delivers roughly £3m to £4m per year of critical backlog related

projects. CIR has a potential on life safety systems and therefore is considered to be an absolute priority as its potentially impacts on patient safety.

The expenditure required to remove all CIR increases to over £220 million over the next 10 years if there is no investment.

Further expenditure would be required to alleviate the risks arising from functional suitability, space utilisation and quality of the environment or Equality Act surveys. Due to Estate Code guidance not assigning a risk or urgency to these facets, these have not been considered within the predictive analysis undertaken, but are estimated to amount to an additional £300 million above the predicted £220 million for CIR.

Total backlog rectification costs by Site and Category for next 10 years (works cost only)

Element	EDGH	Conquest Hospital	Bexhill Hospital	Risk Totals
Physical Condition	£87,115,467	£62,032,662	£3,971,889	£153,120,018
Statutory Compliance	£1,620,819	£885,571	£388,559	£2,894,949
Functional Suitability	£41,635,888	£45,505,250	£6,429,250	£93,570,388
Space Utilisation	£21,922,300	£16,753,800	£2,553,750	£41,229,850
Quality of the Environment	£9,087,374	£4,281,712	£1,455,090	£14,824,176
Equality	£1,175,900	£380,850	£252,000	£1,808,750
Total	**£162,557,748**	**£129,839,845**	**£15,050,538**	**£307,448,131**

Glossary of terms:
Backlog maintenance represents the amount of capital investment needed to bring deteriorating assets, including the buildings, back to a suitable and appropriate standard. It includes all improvements needed regardless of their risk to safety and resilience, but exclude refurbishment or improvement. It is reduced or eliminated through capital investment or disposal.
Critical Infrastructure Risk (CIR) is a sub-set of the total backlog maintenance and represents high and significant risk backlog relating to physical condition and statutory compliance. It represents the amount of capital investment needed to eliminate safety and resilience risks from the operational estate.
Impending backlog relates to the physical condition elements currently classified in Condition B that will fall below Condition B within 5 years, assuming no major investment in the interim.

Source: NIFES 6 facet survey 2018/19 and all costs exclude VAT, fees, decant etc.

The Trust's annual capital programme currently delivers approximately £3m to £4m per year of critical backlog related projects.

Between 2018/19 and 2020/21, the Trust undertook work to remove £12.1 million of backlog maintenance relating to statutory compliance and physical condition. Emphasis was placed on critical infrastructure items, and specifically those that represented a single point of failure.

The significant projects completed in 2020/21 included:

- Main boilers at Conquest
- Chillers at Conquest
- Steam condensate equipment at EDGH
- Oil tanks at both EDGH and Conquest

- Water treatment plant at both EDGH and Conquest
- High voltage transformer at Conquest
- Replacement of poor quality temporary buildings at Conquest
- Lifts at EDGH
- Combined heat and power plant at Conquest

The residual backlog rectification cost relating to statutory compliance and physical condition for the next 10 years is over £149 million nett costs (gross costs circa £300 million).

Backlog completed by 2020/21 (statutory compliance and physical condition) by risk ranking (works cost only)

	High	Significant	Moderate	Low	Total
Eastbourne District General Hospital	£1,301,766	£1,952,584	£447,984	£46,414	**£3,748,747**
Conquest Hospital	£3,453,065	£3,929,411	£974,363	£13,235	**£8,370,074**
Bexhill Hospital	-	-	-	-	-
Total	**£4,754,830**	**£5,881,995**	**£1,422,347**	**£59,649**	**£12,118,822**

Residual backlog rectification costs (statutory compliance and physical condition) by Site for next 10 years (works cost only)

Site	Baseline backlog	Completed backlog	Residual backlog
Eastbourne District General Hospital	£94,324,126	£3,748,747	£90,575,378
Conquest Hospital	£63,827,167	£8,370,074	£55,457,092
Bexhill Hospital	£3,371,677	£0	£3,371,677
Total	**£161,522,970**	**£12,118,822**	**£149,404,148**

Source: NIFES 6 facet survey 2018/19 and all costs exclude VAT, fees, decant etc.

Impact of the Backlog

Functional suitability challenges are primarily due to changes in service provision, work practices and expansions in teams within buildings that are simply too small or which do not provide a suitable layout and space for services.

These result in poor clinical adjacencies impacting on patient experience and staff productivity; insufficient single rooms impacting on infection control management, patient privacy, dignity and confidentiality; inadequately sized accommodation leading to over-crowding and fragmentation of services across locations resulting in poor patient experience, flow and high occupancy rates.

Specific examples of the poor physical condition and functional suitability of the ESHT hospital estate include:

- The pitched roof coverings at Conquest possessing an inherent design flaw whereby the tiles and roof pitch allow water ingress during inclement weather. This presents a significant risk to business continuity, with a specific incident occurring during summer 2020 which necessitated the closure of two respiratory ward bays for a period of four weeks and adversely impacting on the overall bed capacity of the site.
- Outdated electrical infrastructure across the hospital sites impacting on business continuity, with the most recent example being the failure of the electrical infrastructure serving a wing of Conquest hospital including the mortuary in February 2021. This resulted in a business continuity incident for the organisation requiring the transfer of deceased patients and use of temporary mortuary facilities during the second wave of the Covid-19 pandemic.
- Water tank pipework failure at EDGH which flooded one of three stairwells within the main three storey clinical building and required closure of the stairwell for a day and diversion of staff and public footfall.

Many of the windows on the EDGH site are single glazed and beyond their design life, thereby providing poor temperature and noise insulation. As the building is not air conditioned, temperatures on wards and in clinical areas can exceed 30^{o}C during summer, and windows have to be opened to aid ventilation. Furthermore, due to age of the installation there is poor provision of fresh air into the main bedded spaces to dilute airborne contaminants.

Consumerism standards inform the quality of the patient accommodation in respect to privacy & dignity; security & safety; barrier free access; and patient control of the environment.

Spatial elements and sanitary facilities within the Trust inpatient areas are inadequate across our sites and do not meet current guidelines. This has a potentially detrimental affect on infection prevention and control, patient satisfaction and the perception of quality of care.

The main issues arising for ESHT include:

- The **average number of beds sharing a WC** is not compliant with the current national standard of having a maximum of four beds arranged in a multi-bedded room sharing an en-suite WC and an en-suite assisted shower room with WC (average of 2 beds per WC)
- The **proportion of single bedrooms** to the total number of beds is not compliant with the national standard of 70% single rooms or even the benchmark comparator of 50%
- The **average space per bed is 6m^2** compared to the benchmark of 11.2m^2
- The **average distance to each bed centre** (the distance between the centre line of adjacent beds in multi-bed areas) is 2.2 metres compared with the benchmark of 3.6 metres

Average number of beds sharing a WC

	EDGH	Conquest Hospital	Bexhill Hospital	Benchmark
Average	24.9%	19.1%	23.4%	50%
Lower range and location*	0.0% Day Units and Cardiology	0.0% CDU and Day Units	n/a	
Upper range and location	100% Maternity and pre and post op surgery	100% Maternity Delivery Suite	n/a	

	EDGH	Conquest Hospital	Bexhill Hospital	Benchmark
Average	4.78	4.89	3.13	2.0
Lower range and location*	0.62 Delivery Suite	0.62 Delivery Suite	n/a	
Upper range and location	8.33 Hailsham 4	10 Judy Beard Day Unit	n/a	

*Cardiology CCU and Intensive Care CCU at Conquest and ITU and Maternity Day Unit at EDGH show anomalies of 0.00 WCs per bed – these areas do not have patient toilets due to patient acuity

Proportion of single bedrooms to total bed number

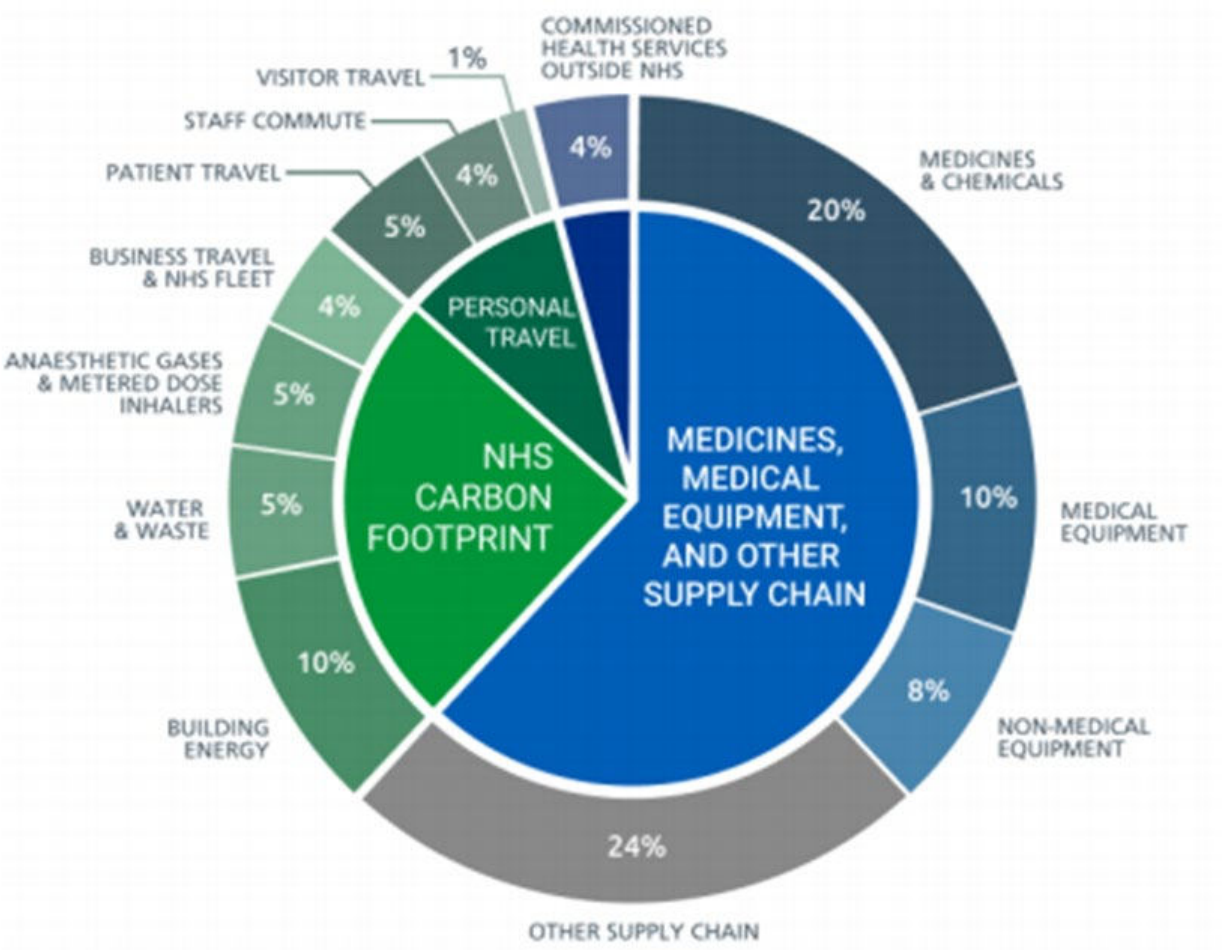
Sustainability of the Environment

The Climate Change Act 2008 sets legally binding targets for the UK to reduce its CO_2 emissions to net zero by 2050 and all public sector organisations in the UK have a responsibility to put in place plans to meet this target.

ESHT partners with Sussex Community NHS Foundation Trust in developing our approach to sustainability through our Green Plan. Through the framework of Care Without Carbon (CWC), the Trust is working through the three key aims of:

- Long term financial sustainability
- Minimising and having a positive impact on the environment
- Supporting staff wellbeing to enable a healthy, happy workforce

Our environmental impact is measured by our carbon footprint. This is made up of the energy used to heat our premises; the energy we consume; the water we use; the emissions from Trust owned vehicles and from our business travel.



Sources of emissions by proportion of NHS Carbon Footprint

ESHT is committed to improving our carbon footprint and reducing the environmental impact of our services, in line with the national NHS aim of being the world's first net zero national health service.

In July 2019 the Trust entered into a Energy Performance Contract with Low Carbon Solutions. In addition to delivering on our primary motivation to reduce carbon emissions, there were also a number of associated benefits:

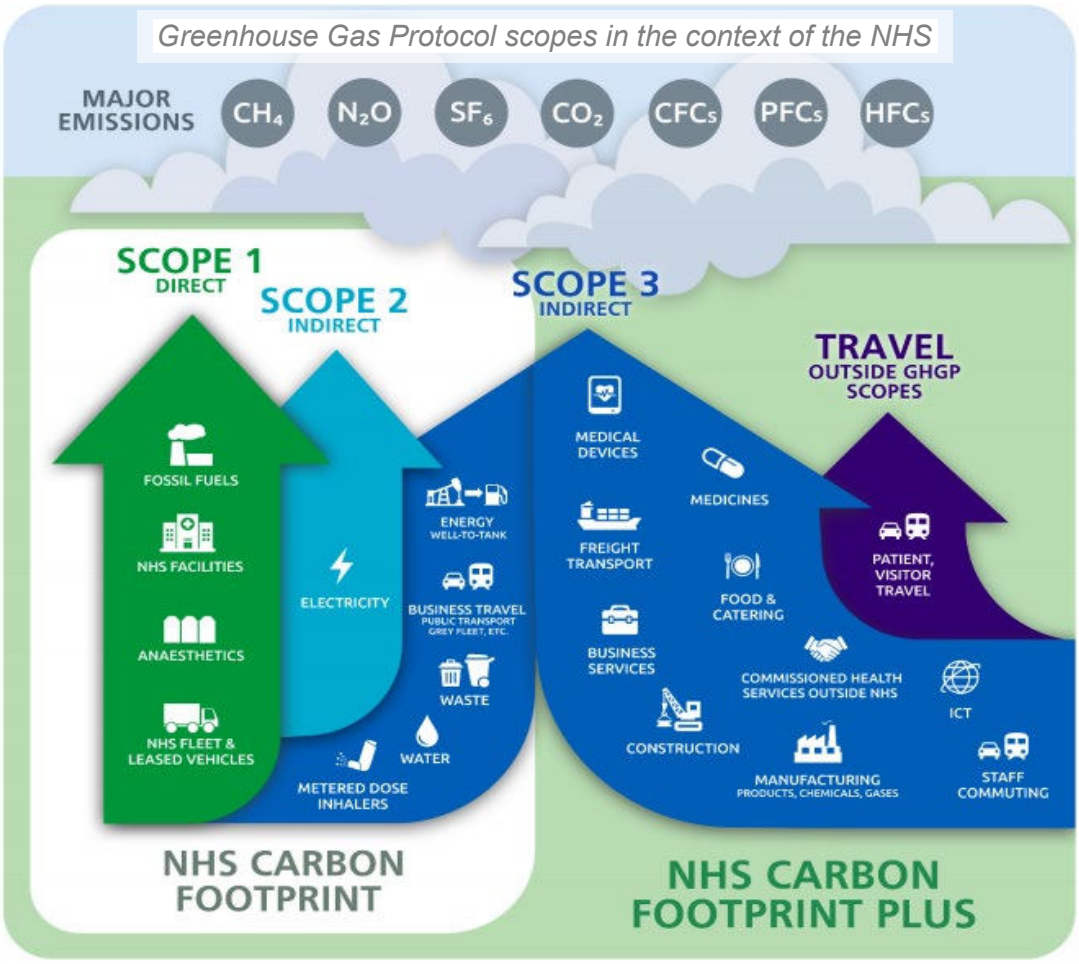
- Reduction of critical infrastructure backlog
- Reduced utility costs
- Cleaner emissions and better air quality
- Greater resilience

In October 2020 the NHS published the "Delivering a Net Zero National Health Service" report. This introduced a future set of carbon emission targets. Through the Carbon Change Act the Trust is required to make a 51% reduction on 1990 carbon baseline. Following this the required reduction is 57% by 2030.

"Delivering a Net Zero National Health Service" extends this to achieving:

- 80% reduction from a 1990 baseline by 2028 to 2032 for emissions controlled directly (the NHS Carbon Footprint), and net zero by 2040

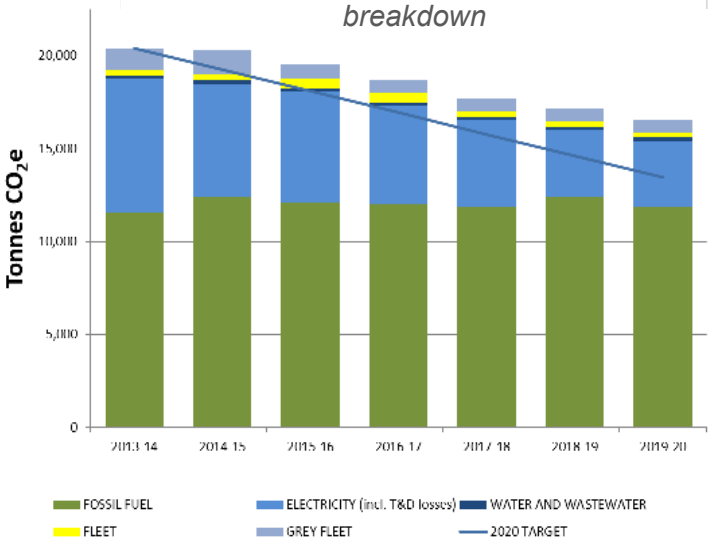
- 80% reduction from a 1990 baseline by 2036 to 2039 for emissions we can influence (our NHS Carbon Footprint Plus), and net zero by 2045



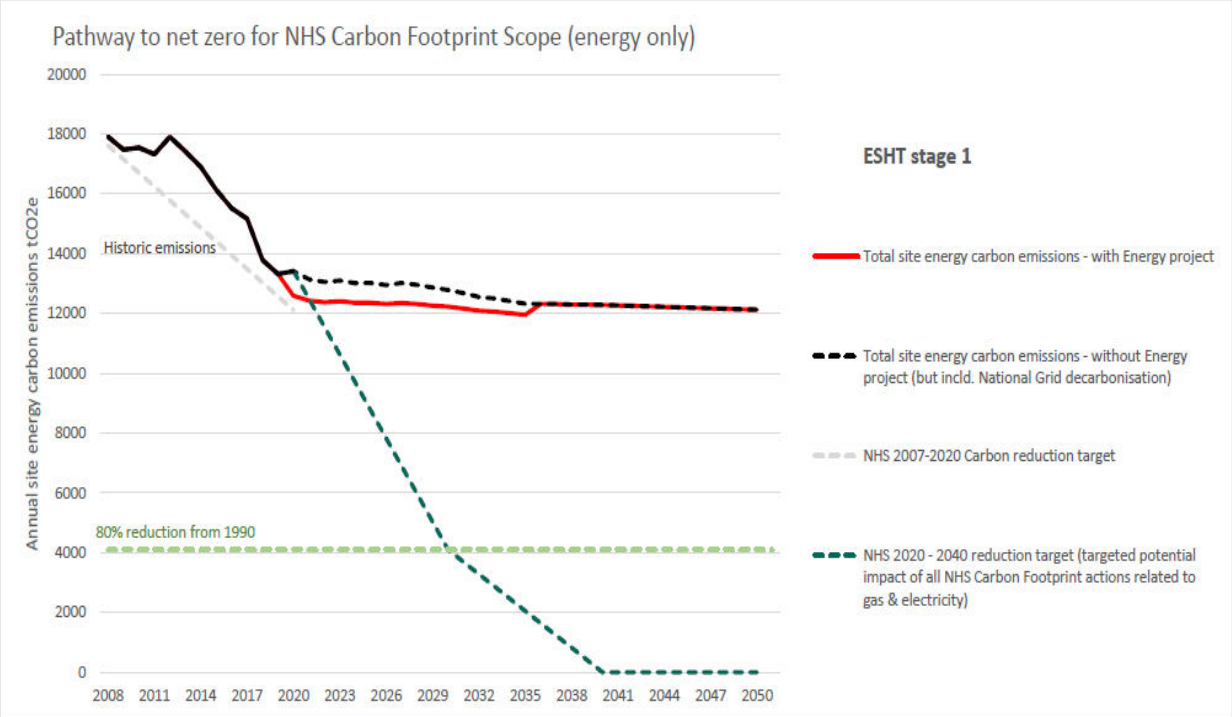
A focus on building energy and decarbonising utilities is a core strategy for the Trust in reducing carbon emissions originating from estates and facilities. Although there has been progress nationally to decarbonise the electricity national grid, in contrast there has been negligible emphasis on decarbonisation of natural gas, which is the most common fuel for space and water heating and used by the Trust combined heat and power units.

Although the Trust carbon footprint has been steadily decreasing since the base year in 2013/14, the ageing meant that the Trust was short of hitting the target to reduce our carbon footprint by 34% by 2020.

Trust estates and facilities carbon footprint breakdown



Carbon curve for ESHT stage 1



PART 2: WHERE DO WE WANT TO BE

This Estate Strategy focuses on our ambition to deliver outstanding healthcare enabled through high quality, flexible and future proofed environments that enhance the patient experience and supports our 7,000 staff to deliver consistent care. Our aim is to improve the integrity and cost effectiveness of the Trust estate, support delivery of the Trust strategies, service and business plans, and improves patient care.

Trust Strategic Aim	Estate Strategy Priority	Estate Strategy Objective
Improving the health of our communities	1 To improve the physical environment to enable delivery of consistent and high quality patient care through clean, safe, secure and suitable environments	To eliminate high and significant backlog maintenance risks
		To eliminate estate related patient safety issues, including management of cross infection risks
		To address patient quality issues in terms of privacy and dignity, levels of amenity available to patients
Collaborating to deliver care better Ensuring innovative and sustainable care	2 To support delivery of the Trust clinical strategies, and service and business plans	To deliver changes to the estate to support the implementation of the ESHT and ICS Clinical Strategy,
		To provide flexible accommodation that enables increased clinical capacity
		To provide the infrastructure that enables digitisation and implementation of new models of care
		To provide modern, efficient and welcoming environment that supports delivery of acute hospital services, and other community services including rehabilitation and social services
Empowering our people	3 To support improvements in environmental and financial sustainability	To improve the environment and facilities for staff, including residential accommodation
		To enhance environmental sustainability of the Trust environments
		To maintain the Estates and Facilities cost in the lower quartile, whilst ensuring resources are set aside for future estates workforce capability/capacity

In delivering the aims and objectives of the Estate Strategy, the following guiding principles will be used for developing the Trust estate:

- Projects will demonstrate alignment with Trust, system and national strategies, and take into account current and prospective needs of patients and staff
-
- Projects will be developed and prioritised with a clear, clinical evidence base and support good clinical practice, support clinical adjacencies and patient care
- Projects are aligned/complimentary and be an enabler to the BFF program
- Projects should contribute to the removal/reduction of critical infrastructure risks and support the wider development of the whole estate
- Wide engagement will be carried out, as appropriate, with staff, service users, partner organisations and the public throughout the prioritisation, scoping, planning, and implementation phases of projects
- Use of the existing Trust estate will be optimised, and we will work collaboratively with services to identify which services and functions can be delivered away from the acute hospital setting. Providing non-clinical services and functions from accommodation that is deemed clinical in use is not as financially efficient, and we will work with services to identify alternative options.

"As part of the Trust's Estate Strategy it is recommended that Statutory Compliance items are addressed first, followed by high-risk backlog items under Physical Condition, followed by significant then moderate and low risk items. It may also be appropriate to address the significant issues identified under Function, Quality and Space during any future capital project works."

NIFES Consulting Group, independent specialist building surveyors

Priority 1 – Improve the Physical Environment

We will:

1.1 Eliminate high and significant backlog maintenance risks

- Target/Prioritise our use of resources to minimise patient safety risks and ensure that buildings and equipment are of a suitable working condition and compliant with modern standards

1.2 Eliminate estate related patient safety issues, including management of cross infection risks

- Implement learning from Covid-19 to ensure resilience from future pandemics e.g. ventilation

1.3 Address patient quality issues in terms of privacy and dignity, and levels of amenity available to patients

- Where possible we will comply with modern standards to increase the number of single rooms in our hospitals and ratio of bathrooms (in particular on any ward refurbishment schemes we undertake)

Why?

- Maintaining the Trust estate so that our buildings and equipment are of a suitable working condition and appropriate standard is an imperative to ensuring the ongoing effectiveness, safety and quality of clinical services
- ESHT has the 10th highest critical infrastructure risk compared with all NHS Trusts in England, with evidence of this already adversely impacting on services. Left unaddressed, there will be further deterioration of the Trust's backlog which further risks the delivery of services into the future.
- The Trust annual capital programme of roughly £3m to £4m of investment per year is less than 1/20th of the Trusts total backlog maintenance. Robust management and focus is required to maximise funds available to the Trust in order to ensure highest value return on investment and prevent further deterioration of the estate which ultimately impacts on clinical service delivery

Priority 2 – Support Delivery of the Trust Clinical Strategy

We will:

2.1 Deliver changes to the estate to support the implementation of the ESHT Clinical Strategy

- Support and enable changes to services, such as the planned changes to interventional cardiology and ophthalmology
- Ensure we periodically review clinical adjacencies to make best use of our space

2.2 Provide **flexible accommodation** that enables increased clinical capacity and resilience to pandemics

- Increase bed capacity in accordance with operational requirements
- Reduce our non-clinical accommodation footprint by 5% overall – working with workforce teams on agile working, and prioritising essential services on acute sites
- Use of SMART digital technologies to maximise the flexible use of space
- Use modelling tools and techniques to review and propose updates to ventilation

2.3 Provide the **infrastructure that enables digitisation** and implementation of new models of care

- In any ward refurbishment scheme, apply and use where required, digital ward environment technologies such as smart medical beds (motion sensors)
- Development of a digital twin hospital to test the real and virtual ward concept and potential technology transfer prior to BFF

2.4 Provide **modern, efficient and welcoming environments** that support delivery of acute hospital services, and other community services including rehabilitation and social services

- New environments will be planned and delivered according to best practice and modern standards

Why?

- Our hospital and community estate is pivotal to supporting delivery of safe, effective and high quality clinical care. Our infrastructure will need to evolve and improve in order to keep up with changes being introduced to our clinical services
- The Trust is expecting high levels of demographic growth and a rising ageing population over the next few decades which will increase demand for our clinical services
- In the future, our estate will need to work harder to support service delivery, and be flexible to accommodate changing models of care

- With regards to lessons learned from the Covid-19 pandemic we will look to create opportunities to separate service provision, where appropriate, to improve future resilience
- Our hospital and community estate is pivotal to supporting delivery of safe, effective and high quality clinical care. Our infrastructure will need to evolve and improve in order to keep up with changes being introduced to our clinical services
- The Trust is expecting high levels of demographic growth and a rising ageing population over the next few decades which will increase demand for our clinical services
- In the future, our estate will need to work harder to support service delivery, and be flexible to accommodate changing models of care
- With regards to lessons learned from the Covid-19 pandemic we will look to create opportunities to separate service provision, where appropriate, to improve future resilience

Priority 3 – Support Improvements in environmental and financial sustainability

We will:

3.1 **Improve the environment and facilities for staff**, including residential accommodation

- Support staff wellbeing and improve recruitment and retention through a residences upgrade strategy / plan

3.2 Enhance **environmental sustainability** of the Trust environments

- Estates and facilities will contribute to the Trust commitment to reducing carbon emissions and achieving net zero carbon

3.3 **Reduce the Estates and Facilities cost**

- Estates and facilities will contribute to reducing the Trust overheads cost by looking to keep the costs in the lower quartile, whilst ensuring resources are set aside for future estates workforce capability/capacity

Why?

- Our on-site residences are pivotal to supporting our staff wellbeing, recruitment and retention
- The Lord Carter review of efficiency in hospitals highlighted ESHT as an outlier in terms of proportion of non-clinical accommodation on our hospital sites.
- Investment in the development of Our Estates and Facilities staff is key to our continued and future success

PART 3: HOW WE WILL GET THERE

This section describes the 3 main pillars that will deliver on these priorities

- Prioritising backlog and estates projects to ensure we avoid risks to operational services and patient care
- Reviewing space utilisation and allocation
- Delivering our “Building for our Future” programme

We then also set out:

- Outline implementation plan
- Potential funding routes
- Risks and Dependencies

Prioritising projects

The processes for prioritising backlog and estates projects will be refined to ensure the active avoidance and mitigation of risks to operational services and patient care.

The prioritisation process will include:

1. Identifying the **required minimum spend** each year to maintain the backlog position – this minimum spend will be **ring-fenced for backlog maintenance** so that the Trust estate does not deteriorate further and add to the critical risks
2. Managing risks over a **3 to 5 year planning window**, with emphasis on identified single points of failure
3. Ensuring **alignment with existing Trust processes** such as business planning, business case development, and capital planning
4. Exploring **how estate projects can be appropriately combined** to reduce risks and maximise value for money
5. Ensuring **timescales for clinical estates projects are realistic and achievable** in the context of clinical and operational pressures, e.g. winter
6. Actively exploring **additional and alternative funding** sources – e.g.ICS, Salix, EPC
7. Looking for **innovation opportunities** to link together schemes to maximise value for money and risk reduction – e.g. through Salix

Why?

The Trust annual capital budget is finite and requires careful balancing of the need to maintain the existing estate, whilst supporting the Trust strategic clinical estate priorities. In order to do this, the governance structure for estates projects will need refining to ensure:

- Phased management of the Trust backlog maintenance to mitigate the risk to clinical services and further deterioration
- Prioritisation and emphasis on mitigation of risks that cause service disruption
- Collaborative decision making to prioritise capital projects according to an agreed set of principles that are aligned with the Trust strategy and part of a 2-5 year medium term capital programme

Reviewing Space Utilisation and Allocation

The utilisation of existing Trust estate will be reviewed and processes for allocation of space will be reviewed and refined to ensure the optimal use of space and reduce the Trust's overall non-clinical accommodation footprint.

The review of space utilisation and allocation will include:

1. Identifying the **baseline non-clinical accommodation footprint**, allocation and utilisation
2. Explore using where **appropriate off-site non-acute accommodation**, where value and appropriateness is proven
3. Collaborate with workforce colleagues to support the implementation of **agile working**, incorporating the principles of flexible accommodation that enables increased clinical capacity and resilience to pandemics
4. Developing a robust, transparent and equitable **process for allocation of non-clinical space** which adheres to the principles of agile working and delivers the Trust service priorities and business needs

Why?

The Trust is an outlier compared with benchmark hospitals in the proportion of non-clinical space on each of our hospital sites.

Reduction in non-clinical space on the hospital sites will enable increase in clinical accommodation to support clinical sustainability to meet demographic growth into the future.

Utilisation of space will need to be optimised to deliver financial sustainability in the long term.

Robust, transparent and equitable processes for space allocation will enhance operational efficiency and improve staff wellbeing and satisfaction.

Building for our Future

The Trust plans for redevelopment of our hospitals at Bexhill, Eastbourne and Hastings are pivotal to delivering the aims and objectives of this estates strategy in the longer term.

In October 2019, the Trust received the welcome news that it had been included within phase 2 of the Government's Health Infrastructure Programme (HIP) and secured seed funding to develop a business case. The Trust has put in place the Building for our Future (BFF) programme to transform services and deliver on its ambition to reshape the Trust estate to meet the needs for the next generation and address the physical and functional deficiencies.

The BFF hospital redevelopment project aims to:

- Provide and estate that is fit for purpose, value for money and flexible to adapt to the changing models of care and changing needs of the local population.
- Support high quality care, patient safety, privacy and dignity, exemplary infection control and staff wellbeing

The key objectives of the hospital redevelopment project are to:

- Reduce critical infrastructure risk across the Conquest, Eastbourne and Bexhill hospitals and create space that is fit for purpose
- Extend and improve facilities for Emergency Care ensuring that the departments are the right size and shape for the model of care
- Provide additional bed capacity, outpatients, theatres, endoscopy, diagnostic services and wards, to ensure alignment to system demand
- Improve access to Interventional Cardiac and ophthalmology facilities

To achieve the above and to inform the schedules of accommodation for hospital redevelopment, there will be a requirement to maximise clinical space and reduce the non-clinical space on the acute sites.

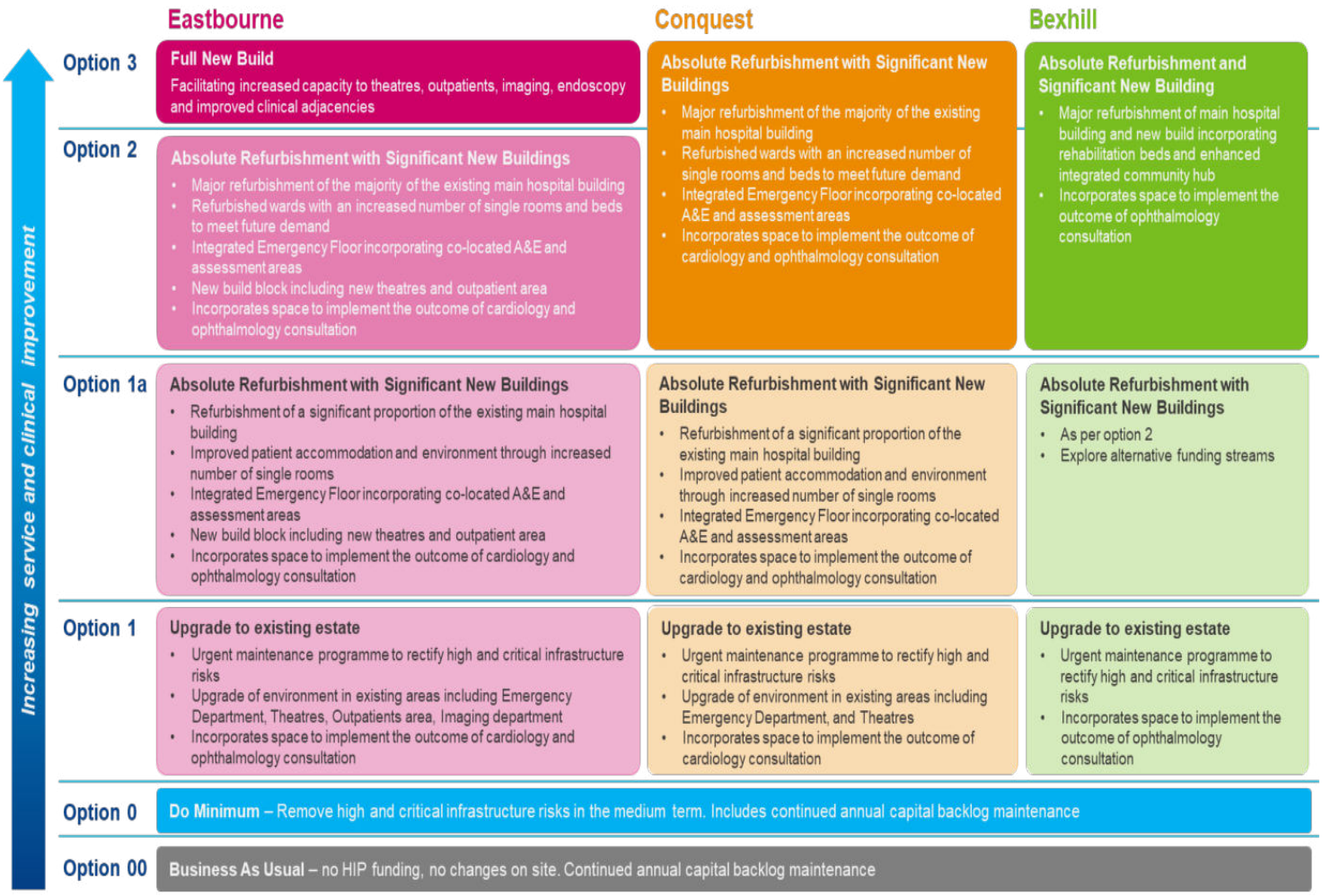
High level Building for our Future programme timeline:

The Trust has considered many options for development in order to deliver on the ambitions of the Trust estate strategy and meet the critical success factors and spending objectives for the hospital redevelopment project.

At the Strategic Outline Case (SOC) stage, the Trust has developed six preferred way forward options that are feasible and offer an opportunity to resolve the significant quality, functionality and efficiency issues relating to the existing hospital sites.

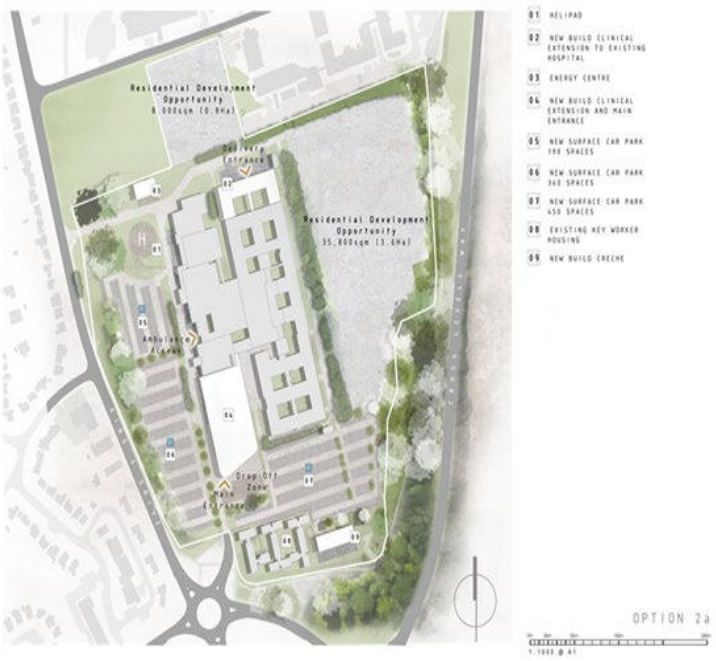
Following review by the New Hospital Programme (NHP) team, the identified preferred way forward options will be taken forward for further consideration at Outline Business Case (OBC Stage).

Six preferred way forward options for hospital redevelopment developed at SOC stage

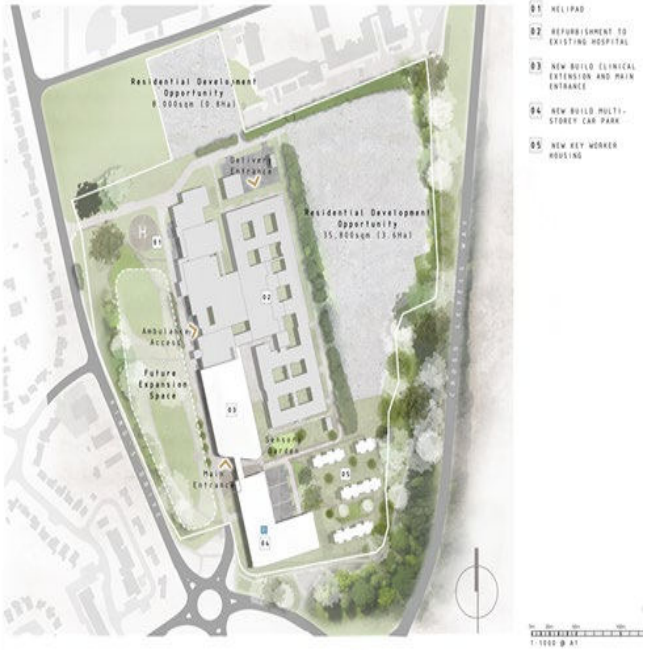


The feasible options for redevelopment of the Trust sites have been progressed into Development Control Plans (DCP) which illustrate what the prospective regeneration opportunities might look like on each of the Trust hospital sites.

There are three prospective options available for Eastbourne, two of which involve different levels of substantial internal and external major infrastructure refurbishment, and a third involving a more efficient new build adjacent to the existing hospital. The less ambitious and intermediate options require significant disruption and decant of services, while the more ambitious option offers the opportunity to complete a significant proportion of fabrication work off-site and thus minimising the impact on clinical services.



Eastbourne DGH DCP (less ambitious)



Eastbourne DGH DCP (intermediate)

Eastbourne DGH DCP (more ambitious)

Bexhill Hospital DCP

The proposal for Bexhill involves a phased process using the Modern Methods of Construction (MMC) process. A substantial volume of this will be possible to do off-site in a factory environment thus lessening the disruptive impact of an onsite new build. The DCP phasing will impact site operations but is envisaged to minimise disruption to services in the existing buildings.

Conquest Hospital DCP

Conquest's DCP phasing is complex and inevitably challenging as significant work is required to adjoin new builds to retained structures; as well as the latter undergoing substantial internal refurbishment. To minimise decants and disruption on site and ensure continuity of services the current proposal is for an eight phase DCP to complete the works required.

In anticipation of the options for the future hospital redevelopments and masterplans for each existing hospital site, the Trust has been working collaboratively with our local partners to develop a joint plan for **residences** at the Eastbourne DGH and Bexhill Hospital sites.

The Trust is currently in the early stages of planning and has engaged specialist residential architects to produce master plans and identify the potential land that could be released from each hospital redevelopment option.

The plans will aim to:

- Determine options for delivery of residences that maximise the number of residential units on each site, dependent upon the land available
- Provide key worker accommodation, a proportion of which would be retained by the Trust to support our staff recruitment and retention strategies
- Dispose of any surplus land for private residential developments
- Maximise financial affordability

Eastbourne DGH (intermediate development option)

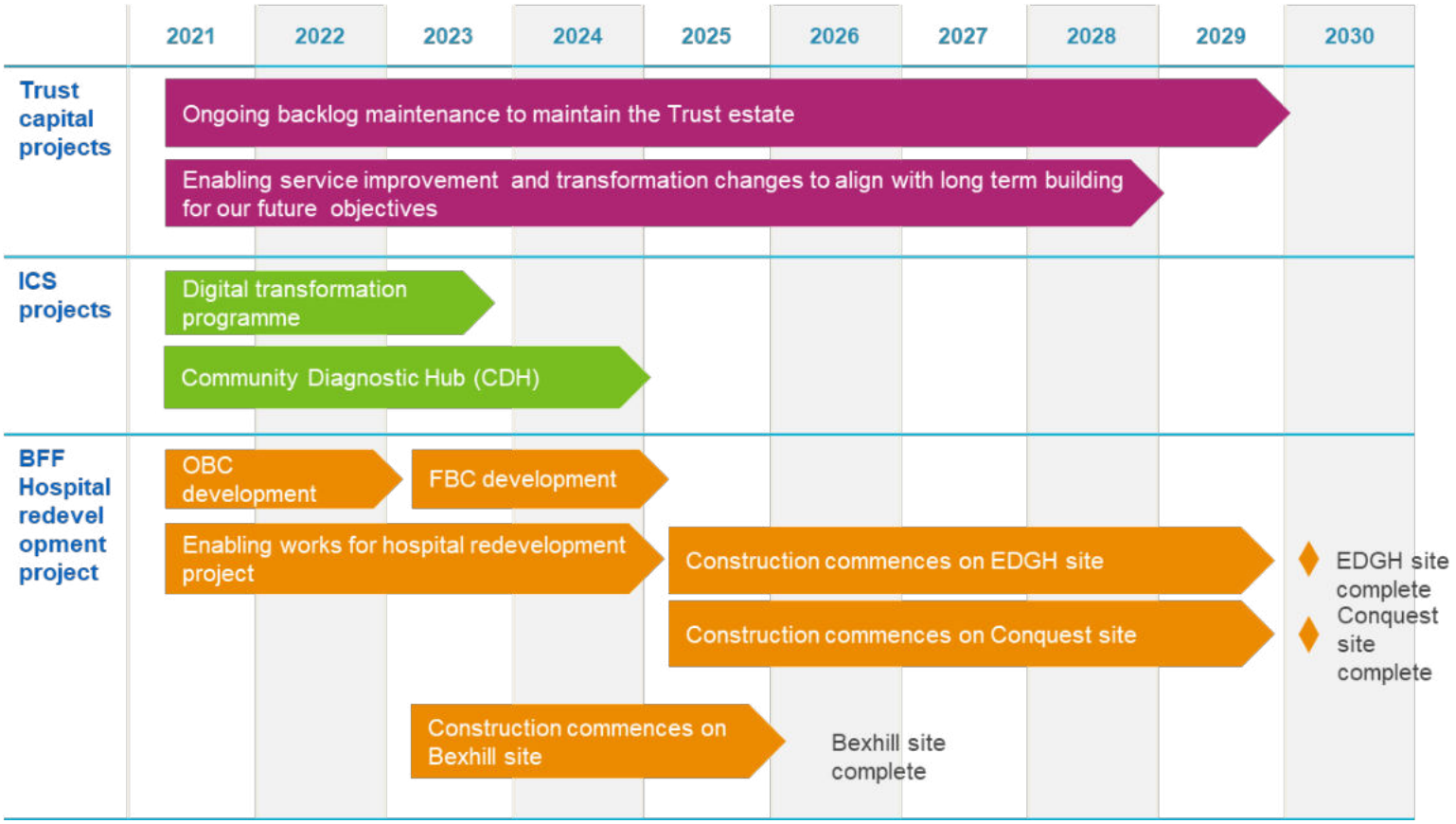
The intermediate development option at EDGH could potentially provide up to 198 residential units

Eastbourne DGH (more ambitious development option)

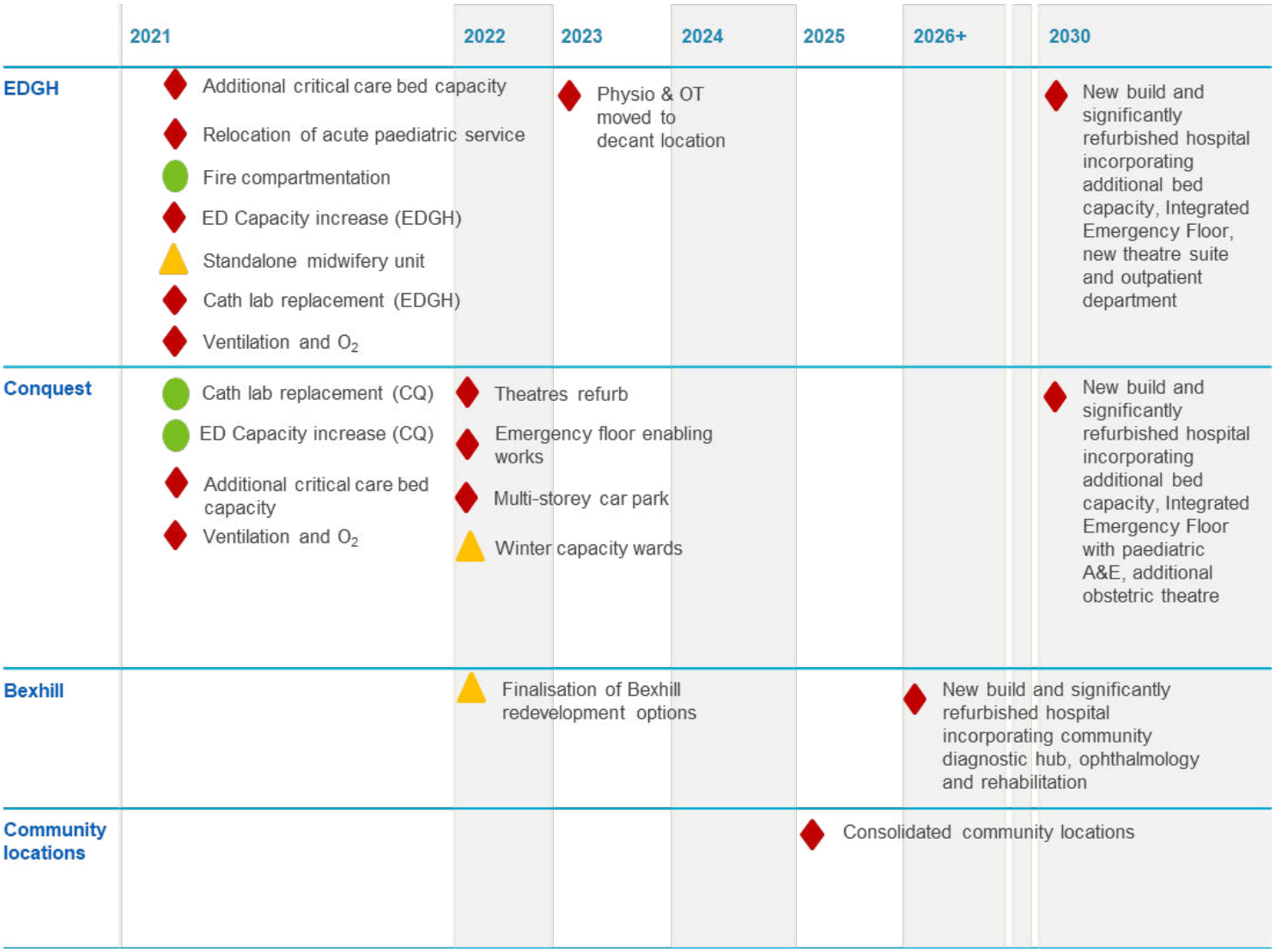
The more ambitious development option at EDGH could potentially provide up to 300 residential units

Implementation Planning

This Estate Strategy, along with other supporting Trust strategies, represents the first phase of the plan to deliver a future proofed estate that can continue to respond to the needs of patients and staff into the future. This implementation plan outlines the key activities required to deliver the whole scale transformation of the Trust estate.



The period from 2021 to 2025 is characterised by key activities that lead up to the delivery and operationalisation of new infrastructure and accommodation for key clinical services. It includes key enabling works and activities for Building for our Future which will be complete by 2030.



Funding Routes

If successful, HIP funding will enable transformation of our hospital estate long term. While we await confirmation of HIP funding, we will manage and prioritise available capital fund as part of the annual capital development programme.

National – HIP funding

The Trust has developed its strategic outline case (SOC) for the BFF programme, and will proceed to the next phase of developing the Outline Business Case (OBC) in order to secure approval and funding for implementing the estate transformation to support the deliverables outlined within this Estate Strategy and other Trust strategies.

Trust Capital Funding

A significant proportion of Trust capital funding is required to maintain statutory compliance and critical backlog maintenance. Although Trust capital funding is limited, some could be used to provide an initial investment for service changes that are required enable longer term transformation.

Regional – ICS Funding

A new approach to NHS Capital Funding was introduced in 2020/21, allocating a capital envelope for each ICS to provide greater clarity and confidence on the level of capital funding available at a regional level, support system working on capital priorities and faster access to national capital funding for critical safety issues. The Trust works with ICS partners to prioritise capital projects and access funding to supplement our own. This includes funding for the implementation of a community diagnostic centre, and the digital aspirant programme.

Other Capital Funding Sources

The Trust will apply for other capital funding sources where available. This includes:

- Decarbonisation Fund
- Charitable donations
- Digital funds

Constraints/Risks and dependencies

The following constraints and dependencies have been identified that will continue to influence the planning and execution of the estate strategy and its potential to deliver significant improvements to the Trust estate and associated benefits for clinical service delivery, ongoing backlog cost reduction and energy efficiency.

Key Constraints/Risks	Key Dependencies
• **Availability of capital fu**nding – will determine the extent to which the Trust will be able to deliver the core objectives and benefits intended. Modernising all the Trust's buildings is likely to be unaffordable, and it is likely that some of the existing estate will have to remain as is and will continue to be energy inefficient and sub-optimal for clinical services. Decant costs to minimise disruption to clinical services are also likely and will be a constraint on the availability of capital for the end solution. External funding routes for critical infrastructure risks/backlog will need. • **Planning permissions** – will be required for development of new hospital buildings or substantial redevelopment of existing sites. The Trust has already been issued planning approval for some enabling works at the Eastbourne and Conquest Hospital sites, and other applications for further enabling works are in progress. The Trust will seek to work collaboratively with the relevant local authorities to obtain the required planning permissions. • **Critical Infrastructure Risk** – as noted elsewhere, the cost and significant risk arsing from the critical infrastructure risks/backlog will mean that the continual focus needs to be on mitigating any risk of failure, whilst seeking external funding bids to supplement the Trusts own capital resource.	• **Securing support from key strategic partners** – progression of the hospital redevelopment plans is dependent on the Trust maintaining the strategic support of the Sussex Health and Care Partnership (ICS) and East Sussex Health and Care System (ICP), and securing support and funding from the New Hospital Programme. • **Digital strategy** – optimal realisation of benefits from the Trust estate programme will be dependent on the digital transformation of the Trust, so that digital technology can be used to enable interoperability across primary, community, social care and secondary care systems. The Trust will work collaboratively with strategic partners to ensure alignment of digital strategies and plans. • **Cooperation of NHS Property Services and other landlords -** the Trust will work in partnership with relevant partners to secure the most effective solutions for service delivery.

We have a wide range of volunteering opportunities and you don't need previous experience in a health setting to volunteer for us.

For more information visit our website:

esht.nhs.uk/volunteering

Visit, follow and subscribe to East Sussex Healthcare NHS Trust (ESHT)

Website: esht.nhs.uk/

Twitter: twitter.com/ESHTNHS

Facebook: facebook.com/ESHTNHS/

YouTube: youtube.com/user/ESHTNHS

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0300 131 4500

Conquest Hospital
The Ridge, St Leonards-on-Sea, East Sussex, TN37 7RD
0300 131 4500

Eastbourne District General Hospital
Kings Drive, Eastbourne, East Sussex, BN21 2UD
0300 131 4500

East Sussex Healthcare
NHS Trust

PEOPLE STRATEGY 2021-2026

To support better care together for East Sussex

www.esht.nhs.uk

CONTENTS

FOREWORD

Steve Aumayer
Chief People Officer

I am proud to share our ambitious strategic Plan for East Sussex Healthcare NHS Trust (ESHT).

I am privileged to work with nearly 8,000 amazing colleagues, thousands of temporary workers and the many volunteers at ESHT who deliver both acute and community care to over half a million residents and to the many visitors and tourists that visit our county all year round. Over thepast 18 months we have experienced unprecedented levels of activity driven by the COVID pandemic, and the entire team has risen to the challenge, on many an occasion putting the care of our patients above their own families and their own wellbeing.

As we come out of the pandemic and the clapping subsides, we face huge challenges going forward, dealing with backlogs in the delivery of care, the long-term impacts of the pandemic and volumes of activity that we have never seen before. This is our “new normal” and we now need to ensure that we can meet the challenges it brings in a safe and sustainable way.

We have made excellent progress on our journey, but also recognise that we may need to so some things differently to get us to where we need to be in the future. This strategic plan is therefore founded on a series of ambitious “breakthrough” initiatives that will both support and enable colleagues continue to transform how we do things and deliver the services that our communities and other stakeholders deserve. It will capture the knowledge built over the years, the learning from the pandemic crisis and will align with the ambitions set out in the Trust Strategy“Better Care Together for East Sussex”.

This strategic plan is based around 4 key themes:

- **Looking after our people** - creating a positive, engaging working environment and keeping colleagues safe, healthy and well - both physically and psychologically
- **Different ways of working and new roles** - being innovative in the ways we work - helping people to realise their true potential for the benefits of our patients, protecting us from national skill shortages and helping us be more effective and efficient than ever before
- **A Culture of inclusion and involvement** - ensuring we are a place where everyone is welcome, everyone can grow, and everyone feels their voices are heard
- **Growing for the future** - being a place where people want to work, where they can develop and expand their roles within an ambitious and ever improving organisation

In order to realise our goals within each of these themes we will need to build further capability ina number of key areas. The document also describes in part how we intend to achieve this. However in order for our themes and proposals to have maximum impact on our service provision, we **must align to the ESHT Clinical strategies.** The operationalisation of our people themes in particular new ways of working; new roles; Career pathway design and education, mustall harmonise with our future clinical needs. It is also important for our people initiatives to align with other enabling strategies e.g. Digital; Building for the future and estates.

At ESHT, we recognise that without our people, we are nothing. We are proud of every individual who chooses to work here and are passionate about delivering outstanding patient care through helping every colleague work towards realising their own true potential.

We believe that through delivering this strategic plan we will be able to continue to build on progress to date, on our journey towards excellence in the delivery of healthcare for the communities that we serve.

1. STRATEGIC PEOPLE DRIVERS AND OUR CHALLENGES

1.1 National Context

The NHS has experienced possibly its toughest period since inception, the post Covid landscape poses challenges hitherto uncharted in terms of backlogged demand and medium term uncertainty.

The non covid related challenges remain - we have an ageing population, many living with multiple long-term conditions. The way we are living our lives is also changing, meaning that younger members of the population are accessing health services more and more. All of this is putting increased demand on the NHS.

In addition, several ongoing national initiatives are in place and delivery is expected.

With regard to the people related agenda we have already established a very sound platform on which to build, but as the ESHT strategy suggests: ‘what got us here, will not get us there’.

In response to these challenges, the NHS published the **NHS Long Term Plan in 2019,** which sets out the priorities for the NHS for the next 10 years. Much of this relies on re-designing care pathways and delivering care in different ways, such as:

- Integrated local care systems
- Stronger network of GPs and community services
- Radically transformed outpatient services
- Avoid unnecessary hospital admittance
- Specific commitments relating to a range of priority areas such as cancer, children’s services, strokeand maternity.

As a Trust, we do not work in isolation and need to respond to the multiple requirements and drivers that impact on our people and the services that they deliver.

Our aim is to continue the excellent work completed so far to align the national context with the local one - benefitting from national initiatives and plans whilst providing absolute focus on our local staff, patients and communities.

NHS England published 'We are the NHS: People Plan for 2020/21' in July 2020. The plan sets out how it should feel working for the NHS focussing on four main commitments through the NHS People Promise - from their leaders and from each other.

It focuses on 4 themes:

1. **Looking after our people** particularly the actions we must all take to keep our people safe, healthy and well – both physically and psychologically

2. **New ways of working and delivering care** emphasising that we need to make effective use of the full range of our people's skills and experience to deliver the best possible patient care

3. **Culture of inclusion and involvement** highlighting the support and action needed to create an organisational culture where everyone feels they belong

4. **Growing for the future** particularly by building on the renewed interest in NHS careers to expand and develop our workforce, as well as retaining colleagues for longer

Furthermore, **NHS 2021 White Paper** is the dual principle of integration and collaboration to improve care. It talks of health services delivering the "Triple Aim" of:

- Improved care/experience
- Improved population health
- Reducing the cost of care

1.2 East Sussex Healthcare NHS Trust

Looking after, developing and valuing our people continues to be a top Trust priority. The level of change we have already delivered and the challenges we face have extensive people implications. **The core 'change' success factors are: colleagues awareness of the detail and implications for them; their buy in and commitment; and leaders supporting those people who may require coaching, upskilling or development.**

Successful change is most often achieved by focussing on 'how we do things' (culture), rather than through just focussing on strategic or operational targets. Now, more than ever, ESHT needs to continue to develop great leaders who understand that how they behave is as important as what they do operationally and for whom values driven behaviours are embedded within their DNA. Some excellent role modelling already exists and we need to continue on our journey towards being a values driven organisation.

For ESHT to deliver in this challenging and multi-faceted environment it requires us to **re-think traditional workforce models and to develop a sustainable and flexible workforce for the future**.

We may also be expected to revolutionise the way we think; the way we operate, for example around 7 day services; cross agency synergies and cross functional working; in particular accelerating and embracing the white paper recommendations related to our Health and Social Care System. Preparing and building for the future is therefore going to be key to our future success.

This People Strategy focuses on exploring both 'what' we need to achieve and 'how' we intend to deliver.

At ESHT, we have experienced many of the same challenges as other Trusts across the country. From a people perspective this is compounded by the geographical challenge of being a coastal Trust as well as being close to the lure of London for healthcare workers. Within our catchment area the socio-demographics are varied with a higher number of frail and elderly within the Eastbourne community whilst Hastings has a younger population with higher volumes of social deprivation and a different set of healthcare needs.

We have not only moved out of special measures for both finance and quality of care, but delivered so much more over the last 24 months. ESHT has become nationally recognised for innovative ways of delivering care to our communities that sets us apart as an exemplar Trust and we are proud of our achievements.

The National People Plan is embedded in our strategic Trust framework; our People Strategy is aligned to both.

Our aim is to go so much further than the basic commitments of the People Plan.
We will develop a range of innovative workforce solutions to address workforce shortages; make a significant impact in supporting Health and Wellbeing and Equality, Diversity and Inclusion, become a centre of excellence for our education and development and to be known as a trust with exceptional leadership at all levels.

These achievements will help ESHT to be seen as a 'great place to work' ensuring we are attractive to new colleagues, but also to all our existing colleagues, including those who work flexibly for us as part of our temporary workforce and our volunteers. We have a real opportunity to continue to develop and realise the **untapped potential of the people who currently work on our bank and volunteer services,** to balance supply and demand and improve access to the workforce we need.

One major aspect of organisational change is to maximise the power of collaboration with local partners. The Sussex Health and Care System (our ICS) offers numerous opportunities for us to work differently as a cohesive system that delivers as one. **Being a part of an integrated and collaborative system will be a pre-requisite to us realising our true potential.**

2. VALUES AND BEHAVIOURS ''HOW'' WE PLAN TO ACHIEVE OUR DELIVERY

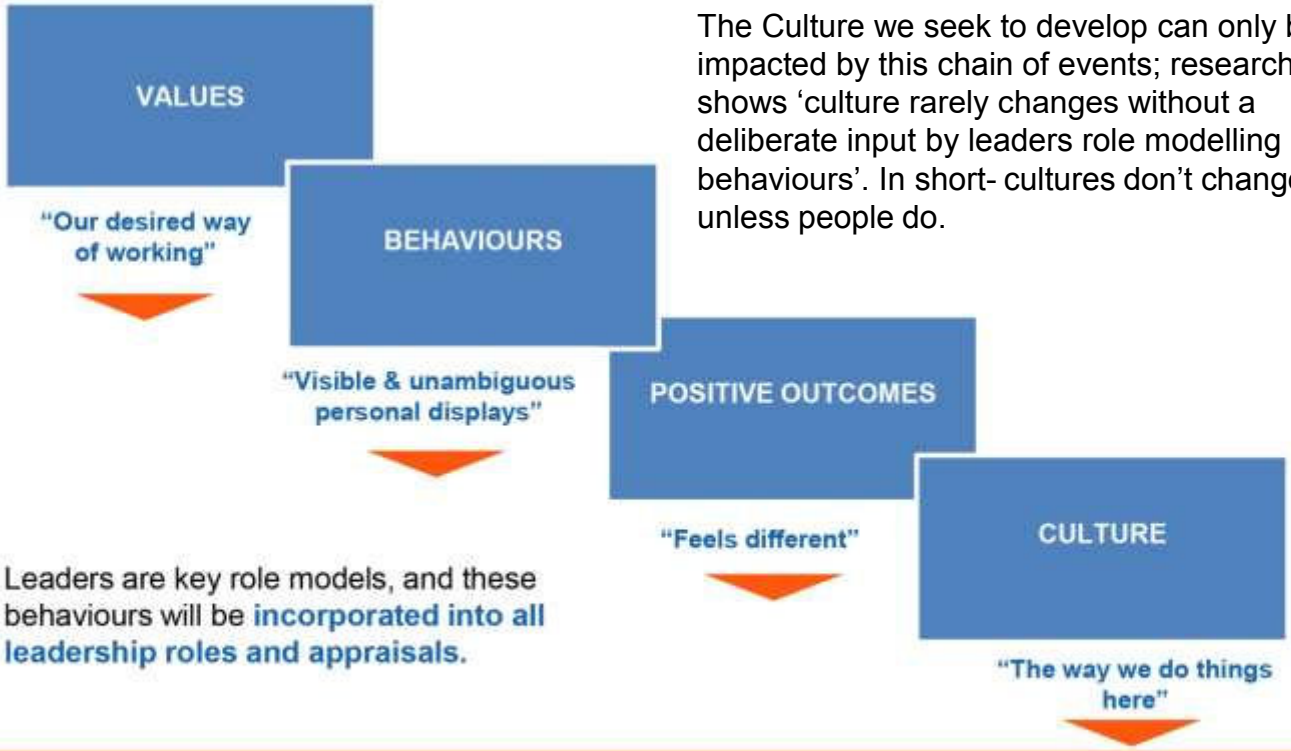
Realise As previously stated, **''how we do things'**, stated, must carry equal importance as to **'what we do''.** Our Trust values are well embedded; understood and prominent. Many shining examples of these values being enacted in every day operations are visible. Our aim is to work further to translate them into a formalised set of leadership behaviours which will further enhance what it feels like to work at ESHT. This will have a significant impact on patient experience within the Trust. More than this, studies suggest that our culture will have an impact on patient outcomes.

Our ESHT values

Moving forward, it is recognised that more important than the words themselves are how these translate into policies, principles, actions and behaviours if we aim to make them core to the **ESHT ways of working. Our journey must take us from words to actions - creating a culture and environment we would all wish to be a part of.**

A significant amount of feedback about our values was collected from colleagues prior to the pandemic. Work has already commenced to develop a **behaviours charter** for the Executive Team to pilot, prior to it being rolled out to the wider leadership population.

The graphic illustrates the journey of how our 4 values can easily be translated into visible daily behaviours, which in turn change outcomes in the workplace.



The Culture we seek to develop can only be impacted by this chain of events; research shows 'culture rarely changes without a deliberate input by leaders role modelling key behaviours'. In short- cultures don't change unless people do.

Leaders are key role models, and these behaviours will be **incorporated into all leadership roles and appraisals.**

To cement these behaviours into sustainable change, policies; processes and systems will require similar changes – we will develop these further to ensure that our governance and controls ("the what") aligns with and promotes the ways of working ("the how") that will drive outstanding performance.

2.1 Our Leadership Behaviour Charter

Our charter below describes **the improved outcomes** we believe will drive a culture based on ESHT values.

''Leadership'' refers to all levels of leaders within the Trust.

This charter is based on a fundamental premise of a **two way relationship** between, 'great leaders' and'engaged staff', where both are interdependent and adopt high levels of personal accountability.

Summary of our 'Charter': Positive outcomes

What you can expect from the Trust		What the Trust expects from you
• To improve services for patients, their families and our community as a whole • To identify mistakes and seek to learn from them • To be flexible and adaptable to deliver services in innovative ways	Working Together	• You are able to thrive at work and we help you to be the best you can. • You take personal accountability for your performance and behaviours • Contribute to and encourage effective team working
• A personal development conversation takes place to enable you to flourish in your role • Quality improvement support and guidance so you can bring about clinical and service improvements in your area • Well planned services = optimum care	Improvement and Development	• To improve services for patients, their families and our community as a whole • To identify mistakes and seek to learn from them • To be flexible and adaptable to deliver services in innovative ways
• Senior leaders who role model compassionate and inclusive leadership • Leader who support colleagues with a range of health and wellbeing interventions • Implementation of our strategy to achieve civility and respect	Respect and Compassion	• You constructively feedback to achieve our shared vision • You respond with humanity and kindness • To be mindful of the choices available to support your work life balance
• We will engage you in service developments at an early stage • You feel confident to raise concerns and you always receive a response when you do so • We will involve and support you in delivering innovation and change	Engagement and Involvement	• You contribute positively to decisions about the services you deliver • If you experience or witness unacceptable behaviours you speak up and say something • You will positively engage with innovation and change initiatives

3. OUR STRATEGIC THEMES

This section outlines the 4 core strategic people themes.

1. Looking After Our People
2. New Ways of Working and Delivering Care
3. Creating a Culture of Inclusion and Involvement
4. Growing for the Future

We describe:

- The theme and why it matters
- Some of the activity that you can expect to see
- What will be different as a result of developing this theme
- Some indicators of 'how we know we are getting it right' both in terms of generic measures and some examples of how it will 'feel'
- Specific measures and KPIS will be set by the Executive Team annually based on performance and priorities

NB: The detailed operational deliverables can be accessed in the appendix

Theme #1 - Looking After Our People

Great leaders demonstrate compassion; kindness and positive behaviours to balance the needs of their team and a safe and well prepared working environment. 'If we look after our people they are more likely to deliver optimised patient care'. Colleagues health and wellbeing is an established priority and will remain central to our people policies. We will look at ways to further reduce the root causes of stress and anxiety at work. Our primary scope will be the workplace but will also extend to supporting our colleagues with advice and signposting on family or financial matters.

We will achieve this by:

- Leaders creating an environment where **care, kindness and compassion** is the norm
- Providing access to a range of **health and wellbeing opportunities and initiatives**
- **Getting the basics right;** having the right staffing levels and skills with the right equipment alongside expertly planned rosters

What can we expect to see?

- Senior leaders will continue to role model compassionate and inclusive leadership and support colleagues with a range of health and wellbeing interventions
- Health and Wellbeing will be discussed and prominent in every aspect of the working day. One to one interactions and team meetings will focus equally on staff wellbeing and operational issues
- Dedicated roles such as the Pastoral Fellows will provide even more valuable support to our colleagues from the moment they join ESHT
- We will improve access to our 'accessible to all' suite of physical and psychological support through a range of professional services e.g. TRIM, Mental Health initiatives, Schwartz Rounds, existing OHS
- The recruitment and induction experience will showcase the Trust values and behaviours from the first contact
- HR Business Partners will support timely communications between the operations and specialist HR areas so we are not only proactive but also respond by keeping our finger on the pulse with a newly designed Health and Wellbeing dashboard

- Our leaders will become fully proficient with the new tools to effectively plan and efficiently deploy staffing rosters that will result in delivering optimum patient care, a balanced skilled workforce and minimise staffing gaps. Roster performance will be seen as a key management skill rather than a routine duty.
- We will continue to offer our colleagues with more flexibility and variety of working hours so they can harmoniously balance the demands of modern day working and home life. We recognise and celebrate the different lifestyles across our diverse workforce

How will we know when we have got it right?

- Health and Wellbeing will be the number one item on every agenda or meeting
- There will be Increased uptake of Health and Wellbeing services
- Our Pulse Survey results continue to be positive
- Our Staff Survey results continue to be positive
- Staff turnover will remain low as more staff choose to stay
- Roster will be set early and aligned with service needs

- Bank fill rates will improve through earlynotification of shifts.
- All staff paid correctly and on time, every time
- There will be reduced unplanned agencyspend
- Numbers of formal grievances will reduce
- Days lost to sickness will reduce
- We will be recognised as a great place to work
- Roster performance scorecard trending positive

How will it feel?

- All colleagues work and learn in an environment that is calm, in control and well led
- Colleagues feel they are treated with respect and compassion by leaders and others
- The health and wellbeing of colleagues is a true priority and is discussed in operational meetings
- Colleagues are encouraged to take personal responsibility for their own Health and Wellbeing and are supported to make adjustments when necessary
- All colleagues feel there is access to adequate resource to do their role within the Trust

NB: Detail of operational deliverables can be found in the appendix

Theme #2 - New Ways of Working and Delivering Care

The changing environment of the NHS requires innovative and integrated ways of working and learning like never before. The lessons from the last 18 months suggest new roles will emerge; more flexible working is required and alliances across the whole health and social care system are essential.

We will achieve this by:

- Use of Workforce planning tools, data and informatics to **plan effective models of care** and identify areas of risk; single points of failure or bottlenecks exist – fully aligning **people thinking with clinical strategies**
- Designing new **innovative roles and structures** to maximise efficient and effective delivery of care and protect us from national skills shortages, especially in specialist roles with specific skill needs.
- Creating an innovative cross functional **improvement network** providing front line colleagues with platforms to redesign work and improve their working environment and service delivery
- **Taking steps to align the new working environment with the range of education delivered** to better prepare newly qualified colleagues and improve patient care

What can we expect to see?

- We will address our ‘hard to fill’ staffing shortages by challenging traditional resourcing, developing new roles and new workforce pipelines for substantive, bank and temporary staffing
- We will continue to offer extended learning opportunities to expand the skills of our bank pool to provide variety and respond to service or operational needs
- We will enhance our use of activity demand and supply data to drive meaningful change in our workforce planning
- We will work closer to operational leaders to support the implementation of the wide range of change and improvement initiatives. The HR Business Partner role will be an integrated member of the divisional leadership teams
- We will develop the skills of operational colleagues to maximise the use and application of workforce systems and tools. These systems and tools will feel more intuitive, easier to navigate and offer a more efficient use of time

- An Improvement Network (described later in this paper) will deliver tangible results through short term 'task and finish' teams which include all levels of staff committed to driving service improvements
- Colleagues will recognise and celebrate the impact of nurturing creativity and delivering results through the Improvement Network in a structured and sustainable way
- The People Strategy and clinical strategies will be aligned so that together they deliver service and organisational changes designed to deliver outstanding care

How will we know when we have got it right?

- Increased productivity and efficiency against target measures
- Reduced unplanned agency and bank usage
- Our national measures e.g. Model Hospital and 'Get it right first time' will show minimal negative variations
- Skill shortages are mitigated by developing new roles and innovative ways of working

- Staff are confident using technology and digitalisation
- We will be recognised as a leading edge well performing Trust
- It is recognised that staff are involved in the cutting edge design and delivery of improvement and change.
- We will train 5% of the workforce as 'Champions of Change' through the improvement network
- Service and workforce needs are fully aligned

How will it feel?

- Colleagues feel the Trust is an exciting place to work based on their positive experience of involvement, innovation, improvement and change
- We are proactive and flexible in responding to future workforce demands - we are less constrained by national skills shortages.
- All colleagues have access to range of innovative formal/informal learning opportunities.
- All colleagues have the opportunity to make improvements in their work area and have their voice and ideas heard
- 'Change' is embraced as a positive concept and resistance is minimised by great caring leaders
- All colleagues work and learn in an environment that is calm, in control and well led

Theme #3 - Creating a Culture of Inclusion and Involvement

We are proud of our diverse Trust community and will continue to promote equality and diversity in our workforce. Culture changes require people, especially leaders, to change their behaviours. Empowering colleagues means many things, not least ensuring they have a voice, a real voice that promotes ideas that can easily be translated into actions.

We will achieve this by:

- Our **Leaders Behaviour Charter** being adopted, modelled and rolled out.
- **Equality, Diversity and Inclusion** being at the heart of our thinking - areas of improvement are constantly being identified; implemented and 'lived' by our leaders.
- **Formal staff partnership forums** will be established to provide a 'real local voice' for colleagues
- Adopting a resolution approach to discipline and grievance policies in line with a **fair and just culture**

What can we expect to see?

We will address our 'hard to fill' staffing shortages by challenging traditional resourcing, developing new roles and new workforce pipelines for substantive, bank and temporary staffing

- We will have a clear set of behavioural standards in place and role modelled initially by the extended Executive team, cascaded over time from Board to Ward.
- All leaders will know what is expected of them and all colleagues will understand the expectations on them and how they are doing through individuals performance discussions
- There will be zero tolerance for poor behaviour with staff confident that Leadership will listen and take action where required
- We will continue to build on our current reputation of a Trust with an outstanding Equality, Diversity and Inclusion (EDI) culture, with measures across all aspects of operations.
- We will embrace and celebrate the strength that a diverse workforce brings. There will be a real sense of belonging through buddying, networks, forums, partnering, education and much more

- We will have Staff Partnership Forums (SPF) at a Trust and divisional levels as well as aligned with major Trust initiatives. These will offer true engagement and inclusion as well as a real local voice for colleagues
- We will seek 'colleague to colleague reconciliation' through a resolution based approach, minimising the 'default' to formal grievance or disciplinary processes

How will we know when we have got it right?

- Extended Executive team feedback, behaviour framework in place and lived
- Retention Improved as colleagues choose to remain within the Trust
- Increased resolutions and reduction in formal investigations
- All measures of EDI are trending upwards

- Achieving 'Outstanding' in the well led domain in the CQC inspections framework
- Colleagues feedback forums and other platforms are well attended and actions implemented
- Improved results in the numerous national surveys including an upper quartile ranking in the National Speak Up metric
- Staff partnership forums operate as business as usual and are seen as true enablers of delivering excellence

How will it feel?

- All colleagues…..
- Feel valued and recognised for the work that they do
- Feel treated fairly and in line with our values
- Feel they are engaged and involved in decisions and necessary changes that impact them
- Have the opportunity to make improvements in their work area and beyond
- Feel confident they are treated fairly, consistently listened to and have their voices heard
- Feel they can raise a concern with their immediate line manager, they will be listened to and the concern addressed
- Will not only be proud to work in the NHS but also proud that they work at our trust in their role

NB: Detail of operational deliverables can be found in the appendix

Theme #4 - Growing for the Future

We have a track record of improvement; by 2020, ESHT had turned a page. We exited financial and clinical special measures in 2018 and 2019 respectively, and secured an overall Care Quality Commission (CQC) rating of “Good” with several services being rated as “outstanding”. To maintain this trajectory we will ensure that we aim to attract the very best; and ensure every colleague has the opportunity to access support services so that they can flourish in their role. As services develop so must our people – the two are inextricably linked.

We will achieve this by:

- Developing **career pathways and workforce pipelines** building capability in line with clinical need and to address an aging work profiles across the Trust.
- Having **meaningful performance management discussions** focussing on personal development, talent management, career progression and succession; learning from sectors outside of the NHS and adopting leading edge approaches.
- **Working across the Health and Social Care System** to create integrated workforce solutions, realising synergies and benefiting from economies of scale whilst recognising we are an anchor organisation for East Sussex and need to support employment across the county.

What can we expect to see?

- We will provide career pathways in key areas supported by an extensive education and training offer so candidates and existing colleagues can plan and shape their future. These career pathways may not remain traditional or single function. Colleagues will have opportunities to gain wider experience in different areas of the service to broaden the skills we offer and in turn improve career opportunities.
- We will see an increase in new roles in many divisions and be able to showcase a wider range of career opportunities in healthcare. We will in particular expand our offer to younger people and hard to access communities.
- We will develop a Trust identity and a proposition of benefits and value that enables us to attract and retain top quality people across all of our key areas of activity
- We will offer our colleagues the opportunity for personal development and career progression based on an objective performance management process which includes personal development and talent management discussions
- We will mitigate risks where there are critical skills shortages or potential

points of knowledge failure (including through an improved succession planning process). We will identify where digital development can enhance our capabilities and efficiencies and work with colleagues to deliver improvements

- We will ensure that colleagues have the right tools and the right training on how to use the necessary technology to flourish in their role and reach their maximum potential
- We will develop tangible cross agency processes and systems to underpin ICS White Paper directive including substantive and collaborative bank, health and social care joint roles, integrated pathways

How will we know when we have got it right?

- We will be recognised as a great place to work
- New candidate pipelines will be in place and delivering access to new candidate groups
- Recruitment will be quicker and retention will improve as highly skilled colleagues choose to remain in our Trust
- There will be tangible evidence of larger candidate pools and a greater offer rates. [Via Trac tool]
- Education pathways will be aligned to new career pathways

- A robust resource planning and management system will be in place to smooth activity peaks or staffing shortages supported by an upskilled substantive bank of staff
- Succession plans will be in place and areas with a critical shortage identified.
- All colleagues will have conversations with their line manager about personal development
- There will be a shared staff bank across the East Sussex Health and Social Care economy

How will it feel?

- Colleagues will be happy to recommend the Trust as a great place to work
- Colleagues are proud of the innovation and flexible ways we care and serve our patients
- All colleagues look forward to coming to work
- All colleagues feel they have the opportunity to develop and flourish
- All colleagues feel a connection to their teams and the Trust in general

NB: Detail of operational deliverables can be found in the appendix

4. OUR LEADERSHIP BEHAVIOUR CHARTER

The wide range of initiatives described in the plan intentionally inter-relate and connect. They are also dependant on some key enablers. These factors are prerequisites that must be in place to facilitate success.

We have identified 4 major enablers which provide the platform for underpinning the strategic initiatives.

These enablers drive **behaviour change; organisational design and development** as well as the expanding use of **technology and systems.**

Enabler #1 - Improvement Network

Year 1 - Develop an integrated approach to improvement initiatives across the Trust:

- Bring together key capabilities from Organisational Development, Quality improvement, GIRFT teams into a single hub to contribute to the delivery of a wide range of improvement ideas and an integrated approach to change
- Develop and approve the rationale for, model and key accountabilities to support the improvement network
- Create a “prioritised access” approach to change capability to ensure that resources are fully aligned with needs

Year 1 and 2 - Pilot and deliver

- Establish the core group to support Change initiatives
- Pilot approach in a strategically critical project - run the network and its associated improvement teams
- Plan / procure and delivery training packages to support” improvement ” and sustain change champions on the front line [internalising the skills]

Year 2 to 5 - Collaborate to develop and implement an integrated approach to improvement initiatives across the trust:

- Evaluate the impact of change initiatives and adapt the model across the Trust and ICS as appropriate

Enabler #2 - HR Business Partners (BP) and Employee Relations Hub

Year 1 - The BP Development Programme has completed and BPs are contracting with HR Centres of Excellence for services:

- The HR extranet ‘’self-service’ platform is in place and user friendly
- Workforce Polices are re-designed to reflect focus on informal resolutions
- Case management is supported by a single Centre of Excellence freeing up other resource to support divisions better
- HR staff time is released from routine enquiries to develop a central proactive, resolution focused Employee Relations Hub. A ‘one stop shop’ for specialist advice
- HR BP’s begin to integrate into Divisional leadership teams

Year 2 - BP role is consolidated into Divisions:

- A Contracting Model (SLA) with Divisions is established and HRBP’s fully absorbed into DivisionalLeadership Teams
- HR Systems data combined with activity and operations data, supports focussed improvement work
- Extranet page is enhanced to support further interactive digital self service

Year 3 to 5 - Continuous Improvement through inclusive Partnering:

- Feedback from service user analysed and providing focus for improvement
- Review and evaluation of the Employee Relations Hub
- Innovative digital solutions continue to be rolled out offering “time and place of need” services whereverpossible

Enabler #3 - Education and Leadership Academy

Year 1 - Collaborate to design an Education and Leadership Academy

- Working in partnership with internal and external partners we will design an Education and Leadership Academy that creates excellence across the whole system.
- As Integrated Education service become a key partner to the business to identify new roles and support new ways of working
- Develop great leaders who will role model behaviours that drive a culture of transformation and innovation
- Develop a sustainable Education and Leadership Academy that will put the "growth for the future" as its key driver
- Refresh Educational Governance processes to meet mandatory KPI's within the new NHS Education Contract

Year 2 - Launch

- We will establish core group of internal and external partners to develop the launch of the new Education and Leadership Academy
- We will formally and in a structured way integrate the functions of the new Education and Leadership Academy across all service partners to join up the dots and avoid duplication or major gaps
- We will launch the initiative and create stage one delivery, once all Partners are aligned and funding is secured

Year 3 to 5 - Working with partners across the system to embed the Education and Leadership Academy

- By piloting key achievements and celebrating success we will grow and promote the academy with other service organisations and the wider system that creates and sustains delivery
- We will embed the Academy to "grow" the future skills/new roles within the workforce to support patient care
- We will evaluate the impact of the Education and Leadership Academy with all partners and make revisions

Enabler #4 - HR Analytical Excellence

Year 1 - Set up a Centre of Excellence to enhance analytical skills and capability within the Trust

- We will create a virtual skills network for analytically minded colleagues who will benefit from sharing skills and experience whilst working on 'live' projects and initiatives
- The network will promote a new data scientist career pathway as well as enhancing wider capabilities to support evidence based change through analysis and insight

Year 2 - Design and build activity demand driven supply and demand workforce models

- Align developmental modelling and with Trust strategic transformation programmes
- Supports compliance for Developing Workforce Safeguards compliance and provides assurance
- Support Improvement Network delivery for all staff groups through the provision of supporting analytics
- Will reduce manual intervention and support a cloud based delivery

Year 3 to 5 - Review and further build on the success of the Trust analytics programme in improving analytical capability

- Evaluate the impact of change initiatives and support and adapt the model for other providers as appropriate

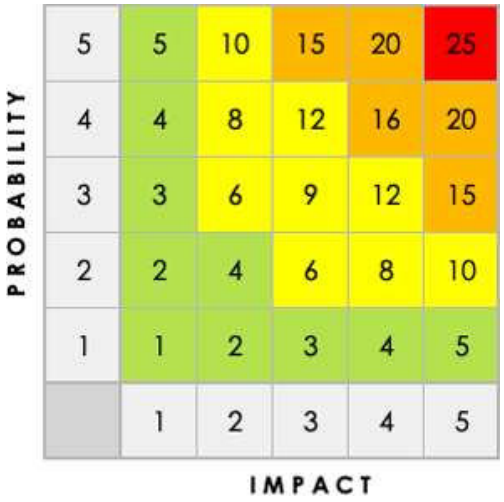
Enabler #5 - Building Resilience

Following discussions at the Board seminar, work will immediately commence on developing a 5th key enabler focusing on the people and process changes to respond to 'the new normal'.

As we know this new normal is a set of predictable high demand, stressful conditions which requiring a new innovative set of working solutions.

For example: These solutions may be designed as a series of 'step up' changes to futureproof the services; patient care and staff certainty. They may describe new flexible roles for back office staff during crisis periods; they may also describe changes and temporary 'freedom to act' scenarios. This proposal will be completed with operations colleagues by the end of Q4 202.

5. RISK REGISTER



Associated with every strategy there are many risks and variables to identify and mitigate. This register aims to **highlight the significant risks and impacts** associated with our ambitious People Strategy. This list is not exhaustive and will be developed constantly.

Each risk has been assessed against the 25 grid risk matrix forprobability and impact of occurrence. This list is likely to change due to internal and external factors.

As this register develops operational teams and their HR colleagues will formulate **actions plans to mitigate each risk** and to protect delivery of the strategy.

Risk Register generic example

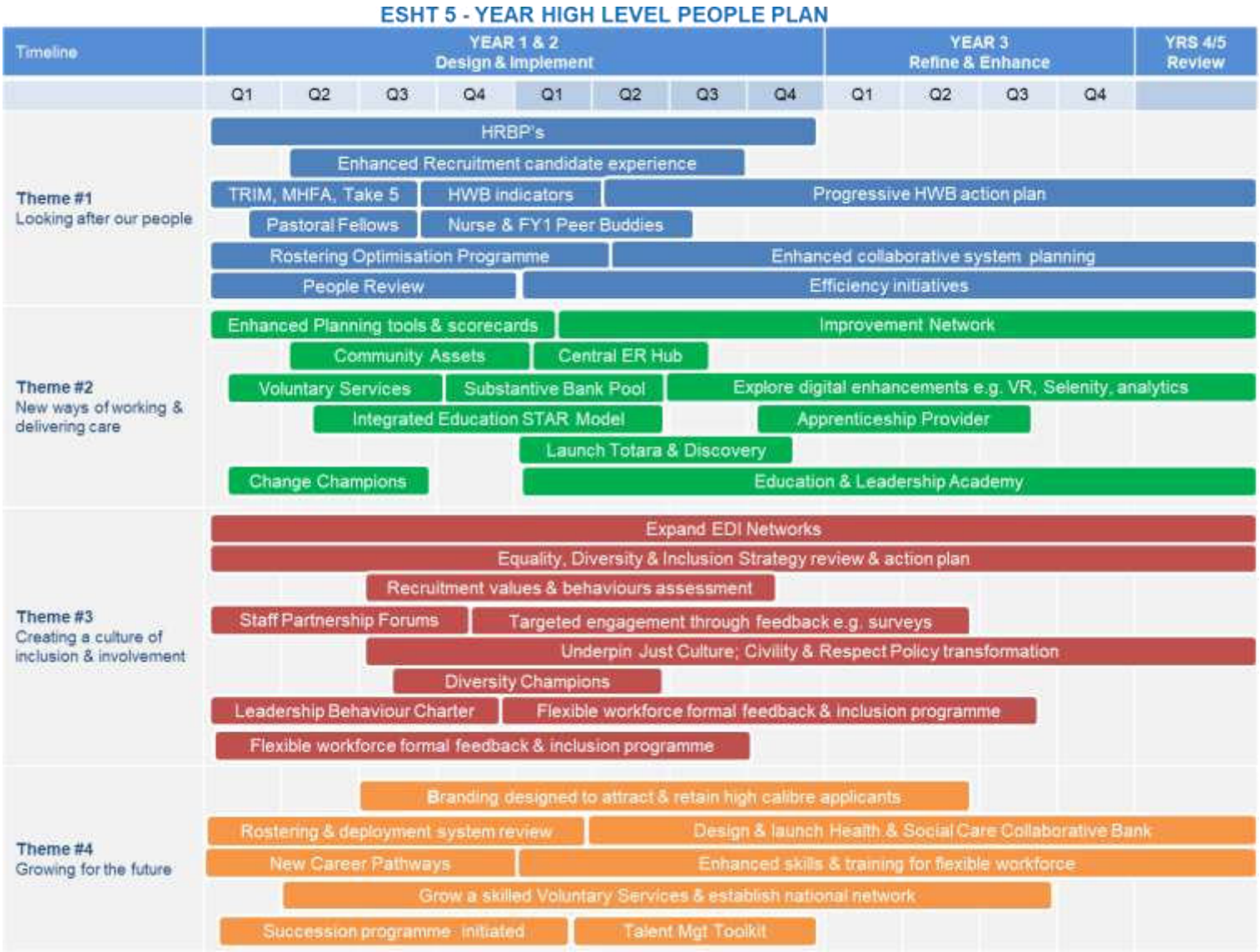
	RISK DESCRIPTION	IMPACT DESCRIPTION	IMPACT LEVEL	PROBABILITY LEVEL	PRIORITY LEVEL	MITIGATION NOTES	OWNER
	Give a brief summary of the risk.	What will happen if the risk is not mitigated oreliminated?	Rate 1 (LOW) to 5 (HIGH)	Rate 1 (LOW) to 5 (HIGH)	(IMPACT X PROBABILITY) Address thehighest first.	What can be done to lower or eliminate theimpact or probability?	Who's responsible? ExecDirector
1	Significant Covid or Major Incident pressures	Impact to our ability to deliver our services	5	5	25		
2	Clinical engagement and buy-in	Failing to adopt a modern innovative change ways of working and integrated structures	4	5	20		
3	Alignment with other functional strategies	Silo mentality, timing not aligned, initiatives not supported, fragmented implementation	4	4	16		
4	Staff burn out	Public perception and positive support replaced with resentment due to backlogs and waitingtimes	4	4	16		
5	Limited HR capacity	Initiative overload, systems not yet refined e.g. self-serve, tools not fully embedded, resistance to change	4	4	16		
6	Leadership focus, personal accountability and the courage to be a catalyst for change	Top 30 leaders are critical to the owning, rolemodelling and championing the People Strategy themes	5	3	15		
7	Limited management capacity	Too busy, not enough staff, people strategy notseen as a priority, focussed on patients not staff	3	4	12		

8	Limited HR capability	Skills and knowledge development is required in areas such as - data use and understanding;HRBP ops role; OD and CM inputs to the Improvement network; and potentially a revised HR structure.	4	3	**12**		
9	Staff resistance to change	Resistance to change	4	3	**12**		
10	Management resistance to change	Seen it all before, doesn't need changing, too busy, just don't like change	3	3	**9**		
11	Limited management capability	Lack of experience, skills need refreshing or development	3	3	**9**		

6. OUR HIGH LEVEL PLAN

The 5 Year High Level People Plan shown below reflects the key deliverables and milestones for the implementation of the strategy. The plan will be subject to change as expected in any transformational programme particularly when considering the complexities of the health and social care systems. Many initiatives are already underway and are shown as Q1 Y1 for convenience.

The details of the operational deliverables behind each theme are included in the appendix to thisstrategy.



APPENDIX:

Detailed Operational Deliverables

The People Strategy, by design, is intended to focus on top level activities and themes describing our direction, key aspects of the needs for change, core themes, achievements and the operational enablers to drive success.

To successfully deliver our ambitious strategy we have identified a more detailed level of tasks and initiatives by theme.

These tasks will formulate our HR operating plan, which will in turn be translated into specific objectives for HR leaders and their teams.

The contents of this appendix will be used to formulate a fully agreed HR operational plan which will be reviewed on an ongoing basis as a part of our Trust strategic and operational governance.

This appendix should therefore be considered for illustrative purposes rather than scrutiny at this stage.

Steve Aumayer

Chief People Officer

August 2021

Theme #1 - Looking After Our People

We will:

Year 1

- Further embed a pathway of physical and psychological support for teams and individuals including access to specialist support from NHS partners e:g Trauma Risk Management (TRIM) and Mental Health First Aid (MHFA), including potential expansion of the 'take 5' initiatives in Professional education
- Provide leaders with a range of tools and processes that enable them to utilise resources in a balance way to reduce unpredictable daily routines. e.g. e-roster training; staff planning scorecard; lead times for bank/agency access; HWB indicators for their area
- Through HR Business Partners, engage with leaders on a regular basis to assist with areas of concern or trends – the HWB conversation must occur regularly and formally. HRBP's can act as the conduit back to the access to HWB interventions
- Further develop the Pastoral Fellows role and embed HWB aspects and values into integrated Education and training
- Develop a HWB dashboard and align with Staff partnership outcomes
- Pilot Nurse/Peer buddy's for Foundation Year Doctors

Year 2

- Review and improve the pathway of physical and psychological support for teams and individuals
- Refine the HWB dashboard assessing local success and improvement areas. We will align with the operational scorecard to assess synergies or correlation
- Lead on work across the system in partnership with the ICS to initiate and share and embed our psychological and HWB initiatives
- Source funding to further develop the Pastoral Fellows role for undergraduate, postgraduate and medical associated professions
- Improve the Trusts openness by enabling staff to easily secure access to their personal data

Year 3 to 5

- Review and improve the pathway of physical and psychological support for teams and individuals
- Explore and refresh solutions for workforce stress based on feedback from stress assessments

- Refine the HWB dashboard assessing local success and improvement areas. We will align with the operational scorecard to assess synergies or correlation
- Complete our transformation of Workforce Policies such as Just Culture; Civility and Respect will underpin the OD and Engagement strategies
- We anticipate ESHT will be seen as a centre of Excellence for innovative and robust HWB initiatives that influence the wider ICS that support all colleague and trainees

Theme #2 - New Ways of Working and Delivering Care

We will:

Year 1

- Deliver new Workforce Planning tools and train leaders and colleagues in their optimal use
- Develop new tactical workforce pipelines through Community Assets for substantive and Temporary Workforce Solutions
- Develop new tactical workforce pipelines for substantive bank pool to balance leave peaks
- Upskill and extend our voluntary resource pool to target non-clinical roles and activities
- Streamline and enhance effective flexible rostering and deployment capability aided by the provision of insight dashboards
- Develop the bank workforce pool skills profile through bite sized learning to extend capability
- Commence Integration of STAR Model methodology in supporting Service Transformation to include new roles, new ways of working, upskilling, supply and leadership
- Embed new Learning Management Systems (Totara) across the Trust
- Embed new LMS for the Library and Information Knowledge Services (Discovery) across the organisation
- Agree a simple and single improvement methodology to apply to our Improvement Network champions and hub
- Identify these new initiatives and embed in the integrated education academy curricula to synchronise learning with the delivery environment
- Scope our existing educational digital footprint and map against TOPOL, HEE/Technology Enhanced Learning (TEL) requirements

Year 2

- Integrate the functions of the new Education and Leadership Academy across integrated education and Staff Engagement and Health and Wellbeing
- Explore new technical ways of learning and teaching to include VR, 360 degree filming etc
- Embed the NHS HEE Star Model into our plans to act as a catalyst to proactively develop new roles, new ways of working, to “grow our own” and maximise existing staff potential
- Start the journey to become an apprenticeship employer/provider
- Embed the refreshed educational governance processes within integrated education

- Create a central ER Hub which will provide a ‘one stop shop’ for quick consistent and legally secure advice on a range of casework and ER issues. SLA’s by division will be created to align need and response. In parallel with the new HR self-serve initiative. this will release HRBP’s to focus on wider operational, developmental and OD activities
- Align data driven analysis [Selenity tool] to the performance of the HR ‘hub’ and identify improvements where appropriate

Year 3 to 5

- Be recognised as a centre for excellence for education and leadership through the implementation of the Education and Leadership Academy service that operates out of state of the art education facilities on both sites
- Embed Technology Enhanced Learning and Teaching across the Trust
- Embed the processes for collaborative working across the ICS and other networks
- Have an HR Service Delivery Model which is fully aligned with operational service delivery and supports the wider ICS

Theme #3 - Creating a Culture of Inclusion and Involvement

We will:

Year 1

- Develop a set of leadership behaviours to support the trust's values statements
- The Executive Team will personally pilot the 'Behaviours charter' and review their progress, revising appraisal and formal feedback processes as needed
- Use the Executive insight to design a range of interventions that will support the successful implementation of our EDI Strategy and policy
- Design and pilot the first new staff partnership forum [SPF] aimed at increasing engagement from our all staff networks at divisional levels, to move away from 'formal committee'' group hierarchies towards discussion and ideas generation at local line semi-formal forums.
- Refresh the insight provided through staff surveys, pulse surveys and subject specific focus groups as an opportunity to triangulate data and opinions to strive for improvements
- Work with the Pastoral Fellows to develop sole/joint initiatives to welcome and integrate new students and trainees to the Trust
- Put in place diversity champions embedded in each division
- Through HRBPs, engage with leaders on the adoption of a 'resolution' based approach to ER issues to reduce formal time on grievances and replace with a more conciliatory process that engages leaders in a more just and fair approach

Year 2

- Launch a Leadership Charter for the top 100 managers: The Executive Team Cascade the Leadership charter throughout the whole Trust; feedback and appraisals will be fully aligned with it
- Review quantitative and qualitative data on staff experience and reset priorities at a Trust, divisional and service level
- Have embedded widespread pastoral/HWB initiatives that drives a positive organisational culture
- Partnership forums will be energised, fully operational and aligned with the Improvement Network agenda and change agenda

Year 3 to 5

- Cascade the Leadership charter throughout the whole Trust; feedback and appraisals will be fully aligned with it
- Review quantitative and qualitative data on staff experience and reset priorities at a Trust, divisional and service level
- Have embedded widespread pastoral/HWB initiatives that drives a positive organisational culture
- Partnership forums will be energised, fully operational and aligned with the Improvement Network agenda and change agenda

Theme #4 - Growing for the Future

We will:

Year 1

- Design and deliver specific career pathways across key functions where retention is an issue e.g. Nursing and AHP. We will align these with our integrated Education Academy and programme
- Launch a new interactive Learning Management Systems for both Education and Library Services
- Be proactive in working with clinical service and other partners in identifying and developing new roles/upskilling to support new/existing career pathways across the Trust
- Design processes and systems to identify a pipeline of talent especially in those areas where it is difficult to retain staff, and difficult to access communities. We will pilot these in an area of urgent need
- Focus on and attract younger people from the local community through apprenticeships and access through the volunteers network
- Plan a range of development activities to provide stretch opportunities for those staff identified as high potential; build personal development plans annually
- Provide training and ongoing support on the Talent Management toolkit
- Agree governance processes to support talent management and succession planning
- Engage with our staff and agency suppliers to ensure we purchase a cost effective rostering system that is 'fit for purpose'
- Create an attraction proposition to recruit the right person at the right time, first time, every time

Year 2

- Launch a collaborative bank across ICS
- Procure 'fit for purpose' rostering systems at competitive rates for all staff groups
- Be externally recognised as an Employer of Choice
- Implement talent management and succession planning across the trust
- Embed the Education Strategy and Branding across the organisation
- Lead on educational exemplar initiatives and strategies across the system supporting workforce transformation and planning.
- Working in collaboration with health and social care partners, develop shared flexible staffing resources to meet the demands of the system

- Through innovation be recognised as the ICS exemplar for both temporary and substantive workforce solutions

Year 3 to 5

- Refine the HR Workforce in line with the requirements of Transformation and Building for the Future
- Refine and revisit the ICS requirements in tandem with ESHT strategy
- Working with our partners, go live supporting initiatives such as graduates, community assets through our ‘grow your own’ academic pipelines
- Develop streamlined support mechanism for delivering progressive workforce profiling by design to futureproof our integrated health service
- Have a proven Education Strategy and Brand that is responsive to new ways of working and learning across the Trust and within the system

We have a wide range of volunteering opportunities and you don't need previous experience in a health setting to volunteer for us.

For more information visit our website:

esht.nhs.uk/volunteering

Visit, follow and subscribe to East Sussex Healthcare NHS Trust (ESHT)

Website: esht.nhs.uk/

Twitter: twitter.com/ESHTNHS

Facebook: facebook.com/ESHTNHS/

YouTube: youtube.com/user/ESHTNHS

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Green Plan

Meeting information:			
Date of Meeting:	8th February 2022	Agenda Item:	10
Meeting:	Trust Board	Reporting Officer:	Chris Hodgson

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 Green Plan is one of our key enabling strategies underpinning our overarching Strategy.

We are required to produce a Green Plan in line with NHSE/I standards and going forward the NHS has set an ambition to be net zero by 2040 for direct emissions and fully net zero by 2045.

As a Trust we have a key part to play in the local, regional (Sussex ICP) places. At a Regional, Sussex ICB level, our plan will be incorporated into the Sussex wide, Care Without Carbon Sustainable Healthcare model.

The Green Plan sets the tone and direction for the Trust to assist the NHS in meeting its future aspirations/goals for Net Zero. This will be mainly driven by the adoption and use of the 8 key elements within the Green Plan to help support delivery of this plan.

The content has been widely consulted within the Trust, including clinical and non-clinical teams and the leads for 8 elements.

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

Strategy Committee 23rd December 2021

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

To approve the Green Plan.

care WITHOUT CARBON

NHS
East Sussex Healthcare
NHS Trust

Our Green Plan

Better Care Together for East Sussex

Contents

Our Green Plan at East Sussex Healthcare NHS Trust has been developed in partnership with Sussex Community NHS Foundation Trust's sustainability team using their framework for sustainable healthcare, Care Without Carbon

Welcome

Welcome to the East Sussex Healthcare NHS Green Plan 2021.

As a Trust, our ambition is to provide 'Better Care Together for East Sussex'. This Green Plan establishes a set of principles and targeted interventions aimed at ensuring we are able to deliver on this in the context of climate change – and that the high quality of care we are providing today is available tomorrow.

Through our framework for sustainable healthcare, Care Without Carbon, we are working with three key aims in mind:

1. Reducing environmental impact: delivering care that is Net Zero Carbon, minimising our impact on the environment and respecting natural resources.

2. Improving wellbeing: supporting the health and wellbeing of our patients, staff and communities.

3. Investing in the future: maintaining long term financial stability through sustainable decision making.

As such, our sustainability vision is: together we lead the way in net zero carbon healthcare, protecting the environment on which our health depends.

At East Sussex Healthcare Trust we are continuing our journey to becoming a more sustainable healthcare provider.

Maintaining high quality, sustainable acute and community services across East Sussex to a community of around half a million people each year requires us to make best use of the resources we have – by being efficient and innovative in everything we do.

We have reflected this in our Five Year Strategic Plan. This Green Plan is central to achieving a key aspect of our vision 'To lead a modern organisation for our people, enabled by technology, agile working and a light environmental footprint' and our strategic aims to 'Ensure innovative and sustainable care'.

Our key environmental target is to meet the carbon reduction targets laid out in the NHSEI Delivering a Net Zero NHS Strategy, reaching Net Zero for our direct emissions by 2040, and for our indirect emissions by 2045. Our initial interim target is a reduction in our carbon footprint of 57% by 2025 against a 2013/14 baseline.

In this strategy we set out clear commitments to deliver against our vision and Net Zero target through our Care Without Carbon framework, with action plans covering eight different areas of work (see Figure 5, page 15).

The case for sustainable healthcare

The links between climate and health are clear. According to The Lancet, climate change is the biggest global health threat of the 21st Century – but tackling it presents the greatest opportunity to improve health that we will see in our life times.

Delivering better care

Health and sustainability go hand in hand. By delivering care in a more sustainable way, and supporting our staff, patients, carers and communities to live more sustainable lifestyles we are enabling better health outcomes in our community.

Meeting our resourcing challenges

Sustainability is shorthand for effective resource management. In the NHS we can identify three key resource challenges:

1. **A social challenge – finding new ways of delivering care that reduces demand and empowers patients as well as looking after the health and wellbeing of our 1.5 million NHS and social care staff;**
2. **An environmental challenge – the NHS is the largest public sector emitter of CO2 in the UK; and**
3. **A financial challenge – with demand on our services and aging estate outpacing funding.**

Figure 1, on page 5 demonstrates the link between the above interrelated and complex challenges.

Figure 1: Care Without Carbon creates a virtuous circle of sustainable healthcare.

The key drivers for this Green Plan are as follows:

Climate emergency = health emergency

Simon Stevens recently described the climate emergency as a “health emergency” and reiterated the need for the NHS to be the change it wants to see. As a healthcare provider we are a first responder to climate change - it is our patient community that is most affected and we must respond.

For a Greener NHS

The For a Greener NHS programme was kick started in January 2020 and aims to build on the great work already been achieved by the NHS, sharing ideas on how to reduce the impact on public health and the environment, save money and, 2040 – reach net zero carbon.

A Sustainable Development Strategy for the NHS, Public Health and Social Care Systems (2014)

Reinforces the urgent need for all NHS organisations to take action to reduce their environmental impact and embed sustainability into their strategies, cultures and communities.

The NHS Standard Contract

The full version of this document mandates that all providers have a Board approved Green Plan.

Commissioning

A Green Plan may be asked for by Commissioners as evidence of our approach to Social Value.

NHS Improvement and NHS England

Expect all NHS providers to have a Board approved Green Plan as these plans are considered a good measure of a well led organisation.

There is a strong business case for taking action to become more sustainable

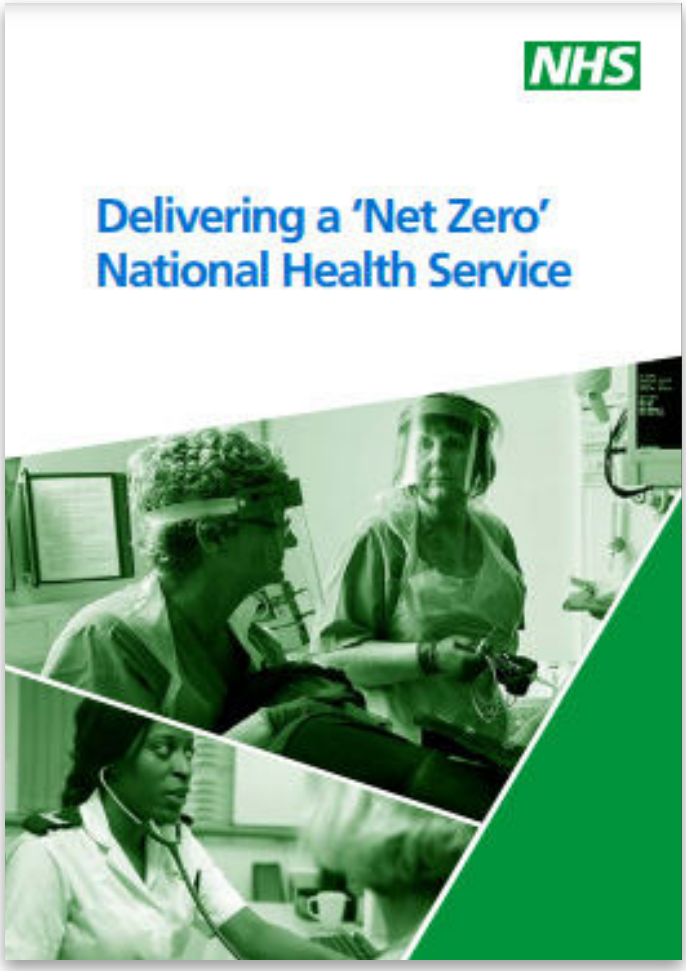
By reducing consumption of resources such as energy, water, fuel and other materials, recycling more NHS organisations can realise significant savings. These can then be reinvested into the frontline care, redeveloping our estate and improving working conditions.

The NHS must help to mitigate the negative impact of climate change on health.

We have been feeling the effects of climate change in the South East for some time, with increasing temperatures, an increase in the magnitude and frequency of extreme weather events (heatwaves and flooding), and a deterioration in air quality. These changes in the climate impact the way we deliver care – from reducing access to our premises for both service users and staff, to altering the health needs of our communities.

The NHS Long Term Plan

If health services around the world were a country, they would be the fifth largest emitter of CO2. The NHS therefore has the potential to make a significant contribution to tackling climate change in the UK.



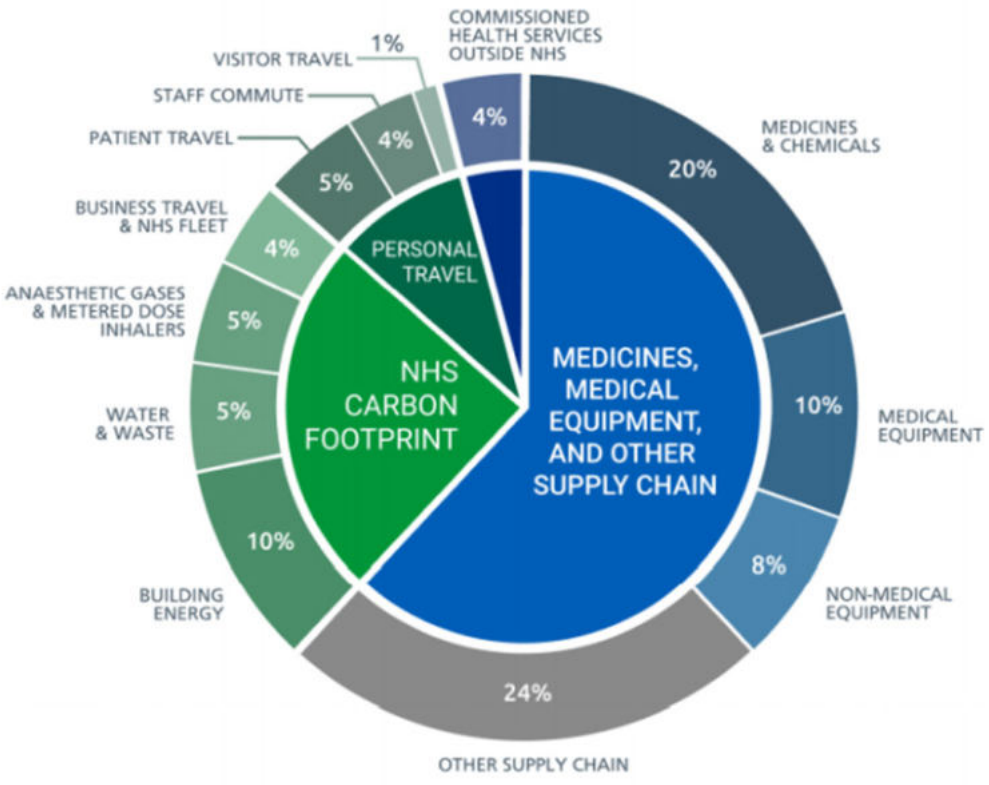


Figure 2: Carbon footprint of NHS in England, Delivering a 'Net Zero' National Health Service (2020)

The Story So Far

We provide acute hospital and community health services for people living in East Sussex and surrounding areas.

- **Our Emergency departments are used 130,000 times.**
- **3,053 children are born in our hospitals.**
- **54,000 people have planned surgery.**
- **414,000 outpatient appointments. interventions per day.**
- **42,000 referrals to community nursing**

We launched our first Green Plan, then known as an SDMP in partnership with Care Without Carbon, in 2015 which was subsequently updated in 2017.

Our carbon footprint

In delivering our services we consume a significant amount of energy and water and produce a large volume of waste. We also require movement of staff and patients across a substantial area of Sussex and purchase a wide range of equipment and services. All of these activities generate CO_2 (carbon dioxide) emissions, which are linked to climate change, and can be collectively summarised as the Trust's carbon footprint.

The carbon footprint (measured in tonnes CO_2e[1]) associated with our services is illustrated in Figures 2 and 3 on the following pages.

The Trust chose to have a 2013/14 base year for emissions due to the availability of data for the Trust.

The NHS measures carbon footprint in CO_2e, in line with national and international conventions. This allows all six greenhouse gases to be measured on a like-for-like basis, which is important as some gases have a greater warming effect than CO_2.

Our absolute carbon footprint has reduced since 2013/14 with an overall reduction of 31%.

The primary reason for this is the reduction in carbon intensity of grid electricity. Although this reduction in the grid emissions factor for electricity will continue over the coming years, it will not be sufficient to meet our 2025 carbon targets, and does not carry any cost reductions. The impetus to reduce our carbon emissions and associated costs further is clear, and we recognise the urgency of taking action now in order to meet our 2025 commitments.

[1] CO_2e refers to six greenhouse gases including carbon dioxide and methane.

Medical gases impacts

For the first time we have measured the carbon footprint of our medical gas use. In 2020/21 this accounted for 1560 tonnes of CO2e. This is a significant source of emissions, accounting for 8% of our overall carbon footprint. Proactive work by our anaesthetists over recent years has seen a reduction of 42% in emissions per litre of anaesthetic gas used since 2013/14 by switching to alternatives with a lower environmental impact. There is more work to do in this area to map our usage of other gases and reduce those emissions. This will be a priority area of focus for us over the next 3 years.

Travel impacts

In 2020/21 we travelled a total of 2.2million miles, of which 1.9million were carried out by staff driving their own vehicles for Trust business. Air pollution is a key issue for our communities with significant health impacts; we are already working on improving access to services through our service strategies to reduce the need for our patients to travel where appropriate; we will be focusing on further reducing our impact in this area through healthier travel choices and encouraging the uptake of electric vehicles.

Waste impacts

In addition to our carbon footprint we produced 2,019 tonnes of waste in 2020/21 including healthcare and non-healthcare waste. 39% of non-healthcare waste was recycled with the remainder sent for incineration with energy recovery. Through our use of reusable sharps containers across the Trust we avoided the incineration of over 19,000 single use containers between January and September 2021.

We will reduce the amount of waste we generate and find more sustainable disposal options, where possible.

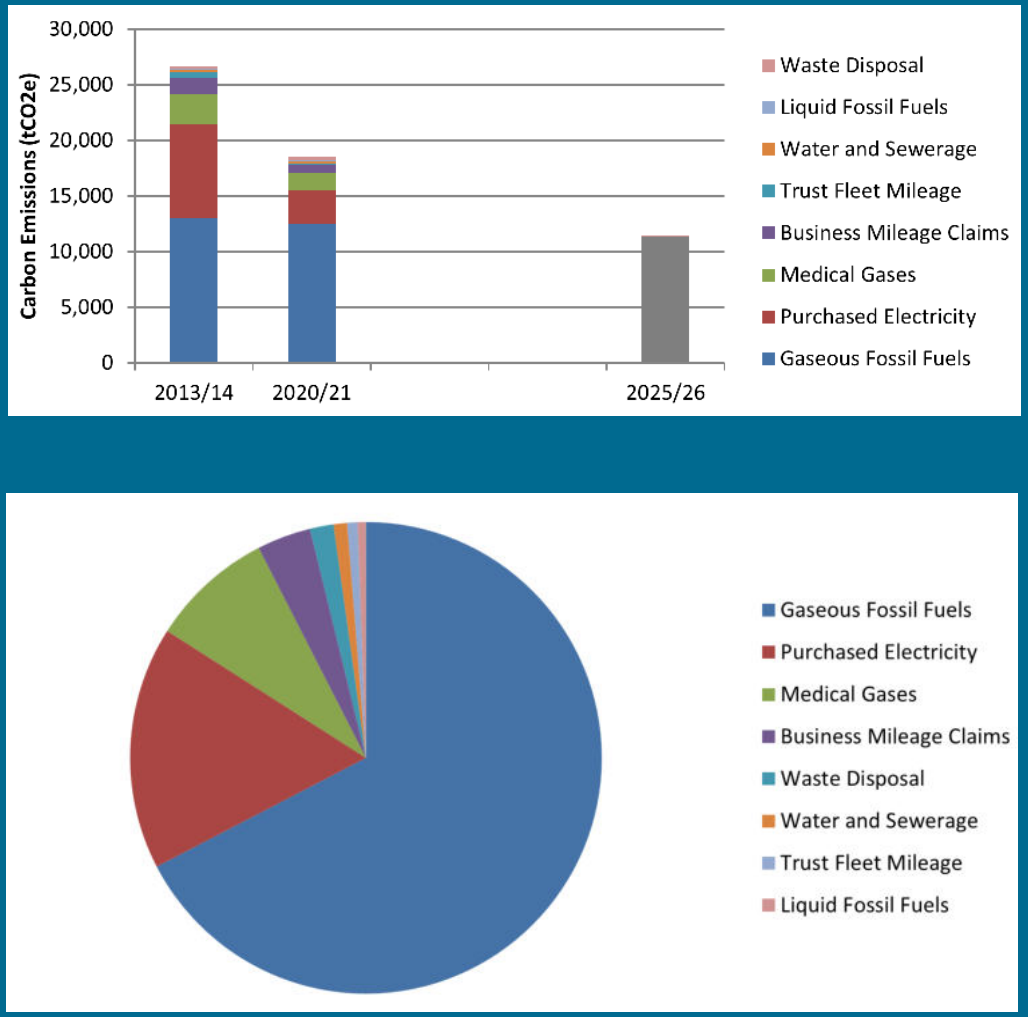


Figure 3: ESHT carbon footprint (tCO2e): trajectory to our 2025 target and detailed breakdown for 2020/21

Emission Source (tCO_2e)	2013-2014	2020-2021
Gaseous Fossil Fuels	13,021	12,460
Purchased Electricity	8,447	3,084
Business Mileage	1,473	683
Water & sewerage	207	172
Trust Fleet	519	132
Liquid Fossil Fuels	71	104
Medical Gasses	2,659	1,560
Waste Disposal	277	300
TOTAL	24,320	16,723

Figure 4: ESHT carbon emissions by source

Since our first Green Plan (known then as an SDMP) in 2014 we have made progress in a number of key areas:

Places: As well as continuing to drive our EPC and laying the path to Net Zero Carbon we continue to purchase renewable electricity after switching in 2018, we are currently investigating a way to better reflect this procurement decision in our carbon reporting. The revenue generated from the Combined Heat and Power unit at Conquest is being used to fund the modernisation of the hospital's centralised heating and cooling systems; reducing backlog maintenance risk as well as future-proofing the site for low carbon heating retrofits once such technology becomes available.

The Trust moved onto a renewable electricity contract on the 1st April 2018 and we are currently investigating a better way to reflect this in the reporting of our electricity emissions. As a result of this procurement decision, emissions from our electrical consumption when using our contract-specific emissions factor were 213 tonnes CO2e, whilst when applying the grid average factor, which is what is required for reporting purposes they were 3,270 CO2e.

Journeys: the Healthy Transport and Active Travel Officer expanded the number of low emission pool cars available to staff to eight in October 2018 and also successfully trialled the offer of a minibus for large meetings in July 2018.

The use of the pool cars has increased significantly, in 2019/20 they travelled 57,000 miles. ESHT have also promoted active travel and carried out projects including; improving cycle shelters and running a program to help staff get back into cycling in conjunction with Sustrans. This is alongside extending the limit of the two cycle to work schemes so staff are able to access electric bikes.

Culture: a Green Champions network was formed at the Trust last year. The group consists of a wide range of Trust staff working on a range of projects. One key project is the continued reduction of the anaesthetic gas Desflourane. To date consultants at ESHT have been working to reduce the use of the gas across both EDGH and Conquest. We have begun measuring the carbon impact of our anaesthetic gases and have integrated this into our carbon footprint.

Circular economy: the Trust started seperating out all cardboard from it's dry mixed recycling in 2018/19, this has allowed the carboard to be bailed and collected seperately which generates income for the Trust. In 2020/21 the effective recycling of disposible coffee cups and patient wash bowls will be investigated with the aim of finding a suitable scheme and introducing recycling facilities for these items over the next few years.

Alongside this the Trust has rolled out reusable sharps containers which have significantly reduced the amount of plastic sent for high temperature incineration.

Collaborations and Partnerships: the delivery, monitoring and reporting of our Green Plan is supported by Sussex Community NHS Foundation Trust's Sustainability and Environment Team. The team assists with implementing key aspects of the program working alongside teams within in the Trust and feeding into the Trust's Board Lead Chris Hodgson, Director of Estates and Facilities. We are in the process of reviewing our governance arrangements.

Net Zero Carbon

Net Zero Carbon means reducing our carbon emissions as much as possible and then offsetting the small amount of residual emissions which remain, ideally through either a centralised Government scheme or, projects such as tree planting which would benefit our communities.

To reach Net Zero we will bring our direct emissions, those which result from our sites and operations (NHS Carbon Footprint) down to Net Zero Carbon by 2040 at the latest and our indirect emissions, those which we can influence i.e. carbon generated through our supply chain (NHS Carbon Footprint Plus) to Net Zero Carbon by 2045.

Our 2025 target is 57% reduction in direct carbon emissions by 2025/26. This interim target keeps us on track for Net Zero Carbon by 2040.

External Factors Affecting Our Carbon Footprint

Although most of our emissions are a direct result of our operations, there are various external factors that can influence the emissions produced by our Trust. These factors include:

National Emissions Factors issued by the government vary from year to year. This will result in a variance on our carbon footprint, even if there are no changes to our estate operation. It is estimated that the grid itself will reach net carbon by 2035 and so hence the focus on switching to technologies that use electricity, rather than fossil fuels, for heating.

Weather changes influence the energy consumption profile of our Trust. For example, a very cold year may increase the need for heating on site, resulting in higher energy consumption (either natural gas or electricity).

Changes to Our Estate The measurement of carbon footprints are an absolute value, so any changes in resource demand will affect our footprint although the Trust is not looking to expand its estate significantly in the foreseeable future.

Future Scenario

The graph below shows the Trust's emissions target against projected emissions under two scenarios. Under the Business As Usual (BAU) scenario it is assumed that current consumption remains constant although carbon savings are achieved in the long term due to changing emissions factors. The Trust will primarily benefit from the decarbonisation of the electricity grid as the carbon footprint of grid-based gas is unlikely to change significantly until the late 2030s.

In the Carbon Reduction Scenario, it is assumed that the Trust makes steady progress on tackling all aspects of its direct carbon footprint (scope 1 and 2 emissions). For example, as the Combined Heat and Power (CHP) units at EDGH and Conquest hospitals reach the end of their operating life it is assumed that they will be swapped out for alternative, low carbon heating solutions. However, in this scenario it is assumed that a significant reliance on natural gas will remain up until at least 2040 due to lack of viable, low carbon technologies that can meet the heat demands of an existing acute site at present. The Carbon Reduction Scenario shows the Trust's emissions on the basis that a number of the actions highlighted within the Green Plan are implemented over time, these are listed within our seven action plans in the body of the document.

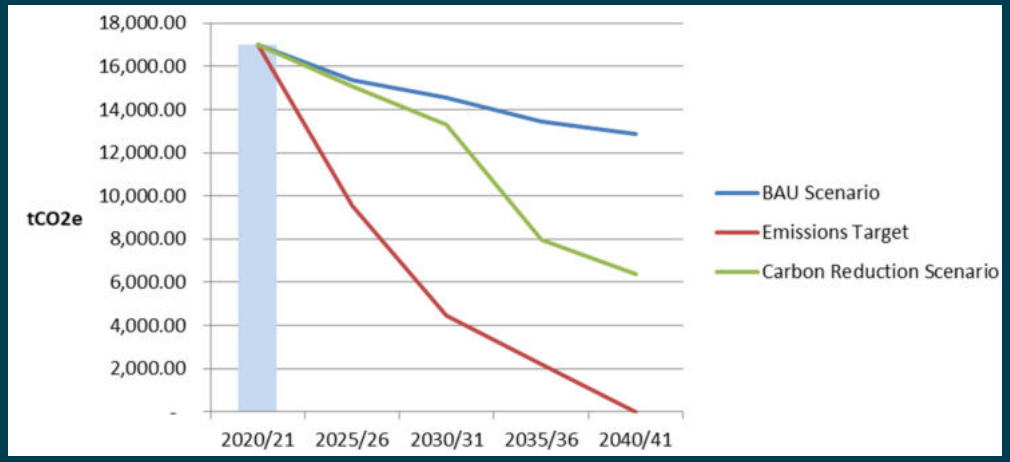


Figure 2: Carbon footprint of NHS in England, Delivering a 'Net Zero' National Health Service (2020)

Our approach to delivering Net Zero Carbon

Overall to meet our targets we need to look at four specific areas:

1. Minimising resource use – ensure that we use only what we need, this applies to all areas of our organisation, from clinical supplies through to paper and water use.
2. Reusing wherever possible – moving away from single use items to choose items which can be sterilised, laundered or reprocessed, reusing heat to pre heat hot water and reusing and redistributing furniture and other items instead of purchasing new.
3. Switching to greener alternatives – if we do need to purchase a new item - looking at lower carbon options wherever feasible, this would include lower carbon pharmaceuticals or moving to electric vehicles.
4. Offsetting – this is our last resort and should only be used for emissions which cannot be reduced using strategies 1-3. We will only offset our emissions through a national scheme or, local schemes which benefit our communities.

We will be partnering with an external provider to carry out detailed scenario modelling and produce a feasibility study enabling the Trust to map out a pathway for our hospitals to reach Net Zero Carbon by 2040.

How we will deliver: our approach

Through this Green Plan we aim to maximise the impact of our efforts through our Care Without Carbon framework.
This includes our new vision and aims for the programme, as well as our sustainable healthcare principles.

These sustainable healthcare principles are based on those developed by the Centre for Sustainable Healthcare and tackle two aspects of the problem. One is to optimise our level of activity through reducing the need for care and making our processes as efficient as possible; the other is to reduce the carbon intensity of the care we do need to provide.

Our new Care Without Carbon framework provides a comprehensive, integrated plan to demonstrate commitment to sustainability, reducing our impact on the environment to 2025 and beyond.

We've illustrated this in Figure X on the following page, showing how this links in to wider Trust strategic initiatives.

Fig X: Care Without Carbon framework

Our action plans

In the next section of this document, we set out our action plans for delivering against our vision, key aims – and our Net Zero Carbon targets.

Our eight 'elements' form our work streams and action plans, and have been updated since our previous strategy to reflect changes in the current landscape and our shift in focus towards the clinical aspect of care delivery.

These action plans set out our commitments in each area as well as a series of specific actions and the key success measures through which we will monitor our progress.

The elements ensure we continue to have an integrated and holistic approach to our sustainable healthcare programme. They are:

Evolving care: developing and enabling lower carbon, more sustainable models of care

Places: ensuring our workplaces are low carbon and protect local biodiversity whilst supporting wellbeing for staff, patients and visitors.

Culture: empowering and engaging people to create change towards our path to net zero.

Circular Economy: respecting our health and natural resources by creating an ethical and circular supply chain.

Journeys: ensuring the transport and travel needed between our care and our communities is low cost, low carbon and conducive to good health and wellbeing.

Wellbeing: supporting people to make sustainable choices that enhance their wellbeing.

Climate Adaptation: building resilience to our changing climate in Sussex.

Partnership & Collaboration: enhancing our impact by working with others.

Fig 5: The eight elements to support delivery on the new CWC strategic framework

Taking Action: Places

Ensuring our workplaces are low carbon and protect local biodiversity whilst supporting wellbeing for staff, patients and visitors.

Key success measure for 2025: 57% reduction in CO_2e against our 2013/14 base year.

Commitments

- We will decarbonise our estate in line with our carbon targets and wider sustainability goals, and develop robust data management and reporting systems to monitor and report on our progress.
- We will raise awareness of climate change and communicate progress with our own CO_2e reduction efforts to our Board, our staff, our patients, our carers and our community.

Actions to 2025

Carbon, energy and water

- Continue with the implementation of our Energy Performance Contract to deliver modernised heating, cooling and lighting systems to the Trust.
- Commit to and develop a long term strategy for becoming net zero carbon, in line with the Net Zero NHS Strategy, NHS Long Term Plan and Climate Change Act targets.
- Drive energy efficiency and CO_2e reductions through our Estates Strategy, setting challenging energy efficiency targets for all new premises least and achieving at least BREEAM Excellent standard for any new-build premises, aiming to exceed this with BREEAM Outstanding where possible.
- Develop a metering strategy to prioritise investment in Automatic Meter Reading (AMR) across our freehold estate, enabling improved carbon management and reporting.
- Benchmark our properties against national energy efficiency standards.
- Actively seek to develop a decarbonisation plan, using external funding opportunities where appropriate.
- Ensure the Building for our Future programme delivers best in class patient pathways and facilities which are energy efficient, sustainable and in line with our net zero commitments.

Taking Action: **Places**

- Work with EPC contractor to develop demand reduction strategies and move to low carbon technologies.
- Continue to evaluate water saving technologies and implement best in class projects where possible.
- Investigate and implement renewable technologies across the estate where appropriate to reduce carbon emissions and increase resilience against volatile price increases.
- Continue to purchase renewably backed (REGO) electricity.
- Continue to work with clinical teams in the anaesthetics department to continue to reduce the amount of carbon intensive anaesthetic gasses used across the Trust.
- Review and install renewable technologies as part of the plant upgrades where possible.

Working with our ICS partners

- Continue to investigate collaborative working opportunities across the whole ICS that will benefit the Trust, and the wider system as a whole.

Develop a more healthy working environment

- Review the current estates utilisation with a view to creating the most staff and patient friendly work environment possible, with adequate provision for break out spaces.
- Ensure any changes to our property portfolio provide ongoing improvements in the working environment for staff and adequate facilities for break and rest periods.
- Improve and promote green spaces on site, increasing biodiversity and considering accessibility and promotion to improve staff patients and visitor wellbeing.

Taking Action: Journeys

Ensuring the transport and travel needed between our care and our communities is low cost, low carbon and conducive to good health and wellbeing.

Key success measure to 2025 – a 57% reduction in all measureable travel CO_2e from a 2013/14 baseline.

Commitments

- We will decarbonise our travel and transport operations and minimise the environmental and health impacts associated with the movement of staff and materials.
- We will maximise our contribution to staff and patient wellbeing through active travel, supporting a shift to more sustainable travel options that deliver additional environmental and health benefits.

Actions to 2025

Staff travel

- Continue to embed a programme of flexible working within the Trust using MS Teams and home working to cut staff travel and make better use of our estate.
- Further develop our staff survey, analyse responses and map these against data on car parking to generate specific recommendations to improve active travel and reduce single occupancy vehicle travel.
- Evaluate the potential benefits for using a liftshare app to encourage staff to share their commute.
- Develop a Sustainable Travel Plan to minimise non-essential travel, decarbonise our essential travel and transport and support more active modes of travel across the Trust. This document will support the update of sustainable travel options including the use of e-bikes, bikes, electric and hybrid vehicles including pool cars.
- Produce a plan to install charging infrastructure on our main hospital sites starting with charging points for our owned fleet and aiming to include staff and eventually patient/visitor charging infrastructure.

Taking Action: Journeys

- In line with the NHS England/Improvement target, where outpatient attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely, resulting in direct and tangible carbon reductions.
- Implement a fully managed parking permit system which will restrict the travel of staff vehicles to site whilst offering active healthier options.

Trust fleet

- Review the current lease car providers to ensure best value and introduce an emissions cap across our fleet.
- Undertake a review of fleet vehicle procurement and deployment to maximise the utilisation of cleaner and more efficient vehicles.
- Continue to promote the use of our low emission pool cars as an alternative to grey fleet.
- Ensure, as a Trust we only lease or purchase that are ultra-low emission vehicles (ULEVs) or zero emission vehicles (ZEVs) by 2023/24 in line with the NHS England/Improvement target.
- Work with procurement to promote our lease cars scheme, focussing on electric and hybrid vehicles including promotion to new starters at the Trust.

Using technology

- Continue to roll out telehealth and health informatics technologies, enabling patients to receive consultations in their own homes and provide a more flexible and convenient service.

Working with our regional partners

- Work with our ICS partners and other local stakeholders to develop a regional approach to improving air quality.
- Work with local borough councils, transport operators, local employers and transport pressure groups to reduce the dependence on motor vehicles and to support low carbon travel alternatives.

Taking Action: **Circular Economy**

Respecting our health and natural resources by creating an ethical and circular supply chain.

Key success measure to 2025: achieve a 10% reduction in total annual waste production by weight.

Commitments

We will work with our suppliers to reduce the environmental impact of our supply chain wherever possible and work towards a circular economy.
We will demonstrate a commitment to ethical trade by integrating ethical trade principles into our core procurement practices.

In order to support a more circular economy in the Trust, we need to:

- Enable our procurement, clinical and waste services to work together and consider whole the lifecycle of a product when choosing the most sustainable options;
- Integrate sustainability criteria into our procurement decisions; and
- Redistribute products and materials at their end of use.

Actions to 2025

Waste management

- By April 2023 deliver a mandatory waste training module for staff, with the aim to improve waste segregation, recycling levels and legislative compliance.
- Measure and reduce the total volume of waste produced from a specific surgical operation by at least 10%.
- Avoid the disposal of 500 items per year by implementing an internal reuse system for products and equipment across the Trust.
- Achieve and maintain a 40% recycling target for our non-clinical waste.

Taking Action:
Circular Economy

- Deliver any remaining commitments within the NHS Plastics Pledge for single use plastic catering products by April 2022. Go beyond these commitments and set an annual target to measure and reduce the number of single use food containers and cups purchased by the Trust.
- Starting with our catering facilities segregate food waste as its own waste stream for onsite treatment or send offsite for anaerobic digestion or composting. Once established use this information measure and reduce food waste across the Trust.
- Between April 2022 and March 2023 communicate to staff 6 news items and rollout 3 posters with the aim to improve waste segregation across the Trust.
- Rollout a waste champions network with the aim to have one representative within each department. From April 2022 hold regular meetings to discuss waste management across the Trust.
- Audit, design and update waste signage and bin labels to ensure a consistent approach across the entirety of the Trust and to support the delivery of the key success measure.
- Achieve and maintain the proportions of healthcare waste segregation outlined by national NHS England & Improvement guidance - 60% low temperature incineration, 20% alternative treatment, 20% high temperature incineration.
- Develop and produce a set of monthly KPIs to track progress against the key success measure and other actions within the Green Plan as appropriate.
- Identify opportunities for reprocessing of metal instruments, medical devices, and walking aids.

Sustainable Procurement

- Using procurement data measure the carbon footprint of our supply chain and undertake a carbon 'hot spots' analysis to help prioritise areas for action. Develop a number of projects to address the carbon 'hotspots' starting with the most carbon intensive items, this should include working proactively with clinical teams and engaging in collaboratively with key suppliers.
- Develop our knowledge and understanding of ethical procurement opportunities within the NHS and put in place a programme of work to tackle key areas of impact.
- Revise the procurement policy to reflect the targets within this Green Plan ensure it is clear how and when sustainability considerations will be taken into account during the procurement process.
- Introduce clear sustainability criteria into tenders and new contracts, with evaluations taking into consideration environmental, social and economic outcomes.
- Continue to purchase 100% recycled paper and drive down paper use across the Trust through the implementation of smarter working practices and the use of electronically based clinical systems.

Work with the ICS and other partners

- Continue to work with ICS partners in the Surrey and Sussex Healthcare Waste Group to share best practice and collaborate.
- Continue to follow best practice through association with NPAG, Chartered Institute of Waste Management and continued professional development
- Integrate sustainability objectives into ICS wide procurement decisions.
- Work with our ICS partners to develop an approach to plastics reduction across the region.
- Examine the viability of a regional reuse project.

Taking Action: Culture

Empowering and engaging people to create change towards our path to net zero.

Key success measure for 2025: 100% of Trust staff engaged with sustainability.

Commitments

- We will inform, empower and support our workforce to take action to deliver high quality care today that does not compromise out ability to deliver care in the future, ensuring this becomes integral to the way we operate.
- We will embed sustainability into our HR policies and practices and ensure that staff development processes support a shift to more sustainable and resilient healthcare delivery with clear senior leadership.

Actions to 2025

Staff engagement

- Continue to embed a programme of flexible working across the Trust.
- Continue to develop our approach to staff engagement, link in with the Trust's Green Champions network to facilitate dissemination of campaigns and communications relating to sustainability.
- Support the Green Champions network to deliver sustainability initiatives within their respective areas of the Trust.
- Provide internal communications materials to promote this Green Plan and support implementation of action plans across the seven elements of Care Without Carbon.
- Identify opportunities for an annual sustainability award as part of our staff awards.
- Include sustainability as a topic within the induction process and STAM training.
- Review our suite of internal training to find opportunities to include sustainability.

Taking Action: **Culture**

People processes

- Develop a sustainability training programme for the Trust, linking in with the Quality Improvement team and other internal training providers to ensure sustainability is linked with other learning programmes.
- Ensure all events are conducted in a low carbon manner, virtually where possible. If events are held, ensure that food and drinks offerings are ethically sourced and local where possible and printed materials are kept to a minimum.

Working with our ICS and other partners

- Work with ICS partners to identify and develop opportunities to coordinate staff engagement and behaviour change activity.
- Participate in national sustainability campaigns such as NHS Sustainability Day and Clean Air Day.

Taking Action: Wellbeing

Supporting people to make sustainable choices that enhance their wellbeing.

Key success measure for 2025: reduce sickness absence rate to 3% and improve staff survey results relating to wellbeing.

Commitments

- Through our Health and People Plan and Programme, support staff coping with pressure to improve our mental and physical health and wellbeing.
- We will reduce sickness absence and workplace stress and measurably improve the overall health and wellbeing of our workforce.

Actions to 2025

Measurement and reporting

- Undertake an analysis of wellbeing data across the Trust to support the development of our Wellbeing Strategy. Identify ways to improve this data set including reviewing the need for a specific wellbeing metric to provide more specific data to support our programme.
- Maximise the use of the staff survey, ensuring analysis feeds directly into our People Plan.

Staff wellbeing

- Undertake a review of our Wellbeing Strategy with colleagues to identify sustainability opportunities under each of our seven priorities.
- Ensure that the goals in this strategy are reflected in the Trust's Wellbeing Strategy and associated action plan.
- Through our Building for our Future programme, create facilities that enhance staff wellbeing.

Element:
Wellbeing

- Develop key areas of work to support the targets to reduce staff sickness and improve wellbeing, for example:
  - Supporting the Travel Smarter September regional air pollution campaign run by Care Without Carbon.
  - Supporting internal team activities or challenges such as implementing walking meetings or the Dare to Care Cycle Challenge.
  - Continue to progress work with Estates to develop and improve our onsite green spaces and courtyard gardens to support staff wellbeing, including consideration of break spaces, spaces for outside meetings.
- Work with local councils and stakeholders to develop Wellbeing Maps for each of our sites, identifying key facilities i.e. green spaces and walking routes, cycle and public transport facilities and sustainable food options.

Communication and engagement

- Through our Wellbeing Group , use our staff communications and engagement on wellbeing issues as an opportunity to promote the links between the environment, productivity and health and wellbeing.
- Link in with our Green Champions group and sustainability engagement programme to ensure wellbeing messages link with the wider wellbeing programme. For example, offering staff advice on areas such as hydration, active travel, flexible working and mental resilience.

Volunteering and fundraising

- Identify opportunities for our volunteering days programme to support our sustainability goals, both for staff and for external organisations.

Working with our ICS and other partners

- Work with our partners across the ICS to identify opportunities for collaboration on wellbeing, including developing a shared wellbeing metric and coordinated wellbeing campaigns.

Taking Action: Climate Adaptation

Building resilience to our changing climate in Sussex.

Commitments

- We will identify and map climate change risks for our organisation, our patients and our communities.
- We will work with our ICS partners to develop an action plan to address climate adaptation in Sussex, together.

Targets

- Undertake a climate impact assessment and integrate findings into our business continuity procedures and longer term strategic health planning.
- Ensure climate change adaptation is a consideration throughout our business processes and service planning.

Actions to 2025

ESHT

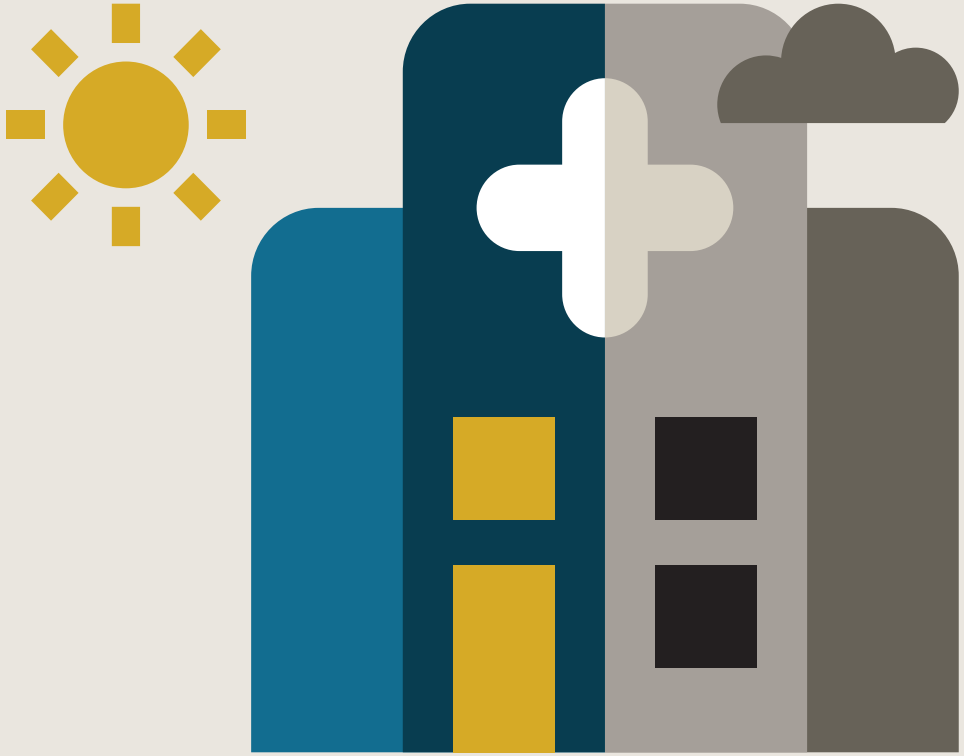
- Integrate climate adaptation into the business continuity planning process, linking with the EPRR Steering Group.
- Map the corporate risk register against our climate related risks.
- Integrate climate change adaptation into our incidents and risks evaluation process with support from colleagues in EPRR.
- Communicate to our staff and our patients on climate adaptation, what it means for them and how it links to healthcare with a focus on the impacts to ESHT.
- Measure instances of heatwaves at the Trust and report these through the Greener NHS quarterly reporting.
- Ensure our Building for Our Future Programme takes into consideration climate change adaptation early in its development.

Taking Action:
Climate Adaptation

- Ensure all our buildings (leased and owned) are fit for the future by planning adaptation measures such as solar shading, Sustainable Urban Drainage Systems, etc. in line with the findings of the Climate Change Impact Assessment.

ICS

- Develop a Sussex-wide Climate Change Impact Assessment with partners in the ICS to understand the impact of climate change on our patients and services.



Taking Action:
Partnership & Collaboration

Enhancing our impact by working with others.

Commitments

- We will work in partnership within our local Integrated Care System and the wider SE Region to decarbonise our local health economy through collaborative projects and approaches.
- We will share best practice and collaborate with others locally and nationally to maximise our opportunity to learn from others.

Targets

- To deliver a minimum of three projects to 2025 in partnership with other organisations.
- To speak at a minimum of three events to 2023 in support of collective action by healthcare organisations to address the environmental crisis.

Actions to 2025

- Integrate sustainable quality improvement principles into our QI programme /measure the environmental benefits of our QI projects.
- Ensure our new strategy is recognised and supported across other Trust strategies, including our clinical strategy and digital transformation.
- Work with colleagues in research and development to measure the benefits of innovative research at the Trust.
- Work with colleagues in our Local Authorities on projects relating to active travel, improving air pollution and improving charging infrastructure.

ICS

- Work with colleagues in research and development to measure the benefits of innovative research at the Trust
- Link with the SE region on key priorities in sustainability including medicines, digital transformation and transport.

Taking Action: Evolving Care

Developing and enabling lower carbon, more sustainable models of care.

Commitments

- To integrate our sustainable healthcare principles at a strategic level across the Trust and our wider ICS partners.
- To support our clinicians to deliver against these principles by making lower carbon, more sustainable choices when delivering care day-to-day.

Targets

- Clinical sustainability specialists in place and delivering change programmes in at least three of our clinical services by 2024.
- SHCP ICS and NHS providers to have integrated sustainable healthcare principles at a strategic level, with a delivery programme in place by 2024.

Actions to 2025

ESHT

- Identify a senior level clinical sponsor for sustainability
- Continue to drive the great work which has been done to reduce Desflourane in theatres.
- Engage with colleagues in maternity to investigate the opportunities for reducing nitrous oxide emissions to atmosphere.
- Evaluate our use of Metered Dose Inhalers and look for ways to reduce including linking with Primary Care.
- Work with colleagues in Pharmacy across the ICS to reduce waste and increase medicines optimisation.
- Review the opportunities for sustainability to be included in our junior doctors training.
- Evaluate the sustainability benefits of digital outpatient appointments at the Trust to date.

Taking Action:
Evolving Care

- Evaluate the use of PPE at the Trust, investigate the opportunities for reusable PPE where appropriate.
- Investigate the use of single use instruments across the Trust.

ICS

- Evaluate the capacity of our HSDU and the opportunities to partner with other organisations in the ICS to provide sterilisation services and reduce single use items.
- Work collaboratively with colleagues in Pharmacy across our ICS to evaluate the carbon impact of pharmaceuticals outside of anaesthetic gasses and Meter Dose Inhalers.

Holding ourselves to account: governance

It is fundamental to being a sustainable organisation that we operate with integrity and responsibility. Effective governance is critical to ensuring that we live up to our vision, and deliver on this strategy.

Our Board lead for Sustainability and Net Zero is Chris Hodgson, Director of Estates and Facilities.

Delivery of this strategy will be overseen by a new Green Plan Steering Committee, led by our Board Lead for Sustainability and Net Zero, and reporting into our Senior Leaders Forum.

The CWC team will support delivery of the Green Plan as required, including providing support to other specialist and enabling departments across the organisation.

Measurement and reporting

Over the course of the first 12 months of this programme, our reporting mechanisms will be reviewed, including the development of new metrics in line with our three core principles.
To achieve excellence in reporting for sustainability, we will:

- **Deliver quarterly performance reports to our Senior Leaders Forum.**
- **Deliver performance update reports to Board every 6 months and develop and gain Board approval for a 12 month sustainability programme action plan each year.**
- **Publish a summary of our progress in our Trust Annual Report.**
- **Meet the national and regional reporting requirements from NHSEI and For a Greener NHS as they develop.**

To find out more about us, contact:

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Freedom to Speak Up Guardian Report

Meeting information:			
Date of Meeting:	8th February 2022	Agenda Item:	11
Meeting:	Trust Board	Reporting Officer:	Steve Aumayer

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

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

Summary:

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

This report seeks to provide an overview of the activity of the Freedom to Speak Up Guardians and includes the nature of concerns raised and an analysis of trends. Due to Covid-19 the FTSUG's have not attended the Board but provide assurance of ongoing work. Data for all 2020-2021 quarters are included for information and oversight. Most recent data Quarters 1, 2 and 3 from April 2021-December 2021 are included. Data has been consistently uploaded to the National Guardian's Office in line with reporting requirements. Themes at ESHT are consistent with the themes reported nationally. The key themes are Bullying and Harassment and Systems and Process. Nationally, Patient Safety and Bullying and harassment have reduced. Nationally there were just over 30% of cases raised in 2020/21 involving an element of bullying and harassment. This was a 5.8 percentage point decrease from 2019/20 and continued the downward trend seen since 2017/18.

ESHT figures for cases raised to the Guardians with an element of bullying and harassment are sadly higher than the national rate at 38% for 2020/21 (Nationally 30.1%) This higher figure is concerning but reflects the staff survey results in relation to Bullying and Harassment.

Staff Survey Results 2020

Q13b

In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from managers?

2016: 14.8% 2017: 13.5% 2018: 12.7% 2019: 12.0% 2020: 12.4%
National Average 12.6%

Q13c

In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?

2016: 19.5% 2017: 20.4% 2018: 20.6% 2019: 21.2% 2020: 21.5%
National Average 19.8%

The National Guardian's Office published its Annual Report for 2020 in March, highlighting the progress of Freedom to speak up in health. The former Secretary of State the Rt Hon Matt Hancock MP said "I remain determined in my commitment to ensure that staff feel they can speak up and that their concerns will be taken seriously." Annual-Speaking-Up-Data-Report-2020-21.pdf (nationalguardian.org.uk)

Overview of Activities Undertaken

Speaking up as 'business as usual' means that all those in the workplace feel confident and safe to speak up about anything which gets in the way of them doing a good job. The National Guardian office refer now to "workers" rather than staff or employees so that all those in the workplace whether they are a volunteer, contractor , employee or apprentice feel confident to speak up. Speaking up is a "gift"; it is an opportunity to learn and improve. The FTSUG's seek assurance from the Board that any issues raised by workers should be in accordance with policies, procedures and good practice. Workers should be thanked for speaking up and effective communication should be promoted to manage expectations effectively. Workers who speak up should be treated in accordance with the values of ESHT. The FTSUG's seek to continue to support groups potentially facing barriers to speaking up, working in partnership with colleagues. Workers should be encouraged to speak up openly, confidentially or anonymously and the FTSUG's appropriately protect workers' confidentiality and demonstrate understanding and empathy for the needs of individuals. Learning_from_Case_Reviews.pdf (nationalguardian.org.uk)

Recent case review from Blackpool enables ESHT to look at any recommendations and best practice guidance to support Speaking up at ESHT.
Blackpool_Teaching_Hospitals_FT_case_review.pdf (nationalguardian.org.uk)

A recent review of West Suffolk NHS Trust is available and the findings of the review illustrate what happens when speaking up is viewed as a threat, when those who speak up are the focus, rather than the matters raised.
West Suffolk Review (england.nhs.uk)

Freedom to Speak up e-learning modules have been developed in association with Health education England (HEE). Speak up, Listen up, Follow up online Speak Up training in ESHT is now available for core workers and managers, and a further module for senior leaders will be launched shortly. The Guardians are aware that this is available via ESR, but not currently considered mandatory. Recent ESR figures at ESHT show only 18 staff have undertaken core training in Speaking Up. If this was mandated, it would give assurance that staff at all levels (including the training for senior leaders soon to be launched) know how to speak up and how to respond. Speaking up forms part of the Well Led domain for CQC inspection. It is the opinion of the National Guardian's Office that all workers should be required to complete training on speaking up and that it should be treated with parity to other mandatory training such as risk management, information management and safeguarding. The Guardians recognise the delicate balance between meeting the needs of mandatory training and the time allocation for staff to undertake this against the impact on service. Guardians will need to consider how the accessibility and uptake of the online training programme could be improved upon and would welcome suggestions in this regard.

Freedom to Speak Up - eLearning for healthcare (e-lfh.org.uk)

2. REVIEW BY OTHER COMMITTEES

Reviewed by the People and Organisational Development (POD) Committee on 20 January 2022.

3. RECOMMENDATIONS

The Board is asked to continue to support the promotion of speaking up as everyday business and to ensure that staff will not face detriment for raising genuine concerns. All staff at ESHT should feel safe to speak up, including temporary workforce and volunteers.

The Board is asked to receive assurance that effective speaking up arrangements are in place to ensure learning and continual improvement, which will protect patients and improve the experiences of NHS workers. We need to continue to promote that Managers and Senior Leaders at ESHT should see concerns as a gift and an opportunity to commit to review concerns in a timely way to enable support, feedback and, where appropriate, solutions. When concerns are raised, staff are thanked and feedback is given to enable learning and improvement.

EXECUTIVE SUMMARY

Freedom to Speak up Guardian Report: February 2022

Purpose

Freedom to Speak Up Guardians are substantively employed at ESHT to support staff to raise concerns when they feel that they are unable to in other ways, and to promote a healthy speaking up culture. The Guardians were recruited and trained in accordance with the recommendations from the Francis Report (2015) and the National Guardian's office. Freedom to speak up is part of the NHS Standard Contract and the CQC well-led inspection. The first Guardian, Ruth Agg, was appointed in 2016. In 2020, Ruth Agg retired and returned to her post part time and was joined by Dominique Holliman. Ruth and Dominique now share the role of Speak Up Guardian across the Trust and carry an active caseload of staff they are supporting. Both Guardians are line managed by the Chief Executive, in line with National Guardian Office guidance.

1) Background

There are now over 800 Freedom to Speak Up Guardians in nearly 500 organisations, including the NHS and independent sector organisations, clinical commissioning groups, hospices, professional bodies, regulators and elsewhere. The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015). These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result. The National Office leads, trains and supports a network of Freedom to Speak Up Guardians in England and conducts case reviews of organisations when it appears that speaking up has not been handled according to best practice.

ESHT Assessment of cases

ESHT is categorised as a medium sized organisation by the National Guardian Office. The Guardians are required to submit quarterly data stating the number of people who access the Guardians, their professional level, the themes raised, the number of those who cite reprisal, the number who elect to share their concern anonymously and whether they would speak up again. In 2021, the National Guardian's Office introduced a category entitled 'worker safety' and quarterly data relating to cases citing worker safety as the primary concern are now collated.

Caseload data from April 2020 to March 2021

Category	Q1	Q2	Q3	Q4	Category Totals
Behavioural / Relationship	26	11	11	19	**67**
Bullying / Harassment	11	4	7	7	**29**
Discrimination Other	0	1	0	1	**2**
Discrimination Racial	1	0	2	0	**3**
Discrimination Sexual	1	0	0	0	**1**
Infrastructure / Environmental	0	0	2	1	**3**
Leadership	0	3	0	1	**4**
Not Known	1	0	0	1	**2**
Patient Safety / Quality	2	0	1	2	**5**
Reprisal	0	1	0	0	**1**
Staff Safety	10	1	3	2	**16**
System / Process	44	27	26	22	**119**
Violence and Aggression	1	1	1	0	**3**
Quarter Totals	**97**	**49**	**53**	**56**	**255**

Caseload Data from April 2021 to December 2021

Category	Q1	Q2	Q3	Category Totals
Behavioural / Relationship	15	7	13	**35**
Bullying / Harassment	8	12	6	**26**
Cultural	1	1	0	**2**
Discrimination Disability	0	1	0	**1**
Discrimination Other	0	2	2	**4**
Discrimination Racial	0	0	2	**2**
Infrastructure / Environmental	0	1	0	**1**
Leadership	0	2	1	**3**
Not Known	1	2	0	**3**
Patient Safety / Quality	3	7	6	**16**
Reprisal	0	0	1	**1**
Staff Safety	0	2	1	**3**
System / Process	25	24	19	**68**
Violence and Aggression	1	0	1	**2**
Worker Safety	4	2	0	**6**
Quarter Totals	**58**	**63**	**52**	**173**

1.1 Impact of Covid

The Covid-19 pandemic undoubtedly increased the number of staff who came forward to share their concerns. Nationally, nearly 10,000 cases were brought to guardians in the first 6 months of the pandemic. Quarter 1 of 2020 saw 97 cases recorded in ESHT, with more than a third of those being raised by registered nurses and midwives. Nurses and midwives also accounted for the biggest proportion of cases raised nationally by any professional group in 2020/21.

Since then, the numbers at ESHT have remained high with between 49 and 63 cases per quarter. Nurses and healthcare assistants were the professional groups with the highest contact rates, followed by administrative and clerical staff. Quarter three, from October to December 2020 – when the second wave of Covid-19 was at its height – saw 5,334 cases reported to Freedom to Speak Up Guardians. This was the highest number reported in any single quarter since the National Guardian's Office was established in 2016. The FTSUG's also received a significant number of calls in relation to the mandated vaccinations for staff in the community attending care homes and Nursing homes. These concerns were fed through to HR and Staff Engagement and the FTSUG's are supporting the mandated Covid Vaccination Group.

1.2 Anonymous cases

According to the National Guardian's Office, there has been a six percentage point decrease in the proportion of cases being raised to guardians anonymously since 2017. This is encouraging and perhaps suggests that people are less fearful of reprisal in the workplace.

In ESHT we are following this national trend, with anonymous respondents reducing from 3% to 1.5% over the same period.

1.3 Patient safety and quality

In 2020/21, 18% of national cases involved an element of patient safety/quality. This was a five-percentage point decrease from 2019/20.

In ESHT, our cases involving an element of patient safety/quality have also reduced from 5.5% in 2019/20 to 2% in 2020/21.

1.4 Bullying and harassment

Nationally, there were just over 30% of cases raised in 2020/21 involving an element of bullying and harassment. This was a 5.8 percentage point decrease from 2019/20 and continued the downward trend seen since 2017/18.

ESHT figures for cases raised to the Guardians with an element of bullying and harassment are sadly higher than the national rate at 38% for 2020/21. This higher figure is concerning but it does represent a 25 percentage point decrease from 2019/20 and the Guardians are working closely with staff engagement and wellbeing to identify proactive measures to continue to address this.

The staff survey demonstrated that bullying, harassment and abuse at work from other colleagues has continued to be above the national average which was 19.8% for 2020 with ESHT at 21.5%. This has been a continued concern since 2017 and is a Trust priority.

Assurance can be given that harassment, bullying or abuse at work from managers still remains below the national average. In 2016, ESHT was 14.8% and significant improvement is indicated from the 2020 score of 12.4%.

1.5 Detriment for speaking up

Disadvantageous and/or demeaning treatment for speaking up (often referred to as 'detriment') may include being ostracised, given unfavourable shifts, being overlooked for promotion or moved from a team. Detriment for speaking up was indicated in just over three per cent of cases nationally (632).

The proportion of cases involving detriment has gradually decreased from 2017/18 (5.1%) to 2020/21 (3.1%)

ESHT figures for detriment have been consistently lower than the national data with just 0.4% of respondents citing detriment in 2020/21.

2) Overview of role

The Trust encourages workers to raise and share concerns with line managers, clinical leads and supervisors, who are well placed to commit to review concerns in a timely and supportive way. A key question we ask is whether the worker has raised their concerns before. On our current caseload, the majority of those approaching the Guardians have already raised their concerns elsewhere. We recognise the need to continue to encourage staff to raise their concerns through the usual reporting channels and to equip line managers with the skills to respond to these.

Due to the Covid-19 infection control risk assessments, Guardians were not present in clinical areas but were available via their mobiles, personal email, Microsoft Teams or the generic speak up inbox. As restrictions eased, regular visits to clinical areas resumed. During Speak Up Month in October, we invited workers to access a series of weekly lunchtime, online webinars related to the topic of speaking up. Regular liaison with the staff engagement and wellbeing team, chaplaincy teams and pastoral fellows also provide valuable soft intelligence to help identify areas which may benefit from targeted support.

Regular walkabouts have taken place at Eastbourne & the Conquest, Bexhill Hospital, Rye Hospital and the Irvine Unit – with repeat visits to some areas. Areas for repeat visits and increased visibility have been determined by a variety of factors, including the number of concerns raised in any one area, individual or team requests for support or discussion and themes arising from Datix or shared intelligence from liaison with other departments.

Roller banners advertising our contact details are prominently displayed around the Trust and information boards have been erected at key events, such as induction meetings. Speak up newsletters have been written and circulated trust wide and 'speak up packs' produced and distributed to our new international staff.

We have promoted our role at staff network groups, the Trust ambassador meetings and steering groups including the pastoral steering group, the staff loss and bereavement group and violence and aggression group.

Some Guardian hours were redeployed during the pandemic to support the Covid-19 vaccination enquires team, manning the wobble room, facilitating virtual support sessions for shielding staff and supporting the Occupational Health team.

Whilst concerns raised in early 2020 were largely related to PPE, risk assessments and redeployment, these concerns became less prominent and we noted increasing issues of poor conduct – certainly heightened by staff anxiety and fatigue.

As the pandemic then continued through waves, concerns regarding self-isolation, management of caring responsibilities and working with family self-isolating and the ensuing childcare disruptions became more frequent. A number of workers perceived inconsistencies in the way that working from home and leave were applied across the divisions. We endeavour to work closely with our HR business partners to seek assurance and resolution in these instances.

Bereavement, loss and the fears of our international staff for the wellbeing of their relatives abroad compounded an already fatigued workforce and we noted a worsening of behaviours and an increasing number of incidents of micro-aggression between staff. The Guardians meet regularly with divisions and HR business partners to review the Datix incidents citing staff on staff aggression to ensure timely and robust responses.

Wherever possible, the Guardians promote local and timely resolution, enabling staff to safely and professionally articulate their concerns, providing scaffolding to enable challenging, respectful conversations to take place. We recognise that persistent poor conduct negatively impacts upon individual and team wellbeing and functioning. We aim to give consistent support, intervention and advice as well as signposting to mediation and/or wellbeing services.

3) Our speak up culture

The Freedom to Speak Up index survey (ftsu_index_report_2020.pdf (nationalguardian.org.uk) is a metric widely used to measure the speaking up culture of an organisation. The results of the index are based upon questions extracted from the staff survey. The Freedom to Speak Up (FTSU) Index is one of the indicators that can help to build a picture of what the speaking up culture feels like for workers. It is a metric for NHS Trusts, drawn from four questions in the NHS Annual Staff Survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns, and if they agree they would be treated fairly if involved in an error, near miss or incident

The latest survey showed that ESHT achieved an index score of 80%; this has remained consistent for the last 2 years. The Guardian's office suggest that a score above 70% is indicative of a healthy speak up culture. Since the introduction of Speak Up Guardians, the index has improved and risen 3.7 percentage points nationally from 75.5% in 2015 to 79.2%.

For the first time in 2021, the NHS staff survey has included a question which asks respondents if they feel safe to speak up about anything that concerns them in their organisation, with 66% nationally 'agreeing' or 'strongly agreeing' with this statement. Within ESHT, our score for this question was 66.9%.

It is of note that the speak up index survey showed a marked disparity between the highest performing organisations and the lowest, with a 21% point difference between the highest and lowest scoring trusts. Overall, the region with the highest index score was the South East.

The national guardian survey tells us that students and junior doctors are less likely to speak up –evidence suggests that this may be due to fear of reprisal or a perception that speaking up may negatively impact upon career progression or successful attainment of their academic programmes.

The Guardians have met with the Pastoral Fellows and attend the pastoral steering group. We will continue to work closely with the fellows to ensure that junior doctors are familiar with the speak up process. Efforts are made to ensure that they are comfortable to raise and share concerns, and any barriers to speaking up are tackled.

The Guardians have delivered sessions at the University to capture 'soon to qualify' students of nursing before they start their first employment. It is anticipated that this will further embed our speaking up culture. We anticipate supporting induction of student midwives.

4) Feedback

Guardians seek feedback from service users and report to the national office as to whether people answer 'yes', 'no' or 'maybe' to the question posed "Would you speak up again?" Following the closure of a case, an online anonymous feedback survey link is sent regarding their experience of the Guardians. This captures opinion as to whether the Guardians responded in a timely manner and were easy to access. It also includes how well the issue was listened to, supported and resolved, along with whether the person perceived that they suffered any reprisal as a result of speaking up and if they would recommend the service to a colleague. Free text fields for them to leave further comments are provided.

Since the start of 2020, over 84% of workers who gave feedback to Guardians nationally said that they would speak up again. In ESHT, our percentage was higher with 97% of respondents saying that they would speak up again.

The FTSUG's at ESHT also offer an online survey, which is anonymous, to seek feedback and any learning.
Speak Up Guardian (onlinesurveys.ac.uk)

Key questions

Have you raised your concerns (with your manager, supervisor or lead) before contacting the FTSUG?

A significant number of staff had raised their concerns prior to seeking support from the FTSUGs. Staff continue to be encouraged to raise concerns with managers, leads and Supervisors. ESHT needs to ensure managers and leads respond in a timely way to concerns. This enables review, support and solutions to move forward, as well as a reduction in staff who contact the FTSUG's as a result of not perceiving that their concerns have been reviewed or supported.

Did you feel supported before you contacted the FTSUG? If not, give any comments

Manager was not forthcoming with response to concerns raised about support for return to work.

Prior to speaking to the Speak Up Guardian, I felt that I had no voice within a grievance process.

Felt that the trust wasn't listening or understanding our situation. I was made to feel like we were making a fuss. The process was complicated & the Speak up Guardian enabled the facilitation and identification of the problem & who would be able to resolve the situation.

Person contacted prior to the speak up guardian was a senior manager who dismissed the team's concerns with a curt email and we were told to 'rein it in and get on with it!'

Would you speak up again? Please add any comments

At first, I was deeply distressed by this incident and it was impacting severely on my mental wellbeing. I felt it was concerning that my line manager could use such damming comments and I could not approach this person. Eventually, with the backing of our Speak Up Guardian, I was able to approach a more senior line manager who responded very positively to my anxiety and dealt with the matter very effectively.

Poorly managed processes and procedures need to be brought of the attention of leadership.

The Speak Up Guardian has been an invaluable resource for me. I do not think I would have coped physically or emotionally and remained in post without her support. The support is ongoing and will facilitate policy change going forward. I cannot thank FTSUG enough for her time, understanding, knowledge, support and excellent advice always given within our professional code of conduct and that of the Trust values.

The guidance/advice I received in how best to deal with the inappropriate behaviour of a colleague toward me was really helpful in finding a positive resolution – I now have a good working relationship with my colleague plus I feel more confident as a lead clinician in our team that I have the skills to deal with challenging behaviour from any colleagues if it were to happen in the future. Thank you so much.

The FTSUG has been the reason we as a team have not walked away from our jobs, which at times we have all felt like doing because of the intolerable and intimidatory situation we found ourselves in. She was both constructive and positive with her advice, actioned what she said she would in a timely manner, kept in regular contact with us and above all made us feel that we were being fairly 'listened' to and not dismissed as 'non-management trouble makers.' The problem has been resolved and as a team we are now motivated and working positively to restore the service to being both safe and effective. The fear and dread of coming into work each day that we experienced for two years has been replaced with hope and a keenness to move forward.

The Speak Up Guardian made the significant difference when I felt ready to walk away from my job as I felt I had nothing left with no support. It really was that bad. The support and listening she provided enabled me to stay functional at work until I could (with her support) work through a difficult time. She made time for me when no one else would, which is really sad in light of Trust Values.

I felt hugely supported by the FTSUG and she really listened to me. She was extremely kind and very clear about what could be done. I liked being given different options to resolve the incident.

It is a very important part of a support network that staff really need – where you can express feelings/concerns without fear of reprisal.

5) Learning and Improvement

There was a planned workstream for ESHT Guardians to regularly meet with HR business partners and divisions to review Datix incidents, including those where staff behaviours have not been in accordance with Trust values. The aim of these is to ensure consistency in reviewing conduct, behaviour and bullying incidents, including discrimination. These meetings continue to be a challenge due to organisational pressure but should support learning throughout the organisation.

Regular meetings with HR business partners, OD and staff engagement, occupational health and pastoral fellows facilitate the sharing of soft intelligence regarding staff wellbeing, patterns and trends. Walkabouts also enable the Guardians to informally drop in to acute and community areas to speak directly with staff and promote the speak up culture.
Given the national increase in appointment of Guardians, this affords an opportunity for the ESHT Guardians to network locally and nationally across all sectors, sharing examples of practice and looking at comparable data. We have attended online regional and pan-sector meetings, and participated in case reviews and webinars delivered by the national guardian office.

The Guardians have also had some interim managerial support from Staff Engagement Lead, Lorraine Mason, who has supported 1-1 and wellbeing checks in recent months.

Key Priorities

- Review of the Freedom to Speak up review tool for NHS Trusts with the Executive team self-review-tool-for-nhs-trusts-and-foundation-trusts-4.docx (live.com) There is guidance for this for the Executive team to support the Board to reflect on its current position to meet the expectations of NHS England and NHSI and the National Guardian office.

  Report template - NHSI website (nationalguardian.org.uk)

- Improving an ongoing culture where staff at ESHT raise concerns as part of everyday business and do not fear any detriment.
- Increasing training for assurance that ESHT staff can speak up and that managers and leads will respond in a timely and supportive way.
- Improving learning from FTSUG cases and sharing within the organisation
- Updating website with resources and guidance for all staff groups to support speaking up.
- Refreshing of commitment to speaking up at ESHT with Senior Managers and leads and Executives.

Learning from FTSUG cases

- Escalation areas and maintaining patient safety and wellbeing.
- Recurrent themes regarding perceived bullying and harassment resulting in formal processes
- Responding to incident concerns in relation to conduct, bullying and harassment to ensure timely response and support to staff members by escalation to appropriate lead to review.
- Recruitment concerns
- Investigations and supporting staff

Gender Pay Gap

Meeting information:			
Date of Meeting:	8th February 2022	Agenda Item: 12	
Meeting:	Trust Board	Reporting Officer: Steve Aumayer, CPO	

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

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

Summary:

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

This report informs the Trust Board on findings in the Gender Pay Gap report.

2. REVIEW BY OTHER COMMITTEES

People & Organisational Development (POD) Committee.

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

The Trust Board are asked to note and accept the contents of this report

EXECUTIVE SUMMARY

Introduction
Gender pay reporting legislation requires employers with 250 or more employees to publish statutory calculations every year showing how large the pay gap is between male and female employees. There are two sets of regulations. The first is mainly for the private and voluntary sectors (that took effect from 5 April 2017) and the second is mainly for the public sector (that took effect from 31 March 2017). Employers have up to 12 months to publish their gender pay gaps.

The results must be published on the employer's website and a government website. They must, where applicable, be confirmed in a written statement by an appropriate person such as a Chief Executive or Chief Peoples Officer.

Gender pay reporting is different to equal pay- equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The gender pay gap shows the difference in the average pay between all men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate there may a number of issues to deal with, and the individual calculations may help to identify what those issues are.

The NHS terms and conditions of service handbook contain the national agreements on pay and conditions of service for NHS staff other than very senior managers and medical staff. Job evaluation (JE) enables jobs to be matched to national job profiles or allows trusts to evaluate jobs locally, to determine in which Agenda for Change pay band a post should sit.

2. Gender Pay Gap Indicators

An employer must publish six calculations showing their:
1. Average gender pay gap as a mean average
2. Average gender pay gap as a median average
3. Average bonus gender pay gap as a mean average
4. Average bonus gender pay gap as a median average
5. Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
6. Proportion of males and females when divided into four groups ordered from lowest to highest pay

To support the data a three year comparator report has been created to monitor trends.

2.2 Average gender pay gap as a mean average

Agenda for Change and Medical & Dental	Male	Female	% diff
Agenda for Change - Mean hrly rate 31/3/19	£14.05	£14.41	**-2.5%**
Agenda for Change - Mean hrly rate 31/3/20	£14.41	£14.81	**-2.7%**
Agenda for Change - Mean hrly rate 31/3/21	£15.02	£15.22	**-1.2%**
Medical & Dental - Mean hrly rate 31/3/19	£36.66	£29.97	**18.2%**
Medical & Dental - Mean hrly rate 31/3/20	£36.61	£30.50	**16.7%**
Medical & Dental - Mean hrly rate 31/3/21	£38.46	£31.15	**19.0%**

The percentage difference for Medical & Dental staff has increased by 2.3% in 20/21 whilst the difference for Agenda for Change staff, where female mean pay is higher than male, has reduced by 1.5% in the last year

2.3 Average gender pay gap as a median average

Agenda for Change and Medical & Dental	Male	Female	% diff
Agenda for Change - Median hrly rate 31/3/19	£12.01	£13.10	**-8.3%**
Agenda for Change - Median hrly rate 31/3/20	£12.38	£13.41	**-7.7%**
Agenda for Change - Median hrly rate 31/3/21	£13.04	£13.79	**-5.4%**
Medical & Dental - Median hrly rate 31/3/19	£34.93	£26.49	**24.2%**
Medical & Dental - Median hrly rate 31/3/20	£34.58	£27.29	**21.1%**
Medical & Dental - Median hrly rate 31/3/21	£38.65	£27.10	**29.9%**

The percentage difference for Medical & Dental staff has increased by 8.8%, in 20/21, whilst the difference for Agenda for Change staff, where female median pay is higher than male, has reduced by a further 2.3%. .

2.6 Average bonus gender pay gap as a mean average

	Male	Female	% diff
Mean bonus payment - 31/3/19	£14,196	£10,570	**25.6%**
Mean bonus payment - 31/3/20	£14,449	£10,087	**30.2%**
Mean bonus payment - 31/3/20	£13,233	£10,509	**20.6%**

The gender pay gap, in respect of mean average, has reduced by 9.6% since 31/3/20

2.7 Average bonus gender pay gap as a median average

	Male	Female	% diff
Median bonus payment - 31/3/19	£9,048	£9,048	**0.0%**
Median bonus payment - 31/3/20	£9,048	£9,048	**0.0%**
Median bonus payment - 31/3/21	£8,596	£9,048	**-5.3%**

The gender pay gap, in respect of median average, has increased by 5.3% so that the female median bonus payment is 5.3% higher than the male.

2.8 Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment

Date	Gender	Trust %	No. receiving bonus	% of those receiving bonus	% medical staff overall
31/3/19	Male	**4.4%**	84	77.8%	59.8%
31/3/19	Female	**0.4%**	24	21.4%	40.2%
31/3/20	Male	**3.8%**	77	76.2%	61.4%
31/3/20	Female	**0.4%**	24	22.2%	38.6%
31/3/21	Male	**3.4%**	72	75.0%	59.0%
31/3/21	Female	**0.4%**	24	25.0%	41.0%

There has been an increase in the proportion of female staff receiving bonus payments across the 3 years, but it is still not proportionate to the gender breakdown of medical staff (the gender breakdown for Consultant staff was 70.3% male, 29.7% female on 31/3/21).

2.9 Proportion of males and females when divided into four groups ordered from lowest to highest pay

	31/3/19		31/3/20		31/3/21	
	Male	Female	Male	Female	Male	Female
Lower	23.2%	76.8%	22.0%	78.0%	21.2%	78.8%
Lower middle	21.0%	79.0%	22.1%	77.9%	22.4%	77.6%
Upper middle	14.9%	85.1%	16.1%	83.9%	17.5%	82.5%
Upper	32.5%	67.5%	32.8%	67.2%	33.3%	66.7%
TOTAL	22.6%	77.4%	23.1%	76.9%	23.1%	76.9%

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3.0 Conclusion:

From reviewing the data it is apparent that ESHT need to better understand any of the disparities with a further deep dive into the data.

One area to note is the bonus payments broken down by gender. In line with national guidance, there were no rounds of applications for Clinical Excellence Awards this year. Instead, and also in line with the national guidance, the funds were distributed to all eligible consultants (not those holding either National or local level 9 awards) pro rata according to hours worked and length of service during the qualifying year

Divisions will be receiving the diversity detail of their workforce which will include gender as part of that information. This should help them to review any gender pay gap imbalance within their teams and more ownership at a local level.

The monitoring of the Action Plan currently sits with the Workforce Equality Group. Discussions will be held to explore other meetings where the Gender Pay Gap should be included in the agenda

East Sussex Healthcare NHS
NHS Trust

Gender Pay Gap Report
(2019 - 2021 comparison)

1. What is the gender pay gap report?

Gender pay reporting legislation requires employers with 250 or more employees to publish statutory calculations every year showing how large the pay gap is between male and female employees. There are two sets of regulations. The first is mainly for the private and voluntary sectors (taking effect from 5 April 2017) and the second is mainly for the public sector (taking effect from 31 March 2017). Employers have up to 12 months to publish their gender pay gaps.

The results must be published on the employer's website and a government website. They must, where applicable, be confirmed in a written statement by an appropriate person such as a Chief Executive. While employers may already be taking steps to improve gender equality and reduce or eliminate their gender pay gap, this process will support and encourage action.

Gender pay reporting is different to equal pay- equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The gender pay gap shows the difference in the average pay between all men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate there may a number of issues to deal with, and the individual calculations may help to identify what those issues are.

The NHS terms and conditions of service handbook contain the national agreements on pay and conditions of service for NHS staff other than very senior managers and medical staff. Job evaluation (JE) enables jobs to be matched to national job profiles or allows trusts to evaluate jobs locally, to determine in which Agenda for Change pay band a post should sit.

2. Gender Pay Gap Indicators

An employer must publish six calculations showing their:

1. Average gender pay gap as a mean average
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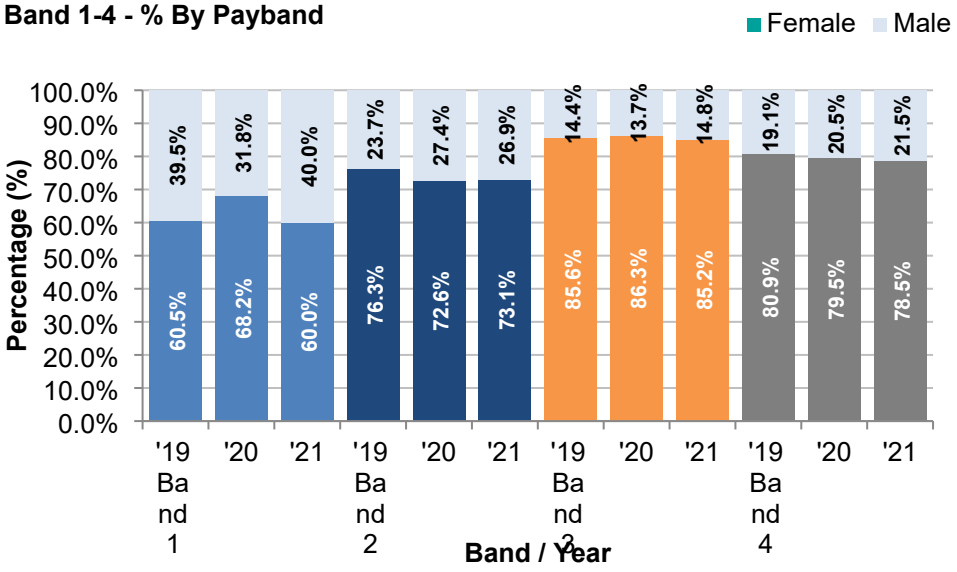
3. Average bonus gender pay gap as a mean average
4. Average bonus gender pay gap as a median average
5. Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
6. Proportion of males and females when divided into four groups ordered from lowest to highest pay

3. East Sussex Healthcare Trust Workforce context

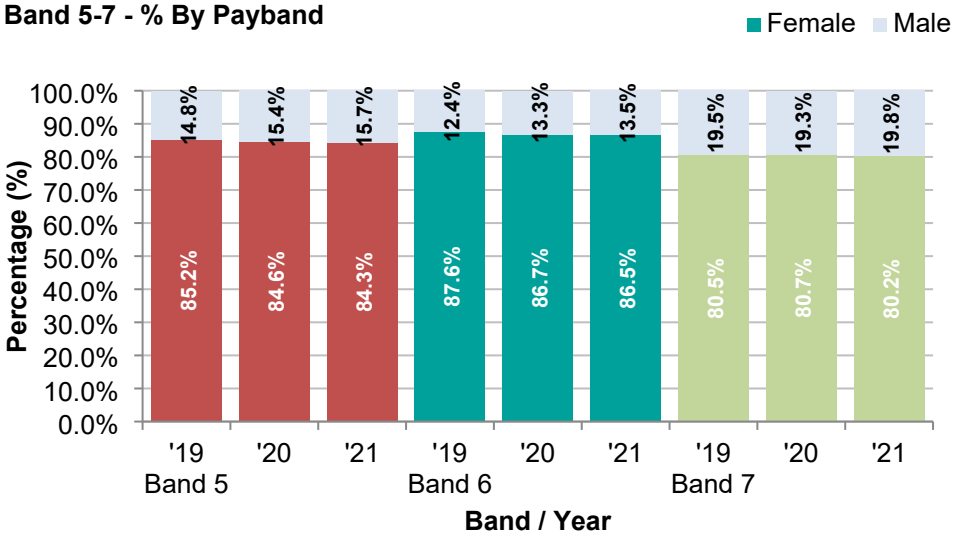
Since, 2019 to 2020, there has been a small increase in the proportion of male staff however in 2020 to 2021 this figure has remained the same.

Gender Breakdown % by Pay Band 31st March 2019, 2020 & 2021

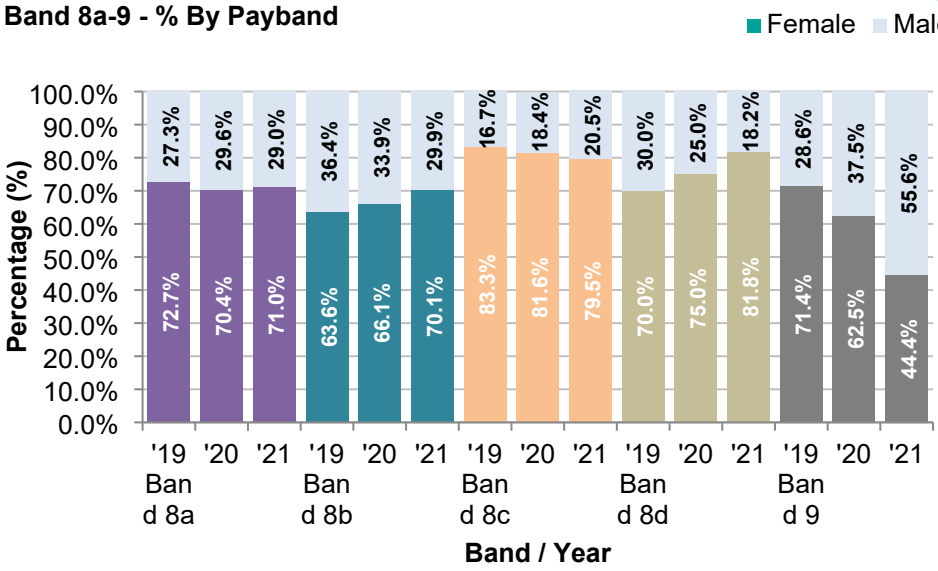
Band 1-4 - % By Payband



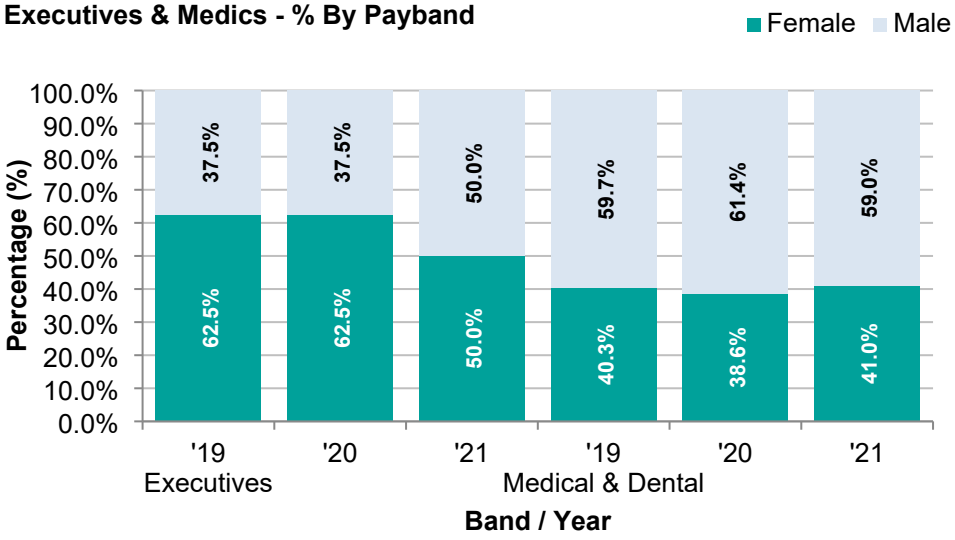
Band 5-7 - % By Payband



Band 8a-9 - % By Payband



Executives & Medics - % By Payband



Source data: *ESR extract for 31st Mar 2019*

4. ESHT Gender Pay Gap Results for 31st March 2019 to 31st March 2021

a) Gender pay gap as a mean (average) showing male to female hourly rate comparison as snapshots on 31st March 2019, 31st March 2020 and 31st March 2021. Hourly rate includes basic pay and additional allowances including Clinical Excellence Awards. This rate does not include overtime or exceptional payments i.e. redundancy.

	Male	Female	% diff
Mean hrly rate 31/3/19	£19.39	£15.17	**21.8%**
Mean hrly rate 31/3/20	£19.84	£15.59	**21.4%**
Mean hrly rate 31/3/21	£20.41	£16.02	**21.5%**

The gender pay gap, in respect of mean hourly rate, has slightly increased by 0.1% since 31/3/20.

The below table shows a breakdown of the mean pay rates split for Agenda for Change and Medical & Dental staff across the last 3 years.

Agenda for Change and Medical & Dental	Male	Female	% diff
Agenda for Change - Mean hrly rate 31/3/19	£14.05	£14.41	**-2.5%**
Agenda for Change - Mean hrly rate 31/3/20	£14.41	£14.81	**-2.7%**
Agenda for Change - Mean hrly rate 31/3/21	£15.02	£15.22	**-1.2%**
Medical & Dental - Mean hrly rate 31/3/19	£36.66	£29.97	**18.2%**
Medical & Dental - Mean hrly rate 31/3/20	£36.61	£30.50	**16.7%**
Medical & Dental - Mean hrly rate 31/3/21	£38.46	£31.15	**19.0%**

The % difference for Medical & Dental staff has increased by 2.3% in 20/21 whilst the difference for Agenda for Change staff, where female mean pay is higher than male, has reduced by 1.5% in the last year.

b) Gender pay gap as a median average showing male to female hourly rate comparison as snapshots on 31st March 2019, 31st March 2020 and 31st March 2021. The median is the middle value of the full range of hourly rates

	Male	Female	% diff
Median hrly rate 31/3/19	£14.03	£13.57	**3.3%**
Median hrly rate 31/3/20	£14.55	£13.85	**4.8%**
Median hrly rate 31/3/21	£15.31	£14.08	**8.1%**

The gender pay gap, in respect of median hourly rate, has increased by 3.3%, since 31/3/20 and is on an upward trend across the 3 years.

The below table shows a breakdown of the median pay rates split for Agenda for Change and Medical & Dental staff

Agenda for Change and Medical & Dental	Male	Female	% diff
Agenda for Change - Median hrly rate 31/3/19	£12.01	£13.10	**-8.3%**
Agenda for Change - Median hrly rate 31/3/20	£12.38	£13.41	**-7.7%**
Agenda for Change - Median hrly rate 31/3/21	£13.04	£13.79	**-5.4%**
Medical & Dental - Median hrly rate 31/3/19	£34.93	£26.49	**24.2%**
Medical & Dental - Median hrly rate 31/3/20	£34.58	£27.29	**21.1%**
Medical & Dental - Median hrly rate 31/3/21	£38.65	£27.10	**29.9%**

The % difference for Medical & Dental staff has increased by 8.8%, in 20/21, whilst the difference for Agenda for Change staff, where female median pay is higher than male, has reduced by a further 2.3%.

c) Bonus gender pay gap as a mean average. Bonuses are payments within the 12 months up to the relevant snapshot dates. In all three years, the bonuses relate purely to Clinical Excellence Awards.

	Male	Female	% diff
Mean bonus payment - 31/3/19	£14,196	£10,570	**25.6%**
Mean bonus payment - 31/3/20	£14,449	£10,087	**30.2%**
Mean bonus payment - 31/3/20	£13,233	£10,509	**20.6%**

The gender pay gap, in respect of mean average, has reduced by 9.6% since 31/3/20.

d) Average bonus gender pay gap as a median average within the 12 months up to the snapshot dates. The median is the middle value of the full range of bonuses.

	Male	Female	% diff
Median bonus payment - 31/3/19	£9,048	£9,048	**0.0%**
Median bonus payment - 31/3/20	£9,048	£9,048	**0.0%**
Median bonus payment - 31/3/21	£8,596	£9,048	**-5.3%**

The gender pay gap, in respect of median average, has increased by 5.3% so that the female median bonus payment is 5.3% higher than the male.

e) Percentage of employees who received a bonus payment. The percentage shown in the table below reflects the male and female split against the overall Trust staffing in that gender. For this Trust the bonuses all relate to Clinical Excellence awards

Date	Gender	Trust %	No. receiving bonus	% of those receiving bonus	% medical staff overall
31/3/19	Male	**4.4%**	84	77.8%	59.8%
31/3/19	Female	**0.4%**	24	21.4%	40.2%
31/3/20	Male	**3.8%**	77	76.2%	61.4%
31/3/20	Female	**0.4%**	24	22.2%	38.6%
31/3/21	Male	**3.4%**	72	75.0%	59.0%
31/3/21	Female	**0.4%**	24	25.0%	41.0%

There has been an increase in the proportion of female staff receiving bonus payments across the 3 years, but it is still not proportionate to the gender breakdown of medical staff (the gender breakdown for Consultant staff was 70.3% male, 29.7% female on 31/3/21).

f) Proportion of males and females when divided into four quartiles. The below table divides all the hourly rates into 4 equal segments from lowest to highest hourly rate

	31/3/19		31/3/20		31/3/21	
	Male	Female	Male	Female	Male	Female
Lower	23.2%	76.8%	22.0%	78.0%	21.2%	78.8%
Lower middle	21.0%	79.0%	22.1%	77.9%	22.4%	77.6%
Upper middle	14.9%	85.1%	16.1%	83.9%	17.5%	82.5%
Upper	32.5%	67.5%	32.8%	67.2%	33.3%	66.7%
TOTAL	22.6%	77.4%	23.1%	76.9%	23.1%	76.9%

East Sussex Healthcare NHS
NHS Trust

EAST SUSSEX HEALTHCARE TRUST GENDER PAY GAP ACTION PLAN 2021			
1 Governance Process			
Action	**By Who**	**When**	**Outcome expected**
1.1:Agree which operational group the Gender Pay Gap actions are reviewed by.	HR Director-OD & Staff Engagement Workforce EDI Lead	March 2022	Gender Pay Gap recommendations are reviewed and actioned at an operational group before going to People and Organisational development committee
2 Data			
Action	**By Who**	**When**	**Outcome expected**
2.1: Divisions to receive diversity details of staff broken down by gender and ACF bandings and medical and dental staff every year	Workforce Information Team Workforce EDI Lead	March 2022	Divisions will better understand any of the disparity ratios in their staff composition
2.2: A system for better recording of staff on leadership training	Training Department Organisation Development Team	March 2022	Information will be recorded on new Learning Management system Cross reference data and link into a talent management programme
3. Clinical Excellence Awards			
Action	**By Who**	**When**	**Outcome expected**
3.1: A review of the distribution of CEAs during the Covid-19 recovery and next steps	Workforce Equality Group Women's and Consultant Women staff network	Placed on hold until rounds of applications for Clinical Excellence Awards are re-established nationally	To review and promote more women applying for CEA

East Sussex Healthcare NHS
NHS Trust

EAST SUSSEX HEALTHCARE TRUST GENDER PAY GAP ACTION PLAN 2021 4. Women's Staff Network			
Action	**By Who**	**When**	**Outcome expected**
4.1: Develop and launch the Women's staff network at ESHT and link into the national network	HR Director-OD, Staff Engagement and Wellbeing Workforce EDI Lead	April 2022	Proposal paper to go to POD and the Trust Board outlining the purpose of the Women's network
4.2: Develop and launch the Women's Consultant Network at ESHT and link into the national Women's Network	HR Director of -OD, Staff Engagement and Wellbeing	September 2021	A staff network relating to women consultants in the NHS to empower women in the workplace. Note: • The group meets for the 2nd time in March. • Terms of reference in place
4.3: Develop a Terms of Reference for each group and widen the participation of each women's network	HR Director of -OD, Staff Engagement and Wellbeing	April 2022	Network members to develop their own Terms of reference to agree to the purpose and scope of the networks The network achieves its priorities and goals therefore through reputation attracts more members The communication plan would target women across the Trust highlighting the benefits of being part of the network

For a copy our SMART Objectives delivery plan please email: esht.workforceinclusion@nhs.net

Charity Annual Report and Accounts

Meeting information:		
Date of Meeting:	8th February 2022	Agenda Item: 14
Meeting:	Trust Board	Reporting Officer: Daman Reid, CFO

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

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

Summary:

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

This report comprises a summary of the; income; expenditure; fund balances; and, fund movements of the Trust's Charitable Funds as at 31 December 2021. These accounts are final and were submitted to the Charity Commission on 28 January 2022.

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

Charity Committee, 28.01.2022.

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

The Board are asked to note the contents of this report.

Charitable Funds Financial Summary as at 31 December 2021

Executive Summary

During the year to Dec-21, the Charity has received income of £195k, and incurred expenditure of £264k, resulting in a net decrease in funds of £69k.

Income

A large part of the income received was for the TRiM project (£105k) - This is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event. £55k was received from individual donations. These 2 streams constitute approximately 85% of total income received.

Table 1 shows the total income received as at the 31 December 2021 categorised into Unrestricted and Designated Income.

Table 1: Income Analysis

Analysis of Income				31 December 2021
Sources of Income	Designated	Unrestricted	Total Income	Total Received
	Actual £	Actual £	YTD £	%
Individuals	62	55,057	**55,119**	28%
Fund Raising Income		3,983	**3,983**	2%
Lottery	170		**170**	0%
Corporate Donations	105,000	5,487	**110,487**	57%
Legacies		8,753	**8,753**	4%
Total Voluntary Income	**105,232**	**73,280**	**178,512**	**91%**
Training Courses		16,636	**16,636**	9%
Other Income	**0**	**16,636**	**16,636**	**9%**
TOTAL INCOME	**105,232**	**89,916**	**195,148**	**100%**

The Unrestricted Funds consist of the five quality funds linked to Bexhill Hospital, Community Services, Conquest Hospital, Eastbourne District General Hospital and an overarching Trust fund. These funds are used to fund Trust wide initiatives as well as bids specific to particular locations.

Expenditure

The Charity has incurred expenditure to quarter 3 of £264k; the majority of which was as a result of Charitable Activities (56%).

Table 2 shows the total expenditure as at 31 December 2021 categorised into Unrestricted and Designated expenditure.

Table 2: Expenditure Analysis

Analysis of Expenditure			31 December 2021	
Sources of Expenditure	Designated Actual	Unrestricted Actual	Total YTD Expenditure	Total Expenditure
	£	£	£	%
Arts In Healthcare	158	37,386	**37,544**	14%
Charitable Activities	53,502	95,039	**148,541**	56%
Fundraising		2,538	**2,538**	1%
Management fee		34,529	**34,529**	13%
TRAINING COURSES	22,947	18,014	**40,961**	16%
TOTAL EXPENDITURE	**76,608**	**187,505**	**264,113**	**100%**

Fund Balances

The Fund Balances report in table 6 shows the breakdown of funds held at 31 December 2021. The Charity has funds of £2.46m of which £2.45m belongs to East Sussex Healthcare NHS Trust's own charitable funds (excluding hosted and non-charitable funds).

Fund Movements

The fund movement tables (table 7) show the decrease in funds of £69k.

During the 9 month period 136 Charitable Fund Expenditure (CFE) Forms were approved with a total value of £266k, and included;

- £105k - Trauma Therapy for NHS staff;
- £27k – Staff medals, in recognition of the NHS being awarded the George Cross.
- £48k – 3 Ultrasound machines at the new Pevensey unit.

There are 6 funds with credit (overspent) balances as detailed in table 3.

Table 3: Credit Balance

Fund	Description	Closing Bal £	Notes
POOL	POOL EXPENSES/INCOME TO BE ALLOCATED	(23,891)	This fund comprises Administration, Management and Fundraising Consultant costs which are allocated across the Funds at year end.
COVW	COVID - WELLBEING FUND	(22,337)	This fund received £30k; £10k each from the Conquest LoF, Eastbourne LoF, and ESHT's Charitable funds
DTAJ	BERWICK WARD	(79)	Fund Holder being contacted for clearance to move to DTAN
DTDQ	MACMILLAN NURSES	(312)	Fund Holder being contacted for clearance.
DTDK	PHYSIOTHERAPY	(891)	Funds overcharged - New CFEs/Adjustments Required
9833	WORKS OF ART - ADMINISTRATION	(16,288)	This fund will be allocated to the general fund at the year end; pending Trustee's accrual.

Cash Position

The Charity has £280k of creditors which all relates to funds owed to the Trust as detailed in Table 4.

Table 4: Cash Requirement

Cash Requirement as at:	31 December 2021
	£
Creditors	
East Sussex Healthcare NHS Trust - intercompany account	
2021/22	(279,549)
Total Creditors	**(279,549)**
Bank Balance	674,080
Balance Net of Creditors	**394,531**

An invoice is in the process of being raised for charges up to 31 December 2021 and will be circulated to the committee for approval.

The trust should also be aware that of the £266k of CFE's that have been approved since 01/04/2021 there is a value of £214k that has not yet been expensed. The cash position should therefore be monitored.

Investment Position

The investments held are summarised on Table 5. below. For the year to 31 Dec 2021, there was an increase of £204k in the value of Investments.

Table 5: Investment Valuation

EAST SUSSEX HOSPITALS NHS TRUST CHARITABLE FUNDS						
Investment Valuation						**31 Dec 2021**
	COIF Charities Fixed Interest Fund	COIF Charities Property Fund	COIF Charities Deposit Fund	M&G Charibond Charities Fixed Interest Common Investment Fund	M&G Equities Investment Fund for Charities (Charifund)	TOTAL
Units held 31.3.21	45,497	539,303		953	4,009	**589,762**
Units held 31.12.21	45,497	558,353		953	4,009	**608,812**
Movement in Units	**0**	**19,050**	**0**	**0**	**0**	**19,050**
Unit Costs (£)	9.33	1.24				
Opening Bid Mkt Value - Mar-21	**421,671**	**599,274**	**1,608**	**40,497**	**1,056,527**	**2,119,577**
Less: Cash Transfers Fees (£)						**0**
Add: Dividends (£)						**0**
Add net gain (loss) on revaluation (£)	2,657	95,541	0	(185)	106,334	**204,348**
Closing Bid Mkt Value Dec-21 (£)	**424,328**	**694,815**	**1,608**	**40,312**	**1,162,861**	**2,323,925**

Fund Amalgamation

Within the policies that govern charitable funds the trustees have the power to close funds that are either deemed to be of low value (under £250) or inactive (no transactions in the prior 18 months). Listed are 20 funds along with a proposed action for the committee to consider.

	Low fund value (under £250)	Balance	Fund manager on record	Action proposed
DTCR	ENDOCRINOLOGY	0.00	M RAVELO	To close - fund managers have been notified on 29.06.21. no objection received
9755	ENDOSCOPY - CONQUEST	0.00	S WINSER	To close - fund managers have been notified on 29.06.21. no objection received
DTCC	PAIN CLINIC - EDGH	0.00	Dr M LONSDALE	To close - Fund manager agreed to Amalgamation with general fund
9614	DECHAM WARD	36.26	Mrs M ELPHICK	To close - Fund manager agreed to Amalgamation with general fund
XMAS	STAFF CHRISTMAS SHOW	68.48	Mr A SUBRAMANIAN	To close per P.Palmer
DTAS	OCCUPATIONAL THERAPY EDUCATION	90.46	A CANBY	To close - fund managers have been notified on 29.06.21. no objection received
9671	BENSON DAY UNIT	108.59	Mrs M ELPHICK	To close - Fund manager agreed to Amalgamation with general fund
DTBV	OUTPATIENTS DEPARTMENT	118.08	Ms N BOOTH	To close - fund managers have been notified on 29.06.21. no objection received
DTEN	NEUROLOGY MEDICAL	174.95	Doctor Y Kai Lee	Remain active - Dr Lee intends to undertake fundraising for fund
DTBD	ADMISSIONS LOUNGE	190.88	Miss A HAWLEY	To close - Fund manager agreed to Amalgamation with general fund
9860	CONQUEST MRI SCANNER	192.55	L WELLS	To close - fund managers have been notified on 29.06.21. no objection received

	No transactions in past 18 months	Balance	Fund manager on record	Action proposed
9840	CHOIR	294.94	P.Palmer	To close - put back into general
5931	LEWES VICTORIA HOSPITAL - PHYSIOTHEF	548.53	J Hall & A Turner	To close - put merge with Lewes Victoria Hospital fund 5930
DTCU	POLEGATE	857.37	Ms K RIPPY	Polegate no longer in existance - K Rippy asked if the fund can be renamed for the benefit of K Rippy's new team, accute frailty practitioners team, or go to community quality fund.
9838	PODIATRY	860.30	A Turner	put into general or community quality fund
9750	KIPLING WARD BEDROOM	941.34	Ms B LYNES-O'MEA	put into Kipling general 9751
GTBT	FACILITIES STAFF - DGH	1,917.76	Mrs M CLEMENTS	30.12.21 Amalgamation Agreed
DTBL	SEAFORD 4 UROLOGY	1,921.53	Mrs M ELPHICK	To close - 30.12.21 Amalgamation Agreed
DTBT	MAXILLOFACIAL	2,110.36	Mr A MOODY	To close - 30.12.21 Amalgamation Agreed
DTEF	CUCKMERE WARD HOIST FUND	3,288.97	R THOMSON	To close - Merge with Cuckmere General Ward fund DTAF
DTDX	DIGESTIVE DISEASES	10,442.84	Mr M SAUNDERS	To close - 30.12.21 Amalgamation Agreed

Table 6: Funds Report

Analysis of Charitable Funds as at:				31 December 2021
		£000's	£000's	£000's
General Quality Funds				
COMM	COMMUNITY QUALITY FUND	5		
9656	CONQUEST QUALITY FUND	12		
DDGH	EASTBOURNE DGH QUALITY FUND	218		
GEN	ESHT QUALITY FUND	49		
9633	BEXHILL HOSPITAL QUALITY FUND	21		
	Total Undesignated Funds		**305**	
Major Designated Funds				
9001	BEXHILL HOSPITAL - PALMER LEGACY	222		
DTBU	CARDIAC EDUCATION	23		
9761	CARDIAC REHABILITATION - CONQ	26		
DTZY	CARDIAC REHABILITATION - EDGH	29		
DTZV	COMBINED CARDIOLOGY FUND	49		
DTAN	CORONARY CARE UNIT - EASTBOURNE	31		
COVD	COVID-19 GRANTS	56		
DTEL	CRISIS RESPONSE	22		
DTBY	CRITICAL CARE - EASTBOURNE	23		
9716	CRITICAL CARE - CONQUEST	65		
9702	DIETETICS	24		
DTBB	EASTBOURNE ANAESTHETIC EDUCATIONAL FUND	22		
DICR	EDGH SCAN EQUIP - INTENSIVE CARE & RADIOLOGY (RES)	145		
DTBZ	EMERGENCY DEPARTMENT - DGH	34		
DTCF	HAEMATOLOGY	43		
7910	IRVINE UNIT	51		
9809	JUDY BEARD DAY UNIT - CONQUEST	44		
9646	MATERNITY BEREAVEMENT SUITE	9		
DTAI	NEW PEVENSEY UNIT	405		
DTAD	PEVENSEY (HAEMATOLOGY)	69		
POOL	POOL EXPENSES/INCOME TO BE ALLOCATED	(24)		
COVW	COVID - WELLBEING FUND	(22)		
COV6	COVID 19 - TRAUMA THERAPIST	85		
DTAX	CANCER TREATMENT	51		
COV3	COVID - DEAF APP	44		
DTAK	SOVEREIGN/EAST DEAN STROKE	18		
COV2	COVID - WHAT MATTERS TO YOU	33		
COV5	COVID-19 SUNFLOWER SCHEME	1		
COV4	COVID-19 TRiM TRAINING	28		
DTEB	SEXUAL HEALTH HIV EDUCATION FUND	26		
	Total Major Funds		**1,633**	
	Other Wards and Departments' Funds		**507**	
Total Own Charitable Funds				**2,446**
Hosted Funds				
7930	BEXHILL RENAL UNIT	3		
5930	LEWES VICTORIA HOSPITAL - GENERAL	13		
	Total Hosted Funds		**16**	
9681	SOUTH EAST ORTHOPEADIC TRAINING		**1**	
Total Funds Managed for Third Parties				**17**
Total Charitable Funds as at 31st December 2021				**2,463**

Table 7: Fund Movement Table

Analysis of Charitable Funds as at:	31 Dec 2021			
SUMMARY	Opening Balance	Reversal of 20.21 YE Accruals	In Year Movement	Closing Balances
General Quality Funds	305,380	11,815	11,726	305,470
Major	1,523,190	125,813	15,654	1,633,349
Hosted	16,475	0	(750.00)	17,225
Minor	462,624	87,002	42,336	507,290
	2,307,669	224,630	68,966	2,463,334

Analysis of Charitable Funds as at:			31 Dec 2021			
Fund Type	Fund	Fund Name	Opening Balance	Reversal of 20.21 YE Accruals	In Year Movement	Closing Balances
General Quality Funds	9633	BEXHILL HOSPITAL QUALITY FUND	21,003	123	201	20,926
General Quality Funds	COMM	COMMUNITY QUALITY FUND	5,055	1,331	1,386	5,000
General Quality Funds	9656	CONQUEST QUALITY FUND	11,016	3,654	3,089	11,582
General Quality Funds	DDGH	EASTBOURNE DGH QUALITY FUND	221,431	6,131	9,070	218,492
General Quality Funds	GEN	ESHT QUALITY FUND	46,875	575	(2,020)	49,471
TOTAL General Quality Funds			**305,380**	**11,815**	**11,726**	**305,470**
Major	DTAX	CANCER TREATMENT	61,591	3,053	13,943	50,701
Major	9761	CARDIAC REHABILITATION - CONQ	27,331	0	1,207	26,124
Major	DTZY	CARDIAC REHABILITATION - EDGH	27,886	0	(1,035)	28,922
Major	COV3	COVID - DEAF APP	52,100	0	8,000	44,100
Major	COVD	COVID-19 GRANTS	41,442	16,651	2,179	55,914
Major	9716	CRITICAL CARE - CONQUEST	43,948	778	(20,737)	65,463
Major	9702	DIETETICS	25,435	0	1,600	23,835
Major	DTBZ	EMERGENCY DEPARTMENT - DGH	24,956	0	(9,394)	34,350
Major	7910	IRVINE UNIT	51,943	1,579	2,200	51,323
Major	9809	JUDY BEARD DAY UNIT - CONQUEST	15,625	23,635	(5,086)	44,345
Major	9646	MATERNITY BEREAVEMENT SUITE	(2,171)	19,070	7,557	9,343
Major	DTAI	NEW PEVENSEY UNIT	413,346	3,484	11,970	404,860
Major	DTAD	PEVENSEY (HAEMATOLOGY)	57,122	10,302	(1,401)	68,825
Major	POOL	POOL EXPENSES/INCOME TO BE ALLOCATED	0	10,801	34,691	(23,891)
Major	COV2	COVID - WHAT MATTERS TO YOU	22,449	12,824	2,312	32,961
Major	COV5	COVID-19 SUNFLOWER SCHEME	10,000	0	9,000	1,000
Major	COV4	COVID-19 TRIM TRAINING	50,000	0	22,437	27,563
Major	COVW	COVID - WELLBEING FUND	0	0	22,337	(22,337)
Major	COV6	COVID 19 - TRAUMA THERAPIST	0	0	(84,562)	84,562
Major Funds with movements under £1,000			600,185	23,636	(1,563)	625,384
TOTAL MAJOR FUNDS			**1,523,190**	**125,813**	**15,654**	**1,633,349**
Hosted	7930	BEXHILL RENAL UNIT	2,209	0	(750)	2,959
Hosted	5930	LEWES VICTORIA HOSPITAL - GENERAL	13,433	0	0	13,433
Hosted	9681	SOUTH EAST ORTHOPEADIC TRAINING	833	0	0	833
TOTAL HOSTED FUNDS			**16,475**	**0**	**(750)**	**17,225**
Minor	DTAJ	BERWICK WARD	(2,559)	1,479	(1,000)	(79)
Minor	COEQ	CONQUEST EQUIPMENT (RESTRICTED)	3,220	0	2,672	549
Minor	DTHH	EDGH VOLUNTARY SERVICES	(1,477)	76	(7,174)	5,773
Minor	DTDY	LUNG & CHEST	4,448	0	1,323	3,125
Minor	9663	MACDONALD WARD	3,444	0	(2,741)	6,185
Minor	DTDQ	MACMILLAN NURSES	(1,271)	2,900	1,941	(312)
Minor	DTBQ	OPTHAMOLOGY - EASTBOURNE	3,933	0	(5,074)	9,007
Minor	DTDK	PHYSIOTHERAPY	983	0	1,874	(891)
Minor	DTAZ	RESUSCITATION EDUCATION FUND	21,565	89	(7,465)	29,119
Minor	DTCT	SADIE - SKILLS FOR ADJUSTING DIET & INSULIN E.SUS	14,800	0	(3,060)	17,860
Minor	9833	WORKS OF ART - ADMINISTRATION	0	21,057	37,344	(16,288)
Minor	DTHI	YOUTH VOLUNTEERING PROJECT	2,391	51,237	22,281	31,347
Minor	DTET	HAILSHAM WARD	0	0	(1,430)	1,430
Minor Funds with movements under £1,000			413,147	10,165	2,846	420,465
TOTAL MINOR FUNDS			**462,624**	**87,002**	**42,336**	**507,290**
TOTAL CHARITABLE FUNDS			**2,307,669**	**224,630**	**68,966**	**2,463,334**

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Charitable Fund

Annual Report and Accounts

Year Ended 31 March 2021

Registered Charity Number 1058599

WHAT **MATTERS** TO YOU
MATTERS TO US ALL

Contents

Charity Report

Report for the Year Ended 31 March 2021

We are delighted to present the annual report together with the financial statements of the Charity for the year ended 31 March 2021.

The annual report and financial statements comply with the Accounting and Reporting by Charities: Statement of Recommended Practice applicable to Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015), the Charities Act 2011 and the UK Generally Accepted Accounting Practice.

Chair's Report

As Chair of the East Sussex Healthcare NHS Trust Charitable Fund (ESHTCF), I am pleased to welcome you to the 2021 Annual Report and Accounts. We hope you find this a useful guide to the important role our Charity plays in supporting NHS patients, their carers, families and staff.

East Sussex Healthcare NHS Trust (ESHT) was made the sole Trustee of the Charity on 3 March 2020. This change enabled us to undertake a thorough review of the way in which the Charity was administered. We invited staff from across our hospitals, community services and back offices to join our Charity Committee meetings, enabling us to hear different perspectives, generate new ideas and activities and increase the awareness of the Charity more broadly across ESHT.

Covid has had a substantial impact on the Charity's activities in 2020/21. Fund raising activities were cancelled and fewer grant applications received. However, the biggest impact on our Charity resulted in the Trust's decision to join NHS Charities Together at the start of the pandemic. NHS Charities Together is the overarching NHS charity which supports a network of over 240 NHS Charities. During the pandemic, NHS Charities together swiftly became a central point for fundraising to support the NHS, with prominent fundraisers including Captain Sir Tom Moore, Joe Wicks and Premier League footballers, and people from across the country raising £150m. NHS Charities Together distributed this to member organisations, and our Charity received almost £350,000 during 2020/21. As well as receiving funding to support our staff during the first and second waves of the pandemic, we also successfully applied to NHS Charities Together to fund a number of projects:

- Virtual leadership support for nurses and matrons in the early stages of the pandemic;
- Funding for 'Our ESHT Story';
- A 'What Matters to You' initiative, providing small items for staff that would make a big difference in the workplace;
- Money to develop a British Sign Language app, for our d/Deaf community;
- Funding for a sunflower lanyard scheme, supporting patients with hidden disabilities;
- Support to provide psychological support for staff in a variety of different ways both during and after the pandemic, including:
    - Trauma Risk Management (TRiM) training, a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event;
    - Psychological team support;
    - GTEP (Group Traumatic Experience Programme), a follow on from the psychological team intervention where required;
    - Trauma therapy for individuals.

The Charity's work is possible thanks to the generous support of patients, staff and local people. Thanks to your efforts, we received £681,000 of income over the last year. Key highlights of our year include provision of:

- Support for the Youth Volunteer project, which identifies and implements opportunities for youth volunteers;
- A state of the art haematology microscope, to enhance service delivery and the diagnosis of cancer patients;
- A PAX scalp cooling system for the Pevensey Day Unit, which reduces hair loss during chemotherapy
- Furnishings for the bereavement suits at Conquest Hospital;
- Emergency grants to help patients suffering from cancer.

I would like to take this opportunity to thank those individuals who have served as Charitable Fund Committee during the year. I would also like to thank all of our supporters – including everyone who has helped raise money for the Charity or given their energy, time and skills to make a difference during this financial year. I hope that, like me, you will be inspired by our plans to help and want to be part of our story. Your donations made this work possible and your future donations are the key to our continued success.

If you would like to donate, details about how to do this are on page 24.

On behalf of the many patients who have benefitted from your generosity, thank you for your continued support.

Karen Manson
Chair

Our Objectives and Activities

East Sussex Healthcare NHS Trust Charitable Fund (ESHTCF) was formed in October 1996 and is registered with the Charity Commission, the Registered Charity Number is 1058599.

At 31 March 2021 the Charity had 138 unrestricted funds and five quality funds linked to Bexhill Hospital, Community Services, Conquest Hospital, Eastbourne District General Hospital and an overarching Trust fund. These funds are used to fund Trust wide initiatives as well as bids specific to particular locations.

The Charity has a further 15 restricted funds, which include money received from NHS Charities Together for specific projects, and the Eastbourne District General Hospital Scanning Equipment Fund which is for the benefit of the Intensive Care and Radiology Department.

The Charity's main purpose is to raise funds and receive donations in service to its objective of providing benefit to the staff and patients of ESHT. This benefit may come in a variety of forms, including:

- improving clinical services;
- enhancing the experiences of patients;
- purchasing equipment that will improve the care given to patients;
- enabling services to be given to patients in innovative ways;
- training staff; and
- improving the welfare of staff where there is a clear benefit to patients in doing this.

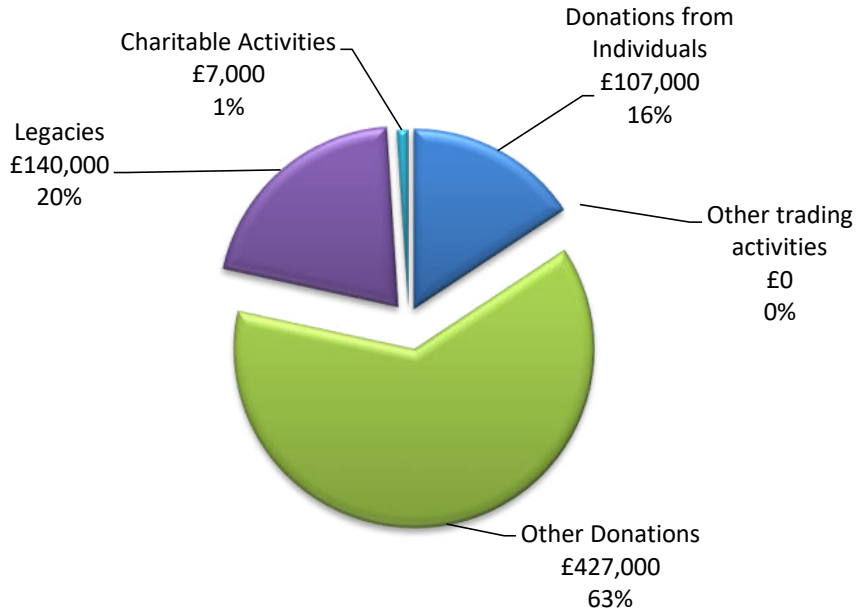
East Sussex Healthcare NHS Trust is the Corporate Trustee for the Charity. It is legally responsible for the overall management and decision making of the Charity, ensuring that it operates in compliance with the Charities Act 2011.

Financial Review

During 2020/21 ESHTCF received income of £681,000 from donations, legacies, investment income and training activities. The Charity utilises the services of a fundraising manager who raises money for the unrestricted quality funds and supports members of staff and the public who wish to raise money for ESHTCF.

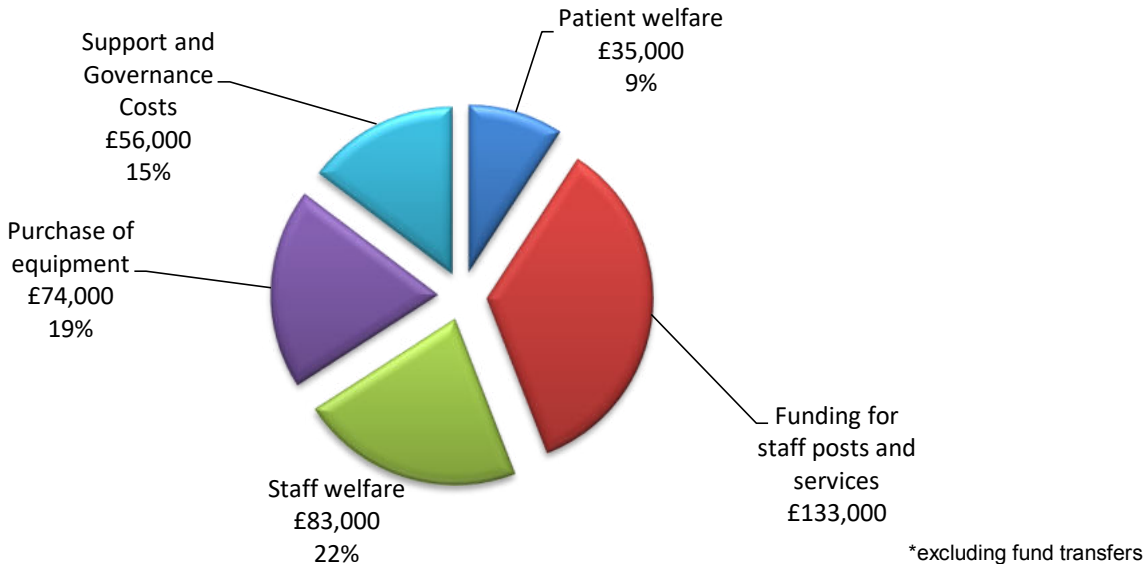
ESHTCF promotes itself by advertising in wards and public areas throughout the Trust and by making it as easy as possible for donations to be made. It also benefits from 50% of the ticket value of the East Sussex Healthcare Lottery, a lottery managed by Sterling Management Centre. The lottery is promoted throughout East Sussex in medical settings.

Donations we received



ESHTCF spent £381,000 during the year on charitable activities, as shown below. This was funded from: £681,000 income receipts.

Money we spent*



The Charity incurred a £321,000 net gain on investment during 2020/21.

Reserves

ESHTCF hold reserves that are considered to be needed to fund planned expenditure. The Charity acknowledges that charitable donations received need to be spent on patient and staff amenities wherever possible and should not be used to build up reserves.

The reserves of the Charity at 31 March 2021 consisted of £2,034,000 unrestricted funds and £273,000 restricted funds. The Charity regularly reviews all funds held to ensure they remain active and where appropriate, a fund which is inactive for a period greater than 18 months will be closed and the funds transferred to the most relevant quality general fund to ensure that they are spent in a timely manner.

Reference and Administration Details

Registered Charity Number: 1058599

Address of Charity:
St Anne's House
729 The Ridge
St Leonards-on-Sea
East Sussex
TN37 7PT

Banker:
Lloyds Bank plc
2 City Place
Beehive Ring Road
Gatwick
West Sussex
RH6 0PA

Solicitors:
Bevan Britten
Kings Orchard
1 Queen Street
Bristol
BS2 0HQ

Auditor:
Grant Thornton LLP
2nd Floor
St John's House
Crawley
RH10 1HS

Trustee Arrangements:
East Sussex Healthcare NHS Trust (ESHT) is the sole Trustee of the Charity. The Trustee confirms that they have referred to the Charity Commission's guidance on public benefit when reviewing the Charity's aims and objectives and in planning future activities.

The Charity Committee Members of ESHTCF during the year, 1 April 2020 to 31st March 2021 were as follows:

Chair:
Karen Manson

Committee Members:
Dr Tom Bate
Angela Colosi
Mike Eastwood
Jill Marsh
Pete Palmer
Paresh Patel
Damian Reid
Gill Reynolds
Lynette Wells
Jeanette Williams

Highlights

During 2020/21 the Charity approved 167 bids, totalling over £360,000. Bids that were approved included:

- Trauma Therapy for NHS staff
- Deaf awarness training for staff
- Refurbishments for a porters' kitchen
- Supplies for scalp cooling equipment which reduces hair loss during chemotherapy
- Clinical supervision for Palliative care teams
- Maternity equipment
- A Hot Water Boiler for the Ophthalmology department
- Physiotherapy equipment
- Portable suction devices to help with treatment for head and neck cancer patients
- Clinical Supervision for counsellers and patients
- An AED Auto Defibbrilator
- Support for staff to attend an Emergency Ultrasound course
- PICC line covers for patients having chemotherapy
- Falls prevention training
- TV for patients in the cardiac care unit
- Support for staff and volunteers during the pandemic, which included refreshments, purchases of small items to improve working conditions and thank you gifts
- The curator for the Arts in Healthcare project, which is designed to enhance patients' experience when they visit the Trust's hospitals:
    - Provides professional management of the artworks displayed throughout the Trust;
    - Facilitates events where artists work with therapists and patients; and
    - Organises the provision of music across the Trust.

Governing Document

ESHTCF's governing document is the Model Declaration of Trust as registered with the Charity Commission. This provides that the Trustees shall hold the funds on trust to apply the income and, at their discretion so far as may be permissible, the capital for any charitable purpose or purposes relating to the National Health Service wholly, or mainly, for the services provided by ESHT, Hastings and Rother Clinical Commissioning Group (CCG) and Eastbourne, Hailsham and Seaford CCG.

Structure, Governance and Management

Under the provisions of the Charities Act 2011, the Charity Commission has agreed that ESHTCF should be treated as a single Charity for the purposes of Part 4 of the Act for registration and of Part 8 of the Act for accounts.

The Charity had five registered non-trading subsidiary charities as at 31 March 2021:

- East Sussex Healthcare NHS Trust Ward Fund;
- East Sussex Healthcare NHS Trust Clinical and Clinical Support Fund;
- East Sussex Healthcare NHS Trust Education Fund;
- East Sussex Healthcare NHS Trust Arts in Healthcare Fund; and
- The East Sussex Healthcare NHS Trust (Expendable Funds) Common Investment Fund.

The East Sussex Healthcare NHS Trust (Expendable Funds) Common Investment Fund is the pooling scheme fund for holding all funds.

Charity Committee Meetings

The Trustees should meet at least four times a year in order to consider any bids for over £5k and to review the management of the Charity. Reports presented to Trustees include information about income and legacies, expenditure, investment performance, and fund balances.

The Covid pandemic, and ensuing pressure on the NHS, made convening meetings during 2020/21 extremely challenging. However, the Committee managed to meet on two occasions utilising Microsoft Teams to meet virtually, and approving bids electronically when appropriate. Attendance was as follows :

Karen Manson, Non-Executive Director and Committee Chair	2/2
Paresh Patel, Non-Executive Director	2/2
Lydia Crouch, Head of Financial Services	2/2
Angela Colosi, Associate Director of Nursing	2/2
Jeanette Williams, Staff Engagement Manager	2/2
Jill Marsh, Deputy Head of Financial Services	1/2
Tom Bate, Anaesthetic Consultant and Deputy Chief of DAS	2/2
Lynette Wells, Director of Corporate Affairs	2/2
Peter Palmer, Assistant Company Secretary	2/2
Mike Eastwood, Fundraising Manager	2/2
Damian Reid, Director of Finance	2/2
Gill Reynolds, Patient Experience Lead	1/1

Governance

The Trustee delegates responsibility for the day-to-day management of the charitable funds to the Director of Corporate Affairs and the Director of Finance. The Director of Corporate Affairs is responsible for:

- the administration and governance of the funds;
- ensuring that spending is in accordance with the objectives and priorities agreed by the Trustees;
- ensuring that the criteria for spending charitable monies are fully met;
- arranging meetings of the Trustees; and
- management of the Fundraising Manager.

The Director of Finance is responsible for:

- ensuring that full accounting records are maintained;
- ensuring the accounts of Charitable Funds show a true and fair view of the year's activity;
- ensuring there is a system of control for all transactions related to expenditure and income;
- ensuring that there is robust oversight of the accounting records; and
- ensuring the accurate reporting of the in-year position to both Trustees and fund holders.

The principal officer overseeing the day-to-day financial management and accounting for the charitable funds for the accounting period 1 April 2020 to 31 March 2021 was the Director of Finance, Damian Reid.

The principal officer overseeing the day-to-day administration and governance for the charitable funds for the accounting period 1 April 2020 to 31 March 2021 was the Director of Corporate Affairs, Lynette Wells.

Financial Management

Expenditure budgets for administration, governance and fundraising costs are approved by the Trustees at the start of the financial year and are monitored throughout the year.

The Charity manages its Charitable Activity spending through appointed fundholders for the individual funds. These fundholders manage the funds on a day-to-day basis with agreed authorisation limits, and in accordance with the Trust's Standing Financial Instructions and Orders. Each fund holder receives a quarterly financial statement of their fund which details income, expenditure and fund balances for the period.

The Charity receives expenditure applications from staff throughout the year which are authorised by the fundholder and submitted to the Deputy Company Secretary, who reviews all applications to ensure that they meet the objectives of the Charity for quality, value for money and patient benefit. Where an application exceeds £5,000 the fundholder is required to present the application to the Trustees' for approval. Where any expenditure is considered inappropriate, feedback is given to the fund manager.

The Charity does not directly employ any staff; the Charity enjoys and values the services of volunteers, but is not wholly dependent on them. The Charity is not financially dependent upon the support of any individuals, corporations or specific classes of donors. No funds are held by the Charity on behalf of individuals.

Investments and Investment Policy

The Charity aims to enhance the value of its funds through sound investment.

Money is invested through CCLA Investment Management Limited and M&G Securities Ltd, with the aim of obtaining a return higher than the FTSE All Share Index (dividends reinvested). During the year, investments were held in the following proportions:

Fund	**2020/21**	**2019/20**
Fixed Interest Funds	22%	21%
CCLA Property Fund	28%	27%
M&G Securities Ltd Equities Investment Fund	50%	52%
Total investments	**100%**	**100%**

The total value of the investment portfolio at 31 March 2021 was £2.12m. The return on investment during the year was a decrease of 2% (2019/20 decrease of 9%)

Risk Management

The major risks to which the Charity is exposed have been identified and reviewed with systems established to mitigate them. The Charity relies on and benefits from the financial controls framework of ESHT.

The most significant risks identified were:

1. possible losses from a fall in the value of the investments; and
2. reputational damage leading to a sudden and dramatic fall in donations

Both risks have been carefully considered and mitigating procedures put in place. Regular review of the investment policy ensures that both spending and firm financial commitments remain in line with income. Both income and expenditure are monitored by the Committee on a quarterly basis in order that any trends can be identified at an early stage in order to avoid unforeseen calls on reserves.

Future plans

In accordance with Charity Commission directives, it is the Charity's continued intention to expend funds for the benefit of both staff and patients.

The Charity took the opportunity offered by the pandemic and the change to a corporate Trustee to review, refresh and refocus our activities and operations.

We developed a two-year strategy which has a strong emphasis on connecting with our staff and our volunteers and strengthening our operations and management systems. Our priorities over the next two years will be to;

- broaden staff representation on the committee that represents our Charity
- develop our brand using a new shorter name coupled with a simple and distinctive logo
- increase awareness with a new charity website, increased visibility across ESHT and raised social media footprint.
- strengthen the resources and management with new volunteer roles, new customer relations management system, Independent Financial Advisor and streamlining our funds.
- increase our fundraising activities particularly focussing on our Lottery, staff fundraising initiatives, a legacy strategy to capture retiring staff and volunteers and expand our corporate relationships within our local communities.

Covid has, not surprisingly, impacted our Charity with various fund-raising events cancelled but it has also sharpened our grant-making focus and prioritised the overhaul of our operations.

We envisage this focus on building our capacity and visibility will be the best use of our resources during these unusual times heavily influenced by Covid - when volunteering is reduced, staff are under heavy pressure at work, and major events and activities carry more risk and uncertainty.

We anticipate that the updated strategy will make our Charity stronger and more effective in fulfilling our objectives in the long term.

Statement of Trustee's Responsibilities

The Trustee is responsible for preparing the Charity's annual report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

Charity law requires the Trustee to prepare financial statements for each financial year that give a true and fair view of the state of affairs of the Charity and of the incoming resources and application of the resources of the Charity for the year. In preparing those financial statements the Trustee is required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP FRS 102;
- make judgements and accounting estimates that are reasonable and prudent;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue in business; and
- ensure the financial statements comply with the Trust Deed.

The Trustee is responsible for keeping accounting records that are sufficient to show and explain the Charity's transactions and disclose with reasonable accuracy at any time the financial position of the Charity and enable them to ensure that the financial statements comply with the Charities Act 2011 and regulations made thereunder. They are also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Approved by the Charity Committee on behalf of the Corporate Trustee on 28 January 2022 and signed on their behalf by:

Signed:

Karen Manson
Chair

Independent examiner's report to the corporate trustee of East Sussex Healthcare NHS Trust Charitable Fund

Commercial in confidence

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Grant Thornton

20 January 2022

Independent Examination of East Sussex Healthcare NHS Trust Charitable Fund

For attention of: the Corporate Trustee of the East Sussex Healthcare NHS Trust Charitable Fund

Grant Thornton LLP have completed an independent examination of the East Sussex Healthcare NHS Trust Charitable Fund (the Charity) draft accounts provided.

The work carried out included (but was not limited to):

- Analytical review of year on year movement in the Statement of Financial Activities and the Balance Sheet to gain assurance that variances were in line with our understanding of the Charity's activities during the year.
- Substantive testing of a sample of transactions from the Charity's accounting records to vouch the transactions to supporting documentation.
- Obtaining supporting documentation for significant balance sheet amounts (including investments and cash) at the year end.
- Discussing significant estimates/judgements made and understanding significant non-routine transactions during the year.
- Completing disclosure checklists and checks of the accounts for casting and internal consistency.

The accounts and working papers provided to us were of a high quality and officers provided clear and prompt responses to all our queries during the independent examination.

Our independent examination did not identify any significant errors, omissions or other issues with the accounts. There were only minor presentational issues which we discussed with officers and which have been corrected in the amended accounts. Our work is complete and we are in a position to provide a signed independent examiner's report for the Charity accounts.

Grant Thornton LLP

Statement of Financial Activities for the year ended 31 March 2021

	Note	2020/21 Unrestricted Funds	2020/21 Restricted Funds	2020/21 Total Funds	2019/20 Total Funds
		£000	£000	£000	£000
Income and endowments from					
Donations	2.1	285	249	**534**	**180**
Legacies	2.2	140	-	**140**	**172**
Charitable activities	2.3	7	-	**7**	**17**
Total income		**432**	**249**	**681**	**369**
Expenditure on Charitable activities					
Patient welfare		(44)	(2)	**(47)**	**(66)**
Funding for staff posts and services		(27)	(113)	**(140)**	**(29)**
Staff welfare		(74)	(29)	**(103)**	**(72)**
Purchase of equipment		(62)	(28)	**(91)**	**(113)**
Spend on charitable activities		**(208)**	**(173)**	**(381)**	**(280)**
Fundraising		(11)	-	**(11)**	**(11)**
Transfer to East Sussex Healthcare NHS Trust		-	(145)	**(145)**	**(2)**
Total expenditure	**4**	**(218)**	**(318)**	**(536)**	**(293)**
Net gains/(losses) on investments	7.1	321	-	**321**	**(219)**
Net income/(expenditure)		**534**	**(69)**	**465**	**(143)**
Transfer between funds		(2)	2	**-**	**-**
Net movement in funds	**6**	**533**	**(68)**	**465**	**(143)**
Reconciliations of funds					
Fund balances brought forward at 1 April		1,502	341	**1,843**	**1,986**
Fund balances carried forward at 31 March		**2,034**	**273**	**2,308**	**1,843**

All gains and losses recognised in the year are included in the Statement of Financial Activities.

Balance Sheet as at 31 March 2021

	Note	2020/21 Unrestricted Funds £000	2020/21 Restricted Funds £000	2020/21 Total Funds £000	2019/20 Total Funds £000
Fixed assets					
Investments	7	1,949	170	**2,119**	2,169
Total fixed assets		**1,949**	**170**	**2,119**	2,169
Current assets					
Debtors	8	1	-	**1**	1
Cash and cash equivalents		324	134	**458**	386
Total current assets		**325**	**134**	**459**	387
Liabilities					
Creditors falling due within one year	9	(240)	(31)	**(271)**	(713)
Net current liabilities		85	103	**188**	(326)
Total net assets		**2,034**	**273**	**2,307**	**1,843**
Funds of the Charity					
Unrestricted		2,034	-	**2,034**	1,502
Restricted		-	273	**273**	341
Total funds	10	**2,034**	**273**	**2,307**	**1,843**

The notes at pages 18 to 25 form part of these accounts.

Approved and authorised for issue by the Trustees on 28 January 2022 and signed on their behalf.

Karen Manson
Chair
Date: 28 January 2022

Damian Reid
Chief Financial Officer
Date: 28 January 2022

Statement of Cash flows for the year ended 31 March 2021

	Note	2020/21 Total Funds £000	2019/20 Total Funds £000
Cash flows from operating activities:			
Net expenditure for the reporting period		470	(143)
Adjustments for:			
(Gains)/losses on investments	7.1	(321)	219
(Increase)/decrease in debtors		0	(1)
Increase/(decrease) in creditors		(448)	(142)
Net cash used in operating activities		**(298)**	**(67)**
Cash flows from investing activities			
Proceeds from sale of investments		**370**	-
Net cash provided by investing activites		**370**	**-**
Change in cash and cash equivalents in the reporting period		**71**	**(67)**
Cash and cash equivalents at 1 April 2020		**386**	453
Cash and cash equivalents at 31 March 2021		**458**	**386**

Notes to the Accounts

1. Accounting Policies

1.1. Accounting Convention

The financial statements have been prepared under the historic cost convention, as modified for the revaluation of certain investments at market value. The financial statements have been prepared in accordance with the Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) and the Charities Act 2011, and UK Generally Accepted Accounting Practice as it applies from 1 January 2015.

The Trust constitutes a public benefit entity as defined by FRS 102.

The Trustee considers that there are no material uncertainties affecting the accounts or the Charity's ability to continue as a going concern and that no subsequent events have been identified which would be material and would require adjustment in the statements to 31/03/2021. The Trustee confirms that they are satisfied that charity reserves are more than sufficient to cover ongoing liquidity needs and pay creditors as they fall due for a period of at least 12 months from the date of signing the statements

1.2. Income Recognition

All income is recognised and included in full in the Statement of Financial Activities as soon as the following three factors can be met:

- Entitlement: control over the rights or other access to the economic benefit has passed to the Charity.
- Probable: it is more likely than not that the economic benefits associated with the transaction or gift will flow to the Charity.
- Measurement: the monetary value or amount of both the income and the costs to complete the transaction can be measured reliably.

Income from legacies are accounted for as incoming resources once the receipt of the legacy becomes probable. This will be once confirmation has been received from the representatives of the estates that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled or are within the Charity's control to fulfil.

1.3. Expenditure Recognition

The accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

Grants payable are payments made to third parties (including NHS bodies) in the furtherance of the charitable objectives. They are accounted for on an accruals basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive the grant. This includes grants paid to NHS bodies.

Support and Governance costs are accounted for on an accruals basis and are recharges of appropriate proportions of the ESHT costs, audit or independent examination fees, fund raising consultancy, support for the accounting software and Trustee Indemnity Insurance.

Support and Governance costs are apportioned across all funds based on the average fund balance for the year.

All items of expenditure under £5,000 are treated as revenue.

1.4. Structure of funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds. The major funds held within these categories are disclosed in note 10.

1.5. Investment Fixed Assets

Investment fixed assets are shown at bid price, which is used to measure fair value for accounting purposes of shares that are traded in an active market. The investments are valued at closing unit prices and the net gains and losses on revaluations and disposals are included on the Statement of Financial Activities.

1.6. Gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise.

Gains and losses on investments are calculated as the difference between sales proceeds and opening fair value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between fair value at the year end and opening fair value (or date of purchase if later).

1.7. Pooling scheme

An official pooling scheme, the East Sussex Healthcare NHS Trust (Expendable Funds) Common Investment Fund is operated for investments relating to the following funds:

- East Sussex Healthcare NHS Trust Ward Fund
- East Sussex Healthcare NHS Trust Clinical and Clinical Support Fund
- East Sussex Healthcare NHS Trust Education Fund
- East Sussex Healthcare NHS Trust Arts in Healthcare Fund
- The East Sussex Healthcare NHS Trust (Expendable Funds) Common Investment Fund

The Scheme was registered with the Charity Commission on 17 March 1998.

1.8. Related Party Transactions

The Trustees of the ESHTCF are **East Sussex Healthcare NHS Trust**

ESHT is the major recipient of funds of the Charity and received grants from the Charity totalling £325,000 during the year (2019/20 £233,000).

ESHT charged a management fee to the Charity of £53,000 (2019/20 £47,000) to recharge administrative costs and services provided.

The Charity owed ESHT £31,000 at 31 March 2021 (£537,000 31 March 2020).

None of the members of ESHT Board, senior staff or parties related to them were beneficiaries of the Charity. None of the Trustees or other Members of ESHT Board has received honoraria, emoluments or expenses in the year.

1.9. Debtors

Debtors are amounts owed to the Charity. They are measured on the basis of their recoverable amount.

1.10. Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the Charity as they fall due. Cash equivalents are short term, highly liquid investments.

1.11. Creditors

Creditors are amounts owed by the Charity. They are measured at the amount that the Charity expects to have to pay to settle the debt. There are no amounts which are owed in more than a year.

2. Details of Income

2.1. Donations

	Unrestricted Funds		Restricted Funds	Total 2020/21	Total 2019/20
	£000		£000	£000	£000
Donations from individuals	107		0	**107**	76
Other trading activities	-		-	**-**	9
Other	178		249	**427**	95
Grants	-		-	**-**	-
Total voluntary income	**285**		**249**	**534**	**180**

2.2. Legacies

L Rondelli	-		-	**-**	5
E Lewis	-		-	**-**	10
A E Wood	-		-	**-**	156
J E M Billings			-	**-**	1
I E Beall	5		-	**5**	-
R J V Sturgis	125		-	**125**	-
E Jones	10		-	**10**	-
Total legacies	**140**		**-**	**140**	**172**

2.3. Charitable Activities

Training courses	7		-	**7**	17
Total charitable activities	**7**		**-**	**7**	**17**

3. Analysis of charitable expenditure before allocation of Support and Governance Costs

	Unrestricted Funds		Restricted Funds	Total 2020/21	Total 2019/20
	£000		£000	£000	£000
Arts in Healthcare	21		0	**21**	22
Other patients welfare and amenities	11		2	**13**	34
Patient welfare total	**32**		**2**	**35**	**56**
Funded staff posts and services	7		76	**83**	12
Funding for Professional Fees	12		37	**49**	9
Funding of staff posts and services total	**19**		**113**	**133**	**21**
Support to staff training	7		7	**13**	32
Annual Staff Awards and retirement gifts	-		-	**-**	4
Other support to staff welfare and amenities	47		22	**69**	23
Staff welfare total	**54**		**29**	**83**	**59**
Purchase of equipment	45		28	**74**	95
Fundraising	11		-	**11**	11
Transfer to East Sussex Healthcare NHS Trust	-		145	**145**	2
Total charitable expenditure	**162**		**318**	**480**	**244**

All charitable expenditure is classified as grant funded activities

4. Analysis and Allocation of Support and Governance Costs

	2020/21 Total Funds	2019/20 Total Funds
	£000	£000
Administration fee	27	24
Preliminary fundraising expenses	-	-
Total support costs	**27**	**24**
Independent Examiner's fee	2	2
Indemnity insurance	1	0
Governance fee	26	23
Total governance costs	**29**	**25**
Total support and governance costs	**56**	**49**

The support costs and governance costs attributable to charitable activities is apportioned based on the total expenditure for the year for each charitable activity as shown in the table below.

	2020/21 Grant funding of activities	2020/21 Support and Governance Costs	2020/21 Total Funds	101 Total Funds
	£000	£000	£000	£000
Allocation of support and governance costs	Note 3			
Patient welfare	35	12	47	66
Funding for staff posts and services	133	7	140	29
Staff welfare	83	20	103	72
Purchase of equipment	74	17	91	113
Active continuing funds	**324**	**56**	**381**	**280**
Fundraising	11	-	11	11
Transferred funds	145	-	145	2
Total allocated	**480**	**56**	**536**	**293**

Grants paid in year to ESHT £325,000 (2019/20 £233,000), Grants paid to individuals in year £4,500 (2019/20 £8,000).

5. Examiner's remuneration

The Independent Examiner's remuneration of £1,800 exclusive of VAT (2019/20 £1,800) related solely to the independent examination with no other additional work undertaken.

6. Changes in Resources Available for Charity Use

	2020/21 Unrestricted Funds	2020/21 Restricted Funds	2020/21 Total Funds	2019/20 Total Funds
	£000	£000	£000	£000
Net movement in funds for the year	534	(69)	**465**	(143)
Net movement in funds available for future activities	**534**	**(69)**	**465**	**(143)**

7. Analysis of Fixed Asset Investments

7.1. Fixed Asset Investments

	2020/21 Total	2019/20 Total
	£000	£000
Market value at start of period	**2,169**	2,388
Net gain on revaluation and sales	**(49)**	(219)
Market value at end of period	**2,120**	**2,169**
Historic cost at end of period	**1,232**	**1,203**

7.2. Market Value

	31 March 2021	31 March 2020
	£000	£000
Investments in a Common Deposit Fund or Common Investment Fund		
CCLA Investment Management Fixed Interest Funds	**422**	415
CCLA Investment Management Property Fund	**599**	585
M&G Securities Fixed Interest Investment Fund	**40**	39
M&G Securities Equities Investment Fund	**1,057**	1,128
Total	**2,118**	**2,167**

Cash held as part of the investment portfolio	**2**	2
Total	**2,120**	**2,169**

All units are held within the UK.

8. Analysis of Debtors

	Balance 31 March 2021	Balance 31 March 2020
	£000	£000
All falling due within one year		
Trade debtors	1	1
Total debtors	**1**	**1**

9. Analysis of Creditors

	Balance 31 March 2021	Balance 31 March 2020
	£000	£000
Falling due within one year		
Accruals and deferred income	234	176
Other creditors	36	537
Total creditors	**271**	**713**

10. Analysis of Funds

10.1.

	Balance 31 March 2020	Income	Expenditure	Transfers	Gains and Losses	Balance 31 March 2021
	£000	£000	£000	£000	£000	£000
Restricted funds	**1,502**	**432**	**(218)**	**-**	**321**	**2,035**
COVID-19	0	135	(52)	(42)	-	**41**
COVID - Deaf App	-	52	-	-	-	**52**
COVID-19 TRiM Training	-	50	-	-	-	**50**
COVID-19 Sunflower Scheme	-	10	-	-	-	**10**
Arts in Healthcare	1	0	(0)	-	-	**1**
COVID - What Matters to You	-	-	(20)	42	-	**22**
Conquest Equipment	3	-	-	-	-	**3**
South East Coast Orthopaedic Training	148	-	-	(145)	-	**2**
Lewes Victoria Hospital	13	-	-	-	-	**13**
EDGH Scanning Equipment for Intensive Care and Radiology	145	-	-	-	-	**145**
Maternity Bereavement Suite	21	-	(24)	-	-	**(3)**
Conquest Courtyards	8	1	(0)	-	-	**9**
Youth Volunteering Project	0	-	(76)	-	-	**(76)**
Kipling Music	2	-	(0)	-	-	**2**
Total Restricted Funds	**342**	**249**	**(173)**	**(145)**	**-**	**272**
Total Funds	**1,843**	**681**	**(391)**	**(145)**	**321**	**2,308**

10.2. Details of the Restricted Income Funds

Name of fund	Description
COVID-19	The fund held to enhance the well-being of NHS Staff, volunteers and patients impacted by COVID-19
COVID - Deaf App	The development of an app for deaf users
COVID-19 TRiM Training	This is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event.
COVID-19 Sunflower Scheme	Project to promote sunflower lanyards, which demonstrate when someone has a hidden disability.
Arts in Healthcare	The promotion of the initiative for the provision of Arts in Healthcare
COVID - What Matters to You	Supporting staff through Covid 19 and beyond – rest areas/ staff room.
Conquest Equipment	The fund held for the purchase of Equipment at Conquest Hospital
South East Orthopaedic Training	To provide training for junior doctors in surgical skills
Lewes Victoria Hospital	The fund held for the benefit of Lewes Victoria Hospital
EDGH Scanning Equipment for Intensive Care an Radiology	The funds held for the purchase of Scanning Equipment for Intensive Care and Radiology at Eastbourne District General Hospital
Maternity Bereavement Suite	The fund held for the refurbishment of the Maternity Bereavement Suite.
Conquest Courtyards	The fund held for the benefit of the Conquest Courtyards.
Youth Volunteering Project	The fund held for the development of youth volunteering opportunities in East Sussex
Kipling Music	The fund held to provide interactive music sessions to Kipling Ward

11. Funding Commitments

As at 31 March 2021 the Trustees had not made commitments other than those shown as creditors, Note 9.

12. Trustee Indemnity Insurance

	2020/21	2019/20
	Amount	Amount
	£000	£000
Trustees' indemnity insurance	1	-
Total	**1**	**-**

Ways in which to support our Charity

There are many ways you can support our Charity.

Donations can be made in the following ways:-

Direct into bank account
Bank: Lloyds Bank
Sort code: 30-92-86
Account number: 00460039
Account name: East Sussex Healthcare NHS Trust Charitable Fund
Reference: Please state the General Fund

By post
Cheque to East Sussex Healthcare NHS Trust Charitable Fund

Please write on the back of the cheque which fund you would like to donate to, e.g. General Fund, and send to:

Charitable Funds
St Anne's House
729 The Ridge
St Leonards-On-Sea
East Sussex
TN37 7PT

By a donation on our 'Just Giving' site
www.justgiving.com/esht

As well as making a general donation, you can also open a page in celebration of and in memory of a loved one. If you are a group or an organisation who is interested in raising money on behalf of the Charity, we would love to hear from you too.

For more information and for support if you are holding your own event, please contact:

Mike Eastwood
East Sussex Healthcare NHS Trust Charitable Fund
Email: mike.eastwood@nhs.net

Gift Aid
Gift Aid is a simple, government initiative which allows us to increase the value of your donations at no extra cost to you. For every pound you give to us we can get an extra 25 pence from HM Revenue and Customs helping your donation go further to help patients and their families. The only condition is that you are a UK tax payer. When making a donation simply let us know that you wish to Gift Aid your donation, to do this all we need is your name and address.

Use of Trust Seal

Meeting information:	
Date of Meeting: 8th February 2022	Agenda Item: 15
Meeting: Trust Board	Reporting Officer: Steve Phoenix, 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 confirm there were no uses of the Trust Seal between 7th December 2021 and 1st February 2022.

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 that the Trust Seal was not used since the last Board meeting.