

EAST SUSSEX HEALTHCARE NHS TRUST

TRUST BOARD MEETING IN PUBLIC

A meeting of East Sussex Healthcare NHS Trust Board will be held on
Tuesday, 11th October 2022 commencing at 09:30 at
Club Room, Horntye Park Sports Complex, Bohemia Road, Hastings, TN34 1EX

AGENDA

				Lead:	Time :
1.	1.1 Chair's opening remarks 1.2 Apologies for absence 1.3 Hero of the Month Award	A	Chair		0930 - 0955
2.	Declarations of interests		Chair		
3.	Minutes of the Trust Board Meeting in public held on 9 th August 2022	B	Chair		
4.	Matters Arising	C			
5.	Board Committee Chair's Feedback	D	Committee Chairs		
6.	Chief Executive's Report	E	CEO		

QUALITY, SAFETY AND PERFORMANCE

					Time :
7.	Integrated Performance Report Month 5 (August) 1. Chief Executive Summary 2. Quality and Safety 3. Our People – Our Staff 4. Access and Responsiveness 5. Financial Control and Capital Development	Assurance	F	CEO CND CMO COO CPO CFO	0955 - 1055

BREAK

STRATEGY

					Time :
8.	Transformation: 1. Cardiology 2. Ophthalmology	Endorsement	G	CEO	1110 - 1155

GOVERNANCE AND ASSURANCE

					Time:
9.	Nursing Establishment Review	Assurance	H	CND	1155 - 1215
10.	Winter Preparedness	Assurance	I	COO	
11.	Board Assurance Framework: Q2 update	Assurance	J	CS	

ITEMS FOR INFORMATION

					Time:
12.	Use of Trust Seal	Assurance	K	Chair	1215 - 1230
13.	Questions from members of the public (15 minutes maximum) The Board welcomes questions from the public on matters covered by the Board agenda			Chair	
14.	Date of Next Meeting: • Tuesday 13 th December 2022			Chair	

Steve Phoenix
Chairman
September 2022

Key:	
Chair	Trust Chair
CEO	Chief Executive
CND	Chief Nurse and DIPC
COO	Chief Operating Officer
CFO	Chief Finance Officer
CS	Chief of Staff
CPO	Chief People Officer
CMO	Chief Medical Officer
DM	Director of Midwifery

Board Meetings in public: Etiquette

As we return to face-to-face meetings, we thought it helpful to offer a reminder of the things that we know contribute to productive meetings and show respect to all members in the room:

- Mobile devices that are not used solely for the purpose of following the meeting ought not to be brought into the meeting
- If you are required to have a mobile device about your person, please keep the use to a minimum, and ensure that it is on silent mode. If you are required to take a call, please do so outside the meeting
- All members of the public are asked to sign in
- Recording devices should not be used in the meeting
- The Trust Board is a meeting in public, not a public meeting. As such, the Chair leads and directs the meeting. Papers are presented to the chair (not to the public) so where points are raised/responses are made these should be directed to the Chair
- Questions from members of the public may only relate to items on the agenda, and these will be considered in the time set aside on the agenda
- If several members of the public wish to raise questions, the Chair will seek to ensure a fair allocation of time among questioners

Board Meetings in public: Details to Year End 22/23

Month	Location	Timing	Any other information
13 th December 2022	St Mark's Church Hall Green Ln Bexhill-on-Sea TN39 4BZ	09.30 – 12.30	
14 th February 2023	Holy Cross Priory Lewes Road Cross-in-Hand Heathfield TN21 0DZ	09.30 – 12.30	

Hero of the Month and Long Service Awards

Meeting information:	
Date of Meeting: 11 th October 2022	Agenda Item: Hero of the Month and Long Service Awards
Meeting: Trust Board in Public	Reporting Officer: Steve Phoenix Report Author: Jacquie Fuller

Purpose of paper: (Please tick)	
Assurance <input checked="" type="checkbox"/>	Decision <input type="checkbox"/>
Has this paper considered: (Please tick)	
Key stakeholders: Patients <input type="checkbox"/> Staff <input type="checkbox"/>	Compliance with: Equality, diversity and human rights <input type="checkbox"/> Regulation (CQC, NHSi/CCG) <input type="checkbox"/> Legal frameworks (NHS Constitution/HSE) <input type="checkbox"/>
Other stakeholders please state:	
Have any risks been identified <input type="checkbox"/> (Please highlight these in the narrative below)	On the risk register?

Summary:

June 2022 Winner

Michelle Bridger - Professional Nurse Advocate for the District Nurses – CHIC

Nomination One

Michelle works in the Staff Engagement & Wellbeing team with the Eastbourne District Nursing Team. Michelle is a well valued member of the team and consistently goes above and beyond to support the wellbeing of the team which is a great moral boost in challenging times. Michelle organised a wonderful celebration for the teams for the Jubilee. She worked hard to decorate the office and supply refreshments. Michelle demonstrated true respect and compassion for the team, even considering those with food intolerances. The staff working across the bank holiday weekend all commented on how wonderful this was and it enabled a true sense of positive team working which in turn supports the care that the team provide to patients in the community.

Nomination Two

Since becoming the Professional Nurse Advocate for the District Nurses, Michelle has worked together closely with the teams to embed Restorative clinical supervision into practice which in turn benefits the wellbeing of all staff and improves the quality of the service.

She also spends a lot of time and energy making sure the teams are included in the treats the acute hospitals get. Previously the community staff have felt forgotten by the Trust. At Christmas and Easter and just this weekend during the Jubilee, those of us working had some lovely food to share.

She is always cheerful and ready to listen if needed, and is very supportive. She has worked together with all the community nursing teams listening to our concerns and reporting back to the powers that be to improve and develop the community service both for staff and patients. She commands respect and has respect for all of the

team members with great compassion for those who may be struggling offering 1:1s, which in turn creates engagement and involvement at every level.

Michelle does a lot more than I have stated here and really goes the extra mile for us, even bringing a plant in from her home to brighten up the office. She is a lovely person who really deserves to be Hero of the month!



July 2022 Winner

Logistics Team – Logistics – Estates & Facilities

Tony and his team work extremely hard and often go unnoticed. They constantly go above and beyond to support colleagues with sourcing or moving just the odd item of furniture to a full office move. Tony and his team has recently supported our move from the very beginning and his knowledge and experience has been invaluable in making sure the this ran smoothly without any hitches.

Tony and his team have demonstrated that they are good humoured, supportive and communicate well to oversee all aspects of what was required. Tony and his team are an asset to the Trust and without their hard work and support this would not be possible. I would personally like to extend a big thank you to the Logistics team for their support in the smooth running of the move.



Long Service Awards

June 2022					
10 Years' Service		25 Years' Service		40 Years' Service	
Caroline	Bishop	Katy	Fox-Dossett	Jackie	Middleton
Dean	Carling	David	Howlett		
Stephen	Chan	Peter	King		
Anne	Eldridge	Gail	Oliver		
Fiona	Jenkins	Sharon	Palmer		
Maria	Johnson	Anthony	Phipps		
Richard	Keeble				
Adeel	Khan				
Alma	Ragudo				
Jonathan	Sykes				
Katie	Toppin				

July 2022					
10 Years' Service		25 Years' Service		40 Years' Service	
Mithal	Abdulnabi	Belinda	Chissell		
Alexandra	Baker	Stephanie	Stanyard		
Lisa	Coleman	Deborah	McKenna		
Heather	Driver	Kerry	Bowman		
Maria	Filyridou	Gary	Wendel		
Jennifer	Gabanes	Nick	Turner		
Trisha	Hamblin				
Kimberley	Hysa				
Leroy	Laban				
Susanna	Marsden				
Mary	Martellini				
Lisa	Pleace				
Paul	Saville				
Lisa	Morton				
Ciara	Pooley				

TRUST BOARD MEETING**Minutes of a meeting of the Trust Board held in public on
Tuesday, 8th August 2022 at 09:30
in the St. Mary's Boardroom, EDGH**

Present: Mr Steve Phoenix, Chairman
Mrs Joe Chadwick-Bell, Chief Executive
Mrs Tara Argent, Chief Operating Officer
Mrs Vikki Carruth, Chief Nurse & Director of Infection Prevention and Control
Mrs Jackie Churchward-Cardiff, Vice Chair
Mrs Miranda Kavanagh, Non-Executive Director
Mrs Karen Manson, Non-Executive Director
Mr Damian Reid, Chief Finance Officer
Dr David Walker, Medical Director
Mrs Nicola Webber, Non-Executive Director

Non-Voting Directors:

Mr Richard Milner, Director of Strategy, Inequalities & Partnerships
Ms Carys Williams, Associate Non-Executive Director

In attendance:

Mr Chris Hodgson, Director of Estates and Facilities
Mrs Jill Jaratina, Interim Associate Director of Corporate Governance (observing)
Ms Brenda Lynes, Director of Midwifery
Mrs Lorraine Mason, Associate HR Director
Mr Peter Palmer Acting Company Secretary (minutes)

051/2022 Chair's Opening Remarks

Mr Phoenix welcomed everyone to the meeting, noting that this was the first meeting that the Trust Board had held in person since February 2020 and that there had been a large number of changes to the Board in the intervening two and a half years.

He reported that Mr Milner had changed role to become Chief of Staff since the last Board meeting. He also noted that the meeting marked Dr Walker's last public meeting as Medical Director, explaining that he had held this role since 2016. He praised the fantastic medical leadership that Dr Walker had shown through a very challenging period, noting his outstanding contribution and thanking him all that he had done. He reported that Dr Walker would be replaced by Dr Simon Merritt as Chief Medical Officer at the start of September.

Mr Phoenix welcomed Mrs Mason, who was covering for Steve Aumayer, and Mrs Jaratina, who had recently joined the Trust as Interim Associate Director of Corporate Governance to the meeting. He also welcomed Paul Jones, who had recently taken over as Staff Side Chair for the Trust from Jan Humber. He

thanked Mrs Humber for her time in that role, noting that the Trust and Board owed thanks to her for all that she had achieved.

i. **Apologies for Absence**

Mr Phoenix advised that apologies for absence had been received from:

Mr Steve Aumayer, Chief People Officer

Mrs Amanda Fadero, Associate Non-Executive Director

Mr Paresh Patel, Non-Executive Director

ii. **Hero of the Month**

Mr Phoenix reported that Hayley Barron, who project managed the acquisition of Spire Sussex Hospital by ESHT, had won the Trust's Hero of the Month Award for April. Beata Nagy, a housekeeper at EDGH, had won the award for May.

He noted that winners of long service awards were also included within the report for the first time, and that Nic Violaris, Jan Talent, Maggie Brook, Fern Skinner and Jackie Middleton had all recently received 40 year service awards at ESHT.

052/2022 **Declarations of Interest**

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

053/2022 **Minutes**

The minutes of the Trust Board meeting held on 14th June 2022 were considered. A number of amendments to the minutes were noted:

- Page 3: in the last sentence the word 'after' should be added following 'staff were well looked'
- Page 7: wording to be revised in penultimate paragraph to read 'should be better than national average'
- Page 6: Should read "care hours per patient day", not "carers per patient day"
- Page 14: Should be an increased uplift of 26%, not 24%.

They were otherwise agreed as an accurate record, and were signed by the Chair and would be lodged in the Register of Minutes.

054/2022 **Matters Arising**

There were no formal matters arising from the meeting on 14th June 2022.

055/2022 **Board Committee Chair's Feedback**

i. **Audit Committee**

Mrs Manson reported that the Audit Committee had met three times since the last Board meeting in public. They had met on 20th and 21st June to approve the

Trust's annual report and accounts. The Committee met again on 28th July where an update on cybersecurity in the Trust had been received. The Committee's Annual Report and review of self-effectiveness had been discussed.

The Committee had received a report on a new NHSE mandated audit of financial governance which was due to be undertaken in August by the Health Financial Management Association. This comprised 72 questions assessing how the organisation had changed during the pandemic. The Trust's annual Value for Money (VFM) assessment had been presented, with the Trust receiving an overall good rating. The annual Counterfraud return had been submitted with an improved rating of green, compared to the amber rating the previous year, demonstrating considerable improvement.

Mrs Manson presented the 2021/22 Audit Committee annual report, noting that the Committee had met its obligation of meeting at least four times during the year. 14 internal audits had been completed during the year and the Trust had received an overall internal audit opinion of reasonable assurance. Regular reports had been presented to the Committee throughout the year by external and internal auditors and the anti-crime team.

The Board noted the Audit Committee summary and 2021/22 Audit Committee Annual Report.

ii. Finance and Investment Committee

Mrs Webber reported that the Finance and Investment (F&I) Committee had met on 28th July 2022. The Committee had discussed its Annual Review of Effectiveness and this was presented to the Board along with the updated ToRs. The Committee had also discussed the Nursing Establishment Review, and Mrs Webber thanks Mrs Carruth and her team for their hard work in completing this. She also thanked Mr Hodgson and his team for their work in realising savings related to the Public Sector Decarbonisation Scheme: Phase 3 (PSDS3), noting that the Board was considering a business case related to PSDS3 in their private meeting later in the day.

The Board noted the Audit Committee summary and 2021/22 F&I Committee Annual Report. The Board approved the updated F&I Terms of Reference.

iii. People and Organisational Development Committee

Ms Williams reported that the People and Organisational Development (POD) Committee had last met on 21st July 2022. The Committee had discussed the continuing workforce challenge and had also reviewed the new POD Workforce Report. A lot of positive stories had been presented during the meeting, and Ms Williams thanked Executive colleagues for their hard work.

The Trust had been awarded disability leader status, the highest available level, and this was an achievement all of the Trust's staff should be proud of. The annual Committee review had been discussed and feedback had shown that members would like more time to allocated to key topics moving forward.

Mrs Churchward-Cardiff asked for further information about the alumni programme mentioned in the Committee report, and Mrs Mason explained that Trust staff who retired still had much to offer the organisation. The programme would initially be on a voluntary basis with ex staff asked to offer advice and guidance; it was hoped that the programme may also attract some retired staff to come back and join the workforce on a part time basis. The programme would start in October.

The Board noted the Committee summary and annual report.

iv. Quality and Safety Committee

Mrs Manson reported that the Quality and Safety (Q&S) Committee had last met on 21st July 2022. The pressure being experienced by Trust services had been discussed in detail, particularly the associated risks for patients who did not meet the criteria to reside (NCTR). A presentation had been received from Spire Premier Health (SPH) who had become a division of the Trust in April 2022 with the acquisition of Spire private healthcare by ESHT. The Committee heard that the Trust had received a positive report from maternity services following a very successful visit from the Ockenden insight team. The challenges of introducing InPhase, new software that was used for assessment by the CQC, were discussed by the Committee.

The Board noted the Committee summary.

v. Strategy Committee

Mrs Churchward-Cardiff reported that the Strategy Committee had last met on 23rd June 2022. The Committee had discussed the development of 'Place' in the ICS from a strategic perspective, noting that this would help to identify what more could be done as a system to allow patients to receive the care they required outside of an acute hospital setting. The introduction of virtual wards would be a key factor in resolving this issue.

The Committee had also discussed transformation, and how this would help the Trust to become more effective, improve its reputation and increase levels of care that could be provided. The new Director of Strategy and Transformation was due to start at the beginning of September and the Strategy Committee's Terms of Reference and structure moving forward would be reviewed once she had joined the Trust.

The Board noted the Committee summary.

056/2022 Chief Executive's Report

Mrs Chadwick-Bell thanked all the Trust's staff, noting that recent months had been very challenging time for the organisation. The pressures that the NHS were under had been highly publicised, and the organisation would not be able to keep looking look after patients without the hard work and dedication of its staff. She welcomed Gbolohan Oluwatunmise who had joined the Trust as Associate Director of Culture, noting that he would contribute to the Trust's

continuous journey of improvement. He would work closely with workforce colleagues and with the Staff Side Chair, Paul Jones.

She reported that the Trust continued to experience considerable pressure each day; Covid remained part of everyday activity for the Trust, and continued to impact on the management of the hospital. Mrs Chadwick-Bell reported that she had enjoyed a pleasant visit to the maternity unit the previous week, thanking the maternity team for all of the great work that they did.

Mrs Chadwick-Bell thanked Dr Walker for his huge contribution as Medical Director over the previous six years, noting that he had been of great support during that time. She explained that he would be moving into semi-retirement once he stepped down from his role, and was delighted that he would continue to work as a Consultant Cardiologist.

She reported that Dr Simon Merritt would start as Chief Medical Officer in September, noting that he had been appointed following a national interview process which had included external interviewers. Brenda Lynes had been appointed as Director of Midwifery for the Trust, having previously been Associate Director for the Women and Children's Division. She praised the work of Mrs Lynes over the previous months. Mr Milner's role had changed and he was now Chief of Staff for the Trust. Finally, Charlotte O'Brien would be joining the Trust as Director of Transformation and Improvement in September, and would look at how improvement could be embedded into everything that the Trust did.

Mrs Chadwick-Bell explained that the Trust's key area of focus was the discharge of patients who no longer needed to be in hospital. On the date of the meeting there were 319 patients who did not meet the criteria to reside (DCTR) in hospital. There were a number of reasons for this large number of patients, and much was being done both within the Trust and as a system to resolve the issue. The number of patients stretched the workforce, as additional capacity had to be opened, and led to staff having to work away from their usual wards and teams. From a patient perspective, the situation meant that patients were unable to leave hospital when they no longer needed to be an inpatient; it also affected the Trust's ability to unload ambulances, and to move patients from A&E into wards. It also had a negative effect on the Trust's financial position, as the additional capacity was not within budgets and reduced capacity for elective work.

The Special Care Baby Unit (SCBU) at Conquest Hospital had recently become the first Level One unit in the country to achieve Gold Accreditation in The Bliss Baby Charter. All NHS staff had been awarded the George Cross a couple of weeks before and Mrs Chadwick-Bell noted that colleagues should be proud of this achievement. She explained that the Trust had ordered medals and recognition certificates for staff, apologising that these had taken some time to arrive.

Mrs Chadwick-Bell reported that she and her executive colleagues had been spending time in the organisation talking and listening to colleagues. She had

recently opened Park View in Bexhill, a community paediatric site which was a fantastic venue for staff, parents and children. She had also welcomed new foundation doctors to the Trust and thanked second year doctors for their hard work as they left the organisation. Mrs Chadwick-Bell had also visited the mammography department and had seen the innovative service that was offered; she thanked the team for their great work.

Good progress continued to be made on energy efficiency improvements at Eastbourne District General Hospital; £28m of external Salix funding had been received to improve fascias, windows and insulation representing an exciting opportunity for the Trust.

Mrs Chadwick-Bell noted that the chair of the Trust's Disability Network, January Newton-Baxendine, was in attendance at the meeting. She thanked her for her work in leading the network, noting that she was delighted that the Trust had recently become a Disability Confident Leader (DCL).

Mrs Kavanagh noted that she was concerned that some of the key performance indicators, such as A&E, cancer, never events and staffing, had recently deteriorated and asked how improvements were being managed. Mrs Chadwick-Bell noted the large impact that Covid had made on the organisation, particularly on elective performance and on the Trust's workforce; recovery from the pandemic continued, with staff still absent due to covid, and continued red and green patient streaming led to reduced efficiency. An additional challenge was the number of NCTR patients. The Trust's four hour A&E performance continued to compare well to peer organisations. Some of the metrics that were reducing were being driven by how full the Trust was, with additional areas that would not normally look after patients. The Trust was working closely with the system and with partner organisations to continue to deliver activity, while ensuring that clinical indicators remained good. Mr Phoenix noted that the Trust was in the top quartile of national performers, and was the best performing Trust in Sussex by some margin. Despite this, the Trust was not where it wanted to be and would continue to work to improve performance and quality metrics for the benefit of both staff and patients.

The Board noted the Chief Executive's Report.

057/2022

Integrated Performance Report (IPR) for Month 3 (June)

Mrs Chadwick-Bell noted that page five of the IPR reported that the Trust was treating 75 patients with Covid, a figure that had subsequently increased to a peak of 125 patients, but was thankfully now reducing. In June, the Trust had reported its best performance against the DMO1 standard (patients waiting for less than six weeks for a diagnostic test) since April 2020. The Trust's new Community Diagnostic Centre (CDC) was due to open in Bexhill in the autumn and would improve diagnostic performance further.

The Trust was continuing to develop its two hour emergency response service which would help to relieve pressure on A&E services. An increase in the number of patients treated in Urgent Treatment Centres (UTCs) had been seen in June,

along with an improvement against the four hour A&E standard. The Trust also remained on target for treating long waiting elective patients, and for capital spending for the year. Key areas of challenge that were being addressed were ambulance conveyances and handovers, finance and staff sickness rates.

i. Quality and Safety

Mrs Carruth reported that the recent surge in Covid infections that had been seen was now subsiding. The R rate for new variants was over 18, but the pathology of these variants meant that people were generally less unwell. Visiting guidance had not changed and she asked that the public continued to support the Trust by adhering to this guidance.

There had been a significant number of clostridium difficile cases reported in the first quarter of 2022/23, with four cases in July against an internal limit of five. The number of DCTR patients was making it challenging to maintain infection control precautions, particularly for patients who wandered, were confused or who refused to follow guidance or advice. There had been one Never Event and one Serious Incident (SI) reported in June, with both patients involved remaining well. A historic category five incident, which was a multi-agency issue, had been declared which was under investigation by paediatric colleagues. An increase in falls had been seen in June, reflecting the increasing frailty and complexity of adult inpatients who did not meet criteria to reside.

Feedback from Friends and Family Testing remained very positive overall, although there had been a decline in positive recommendation rates in A&E due to delays and overcrowding. Almost 3,200 comments had been received by the Trust in June and July, with the vast majority very positive, including many positive comments about staff. Themes for negative feedback received included food, waiting for staff, noise at night, communications between teams and discharge. During June there had been an increase in care hours per patient per day, but this had reduced in July due to the significant increased capacity required. Discussions were taking place about how clinical staff could be freed to undertake mandatory training during busy periods.

Mrs Carruth reported that she had had a back to the floor day on a frailty ward the previous week, which had been a privilege and a pleasure. She had seen skilled, compassionate care provided in difficult circumstances. Staff had cared for patients in a fantastic way and she had been humbled to see them overcome the challenges that they faced on a daily basis. The Trust had almost ten wards worth of patients who did not need to be in hospital, and those patients could be particularly challenging to care for due to their nutrition and hydration requirements, disorientation and a tendency for some to fall. Staff were going to great lengths to look after these patients, and she thanked the frailty team and patients on the ward for allowing her to spend the day with them.

Mrs Webber explained that when she had read the IPR before the meeting she had not been assured that the Trust remained safe, noting the challenges of caring for patients in areas that were not always designed for care. She explained that she was proud that the organisation continued to provide safe care in very

challenging circumstances, noting that sickness, turnover and retention rates reflected the challenges faced by the Trust's workforce. Despite the numerous challenges, she found the positive verbal report to the Board, in combination with some aspects of data in the IPR including falls trends remaining static, to be positive frames of reference for what was otherwise difficult information.

Mrs Churchward-Cardiff asked for an update on safeguarding for children and adults with mental health issues. Mrs Carruth explained that the while Trust was collaborating closely with system colleagues, huge challenges arose on a daily basis. The number of children who required acute inpatient care for mental health issues was minimal, but there were a number of high risk, vulnerable children who needed to be in a safe place to receive support. The children's ward in an acute hospital was not the best environment for these patients and conversations were ongoing about how to get them to the correct place for their care. In addition, a huge number of vulnerable and at risk patients were stranded in hospital and resolution of this issue was being discussed by the Integrated Care System (ICS) at the highest level. Mrs Argent noted that this was a national issue, and that the impact on A&E, which was a designated safe space where police could bring patients with mental health issues to await assessment, was significant. Mrs Chadwick-Bell noted that there was an East Sussex mental health collaborative; this was being refreshed, with strengthened governance that would enable it to set priorities to address the issues being discussed.

In response to a query from Mrs Webber, Mrs Carruth explained that links between two of the clostridium difficile cases had been found as a result of multiple factors including covid, workforce pressures and confused patients. No links had been found between the other cases, which had covered eight different clinical areas, but all the cases had been subject to review.

Dr Walker presented the Trust's mortality data, reflecting on the outstanding progress that had been made over the past six years. The Summary Hospital-level Mortality Indicator (SHMI) had been as high as 116 in the past, but had moved to below the national average in 2017 and had remained there ever since. ESHT remained in the top quartile of Trusts for its Risk Adjusted Mortality Index (RAMI) performance, and Dr Walker noted that he had included data in the IPR showing weekend vs weekday RAMI rates. He explained that all trusts saw slightly increased mortality at weekends; ESHT had worked hard to improve weekend performance and the RAMI rate was considerably lower than national average at weekends, something the Trust should be very proud of.

Mrs Churchward-Cardiff asked about the 18 deaths reported where no cause of death had been entered on the Trust's mortality database. Dr Walker explained that there were times when a cause of death was unclear; each death was subject to review by the mortality review group, but the exact cause of death was not always established.

Mrs Kavanagh asked why there was a difference between weekday and weekend mortality. Dr Walker explained that at the weekend there were fewer clinical staff in hospitals, so less was support available when there were

complications. Weekend clinical support had greatly improved in comparison to a few years before, which was why the mortality rate a weekends had improved. The NHS as a whole was trying to address this by looking at different ways of working to achieve a more even spread of staff across the week. Mrs Carruth noted that nursing numbers were largely the same on weekdays and weekends.

ii. Our People – Our Staff

Mrs Mason thanked Dr Walker for his contribution to the Trust, noting that he had been a great asset and supporter of the Human resources team during his time as Medical Director. She reported that June had been challenging, particularly from a workforce perspective. Staff sickness had increased from 5% to 5.5%, with the main reasons for absence being respiratory issues and chest infections. Staff were also unwell for longer, and this was being closely monitored with interventions offered where appropriate. An increase in staff turnover to 12.3% was seen during the month, which remained good compared to comparator organisations but was being monitored. A lot of work was being undertaken to improve retention of staff, with the top reasons for staff leaving being retirement and work/life balance. During month three, operational pressures had led to reduced appraisal rates, mandatory training compliance and job planning compliance.

Mrs Mason reported that the Trust's workforce having grown slightly during the month, but that it remained challenging to recruit staff. The Trust had recently introduced a new system, MYLearn, which would allow for a proactive talent management system to be developed in the organisation, benefiting all staff.

The Trust's recent quarterly meeting with the Integrated Care Board (ICB) had been primarily focussed on people, and the Trust had received very positive feedback, particularly about the progress that was being made towards becoming a positive, inclusive culture. The Trust had been asked to share this work with other organisations in the Integrated Care System (ICS).

The HR team was working hard to support the operational business of the organisation and had recently introduced HR Solutions, a one-stop shop providing 24 hour advice and guidance on workforce policies for colleagues. The financial wellbeing of colleagues was a key concern for the Trust, and the wellbeing team were offering a range of interventions; 50 queries had been received from staff in July relating to financial wellbeing. A staff partnership forum was being set up to ensure that the voices of staff were heard.

Mrs Churchward-Cardiff noted that the time to hire for ancillary and estates staff seemed high. Mr Hodgson explained that the estates team were working closely with HR colleagues to reduce the time to hire. Ms Williams noted that the time to hire was monitored through POD.

Mrs Manson noted that average sickness days had risen consistently over the last year, but had not gone up initially during the pandemic. Mrs Mason explained that a deep dive was being undertaken to fully understand the reasons for the increase. Staff who had recently got Covid were off work for longer than those

who had got Covid at the start of the pandemic. Mrs Churchward-Cardiff noted that staff exhaustion due to the relentless pressure might be a factor, and looked forward to seeing the outcome of the deep dive.

iii. Access and Responsiveness

Mrs Argent thanked Dr Walker for all his hard work. She explained that he had been hugely supportive during her time with the Trust and that she would miss him greatly.

She reported that resolving the issue of patient flow through the organisation would be crucial to resolving wider issues within the Trust. As of that morning, the Trust had 302 NCTR patients, with 135 medically ready for discharge. Mrs Argent had spent time with colleagues, including working in the discharge hub, to fully understand any blocks that were encountered when discharging patients and had found both internal and external issues that were being resolved.

A system workshop had been organised the following week which would develop a place based system for resolving issues. Discussions were taking place about how care could be offered differently, as there was currently insufficient capacity in the care market. Discharge co-ordinators would be introduced in Emergency Departments (EDs) to begin to plan patient discharge at the point of admission; the intention was that patient discharge would become the mission of every member of staff in the Trust.

The live bed state module of Nerve Centre had gone live on 3rd August, with floor walkers, superusers and representatives from Nerve Centre supporting the Trust with the introduction, which had been well received by staff. Site teams had had been very engaged, using tablets to receive live information about patients. The Nerve Centre lead had fed back about how impressed she had been with the ward staff, front door staff and operational control in the Trust.

The delivery of 104% of elective performance against the 2019/20 baseline continued to be challenging. The upward trend of activity levels seen in May and June had fallen due to acute demand impacting bed occupancy. The diagnostic ask of 120% against 2019/20 baseline activity continued to be delivered. Community teams had seen referrals to both adult and paediatric teams increasing in excess of contracted activity, with long term plans in place to reduce waiting times for these services.

Long term pressures in cancer services remained, but the Trust had recently been congratulated by the Surrey and Sussex Alliance for its performance during the week ending 10th July when only 4% of the Trust's cancer waiting list had waited for over 62 days, the lowest backlog in the Alliance and in the South East, and the eighth lowest in the country.

The Trust's ambition was to remain in the top 50% of organisations for urgent care performance, aspiring to be in the upper quartile. During month three, the Trust had been 26th in the country for four hour ED performance, which was testament to the work of amazing colleagues who were working under

considerable pressure. Livi, the virtual GP appointment system used by the Trust, had redirected 3,850 patients from the Trust's front door to more appropriate care in the previous six months. South East Coast Ambulance NHS Foundation Trust (SECamb) had direct access to Livi, with paramedics able to book appointments directly with GPs when appropriate.

In response to questions from Mrs Churchward-Cardiff and Mr Phoenix, Mrs Argent explained that the Trust provided some patients with an estimated date of discharge on admission, which was updated and constantly monitored during a patient's stay. NHSE had been asked by the Trust to undertake a review of best practice for patient pathways, giving independent verification that the Trust was getting the basics correct.

Mrs Churchward-Cardiff asked whether readmission rates were monitored, and Dr Walker explained that these were recorded using the central NHS system, CHKS. This system notified the Trust if readmissions went above a certain level in any area, and this was then reviewed; this had only happened on a couple of occasions in recent years and neither had been a cause of concern.

Mrs Manson asked about the increase in Medically Ready to Discharge (MRD) patients on pathways 1-3 that was reported in December 2021. Mrs Argent explained that the increase was linked to the Trust no longer having access to discharge to assess beds. Teams were now used to the MRD process, but it was important that conversations about the correct pathway for patients took place with patients and relatives soon after admission.

Mrs Manson asked about the anticipated impact of Park View in Bexhill on paediatric community waiting times. Mrs Lynes explained that Park View would double the paediatric community capacity of the Trust. Clinicians and nurses had been successfully recruited for the service, but further recruitment was required. A transformation plan was being developed to address the backlog by utilising more specialist nurses and less medical staff. She anticipated that improvements to waiting times would start to be seen in around four months.

iv. Financial Control and Capital Development

Mr Reid explained that the main recent focus of the organisation had understandably been on managing the number of NCTR patients, but alongside this the Trust had continued to try to meet its financial target for the year. During month three financial performance had been £2.3m worse than plan. He noted that there had been central recognition that the 104% target would not be completely deliverable by Trusts in 2022/23, and that as a result changes had been made to clawback payments made by the Trust up to month three for not meeting this target. This was likely to lead to improved financial performance for months one-three. He was unsure if this change would continue throughout the financial year. Operating theatres at Conquest were now reopened following improvement work allowing for additional activity to take place.

Mr Reid explained the of scale of pressures related to inflation faced by the organisation, noting that any direct inflationary pressure faced by the Trust would

be recognised in reporting to the Board. £13.4m of Cost Improvement Plans (CIPs) for the financial year had been identified so far, but a significant increase would be needed from month seven onwards in order to meet the £23m target for the year. Mr Reid noted that over-delivery of capital plans had been built into the annual plan, and did not believe that there was any risk to delivery of this plan as of month three.

Staff sickness, alongside the cost pressure on the organisation from NCTR patients, had led the monthly run rate to be above planned levels, although an improvement had been seen in month four. Central controls had been introduced to maintain control of spending against 2019/20 levels with an ambition of reducing agency usage by 10% compared to 2020/21. Mrs Churchward-Cardiff asked whether any additional funding for winter was anticipated and Mr Reid explained that there had not been any discussions about this so far.

Mrs Webber asked whether financial modelling for 2022/23 had seasonality built in, and Mr Reid explained that this was included, although the expansion of wards was not. Modelling did include virtual wards, which should lead to a reduction in patients who needed to come to hospital for treatment. In addition, the Trust was recruiting a Home First team which should have a further positive impact on the number of patients attending hospital.

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

058/2022

Maternity Overview Report

Mrs Lynes presented the maternity services report for quarter one of 2022/23. She highlighted the maternity service review, noting that the outcomes from the review would contribute the national ambition to reduce rates of maternal deaths by 2025. The maternity service's long term plan was aligned to the Trust's clinical strategy. She reported that a recent presentation by NHSI to the Trust Board had highlighted four key questions that the Board should be able to answer to take assurance about maternity services in the Trust, explaining that answers to these four questions were included in the report to the Board.

Mrs Lynes reported that there had sadly been one intrapartum stillbirth in the Trust, which remained under investigation. There had also been one Serious Incident, but no recommendations had been received from the Healthcare Safety Investigation Branch (HSIB) and the baby involved was doing well. The Trust's rolling stillbirth rate was 4.16/1000 births, comparable with The Office for National Statistics (ONS) statistics of 4.2/1000 births in 2021 across the NHS. The Trust and local system had an ambition to reach 2.5/1000 births. There had also sadly been a maternal death during the first quarter of the year, which had taken place at home 50 days post-partum. This was being investigated.

Reducing smoking during pregnancy remained a key focus for the maternity service and work was being undertaken to identify how smoking cessation services could be localised to benefit those who most needed them. Staffing remained challenging in June, with a fill rates of 81.7%. However, a local

midwifery staffing uplift to 26.4% had recently been approved by the Trust, resulting in additional funding for 6.23 whole time equivalent (wte) midwife/maternity support worker posts. Sickness levels remained at around 5%. The service was funded for 14 whole time equivalent consultants, but currently only employed 12 consultants. Work was taking place to recruit additional consultants which would allow for increased weekend cover that would meet national requirements.

Mrs Lynes reported that good progress was being made by the Trust against the initial seven Immediate and Essential Actions (IEAs) from the Ockenden Report, as well as the further 15 IEAs added since that report. Good progress was also being made against the ten Clinical Negligence Scheme for Trusts (CNST) safety actions.

Mrs Lynes reported that the results of the staff survey had been very positive for the maternity team. An action plan to address issues that had emerged from the survey been developed in a co-creative manner with staff, and positive feedback about the changes made had been received from staff. NHSE/I had recently undertaken an insight visit of the service, with initial feedback overwhelmingly positive.

Mrs Kavanagh thanked Mrs Lynes for her report, noting concern that the staff survey had found that 82% of staff didn't feel that there were sufficient staff in the department to do their job well. Mrs Lynes explained that the vacancy rate in the maternity department had been 11% when the survey was taken but had now reduced to 5%. Sickness levels had also been high at 11%, with an additional 11% of staff on maternity leave. These issues were now greatly improved, but staffing remained challenging. She praised the way in which staff had worked together to meet the workforce challenges.

Mrs Carruth reported that the resilience of staff and the safety of service users were discussed on a daily basis during safety huddles. She praised the midwives for their resilience in meeting recent challenges, including mental health and safeguarding issues, but noted that they were extremely tired. Mrs Lynes explained that the recent national focus on NHS maternity services had also been exhausting for staff, although had also resulted in a number of positive changes. Senior leaders in the maternity team, including Mrs Lynes, helped staff by carrying out shifts on the wards.

Mrs Churchward-Cardiff explained that Mrs Lynes' presentation had been reassuring. She asked about the shortage of health visitors, and Mrs Lynes explained that a mitigation plan was in place to address this issue. There was a national issue with the banding of health visitors and incentives were being offered to encourage staff to take on these roles. Additionally, there had been a reduction in the workload for health visitors and recruitment of Band 4 health visitor supporters. These adaptations had been positively received.

Mrs Webber commended Mrs Lynes for leading by example by doing shifts on wards, noting that this would help motivate staff. She asked whether she should

be worried by the three intrapartum still births that had taken place in the last year when there had been none the year before. Mrs Lynes explained that the Trust was not an outlier for intrapartum stillbirths, and that there had been an increase seen nationally. However, the maternity team were concerned about the increase and were working hard to reduce incidences.

Mrs Churchward-Cardiff reported that she had recently visited the maternity department and had spoken to midwives who had described the increased complexity of needs required by women using the service. She asked whether these additional complexities were adding more pressure for staff. Mrs Lynes agreed, noting that in addition service users were now given a wider choice of birthing options. Mrs Webber asked how often midwife numbers were assessed, and Mrs Carruth explained that Birthrate plus was used to identify the number of midwives required to managed the level of complexity that was being seen; this was formally undertaken every three years, whilst also subject to additional reviews on a regular basis.

059/2022 **Update to Standing Financial Instructions**

Mr Reid asked the Board for approval for an additional line to be added to the Standing Financial Instructions (SFIs) to allow the Trust to make bids swiftly when opportunities to bid for short notice capital arose.

“The Executive Team is authorised to respond to short notice national capital bids. For any elements over £5m the CEO will have consulted the Chair of the Board before preparing a bid. For the avoidance of doubt F&I and the Board retain control over final authorisation of business cases.”

He noted that the final authorisation for any business cases would still need to be made by the F&I Committee or the Board depending on value. The proposed wording had been endorsed by both the F&I and Audit Committees.

The Board approved the addition to the SFIs, noting that they would be updated and republished following the meeting.

060/2022 **East Sussex Healthcare NHS Charity Update**

Mrs Manson reported that during 2020, ESHT’s charity had changed from a Board trustee model to a corporate trustee model. The limited opportunities for fundraising during the pandemic had been used to review the way the charity operated and its governance processes. As a result, it had been agreed that a clearer name and identity was needed for the charity to make it more recognisable and easier for the public to make donations. The Charity Committee had approved a new name of East Sussex Healthcare NHS Charity, which was in line with many other NHS charities and a new logo for the charity, and Mrs Manson asked the Board for their approval of the changes.

The Board approved the change of the Trust’s charity’s name to East Sussex Healthcare NHS Charity and the new logo.

061/2022 **Use of Trust Seal**

The Board noted two uses of the Trust Seal since the last Board meeting.

062/2022 **Questions from members of the public**

Mr Hardwick asked whether escalating energy costs were having an adverse effect on the Trust. Mr Reid explained that increasing energy costs had been factored into the Trust budget for the year, noting that he was unsure if this would fully account for the scale of increases being seen. Mr Hodgson reported that the Trust purchased energy through a consortium so some of the cost was already known. Mrs Webber noted that the issue was an area of focus for the F&I Committee.

Mr Hardwick noted that the Trust recruited staff both locally and internationally, asking whether local recruitment remained strong. Mrs Mason explained that the Trust's record of recruiting locally was excellent and that a majority of staff who were trained locally came to work for the Trust. The Trust was keen to employ people who worked and lived locally where possible to support the local economy, but would also continue to recruit from abroad. Mrs Carruth explained that the diversity and fresh perspectives of colleagues from around the world was very helpful to the Trust. Mr Phoenix reported that the Trust employed staff from 106 different countries. The NHS workforce was always international and diverse, but the Trust was mindful of the pressure that international recruitment could place on other countries.

Mr Hardwick asked whether the Trust planned to hold in person staff awards in the future. Mrs Mason noted that awards had been continued to be held during the pandemic, but had taken place in a safe manner. She hoped that larger events could return in the future.

Mr Campbell asked what action the Trust was taking following recent recommendations from the Health Oversight and Scrutiny Committee (HOSC) on cardiology and ophthalmology services at the Trust. Mr Milner explained that the Trust was obliged to comment and reflect on each of the recommendations as part of the decision making business case. Work on this was ongoing.

Mr Campbell asked whether the Trust was participating in East Sussex council's transportation review, and whether transport recommendations from HOSC would be met. Mr Milner explained that the recommendations had been reviewed and were being taken into consideration as business cases were developed. However, no changes would be made until the final decisions about cardiology and ophthalmology services had been made. He anticipated that the business case would be presented to HOSC in December.

Mr Campbell noted that the Integrated Care Board (ICB) and NHS Sussex were now fully functional and asked Mrs Chadwick-Bell for her reflections on the ICB Board. He also asked whether future Board meeting papers could include a description of any ICB meetings attended by Trust staff to understand the implications of ICB activities on the Trust. Mrs Chadwick-Bell explained that provider representatives from across Sussex would sit on the ICB, but that she

had not been able to attend the first meeting due to being on leave. She would reflect on how best to update the ESHT Board on another body's outcomes, noting that any matters that would impact the Trust from the wider system would be included in the CEO's report to the Board. She explained that it would not be possible to summarise attendance at system meetings.

Mr Campbell asked whether the number of partnership meetings that took place were of concern, noting that these had no public visibility but might have a significant impact on the local NHS system. Mr Phoenix agreed that the ICB would generate more meetings for the Trust, but noted that CCG meetings no longer took place as this organisation did not exist anymore. He agreed that it would be helpful to internally monitor the value these meetings added to both the Trust and the system, and noted that robust discussions took place at system level about the correct approach to governance.

Mr Campbell asked how much the recent Kingsgate review had cost and whether this was self-financing. Mr Reid reported that it had cost around £130k, and was a benchmarking review against the Trust's 2019/20 position to help identify areas where savings could be realised through efficiencies. The review would be used to develop Trust efficiency plans.

Mr Jones explained that he had recently visited Bexhill and was concerned by the number of patients who had not attended appointments. He asked how this was being addressed. Mrs Argent explained that recently a small number of patients had not received their initial appointment letter due to a failed print run. This error had not been realised until patients had not attended their appointments, and the Trust was now texting and calling patients in advance of appointments. This allowed for any empty appointments to be taken by other patients, and this system was working well.

Mr Jones explained that he had received feedback from staff who did not feel that they were fully informed about what was happening in the organisation, asking how communication could be improved. Mrs Chadwick-Bell reported that Mr Oluwatunmise had already spent over 100 hours speaking to staff, which had included conversations about communication. He would be reporting back on these conversations to Executives. She noted that a monthly staff briefing took place, weekly emails were sent to all staff and Executives regularly visited different departments. However, this was not enough, and Executives would review how they could better communicate with 7,500 colleagues in a consistent manner. She noted that she was planning to start a blog, and to tweet more often, and explained that she would welcome feedback and ideas from Mr Jones.

063/2022

Date of Next Trust Board Public Meeting

The next meeting of the Trust Board would be on Tuesday 11th October 2022 at
Horntye Park Sports Complex, Hastings

Signed

Position

Date

East Sussex Healthcare NHS Trust

**Progress against Action Items from East Sussex Healthcare NHS Trust
9th August 2022 Trust Board Meeting**

There were no matters arising from the meeting on 9th August 2022.

Audit Committee Report – 22nd September 2022

The Audit Committee last met on the 22nd September 2022.

Data Quality Update

The new Data Quality Framework and Data Quality Assessment Matrix were presented to the Committee. The Matrix would be used to assess the suitability of both existing systems and potential new ones before they were implemented. Updates on progress towards achieving the Data Strategy would continue to be provided to the Audit Committee via the Information Group.

Board Assurance Framework (Q1/Q2)

The Committee reviewed the Board Assurance Framework (BAF) noting that it had been extensively rewritten following input on the key strategic organisational risks from the Trust Board. The Committee provided feedback on the updated BAF, noting a number of areas that could be improved before the Q3 update was presented in November and noting the good progress that had been made to date.

Trust Policy Annual Report

A risk register entry had been drafted to reflect that a number of policies were due to be updated. Updates were being rigorously pursued. Many of the policies would only require minimal updating and some, once reviewed, were likely to be considered to no longer be required. A piece of work to assess the best way forward (including greater automation of monitoring) and provide assurance about the inherent level of risk was planned.

EPRR Annual Update

The Trust had achieved partial compliance against the 68 core EPRR standards mandated by NHS E/I and was expected to be substantially compliant within the week. ESHT had moved its Chemical Biological Radiological Nuclear (CBRN) training online which had been commended as good practice. An EPRR workplan had been requested from NHSE/I and it was agreed that the EPRR steering group would report into the Audit Committee by summary.

Information Governance Toolkit Update

The Data Security and Protection Toolkit (DSPT) would run from July 2022 to June 2023 and not alongside financial reporting years as in the past. A new Data Protection Impact Assessment (DPIA) developed with other Trusts across Sussex had been approved and saved on the Information Sharing Gateway (ISG) portal. This would align documentation and approaches across the patch.

Tenders and Waivers

Following implementation of revised Standing Financial Instructions in April, the number of waivers had continued to be low. The Procurement department challenged all waivers that had been presented, or would have potentially been presented, to ensure all compliant routes to purchase were considered and value for money was achieved.

Trust Response to External Audit Recommendations – Update

All ten actions recommended to the Trust by external auditors in July (four 'audit' and six 'value for money') were in progress or substantially completed.

Internal Audit

The following final reports had been issued since the last meeting: Data Security and Protection Toolkit (DSPT) v4 – part 2 (2021/22) – Substantial Assurance; Workforce: Appraisals – Limited Assurance; HealthRoster System – Reasonable Assurance. Some changes to the annual internal audit work programme were approved due to shifting priorities.

Anti-Crime Specialist (ACS) Service Progress Report

The ACS team had conducted a random sample test of 25 staff members with regards to conflicts of interest declarations since August and found nothing untoward. Two fraud check reviews were planned for the coming months: one around manipulation of Disclosure and Barring Service (DBS) documents and another linked to duplicate and secondary employment.

Paresh Patel (Chair – Audit Committee)

Finance and Investment Committee Summary

1. Introduction

A Finance & Investment (F&I) Committee was held on 22 September 2022. A summary of the items discussed is set out below.

2. Board Assurance Framework (BAF)

It was recognised that the BAF had been significantly updated for 2022/23, and that the risks assigned to the F&I committee required further work to ensure that controls and actions were appropriate, specific and forward looking.

3. Month 5 Financial Performance

It was noted that the year-to-date performance had been impacted by the unusually high number of patients not meeting the criteria to reside which was impacting on flow and elective performance. Key risks to outturn were the potential for clawback to Emergency Recovery Funding and winter pressures. At month 5, capital expenditure was marginally ahead of plan but it was expected that delivery of H2 would be challenging. A £1.2m funding gap on the PSDS3 project had been identified and negotiations with the contractor were ongoing to close this.

4. 5 Year Capital Plan

The Committee received a paper detailing the proposed five year capital plan. It was noted that the Trust's capital allocation was still subject to discussion with the ICB. Given the uncertainty of allocation, and the significant slippage within years two and three in the presented plan, the Committee supported the direction of travel but deferred approval of the plan greater certainty of funding could be provided.

5. National Cost Collection

The National Cost Collection (NCC) data for the year 2020/21 was presented, showing that ESHT had a NCC Index of 98 (below average of 100 and a significant improvement on 109 in 19/20). It was noted that the significant change was likely to be down to a number of factors including changes in date quality and cost allocation, as well as process efficiencies. A material factor was the relatively low rehabilitation costs within ESHT. Despite the inherent difficulties in making like-for-like comparisons, taken together with other benchmarking and sources of best practice, the NCC would help identify areas which look out of step with peers and where further work to identify efficiencies can be focused.

6. Sussex Premier Health

The Committee received an update on the performance of Sussex Premier Health (SPH). Whilst revenue was behind forecast, costs had been controlled and overall performance was in line with plan. Difficulties with the IT systems were noted and a post-implementation review would consider lessons to be learned. The Committee will receive KPI reporting quarterly going forward.

7. Efficiency Update

The Trust delivered £1.4m efficiencies in month and £7m YTD, in line with plan. A gap of £6.5m remains to reach the 22/23 target of £23m. The challenge associated with H2 was acknowledged.

7. Ophthalmology Expansion at Bexhill

The business case setting out the proposal to reconfigure and expand the ophthalmology outpatient department at Bexhill Hospital was presented. The development of the new CDC had provided an opportunity to provide fit for purpose accommodation for ophthalmology at Bexhill, meeting the needs of a growing service. It was noted that the work was agnostic as to

the outcome of the public consultation; this project was about best utilising existing space for the existing service. The impact of local competitors, the ability to staff the service and the sources of funding for equipment were discussed. The Committee approved the business case and recommend it for approval to the Board.

7. EDGH Cath Lab Tender

The Committee received the tender report for the EDGH Cath Lab Tender. It was noted that the committee was yet to receive a business case. It was anticipated that the business case would be ready for the October Board meeting and the Committee therefore agreed that the Board should review the business case before approving the tender award. The Committee did note the quality of the tender process and supported its recommendations should the business case be approved at Board.

7. Virtual Wards

As a national scheme, the Trust has been advised of its funding allocation and the number of virtual beds to be provided. The Committee noted the benefits of the programme, and the planning underway. Staffing, digital support and medical cover were all discussed, with risks cross-referred to the POD, Strategy and Q&S committees for monitoring. The Committee supported the plan and recommended this for approval to the Board.

Nicki Webber

Chair of Finance & Investment Committee

3 October 2022

POD Committee Executive Summary 15 September 2022

Meeting information:	
Date of Meeting:	Agenda Item:
Meeting: Trust Board	Reporting Officer: Carys Williams

Purpose of paper: (Please tick)	
Assurance <input checked="" type="checkbox"/>	Decision <input type="checkbox"/>
Has this paper considered: (Please tick)	
Key stakeholders: Patients <input type="checkbox"/> Staff <input checked="" type="checkbox"/>	Compliance with: Equality, diversity and human rights <input checked="" type="checkbox"/> Regulation (CQC, NHSi/CCG) <input checked="" type="checkbox"/> Legal frameworks (NHS Constitution/HSE) <input type="checkbox"/>
Other stakeholders please state:	
Have any risks been identified <input type="checkbox"/> (Please highlight these in the narrative below)	On the risk register?

Summary:

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

Executive summary attached for POD Committee meeting that was held on 15 September 2022.

2. REVIEW BY OTHER COMMITTEES

N/A

3. RECOMMENDATIONS

The Board are asked to note the contents of the Executive summary.

East Sussex Healthcare NHS Trust

People & Organisational Development (POD) Committee

Introduction

Since the Board last met a POD Committee meeting was held on 15 September 2022. A summary of the items discussed at the meeting is set out below.

Review of Action Tracker

The outstanding items on the action tracker were reviewed and further updates would be provided at the next meeting.

Workforce Report

The Workforce Report was presented to the Committee, key highlights:

Sickness

- 23% reduction over the previous month given lower levels of Covid
- Currently 5.2% which puts us within 0.6% of pre-Covid sickness rates for 2019
- 15.09.22 - 320 staff members sick of which 38 due to Covid.

Holiday Absences

- Many staff members were beginning to take family holidays again
- All areas had been reminded about discipline when booking leave
- Already looking at half term and Christmas predictions to ensure they are managed.

Escalation

- Circa 100 beds open over planned activity, which stretches staffing
- Running at nearly full capacity which creates a constant flow challenge, which has an impact on staff and patients
- Significant operational challenges.

Turnover Rate

- 13.4% as opposed to 12.9% last month

Vacancy Rate

- Increased to 8.9% although when budgeted increases in establishment are removed the underlying rate was flat
- Workforce had increased by 350 since 2019.

Workforce Summit Update

The workforce summit considered activity data, workforce numbers and workforce costs with the aim of working towards understanding some really important workforce productivity ratios for each division.

Key points:

- Divisions to put in place a broad set of activity and performance measures that they will be held to account for (balance of financial, operational and efficiency)
- Current Integrated Performance Reviews (IPRs) to focus on quality, HR and safety
- Build efficiency and productivity into annual planning cycle
- All operational/activity changes to include a section on productivity within the proposed plans
- Consider introducing some high level productivity ratios to demonstrate the ongoing efficiency of the Trust.

Freedom to Speak Up Guardian Report

An update was provided of the Freedom to Speak Up Guardian report, which included the nature of concerns raised and an analysis of trends.

The POD Committee received assurance that staff were speaking up via data and incident reporting for patient safety and clinical concerns.

Guardian of Safe Working Hours Report

An update was provided of the Guardian of Safe Working Hours report highlighting the data for exception reporting (ER), which included an update on the Fatigue and Facilities Charter.

Key highlights:

- Significant increase in exception reporting compared to the previous year. It was widely noticed across HEE KSS that all Trusts has experienced reduction of ER during Covid, perhaps due to reduction of most elective activities.
- 26 education exception reports submitted compared to 20 for the previous year. The pastoral fellows had been supportive to trainees requiring support in many areas.
- 39 less than full time work patterns were created to reflect part time working.
- Introduction of new vending machines on both sites with improved menus.
- Improved lighting and safety measures in staff car parks on both sites.
- Doctors mess open in Eastbourne Hospital, which has made a huge difference and is frequently used.
- Doctors mess in Conquest being improved.
- Acting Down policy needs progressing.

Health and Wellbeing Update

An update was provided on Health and Wellbeing.

Key highlights:

- Recognising that exiting out of a pandemic can be equally as perilous as going into a pandemic in terms of retention and staff morale.
- Detailed report on retention to include cause and effect will be shared with the POD Committee in December 2022.
- Currently working on the Retire and Return process to offer different options to staff, flexibility and the creation of an alumni.
- Being aware of the cost of living crisis with work being undertaken on financial wellbeing.

For noting

The following reports were for noting:

- Gender Pay Gap
- Time to Hire
- Allied Health Professionals (AHPs)
- Board Assurance Framework (BAF)

Carys Williams
Chair of POD Committee
September 2022

Strategy Committee Report – 25th August 2022

The Strategy Committee last met on 25th August 2022, the main points discussed are as follows:

Transformation

The Committee will want to see clarity on what measures from the transformation programme will impact on strategy. This will be led by the newly appointed Director of Transformation, who will take the Executive lead and report to the Committee for oversight and assurance.

The Committee is keen to see how Virtual Wards can be established at pace to ease bed pressures and provide appropriate care in the best setting for patients.

Integrated Care System (ICS) Progress

This is maturing and the issue for East Sussex will be how we will deliver “Place” system objectives. Currently East Sussex has a good record for working collaboratively and there is no deviation from system strategies.

Cardiology & Ophthalmology transformation

Revised capital costs have been submitted to the Integrated Care Board (ICB) and it is expected that the decision making case will be submitted to the ESHT Board in October.

Pathology

The Committee took assurance that there is a clear vision for pathology services across the ICS, and supported the option for TOM2 (Target Operating Model second option). The ESHT preference has been submitted and the Committee was keen to see early resolution in order to address delivery issues in key services such as Histopathology.

Maternity

The Committee received the Maternity Strategy and endorsed the key objectives, noting that there was a risk to delivery from staffing issues. That said, the recent recruitment and engagement successes were noted and this gave assurance on the Trust’s focus on delivering against the national objectives. The service has shown steady improvement and provides a safe and individualised service.

Jackie Churchward-Cardiff, Strategy Committee Chair

5th September 2022

CEO Report

Meeting information:			
Date of Meeting:	11 th October 2022	Agenda Item:	6
Meeting:	Trust Board in Public	Reporting Officer:	Joe Chadwick-Bell, Chief Executive
		Report Author:	Joe Chadwick-Bell, Chief Executive

Purpose of paper: (Please tick)			
Assurance	<input type="checkbox"/>	Decision	<input type="checkbox"/>
Has this paper considered: (Please tick)			
Key stakeholders:		Compliance with:	
Patients	<input type="checkbox"/>	Equality, diversity and human rights	<input type="checkbox"/>
Staff	<input type="checkbox"/>	Regulation (CQC, NHSi/CCG)	<input type="checkbox"/>
		Legal frameworks (NHS Constitution/HSE)	<input type="checkbox"/>
Other stakeholders please state:			
Have any risks been identified (Please highlight these in the narrative below)	<input type="checkbox"/>	On the risk register?	

Summary:

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

I am very proud to announce that the Trust received confirmation that it has been awarded the SOF 1 rating (System Oversight Framework and 1 being the highest). This reflects the tremendous work which our teams undertake every day and reflects the leadership, quality, financial and performance measures as rated by NHS England and the Integrated Care Board.

That said, services continue to be under pressure and the Trust continues to work on its key priorities which are:

- Maintain safe services
- Workforce and Wellbeing
- Deliver financial balance
- Deliver 104% elective activity
- Sustainable urgent care
- Reduction in patients who no longer need acute or community care to be discharged to an appropriate place

Colleagues will highlight how we are doing against these priorities and the risks associated with delivery within their presentations of the Integrated Performance Report (IPR), including how we are doing compared to other Trusts.

Government Priorities and Secretary of State Priorities

The government have now released its plan for patients which includes the following priorities:

- Patients will be empowered to play a greater role in decision making
- Prevention services will move closer to people's homes
- Primary Care will meet public expectations on accessing appointments
- Performance & Productivity to deliver improvements in care

The Secretary of State's Priorities are:

- Ambulances – focus on response times, handovers and fallers – four hour target is not changing
- Backlogs – continued focus on reduce waiting lists and meeting the 62-day cancer target
- Care - £500m adult social care discharge fund – reduce the number of Medically Ready for Discharge (MRD) patients
- Doctors and Dentists – increase access to General Practice

Urgent Care

Our four hour performance has been declining over the last few months and this correlates with a reduction in discharge to assess capacity; however as a Trust we are focusing on a set of actions which both improve performance over the coming weeks, but also offer more strategic solutions to reduce demand at our front doors and reduce length of stay.

To optimise delivery the Trust is working in collaboration with system partners to focus on five key areas, to ensure a safe winter and ensure patients have access both to urgent care but also to maintain planned care services:

1. Reduction in conveyance and admission for non-injury fallers
2. Frailty, additional support to care homes and avoid admissions
3. Proactive approach to reduce need for urgent care and reduce admission – Cardiology and Respiratory
4. Discharge, improve efficiency of discharge pathways
5. Virtual wards, increase pace of delivery to support winter

Each workstream will have clinical and operational leadership, and additional resource will be required to support the community transformation

Integrated Care Board (ICB) Strategy

There is a requirement for the ICB to develop a strategy by the end of December 2022 and a supporting delivery plan by March 2023. The Trust is engaged in this process and it will reflect the East Sussex priorities as described in the Health and Wellbeing Board Strategy. However, this will be tested with wider stakeholder groups in order to ensure it reflects local needs.

Capital Update

1. **Eastbourne Net Zero Carbon Project:** The project continues to make good progress and the first sections of the new façade are being put up on the South side elevation over the coming weeks.
2. **Eastbourne Emergency Department:** Construction work is due for completion shortly and will bring additional rapid assessment capacity.
3. **Eastbourne Day Surgery Unit:** Construction work is due for completion shortly and the project will bring additional operating theatre recovery capacity for our elective care programme.
4. **Bexhill Community Diagnostic Centre:** The construction works to establish our new Bexhill Community Diagnostic Centre are making good progress and we will open the facility in the fourth quarter of 2022.

Leadership Changes

Dr Simon Merritt – Chief Medical Officer

Simon Merritt has commenced in his role as the new Chief Medical Officer.

Simon has been a consultant at the Trust since 2009 and is a consultant in respiratory and sleep medicine. He is also the Chief of Medicine and was previously the Clinical Unit Lead for Specialist Medicine.

I am confident that Simon will make a positive contribution to the Trust Board and will continue to drive our high standards of care and optimum outcomes for our patients.

Charlotte O'Brien - Director of Transformation and Improvement.

Charlotte O'Brien has commenced in her role as our new Director of Transformation and Improvement.

Charlotte was Director of Strategic Partnerships at Sussex Partnership NHS Foundation Trust and had been supporting the Trust in developing its role as the lead provider for a number of specialist provider collaboratives, developing the Sussex ICS Mental Health Collaborative Programme and developing the Trust's approach to performance and assurance.

She started her career as a cardiac nurse in London and has more than 20 years of management experience working in senior operational and service transformation roles across primary, secondary and tertiary care. Charlotte has also worked for NHS England and NHS Improvement as a member of the South East regional oversight and assurance team.

As Director of Transformation and Improvement, Charlotte will be responsible for our transformation and improvement programme, Building for our Future and embedding the quality improvement approach throughout the organisation. The new role will bring together existing programmes, including the development of the Hospital Development Scheme work in order that the Trust has a structured approach, built on best practice, to continue to improve our services for patients. This is a key role working with the divisions to enable us to continue on our journey towards being an outstanding organisation.

Tara Argent – Chief Operating Officer

Tara will be leaving us on 21st October to take on the Chief Operating Officer role at St. George's University Hospitals NHS Foundation Trust. I wish Tara all the very best in her new role and would like to thank her for all her hard work.

Integrated Quality & Performance Report

**Prepared for East Sussex Healthcare NHS Trust Board
For the Period August 2022 (Month 5)**

Content

1.	About our Integrated Performance Report (IPR)	
2.	Chief Executive Summary	
3.	Quality and Safety <ul style="list-style-type: none"> - Delivering safe care for our patients - What our patients are telling us? - Delivering effective care for our patients 	
4.	Our People – Our Staff <ul style="list-style-type: none"> - Recruitment and retention - Staff turnover / sickness - Our quality workforce - What our staff are telling us? 	
5.	Access and Responsiveness <ul style="list-style-type: none"> - Delivering the NHS Constitutional Standards - Urgent Care - Front Door - Urgent Care – Flow - Planned Care - Our Cancer services 	
6.	Financial Control and Capital Development <ul style="list-style-type: none"> - Our Income and Expenditure - Our Income and Activity - Our Expenditure and Workforce, including temporary workforce - Cost Improvement Plans - Divisional Summaries 	

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

Safety	Target / Limit	Last Month	This Month	Variation	Assurance
Patient Safety Incidents (ESHT and non-ESHT)	M	1082	1105	Common Cause	
Serious Incidents	M	4	1	Common Cause	
Never Events	M	0	0	Common Cause	
Inpatient Falls per 1,000 Bed days	M	5.8	6.4	Common Cause	
Pressure Ulcers, grade 3 to 4	0	6	2	Common Cause	Consistently Missed
MRSA Cases	0	0	1	Concern	Inconsistent
Cdiff Cases	<5	6	11	Common Cause	Inconsistent
MSSA Cases	M	1	2	Common Cause	
RAMI	94	85.8	86.9	Common Cause	Consistently Hit
SHMI (NHS Digital monthly)	0.99	0.98	0.99	Concern	Consistently Hit
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	86%	85%	Concern	Consistently Missed
Nursing Fill Rate (Including Escalation)	100%	86%	85%	Common Cause	Consistently Missed

Patient Experience	Target / Limit	Last Month	This Month	Variation	Assurance
Complaints received	M	30	38	Common Cause	
A&E FFT Score	M	60%	100%	Common Cause	
Inpatient FFT Score	M	99%	99%	Common Cause	
Maternity FFT Score	M	100%	98%	Common Cause	
Out of Hospital FFT Score	M	100%	96%	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%	65.4%	65.1%	Concern	Consistently Missed
A&E Non Admitted	M	71.3%	71.6%	Concern	
A&E > 12 hours from arrival to discharge	0	525	638	Concern	Consistently Missed
A&E waits over 12 hours from DTA	0	0	0	Common Cause	Consistently Hit
UTC 2 hour	>98%	66.7%	69.2%	Concern	Consistently Missed
Cancer 2ww	>93%	83.0%	85.6%	Concern	Inconsistent
Cancer 62 Day	>85%	68.7%	72.4%	Common Cause	Consistently Missed
62 day Backlog	M	87	106	Improvement	
104 day Backlog	M	19	21	Improvement	
RTT under 18 weeks	>92%	61.4%	59.0%	Concern	Consistently Missed
RTT 52 week wait	0	647	723	Concern	Consistently Missed
RTT Total Waiting List Size	36,833	49,009	51,096	Concern	Consistently Missed
Overdue P2	M	252	285	Common Cause	
CHIC wait times < 13 weeks	>75%	82.9%	84.2%	Common Cause	Consistently Hit
Diagnostic <6 weeks	<1%	15.2%	15.1%	Improvement	Consistently Missed

Our People	Target / Limit	Last Month	This Month	Variation	Assurance
Establishment (WTE)	M	8,072.8	7,971.8		
Vacancy Rate	<5%	8.5%	8.9%	Concern	Consistently Missed
Staff Turnover	<9.9%	12.9%	13.4%	Concern	Consistently Missed
Retention Rate	>92%	90.0%	89.6%	Concern	Consistently Missed
Sickness - Absence % (rolling 12 mths)	<4.5%	6.0%	6.0%	Concern	Consistently Missed
Sickness - Average Days Lost per Fte	<16	22	22	Concern	Consistently Missed
Staff Appraisals	>85%	72.4%	74.2%	Common Cause	Consistently Missed
Statutory & Mandatory Training	>90%	88.5%	88.4%	Common Cause	Consistently Missed

Our Productivity	Target / Limit	Last Month	This Month	Variation	Assurance
4 hour theatre sessions	M	415	430	Common Cause	
Average Cases per 4 hour session	M	2.4	2.4	Common Cause	
Clinic run rate	M	80.3%	78.6%	Common Cause	
Non Face to Face Outpatients	>25%	28.1%	27.2%	Concern	Consistently Hit
Elective Length of Stay	2.7	3.2	3.5	Common Cause	Inconsistent
Non Elective Length of Stay	3.6	4.5	5.0	Concern	Consistently Missed

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Chief Executive Summary

The Trust is proud to have been categorised under the system oversight framework as a category 1 provider (highest category ranging from 1-4), which recognises that despite the challenges with discharge and increasing demand we have been recognised as a successful organisation. However we strive for continued improvement and the focus remains on delivering safe and effective care to our patients on our wards, in our emergency departments as well as all of our elective patients awaiting treatment and we continue to focus on reducing wait times in all areas and within our community based services. Going forward we will be working with our system partners to identify different ways of managing this change in service provision so as to support discharge, improve flow, reduce the impact on our elective programme whilst addressing high bed occupancy challenges.

Key Areas of Success

- 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
- Our long waiting patients (planned care) continue to be the lowest in the region and we have come in under agreed trajectory
- Our diagnostic DM01 position has seen an in month improvement and with the community diagnostic centres opening soon, this will continue to improve further for our patients
- Our Urgent Treatment Centres compliance to the 4hr standard remains above the required standard with 98% of patients managed within 4 hours.
- Year to Date our Capex spend of £7.5m is £0.8m ahead of plan, with out forecast to deliver as planned.
- Although an area of focus and requiring further improvement, the Trust is in the top quartile nationally for Cancer 62 day standard
- The positive recommendation rates for August from our Friends and Family Tests (FFT), compared to the most recent data released by NHSE show the Trust to be higher in all areas than the national average

Key Areas of Focus

- Although reflective of the national picture, the decline in our urgent care 4hour performance is an area that presents opportunities for us to improve. As well as working collaboratively with system partners to improve system capacity and create flow within our hospitals and a recovery plan has been developed which will form part of the winter plan and will be overseen through the Executive Team.
- Our ability to discharge will be a key driver in improving the 4 hour standard. With a high bed occupancy, this limits the exit routes from our emergency departments to enable flow
- The continued pressure across our services is impacting staff and the wellbeing of all continues to be a focus point for the Trust
- Staff turnover has increased to a new high of 13.4%. This places an increased pressure on the temporary workforce team to fill gaps, the financial burden, and the wellbeing of the workforce collectively. There is now a dedicated Trust Lead (People Potential Manager) focussing on the retention of staff to gain insight and understanding through direct engagement with staff groups and areas. This will be dovetailed with data to draw up a draft action plan for hot spots.
- The Trust is reporting a year to date deficit position of (£0.5m) against a planned deficit of (£0.7m), a favourable variance of £0.2m. The Trust's position currently reflects a national request from NHSE/I not to recognise any ERF clawback – YTD against plan this is £1.2m favourable. There are still pay pressures from supernumerary and temporary staffing, plus unfunded Escalation costs, offset by lower non pay costs and recognition of Drugs cost and volume funding YTD.

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

Quality & Safety - August 2022 Data

COVID - 19

Prevalence of COVID reduced during August which resulted in fewer positive patients treated in ESHT. There were no reportable outbreaks in August. Face masks continue to be worn in all clinical areas. Teams continue to use COVID inpatient information from Nervecentre to manage beds in co-horted bays with the aim of safe patient placement and zero void beds. Trusts were issued guidance to pause asymptomatic testing of COVID which has resulted in reduced testing.

Infection Control

The limit for C. difficile infections has been exceeded each month this year. Many Trusts in the region are reporting higher numbers of CDI and ESHT is ribotyping each positive case to assist with detection of cross infection or outbreak. The patients are elderly and have received several antibiotics. Antimicrobial stewardship is a focus with as much consultant microbiology support as possible. An MRSA bacteraemia has been identified that is attributable to the Trust and is under investigation to establish if this could have been avoided.

Incidents

One serious incident was reported in August 2022. This related to a delay in following up on MRI findings. A weekly tracker is now in place to enable the close monitoring of overdue amber reports.

Pressure Ulcers

Although just within control limits, there has been an increase in Cat 2 PUs amongst acute hospital inpatients during August which is being investigated. One category 4 PU was reported related to a patient discharged home following a 7 week stay in hospital. The patient was receiving palliative care and had been admitted with multiple existing areas of pressure damage, one of which deteriorated. A full investigation has commenced and is exploring whether all measures were taken to provide this patient with the best possible care, treatment and equipment on discharge.

Falls

Falls per 1,000 bed days increased in August. There were no severity 4 or 5 falls in August but several patients who had multiple falls – an ongoing indicator of the huge numbers of stranded patients many of whom are frail, dependent and high risk. A recent review showed that 40% of falls with harm over the past 3 years have involved patients who were medically fit for discharge (MFD).

Patient Experience - Complaints/Friends & Family Test (FFT)

Teams continue to work through the backlog with 14 overdue complaints at the end of August. FFT submissions remain lower than pre-COVID with recommendation rates still very high between 95.53% and 100% for inpatient areas, Maternity, Outpatients, Community and A&E. Work looking at alternative ways of promoting FFT is being explored with the Patient Experience and the Communication teams.

Nursing & Midwifery Staffing

The requirement for significant additional inpatient bed capacity (circa 100) continued throughout August. The trust continues to see huge numbers of stranded patients most of whom are frail, vulnerable and very dependent. Nurse staffing in August remained very stretched in most areas which is likely to have had an impact on some of the key quality metrics especially unwitnessed falls, indirect care such as documentation, communication, discharge planning etc and on staff wellbeing due to the sustained pressures. The 2021/2022 ward establishment review for nursing was presented to the Finance Committee with funding yet to be identified. The 2022/2023 Nursing Establishment Review data collection commenced on 19th September 2022 to inform the next planned review.

Safeguarding

The quality improvement work remains ongoing and meetings have taken place with corporate and divisional ADNs to support this. There is a new weekly tracker to monitor and action any concerns/themes. Discussions with mental health colleagues are also ongoing. Alongside the sustained increase in the numbers of safeguarding cases within all areas, (maternity, children and adults) there has been an observable change in presentation with cases noted to be more complex and with multi-layered risk. Of particular note in the last month there was a noted potential risk in the ICS of completed child suicide. This risk was highlighted to Operations leads and management plans identified by providers.

Mortality

Both SHMI and RAMI indices of mortality remain better than peers. SHMI has increased slightly this month and rolling 12 month RAMI remains in the top quartile across NHS England Acute Peers.

Author(s)



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



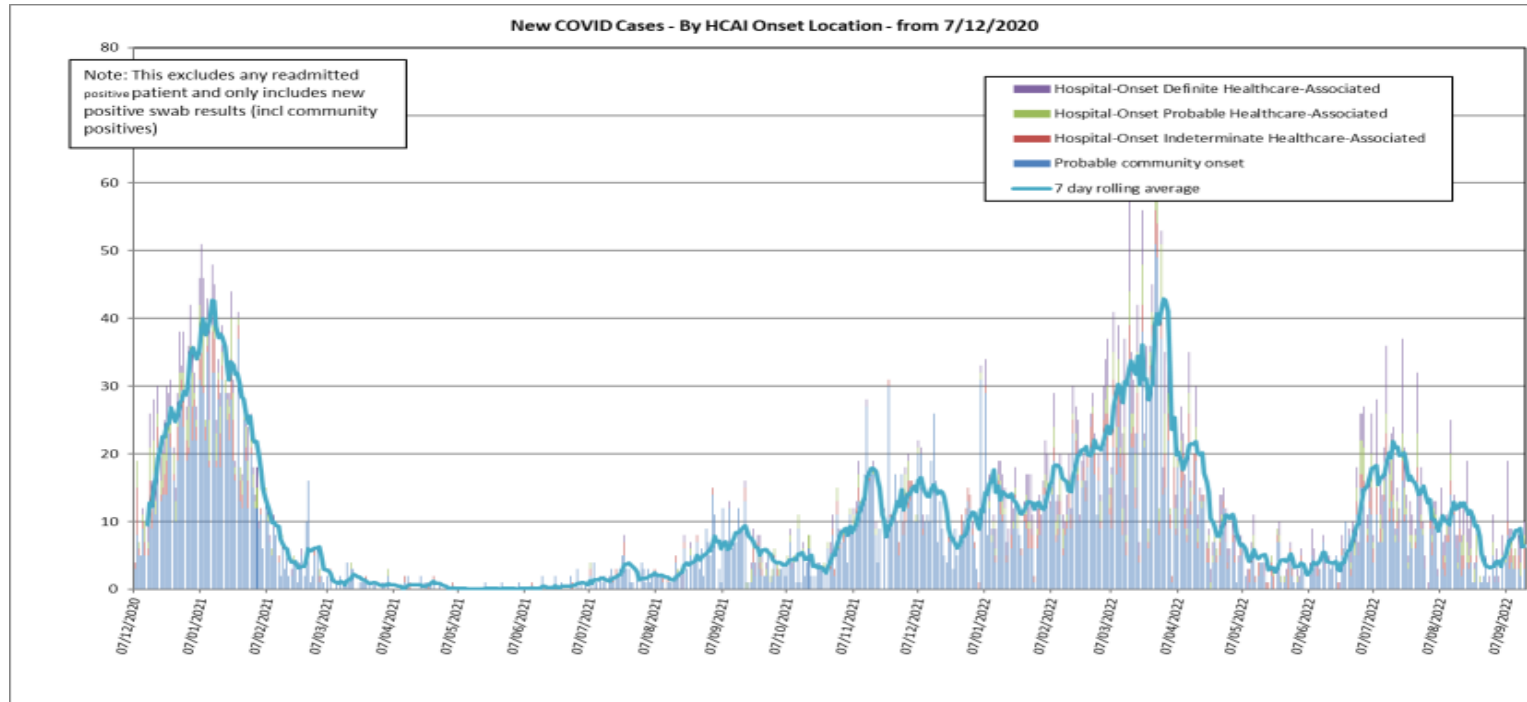
Simon Merritt
Chief Medical
Officer

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Prevalence

COVID in the local community reduced once again during August with E Sussex showing a prevalence of 53/100,000 with an England rate of 43/100,000 - prevalence remained higher in Eastbourne (66) and Hastings (61). The number of COVID positive patients at ESHT has remained at an average of 40 positive patients in the Trust each day. Face masks continue to be worn in all clinical areas. Teams continue to use COVID inpatient information from Nervecentre to manage beds in cohorted bays with the aim of safe patient placement and zero void beds.



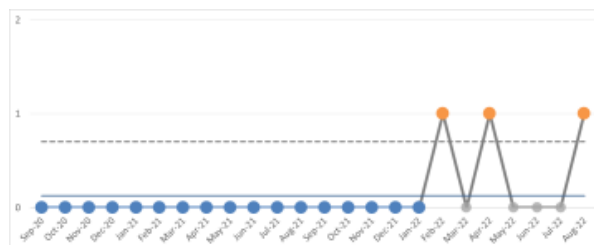
The Omicron BA.5 remains the most common lineage in our area. During August, ESHT reported no outbreaks of COVID, with cases being mainly confined to exposure within bays, few patients required additional treatment for their infection. The IPC team continue to work closely with operational teams and updating Nervecentre to minimise the impact of outbreaks on bed capacity. On 24th August, new guidance was issued proposing a pause in asymptomatic testing for COVID during the period of low community prevalence. The Trust has revised testing for COVID taking into account local patient risk factors and services.

Safe Care - Infection Control

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

MRSA cases

Variation: Normal
Current Month: 1

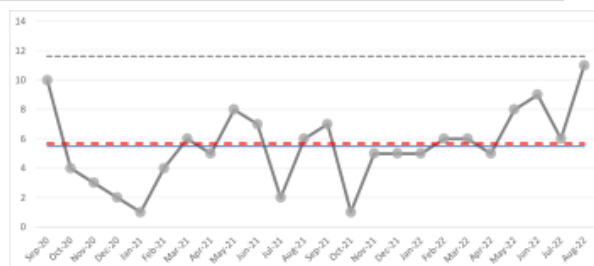


MRSA bacteraemia (MRSA)

One MRSA bacteraemia case to report for the month of August. Source of bacteraemia is being assessed as part of the root cause analysis (RCA) process that is not yet complete. The patient was transferred to St Thomas's hospital for treatment of their injuries post road traffic incident.

CDIFF cases

Limit: 5.66
Variation: Normal
Current Month: 11



Clostridium Difficile Infection (CDI)

11 cases of CDI were reported in August, against a monthly internal limit of 5. All of which were HOHA (Hospital Onset Healthcare Associated). Post infection reviews are underway. Each sample was ribo-typed and there is currently no evidence of cross infection or outbreak.

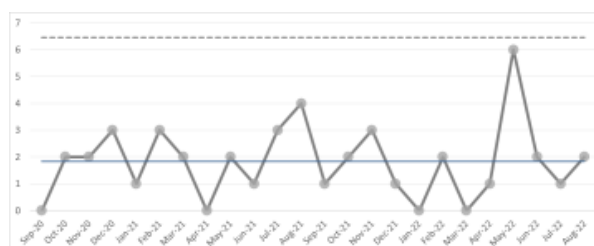
CDIFF per 1000 bed days

Variation: Normal
Current Month: 0.31



MSSA

Variation: Normal
Current Month: 2



MSSA bacteraemia

Two MSSA bacteraemia were reported in August. Both were reported as unavoidable Hospital Onset Healthcare Associated infections. Source of bacteraemia for the first case were assessed as being skin/soft tissue related infection, was treated with antibiotics and was assessed as an unavoidable infection related to dermatitis. The second was of an unknown cause despite investigation, treated with antibiotics and unknown if this was avoidable infection.

04/10/2022

Safe Care – Incidents



East Sussex Healthcare
NHS Trust

Author:

Margaret England – Head of Governance

Status
Report

There were 1,106 incidents reported (from Datix on 16/09/2022).
969 **ESHT** only incidents and of these:

Severity 1 None/Near Miss - 669
Severity 2 Minor - 280
Severity 3 Moderate - 20
Severity 4 Major - 0
Severity 5 Catastrophic - 0

Top five locations:

Patients Home - 69
Irvine Unit Intermediate Care Unit - 56
Emergency Unit Eastbourne - 33
Delivery Suite Conquest - 32
Emergency Unit Conquest - 32
Jevington Ward - 31

Top three categories:

Slips Trips and Falls - 180
Medication Errors and Other Medication Related Incidents - 124
Diagnosis and Diagnostic Services - 97

One SI reported in August 2022:

- Delay in following up on MRI findings, RCA underway and will report to PS&QG.

Challenge &
Risk:

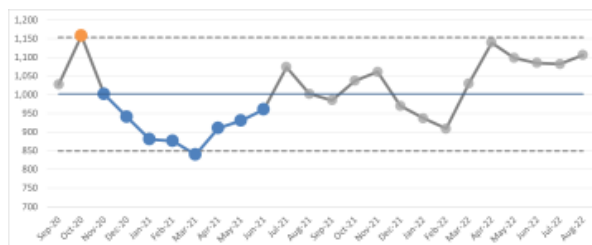
The Patient Safety Incident Response Framework (PSIRF) was published on 17 August 2022. After Action Review (AAR) training has been arranged for 2 dates in October 2022 and divisional colleagues have secured places. Healthcare Safety Investigation Branch (HSIB) courses have been made available to staff to book onto to support investigations as part of the PSIRF implementation. Concerns re: availability of HSIB courses to have a large enough number of divisional staff trained to undertake investigations.

Actions:

PSIRF implementation planning will continue alongside preparation for Datix Cloud IQ (new online system for collating incidents and experience) and Learning from Patient Safety Events (LFPSE). The Trust anticipates fully implementing PSIRF by August 2023.

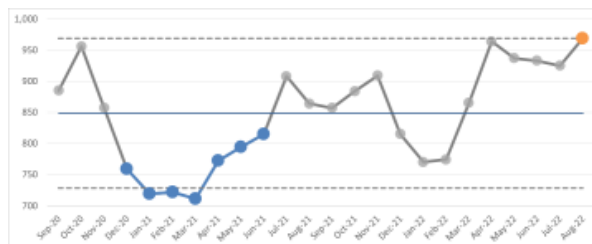
Patient Safety Incidents (Total incidents ESHT and Non-ESHT)

Variation: Normal
Current Month: 1,106



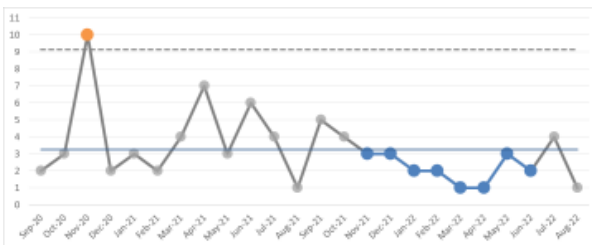
Patient Safety Incidents (ESHT incidents)

Variation: Normal
Current Month: 969



Serious Incidents (SIs) (Incidents recorded on Datix)

Variation: Normal
Current Month: 1



04/10/2022

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Safe Care – Falls

Author: **Margaret England – Head of Governance**

Status
Report

There were a total of 180 falls in August, a tiny increase on the previous month with 176.

Repeat falls:

- 19 high risk patients totalling 48 falls

Areas reporting the highest numbers of falls during August 2022:

Irvine Unit – 17
Jevington ward - 11
Benson ward – 9
De Cham - 9
Devonshire – 8
Stroke unit - 8

There were 14 falls reported in non ward areas.
The highest reporting areas were:

Emergency Unit Conquest – 5
Michelham Urology Assessment Unit – 3
Emergency Unit EDGH - 2

There were no severity 4 or 5 falls reported during August 2022.

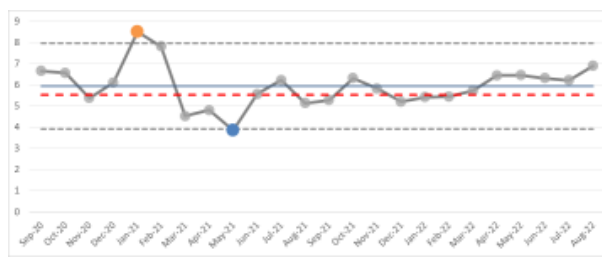
Challenge
& Risk:

Significant additional capacity is still open with very large numbers of patients not meeting criteria to reside (NCTR) and medically fit for discharge (MFD), many of whom are frail and dependent with increased risk of harm and many who are confused and prone to wandering admitted with a history of falls. A recent review showed that 40% of falls with harm (SIs) over the past 3 years have involved patients who are MFD. Work continues to try to describe risk/harm to those patients including deconditioning with concerns about the impact on this group of vulnerable adults.

Inpatient Falls Per 1,000 Bed Days (Acute)

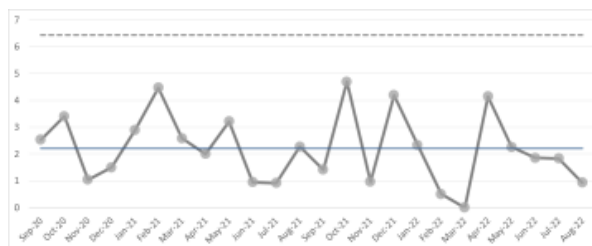
Average: 5.52

Variation: Normal
Current Month: 6.9



Inpatient Falls Per 1,000 Bed Days (Intermediate Care)

Variation: Normal
Current Month: 0.9



04/10/2022

11

Safe Care - Pressure Ulcers

Author:

Tina Lloyd - Associate Director of Nursing

Status Report

The rate of all Pressure Ulcers (PUs) per 1000 bed days increased in August (largely Cat 2's), another likely indicator of the huge number of stranded inpatients who are at high risk of harm with many admitted with a history of harm inc pressure damage. For these patients deconditioning is also a factor as is poor nutrition and hydration as many patients are non concordant with care due to underlying cognitive impairment. The PU Review Group (PURG) is reviewing any clusters or areas for investigation.

The total number of PUs reported amongst patients in their own home and in care homes has also seen a slight increase for the third month.

One Cat 4 PU was reported in Aug on an inpatient discharged home. On investigation the patient had multiple existing pressure damage on admission to hospital. One area deteriorated, which may have been unavoidable due to the patient's palliative condition. The case is under investigation and will be presented to the PURG once completed.

Whilst the number of PUs reported in patients own home remains consistent, the number reported in care homes is smaller and more unpredictable. The CHIC division works closely with other care providers to review patients at risk and those with PUs and this has not highlighted any particular theme or area of concern.

Challenge & Risk:

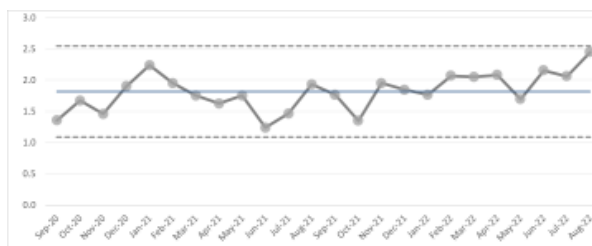
Significant additional capacity still open (circa 110 beds) with very large numbers of patients not meeting the criteria to reside (NCTR) and medically ready for discharge (MRD), many of whom are frail, wander some and very dependent. Many need 2 staff and/or enhanced observation with increased risk of harms and history of harm prior to admission.

Actions:

A revised Transfer of Care (TOC) form is being introduced with the aim of improving documentation on discharge from hospital related to PUs, including assessment, origin and treatment plan. This will be used until an electronic version can be developed by the digital team.

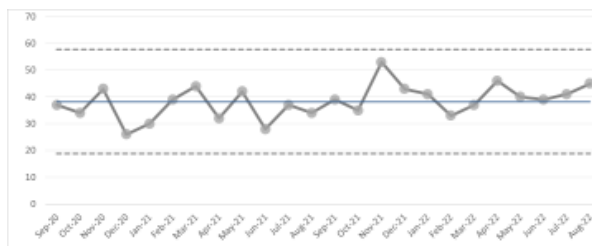
Pressure Ulcers Per 1000 bed days Inpatients all categories

Monitoring
Variation: Normal
Current Month: 2.45



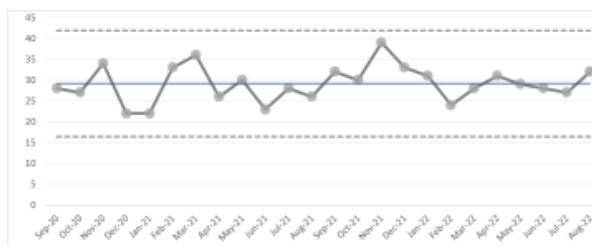
Pressure Ulcers Non Inpatients all categories

Monitoring
Variation: Normal
Current Month: 45



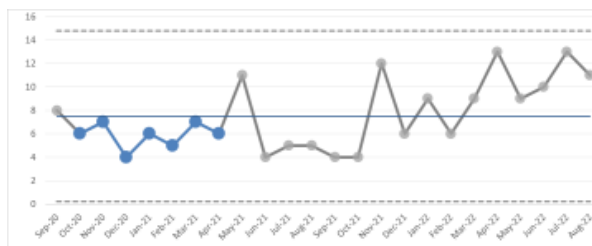
Pressure Ulcers Category all categories Patient Home

Monitoring
Variation: Normal
Current Month: 32



Pressure Ulcers Category all categories Other care provider

Monitoring
Variation: Normal
Current Month: 11



04/10/2022

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What patients are telling us?

Amy Pain- Patient Experience Lead

Status
Report

There were 83 **open complaints** at the end of August (July = 78) . Of the 38 complaints received in August, 4 related to an incident that had occurred in excess of **six months ago** and 6 related to an incident that had occurred in **excess of 12 months ago**.

In August, compliance with the **three day acknowledgment** standard for new complaints was 100%.

The top three primary complaint subjects were:

- Clinical Treatment = 10 (July= 8, June = 11, May = 9, April = 12)
- Communication = 8 (July= 9, June = 6, May = 8, April = 5)
- Patient Care = 7 (July=1, June=5, May= 8, April= 6)

Top complaint locations:

- Emergency Department CQ (7)
- Outpatients Department EDGH (3)
- Berwick ward (2)
- Kipling (2)

8 complaints were **reopened** (July =11, June = 8, May = 5, April = 6, March = 11, February = 11).

There were **14 overdue** complaints at the end of August - the oldest complaint was 37 working days overdue. These complaints were overdue for various reasons but no specific themes identified.

The overall response rate for the month was 56%, an improvement on July (45%). For 35 working days this was 57% and for 50 working days it was 50%.

The Trust received one outcome contact from the Parliamentary and Health Service Ombudsman (**PHSO**) in August .

528 Patient Advice & Liaison Service (**PALS**) contacts were received, compared to 522 in July (=517), May (= 545), April (= 574) March (= 742) and February (= 616).

Seven 4 and 5 star reviews were posted on the NHS website and two positive reviews posted on Healthwatch feedback centre.

The Trust received **1,489 plaudits** in August now captured on InPhase with plans underway on how best to report given the huge amount of qualitative data. A more detailed report is discussed at Q&SC.

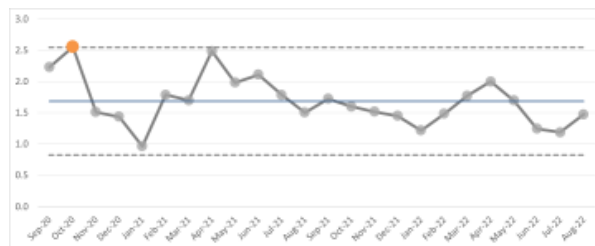
Challenge:

Ongoing operational pressures still affecting response times.

Actions:

Capacity discussed at Quality & Safety Committee re need to ensure equal focus on quality and governance. Compliance Officers are meeting regularly with Heads of Nursing to discuss the current open complaints and where the delays are occurring. The team are looking at alternative ways in which they communicate with staff and arranging time to support them in providing a written account. A third member of the Exec team is now a designated signatory.

Complaints Received
per 1,000 bed days



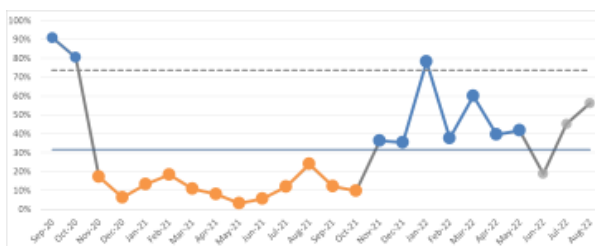
Variation: Normal
Current Month: 1.5

Total Complaints
Received



Variation: Normal
Current Month: 38

Complaints Response
Times



Monitoring
Variation: Normal
Current Month: 56.3%

04/10/2022

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What patients are telling us?

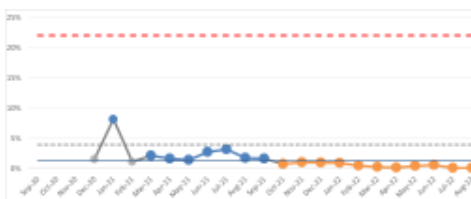
F&FT – A&E Score

Current Month: 100%



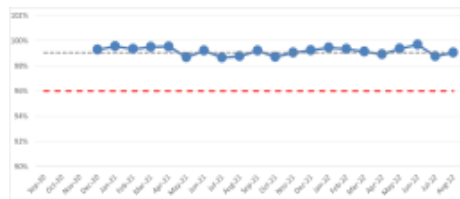
F&FT – A&E Response

Current Month: 0.1%



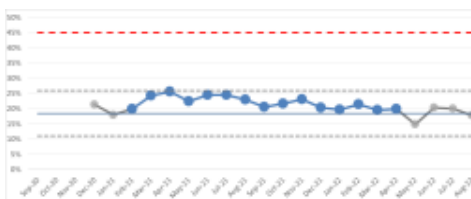
F&FT – Inpatient Score

Current Month: 99.1%



F&FT – Inpatient Response

Current Month: 17.9%



F&FT – Maternity Score

Current Month: 98.2%



F&FT – Maternity Response

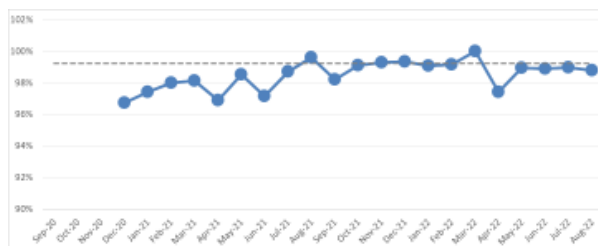
Current Month: 26.2%



F&FT – Outpatient Score

Variation:
Normal
Current Month:
98.8%

04/10/2022



Author:

Amy Pain - Patient Experience Lead

Status
Report

The **total number** of Family & Friend Tests (FFT) surveys returned in August was **1,612** (July= 1,799, June = 1,909, May = 1,680, April = 1,710, March = 1,926).

Response rates continued to be affected by the sustained operational pressures especially in the Emergency Depts.

The **positive recommendation rates** for August, compared to the most recent data released by NHSE (July) continued to be higher than the national average.

A&E	100% , nat avg July 75% (ESHT resp rate 0.11%)
Inpatient	99.06% , nat avg July 94% (ESHT resp rate 17.85%)
Maternity	98.20% , nat avg July 92% (ESHT resp rate 49.56%)
Outpatients	98.79% , nat avg July 93% (248 surveys)
Community	95.53% , nat avg July 92% (179 surveys)

The top three scoring questions on the FFT inpatient survey were:

- Were you always treated with kindness?
- Did all staff have a smiling and friendly approach?
- Did you feel the staff responded appropriately to any questions or concerns you raised?

Themes related to dissatisfaction were with discharge processes and pain management.

Challenge
& Risk:

Both ED's continued to face considerable operational pressures with crowding and longer wait times.
A&E, Maternity, Endoscopy and Ophthalmology outpatient areas now offer a digital platform for the survey to be completed. Alternative ways of promoting this platform are being considered.

Actions:

A review of the process for capturing Out Patient Departments' (OPDs) patient experience is underway, with a focus on virtual appts and capturing those specialities using OPDs as a location.

Effective Care – Nursing & Midwifery Workforce

Author: **Angela Colosi Assistant Director of Nursing - Corporate**

Status
Report:

Care Hours per Patient Day (CHPPD*)

The red line indicates the ESHT CHPPD when level 2 & 3 areas are excluded - Critical Care, SCBU, CCU and paediatrics. These areas have notably higher CHPPD and therefore skew the average. Ward level breakdown with registered and unregistered staff split is discussed in the Safer Staffing report that is presented at the Quality & Safety Committee with some significant variation across areas. In August, **24 out of 39 areas were under 8.0 CHPPD**.

Fill Rate

August's average fill rate against the planned budgeted establishment **for substantive wards only** was 85.3% for nursing, noting some variation across wards. Additional capacity remained open for medical patients on Devonshire, Polegate, Murray, Litlington, the Discharge Lounge at CQ, with additional beds in Seaford annexe, SDEC Conquest, SDEC EDGH and AAU. The fill rate including escalation was 84.9%. This appears higher than in practice as SDEC and D/C lounge have high CHPPD (as not inpatient wards) which skews the data, D/C lounge (31.7) and SDEC EDGH (32.4).

It is not possible to separate the additional beds used on existing wards such as Murray. The additional staffing on these areas are therefore not captured within the fill rate including escalation (red line). Additional duties created are also not currently included in this data so it does not include the extra staff required for 1:1 interventions. With increased dependency of the patients who are medically ready for discharge the number of patients who require 1 to 1 care can be significant.

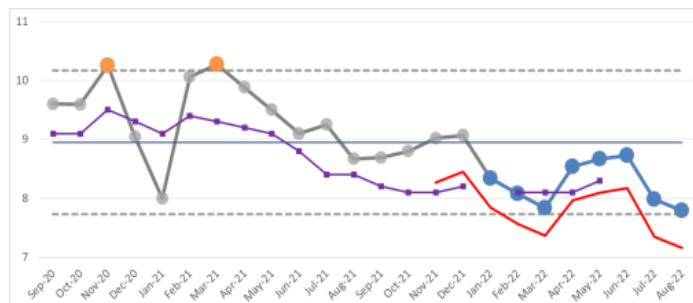
Challenge
& Risk:

- Significant additional capacity still open
- Resource to enable staff to undertake mandatory and essential training
- Risk of impact on staff well being from ongoing additional capacity and escalation
- Identifying funding for NER recommendations

Actions:

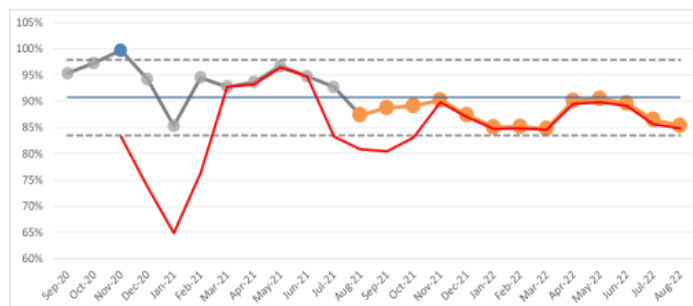
- Twice daily staffing reviews to ensure risk is mitigated as much as possible
- Review of Supernumerary time for International Nurses - now filling HCA shifts at the appropriate time in their induction

CHPPD (Trust)



National
Median: 8.3 (May 22)
Level 2 and Level 3
Areas Excluded: 7.2
Current Month: 7.8

Staff Fill Rate (total)



Current Month:
85.3%
Incl. escalation:
84.9%

*CHPPD is calculated by dividing the actual hours worked by the number of patients in beds at midnight.

04/10/2022

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Effective Care – Nursing Workforce

Author: **Angela Colosi, Assistant Director of Nursing - Corporate**

Status Report: Eastbourne & Conquest fill rate data does not fully represent the impact of the additional areas open as only Polegate and Devonshire at EDGH are captured as unfunded areas.

In addition, Murray ward escalation beds are also funded as part of the ward and therefore not included in the fill rate calculation.

Fill rates at Bexhill remained stable during Aug at 86.9% in addition to providing significant staffing support to Rye Memorial who have ongoing vacancies. Rye fill rate is slowly improving.

ESHT International Nurse Recruitment has been shortlisted in the Nursing Times Workforce Awards. Ceremony in November.

Challenge & Risk: The challenge now is the balance of all of the clinical and non clinical elements of care such as responding to complaints, incident investigations, essential documentation/handover on discharge, ASC assessments and management of flow. In addition there is a need to ensure compliance with mandatory and essential training that has been affected over the last 2 and a half years because of the pandemic.

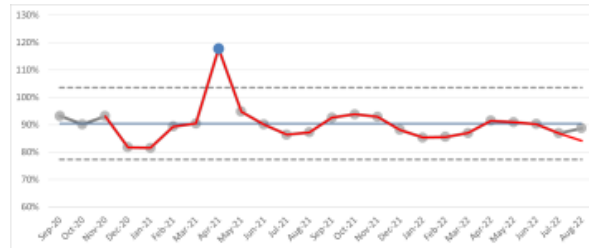
Senior Staff's time/ability to access and sign off Rosters in Healthroster is a challenge, to ensure effective and efficient rostering, as many of the Matrons are working clinically and Heads of Nursing (who 2nd line approve) remain heavily involved in operational issues of flow and discharge.

Actions: Healthroster compliance sessions continue.

International nurses contributing to support worker shifts as part of their induction from the 1st November.

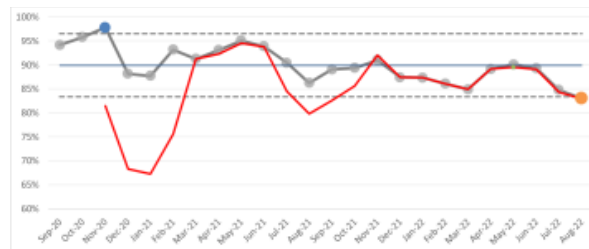
Staff Fill Rate (Bexhill)

Variation: Normal
Current Month: 88.7%
Incl. escalation: 84.2%



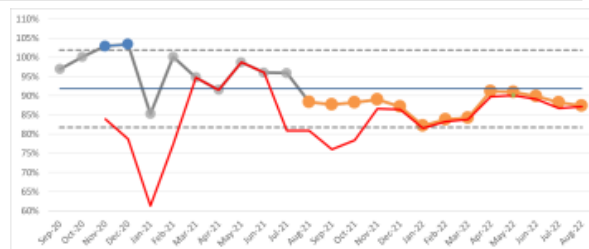
Staff Fill Rate (Conquest)

Variation: Normal
Current Month 83.1%
Incl. escalation: 82.9%



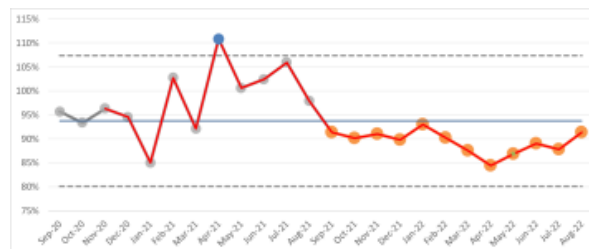
Staff Fill Rate (Eastbourne DGH)

Variation: Normal
Current Month: 87.4%
Incl. escalation: 87.2%



Staff Fill Rate (Rye Memorial)

Variation: Normal
Current Month: 91.4%
Incl. escalation: 91.4%



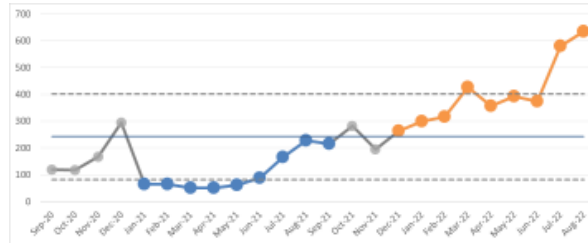
04/10/2022

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Effective Care – Nursing Workforce

Red Flags

Current Month: 634



Author: **Angela Colosi Assistant Director of Nursing - Corporate**

Status Report: The reporting of Red Flags has risen significantly in the last 2 months. This may be a result of more education as the rate of reporting has not yet stabilised. All eligible wards have been trained for the last 3 months. The details of the 9 categories are provided in the Safe Staffing report which reports to the Quality and Safety Committee each month.

The reporting of red flags is in conjunction with the reporting of patient acuity scoring which occurs via the SafeCare system three times per day.

Red flag reporting allows real time mitigation of risk, whereas Datix reporting is for when an incident has occurred.

Skill mix for Registered Nursing staff overall was at 53.2% in June with notable variation across areas as described in the more detailed Safer Staffing report.

Challenge & Risk: Compliance in SafeCare completion is improving and dependant on the right funded staffing establishment being in place.

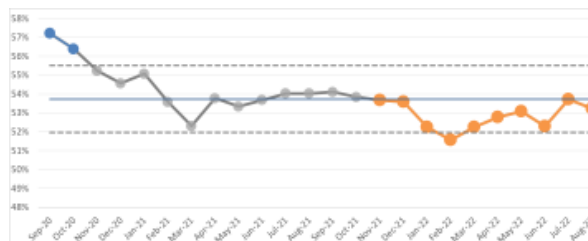
Skill mix balance is a risk as more new staff (International nurses and 'New to Care' staff) are supported by substantive staff who are also supporting additional patients in the escalation beds.

Actions: Supernumerary time for International Nurse (INs) recruits has been reviewed in line with ICS colleagues and by engaging our INs. It has been agreed that as part of their induction they can be formally rostered/reported as contributing as support workers. Healthroster compliance sessions continue and are supported by the SafeCare Lead Nurse and Heads of Nursing.

SafeCare Lead Nurse continues to focus on Healthroster compliance as well as ensuring staff undertake the acuity scoring of patients to determine safe staffing levels accurately and in a timely way.

Registered Skill Mix (%) (Registered vs unregistered staff)

Current Month: 53.2%



04/10/2022

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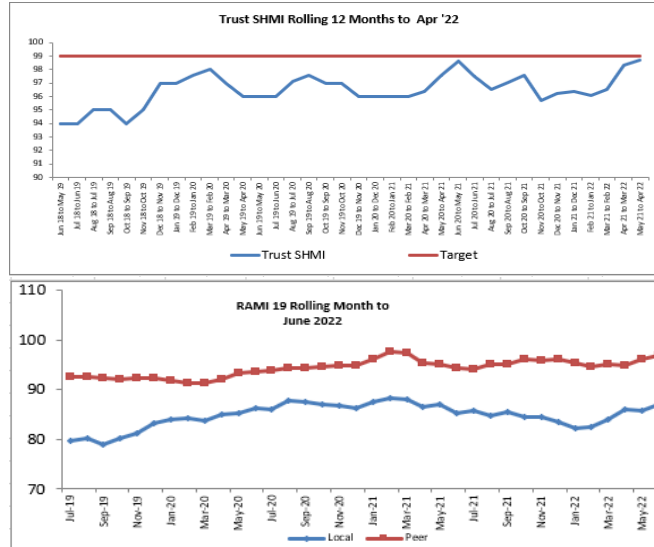
Effective Care - Mortality

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)

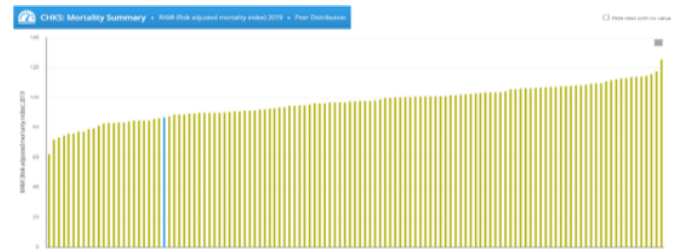
Ratio between the number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures

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



- SHMI – May 2021 to April 2022 is showing an index of 0.99. SHMI remains higher at Conquest.
- RAMI 19 – July 2021 to June 2022 (rolling 12 months) is 87 compared to 85 for the same period last year. June 2021 to May 2022 was 86.
- RAMI 19 was 85 for the month of June and 80 for May. Peer value was 92 for June.
- Crude mortality without confirmed or suspected covid-19 shows Jul 2021 to Jun 2022 at 1.54% compared to 1.38% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 58% for June 2022 deaths compared to 59% for May 2022 deaths.

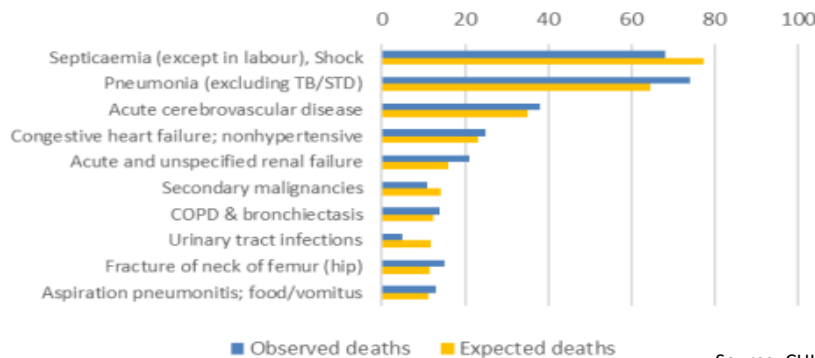
RAMI Peer Distribution without confirmed or suspected covid-19



RAMI v Peer

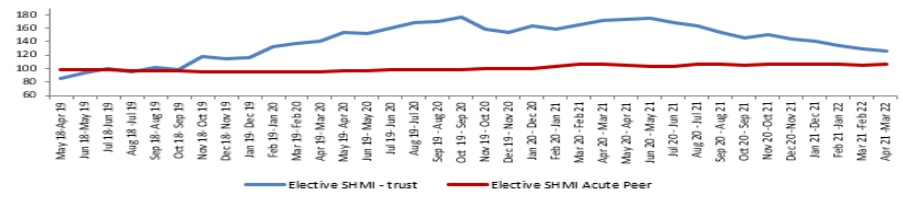
This shows our position nationally against other acute trusts - currently 24/123

SHMI - comparison of observed and expected deaths by diagnosis (top 10 shmi groups by volume of expected) Jan-Mar 2022

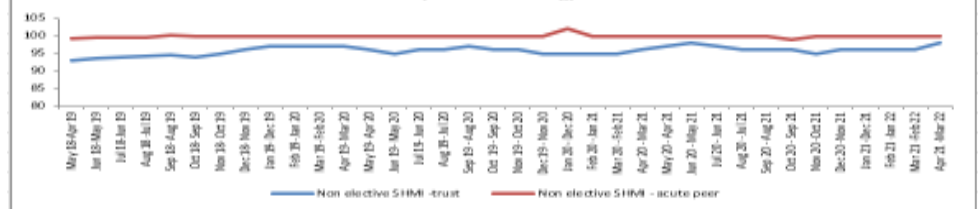


Source: CHKS

Elective SHMI (12 month rolling) to Mar '22



Non-elective (12 month rolling) to Mar '22



04/10/2022


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

	Positives	Challenges & Risks	Author
Responsive	<p>Monthly sickness has reduced by -1.5% to 5.2%</p> <p>Annual sickness is unchanged at 6.0%.</p> <p>Appraisal compliance has increased by 1.8% to 74.2%</p>	<p>Annual turnover has increased by 0.5% to 13.4%, reflecting 876.5 fte leavers in the rolling 12 months</p> <p>Vacancy rate has increased by 0.4% to 8.9%.</p> <p>Current vacancies are showing as 691.3 ftes</p> <p>Mandatory Training rate has reduced slightly by -0.1% to 88.4%</p>	 <p>Steve Aumayer Chief People Officer</p>

Overview:	<p>Monthly sickness has reduced by -1.5% to 5.2%, following last month's spike due to Covid, with a monthly reduction of 2.662 fte days lost in month due to Chest & Respiratory illnesses. Staff off sick due to Covid, fell from 166 at the end of July to 36 at the end of August (and averaged 50 across August). Anxiety, Stress & Depression illnesses also reduced this month by 231 fte days lost. There is a clear correlation between Covid sickness and anxiety levels i.e. when Covid peaks, so anxiety rises.</p> <p>Turnover continues to increase by a further 0.5% to a new high of 13.4% (876.5 fte leavers in the last 12 months, an increase of 33.1 fte leavers on last month). Registered Nursing & Midwifery turnover has increased by 0.7% to 12.6% (253.6 fte leavers, an additional 16.3 fte leavers this month), AHP turnover has increased by 0.8% to 15.7% (81.0 fte leavers), Additional Clinical Services turnover increased by 0.7% to 14.0% (205.4 fte leavers) and Admin & Clerical turnover increased by 0.6% to 13.2% (181.7 fte leavers). Medical & Dental turnover, however, has reduced by -1.4% to 13.5% (41.1 fte leavers). There is a dedicated Trust Lead (People Potential Manager) focussing on the retention of staff to gain insight and understanding through direct engagement with staff groups and areas. This will be dovetailed with data to draw up a draft action plan for hot spots.</p> <p>The increase in turnover is reflected also in the increase in the Trust vacancy rate by 0.4% to 8.9% (691.3 fte vacancies, an increase of 34.7 fte vacancies compared to last month). The largest monthly increase was for Additional Clinical Services staff where the rate increased by 2.6% to 13.1% (an increase of 48.0 fte vacancies to 222.5 fte vacancies. This was partly due to an increase of 36.5 ftes in the substantive establishment for this staff group, including some skill mix adjustment of posts from Registered Nursing to Unregistered). Registered Nursing & Midwifery vacancy rate slightly increased by 0.2% to 7.5% (an increase of 2.2 fte vacancies to 171.8 fte vacancies), whilst the Medical & Dental vacancy rate reduced by -0.9% (a reduction of -7.4 fte vacancies to 113.4 fte vacancies) and AHP vacancy rate reduced by -0.8% (a reduction of -4.8 fte vacancies to 84.6 fte vacancies).</p> <p>Although monthly sickness has started to reduce, the increase in vacancies does mean that there is still pressure on TWS supply. Work continues to increase the number of candidates on TWS. Communication has been made with colleagues to join the bank as dual contracts to meet the current demand. Additional HCAs and Nurses have been placed on the Bank. Continued activity to increase the number of additional framework agencies being sourced to assist with both current and future supply. Continued communication with departments to ensure awareness of TWS processes and procedures to assist with Time To Hire and reduce potential "blockages".</p>
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04/10/2022

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Workforce – Contract type

Author:

David Moulder, Greig Woodfield

Status
Report

Substantive usage reduced by -14.8 ftes, bank usage reduced by -13.7 ftes and agency usage reduced by -8.2 ftes.

Temporary workforce utilisation was 9.6%, a -0.3% reduction from last month. The Trust vacancy rate increased by 0.4% to 8.9%.

Staff group	Vacancies ftes	Recruitment Process (ftes)	Offers & Start Dates (ftes)	Time to Hire (days)
Med & Dental	113.4	63.5	73.6 (plus 60 deanery)	85
Reg Nurse	171.8	175	120	75
Addit Clin Serv	222.5	127	68.4	60
AHP	84.6	81.4	51.7	79
Prof, Sci, Tech	12.2	15.4	4.6	75
Healthcare Scs	-0.5	14	9.6	58
A&C	104.5	90.6	80.9	56
Estates & Ancillary	38.6	25.4	20 plus 35 bank	67
Trust	691.3	592.3	408.8	69.4

Challenge
& Risk:

Demand for TWS services remains high for Midwives, Theatre staff, Doctors, Sonographers as well as in the Emergency Dept. There is a continuing challenge to support through agency and bank.

Tier 1 & Tier 2 agencies have been engaged to assist with demand, at times they have struggled to respond and off-framework supply has been sought but is minimal. Direct contact has been made at times to ensure supply.

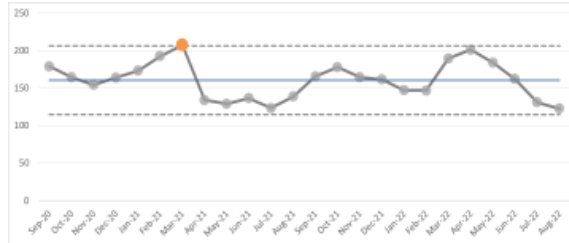
Actions:

Focus remains on increasing the number of candidates on TWS. Communication has been made with colleagues to join the bank as dual contracts to meet the current demand. Additional HCAs and Nurses have been placed on the Bank.

Continued activity to increase the number of additional framework agencies being sourced to assist with both current and future supply.

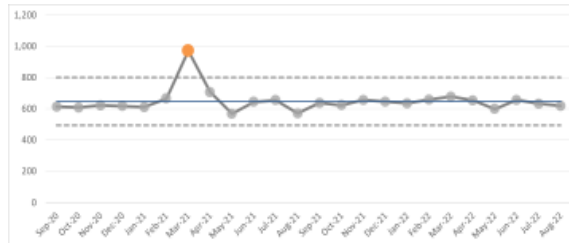
Continued communication with departments to ensure awareness of TWS processes and procedures to assist with Time To Hire and reduce potential “blockages”. Workshop for medical administrators being scoped.

Agency FTE Usage



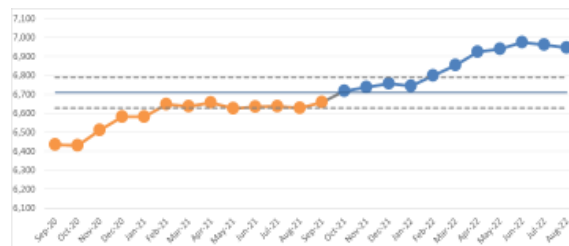
Current Month:
122.6

Bank FTE Usage



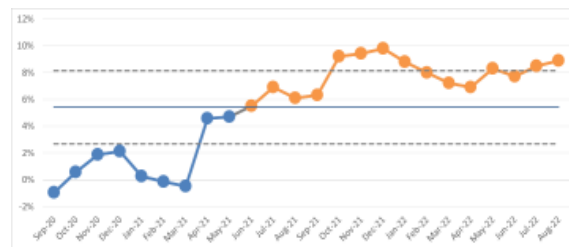
Current Month:
618.6

Substantive FTE Usage



Current Month:
6,946.5

Vacancy Rate

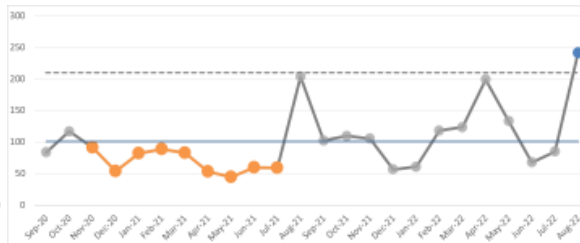


Target: 5%
Current Month: 8.9%
04/10/2022

Workforce - Churn

Author: David Moulder, Greig Woodfield

Starters FTE



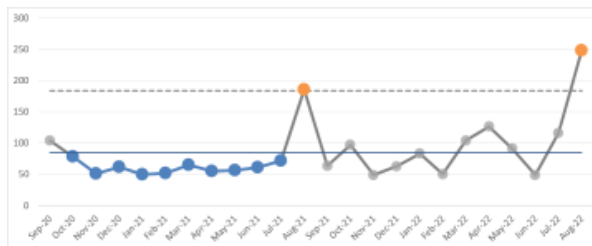
Current Month: 240.9

Status Report

The Trust starters & leavers monthly net total as at Aug 22 is fete -5.5 with +240.9 starters fte and -248.3 leavers fte & +1.9 internal changes. Over the last 12 months there was +1,523.1 starters fte & -1,175.4 leavers fte & -15.3 internal changes fte giving a net total of +332.3.

The Trust turnover rate has increased by 0.5% to 13.4%. There were 876.5 fte leavers in the previous 12 months. The Trust Retention rate (i.e. % of staff with at least one year's service) has reduced by -0.4% to 89.6%.

Leavers FTE



Current Month: 248.3

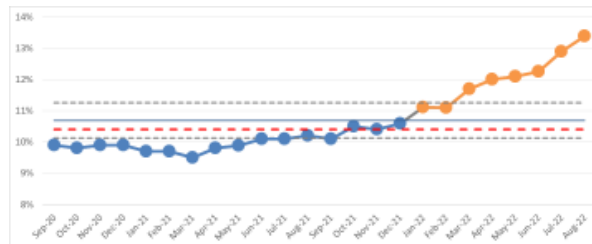
Challenge & Risk:

Primary risk is that turnover continues to increase. Recruitment activity continues to remain busy year on year, with additional activity due to additional budget establishments. c600 actions currently underway on TRAC. Primary areas of activity are Emergency Medicine, Medical and AHPs. Resourcing assistants dealing with c60 posts for AfC c.30 plus offers out for medical.

Success with continued targeting of "hard to recruit" posts, Consultants for Obs and Gynae, Ophthalmology and Colorectal have been sourced and are at offer. Activity to address AHPs remains focussed around Sonographers and Radiographers. Other areas of activity are Community Nurses, Estates & Facilities and A&E.

Sufficient accommodation for International nurses and Radiographers still remains a concern due to lack of rental properties particularly in the Rye area. Air B&B being sourced.

Annual Turnover Rate



Target: 9.9%
Current Month: 13.4%

Actions:

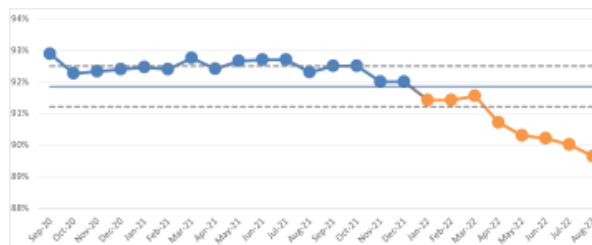
There is a dedicated Trust Lead focussing on the retention of staff to gain insight and understanding through direct engagement with staff groups and areas. This will be dovetailed with data to draw up a draft action plan for hot spots.

There is a strong pipeline of international nurses in place. A further c.30 nurses are due to arrive by the end of Sept, with planned cohorts for the rest of the year. Successful bid for NHSE funding received for AHPs. OT interviews booked for end of Sept/Oct onwards.

Hard to recruit medical posts are with Medacs and other additional agencies, as required. Two additional agencies sourced and discussions ongoing with Procurement. Targeted phased approach to filling medical posts. Successful onboarding of 132 Junior Doctors.

Trying to source additional providers for accommodation for International Nurses.

Retention Rate



Target: 92%
Current Month: 89.6%

04/10/2022

22

Workforce - Sickness

Author: **David Moulder, Julian Fuller**

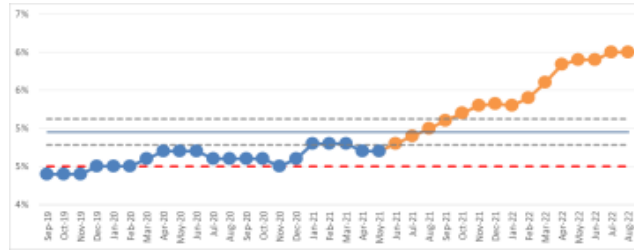
Status Report *n.b. the sickness charts have been amended to show a 3 year period, to illustrate the impact of Covid.*

Monthly sickness % has reduced by -1.5% to 5.2%. The annual sickness rate is unchanged at 6.0%.

Sickness average is also unchanged at 22.0 days per FTE.

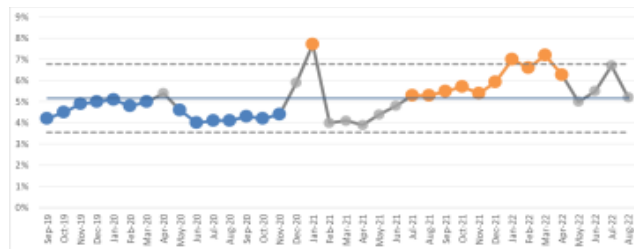
Annual Sickness

Target: 4.5%
Current Month: 6.0%



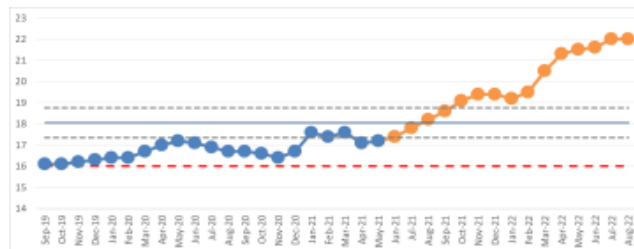
Monthly Sickness

Current Month: 5.2%



Average sickness Days per FTE

Target: 16
Current Month: 22.0



Challenge & Risk: This month has seen a reduction in absence mainly due to the reduction in Covid related absence. Staff continue to feel under immense pressure to deliver for their patients and this will have impacted on the other sickness reasons.

With the planned roll out of the Covid and Flu vaccines, consideration needs to be given as to the effect of the vaccinations and potential absence due to symptoms created by these.

Due to the acuity on wards with a lot of frail patients there has been a notable increase in assaults by patients against our staff

Actions: HRBPs to work with People Potential Manager on ways of supporting staff to be in work and how we can highlight the offer available through Wellbeing and Occupational Health

Discussion with the Health and Wellbeing team to ensure support is offered to the wards to aid prevention of assaults by patients on staff and support those staff affected.

04/10/2022

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Workforce - Sickness

Author: David Moulder; Julian Fuller

Status Report

Reason	fte Days Lost +/-	Total fte Days Lost
Anxiety, stress & depression	▼ -231.3	1,747.2
Back problems	▲ +173.8	722.24
Chest & respiratory	▼ -2,661.7	2,329.3
Cold, cough & flu	▼ -141.7	341.5
Gastrointestinal	▲ +158.4	952.2
Other MSK problems	▼ -5.1	1,588.9
Other reasons	▼ -480.2	3,802.1
All reasons	▼ -3,187.7	11,483.4

Challenge & Risk:

The reduction in monthly sickness is largely due to the decrease in Chest & Respiratory illnesses as the Covid upsurge waned. Anxiety, Stress & Depression illnesses also fell significantly and there does appear to be some correlation with Covid trends.

Actions:

People Potential Manager has revised the Psychological Wellbeing and Safety of Staff policy. HR teams to work closely with managers to ensure that they are aware of the tools available to help staff when they identify particular stresses.

Promotion of the wellbeing conversations continuing, to help with this process

Anxiety/Stress/Depression



Back Problems



Chest & Respiratory Problems



Cough, Cold & Flu



Gastro-intestinal Problems



Other MSK problems



04/10/2022

24

Workforce - Compliance

Author:

Dawn Urquhart

Status
Report

We continue to progress with staff enrolling onto MyLearn

There was a slight decrease of -0.1% in Core Skills Training but generally compliance rates are positive when considered against the back drop of significant service pressures that the Trust has been under. These pressures are a national issue currently, to provide the regional context..

Appraisal compliance rose by 1.8% slightly which, after the last few months of decline, is very helpful.

The development of the new Appraisal Tool and process to be hosted on MyLearn continues and a draft iteration of the tool has been loaded onto the system for managed feedback from clinical and HR colleagues in the first instance.

DNA Rates continue to be high but again this is reflective of the ongoing clinical situation that is having an adverse affect on education and training especially CST.

Challenge
& Risk:

The continuing national situation of post COVID impacts on patient care and shortages of staff across the full range of both professional and non professional roles is having an impact on patient pathways especially in such areas as ED, UTC , Medicine etc

The continued issue of the increased OSCE waiting time and subsequent risks to the provision of accommodation and visa status etc is both highlighted and being closely monitored through the HRQS.

Actions:

The Trust Essential/Mandatory Training paper is nearing completion and will be presented to ESG on the 22nd September and PAG for the meeting on the 30th Sept for discussion and agreement of next steps.

As an organisation, we continue to escalate the increasing waiting times for OSCE to the NMC and NHS Employers. In addition, concerns have been raised on the quality of examinations in the Leeds OSCE Test centre.

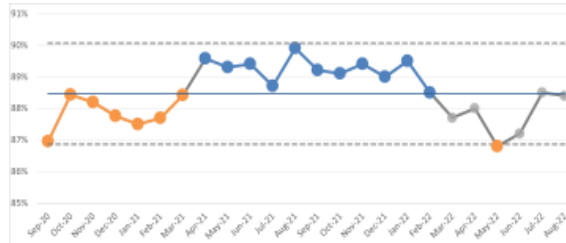
Launching a managed feedback with clinical and non clinical colleagues of the refreshed Appraisal Tool for 6-8 weeks. Time frames and pilot sites/people to be agreed in collaboration with the HWB and Staff Engagement Team.

25

Mandatory Training Compliance

Target: 90%

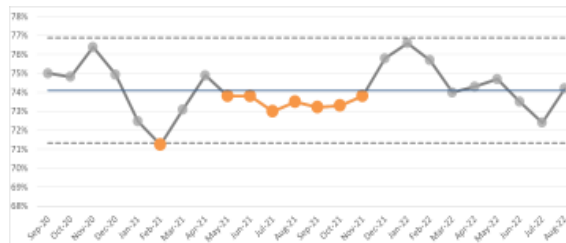
Current Month: 88.4%



Appraisal Rate

Target: 85%

Current Month: 74.2%

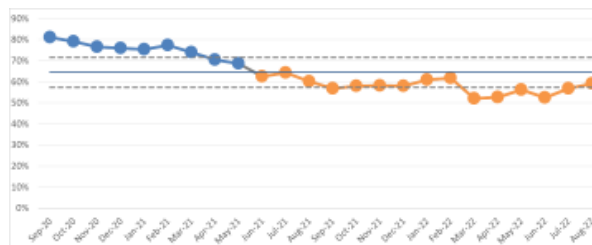


04/10/2022

Workforce – Job Planning

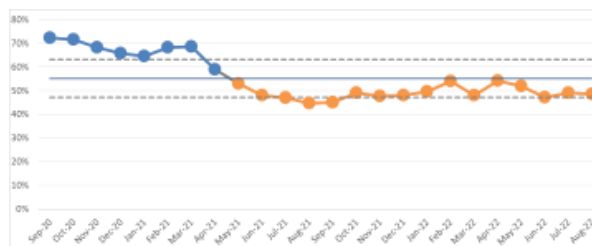
Consultant eJob-Planning Fully Approved Rate

Current Month: 59.2%



SAS Grades eJob-Planning Fully Approved Rate

Current Month: 48.5%



Author:

Jo Gibson

Status Report

Medical job plans have seen a small increase of 1.0% this month, with a total sign off rate of 56%

- 155 of 262 Consultants have a completed eJobPlan (59.2%)
- 49 of 101 SAS Doctors have a completed eJobPlan (48.5%)

Challenge &
Risk:

Users are beginning to get to grips with the new layout of the e-JobPlan system, but sign off managers continue to struggle with the layout. Training on the system is actively being provided.

Annual leave during the summer months has continued to protract the sign off process, there are a further 33 (9%) job plans in the pipeline awaiting 1st and 2nd manager sign off. Reminders are sent to those sign off managers on a bi-weekly basis.

The next review period is on the horizon, and as part of the NHSE LoA requirements, all job plans must be reviewed again to ensure they meet demand and capacity plans.

Changes to the payroll system could prevent ESR being updated efficiently, and medics being paid incorrectly. A new process to notify of PA & element changes will need to be developed, and followed by the Service Managers and Specialty Leads.

Actions:

As part of the NHSE Levels of Attainment a eJob Planning Board is to be formed once approved by the Chief Medical Officer.

The Extranet job plan page has now been updated to introduce new supporting material for colleagues.

Continue to push sign off managers to review and complete the review of the job plans within their respective specialties.

04/10/2022

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Workforce – Roster Completion

6 week Nursing Management Roster Approval Rate

Current Month: 53%



Author: Penny Wright; David Moulder

Status Report

For the roster starting on 8th Aug, 53% of rosters had been approved at 6 weeks before the go live date which is a 8% improvement on the previous month. 22% had been approved at 8 weeks prior to commencement which is an improvement of 5%.

Reporting and insight to nursing colleagues have supported the trending improvement of approval rates.

8 week Nursing Management Roster Approval Rate

Current Month: 22%



Challenge & Risk:

Approval rates continue to improve, for the third consecutive month.

There are some areas that have flagged operational differences that mean 4 week approval cut off for their respective areas however this does not follow the guidance provided in Lord Carter's report. Further engagement to refine this is underway.

Actions:

New roster profiling tool has been developed for ward based nursing and is currently being piloted in the back office. This will be launched in the coming weeks. It provides the capability to forecast by individual roster for any time period i.e. half term, Christmas etc.

This tool will support the cross-site meetings where site leads report shortfall using the Safecare Wheel but will add insight into what is driving the gap i.e. increased additional duties and/or unavailability planning

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



Tara Argent
Chief
Operating
Officer

	Positives	Challenges & Risks	
Responsive	<p>The diagnostic standard (DM01) is to deliver 99% of all diagnostic requests within 6 weeks of referral. The Trust has delivered 84.9% The Trust remains in the top quartile for this standard nationally.</p> <p>Our urgent care response 2 hour target has again been met and has improved on previous month. This has been achieved despite the increase in referrals to our Urgent and Emergency care team.</p> <p>The Trust's plan to reduce the number of patients waiting over 52 weeks for treatment remains well ahead of trajectory and we continue to have the lowest number of long waiting patients in the region with zero patients waiting over 78 weeks in August.</p>	<p>ED Performance: Challenges continue for our emergency departments. Despite a slight decrease in attendances, staffing challenges as well as "exit blocks" due to high bed occupancy, limited discharges and poor access to onward care beds is impacting on performance.</p> <p>Medically Ready for Discharge (MRD): The Trust has seen a rise in the number of patients who in both Medically Ready to Discharge (MRD) and Not Meeting the Criteria to Reside (NCTR) but who we are unable to discharge to intended designations because of increased capacity challenges in the Adult Social Care market and the loss of D2A beds. This is driving up overall LoS and impacts on our ability to stream patients from our emergency departments</p> <p>Cancer: Although we are in the top quartile nationally for our 62 day performance, the challenge remains about our delivery against the 28 day faster diagnosis standard (FDS). Further work with endoscopy; a focus on delivering the breast triple assessment service; and implementation of the Community Diagnostic Centre, are key areas the Trust is focusing on which will improve this standard.</p>	
Actions:	<ul style="list-style-type: none"> • New forecast tool also explores how many patients will need to go to SDEC's • Work collaboratively with Local Authority on how we can mitigate the loss of D2A beds (workshop 2 09/09/2022) • Continued validation of elective waiting lists with additional external support • ECIST critical friend visit at EDGH in September, with Conquest planned for October. • Work with system on the opening of the community diagnostic centre (CDC) 		

04/10/2022

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NHS Constitutional Standards

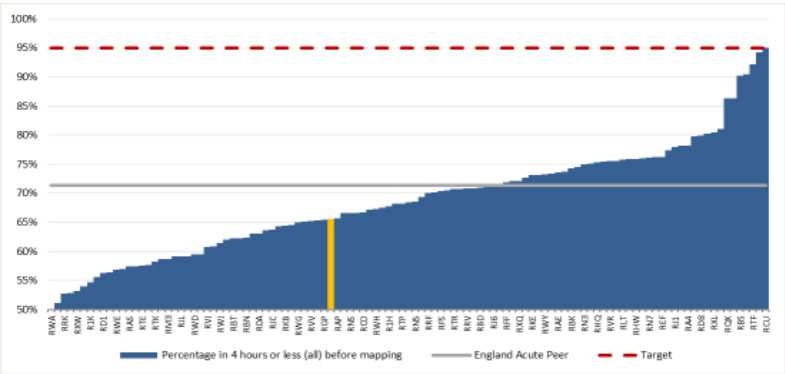
*NHS England has yet to publish all August 2022 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

August 2022 Peer Review

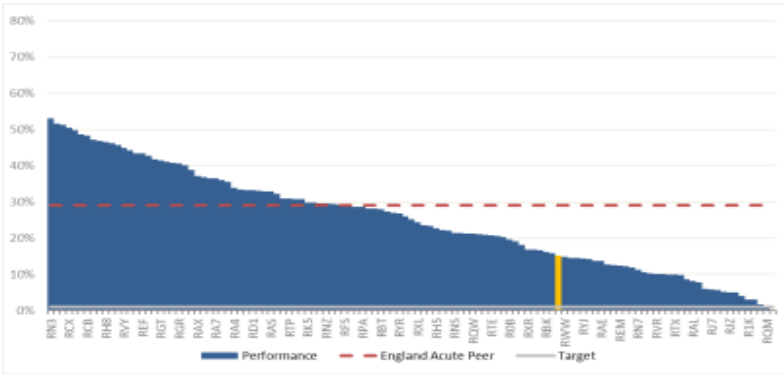
National Average: 71.4% ESHT Rank: 69/112



Planned Care – Diagnostic Waiting Times

July 2022 Peer Review*

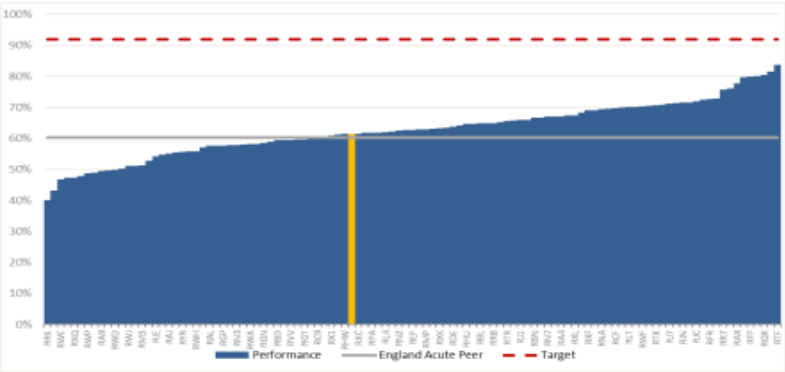
National Average: 29.0% ESHT Rank: 36/119



Planned Care – Referral to Treatment

July 2022 Peer Review*

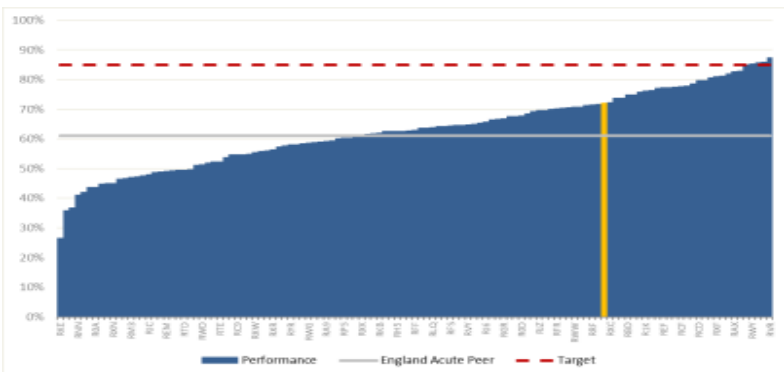
National Average: 60.2% ESHT Rank: 63/109



Cancer Treatment – 62 Day Wait for First Treatment

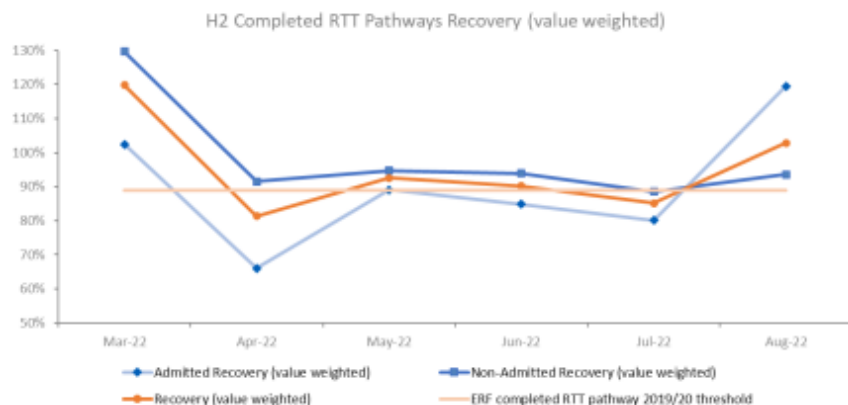
July 2022 Peer Review*

National Average: 61.1% ESHT Rank: 28/121



04/10/2022

Planned Care – Recovery KPIs



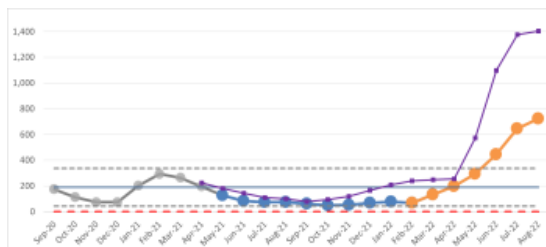
Delivery of 104% of the 19/20 activity baseline continues to be challenging, although the Trust has seen a growing uplift in activity levels in August. Elective inpatient activity was lower than expected in August as a result of a reduction in elective bed capacity. This was due to the impact of delays in discharging patients into onward care, increasing bed occupancy to over 95%. There was, however, a planned increase in the volume of day case activity going through our theatres to ensure we maximise theatre productivity in line with available beds. In line with the national ask, we also reduced out outpatient follow up appointments in August.

The Trust remains comfortably below the agreed trajectory for long waiting patients (>52 weeks waiting) in August and it is anticipated that the Trust will also deliver against trajectory in September. Divisions continue to work on and develop specialty level plans to ensure that this is not only sustained but we get to our target position of 0 patients waiting >52 weeks by March 2023.

The Trust continues its work with Source group to validate follow-up pathways as part of the super September initiative. Source Group work closely with specialties to support the validation of follow up waiting lists and increase the number of patients to be moved onto a patient initiated follow up (PIFU) pathway. These pathways are clinically led and are reducing the backlog in follow up demand and improve the new : follow up ratio on clinical pathways moving forward.

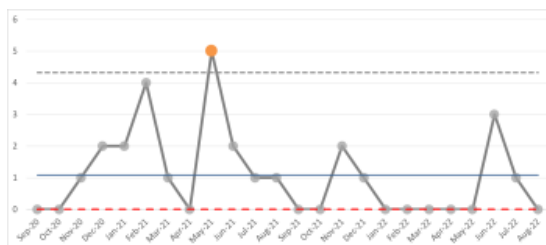
RTT 52 Week Waiters

Target: 0
Trajectory: 1,404
Current Month: 723



RTT 78 Week Waiters

Target: 0
Current Month: 0



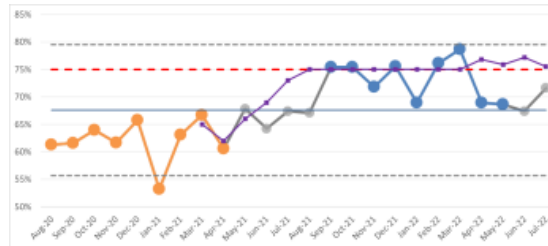
04/10/2022

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Planned Care –Recovery KPIs

28 Day FDS (Faster Diagnosis Standard)

Target: 75%
Trajectory: 75.5%
Current Month: 71.6%

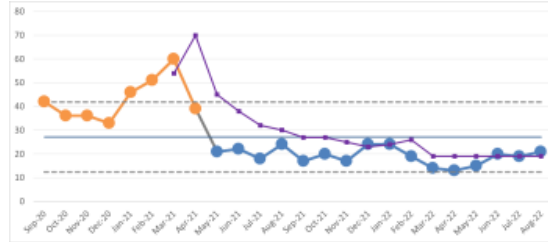


The Trust remains committed to improving the FDS standard however it is expected that the FDS performance will deteriorate in August. This is due to multi-factorial reasons including; the continued increase in 2ww referrals, delays due to patient choice, the August peak annual leave period and delays in histology reporting. The Locum Breast Consultant starting has seen a significant improvement in month for Breast FDS. It is expected this will continue in September.

Cancer 104 Days Backlog

Unify 104 Days Backlog (excludes Tertiary patients)

Target: Monitor
Trajectory: 19
Current Month: 21

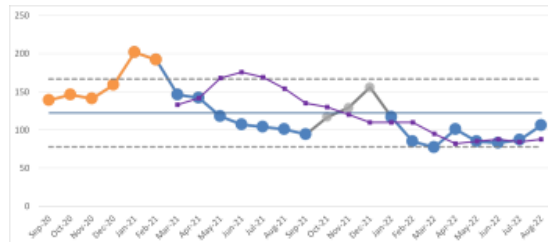


Divisions remain focused on the backlog for 62 and 104 days and are continuously monitoring performance. Long waiting patients are regularly clinically reviewed to ensure pathways are expedited and next steps are in place. However the trajectory for 62 days and 104 days in August was not met, primarily due to delays in our histology reporting which is outsourced, however our figures remain within the 5% threshold. Patient initiated delays have also increased due to the peak holiday season.

Cancer 62 Days Backlog

Unify 62 Days Only Backlog (excludes Tertiary patients)

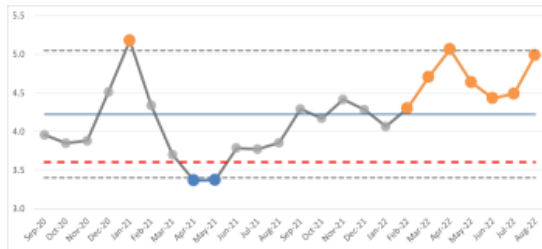
Target: Monitor
Trajectory: 88
Current Month: 106



Patient Care- Flow

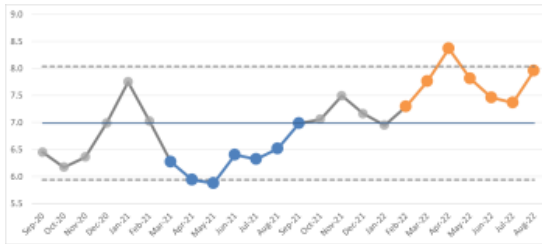
Non-elective Length of Stay (Acute)

Target: 3.6
Current Month: 5.0



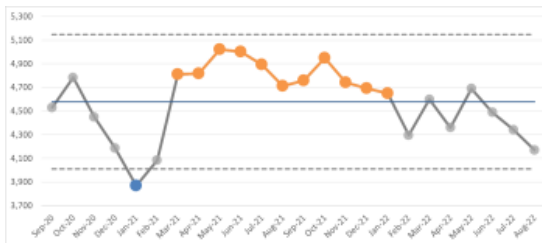
Non-elective Length of Stay, excluding zero LoS (Acute)

Target: Monitor
Current Month: 8.0



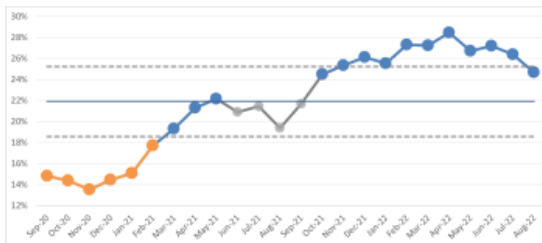
Non Elective Spells

Target: Monitor
Current Month: 4,171



Medical Non Elective Admissions (% SDEC)

Target: Monitor
Current Month: 24.7%



August has seen a considerable increase in the Trust Non-Elective Length of Stay (LoS). This increase was predicted in previous reports, and the forward view for September is expecting this increase to continue without intervention at place level

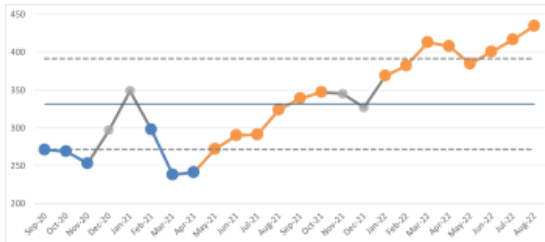
The ESHT acute bed gap, in line with the national cessations of HDF funding is a factor in the increase in length of stay. This takes into account the reduction in Discharge to Assess beds to 46 (Net loss of 67 beds)

August data shows a reduction in Same Day Emergency Care (SDEC) utilisation which could be attributed to having to open a bay on SDEC at EDGH as an overnight bedded bay during peaks in high demand during August which is linked to the Trust's bed occupancy and increase in delayed/stranded patients and increased urgent care demand. From September, SDEC has been adapted so that it is no longer available as an escalation area in line with the national guidance.

Patient Care - Flow

Adult inpatients in hospital for 7+ days (Acute)

Target: Monitor
Current Month: 435



August data shows that the Trust has seen a further increase in the number of patients in a hospital bed with a length of stay of over 7 and 21 days. A major contributor to this will be the reduction in number of Discharge to Assess beds (D2A) across Sussex from 1 July 2022.

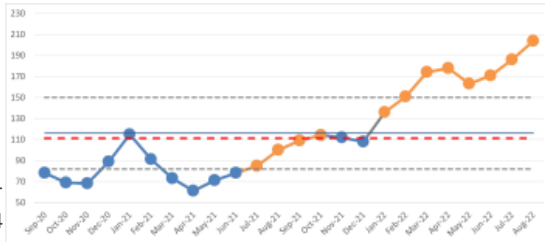
This in turn has led to delays in discharging to onward care in both Medically Ready to Discharge (MRD) and Not Meeting the Criteria to Reside (NCTR) patients within the hospital which is expected to continue through September and October. Unfortunately patients are having to wait longer for D2A beds to become available, and so will have an increased length of stay in hospital. In order to mitigate this, the Trust is working at pace to promote and increase initiatives such as the use of virtual wards and the development of our Home First service, alongside a review of our discharge pathways, roles and responsibilities with our local authority colleagues.

At the same time, the Trust is working with system partners on the '10 best practice initiatives' which forms part of the NHS England '100 Day Discharge Challenge' in order to improve flow and improve discharge:

1. Identify patients needing complex discharge support early
2. Ensure multidisciplinary engagement in early discharge plan
3. Set expected date of discharge (EDD), and discharge within 48 hours of admission
4. Ensuring consistency of process, personnel and documentation in ward rounds
5. Apply seven-day working to enable discharge of patients during weekends
6. Treat delayed discharge as a potential harm event
7. Streamline operation of transfer of care hubs
8. Develop demand/capacity modelling for local and community systems
9. Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges
10. Revise intermediate care strategies to optimise recovery and rehabilitation

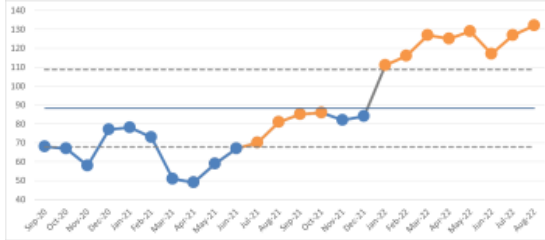
Adult inpatients in hospital for 21+ days (Acute)

Target: Monitor
Current Month: 204



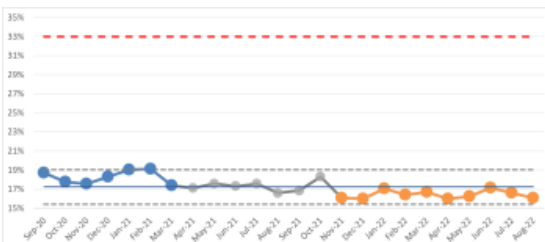
MRD on Pathways 1-3

Target: Monitor
Current Month: 132



Patients discharged before midday %

Target: 33%
Current Month: 16.1%



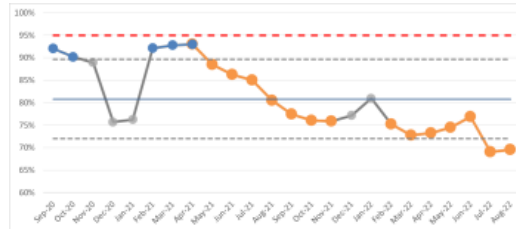
04/10/2022

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Urgent Care – Front Door

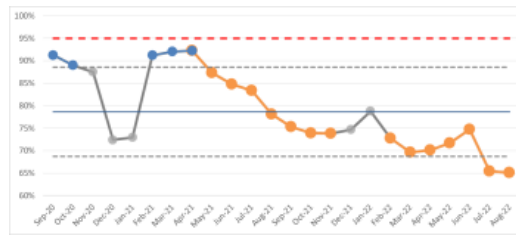
A&E Performance (Local System)

Target: 95%
Current Month: 69.6%

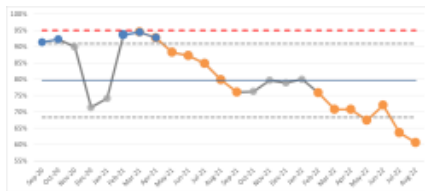


A&E Performance (ESHT Total Type 1 & 3)

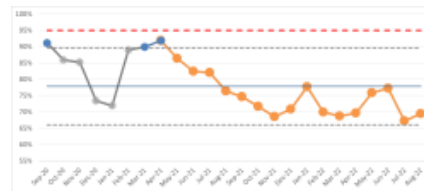
Target: 95%
Current Month: 65.1%



CONQ

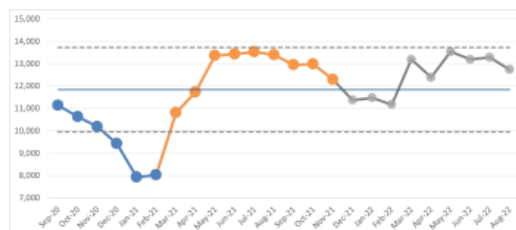


EDGH



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

Target: Monitor
Current Month: 12,734



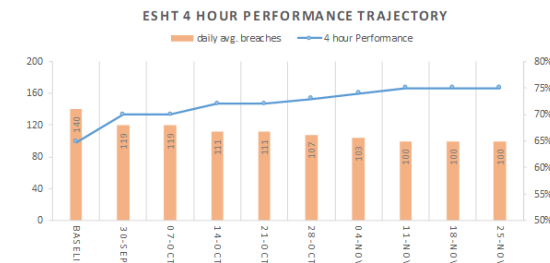
Attendances have seen a slight decrease over the month, in both type 3 and type 1 activity but despite the decrease the impact of increased length of stay is preventing the division from feeling the benefit of any reduction.

The number of streaming and re-directed patients has significantly increased with the majority of this contributed to re-direction following full recruitment to UTC coordinators and navigators at the Conquest site.

Live Stream GP pods are being explored at both sites utilising existing budget to increase UTC activity further and reduce non-admitted breaches.

A proactive approach and improvement plan is being developed across all divisions to support an improvement in the 4 hour ED performance

A trajectory has been worked through



This is part of the Trust wide operational plan which underpins the Trust's winter planning.

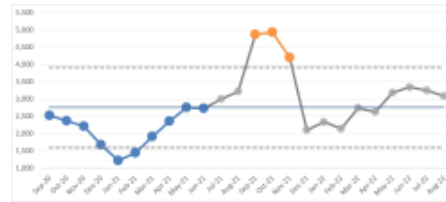
04/10/2022

Urgent Care – Front Door

ESHT Total Type 1

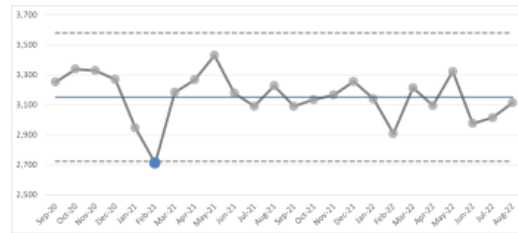


ESHT Total Type 3



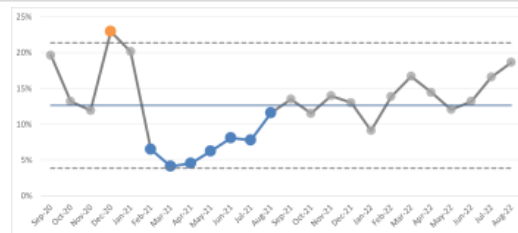
Conveyances
(ESHT – CQ and EDGH)

Target: Monitor
Current Month: 3,114



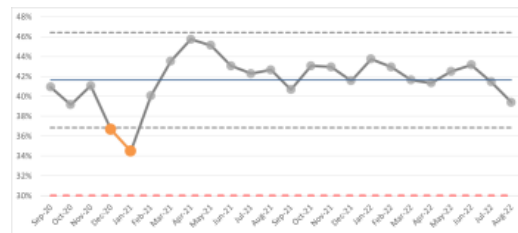
Conveyance Handover >30
(ESHT – CQ and EDGH)

Source: SECAMB
Target: Monitor
Current Month: 18.6%



Same Day Emergency Care
(ESHT – CQ and EDGH)

Target: 30%
Current Month: 39.4%



Performance in relation to non-admitted remains challenged, with a continued decrease at Conquest but a positive increase in performance at Eastbourne. Conquest performance has decreased as a direct correlation of the bed occupancy increase. Which limits flow from the ED as patients are having to be treated in the ED due to lack of bed availability.

Conveyances to urgent care have seen an increase but a decrease in direct admission to gateways areas, despite SDEC launching a direct access for SECAMB pathway. This is part of the improvement programme the Divisions own.

Whilst this is often viewed as a failure to turn people around within urgent care this does in reality reflect three key factors:

- Patients requiring bedded care are delayed in the department due to bed availability
- Patients who should have their care delivered in a gateway were unable to access it.
- Patients received the entire short stay episode in the emergency department rather than AMU/AAU, SSPAU or SAU.

Actions are being taken across all Divisions to improve access to gateways, reduce non admitted breaches and patient waiting times and at the same time support our staff and improve the Trust's 4 hour performance. It is expected the benefits will be realised through October/November.

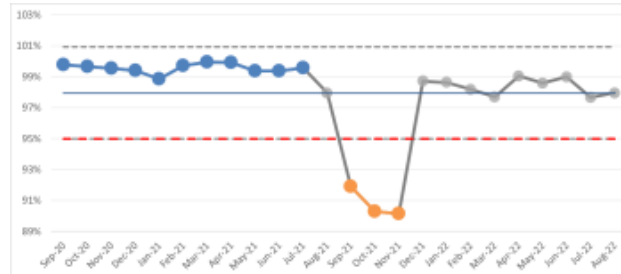
04/10/2022

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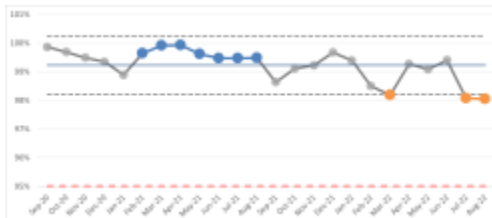
Urgent Care – UTC

UTC 4 hour standard
(Visit complete within 4 hours)

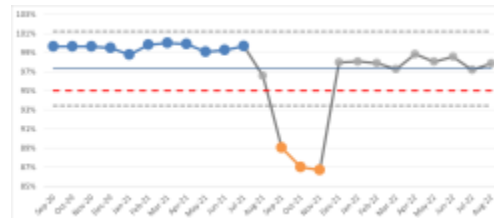
Target: 95%
Current Month: 98.0%



CONQ



EDGH



UTC compliance to the 4hr standard remains above the required standard however compliance against the 2hr standard is currently at 66.7%.

The UTC has continued to meet performance for the 4 hour standard and is looking to broaden its scope of symptoms seen within the UTC like cardiac chest pain with normal ECG presentations to help increase flow and performance.

Further resourcing will enable not only the throughput of patients to be maximised but reduce the wait time in this area as well.

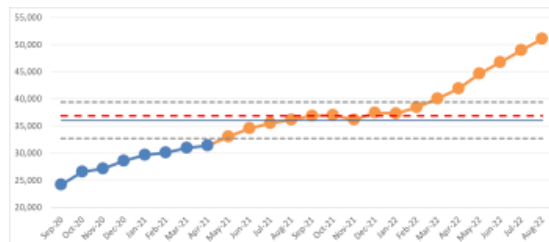
The 3 x UTC Coordinators have been fully recruited to and once in post (November) will support re-direction to agreed external services

One key feature to increasing productivity of the UTC is estates. Space is very limited. Without further clinical space further development within the UTC is restricted.

Planned Care – Waiting Times

RTT Total Waiting List Size

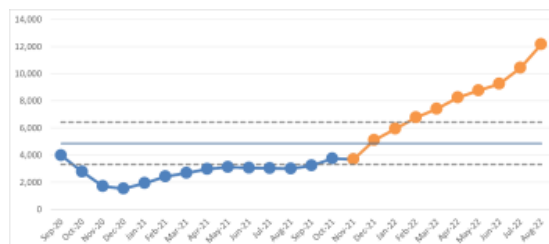
Target: 36,833 (Sep-21)
Current Month: 51,096



The volume of patients on the RTT pathway has increased in compared to 19/20 across almost all specialities. The volume of patients over 26 weeks is at the highest level the Trust has experienced and demand is often outstripping capacity. The Trust will need to ensure elective and non elective demands are balanced to support delivery of the national ask.

RTT 26 Week Waiters

Target: Monitor
Current Month: 12,164



The RTT waiting list position is being closely monitored through; enhanced PTL validation; pathway redesign; and work to increase both Outpatient and Theatre utilisation. These measures support the Trust continued position of zero 78 weeks breaches.

Cancellations On The Day (Activity %)

Target: 5%
Current Month: 8.3%

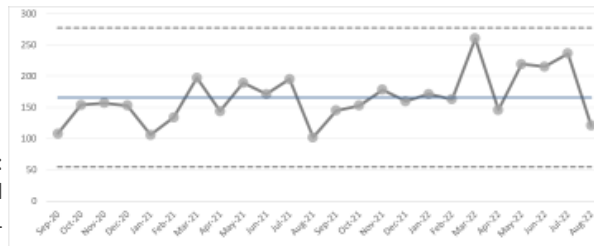


Cancellations on the day fell slightly in August but continue to be higher than previous years. Cancellations on the day occur for a variety of reasons, but mainly as a result of medical reason. There is a robust escalation process before any decision is made to cancel a patient and any patients who are unfortunately cancelled, do get rebooked within the 28 day standard.

Paediatric Community (non RTT) Waiting Times East Sussex Healthcare NHS Trust

Total Referrals

Target:
Variation : Normal
Current Month: 121



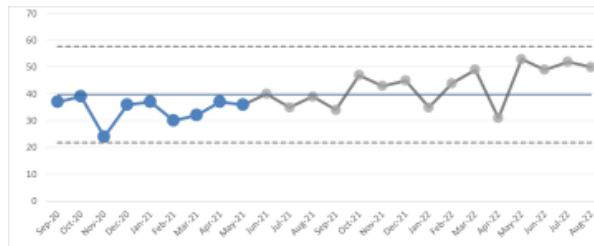
Demand continues to outstrip capacity with increasing wait times as a result. The dip in August referrals was expected and is attributed to the school holiday period and it is expected that referral rates will increase again from September.

Recovery measures are being worked through to help address backlogs. Recruitment strategies are in place and being further developed to support recruitment to new and existing posts including' ADHD nurses, clinical psychologist and nursing support posts. A band 4 admin support post for the child development team has been recruited and a start date agreed. This will support plans to improve wait times going forward. However currently, the number of children waiting for a new Child Development Clinic (CDC) appointments continues to increase month on month. Pre-school children, safeguarding welfare, and looked after children are prioritised but there is still a long wait time for an appointment. The average wait time for children over 5 has Increased from 40 weeks to 75 weeks. The wait time for children under 5 has decreased from 52 weeks to 50 weeks. Longest waiters exceeding 3 years have plateaued in July and August.

Plans are being progressed to release and increase medical and AHP clinical capacity through upskilling existing nurse and admin workforce, and to back fill through recruitment of new junior staff.

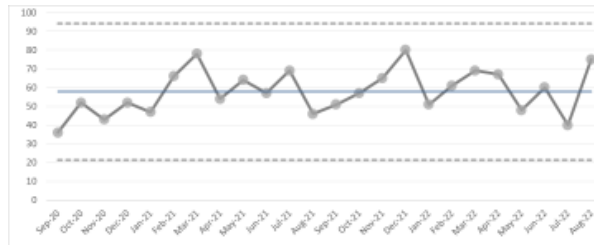
Under 5: Waiting time to first Appt of children seen in month

Target:
Variation : Normal
Current Month: 50 weeks



5-16 : Waiting time to first Appt of children seen in month

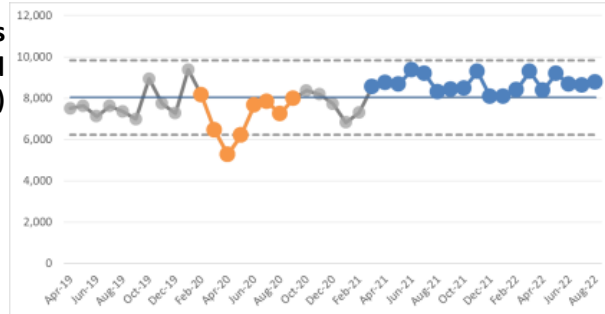
Target:
Current Month: 75 weeks



Adult Community (non RTT) Waiting Times

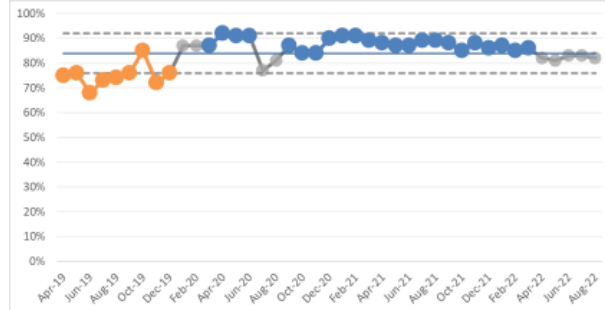
Number of Referrals Received (Planned)

Current Month: 8,765



% of Patients seen within agreed waiting time targets (Planned)

Current Month: 82%



Community Non-RTT Waits

Service	Provider	CCG	Wait List	Ave Wait Time	Median WT	>52 wks	>104 weeks
ESHT Bladder and Bowel	ESHT		471	10	7	0	0
ESHT Community Nursing	ESHT		74	0	0	0	0
ESHT Community Stroke and ESD	ESHT		3	4	4	0	0
ESHT Crisis Response	ESHT		45	1	1	0	0
ESHT Dietetics	ESHT		1159	13	11	2	0
ESHT Fracture Liaison	ESHT		1262	0	0	0	0
ESHT Frailty Service	ESHT		70	3	2	0	0
ESHT JCR and Falls Prevention	ESHT		1156	6	5	0	0
ESHT MSKt	ESHT		1222	5	5	0	0
ESHT Neuro Op	ESHT		358	19	20	0	0
ESHT Orthotics	ESHT		300	8	6	0	0
ESHT Physiotherapy	ESHT		3951	9	9	0	0
ESHT Podiatry	ESHT		1598	10	8	0	0
ESHT Speech and Language Therapy	ESHT		717	16	12	0	0
ESHT Tissue Viability	ESHT		0	0	0	0	0
ESHT Community Respiratory	ESHT		224	16	19	0	0
ESHT Heart Failure	ESHT		0	0	0	0	0
ESHT Community Paediatrics	ESHT		2699	59	45	1206	479

Division	Key
CHIC	
MED	
WAC	

Adult services have seen an increase in referrals in August with a slight reduction in the percentage of patients seen within the agreed waiting times. Validation across community services is underway to ensure accuracy of data and appropriateness of patients on Adult Community waiting lists.

Particular areas of focus within adult community services are:

SLT: Continued increase of referrals above baseline with patients significantly impacted by increased complexity as a result of long waits, however there are now zero patients waiting over 52 weeks.

Neurology: An increase in referrals has led to a capacity and demand gap that is currently being worked through to address.

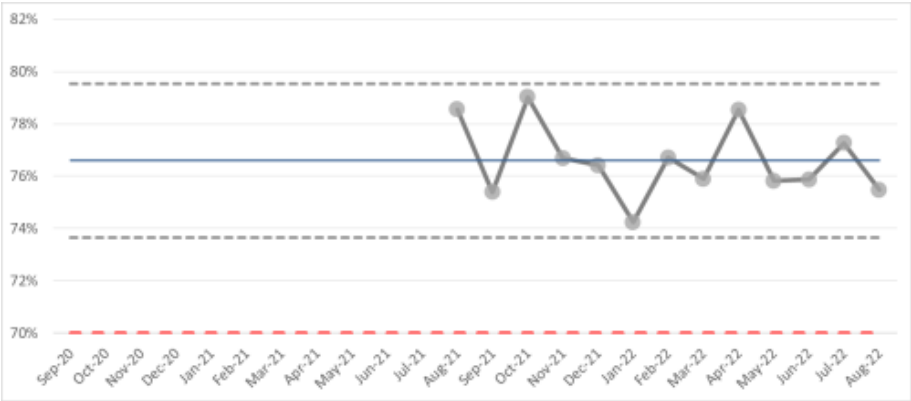
Bowel and Bladder: Currently undertaking a data cleanse and validation which will improve the services reported position.

Community (non rtt) wait times have improved in adult services, there are zero patients waiting over 104 weeks and patients waiting over 52 week has reduced to two.

Urgent Community Response

Crisis Response Within 2 Hours

Target: 70%
Current Month: 75.5%

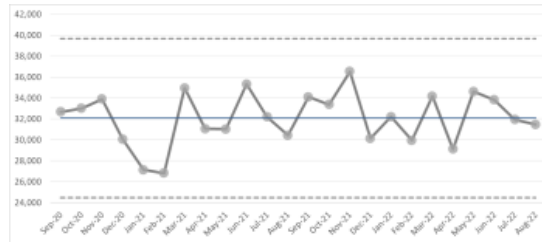


The Trust's community teams continue to deliver above target for 2 hour UCR response and this measure should look to improve further as we enhance the team and service over a 7 day period. Increasing 2 hour support will help the Trust's front door position and reduce demand on our emergency departments by keeping patients in their own homes with appropriate support and clinical oversight.

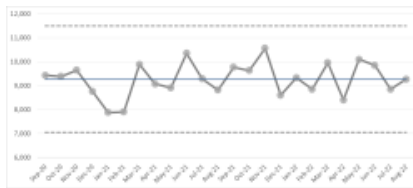
Planned Care – Outpatient Delivery

Outpatient Total Activity (New and Follow-up)

Target: Monitor
Current Month: 31,477



New

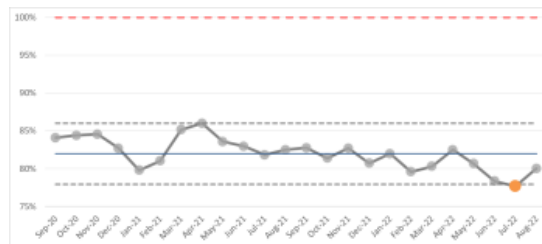


Follow-up



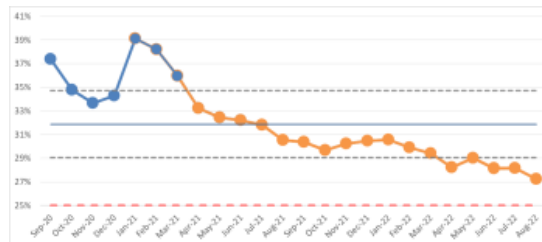
Outpatient Utilisation (Consultant and nurse led Clinics)

Target: 100%
Current Month: 80.0%



Non Face to Face Outpatients Activity (Activity %)

Target: 25%
Current Month: 27.2%



Activity levels are reviewed weekly to understand specific challenges in underperforming areas, as well as recognising and learning from areas performing well. Any issues identified are picked up in the Trust's Elective Access Group and recovery plans continue to be worked through to address backlogs and resulting wait times.

Outpatient activity in August is below expected levels. Utilisation remains a key area to address to support recovery from the loss of activity. Utilisation of clinics is also a key focus point for transformation. The Trust will work with system and national colleagues to introduce best practice to improve performance. This is being addressed as part of the Trust's transformation programme.

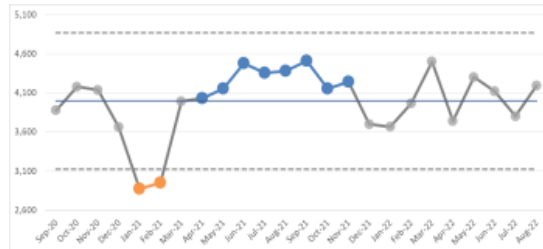
The DNA rate continues to fall, supported by the text reminder service being active for all consultant led services and ongoing validation of the PTL.

27.2% of our outpatient appointments were delivered virtually allowing us to comfortably meet the national target of 25%. Whilst we continue to deliver a high volume of outpatient appointments virtual we are adopting a balanced approach to ensure all outpatient appointments are of value to both patient and clinician.

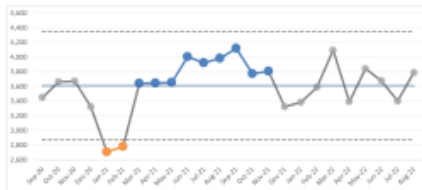
Planned Care – Admitted Delivery

Elective Spells (Day case and Elective IP)

Target: Monitor
Current Month: 4,190



Day case

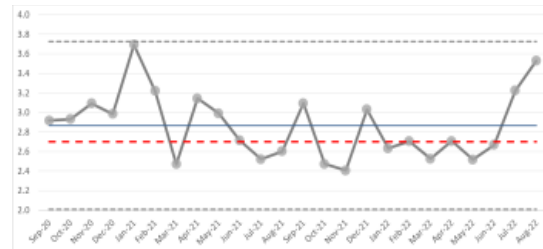


Elective IP



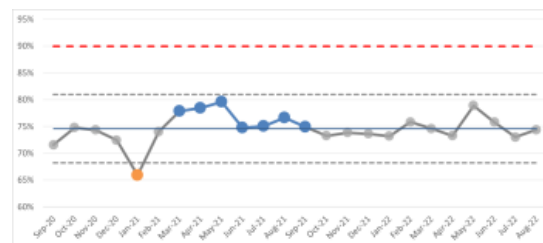
Elective Average LoS (Acute)

Target: 2.7
Current Month: 3.5



Theatre Utilisation

Target: 90%
Current Month: 74.4%



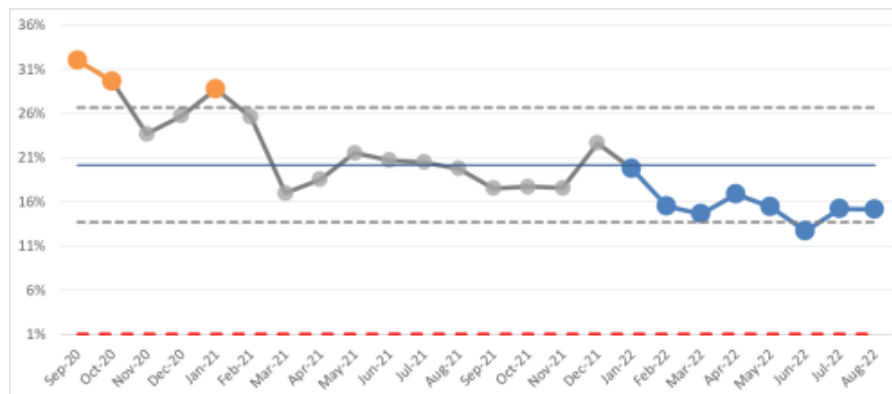
August saw an increase in theatre capacity, particularly in day case activity. Divisions continue to work hard to balance priorities and support the delivery of elective activity, ensuring we are treating patients with the highest priority. The increase in Elective LoS can, in part, be attributed to the volume of complex P2 (urgent and cancer) cases that were seen in August

The opening of the Day Surgery unit this Autumn, as well close monitoring of cancellations, led by the new General Manager for Theatres, and with robust forward planning of workforce schedules, will improve capacity and enable flex in the booking to increase utilisation. Addressing gaps within pre-assessment capacity are also needed to support better utilisation of Theatres.

Planned Care – Diagnostic

Diagnostic Standard

Target: < 1.0%
Current Month: 13.39%



Diagnostic activity has continued to perform well, showing 121% against 19/20 baseline activity levels, with the ask being to deliver over 120%. This position should only improve further once the Bexhill CDC opens in late September 2022.

DM01 performance improved in August and was at 86.61% against the 99% ask. Insourcing; outsourcing; utilisation of IS capacity; as well as utilising available capacity at alternative trusts within the ICS, have all continued to support the Trust's improving DM01 position.

Cancer Pathway

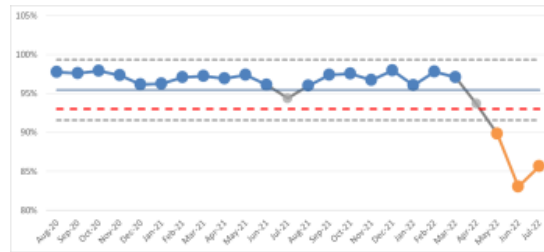
Two Week Wait Referrals

Target: Monitor
Current Month: 2,471



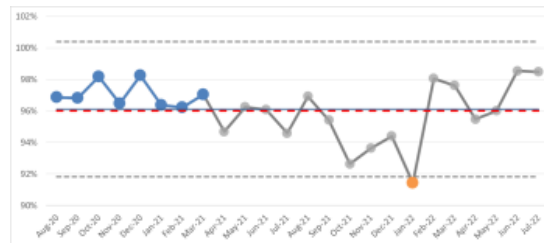
Cancer 2WW Standard

Target: 93%
Current Month: 85.6%



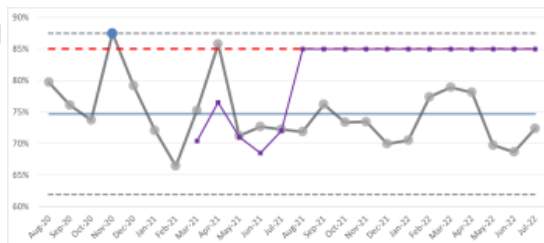
Cancer 31 Day Standard

Target: 96%
Current Month: 98.5%



Cancer 62 Day Standard

Target: 85%
Trajectory: 85%
Current Month: 72.4%



The Trust experiences a continued and sustained increase in 2ww with August seeing the 2nd highest number of referral received. This has created pressures in all phases of the pathway. This, alongside patient choice and peak annual leave period is expecting to result in a deterioration of performance in August, although currently unvalidated.

The Teams continue to focus on patient pathways to expedite assessment, diagnostics and treatment but this has remained challenging with patient availability as well as staffing due to vacancies and leave.

Turnaround times within pathology (especially outsourced histology) remain an area of concern for the 28 FDS standard. These are being closely monitored and the Core Services Division are working with our providers to improve.

Focussed efforts continue to improve waiting times and a Cancer Week is planned in September to further support expediting pathways where possible and appropriate.

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

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Capital	10
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Exec summary

£m	RAG	YTD Plan	YTD actual	Var F/(A)	Commentary
Surplus/deficit	A	(0.7)	(0.5)	0.2	<ul style="list-style-type: none"> Trust is reporting a year to date deficit position of (£0.5m) against a planned deficit of (£0.7m), a favourable variance of £0.2m. The Trust's position currently reflects a national request from NHSE/I not to recognise any ERF clawback – YTD against plan this is £1.2m favourable. There are still pay pressures from supernumerary and temporary staffing, plus unfunded Escalation costs, offset by lower non pay costs and recognition of Drugs cost and volume funding YTD.
Income	A	235.8	237.7	1.9	<ul style="list-style-type: none"> Income is favourable to plan driven ERF favourable against plan £1.2m, NHSE Drugs £1.2m, offset by Car Parking delay on staff charging until September and SPH income adverse position (which is offset against non pay below).
Pay	A	(155.1)	(157.4)	(2.3)	<ul style="list-style-type: none"> Pay cost variance is related to £0.7m of supernumerary costs for overseas/back to care staffing, Unfunded Escalation costs of £0.5m and pressures from Locum/agency usage in Clinical Divisions of £0.5m. CEA accrual YTD £0.8m The Trust is using 5% more staff than in 21/22 (excluding SPH)
Non-pay	A	(81.4)	(80.7)	0.7	<ul style="list-style-type: none"> Non-pay costs are lower than budget mainly driven by Utility costs £0.2m, SPH low costs (£0.3m – offset by income as above). Underspends commensurate with the elective activity shortfall have been reported in relevant specialities.
Efficiency	A	7.0	7.0	-	<ul style="list-style-type: none"> The trust has delivered the £1.4m efficiency plan for the month and £7.0m year to date The target for the year is £23m, this reflects the increase of £2m following the resubmission of the plan in June. So far £16.5m has been identified, leaving a gap of £6.5m for the Divisions to find, an improvement of £1.5m in the month.
Capital	G	6.7	7.5	0.8	<ul style="list-style-type: none"> Capex spend of £7.5m which is £0.8m ahead of plan. FOT remains to deliver to plan.
Risk	A	n/a	n/a	n/a	<ul style="list-style-type: none"> Risk analysis shows a potential range from £16.4m deficit to a breakeven position downside and upside cases respectively. The base case is showing a expected deficit of £0.6m which is immaterial to the scale of Trust turnover so no seen as a trigger point for changing the forecast

04/10/2022

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Income and Expenditure

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Plan	Act	Var	Plan	Act	Var
Income						
Contract income	42,073	38,777	(3,296)	210,367	211,591	1,224
Divisional	4,399	4,919	519	20,005	19,533	(472)
ERF	771	5,774	5,002	4,381	5,774	1,393
Covid - variable	217	184	(33)	1,085	821	(264)
Total Income	47,461	49,654	2,193	235,838	237,718	1,880

Operating Expense

Pay

Permanent	(29,114)	(27,473)	1,641	(148,505)	(134,487)	14,018
Temporary	(1,233)	(4,756)	(3,523)	(5,857)	(21,778)	(15,921)
Total pay	(30,347)	(32,228)	(1,882)	(154,361)	(156,265)	(1,903)

Non-pay

Drugs	(1,068)	(1,173)	(105)	(5,341)	(5,219)	121
TEDD	(3,477)	(3,792)	(315)	(17,385)	(19,056)	(1,671)
Clinical supplies	(3,908)	(3,985)	(77)	(19,195)	(18,217)	978
Purchased services	(939)	(842)	97	(4,810)	(4,497)	313
Finance costs	(2,956)	(2,309)	647	(11,762)	(11,518)	244
Other	(4,211)	(4,745)	(533)	(22,113)	(21,588)	525
Total non-pay	(16,559)	(16,845)	(286)	(80,606)	(80,095)	511

Covid exp - block	(449)	53	503	(449)	(1,001)	(552)
Covid exp - variable	(243)	(184)	59	(1,106)	(821)	285
Total Expense	(47,598)	(49,204)	(1,606)	(236,523)	(238,182)	(1,659)

Surplus/(Deficit)	(137)	450	587	(685)	(464)	221
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Memo:

WTE (worked)	7,919	7,622	(297)	7,948	7,645	(303)
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I&E position

- The month 5 in month position is £0.5m surplus, a £0.6m favourable variance to plan of £0.1m deficit.
- Year to date the Trust has delivered a £0.5 deficit, £0.2m favourable to the YTD plan of £0.7m deficit.
- Note: The Trust's position reflects a national request from NHSE/I not to recognise any ERF clawback in Trust's position

Income

- The position is favourable YTD by £1.9m, the main drivers being;
 - ERF is still impacted by clawback not occurring, this is an absolute impact of £4.0m and £1.4m favourable versus plan;
 - NHSI Drugs C&V £1.0m; partially offset by
 - Staff Car Parking Charges delay of implementation until Sept 1st £0.2m underachievement.
 - SPH underachievement of income £0.3m (this is offset via a non pay underspend).

Expense

- The Trust has an in month £1.4m adverse pay position variance, YTD £2.3m which is related to Supernumerary costs for overseas/back to care staffing, temporary staffing and unfunded escalation costs. Also £0.8m accrual in month for CEA YTD.
- Vacancies are broadly adequate to cover temporary staffing costs
- Use of temporary staff at higher unit cost partially offset by WTE usage below budget.
- Non-pay costs are lower than budget by £0.7m YTD driven by lower than expected Utility costs £0.2m, SPH non pay £0.3m (offset in income) and one off adjustments for Endoscopy.

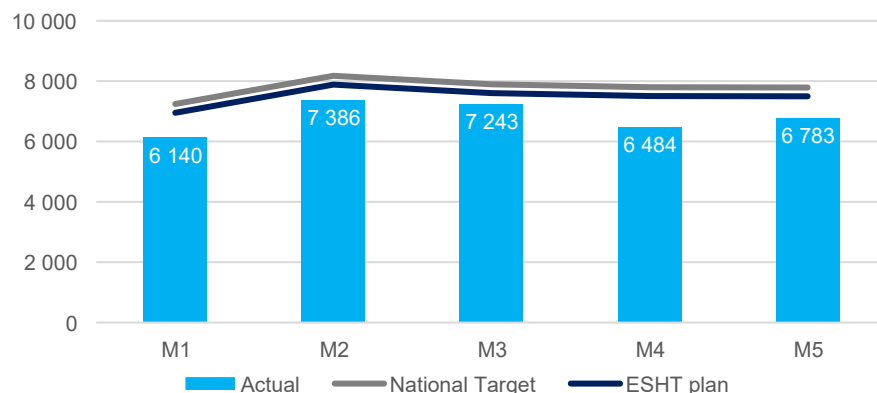
ERF - Trust

East Sussex Healthcare

ERF performance

- The internal plan is £4.5m below national targets (£0.3m per month) this translates into a £3.5m expected full year clawback (at 75%)
- M5 delivery was £0.7m behind plan which would equate to a £0.5m loss of income (YTD £3.4m variance or £2.5m additional clawback).
- National request not to include clawback in the figures means this has not impacted the I&E.
- The worst performing specialties are Cardio, Respiratory and Maxillo-Facial.

ERF performance (£'000)



	In Month				YTD			
	Plan	Actual	Var		Plan	Actual	Var	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Daycase	2,809	2,584	(224)	(8.0%)	14,253	13,030	(1,223)	(8.6%)
Elective	1,627	1,276	(350)	(21.5%)	8,031	6,823	(1,209)	(15.1%)
New OP	1,607	1,548	(59)	(3.7%)	8,127	7,500	(627)	(7.7%)
OP Procedures	1,454	1,346	(108)	(7.4%)	7,029	6,541	(488)	(6.9%)
ERS	-	28	28		-	142	142	
ERF	7,496	6,783	(713)	(9.5%)	37,440	34,036	(3,405)	(9.1%)
Follow-up	1,438	1,840	402	28.0%	7,222	9,371	2,150	29.8%
Planned care	8,934	8,623	(311)	(3.5%)	44,662	43,407	(1,255)	(2.8%)

	In Month			YTD		
	Plan	Actual	Var	Plan	Actual	Var
	£'000	£'000	£'000	£'000	£'000	£'000
Cardiology	616	483	(133)	2,975	2,467	(507)
Respiratory Medicine	203	83	(119)	853	531	(322)
Maxillo-Facial Surgery	246	135	(111)	1,120	834	(286)
Trauma & Orthopaedics	1,116	1,020	(96)	6,541	5,536	(1,005)
Respiratory Physiology	75	-	(75)	303	-	(303)
Respiratory Physiology	75	-	(75)	303	-	(303)
Rheumatology	176	132	(44)	901	705	(196)
General Medicine	50	16	(34)	129	63	(67)
General Surgery	773	739	(34)	3,615	3,779	164
Geriatric Medicine	40	10	(30)	198	115	(83)
Urology	680	654	(26)	3,234	3,348	114
Clinical Haematology	321	297	(24)	1,537	1,231	(306)
Vascular Surgery	61	38	(23)	201	188	(13)
Gynaecology	423	402	(22)	2,013	2,068	54
Orthodontics	44	23	(21)	218	131	(88)
Transient Ischaemic Attack	54	34	(20)	248	227	(21)
Clinical Oncology	282	262	(20)	1,380	1,403	23
Gastroenterology	505	487	(18)	2,499	1,908	(591)
Breast Surgery	202	188	(14)	1,102	854	(248)
Interventional Radiology	62	48	(14)	321	168	(153)
Stroke Medicine	14	3	(11)	72	16	(56)
Paediatric Surgery	14	7	(7)	36	46	10
ENT	232	226	(6)	1,416	1,104	(312)
Anaesthetics	11	10	(1)	52	44	(8)
Chemical Pathology	5	4	(1)	24	33	9
Hepatology	2	1	(1)	9	3	(6)
Palliative Medicine	1	0	(0)	3	1	(2)
Neonatology	-	-	-	-	0	0
Paediatric Diabetic Medicine	-	0	0	-	0	0
Obstetrics	-	1	1	-	1	1
Acute Internal Medicine Service	-	2	2	-	11	11
Paediatric Dermatology	-	3	3	-	16	16
Endocrinology	57	61	4	242	251	9
Accident & Emergency	-	4	4	7	24	17
Paediatric Epilepsy	0	5	4	4	22	18
Ophthalmology	821	830	9	4,377	4,222	(155)
Diabetic Medicine	10	21	11	55	87	33
Paediatric Trauma And Orthopaedics	-	11	11	-	34	34
Screening	25	36	11	79	176	97
Neurology	111	125	14	412	600	188
Dermatology	147	163	16	678	818	140
Paediatrics	117	145	28	619	758	139

04/10/2022 Note: Figures are shown gross before marginal rate at 75%

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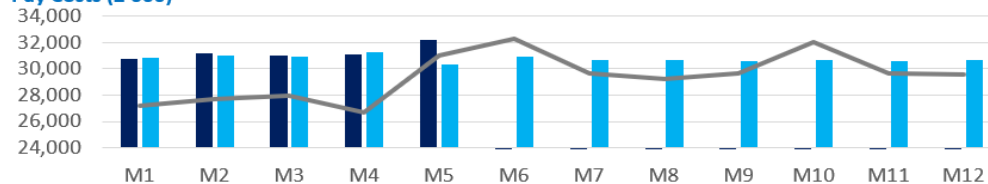
Pay costs

Pay analysis

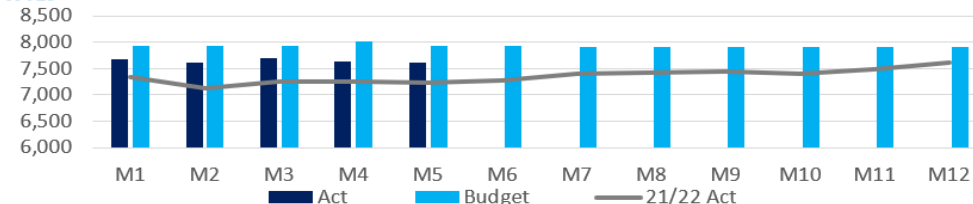
All staff	Pay costs (£'000) - In Month					WTE				
	Act	Var	PY	YTD var	YTD ave	Act	Var	PY	YTD var	YTD Ave
Medical	(7,415)	(370)	(8,798)	(2,095)	(7,484)	800	(8)	794	(5)	812
Nursing	(13,347)	(979)	(13,171)	(953)	(12,901)	3,631	(21)	3,326	(85)	3,626
AHP	(4,330)	195	(4,034)	1,693	(4,102)	1,084	(130)	1,088	(100)	1,096
Admin	(3,557)	342	(3,492)	1,215	(3,598)	1,314	(89)	1,287	(75)	1,313
Other	(3,579)	(1,070)	(2,426)	(1,764)	(3,169)	793	(48)	731	(38)	798
Total	(32,228)	(1,882)	(31,922)	(1,903)	(31,253)	7,622	(297)	7,226	(303)	7,645

Temporary	Pay costs (£'000)					WTE				
	Jun	Jul	Aug	PY	YTD	Jun	Jul	Aug	PY	YTD Ave
Bank	(1,526)	(1,426)	(1,606)	(2,066)	(7,559)	464	452	467	402	467
Medical	(561)	(677)	(447)	(693)	(2,560)	42	40	37	32	37
Nursing	(491)	(420)	(939)	(554)	(2,968)	90	66	68	66	89
AHP	(23)	(153)	(351)	(97)	(649)	11	14	14	16	14
Admin	(68)	15	38	5	(95)	3	3	1	14	2
Other	-	-	-	-	-	-	-	-	-	-
Agency	(1,142)	(1,236)	(1,700)	(1,339)	(6,273)	146	124	120	129	143
Locum	(1,525)	(1,406)	(1,432)	(1,827)	(7,033)	136	109	109	110	110
WLI	(57)	(276)	(281)	(260)	(1,116)	22	32	21	25	25
Total Temp	(4,251)	(4,343)	(5,019)	(5,492)	(21,981)	767	717	718	665	745

Pay Costs (£'000)



WTEs



Pay analysis

- M5 pay costs are higher than budget.
- Overall the in month spend of £32.2m is £0.3m higher than 21/22 comparator with SPH impact (£0.3m) adjusted
- Nursing & Medical staffing groups are over spending.
- Nursing spending is impacted by the continuation of escalation wards and supernumerary double running costs, and NER pressures.
- Whilst WTEs are below budget, cost are above. This is driven by use of temporary workforce which is more expensive.
- In month accrual of £0.8m ytd for CEA award

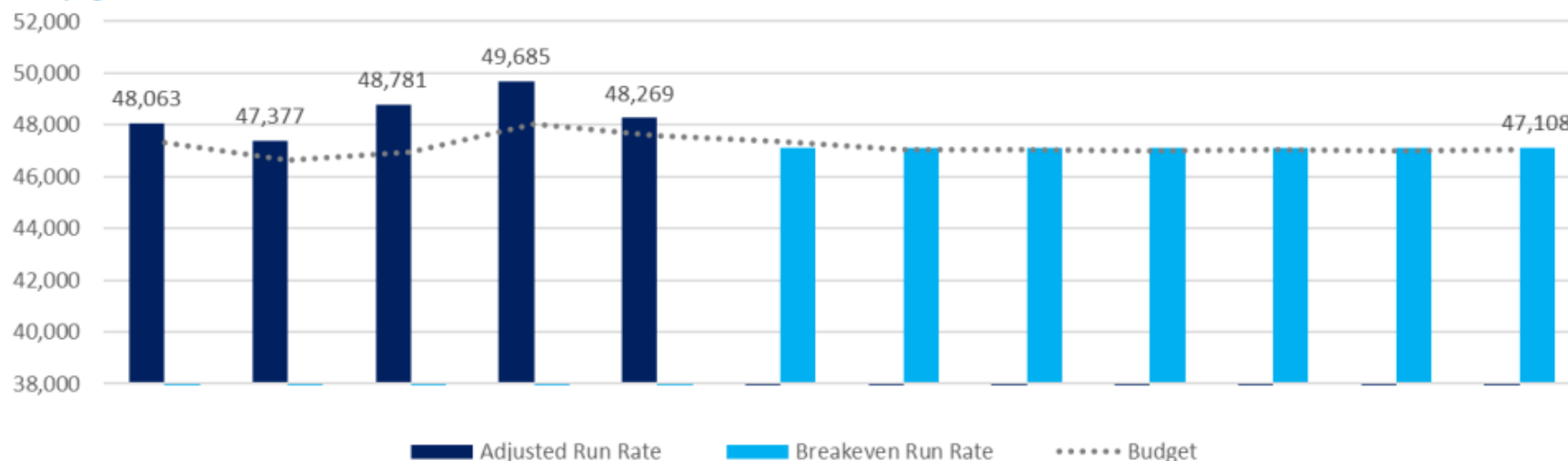
PY comparison

- Pay (£) is overall is above the 21/22 comparator although the underlying related activity trends are quite dissimilar (covid and non-covid).
- When compared to 21/22 in particular costs are materially higher in 22/23.
- Pay FTE is higher than the prior year comparator but this has to be seen as a BAU including COVID vs a high COVID lowered activity baseline.
- Pay FTE includes 92 FTE for SPH so like for like the FTE is 304 fte higher.

04/10/2022 Note: Due to the impact of Covid, the 19/20 equivalent has been used as the prior year comparator with inflation applied

Run Rate

Underlying run rate



Methodology

- Graph shows net expenditure (Pay, Non-Pay and income variance)
- Adjustments have been made to show underlying run rate. These account for one off/non-recurrent items unrelated to the activities in month (eg credit note received from prior year) and for catch up where cost or income relating to multiple periods is reflected in one months ledger.
- This has been implemented formally at M4 and it is likely that some transactions from previous months may have been missed (for example M2 appears low).
- One-off items - whilst removed from the run rate - will impact the required run rate to achieve breakeven and this has been accounted for.

Run rate

- The graphs shows an decrease in underlying run rate from M4 to M5 of £1.4m (M4 appears high due to some issues in divisional income). However this is still £0.7m above the budget of £47.6m.
- The analysis has removed net £5.9m of one-off items which whilst don't impact the run rate will still impact the in year financial position.
- Current average run recurrent rate (M1-5) extrapolates (straight-line) to overall spend of £581.2m, against a plan of £566.0m, an overall gap of **£15.2m** (this adjusts to £9.3m when the one-offs are adjusted for).
- Mitigations are currently being worked through, with some central reserve support expected to be required
- Further mitigations will be required from divisional management to ensure progress is made to reduce run rate to the required level by Mar-23, currently around a **£1.1m** reduction per month compared to M5.

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Divisional Summary

Divisional position

Division	Variance to budget - M5					YTD overall Variance	Run rate analysis (unadjusted)		
	Income	Pay	Non pay	Overall Variance	WTE		May	Jul	Aug
	£'000	£'000	£'000	£'000	WTE		£'000	£'000	£'000
CHIC	58	246	23	327	(92)	903	(3,600)	(3,535)	(3,360) P
Core Services	19	143	(294)	(132)	(45)	107	(6,281)	(5,690)	(6,114) Q
Estates & Facilities	(45)	(40)	41	(45)	(42)	181	(3,168)	(2,694)	(2,583) P
Medicine	88	(945)	63	(795)	+70	(1,922)	(7,716)	(7,377)	(7,816) Q
DAS	155	(384)	(140)	(368)	(8)	(950)	(7,820)	(7,719)	(8,099) Q
Urgent Care	(16)	(62)	(13)	(91)	(34)	(561)	(2,239)	(2,237)	(2,156) P
WCSH	(40)	(13)	(41)	(94)	(59)	345	(2,797)	(2,899)	(2,836) P
Corporate Services	234	23	(241)	16	(62)	925	(3,775)	(4,019)	(3,853) P
SPH	138	42	(143)	37	(4)	237	(45)	23	(8) Q
Central/Trust wide	1,289	(891)	1,022	1,420	(32)	956	36,655	35,359	38,621 P
ESHT	1,880	(1,882)	276	275	(307)	221	(786)	(787)	1,796 P

Division	YTD Variance M5 - Top Level Narrative
CHIC	Vacancies ytd, including 21-22 investment in UCR/EHCH
Core Services	Vacancies ytd in CDC and Pharmacy
Estates & Facilities	Ancillary vacancies and lower ytd than expected Utility costs
Medicine	Supernumerary posts, Escalation, Cardiology agency, Covid backfill
DAS	Supernumerary posts, Critical Care (Bus Case pending), Theatre Agency
Urgent Care	Supernumerary posts, Agency premium
WCSH	Maternity vacancies, Sexual Health vacs, lower non pay ytd
Corporate Services	Vacancies in Finance/HR/Digital. Non pay LDA funding underspent
SPH	Vacancies and lower pay costs v budgeted unit costs

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Efficiency

Division	In Month			Ytd – M5			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	173	8	(164)	850	28	(823)	400	39	440	2,912	(2,472)	6
Emergency Care	49	1	(48)	235	5	(230)	77	2	79	783	(704)	11
DAS	168	88	(80)	855	668	(188)	607	725	1,332	3,029	(1,697)	15
Core Services	144	237	93	511	624	113	577	928	1,505	2,393	(888)	17
CHIC	94	247	153	450	810	360	24	1,500	1,524	1,539	(15)	4
WCSH	39	159	120	187	234	47	18	938	956	1,172	(216)	5
Estates & Facilities	47	15	(31)	224	233	10	113	420	533	1,026	(492)	8
Corporate	61	215	153	292	920	628	593	892	1,485	1,177	308	10
Trustwide	671	476	(195)	3,407	3,490	84	8,686	-	8,686	8,964	(277)	3
Total	1,447	1,447	0	7,011	7,012	1	11,096	5,445	16,541	22,994	(6,453)	79
<i>Unidentified</i>	-	-	-	-	-	-	-	-	6,453	-	6,453	-
Total	1,447	1,447	0	7,011	7,012	1	11,096	5,445	22,994	22,994	-	79
<i>Movement from last month</i>	<i>(136)</i>	<i>(136)</i>	<i>(0)</i>	<i>1,447</i>	<i>1,447</i>	<i>0</i>	<i>(753)</i>	<i>2,218</i>	<i>1,466</i>	<i>-</i>	<i>1,466</i>	<i>5</i>

Overview

- The trust has delivered the £1.4m efficiency plan for the month and £7m year to date.
- The divisional plan values in the month represent the phased targets rather than the planned values for schemes that have been approved.
- The target for the year is £23m, this reflects the increase of £2m following the resubmission of the plan in June. So far £16.5m has been identified, leaving a gap of £6.5m for the Divisions to find, an improvement of £1.5m in the month.
- 33% of the £16.5m identified is non-recurrent.

Capital

			YTD			2022/2023	
Trust Lead		Draft Programme £'000	Cumulative Expenditure £'000	Cumulative Forecast £'000	Forecast Variance £'000	Current Plan £'000	Forecast Outturn £'000
Capital Scheme							
Original							
DIG	Digital Programmes	4,500	482	840	(358)	4,500	4,500
	Total Digital	4,500	482	840	(358)	4,500	4,500
EME	Diagnostic Equipment	500	400	-	400	500	500
EME	Medical Equipment	2,500	603	450	153	2,500	2,500
	Total Medical Equipment	3,000	1,003	450	553	3,000	3,000
EST	Fire	1,500	71	470	(399)	1,500	1,500
EST	Backlog	6,750	1,176	1,219	(43)	6,750	6,750
EST	Day Surgery capacity	1,100	948	1,055	(107)	1,100	1,100
EST	Theatre 5 & 8	280	375	248	127	280	280
EST	CTScanner	250	-	244	(244)	250	250
EST	Westham	150	415	138	278	150	150
EST	Conquest ED	250	233	240	(7)	250	250
EST	Baird Ward	100	0	50	(50)	100	100
EST	Cath Lab Replacement	1,700	14	65	(51)	1,700	1,700
EST	Cat 3 Microbiology	50	-	-	-	50	50
EST	Gynae Footprint	400	156	75	81	400	400
EST	ICU adaptations Cong	1,500	14	50	(36)	1,500	1,500
EST	Ophthalmology Bex	1,000	3	50	(47)	1,000	1,000
EST	Cardiology Business Case	150	-	25	(25)	150	150
EST	Friston Paeds	1,000	136	50	86	1,000	1,000
EST	Decant Ward	4,000	18	200	(182)	4,000	4,000
EST	Ward Refurbishment	1,250	309	350	(41)	1,250	1,250
EST	Rolling Ward Refurbishment	-	35	-	35	-	-
	Total Estates	21,430	3,902	4,528	(626)	21,430	21,430
FIN	Business Case Development	400	-	120	(120)	400	400
FIN	Divisional Small Works	500	-	110	(110)	500	500
FIN	Minor Capital	1,000	181	280	(99)	1,000	1,000
FIN	Unplanned Urgents	500	66	140	(74)	500	500
FIN	Planned slippage/prioritisation	(4,910)	-	(1,507)	1,507	(4,910)	(4,910)
	Total Finance	(2,510)	247	(857)	1,105	(2,510)	(2,510)
	Total Original Planned	26,420	5,635	4,961	675	26,420	26,420
New							
EME	Community Diagnostic Centre	500	377	400	(23)	500	500
	Additional Medical Equipment	500	377	400	(23)	500	500
EST	Building For Our Future	1,060	189	368	(179)	1,060	1,060
EST	Community Diagnostic Centre	1,500	1,124	1,000	124	1,500	1,500
EST	Elective Care Centre (EDGH)	-	167	-	167	-	-
	Additional Estates	2,560	1,480	1,368	112	2,560	2,560
DIG	EPR Match Funding (external)	750	-	-	-	750	750
	Additional Digital	750	-	-	-	750	750
	Total Additional Capital	3,810	1,857	1,768	89	3,810	3,810
	Total Capital	30,230	7,492	6,729	763	30,230	30,230
EST	PSDS3	28,822	4,854	4,822	32	28,822	28,822
EST	PSDS3 Income	(28,822)	(4,853)	(4,822)	(31)	(28,822)	(28,822)
	Total Grant Capital	-	1	-	1	-	-
FIN	Donated Expenditure	1,000	675	280	395	1,000	1,000
FIN	Donated Income	(1,000)	(675)	(280)	(395)	(1,000)	(1,000)
	Total Donated Capital	-	0	-	0	-	-
	Total Capital	30,230	7,493	6,729	764	30,230	30,230

Capital

- The planned capital allocation for 2022/23 is £30.2m and is made up of the core ICS allocation of £26.4m plus national programmes expected in year of £3.8m.
- The programme includes the public sector decarbonisation scheme which is a government grant funded scheme of £28.8m.
- The capital expenditure incurred to the end of August totals £13m which is slightly ahead of plan by £0.8m.
- Cost incurred on Leases is excluded from this table.
- Expenditure in M5 was largely driven by the following schemes:
 - Medical Equipment £1,003k (includes diagnostic equipment of £400k);
 - Estates works of £3.9m, the main schemes being backlog maintenance (£1,176k), Westham remodelling and refurbishment (£415k), Theatre 5 & 8 upgrade including laminar flow (£375k), Conquest ED project delivering new clinical space and staff area (£233k), and Day Surgery redesign at EDGH (£948k);
 - Community Diagnostics Centre £1,501k made up of equipment costs (£377k) and estates costs (£1,124k);
 - Elective Care Centre (£167k). This has been corrected this month and some costs remapped to Day Surgery.

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Assets and Liabilities

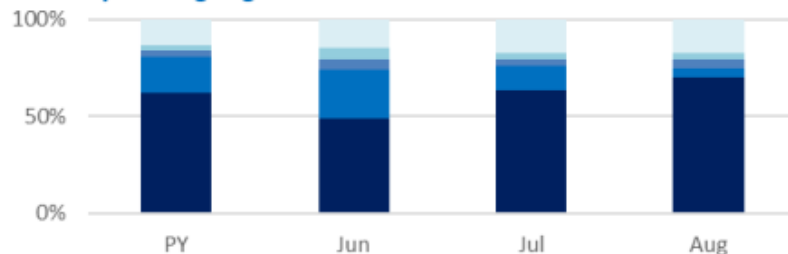
Trust Assets and Liabilities

	Jun	Jul	Aug	Change
	£'000	£'000	£'000	£'000
Non-current assets	298,795	295,367	297,247	1,880
Inventories	7,689	8,031	7,529	(501)
Trade and other receivables	23,280	35,218	30,232	(4,986)
Cash and Cash equivalents	49,714	47,407	49,082	1,675
Current Assets	80,684	90,655	86,843	(3,812)
Trade and other payables	(46,679)	(50,401)	(48,947)	1,454
Other liabilities	(10,275)	(11,661)	(11,022)	639
Current Liabilities	(56,954)	(62,062)	(59,969)	2,093
Non-current liabilities	(14,613)	(13,208)	(12,941)	267
Total assets employed	307,912	310,752	311,180	428

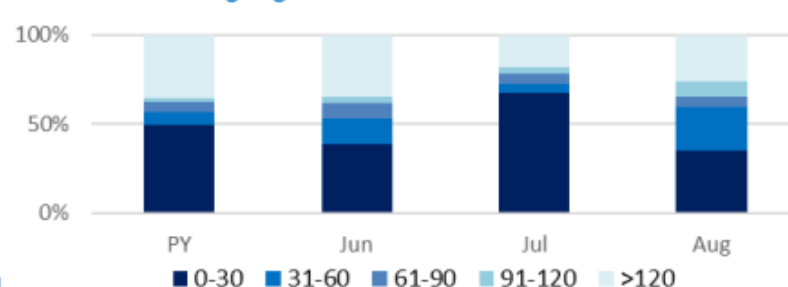
BPPC (Based on invoice count)

Trade	76.5%	78.5%	80.4%	1.9%
NHS	98.7%	98.6%	98.7%	0.1%

Trade Payables Ageing



Trade receivables Ageing



Balance sheet

- Non-current asset values have increased by £1.8m as a result of PPE expenditure.
- Current assets has decreased in month by £3.8m. This has predominantly been caused by a reduction in trade and other receivables offset by an increase in cash held.
- Current liabilities has increased in month by £2.1m however remains consistent with an average position from June and July.
- The Trust continues to hold very significant cash balances at £49.1m.

Better Payment Practice Code (BPPC)

- Slight improvements in BPPC for Trade and non-NHS in month. The Financial Services team continue to prioritise performance, with non-NHS payables a particular focus. Poor performance is largely due to issues with no purchase orders or delays to receipting of goods and services.

Trade and Other Payables

- An increase in month of £0.8m on the creditor position increasing the purchase ledger total to £10.1m.
- 81% of the outstanding invoices are payable to trade (Non NHS) suppliers and the balance to NHS providers. The Trust processes weekly payment runs.
- The majority of aged invoices are stuck in the system due to issues relating to the 'No PO, No Pay' policy.

Trade and Other Receivables

- The sales ledger balance decreased by £3.7m in month to a total of £6.0m.
- The ageing profile of debt due has increased by £0.7m in month and now totals £3.9m.

Key risks

Risk adjusted forecast outcome

- Risk analysis shows a potential range from £16.4m deficit to a breakeven position downside and upside cases respectively. The base case is showing a expected deficit of £0.6m which is immaterial to the scale of Trust turnover so no seen as a trigger point for changing the forecast. Risks are set out below.

	Downside £'000	Base £'000	Upside £'000	Commentary
M5 YTD	221	221	221	

Risks

ERF delivery	(7,000)	(2,960)	1,107	<p><i>There remains a significant shortfall against our plan for elective activity. There is a high degree of uncertainty around whether clawback will be in operation</i></p> <p>Base Case: the current level of underperformance continues (£0.5m per month) and that clawback applies from H2.</p> <p>Upside: No clawback for the year meaning clawback within plan doesn't happen resulting in an overperformance</p> <p>Downside: the M5 underperformance is replicated from M6-12 and clawback applies</p>
ERF value	(3,500)	-	-	<p><i>The ICB is considering whether the allocation of ERF money was correct.</i></p> <p>For Base and upside we assume no change, for downside we are showing initial figures from the ICB</p>
Efficiency	(1,644)	-	-	<p><i>The shortfall in the efficiency programme is being partially offset by savings in overall expenditure. Divisions continue to work to progress schemes and develop plans to close the gap. Ownership and engagement is high but significant progress will need to be made in the coming weeks to ensure the programme remains on track for full delivery.</i></p> <p><i>Mitigations for slippage has been found in some areas.</i></p> <p>The current plan is for an improvement in run rate of £0.3m per month in the second half of the year. For base case and upside we are assuming this delivers, for worst case that this is not achieved</p>
Run rate	(5,831)	(3,887)	(1,944)	<p><i>Current levels of temporary staffing, in part due to high levels of sickness, and expenditure growth in areas of activity, notably high cost drugs, are areas of particular concern and are under review</i></p> <p>Base: Extrapolation of current run rate adjusting for ERF and assumed efficiency upside. Upside and downside case have been adjusted by 50% of this value.</p>
Winter pressures	(2,000)	-	-	<p><i>Increasing expenditure based on additional operational demand over winter</i></p> <p>Downside: expectation of additional costs for winter pressures over and above those included in the run rate</p> <p>Base: the run rate includes existing open escalation beds so that level is incorporated into run rate</p>
Pay award	(1,678)	-	-	<p><i>There is a risk that the full cost is not fully funded</i></p> <p>Base Case: variance against fully costed model based on draft ICB workings of total ask vs allocation - at this point it appears there is sufficient funding at 50%</p> <p>Upside: Pay award is fully funded</p> <p>Downside: the gap between costed pay award and national guidance of 1.66% on contracts</p>

Mitigations

One-off recovery actions	6,000	6,000	616	
Scenario FOT	(15,431)	(626)	-	
Prior month	(13,000)	(2,691)	197	

Cardiology Transformation Programme

Meeting information:			
Date of Meeting:	11 th October 2022	Agenda Item:	8.1
Meeting:	Trust Board in Public	Reporting Officer:	Chief Executive

Purpose of paper: (Please tick)			
Assurance	<input type="checkbox"/>	Decision	<input checked="" type="checkbox"/>
Has this paper considered: (Please tick)			
Key stakeholders:		Compliance with:	
Patients	<input checked="" type="checkbox"/>	Equality, diversity and human rights	<input checked="" type="checkbox"/>
Staff	<input checked="" type="checkbox"/>	Regulation (CQC, NHSi/CCG)	<input checked="" type="checkbox"/>
		Legal frameworks (NHS Constitution/HSE)	<input checked="" type="checkbox"/>
Other stakeholders please state: NHSE/I, Clinical Senate, GPs, MPs, Healthwatch, SECamb (a full list of stakeholders can be found within the DMBC)			
Have any risks been identified (Please highlight these in the narrative below)	<input checked="" type="checkbox"/>	On the risk register? Yes	

Summary:

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

The purpose of this paper is to set out the process and outcomes that have informed the Decision-Making Business Case (DMBC) and to confirm the final proposals provide a model of care that will improve the cardiology services, their sustainability, and outcomes for the benefit of the local population.

This document also describes the wide engagement to date, including the public consultation, and the processes East Sussex Healthcare NHS Trust and NHS Sussex have followed in developing proposals, ensuring clinical assurance of the model, seeking wide engagement and feedback, and finalising proposals for decision-making.

The full DMBC will be published and is available to all Board members on request. It recommends one option to take forward for implementation, which, if approved by the Integrated Care Board, will be submitted to the East Sussex Health Overview Scrutiny Committee who will decide if they consider this to be in the best interests of the local population.

The model of care has been confirmed throughout the process as the right strategic proposal to improve acute cardiology services and outcomes for the local population and is supported by stakeholders across local communities. It remains unchanged from the previously approved pre-consultation business case. Services on both sites would deliver improvements for all local people with the development of cardiac response teams and hot clinics, and the specialist interventional services, would be located on one of the two acute sites. The introduction of the Cardiac Response Team in A&E and hot clinics will ensure faster senior clinical input, faster assessment, treatment and diagnostics, reduced waiting times, more procedures being completed on an outpatient basis at both sites, a higher proportion of elective procedures completed as day cases resulting in fewer overnight stays, and fewer repeat outpatient visits. The carefully considered assessment of this has concluded that the proposed specialist site should Eastbourne District General Hospital.

When developing our options, our final draft proposals, the Pre-consultation Business Case and Decision-Making Business Case we undertook a wide range of steps consistent with service reconfiguration duties and requirements, considered insight from local people and clinicians from engagement and consultation; continually assessed our developing proposals in relation to equality, health inequality and quality impact and took associated action: commissioned independent travel analysis; took account of South East Clinical Senate recommendations; were informed by feedback from East Sussex Health Overview and Scrutiny Committee;

assessed proposals against the NHS Four Tests for service reconfigurations ; undertook stage one and two NHSEI assurance; and developed our proposals and associated plans in line with the Gunning Principles.

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

- ESHT Executive Committee, 04.10.2022
- Non-Executive Directors Meeting, 29.09.2022
- Sussex Executive Committee (ExCo), 03.10.2022

Pending Committees:

- Sussex Integrated Care Board, 02.11.2022
- East Sussex Health Overview and Scrutiny Committee, 15.12.2022

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

The members of the Trust Board are asked to:

1. **Endorse** the following recommendations and **approve** the submission of the endorsement to NHS Sussex's Integrated Care Board:
 - a. approve the post-consultation Decision-Making Business Case, specifically to:
 - i. form a Cardiac Response Team to support patients on their arrival at A&E, alongside 'hot clinics' that will provide consultant-led rapid assessment at both of our acute hospital sites (approximately 97% of patients using cardiology services will benefit from these improvements)..
 - ii. co-locate the most specialist cardiac services, needed by a small number of patients (impacting approximately 3%), at Eastbourne District General Hospital. These specialist cardiac services include surgical procedures, investigations or treatments that might require access to a catheter laboratory, Coronary Care Unit or cardiology inpatient beds.
 - b. note the consultation findings, how these have informed the Decision-Making Business Case, and how they have resulted in the post-consultation proposal;
 - c. note and approve additional actions to further mitigate any potential adverse impacts of the post-consultation proposal on groups highlighted in the comprehensive Equality and Health Inequalities Impact Assessment (EHIA) that has been iterated throughout the programme and was carefully considered in developing the final proposal, in particular as part of the site options appraisal process;
 - d. note the East Sussex Health Overview and Scrutiny Committee's Review Board's recommendations have informed the Decision-Making Business Case and the above additional actions to further mitigate any potential adverse impacts on our local population
 - e. approve the submission of the proposal for decision by the NHS Sussex Integrated Care Board
 - f. note that the decision of the NHS Sussex Integrated Care Board will subsequently be submitted to the East Sussex Health Overview and Scrutiny Committee for their consideration.

Report to:	East Sussex Healthcare NHS Trust Board
Meeting date:	11 October 2022
Report Title:	Decision Making Business Case Summary for Cardiology Transformation at East Sussex Healthcare NHS Trust
Key question:	<p>The committee is recommended to review the outcome of the consultation and additional activity undertaken to support a recommendation on the cardiology model of care, and the preferred site for the interventional cardiology service</p> <p>The committee is asked to confirm the committee members are satisfied that:</p> <ul style="list-style-type: none"> • This will deliver improved outcomes and experience for people in East Sussex • The clinical model has been confirmed as able to deliver high quality services in a sustainable way • The feedback from the public consultation has informed the final proposal • The equality health impact assessment and the quality impact assessment has been robustly undertaken and informed the proposal and planned implementation.
Sponsor:	<p>Richard Milner, Chief of Staff</p> <p>Jessica Britton, Executive Managing Director, East Sussex <u>(Programme Sponsor)</u></p>
Author:	<p>Victoria Hill, Senior Planned Care Manager</p> <p>Michael Farrer, Head of Strategic Transformation</p>
Outcome/ action requested:	
<p>Members of the Board are asked to endorse the following recommendations and approve their submission <u>of the endorsement</u> to NHS Sussex Integrated Care Board::</p> <ul style="list-style-type: none"> • approve the post-consultation Decision-Making Business Case, specifically to: <ul style="list-style-type: none"> ○ form a Cardiac Response Team to support patients on their arrival at A&E, alongside 'hot clinics' that will provide consultant-led rapid assessment at both of our acute hospital sites (all patients will benefit from these improvements). ○ co-locate the most specialist cardiac services, needed by a small number of patients (impacting approximately 3%), at Eastbourne District General Hospital. These specialist cardiac services include surgical procedures, investigations or treatments that might require access to a catheter laboratory, Coronary Care Unit or cardiology inpatient beds. • note the consultation findings, how these have informed the Decision-Making Business 	

Case, and how they have resulted in the post-consultation proposal;

- note and approve additional actions to further mitigate any potential adverse impacts of the post-consultation proposal on groups highlighted in the comprehensive Equality and Health Inequalities Impact Assessment (EHIA) that has been iterated throughout the programme and was carefully considered in developing the final proposal, in particular as part of the site options appraisal process;
- note the East Sussex Health Overview and Scrutiny Committee's Review Board's recommendations have informed the Decision-Making Business Case and the above additional actions to further mitigate any potential adverse impacts on our local population
- approve the submission of the proposal for decision by the NHS Sussex Integrated Care Board
- note that the decision of the NHS Sussex Integrated Care Board will subsequently be submitted to the East Sussex Health Overview and Scrutiny Committee for their consideration.

Executive summary:

The purpose of this paper is to set out the process and outcomes that have informed the Decision-Making Business Case (DMBC) and to confirm the final proposals provide a model of care that will improve the cardiology services, their sustainability, and outcomes for the benefit of the local population.

This document also describes the wide engagement to date, including the public consultation, and the processes East Sussex Healthcare NHS Trust and NHS Sussex have followed in developing proposals, ensuring clinical assurance of the model, seeking wide engagement and feedback, and finalising proposals for decision-making.

The full DMBC will be published and is available to all committee members on request. It recommends one option to take forward for implementation, which, if approved by the Integrated Care Board, will be submitted to the East Sussex Health Overview Scrutiny Committee who will decide if they consider this to be in the best interests of the local population.

The model of care has been confirmed throughout the process as the right strategic proposal to improve acute cardiology services and outcomes for the local population and is supported by stakeholders across local communities. It remains unchanged from the previously approved pre-consultation business case. Services on both sites would deliver improvements for all local people with the development of cardiac response teams and hot clinics, and the specialist interventional services, would be located on one of the two acute sites. The introduction of the Cardiac Response Team in A&E and hot clinics will ensure faster senior clinical input, faster assessment, treatment and diagnostics, reduced waiting times, more procedures being completed on an outpatient basis at both sites, a higher proportion of elective procedures completed as day cases resulting in fewer overnight stays, and fewer repeat outpatient visits. The carefully considered assessment of this has concluded that the proposed specialist site should Eastbourne District General Hospital.

When developing our options, our final draft proposals, the Pre-consultation Business Case and Decision-Making Business Case we undertook a wide range of steps consistent with service reconfiguration duties and requirements, considered insight from local people and clinicians from engagement and consultation; continually assessed our developing proposals in relation to equality, health inequality and quality impact and took associated action: commissioned

independent travel analysis; took account of South East Clinical Senate recommendations; were informed by feedback from East Sussex Health Overview and Scrutiny Committee; assessed proposals against the NHS Four Tests for service reconfigurations¹; undertook stage one and two NHSEI assurance; and developed our proposals and associated plans in line with the Gunning Principles².

Trust Board governance and engagement pathway to date:

Org./Group/ Name	Date	Outcome
F&I Strategy Committee	26 November 2020	Case for change approved
Trust Board Meeting	13 April 2021	Update on engagement and workshops to develop options, and following HOSC update in March 2021
F&I Committee	26 August 2021	Progress update and approval to proceed, following PCBC draft and development, and clinical senate review.
Cardiology Deep Dive Presentation	6 September 2021	Following drafting of PCBC, and in readiness for NHSE/I Stage 2 Assurance.
Joint Sussex Committee	17 November 2021	The committee noted progress to date, including development of the PCBC and completion of a Stage 2 Assurance Check Point. The committee reviewed the summary PCBC, together with the EHIA and QIA and approved the case for consideration by the East Sussex Health Overview and Scrutiny Committee. The committee also endorsed the recommendation that the PCBC proposal should be subject to formal public consultation.
East Sussex Healthcare NHS Trust Board	30 November 2021	The Board noted progress to date, including development of the PCBC and completion of a Stage 2 Assurance Check Point. The Board reviewed the summary PCBC, together with the EHIA and QIA and endorsed the case for consideration by the Joint Sussex Committee and East Sussex Health Overview and Scrutiny Committee.
East Sussex Health Overview and Scrutiny Committee	2 December 2021	The committee noted progress to date, including development of the PCBC and completion of a Stage 2 Assurance Check Point. The committee reviewed the summary PCBC, together with the EHIA and QIA. The committee also considered the proposal to be a substantial variation, and therefore asked that the programme consulted with East Sussex Health Overview and Scrutiny Committee.

¹ <https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf>

² <https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf>

Formal public consultation	6 December 2021 – 11 March 2022	Opportunity for the programme to set out the quality improvements anticipated from the proposed transformation, together with the site options The consultation included virtual public meetings, stakeholder events and face-to-face listening events, and included a wide range of activities including a focus on groups identified by the Equality and Health Inequalities Impact Assessment (EHIA).
Consultation with East Sussex HOSC	April-June 2022	A HOSC Review Board was set up to consider the proposals, consultation process and interim consultation feedback, which met on three occasions before reporting to the full Committee on 30 June 2022 where they agreed their response to the NHS, together with recommendations.
Strategy Committee	23 June 2022	Update following the HOSC Review Board, and on the proposed process to identify the preferred site.
NHS Sussex Executive Committee	3 October 2022	The committee noted progress to date, including the feedback from the public consultation, development of the DMBC, and the preferred site. The Board reviewed the summary DMBC, and endorsed the case for consideration by the NHS Sussex ICB and East Sussex Health Overview and Scrutiny Committee.
East Sussex Healthcare NHS Trust Board	11 October 2022	The Board noted progress to date, including the feedback from the public consultation, development of the DMBC, and the preferred site. The Board reviewed the summary DMBC, and endorsed the case for consideration by the NHS Sussex ICB and East Sussex Health Overview and Scrutiny Committee.

What happens next?

Following approval by the NHS Sussex ICB, this will be submitted to the East Sussex Health Overview and Scrutiny Committee for approval that this decision is in the best interests of our local population.

Milestone	Date
Final Decision-Making Business Case Summary submitted to the Sussex Integrated Care Board	2 November 2022
East Sussex Health Overview and Scrutiny Committee Meeting to review the post-consultation decision made by the Sussex Integrated Care Board	15 December 2022
Communications and public messaging confirming our decision	December 2022-March 2023
Designing	January-June 2023
Planning	April-June 2023

Construction	July 2023- December 2024
Full implementation	January-March 2025
Evaluation – review implementation and benefits realisation	March 2026

Decision Making Business Case Summary for Cardiology Transformation at East Sussex Healthcare NHS Trust

1 CONTEXT

- 1.1 NHS Sussex works in partnership with health and care organisations across Sussex as part of our Integrated Care System. Our aim is to ensure better health and care for all now and in the future. Our ambition is for every person living in Sussex to have access to the best health and care from the moment they are born and throughout their lives. We want:
- People to live for longer in good health.
 - To reduce the gap in life expectancy between people living in the most and least disadvantaged communities.
 - People's experience of using services to be better.
 - Staff to feel supported and work in a way that makes the most of their dedication, skills and professionalism.
 - The cost of care to be affordable and sustainable in the long term.
- 1.2 Our proposals sit within this context and focus on the improvement of hospital-based cardiology services to benefit our population in East Sussex. We want to ensure sustainable services into the future. This means that there is a focus on expanding services within local communities and recognising that for some of our more specialist services, consolidating these in one place will ensure the retention of this specialist expertise within East Sussex in a way that offers the best outcomes for local people. Our commitment to two thriving district general hospital sites, both with A&E departments and a wide range of services, is supported by specialist services at one or other site in order to deliver the best outcomes for patients.

East Sussex Healthcare NHS Trust Services

- 1.3 East Sussex Healthcare NHS Trust has made significant improvements for patients and local residents in recent years. The Trust is rated 'good' by the CQC, with several 'outstanding' services and has ambitious plans for the future, enabling residents to access the best care in the most appropriate place: at home; in the community; or when they need to come into hospital.
- 1.4 As an integrated acute and community provider, an important part of the trust's five-year strategy to best meet the healthcare needs of our population is to increase and improve the care provided outside of hospital. This means being proactive in supporting the health of local residents, preventing avoidable hospital visits and stays, improving patient outcomes and experience and making better use of resources. This has helped the trust to focus their hospitals to build on their strengths while improving how services work together across the whole health and care system.
- 1.5 The trust has two acute hospital sites, Conquest Hospital, Hastings and Eastbourne District General Hospital. Both sites provide urgent and emergency services, along with specialist

acute medical and intensive care units. The trust is focused on driving innovation and best practice. This will improve services across East Sussex and is particularly suited to the population the hospital serves. A number of services are located solely or primarily at one or other of our acute sites, Conquest Hospital and Eastbourne District General Hospital.

1.6 The Conquest Hospital is home to the trust's main theatres and therefore looks after most specialist surgical services, like general, vascular and orthopaedic surgery, and patients needing closer medical monitoring and support when giving birth. This includes:

- Main Theatres
- Majority of Surgical Specialties, such as:
 - General Surgery
 - Vascular Surgery
 - Orthopaedic Surgery
- Designated Trauma Centre
- Specialist Maternity Services, including consultant led services and specialist Obstetrics and Gynaecology Services
- More anaesthetic and Intensive Care Unit (ICU) provision to support the theatres and surgical services
- Specialist Inpatient paediatrics
- Sleep Studies (Respiratory Physiology)

1.7 Eastbourne District General Hospital looks after the most serious stroke cases, patients needing inpatient diabetes care, day case eye surgery, and a diabetic foot service. There are also inpatient endocrinology beds and the trust's urology service, which includes recent investment in a dedicated investigation suite, robotic surgery and non-invasive treatment for kidney stones. The services include:

- Stroke Services, including a Hyper Acute Stroke Unit
- Ophthalmology Jubilee Eye Suite, a day case theatre. Note: Other Day Cases for *Ophthalmology are undertaken at Bexhill Hospital.*
- Urology, including a Urology Investigation Suite, Robotic Surgery, and Lithotripsy
 - Specialist Medicine Services including specialist endocrine and diabetic inpatient beds.
- Cardiology Electrophysiology
- Endobronchial ultrasound for respiratory
- Diabetic Foot service.

2 INTRODUCTION

2.1 The purpose of the Decision-Making Business Case (DMBC) is to describe the final proposals to provide a model of care that will improve the cardiology services, their sustainability, and outcomes for the benefit of the local population. It describes the evidence base, the process for the development of the proposals, quality and equality impact assessment and details key enablers such as workforce and finance.

- 2.2 This document also describes the wide engagement to date, including the public consultation, and the processes East Sussex Healthcare NHS Trust and NHS Sussex have followed in developing proposals, ensuring clinical assurance of the model, seeking wide engagement and feedback, and finalising proposals for decision-making.
- 2.3 The full DMBC will be published and is available to all committee members on request. It recommends one option to take forward for implementation, which, if approved by the Integrated Care Board, will be submitted to the East Sussex Health Overview Scrutiny Committee who will decide if they consider this to be in the best interests of the local population.
- 2.4 The DMBC follows the approved Pre-Consultation Business Case and subsequent formal public consultation and shows how all available information and evidence has been considered, together with feedback captured from the public consultation. This has informed the final proposal to transform acute cardiology services that has been developed by NHS Sussex, in partnership with the East Sussex Healthcare NHS Trust (ESHT). Approval of this proposal will enable the transformation to be fully implemented within the timeframe outlined, by January-March 2025. Early implementation of some elements of the model will be sooner than this, in order to realise quality benefits as quickly as possible.
- 2.5 The document provides a summary of the context and of the case for change as outlined in the Pre-Consultation Business Case. It also provides an analysis of the feedback received from the public consultation and the consultation with the East Sussex Health Overview and Scrutiny Committee, and the updated post-consultation proposal that has been informed by the feedback received from local people and stakeholders during the consultation process.
- 2.6 A significant majority of respondents to the public consultation agreed with the proposal and views differed on which site should be preferred for the delivery of the most specialist services. NHS Sussex recognises the importance of access to services and has carefully and systematically analysed the consultation outcomes and balanced it with evidence that has been collected since the Pre-Consultation Business Case (PCBC) and in response to the consultation. This process informed NHS Sussex's considerations during the Decision-Making Business Case (DMBC) development process in order to ensure consultation feedback informs final proposals.
- 2.7 The model of care has been confirmed throughout the process as the right strategic proposal to improve acute cardiology services and outcomes for the local population and is supported by stakeholders across local communities. It remains unchanged from the previously approved pre-consultation business case. Services on both sites would deliver improvements for all local people with the development of cardiac response teams, and the specialist interventional services, would be located on one of the two acute sites. The carefully considered assessment of this through an independently facilitated site panel, has concluded that the proposed site should Eastbourne District General Hospital.
- 2.8 In summary, the proposal is to improve the services at both acute hospital sites through forming a Cardiac Response Team to support patients on their arrival at A&E, alongside "hot clinics" that will provide consultant-led rapid assessment at both of our acute hospital sites and locate the most specialist cardiac services, needed by a small number of patients, at Eastbourne District General Hospital.

2.9 The introduction this model, with a Cardiac Response Team in A&E, together with hot clinics will ensure faster senior clinical input, faster assessment, treatment and diagnostics, reduced waiting times, more procedures being completed on an outpatient basis (at both sites), a higher proportion of elective procedures completed as day cases (and therefore fewer overnight stays), and fewer repeat outpatient visits.

2.10 The changes to services as a result of the proposals are summarised below:

Services that would remain on both sites

- Outpatient services will continue to be provided at both sites, this includes new patients, follow up and monitoring appointments, treatment plan appointments and discussions, pre-surgical assessment and post-surgical follow up, and diagnostic services. There are approximately 50,000 appointments per year for these outpatient services.
- Cardiac monitoring will continue to be available at both sites, as cardiac monitors are available in multiple areas and services, not just within cardiology. The emergency department and the acute medical units / acute assessment units all have cardiac monitored beds, which will continue to be available at both sites.

Services that would be new to both sites

- Cardiac Response teams which will provide all front-end care, including cardiac triage, assessment, diagnostics (including radiology and pathology), prescribing, treatment and onward referral, if required. This change, from the current model of care, is that this would all be completed on the patient's arrival to A&E, rather than later in the patient's pathway as is the process at present. This means patients will receive a faster diagnosis, reduced waiting times, reduced number of appointments required for patients and a reduced length of time patients have to stay in hospital.
- Hot clinics that will provide patients with consultant-led rapid assessment, which will also ensure faster diagnosis, reduce waiting times, reduce the number of appointments required for patients and reduce the length of time patients have to stay in hospital.
- Some day-case procedures will be able to be completed as an outpatient procedure, rather than as an inpatient, and these will also be available from both acute sites along with all other outpatient appointments.

Services that would change and be co-located to one acute site

- The most specialist cardiology services, which will be co-located at Eastbourne District General Hospital, and supports approximately 3,000 patients per year, including those who require catheterisation laboratories, Coronary Care Unit and cardiology inpatient beds. This would mean approximately 1,500 patients, who would have previously attended Conquest Hospital for these services, would now have their treatment provided at Eastbourne District General Hospital.

2.11 This proposal will have positive impacts for our patients improving patient experience, patient outcomes and our performance against national standards in the long term, whilst making the service more efficient and sustainable for the future, alongside positive impact for our

workforce now and in the future. Our proposal to introduce Cardiac Response Teams and rapid assessment hot clinics will positively impact all cardiology patients across both hospital sites. Approximately 1,500 patients who would have previously attended Conquest Hospital for the most specialist cardiology services, will now have their treatment provided at Eastbourne District General Hospital, these patients will be variably impacted by these proposals depending on where they live, whether they are accessing the service on an emergency or planned basis and their mode of transport informed by clinical advice.

- 2.12 The evolution of the Covid-19 pandemic required East Sussex Healthcare NHS Trust to take steps to increase its critical care capacity during the summer months of 2020. As part of this, cardiology facilities at the Conquest Hospital were identified as required to support the response to the pandemic; meaning that the Conquest Cardiac Catheter Labs were unable to be used for cardiology procedures. The interventional service therefore had to be temporarily consolidated to Eastbourne District General Hospital.
- 2.13 As part of the temporary change to services due to the Covid-19 pandemic, cardiology services were also able to test out a front-end model of care in the Emergency Department; where senior clinicians were able to provide assessment and opinion to patients presenting to A&E. This enabled the service to provide more timely access to expert opinion, appropriate diagnostics, and treatment; in many cases reducing the need for admission whilst also improving the quality of care received. From this perspective of cardiology service provision, the change in provision of interventional services demonstrated the associated benefits of a front-end model.

3 CONSIDERATIONS

- 3.1 The Case for Change was developed by a wide range of stakeholders including clinicians, operational staff and experts by experience. It was recognised that the current service is unsustainable. We have reviewed the strategic drivers for change and the existing acute cardiology services. This led us to the following conclusions:
 - Subspecialisation – cardiology has become increasingly complex and specialised, and the current configuration of services limits our effectiveness by spreading our sub-specialist workforce across sites and reducing opportunities for effective multidisciplinary team working.
 - Workforce – operationally providing complete and comprehensive services that directly mirror each other on both sites is a significant workforce challenge that does not maximise the opportunities of subspecialisation and is further complicated by difficulties with recruitment and retention of the workforce. For example, East Sussex Healthcare NHS Trust's vacancy rate for specialist staff is between 10-15% (many staff work across both sites).
 - Quality - performance indicators and national guidance. There are a range of performance indicators and national guidance for cardiology care, but East Sussex Healthcare NHS Trust is not currently able to consistently meet all of these due to the service's current configurations.
 - Net Zero NHS - the NHS is committed to reach net zero carbon by 2050 which means we

need to significantly reduce carbon emissions caused by procedures, travel, estates, etc. The NHS Long Term Plan encourages service delivery to happen virtually, where appropriate.

- IT / Digital - it has been recognised that improvements to the digital infrastructure can benefit and support patient pathways.
- Estates and equipment - the engineering infrastructure is no longer fit for purpose, some of the catheterisation labs are due for replacement and are not operating reliably.
- Making best use of our resources - we want to ensure that our services are delivered in a way that gives the greatest benefit for local people.
- The national Getting It Right First Time (GIRFT)³ programme reviewed the cardiology service in November 2019 making a range of recommendations including consolidating inpatient cardiology, ensuring clinicians are performing the right numbers of procedures to ensure clinical quality.

3.2 The case also considered the national picture and what the future of cardiology services looks like. This includes medical advancements in research and technology that are reshaping the way in which we will deliver cardiology care. Increasing subspecialisation means that cardiologists now specialise in one or two types of treatment, rather than offering the full range, along with the development of new technologies, diagnostics and treatment options. These modernising changes reduce risk, pain and infection, and allow patients to recover more quickly; which means that many planned procedures are now done safely as day-cases, without having to stay overnight in hospital.

3.3 As a result, the Decision-Making Business Case proposes changes to a range of acute cardiology services provided by East Sussex Healthcare NHS Trust.

4 PROCESS TO DATE

Our Case for Change and developing our Pre-Consultation Business Case

4.1 Following analysis of the current service provision and the emerging future needs of local people, we developed a Case for Change that outlined the key drivers for service transformation. This provided the basis for our engagement with local people, clinicians and other professionals to further understand what is important to them about cardiology services. This initial engagement indicated several key themes as important to local people:

- Care provided
- Equality and diversity
- Access and transport
- Clinical services.

4.2 Alongside finding out what is important to local people and clinicians, we reviewed local health needs in East Sussex. This told us that there are some groups of local people who

³ The Getting It Right First Time (GIRFT) programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.

have particular needs and may be disadvantaged in accessing current services. We took account of these needs in our proposals and sought to mitigate those disadvantages through the proposals outlined in the Pre-Consultation Business Case (more detail on this can be found in the DMBC: Appendix 1 – Equality and Health Inequalities Impact Assessment (EHIA) and Appendix 2 – EHIA Actions).

- 4.3 Following pre-consultation engagement, three options development and appraisal workshops (independently chaired and facilitated by Opinion Research Services – ORS4) took place, during March 2021, to identify and consider a longlist of possible options for the future provision of acute cardiology services, including sites where the service would be delivered from, to appraise these options and make recommendations for preferred viable options.
- 4.4 Following this, and as part of our in-depth comparative analyses for the Pre-Consultation Business Case, we also reviewed quality indicators, travel analysis, the impact this transformation could have on other services (within Sussex and outside of Sussex), the impact this transformation could have on the equality and health inequalities of our population, and the financial feasibility of each option.
- 4.5 A Pre-Consultation Business Case was developed to make the case for change and set out the plans for a Public Consultation around the transformation of acute cardiology services at East Sussex Healthcare NHS Trust. It was approved by East Sussex CCG and East Sussex Healthcare NHS Trust, on 17 and 30 November 2021 respectively, and submitted to the East Sussex Health Overview and Scrutiny Committee on 2 December 2021 prior to formal public consultation. An independent report on the findings of the consultation has been produced and this report presents the feedback from those who participated in the consultation.
- 4.6 When developing our options, our final draft proposals, the Pre-consultation Business Case and Decision-Making Business Case we considered insight from local people and clinicians from engagement and consultation; continually assessed our developing proposals in relation to equality, health inequality and quality impact and took associated action: commissioned independent travel analysis; took account of South East Clinical Senate recommendations; were informed by feedback from East Sussex Health Overview and Scrutiny Committee; assessed proposals against the NHS Four Tests for service reconfigurations ; undertook stage one and two NHSEI assurance; and developed our proposals and associated plans in line with the Gunning Principles .
- 4.7 The Joint Sussex Committee reviewed the summary PCBC, together with the EHIA and QIA and approved the case for consideration by the East Sussex Health Overview and Scrutiny Committee, following which (on 2 December 2021) East Sussex Health Overview and Scrutiny Committee reviewed the summary PCBC, together with the EHIA and QIA and considered the proposal to be a substantial variation, and therefore asked that the programme consulted with East Sussex Health Overview and Scrutiny Committee.

Public Consultation

- 4.8 The formal public consultation into the proposal to transform cardiology services at East

⁴ Opinion Research Services is a social research organisation, whose mission is to provide applied social research for public, voluntary and private sector organisations across the UK.

Sussex Healthcare NHS Trust began on 6 December 2021 and ended on 11 March 2022. It set out the quality improvements anticipated from the proposed transformation, together with information about the two possible sites for specialist services. Opinion Research Services (ORS), was appointed to advise on, independently manage and report on the public consultation programme of engagement with service users, their families and carers, clinicians and other NHS staff and other stakeholders. The full report can be found as an appendix to the Decision-Making Business Case at Appendix 3.

- 4.9 The consultation included virtual public meetings, stakeholder events and face-to-face listening events, and included a wide range of activities including a focus on groups identified by the Equality and Health Inequalities Impact Assessment (EHIA).
- 4.10 A number of common themes were identified during the public consultation process. These included:
- Travel and access, for example:
 - Older people and people with disabilities, severe clinical needs, multiple complex needs, young children, among others
 - Those from more rural areas and those on lower incomes who might have to pay for taxis to access services
 - Anyone without access to private transport, or who finds long journeys challenging or distressing
 - Staff members who have to travel further or face increased costs, which could impact their well-being
 - Staff recruitment and retention, and/or job security especially at non-specialist site
 - Impacts on other services, for example. South East Coast Ambulance Service (SECAmb), and concerns about infrastructure and patient transport
 - Implications for cardiology patient care on other wards, for example monitoring equipment

Key actions following public consultation

- 4.11 Alongside public consultation, East Sussex HOSC established a Review Board to carry out a detailed review of the proposals and produce a report and recommendations on behalf of the Committee. In addition, following feedback from the public consultation regarding travel and access, we established a Travel and Transport Review Group to review our developing proposals and make recommendations. The feedback from the HOSC Review Board and the Travel and Transport Group are outlined below, followed by the recommendations and associated planned action.

Engagement with East Sussex Health Overview and Scrutiny Committee (HOSC) – HOSC Review Board

- 4.12 The Review Board carried out its review between April and June 2022. A full report (Appendix 4 of the DMBC) sets out the evidence the Board considered, along with its conclusions and recommendations. The East Sussex HOSC was presented with the Review Board's report, findings and recommendations at their meeting on 30 June 2022, where it was approved by the membership. The recommendations made by the East Sussex HOSC were as follows:

4.13 The Committee endorsed the proposed new clinical model for cardiology including:

- Cardiology catheter labs should be single-sited;
- That both Eastbourne District General Hospital and Conquest Hospital sites are viable sites;
- There is potential for new services to improve patient care and outcomes via the 'Front Door' model and 'Hot Clinics';
- There will be better services for patients at either Emergency Department (ED) sites; and
- Other services provided at each of the hospitals will not be affected or downgraded by the proposals for cardiology

4.14 The HOSC Review Board carefully considered a range of evidence on the proposals for the reconfiguration of cardiology services in East Sussex and agreed the clinical case for change is sound and addresses the staffing challenges and future sustainability of specialist interventional cardiology services. The HOSC Review Board acknowledged that members of the public may ideally wish to see interventional services retained at both acute hospitals, but it would be in patients' best interests if such services continue to be provided in East Sussex at whichever hospital is selected. There are clear patient benefits arising from the 'Front Door' cardiac responses teams in A&E and 'Hot Clinic' models and the HOSC Review Board advised they would like to see these proposals implemented as soon as possible.

4.15 On balance, the HOSC Review Board considered the clinical considerations, patient benefits and the need to address staffing challenges, outweigh any disbenefits of the proposals in terms of increased travel. It was also considered important that access is taken into account in the development of the Decision-Making Business Case and throughout the implementation of the proposals. As part of their review, the HOSC Review Board made a series of recommendations, the key ones of which are summarised in section 4.23.

4.16 These recommendations have been taken into account and further details on how these have been considered and addressed, for our post-consultation proposal and as part of the development of the Decision-Making Business Case, can be found in section 8 of the DMBC.

4.17 At this stage, initial actions in response to insight from the public consultation included a review and update of the Quality Impact Assessment, Equality and Health Inequalities Impact Assessment, as well as updating of previous EHIA actions, and the establishment of a Travel and Transport Review Group.

Travel and Transport Review Group

4.18 During the public consultation, travel and transport (public and private transport, including access and parking) were raised by many respondents as issues to be addressed. Therefore, we established a Transport and Travel Review Group to consider the issues raised.

4.19 The group was tasked with reviewing findings from the pre-consultation engagement processes, options development and appraisal processes, Equality and Health Inequalities Impact Assessment (EHIA), the Public Consultation, as well as independent travel analysis carried out by external consultants, and considering the conclusions to make suggestions

and recommendations on possible transport solutions for those who may be affected by the proposed service change.

- 4.20 People responding to the consultation identified key groups who may be adversely affected by transport and travel impacts created by the proposals, e.g. some people having to travel further to see their loved ones and some staff having longer journeys to work. Alongside this, respondents made some suggestions, e.g. to work with authorities in relation to public transport, consider parking, consider financial reimbursement.
- 4.21 Following the review outlined above including insight from the public consultation, the Travel and Transport Review Group made several recommendations some for implementation and some for further investigation. The key actions are summarised in 4.23.

Recommendations and associated action/action plans from HOSC Review Board and Travel and Transport Review Group

- 4.22 HOSC Review Board and the Travel and Transport Group made a range of recommendations which have been taken account of as we have developed our proposals and our developing draft mobilisation planning (subject to decision making).
- 4.23 The HOSC Review Board and the Travel and Transport Review Group made a range of recommendations which have been taken account of as we have developed our proposals and our developing draft mobilisation planning (subject to decision making). These key recommendations were focused on travel and transport and included providing travel support for local people; the introduction of Travel Liaison Officer at East Sussex Healthcare NHS Trust; improved communication about travel options; liaising with patients about their individual travel and access needs; supporting patients with information and processes about accessing financial reimbursement where eligible; improving information for patients about alternative transport options and exploring over the longer-term improvements to public transport; and measures to support recruitment and retention of staff.
- 4.24 In response to these recommendations, some have been implemented and others have been committed to and we are progressing them as this programme continues and we implement our proposals. A summary is provided below:
- The priority recommendation of the establishment of a travel and transport liaison officer has been committed to by the Trust and will be implemented alongside these proposals
 - Work has taken place within the Trust to ensure information provided via its website, patient letters and patient information leaflets is clear for patients around travel, transport and access options and parking to its various sites. This work will continue to be reviewed and updated as additional actions and recommendations are addressed
 - Work has taken place to ensure staff are aware of travel opportunities, such as Trust schemes, are promoted and this will be included in staff messages on a frequent basis
 - Work has taken place with ICS colleagues to understand learning around travel arrangements for the recent vaccination programme
 - A commitment has been made to monitor staff recruitment and retention measures and these have been included in the Key Performance Indicators (KPIs) of this programme
 - As part of the upcoming communications plan, post decision, further work will take place

to ensure information around the changes will be shared with our local stakeholder and population, including a Frequently Asked Questions document

- Working with Trust and primary care colleagues to ensure individual needs of patients are recognised and taken account of when booking appointment and procedures, along with clear communications to patients to raise awareness of the options available to them
- Work is in progress to compile a directory of any, and all, transport services, including community, volunteer and charity organised services, and their eligibility criteria where necessary, to which patients could be signposted
- Work with voluntary, community and social enterprise and patient representatives to ensure changes to services and facilities is co-designed
- Consideration by the Trust of a long-term travel and transport strategy

4.25 There are also a number of recommendations which are being explored by the wider NHS Sussex system, as these do not solely relate to cardiology patients who attend East Sussex Healthcare NHS Trust, such as:

- Exploring the options for a pilot shuttle bus service
- Working with NHS colleagues on additions to the Non-Emergency Transport Service (NEPTS), such as a digital tracking element and eligibility criteria
- Working with local authority and public transport providers on and potential future services

4.26 Considering options and developing a preferred site for specialist cardiology

Appraisal on preferred site

4.27 Our Pre-Consultation Business Case (PCBC) outlined our intention to consult on the proposed model, alongside proposed sites for the specialist service as there was no significant information or evidence at that stage that would indicate a site preference for these. We were clear we would assess and recommend a decision based on the range of published information and evidence, together with feedback from the public consultation, any further information following publication of the PCBC and required further analysis.

4.28 This information would be used to assess each of the site options against weighted criteria that considered information from our Pre-Consultation Business Case, Equality and Health Inequality Impact Assessment, Quality Impact Assessment, and new or updated information since the public consultation. It was recognised that there will be differential impacts, benefits and risks associated with each site option.

Independently facilitated site panel

4.29 On 12 September 2022, following the close of the public consultation and the completion of analysis of consultation feedback, NHS Sussex convened an independently facilitated site panel to consider the two possible locations, Conquest Hospital, Hastings and Eastbourne District General Hospital, and to undertake an appraisal exercise aligned to five key criteria, listed below, and a number of sub-criteria that took into account issues such as population demographics, health inequalities, travel times, workforce issues, infrastructure on sites activity and finance. This is not intended as an exhaustive list, the full report from the

independently facilitated site panel is contained in the report from Opinion Research Services (ORS) which is attached to the DMBC at Appendix 7.

- Quality and Safety
- Clinical Sustainability
- Access and Choice
- Deliverability
- Financial Sustainability

4.30 The purpose of the panel was to gather views from key stakeholders on the available evidence to inform a site preference. The outcome was not, on its own, a decision on site for the location of specialist cardiology inpatient services and catheter laboratories in East Sussex. The outcome was then reviewed alongside evidence regarding clinical quality and sustainability, public health analysis, detailed financial analysis, speed of implementation, and alignment with the travel and access analysis in order to test this preference. The panel included a variety of different stakeholders to consider and discuss the evidence, provide insight and undertake indicative scoring. The stakeholders represented a balance of attendees, particularly in terms of those attendees with a strong connection to just one or other of the sites, and included:

- Patient representatives and service users
- Voluntary, community and social enterprise organisation representatives
- Cardiology service staff, including consultants, nurses and junior doctors
- Clinicians from other services, such as anaesthetics, physiology, radiology
- GP Clinical Lead
- Healthwatch
- NHS Sussex and East Sussex Healthcare NHS Trust Managers, such as senior finance, quality, health inequalities
- Public Health
- South East Coast Ambulance Service (SECAmb), and;
- a number of voluntary, community and social enterprise organisation representatives

4.31 The panel assessed against the appraisal criteria using recognised methodology and tested the weighting of the criteria fairly evenly. The outputs from the panel are included in the DMBC at section 9, the full report from the independently facilitated site panel is contained in the report from Opinion Research Services (ORS) which is attached to the DMBC at Appendix 7.

4.32 The summary outputs is as follows:

- Overall, Eastbourne District General Hospital was identified as somewhat⁵ better able to fulfil the criteria used to appraise the sites than Conquest Hospital, although it should be noted that both sites tended to be viewed nearly equally able to fulfil the criteria of Quality and Safety and Access and Choice, with a very slight favour toward Conquest Hospital.

⁵ Likert scale is a scale used to represent people's attitudes to a topic; the panel used a five point scale ranging from criteria fulfilled equally at either site, somewhat or a lot better at one or other site

- It is important to note, that there was evidence of strongly differing views among those who indicated a particular connection or affiliation to one site over the other, and for those with no affiliation this was more balanced.
- The overall outcomes indicate that, on average, all stakeholder groups and three of the four site connection groups felt that Eastbourne District General Hospital fulfils the appraisal criteria somewhat better than Conquest Hospital.

Preferred site

- 4.33 We have carefully considered our equality and health inequality impact assessment and recognise the importance of supporting prevention and timely access to care and treatment through improved local services. This is addressed by this proposal which improves cardiology services for all service users and for 97% of cardiology service users, these improvements will be implemented locally at both the Conquest Hospital, Hastings, and Eastbourne District General Hospital. This, alongside improved access (shorter waiting times for treatment) in the longer term is anticipated to have a positive impact in reducing the numbers of people who will require more specialist care as they are accessing improved care assessment, diagnosis and treatment earlier on in their clinical pathway.
- 4.34 For those patients who require a specialist service further along their clinical pathway, in making these improvements, it is necessary to consolidate our most specialist cardiology services onto a single site – Eastbourne District General Hospital - which also will result in significantly improved clinical sustainability of the service. This change will mean that a small proportion of patients from Hastings and Rother area will travel further for these specialist services. Of those who will travel further we have considered the recognised larger deprived population in Hastings as compared to Eastbourne, noting there is also significant deprivation within Eastbourne.
- 4.35 Part of our population based analysis considered the potential impact on people living in our most deprived wards in Eastbourne and Hastings. Based on the percentage of people in our most deprived wards, this indicates that there is a net differential impact of approximately 300⁶ people who will be affected, who would have to travel further for their most specialist cardiology care. Approximately half of these will travel by ambulance or cross-site transfer. For those patients who would previously have accessed specialist care at the Conquest for a planned procedure and choose to travel by car there will be an average increase in travel of 15 minutes ⁷. It should be noted that if the service were sited in Hastings, there would also be people from our deprived communities having to travel further. This further travel for some patients has been analysed and balanced with the clinical sustainability of the specialism that will ensure a viable service for the whole population.

⁶ This is based on, of the approximately 1,500 people who use the Trust's specialist cardiology services at each site, approximately 600 people from the most deprived wards in Hastings are likely to be affected if the specialist service is at Eastbourne District General Hospital, and 300 people from the most deprived wards in Eastbourne are likely to be affected if the specialist service is at Conquest Hospital. This is based on the percentage of people in our most deprived wards who would be affected. In 2019-20, Conquest Hospital provided 1,536 interventional procedures and inpatient stays requiring a specialist cardiology bed and Eastbourne District General Hospital performed 1,630.

⁷ Note, for clinical reasons patients are advised not to use public transport

- 4.36 We have taken account of feedback from our public consultation, HOSC Review Board recommendations and Travel and Transport Review Group recommendations to develop a package of measures to better support patients who may need support to travel to hospital as summarised in section 4.24.

Plans for implementation

- 4.37 This Decision-Making Business Case presents the public consultation feedback together with additional information and evidence that have been collated as part of this document's development and in response to the consultation. The purpose of the Decision-Making Business Case is to enable and support the NHS Sussex Integrated Care Board's decision-making process.
- 4.38 Once the post-consultation proposal is supported and the Decision-Making Business Case is formally approved through our governance process, we will enact our implementation plan from December 2022 for full implementation in January-March 2025, although early implementation of some elements of the model will be sooner than this, in order to realise quality benefits as quickly as possible.

Decision-making

- 4.39 The purpose of the Decision-Making Business Case is to ensure that the proposals have been consulted upon, are clinically sound, financially viable, and in line with the improved outcomes agreed in the Pre-Consultation Business Case. The final decision will rest with NHS Sussex, with a recommendation also from East Sussex Healthcare NHS Trust, whose respective decisions will be made at meetings in public.
- 4.40 The recommended decision has been determined in two parts:
- Firstly, confirmation that the case for change and pre-consultation proposals remain valid and have received support through the public consultation, and
 - Secondly, which of the two sites (Eastbourne District General Hospital or Conquest Hospital, Hastings) provides the best location for the very specialist reconfigured services. This was arrived at by reviewing all the evidence that has been used to inform this Decision-Making Business Case, including our pre-consultation engagement, public consultation feedback, our Equality and Health Inequalities Impact Assessment, Quality Impact Assessment, and the independently-facilitated site panel, and in light of this recommends Eastbourne District General Hospital as the preferred site.
- 4.41 Following the decision by NHS Sussex, the outcome will be submitted to the East Sussex Health Overview and Scrutiny Committee who will consider if the change is in the best interests of the local population.

5 IMPLICATIONS

Financial implications:

- 5.1 There would be a positive financial impact on the Trust of implementing the changes

outlined, this is as a result of implementing best practice and benefiting from resulting economies of scale.

Revenue

- 5.2 The case shows that under co-location there will be net efficiency savings, which takes into account the cost of capital, resulting in a favourable revenue position from year 3 for the recommended option. For comparison, the Conquest option results in a favourable position by year 4, once efficiencies can be realised.
- 5.3 The table shows the annual surplus / deficit position for both options when compared with the do nothing option. The preferred option (5a Eastbourne) is financially favourable, with an average 400k per annum additional efficiency savings above 5b Conquest, over the 10-year period.

Heading, £000s	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
5a (Eastbourne) vs. Do Nothing	(73)	(283)	1,081	1,171	1,305	1,449	1,604	1,770	1,950	2,142
5b (Conquest) vs. Do Nothing	(30)	(90)	(355)	802	927	1,061	1,205	1,360	1,527	1,706

- 5.4 The difference between the options is driven by lower capital investment due to less new infrastructure required, and earlier realisation of efficiencies for the preferred option due to the earlier implementation timescales.

Capital

- 5.5 The total capital required capital for the recommended option (5a Eastbourne) is £12.4m, with capital expenditure phased over three financial between 2023/24 and 2025/6. Full implementation of the model of care is planned from quarter 4 2024/25.
- 5.6 This compares to a total capital required capital for option 5b Conquest of £13.9m, with capital expenditure phased over three financial years between 2023/24 and 2025/6. Full implementation of the model of care is planned from quarter 4 2025/26.
- 5.7 The levels of capital outlined in this case for the recommended option can be funded within the Integrated Care System’s Capital allocation, in agreement with system partners.

Legal implications:

- 5.8 NHS Sussex has a legal requirement under the NHS Act 2006 to ensure patients and the public are involved in service changes. Therefore, the Gunning Principles as outlined above have been followed.
- 5.9 This underpins the pre-consultation engagement and the public consultation processes that have been followed for this programme.
- 5.10 Our Pre-Consultation and Decision-Making Business Cases have demonstrated compliance with CCG and ICB statutory duties.

Other compliance

Data and Privacy Impact Assessment (DPIA)

- 5.11 The proposal has no impact or changes to what data would be processed nor how it would be processed. There would be no new or different organisations and/or providers involved in accessing and/or sharing patient information, and no new data processing systems would be utilised. No further Data Privacy Impact Assessment is, therefore, required.

NHSE/I Five Tests for service reconfiguration

- 5.12 Part of the evaluation of any service reconfiguration is the demonstration that five specific areas have been considered to determine the value of the project:
1. that service users and the public are involved in the development of the proposals
 2. whether any proposed redevelopment would maintain the availability of service user choice
 3. demonstration of sufficient clinical evidence and clarity on the case for change
 4. assurance that the proposals have the approval of local commissioners
 5. relates to any proposal including plans to significantly reduce hospital bed numbers
- 5.13 Full consideration has been given to these points and details of which have been included in our DMBC. In brief, the process has been clinically informed and led. Defining the vision for improved acute cardiology services across East Sussex involved a wide range of partners, these included service users, carers and their families, clinicians, including the service's workforce, and other local communities and key stakeholder organisations such as Healthwatch. Feedback collated from the pre-consultation engagement was provided to inform decision-making and a wide range of stakeholders were involved in the options development and appraisal process to ensure different perspectives could be heard and accounted for in the decisions made. There will be no reduction in bed numbers.

Risks

- 5.14 As an Integrated Care Board, we have in place a risk management process that facilitates effective recognition and management of risks. All risks are recorded on a central risk register, and they are regularly reviewed and monitored and escalated to the Integrated Care Board, when appropriate. New risks are added to the central risk register as they are identified. The Joint Cardiology and Ophthalmology Steering Board will continue with responsibility for managing risks to this programme, in line with its programme risk log, and these will be reported through the programme governance as required.

Quality and Safety implications

- 5.15 The aim of transforming these services is to deliver significant clinical improvements that will improve quality, outcomes and safety for patients.
- 5.16 The Quality Impact Assessment (QIA) has been completed in relation to the recommended option and in conjunction with the quality team. The QIA is a live document and has been re-iterated throughout each phase of the programme and shown to have positive impacts.

Equality, diversity, and health inequalities

- 5.17 ICBs have a duty to reduce inequalities between patients in respect to outcomes and access and this transformation has embedded health inequality considerations into the redesign process.
- 5.18 A Screening Equality and Health Inequalities Assessment (EHIA) was initially developed, followed by a full EHIA taking account of feedback from ICS colleagues and NHSE/I. This EHIA is a live document and has been re-iterated throughout each phase of the programme. Action from this has been undertaken, is reflected in the model of care, informed our public consultation and communications and engagement delivery plan, our site panel, and our communications plan post-decision.

Patient and public engagement

- 5.19 Following historical informal engagement, full pre-consultation engagement took place to understand what is important to local people. The information gathered during this engagement process informed our model of care and options appraisal process.
- 5.20 The transformation programme has been further informed by local people through our formal public consultation process, where the proposals were broadly welcomed with overall agreement on the proposed model of care, as there was recognition for the need to make changes to address challenges and deliver improvement to acute cardiology services.
- 5.21 In addition, our options development and appraisal process; our independently facilitated site panel included patients and patient representatives to inform our proposals as they have developed.
- 5.22 The feedback was helpful and a number of common themes were identified during the public consultation process, and initial actions in response to insight from the public consultation have included a review and update of the Quality Impact Assessment, Equality and Health Inequalities Impact Assessment, as well as updating of previous EHIA actions, and the establishment of a Travel and Transport Review Group, the actions of which have been, or are currently being, taken forward as part of the programme.

Health and wellbeing implications

- 5.23 The transformation of services in East Sussex is expected to improve access to care and health outcomes for our patient population, supporting the health and wellbeing agenda and reducing inequalities.

6 CONCLUSION

- 6.1 The process to develop these proposals has been comprehensive and the recommended model will deliver benefits for our local populations. We are proposing to improve services for the vast majority of patients who access cardiology services at both hospital sites, alongside consolidating our very specialist services onto a single site to improve clinical sustainability of these and the overall service, ensure future quality of clinical care and enable the introduction of Cardiac Response Teams and hot clinics at both sites. To make sure that the majority of patients receive good quality care close to home, outpatients, non-invasive diagnostics, cardiac monitored beds, cardiac rehabilitation and heart failure services will stay

at both hospitals or in the community. For the many patients who are referred to a consultant by their GP for non-urgent cases, they will continue to be seen in outpatient clinics, which will still be provided at both hospitals and some clinics in the community.

- 6.2 Through our engagement and options development and appraisal process we developed five potential model of care options. During the Pre-Consultation Business Case, and public consultation, with patients, the public and local stakeholders, the conclusion was to recommend the post-consultation proposal detailed in the Decision-Making Business Case. This is the same model of care that was appraised as the one that will best provide good patient experience, support improved outcomes for local people and a high-quality sustainable service that enables the model of care to be implemented that will realise these benefits and is deliverable, as part of our options development and appraisal and pre-consultation processes.
- 6.3 We recognise that this will represent a change for some people who currently use these services and we will continuously engage with local people and stakeholders throughout the implementation and evaluation processes to continue to understand the implications of our proposal. All new information and evidence gathered as part of an evaluation will inform how the final proposal is working.
- 6.4 Once a decision is confirmed, during any implementation and transition stages we will ensure that changes are communicated in a clear and timely manner. This would include working with local people and stakeholders to understand how best to provide easily accessible information to support local people and professionals about the changes, and to communicate the changes to existing services, the nature of new services and how to access them and to ensure people who use these services at East Sussex Healthcare NHS Trust continue to access the care and support they need.

7 RECOMMENDATIONS

- 7.1 Members of the Board are asked to **endorse** the following recommendations and **approve** their submission of their endorsement to NHS Sussex Integrated Care Board:
 - approve the post-consultation Decision-Making Business Case, specifically to:
 - form a Cardiac Response Team to support patients on their arrival at A&E, alongside 'hot clinics' that will provide consultant-led rapid assessment at both of our acute hospital sites.
 - co-locate the most specialist cardiac services, needed by a small number of patients, at Eastbourne District General Hospital. These specialist cardiac services include surgical procedures, investigations or treatments that might require access to a catheter laboratory, Coronary Care Unit or cardiology inpatient beds.
 - note the consultation findings, how these have informed the Decision-Making Business Case, and how they have resulted in the post-consultation proposal;
 - note and approve additional actions to further mitigate any potential adverse impacts of the post-consultation proposal on groups highlighted in the comprehensive Equality and Health Inequalities Impact Assessment (EHIA) that has been iterated throughout the

programme and was carefully considered in developing the final proposal, in particular as part of the site options appraisal process;

- note the East Sussex Health Overview and Scrutiny Committee's Review Board's recommendations have informed the Decision-Making Business Case and the above additional actions to further mitigate any potential adverse impacts on our local population
- approve the submission of the proposal for decision by the NHS Sussex Integrated Care Board
- note that the decision of the NHS Sussex Integrated Care Board will subsequently be submitted to the East Sussex Health Overview and Scrutiny Committee for their consideration.

Ophthalmology Transformation Programme

Meeting information:			
Date of Meeting:	11 th October 2022	Agenda Item:	8.2
Meeting:	Trust Board in Public	Reporting Officer:	Chief Executive

Purpose of paper: (Please tick)			
Assurance	<input type="checkbox"/>	Decision	<input checked="" type="checkbox"/>
Has this paper considered: (Please tick)			
Key stakeholders:		Compliance with:	
Patients	<input checked="" type="checkbox"/>	Equality, diversity and human rights	<input checked="" type="checkbox"/>
Staff	<input checked="" type="checkbox"/>	Regulation (CQC, NHSi/CCG)	<input checked="" type="checkbox"/>
		Legal frameworks (NHS Constitution/HSE)	<input checked="" type="checkbox"/>
Other stakeholders please state: NHSE/I, Clinical Senate, GPs, MPs, Healthwatch, SECamb (a full list of stakeholders can be found within the DMBC)			
Have any risks been identified (Please highlight these in the narrative below)	<input checked="" type="checkbox"/>	On the risk register? Yes	

Summary:

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

The purpose of this paper is to set out the process and outcomes that have informed the Decision-Making Business Case (DMBC) and to confirm the final proposals provide a model of care that will improve the ophthalmology services, their sustainability, and outcomes for the benefit of the local population.

This document also describes the wide engagement to date, including the public consultation, and the processes East Sussex Healthcare NHS Trust and NHS Sussex have followed in developing proposals, ensuring clinical assurance of the model, seeking wide engagement and feedback, and finalising proposals for decision-making.

The full DMBC will be published and is available to all Board members on request. It recommends one option to take forward for implementation, which, if approved by the Integrated Care Board, will be submitted to the East Sussex Health Overview Scrutiny Committee who will decide if they consider this to be in the best interests of the local population.

The model of care has been confirmed throughout the process as the right strategic proposal to improve ophthalmology services and outcomes for the local population and is supported by stakeholders across local communities. It remains unchanged from the previously approved pre-consultation business case. Services would deliver improvements for all local people with the development of one-stop clinics at both sites, Bexhill Hospital and Eastbourne District General Hospital, and a diagnostic eye hub at Bexhill Hospital.

When developing our options, our final draft proposals, the Pre-consultation Business Case and Decision-Making Business Case:

- We considered the outputs from engagement and consultation with local people and clinicians and used these to inform the Pre-Consultation Business Case and Decision-Making Business Case.
- We developed the Pre-Consultation and Decision-Making Business Cases with due regard to our duties to reduce inequalities and promote integration of health services where this will improve the quality of those services, in addition to ensuring compliance with all relevant equality duties.
- We assessed the impacts of our proposals by undertaking a Quality Impact Assessment and an Equality and Health Inequalities Impact Assessment to identify any potential negative impacts and identified appropriate mitigating actions.

- We commissioned an independent travel analysis to understand the impact of the proposals in this regard.
- We took into account the recommendations of the South East Clinical Senate.
- We considered opinions and insight from a number of service leads and managers within our acute hospitals in East Sussex that represent a broad range of clinical specialties.
- We were informed by feedback from the East Sussex Health Overview and Scrutiny Committee.
- We assessed our proposals against the NHS Four Tests for service reconfigurations.¹
- We undertook stage one and stage two process with NHSE to assure our plans prior to public consultation.
 - We developed our proposals and associated consultation plans in line with the Gunning Principles² to ensure that:
 - a decision would not be taken until after public consultation
 - local people and stakeholders had information that enabled them to engage in the consultation and inform our decision;
 - there was adequate time for people to participate in the consultation
 - we could demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this

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

- ESHT Executive Committee, 04.10.2022
- Non-Executive Directors Meeting, 29.09.2022
- Sussex Executive Committee (ExCo), 03.10.2022

Pending Committees:

- Sussex Integrated Care Board, 02.11.2022
- East Sussex Health Overview and Scrutiny Committee, 15.12.2022

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

The members of the Trust Board are asked to:

1. **Endorse** the following recommendations and **approve** the submission of the endorsement to NHS Sussex's Integrated Care Board:
 - a. approve the post-consultation Decision-Making Business Case; specifically to locate ophthalmology services at two hospital sites, Eastbourne District General Hospital and Bexhill Hospital, supported by one-stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital.
 - b. note the consultation findings, how these have informed the Decision-Making Business Case, and the post-consultation proposal;
 - c. note and approve additional actions to further mitigate any potential adverse impacts of the post-consultation proposal on groups highlighted in the comprehensive Equality and Health Inequalities Impact Assessment (EHIA) that has been iterated throughout the programme and was carefully considered in developing the final proposal;
 - d. note the East Sussex Health Overview and Scrutiny Committee's Review Board's recommendations have informed the Decision-Making Business Case and the above additional actions to further mitigate any potential adverse impacts on our local population
 - e. approve the submission of the proposal for decision by the NHS Sussex Integrated Care Board
 - f. note that the decision of the NHS Sussex Integrated Care Board will subsequently be submitted to the East Sussex Health Overview and Scrutiny Committee (HOSC) for their consideration.

¹ <https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf>

² <https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf>

Report to:	East Sussex Healthcare NHS Trust Board
Meeting date:	11 October 2022
Report Title:	Decision Making Business Case Summary for Ophthalmology Transformation at East Sussex Healthcare NHS Trust
Key question:	<p>The committee is recommended to review the outcome of the consultation and additional activity undertaken to support a recommendation on the ophthalmology cardiology model of care, and to confirm the committee members are satisfied that:</p> <ul style="list-style-type: none"> • This will deliver improved outcomes and experience for people in East Sussex • The clinical model has been confirmed as able to deliver high quality services in a sustainable way • The feedback from the public consultation has informed the final proposal • The equality health impact assessment and the quality impact assessment has been robustly undertaken and informed the proposal and planned implementation.
Sponsor:	<p>Richard Milner, Chief of Staff</p> <p>Jessica Britton, Executive Managing Director, East Sussex (Programme Sponsor)</p>
Author:	<p>Victoria Hill, Senior Planned Care Manager</p> <p>Michael Farrer, Head of Strategic Transformation</p>
Outcome/ action requested:	
<p>Members of the Board are asked to endorse the following recommendations and approve their submission of the endorsement to NHS Sussex Integrated Care Board:</p> <ul style="list-style-type: none"> • approve the post-consultation Decision-Making Business Case; specifically to locate ophthalmology services at two hospital sites, Eastbourne District General Hospital and Bexhill Hospital, supported by one-stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital. • note the consultation findings, how these have informed the Decision-Making Business Case, and the post-consultation proposal; • note and approve additional actions to further mitigate any potential adverse impacts of the post-consultation proposal on groups highlighted in the comprehensive Equality and Health Inequalities Impact Assessment (EHIA) that has been iterated throughout the programme and was carefully considered in developing the final proposal; • note the East Sussex Health Overview and Scrutiny Committee's Review Board's recommendations have informed the Decision-Making Business Case and the above additional actions to further mitigate any potential adverse impacts on our local population • approve the submission of the proposal for decision by the NHS Sussex Integrated Care Board 	

- note that the decision of the NHS Sussex Integrated Care Board will subsequently be submitted to the East Sussex Health Overview and Scrutiny Committee for their consideration.

Executive summary:

The purpose of this paper is to set out the process and outcomes that have informed the Decision-Making Business Case (DMBC) and to confirm the final proposals provide a model of care that will improve the ophthalmology services, their sustainability, and outcomes for the benefit of the local population.

This document also describes the wide engagement to date, including the public consultation, and the processes East Sussex Healthcare NHS Trust and NHS Sussex have followed in developing proposals, ensuring clinical assurance of the model, seeking wide engagement and feedback, and finalising proposals for decision-making.

The full DMBC will be published and is available to all committee members on request. It recommends one option to take forward for implementation (this is the same option upon which we consulted), which, if approved by the Integrated Care Board, will be submitted to the East Sussex Health Overview Scrutiny Committee who will decide if they consider this to be in the best interests of the local population.

The model of care has been confirmed throughout the process as the right strategic proposal to improve ophthalmology services and outcomes for the local population and is supported by stakeholders across local communities. It remains unchanged from the previously approved pre-consultation business case. Services would deliver improvements for all local people with the development of one-stop clinics at both sites, Bexhill Hospital and Eastbourne District General Hospital, and a diagnostic eye hub at Bexhill Hospital.

When developing our options, our final draft proposals, the Pre-consultation Business Case and Decision-Making Business Case:

- We considered the outputs from engagement and consultation with local people and clinicians and used these to inform the Pre-Consultation Business Case and Decision-Making Business Case.
- We developed the Pre-Consultation and Decision-Making Business Cases with due regard to our duties to reduce inequalities and promote integration of health services where this will improve the quality of those services, in addition to ensuring compliance with all relevant equality duties.
- We assessed the impacts of our proposals by undertaking a Quality Impact Assessment and an Equality and Health Inequalities Impact Assessment to identify any potential negative impacts and identified appropriate mitigating actions.
- We commissioned an independent travel analysis to understand the impact of the proposals in this regard.
- We took into account the recommendations of the South East Clinical Senate.
- We considered opinions and insight from a number of service leads and managers within our acute hospitals in East Sussex that represent a broad range of clinical specialties.
- We were informed by feedback from the East Sussex Health Overview and Scrutiny Committee.

- We assessed our proposals against the NHS Four Tests for service reconfigurations.¹
- We undertook stage one and stage two process with NHSE to assure our plans prior to public consultation.
- We developed our proposals and associated consultation plans in line with the Gunning Principles² to ensure that:
 - a decision would not be taken until after public consultation
 - local people and stakeholders had information that enabled them to engage in the consultation and inform our decision;
 - there was adequate time for people to participate in the consultation
 - we could demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this.

Trust Board governance and engagement pathway to date:

Org./Group/ Name	Date	Outcome
F&I Strategy Committee	26 November 2020	Case for change approved
Trust Board Meeting	13 April 2021	Update on engagement and workshops to develop options, and following HOSC update in March 2021
F&I Committee	26 August 2021	Progress update and approval to proceed, following PCBC draft and development, and clinical senate review.
Ophthalmology Deep Dive Presentation	8 September 2021	Following drafting of PCBC, and in readiness for NHSE/I Stage 2 Assurance.
Joint Sussex Committee	17 November 2021	The committee noted progress to date, including development of the PCBC and completion of a Stage 2 Assurance Check Point. The committee reviewed the summary PCBC, together with the EHIA and QIA and approved the case for consideration by the East Sussex Health Overview and Scrutiny Committee. The committee also endorsed the recommendation that the PCBC proposal should be subject to formal public consultation.
East Sussex Healthcare NHS Trust Board	30 November 2021	The Board noted progress to date, including development of the PCBC and completion of a Stage 2 Assurance Check Point. The Board reviewed the summary PCBC, together with the EHIA and QIA and endorsed the case for consideration by the Joint Sussex Committee and East Sussex Health Overview and Scrutiny Committee.

¹ <https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf>

² <https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf>

East Sussex Health Overview and Scrutiny Committee	2 December 2021	The committee noted progress to date, including development of the PCBC and completion of a Stage 2 Assurance Check Point. The committee reviewed the summary PCBC, together with the EHIA and QIA. The committee also considered the proposal to be a substantial variation, and therefore asked that the programme consulted with East Sussex Health Overview and Scrutiny Committee.
Formal public consultation	6 December 2021 – 11 March 2022	Opportunity for the programme to set out the quality improvements anticipated from the proposed transformation, together with the site options The consultation included virtual public meetings, stakeholder events and face-to-face listening events, and included a wide range of activities including a focus on groups identified by the Equality and Health Inequalities Impact Assessment (EHIA).
Consultation with East Sussex HOSC	April-June 2022	A HOSC Review Board was set up to consider the proposals, consultation process and interim consultation feedback, which met on four occasions before reporting to the full Committee on 30 June 2022 where they agreed their response to the NHS, together with recommendations.
Strategy Committee	23 June 2022	Update following the HOSC Review Board
NHS Sussex Executive Committee	3 October 2022	The committee noted progress to date, including the feedback from the public consultation, and the development of the DMBC. The Board reviewed the summary DMBC, and endorsed the case for consideration by the NHS Sussex ICB and East Sussex Health Overview and Scrutiny Committee.
East Sussex Healthcare NHS Trust Board	11 October 2022	The Board noted progress to date, including the feedback from the public consultation, and the development of the DMBC. The Board reviewed the summary DMBC, and endorsed the case for consideration by the NHS Sussex ICB and East Sussex Health Overview and Scrutiny Committee.

What happens next?

Following approval by the NHS Sussex ICB, this will be submitted to the East Sussex Health Overview and Scrutiny Committee for approval that this decision is in the best interests of our local population.

Milestone	Date
Final Decision-Making Business Case Summary submitted to the Sussex Integrated Care Board	2 November 2022

East Sussex Health Overview and Scrutiny Committee Meeting to review the post-consultation decision made by the Sussex Integrated Care Board	15 December 2022
Communications and public messaging confirming our decision	December 2022-March 2023
Designing	July-November 2022
Planning	September 2022-February 2023
Procurement and Contracting process	January-March 2023
X-ray services currently at Bexhill to be moved into new Community Diagnostic Centre(s)	March-April 2023
Construction of Bexhill car park expansion	April-September 2023
Refurbishment of existing clinical space in Bexhill	April-September 2023
Reprovision of physiotherapy and x-ray clinical space in Bexhill for ophthalmology	May-October 2023
Procurement and installation of equipment	September-November 2023
Full implementation	December 2023-May 2024
Evaluation – review implementation and benefits realisation	June 2024

Decision Making Business Case Summary for Ophthalmology Transformation at East Sussex Healthcare NHS Trust

1 CONTEXT

- 1.1 NHS Sussex works in partnership with health and care organisations across Sussex as part of our Integrated Care System. Our aim is to ensure better health and care for all now and in the future. Our ambition is for every person living in Sussex to have access to the best health and care from the moment they are born and throughout their lives. We want:
- People to live for longer in good health.
 - To reduce the gap in life expectancy between people living in the most and least disadvantaged communities.
 - People's experience of using services to be better.
 - Staff to feel supported and work in a way that makes the most of their dedication, skills and professionalism.
 - The cost of care to be affordable and sustainable in the long term.
- 1.2 Our proposals sit within this context and focus on the improvement of hospital-based cardiology services to benefit our population in East Sussex. We want to ensure sustainable services into the future. This means that there is a focus on expanding services within local communities and recognising that for some of our more specialist services, consolidating these in one place will ensure the retention of this specialist expertise within East Sussex in a way that offers the best outcomes for local people. Our commitment to two thriving district general hospital sites, both with A&E departments and a wide range of services, is supported by specialist services at one or other site in order to deliver the best outcomes for patients.

East Sussex Healthcare NHS Trust Services

- 1.3 East Sussex Healthcare NHS Trust has made significant improvements for patients and local residents in recent years. The Trust is rated 'good' by the CQC, with several 'outstanding' services and has ambitious plans for the future, enabling residents to access the best care in the most appropriate place: at home; in the community; or when they need to come into hospital.
- 1.4 As an integrated acute and community provider, an important part of the trust's five-year strategy to best meet the healthcare needs of our population is to increase and improve the care provided outside of hospital. This means being proactive in supporting the health of local residents, preventing avoidable hospital visits and stays, improving patient outcomes and experience and making better use of resources. This has helped the trust to focus their hospitals to build on their strengths while improving how services work together across the whole health and care system.
- 1.5 The trust has two acute hospital sites, Conquest Hospital, Hastings and Eastbourne District General Hospital. Both sites provide urgent and emergency services, along with specialist acute medical and intensive care units. The trust is focused on driving innovation and best

practice. This will improve services across East Sussex and is particularly suited to the population the hospital serves. A number of services are located solely or primarily at one or other of our acute sites, Conquest Hospital and Eastbourne District General Hospital.

1.6 The Conquest Hospital is home to the trust's main theatres and therefore looks after most specialist surgical services, like general, vascular and orthopaedic surgery, and patients needing closer medical monitoring and support when giving birth. This includes:

- Main Theatres
- Majority of Surgical Specialties, such as:
 - General Surgery
 - Vascular Surgery
 - Orthopaedic Surgery
- Designated Trauma Centre
- Specialist Maternity Services, including consultant led services and specialist Obstetrics and Gynaecology Services
- More anaesthetic and Intensive Care Unit (ICU) provision to support the theatres and surgical services
- Specialist Inpatient paediatrics
- Sleep Studies (Respiratory Physiology)

1.7 Eastbourne District General Hospital looks after the most serious stroke cases, patients needing inpatient diabetes care, day case eye surgery, and a diabetic foot service. There are also inpatient endocrinology beds and the trust's urology service, which includes recent investment in a dedicated investigation suite, robotic surgery and non-invasive treatment for kidney stones. The services include:

- Stroke Services, including a Hyper Acute Stroke Unit
- Ophthalmology Jubilee Eye Suite, a day case theatre. *Note: Other Day Cases for Ophthalmology are undertaken at Bexhill Hospital.*
- Urology, including a Urology Investigation Suite, Robotic Surgery, and Lithotripsy
 - Specialist Medicine Services including specialist endocrine and diabetic inpatient beds.
- Cardiology Electrophysiology
- Endobronchial ultrasound for respiratory
- Diabetic Foot service.

2 INTRODUCTION

2.1 The purpose of the Decision-Making Business Case (DMBC) is to describe the final proposals to provide a model of care that will improve the ophthalmology services, their sustainability, and outcomes for the benefit of the local population. It describes the evidence base, the process for the development of the proposals, quality and equality impact assessment and details key enablers such as workforce and finance.

2.2 This document also describes the wide engagement to date, including the public

consultation, and the processes East Sussex Healthcare NHS Trust and NHS Sussex have followed in developing proposals, ensuring clinical assurance of the model, seeking wide engagement and feedback, and finalising proposals for decision-making.

- 2.3 The full DMBC will be published and is available to all committee members on request. It recommends one option to take forward for implementation, which, if approved by the Integrated Care Board, will be submitted to the East Sussex Health Overview Scrutiny Committee who will decide if they consider this to be in the best interests of the local population.
- 2.4 The DMBC follows the approved Pre-Consultation Business Case and subsequent formal public consultation and shows how all available information and evidence has been considered, together with feedback captured from the public consultation. This has informed the final proposal to transform ophthalmology services that has been developed by NHS Sussex, in partnership with the East Sussex Healthcare NHS Trust (ESHT). Approval of this proposal will enable the transformation to be fully implemented within the timeframe outlined, by December 2023. Early implementation of some elements of the model will be sooner than this, in order to realise quality benefits as quickly as possible.
- 2.5 The document provides a summary of the context and of the case for change as outlined in the Pre-Consultation Business Case. It also provides an analysis of the feedback received from the public consultation and the consultation with the East Sussex Health Overview and Scrutiny Committee, and the updated post-consultation proposal that has been informed by the feedback received from local people and stakeholders during the consultation process.
- 2.6 There was broad recognition for the need to make changes to address challenges and deliver improvement, and broad agreement on the proposed model of care across the public consultation feedback. NHS Sussex recognises the importance of access to services and has carefully and systematically analysed the consultation outcomes and balanced it with evidence that has been collected since the Pre-Consultation Business Case (PCBC) and in response to the consultation. This process informed NHS Sussex's considerations during the Decision-Making Business Case (DMBC) development process in order to ensure consultation feedback informs final proposals.
- 2.7 The model of care has been confirmed throughout the process as the right strategic proposal to improve ophthalmology services and outcomes for the local population and is supported by stakeholders across local communities. It remains unchanged from the previously approved pre-consultation business case. Services would deliver improvements for all local people with the development of one-stop clinics at both sites, Bexhill Hospital and Eastbourne District General Hospital, and a diagnostic eye hub at Bexhill Hospital. Outpatient and day case surgery that currently takes place at Conquest will be moved to Bexhill. Emergency and general anaesthetic surgical ophthalmology cases (including cases which require overnight stay) will continue to be at Conquest Hospital: these services will not be affected by these proposals.
- 2.8 The approved PCBC upon which we consulted was very clear as to why Bexhill Hospital was preferred rather than the Conquest Hospital. This was detailed as part of a full options appraisal in the PCBC explaining the limitations of current theatre capacity at Conquest; ophthalmology not having clinical interdependencies that mean that it can be sited at Bexhill

whilst other specialities could not; adapting the Conquest site would be prohibitively costly in terms of capital requirements; and there are physical space limitations that would make it difficult to expand and build the infrastructure required.

- 2.9 In summary, the proposal is to improve the services at both hospital sites through forming one-stop clinics, and at Bexhill Hospital through forming a diagnostic eye hub, both of which will provide rapid assessment for patients which will reduce waiting times and the number of appointments needed. It demonstrates that we believe this is the right strategic proposal to improve ophthalmology services for the local population and is supported by stakeholders across local communities.
- 2.10 The proposed transformation, with the one-stop clinics and diagnostic eye hub, will make key quality improvements to the service, such as:
- enable a redesigned ophthalmology pathway that will increase quality of care ensuring patients are seen by the right person, in the right place, and at the right time
 - ensure that we can better meet service standards so that patients receive care in a timely manner, meaning faster diagnosis, shorter waiting times, fewer repeat appointments for tests and therefore less travelling for patients
 - provide a consultant-led model of working that efficiently utilises skill mix across the workforce and provides training opportunities
 - ensure staff and expert knowledge are consolidated, allowing for improved supervision and opportunities for training and educational needs for staff who wish to upskill. Thereby, gradually improving the skills in the workforce to improve the service quality and care provided to our population.
- 2.11 This proposal will have positive impacts for our patients, as well as workforce, and will improve patient experience, patient outcomes and our performance against national standards in the long term by reducing waiting times alongside repeated travel for patients, whilst making the service more efficient and sustainable for the future. It also supports the wider Sussex Ophthalmology plan enabling future training and supervision from ophthalmology consultants to upskill the community Optometry workforce.

3 CONSIDERATIONS

- 3.1 The Case for Change was developed by a wide range of stakeholders including clinicians, operational staff and experts by experience. It was recognised that the current service is unsustainable. We have reviewed the strategic drivers for change and the existing ophthalmology services. This led us to the following conclusions:
- Quality: healthcare systems are required to minimise the risk of significant harm, through delivering timely follow-up for patients with chronic conditions. The high and growing number of these cases within ophthalmology makes this a challenge.
 - Service performance: nationally, ophthalmology outpatient services are the largest of all outpatient services that people use, with East Sussex Healthcare NHS Trust seeing

18,075 new outpatients and 65,511 follow-up appointments in 2019-2023. The Covid-19 pandemic has impacted heavily on ophthalmology provision and this, coupled with the very high levels of need for care, has led to East Sussex Healthcare NHS Trust no longer meeting national waiting time standards.

- Growing need: It is estimated that, over the next 20 years, the need for cataract services will rise by 50%, glaucoma cases by 44% and medical retina by 20%.
- IT / Digital: making the best possible use of modern digital technology in ophthalmology services would be a significant benefit to patients, for example Electrical Eyecare Referral System (EERS)⁴. Modern technology presents opportunities to improve patient pathways and better manage the growing need for ophthalmology services. This system will improve patient safety, deliver eye care more efficiently and effectively, and facilitate other improvements for optometrists and dispensing opticians who work with hospital colleagues. This includes the development and improvement of communication, advice and guidance, feedback, shared care, discharge to primary care and supporting extended primary eye care services.
- Workforce: a census carried out by the Royal College of Ophthalmologists (RCOphth) in 2019 identifies gaps in recruitment for ophthalmologists and workforce planning, amid a predicted 40% increase in need for ophthalmology services over the next 20 years.
- Net Zero NHS: the NHS is committed to reach net zero carbon by 2050 which means we need to significantly reduce carbon emissions caused by procedures, travel, estates, etc. The NHS Long Term Plan encourages service delivery to happen virtually, where appropriate.
- Estates and equipment: diagnosis and monitoring of ophthalmic patients is highly dependent on equipment. Much of the equipment currently used by the department across its three sites is old, which impedes the service's ability to work efficiently and effectively. There are limitations of physical space in the current service configuration limiting the capacity of the service to meet the current and growing need of the local population which contributes to challenges in meeting service standards.
- Making best use of our resources: we want to ensure that our services are delivered in a way that gives the greatest benefit for local people.
- The national Getting it Right First Time (GIRFT)⁵ programme reviewed the ophthalmology service in March 2018. It was recommended that:
 - Review pre-assessment clinics and review/audit coding for complex cataracts to ensure the patient pathway for cataract surgery is optimised.
 - Continue to develop health care professional staff by training and developing all members of the multi-disciplinary team, whilst utilising competency frameworks to increase the number of non-consultant clinical staff.
 - Look into using consultant-led and technician-provided virtual clinics for age-related macular degeneration (AMD) and glaucoma to improve refinement of treatment plans.

³ 2019-20 has been used throughout our Pre-Consultation Business Case, public consultation and Decision Making Business Case as the last full year of data that was not skewed by the Covid-19 pandemic.

⁴ An Electronic Eyecare Referral System is essentially shorthand for a secure, electronic system for the two-way transfer of patient and clinical data (including images) between eye care services (and with GPs).

⁵ The Getting It Right First Time (GIRFT) programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.

- Review of coding practices to ensure accuracy, particularly around complex cataracts, corneal grafts, strabismus follow-ups and vitreo-retinal conditions.
- Continue to refer to the Royal College of Ophthalmologist's "The Way Forward"⁶ document to identify options to help meet demand and the Common Competency Framework to support health care professional staff development.

3.2 As a result, the Decision-Making Business Case proposes changes to a range of ophthalmology services provided by East Sussex Healthcare NHS Trust.

Covid-19 Pandemic

- 3.3 In response to Covid, East Sussex Healthcare NHS Trust had to reconfigure their hospital services to ensure they operated in a safe manner and also increased the number of beds available for Covid patients. With adult and paediatric ophthalmology services operating at a reduced level of capacity, the service was moved to operate solely from Bexhill during the first peak with particular focus on urgent services. This was also important from the perspective of infection, prevention and control and services responding to the pandemic. With its staff together at one location it enabled the department to deliver whole-team training events for its staff and learn from different ways of arranging services that had not been previously explored.
- 3.4 The requirement of the service to respond to the needs of local people in a different way during the early stages of the Covid response, coupled with the service being temporarily consolidated on one site, led to the service working in new ways including new diagnostic pathways and virtual clinics. Feedback from the service is that working in this way has been positive, improving the working relationships of the team through improved communication, and more supervision and support for junior staff.

4 PROCESS TO DATE

Our Case for Change and developing our Pre-Consultation Business Case

- 4.1 Following analysis of the current service provision and the emerging future needs of local people, we developed a Case for Change that outlined the key drivers for service transformation. This provided the basis for our engagement with local people, clinicians and other professionals to further understand what is important to them about ophthalmology services. This initial engagement indicated several key themes as important to local people:
- Care provided
 - Equality and diversity
 - Access and transport
 - Clinical services
 - Community optometry.

⁶ The Royal College of Ophthalmologists, 2016, *The Way Forward*

- 4.2 Alongside finding out what is important to local people and clinicians, we reviewed local health needs in East Sussex. This told us that there are some groups of local people who have particular needs and may be disadvantaged in accessing current services. We took account of these needs in our proposals and sought to mitigate those disadvantages through the proposals outlined in the Pre-Consultation Business Case (more detail on this can be found in Appendix 1 and Appendix 2 of the Decision-Making Business Case).
- 4.3 Following pre-consultation engagement, three options development and appraisal workshops (independently chaired and facilitated by Opinion Research Services - ORS⁷) took place, during March 2021, to identify and consider a longlist of possible options for the future provision of acute ophthalmology services, including sites where the service would be delivered from, to appraise these options and make recommendations for preferred viable options.
- 4.4 Following this, and as part of our in-depth comparative analyses for the Pre-Consultation Business Case, we also reviewed quality indicators, travel analysis, the impact this transformation could have on other services within Sussex and outside of Sussex, the impact this transformation could have on the equality and health inequalities of our population, and the financial feasibility of each option.
- 4.5 A Pre-Consultation Business Case was developed to make the case for change and set out the plans for a Public Consultation around the transformation of ophthalmology services at East Sussex Healthcare NHS Trust. It was approved by East Sussex CCG and East Sussex Healthcare NHS Trust, on 17 and 30 November 2021 respectively, and submitted to the East Sussex Health Overview and Scrutiny Committee on 2 December 2021 prior to formal public consultation. An independent report on the findings of the consultation has been produced and this report presents the feedback from those who participated in the consultation. This is found at Appendix 3 of the DMBC.
- 4.6 When developing our options, our final draft proposals, the Pre-consultation Business Case and Decision-Making Business Case:
- We considered the outputs from engagement and consultation with local people and clinicians and used these to inform the Pre-Consultation Business Case and Decision-Making Business Case.
 - We developed the Pre-Consultation and Decision-Making Business Cases with due regard to our duties to reduce inequalities and promote integration of health services where this will improve the quality of those services, in addition to ensuring compliance with all relevant equality duties.
 - We assessed the impacts of our proposals by undertaking a Quality Impact Assessment and an Equality and Health Inequalities Impact Assessment to identify any potential negative impacts and identified appropriate mitigating actions.
 - We commissioned an independent travel analysis to understand the impact of the proposals in this regard.
 - We took into account the recommendations of the South East Clinical Senate.

⁷ Opinion Research Services is a social research organisation, whose mission is to provide applied social research for public, voluntary and private sector organisations across the UK.

- We considered opinions and insight from a number of service leads and managers within our acute hospitals in East Sussex that represent a broad range of clinical specialties.
- We were informed by feedback from the East Sussex Health Overview and Scrutiny Committee.
- We assessed our proposals against the NHS Four Tests for service reconfigurations.⁸
- We undertook stage one and stage two process with NHSE to assure our plans prior to public consultation.
- We developed our proposals and associated consultation plans in line with the Gunning Principles⁹ to ensure that:
 - a decision would not be taken until after public consultation
 - local people and stakeholders had information that enabled them to engage in the consultation and inform our decision;
 - there was adequate time for people to participate in the consultation
 - we could demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this.
 - we could demonstrate how we have taken account of engagement and formal consultation by publication of a consultation feedback report describing this.

Public Consultation

- 4.7 The formal public consultation into the proposal to transform ophthalmology services at East Sussex Healthcare NHS Trust began on 6 December 2021 and ended on 11 March 2022. It set out the quality improvements anticipated from the proposed transformation, together with the site options. Opinion Research Services (ORS), was appointed to advise on, independently manage and report on the public consultation programme of engagement with service users, their families and carers, clinicians and other NHS staff and other stakeholders. The full report is Appendix 3 of the Decision-Making Business Case.
- 4.8 The consultation included virtual public meetings, stakeholder events and face-to-face listening events, and included a wide range of activities including a focus on groups identified by the Equality and Health Inequalities Impact Assessment (EHIA).
- 4.9 A number of common themes were identified during the public consultation process. These included:
- Travel and access, for example:
 - Older people and families with young children, people with significant visual impairment, particularly those with macular degeneration who require regular and frequent treatment;
 - People with other disabilities and long-term conditions or additional needs;
 - People with low incomes and from deprived communities – particularly those living in and around Hastings – and anyone without access to a private vehicle.

⁸ <https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf>

⁹ <https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf>

- Potential loss of services from Conquest Hospital
- Buildings at Bexhill Hospital were reported to be older with poorer accessibility and facilities
- Sufficient investment required to develop Bexhill site.

Key actions following public consultation

- 4.10 Alongside public consultation, East Sussex HOSC established a Review Board to carry out a detailed review of the proposals and produce a report and recommendations on behalf of the Committee. In addition, following feedback from the public consultation regarding travel and access, we established a Travel and Transport Review Group to review our developing proposals and make recommendations. The feedback from the HOSC Review Board and the Travel and Transport Group are outlined below, followed by the recommendations and associated planned action.

Engagement with East Sussex Health Overview and Scrutiny Committee (HOSC) – HOSC Review Board

- 4.11 The Review Board carried out its review between April and June 2022. A full report (Appendix 4 of the DMBC), sets out the evidence the Board considered, along with its conclusions and recommendations. The East Sussex HOSC was presented with the Review Board's report, findings and recommendations at their meeting on 30 June 2022, where it was approved by the membership. The recommendations made by the East Sussex HOSC were as follows:
1. The Committee endorsed the reasons for reconfiguring ophthalmology including:
 - Clinical case for change and the potential for new services to improve patient care and experience.
 - The creation of the 'Centre of Excellence' diagnostic hub, one-stop clinics, and measures to support staff recruitment and retention.
 2. The Committee noted the proposed choice of the Bexhill Hospital to consolidate ophthalmology services and recommended that mitigation measures are put in place to address the concerns about travel and access to this site, such as:
 - increasing and maximising the number of on-site parking spaces at the Bexhill Hospital site.
 - ongoing monitoring of Did Not Attend (DNA) information is undertaken after implementation of the proposals to establish the reasons why patients do not attend appointments and review the travel and access mitigations in light of this information. It was reported that Bexhill Hospital had the fewest number of patients that Did Not Attend.
- 4.12 The HOSC Review Board carefully considered the clinical case for change and the anticipated benefits for patients from the proposed service reconfiguration. The Review Board also examined the proposed choice of the Bexhill Hospital site for the consolidation of some services serving the east of the county, and noted that the Bexhill site presents a number of challenges for travel and access to services based there.

- 4.13 On balance, the HOSC Review Board considered that the proposed changes to the ophthalmology services in East Sussex are in the best interests of patients, but asked that adequate mitigations be put in place to address the travel and access issues that were identified.
- 4.14 These recommendations have been taken into account and further details on how these have addressed, for our post-consultation proposal and as part of the development of the Decision-Making Business Case, can be found in section 6 of the DMBC.
- 4.15 Initial actions in response to insight from the public consultation included a review and update of the Quality Impact Assessment, Equality and Health Inequalities Impact Assessment, as well as updating of previous EHIA actions, and the establishment of a Travel and Transport Review Group.

Travel and Transport Review Group

- 4.16 During the public consultation, travel and transport (public and private transport, including access and parking) were raised by many respondents as issues to be addressed. Therefore, we established a Transport and Travel Review Group to consider the issues raised.
- 4.17 The group was tasked with reviewing findings from the pre-consultation engagement processes, options development and appraisal processes, Equality and Health Inequalities Impact Assessment (EHIA), the Public Consultation, as well as independent travel analysis carried out by external consultants, and considering the conclusions to make suggestions and recommendations on possible transport solutions for those who may be affected by the proposed service change.
- 4.18 People responding to the consultation identified key groups who may be adversely affected by transport and travel impacts created by the proposals, e.g. some people having to travel further to see their loved ones and some staff having longer journeys to work. Alongside this, respondents made some suggestions, e.g. to work with authorities in relation to public transport, consider parking, consider financial reimbursement.
- 4.19 Following the review outlined above including insight from the public consultation, the Travel and Transport Review Group made several recommendations some for implementation and some for further investigation. These are outlined in section 4.3.3.

Recommendations and associated action/action plans from HOSC Review Board and Travel and Transport Review Group

- 4.20 The HOSC Review Board and the Travel and Transport Review Group made a range of recommendations which have been taken account of as we have developed our proposals and our developing draft mobilisation planning (subject to decision making). These key recommendations were focused on travel and transport and included providing travel support for local people; the introduction of Travel Liaison Officer at East Sussex Healthcare NHS Trust; improved parking at Bexhill Hospital; improved communication about travel options;

liaising with patients about their individual travel and access needs; supporting patients with information and processes about accessing financial reimbursement where eligible; improving information for patients about alternative transport options and exploring over the longer-term improvements to public transport; and measures to support recruitment and retention of staff.

4.21 In response to these recommendations, some have been implemented and others have been committed to and we are progressing them as this programme continues and we implement our proposals. A summary is provided below:

- The programme has committed to improve car parking on the Bexhill Hospital site. This has been included in our final proposals to ensure it is implemented in line with this transformation
- The establishment of a travel and transport liaison officer has been committed to by the Trust and will be implemented alongside these proposals
- Work has taken place within the Trust to ensure information provided via its website, patient letters and patient information leaflets is clear for patients around travel, transport and access options and parking to its various sites. This work will continue to be reviewed and updated as additional actions and recommendations are addressed
- Work has taken place to ensure staff are aware of travel opportunities, such as Trust schemes, are promoted and this will be included in staff messages on a frequent basis
- Work has taken place with ICS colleagues to understand learning around travel arrangements for the recent vaccination programme
- A commitment has been made to monitor staff recruitment and retention measures and these have been included in the Key Performance Indicators (KPIs) of this programme
- As part of the upcoming communications plan, post decision, further work will take place to ensure information around the changes will be shared with our local stakeholder and population, including a Frequently Asked Questions document
- Working with Trust and primary care colleagues to ensure individual needs of patients are recognised and taken account of when booking appointment and procedures, along with clear communications to patients to raise awareness of the options available to them
- Work is in progress to compile a directory of any, and all, transport services, including community, volunteer and charity organised services, and their eligibility criteria where necessary, that patients could be signposted to
- Work with voluntary, community and social enterprise and patient representatives to ensure changes to services and facilities is co-designed.
- Consideration by the Trust of a long-term travel and transport strategy.

4.22 There are also a number of recommendations which are being explored by the wider NHS Sussex system, as these do not solely relate to cardiology patients who attend East Sussex Healthcare NHS Trust, such as:

- Exploring the options for a pilot shuttle bus service
- Working with NHS colleagues on additions to the Non-Emergency Transport Service (NEPTS), such as a digital tracking element and eligibility criteria
- Working with local authority and public transport providers on and potential future

services.

Plans for implementation

- 4.23 This Decision-Making Business Case presents the public consultation feedback together with additional information and evidence that have been collated as part of the document’s development and in response to the consultation. The purpose of the Decision-Making Business Case is to enable and support the NHS Sussex Integrated Care Board’s decision-making process.
- 4.24 Once the post-consultation proposal is supported and the Decision-Making Business Case is formally approved through our governance process, we will enact our implementation plan from December 2022 for full implementation in December 2023, although early implementation of some elements of the model will be sooner than this, in order to realise quality benefits as quickly as possible.

Decision-making

- 4.25 The purpose of the Decision-Making Business Case is to ensure that the proposals have been consulted upon, are clinically sound, financially viable, and in line with the improved outcomes agreed in the Pre-Consultation Business Case. The final decision will rest with NHS Sussex, with a recommendation also from East Sussex Healthcare NHS Trust, whose respective decisions will be made at meetings in public.
- 4.26 Following the decision by NHS Sussex, the outcome will be submitted to the East Sussex Health Overview and Scrutiny Committee who will consider if the change is in the best interests of the local population.

5 IMPLICATIONS

Financial implications:

- 5.1 There would be a positive financial impact on the Trust of implementing the changes outlined, this is as a result of implementing best practice and benefiting from resulting economies of scale.

Revenue

- 5.2 The case shows that under co-location there will be net efficiency savings, which takes into account the cost of capital, resulting in a favourable revenue position from year 2 for the preferred option (two sites).

£'000	Yr1	Yr2	Yr3	Yr4	Yr5	Yr6	Yr7	Yr8	Yr9	Yr10
Preferred Option vs. Do Nothing	(85)	49	232	427	658	902	1,160	1,433	1,692	1,959

Capital

- 5.3 The total capital required for the recommended option is £3.5m, with capital expenditure phased over two financial years between 2022/23 and 2023/24. Full implementation of the model of care is planned from quarter 3 2023/24.
- 5.4 The levels of capital outlined in this case for the recommended option can be funded within the Integrated Care System's capital allocation, in agreement with system partners.

Legal implications:

- 5.5 NHS Sussex has a legal requirement under the NHS Act 2006 to ensure patients and the public are involved in service changes. Therefore, the Gunning Principles as outlined above have been followed.
- 5.6 This underpins the pre-consultation engagement and the public consultation processes that have been followed for this programme.
- 5.7 Our Pre-Consultation and Decision-Making Business Cases have demonstrated compliance with CCG and ICB statutory duties.

Other compliance:

Data and Privacy Impact Assessment (DPIA)

- 5.8 The proposal has no impact or changes to what data would be processed nor how it would be processed. There would be no new or different organisations and/or providers involved in accessing and/or sharing patient information, and no new data processing systems would be utilised. No further Data Privacy Impact Assessment is, therefore, required.

NHSE/I Five Tests for service reconfiguration

- 5.9 Part of the evaluation of any service reconfiguration is the demonstration that five specific areas have been considered to determine the value of the project:
 - 1. that service users and the public are involved in the development of the proposals
 - 2. whether any proposed redevelopment would maintain the availability of service user choice
 - 3. demonstration of sufficient clinical evidence and clarity on the case for change
 - 4. assurance that the proposals have the approval of local commissioners
 - 5. relates to any proposal including plans to significantly reduce hospital bed numbers
- 5.10 Full consideration has been given to these points and details of which have been included in our DMBC. In brief, the process has been clinically informed and led. Defining the vision for improved ophthalmology services across East Sussex involved a wide range of partners, these included service users, carers and their families, clinicians, including the service's workforce, and other local communities and interested organisations such as Healthwatch. Feedback collated from the pre-consultation engagement was provided to inform decision-making and a wide range of stakeholders were involved in the options development and

appraisal process to ensure different perspectives could be heard and accounted for in the decisions made. There will be no reduction in bed numbers.

Risks

- 5.11 As an Integrated Care Board, we have in place a risk management process that facilitates effective recognition and management of risks. All risks are recorded on a central risk register, and they are regularly reviewed and monitored and escalated to the Integrated Care Board, when appropriate. New risks are added to the central risk register as they are identified. The Joint Cardiology and Ophthalmology Steering Board will continue with responsibility for managing risks to this programme, in line with its programme risk log, and these will be reported through the programme governance as required.

Quality and Safety implications

- 5.12 The aim of transforming these services is to deliver significant clinical improvements that will improve quality, outcomes and safety for patients.
- 5.13 The Quality Impact Assessment (QIA) has been completed in relation to the recommended option and in conjunction with the quality team. The QIA is a live document and has been re-iterated throughout each phase of the programme and shown to have positive impacts.

Equality, diversity, and health inequalities

- 5.14 ICBs have a duty to reduce inequalities between patients in respect to outcomes and access and this transformation has embedded health inequality considerations into the redesign process.
- 5.15 A Screening Equality and Health Inequalities Assessment (EHIA) was initially developed, followed by a full EHIA taking account of feedback from ICS colleagues and NHSE/I. This EHIA is a live document and has been re-iterated throughout each phase of the programme. Action from this has been undertaken, is reflected in the model of care, informed our public consultation and communications and engagement delivery plan, and our communications plan post-decision.

Patient and public engagement:

- 5.16 Following historical informal engagement, full pre-consultation engagement took place to understand what is important to local people. The information gathered during this engagement process informed our model of care and options appraisal process.
- 5.17 The transformation programme has been further informed by local people through our formal public consultation process, where the proposals were broadly welcomed with overall agreement on the proposed model of care, as there was recognition for the need to make changes to address challenges and deliver improvement to ophthalmology services.
- 5.18 The feedback was helpful, and a number of common themes were identified during the public consultation process, and initial actions in response to insight from the public consultation have included a review and update of the Quality Impact Assessment, Equality

and Health Inequalities Impact Assessment, as well as updating of previous EHIA actions, and the establishment of a Travel and Transport Review Group, the actions of which have been, or are currently being, taken forward as part of the programme and when informing our final Decision Making Business Cases and recommendations, as summarised in section 2 above.

Health and wellbeing implications:

- 5.19 The transformation of services in East Sussex is expected to improve access to care and health outcomes for our patient population, supporting the health and wellbeing agenda and reducing inequalities.

6 CONCLUSION

- 6.1 The process to develop these proposals has been comprehensive and the recommended model will deliver benefits for our local populations. Services would deliver improvements for all local people with the development of one-stop clinics at both sites, Bexhill Hospital and Eastbourne District General Hospital, and a diagnostic eye hub at Bexhill Hospital. Outpatient and day case surgery that currently takes place at Conquest will be moved to Bexhill. Emergency and general anaesthetic surgical ophthalmology cases (including cases which require overnight stay) will continue to be at Conquest Hospital: these services will not be affected by these proposals. The introduction of one-stop clinics and a diagnostic eye hub will ensure faster diagnosis, reduce waiting times, reduce number of appointments required for patients to attend and repeated tests. These are key quality improvements to the ophthalmology service.
- 6.2 To deliver this model of care we need to bring staff together across a range of disciplines into multidisciplinary teams and the proposal enables the physical space for these staff to work together in this way. This also improves access to senior decision making and input when it is required in relation to patient care so that patients will see the right people at the right time and reducing repeat attendances.
- 6.3 Through our engagement and options development and appraisal process we developed five potential model of care options. During the Pre-Consultation Business Case, and public consultation, with patients, the public and local stakeholders, the conclusion was to recommend the post-consultation proposal detailed in the Decision-Making Business Case. This is the same model of care that was appraised as the one that will best provide good patient experience, support improved outcomes for local people and a high-quality sustainable service that enables the model of care to be implemented that will realise these benefits and is deliverable, as part of our options development and appraisal and pre-consultation processes.
- 6.4 We recognise that this will represent a change for some people who currently use these services and we will continuously engage with local people and stakeholders throughout the implementation and evaluation processes to continue to understand the implications of our proposal. All new information and evidence gathered as part of an evaluation will inform how

the final proposal is working.

- 6.5 Once a decision is confirmed, during any implementation and transition stages we will ensure that changes are communicated in a clear and timely manner. This would include working with local people and stakeholders to understand how best to provide easily accessible information to support local people and professionals about the changes, and to communicate the changes to existing services, the nature of new services and how to access them and to ensure people who use these services at East Sussex Healthcare NHS Trust continue to access the care and support they need.

7 RECOMMENDATIONS

- 7.1 Members of the Board are asked to **endorse** the following recommendations and **approve** their submission of the endorsement to NHS Sussex Integrated Care Board:

- approve the post-consultation Decision-Making Business Case; specifically to locate ophthalmology services at two hospital sites, Eastbourne District General Hospital and Bexhill Hospital, supported by one-stop clinics at both hospitals and a diagnostic eye hub at Bexhill Hospital.
- note the consultation findings, how these have informed the Decision-Making Business Case, and how they have resulted in the post-consultation proposal;
- note and approve additional actions to further mitigate any potential adverse impacts of the post-consultation proposal on groups highlighted in the comprehensive Equality and Health Inequalities Impact Assessment (EHIA) that has been iterated throughout the programme and was carefully considered in developing the final proposal, in particular as part of the site options appraisal process;
- note the East Sussex Health Overview and Scrutiny Committee's Review Board's recommendations have informed the Decision-Making Business Case and the above additional actions to further mitigate any potential adverse impacts on our local population
- approve the submission of the proposal for decision by the NHS Sussex Integrated Care Board
- note that the decision of the NHS Sussex Integrated Care Board will subsequently be submitted to the East Sussex Health Overview and Scrutiny Committee for their consideration.

2021/22 Ward Nurse Establishment Review (NER)

Meeting information:			
Date of Meeting:	11 th October 2022	Agenda Item:	9
Meeting:	Trust Board in Public	Reporting Officer:	Vikki Carruth, Chief Nurse

Purpose of paper: (Please tick)			
Assurance	<input checked="" type="checkbox"/>	Decision	<input type="checkbox"/>
Has this paper considered: (Please tick)			
Key stakeholders:		Compliance with:	
Patients	<input checked="" type="checkbox"/>	Equality, diversity and human rights	<input checked="" type="checkbox"/>
Staff	<input checked="" type="checkbox"/>	Regulation (CQC, NHSi/CCG)	<input checked="" type="checkbox"/>
		Legal frameworks (NHS Constitution/HSE)	<input checked="" type="checkbox"/>
Other stakeholders please state:			
Have any risks been identified	<input checked="" type="checkbox"/>	On the risk register?	
There is no funding identified currently to support the requirements of the latest ward NER. As budgets were re-set to 2019 levels this has meant a gap in funding the required establishments, as described in the full report to F&IC in July 2022.		There are various entries regarding workforce on divisional risk registers.	

“The Nursing workforce is the most important factor in the provision of safe, effective high quality compassionate care in a timely, cost-effective and sustainable manner. Nursing staff work alongside a team of health and social care professionals to ensure the safety and highest level of care for those we care for. However, it is nurses who understand the complexity of nursing care provision and the nursing workload. It is registered nurses and nursing support workers who provide nursing care. Therefore, it must be nurses who set the standard for nurse staffing and be assured that the nursing workforce is safe for the acuity and dependency of those they care for”.

Rachel Hollis FRCN, Chair of RCN Professional Nursing Committee.

Royal College of Nursing – Nursing Workforce Standards July 2021¹.

Standard 1 of the 14 Nursing Workforce Standards states that “Executive Nurses are responsible for setting nursing workforce establishment and staffing levels. All members of the corporate board are accountable for the decisions they make and the action they do or do not take to ensure the safety and effectiveness of service provision”.

In addition, section 2 of the Developing Workforce Safeguards (DWS) recommendations state that Trusts must ensure the three components are used in their safe staffing processes:

¹ [RCN Workforce Standards | Publications | Royal College of Nursing](#)

- **Evidence-based tools (where they exist)**
- **Professional judgement**
- **Outcomes.**

As per the previous annual ward establishment reviews, the full report provided to the Finance and Investment Committee (F&I) in July 2022 described the process undertaken using nationally recommended methods and describes the nurse staffing required in the wards listed to ensure the ongoing provision of safe, effective and efficient care. Nursing in this context is defined as all Registered Nurses (RN), Health Care Assistants (HCA) and Registered Nursing Associates (RNA). In scope were all inpatient wards where patients may stay overnight (excluding Maternity) including the 2 community hospital sites Bexhill Irvine Unit and the Rye Memorial Care Centre with Maternity covered separately.

As part of the triangulation using nationally recognised methods and tools, the Shelford Safer Nursing Care Tool (SNCT) (a decision support tool) was used with a four week data collection undertaken in November 2021. The results were collated by the Information Management team, analysed by the Divisional Assistant Directors of Nursing, the Divisional Heads of Nursing and the Corporate Assistant Director of Nursing incorporating clinical and professional judgement as well as a review of patient outcomes. The data was then scrutinised and challenged by the Chief Nurse. Occupancy and dependency/acuity were on some occasions distorted due to COVID outbreaks and the essential Infection Prevention and Control (IPC) requirements and this was considered in the round when reviewing the information and applying Professional Judgement. The NER was also scrutinised by Kingsgate as part of work undertaken in the Summer of 2022.

There were several movements in the budgeted nursing establishment between 2020/21 and 2021/22 outside of the NER process due to the impact of national/central planning changes because of the COVID-19 pandemic, budget realignment in H1 (first 6 months) and H2 (second six months) and the late agreement for the 2020/2021 NER which was presented to F&I in October 2021.

In October 2021, the evidence from the NER suggested an increase of 130 Full Time Equivalent (FTE) which was not supported as deemed to be possibly anomalous because of the pandemic as the data collection was during November 2020. The recommendation at the October 2021 F&I was to retain the nursing establishment as at December 2019 with allowances made for any changes to bed numbers. An increase of 10 FTE for Cookson Attenborough to run as a 24-hour seven-day elective ward was approved.

The budgeted establishment as of December 2019 was therefore requested as the baseline for comparison. 2019 and subsequent years are not comparable given the sustained and prolonged use of significant escalation beds supported by substantive wards (circa 100), changes in templates as a result of managing COVID, an increase in bed numbers, a change

in patient case-mix (currently still 300 stranded dependent patients) and the necessary planned elective recovery.

Over recent years, the bed base and configuration of services has changed and there has been a considerable change to the footprint and bed stock with more beds.

Data excludes Critical Care

Data supplied by Finance @ ESHT March 2022

Division	Beds 2017	Beds 2019	Beds 2020	Dec 2017	Dec 2019	Dec 2020	NER Recommendations 2021/2022
				Agreed FTE	Agreed FTE	Agreed FTE	Suggested FTE
Medicine	430	470	465		779.06	807.63	823.21
DAS	238	213	235		329.71	336.29	336.29
WCSH	34	34	34		74.99	79.82	79.82
CHIC	61	57	73		99.11	112.09	112.09
Total	763	774	807	1,322	1,337.6	1335.83	1,351.41

The latest NER evidence recommending 1,351 FTE nurses for the now 811 beds (1.66 FTE per bed) is an overall reduction, compared to the agreed funded FTE of 1,322 in the 2017/18 NER for 763 beds (1.73 FTE per bed). If not approved and establishments remain at 2019 funding, then this ratio falls to 1.64 FTE per bed for the wards included in the review.

There was no challenge at that time or any evidence to suggest that the staff to bed ratio in 2017 was inappropriate or excessive. There is no challenge now or any evidence to suggest that the proposed staff to bed ratio is inappropriate or excessive.

As discussed at F&I in July, it is important to note that the actual gap in funding is less than as described financially. This is because of two things. Firstly, the non-weight bearing beds at Bexhill Irvine Unit are already funded so 13 WTE is already accounted for. Secondly, there have been recent agreed changes in line with others in the Integrated Care System (ICS), to the supernumerary status for overseas Registered Nurses undertaking their Objective Structured Clinical Examinations (OSCEs) awaiting Nursing and Midwifery Council (NMC) registration. This means there is a benefit, as in addition to protected time for learning these staff contribute to patient care supporting the support worker (HCA) contribution on the wards. As there is a constant/rolling supply of these staff at the moment, there is a constant/rolling number who are supernumerary so an additional benefit of circa 45 fte at band 3/4. If/when this situation changes this will obviously have to be reviewed, but it is likely that this will continue for the next two to three years.

The outcome from the discussion at the July F&I was that there was no challenge to the recommended FTE for the wards with an acknowledgement that there is as yet no identified funding to support it.

Whilst there is now a funding gap due to the resetting of budgets, it is important to clarify that this is mostly due to the reduction in funding as budgets were re-set to 2019 levels rather than a sudden and significant increase in the staffing required.

As there is no identified funding to bridge this financial gap, the divisional clinical leadership teams have been asked in the first instance to review all of their services and look to move resources on the basis of risk. The first round of workforce summits have taken place in September 2022 and this work will continue and needs to include all establishments in all services.

If the ward nursing establishments are not funded as required as described in the review, it is likely that there will be an impact. As staff will always prioritise patient care and patient safety in the first instance, it is likely that other indirect elements of care will be affected such as discharge planning, documentation, communication, clinical/quality audits etc. It is also possible that there will be an increased risk of some harms to high risk patients, especially as the current patient population is now comprised of over 300 stranded patients at any time many of whom are at high risk of harms (and have a history or risk/harms such as falls, malnutrition and/or pressure damage) and require considerable personal care involving one or two staff at any time.

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

Finance and Investment Committee, July 2022.

Private Trust Board, August 2022.

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

- The Board is asked to note that the annual ward NER has been undertaken and the results have been discussed at F&I and Private Trust Board.
- No funding has been identified to date and the clinical divisions have been asked to review their services to suggest reallocation of funds.
- The likely impact has been described if the establishments are not funded/supported as described.

Winter Preparedness

Meeting information:			
Date of Meeting:	11 th October 2022	Agenda Item:	10
Meeting:	Trust Board in Public	Reporting Officer:	Tara Argent
		Report Author:	Tara Argent

Purpose of paper: (Please tick)	
Assurance	<input type="checkbox"/>
Decision	<input checked="" type="checkbox"/>

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

Summary:

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

In 2022 we have not seen the normal reduction of pressure coming out of winter, pressures have not abated and so are likely be layered on top of current demand. The Trust plans for winter 2022/23 have been made with the following assumptions that are consistent with the overarching Sussex model and NHSE guidance.

- No significant increase in COVID cases
- No significant flu or infectious disease pressure, although we have included a rise in flu in December as per predictions from the UK Health Security Agency (UKHSA)
- Assumes that there will be the seasonal step up in winter pressures layered on top of existing demand
- Escalation capacity which is currently open continues to be so
- Initial winter plan actions to mitigate risk applied:
 - These have been drawn from discussions with Divisional leads for each area. Where projects are not fully developed with agreed impact or the risk of delivery is significantly high, the projects have been included but not quantified
 - The impact of an increase in Virtual Ward beds is shown through Q4. This will need further development and will expand in line with the recruitment of staff to support virtual capacity. Direct funding for £1.5m staffing has been received from national funding which should be maintained next year.
 - No additional change in Hospital Discharge Programme (HDP) funding from Q2 – Discharge to assess beds remain at 46 for ESHT
 - No reduction in the provision of Elective Care

The modelling undertaken has shown that there is a gap between the maximum capacity required (CR) and our current General and Acute bed base, which includes open escalation (min planned capacity), this is shown in the following tables but to summarise:

- Conquest - 56 bed gap at peak demand against maximum capacity (including all available escalation beds)
- EDGH - 79 bed gap at peak demand against maximum capacity (including all available escalation beds)

ESHT : Eastbourne	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
min Planned Capacity	388	388	388	388	372	372	372	372	372	372	332	332
max Capacity Requirement	389	393	393	393	414	445	451	428	416	418	397	399
Remaining gap to CR	1	5	5	5	42	73	79	56	44	46	65	67

ESHT : Conquest	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
min Planned Capacity	379	379	379	379	375	375	375	375	375	375	363	363
max Capacity Requirement	373	385	387	387	428	431	427	405	408	409	382	376
Remaining gap to CR	0	6	8	8	53	56	52	30	33	34	19	13

1.1 Sussex wide approach

The Trust is working with the Integrated Care Board's (ICB) Urgent and Emergency Care/Winter Transformation Director to ensure that the Sussex model accurately reflects the ESHT position, working with system partners on the priorities for the Sussex programme which are:

- Frailty (avoidable admissions) pathway across Sussex
- Falls prevention and pick up in the community setting
- Support to care homes (protocol for response to care home (pts should not be conveyed unless clinically appropriate) and End Of Life Care in place of residence
- Ability to turn around at the front door
- Cardiovascular pathway – prevention avoidable admissions (hypertension) – based on data
- Respiratory – chronic conditions and care plans for escalation of care – based on data
- Mental Health patients in crisis
- Discharge Programme – Sussex level vs place a review of the model post 1st July 2022
- Communication and messaging to the public – managing expectations and new models of delivery
- Virtual wards - Increase pace and scale
- Urgent community responses (UCRs) to avoid admissions (from 999 and 111)
 - Minimise length of time crews in patients' homes (cycle time)
 - Strategic approach community/social care will be the response for patients who don't need conveyance – need to standardise across Sussex

On the 28th of September, Trust representatives will be attending the South East Winter Preparedness: Reducing Risk and Sharing Good Practice, lessons learnt from this will be brought back to the organisation for inclusion in the Trust plans.

1.2 Trust approach

The Trust has identified key areas of internal focus that provide opportunities for improvement in overall performance but will also mitigate a proportion of the bed gap.

The actions managed by of an overarching operational planning document owned at Divisional level. The key milestones from the operational planning document are monitored weekly at the Trust Executive meeting the key areas of focus/milestones are:

- Acute Frailty Units (AFU): Establish AFU on EDGH and identify capacity to deliver AFU on Conquest site
- Trauma and Orthopaedic Same day emergency care (SDEC) Pathway: Establish Trauma assessment bay at Conquest
- Gynaecology SDEC pathway: Strengthen streaming into Gynaecology SDEC, identify estate to move Early Pregnancy Unit (EPU) to free

- Paediatric SDEC Pathway - Embed a paediatric SDEC at both sites, improve the GP 111, 999 direct admission
- Medical SDEC Pathway - Improved streaming into medical SDEC from GP 111 and 999 patients to be pulled from Emergency Departments (ED) directly
- Surgical Assessment Unit (SAU) SDEC Pathway - Improved streaming into SAU SDEC
- Urgent Assessment Unit (UAU) SDEC Pathway - Improved streaming into medical SDEC
- Implement Rapid Assessment Triage (RATS) within EDs, securing Rapid Assessment area
- Reduce Non-Admitted Breaches to ensure minimum delivery of 70% of the 4 hour target
- Emergency Care Improvement Support Team (ECIST) training: Undertake training with ECIST and consultants re criteria to admit and criteria to reside.
- Urgent Treatment Centre (UTC) activity: to be at 60% or higher
- Ambulance delays & escalation: Embed surge protocol
- Home First: recruit to the 56 whole time equivalents (wte) to deliver additional community capacity
- Virtual Wards: Implement 76 virtual ward beds by December 2022, with appropriate staffing skillset and capacity
- Reduction of No Criteria to Reside (NCTR) patients to 50 Trust wide
- 21 day review: currently % of beds occupied by patients = 32.2% reduce to 18%
- Patient flow lead: Appoint 1 wte Operational clinical Associate Director for patient flow

The Divisional teams have reviewed the escalation plan developed last year with triggers relating to staffing levels and/or COVID or Flu surges. This identifies action that need to be taken when a particular trigger is activated or patient numbers climb in relation to COVID or Flu. We are very clear that we will protect the elective programme and any changes to ringfenced capacity must be approved by the CEO in advance of any changes.

The Trust is committed to deliver the fire compartmentalisation and cladding Estates work at EDGH that is taking place and we have agreed that if there is a need to super surge then we will release a bay at a time rather than decant a whole ward. The appropriate risk assessments will be undertaken by the operational and estates teams.

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

Weekly presentation to Executive Directors Committee

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

This paper is to provide the Board with a summary of the key work programmes being undertaken to support flow through the winter across the acute and community setting both at a Trust level but also as a system.

Board Assurance Framework: Q2 update

Meeting information:			
Date of Meeting:	11 October 2022	Agenda Item:	11
Meeting:	Trust Board	Reporting Officer:	Chief of Staff

Purpose of paper: (Please tick)			
Assurance	<input checked="" type="checkbox"/>	Decision	<input type="checkbox"/>

Has this paper considered: (Please tick)			
Key stakeholders:		Compliance with:	
Patients	<input type="checkbox"/>	Equality, diversity and human rights	<input type="checkbox"/>
Staff	<input checked="" type="checkbox"/>	Regulation (CQC, NHSi/CCG)	<input checked="" type="checkbox"/>
		Legal frameworks (NHS Constitution/HSE)	<input type="checkbox"/>
Other stakeholders please state:			
Have any risks been identified	<input type="checkbox"/>	On the risk register?	
Yes		<i>Links with the risk register are within the BAF</i>	

Summary:

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

As Board members are aware, the Trust is required to refresh the focus of our Board Assurance Framework (BAF) each year, reflecting the risks to delivering strategic and organisational priorities over the coming 12 months.

Members will recall that we made a conscious decision as a Board to re-base our risks and consider the risk appetite for each. This has led to a somewhat different process this year from previous years, but we are confident that the BAF – for all except two risks – has followed process to date, with reviews being undertaken through Finance & Investment, People & OD and Strategy Committees during August/September.

We recognise, however, that this means the BAF is incomplete for two risks as at Q2. This was noted at the Audit Committee. As the summary report makes clear, we have an agreed way forward to conclude this process and are confident that the Q3 update will be in full.

As per the suggestion of the Audit Committee, we therefore only include the summary BAF YTD. It is our expectation that for the December update we will also provide a review of the ongoing controls/mitigations against each of our thirteen BAF risks as we track progress from residual risk to target risk.

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

As noted above, 11 of the 13 BAF risks have been reviewed by the relevant Committees and reflect the position as at Q2.

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

The Board is asked to note the progress on the process and content of the BAF for 2022/23 and agree to the proposed change as set out at the Audit Committee, moving BAF risk 12 to Strategy Committee for monitoring purposes.

1. Introduction and purpose of the paper

- 1.1 The Trust is required annually to consider the risks that prevent it from delivering both strategic aims and in-year priorities. These risks are collected and laid out, together with the actions to control/mitigate them, in the Board Assurance Framework (BAF). The Trust has thirteen such risks for 22/23 and these are monitored through four Board sub-Committees.
- 1.2 Each BAF risk is assigned to a relevant sub-Committee of the Trust Board and quarterly updates on the effectiveness or otherwise of the controls/mitigations are presented to these sub-Committees by the risk owner (relevant Executive Director). Table 1 summarises the split by sub-Committee and risk owner.

Board Sub-Committee	Number of BAF risks	Risk owner
Quality & Safety	2	CMO/CNO/COO
Audit	1	CFO
Finance & Investment	5	CFO
People & Organisational Development	2	CPO
Strategy	3	COS

- 1.3 The full BAF is presented to the Audit Committee for assurance, and then to the Board for approval (both quarterly). The workplan for the BAF through to the end of this FY is therefore a Q3 update to the December Board and a final review covering Q4 and year-end in April 2023.
- 1.4 The purpose of this paper is to:
- 1) Reflect the development and progress we have made in updating the Trust BAF for 22/23, noting that we have – by choice – taken a different approach this year. This update paper focuses on two aspects; a) the process we have followed and b) the content of the BAF as at September (Q2). Appendix 1 shows a summary of the BAF that is up-to-date as at Q2.
 - 2) Ask the Board to agree the proposed change to the BAF risk committee allocation from the agreed position of the 09 August Board; that risk 12 moves to being monitored by Strategy Committee, not by Quality & Safety.

2. Process of BAF development

- 2.1 Colleagues will be aware that we have taken a longer run-up to this year's BAF and that this was a conscious decision by the Board. Initial planning for the 22/23 BAF began with a provisional paper for discussion to the **14 June Board**, where it was agreed that further discussion would be required and we took the decision to dedicate almost all our **12 July Board Seminar** to the development of both the risks (language and focus) and the risk appetite (avoidant or confident) for each of the risks, using the Good Governance Institute risk appetite matrix to guide our discussions. At the **09 August Board** the finalised risks and appetites were shared, together with a timeline for updates to YE 22/23, a proposal for the sub-Committee updates that placed greater focus on the controls/mitigations toward the target risk score and an alignment of each risk to our strategic aims.
- 2.2 Following approval/minor amendments post the August Board, risk owners met with the corporate governance team to shape the risks going to their sub-Committees for review.

Board Sub-Committee	Meeting date
Quality & Safety	Did not meet
Audit	22/09
Finance & Investment	22/09
People & Organisational Development	15/09
Strategy	25/08

- 2.3 As the table on page 2 shows, BAF risks were taken to relevant Committees, except for the Quality & Safety risks - and the Q&S Committee did not meet in September. Upon presentation to the Audit Committee on 22 September, this incompleteness of the BAF was noted, along with some queries as regards fit with the corporate risk register. The Audit Committee also noted that there was a plan to ensure that this would be rectified ahead of the Q3 update in order to enable the Trust to remain on track to assure both Audit and the Board of our progress. The Audit Committee supported the split of risks, with 10 and 11 remaining with Q&S and 12 moving to Strategy. The proposed summary position of the BAF is shown below (scoring is in Appendix 1)

Strategic Aims to 25/26	Trust 22/23 Priorities	22/23 BAF risk descriptions (revised wording post-seminar)	Board Sub-Committee (ED)
Collaborating to deliver care better	<ul style="list-style-type: none"> Deliver 104% of our 19/20 activity baseline Limit patients not meeting the Criteria to Reside to 50 to maintain acute flow 	1. Minimal benefits from collaboration (e.g. better resource use & improved outcomes) for those in greatest need, due to System/Place focus on governance and architecture	StratCom (COS)
Empowering our People	<ul style="list-style-type: none"> Develop new roles to sustain our workforce & support new models of care Support team morale in core impact services by focusing on what our people tell us matters to them 	2. Failure to attract, develop & retain a workforce that delivers the right care, right setting, right time 3. Decline in staff welfare, morale and engagement that impacts standards of care in 22/23	POD (CPO)
Ensure Innovative & Sustainable Care	<ul style="list-style-type: none"> Deliver financial plan to break even Manage sustainable ED performance, minimising unwarranted variation in waiting times for patients 	4. Failure to deliver income levels/manage cost/expenditure impacts savings delivery 5. Insufficient focus on recurrent delivery of income/cost/savings creates a viability issue post 22/23 6. Impaired estates/capital limits the ability to provide services & equipment safely for patients/staff 7. Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack 8. Failure to develop business intelligence weakens insightful and timely analysis to support decisions 9. Failure to transform digitally and deliver associated improvements to patient care	F&I (CFO)
Improving the health of our communities	<ul style="list-style-type: none"> No priority metrics for 22/23, tracking priority transformation milestones only 	10. Failure to maintain focus on improving care 11. Inability to ensure that patients are treated in the right settings 12. Failure to play our part in Sussex public health priorities - e.g. mental health, CVD - to strengthen delivery against ICB target areas 13. Insufficient focus given to the patient/stakeholder voice in service development and transformation to develop fit for purpose and fit for the future services	Q&S (COO/CMD/ CN) StratCom (COS)





3. BAF Content development

- 3.1 It is worth noting that the September sub-Committees were largely seeing the content covering mitigation and scoring of the risks for the first time, so it should not be unsurprising that some amendments will occur before the Committees are comfortable with the content.
- 3.2 The proposed change to the Q&S risk allocation can be resolved in this month (October) as both Strategy and Q&S are meeting this month. The Audit Committee recommendations can also be made within this period. We anticipate having no substantive gaps for the Q3 update to the Audit Committee in November and Trust Board in December.
- 3.3 We are mindful that colleagues are keen to ensure that the updating of the BAF is seen as more than merely an administrative exercise. To help assure colleagues, we will be putting in place two changes from the previous year. The first is to ensure that BAF updates are considered at Executive Team level, to strengthen a co-ordinated approach across the risk owners and the second is to ensure that updates focus mainly on the effectiveness of the controls/mitigations. While we remain committed to the current format for the start (Q1) and completion of the BAF (Q4), mainly as it has received plaudits from our auditors, we also recognise that the updates can be shorn of some of the text so that the 'real time' focus of the actions we are taking becomes clearer.

4. Recommendation

- 4.1 The Board is asked to note the progress on the process and content of the BAF for 22/23 and agree to the proposed change as set out at the Audit Committee, moving BAF risk 12 to Strategy Committee for monitoring purposes.

Appendix 1

BAF Ref	RISK SUMMARY	Monitoring Committee	Strategic Aims Impacted				Inherent Risk	Current position (Residual risk)				Change	Risk Appetite	Target Risk	Target date
								2022/23							
								Q1	Q2	Q3	Q4				
1	Minimal benefits from collaboration (e.g. better resource use & improved outcomes) for those in greatest need, due to System/Place focus on governance and architecture	Strat	X			X	12	9	6			NEW	Seek / Significant	6	Review every two months
2	Failure to attract, develop & retain a workforce that delivers the right care, right setting, right time	POD		X	X	X	16	12	12			◀▶	Open	9	Ongoing
3	Decline in staff welfare, morale and engagement that impacts standards of care in 22/23	POD		X	X	X	20	16	16			◀▶	Cautious / Open	12	Ongoing
4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery	F&I			X	X	20	20	16			▼	Cautious	8	31/01/23
5	Insufficient focus on recurrent delivery of income/cost/savings creates a viability issue post 22/23	F&I			X	X	15	10	10			◀▶	Seek	10	31/03/23
6	The Trust's aging estate and capital allowance limits the way in which services and equipment can be provided in a safe manner for patients and staff	F&I		X	X	X	20	16	16			◀▶	Cautious	8	Ongoing
7	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack	Audit	X	X	X	X	20	16	16			◀▶	Minimal	12	Ongoing
8	Failure to develop business intelligence weakens insightful and timely analysis to support decisions	F&I			X	X	20	16	16			◀▶	Open	12	Ongoing
9	Failure to transform digitally and deliver associated improvements to patient care	F&I			X	X	20	16	16			◀▶	Significant	9	31/03/25
10	Failure to maintain focus on improving care	Q&S					-	-	-			-	Cautious / Open	-	-
11	Risk of not being able to maintain delivery of safe, high quality effective care due to huge numbers of patients that no longer meet the criteria to reside.	Q&S	X	X	X	X	20	16	16			◀▶	Open / Seek	12	Ongoing
12	Failure to play our part in Sussex public health priorities - e.g. mental health, CVD - to strengthen delivery against ICB target areas	Strat					-	-	-			-	Cautious / Open	-	-
13	Insufficient focus given to the patient/stakeholder voice in service development and transformation to develop fit for purpose and fit for the future services	Strat	X			X	15	12	12			NEW	Open	6	31/03/23

	Strategic Aim 1: Collaborating to deliver care better		Strategic Aim 2: Empowering our People		Strategic Aim 3: Ensure Innovative & Sustainable Care		Strategic Aim 4: Improving the health of our communities
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Use of Trust Seal

Meeting information:			
Date of Meeting: 11 th October 2022		Agenda Item: 12	
Meeting: Trust Board		Reporting Officer: Chairman	
Purpose of paper: (Please tick)			
Assurance <input checked="" type="checkbox"/>		Decision <input type="checkbox"/>	
Has this paper considered: (Please tick)			
Key stakeholders:		Compliance with:	
Patients	<input type="checkbox"/>	Equality, diversity and human rights	<input type="checkbox"/>
Staff	<input type="checkbox"/>	Regulation (CQC, NHSi/CCG)	<input type="checkbox"/>
		Legal frameworks (NHS Constitution/HSE)	<input type="checkbox"/>
Other stakeholders please state:			
Have any risks been identified <input type="checkbox"/> (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 Trust Seal was used to seal the following documents between 1st August 2022 and 3rd October 2022:

Sealing 84 – Integrated Health Projects, 26th September 2022

Framework agreement for the management and delivery of the Building for our Future project.

Sealing 85 – Smarta Water Ltd, 26th September 2022

Agreement to supply water, wastewater and ancillary services for two years.

Sealing 86 – Veolia Energy and Utility Services PLC, 29th September 2022

Agreement for provision of energy and energy management services for eighteen years.

2. REVIEW BY OTHER COMMITTEES

Not applicable.

3. RECOMMENDATIONS

The Board is asked to note that the three uses of the Trust Seal since the last Board meeting.