East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Board Agenda

Date: Tuesday 13th December 2022

Time: 09:30 – 12:30

Venue: St. Mark's Church Hall, Green Lane, Bexhill, East Sussex, TN39 4BZ

	Item	Lead	Action	Time
1	**Welcome and apologies**	Chair	Note	09:30
2	**Staff Recognition**	Chair	Note	09:35
3	**Declarations of Interest**	Chair	Note	
4	**Minutes of the Trust Board Meeting in public held on 11th October 2022**	Chair	Approval	09:40
5	**Matters Arising**	Chair	Approval	
6	**Board Committee Chair's Feedback**	Committee Chairs	Note	09:45
7	**Chief Executive's Report**	CEO	Note	09:55
	Quality, Safety and Performance			
8	**Integrated Performance Report, Month 7 (October)** 1. Chief Executive Summary 2. Quality & Safety 3. Our People 4. Access and Responsiveness 5. Financial Control and Capital Development	 CEO CND/CMO CPO WD CFO	Assurance	10:05
9	**Maternity Overview**	DM	Assurance	10:50
10	**Learning from Deaths, Quarter 4**	CMO	Assurance	11:05
	Break (15 mins)			

Strategy				
11	**Verbal Cardiology and Ophthalmology Update**	CS	Note	11:25
Governance and Assurance				
12	**Board Assurance Framework, Quarters 1 & 2 Update**	CS	Assurance	11:35
13	**Annual Reports** • Safeguarding • Infection Prevention and Control • Patient Experience • Workforce Race Equality Standard (WRES) • Workforce Disability Equality Standard (WDES) • Gender Pay Gap • Guardians of Safe Working Hours	 CND CND CS CPO CPO CPO CPO	Assurance	11:40
Items for Information				
14	**Use of Trust Seal**	Chair	Note	12:10
15	**Trust Board Planner 2023**	Chair	Note	
16	**Questions from Members of the Public**	Chair	Note	12:15
17	**Date of Next Meeting** Tuesday 14th February 2023	Chair	Note	
18	**Close**	Chair		

Steve Phoenix
Chairman
November 2022

Key:	
Chair	Trust Chair
CEO	Chief Executive
CND	Chief Nurse and DIPC
WD	Winter Director
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: 2023

Month	Location	Timing	Any other information
14th February	Holy Cross Priory Lewes Road Cross-in-Hand Heathfield TN21 0DZ	09.30 – 12.30	
11th April	Grange Room, Locker Room, College Road, Eastbourne, East Sussex, BN21 4JJ	09.30 – 12.30	
13th June	Venue TBC	09.30 – 12.30	
8th August	St. Mark's Church Hall, Green Lane, Bexhill, East Sussex, TN39 4BZ	09.30 – 12.30	
10th October	Uckfield Civic Centre, Bellfarm Lane, Uckfield TN22 1AE	09.30 – 12.30	
12th December	Venue TBC	09.30 – 12.30	

East Sussex Healthcare NHS Trust

Staff Recognition

Purpose of the paper	East Sussex Healthcare NHS Trust recognises that the high standard of care and quality of service it provides is dependent on the contribution, effort and loyalty of the employees. As such, this is an opportunity for the Trust to demonstrate that the contribution, exceptional performance, behaviour and achievements colleagues and volunteers have made to the organisation						
	For Decision		For Assurance		For Information	x	
Sponsor/Author	Steve Aumayer, Chief People Officer Jacquie Fuller Assistant Director HR- Engagement & Wellbeing						
Governance overview	Trust Board						

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
			x	

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

Recommendation	N/A

Executive Summary

Hero of the Month

August 2022

Gregg Wicks – Porter – Sussex Premier Care

Gregg was working late on 11.08.22 and noticed an elderly gentleman was the last in a clinic and the patient was a bit anxious about being so late leaving the hospital. Gregg waited for him to finish as he knew they were both getting the bus home. He ended up getting a second bus with the patient just to make sure he got home safe.
What an absolute gent Gregg is. Always thinks of others, never complains, and think he is totally deserving of a Hero award.

September 2022

Felicity Parsons – Decham ward, Conquest

Nomination 1. Felicity works as a ward Clarke and as Matrons assistant, on Decham ward, she is always at work early and often does not leave on time, on her days off and after work Felicity is always updating the ward on important information and is always helping staff with questions when not at work.

Felicity is extremely patient and understanding and works extremely hard to achieve the jobs she is given for the better of the ward and staff

Nomination 2. Felicity works as a ward clerk and matrons assistant on Decham ward, she is kind, thoughtful and considerate to all of her work colleagues, no matter what she is doing, she will always stop and help, she is always at work early and nearly always leaves late, nothing is ever too much trouble.

October 2022

Louise Myeni, Fran Williams & Ella Butler - Community Therapies - CHIC

I would like to nominate Louise Myeni, Fran Williams and Ella Butler- the Physio and OT development team for the Hero of the month award.

They have been putting in a Herculean effort to implement an AHP preceptorship programme for the AHP's within the CHIC division. This programme has moved from idea to concept to production and implementation within the last year thanks to the hard work and commitment of the 3 involved including working extra bank shifts to complete the work. They have collaborated with over 50 people to produce the programme and been true innovators displaying the trust values at every step.

Long Service Awards

August					
10 Years' Service		**25 Years' Service**		**40 Years' Service**	
Tracy	Anderson	Steven	Bance	Lorraine	Hughes
Kamala	Baniya Khadka Budhathoki	Janice	Fowler		
Kalpana	Pun				
Joanne	Dummer				
Benjamin	Hosker			**50 Years' Service**	
Anne-Marie	Lovett			Radha	Johnson
Debbie	Lucas				
Asad	Manzoor				
David	Noakes				
Kristel	Winters				

September					
10 Years' Service		**25 Years' Service**		**40 Years' Service**	
Elizabeth	Attwood	Tammy	Bondarenko	Catherine	Keen
Rebecca	Bell	Sarah	Catterall	Janet	Large
Paul	Bruce	Claire	Chambers	Trevor	Morley
Sheila	Caister	Xanthe	Knowles		
Elaine	Ellis	Dierdre	Parter		
Luke	Everest	Wendy	Southan		
Mary-Ann	Glover	Donna	Taylor		
Sally	Grainger	Rosalyn	Thomson		
Anne	Haffenden	Dr David	Hughes		
Nicola	Haselden				
Shelley	Johnson				
Deborah	Rycroft				
Joanna	Swap				
Credence	Tarukwasha				
Lucy	Terry				
Linda	Upton				
Rebecca	Ware				
Deborah	Webster				

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October								
10 Years' Service			**25 Years' Service**			**40 Years' Service**		
Louise	Bicknell		Karen	Cornelius		Joanne	Penfold	
Emily	Eden		Sandra	Francis		Orlando	Vieira	
Samuel	Fairbrother		Timothy	Pearce				
Maura	Figueira Camacho De Jesus		Sharon	Reed				
Robert	Hilton		Anna	Tagliaferro				
Elaine	Morton		Caroline	White				
Lesley	Shadbolt							
Iliyana	Tsvetanova							
Sarah	Walsh							
Sue	Snelgrove							
Carolyn	Fardella							
Alexander	Baker							
Sarah	Cocks							
Tessa	Waterfall							

Next steps	N/A

TRUST BOARD MEETING

Minutes of a meeting of the Trust Board held in public on Tuesday, 11th October 2022 at 09:30 in the Club Room, Horntye Park Sports Complex, Bohemia Road, Hastings, TN34 1EX

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
Dr Simon Merritt, Chief Medical Officer
Mr Paresh Patel, Non-Executive Director
Mr Damian Reid, Chief Finance Officer
Mrs Nicola Webber, Non-Executive Director

Non-Voting Directors:
Mr Steve Aumayer, Chief People Officer
Mr Richard Milner, Director of Strategy, Inequalities & Partnerships
Ms Carys Williams, Associate Non-Executive Director

In attendance:
Mr Mike Farrer, Head of Strategic Transformation (for item 071/2022 only)
Professor Nik Patel, Deputy Chief of Medicine and Cardiology Service Lead (for item 071/2022 (i) only)
Mr Kash Qureshi, Ophthalmology Service Lead (for item 071/2022 (ii) only)
Mr Peter Palmer Acting Company Secretary (minutes)

064/2022 **Chair's Opening Remarks**

Mr Phoenix welcomed everyone to the meeting, noting that this was Dr Merritt's first Board meeting in public since he had started as Chief Medical Officer and . Mrs Argent's final meeting as Chief Operating Officer. Mr Phoenix praised the remarkable leadership Mrs Argent had shown, thanking her for her work at the Trust, particularly during the pandemic, and wishing her well with her new role.

It was also Mrs Kavanagh's final Board meeting after seven years as a Non-Executive Director. Mr Phoenix noted that she had been part of the Board leadership that had helped steer the Trust from difficult times to a much better position in recent years and he thanked her for all she had done.

i. **Apologies for Absence**

Apologies for absence had been received from Mrs Amanda Fadero, Associate Non-Executive Director

ii. **Hero of the Month**

Mr Phoenix reported that Michelle Bridger, Professional Nurse Advocate for the District Nurses, had won the Trust's Hero of the Month Award for June. The Estates and Facilities Logistics team at EDGH, had won the award for July.

065/2022 **Declarations of Interest**

The Chair noted that no potential conflicts of interest had been declared.

066/2022 **Minutes**

The minutes of the Trust Board meeting held on 8th August 2022 were agreed as an accurate record noting the amendment below;

- Page 14, paragraph two. Mrs Chadwick-Bell had recently visited maternity, not Mrs Churchward-Cardiff.

067/2022 **Matters Arising**

There were no formal matters arising from the meeting on 8th August 2022.

068/2022 **Board Committee Chair's Feedback**

i. Audit Committee

The Board noted the Committee summary.

ii. Finance and Investment Committee

The Board noted the Committee summary.

iii. People and Organisational Development Committee

The Board noted the Committee summary.

iv. Strategy Committee

The Board noted the Committee summary.

069/2022 **Chief Executive's Report**

Mrs Chadwick-Bell reported that the Trust had recently gained a System Oversight Framework (SOF) score of one which was the highest possible level. This highlighted that the Trust was considered to be consistently high performing and playing an active leadership role in supporting and driving both local and Integrated Care System (ICS) priorities. This was a significant achievement for the organisation and she paid tribute to colleagues and system partners.

She emphasised the current key organisational priorities, which were:

- Maintaining safe services;
- Workforce and Wellbeing;
- Delivering financial balance;
- Delivering 104% elective activity;
- Sustainable urgent care;
- Reducing numbers of patients who no longer required acute or community care, with discharge to an appropriate place.

The government and Secretary of State had recently released plans for patients including a number of priorities:

- Ambulances, with a focus on improving response times, handovers and responding to non-injured fallers in a different way;
- Continuing to reduce waiting lists and meeting the 62 day cancer standard;
- Reducing the significant number of inpatients in hospital who would be better cared for in a different setting;
- Increasing access to general practice.

She noted that urgent care performance in the Trust had historically been good, but since the reduction of discharge to assess capacity in the Trust there had been a significant reduction in performance. The Trust was looking at actions that could be taken internally to improve the discharge of patients, as well as working closely with System partners to address the issue.

Mrs Chadwick-Bell reported that winter planning was a significant area of focus for both the Trust and the System. The Trust was focussing on five key areas of work in collaboration with system partners, to plan for winter pressures:

1. Reducing conveyances and admissions for non-injury fallers
2. Providing additional support to care homes and avoiding admissions for frail patients
3. Taking a proactive approach to reduce the need for urgent care and reducing admissions for cardiology and respiratory patients
4. Improving the efficiency of discharge pathways
5. Increasing the pace of delivery of virtual wards to support winter plans

Patient pathways were being reviewed to identify where they could be changed to allow patients to safely receive treatment in community settings and a winter plan was being developed by the ICB in collaboration with system partners.

Mrs Chadwick-Bell reported that the Trust was planning to build a high volume, low intensity unit at EDGH which would provide care for day case elective patients. Construction work for the Bexhill Community Diagnostic Centre (CDC) was progressing well and the facility was due to open in the fourth quarter of 2022.

Mrs Chadwick-Bell welcomed Dr Merritt and Charlotte O'Brien to the Trust, and thanked Mrs Argent for the support that she had given her during her time with the Trust.

Mrs Kavanagh asked about staff morale in the Trust, and Mrs Chadwick-Bell reported that staff were tired due to the unrelenting demand and pressure they were under. High levels of staff sickness were being seen, along with colleagues choosing to retire at an earlier age than they were doing before the pandemic and this was the picture nationally, reflecting the ongoing pressure on the whole NHS. Executives were developing plans to identify areas where the organisational culture could be improved in order to increase staff morale.

Mrs Churchward-Cardiff asked how many patients the Trust should be discharging in order to accommodate all those who required admitting each day. Mrs Argent explained that the Trust predicted the number of admissions that would be required on a daily basis, and expected to at least match this number with discharged patients. There had been 296 inpatients who had no longer met the criteria to reside (NCTR) in the Trust the previous morning.

Mrs Churchward-Cardiff asked for an update on the Trust's winter flu campaign and Mr Aumayer reported that this had launched the previous day. The majority of colleagues who had been vaccinated had opted for both a flu vaccination and a covid booster vaccination. The ambition was to vaccinate colleagues as quickly as possible.

Mr Patel noted that he had recently visited Bexhill CDC with Mrs Manson and gave credit to the estates team for what they had achieved. He felt that the CDC would be a fantastic asset to the Trust.

The Board noted the Chief Executive's Report.

070/2022 **Integrated Performance Report (IPR) for Month 5 (August)**

Mrs Chadwick-Bell explained that urgent care performance in the Trust was not currently where she wanted it to be, and improving this was a focus for the whole organisation. She noted that in comparison to other NHS Trusts, ESHT continued to perform well, but the impact of NCTR patients on services was beginning to be seen in some quality measures and in reduced patient flow throughout the organisation. Diagnostic performance continued to be good.

i. Quality and Safety

Mrs Carruth reported that August had been a challenging month for the Trust due to the increased number of Covid patients being treated, along with positive Covid tests for Trust staff. There had been 11 clostridium difficile (c. diff) cases reported in the month; all were being investigated with no indication of cross infection or outbreaks found in any of the cases. C. diff numbers had reduced in September, but the Trust was close to its annual limit for cases. Mrs Carruth noted that while the reasons for the increase were unclear, they could due to increased bed occupancy and the large numbers of NCTR patients in the Trust.

A review of medication incidents had shown that 91% of these had resulted in no harm to patients. The pharmacy team would be attending an upcoming Quality and Safety (Q&S) Committee meeting to discuss medication safety in detail. The number of pressure ulcers reported had increased in August, reflecting the increased bed occupancy being seen. Friends and Family testing feedback remained good at over 90%, although there had been a reduction in the number of tests completed during August. Care hours per patient day remained lower than expected as a result of the significant additional bed capacity during the month.

Mrs Carruth reported that nursing recruitment in Rye was currently challenging and work was being undertaken to address this issue. Mrs Chadwick-Bell added that housing prices in Rye were a barrier to recruitment and innovative solutions were being sought. She noted that it was vital that the Trust did not plan for services where they could not be staffed and explained that this issue would be discussed at a future Strategy Committee. **PP**

Mrs Carruth reported that she had recently worked a shift on Jevington ward and had been struck by how dependant and complex a number of the patients had been. A review of nursing documentation was being undertaken to ensure that this was as succinct and easy to complete.. She praised the Trust's security team for their work in keeping both patients and staff safe. She also praised staff and the matron on the ward for their compassionate and individualised care, thanking them for all their hard work.

Mrs Churchward-Cardiff asked whether any statistics were available to compare falls in hospitals with single rooms against hospitals with wards. Mrs Carruth noted that the reasons for patients falling were multifactorial; following review of falls data, the most likely locations and times of day when patients were likely to fall were known. This information was factored into the redesign of wards and side rooms that took place. Mrs Manson noted that analysis had also been carried out into repeated falls on wards, which had shown that 30% of patients fell more than once. Many of these were frail patients who were medically fit for discharge from hospital.

Mrs Webber expressed her concern about the IPR, in particular the decline in some quality measures that were being reported. She noted that in comparison to other Trusts, ESHT continued to perform well, but noted that there were issues that needed to be addressed and difficult decisions would have to be taken moving forward. Mrs Chadwick-Bell explained that understanding the context of the Trust's performance was important and highlighted the challenges facing health and social care nationally. The Trust was focusing on ensuring that services remained safe, that productivity was maintained within the capacity that was available, that money was not put before quality and safety when making decisions and that the workforce was in the correct place.

Mrs Webber hoped that the Trust would be able to look at how services could be offered differently to provide greater benefit to patients. Mr Phoenix noted that

while the Trust was not where it wanted to be at present, in comparison to peer organisations in Sussex and the South East, it continued to perform well. The Trust was managing the current pressures well, and was taking innovative approaches to maintain the quality and safety of services that were being provided. Mrs Chadwick-Bell agreed that innovative ideas for services were being considered to address the current pressures on the organisation. The Integrated Care Board (ICB) strategy was currently being written and would reflect that partner organisations would need to work together differently moving forward to manage demand on services and create additional capacity.

Mrs Manson noted that viewing the current reduced performance in some areas at ESHT in the context of the national pressures being experienced by the NHS was crucial. She noted that Mrs Chadwick-Bell and Mrs Argent were experts in improving performance, and that Mrs Chadwick-Bell had been instrumental in the improvements that had been seen at ESHT in the last five years. She felt that while innovation was important, it was important to remember that the Trust did not have control of all of the factors that were leading to the pressures being seen. Mr Phoenix agreed, noting that the Trust would continue to try to be as good as possible, improving all the factors that it could control and working closely with system partners to improve as a system in East Sussex.

Dr Merritt presented August's mortality data, reporting that the Trust's most recent Summary Hospital-level Mortality Indicator (SHMI) score was 0.99 against an expected rating of one. This was slightly higher than it had been four months previously, but the increase was not of concern. The Risk Adjusted Mortality Index (RAMI) score for an average NHS Trust was 100, and the Trust's most recent score had been 87. This was slightly higher than it had been at the same time in the previous year, reflecting both Covid mortality and the increased number of patients treated by the Trust. The Trust's RAMI score remained in the top quartile nationally.

ii. Our People – Our Staff

Mr Aumayer thanked clinical colleagues for working flexibly by moving to different areas of the organisation due to operational pressures to ensure that services continued be delivered safely. He noted the toll that this took on staff and explained that all efforts were made to minimise movement of staff in this way. Colleagues were working incredibly hard to manage the increased pressure caused by having 100 additional beds open.

The Trust aspired to be the best employee possible, and a number of measures including the New Care Programme and Skills Boot Camps had been introduced to support staff and to help with recruitment. The Trust's staff health and wellbeing programme and financial support programmes were considered to be exemplar programmes nationally.

The number of staff who had been off sick with Covid had reduced in August, with overall sickness also reduced to 5.2% for the month, the second lowest figure seen in the last 12 months. These figures were now increasing again, with 77 colleagues unwell with Covid that morning. August had also been a

challenging month with holiday absences, and the HR department worked closely with managers to ensure that effective rostering took place to allow for management of staffing levels during busy periods. Turnover for the month had increased to 13.4%, with the main reasons for leaving being retirement or leaving the NHS. The vacancy rate for August had increased to 8.9%.

Mr Aumayer reported that the Trust's new Partnership Forum had successfully launched the previous week. This brought together colleagues from across the organisation, allowing them to engage on the future of the Trust and for different perspectives to be heard. He was very excited about the opportunity that the Forum gave for creating a powerful voice for colleagues, and to work in partnership to deliver changers that would keep ESHT a high performing organisation.

Mrs Webber asked whether it was possible to present future staff sickness data with Covid both included and excluded to allow greater understanding of the information, and Mr Aumayer agreed to see if this was possible. **SA**

Mrs Webber asked about the importance of workforce job planning. Mr Aumayer explained that the earlier rostering took place the better, both for staff and for the Trust. Colleagues knew at an early stage when they would be working, and the Trust was able to identify and address any gaps in rosters as soon as possible. Consultant job planning allowed the Trust to predict consultant activity and ensure that this aligned to Trust priorities. Dr Merritt noted that decreases in job planning compliance tended to reflect consultants whose job plans had expired and needed to be renewed. Ms Williams noted that job planning was being closely monitored by POD and updates would be presented to the Board when appropriate.

Mrs Manson asked for further information about 'New to Care' staff. Mr Aumayer explained that New to Care was part of the Trust's innovative approach to recruitment, with just under 100 staff falling into this category. New to Care was an intensive training programme to give new staff the skills they required quickly, opening up opportunities for a wider group of people to work for the Trust, and across the system. He noted that the number of new nurses and doctors available were governed by medical schools, and that the Trust continued to recruit as many of these staff as possible. Nurse and doctor shortages were a national issue over which the Trust had no control.

iii. <u>Access and Responsiveness</u>

Mrs Argent reported that staff across the organisation were working closely with Executives to meet the current pressure on the organisation. ESHT was the only Trust in the region with no patients who had waited for over 78 weeks for treatment, and was fifth for patients waiting over 52 weeks. However, the Trust's waiting list was growing with a number of patients approaching 78 weeks; these were being closely monitored, and the Trust was working with partners to offer mutual aid wherever there was a shortage of capacity in the system.

During August the Trust delivered 84.9% against the 99% diagnostic standard (DM01), remaining in the top quartile nationally. The Trust also remained in the top quartile nationally for 62 day cancer performance, and was second best in the region; work was nonetheless ongoing to improve this. Community referral to treatment waiting times were improving for adults, but remained challenging for paediatric referrals due to a lack of capacity. The Trust was working hard to reduce these waiting times.

The Emergency Department (ED) performance and ambulance handover times remained areas of concern, with recovery trajectories in place for both. The Trust had been visited by the Emergency Care Improvement Support Team (ECIST) and were implementing improvement recommendations following this visit. A follow up visit was planned in October 2022. There had been a significant increase in the number of patients being seen in the Urgent Treatment Centres (UTCs), and the Trust was working closely with the South East Coast Ambulance Service (SECAmb) to improve ambulance handover times. Mrs Argent noted increased handover times were regional and national issues. Bed occupancy remained extremely high, with 98.8% of beds having been occupied the previous day.

Mrs Argent reported that discharge workshops had been held with system colleagues to identify different ways of working to manage winter pressures. The Trust had amazing teams who monitored patient pathways on a daily basis, identifying areas of improvement. The Trust was also working with the voluntary sector to improve patient discharge. The Trust's winter plan was being finalised, supported by a huge amount of work that had been undertaken to identify key escalation and trigger points, as well as the Trust's operational delivery plan. She reported that a bed gap had been identified in winter plans and work was being undertaken as a system about how this would be addressed. The Trust was working closely with system colleagues to develop realistic and achievable trajectories but it was important that bed space was made available in the Trust in order to be able to manage winter pressures effectively.

Mrs Churchward-Cardiff noted that the Trust's winter plan described a bed gap despite the assumption that all escalation capacity would remain open. She asked why more patients were not discharged before lunchtime. Mrs Argent explained that the Trust worked closely with partners to discharge patients earlier in the day, and managed discharge in a dynamic manner. Space had been identified for an un-bedded discharge lounge at EDGH.

Mrs Webber noted that a number of presumptions were included within the winter plan, and asked about the level of risk included in the plan. Mrs Argent explained that the system's plan was ambitious, modelling a 500 bed shortage in the worst case scenario. Organisations had been asked to submit ideas for innovative ways of working that could alleviate winter pressures, and the Trust had submitted a plan for two mobile wards. Mrs Chadwick-Bell acknowledged that the winter would be very challenging for the Trust, explaining that a back to basics approach was being taken, looking at admission avoidance, improvements in ED and patient discharge to realise marginal gains.

Mrs Manson noted that no reduction in NCTR patients had been achieved in recent months and asked how she could be reassured that actions to address this issue were working. Mrs Chadwick-Bell explained that the Trust's winter plan contained a number of areas of improvement within the Trust including the time it took to assess NCTR patients. She explained that she was unable to give assurance about improvements that would take place, as these were governed by factors outside the control of the Trust. Mr Phoenix agreed, explaining that the scale of issues being faced by the NHS and social care were unprecedented.

iv. Financial Control and Capital Development

Mr Reid reported that in month five the Trust's financial position was £200k ahead of its annual plan. The Trust continued to target a breakeven position for the year, and he anticipated that a further £500k improvement would be delivered during months six and seven.

The Trust was trying to recruit staff for the virtual wards and home care teams, in order to relieve pressure on acute services, however, this recruitment was placing pressure on wards as ward staff were interested in undertaking these new roles. The additional recruitment was the right thing for the Trust to do as long as it delivered the anticipated level of care and reduced pressure on acute sites. The Trust had been assured that it would receive funding for the additional recruitment.

Mr Reid reported that the Trust would not be subject to clawback during the first five months of the financial year for not delivering 104% of the 2019/20 activity. This would save around £1.2m. He hoped that clawback would not be applied for the remainder of the year which would be worth an additional £3m to the Trust. He reported that the Trust had received additional funding to meet increasing drug costs. The additional cost of escalation capacity, including additional staffing that was required, was around £2.3m. The Trust was planning to further increase savings from efficiency measures during the second half of the year, with an ambition of returning to 2019/20 levels of efficiency. He reported that income from Sussex Premier Health had been slightly lower than expected for the year to date, but that this had been offset by lower than expected costs.

Mr Patel asked whether there was a risk to the financial plan from the increasing costs of clinical supplies, drugs and energy. Mr Reid explained that the Trust had received some additional funding for the increased cost of drugs. Energy costs in August had been lower than plan, but an overall increase for the year of around 10% was anticipated for the year. Energy costs would continue to be closely monitored.

Mrs Churchward-Cardiff asked whether the Trust would be fully funded for the recent staff pay awards. Mr Reid explained that he believed that this would be funded nationally. Mr Aumayer advised that colleagues had received back dated pay increases in September.

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

071/2022

Transformation

i.

Cardiology

Mrs Chadwick-Bell welcomed Mr Farrer and Professor Patel to the meeting, explaining that they had joined to answer questions about the cardiology transformation. The cardiology transformation process had been clinically led and had taken place over a number of years and had concluded that the proposed specialist site for acute cardiology services should Eastbourne District General Hospital. Best practice evidence and the optimisation of care had been key aspects of the process, and the Board had received updates throughout the process. The papers presented to the Board set out the processes and outcomes that had informed the Decision-Making Business Case (DMBC) and confirmed the final proposal for an improved model of care. She noted that the Board was being 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 (all patients 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 (HOSC) for their consideration.

Mrs Chadwick-Bell explained that once the Board had made a decision, the paper would be presented to the East Sussex ICB, and considered by HOSC. She reported that she sat on the ICB Board and would leave the meeting when cardiology transformation at ESHT was discussed.

Mr Milner explained that 97% of cardiology patients would see no change to the service that was provided following the transformation. The transformation plan was for specific interventional work to be single sited at Eastbourne. The full business case (FBC) for the transformation was around 200 pages long and would be published following the Board meeting. The paper presented to the Board provided a summary of the FBC and exactly the same paper would be presented to the ICB in November. The Trust had been challenged by the Sussex clinical senate around the clinical implications and impact of the changes; two separate deep dives had been undertaken with HOSC to review the proposals from the perspective of local people, and the plans had also gone through a public consultation. Feedback from all the processes had been included within the FBC.

Mr Phoenix asked how the proposed transformation would be better for patients. Prof. Patel explained that the proposed model would result in quicker diagnosis and treatment for patients. He noted that the cardiology service could not survive in its current configuration due to the workforce not meeting national guidance.

Mr Phoenix asked whether the transformation represented good value for money. Mr Farrer explained that the plan had been scrutinised by both Trust and ICB finance teams and had been found to represent best value for money when balanced against quality. The proposed model would represent efficiency savings over the current model, largely due to the current cost of locum and agency staff. There were no plans to reduce the number of substantive staff employed. Mr Milner noted that the inflationary impact of delivery of the service over the next ten years had been recently reviewed, leading to a slight delay in presentation of the plans to the Board, to ensure that the included financial assumptions remained correct and affordable.

Mrs Churchward-Cardiff noted that one of the key determinants for EDGH being the site chosen for interventional cardiology was the speed at which change could be delivered. She asked what configuration constraints had led to that conclusion. Mr Farrer explained that a number of different configurations had been considered; many were not viable due to unaffordability, and only those

that were affordable and deliverable had been included in the DMBC. There were constraints on the estate on both sites, but these were greater at Conquest where a largely new build would be required to house the service, taking around three years. Reconfiguration at EDGH could be undertaken within the current footprint and would take around two years.

Mrs Churchward-Cardiff asked for assurance about the medical cover that would be provided for the service from cardiology and other specialities. Prof. Patel explained that under the current model, medical cover was provided by teams from both Conquest and EDGH, and that this would not change under the proposed new model. Cardiac services at Conquest were currently covered on alternative weeks by EDGH consultants. The out of hours provision would also not change. The cardiology service received excellent support from medical teams and this would continue following the reconfiguration.

Mrs Churchward-Cardiff asked about hot clinics and Prof. Patel explained that there were two scenarios for hot clinics: acute and elective. For acute cases, patients currently attended either main site, received cardiology care and were then transferred to an appropriate bed. Under the enhanced model patients would receive a review more quickly from a small senior cardiology team. The elective outpatient model would be enhanced under the transformation with cardiologists seeing patients at an earlier stage, leading to a reduction in waiting times of around 70%. Daily nurse clinics would continue, with patients contacted within 36 hours to ascertain whether they still needed to be seen; around 40% of the patients who were referred to the service did not need to be seen by the cardiology team.

Ms Williams asked about the implications of the proposal for staff and what engagement had taken place. Mr Farrer explained that engagement had taken place regularly with staff throughout the process. A full consultation would be undertaken by the Human Resources department once the final decision about service transformation had been made by the ICB, but conversations with staff about the personal implications of any decision had already begun. Staff had been reassured that no reduction in the cardiology workforce was planned, but it was understood that any changes may not meet the personal requirements of some staff and the Trust would work with the individuals to ensure an optimal outcome for them. Prof. Patel reported that working groups had been set up to ensure that staff remained well informed about the transformation process over the next couple of years, noting that this would provide opportunities for staff both within and outside of the cardiology department.

Mrs Chadwick-Bell noted that staff morale tended to be lowest before a decision was made. Once confirmed, staff would either be happy with the outcome, or could start to hold discussions about the future. Mr Milner noted that the Trust had struggled historically to recruit cardiology consultants, but had recently successfully recruited a consultant who had trained at ESHT and had decided to return. He felt that cardiologists now considered working for the Trust as one team, rather than working on a specific site and that the transformation would help the Trust to recruit additional cardiology staff.

Mr Patel asked what impact the decision would have on neighbouring trusts. Mr Farrer explained that ESHT had maintained open communication with neighbouring trusts throughout the process. Maidstone and Tunbridge Wells NHS Trust were proposing a similar transformation of their cardiology services and no major transfers of patients were anticipated between the trusts. The maximum number of patients modelled to be transferred to either University Hospitals Sussex NHS Foundation Trust or to Ashford and St. Peter's Hospitals NHS Foundation Trust was six per annum, and any diversion would be an SEACAmb decision.

Mrs Kavanagh asked about support that would be offered to vulnerable patients and patients on low incomes to help manage any additional journey times and costs. Mr Farrer explained that for the around 1,500 patients per annum affected by the changes, half would either be taken to the correct site by ambulance, or would have transport arranged for them by the Trust. The remaining 750 patients a year would be asked to attend by car and with a chaperone, and most would undergo elective day case procedures. Most patients would only need to undertake this journey once or twice in their lifetime, and mechanisms for reimbursing patients were already in place in the Trust. A number of recommendations from a transport review group had been included in the DMBC, including the recommendation that a Travel Liaison Officer be employed to help patients. The Trust was also working with the local council and Stagecoach to review public transport routes, although clinical advice was to not take public transport following cardiology intervention. The Trust was working hard to ensure that the small number of people affected were not disadvantaged.

Mrs Manson noted that there were areas of inequality across East Sussex, and asked how the transformation would ensure that people were not disadvantaged. Mr Milner explained that vulnerable and challenged patients tended to access cardiology care in emergencies rather than electively. The emergency cardiology support that would be available to patients in EDs following the transformation would therefore be of great benefit to these patients. In addition, preventative community work for cardiology patients was being explored. Mr Farrer confirmed that extensive work had been undertaken to look at inequalities while developing transformation plans, noting that the proposed changes only affected acute interventional care for patients rather than care in the community. The Trust already offered safe interventional care to patients regardless of geography, with patients receiving the care they needed. He noted that patients from deprived areas tended to access care slightly later than others; the transformation would benefit around 50,000 patients per annum with faster access to cardiology pathways.

Mr Phoenix thanked Mr Farrer and Prof. Patel for their work on the cardiology transformation, asked the Board to endorse the recommendations set out in the DMBC, and to approve the submission of the endorsement to NHS Sussex's ICB.

The Board endorsed the recommendations set out in the DMBC, and approved submission of the endorsement to NHS Sussex's ICB.

ii Ophthalmology

Mrs Chadwick-Bell welcomed Mr Qureshi to the meeting. She reported that the process underlying ophthalmology transformation plans had been clinically led, robust and had taken place over a number of years and proposed the consolidation of ophthalmology services between the Hastings and Bexhill sites, enhancing the delivery of both community models of care and the acute delivery of services. She noted that the Board was being 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.

Mr Milner explained that the process had been led by Consultants and supported ongoing primary care transformation to allow patients to access ophthalmology treatment in the community. ICB colleagues planned to make ophthalmology more accessible as part of this transformation, including provision for the Trust's consultants to train high street optometrists.

Mr Qureshi explained that proposed reconfiguration was being driven by demand from the increasing elderly population in East Sussex. The utilisation of a multi-disciplinary team approach would allow this demand to be met,

making best use of the Trust's workforce and allowing Consultants to maximise their expertise in overseeing the service.

Mrs Churchward-Cardiff asked whether the plan was dependant on the completion of the Community Diagnostic Centre (CDC) in Bexhill to allow for more space. Mr Farrer explained that an x-ray machine would move from Bexhill Hospital to the CDC, but that otherwise the two plans were unrelated.

Mrs Churchward-Cardiff asked what would be done to address the difficulties in parking and travel for patients and staff at Bexhill Hospital. Mr Farrer explained that a travel and transport review had been undertaken, and increased car parking had been included within the DMBC. The Trust had discussed a review of bus routes to the hospital with the council and Stagecoach.

Mrs Churchward-Cardiff noted that growth projections for the ophthalmology service were one of the drivers for the transformation and asked whether any loss to other providers had been assumed during planning. Mr Qureshi explained that this was challenging to model as other providers had not yet started operating in East Sussex. He noted that ESHT offered a different type of service to the independent sector who specialised in fewer conditions. The Trust's ophthalmology patients tended to be very elderly, with multiple co-morbidities and were not suitable for independent providers so he anticipated that there would not be a significant reduction in patients.

Mrs Webber asked whether the Trust was proactively identifying patients who might qualify for financial assistance for transport, and if not whether this was possible. Mr Farrer explained that work had been undertaken to identify patients who were most likely to be impacted by the transformation and communications had been developed to publicise the help available. Patients were also being proactively identified using the Trust's own data.

Mrs Webber asked whether a transport voucher scheme could be considered for people who might not have sufficient money to pay for a bus or taxi. Mr Farrer explained that the Transport Liaison Officer would consider this, and other options for supporting patients, when they joined the Trust.

Mr Patel asked whether the paediatric ophthalmology service would move from Conquest to Bexhill as part of the transformation, and Mr Qureshi confirmed that this was the case.

Mr Phoenix thanked Mr Qureshi and Mr Farrer for their work on the Ophthalmology transformation.

The Board endorsed the recommendations set out in the DMBC, and approved submission of the endorsement to NHS Sussex's ICB.

072/2022 **2021/22 Ward Nurse Establishment Review**

Mrs Carruth presented a summary of the 2021/22 Ward Nurse Establishment Review (NER), explaining that the full report had already been subject to review

by Executives, Board Committees and the Trust Board in private. The review recommended an increase in nursing staff, but represented a reduction in the ratio of nursing staff to beds compared to five years before. She asked the Board to note the nursing gap and the likely impact and risks of this gap.

Mrs Churchward-Cardiff noted that no funding for the recommended increase had been identified and that clinical divisions had been asked to review their services to suggest reallocation of funds. She asked what would happen if divisions were unable to release funds. Mrs Chadwick-Bell explained that staffing reviews were undertaken throughout every day across the organisation, so the associated risk did not sit within one division but across the Trust. She believed that there were sufficient mitigations in place to ensure that services remained safe. She noted that there was a national shortage of nurses which would make increasing the nursing establishment challenging. On a daily basis, the Trust ensured that safe staffing decisions were made for wards, and she noted that this did not always mean remaining within staffing budgets.

Mrs Carruth explained that as Chief Nurse, she felt that the recommendation made in the NER was correct, however, as an Executive she understood that there was a gap in available funding. A Trust-wide establishment review had begun which would help to understand if there were opportunities elsewhere which could help to address the gap. The NER did not recommend a significant increase in staffing, but this had to be balanced against the significant reduction in available money relative to the number of beds that were open.

Mrs Churchward-Cardiff asked whether the recommendation from the NER would be included within baseline funding for 2023/24. Mr Reid explained that the national financial rules for 2023/24 had not yet been published; however, it was crucial that the growth in escalation wards was fully understood and included within planning for the following year.

Mrs Webber encouraged Executive colleagues to ensure that the ideal nursing establishment was agreed prior to budget setting for 2023/24 so that this could be aligned with budget planning cycles. Mrs Chadwick-Bell agreed, noting the importance of aligning budget setting processes. Mrs Carruth reported that the process of monitoring acuity had already taken place to ensure that it would align with the budget planning process.

Mrs Webber asked whether triggers for bringing the NER back to the Board prior to the next budget cycle had been identified. Mrs Chadwick-Bell explained that the business planning process for 2023/24 was due to start over the next couple of months. If fundamental changes to the patient profile were identified during the process then the establishments of specific wards would be subject to review. Conversations about how the NHS was funded would continue at both ICB and national levels.

The Board noted the annual ward Nurse Establishment Review, and that as a result of no additional funding having been received to date, clinical divisions had

been asked to review their services to suggest reallocation of funds; they also noted the likely impact if establishments were not supported as described.

073/2022 **Winter Preparedness**

The Board noted the work that was being undertaken in the Trust and across the local NHS system to prepare for winter pressures.

074/2022 **Board Assurance Framework Q2 Update**

Mr Milner presented an update on the Board Assurance Framework (BAF) highlighting the changed process for 2022/23. He reported that corporate risks had been reviewed and updated, and that each strategic risk had been updated to include organisational risk appetite. The process had taken longer than previous years but was now up to date. The full BAF had been presented to the Audit Committee where it had been noted that two of the risks had not been completed as recommendations had been made by other Committees to change the reviewing sub-Committee.

The Quarter 3 position would be presented to the Board in December, with the two gaps addressed and a strong focus on actions in place to mitigate risks and on controls. It was important that the BAF was a dynamic document reflecting that actions to manage risk changed throughout the year. Executives would review the BAF regularly to ensure that it remained effective. Mr Phoenix noted that the full BAF had already been subject to review by the Board's sub-Committees.

The Board approved the Q2 update of the BAF, and agreed to the proposed change of oversight of BAF 12 from the Quality and Safety Committee to the Strategy Committee.

075/2022 **Use of Trust Seal**

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

076/2022 **Questions from members of the public**

Mr Paul Jones asked what the Trust was doing to ensure that meal times were protected for patients with dementia. Mrs Carruth explained that, as a principle, all wards tried to protect meal and rest times for their patients but there were occasions when it was essential to disrupt this, such as patients undergoing tests or for ward rounds. She agreed to liaise with colleagues in radiology to see if tests could be scheduled around meal and rest times, noting the challenges of co-ordinating this when hospitals were busy. **VC**

Mr Jones asked what the current handover times were for ambulances, noting that there had been queuing in corridors during his last portering night shift. Mrs Argent explained that she was unsure of the current system wide waiting times, noting that the Trust aimed to undertake handovers of between 5-15 minutes. She noted that the current demand on SECAmb was huge, and that the Trust used corridor escalation when under the most intense pressure.

Mr Jones asked how staff leave would be managed during the Christmas period to minimise its impact. Mr Aumayer explained that the Trust used a planning tool to forecast the impact of leave and identify periods of pressure. Staff were encouraged to plan ahead to reduce the need for temporary staffing, but Christmas would nonetheless be a challenging period.

Mr Phoenix noted that Mr Colin Campbell had submitted three questions in advance of the meeting.

1. *Now that the Director of Transformation and Improvement has been appointed and having read through the job description pack covering the role, when can we expect to have a strategy document identifying the deliverables and their timeframes for the activities covered by the role to be published, especially as the Integrated Care Strategy is being developed NHS Sussex over the next six months?* Mr Phoenix explained that any updated Trust strategy would be supportive of the system's Integrated Care Strategy.

2. *Again, given the scope of change currently in progress in Sussex, does the Board consider that a new Transformation and Improvement Committee with Non-executive membership should be created to monitor and manage the progress of all the changes that are in development, both internal to ESHT and those that interface with the ICS e.g. health inequalities?* Mr Phoenix noted that the Trust already had a Strategy Committee in place.

3. *Would it be possible to translate the data contained in the Balanced Scorecard into a numeric score that appears on the page and actually provides a measure of performance? It would also help if there were no blank entries on the Scorecard.* Mrs Chadwick-Bell explained that the Trust had developed the balanced scorecard in line with NHSE best practice, and had no intention of changing this.

077/2022

Date of Next Trust Board Public Meeting

The next meeting of the Trust Board would be on Tuesday 13th December 2022 at St Mark's Church Hall, Green Lane, Bexhill-on-Sea TN39 4BZ

Signed ……

Position ……..

Date ……

Matters Arising

Agenda Item	Action	Lead	Progress
070/2022 (i)	Item to be added to Strategy Committee planner for future discussion about innovative solutions to staffing shortages	Pete Palmer	Complete
070/2022 (ii)	Mr Aumayer to explore whether staff sickness data in the IPR can be presented both inclusive and exclusive of Covid sickness	Steve Aumayer	Complete
076/2022	Mrs Carruth to liaise with radiology colleagues to understand if patient tests can be scheduled around patient meal and rest times.	Vikki Carruth	

East Sussex Healthcare NHS Trust

Audit Committee Summary, 24th November 2022

Purpose of the paper	Executive summary attached for Audit Committee meeting that was held on 24.11.2022						
	For Decision		For Assurance	✓	For Information		
Sponsor/Author	Paresh Patel, Chair, Audit Committee						
Governance overview	Trust Board						

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
	✓		✓	✓

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	✓	✓	✓	✓

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

Executive Summary

Data Quality Update – Key Milestones and Interdependencies Until Mid-2023
The Data Quality Reporting Steering Group had begun meeting and their first monthly report would be brought to the Audit Committee in January. Outsourcing of some data processing to a third-party cloud services provider was being explored to potentially improve reporting, particularly around Power Business Intelligence and community provision. The Data Quality Training Group had started to develop training plans, with ongoing reviews embedded, to provide assurance around data inputs.

Board Assurance Framework (BAF) Q2
An finalised Q1/2 BAF was presented to the Committee, which included an interim Q3 update. The full Q3 update would be presented in January. It was noted that BAF risk 10 ('failure to maintain focus on improving care') would be monitored by the Strategy Committee moving forward.

Information Governance (IG) Toolkit Update
89 of 113 evidence lines for the latest Data Security Protection Toolkit (DSPT) had already been reviewed ahead of the 30 June 2023 submission deadline. A two-part audit would take place before the final submission. There were no open incidents being investigated by the Information Commissioner's Office (ICO).

Tenders and Waivers
Assurance was provided that further steps were being reviewed and undertaken to ensure the trend of keeping the number of waivers low continued. Any prospective waivers were discussed with the Committee Chair and Chief Finance Officer prior to being approved.

Spire Healthcare - Audit Findings Report
The Trust had accepted the external auditor's recommendation that the accounting entry relating to the Spire Healthcare Limited acquisition in the Trust's Statement of Financial Position as at 31 March 2022 should be amended, without impact to the Statement of Comprehensive Income. The General Ledger was updated accordingly.

	Internal Audit The following reports had been issued since the previous meeting: Final Reports: • Bank and Agency (Nursing) – Reasonable Assurance. Draft Reports: • ICT: Cyber, Cloud Services – Assurance rating to be advised • Risk Management and BAF – Reasonable Assurance • Emergency Preparedness, Resilience and Response – Reasonable Assurance. It was agreed that the review of ICS Governance should be deferred on the basis that the ICS had not yet fully developed its governance arrangements and as such, the Trust had not been able to align strategy and processes with those of the ICS. **Anti-Crime Specialist (ACS) Service Progress Report** Recent open-source sampling checks around declarations of interest had found nothing of concern. Following a recent audit, Trust Charity governance processes were commended.

Next steps	N/A

East Sussex Healthcare NHS Trust

Finance & Investment Committee Summary, 24th November 2022

Purpose of the paper	Executive summary attached for Finance & Investment Committee meeting that was held on 24.11.2022						
	For Decision		For Assurance	✓	For Information		
Sponsor/Author	Nicola Webber, Chair, Finance & Investment Committee						
Governance overview	Trust Board						

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
	✓		✓	✓

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	✓	✓	✓	✓

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

Executive Summary

Month 7 Financial Performance
The Committee noted that the Trust was reporting a year-to-date breakeven position against a planned deficit of £0.2m, but recognised that the M7 position had been supported by a balance sheet movement of £1.2m. The M7 position also reflected the national assumption from NHSE not to recognise any Elective Recovery Fund (ERF) clawback. The Committee discussed the run-rate and anticipated outturn, noting that whilst the Trust expected a full year break even position, the run rate at year end was likely to result in challenges in 2023/24. The Committee discussed the impact of increased staff numbers on the Trust's cost base (when compared to 2019/20), with additional analysis to be considered at the next meeting.

Month 7 Capital Update
Operational pressures and a challenging external environment (particularly in terms of lead times for delivery of capital items) have combined to result in some risk to the full delivery of the capital programme. As a result, the Committee authorised the CFO to have delegated authority to return up to £2m of capital funds to the ICS for reallocation within the local system, should he feel it is appropriate to do so. Any such return would be for the benefit of the local health system as a whole.

Efficiency Update
The Committee recognised that the run rate, in terms of identifying and achieving efficiencies, was reducing relative to target, impacting the Trust's run rate. This was factored into the year-end projections. Teams continued to work towards maximising efficiencies.

Update on Pathology Network
The Committee received an update on the pathology network, with work proceeding at pace across the network. The team anticipated tendering prior to the year end in order to secure national funding for the Lab Information System. Board sign off would be requested in due course. It was noted that the Committee continued to be supportive of the project.

Winter Bed Plan
The Committee noted the continued operational demand requiring use of escalation beds over and above the established bed base, with an anticipated cost of £3.5m to

	year end. The additional cost was included in forecasts and the run rate as previously discussed. The Committee discussed the anticipated bed gap and it was noted that additional national funding would potentially allow some patients to transfer into more appropriate care settings thereby reducing bed pressures on the Trust. It was also noted that the Chief Medical Officer, Chief Nurse and Executive Winter Director were working closely together and with the wider system to reduce bed occupancy numbers and de-escalate beds. The central funding is due in two tranches in December 2022 and January 2023. *The Committee recommends to the Board that it approves an adjustment to forecast to spend £3.5m for the continued use of 78 escalation beds until 31 March 2023.*

Next steps	N/A

East Sussex Healthcare NHS Trust

People and Organisational Development (POD) Committee Summary 17 November 2022

Purpose of the paper	Executive summary attached for POD Committee meeting that was held on 17.11.22					
	For Decision		For Assurance	✓	For Information	
Sponsor/Author	Carys Williams					
Governance overview	Trust Board					

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
	✓		✓	✓

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	✓	✓	✓	✓

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

Executive Summary

Introduction
Since the Board last met a POD Committee meeting was held on 17 November 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
A brief overview of the workforce data for October was presented and it was noted that it had been a challenging month for a number of reasons:

- Higher levels of sickness driven by COVID increased from 1.3% to 6.5%. Annual sickness rate increased by 0.1% to 6.1%.
- Turnover had increased very slightly by 0.1% to 13.8%. The Trust vacancy rate reduced by 1.1% to 8.0%
- The mandatory training rate had reduced by 1.1% to 86.6%. The largest compliance reductions were for Health & Safety, fire training and Infection Control.
- The appraisal rate had reduced by 0.8% to 73.4%. A report with appraisal rate data to be presented to the Committee for assurance in January 2023.

Vaccination Programme
Vaccination programme for flu and Covid was well underway looking to complete within the next 2 weeks. The programme was available for all staff from this week.

Staff Survey
Around 40% of staff had responded to this year's survey, which was 8% down from the same time last year. The survey had also been opened up to TWS staff this year.

Industrial Action
ESHT staff had voted in favour of industrial action by the Royal College of Nursing; further information was expected from the Royal College of Midwives, physios and junior doctors who had all indicated that they would ballot. A significant programme of work was underway to plan for potential strike action.

Workforce Planning

	An update was provided on workforce and business planning, which was aligned with the Trust's clinical strategy, people strategy and overall strategic plan. The business planning section provided a very high level timetable and displayed when we are delivering, what activity profile and volumes look like and how this activity drives the size and shape of our workforce. **People Strategy Update** An update was provided on the People Strategy. The delivery of the People Strategy had entered quarter 4 of the year 1 programme. The report provided an update on the status of current workstreams, alerts and risks. It was highlighted that this was a great achievement within one year. **Staff Wellbeing – Retention** An update was provided on the Retention of our People paper. The paper provided an overview of a number of workstreams currently underway within ESHT to support the organisation in addressing workforce challenges in relation to the increasing turnover of our people. The top 3 priorities were: • Data collated from the notification of leaver form and work ongoing with the workforce team to capture secondary information as these forms were completed by the line manager. • New roles looking at retire and return and linking in with the NHS fellowship. • Accommodation for international staff to make a difference when they arrive. **Staff Wellbeing - Flexible** An update was provided on Health and Wellbeing. As part of the NHS People Plan, the NHS People Promise sets out a series of commitments, one of which is we work flexibly. **Schwartz Round Report** An update was provided of the annual Schwartz Round report. Schwartz Rounds are safe and confidential facilitated meetings whereby all staff clinical and non-clinical come together to reflect on psychosocial emotional aspects of the work that we do. These voluntary sessions provide 1 hour of external CPD. Due to the pandemic the meetings were taking place virtually, which had proved different qualities and different challenges. The intention was to return to a hybrid model of face to face and virtual rounds.

Next steps	N/A

East Sussex Healthcare NHS Trust

Strategy Committee Summary, 27th October 2022

Purpose of the paper	Executive summary attached for Strategy Committee meeting that was held on 27.10.22						
	For Decision		For Assurance	✓	For Information		
Sponsor/Author	Jackie Churchward-Cardiff						
Governance overview	Trust Board						

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
	✓		✓	✓

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	✓	✓	✓	✓

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

Executive Summary

ICP Strategy

The draft Integrated Care Partnership (ICP) Strategy had previously been discussed at the Integrated Care Board (ICB) and with Chief Executives across Sussex. A case for change was being developed to focus on a 5-year strategy which emphasised ambition and aspiration. A focus would be on services that linked with community-based care, the voluntary sector, and acute care.

The Committee received an overview on the Vision 2025 programme which would focus on integration, prevention and engaging with the voluntary sector.

A full discussion was held on the structure of the programme in terms of executive/place sponsorship, and alignment with East Sussex priorities. A further update was due in December

Annual Review 2021/22 Terms of Reference (ToRs)

An update was received on the ToRs, with a proposed name change to the Strategy & Transformation Committee. This recognised the role of Trust-wide transformation programmes that delivered strategies across the Trust. Future Committee meetings would include a regular update on Health Inequalities and reporting on improvements to increase access to healthcare.

A further addition was agreed regarding members having oversight of the delivery of strategy. Quorum for the Committee was noted as being two Non-Executives and two Executives (or nominated deputies) in attendance.

Transformation Progress

An overview was presented of 12 large-scale transformation programmes of work focused on delivering Trust strategies over the next two to five years. Transformation Priorities were for cross-divisional projects, and these each had a named Executive Lead, Clinical Lead and Project Lead to support delivery.

Divisional projects were previously reported via Building For our Future and they would now be delivered via the divisions and overseen through Business As Usual (BAU) governance processes.

	The strategic transformation programmes would report through the Transformation Board and then to the Strategy Committee. **Pathology Network** The Pathology Network programme was due to be finalised. There has been good engagement from all members of the network. A workshop was due to take place but had been pushed back due to the LIMS programme of work being finalised. The timetable for sign off on the procurement for the LIMS provider was due by the end of March 2023. An additional £2m has been agreed as part of delivering to this deadline making a total of £6.5m. The Committee noted the tight deadline for delivery of the programme by March 2023. **Virtual Wards** Good progress was being made with implementation of an initial 60 virtual ward beds and a further 60 virtual ward beds during December. Progress would be reported to the Strategy Committee with workforce risks reported to the People and Organisational Development (POD) Committee and quality risks monitored by the Quality and Safety Committee (QSC). The Committee asked for a one-page update report to be circulated to members of the Committee in November. **BAF Risk 12** The programme had been reviewed on the first two risk factors that had been presented to the Committee. BAF 12 reflected the ESHT priorities as part of the wider Sussex public health priorities, based on the health inequalities function. Risk ratings are to be revised in time for the December review of all Strategy Committee BAF risks. **Rye and Uckfield** Details of the future of day surgery and the elective hub at Uckfield was discussed and required a forward work plan. Community services staffing levels at Rye had been an issue indicating that the clinical and Trust strategy requires a refresh to further develop the community pathways. A further update would be provided at the December Strategy Committee meeting.

Next steps	N/A

East Sussex Healthcare NHS Trust

Chief Executive's Report

Purpose of the paper	To provide an update on key strategic items					
	For Decision		For Assurance	***X***	For Information	***X***
Sponsor/Author	Joe Chadwick-Bell					
Governance overview						

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
	X	x	x	x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	X	x	x	x

Recommendation	The Board is asked to note the updates and assurances provided by the CEO

Executive Summary

As always, I'd like to start with a thank you to all our colleagues who continue to work so hard to make sure we deliver excellent care for our patients and our communities.

Autumn Statement

As you will be aware the Chancellor has announced some financial changes which affect the NHS, and the Minster for Health has restated some of the immediate priorities for the NHS.

The settlement is fair but challenging, and should provide sufficient funds to deliver the key priorities across the NHS. There are of course some unknowns regarding future inflation, future pay deals, Covid and industrial action. It has also been announced that Patricia Hewitt will be undertaking a review of ICBs and their maturity, accountability, and autonomy.

The NHS will need to continue to focus on:

- Reducing the longest waiters on elective pathways
- Earlier cancer diagnosis and reducing cancer backlogs (patients over 62 days)
- Supporting the improvement for ambulance response times, in particular category 2
- Improving the 4 hour target for urgent care
- Improving access to primary care
- Improving efficiency back to 2019/20 levels

For ESHT, whilst we have a role to pay across all the areas above, we will need to ensure:

- 0 patients waiting for over 78 weeks
- Continue to reduce the number of patients waiting over 52 weeks
- Increase productivity across our services, for example in out-patients and theatres. This doesn't necessarily mean working harder but ensuring we use our resources wisely

- Rapidly improving our 4-hour performance across our two sites. We are currently around the mid-point for performance nationally, but we aim to be within the top 25 to 30 organisations nationally.

It was also confirmed that a national £500m discharge fund would be made available with the first tranche being available in December and the second in January. Sussex providers and the local authority are working together through the ICB to agree a list of schemes which provide some immediate solutions as well as some longer-term sustainable schemes. The aim is to see some benefit in December. As highlighted before, the number of patients awaiting discharge affects a range of indicators across quality, finance, performance and importantly also has an impact on our staff.

Critical Care Sensory Garden

I am very proud of how teams are continuously striving to ensure our sites are as welcoming as possible for staff, patients, and visitors alike. I had the pleasure of visiting the new Critical Care Sensory Garden on the Conquest site in November, which was fundraised for, designed, project managed and built by our incredible staff. This is a great example of how unused space can be changed into something of such value.

Industrial Action

The Royal College of Nursing (RCN) has announced that industrial action will be taking place on Thursday 15th December and Tuesday 20th December 2022. Providers have completed a Self-Assessment Checklist to support preparations, with ICBs responsible for consolidating and reviewing returns and providing assurances to the Regional teams. The Trust has regular and open engagement with the unions, as well seeking advice and guidance from Capsticks to ensure legal clarity around any decisions made. However as a Trust we have not been identified as a site where the initial strikes will take place.

ESHT's initial derogation list has been constructed and is planned for negotiation and approval with Union Representatives. An FAQ for staff and managers will be available on the extranet.

Senior Leadership Changes

I'd like to welcome Sheila Roberts to the Trust, Sheila will be acting as the Winter Director whilst we are recruiting to the Chief Operating Officer position. Interviews for this role are planned for December and further updates will be shared once the appointment has been made.

There are also some further changes within the senior team, there comes a time in organisational life cycles when several changes happen at once. We have all posts covered through the winter, but this offers an excellent opportunity to build on the existing operational teams and generate some new thinking and energy.

- Garry East, Deputy Chief Operating Officer will be taking up a new post in the Trust as the Divisional Director of Operations for the DAS (Diagnostics, Anaesthetics and Surgery) Division. I'd like to thank Michelle Elphick who has held the post for 6 years and will be retiring in January.
- Abigail Jago will be leaving her role as the Deputy Chief Operating Officer for Planned Care and Jo Dale will be covering the post whilst we recruit.
- The following senior posts are currently in the process of being recruited to
    - Deputy COO – Urgent Care
    - Deputy COO – Planned Care
    - Divisional Director – Specialist Medicine

We have also appointed three new Chiefs of Division; posts are normally held for 3 years. The remaining posts will be advertised shortly, Urgent Care, Core and DAS.

- Joel Newman – Chief Specialist Medicine
- Kate Murray – Chief Clinical Information Officer (re-appointed)
- Matthew Clark – Chief Women's and Children

Capital Update

Eastbourne Net Zero Carbon Project: The project continues to make good progress with new windows having been installed on the South and East Sides. We have also obtained planning permission for solar panels on the main staff car park.

Eastbourne Emergency Department: Construction work was completed last month to bring additional new clinical facilities into the Emergency Department, including rapid assessment and treatment areas.

Eastbourne Day Surgery Unit: Construction work completed last month, and the project delivered additional new clinical facilities, including theatre recovery capacity for our elective care program.

Bexhill Community Diagnostic Centre: The construction works to establish our new Bexhill Community Diagnostic Centre were completed earlier in the month, and we are in the process of commissioning medical equipment, such as new X-ray equipment. Plans are to fully open the facility in the fourth quarter of 2022/23.

Cardiology and Ophthalmology

At the beginning of November, the plans to improve our Cardiology and Ophthalmology services were approved by the NHS Sussex ICB.

The proposal is to consolidate Ophthalmology services currently provided at Eastbourne District General Hospital (EDGH), Bexhill Hospital (BH) and Conquest Hospital (CQ) into two sites at EDGH and BH.

For Cardiology, the proposal is to create new cardiac response teams at the front door and in the Emergency Departments (EDs) at CQ and EDGH, and to concentrate the most highly specialised cardiac services at EDGH.

The next stage of the process will see East Sussex Health Overview and Scrutiny Committee (HOSC) consider the plans at its meeting in December.

Payroll

As of 1st November 2022, ESHT Payroll and Pensions Service has been managed by the Sussex Health and Care Payroll Hub. This will ensure quicker and easier to access payroll and pension services, with a new Employee Service Desk (ESD) and online portal to answer payroll and pension queries.

The first payroll from the new hub took place on the 24th of November.

Staff Vaccinations

Seasonal flu and COVID-19 booster vaccinations are available for all staff, with drop-in clinics open Monday to Friday across the EDGH and CQ sites. We will be vaccinating until 2nd December and are actively encouraging all staff to take advantage of these clinics.

New Hospital Development

We are hoping for an update on the new hospital programme in the new year; the commitment to the programme has been restated nationally. At this stage there are no firm timescales although we anticipate builds potentially starting in 2026 and being completed by 2030. The national programme is aiming to maximise value for money and working with the construction industry to be innovative about how hospitals are built, reducing time and spend by standardising where possible. It is also working with local Trusts on the co-production of design and business cases to meet the local needs.

	Visible Leadership Executive and Non-Executive Director (NED) visits take place on a regular basis, with the intention of meeting with staff, observing how care is being delivered and listening to feedback from staff, visitors, and patients. A new internal Out and About tracker has been implemented to allow us to track the visits more efficiently, as well as provide a centralised place to record, review and report on the feedback gained at these visits. Visits were undertaken with teams and wards across multiple ESHT sites over the last couple of months, both by Executives and NEDs. A range of different services were visited, from our Community Dietetics team, to Digital, to our Same Day Emergency Care units. A couple of really positive moments for me during these visits were getting to see the new day surgery unit at EDGH, as well as the newly redesigned frailty unit.

Next steps	

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

For the Period October 2022 (Month 7)

Content

East Sussex Healthcare NHS Trust

1.	About our Integrated Performance Report (IPR)	
2.	Chief Executive Summary	
3.	Quality and Safety - Delivering safe care for our patients - What our patients are telling us? - Delivering effective care for our patients	
4.	Our People - Recruitment and retention - Staff turnover / sickness - Our quality workforce - What our staff are telling us?	
5.	Access and Responsiveness - Delivering the NHS Constitutional Standards - Urgent Care - Front Door - Urgent Care – Flow - Planned Care - Our Cancer services	
6.	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	

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.

- Throughout our work we remain committed to delivering and improving on:
  - Care Quality Commission Standards
    - Are we safe?
    - Are we effective?
    - Are we caring?
    - Are we responsive?
    - Are we well-led?
  - Constitutional Standards
  - Financial Sustainability in the long term plan

- Our IPR, therefore, aims to narrate the story of how we are doing and more importantly how we will be doing as we look towards the future.

- Detailed data can be found within the IPR Data Detail (appendix A).

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

Balanced Scorecard

East Sussex Healthcare NHS Trust

Key Metrics

Safety	Target / Limit	Last Month	This Month	Variation	Assurance
Patient Safety Incidents (ESHT and non-ESHT)	M	1104	1230	Common Cause	
Serious Incidents	M	0	3	Improvement	
Never Events	M	0	0	Common Cause	
Inpatient Falls per 1,000 Bed days	M	5.9	6.2	Concern	
Pressure Ulcers, grade 3 to 4	0	1	5	Common Cause	Consistently Missed
MRSA Cases	0	1	0	Common Cause	Inconsistent
Cdiff Cases	<5	6	7	Common Cause	Inconsistent
MSSA Cases	M	2	3	Common Cause	
RAMI	94	87.0	87.8	Common Cause	Consistently Hit
SHMI (NHS Digital monthly)	0.99	0.98	0.98	Common Cause	Consistently Hit
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	88%	86%	Common Cause	Consistently Missed
Nursing Fill Rate (Including Escalation)	100%	87%	86%	Common Cause	Consistently Missed

Patient Experience	Target / Limit	Last Month	This Month	Variation	Assurance
Complaints received	M	38	45	Common Cause	
A&E FFT Score	M	92%	69%	Common Cause	
Inpatient FFT Score	M	99%	99%	Common Cause	
Maternity FFT Score	M	100%	100%	Common Cause	
Out of Hospital FFT Score	M	98%	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%	65.6%	64.7%	Concern	Consistently Missed
A&E Non Admitted	M	72.5%	71.3%	Concern	
A&E > 12 hours from arrival to discharge	0	639	726	Concern	Consistently Missed
A&E waits over 12 hours from DTA	0	0	0	Common Cause	Consistently Hit
UTC 2 hour	>98%	68.8%	70.0%	Concern	Consistently Missed
Cancer 2ww	>93%	78.9%	77.4%	Concern	Inconsistent
Cancer 62 Day	>85%	66.8%	73.2%	Common Cause	Consistently Missed
62 day Backlog	M	132	114	Common Cause	
104 day Backlog	M	19	24	Improvement	
RTT under 18 weeks	>92%	55.9%	54.8%	Concern	Consistently Missed
RTT 52 week wait	0	940	1145	Concern	Consistently Missed
RTT Total Waiting List Size	36,833	52,732	54,273	Concern	Consistently Missed
Overdue P2	M	289	269	Common Cause	
CHIC wait times < 13 weeks	>75%	80.0%	83.2%	Common Cause	Consistently Hit
Diagnostic <6 weeks	<1%	15.0%	16.7%	Improvement	Consistently Missed

Our People	Target / Limit	Last Month	This Month	Variation	Assurance
Establishment (WTE)	M	7,958.6	7,973.6		
Vacancy Rate	<5%	9.1%	8.0%	Concern	Consistently Missed
Staff Turnover	<9.9%	13.7%	13.8%	Concern	Consistently Missed
Retention Rate	>92%	89.4%	89.4%	Concern	Consistently Missed
Sickness - Absence % (rolling 12 mths)	<4.5%	6.0%	6.1%	Concern	Consistently Missed
Sickness - Average Days Lost per Fte	<16	21.9	22.172	Concern	Consistently Missed
Staff Appraisals	>85%	74.2%	73.4%	Common Cause	Consistently Missed
Statutory & Mandatory Training	>90%	87.6%	86.6%	Concern	Consistently Missed

Our Productivity	Target / Limit	Last Month	This Month	Variation	Assurance
4 hour theatre sessions	M	496	481	Common Cause	
Average Cases per 4 hour session	M	2.5	2.4	Common Cause	
Clinic run rate	M	79.1%	82.7%	Common Cause	
Non Face to Face Outpatients	>25%	27.3%	25.1%	Concern	Consistently Hit
Elective Length of Stay	2.7	2.8	3.1	Common Cause	Inconsistent
Non Elective Length of Stay	3.6	5.2	5.2	Concern	Consistently Missed

Chief Executive Summary

East Sussex Healthcare NHS Trust

The Trust has worked hard to tackle key areas outlined in the national planning guidance and as a result of this, has gained recognition as a higher performer across a number of standards. To include cancer, elective recovery and management of long waiting patients. Another of our focus points continues to be the 4 hour target. This has been a challenge for our Trust in recent months as we adapt plans to meet the changing demand on our emergency departments. It is evident from our analyses that our 4 hour performance is multi-factorial. The high bed occupancy in our hospitals, our growing length of stay and our limited ability to discharge to onward care beds are challenges that we and our system partners are working collaboratively to address. As an outlier for our Long Length of Stay patients, with over 30% of our beds occupied with patients residing 21 days or longer, this will be a key priority. Our executive winter director is working with divisions internally and external stakeholders to improve discharge and drive down overall length of stay.

Notwithstanding the above, we continue to focus on: 60 minute handover delays, patients in A&E over 12 hours and separately patients awaiting mental health review or bed, number of super surge beds (beds over our available bed base). We also remain focused on our elective and cancer recovery and continue to balance priorities daily to ensure the elective programme continues to be delivered despite all of the challenges with high bed occupancy and long length of stay.

We do recognise the impact that this increased demand is having on our workforce and we continue to support staff with wellbeing conversations and initiatives

Key Areas of Success

- We remain in the top quartile nationally for our performance in
  - Our diagnostic DM01 standard (the ask to complete diagnostic tests within 6 weeks of referral date)
  - Cancer 62 day target (ability to treat patients with a confirmed cancer within 62 days from date of referral)
- Our vacancy rate has fallen by 1.1% to 8% and our turnover has stabilised. Successful recruitment campaigns in some key disciplines have contributed to this.
- Trust is reporting a year to date breakeven position against a planned deficit of (£0.2m), a favourable variance of £0.2m

Key Areas of Focus

- Our key area of focus in the coming months is to address the overall average length of stay in our acute and community beds
- The Trust has in place an operational recovery plan to recover the 4 hour performance, working across the emergency departments and other divisions, all who have have roles and responsibilities within plan. We will be rolling out key messages across the trust and how this impacts patient care, staff wellbeing and the trust's reputation, with a focus on lets get you home for Christmas.
- The elective recovery of our long waiting patients has deviated from trajectory. Workforce challenges and pressures are a common factor. Divisions will continue to focus on reducing long waits and will work collaboratively with system partners to mitigate capacity constraints where possible

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 - October 2022 Data

East Sussex Healthcare NHS Trust

Author(s)

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

Simon Merritt
Chief Medical Officer

COVID – 19
In October Omicron BA.5 remained the dominant variant in circulation and is highly transmissible. The Trust reported 9 ward outbreaks in addition to multiple outbreaks in bays. Testing has been revised in line with national guidance and staff are now testing symptomatic patients for RSV and seasonal influenza as well as COVID. Facemask wearing in clinical settings remains in place for staff and visitors. This has been agreed as an ICS approach for winter and will be kept under review.

Infection Control
The limit for C. difficile infections was exceeded in October and the Trust has now reached the limit for the year. Many Trusts are reporting higher numbers of CDI and reasons are not fully known and will be discussed at a national workshop in December. ESHT is ribotyping each case and the ongoing high number of cases do not appear related to outbreak or cross infection. Ebola preparedness was completed as requested by UKHSA.

Incidents
There were three serious incidents reported during October:
- a fall resulting in significant harm
- a delay in diagnosis and treatment for cancer with patient lost to follow up.
- a very significant Medication incident.

A weekly tracker is in place to enable the close monitoring of overdue amber reports, particularly within WC&SH division.

Pressure Ulcers
The rate of pressure ulcers per 1,000 bed days for all inpatients increased in October. Similarly the number of PUs reported amongst people in their own home also increased. This may in part be due to incorrect reporting/coding of incidents on Datix which have yet to be reviewed and validated by clinical leads (handlers). Three category 3 & 4 PUs were also reported in October (2 patients in their own home and 1 inpatient). Each will undergo an RCA investigation and will be reported to the Pressure Ulcer Review Group (PURG).

Falls
There were two severity 4 falls in October. Several patients had multiple falls, an ongoing indicator of the huge numbers of stranded patients many of whom are frail, confused, wandersome and high risk. Ongoing Staffing challenges exacerbated by the need for surge and supersurge capacity is impacting on the ability to provide enhanced observations.

Patient Experience
2,187 pieces of patient feedback were received in October, 2.05% of feedback was a formal complaint (45). Teams continue to work through the backlog with 18 overdue complaints at the end of October. FFT submissions remain lower than pre-COVID and in October Maternity only received 5 completed surveys. The Patient Experience team have worked with ED to increase the response rate. Oct saw 96 completed surveys with a recommendation rate of 68.42%. The Patient Experience and Communication Team are looking at ways of promoting FFT with updated posters, updated website and survey questions are being reviewed.

Nursing & Midwifery Staffing
The requirement for significant additional inpatient bed capacity continued throughout Oct with additional supersurge capacity open on three sites. The trust continues to see huge numbers of stranded patients most of whom are frail, vulnerable and very dependent with examples of people with complex Learning Disabilities now being stranded. Our Safeguarding team are closely involved with new weekly meetings started in Nov for long length of stay pts. Ward staffing in Oct remained very stretched in most areas which is likely to have had an impact on key quality metrics especially unwitnessed falls, documentation, communication, discharge planning and staff wellbeing due to the sustained pressures.
The 2022/2023 Nursing Establishment Review data collection was completed as planned in Oct and review meetings are being arranged. Preparations are underway in an attempt to mitigate risk with regard to the planned industrial action for nurses who are members of the RCN.

Safeguarding
Quality improvement work is ongoing with a robust action plan and weekly meetings with our divisional ADNs. Safeguarding referrals are monitored via the weekly tracker which includes those raised about the trust. Themes include discharge and skin integrity and this has been raised as an organisational risk. Incidents have increased nationally with changes in presentation and cases noted to be more complex with multi factorial risks.
There have been several complex cases involving people with learning disabilities where care settings have declined the person's return or a change in funding has left them stranded.
Work continues regarding Deprivation of Liberty Safeguards (DoLS) as well as ongoing discussions to ensure staff are prepared for the introduction of Liberty Protection Safeguards (LPS) planned to replace DoLS.
For children and young people, mental ill health continues to be the predominant theme of the weekly risk meeting with recent examples of some high risk children stranded for months with court involvement necessary to secure foster care.

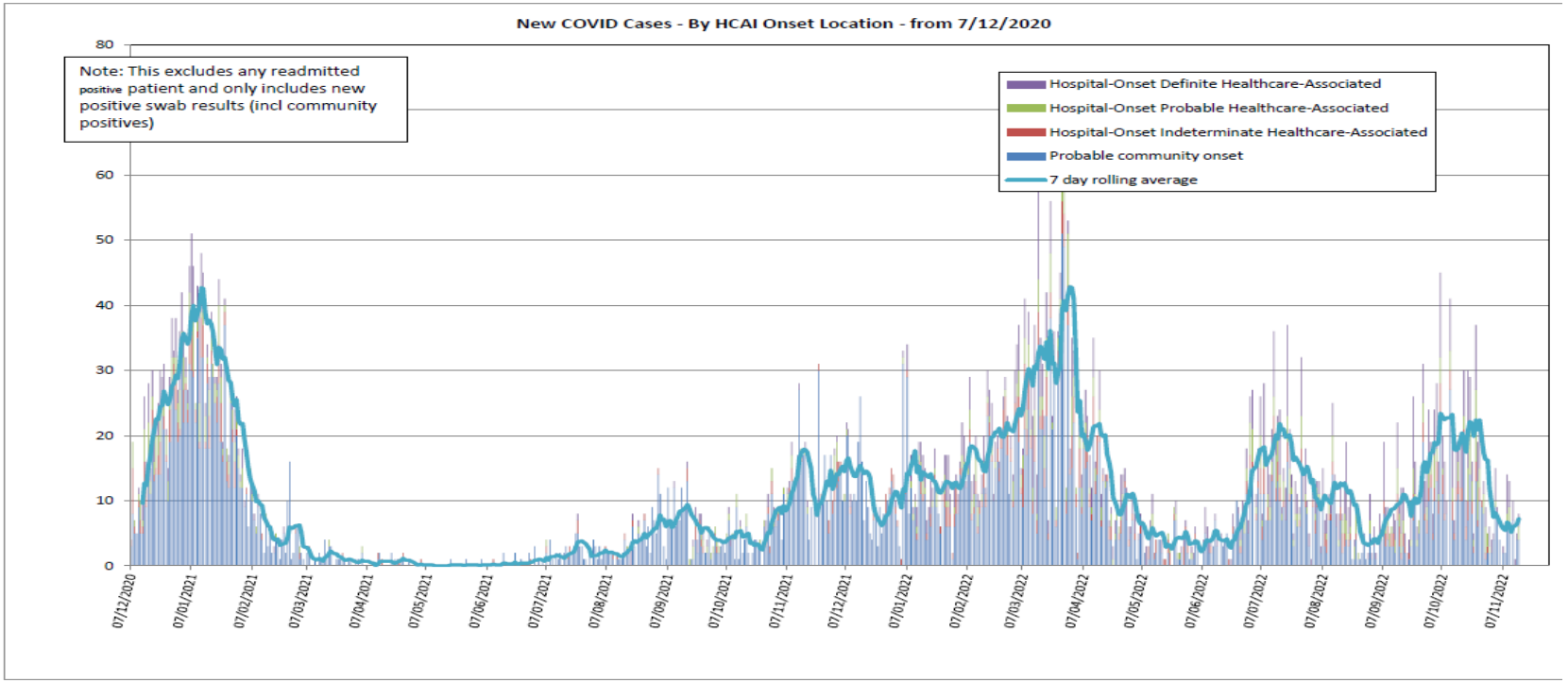
COVID-19

East Sussex Healthcare NHS Trust

Quality and Safety

Prevalence

Prevalence of COVID in the local community has significantly declined again. As of 10th November 2022, COVID prevalence for England was 42.7/100,000 population, East Sussex was 50.5/100,000 with Hastings showing highest prevalence in the area at 61.6/100,000. This represents a more than 50% decrease in positive tests reported in the previous week, noting this may be a conservative number as community testing has reduced. The number of patients presenting to our hospitals has declined and at 15th Nov there were only 27 patients diagnosed with a current COVID infection. The COVID variant that is most common in our area is still Omicron BA.5.



Outbreak control measures and reporting has been in line with trust and national requirements. There were 9 outbreaks meeting criteria for external reporting during Oct and these were managed in line with agreed trust process and external reporting requirements.

The IPC winter plan for Sussex has been revised by the Sussex IPC cell. The plan is reviewed regularly at the Sussex IPC Cell meetings with the aim to have a system approach as much as possible. Patients presenting with respiratory symptoms are now being tested for COVID, Flu and Respiratory Syncytial Virus (RSV) as part of winter preparedness. The testing protocol agreed by the Clinical Advisory Group has been implemented and will be reviewed if there is significant change in prevalence.

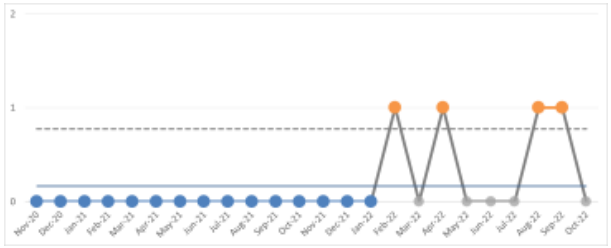
Safe Care - Infection Control

East Sussex Healthcare NHS Trust

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

Quality and Safety

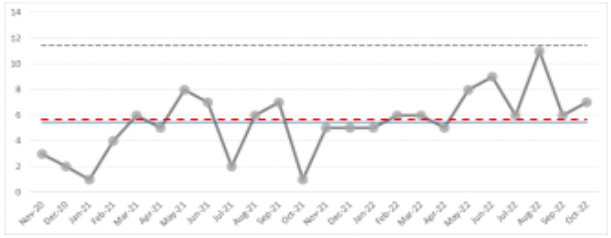
MRSA cases



Variation: Normal
Current Month: 0

MRSA bacteraemia (MRSA)
There were no MRSA bacteraemias to report for October.

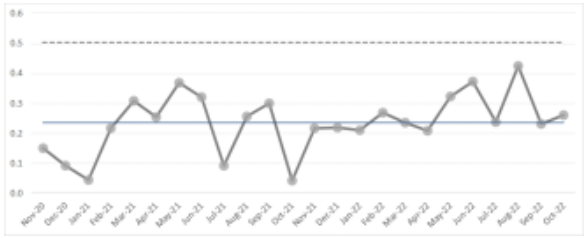
CDIFF cases



Limit: 5.66
Variation: Normal
Current Month: 7

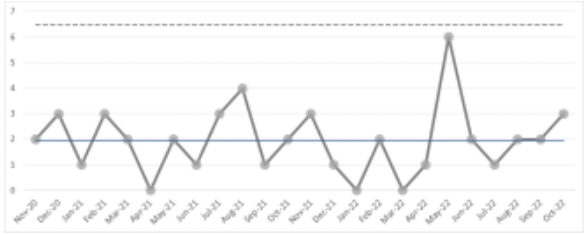
Clostridium Difficile Infection (CDI)
For the month of October, the Trust reported 7 cases of CDI against a monthly limit of 4. All were reported as Hospital Onset Healthcare Associated (HOHA). Six of the cases were identified at EDGH and three of these were patients on one ward. Ribotyping indicates that the infections are not related to each other and therefore do not represent cross infection. Post infection reviews are being arranged to assess if there has been any contributory lapses in care.

CDIFF per 1000 bed days



Variation: Normal
Current Month: 0.26

MSSA



Variation: Normal
Current Month: 3

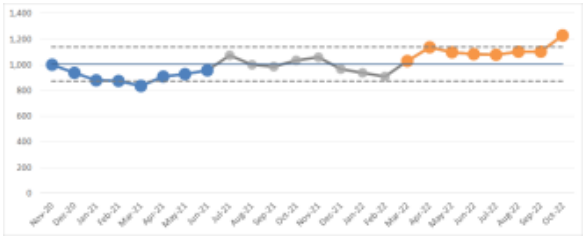
MSSA bacteraemia
Three MSSA bacteraemias were reported in October. All were reported as Hospital Onset Healthcare Associated (HOHA). One case was related to a community acquired pneumonia, treated with antibiotics. Another was a skin/soft tissue infection, treated with antibiotics. One case was of an unknown source.

Safe Care – Incidents

East Sussex Healthcare NHS Trust

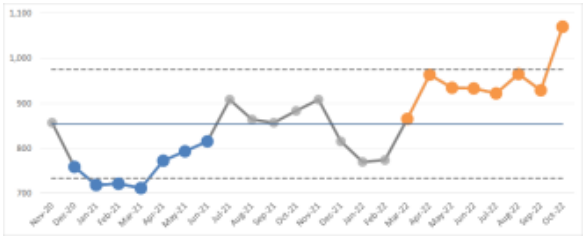
Quality and Safety

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



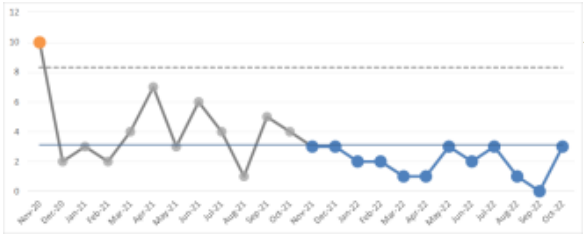
Variation: Normal
Current Month: 1,230

Patient Safety Incidents (ESHT incidents)



Variation: Normal
Current Month: 1071

Serious Incidents (SIs) (Incidents recorded on Datix)



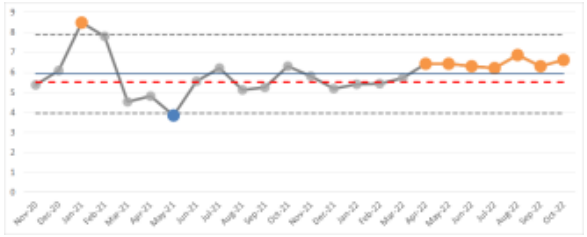
Variation: Normal
Current Month: 3

Author:	**Margaret England – Head of Governance**
Status Report	There were 1,230 incidents reported (from Datix on 17/11/2022). 1,071 were **ESHT only** incidents and of these: Severity 1 None/Near Miss - 737 Severity 2 Minor - 299 Severity 3 Moderate - 30 Severity 4 Major - 5 Severity 5 Catastrophic - 0 **Top five reporting locations**: Patients Home - 74 Office/Administration Area - 56 Emergency Dept Eastbourne - 50 Emergency Dept Conquest - 44 Irvine Unit Intermediate Care Unit - 44 Acute Medical Unit Eastbourne - 39 **Top reported categories:** Slips Trips and Falls - 191 Diagnosis and Diagnostic Services - 95 Medication Errors and Other Medication Related Incidents -95 Pressure Ulcer ESHT Acute Hospital - 79 There were three SIs reported in Oct. • Fall resulting in head injury • Delay in diagnosis and treatment for cancer with patient lost to follow up • Medication incident where magnesium was erroneously mixed with an antibiotic instead of water
Challenge & Risk:	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. After Action Review training was successfully delivered in October 2022 but many staff didn't attend their booked sessions which reduces the number of trained staff in divisions.
Actions:	PSIRF implementation planning will continue alongside prep for Datix Cloud IQ (new online system for collating incidents & experience) and Learning from Patient Safety Events (LFPSE). The Trust anticipates implementing PSIRF by Aug 2023.

Safe Care – Falls

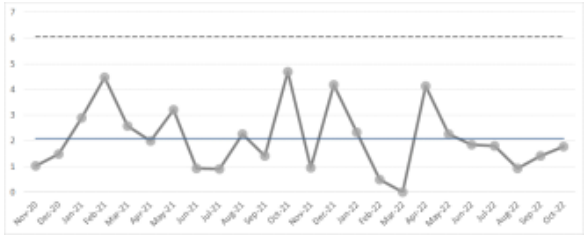
East Sussex Healthcare NHS Trust

Inpatient Falls Per 1,000 Bed Days (Acute)



Average: 5.52
Variation: Normal
Current Month: 6.6

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



Variation: Normal
Current Month: 1.79

Author:	**Margaret England – Head of Governance**
Status Report	There were a total of 191 falls in Oct. Repeat falls: • 13 patients who had 2 falls each • 6 patients who had 3 falls each • 2 patients who had 4 falls each • 1 patient who had 5 falls Areas reporting the highest numbers of falls during Oct: Irvine Unit Intermediate Care Unit - 17 Devonshire Ward - 12 Acute Medical Unit Eastbourne - 11 De Cham Ward - 10 Newington Ward - 10 There were 22 falls reported in non ward areas. The highest reporting area was Emergency Dept Conquest with 5. There were three severity 4 falls reported during Oct on Baird ward, the Irvine Unit and MAU at Conquest.
Challenge & Risk:	Significant additional capacity is still open now with supersurge capacity open on three sites. There are huge numbers of patients not meeting criteria to reside (NCTR) and medically fit for discharge (MFD), many of whom are frail, confused and dependent with increased risk of harm. Many are confused and prone to wandering and 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 were MFD. Work continues regarding harm reviews for these patients including deconditioning with discussions about Safeguarding and deprivation of liberties ongoing.

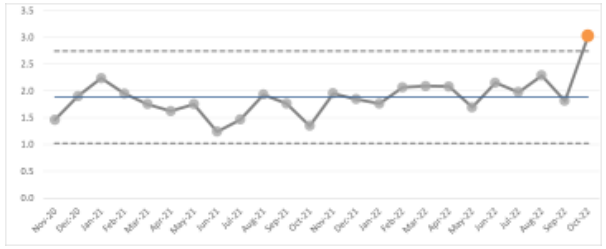
Safe Care - Pressure Ulcers

East Sussex Healthcare NHS Trust

Quality and Safety

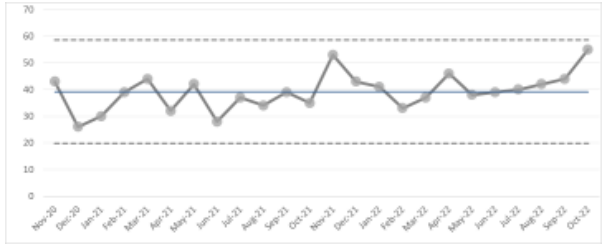
Pressure Ulcers Per 1000 bed days
Inpatients all categories

Monitoring
Variation: Normal
Current Month: 3.02



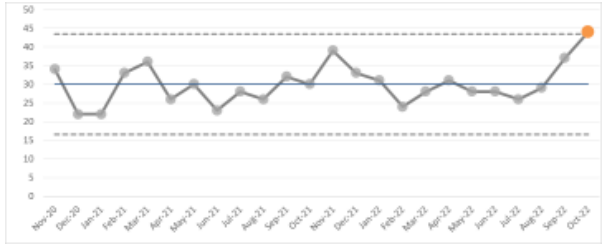
Pressure Ulcers
Non Inpatients all categories

Monitoring
Variation: Normal
Current Month: 55



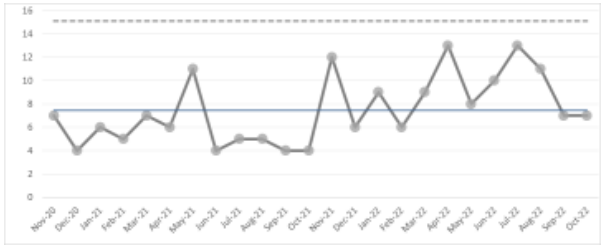
Pressure Ulcers Category all categories
Patient Home

Monitoring
Variation: Normal
Current Month: 44



Pressure Ulcers Category all categories
Other care provider

Monitoring
Variation: Normal
Current Month: 7



Author:	**Tina Lloyd – Assistant Director of Nursing**
Status Report:	The rate of all Pressure Ulcers (PUs) per 1,000 bed days significantly increased in Oct above the expected expected control limits (Graph 1). The increase is associated with the reporting of minor/Cat 2 damage reported amongst hospital inpatients. Due to ongoing busyness not all of these have been validated. Until all of the Datix incidents are reviewed by the incident handlers (Matrons) this number cannot be fully validated. Moisture damage or trauma are often incorrectly reported as pressure damage. The PU Review Group (PURG) has identified 5 wards which have reported clusters of cases (5 or more) which are under investigation. This included orthopaedics and areas with large numbers of stranded patients in medicine. A review of orthopaedics is underway. In October there was 1 cat 3 (pts home) and 2 Cat4 (1 acute 1 pts home) ulcers reported, all subject to RCA. The number of PUs reported amongst patients not in a hospital setting (known to ESHT community services) has increased again (Graph 2). Whilst the number of PUs reported in patients own home has increased, the number reported in care homes is smaller and more unpredictable (Graph 4). 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 supersurge capacity also now open. 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:	The revised Transfer of Care (TOC) form was approved by the Policy ratification group in October and will be launched shortly. The new form will help to improve 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.

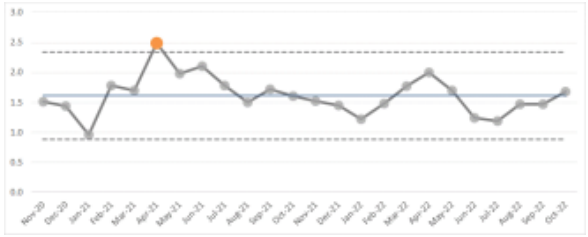
What patients are telling us?

East Sussex Healthcare NHS Trust

Amy Pain- Patient Experience Lead

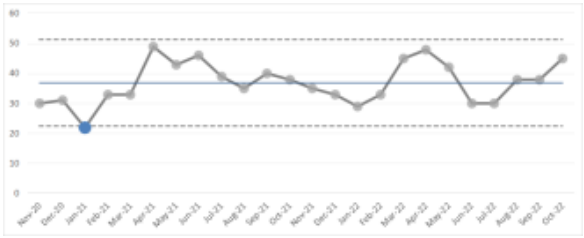
Quality and Safety

Complaints Received per 1,000 bed days



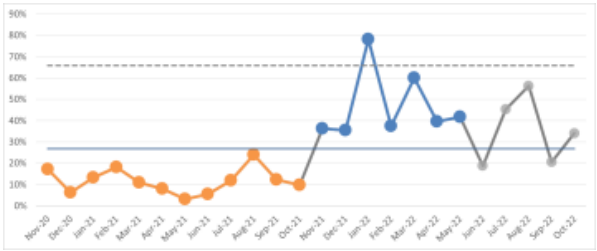
Variation: Normal
Current Month: 1.7

Total Complaints Received



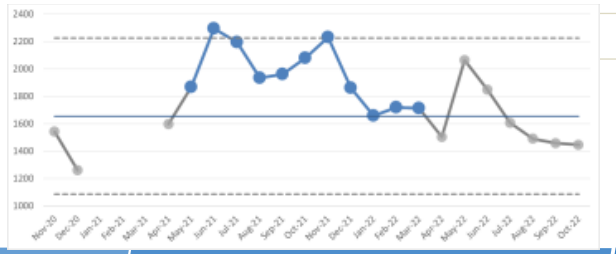
Variation: Normal
Current Month: 45

Complaints Response Times



Monitoring
Variation: Normal
Current Month: 34.0%

Plaudits Received



Monitoring
Variation: Normal
Current Month: 1445

Status Report

In October ESHT received 2,187 pieces of patient feedback.
This feedback was made up of:

- 1,551 FFT surveys completed (of which 1,367 included plaudits)
- 78 plaudits in the form of letters and thank you cards
- 10 positive reviews posted on Healthwatch website and NHS website
- 45 complaints received (September =38)
- 8 reopened complaints (September =8)
- 225 PALS concerns
- 263 PALS advice
- 5 negative reviewed posted on Healthwatch and NHS website
- 2 PHSO enquiry contacts

Of the 45 complaints received in October, 3 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**.

The top three primary complaint subjects were:

- Clinical Treatment = 13 (September =9,August=10, July= 8, June = 11, May = 9)
- Communication = 6 (September =6, August= 8, July= 9, June = 6, May = 8)
- Patient Care = 5 (September =8, August= 7, July=1, June=5, May= 8)

Top complaint locations:

- Emergency Department = 9 (CQ =4 and EDGH =5)
- Outpatient Department =8 (CQ= 4 and EDGH=4)
- Office/ Administration area (2)
- Richard Ticehurst SAU (2)

There were **18 overdue** complaints at the end of October - the oldest complaint was 20 working days overdue. These complaints were overdue for various reasons but no specific themes identified.

The overall response rate for the month was 34%, a increase on September (21%). For 35 working days this was 37% and for 50 working days it was 17%.

The top three primary PALS subjects were:

- Communication =63
- Appointments =55
- Patient Care =34

Top PALS locations:

- Outpatient Departments (EDGH) =61
- Outpatient Departments (CQ)= 33
- Office/ Administration area =21

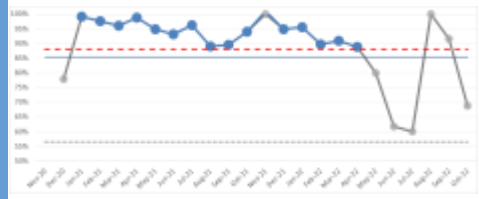
Challenge: Ongoing and increasing operational pressures still affecting response times.

Actions: Capacity discussed at Quality & Safety Committee re need to ensure equal focus on quality and governance. Patient Experience Officers (prev known as Complaints 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. We will be reviewing the content of our complaint responses to ensure the language and tone used is appropriate.

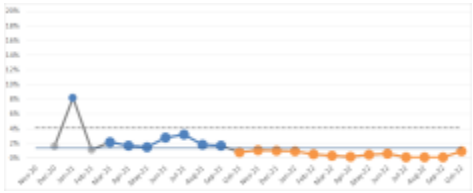
What patients are telling us?

East Sussex Healthcare NHS Trust

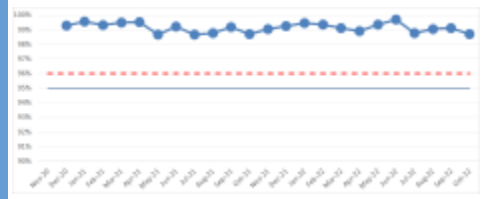
F&FT – A&E Score
Current Month: 68.8%



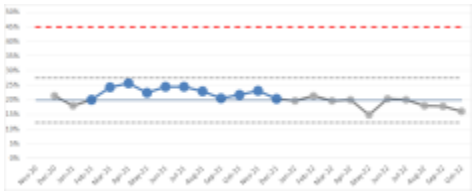
F&FT – A&E Response
Current Month: 0.9%



F&FT – Inpatient Score
Current Month: 98.7%



F&FT – Inpatient Response
Current Month: 16.0%

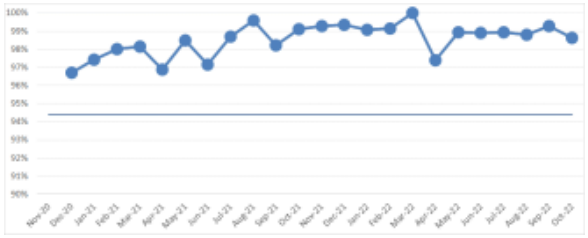


F&FT – Maternity Score
Current Month: 100.0%

F&FT – Maternity Response
Current Month: 1.3%

F&FT – Outpatient Score

Variation: Normal
Current Month: 98.6%



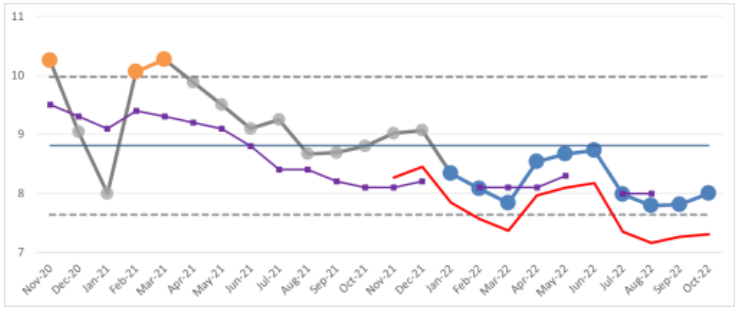
06/12/2022

Author:	**Amy Pain - Patient Experience Lead**
Status Report	The total number of Family & Friend Tests (FFT) surveys returned in October was 1,551 (September= 1,579, August 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 and Maternity. The **positive recommendation rates** for October, compared to the most recent data released by NHSE (August) with the exception of A&E ESHT continues to be higher than the national average. **A&E** 68.75% , nat avg Aug 77% (ESHT resp rate 0.90%) **Inpatient** 98.70% , nat avg Aug 94% (ESHT resp rate 16.04%) **Maternity** 100% , nat avg Aug 93% (ESHT resp rate 2.20%) **Outpatients** 98.63% , nat avg Aug 93% (291 surveys) **Community** 96.27% , nat avg Aug 94% (161 surveys) The top three scoring questions on the FFT inpatient survey were: • Were you always treated with kindness? • Did you feel the staff responded appropriately to any questions or concerns you raised? • Did all staff have a smiling and friendly approach? Themes related to dissatisfaction for the adult inpatient survey were with discharge processes.
Challenge & Risk:	Both ED's continued to face considerable operational pressures with crowding and longer wait times. Maternity continues to experience significant decrease in the number of surveys completed in October. Work is under way to review and streamline the questions asked and promotional opportunities for the completion of FFT.
Actions:	A review of the process for capturing Out Patient Departments' (OPDs) patient experience is still underway. Members of the Patient Experience team are promoting the completion of FFT in Emergency Department EDGH. Maternity surveys have been streamlined and revised posters displayed on the unit promoting completion of FFT.

Effective Care – Nursing & Midwifery Workforce

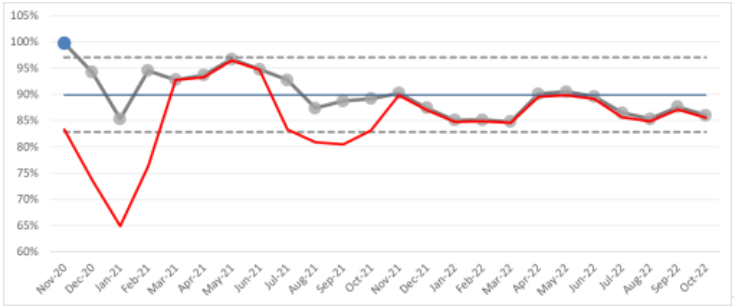
East Sussex Healthcare NHS Trust

CHPPD (Trust)



National Median: 8.0 (Aug 22)
Level 2 and Level 3 Areas Excluded: 7.3
Current Month: 8.0

Staff Fill Rate (total)



Current Month: 86.0%
Incl. escalation: 85.6%

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

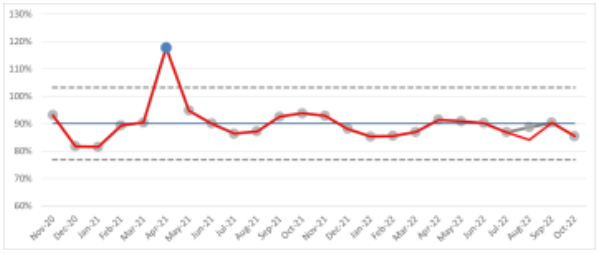
Author:	**Angela Colosi Assistant Director of Nursing - Corporate**
Status Report:	**Care Hours per Patient Day (CHPPD)** The red line indicates the ESHT CHPPD when level 2 & 3 areas are excluded - Critical Care, SCBU, CCU and paediatrics. These areas have notably higher CHPPD and therefore skew the average. Ward level breakdown with registered and unregistered staff split is discussed in the Safer Staffing report that is presented at the Patient Safety and Quality Group with exceptions to the Quality & Safety Committee with some significant variation across areas. In October, **24 out of 40 areas were under 8.0 CHPPD, with 15 areas under 7 CHPPD**. **Fill Rate** October's average fill rate against the planned budgeted establishment **for substantive wards only** was 86% for nursing, noting some variation across wards. The red line which is the fill rate inclusive of escalation only includes Polegate and Devonshire wards but other escalation beds were open in October. It is not possible to separate out 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). At time of writing additional supersurge capacity also open. Additional capacity remained open for medical patients on Devonshire, Polegate, Murray, Litlington, the Discharge Lounge at CQ, Seaford annexe, SDEC Conquest, and SDEC EDGH. The fill rate including escalation was 85.6%. 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 and 'supersurge' 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 for in-patient areas
Actions:	• Twice daily staffing reviews to ensure risk is mitigated as much as possible • Preparations are underway to mitigate risk to patient safety in the event of industrial action.

Effective Care – Nursing Workforce

East Sussex Healthcare NHS Trust

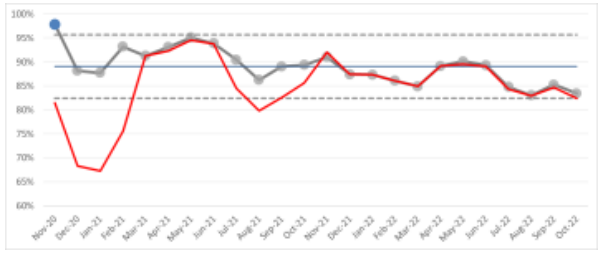
Staff Fill Rate (Bexhill)

Variation: Normal
Current Month: 85.4%
Incl. escalation: 85.4%



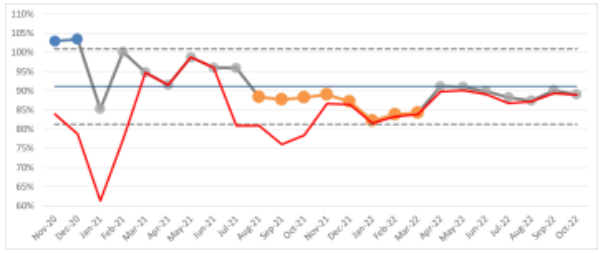
Staff Fill Rate (Conquest)

Variation: Normal
Current Month 83.4%
Incl. escalation: 82.4%



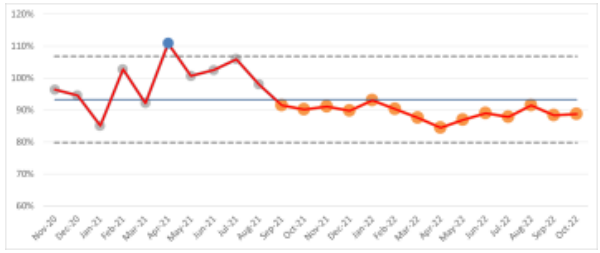
Staff Fill Rate (Eastbourne DGH)

Variation: Normal
Current Month: 89.0%
Incl. escalation: 88.9%



Staff Fill Rate (Rye Memorial)

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

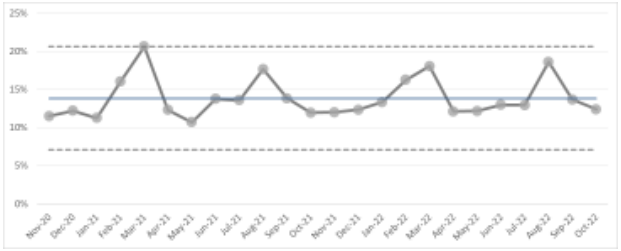


Author:	**Angela Colosi, Assistant Director of Nursing - Corporate**
Status Report:	Eastbourne & Conquest fill rate data does not fully represent the impact of the additional areas open as only Polegate and Devonshire at EDGH are captured as unfunded areas. In addition, Murray, and Seaford, escalation beds are also funded as part of the ward and therefore not included in the fill rate calculation. As well as escalation beds additional beds have been opened as part of the risk assessed 'Supersurge beds'. This means that patients are placed into areas on a ward that have not previously been part of the funded bed stock e.g. treatment or MDT rooms. These additional patients are cared for by the substantive staff on that ward. Fill rates at Bexhill remained stable during October at 85.4% in addition to providing significant staffing support to Rye Memorial Hospital who have ongoing vacancies. Some additional beds have been occasionally opened in the Atrium space at Bexhill following a full risk assessment. 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 supporting continuous flow. In addition there is a need to ensure compliance with mandatory and essential training to ensure retention of staff. Scrutiny of the availability of nursing staff and identified gaps over the Christmas period is underway.
Actions:	• Healthroster compliance sessions continue. • International nurses contributing to support worker shifts as part of their induction from the 1st November.

Effective Care – Nursing Workforce

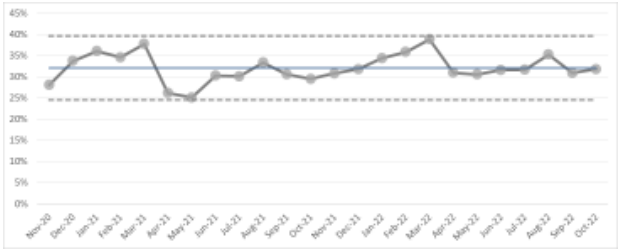
East Sussex Healthcare NHS Trust

Annual Leave (%)



Current Month: 12.4%

Total Unavailability (%)



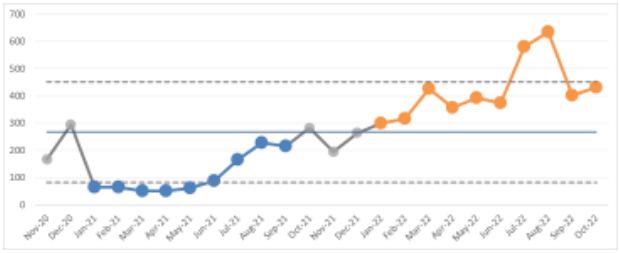
Current Month: 31.8%

Author:	**Angela Colosi Director of Nursing - Corporate**
Status Report	Additional work is underway in conjunction with the HR Assistant Director for Workforce Systems, Planning & Insight, to review compliance in relation to the booking of annual leave. The standard is between 11% and 17%. Compliance during October was 12.4% for nursing so within agreed parameters.
Challenge & Risk:	Availability of nursing staff in the last 2 quarters of the year can be a challenge due to both planned and unplanned leave. With the possibility of industrial action, increased admissions of patients with respiratory conditions (also affects some staff) and the possibility of adverse weather conditions it is important that plans and processes are in place to ensure safe levels of staffing both in the in-patient areas and in the community setting.
Actions:	• A position forecast of the Christmas period and leading up to the end of the financial year has been produced for review and actions • Monthly healthroster compliance sessions led by the Heads of Nursing and supported by the SafeCare Lead Nurse • Industrial action task force meeting • Divisional review of business continuity plans and risk assessments • HoNs to escalate staffing issues to ADN corporate

Effective Care – Nursing Workforce

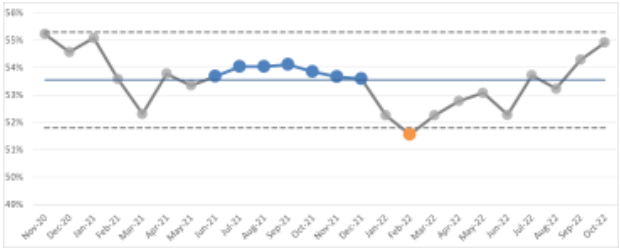
East Sussex Healthcare NHS Trust

Red Flags



Current Month: 431

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



Current Month: 54.9%

Author:	**Angela Colosi Assistant Director of Nursing - Corporate**
Status Report:	All in scope in-patient areas have now received training from the SafeCare Lead Nurse. 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 and is now within upper and lower control limits for October. 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 54.9% in October.
Challenge & Risk:	Compliance in SafeCare completion continues to improve and is 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. • The 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.

Our People

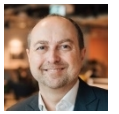
Recruitment and retention
Staff turnover / sickness
Our quality workforce
What our staff are telling us?

Safe patient care is our highest priority

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

Summary

East Sussex Healthcare NHS Trust

	Positives	Challenges & Risks	Author
Responsive	**Vacancy rate** has reduced by -1.1% to 8.0% **Net Substantive** Increase of 54 fte this month **Current vacancies** are showing as 624.4 ftes **Substantive usage** increased by 85.0 ftes **Total Pay Expenditure** has reduced in month by £2.6 mill **Temp workforce cost** reduced by £0.4 mill **Turnover** has stabilised with the smallest increase for 6 months	**Monthly sickness** increased by 1.3% to 6.5% **Annual sickness** increased by 0.1% to 6.1%. **Mandatory Training** rate has reduced by -1.1% to 86.6% **Appraisal** compliance reduced by -0.8% to 73.4% due to operational pressures	 **Steve Aumayer** Chief People Officer

Overview:

The increases in sickness rate this month were due to an increase in Chest & Respiratory illnesses, which went up by 1,453 fte days lost. At the start of Oct, Covid sickness started to increase, up to a peak of 101 staff off sick, on 21 Oct. Since that peak, however, numbers have fallen and, as of 11 Nov there were 41 staff off sick with Covid. Other Cold, Cough Flu absences also saw a seasonal rise this month of 678 fte days lost, whilst there was an increase in absence due to Anxiety/Stress, up by 537 fte days lost (such absence has tended to rise and fall in tandem with Covid sickness).

Turnover increased very slightly again this month, by 0.1% to a new high of 13.8% (911.4.fte leavers in the last 12 months, an increase of 12.2 fte leavers on last month). Registered Nursing & Midwifery turnover, however, was unchanged at 12.9% (263.3 fte leavers), whilst Medical & Dental turnover reduced by 0.2% to 13.6% (42.2 fte leavers, a reduction of 0.2 fte leavers) and AHP turnover reduced by 0.5% to 15.7% (82.4 fte leavers, a reduction of 2.0). The increase was in Admin & Clerical turnover which went up by 1.1% to 14.1% (196.4 fte leavers, an increase of 16.5 fte leavers).

The Trust vacancy rate reduced (-81.0 fte vacancies compared to last month, down to 624.4 fte vacancies). This is due to successful recruitment. Medical & Dental vacancies reduced by 3.9 ftes, Registered Nursing & Midwifery by 32.2 ftes, AHPs by 5.9 ftes and Additional Clinical Services by 53.7 ftes. Admin & Clerical vacancies, however, increased by 20.3 fte vacancies but this was due to increases in the fte budgeted establishment in Corporate due to adjustment for Digital staff previously transferred to capital, and a delay in reducing vacancies for CIP in Oct in Corporate areas. Some success with continued targeting of "hard to recruit" posts, Consultants for Obs and Gynae Locums, Consultant and FY2s for Acute/Gastro/Stroke and Geriatrics. Activity remains focused around Theatre ODPs, Community Nurses and AHPs. Support for CDC with regards to Radiographers and Sonographers. Focus also on UTC, Estates & Facilities and A&E

Demand for TWS services remains high for Midwives, Theatre staff, Doctors, Sonographers and the Emergency Dept. There is a continuing challenge to provide bank support, with demand outstripping supply. Bank fill rate across the Trust is 49%. Medics Agency and Bank c60%.

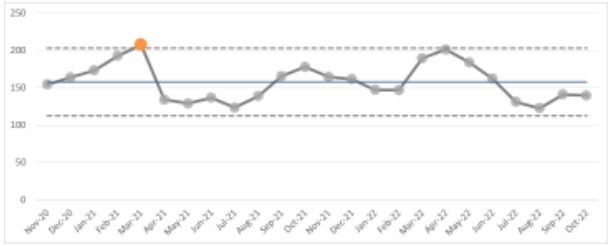
Continued actions to reduce agency spend by ensuring adherence to the governance process. Working across ICS to look at standardising rates. Tier 1 & Tier 2 agencies have been engaged to assist with demand. Ongoing activity to increase bank supply, both dual contracts and bank only. Focus remains on increasing the number of candidates on TWS. Ongoing communication has been made with colleagues to join the bank as dual contracts to meet the current demand. Local advertising campaigns. Additional HCAs and Nurses have been placed on the bank through recruitment activity.

Workforce – Contract type

East Sussex Healthcare NHS Trust

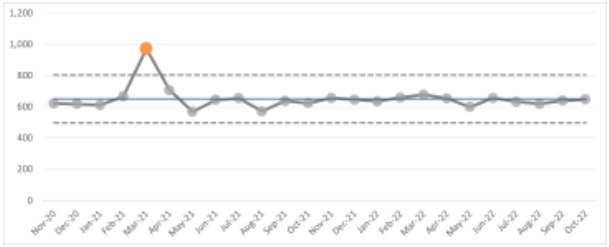
Author: **David Moulder, Greig Woodfield**

Agency FTE Usage



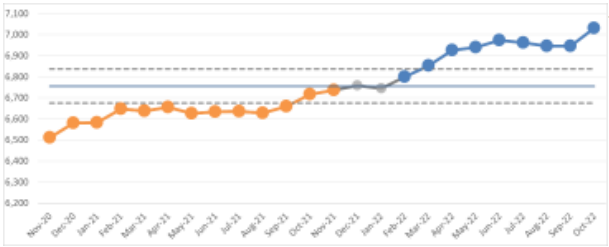
Current Month: 139.5

Bank FTE Usage



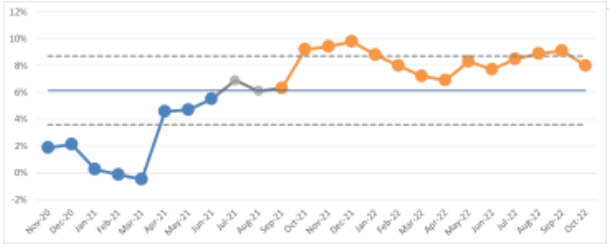
Current Month: 646.9

Substantive FTE Usage



Current Month: 7030.3

Vacancy Rate



Target: 5%
Current Month: 8.0%

Status Report

Substantive usage increased by 85.0 ftes, bank usage increased by 8.7 ftes and agency usage reduced by -1.4 ftes.

Temporary workforce utilisation was 8.3%, a -1.8% reduction from last month. The Trust vacancy rate reduced by -1.1% to 8.0%.

Staff group	Vacancies ftes	Recruitment Process (ftes)	Offers & Start Dates (ftes)	Time to Hire (days)
Med & Dental	98.8	71.7	68 (incl 10 bank	79
Reg Nurse	135.5	211.7	113	67
Addit Clin Serv	210.5	167	103.2 (inc 19 bank)	57
AHP	75.8	73	52.1	79
Prof, Sci, Tech	13.0	7	8	75
Healthcare Scs	4.0	22.2	7.8	58
A&C	99.4	125.8	72.5 (inc22 bank)	59
Estates & Ancillary	49.2	77.3	31	58
Trust	624.4	755.7	455.6	66.5

Challenge & Risk:

Demand for TWS services remains high for Midwives, Theatre staff, Doctors, Sonographers and the Emergency Dept. There is a continuing challenge to provide bank support, with demand outstripping supply. Bank fill rate across the Trust is 49%. Medics Agency and Bank c60%

Continued actions to reduce agency spend by ensuring adherence to the governance process. Working across the ICS to look at standardising rates.

Tier 1 & Tier 2 agencies have been engaged to assist with demand. Ongoing activity to increase bank supply, both dual contracts and Bank only.

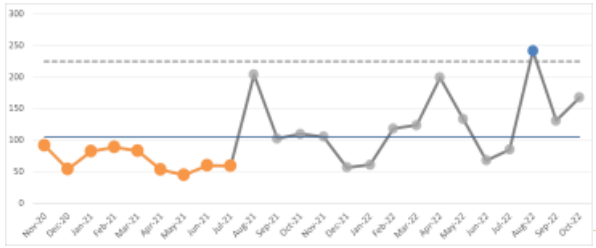
Actions:

Focus remains on increasing the number of candidates on TWS. Ongoing communication has been made with colleagues to join the bank as dual contracts to meet the current demand. Local advertising campaigns. Additional HCAs and Nurses have been placed on the bank due to recruitment activity.
Continued activity to increase the number of additional framework agencies being sourced to assist with both current and future supply. Activity underway to increase TWS colleagues and improve rostering governance. Ongoing activity to increase volunteer numbers across the Trust and increase diversity.

Workforce - Churn

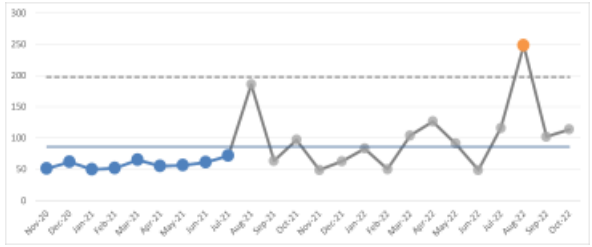
East Sussex Healthcare NHS Trust

Starters FTE



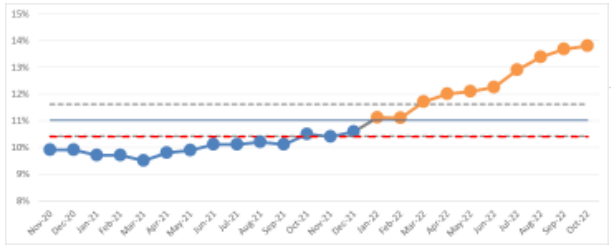
Current Month: 167.0

Leavers FTE



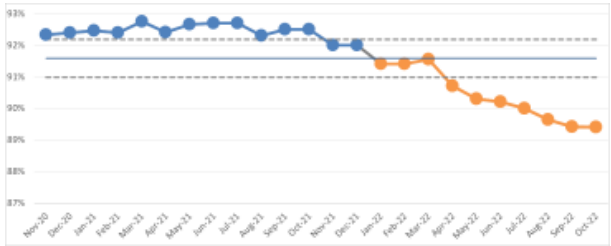
Current Month: 113.6

Annual Turnover Rate



Target: 9.9%
Current Month: 13.8%

Retention Rate



Target: 92%
Current Month: 89.4%

Author: **David Moulder, Greig Woodfield**

Status Report

The Trust starters & leavers monthly net total as at Oct 22 is +54.5 with +167.0 starters fte and -113.6 leavers fte & +1.1 internal changes fte. Over the last 12 months there was +1,549.9 starters fte & -1,209.9 leavers fte & -14.0 internal changes fte giving a net total of +326.1

The Trust turnover rate has increased by 0.1% to 13.8%. There were 911.4 fte leavers in the previous 12 months. The Trust Retention rate (i.e. % of staff with at least one year's service) was unchanged at 89.4%.

Challenge & Risk:

Turnover continues to increase. Recruitment activity, year on year, remains high with additional activity due to additional budget establishments. c700 actions currently underway on TRAC. Primary areas of activity are Emergency Medicine, Medical, AHP and HCAs.

Some success with continued targeting of "hard to recruit" posts, Consultants for Obs and Gynae Locum x2, Consultant x1, FY2s for Acute/Gastro/Stroke and Geriatrics. Activity remains focused around Theatre ODPs, Community Nurses and AHPs. Support for CDC with regard to Radiographers and Sonographers. Focus also on UTC, 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 Band B being sourced.

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 insight from data to draw up a draft action plan for hot spots.

There is a strong pipeline of international nurses in place. A further c20 nurses due to arrive at the end of Nov, with planned cohorts for rest of the financial year. Successful NHSE funding received for AHPs and International Nurses. OT interviews have taken place with 6 offers, also 6 offers for Radiographers.

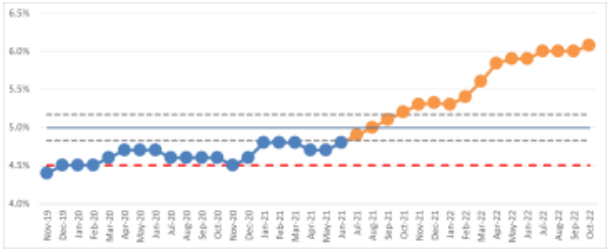
Open Days planned at both sites for ISW/HCAs and Nursing. Recruitment merchandising being sourced to assist with local recruitment campaigns

All hard to recruit medical posts are with Medacs and other additional agencies, as required. Additional agencies being sourced via procurement. Targeted phased approach to filling medical posts.
Steps being take to source additional accommodation providers for international nurses.

Workforce - Sickness

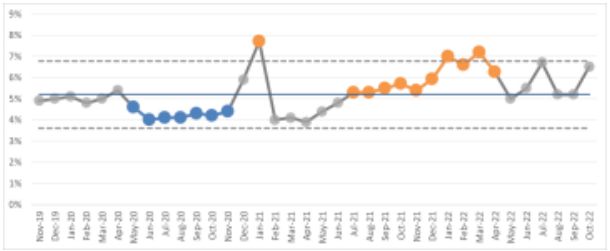
East Sussex Healthcare NHS Trust

Annual Sickness



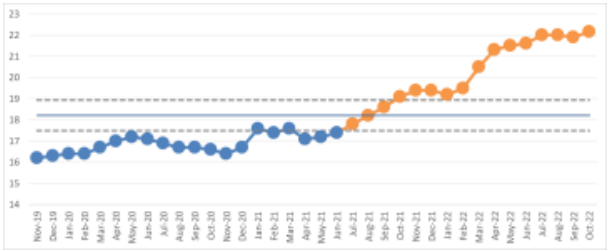
Target: 4.5%
Current Month: 6.1%

Monthly Sickness



Current Month: 6.5%

Average sickness Days per FTE



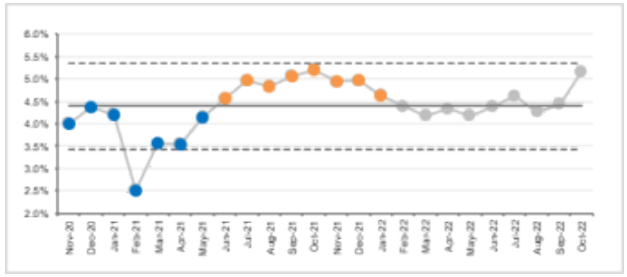
Target: 16
Current Month: 22.2

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 increased by 1.3% to 6.5%, whilst annual sickness rate has increased by 0.1% to 6.1%. Sickness average days per fte has increased by 0.2 to 22.2 days per fte.
Challenge & Risk:	It is recognised that due to pressures, managers can struggle with time to support staff when off sick and to manage those cases. Support is provided where possible by the HR team. Managers are encouraged to discuss the ability to deliver management tasks with their own line manager to seek further support to be able to deliver this vital work.
Actions:	Potential interventions to address absence rates continue to be explored with HR Specialists. It is anticipated that the vaccination roll-out will help minimise absences due to Covid and Flu over the coming months, with current absences for Covid continuing to fall. Wellbeing conversations continue to be championed across the Trust to tackle anxiety and stress related concerns as we move into the seasonal pressures. Progression of long term absence cases with consideration to return to work if fit or ill health retirement/dismissal.

Workforce - Sickness

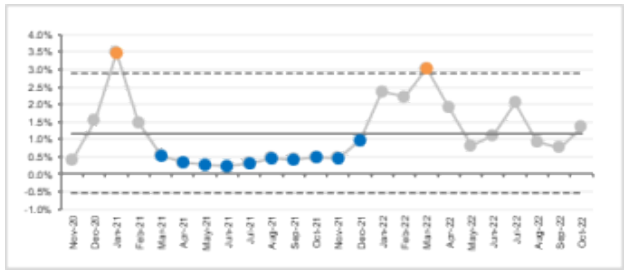
East Sussex Healthcare NHS Trust

Monthly Sickness (Without Covid-19)



Current Month: 5.2%

Monthly Sickness (Covid-19 Only)



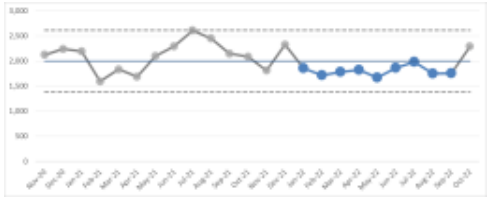
Current Month: 1.3%

Author:	**Steven Goacher**
Status Report	Monthly sickness % (without covid-19) has increased by 0.7% to 5.2%. Monthly sickness % (covid-19 only) has increased by 0.6% to 1.3%.
Challenge & Risk:	It is recognised that due to pressures, managers can struggle with time to support staff when off sick and to manage those cases. Support is provided where possible by the HR team. Managers are encouraged to discuss the ability to deliver management tasks with their own line manager to seek further support to be able to deliver this vital work.
Actions:	Potential interventions to address absence rates continue to be explored with HR Specialists. It is anticipated that the vaccination roll-out will help minimise absences due to Covid and Flu over the coming months, with current absences for Covid continuing to fall. Wellbeing conversations continue to be championed across the Trust to tackle anxiety and stress related concerns as we move into the seasonal pressures. Progression of long term absence cases with consideration to return to work if fit or ill health retirement/dismissal.

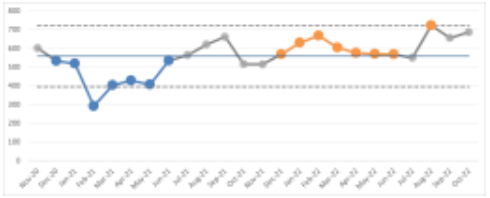
Workforce - Sickness

East Sussex Healthcare NHS Trust

Anxiety/Stress/Depression

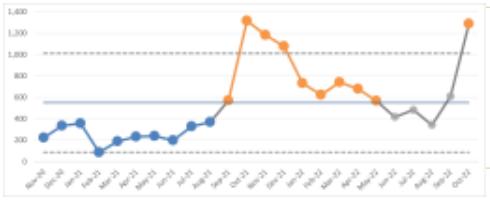


Back Problems



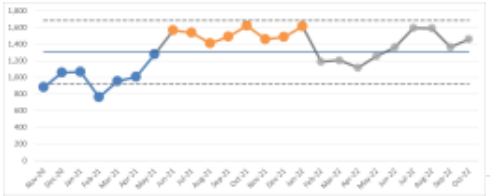
Chest & Respiratory Problems

Cough, Cold & Flu



Gastro-intestinal Problems

Other MSK problems



Author: **David Moulder; Julian Fuller**

Status Report

Reason		fte Days Lost +/-	Total fte Days Lost
Anxiety, stress & depression	▲	+536.7	2,289.8
Back problems	▼	+30.3	685.5
Chest & respiratory	▲	+1,453.0	3.463.4
Cold, cough & flu	▲	+678.2	1,287.3
Gastrointestinal	▼	-19.3	906.4
Other MSK problems	▲	+93.9	1,458.2
Other reasons	▲	+650.2	4,237.2
All reasons	▲	+3,423.0	14,417.8

Challenge & Risk:

There was an upsurge in Covid sickness in the first part of Oct, though this has since started to fall. Seasonal cold, cough & flu has also increased and so has anxiety/stress/depression which does tend to trend in line with the Covid trend.

Actions:

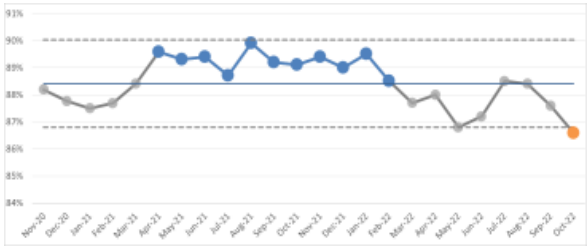
Occupational Health are rolling out the seasonal vaccination programme and will offer both the Flu vaccine and COVID boosters. Drop in clinics are now also being advertised. The programme will begin with clinical staff, and will be extended to non-clinical staff.

MSK reasons for absence are of concern and where possible these will be escalated through Occupational Health for support and expediting of referral to specialists as appropriate.

Workforce - Compliance

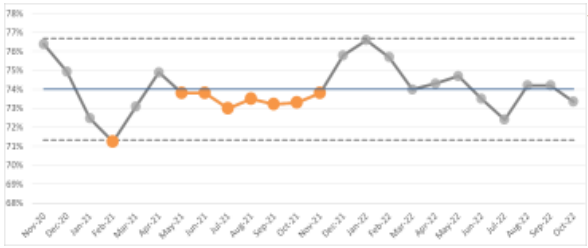
East Sussex Healthcare NHS Trust

Mandatory Training Compliance



Target: 90%
Current Month: 86.8%

Appraisal Rate



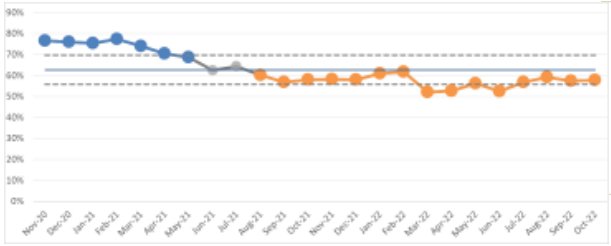
Target: 85%
Current Month: 73.4%

Author:	**Dawn Urquhart**
Status Report	We continue to progress with MyLearn with over 7,000 staff having now logged into the system. There has been some downtime on the system this week as a result of a change to server provider, Current compliance (CST) stands at 86.6%, a further decrease of 1.0%. Although this is disappointing, this is reflective of the on going service and staffing shortage pressure. The areas of most significant decrease are Infection Control, a decrease of 1.2% to 83.9%, and Information Governance at 81.7% a decrease of 0.8%. Both of these modules are on line, and we can provide support to colleagues to access computers within both libraries to support their completion. Appraisal compliance also decreased by 0.8% to 73.4%, again as a result of service demands in the main. Work is nearing completion on MyLearn to develop both the new appraisal tool and process.
Challenge & Risk:	The continuing post COVID environment with 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. This will be exacerbated with the prospect over the coming weeks of Industrial Action. DNA Rates continue to be high but again this is linked to the current service pressure which is not a local but a national experience. OSCE exams – we continue to experience up to 12 week delays for our staff to access their OSCE exams with the knock on effects on the provision of accommodation and visa status. Both are being closely monitored through the HRQS. and escalated as required to the NMC. Ongoing pressures across the Trust as we come into winter including increased staff sickness rates, the possibility of industrial action and the need to increase capacity for Induction training may further impact on compliance rates over the coming months. Arctic Willow exercise is to be put into action nationally across Trusts.
Actions:	Working with HR Recruitment and trainers to deliver increased Induction capacity whilst limiting the impact on planned mandatory face to face training. Work has commenced to reduce educational activity across the months of Dec and Jan. The impact of Trust Essential Training has been mapped and discussed with ADNs, and educational colleagues and an update will be presented to PAG of the proposal for the development of a Trust Essential Passport.

Workforce – Job Planning

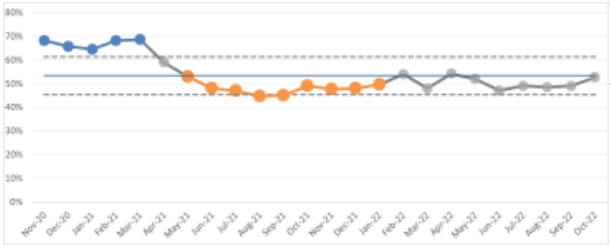
East Sussex Healthcare NHS Trust

Consultant eJob-Planning Fully Approved Rate



Current Month: 57.8%

SAS Grades eJob-Planning Fully Approved Rate



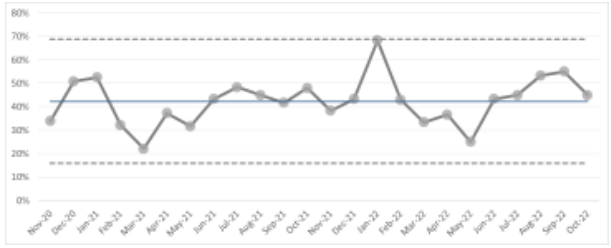
Current Month: 52.6%

Author:	**Joanne Penfold**
Status Report	Medical job plans have seen an increase of 1.0% this month, with a total sign off rate of 56% • 152 of 263 (58%) Consultants have a completed eJobPlan • 51 of 97 (53%) SAS Doctors have a completed eJobPlan
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. There are a further 32 (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.
Actions:	As part of the NHSE Levels of Attainment, a Job Plan Consistency panel will need to be formed. The Extranet job planning page includes guidance for medic and sign off users. Continue to push sign off managers to review and complete the review of the job plans within their respective specialties.

Workforce – Roster Completion

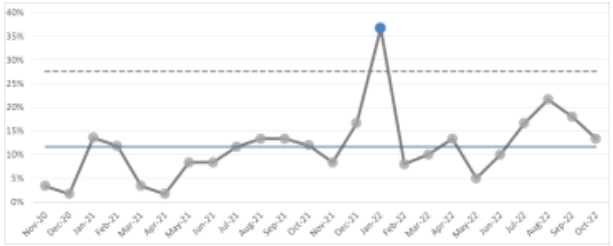
East Sussex Healthcare NHS Trust

6 week Nursing Management Roster Approval Rate



Current Month: 45%

8 week Nursing Management Roster Approval Rate



Current Month: 13%

Author:	**Penny Wright; David Moulder**
Status Report	For the roster starting on the 3rd Oct, 45% of rosters had been approved at 6 weeks before the go live date which is a -10% decrease on the previous month. 13% had been approved at 8 weeks prior to commencement which is a reduction of -5%.
Challenge & Risk:	Approval rates at 6 weeks prior have fallen back, for the first time since May 22. 8 week prior approval continues to be challenging. 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. 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

East Sussex Healthcare NHS Trust

Access and Responsiveness

	Positives	Challenges & Risks	Author
Responsive	The Minerva bridging service came online on 14.10.22 enabling further improvement in our Urgent Care Response team's performance. The Trust continues to exceed the 70% target for referred patients to be seen within 2 hours, achieving 81.9% in October, an increase of 12%. We continue to remain in the top quartile nationally for the diagnostic standard (DM01). The Trust has delivered 85.1%. Whilst at the same time, continuing to deliver over 120% activity compared to 2019/20 baseline and exceeding the national ask We are seeing an improvement in our Cancer 28 day FDS standard with the Breast Triple Assessment service coming online. Our Cancer 62 day performance remains in the top quartile nationally	Length of Stay (LoS): Our overall average LoS for non elective patients has increased by 0.4 days to 8.9 in the month of October. This has impacted on our bed occupancy across both acute sites and has limited patient flow from the emergency departments through to our gateway areas and wards. This is now one of the highest priorities for the Trust, and there is a focused piece of work both internally and externally with system partners to address this challenge. ED Performance: The departments saw a rise in the number of attendances through October with a higher than average volume of patients being type 1 (non admitted). This, coupled with the high bed occupancy rate is limiting ability to stream from ED to specialties in a timely manner. This ties into the LoS challenge above, for which a plan has been implemented Electives: The Trust's plan to reduce the number of patients waiting over 52 weeks for treatment has fallen below trajectory and whilst we continue to have the lowest number of long waiting patients in the region, further focus is required to support a sustained reduction of our long wait position.	 **Tara Argent** Chief Operating Officer
Actions:	• Focused work on the Long Length of Stay patients with multi disciplinary / agency meetings chaired by the executive winter director, held twice weekly to address challenges at patient level detail	• Review of all long waiting elective patients to assess suitability for mutual aid with other providers	

NHS Constitutional Standards

East Sussex Healthcare NHS Trust

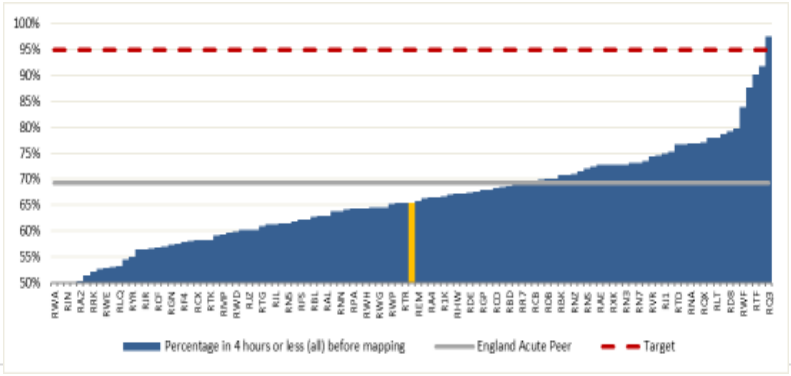
*NHS England has yet to publish all October 2022 Provider based waiting time comparator statistics

ESHT denoted in orange, leading rankings to the right

Urgent Care – A&E Performance

October 2022 Peer Review

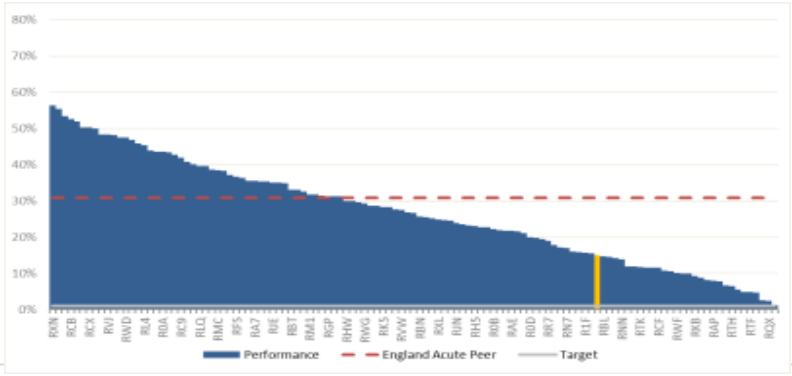
National Average: 69.31% ESHT Rank: 57/112



Planned Care – Diagnostic Waiting Times

September 2022 Peer Review*

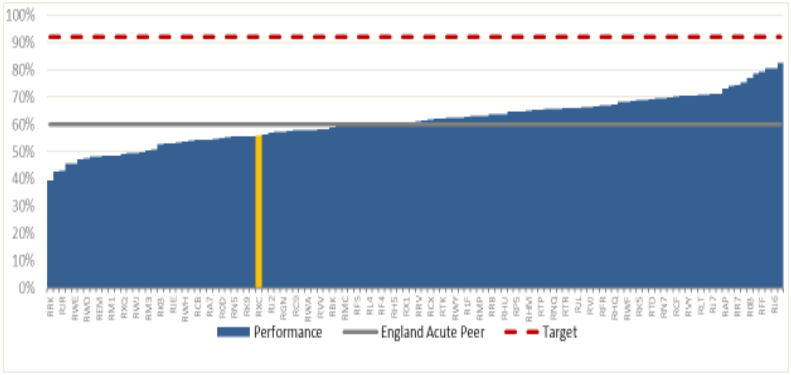
National Average: 30.8% ESHT Rank: 30/119



Planned Care – Referral to Treatment

September 2022 Peer Review*

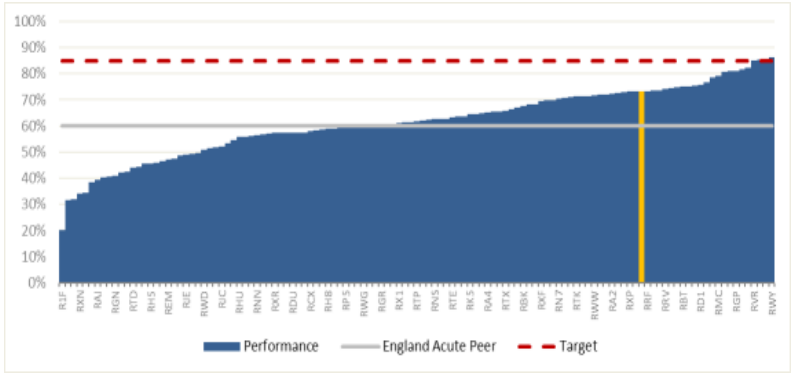
National Average: 58.6% ESHT Rank: 86/120



Cancer Treatment – 62 Day Wait for First Treatment

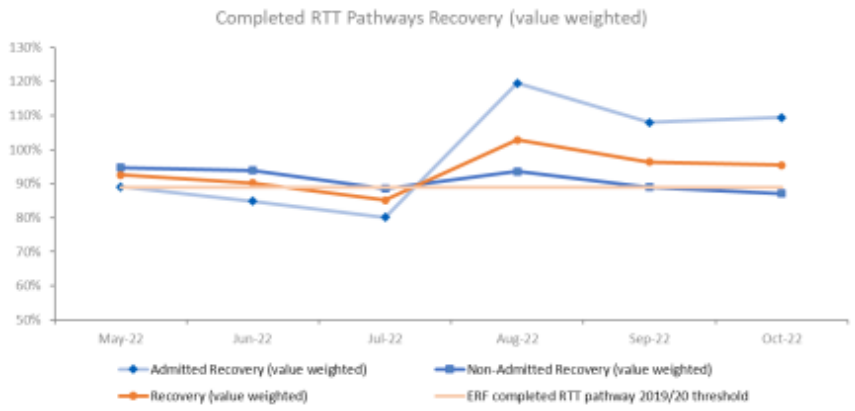
September 2022 Peer Review*

National Average: 60.1% ESHT Rank: 23/121



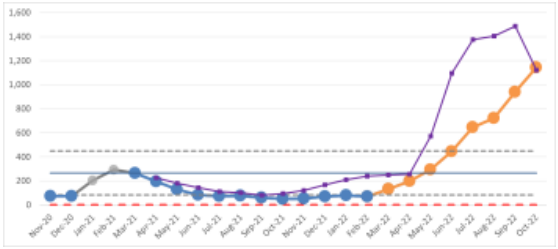
Planned Care – Recovery KPIs

East Sussex Healthcare NHS Trust



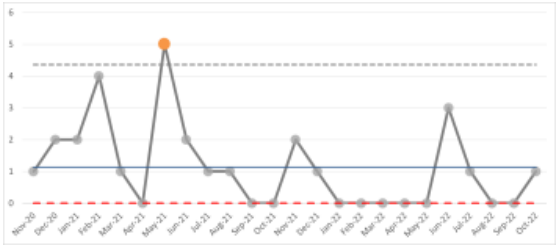
RTT 52 Week Waiters

Target: 0
Trajectory: 1,123
Current Month: 1,145



RTT 78 Week Waiters

Target: 0
Current Month: 1



Delivery of 104% of the 19/20 activity baseline continues to be challenging and activity levels have remained static in October. Workforce constraints as a result of sickness and vacancies continue to impact for many specialities. Non-Admitted value weighted activity continues to be lower than expected in October, in part as a result of an increase in FU activity as a result of the long wait position and the additional activity as a result of ESOPS and Community Cardiac closure.

The volume of patients who are waiting >52 weeks continues to increase, and rose above trajectory in October. The increase in the volume of patients waiting over 52 weeks is largely due to challenges within T&O, ENT, Urology, Uro-Gynaecology and Respiratory services, with demand outstripping capacity and it is not anticipated that the Trust will deliver against trajectory in November either. Plans are being progressed to tackle the long wait position; with T&O elective beds capacity addressed in November to allow for the reinstatement of T&O joint surgery; Respiratory insourcing due to commence in December; continued utilisation of SPH NHS capacity to support position; validation of patients over 26 weeks without a First Outpatient Appointment in ENT, General Surgery, Gynaecology, Respiratory and Urology to start in November; and mutual aid agreed for some ENT elective patients.

The Trust had one patient waiting over 78 weeks in October but remains in the top eleven trusts nationally in regards to 78 week waits.

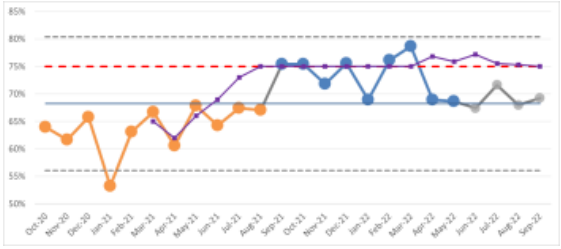
Planned Care –Recovery KPIs

East Sussex Healthcare NHS Trust

Access and Responsiveness

28 Day FDS (Faster Diagnosis Standard)

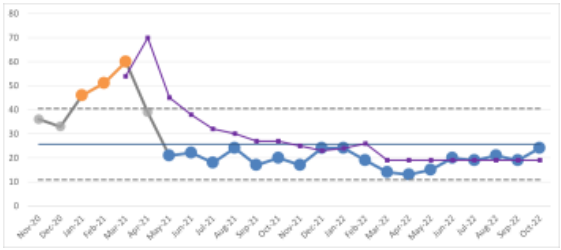
Target: 75%
Trajectory: 75.1%
Current Month: 69.2%



Cancer 104 Days Backlog

Unify 104 Days Backlog (excludes Tertiary patients)

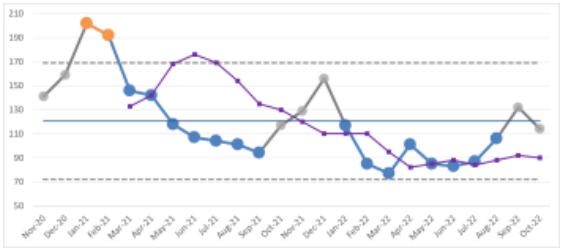
Target: Monitor
Trajectory: 19
Current Month: 24



Cancer 62 Days Backlog

Unify 62 Days Only Backlog (excludes Tertiary patients)

Target: Monitor
Trajectory: 92
Current Month: 114



The Trust continues to focus on the improvement of the cancer waiting times standards and the backlog of patients waiting over 62 days. Focussed efforts on endoscopy waiting times in October have reduced the waiting time which, along with a reduction in 1st seen appointment times, which should support an improvement in FDS performance in the future. 2ww referral numbers have stabilised in October across most specialties and the Skin service is slowly recovering, although high referrals numbers along with sickness is continuing to create a capacity gap. Lung 2ww times are also challenged but plans are in place to mitigate the clinical risk and reduce future waiting times. The Breast Symptomatic waiting time standard achieved in October which is the first time since March 2022.

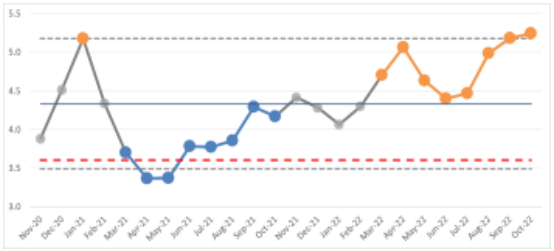
The Trust remains concentrated on the backlog for 62 and 104 days and are continuously monitoring performance. Our backlog has increased in October and is currently +5 over plan for patients waiting over 104 days and + 24 for patients waiting over 62 days. It is noted however in November our backlog was 6.1% of the total Patient Tracking List (PTL) in comparison with the national average of 12%. Long waiting patients are regularly clinically reviewed to ensure pathways are expedited and next steps are in place. The Local Cancer Access Policy is also closely adhered to.

Patient Care- Flow

East Sussex Healthcare NHS Trust

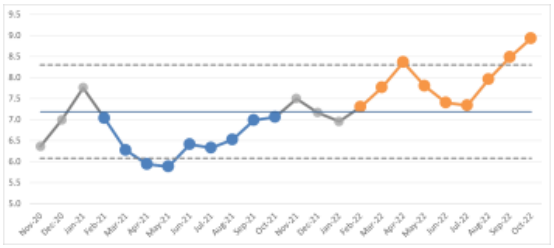
Non-elective Length of Stay (Acute)

Target: 3.6
Current Month: 5.2



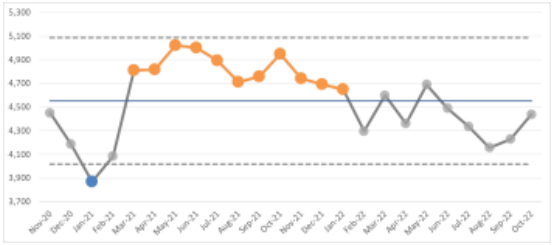
Non-elective Length of Stay, excluding zero LoS (Acute)

Target: Monitor
Current Month: 8.9



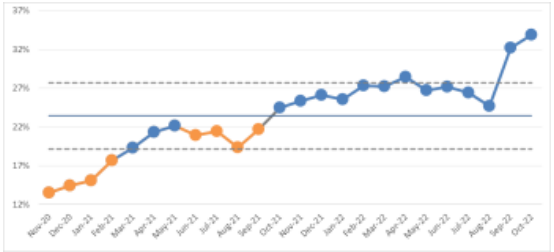
Non Elective Spells

Target: Monitor
Current Month: 4,438



Medical Non Elective Admissions (% SDEC)

Target: Monitor
Current Month: 33.9%



As predicted in previous reports, a further increase in the Trusts Non-Elective Length of Stay (LoS) was observed in October.. The long length of stay meeting is to be reintroduced in November as a support to help in reducing LoS.

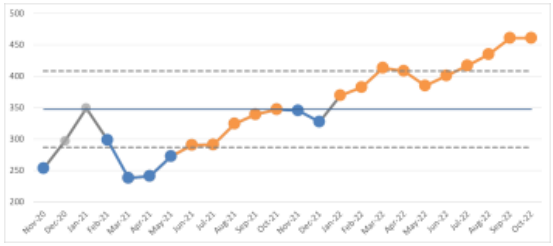
The ESHT acute bed gap, in line with the national cessations of HDF funding is a factor in the increase in length of stay. This takes into account the reduction in Discharge to Assess beds to 46 (Net loss of 67 beds)

October data shows a continued increase in Same Day Emergency Care (SDEC) utilisation which can be attributed to the Trust focused objective of ringfencing the SDEC units and not using the areas as escalation overflow beds, which is a positive step forward. The teams are also continuing to work on further improvement such as introducing forecast tools that highlights how many patients will need to go to SDEC units.

Patient Care - Flow

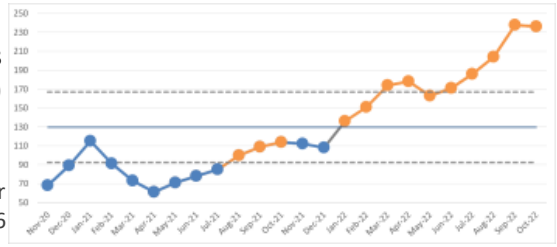
East Sussex Healthcare NHS Trust

Adult inpatients in hospital for 7+ days (Acute)



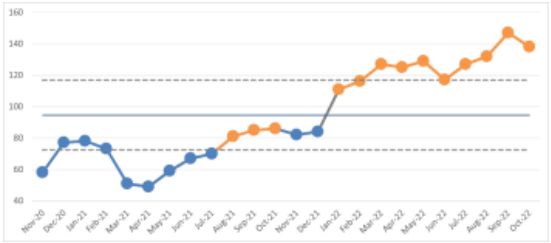
Target: Monitor
Current Month: 461

Adult inpatients in hospital for 21+ days (Acute)



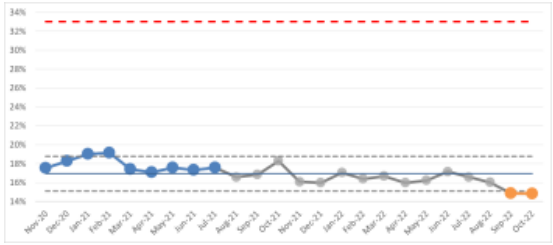
Target: Monitor
Current Month: 236

MRD on Pathways 1-3



Target: Monitor
Current Month: 138

Patients discharged before midday %



Target: 33%
Current Month: 14.8%

October 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 November. 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.

September saw a reduction in percentage of patients discharged before midday, and the position has remained static throughout October. This downward trend could be contributed to the loss of discharge lounge capacity on both sites. Plans are being worked up to identify a suitable location for a discharge lounge at the EDGH as this was lost to the Polegate escalation ward earlier in the year. Unfortunately the discharge lounge at the Conquest has had to be utilised as an escalation area over the past month which has impacted on discharges before midday.

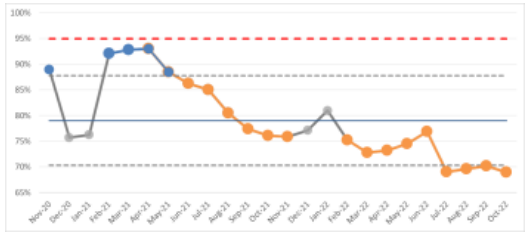
Urgent Care – Front Door

East Sussex Healthcare NHS Trust

Access and Responsiveness

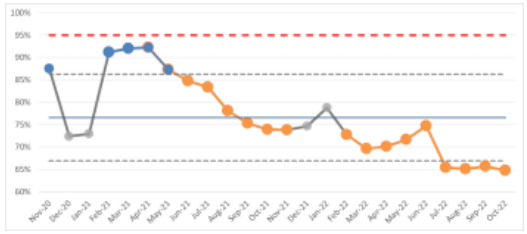
A&E Performance
(Local System)

Target: 95%
Current Month: 68.9%

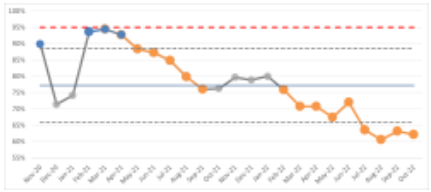


A&E Performance
(ESHT Total Type 1 & 3)

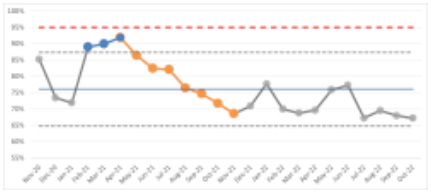
Target: 95%
Current Month: 64.7%



CONQ

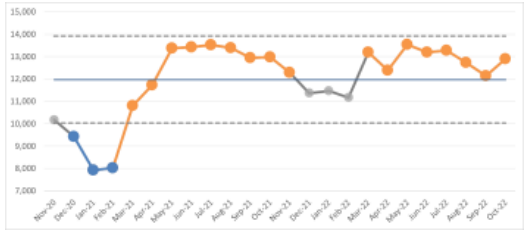


EDGH



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

Target: Monitor
Current Month: 12,904



Attendances have increased in the last month, with the increase only notable in type 1 activity likely reflecting an increase in those with respiratory illness starting to attend as part of an expected spike in activity ahead of winter surge.

Redirecting people from the front door to alternative services continues to be a focus, with October numbers higher than September again recording the most effective re-direction month to date. however, despite the decrease in attendances alongside the re-direction of patients the overall length of stay is exceptionally high which continues to have a direct and detrimental impact on safety and performance of both the emergency department and the urgent treatment centres on both sites.

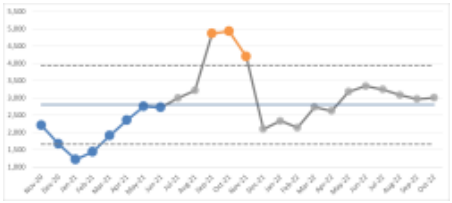
Rapid Assessment and Treatment Service has been launched this month on the Eastbourne site with plans to launch at the Conquest site in November which will reduce time to treatment, improve decision making and aims to reduce length of stay overall.

Urgent Care – Front Door

East Sussex Healthcare NHS Trust

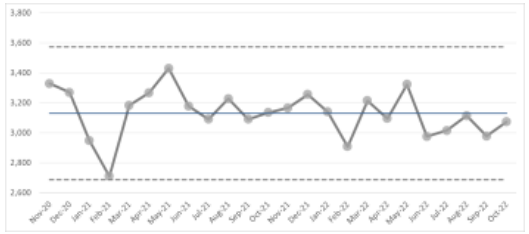
ESHT Total Type 1 Attends

ESHT Total Type 3 Attends



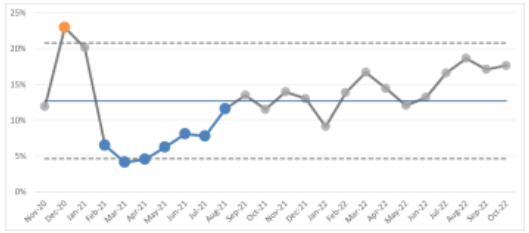
Conveyances
(ESHT – CQ and EDGH)

Target: Monitor
Current Month: 3,073



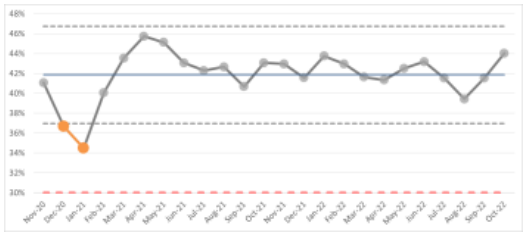
Conveyance Handover >30
(ESHT – CQ and EDGH)

Source: SECAmb
Target: Monitor
Current Month: 17.6%



Same Day Emergency Care
(ESHT – CQ and EDGH)

Target: 30%
Current Month: 44.0%



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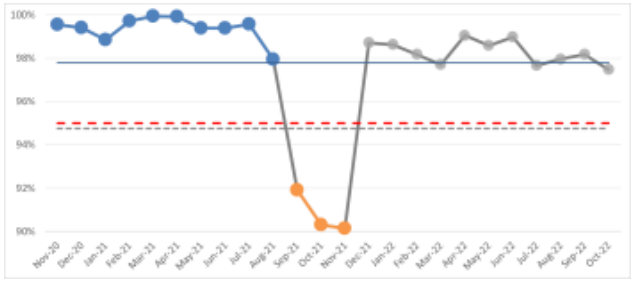
East Sussex Healthcare NHS Trust

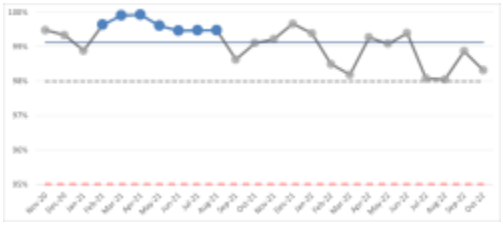
Urgent Care – UTC

UTC 4 hour standard
(Visit complete within 4 hours)

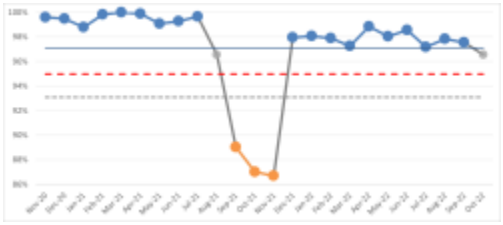
Target: 95%
Current Month: 97.5%



CONQ



EDGH



UTC compliance to the 4hr standard remains above the required standard although a decline has been noted for this month which is likely related to the division actively looking to increase activity.

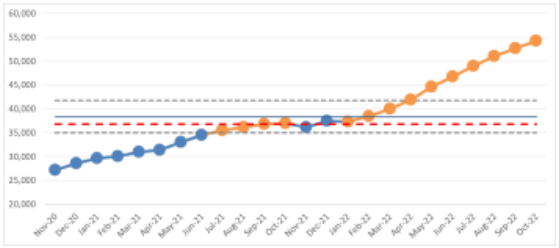
The division have clear plans to improve activity and reduce length of stay and are awaiting allocation of winter funds to launch supportive services through virtual consultation booths

Planned Care – Waiting Times

East Sussex Healthcare NHS Trust

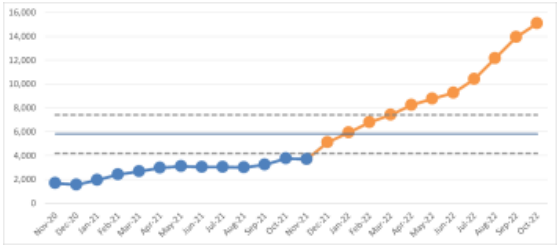
Access and Responsiveness

RTT Total Waiting List Size



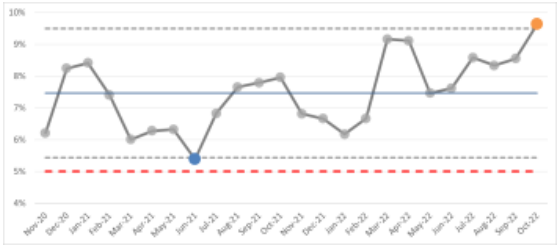
Target: 36,833 (Sep-21)
Current Month: 54,273

RTT 26 Week Waiters



Target: Monitor
Current Month: 15,100

Cancellations On The Day (Activity %)



Target: 5%
Current Month: 9.6%

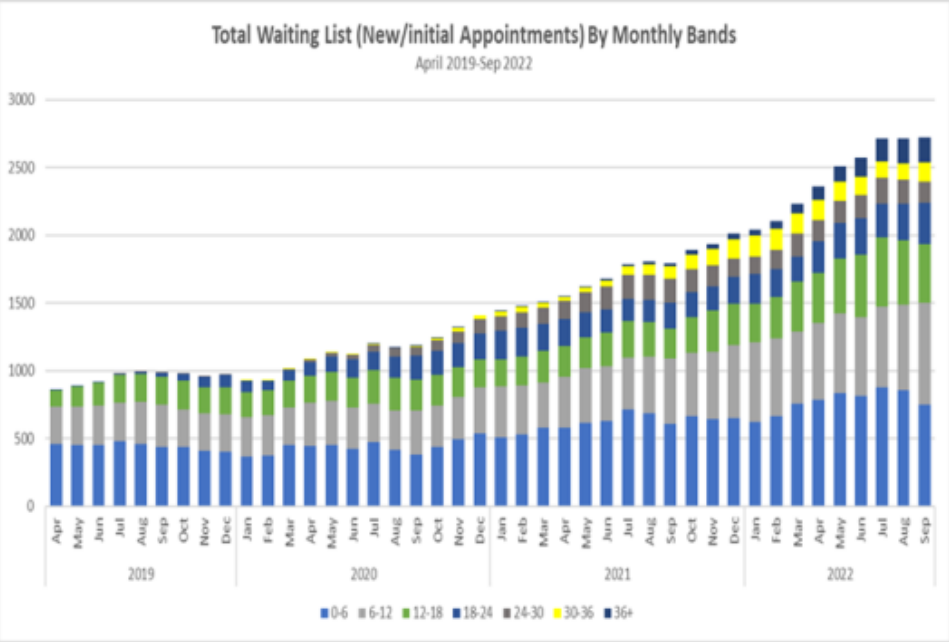
The growth in the RTT waiting list continued to increase above expected levels in October and the volume of patients over 26 weeks is at the highest level seen. Referrals have increased on average by 6 per working day compared to 19/20, with a decrease in routine referrals but a significant increase in urgent referrals which further impacts routine waiting times for First Outpatient Appointments.

Divisions continue to monitor their long waiting patients through weekly PTL meetings to address and reduce long waiters, ensuring that patients are treated in order of clinical priority and /or chronologically.

The percentage of admitted cancellations on the day, both patient and hospital initiated, have increased to the highest level seen this year. Cancellations on the day occur for a variety of reasons, but mainly as a result of medical reasons or overrunning theatre lists. There is a robust escalation process before any decision is made to cancel a patient and any patients who are unfortunately cancelled by the hospital for non clinical reasons, do get rebooked within 28 days.

Paediatric Community (non RTT) Waiting Times

East Sussex Healthcare NHS Trust



October saw a further increase in referrals to Community Paediatrics. Average wait times continue to increase as capacity cannot meet the demand, although there has been a small reduction in the total waiting list, which now Uri stands at 2524.

The outsourcing of 90-100 ASD assessments to a private provider is due to commence in January 23, which will be funded directly from CITEs budget as part of the wider recovery/transformation plan for Community Paediatrics. Option to outsource a further 5-600 as part of the recovery/ transformation plan is under investigation to support the service.

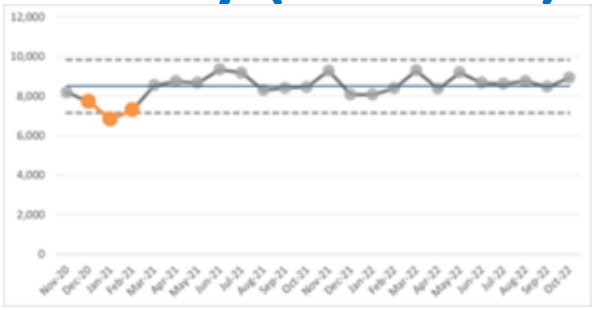
Adult Community (non RTT) Waiting Times

East Sussex Healthcare NHS Trust

Access and Responsiveness

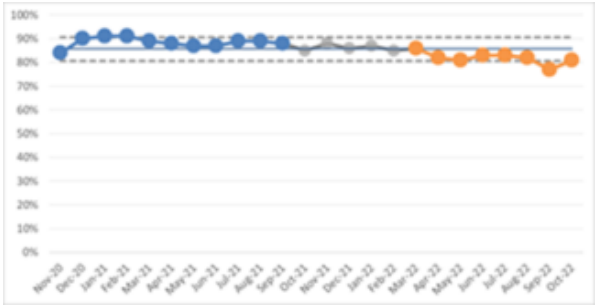
Number of Referrals Received (Planned)

Current Month: 8, 918



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

Current Month: 81%



Referrals to Adult services have increased in October and overall waiting times have slightly increased in many community services. Despite the increase there has been an improvement in the percentage of patients seen within the agreed waiting times with 81% of patients seen within agreed waiting time targets, an increase from 77% in September.

Adult community long wait position has seen a very slight deterioration in the long wait position, with one patient now waiting over 52 weeks. Neuro OP, salt, Dietetics, Podiatry and JCR are all areas of concern due to the continued increase in referrals that is driving up waiting times in these areas as a result of a capacity and demand gap that is currently being worked through to address.

Community Non-RTT Waits

Service	Provide	CCG	Wait Lis	Ave Wait Tim	Median W	>52 wks	>104 weeks
ESHT Bladder and Bowel	ESHT		478	13	12	0	0
ESHT Community Nursing	ESHT		109	2	0	0	0
ESHT Community Stroke and ESD	ESHT		2	1	1	0	0
ESHT Crisis Response	ESHT		23	1	0	0	0
ESHT Dietetics	ESHT		1214	17	14	0	0
ESHT Fracture Liaison	ESHT		1389	1	0	0	0
ESHT Frailty Service	ESHT		65	6	5	0	0
ESHT JCR and Falls Prevention	ESHT		1166	9	8	0	0
ESHT MSKt	ESHT		1296	7	7	0	0
ESHT Neuro Op	ESHT		394	23	22	1	0
ESHT Orthotics	ESHT		252	8	7	0	0
ESHT Physiotherapy	ESHT		4527	11	11	0	0
ESHT Podiatry	ESHT		1791	14	13	0	0
ESHT Speech and Language Therapy	ESHT		690	18	16	0	0
ESHT Tissue Viability	ESHT		0	0	0	0	0
ESHT Community Respiratory	ESHT		234	21	24	0	0
ESHT Heart Failure	ESHT		0	0	0	0	0
ESHT Community Paediatrics	ESHT		2508	54	42	1024	352

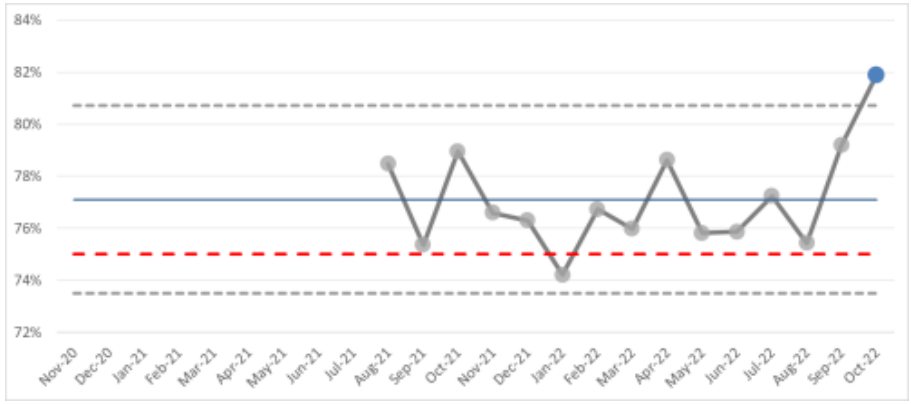
Division	Key
CHIC	
MED	
WAC	

Urgent Community Response

East Sussex Healthcare NHS Trust

Crisis Response Within 2 Hours

Target: 75%
Current Month: 81.9%



The Trust's community health and integrated care divisions have continued to deliver above target for 2 hour Urgent Crisis Response (UCR) with improvement observed in October as a result of the Minerva bridging service coming online on 14.10.22. Further supportive measures are being developed to enhance the team which will further improve the service. With improved recruitment to this team , the Trust will be able to increase its 2 hour UCR, which will help the front door position and reduce demand on our emergency departments by keeping patients in their own homes, with appropriate support and clinical oversight.

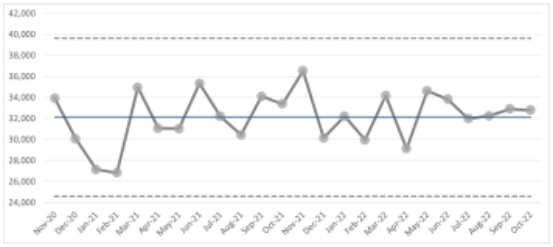
Planned Care – Outpatient Delivery

East Sussex Healthcare NHS Trust

Access and Responsiveness

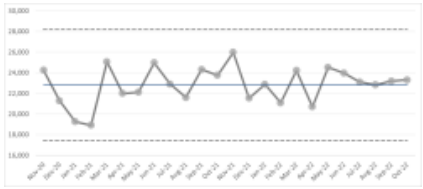
Outpatient Total Activity
(New and Follow-up)

Target: Monitor
Current Month: 32,781



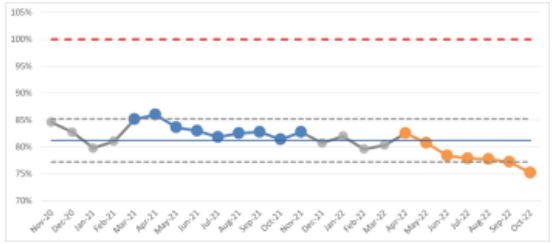
New

Follow-up



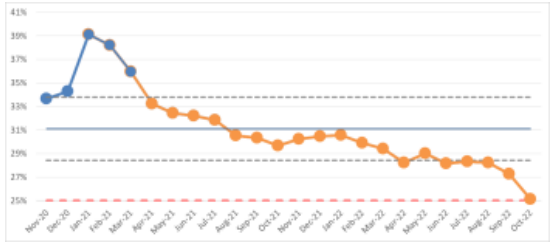
Outpatient Utilisation
(Consultant and nurse led Clinics)

Target: 100%
Current Month: 75.2%



Non Face to Face Outpatients Activity
(Activity %)

Target: 25%
Current Month: 25.1%



Outpatient activity remained static in October. Utilisation remains a key area to address to both support recovery and improve activity, especially for New appointments.

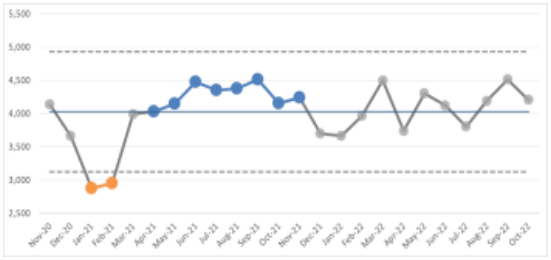
Outpatient utilisation decreased in October. The deterioration of outpatient utilisation is multifactorial; corresponding to a rise in the volume of DNAs as well as difficulties in booking, as a result of staffing gaps within clinic admin and difficulty in contacting patients, compounded further by strike action. Further work is required to ensure clinic templates are accurate and clinics that are not required are removed from PAS to ensure reported utilisation is accurate.

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.

Planned Care – Admitted Delivery

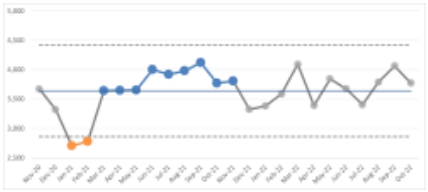
East Sussex Healthcare NHS Trust

Elective Spells
(Day case and Elective IP)



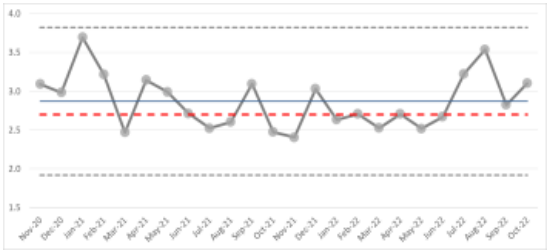
Target: Monitor
Current Month: 4,204

Day case



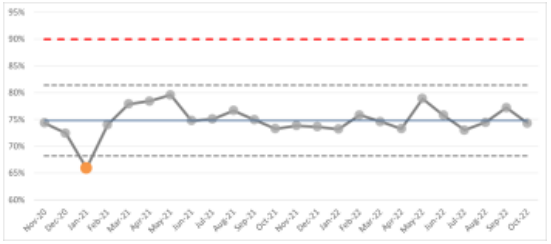
Elective IP

Elective Average LoS
(Acute)



Target: 2.7
Current Month: 3.1

Theatre Utilisation



Target: 90%
Current Month: 74.3%

High sickness levels within Theatres resulted in a planned reduction in theatre sessions resulting in a decrease in elective activity in October compared to September for both day case and Elective IP. 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 treated in October.

6-4-2 meetings are in place to support Theatre efficiency. It is recognised that further work is needed in some areas to support Theatre utilisation as a whole. Plans are also being progressed to address gaps within pre-assessment capacity that will support better utilisation of Theatres.

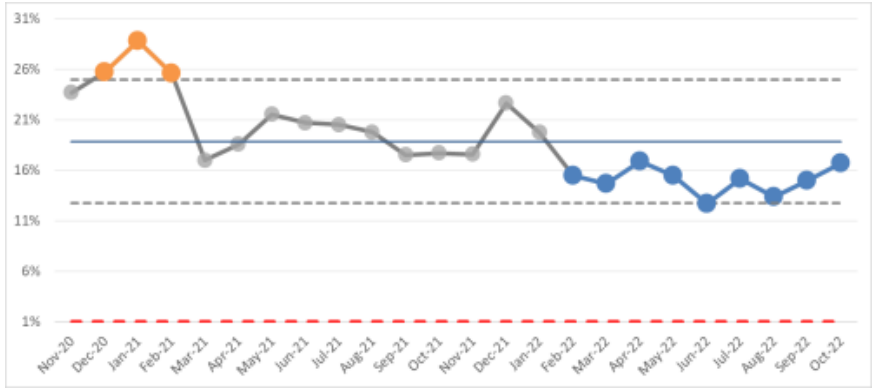
Planned Care – Diagnostic

East Sussex Healthcare NHS Trust

Access and Responsiveness

Diagnostic Standard

Target: < 1.0%
Current Month: 16.7%



The Trust is continually delivering over the national ask of 120% of diagnostic activity compared to the 19/20 baseline and it is expected that this position should only improve further once the Bexhill CDC opens in mid November 2022.

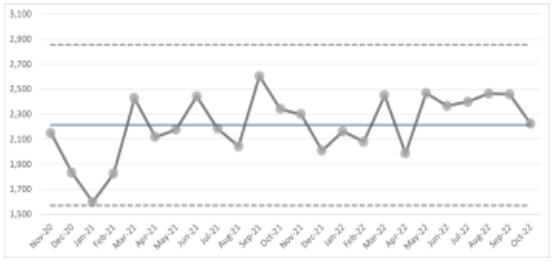
Despite an increase in activity, DMO1 performance remains a challenge for the organisation. DM01 compliance in October decreased for the second consecutive month with compliance at 83.30%, down from 85.02% in September (target 99%). Cardiology and audiology are areas that have observed the largest increase in breach rates with increasing demand driving up the volume of 6 week breaches for these modalities.

Cancer Pathway

East Sussex Healthcare NHS Trust

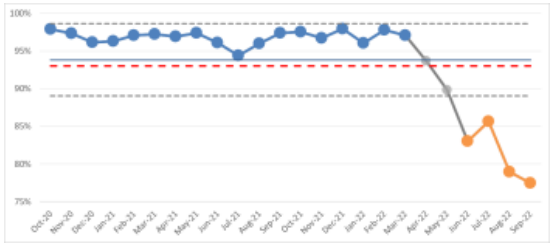
Two Week Wait Referrals

Target: Monitor
Current Month: 2,224



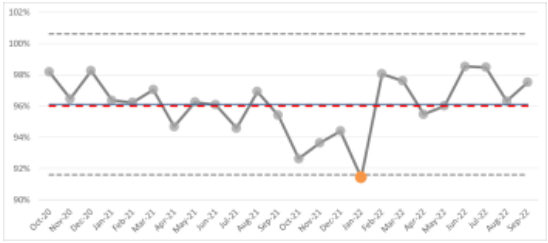
Cancer 2WW Standard

Target: 93%
Current Month: 77.4%



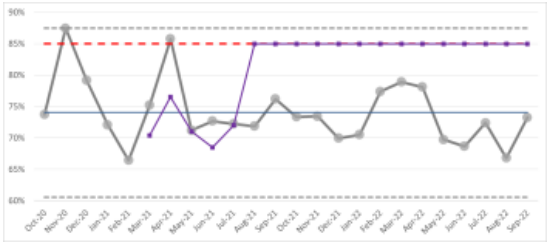
Cancer 31 Day Standard

Target: 96%
Current Month: 97.5%



Cancer 62 Day Standard

Target: 85%
Trajectory: 85%
Current Month: 73.2%



The Trust experiences a continued and sustained increase in 2ww. In October the referrals reduced slightly, however remained high at over 2000 referrals. The continuing high referrals continues to create pressure in all phases of the pathway and options are explored to increase activity with additional sessions as well as insourcing and outsourcing. National cancer campaigns are being advertised across the media which is expected to result in a continued high referral rate.

Turnaround times within pathology (outsourced histology) remains challenged for the 28 FDS standard and 62 Day standard, however, these are closely monitored and tracked.

Improvement plans are in place with tumour sites to support patient experience and performance.

Regular patient tracking meetings are undertaken to ensure patient pathways are expedited where possible and next steps are in place. These meetings are multi-disciplinary and often include clinical team members to support decision making.

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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East Sussex Healthcare NHS Trust

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Exec summary

East Sussex Healthcare NHS Trust

£m	RAG	YTD Plan	YTD actual	Var F/(A)	Commentary
Surplus/deficit	G	(0.2)	0.0	0.2	• Trust is reporting a year to date breakeven position against a planned deficit of (£0.2m), 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 £2.0m favourable. • The position in month has been supported by the release of £1.2m of reserves
Income	A	335.2	340.5	5.3	• Income is favourable to plan driven ERF favourable against plan £2.0m, NHSE Drugs £2.0m, and £1.2m of revenue reserve release.
Pay	A	(221.7)	(226.0)	*(4.3)*	• Pay cost variance is related to £1.0m of supernumerary costs for overseas/back to care staffing, Unfunded Escalation costs of £1.8m and pressures from Locum/agency usage in Clinical Divisions of £1.0m. CEA accrual YTD £1.1m • The Trust is using 5% more staff than in 21/22 (excluding SPH)
Non-pay	A	(113.8)	(114.6)	*(0.8)*	• Non-pay costs are higher than budget mainly driven by Utility costs £0.2m, £300k Pathology/Radiology outsourcing and Inpulse Ambulance £200k. Underspends commensurate with the elective activity shortfall have been reported in relevant specialities.
Efficiency	A	10.9	10.0	*(0.9)*	• The trust has delivered £1.7m efficiency plan for the month and £10m year to date, £0.6m and £0.9m behind plan respectively, £0.6m of this relates to some of the escalation beds being expected to have closed by now, but they remain open, plus unidentified values in the divisions. • The target for the year is £23m. So far £18m has been identified, leaving a gap of £5m for the Divisions to find, an improvement of £1m in the month.
Capital	A	11.3	11.9	0.2	• Capex spend of £11.3m which is £0.6m behind plan. FOT remains to deliver to plan.
Risk	G	n/a	n/a	n/a	• Risk analysis shows a potential range from £5.0m deficit to a breakeven position downside and upside cases respectively. The base case is showing a expected deficit of £1.4m which is immaterial to the scale of Trust turnover so not seen as a trigger point for changing the forecast given a view that non-pay was extremely high in month and may recover next month

Income and Expenditure

East Sussex Healthcare NHS Trust

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Plan	Act	Var	Plan	Act	Var
Income						
Contract income	42,353	44,327	*1,974*	299,157	302,522	*3,364*
Divisional	4,457	4,992	*535*	28,459	28,974	*516*
ERF	855	1,155	*300*	6,111	8,083	*1,972*
Covid - variable	217	106	*(111)*	1,519	999	*(520)*
Total Income	**47,881**	**50,579**	***2,698***	**335,246**	**340,578**	***5,332***
Operating Expense						
Pay						
Permanent	(30,011)	(28,142)	*1,869*	(212,881)	(193,164)	*19,717*
Temporary	(979)	(4,667)	*(3,687)*	(7,729)	(31,384)	*(23,655)*
Total pay	**(30,991)**	**(32,809)**	***(1,818)***	**(220,610)**	**(224,548)**	***(3,938)***
Non-pay						
Drugs	(1,114)	(1,129)	*(15)*	(7,523)	(7,470)	*53*
TEDD	(3,477)	(3,987)	*(510)*	(24,339)	(26,404)	*(2,065)*
Clinical supplies	(4,044)	(4,269)	*(226)*	(27,110)	(25,853)	*1,257*
Purchased services	(891)	(952)	*(61)*	(6,669)	(6,367)	*303*
Finance costs	(2,352)	(2,273)	*79*	(16,466)	(16,296)	*170*
Other	(4,507)	(5,044)	*(537)*	(30,574)	(31,398)	*(824)*
Total non-pay	**(16,385)**	**(17,655)**	***(1,269)***	**(112,681)**	**(113,787)**	***(1,106)***
Covid exp - block	(90)	(97)	*(7)*	(629)	(1,237)	*(607)*
Covid exp - variable	(223)	(153)	*70*	(1,564)	(1,047)	*518*
Total Expense	**(47,689)**	**(50,714)**	***(3,024)***	**(335,484)**	**(340,619)**	***(5,134)***
Surplus/(Deficit)	**191**	**(135)**	***(326)***	**(238)**	**(41)**	***198***
Memo:						
WTE (worked)	7,921	7,765	*(155)*	7,905	7,663	*(241)*

I&E position

- The month 7 in month position is an adverse position of £0.1m, a £0.3m adverse variance to plan of £0.2m surplus.
- Year to date the Trust has delivered breakeven, £0.2m favourable to the YTD plan of £0.2m deficit.
- Note: The Trust's position reflects a national request from NHSE/I not to recognise any ERF clawback in Trust's position. We believe this will continue for H2 also.

Income

- The position is favourable YTD by £5.3m, the main drivers being;
  - ERF is still impacted by clawback not occurring, this is an absolute impact of £4.0m and £2.0m favourable versus plan;
  - NHSI Drugs C&V £2.0m
  - Community Income Old Year £1.2m
  - Staff Car Parking Charges delay of implementation until Sept 1st £0.2m underachievement.

Expense

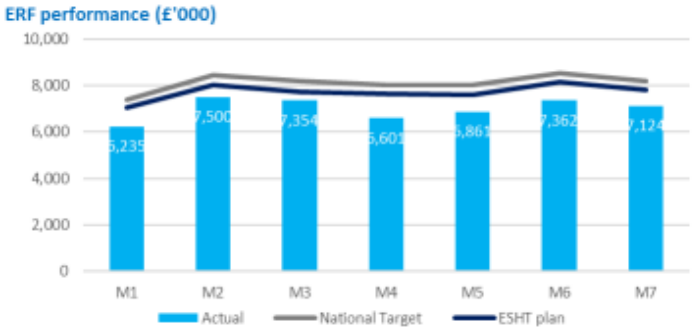
- The Trust has an in month £1.8m adverse pay position variance, YTD £3.9m which is related to Supernumerary costs for overseas/back to care staffing, temporary staffing and unfunded escalation costs. Also £1.1m accrual for CEA YTD.
- Use of temporary staff at higher unit cost partially offset by WTE usage below budget.
- Non-pay costs are higher than budget by £1.1m YTD driven by Utility costs £0.2m, £0.3m Radiology/Pathology outsourcing and £0.2m Inpulse Ambulance service.

ERF - Trust

East Sussex Healthcare NHS Trust

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%)
- M7 delivery was £0.7m behind plan which would equate to a £0.5m loss of income (YTD £4.9m variance or £3.7m additional clawback).
- National request not to include clawback in the figures means this has not impacted the I&E.
- The main underperforming specialties are T&O, Cardio, Respiratory , ENT and Maxillo-Facial.



	In Month				YTD			
	Plan	Actual	Var		Plan	Actual	Var	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Daycase	2,968	2,714	(254)	(8.6%)	20,613	19,091	(1,521)	(7.4%)
Elective	1,682	1,466	(216)	(12.9%)	11,550	10,050	(1,499)	(13.0%)
New OP	1,726	1,529	(197)	(11.4%)	11,754	10,398	(1,357)	(11.5%)
OP Procedures	1,445	1,385	(60)	(4.1%)	10,102	9,296	(806)	(8.0%)
ERS	-	29	29		-	202	202	
ERF	**7,821**	**7,124**	**(698)**	**(8.9%)**	**54,018**	**49,038**	**(4,981)**	**(9.2%)**
Follow-up	1,544	1,661	117	7.6%	10,420	12,725	2,305	22.1%
Planned care	**9,365**	**8,785**	**(581)**	**(6.2%)**	**64,438**	**61,763**	**(2,675)**	**(4.2%)**

	In Month			YTD		
	Plan	Actual	Var	Plan	Actual	Var
	£'000	£'000	£'000	£'000	£'000	£'000
Cardiology	650	504	(146)	4,361	3,487	(874)
Dermatology	133	26	(107)	976	723	(253)
Trauma & Orthopaedics	1,371	1,288	(83)	9,584	8,232	(1,352)
Respiratory Medicine	169	96	(73)	1,196	725	(470)
Respiratory Physiology	70	-	(70)	448	-	(448)
Breast Surgery	243	187	(56)	1,572	1,249	(323)
Clinical Oncology	305	250	(55)	2,002	2,012	10
Clinical Haematology	298	245	(53)	2,170	1,796	(374)
Rheumatology	196	150	(46)	1,275	1,040	(235)
Orthodontics	55	27	(28)	325	189	(136)
Maxillo-Facial Surgery	198	171	(28)	1,530	1,144	(386)
Vascular Surgery	45	19	(25)	299	249	(50)
General Surgery	725	701	(23)	5,249	5,529	280
Interventional Radiology	73	50	(22)	466	249	(217)
Gastroenterology	519	500	(20)	3,680	3,169	(511)
Geriatric Medicine	43	24	(19)	274	156	(119)
Stroke Medicine	22	4	(18)	106	29	(77)
Endocrinology	61	47	(14)	353	330	(23)
ENT	263	254	(9)	2,019	1,633	(386)
Palliative Medicine	1	0	(0)	4	2	(2)
Accident & Emergency	-	-	-	8	24	16
Paediatric Dermatology	-	-	-	-	13	13
Paediatric Diabetic Medicine	-	0	0	-	0	0
Paediatric Epilepsy	2	3	1	7	29	22
Anaesthetics	9	10	1	71	64	(7)
Chemical Pathology	6	8	2	39	44	4
Paediatric Trauma And Orthopaedics	-	3	3	-	39	39
Hepatology	1	4	3	13	6	(6)
Gynaecology	398	406	7	2,875	2,957	82
Paediatric Surgery	6	14	8	49	70	20
Acute Internal Medicine Service	-	8	8	-	19	19
Neurology	99	108	9	628	845	217
Diabetic Medicine	11	37	27	76	127	51
Urology	704	732	28	4,595	4,772	177
Ophthalmology	941	973	31	6,373	6,274	(100)
Paediatrics	124	160	37	892	1,087	195
Respiratory Physiology	-	49	49	(30)	314	344

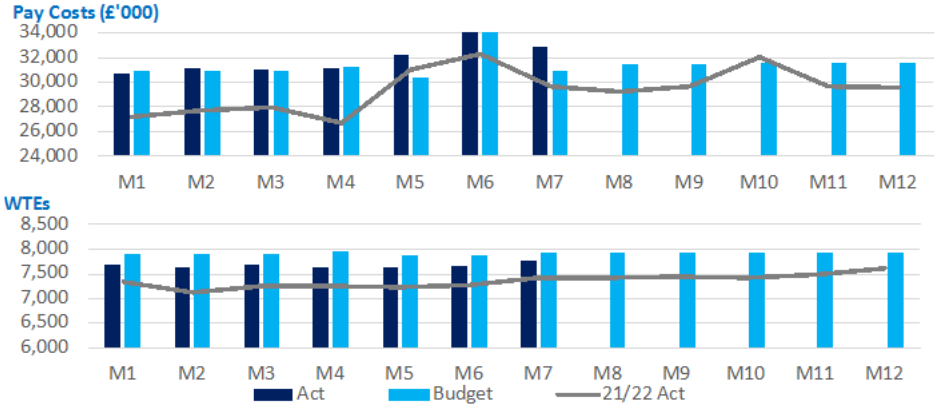
Pay costs

East Sussex Healthcare NHS Trust

Pay analysis

All staff	Pay costs (£'000) - In Month					WTE				
	Act	Var	PY	YTD var	YTD ave	Act	Var	PY	YTD var	YTD Ave
Medical	(8,219)	(929)	(7,941)	(2,768)	(7,708)	852	44	820	3	817
Nursing	(13,616)	(618)	(12,397)	(2,167)	(13,486)	3,670	23	3,421	(55)	3,636
AHP	(4,323)	20	(4,182)	2,090	(4,274)	1,118	(108)	1,109	(93)	1,099
Admin	(3,761)	244	(3,534)	1,273	(3,797)	1,315	(87)	1,289	(65)	1,311
Other	(2,889)	(536)	(2,477)	(2,366)	(2,813)	809	(27)	770	(32)	800
Total	**(32,809)**	**(1,818)**	**(30,531)**	**(3,938)**	**(32,078)**	**7,765**	**(155)**	**7,408**	**(241)**	**7,663**

Temporary	Pay costs (£'000)					WTE				
	Aug	Sep	Oct	PY	YTD	Aug	Sep	Oct	PY	YTD Ave
Bank	**(1,606)**	**(2,081)**	**(1,592)**	**(1,519)**	**(11,232)**	**467**	**490**	**480**	**453**	**472**
Medical	(447)	(550)	(460)	(574)	(3,571)	37	36	35	35	37
Nursing	(939)	(417)	(437)	(405)	(3,823)	68	86	85	86	88
AHP	(351)	(81)	(78)	(112)	(808)	14	15	16	21	14
Admin	38	(9)	(1)	32	(106)	1	1	1	12	2
Other	-	-	-	-	-	-	-	-	-	-
Agency	**(1,700)**	**(1,058)**	**(976)**	**(1,059)**	**(8,307)**	**120**	**138**	**137**	**154**	**141**
Locum	**(1,432)**	**(1,558)**	**(1,813)**	**(1,495)**	**(10,405)**	**109**	**110**	**137**	**107**	**114**
WLI	**(281)**	**(237)**	**(278)**	**(298)**	**(1,631)**	**21**	**24**	**20**	**23**	**24**
Total Temp	**(5,019)**	**(4,933)**	**(4,659)**	**(4,371)**	**(31,574)**	**718**	**763**	**774**	**736**	**751**



Pay analysis

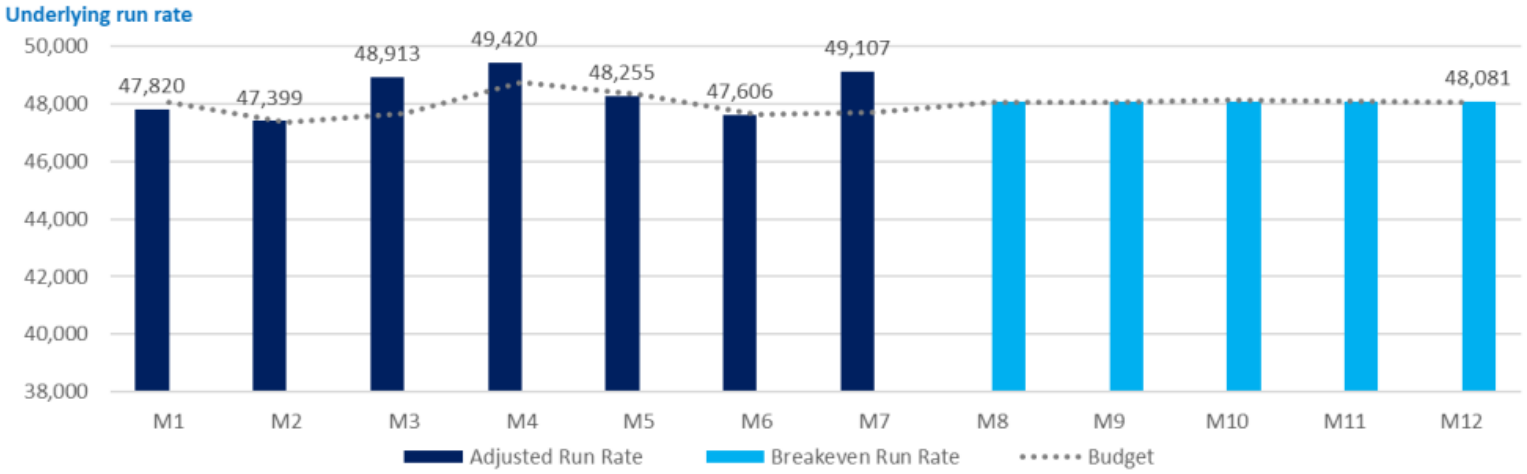
- M7 pay costs are higher than budget.
- Overall the in month spend of £32.8m is £2.3m higher than 21/22 comparator with SPH impact (£0.3m) adjusted. Versus month 6 a net £0.6m increase, aligned to 60 fte extra substantive staff, 23 fte escalation staffing in month.
- Nursing & Medical staffing groups 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.
- Accrual of £1.1m 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 88 FTE for SPH so like for like the FTE is 269 fte higher.

Run Rate

East Sussex Healthcare NHS Trust



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 in 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.
- Compared to previous months the ERF benefit has now been considered recurrent and therefore the benefit has not been removed.

Run rate

- The graphs shows an decrease in underlying run rate from M6 to M7 of £1.5m (which translates to a variance to budget of £1.4m), this is driven by pay of £0.5m, non-pay £1.5m partially offset by income ahead of plan. Non-pay appears high and is expected to reduce next month. Further analysis is being undertaken.
- The analysis has removed net £3.0m of one-off items which whilst don't impact the run rate will still impact the in year financial position.
- Taking the current months run rate and extrapolating gives an overall spend of £584.1m, against a plan of £575.09, an overall gap of **£8.2m** (this adjusts to £5.1m 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 **£1.0m** reduction per month compared to M7.

Divisional Summary

East Sussex Healthcare NHS Trust

Divisional position

Division	Variance to budget - M7					YTD overall Variance	Run rate analysis (unadjusted)			
	Income	*Pay*	*Non pay*	Overall Variance	WTE		Aug	Sep	Oct	
	£'000	*£'000*	*£'000*	£'000	WTE	£'000	£'000	£'000	£'000	
CHIC	*(41)*	*303*	*(5)*	257	(69)	*1,258*	(3,360)	(4,534)	(3,556)	▲
Core Services	*39*	*(589)*	*(70)*	(620)	(23)	*(661)*	(6,114)	(7,055)	(6,343)	▲
Estates & Facilities	*37*	*(47)*	*(419)*	(429)	(30)	*(177)*	(2,583)	(3,060)	(3,201)	▼
Medicine	*(7)*	*(1,053)*	*(90)*	(1,149)	+125	*(3,610)*	(7,816)	(9,182)	(8,305)	▲
DAS	*163*	*(615)*	*(287)*	(740)	+8	*(1,641)*	(8,098)	(9,073)	(8,463)	▲
Urgent Care	*(5)*	*(197)*	*(23)*	(225)	(37)	*(706)*	(2,156)	(2,456)	(2,334)	▲
WCSH	*20*	*(72)*	*(58)*	(110)	(39)	*168*	(2,836)	(3,657)	(3,082)	▲
Corporate Services	*311*	*(91)*	*(232)*	(12)	(64)	*481*	(3,853)	(4,925)	(3,777)	▲
SPH	*74*	*53*	*(112)*	15	(5)	*232*	(8)	14	78	▲
Central/Trust wide	*4,741*	*490*	*88*	5,319	(111)	*4,853*	36,039	43,141	40,779	▲
ESHT	***5,332***	***(1,818)***	***(1,206)***	**2,307**	(247)	**198**	**(786)**	**(787)**	**1,796**	▲

Division	YTD Variance M7 - Top Level Narrative
CHIC	Vacancies ytd, including 21-22 investment in UCR/EHCH
Core Services	Vacancies ytd in CDC and Phar, offset by non pay outsourcing Path/Rad
Estates & Facilities	Ancillary vacancies offset by Utility costs over budget M7
Medicine	Supernumerary posts, Escalation, Cardiology agency
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. NP offset income

Efficiency

Division	In Month			Ytd – M7			Full Year					
	Plan	Actual	Var	Plan	Actual	Var	Rec	NR	Total	Target	Gap	Schemes
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	#
Medicine	316	2	(314)	1,350	31	(1,319)	365	306	671	2,912	(2,241)	8
Emergency Care	83	9	(74)	368	16	(352)	66	2	68	783	(715)	11
DAS	334	375	41	1,380	1,245	(136)	238	1,711	1,949	3,029	(1,080)	14
Core Services	284	218	(66)	949	1,011	62	653	1,185	1,838	2,393	(555)	19
CHIC	166	349	183	710	1,362	651	24	2,023	2,047	1,539	508	5
WCSH	74	31	(43)	300	303	3	18	944	962	1,172	(210)	5
Estates & Facilities	125	118	(7)	395	362	(33)	111	419	530	1,026	(495)	9
Corporate	136	183	46	489	1,316	827	615	1,327	1,941	1,177	764	10
Trustwide	811	440	(371)	5,023	4,375	(648)	8,079	-	8,079	8,964	(885)	3
Total	**2,329**	**1,724**	**(604)**	**10,965**	**10,021**	**(944)**	**10,169**	**7,917**	**18,085**	**22,994**	**(4,909)**	**84**
Unidentified	-	-	-	-	-	-	-	-	*4,909*	-	*4,909*	-
Total	**2,329**	**1,724**	**(604)**	**10,965**	**10,021**	**(944)**	**10,169**	**7,917**	**22,994**	**22,994**	**-**	**84**
Movement from last month	*704*	*441*	*(263)*	*2,329*	*1,724*	*(604)*	*(533)*	*1,612*	*1,079*	*-*	*1,079*	*2*

Overview

- The trust has delivered £1.7m of efficiencies in the month and £10m year to date, this is £0.6m behind the in month plan and £0.9m year to date.
- Over-performance in Core, CHIC and Corporate are partially offsetting under-performance in Medicine, Emergency Care, DAS, Estates and facilities and Trust-wide.
- The largest in month variance is in Trust-wide and this is due to the escalation beds still being open.
- The target for the year is £23m, this reflects the increase of £2m following the resubmission of the plan in June. So far £18.1m has been identified, leaving a gap of £5m for the Divisions to find, an improvement of £1m in the month.
- 44% of the £18m identified is non-recurrent.

Capital

Trust Lead	Capital Scheme	YTD Actual £'000	2022/2023 Plan £'000	Fcast £'000	Fcast RAG	Variance £'000
	Original					
DIG	Digital Programmes	1,377	4,500	5,099		599
	Total Digital	**1,377**	**4,500**	**5,099**		**599**
EME	Diagnostic Equipment	400	500	500		-
EME	Medical Equipment	772	2,500	2,500		-
	Total Medical Equipment	**1,172**	**3,000**	**3,000**		**-**
EST	Fire	125	1,500	1,500		-
EST	Backlog	2,116	6,750	6,750		-
EST	Day Surgery capacity	1,258	1,100	1,350		250
EST	Theatre 5 & 8	388	280	388		108
EST	CT Scanner	-	250	350		100
EST	Westham	417	150	417		267
EST	Conquest ED	234	250	250		-
EST	Baird Ward	0	100	0		(100)
EST	Cath Lab Replacement	26	1,700	1,500		(200)
EST	Cat 3 Microbiology	-	50	-		(50)
EST	Gynae Footprint	156	400	400		-
EST	ICU adaptations Conq	30	1,500	500		(1,000)
EST	Ophthalmology Bex	40	1,000	750		(250)
EST	Cardiology Business Case	-	150	150		-
EST	Friston Paeds	207	1,000	1,000		-
EST	Decant Ward	154	4,000	1,000		(3,000)
EST	Ward Refurbishment	392	1,250	1,050		(200)
	Total Estates	**5,544**	**21,430**	**17,355**		**(4,075)**
FIN	Business Case Development	13	400	13		(387)
FIN	Divisional Small Works	-	500	250		(250)
FIN	Minor Capital	271	1,000	900		(100)
FIN	Unplanned Urgents	66	500	66		(434)
FIN	Planned slippage/prioritisation	-	(4,910)	-		4,910
	Total Finance	**350**	**(2,510)**	**1,229**		**3,739**
	Total Original Planned	**8,443**	**26,420**	**26,683**		**263**
	New					
EME	Community Diagnostic Centre	377	500	500		-
	Additional Medical Equipment	**377**	**500**	**500**		**-**
EST	Building For Our Future	281	1,060	1,060		-
EST	Community Diagnostic Centre	1,960	2,650	2,650		-
EST	Elective Care Centre (EDGH)	232	2,025	2,025		-
	Additional Estates	**2,473**	**5,735**	**5,735**		**-**
DIG	EPR Match Funding (external)	-	750	750		-
	Additional Digital	**-**	**750**	**750**		**-**
	Total Additional Capital	**2,850**	**6,985**	**6,985**		**-**
	Total Capital	**11,293**	**33,405**	**33,668**		**263**
EST	PSDS3	8,503	28,822	28,822		-
EST	PSDS3 Income	(8,538)	(28,822)	(28,822)		-
	Total Grant Capital	**(35)**	**-**	**-**		**-**
FIN	Donated Expenditure	668	1,000	1,000		-
FIN	Donated Income	(671)	(1,000)	(1,000)		-
	Total Donated Capital	**(3)**	**-**	**-**		**-**
	Total Capital	**11,255**	**33,405**	**33,668**		**263**

East Sussex Healthcare NHS Trust

Capital

- The planned capital allocation for 2022/23 is £33.4m and is made up of the core ICS allocation of £26.4m plus national programmes expected in year of £7m.
- Of the additional PDC expected, MOU's have been received for Building for Our Future (£1,060k) and Elective Care Centre (£2,025k). Cash draws will be made once commitments have been made and expenditure incurred.
- 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 October totals £11.3m.
- Expenditure in M7 was largely driven by the following schemes:
  - Medical Equipment £1,549k (includes diagnostic equipment of £400k and equipment for the Community Diagnostics Centre (£377k);
  - Estates works of £5.5m, the main schemes being backlog maintenance (£2,116k), Westham remodelling and refurbishment (£417k), Theatre 5 & 8 upgrade including laminar flow (£388k), Conquest ED project delivering new clinical space and staff area (£234k), and Day Surgery redesign at EDGH (£1,258k);
  - Community Diagnostics Centre £2,337k made up of equipment costs (£377k) and estates costs (£1,960k);
  - Elective Care Centre £232k.

Assets and Liabilities

East Sussex Healthcare NHS Trust

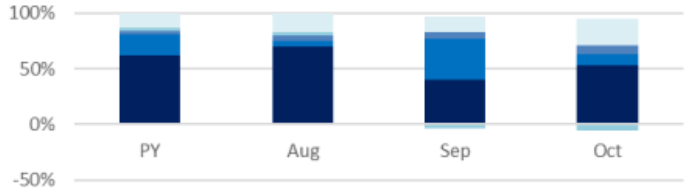
Trust Assets and Liabilities

	Aug £'000	Sep £'000	Oct £'000	Change £'000
Non-current assets	**297,247**	**297,147**	**297,136**	**(12)**
Inventories	7,529	7,922	8,786	864
Trade and other receivables	30,232	23,963	27,434	3,471
Cash and Cash equivalents	49,082	51,446	45,403	(6,043)
Current Assets	**86,843**	**83,331**	**81,623**	**(1,708)**
Trade and other payables	(48,947)	(48,756)	(44,305)	4,451
Other liabilities	(11,022)	(7,618)	(10,583)	(2,965)
Current Liabilities	**(59,969)**	**(56,374)**	**(54,888)**	**1,486**
Non-current liabilities	**(12,941)**	**(12,462)**	**(12,462)**	**-**
Total assets employed	**311,180**	**311,643**	**311,409**	**(234)**

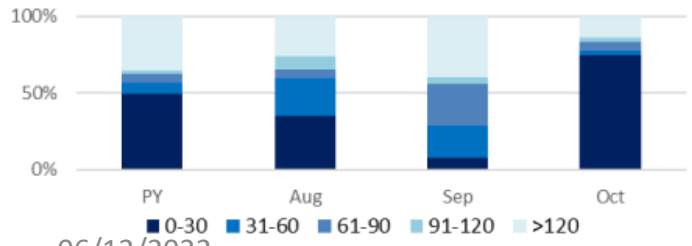
BPPC (Based on invoice count)

Trade	80.4%	81.7%	82.3%	0.7%
NHS	98.7%	98.5%	98.5%	0.0%

Trade Payables Ageing



Trade receivables Ageing



Balance sheet

- Non-current asset values have decreased slightly by £0.01m.
- Current assets has decreased in month by £1.7m. This has predominantly been caused by an increase in trade and other receivables offset by a reduction in cash held. M7 had 4 payment runs however one run was higher than average and included a payment to Veolia for PSDS3.
- Current liabilities has decreased in month by £1.5m, this relates to income prepayments increasing at M7.
- The Trust continues to hold very significant cash balances at 45.4m.

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

- A decrease in month of £4.8m on the creditor position reducing the purchase ledger total to £8.0m.
- 77% 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 increased by £8.6m in month to a total of £14.8m.
- The ageing profile of debt due has decreased by £1.0m in month and now totals £3.8m.

Key risks

East Sussex Healthcare NHS Trust

Risk adjusted forecast outturn

- Risk analysis shows a potential range from £5.0m deficit to a breakeven position downside and upside cases respectively. The base case is showing a expected deficit of £1.4m which is immaterial to the scale of Trust turnover so not seen as a trigger point for changing the forecast given a view that non-pay was extremely high in month and may recover next month.
- The downside position has improved due to confirmation that the ICB will not reduce the ERF value, however this is partially offset by a deterioration in run rate which has worsened the base case position. Risks are set out below.

	Downside £'000	Base £'000	Upside £'000	Commentary
M7 YTD	**198**	**198**	**198**	
Risks				
ERF value	-	-	-	*The ICB was considering whether the allocation of ERF money was correct. Now been informed there is no adjustment for 22-23.*
Efficiency	(1,370)	(1,370)	-	*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. Mitigations for slippage has been found in some areas.* 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 **downside** we are assuming the current run rate continues and this is not achieved, for upside **case** that this is delivered.
Run rate	(5,640)	(3,760)	(1,880)	*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* **Base**: Extrapolation of current run rate adjusting for ERF and assumed efficiency updside. **Upside** and **downside** case have been adjusted by 50% of this value.
Winter pressures	(750)	(500)	-	*Increasing expenditure based on additional operational demand over winter* **Base:** assumes an increase of £4m over the the second half of the year compared to budgeted establishment, however this is largely reflected in the run rate so a a nominal £0.5m is included here **Downside**: expectation of additional costs for winter pressures over and above those included in the run rate at and additional 50%
Pay award	(1,414)	-	-	*There is a risk that the full cost is not fully funded. However,it appears H1 has been absorbed within the funding.* **Base Case**: assume continued run rate on pay award abosbed through additional funding **Upside**: Pay award is fully funded **Downside**: based on the theoretical gap identified in the pay workings
Mitigations				
One-off recovery actions	**4,000**	**4,000**	**1,682**	
Scenario FOT	**(4,976)**	**(1,432)**	**-**	
Prior month	**(7,102)**	**108**	**-**	

East Sussex Healthcare NHS Trust

Maternity Overview Report: Q2 2022/23

Purpose of the paper	The Trust Board is requested to note this report, which provides an overview of the quality and safety of our perinatal services, an overview of our progress in ESHT with meeting the perinatal clinical quality surveillance standards at Trust level, and our actions to proactively identify and mitigate any quality and safety concerns and risks. The report also provides an overview of Maternity planning, progress and activity during quarter two 2022. The report includes an overview and assurance from ESHT perspective with regards to the East Kent Report Maternity and neonatal services report 'Reading the signals'
	For Decision: ; For Assurance: x; For Information:
Sponsor/Author	Executive Director Vikki Carruth, Chief Nurse Report Author: Brenda Lynes, Director of midwifery
Governance overview	W&C Division Governance & Accountability Meeting: November 2022 Maternity Assurance Meeting: November 2022 Quality & Safety Committee: November 2022

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
	x	x	x	x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

Recommendation	The Trust Board is asked to. • Review the update and progress within maternity and neonatal services during Q2 2022/23 • Agree and Endorse: 1. The CNST/MIS year 4 assurance paper confirming compliance to all 10 safety actions 2. The 6 month workforce review report in line with CNST requirement, including 3. The Acuity and Red flag quarterly report 4. The MVP annual plan 5. The overview and assurance paper *from ESHT* perspective with regards to the East Kent Report Maternity and neonatal services report 'Reading the signals'
Executive Summary	This report provides an overview of the quality and safety of our perinatal services, an overview of our progress in ESHT with meeting the perinatal clinical quality surveillance standards at Trust level, and our actions to proactively identify and mitigate any quality and safety concerns and risks. The report provides an overview of Maternity planning, progress and activity during quarter two 2022. The report includes an overview and assurance from ESHT perspective with regards to the East Kent Report Maternity and neonatal services report 'Reading the signals'. This paper provides assurance that overall ESHT are providing safe care in line with National requirements, Trust values and our maternity strategy. Where issues are identified clear action is put in place with regular review and/or surveillance of key concerns to provide ongoing assurance. • A quarterly update approach was agreed through the Trust Board seminar in

	August 2022 • Continuous review and surveillance of maternity services is reviewed internally through monthly Governance and Accountability, Internal performance review meetings, Quality and Safety Committee meetings and quarterly reports to the Trust Board. Externally through monthly LMNS Quality and Safety meetings and quarterly through the LMNS Board
Next steps	• The endorsement from Q&S CNST/MIS year 4 assurance paper confirming compliance to all 10 safety actions will be further endorsed by the ICS and Trust Board prior to submitting to NHS Resolutions by 12 midday on 2/2/2023 • The MVP annual plan will be progressed and be implemented as planned • The overview and assurance paper from ESHT perspective with regards to the East Kent Report Maternity and neonatal services report 'Reading the signals' will be used to support further actions expected imminently from NHSE/I • The CQC actions will provide evidence of improvements once the full report is received • A quarter 3 follow up and update paper will be provided February 2023

Maternity Overview Report: Q2 2022

Executive Summary

The Trust Board is requested to note this report which provides an overview of the quality and safety of our perinatal services, an overview of our progress in ESHT with meeting the perinatal clinical quality surveillance standards at Trust level, and our actions to proactively identify and mitigate any quality and safety concerns and risks. The report provides an overview of Maternity planning, progress and activity during quarter two 2022.

Introduction

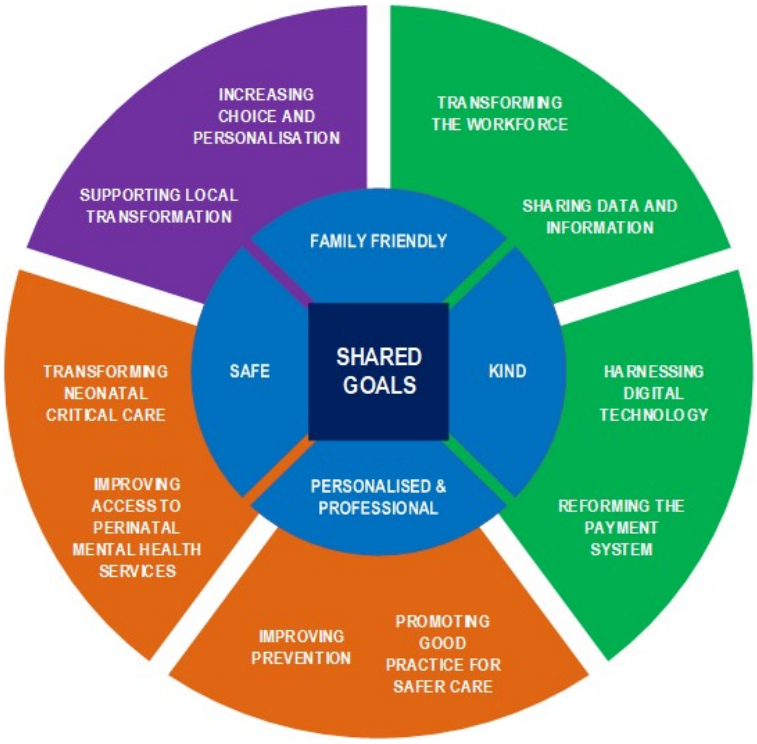
The National Maternity and Neonatal Safety Improvement programme[1] (MatNeoSip) was launched in 2019. This programme is supported by our Local Maternity and Neonatal System (LMNS), the programme aims to;

1. Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high-quality healthcare experience for all women/birthing people, babies and families across maternity and neonatal care settings in England

2. Contribute to the national ambition set out in the Transformation plan (previously Better Births of reducing rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 2025

[1] NHS England » Maternity and Neonatal Safety Improvement Programme

The Maternity Transformation Programme seeks to achieve the vision set out in Better Births by bringing together a wide range of organisations to lead and deliver against 10 work streams as shown in the diagram below:



East Sussex Healthcare Trust's Clinical Strategy[2] is aligned to this long-term plan. The ICS through our Local Maternity and Neonatal System and our local Maternity Voices partnership (MVP) are working in partnership to achieve these ambitions. Recommendations made in the final Ockenden report (March 2022), are supportive steps towards this greater ambition. ESHT's dashboard provides data for scrutiny and analysis to provide assurance to the Board surrounding these key areas.

This paper provides assurance surrounding the safety of services. We ask ourselves four key questions:

1. Are we safe against the national safety ambition
2. Perinatal mortality rates
3. What is our data telling us
4. Staff and service users – are staff and service users telling us we are safe

Continuity of carer model

Describes actions to achieve a national target to provide a continuity of carer model for:

- 20% women/birthing people by 2019
- 75% of women/people from Black, Asian and minority ethnic communities by March 2024
- 75% of women/people from the most deprived groups by March 2024

[2] Clinical Strategy (esht.nhs.uk)

This target was amended following a letter received from NHS England on 21 September 2022, it states;

> *Trusts are not expected to deliver against a target level of MCoC, and this will remain in place until maternity services in England can demonstrate sufficient staffing levels to do so. However as previously discussed*
>
> *Trusts that cannot meet safe minimum staffing requirements to further roll out MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.*

Continuity of carer

ESHT will continue with the two current MCoC teams, however, will not commit to further rollout until staffing has improved and key requirements are in place. The existing two teams will be reviewed to ensure they are meeting key requirements to support those from the most deprived groups and those from women/people from Black, Asian and minority ethnic communities

Personalised care

Safer care, as personalised care recognises that every person, every pregnancy and every baby and family is different. Personalised care provides access to information to enable decisions about care that is centred on individual needs and circumstances.

Safe Staffing

Essential to providing safe care. This includes the entire Midwifery workforce (Medical, nursing, ancillary, allied health staff).

Safety of Services

The Maternity Safety Strategy comprises evidence-based initiatives to support the maternity system to strengthen leadership, implement best clinical practice and develop cultures of continuous learning for improvement. These are essential components for achieving the National Maternity Safety Ambition to achieve the following, by 2025:

- Halve the rate of stillbirths, neonatal deaths, brain injuries that occur soon after birth and maternal death
- Reducing the preterm birth rate from 8% to 6%

MBRRACE [3](Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), provide a 3-yearly report (due to numbers being small). At the time of the last publication (2019), national indicated that mortality and morbidity rates at ESHT compared favourably with other NHS organisations.

The following methods are used to monitor and measure the safety of maternity services.

[3] MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | NPEU (ox.ac.uk)

HSIB Referrals (Q2)

Since 2021, all HSIB cases accepted for investigation are raised as SI's. ESHT have reviewed all cases and no trends have been noted. During quarter two there has been no Serious Incidents and no HSIB referrals

Closed Serious Incidents and analysis during Q2

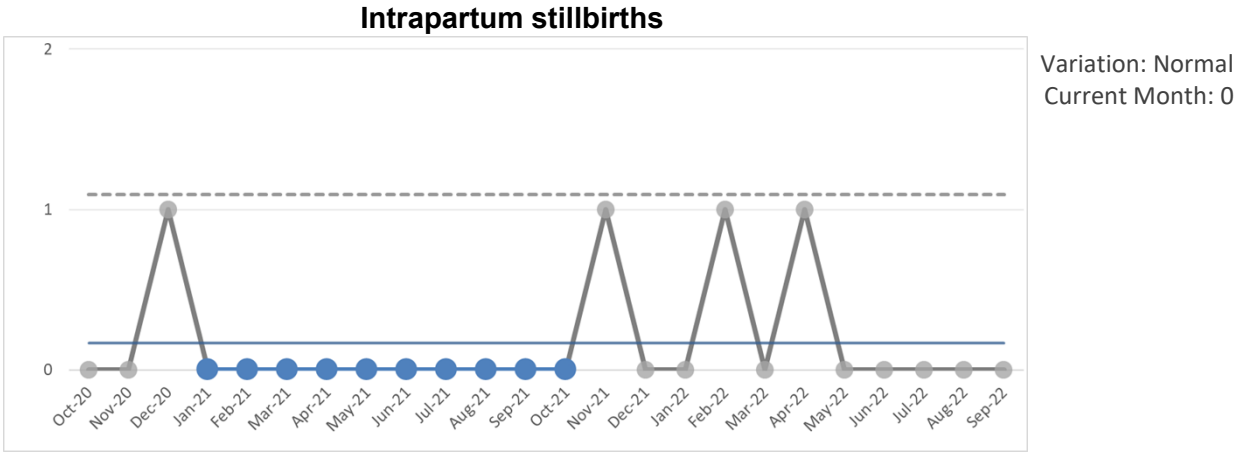
There have been no closed Maternity Serious Incidents during quarter 2 2022/23

Completed HSIB referrals during Q2

Two completed investigations by HSIB during quarter 2 2022/23. Sadly, both cases involved stillbirths, no trends have been noted. Reports have been shared with the respective parents. Tripartite meetings have been held with both parties. Completed safety actions included close support, supervision and retraining of key staff. Scheduling of an appointments audit to ensure robust adherence to national guidance. All actions are reviewed at the Women's Risk meeting on a quarterly basis.

Stillbirth data (Q2)

The table below shows the number of intrapartum stillbirths reported between October 2020 and September 2022:



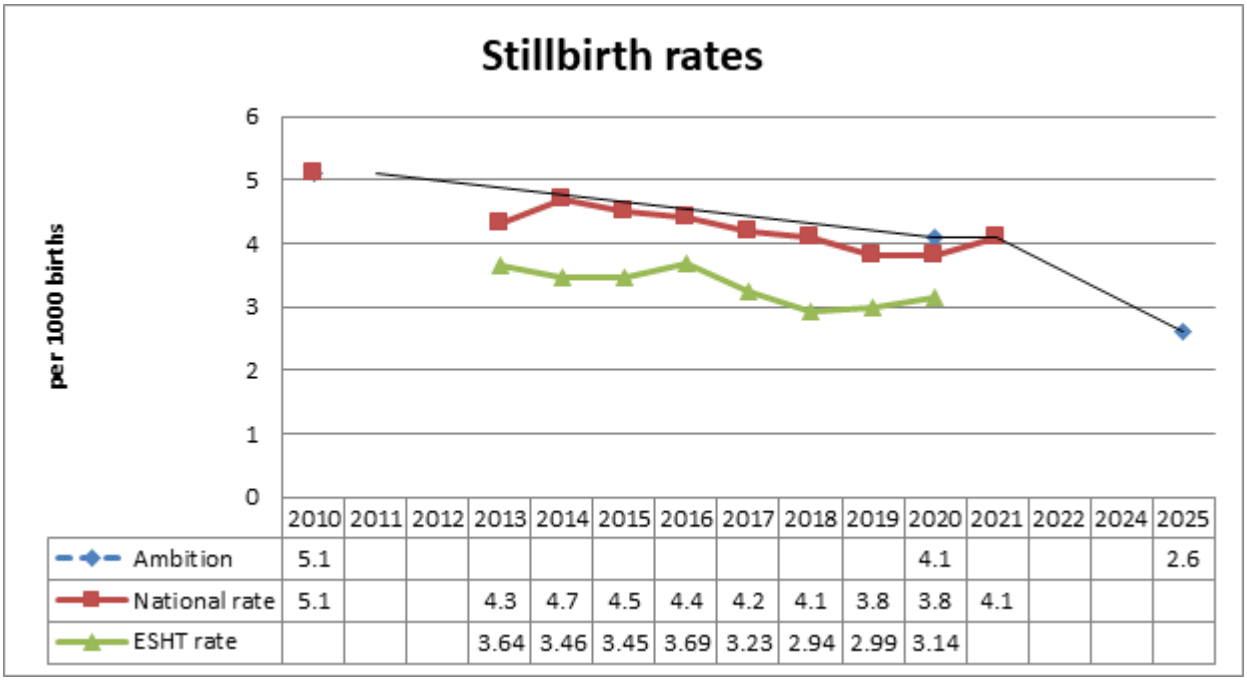
The department has completed a thematic review during the last quarter, following the cluster of stillbirths between October 2021 and May 2022. There were no stillbirths during quarter 2 2022/23. Six cases in total were reviewed, 2 cases from 20/21 and 4 cases in 22/23, all cases were reported as per national requirement (with external reviewers and consultants in attendance at PMRT). Reduced fetal movements was a factor in 50% of the cases. ESHT advice and guidance was reviewed and confirmed as in line with NICE Guidance. Leaflets for advice and guidance are available on our electronic records system Badgernet, an audit is underway to review how many service users access these leaflets once advised at booking, further discussion regarding access to leaflets is taking place through the Maternity Voices Partnership. Further to this, the Maternity Day Assessment Unit is adopting the [4]Birmingham Symptom-specific Obstetric Triage System (BSOTS), with an implementation date of 30/1/2023.

The Trust's fetal monitoring study day, is attended by all Maternity staff annually, which includes education surrounding reduced fetal movements.

[4] Birmingham Symptom-specific Obstetric Triage System (BSOTS) | AHSN Network Innovation Exchange (ahsninnovationexchange.co.uk)

Stillbirth rates have seen a slight increase nationally, this is currently under review, please see table below. ESHT continue to work robustly with Saving Babies Lives care bundle v2, with which services are fully compliant with all five areas. A historical Serious Incident review, where all Serious Incidents from 2015 to present will be thematically reviewed for trends and robust implementation of actions and audit. This is currently being arranged between ESHT and external LMNS colleagues to consider any trends, changes to practice and subsequent required actions, including ongoing audit processes.

Stabilised and adjusted stillbirth rates per 1000 birth (2010–2021) ONS/MBBRACE data October 2022



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2024	2025
Ambition	5.1										4.1				2.6
National rate	5.1			4.3	4.7	4.5	4.4	4.2	4.1	3.8	3.8	4.1			
ESHT rate				3.64	3.46	3.45	3.69	3.23	2.94	2.99	3.14				

The Trust neonatal death rate is currently 0.68/1000 births. This is significantly below ONS data which reported 2.7 neonatal deaths per 1000 births in 2020.

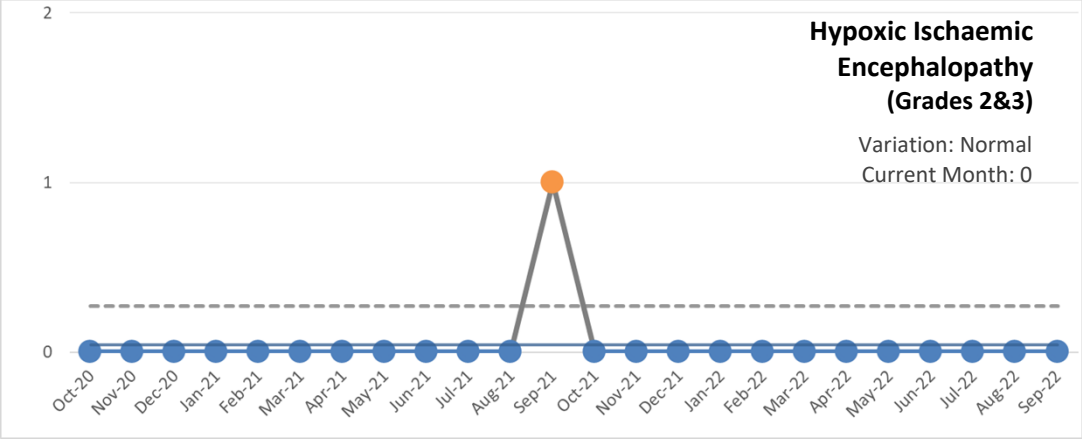
Findings from local Perinatal Mortality Review Tool (PMRT) Reviews

For PMRT reviews, external reviewer presence ambition is 100%. Q2 meeting, no external attendance, however papers were reviewed externally and commented on prior to the meeting. All cases meeting criteria were reported to MBRRACE within 7 working days. Two cases were reviewed, whilst no issues of care were noted, there was an action for Midwives to be reminded of how to use Badgernet software to ensure appropriate grading of risk antenatally was identified.

Discussions continue to review Serious Incidents in line with the Patient Safety Incident Response (PSIRF) framework, to ensure PQS compliance is achieved in line with national ambition, the LMNS agreed pool of external reviewers will also provide scrutiny for PMRT.

Neonatal Brain Injury

There have been no cases of neonatal brain injury during quarter 2 2022/23



Maternal Mortality

No maternal deaths during Q2, sadly, one late maternal death was reported in Q1. This occurred 50 days post-partum, at home and has been reported to [5]MBRRACE. The cause of death was drug toxicity secondary to drug dependence as advised by the coroner. Actions for the maternity department include ensuring robust enhanced packages of care are regularly monitored for all high risk women and birthing people.

Maternity Staffing

A midwifery staffing overview report, covering staffing and safety issues for the period April to September 2022 is completed bi-annually *(Appendix A: Six Monthly Midwifery Staffing Review, Apr-Sep 22)*

Workforce

As of 30th September 2022, the midwifery workforce vacancy rate was 9.4% (Band 5-7 RM) within the service. Seven whole time equivalent (wte) newly qualified midwives commenced with the Trust in the first week of October. Overall staffing rates have improved within Maternity services. (at 5.3% December 2022).

A recruitment and retention lead for maternity commenced in post in October 2022, plans in place to consider advanced clinical Midwifery posts for prospective employees. A retention plan is under development. A website upgrade is underway with the aim of attracting both staff and birthing people to our services.

Red Flag Incidents

Red flag incidents are recorded via the internal escalation process and datix system and a quarterly report is produced *(Appendix B: Maternity Workforce, Acuity, & Red Flag Incident Reporting Q2 2022)*. The main indication for recording a red flag incident during quarter 2, included delays or re-scheduling of induction of labour (IOL) to maintain safe services. The department acknowledges that this can lead

[5] MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | NPEU (ox.ac.uk)

to increased anxiety and poor patient experience. No harm occurred to any of the service users involved.

Like many maternity units regionally and nationally, the service has experienced ongoing workforce challenges due to short and long-term sickness absence. The table below shows that sickness levels have reduced significantly, from 6.9% in April to 2.8% in September 2022:

	April	May	June	July	August	September
Sickness Levels (%)	6.9%	5.3%	6.8%	7.3%	4.9%	2.8%
Of which COVID sickness related	2.9%	1.3%	1.9%	2.6%	0.8%	0.0%
Of which anxiety, stress or depression related	1.3%	0.9%	2.5%	3.9%	2.1%	0.8%
% of sickness as long term (28 days+)	46.5%	36.9%	41.4%	41.4%	67.0%	23.2%

The table below highlights that maternity leave increased from 5.8% in April to 6.4% in September. Maternity leave is backfilled where possible. Annual leave is maintained overall at 17%:

	Apr	May	June	July	August	September
Maternity Leave	5.8%	6.0%	5.6%	5.7%	6.6%	6.4%

One to one care in established labour is reviewed monthly as part of the PQS dashboard. The rates of one-to-one care during are shown below, demonstrating safe care provision overall.

	April	May	June	July	August	September
1:1 Care In Labour	97%	98.00%	99.00%	96.00%	99.00%	98%

Fill rates

During the reporting period, a deficit can be seen between the monthly planned and actual hours worked in a 24-hour period prior to escalation and support offered by specialist midwives/managers.

On review of Healthroster shift assignment counts, this equated to most shifts being 2-3 under the agreed template.

Planned v. Actual Clinical Midwifery Hours (acute unit) via Healthroster						
	April	May	June	July*	Aug*	September*
Fill Rate	82%	86.50%	81.70%	81.90%	83.10%	77.40%
Planned	5514.80	5797.30	5520.00	5694	5902	5641
Actual	4517.50	4939.40	4510.00	4664	4746	4365
Variance	-997	-767.9	-1010	-1030	-966	-1276

When staffing falls below requirements for activity, or activity/acuity exceeds capacity of the staffing available, the escalation policy is enacted to bring managers and specialist midwives to work clinically in hours and on call midwives out of hours to maintain safe staffing.

MDT Training

Compliance with CTG and fetal monitoring training competency is as follows:

	% Compliance
Medics	100%
Midwives	92%
Combined	92.00%

Core competency (PROMPT) training. As of the end of September 2022, combined profession compliance with MDT training is 95.5%.

Obstetric, Neonatal & Anaesthetic Staffing

Obstetric Workforce

There is a local guideline in relation to the duties of the Hot Week Consultant. This incorporates the principles outlined in the RCOG Workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'. Compliance with the recommendations within the guideline has been demonstrated in a recent audit. The audit and action plan has been shared with the consultant body and will be monitored by the clinical effectiveness midwife and through the divisions audit meeting.

The maternity department is compliant with the requirement for twice daily consultant ward rounds, 7 days per week. This is monitored monthly via the PQS dashboard which is shared with the Trust Board and LMNS.

Anaesthetic Workforce

Anaesthetic workforce rotas demonstrate compliance with the ACSA standard: the requirement for a duty anaesthetist to be immediately available for the obstetric unit 24 hours a day, with clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients.

Neonatal Medical Workforce

The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

Neonatal Nursing Workforce

The neonatal unit meets the service specification for neonatal nursing standards and uses a specific workforce calculation tool.

Positives within staffing

Clear escalation of ongoing midwifery workforce challenges continues.

Culture within maternity Services

The most recent staff survey is currently underway. The 2021 survey was mid-way through the third wave of the Covid pandemic, indicated:

- 91% said they know what their responsibilities are at work
- 92% said they are trusted to do their job
- 92% feel the care they give makes a difference
- 84% enjoy working with their colleagues
- 47% would recommend the Trust as a place to work, and feel they can speak up about concerns

The following areas were highlighted for improvement:

- 82% people did not feel there was enough staff to do the job well
- 78% people felt worn out after a shift
- 71% people work 5 or more additional unpaid hours (majority is <5 hours)
- 69% felt emotionally exhausted
- 60% felt burnt out

A Staff survey action plan was coproduced with our staff during two listening events in June 2022, their ideas include, all staff to be offered a wellbeing conversation to include discussion on feeling safe at work and flexible working. A plan to showcase some of the great work delivered within services. Ensure staff receive positive feedback. Walk and talk in the grounds of EDGH and Conquest to be advertised to allow safe group events. We continue to improve bi-directional communication between acute and community services and invite members from Governance, risk and IPC to staff meetings to support staff in understanding these vital roles. The unit is also planning a low meeting day weekly to allow managers to go back to the clinical areas and support teams. Ongoing listening events continue within the division.

The last Score survey was in 2018, the latest staff survey commenced in September 2022. The next Score survey is due to commence in Spring 2023, no definite dates have been noted to date. Further to this, the Maternity senior team and HR are in discussions as to how we best hear all the voices of our staff in multiple ways to ensure we hear the lesser heard voices.

The quadrumvirate senior team are also part of cohort 1 of the Perinatal culture and leadership programme, which is a supportive program provided by NHSE, which is supporting our thinking around the continuous review of culture within our services. All Maternity staff as part of mandatory training receive training on civility counts, this is part of our multi-disciplinary team training (PROMPT)

Voice of Service Users

Friends and Family Test (FFT) positive feedback scores are in the range of 95-100%. Work continues to encourage all service users to complete their FFT, a QR code is now available with plan to add this to our electronic records system, Badgernet in the coming month.

Service user feedback via the Maternity Voices Partnership (MVP) has included:

Two pieces of feedback received and shared with relevant colleagues for response. This centred around differing consultant clinical opinions regarding timing and location for birth. Service users didn't feel listened to or empowered. This is an ongoing theme for the Trust and the LMNS. Training sessions are being organised for new to post Midwives and junior doctors, with ongoing feedback for action with existing staff.

Access for birth supporters

This is a continued theme. Opening hours for the Maternity Antenatal and postnatal wards were reviewed in October 2022, one supporter is now able to attend between 7am and 11pm, which has been welcomed.

MVP meetings continue on a quarterly basis, this is well attended by all key stakeholders. An annual action plan has been agreed and a 15 steps event will take place early in 2023 *(Appendix C: East Sussex MVP Annual Work Plan)*. Work to co-create service improvements and redesign continue with MVP input into reviews of ESHT's Induction of labour pathway, our BSOTS implementation into day unit and upgrade of the Maternity website.

MVP Positive feedback

Caring staff: two couples and two solo parents said what an amazing job the team are doing and how well they were looked after at the Conquest. Service users also stated; The staff couldn't do enough for them, they were made to feel so comfortable and were well looked after. The food was also recognised as being "amazing". A service user reported on the survey that midwives were "inspiring" and "empowering". Continuity of Care services received lots of positive comments. The MVP survey identified that seeing the same or a small number of MW's/Drs during their antenatal care is certainly something that service users want. 7 respondents said it was "very important" to them, 7 "important" and 1 "somewhat important".

Anaesthetist care was noted, service users said anaesthetists were helpful, supportive and professional during their caesarean births.

Progress with Ockenden recommendations / East Kent Report

Evidence of good progress with Ockenden 7 IEA's – position as submitted to NHSE/I 15th April 2022 with compliance at 82%, this has now risen to 97%. Audits have been completed with action plan delivery progressing, compliance is monitored at the divisional Governance and Accountability Maternity meeting and at the monthly Maternity Assurance meeting. The Trust Maternity website is in the process of being updated. Following the NHSE/I assurance visit, an action plan is in place to ensure full compliance.

The Maternity department have commenced a benchmarking exercise against the Final Ockenden report and the 15 IEA's which build on the first 7 IEA's, overall good progress is being made. The Sussex Maternal Medicine Network is now fully functioning.

NHSE/I have advised that reporting against the final IEA's will be combined with the East Kent report, an interim overview and assurance paper has been completed by the Trust *(Appendix D: East Kent Summary Report & ESHT Assurance)*

NHSE Insight visit

ESHT hosted an NHSE Ockenden Insights visit on 24th July 2022, ESHT received final feedback in September 2022. Feedback from the team was extremely positive and highly supportive of the excellent work and service delivery throughout Maternity services, including our high-quality governance and audit processes, it was noted that ESHT are the only Trust in the sector to have completed such a comprehensive audit process as required by Ockenden. Staff were commended in the progress ESHT have made during the past months against all 7 IEA's. There were 11 actions for ESHT from the final report, all are now nearing completion. *(Appendix E: Ockenden Assurance Insight Visit Report Action Plan)*

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 4

The scheme incentivises ten maternity safety actions, trusts that can demonstrate they are compliant with **all 10** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. *(Appendix F: Maternity Incentive Scheme CNST Year 4 report)*

The maternity incentive scheme (MIS) year 4 was relaunched on 6th May 2022, with further adjustments during October 2022. ESHT have completed an internal audit of all 10 safety actions (4/11/22) and confirm full compliance with all actions. The Trust has remained compliant for all four years of the scheme.

A further external tiaa audit of the compliance with the 10 safety actions took place on 14 November 2022 with the final report for submission to Trust Board for sign off in December 2022. CNST timelines for submission have been moved by four weeks to 4 February 2023. *(Appendix G: tiaa CNST MIS Internal Audit Validation)*

Digital Strategy

ESHT have produced a digital strategy, approved through the Quality and Safety Committee, *(Appendix H: Maternity Digital Strategy - will be available for Trust Board)*

CQC visit October 2022

The Care Quality Commission have inspected East Sussex Healthcare Trust on four occasions between 2016 and 2022. Maternity Services have been inspected on three of these four visits:

- ✓ October 2016 (report published January 2017)
- ✓ March 2018 (report published June 2018)
- × November-December 2019 (report published February 2020) – Maternity Services were not inspected
- ✓ October 2022 (report is currently pending)

The summary report provides assurance on the maternity services journey of improvement. We await the 2022 visit final report and are currently working to implement the Birmingham Symptom-specific triage system (BSOTS) within the Day Assessment Unit which responds to the safety concern raised at the October 2022 visit. The implementation of BSOTS has been worked on by the area Matron for the past 6 months. Full Implementation is planned for 30/1/2022 following standardised training for key staff. *(Appendix I: CQC Report 2016 – 2022).*

Areas for improvement
1. The training record does not indicate that staff on the MLU have recently completed evacuation of the pool or neonatal transfers using the POD training or drills. 2. There was no evidence in the day assessment unit that the correct arrival time and time seen were monitored effectively to ensure women were seen within safe time frames. 3. In the day assessment women arriving at the unit were asked to sit in the corridor there was no line of sight which meant staff could not be assured that women were safe whilst awaiting a review. 4. There was not a standard operating procedure for day assessment unit. Which means that staff were unclear about the remit between other areas and there was no rag rating of women based on their clinical need. All actions are currently underway. Action 1 and 2 have been completed, action 3 is under review and a standard operating procedure for Day Unit is being written in conjunction with the introduction of BSOTS, which has an implementation date of 30/1/2023.
Positive findings
1. Safeguarding systems were robust and made sure that families were holistically reviewed and involved in the decision-making process. 2. The continuity of carer team had established good relationships with women and were able to offer good care. 3. BadgerNet implementation was positive and will enable leaders to effectively monitor services in the future.

Celebrations of success as we move forward on our journey of transformation

The public health agenda within maternity care in England is wide ranging and complex. Our Public Health Lead Midwife has been in post through LMNS funding since 2021, with annual funding reviews. Her remit includes

Immunisation

There was a decrease in the overall seasonal flu vaccine uptake across the clinical risk groups in 2019/20 in Kent, Surrey & Sussex[6] and it was hoped that the ESHT service would contribute to an increase in uptake by targeting patients. The ambition was to achieve the minimal target of 75% vaccine uptake (previously 55%).

Maternity services are encouraged to provide the vaccine as part of routine care for all pregnant women. It is recognised that offering immunisation at the health venue women attend most when pregnant, and it being offered by their midwife, is the ideal route to improve access to, and uptake of, this vital protection for pregnant women. Therefore, vaccination is offered at ultrasound appointments on both ESHT sites, this demonstrated a significant improvement in uptake during 2021. It is clear that the

[6] Seasonal flu vaccine uptake in GP patients: winter 2018 to 2019 - GOV.UK (www.gov.uk)

availability of vaccination at the USS clinic improves uptake rate and thus consideration for permanent staffing to deliver this is underway.

Smoking

Smoking in pregnancy is the leading modifiable risk factor for poor pregnancy outcomes. Smokers are 27% more likely to have a preterm birth, 32% more likely to miscarry and 47% more likely to have a still birth. Women/pregnant people from deprived communities are 10 times[7] more likely to smoke during pregnancy than those from more affluent areas and are therefore disproportionately susceptible to poor health outcomes. Maternal smoking during pregnancy costs the NHS in England approx. £21 million each year in secondary care costs[8] and exposure of children to second-hand smoke costs at least £5 million each year.

At ESHT the Smoking at Time of Delivery (SATOD) rate averages at 12.2% which is higher than the national average of 8.8%[9]. Smoking rates in Hastings (22.8%[10]) are significantly above the South East average (10.8%[11]) which makes it a priority region for reducing health inequalities.

The NHS prevention programme was established to take forward the specific commitments set out in the NHS long term plan to drive consistent focus on prevention across all of its services. Explicitly supporting the NHS to make connections in tobacco dependence treatment especially in areas with the highest rates of deprivation and ill health.

Progress
NHS Stop Smoking Services in England reported that between Apr 21 and Sept 21 46.7% of pregnant women self-reported a 4-week quit. The inhouse services report quit rates of 41.6% between Apr 22 to sept 22. The model adopted from the Greater Manchester model has a multifaceted approach to smoking cessation support which ESHT in-house team aim to replicate. It has high levels of compliance with CO monitoring, an opt out referral system, financial incentives and is led by tobacco support MSWs.

This model for tobacco dependence treatment services is offered to the young parent caseload who historically equate to approx. 35% of ESHT's pregnant smoking cohort, the table below compares the traditional model to ESHT's in-house model

REFERRALS FROM BOOKING	In House	External
Referral Offered Target ≥ 90%	**Av Q2 22/23 = 100%** Jul 1/1 = 100% Aug 3/3 = 100% Sept 6/6 = 100%	**Av Q2 22/23 = 95.9%** Jul = 93.1% Aug = 96.9% Sept = 97.5%
Referral Accepted Target ≥ 60%	**Av Q2 22/23 = 90%** Jul = 0% Aug 3/3 = 100% Sept 6/6 = 100%	**Av Q2 22/23 = 44.7%** Jul = 59.2% Aug = 43.75% Sept = 34.2%

[7] Health of women before and during pregnancy: health behaviours, risk factors and inequalities (publishing.service.gov.uk)
[8] Hiding in plain sight: Treating tobacco dependency in the NHS | RCP London
[9] Microsoft Power BI
[10] 2021 GP Patient Survey Results Released | Ipsos
[11] Women known to be smokers at time of delivery - NHS Digital

The Lead Midwife for tobacco dependence treatment services is planning further work to support collaboration with external services for the postnatal referral pathway and a business case is being considered by the ICB to extend the inhouse service to all pregnant smokers.

Encouraging data for Q2 as there has been an increase in the percentage of women with CO≥4ppm at booking and <4ppm at 36 weeks, this is also even more encouraging seeing as compliance with CO monitoring has improved, demonstrating good intervention technique.

Standard 6 Element 1- Saving Babies Lives Care bundle V2

4-month Average If over 95% no further data required
if <95% an action plan will be included below
If <80% failure of standard 6

	Quarter 1 Report Apr, May, June	**Quarter 2 Report** Jul, Aug, sept	**Rolling 4 monthly average**
CO monitoring rate @ Booking	Apr 90.8% May 92.3% June 90.2% **Average Q1= 91.1%**	Jul 85.2% Aug 86.7% Sept **95%** **Average Q2 = 88.9%**	**89.3%**
CO monitoring rate @ 36 weeks	Apr 65% May 70% June 83% **Average Q1= 72.7%**	Jul 88.8% Aug 84.8% Sept 88% **Average Q2 = 87.2%**	**86.3%**

Weight Management

Obesity is becoming increasingly prevalent in the UK population and has become one of the most commonly occurring risk factors in obstetric practice with 21.3% of the antenatal population being obese and fewer than one-half of pregnant women (47.3%) having a body mass index (BMI) within the normal range[12].

Challenges

- ESHT has above national average women booked with a BMI≥30.
- Unknown what dietary advice is given to women/pregnant people by healthcare professionals
- Currently there is no pathway of referral to healthy weight management services for overweight pregnant women/people.
- Low uptake of Vitamin D for those with raised BMI
- Low uptake of correct dosage of Folic Acid

Progress

- Survey of dietary advice given has commenced
- A pilot scheme is being designed, in conjunction with local authority, to offer targeted support to those with a BMI ≥30 which will be run by the new to post Deputy Public Health Nurse in November.
- Pathway for a universal offer of tier 1 services soft launch in October.
- Mandatory training to include dietary advice and supplementation.
- Exploration of PGD for correct folic acid dosage to be supplied by CMWs

[12] NMPA Project Team. National Maternal and Perinatal Audit: Clinical Report 2017. London: RCOG; 2017.

Table of delivered women Q2 (BMI rates)

	July 2022	Aug 2022	Sept 2022	**AV Quarter 2**	Quarter 1 22/23
Women Delivered	256	235	252	**743**	722
BMI ≥30	37 (14.5%)	47 (20%) ↑	39 (15.5%) ↓	**123 (16.6%)** ↑	100 (13.9%)
BMI ≥35	18 (7%)	16 (6.9%) ↓	17 (6.1%) ↓	**51 (6.6%)** ↓	58 (8%)
BMI ≥40	9 (3.5%)	5 (2.1%) ↓	13 (5.1%) ↑	**27 (3.6%)** ↓	27 (3.7%)
BMI ≥50	3 (1.2%)	2 (0.9%) ↓	0 (0%) ↓	**4 (0.5%)** ↓	8 (1.1%)
Total ≥30	26.2%	29.8% ↑	27.4% ↑	**27.5%** ↑	26.7%

Postnatal Contraception

Background

With 1 in 13 women presenting for an abortion or delivery having conceived within a year of a previous birth and 1 in 3 pregnancies being unplanned or ambivalent, information about contraception after childbirth should be offered in the antenatal period to support informed decision-making and facilitate provision of contraception by maternity services.

A planned pregnancy is likely to be a healthier one as unplanned pregnancies may represent a missed opportunity to optimise pre-pregnancy health.

Outcomes for young parents and their children are disproportionately poor, contributing to inter-generational inequity with higher rates of infant mortality, low birthweight and poor maternal mental health, amongst other adverse outcomes and 12% of births among young women under the age of 20 occur in women who are already mothers.

Challenges

- ESHT services in 2020-21 had 181 bookings which were within 1 year of a previous birth (8.3%). 62.2% were unplanned. 42.2% met NICE recommendation of booking before 10 weeks compared to 64.6% nationally and noticeably 53.3% of bookings had complex social factors compared to 12.5% nationally. ESHT had 40.8% of bookings with complex social factors in total.

- 22% of ESHT young parent caseload had an interpregnancy interval of less than a year in 2020/21.

- Currently, only the young parent caseload is offered postnatal contraception before discharge by their midwife along with antenatal contraception advice. The rest of the cohort receive contraception advice upon discharge from the postnatal ward and from the community. The pathway is to signpost to Primary care.

- Unplanned pregnancy is not only an issue for teenagers, but also an issue for women who are over the age of 35, and right through to menopause. This group are the least likely to be using adequate contraception, despite being sexually active and not wanting to conceive. Rising rates of abortion in this age group support this finding.

- Work to further the offer to the whole cohort has been delayed by operational pressure but plans to commence training of more staff are underway with the aim to commence training in Q4 22/23.

Progress

- 2021/22 had only 91 bookings which were within 1 year of a previous birth (2.9%) a significant decrease from the previous year. However, it is worth acknowledging that it is expected that the Covid-19 pandemic may have influenced the data from that period.

- Discussion with sexual health services and commissioners continue to roll out further training to support and train midwives to offer antenatal counselling and postnatal contraception to the wider cohort, thus building on the success of the pilot.

- With the appointment of the Deputy Public Health Nurse the possibility of a postnatal contraception clinic/ward round will also be explored.

Healthy Start Programme

The scheme allows lower income women/people who are more than 10 weeks pregnant or have a child under 4 access to funds to buy healthy food and milk and vitamins to support them through pregnancy. Research shows that women who are introduced to the scheme by a health professional, who takes the time to explain its public health context and health benefits, are more likely to understand the benefits and make better use of the scheme.

Healthy Start vitamins contain folic acid and vitamins C and D for pregnant and breastfeeding women and are important because families in lower-income groups tend to have less vitamin C in their diet and all pregnant and breastfeeding women/people are at risk of vitamin D deficiency (teenagers, younger women and those from ethnic minorities are particularly at risk)

Challenges

- Uptake within East Sussex averaged at 45% of all those eligible for the scheme in 2020/21.
- Change over from paper voucher scheme to digital card
- Language barriers in application

Progress

- With targeted promotion and MSW support Q3 21/22 has shown an increase to an average of 57.6% uptake.
- Continue to work with Local authority and Health visitors to assist with change over and application. Healthy pregnancy support worker supports all eligible candidates in her caseload
- The newly appointed healthy pregnancy support worker, immunisation nurse and public health deputy will also be aiding promotion and assistance to engage with targeted intervention for pregnant women where English is not their first language.

Excellent progress is being made through our public health and Saving Babies Lives Specialist Midwives

CONCLUSION

In conclusion, based on national guidance ESHT measure our Maternity services against four key questions described above our services are well led, well managed, staff are all trained in line with national requirement and governance processes are robust. Maternity services currently have safe and appropriate staffing to provide high quality care with the caveat of the increase in the current uplift recommendation is 26.4%, where staffing falls under template, immediate escalation plans are actioned. Overall, we consider services to be safe.

NHS
East Sussex Healthcare
NHS Trust

Learning from Deaths 1st April 2017 to 31st March 2022

Purpose of the paper	Regular reporting of Learning from Deaths to the Trust Board is a Care Quality Commission requirement. The Board receives updates on a quarterly basis.						
	For Decision		For Assurance	**X**	For Information		
Sponsor/Author	Dr Simon Merritt						
Governance overview	Mortality Review Audit Group						

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
		x		

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
		x	x	

Recommendation	The Board are requested to note the report.

Executive Summary	The attached report on "Learning from Deaths" is a requirement in the Care Quality Commission review. All deaths in hospital are reviewed by our team of Medical Examiners and any cases requiring further scrutiny are highlighted to divisions and discussed at specialty Mortality and Morbidity meetings. The current "Learning from Deaths" report details the April 2017 – March 2022 deaths, recorded and reviewed on the mortality database. The Mortality Review Audit Group continues to review the deaths with a higher likelihood of avoidability, on a quarterly basis, to ensure accuracy in reporting. Deaths going to inquest, SIs, Amber reports, complaints and "low risk" deaths are all reviewed for completeness. Learning disability deaths are being reviewed externally against the LeDeR (learning disability mortality review) programme. Trusts are now receiving feedback from these reviews, although the process is slow. We continue to review deaths of patients with learning disabilities internally due to the delays in the external process, in order to mitigate any risk.

Next steps	"Learning from Deaths" reports are required to be presented to the Trust Board on a quarterly basis.

EAST SUSSEX HEALTHCARE TRUST: Learning from Deaths Dashboard March 2021-22

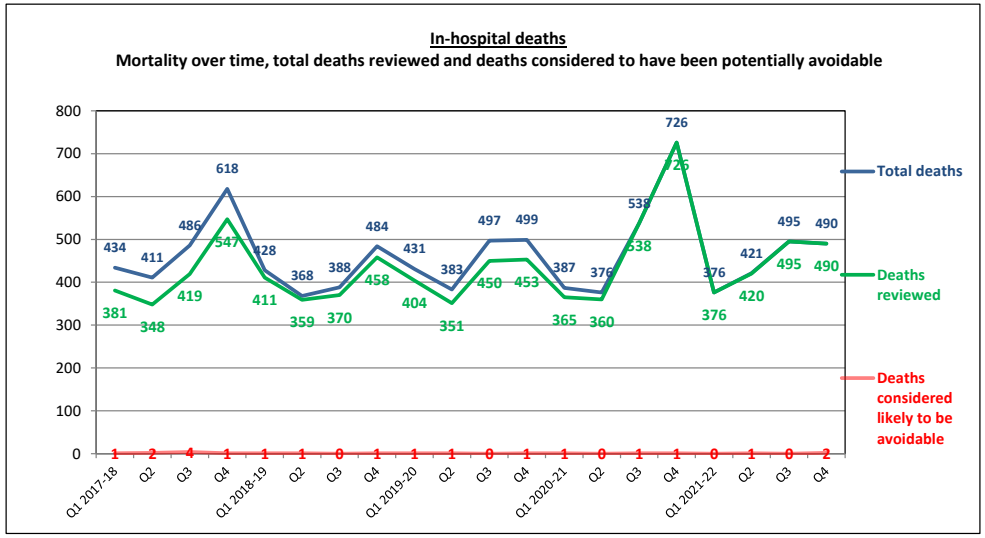
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 09/11/2022)

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

Time Series:	Start date	2017-18	Q1	End date	2021-22	Q4

Total number of deaths in scope		Total deaths reviewed		Total number of deaths considered to have been potentially avoidable (RCP Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
161	155	161	155	1	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
490	495	490	495	2	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1782	2027	1781	1989	3	3



Total deaths reviewed by RCP methodology score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	1	50.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	50.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	20.0%	This Quarter (QTD)	1	20.0%	This Quarter (QTD)	1	20.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	40.0%
This Year (YTD)	0	0.0%	This Year (YTD)	1	12.5%	This Year (YTD)	2	25.0%	This Year (YTD)	3	37.5%	This Year (YTD)	0	0.0%	This Year (YTD)	2	25.0%

Data above is as at 09/11/2022 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There were four care concerns expressed to the Trust Bereavement team relating to Quarter 4 2021/22 deaths. None were taken forward as complaints.
Complaints - There was 1 complaint closed during Quarter 4 2021/22 relating to 'bereavement' in hospital. The overall care rating on the mortality database is '4 - good care' .
Serious incidents - There were no severity 5 serious incidents raised in Q4 2021/2022..
As at 04/11/2022 there are 515 April 2017 - March 2022 deaths, still outstanding for review on the Mortality database.

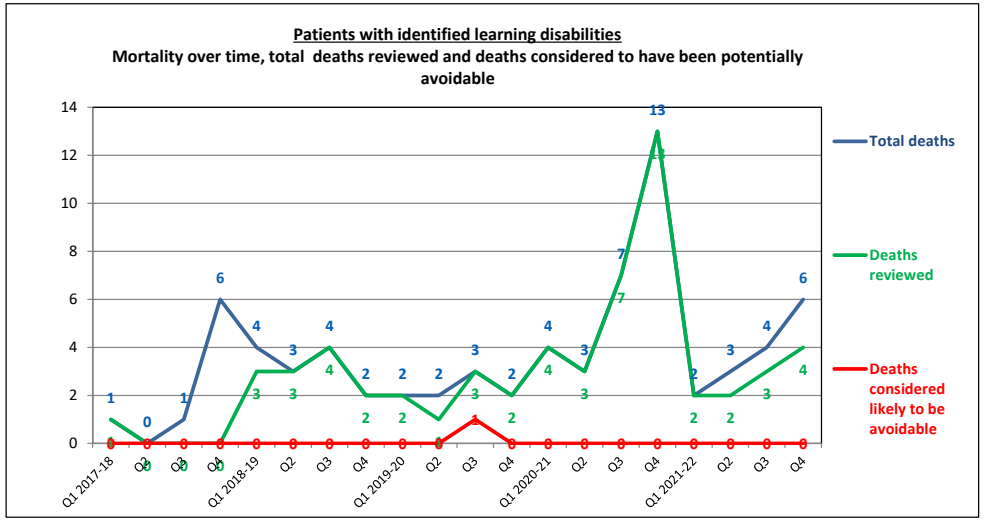
Summary of total number of deaths and total number reviewed for patients with identified learning disabilities (Data as at 09/11/2022)

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

Time Series:	Start date	2017-18	Q1

End date	2021-22	Q4

Total number of deaths in scope		Total deaths reviewed through the LeDeR methodology (or equivalent)		Total number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	3	1	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
6	4	4	3	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
15	27	11	27	0	0



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

East Sussex Healthcare NHS Trust

Board Assurance Framework (BAF) Update

Purpose of the paper	This paper updates the Board as to the progress in managing the Board Assurance Framework (BAF) ahead of the finalised Q3 position. A full Q3 paper (with the BAF templates for each risk) will be coming to the January 2023 Audit Committee, then the February Trust Board.					
	For Decision		For Assurance	x	For Information	
Sponsor/Author	Chief of Staff					
Governance overview	Each BAF risk has been reviewed by the Chief of Staff and the Executive Risk Owner. Collectively the full BAF is reviewed at Executive Directors and was shared with the Audit Committee in November before coming to the December Trust Board. Each Board sub-Committee is expected to review the BAF risks it oversees four times a year. This typically takes place one month after the end of each FY quarter.					

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
				x
Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
		x		

Recommendation	The Board is asked to note: 1) The completed summary position for BAF risks and provisional Q3 positions of each risk, as shared by the Executive risk owners. 2) The rationale behind the expected position for each BAF risk in Q3 (which will formally be reported via the relevant sub-Committees in December/January) and onto the Audit and Trust Board in January/February 2023.
Executive Summary	This paper provides a provisional view of the Q3 risk position for each of the BAF risks, following discussions with executive risk owners. The paper summarises the current BAF risk position for all 13 risks and addresses the concerns – shared previously at the September Audit Committee – that this had not been completed. Aside from one issue (with BAF 10) addressed in the report, all risks have a provisional rating that will be formalised ahead of the January Audit Committee. Additionally, the paper seeks to show a more dynamic approach to managing the risk via controls/mitigations by providing a commentary on the anticipated Q3 positions and the supporting rationale. This will be firmed up in the formal Q3 BAF reports and additional controls/mitigations will be shared there as appropriate and reviewed through the relevant committees.
Next steps	As noted, each of these BAF risks will be reviewed by the relevant Committees before presentation as the formal Q3 update to the Audit Committee in January and then Trust Board in February.

Board Assurance Framework (BAF) Update

1. Introduction

1.1 The Board Assurance Framework (BAF) supports the Board in focussing on the key risks which might compromise the achievement of the organisation's strategic and in-year objectives. The BAF maps out the key controls which are in place to support delivery of the Objectives and to mitigate risk and provide a framework of assurance which the Board can draw upon when considering the effectiveness of those controls.

1.2 At the previous Audit Committee and Trust Board we updated for Q2 provisionally. In this report we are confirming Q2 positions and updating Q3 provisionally. We therefore anticipate that the January Audit Committee will confirm Q3 scores and at the March Audit Committee we will report the Q4 (YE) BAF risk position.

2. Provisional Q3 scores in summary

2.1 Following reviews with all Executive SROs, we have completed provisional assessments for the Q3 summary BAF (see figure 1). The detail behind each of these will follow at the Strategy Committee in December and other Committees in January – and what we have sought to show in this update is a brief rationale for each of the provisional Q3 assessments.

2.2 Figure 1 shows that Executive SROs are anticipating that of the 13 BAF risks, 8 will show no significant change to the residual risk score for Q3. Three BAF risks are likely to show a reduction in residual risk, suggesting the mitigations and controls are showing a degree of effectiveness. However, in the case of the two remaining BAF risks, the residual risk has increased. The rationale is summarised in each case in section 3.

Figure 1: BAF Summary for Q1, Q2 and provisionally for Q3

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 (Prelim)	Q4	Prelim			
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	6		◄►	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	20		▲	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	16		◄►	Cautious / Open	12	Ongoing
4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery	F&I			X	X	20	20	16	8		▼	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	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	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	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	16		◄►	Open	12	Ongoing
9	Failure to transform digitally and deliver associated improvements to patient care	F&I			X	X	20	16	16	16		◄►	Significant	9	31/03/25
10	Failure to maintain focus on improving care	Strat		X	X		12	12	12	9		-	Cautious / Open	9	Review at YE
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	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	X			X	9	9	6	9		▲	Cautious / Open	4	Review every two months
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	9		▼	Open	6	31/03/23

2.3 By way of explanation for BAF risk 10, we recognise that there has been a suboptimal monitoring process to date and wanted to bring to colleagues' attention the progress made. Following further discussions with Q&S Committee members, we have agreed that this risk will reflect the delivery of the continuous improvement methodology – which we recognise is fundamental to the delivery of our transformation/improvement programme (which, in turn, is the "how" of our strategy – hence its importance and inclusion within the BAF).

2.4 Having reviewed both the inherent risk and progress to date we have agreed the trajectory indicated within Figure 1 (greyed out to reflect that this has not yet been agreed through the relevant Committee), and the progress summarised in table 2. For completeness, we will be undertaking a full review of BAF risk 10 at the Strategy Committee in December.

3. Rationale for provisional Q3 position

3.1 Colleagues have previously reflected the importance of the BAF risk scores taking into account changes in both the operating environment and the efficacy of the initial controls and mitigations set out for Q1. In shorthand, we have referred to this as ensuring that our BAF is a dynamic tool, adaptive to our circumstances.

3.2 In the rationale that follows for each BAF risk we seek to show how we have reflected this in our provisional Q3 position. Please refer to Figure 1 for the risk summary descriptions.

Table 1: Preliminary assessment of changes to each BAF risk for Q3 and supporting rationale

BAF risk no.	Anticipated Q3 change	Rationale	Next steps
1	No change	The Trust remains well engaged with both ICB and Place initiatives that focus on improved outcomes. Examples include the System Planned Care Board and the ongoing NHSE-led work on Place Development (which has previously reported through StratCom) Senior presence is currently not compromised in terms of managing internal priorities while also supporting Place/System initiatives	Given the current controls/ mitigations appear to function well in the current operating environment, we do not envisage the need for additional resource/support – no change to current BAF controls/mitigations are proposed for Q3 onward at this point
2	Increased from 12 to 20	The Royal College of Nurses have voted to take strike action which will impact on our available resources. Additionally, a number of other unions are balloting members.	An industrial action project has been implemented to mitigate the impact of colleagues taking industrial action. Daily resource meetings are attached to site meetings. In the event of industrial action, reduced services will be considered to ensure all urgent and derogated services are delivered.
3	No change	Elongated industrial action without resolution may further impact on the motivation and morale of colleagues	The threat of industrial action is being closely monitored. Any impact on colleagues will be reflected in future BAF updates.
4	Reduced from 16 to 8	We are assuming that clawback will no longer be applied for 2022/23	Delivery of annual financial plans and efficiencies will continue to be closely monitored.

5	No change	There remains a reliance on non-recurrent funding, so the risk that the Trust will not be able to deliver a balanced financial position in 2023/24 and onwards remains.	Focus on productivity. Support system to mitigate risk of any overspend in 22/23. Be aware of increasing financial challenge into 23/24
6	No change	Available capital continues to be limited	Support the prioritisation of ESHT schemes within the Sussex ICS capital process
7	No change	The Trust's IT network and infrastructure continues to be vulnerable to prolonged outage	Methods of management and control continue to be utilised to manage threats.
8	No change	There continue to be gaps in both business continuity plans and concerns about the quality and assurance of data used for reporting.	Review of data assurance has started by newly appointed data quality and assurance lead. Review of business continuity plans in the Trust being undertaken by EPRR team.
9	No change	Lack of capital and digital funding to deliver improved digital maturity continues.	Continue to support Trust Electronic Patient Record bid process
10	Reduced from 12 to 9	The inherent risk reflects the scale of the challenge – to revitalise and raise both the awareness and profile of continuous improvement, and doing so with very limited resource	With the ED for Transformation and Improvement in place, an approach to meet our ambitions is underway and we have commissioned targeted advisory support to assist in the short term. Plans will come via StratCom
11	No change	Pressure on the organisation continues with very large numbers of stranded patients and significant extra bedded capacity open now including "supersurge"/critical capacity.	Significant additional capacity remains open, with staffing levels closely monitored to maintain safety. Collaborative system work taking place to identify solutions.
12	Increased from 6 to 9	Following review by StratCom in October, it was agreed that the initial risk rating was too low given the range of challenges articulated within the risk assessment	Remedial actions re: mitigation/ control remain in place and are being worked through
13	Reduced from 12 to 9	Plans are underway for a patient engagement strategy in Q4 that will provide a structured approach for the Trust re: engagement priorities and co-design. This will combine the communications, inequalities and patient experience team	Practical steps have begun – including reaching out to HealthWatch to build a constructive relationship where HW can support Trust work directly and share its contacts/ links from across the third sector

3.3 As noted earlier, the full update of the detailed BAF risks will take place during December (for presentation to the February Audit Committee). A final review of Q4/YE BAF risks will take place, as usual, at the April Audit and Board.

Safeguarding annual report

Purpose of the paper	The report is to provide oversight of ESHT Safeguarding activity 2021-2022 noting successes and achievements and the challenges going forward.					
	For Decision		For Assurance	x	For Information	x
Sponsor/Author	Sponsor: Vikki Carruth, Chief Nurse and Executive Director for Safeguarding Author: Gail Gowland, Head of Safeguarding					
Governance overview	Quality & Safeguarding Committee Safeguarding Strategic group					

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
	x	x		

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

Recommendation	The board is asked to note the Safeguarding activity across all patient demographics, (children, adults and maternity services) the positive developments, the considerable increase in activity and complexity and the likely challenges ahead. These are national issues and felt to be an ongoing effect of the pandemic impacting on hidden vulnerable people and children. The board is also asked to note the suggested impact of the introduction of Liberty Protection Safeguards next year noting the date has been/is subject to change still.

Executive Summary	The ESHT Safeguarding team support staff and patients on a daily basis responding to any and all safeguarding issues. They provide expert advice and guidance as well as training and education and provide safeguarding supervision to senior staff and Named Clinicians, especially in complex cases. The team work with the NHS Sussex Safeguarding Team and multiagency partners including the Police, Education and the Local Authority. The team have built on the 'Think Family' ethos first launched in 2020 which has continued monthly as virtual training for all registered staff. The aim of the programme is that trust staff are cognisant that safeguarding issues affect the whole/wider family and to encourage colleagues to think holistically and about a person's lived experience, within a whole/wider family context. *Actions taken* • *Training updated in accordance with latest research to ensure that it remains current and evidence based.* • *A mixed offer is planned for 2023 inc virtual and classroom learning, dependent on any ongoing/future IPC requirements.* The report highlights the continued increase in those presenting with mental ill health across all populations. Mental illness is the predominant theme of the weekly children's risk meeting and a key feature in several complex maternity cases in the last year. The management of those patients who are experiencing mental ill health or crises within the context of general wards can be a significant challenge.

Actions taken

- *Data is now captured for those waiting in the Emergency Departments over 6 and 12 hours due to mental ill health for both adults and children. This is discussed at Divisional governance meetings and multi-agency meetings with SPFT.*
- *The trust facilitated the 'We can Talk' training programme with the aim of increasing staff confidence in talking to young people about mental ill health.*
- *The Chief Nurse now facilitates a weekly escalation call to discuss complex/high risk patients of all ages*. Many are known to all services and are regular attenders and/or inpatients.
- *Key senior staff now attend escalation calls with the Child and Adolescent Mental Health Services (CAMHS) part of Sussex Partnership Foundation Trust (SPFT).*
- *Regular meetings occur with Meath Health Liaison team SPFT*

There has been a continued upward trend in safeguarding adult's enquiries noting themes of neglect (the largest category covering many issues), self-neglect, and domestic abuse/violence. The Trust (like many others) now has huge numbers of stranded patients, many of who are high risk and vulnerable with a length of stay of many weeks and at times months.

Actions taken

- *Weekly inhouse reporting to ensure visibility and prompt replies/actions are taken.*
- *The rapid assessment screening tool for Domestic Abuse is now available for staff on System1 and Nerve centre.*
- *The team alongside the Domestic Abuse worker have developed training for Domestic Abuse champions within the organisation.*
- *Improvement plan developed with a focus on themes and/or any hotspots.*

Actions going forward

- *Weekly meetings with Head of safeguarding and Div ADNs to review all concerns/cases.*
- *Revised Transfer of care form being launched to ensure communication on handover/discharge is robust esp in relation to harms in high-risk patients.*
- *Inclusion of questions about domestic abuse aims to ensure a process for 'routine enquiry' is considered as part of the integrated patient documents and future electronic patient records.*
- *Future electronic records to also include body maps.*
- *Deep dive of risk/harm to stranded pts with work ongoing regarding a process of monitoring and reporting this going forward.*

The presentation of safeguarding issues is increasingly complex, with individuals and families often appearing to have more than one safeguarding concern, this has been particularly evident in the adult and maternity areas.

Actions taken

- *New/revised databases have been established to capture information but this needs further support and investment/resources.*
- *Weekly internal reporting to ensure real time monitoring and response to concerns.*

Actions going forward

- *To gain greater oversight of the layers of complexity, data collection systems and processes need to be refined and developed.*
- *Further support and resources are required to support the team and the in-house systems.*

A key point identified within the report is the proposed legislative changes to the Mental Capacity Act. This will move the Deprivation of Liberty Safeguards to a new framework referred to as Liberty Protection Safeguards (LPS). This change and the development

	of LPS will have a significant impact on the trust. *Actions taken* • *Safeguarding leads attend a monthly Sussex Wide LPS steering group which discusses the information available nationally and how the change is likely to affect the organisation.* • *The team has changed the skill-mix in the team and has recruited to a Mental Capacity Lead role to ensure staff understand the current and complex DoLS processes and support the changes going forward.* *Actions going Forward* • *Development of a training programme to support staff to understand the changes.* • *Development of the Mental Capacity Act resources.* • *Development of robust data monitoring for LPS and systems and processes by which LPS would be authorised.* • *Development of processes to ensure that LPS is a thread considered in all areas.*

Next steps	Improvement of data collection in all areas of safeguarding (needs a robust database solution) and improved documentation/handover for high-risk vulnerable patients. Robust process for monitoring and reporting risks and harms to high risk stranded Review resources and describe workforce requirements that are needed to meet the legal requirements of Liberty Protection Safeguards.

East Sussex Healthcare NHS Trust

Infection Prevention and Control Annual Report

Purpose of the paper	The aim of this report is to provide assurance of Trust compliance with the Infection Prevention and Control Board Assurance Framework that was introduced in 2020. It is based on the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.					
	For Decision		For Assurance	X	For Information	
Sponsor/Author	Vikki Carruth/Lisa Redmond					
Governance overview	The report is approved by the Trust Infection Prevention and Control Group and the Quality and Safety Committee in November 2022.					

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
		x		x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x		x	

Recommendation	The Board is asked to consider the report in the context of the current COVID-19 pandemic.

Executive Summary

Executive Summary

This report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare NHS Trust (ESHT) for the financial year 2021/22. Arrangements made by ESHT to allow the early identification of patients with infections, measures taken to reduce the spread of infections to others, audit, surveillance, achievements, and challenges are presented.

Key points during 2021/22

- COVID-19 continued to dominate the work of the IPC team. Peaks in prevalence occurred throughout the year because of new variants Delta and Omicron, which proved challenging and were associated with high transmission within a bay.
- ESHT reported 46 ward outbreaks in addition to incidences of transmission within a bay. Fewer patients required respiratory support since Omicron became the dominant variant. There was no time during the year when COVID was not circulating.
- Work was undertaken to establish surveillance via Nervecentre which supported IPC and Operational Teams to manage the risk of infection while maintaining services whenever possible.
- A thematic review has been undertaken to outline contributory factors and lessons learnt.
- The requirement for mandatory surveillance of healthcare associated infections has been met.
- *Clostridium difficile* infections (CDI) limits were exceeded. 69 cases were attributed to ESHT against a limit of 56. Six cases were assessed as potentially avoidable due to antimicrobial prescribing. There were no outbreaks or proven cross infections. There has been a national increase in incidence of CDI that the national IPC team is assessing to understand root causes.
- The number of MRSA bacteraemia cases reported was 1 potentially unavoidable infection. We are therefore compliant with the limit of zero avoidable MRSA bacteraemia.
- Intravenous catheters continue to be a source of potentially avoidable MSSA bacteraemia and collaboration with the vascular access team is required to fully understand how this risk can be further reduced.
- ESHT is an outlier for surgical site infection in hip replacement surgery. This has been considered by the surveillance group and it is considered that the

	outlier status reflects the changes to surgery during the pandemic with less operations taking place and on higher risk patients. - The national specification for cleanliness was maintained throughout the year which reduced risk of acquisition of infection from the environment or equipment. Please note that the full IPC Annual Report is available in the appendix to the Board papers.
Next steps	How the pandemic has impacted on wider health issues and the risk of developing infections other than COVID is yet to be fully understood and we will work with ICS and regional colleagues to identify where improvements may be made. Within ESHT renewed antimicrobial stewardship is required to minimise the risk of C. difficile and infections caused by resistant gram-negative organisms. We will undertake quality improvement work with National and Regional NHSE colleagues to improve processes around prevention and control of C. difficile infections. We will continue with robust processes that ensure patients are cared for in a clean safe environment. We will support the vascular access team to strengthen training and practice in relation to aseptically managing central venous lines to reduce blood stream infections. We will continue to plan for surges in COVID prevalence alongside the risk of other respiratory infections. We will implement the new national Infection Prevention and Control Manual for England and renew focus on standard and transmission-based Infection Control Precautions.

East Sussex Healthcare NHS Trust

Patient Experience Annual Report 2021/22

Purpose of the paper	The information within this annual report provides an analysis of all patient/ carer feedback received, including the complaints received, together with an overview of concerns raised with the Patient Advice and Liaison Service (PALS), in accordance with The National Health Service Complaints (England) Regulations (2009).					
	For Decision		For Assurance	x	For Information	x
Sponsor/Author	Richard Milner, Chief of Staff Vikki Carruth, Chief Nurse and DIPC Amy Pain, Patient Experience Lead					
Governance overview	This report has been discussed within Patient Experience and presented at Quality and Safety Committee (17.11.22).					

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
		x		x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

Recommendation	The Trust Board is asked to note the contents of this annual report and the feedback ESHT has received during 2021/22.

Executive Summary

ESHT received 30,901 pieces of patient feedback during 2021/22, of which 465 were categorised as a formal complaint (1.5%).

The positive response rate for ESHT Friends and Family Test substantially exceeded the national positive response rate. This is most marked for ED, where the rate of positive response was around 10% higher for ESHT than the national rate.

Overwhelmingly (98.80%) of adult inpatient responders said they were always treated with kindness and said, “staff responded appropriately to any questions or concerns raised” (98.38%). The three bottom scoring questions for 2021/22 relate to the “discharge process”.

In total 50 4- and 5-star comments were posted on the NHS website.

During 2021/22 ESHT met its target of 100% of all complaints acknowledged within 72 working hours. Operational pressures resulted in a reduction against each response rate metric compared to 2020/21 (35 working days= 26%, 50 working days 22% and overall, 22%).

In 2021/22, 77 complaints were reopened; this was a significant increase in comparison to the 32 in 2020/21. Many of the reopened cases relating to care and bereavement issues linked to COVID-19.

In 2021/22, ESHT coded complaints to 21 different primary complaint subjects, the top three were:

1. Standard of care (223)
2. Communication (78)
3. Patient Pathway (50)

PALS contacts in 2021/22 increased by 20% on 2020/21, these were categorised as:

- Advice, Assistance, and Information (3881)
- Compliment (95)
- Concern/Issue (2134)

	• Suggestion/Comment (13) Looking forward to 2022/23 the priorities for the Patient Experience team are: • Review the approaches and processes to handling patient/ carer feedback (including policy and SOP) • Look at alternative ways to share/ distribute feedback (positive and negative feedback) • Support divisions with local ownership and embedding learning from their complaints • Implement to The PHSO's ""NHS Complaint Standards" pilot (learning from complaints as a priority for divisions to embed learning from feedback) • Exploring opportunities for PALS and the Complaints Team to work together Please note that the full Patient Experience Annual Report is available in the appendix to the Board papers.
Next steps	The Patient Experience Annual Report will be available on the website and shared widely within ESHT.

East Sussex Healthcare NHS Trust

Workforce Race Equality Standard

Purpose of the paper	The purpose of this report is to provide analysis on the Workforce Race Equality Standard (WRES) indicators and any disparities and provide recommendations on how to advance the agenda for race equality within ESHT. ESHT is required to use the indicator data to develop and publish an action plan which must be approved by Board.
	For Decision: ; For Assurance: x ; For Information:
Sponsor/Author	Steve Aumayer- Deputy Chief Executive Sarah Feather- Workforce Lead for Equality Diversity and Inclusion
Governance overview	Personal and Organisational Development (POD) Committee September 2022 Workforce Equality Meeting September 2022

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
			x	x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

Recommendation	The Board is asked to note the report and endorse the associated action plan.

Executive Summary	The purpose of this report is to provide analysis on the WRES indicators and any disparities and to provide recommendations on how to advance the agenda for race equality within ESHT. The data covers the period from the 1st of April 2021 to 30th March 2022. Indicators 4 – 9 are drawn from the National NHS Staff Survey 2021 results. For all the other Indicators, the data has been obtained from ESR and TRAC. When referring to black, Asian and minority ethnic (BME) staff in this report this refers to our multicultural colleagues as defined by the Equality Act 2010 **Indicator 1 - During 2021 – 2022**. As of 31 March 2022 ESHT employed 8,023 staff of which 20.1% identified as BME, 76.4% identified as White and 3.5% had not disclosed their ethnicity on ESR. The 2022 data shows that we employ more BME staff than both the local BME population and national BME population. **Indicator 2 – Relative likelihood of staff being appointed from shortlisting across all posts.** BME candidates are 0.81 more likely to be appointed than White candidates. The Trust score of 0.81 falls in line with the national median/benchmark value of 0.8 - 1.25 and is an improvement on last year's score of 1.07. 0.8-1.25 is the non-adverse likelihood range set by the NHS WRES team. It is between these two values where the national WRES team feels there is not significant difference or an adverse effect. This result, which has continuously improved since 2019, should in turn lead to improvements in Indicator 1. **Indicator 3 - Relative likelihood of a BME staff member entering a formal**

disciplinary process
This has fallen from 1.00 in 2021 to 0.84 in 2022. The national median/benchmark value of 0.8 - 1.25 is the non-adverse likelihood range set by the NHS WRES Strategy team. It is between these two values where the WRES team feels there is not significant difference or an adverse effect. The Trust is just below that figure and means that white staff are more likely to enter the formal disciplinary process.

Indicator 4 - Relative likelihood of staff accessing non-mandatory training and continuous professional development
This was 0.56 for BME colleagues meaning that a White member of staff was less likely to access non-mandatory training compared to a BME staff member between 1 April 2020 – 31 March 2021. This may be explained by the targeted approach of both local and systemwide training to the staff network.

The following four indicators are drawn from the results of the 2021 staff survey and compare the outcomes of the responses for White and BME staff

Indicator 5 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months.
The national benchmark for BME staff is 28.8%. ESHT has a higher percentage of BME staff experiencing harassment, bullying or abuse from patients, relative or the public (33.9%) and is at its highest for five years. There was increased reporting in the 2021 staff survey of both BME and White staff experiencing harassment, bullying or abuse from patients, relatives or the public. However, BME staff have seen an increase of 4.6% from 29.3% in 2020 to 33.9% in 2021 and are disproportionately affected by abuse from members of the public and patients compared to their white colleagues in the 2021 staff survey.

Indicator 6 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

The data shows us that BME staff reported an increase in experiencing harassment bullying and abuse from other staff from 29% in 2020 to 31.8% in 2021. White staff reported a decrease in 2020 from 26.6% in 2020 to 25.9% in 202. BME staff remain disproportionately affected by harassment, bullying and abuse.

Work has already begun to identify ways to reduce these figures with two Task and Finish Groups looking at bullying and harassment and violence and aggression. This will remain a priority for 2022/23 and the Trust will also continue to support the system-wide work in this area and has signed the joint statement on being anti-racist.

Indicator 7 - Percentage believing that Trust provides equal opportunities for career progression or promotion.

The national benchmark for BME staff is 44.6% and for the Trust is slightly higher at 46%. The 2021 staff survey has seen a 0.4% decrease for BME staff (46.4% in 2020 and 46%) believing the Trust act fairly with progression.

Indicator 8 – Staff personally experiencing discrimination by a managers/team leader or another colleague.

There was a 2.4% increase in BME staff and a 1% increase in white staff that have personally experienced discrimination by a managers/team leader or another colleague from 2020 to 2021.

Indicator 9 – BME Board Membership
In considering the 2021 data it is important to note that our Trust Board have 100% ethnicity declaration rates as of 31 March 2022, although the overall make up of the Board is lower than that of the overall workforce.

Risks identified

	• Unsatisfactory performance in providing services and employment will be a risk to reputation and leave the Trust open to legal claims. • The Trust is required to demonstrate that all staff are given equal opportunities and are not discriminated because of their protected characteristics. Not doing so risks attrition of our multicultural colleagues and not being seen as an employer of choice. Please note that the full WRES Report is available in the appendix to the Board papers.

Next steps	Once approved the action plan will be published on the Trust's website. The Race Equality Task and Finish Group meets quarterly, and the Workforce Equality meeting will oversee the progress on actions and report to POD committee. **Next Steps for Race Equality 2022-24** • Addressing Bullying and Harassment in the workplace • Continue BME Leadership development • Further investigation into staff turnover and internal promotion opportunities • Support the continued development of the Multicultural Staff Network, with Chair and Executive Support. • Continued involvement at the Sussex Race Equality Transformation Board.

East Sussex Healthcare NHS Trust

Workforce Disability Equality Standard

Purpose of the paper	The purpose of this report is to provide analysis on the Workforce Disability Equality Standard (WDES) metrics, identify any disparities and provide recommendations on how to advance the agenda for disability equality within ESHT. ESHT is required to use the metrics data to develop and publish an action plan which must be approved by Board.					
	For Decision		For Assurance	x	For Information	
Sponsor/Author	Steve Aumayer- Deputy Chief Executive Sarah Feather- Workforce Lead for Equality Diversity and Inclusion					
Governance overview	Personal and Organisational Development (POD) Committee September 2022 Workforce Equality Meeting September 2022					

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
			x	x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

Recommendation	The Board is asked to note the report and endorse the associated action plan.

Executive Summary	The purpose of this report is to provide analysis on the WDES metrics and any disparities and provide recommendations on how to advance the agenda for disability equality within ESHT. The data covers the period from the 1st of April 2021 to 30th March 2022. Metrics 4 – 9 are drawn from the National NHS Staff Survey 2021 results, for all the other metrics, the data has been obtained from ESR and TRAC. When referring to Disability in this report this also refers to those that have a long-term health condition as defined by the Equality Act 2010 **Metric 1 - During 2021 – 2022** ESHT has increased its overall staff who have a disability representation from 3.96% in 2021 to 4.39% in 2022. The main concern here is the number of staff who have not declared whether they have a disability or not at 22.85%. This remains a key figure to improve on in 2022/23. **Metric 2 – Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.** Staff who are disabled are almost as likely to be appointed as non-disabled staff. The Trust score of 1.16 falls in line with the national median/benchmark value of 0.8 - 1.25 and is an improvement on last year's score of 1.48. 0.8-1.25 is the non-adverse likelihood range set by the NHS WDES Strategy team. It is between these two values where the national WDES team feels there is not significant difference or an adverse effect. This result, which has continuously improved since 2019, should in turn lead to improvements in Metric 1.

Metric 3 - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process
This has increased slightly from 1.00 in 2021 to 1.06 in 2022. This data puts the Trust in the non-adverse range and so therefore there is no significant bias towards disabled staff entering a formal capability process.

Metric 4a i - Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients and service users, their relatives or other members of the public
Metrics taken from the staff survey show an increase in staff experiencing bullying, harassment and discrimination from either patient or carers.

Metric 4a ii and iii - Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers and other colleagues
Metrics taken from the staff survey show a very slight decrease in staff experiencing bullying, harassment and discrimination from either managers or colleagues. The Trust is below the average for staff experiencing bullying and harassment from colleagues and below the national average for staff experiencing bullying and harassment from managers.

Metric 4b – Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.
There is a slight decline in reporting harassment and bullying for staff with a long-term health condition or illness and a slight increase for staff without a long-term health condition or illness.

Metrics 4a and 4b show that bullying and harassment still persists for all colleagues from patients, carers, managers, and colleagues. Work has already begun on ways to reduce these figures with two task and Finish Groups looking at bullying and harassment and violence and aggression. This will remain a priority for 2022/23 and the Trust will continue to support the system wide work in this area.

Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
The most recent data suggests that there is a slight increase in staff with long-term health conditions and a slight decrease in staff without long-term health conditions feeling that the Trust acts fairly with progression.

Metric 6 - Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
The data shows us that there is an increase in staff with long-term health conditions feeling pressured to attend work and a slight decline in staff without long-term health conditions.

A disability and health passport has been introduced to support staff and their managers in having conversations about health and reasonable adjustments. The work to promote this will continue in 2022/23.

Metric 7 - Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
The data indicates that staff without a long-term health condition or illness feel more valued for the work that they do compared to staff with long-term conditions or illness.

Metric 8- The percentage of staff with a long-lasting health condition saying their employer has made adequate adjustment(s)
This metric has fallen for the third consecutive year but remains above the benchmark median. This metric only includes the response of Disabled staff. The actions set out in the plan will be focussing on increasing the understanding of the importance of

	reasonable adjustments in the workplace. **Metric 9 - The staff engagement score for Disabled staff** The score is lower (6.5) compared to non-disabled staff (7.0) but above the national average (6.4). The promotion of the staff network and involvement in Trust activities should help to increase this score. **Metric 10 – Board Membership** The data captured on ESR shows that there are no Trust Board members that have declared a disability as of 31 March 2022. **Risks Identified** • Unsatisfactory performance in providing services and employment will be a risk to reputation and leave the Trust open to legal claims. • The Trust is also required to demonstrate that all staff are given equal opportunities and are not discriminated because of their protected characteristic, not doing so risks attrition of staff with disabilities and not being seen as an employer of choice. Please note that the full WDES Report is available in the appendix to the Board papers.

Next steps	Once approved the action plan will be published on the Trust's website. The Disability Workforce Task and Finish Group meets quarterly and the Workforce Equality meeting will oversee the progress on actions and report to POD committee. **Next steps for disability equality 2022-2024** • Raise the profile of colleagues with a disability to ensure they feel engaged and supported to meet their potential. • To decrease the numbers of colleagues who are 'undeclared' on ESR whether they consider themselves to have a disability or not. • Support the continued development of the (dis)Ability Staff Network, the chair and Executive Support. • Look into data relating to bullying and harassment and the recording and reporting of incidents that are related to a person's disability. • Review of reasonable adjustments process to include continuing to promote the (Dis)Ability and Health Passport and increase knowledge, access to and understanding of reasonable adjustments. • Ensure our sites and facilities meet national requirements on accessibility.

East Sussex Healthcare NHS Trust

Gender Pay Gap Annual Report

Purpose of the paper	The purpose of this report is to provide analysis on the Gender Pay Gap within ESHT. In 2017, it became mandatory for all public sector employers with more than 250 employees to measure and publish their gender pay gap (GPG) information on the government website and their own.
	For Decision: ; For Assurance: ; For Information: x
Sponsor/Author	Sponsor- Steve Aumayer- Deputy Chief Executive Author -Sarah Feather- Workforce Lead for Equality Diversity and Inclusion
Governance overview	Personal and Organisational Development (POD) Committee September 2022 Workforce Equality Meeting September 2022

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
			x	x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

Recommendation	The Board is asked to note the report and endorse the associated action plan.

Executive Summary	Our Gender Pay Gap report for 2022 contains a number of elements: • The specific information published on the government website for the snapshot date of 31st March 2022. • A comparison with the 2021 figures. • An analysis of the pay gap across specific staff groups within East Sussex Healthcare NHS Trust • Recommendation as to future action to reduce the Gender Pay The gender pay gap shows the difference in the average pay between all men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate there may be several issues to deal with, and the individual calculations may help to identify what those issues are. The NHS terms and conditions of service handbook contain the national agreements on pay and conditions of service for NHS staff other than very senior managers and medical staff. Job evaluation (JE) enables jobs to be matched to national job profiles or allows trusts to evaluate jobs locally, to determine which Agenda for Change pay band a post should sit. Gender Pay Gap Indicators An employer must publish six calculations showing their: 1. Average gender pay gap as a mean average 2. Average gender pay gap as a median average 3. Average bonus gender pay gap as a mean average 4. Average bonus gender pay gap as a median average 5. Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment 6. Proportion of males and females when divided into four groups ordered from

	lowest to highest pay We have reported similar pay gap figures for the last three years and, like the majority of other NHS Trusts, we have a gender imbalance. Across the Trust as a whole, women's mean hourly wage was 19.9 % lower than men's, a shrinking of 1.5% in that gap since 2020. The gender pay gap, in respect of mean hourly rate, has reduced by 0.6% since 31/3/21 after a slight increase in the previous year. The median pay gap is more typical of the gap between most men and women. **Proportion of women in each pay quarter** Pay quarters are calculated by splitting all employees in the Trust into four even groups according to their level of pay. Looking at the proportion of women in each quarter gives an indication of women's representations at different levels of the Trust. Women represent 66.9% of the highest pay quartile, a marginal decrease of one point over five years. Men represent 22.1% of the lowest pay quartile, a marginal decrease of two points over five years. **Gender bonus gap** In line with national guidance, there were no rounds of applications for Clinical Excellence Awards this year. Instead, and also in line with the national guidance, the funds were distributed to all eligible consultants (not those holding either National or local level 9 awards) pro rata according to hours worked and length of service during the qualifying year Reducing our gender pay gap implies either increasing the proportion of men in lower grades or increasing the proportion of women occupying the more senior roles in ESHT. Effective policies for closing the gender pay gap not only seek to address factors and barriers common to all women (such as the number in lower grade jobs with lower pay), but they also target the inequalities faced by women belonging to specific groups, based on characteristics such as ethnicity, age and profession. **Risk Implications** Unsatisfactory performance in providing services and employment will be a risk to reputation and leave the Trust open to legal claims. The Trust is also required to demonstrate that all staff are given equal opportunities and are not discriminated because of their protected characteristic. Please note that the full Gender Pay Gap Annual Report is available in the appendix to the Board papers.
Next steps	The workforce equality meeting will oversee the progress on actions and report to POD committee. **Next Steps for Gender Equality 2022-2024** • Promote a wide range of flexible working practices and explore adding flexible working to all job adverts. • Actively promote shared parental leave to all staff. • Monitor uptake of female apprenticeships and where they take up a position. • Investigate feasibility of a Women's Staff Network to support women in the workplace and identify any additional support requirements following discussion and gaining insight from the Women's consultant network. • Celebrate International Women's Day – 8th March 2023 to promote and engage staff on gender equality.

Guardian of Safe Working Hours Annual Report

Purpose of the paper	Guardians of Safe Working Hours provide assurance to doctors and employers that doctors are able to work within safe working hours. This annual report provides assurance to the Trust Board.					
	For Decision		For Assurance	X	For Information	
Sponsor/Author	Sponsor: Steve Aumayer, Chief People Officer Author: Mr Waleed Yousef, Guardian of Safe Working Hours					
Governance overview	Reviewed by the People and Organisational Development Commitee					

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
		x	x	x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

Recommendation	• The Guardians recommend that departments (particularly those mentioned in the report below) review the actual number of juniors needed to cover wards and other clinical activities and consider creating extra non-training posts when necessary. • The Guardians would appreciate that lists of clinical supervisors are given in a timely manner to our administrators to ensure that all juniors are given their logging details before the start of the rotation to comply with their contract. • Managers of all departments should be familiar with the acting down policy and having a clear understanding of process of covering sickness at short notice.
Executive Summary	Full report is produced below.
Next steps	• To be shared at the next LNC meeting including the trainee representatives • Part of the report may be shared with HEE KSS Guardian of safe working Network group. • Relevant parts of the report could be shared at the Local academic board meeting and relevant LFG meeting with clinical and educational supervisors.

Guardian of Safe Working Hours – Annual Report 2021/22

Purpose
The purpose of this report is to provide an update to the Trust Board by the Guardians of Safe Working Hours, on compliance of juniors working hours with their work schedule. This Report reflects our findings from the last 12 months for the junior doctor workforce.

Background
All doctors in training (DiT) are employed on the 2016 Terms and Condition of Service for NHS Doctors and Dentists in Training (England) 2016 Version 9 and the total number of DiTs is 254.

Exception Reporting
Trainees can Exception Report for a breach of working hours or for educational reasons. Training and information on Exception Reporting have been provided to trainees at Induction and they are offered the opportunity during the year to contact or meet and discuss areas of concern with Medical Staffing, the GoSWH and the DME.

Exception reporting for hours
As it is shown from the following table, there has been significant increase of Exception reports (ER) for hours for the period of August 21- July 22 (202) compared to the previous year (111). This increase is still below the level of pre-COVID years (236 ER for the period of August 19- July 20). 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. This increase was expected due to the return of normal clinical services to pre-COVID time. The number of exception reports are widely distributed among all department, but the Guardians noticed increase in the following departments: General surgery, Cardiology, AAU and Ortho/ Geriatrics at the Conquest site, and Stroke, Gastro and Urology at Eastbourne site. The reason of most of exception reports are due to low level of staffing, and not having enough time to finish tasks during normal hours.

The Guardian for Eastbourne has been working with the Urology department during the last year campaigning for more staffing at junior level for Urology department. The urology department service manager has been proactive in filling gaps and conducting regular meetings with juniors to listen to their concerns. We are very pleased to notice significant increase of number junior trainees. This has been reflected on the junior's positive feedback at the last GMC survey.

Exception Reporting Education
There were 26 education exception reports submitted for the period August 2021 – July 2022 compared to 20 for the period August 2020 – July 2021.

The Pastoral Fellows have been supportive to trainees requiring support in many areas. The SuppRTT Champion is engaging with LTFT trainees and those returning from maternity leave, advising how to secure funding to support "back to work" initiative for on call work and supernumerary cover.

The Guardians noticed that there is no cear understanding from some departments of how we cover a junior doctors' sickness at short notice. Acting down policy has not been impleneted in some situations and the other junior doctors are left to carry two bleeps during the same shift.

MONTHLY ANALYSIS OF EXCEPTION REPORTING - AUGUST 2021 TO JULY 2022

Month	Total Number of Posts (DiT)	No of Drs Who Submitted an Exception Report	No of ER Processed for Payment By Month 01.08.21 - 31.07.22	Previous Year 01.08.20 - 31.07.21	No of ER's processed previous year 01.08.20 - 31.07.21	Total Hours Paid at Basic Rate	Total Monetary Amount Paid at Basic Rate to Trainees	Total Hours Paid at Enhanced Rate	Total Paid at Enhanced Pay	Total Hours Paid Overall	Overall Cost of ER
Aug-21	244	18	35	**Aug-20**	8	75.50	**2350.87**	1.00	**44.72**	85.50	2395.59
Sep-21	244	13	30	**Sep-20**	14	38.75	**1024.74**	0.25	**8.16**	39.00	1032.90
Oct-21	244	14	23	**Oct-20**	22	33.50	**963.89**	1.00	**37.79**	34.50	1001.68
Nov-21	244	6	9	**Nov-20**	8	15.75	**396.06**	0.00	**0.00**	15.75	396.06
Dec-21	244	10	16	**Dec-20**	12	12.00	**319.21**	1.50	**67.08**	17.50	386.29
Jan-22	244	10	12	**Jan-21**	11	11.75	**264.36**	0.00	**0.00**	11.75	264.36
Feb-22	244	6	10	**Feb-21**	7	7.50	**191.94**	1.00	**44.72**	8.50	236.66
Mar-22	244	13	9	**Mar-21**	5	16.25	**407.33**	0.00	**0.00**	16.25	407.33
Apr-22	244	10	13	**Apr-21**	7	14.50	**397.70**	0.00	**0.00**	14.50	397.70
May-22	244	10	18	**May-21**	13	16.75	**470.55**	0.50	**16.32**	16.00	486.87
Jun-22	244	7	16	**Jun-21**	9	15.50	**400.74**	4.00	**166.80**	0.00	567.54
Jul-22	244	9	11	**Jul-21**	7	13.00	**384.68**	0.50	**18.90**	0.00	403.58
			202		111					Total	**7976.56**

MONTHLY ANALYSIS OF EXCEPTION REPORTING

Last quarter of the year May-July

Month	Total Number of Posts (DiT)	No of Drs Who Submitted an Exception Report	No of ER Processed for Payment By Month	Total Hours Paid at Basic Rate	Total Monetary Amount Paid at Basic Rate to Trainees	Total Hours Paid at Enhanced Rate	Total Paid at Enhanced Pay	Total Hours Paid Overall	Overall Cost of ER
May-21	244	6	13	16.00	**507.09**	0.00	**0.00**	16.00	507.09
Jun-21	244	5	9	10.50	**316.29**	1.50	**67.08**	0.00	383.37
Jul-21	244	6	7	7.50	**180.61**	1.50	**54.11**	0.00	234.72
Total			**29**						**1125.18**
May-22	244	10	18	16.75	**470.55**	0.50	**16.32**	16.00	486.87
Jun-22	244	7	16	15.50	**400.74**	4.00	**166.80**	0.00	567.54
Jul-22	244	9	11	13.00	**384.68**	0.50	**18.90**	0.00	403.58
Total			**45**						**1457.99**

Working pattern reviews

39 Less Than Fulltime work patterns were done to reflect part time working during the period May 202 to August 2022. This included the new trainees starting in August 2022 and existing LTF trainees for all specialties in the Trust. This determines their total pay for the Trainee whilst working this chosen way. It encompasses their reason(s) for requesting to work and the days/shifts they require off which is usually due to family responsibilities and childcare. A noticeable increase is male trainees now electing to work part time and an increase generally year on year.

Self-Development Time is being embedded in work patterns were requested to ensure this time is protected to carry out work relating to their curriculum and career aspirations. This Self-Development Time is similar to Supporting Professional Activity (SPA) time included in the Consultant Contract. Currently this varies and averages from 2hrs – 4 hrs per week.

Guardian Fines

Period	No of Drs Who Submitted an Exception Report	No of ER Processed for Payment By Period	Total Hours Paid at Basic Rate	Total Monetary Amount Paid at Basic Rate to Trainees	Total Hours Paid at Enhanced Rate	Total Paid at Enhanced Pay	Total Hours Paid Overall	Overall Cost of Guardian Fines
07.12.16 - 30.04.17	76	379	254.25	**7369.78**	1	**43.46**	255.25	**7413.24**
01.05.17 - 31.07.17	28	153	279.55	**8089.73**	0	**0.00**	279.55	**8089.73**
01.08.17 - 31.10.17	50	241	74.15	**2372.69**	2	**78.86**	76.15	**2451.55**
01.11.17 - 05.12.17	20	50	1.00	**27.69**	0	**0.00**	1.00	**27.69**
06.12.17 - 31.03.18	26	83	0.00	**0.00**	2.3	**65.86**	2.30	**151.48**
01.04.18 - 31.07.18	17	105	0.00	**0.00**	0	**0.00**	0.00	**0.00**
01.08.18 - 30.11.18	24	82	12.00	**338.88**	0	**0.00**	12.00	**338.88**
01.12.18 - 31.03.19	22	57	0.00	**0.00**	0	**0.00**	0.00	**0.00**
01.04.19 - 31.07.19	16	45	0.00	**0.00**	0	**0.00**	0.00	**0.00**
01.08.19 - 30.11.19	30	157	0.00	**0.00**	2.25	**88.80**	2.25	**88.80**
01.12.19 - 31.03.20	18	65	0.00	**0.00**	0	**0.00**	0.00	**0.00**
01.04.20 - 04.08.20	13	22	15.50	**585.74**	0	**0.00**	15.50	**585.74**
05.08.20 - 01.12.20	17	62	0.00	**0.00**	0	**0.00**	0.00	**0.00**
02.12.20 - 31.03.21	12	33	0.00	**0.00**	0	**0.00**	0.00	**0.00**
01.04.21 - 31.07.21	13	34	0.00	**0.00**	0	**0.00**	0.00	**0.00**
01.08.21 - 30.11.21	33	103	166.75	**1202.35**	1.25	**76.60**	168.00	**1278.95**
01.12.21 - 05.04.22	24	56	0.00	**0.00**	0	**0.00**	0.00	**0.00**
06.04.22 -02.08.22	20	54	0.00	**0.00**	0	**0.00**	0.00	**0.00**
				19986.86		353.58	TOTAL	**20426.06**

Guardian Fines total remaining after subtraction of sum of fine application by DiT conclusion/summary £11,098.12

Fatigue and Facilities Charter

During the last year we have liaised with the new Facilities Manager who introduced new vending machines on both sites with an improved menu for hot food including vegan, vegetarian i.e., healthy eating, which was requested by the trainees, particularly those working at night, but this is for the benefit of all staff groups that work overnight.

Utilising the charter money, we were able to fund ward areas with lockers for junior doctors and ancillary items for the rest rooms such as kitchen appliances and reclining chairs.

We liaised with trust Security on improved lighting and safety in the car parks on both sites and both car parks which is now is accredited under the Association of Chief Police Officers as being safe having CCTV surveillance, vegetation, lighting and patrolling.

The query pertaining to noisy closing on call room doors which were too old to correct and falls under capital replacement. Sound proofing is also under the capital replacement expenditure programme however, new bathrooms and kitchens installed in some areas at the Conquest.

There are circa £16,000 remaining from the Improving Working Lives capital for trainees to use.

Conclusion/Summary

There have been a great improvement of working conditions of juniors in many areas particularly after opening the new “Doctor’s Mess” at Eastbourne and providing extra facilities utilising the Charter’s money.

The Guardians are very appreciative of the great effort made by our juniors to maintain patient’s safety and provide excellent quality of care. We are very happy with the support given by the senior management on many occasions. We acknowledge the support given by the previous medical Director Dr David Walker in solving many of the concerning areas raised by the Guardians.

Unfortunately, some trainees have raised concerns about the critical shortage of junior staff on the ground to help provide safe services for patients. On many occasions, juniors have been going out of their way to ensure patient’s safety. The work of the two pastoral fellows has been extremely helpful to ensure juniors’ moral and giving them practical support.

The gaps in some of the training and non- training posts as well as some of the consultant posts have a major impact on junior doctors’ hours, in some situations, low morale of juniors. A good example of how this can be reversed, is the positive GMC survey in the urology department recently, following the employment of more juniors relevant to the scale of clinical activities in the department.

We would like to encourage the departments to ensure that all managers are aware of acting down policy and having a clear protocol in the case of unforeseen rota gaps at short notice.

We urge all departments to provide timely updated lists of Clinical supervisors of juniors so that DiT are given their logging details for the Exception Reporting system before the start of each rotation, according to the DiT contract.

The Guardian team would like to thank Dr Nadia Muhi Iddin for her hard work as a Guardian of safe working Hours as she now has moved to a different role and welcome Dr Gez Gould as the new Guardian of safe working hours for the Conquest site.

East Sussex Healthcare NHS Trust

Use of Trust Seal

Purpose of the paper	To inform the Board of the use of the Trust Seal						
	For Decision		For Assurance		For Information	X	
Sponsor/Author	Chief of Staff						
Governance overview	Not applicable						

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement

Recommendation	The Board is asked to note the single use of the Trust Seal since the last Board meeting

Executive Summary	The Trust Seal was used to seal the following document between 4th October 2022 and 6th December 2022: **Sealing 87 – Stryker UK Ltd, 21st November 2022** Agreement for hip and hemiarthroplasty protheses for a four year period.

Next steps	Not applicable

	Trust Board Meeting in Public 12-month forward plan					
Agenda sections	14th February 2023	11th April 2023	13th June 2023	8th August 2023	10th October 2023	12th December 2023
Location	Holy Cross Priory Lewes Road Cross-in-Hand Heathfield TN21 0DZ	Grange Room Locker Room College Road Eastbourne BN21 4JJ	Venue TBC	St. Mark's Church Hall Green Lane Bexhill TN39 4BZ	Uckfield Civic Centre Bellfarm Lane Uckfield TN22 1AE	Venue TBC
General				Board Committee Annual Reviews and Annual Reports		
Quality, Safety and Performance	Maternity Overview Q3 Learning From Deaths Q1	Maternity Overview Q4 Learning From Deaths Q2	Learning From Deaths Q3	Maternity Overview Q1	Maternity Overview Q2 Learning From Deaths Q4	Learning From Deaths Q1
Strategy	Sussex Assembly Strategy Update					
Governance and Assurance	BAF Q3 ESHT Health & Safety Strategy (Jenny Newbury) Trust Annual plan, budget and capital plan 2021/22 Speak Up Guardian Update	BAF Q4 Sussex Premier Health - One Year Update Ambulance Handover - One Year Update (from April 2022 Board) Quality Improvement Priorities 2022/23 Delivering same sex accommodation - annual declaration of compliance Annual Self Certification (governance declaration) Delegation of approval of Annual Report and Accounts 2021/22	CNST Incentive Scheme Nursing Establishment Review Quality Account Priorities & Delegation of approval of Quality Account 2021/22	BAF Q1	BAF Q2 Winter Preparedness Speak Up Guardian Update	Governing Document Annual Review
Annual Reports	ESHT Charity Annual Report and Accounts			Organ Donation Revalidation - nursing and medical	WRES & WDES Gender Pay Gap Guardian of Safe Working Hours	Infection Control Safeguarding Complaints EPRR
Items for Information						Meeting Dates for 2023
Additional Items to be scheduled during the year:	Inequalties Strategy Principles from National Guidelines Provider Licensing Trust Business Plan					

East Sussex Healthcare
NHS Trust

Midwifery Staffing Review

April - September 2022

(presented October 2022)

Alison Newby - Head of Midwifery

Introduction

This paper is to provide assurance to the Trust Board that Midwifery staffing (April - September 2022) meets safety requirements, CNST requirements and are at an appropriate level to enable the continued roll out of Continuity of Carer (CofC), as recommended by Better Births (NHSE, 2016).

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (appendix 2)

The scheme incentivises ten maternity safety actions. Trusts that can demonstrate they are compliant with **all 10** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard? To meet safety requirements, we must provide:

1. **Evidence that a systematic, evidence-based process has been undertaken to calculate midwifery staffing establishment**

   A re-review of the midwifery workforce was undertaken by BirthRate Plus (BR+) in January 2022. The final report was received in February 2022. The report was reviewed by the Trust Board in June 2022 and has been shared with the LMNS (April 2022).

   A local headroom uplift review was undertaken by the Trust, as recommended in the Ockenden Final Report (2022). Taking into consideration the previous three years' data for all absences including sickness, mandatory training, annual leave, and maternity leave, a recommendation was made to increase local headroom uplift from 21% to 26.4%. This equates to 6.23wte across band 3-7. Funding for these additional posts has been supported by the ICS.

2. **Evidence that a supernumerary Labour Ward Coordinator, defined as having no caseload of their own during the shift, is provided on each shift to provide oversight of all birth activity within the service**

   Updated guidance regarding year 4 of the Maternity Incentive Scheme (MIS), received from NHS Resolution (NHS R), in October 2022 confirmed the labour ward coordinator should:

   - Provide oversight of the labour ward
   - Give support and assist other midwives, e.g. CTG 'fresh eyes', second opinions, reviews, assisting at birth when required, support with suturing etc.
   - NOT be solely responsible for any 1:1 care for a labouring woman or relieve for a break, (or any short period of time) a midwife who is providing 1:1 care for a high-risk woman requiring constant observation. This includes supervising a student midwife providing 1:1 care

The guidance highlights that supernumerary status will be lost if the above requirements are not met.

A web-based application (app) is used to report and monitor acuity and red flag incidents. Staffing, acuity and red flag information is entered on the BR+ Acuity App every four hours (0800, 1200, 1600, 2000 and mid-night) by the shift co-ordinator. Ongoing workforce challenges and increased case complexity requiring senior midwifery support has affected timely completion. Consequently, cumulative compliance is current 71%. To ensure data confidence, a compliance rate of 85% is recommended.

Assurance that the above requirements have been met is provided via a quarterly acuity and red flag report. This is presented to the Maternity Assurance meeting and the Trust Quality & Safety Committee. Assurance is also provided to the Trust Board via the quarterly Maternity Oversight report.

A supernumerary labour ward coordinator is allocated to all shifts. Due to short-term sickness and parental leave within the labour ward matron team, there were four occasions when a Band 7 labour ward co-ordinator shift was vacant: one night shift in April, one night shift in May and two night shifts in August. On all occasions, an experienced band 6 midwife acted as the supernumerary shift coordinator. Additional support was available, as required, from the on-call senior midwife. All remaining shifts during the reporting period were filled.

The majority (62/49%) of red-flag incidents reported in the BR+ acuity app during the reporting period, related to the shift coordinator not being supernumerary. Triangulation of data with DATIX incident report did not provide detail of the activity undertaken. It is evident from speaking with members of the labour ward matron team, that there is variation in the understanding of what is meant by supernumerary status, thus affecting the accuracy of reporting.

To aid accurate reporting, it has been confirmed with the matron team that when acuity is extremely high the co-ordinator does not lead the care for a labouring woman, but may oversee the care of a postnatal woman, day unit attender or antenatal ward attender on labour ward.

3. All women in active labour receive one-to-one midwifery care

One to one care in established labour is reviewed monthly as part of the PQS dashboard. The rates of one-to-one care during are shown below:

	April	May	June	July	August	September
1:1 Care In Labour	97%	98.00%	99.00%	96.00%	99.00%	98%

Rates of one-to-one care in labour are generally very high as we have a robust escalation policy, utilising on call staff or specialists/managers to support activity, during times of high acuity or staffing challenge. This means we can support one to

one care provision while still ensuring the other parts of the service are safe. The escalation policy is well understood by the labour ward co-ordinators and enacted to protect the provision of one-to-one care in labour. If it is not possible to provide one-to-one care in labour a Datix incident report is completed.

All data entries for births identified as not receiving one to one care, during the reporting period have been reviewed by the reporting officer. This provided assurance that one to one care was provided for all pregnant people, in established labour, within the hospital setting received one to one care. The deficit can be attributed to pregnant people who labour and birth at home before a midwife arrives (BBA – Born Before Arrival).

4. Evidence of a bi-annual midwifery staffing overview report that covers staffing/safety issues to the Board

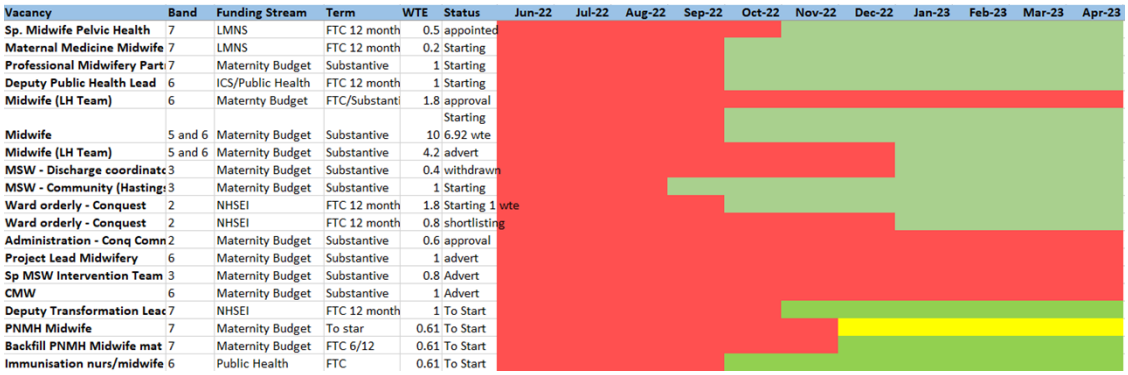
A midwifery staffing overview report, covering staffing and safety issues for the period November to March 2022, was presented to the Trust Board in June 2022.

5. Workforce

A BR+ review has been completed (see above).

As of 30th September 2022, the midwifery workforce vacancy rate was 9.4% (Band 5-7 RM) within the service. Seven whole time equivalent (wte) newly qualified midwives are due to start with the Trust in the first week of October.

The trajectory below, highlights current vacancies and predicated start dates. Adverts are out on TRAC for community and continuity of care midwives (5wte), for which there are 4 external applications. There are plans in place to review all vacancies to ensure it is attractive to prospective employees.



Vacancy	Band	Funding Stream	Term	WTE	Status
Sp. Midwife Pelvic Health	7	LMNS	FTC 12 month	0.5	appointed
Maternal Medicine Midwife	7	LMNS	FTC 12 month	0.2	Starting
Professional Midwifery Part	7	Maternity Budget	Substantive	1	Starting
Deputy Public Health Lead	6	ICS/Public Health	FTC 12 month	1	Starting
Midwife (LH Team)	6	Maternty Budget	FTC/Substanti	1.8	approval
					Starting
Midwife	5 and 6	Maternity Budget	Substantive	10	6.92 wte
Midwife (LH Team)	5 and 6	Maternity Budget	Substantive	4.2	advert
MSW - Discharge coordinato	3	Maternity Budget	Substantive	0.4	withdrawn
MSW - Community (Hasting:	3	Maternity Budget	Substantive	1	Starting
Ward orderly - Conquest	2	NHSEI	FTC 12 month	1.8	Starting 1 wte
Ward orderly - Conquest	2	NHSEI	FTC 12 month	0.8	shortlisting
Administration - Conq Comn	2	Maternity Budget	Substantive	0.6	approval
Project Lead Midwifery	6	Maternity Budget	Substantive	1	advert
Sp MSW Intervention Team	3	Maternity Budget	Substantive	0.8	Advert
CMW	6	Maternity Budget	Substantive	1	Advert
Deputy Transformation Lead	7	NHSEI	FTC 12 month	1	To Start
PNMH Midwife	7	Maternity Budget	To star	0.61	To Start
Backfill PNMH Midwife mat	7	Maternity Budget	FTC 6/12	0.61	To Start
Immunisation nurs/midwife	6	Public Health	FTC	0.61	To Start

Like many maternity units regionally and nationally, the service has experienced ongoing workforce challenges due to short and long-term sickness absence. The table below shows that sickness levels have reduced significantly, from 6.9% in April to 2.8% in September.

	April	May	June	July	August	September
Sickness Levels (%)	6.9%	5.3%	6.8%	7.3%	4.9%	2.8%
Of which COVID sickness	2.9%	1.3%	1.9%	2.6%	0.8%	0.0%

related						
Of which anxiety, stress or depression related	1.3%	0.9%	2.5%	3.9%	2.1%	0.8%
% of sickness as long term (28 days+)	46.5%	36.9%	41.4%	41.4%	67.0%	23.2%

The table below highlights that maternity leave increased from 5.8% in April to 6.4% in September.

	Apr	May	June	July	August	September
Maternity Leave	5.8%	6.0%	5.6%	5.7%	6.6%	6.4%

Currently, there are approximately 14 (headcount) members of staff who are on maternity leave across the service. A further two members of staff are due to commence maternity leave in November 2022. In total this equates to 12.07 wte.

The maternity leave trajectory below highlights three members of staff across the service are due to return from maternity leave in December, with a further three in January, one in February and two in March. These members of staff will take accrued annual leave before returning full to the maternity rota.

Maternity Leave							
MW 1 (CQ)	6	Maternity Budget	Substantive	0.6	due back	Due back	Dec-22
MW 2 (CQ)	6	Maternity Budget	substantive	0.92	due back	Due back	Dec-22
MW 3 (CQ)	6	Maternity Budget	Substantive	0.6	Due back	Due back	Dec-22
MW 4 (IVY)	6	Maternity Budget	Substantive	0.8	Off	Due back	Jan-23
MW 5 (LH)	6	Maternity Budget	Substantive	1	Off	Due back	Jan-23
MW 6 (CQ)	7	Maternity Budget	Substantive	0.6	Off	Due back	Jan-23
MW 7 (CQ)	6	Maternity Budget	Substantive	0.6	Off	Due back	Feb-23
MW 8 (EMU)	6	Maternity Budget	Substantive	0.61	Off	Due back	Mar-23
MW 9 (LH - PNMH)	6	Maternity Budget	Substantive	0.61	Due Off	Due back	Mar-23
MW 10 (CQ)	7	Maternity Budget	Substantive	0.92	Off	Due back	Apr-23
MW 11 (CQ Comm/Sp MW)	6	Maternity Budget	Substantive	1	Off	Due back	May-23
MW 12 (IVY)	6	Maternity Budget	Substantive	0.92	Off	Due back	May-23
MW 13 (EB Comm)	6	Maternity Budget	Substantive	0.75	Due Off	Due back	Aug-23
MW 14 (EMU)	6	Maternity Budget	Substantive	1	Due Off	Due back	Aug-23
MW 15 (Sp MW)	8a	External Funding	Secondment	1	Due Off	Due back	Sep-23
MW 16 (CQ) FTC	6	Maternity Budget	Substantive	0.74	Due Off	End of FTC	
		Plan to try and backfill these po		12.07			

Where possible, annual leave is maintained within the Trust target of 17%. This is affected by new joiners with leave agreed and some small teams. Study leave has been reduced as far as possible to maintain safe staffing (Multidisciplinary Emergency Drill training and fetal monitoring training has continued).

There continues to be minimal uptake of agency shifts due to higher rates being offered in other Trusts, closer to home. Incentives have been offered to internal, registered staff, for all shifts that fall two or more below the recommended template of 8 in the acute unit.

It is important to highlight that shifts with less than template staffing may still have enough staff available to manage activity on that shift, acuity is reviewed 24/7. Where staffing falls below requirements for activity or activity/ acuity exceeds capacity of staffing available, the escalation policy is enacted to redeploy staff to maintain one-to-one care in labour and safety of service users and staff.

When escalation is required, support is obtained via the on-call community/continuity team midwives. This can be for varying durations of time depending on the needs of the service (call in information available if required).

Between April and early July, specialist midwives were offering up to four hours support per day, via a helping hands rota. On review of the off duty between July and September, it was evident that further support was required. Therefore, between

July and September, specialist midwives and the midwifery management team supported the acute unit by working a rostered clinical shift, Monday to Friday 07.15-13.30 or 13.30-19.45. Overnight and at weekends, the maternity escalation policy was frequently implemented to obtain additional support from on-call community staff. This has had a detrimental impact on day-to-day workload, staff wellbeing and morale.

Financial incentives have also been offered to substantive registered staff working additional hours where shifts fell two or more below the recommended template.

6. Escalation of Concerns

Workforce requirements are reviewed each morning (more frequently if required) and a plan is made to ensure timely action is taken to maintain safe staffing levels in line with the local and system-wide escalation policy.

When required, clinical staff are re-deployed to support clinical activity. Overnight the on-call community/continuity team midwives are asked to support the acute unit. This is demonstrated in the table below.

A weekend plan is developed each week and is shared with senior midwives on call, Divisional and Trust on call staff.

7. Red Flag Incidents

Red flag incidents are recorded via the internal escalation process and are documented on the BR+ acuity app by the labour ward shift coordinator. This is triangulated against DATIX incident reports and escalation forms if available.

It is important to acknowledge that the completion of the BR+ acuity app, documentation of escalation/red flag events and completion of a DATIX incident form on individuals having the capacity to complete it within their shift. This is more challenging to achieve when there are workforce challenges or labour ward acuity is high. Subsequently, data accuracy may be affected if this has not been possible.

One hundred and twenty-six red flags were reported during this reporting period. The main indication for recording a red flag incident included:

- Delays or re-scheduling of induction of labour (IOL) to maintain safe services. The department acknowledges that this can lead to increased anxiety, poor patient experience and increased PALS contacts or formal complaints. To negate this, all staff are aware of the requirement to undertake a thorough risk assessment and communicate effectively with pregnant people.

  On review of submitted DATIX incidents relating to delayed IOL, this was due to either not having a lateral flow result prior to admission or extreme workforce/acuity challenges at the time of admission which would impact on safety. No harm occurred to any of the service users involved.

- Supernumerary labour ward coordinator – section 2 above
- One to One Care in Labour – section 3 above

8. Maternity Transformation (Better Births) – A Five Year Forward View for Maternity Care

ESHT Maternity services have established service transformation plans which have been shared with the Trust Board and the LMNS. These plans incorporate the Maternity Transformation Programme (Better Births), vision to:

"…for maternity services across England to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances. And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries." (Better Births, 2016)

Following publication of the final Ockenden report in March 2022, a revised MCofC plan was completed and shared with the Trust Board in May 2022.

A further update was received from NHS E/I in September 2022. This communication advised, "*…there is no longer a national target for MCoC. Local midwifery and obstetric leaders should focus on retention and growth of the workforce, and develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths."*

During the six-month reporting period, continuity of care (MCofC) was provided as follows:

Target >35%	**April**	**May**	**June**	**July**	**August**	**Sept**
Number of people placed on continuity of care pathway at 29 weeks gestation	26.7%	18.80%	20.80%	26.60%	27.00%	21.90%
Number of Black/Asian people placed on continuity of care pathway at 29 weeks gestation	36.4%	43.80%	Not available	33.30%	33.30%	8.30%
Number of people living in the most deprived area, placed on continuity of care pathway at 29 weeks gestation	27.3%	11.10%	40%	30.80%	35.70%	12.50%

There have been expected monthly fluctuations observed. However, there was a significant reduction in September data. This has been attributed to the removal of data relating to the Maple Team as they are no longer providing full continuity of care for diabetic pregnant people.

The maternity department is in the process of reviewing local data and community teams in order to establish continuity of care in the antenatal and postnatal period for those most vulnerable living in our geographic area. The two established continuity teams will also be reviewed in line with this recommendation.

Conclusion

ESHT maternity services currently have safe and appropriate staffing to provide high quality care with the caveat of the increase in the current uplift recommendation is 26.4%.

The ongoing COVID-19 pandemic has impacted negatively on the maternity workforce. Not only in terms of staffing gaps, but also on the wellbeing of staff. This resulted in an additional strain on the service, requiring additional clinical support from specialist midwife and the management team. Occasionally, services are reconfigured for a short period of time to maintain safety.

We have been successful in the recruitment and retention of midwifery staff; this is mainly due to our excellent preceptorship programme which supports newly qualified midwives and new midwives to the Trust. New staff have expressed how much they have been welcomed and supported since joining the midwifery team, with some expressing an interest in working bank shifts or increasing their hours. There is also a new senior midwifery management team. Six-weekly listening events have been implemented and staff have commented that they feel much more involved with discussions and decision making.

Our escalation processes used at times of high acuity/ staffing challenge is robust and mitigates risk. Our staffing provision meets the requirements of the CNST Incentive Scheme.

We have successfully met these standards for the last three years

Action Plan from previous report (November 2021, updated October 2022)

Issue to be addressed	Actions required	Action owner	Evidence of completion	Due date	Progress
One to one care rates not on dashboard	Add to dashboard	Head of Midwifery	On dashboard	January 2022	Complete – implemented as part of new PQS dashboard
Supernumerary status of coordinator not on dashboard	Add to dashboard	Head of Midwifery	Not yet on dashboard. To discuss with LMNS	November 2022	
Acuity tool malfunction April 2021 – replacement system required	Explore options within the BadgerNet system Funding business	Head of Midwifery	Acuity tool in use	Dec 2021	Implemented Feb 22.

	case if standalone system required				
Achieve consistent 85% compliance with Data completion in BR+ App	Explore options with matrons	Head of Midwifery	Consistently 85% compliance with reliable narrative	Dec 2022	Currently 75%. Some additional training required
Revised MCofC model to be presented to LMNS June 2022	Completion of report. Review at Maternity Assurance. Share with LMNS	Transformation Lead	Minutes of MAM meeting/LMNS Board	June 2022	Complete. Updated report and roll-out trajectories reviewed and shared with LMNS.
Review MCofC model to ensure provision of continuity to those most vulnerable in our communities, in the antenatal and postnatal period	Review current provision and community teams. Identify locations suitable for delivering clinical care	Transformation lead	Plan presented at MAM/Trust/LMNS	March 2023	

Appendix 1 – BirthRate + Report

East Sussex NHS Trust_Birthrate Plus Fi

Appendix 2 – CNST Incentive Scheme updated October 2022

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard? **Required standard**

a) A systematic, evidence-based process to calculate midwifery staffing establishment is complete.
b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
c) All women in active labour receive one-to-one midwifery care
d) Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board.

Minimum evidential requirement for trust Board

The bi-annual report submitted will comprise evidence to support a, b and c progress or achievement.
It should include:
 A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.
 Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing.
 An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified.
 Maternity services should detail progress against the action plan

to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.
 The midwife: birth ratio. No recognised calculation tool available.
 The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.
 Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Appendix 3 – Quarterly Acuity Report

Acuity Report Q2 - July to September 20

Maternity Workforce, Acuity, & Red Flag Incident Reporting (Q2 2022)

Meeting information:	
Date of Meeting: 26th October 2022	Agenda Item: Maternity Workforce, Acuity, and Red Flag Incident Report – Q2 (July-September 2022)
Meeting: Maternity Assurance Meeting	Reporting Officer: Alison Newby – Head of Midwifery

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

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

Summary:

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

Maternity Workforce, Acuity & Red Flag Incidents

1.1. A new web-based application (App) to monitor acuity and red flag incidents was introduced in February 2022. To give confidence in the data, compliance with four-hourly reporting has been reviewed weekly by the BirthRate Plus (BR+) team.

All matrons are aware of the requirement to complete the web-based app, every four hours, with information relating to staffing, acuity, and red flags. Completing the acuity app at the designated time (0800, 1200, 1600, 2000 and midnight) has been especially difficult due to ongoing workforce challenges and increased acuity requiring support from the shift coordinator. Current cumulative compliance is 75%.

1.2. It is important to highlight that shifts with less than template staffing may still have enough staff available to manage activity on that shift, acuity is reviewed 24/7.

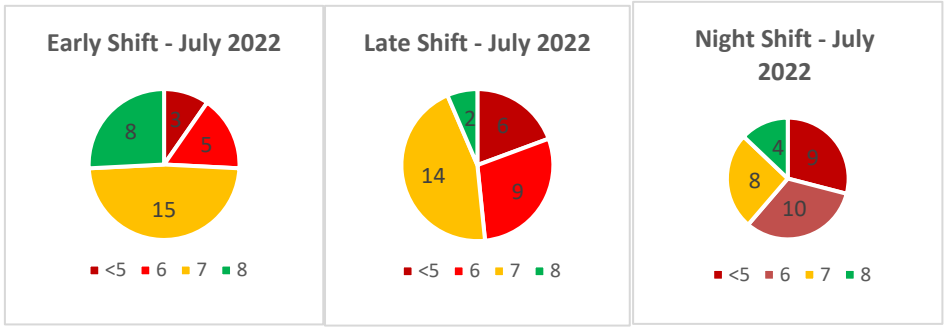
1.3. Two night shifts in August did not have an allocated supernumerary Labour Ward Co-ordinator due to vacancy or sickness within the matron team. On both occasions, a senior band 6 midwife acted as the supernumerary shift coordinator with additional support available as required from the on-call senior midwife. All remaining shifts during the reporting period were filled.

1.4. The template for the Conquest acute unit is 8 registered midwives per shift. Where staffing falls below requirements for activity or activity/ acuity exceeds capacity of staffing available, the escalation policy is enacted to redeploy staff to maintain one-to-one care in labour and safety of service users and staff. During escalation midwives are called in for varying durations depending on the needs of the service (call in information available if required).

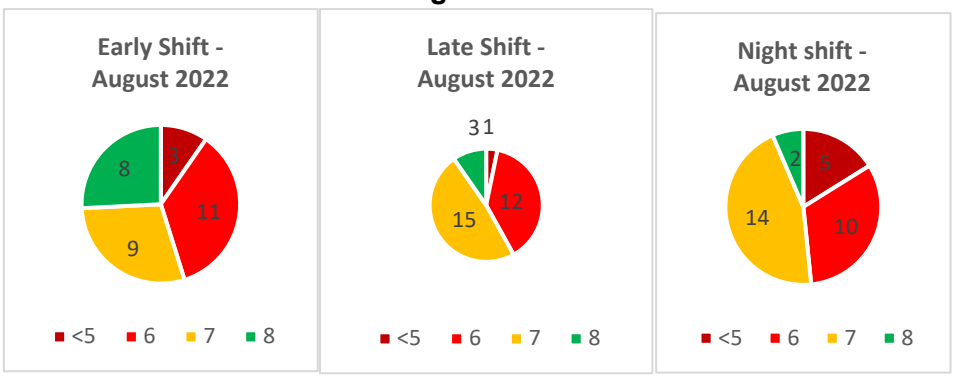
During the reporting period, specialist midwives and the midwifery management team supported the acute unit by working a rostered clinical shift, Monday to Friday 07.15-13.30 or 13.30-19.45.

The following charts demonstrate midwifery staffing allocation, including specialist midwives/managers working an early/late shift. Night shift allocation shown is **prior to escalation**.

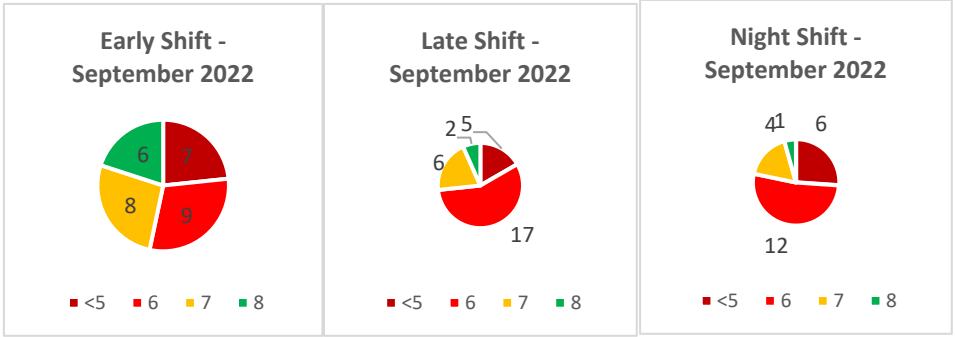
July 2022



August 2022



September 2022



Data extracted from the BR+ acuity app, demonstrates that unfilled shifts were a contributory factor when calculating workforce and acuity during this reporting period.

Number & % of Staffing Factors Recorded

From 01/07/2022 to 30/09/2022

SF1	Unexpected midwife absence / sickness	80	24%
SF2	Unable to fill vacant shifts	212	64%
SF3	Midwife on transfer duties	3	1%
SF4	Midwife redeployed to other area	0	0%
SF5	Support staff less than rostered number	31	9%
SF6	CoC MW unavailable	0	0%
SF7	CoC midwife available	5	2%
	Total	331	

Data extracted from the Trust Healthroster system, was used to triangulate the information above. It is evident that during this reporting period many shifts, particularly at night, were 2-3 under template.

Workforce requirements are reviewed each morning (more frequently if required) and a plan is made to ensure safe staffing levels in line with the local and system-wide escalation policy. When required, clinical staff are re-deployed to support clinical activity. Overnight the on-call community/continuity team midwives are asked to support the acute unit. This is demonstrated in the table below.

Number & % of Management Actions Taken
From 01/07/2022 to 30/09/2022

MA1	Redeploy staff internally	13	9%
MA2	Redeploy staff from community	21	15%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	24	17%
MA5	Staff working beyond rostered hours	3	2%
MA6	Specialist Midwife working clinically	11	8%
MA7	Manager / Matron working clinically	9	7%
MA8	Staff sourced from bank / agency	0	0%
MA9	Utilise on call midwife	52	38%
MA10	Escalate to manager on call	5	4%
MA11	Maternity unit on divert	0	0%
	Total	138	

At times when on-call staff are asked to work overnight to support the acute unit, they are asked to undertake only essential work go home early for a break before their on-call shift starts.

The department recognises this is not always easy to achieve and may result in some on-call staff are working excessive hours. To mitigate against this and protect staff wellbeing, a whole service on-call consultation is being launched in November. This will ensure an additional midwife is available to offer additional support when there are workforce challenges or acuity is high.

1.5. **Acuity & Red Flag incidents**

Red flag incidents are recorded via the internal escalation process and are documented on the BR+ acuity app by the labour ward shift coordinator. This is triangulated against DATIX incident reports and escalation forms if available.

It is important to acknowledge that the completion of the BR+ acuity app, documentation of escalation/red flag events and completion of a DATIX incident form on individuals having the capacity to complete it within their shift. This is more challenging to achieve when there are workforce challenges or labour ward acuity is high. Subsequently, data accuracy may be affected if this has not been possible.

During this reporting period, there has been significant improvements to data input within the BR+ app, achieving a confidence factor of 71.5. To ensure data is reliable, the aim is to achieve an overall confidence factor of 85%.

Data extracted from the BR+ app indicated that on 53 occasions, it was necessary to delay commencing or continuing with induction of labour to maintain safe services. The department acknowledges that this impacts on patient experience and may result in increased contact with PALS or a formal complaint. To negate this, all staff are aware of the requirement to undertake a thorough risk assessment and communicate effectively with pregnant people.

Number & % of Clinical Actions Taken

From 01/07/2022 to 30/09/2022

CA1	Decline in-utero transfer	0	0%
CA2	Delay in accepting transfers	1	2%
CA3	Delay in commencing IOL (as per Trust guidance)	53	85%
CA4	Delay/ Cancel planned procedure	7	11%
CA5	Delay in transfer of cases to theatre	1	2%
CA6	Delay in El LSCS > 24hrs	0	0%
	Total	62	

Red Flags:

Forty-nine red flags were reported during this reporting period.

Number & % of Red Flags Recorded
From 01/07/2022 to 30/09/2022

RF1	Delayed or cancelled time critical activity	5	10%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	2	4%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	1	2%
RF5	Delay between presentation and triage	3	6%
RF6	Full clinical examination not carried out when presenting in labour	1	2%
RF7	Delay between admission for induction and beginning of process	7	14%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	5	10%
RF10	Coordinator unable to maintain supernumerary status	25	51%
	Total	49	

Supernumerary Shift Co-ordinator:
The most frequent reason (25/515) for reporting a red flag related to the shift coordinator not being able to maintain supernumerary status.

The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, helping midwives at birth when required, supporting junior midwives undertaking suturing etc. In accordance with CNST (MIS) year 4 guidance (October 2020), to maintain supernumerary status, the labour ward coordinator **must not** be solely responsible for any 1:1 care for a labouring woman or relieve for break, (or any short period of time) a midwife who is providing 1:1 care for a high risk woman requiring constant observation. This includes supervising a student midwife providing 1:1 care.

Having reviewed submitted DATIX incidents (1) and discussed this with the labour ward coordinator team, assurance has been given that labour ward coordinators have not provided 1:1 care for a person in established labour, and nor have they provided break relief for a midwife who is providing 1:1 care for a high risk woman requiring constant observation.

To ensure accurate reporting, matrons have been advised of CNST requirements to ensure accurate reporting.

Delay between admission for IOL and beginning of process (7/14%):
It is sometimes necessary to delay procedures due to workforce/acuity, it is acknowledged that this can lead to poor patient experience. During the reporting period, three DATIX incidents submitted for delay between admission and beginning of process. On review it was clear the reason for the delay included not having a lateral flow result prior to admission and workforce/acuity challenges at the time of admission. No harm occurred to any of the service users involved.

Midwife unable to provide continuous 1:1 care and support in established labour:
Five red flags were highlighted in the BR+ acuity app. One to one care in established labour is reviewed monthly as part of the PQS dashboard. Data entries for all service users identified as not receiving one to one care during labour have been reviewed by the reporting officer. Assurance has been gained that all pregnant people in established labour within the hospital setting, received one to one care during the reporting period.

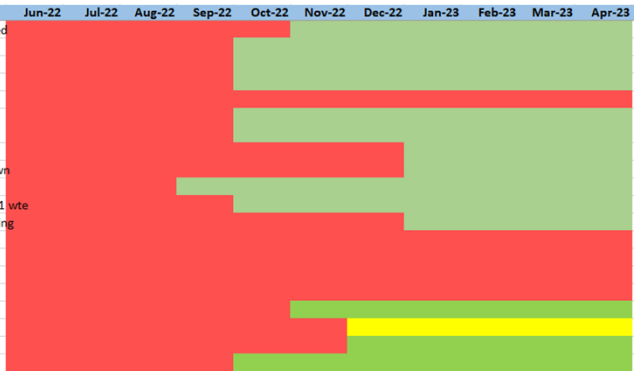
1.6. **General workforce information**

1.6.1. A midwifery staffing uplift to 26.4% has recently been approved by the Trust, resulting in additional funding for 6.23wte midwife/maternity support worker posts. These are advertised on the TRAC system.

1.6.2. As of 30th September 2022, the midwifery workforce vacancy rate was 9.4% (Band 5-7 RM) within the service. Seven whole time equivalent (wte) newly qualified midwives are due to start with the Trust in the first week of October.

The trajectory below, highlights current vacancies and predicated start dates. Adverts are out on TRAC for community and continuity of care midwives (5wte), for which there are 4 external applications. There are plans in place to review all vacancies to ensure it is attractive to prospective employees.

Vacancy	Band	Funding Stream	Term	WTE	Status
Sp. Midwife Pelvic Health	7	LMNS	FTC 12 month	0.5	appointed
Maternal Medicine Midwife	7	LMNS	FTC 12 month	0.2	Starting
Professional Midwifery Part	7	Maternity Budget	Substantive	1	Starting
Deputy Public Health Lead	6	ICS/Public Health	FTC 12 month	1	Starting
Midwife (LH Team)	6	Maternty Budget	FTC/Substanti	1.8	approval
					Starting
Midwife	5 and 6	Maternity Budget	Substantive	10	6.92 wte
Midwife (LH Team)	5 and 6	Maternity Budget	Substantive	4.2	advert
MSW - Discharge coordinato	3	Maternity Budget	Substantive	0.4	withdrawn
MSW - Community (Hasting	3	Maternity Budget	Substantive	1	Starting
Ward orderly - Conquest	2	NHSEI	FTC 12 month	1.8	Starting 1 wte
Ward orderly - Conquest	2	NHSEI	FTC 12 month	0.8	shortlisting
Administration - Conq Comn	2	Maternity Budget	Substantive	0.6	approval
Project Lead Midwifery	6	Maternity Budget	Substantive	1	advert
Sp MSW Intervention Team	3	Maternity Budget	Substantive	0.8	Advert
CMW	6	Maternity Budget	Substantive	1	Advert
Deputy Transformation Lead	7	NHSEI	FTC 12 month	1	To Start
PNMH Midwife	7	Maternity Budget	To star	0.61	To Start
Backfill PNMH Midwife mat	7	Maternity Budget	FTC 6/12	0.61	To Start
Immunisation nurs/midwife	6	Public Health	FTC	0.61	To Start



1.6.3. Like many maternity units regionally and nationally, the service has experienced ongoing workforce challenges during Q2 (July-September), due to short and long-term sickness absence. The table below shows that sickness levels have reduced signifantly in Q2, from 7.3% to 2.8%.

	July	August	September
Sickness Levels (%)	7.3%	4.9%	2.8%
Of which COVID sickness related	2.6%	0.8%	0.0%
Of which anxiety, stress or depression related	3.9%	2.1%	0.8%
% of sickness as long term (28 days+)	41.4%	67.0%	23.2%

1.6.4. Maternity leave in Q2 has been recorded as follows:

	July	August	September
Maternity Leave	5.7%	6.6%	6.4%

This represents 14 (headcount) members of staff who are currently on maternity leave across the service. Two members of staff are due to commence maternity leave in November 2022. In total this equates to 12.07 wte.

The maternity leave trajectory below highlights that three members of staff, across the service, are due to return from maternity leave in December, with a further three in January, one in February and two in March. These members of staff will take accrued annual leave before returning full to the maternity rota.

Maternity Leave							
MW 1 (CQ)	6	Maternity Budget	Substantive	0.6	due back	Due back	Dec-22
MW 2 (CQ)	6	Maternity Budget	substantive	0.92	due back	Due back	Dec-22
MW 3 (CQ)	6	Maternity Budget	Substantive	0.6	Due back	Due back	Dec-22
MW 4 (IVY)	6	Maternity Budget	Substantive	0.8	Off	Due back	Jan-23
MW 5 (LH)	6	Maternity Budget	Substantive	1	Off	Due back	Jan-23
MW 6 (CQ)	7	Maternity Budget	Substantive	0.6	Off	Due back	Jan-23
MW 7 (CQ)	6	Maternity Budget	Substantive	0.6	Off	Due back	Feb-23
MW 8 (EMU)	6	Maternity Budget	Substantive	0.61	Off	Due back	Mar-23
MW 9 (LH - PNMH)	6	Maternity Budget	Substantive	0.61	Due Off	Due back	Mar-23
MW 10 (CQ)	7	Maternity Budget	Substantive	0.92	Off	Due back	Apr-23
MW 11 (CQ Comm/Sp MW)	6	Maternity Budget	Substantive	1	Off	Due back	May-23
MW 12 (IVY)	6	Maternity Budget	Substantive	0.92	Off	Due back	May-23
MW 13 (EB Comm)	6	Maternity Budget	Substantive	0.75	Due Off	Due back	Aug-23
MW 14 (EMU)	6	Maternity Budget	Substantive	1	Due Off	Due back	Aug-23
MW 15 (Sp MW)	8a	External Funding	Secondment	1	Due Off	Due back	Sep-23
MW 16 (CQ) FTC	6	Maternity Budget	Substantive	0.74	Due Off	End of FTC	
		Plan to try and backfill these po		12.07			

1.6.5. Where possible, annual leave is maintained within the Trust target of 17%. This is affected by new joiners with leave agreed and some small teams. Study leave has been reduced as far as possible to maintain safe staffing (Multidisciplinary Emergency Drill training and fetal monitoring training has continued).

1.6.6. There continues to be minimal uptake of agency shifts due to higher rates being offered in other Trusts, closer to home. Incentives have been offered to internal, registered staff, for all shifts that fall two or more below the recommended template of 8 in the acute unit.

1.6.7. **Obstetric, Neonatal & Anaesthetic Staffing**: no concerns have been identified.

1.6.7.1. Obstetric Workforce: There is a local guideline in relation to the duties of the Hot Week Consultant. This incorporates the principles outlined in the RCOG Workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'. Compliance with the recommendations with in the guideline has been demonstrated in a recent audit. An action plan has been shared with the consultant body and will be monitored by the clinical effectiveness midwife.

The maternity department is compliant with the requirement for twice daily consultant ward rounds, 7 days per week. This is monitored monthly via the PQS dashboard which is shared with the Trust Board and LMNS.

1.6.7.2. Anaesthetic Workforce: Anaesthetic workforce rotas demonstration compliance with ACSA standard 1.7.21 - the requirement for a duty anaesthetist to be immediately available for the obstetric unit 24 hours a day, with clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients as detailed below:

Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff	
2.6.5.1	A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident
2.6.5.2	A separate anaesthetist is allocated for elective obstetric work
2.6.5.3	Where the duty anaesthetist has other responsibilities, an anaesthetist must be immediately available (within five minutes) to deal with obstetric emergencies
2.6.5.4	Medically-led obstetric units have, as a minimum, consultant anaesthetist cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed)
2.6.5.5	There is a named consultant anaesthetist or intensivist responsible for all level two maternal critical care patients (where this level of care is provided on the maternity unit)
2.6.5.6	The duty anaesthetist for obstetrics attends hand over meeting daily

1.6.7.3. Neonatal Medical Workforce: The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

1.6.7.4. Neonatal Nursing Workforce: The neonatal unit meets the service specification for neonatal nursing standards and uses a specific workforce calculation tool.

1.7. **Escalation of concerns**

1.7.1. The service has a robust escalation policy to mitigate staffing gaps; this plan is aligned to the system Mutual Aid and Escalation Plans. On call staff are part of this escalation and are called into the acute unit to support when needed, this can impact on their ability to complete their workload the following day. There is a Senior Midwife on call out of hours to assist with decision making and response.

1.7.2. A daily Safety Huddle is held by the senior midwifery team chaired by the Head of Midwifery or Deputies every weekday morning to ensure staffing gaps are acted upon at the earliest opportunity. Team members can escalate concerns to their team lead who attends this meeting, this is then escalated to senior management as required.

1.7.3. Homebirth provision is reviewed during the daily Safety Huddle. Staffing and activity across the acute unit, birth centre, community and MCoC teams is reviewed to determine if it is safe to offer homebirths. These discussions take place Monday-Friday with arrangements for the weekend confirmed at the Friday afternoon meeting.

1.7.4. As required, a senior midwife attends the Trust staffing meeting twice daily and the weekly Trust Workforce Forum to escalate concerns and request assistance if required. Escalation and requests for support to the Trust workforce lead nurse resulted in support from nursing teams when possible.

1.7.5. A weekend plan is developed each week and shared with the senior midwives on call, Divisional and Trust on call staff.

1.7.6. A senior midwife is on call out of hours to support with escalation and decision making. The Division support with a 'Silver' on call out of hours where any medical staffing issues are managed, and additional support provided to the Midwifery teams where required.

1.7.7. There is an accessible and responsive midwifery leadership team who encourage contact from staff in person or via email/ telephone.

1.7.8. The contact details of the Maternity Safety Champion team are widely advertised.

1.7.9. Monthly Safety Forums are facilitated by the Executive and Non-executive Maternity Safety Champions and accessible to all staff. Actions and decisions from these forums are circulated to all staff.

1.7.10. Every effort is made to keep staff updated regarding the staffing challenges and mitigations, however, at times the gaps are significant and sudden, particularly due to Covid isolation requirements making effective communication challenging.

1.7.11. The Head of Midwifery or deputy attends the monthly South East Maternity 'Hot Call' chaired by the Regional Chief Midwife, to escalate staffing and other concerns within the maternity service. Situation reports are completed twice weekly. This information is shared with the national maternity team.

2. Any incidents reported which may be attributed to low staffing in maternity at the Conquest.

There has been a 50% reduction in the number of DATIX incident reporting forms submitted due to low staffing within the maternity department at Conquest, from 31 in Q1 to 15 during Q2.

- Eight incidents related to workforce challenges resulting in community/continuity team midwives on-call being redeployed to support the acute unit (as described above).
- Three workforce incidents resulted in the temporary suspension of homebirths during Q2. It is likely this has been under-reported. All plans are reviewed as described and where necessary planned homebirths are re-directed to EMU, or Conquest. If a pregnant person declines to come into either location, a discussion takes place regarding the risk of birthing without midwifery support and safety netting advice in respect of contacting ambulance services and the department if there are any concerns.
- Three incidents resulted in the temporary suspension of births at EMU. This decision is made following a workforce risk assessment. Births are redirected to Conquest. Again, if declined the process described above is followed.
- One incident was reported to due to the labour ward matron not being supernumerary. This is described in more detail above.

No adverse outcomes resulted from these delays although the experience for the families is not what we aspire to. Staff morale is also low due to the ongoing challenges.

3. One to one care during labour at the Conquest.

See section 1.5 above.

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4. Narrative around how the services have been reconfigured to consider staffing levels currently.

Throughout the pandemic and ongoing period of workforce challenge, out of hospital birth services have been temporarily suspended for defined periods either to consolidate activity and staffing to maintain safety.

4.1. As described above, daily review of staffing and escalation took place. As workforce difficulties persisted the following mitigations were implemented:

4.2. Workforce issues are included on the Divisional Risk Register.

4.3. Specialist midwives, matrons and the senior midwifery management team have supported the acute clinical area by working a rostered six-hour shift, Monday-Friday 07.15-13.30 or 13.30-19.45 hours. The impact this has on their ability to complete their own workloads is on the Divisional Risk Register.

4.4. Day Assessment opening hours have been extended to include a slightly longer day and weekend work. Day Assessment Unit twilight shifts are ongoing to assist with mitigating staffing pressures out of hours.

4.5. A full-service on call consultation is being reviewed with an aspiration to launch in November. Staff engagement events commenced in October.

5. Summary

This report highlights the persistent difficulties being experienced within the maternity service due to vacancy and staff absence. Also highlighted is the action taken to maintain quality of care and safety of service users and staff during this difficult time.

Projected staffing level indicate an improving workforce from 31.10.22, with templates reaching 7 registered midwives per shift. Rota coordinators have been asked to ensure all nights and weekend shifts are up to full establishment. If required, specialist midwives, matrons and managers will be asked to provide continued support during office hours.

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

Divisional Governance and Accountability meeting
Maternity Assurance Meeting
Quality & Safety Committee
LMNS

- Dates to be confirmed.

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

Continued support for the executive team, for reconfiguration of services offered by ESHT maternity to maintain high quality and safe care for those using our services.

EAST SUSSEX MATERNITY VOICES PARTNERSHIP
WORK PLAN – Sept 2022- March 2024

	TOPIC	TASK	LEAD	NOTES/PROGRESS TO DATE	TIMELINE
1	**Service User Feedback**	Continue to collect service user feedback through **Walk the Patch** (WTP) online survey and collate into **report bi-annually** for maternity & obstetric managers. Survey to be maintained and advertised to improve data collection and reach.	MVP Co-Chair (HR)	Latest report collates responses from July to Sept 21 October-Dec 21 responses will not be officially reported on but will be available for review. Report for Jan-June 22 responses will be completed by Oct 22 Report for July-Dec 22 responses due to be completed by Feb 23	On-going +report bi-annually
		Deep Dive into the latest WTP report **bi-annually**- an opportunity for collaborative analysis and for department leads to take ownership of SU feedback and develop follow up actions that will be diversified to sub-groups and reviewed by the whole MVP.	DOM/HOM	Last Deep Dive July 21 Scheduling DD has been difficult due to ongoing staffing pressures. Next suggested date 19th Sept 22-Cancelled due to state funeral (12/09/22) Alternative dates suggested (12/09/22)	Bi-annually
		Theme based Service User Feedback to be **submitted monthly** to the HOM for inclusion in the Trusts **Ockenden** submissions- opportunity to include experiences heard via MVP members including Service User representatives whilst they attend/facilitate parent/baby groups in the local community and whilst in their professional roles. Actions to be informed by this and added to the ongoing 'action log' to be followed up at midwifery meetings.	MVP Co-Chair (HR)&HOM	Volunteer SU reps in place in the community to engage and listen. Their thoughts are collected once a month. Feedback from the MVP usually submitted by the end of the second week of the following month. MVP submissions all up to date 06/09/22	Monthly On-going
		Celebrating staff- Continued appreciation to be passed on to members of staff that are named as going "Above and Beyond" via our online survey or from experiences heard from SU's – Maternity staff, health visitors etc,	MVP Chairs	Thank you emails sent to as many people who were named and could be identified from the WTP online survey up to May 22. Next batch to be sent Oct/Nov 22	On-going

		'15 steps' to be carried out across both ESHT sites (Conquest & Emu) each year. The visiting team must be representative of the MVP membership.	MVP Chairs & HOM	Planned for Dec 22/Jan 23 Neonatal to be included at the Conquest	By the end of 22/23
2	**Online/Digital platforms**	Review, maintain and grow social media and website pages for East Sussex MVP. Use for greater engagement and communication as well as keeping service users up to date with what we are doing.	MVP Vice Chair (HD)	Facebook account active. Instagram and Twitter accounts created 05/09/22 Potential for MVP page on LMNS website once up and running 31/08/22	On-going
3	**Co-production & Sub groups**	Provide service user representation at Trust and LMNS meetings as well as active involvement in changes to services via sub-groups including Equality& Equity Perinatal Mental Health Infant feeding Maternity Hub development (EMU) Induction Caesarean Birth Discharge Planning Neonatal PAG Personalised Care and Support Planning (PCSP) & COC Progress/updates to be reported back verbally at full MVP meetings Continue co-production of patient communications and leaflets/documentation – including website review	MVP Chairs and volunteer SU members	ESMVP Chairs invited to ESHT's W&C Governance & Accountability monthly meeting Sussex MVP Chairs are invited to LMNS Quality & Safety monthly Forum Sussex MVP Chairs are invited to LMNS monthly Programme Board Quadrumvirate co-production training booked via NHS England/SE Maternity for Nov 22 **Sub-group update:** **Perinatal Mental Health-** Birth debrief evaluation tool-SU identified to help develop evaluation Tool-May 22 MVP Co-Chair (HR) engaged and fed back thoughts to debrief midwives and Consultant M/W- June 22 Draft version to be sent to the same SU to 'try out'- Sept 22 Trauma informed care-Outstanding question re impact of Badgernet in relation to "stickers"-Teardrop symbol?	On-going Monthly By end of 2022

				Infant feeding MVP Co-Chair (HR) has open lines of communication and a productive relationship with ESHT's Infant Feeding Lead M/W. Following SU feedback an idea for the MVP to provide information of current free infant feeding support available in the community in order to co-produce a leaflet to signpost by the end of the year-31/08/22 **Maternity Hub development (EMU)** Sub-group to consider immediate publicity & marketing of EMU after Covid closures, longer-term estates plan for location, and interaction with potential community hub funding. First discussion attended by MVP Co-chair and presentation of SU made- August 22 Volunteer SU identified to be involved in the future-Aug 22 **Induction** SU's identified to input into ESHT's work that has been started-Aug 22 **Caesarean Birth** SU's identified to be involved in ESHT's future review-Aug 22 **Discharge Planning** SU's identified to be involved in ESHT's future review-Aug 22 **Neonatal PAG** Anna Francis& Marie Christian to be included at full MVP meetings to update. **Personalised Care and Support Planning (PCSP) + COC** Support roll-out and use. Review how hard copy PCSP works with	

				digitalisation. MVP Co- Chair's (HR) previous role was the Service User Lead during the development of "My Choices for Pregnancy Birth and Beyond" hard copy.	
4	**Equality and Equity**	Support delivery of NHS Equity plan Focus this year is Health Inequalities- improving engagement with identified lesser heard voices – Black, Asian and mixed communities as well as young parents and those who live in areas of social deprivation Continue active work to improve diversity of MVP membership	MVP	Dedicated budget allocated for this 22/23 Listening event (planned for October 22) invite co-produced and disseminated summer 22 however only 2 responses. Links made and volunteer SU rep recruited from LGBTQ+ community third party support group- summer 22 MVP Vice Chair appointed Sept 22 and will make contacts and attend groups in the local community with a focus on the recognised characteristic communities. MVP Chairs are part of the LMNS East Sussex Perinatal Equity and Equality steering group	Ongoing
5	**Future Estate Funding**	Consider and develop estate-type plans for improved maternity facilities. (eg: single rooms at Conquest, new EMU site, potential community hub for maternity)	DOM/HOM	See above notes for maternity hub development.	On-going
6	**Shared learning**	Identify good working practice from other MVP's	MVP Chairs	Constant discussion with other ESMVP & SE chairs	On-going
7	**MVP Membership**	Ongoing review of MVP membership to ensure that all parties and communities are represented.	MVP Chairs	Increased Volunteer SU representatives now on team- 2022 Regular Obstetric attendance required- DOM has suggested Full MVP meets to be arranged slightly later after clinic.	On-going

8	**Data & Statistics**	Regular updates to MVP from "scorecard" information. Agreed actions required in response to any trends identified.	DOM/HOM MVP Co-Chair (RH)	MVP members to be updated at full meets.	On-going

East Sussex Healthcare NHS Trust

East Kent Report Summary and ESHT Assurance

Meeting information:	
Date of Meeting: 16/11/22	Agenda Item: Maternity Overview Report Q2
Meeting: Quality & Safety Committee	Reporting Officer: Brenda Lynes

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

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

Summary:

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

The East Kent Report was published on 19th October 2022, this report is not the only independent investigation into NHS maternity services published in recent years, but that makes its findings even more crucial. The themes identified by the Independent Investigation into East Kent Maternity Services, led by Dr Bill Kirkup are sadly too familiar.

As are the circumstances through which the investigation came about: through their trauma and grief, families somehow finding the energy to fight for answers.

We owe a huge debt of thanks to those whose dedication to finding out exactly what happened to their babies, and refusal to accept false information and hallow assurances, has led to us all knowing the truth. They've provided us with another opportunity to prevent avoidable tragedies in the future.

Whether we choose to learn from today's report and the Morecambe Bay and Shrewsbury and Telford reports that preceded it is now down to us.

Key points: 'Reading the signals: Maternity and neonatal services in East Kent – the Report of the Independent Investigation'

1. The investigation examined East Kent Hospitals University NHS Foundation Trust's maternity services in two hospitals, The Queen Mother Hospital in Margate. and the William Harvey Hospital in Ashford, between 2009 and 2020

2. The report details that, over that period, the Trust provided clinical care that was "suboptimal" and led to significant harm

3. The report shows that, during this period, there were multiple missed opportunities that should have led to problems being acknowledged and tackled effectively

4. Had care been given to the nationally recognised standards, the outcome could have been different in nearly half of the 202 cases assessed by the Investigation's panel. The outcome could have been different in 45 of the 65 baby deaths, which is just more than two-thirds of cases.

5. The report acknowledges that it includes "minimum estimates" of the frequency of harm, with the panel having only worked with families who volunteered to be involved in the report

6. Alarmingly, the panel has "not been able to detect any discernible improvement in outcomes or suboptimal care" in the decade between 2009 and 2020

Alongside listening to families, the Investigation involved interviews with 112 current and former staff at East Kent Hospitals University NHS Foundation Trust, and with others whose work brought them into contact with the Trust's maternity and neonatal services.

The themes identified were:

1. **Failures in teamwork:** The report refers to "grossly flawed teamworking among and between midwifery and medical staff".

2. **Failures in professionalism:** "Staff were disrespectful to women and disparaging about the capabilities of colleagues in front of women and families," says the report.

3. **Failures of compassion:** "Caring for patients in any setting requires not only technical skills but also kindness and compassion. This is no less true for mothers and babies in maternity care," states the report. "Yet we heard many graphic accounts, from staff as well as families, that showed just how far from the required standards behaviour had fallen at the Trust."

4. **Failure to listen:** Which, "directly affects patient safety, as we found repeatedly in the Trust's maternity services, because vital information is ignored," says the report.

5. **Failures around investigations**: "…there appears to have been a collective unwillingness to engage with families and a reluctance to invite them to contribute to investigations; some families were not even made aware that an investigation was taking place," explains the report.

6. **Failures when responding to investigations:** For example, one midwife recalled how, when new guidelines were introduced in response to incidents but no one explaining why: "Staff weren't involved in improvement plans and yet they knew what went wrong. They [knew] how it could be fixed but they weren't invited to comment."

This report makes for stark reading, including harrowing case studies and quotes that build a full picture of an organisation "characterised by both internal and external denial with many missed opportunities to investigate and correct many of the devastating failings".

Individual families' stories are unique, but the problems that led to their trauma are, unfortunately, not. The issues identified at East Kent are recognisable.

Many of these themes were identified in Donna Ockenden's review of maternity services at Shrewsbury and Telford NHS Trust, which was published in March 2022, and within 'The Morecambe Bay Investigation' into maternity and neonatal services in University Hospitals Morecambe Bay NHS Foundation Trust, also led by Dr Bill Kirkup, published in 2015.

Similar themes are likely to be investigated by Donna Ockenden in her Independent Review into Maternity Services at the Nottingham University Hospitals NHS Trust, which launched in September

Dr Bill Kirkup himself said:

> "When I reported on Morecambe Bay maternity services in 2015, I did not imagine for one moment that I would be back in seven years' time talking about a rather similar set of circumstances and that there would have been another two large, high-profile maternity failures as well on top of that." "We cannot go on like this. We have to address this in a different way. We can't simply respond to each one as if it's a one-off, as if this is the last time this will happen. We have to do things differently."

The Maternity department within ESHT support the recommendations in the East Kent report, which are (in summary)

Recommendation 1

- The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

Recommendation 2

- Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.
- Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.

Recommendation 3

- Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.

- Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development

Recommendation 4

- The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.
- Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.
- NHS England (NHSE) reconsider its approach to poorly performing trusts, with particular reference to leadership.

Recommendation 5

- East Kent Hospitals University NHS Foundation Trust to accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

Today needs to be a turning point for NHS maternity services across the country, and so we must work together with an agreed understanding of the problems and build a united vision of the steps that need to be taken to ensure safer maternity services for all.

ESHT ASSURANCE AGAINST FINDINGS OF THE REPORT

NHSE/I have advised that a single assurance process will be provided to Trusts in order that they upload evidence, at present this tool has not been disseminated.

It has been agreed with the LMNS that a system wide assurance tool will be provided for use at Trusts within our LMNS to ensure a unified process for assurance, at the time of writing this report the tool has not been disseminated.

An initial gap analysis has been completed within ESHT and assurance identified and evidenced as below:

Rec	Assurance	Immediate actions
1	1. Using National data sets to compare against local data e.g. stillbirth data. 2. PQS assurance process introduced in April 2022 allows good oversight of key safety and quality data and analysis at LMNS and Trust level, including monitoring of mandatory Trust and mandatory maternity training 3. ESHT have a robust Governance process within maternity and Neonatal services which includes external overview of higher risk cases as part of the agreed LMNS process (in line with Ockenden requirement)	Awaiting a National update, currently using data sets and analysis to inform actions/audits/reviews Maternity services are working locally and with the Trust & LMNS to introduce the PSIRF process (timeline for commencement April 2023) DOM/HOM working with Governance team to further improve the triangulation of data 8. Historical SI 2015-present thematic review (including

	4. DOM/HOM/Clinical lead have good oversight of service delivery, attend risk management, M&M, ATAIN, MBBRACE meetings as examples 5. Monthly triumvirate meetings for service overview, with action taken as required 6. HSIB cases 2017 - 2021 thematic review completed 7. Digital quality Improvement Steering Group/Process Map/Alignment of measures on PQS dashboard to regional and national measures Appointment of maternity specific data analyst. LMNS has given support to ensure correct reporting	external representation) planned for Q4 22/23
2	1. Trainee mandatory maternity specific training currently <90% 2. Medical Appraisal rate for Maternity 100% 3. Multidisciplinary training (Prompt) includes civility matters & key clinical local learning is included within sessions (updated annually). >90% compliance 4. RCOG – Duties of a Hot Week consultant guideline – audited annually (and ESHT are compliant) 5. ESHT are CNST compliant with robust processes for listening to families and acting on this feedback – excellent MVP processes – LMNS and Board approved LMNS annual plan for improvement 6. Consultant workforce fully recruited 7. Obstetric leadership requirement in line with Ockenden requirements 8. Robust performance improvement process within ESHT 9. Quarterly Local Faculty group meetings – overall positive feedback in October 2022	Awaiting a National update, however ESHT have good processes in place Antenatal education – increasing need in East Sussex to ensure birthing people are fully informed and enabled to make informed choices – discussed at October MVP meeting Continued focussed work on ensuring all staff complete Mandatory training & staff appraisals Working to improve data triangulation and audit annually to assure ourselves of continued improvement
3	1. Quarterly Local Faculty group meetings – overall positive feedback in October 2022 2. Excellent preceptorship programme for newly qualified midwives and Midwives new to ESHT	*Awaiting National update*

	3. Recruitment and Retention project lead in post 4. Excellent communication links between Brighton University HOM/DOM – timely response to any concerns raised	
4	1. National guidance adhered to in respect of family involvement e.g. MBRRACE/ PMRT/ Investigations 2. Maternity Board bi-monthly with Board Safety Champion and Trust Board representation 3. DOM presents a quarterly overview and assurance paper at Trust board 4. HOM/DOM provide monthly Assurance/risk analysis to Quality and safety committee 5. DOM in assurance post, managed by Chief nurse 6. Positive NHSE/I assurance visit in August 2022 – actions addressed and monitored through Maternity Governance processes 7. Divisional quadumvirate are participating in cohort 1 of the perinatal culture and leadership program (commenced November 2022)	*Awaiting National update*

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

Governance & Accountability Meeting 25/11/22
Maternity Assurance Meeting 30/11/12

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

This report is for assurance.

Ockenden Assurance & Insight Visit Report
ESHT progress against Action Items
V1.2 November 2022

KEY
Blue - Complete
Green - on target for completion
Amber - unlikely to reach target
Red - overdue

	Recommendations	Requirement	Action Required	RAG Status	Lead/Date for completion	In progress/completion comments
1	Trust to work with the LMNS & Region to ensure there is an effective system wide process to attain external reviewer's opinion on all perinatal deaths and neonatal brain injury.	Limited external reviewers. Midwifery reviewer attends: PMRT, professional reviews. SI submitted to external reviewer, L3 discussed at LMNS once complete.	Link with LMNS and central governance to set up a system of external reviewers, including maternity, obstetrics and neonatology, anaesthetics		BL - process agreed for implementation with immediate effect.	Meeting held Oct 22 to discuss implementation of a robust process, database now available with external reviewers by profession. Further meeting with Trust Governance Lead (Margaret England). Agreed to implement review process with external reviewers with immediate effect.
2	The Trust are encouraged to create opportunities that provides the regular contact for the NED & MVP to meet and share ideas.	NED attends bi monthly MVP meetings. To plan regular walkabouts from October 2022	DOM will discuss further opportunities with NED and MVP Chair.		BL - met with NED safety Champion 21/10/22 and agreed annual engagement plan.	Deep dive completed October 2022 with MVP. Annual plan agreed, bimonthly meetings in progress, 15 steps walkabout date TBC.
3	Trust to add the role descriptor for the NED to the Maternity Board ToR and set out the role of individual key members.		BL/DP TORS reviewed, included role descriptors, approved at Maternity Board 9/9/22		BL - completed - available in S drive (maternity Board TOR's)	Completed 9/9/22
4	A robust solution is urgently required to address the current issues around staffing levels and the unsustainable on call cover provided by community midwives .	In progress: full service on call provision, consultation to be launched Dec 22 complete by Feb 23		Target for completion Feb 23	AN - Entire process due for completion Feb 2023	On track for completion by planned date. Listening events completed October/November 2022
5	Trust to specify the timing of the consultant led ward rounds within the 'Duties of the Hot Week Consultant' document in line with the Ockenden recommendations	Ward rounds at 08:30 and 17:30 hrs daily, added to duties of the hot week consultant guideline Sep 22.	Action completed		BL/NR - completed - available-within roles of the hot week consultant guideline	Completed July 2022
6	Trust SOP / Guideline where the specification that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead to be shared with the LMNS and Regional Maternity Team.	Personal Care Guideline contains details. No specific SOP or guideline for complex as whole, have individual guidance dependent on specific complexity - DP/ GC currently working on this guideline Maternal medicine hub guidelines in progress Badgernet provides triggers for midwives booking women and birthing people for referral of varying conditions and referral timings	Action progressing, target completion date: end October 22, approval via governance process by end of Nov 22.	Target for completion Nov 22.	NM (consultant Midwife) - progressing as planned	Areas of the guidance required review by paediatrics - now completed - guideline scheduled for November Governance & Accoutnabilty Meeting.
7	The Trust to review the guidance on personalised care and include that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead. And to specify the minimum expectation on the referral to appointment time with the consultant for women with complex pregnancies.	Currently being updated in line with action 6	Action progressing, target completion date: end October 22, approval via governance process by end of Nov 22.	Target for completion Nov 22.	NM (consultant Midwife) - progressing as planned	Guideline scheduled for November Governance & Accoutnabilty Meeting.

8	Trust to ensure all staff are aware of and have access to guidelines. Ensure guideline embedded into staff clinical practice	Currently available on the Extranet. Information shared on medical induction. Access covered in mandatory study days annually.	Trust to improve Extranet documentation search function.	Target date Dec 22	Transformation midwife (AN)	Raised through IPR in Oct 22, remains challenging to access guidelines and policies. For further discussion at IPR Nov 22. 1. Setup new 'Maternity policies, guidelines and SOPs' page on the Maternity area on our Extranet, which has direct links to all maternity policies and guidelines and SOPs, under two headings, for ease of use: http://nww.esht.nhs.uk/task/maternity/maternity-policies-guidelines-and-sops/ - staff advised 2. Reviewed SOPs and guidelines for most frequenctly used search terms to improve effectivness of search funcation (GC)
9	Inclusion of the definition of Antenatal Risk Assessment to be included within the Trust guidance.	In progress	To include in personalised care plan	Target for completion Nov 22	Nicky Mason	Guideline scheduled for November Governance & Accoutnabilty Meeting.
10	Trust to continue to work with the LMNS regarding their QI project of reintroducing the My Choices for pregnancy, birth and beyond.	PCSP action taken forward within the WASP training programme. This is personalised care training provided by an external team (12 ESHT applicants MW's and MSW's) on the course.	QI plan to relaunch the PCSP. Posters prepared to put up in staff areas and we VLOG to support staff re discussing PCSP at each contact. To set up procurement order hard copies. Action for : Deputy transformation lead	Target for completion Nov 22.	Interim Transformation lead to commence and complete November 2022 RP/AN	Progressing as planned by Lead Transformation Midwife Xanthe Hayes - new interim lead to complete this action Nov 2022
11	Trust to share the link to the 'Useful Information and Leaflets' web page once updated with the Regional Team.	Maternity website is currently being updated as part of digital workstream. Videos completed for updated unit tours specialist discussing roles and services offered, currently being edited. MVP involvement throughout this process	To create QR codes for A/N and inpatient waiting areas for direct access to videos = website access. Leaflets currently being updates. Action for completion Oct/Nov: RP: Maternity Service manager	Target for completion Nov 22.	Interim Transformation lead to commence and complete November 2022 RP/AN	progressing as planned by Lead Transformation Midwife Xanthe Hayes - new interim lead to complete this action Nov 2022

Maternity Incentive Scheme (CNST) – Year 4

Meeting information:	
Date of Meeting: 26th October 2022	Agenda Item:
Meeting: Maternity Assurance	Reporting Officer: Alison Newby Head of Midwifery, Brenda Lynes, Director of Midwifery

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

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

Summary:

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

NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS) to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in previous years, members contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions (as described in this report). Trusts that can demonstrate they have achieved compliance with all ten safety actions, will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that are unable to demonstrate compliance, will not recover their contribution to the CNST incentive fund, but may be eligible for a small discretionary payment from the scheme to help make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Year four of the maternity incentive scheme was relaunched in May 2022, with further updates received in October 2022.

This report provides confirmation that ESHT (Women, Children and Sexual Health Division) have met the criteria for all ten safety actions in line with guidance provided by NHS Resolution. Each safety action with criteria is set out within this report; further evidence is stored within a secure database, available for review upon request.

An internal review of all 10 actions was completed by the division on 3/11/22, a further audit of evidence was completed by the TIAA on 14/11/22, both reviews found ESHT compliant with meeting the criteria for all ten safety actions.

Division Report WCSH

Meeting information:	
Date of Meeting: 26/10/2022	
Meeting: Maternity Assurance Meeting	Reporting Officer: Alison Newby / Brenda Lynes

1. Introduction

ESHT have reviewed its compliance against the CNST and confirm compliance against all Safety actions currently as listed within this report.

Safety action 1
Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths to the required standard?

ESHT confirm compliance with this safety action.

The NPMRT tool into Governance arrangements; this process has been in place since January 2018. In line with the required standard:

- All perinatal deaths eligible to be notified to MBRRACE-UK from 6th May 2022 onwards, have been notified to MBRRACE-UK within the required 7 working day timeframe. Deaths have been excluded where surveillance forms needed assignment to another Trust for additional information.
- A PMRT review was undertaken within two months of each death, for all deaths reported in Q1 (April – June 2022). No eligible cases were reported in Q2 (June-September)
- A multidisciplinary (MDT) PMRT review was completed, within four months of the death, in 80% of cases reported in Q1. Compliance is 50%.
- A multidisciplinary PRMT review report was published within six months of each death, for 80% of cases reported in Q1. Compliance is 50%.
- Parents' perspectives and questions/concerns have been sought for all reported deaths in Q1. Compliance is 95%.

Quarterly reports and action plans have been reviewed and submitted to the Trust Board. These reports include details of all deaths reviewed and have been discussed with the Trust maternity safety and Board level safety champions.

Safety action 2
Are you submitting data to the Maternity Services Data Set to the required standard?

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

ESHT can confirm full compliance with the following requirements:

- An updated digital strategy has been agreed by the Trust Board. This aligns with the wider Trust digital strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy has also been shared with Local Maternity Systems for sign off by the Integrated Care Board. As part of this, dedicated Digital Leadership is in place within the Trust and engagement with the NHSEI Digital Child Health and Maternity Programme has taken place.

  Updated guidance received in October 2022, stated that if it is not possible to obtain Integrated Care Board sign-off for new strategies, then sign-off by another appropriate governance board will be acceptable (e.g. LMNS Board). The ICS signoff process is currently being finalised.

- Interim assurance has been provided that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file, for data submissions relating to activity in July 2022, is required. This includes:

    - Height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in July
    - Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in July.
    - Antenatal personalised care plan fields completed for 95% of women booked in July. (MSD101/2)
    - Valid ethnic category (Mother) for at least 90% of women booked in July (*not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstance*s). (MSD001).

In addition, data quality criteria in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022, has been achieved for the following metrics:

    - Midwifery Continuity of carer (MCoC)
    - Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.
    - Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.
    - At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion.

- Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation.

- Criteria iii are fundamental building blocks and a necessary step towards measuring whether or not women have received midwifery continuity of carer (though it is not the complete measurement).

Final confirmation is expected during October 2022.

Safety action 3
Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

ESHT confirm that compliance has been achieved with all required elements of this Safety Action:

- Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.
- The pathway of care into transitional care has been fully implemented and is audited quarterly using data captured via the Badgernet system. Audit findings from Q4 (Jan-March 2022) and Q1 (April-June 2022) have been shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting. Quarter two (July-September 2022) will be shared in December.
- Data relating to all term babies admitted or transferred to the neonatal unit is in place, electronically via Badgernet and on paper via the admission book.
- Existing transitional care activity (regardless of place - which could be a Transitional Care

(TC), postnatal ward, virtual outreach pathway etc.) for all babies between 34+0 and 36+6 weeks gestation at birth is captured via Badgernet. This is monitored monthly.

- Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2, is available and is shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.
- Reviews of babies admitted or transferred to the neonatal unit are undertaken on monthly via ATAIN review meeting. In addition, transfers/admissions to the neonatal unit, that would have met Transitional care criteria, but were transferred/admitted to the neonatal unit due to capacity or staffing issues, or those who remained on the neonatal unit because of nasogastric tube feeding have also been shared with the maternity, neonatal and Board level safety champion, LMNS and ICS quality surveillance meeting for Q4 and Q1.
- ESHT have an action plan which has been discussed and agreed at Board level (IPR) and with our Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews.
- Progress with the agreed action plan has been shared at the ATAIN Business Meeting, Maternity Board and with the LMNS & ODN.

ESHT continue to assess our transitional care provision, in line with ATAIN. Learning from Q4 and Q1 audit findings includes:

- Improved documentation secondary to the implementation of Badgernet within the maternity department. However, examinations prior to assisted birth and the reason for change to devices used needs to be clearly documented, along with APGAR scores, cord blood gasses and estimated blood loss (EBL).
- Review affected by the availability of a printed CTG recording. Appropriate storage of printed CTG recordings until solution found to WIFI connectivity to allow for automatic storage to Badgernet. This is currently a risk register entry.
- There needs to be clearly documented discussion and care planning in respect of the risk of SCBU admission where a diagnosis of gestational diabetes (GDM) is made
- Regarding the assessment of fetal growth, two cases highlighted a discrepancy between the estimated and birth weight. This is being monitored by the ultrasonography manager.
- Planned review in respect of practice requirements and advanced skills of nursery nurses to manage nasogastric tube feeding as transitional care.
- Hypothermia has been identified as a secondary reason for admission to SCBU. ESHT have implemented an ongoing joint perinatal improvement project as part of the MatNeo Improvement Hub.
- There is a Prevention of Dropped baby Leaflet and a form to be completed on Badgernet. There was a low-risk rating as the mother had no analgesia, other than paracetamol 20 minutes earlier.

Safety action 4
Can you demonstrate an effective system of medical workforce planning to the required standard?

ESHT confirm that we achieve the required Safety action;

A) Obstetric Workforce:
There is a local guideline in relation to the duties of the Hot Week Consultant. This incorporates the principles outlined in the RCOG Workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'.

Compliance with the recommendations within the guideline has been demonstrated in a recent audit. An action plan has been shared with the consultant body and will be monitored by the clinical effectiveness midwife.

The maternity department is compliant with the requirement for twice daily consultant ward rounds, 7 days per week. This is monitored monthly via the PQS dashboard which is shared with the Trust Board and LMNS.

B) Anaesthetic Workforce:
Anaesthetic workforce rotas demonstrate compliance with ACSA standard 1.7.21 - the requirement for a duty anaesthetist to be immediately available for the obstetric unit 24 hours a day, with clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients as detailed below:

Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff

2.6.5.1 A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident

2.6.5.2 A separate anaesthetist is allocated for elective obstetric work

2.6.5.3 Where the duty anaesthetist has other responsibilities, an anaesthetist must be immediately available (within five minutes) to deal with obstetric emergencies

2.6.5.4 Medically-led obstetric units have, as a minimum, consultant anaesthetist cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed)

2.6.5.5 There is a named consultant anaesthetist or intensivist responsible for all level two maternal critical care patients (where this level of care is provided on the maternity unit)

2.6.5.6 The duty anaesthetist for obstetrics attends hand over meeting daily

C) Neonatal Medical Workforce:
ESHT can confirm the neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

D) Neonatal Nursing Workforce:
ESHT can confirm that the neonatal unit meets the service specification for neonatal nursing standards and uses a specific workforce calculation tool.

Details of the maternity team workforce; midwifery, obstetric, neonatal and neonatal nursing is included in a six-monthly review, which is submitted to the Trust Board and LMNS.

Safety action 5
Can you demonstrate an effective system of midwifery workforce planning to the required standard?

ESHT confirm that we achieve the required Safety action;

A systematic, evidence-based process is used to calculate midwifery staffing establishment this was last completed in February 2022 using Birthrate+. This was supplemented with a bespoke local workforce uplift review and further workforce review on behalf of the Regional Chief Midwife's office. Results have been shared with the Trust Board and the LMNS to confirm budgets reflect establishment.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.

The obstetric unit midwifery labour ward coordinator has supernumerary status enabling oversight of all birth activity in the service, supporting and assisting other midwives. Updated guidance received in October 2022, defines supernumerary status as not having sole responsibility for any 1:1 care for a labouring woman or relieving for a break (even for a short period) a midwife who is providing 1:1 care for a high risk woman requiring constant observation. This also includes supervising a student midwife providing 1:1 care. This is monitored via the quarterly workforce, red flag and acuity report which is shared with the Trust Board and LMNS.

Women cared for within ESHT's delivery suite receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on). This is monitored via the monthly PQS dashboard which is shared at the Maternity Assurance Meeting, Trust Quality and Safety Committee and LMNS.

ESHT provide a Bi-annual report that covers staffing/safety issues is submitted to the Trust Board (Maternity Board and IPR), this includes planned versus actual midwifery staffing levels, with an action plan to address findings.

Safety action 6
Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?

ESHT confirm that we achieve the required safety standard;

The Saving Babies Lives Care Bundle version two has been fully integrated into the maternity department since 2019.

Each element of the SBLCBv2 has been implemented and the department is fully compliant with quarterly survey and reporting requirements. Outcomes are shared with the Trust Board quarterly via the Maternity Assurance Meeting and Quality and Safety committee meeting.

Full compliance has been achieved in relation to the requirements for **element 1**:

A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.
B. Percentage of women where CO measurement at 36 weeks is recorded.

An action plan has been agreed to achieve the target rate of >95% compliance with CO monitoring at booking and 36 weeks' gestation.

All interventions outlined in **element 2** have been successfully implemented, the introduction of the badgernet maternity system has seen an improvement on a more robust risk assessment for FGR at booking, this allows correct stratification into high, moderate and low risk with a surveillance pathway as per the Saving babies' lives scanning algorithm and incorporates the aspirin risk assessment using the algorithm in Appendix C of SBL, these are also incorporated into our local guidelines.

Full compliance with **element three** has been achieved through the implementation of Badgernet, which has enabled an automatic recommended reading 'push notification' of the Tommy's evidence based fetal movements information leaflet to all pregnant people's Badgernet app by 24 weeks of pregnancy, we are therefore 100% compliant with the SBL process indicator that people who have booked for antenatal care receive leaflet/information by 28 weeks of pregnancy.

Dawes Redman computerised CTG analysis and RFM checklist is embedded within ESHT practice and guidance. RFM management and computerised CTG use audited monthly.

Computerised CTG analysis is included within our MDT fetal monitoring day both practical equipment use and Dawes Redman guidance.

All obstetric staff that contribute to the obstetric rota and midwifery staff undertake annual training and competency assessment. We have introduced a full MDT fetal monitoring study day since February 2022 and are in the process of transitioning from K2 fetal monitoring package. This along with CTG equipment training, intrapartum risk assessment, situational awareness, human factors and escalation training has contributed to full compliance with **element 4**. In addition, the Fetal Wellbeing Lead attends the monthly LMNS safety forum to examine outcomes, understand variation and inform potential improvements across the system.

The Trust is compliant with all actions contained within **element 5**. The department has a dedicated Lead Consultant Obstetrician, with demonstrated experience to focus and champion best practice in preterm birth prevention. The risk of pre-term birth is assessed at booking for ALL pregnant people. Identified pregnancies at intermediate or high risk of preterm birth are referred to consultant led care. MSUs are sent for all at booking to screen for asymptomatic bacteriuria. People at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided.

Placental histology is undertaken for ALL births <34 weeks' gestation. This is to determine whether it was associated with placental disease. A full aspirin risk assessment is undertaken at booking which includes placental disease as criteria for aspirin to be prescribed as per appendix C of SBL.

Corticosteroids for fetal lung maturation and magnesium sulphate for fetal brain protection is well established and all preterm births are audited monthly for compliance by the fetal wellbeing team, who review all preterm births <34 weeks to identify any learning points or missed opportunities to optimise preterm birth.

Any cases identified as being non-compliant with any with any Saving babies lives intervention are outlined in each quarterly report which is submitted to the Trust Board via the Maternity Assurance and Quality & Safety Committee.

Safety action 7
Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

ESHT confirm that we achieve the required Safety action;

ESHT has strong feedback mechanisms ranging from online platforms to user forums to allow for the continuous improvement of maternity services and to enhance the experience of its patients.

One mechanism used is the (Maternity Voices Partnership) MVP which includes staff and service users. The forum is active at both the EDGH and the Conquest Hospital. In addition to ad hoc and regular monthly service user feedback, quarterly meetings are scheduled. These meetings are chaired by a lay co-chair. There is a formal agenda, a programme and minutes are circulated after each meeting (available on request). Discussions in these meetings comprise service user feedback, and initiatives and improvements currently being undertaken at ESHT. The MVP has an agreed work programme and is also part of a project group working to develop the Eastbourne Midwife Unit (EMU). Further co-produced projects, including fifteen steps and induction of labour pathway. A co-produced annual plan of work informs ESHT's annual maternity plan.

To enable greater reach of feedback there are also informal feedback mechanisms that are administered by the maternity team on online platforms such as Facebook. This allows for candid feedback and a greater portfolio of feedback to ensure the service meets the need of all of its users. This has helped staff morale as the feedback through these platforms is easier to give and the service often receive very complimentary feedback.

The Friends and Family Test is another mechanism that has been embedded into the service to drive improvement. The results are shared amongst all staff through team meetings, Frankie's News and Theme of the Fortnight, by the Matrons as a regular agenda item. Any issues are discussed, and an atmosphere of learning has been developed to allow for fast action and mitigation of risk. Service users also have the ability to feed back through the Trust's website.

Maternity strategy – The Trust's maternity services strategy was been developed with the multidisciplinary team and MVP feedback.

Safety action 8
Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year

The maternity department has an agreed training needs analysis which includes all six core modules of the Core Competency Framework, over 3 years, starting from the launch of MIS year 4 in August 2021.

Updated guidance received in October 2022 specifies the reporting period to be any 12 consecutive months within the period: 1st August 2021 until 5th December 2022.

The training syllabus is based on current evidence, feedback on local and neonatal outcomes, national guidelines and national and local recommendations, relevant local audit findings, risk issues and case review feedback are used to plan the sessions, this includes the use of local charts, emergency boxes, algorithms and proformas. The Board has sight of training numbers monthly via the PQS dashboard and annually in the training report.

The division uses PROMPT training, which includes fetal monitoring in labour; using integrated team-working, relevant simulated emergencies and/or hands-on workshops.

ESHT can confirm we comply with the requirements as set out below;

Maternity Unit Staff Group	*% attended Training year ending March 31st 2019*
Obstetricians (including Consultants, staff grades and trainees);	*The Obstetric Consultants/Registrars are either leads or helpers on the PROMPT day throughout the year –**100%** of the Obstetricians have completed PROMPT*
Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres) and bank midwives); Including Maternity Support workers and Maternity staff nurses Nursery Nurses and Specialist Midwives	MSW – unqualified staff **92%** Midwives and Staff nurses Qualified **95%**
Training also open to, Theatre staff, Student Midwives join us on a regular basis	Maternity Theatre staff **96%**
Anaesthetist	**100%**
Neonatal	Staff in attendance at deliveries should be included for immediate newborn resuscitation training as lited below • Neonatal Consultants or Paediatric consultants covering neonatal units 100% • Neonatal junior doctors (who attend any deliveries) **100%** • Neonatal nurses (Band 5 and above) **92%** • Midwives (including midwifery managers and matrons,

	community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and Maternity theatre midwives who also work outside of theatres. **95%**

Safety action 9
Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

ESHT confirm that we achieve the required Safety action

There is an agreed pathway that describes how safety intelligence is shared from floor to Board, through the local maternity and neonatal systems, which has been reviewed by the Regional Chief Nurse. The agreed perinatal quality surveillance system reports are shared monthly through the Trust, LMNS, ICS and regional quality groups as required.

The Trust Board have been sighted on the local improvement plan and updated on progress, impact and outcomes

- LMS quality and safety meetings are attended by the Director of Nursing (Safety Champion), Director of Midwifery and HOM (Safety Champion)
- Safety Champions are key members of the maternity Board
- The Maternity PWS dashboard is published to staff and the Trust Board monthly/quarterly. Staff concerns are discussed at the Midwifery Information Forum (MIF). Action plans from the Staff Survey are tracked through MIF.
- Monthly safety forums take place online with the HOM, Board and Non-Exec safety champion and staff members.
- Monthly safety champion walkabouts are scheduled but have been affected by extreme pressures within the Trust. Regular walkabouts have now been scheduled.
- Posters with details of Safety champions are displayed in all clinical areas. Safety Champions are invited and attend Maternity Board meetings
    - Board Safety Champion – Vikki Carruth (Director of Nursing)
    - Trust Safety Champion – Dexter Pascal (Clinical Lead for Maternity)
    - Neonatal Safety Champion – Mani Kandasamy (Neonatal Lead)
    - Maternity Safety Champion - Alison Newby (Head of Midwifery)
    - Non-Executive Safety Champion – Amanda Fadero (Non-Executive Director)

Board level and Maternity safety champions champions actively support capacityand capability building for staff to be involved the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)

Trust Boards have reviewed current staffing in the context of letters to systems on 1st April 2022 and 21 September 2022 regarding the rollout of Midwifery Continuity of Carer (MCoC) as the default model of care. A decision was made regarding the continued roll out of MCoC.

Safety action 10
Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?

The Trust Board have sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team.

ESHT can confirm that we have a Governance process in place which includes reporting all qualifying incidents to NHS Resolution under the early Notification scheme reporting criteria through Legal Services.

Artillery House
Fort Fareham
Newgate Lane
Fareham, PO14 1AH

06 December 2022

Vikki Carruth
Chief Nurse and Director of Infection Prevention and Control
East Sussex Healthcare NHS Trust

Dear Vikki

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Return: Internal Audit Validation

The purpose of this letter is to report our findings and conclusions following a meeting on Monday 14th November with Maternity Services management, when we went through the evidence that supports the Trust's self-assessment against the CNST MIS return. The Trust has self-assessed as compliant with the 10 MIS safety actions.

The scope of the review is to provide assurance to the Board on the validity of the completed CNST MIS self-assessment. The assurance supports the Board's review and the requirement for the Board to give permission to the Chief Executive Officer to sign the Board Declaration Form.

Findings and Conclusion:

Evidence was presented by the Maternity Services team in support of each of the 10 maternity safety actions set out in the NHS Resolution document 'Maternity incentive scheme – year four'. The focus of the review was on the 'minimum evidential requirement for Trust Board' as described in the document for each action.

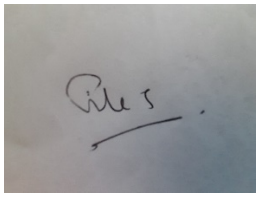
The evidence was presented via a spreadsheet record with embedded supporting documents and links. The evidence was found to be comprehensive and relevant to the action and required standards. Further explanation and supporting evidence was provided for elaboration on some of the actions, although it should be noted that the audit did not entail a comprehensive 'deep dive' across each of the actions. For a few actions, it was agreed that linking further information would enhance the evidence base.

A triangulation exercise was also undertaken with the Maternity Services team in respect of a recent NHSE / Insight review and a recent CQC inspection. The action items from these external reviews were considered and it was noted that these did not conflict with the MIS assessment. It was also evident that there has been regular reporting on progress with MIS and other action plans through to the Quality and Safety sub-committee of the Board.

On the basis of the above, TIAA can give assurance that there is a good body of evidence which supports the Trust's self-assessment against the 10 MIS safety actions.

Please let us know if you have any queries.

Yours sincerely



Giles Parratt

Director of Audit

cc see distribution with covering email

ESHT DIGITAL STRATEGY 22/23 - 24

ESHT has an extensive programme of digital works planned for 22/23 to deliver its SMART objectives, with a high-level roadmap to 2024. All planned digital development is in line with the NHS long term plan and national Equity and Equality priorities, specifically priorities 2, 3 and 4b.

Sussex LMNS' key objectives are to; develop solid digital foundations across Sussex to ensure seamless transition of care between trusts to improve safety and data quality. Develop a solid digital strategy and roadmap to facilitate the codesign of digital systems and services to empower service users to self-serve. Aim to have a Service User Experience consultant working with strategic digital experts on all projects. Build on our perinatal equity analysis to engage specifically with population groups and measure progress through the development and capture of a wide range of outcome measures which are broken down by ethnicity, protected characteristics, and deprivation.

The LMNS digital transformation strategy aligns with the MTP key priorities and NHS Digital's 'What Good Looks Like' framework, these are outlined below - ESHT have combined the key objectives of the LMNS and have aligned to the ESHT digital strategy

MTP 7 key priorities

1. To empower Women
2. Improve patient safety
3. Digital maturity
4. Personal maternity digital care records
5. Mitigate against digital exclusion
6. Improved Data
7. Action on maternal mortality, morbidity, and experience

No	Project	Project overview	Strategic Goal	ESHT Goal + Action	ESHT Trust Digital Strategy	Deadline	LMNS RAG	LMNS Project detail	ESHT RAG	ESHT Project update
1	**Digital Personalised Care and Support Plan** Pilot	Take the paper PCSP and create a digital version that is accessible via a smart device. Run a pilot to collect user data before rolling out across Sussex.	**To Empower Women** to access the and interact with curated healthcare information, personalised care and support plan and their data in order to make informed decisions **Action on maternal mortality, morbidity and experience** - Guidance for local maternity systems describes how to implement PCSPs, including the need for a risk assessment at every contact.	Not started as yet. Rollout plan for Dec 2022	Patient Self Service and Engagement	 TBC	Not Started	**Digital Personalised Care and Support Plan** LMNS- We are piloting our locally developed digital PCSP with one Trust for 1/3rd of our service users. We have developed sign up using the NHS app and worked with PKB to get the PCSP inside the Sussex My Health and Care Record. We need digital expert resource to further develop the final digital product through service user engagement and co-production. We aim to offer translated and 'easy read' formats, replicating the hard copy approach, and make available to 100% of our service users. Levelling up access, reflecting our perinatal equity analysis identified needs. Aligned with MTP priority 1 and 7 and NHS D WGLL Success measure 5, Empower citizens. NHS Planning guidance KLOE FOR PCSP's in multiple formats. Q6/21 - to date - Pilot will stay live until full rollout is complete across LMEs. Pilot still collecting user data which will roll into live environment.	Not Started	**Digital Personalised Care and Support Plan** Continuous involvement in the LMNS Transformation steering groups to support the development of the digital PCSP across the system and mitigate any delays in the rollout. Temporary and less detailed Personalised care plan being used with the Maternity IT system- BadgerNet.
2	**Maternity Information System**	Offer ongoing support to Trusts with the rollout and implementation of new MIS systems.	**Improved Patient Safety clinical** and other practitioners have access to relevant and timely information at any point of care that allows them to ensure the best health and care outcomes for pregnant women. **Digital Maturity** – Improving the user experience for clinicians and women including the reduction in burden of data entry, on reducing duplicate data entry and driving towards paperless environment.	Badgernet system implemented within ESHT. Wi-Fi upgrade in progress, once completed remote CTG function will be added. Upgrade and integration of Viewpoint.	Reduction in Clinical system, Patient held Records, integration between system, convergence across ICS and LMNS	21/24	On Track	**Maternity information system (MIS) including electronic maternity records** Nationally compliant MIS are in place in 4 of 6 maternity sites currently, with 33% of service users having full access across the pathway and 30% having antepartum access with the intrapartum model going live Dec 21. Uni Sx West are submitting a bid to roll out the MIS to their remaining two sites which will mean 100% of Sussex service users have access to e-records. Digital expert resource required to align implementation of key Sussex wide aspects of the maternity digital approach, ensuring service user access does not vary between sites and midwives can provide seamless care in Sussex is key and enables interoperability with the wider Sussex SDL and my health and care record. Aligned with priority 2, 4, 6 and NHS D WGLL Success measure 2, Ensure smart foundations 6, Improve care, 4, Support people. Improve data capture and therefore quality, meeting the requirement for MSDS2 data from each service. E-records aligns with priority 1, 3 and NHS D WGLL Success measure 5, Empower citizens, 6, Improve care.	On Track	**Maternity information system (MIS) including electronic maternity records** Badgernet rollout complete.
3	**Self-Referral forms**	Utilise Digital technology and systems, such as BadgerNet and PAIL to identify and improve digital functions across Sussex.	**Improved Patient safety** – Enabling digital solutions and developments to address locally identified digital improvements to support quality and safety improvements/concerns	ESHT digital team to support the Sussex rollout	Patient Self Service and Engagement	21/24	Not Started	**Digitise requirements forms for maternity and postnatal physiotherapy** Sussex, as an early adopter for perinatal pelvic health services, is developing a single pathway for postnatal physio including a SPOA which will achieve the national deliverables for this work including increased identification, prevention of and access to treatment. We currently have 4 pathways in Sussex, with significant variation in service user access and experience, variable midwifery knowledge of pelvic health and subsequently differing rates of pelvic damage. We will develop, training materials, standardised digital referrals, and push notifications along our pathway to support increased service user awareness and support to prevent harm, improve midwifery knowledge and prevention as well as a seamless referral process through the My Health and Care Record. Utilise digital technology and systems to identify and improve digital functions across Sussex. Aligned with priority 1, 3, 6 and NHS D WGLL Success measure 5, Empower citizens, 6, Improve care.	Not Started	**Digitise requirements forms for maternity and postnatal physiotherapy** ESHT physio leading on this project and newly appointed midwife at ESHT to support the delivery of improvements within this service. Predicted start date September/October 2022. Pelvic dysfunction risk assessments are being developed and work has begun to integrate these into ESHT's MIS system to streamline referals and expedite prevention/treatment pathways. Antenatal, intrapartum and postnatal pathway mapping has been completed and a Training needs analysis is being drafted.
4	**Website**		**To Empower Women to access the and interact with curated healthcare information,** personalised care and support plan and their data in order to make informed decisions	ESHT Maternity website is currently in the process of being updated	Patient Self Service and Engagement	21/24	On Track	**LMNS website** We currently have a page on the SHCP website which does not meet the national requirements for an LMNS website, which must support access to curated information and support for service users. The PCSP mitigates this to some extent as all information is linked to curated national sources. The website will enable curated Sussex information to be accessed easily, as well as providing information on our local services and quality information to support choice. Aligned to the ICS preferred platforms and approach and purchase a mechanism for translating content in addition to the content we develop for different population groups. The website will need to meet accessibility criteria, focused digital planning, engagement, and co-production. Aligned with priority 1 and NHS D WGLL Success measure 5, Empower citizens	On Track	**ESHT website** ESHT have midwives involved with the local maternity website design. On-track to launching website in September/October 2022. Website structure and content is being reviewed. Plans for video and 360 photos to be uploaded. MVP and service user involvement has already been initiated.
5	**Data** Data Quality improvement Health inequalities data requirement Equity & Equality Data requirements	Review data quality in line with national requirements.	**Ensure datasets are complete and timely** - on maternity information systems continuously improve the data quality of ethnic coding and the mother's postcode.	ESHT are working with LMNS & BI team to improve data quality. To work with Equality lead to further improve. Maternity Dat Analyst successfully recruited and starts on 1/6/22.	Improved Data Quality, increase reporting and Assurance	Ongoing	On Track	**Improved data quality** Work to develop the Perinatal Quality Surveillance model has identified significant variation in digital capture of robust maternity data, varying alignment of MIS with reporting into the MSDS2 data set and undermines the level of assurance of safety, outcomes and quality in maternity services locally. This has been discussed at our LMNS Board and captured as a corporate risk. Aligned with priority 2, 6, 7 and NHS D WGLL Success measure 4, Support people, 6, Improve care.	On Track	**Improved data quality** LMNS- Work to develop the Perinatal Quality Surveillance model has identified significant variation in digital capture of robust maternity data, varying alignment of MIS with reporting into the MSDS2 data set and undermines the level of assurance of safety, outcomes and quality in maternity services locally. This has been discussed at our LMNS Board and captured as a corporate risk. Aligned with priority 2, 6, 7 and NHS D WGLL Success measure 4, Support people, 6, Improve care. ESHT- Data Analyst role commencing 1/8/22- supported by the LMNS ESHT- data collected from the MIS for ethnicity and postcodes. On-going task and finish groups to ensure this data is collected and input accurately. This will be led by the data analyst when in post.
6	**Handheld digital notes**	Review what Badgernet offers in terms of handheld notes. Review what PKB can offer for maternity. Scope both out.	**Enable all pregnant women in England to access their personal maternity digital care records,** together with directed and assured supporting information, by March 2023 with full implementation by March 2024.	ESHT have implemented Badgernet which provides digital Maternity notes for all service users		21/24	On Track	**Handheld Digital Notes** Regional Teams are working to deliver My Health and Care records, a product that gives service users access to their healthcare record via the NHS app on their smart device or computer. The LMNS is utilising the same technology to deliver the PCSP and self-referral forms. The BadgerNet app also offers service users access to their maternity notes. Aligned to priority 1, 2, 3 & 4 and NHS digital's WGLL measure 2 Ensure smart foundations, and measure 5 empowers citizens.	On Track	**Handheld Digital Notes** Same as LMNS- Regional Teams are working to deliver My Health and Care records, a product that gives service users access to their healthcare record via the NHS app on their smart device or computer. The LMNS is utilising the same technology to deliver the PCSP and self-referral forms. The BadgerNet app also offers service users access to their maternity notes. Aligned to priority 1, 2, 3 & 4 and NHS digital's WGLL measure 2 Ensure smart foundations, and measure 5 empowers citizens.
7	**Digital Poverty** Sussex wide strategy for digital exclusion Focus Digital PCSP, PHBT Guidance and co-design with staff and MVPs	Work with and support IT teams across Sussex to develop and deliver a digital poverty strategy.	**Mitigate against digital exclusion** – ensure personalised care and support plans (PCSPs) are available in a range of languages and formats, including hard copy PCSPs for those experiencing digital exclusion	ESHT currently provide hard copies of records/ PCSP's and leaflets for those who experience digital exclusion. Leaflets can be printed in multiple languages		tbc	On Track	**Digital Poverty** Development of the Digital PCSP in both hardcopy and digital offers service users a choice in how they receive information about their care. The new LMNS website will offer users an accessibility bar that will support screen readers, translation and other accessibility tools to support disabled users. All information on the LMNS website can be printed by staff and given to those service users that do not have a digital device. Aligned to priority 2, 5 and NHS digital's WGLL measure 2 Ensure smart foundation's and 5 empowers citizens.	On Track	**Digital Poverty** Same as LMNS- Development of the Digital PCSP in both hardcopy and digital offers service users a choice in how they receive information about their care. The new LMNS website will offer users an accessibility bar that will support screen readers, translation and other accessibility tools to support disabled users. All information on the LMNS website can be printed by staff and given to those service users that do not have a digital device. ESHT will plan to integrate this onto the Maternity website when rolled-out within the LMNS website. Aligned to priority 2, 5 and NHS digital's WGLL measure 2 Ensure smart foundation's and 5 empowers citizens.
9	**Sussex training programme for BadgerNet**	Support Trusts in delivering BadgerNet digital training programme	**Ensure smart foundations** – Your workforce is digitally literate and are able to work optimally with data and technology. Digital and data tools and systems are fit for purpose and support staff to do their jobs well..	This priority sits with the LMNS	Supporting staff, providing the right tool and data	21/24	On Track	**Badgernet Training** Sussex LMNS will be developing digital MIS Badgernet training material with the digital leads and digital midwives across Sussex. The material will be accessible to clinical staff via the Professionals section of the LMNS website. ESHT is developing an e-learning package for new users to Badgernet. Aligned to priority 2, 3 & 6 and NHS digital's WGLL measure 2 Ensure smart foundations and 4 Supporting people.	On Track	**Badgernet Training** Sussex LMNS will be developing digital MIS Badgernet training material with the digital leads and digital midwives across Sussex. The material will be accessible to clinical staff via the Professionals section of the LMNS website. Aligned to priority 2, 3 & 6 and NHS digital's WGLL measure 2 Ensure smart foundations and 4 Supporting people.
8	**National requirements** Interoperability (what does this mean in practice?) National Record Standards	Support Trusts in delivering national requirements	**Digital Maturity** – Improving the user experience for clinicians and women including the reduction in burden of data entry, on reducing duplicate data entry and driving towards paperless environment.	ESHT working with the LMNS to improve the data set quality		21/24	On Track	**National Deadlines** Ensuring all national requirements are met.	On Track	**National Deadlines** Ensuring all national requirements are met.

Maternity Services: CQC 2017 - 2022 (item 12 & 13)

Purpose of the paper	The Chief Executive asked for an assurance paper reviewing CQC visit actions from 2016 until the present day. This report provides assurance that overall actions identified have been delivered and ongoing audit and review processes are in place to ensure services remain safe, effective, caring, responsive and well-led					
	For Decision		For Assurance	x	For Information	
Sponsor/Author	Sponsor: Vikki Carruth Author: Brenda Lynes					
Governance overview	WCSH Governance & Accountability Meeting 24/11/22 Maternity Assurance meeting 30/11/22 Trust Board 13/12/22					

Strategic aims addressed	Collaboration	Improving health	Empowering people	Efficient/Sustainable
		x		x

Values reflected	Working Together	Improvement & Development	Respect & Compassion	Engagement & Involvement
	x	x	x	x

Recommendation	The Board is asked to note the continued progress of the Maternity Service's improvement journey for assurance purposes

Executive Summary	The Care Quality Commission have inspected East Sussex healthcare Trust on four occasions between 2016 and 2022. Maternity Services have been inspected on three of these four visits: ✓ October 2016 (report published January 2017) ✓ March 2018 (report published June 2018) × November-December 2019 (report published February 2020) – Maternity Services were not inspected ✓ October 2022 (report is currently pending) This summary provides assurance on the maternity services journey of improvement. We await the 2022 visit final report and are currently working to implement the Birmingham Symptom-specific triage system (BSOTS) within the Day Assessment Unit which responds to the safety concern raised at the October 2022 visit. The implementation of BSOTS has been worked on by the area Matron for the past 6 months. Full Implementation is planned for 30/1/2022 following standardised training for key staff.

Next steps	The endorsement of this paper will allow for continued work as planned to continue the maternity improvement journey.

Maternity CQC Report 2017 - 2022

The Care Quality Commission have inspected East Sussex healthcare Trust on four occasions between 2016 and 2022. Maternity Services have been inspected on three of these four visits:

- ✓ October 2016 (report published January 2017)
- ✓ March 2018 (report published June 2018)
- × November-December 2019 (report published February 2020) – Maternity Services were not inspected
- ✓ October 2022 (report is currently pending)

1. 2016 versus current

A full inspection of maternity services took place in October 2016 with a number of actions identified as should do. Table A lists actions required and current position for those actions in November 2022. Table B outlines additional recommendations (noted as business as usual) which the department continue to deliver.

TABLE A

Actions from 'should do' recommendations
CQC inspection October 2016, report published January 2017

Action Required	Responsible (Lead/Group/ Committee)	Expected Outcome of Action	Actions taken 2017	Where we are: 2022 Update
Policies & Procedures Review maternity policies and procedures that are outside their review date and update so that they reflect current national and evidence-based guidance.	General Manager/Head of Midwifery W&C (Maternity IPR / Maternity Board)	A framework is in place to support the Division in ensuring policies are reviewed in a timely manner and reflect national evidence-based guidance.	All policies reviewed and framework in place. (Apr 17)	Framework remains in place. A policy section within the WCSH monthly Governance meeting monitors all policies & guidelines, out of date policies & guidelines escalated if action by identified staff has slipped. Currently for Maternity and Obstetrics 141 policies and guidelines – 17 out of date (12%), all 17 are currently under review and at various stages of being ratified
Medication locks Review all medication locks and ensure none allow unauthorised patient access.	Head of Midwifery/ward matron (Maternity IPR)	There are effective processes in place to ensure that all medication is secure and can only be accessed by authorised individuals.	All medication locks reviewed and effective (Feb 17)	A separate drug preparation room was completed during 2022, all drugs are double locked within this room (which has a keypad entry). Lockable Bedside service user self-administration boxes available – keypads to be added instead of keys (awaiting MI – Oct 2022) Delivery suite: all medication is locked in a cupboard within a lockable drug preparation room
Pool Evacuation Review the policy and procedure for pool evacuation to ensure actions required are clear	General Manager/Head of Midwifery W&C (Maternity IPR / Maternity Board)	The department has a robust policy in place - which has been tested - to enable a safe procedure for pool evacuation which is known by all staff.	Policy reviewed (Mar 17) Skills drills scheduled throughout 2017	Annual operational risk assessment currently written available on the assure site. Skills drill completed annually. Last drills: Conquest: March 2022 EMU: 25/11/22
Environment of the Day Assessment Unit Replace/repair the flooring in the Day Assessment Unit as it could be a trip hazard and improve the environment to make the room feel more welcoming.	General Manager/Head of Midwifery W&C (Maternity IPR / Maternity Board)	Women will have access to a Day Unit appropriate to their needs	Flooring replaced (Jun 17)	Day Assessment unit moved from Murray ward to Mirlees ward during 2021, this separated outpatient services from in-patient services. Mirlees ward has received a refurbishment during 2022 with further work planned during 2023. Most outpatient obstetric clinics have moved to Area B of outpatients on Level 3.

Action Required	Responsible (Lead/Group/ Committee)	Expected Outcome of Action	Actions taken 2017	Where we are: 2022 Update
HSA4 notification Develop a robust mechanism to monitor and audit abortion HSA4 notification completion.	General Manager/Head of Midwifery W&C (Maternity IPR / Maternity Board)	There is a process in place that supports compliance and monitoring with HSA4 and appropriate training is provided to relevant staff	Completed. Process in place, monitoring in progress. (Jun 17)	There is a robust process in place that supports compliance and monitoring with HSA4 and appropriate training is provided to Maternity staff (Medics and Midwives). Bereavement team available 5 days per week currently The bereavement MSW sends off all HSA4 forms to the DoH and uploads a copy of the form to Badgernet. Audit process is currently under review
Resuscitation Trollies Check that resuscitation trollies are fully stocked with items that are in date	General Manager/Head of Midwifery W&C (Maternity IPR / Maternity Board)	Resuscitation trollies are checked and stocked in line with trust policy and there is a clear process for monitoring this	Trollies checked regularly, audited by ward matron (Feb 17)	Weekly equipment checks Audited by the ward matron on a weekly basis
Cleaning Schedules Implement a process to ensure cleaning schedules are adhered to and audits are appropriately used to monitor this in the obstetric theatres.	General Manager/Head of Midwifery W&C (Maternity IPR / Maternity Board)	The department will be able to evidence consistent compliance with cleaning audits and improved practice as a result of audit data that is acted upon.	Nurse/Midwife cleaning scores 98 - 100% (Jan & Feb 17. One standardised cleaning schedule now in place for all 3 Maternity areas. (Mar 17)	There is a robust Trust/department process for cleaning schedules Audits are uploaded monthly & monitored at the (PEAM) meeting monthly- Ward Matron accountable at ward level – evidence available Improvement has been sustained since the 2017 visit

TABLE B

Additional recommendations following 2016 visit noted as business ongoing				
Action Required	Responsible (Lead/Group/ Committee)	Expected Outcome of Action	Actions taken 2017	Where we are: 2022 Update
The trust should review why they are an outlier for maternal readmissions to hospital after discharge.	O&G speciality lead	To understand the reason for readmissions and cease to be an outlier	Deep dive audit carried out during 2017 it was noted that some readmissions were due to incorrect coding (if a baby was readmitted the mother was also readmitted). A further issue noted was that if a woman who had delivered in the past 28 days represented even for a non-obstetric reason this was being classed as a re- attender. A piece of work was completed by the coding team to resolve this.	ESHT are no longer an outlier, audits continue, a further audit was completed in October 2022 (awaiting results)
The bereavement facilities were clinical, in need of updating and unsuitable for the needs of grieving families. The trust had money raised by a charity to upgrade the bereavement room but had not started to make the much needed improvements.	Maternity Bereavement Team/Estates	To commence building works once plans agreed (expected timeframe 2 years)	The team worked with SANDS to create a dedicated Bereavement suite (delayed due to multiple factors).	Dedicated bereavement suite opened early 2022

2. 2016 - 2018

A further review of ESHT service took place in March 2018 (report published June 2018), there were no new actions for maternity identified. Maternity services were included in an overall rating of good in all domains, noting major improvements and a cultural shift with staff buying into the vision and supporting the goal to be outstanding.

TABLE C

CQC Ratings 2016

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

CQC Ratings 2018

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Jun 2018	Requires improvement ↔ Jun 2018	Good ↔ Jun 2018	Requires improvement ↔ Jun 2018	Good ↑ Jun 2018	Requires improvement ↔ Jun 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Good ↑ Jun 2018	Good ↔ Jun 2018	Good ↔ Jun 2018	Good ↑ Jun 2018	Good ↔ Jun 2018	Good ↔ Jun 2018

3. 2018 – present 2022

Maternity services have continued to progress and improve since the last CQC formal inspection. In this period ESHT have responded to The Ockenden initial report (December 2020) with a support visit from NHS England in August 2022 to monitor improvements, where actions identified have been completed.

A further CQC inspection took place on 15 October 2022, whilst the final report has not yet been received by the Trust, initial feedback was received on 24th October 2022. Positive findings noted that safeguarding systems were robust and made sure that families were holistically reviewed and involved in the decision-making process. The continuity of carer teams had established good relationships with women and birthing people and were able to offer good care. The BadgerNet system implementation was positive and will enable leaders to effectively monitor services in the future. Table D sets out the key requirements and action taken to date in response to immediate findings.

TABLE D

CQC Action plan from visit October 2022			
Action Required	Responsible (Lead/Group/ Committee)	Expected Outcome of Action	Actions taken to date 2022
The training record does not indicate that staff on the MLU have recently completed evacuation of the pool or neonatal transfers using the POD training or drills.	Deputy HOM/ MLU Matron (G&A)	MLU Matron to ensure a pool evacuation training session is completed within 4 weeks Future dates to be planned to ensure competencies are maintained	MLU Dates for pool evacuation: 25/11/22, 16/1/23 MLU Dates for skills drills: 7/12/22, 10/1/23
There was no evidence in the day assessment unit that the correct arrival time and time seen were monitored effectively to ensure women were seen within safe time frames.	HoM/ Antenatal ward matron G&A/MAM	Immediate action taken to ensure arrival and assessment time is monitored (evidence available), commenced 16/10/22 Prioritisation of women & birthing people who present with specific conditions are assessed via telephone triage and advised to attend immediately for review – BSOTS will provide a nationally standardised process	BSOTS to be implemented in ESHT on 30/01/23. *BSOTS currently implemented in 75 of 137 UK units* ESHT are signed up to the national BSOTS terms of reference (24/11/22), meeting with national team on 07/11/22 Badgernet has online forms which ensures all data is captured for audit purpose
In the day assessment women arriving at the unit were asked to sit in the corridor there was no line of sight which meant staff could not be assured that women were safe whilst awaiting a review.	HoM/Antenatal ward matron G&A/MAM	Review of options available within the DAU footprint. Plan to have 4 chairs within the unit corridor. risk assessment completed date 24/11/22	Risk assessment completed 24/11/22, plan to put 4 chairs within unit corridor as proposed

There was not a standard operating procedure for day assessment unit. Which means that staff were unclear about the remit between other areas and there was no rag rating of women based on their clinical need.	Deputy HoM/Antenatal ward matron G&A/MAM	At present the unit uses multiple guidance/policies based on clinical issue e.g. Reduced fetal movements guideline, Antepartum haemorrhage guideline	As part of the BSOTS implementation a single guideline is being written which links to all relevant guidelines and policies to improve ease of use

Conclusion

There has been increasing good progress in line with NICE and national guidance over the past six years within ESHT Maternity Services. Ongoing action planning continues to ensure compliance of any outstanding actions noted by the CQC and to ensure full compliance with CNST, the Ockenden initial and final reports and the latest report regarding East Kent. Ongoing monitoring of all action plans continue via WCSH governance meetings and the Quality and Safety committee.

East Sussex Healthcare
NHS Trust

Annual Safeguarding Report

2021 – 2022

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Message from the Executive for Lead for Safeguarding Adults and Children Vikki Carruth

As Executive Lead for Safeguarding Children and Adults, it is my responsibility to ensure that East Sussex Healthcare NHS Trust (ESHT) meets the statutory requirements required and is assured and updated via this report to the board.

This work includes ensuring robust governance in recruitment, up to date policies, local and Sussex wide procedures, up to date learning and development and multiagency working including representation on both local safeguarding boards. The Chief Nurse also works closely with the Chief Operating Officer and others to ensure systems and processes are in place to safeguard patients presenting with mental ill-health who also need ESHT services.

This last year, the Safeguarding Team have worked hard to ensure that throughout and following the impact of the Covid 19 pandemic, staff have continued to have the appropriate access to safeguarding support and advice, this has been a mix often of virtual and face to face support and training within the last year.

There has been continued focus to ensure that Safeguarding Policies, Procedures, and practices in place remain up to date, are reviewed regularly and are fit for purpose. All policies and procedures are accessible to staff via the Safeguarding Children and Safeguarding Adults pages on the trust intranet and advice and support is provided by our Safeguarding team.

The last year has once again seen an increase in the numbers and complexity of cases of abuse across the whole population. Cases referred to respective child or adult social care teams rose, and this increase has been sustained.
Throughout the year, the principal impact has continued to be on young people experiencing a mental health crisis, with young people requiring mental health support receiving care in acute in-patient beds. This lack of appropriate in-patient mental health beds and of emergency foster placements is at both a county wide and national level.

A key area of work for this year has been to review the Deprivation of Liberty (DOLS) process in readiness for forthcoming changes planned for 2022 with the implementation of Liberty Protection Safeguards (LPS). As a result, the team employed a Specialist Mental Capacity lead to support this work going forward. The impact of LPS will be very significant on ward nursing staff.

The Trust is involved in both local Safeguarding Partnerships; (ESSCP for children and young people and the SAB for adults) and is committed to interagency working and positively supports opportunities to work with other agencies.

I would like to thank all staff for their continued support with this complex agenda and thank system and multiagency partners for their collaborative and collegiate approach.

1.0 - Introduction

The 2021/2022 Annual Safeguarding Report provides the East Sussex Healthcare NHS Trust (ESHT) Board with an overview of the safeguarding work undertaken during the year, the work planned to further transform safeguarding practice in 2021/2022 and assurance regarding the Trust's compliance with the legislative and regulatory framework. This includes;

- Working Together to Safeguard Children (2018)
- The Children's Act (2004) - ESHT must be able to demonstrate that it safeguards children who access our care under section 11 of the act
- Safeguarding Vulnerable Adults in line with the Care Act (2014)
- Department of Health Care & Support Statutory Guidance under the Care Act (2014)
- The Mental Capacity Act (2005)
- Deprivation of Liberty Safeguards (2007), Mental Capacity amendment (2019)
- The Modern Slavery Act (2015)
- Safeguarding Children & Young People: Roles & Competences for Health Care Staff (2019)
- Safeguarding Adults: Roles & Competences for Health Care Staff (2018) The Female Genital Mutilation Act (2003)
- Promoting the Health and well-being of Looked After Children (2015)
- Domestic Abuse Bill (2021)

2.0 - Safeguarding Governance

2.1 ESHT Safeguarding

Providers of NHS funded healthcare are required by NHS England to comply with the "Safeguarding Vulnerable People in the NHS Accountability Framework" (2015). ESHT must demonstrate that it is has effective arrangements to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators, and commissioners that these arrangements are working. These arrangements include;

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable adults, as appropriate.
- A suite of policies including Safeguarding & Safeguarding Supervision
- Effective safeguarding training for all staff commensurate with their role and in accordance with.
    - Safeguarding Children and Young People: roles and competences for healthcare staff. Royal College of Paediatrics and Child Health (2019)
    - Looked After Children: Knowledge, skills and competences of healthcare staff. Royal College of Paediatrics and Child Health (2016)
    - Safeguarding Adults: Roles and Competences for Health Care Staff (2018)

- Effective safeguarding supervision arrangements for staff working with children/families or adults at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies.

- Named Safeguarding Professionals covering specific specialist areas: Head of Safeguarding and Mental Capacity Act Lead posts.
- A statutory role in managing safeguarding allegations against staff, alongside Adult Social Care & HR colleagues.
- Developing an organisational culture where all staff are aware of their personal responsibility to report concerns and to ensure any poor practice is identified and tackled.
- Policies, arrangements, and records to ensure consent to care and treatment is obtained in line with legislation and guidance, including MCA (2005) and the Children's Act (2004).

The Intercollegiate Document (2019) requires NHS organisations to have structured safeguarding leadership with clinical and safeguarding expertise. The Chief Nurse is the Executive Lead and has responsibility for ensuring effective trust wide safeguarding governance, available advice and expertise, and that robust arrangements and reporting are in place. The Chief Nurse supports the Head of Safeguarding and the Safeguarding team, and co-ordinates with the Divisional Assistant Directors of Nursing who are responsible for ensuring robust safeguarding arrangements and practice in each of their clinical areas. The Chief Nurse also ensures there is support and development for the Safeguarding team to ensure that knowledge and practice is current with suitable supervision of cases.
The Trust governance and reporting arrangements are based on legislative changes and statutory requirements. Safeguarding Leads are required to provide support, advice, scrutiny, and assurance. ESHT safeguarding policies for adults and children set out the key arrangements for safeguarding practice, roles and responsibilities. During 2021/2022.

- Safeguarding governance structures have been strengthened to improve operational understanding of safeguarding responsibilities.
- The Safeguarding Adults Policy and associated training was updated in 2020/2022 to reflect current safeguarding issues, including Domestic Abuse, PREVENT (radicalisation), Exploitation, Female Genital Mutilation, Cuckooing, Modern Slavery and Human Trafficking; this continues to be reviewed in line with national guidance.
- The Deprivation of Liberty Policy has been updated to ensure clear guidance on the process and a Court of Protection Policy has been introduced
- A new policy to support staff to understand the Court of Protection Processes has been introduced
- Compliance with all safeguarding policies being up to date was maintained at 100% throughout 2021/2022.
- The Domestic Abuse Bill passed through parliament in 2021 and the Think Family training delivered by the ESHT Safeguarding Team, and the Domestic Abuse training reflects the new legislation.
- The Looked after Children Policy was reviewed and updated, will be Children in Care gong forward.

2.2 System Safeguarding and Covid 19

The legislative and regulatory safeguarding requirements set out duties for ESHT to co-operate with and support the wider system safeguarding practice and statutory partners including the Local Authority and the Police. The Chief Nurse and Head of Safeguarding are members of both the Local Safeguarding Adults and the Local Safeguarding Children's Boards in East Sussex. The Head of Safeguarding and members of the team fully support the sub-committees, groups and processes of

both safeguarding boards enabling ESHT to drive forward both the national and local safeguarding agenda in partnership with others. This ensures active learning from safeguarding reviews; partner agency reports, national safeguarding challenges and local issues, driving improvements in practice. The pandemic continued to have an impact on both the structure of the ESHT Safeguarding team and the broader context of Safeguarding throughout 2021/2022.

- There were staffing challenges within the Safeguarding team with vacancies within the Named Nurse cohort of staff, these posts were successfully recruited to in April and December respectively.
- The Safeguarding team are involved in Sussex wide work developing integrated health and social care for the residents of East Sussex. The team provides safeguarding advice and expertise to a range of colleagues and Safeguarding Board members, this moved to a virtual offer during the Pandemic which has continued.
- The Safeguarding team continued to develop and implement the 'Think Family' Safeguarding training, which has been facilitated as a virtual webinar since March 2020.This is continually reviewed and refreshed to reflect feedback from delegates and emerging research
- During periods of significant operational pressures and demand across the Divisions, the usual practice of monthly Safeguarding Operational and Strategic meetings was suspended. The Head of Safeguarding continued to provide monthly safeguarding summaries to the Chief Nurse during this period.
- Divisional safeguarding reporting, via a standardised reporting tool, has improved visibility of safeguarding practice in clinical areas and highlighted challenges and good practice. This tool has been revised in 2021 to allow all Divisions to have oversight of Safeguarding trends and themes, ensuring that 'Safeguarding is everybody's responsibility'. These reports are a standing item at every Strategic Children and Adults Safeguarding Group meeting.
- The Head of Safeguarding participates in Divisional governance meetings and the weekly patient safety summit, ensuring that Safeguarding is a standing agenda item and to enable increased Divisional ownership and engagement.
- The Head of Safeguarding and Named Professionals participate in both Sussex wide Safeguarding forums, led by the CCG and in monthly national forums, to share practice.

During the Covid 19 pandemic, Staff were signposted to access the national e-learning Prevent and WRAP training packages. This has continued since it ensures a robust method of capturing compliance data.

2.3 Care Quality Commission (CQC) Inspection

The CQC inspection of the Trust in 2019/2020 found outstanding practice in relation to Safeguarding. There was specific mention of the changes to safeguarding practices following concerns raised, (Child T Serious Case Review). An example given was that clinical staff informed the inspectors that the trust had begun to run a level 3 "Think Family" safeguarding study day. Topics covered included dealing with difficult family dynamics, female genital mutilation, forms of abuse including sexual abuse and the impact of parental mental health conditions.
There has not been an inspection in the year 2021/2022; and work on the Think Family agenda has continued to progress, attracting interest from other trusts.

3.0 - Key Achievements in Safeguarding 2021 - 2022 by various colleagues and teams

- The Safeguarding Team have continued to support the Divisions with Safeguarding issues throughout 2021-2022
- The Safeguarding holistic 'Think Family' training has continued as a virtual webinar offer, to ensure that mandatory level 3 safeguarding continued. Following feedback, the training was adapted in 2021 from three separate virtual sessions to comprise an assessed e-learning module followed by a virtual half-day. The safeguarding team have encouraged all practitioners Band 5 and over, to attend level 3 to ensure a consistent offer within the organisation. The training is facilitated on a weekly basis.
- The Domestic Abuse rapid assessment tool, developed to support staff to discuss domestic abuse, has been adapted and uploaded to System one for use by all Community and Integrated staff.
- The Safeguarding Transition Specialist Nurse works with children from the age of 13 to 25 to ensure that work undertaken is both preventative and proactive, and the practitioner moreover dovetails with the broader trust transition team to ensure a cohesive service.
- Safeguarding Staff worked with Sussex Partnership to implement the Healthy Teen Minds 'We Can Talk' programme across the organisation. This project, supported by Health Education England, provides staff with knowledge and information about talking to young people in mental health crisis through a series of vignettes delivered as e-learning, with the aim of increasing their confidence and awareness of young people experiencing mental health crisis within the acute sector and thus make every contact count. 243 staff signed up to the project, placing ESHT 3rd nationally.
- The team continue to develop and refine safeguarding governance systems and processes ensuring increased collaborative working with clinical and operational teams.
- Multi-disciplinary work has been undertaken with the CCG, Sussex Partnership and East Sussex Children's Social Care to enable information to be shared with schools when a child accesses health care as a result of an overdose and the relevant consent is obtained.
- The Safeguarding Team and Health Independent Domestic Violence Advisor (HIDVA) asked for expressions of interest for Domestic Abuse Champions across the organisation. The team developed some specific training to support this, and thirty members of staff expressed interest.
- The team have worked hard to raise the profile of Deprivation of Liberty Safeguards as a precursor to the forthcoming changes to Liberty Protection Safeguards. ESHT recruited a Mental Capacity lead who has been supporting clinical areas to recognise the requirement for DOLS. Both the Head of Safeguarding and the Named Nurse Adults are part of a Sussex wide LPS steering group. The impact of LPS will be very significant on staff.
- The team supported the implementation of the mandatory Female Genital Mutilation Information System (FGM-IS) in maternity.
- Maternity Safeguarding Midwives continue to raise the profile of domestic abuse. They work closely with maternity staff supporting strategies to enable them to discuss the issue of domestic abuse with all pregnant women during their antenatal and postnatal care.
- The team worked closely with the Women's and Children's Division and Urgent Care to address concerns regarding the experiences of patients with Mental ill-health, specifically through audit, including a review of the Risks on the Trust Risk Register and development of a more robust process of monitoring patients that are referred to Child and Adolescent Mental Health and Children's Social Care database (GDPR compliant).

- The team have continued to provide a Safeguarding Supervision offer throughout 2021/2022, in Adult and Children's areas, specifically to teams which have to manage complex caseloads, the mode of delivery continues to be a virtual Micro-Soft teams offer.
- Contributing to ESSCP Quality Assurance Subgroup in monitoring and evaluating the effectiveness of the work carried out by board partners by contributing to 2 multiagency audits (injuries to infants and young children and domestic abuse)
- ESHT have contributed to the ESSCP Learning and Development subgroup to consider the multi-agency training programmes going forward that are in line with current themes.
- Whole-team safeguarding meetings have continued to occur monthly, alongside Specialist area 'huddles' to share best practice and learning in both adult and child cases.
- The maternity safeguarding team has begun to provide targeted training/updates regarding domestic abuse, trafficking, forced marriage and modern slavery to the maternity day unit and early pregnancy clinic.
- The National Maternity Safeguarding Network together with The Centre for Child and Family Justice Research at Lancaster University are currently undertaking a piece of work exploring women (and families) who have their babies removed at birth due to care proceedings. Part of this work is exploring the trauma by an informed approach of gifting the women and their baby, a box filled with small keepsakes and memories. The ESHT maternity safeguarding team is working closely with this national group as this idea was implemented at ESHT in 2019.
- Since the introduction of Baby Boxes at ESHT, maternity safeguarding has provided approximately 40 boxes. The team are now offering both parents a Baby Box rather than one per couple.

Safeguarding supervision is offered to all midwives and maternity support workers annually and to the community maternity teams quarterly. Safeguarding supervision will develop over the next fiscal year to include quarterly supervision to specialist midwives and the maternity day assessment unit. Throughout 2021/2022, ESHT has supported changes in practice as a result of learning from Safeguarding Case Reviews (SCR's) including.

- Continued work alongside the CCG to develop pathways for the sharing of Safeguarding referrals with health partners such as GP's.
- Working alongside STAR and clinical staff to develop a joint policy for vulnerable people using substances and alcohol (Adult C and a DHR).
- Safeguarding learning will inform the work underway regarding discharge planning (Adult C - Safeguarding Adult Review)
- In three Domestic Homicide Reviews in 2020-2021, a lack of routine inquiry is a theme. The rapid assessment tool developed to support staff to enquire about Domestic Abuse, is now embedded in some digital systems notably Systm one and Nerve Centre.

4.0 - National Context

4.1 Covid and Safeguarding

In December 2021 the Local Government Association published the third report from the Insight Project, which was developed with the aim of creating a national picture regarding Safeguarding

Adults activity during the pandemic. The findings are drawn from data received from fifty local authorities and highlighted several key themes which have been mirrored locally.

- Safeguarding concerns continue to show a long-term upward trend, tending to decrease during periods of lockdown
- Due to lockdown regulations, many safeguarding concerns were reported to adult social care services later than prior to the pandemic. This was noted for types of abuse, such as domestic abuse and self-neglect where lockdowns have increased the isolation of those experiencing abuse.
- Delays in referral have meant that there have been more acute or severe consequences, making preventative measures more difficult to implement or situations have been more likely to require crisis management.

In June 2020, the NSPCC produced a report that summarised the impact of the Pandemic and lock-down on Safeguarding Children (www.nspcc.org 2022). The report suggested that the conditions created by COVID-19 increased the probability that both stressors and vulnerability will increase, at a time when the protective services have been weakened, and families have reduced social support and connections to rely on, the reports cited three main areas of risk:

- Increase in stressors to parents and care givers.
- Increase in children's and young people's vulnerabilities.
- Reduction in normal protective services.

The NSPCC report was written after the primary lockdown and the risks identified have been mirrored in local data with increases in referrals by ESHT Safeguarding to the Case Review panels of Serious Cases.

The Social Care Institute for Excellence recognises similar patterns for vulnerable adults but with the addition of the risk of exploitation and Domestic Abuse increasing because of social isolation. Furthermore, for both young people and adult's, difficulties with mental health and drug and alcohol dependencies due to both isolation and a state of heightened anxiety have been cited and are also a theme reflected in local data.

4.2 Child Safeguarding Arrangements

The East Sussex Safeguarding Children's Partnership board (ESSCP) brings together several key agencies as well as voluntary organisations and lay members, across the county, to ensure a collaborative approach to safeguarding children. Three key agencies, Local Authorities, Health and Police are integral to the forum and jointly oversee the multi-agency arrangements to safeguard children.

A sub-group of the ESSCP, the Case Review group holds responsibility for the management of Serious Case Reviews now referred to as a Child Practice Review (CPR). Additionally, there is a national independent body which oversees the learning framework for inquiries into child deaths (CDOP) and to which local boards are now accountable where children have experienced serious harm.

Serious Practice reviews with East Sussex are managed within these frameworks which highlight the importance of rapid response and transparency in publicising how an area has learned from an incident and what has changed in local practice learning.

4.3 Adult Safeguarding Arrangements

Both the Chief Nurse and Head of Safeguarding are members of the East Sussex Safeguarding Adults Board (SAB), . The Head of Safeguarding also participates in sub-groups of the SAB.
'*The requirement of the SAB is to lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies' www.scie*.org.uk
The SAB is also instrumental in commissioning safeguarding adults' reviews for any serious cases which meet the threshold criteria. Moreover, locally the SAB has developed resources such as the adult death protocol when abuse could be attributed as a factor in an adult's death.

5.0 - Response to national themes and Trends

5.1 The impact of County Lines

During 2021/2022, the virtual Think Family Safeguarding Training and Supervision has continued to include content on 'County Lines' which is the term used to describe the distribution of drugs from major cities into counties. ESHT continues to support Emergency Department staff, the Police and other agencies to identify children at risk of being drawn into serious crime including drug dealing with pressure to carry weapons. Children in Care have been overly represented in the overall amount of 'County Lines' related cases presenting to our ED department bought in by Police.

The Specialist Safeguarding Nurse for Transitions participates in the Multi-Agency Child Exploitation meetings (MACE), held monthly to discuss young people under the age of 18 at high risk of exploitation. Those young people discussed within the meeting are identified at risk and flagged on the trust e-searcher system.

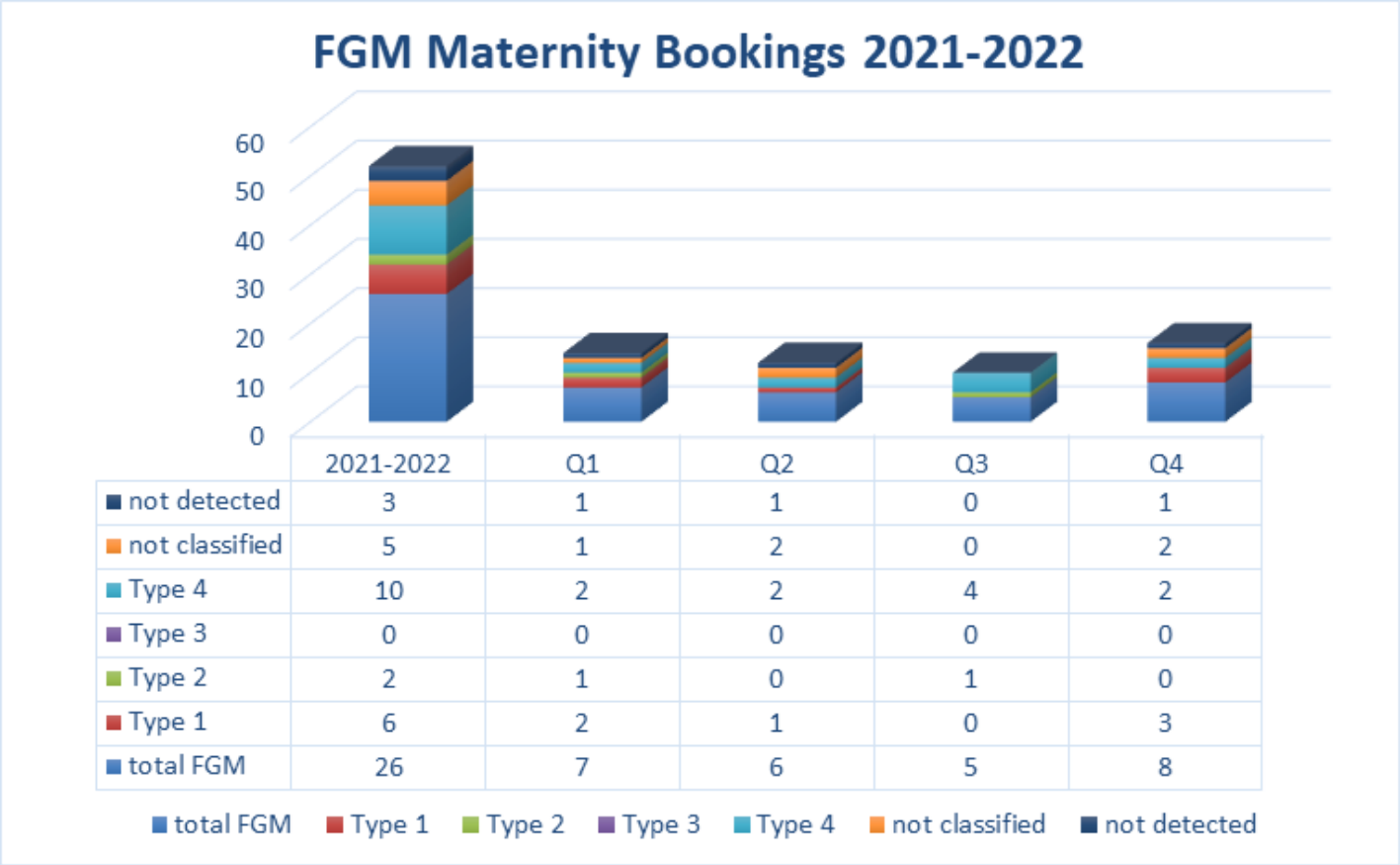
5.2 Modern Slavery/Human Trafficking

ESSCP, including its partner members, has pledged to reduce the risk of children being sexually exploited, trafficked or going missing from/in East Sussex. Section 54(1) of the Modern Slavery Act (2015) places a legal requirement on ESHT to prepare our staff to identify patients at risk of modern slavery and being trafficked. Whilst it is not a mandated requirement yet to provide information centrally, ESHT continues to identify suspected cases which have been reported to the police.
Members of the Safeguarding team participate in a monthly meeting chaired by Discovery that reviews local 'hot-spots' and multi-agency actions to safeguard victims. Both the Head of Safeguarding and Named Nurse Adults are listed within a local directory as points of contact**.**
Locally in the period April 2021-April 2022 we have referred two potential cases to the Discovery team.

5.3 Multi – Agency Female Genital Mutilation (FGM) Guidance

ESHT has effective arrangements in place to meet the requirements set out in the Home Office guidance for FGM. The FGM Lead is responsible for all mandatory returns, monitoring local incidences of FGM and staff training and support to ensure staff can identify females at risk, detect FGM and report it effectively. Information about FGM is included in the 'Think Family' training.

Between April 1st 2021 and 31st March 2022 there were 26 cases of FGM reported by ESHT with data entered onto the NHS Digital National FGM Enhanced Dataset (figure 1). All information was reported by maternity teams.



	2021-2022	Q1	Q2	Q3	Q4
not detected	3	1	1	0	1
not classified	5	1	2	0	2
Type 4	10	2	2	4	2
Type 3	0	0	0	0	0
Type 2	2	1	0	1	0
Type 1	6	2	1	0	3
total FGM	26	7	6	5	8

Figure1

NHS Digital collects data on FGM on behalf of the Department of Health (DH) from NHS acute trusts, mental health trusts and GP practices.

FGM information sharing, known as FGM-IS, is a national IT system linked to the NHS spine that supports the early intervention and ongoing safeguarding of females, under the age of 18, who have a family history of Female Genital Mutilation (FGM). ESHT has implemented the system which is led by the Named and Deputy Named Midwife for Safeguarding.

5.4 The Care Act (2014) - Making Safeguarding Personal

It had been agreed that to enable ESHT to deliver MSP focused safeguarding practice, a framework of reflection and revised training alongside the learning from complaints, safeguarding enquiries and case reviews was required. The Care Act (2014) defined safeguarding adults as 'protecting an adult's right to live in safety, free from abuse and neglect'. Making Safeguarding Personal (MSP) defines an approach to safeguarding which focuses on outcomes rather than process. It aims to answer, in partnership with the adult at risk / their advocate, three questions.

- What difference would they want or desire?

- How will you work with someone to enable that to happen?
- How will you know a difference has been made?

Historically Safeguarding Supervision had been the forum within which the ethos of Making Safeguarding personnel had been discussed, however, the Pandemic affected the programme of Supervision facilitated within the organisation. Supervision continued for some groups of staff via video meetings, such as Dieticians and Sexual Health and the safeguarding team are available for 'hot' de-briefs and support for ward staff as required.
As a result, the Think Family training offer, which incorporates all staff at band 5 and above has been vital to deliver the MSP message to staff.

5.5 PREVENT

The Head of Safeguarding is the Trust lead for the PREVENT programme, which supports the local and national counter terrorism strategy, and is a requirement under the Counter Terrorism and Security Act, 2015.
Locally the Trust is active on the PREVENT Board and submits numbers of PREVENT (Channel) referrals from health quarterly to the CCG and NHSE.
During the Pandemic, PREVENT training moved to an e-learning format, compliance initially fell; this is in part due to the impact of the pandemic but predominately as the training requisite as altered from a one-off session to 3 yearly requirement. This was raised as a risk within the organisation but is now closed as compliance improved.

- Staff accessing the 'Think Family training' are sign-posted to complete their PREVENT training
- PREVENT training is now being included within the mandatory training matrix

5.6 Domestic Abuse and Multiagency Risk Assessment Conference (MARAC)

MARAC is a multiagency forum managing high risk cases of domestic abuse, stalking and honour-based violence. Chaired by Swift, they bring together statutory and voluntary partner organisations to share information and work collaboratively to safeguard the person at risk by developing a coordinated plan of protection. ESHT are members of both MARACs in East Sussex, where specialist nurses and midwives represent the Trust.

Confirmed cases of domestic abuse are flagged on patient administration systems. To strengthen arrangements, the "Care Grow Live" organisation and Sussex CCG resumed the funding for the Health Independent Domestic Violence Advisor (HIDVA) in October 2020 and this is now in place for five years. The role focuses on supporting staff to identify domestic abuse through the process of referral, once made. In addition to supporting staff to manage cases of abuse, the practitioner also works directly with victims and is developing the Domestic Abuse training offer within the

organisation. Referrals received by the HIDVA in the last year are documented in figure1 below.

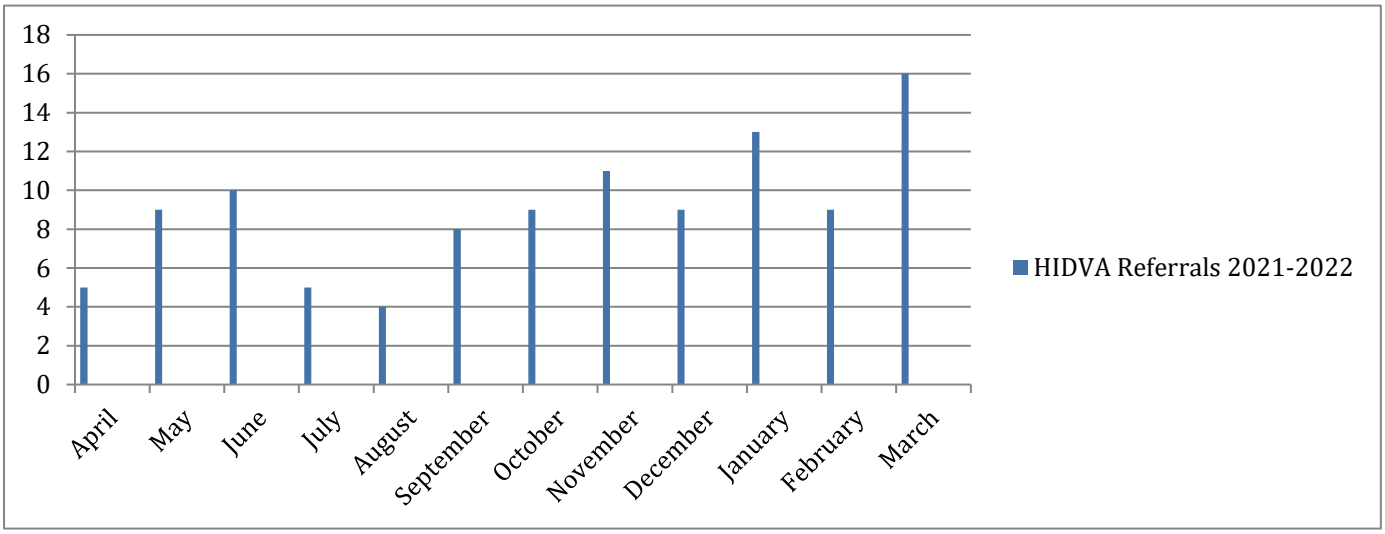


Figure 2

6.0 - Local Serious Case Reviews and referrals

Domestic Homicide Reviews, Safeguarding Practice Review (child) or Serious Adult Review are a multi-agency analysis, undertaken when it is considered that abuse has contributed to the death or serious injury. The purpose of which is to identify whether there is learning. As part of any serious review ESHT alongside other partner agencies submit detailed reports and participate in panel meetings and practitioner learning events. The final reports, identifying lessons to be learned, and recommendations are compiled by an independent reviewer or author and may be published.

6.1 Domestic Homicide reviews.

There continue to be several domestic homicide reviews progressing at differing stages within the East Sussex area, most deaths occurred between 2018-2020, with one historic case from 2016. Of these cases, two will not be published but information is disseminated through learning briefings, and a further four cases are awaiting sign off by the Home Office.
Two cases occurred in 2021 and initial reports have been submitted and further meetings awaited
The victims were predominantly female, 8 of the cases, with two male victims being reviewed.

The predominant theme featured in 7 of the cases was that there was a history of domestic abuse. Substance and alcohol misuse is also a key feature within the cases (figure 2).
From a health perspective there is a continuing thread of a lack of professional curiosity alongside a lack of routine enquiry.
In two of the cases, the victims had presented with injuries prior to their death which they had reported as being the result of Domestic Violence.
The effect of the Covid 19 pandemic is only cited in one of the cases

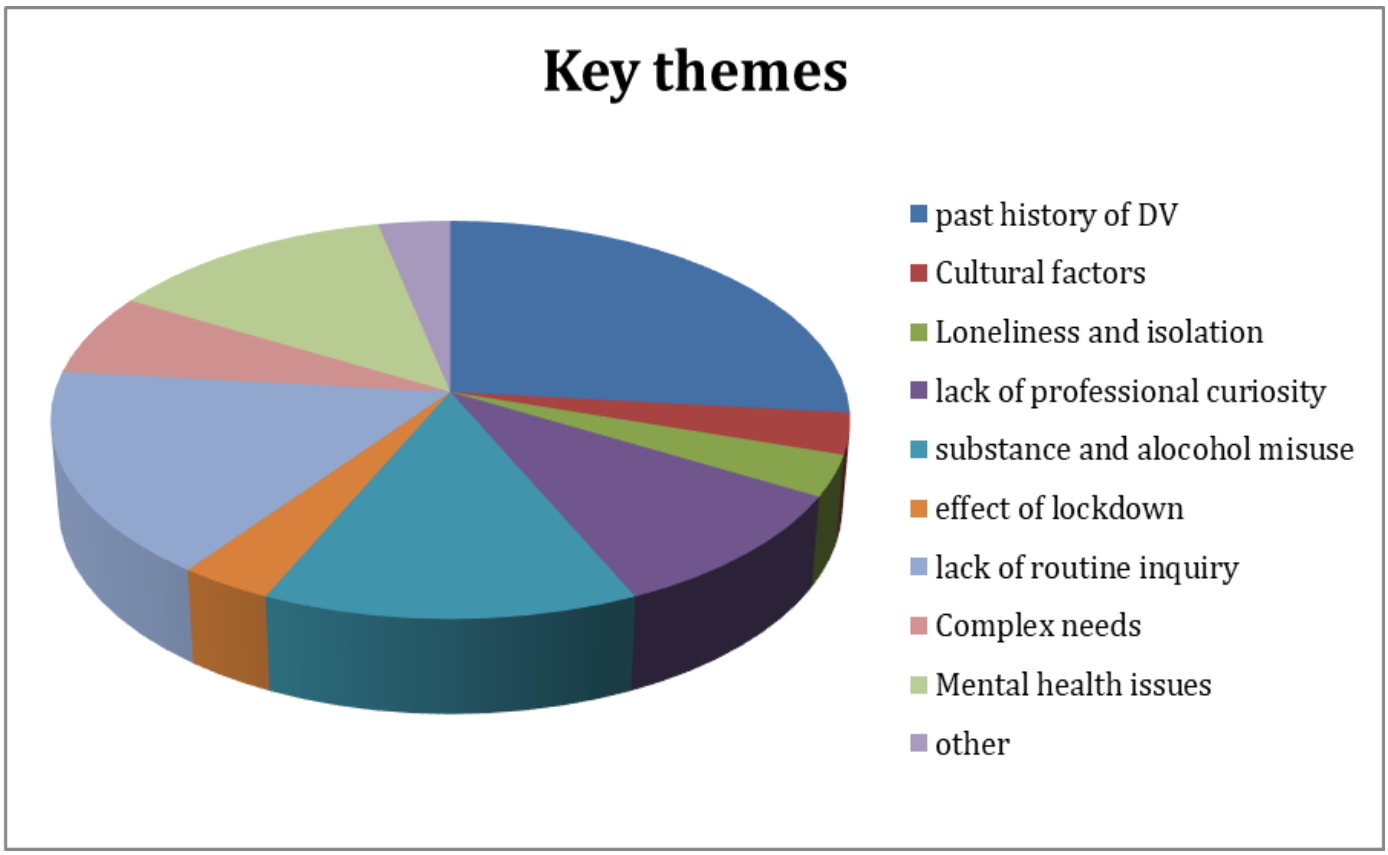


Figure 3

6.2 Children's Activity

In the period April 2021- April 2022, ESHT referred four cases to the ESSCP case review panel and a further case pertaining to an East Sussex Child was submitted by University Hospitals Sussex and all the cases were subject to a rapid review as per the national guidance. Overall ESHT Safeguarding contributed research to six rapid review serious cases, two of the cases are in progress as child practice reviews.

Two child cases have been completed within this year Child X and Y, and it was considered appropriate to publish anonymously on the NSPCC national repository learning and action plans have been shared within the organisation.
An historic child case dating from 2018/19 is yet to be published, due to the delays in criminal proceedings as a result of Covid. The action plan was shared within the Safeguarding Strategic Committee for the Chief Nurse to have assurance.

6.3 Safeguarding Adult Referrals

Three Safeguarding Adults Reviews were taken forward by the Safeguarding Adults Board, and a further case referred by ESHT is being considered as a learning event.

SAR Anna considered an elderly person who was thought to be a victim of Domestic Abuse. The case held similarities with an historic case referred to as Adult B and as such the organisation were asked to audit against the previous action plan as a basis for the review. The review was completed and published in 2022.

SAR Ben considered the issues of self-neglect and mental capacity and mirrored an historic case known as Adult A. The review was completed in 2022.

A thematic review considered areas of multi-agency learning to be taken forward in relation to how well services identify and respond to a history of trauma. The review analysed the deaths by suicide of four people and considered how well agencies can work together to address domestic abuse for women with multiple complex needs.

A further case, in Spring 2021, was referred under the criteria of the Adult Death Guidance

7.0 - Deprivation of Liberty (DOLS)

East Sussex Healthcare applies the Deprivation of Liberty Safeguards (DOLS) to those patients that are deemed to lack mental capacity. The Deprivation of Liberty Safeguards were an amendment to the Mental Capacity Act 2005 and within which the procedure, as prescribed in law, cites when it is necessary to deprive a resident or patient of their liberty, when the person lacks capacity to consent to their care and treatment, in order to keep them safe from harm.
This legislation was further developed following a supreme court judgement in 2014, referred to as the Cheshire West directive, which referred to the 'acid test' to see whether a person is being deprived of their liberty, and which consisted of two questions:

- Is the person subject to continuous supervision and control? *and*
- Is the person free to leave? – with the focus, being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave.

In 2021 it was identified that not all clinical areas had not embedded the ethos of Cheshire West and that the view of staff was to apply DOLS should the patient be seeking to leave. To change practice and develop readiness for the forthcoming Liberty Protection Safeguards;

- A DOLS/ LPS page has been established on the intranet to provide information for staff.
- A Mental Capacity lead commenced in post February 2022, the impact of the recruitment to this role is demonstrated in figure 4.
- Head of Safeguarding and Named Nurse Adults participate in a Sussex LPS steering group and information disseminated via the Professional Advisory group within the trust.
- The Safeguarding team attends Matrons and Divisional meetings to discuss the updates on the forthcoming changes.
- Dols and LPS presented to the patient Safety and Quality Group.

There are significant changes as a result of an amendment to the Mental capacity Act (2005) delayed by the Covid pandemic and changes DOLS to Liberty Protection Safeguards (LPS). A draft consultation was launched in 2022 and it is now anticipated that Liberty Protection Safeguards (LPS) are likely to be commence in 2023, with a significant impact on ward nursing staff in terms of time and resources.

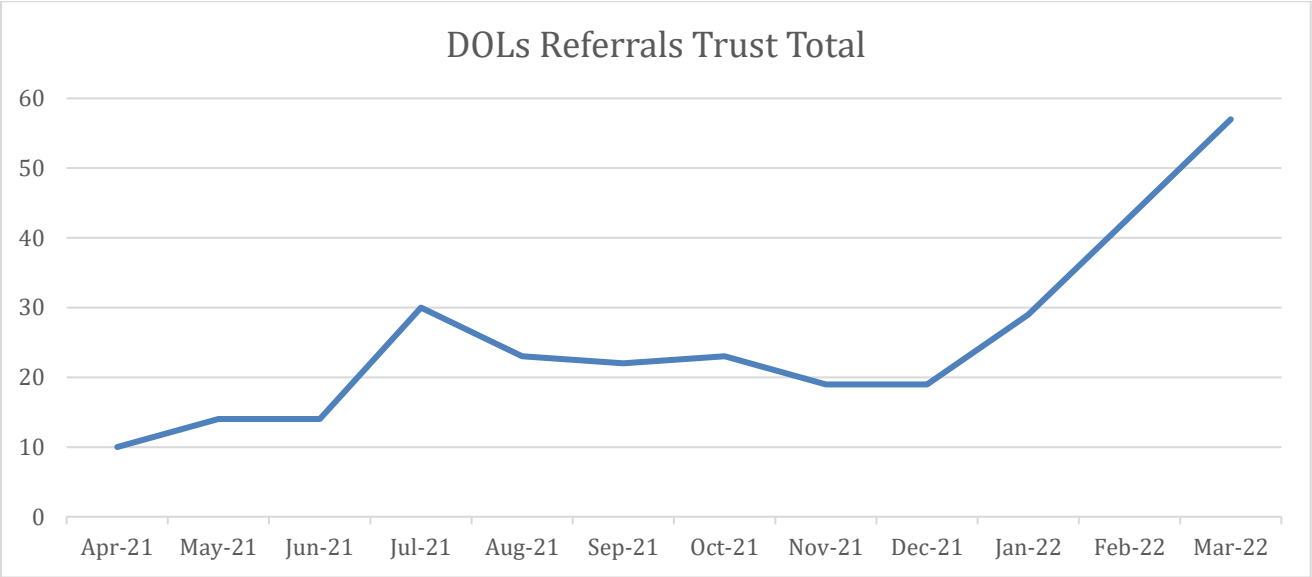


figure 4

8.0 - Safeguarding Work Plans

The work plans for all aspects of safeguarding and learning disabilities and the processes for reviewing and reporting progress, risks and compliance were revised as part of an overall review of safeguarding governance. During the period 2021/2022, the monthly Safeguarding Work Plan meetings, which ensures there is a responsive forward strategy with work to be undertaken by the team, addressing both local and national Safeguarding agenda's, has been re-introduced. The Safeguarding Children and Adults Strategic Group continues to monitor progress, compliance and risk through the Head of Safeguarding Report and the Divisional Safeguarding Reports received at each meeting. (Appendix 1)

9.0 - Safeguarding Activity

9.1 Maternity Safeguarding

- Maternity launched phase one of Badgernet July 2021 and it is now being used throughout maternity from booking until postnatal discharge. Badgernet allows healthcare professionals to record notes on maternity patients in real-time, whether they are in the hospital, the community or at home. Maternity service users can use a PC, tablet, or smartphone to read their own maternity notes and test results, look at healthcare leaflets and view upcoming appointments. Maternity records can be easily updated and are available to be viewed personally and professionally throughout maternity care including postnatally. Maternity have struggled in the past with obtaining the return of 100% of all hand-held maternity notes. Badgernet will solve this problem, as all information is stored digitally.
- Maternal safeguarding has seen an increase in complex cases and those presenting with mental ill health who have required additional support and liaison with partner agencies (figure 5)

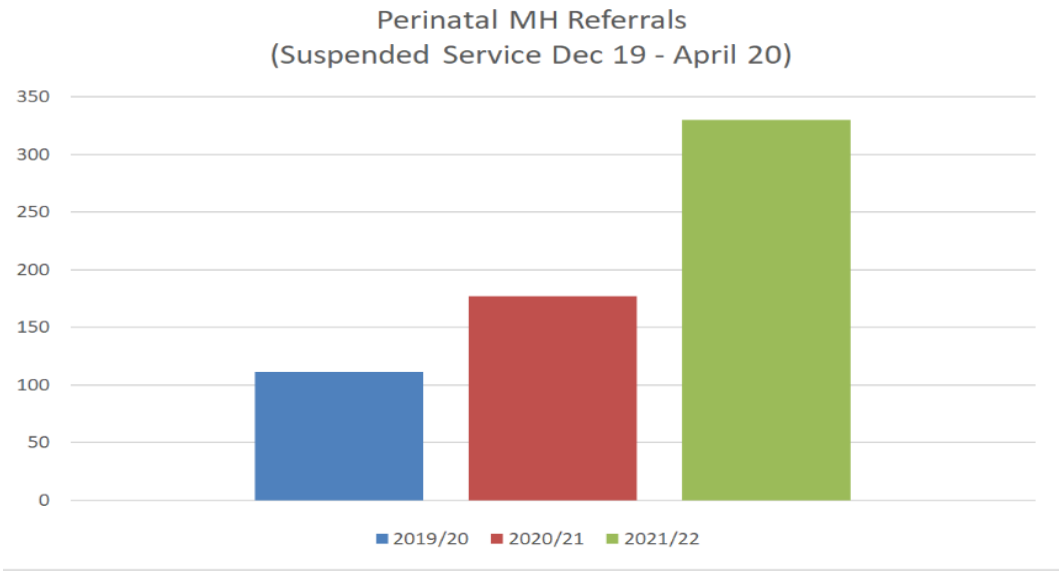


Figure 5

9.2 Safeguarding Children

The Safeguarding Children's speciality scrutinise child presentations within ESHT, predominantly the Emergency department and Children's ward, to ensure that safeguarding pathways are recognised and followed. Safeguarding data is collated, such as the numbers of statements of referrals (SOR forms) submitted by the trust to children's Social Care, furthermore any relevant information shared with colleagues, such as the Health Visiting service. The team participate in strategy meetings and host a weekly multi-agency forum that reviews attendances and admissions where there is a potential safeguarding risk.

Since Covid, there has been an increase in safeguarding children's referrals, the majority of which are submitted by the Emergency Departments (figure 6).

The Children's Social Care front door, referred to as the Single Point of Advice (SPOA) has Mental Health Practitioners within the workforce, hence Statement of Referrals forms are also submitted for those Children requiring non-urgent mental health support. The proportion of referrals submitted for mental health presentations and safeguarding issues are differentiated (figure 7).

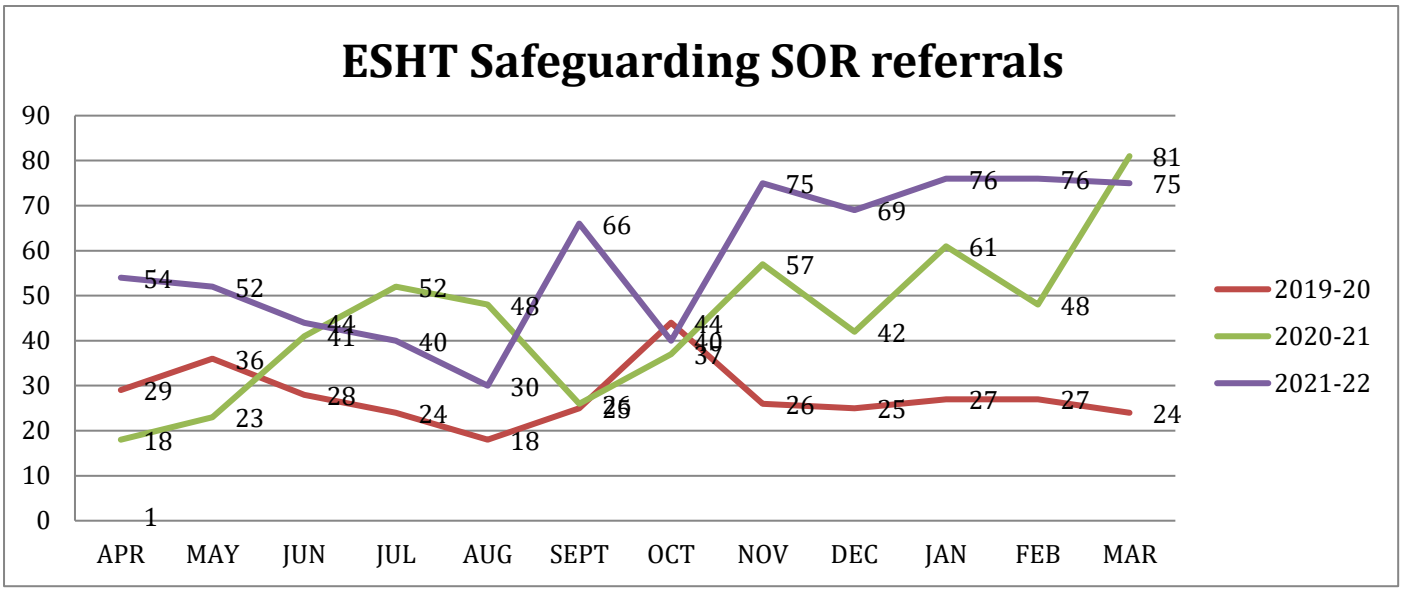


Figure 6

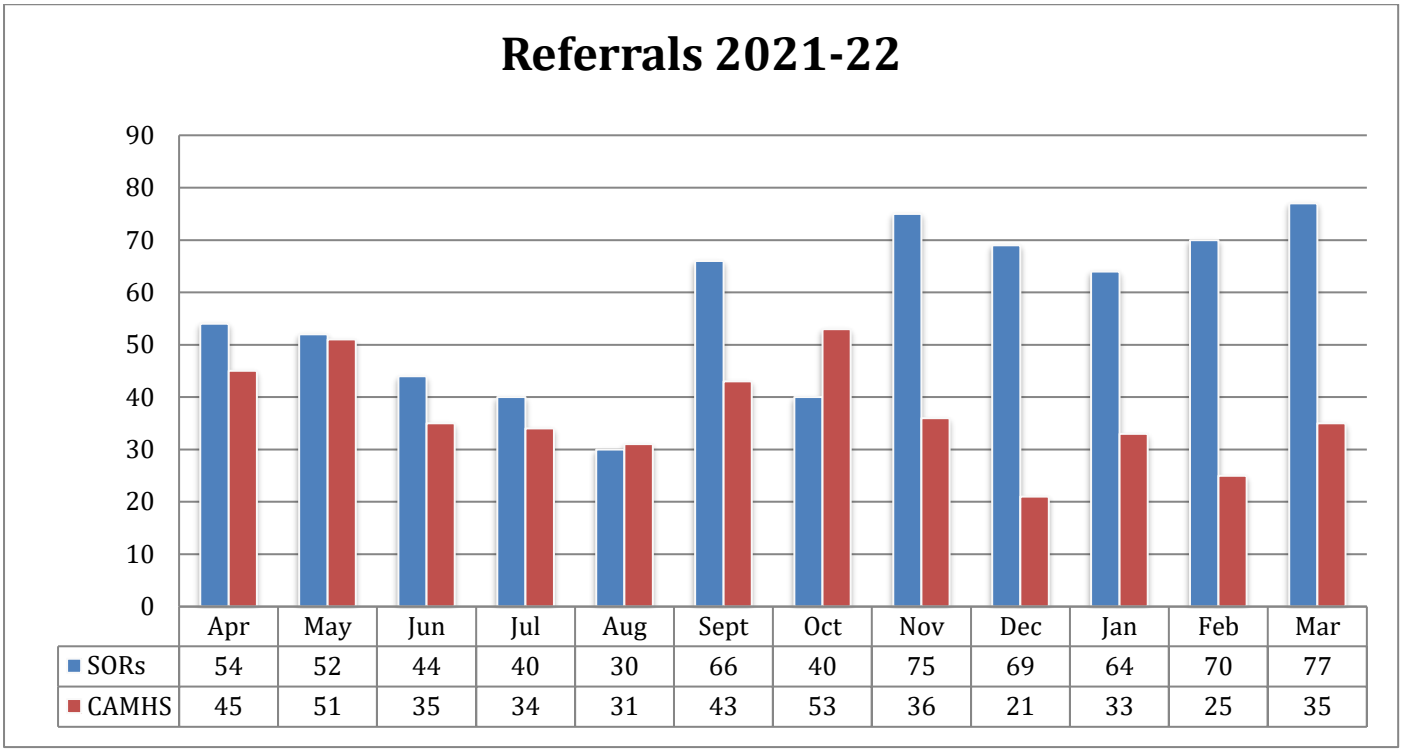


Figure 7

9.2 Mental Health Presentations under 18

The predominant theme discussed within the weekly children's Safeguarding risk meeting has continued to be mental health issues, demonstrated by presentations following overdose and various forms of self-harm in addition to an increase in referrals to Child and Adolescent Mental Health Services (figure 8).

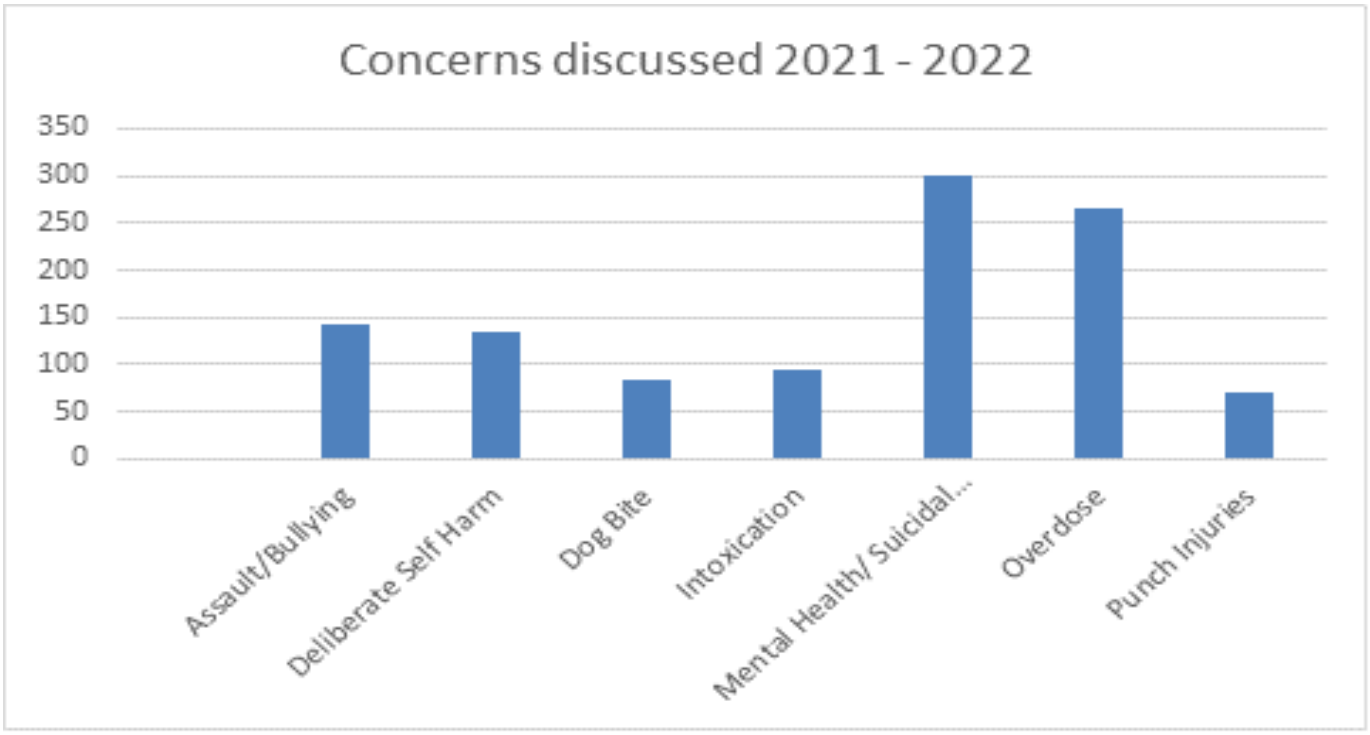


Figure 8

The increasing trend in children seen with mental health concerns discussed in the risk meeting can be viewed over five years
(Figure 9)

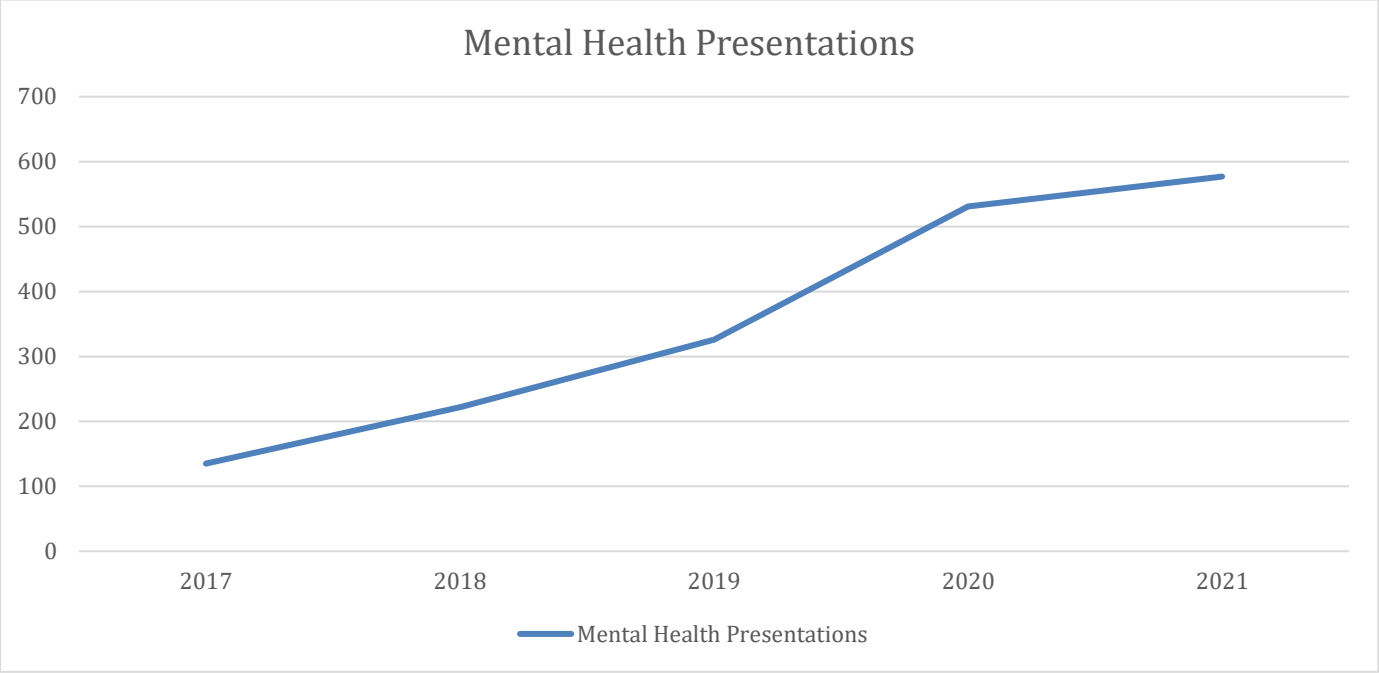
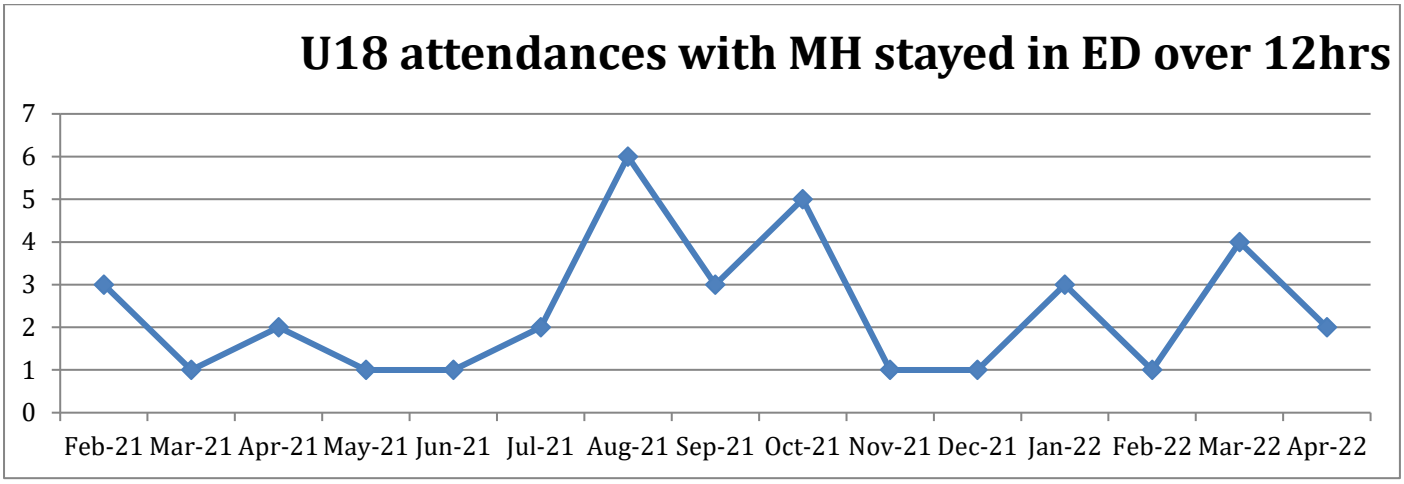


Figure 9

The picture is also with adolescents presenting with complex mental health and psychosocial needs being admitted to the Paediatric ward. A further complication has been the lack of available Specialist Paediatric mental health in-patient beds to transfer patients with a result that some admissions have been for a sustained period whilst professionals sought therapeutic accommodation. This difficulty is reflected in neighbouring trusts, with a predominant theme of eating disorders. Also, an issue with children and young people has been those stranded needing emergency foster placement not a mental health bed.

- The Chief Nurse has raised this issue at system and regional levels.
- Head of Safeguarding is part of a Sussex Wide forum for stranded children.

Due to Operational pressure within the organisation within the last year there has been an additional risk where children with Mental Health issues have waited in the Emergency department (figure 10 and 11) for prolonged periods, (this is not unique to ESHT).



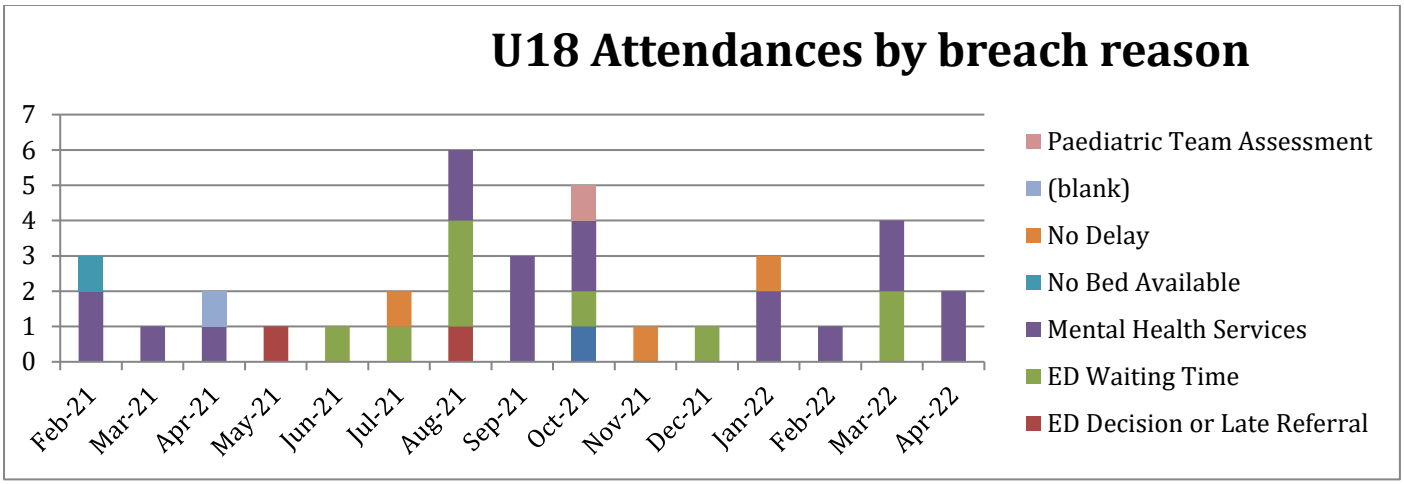


Figure 11

9.3 Named Doctors for Safeguarding Children

There are three named Doctors, two acute based and one community, all three work closely with the Head of Safeguarding and the Specialists Nurses for safeguarding Children. The three Named Doctors provide clinical advice guidance and support. Their work within the last year has included,

.

- Participation in national network of named professionals to share best practice
- Regular meetings with CSC locality managers to improve inter-agency communication and working
- Support for liaison nurses in considering referrals for possible child protection medical examinations
- Support of colleagues at strategy meetings and case conferences, and in provision of written safeguarding medical reports.
- Leading and facilitating bi-monthly peer support meetings to consider children with Perplexing Presentations
- Support for medical and nursing colleagues in dealing with the massive increase in patients with mental ill health and complex psycho-social problems admitted to the children's ward, many of whom have no physical health needs.
- Training for and supporting colleagues in managing young people with eating disorders
- Consultant peer review of safeguarding cases, provision of safeguarding induction to paediatric and ED physicians, development of regular paediatric and ED safeguarding teaching programme (the last is a work in progress)

- Organising training on the application of the Mental Health Act

Within a child protection investigation, Paediatricians may be asked to conduct an urgent child protection medical or welfare medical. The process for medical examinations has been more clearly defined and is constantly reviewed and refined as necessary, for example with provision of rapid feedback to social workers of initial opinions, and data is now collated as to how many medicals occur during a monthly period. Welfare medicals were adversely impacted due to the Pandemic as it was necessary to repurpose their clinic spaces.

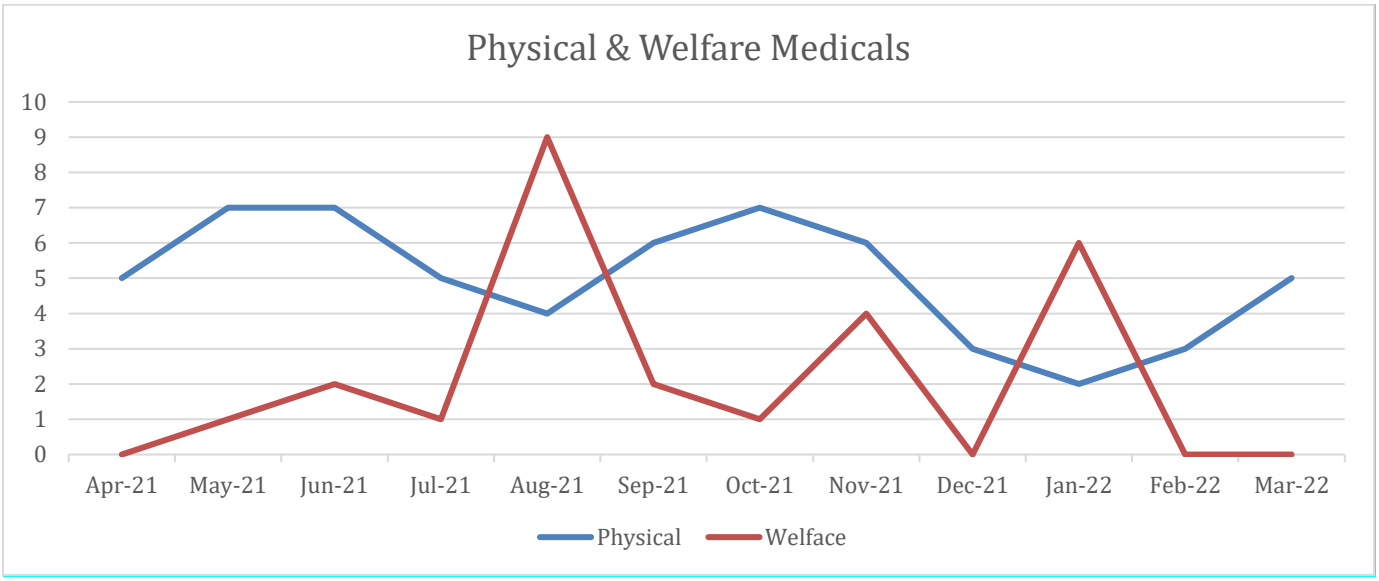


Figure 12

9.4 Safeguarding Adult Referrals

Safeguarding alerts/referrals can be raised by staff, patients, family members or the public and are received by Adult Social Care (ASC), who apply three key tests to decide if the concern raised meets the threshold for a Section 42 Adult Safeguarding concern. Of the referrals ASC receive, not all result in a Section 42 Enquiry, and may not progress after information gathering. The work undertaken within the safeguarding team for section 42 enquires and information gathering is however similar.

During 2021/2022 ESHT raised and or were involved in 543 safeguarding enquiries, this is a continued upward trend over the last few years (figure 13). This covers both acute and community services, however it should be noted that not all enquiries meet the threshold following investigation for section 42.

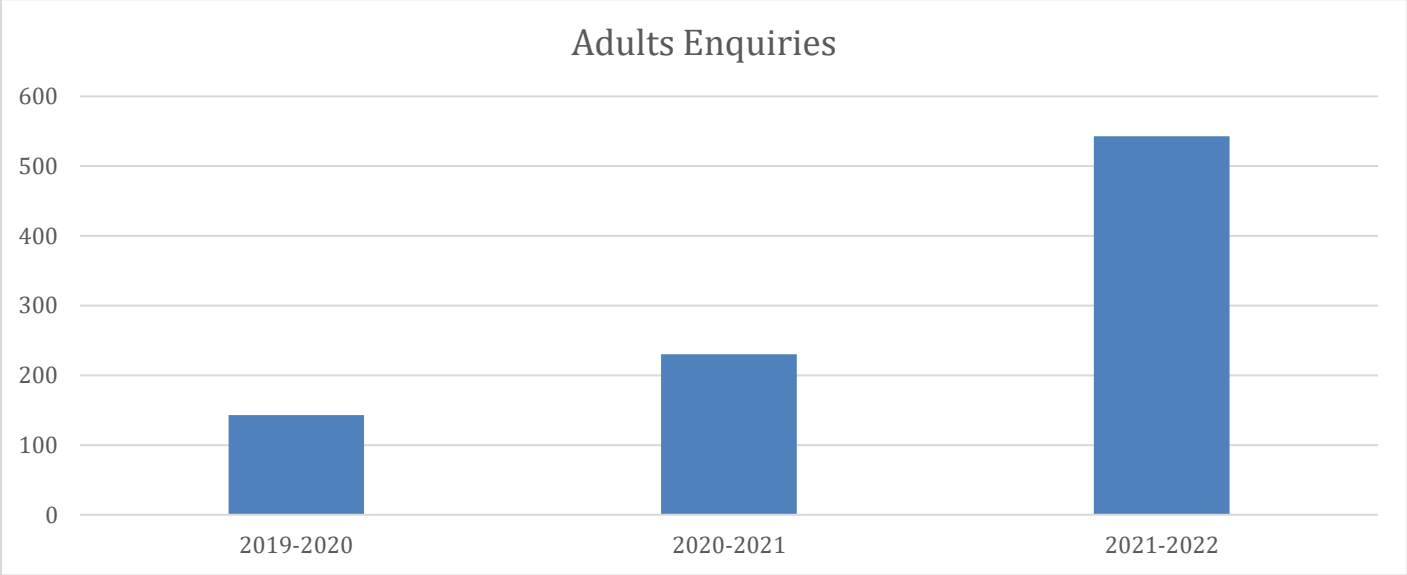


Figure 13

Neglect, self-neglect, and domestic abuse are identified as themes raised as safeguarding enquiries (figure 14). The presentation of safeguarding issues has shown an increase in the complexity of cases, the Safeguarding Adults Speciality submitted a referral under the criteria for the Safeguarding Adults Board (SAB) adult death protocol in the last year and a referral to the newly convened Multi-Agency Risk Meeting (Marm).

Safeguarding supervision for some clinical teams was paused during the acute phases of the pandemic and has been offered virtually via Micro-Soft teams for those staff enabled to access, such as Dietetics and Sexual Health. The Safeguarding team are reinstating supervision and have made connections with both the community and acute settings. This has enabled teams to access team support whilst managing complex safeguarding cases and has also enabled the “Think Family” approach to be embedded further.

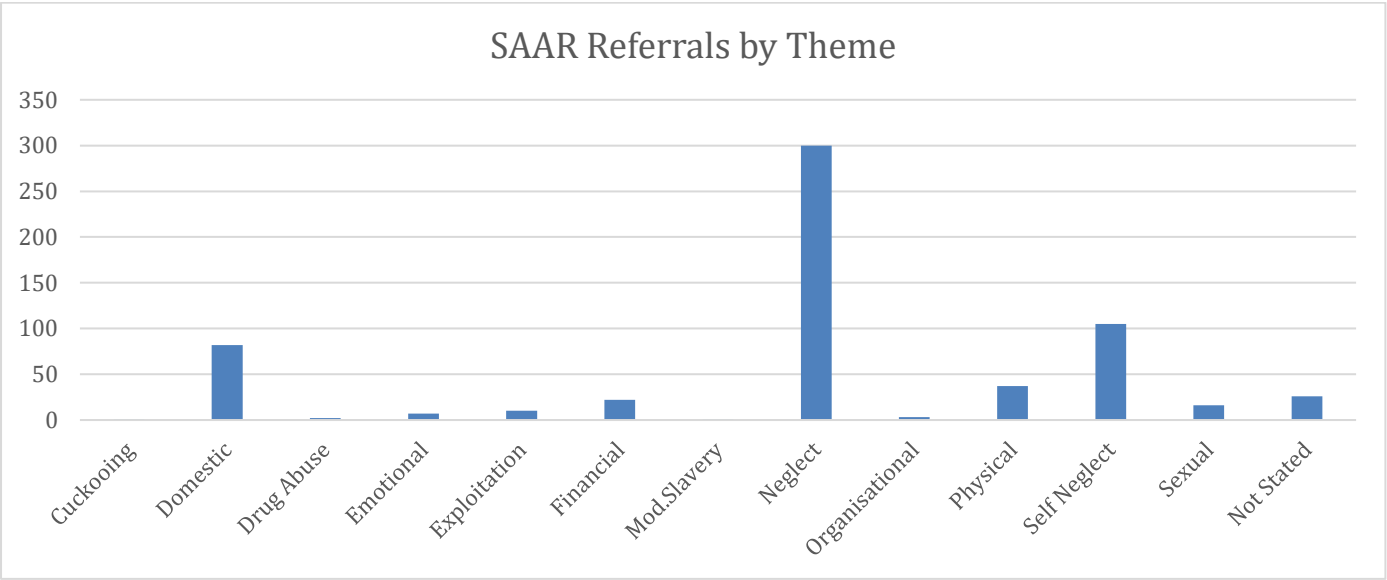


Figure 14

10.0 - The Mental Health Act – ESHT Duties

There continues to be a service level agreement with Sussex Partnership NHS Foundation Trust (SPFT) to enable the Trust to meet its legal requirements and ensure patients admitted to inpatient beds have their rights protected and their mental health care needs are met by a Responsible mental health clinician. The Head of Safeguarding attends monthly Mental Health Act meeting with colleagues from SPFT, escalating risk when necessary to the Chief Nurse. The team has strived to improve safeguarding governance in monitoring ESHT compliance and works collaboratively with SPFT teams to address any areas of non-compliance. This work has included the following:

- The site team have all been trained to undertake the duties of the receiving officer and maintain detained patients' rights
- Section 135/136 training for ED staff continues to be delivered
- Revision of the Policy for the Mental Health Act to support staff
- Ongoing monthly mental Health Act meetings and Liaison meetings

10.1 Mental Health Presentations

Similar to Paediatric Mental Health Presentations, adult detentions under the mental health act are increasing (figure 15), this is predominantly sections 2 and 5 with section 3 remaining stable.

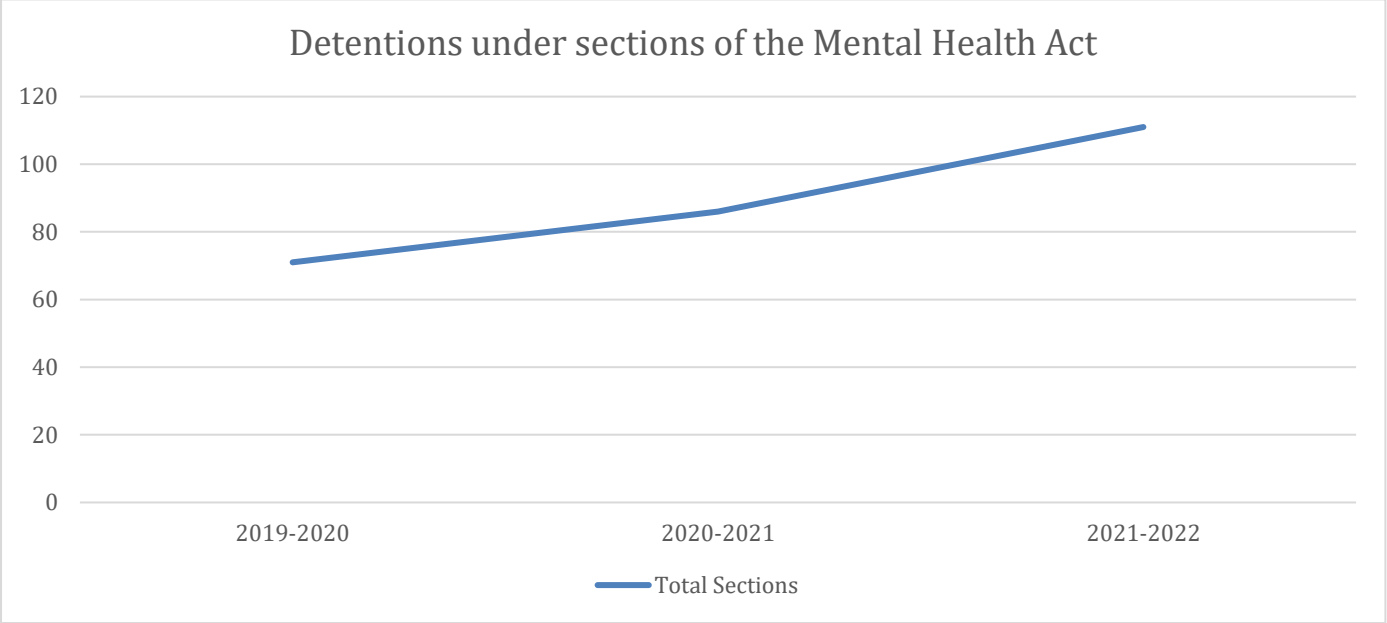


Figure 15

Section 136 detentions which the Police bring to the Emergency Department when alternatives are unavailable and are increasing, also high as a proportion of Sussex wide detentions.

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Total s136 Sussex-wide	92	94	80	93	97	69	84	70	79	58	79	83
Total s136 in East Sussex	35	38	31	32	45	33	31	22	25	28	27	31
Total s136 brought to Conquest	8	8	7	7	15	7	6	8	9	11	9	10
Total s136 brought to Eastbourne DGH	7	12	9	12	15	7	12	5	5	7	13	13

There has been a significant increase in the numbers of people brought by the Police to our ED's for assessment by mental health staff. This has been impacted by the lack of 136 suites county wide and this has been discussed at director level with multi-agency partners.

11.0 - Safeguarding Training

ESHT Safeguarding launched a new model of training in 2020, combining both adults and children's level 3 into a holistic, Think Family offer.
Furthermore, to provide consistency across the organisation and avoid fragmentation all registered staff Band 5 and above have been migrated across to undertake Think Family; this provides assurance in line with the Intercollegiate frameworks (2019) that all registered staff have accessed the required competency. Some of this cohort however previously may have accessed level 2 training for either strand, whilst the migration of staff continues within the next year this will show as a compliance fall, further impacted by the pandemic.
The Think Family project was piloted prior to the Pandemic and launched in February 2020 as a whole day face to face training; at the start of the pandemic this was changed to a virtual offer. Due to Divisional requirement the training was adapted to that of an assessed e-learning module followed by a 3.5-hour webinar. Each of the training sessions is facilitated by two members of staff from the safeguarding team on a weekly basis. There is a fall in compliance for level 3, in part due to the impact of the pandemic and staff access to the webinar but also as a result of now migrating all trained staff Band 5 and over onto the Think Family programme.
The training identifies current safeguarding themes and trends both locally and nationally and has been positively received and well evaluated. However, as a virtual meeting it has been recognised that it does not provide staff with detailed practical elements such as compiling referrals. This has been addressed through flowcharts and the team being more visible in clinical areas to support staff.

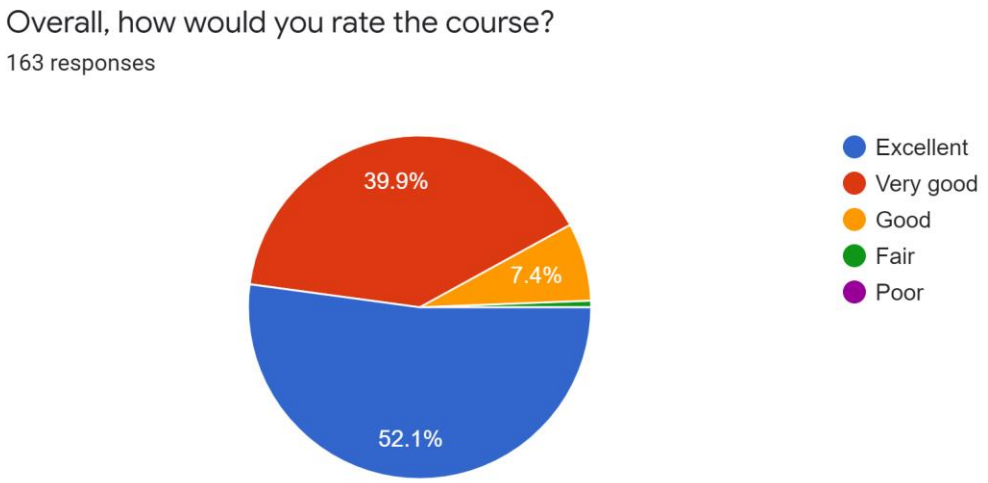


Figure 16

Safeguarding Training compliance

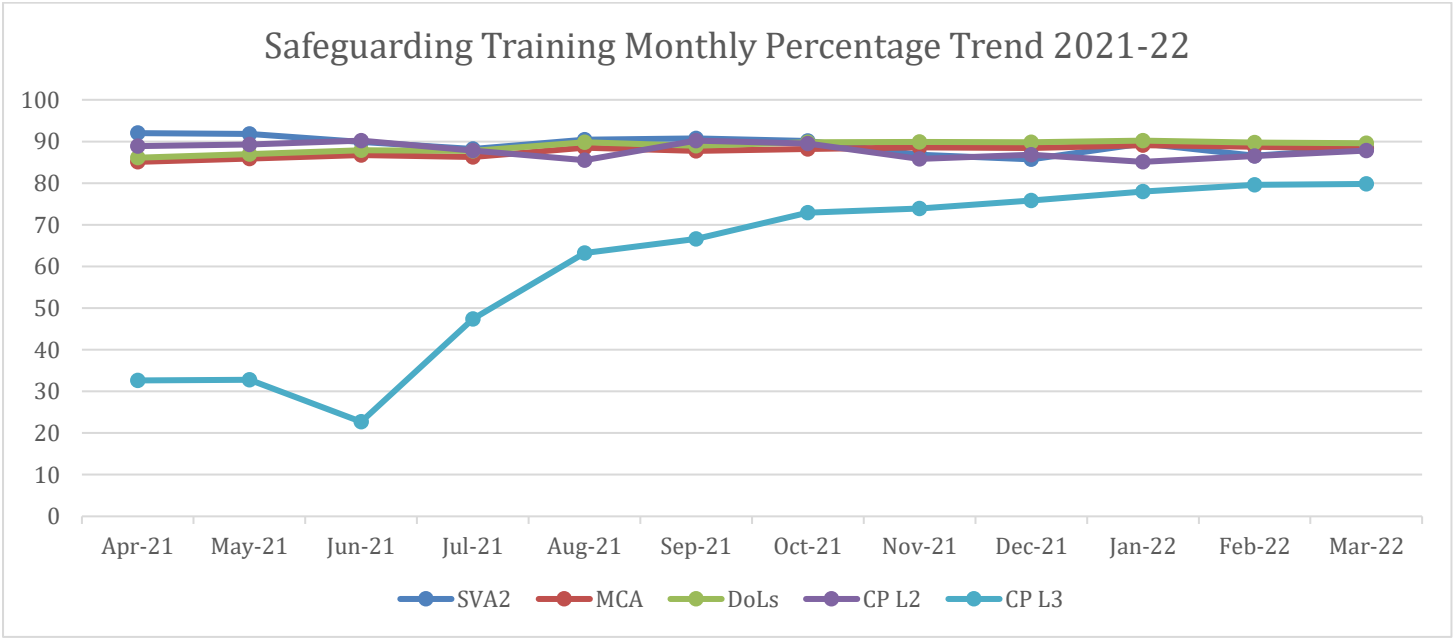


Figure 17

12.0 - Learning Disabilities Safeguarding

The Trust has a Lead Liaison Nurse for Learning Disabilities a post that is jointly funded by SPFT, the ICS and ESHT and aim to, support and facilitate equality, access and treatment for children and adults with learning disabilities who access ESHT services, ensuring compliance with the Mental Capacity Act (2005) and the Equalities Act (2010) through training and advice/support.
The Chief Nurse and Head of Safeguarding highlighted to the CCG that there was a need for an increase in the Learning Disability resource within the organisation. The CCG responded positively and there is now additional LD resources funded by the CCG and working alongside the trust post-

holder. Work continued throughout 2021/2022 to flag' on information systems when a patient has a diagnosed LD. By flagging patients, it is hoped that we will be better able to anticipate and meet patients' needs and enhance the quality of the care people with LD receive. The Learning Disability Liaison Nurses contribute to the NHS England 'LeDeR - Learning from Lives and Deaths' process to highlight improvement needs and good practice within the Trust.

13.0 - Children in Care (CIC) / Looked After Children

The whole team have been creative and worked innovatively to both maintain and improve service contacts, quality and performance during the second year of the pandemic. They all continue to work flexibly.

The challenge of managing the health records of adopted children within the current legislation continues, however the working group has been suspended pending national guidance.

There has been an agreement across the Trust to cease using the term 'LAC' for Looked After Children and move to the term 'Children in care' (CIC), as asked for by children.

Medical staffing has been challenged with unfilled vacancies and there was nurse sickness and vacancies for extended periods throughout the year, but workload has been somewhat supported by exemplary staff attendance throughout the year and some individuals undertaking additional hours to support the KPI of RHA completion.

Review Heath Assessment (RHA) performance continues to be affected predominantly by late requests from children's services, although fewer are being rejected due to incomplete or incorrect documentation by the nurse team due to revised, less restrictive criteria being created by the Named Nurse. Requests by Other Local Authorities (OLA) for RHA and the associated caseload work for these complex cases has been significant. Collecting child and carer feedback continues to be a challenge. The Named Nurse has met with the ESHT patient experience manager for support in undertaking meaningful consultation and has subsequently begun consultation with the Care Leavers forum, the Children in Care Council and Healthwatch.

Covid and the associated lockdowns have had a significant impact on CIC workload and practices with clinical staff almost exclusively working from home for all of 21-22.

The trust has worked to support staff wellbeing, maintain team communication, flow and looked to protect staff, children, and carers by extending our Covid safe venues for face-to-face contacts with access to appropriate PPE. Some Unaccompanied Asylum-seeking Children (UASC) have been seen in a sexual health clinic that has proved to be a suitable environment.

Lansdown Secure Unit

NHS England looked for contract bids for a prime provider. Sussex Partnership Foundation Trust were awarded the contract and therefore East Sussex Health Care NHS Trust ceased to provide the physical health nurse offer and administration to the home from 1st July 2021.

13.1 LAC profile

	Year	Children who started to be looked after	Children who ceased to be looked after	Total number of looked after children
East Sussex	2017	198	185	555
	2018	203	162	602
	2019	192	192	600
	2020	193	203	590
	2021 (data unverified)	206	174	612
	2022 (data from CCG)	236	200	628

12.2 Initial Health Assessments (IHA)

The IHA performance target within the Service Level Agreement is set at 85% completed within timescale

IHA	Distributed 20 days from entering care	Distributed 16 days from complete paperwork (referral) received
Q1	31%	61.5%
Q2	21%	48%
Q3	52%	52%
Q4	50%	61%
Year-end total	**38.8%**	**58.5%**

13.3 Review Health Assessments

The RHA performance target within the Service Level Agreement is 85% completed by due date

	0-18 years combined
Q1	65%
Q2	63%
Q3	59%
Q4	63%

A Performance Improvement Action Plan was developed between the commissioner and ESHT initiated in November 2021 and ESHT worked to improve the KPIs for both initial and review health assessments from the rest of the financial year. See below

Looked After Children Performance

Over the 12 months the frequency of RHA requests that are rejected by the nurse team has reduced. A data cleansing exercise is underway to ensure that ESCC and ESHT have the same CIC children and RHA dues dates on their systems. There continues to be a significant proportion of RHA that are not being requested by the Local Authority.

13.4 Leaving Care Health Summaries

'Health Care Summary' document has been agreed for use across the ICS and work is ongoing to agree guiding principles for managing Leaving Care Health summaries.

Quarter	Number eligible/due	Number and percentage of completed health summary on personal record as child turns 18 years
Q1	**Total - 19**	**15 =79%**
Q2	**Total - 21**	**16=76%**
Q3	**Total - 24**	**19=79%**
Q4	**Total - 24**	**16=66.6%**

It has been agreed locally with the Named Doctor that for young people who enter care aged 17yrs plus the Dr will include additional information on health promotion in the IHA to enable the IHA report to double up as the Leaving Care Health Summary. We will need to consider how we are going to capture this activity for reporting purposes.

13.5 Quality Assurance by Audit of Health Assessments 'Quality and Dip samples'

The Named Nurse undertakes dip sampling throughout the year of East Sussex RHAs and Other Local Authority (OLAs) RHAs undertaken by the ESHT CIC nurse team. This is usually on a quarterly basis.

Due to long term sickness and vacancies in the nurse team, the Named Nurse has taken on some case loading for children in care and subsequently had not had capacity to complete the Quality assurance process robustly for the year. However, some dip sampling has taken place.

"RHAs continued to be offered in a variety of ways, either telephone, Video calls or face to face. The quality of the RHA's remains high. The RHAs remain detailed and thorough. Strength and Difficulties questionnaires are not always completed by the carer, completion ranging from 52-68%. This is fed back to the SW via the health action plan. The RHAs are person centred and I always hear the voice of the child when I am dip sampling the RHAs."

13.6 Supervision and Training

Supervision

Specialist nurses continue to have access to quarterly supervision with the Named nurse in addition to 6-8 weekly 1:1s with the service manager. Compliance with supervision has been between 47-100%, due to long term sickness, and Named Nurse covering clinical caseload work for an extended period of time in quarter 4. Furthermore, Specialist nurses the have opportunity bi-monthly to discuss cases with the Named Doctor.

All doctors undertaking CIC assessments have the opportunity for monthly supervision. This is usually group supervision but is occasionally 1 to 1 if felt to be more appropriate.

Named and designated doctors have additional meetings with opportunity for supervision (these are also monthly), there is informal supervision on an ad hoc basis between these also.

Training

To effectively promote the health and well-being of Children in Care, all staff working in healthcare settings must have the knowledge and skills to carry out their roles, as set out in the Looked After Children; Knowledge, skills and competencies of healthcare staff, intercollegiate Framework (RCPCH, RCN, 2020)

ESHT ensures that the staff within the organisation are trained commensurate to their roles and identified through regular performance appraisal. Level 2 and 3 LAC training is now mandatory for all relevant staff. Level 3 training is now delivered via MS teams, as a webinar monthly by the CIC nurse specialists with support from the Named nurse. It is anticipated that it will take until 2023 for the Trust to gain full compliance with the Level 3 training of the relevant staff groups.

The Named Nurse has led a Sussex wide Level 2 training online e-learning package. training.

All CIC nurses have maintained a high level of compliance with their mandatory training including their Level 4 competencies.

14.0 - Challenges Going Forward

Implementation of Liberty Protection Safeguards, within which there are key changes will have a significant impact on ESHT;

- LPS can be applied to a person aged 16 and above
- If the LPS is applied for within and NHS setting, the 'hospital manager' (the trust), become the responsible body
- An LPS may move with the person to differing settings i.e., between a care home and hospital
- An LPS can be applied to a patients' home environment, which will impact community staff requiring additional time to assess a patient's mental capacity and complete the documentation.
-

Increase in numbers of Safeguarding presentations neglect, self-neglect, and domestic abuse across the population, alongside the complexity of cases.

Increases the numbers of Domestic Homicide reviews and serious case reviews.

The Impact of an increase in mental ill health presentations across the population

The impact of the increased vacancies within the Health Visiting service which has resulted in withdrawal from ante-natal contacts, reduced presence within child protection conferences and changes to work practice to a generic model.

15.0 Conclusion

Safeguarding continues to be challenging with increased numbers in safeguarding numbers and presentations across all sectors. Moreover, there are changes in the demographic with a rise in the complexity of cases, first seen against the backdrop of the pandemic but sustained since. As a trust

we have seen rise in both children and adults suffering with mental health issues and with the economic challenges this is likely to continue, with fuel poverty a real issue.

The introduction of the Mental Capacity Lead role has been shown to have a positive impact with clinical areas recognising and submitting Dols applications

The team have remained passionate and professional continuing to support and advise all clinical areas in addition to driving forward the Think family agenda.

The Q&SC and the board are asked to note the contents of this report and to continue to offer their support for what is an increasingly complex and challenging agenda.

Name: Head of Safeguarding
Date:

References

Intercollegiate Document: Safeguarding Children and Young People roles and competencies for healthcare staff (2014) Royal College of Paediatric and Child Health.

Intercollegiate Role Framework: Looked After Children Knowledge, Skill and Competences of Healthcare staff (March 2015) Royal College of Paediatric and Child Health

Adult Safeguarding: Roles and Competencies for Health Care Staff (First edition: August 2018) Royal College of Nursing

Mental Capacity Act 2005 and the Deprivation of Liberties Code of Practice
https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

Equality Act (2010) HM Government

Working Together to Safeguard Children (2013,2015,2018) HM Government

Children Act (1984, 2004) HM Government

Care Act (2014) HM Government

The Modern Slavery Act (2015) HM Government

Isolated and struggling Social isolation and the risk of child maltreatment, in lockdown and beyond Eleni Romanou and Emma Belton NSPCC Evidence team June 2020

COVID-19 adult safeguarding insight project - third report (December 2021) | Local Government Association

Appendix 1 - Work Plan

Action Number	Source	Requirement	Action	Executive Lead	Responsible PERSON	Progress
1	Children Act 1989 and 2004 and the Care Act 2014	East Sussex Healthcare NHS Trust Safeguarding Team must ensure that it meets its statutory responsibilities identified within the Children Act 1989 and 2004 and the Care act 2014	Comply with the legislative guidance within the Safeguarding Acts and meet the statutory responsibilities training compliance all staff all settings Documentation of MCA processes in records	DON	Head of Safeguarding	
2	ESSCP Current Child Practice Reviews (CPR)	To undertake the ESSCP Child Practice review	To undertake any action as required by the ESSCP in relation to commissioned child practice reviews	DON	Named Nurse for children	
3	SAB SAAR	To undertake the SAB Safeguarding Adult Case reviews	Complete all actions to implement recommendations following publication	DON	Named Nurse for Adults	
4	SAB DHR	To undertake the Domestic Homicide Reviews	Complete all actions to implement recommendations following publication	DON	Named Nurse for Adults	
5	NHSE / NHS	To comply with the LD Improvement Standards for NHS Trusts (2018)	Baseline assessment and action plan to address any noncompliance's with LD standards to achieve ESHT compliance	DON	Specialist Nurse Learning Disability	
6	CQC / Safeguarding Legislation	Competent and trained workforce who are able to discharge their safeguarding responsibilities in line with the Safeguarding Roles and Responsibilities (Intercollegiate Documents)	All divisions to meet standards of compliance with training and remedial action plans in place to address any noncompliance	DON	Assistant Directors of Nursing April 2020	
7	CQC / Safeguarding Legislation	To ensure there is a competent and trained workforce who are able to discharge their safeguarding responsibilities in line with the Safeguarding Roles and Responsibilities (Intercollegiate Documents)	All divisions to meet standards of compliance with safeguarding supervision and remedial action plans in place to address any noncompliance	DON	Assistant Directors of Nursing April 2020	
8	Mental Health Act (2017)	To comply with the requirements set for acute NHS providers in relation to detained patients and staff competency	To comply with the legislative guidance within the Mental Health Act and meet the statutory responsibilities	DON	Deputy Chief Operating Officer	
9	Mental Health Act (2017)	To ensure the annual KP90 return is submitted for ESHT	Complete and submit the KP90 return annually	DON	Deputy Director of Nursing	
10	PREVENT Statutory Duty (s26 Counter-Terrorism and Security Act 2015) to safeguard	To meet the statutory requirement to promote the national PREVENT strategy at a local level throughout the NHS	Ensure that there is a nominated lead for PREVENT, staff are trained in PREVENT awareness and WRAP and that the quarterly PREVENT return is submitted for ESHT	DON	Head of Safeguarding	
11	Female Genital Mutilation (FGM) Statutory Duty to safeguard	To meet the statutory requirement to promote the national FGM strategy at a local level throughout the NHS	Ensure that there is a lead for FGM, staff receive training in FGM Awareness at the appropriate level, and the quarterly FGM return is submitted for ESHT	DON	Named Midwife	

East Sussex Healthcare NHS
NHS Trust

Infection Prevention & Control

Annual Report
2021 - 2022

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Executive Summary

This report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare NHS Trust (ESHT) for the financial year 2021/22. Arrangements made by ESHT to allow the early identification of patients with infections, measures taken to reduce the spread of infections to others, audit, surveillance, achievements, and challenges are presented.

The prevention of avoidable infections is fundamental to safe patient care. ESHT employs a team of specialist nurses and support staff to advise and co-ordinate activities to prevent and control infection, but it is the responsibility of all staff in the organisation to comply with Trust policies and implement these.

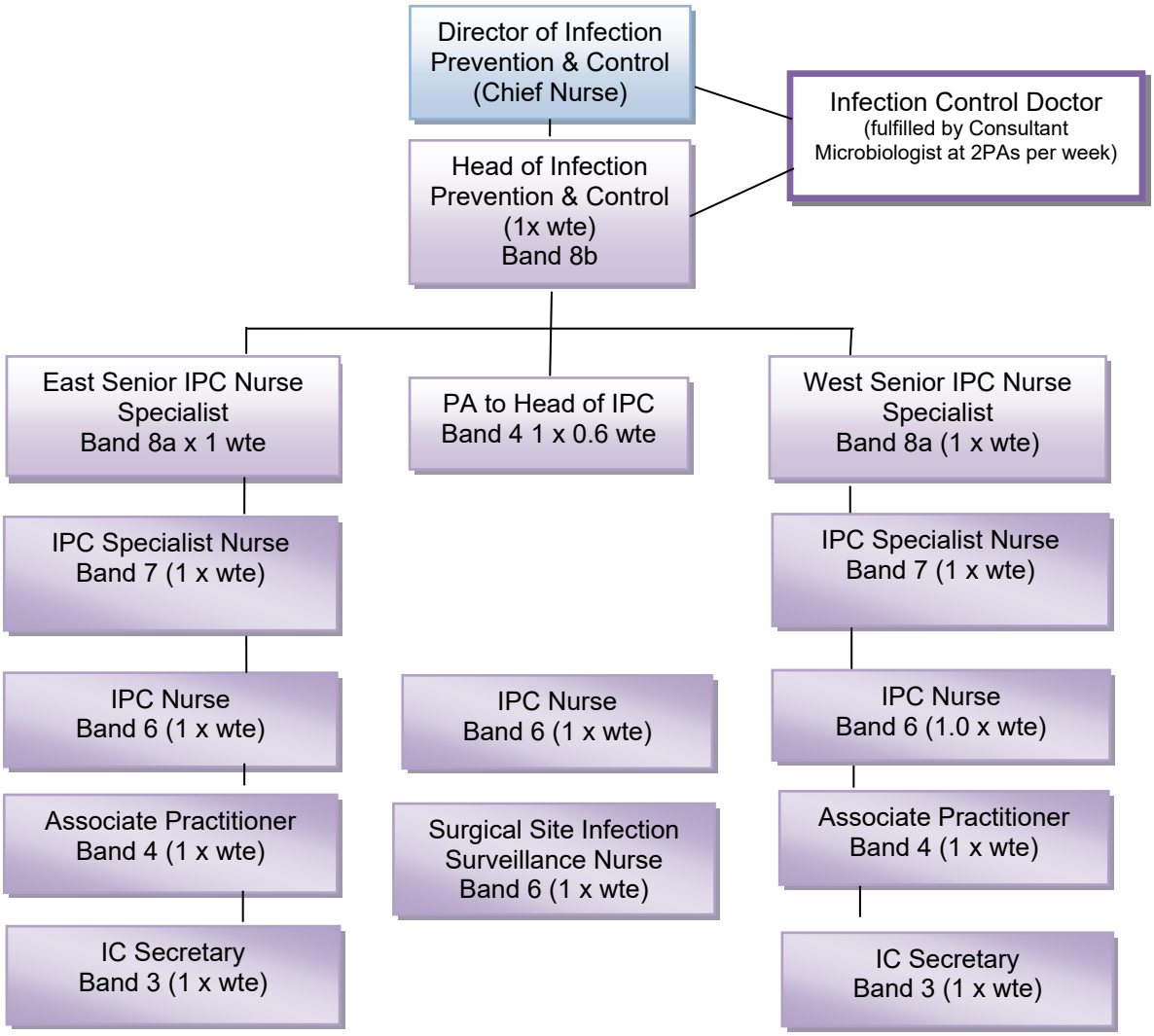
Key points during 2021/22

- COVID-19 continued to dominate the work of the IPC team. Peaks in prevalence occurred throughout the year because of new variants Delta and Omicron, which proved challenging and were associated with high transmission within a bay.
- ESHT reported 46 ward outbreaks in addition to incidences of transmission within a bay. Fewer patients required respiratory support since Omicron became the dominant variant. There was no time during the year when COVID was not circulating.
- Work was undertaken to establish surveillance via Nervecentre to support IPC and Operational Teams to manage the risk of infection while maintaining services whenever possible.
- A thematic review has been undertaken to outline contributory factors and lessons learnt.
- The requirement for mandatory surveillance of healthcare associated infections has been met.
- *Clostridium difficile* infections (CDI) limits were exceeded. 69 cases were attributed to ESHT against a limit of 56. Six cases were assessed as potentially avoidable due to antimicrobial prescribing. There were no outbreaks or proven cross infections.
- The National Specification of Cleanliness audits show compliance with a clean environment and clinical equipment.
- The number of MRSA bacteraemia cases reported was 1 potentially unavoidable infection. We are therefore compliant with the limit of zero avoidable MRSA bacteraemia.
- Intravenous catheters continue to be a source of potentially avoidable MSSA bacteraemia and collaboration with the vascular access team is required to fully understand how this risk can be further reduced.
- The mandatory orthopaedic surgical site infections surveillance scheme data indicates that the incidence of infection with orthopaedic hip infection is higher than national average this is believed to be due to patient related risk factors and changes to type and number of patients having this surgery in ESHT.

Lisa Redmond, Head of Infection Prevention and Control

1. Structure

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



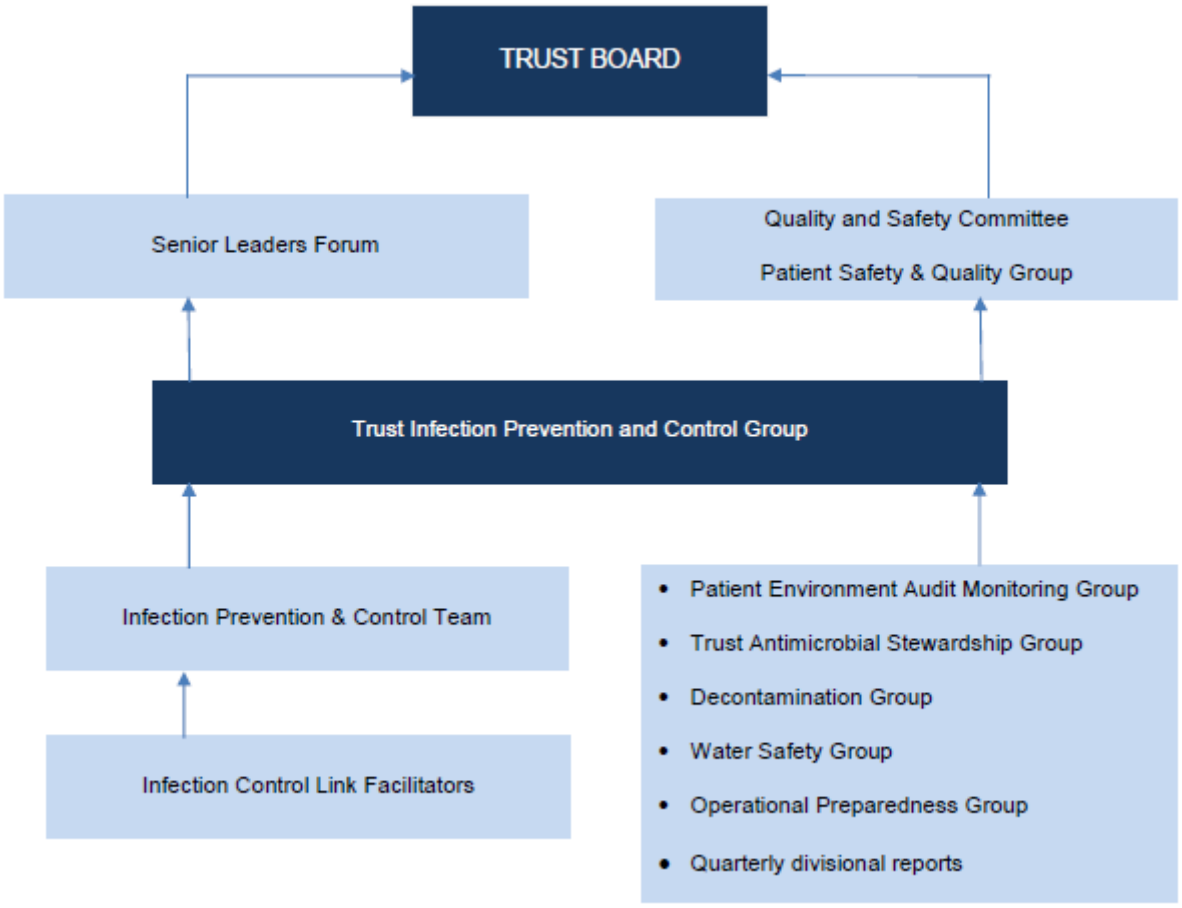
Infection Prevention & Control Team Structure

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

In addition to the IPCT, the Trust also funds 4 x wte Consultant Microbiologist posts (2 on each acute site) based within the Core Services Division who work with the IPCT, one of whom undertakes the role of Infection Prevention and Control Doctor.

An Orthopaedic Surgical Site Infection Surveillance Nurse post has now been moved from the Diagnostics Anaesthetics and Surgery Division to the IPC service and an Antimicrobial Prescribing Lead post is appointed within the Core Services Division.

1.1 Infection Prevention & Control internal reporting arrangements



The Trust Infection Prevention and Control Group (TIPCG) are chaired by the DIPC/ Chief Nurse. The Group meets monthly and has wide representation from throughout the Trust including from Divisions, Occupational Health, Pharmacy, Integrated Care Board, and external membership from the local department of UK Health and Security Agency (UKHSA). The TIPCG reports monthly by exception, to Patient Safety and Quality Group regarding performance and operational issues and compliance against the Infection Prevention and Control Board assurance Framework (BAF). There has been no reporting to the senior leader's forum, but IPC contributes to the Clinical Advisory Group which has been established to support the COVID pandemic response.

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

1.2 Infection Prevention & Control external reporting arrangements

External reporting arrangements have been subject to change in the past year due to development of the Integrated Care Board (ICB). The DIPC and Head of IPC discuss any significant IPC issues with the ICB Head of Quality and Nursing and the Southeast

Lead for NHSE/I. Daily external reporting relating to COVID and additional outbreak reporting processes in relation to COVID outbreaks have continued during 2021/22. ESHT has been compliant with reporting requirements throughout the year.

1.3 Infection Control Link Facilitators

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

The ICLF role has been limited by severe staffing shortages during the year, primary focus remains on hand hygiene and sharing good practice and disseminating guidance relating to COVID. A new programme for link training via MS Teams is in place for 2022/23.

1.4 Joint working across the local system

The Trust IPCT continues to work with the Integrated Care Board (ICB), United Kingdom Health and Security Agency (UKHSA) and NHSE colleagues towards joint strategies for the reduction of healthcare associated infections which can lead to hospital admission.

The IPC specialist nurses are members of the Infection Prevention Society and the senior ICNs participate in the newly convened Sussex IPC cell which aims to share and discuss local initiatives, innovations, and work towards common goals across Sussex.

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

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

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

The Infection Control Board Assurance Framework is structured around the 10 criteria set out in the Code of Practice on the Prevention and Control of Infection linked to Regulation 12 of the Health and Social Care Act 2008. The framework was revised several times during the year to reflect learning and progress of the COVID pandemic.

The Trust performance against framework standards is discussed at the Trust Infection Prevention and Control Group (TICPG) which also receives reports from Divisions as evidence of local compliance and assurance. Compliance with the BAF is then reported

to the Quality and Safety Committee who receive monthly updates on performance, agree actions and report/requirements escalate to the Trust Board as required.

As a result of this new guidance, our lived experience of current Omicron variant of SARS-CoV-2 and reducing local prevalence, we moved forward with reducing the period of isolation for infected and exposed patients and revised the social distancing requirements to increase access to all services and enable greater mixing of staff and patients. We continue to consider the hierarchy of controls, with face masks, triage of patients, hand hygiene and promotion of good ventilation understanding that social distance must not limit access to services. There has been considerable work taking place in all divisions to revise patient pathways and testing requirements as part of moving forward and "living with COVID".

It should be noted that the IPC BAF is iterative and has changed over time.

Key Lines of Enquiry	Compliance Status	Continuous improvement / Actions	Progress with compliance
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.	**Partial**	• There is a new requirement to have a seasonal respiratory winter plan and policy	The Seasonal flu plan is being updated to take account lessons learnt from COVID
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	**Compliant**		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	**Compliant**		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion	**Compliant**		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	**Compliant**		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	**Compliant**		
7. Provide or secure adequate isolation	**Partial**	Unable to audit	Working

facilities		patient compliance with mask wearing.	with governance to seek a solution.
8. Secure adequate access to laboratory support as appropriate	**Partial**	Put in place process to support increased use of lateral flow device testing.	Review of elective care pathway.
9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections	**Partial**	Audit of IPC practice is not robust.	Working with governance team
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	**Compliant**		

Some KLOE in the BAF show amber compliance which reflects new criteria set in the revised guidance on which we are seeking assurance or putting in place new processes. There are only a small number of elements that require further work. Support is being provided to enable robust auditing and reporting of hand hygiene compliance and other IPC standards using the Inphase audit programme recently introduced to the Trust.

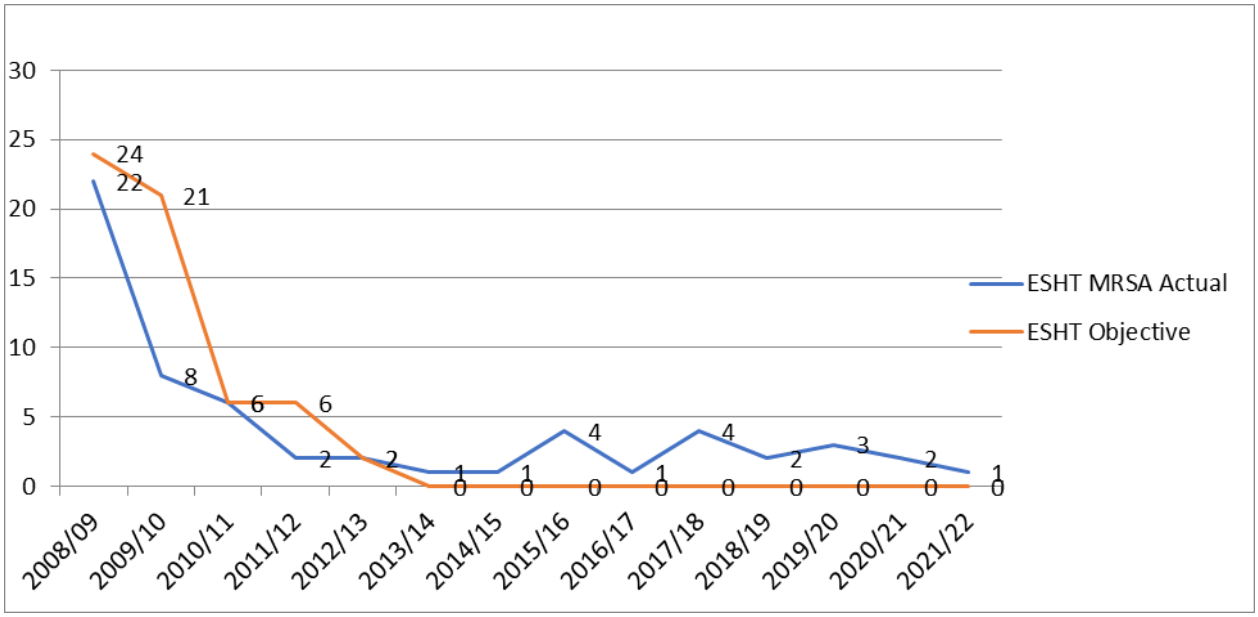
3. Mandatory Surveillance

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

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

3.1 MRSA bacteraemia

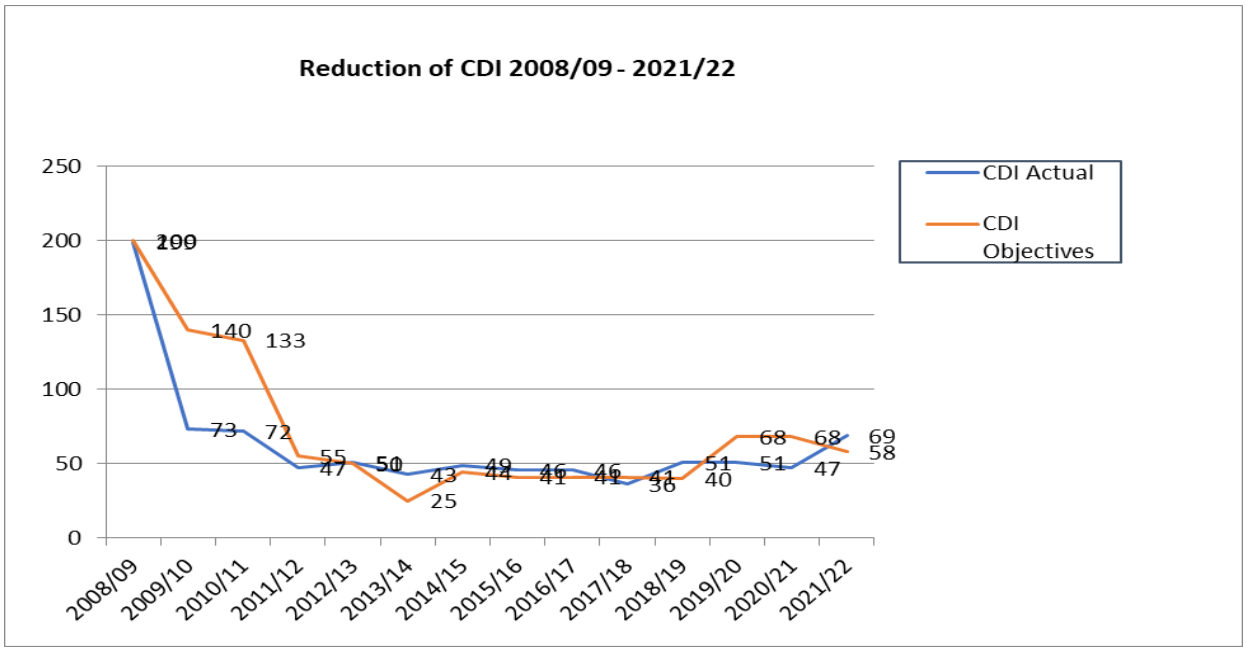
ESHT continues to have a zero tolerance to cases of MRSA bacteraemia which could potentially be avoidable. ESHT reported 1 case of healthcare associated MRSA bacteraemia in 2021/22 compared to 2 cases in 2020/21.



MRSA bacteraemia in a patient who had an extensive history of MRSA colonisation dating back to 1985. The patient had a positive blood culture on admission as well as positive screening from nose, axilla, ulcer swab and CSU. The source was osteomyelitis and endocarditis. Trust policy was followed, and it was assessed that we were unlikely able to avoid this bacteraemia. The subsequent blood culture after 14days of admission required reporting as an ESHT case. The patient was successfully treated with antibiotics.

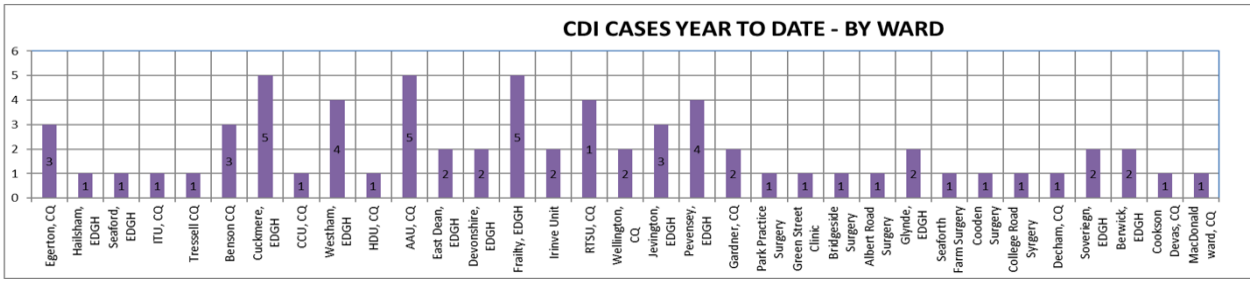
3.2 *Clostridium difficile* infection (CDI)

The annual limit set for 2021/22 was 58 cases for ESHT to take account of prior healthcare exposure within 28 days. In total 69 cases were attributed to ESHT for 2021/22. 17 cases were community onset healthcare associated because the CDI diagnosis was made within 28 days of a patient's previous treatment in hospital rather than related to a current admission. The number of *C.difficile* infections reported annually within ESHT is shown in the chart below.



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

Most cases (39) occurred in Medicine and Urgent Care which is to be expected given risk factors for developing CDI are greater in elderly frail patients and those with gastrointestinal illness. 32 infections occurred at EDGH compared with 18 at Conquest.



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

>72hrs CDI	2021/22
No Lapse in Care	**15**
Lapse in Care likely to have contributed to outcome	**6**
Lapse in Care unlikely to have contributed to outcome	**31**
Community Onset Healthcare associated (PIR not undertaken)	**17**
TOTAL cases	**69**

It was considerably more challenging during the pandemic to arrange the multi-professional post infection review (PIR) but with perseverance each case has been assessed with involvement of the relevant clinical teams. Most of the non-contributory lapses were related to lack of documentation of loose stools and delay in sending stool samples.

Lapses in Care

The year ended with 6 cases thought to have been lapses in care. Three of the patients had a prior history of CDI. The assessment that a lapse may have occurred related primarily to antibiotic prescribing practice in all cases. The Consultant microbiologists and antimicrobial pharmacists have agreed to provide increased support to medical teams in relation to antimicrobial prescribing. It was acknowledged that there has been reduced frequency of antimicrobial audit and antimicrobial stewardship rounds due to the impact of the pandemic on staffing levels and workload.

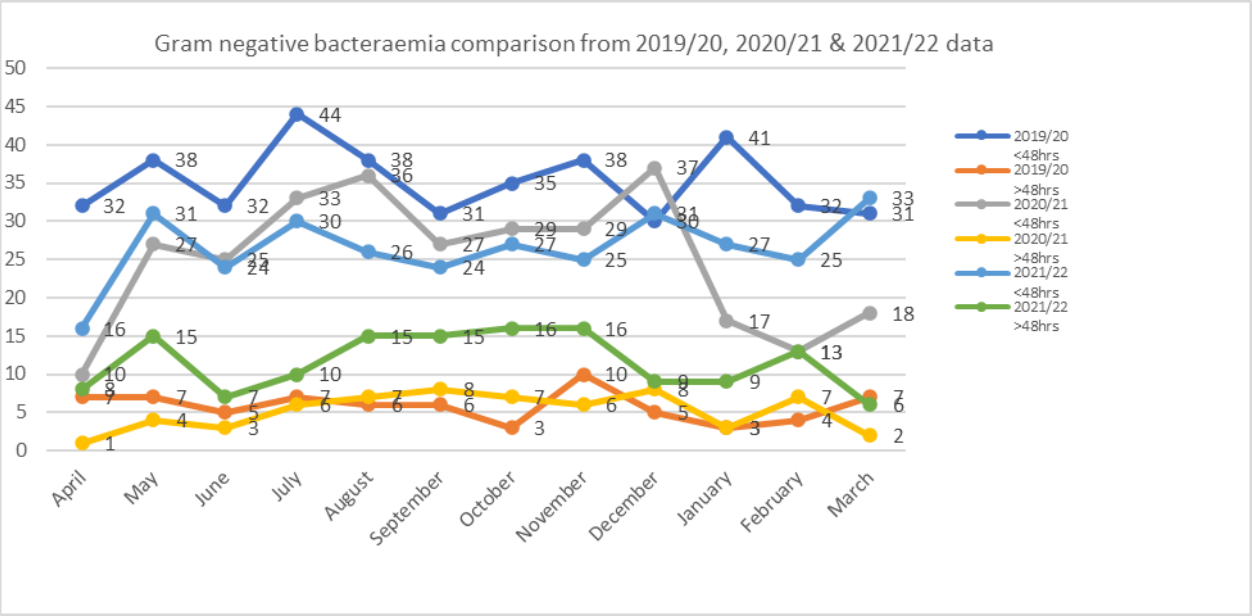
Outbreaks and Periods of Increased Incidence (PIIs)

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

There were three incidences when two cases were considered to be possibly related on three different wards, Frailty, Jevington and Pevensey. These were fully investigated by the IPC team. On frailty ward one sample was not suitable for ribotyping and could not be excluded as possible cross infection could not be fully excluded. The ribotyping of other cases indicated that each incidence was not related to each other and therefore not an outbreak.

3.3 Gram-negative Bacteraemias

The reporting of Gram-negative bacteraemia is mandatory for all provider Trusts. The Government announced its revised plan to reduce healthcare associated Gram-negative bloodstream infections in England by 50% by 2024.



E. coli remains the most common cause of GNB, and this is where we had been focusing improvement work and in 2019/20 ESHT achieved a 26% reduction by reporting 46 cases. The IPC team has been unable to sustain this work during the pandemic.

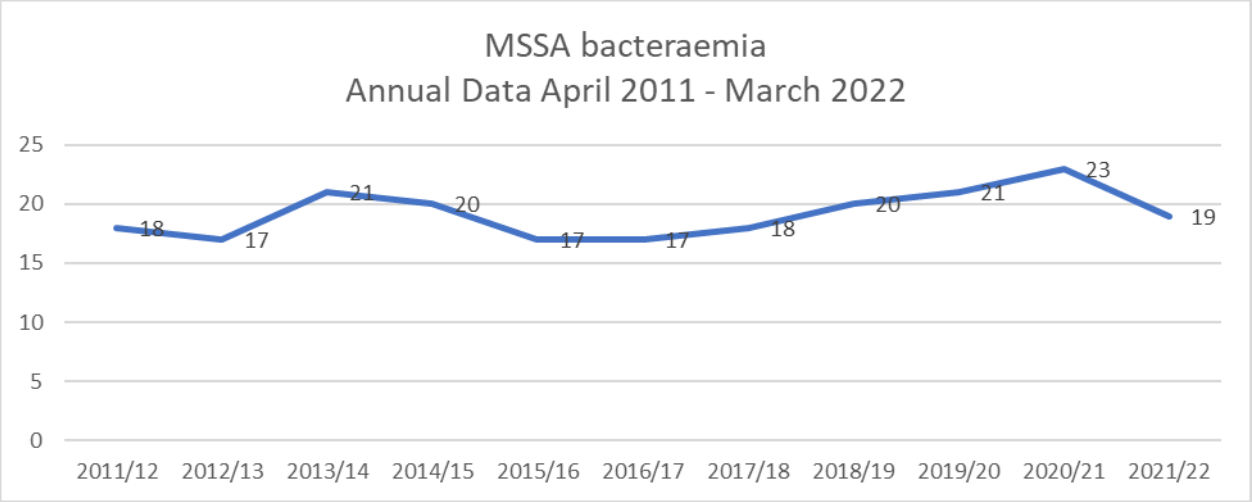
We have reported 44 cases of Hospital onset Healthcare associated (HOHA) E. coli bacteraemia and a further 42 cases of community onset infection where the patient had prior healthcare within 28days. The IPC team is also currently undertaking the *E.coli* bacteraemia primary care data collection on behalf of the ICB under a service level agreement (SLA).Further collaboration as and ICS is required to fully understand how we can positively impact on reducing these infections.

Organism	Total	UTI source	CAUTI source	Biliary	Other	Unknown
E. coli	86	32	16	21	14	19
Klebsiella sp.	38	14	7	5	7	12
Pseudomonas	15	4	3	2	6	3
Total (%)	139	50	26	28	27	34

When the IPCT undertake the surveillance of each case, every effort is made to identify the source, and this includes discussion with the consultant microbiologist. There was

less time to spend on each investigation due to the increased work from the COVID pandemic, but all mandatory reporting requirements were met.

3.4 Mandatory reporting of Methicillin sensitive Staphylococcus aureus (MSSA)



The number of MSSA bacteraemias at ESHT has reduced by 10% this year, returning to pre-pandemic levels. Mandatory surveillance has been undertaken and if source is considered avoidable then every effort is made to investigate further. Two cases were considered possibly avoidable related to intravenous catheters. The Vascular Access Team is contacted when a bacteraemia is considered line related to ensure staff is aware of the correct management of intravascular lines and vessel health preservation.

3.5 Mandatory Surgical Site Infection Surveillance Scheme

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

Please note: PHE SSISS studies are undertaken prospectively and submitted quarterly but results are published 12 months retrospectively as infection rates are influenced by performance and readmissions within the audit population over each 12 month surveillance period. Finalised results are therefore only available up until the end of March 2021 although data from April 2021 onwards is within the surveillance system and continues to be analysed and officially reported by PHE at the end of the following year. ESHT submitted data for the four quarters of the year (April 20 – March 2021).

Core data 1st April 2020 – 31st March 2021

Category of surgery	Number of procedures	Number of infections	Infection rate	Mean infection rate for all participating Trusts (data April 2015 -March 2021)
Total hip replacement	145	2	1.4%	0.4%

Total knee replacement	136	0	0.0%*	0.4%

There has been good engagement with the Orthopaedic Consultants and the Surveillance Nurse and this engagement has facilitated improvements in the Orthopaedic Pathway.

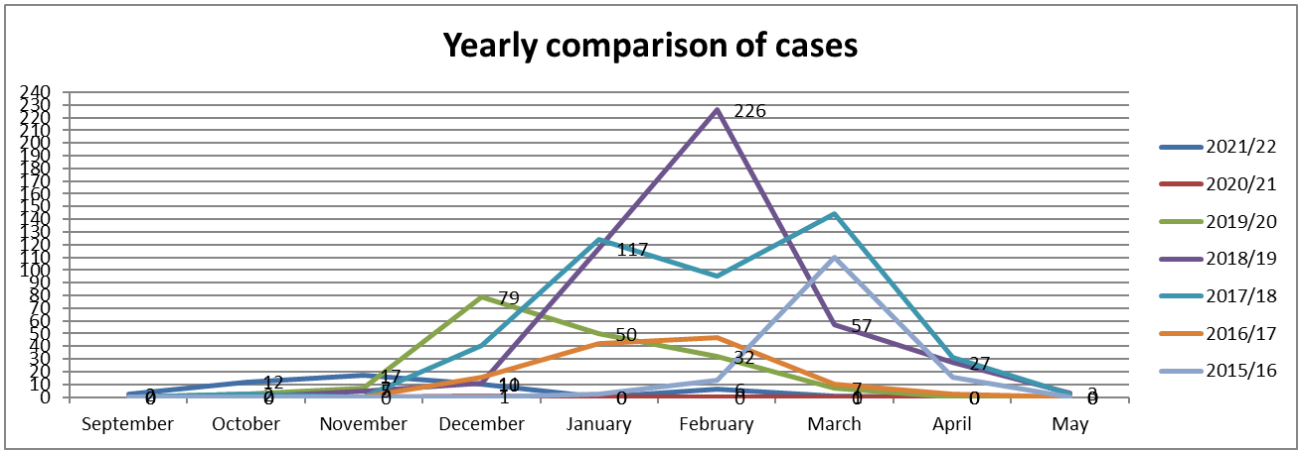
ESHT reported a high rate of surgical site infection in orthopaedic hip and knee surgery in period July to Dec 2021 and the service agreed an action plan and have actively worked to ensure compliance with NICE standards for reducing surgical site infection. The process for agreeing cases that meet the definition for reporting to PHE has been strengthened. A multi-professional group chaired by the Chief Nurse (DIPC) is in place to assess cases prior to submission to PHE. The group reported that higher infection rates were due to patients having significant co-morbidities and due to COVID, the patients were deconditioned whilst on the waiting list. We do not have any indication that the infections we identified related to cross infection. As a result of the COVID pandemic, operation numbers were greatly reduced from normal activity, and this also affects the data. The Orthopaedic team are introducing a pathway for using PICO dressings prophylactically for high-risk patients. This is supported by the NICE Guidance -Using PICO negative pressure wound dressing for closed incision management- MTG43.

Since Oct 2021 the infections that we have identified have been caused by Enterococcus faecium, Staphylococcus aureus and MRSA. Following the positive experience of participating in the QIST (Quality Improvement in Surgical Teams) programme, it was agreed to continue with routine decolonisation of patients having planned orthopaedic implant surgery to reduce the risk of MRSA and MSSA infection. We currently still do not swab for MSSA. Patients now receive a YouTube link from the company for both body wash and nose gel. As part of our quality improvement work regarding surveillance and orthopaedics, pre- assessment is working towards re-establishing the Joint Schools on both sites and are in talks with all the departments to look at developing a video that can be shared with patients giving them an insight into all the teams that will be involved in their care pre-operatively and post operatively, to ensure patients are fully able to manage expectations prior and post-surgery.

The ICN undertaking the role of Orthopaedic Surveillance Nurse has undertaken training with the surgical teams on the wards and theatre and ward staff have had additional training on use of PICO dressings.

3.6 Influenza

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



Only 48 patients were diagnosed with Influenza during the year, 33 were influenza A, 7 Influenza A&B and 6 cases of Influenza B and 2 others. This was an increase on the previous year but much lower than pre-pandemic. Three cases were possibly hospital acquired because of exposure to a patient likely to be incubating the infection but testing negative on admission.

Once again, a successful campaign to vaccinate ESHT frontline clinical staff for flu and COVID booster was managed by Occupational Health and Wellbeing and successful utilisation of a peer vaccination scheme and COVID vaccination hubs.

3.7 Norovirus

During the winter months Norovirus is often circulating in the community and the risk of outbreaks in the in-patient setting related to Norovirus increases. There were no outbreaks of Norovirus in 2021/22 which is most unusual and thought to reflect increased social distancing and mask wearing in healthcare settings and the wider community.

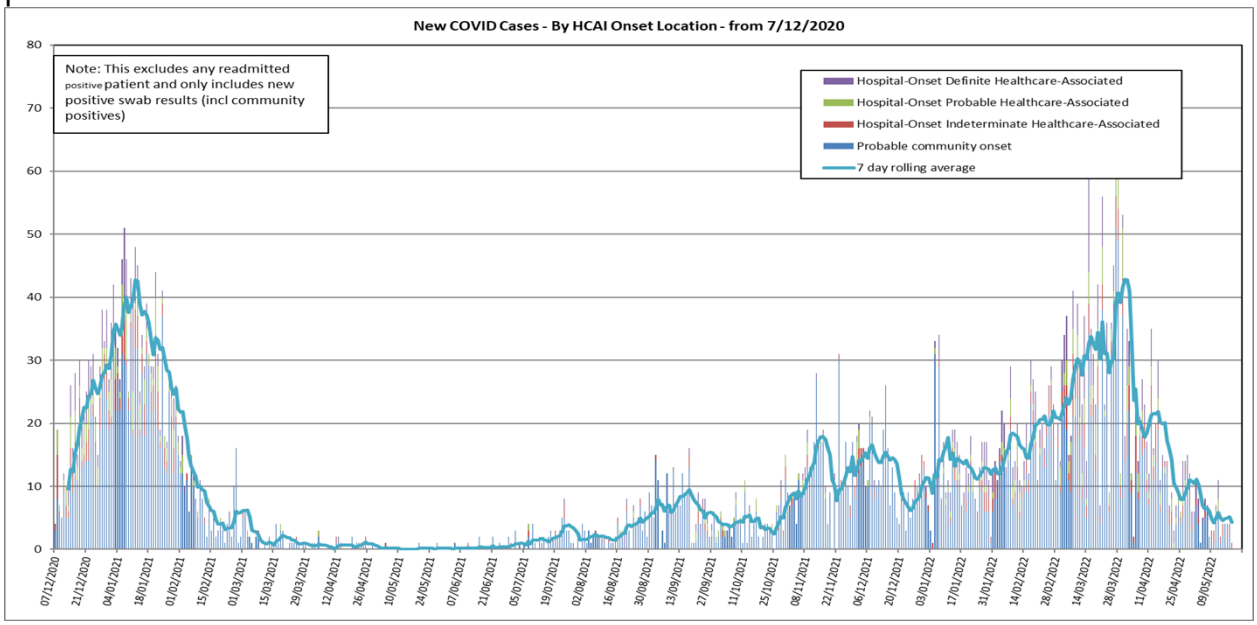
4. Emerging Threats and Operational Preparedness

- The Trusts 'Emergency Preparedness , Resilience & Response' (EPRR) Team is charged with ensuring that the Trusts fulfils its roles under the Civil Contingencies Act 2004 and the NHS EPRR Framework, in ensuring the Trust is prepared to meet internal and external Threats and can respond to a range of risk-assed incidents as when they occur.
- The EPRR Team remains fully linked to the Infection Prevention & Control Team, and as part of its remit, provides a horizon-scanning service, and is heavily engaged in risk-assessing identified threats and challenges.
- 2020 and 2021 have been dominated by preparedness for, and the response to the on-going Covid-19 pandemic. NHS E/I mandated that the NHS pandemic response would be coordinated in line with EPRR principles, and this has resulted in the Trusts EPRR Team being totally engaged in the Trusts response, which heavily engaged the IPC Team, over this period.
- The winter 2021 coordination of the 2nd wave was also combined with response and reporting arrangements for both NHS winter 20-21 planning and EU Exit arrangements.
- From the 1st wave through to the on-going 3rd wave, the Trust's arrangements have included:
    - A command-and-control structure with identified Strategic, Tactical and Operational leads

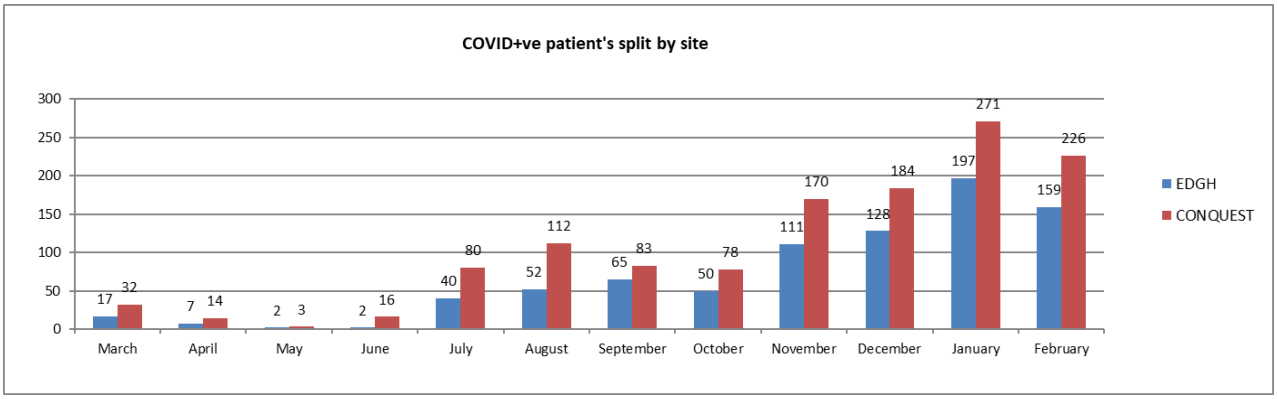
    - A staffed ‘Incident Coordination Centre’ (managing information flow and reporting)
    - Regular ‘Incident Management Team’ meetings (with frequency varied according to need).
- The EPRR team have been heavily supporting all 3 of the above with on-going EPRR advice and support, as well as managing EPRR actions relate to the pandemic. The IPC Team have been fully engaged in this work and in tasks mentioned throughout this report. Team managers have attended IMT meetings as operational leads for the service.
- Other ‘usual’ EPRR activity has had to take a back seat due to the pandemic. To ensure the Trust is fully prepared requires activities across a range of areas, many of which have bene curtailed over this period. Significantly:
    - External liaison (with the Sussex Resilience Forum and Sussex Local Health Resilience Partnership has been on-going but at a reduced level.
    - Training and exercising were halted during the peaks of the first 2 waves but has now re-commenced with social-distancing arrangements.
    - The Team have worked to progress Business Continuity planning arrangements at service-level across the Trust, so that services are resilient to the internal impacts of business challenges such as shortages of staff or utilities etc, (which has been recognised as being of importance throughout the pandemic).
    - The Team also planned and ran a further de-brief process for COVID-19 after the 2nd wave.
- During the pandemic response the Trust has been also subject to unrelated but simultaneous BC incidents, which have required incident management arrangements to be implemented. These have included the recurring loss of key digital platforms and an electrical failure which closed the Conquest Mortuary for several weeks. (The latter also required management input from the IPC Team).
- At the time of writing the current 3rd wave is on-going, and both the EPRR and the IPC Teams remain heavily involved in the ongoing response.

4.1 SARS-CoV-2, COVID-19

The chart below shows that the prevalence of COVID has been sustained. Over 2,000 patients were diagnosed during 2021/22 and this is largely a reflection of the local prevalence in East Sussex.



The year has been dominated by the COVID Omicron variant. This variant has been associated with high transmission and if a patient is identified within a bay most of those in the bay go on to test positive for COVID within 5 days. The high level of vaccination has meant that many patients do not require significant additional treatment for their infection and the burden on Critical Care has been low.



The year has been dominated by the COVID Omicron variant. This variant has been associated with high transmission and if a patient is identified within a bay most of those in the bay go on to test positive for COVID within 5 days. The high level of vaccination has meant that many patients do not require significant additional treatment for their infection so the need for Critical Care and respiratory support was much less than last year.

4.2 Role of the IPC team in the COVID pandemic

Developing patient pathways

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

Surveillance and Contact Tracing

The IPC team has undertaken surveillance on every hospital onset COVID case identified in ESHT. Each case was reviewed, and contacts identified to assist with minimising onward transmission to others. The surveillance also captured important epidemiological data to inform knowledge of the disease.

A new process has been developed during the year with the support of Nervecentre. An IPC dashboard shows where COVID positive patients are and when they can be stepped down from IPC precautions, there is also information and guidance from the team and smart lists identifying patients in single rooms who have been assessed by the IPCT as no longer requiring isolation enable the clinical site and ward teams to free up rooms for those most in need of isolation.

Liveflo dashboards also provide real-time information regarding the location of patients recently recovered from COVID and this has been important to enable best use of all ESHT beds with the intention of zero void beds due to COVID.

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

Outbreak Management
Outbreaks are managed as per public health (PHE) and NHS improvement guidance. On detection of an outbreak multidisciplinary outbreak control meetings are arranged to agree key actions with DIPC involvement. Outbreak reporting to PHE and the ICS of COVID outbreaks has been undertaken by the IPC team to provide information about number of patients and escalation or closure of outbreaks. The IPC team liaise with operational site team three times daily to agree how to contain outbreaks and provide safest bed capacity for those accessing services.

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

5 Incidents related to infection

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

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

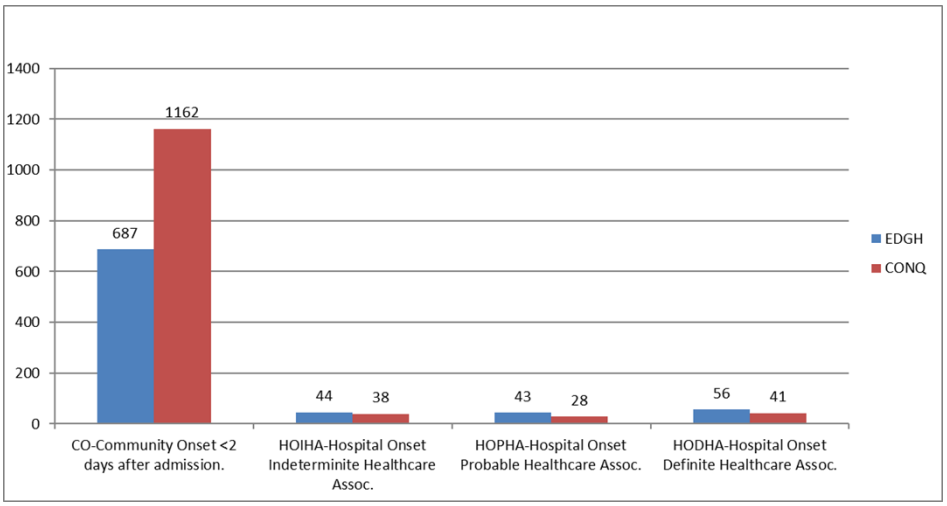
5.2 Outbreaks related to outbreaks of COVID

Due to the continued prevalence of COVID and subsequent outbreaks a thematic review of wave 1, 2 and 3 was undertaken to capture the experience and learning from outbreaks of COVID infection in our hospitals. This was a considerable piece of work undertaken by the Clinical Governance lead at the request of the Director of Infection Prevention and Control. The report has been finalised and is being circulated for consideration prior to sign off. Lessons learnt to date from early outbreaks both at local and national level are:

- There is increased evidence that airborne transmission occurs easily and therefore the percentage of people testing positive if sharing a common space

will be high. As a result, ESHT staff have been advised to wear higher level respiratory protection when caring for COVID positive patients.

- The role of ventilation has been shown to be important in reducing transmission. The ventilation and air handling varies across the Trust, hepa filter units have been purchases to clean the air in a bay and thus improve air quality and try to reduce transmission.



The table above shows the number of patients diagnosed on each acute site with COVID-19 at time admission or subsequently during their hospital stay. The requirement to report outbreaks externally changed in recognition that transmission within a bay is difficult to prevent. Only outbreaks involving the ward were reportable. ESHT reported 46 ward outbreaks of COVID during 2021/22.

6. Promoting Standard Infection Prevention Precautions

6.1 Hand Hygiene Promotion

The Trust IPCT continues to co-ordinate an annual programme to promote effective hand hygiene throughout the Trust including monitoring of compliance by clinical staff with monthly audits, training of ICLFs to undertake practical hand hygiene training of clinical staff. We continued to promote the importance of hand hygiene for staff, visitors and patients including participation in the International World Hand Hygiene Day during May 2021.

6.1.2 Hand Hygiene Compliance

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

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

The charts below provide details of the overall Trust compliance.

Inpatient Areas 2021 – 2022

Overall data												
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Totals	April	May	June	July	August	September	October	November	December	January	February	March
Overal ESHT Totals	415	473	390	423	425	378	371	369	348	406	355	373
Quarterly #		1278			1226			1088			1134	
HH Before %	99.5%	99.3%	99.9%	99.7%	98.8%	99.6%	99.6%	116.4%	98.4%	99.2%	98.9%	99.1%
Quarterly HH Before		99.5%			99.4%			104.8%			99.1%	
HH After %	99.8%	99.6%	99.4%	98.6%	99.7%	99.2%	99.4%	99.0%	99.5%	99.4%	99.4%	99.8%
Quarterly HH After		99.6%			99.2%			99.3%			99.6%	
BBE %	99.2%	99.4%	98.9%	97.5%	98.7%	99.1%	99.4%	98.7%	98.6%	99.0%	97.7%	99.3%
Quarterly BBE		99.2%			98.4%			98.9%			98.6%	
Total areas Submitting audit	33	38	32	39	38	36	36	38	32	43	35	35
Average for the quarter		34			38			35			38	

Outpatient Areas 2021 – 2022

Average data												
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Totals	April	May	June	July	August	September	October	November	December	January	February	March
Overal ESHT Totals	52	44	82	88	115	53	84	105	53	87	82	85
Quarterly #		178			256			242			254	
BBE %	100.0%	100.0%	100.0%	98.8%	100.0%	96.8%	100.0%	100.0%	n/a	100.0%	100.0%	100.0%
Quarterly BBE		100.0%			98.5%			100.0%			100.0%	
Glow Box training %	42.4%	78.5%	38.5%	49.2%	60.2%	55.0%	70.4%	72.6%	n/a	65.6%	74.8%	54.2%
Quarterly Glow Box training		53.1%			54.8%			71.5%			64.9%	
Total areas Submitting audit	5	3	8	10	14	8	14	16	9	11	16	14
Average for the quarter		5			11			13			14	

Community Areas 2021 – 2022

Average data												
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Totals	April	May	June	July	August	September	October	November	December	January	February	March
Overal ESHT Totals	23	12	22	19	23	3	13	27	10	8	14	3
Quarterly #		57			45			50			25	
BBE %	90.0%	94.4%	96.7%	100.0%	100.0%	100.0%	100.0%	92.9%	93.0%	100.0%	100.0%	100.0%
Quarterly BBE		93.7%			100.0%			95.3%			100.0%	
HH Kit available %	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Quarterley HH kit available %		100.0%			100.0%			100.0%			100.0%	
Aware of replenishment proc	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Quarterley awareness of rep		100.0%			100.0%			100.0%			100.0%	
Gel/Foam attached %	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Quarterley Gel/Foam attache		100.0%			100.0%			100.0%			100.0%	
Total areas Submitting audit	3	2	3	3	4	1	2	4	1	2	2	1
Average for the quarter		3			3			2			2	

The overall hand hygiene compliance for the in-patient areas has been excellent. Ranging from the average score of 98% to 99% in all in-patient areas. It has been a challenging year for monitoring hand hygiene compliance not only due to workload but also because a new audit system has been introduced which we believe will be of great benefit going forward but has required adaptation to produce the detail around hand hygiene compliance that we require. Regular meetings with the provider company, governance team and IPC are now in place to progress an improved audit and reporting process.

6.2 Infection Prevention & Control Compliance Monitoring Programme

Compliance monitoring data for the year 2021/2022																		
AUDIT	Quarter 1				Quarter 2				Quarter 3				Quarter 4				Overall Data	
	EB	CQ	Total Compliance		EB	CQ	Total Compliance		EB	CQ	Total Compliance		EB	CQ	Total Compliance		Total Compliance	
			#	%			#	%			#	%			#	%	#	%
MRSA compliance monitoring																		
Total audits	145	59	**204**		90	50	**140**	**84**	75	13	**88**	**71.5**	20	6	**26**	**57.6**	**458**	
Complied	125	56	**181**	**88.7**	84	42	**126**		53	10	**63**		15	0	**15**		**385**	**84.0**
Hand Hygiene Audit																		
Total audits	127	137	**264**		82	134	**216**	**82%**	53	107	**160**	**75.625**	80	102	**182**	**88.4**	**822**	
Complied	93	118	**211**	**79.9242**	65	112	**177**		31	90	**121**		70	91	**161**		**670**	**81.5**
Audit of universal precautions																		
Total audits	157	116	**273**		76	109	**185**	**80.7**	52	95	**147**	**82.3**	65	93	**158**	**84.8**	**763**	
Complied	93	86	**179**	**65.5**	64	88	**152**		40	81	**121**		50	84	**134**		**586**	**76.8**
Bare Below Elbow Audit																		
Total audits	305	55	**360**		125	79	**204**	**97.549**	142	83	**225**	**98.2**	90	88	**178**	**99.4**	**967**	
Complied	300	54	**354**	**98.3**	124	75	**199**		138	83	**221**		90	87	**177**		**951**	**98.3**
Commode Audit																		
Total audits	163	38	**201**		149	29	**178**	**88.2**	7	34	**41**	**90.2**	45	27	**72**	**88.8**	**492**	
Complied	137	36	**173**	**86.0**	131	26	**157**		6	31	**37**		38	26	**64**		**431**	**87.6**
Sharps audit																		
Total audits	52	128	**180**		65	111	**176**	**77.8**	9	61	**70**	**71.4**	120	156	**276**	**84.4**	**702**	
Complied	44	97	**141**	**78.2**	54	83	**137**		6	44	**50**		108	125	**233**		**561**	**79.9**

The Infection Control Associate Practitioners undertake compliance monitoring and with the ICNs they support those services where compliance is found to be reduced. The bare below the elbows audit shows equally good results to the hand hygiene audit undertaken by the ICLFs. Audit of MRSA compliance with decolonisation treatment has shown that teams needed reminding of documentation and allowed a refocus on the MRSA policy during a time when staff were more focused on COVID.

6.3 Training and Education

The IP&C specialist nurses provide a comprehensive training and education programme for all Trust staff and volunteers related to all aspects of infection prevention and control, both planned and as required. Infection Prevention and Control is part of mandatory induction and update. Compliance with mandatory IPC training remained above 85% overall but fewer Adhoc sessions were provided due to social distancing and the increased availability of online resources.

Since the onset of the COVID pandemic the focus of the IPCT training has been on the safe appropriate use of personal protective equipment for use during the COVID-19 pandemic to provide safe care for patients and staff. This has involved considerable resource using online and practical demonstrations and development of training material and printed visual instruction and guidance. This work has continued throughout the pandemic and has been very challenging at times as the national IPC guidance continued to change during the year.

6.4 Audit activity

The audit programme has been limited to Hand hygiene, supporting NSC audits and compliance monitoring. No new audits have been undertaken during the year due to managing resources required for the COVID response.

6.5 Professional Development

Specialist nurses within the team maintain professional competence and attend relevant study and training. Networking with other clinical specialists is supported through attendance at regional meetings which have taken place online in the past year.
The team have accessed online training and seminars to gain knowledge of COVID as new information became available.

We have collaborated with other specialists via regional and local network meetings to contribute to the development of national guidance on the IPC management of COVID and continue to take a proactive part in reviewing guidance and best practice for IPC.
The head of IPC has completed the Florence Nightingale Foundation award for IPC leaders and two ICNs are being supported with training under the auspices of NHS England.

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

The National Specification of Cleanliness (NSC) audits continue to be monitored via the Patient Environmental Action Meeting (PEAM) and the Trust Infection Prevention control group (TIPCG) and the Divisional Integrated Performance Reviews.

We have restructured the department changing the reporting lines and introducing a completely new team of auditors at Eastbourne, with one vacancy left to fill. The Trust NSC target score for Clinical equipment and Housekeeping was assessed as >92%, overall, this was achieved although there were some low scoring areas. Where an area has consistently scored low, they are asked to attend the Patient Environmental Audit Meeting (PEAM) to provide assurance of the actions being taken to address the low compliance and this is discussed at the TIPCG which is chaired by the DIPC.

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-201	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
House Keeping	94.48	97.53	97.88	98.06	98.00	98.60	97.96	98.84	94.61	97.03	97.52	97.18
Clinical Staffing	94.36	92.35	90.62	92.19	90.67	94.03	94.43	95.75	95.30	91.81	89.73	91.66
Estates	95.54	94.60	95.08	95.23	95.15	95.71	95.25	95.31	96.87	95.02	95.20	93.85

The Clinical Orderly role continues to support cleaning of clinical equipment, where there are some vacancies, some areas have struggled to maintain the high scores, particularly in the community sites. Estates scores are considered as either a cleanliness or a maintenance concern. Cleanliness is reported and discussed at PEAM. Maintenance issues are directed straight to Estates department. Most estates failures are around maintenance issues relating to aging infrastructure which requires investment, works are prioritised by risk; the average annual cleanliness score for estates (92%) is compliant with NSC. It is anticipated that forthcoming “Building for Our Future” project work being led by our Estates and Facilities team, will significantly improve the standards of the estate.

New National Standards of Cleanliness

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

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

In addition, the audit scoring reporting methodology has now changed to show as a star rated system rather than a % score.

We have begun the implementation of the new standards from May 2022.

7.1 Housekeeping

The Housekeeping services for ESHT continue to be provided by the in-house team within Facilities. Housekeeping resources are matched to each area in line with the National Specification for Cleanliness (NSC 2020)

We continue to clean with Bleach based products as we recover from the pandemic and increased touch point cleaning remains in place particularly for our respiratory ward areas.

7.2 Deep clean programme

The Rapid Response team continue to provide cover 24/7 and are an integral part of the housekeeping team. We have seen a rise in deep clean requests peeking at an average of 1000 per month. Although the numbers have dropped slightly since Feb 2022, they remain significantly higher than pre-pandemic.

Years	19/20	20/21	21/22
Av. No. of Deep cleans carried out on the Acute Sites	688	1103	855

19/20 – Highest month in this year was December 2019 with 839 cleans and the lowest month was September 2019 with 598 cleans

20/21- Highest month in this year was January 2021 with 2229 cleans and the lowest month was March 20 with 688 cleans

21/22 - Highest month in this year was March 2022 with 1275 cleans and the lowest month was May 21 with 389 cleans.

7.3 Activity

Housekeeping continues to receive various demands form the site team to assist with maintaining bed capacity. We have seen an increase in discharge and bedspace cleaning demands from all areas as the Trust continues its pandemic recovery plan. To meet this demand calls for cleans are prioritised and communication and support is structured from the IPCT, and clinical site teams and clear plans are in place at all levels to ensure disruption is minimised.

7.4 Service Development

The Housekeeping department renewed its HPV (Hydrogen Peroxide Vaporisation) contract and continued to support Infection Control Procedures, this process is predominantly undertaken by the rapid response team who are on site 24hrs and can be deployed to any site if called upon. This will be sustained in the modernisation plan. We are currently exploring the potential to introduce Ultraviolet decontamination technology to support our current processes.

To support IPCT working practices and water safety staff undertake annual refresher training to include sink cleaning procedures. We continue to review and revise all our Standard operating procedures in line with new National guidance and processes.

8. Antimicrobial Stewardship Activities and Innovation

The Trust Antimicrobial Stewardship Group (ASG) core membership consists of a consultant medical microbiologist, antimicrobial pharmacist, and a CCG representative. The purpose of the ASG is to support the prudent use of antimicrobials to reduce the development and spread of antimicrobial resistance.

This is achieved by:

- Developing and maintaining evidence based antimicrobial policies and guidelines for use in secondary and primary care
- Developing a strategic plan with the aim to continuously improve antimicrobial prescribing practice
- Ensuring safe and cost-effective antimicrobial use.
- Monitoring antimicrobial expenditure data and addressing identified issues
- Undertaking audit on antimicrobial prescribing practice and providing feedback to TIPCG, ASG and MOG
- Providing advice to other specialist groups/committees on antimicrobial use
- Providing education to staff on all matters relating to antimicrobials.
- Educating patients and members of the public on antimicrobial stewardship
- The lead antimicrobial pharmacist providing feedback from lesson learnt, following a Post Infection Reviews to the pharmacy team.

The Adult and Paediatric antimicrobial guidelines are reviewed, on a regular basis, by the Antimicrobial Stewardship Group (ASG). The guidance is evidence based and Consultants and/or Allied Health professional (AHP) are consulted. Any major change to the Trust antimicrobial guidance must be submitted to the Medicines Optimisation Group (MOG) for consideration.

8.1 Multi-disciplinary team (MDT) Ward Rounds

The aim of MDT ward rounds provides specialist support to improve patient care. The ward round should reduce inappropriate prescribing of antibiotics, treatment failure rate and the development of antimicrobial resistance.

The MDT ward round provides support to the prescribing team with specialist input into the highest risk and/ or most critical patients in the hospitals.

Regular AMS MDT ward rounds are undertaken in the following areas:

1. Diabetic Foot Management
2. Orthopaedics
3. Acute medical units
4. Wards highlighted by Infection control team e.g., CDI rate
5. Endocarditis (TBC)
6. Intensive Care Units

AMS wards rounds are targeted to a ward or area with a concern, for example a ward with an unexpected high use of broad-spectrum antibiotics.

The review of antimicrobial prescribing follows standards outlined in the PHE “Start Smart then Focus” document (March 2015).

The AMS ward round has made several interventions that include.

1. Stopping treatment.
2. Escalating / de-escalating treatment.
3. Switching administration route from an intravenous to oral treatment.
4. Continuing current treatment and providing advice on duration/review date.
5. Providing advice to the medical or surgical team on the prescribing of antibiotics for a CDI antigen or toxin positive patient.

8.2 Training

An in-house on-line module is used for induction and the 3 yearly assessment.

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

8.3 Antibiotic Incident reports

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

8.4 Audit of antimicrobial usage

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

To help provide assurance on AMS practice, pharmacy undertakes a monthly antimicrobial stewardship audit. The audit should identify AMS issues and highlight areas for improvement If warranted, the concern will be escalated to the Antimicrobial Stewardship and Infection Prevention and Control Groups

The electronic prescribing and medication administration system (ePMA) is partially rolled out. The ePMA system helps pharmacy identify antimicrobial prescribing, and to prioritise patients to be reviewed for the AMS MDT ward round.

9. Water Safety

The Trust water safety Group reports to the TICPG quarterly. There is a robust programme of work to manage the risk from water related pathogens such as Legionella species and Pseudomonas species.

Legionella pneumophila serogroup 1 is the most virulent strain causing the majority of infections. The remaining non-pneumophila species (found in water and soil) are considered non-pathogenic until shown to cause disease, mainly associated with severely immunosuppressed patients. There has been no known hospital acquired cases of *Legionella* to date. Pseudomonas species has been detected in routine water sampling in several clinical areas and has been well managed by the Estates and Facilities team.

Considerable remedial work has been needed at Conquest than EDGH because EDGH estate benefits from water treatment processes via Copper and Chlorine systems. There has been agreement to introduce water treatment at Conquest in the coming year which should reduce the work required to manage the risk from these pathogens.

East Sussex Healthcare
NHS Trust

Patient Experience Annual Report 2021/22

www.esht.nhs.uk

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1. Introduction

ESHT is committed to ensuring continuous improvement in patient experience and in the overall quality of care that we provide.

To support this, we gather information on patient experience from many different sources, and work with patients, carers, and external stakeholders to ensure that the services we provide are responsive to the needs of our population.

In 2021/22 we delivered

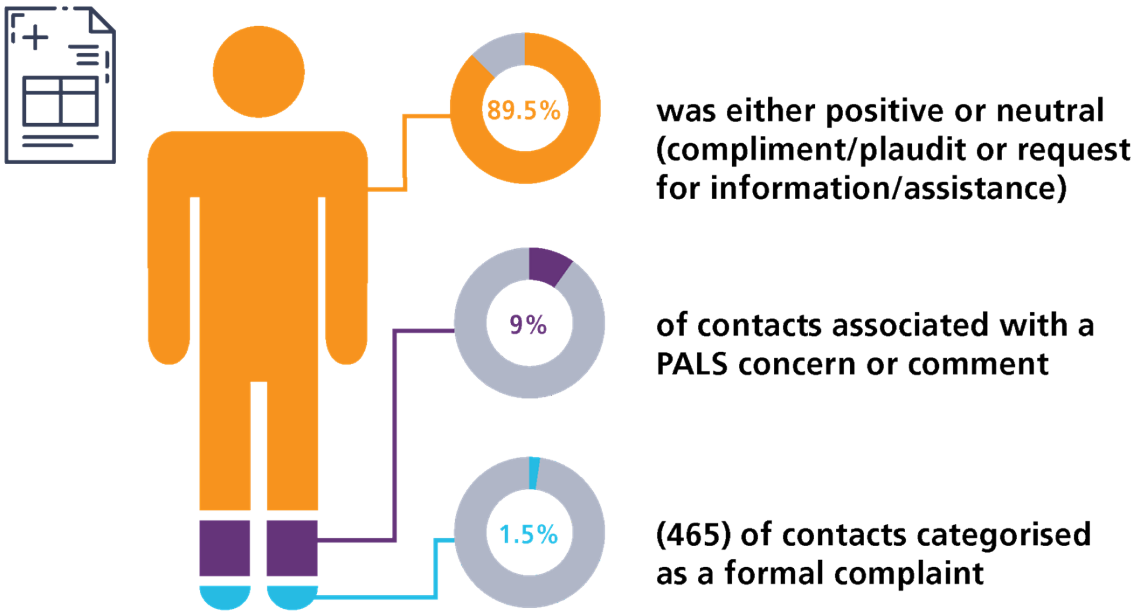
683,432

episodes of care *

and received

30,901

pieces of patient feedback:



was either positive or neutral (compliment/plaudit or request for information/assistance)

of contacts associated with a PALS concern or comment

(465) of contacts categorised as a formal complaint

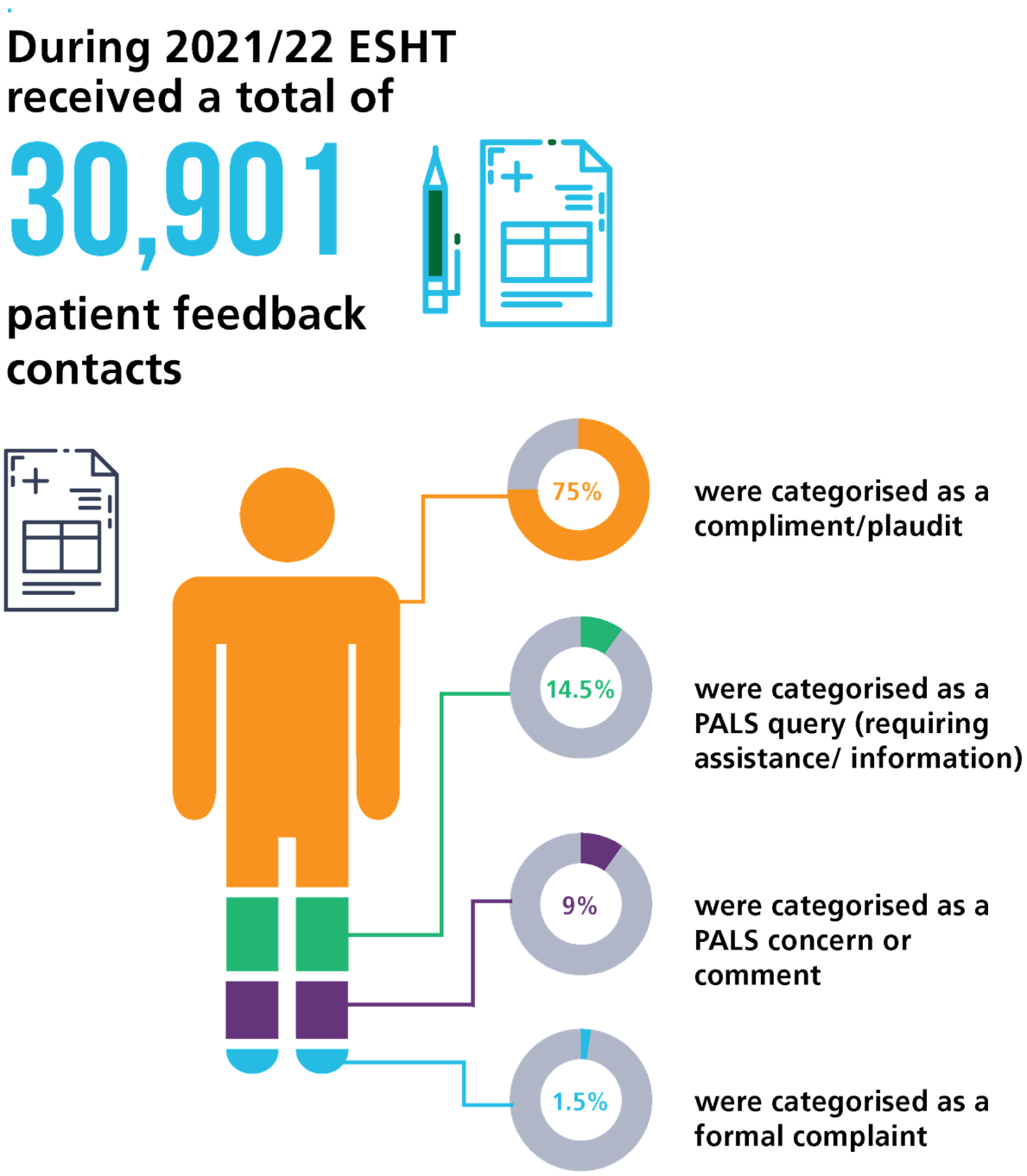
*

Episodes of care could be an outpatient appointment, attendance at Emergency Department (ED) or an inpatient episode of care

This report provides an overview of the feedback we received during 2021/22 and to meet the requirements of The National Health Service Complaints (England) Regulations (2009), it provides an analysis of complaints received; alongside this we have included in this report an overview of concerns raised with the Patient Advice and Liaison Service (PALS).

Given the relatively small number of complaints, the breakdowns contained in this report do not indicate that we have cause for concern in those areas. However, we take every complaint seriously and use this as an opportunity to generate insight to improve access, quality, and outcomes for our patients.

2. Patient Feedback



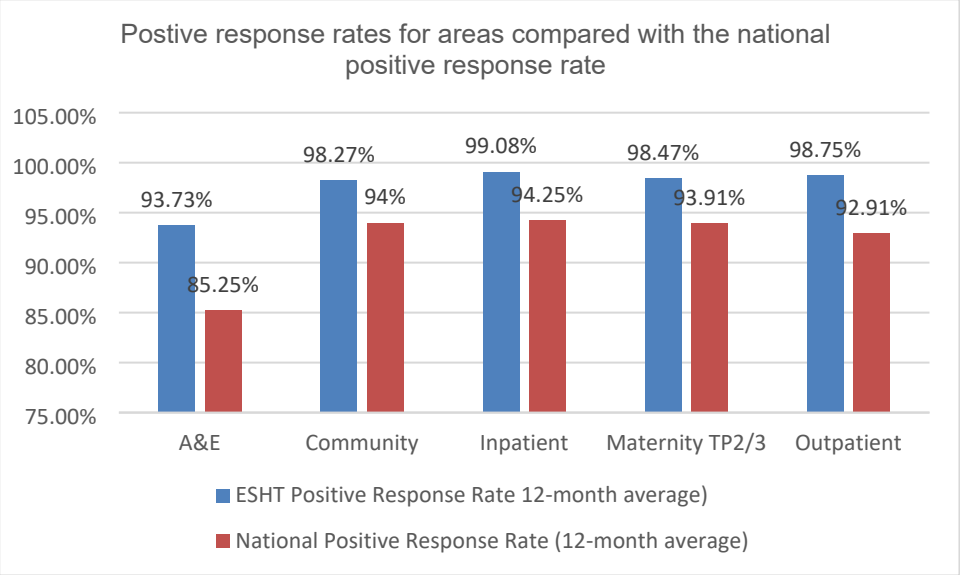
3. Compliments/Plaudits

ESHT received 23,195 compliments/plaudits in 2021/22. The majority of these plaudits (21,534) were generated by positive comments and compliments expressed in the Friends and Family Test (FFT), 1,571 plaudits being received by various other expressions of gratitude including thank-you cards or positive reviews posted to the NHS website and 90 plaudits were received through PALS. Feedback received via the Patient Experience Team is shared with the staff/team(s) involved and recorded on the relevant system.

4. Friends and Family Test (FFT)

FFT asks “overall, how was your experience of our service?” and invites further feedback on the response with “please can you tell us why you gave your answer”. Table 1 below shows that for all service areas, the positive response rate for ESHT substantially exceeded the national positive response rate. This is most marked for ED, where the rate of positive response was around 10% higher for ESHT than the national rate.

Table 1- Positive response rates for areas compared with the national positive response rate



The local Adult Inpatient FFT asks a further seven questions, about the patients/carers experience whilst on a ward. Overwhelmingly (98.80%) responders said they were always treated with kindness and said, “staff responded appropriately to any questions or concerns raised” (98.38%). All questions are monitored to identify where changes can be made to improve patient experience. The three bottom scoring questions for 2021/22 relate to the “discharge process”, the responses to these questions will be monitored and used to contribute towards the ongoing work to improve the discharge process.

5. 4- and 5-Star Reviews Posted on the NHS Website

In total 50 4- and 5-star comments were posted on the NHS website, below are three examples of feedback received:

"In for ENT day surgery yesterday, I had an amazing anaesthetist who was very informative and caring from coming to see me on the ward, just before surgery, then in recovery and back on the ward. Thank you so much for your consideration you are great at your job the ENT team was great".

"A very big thank you to all the Doctors and Nursing staff for their care and kindness to me during my recent stay in CCU. The professionalism and care shown by all members of staff was second to none. Once again, thank you."

"Had a biopsy and the staff were amazing. From reception to the surgeon. Everyone friendly and informative."

6. Complaints Received in 2021/22

During 2021/22 ESHT met its target of 100% of all complaints acknowledged within 72 working hours. Overall, very few patients/ relatives complained about their care with fewer than one in ten thousand patient contacts resulting in a complaint. In 2021/22 the total number of complaints received increased by 100 compared with 2020/21 (365). However, caution should be taken when interpreting this as an increase as there was a reduction in complaints received for the first quarter of 2020/21, due to the COVID-19 pandemic and the national pause placed on complaint handling by NHS England. Table 2 and Appendix A further indicate that the proportion of complaints by volume of activity overall has remained consistently low across a 3-year period,

Table 2 sets out complaints received as a ratio of all clinical activity and as a ratio of inpatient activity.

Table 2- Complaints Received Compared to Clinical Activity

Activity	**2019/20**	**2020/21**	**2021/22**
Admitted Patient Care-Elective	54,102	38,157	50,127
Admitted Patient Care-Non-Elective (Emergency)	51,146	44,773	50,765
Admitted Patient Care-Non-Elective (Non-Emergency)	7,230	6,251	6,363
ED Attendances	135,877	116,213	150,865
Outpatient Attendances	410,448	357,539	425,312
TOTAL ACTIVITY	**658,803**	**562,933**	**683,432**
Number of Complaints Received	583	365	465
Complaints as a % of All Activity	0.09%	0.06%	0.07%
Complaints as a % of All Admitted Patient Care	0.52%	0.41%	0.43%

Complaints received by month (see appendix A).
Complaints received by mode of receipt (see appendix B).

7. Complaint Themes

In 2021/22, ESHT coded complaints to 21 different primary complaint subjects. Table 3 below sets out the 5 most identified primary complaint subjects with the bracketed figures relating to data for 2020/21 (see note above on caution in comparisons with 2020/21)

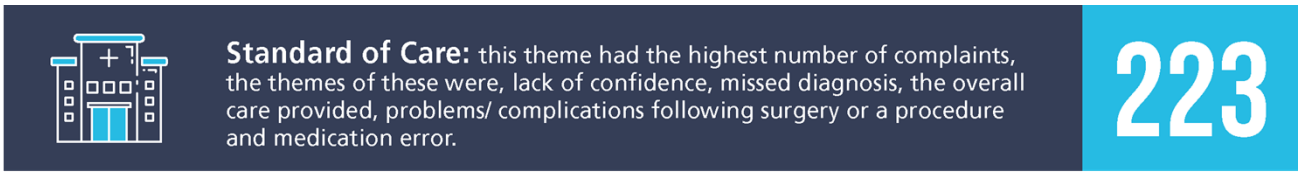
Table 3: Top 5 Primary Complaint Subjects

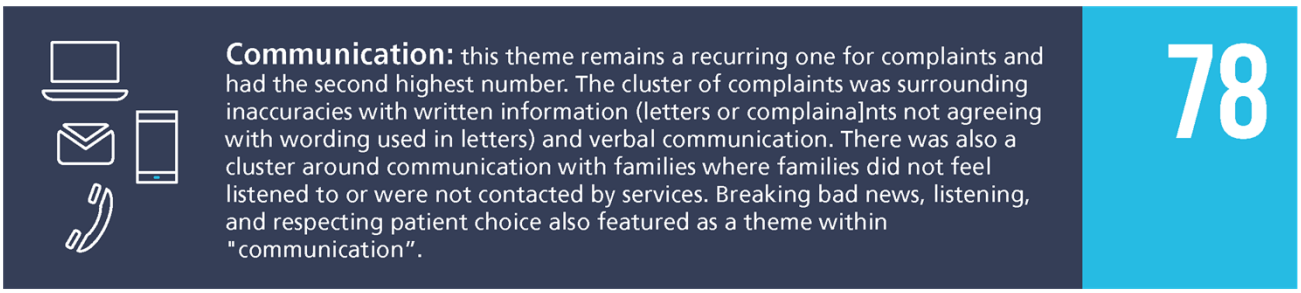
Primary Complaint Subject	**Count**	**% of All Complaints**
Standard of Care (1)	223 (165)	48% (45%)
Communications (2)	78 (66)	17% (18%)
Patient Pathway (3)	50 (52)	11% (14%)

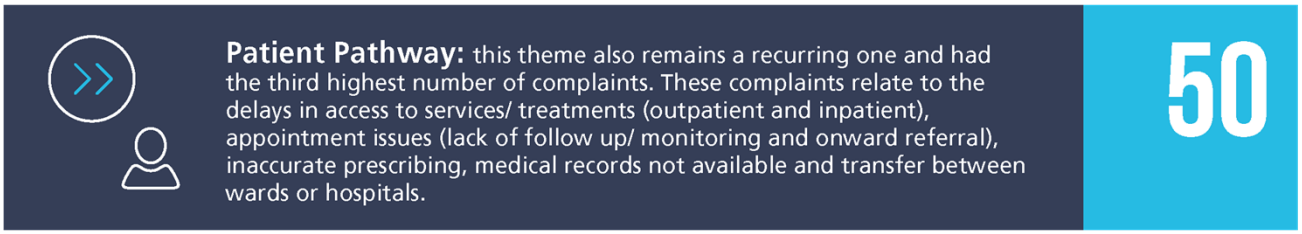
Attitude (5)	28 (19)	6% (5%)
Discharge (4)	28 (28)	6% (8%)
Proportion of all complaints in top five categories		88% (90%)

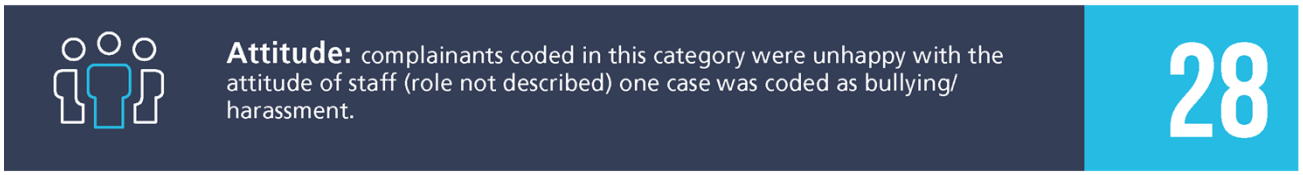
The top 5 complaint subjects account for most of all complaints in 2021/22. Although there has been some variation between years in the number of complaints by subject, the small number of complaints, together with the national changes in complaints handling associated with managing COVID-19 mean that it is difficult to interpret whether these changes in the number of complaints in each category are significant. Appendix C breaks down cause of complaint by Division and as might be expected given the nature of these service areas indicates that Medicine and Urgent Care and Diagnostics, Anaesthetics and Surgery where areas with the highest number of complaints, and where complaints subjects cluster in areas such as attitude and discharge.

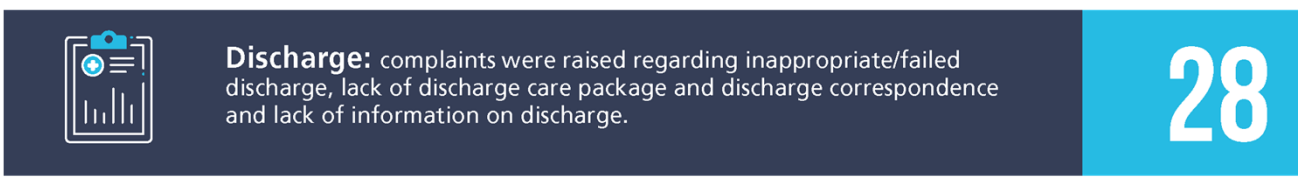
In addition to a primary complaint subject, all complaints are also coded with a secondary complaint subject that represents the major/most significant element of that complaint. Secondary categories of the top primary complaint subjects are set out below.











Primary Complaint Subject by Division (see appendix C)

8. Complaints Compliance

The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009) set out the rights of complainants to receive an investigation and formal response to their complaint in an appropriate and timely timescale. ESHT fully met the national requirement to formally acknowledge each complaint within 72 working hours.

In addition, we have set ourselves two locally agreed timescales by which we aim to formally respond 35 working days for non-complex complaints and 50 working days for complex complaints. A similar number of complaints were responded to within local target times in 2020/21 and 2021/22. However, the increased volume of complaints in 2021/22, particularly in respect of 35 working day complaints, means that the proportion meeting the target has reduced.

Operational pressures resulted in a reduction against each response rate metric compared to 2020/21. Table 4 below sets out complaints compliance for each metric and compares this to figures from 2020/21.

Table 4: Complaints Compliance

Metric	**2020/21**		**2021/22**	
72 working hours acknowledgement	100%		100%	
Total Complaints Closed	365		583	
	In Time	%	In Time	%
35 Working Days	129/301	43%	133/510	26%
50 Working Days	17/64	27%	16/73	22%
All Complaints	146/365	40%	149/583	26%

Complaints compliance for the period April 2020 to March 2022 by month (see appendix D). Complaint's compliance by division for 2021/22 (see appendix E).

9. Reopened Complaints

In 2021/22, 77 complaints were reopened; this is a significant increase compared to 32 in 2020/21, with many of the reopened cases relating to care and bereavement issues linked to COVID-19 and/or further questions raised because of the initial complaint response. Table 5 sets out the number of complaint files reopened for each division.

Table 5: Reopened Complaints by Division

Division	**Count**
Community Health and Integrated Care	4
Core Services	2
Corporate Services	1
Diagnostics, Anaesthetics and Surgery	15
Medicine and Urgent Care	44
Women, Children and Sexual Health	7
Multiple Divisions	4
Total	77

Given Medicine and Urgent Care accounted for 59% of all complaints received in 2021/22 and represent care areas handling some of the highest numbers of patient activity such as

the ED and COVID-19 wards, it is understandable that they would also top the list of divisions with complaint files reopened.

10. Parliamentary and Health Service Ombudsman (PHSO)

The PHSO make final decisions on complaints that have not been resolved locally by an NHS provider, and they do this fairly and without taking sides.

ESHT received 8 new case enquiries, 1 notice of intent to investigate and 4 case outcomes details can be found in appendix F. Levels of PHSO referrals remain consistently low across both years with 8 new case enquiries, 1 upheld, 2 not upheld and 1 not investigated further in 21/22.

PHSO activity 2020/21 -v- 2021/22 (see appendix G)

11. Upheld Complaints

Regulation 17, Section (b), of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009), states that the Trust is required to record an outcome for each complaint.

ESHT treats all complaint as important and takes the opportunity to provide an apology to the complainants, for their experience of care and as a learning opportunity. The outcome codes we use are a variant of those used by regulatory bodies including NHS England and the PHSO. The following table (7) sets out complaints closed (new complaints received and reopened complaints) by outcome in terms of numerical and percentage values:

Table 7: Complaint Outcomes

Outcome	**Count**	**%**
Investigation Completed, Apologies Required and Actions/Learning Identified (Upheld)	153	29%
Investigation Completed, Apologies Required But No Actions or Learning Identified (Partially Upheld)	305	57%
Investigation Completed, No actions or Learning Identified (Not Upheld)	66	12%
Other*	8	2%
Totals	**532**	

*these are complaints that did not require investigation or were withdrawn
Please note the number of complaint outcomes differ to the total number of complaints closed as cases reopened and closed again cannot be allocated a second outcome code.

12. Patient Advice and Liaison Service (PALS)

The role of PALS is to provide, advice and information, or deal with any concerns or issues that can be handled and resolved quickly and locally without the need for a formal complaint.

Table 8 sets out PALS activity for 2021/22 and is shown in comparison with activity for 2020/21.

Table 8: PALS Activity 2021/22 -v- 2020/21

Contact Type	2021/22		2020/21	
	Count	%	Count	%
Advice, Assistance and Information	4503	61%	3881	63%
Compliment	90	1%	95	2%
Concern/Issue	2725	37%	2134	35%
Suggestion/Comment	13	0%	13	0%
Totals	7331		6123	

Whilst contacts with PALS in 2021/22 increased by 20% on 2020/21, the proportion of contacts by type noted only slight change.

Overview of PALS contacts received by month (see appendix H).
Distribution of PALS contacts that raised a concern or issue, data by division (see appendix I).

As with complaints, concerns raised with PALS are also coded with a primary contact subject. Table 9 below sets out the five most commonly identified primary contact subjects for concerns raised with PALS in 2021/22, with the bracketed figures relating to data for 2020/21.

Table 9: Top 5 Primary Contact Subjects (PALS Concerns)

Primary Contact Subject	Count	% of All Concerns
Patient Pathway (2)	710 (455)	29% (26%)
Communication (1)	659 (649)	27% (37%)
Standard of Care (3)	403 (248)	17% (14%)
Attitude of Staff (4)	248 (111)	10% (6%)
Provision of Services (5)	122 (85)	5% (5%)
Other		12% (12%)

13. Learning from Patient Experience

Theme	Action	Comment
Bottom 3 FFT questions (relating to discharge process) and complaints recorded under "Discharge" subject code.	Operational Team to build on the work undertaken as part of the Quality Account Priority 2021/22 "Perfecting Discharge". Medicine are also undertaking communication training regarding information given at the point of discharge.	Patient Experience Team to continue to share intelligence gathered through patient feedback.
Complaint theme "Standard of Care".	The change in reporting codes should enable us to better understand this theme of complaints.	Reporting codes were changed on the 1st April 2022.
Complaint theme "Communication".	Learning and Development have commissioned multi professional "Advanced Communication Course" which delivered over two days.	Visiting restrictions impacted the clinician's availability to have conversations with relatives/ carers, with the visiting restrictions now lifted it is hoped that clinicians and family members can resume those conversations.
Complaint theme "Patient Pathway".	The change in reporting codes should enable us to better understand this theme of complaints.	Reporting codes were changed on the 1st April 2022.
Complaint theme "Attitude".	The change in reporting codes should enable us to better understand this theme of complaints.	Reporting codes were changed on the 1st April 2022.

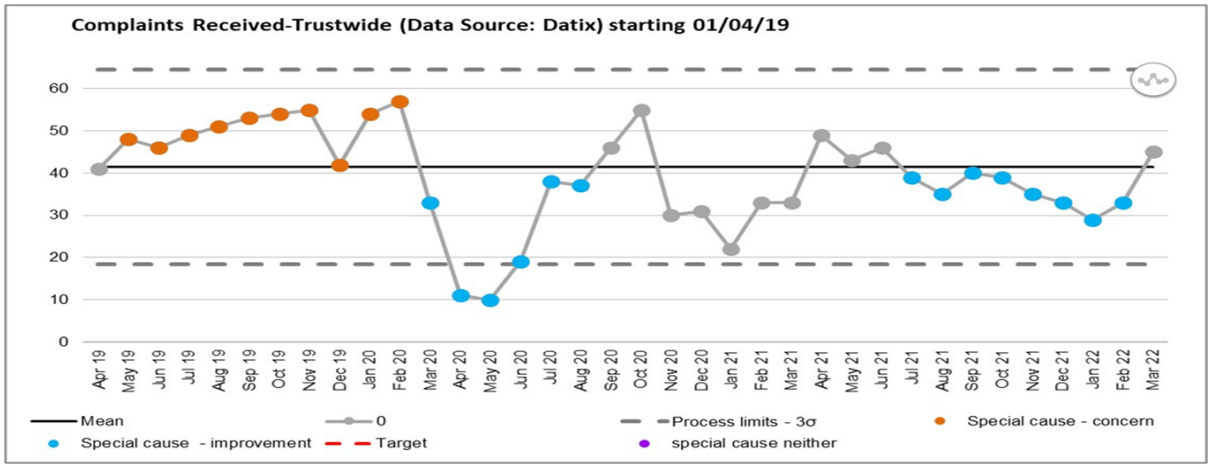
14. Looking Forward/ Actions for 2022/23

In 2022/23 the Patient Experience Lead and/or Complaints, PALS and Patient Experience Manager will undertake the following:

	Action
1.	Review our approaches and processes to make sure that we are systematically seeking input from patients as part of a quality improvement approach, ensuring that information from PALS and Complaints is included in this as actionable insight
2.	Work with our partners in the ICB to implement statutory guidance on working with people and communities, including recognising and utilising complaints, PALS contacts and patient surveys as a valuable source or insight.
3.	Look at alternative ways to share/ distribute feedback, learning from positive and negative experiences as part of the overall improvement culture.
4.	Complaints and PALS team to move from Datix RichClient reporting function to Datix Web.
5.	Complaints and PALS Team will start using the subject codes used for The Hospital and Community Health Services Complaints Collection (KO41a) which are used nationally. This will improve the range of codes used and allow our complaints data to be comparable with other Trust's for benchmarking purposes.
6.	Review the Standard Operating Procedure (SOP) for Complaint Handling.
7.	Review the Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (The 4C's Model).
8.	Support divisions with local ownership and embedding learning from their complaints.
9.	Implement to The PHSO's ""NHS Complaint Standards" pilot.
10.	Review Patient Experience training delivered (trust wide).
11.	Patient Experience Quality Account Priority 2022/23 is "Learning from Complaints", ensuring that data/ information collected is used to better inform changes/ learning.
12.	Launch a new post-complaint satisfaction survey and gain further feedback from our colleagues (stakeholder who contribute towards the complaints process).
13.	Explore opportunities for PALS and the Complaints Team to work together more closely offering our service users a better experience when accessing our teams.

From April 2022, The Patient Experience Team have been moved under the Chief of Staff to work closely with Engagement and Health Inequalities. These changes provide an opportunity to review and embrace new ways of sharing the experiences of those who have accessed our services and contribute towards service improvements.

Appendix A- Complaints Received (by month 1.4.19-31.3.22)



The deviation outside of the lower process limit represents the onset of COVID-19 and its impact on complaints being received. It is worth noting that some complaints received relate to care provided more than 6 or 12 months prior to making the complaint (and not the month the complaint was raised) but met the timescales for handling in accordance with the National Health Service Complaints (England) Regulations (2009).

Appendix B- Complaints Received by Mode of Receipt

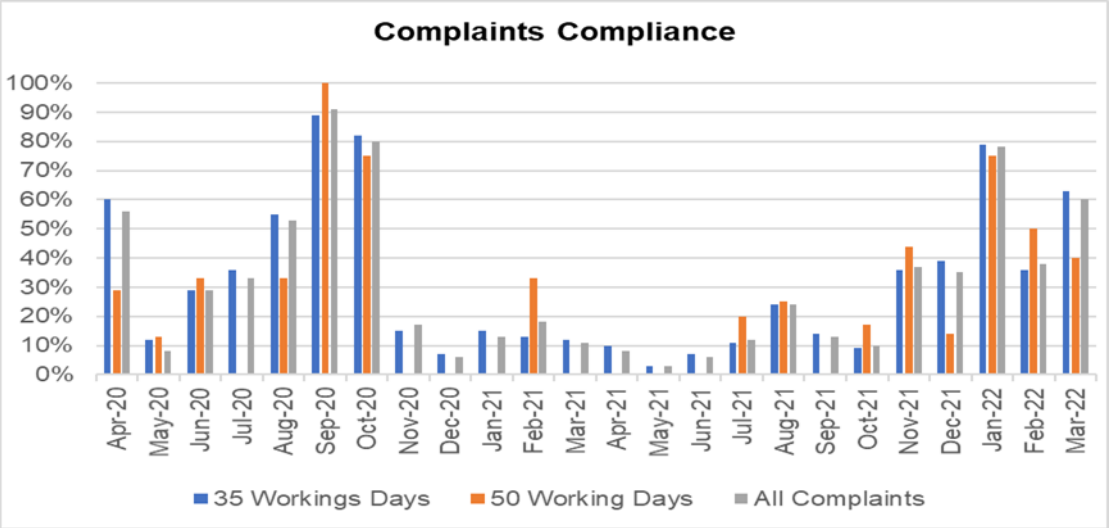
The Trust receives complaints in several different ways, the table below shows the number of complaints received for each method of receipt.

Method Complaints Received	Count	%
Complaints Form	157	34%
E-Mail	160	34%
Letter	100	22%
Phone Call	5	1%
Referred From PALS	43	9%
Totals	465	

Appendix C- Primary Complaint Subject by Division

	Corporate - CEO	Corporate - Corporate Affairs	Corporate - Finance	Core Services	Corporate - Nursing and Governance	Diagnostics, Anaesthetics and Surgery	Estates and Facilities	Medicine/Urgent Care	Community Health and Integrated Care	Women, Children's, and Sexual Health	Total
Access to Treatment or Drugs	0	0	0	0	0	0	0	1	0	0	1
Admissions and Discharges	0	0	0	0	0	0	0	3	0	0	3
Appointments	0	0	0	2	0	0	0	2	0	0	4
Attitude	0	0	1	1	0	5	1	17	1	2	28
Bereavement	0	0	0	0	0	0	0	4	0	0	4
Clinical Treatment	0	0	0	0	0	1	0	4	1	2	8
Communications	0	0	1	8	2	18	0	39	3	7	78
Consent	0	0	0	1	0	0	0	0	0	1	2
Discharge	0	0	0	0	0	2	0	26	0	0	28
End of Life Care	0	0	0	0	0	0	0	2	0	0	2
Environment	1	0	0	0	0	1	1	1	0	0	4
Equality and Diversity	0	1	0	0	0	1	1	1	0	0	4
Infection Control	0	0	0	0	0	1	0	1	0	1	3
Patient Care	0	0	0	0	0	0	0	5	1	0	6
Patient Pathway	0	0	0	4	0	17	0	22	1	6	50
Privacy, Dignity and Well-being	0	1	0	0	0	0	0	0	0	0	1
Provision of Services	0	0	0	1	0	3	0	4	0	2	10
Results of Tests	0	0	0	1	0	0	0	1	0	1	3
Standard of Care	0	0	0	3	0	47	0	139	6	28	223
Trust Admin/Policies/Procedures	0	0	1	0	0	0	0	0	0	0	1
Values and Behaviours (Staff)	0	0	0	0	0	1	1	0	0	0	2
Totals:	1	2	3	21	2	97	4	272	13	50	465

Appendix D- Complaints Response Rate Compliance for the period 1.4.2020 to 31.3.2022 by month



Appendix E- Complaints compliance by division for 2021/22 (see comments at Appendix B and D)

Division	35 Working Days		50 Working Days		All Complaints	
	In Time	%	In Time	%	In Time	%
Community Health and Integrated Care	2/18	11%	0/2	0%	2/20	10%
Core Services	4/20	20%	N/A	N/A	4/20	20%
Corporate Services	4/6	67%	0/1	0%	4/7	57%
Diagnostics, Anaesthetics and Surgery	29/112	26%	3/17	18%	32/129	25%
Estates and Facilities	3/6	50%	N/A	N/A	3/6	50%
Medicine and Urgent Care	80/289	28%	13/48	27%	93/337	28%
Women, Children and Sexual Health	11/59	19%	0/5	0%	11/64	17%
All Complaints	133/510	26%	16/73	22%	149/583	26%

Appendix F- PHSO case outcomes (see comments at Appendix B and D)

Details of Outcome
The PHSO advised they would not be upholding this case in the favour of the complainant as they could not identify any failings in the provision of care or the Trust's complaint response.
The PHSO advised they would be upholding this case in the favour of the complainant as they identified failures in the patients care, and a lack of communication with the patient regarding a latter diagnosis. The Trust were directed to (a) issue a letter of apology to the complainant for the failures identified by the PHSO, (b) develop and share an action plan to address the failures identified by the PHSO and (c) pay the complainant £500.00 in recognition of the significant distress caused to the complainant and their family.
The PHSO advised they would not be upholding this case in the favour of the complainant as they could not identify any failings in the provision of care.
The PHSO advised they would not be looking further into this case.

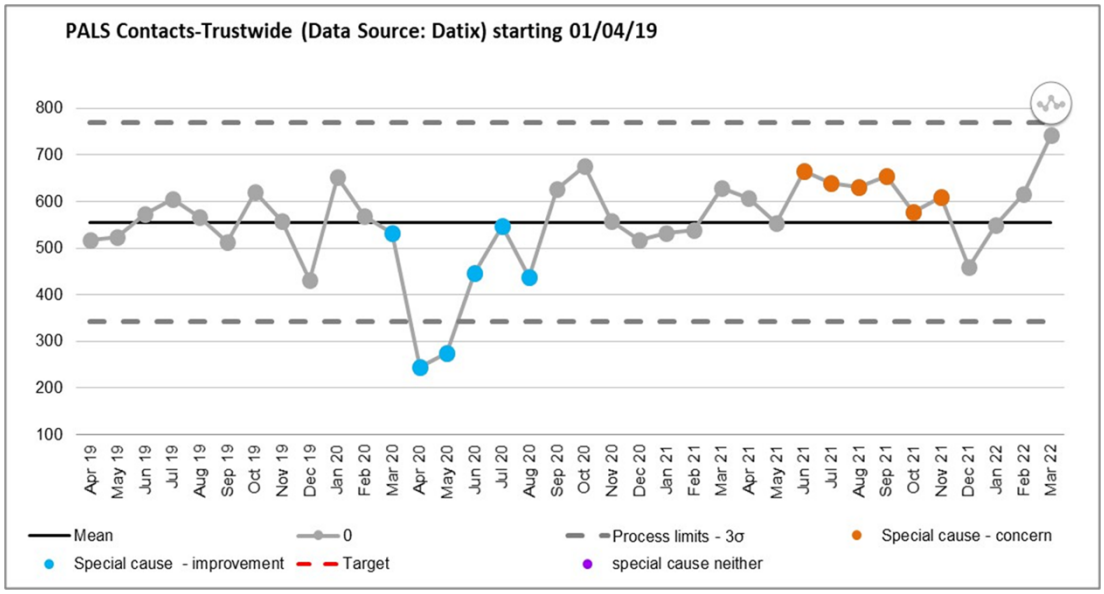
Appendix G- PHSO Activity 2020/21 -v- 2021/22

PHSO Activity 2020/21 -v- 2021/22

Contact Type	2020/21	2021/22
New Case Enquiries	10	8
Note of Intent to Investigate	1	1
Outcome – Upheld	2	1
Outcome – Not Upheld	1	2
Outcome – Not Investigating Further	2	1
Outcome – Referred Back For Local Resolution	2	0

Appendix H- Overview of PALS contacts received by month "see comments at Appendix B and D)

As with the complaints SPC chart, the deviation outside of the lower process limit represents the onset of COVID-19 and its impact on contact with PALS.



Appendix I- Distribution of PALS contacts that raised a concern or issue, data by division (see comments in Appendix B and D by Division)

Division	Count	%
All Divisions	1	0%
Corporate - Corporate Affairs	9	0%
Corporate - Finance	28	1%
Corporate - Human Resources	1	0%
Core Services	162	6%
Corporate - Nursing and Governance	12	0%
Diagnostics, Anaesthetics and Surgery	748	27%
Estates and Facilities	27	1%
Medicine/Urgent Care	1301	48%
Community Health and Integrated Care	108	4%
Corporate - Operational	11	0%
Non ESHT organisations	10	0%
Patient Access Teams	4	0%
Women, Children and Sexual Health	303	11%
Totals	2725	

East Sussex Healthcare NHS
NHS Trust

East Sussex Healthcare Trust Workforce Race Equality Standard Report 2022

If you require this report in an accessible format, please contact:
esht.workforceinclusion@nhs.net

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INTRODUCTION

In 2014 the NHS Equality and Diversity Council had agreed action to ensure from employees Black and Minority Ethnic (BME) backgrounds have equal staff receive equal opportunity to career opportunities and fair treatment in the workplace. In 2015 the Workforce Race Equality Standard (WRES) was mandated for all Trusts and forms part of inspection framework under the Well Led domain. The WRES also offers NHS organisations tools through nine progress indicators to understand their race equality performance, including the BME representation at senior management and board level. It helps East Sussex Healthcare Trust (ESHT) to focus on where we are right now, where we need to be and how to get there as well as track our progress.

East Sussex Healthcare NHS Trust (ESHT) has continued to hold itself accountable to the WRES indicators which have provided the opportunity to demonstrate our commitment to advancing equality and equity for the diverse workforce we employ.

The Trust continues to explore and take action to improve the experience and working lives of their BME staff and ensuring they have fair opportunities to progression.

The 2022 report shows progress in many areas where improvements are made and the highlights for 2021/2022. The report also highlights our aspirational goals in leadership and ensuring we link the WRES Indicators to NHS Peoples Plan which states that “for the future, the NHS needs more people, working differently, in a compassionate and inclusive culture”.

As a Trust we recognise the ambiguities surrounding the terms BAME and BME. Where the Trust is reporting/has reported to national standards, BAME and BME have been used in line with national reporting standards. Where possible, the term 'ethnic minority' or reference to specific ethnicities e.g., 'Bangladeshi’ has been used.

Data Collection and Monitoring

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

The 2011 Census continues to remain the most up to date information we have available to identify Ethnicity in the local areas. As highlighted in previous reports, using East Sussex in Figures, East Sussex, is less ethnically diverse than the South East region or nationally” (ESiF 2012). The local BME populations are around 10.5% which is lower than the South East (20%) and England (17%). Eastbourne and Hastings have the highest percentage of BME groups at 13%.

As of 31 March 2022 ESHT, employed 8023 staff of which 20.1% Identify as BME. 76.4% identify as White and 3.5% have not disclosed their ethnicity on Electronic Staff Records (ESR). The 2022 data shows that we employ more BME staff than both the local and national BME population.

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

Workforce Race Equality Standard Indicators 2021/22

The data relates to a reporting period is from 1 April 2021 – 31 March 2022 all staff captured on the ESR as of 31 March 2022 that are on permanent, fixed term and seconded contracts.

INDICATOR1. Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce:

Non-clinical and Clinical AFC Bandings

	WHITE		BME		ETHNICITY UNKNOWN/NULL		Grand Total	
1a) non-Clinical workforce	%Band Total	%All Staff	%Band Total	%All Staff	%Band Total	%All Staff	%Band Total	% All Staff
Band 1	71.4%	0.1%	28.6%	0.0%	0.0%	0.0%	100%	0.1%
Band 2	88.5%	10.2%	7.4%	0.8%	4.1%	0.5%	100%	11.5%
Band 3	94.9%	4.2%	2.6%	0.1%	2.6%	0.1%	100%	4.4%
Band 4	93.5%	3.9%	3.3%	0.1%	3.3%	0.1%	100%	4.2%
Band 5	90.5%	2.5%	6.3%	0.2%	3.2%	0.1%	100%	2.8%
Band 6	93.5%	1.2%	5.6%	0.1%	0.9%	0.0%	100%	1.3%
Band 7	92.7%	0.9%	3.7%	0.0%	3.7%	0.0%	100%	1.0%
Band 8A	85.7%	1.0%	9.9%	0.1%	4.4%	0.0%	100%	1.1%
Band 8B	90.9%	0.4%	9.1%	0.0%	0.0%	0.0%	100%	0.4%
Band 8C	91.7%	0.3%	8.3%	0.0%	0.0%	0.0%	100%	0.3%
Band 8D	100.0%	0.1%	0.0%	0.0%	0.0%	0.0%	100%	0.1%
Band 9	71.4%	0.1%	28.6%	0.0%	0.0%	0.0%	100%	0.1%
VSM	100.0%	0.1%	0.0%	0.0%	0.0%	0.0%	100%	0.1%

	WHITE		BME		ETHNICITY UNKNOWN/NULL		Grand Total	
1b)Clinical workforce of which non-Medical	%Band Total	% All Staff	%Band Total	% All Staff	%Band Total	%All Staff	%Band Total	% All Staff
Band 1	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Band 2	76.6%	8.4%	21.2%	2.3%	2.2%	0.2%	10.9%	10.9%
Band 3	77.9%	7.0%	17.3%	1.6%	4.7%	0.4%	9.0%	9.0%
Band 4	91.6%	2.6%	6.2%	0.2%	2.2%	0.1%	2.8%	2.8%
Band 5	54.9%	8.0%	42.2%	6.1%	2.9%	0.4%	14.6%	14.6%
Band 6	79.3%	11.5%	16.5%	2.4%	4.2%	0.6%	14.5%	14.5%
Band 7	89.1%	7.5%	9.3%	0.8%	1.6%	0.1%	8.4%	8.4%
Band 8A	87.9%	1.5%	8.6%	0.1%	3.6%	0.1%	1.7%	1.7%
Band 8B	94.1%	0.6%	5.9%	0.0%	0.0%	0.0%	0.6%	0.6%
Band 8C	88.9%	0.2%	11.1%	0.0%	0.0%	0.0%	0.2%	0.2%
Band 8D	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Band 9	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
VSM	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

	WHITE		BME		ETHNICITY UNKNOWN/NULL		Grand Total	
Of which Medical & Dental	% Band Total	% All Staff	% Band Total	% All Staff	% Band Total	% All Staff	% Band Total	% All Staff
Consultants	57.7%	2.1%	36.4%	1.3%	5.8%	0.2%	3.6%	3.6%
of which Senior medical mar	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Non-consultant career grade	25.1%	0.5%	65.5%	1.4%	9.4%	0.2%	2.1%	2.1%
Trainee grades	41.5%	1.6%	54.4%	2.1%	4.1%	0.2%	3.9%	3.9%
Other	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Summary

During 2021 – 2022 ESHT has increased its overall BME staff representation from 17.5% in 2021 to 19.7% in 2022.

Non-Clinical AfC bandings staff as of 31 March 2022

- Non-Clinical AfC pay grades make up 27.4 % of the overall workforce as of 31 March 2022 and comprise of 1.6% staff identifying as BME and 24.9 % staff identify as white staff.
- BME staff are underrepresented across AfC pay grade Bands 2 to Band 8 when compared with the total workforce BME average of 19.7%.

Clinical staff AfC bandings as of 31 March 2022

- Clinical staff AfC pay grades account for 62.9% of all roles across the Trust as of 31 March 2022 and comprise of 13.6% staff identifying as BME and 47.3% staff identifying as white.
- BME staff are underrepresented across pay grade Bands 3, 4 and Band 6 to VSM compared with the workforce BME average of 19.7%

Medical and Dental staff as of 31 March 2022

- Medical and Dental staff account for 9.7% of all roles across the Trust
- BME Medical Trainees (65.5%) and Non-Consultant Career Grade doctors (54.4%) have a higher representation than their White colleagues (25.1% and 41.5%)
- There is 21.3% higher representation of white Consultants compared to BME Consultants as of 31 March 2022

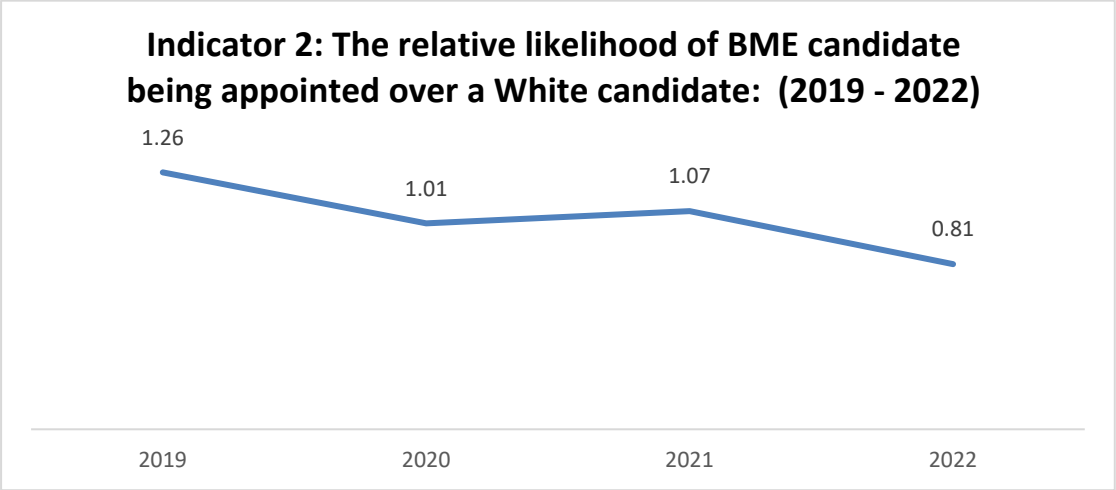
INDIACTOR 2. Relative likelihood of staff being appointed from shortlisting across all posts

Definitions:

- Relative likelihood – compares the likelihood of white staff being appointed with the likelihood of BME staff being appointed (ratio)
- Appointed – is required other than "recruited". The two may well be the same, but it is "appointed" staff numbers which should be used according to the WRES technical guidance
- All posts – means all directly employed posts.

Calculation Formula

	White	BAME	Unknown
No. Shortlisted Applicants	4704	1471	484
Appointed from Shortlisting	1168	450	234
Relative likelihood appointment from shortlisting	24.83%	30.59%	48.35%



Summary

BME candidates are 0.19 more likely to be appointed than White candidates. A relative likelihood of 1.0 indicates that there is no difference with BME and White staff being appointed from shortlisting.

The Trust score of 0.81 falls inline with the national median/benchmark value of 0.8 - 1.25. This is the non-adverse likelihood range set by the NHS WRES Strategy team. It is between these two values where the national WRES team feels there is not significant difference or an adverse effect.

NB: Calculations include our international recruitment of Radiographers and international nurses.

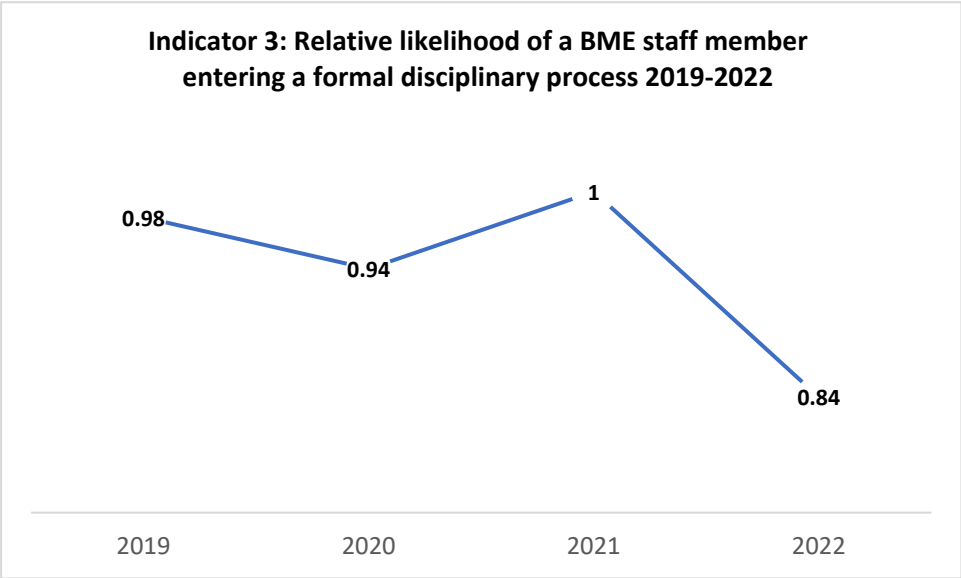
INDICAOR 3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Definitions:

- This indicator refers to staff in the overall workforce (as defined in indicator 1) who have entered a formal disciplinary as prescribed by the local disciplinary process.
- Data is counted as year end data 31 March 2022.
- Only new entries into a formal process in each year's WRES annual report i.e.,the start date falls within the reporting period.

Calculation Formula

	White	BAME	Unknown
Number of staff entering a formal disciplinary process	21	4	0
Likelihood of staff entering a formal disciplinary process	0.34%	0.25%	0%



Summary

Relative likelihood of a BME staff member entering a formal disciplinary process has fallen from 1.00 in 2021 to 0.84 in 2022.

The national median/benchmark value of 0.8 - 1.25 is the non-adverse likelihood range set by the NHS WRES Strategy team. It is between these two values where the WRES team feels there is not significant difference or an adverse effect. The Trust is just below that figure and means that white staff are more likely to enter the formal disciplinary process.

INDICATOR 4. Relative likelihood of staff accessing non-mandatory training and Continuous Professional Development

Definitions:

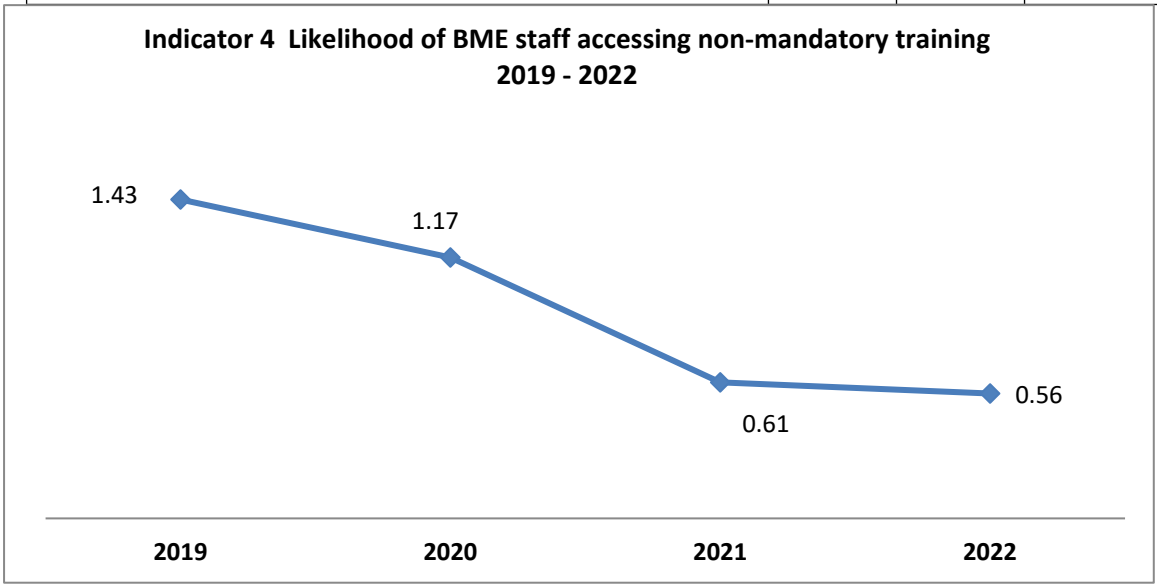
- Non-mandatory training refers to any learning, education, training or staff development activity undertaken by an employee, the completion of which is neither a statutory

requirement (e.g., fire safety training) or mandated by the organisation (e.g., clinical records system training).

- Accessing non-mandatory training and continuing professional development (CPD) in this context refers to courses and developmental opportunities for which places were offered and accepted.
- A relative likelihood of 1.0 indicates that there is no difference between BME or White staff accessing non-mandatory training

Calculation formula

	White	BAME	Unknown
Number of staff accessing non-mandatory training and CPD	241	112	12
Relative likelihood of accessing non-mandatory and CPD	3.93%	6.96%	4.33%



Summary

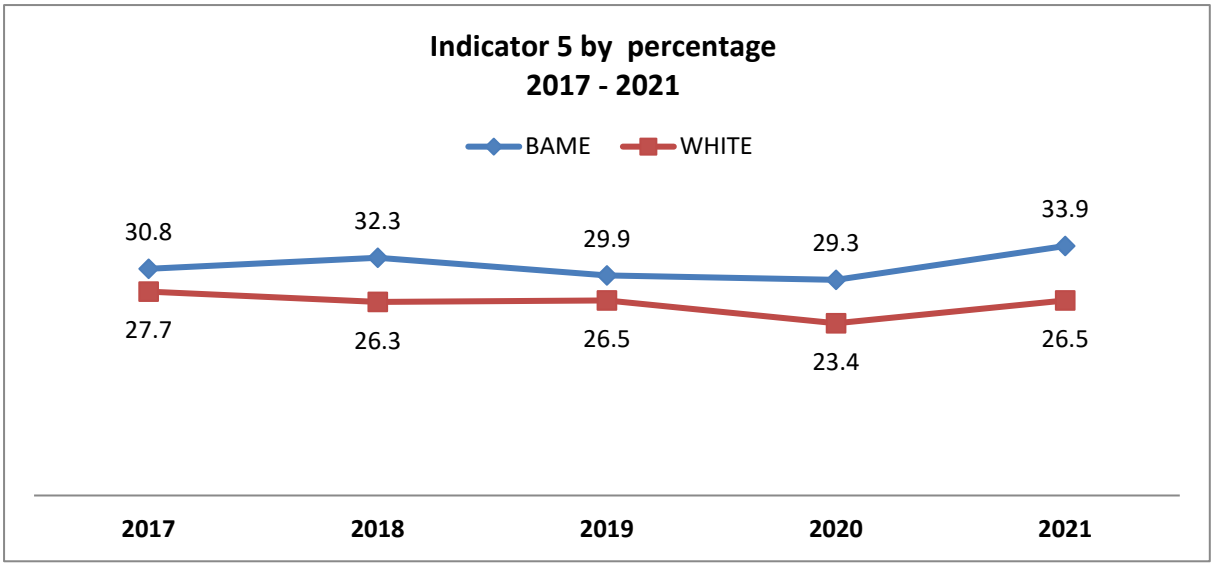
The above table demonstrates that a White member of staff was less likely to access non-mandatory training compared to a BME staff member during 1 April 2021 – 31 March 2022.

The national median/benchmark value of 0.8 - 1.25 is the non-adverse likelihood range set by the NHS WRES Strategy team. It is between these two values where the WRES team feels there is not significant difference or an adverse effect. For the Trust white staff are less likely to access non-mandatory training. This may be explained by the targeted approach of both local and systemwide training to the staff network.

The following four indicators are drawn from the 2021 staff survey and compare the outcomes of the responses for White and BME staff

Source: NHS Staff Survey 2021 Benchmark Reports (nhsstaffsurveys.com)

INDICATOR 5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months



Summary

The national benchmark for BME staff is 28.8% - our Trust has a higher percentage of BME staff experiencing harassment, bullying or abuse from patients, relative or the public (33.9%) and is at its highest for five years.

33.9% of BME staff represents a head count of 194 responses to the survey question.

The national benchmark for White staff is 26.5% and our Trust is equal on that response.

26.5% of White staff represents a head count of 1117 responses to the survey question.

For both BME staff and White staff there has been an increase in staff experiencing harassment, bullying or abuse from patients, relatives or the public.

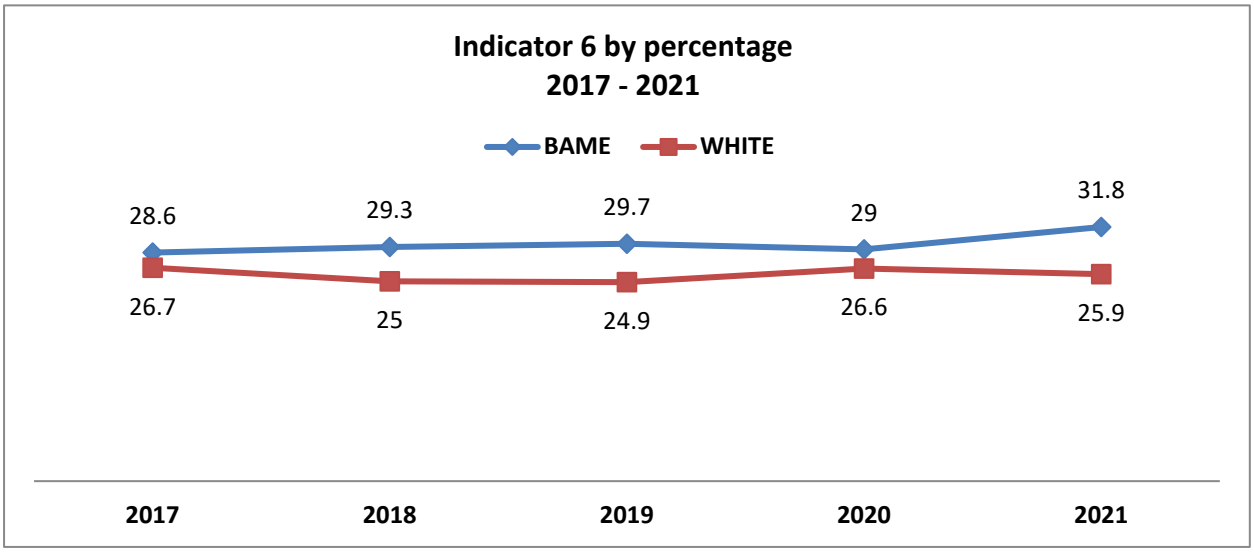
BME staff have seen an increase of 4.6% from 29.3% in 2020 to 33.9% in 2021.

White staff have seen an increase of 3.2% from 26.5% in 2020 to 23.4% in 2021.

BME staff are disproportionately affected by abuse from members of the public and patients compared to their white colleagues in the 2021 staff survey.

In the past year several initiatives have been put in place, such as the Violence and Aggression Group and yellow card system. This may mean that staff have felt more confident in reporting bullying and harassment because they see the Trust taking steps to tackle it.

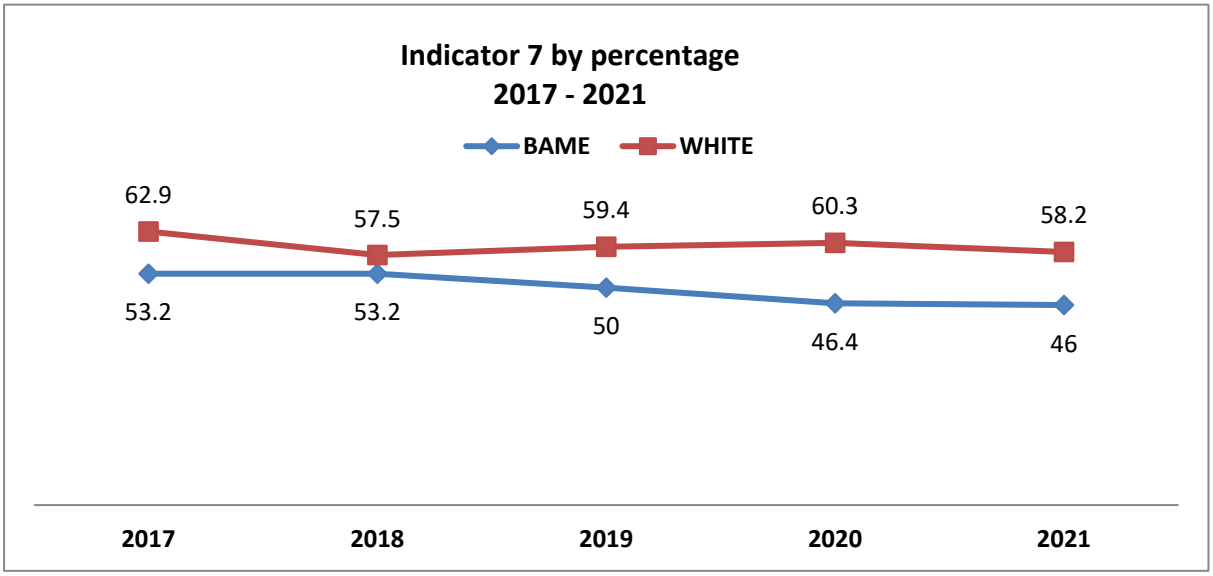
INDICATOR 6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



2021 Summary

- The national benchmark for BME staff is 28.5% - our Trust has a higher percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months (31.8%)
- 31.8% of BME staff represents a headcount of 181 responses to this survey question
- The national benchmark for White staff is 23.6% - our Trust has a slightly higher percentage at 25.9%
- 25.9% of White staff represents a headcount of 786 responses to the survey
- BME staff reported an increase in feeling, harassment bullying and abuse for other staff from 29% in 2020 to 31.8% in 2021.
- White staff reported a decrease in 2020 from 26.6% in 2020 to 25.9% in 2021
- BME staff remain disproportionately affected by harassment, bullying and abuse.

INDICATOR 7. Percentage believing that Trust provides equal opportunities for career progression or promotion



Summary

The national benchmark for BME staff is 44.6% and for the Trust is slightly higher at 46%

46% of BME staff represents a headcount of 261 responses to the survey question

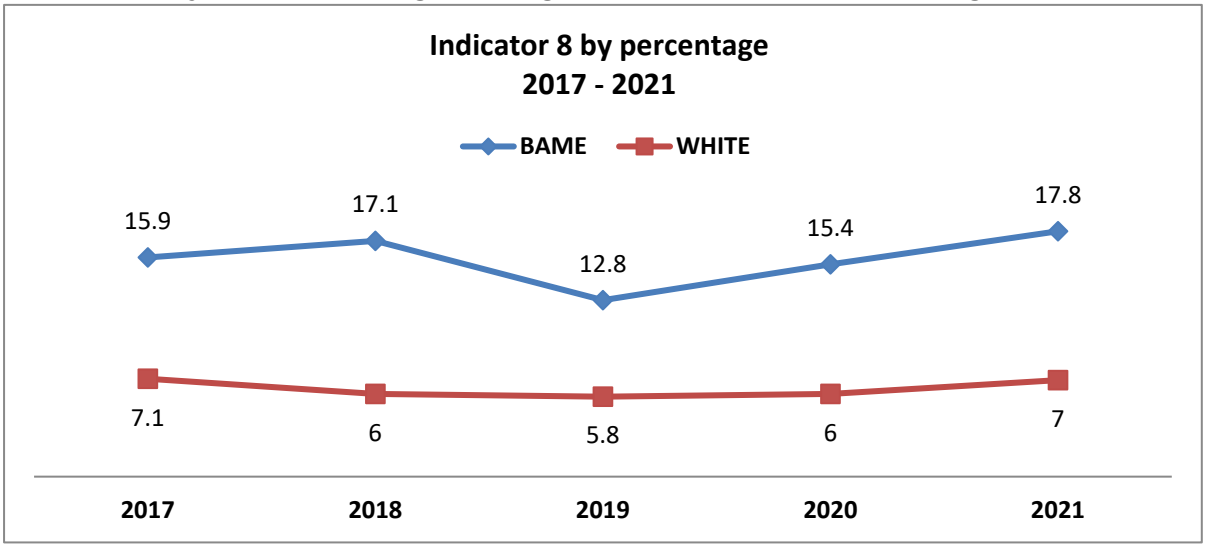
The national benchmark for White staff is 58.6%

58.2%of White staff represents a headcount of 1808 responses to the survey

There has been a decrease by 2.1% of White staff that believe the Trust acts fairly from 60.3% in 2020 – 58.2% in 2021

The 2021 staff survey has seen a 0.4% decrease for BME staff (46.4% in 2020 and 46%) believing the Trust act fairly with progression.

INDICATOR 8. In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues.



Summary

The national benchmark for BME staff is 17.3%. Our Trust has a slightly higher percentage of BME staff who have personally experienced discrimination at work from a manager/team leader or other colleague at 17.8%

17.8% of BME staff represents a headcount of 105 responses to the survey question

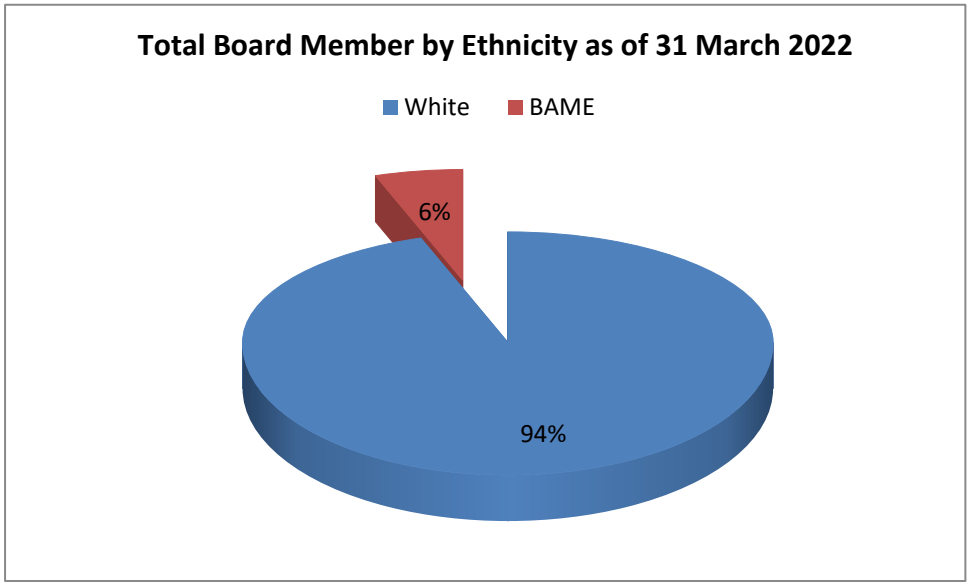
The national benchmark for White staff is 6.7% and the Trust has a slightly higher percentage at 7%. This represents a headcount of 212 responses to this survey question.

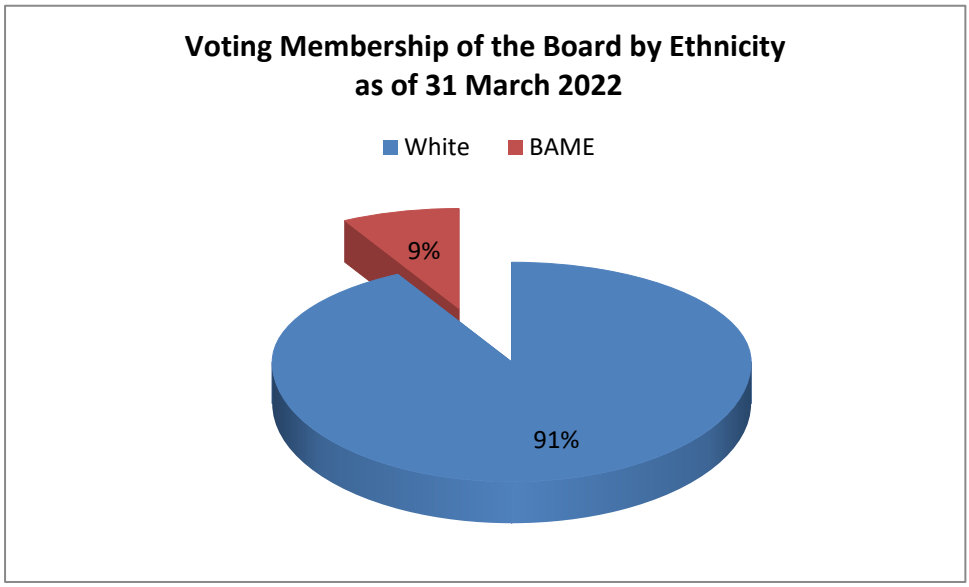
There is a 2.4% increase in BME staff and a 1% increase in white staff that have personally experienced discrimination by a managers/team leader or another colleague from 2020 to 2021

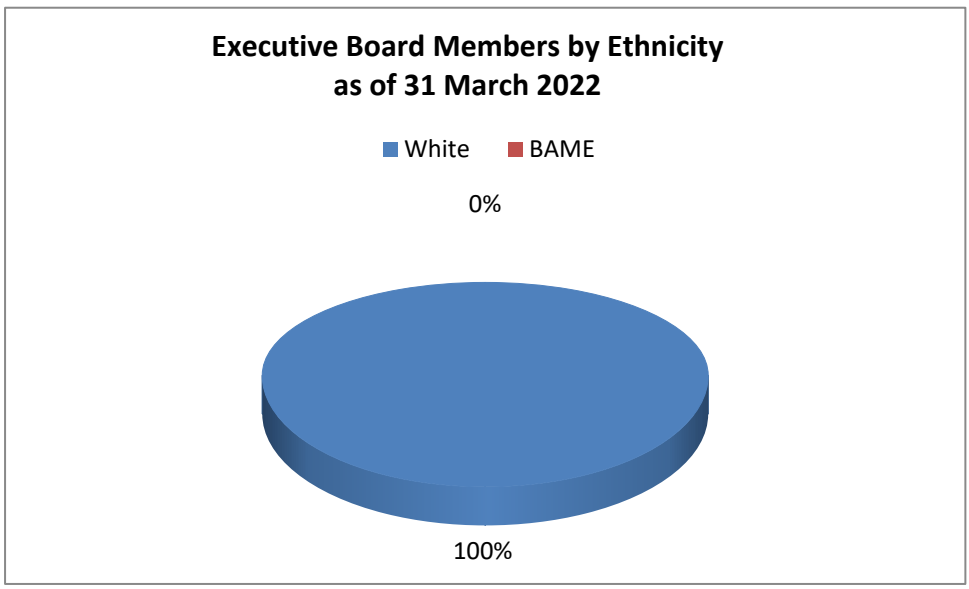
INDICATOR 9. Percentage difference between the organisation's Board membership and its overall workforce disaggregated:
Definitions:

- Very senior managers (VSM) are defined as:
- Board level management (Chair / chief executives / executive directors)
- Senior medical manager
- Other senior managers with board level responsibility who report directly to the chief executive.

In considering the 2021 data it is pleasing to note that our Trust Board have 100% ethnicity declaration rates as 31 March 2022







SUMMARY OF ACTIVITIES 2021-2022

1. WRES

The national WRES team data analysis report for 2021 that was published in March 2022 highlighted the Trust for being one on the top ten performing Trusts for Indicator three the

relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

2. Health and Wellbeing

As we continue to feel the effects of the Covid-19 pandemic, the Trust also continues to implement robust Risk Assessments to all staff including ethnic minority staff. At the start of 2022, information regarding mandatory vaccines for NHS staff surfaced. In recognition of the disproportionate effect Covid-19 has on ethnic minority communities, we sought to support ethnic minority staff during this time and help them make the best decisions for themselves. Through support groups, panel discussions and pop-up events, clinical and emotional guidance was offered to staff experiencing vaccine hesitancy.

In addition to Covid-19 support, our Health & Wellbeing Department has a dedicated team that offer support to managers and staff these include:

- Mental Health First Aiders
- Visits to wards and departments
- Bespoke wellbeing support for individuals and teams.

Our health and wellbeing work for our ethnic minority staff also stretches into our external support services. Our BAME staff network works closely with Sussex Staff in Mind to ensure that we offer culturally competent wellbeing support to our staff.

Looking after our ethnic minority staff remains a key priority for 2022/23.

International Nurses
During the reporting year we recruited over 150 nurses from mainly from Asia and Africa.

We recognise that travelling to a new country for work is very difficult and generates challenges. To help our international nurses adapt to their new environment and settle into ESHT, an induction period has been developed to situate the nurses with ESHT and the surrounding areas. Within this period, the nurses get to meet a variety of different teams including the Recruitment Team, Health and Wellbeing Team, Chaplaincy and EDI Team to name a few. As well as providing practical support, the induction period provides pastoral support by helping the nurses transition into UK culture and settle into their lives in East Sussex.

BAME Staff Network
Listening to the voices and concerns of our BAME staff is a priority. Our BAME staff network has direct access to the Trust Board. The network is sponsored by the Trust Board Chair Steve Phoenix with an annual budget to carry out activities. In addition to the above Chief Executive Officer Joe Chadwick Bell and Chief People Officer Steve Aumayer, meet with the network chairs on a regular basis and listen to emerging themes and act upon concerns raised.

Leadership Development
The Organisation Development (OD) Team actively include WRES targets in their work. Focusing on our leadership offer, the last year has seen the following engagement around WRES:

ESHT continues to work in collaboration with Henley Business School to provide leadership development opportunities. In early 2022 ESHT recruited its newest cohort for the Postgraduate Diploma in Leadership. This cohort is comprised on of 43% BME of the students. The Postgraduate in Leadership provides the opportunities for staff to Understand their personal strengths as a leader and how to use them to deliver high performance.

The OD Team continue the offer of Career Progression Conversations, which target career development, through skills and tools. Career Progression Conversations have been tailored towards BME staff in order overcome some of the barriers preventing career progression. In addition to this, throughout 2021/22 our Aspiring Leaders Programme continued to run. The Aspiring Leaders Programme is designed to help individuals explore leadership and whether it is a path they wish to take.

System –wide collaborative

ESHT continues to participate in system wide collaboration. Being an active member in the BAME Disparity Programme, ESHT remains committed to the BME Workforce Disparity Reduction Roadmap with priorities to:

- Improve BME representation on all Boards to reflect the corresponding local BME workforce or population demographic, whichever is greater
- Improving BME representation on all Boards to reflect the corresponding local BME workforce or population demographic, whichever is greater
- Identifying and removing disparities in the recruitment and selection process:
- Eliminating bullying, harassment and discrimination in the workplace

ESHT's Chief People Office, Deputy Director of Culture and BAME Network Chair were present at the Sussex Race Equality Away Day. During the event, a headline mission statement was agreed along with a plan of action with reference to progressing race equality across Sussex. This will be implemented across ESHT, and compliance will be monitored by the Chief People Officer.

CONCLUSION

The results of the 2022 WRES show the data driven indicators 1-4 and 9 have either been maintained or slight improvements have been made.

The main areas of concern relate to the increase in staff experiencing bullying and harassment from patients, colleagues, or their managers (indicators 5,6 and 8) and to Indicator 7 relating to the belief that the Trust offers equal opportunities for career progression and promotion as although it remains above that of the national benchmark it has fallen slightly for the Trust. Work in this area has already begun and will be built on in 2022/2023.

Health & Wellbeing remains a key priority. We continue to offer wellbeing conversations and increase the inclusivity of our health and wellbeing services.

To progress in our priorities a WRES action plan has been developed. To ensure our action plan generates tangible outcomes a group of key stakeholder's report to the bi-monthly WRES task and finish group. Membership to the group is formed of key stakeholders which include representatives from the Apprenticeship team, BAME Staff Network, Workforce EDI Team, Health & Wellbeing Team, Recruitment Team, Operational HR department and the Training department. Collaborating with the BAME Staff Network is crucial to generating meaningful and long-lasting change – the network contributes to reporting, assessing, and generating the changes.

As a Trust we remain committed to progressing on all indicators that need attention as part of our Workforce EDI strategy over the next 3 years. As we move into the forthcoming year we remain committed and continue to hold ourselves accountable to WRES indicators.

OUR TOP PRIORITIES FOR 2022-2024

1. Addressing Bullying and Harassment in the workplace
2. To continue with BME Leadership development programme
3. Further investigation into staff turnover
4. Further investigation into internal promotion opportunities

A detailed action plan is attached.

For further information contact esht.workforceinclusion@nhs.net

WRES Action Plan 2022-2024

WRES indicator	Likelihood of ethnic minority candidates being appointed from shortlisting in comparison to White candidates			
	Action	**Outcome**	**Lead**	**Timescale**
1 2	Regular review of recruitment processes to ensure they remain fair and inclusive	Ethnic minority representation continues to improve in line with national trajectory	Recruitment team	Ongoing until March 2024
1 2	Advertise the staff networks on recruitment documentation	Highlight ESHT as an inclusive employer		October 2022
	Ethnic minority staff report higher levels of bullying, harassment or abuse			
5 6 8	Include ethnicity within datix reporting form	Ensure that ESHT provides a safe and healthy environment for ethnic minority staff	Health and Safety Manager	April 2023
	Trust and System Wide Review on Violence and Aggression within the Trust	Reduce incidences of violence and aggression	Associate HR Director-Staff Engagement & Wellbeing	March 2023
	Raising the profile of ethnic minority across the Trust			
5 6 7 8	Diversity Dialogue session to be held on numerous topic	Facilitate conversations on potentially sensitive topics and subjects	EDI Team	December 2022
All	Celebrate the contribution of ethnic minority staff to the experience of patients at ESHT	Using existing mechanisms to promote diversity in workforce and develop new mechanisms	EDI Team Staff Engagement & Wellbeing Manager	Ongoing until March 2024
1 9	Continue to improve ESR self-reporting of ethnicity data	Reduced undeclared ethnicity data on ESR	EDI Team	January 2023
1 9	Increase awareness of the diversity makeup of teams	Embed the diversity toolkit within divisions		October 2023
5 6 7 8	Ensure representation of ethnic minorities at Staff Partnership Forum	Ensure involvement within decision-making process	EDI Team People Experience Manager	September 2023
	Percentage of ethnic minority staff accessing career promotion or progression			
4	Promote structures that support career progression and opportunities for ethnic minorities	Create equitable opportunities for ethnic minorities staff	OD Team	March 2024
4 7	Monitor learning and development attendance by ethnicity status		OD Team Training Team	June 2023
All	Health and Wellbeing support	Keep the ethnic minority workforce physically and mentally healthy by tailoring support to their needs	Health and Wellbeing Team	January 2023

East Sussex Healthcare Trust WORKFORCE DISABILITY EQUALITY STANDARD REPORT 2022

If you would like this report in a different format contact
esht.workforceinclusion@nhs.net

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1. INTRODUCTION

The Workforce Disability Equality Standard (WDES) is a set of ten specific, evidence-based measures (metrics) that enables NHS organisations to compare the experiences of disabled and non-disabled staff. This information is used to develop an action plan and enable East Sussex NHS Healthcare Trust (ESHT) to demonstrate progress against the METRICs of disability equality. The rationale for the WDES is founded upon the wider context of Disabled people and their experiences in employment and work.

The WDES was commissioned by the Equality and Diversity Council (EDC) and developed through a pilot and extensive engagement with Trusts and key stakeholders. It is mandated through the NHS Standard Contract and was restricted to NHS Trusts and Foundation Trusts for the first two years of implementation.

East Sussex Healthcare NHS Trust welcomed the standard which has provided the opportunity to review disability workforce data enabling us to identify areas of practices where disability equality is lagging and develop action plans to advance disability equality.

The WDES is underpinned by the Social Model of Disability, which proposes that people are disabled because of societal barriers, rather than a long-term health condition. With the social model in mind, the WDES aims to highlight data that will drive forward year on year improvements in reducing barriers that impact most on the career and workplace experiences of Disabled staff or with long-term health conditions. With robust data reported yearly ESHT use the annual report to drive forward changes in attitudes, and confidence to improve employment and career opportunities that lead to long-lasting change for Disabled people employed or seeking employment opportunities at ESHT.

The metrics are used as a tool to help identify and close gaps between disabled and non-disabled staff within the organisation. The report is used to support us in improving recruitment practices and the experience of disabled staff across the organisation.

The WDES is being used to assist the Trust in ensuring our workforce can be confident that we are giving due regard to using the METRICs (below) contained in the WDES to help ensure inequalities are identified and addressed.

The regulators, the Care Quality Commission (CQC) and NHS England & Improvement (NHSEi) monitor the WDES along with other equality reports to help assess whether East Sussex Healthcare NHS Trust is inclusive and well-led.

To demonstrate our commitment to advancing equality of opportunity as an equal opportunities' employer, we use the outcomes of the ten metrics to improve representation and disability equality for staff. This supports us in becoming an inclusive organisation whilst fulfilling its legal duties to comply with the Public Sector Equality Duty.

1.2 Data Collection and Monitoring

Electronic Staff Records (ESR) is the system used to hold employee information. As of 31st March 2022, we employed 8023 members of staff of which 352 (4.39%) staff members were recorded as having a disability. Metrics 4 – 9 are drawn from the National NHS Staff Survey 2021 results.

The 2011 Census is still the most up to date information available to identify disability in the local areas. 'East Sussex in Figures' provides actual figures of the total local populations in 2021, along with 'projections' of the number of people living with a disability from 2019 –

2034. It is estimated that around 96,995 people with a disability live in East Sussex in 2020.

When referring to Disability in this report this also refers to those that have a long-term health condition as defined by the Equality Act 2010.

2.0 WDES METRICS

2.1 METRIC 1: Percentage of staff by disability status in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members)

Definitions

Definitions for these categories are based on Electronic Staff Record occupation codes except for medical and dental staff, which are based upon grade codes

Table 1 Non-clinical staff

Percentage of non-clinical staff within cluster as of 31 March 2022			
Cluster 1	Disabled	Non-disabled	Unknown/not declared
1: AfC Band 1, 2, 3 and 4	5.2%	68.7 %	26.2%
2: AfC Band 5, 6 and 7	6.8%	73.7%	19.5%
3: AfC Band 8a and 8b	7.3%	67.7%	25.0%
4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)	4.4%	62.2%	33.3%
Total Non-clinical	**5.6%**	**69.4%**	**25%**
Total in workforce clinical and non-clinical	**4.39%**	**72.77%**	**22.85%**

Table 2 Clinical staff

Percentage of clinical staff within cluster as of 31 March 2022			
Cluster 2	Disabled	Non-disabled	Unknown/not declared
1: AfC Band 1, 2, 3 and 4	3.7%	74.6%	21.7%
2: AfC Band 5, 6 and 7	4.6%	73.0%	22.5%
3: AfC Band 8a and 8b	4.2%	73.3%	22.5%
4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)	0%	63.6%	36.4%
Total Clinical	**4.2%**	**73.5%**	**22.2%**
Total in workforce	**4.39%**	**72.77%**	**22.85%**

Table 3 Medical and Dental staff

Percentage of Medical Staff as of 31 March 2022			
Cluster 3	Disabled	Non-disabled	Unknown/not declared
Consultant	1.37%	60.82%	37.80%
Non-Consultants Career Grade	2.92%	77.19%	19.88%
Trainee Grades	2.22%	92.41%	5.38%
Total by medical workforce	**2.06%**	**77.25%**	**20.69%**
Total in workforce	**4.39%**	**72.77%**	**22.85%**

Summary

During 2021 – 2022 ESHT has increased its overall staff declaring a disability from 3.96% in 2021 to 4.39% in 2022. When this data is cross-referenced with the 2021 NHS Staff Survey, a self-declaration of 10.9% of staff identifying as disabled is noted. There might be many reasons for this disparity, which need to be understood and addressed.

Non-Clinical AfC pay grades show the most marked increase in declarations but the number of staff that do not declare whether they would describe themselves as having a disability or not remains high at 22.85%.

Medical staffing data shows a smaller declaration of disability than either clinical or non-clinical staff.

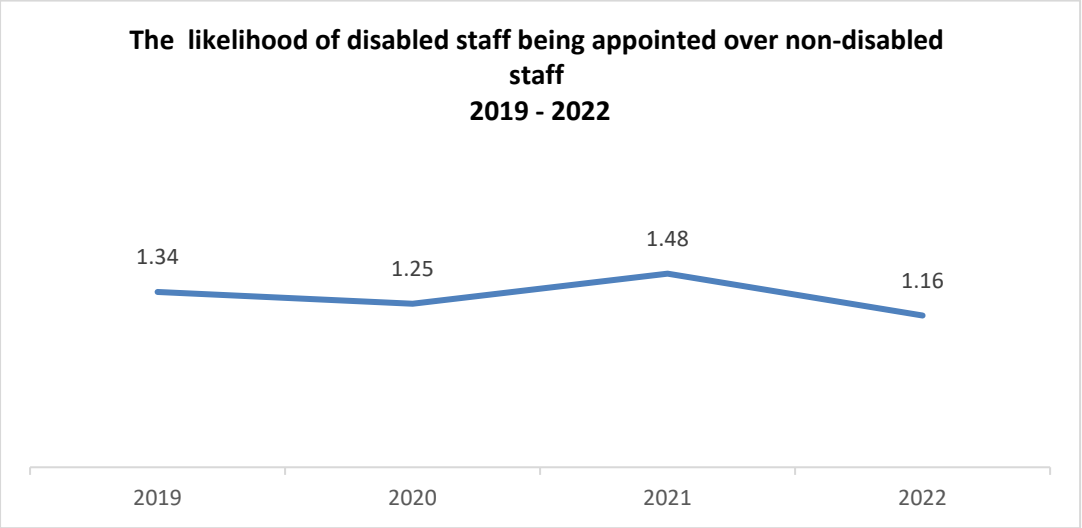
Reducing the unknown/not declared figures will be a priority for 2022/23.

2.2 METRIC 2: Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts

Definitions
This refers to all advertised for both internal and external posts from 1 April 2021 – 31 March 2022.

Calculation Formula

	Non-disabled	**Disabled**	**Unknown**
No. Shortlisted Applicants	5593	480	124
Appointed from Shortlisting	1334	99	388
Relative likelihood appointment from shortlisting	0.21	0.24	0.50



Summary

A figure below 1:00 indicates that a non-disabled candidate is more likely than disabled candidate to be appointed from shortlisting.

During 1 April 2021 – 31 March 2022, a non-disabled candidate being appointed over a disabled candidate is 1.16 times more likely.

Since the 2021 return, successful outcomes for disabled candidates have increased.

Work has already begun on reviewing the recruitment process to ensure it is as accessible as possible.

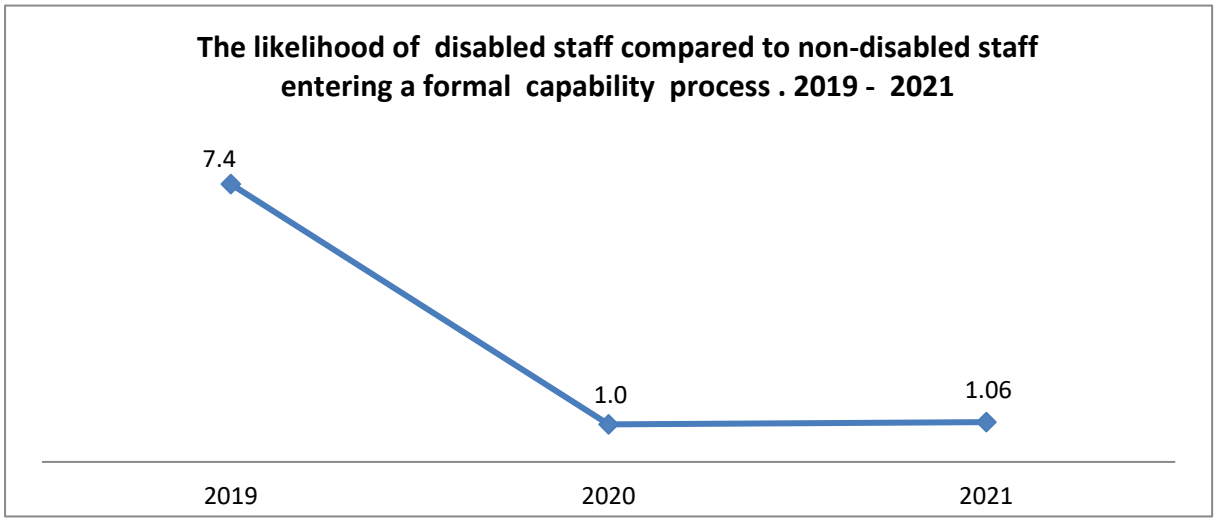
2.3 METRIC 3: Relative likelihood of non-disabled staff, compared to disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

Definitions

- This metric was mandated in 2020.
- This metric is based on data from a two-year rolling average of the current year and the previous year.
- This metric looks at capability on the grounds of performance, rather than ill health.

Calculation Formula

	Non-Disabled	Disabled	Unknown
Number of staff entering a formal capability process	23.5	1.5	8.5
Likelihood of staff entering a formal capability process	0.00	0.00	0.00



Summary

A figure above 1:00 indicates that disabled staff are more likely than non-disabled staff to enter the formal capability process.

The data shows us that over a 2-year period there is no significant bias towards disabled staff entering a formal capability process.

Metrics 4-9

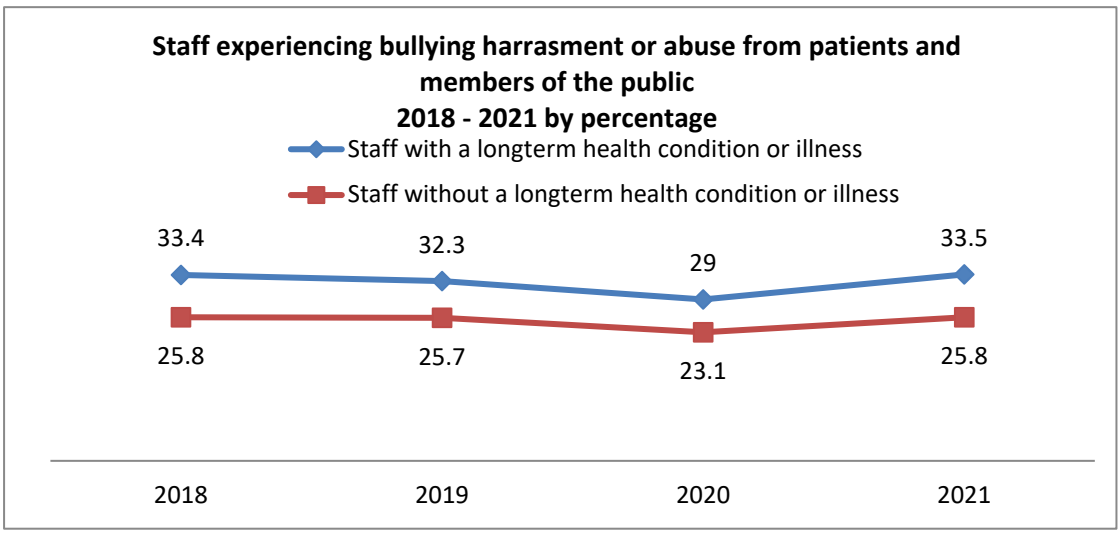
For each of the following metrics 4-9, data is drawn from the staff survey results. Data compares the experiences of our disabled staff and non-disabled staff. The WDES breakdowns are based on the responses to q26a. "Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more"?

Source: NHS Staff Survey 2021 Benchmark Reports (nhsstaffsurveys.com)

NB: Historically there are more staff that declare a disability completing the staff survey (n.875 in 2021) than declare their disability status on ESR at the Trust (n.352).

2.4.1 METRICs 4 (a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

i. Patients/Service users, their relatives, or other members of the public



Summary

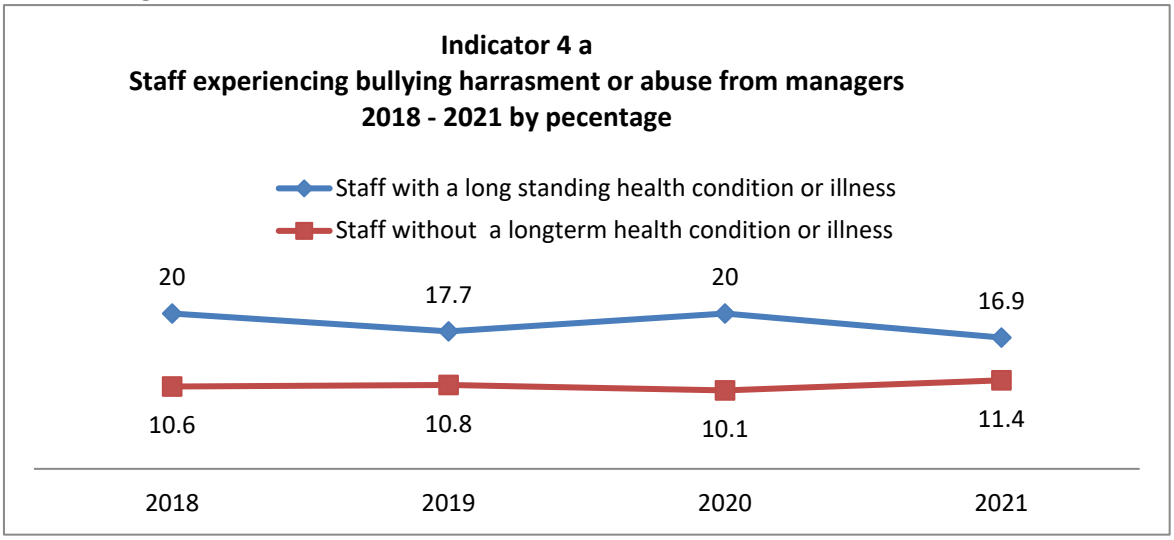
The national average for staff with a long-term health condition or illness is 32.4%

All staff have seen an increase in 2021 in from bullying harassment and abuse from patients and members of the public.

Staff members with a long-term health condition or illness are disproportionately affected than those who do not disclose a long-term health condition.

33.5% represents a head count of 293 staff who completed the staff survey that declared a long-term health condition or illness on ESR.

ii. **Managers**



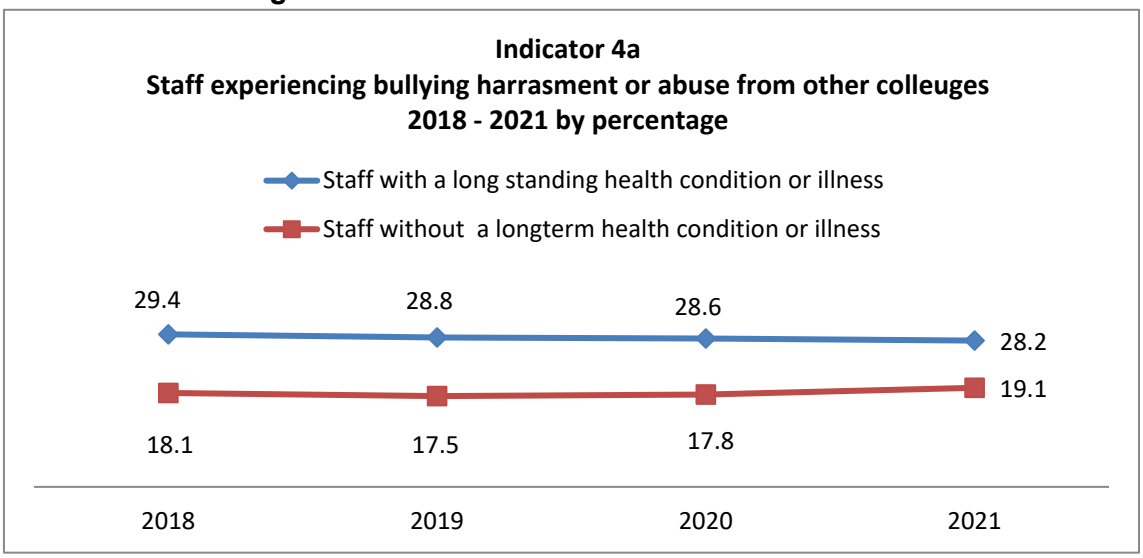
Summary

The national average in 2021 for this metric for staff with a long-term health condition or illness is 18%. ESHT is below that average.

147 staff, who completed the survey, with a long-term health condition or illness responded as having experienced bullying and harassment from their managers.

314 staff, who completed the staff survey, without a long-long term health condition or illness responded as having experienced harassment and bullying from a manager.

iii. **Other colleagues**



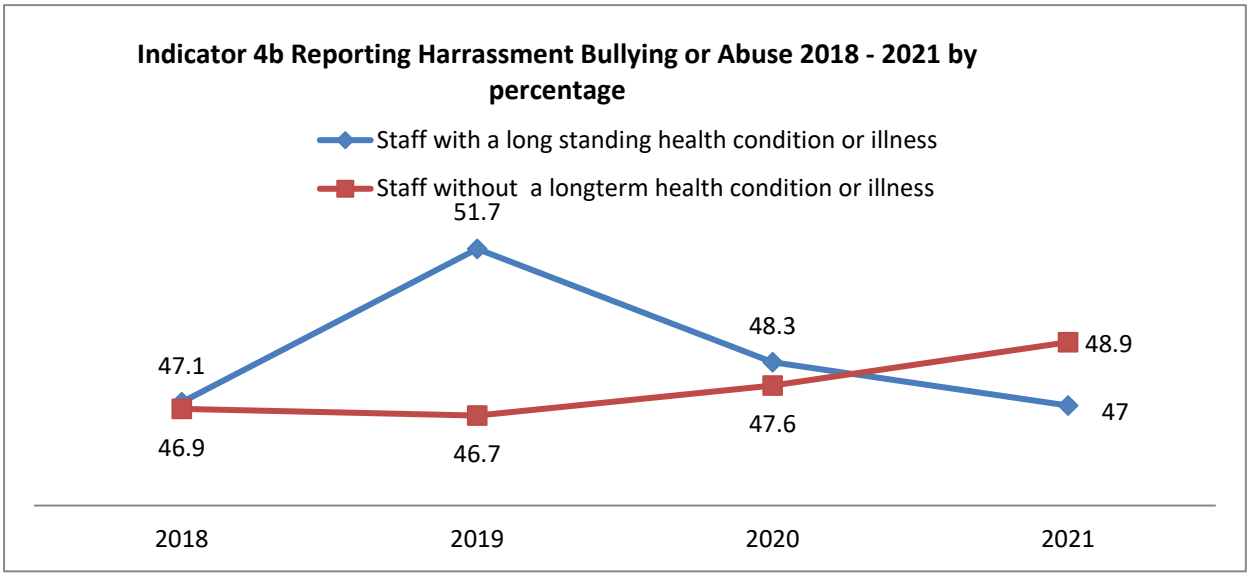
Summary

The national benchmark for staff with a long-term health condition or illness is 26.6%. ESHT is slightly above this average.

28.2% represents a headcount of 246 staff who completed the staff survey with a long-term health condition or illness that responded as having experienced harassment and bullying from another colleague.

527 (19.1%) staff without a long-term health condition or illness who completed the survey, that responded that they experienced harassment and bullying from another colleague.

2.4.2 METRIC 4(b): Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.



Summary

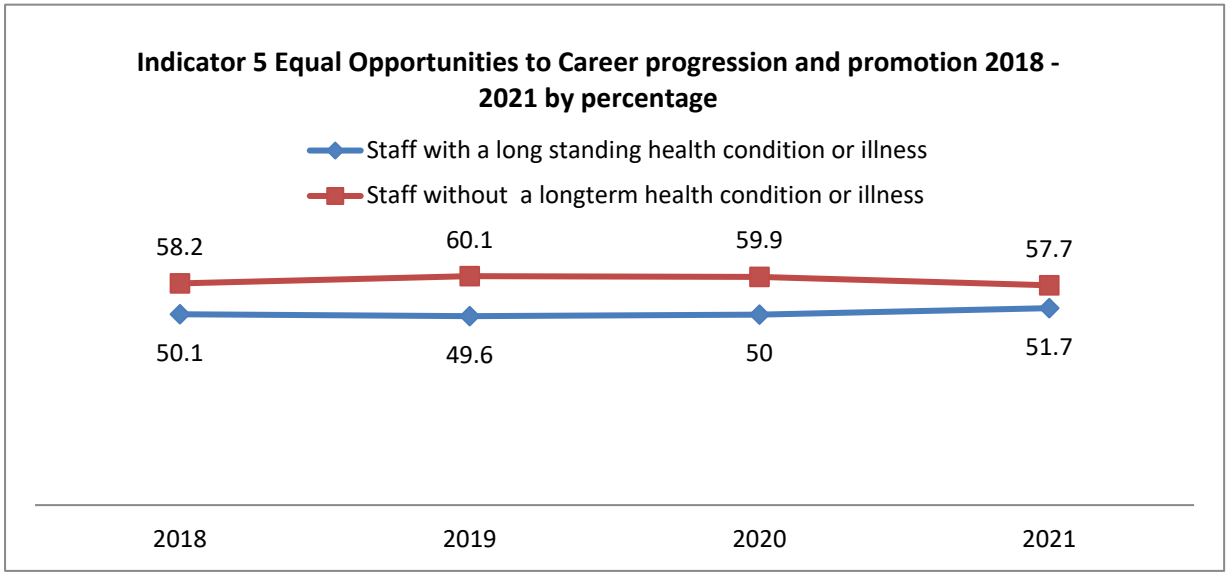
The national average for staff with a long-term health condition at work, say that they or a colleague reported harassment or bullying is 47%. ESHT is equal to that average. This represents a headcount of 389 for staff with a long-term health condition or illness who completed the survey.

48.9% represents a head count of 1351 without a long-term health condition or illness.

The data shows us that there is a slight decline in reporting harassment and bullying for staff with a long-term health condition or illness and a slight increase for staff without a long-term health condition or illness.

Metrics 4a and 4b show increases of bullying and harassment for all colleagues from patients, carers, managers, and colleagues. Work has already begun on ways to reduce these figures with two task and Finish Groups looking at bullying and harassment and violence and aggression. This will remain a priority for 2022/23 and the Trust will continue to support the system wide work in this area.

2.5 METRIC 5: Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.



Summary

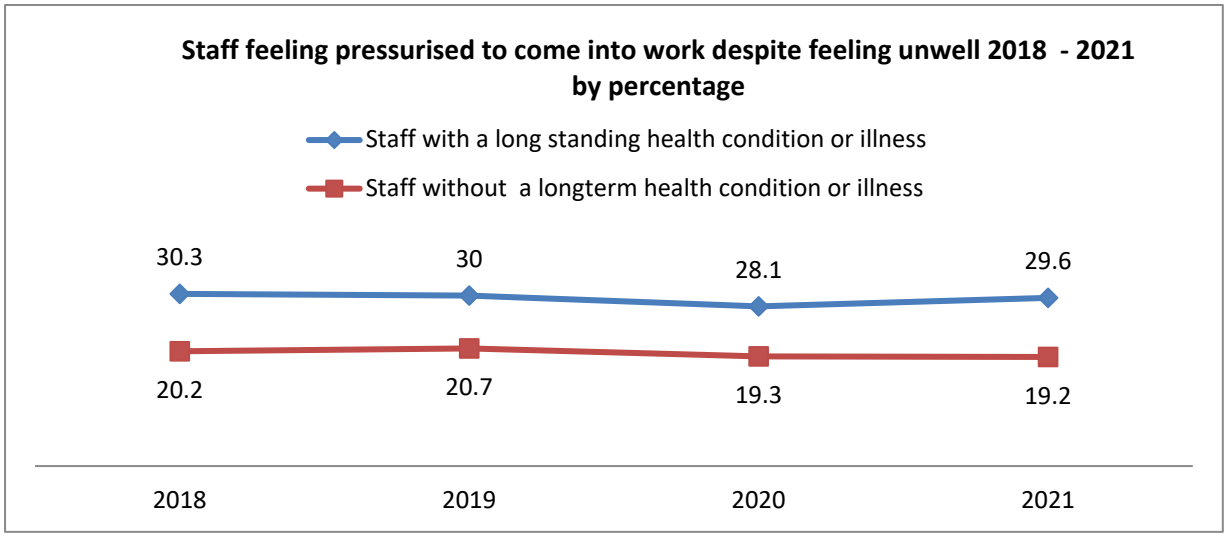
The national average for staff with a long-term health condition or illness feeling that their Trust acts fairly with progression is 51.4%

ESHT is slightly above the national average at 51.7%, which represents a headcount of 452 staff with a long-term health condition or illness who completed the survey.

57.7% represents a headcount of 1594 staff without a long-term health condition or illness who completed the survey.

The data suggests that there is a slight increase in staff with long-term health conditions and a slight decrease in staff without long-term health conditions feeling that the Trust acts fairly with progression.

2.6 METRIC 6: Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.



Summary

The national benchmark for staff with a long-term health condition or illness feeling pressure to come into work feeling unwell is 32.2%

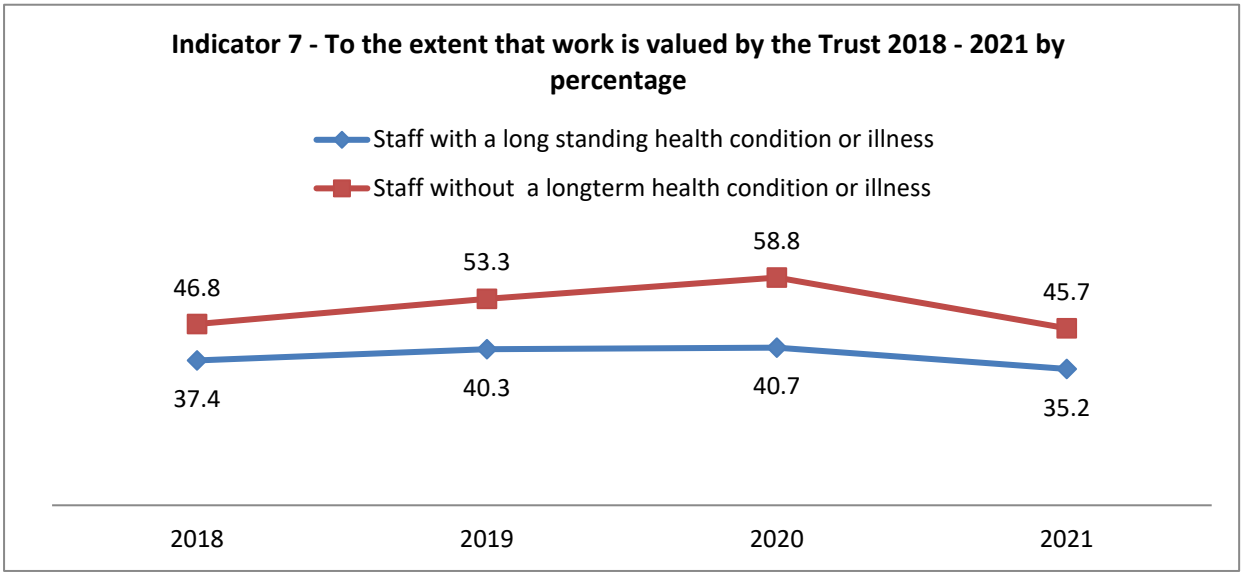
ESHT is below the national average at 29.6%, which represents a headcount of 259 staff with a long-term health condition or illness feeling pressured to come into work feeling unwell who completed the survey.

19.2% represents a headcount of 530 staff, who completed the survey, without a long-term health condition or illness feeling pressured to come into work feeling unwell.

The data shows us that there is an increase in staff with long-term health conditions feeling pressured to attend work and a slight decline in staff without long-term health conditions.

A disability and health passport has been introduced to support staff and their managers in having conversations about health and reasonable adjustments. The work to promote this will continue in 2022/23.

2.7 METRIC 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.



Summary

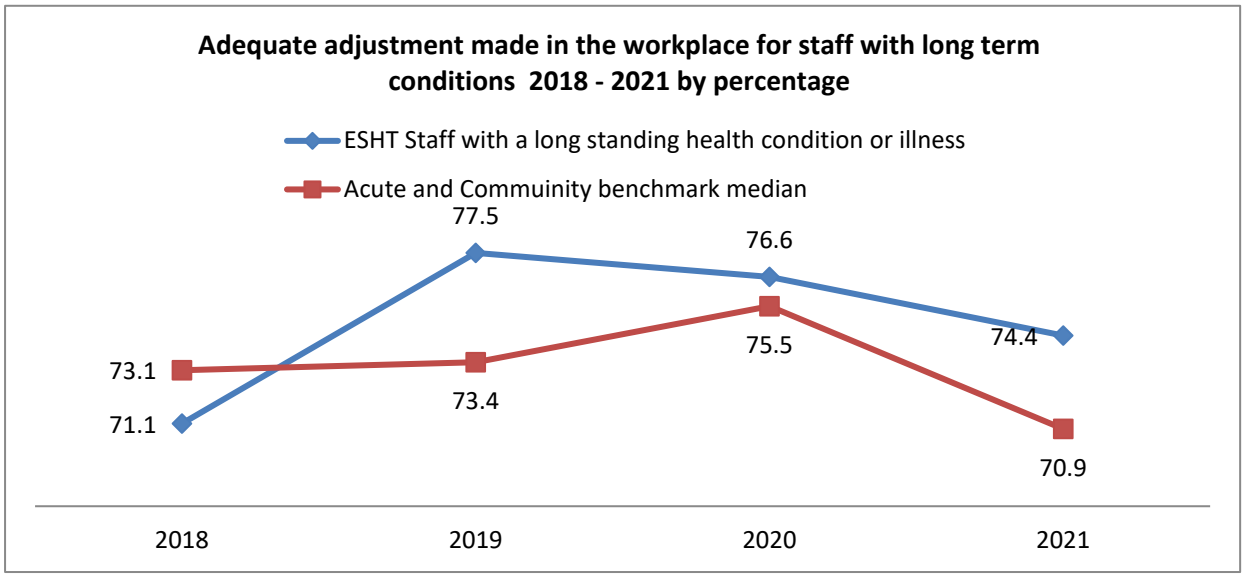
The national average for staff with a long-term health condition or illness feeling that the Trust values their work is 32.6%.

ESHT is above the national average at 35.2%, which represents a headcount of 308 staff, who completed the survey, with a long-term health condition or illness feeling valued in the workplace.

45.7% represents a headcount of 1262 staff, who completed the survey, without a long-term health condition or illness feeling valued in the workplace.

The data indicates that staff without a long-term health condition or illness feel more valued for the work that they do compared to staff with long-term conditions or illness.

2.8 METRIC 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. This metric only includes the response of Disabled staff.



Summary

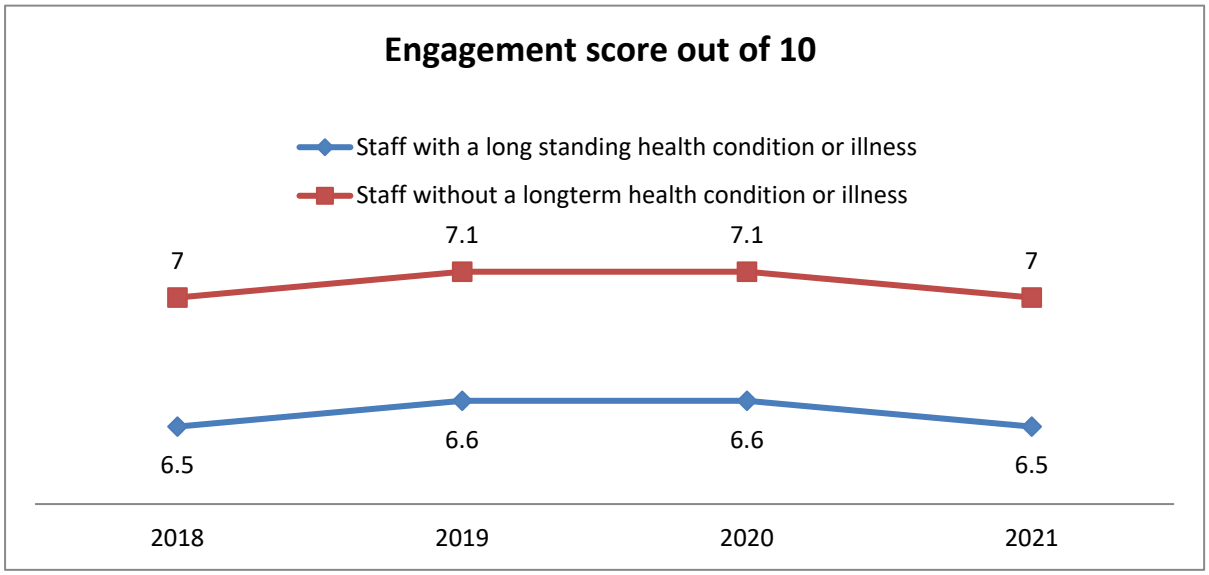
During 2021, ESHT (74.4%) was above the benchmark median for Acute and Community Trusts of 70.9% for making adequate adjustments in the workplace

74.4% represents a headcount of 651 staff that responded to adequate adjustments made in the workplace.

The percentage of staff with a long-lasting health condition saying their employer has made adequate adjustment(s) has fallen for the third consecutive year but remains above benchmark median.

A disability and health passport has been introduced to support staff and their managers in having conversations about health and reasonable adjustments. The work to promote this will continue in 2022/23.

2.9 METRIC 9a: The staff engagement score for Disabled staff, compared to non-disabled staff.



Summary

The national average engagement score for staff with a long-term health condition or illness is 6.4 out of a score of 10.

ESHT engagement score for staff with a long-term health condition or illness is 6.5, this has remained relatively unchanged over the last four years and repeatedly below that is staff without a long-term health condition or illness.

Further promotion of the (dis)Ability staff network as a forum to take Trust initiatives for discussion will take place in 2022/23.

2.9.1 METRIC 9b: Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)
Yes

We have an independently run (Dis)Ability staff network that meets bi-monthly and has an elected Chair along with an Executive Board sponsor that supports the staff network's objectives.

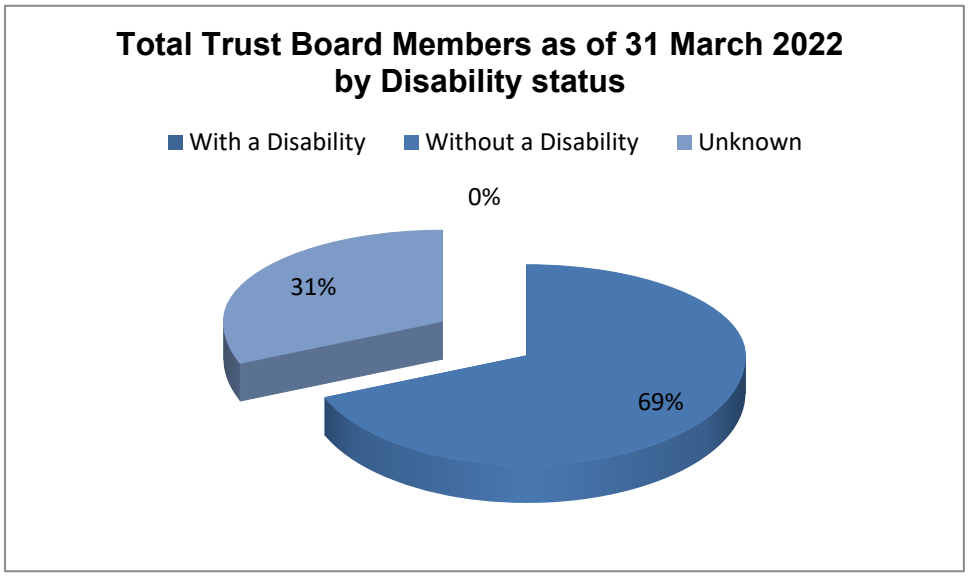
Members of the network are invited and included in our WDES Task and Finish group that meet bi-monthly to ensure actions are driven into tangible outcomes. Our network chair is also a member of the Workforce Equality Group that feeds into the People and Organisation Development committee.

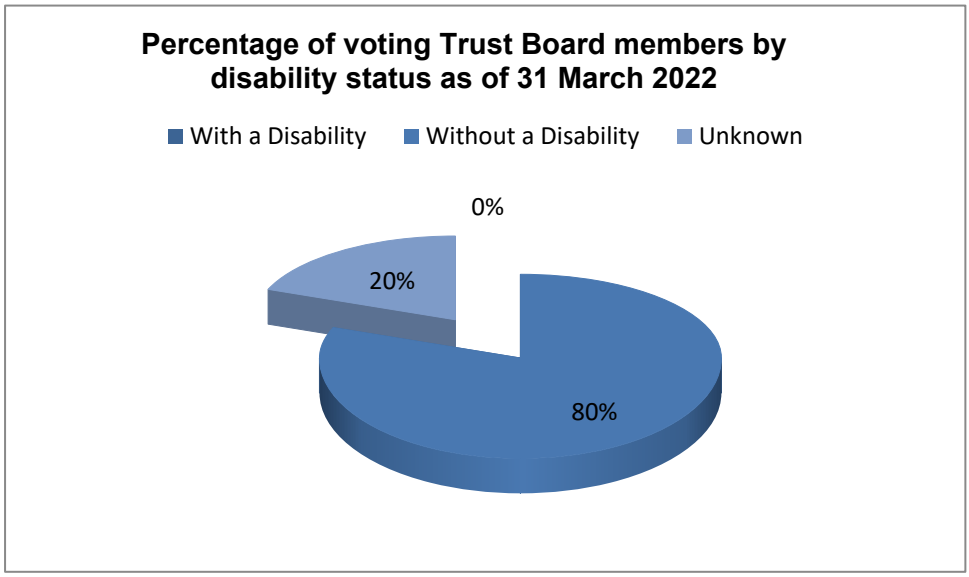
To ensure that the voices of disabled staff are amplified across the Trust, the Trust Board sponsor, Chief Executive Officer and Chief Peoples Officer meet with the (Dis)Ability staff network chair on a regular basis. This gives our (Dis)Ability staff network Chair direct contact to Trust Board members so that they are informed around the working experience and progress of staff that have a disability or long-term health condition.

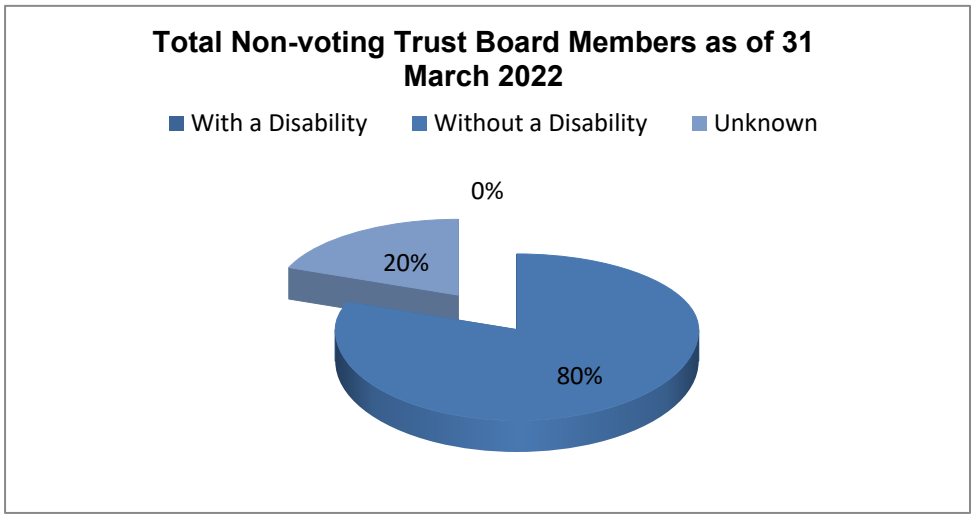
2.10 METRIC 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

• By voting membership of the Board

• By Executive membership of the Board







2021 Summary

- The data captured on ESR shows that there are no Trust Board members that have declared a disability as of 31 March 2022.

3.0 Summary of Activities 2021/22

3.1 Health & Wellbeing

As we continue to feel the effects of the Covid-19 pandemic, the Trust also continues to implement robust Risk Assessments to support all staff including those with a long-term health condition or illness. At the start of 2022, information regarding mandatory vaccines for NHS staff surfaced. In recognition of the impact this may have on disabled staff the Trust ran panel discussions, support groups, pop up events and clinical and emotional support to guide staff through the tremulous time.

The Trust is also providing a positive experience to staff who were shielding due to Covid-19 by undertaking risk assessments prior to their return to work and implementing appropriate support measures where necessary to ensure they feel sufficiently safe to return to the workplace. Our Health & Wellbeing Team has a dedicated team that offer support to managers and staff these include:

- Mental Health First Aiders
- Visits to wards and departments
- Bespoke wellbeing support for individuals and teams.

We recognise that to maximise some individuals' experience at work, reasonable adjustments need to be made to enable staff to carry out their role without additional barriers.

Looking after our staff with a long-term health condition or illness remains a key priority for 2022/23

3.2 (Dis)Ability Staff Network

Throughout 2021/22 the (Dis)Ability Network continued to run bi-monthly meeting with ad-hoc compassionate check-ins during times of heightened covid-19 pressures. The (Dis)Ability Network have regular input into the EDI agenda and have contributed to significant changes across the Trust. Alongside the Equality, Diversity and Inclusion Team, the (Dis)Ability Network Chair developed the (Dis)Ability and Health Passport to encourage staff who have a disability and managers to track their health status and manage their reasonable adjustments. Feedback from the passport has been positive and the Trust continues to promote it through quarterly training sessions and via Trust wide communications.

Other highlights from the year include:

- Disability History Month was celebrated with the guest speaker Paralympian Hannah Cockcroft
- Diversity dialogues and staff quiz.
- Increase in the membership of the network from around 40 – 50 members.

3.3 Organisation Development (OD)

To support our (Dis)Ability staff network our OD team have provided dedicated career progression sessions to network members. The (Dis)Ability staff network chair meets regularly with the OD team and their sessions consist of developing leadership skills and personal development within leadership.

3.4 (Dis)Ability and Health Passport, Reasonable Adjustments and Access to Work

The (Dis)Ability and Health passport and supporting documents (Reasonable Adjustments and Access to Work) have been implanted across the Trust with training sessions being delivered every quatre.

Our next steps include integration of the passport within recruitment documentation.

We envisage that the success of the implementation of the passport may encourage more staff to declare their disability or health condition on ESR.

4.0 Conclusion

This is the fourth year that the Workforce Disability Equality Standard has operated which now gives us the opportunity to make a comparison to the previous years. This report includes some comparisons which indicate that we made some progress in improving the experience staff with disabilities and some comparisons where progress remains static or has experience has declined.

Over the duration of 2021 and into 2022, the Covid 19 pandemic has continued to be of influence on our workforce. Many of our staff who have disabilities have been shielding, are self-isolating or are working remotely. Efforts have been directed to ensure that these members of staff were fully supported by the Trust where possible and included in meetings

using MS Teams and other technology applications. At the beginning of 2022, NHS Trusts were faced with the proposition of mandatory Covid-19 vaccinations. In response to the concerns of staff, including disabled staff, we ran people panels, pop-up events and educational videos to inform staff on what implications the mandatory vaccination may have on them. These events also provided the space for staff to ask questions about the vaccination, and for the Trust to listen to concerns and act upon them where possible.

The majority of workforce across all clusters in both our clinical and non-clinical workforces are either non-disabled or not disclosed. During 2021/22 there has been a push for staff to self-disclose their protected characteristics, this will continue into 2022/23. There are several suggestions that may contribute to the gap in our data. This includes staff developing long-term health conditions or illnesses after commencing employment and not informing Human Resources (HR). We also recognise that some people may choose to keep their status private but will disclose this on an anonymised survey such as the Staff Survey – this may lead to discrepancies within the data. Other staff may feel that they will be unfairly disadvantaged by disclosing their disability and choose to keep it private.

This list is not exhaustive and further exploration is needed to understand and begin closing the data gap; this will be considered in the 2022 action plan.

With employee relation cases, it is pleasing to note; for two years running there is no overrepresentation between staff that has a long-term health condition or illness with those that does not within the formal capability cases.

The robust and fair management of all disciplinary cases is a focus for the Operational HR team who are committed to ensuring that continuous improvements continue to address the experience for all staff involved in a capability or disciplinary matter and avoiding formal processes wherever possible

This year's results also indicate that we are above the national average for making adequate adjustments in the workplace, although this figure has fallen from last year a more detailed investigation will be commissioned.

The results also indicate a reduction in disabled staff experiencing harassment, bullying or abuse from colleagues and managers; however, percentages increased for disabled staff experiencing harassment, bullying or abuse from patients.

A Trust wide initiative has been implemented to take a deep dive into the culture of bullying and harassment within the Trust. Through collaboration with our Violence and Aggression group sub-group, Violence and Aggression Steering group and input from the ICB, the Trust will review ways of encouraging staff to speak up, report incidents of harassment and abuse and target incivility within the workplace. This is being supplemented by the new post – Director of Culture – whose role will be dedicated to ensuring the Trust values are enacted in the workplace.

Finally, the Trust Board have 31.25% of its members that have not disclosed their disability status. Members should be encouraged to declare their disability status during 2022/23 to 100%.

5.0 Our top priorities for 2022-24

Raise the profile of colleagues with a disability to ensure they feel engaged and supported to meet their potential.

To decrease the numbers of colleagues who are ‘undeclared’ on ESR whether they consider themselves to have a disability or not.

Support the continued development of the (dis)Ability Staff Network, the chair and Executive Support.

Look into data relating to bullying and harassment and the recording and reporting of incidents that are related to a person’s disability.

Review of reasonable adjustments process to include continuing to promote the (Dis)Ability and Health Passport and increase knowledge, access to and understanding of reasonable adjustments.

Ensure our sites and facilities meet national requirements on accessibility.

6.0 WDES Action plan 2022-2024

WDES Metrics	**Disabled applicants less likely to be appointed through the recruitment process than non-Disabled applicants**			
	Action	Outcome	Lead	Timescale
1 2	**Phase one** - Draft template of interview questions has been shared and piloted with the recruitment team and managers. Feedback received and amendments made. **Phase two** - Interview template distributed to all managers before interview **Phase three** - People panel and training being developed to embed knowledge. **Phase four** - Review and continue to make improvements	A regular review of the recruitment processes will help ensure they are fair and inclusive.	Recruitment Team	December 2022
1 2	Advertise the staff networks on recruitment documentation	ESHT more likely to be seen as an employer of choice.	Recruitment Team	October 2022
	Become a Disability Confident Leader	Provide a structure for addressing HR/ recruitment issues around providing appropriate support to disabled staff and candidates	HR Manager EDI Facilitator	January 2023 *Application from has been submitted to Disability Confident Leader Accreditor. A follow up conversation will take place

				to provide the evidence for the grading.
	Disabled staff are disproportionately affected by bullying and harassment			
5 6 8	Include disability within datix reporting form	To ensure that ESHT provides a safe and healthy environment for staff who have a disability	Health and Safety Manager	April 2023
5 6 8	Trust and System Wide Review on Violence and Aggression within the Trust	Reduce incidences of violence and aggression	Associate HR Director-OD & Staff Engagement Staff Engagement & Wellbeing	March 2023
	Percentage of disabled staff able to easily access appropriate reasonable adjustments			
8	Embed Reasonable Adjustment process throughout the Trust	Increase number of Reasonable Adjustments in the Trust. Improvements of disabled staff satisfaction specifically related to adjustments	EDI Team	March 2023
	Investigate centralised funding and asset register for Reasonable Adjustments (e.g., Access to work)		EDI Team	December 2022
1 9	Continue to improve ESR self-reporting of disability data	Decrease the numbers of staff who are undeclared on ESR whether they consider themselves to have a disability or not for a fuller picture of staff within the Trust	EDI Team	September 2024
	Percentage of disabled staff accessing career promotion or progression			
4 7	Promote structures that support career progression and opportunities for disabled staff	Create equal and equitable opportunities for disabled staff	OD Team	March 2023
1 5 7	Monitor learning and development attendance by disability status		OD Team Training Team	April 2023
	Continue to raise the profile of disability across the Trust			

5 7 9	Diversity Dialogue session to be held on numerous topic - one being (Dis)Ability	Facilitate conversations on potentially sensitive topics and subjects	EDI Team	Ongoing until September 2024
	Promote the (Dis)Ability Staff Network to increase the voice of disabled staff	Facilitate the voice of disabled staff members and initiate positive change	Staff network	Ongoing until September 2024
All	Celebrate the contribution of disabled staff to the experience of patients at ESHT	Increasing profile of staff experiences in the workplace so that ESHT is seen as an employer of choice	EDI Team Jacqui Fuller	Ongoing until September 2024
5 7 9	Increase awareness of the diversity makeup of teams	Embed the diversity toolkit across ESHT	EDI Team	September 2023
7 9	Increase Health and Wellbeing offer to staff with disabilities	Increase number of Reasonable Adjustments in the Trust. Improvements of disabled staff satisfaction specifically related to adjustments	Health and Wellbeing Team	June 2023
7 8 9	Increase number of accessible toilet facilities	Improvements of disabled staff satisfaction specifically related to adjustments	Estates and facilities	March 2023
5 6 7 8	Ensure representation of disabled staff at Staff Partnership Forum	Ensuring all staff have a voice within the Trust	Melanie Adams	September 2023

East Sussex Healthcare NHS Trust

Gender Pay Gap Report

(2020 - 2022 comparison)

Introduction

Gender pay reporting legislation requires employers with 250 or more employees to publish statutory calculations every year showing how large the pay gap is between male and female employees. There are two sets of regulations. The first is mainly for the private and voluntary sectors (that took effect from 5 April 2017) and the second is mainly for the public sector (that took effect from 31 March 2017). Employers have up to 12 months to publish their gender pay gaps.

The results must be published on the employer's website and a government website. They must, where applicable, be confirmed in a written statement by an appropriate person such as a Chief Executive or Chief Peoples Officer.

Gender pay reporting is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The gender pay gap shows the difference in the average pay between all men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate there may a number of issues to deal with, and the individual calculations may help to identify what those issues are.

The NHS terms and conditions of service handbook contain the national agreements on pay and conditions of service for NHS staff other than very senior managers and medical staff. Job evaluation (JE) enables jobs to be matched to national job profiles or allows trusts to evaluate jobs locally, to determine in which Agenda for Change pay band a post should sit.

2. Gender Pay Gap Indicators

An employer must publish six calculations showing their:

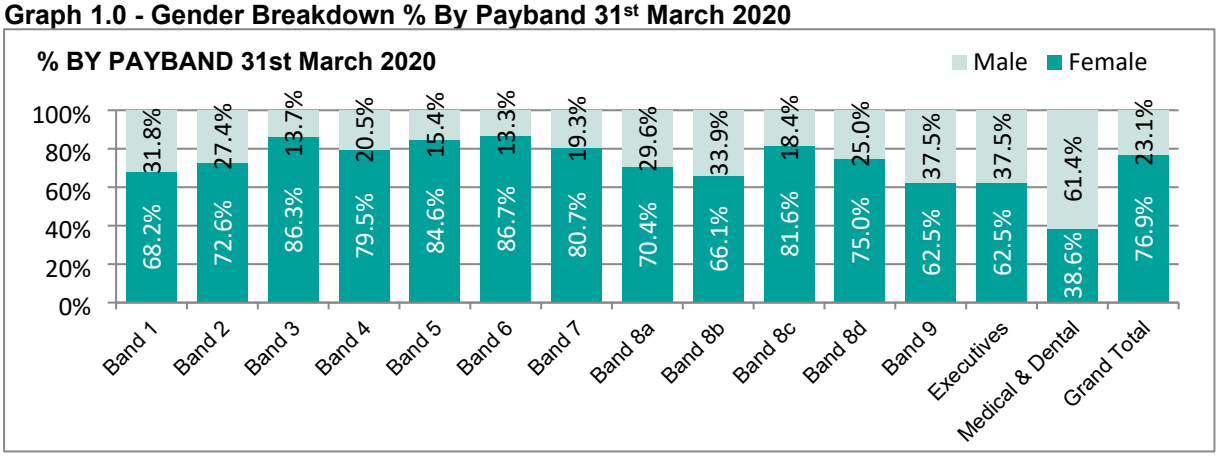
1. Average gender pay gap as a mean average
2. Average gender pay gap as a median average
3. Average bonus gender pay gap as a mean average
4. Average bonus gender pay gap as a median average
5. Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
6. Proportion of males and females when divided into four groups ordered from lowest to highest pay

To support the data a three-year comparator report has been created to monitor trends.

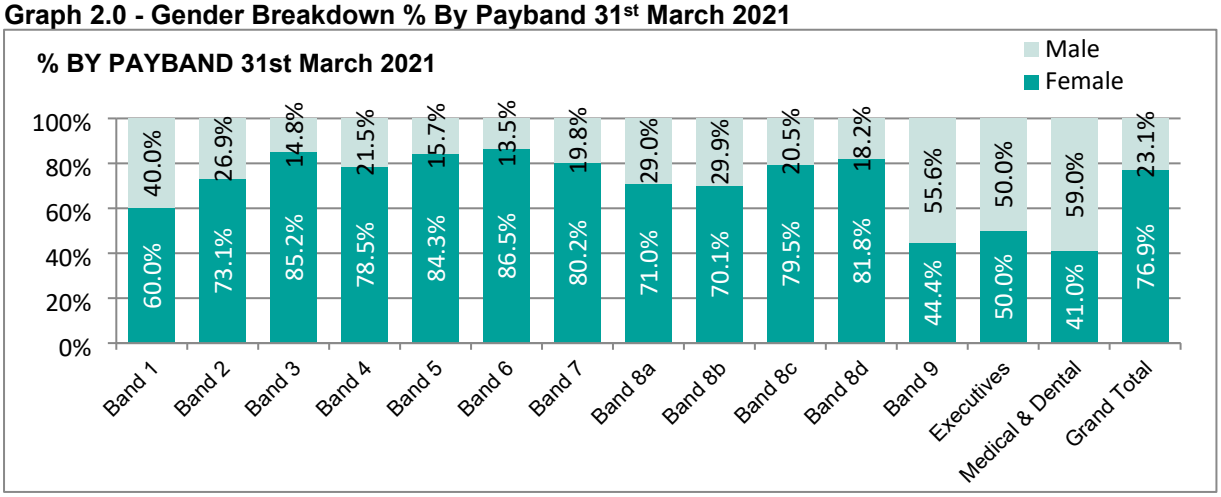
3. East Sussex Healthcare Trust Workforce context

The proportion of male staff was unchanged 2020 – 21 but has shown a small increase in 2022.

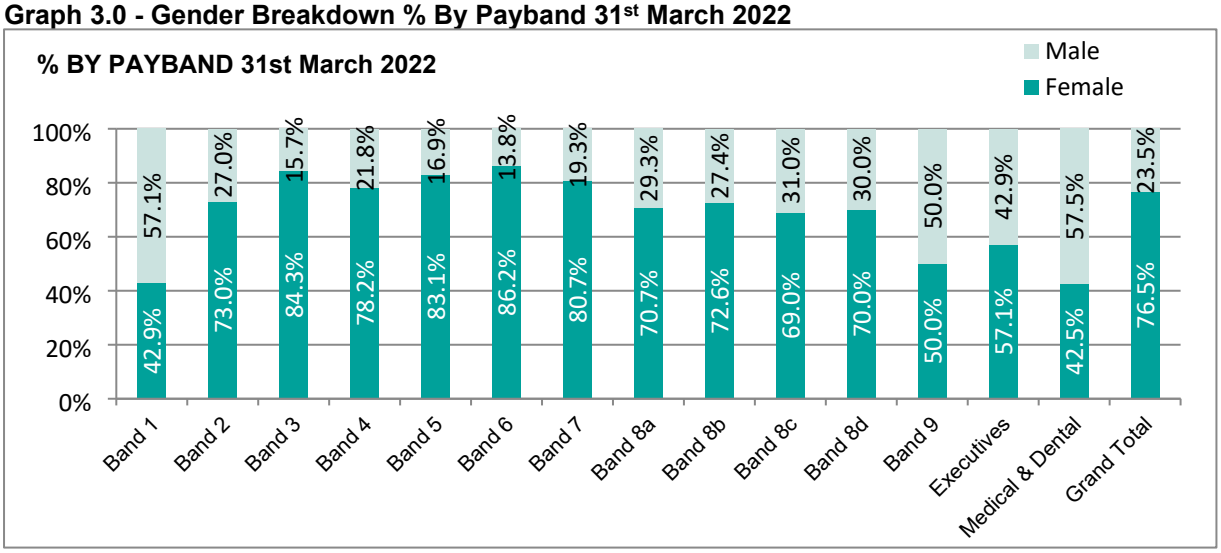
Graph 1.0 - Gender Breakdown % By Payband 31st March 2020



Graph 2.0 - Gender Breakdown % By Payband 31st March 2021



Graph 3.0 - Gender Breakdown % By Payband 31st March 2022



4. ESHT Gender Pay Gap Results for 31st March 2020 to 31st March 2022

a) Gender pay gap as a mean (average) showing male to female hourly rate comparison as snapshots on 31st March 2020, 31st March 2021 and 31st March 2022. Hourly rate includes basic pay and additional allowances including Clinical Excellence Awards. This rate does not include overtime or exceptional payments i.e., redundancy.

	Male	Female	% diff
Mean hrly rate 31/3/20	£19.84	£15.59	**21.4%**
Mean hrly rate 31/3/21	£20.41	£16.02	**21.5%**
Mean hrly rate 31/3/22	£20.77	£16.63	**19.9%**

The gender pay gap, in respect of mean hourly rate, has reduced by 0.6% since 31/3/21 after a slight increase in the previous year.

The below table shows a breakdown of the mean pay rates split for Agenda for Change & Executive and Medical & Dental staff across the last 3 years.

Agenda for Change & Exec and Medical & Dental	Male	Female	% diff
Agenda for Change & Exec - Mean hrly rate 31/3/20	£14.41	£14.81	**-2.7%**
Agenda for Change & Exec - Mean hrly rate 31/3/21	£15.02	£15.22	**-1.2%**
Agenda for Change & Exec - Mean hrly rate 31/3/22	£15.70	£15.89	**-1.2%**
Medical & Dental - Mean hrly rate 31/3/20	£36.61	£30.50	**16.7%**
Medical & Dental - Mean hrly rate 31/3/21	£38.46	£31.15	**19.0%**
Medical & Dental - Mean hrly rate 31/3/22	£39.43	£32.27	**18.2%**

The % difference for Medical & Dental staff has reduced by 0.8% in 21/22 whilst the difference for Agenda for Change & Executive staff, where female mean pay is higher than male, is unchanged from last year.

b) Gender pay gap as a median average showing male to female hourly rate comparison as snapshots on 31st March 2020, 31st March 2021 and 31st March 2022. The median is the middle value of the full range of hourly rates

	Male	Female	% diff
Median hrly rate 31/3/20	£14.55	£13.85	**4.8%**
Median hrly rate 31/3/21	£15.31	£14.08	**8.1%**
Median hrly rate 31/3/22	£15.77	£14.68	**6.9%**

The gender pay gap, in respect of median hourly rate, has reduced by 1.2% in 21/22.

The below table shows a breakdown of the median pay rates split for Agenda for Change & Executive and Medical & Dental staff

Agenda for Change and Medical & Dental	Male	Female	% diff
Agenda for Change - Median hrly rate 31/3/20	£12.38	£13.41	**-7.7%**
Agenda for Change - Median hrly rate 31/3/21	£13.04	£13.79	**-5.4%**
Agenda for Change - Median hrly rate 31/3/22	£13.42	£14.33	**-7.0%**
Medical & Dental - Median hrly rate 31/3/20	£34.58	£27.29	**21.1%**
Medical & Dental - Median hrly rate 31/3/21	£38.65	£27.10	**29.9%**
Medical & Dental - Median hrly rate 31/3/22	£37.90	£27.32	**27.9%**

The % difference for Medical & Dental staff has reduced by 2.0%, in 21/22, whilst the difference for Agenda for Change & Executive staff, where female median pay is higher than male, has increased by 1.6%.

c) Bonus gender pay gap as a mean average. Bonuses are payments within the 12 months up to the relevant snapshot dates. In all three years, the bonuses relate purely to Clinical Excellence Awards.

	Male	Female	% diff
Mean bonus payment - 31/3/20	£14,449	£10,087	**30.2%**
Mean bonus payment - 31/3/21	£13,233	£10,509	**20.6%**
Mean bonus payment - 31/3/22	£13,155	£9,821	**25.3%**

The gender pay gap, in respect of mean average, has increased by 4.7% since 31/3/21.

d) Average bonus gender pay gap as a median average within the 12 months up to the snapshot dates. The median is the middle value of the full range of bonuses

	Male	Female	% diff
Median bonus payment - 31/3/20	£9,048	£9,048	**0.0%**
Median bonus payment - 31/3/21	£8,596	£9,048	**-5.3%**
Median bonus payment - 31/3/22	£8,596	£6,032	**29.8%**

The gender pay gap, in respect of median average, has increased by 35.1% from higher for female in 20/21 to 29.8% higher for male in 21/22.

e) Percentage of employees who received a bonus payment. The percentage shown in the table below reflects the male and female split against the overall Trust staffing in that gender. For this Trust the bonuses all relate to Clinical Excellence awards

Date	Gender	Trust %	No. receiving bonus	% of those receiving bonus	% medical staff overall
31/3/20	Male	**3.8%**	77	76.2%	61.4%
31/3/20	Female	**0.4%**	24	22.2%	38.6%
31/3/21	Male	**3.4%**	72	75.0%	59.0%
31/3/21	Female	**0.4%**	24	25.0%	41.0%
31/3/22	Male	**3.0%**	66	74.2%	57.5%
31/3/22	Female	**0.3%**	23	25.8%	42.5%

The proportion of female staff receiving bonus payments in 21/22 has dropped slightly. The proportion of male staff has also dropped. As these bonuses are Clinical Excellence awards and only relate to medical staff, a truer comparison is with the gender breakdown of medical staff and, in fact, Consultant medical staff, who are eligible for these awards. The gender breakdown for Consultant staff on 31/3/22 was 68.0% male and 32.0% female, so there is still a disparity.

f) Proportion of males and females when divided into four quartiles. The below table divides all the hourly rates into 4 equal segments from lowest to highest hourly rate

	31/3/20		31/3/21		31/3/22	
	Male	Female	Male	Female	Male	Female
Lower	22.0%	78.0%	21.2%	78.8%	22.1%	77.9%
Lower middle	22.1%	77.9%	22.4%	77.6%	22.8%	77.2%
Upper middle	16.1%	83.9%	17.5%	82.5%	17.9%	82.1%
Upper	32.8%	67.2%	33.3%	66.7%	33.1%	66.9%
TOTAL	23.1%	76.9%	23.1%	76.9%	23.5%	76.5%

5. Conclusion

Reducing our gender pay gap implies either increasing the proportion of men in lower grades or increasing the proportion of women occupying the more senior roles in ESHT. Effective policies for closing the gender pay gap not only seek to address factors and barriers common to all women (such as the number in lower grade jobs with lower pay), they target the inequalities faced by women belonging to specific groups, based on characteristics such as ethnicity, age and profession.

One area to note is the bonus payments broken down by gender. In line with national guidance, there were no rounds of applications for Clinical Excellence Awards this year. Instead, and also in line with the national guidance, the funds were distributed to all eligible consultants (not those holding either National or local level 9 awards) pro rata according to hours worked and length of service during the qualifying year

Divisions will be receiving the diversity detail of their workforce which will include gender as part of that information. This should help them to review any gender pay gap imbalance within their teams and more ownership at a local level.

The monitoring of the Action Plan currently sits with the Workforce Equality Group. Discussions will be held to explore other meetings where the Gender Pay Gap should be included in the agenda

Gender Pay Gap Action Plan

Area and Objective	Lead	Timescales
Promote a wide range of flexible working practices. Explore adding flexible working to all job adverts	HR team/Recruitment team	Quarterly throughout 2022
Caring and shared parental leave - actively promote shared parental leave to staff.	HR Team/ HRBPs	Quarterly throughout 2022
Monitor take up of female apprenticeships and where they take up a position	OD/Apprenticeship Lead	Have analysed data by January 2023
Publish Gender pay Gap Report on external facing website for transparency.	Workforce Information Manager/ EDI Manager	By 30 December 2022
Analysis of data by Divisions to help inform the underlying causes of their pay gaps.	HR Team/ HRBPs	Analysis carried out by March 2023
Investigate feasibility of a Women's Staff Network to support women in the workplace and identify any additional support requirements following discussion and gaining insight from the Women's consultant network.	EDI Team	By April 2023
Celebrate International Women's Day – 8th March 2023 to promote and engage staff on gender equality.	EDI Team/ Communications	March 8th 2023
**Understand barriers to women applying for Clinical Excellence Awards In light of the effects of the pandemic, and requirement	EDI Team/Medical Staffing	** unable to progress at this stage

to focus resources on recovery effort, employers were required to equally distribute clinical excellence award funds among all eligible consultants. This was agreed by NHS England and NHS Improvement (NHSEI) and the Department for Health and Social Care (DHSC) This approach has meant, that in the past year, work to address the gap has not progressed where promoting the CEA process to under-represented groups and engaging women medics in promoting/supporting applications has not been feasible.		
Offer specific sessions to women on understanding their pensions	EDI Team Pensions Team	End of April 2023