East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Board Agenda

Date: Tuesday 10th October 2023

Time: 09:30 – 12:30

Venue: Uckfield Civic Centre, Bellfarm Lane, Uckfield TN22 1AE

	Item	Lead	Action	Time
1	**Welcome and apologies**	Chair	Information	09:30
2	**Staff Recognition**	Chair	Information	09:30
3	**Declarations of Interest**	Chair	Information	
4	**Minutes of Trust Board Meeting in public 08/08/2023**	Chair	Approval	09:35
5	**Matters Arising**	Chair	Approval	
6	**Chief Executive's Report**	CEO	Information	09:45
7	**Taking organisational assurance post R v Letby**	Chair / COS	Information/ Assurance	10:00
	Quality, Safety and Performance			
8	**Integrated Performance Report, Month 5 (August)** 1. Chief Executive Summary 2. Quality & Safety 3. Our People 4. Access and Responsiveness 5. Financial Control and Capital Development	 CEO CNO/CMO CPO COO CFO	Assurance	10:15
9	**Maternity Overview Q1**	Alison Newby	Assurance	10:55
10	**Learning From Deaths Q4**	CMO	Assurance	11:05

Break – 10 minutes

Strategy				
11	**Winter Preparedness 2023/24**	COO	Assurance	11:15
12	**RAAC Synopsis and Surveys**	CEO	Assurance	11:25
Governance and Assurance				
13	**Notes from Board Committees**	Committee Chairs	Assurance	11:35
14	**Fit and Proper Person Test**	COS	Assurance/ Information	11:45
15	**Patient Safety Incident Response Framework (PSIRF)**	CNO	Assurance	11:50
16	**Board Assurance Framework Quarter Two**	COS	Assurance	12:05
17	**Equality Annual Report**	CPO	Assurance	12:10
Items for Information				
19	**Use of Trust Seal**	Chair	Information	
20	**Questions from Members of the Public**	Chair		12:15
21	**Date of Next Meeting** Tuesday 12th December 2023	Chair	Information	
22	**Close**	Chair		12:30

Steve Phoenix
Chairman
14th September 2023

Key:	
Chair	Trust Chair
CEO	Chief Executive
CNO	Chief Nurse and DIPC
COO	Chief Operating Officer
CFO	Chief Finance Officer
COS	Chief of Staff
CPO	Chief People Officer
CMO	Chief Medical Officer
DOM	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
12th December	Cornwallis Room Horntye Park Sports Complex Bohemia Road Hastings TN34 1EX	09.30 – 12.30	

Board Meetings in public: 2024

Month	Location	Timing	Any other information
13th February	TBC	09.30 – 12.30	
9th April	TBC	09.30 – 12.30	
11th June	TBC	09.30 – 12.30	
13th August	TBC	09.30 – 12.30	
10th September – Annual General Meeting	TBC	TBC	
8th October	TBC	09.30 – 12.30	
10th December	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 its people. As such, this is an opportunity for the Trust to demonstrate and acknowledge the exceptional performance, behaviour, achievements and contribution that our colleagues and volunteers have made to the organisation						
	For Decision		For Assurance		For Information	x	
Sponsor/Author	Jacquie Fuller / Melanie Adams						
Governance overview	Trust Board						

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	N/A

Executive Summary

Hero of the Month

June 2023

Overall Winner 1 – Claire Wyse, Intermediate Care – CHIC

Claire assisted a patient who choked on a piece of meat in front of the other patients and went into cardiac arrest. Claire led the team so everyone knew what to do while she actively helped the patient and managed to clear his airway and he started breathing again.

The patient is now absolutely fine and back to his normal self but without Claire on the scene the outcome could have been very different. I will never forget that, and how calm and professional she remained during the very stressful and difficult situation. I am nominating her as I think she truly deserves a medal!

Overall Winner 2 – Kevin Piper, Radiology Housekeeper – Core Services

As a team we would like to nominate Kevin as he goes above and beyond in keeping our work area lovely and clean. He is always willing to help, will do anything for us, and is just an overall lovely guy.

We feel he deserves recognition for his endless hard work, and to show our thanks for what he does. He is liked, appreciated and respected by everyone in the department.

Kevin Piper receiving his award from the Chairman

July 2023

Overall Winner – James Banks, Emergency Department Security – Estates and Facilities

We have seen a huge rise in mental health patients waiting for beds in the community and this can be a real struggle for A&E staff to manage. James goes above and beyond to keep the department calm and always gives patients the time of day when they are at their most vulnerable/in a crisis.

A good example of this was a patient who was really worried and stressed out because their mobile phone was not working. James went to the shops out of work to get them a new sim card with £10 credit so the patient could keep in contact with their family. This patient remained relaxed and calm due to what James did and it is really appreciated by everyone in the department.

Another example of what the security team do when they go above and beyond is that they often will take the patients for a walk to take pressure off the A&E nurses. The whole security team are contractors to the NHS BUT remain a big part of the team. I feel they should be recognised for the work they do, not just in A&E but in the Trust as a whole on both sites.

James Banks receiving his award from the Chairman

Long Service Awards

Aug-23					
10 Years' Service		**25 Years' Service**		**40 Years' Service**	
Howard	Allen	Ruth	Atkins	Mark	Whitehead
Danielle	Brown	Rachel	Brook	Tina	Scott
Charlotte	Comper	Mark	Eve		
Danielle	Draper	Fergal	Flanagan		
Patricia	Easton	James	Goddin		
Louise	Ford	Louise	Holmes		
Justin	Harris	Sophie	Horton	**50 Years Service**	
Vanaja	Machavarapu	Louise	Hunter	Catherine Marie	Doe
Jessica	Mackenzie	Sheree	Wilson	Kim	Brown
Jeffrey	Wells	Tina	Scott		
Kristopher	Woodley				

Sheree Wilson receiving her 25 Years' Service certificate

Next steps	Not applicable

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust Board Minutes

Date: Tuesday 8th August 2023

Time: 09:30 – 12:30

Venue: The Relais Cooden Beach, Cooden Sea Rd, Bexhill-on-Sea TN39 4TT

		Actions
	Attendance: Mr Steve Phoenix, Chairman Mrs Joe Chadwick-Bell, Chief Executive Mrs Vikki Carruth, Chief Nurse & Director of Infection Prevention and Control Mrs Karen Manson, Non-Executive Director Mrs Charlotte O'Brien, Chief Operating Officer Mr Paresh Patel, Non-Executive Director Mr Damian Reid, Chief Finance Officer Ms Carys Williams, Non-Executive Director Non-Voting Directors Mrs Ama Agbeze, Associate Non-Executive Director Mr Steve Aumayer, Deputy Chief Executive and Chief People Officer Mrs Amanda Fadero, Associate Non-Executive Director Mr Richard Milner, Chief of Staff Mr Frank Sims, Associate Non-Executive Director In Attendance Ms Brenda Lynes, Director of Midwifery Dr James Wilkinson, Deputy Medical Director Mr Peter Palmer, Board Secretary (minutes)	
	Apologies: Mrs Jackie Churchward-Cardiff, Vice Chair and Non-Executive Director Dr Simon Merritt, Chief Medical Officer Mrs Nicola Webber, Non-Executive Director	
53 / 2023	**Chair's Opening Remarks** Mr Phoenix welcomed everyone to the meeting, thanking staff at the hotel for providing a venue at short notice. He noted that it was Mrs O'Brien's first meeting as Chief Operating Officer having previously been Director of Strategy and Transformation. Dr Simon Dowse would start his role as Director of Strategy and Transformation on 4th September. He welcomed Dr Wilkinson who was deputising for Dr Merritt. Hero of the Month Mr Phoenix reported that Hayley Tullett, a member of the Residences team, had won the Trust's Hero of the Month Award in April. Mary Patabadige, a member of the Catering Department, had won the award in May. He explained that it had been a pleasure to meet both of the award winners, noting that presenting the awards was one of his favourite parts of his role.	
54 / 2023	**Declarations of Interest** In accordance with the Trust's Standing Orders that directors should formally disclose any interests in items of business at the meeting, the Chair noted that no potential conflicts of interest had been declared.	

55 / 2023	**Minutes** The minutes of the Trust Board meeting held on 13th June 2023 were considered. One amendment to the minutes were noted: • 46/2023 – Paragraph 3 – the minute was amended to reflect that Ms Williams had requested greater clarity, not greater detail. They were otherwise agreed as an accurate record, and were signed by the Chair and would be lodged in the Register of Minutes.	
56 / 2023	**Matters Arising** There was one formal matter arising from the meeting on 13th June 2023: *Outsourced Community Paediatric Services* An update was provided which reported that assurance had been sought in advance of outsourcing using a review of sample reports. The permanent team had reviewed the first tranche of referrals to receive additional assurance, and regular contracting meetings took place with suppliers; it was noted that it was not possible to review every report due to the number that were issued.	
57 / 2023	**Board Committee Chairs' Feedback** *Audit Committee* Mr Patel presented a report on the last meeting of the Audit Committee which had taken place on 27th July 2023. He reported that the Committee had accepted a recommendation that an external Well Led Review of the Trust should be undertaken in line with best practice. *The Board noted the report.* *Finance and Productivity Committee* Mr Reid presented a verbal report on the last meeting of the Finance and Productivity (F&P) Committee which had taken place on 27th July 2023. He reported that the adverse variance of £750k for the first three months of the year had been discussed which had been driven by activity shortfall due to strikes and staffing pressures. A number of business cases had been reviewed, including the Outline Business Case for Electronic Patient records (EPR), with a Full Business Case anticipated in December. Briefings on activity performance and the Trusts Cost Improvement Programme had also been discussed. *The Board noted the report.* *People and Organisational Development Committee* Ms Williams presented a report on the last meeting of the People and Organisational Development (POD) Committee which had taken place on 20th July 2023. She noted that the Chair's report included details of items discussed at both June and July's meetings. She reported that the Trust was making good progress with improving appraisal compliance alongside a focus on ensuring that these remained of good quality. *The Board noted the report.* *Quality and Safety Committee* Mrs Fadero presented a report on the last meeting of the Quality and Safety (Q&S) Committee which had taken place on 20th July 2023. She reported that the Board Assurance Framework (BAF) had been discussed by the Committee. Actions against a historic Violence and Aggression contravention notice issued by HSE had been discussed, which were being overseen by Trust's Violence Reduction Group. Mrs Fadero noted that the Q&S Committee's agenda was significant; a dashboard was being developed which would aid identification of key areas of concern and achievement. *The Board noted the report.*	

	Strategy and Transformation Committee Mr Milner presented a report on the last meeting of the Strategy and Transformation Committee which had taken place on 22nd June 2023. He reported that the Committee had discussed the governance of NHS Sussex's Shared Delivery Plan, with Key Performance Indicators from the 11 underpinning workstreams being presented to the Trust's Committees. The three risks overseen by the Strategy Committee on the Quarter One BAF had been discussed. Reports had been presented on the Trust's transformation programmes and assurance had been received about the alignment of ESHT's focus on health inequalities with NHS Sussex. *The Board noted the report.*	
58 / 2023	**Chief Executive's Report** Mrs Chadwick-Bell thanked all of the Trust's staff, explaining that she was very proud of the hard work that they continued to do in a challenging environment. Ensuring that the Trust's culture was positive was very important as this would lead to a better workplace for colleagues and better outcomes for patients. The Trust already had a good culture but always wanted to improve. The Trust had developed values prior to the pandemic which were now being tested with colleagues to see whether they needed to be updated. Around 400 colleagues had attended engagement sessions, with more sessions planned. The outcomes from the sessions would be shared in due course. Celebrations of the NHS' 75th anniversary had taken place across the Trust, including the annual Staff Awards held on the 5th July. It had been a great evening, recognising the work and achievements of colleagues from across the Trust. The Trust continued to support staff who were taking industrial action, but services and patients continued to be impacted. The NHS Long Term Workforce Plan had recently been published, as had the NHSE Equality, Diversity and Inclusion (EDI) improvement plan; both had been discussed at a recent Board Seminar. Planning for winter was a continuous process for the Trust and the system, with outstanding work already undertaken. High impact actions would be reviewed to understand if more improvements could be realised. Mrs Chadwick-Bell noted that the Sussex Health and Care Partnership had recently published their Improving Lives Together shared delivery plan (SDP), setting out what healthcare would look like in Sussex over the next five years. The full document was included as an appendix to the Board papers. All approvals required for the Elective Care Hub at EDGH had been received and building work had commenced. The Trust continued to be part of the New Hospital Programme (NHP), and was developing communications for staff and stakeholders which would be published once more information was available. The Trusts' strategic outline case for NHP would be rewritten prior to the development of a full business case by 2025 when a national re-prioritisation of all schemes would be undertaken. Mr Sims asked whether plans were being made to better utilise the integrated nature of the Trust in order to support both Trust and system priorities. Mrs Chadwick-Bell explained that a review of community services was being undertaken to ensure that these were correctly sized; this could also lead to a reshaping of acute services to better support community services. She noted that the Trust might be able to access additional capital during 2024/25 if performance targets were achieved in 2023/24; the expansion of virtual wards throughout Sussex was being explored. Mr Phoenix noted the challenges of spending additional funding received at short notice. Mrs Fadero asked whether there was a community focus within the 11 Sussex workstreams that underpinned the SDP. Mrs Chadwick-Bell explained that the workstreams were Sussex wide and focussed on a number of areas; there was no specific community workstream, but community was embedded within other workstreams. Discussions about how community and acute services at ESHT could be balanced would take place at the Trust's Strategy Committee.	

	Mr Patel asked whether the use of virtual wards would be increased for winter. Mrs O'Brien reported that virtual ward capacity had been increased to 51 beds that week, and feedback received from patients had been very positive. The possibility of further increasing capacity was being explored. *The Board noted the report.*	
59 / 2023	**Integrated Performance Report, Month 3 (June)** Mr Phoenix noted that the Trust continued to perform well in comparison to peer organisations despite not meeting all performance targets. Emergency Department (ED) performance in June had placed the Trust 26th out of 125 Trusts nationally. *Quality* Mrs Carruth reported that no serious incidents had been reported in June. Inpatient fall rates had remained stable, with one severity three and three severity four falls reported in June. One category four pressure ulcer had been reported in the community, and one category three ulcer in an acute setting. Falls, pressure ulcers and clostridium difficile (c.diff) rates had increased during the year due to changes in the inpatient population as a result of the large numbers of discharge ready patients in hospital. Nurse fill rates in inpatient areas had remained largely stable, and work continued to reduce bed occupancy in the Trust. Staff had worked hard to minimise the impact of industrial actions on patients. 2,100 plaudits had been received in June, with complaint numbers remaining relatively low. Friends and Family Test (FFT) response rates in maternity and outpatients had remained stable and were above the national average. FFT responses in ED had dropped notably in recent years, likely as a result of how busy EDs had been. Both infection and Covid rates in the Trust had been very low in June, although there had been some cases of norovirus identified. There had also been two unrelated MRSA infections which were being investigated, but no evidence of any contributory lapses in care or concerns had been identified. 20 c.diff cases had been reported during the year against the self-defined target of 15, with only one likely due to a lapse in care; this was an improved position in comparison to 2022. A range of measures were being looked at to reduce infections, and GAMA Healthcare had recently provided additional infection control training to 250 staff with further training planned. An unprecedented number of patients were presenting to ED with an increasing complexity of mental health and safeguarding issues. Discussions about how best to support both patients and staff took place to manage risks for both patients and staff during waits for appropriate treatment. Work was being undertaken by the system around the management and expedition of treatment for these patients, and Mrs Carruth praised and thanked the Trust's safeguarding and security teams for the help in managing cases. Mrs Carruth reported that she had recently visited health visiting teams in Bexhill and Rye, who provided support to vulnerable families. She had also recently visited the Trust's health records facility at Apex Way in Hailsham, and thanked all the teams for their warm welcomes. Mr Sims asked for more information about patients attending hospital with mental health issues, and what the system was doing to address this issue. Mrs Carruth explained that the pandemic had exacerbated mental health issues for both adults and children, including anxiety and eating disorders. Recent capacity changes at Sussex Partnership NHS Foundation Trust (SPFT) had impacted on ESHT; the Trust had a good relationship with SPFT, and had discussed the issues with them and as a system. Mrs O'Brien reported that SPFT had developed their own Urgent and Emergency Care plan which was being rolled out in West Sussex. This would then move to East Sussex, and it included improvements to patient pathways, escalation processes and ensuring patients were moved to an appropriate place of care as soon as possible. Mr Sims asked whether the third sector could be used to provide additional support for patients and Mrs O'Brien explained that a lot of work was already being undertaken with the	

voluntary sector including crisis cafes and embedding teams into EDs to signpost people to appropriate care. Mrs Chadwick-Bell noted that the management of patients with mental health issues was a national problem and not limited to East Sussex.

Mrs Fadero thanked Mrs Carruth and her teams for all of their hard work in keeping patients safe and harm free. She noted that the imminent introduction of the Patient Safety Incident Response Framework (PSIRF) to the NHS would change the organisational culture; she hoped that the Board would have a further opportunity to discuss PSIRF prior to its introduction to the Trust.

Mr Phoenix asked about preparations for winter flu, noting that severe flu was being seen in Australia which was usually an indicator of what would occur in the UK. Mrs Carruth explained that the Trust had historically seen a good uptake of flu vaccinations for staff, and that planning for winter had already begun. Mr Aumayer noted that it was unclear whether additional Covid vaccinations would be offered.

Dr Wilkinson reported that the Trust's Summary Hospital-level Mortality Indicator (SHMI) and Risk Adjusted Mortality Indicator (RAMI) were both better than the national average, and the Trust was in the top quartile for RAMI. Improvement continued to be sought, with detailed reviews of any variations that occurred and monthly meetings to discuss mortality reporting. Causes and factors of patient deaths were tracked, and independent medical examiners assessed every patient who died in the Trust, commenting on the quality of their care and documentation to identify areas of learning. Specialities held monthly mortality and morbidity meetings to discuss useful learning. The main causes of death in the Trust continued to be septicaemia, pneumonia, cerebrovascular disease, and cardiac disease. Elective mortality had dramatically improved during the previous two years.

Mr Aumayer noted that the SHMI, although within range, had increased from 96 in 2020 to 100.6 in recent years. The RAMI had remained relatively stable and he asked the reasons for this. Dr Wilkinson explained that SHMI and RAMI measured mortality in different ways. SHMI data included any deaths that occurred within a month of a patient leaving the Trust, which had a disproportionate effect at ESHT due to the elderly local population. Both measures had been adjusted to take account of Covid. A lot of work had been undertaken to understand the rise in SHMI, with one cause being a reduction in the quality of patient notes due to how busy hospitals had become following the pandemic; this led to a reduced depth of clinical coding. No deficiencies of care had been identified to account for the change, but it was of concern. Improvements would be realised through the learning from deaths process and accurate, prompt clinical coding of episodes.

Workforce and People

Mr Aumayer reported that there had been industrial actions from consultants and junior doctors in July, with another action scheduled by junior doctors in the next few days. Strike actions continued to stretch the Trust's services, but the Trust was working hard to minimise the impact and ensure that patients and staff remained safe. Workforce metrics had improved during June, with turnover reducing for the seventh month in succession. Sickness levels had remained low with appraisal rates the highest in four years and mandatory training at its highest since January 2022. A positive impact from the recent focus on roster efficiency was being seen. The Trust's vacancy rate had increased during the month due to technical adjustments.

Access and Responsiveness

Mrs O'Brien reported that the Trust had delivered 76.3% performance against the ED standard in June, a considerable improvement on the previous month which reflected the hard work of teams across all divisions. Performance had reduced in July and a recent workshop to map front door processes had been held, with patients sign posted to community services where appropriate. Medical staffing was being aligned with anticipated peaks in attendance. Performance against the urgent community response standard was good, with 77.4% of patients being seen within the 2 hour response window in June.

There had been a slight increase in non-elective length of stay during the month, but a reduction in seven day, 21 day, and intermediate care lengths of stay. There had also been

a reduction in the number of patients who did not meet criteria to reside (NCTR), which had enabled the closure of Friston ward; this in turn would allow the cardiology transformation programme to progress, which would realise savings for the Trust.

The Trust continued to focus on treating patients who had been waiting for the longest, although this had a detrimental impact on the Trust's Referral to Treatment (RTT) position in the short term. The Trust's waiting list continued to grow, and there was a focus on reducing waiting times for first outpatient appointments. A system wide validation programme was being undertaken which would impact on the Trust's RTT position.

Mrs O'Brien reported that there had been a reduction in the number of patients on the 104 day cancer pathway from 36 to 27 in July, with the 62 day backlog ahead of trajectory. The Trust was working with system colleagues to address community paediatric waiting times, with increased capacity realised through working with the independent sector. June's diagnostic performance had been 88.46% against the 95% target, the highest it had been since April 2020. Industrial actions continued to impact productivity, but outpatient activity was above 108% of 2019/20 levels, with plans in place to improve theatre productivity. Accounting and clinical coding were areas of focus in order to ensure that the Trust was appropriately remunerated for the activity being undertaken.

Ms Williams noted that the Trust was part of the Discharge Frontrunner Programme and asked whether this would realise improvements. Mrs Chadwick-Bell explained that Sussex was a national outlier for 21 day length of stay and NCTR patient metrics. The Programme was driving improvements in health and care to resolve these issues, and significant improvements had already been seen. The system was looking at further support that was available and wanted to understand how regions that were performing better than Sussex were operating. Additional support and challenge provided a helpful new perspective on issues and had been very helpful.

Mrs O'Brien confirmed that the improvements being seen in 21 day length of stay were being replicated for seven and 14 day lengths of stay in response to a query from Mrs Manson. Mrs Manson asked whether the long waiting times for paediatric services were being seen nationally. Mrs O'Brien confirmed that the issue was being seen nationally; the Trust was working with the independent sector to provide additional capacity. Conversations about additional solutions were being held with the system.

Mrs Fadero noted that the average number of NCTR patients was 211 during June. The BAF set out a target of less than 50 patients awaiting discharge and asked how this was being managed. Mrs Chadwick-Bell explained that she had set teams a challenge of reducing the number of patients waiting for discharge for more than 21 days to 50 ahead, noting that the BAF should be updated to reflect this. The lowest number of patients waiting more than 21 days that the Trust had recorded was 76. Reducing NCTR patients formed a part of the Sussex wide improvement plan, and should be included in metrics reported to the Board. Mrs Fadero agreed, noting that it was challenging to track progress at present.

Finance

Mr Reid reported that the Trust had reported a £0.1m favourable position against its breakeven plan during month three. The Trust had benefitted from a national decision not to adjust for shortfalls in delivery of Elective Recovery Fund (ERF), but year to date the Trust was reporting a £0.8m adverse position against its breakeven plan. The annual elective target would be subject to adjustment due to the industrial actions that had taken place, and Mr Reid anticipated that this would result in the Trust receiving block income as a result. The Trust continued to try to meet recovery targets as this would increase income on a payment by results basis. He anticipated that the Trust would report positively against the breakeven position in June before returning to a deficit position in July as a result of pay pressures.

Financial controls were in place across the organisation, with £20m of efficiency plans developed against the £32.5m target required to reach a breakeven position. The Trust's underlying financial position meant that a year end deficit was being predicted at present. National advice had been received that each Integrated Care System (ICS) should develop

	a high level eight week medium term financial plan to fully understand the financial position of trusts and systems before the business planning cycle for 2024/25 was commenced. The Trust was therefore commencing a high level medium term financial review which was anticipated to be completed within eight weeks. Nationally inflation remained high, which had led to increased costs for the Elective Hub at EDGH. Mr Reid anticipated that the Trust would receive significant capital for enabling works under the NHP, with building work beginning during 2023/24. The Trust had bid for additional funding for diagnostic areas, and was awaiting the outcome of these bids. Mrs Fadero asked whether it was positive that capital spending was £1m ahead of plan, and Mr Reid confirmed that this was as it would allow the Trust to take advantage of new bids that had been submitted. The Trust was required to develop a medium term capital plan alongside the medium term financial plan, which would consider how national funding could be managed alongside inflationary pressures. He anticipated that the Trust's capital would be constrained during 2024/25, but would improve from 2025/26. Mr Patel noted that although monthly performance had been good, the underlying run rate remained a cause for concern unless activity levels increased. Mr Phoenix reported that the Trust's run rate had been discussed in detailed by the F&P Committee recently; he agreed that the annual position remained of concern. Mrs Fadero asked whether the overall financial performance of the ICS could lead to adjustments being made to the Trust's financial targets. Mr Reid explained that the Sussex ICS was performing well, which meant that it was subject to less financial controls than systems that were not performing as well. Should the ICS' financial performance deteriorate then it might become subject to more stringent financial controls, which would affect trusts within the ICS. *The Board noted the Month 3 IPR.*	
60 / 2023	**Long Term Workforce Plan** Mr Aumayer reported that the NHS Long Term Workforce Plan had been published in June and set out how significant investment would support an increase in training of 50-60% and workforce growth rate of between 2.6-2.9% a year, significantly increasing the NHS workforce in the long term. The government would be investing £2.4bn to kickstart the plan over the next two years. The plan would impact on the Trust's workforce strategy and the ICS' people plan, and these would be updated accordingly. ESHT was a leading organisation for the development of new roles, apprenticeships and the onboarding of staff and he was encouraged that the Trust was already undertaking a lot of elements of the NHS plan. ESHT was one of the few organisations named within the plan for the innovative approach taken with doctor's assistants, and Mr Aumayer was delighted that the Trust had been recognised in the way. He looked forward to receiving further information about how the proposed workforce changes would take place and would be funded, as this was a significant change from the approach seen in the NHS over the last couple of years. Mr Reid reported that he was excited by the plan and was pleased to see a focus on recruitment and retention. The Trust would need to fully understand the impact of additional junior doctors, ensuring that they were put into active roles; divisional plans would need to be developed to take advantage of new roles. Mrs Fadero noted that the plan included an ambition for a 13% increase in training places in 2023/24, along with a 60-100% increase in medical school places by 2030/31 and asked whether this was achievable. Mr Aumayer explained that the numbers included in the plan were incredible; he was encouraged by the fact that the plan included a lot of new approaches to how roles and skillsets could be better utilised by the NHS. He felt that investment in bringing people into the NHS in different ways, removing barriers to entry at all levels, would allow for a transformation in the NHS workforce. Mrs Manson explained that while she had like the aspirational nature of the plan, she was concerned that it did not address how the transition and retraining of staff into new roles	

	would be managed. Mr Aumayer explained that the plan recognised the challenge of funding backfilling of staff while they trained for new roles, allowing growth of the existing skill base. There was currently no backfill funding available, so staff were lost from roles when they were retraining and there would need to be a policy change to support this. Mrs Chadwick-Bell noted that the principles contained within the plan were sound, but some underlying questions remained, including around funding and barriers for entry. It was important that the Trust and the NHS continued to encourage people to join while these details were resolved. Mrs Agbeze asked how adaptable the plan would be to allow for local nuances. Mr Aumayer hoped that the plan would flex to the needs of individual organisation, but was unsure of the level of governance and control that would be introduced. Mr Phoenix hoped that if organisations could evidence why they needed to deviate from the plan then this would be acceptable. *The Board noted the NHS Long Term Workforce Plan.*	
61 / 2023	**Equality, Diversity and Inclusion Improvement Plan** Mr Aumayer reported that Board had discussed the NHS Equality, Diversity and Inclusion Improvement Plan at a recent Seminar. The plan was published in June 2023 and set out six high impact actions for the NHS. The Trust had assessed its performance against each of the actions to assess and had agreed an overall Board Equality, Diversity and Inclusion (EDI) objective, alongside individual EDI objectives for Board members. A governance route for EDI and inequalities in the Trust would be agreed, and detailed action plan against the EDI plan would be presented to the Board in November. The Trust was assessing whether its four existing EDI objectives were aligned with the NHS EDI plan's high impact actions. Mr Phoenix explained that he had found the plan to be helpful, noting that the Trust's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) scores had been positive in recent years. Mr Aumayer agreed, noting that WRES had shown no discrimination based on race for a number of metrics. WDES had highlighted some concerns, but had the Trust had performed well in comparison to other organisations. Mr Phoenix explained that an Equalities Committee would be formed, with a focus on health inequalities. It would build on current successes and focus on ensuring that issues were visible. The Trust had performed well so far due to its focus on being fair to all staff and this approach should continue. He would Chair the Committee, supported by Non-Executives. *The Board supported the recommendations included within the paper.*	
62 / 2023	**Board Assurance Framework Quarter One** Mr Milner presented the Quarter One BAF, explaining that this set out the major risks to the strategic direction of the organisation. These risks were assigned and reviewed by Board Committees prior to the full BAF being reviewed by the Audit Committee and then presented to the Board. A collective agreement about how target dates were utilised on the BAF was being sought, along with the inclusion of future elements that may impact on the risks during the year. Chairs of Committees were asked to include more details about conversations about the BAF that had taken place at their Committees to enhance the information that was presented to the Board. Twelve risks had been included on the 2023/24 BAF, four of which were rated at their anticipated year end risk target and eight of which were rated more highly than their end of year target. The Quarter two BAF would be presented to Committees in September and to the Board in October. Ms Williams noted that not all anticipated year end risks ratings on the BAF were reflective of the year end risks that were being faced, explaining that this had been discussed by POD. She explained that the BAF should be a dynamic document reflecting the current position, rather than a historic look back at the last quarter. Mr Milner agreed, noting that in	

	the past anticipated year end risk ratings had been set at the start of the year and not adjusted. Risk ratings would be adjusted in year, reflecting how the nature of the risks changed during the year. Ms Williams offered her support for this process if required. Mr Sims asked how risks from the Trust were monitored by the system and vice versa. Mr Milner reported that he had recently met with the Integrated Care Board's (ICB) governance and assurance manager to discuss this; the ICB had their own BAF which had areas of overlap with the Trus's BAF. A process of reflecting provider risks was being designed by the ICB. Mrs Chadwick-Bell explained that the ICB's BAF was an organisational BAF rather than a BAF for the system. Each provider in the ICS held a regular assurance meeting where matters could be escalated, and Executives also escalated issues directly with ICS counterparts.	
63 / 2023	**Medical Revalidation Annual Report 2022-23** Dr Wilkinson reported that Trust revalidation team was small but extremely dedicated and was responsible for the annual process of revalidation for medical staff. The Trust was 100% compliant for medical appraisals for the year, although a small number of staff had their appraisals deferred for medical reasons. There had been no episodes of non-engagement during the year and 110 reported revalidation recommendations all of which had been completed on time. He praised the achievement of the team, noting that a new Deputy Medical Director, Dr Gez Gould had recently been appointed who would continue to support the process. He noted that the number of appraisers in the Trust presented an ongoing challenge, as the training and time commitment needed was a significant undertaking. A number of appraisers had stepped down due to retirement or clinical commitments, and work was being undertaken to replace them. Mr Phoenix asked whether there was any lay member input into the revalidation process and Dr Wilkinson explained that he was not aware that this occurred. Mrs Chadwick-Bell noted that the Trust last underwent a peer review of revalidation processes in 2013. She asked whether Dr Wilkinson was assured that processes in the Trust were sufficiently robust, and whether a further peer review should be arranged as the Trust was a learning organisation. Dr Wilkinson agreed that while robust processes were in place a peer review should be arranged as it had been nine years since the last review had been carried out.	
64 / 2023	**Use of Trust Seal** Three uses of the Trust Seal were noted since the previous meeting of the Board.	
65 / 2023	**Questions from members of the public** <u>New Hospital Programme</u> Mrs Walke asked whether current improvement works taking place at EDGH were part of the NHP. Mrs Chadwick-Bell explained that the Elective Hub was not formally part of the NHP. Communications were being developed to explain the various improvements that were being planned, including under NHP. Mr Phoenix noted that work under the NHP would not commence for a couple more years, and had not yet been finalised. Mrs Chadwick-Bell reported that the Trust would work closely with the NHP to ensure that it met the requirements of the programme, as some aspects, such as the need for side rooms, had been standardised at a national level. <u>Patient Appointment Letters</u> Mr Campbell asked whether standard patient appointment letters issued by the Trust contained information about patient transport services. Mrs Chadwick-Bell confirmed that letters did not contain this information, but that work was being undertaken to see if this could be included along with appointment detail on a single page, as a second page had huge cost implications for the Trust. If this was not possible that the Trust would develop different ways of ensuring that patients received information about hospital services.	

	Virtual Wards Mrs Walke asked what a virtual ward was, and Mrs Chadwick-Bell explained that this allowed patients who would normally receive acute bedded care to receive that care at home. The service was consultant led, but delivered by expert teams of therapists and nurses, allowing patients to return home earlier in their acute pathways, or to be referred directly to virtual wards to prevent an admission. Patients were sometimes issued with wearable devices to enable them to be monitored at home. Electronic Patient Records Mr Campbell asked whether patients would be involved in the development of the Electronic Patient Record Programme. Mr Reid explained that the Trust was currently focussing on how patient records were shared in hospital, removing any barriers that existed in acute settings. He anticipated that patients would be involved in the development of EPR moving forward and agreed to find out more information following the meeting. Mortality Reporting Mrs Walke asked whether unexpected deaths were reported in the same way as expected deaths as this information was not included in the IPR. Mr Phoenix noted that the Board received a quarterly Learning from Deaths report which included information about unexpected deaths. Clinical Leaders Programme Mr Campbell noted that the SDP mentioned a Clinical Leaders' Programme, and asked whether there would be any restriction on which staff would be able to access this. Mr Aumayer agreed to find out more information following the meeting, noting that there was an intention to have a common clinical leaders' programme across the system that was not just focussed on medical leaders. Miscellaneous Mr Steeples explained that he had been involved in helping patients access the NHS App, and had now become a digital ambassador. He supported the idea of members of the public becoming members of groups and Committees to ensure that the voices of patients were heard when decisions were being taken by the Trust. Mrs Walke praised the honesty of the Trust's reporting, noting that it contained a number of metrics which required improvement. Mrs Walke reported that she was no longer involved with Save the DGH campaign, but was now part of the Eastbourne Borough Council hospital programme and chair of the Eastbourne Patient Participation Group (PPG).	**DR** **SA**
66 / 2023	**Date of Next Trust Board Public Meeting** The Trust's AGM would be taking place on Tuesday 12th September at 1400 in St Mark's Church Hall, Bexhill. The next meeting of the Trust Board would be taking place on Tuesday 10th October 2023 at 0930 at Uckfield Civic Centre	

Matters Arising from the Board meeting of 8th August 2023

Agenda Item	Action	Lead	Progress
65/2023 – Questions from members of the public	Mr Campbell asked whether patients would be involved in the development of the Electronic Patient Records (EPR) programme?	Damian Reid	All members of the EPR Programme firmly believe patients having a greater ownership of their information and feeling empowered in terms of their involvement with their care is extremely important. Patients will benefit from only having to tell their story once, regardless of where they receive healthcare and can take assurance from the knowledge our staff will have access to all relevant clinical information required as part of that treatment. As an example of patient involvement in how we design our care, we previously undertook a number of patient interviews within both the frailty and peri-operative pathways to gain a better understanding of what worked well for patients and what needed to be improved up. The outputs from these interviews will for part of pathway refinement, allowing the Trust to learn from our patients at first hand. Once the EPR Programme moves closer to the implementation phase we will look to have patient representation on the EPR Board, ensuring we always have patient insight and engagement in what will be a significant transformation programme for the Trust. Within that programme we have a communications and engagement plan which includes our patients among the stakeholders and we will tailor our communications to ensure their needs are met. As we approach the go live period of the new EPR solution there will be increased patient-level communication to help manage their expectations should things take slightly longer in those very early days, resultant from the Trust staff using a new system and following new processes.
	Mr Campbell asked whether the multi-professional Leadership Academy for clinical leaders mentioned in the Shared Delivery Plan would be accessible to nursing as well as medical staff?	Steve Aumayer	The Clinical Leadership Academy sits under the NHS Leadership Academy. Courses available are open to all groups of staff that is on a leadership journey. Further information can be found on the NHS Leadership Academy website.

East Sussex Healthcare NHS Trust

Chief Executive Report

Purpose of the paper	To update on key items of information which are relevant but not covered in the performance report or other papers						
	For Decision		For Assurance		For Information	x	
Sponsor/Author	Joe Chadwick-Bell						
Governance overview	Not applicable						

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

Letby Case

The recent judgment following the Lucy Letby case has prompted myself and the wider Executive Team to reflect on our own leadership approach and governance arrangements, as well as our approach to speak up and listen up. There is a separate paper at Board today for further discussion, but I wanted to flag the impact it has had on myself and the wider leadership team.

I wrote out to all staff to remind them of the importance of speaking up and we will continue to encourage staff to do so, but also for leaders to ensure they 'listen-up' and that incidents and risks are flagged through our existing arrangements.

Our current governance structures have served us well. However as part of the Trust's approach to continuous improvement we have commissioned a well led review and in parallel we will also be reviewing our current arrangements across our clinical and wider corporate governance arrangements.

Any learning from Letby will be considered as part of this review.

NHS Managers Regulation

There has been discussion over the past couple of years regarding the need for regulation of NHS managers and national intent is to put that in place. However, at this time the details are not yet available. Further updates will be shared in due course.

Leadership Update

I would like to welcome Simon Dowse to the Executive Team as the Director Strategy, Transformation and Improvement. Simon was previously the Trust's Head of Strategy and through a competitive process has been appointed into role and started on 3rd September, taking up the post from Charlotte O'Brien who is now Chief Operating Officer. Simon will work as part of the Executive Team and join the Board informally through Board seminars and has a key role to play within Board committees.

Visit from Lord Markham

We were delighted to host a visit on 29th September of Lord Markham, Parliamentary Under Secretary of State at the Department of Health and Social Care. I'm delighted that colleagues within the organisation and across partner organisations and local MPs were able to join us.

Royal College Surgeons – Sexual Assault

As you may have seen in the media, the RSC issued a report which both saddened and disappointed me. The report revealed the extent of sexual misconduct by colleagues – including sexual harassment, sexual assault, and rape - within the UK surgical workforce in the last five years.

The study, which has been published in the British Journal of Surgery, analysed anonymous online survey responses from 1,434 participants (51.5 per cent women) from the surgical workforce. The team found that two-thirds of women (63.3 per cent) had been the target of sexual harassment from colleagues, along with almost a quarter of men (23.7 per cent).

I would like to make it clear that there is no place in our organisation for sexual misconduct. I can promise that any claims of sexually inappropriate behaviour will be investigated, and the necessary action will be taken.

NHS Staff Survey -% return week 1

On the 18th of September we launched our annual staff survey, which gives staff a chance to provide their views and experiences around working for the NHS. As we continue to change and evolve as an organisation, it is important to take staff feedback on board. Having a healthy, motivated, supported and engaged workforce leads to better outcomes and experiences for patients.

Below are the results of our first week, as of 22nd September 2023:

Survey Completion Rate	2023	2022
Substantive Staff	11%	5%
Bank Staff	9%	4%

Industrial Action Update

I would like to say a huge thank you to our hard-working, dedicated staff for their response to the NHS strikes. We continue to see both junior doctor and consultant strikes and have seen the first 'double' strike affecting both staff groups. Whilst we will continue to prioritise urgent and emergency care it has been extremely disruptive in terms of planned care and will impact on our ability to deliver reductions in our waiting times and volumes. In time this has the risk of impacting clinical outcomes and although harm reviews are undertaken for long wait patients it is likely that harm will happen.

It will in time have a more significant impact, as the time devoted to mitigating strike risks is preventing operational and clinical leaders from focusing on other areas of improvement, including service efficiency which has the risk of impacting our financial recovery.

MSK procurement

Sussex Integrated Care System (ICS) are progressing the tender of the Sussex Musculoskeletal (MSK) services. This is focused on the provision and delivery of the Community MSK service. The service specification was published on 15th September, and the Trust is currently working through the details of this. The next deadline is Friday 29th September, when we have an opportunity to raise any clarification questions.

	The Trust has set up an Internal Project Team to work through the tender and to develop the Trust's response. The impact on the Trust will be understood as the tender process continues. **Visible Leadership** I have been out and about visiting the wards and, as always, have enjoyed seeing our incredible, hard-working staff in action. During our Executive visits, teams have the opportunity to raise concerns/issues and also share what they enjoy about their work. This gives the Executive team an insight as to what may need changing or improving in the future. Visits were undertaken with teams and wards across multiple ESHT sites over the last couple of months, both by Executive and Non-Executive Directors. A range of different services were visited, from our Eastbourne DGH Infusion Suite to our Maternity and Estates Departments. A particular highlight this month was my visit to Rye, where the Trust Chair and I had some great conversations with the ward staff and we were also provided with an insightful tour of the nursing wing. The Chair had the honour of presenting August's hero of the month award to James Banks, Emergency Department Security at Eastbourne DGH. James's work colleagues said 'James is known to go above and beyond to keep the department calm and always gives patients the time of day when they are at their most vulnerable or in crisis'. We really enjoy spending time on the wards and encourage staff to request visits via the Visible Leadership page on the intranet. **New Hospital Planning** In May 2023, the secretary of State for Health and Social Care announced a £20 billion investment in hospital infrastructure and continued commitment to the current schemes. We are excited that ESHT is one of the 48 Hospital Trusts to be included within this. The NHP forms part of the wider Health Infrastructure Plan, a strategic rolling long-term investment in hospital infrastructure to ensure our healthcare system is fit for the future. This will include the redevelopment of three hospital sites at Conquest hospital, Eastbourne DGH and Bexhill Community hospital. **Flu/ COVID Vaccinations** This year, we are supporting the national COVID-19 booking system by providing COVID -19 booster vaccinations to patient facing colleagues. This will be offered through two hubs based at our acute sites. Colleagues who are non- patient facing who would like to book in nearer to home can access the National Booking System via the NHS website, the booking link will be available via the extranet. • Conquest 9th – 15th October inclusive • EDGH 16th -22nd October inclusive Locations of clinics • Conquest – Committee Room • EDGH – Flemming House Ground Floor Meeting Room All Flu Vaccinations will be arranged within individual areas.

Next steps	N/A

East Sussex Healthcare NHS Trust

Taking organisational assurance following R -v- Letby

Purpose of the paper	Following the decision in R -v- Letby, this paper sets out a summary of the procedures, policies and actions that this Trust has in place to guide and support our assessment of individuals who join our organisation and how we aim to support people who wish to speak up/out.					
	For Decision		For Assurance	x	For Information	x
Sponsor/Author	Executive Director: Richard Milner, Chief of Staff Report Author: Richard Milner, Chief of Staff					
Governance overview	This report has been shared with executive directors for comment before being brought to the Board.					

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 Board is asked to note the contents of this report.
Executive Summary	Commentators were quick to note that several aspects of R -v- Letby echoed earlier cases (Shipman, Allitt) not least in that they were crimes against the vulnerable, who needed care the most. While this is tragically and undoubtedly true, when considering the risk (however statistically minimal) we must consider mitigations that go beyond specific services (e.g. care of the elderly, neonatal services) and staff groups to ensure we are alert to the wider potential. There are many lessons to draw from the case of R -v- Letby and, without doubt, more will emerge from the statutory enquiry. One lesson that goes beyond merely effective procedural checks and balances, as important as they are, is the establishment and the continued nurturing of a workplace culture that prioritises open, timely and regular reflection (more commonly known as 'feedback'). This is especially important in times of perceived behaviour that run counter to shared values. Our culture-driven work picks up on both this imperative to 'call out' troubling attitudes and behaviours while also – through our values – identify and embed a clear set of expected ways of working.
Next steps	The Board is apprised routinely of our ongoing culture work and, separately, will be updated on the process changes to the Fit and Proper Persons Test (FPPT).

1. Introduction

1.1 Mr Justice Goss, delivering his sentencing remarks in the case of R – v – Letby, notes that the defendant's actions were "…contrary to the normal human instincts of nurturing and caring for babies and in gross breach of the trust that all citizens place in those who work in the medical and caring professions[1]".

1.2 Such actions are mercifully rare but their impact has led many people to consider their own reactions to the crimes; what would I have done if I were a colleague? A parent? A Board member? Some may have asked themselves similar questions in 2000 following the conviction of Harold Shipman or for Beverley Allitt in 1993.

1.3 A focus on individual cases finds an echo in the media's portrayal of serial killers[2] and the causes of their behaviour. While this is evidently beneficial from a psychological/ motivational perspective, it can ignore the context in which this phenomenon occurs, including institutional frameworks and opportunity structures.

1.4 The FBI estimates that serial killers comprise 0.000015% of the population and what has been characterised as an explicit power relationship in healthcare settings (clinician/patient) may even attract individuals with just such tendencies. While statistically the likelihood of proximity is low, in light of this case there is no room for complacency.

1.5 This brief paper seeks to review what policies and procedures we have in place to minimise the potential risk to this organisation, and how we are seeking to encourage staff to speak up/out and senior leaders to listen when they do as part of our wider work on our organisational culture.

2. Processes already in place

2.1 We recognise that the central responsibility for the events that took place in this case, of course, must lie with the defendant.

2.2 However, in light of surrounding issues that have already been shared either during the court case or across the media, and the undoubted points that will emerge from the forthcoming government-commissioned enquiry, it is prudent that we check the safeguards and assurance mechanisms currently in place across our organisation.

2.3 We have grouped our assurance into three broad areas; HR processes pre- and during events, attitudes around speaking up, and data-driven insights. These are summarised below for brevity (in reality, the processes involve significantly more stages than those reflected below.

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[1] https://www.judiciary.uk/wp-content/uploads/2023/08/LETBY-Sentencing-Remarks.pdf

[2] *"Serial killing is the rarest form of homicide, occurring when an individual has killed three or more people who were previously unknown to him or her, with a 'cooling off' period between each murder*", The Social Study of Serial Killers 2011 Centre for Crime and Justice Studies

HR processes

2.3.1 We ensure compliance with the fit and proper persons test (FPPT) framework, consistent with the principles of good governance. Coincidentally, a revised framework will be rolled out nationally from September 2023 and will complete by 31 March 2024. We will seek to move as rapidly as possible to ensure the revised framework is in place ahead of these dates.

2.3.2 We take up all references when a post is offered as per the standard process and, where it is felt to be necessary, follow up with virtual conversations in the event that the references provided offer insufficient information[3].

2.3.3 At ESHT, exclusion of an individual is considered as a matter of course when significant allegations of harm and/or safety are made, mindful that it is a neutral act and protects all involved in the process.

2.3.4 We commission external independent reviews (e.g. Royal Colleges, external experts/ investigators) to ensure an even-handed and speedy process, as necessary.

2.3.5 We routinely undertake listening events when we identify that there are challenges in specific areas, so that we provide a safe forum for people to raise the issues that they have.

2.3.6 Through our Wellbeing Team we offer proactive health and wellbeing support where there are traumatic events, offering everyone the opportunity to speak / reflect in the immediate aftermath.

Attitudes around speaking up and out

2.3.7 Fundamental to this case is encouraging teams to speak up and speak out in a timely manner. This is a key part of the culture work we are doing across the whole of the Trust, seeking to understand and break down barriers that may prevent people from coming forward.

2.3.8 Speaking up about behaviours – publicising the need to speak out and that support will be available for colleagues. We have regular updates to the Board from our Freedom To Speak-Up Guardians (FTSUGs), and staff are encouraged to come forward with the reassurance that they will be believed even when other colleagues are not forthcoming.

2.3.9 The most recent FTSUG report to the Board was in June 2023 and it set out the cases and themes that the team covered during 2022/23. Around 45% of the issues raised covered 'attitude/behaviour' (the largest reporting category) and 16% of issues related to patient safety issues.

2.3.10 Importantly, the National Guardian Office has noted three risk areas that all Trusts should review: low numbers of cases, cases reported anonymously and a high number of cases raised around 'detrimental impact for speaking up'. Across all three areas, the Trust performs well; we have good numbers of cases when compared to our peers in the Southeast and very low numbers of people speaking on condition of anonymity or reporting that they feel speaking up has been detrimental.

[3] *The Clothier Inquiry of 1993 (set up post-Allitt) noted that "no candidate for nursing in whom there is evidence of major personality disorder should be employed in that profession"*

2.3.11 Our training package now contains three levels of modules covering speaking up are available to support colleagues, with senior leaders expected to complete all three.

2.3.12 The Board made the decision in November 2022 that all managers must complete the "Listen Up" National Guardian Office and Health Education England e-learning course as part of mandatory training. The training supports consistency and learning for those best placed to respond to concerns. In addition, all members of the Trust Board are expected to complete "Follow Up" National Guardian Office and Health Education England speak up e-learning course before YE.

2.3.13 Our intranet also explains to staff that they can contact both the CEO and our Senior Independent Director (Non-Executive) directly, who can help to support and direct our staff.

2.3.14 The benefits of a multi-disciplinary team approach (MDT) include helping to identify patient issues from a range of perspectives and ensures challenge across the professional groups.

Data-driven insights

2.3.15 We already consider mortality rates for the Trust at each Trust Board in public, and this is supported by further review at the private Board, where the serious incident reports are able to provide the Board with more information on every case that has been reported through the governance process.

3. Enhancements to existing processes

3.1 **FPPT:** We will ensure a speedy implementation of the revised FPPT framework, some of which will apply from 30 September 2023, working toward full implementation by 31 March 2024. This aims to help senior board members and will strengthen board governance, boost leadership and improve patient safety.

3.2 **Data:** As part of a wider stocktake of data and information requirements for operational teams, we are looking at bringing back into wider circulation specialty-specific mortality rates, to be shared via the monthly Divisional IPRs, providing executives with more detail than we have previously seen, with Divisional Leadership Teams to provide assurance as required.

3.3 We are working on ensuring that the mortality trends we review are as recent and as specific as our systems reliably allow. We are also considering how we may include comorbidities etc. into this data and will also ensure that unanticipated deaths are added to the list of deaths discussed in the mortality review group.

4. Additional process improvements

4.1 We have already begun a review that seeks to strengthen governance at divisional and specialty level – specifically how divisions take assurance from their specialities in an

integrated way (clinical/quality, workforce, finance and operational) ahead of coming to the monthly IPR with executives.

4.2 As regards the specifics of the Letby case, this additional control/check would involve divisional leadership teams reviewing mortality rates, complaints levels and any team/HR issues such as events requiring mediation.

5. Actions as a Board

5.1 We have previously noted that, for executive board members, being and becoming more visible across our sites and with clinical teams has been a priority for some time now. 'Visible Leadership' takes many forms and includes once-weekly visits to clinical areas as well as information-sharing at staff group forums and listening to feedback from staff, as we have recently done as part of our work on the Trust Value-shaping.

5.2 Non-Executives also undertake service visits and we are currently strengthening this process to systematise these visits, so that each Non-Executive will have visited six sites over the course of the year. We are aware that some staff may feel more confident speaking in front of Non-Executives and we are keen to ensure that, via these visits, our listening-led approach provides an alternative way through which the Board can hear the insights from our people.

5.3 One example of where such visits have made a difference to the working lives of our staff is following a visit from the Trust Chair to frontline staff in the community. Previously laptop connectivity was linked to WiFi proximity only. As a result of feedback through the relevant support team and describing the scale of challenge this was causing to our people as well as the benefits of improved connectivity, the teams received replacement equipment that enabled 4G/5G network access – greatly improving their experience as well as their effectiveness..

6. Listening to stakeholders and working with regulators

6.1 Across maternity services in particular, our Director of Midwifery has led the work on strengthening the workplace culture through improved support for staff, which has seen results in the form of increasing numbers of new joiners to the team and a reduction in vacancies.

6.2 One of the clearest examples of this is the Maternity Voices Partnership (MVP), which is a multi-disciplinary team (clinicians, managers and around 10-12 service users and the Non-Executive Safety Champion), meeting bi-monthly that encourages open discussion of what matters to staff and patients.

6.3 The group discusses a range of quality-related issues covering the service, and also takes responsibility for the co-production of the action plan resulting from the CQC annual survey. Users and staff are encouraged to provide feedback via the MVP – users via the QR codes (where issues are escalated directly to the Director of Midwifery/Head of Midwifery) and staff via the listening events held regularly.

Additionally, the safety champions from across the services meet monthly to discuss key issues affecting the teams (e.g. staffing levels).

6.4 Another example of strengthening our engagement is the rolling programme of "Enter and View" surveys, led by East Sussex Healthwatch volunteers, into a selected range of our services. The aim is to seek the views of service users on topics that agreed between Healthwatch and the services that have welcomed the volunteers, with the intention that the views of these users will support and shape decisions and priorities. We anticipate that this will be particularly useful as service models evolve and change as we begin the remodelling of our estate as part of the New Hospitals Programme. We are particularly proud of how engaged our teams have been in reaching out for insight from service users.

6.5 Where relevant we will be triangulating the intelligence from these surveys with the wider data and insight collected by our patient experience team that is shared with divisions each month. This data includes feedback provided through the Friends and Family Test (FFT) for community teams, inpatient services, outpatients and maternity services, where for each of these areas we perform consistently above the national average and we are working with teams to increase the volume of responses from patients.

East Sussex Healthcare NHS Trust

Integrated Quality & Performance Report

Prepared for East Sussex Healthcare NHS Trust Board

For the Period August 2023 (Month 5)

Content

East Sussex Healthcare NHS Trust

Content

About our IPR

East Sussex Healthcare NHS Trust

- 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 (2023/24), is being delivered.

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

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

Our vision describes our ambition for the organisation over the five years of this plan:

- **To develop outstanding services, building a reputation for excellence in care, becoming "the best DGH and community care provider"**
- **To lead a modern organisation for our people, enabled by technology, agile working and a light environmental footprint**
- **To harness existing strong relationships to forge a vanguard collaborative tackling the social and health challenges that face our coastal towns**
- **To make a demonstrable economic and social impact through our partnership commitments; on health, employment, education, training and skills development across Sussex**
- **To develop as a financially sustainable and innovation-led organisation**

Chief Executive Summary

East Sussex Healthcare NHS Trust

Executive Summary

August has been an exceptionally challenging month, not just for the Trust, but for the whole region. Specific key areas of challenge have been the demand on our Emergency Departments, bed occupancy and patient flow, as well as the long wait pressures in both cancer and routine elective care. Industrial Action continues to impact on service provision; however, we continue to remain focused on improving performance against a range of key indicators and are committed to maintaining high standards in quality of care . Our priorities continue to be improving Emergency Access, optimising length of stay and getting patients' home in both our acute and community bed bases. The Trust remains equally focused on elective recovery and an assurance pack (which includes trust self-certification) has been agreed in line with Trust governance, signed off by CEO and submitted to NHSE. This will be included in papers going to Trust Board in October and outlines the measures the Trust is taking to take to deliver the elective recovery programme (ensuring zero 65 week waits by March 2023).

Key Areas of Success

- Our Friends and Family Tests (FFT) indicate that 98.8% of our outpatient patients would recommend us, with 99.2% recommendation rates for our inpatient areas. The positive FFT recommendation rates for August, when compared to the most recent data released by NHS England (July), show that ESHT continues to be higher than the national average across these areas.
- Although not achieving the 4-hour standard, we are 31st in the country and remain above the national average. We have a comprehensive action plan in place to support recovery of this standard.
- We are sustainably delivering above target for our 2-hour urgent community response.
- The number of patients waiting >65weeks for first definitive treatment continues to be ahead of agreed trajectory for our year-end target of zero and the Trust is expected to deliver zero 78 week waits in September.
- There has been an improvement in income received against the Elective Recovery Fund (ERF) from £6,959k to £7,623k
- Staff turnover continues to fall across most staff groups and is at the lowest level since Dec 21.

Key Areas of Focus

- Sustainable and consistent delivery of 76% (national standard) against the Emergency Access Clinical Standard.
- Reducing the length of time patients wait to access cancer care with a focus on reducing first outpatient appointments to a maximum of seven days to support delivery of both the FDS and 62 day standards.
- Ensuring all patients in the 23/24 65 week wait risk cohort have had a first outpatient appointment day 31.10.23
- Continued focus at both Trust and Divisional level to improve productivity and ERF performance against plan; mitigating the impact of Industrial Action on elective activity where possible.
- Ensuring the well-being of all staff and that services are able to operate safely during planned ongoing Industrial Action.

Balanced Scorecard

East Sussex Healthcare NHS Trust

Key Metrics

Safety	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Patient Safety Incidents Causing Harm	0	3	4	5	Common Cause	Inconsistent
Serious Incidents	0	3	4	6	Common Cause	Inconsistent
Never Events	0	0	0	0	Improvement	Inconsistent
Inpatient Falls per 1,000 Bed days		3.87	4.59	4.27	Common Cause	Target required
Pressure Ulcers, category 3 to 4	0	1	3	0	Common Cause	Inconsistent
MRSA Cases	0	0	0	1	Common Cause	Inconsistent
Cdiff Cases	4	5	10	4	Common Cause	Inconsistent
MSSA Cases	0	1	7	1	Concern	Inconsistent
RAMI	94	91.1	92.5	78.9	Concern	Achieving
SHMI (NHS Digital monthly)	99%	101%	101%		Concern	Inconsistent
Nursing Fill Rate (IP - RN, RNA and HCA)	100%	88.4%	90.5%	91.8%	Common Cause	Not Met

Patient Experience	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Complaints received		36	39	51	Common Cause	Target required
Complaints Response Compliance		58.3%	34.5%		Common Cause	Target required
Reopened Complaints		8	1	3	Common Cause	Target required
A&E FFT Score	85%	79.9%	79.1%	92.9%	Common Cause	Inconsistent
A&E FFT Response Rate		1.35%	0.832%	4.47%	Common Cause	Target required
Inpatient FFT Score	95%	99.2%	99.2%	97.3%	Common Cause	Achieving
Maternity FFT Score	95%	100%	100%	97.8%	Common Cause	Inconsistent
Outpatient FFT Score	95%	98.8%	98.8%	97.1%	Common Cause	Achieving
Post Covid19 Assessment FFT Score	95%	100%	0%		Concern	Inconsistent

Our People	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Establishment (WTE) All		8,255	8,170	7,136	Improvement	Target required
Agency Rate	3.6%	1.47%	1.36%	1.38%	Improvement	Achieving
Vacancy Rate	7.5%	10.1%	8.8%	10.5%	Concern	Inconsistent
Staff Turnover	11.6%	11.6%	11.0%	10.6%	Improvement	Inconsistent
Retention Rate	90%	90.7%	91.7%	91.7%	Common Cause	Achieving
Monthly Sickness - Absence %	4.7%	4.93%	4.92%	4.6%	Common Cause	Inconsistent
Sickness - Average Days Lost per Fte	17	19.2	19.1	16.1	Improvement	Not Met
Staff Appraisals	85%	81.5%	82.6%	78.6%	Improvement	Not Met
Statutory & Mandatory Training	90%	89.5%	88.7%	88.1%	Common Cause	Not Met

Our Performance	Target/ Limit	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
4 hour standard	76%	74.1%	75.1%	88.6%	Common Cause	Inconsistent
A&E > 12 hours from arrival to discharge	0	334	333	73	Common Cause	Not Met
A&E waits over 12 hours from DTA	0	0	0		Improvement	Inconsistent
Conveyance handover >60 mins	0%	0.679%	1.19%	0.678%	Common Cause	Inconsistent
Non Elective Length of Stay	4.48	4.11	4.38	3.76	Common Cause	Inconsistent
Average daily NCTR		185	178		Empty	Target required
104 day Backlog	35	22	22	34	Concern	Achieving
Elective Activity (ELIP,DC,OPFA, OPFUP P...	108%	97.1%	106%		Common Cause	Not Met
RTT under 18 weeks	92%	48.4%	48.9%	89.2%	Concern	Not Met
RTT 65 week wait	280	260	247	0	Concern	Achieving
RTT Total Waiting List Size	58968	63301	62291	28567	Concern	Achieving
Diagnostic <6 weeks	1%	11.9%	14.2%	1.61%	Improvement	Not Met
Urgent Community Response within 2 h...	70%	75.6%	76.0%		Common Cause	Inconsistent
CHIC wait times < 13 weeks	75%	81.9%	82.2%	84.1%	Common Cause	Achieving
Intermediate Care Length of Stay	30	44.4	35.6	27.2	Common Cause	Inconsistent
Cancer 2WW	93%	95.4%	81.7%	94.6%	Concern	Inconsistent
Cancer 62 Day	85%	62.1%	54.2%	77.4%	Concern	Not Met
28 Day General FDS	75%	75.1%	73.6%		Improvement	Inconsistent

Finance	Target/ Limit	Previous Month	Current Month	1920 Same period	Variation	Assurance
Surplus/(deficit) (£'000) - in month	(3)	(666)	(775)	n/a	n/a	Not met
Surplus/(deficit) (£'000) - YTD	31	(1,399)	(2,174)	n/a	n/a	Not met
ERF (£'000) - in month	7,924	6,959	7,623	n/a	n/a	Not met
ERF (£'000) - YTD	40,366	30,538	38,161	n/a	n/a	Not met
Efficiency (£'000) - in month	2,376	2,226	1,809	n/a	n/a	Inconsistent
Efficiency (£'000) - YTD	10,371	7,082	8,890	n/a	n/a	Not met
Capital (£'000) - YTD	8,561	6,258	7,491	n/a	n/a	Inconsistent
Capital (£'000) - FOT	65,645	56,495	65,645	n/a	n/a	Not met

Constitutional Standards | Benchmarking

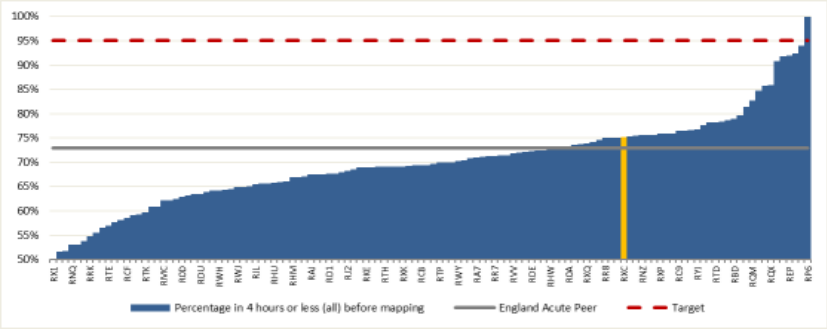
East Sussex Healthcare NHS Trust

*NHS England has yet to publish all August 2023 Provider based waiting time comparator statistics

Urgent Care – A&E Performance

August 2023 Peer Review

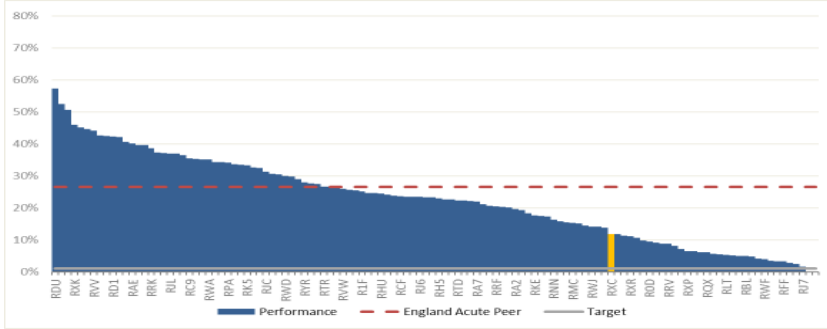
National Average: 72.98% ESHT Rank: 31/124



Planned Care – Diagnostic Waiting Times

July 2023 Peer Review*

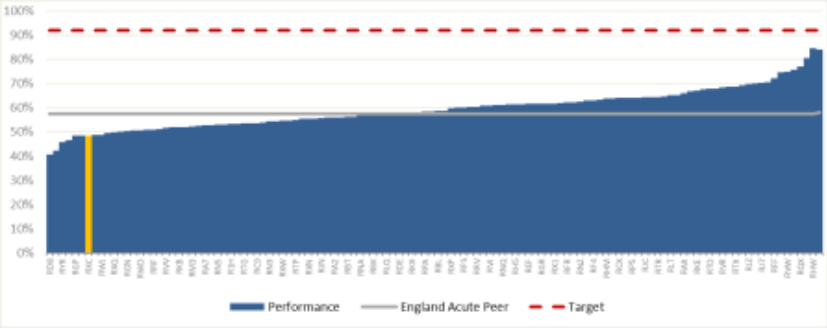
National Average: 26.5% ESHT Rank: 33/120



Planned Care – Referral to Treatment

July 2023 Peer Review*

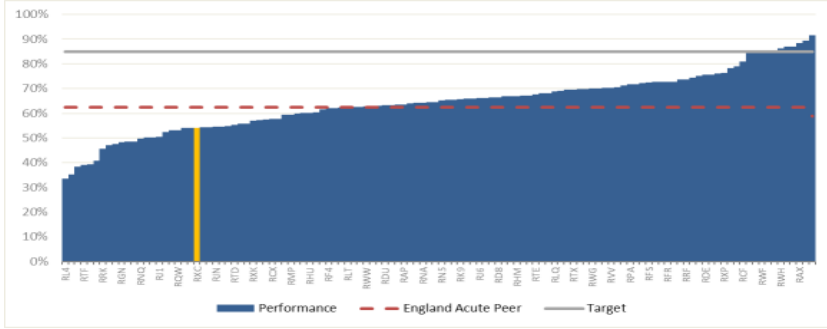
National Average: 57.5% ESHT Rank: 114/120



Cancer Treatment – 62 Day Wait for First Treatment

July 2023 Peer Review*

National Average: 62.5% ESHT Rank: 99/120



ESHT denoted in orange, leading rankings to the right

East Sussex Healthcare NHS Trust

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

Quality and Safety | Executive Summary

East Sussex Healthcare NHS Trust

Quality and Safety

Covid 19
Prevalence of COVID increased once again in August and was similar to levels experienced in April/May. Transmission within bays also increased. It is not known if there are cases of the new variant as a PCR test is not routinely undertaken as per national directive. Outbreaks involved several bays on a ward and on occasions wards were closed to new admissions with a continued commitment to zero void beds with IPC colleagues and clinical teams minimising the overall clinical and operational impact.

Infection Control
The CDI limit was exceeded in August as 10 cases were reported against a limit of 5 (6 HOHA and 4 COHA). 2 occurred on one ward but were shown to be unrelated. All were sent for ribotyping. None of the cases were found to be due to cross infection.
There were no MRSA bacteraemias reported in August.
There was a higher than usual number of *MSSA* bacteraemias reported by both the ICB and ESHT in August. The reason is not fully understood at present. 7 were reported by ESHT in August, 5 HOHA and 2 COHA. One HOHA case was reported as possibly avoidable and likely due to wound infection post limb amputation at another Trust. Of the 2 COHA cases, one was reported as possibly avoidable and probably due to urinary tract infection post ureteric stent insertion. All remaining cases were reported as unavoidable and full PIRs are underway.

Incidents
There were 4 serious incidents reported in August. They related to a pregnancy loss at 26 weeks, a missed fracture, a missed diagnosis of hyponatraemia and a delayed intubation. The last incident has subsequently been downgraded following further information with a full incident report in part 2. Of the 913 reported ESHT incidents, 894 were low or no harm (cat 1-2) with 19 at cat 3-5.

Harms
There were three incidents of Category 3 pressure damage reported in August 2023 in patients residing in their own home all subject to investigation to determine if any lapses or learning.

There was one severity 3 and one severity 4 inpatient fall in August. Bexhill Irvine Intermediate Care Unit reported the highest number of falls with 15 noting it's patient cohort and rehab speciality with some very complex patients some of whom are resistant to care requiring MH input and/or DOLS.

Mortality
RAMI indices of mortality rolling 12 months remains better than peers positioned at 29 out of 122 Acute Peer Trusts. SHMI has decreased slightly this month and is within the expected range. EDGH is showing an index of 99 and Conquest 101. The increase in mortality from October 21 has been mirrored throughout the South East. We are looking into this in more detail currently. It would appear crude mortality did not change over that period.

Patient Experience
In August, ESHT received 39 new complaints. 4 complaints received were categorised as "high risk". 1 complaint was reopened as the family had additional questions and the Trust received 4 contacts from the PHSO in the month.
Divisional teams continue to focus on the 21 overdue complaints at the end of August. Ongoing operational pressures in August impacted on response rates, which overall for August was 34%. The positive FFT recommendation rates for August, when compared to the most recent data released by NHS England (July), show that ESHT continues to be higher than the national average except for the Emergency Departments.

Workforce (Nursing)
The number of additional beds for inpatient capacity increased during August with the use of super surge beds despite a reduction in long length of stay patients. At time of writing supersurge beds are still open. In addition, there are still significant numbers of patients whose primary need is mental health in our Emergency Departments (ED) and our gateway areas esp. at Eastbourne. Some patients present with extremely challenging behaviour and are resistant to care and are often aggressive and/or violent. The Health and Well-being Team are providing support to colleagues. Additional staff including Registered Mental Health Nurses and security have been in place for those high-risk areas with one especially difficult week resulting in 5 security guards on our AMU at Eastbourne at any time. Ward staffing in August remained stretched to cover the additional requirements with community teams also under continued pressure. In in-patient areas this is likely to have had an impact on key quality KPIs and at times staff wellbeing with sustained pressures. Focus continues regarding Healthroster compliance, use of temporary workforce, authorisation of additional shifts and supernumerary time with significant improvements noted around the use of additional shifts. Plans are underway with workforce colleagues to modify reporting to ensure it is more inclusive in terms of non-bedded services/locations and professions.

Safeguarding
The current "*Think Family*" programme is being updated to ensure that the information remains current, and evidence based. Going forward, staff will access an enhanced e-learning package comprising four modules prior to attending a facilitated masterclass to ensure that it meets the required standard of level 3 safeguarding training.
An audit of Safeguarding Closures received between January and June (but which were opened in 2022) is near completion with, early results demonstrating key learning regarding communication.
The PREVENT Policy is being updated and the Safeguarding team are working with Security colleagues to ensure a more cohesive approach.

Author(s)

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

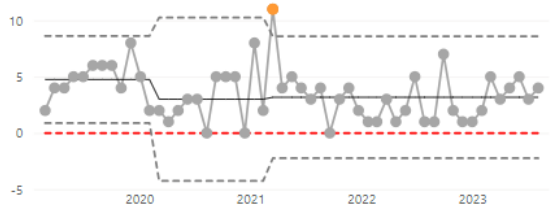
Simon Merritt Chief Medical Officer

Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

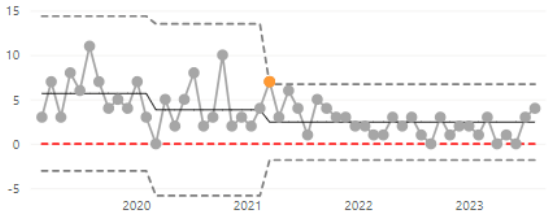
Patient Safety Incidents Causing Harm: Total, Safety

Inconsistent	Common Cause	4



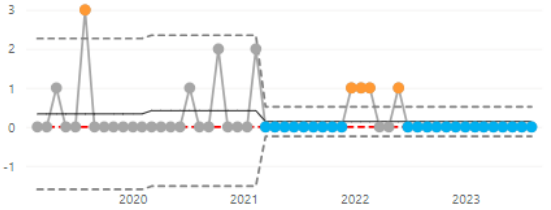
Serious Incidents: Total, Safety

Inconsistent	Common Cause	4



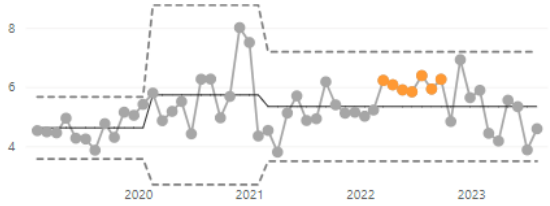
Never Events: Total, Safety

Inconsistent	Improvement	0



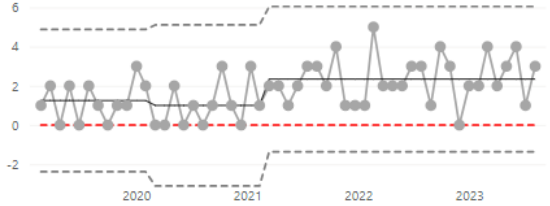
Inpatient Falls per 1,000 Bed days: Total, Safety

Target required	Common Cause	4.59



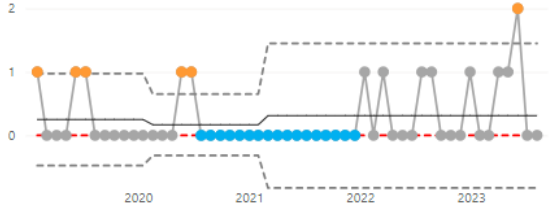
Pressure Ulcers, grade 3 to 4: Total, Safety

Inconsistent	Common Cause	3



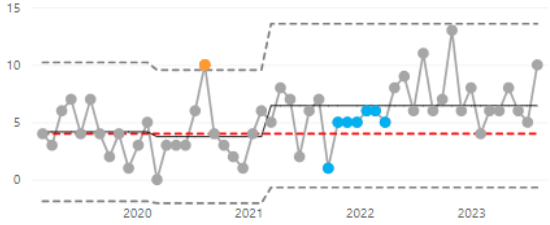
MRSA Cases: Total, Safety

Inconsistent	Common Cause	0



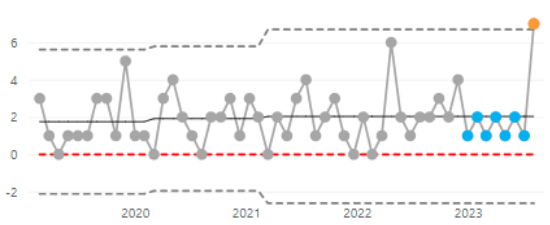
Cdiff Cases: Total, Safety

Inconsistent	Common Cause	10



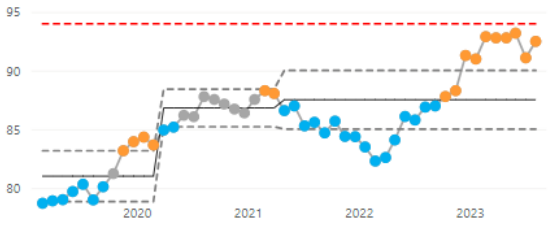
MSSA Cases: Total, Safety

Inconsistent	Concern	7



RAMI: Total, Safety

Achieving	Concern	92.5

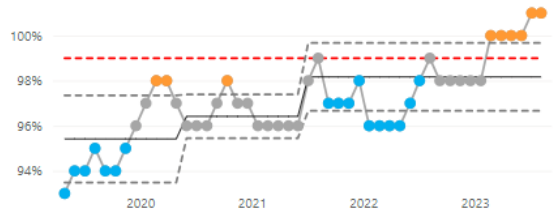


Quality and Safety Core Metrics

East Sussex Healthcare NHS Trust

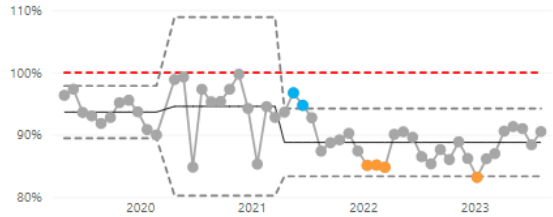
SHMI (NHS Digital monthly): Total, Safety

Inconsistent	Concern	101%



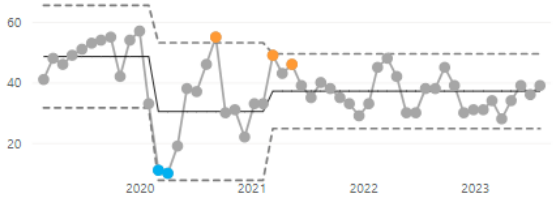
Nursing Fill Rate (IP - RN, RNA and HCA): Total, Safety

Not Met	Common Cause	90.5%



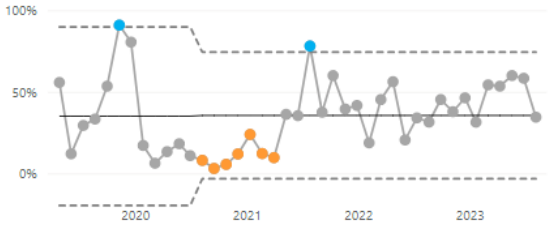
Complaints received: Total, Patient Experience

Target required	Common Cause	39



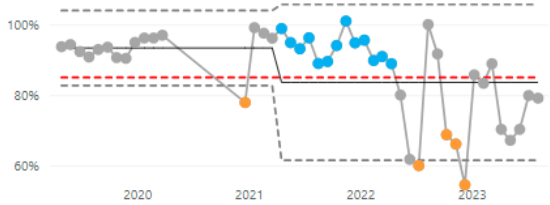
Complaints Response Compliance: Total, Patient Experience

Target required	Common Cause	34.5%



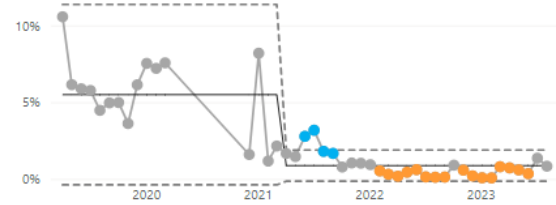
A&E FFT Score: Total, Patient Experience

Inconsistent	Common Cause	79.1%



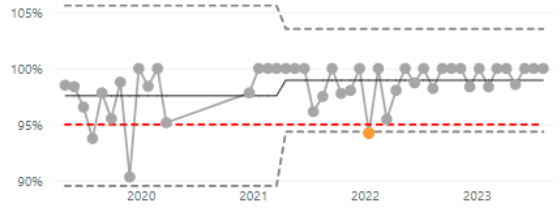
A&E FFT Response Rate: Total, Patient Experience

Target required	Common Cause	0.832%



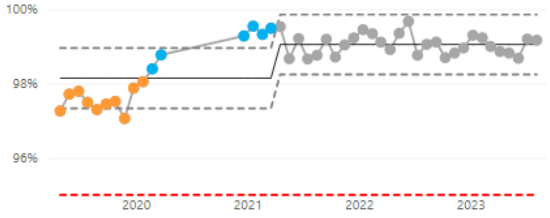
Maternity FFT Score: Total, Patient Experience

Inconsistent	Common Cause	100%



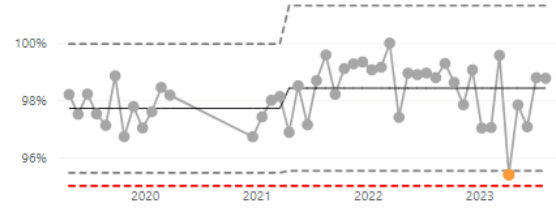
Inpatient FFT Score: Total, Patient Experience

Achieving	Common Cause	99.2%



Outpatient FFT Score: Total, Patient Experience

Achieving	Common Cause	98.8%



Quality and Safety | Areas of Focus

East Sussex Healthcare NHS Trust

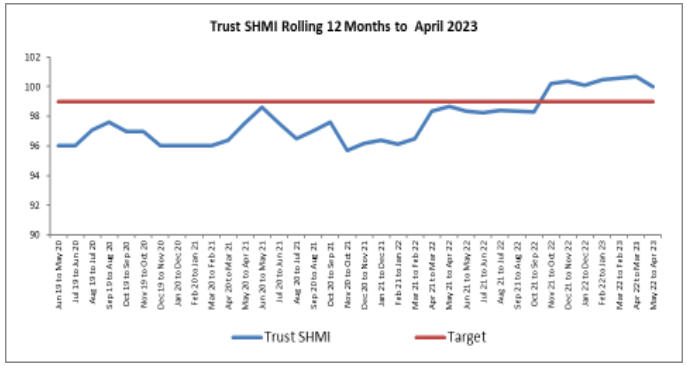
Title	Summary	Actions
Patient Safety Incident Response Framework (PSIRF)	• The Patient Safety Incident Response Plan (PSIRP) and Policy have been completed. They have been presented at the Executive Committee and Quality & Safety Committee and the Trust Board today. The aim is for a go live date of 20/11/23. There is ongoing engagement with the clinical teams. Response templates and information leaflets for staff and patients have been completed	• To continue to disseminate PSIRP with clinical teams. • To finalise PSIRP and associated Policy at the Trust Board • To provide Trust Board with more information about PSIRF and how it is anticipated it will work in ESHT.
Nursing & Midwifery Workforce	• Additional super surge beds and significant number of patients requiring enhanced observation for cognitive impairment, high risk of falls or patients with challenging/violent behaviour during August resulted in additional staffing requirements. CHPPD overall was 8.9 for August (noting distortion by specialist areas) with 18 areas less than 8. Nursing fill rates for day shifts RN 89% and HCSW 82% and night shifts 97% for RN and 90% for HCSW	• The Nursing Establishment Review for wards and community nursing has commenced in September with work underway for Theatres • Plans in place to review and revise reporting to ensure more inclusive in terms of services and roles • Nursing/Midwifery Roster compliance sessions continue with evidence of good controls • Work on improving the career progression framework continues
Inpatient Falls	• Rates remain between upper and lower control limits with some variation in the last 7 months.	• Work on reconditioning continues supporting the focus on discharge planning with the numbers of patients who are Discharge Ready (Not Meeting Criteria to Reside) still high albeit improving. (The Chief Nurse is now the SRO) ESHT are undertaking harm reviews with colleagues from the ICB for patients with extended LoS.
Patient Experience	Complaints graded by risk (01.07.2023 – 31.07.23): • 4 high risk (June = 4) a complaint where the action or omission of Trust staff has placed a patient at risk of or where harm has occurred • 22 moderate risk (June = 24) a complaint involving aspects of clinical care • 10 low risk (June = 10) a complaint that does not involve any aspect of clinical care.	• All new complaints received investigated and responded to in line with the Standard Operating Procedure. • The PE Team will continue to work with the Emergency Departments to explore how FFT response rates could improve.
Pressure Damage	• Three Category 3 incidents were reported in August 2023 all in patients in their own home with complex needs. • New national guidance related to (unstageable) pressure ulcers that was due to be published in August 2023 has been delayed whilst NHSE undertake diagnostics with some trusts.	• Investigations are underway to determine if any lapses and any lessons learned for sharing. • The Pressure Ulcer Steering Group (PUSG) are working with the Trust Patient Safety Lead, to implement PSIRF going forward.

Effective Care - Mortality

East Sussex Healthcare NHS Trust

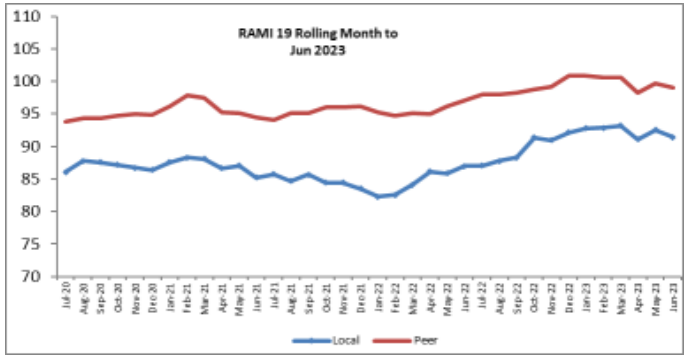
Why we measure Mortality – it's used as an indicator of hospital quality in order to look for improvement in mortality rates over time, improve patient safety and reduce avoidable variation in care and outcomes.

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

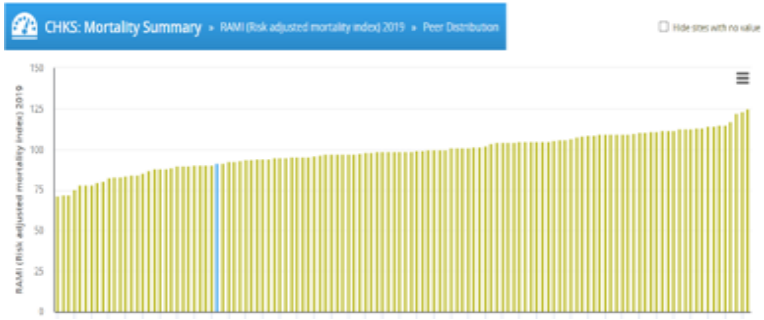


- SHMI – May 2022 to Apr 2023 is showing an index of 100 and is within the expected range. EDGH is showing 99 and Conquest is 101.
- RAMI 19 – July 2022 to June 2023 (rolling 12 months) is 91 compared to 87 for the same period last year. June 2022 to May 2023 was 93.
- RAMI 19 was 74 for the month of June and 96 for May. Peer value was 86 for June.
- Crude mortality without confirmed or suspected covid-19 shows Jul 2022 to Jun 2023 at 1.66% compared to 1.54% for the same period last year.
- Consultant acknowledgement rates of the Medical Examiner reviews was 55% for June 2023 deaths compared to 70% for May 2023 deaths.

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



RAMI Peer Distribution without confirmed or suspected covid-19



This shows our position nationally against other acute trusts – currently 29/122

Effective Care – Mortality (continued)

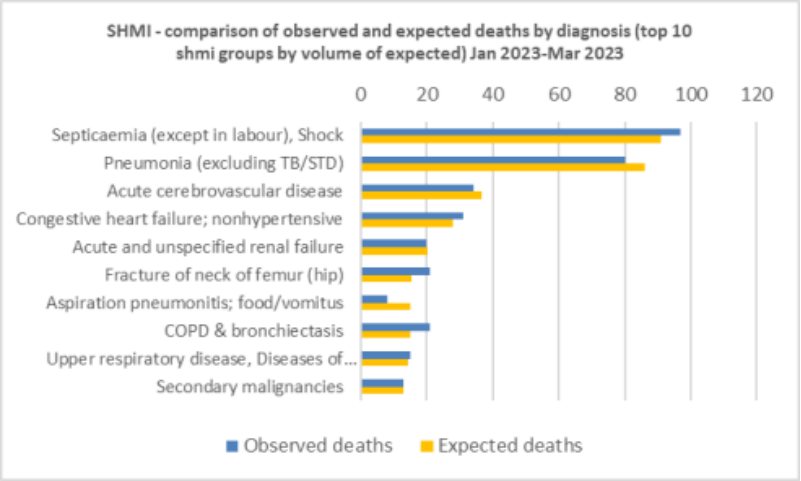
August 2023 Main Cause of In-Hospital Death Groups (ESHT)

Description	Deaths
Sepsis/Septicaemia	25
Cancer	16
Pneumonia	12
Stroke	8
Myocardial Infarction (MI)	7
Heart Failure	6
Chronic Obstructive Pulmonary Disease (COPD)	5
Frailty of old age	4
Aspiration Pneumonia	3
Community-acquired Pneumonia	3
COVID-19	3
Urosepsis	2
Atrial Fibrillation (AF)	1
Bowel Perforation	1
Dementia	1
Hospital-acquired Pneumonia	1
Liver Disease	1

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

10 cases for which no CoD has been entered on the database and therefore no main cause of death group selected.

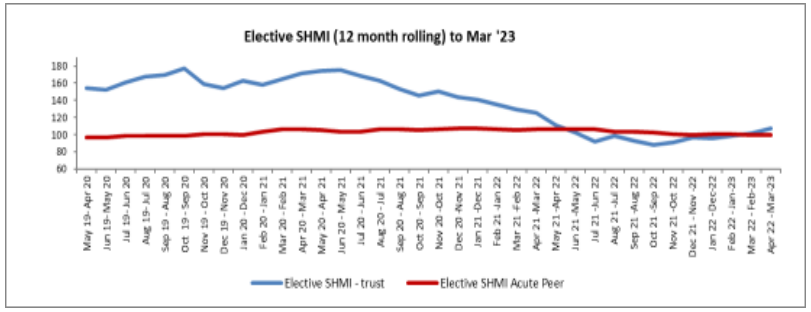
SHMI Diagnosis Main Groups

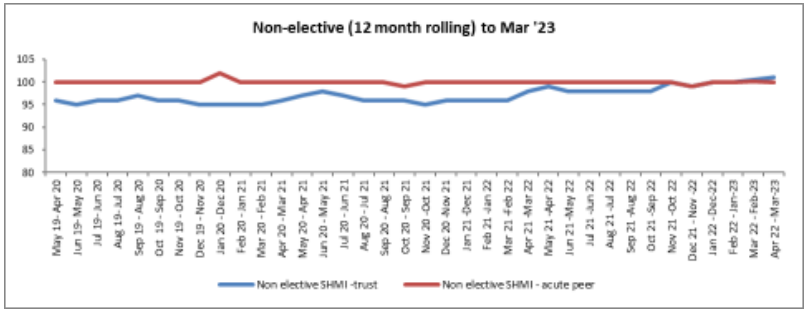


The top 2 SHMI groups (by volume of expected deaths) , septicaemia and pneumonia are showing less deaths than expected for the period.

Summary Hospital Mortality Indicator (SHMI)

Elective and Non elective Inpatient Trends





East Sussex Healthcare NHS Trust

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

Our People | Executive Summary

East Sussex Healthcare NHS Trust

	Positives	Challenges & Risks	Author
Responsive	**Turnover has reduced by 0.6% to 11.0%,** which equates to 751.0 fte leavers in the last 12 months **Vacancy rate reduced by 1.3% to 8.8%.** Current vacancies are showing as 712.5 ftes **Monthly sickness was unchanged at 4.9%,** whilst **Annual sickness reduced by 0.1% to 5.2%** **Appraisal compliance increased by 1.1% to 82.6%.**	**Industrial Action**: Consultants 19 – 21 Sept; Junior Doctors 20 – 23 Sept **Mandatory Training rate reduced by 0.8% to 88.7%**	 **Steve Aumayer** Chief People Officer

Overview:

Turnover continues to fall by a further 0.6% to 11.0%, the lowest level since Dec 21. The rate is returning to pre pandemic levels, following suppression during the height of the pandemic then an increased rate as restrictions were lifted. All staff groups had reduced turnover rates this month, with the exception of Medical & Dental turnover which increased by 0.5% to 10.6% (33.2 fte leavers).

The Trust vacancy rate reduced by 1.3% to 8.8% (712.5 fte vacancies). This was due to a combination of successful recruitment and the fact that Cost Improvement Programme (CIP) expectations increased in Aug, which reduced the fte budget by a further 98 ftes. These CIP adjustments are linked to length of stay. Vacancy percentages are highest for Medical & Dental staff at 19.7% (161.7 ftes), though a reduction of 0.9% from last month, Additional Clinical Services (unregistered clinical staff) at 15.7% (289.5 ftes), a reduction of 0.4% and Allied Health Professionals at 13.3% (86.1 ftes), a reduction of 0.3%. Registered Nursing & Midwifery vacancies were 6.9% (161.9 ftes), an increase of 0.2%.

The monthly sickness rate was unchanged at 4.9%. Chest & Respiratory illnesses increased by 243 fte days lost and there is evidence of a small upsurge in Covid absence amongst staff, from 17 at the start of the month to 36 on 31 Aug (41 on 12 Sept). The potential effect of the newly identified variant BA.2.86 will continue to be monitored. This increase has been offset by a reduction in Anxiety, Stress & Depression illnesses, from last month's high (-114 fte days lost), and a reduction in absence due to Back Problems (-135 fte days lost). Annual sickness continued to reduce by -0.1% to 5.2%, as the effect of Covid sickness is still less marked than for this time last year.

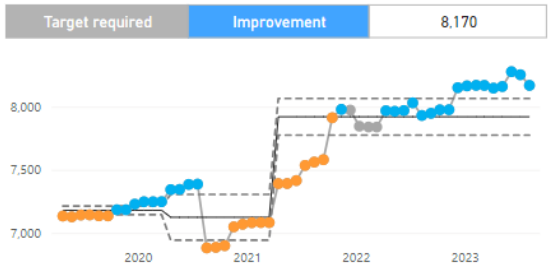
The monthly training rate reduced by 0.8% to 88.7%, potentially reflecting the effect of the industrial action in Aug. Compliance remains lowest for Information Governance at 84.8% (-1.1%), Fire Safety at 85.9% (-1.4%) and Mental Capacity Act & Deprivation of Liberties training at 86.1% (-0.1%). Medical & Dental compliance remains the lowest at 68.1% overall.

The appraisal rate also continues to improve by a further 1.1% to 82.6%, again the highest rate in the last four years and is the eighth consecutive monthly increase. Scientific & Technical staff still have the lowest compliance rate at 76.5%, though this is an improvement of 7.3% on last month, followed by Healthcare Scientists at 76.7% (+4.0%) and Allied Health Professionals at 77.1% (-2.9%). Registered Nursing & Midwifery compliance was 81.5% (+1.6%).

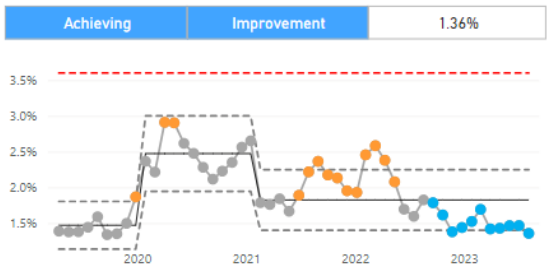
Our People Core Metrics

East Sussex Healthcare NHS Trust

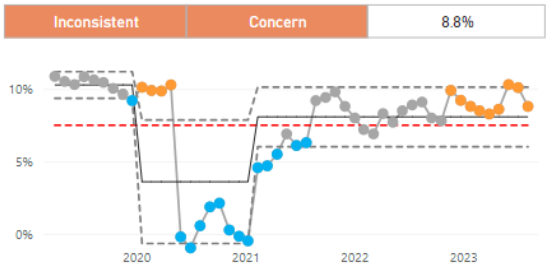
Establishment (WTE) All: Total, Our People



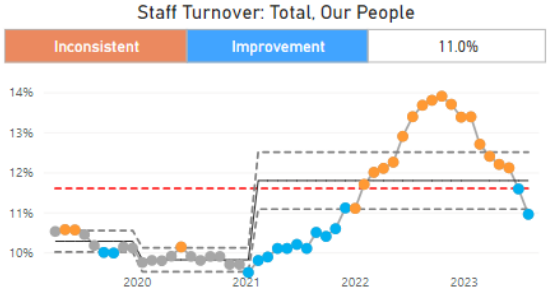
Agency Rate: Total, Our People



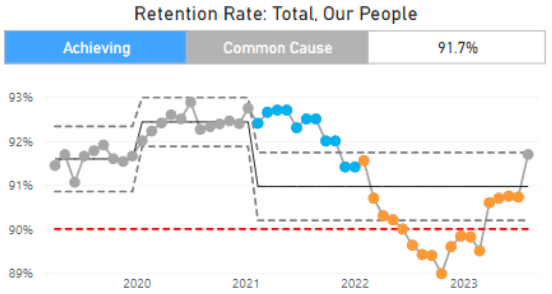
Vacancy Rate: Total, Our People



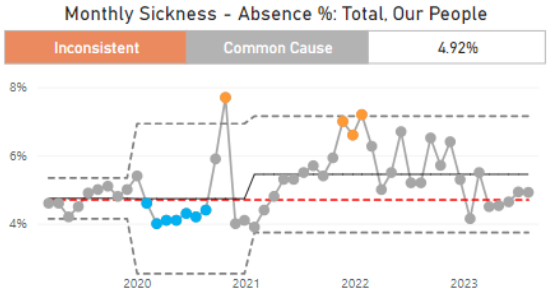
Staff Turnover: Total, Our People



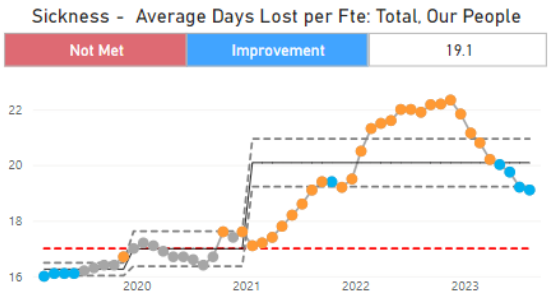
Retention Rate: Total, Our People



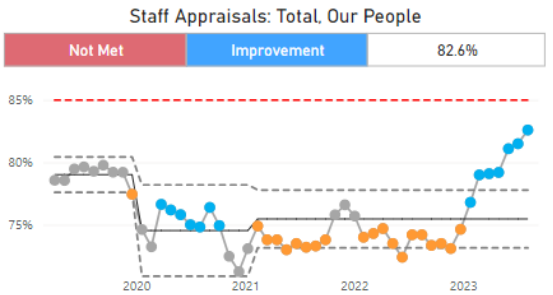
Monthly Sickness - Absence %: Total, Our People



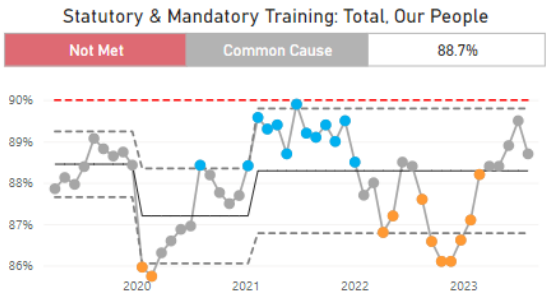
Sickness - Average Days Lost per Fte: Total, Our People



Staff Appraisals: Total, Our People



Statutory & Mandatory Training: Total, Our People



Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Turnover & Retention	**Reduction of 0.6% to 11.0**% represents 9 month downward trend from high of 13.9% in Nov 22. ICB target of 11.6% exceeded. Staff were more cautious about changing jobs during the pandemic, leading to a pent up surge in leavers immediately after restrictions were lifted. These increases continue to work their way out of the figures with turnover returning to pre pandemic levels.	A retention stakeholder group focusing on the experiences of internationally recruited (IR) colleagues has been convened to respond to feedback from the recent retention survey shared with our IR colleagues. An immediate improvement has been the reintroduction of a face to face induction for new IR colleagues which happened this month and was very well received. A paper outlining proposed changes to the entire exit process has been presented to HRSLM with an aim to improve the quality and range of data from colleagues either leaving or moving within the organisation. The intention is to not only identify colleagues who could be retained within the Trust but to promote a positive exit experience for those who do decide to leave, in order to improve the reputation of ESHT as an employer of choice
Vacancy Rate	**Vacancy rate reduced by 1.3% to 8.8%** (712.5 fte vacancies). This is due to a combination of successful recruitment and the fact that Cost Improvement Programme (CIP) expectations increased in Aug, which reduced the fte budget by a further 98 ftes. These CIP adjustments are linked to length of stay.	Successful onboarding of Junior Drs completed and successfully recruited to identified gaps. Some success with difficult to recruit medical posts e.g. Consultants Acute Medicine/Intensive Care/Genitourinary and HIV/Microbiology Working in partnership with local DWP to promote posts and an exciting new venture with the Princes Trust. They are offering 3 day virtual training for young people who may not have worked before, covering basic admin skills and a New to Care promotion. We have produced an advert for them to apply immediately after the course ends and will support successful applicants into employment New to Care assessment centres, 2 per month. Pre assessed candidates are invited to a 2 hour event with presentations by Pastoral Nurse for New to Care and Education followed by group exercise to test communication skills and team building skills & 1-1 competency based interviews. So far, we have recruited 35 candidates TWS admin open days have resulted in over 30 recruits.

Our People | Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Sickness	**Monthly sickness was unchanged at 4.9%** but annual sickness continued to reduce by 0.1% to 5.2%. This is because the monthly rate was lower than for the corresponding month last year, when it was 5.2%. The annual rate has continued to fall from a high of 6.1% in Dec 22 as we recover from the effects of the pandemic. As a result, a**verage sickness days per fte continue to fall, down 0.1 this month to 19.1 from a high of 22.3 in Dec 22**. This is the lowest level since Oct 21 **Chest & Respiratory Anxiety/Stress/Depression illnesses increased this month** up by 243 fte days lost to 1,074.	It is noted that there has been an increase in Covid absence, with numbers of staff off absent increasing from the mid teens at the start of the month to the mid thirties by the end of the month. Anxiety, Stress & Depression remains the highest identified cause of absence though has reduced by 114 fte days lost from last month's high. Where there are a number of Anxiety & Stress cases in one area, HR and Managers will review to ensure there are no themes that are work related. All staff continue to be supported appropriately by Wellbeing, and HR. In addition some Divisions hold regular meetings with staff representatives to highlight wellbeing concerns or hold monthly drop-in sessions to provide a forum to discuss issues, this has also helped with staff wellbeing.
Statutory & Mandatory Training	**Trust compliance has reduced by 0.8% to 88.7%** and is reflective of the fact that August is the peak holiday period. It is anticipated that there will be an improvement during September and October however there are two significant joint days of Industrial Action during these months.	Integrated Education is continuing to work with Divisional Colleagues and HR Business Partners, as well as actively contacting individual colleagues to complete modules and improve the rates. The main focus for the next 4 weeks will be on Medicine division across a range of sub specialities and particularly medical staff in Medicine.
Appraisal	**Compliance continues to increase, up by a further 1.1% to 82.6%.** This is the highest the rate has been in the last four years, yet work continues to meet the target of 85%.	Education continue to monitor appraisal rates and offer support to areas of low compliance, the focus will be centred on Medicine Division and also some of the smaller teams where compliance is low but numbers required to reach 100% will also be manageable to achieve.

East Sussex Healthcare NHS Trust

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

Access and Responsiveness| Executive Summary

East Sussex Healthcare NHS Trust

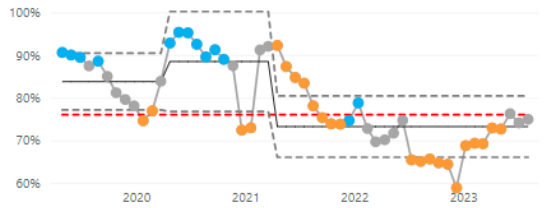
	Positives	Challenges & Risks	Author
Responsive	**Urgent Community Response (UCR)** The UCR standard of 70% has been consistently achieved year to date, with 76% of patients seen within the 2-hour response window in August. **Cancer** The volume of patients on the Cancer PTL backlog (patients >62days) continues to be both below trajectory and below the national target backlog of 6.4%. **Elective waiting list:** The Trust has continued to reduce the number of patients who have waited over 78 weeks during August and are expected to report 0 in September, in line with trajectory. **Community Paediatric Wait times** Although community paediatrics remains an area of focus there has been a significant decrease in the volume of longest waiters as a result of recovery plans, with a 532 reduction since September 2022.	**4 Hour Emergency Access Clinical Standard** The Trust saw a small increase of 1% in August, achieving 75.1% against the Emergency Access Clinical standard, compared to 74.1% in July . The Trust continues to focus on reducing the length of time it takes to assess and appropriately treat patients at our front door in order to sustainably deliver the 76% (national standard). **Elective waiting list:** The number of patients waiting more than 52 weeks for elective treatment continues to be an area of focus. Although comfortably below trajectory (delivering 260 against a trajectory of 280) for >65 weeks the Trust reported 3 greater than 78-week breaches in month. The Trust is on target to deliver 0 78 week waits from September. **Cancer** The Trust has reported 73.6% for the Faster Diagnosis Standard (FDS) in July. The Trust is not anticipating recovery of the standard in August. There is a focus on reducing the waiting time to first appointment and on reducing diagnostic delays to support improvements in the delivery of the FDS standard.	 **Charlotte O'Brien** Chief Operating Officer
Actions:	• Delivering on the agreed actions from the Elective Deep Dive assurance pack to support achieving zero 65 week waits by March 2024. The final assurance pack (which includes trust self-certification) has been agreed in line with Trust governance, signed off by CEO and submitted to NHSE. This will be included in papers going to Trust Board in October. • Embedding actions from the Urgent Care Improvement Plan to support sustainable delivery of the 76% Emergency Access Clinical Standard. Winter planning commenced. • Delivering on elective recovery and a paper, that will be going to Board in October, and has been agreed with CEO and COO has been submitted to NHSE, after regional review, outlining the measures the Trust is taking to take to deliver the elective recovery programme (ensuring zero 65 week waits by March 2023). • Focus on 28 day FDS achievement across all departments, reducing the 62 day backlog and eliminating 104 day waits.		

Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

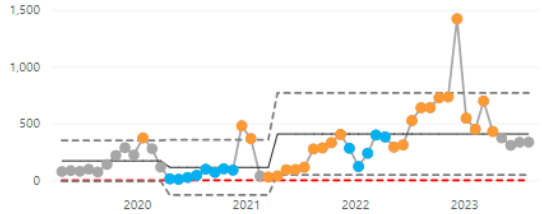
4 hour standard: Total, Our Performance

Inconsistent	Common Cause	74.9%



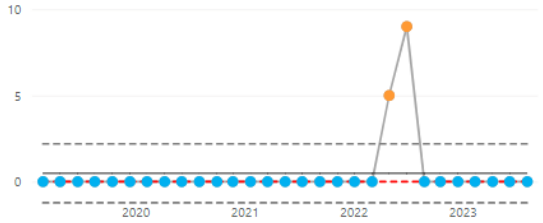
A&E > 12 hours from arrival to discharge: Total, Our Perfor...

Not Met	Common Cause	335



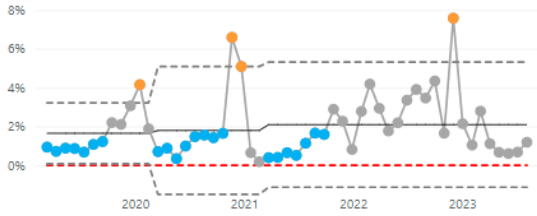
A&E waits over 12 hours from DTA: Total, Our Performance

Inconsistent	Improvement	0



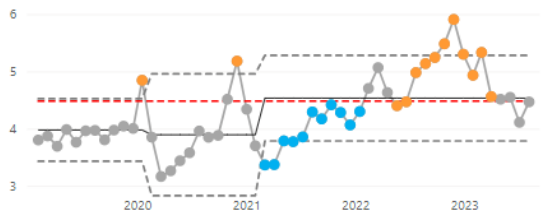
Conveyance handover >60 mins: Total, Our Performance

Inconsistent	Common Cause	1.19%



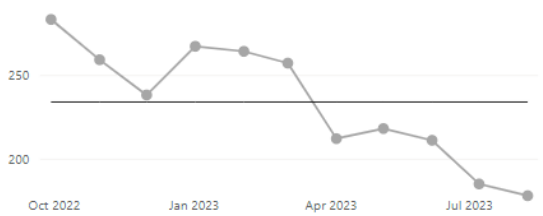
Non Elective Length of Stay: Total, Our Performance

Inconsistent	Common Cause	4.47



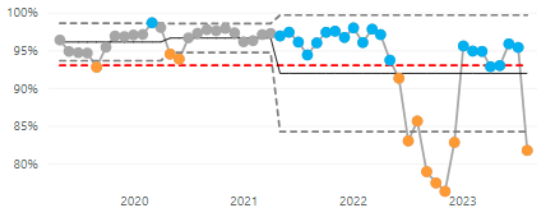
Average daily NCTR: Total, Our Performance

Target required	Empty	178



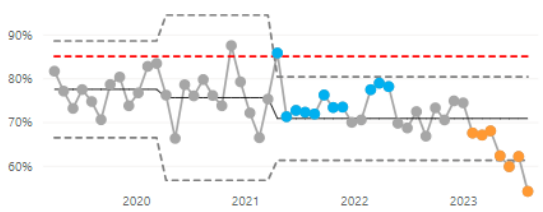
Cancer 2WW: Total, Our Performance

Inconsistent	Concern	81.7%



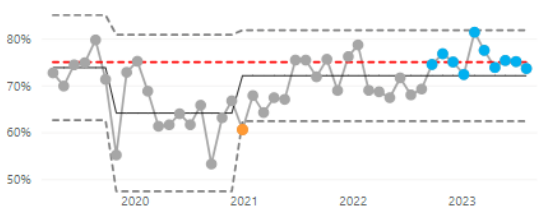
Cancer 62 Day: Total, Our Performance

Not Met	Concern	54.2%



28 Day General FDS: Total, Our Performance

Inconsistent	Improvement	73.6%

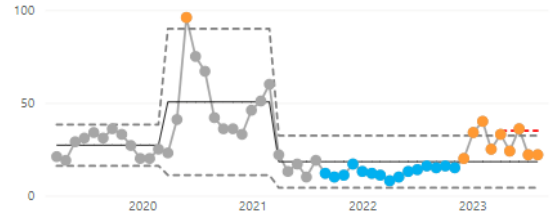


Access and Responsiveness Core Metrics

East Sussex Healthcare NHS Trust

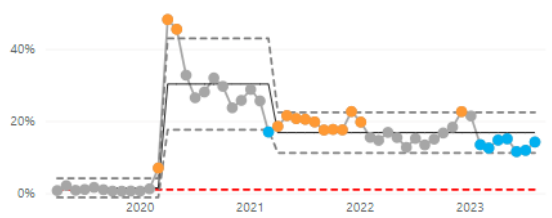
104 day Backlog: Total, Our Performance

Achieving	Concern	22



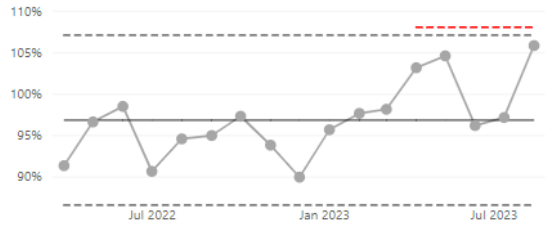
Diagnostic <6 weeks: Total, Our Performance

Not Met	Improvement	14.2%



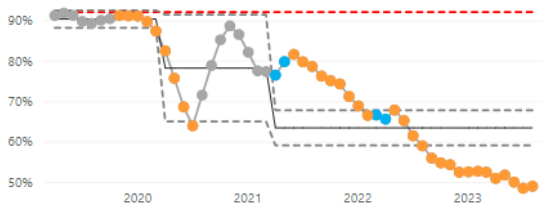
Elective Activity (ELIP,DC,OPFA, OPFUP Proc): Total, Our Perf...

Not Met	Common Cause	106%



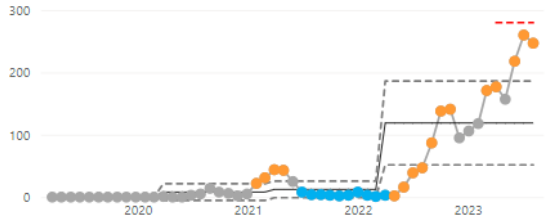
RTT under 18 weeks: Total, Our Performance

Not Met	Concern	48.9%



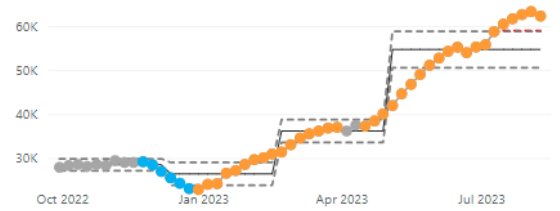
RTT 65 week wait: Total, Our Performance

Achieving	Concern	247



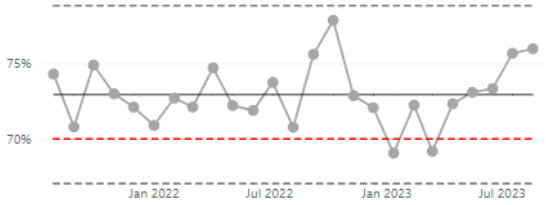
RTT Total Waiting List Size: Total, Our Performance

Achieving	Concern	62291



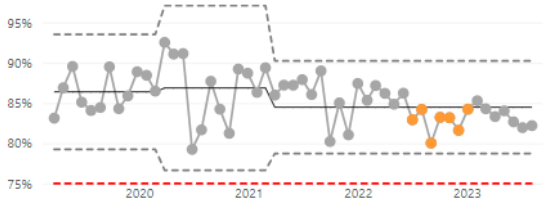
Urgent Community Response within 2 hours: Total, Our Perf...

Inconsistent	Common Cause	76.0%



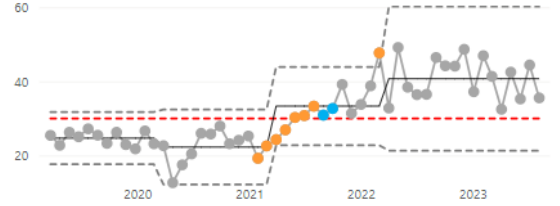
CHIC wait times < 13 weeks: Total, Our Performance

Achieving	Common Cause	82.2%



Intermediate Care Length of Stay: Total, Our Performance

Inconsistent	Common Cause	35.6



Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Emergency Access Clinical Standard	76% patients should be seen and discharged, treated or admitted within 4 hours. The Trust achieved 75.1% against the standard in August 2023.	• Reducing time to initial assessment • Ongoing focus to support a reduction in non-admitted breaches. • Protecting CDU, increasing **s**treaming to Medical, Surgical and Women and Children SDEC areas • Review of medical rotas to reflect peaks in attendances and to reduce the number of non-admitted and admitted breaches overnight • Clinical leadership training to support overnight performance
Patients in department over 12 hours from arrival to discharge	There was no significant change in August for the number of patients waiting over 12 hours from arrival to discharge with 334 patients.	• Work with system partners around timely support for patients awaiting mental health review / assessment and or mental health bed • Ongoing focus on maintaining reductions in LOS and the number of NCTR patients in both the acute and community bed base
Conveyance Handover >60 mins	The percentage of conveyed patients handed over >60 mins has increased from 22 out of 3238 in July to 40 out of 3366 in August.	• A task and finish group has been established to agree key actions that will improve the efficiency of the handover process and will include reviewing the Rapid Assessment and Triage model.
Non elective Length of Stay	August has seen the Trusts non-elective Length of Stay (LoS) increase from an average of 4.11 days in July to 4.47 days in August. This is against a target of 4.48 days. There are a number of factors that have contributed to this, such as the continued Industrial Action, Annual Leave throughout the summer months and the recent increase in Covid (both patients and staff) during August.	• Divisional teams undertaking long length of stay reviews for patients over 7, 14 and 21 days. • Divisional LOS reviews weekly and escalated to the Trust Transfer of Care Hub (TOCH). Weekly CNO meetings with the Head of Discharge around complex cases and will link in with CMO as required. • Criteria to Discharge Pilot started 2 wards (each site): 2 wards each site have been agreed. Utilising ECIST guidance and good practice. Heads of Nursing and Matron support from Medicine and Urgent Care Divisions • Establishment of an Integrated Transfer of Care Hub ahead of Winter, with an increase of Discharge nurses and co-ordinators to enable ward discharge support. • Over 21 days LOS – Only 6 patients over 100 days. 4 are Discharge Ready and 2 are meet the criteria to reside.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
Elective Activity	Delivery of 108% activity on the 2019/20 baseline is a continued areas of focus. Industrial action continues to impact activity. First Outpatient Appointment activity continues to exceed 108%, and there are plans in place to increase admitted activity (both day case and Elective inpatients).	• Outpatient productivity programme underway • Review of pre-assessment procedures to support theatre utilisation. • Continued and improved utilisation of the Care Coordination Service to support more efficient waiting list management and improve utilisation. • Review of counting and coding to ensure accurate capture of activity.
Cancer	The number of patients waiting more than 62 days on a Cancer pathway was 134 patients (versus a trajectory of 190) as at the end of August. This equates to 6.3% of the total PTL, against a national target backlog of 6.4% and the national average currently at 9.0%. The Trust reported 39 >104 waits at the end of August against a trajectory of 33. The Cancer Waiting Time Standards were all challenged in July (2ww 81.7%, FDS 73.6% and 62 Day 54.2%.). This was partly related to high number of referrals received in June creating pressure in all phases of the patient pathway and industrial action resulting a loss of activity. The Trust continues to receive high number of suspected Cancer referrals with 2719 received in June, 2591 in July and 2670 in August, an overall 10% increase compared the same months in 2022.	• Twice weekly PTLs in place to focus on reducing the number of patients in the >62 day backlog and to expedite patient pathways. • PTLs include 28 day FDS reviews to ensure timely patient communication. • Supporting plans including working with other providers to support the treatment of patients who have been waiting >104 days. • Weekly focus on patients waiting >104 days and patients approaching >104 days. • Patient Information leaflet updated and approved and to be included on Patient Knows Best for all 2ww referrals to help support all pathways. • Development of plans to reduce first seen/contact to 7 days to support to support improvement and achievement of 28 FDS. • Plans to review capacity and demand for first seen/contact and BBN in Divisions.
Diagnostic DMO1	The Trust delivered 85.8% against the 95% DMO1 standard in July. This is a 2% reduction from July. Capacity was affected by a combination of equipment failure (CT and MRI at Conquest), staffing challenges (industrial action, annual leave). Improvement in endoscopy and NOUS continued. Areas that remain under pressure are Cardiac Echo, Audiology and MRI.	• Insourcing continues in both Endoscopy and Cardiac Echocardiography to increase capacity. • Further use of Bexhill CDC to increase Echo capacity • Additional MRI sessions provided by MIP and paid through CDC at Conquest. • Review of booking arrangements to ensure all lists are fully utilised. • Comprehensive review of demand and capacity plans for Cardiology to support recovery of the standard and to ensure that surveillance patients are booked appropriately.

Access and Responsiveness| Areas of Focus

East Sussex Healthcare NHS Trust

Title	Summary	Actions
RTT Total Waiting List Size	The volume of patients on a referral-to-treatment (RTT) pathway continues to increase when compared to 2019/20 across the majority of specialities. Targeted technical validation is currently underway for pathways in the 65-week risk cohort, with validation of all pathways over 12 weeks due to commence in October 2024.	• Review of capacity to support a reduction in FOPA waiting times. • Continued use of insourcing in Endoscopy (supporting both Gastroenterology and General Surgery RTT pathways) and Thoracic Medicine. • Plans to commence insourcing to support a reduction in waiting times for other specialities including Urology and Uro-Gynaecology • Launch of a validation and pathway management review to ensure a more accurate PTL, and support the development of modernised pathways, training and better use of digital technology. • ESHT will be an early adopter of PIDMAS (Patient Initiated Mutual Aid), launching on 10.10.23, ahead of the National launch on 31.10.23
RTT long wait position (78 and 65 weeks)	Whilst the Trust is comfortably below trajectory for 65 week waits, ensuring zero 65 week waits by March 2024 remains challenging. The Trust reported 3 patients who waited >78 weeks in August, against a trajectory of 7. The Trust is expected to report 0 78-week waits in September 2023.	• Services are currently working through plans, as part of a National ambition, for all patients in the 65 week risk cohort for 23/24 to have a FOPA. This will support reducing the long wait position. • Weekly COO led review of all >78 week risks • Daily monitoring of the longest waiting patients to ensure pathways are progressing. • Utilisation of SPH where possible to support long wait position. • Exploring mutual aid, both via the ICS and the Digital Mutual Aid System, including PIDMAS.
Community Waiting Times	Paediatrics continues to be the Trust's most challenged community service in terms of waiting times. Demand continues to outstrip capacity. This is coupled with a follow-up backlog that continues to increase. Outsourcing to Psicon continues and this has supported a decrease in the waiting list for New appointments over the last 12 months (from 2724 to 2455). The number of children waiting over 3 years has also decreased from 187 in Sept 22 to 30 in Aug 23. The number of children waiting over 18m has reduced from 794 in Sept 22 to 262 in Aug 23. This is a 67% reduction in the longest waiters.	• Outsourcing to Psicon ongoing • Ongoing recruitment initiatives to support the service. • Pathway redesign work continues for Sleep/melatonin, supported by the ICB. • Ongoing validation of the community waiting list for NEW and FU patients. • Work continues with system partners to develop a sustainable plan to address the growing backlog.

East Sussex Healthcare NHS Trust

Financial Control and Capital Development

Our Income and Expenditure

Our Elective Recovery

Our Run Rate

Efficiency

Capital

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

Finance| Executive Summary

East Sussex Healthcare NHS Trust

	Positives	Challenges & Risks	Author
Responsive	• In month deficit deteriorated from £666k to £775k • ERF improved from £6,959k to £7,623k • Efficiency deteriorated from £2,376k to 2,226k • Capital spend is £1,070k behind plan	Risk analysis shows a potential range from £16.0m deficit position (improved) for the downside to a £6.4m deficit position (improved) against the base case. This is however predicated on a number of assumptions – particularly the improved run rate for CIP delivery and recovery of the elective position. Main risks are: delivery of efficiency plan, elective activity, non-pay inflation and pay award funding.	 **Damian Reid** Chief Financial Officer

Overview:

I&E: For M5 the Trust reported a £0.8m adverse position against a breakeven plan, YTD this is £2.2m adverse. This reflects a lower-than-expected performance against elective activity targets of £0.5m across M1-5 (improved from M4), plus pay pressures across UC/Med/DAS caused by temporary staffing. Industrial action cover costs caused a pressure of £0.4m in month against pay. The under-performed against its plan by £0.3m in month and £2.2m YTD based on initial data. As with M4 we have been asked not to show clawback for M5 reporting which is a £1.4m benefit to the position.

Run rate: The run rate improved by £0.1m to a £1.1m deficit in month. To Breakeven run rate needs to reduce by £1.3m per month, a straight-line forecast would therefore suggest a forecast deficit of £11.3m.

Efficiency: The Divisions have delivered £8.9m efficiency YTD against the plan of £10.4m resulting in £1.5m adverse position. This is largely associated with the ERF delivery offset by vacancy slippage and CNST maternity rebate. The RAG is amber due to 48% of the YTD actual being non-recurrent and there is slippage in ERF delivery of £2.5m, which is being offset by vacancy slippage, however, there has been a significant increase in temporary workforce spending in the month.

Capital: Total plan for 2023/24 is £65.6m. Capital spend is behind plan at M5 by £1.1m. However, the plan is back phased with 89% still to deliver. Following revision of the capital plan last month the current capital forecast is to achieve plan.

Income and Expenditure

East Sussex Healthcare NHS Trust

Finance

Trust I&E position

	Month (£'000)			YTD (£'000)		
	Plan	Act	Var	Plan	Act	Var
Income						
Contract income	44,644	44,628	*(16)*	225,151	225,429	*278*
Divisional	9,369	8,952	*(417)*	38,084	37,186	*(898)*
ERF	1,297	1,137	*(160)*	6,486	5,687	*(799)*
Covid - variable	20	24	*4*	98	103	*4*
Total Income	**55,329**	**54,741**	***(588)***	**269,819**	**268,404**	***(1,415)***
Operating Expense						
Pay						
Permanent	(37,315)	(33,156)	*4,158*	(179,346)	(159,785)	*19,560*
Temporary	(487)	(5,142)	*(4,655)*	(2,651)	(23,154)	*(20,503)*
Total pay	**(37,802)**	**(38,299)**	***(497)***	**(181,997)**	**(182,940)**	***(943)***
Non-pay						
Drugs	(1,116)	(1,329)	*(213)*	(5,581)	(6,865)	*(1,284)*
TEDD	(3,470)	(3,678)	*(209)*	(17,370)	(17,943)	*(573)*
Clinical supplies	(4,163)	(4,292)	*(129)*	(21,090)	(20,690)	*401*
Purchased services	(1,141)	(1,096)	*45*	(5,694)	(5,932)	*(239)*
Finance costs	(2,504)	(2,437)	*67*	(12,520)	(12,512)	*9*
Other	(5,119)	(4,391)	*728*	(25,453)	(23,526)	*1,927*
Total non-pay	**(17,513)**	**(17,224)**	***289***	**(87,708)**	**(87,468)**	***241***
Covid exp - block	-	(6)	*(6)*	-	(77)	*(77)*
Covid exp - variable	(17)	(22)	*(5)*	(83)	(94)	*(11)*
Total Expense	**(55,332)**	**(55,551)**	***(219)***	**(269,788)**	**(270,578)**	***(790)***
Surplus/(Deficit)	**(3)**	**(809)**	***(807)***	**31**	**(2,174)**	***(2,205)***
Memo:						
WTE (worked)	8,167	8,026	*(141)*	8,262	7,921	*(341)*

I&E position

- In Month 5 the Trust is reporting an adverse position of (£0.8m) against a breakeven plan. YTD the Trust is (£2.2m) adverse versus a breakeven plan. Income is underachieved mainly due to ERF and pay award funding, pay pressures continue on temp staffing in Med/UC/DAS aligned with Industrial Action cover costs, with pressures on non pay being supported by LA funding.

Income

- The position is adverse by (£1.4m) ytd, the main drivers being;
  - Lower than planned elective activity against target by £0.8m (partially offset by lower associated costs), this is after non-application of clawback, underlying position is £2.2m shortfall.
  - Note that the Doctors' strike days would have contributed in part to this in April (15% of working days impacted) and June (16%) and July (16% Junior plus Consultant days).
  - Pay Award income shortfall (offsetting pay variance) of £0.7m for M1-5.

Expense

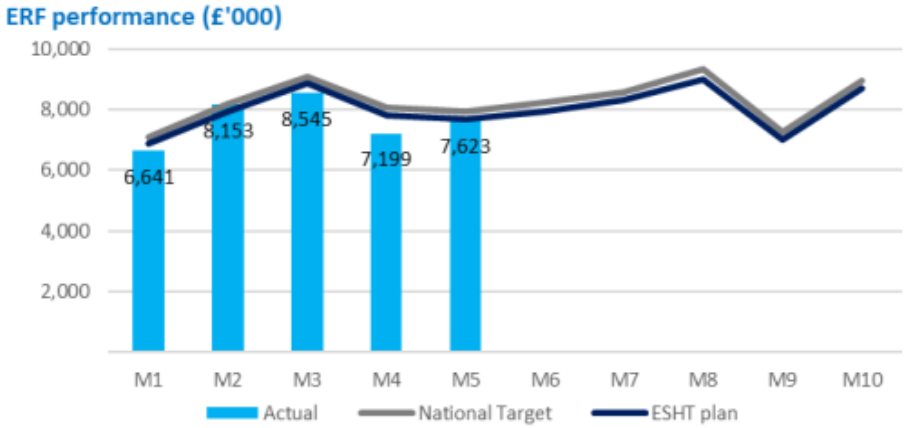
- The Trust has a (£0.9m) adverse pay position YTD caused by temporary and premium staffing costs in Urgent Care and DAS plus Industrial Action cover costs of £0.4m in month 5. This is partly offset by CDC and VW vacancies.
- M5 Pay overspent by (£0.5m) due to IA covers costs of £0.4m, Theatres activity and partial catch up in Month of £0.2m, partly offset by vacancies in CDC/VW. Pay Award for 23-24 was processed in month 3. An overall shortfall of commissioner income of £2m FYE, but currently offset by vacancy level in the Trust as at M5.
- Use of temporary staff at higher unit cost partially offset by WTE usage below budget but still overspent.
- Month 5 Non pay was £0.3m underspent of which continuing pressures against Theatres, CORE and Medicine were offset by LA support of £0.5m. Overall underspend M1-5 of £0.1m is supported by LA support of £1.7m, so net non pay is actually pressured ytd.

ERF - Trust

East Sussex Healthcare NHS Trust

ERF performance

- The under-performed against its plan by £0.3m in month and £2.2m YTD based on initial data. As with M4 we have been asked not to show clawback for M5 reporting which is a £2.2m benefit to the position.
- It should be noted that there is a two month lag on freeze data and we have seen a material improvement in the M1-3 position now in M4 with around £0.6m additional activity added. If this replicates (reasons are being investigated) then the variance may be materially lower – however please note that because of clawback not being reported this would not impact the trust bottom line.
- T&O represents 65% of the underperformance, cardiology ad ENT are also exhibiting material adverse variance.

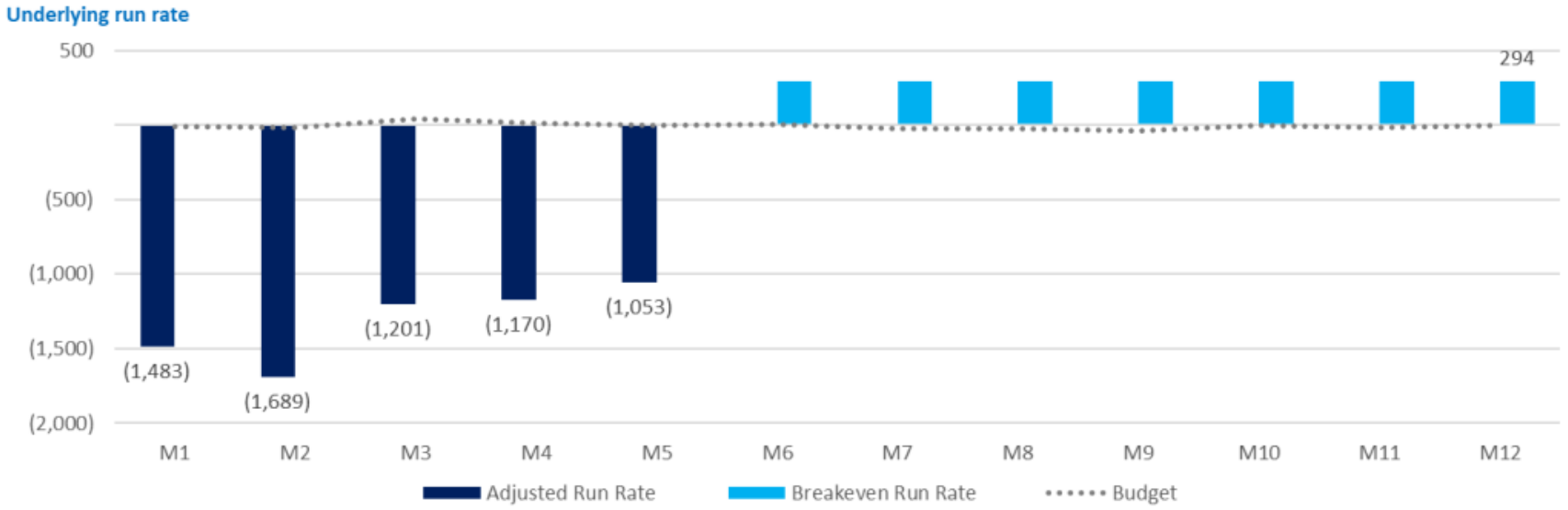


	In Month				YTD			
	Plan	Actual	Var		Plan	Actual	Var	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Daycase	2,735	2,823	89	3.2%	14,403	13,651	(752)	(5.2%)
Elective	2,062	1,523	(539)	(26.1%)	10,490	8,340	(2,150)	(20.5%)
New OP	1,457	1,480	24	1.6%	7,422	7,214	(208)	(2.8%)
OP Procedures	1,599	1,612	14	0.9%	7,718	7,989	271	3.5%
Ward Attenders	73	147	75	103.0%	333	782	449	134.6%
ERS	-	37	37		-	185	185	
Internal plan	**7,924**	**7,623**	**(301)**	**(3.8%)**	**40,366**	**38,161**	**(2,205)**	**(5.5%)**

	In Month			YTD		
	Plan	Actual	Var	Plan	Actual	Var
	£'000	£'000	£'000	£'000	£'000	£'000
Cardiology Service	662	512	(150)	3,276	2,529	(747)
Respiratory Medicine Service	195	92	(103)	885	655	(230)
Urology Service	826	750	(76)	3,793	3,782	(10)
Interventional Radiology Service	71	-	(71)	330	113	(217)
Clinical Haematology Service	256	199	(56)	1,239	1,057	(182)
Vascular Surgery Service	86	31	(54)	260	191	(69)
Gastroenterology Service	518	475	(43)	2,534	2,230	(304)
Maxillofacial Surgery Service	168	133	(35)	802	666	(136)
Trauma and Orthopaedic Service	1,244	1,217	(27)	7,715	6,291	(1,424)
Gynaecology Service	548	528	(20)	2,631	2,546	(86)
Respiratory Physiology Service	60	41	(19)	233	137	(96)
Neurology Service	134	116	(18)	537	528	(9)
Orthodontic Service	47	34	(13)	234	128	(106)
General Internal Medicine Service	23	10	(12)	98	83	(16)
General Surgery Service	907	894	(12)	4,320	4,366	46
Paediatric Surgery Service	19	8	(11)	47	42	(6)
Transient Ischaemic Attack Service	48	39	(9)	223	188	(35)
Chemical Pathology Service	14	7	(7)	60	53	(7)
Stroke Medicine Service	8	3	(5)	35	17	(18)
Breast Surgery Service	194	191	(4)	1,013	951	(62)
Clinical Oncology Service	106	105	(1)	560	571	11
Palliative Medicine Service	0	0	(0)	1	1	0
Hepatology Service	-	0	0	-	1	1
Anaesthetic Service	11	11	1	52	49	(3)
Paediatric Epilepsy Service	1	3	2	8	18	10
Paediatric Dermatology Service	-	5	5	-	27	27
Paediatric Trauma and Orthopaedi	-	7	7	-	27	27
Diabetes Service	7	15	8	41	63	22
Ear Nose and Throat Service	306	314	8	1,873	1,476	(397)
Paediatric Service	128	137	8	678	781	104
Elderly Medicine Service	26	37	10	137	108	(29)
Rheumatology Service	217	228	11	1,086	990	(96)
BCSP	28	40	12	83	186	103
Acute Internal Medicine Service	-	59	59	-	249	249
Dermatology Service	144	220	76	651	1,038	387
Ophthalmology Service	879	1,117	238	4,704	5,766	1,062
Total	7,924	7,623	(301)	40,366	38,161	(2,205)

Run Rate

East Sussex Healthcare NHS Trust



Methodology

- Adjustments have been made to show underlying run rate. These account for one off/non-recurrent items unrelated to the activities in month (e.g. credit note received from prior year) and for catch up where cost or income relating to multiple periods in reflected in one months ledger.
- One-off items - whilst removed from the run rate - will impact the required run rate to achieve breakeven and this has been accounted for.

Run rate

- The graphs shows a run rate of (£1.1m). The analysis has removed net £4.5m of one-off items which whilst don't impact the run rate will still impact the in year financial position. Driven by:
  - £1.4m of ERF non-clawback, depending on further guidance received this may be considered a non-adjusting item (as a result of compensating for strike actions);
  - £1.5m of contract income phasing which will reverse over the course of the year. Contract income has been phased to deliver a balanced plan each month meaning as a result of CIP phasing, additional amounts are recognised early in the year compared to a flat line profile.
- M5 underlying run rate is a (£1.1m deficit), this is in line with the prior month (£1.2m deficit). Taking the current average months run rate and extrapolating gives an overall deficit of £11.3m
- 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-24, currently around a **£1.3m** reduction per month compared to M5.

Divisional Summary

East Sussex Healthcare NHS Trust

Division	Variance to budget - M5					YTD overall Variance	Underlying Run Rate			
	Income	*Pay*	*Non pay*	Overall Variance	WTE		**Jun**	Jul	Aug	
	£'000	*£'000*	*£'000*	£'000	WTE	£'000	£'000	£'000	£'000	
CHIC	*(77)*	*83*	*(11)*	(5)	(30)	*(307)*	(4,199)	(4,131)	(4,109)	p
Core Services	*(65)*	*223*	*(201)*	(43)	(54)	*(462)*	(6,521)	(6,557)	(6,487)	p
Estates & Facilities	*11*	*(76)*	*131*	67	+2	*217*	(3,140)	(3,110)	(3,118)	q
Medicine	*62*	*(408)*	*(97)*	(443)	+9	*(2,082)*	(4,089)	(3,984)	(3,642)	p
DAS	*437*	*(608)*	*(131)*	(302)	+42	*(2,953)*	(3,512)	(4,109)	(3,727)	p
Urgent Care	*68*	*(454)*	*(75)*	(461)	+36	*(1,365)*	(4,725)	(4,817)	(4,998)	q
WCSH	*(2)*	*57*	*(93)*	(38)	(52)	*133*	(2,292)	(2,474)	(2,561)	q
Corporate Services	*(193)*	*283*	*280*	369	(39)	*1,692*	(5,410)	(5,118)	(5,496)	q
SPH	*(103)*	*3*	*(68)*	(168)	(13)	*(117)*	186	(178)	(64)	p
Central/Trust wide	*(724)*	*402*	*541*	218	(256)	*3,040*	32,500	33,309	33,148	q
ESHT	***(588)***	***(497)***	***278***	**(807)**	(354)	**(2,205)**	**(1,201)**	**(1,170)**	**(1,053)**	p

- **CHIC** – headroom has gradually been reducing as recruitment is catching up to investments and we have now seen in M1-5 overspends in the division for the first time in a number of years, however lowering in M5. Pay pressures due to Minerva contract supporting Urgent Community response now above budgeted levels albeit at a lower level in M5. VW position now showing in Pay and Income.
- **Core Services** – Underspend on pay driven by below budget spend on Pathology cost and CDC underspend, this is matched in income. Non pay pressures M5 attributed to catch up and activity aligned to outsourcing in Radiology and out of date drug stock.
- **E&F** – Overspend driven on pay by Covid legacy costs (eg housekeeping) which are no longer funded. Utilities inflation/usage pressure on non pay reversed M5 due to actual consumption/tariff lower than forecast for 23-24. Tariff element £0.2m underspent ytd.
- **Medicine** – Overspend driven Escalation beds above funded ytd, this is exacerbated by significant service overspends in Gastro, haematology and Cardiology. Supernumerary staffing and premium staffing continues to be a driver of these variances. Non pay pressures in month 5 attributed to CIP LoS scheme.
- **DAS** – Electivity activity lower than plan ytd with under performance of £1.1m with improvement in T&O in the month. Urology and General & Breast pressures in pay due to premium costs. DAS is also using more staff than budget in some areas (Urology & T&O above establishment but no helped by Junior Doctor rotations). Excluding CIP target the division is overall below establishment (also true for Urgent Care). DAS overall is the worst performing division with Urgent Care and Medicine second and third on the list respectively.
- **UC** – Premium costs for Medical staffing continuing to cause pressures alongside supernumerary staffing.
- **Corporate services** – underspend driven by external training funding, some of which of the costs will be in the divisions, this is reconciled later in the year when schedules received from HEE.
- **SPH** – Actual SPH income used for M1-5 resulting in lower performance than forecast ytd. Issues with compucare however still to be sorted.

Efficiency

East Sussex Healthcare NHS Trust

Division	In Month			Ytd – M5			Full Year				
	Plan	Actual	Var	Plan	Actual	Var	Rec	NR	Total	Target	Gap
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Medicine	785	96	(689)	2,607	1,163	(1,444)	6,589	376	6,964	9,247	(2,283)
Urgent Care	120	(58)	(177)	322	351	29	1,385	159	1,544	1,919	(375)
DAS	768	705	(63)	3,295	1,838	(1,457)	6,132	771	6,903	9,235	(2,332)
Core Services	159	156	(3)	908	814	(94)	3,725	-	3,725	3,504	221
CHIC	52	141	89	364	748	384	177	1,426	1,603	844	759
WCSH	84	295	211	684	1,659	975	1,263	1,305	2,568	1,980	587
Estates & Facilities	146	94	(52)	758	615	(142)	186	1,313	1,500	1,697	(197)
Corporate	261	387	127	1,431	1,718	288	2,380	1,462	3,841	3,538	304
Sussex Premier Health	1	(9)	(10)	2	(17)	(19)	67	-	67	543	(476)
Total	**2,376**	**1,809**	**(568)**	**10,371**	**8,890**	**(1,480)**	**21,903**	**6,811**	**28,714**	**32,507**	**(3,793)**

Overview

- The plan has been revised to the programme plans as advised last month.
- The divisions have delivered £1.8m of efficiencies in the month, this is £0.6m adverse to the £2.4m plan.
- The in-month variance is largely due to a significant increase in temporary workforce spend as well as LoS not delivering to plan. This is offset by over-delivery of ERF as well as a slight catch up on pharmacy.
- The target for the year is £32.5m, this is made up of the original £25m target plus the stretch target of £7.5m that was needed for the system to deliver a breakeven plan. The full £32.5m has been allocated out to the Divisions based on the Programme opportunities. We are behind plan by £1.5m YTD, this is largely driven by £2.3m under-delivery on ERF (slightly lower than last month as Theatres has slightly exceeded the planned value for the month and Outpatients and Improving Patient Data Capture continue to over-deliver), this is offset by vacancy slippage and the CNST rebate (received earlier than planned).
- The current forecast has a £3.8m gap, however the risk assessed forecast is £23.7m, so the gap is higher at £8.8m, this is £0.6m reduction from last month.
- Currently 24% of the £28.7m is non-recurrent, of this £6.2m is vacancy slippage, however the proportion of non-recurrent is 48% on the year-to-date position. It is not a surprise that there will initially be a higher proportion of non-recurrent schemes whist the productivity programmes are developed, and the projects move into delivery.

Capital

East Sussex Healthcare NHS Trust

Trust Lead	Capital Scheme	In Month Plan £'000	In Month Actual £'000	In Month Variance £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	Full Year Original Plan £'000	Full Year Revised Plan £'000	Full Year Variance £'000
	Original									
DIG	Digital Programmes	164	212	48	590	990	400	3,000	3,500	500
DIG	Our Care Connected	-	-	-	-	-	-	900	900	-
	Total Digital	**164**	**212**	**48**	**590**	**990**	**400**	**3,900**	**4,400**	**500**
EME	Diagnostic Equipment	175	3	(172)	263	169	(93)	1,750	1,750	-
EME	Medical Equipment	225	52	(173)	338	91	(246)	1,750	2,250	500
	Total Medical Equipment	**400**	**55**	**(345)**	**600**	**261**	**(339)**	**3,500**	**4,000**	**500**
EST	Fire	48	85	37	144	454	310	2,000	1,600	(400)
EST	Backlog	212	59	(153)	637	1,295	658	5,300	10,575	5,275
EST	Cath Lab Replacement	413	302	(111)	1,238	1,392	155	1,250	1,650	400
EST	Cardiology Business Case	300	21	(279)	800	23	(777)	4,200	2,000	(2,200)
EST	Clinical - Prior Year	-	(2)	(2)	-	66	66	-	-	-
EST	Decant Ward	15	131	116	25	408	383	6,000	500	(5,500)
EST	Discharge Lounge	75	34	(41)	325	395	70	-	500	500
EST	Elective Hub	373	22	(350)	522	112	(410)	7,451	7,451	-
EST	Friston Paeds	75	3	(72)	375	128	(247)	1,100	375	(725)
EST	ICU adaptations Conq	13	0	(12)	28	0	(27)	500	50	(450)
EST	Ophthalmology Business Case	300	121	(179)	800	554	(246)	1,350	2,000	650
EST	Ward Refurbishment	63	78	16	213	330	118	1,000	1,250	250
	Total Estates	**1,885**	**856**	**(1,029)**	**5,105**	**5,159**	**54**	**30,151**	**27,951**	**(2,200)**
FIN	Business Case Development	-	-	-	-	26	26	-	-	-
FIN	Divisional Small Works	40	15	(25)	200	21	(179)	500	500	-
FIN	Minor Capital	72	-	(72)	360	193	(167)	900	900	-
FIN	Planned slippage/prioritisation	(32)	-	32	(94)	-	94	(1,721)	(521)	1,200
	Total Finance	**80**	**15**	**(64)**	**466**	**239**	**(227)**	**(321)**	**879**	**1,200**
	System Capital	**2,529**	**1,138**	**(1,391)**	**6,761**	**6,649**	**(112)**	**37,230**	**37,230**	**-**
	New									
EST	Building For Our Future	85	49	(36)	424	194	(230)	1,060	1,060	-
EST/EME	Community Diagnostic Centre	250	26	(224)	750	280	(470)	1,000	1,000	-
EST	Elective Hub EDGH	448	4	(444)	627	89	(538)	10,249	8,956	(1,293)
DIG	Diagnostics Digital Capability (LIMS)	-	4	4	-	279	279	3,490	914	(2,576)
DIG	Diagnostics Digital Capability (OCS)	-	-	-	-	-	-	1,610	451	(1,159)
DIG	Diagnostics Digital Capability (Image Sharing)	-	-	-	-	-	-	-	1,000	1,000
DIG	Frontline Digitalisation (EPR)	-	-	-	-	-	-	5,300	5,300	-
EST	NHP Enabling Fees	-	-	-	-	-	-	4,734	4,734	-
EST	Endoscopy	-	-	-	-	-	-	-	5,000	5,000
	Total Additional Capital	**783**	**82**	**(701)**	**1,801**	**842**	**(959)**	**27,443**	**28,415**	**972**
	Total Capital	**3,312**	**1,220**	**(2,092)**	**8,561**	**7,491**	**(1,071)**	**64,673**	**65,645**	**972**
EST	PSDS3	-	-	-	-	2,454	2,454	165	165	-
EST	PSDS3 Income	-	-	-	-	(2,454)	(2,454)	(165)	(165)	-
	Total Grant Capital	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
FIN	Donated Expenditure	120	2	(118)	600	29	(571)	1,500	1,500	-
FIN	Donated Income	(120)	(29)	91	(600)	(29)	571	(1,500)	(1,500)	-
	Total Donated Capital	**-**	**(28)**	**(28)**	**-**	**-**	**-**	**-**	**-**	**-**
	Total Capital	**3,312**	**1,193**	**(2,119)**	**8,561**	**7,491**	**(1,071)**	**64,673**	**65,645**	**972**

Capital

- The planned capital allocation for 2023/24 is £65.6m and is made up of the core ICS allocation of £37.2m plus national programmes expected in year of £28.4m.
- The overall allocation has increased in month by £972k. Elective Care Hub and Digital Diagnostics have been revised downwards to reflect latest information (£4m) and Endoscopy Suite has been included (£5m).
- The capital expenditure incurred totals £7.5m compared to a plan of £8.6m. The current position is therefore behind plan by £1.1m. The plan is back loaded in-line with trends from previous years.
- Capital expenditure was largely driven by the following schemes:
  - Estates works of £5.2m, the main schemes being fire compartmentalisation (£454k), backlog maintenance (£1,295k), cath lab replacement (£1,392k), decant ward (£408k), discharge lounge (£395k), ophthalmology business case (£554k), and ward refurbishments (£330k).
  - Community Diagnostics Centre £280k which combines costs for both equipment and works.
  - Diagnostics Digital Capability £279k.
  - Building for Our Future £194k.
- Following the revised plan being agreed, a revised forecast needs to be worked through to assess the risk of delivery.

East Sussex Healthcare NHS Trust

Maternity Overview Report for Q1 2023/24

Purpose of the paper	This report seeks to assure the Board on our the progress being made by Maternity Services across three areas: 1. The quality and safety of perinatal services, our progress with meeting the perinatal clinical quality surveillance standards and actions to proactively identify/mitigate quality and safety risks or concerns. 2. Progress being made by ESHT Maternity services against the ESHT Maternity Transformation plan and the Saving Babies Lives version 2 Annual Report. 3. Quarter One 2023/24 progress against the Three-Year Delivery plan, in line with national recommendations.
	For Decision: ; For Assurance: x; For Information:
Sponsor/Author	Executive Director Vikki Carruth, Chief Nurse Report Author: Brenda Lynes, Director of Maternity Services
Governance overview	The three areas covered in this report have been discussed in the Women and Children's Governance and Accountability monthly meetings, IPR monthly meetings for Maternity Services and by the Quality and Safety Committee in September 2023.

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 take assurance about: 1. The quality and safety of perinatal services, our progress with meeting the perinatal clinical quality surveillance standards and actions to proactively identify/mitigate quality and safety risks/concerns. 2. The update on Q1 2023/24 progress on actions relating to the single delivery plan [1], published on 30 March 2023, which replaces the long-term plan of 2019. The Board is also asked to approve the ESHT Maternity Transformation plan and the Saving Babies Lives version 2 Annual Report, which are provided as appendices to the main Board papers.
Executive Summary	**Quality and safety of perinatal services at ESHT** As part of the Ockenden Report findings, all NHS Trusts are required to update Boards on the quality and safety aspects of their maternity services. The maternity team continues to focus on improving the workplace culture, with early successes evidenced by a considerable improvement in the vacancy rate from October 2023. The team has now achieved full compliance with the Ockenden immediate and essential actions (IEAs) and perinatal mortality data shows normal variation with no cause for concern. Complexity and acuity within our local population continues to impact our delivery of services. Workforce can still prove a challenge within maternity services during high

[1] B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk)

	activity/acuity and increasing numbers of cases where medical and social complexities means that despite staffing improvements the clinical floor can feel increasingly busy. **Overview of two annual reports** These reports are presented for approval through the Trust Board. The ESHT Maternity Transformation plan provides an overview of planned projects in line with the LMNS during the next year. The Saving Babies Lives version 2 Annual Report 2022/2023, provides an overview of the excellent educational work that is being delivered by our team. ESHT is fully compliant with this Care Bundle, which was produced to reduce perinatal mortality . **Overview of the Single Delivery plan with progress during Q1** The three-year maternity delivery plan was published by NHSE on 30 March 2023, replacing the Long-Term Delivery plan published in 2019. The four key themes from the plan are outlined with key areas highlighted where action is required. Main areas for action include. • Lack of funding to implement the full Maternal Mental Health Service Offer, which has been logged on the investment log of the ICB. • The Maternal Mental Health Service funded bereavement pathway is not fully implemented, due to workforce challenges in psychology / psychological support and increasing complexity within our local population. • Workforce gaps are impacting achievement of the Ockenden, final report implementation, safe staffing levels and Midwifery Continuity of Carer roll out, proactive recruitment continues to be a main focus • Data quality continues to be a risk, with action via the Data Quality Improvement Group addressing issues as they are identified and progressing data segmentation. • Lack of neonatal ICU capacity to implement the 32-week gestational threshold in Sussex. ESHT level 1 SCBU at present continues to accept babies between 31 and 32 weeks, NHSE are fully appraised of this and our staff are trained and confident to manage this group of babies. Regular meeting are held within our LMNS to work on a solution.

Next steps	The Q2 2023/24 paper will expect to provide a full update of our CNST/MIS year 5 submission.

Maternity Overview Report: Q1 2023/24

Executive Summary

The Trust Board is requested to note this Q1 report, which covers the three areas of the NHS England three-year delivery plan[1] in line with the Trust Maternity Strategy

1. Part one 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 and progress and activity during quarter 1, 2023/24. This is in line with the National Maternity and Neonatal Safety Improvement programme[2] (MatNeoSip), launched in 2019 aimed to:

    - 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

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

    East Sussex Healthcare Trust's Clinical Strategy[3] is aligned to the Three-Year Delivery Plan. The ICS, through our Local Maternity and Neonatal System (LMNS) and our local Maternity and Neonatal Voices partnership (MNVP), are working in partnership to achieve these ambitions through the NHS England Three-year delivery plan for maternity and neonatal services. This plan responds to the latest recommendations made in the final Ockenden report (March 2022) and Reading the Signals, Maternity and neonatal services in East Kent. ESHT's dashboard provides data for scrutiny and analysis to provide assurance to the Board surrounding these key areas. This paper provides assurance that ESHT are.

        1. Safe against the national safety ambition, evidenced through our data on a quarterly basis.
        2. That Perinatal mortality rates are within national parameters.
        3. We are responding to what staff and service users telling us.

2. Part two discusses two annual reports presented for approval through the Trust Board, The ESHT Maternity Transformation plan and the Saving Babies Lives Annual Report.

3. Part 3 provides an overview of the 3-year delivery plan and our progress during quarter 1.

[1] B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk)
[2] NHS England » Maternity and Neonatal Safety Improvement Programme
[3] Clinical Strategy (esht.nhs.uk)

Table of Contents

1. Perinatal quality and safety update

1.1 Continuity of carer (CoC) model

As colleagues are aware, the three-year delivery plan and specifically the NHSE transformation plan requires Trusts to identify how they provide dedicated support from the same midwifery team throughout pregnancy. ESHT continues with the two current midwifery Continuity of Carer teams. As staffing improves, we will commit to rolling out two further teams, timings to be confirmed. The existing two teams continue to review their criteria to ensure we are meeting key requirements to support those from the most deprived groups and women and people from Black, Asian and Minority Ethnic communities in line with our local Equity and Equality plan.

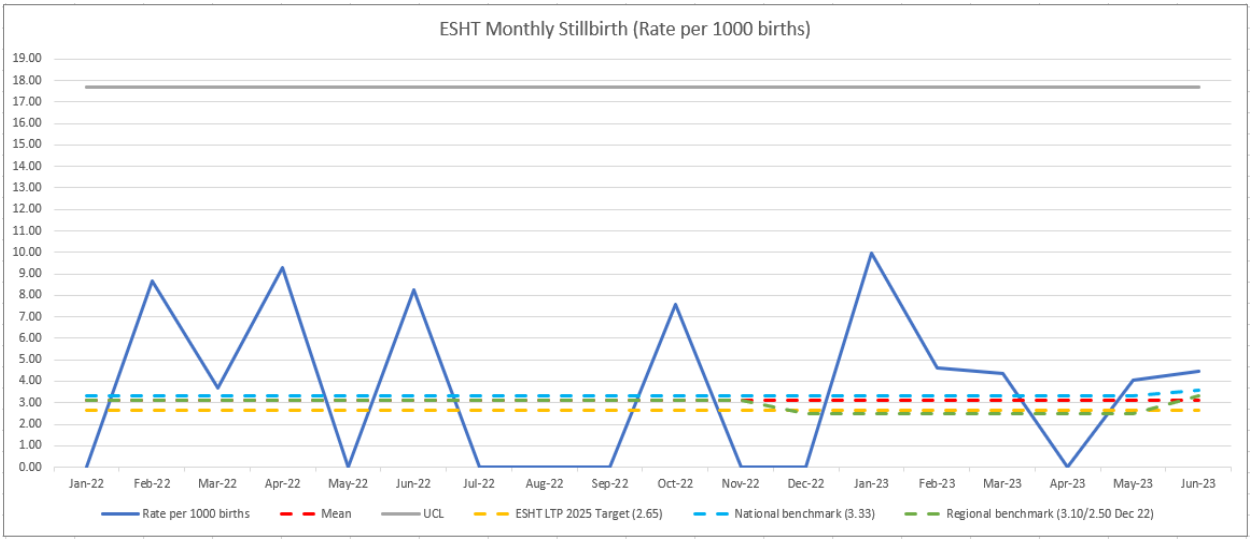
1.2 Healthcare Safety Investigation Branch (HSIB) Referrals for Q4

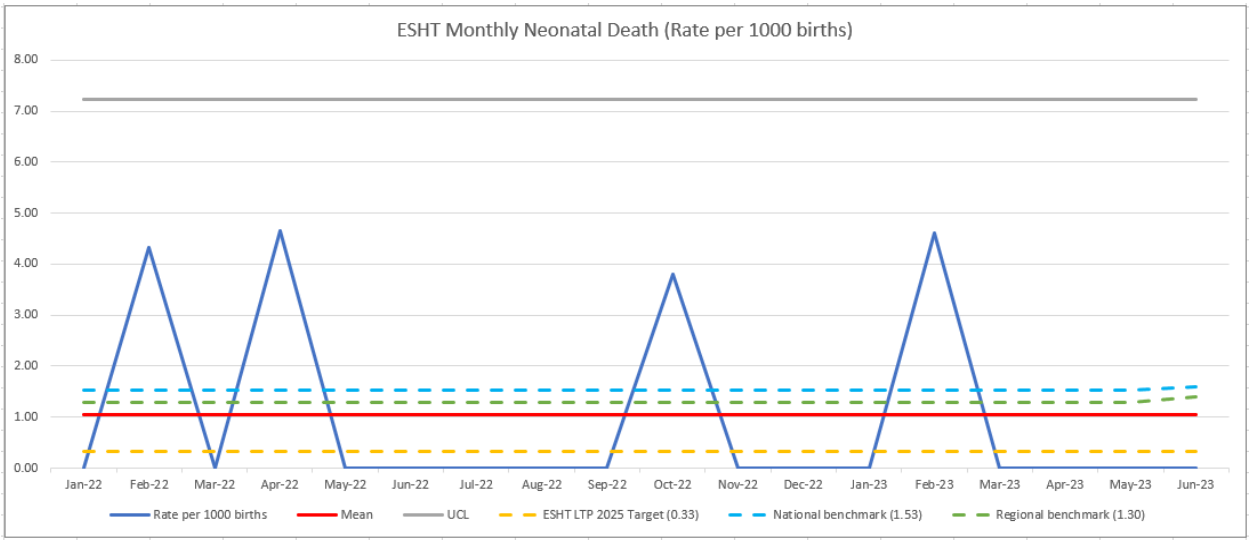
Since 2021, all HSIB cases accepted for investigation are raised as serious incidents (SIs). During Q1 there were there have been no HSIB referrals.

Incident type	No of cases Q1	Recommendations/actions
Closed Serious Incidents	1 (Intrauterine death 30 weeks gestation	Listening to the concerns of parents and ensuring we review the capacity of USS to ensure timely ultrasound scans, this is ongoing work for the sonography department.
Completed HSIB referrals	0	
Neonatal Brain Injury (HIE)	0	

1.3 Stillbirth data (Q1)

The table below shows the stillbirth rate per 1000 births reported between January 2022 and June 2023





Points to note:

- SPC Charts are set using 2022 (Jan-Dec 2022) as the 12-baseline period
- Each chart maps an average line (mean) as well as an upper and lower control limits. These control limits are set using the moving range and average of ESHT baseline period (2022) in line with LMNS agreement
- These charts highlight variation in ESHT and identify normal variation as well as good practice and opportunities. This data currently shows no cause for concern
- The monthly rates per 1,000 births can look higher than expected because we are dealing with small numbers (actual numbers can be seen below)

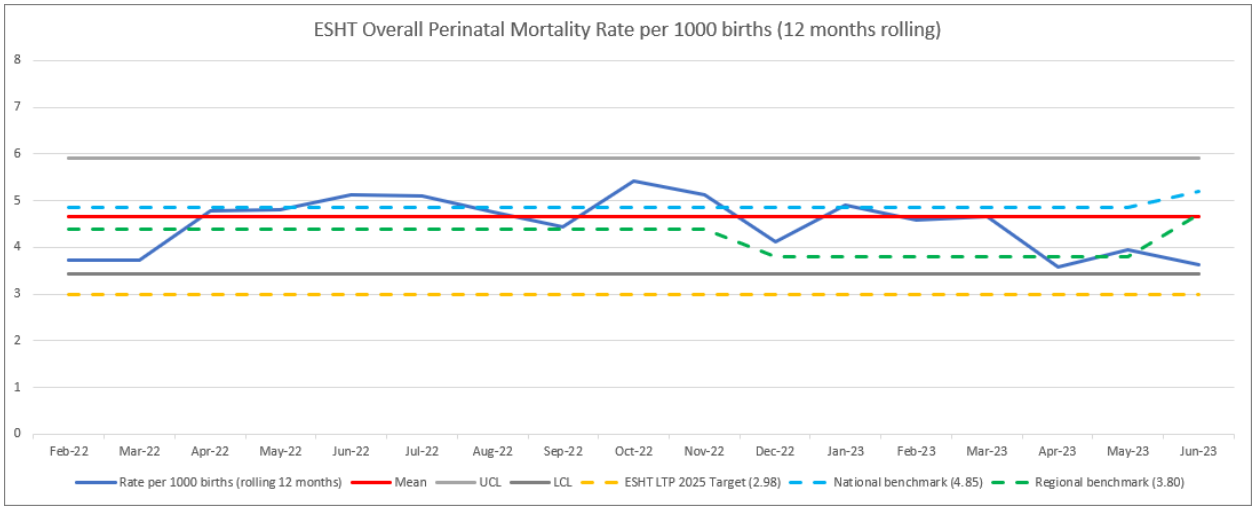
Monthly	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Total births	253	231	269	215	260	242	258	237	252	263	214	206	201	216	228	212	247	224
Number of stillbirths	0	2	1	2	0	2	0	0	0	2	0	0	2	1	1	0	1	1
SB per 1000 births	0.00	8.65	3.71	9.30	0.00	8.26	0.00	0.00	0.00	7.60	0.00	0.00	9.95	4.62	4.38	0.00	4.04	4.46
NND	0	1	0	1	0	0	0	0	0	1	0	0	0	1	0	0	0	0
NND per 1000 births	0.00	4.32	0.00	4.65	0.00	0.00	0.00	0.00	0.00	3.80	0.00	0.00	0.00	4.62	0.00	0.00	0.00	0.00
PMR	0	3	1	3	0	2	0	0	0	3	0	0	2	2	1	0	1	1
PMR per 1000 births	0.00	12.98	3.71	13.95	0.00	8.26	0.00	0.00	0.00	11.40	0.00	0.00	9.95	9.25	4.38	0.00	4.04	4.46

1.4 Monthly Overall Perinatal Mortality Rates

- The national & regional perinatal mortality rates were adjusted from June 2023
- Average (mean) for ESHT has been constantly below the national benchmark, and was below the regional benchmark rate from June
- ESHT's overall Perinatal Mortality rate is highlighting no common cause for concern – all within normal levels of variation
- The ESHT long term plan (LTP) target of 2.98 is our target by March 2024; the graph below demonstrates that we are making good progress towards achieving this target
- ESHT LTP trajectory for brain injury has been consistently met
- The average (mean) stillbirth rate meets the regional benchmark rates up until Dec 22 when the regional rate was reduced from 3.10 to 2.50 per 1,000 births following the

publication of the latest MBRRACE report, neonatal death (NND) rates are below regional benchmark rates and overall perinatal mortality rate (PMR) was meeting the regional benchmark rates up until Dec 22 when the regional rate was reduced from 4.40 to 3.80 per 1,000 births. There is a risk that these new regional targets may not be achieved but national benchmarks continue to be achieved. Ongoing work continues through the Saving babies Lives care bundle (see part 2).

1.5 ESHT Rolling Perinatal Mortality Rate



1.6 Transitional Care audits (TC)

The British Association of Perinatal Medicine (BAPM) Neonatal Transitional Care (TC) framework (2017)[4] recognises that keeping mothers and babies together is the cornerstone of newborn care; the framework recognises this is a pathway rather than a place. Implementation of this pathway (as is the case within ESHT) prevents many admissions per year to our neonatal unit by providing enhanced care on the postnatal ward.

We are required to audit this pathway quarterly. Findings from the quarter one report found that all babies eligible for TC needing antibiotics, phototherapy or management for hypoglycaemia were managed successfully on the postnatal ward. We are currently working to improve our pathway; the Head of Midwifery and Neonatal Matron are leading the TC group which will educate Midwifery Support Workers and Nursery nurses to deliver nasogastric feeds, manage cold babies and intensive phototherapy. A robust action plan has been agreed with the Neonatal and Maternity Safety Champions and is monitored through the Maternity Board.

1.7 Avoiding Term Admissions into Neonatal units (Atain)

Atain is a programme of work to reduce harm leading to avoidable admission to a neonatal unit for infants born at term (over 37 weeks gestation). The programme focuses on four key clinical areas related to term admission: respiratory conditions; hypoglycaemia; jaundice; and asphyxia (perinatal hypoxia–ischaemia). These represent some of the most frequently recorded reasons for admission according to neonatal hospital admissions data and represent a significant amount of potentially avoidable harm to babies.

[4] British Association of Perinatal Medicine (amazonaws.com)

Furthermore, there is overwhelming evidence that separation of mother and baby at or soon after birth interrupts the normal bonding. Not only is there the potential for significant impact on maternal mental health and bonding, but also the adverse impact on successful breastfeeding. 'Full-term' or 'term' admissions include all babies born at or after 37 weeks gestation and admitted to a neonatal unit within the first 28 days after birth.

For all unplanned admissions to a neonatal unit for medical care at term a thorough and joint clinical review by the maternity and neonatal services identifies learning points to improve care provision, considers the impact service re-design might have on reducing admissions and identify avoidable harm.

The National Neonatal Audit Programme (NNAP) benchmark is <5% term admissions to the Neonatal Unit. ESHT SCBU met this target for Q1 at an average of 4.61%. Avoidable admissions during quarter one were babies who could have had transitional care and one case where potentially an earlier intervention on the delivery suite may have avoided admission. No harm was identified in relation to any of the avoidable admissions and the actions described above will improve our Atain rates in the future.

1.8 Findings from local Perinatal Mortality Review Tool (PMRT) Reviews

The Perinatal Mortality Review Tool (PMRT) was developed in 2018 by MBRRACE–UK in collaboration with user and parent involvement. The aim is to support high quality standardised perinatal mortality reviews across NHS maternity and neonatal Units.

Within ESHT, all cases meeting the relevant criteria were reported to MBRRACE within seven working days in line with national requirements.

During quarter one, five cases were reviewed. One of these cases is currently being reviewed as a Serious Incident while in the four remaining cases no care or service delivery issues were identified. Good practice was commended by all parents noting high quality care from the entire maternity team. The British Association of Perinatal Medicine (BAPM) Extreme Prematurity Framework for Kent Surrey and Sussex and Neonatal Operational Delivery Framework has now been adopted by ESHT. Discussions with the LMNS continue regarding transferring pre-term infants where tertiary units are unable to accept and how we reflect this in local guidance.

We continue to work towards implementing the Patient Safety Incident Response framework (PSIRF), a move away from "what went wrong" to "how to minimise" and learn from risks and incidents with plans to commence implementation within maternity services during the autumn.

1.9 Maternal Mortality

Sadly, there was one coincidental maternal death during Q1, this case has been reported to MBBRACE. This was due to a road traffic accident.

1.10 Maternity & Neonatal (Matneo) Incidents, Complaints & Claims

Following the publication of the latest Clinical Negligence Scheme for Trusts. (CNST) scorecard (2012-2022) in August 2022, we have triangulated our data in a quarterly scorecard. Three claims, submitted in 2021/22, were reviewed. Key themes identified were: service provision, pathway of care documentation and communication. Actions identified have been completed. Of the claims received between 2012-2022 top injuries by value included cerebral palsy, brain damage, bruising/extravasation, psychiatric/psychological damage, and incontinence. The top causes by value centred around failure to recognise complications, delayed treatment/diagnosis, failure to interpret ultrasound scan reports and inappropriate treatment.

During the reporting period, there were no avoidable deaths, brain injuries or HSIB referrals and therefore no similar themes could be identified in relation to injuries by value or cause. We identified 20 actions, 11 of which have been completed.

1.11 Maternity Staffing (workforce)

During the reporting period, appropriate mitigations were implemented to ensure the department provides and maintains safe and consistent maternity services, whilst ensuring positive perinatal outcomes.

Midwifery workforce remained at similar levels to the previous quarter. The vacancy rate increased from May 23 due to changes in how rates are reported (this now includes vacant internal posts due to internal secondment) to provide a clearer vacancy picture. Staff on secondment (4 WTE) are generally covered through Bank usage. Around 5 wte additional posts have been filled with recruitment progressing. We also have 7.3 wte newly qualified midwives commencing in October 2023.

Month	Sickness rates	Maternity leave	Vacancy rates
April	4.3%	3.6%	2.7%
May	3.5%	3.6%	8.3%
June	4.6%	2.9%	7.2%
Difference in % from Q4 to Q1	Down by 2%	Down by 7.2%	Up by 1%

Workforce can still prove a challenge within maternity services during high activity/acuity periods and increasing numbers of cases where medical and social complexities means that despite staffing improvements the clinical floor can feel increasingly busy. However significant improvements continue with a focus on quality and safety to provide consistent safe care. A new multidisciplinary safety huddle (held 12 hourly on the clinical floor) has supported this work.

The number of DATIX/red flag incidents reported in relation to staffing and resources decreased by 20% during the reporting period. Six incidents were related to workforce and acuity, two related to the suspension of births at Eastbourne Maternity Unit (EMU), due to staff sickness absence. No adverse outcomes resulted from any of the above incidents, although the experience for birthing people and their families was affected and not what we aspire to. The department has continued to maintain supernumerary status and is compliant with the required elements.

1.12 Themes Q1

Delay between admission for Induction of Labour (IOL) and commencement of procedure (52%) - 11 cases	No harm occurred because of these delays and mitigation appropriately implemented.

1-1 care in labour	Jan	Feb	Mar	Apr	May	Jun
All births booked in ESHT for 1:1 Care In Labour	98%	97%	98%	97%	95.9%	95.6%
1:1 care in labour provided for those eligible & delivered in ESHT	100%	100%	100%	100%	100%	100%

This data is currently under review as it includes babies that were born before arrival of the midwife (BBA) and all births potentially eligible for 1-1 care, once reviewed the compliance for ESHT is 100%.

1.13 Maternity Workforce Fill Rates

Maternity workforce fill rates at the acute site remain stable where there is less than the agreed staffing template, the escalation process is implemented. Fill rate for the midwife -led unit is covered by a community midwife.

	Oct	Nov	Dec	Q3 Average	Jan	Feb	March	Q4 Average	April	May	June	Q1 Average
Maternity Conquest fill rate (%)	78.2%	84.5%	77.7%	80.0%	82.8%	82.0%	79.3%	80.0%	79.6%	83.2%	82.9%	81.9%

	Oct	Nov	Dec	Q3 Average	Jan	Feb	March	Q4 Average	April	May	June	Q1 Average
Maternity EMU fill rate (%)	64.7%	70.0%	56.4%	63.7%	68.7%	69.7%	65.1%	67.8%	69.7%	74.8%	66.2%	70.2%

1.14 Obstetric staffing

The obstetric consultant team and maternity senior management team commit to incorporating the principles as outlined within the 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'. An audit is completed quarterly which has evidenced good compliance within all areas. Audit findings in relation to employing short term locums in line with RGOG guidance found ESHT fully compliant during quarter one.

Full compliance with consultant attendance for clinical situations was recorded in line with guidance.

No challenges have been reported within the obstetric workforce and cohesive and collaborative working by Consultants has ensured a safe and consistent service delivery. This has at times been challenging, particularly during multiple doctors' strikes, but thorough and pre-emptive plans were put in place early to avoid disruption.

1.15 Neonatal (Medical & Nursing) and Anaesthetic workforce

The Trust currently meets the standards as set out within the British Association of Perinatal Medicine (BAPM) Perinatal Medicine Service and Quality standards for the provision of Neonatal Care, with close and co-operative working between units within our Operating Delivery Network (ODN). At present the unit accepts babies from 31 weeks; an LMNS working group are reviewing this in line with the current national recommendation of moving to a 32-week threshold. Work is ongoing within University Hospitals Sussex (UHSx) to improve transitional care pathways, in order to accommodate all 31-week threshold. Regular Local Maternity System meetings focus on these actions. NHS England are fully appraised of this issue.

Neonatal nursing levels currently meet the requirement in line with the ODN workforce calculator. As per the Department of Health Toolkit, a minimum of 70% of registered nursing and midwifery workforce establishment should hold a Qualified in Speciality (QIS) qualification. At ESHT, new to service staff do not have this qualification, and a robust plan of training is in place which is approved by the ODN and in line with national requirements. Currently 62% of SCBU nursing staff hold the post registration qualification, with the remaining staff on the training programme. Over the past 6 months zero shifts fell short for QIS trained staff per shift (Badgernet data). Excellent Multi-Disciplinary Team (MDT) working continues between the medical, nursing and maternity team.

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day with clear lines of communication to the supervising anaesthetic consultant at all times, in line with ACSA standard 1.7.2.1.

No concerns were highlighted in respect of the neonatal or anaesthetic workforce. Innovative ways to increase flow within the service and discussions around the importance of having a second theatre, with staff to support this are ongoing. Rotas are available for all medical staffing within maternity services.

1.16 MDT Training

Compliance with CTG and fetal monitoring training competency is as follows for quarter 1 23/24. This is similar to Q4 data and no cause for concern.

Q1	
CTG compliance	% Compliance
Medics	94%
Midwives	95%
Combined	95%

Combined core competency (PROMPT) training for Q1 was at 91%, which was consistent with the rate seen in Q4 (91%). Mindful of the challenges raised in the CQC inspection report, it is important we see this training in the context of other Trust mandatory training issues. Mandatory training is improving. PDR's are now at 90%, work continues with junior medical staff to ensure all receive mandatory training.

Q1	
PROMPT compliance	% Compliance
Medics	96%
Midwives	90%
Combined	91%

1.17 Training Needs Analysis (TNA)

In collaboration with national maternity partner organisations including the Royal Colleges, HSIB, NMC and NHS Resolution, the Maternity Transformation Programme has led on the development of a Core Competency Framework to address known variation in training and competency assessment and ensure that training to address significant areas of harm is included as a minimum core requirement for every maternity and neonatal service.

Professional and Clinical updating is a recognised requirement of East Sussex Healthcare Trust. Training is an essential control measure when managing risk in line with this extensive national guidance. The purpose of our TNA is to identify the specialist training within our maternity services.

The TNA includes collaborative, multidisciplinary practice sessions or 'drills' for dealing with emergency situations which will allow members of staff to know and understand their specific roles and responsibilities in an emergency. Obstetric medical staff of all grades, midwives and other staff relevant to emergency situations train together to ensure efficient team working. Our TNA is updated annually in line with the national requirement.

Culture within maternity services

1.18 Staff Survey results for Maternity

The staff survey identified four key areas of focus for the maternity department, which includes both midwifery and medical staff (obstetric and anaesthetic staff). Staffing levels have been a focus for the past year and we are now seeing the benefits as vacancy levels have improved considerably. Harassment and Bullying from service users remain a focus; the Trust's zero tolerance attitude is clearly articulated within the maternity department and work continues to be undertaken with staff to ensure the early escalation of emerging issues. The department held a focus group to understand further detail relating to these points and an action plan has been co-produced Positively, staff are identifying that they feel valued by both their teams and line managers.

The SCORE (Safety Culture, Operational Risk, Reliability/burnout and Engagement) survey is undertaken by Trusts every 4-5 years. The survey aims to assess aspects of our local team culture, including safety, communication, and teamwork. The ESHT score survey closed on 19 May 2023 with a good response rate of 43%. We have received the initial results and the senior team are continuing to work with our staff and national team to fully understand these results. Cultural strengths include staff receiving feedback about performance, with local leadership regularly making time to provide positive feedback and pause and reflect about individuals' work. Engagement strengths include that our decision-making processes are clear to staff, any queries can be discussed with a direct line manager and staff feel they have freedom in carrying out their work activities.

Cultural opportunities include ensuring all staff have a break, and engagement opportunities include reviewing growth and progression opportunities for staff. We are currently working with staff through listening events supported our external survey lead to co-produce a plan of action. We are also progressing with our three year recruitment and retention plan.

General listening events for all maternity staff continue to be held every six weeks, which we plan to continue at staff request until the end of quarter two and then review. In recent times staff are reporting that they "know staffing is improving and that "services feel more settled". Staffing levels versus acuity remains a key area of discussion and will be reviewed using Birthrate+ in 2024.

The Professional Midwifery partner team have held a world café event and off-site safe spaces to hear staff views. Current actions include a review of rotas and work to encourage any hours working where additional resource is required.

Robust staff support is offered via generic Trust services, and the Maternity department includes the offer of a Professional Midwifery partner for all staff. A midwifery preceptorship program is in place for all newly qualified midwives which is robust and nationally recognised for its excellent support. We have recently increased support to include out of hours clinical support which has been very well received by staff.

On occasion an event happens that is truly shocking and makes us stop and think. Particularly for those who dedicate their lives to caring for others the Lucy Letby case is one of those events. There are no words to describe how appalling these crimes were.

This case has highlighted how essential fostering a culture of openness and safety, where everyone can feel confident and safe to speak up, must be at the core of everything we do. There are too many examples across the NHS where people stay quiet for fear of speaking out, or where workers feel speaking up is futile – that nothing will be done as a result, or as in this case where it seems those that spoke out weren't listened too.

Within Maternity and Neonatal care everyone's voice matters – regardless of background, position, or circumstances.

Line managers or the divisional leads are the first route to speaking up and as a team we are committed to listening to all concerns. We have recently reinforced this through communications, emphasising the importance of Psychological Safety where no one is punished or humiliated for speaking up with ideas, questions, concerns, or mistakes. We are providing a foundation to encourage high performing, resilient teams, where people feel encouraged to share creative ideas, ask for help, admit mistakes, raise concerns and appropriately challenge the ways of working and the ideas of others. We continue to strive to build an environment where staff feel accepted and respected.

We have also reinforced the work of the Freedom to Speak up Guardians, the human resources and wellbeing teams and access to the Chief Executive.

1.19 The Service User Voice

Response rates for the Friends and Family Test (FFT) scores during Q1 have improved from 20% to 30% with 99% of responses containing a positive recommendation. We continue to look at ways of increasing these response rates.

Following the 15 steps exercise to review maternity services across Eastbourne and Conquest, there has been good progress in both units in line with the action plan. Progress will be reviewed at our department governance meeting. A follow up walkabout will take place in October 2023 to review the progress of all actions.

Service user feedback via the Maternity and Neonatal Voices Partnership (MNVP) is provided monthly. The MNVP annual report includes reports of much positive progression during the past year.

The Maternity department continue to work closely with the MNVP to review and collate all feedback from service users, this includes feedback from complaints, FFT, MNVP focussed monthly feedback, information from service user debriefs, HSIB and PMRT cases as well as feedback following Trust RCA's.

A coproduced action plan has been agreed which will be monitored quarterly via divisional governance routes. This allows our MNVP Chairs to provide real-time feedback to service users about the progress our services are making.

Further to this, it is important to include our positive feedback which included 30 individuals (including medical, neonatal and midwifery staff), being named as going above and beyond. Please see comments below from service users as examples of the great work of our staff

> *"[My Midwife] was so supportive and made my pregnancy so blissful compared to what it could have been. She has dealt with all my worries and questions and helped my mental state a lot. She was a real friend someone I could confide in without worrying about the professional barrier. Brilliant midwife anyone will be lucky to have her "*

> *"[My Consultant] and his team who performed my c section made me feel so comfortable and relaxed after being so anxious about the whole thing".*

> *"I would like to thank the nurse from SCBU, she made me feel very calm and comfortable and she was the only person I felt comfortable with leaving my baby in SCBU to go home and rest, she showed me reassurance and made me feel comfortable to speak to her on any occasion and with any questions I had".*

As colleagues are aware, the NHS Maternity Services Survey[5] is a national event commissioned by the Care Quality Commission, with individuals over 16 invited to participate. The survey is split into three sections covering antenatal, labour and birth and postnatal care and has been carried out annually since 2019. It asks women and birthing people a range of questions about their experience of choice and continuity of care in maternity services in hospital. In total 114 (94%) of the 121 participating trusts submitted attribution data.

The action plan is now complete with the launch of the new maternity website during August 2023. We await this year's survey, which will be published in early 2024.

1.20 Ockenden Recommendations/East Kent Report/NHSE Insight visit

There were 11 actions for ESHT from the final report, with no further outstanding actions. A follow up supportive visit is expected during 23/24.

1.21 Maternity Incentive Scheme (MIS) Year 5

CNST incentivises ten maternity safety actions and Trusts that can demonstrate compliance 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. Year 5 version 1.1 was published in July 2023, work to deliver compliance in all areas is underway.

Perinatal Quality & Safety conclusion

Our services are managed effectively and safety is maintained clinically. As a minimum staffing levels are reviewed on a daily basis and escalation plans are activated when required to ensure we maintain safe services. A 12 hourly safety huddle reviews any emerging clinical concerns. Recruitment and retention planning is an ongoing key part of service planning. Perinatal mortality data shows normal variation and no cause for concern.

We maintain a robust governance process and our data provides evidence that perinatal mortality rates remain in line with national ambition, local scrutiny of all ESHT cases form part of our governance process in line with national requirement.

Our services are well led overall and well managed on a day-to-day basis as confirmed following the CQC visit in October 2022. Staff compliance with maternity specific training in line with national requirements has been maintained. A robust plan of action is underway to ensure Trust targets are met with regards to trust mandatory training. Mandatory training for key groups such as junior medical staff continues to improve and a plan is being developed with the education team to proactively manage training as this group join the Trust annually. Once all actions are achieved the Trust are required to report all completed actions to the CQC.

[5] NHS Maternity Services Survey 2022 Benchmark Report

2. Annual reports

2.1 Saving Babies Lives Annual Report

This annual report is based on the implementation of Saving babies lives Version 2[6] - Version 3 (June 2023) which will begin implementation from Q2 23/24.

The NHS Long Term Plan reiterates the NHS's commitment to a 50% reduction in stillbirths, maternal mortality, neonatal mortality and serious brain injuries and a reduction in preterm birth rates, from 8% to 6%, by 2025. Implementation of the care bundle has been included in NHS contracts and is a requirement of the CNST Maternity Incentive Scheme. The initiative brings together five elements of care that are recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth
3. Raising awareness of reduced fetal movements
4. Effective fetal monitoring in labour
5. Reducing preterm birth.

We have been successful in fully implementing the Saving babies' lives care bundle and embedded all interventions as set out in the document.

2.2 Reducing smoking in pregnancy

ESHT is compliant with the NHS Long Term Plan target of >95% of pregnant smokers offered in house referral to Tobacco Dependency Treatment (TDT) services by 23/24. Stopping smoking is the single most effective way of reducing health Inequalities.

Collaborative working with the Local Authority enables ESHT to provide targeted interventions such as financial incentives for young parents who smoke. This has now been extended to those in deprived areas.

35.7% of young smokers engaging with the service were non-smokers at time of delivery compared to 3% the year prior to implementation of the in-house service. 31% of the rest of the cohort who engaged with the service quit smoking by delivery in the first 6 months of the inhouse service being offered to all smokers.

For data quality purposes the smoking status for booking and delivery is now for the same cohort of women. This has not been the case prior to 2022/23. Over the last year we saw an average reduction in those who were smoking at time of delivery by 2.3%, which saw 62 more babies go home to a smokefree home.

Compliance with carbon monoxide (CO) monitoring remains above 95% at booking and although not above 95% at 36 weeks is above the required 80% in line with CNST requirement. An action plan is now in place for improvement of 36 week CO monitoring, supported by promotion, training, and identification of non-compliance via the Lead Midwife for TDT services.

New process measures outlined in the Saving Babies lives care bundle version 3 now include smoking status recorded at booking and 36 weeks. Last quarter ESHT identified 100% of smokers at booking and 94.8% at 36 weeks; the Trust is on target to identify

[6] Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf (england.nhs.uk)

>95% of smokers at 36 weeks. 42.9% of those engaged with the financial incentive scheme achieved a 4-week quit during the last quarter. In April, 32.4% of smokers at the time of booking were from the 10% most deprived area and 21.1% at delivery. Now all smokers from the 20% most deprived areas will be offered financial incentives to quit smoking. ESHT maternity tobacco dependency services were ranked as 4th out of 42 ICSs across the country during Q2 of 2023.

2.3 Risk assessment and surveillance for fetal growth

There is strong evidence to suggest that Fetal growth restriction (FGR) is the biggest risk factor for stillbirth. Therefore, antenatal detection of growth restricted babies is vital and has been shown to reduce stillbirth risk significantly because it gives the option to consider timely delivery of the baby at risk. We have fully implemented and adopted effective management of early onset growth restriction detected prior to 34 weeks.

2.4 Raising awareness of reduced fetal movements (RFM)

Enquiries into stillbirth have consistently described a relationship between episodes of RFM and stillbirth. In all reports unrecognised or poorly managed episodes of RFM have been highlighted as contributory factors to avoidable stillbirths. In addition, a growing number of studies have confirmed a correlation between episodes of RFM and stillbirth. This relationship increases in strength when women have multiple episodes of RFM in late pregnancy (after 28 weeks' gestation).

The Tommy's evidence based 'baby movements leaflet' is incorporated into our BadgerNet (electronic patient records system) library and a push notification is sent at 24 weeks.

We have well established use of the recommended reduced fetal movements checklist that is incorporated in to the BadgerNet system in addition to computerised CTG analysis available on all sites. Audit demonstrated that 99% of all RFM attendances received a computerised CTG analysis which is considered the gold standard of antenatal fetal monitoring.

Our guidance follows national recommendations of ensuring appropriate use of induction of labour when RFM is the only indication not to be performed before 39 weeks. There have been no stillbirths that have had issues associated with RFM during the past year.

2.5 Effective fetal monitoring in labour

The importance of good fetal monitoring during labour in achieving the delivery of a healthy baby is underlined in various national reports. Appropriate risk assessment and level of monitoring at the onset, during labour and level of monitoring for both intermittent auscultation and cardiotocograph CTG monitoring is paramount. CTG is a well-established method of confirming fetal wellbeing and identification of potential fetal hypoxia.

2.6 Reducing preterm birth

Preterm birth is defined as delivery less than 37 weeks gestation and is a common complication of pregnancy, comprising of around 8% of births in England and Wales. It is the most important single determinant of adverse infant outcome with regards to survival and quality of life. The interventions of element 5 aim to reduce the number of preterm births and optimise care when preterm delivery cannot be prevented. The national ambition is to reduce the preterm birth rate from 8% to 6%.

Our singleton preterm birth rate for 2022/23 is 6.2% and our late second trimester losses 0.98% were in line with the national average of 1-2% of pregnancies.

In conclusion, we have successfully implemented Saving babies lives version 2 with high levels of compliance and sustainability. This has given us a good foundation to begin implementation of Saving babies' lives Version 3 with the aim for full implementation by March 2024. Further, we have completed a peer review with support of the LMNS for SBL v2. The main risks are sonography services (which is a nationwide risk due to vacancy factor) and wi-fi to enable ESHT to review CTG's remotely; this area of work is progressing within ESHT.

3. The maternity transformation plan

This section updates colleagues on a range of maternity transformation objectives which the maternity department are working towards delivering as part of our maternity transformation plan. These will ensure maternity and neonatal care is safer, more personalised and more equitable, in accordance with NHSE 2022/2023 priorities and operational planning guidance[7] *C4 Deliver improvements in maternity care*. This includes themes and objectives that are aligned to the Three-Year delivery Plan for maternity and neonatal services.

3.1 Midwifery Continuity of Carer (MCoC)

At present we have two continuity teams and we plan to roll out of two further teams from July 2024. Prior to this we will ensure the building blocks below are in place:

1. Linked obstetricians will work closely with our continuity teams
2. Support for midwives to complete training in line with our training needs analysis for continuity teams in preparation for rollout
3. Review the process for pay for continuity teams with support from payroll and finance with a plan to offer an alternative process for pay (4.5% uplift plus unsocial hours), this is not expected to affect overall budgets for maternity
4. Estates review to ensure adequate accommodation for the continuity teams

3.2 Perinatal Equity and Equality

Colleagues have previously approved the perinatal Equity plan, a lead practitioner will lead on this plan during the next year.

3.3 Personalised Care and Support Plans (PCSP)

Work continues to review and improve Badgernet PCSP so that it meets national requirements. We are working closely with the Maternity and Neonatal Voices partnership (MNVP) to support empowering women and birthing people to own their plan. Whilst waiting for national updates for Badgernet, ESHT have updated their PCSP hardcopy booklets which are now distributed at booking

3.4 Midwifery Support Worker (MSW) project

The Head of Midwifery is working with the education team to support MSW's against their competency framework which concludes in an uplift from band 2 to band 3.

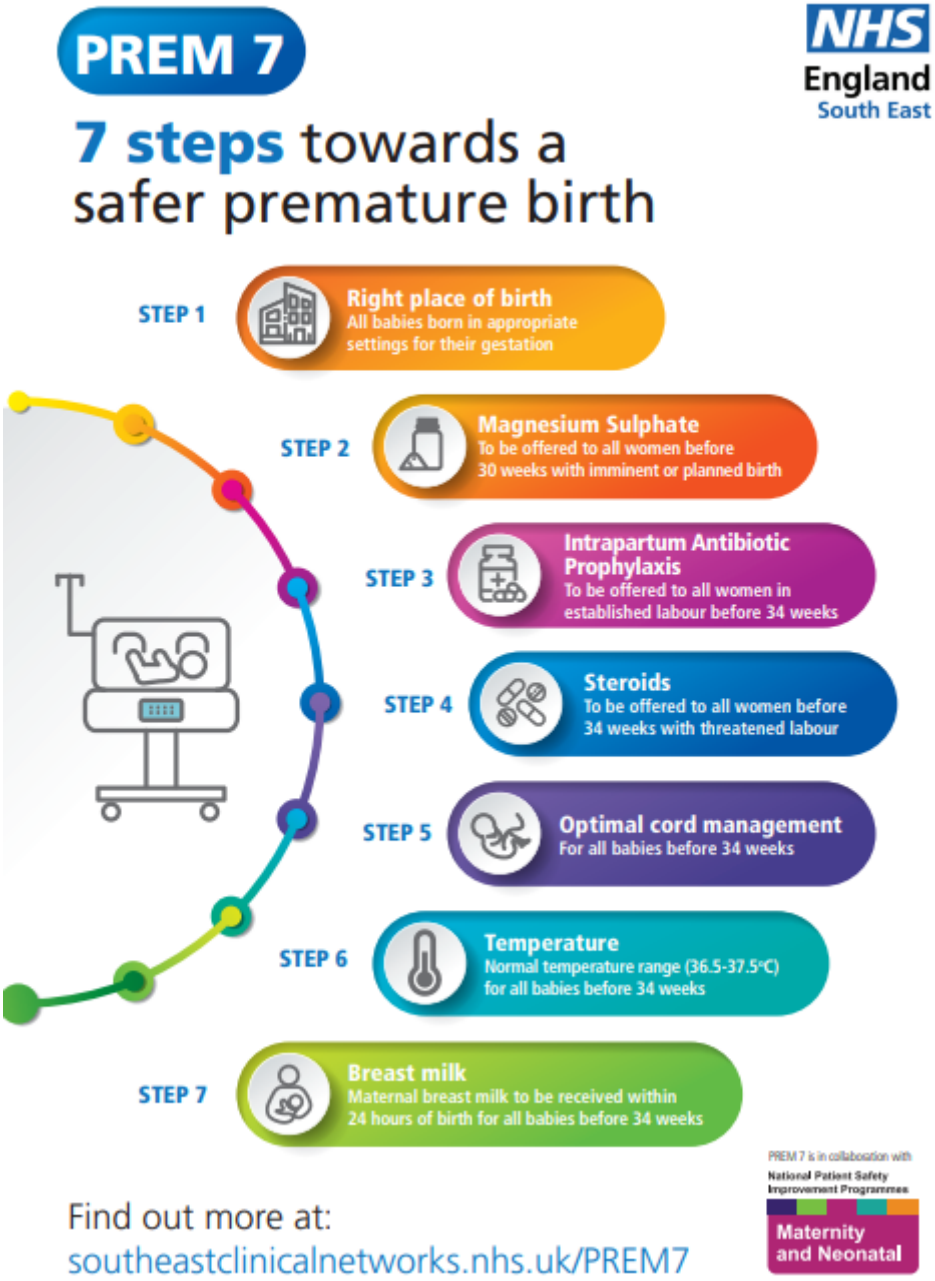
3.5 Perinatal Pelvic Health

The NHS long term plan has committed to improving access to pelvic health conditions during pregnancy and after birth so that all women and pregnant people have access to multidisciplinary pelvic health services and pathways by 2024. ESHT expects to commence its specialist service in late Autumn 2023.

[7] 20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf (england.nhs.uk)

3.6 PREM 7

Prem 7 is a perinatal project aiming at improving outcomes for babies who are born prematurely (under 34 weeks gestation) in the Southeast region. Based on best practice, the seven interventions can have a significant and positive impact on reducing brain injury and mortality rates amongst babies born prematurely. ESHT are working towards ensuring all seven drivers are in place for every baby born prematurely.



4. Delivering the Three Year Maternity and Neonatal Programme in East Sussex

In summary, progress against three year delivery plan for maternity services in East Sussex against the 4 themes is described below. The Board is asked to note the progress made in East Sussex with delivering the maternity and neonatal programme and the mitigations in place.

Theme 1 (Listening to Women) - all but one of the actions are on track or have a plan to achieve compliance

Theme 2 (Growing, retaining and supporting our workforce) - all but one action are on track or have a recovery plan in place for delivery

Theme 3 (Developing and sustaining a culture of safety, learning, and support) - all actions are on track with a recovery plan for delivery

Theme 4 (Standards and structures that underpin safer, more personalised, and more equitable care) - all actions are on track

The key risks and issues impacting delivery are:

- Lack of funding to implement the full Maternal Mental Health Service Offer, which has been logged on the investment log of the ICB. (Theme 1)
- The Maternal Mental Health Service funded bereavement pathway is not fully implemented, due to workforce challenges in psychology / psychological support and increasing complexity within our local population. (Theme 1)
- Workforce gaps are impacting achievement of the final Ockenden report implementation, safe staffing levels and Midwifery Continuity of Carer roll out, proactive recruitment continues to be a main focus (Theme 2)
- Data quality continues to be a risk, with action via the Data Quality Improvement Group addressing issues as they are identified and progressing data segmentation. (Theme 4)
- Lack of neonatal ICU capacity to implement the 32-week gestational threshold in Sussex (Theme 2)

The Trust remains well placed to implement the Three Year Delivery Plan, with the risks to delivery being know to both ESHT and the LMNS Board. Mitigations are in place to minimise these risks, where they are not dependent on additional funding.

East Sussex Healthcare NHS Trust

Mortality Report: Learning from Deaths 1 April 2017 to 31st March 2023

Purpose of the paper	The reporting of "Learning from Deaths" to the Trust Board 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.					
	For Decision		For Assurance	x	For Information	
Sponsor/Author	Dr Simon Merritt					
Governance overview	N/A					

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. "Learning from Deaths" reports are presented on a quarterly basis.

Executive Summary	The current "Learning from Deaths" report details the April 2017 – March 2023 deaths, recorded and reviewed on the mortality database. Learning disability deaths are subject to external review 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	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.

EAST SUSSEX HEALTHCARE TRUST: Learning from Deaths Dashboard March 2022-23

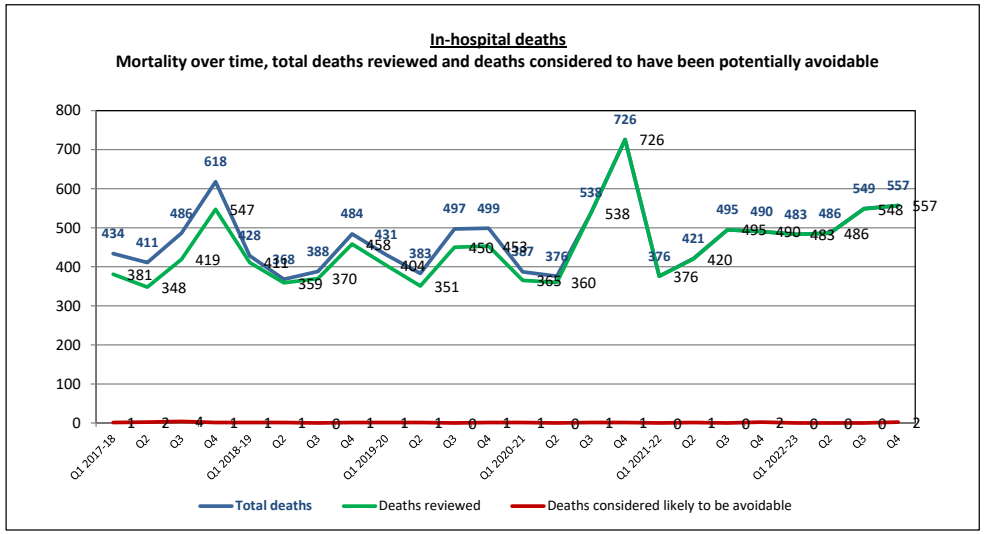
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of in-hospital deaths and total number of cases reviewed under the Structured Judgement Review methodology (Data as at 20/09/2023)

Total number of in-hospital deaths, deaths reviewed and deaths deemed avoidable (does not include patients with identified learning disabilities). Avoidability is recorded when the overall care has been judged to be poor or very poor.

Time Series:	Start date	2017-18	Q1	End date	2022-23	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
206	160	206	160	0	2
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
557	549	557	548	2	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2075	1782	2074	1781	2	3



Total deaths reviewed by RCP methodology score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Possibly avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	40.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	20.0%	This Quarter (QTD)	2	40.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	2	40.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	20.0%	This Year (YTD)	2	40.0%

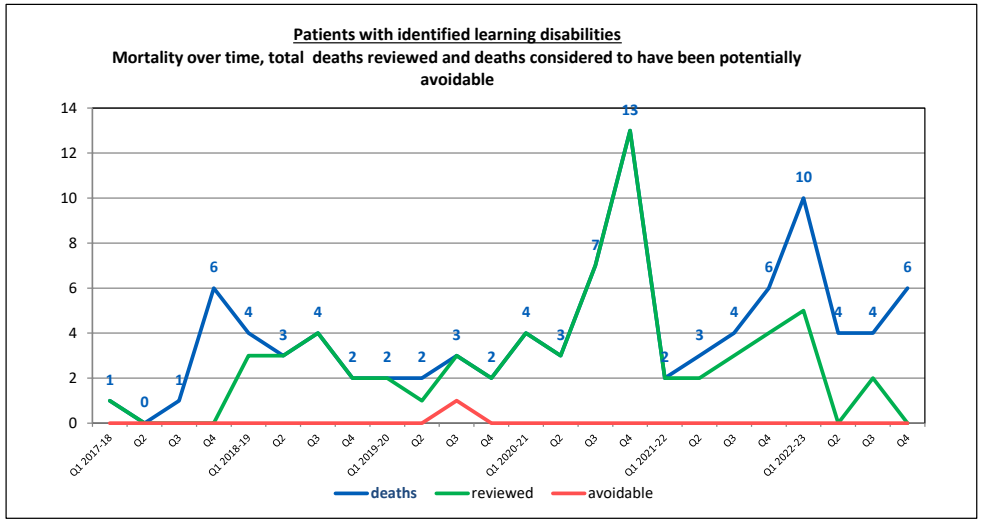
Data above is as at 20/09/2023 and does not include deaths of patients with learning disabilities.
Family/carer concerns - There was one care concern expressed to the Trust Bereavement team relating to Quarter 4 2022/23 deaths. This wasn't taken forward as a complaint.
Complaints - Of the complaints closed during Quarter 4 2022/23 which related to to 'bereavement in hospital', the majority had an overall care rating of 'good care', two had an overall care rating of 'adequate care' and one 'excellent care'.
Serious incidents - There were two severity 5 serious incidents raised in Q4 2023/2024..
As at 20/09/2023 there are 516 April 2017 - March 2023 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 20/09/2023)

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	2022-23	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
5	1	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
6	4	0	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
24	15	7	11	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

Winter Preparedness 2023/24

Purpose of the paper	This paper seeks to provide an update on the development of the Trust's Winter Plan for 2023/24. It sets out key areas of focus and development and draws on learning from last year.						
	For Decision		For Assurance	x	For Information		
Sponsor/Author	Charlotte O'Brien, Chief Operating Officer						
Governance overview							

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	

Recommendation	The Board is asked to **note** the work undertaken to date to develop the winter plan and the further work required in order to finalise the plan.

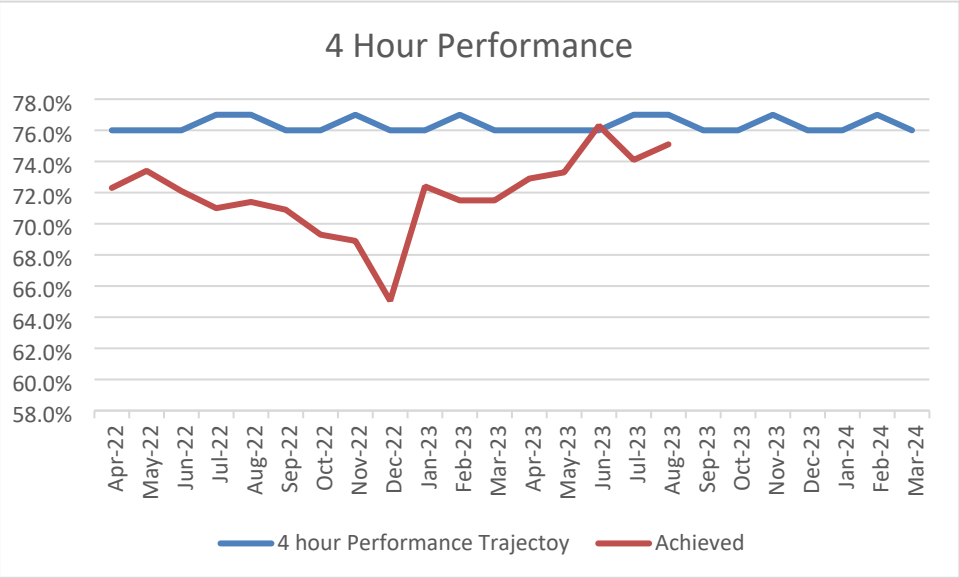
Executive Summary	This paper provides an update on the development of the Trust's Winter Plan for 2023/24. It sets out key areas of focus and draws on learning from last year. The Trust are working as part of the broader Sussex system to develop the 2023/24 Winter Plan which covers the requirements of the NHS England Winter letter and considers the specific needs of the Sussex system. As a trust we have undertaken comprehensive demand and capacity modelling which enables us to quantify predicted bed requirements (including those required to maintain our elective activity) through-out the year and takes into account the impact of work focused on both reducing length of stay and the number of patients not meeting the criteria to reside in our hospital beds. To support sustained delivery of the 76% emergency access clinical standard, the Trust has an improvement plan in place which focuses on a number of key areas. As part of our approach to planning, roles and responsibilities associated with the delivery of the plan and the approach to day-to-day management of operational pressures are being clarified and we will continue to work with system partners to iterate the plan over the coming weeks.

Next steps	The Trust plan will be finalised over the coming weeks in line with the requirements to submit to ICS colleagues by 10th October prior to onward submission of a system plan to NHS England.

1. Introduction – Winter 2023/24

Each year, providers and systems are required to develop a shared Winter Plan as a means for coordinating system wide efforts and available resources, for what is the busiest time of the year for urgent care demand and related activity.

Over the past year, the Sussex system, similar to other systems across the country, has continued to see sustained high demand on urgent and emergency care services. Performance at the Trust has improved over the last 8 months and there is a demonstrated improvement relative to 12 months ago, however we are not yet achieving consistent delivery of the 4-hour standard in our emergency departments at the target level set by NHS England for this year (76%).



The causes are varied and include increased demand across primary, secondary, community and mental health services, challenges in recovery productivity post pandemic, ongoing industrial action and staff vacancies.

These challenges will continue over the winter months and will, as in other years, be compounded by additional factors such as seasonally driven increases in illness (respiratory, norovirus etc), cold weather and the ongoing impact from the cost of living crisis.

2. System approach to developing the Winter Plan

The approach to developing the winter plan has been driven by two key influences; national and local requirements.

Each year, national requirements for Winter planning are published, reflecting a response to the trends in operational pressures observed at a national level and the actions required to deliver national policy objectives. This year the guidance '*PRN00645 Delivering operational resilience across the NHS this winter*' was issued on 27 July 2023.

NHS England have set out a number of key requirements and expectations with systems being asked via a self-assessment process to identify four of the ten high impact interventions (HII) that would be the areas of most beneficial focus. In Sussex to support winter preparedness these have been identified as 1) In Patient Flow; 2) Community Beds, Productivity; 3) Urgent Community Response and 4) Virtual Wards. These areas are all in line with the Trust's Emergency Access Improvement plan.

In addition to the national requirements, consideration has been given to specific priorities that best meet the needs of our local population (based on locally observed demand and capacity) and the governance arrangements required to ensure all parts of the system are working together to best mitigate risks thereby providing access to high quality, timely care for patients presenting to our services. A key area of focus across the system is to consider how to reduce the duplication of asks, in particular those that fall on the

same clinical or operational teams for delivery, and to ensure there are a small number of data driven areas of focus.

3. Trust Approach

While the Sussex Winter plan is still in development, this paper aims to update the Board on the Trusts approach to Winter planning for 2023/24 and the areas of focus.

As previously referenced a robust demand and capacity modelling exercise has been undertaken. This modelling evidences the baseline bed requirement and is based on a number of assumptions including:

- Elective activity at 107% of 2019/20 actual
- Non-Elective 2022/23 demand plus 3% growth
- 2022/23 Length of Stay as a baseline

Since July 2023 it has been possible to close a 28 bedded ward as a result of focussed work to reduce the Length of Stay and number of patients not meeting the criteria to reside at Eastbourne. The modelling indicates it will be necessary to re-provide this capacity to manage winter pressures, whilst continuing to focus on optimising length of stay, with particular opportunities in Geriatric Medicine, General Medicine and Stroke.

At Conquest the modelling indicates there is a need to increase Trauma and Orthopaedic capacity and plans are in place to support this. There is also a requirement for additional medical bed capacity and this will be achieved by using beds on Murray Ward and through realising further Length of Stay savings opportunities in Geriatric Medicine, General Medicine, Gastroenterology and Cardiology.

Progress with delivering the Length of Stay reductions, alterations to the current bed configuration and Winter Planning are discussed and overseen at the monthly Urgent and Emergency Care oversight group, which provides regular updates to the Executive Committee. It should be noted the Trust has made good progress with implementing and expanding the Virtual Ward service. There is now capacity to manage 54 patients within their own homes. It should also be noted that in the last week the organisation have had confirmation of £500k to implement the Transfer of Care Hub which will positively impact on discharge processes across the organisation.

Divisional teams are finalising their review of the 2022/23 escalation plan including the triggers relating to staffing levels and Infection, Prevention Control requirements associated with COVID, Flu and Noro-Virus. The revised plan will confirm the actions required when a particular trigger is activated or the number of patients with COVID or Flu increase. We are very clear that we will protect the elective programme and any changes to ringfenced capacity must be approved by the CEO in advance of any changes.

Key areas of focus within the Emergency Access Improvement Plan include:

- Reducing the number of Non-Admitted breaches to improve aggregate Trust performance
- Increasing the number of patients being seen in the Urgent Treatment Centre (UTC) and eliminating type 3 breaches
- Reviewing the medical rotas in our Emergency Departments so they are mapped to the attendance profile
- Consistent implementation of rapid assessment and triage in both EDs to support offloading ambulances and minimising handover delays
- Continuing to improve streaming into SDECs from GP 111 and Emergency Departments
- Continuing to focus on reducing the number of patients with a Length of Stay of greater than seven days and the number of patients who do not meet the criteria to reside
- Implementing the Transfer of Care Hub
- Working with system colleagues to reduce the length of time that patients presenting with a primary mental health condition spend in acute hospital environment

The Trust plan will be finalised over the coming weeks in line with the requirements to submit to ICS colleagues by 10th October prior to onward submission of a system plan to NHS England.

East Sussex Healthcare NHS Trust

Reinforced Autoclaved Aerated Concrete (RAAC) Synopsis and Timeline of Surveys

Purpose of the paper	To provide assurance that a RAAC assessment, including surveys where appropriate, has been completed across the ESHT property portfolio.					
	For Decision		For Assurance	x	For Information	
Sponsor/Author	Michael Chewter – Head of Capital Development Chris Hodgson – Director of Estates and Facilities					
Governance overview	Executive Committee – 13th September 2023					

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 Trust Board is asked to take assurance from the report that a RAAC assessment and surveys have been completed at ESHT in accordance with NHS England and NHS Improvement requests.

Executive Summary	RAAC is a lightweight form of precast concrete which was frequently used in public sector buildings in the UK from the mid-1960s to the 1990s. It is mainly found in roofs and occasionally in floors and walls. It is less durable than traditional concrete and there have been problems as a result, which could have significant safety consequences. Research has shown that this material has a far lower structural loading capacity than other generic reinforced concrete products. The lifespan of RAAC planks has been estimated to be around 30 years. For the purpose of this paper, reference to the term RAAC refers to RAAC planks and not RAAC building blocks. These building blocks are used in walls and are not subject to scrutiny (the trade name Celcon or Thermalite better describes the block type). You will still see these being used on sites today. More detailed information about the issues identified with RAAC planks can be found by following the hyperlink below: Failure of reinforced autoclaved aerated concrete (RAAC) planks On the 11th of November 2019 NHS England and NHS Improvement wrote to all NHS organisations requesting the completion of a survey reporting on the use of RAAC within its built environment. In light of recent reports in the media about the use of RAAC in public buildings, and requests for assurance from the Reginal Operations Centre (Southeast) about the use of RAAC at ESHT, this report is presented for the assurance of the Board. Through various desktop reviews and surveys undertaken at EDGH as noted in the report, it is considered that the presence of RAAC is very unlikely in our properties.

Next steps	No further action is required at this time.

1. Introduction

On the 11th of November 2019 NHS England and NHS Improvement wrote to all NHS organisations requesting the completion of a survey reporting on the use of RAAC within its built environment. The survey required confirmation on whether RAAC had been used in the construction of buildings and if it had, required assurance that the material had been assessed for condition and adequacy. The letter also attached a report that was issued to government departments, local authorities and the NHS in May of that year, although we have no record of receiving that report before the 11th of November. The report, issued by The Institute of Structural Engineers under the reference SCOSS alert May 2019 can be found here.

2. ESHT Response

The survey was completed and returned to the NHS Improvement on the 12th of November 2019, confirming that our local records had been reviewed, that unknown areas had also been reviewed and no RAAC had been found. The CEO at that time (Dr. Adrian Bull) was informed at the same time, which was a requirement of the assurance measures required under the survey.

On the 2nd of August 2021, due to our submission of the Outline Business Case for the New Hospital Programme (NHP), an additional review of the possible use of RAAC in our estate was requested by the Director of Estates and Facilities. The following strategy was proposed:

1. A further review of drawings and specifications of the existing data we had, looking at all buildings under the ownership of the Trust built within the periods 1960-1985 was to be undertaken internally. This was completed at the end of September 2021 and no RAAC was found.

2. At EDGH we invited ESHT estates and projects team, along with our established contracting workforce, to a meeting where a Building Surveyor, from Hamson Barron Smith provided a short lecture on RAAC. After the lecture we asked all present to confirm whether during their tenure at the site of EDGH any material like RAAC had been observed. EDGH was by this time our only area of concern due to the size of the estate and its many adaptions over the years. No areas of concern on RAAC were found. This gave us the most assurance in the whole fact-finding procedure and was completed on 1st December 2021.

3. An inspection by an independent surveyor ratified the above findings over a three-day period.

Although our strategy of survey was successful in areas one and two, the inspection under section three was not undertaken as quickly as we had hoped. Interest in RAAC was gaining momentum in the press and the risk associated with surveying meant that regular surveying firms were stepping back from involvement. In May 2022 we found a practitioner who would survey our EDGH site, on our terms. Over the following two months we commissioned and received a report.

- 4th May 2022 –Chawton Hill engagement.
- 15th June 2022 – Survey took place.
- 24th June 2022 – Report received.

The report and its content reinforced the conclusion that we had reached internally that RAAC was not present within the buildings at EDGH. The main building at EDGH was built in two principal phases and neither of the phases of construction specified the use of RAAC within the design intent; there was no physical evidence of RAAC in their construction and both areas had seen substantial modifications, including core drilling through concrete floors and roof structures, that would have given ample warning of the presence of RAAC over the last 30 years.

Greater levels of scrutiny were given to the potential presence of RAAC at EDGH than to other areas of the Trust's estate. The reasons for this were:

- The scrutiny at EDGH was driven by its involvement with NHP, not by additional scrutiny for the whole estate from external audit.
- The Conquest site is outside of the prescribed time frame (1960s to 1980s), as is the majority of Bexhill site.
- Our remaining estate is formed of smaller buildings and construction is far easier to sample and survey. As an example, Irvine Unit was constructed between 1971 and 1975 and would have been a prime candidate for RAAC; however its size and accessible layout enabled us to verify easily that no RAAC was used within its construction. Extensions to the Unit were added after 1990.

On the 4th of January 2023, the Regional Operations Centre (Southeast) wrote to the Integrated Care Board (ICB) with additional guidance on RAAC. The letter detailed the request of November 2019 and asked for additional assurance that as well as the desktop study previously requested, a physical inspection should also be carried out. Additional guidance was issued by Institute of Structural Engineers (ISS) for the management of RAAC, rather than concerning identification. Of interest was the fact that the dates suggested for RAAC use had been elongated, now starting in the lates 1950s to the 1990s. In response to this request, and as we had already carried out physical inspections in our non-leased estate, we confirmed that we had no RAAC.

The leased estate, which was previously the responsibility of landlords, now became part of the review. We wrote to all of our landlords asking them to identify whether any of the areas or buildings that ESHT leased from them had RAAC present. All responded to confirm that to their knowledge they had no RAAC present.

On the 5th of May 2023, the Regional Operations Centre (Southeast) wrote again, this time asking for a formal response on an online questionnaire by the 2nd of June. Our formal response was logged on a portal on the 25th of May 2023. The portal referenced the same guidance from the ISS and the Trust confirmed that no use of RAAC had been identified within the ESHT estate. No further action was required.

3. Conclusion

RAAC was a mass-produced solution used for spanning large areas for a cost advantage in complete building fabrication. There are some small areas of the Trust which have not been surveyed due to the size and complexity of the Trust's estate, but any use of RAAC in these areas is considered to be unlikely when it has not been seen in other areas of Bexhill, Conquest or EDGH. The Trust therefore considers that the presence of RAAC is very unlikely within the estate at ESHT.

East Sussex Healthcare NHS Trust

Audit Committee
28 September 23

Summary of meeting for Trust Board

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
068/23	Trust Policy Annual Report	• Of the Trust's 1330 procedural documents, 26% were due for review. This was the same figure as at the previous annual report. • From these, a list of priority documents to be updated had been drafted. • Documents relating to Covid-19 had been archived, where appropriate.	
069/23	Board Assurance Framework	• The risk rating for BAF 6 had been reduced from 16 in Q1 to 12 in Q2. This was due to the creation of a Cyber Action Plan which has which lowered the Trust to medium risk status. • The year-end target risk ratings had increased since Q1 for BAF 2 (from 12 to 15) and BAF 3 (from 12 to 16) due to the ongoing and escalating doctors' industrial action.	• Chief Finance Officer to liaise with the Chief of Staff and the wider system around an action plan for BAF 11.
070/23	Corporate Risk Register	• There were a total of 72 risks which qualified as Corporate Risks. This was an increase by five risks from August 2023 (67 risks). • Eight risks were added, one risk score was reduced below extreme rating and two risks were closed in August 2023.	• Head of Governance to review whether a mobile CT scanner for the Conquest site had been considered and advise of viability.
071/23	Information Governance Toolkit Update	• The 2023/24 Data Security & Protection Toolkit (DSPT) was published in August, and evidence providers were reviewing and updating evidence. • ESHT did not have any Information Governance breaches open with the ICO (Information Commissioner's Office).	

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
072/23	External Audit Report	• All external audit work for 22/23 had been completed and work against the 23/24 year would begin in detail from January 2024. • There was not expected to be any change in audit requirements for the coming year.	
073/23	Internal Audit Report	• The following Final Internal Audit Reports had been issued: - Private Patients (3.23/24) – Reasonable Assurance - Digital Strategy (4.23/24) - Reasonable Assurance	• It was agreed that the sector updates and benchmarking reports would be shared with the wider Trust Executive team.
074/23	Anti-Crime Specialist (ACS) Service Progress Report	• The ACS Service advised that across the sector there had been an increase in the abuse of visas and misuse of certificates of sponsorship. • Two new referrals had been made since the previous meeting; one of these had already been closed. • A review around job planning had recently begun and lots of information had already been provided by the Trust. • ESHT benchmarked lower than average for waivers used but the percentage used by reason for 'continuity of service' and 'other' was higher than the average. It was noted that some Trust waivers were for systemwide contracts.	• The Chief Finance Officer would liaise with the ACS Service around delivering further engagement with counter-fraud training across a wider cohort of the Trust.

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
075/23	EPRR Annual Update	• The EPRR Team had submitted all 2023 assurance documentation. The Trust was aiming to achieve 'Full Compliance' this year, however there was understanding that given the current level of industrial action and available resource that maintaining 'Substantially Compliant' would be in line with the expectations of the ICB and NHSE. • ESHT had completed a number of EPRR training exercises at both internal and ICB level. A new and improved training package for On-Call staff was being developed. • A full EPRR update would be brought to Trust Board in December, in line with NHSE guidance.	
076/23	Revised Audit Committee Terms of Reference	• The Terms of Reference had been updated after their annual review and the revised version was approved by the Committee.	

East Sussex Healthcare NHS Trust

East Sussex Healthcare NHS Trust

Audit Committee Annual Report 2022/2023

1. Introduction

The purpose of this report is to formally appraise the Board of the work of the Audit Committee during the period 1st April 2022 to 31st March 2023 and to set out how it has met its terms of reference [attached as Appendix A] and priorities.

2. Meetings of the Committee

The Committee is chaired by a non-executive director with a financial background and membership comprised three other non-executive directors. This reflects and meets the need for independence and objectivity. The Committee convened on eight occasions throughout the financial year and all of the meetings were quorate. Meetings were also held with auditors in private session.

The Audit Committee was chaired throughout this period by Paresh Patel.

Non-Executive Director attendance at meetings was as follows:

Paresh Patel	Audit Chair	7/8
Nicola Webber	Non-Executive Director	7/8
Karen Manson	Non-Executive Director	8/8
Ama Agbeze	Associate Non-Executive Director	1/2

Mrs Webber is the chair of the Finance and Productivity Committee and Mr Patel a member. Mrs Manson and Ms Agbeze are also members of the Quality and Safety Committee.

3. Governance, risk management and internal control

The Committee reviewed relevant disclosure statements, in particular the Annual Governance Statement together with the Head of Internal Audit opinion, External Audit opinion and other appropriate independent assurances, and considered that the Annual Governance Statement was consistent with the Committee's view on the Trust's systems of internal control. Accordingly, the Committee supported Board approval of the Annual Governance Statement.

The Committee provides assurance as to the adequacy and effectiveness of the organisation's systems and processes for risk management. To facilitate this, the Trust's Board Assurance Framework (BAF) and high-level Risk Register were presented to the Committee and scrutinised to test assurances and ensure mechanisms were in place to effectively control and mitigate risks. The articulation of risks has continued to improve, and there is increased scrutiny at sub-committee level. The updated BAF continued to be embedded and improved during the year.

Progress against achieving compliance with the Data Security and Protection Toolkit (DSPT) was monitored throughout the year. The DSPT year-end submission would be due on 30 June 2023.

4. Internal audit

The internal audit service for 2022/23 was provided by TIAA Limited. An internal audit representative attended all six meetings of the Committee to which an invitation was received during the year.

The Audit Committee approved the internal audit programme of work. There were several changes to the internal audit programme during the year, reflecting changes in priority and to accommodate a mandated audit of Financial Sustainability based on the HFMA checklist. The delivery of the internal audit work for 2022/23 was impacted by operational pressures at the Trust and it was not possible to complete reviews of Theatre Productivity and Inequalities, with the time repurposed to support transition and handover of the internal audit service to new providers from 2023/24 and to undertake detailed follow-up and updating of the audit recommendations tracker. This did not, however, affect TIAA's ability to provide a Head of Internal Audit Opinion based on the work carried out, with all fundamental review areas on the plan having been completed. The Committee received a report from the internal auditor at each of its committee meetings which summarised the audit reports issued since the previous meeting. Committee members are also sighted on all finalised Internal Audit Reports.

TIAA carried out 18 assurance and eight advisory reviews, which were designed to ascertain the extent to which the internal controls in the system are adequate to ensure that activities and procedures are operating to achieve the Trust's objectives. Three audits gave 'substantial assurance', eleven audits gave 'reasonable assurance' and four gave 'limited assurance'. In addition, there were eight advisory reviews which did not assign an assurance opinion.

Throughout the year, the Committee worked effectively with internal audit to strengthen the Trust's internal control processes. The overall annual opinion from TIAA was Reasonable Assurance on the adequacy of the Trust's risk management, control and governance processes.

From 1st May 2023, RSM will provide internal audit services for the trust, appointed for a period of three years with two twelve-month options to extend.

5. External audit

The external audit service is provided by Grant Thornton UK LLP, appointed for a period of three years during the 2022/23 financial year. An external audit representative attended seven of the eight meetings of the Committee during the year.

The Committee approved the External Audit Plan at the start of the financial year and received regular updates on the progress of work. At each meeting, the Committee received reports and briefings from the external auditors in accordance with the national requirements. These included: the annual audit letter; final accounts memorandum; a report on the audit of financial statements; and briefings on specific issues.

6. Counter-Fraud Services

The Trust's Counter Fraud services are provided under contract by TIAA Limited to enhance the Trust's overall anti-fraud arrangements through a range of agreed activities, managed and monitored against an approved counter fraud work plan for 2022/2023. A Counter Fraud representative attended all six meetings of the Committee during the year to which an invitation was received during the year.

The Accredited Anti-Crime Specialist works with the Trust to ensure that they are compliant with the Government Functional Standard 013: Counter Fraud (GFS: CF).

The Chief Financial Officer has overall responsibility for the Counter Fraud Service. In addition, the Trust has a nominated Fraud Champion which is a requirement of the NHS CFA, and satisfies the requirement of the GFS: CF.

The Senior Anti-Crime Manager and the Anti-Crime Specialist are regular attendees of the Trusts Audit Committee where they report on progress made against active fraud investigations where the Trust is a potential victim, as well as on planned proactive work.

The Counter Fraud Service undertakes proactive work to detect abuse or fraud as well as investigating suspicions of fraud. There is a full set of policies and procedures in place and contact information is available on the Trust intranet and included in staff updates.

During 2022/23, the activities of the fraud service included:

• Issuing national and local Fraud Alerts to the Trust for circulation to relevant staff

• Issuing Fraud Stop Newsletters for circulation to all staff

• Issuing TIAA's seventh annual Fraud Digest, which is used to measure the level and direction of fraud across the client base

• Monitoring the National Fraud Initiative for the Trust

• Offering TIAA webinars on key issues

• Developing with the Trust an e-learning Counter Fraud module to be used as part of Trusts training programme

• Providing two Fraud Stands attended by Counter Fraud representatives across both sites as part of International Fraud Awareness Week

• Reviewing policies to ensure fraud proofed prior to submission to the Policy Ratification Group

• Undertaking full Counter Fraud Risk Assessment 22/23 in line with requirements of the CFS: CF.

• Proactive reviews on expenses contract management, charity arrangements and overlapping employment and agency staff.

• Completing monthly sample checks of Declarations of Interest for period June 2022 to March 2023.

• Initial enquiries and investigations in respect of concerns raised regarding a variety of topics, including staff working whilst sick, submission of claims by staff for private work when not undertaken and staff not working contracted hours.

The Trust has not undergone any inspection by NHS CFA in the current year.

From 1st May 2023, RSM will provide counter fraud services for the trust, appointed for a period of three years with two twelve-month options to extend.

7. Management

The Committee gave constructive challenge to the assurance process when appropriate and requested and received assurance reports from Trust management and various other sources both internally and externally throughout the year.

The Committee worked closely with the executive directors to ensure that the assurance mechanisms within the Trust were fully effective and that a robust process was in place to ensure that actions resulting from external reviews were implemented.

8. Financial reporting

The Committee reviewed the annual financial statements before submission to the Board and considered them to be accurate.

9. Review of the effectiveness and impact of the Audit Committee

The Committee performed its duties during the year as delegated by the Trust Board and mandated through governance requirements, ensuring compliance with, and further developing, good practice.

The Committee undertakes a review of its Terms of Reference on an annual basis and will present updated documents to the Board in August.

10. Audit Committee Chair's Comments

The Audit Committee has supported the Board by critically reviewing the governance and assurance process on which the Board places reliance. The Committee has sought and found assurance that internal controls (clinical and non-clinical) are reliable, robust, appropriately applied, and support the Trust's objectives, and has sought reports and assurances from officers as appropriate.

The Committee has ensured that there are effective internal and external audit and counter-fraud functions which provide appropriate independent assurance to the Committee, the Chief Executive and the Board, and has monitored the integrity of the Trust's financial systems, and systems of control, and found these to be effective.

The Committee has appropriately reported issues to the Board on an exception basis, and there are no matters of which the Committee is aware that have not been appropriately disclosed.

Paresh Patel

Audit Committee Chair

2023

East Sussex Healthcare NHS Trust

Audit Committee - Terms of Reference

1. Constitution

The Board has resolved to establish a committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. These terms of reference shall apply for as long as the Trust is an NHS Trust and can only be amended by the Trust Board.

2. Purpose

The Audit Committee will support the Board by critically reviewing governance and assurance processes on which the Board places reliance. It will seek assurance that financial reporting and internal control principles are applied, and maintain an appropriate relationship with the organisation's auditors, both internal and external. This includes the power to review other committee's work, including in relation to quality, and to provide assurance to the board with regard to the reliability and robustness of internal controls.

The Committee will agree and work to an annual programme that takes into account the need to contribute to the timely sign-off of statutory requirements such as the annual accounts. This programme will be reviewed by the Board. The Committee may be commissioned by the Board to undertake particular studies or investigations, or to focus attention on any matters relating to finance and investment as the Trust Board thinks fit.

3. Membership

The Committee shall be appointed by the Chairman of the Trust Board from amongst the non-executive directors of the Trust and shall consist of not less than three members.

One of the members will be appointed Chair of the Committee by the Trust Board Chairman. One member should also be a member of the Quality and Safety Committee and one member a member of the Finance and Productivity Committee.

At least one member of the Committee should have recent and relevant financial experience.

The Chairman of the Trust shall not be a member or act as substitute for a member of the Committee.

Other non-executive directors of the Trust, including any designate non-executive directors, may substitute for members of the Audit Committee in their absence and will form part of the quorum.

4. Attendance

Members of the Committee are expected to attend all meetings; if this is not possible then another non-executive director may substitute as outlined in the preceding paragraph.

The Chief Financial Officer and appropriate Internal and External Audit representatives shall normally attend the meetings.

At least once a year the Committee should meet privately with the internal and external auditors.

The Chief Executive and other executive directors shall be invited to attend particularly when the Committee is discussing areas that are the responsibility of that Director.

The Chief Executive shall be invited to attend, at least annually, to discuss with the Committee the process of assurance that supports the Annual Governance Statement.

The Company Secretary (or their nominee) shall attend the meetings to provide appropriate support and advice to the Chairman and committee members.

5. Quorum

A meeting of the Committee shall be quorate if at least two members are present, one of whom shall be the Chairman of the Committee or his delegated nominee. Other non-executive directors of the Trust, including any associate non-executive directors who are substituted for members, may form part of the quorum.

6. Frequency

Meetings shall be held not less than four times a year and at such other times as the Chairman of the Committee shall require. The external auditor or head of internal audit may request a meeting if they consider that one is necessary.

7. Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference and in line with the Committee's prime purpose of providing assurance to the Board.

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

8. Duties

8.1 <u>Governance, Risk Management and Internal control</u>

The Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- the board assurance framework, risk management system, Annual Governance Statement together with an accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to discussion by the Board where possible

- the information governance system, including requirements under the Data Security & Protection Toolkit (DSPT) and progress in implementing the General Data Protection Regulations (GDPR)

- the rigour of the processes for producing the quality accounts, in particular whether the information included in the quality account is reported accurately and whether the quality account is representative in its reporting of the services provided and the issues of concern to its stakeholders.

- the underlying assurance processes, the effectiveness of the management of principal risks and the appropriateness of the Annual Governance Statement

- the policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting

- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service

- Standing Financial Instructions (SFIs) and Standing Orders (SOs) on an annual basis.

- the Committee shall report issues in relation to audit, risk or internal control to the Board of Directors on an exception basis in addition to an annual report focused on the effectiveness of the Committee in exercising these duties.

- the Committee will be responsible for forming a panel to procure and appoint both internal and external auditors

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions.

It will also seek reports and assurances from officers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

8.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board. The Committee will approve the appointment of any new internal auditor for the Trust. This will be achieved by:

- Consideration of the provision of the Internal Audit Service, the cost of the audit and any questions of resignation and dismissal.

- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that it is consistent with the audit needs of the organisation as identified in the Assurance Framework and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

- Review of the major findings of Internal Audit work, management's response and the implementation of management action

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.

- An annual review of the effectiveness of internal audit.

8.3 External audit

The Committee shall review the work and findings of the External Auditors and consider the implications and management's responses to their work. The Committee will approve the appointment of any new external auditor for the Trust. This will be achieved by:

- consideration of the appointment and performance of the External Auditor as far as the rules governing the appointment permit.

- discussion and agreement with the External Auditor, before the audit commences on the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate with other external and internal auditors in the local health economy.

- discussion with the External Auditors of the local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

- review of all external audit reports including agreement of the annual audit letter before submission to the Board for any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

8.4 Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of Counter Fraud work.

8.5 Other assurance functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include but will not be limited to reviews by:

- Department of Health
- Care Quality Commission
- NHS Litigation Authority

- Other regulators and inspectors
- Professional bodies with responsibility for performance of staff or functions including Royal Colleges and accreditation bodies
- The Trust's internal assurance function

In addition, the Committee will review the work of other Committees within the organisation whose work can provide relevant assurance to the Audit Committee's own scope of work; in particular this will include the Quality and Safety Committee and the Finance and Productivity Committee. In reviewing the work of the Quality and Safety Committee and issues around clinical risk management, the Audit Committee will wish to satisfy itself that appropriate assurance that can be gained from the clinical audit function and to take the advice of the Quality and Safety Committee on how this function should best be utilised.

8.6 Hosted arrangements

The Committee will, on an exception basis, review and provide assurance to the Board in respect of any hosted arrangements or services, both those services hosted by the Trust and also those services hosted elsewhere but to which the Trust is a party.

8.8 Management

The Committee shall request and review reports and positive assurances from Directors and Managers on the overall arrangements for governance, risk and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example clinical audit) as they may be relevant to the overall arrangements.

8.9 Financial reporting

The Committee shall monitor the integrity of the financial systems of the Trust and systems of financial control.

The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- changes in and compliance with accounting policies and practices.
- unadjusted mis-statements in the financial statements.
- significant judgments in preparation of the financial statements.
- significant adjustments resulting from the audit.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

9. Reporting arrangements

Minutes of the Committee meetings shall be formally recorded by the Company Secretary, or their nominee, and submitted to the Board. The Chair of the Committee shall present a short written summary of Committee meetings to the Board in order to draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness of purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and compliance with CQC registration standards.

The Committee shall undertake a self-assessment of its effectiveness on at least an annual basis and this will be timetabled into the schedule of audit committee business.

This assessment will follow best practice as outlined in the NHS Audit Committee Handbook and may be facilitated by independent advisors if the Committee considers this appropriate or necessary. A copy of the self-assessment and any proposed actions will be reviewed by the Trust Board.

These Terms of Reference shall be reviewed by the Committee and Trust Board at least annually.

East Sussex Healthcare NHS Trust

Finance and Productivity Committee 28 September 23

Summary of meeting for Trust Board

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
146/23	Board Assurance Framework	• BAF 4 risk rating remains at 12. Likelihood aspect of risk rating was challenged and discussed. • BAF 5 risk rating remains at 16 • BAF 7 risk rating remains at 16. Focus of BAF description challenged. • BAF 8 risk rating remains at 16	• BAF 7 to be discussed and revised by Executive team to widen focus to include Business Intelligence aspects from across the organisation and not just clinical systems.
147/23	M5 Financial Performance	• Presentation of Trust's financial position both within M5 and year to date presented, with key issues highlighted. • Trust was £2.2m behind internal plan in year, driven by additional expenses associated with industrial action and caring for patients with mental health issues	• Committee noted the update
148/23 (a)	Productivity Portfolio Update	• Improvements in elective and day case performance were noted. • Focus now moving to improving length of stay performance	• Committee noted the update and thanked teams for overachieving on elective and day case performance.
148/23 (b)	Trust Response to "Protecting and Expanding Elective Capacity" Letter	• Presentation on interventions and recovery actions in place to address areas of under performance against the 108% elective ask following receipt of letter from NHSE in August 2023	• Committee noted the actions being taken. • More sophisticated Business Intelligence reporting was being developed by the Trust to support process.
148/23 (c)	KPI Dashboard	• Performance metrics presented	• Request for a change to presentation of data to allow trends to be more easily identified • Update on 6:4:2 theatre productivity to be included in October's report

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
149/23	System Financial Performance	• Update on month 5 financial performance of the Sussex system presented.	• Committee noted that system's financial position
150/23	M5 Capital Position	• Update on Trust's month 5 capital position presented. • Trust was £1.1m behind planned expenditure of £8.6m, but anticipate that end of year target will be achieved.	• Summary of material risks to 2023/24 capital plan to be presented at next meeting
151/23	Sussex Premier Health (SPH) Six Month Update	• Update on financial and operational performance of SPH presented	• Committee noted the update
152/23	Items for escalation from CRG	• Discussion about correct governance process for approving business plans for enabling works for NHP took place	• Governance process and indicative timelines for enabling works to be presented to Committee

East Sussex Healthcare NHS Trust

People and Organisational Development Committee 21 September 23

Summary of meeting for Trust Board

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
3.1	Workforce Insight Report	Update on August People Insight Report	Committee noted the report. Discussion took place about the increase in Temporary Workforce expenditure; it was agreed that impact of Industrial Action would be provided.
4.1	Board Assurance Framework Q2	BAF 2 - Assessed at 15 – national recruitment challenges remain in some specialties. BAF 3 - Assessed at 16 data demonstrates reduced engagement at local and wider NHS level	Clarity provided that BAF3 position was unchanged from Q1
5.1	Health & Wellbeing	Highlight report on priority actions over 12 months	Committee noted the report
5.2	Partnership Forum	Verbal presentation of key actions of partnership forum	Committee noted the progress and offered support
6.1	Guardian of Safe Working Hours Quarterly Update	Exception Reporting remain low but in line with previous years reporting. Exception reporting is now extended to Locally Employed Doctors No immediate safety concerns noted	Committee noted the report
7.1	Appraisal Compliance	Identification of 'hot spot' areas for appraisal compliance Proposed actions to improve compliance.	The committee noted the continual improvement in appraisal compliance and supported the proposed action.

Annual Review of Effectiveness - People & Organisational Development Committee

Purpose of the paper	It is best practice for every Committee of the Trust to conduct an annual self-assessment review of its effectiveness and to produce an Annual Report for the Board. The attached report provides an overview of the activities of the Committee and confirms how it has complied with its Terms of Reference. It sets out the outcome of the effectiveness review which was conducted via a questionnaire to all Committee members in May 2023. The Terms of Reference were reviewed at the May 2023 and finalised at the June 2023 meeting.						
	For Decision		For Assurance	x	For Information		
Sponsor/Author	Carys Williams – Non-Executive Director (Chair of POD Committee) Steve Aumayer – Deputy CEO and Chief People Officer						
Governance overview	Report will be presented to Trust Board in August 2023.						

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 Committee is requested to review and endorse the attached report.

Executive Summary

1. Introduction

The purpose of this paper is to provide assurance to the Trust Board that the People and Organisational Development Committee (POD) has conducted its objectives in accordance with its Terms of Reference set by the Trust Board.

2. Authority and Duties

POD is a sub-committee of the Board and was established in March 2016. The Committee's Terms of Reference were last reviewed and updated in June 2023. POD has responsibility for strategic oversight of workforce development, planning, performance and culture. It provides assurance to the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting the Trust objectives and organisational success.

The Committee meets monthly and is chaired by a Non-Executive Director of the Trust and includes a broad membership including, HR and OD staff, senior managers, staff-side and equality and diversity representatives.

3. Annual Self-Assessment of Effectiveness

In May 2023, the Committee undertook an annual self-assessment of its effectiveness, completed by 10 members. Members stated that the monthly Committee meetings were effective with good attendance.

Committee members felt that agendas were appropriately well-structured with 1 member requesting assurance on managing key risks and basic aspects such as appraisals. 1 member requested for papers to be circulated with enough time to read them in advance of the meeting to improve the effectiveness of the Committee.
Members concurred that matters considered and decisions made by the Committee were taken on an informed basis and that these decisions were understood, owned and properly recorded and would bear scrutiny; subsequent implementation of decisions and progress had been reported back to the Committee.

An effective feedback mechanism from POD Committee to the Board was in place, with the minutes being received and matters highlighted by the Committee Chair at each Board meeting. 1 member suggested this could be more widely communicated relating to the outcomes from the Board.

4. Annual review of terms of reference and work plan

The Annual Work Programme was set at the start of the year and matters considered over the past year have included:

- Updates on national workforce agenda
- Employee Relations trends and good practice
- Guardian of Safe Working Hours
- Freedom to Speak Up Guardian
- Workforce planning and metrics
- Staff and doctor surveys and action plans
- Equality and diversity and Workforce Race Equality Standards
- CQC Well Led Framework
- Appraisal Rates
- Retention Strategy
- Integrated Education to include funding issues, apprenticeships and training needs analysis
- Leadership development
- Staff health and Wellbeing
- Staff Survey
- People Strategy
- Deep Dives:
    - Looking after our people
    - New ways of working and delivering care
    - Creating a culture of inclusion and involvement
    - Growing for the future

The self-effectiveness review was considered as part of the review of the Terms of Reference at the May 2023 Committee meeting and it was agreed to continue to meet on a monthly basis, although meetings may be cancelled in exceptional circumstances (for example due to operational pressures). The membership was reviewed and job titles updated.

At each meeting, the Committee will focus on:

- Operational updates
- Deep Dive – Rotating between the 4 strategic themes
- Items drawn from the rolling POD Committee Work Planner

Carys Williams
People and Organisational Development Committee
Committee Chair
June 2023

People and Organisational Development (POD) Committee

Terms of Reference

1.	**Constitution and Purpose**
	The Board has resolved to establish a Committee of the Board to be known as the People and Organisational Development Committee (the Committee). The Committee's remit will encompass strategic oversight of workforce development, planning and performance. It will provide assurance to the Board that the Trust has the necessary strategies, polices, procedures and capabilities in place to ensure a high performing and motivated workforce that is supporting the Trust objectives and organisational success. Where broader organisational policies or processes inhibit the performance or motivation of individuals and their ability to contribute to the delivery of Trust strategy and goals, it will highlight such issues as appropriate for further consideration and review. The Committee will consider cultural development within the Trust to align behaviours with strategic objectives to promote a learning and supporting work environment. This would encompass consideration of staff development, career progression and managerial culture.
2.	**Membership**
	Non-Executive Director (Chair) Non-Executive Directors x 2 Chief People Officer Chief Nursing Officer Chief of Staff Deputy Director of People Deputy Director of Culture Deputy Chief Medical Officer Staff Side Chair Deputy Staff Side Chair Partnership Forum Lead Assistant Director HR – Education Company Secretary Director of Medical Education Divisional Chair Workforce, Equality, Diversity and Inclusion Lead Other Board members may attend by open invitation.
3.	**Quorum**
	The Committee shall be quorate when one third of members are present. Nominated Deputies will count towards the quorum. At least one Non-Executive Director must be present (this may be the chair or another Non-Executive).
4.	**Attendance**
	Other staff, including members of the People Directorate may attend to address specific agenda items.

5. Frequency of meetings and administration

The Committee shall normally meet on a monthly basis, although meetings may be cancelled in exceptional circumstances (for example due to operational pressures).

At each meeting the Committee will focus on:

- Operational updates
- Deep Dive – Rotating between the 4 strategic themes
- Items drawn from the rolling POD Committee Work Planner

The Chair can call a meeting at any time if issues arise. Administrative support for the Committee will be provided by the EA to the Chief People Officer.

6. Duties

To monitor and advise on:

- Organisational response and fit with strategic objectives
- Promotion of Trust values and vision and goals as part of staff development
- Learning and best practice propagation opportunities and uptake across the Trust
- The strategy for people in ESHT, its implementation and key trends in human resource metrics
- Equality and diversity in the workforce
- The strategic and assurance processes for the management of human resources risks to include health, safety and wellbeing and the quality of implementation of those processes
- External developments, best practice and trends in employment practice
- Staff recruitment, retention and talent management
- Staff engagement
- The incentive and reward strategy for ESHT, its integrity and effectiveness, including appraisal and the management of performance
- Training and development activity
- The alignment of people and capabilities with organisational strategies and plans
- The inclusion of people and OD thinking and support in the delivery of major Trust projects and initiatives
- The embedding of transformational capabilities within the organisation to support the delivery of a high performing organisation
- The efficiency of the workforce and its alignment with the delivery of our operational goals
- Other organisation development/organisational change management considerations in the delivery of a high performing organisation
- Any other significant matters relating to the performance and development of the workforce.

To convene task and finish groups to undertake specific work identified by itself or the Trust Board.

7. Parent Committees and reporting procedure

The Committee Chair will report activities to the Trust Board following each meeting or as required. The minutes of the meetings will be provided to Trust Board for information.

These Terms of Reference shall be reviewed by the Committee and Trust Board at least annually. In addition, the Committee shall undertake a self-assessment of its effectiveness on at least an annual basis and this will be timetabled into the schedule of Committee business.

The Committee will provide an annual report to the Board on the effectiveness of the Committee.

8. Sub-Committees and reporting procedure

Education Steering Group
HR Quality & Standards Group
Health & Safety Steering Group
Talent Management Group

East Sussex Healthcare NHS Trust

Quality & Safety Committee 21 September 23

Summary of meeting for Trust Board

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
143/2023	Patient Safety & Quality Group	• Violence & aggression remain a concern • Sustained increase in patients with mental health issues and a notable rise in incidents of aggression. • Assurance sought that rapid assessment tool relating to domestic abuse being used.	• Violence & aggression Reduction Group working through action plan. • Ongoing discussions with Sussex Partnership Foundation Trust and the Integrated Care Board Mental Health Board. • Maternity and Sexual Health teams to be asked for audit data.
144/2023	Patient Safety Incident Response Framework and Plan	• Framework and plan presented. Go live date of 20 November 2023.	• Committee noted and recommended that the plan be passed to Trust Board for approval.
145/2023	Harm Reviews	• Concern noted regarding gynaecology numbers.	• Chief Medical Officer and Karen Manson (NED) to meet to discuss.
146/2023	Division Report – Core Services	• Recruitment to histopathology post but vacancies continued to present a risk. • Increase in Mortuary freezer capacity required. • Estates issues related to leaking and damages ceilings.	• Risks remained on the register but would be reviewed and captured in one succinct risk. • Paper being prepared for the Capital Expenditure Group to obtain funding. • Support from Estates and Facilities Team noted.
147/2023	Governance Quality Report (Aug 23 data)	• Unusually - Critical Care featured in the top three reporting locations. Mainly due to inability to discharge patients. • Increase in medication errors. Low harm, no specific themes or trends. • 4 Serious Incidents. Maternity top location over the year but no obvious themes or trends. • Icloud Risk Management system due to go live in October 2023	• To be monitored. • To be monitored.

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
149/2023	Maternity Clinical Quality Surveillance Report (Jul 23 data)	• Continued challenges regarding workforce but steady improvement.	
150/2023	Quality & Safety Dashboard	• No progress with a new/more detailed dashboard.	• Chief Nurse to convene a meeting with involved colleagues to progress and a new iteration to be available at the October 2023 meeting.
151/2023	Safer Staffing (Jun/Jul 23 data)	• Additional staff requirements in the Emergency Departments due to significant numbers of patients with mental health issues. • Nursing Establishment Review data collection period underway. • Pilot of Community Safer Staffing Tool to commence October 2023.	• Case for mental health outreach team being developed.
152/2023	Infection Prevention & Control Board Assurance Framework	• Improvement overall and where partial compliance this was due to evidence being collated and not a lack of compliance. • Food safety (patient owned food). • Antimicrobial stewardship and Cdiff exceedance. • Out of date policies.	• Policy in development. • Pharmacy colleagues linking with Infection Prevention and Control colleagues to address. Paper to execs. • Being reviewed and a plan for sharing of policies within the Integrated Care System to achieve consistent approach and reduce burden.
153/2023	Quality Account Priorities for 2023/2024 – Progress Quarter 1	• Progress in all three priorities. • End of Life Care may need medical support.	• Review Quarter 2. Plans to look at medical leadership in End of Life Care and ReSPECT.

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
159/2023	Corporate Safeguarding – 6 monthly report	• Risk and poor patient experience due to ongoing large numbers of pts with no physical health need known to MH services (maternity/perinatal in particular). Violence and Aggression increasing.	• Mental health outreach team being considered along with further staff training to mitigate risk and keep patients safe. Environmental risks need further/exec discussion.
161/2023	Occupational Safety & Health Improvement Plan	• For deeper discussion at the October 2023 meeting but noted improvements being made following ligature risk audit. • Policy approved by the Patient Safety & Quality Group.	
162/2023	Annual Review of QSC Effectiveness and Terms of Reference	• Discussion about how to resolve lengthy agenda and volume of papers. • QSC Dashboard and Balance Scorecard key documents required as points of reference. • Reinforcement of escalation and assurance role of the Committee. • Minor amendments to Terms of Reference approved.	• Chief Nurse, Chief Medical Officer to review the report schedule to ensure it is relevant and manageable and review ToR and membership. • To look at all reports and propose use of SBAR. • To review PS&QG ToR and function. • Chief Nurse convening meeting to progress the dashboard and confirm what the next iteration will look like.

Agenda item number	Title and function of the paper	Key points made in the paper	Associated actions (as necessary)
154/2023	Board Assurance Framework – Quarter 2	• Review of BAF 10 *Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that are discharge ready with an extended length of stay.* Challenge regarding the rating of 16. • Review of BAF 12 *Failure to meet the four-hour standard (shared risk with the Chief Medical Officer and the Chief Operating Officer).*	• Chief Nurse to review again the rating and gaps in assurance.
155/2023	Maternity Overview Board Report – 2023/2024 – Quarter 1	• No specific concerns in relation to quality & safety. • Improvement in transitional care. • Continued neonatal staffing issues but expected to improve October 2023 with the arrival of newly qualified. • Increasing complexities of service users impacting staffing. • Reinforcement of freedom to speak up. • 3 year delivery plan – good progress. • Risk related to Special Care Unit taking babies born from 31 weeks (instead of 32) due to capacity issues at UHSx. • Ultrasound scan capacity issues.	• To clarify and discuss SCBU in MatNeo Assurance meeting. • Midwives trained but additional support needed from Radiology but a national issue.
157/2023	Getting It Right First Time (GIRFT) – 6 monthly progress report	• Steady progress. • Focus on High Volume Low Complexity and system work ongoing to reduce elective/planned surgery backlogs. • Virtual elective recovery deep dive visit took place 14 September 23 – recommendations to come.	

East Sussex Healthcare NHS Trust

New Standards for NHS Board Members: The Fit & Proper Person Test (FPPT) Framework

Purpose of the paper	This paper sets out a summary of the purpose and content of the Fit and Proper Person Test (FPPT) Framework our actions to ensure compliance.					
	For Decision		For Assurance	x	For Information	x
Sponsor/Author	Sponsor: Richard Milner, Chief of Staff Author: Pete Palmer, Board Secretary					
Governance overview	This report has been shared with the Chairman and Chief Executive for comment before being brought to the Board.					

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 new requirements for the FPPT for Board members and the actions being taken to ensure compliance.

Executive Summary	In 2014, the Government introduced a requirement, via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations), on all health and adult social care providers registered with the Care Quality Commission (CQC). This was to ensure board directors, board members and individuals who perform the functions equivalent to the functions of a board director and member, were 'fit and proper' for their roles. On 2nd August 2023 , NHS England published the Fit and Proper Person Test (FPPT) Framework, in response to the Seven Recommendations - The Kark Review. The framework supports good governance, leadership and board development and applies to all board members (including interim appointments and non-voting members) of NHS provider and FT trusts, ICB, CQC and NHSE board members. The requirements build on existing FPPT processes. Core elements are: good character; possessing qualifications, skills and experience required; and financial soundness. These are in addition to standard employment checks that are undertaken for all staff. FPPT testing needs to be undertaken whenever a Board member joins a new organisation, starts in a new Board role and on an annual basis. Standardised board member references now need to be created whenever a Board member leaves an NHS organisation (regardless of whether they are moving to another NHS organisation) and should be sought by employing NHS organisations when making a job offer.

Next steps	1. All Board members to be subject to an FPPT test during 2023/24 with the process completed and submitted to regional NHSE director by 31st March 2024 2. FPPT testing and Board member appraisals to be aligned from 2024/25 3. Progress to be monitored by Remuneration Committee 4. Annual update to Trust Board on FPPT compliance to be scheduled

1. Background

1.1 NHSE published a new Fit and Proper Persons Test (FPPT) Framework on 2nd August 2023, alongside guidance for chairs and for board members on its implementation. Some elements of the framework need to be implemented from 30th September 2023, with full implementation by 31st March 2024. While this is a non-statutory framework, the statutory requirements for FPPT are set out in Regulation 5 of the Health and Social Care Act 2008.

2. Key Points

2.1 The framework supports good governance, leadership and board development and applies to all board members (including interim appointments and non-voting members) of specified NHS organisations (NHS provider and FT trusts, ICB, CQC and NHSE board members).

2.2 The requirements build on the existing FPPT processes. Core elements are: good character; possessing qualifications, skills and experience required; and financial soundness. These are in addition to standard employment checks that are undertaken for all staff.

2.3 Standardised board member references need to be created whenever a board member leaves an NHS organisation, regardless of whether they are moving to another NHS organisation and should be sought by employing NHS organisations when making a job offer. The reference template is based on the NHS standard reference template, with some additional questions relevant to FPPT.

2.4 ESR will be used to store information related to FPPT checks and references.

Timeline for implementation		
By 30 September 2023	**By 31 March 2024**	**By end of Q1 2024/25**
• Chair to communicate new process to members of the Board, including that their details will be included on ESR for FPPT purposes. Circulate privacy notice for information. • Use new reference template for all Board appointments • Complete and retain references for all Board members who leave the organisation or start a new Board role in the organisation • Use the forthcoming NHS Leadership Competency Framework as part of the recruitment process for all Board roles	• Full annual FPPT review of all Board members completed • Individual annual self attestations completed for all Board members • Annual submission form completed and submitted to regional NHSE directors • ESR database updated	• Incorporate NHS Leadership Competency Framework into annual appraisal process for all Board members • Align FPPT process for 2024/25 with Board member appraisal dates

2.5 A full FPPT (see bullet points over the page) will be undertaken whenever new Board appointments are made and/or if a Board member moves to a new role within their current organisation, and annually thereafter.

2.6 The chair of the board is accountable for taking all reasonable steps to ensure the FPPT is effectively implemented in their organisation.

2.7 The framework will be subject to an evaluation by NHSE of its effectiveness 18 months following its launch. Future considerations include implementing a public facing register and including other 'significant roles' within the scope of FPPT.

2.8 Previously annual FPPT testing has been undertaken by the Board Secretary, reported to the Remuneration Committee, and included checks on Companies House and charity commission websites. FPPT's will now need to be undertaken at the same time of year as annual appraisals (incorporating the competency review) and signed off by the Chair (for NEDs), SID (for Chair) and CEO (for Execs). The process will continue to be undertaken and supported by the Board Secretary.

2.9 FPPTs were previously checked by external auditors as part of the year end process. An annual declaration will now need to be completed by the Trust Chair and submitted to the NHSE regional director confirming that each member of the Board during the previous financial year has been subject to FPPT and that they have been confirmed as fit and proper.

2.10 There is a long list of checks that will need to be undertaken when recruiting Board members, which are set out below. NHSE currently undertakes pre-employment checks for the Chair and NEDs, and it is currently unclear whether NHSE will undertake all of the checks below. The Trust undertakes checks for Associate NEDs and Executives. Checks in bold will need to be undertaken when starting in a role and also on an annual basis:

1. First/Second name
2. Organisation (current employer)
3. Staff Group
4. Current Job Title
5. Occupation Code
6. Position title
7. Employment History
8. References
9. Date of Medical (Occupational Health) clearance
10. **Training and Development**
11. **Last Appraisal and Date**
12. **Disciplinary Findings (upheld)**
13. **Grievances against**
14. **Whistleblowing claims against**
15. **Behaviour not in accordance with organisation values**
16. **DBS disclosure and date undertaken (should be renewed on a three year cycle)**
17. **Date of professional register check (if appropriate**)
18. **Insolvency check**
19. **Disqualified Directors Register check**
20. **Disqualification from being a Chairty Trustee check**
21. **Employment tribunal judgement check**
22. **Social media check**
23. **Self Attestation form signed**
24. **Sign off by Chair, SID and CEO**

2.11 There are a number of grounds under which a Board member may be found to be unfit under FPPT but may be considered to still be fit to be appointed (for example lack of qualifications but has relevant appropriate experience). In these circumstances a documented explanation approved by the chair, of why an individual is deemed to be fit to be appointed, should be included in the annual return to the NHSE regional director.

2.12 Should a breach of FPPT be identified during testing that is so serious that the board member will never be considered to be fit and proper (such as a criminal conviction or safeguarding incident) then the board member is not appointed or leaves with immediate effect. A dispute resolution process has been developed to support this. The Chair will notify the NHSE regional director through the annual return, or as an ad hoc update.

2.13 If an identified breach can be resolved (for example development of competency) then actions and a timeline should be agreed, and the NHSE regional director notified.

2.14 Quality assurance checks of FPPT will be undertaken by: the CQC, as part of their well led inspections; NHSE, through receipt and review of annual submissions; internal/external review – every three years internal audit should assess FPPT processes, controls and compliance. This should also be reviewed as part of any commissioned well led review.

3. Governance requirements

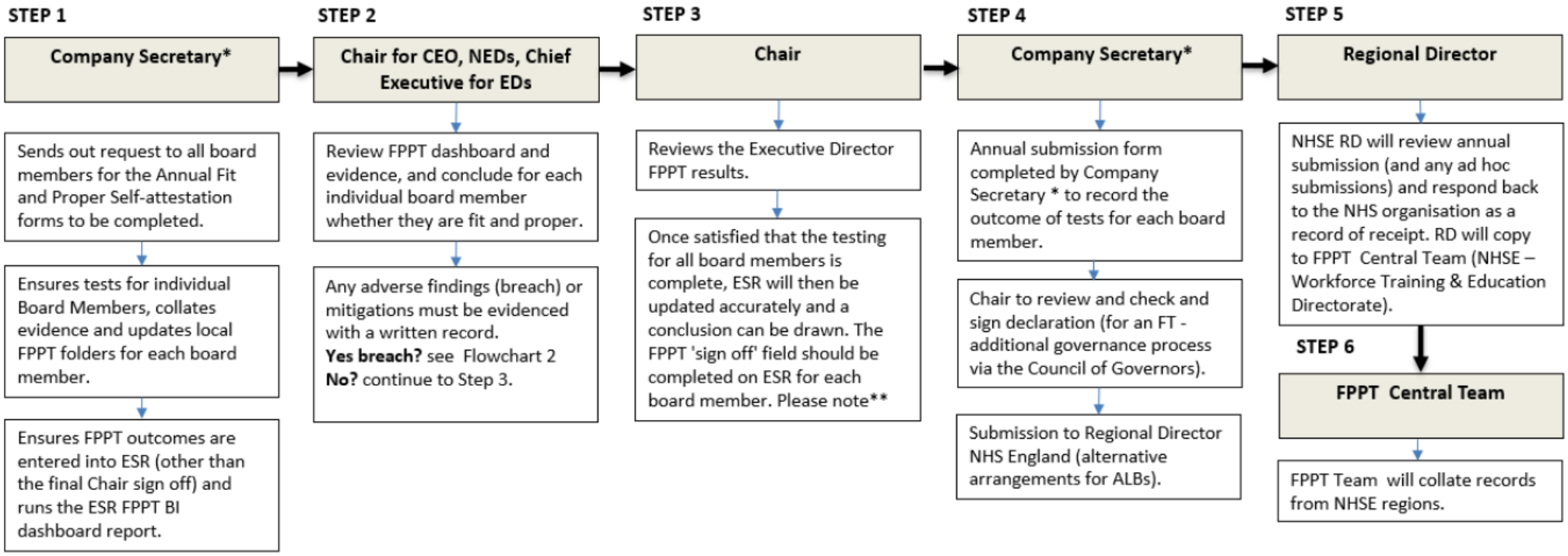
3.1 An annual update should be provided at a Board meeting in public to confirm that the requirements of FPPT have been met, and the Audit Committee should consider whether internal or external audit reviews of FPPT should be included within the audit programme. In addition, an annual report on FPPT compliance will be presented to the Remuneration Committee.

4 Actions

4.1 The following actions are now in place:

- Conversation has been held with ESR team who have confirmed that functionality and appropriate permissions are in place to allow for FPPT checks, reporting and recording. Board Secretary will need permission to review records of Board members (a standard privacy notice setting out how individual's data will be used is available and will need to be signed by all Board members and placed in their personnel file).
- Liaise with recruitment teams to ensure that they are undertaking all required checks for new Board members moving forward.
- Brief Board members about the new FPPT regime.
- Begin process of annual checks (10-24 above) for Board members, ahead of submission of confirmation of checks prior to 31st March 2024.
- Where 2023/24 FPPT testing does not align with appraisal dates, FPPT testing will be carried out prior to the end of the financial year to ensure compliance. From 2024/25 these will be aligned with appraisals.
- Schedule update to RemCom before YE 23/24, and then update to Board in M1 24/25.

Annual FPPT Process



*Or senior member of staff nominated by and behalf of, the Chair, eg HRD
** SID/Deputy Chair to carry out FPPT on the Chair and 'sign off'
SID = Senior Independent Director
ESR= Electronic Staff Record

East Sussex Healthcare NHS Trust

Implementation of Patient Safety Incident Response Framework

Purpose of the paper	To enable the Trust Board to understand the Patient Safety Incident Response Framework (PSIRF), how it will be implemented in ESHT and to approve the Patient Safety Incident Response Plan (PSIRP) and Policy.					
	For Decision	X	For Assurance	X	For Information	
Sponsor/Author	Vikki Carruth, Chief Nurse / Lisa Forward, Assistant Director of Clinical Governance					
Governance overview	Quality and Safety Committee 21/09/2023					

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 are asked: • to note the contents of the report. • to approve the Patient Safety Incident Response Plan (PSIRP) and Policy

Executive Summary	PSIRF is replacing the Serious Incident Framework and is a fundamental change in how organisations respond to incidents/events. It focuses on a proportionate response to incidents/events with emphasis on compassionate inclusion and engagement of those involved and on systems and processes. There will be a cultural shift in approach with an increased importance on Just Culture. There will be no change in how staff report incidents and the Weekly Patient Safety Summit will continue to discuss all severity three and above incidents, but the response will be proportionate and based on an appropriate template. The focus is on learning and how this informs improvement both locally and Trust wide. There will be more opportunity to link responses and outcomes to ongoing Trust initiatives e.g., Reconditioning programme, discharge programme, Subject Matter groups (EoLC, Falls, Nutrition and Hydration) The response and template are based on the ESHT patient safety incident profile outlined in the Plan and Policy. The Patient Safety Improvement Profile is based on a review of multiple data sources e.g. all incidents, complaints, inquests. There is a mandatory requirement that the PSIRP and Policy are approved at Board or a delegated committee before being submitted to the ICB for approval. Responses that have been completed will be collated and reviewed by the PSIRF Review Group (replaces the current RCA Review Group). Outcomes of responses will be kept on a master log by the Patient Safety Team and used for reporting and to link with other groups/improvement. It will also inform future patient safety incident profiles.

Next steps	If approved, the PSIRP and Policy will be submitted to NHS Sussex for final approval.

East Sussex Healthcare NHS Trust

Implementation of Patient Safety Incident Response Framework

September 2023

Patient Safety Incident Response Framework (PSIRF)

East Sussex Healthcare NHS Trust

What is it?

- New framework which is replacing the Serious Incident Framework
- Fundamental change in how organisations respond to incidents/events
- Focus on proportionate response
- Compassionate inclusion and engagement

Key difference

East Sussex Healthcare NHS Trust

- Culture shift – in approach
- No blame – Just culture
- Involvement and engagement – patient/families and staff
- Proportionate response using defined templates
- Response and template based on patient safety incident profile outlined in Plan and Policy
- Focus on learning – more timely
- Focus on improvement locally and linking with ongoing trust initiatives e.g. Reconditioning programme, discharge programme, Subject Matter groups (EoLC, Falls, Nutrition and Hydration)

Implementation

East Sussex Healthcare NHS Trust

- Implementation Plan – aiming to go live 20 Nov 23
- Response templates adapted from national versions
- Stakeholder engagement – now and ongoing, particularly staff
- PSIRP and Policy completed
- Ongoing communications and development of a strategy
- Development of education strategy – some education in place e.g. MyLearn modules, higher level training (patient safety team) and AAR
- First year – transitional
- Second year – transformational

Patient Safety Incident Response Plan (PSIRP) and Policy

East Sussex Healthcare NHS Trust

- Mandatory requirement
- National template – adapted for local use
- Outlines ESHT Patient Safety Improvement Profile based on a review of multiple data sources e.g. all incidents, complaints, inquests
- Provides recommended response templates for the improvement profile
- Supported by PSIRF policy – describes approach in more detail
- PSIRP and Policy require approval at Board
- PSIRP and Policy require submission to ICB for approval

How will PSIRF work?

East Sussex Healthcare NHS Trust

- Immediate process unchanged – incident reported on Datix. WPSS for severity 3+. Severity 1 and 2 as current process with option to use templates
- WPSS – agree response template(s)
- If PSII – PST will lead.
- Response completed and review by PSIRF Review Group
- Outcomes of responses kept on master log by PST. Link with other groups/improvement. Monitor to inform further patient safety incident profile
- Learning and action taken forward by clinical teams and/or responsible group
- Board (or delegated responsibility) to sign off PSII's

Assurance and monitoring

East Sussex Healthcare NHS Trust

- Patient Safety Team will monitor the responses and capture the outcomes
- Current reports to divisions and other trust groups will continue
- Reports for QSC will remain the same initially after PSIRF goes live
- Anticipate the reports will then evolve
- How assurance is provided will evolve

Patient Safety education module for Board and Senior Leadership teams

East Sussex Healthcare NHS Trust

- There is an e-learning patient safety module on MyLearn for Board and senior leadership teams. It is access via MyLearn on the extranet.

MYLearn: Log in to the site

- Individuals will need their own log in details. To register you will need your employee number.
- Once logged into MyLearn, select course catalogue.
- Select Patient Safety training level 1: Essentials of patient safety for Boards and Senior Leadership teams.
- The module takes approximately 15 minutes to complete.

East Sussex Healthcare NHS Trust

Patient safety incident response plan

Effective date: 20th November 2023

Estimated refresh date: April 2024

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Contents

1. Introduction

The NHS Patient Safety Strategy 2019 describes the Patient Safety Incident Response Framework (PSIRF) as a 'foundation for change' therefore it challenges us to think and respond differently when a patient safety incident occurs. This new framework replaces the Serious Incident Framework (SIF). This document is East Sussex Healthcare Trust (ESHT) Patient Safety Incident Response Plan (PSIRP). It describes how ESHT has prepared for the 'go live' with the PSIRF.

The PSIRF Policy and Plan are in this first iteration transitional in approach to enable ESHT to be compliant for a 'go live' date. We fully anticipate and expect that eventually this new framework once it has started will become transformational for patient safety with the learning from incidents/events embedded in ESHT services and organisation culture and behaviour.

This PSIRP sets out how ESHT intends to respond to patient safety incidents over a period of 12 to 18 months. The Plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

This Plan is underpinned by our Trust policies on incident reporting and investigation available via our organisation's intranet (available to staff only) and ESHT as part of the PSIRF national plan will be developing a specific PSIRF policy ready for the **go live launch on 20th November 2023**.

Expected schedule to go-live:

Divisional review of the PSIRF Plan and Policy	August 2023 – The Patient Safety Specialist/Lead and Patient Safety Team discussing the draft plan and policy with the Divisional senior managers.
Trust Board review via presentation by the Assistant Director of Clinical Governance.	September 2023 - Trust Board members seminar to receive a presentation and have an opportunity for questions and answers on the draft Plan and Policy.
Trust Board approval	September or October 2023 - The Trust Board may delegate this duty to the Quality and Safety Committee late September or take it to Trust Board 10th October 2023 for formal approval.
Transition period from the Serious	October 2023 – The Trust will enable the transition to the new framework via the decision-making group on level of clinical harm for

Incident framework to the PSIRF	patient safety incidents/events on a weekly basis at the Weekly Patient Safety Summit (WPSS).
ICB approval Trust go-live	November 2023 – The ICB will receive the Trust approved PSIRF Plan and Policy for review. These documents will be shared with the LMNS by the Trust/ICB. Formal approval by the ICB will be at the Quality Reporting Monitoring Group on November 17th. The Trust will go live with PSIRF 20th November and ensure the documents are available for all staff and the public on our Trust intranet and internet pages via the Trust Communication Team.

It will provide further clarity for staff on the various incidents and appropriate templates for review or investigation to achieve the best systems and organisational learning. Additionally, the policy will enable the staffs' understanding on pathways for escalation safety action development plans and monitoring improvement.

PSIRF is ***very different,*** and it is very exciting.
Unlike previous frameworks, PSIRF is not a tweak or adaptation of what came before. PSIRF is a whole system change to how we think and respond when an incident happens to prevent recurrence. Previous frameworks have described when and how to investigate a serious incident, PSIRF focusses on learning and improvement. With PSIRF, the Trust is responsible for the entire process, including what to investigate and how. There are no set timescales except for the completion of a Patient Serious Incident Investigation (PSII) or submitting reports for external agency to approval. There are a set of principles that the organisation will work within but outside of that, it is up the Trust.

The initial phases and timelines to get all of the elements drafted, shared, and discussed with internal services/Divisions and external parties has been slow due to capacity in the Trust Patient Safety Team. The team have still had to monitor and report appropriate incidents and investigate SI's as per the SIF 2015 framework. There are and remain many challenges.

The immediate work on PSIRF has commenced by the Patient Safety Team, Patient Safety Specialist/Lead and overseen by the Assistant Director of Clinical Governance. Monthly updates progress reports are provided to the Trust Patient Safety & Quality Group with regular updates to QSC.

One of the underpinning principles of PSIRF is to do fewer investigations but to do them better. This means taking time to conduct systems-based investigations by people who have been trained to do them. This Plan and associate policies and guidelines will describe how it all works. The NHS Patient Safety Strategy 2019 challenges the NHS to think differently about learning and what this means for a healthcare organisation.

Carrying out investigations for the right reasons can and does identify learning. Removal of the serious incident process does not mean do nothing, it means respond in the right way depending on the type of incidents and associated factors. It means the Trust responds in a timely way,

working even more closely with the patient/families and staff to achieve effective sustainable learning and change, where appropriate.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, simply giving the process a new label. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from the other patient safety incidents and the insights this will provide the organisation in terms of learning and any recommendations for quality improvement.

PSIRF recognises the need to ensure we have support structures for staff, patients and families involved in patient safety incidents. Part of this is the fostering of a psychologically safe culture shown in our leaders, our Trust-wide strategy, and our reporting systems.

There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of systems-based learning and improvement. There is no remit within this Plan or PSIRF to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. It is outside of the scope of PSIRF to review matters to satisfy processes relating to complaints, Human Resources (HR) matters, legal claims and inquests.

This plan explains the scope for a systems-based approach to learning from a patient safety perspective. ESHT will identify incidents to review through nationally and locally defined patient safety priorities, an analysis of which is explained within this document; see Tables 1, 2 and 3.

There are four strategic aims of PSIRF upon which this Plan is based:

- Improve the safety of the care we provide to our patients.
- Improve the experience of patients, their families, and carers wherever a patient safety incident or need for a PSII is identified.
- Improve the use of valuable healthcare resources.
- Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.

ESHT aims to incorporate a patient perspective into future Patient Safety Incident Reporting (PSIR) planning through the introduction of Patient Safety Partners (PSPs) in 2024.

- Further information on the national PSP programme can be found on the NHS England website: https.//www.england.nhs.uk/patient-safety/framework-for-involving-patients-in-patient-safety/

2. Our services

ESHT has made significant improvements for patients and local residents in recent years. The Trust is rated Good by the Care Quality Commission (CQC), with several Outstanding services and has ambitious plans for the future, enabling residents to access the best care in the most appropriate place: at home, in the community, or when they need to come into hospital.

As an integrated acute and community provider, an important part of the Trust's five-year strategy to be the best to meet the healthcare needs of our population, is to increase and improve the care provided outside of hospital. This means being proactive in supporting the health of local residents, preventing avoidable hospital visits and stays, improving patient outcomes and experience and making better use of resources. This has helped the Trust to focus our hospitals to build on our strengths while improving how services work together across the whole health and care system.

The Trust has two acute hospital sites, Conquest Hospital, Hastings, and Eastbourne District General Hospital. Both sites provide urgent and emergency services, along with specialist acute medical and intensive care units. The Trust is focused on driving innovation and best practice. This will improve services across East Sussex and is particularly suited to the population the hospital serves. A number of services are located solely or primarily at one or other of our acute sites, Conquest Hospital and Eastbourne District General Hospital. The Conquest Hospital is home to the Trust's main theatres and therefore looks after most specialist surgical services, such as general, vascular, and orthopaedic surgery, and patients needing closer medical monitoring and support when giving birth. This includes:

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

Eastbourne District General Hospital looks after the most serious stroke cases, patients needing inpatient diabetes care, day case eye surgery, and a diabetic foot service. There are also inpatient endocrinology beds and the Trust's urology service, which includes recent investment in a dedicated investigation suite, robotic surgery, and non-invasive treatment for kidney stones, Ophthalmology Jubilee Eye Suite, a day case theatre. Note: Other day cases for Ophthalmology are undertaken at Bexhill Hospital. Urology, including a Urology Investigation Suite, Robotic Surgery, and Lithotripsy, Specialist Medicine Services including specialist endocrine and diabetic inpatient beds. Cardiology Electrophysiology, Endobronchial ultrasound for respiratory and Diabetic Foot service.

The community services are also extensive with Crisis Response Team, District Nursing teams, therapist and dietetic services, paediatric care teams. Inpatient rehabilitation beds are sited at the Irvine Unit at Bexhill Community Hospital and Rye Memorial Community Hospital.

Sussex Premier Health (SPH private care) are covered and work within ESHT governance arrangements.

Further information can be found on the ESHT website pages.

3. Defining our patient safety improvement profile

The patient safety risk process is a collaborative process. To define the ESHT patient safety risks and responses for 2023/24 the following list of groups and work was undertaken:

Stakeholders involved:

- Staff – through the incidents reported on the ESHT Datix incident reporting and management system.
- Ongoing discussions received from the Divisional Governance and Risk meetings.
- Discussion with stakeholders for the Trust 2023/24 Quality Account.
- Discussions at Trust Patient Safety Quality Group and Quality and Safety Committee meetings.
- Discussions at the Trusts Medication, Falls, Tissue Viability groups.
- Review of data from the Patient Advice and Liaison Services (PALS) contacts.
- Review of data/key themes provided by the Complaints team and the Healthcare Litigation Clinical Claim and Inquest Team.
- Review of data/key themes provided by the bereavement team for learning from deaths principles.
- Discussions with the Integrated Care Board (ICB) at the local and national Patient Safety Specialist forums and the national discussion on the Futures Platform for Patient Safety Specialists.

ESHT Gap analysis:

- The ESHT Patient Safety Team undertook a gap analysis reviewing the last 4 years of Datix and Serious Incidents data – January 2019 to April 2023.
- The areas in Tables 2 and 3 in this plan are the incidents/events that have been significant for ESHT. At the time of completing the gap analysis consideration was given to the data on Complaints/PALS, learning from deaths and inquests/claim's themes. The Patient Safety Team in this first incidence found the themes from SI's mirrored these issues.

The key areas highlighted are reflected in Tables 2 and 3 in this Plan:

- Slips /Trips/Falls – the numbers of incidents are mainly severity 1 and 2's (no or low harm) and since 2022 all severity 3, 4 incidents and as appropriate severity 5 falls incidents have had SWARM Falls template completed. These are further presented and discussed at the Trust Falls Steering Group to share the learning and recommendations / actions both relevant for the service and Divisions.
- Surgical invasive – this is a broad category that encapsulates all aspects of surgical and post-surgical issues across all specialities who undertake a surgical intervention.
- Treatment delays - this is a broad category that encapsulates all aspects of treatments and care pathways where issues have arisen across all specialities.
- Healthcare Associated Infections (HCAI – thematic review may need to be considered depending on the outcome of the National Infection Control Team's response for Trusts on PSIRF. The ESHT Director of Infection Prevention and Control (Chief Nurse) may consider a repeat of the thematic review on outbreaks experienced during the COVID19 pandemic 2020/21.

- Suboptimal care/delay in diagnosis - this is a broad category that encapsulates all aspects of treatments and care pathways where issues have arisen across all specialities.
- Pressure Ulcers – Tissue Viability Nurses have already adapted appropriate processes for reviewing and investigating. The Team is awaiting the National Tissue Viability Services response to PSIRF, and the Trust is awaiting the outcome of this publication. The Trust in the meantime is considering undertaking a thematic review to highlight the breadth and depth of learning so far in the organisation especially with the National Wound Care Strategy.
- Maternity - this is a broad category that encapsulates all aspects of treatments and care pathways in obstetrics both the care of the mother (parents) and baby. The Trust has included its first iteration of the internal processes to be utilised in the event of an obstetric incident in this plan and in the Trust PSIRF Policy, see Table 4 on page 16.

The ESHT patient safety risks were identified through the data sources mentioned above and the various reports prepared and presented to the groups.

Local patient safety risks have been developed and will be further defined as the list of risks identified through the various groups/stakeholder involvement and data mining as completed for the Trust patient safety plan gap analysis. ESHT anticipates that the list of risks will further be refined over the coming 12 months from the launch date in August 2023.

- Table 1 sets out the full list of national priorities that will require a response.
- Table 2 sets out the local patient safety risks which when identified represent opportunities for learning and improvement in the ESHT healthcare system.
- Table 3 details local additional methods and tools.

ESHT has utilised the following criteria to define the top local patient safety risks:

- Potential for harm: People – physical, psychological, loss of trust (patients, family, care givers); Service delivery – impact on quality and delivery of healthcare services, impact on capacity; Public confidence – including political attention and media coverage; Likelihood of occurrence – persistence of the risk, frequency, and potential to escalate.

4. Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in the national policies or regulations. These responses may include review by, or referral to, another organisation/team depending on the nature of the event.

Incidents meeting the Never Events criteria (2018) and deaths identified more likely than not due to problems in care (i.e., incidents meeting the Learning from Deaths criteria for Patient Safety Incident Investigation (PSII) will require a locally led PSII by an ESHT Patient Safety Team investigator (see Appendix 1 process flowchart of an incident/event to review).

Table 1 below sets out the local or national mandated responses. As ESHT does not directly provide mental health or custodial services it is more likely that the organisation will be a secondary participant rather than a lead for those incident types 6 to 11 in the table.

Table 1 National priorities and expected response by ESHT.

	Patient safety incident type	**Required response by ESHT**	**Anticipated improvement route**
1.	Incidents that meet the criteria set in the Never Events list 2018.	PSII	Create local organisational learning and actions. Feed these into the quality improvement strategy for that service.
2.	Learning from Deaths (LfD) due to, for example, care and service issues when reviewed rated between 1-3 using the LfD Framework and rating criteria.	PSII	Create local organisational actions and feed these into the Trust/service quality improvement strategy.
3.	Obstetrics, for example, incidents that meet Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch (HSIB) for independent patient safety incident investigation.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy.

4.	Child deaths	Refer for Child Death Overview Panel decision via the Trust's Safeguarding Team. Locally led – could be a PSII or another response, for example After Action Review (AAR) alongside the Panel review. The Trust's Director of Midwifery is reviewing this process in accordance with national guidance.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy.
5.	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review using the Learning from Lives and Deaths framework. (LeDeR). Locally led – could be an PSII or another response, for example After Action Review (AAR) alongside the Panel review.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy.
6.	Safeguarding incidents in which: Baby, child or young person is on a child protection plan; looked after plan or is a victim of wilful neglect or domestic abuse/ violence. Adults (over 18 years old) who are in receipt of care and support needs by their Local Authority. The incident relates to female genital mutilation (FGM), PREVENT (radicalisation to terrorism); modern day slavery and human trafficking or domestic abuse/violence.	Refer to Trust Safeguarding Lead, Local Authority Safeguarding Lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.

7.	Incidents relating to screening programmes.	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. Reference: *Guidance for managing incidents in NHS screening programmes, NHS England, published 01/03/2015 and last updated 16/07/2021.*	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.
8.	Deaths in custody (e.g., police custody, in prison, etc,) where health provision is delivered by the NHS.	In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.
9.	Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria).	Locally led PSII by the provider in which the event occurred.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.
10.	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII. Locally led PSII may be required with mental health provider.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.
11.	Domestic Homicide	A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.

		whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, set out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.	

5. Our patient safety incident response plan: local focus

ESHT considers that all of the 10 incident types set out in Table 2, below, have relevance for all of our inpatient and community services (including maternity) and all except two (items 2 and 7) have relevance for all our inpatient and community services. To this end, this is an organisation wide PSIRP and there are no separate patient safety incident response plans for individual services.

Local focus incidents are based on incidents on Datix of severity 3, 4 or 5 these cases will be discussed at the Weekly Patient Safety Summit (WPSS) to confirm the level of harm and investigation/review template the service will utilise. Where an incident remains at a severity 3 or above the services must undertake and complete verbal and written Duty of Candour as part of the Trust's legal responsibility.

Table 2: Trust local response

	Patient safety incident type or issue	**Description**	**Planned response**	**Anticipated improvement route**
1.	Transfer of care	Potential for patient harm as a result of missed communication with one or more stakeholders for on-going safe patient care.	After Action Review (AAR), or Hot Debrief, or Multi-Disciplinary Team (MDT) discussion.	E.g., create local safety actions and discuss at Divisional Governance/Risk meetings. The Division service to feed these into a quality improvement strategy if appropriate or severe enough to raise on the Divisional risk register.
2.	Discharge	Discharge where a delay has led to adverse outcome within the length of stay and after the patient was medically optimised for discharge.	AAR, or Hot Debrief, Chronology or MDT.	E.g., create local safety actions and discuss at Divisional Governance/Risk meetings. The Division service to feed these into a quality improvement strategy if appropriate or severe enough to raise on the Divisional risk register.
3.	Never Events – medication, surgical, mental health and general (Reference: Never Events List 2018 (updated Feb. 2021)	Any clinical incident that meets the Never Event List	PSII (a chronology must be completed prior to an PSII being started)	Actions developed will be in the report and will be recorded on Datix through to completion.

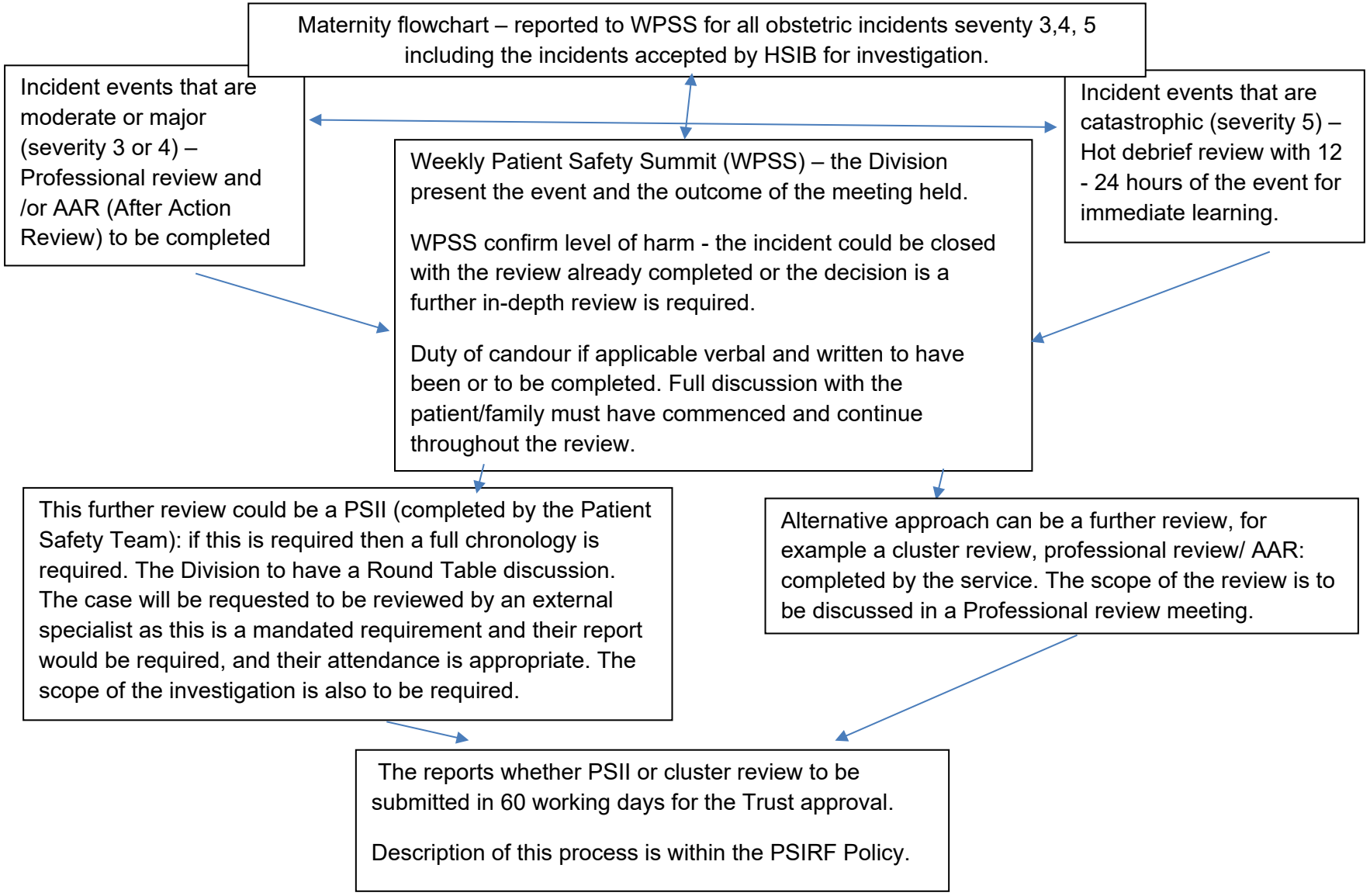
4.	Validation of results	Potential for patient harm as a consequence of missed/delayed/non-communication or action of diagnostic results.	MDT or service review with outsourced companies. Depending on the level of harm this could be considered for PSII.	Actions developed will be in the report and will be recorded on Datix through to completion.
5.	Digital systems	Emerging risks identified as a result of the use of the Trust Digital Systems.	Thematic review/ Cluster review.	Actions developed will be in the report and will be recorded on Datix through to completion.
6.	Clinical care and treatment	Covers all service across the acute and community service and inpatient services.	AAR, Chronology, Hot Debrief.	Actions developed will be in the report and will be recorded on Datix through to completion.
7.	Falls	Inpatient falls resulting in a bone fracture or haemorrhage.	SWARM fall template.	Actions developed will be in the report and will be recorded on Datix through to completion. The Swarm template once completed will be reviewed at the Trust Falls Steering Group.
8.	Tissue Viability – pressure damage, surgical wounds, leg ulcers	Tissue Viability (TV) Team discusses cases at the appropriate group meeting and according to the level of harm TV templates are completed.	TV templates / AAR/ Cluster reviews/ TV service templates	Actions developed will be in the report and will be recorded on Datix through to completion.
9.	Medication	Opioids management, Gentamycin, Vancomycin, medication patches, extravasation, Diabetes Mellitus medication management, thromboprophylaxis	AAR, Chronology, for DVT/PE non-fatal hospital associated thrombosis (HAT) or fatal HAT	Actions developed will be in the report and will be recorded on Datix through to completion.

		(pulmonary embolism (PE)/deep vein thrombosis (DVT).	templates are available.	
10.	Multiple cases similar and recorded at various levels of severity	These cases can be clustered and considered for further review/investigation.	Thematic review / cluster review or the use of PSII.	Actions developed will be in the report and will be recorded on Datix through to completion.
11.	Other	Patient safety incidents which meet a criterion for harm or potential harm not included in the areas highlighted above.	Where an incident does not fall into any of the categories 1-10 above then an investigation and / or review method as described in Table 3 below may be used by the local services except PSII (which must be undertaken by the Trust Patient Safety Team who have undertaken and completed additional investigation training). The local methods such as the national Perinatal Mortality Review Tool (PMRT) and Structured Judgement Review (SJR) tools and/ or structured local proformas maybe used. The Trust Infection Control Team in collaboration with the Trust Patient Safety Team will ensure robust PSIRF compliant templates are available for the service for infection control issues, events/incidents, as highlighted in a letter received 16/08/2023 Alignment of Infection Prevention and Control (IPC) with the Patient Safety Incident Response Framework (PSIRF). The completion of a narrative response on the Trust Datix incident reporting management system incident module will also be updated.	

Table 3 Local additional methods and tools

1.	PSII – Patient safety Incident Investigation	PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple PSII's and other responses into a similar incident type. Recommendations and improvement plans are then designed to address those systems factors and help deliver safer care for our patients effectively and sustainably.
2.	AAR – After Action Review	A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.
3.	PSA – Patient Safety Audit	A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g., in a policy or guidelines).
4.	PMRT – Perinatal Mortality Review Tool	Developed through a collaboration led by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRACE-UK) with user and parent involvement, the PMRT ensures systematic, multi-disciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care; refer to: Perinatal Mortality Review Tool/National Perinatal Epidemiology Unit (NPEU).
5a. 5b. 5c.	SJR – Structured Judgement Review Learning from Deaths Cluster review or Thematic Reviews	Developed by the Royal College of Physicians as part of the national Quality Board guidance on Learning from Death; the SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. Refer to National Guidance Learning from Deaths Framework (NHS England). These types of reviews are useful to see the trends and be able to offer analysis for the Trust services to take forward learning and embed as appropriate.

Table 4 Maternity process flowchart



Glossary

PSIRP – Patient Safety Incident Response Plan – ESHT local plan sets out how the Trust will carry out the national PSIRF by adhering to national requirement and introduction of local processes. This framework and the Plan cover all the Trust Divisions and supported by the Trust Patient Safety Team and analysis of local data.

PSIRF – Patient Safety Incident Response Framework – building on evidence gathered and wider industry best practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

Never Event – Patient Safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

List the patient safety incident types that must be responded to according to national requirements (see Appendix A: National event response requirements in the Guide to responding proportionately to patient safety incidents).

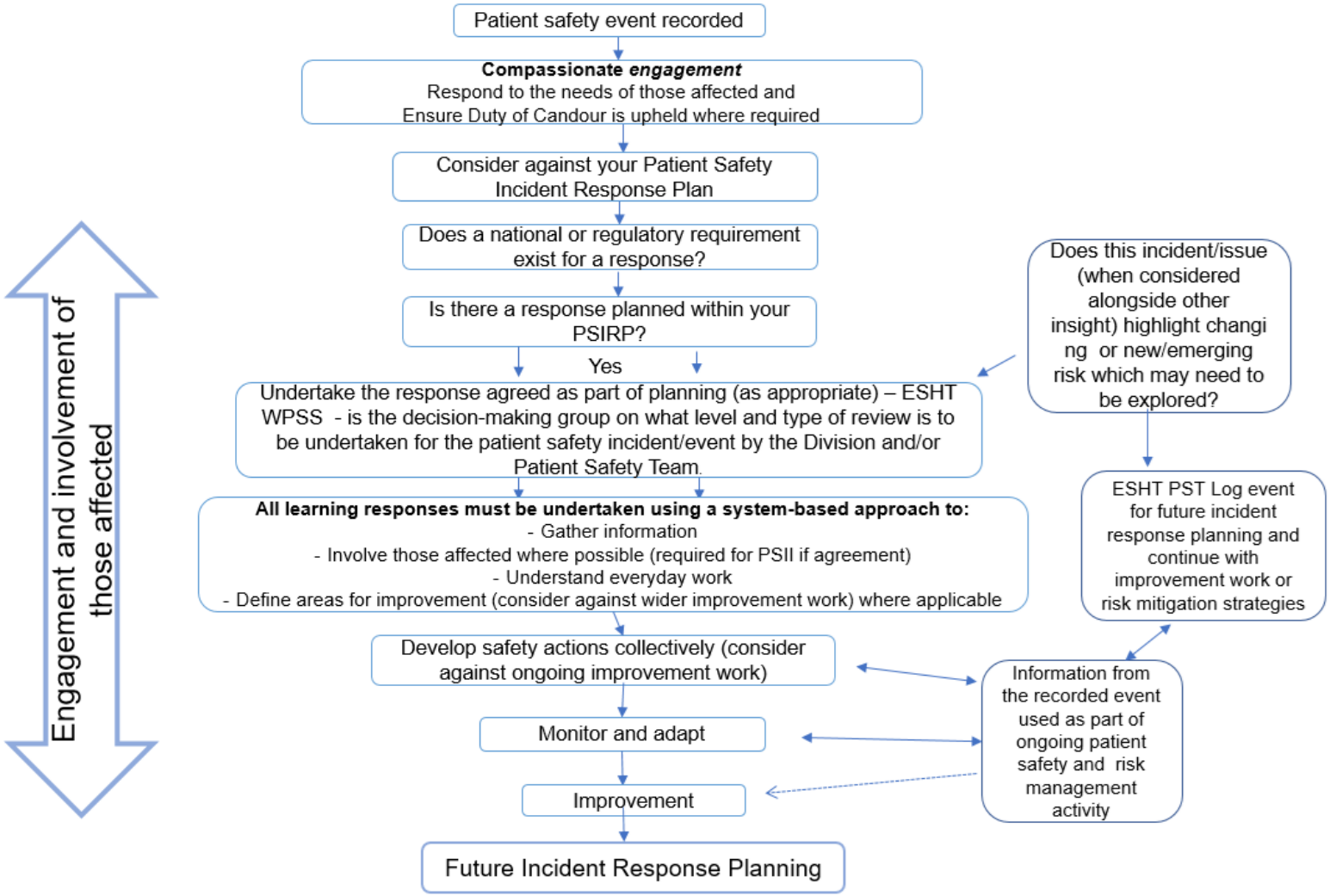
PSII – Patient Safety Incident Investigation – this process will be a flexible approach, informed by local and national priorities. ESHT will be utilising the Weekly Patient Safety Summit (WPSS) to discuss the incident and decide on the level of severity. If the incident remains at a severity 3 or above on Datix then other modes of review/investigation will be considered before a PSII is considered.

Patient safety incidents are events where a patient experienced or could have experienced harm during an encounter with healthcare. An incident is the system showing us symptoms that something is wrong with it.

Duty of Candour (statutory requirement where the incident is a level of harm severity 3 or above). There is no legal duty to investigate a patient safety incident. Once an incident that meets the statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must:

- Tell the person/people involved (including family where appropriate) that the safety incident has taken place.
- Apologise. For example, ‘We are very sorry that this happened.’
- Provide a true account of what happened, explaining whatever we know at that point.
- Explain what else we are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
- Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
- Keep a secure written record of all meetings and communications.

Appendix 1 Process Flowchart – incident/event to review.



East Sussex Healthcare NHS Trust

Patient safety incident response policy

Effective date: 20th November 2023

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Reviewer	**Lisa Forward**	**Assistant Director of Clinical Governance**		
Authoriser	**Vikki Carruth**	**Executive Chief Nurse**		

Associated Documents:	Incident Reporting and Management Policy Being Open & Duty of Candour Policy Policy for Supporting Staff Involved in Incidents, Complaints or Claims Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (4C Model) Legal Policy (Management of Claims, Inquests and Access to Legal Assistance)

CONTENTS

1. Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out how East Sussex Healthcare Trust (ESHT) will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF and which we can also align to our current Trust values:

- compassionate engagement and involvement of those affected by patient safety incidents (Respect and Compassion)
- application of a range of system-based approaches to learning from patient safety incidents (Improvement and Development)
- considered and proportionate responses to patient safety incidents and safety issues (Working Together)
- supportive oversight focused on strengthening response system functioning and improvement. (Engagement and Involvement)

This policy should be read in conjunction with our current patient safety incident response plan, which is a separate document setting out how this policy will be implemented.

2. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across ESHT.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a person-focused approach where the actions or inactions of people, or human error, are stated as the cause of an incident.

Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. Such processes as those listed below are therefore outside of the scope of this policy:

- claims handling,
- human resources investigations into employment concerns,
- professional standards investigations,
- information governance,
- estates and facilities concern,
- financial investigations and audits,
- safeguarding concerns,
- coronial inquests, and criminal investigations,
- complaints (except where a significant patient safety concern is highlighted).

For clarity, the Trust considers these processes as separate from any patient safety investigation. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

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3. Our patient safety culture

ESHT has continued to work over a number of years to move to establishing a restorative just culture within the organisation.

The main goals of restoration when an incident has happened which have been outlined as follows in the literature, are moral engagement, emotional healing, reintegration of the practitioner, organisational learning and prevention.

PSIRF will enhance these by creating much stronger links between a patient safety incident, learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at such learning and improvement within the culture we endeavour to foster. This will continue to increase transparency and openness amongst staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

ESHT is clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define voidability or cause of death.

ESHT safety culture continues to improve and progress in a positive way with the reporting of patient safety incidents. To enhance the Trust safety culture, we have introduced safety huddles in clinical services across all Divisions at all levels of the organisation which consider risks emerging or known and the insight offered from incidents that have occurred and an opportunity to share learning. This learning is then taken forward by the clinical services go the Divisional Governance and Risk meetings.

The organisation also utilises findings from the staff survey metrics based on specific patient (and staff) safety questions to assess if we are sustaining our ongoing progress in improving our safety culture.

4. Patient Safety Partners

The Patient Safety Partners (PSPs) are new and evolving roles developed by NHS England and Improvement to help improve patient safety across the NHS in the UK.

PSPs will be expected to communicate rational and objective feedback focused on ensuring that patient safety is maintained and improved. This may include attendance at governance meetings reviewing patient safety, risk and quality and being involved with contributing to documentation including policies, investigations, and reports. This information may be complex, and the PSPs will provide feedback to ensure that patient safety is our priority. As the role is expected to evolve the PSP could be asked to participate in the investigation of patient safety events, assist in the implementation of patient safety improvement initiatives and develop patient safety resources. This will be underpinned by training and support specific to this new role in collaboration with the Patient Safety Team to ensure PSPs have the essential tools.

PSPs will be supported in their honorary role by the Patient Safety Specialist for the Trust who will provide expectations and guidance for the role, but this will be further discussed once recruitment commences in 2024.

Further updates on this role will be added in 2024.

5. Addressing health inequalities

ESHT recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Trust as a public authority is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. The new DCIQ (Datix) electronic incident database/ system is expected once all the work is complete, to integrate with the PAS database whereby staff will be able to look up the patient by their NHS or X number and the information will automatically populate the necessary fields or they can manually input it if necessary. We will have whatever information is available in the PAS electronic patient database e.g., fields for date of birth, gender, ethnicity, nationality. At this time the Trust Datix Team are unsure, if we can have the religion section completed but this is expected to be confirmed following further testing, but the field is there, so it can be completed manually.

Staff information will eventually integrate with ESR (electronic staff database) in the same way, but this will be introduced at a later date. When it has been introduced it will enable the Trust to have more protected characteristic information available

Within our patient safety response toolkit, we will directly address if there are any particular features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities, and this will be built into our documentation and governance processes.

ESHT will also address apparent health inequalities as part of safety improvement work. Our services provide care to significant numbers in the Core10PLUS5 population cohort identified by NHS England and Improvement (2021) see Appendix 1. ESHT does contribute to this national data requirement. In establishing our plan and policy we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of our patient safety incident response plan and this policy. This needs to be considered as an integral part of the future development process.

Engagement of patient, families and staff following a patient safety incident is critical in the review of patient safety incidents and their responses. The Trust will ensure that we use available tools such as easy read translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

The Trust's commitment to transforming organisation culture to that of restorative justice has already been outlined. Further to this, the Trust has affirmed that it endorses a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients / service users, carers, and families. System based approach to patient safety

responses is at the heart of PSIRF best practice and will be incorporated in any patient safety training for staff delivered in-house.

6. Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

ESHT are firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, families, carers to prevent recurrence.

We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers.

Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.

Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made.

As well as meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident.

As part of our new policy framework, we will be outlining procedures for patient families and staff by the introduction of handbooks and leaflets that support patients, families and carers and staff – based on our existing Duty of Candour Policy.

ESHT has a Patient Advice and Liaisons Service (PALS):

esh-tr.PatientExperience@nhs.net 0300 131 4784 or 0300 131 5309. People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of the care team. Should the care team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing patient and family concerns. The PALS team will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

Appendix 2 relates to other forms of support that can help those affected by a patient safety incident and we will work with patients, families, and carers to signpost to their preferred source for this assistance.

7. Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Our patient safety incident response plan will detail how this has been achieved as well as how the Trust will meet both national, local focus for patient safety incident responses and on page 24 the Trust Maternity/Obstetric process flowchart.

See Appendices 3, 4 and 5 – the tables used in the PSIRF Plan.

7.1 Resources and training to support patient safety incident responses.

The Trust remains committed to ensuring that we fully embed PSIRF and meet its requirements. This policy therefore has used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

The Trust will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

Responsibility for the proposal to designate leadership of any learning response sits within the senior leadership team of the relevant Division. A learning response lead within the Division should be the *Divisional Governance Manager or appropriately nominated other* by the Division and the individual should have an appropriate level of seniority and influence within the Trust – this may depend on the nature and complexity of the incident and response required, but learning responses are led by staff at Band 8a and above.

The Trust will have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. The *Divisional Governance Managers including the designated member of the senior leadership team will manage the selection of an appropriate learning responses to ensure the rigour of* the approach for the review and will maintain records to ensure an equitable allocation. The Patient Safety Team will support learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All Trust managers will work within our just and restorative culture principles and utilise other teams such as Health and Wellbeing to ensure that there is a dedicated staff resource to support such engagement and involvement. Divisions will have processes in place to ensure that managers work within this framework to ensure psychological safety.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proof reading.

7.1.1 Staff Training

The Trust has implemented a patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows.

- Level one

National and Internal - This comprises a local incident eLearning module setting out the Trust's expectations of staff for reporting and responding to incidents, including an outline of staff responsibility for Duty of Candour. This has been aligned to the national patient safety syllabus.

National – Health Education England patient safety syllabus module (Essentials for patient safety)

All staff, clinical and non-clinical are expected to undertake these on induction and to repeat each three years.

These modules are available as eLearning via MyLearn access.

National – Health Education England patient safety syllabus module (Essentials of patient safety for boards and senior leadership teams

This module can be accessed directly from the Health Education England eLearning for healthcare platform or Mylearn.

- Level two

National – Health Education England patient safety syllabus module (Access to Practice) – this is to be undertaken by all clinical staff at Agenda for Change (AFC) Band 7 or above, with potential to support or lead patient safety incident management in their area.

This module is available as eLearning via MyLearn access.

7.1.2 Learning response leads training and competencies.

- Training

Any Trust learning response will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents or the equivalent in dealing with patient safety response both in the current and or former NHS roles. Records of such training will be maintained by the Learning and Development team as part of their general education governance processes.

Learning response leads must have completed as minimum the national Level one and two patient safety syllabuses on the Trust MyLearn.

Learning response leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise the Trust will undertake an annual networking event for all learning response leads via our Trust-wide leadership forums.

Learning response leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the relevant Divisional Governance teams and the Patient Safety Team will support this.

- Competencies

As a Trust we expect that those staff leading learning responses are able to

a. Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.

b. Summarise and present complex information in a clear and logical manner and in report form.
c. Manage conflicting information from different internal and external sources.
d. Communicate highly complex matters and in difficult situations.

Support for those new to this role will be offered from Divisional senior managers, Divisional Risk and Governance teams and the Patient Safety Team.

7.1.3 Engagement and involvement training and competencies

- Training

Engagement and involvement with those affected by a patient safety incident/event will be undertaken by those staff who have undergone a minimum of six hours training or equivalent in experience in patient safety incidents/events in the current or past roles in the NHS, such as the Duty of Candour training provided via the Patient Safety Team from 2021 and since this date the training has been delivered via eLearning.

Records of such training will be maintained by the Learning and Development team as part of their general education governance processes.

Engagement leads must have complete Level one and two of the national patient safety syllabuses.

Engagement leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise the Trust will undertake an annual networking event for all engagement leads via our Trust-wide leadership forums.

Engagement leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the Patient Safety Team and supported by Divisional Risk and Governance leads.

- Competencies

As a Trust we expect that those staff who are engagement leads to be able to

a. Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
b. Listen and hear the distress of others in a measured and supportive way.
c. Maintain clear records of information gathered and contact those affected.
d. Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation.
e. Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

7.1.4 Oversight roles training and competencies

- Training

All patient safety response oversight will be led/conducted by those who have had a minimum of two days formal training and or experience/knowledge either in their current or previous NHS roles the development in learning from patient safety incidents and understanding the need for the oversight of learning from patient safety incidents. Records of any local training will be maintained by the Learning and Development team as part of their general education governance processes.

Those with an oversight role on our Trust Board and leadership team (i.e., executive leads) must have completed the appropriate modules from the national patient safety syllabus - Level one - essentials of patient safety and essentials of patient safety for Trust Boards and senior leadership teams.

All those with an oversight role in relation to PSIRF will undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

- Competency

As a Trust we expect staff with oversight roles to be able to

a. Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
b. Apply human factors and systems thinking principles.
c. Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources.
d. Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.
e. Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
f. Summarise and present complex information in a clear and logical manner and in report form.

7.1.5 Training associated for Patient Safety Incident Investigators (PSII) – currently only the Patient Safety Team, have all been trained and are qualified via HSIB level 2 (Gold and Silver standards). Other Trust staff can and are encouraged to do part or all of the training to understand systems thinking, learning from incidents, and setting appropriate recommendations / action plans for a PSII report with the investigator and the patient/family/carer and staff involved.

What are systems thinking:

Systems Engineering Initiative for Patient Safety (SEIPS) it is a systems-based framework endorsed by PSIRF. It is a framework for understanding outcomes within complex systems which can be applied to support the analysis of incidents and safety issues more broadly. A

SEIPS quick reference guide and work system explorer is provided in the patient safety incident response toolkit. All the national PSIRF tools are based on SEIPS.

The SEIPS model draws on three core human factors principles:

- Systems-orientation,
- Person-centredness and
- Design - driver improvements.

Systems approach for patient safety is based on rather than focusing on corrective efforts on punishment or remediation. The systems approach seeks to identify situations or factors likely to give rise to human error and change the underlying systems of care in order to reduce the occurrence of errors or minimize their impact on patients.

7.1.6 Our Patient Safety Incident Response Plan

Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

A copy of the Trust current PSIRF plan can be found on the relevant Trust internet page.

The Guide to responding proportionately to Patient Safety Incidents PSIRF 2022, page 7 figure 1 and the table 1 that goes on to add further narrative for each aspect, describes a cyclical diagram called the patient safety incident response planning process:

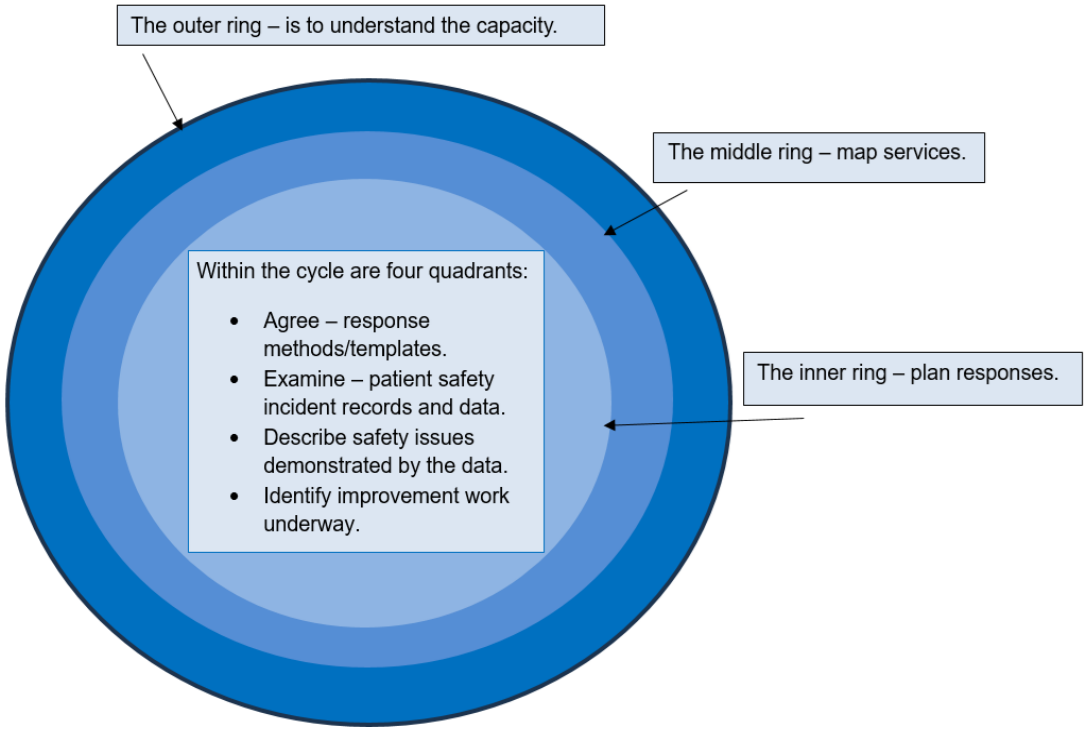
1. the outer ring – understand the capacity

2. the middle ring – map services

3. the inner ring – plan responses

Within the cycle are four quadrants:

- Agree - response methods/templates.
- Examine - patient safety incident records and data.
- Describe - safety issues demonstrated by the data.
- Identify - improvement work underway.



7.1.7 Reviewing our Patient Safety Incident Response Policy and Plan

Our patient safety incident response plan is a living document that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 24 months to ensure our focus remains up to date, with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 24 months.

Updated plans will be published on our website, replacing the previous version.

ESHT is proposing that moving forward with PSIRF it will initiate a rigorous planning exercise that will be undertaken every four years and more frequently if appropriate (as agreed with our Integrated Care Board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational reporting data (for example, PSII reports, improvement plans, complaints, claims, staff survey results, inequalities data, learning from deaths data) and sharing our findings with a wider stakeholder engagement.

8. Responding to patient safety incidents

All staff are responsible for reporting any potential or actual patient safety incident on the Trust incident reporting system currently Datix (DCIQ) and will record the level of harm they know has been experienced by the person affected (see Appendix 6 for the complaints and appeals process used by the Trust).

Divisions will have daily review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to service teams where Duty of Candour (DoC) applies (See ESHT Policy Being Open 2022). Most incidents will only require local review within the service, however, where it is felt that the opportunity for learning and improvement is significant, these should be escalated within the Division (see Patient Safety incident response decision-making section). This will be via the Weekly Patient Safety Summit (WPSS).

Divisions will highlight to the Patient Safety Team any incident which appears to meet the requirement for reporting externally. This may be to allow the Trust to work in a transparent and collaborative way with our ICB or regional NHS teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

The Patient Safety Team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

8.1 Patient safety incident response decision-making

The Trust will have arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRF plan and in Appendices 3, 4 and 5 in this policy.

PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. The Trust has developed its own response mechanisms to balance the effort between learning through responding to incidents or exploring issues and improvement work. In the work to create our plan we have considered what our incident insight and engagement with key internal and external stakeholders has shown us about our patient safety profile. We have used this intelligence to build our local priorities for PSII and our toolkit for responding to other patient safety incidents.

We are currently establishing a process for our response to incidents which allows for a clear 'Ward to Board' set of mechanisms allowing for oversight of incident management and our PSIRF response.

Divisions will have escalation arrangements in place for the monitoring of patient safety incidents and this includes daily escalation of incidents which appear to meet the need for further exploration as a rapid review, for example completion of a detailed Chronology has shown that the incident/incidents could possibly meet the criteria as PSII or patient safety review (Patient Safety Review (PSR) using one of the appropriate agreed Trust PSIRF templates) due to the potential for learning and improvement or an unexpected level of risk. The Trust Weekly Patient Safety Summit (WPSS) will consider the incident, the additional information from the Division/Service and discuss, determine the level of harm and the scope of potential learning, and determine the level of review/investigation required for incidents presented.

The Trust WPSS will have delegated responsibility for the consideration of incidents for PSII or PSR. This group and the Patient Safety Team will keep an oversight/monitoring of the outcomes of such reviews to ensure that recommendations are founded on a systems-based approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required.

The Trust Patient Safety & Quality group (PSQG) and Quality & Safety Committee will have overall oversight of such processes and will challenge decision making of the WPSS to ensure that the Board can be assured that the true intent of PSIRF is being implemented within our organisation and we are meeting the national patient safety incident response standards.

Any incident highlighted will follow the process outlined below which can be seen in diagram form in Appendix 4.

Divisional Governance & Risk groups may commission thematic reviews of such incidents to consider and understand potential emerging risks in discussion and agreement with the Trust Patient Safety Team.

Incidents with positive or unclear potential for PSII – all staff (directly or through their line manager) must ensure notification of incidents that may require a higher level of response as

soon as practicable after the event through Divisional escalation processes (including out of hours) and this must include the Divisional Risk and Governance team. Duty of Candour disclosure should take place according to Trust guidance. Where it is clear that a PSII is required (for example, for a Never Event) the Division should notify the Patient Safety Team as soon as practicable so that the incident can be shared to executive level staff and discussed at WPSS. A chronology needs to be completed prior to a PSII being undertaken by the clinical service or the Patient Safety Investigator so that the scope of the investigation can be understood, and the patient/family can be informed and be part of the process.

Other incidents with unclear potential for PSII, must also be reported to the Patient Safety Team. Decision making with regard to escalation to the Trust WPSS can be considered at the next weekly meeting. A rapid review will be undertaken by the Division to inform this decision making. Significant incidents which may require consideration for ad-hoc PSII due to an unexpected level of risk and/or potential for learning should be included in this category.

The Trust WPSS meet weekly to discuss the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), any mitigation identified by the rapid review or that is still required to prevent recurrence and whether the Duty of Candour requirement has been met. The investigator with the service and the patient/family will define the terms of reference for a PSII to be undertaken by an appropriate investigator in the Patient Safety team. The WPSS will also designate subject matter expert input as required /appropriate for any investigation or highlight any cross system working that may be necessary, as well as indicating how immediate learning is to be shared.

Where an incident does not meet the requirement for PSII, the Trust WPSS may request a patient safety review (PSR templates) and closure of the incident at a local level, with due consideration of any Duty of Candour requirement being met. It will be at the WPSS discretion in such circumstances to specify a particular tool is used to complete a PSR. The Trust PSIRF Response Group will also indicate and discuss with the Division how immediate learning is to be shared.

Incidents requiring possible (patient safety response (PSR) – all staff (directly or through their line manager) must ensure notification of incidents that may require a patient safety review utilising one of the reporting Templates to enable a response as soon as practicable after the event through Divisional escalation processes (including out of hours) and this must include the Divisional Risk and Governance team. A rapid review will be undertaken by the Division/Service to inform immediate actions taken so that this information can be shared at WPSS.

The Divisional Governance Manager will discuss with the clinical service/s at the earliest time and opportunity to discuss the nature of the incident/event, immediate learning (which should share via an appropriate platform), any mitigation that is needed to prevent recurrence and whether the Duty of Candour requirement has been met and the Division update WPSS accordingly.

The Trust WPSS will make the final decision on whether an incident meets a PSII criteria or other means of PSR. The PSR tool (template) to be utilised for the review will be specified and a suitable member of the Divisional team to undertake the review will be allocated. Where it is deemed the incident meets the criteria for a PSII this level of investigation will be undertaken by

the Patient Safety Team. This will not be any staff involved in the incident or by those who directly manage the staff. The Division will also specify any subject matter expert input required. A detailed chronology by the service will be required prior to the investigator undertakes the PSII. There will be clear records maintained regarding this decision-making process and held by the Patient Safety Team.

Divisional Governance teams are to keep the Trust Patient Safety Team updated so that a master log of reviews / actions and improvements for PSIIs and PSRs are maintained, and that reports/data is generated for reports to patient safety groups and committees to offer ongoing assurance on adherence to the PSIRF and future updates to the PSIRP.

The Patient Safety Team will have processes in place to communicate and escalate necessary incidents within NHS commissioning and regional organisations and the Clinical Quality Commission (CQC) according to accepted reporting requirements. Whilst this will include some incidents escalated as PSII, the Patient Safety Team will work with the Divisions to have effective processes in place to ensure that any incidents meeting external reporting needs are appropriately escalated.

Process for the Trust Approval of PSII reports and PSR templates:

- PSII reports will be reviewed by the Trust PSIRF Response Group, Divisional senior manager and then the report will be submitted for final approval to the Trust Executive lead/s.
- The Trust Board will either receive and give final of all PSII reports.
- PSR templates will be reviewed by the Trust PSIRF Response Group following Divisional approval.

The Trust Patient Safety Team will monitor the process through to completion and maintain a monitoring master log.

Through this mechanism the Board will be assured that it meets expected oversight standards but also understands the ongoing and dynamic patient safety and improvement profile within the organisation.

The terms of reference will reflect the decision making by WPSS see appendix 9.

Responding to cross-system (external organisations) incidents/issues

The Patient Safety Team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation’s patient safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.

The Trust will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Patient Safety Team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

The Trust will defer to the commissioners Integrated Care Board (ICB) for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

8.2 Timeframes for learning responses

Timescales for Patient Safety - PSII

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No local PSII should take longer than six months.

The time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) the Trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the Trust WPSS panel.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

Timescales for other forms of learning response (this list will be further developed as the Trust implements and reviews the processes)

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months to complete. Examples of expected time scales are:

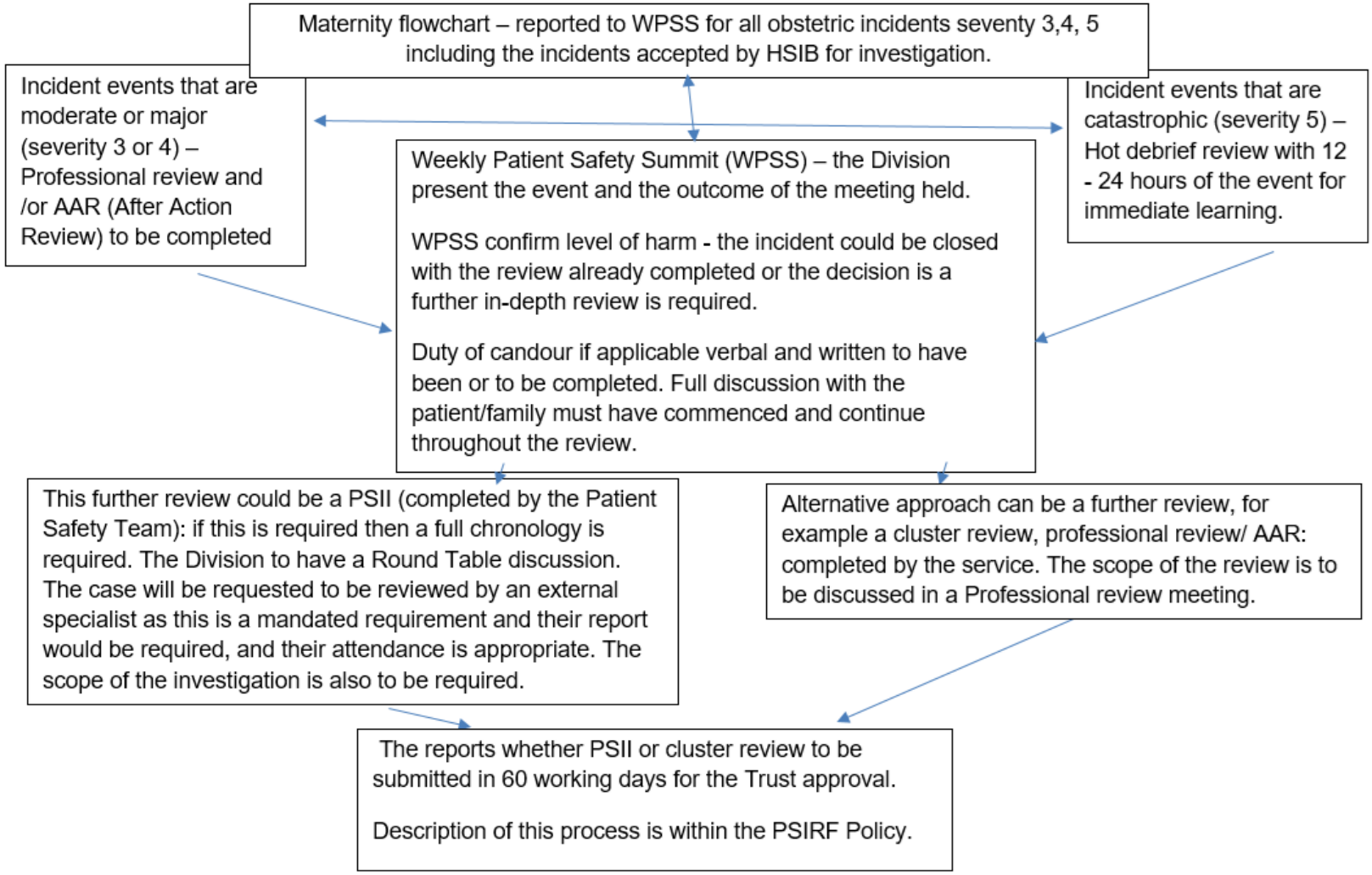
- SWARM falls template – this should be completed within two weeks from the incident date.
- Timeline/chronology should be completed within 2- 4weeks from the date of the incident and before a PSII will be started.

- Hot Debrief (rapid review) should be completed within 2 - 72 hours from the time of the incident.
- Debriefing session – 4-6weeks since the incident. Other reviews of the incident may have been completed and the learning/recommendations and actions already completed and in place and or being considered.
- After Action review (AAR) should be completed within 2-4 weeks from the date of the incident.
- Multi-Disciplinary Team – approach to be completed within 4-6 weeks of the incident.
- Cluster review – approach should take no longer than 1-3 months to complete.

8.3 ESHT Maternity/Obstetric process flowchart

The flowchart (in this report page 24) highlights the service process for incidents and patient safety events. This has been agreed by the service and will be reviewed and updated as indicated in the PSIRF Plan.

Table 4 Maternity process flowchart



8.4 Safety action development and monitoring improvement

The Trust acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety actions are needed.

The Trust will have systems and processes in place to design, implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm – areas for improvement. The Trust will generate safety actions in relation to each of these defined areas for improvement. Following this, the Trust will have measures to monitor any safety action and set out review steps.

Learning response should not describe recommendations as this can lead to premature attempts to devise a solution - safety actions in response to a defined area for improvement depend on factors and constraints outside of the scope of a learning response. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from Divisions.

Safety Action development

The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows:

1. Agree areas for improvement – specify where improvement is needed, without defining solutions

2. Define the context – this will allow agreement on the approach to be taken to safety action development

3. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved

4. Prioritise safety actions to decide on testing for implementation

5. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics

6. Safety actions will be clearly written and follow SMART principles and have a designated owner

Safety Action Monitoring

Safety actions must continue to be monitored within the Divisions governance arrangements to ensure that any actions put in place remain impactful and sustainable. Divisional reporting on the progress with safety actions including the outcomes of any measurements will be made to the Trust Patient Safety Quality Group reports completed by the Divisions.

For some safety actions with wider significance, this may require oversight by the ESHT Quality & Safety Committee, and this would be presented in the Assistant Director of Clinical Governance report.

The Patient Safety Team will maintain an oversight and monitor actions until completion and maintain a 'master log' with the information data to be utilised for patient safety reports.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. The Trust has several overarching safety improvements plans in place which are adapted to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes or CQUINs.

The Trust PSIRP has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm (these Tables 1, 2, and 3 are Appendices 3,4,5 and have been included in this Policy).

The Trust will use the outcomes from existing patient safety incident reviews (Serious Incident Root Cause Analysis reports) where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work. The Divisions will work collaboratively with the Patient Safety Team and others to ensure there is an aligned approach to development of plans and resultant improvement efforts.

There are no thresholds for when a safety improvement plan should be developed; for example, after completing a certain number of learning responses. The decision to do so must be based on knowledge gained through the learning response process and other relevant data.

Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan will be developed by the service and overseen by the Deputy Chief Nurse for Quality and Policies. These will be identified through Divisional governance processes and reports to the Trust Patient Safety & Quality Group by the Trust Patient Safety Team and by exception by the Assistant Director for Clinical Governance to the Trust Q&S Committee who may commission a safety improvement plan. Again, the Divisions will work collaboratively with the Patient Safety Team and others to ensure there is an aligned approach to development of the plans and resultant improvement efforts.

Monitoring of progress with regard to safety improvement plans will be overseen by reports received from the Divisional Governance Manager to the Patient Safety Quality Group.

9. Oversight roles and responsibilities

Principles of oversight

Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures.

The Trust followed the 'mindset'/principles to underpin the processes we have put in place to allow us to implement PSIRF as set out in the supporting document (NHS England (2022), p 3).

Responsibilities

Alongside our NHS regional and local ICB structures and our regulator, the Care Quality Commission (CQC), we have specific organisational responsibilities with the Framework.

In order to meet these responsibilities, the Trust has designated the Executive Chief Nurse and Chief Medical Officers to support PSIRF as the Executive leads.

1. Ensuring that the organisation meets the national patient safety standards

The named Executives will oversee the development, review and approval of the Trust's policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the restorative just working culture that the Trust aspires to.

To achieve the development of the plan and policy the Trust will be supported by internal resources within the Patient Safety Team led by the Assistant Director for Clinical Governance and supported by the Deputy Chief Nurse, Patient Safety Specialist /Lead and the Trust named Executives.

To define its patient safety and safety improvement profile, the Trust will undertake a thorough review of available patient safety incident insight and engagement with internal and external stakeholders. This will be undertaken by the Trust Patient Safety Specialist /Lead and overseen by the Assistant Director of Clinical Governance.

2. Ensuring that PSIRF is central to overarching safety governance arrangements

The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Quality & Safety Committee via assurance reports. This will be provided by the Assistant Director of Clinical Governance.

The PSQG will provide assurance to the Quality & Safety Committee that PSIRF is in place and reporting appropriately managed via the Patient Safety Team and WPSS. Divisions will be expected to report on their patient safety incident learning responses and outcomes. This will include reporting on ongoing monitoring and review of the PSIRP and delivery of safety actions and improvement.

Divisions will have arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

The Trust will source necessary training such as the NHS England Health Education on the patient safety syllabus modules and other patient safety training across the organisation as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to incidents.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years or sooner as necessary to comply with Trust guidance on policy development, alongside a review of all safety actions.

3. Quality assuring learning response outputs

The Trust will implement a PSIRF Response Group to ensure that PSIIs are conducted to the highest standards and to support the trust Executive sign off process and ensure that learning is shared, and safety improvement work is adequately directed.

10. Complaints and Appeals

ESHT recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided by the Trust.

It is important to understand that there is a distinction made between complaints and concerns as the use of the word complaint should not automatically mean that someone expressing a concern enters the complaints process.

The first point of contact with the Trust is the Patient Advice and Liaison Service (PALS) who will support the resolution of any concerns raised ESHT PALS details are esh-tr.PatientExperience@nhs.net Telephone contact: 0300 1314784 or 0300 1315309.

It is important to address any issue/s raised at the earliest opportunity as this may reduce the risk of escalation and increases the possibility of finding a satisfactory resolution to the problem. It may be more appropriate to deal with and resolve in a more immediate and timely manner so long as this is with the agreement of the person raising the concern.

Complaints are defined as expressions of dissatisfaction from a patient, service user, their family or carer, a person acting as their representative, or any person who is affected or likely to be affected by the action, omission or decision of the Trust and requires a formal review.

The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services.

Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.

> If a concern cannot be resolved and the complaints team are undertaking a formal review the complaints team will contact the complainant and can be contacted directly. ESHT complaints team, contact details are esh-tr.complaints@nhs.net

See Appendix 6 for the Trust Complaints factsheets sent to complainants.

Appendix 1 CORE20PLUS5

Core20PLUS5 (adults) – an approach to reducing healthcare inequalities.

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

The approach, which initially focussed on healthcare inequalities experienced by adults, has now been adapted to apply to children and young people.
The information below outlines the Core20PLUS5 approach for adults.

Core20

The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

PLUS

PLUS, population groups should be identified at a local level. Populations we would expect to see identified are ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups coastal communities (where there may be small areas of high deprivation hidden amongst relative affluence).

Inclusion health groups include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

5

There are five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims.

1. Maternity

- Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.

2. Severe mental illness (SMI)

- Ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

3. Chronic respiratory disease

- A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

4. Early cancer diagnosis

- 75% of cases diagnosed at stage 1 or 2 by 2028.

5. Hypertension case-finding and optimal management and lipid optimal management

- To allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

Appendix 2 Other sources mentioned in the section on PALS in this policy.

National guidance for NHS Trusts engaging with bereaved families – https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf

Learning from deaths – information for families – https://www.england.nhs.uk/publication/learning-from deaths-information-for-families/ it explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

Help is at Hand – for those bereaved by suicide – https://www.nhs.uk/Livewell/Suicide/Documents/Help - this booklet offers practical support and guidance who have suffered loss in this way.

Mental Health Homicide support – https://www.england.nhs.uk/London/our-work/mental-health-support/homicide-support/ for staff and families. This information has been developed by the London region independent investigation team in collaboration with the metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of Duty of Candour are extended beyond the family and carers of the person who died, to family of the perpetrator and others who died, and to other surviving victims and their families.

Child death support – https://www.childbereavementuk.org/grieving-for-a-child-of-any-age and https://www.lullabytrust.org.uk/bereavement-support/ Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.

Complaint's advocacy - https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints

Healthwatch - https://www.healthwatch.co.uk/ Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters.

You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch site https://www.healthwatch.co.uk/your-local-healthwatch/list

Parliamentary and Health Service Ombudsman - https://www.ombudsman.org.uk/ makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

Citizens Advice Bureau https://www.citizensadvice.org.uk/ provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

Appendix 3 (PSIRF Plan Table 2)

Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in the national policies or regulations. These responses may include review by or referral to another organisation/team, depending on the nature of the event.

Incidents meeting the Never Events criteria (2018) and deaths identified more likely than not due to problems in care (i.e., incidents meeting the Learning from Deaths criteria for Patient Safety Incident Investigation (PSII) will require a locally led PSII by an ESHT Patient Safety Team investigator.

Table 1 below sets out the local or national mandated responses. As ESHT does not directly provide mental health or custodial services it is more likely that the organisation will be a secondary participant rather than a lead for those incident types 6 to 11 in the table.

Table 1 National priorities and expected response by ESHT.

	Patient safety incident type	**Required response by ESHT**	**Anticipated improvement route**
1.	Incidents that meet the criteria set in the Never Events list 2018.	PSII	Create local organisational learning and actions. Feed these into the quality improvement strategy for that service.
2.	Learning from Deaths (LfD) due to for example care and service issues when reviewed rated between 1-3 using the LfD Framework and rating criteria.	PSII	Create local organisational actions and feed these into the Trust/service quality improvement strategy.

3.	Obstetrics, for example, incidents that meet Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch (HSIB)for independent patient safety incident investigation.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy.
4.	Child deaths	Refer for Child Death Overview Panel decision via the Trust's Safeguarding Team. Locally led – could be a PSII or another response, for example After Action Review (AAR) alongside the Panel review. The Trust Director of Midwifery is reviewing this process in accordance with national guidance.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy.
5.	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally led – could be an PSII or another response, for example After Action Review (AAR) alongside the Panel review.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy.
6.	Safeguarding incidents in which: Baby, child and young person is on a child protection plan; looked after plan or is a victim of wilful neglect or domestic abuse/ violence. Adults (over 18 years old) who are in receipt of care and support needs by their Local Authority.	Refer to Trust Safeguarding Lead, Local Authority Safeguarding Lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.

	The incident relates to female genital mutilation (FGM), Prevent 9radicalisation to terrorism); modern day slavery and human trafficking or domestic abuse/violence.		
7.	Incidents relating to screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. Reference: *Guidance for managing incidents in NHS screening programmes, NHS England, published 01/03/2015 and last updated 16/07/2021.*	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.
8.	Deaths in custody (e.g., police custody, in prison, etc,) where health provision is delivered by the NHS.	In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.
9.	Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents	Locally led PSII by the provider in which the event occurred.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.

	meeting the Learning from Deaths criteria).		
10.	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII. Locally led PSII may be required with mental health provider.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.
11.	Domestic Homicide	A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, set out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.	Respond to recommendations as required and feed actions into the Trust/service quality improvement strategy as appropriate.

Appendix 4 (PSIRF Plan Table 2)

Our patient safety incident response plan: local focus

ESHT considers that all of the 10 incident types set out in Table 2, below, have relevance for all of our inpatient and community services (including maternity) and all except two (items 2 and 7) have relevance for all out inpatient and community services. To this end this is an organisation wide PSIRP and there are no separate patient safety incident response plans for individual services.

Local focus incidents are based on incidents on Datix of severity 3, 4 or 5 these cases will be discussed at the Weekly Patient Safety Summit (WPSS) to confirm the level of harm and investigation/review template the service will utilise. Where an incident remains at a severity 3 or above the services must undertake and complete verbal and written Duty of Candour as part of the Trust legal responsibility.

Table 2: Trust local response

	Patient safety incident type or issue	**Description**	**Planned response**	**Anticipated improvement route**
1.	Transfer of care	Potential for patient harm as a result of missed communication with one or more stakeholders for on-going safe patient care.	After Action Review (AAR), or Hot Debrief, or Multi-Disciplinary Team (MDT) discussion.	E.g., create local safety actions and discuss at Divisional Governance/ Risk meetings. The Division service to feed these into a quality improvement strategy if appropriate or severe enough to raise on the Divisional risk register.
2.	Discharge	Discharge where a delay has led to adverse outcome within the length of stay and after the patient was	AAR, or Hot Debrief, Chronology or MDT.	E.g., create local safety actions and discuss at Divisional Governance/ Risk meetings. The Division service to feed these into a quality improvement strategy if appropriate or severe enough to raise on the Divisional risk register.

		medically optimised for discharge.		
3.	Never Events – medication, surgical, mental health and general (Reference: Never Events List 2018 (updated Feb. 2021)	Any clinical incident that meets the Never Event List	PSII (a chronology must be completed prior to an PSII being started)	Actions developed will be in the report and will be recorded on Datix through to completion.
4.	Validation of results	Potential for patient harm as a consequence of missed/delayed/non-communication or action of diagnostic results.	MDT or service review with outsourced companies. Depending on the level of harm this could be considered for PSII.	Actions developed will be in the report and will be recorded on Datix through to completion.
5.	Digital systems	Emerging risks identified as a result of the use of the Trust Digital Systems.	Thematic review/ Cluster review.	Actions developed will be in the report and will be recorded on Datix through to completion.
6.	Clinical care and treatment	Covers all service across the acute and community service and in-patient services.	AAR, Chronology, Hot Debrief.	Actions developed will be in the report and will be recorded on Datix through to completion.
7.	Falls	Inpatient falls resulting in a bone fracture or haemorrhage.	SWARM fall template.	Actions developed will be in the report and will be recorded on Datix until completed. The Swarm template once completed will be reviewed at the Trust Falls Steering Group.

8.	Tissue Viability – pressure ulcers, surgical wounds, leg ulcers	Tissue Viability (TV) Team discusses cases at the appropriate group meeting and according to the level of harm TV templates are completed.	TV templates / AAR	Actions developed will be in the report and will be recorded on Datix through to completion.
9.	Medication	Opioids management, gentamycin vancomycin, medication patches, extravasation, Diabetes Mellitus medication management, thromboprophylaxis (pulmonary embolism (PE)/deep vein thrombosis (DVT).	AAR, Chronology, for DVT/PE non-fatal hospital associated thrombosis (HAT) or fatal HAT templates are available.	Actions developed will be in the report and will be recorded on Datix through to completion.
10.	Multiple cases similar and recorded at various levels of severity	These cases can be clustered and considered for further review / investigation.	Thematic review / cluster review or the use of PSII.	Actions developed will be in the report and will be recorded on Datix until completed.
11.	Other	Patient safety incidents which meet a criterion for harm or potential harm not included in the areas highlighted above.	Where an incident does not fall into any of the categories 1-10 above then an investigation and / or review method as described in Table 3 below may be used by the local services except PSII (which must be undertaken by the Trust Patient Safety Team who have undertaken and completed additional investigation training). The local methods such as the national Perinatal Mortality Review Tool (PMRT) and Structured Judgement Review (SJR) tools and/ or structured local proformas maybe used. The Trust Infection Control Team in collaboration with the Trust Patient Safety Team will ensure robust PSIRF compliant templates are available for the service for infection control issues, events/incidents, as highlighted in a	

			letter received 16/08/2023 Alignment of Infection Prevention and Control (IPC) with the Patient Safety Incident Response Framework (PSIRF). The completion of a narrative response on the Trust Datix incident reporting system incident and management module will also be updated.

Appendix 5 (PSIRF plan Table 3)

Local additional methods and tools

1.	**PSII** – Patient safety Incident Investigation	PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple PSII's and other responses into a similar incident type. Recommendations and improvement plans are then designed to address those systems factors and help deliver safer care for our patients effectively and sustainably.
2.	AAR – After Action Review	A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.
3.	PSA – Patient Safety Audit	A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g., in a policy or guidelines).
4.	PMRT – Perinatal Mortality Review Tool	Developed through a collaboration led by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRACE-UK) with user and parent involvement, the PMRT ensures systematic, multi-disciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care; refer to: Perinatal Mortality Review Tool/National Perinatal Epidemiology Unit (NPEU) (ox.ac.uk)
5a. 5b.	SJR – Structured Judgement Review Learning from Deaths	Developed by the Royal College of Physicians as part of the national Quality Board guidance on Learning from Death; the SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. Refer to National Guidance Learning from Deaths Framework (NHS England).

5c.	Cluster review or Thematic Reviews	These types of reviews are useful to see the trends and be able to offer analysis for the Trust services to take forward learning and embed as appropriate.

Appendix 6 Complaints fact sheets

Number 1. **Complaints Factsheet**
This factsheet explains what we will do with the complaint you have raised about your experience, or that of a relative, friend or loved one, in respect of the care, treatment, services or amenities provided by the Trust. We treat all complaints seriously and aim to resolve them within the timescales set out in the acknowledgement letter that accompanies this factsheet. You can also be assured that making a complaint will never affect ongoing or future care or treatment at the Trust, and complaints are never filed in a patient's medical records.

What can I expect from raising a complaint?

We acknowledge all complaints received within three working days and after reviewing your complaint (in conjunction with your medical records if necessary), we will undertake a full investigation. If you have given us your telephone number or email address, we will also try to contact you to discuss your complaint.
We will then ask appropriate members of staff to provide a response to the complaint issues you have raised, and we may ask for a review of clinical care to be undertaken where appropriate. We will also endeavour to provide you with an update on the progress of your complaint and if we experience any delays in completing the complaint investigation, we will contact you to advise of this.
Once the investigation has been finished, the Patient Experience Team will prepare a written response. The Chief Executive will read your complaint, the investigation records and then the written response that has been prepared and if the response is satisfactory, it will be signed and sent to you. If the Chief Executive has questions about the investigation or the response, it will be returned to the Patient Experience Team to address these and ensure that the final response meets our quality standards.
What will you learn from my complaint?
You will be assured to know that we find complaints to be a very helpful source of feedback and any actions and/or learning identified as a result of your complaint will be shared with the relevant staff, wards or units. We have internal processes to ensure these actions and/or learning are logged, tracked, and implemented to prevent similar issues from happening in the future, as it is important that no-one else has the same experience you have had cause to complain about. **What can I do if I am not happy with your response?**
If you are not happy with our response to your complaint, please contact the Patient Experience Team in the first instance to let us know.
We can, in discussion with you, re-open your complaint and look again at any issues you feel we have not dealt with to your satisfaction or that require further clarification. We can also arrange for you to speak with relevant managers or clinical staff (subject to any restrictions), as this may provide further explanations or clarifications you need to help answer your questions.
It is important to us that we make every effort to resolve your complaint locally and, as far as it is possible, to your satisfaction. However, there may be occasions when we are unable to achieve this and, in these cases, you have the right to ask the Health Service Ombudsman to review your complaint. The contact details for the Parliamentary and Health Service Ombudsman are set out below.
Write To: Parliamentary and Health Service Ombudsman
Millbank Tower
Millbank
London
SW1P 4QP
Telephone: 0345 015 4033
Email: phso.enquiries@ombudsman.org.uk

Website: www.ombudsman.org.uk

Other formats

If you require this leaflet in a different format, such as large print or an alternative language, please contact the Patient Experience Team:
Dial 0300 13 14 500 and select extension 770358.

Complaints Team fact sheet number 2 -

Independent Health
Complaints Advocacy (IHCA)

Support in raising a complaint when NHS care and treatment hasn't been at the standard you expect.

How we can help

Sometimes things don't go as well as we would expect when we receive care and treatment from the NHS.
When this happens, we have lots of questions: why did this happen? how can it be put right? will it happen to someone else?
The Advocacy People can support you to make a complaint and get answers to your questions. We offer different levels of support. Our self-help Factsheets can guide you through making your own complaint. Or one of our Independent Health Complaints Advocates can work with you from the beginning or at any stage.
For more information and to make a referral:
Call: 0330 440 9000
Web: www.theadvocacypeople.org.uk
Email: info@theadvocacypeople.org.uk
Write: PO Box 375, Hastings, East Sussex, TN34 9HU
Text: 80800 start messages with PEOPLE

Appendix 7 Level of harm explained.

Level of Harm

Levels of harm were previously set out in the National Reporting and Learning Service guidance on reporting patient safety incidents.

In summary harm is defined as follows and recorded on ESHT DCIQ electronic risk management system (Datix).

No harm - Severity 1

This has two sub-categories:

No harm (Impact prevented) – Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. This may be locally termed a 'near miss'.

No harm (impact not prevented) - Any patient safety incident that ran to completion, but no harm occurred to people receiving NHS funded care. Ensure that the

Low harm – Severity 2

Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care.

Moderate harm – Severity 3

Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Severe harm - Severity 4

Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.

Death/ catastrophic life changing Severity 5– Any unexpected or unintended incident that directly resulted in the death of one or more persons.

Appendix 8 Process followed by ESHT Datix Team in notification from Datix to Divisions, managers etc and action expected.

The ESHT Datix Team overseeing the clod based DCIQ risk management electronic database do not have a flowchart only narrative to explain the process followed.

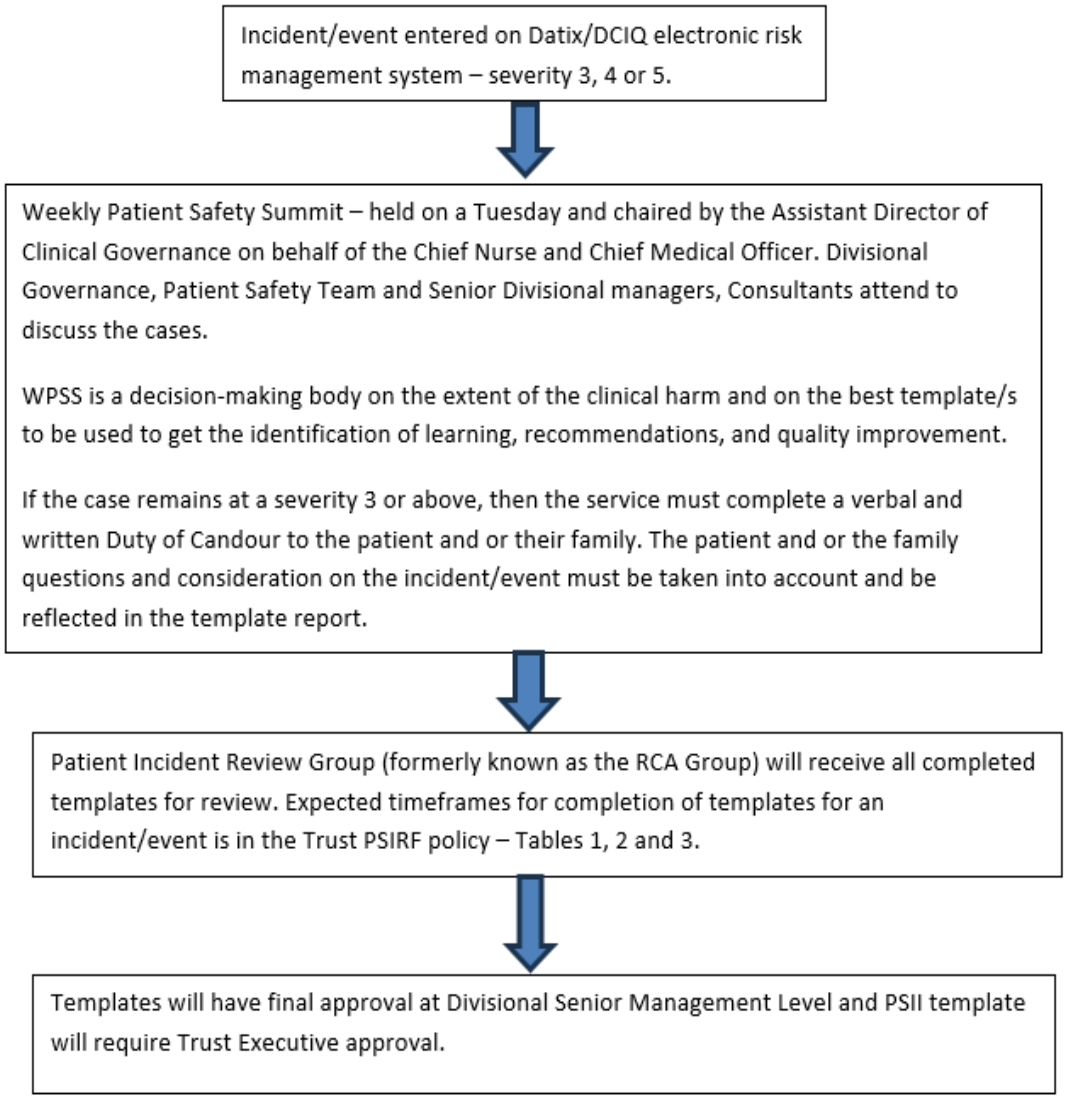
Notifications from DCIQ are determined by the profiles or on request of the Users themselves. Although the Trust Datix team have written the new profiles already for DCIQ we have not added notifications to any of these yet, so we will be discussing this with the project lead prior to Go Live. In general, though, the Trust Datix team try to minimise the email notifications as much as possible. They currently send out the following generic notifications and expect the new system will be much the same: -

- Managers receive an email notification when incidents are reported at severity 3,4 or 5 for their dept/service.
- Handlers or Investigators when any staff are assigned as Handlers or requests to investigate.
- Specialist staff also receive notifications when particular types of incidents have been reported e.g., Pressure Ulcers are sent directly to the Tissue Viability Nurses (TVN) team email inbox.
- When incidents are updated, the system notifies staff who have already received any of the above notifications again to inform them that the form has been updated.
- Reporters receive an email notification with feedback when the form is closed.

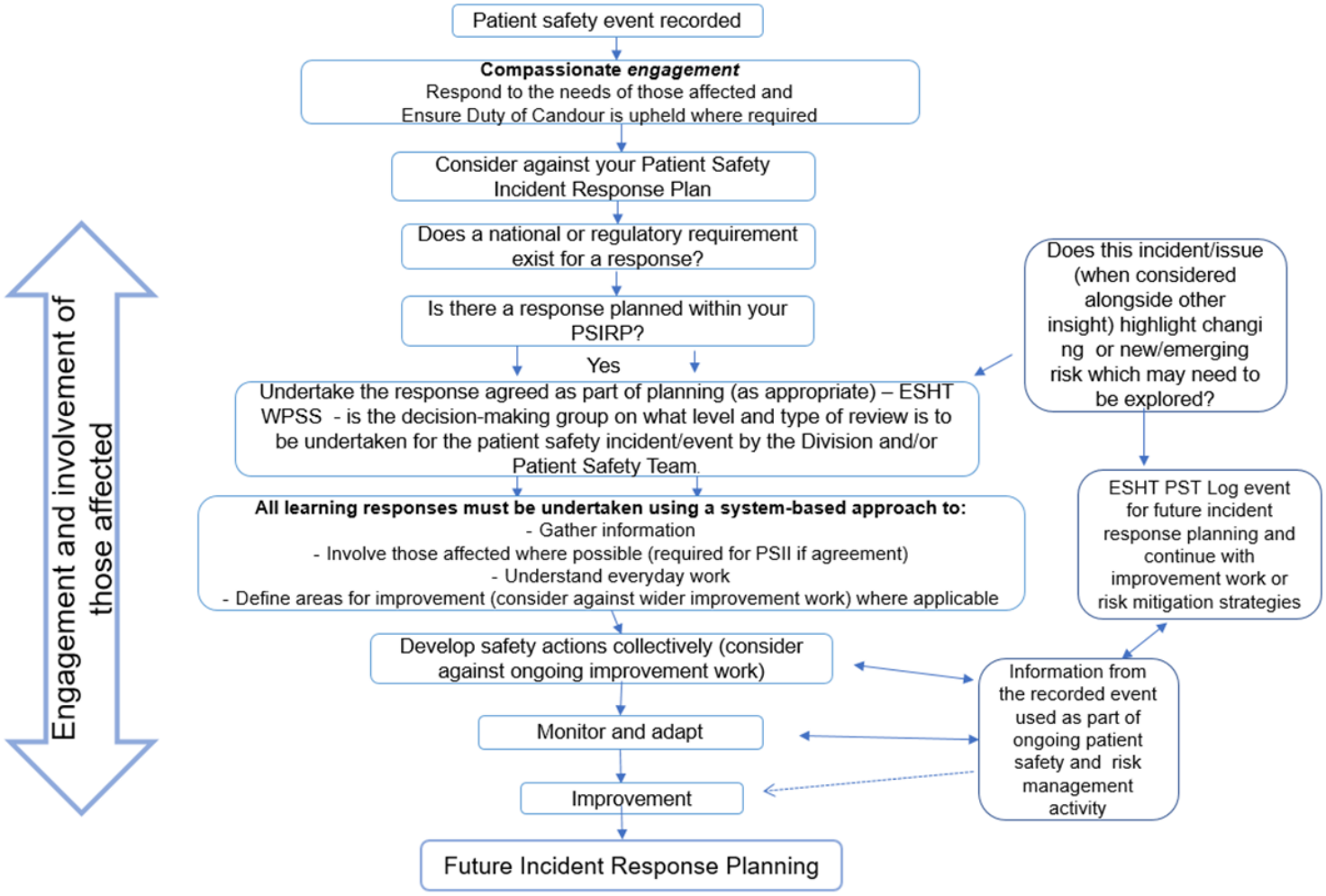
All other notifications are on the request of staff themselves and we set these up individually, but we again try to keep the email traffic from Datix as light as possible so that staff do not become bogged down by a large volume of emails and ignore the important emails.

Appendix 9

WPSS decision making process.



Appendix 10 Process Flowchart from incident/event to review.



References

NHS England (2021) Core20PLUS5: An Approach to Reducing Health Inequalities

core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)

NHS England (2022) Patient safety incident response standards

B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)

NHS England (2022) Safety action development guide

https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Note that the policy is based on NHS England's Patient Safety Incident Response Framework (PSIRF) 2022.

Our patient safety culture based on PSIRF preparation guide 2022 to complete this section

Patient safety partners (PSPs) for further information see Framework for involving patients in patient safety guidance 2022

Engaging and involving patients, families and staff following a patient safety incident refer to the Engaging and involving patients, families and staff following a patient safety incidents guidance, patient safety incident response standards and the PSIRF preparation guide 2022 to complete this section

Patient safety incident response planning refer to the Guide to responding proportionately to patient safety incidents, patient safety incident response standards and the PSIRF preparation guide 2022 to complete this section

Resources and training to support patient safety incident response refer to the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

Our patient safety incident response plan refer to page 7 and page 9 see Figure 1 and Table 1 in the Guide to responding proportionately to patient safety incidents 2022 used to inform this section.

Reviewing our patient safety incident policy and plan refer to Patient safety incident response standards and roles and responsibilities 2022 documents.

Responding to patient safety incident section refer to NHS England » Report a patient safety incident 2022 used to inform this section.

Patient safety incident response planning refer to the Guide to responding proportionately to patient safety incidents, patient safety incident response standards and the PSIRF preparation guide 2022 used to complete this section.

Responding to cross-system incidents / issues refer to the Oversight roles and responsibilities specification 2022 used to complete this section.

Safety action development and monitoring improvement refer to the learning from incident responses to inform improvements, see the Safety action development guide 2022.

Oversight roles and responsibilities refer to the Oversight roles and responsibilities specification and Patient safety incident response standards 2022 for further information and Patient safety incident response standards 2022 used to complete this section.

Provider PSIRF Implementation Plan - ESHT

TASKS	TASK Lead	Proposed completion date	Months: Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Comments
PSIRF orientation (months 1–3)																
Create an implementation team	NC/LF	30/09/2023														
Allocate time for reading and reflection	NC/PST	Completed														
Identify knowledge and support needs for getting started	NC	31/10/2023														To consider if a staff survey would be a way of achieving this
Create a stakeholder list and plan engagement	LF/NC	31/10/2023														
Agree structures and processes for programme management	NC/LF	31/10/2023														Project and Business Support Manager to support
Set ambition for PSIRF implementation	NC/LF	31/10/2023														Need to agree a set date for implementation and communicate it (November 2023)
Diagnostic and discovery (months 4–7)																
What is being done to support open and transparent reporting?	CH/JW	31/10/2023														We have a good reporting culture. Need to link with HR regarding staff survey
How do you engage and involve those affected by patient safety incidents?	CH.JW	Ongoing														Needs a leaflet for staff that explains the process and includes patient engagement. Review patient safety page on Extranet. PSPs need to be recruited (next year). DoC leaflet and staff booklet
What is being done to support the development of a just culture?	NC/ LF/GO	Ongoing														Links to work with Gbolahan Oluwatunmise
What is your incident response capacity and what are your training needs? (Trust wide)	NC	31/03/2024														Needs a Trust wide TNA and a review of the MyLearn modules
How do you use learning from incident responses to inform improvement?	LF/NC	Ongoing														PSIRF will enable this learning
What do you need to do next?	NC/LF	Ongoing														Develop a project plan
Governance and quality monitoring (months 6–9)																
Develop processes for incident response decision-making	NC/LF	31/10/2023														Agree TORs for repurposing the WPSS and the RCA Group
Define how system effectiveness will be monitored	LF/NC	31/10/2023														Possibly through the RCA Group themes and trends but also Divisional learning about closing the loop on agreed actions.
Develop processes for reporting cross-system issues	NC/LF	31/12/2023														Sharing learning cross Divisions, bulletins, patient safety day etc
Define how PSIRF implementation will be monitored	LF/NC	31/10/2023														Through the project plan
Patient Safety Incident Response Planning (months 7–10)																
Map your services	NC/LF	Completed														
Examine patient safety incident records and safety data	LF/NC	31/10/2023														Need to have an objective data triangulation report process for 2024/25
Describe the safety issues revealed by the data	NC/LF	31/10/2023														
Identify work underway to address contributory factors	LF/NC	31/12/2023														Focus on factors that haven't been addressed yet
Agree how you intend to respond to issues listed in your patient safety incident profile	LF/NC	31/10/2023														Amended templates for various response methodologies
Curation and agreement of policy and plan (months 9–12)																
Populate the policy and plan templates and share these with stakeholders	NC/PST	31/10/2023														
Respond to stakeholder feedback on the draft policy and plan	LF/NC	31/10/2023														
Agree how to manage transition	LF/NC	31/10/2023														Agree cut off point for SIs ? 31st October
Ensure commitment to delivering required improvement	LF/NC	31/10/2023														
Seek policy and plan approval/sign-off and agree 'transition date'	LF/AC	31/10/2023														
Transition																

KEY

NC - Nicky Creasey	Task completed
LF - Lisa Forward	On track for completion
PST - Patient Safety Team	Some minor delays
CH - Chloe Howarth	No progress
JW - Jo Williams	Anticpated end
AC - Angela Colosi	
PST - Patient Safety Team	
GO - Gbolahan Oluwatunmise	

Next Steps

Complete [Plan and Policy ready for sign off
Communications strategy, need to involve focus groups
Preparing for Patient Safety Day 17th September
Patient Engagement Strategy
TNA
Band 6 induction to initially focus on PSIRF
Describe process for how patient safety improvement links to Trust continuous learning and improvement activity

East Sussex Healthcare NHS Trust

Board Assurance Framework (BAF) Update

Purpose of the paper	This paper updates the Trust Board as to the progress in managing the Board Assurance Framework's (BAF) Q2 2023/24 position.						
	For Decision		For Assurance	x	For Information		
Sponsor/Author	Chief of Staff/Board Secretary						
Governance overview	All BAF risks were refreshed for 23/24 at the May Seminar and drafted initially by sub-committee Chairs and relevant EDs. They were reviewed by the Board and amendments were made and shared with the Board Secretary. Each BAF risk has been reviewed by the Chief of Staff and Executive Risk Owner. Collectively the full BAF is reviewed at Executive Directors and shared quarterly with the Audit Committee before going to the next scheduled 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		x	x

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

Recommendation	The Trust Board is asked to note the completed summary position for BAF risks and Q2 positions of each risk, having been reviewed by each Board sub-Committee
Executive Summary	This paper provides an overview of the Q2 risk position for each of the twelve BAF risks, following discussions with executive risk owners and interrogation at the relevant Board sub-Committees. Each sub-Committee has reviewed the risk descriptions, mitigations and positions contained within the Q2 update. The risk rating for BAF 6 has been reduced from 16 in Q1 to 12 in Q2. This is due to the creation of a Cyber Action Plan which has which has got the Trust to medium risk status. Against the YE target risk, eight of the twelve are shown at this level for Q2 with the remainder above the target risks, for reasons that are contained within the BAF risks and that have been shared with the relevant sub-Committees. The YE target risk ratings have increased since Q1 for BAF 2 (from 12 to 15) and BAF 3 (from 12 to 16) due to the ongoing and escalating doctors' industrial action.
Next steps	Mitigating actions as detailed in each BAF risk summary remain under review by the Board sub-Committees and will be reported in the Q3 update.

Board Assurance Framework (BAF)

East Sussex Healthcare NHS Trust

Quarter 2 Update 2023/24 Overview

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

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

The Trust Board discussed an updated BAF In April and May 2023, agreeing updated BAF risks and the organisation's risk appetite for each. The Trust's Corporate Risk register contains all of the risks in the Trust that are rated as 15 or more. The majority of risks included on the BAF are included on the Corporate Risk Register, which is presented in full to the Audit Committee alongside the BAF.

Links between each BAF risk and the risks on the Trust's Corporate Risk Register can be found in Appendix One.

Quarter 2 Update 2023/24 Movement from Q1

As the summary shows over the page, there has been little movement across many BAF risks since Q1. Due to the cancellation of StratCom in August, three of the twelve risks have not yet been reviewed by the Committee (this will take place at the October StratCom). The position statements for these BAF risks at Q2 therefore reflect the view of the ED responsible based on evidence to date but have not yet been agreed through the Committee.

The risk that has reduced from Q1 is BAF 6, relating to our vulnerability to cyber-attack. With the implementation of the cyber action plan now underway, designed to strengthen our resilience, this delivery should be reflected in the level of risk that we anticipate and so the rating is down from 16 to 12.

The BAF risks currently shown as over their YE expected profile reflect the challenges that we see in the operating environment currently and that have significant impact on our ability to deliver our in-year objectives. These are:

- The ongoing pressure on digital and BI teams to deliver more for teams from within the current resource envelope (BAF risks 7,8),
- The scale and pace required of our continuous improvement programme (BAF risk 9),
- The on-going industrial action that challenges a) delivery of elective activity against plan b) our emergency access target, impacted by an absence of doctors on wards available to discharge patients who no longer need to be in an acute setting (BAF risk 10).

Over Q3 and Q4 colleagues remain focused on bringing these closer to our anticipated YE position for the BAF risks.

BOARD ASSURANCE FRAMEWORK - SUMMARY PAGE

NHS
East Sussex Healthcare
NHS Trust

BAF Ref	RISK SUMMARY	Monitoring Committee	Strategic Aims Impacted				Inherent Risk	Current position (Residual risk)				Change	Risk Appetite	Anticipated Year End Risk	Target date
								2023/24							
								Q1	Q2	Q3	Q4				
1	Capacity constraints associated with supporting the collaborative infrastructure	Strat	X			X	9	6	6			◄►	Seek / Significant	6	Review every two months
2	Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time.	POD		X	X	X	15	15	15			◄►	Open	15	Ongoing
3	Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.	POD		X	X	X	20	16	16			◄►	Cautious / Open	16	Ongoing
4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery	F&P			X	X	20	12	12			◄►	Cautious	12	31/01/23
5	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&P		X	X	X	20	16	16			◄►	Cautious	16	Ongoing
6	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack	Audit	X	X	X	X	16	16	12			▼	Minimal	12	Ongoing
7	Failure to develop business intelligence weakens insightful and timely analysis to support decisions	F&P			X	X	16	16	16			◄►	Open	12	Ongoing
8	Failure to transform digitally and deliver associated improvements to patient care	F&P			X	X	16	12	12			◄►	Significant	8	31/03/26
9	Failure to maintain focus on improvement	Strat				X	16	16	16			◄►	Open	12	Review every two months
10	Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that are discharge ready with an extended length of stay	Q&S	X	X	X	X	20	16	16			◄►	Open / Seek	12	Ongoing
11	Failure to demonstrate fair and equal access to our services	Strat	X			X	15	9	9			◄►	Cautious / Open	9	Review every two months
12	Failure to meet the four-hour standard	Q&S	X	X	X	X	20	16	16			◄►	Minimal	16	Ongoing

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

Key to Risk Appetite Ratings		
0	None	Avoidance of risk is a key organisational objective
1	Minimal	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential
2	Cautious	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential
3	Open	Willing to consider all potential deliver option and choose while also providing an acceptable level of reward
4	Seek	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)
5	Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust

Key to Risk Rating Types	
Inherent Risk Rating	The amount of risk that exists in the absence of controls
Residual Risk Rating	The amount of risk that remains after controls are accounted for.
Target Risk Rating	The desired optimal level of risk.

RESIDUAL RISK MATRIX (Risk assessment post-controls/mitigation)

		Collaborating to deliver care better	Empowering our People	Ensure Innovative & Sustainable Care	Improving the health of our communities
BAF 1	Capacity constraints associated with supporting the collaborative infrastructure	6			6
BAF 2	Failure to attract, develop and retain a workforce that delivers the right care in the right place at the right time.		15	15	15
BAF 3	Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.		16	16	16
BAF 4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery			12	12
BAF 5	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		16	16	16
BAF 6	Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack	12	12	12	12
BAF 7	Failure to develop business intelligence weakens insightful and timely analysis to support decisions			16	16
BAF 8	Failure to transform digitally and deliver associated improvements to patient care			12	12
BAF 9	Failure to maintain focus on improvement		16		16
BAF 10	Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that no longer meet the criteria to reside	16	16	16	16
BAF 11	Failure to demonstrate fair and equal access to our services	9			9
BAF 12	Failure to meet the four hour standard	16	16	16	16

Risk Summary							
BAF Reference and Summary Title:	BAF 1: Capacity constraints associated with supporting the collaborative infrastructure			Strategic Aims Impacted			
				x			x
Risk Description:	Resourcing pressure arising from support/presence at partnership initiatives diverts leadership resource from internal ESHT priorities						
Lead Director:	Chief of Staff	Lead Committee:	Strategy & Transformation Committee		Date of last Committee review:	22/06/2023	

BAF Risk Scoring									
Inherent Risk	Residual Risk	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
	Likelihood:	2	2			The synergy between System-level success and organisation-led delivery to achieve this aligns Sussex-wide goals with what Trusts are doing.	Likelihood:	2	
	Consequence:	3	3				Consequence:	3	
(3x3)	Risk Level:	6	6			However, this risk reflects the potential disadvantage of this tie-up; namely that key senior leaders' capacity is stretched across external meetings as well as internal ones.	Risk Level:	6	Review every two months
9						To date, the Trust has managed within its existing resources and we intend to do so (hence the risk score for Q1) but – especially in certain areas – there is a recognition that ICB resource is well-provided for and, with this, comes a commensurate range of ambitions and scale of workload.			

Cause of risk:	• New/evolving governance forums leading to the time commitment of ESHT senior leaders being compromised	Impact:	• Internal priorities focused on delivery of ESHT 23/24 objectives may be compromised by relevant senior leaders being at other meetings
Current methods of management (controls)	A. Robust monitoring process via EDs, IPRs enabling teams to flag where pressures arise – either on external commitments or internal presence being compromised to the point where senior leaders' grip on internal priorities is suboptimal		

Assurance Framework – 3 Lines of Defence – linked to control (above)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Teams to consider alternative options/resources to ensure ESHT collaboration is maintained at an appropriate level	• Teams able to escalate to EDs for review/support/mitigation options • EDs to consider alternative resource and appropriateness to the responsibility levels	• EDs to raise with external partners as required where no alternative resource is available

Gaps in control/assurance:
• None seen currently

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**

Current proactive management means that we are at the target level for this risk. We have strong and open relations with ICB colleagues, so have already escalated constructively where we feel that there is a stretch on internal resource in order to support ongoing ICB areas. Attendance issues are flagged via Executive Directors meeting and/or Divisional IPRs and our discussions with the relevant partners to seek to manage expectations on attendance have so far been extremely positive.

Risk Summary							
BAF Reference and Summary Title:	BAF 2: Failure to attract, develop & retain a workforce that delivers the right care, right setting, right time				Strategic Aims Impacted		
						x	x	x
Risk Description:	There is a risk that the available workforce does not meet the organisation's resource requirements in the short, medium and long term						
Lead Director:	Chief People Officer	Lead Committee:	People and Organisational Development Committee	Date of last Committee review:	27/07/2023		

	BAF Risk Scoring								
Inherent Risk	Residual Risk	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(5x3) 15	Likelihood:	5	5			There are pockets of specialities where recruitment is challenged, although these largely reflect national difficulties. Ongoing success with recruiting into some 'Hard to Recruit' substantive posts, particularly Consultant posts. Retention is a clear risk given the ongoing operational pressures being experienced locally and across the NHS. The Trust's age profile presents a specific risk to longer term retention with around 20% of our workforce are at a point where they are technically able to retire. Industrial action relating to the BMA and consultants continues to present short term workforce issues and disquiet in the workforce. The risk rating remains as for Q4 20223/23 based on the nature of the industrial action. The anticipated year end risk is based on industrial action being resolved through national agreement. **Update:** Further vote from junior doctors and escalation of joined up industrial action between consultants and junior doctors has led to an increase in the anticipated year end risk to 15.	Likelihood:	5	*Ongoing*
	Consequence:	3	3				Consequence:	3	
	Risk Level:	15	15				Risk Level:	15	

Cause of risk:	• Industrial action • Recognised national shortages in some staff groups • Geographical location, demographics and age profile of workforce • Continued operational pressure in a number of clinical areas • Lack of opportunity for career development • Working pressures over the last two years have had a detrimental impact on staff retention • Withdrawal of Brighton University from East Sussex may impact on the number of trainees choosing to base themselves in East Sussex during their training, which may reduce the number of doctors	Impact:	Failure to maintain workforce stability gives rise to risk of: • Not being able to deliver activity in line with operational needs • Detrimental impact on patient care and experience • Detriment to staff health and well-being • Detriment to staff development as result of reduced ability for staff wanting to attend education/training due to staff shortages in key areas • Failure to comply with regulatory requirements and constitutional standards

	• seeing the Trust as a natural first choice for post training employment • Withdrawal of funding for registered nurses associates to undertake two year degree to become fully registered nurses		• Detriment to performance and productivity • Increased workforce expenditure due to agency requirements • Inability to ensure 'great place to work' culture and climate thus frustrating strategies and efforts to attract, recruit, retain, deploy, and develop staff
Current methods of management (controls)	A. Ongoing monitoring of Attraction, Recruitment and Retention Strategy and developing wide range of recruitment methodologies (events, social media, recruitment consultancies, targeted recruitment activity, including a significant overseas recruitment plan) B. Talent management, succession planning, appraisals and development programmes C. Developing new roles and "growing our own" e.g. New to Care D. Workforce efficiency metrics in place and monitored E. Quarterly reviews in place to determine workforce planning requirements. F. Review of nursing establishment 6 monthly as per Developing Workforce Safeguards G. Full participation in HEKSS Education commissioning process and regional medical role expansion programme – Foundation and some Speciality Training programmes H. Stay interview and exit interview programmes I. Use of bank and agency where required J. Focus on retention particularly on understanding why people may want to leave the Trust. K. Use of government initiatives e.g. Kickstart L. Flexible working M. More flexible use of retire and return N. Proactively building our positive reputation as an employer O. Implementation of an industrial action project to mitigate the impact of colleagues taking industrial action P. Assurance is being provided re industrial action preparedness to system and region via self-assessment checklist		

Assurance Framework – 3 Lines of Defence – linked to controls (A-P)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Monthly reviews of vacancies together with vacancy/turnover rates (A)(H)(D) • Twice yearly establishment reviews (F) • Success with some hard to recruit areas e.g. consultants in Histopathology, Radiology, Neurology, Orthopaedics and Acute medicine.(A) (C) • In house Temporary Workforce Service to facilitate bank and agency requirement (I) • Workforce efficiency metrics (D) • New AHP /HCSW initiatives (C)	• Workforce strategy aligned with workforce plans, strategic direction and other delivery plans and metrics reviewed by POD and Trust Board (A) (B) (D) (E) (F) (G) • Three-year Attraction and Recruitment Strategy refreshed (A) • Improvements to Applicant Tracking system (Trac) have led to reduced time to hire for new staff (not including Medical & Dental staff). (D) • Temporary workforce costs scrutinised by Finance and Productivity Committee (I)	• National Staff Friends and Family Test (A) (G) (H) • Clinical Commissioning Group Quarterly Workforce meetings (D) • Internal audits of workforce policies and processes (A) (D) (E) • NHS Staff Surveys and Pulse Surveys and benchmarking data (A) (B) (C)

Assurance Framework – 3 Lines of Defence – linked to controls (A-P)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
	• Continued International Nurse recruitment. c70 in total for 2023/24 (A) • Additional Headhunter Agencies engaged for hard to recruit Medical Posts (A) • Regular meetings with Regional Post Graduate Deans for Acute and Primary care (C)(J)(N) • Job plans in place for all doctors (B) • Industrial Action working group and daily resource meetings attached to site meetings (O)(P) • In the event of industrial action, reduction in services to ensure all urgent and derogated services are delivered (O)(P)	• Wellbeing offering enhance (includes Pastoral Fellowes support) and reviewed by POD (K) • People Strategy is being delivered (A)(B)(C)(D)(E)(F)(I)(K) • Ongoing recruitment campaigns for hard to fill roles (A) • Delivery of an employee value proposition (EVP) in 2023 • NHS Workforce long term plan implementation	
Gaps in control/assurance:			
• None identified			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	Continue with recruitment initiatives and international sourcing of medical candidates, including Radiographers, Sonographers, Gastro and Endoscopy	Chief People Officer	Ongoing	• Continued recruitment campaigns with both Medacs and MSI agencies to source International Nurses and Medics. Target of 70 nurses this financial year(2023/24).Interviews commenced and on target to deliver required numbers .Planned cohorts to assist with winter planning. • Local and UK recruitment campaigns continue. New recruitment stand and collateral acquired to assist with Trust Branding in support of these campaigns. • 6 International Radiographers/Sonographers joined Trust in August 2023. • Trust continues to work with external recruitment agencies to assist with recruiting 'hard to fill posts'. Number of	G

				initiatives in place to support recruitment e.g. assistance with relocation/onboarding of new colleagues • Increased number of direct applicants to hard to recruit posts i.e. Radiology and Respiratory Drs	
2.	Local outreach initiatives	Chief People Officer	Ongoing	• Trust working with DWP and Princes Trust. To date c60 young adults supported with Prince Trust initiative. Recruitment events attended in conjunction with DWP. • Trust working with other ICB organisations with regards local recruitment activities and initiatives e.g. 'Recruitment Hub' • Trust involved with both Little Gate Farm and Project Search initiatives	G
3.	Focus on Advanced Practitioner role and roles that support medicine such as Physician Assistants, Surgical Care Practitioners, Anaesthesia Associates (new national curriculum due soon), increase number of Doctors Assistants	Chief People Officer	Ongoing	• SCP :We continue to have two SCP on programme at Anglia Ruskin University the course is for 2 years part time. Meeting scheduled to discuss future SCP development for 23/24 to 27/28 for the NHS England Workforce Training and Education commissioning process. • PA Role : Conversations to formalise the lead PA appointment. There is a one off payment of 20k funding from the ICB to support this role, with additional funding for a Band 7/8a to support the. A meeting, in collaboration with UHSx is scheduled to discuss support to take the role forward in light of new NHS Workforce Plan released this week. • Education Steering Group: ToRs are currently being reviewed. The new Deputy Chief Medical Office – Workforce will co-chair the group. • • Anaesthetic Associates: Recent meetings held with clinical lead and division, as well as with the GMC's lead for anaesthetic associates. NHS England announced pump prime funding to support development of the role in Trusts. Business case to be written for development of x2 anaesthetic associate roles in the service with funding from NHS England.	G

Risk Summary							
BAF Reference and Summary Title:	BAF 3: Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.				Strategic Aims Impacted		
						x	x	x
Risk Description:	There is a risk that any decline in staff motivation negatively impacts on our ability to deliver the required levels of activity to the standards we require.						
Lead Director:	Chief People Officer	Lead Committee:	People and Organisational Development Committee	Date of last Committee review:	20/07/2023		

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(5x4) 20	Likelihood:	4	4			Data is showing that engagement levels across the NHS and locally have reduced over the past three years Elongated industrial action without resolution may further impact on the motivation and morale of colleagues taking industrial action and those directly impacted by it, and our ability to deliver services in a timely and efficient way. The anticipated year end risk is based on industrial action being resolved through national agreement. **Update:** Further vote from junior doctors and escalation of joined up industrial action between consultants and junior doctors has led to an increase in the anticipated year end risk to 16.	Likelihood:	4	Ongoing
	Consequence:	4	4				Consequence:	4	
	Risk Level:	16	16				Risk Level:	16	

Cause of risk:	Ongoing operational instability and pressures, alongside workforce availability.	Impact:	Adverse impact on staff engagement, health and wellbeing could lead to increased absences and turnover, and an associated inability to deliver services, possible closure of services and adverse impact on patient experience and reputational risk.

Current methods of management (controls)	A. Training for managers to have compassionate conversations about risk assessments with vulnerable staff B. Systems and processes in place both reactive and proactive to manage violence and aggression – including conflict resolution training, OH support, risk assessments and security support. C. Working with the ICS to develop a system wide strategy and policy on violence prevention D. Improved de-brief process and package of support for staff involved in violence and aggression or distressing situations at work. E. Reviewing and implementing best practice from other areas (e.g. TRiM, MHFA) F. Targeted support for implementing TRiM in ED departments through a dedicated resource for a period of three months G. Range of wellbeing/pastoral support available and being further developed across all professional groups H. Development of Health and Wellbeing Conversations for all colleagues I. Ongoing focus on Violence and Aggression with ambition to become upper quartile organisation J. Ongoing National vaccination programmes

	K. Workforce Efficiency and Availability Reviews L. Workforce Strategy M. Admission avoidance and discharge activity through operational teams N. Working with the entire system, third sector and independent health and social care organisations to assist them with recruitment and training. O. Effective rostering and leave management P. Undertaking deep dive cultural reviews in areas where there is particular concern regarding colleague engagement and morale

Assurance Framework – 3 Lines of Defence – linked to controls (A-P)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Ongoing monitoring of, and response to, key workforce metrics/staff survey • Completion of risk assessments to be recorded on ESR. (A) • Promoting wellbeing support available and training to line managers (G) • DME monitor/reviews confidential trainees in difficulty register • Workforce efficiency and availability reviews considering registered and unregistered nurses, and AHPs (I) • Appropriate PPE provided (A) • Ongoing reviews of effectiveness and efficiency of rostering to deliver the required staffing levels	• Occupational Health and Health and Safety Team support and audit of risk assessments and Datix incidents (A) (B) (D) • Occupational and staff wellbeing support to staff (E) (H) (I) • Metrics reported to executive team, POD and Trust Board – increased compliance with completion of risk assessments (A) • Local Security Management Specialist advice and support (D) • Oversight and monitoring by Health and Safety Steering Group (D) • Deep dive cultural Reviews (P) • Implementation of NHS Long term workforce plan	• ICS undertaking assurance reviews (A) • Sussex network meeting in place and liaising with SECAMB on Trauma Risk Management (F) • Health and Safety Executive review of violence and aggression (D) • Collaboration with ESCC on lone working (F) • GMC outcomes have action plans with quality virtual visits in place to provide assurance to HEEKSS/Trust (H)(L)
Gaps in control/assurance:			
• *None identified*			

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

No.	Action Required	Executive Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	People Strategy	Chief People Officer	Ongoing	• People Strategy has undergone year 2 refresh and this established programme of works and has reported to POD. • Further updates will continue on a quarterly basis	G

Risk Summary							
BAF Reference and Summary Title:	BAF 4: Failure to deliver income levels/manage cost/expenditure impacts savings delivery			Strategic Aims Impacted			
						x	x
Risk Description:	At month five the Trust is expected to assume ERF income at plan. However, there remains a need to deliver the cost efficiencies required to breakeven. In addition there is a risk that we will not receive the full year of income at budget level if we do not deliver the associated activity.						
Lead Director:	Chief Financial Officer	Lead Committee:	Finance and Productivity Committee	Date of last Committee review:	27/07/2023		

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(5x4) 20	Likelihood:	3	3			**Likelihood**: There is a need to identify £6-8m of efficiencies beyond the current Cost Improvement Programme. Also there are additional pressures caused by strikes in 2023/24. **Consequences**: Whilst the consequences are potentially severe, we are cognisant that the challenges faced by the Trust are common with many NHS providers and therefore the regulatory response will likely be proportionate in that context. Therefore, the consequence has been capped at a 4. In the year to date we have assumed no loss of income from industrial action which would, if included in the year to date actuals, have been £1.9m worse by month four. The full year deficit will be impacted by national assumptions on activity that is not delivered during industrial action.	Likelihood:	3	31/03/2024
	Consequence:	4	4				Consequence:	4	
	Risk Level:	12	12				Risk Level:	12	

Cause of risk:	• Failure to deliver on the ERF activity plan; • Increased operational pressures and in particular patients not meeting the criteria to reside meaning that we are unable to deliver to the escalation bed plan; • Failure to deliver recurrent efficiencies • Ongoing lack of resolution of strike actions	Impact:	Failure to maintain financial sustainability gives rise to risk of: • Unviable services and increased cost improvement programme; • If the system declares a deficit, there is a risk that additional controls will be imposed by the national team. At the moment, Sussex is rated as risk level 1 but could be escalated to risk level 2-4; • Damage to Trust's stakeholder relationships and reputation. • Impact of delivery below the ERF activity plan has been mitigated by a national assumption to record income at planned activity level

Current methods of management (controls)	A. Efficiency programme is in place with targets set and monitored at divisional level; B. Divisions held to account for overall financial performance through IPR process based on budgets agreed through the Divisions and Executive; C. Scheme of Delegation (SoD) and Standing Financial Instructions (SFIs) in place to manage expenditure across pay and non-pay; D. Staffing controls through establishment control, including vacancy panel; E. Productivity Director recruited and has implemented project controls on CIP plans

Assurance Framework – 3 Lines of Defence – linked to controls (A-D)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Work continues through divisional meetings, at IPRs and joint COO/CFO additional reviews to both maintain contingency and to strengthen recurrent delivery of overall financial position and the efficiency programme. (A) (B) (D) • Procurement, Temporary Workforce Services and vacancy panel all monitor compliance as appropriate with scheme of delegation and SFIs (C) (D)	• Oversight by Efficiency Committee and Finance & Productivity Committee (A) • Revised SFIs and SoD (C)	• Internal audit reviews (A) (B) (D) • External audit programme in place (A) (B) (C)
Gaps in control/assurance:			
None identified but need to ensure that the system of internal financial control remains robust.			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	Finalise CIP plan for year with an emphasis on controlling costs as well as delivering increased activity	Chief Financial Officer	31/10/2023	• At M5 there has been some assurance for £32m of the £32.5m CIP. However, there have been some temporary staffing costs and some elements of waiting list initiatives which resulted in a deficit of £1.4m by month four. • Following the decision to accrue income to budget, the remaining deficit on a straight line basis would be just over £5m. • Additional actions will need to be taken to reduce the gap further.	A
2.	Establish a finance and activity focused accountability session chaired by COO and CFO with each division covering financial performance, activity and efficiency to increase scrutiny, grip and control above the existing IPR process	Chief Financial Officer	30/10/2023	• First meetings took place in August. • Key actions will be shared with the Finance and Productivity Committee	A

Risk Summary							
BAF Reference and Summary Title:	BAF 5: 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			Strategic Aims Impacted			
					x	x	x
Risk Description:	There is a risk that there may be unplanned outages in equipment, buildings and facilities not being available for clinical purposes						
Lead Director:	Chief Financial Officer	Lead Committee:	Finance and Productivity Committee		Date of last Committee review:	27/07/2023	

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(5x4) 20	Likelihood:	4	4			The Trust's capital budget for 2023/24 is £23.3m, comprising £3.5m on diagnostic and medical equipment, £3m on digital, £7.3m on estates backlog and other schemes. Given the overall level of backlog for the estate, medical equipment and digital, the planned annual expenditure is not enough to meet the significant backlog that exists. Following completion of the options appraisal for Building for our Future (BFF) we will have a greater understanding of the residual backlog which will be left post the BFF works. We anticipate that this work will be completed in early 2024. We will be working with a consultancy to undertake a review of critical infrastructure and clinical activity/risk which should be completed in late 2023. This should clarify the level of capital backlog and how that will affect future capital spend and may result in a risk rating on the BAF.	Likelihood:	4	Ongoing
	Consequence:	4	4				Consequence:	4	
	Risk Level:	16	16				Risk Level:	16	
Cause of risk:	Insufficient capital to meet significant backlog					Impact:	Lack of capital for investing in the future sustainability of the Trust gives rise to risk of a significant impact on the Trust's ability to meet its requirements to provide safe, modern and efficient patient care.		
Current methods of management (controls)	A. Significant work is always undertaken to deliver the capital plan B. Essential work prioritised with estates, IT and medical equipment								

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

Gaps in control/assurance:

- Longer term capital programme has been produced; however, significantly more capital is required to address this than is available to the Trust.
- New Hospital Programme/BFF funding envelope delayed and not clear at present
- Availability of project managers to deliver the backlog programme

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	ICS will undertake a medium term financial plan	Chief Finance Officer	Ongoing	• Expenditure monitored • Progress reported regularly to Finance and Productivity Committee	A
2.	Through New Hospital Programme business case process and associated enabling business cases, Trust will be addressing solutions for backlog maintenance	Chief Finance Officer	March 2024	• Priorities to be developed into the New Hospital Programme Case	A
3.	Options appraisal for Building for our Future (BFF) to be undertaken	Programme Director BFF	March 2024	• We anticipate that this work will be completed in early 2024.	A
4.	Work to be undertaken with consultancy to review critical infrastructure and clinical activity/risk in order to clarify the level of capital backlog and how this will affect future capital spend.	Director of Estates and Facilities	January 2024	• Work with consultancy will commence in September 2023.	A

Risk Summary							
BAF Reference and Summary Title:	BAF 6: Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack				Strategic Aims Impacted		
					x	x	x	x
Risk Description:	Current mitigations include rollout of MFA to key users, plan to minimise non-supported software and contain software that cannot currently be removed, and ensure offsite backup.						
Lead Director:	Chief Financial Officer	Lead Committee:	Audit Committee	Date of last Committee review:	27/07/2023		

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(4x4) 16	Likelihood:	4	3			A number of elements of the cyber action plan have been delivered, reducing our cyber exposure. There are a number of robust controls in place, but further mitigation can be achieved by implementing a formal programme of work that addresses the wider information security agenda. A significant amount of work has been done to increase the robustness of the Trust Cyber security posture. The current security risk status has reduced to which has been a great achievement. But the threat level in the NHS has increased with a number of attacks on NHS Trusts or provider organisations. We have created a Cyber Action Plan, which has got the Trust to medium risk status, which has resulted in the risk rating being reduced to 12. We continue to work towards receiving Cyber Essentials Plus accreditation. The action plan has four elements: 1. Internal Audit recommendation 2. Cyber Essentials Self-assessment recommendations 3. External Penetration Test recommendations 4. 12 Risks on the trust risk register	Likelihood:	3	Ongoing
	Consequence:	4	4				Consequence:	4	
	Risk Level:	16	12				Risk Level:	12	

Cause of risk:	• Global malware attacks infecting computers and server operating systems. The most common type of cyber-attack are phishing attacks, through fraudulent emails or being directed to a fraudulent website.	Impact:	• A shut down of key IT systems could have a detrimental impact on patient care and access. They can lead to a loss of money and data as well as access to files, networks or system damage.

	• Infrastructure Hardware failure, due to unsupported systems or lack of Capital Refresh.		
Current methods of management (controls)	A. Network Monitoring solution implemented to defend against hacking /malware. Regular scanning for vulnerability. B. Anti-virus and Anti-malware software in place with programme of ongoing monitoring. Client and server patching programme in place and monitored. C. Process in place to review and respond to national NHS Digital CareCert notifications. D. Self-assessment against Cyber Essential Plus Framework to support development of actions for protection against threats. E. Ongoing Education campaign to raise staff awareness. F. System patching programme in place and upgrade of client and server operating systems G. Wider engagement including NHS Secure Boundary H. Continual Network monitoring for abnormal activity / behaviour I. Vulnerability scanning, to identify vulnerabilities and remediate J. Migration of Clinical Systems to the Cloud K. Strategy of Cloud first, so Software as a service or platform as a service on any new procurements L. Rolling refresh of infrastructure Hardware, LAN, Wi-Fi, Servers, and Client Devices.		

Assurance Framework – 3 Lines of Defence – linked to controls (A-L)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Cyber Essential Plus Framework assessment reviewed by division (D) • Day to day systems in place and support provided by cyber security team with increased capacity (A) (B) (C) (F) (H) (I)	• Policies, process and awareness in place to support data security and protection and evidence submitted to the DSPToolkit (D) • Information sharing and development with organisations within the Sussex ICS (G) • Regular quarterly security status report to IG Steering Group and every six months to Audit Committee (D) • Monthly reporting via NHS Digital on Cyber Exposure score (D)	• Cyber security testing and exercises e.g. ICB cyber simulation event with all NHS organisations in Sussex, and two internal events at ESHT with senior leaders (E) • Trust to date has had no ransomware attack (A) (B) (C)(H)(I) • RSM internal audits throughout 2023/24 (D) • Final submission of DSPT for assurance to internal auditors took place in June 23 (D)
Gaps in control/assurance:			
• Obtain Cyber Essentials Plus to provide assurance on reliability and security of systems and information. Continue with patching programme and address points raised by internal audit • Cyber Action plan developed which sets out all of the actions that would need to be taken to mitigate cyber risks			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	Cyber Essentials framework.	Chief Finance Officer	Ongoing	• Internal Cyber Essentials self-assessment completed with identifies gaps in compliance • Gaps have been used to create the cyber action plan • Next step is to mitigate gaps in compliance	*G*
2.	Medical devices with network connectivity asset list	Chief Finance Officer	2024	• Celera, an auditing tool, has been installed and is now running network audit. Further work required to enable greater visibility • Anticipate that full visibility will be delivered at EDGH by October 2023 • Conquest delivery anticipated in 2024	*G*
3.	LAN Refresh EDGH	Chief Finance Officer	December 2023	• Replace the Core Network and Fibre connections to the Edge Switches anticipated to be complete by December 2023	*G*
4.	LAN Refresh Conquest	Chief Finance Officer	March 2024	• Replace the Core Network and Fibre connections to the Edge Switches • Suitable locations identified with estates and design has now been completed	*G*
5.	24/7 Cyber Operations Centre	Chief Finance Officer	September 2023	• Business case has been developed; funding is being identified.	*A*
6.	Active directory migration	Chief Finance Officer	December 2024	• New domain has been built • Migration of users December 2023 • Migration of devices January 2024 • Migration of services December 2024	*G*

Risk Summary							
BAF Reference and Summary Title:	BAF 7: Failure to develop business intelligence weakens insightful and timely analysis to support decisions				Strategic Aims Impacted		
							x	x
Risk Description:	Currently developing daily, weekly and monthly dashboard. Aim to develop self-serve as a second stage.						
Lead Director:	Chief Financial Officer	Lead Committee:	Finance and Productivity Committee		Date of last Committee review:	27/07/2023	

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(4x4) 16	Likelihood:	4	4			A large number of clinical systems and complex data structures, along with a variety of reporting methods and a lack of controls around the data quality leads to a lack of confidence in the data that we produce.	Likelihood:	3	Ongoing
	Consequence:	4	4				Consequence:	4	
	Risk Level:	16	16				Risk Level:	12	

Cause of risk:	• There are a large number of complex clinical systems used across the Trust. • Variable quality of data input into systems • Number of systems can lead to duplication of data entry • Limited assurance available about the data reported outside of the organisation	Impact:	• Inability to make clinical decisions. • Impact of potentially incorrect data on business planning • Impact of using potentially incorrect data when reporting nationally.
Current methods of management (controls)	A. Local data management policy which includes clear reference to performance data collection, collation and reporting processes; offers a localised point of reference that can provide more clarity to Trust officers than relying solely on national guidance. B. Standard Operating Procedures which assist in ensuring a consistent approach in line with policy by all involved in processes. C. Awareness Training D. Process Mapping E. Responsibilities of all staff groups involved in the process are clearly defined and documented. F. Manual Validation of collected data prior to reporting. G. System Validation – automated checking (such as reasonableness, completeness) of data prior to reporting.		

Assurance Framework – 3 Lines of Defence – linked to controls (A-G)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Incidents – there have been incidents (or no incidents) relating to the accuracy of data in this metric. (A)(B)(C)(D)(E) • Process Improvement – processes relating to the collection/collation/reporting of data have been subject to improvement. (A)(B)(C)(D)(E)(G) • Recruitment of Data Quality lead (A)(B)	• Observation/Feels Right – the executive and/or operational lead considers that the reported figures feel correct and are consistent with observations and frontline feedback. (F) • Benchmarking – reported figures for the Trust are comparable with similar organisations. (F) • Business Intelligence Team View – Business Intelligence/Knowledge Management opinion on the accuracy of the data being reported. (F)	• External Review – external organisations (e.g. CQC) have recently reviewed the data and/or data collection processes. (F) • Internal Audit/Granularity – Internal Audit (or another assurance function) has conducted a recent, detailed review of the current process. (A)(B)(F)

Gaps in control/assurance:

- Clear national guidance reduces the risk of inaccurate data being reported and is not available for all metrics.
- Level of automation. Significant manual intervention increases the risk of human input errors.
- Complexity of rules, where the rules set out in national guidance are highly complicated and risk misinterpretation.
- System set-up. Nationally validated systems tend to assist in providing consistency in application of rules and reported data across multiple organisations, providing a greater source of confidence than locally developed systems.
- Weakest link, where there may be a single point in the process where data quality could be compromised, such as an individual making a process error that impacts on reportable figures.
- Sensitivity, where small reportable numbers mean any error is exacerbated.
- Dependency on external bodies to validate data prior to reporting.
- Opportunity for manipulation if there is any point within the process whereby any individual (or group) can alter reportable figures so that the data is no longer true or accurate.

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	Recruitment of replacement Data Quality and Assurance Lead	Chief Finance Officer	September 2023	• Data Quality and Assurance Lead being recruited. • Continue data quality steering group and further development of framework	A
2.	Electronic Patient Record (EPR) procurement	Chief Finance Officer	March 2024	• Outline business case and specification completed, and review of invitation to tender being completed. • OBC has been signed off by the national EPRIB Board • Procurement will start in March 2024 • A large number of posts have been recruited to support procurement and implementation.	G
3.	Development of Power Business Intelligence (BI) Reporting	Chief Finance Officer	Ongoing	• Daily, weekly, and monthly dashboards have been completed • Development of divisional reporting • Development of updated Board IPR	G
4.	Upskilling the Business Intelligence team	Chief Finance Officer	Ongoing	• Provision of suitable training in the development of Power BI	A
5.	Development of new data warehouse	Chief Finance Officer	December 2024	• Move Systm One to Azure Modern Data Platform (MDP) • Move NerveCentre to MDP • Integration of new EPR into MDP	A

Risk Summary							
BAF Reference and Summary Title:	BAF 8: Failure to transform digitally and deliver associated improvements to patient care				Strategic Aims Impacted		
							x	x
Risk Description:	Currently targeted investment in LIMS Pathology, Sectra Radiology, and virtual wards. Full Business Case for Electronic Patient Records to be developed in 23/24.						
Lead Director:	Chief Financial Officer	Lead Committee:	Finance and Productivity Committee	Date of last Committee review:	27/07/2023		

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(4x4) 16	Likelihood:	3	3			**Likelihood**: To enable to Trust to transform digitally and develop a culture which embraces significant change there is a dependency on investment and resources however, currently the Trust is reliant on non-recurrent funding making it challenging to plan for large scale changes or recruit to roles. **Consequence**: Long term impact of not embracing the changes needed to support a digital transformed trust are significant, as the population/patient will expect the Trust to deliver services using enhanced digital solutions The progress on Electronic Patient Record (EPR) procurement has increased the level of engagement across the organisation and the need for digital and structured data.	Likelihood:	2	31.03.26
	Consequence:	4	4				Consequence:	4	
	Risk Level:	12	12				Risk Level:	8	

Cause of risk:	• Lack of capital and digital funding to deliver improved digital maturity. • Lack of staff and capability to deliver, support and manage transformative digital solutions. • Lack of time, Business as Usual activity and operational pressures reduce the time required and available to support the change required for digital transformation. • Inconsistent processes in relation to be purchase & implementation of new systems, which results in additional steps and handoffs in the process for patient care. • Potential organisational unwillingness to embrace change. • Trust-wide digital transformation programme requires significantly enhanced capacity and capability to manage change	Impact:	• Acceptance of change needed to support new and innovative solutions is disparate across the Trust • Lack of capital for investing in the future sustainability of the Trust • Loss of key staff • Digital solutions developed in silos and unsupported by the Digital team, impacting on the management of patient pathways due to increase in process steps

Current methods of management (controls)	A. Digital Steering Group setup and established to monitor, support, and approve any Trust wide digital initiative and alignment to digital strategy B. Project Prioritisation Matrix to track and manage priorities for digital C. Working with the ICS to develop a system wide strategy for digital innovation D. Digital Benefit lead role established and currently embedding benefits into all digital activity E. Process Mapping to facilitate change acceptance and benefits management F. Transformation programmes to be put place to realise benefits of cost effectiveness G. Longer term capital plan to support delivery of sustainable services

Assurance Framework – 3 Lines of Defence – linked to controls (A-G)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Digital Steering Group to continue to management and approve any digital activity (A) • Process Improvement - process relating to the prioritisation of project / programmes with digital (C) (E) (F) (G) • Benefits Strategy approved (D)	• Oversight by Finance and Productivity and Strategy and Transformation Committees (G) • Digital IPR (A) (B) (F) (G) • Transformation Board (monthly) (F) (G)	• Capital Business cases reviewed by ICS (G) • Internal RSM audits (A) (B) (D)

Gaps in control/assurance:
• Level of automation. Significant manual intervention impacts on the acceptance of change within the Trust • Complexity and changes to national guidance retain to the patient pathways

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	EPR procurement	Chief Medical Officer	March 2024	• Outline business case and specification completed, and review of invitation to tender being completed • OBC was signed off by the national EPRIB Board with some conditions; these are being reviewed by the regional team • Procurement anticipated to start in October 2023 • A large number of posts have been recruited to support procurement and implementation.	G
2.	Digital transformation roadmap based on supporting the digital strategy	Chief Finance Officer	December 2023	• Review of progress on the digital strategy and development of the next 12–24-month road map	A
3.	Digital Literacy Assessment	Chief Finance Officer	March 2024	• Evaluate the current level of digital literacy across the staff groups. • Development of a plan to increase digital literacy	A
4.	Increase digital culture	Chief Finance Officer	March 2024	• Communications strategy and engagement	A

Risk Summary						
BAF Reference and Summary Title:	**BAF 9: Failure to maintain focus on improvement**			**Strategic Aims Impacted**		
					X		X
Risk Description:	**Insufficient focus leads to a failure to embed a QI culture as "the ESHT way" of securing change and the expected improvement outcomes/benefits are therefore not realised**					
Lead Director:	**Director of Transformation and Improvement**	**Lead Committee:**	**Strategy and Transformation Committee**	**Date of last Committee review:**	**22/06/2023**	

	BAF Risk Scoring								
Inherent Risk	**Quarter**	**23/24 Q1**	**23/24 Q2**	**23/24 Q3**	**23/24 Q4**	**Rationale for Risk Level**	**Anticipated Year End Risk**		**Target Date**
(4x4) 16	**Likelihood:**	4	4			The current risk position takes account of the challenge of securing the changes and identifying the improvements actively brought about by deploying the methodology that we identified in 22/23. We recognise that this will be a tougher ask in a year where more pressing needs will absorb staff time commitments	**Likelihood:**	3	Review every two months
	Consequence:	4	4				**Consequence:**	4	
	Risk Level:	16	16				**Risk Level:**	12	

Cause of risk:	• People trained under previous model have been inactive • Need to build capacity & training infrastructure of new model • Challenge of delivering improvement aims in a operationally/ financially challenged environment	**Impact:**	• No current systemic approach to delivering improvements • Persistence of training gaps esp. with senior leaders across the Trust
Current methods of management (controls)	A. Stocktake via the creation of ED Transformation Improvement B. Provide regular reporting via EDs/StratCom as regards the current transformation programme		

Assurance Framework – 3 Lines of Defence – linked to controls (A-B)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Through reporting to EDs	• Engage strategic partners to capacity build within our teams and clarify approach/model	• Potential for peer review, especially with strategic partner and their experiences elsewhere

Gaps in control/assurance:
• None seen currently

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1	Identification and launch of continuing improvement (CI) programme with our strategic partner ("Brilliant Basics")	Director of Transformation and Improvement	June (to start)	• This is reviewed via the bi-weekly review meetings – there remains work to be done to prioritise programmes but no current risks to flag	A

Risk Summary							
BAF Reference and Summary Title:	BAF 10: Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that are discharge ready with an extended length of stay.				Strategic Aims Impacted		
					x	x	x	x
Risk Description:	The Trust has very large numbers of patients who do not need the specialist inpatient care provided by ESHT (discharge ready) resulting in a requirement for significant additional capacity and staffing. There is an impact on flow of patients and an increased risk of deconditioning and harms (both physical and mental health) due to the very extended length of stay of some of these patients. In addition there is a negative impact on patient experience as a result.						
Lead Director:	Chief Operating Officer / Chief Nursing Officer / Chief Medical Officer	Lead Committee:	Quality and Safety Committee	Date of last Committee review:	20/07/2023		

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(5x4) 20	Likelihood:	4	4			Evidence on a daily basis of the impact of greater than 50 patients who are discharge ready and the impact that this has on flow and increasing risk to patients and staff. Situation continues with very large numbers of patients who are discharge ready and significant extra bedded capacity open including "supersurge" capacity. In addition in times of extremis it has been necessary to pre-emptively place (board) additional patients on wards until a bed space is available.	Likelihood:	4	Ongoing
	Consequence:	4	4				Consequence:	4	
	Risk Level:	16	16				Risk Level:	16	

Cause of risk:	Impact:
• Sustained pressure on care home sector resulting in reduced staffing, capacity and acceptance criteria • Closure of care homes across Sussex • Pressures on primary care • Lack of sufficient suitable alternative pathways for patients • Lack of sufficient assessment and treatment capacity in mental health • Lack of sufficient capacity for urgent placement of children at risk • Lack of sufficient suitably trained staff for all capacity that is in use • National removal of discharge to assess funding • Reduction from 113 Discharge to Assess beds to 46 • Increased length of stay in the acute and onward care settings	• Delays for some patients in being able to access care • Delays to assessment and treatment • Patients in inappropriate locations • Poor experience for patients and staff • Delays with discharge planning and process given the significant numbers of additional and/or complex patients • Risk of harm to patients, e.g. self-harm, harm to others, risk of absconding, violence and aggression • Patients are deteriorating and deconditioning due to length of stay once discharge ready • Increase in safeguarding concerns given the huge numbers of vulnerable patients, many of whom are resistant to care and have a very considerable length of stay

	• Ongoing negative impact of the pandemic e.g. elective backlog of patients, impact on non-elective patients who have not accessed healthcare as a result of the pandemic • Ongoing industrial action by various staff groups		

Current methods of management (controls)	A. Significant additional capacity remains open B. Significant attempts to safely staff all capacity C. Systems in place to identify and escalate NCTR/discharge ready patients D. Ongoing collaborative system working to identify solutions, with discussion at ICB level E. Audit of stranded patients undertaken to investigate risks and/or harms F. Weekly long length of stay panel meeting to support expediting discharge of patients with the longest length of stay G. Full capacity protocol, escalation protocol under review. Pre-emptive placement protocol drafted. H. Four staff summits undertaken to ensure whole Trust approach in supporting this work. Future work required with plans underway.

Assurance Framework – 3 Lines of Defence – linked to controls (A-H)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Robust management of all capacity • Thrice daily reviews of staffing • Redeployment of staff as required • Safety huddles in all clinical areas • Real time bed state/information available • Monitoring of quality and safety KPIs • Assurance through Urgent Care improvement plan overseen by Urgent Care Oversight Group • Daily capture and monitoring of escalation and supersurge capacity	• Use of any additional specialist advice or support, including visits to ESHT and ESHT staff visiting other locations • Patient pathway review with adult social care to agree shared risk and ownership • Clear oversight and responsibility for operational delivery, and of quality and safety • Work being undertaken with Nervecentre to develop capture and monitor patients who are pre-emptively placed	• Regular meetings with CQC to discuss data, intelligence and KPIs • Challenge at Trust Board • Provider assurance meetings and system clinical quality review meetings

Gaps in control/assurance:

- Workforce demand outstripping supply due to significant additional capacity required
- Lack of suitable physical space for surge capacity
- Lack of sufficient equipment for surge capacity
- In extremis overcrowding due to additional beds and equipment
- Unable to completely avoid all inappropriate attendances/admissions
- Lack of Adult Social Care capacity
- Currently unable to easily/accurately describe the impact or harm from reconditioning

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	Ensure clinical areas are staffed as safely as possible	COO/CNO/CMO	Ongoing	• Still have significant additional capacity open • Workforce pressures remain • Escalation process in place • Escalation capacity forms part of the main financial risk for 2023/24	A
2.	Ensure as far as possible that patients are placed as safely and appropriately as conditions permit	COO/CNO/CMO	Ongoing	• All escalation areas remain open with additional supersurge capacity remaining open and pre-emptive placement of patients when in extremis.	A
3.	Ensure high risk patients are assessed and flagged appropriately	COO/CNO/CMO	Ongoing	• Divisional long length of stay meetings • Interim Head of Discharge and Flow in post • Weekly high risk patient meeting introduced by CNO	G
4.	Need to design process for capturing and reporting on the impact of deconditioning	COO/CNO/CMO		• Reconditioning group to be established with clear process for monitoring and reporting	

Risk Summary							
BAF Reference and Summary Title:	BAF 11: Failure to demonstrate fair and equal access to our services				Strategic Aims Impacted		
					X		X
Risk Description:	Combined operational and financial pressures means that the additional analysis and support is not prioritised in-year						
Lead Director:	Chief of Staff	Lead Committee:	Strategy Committee	Date of last Committee review:	22/06/2023		

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(5x3) 15	Likelihood:	3	3			This risk has evolved from the previous BAF risk 12, around public health priorities. While progress was made last year in the creation of an approach to health inequalities, the challenge this year will be on prioritising the data collection and reporting as part of Trust BAU business intelligence. This also comes against a more challenging set of operational and financial standards, compared with 22/23, so resource prioritisation from within ESHT staff will be difficult.	Likelihood:	3	Review every two months
	Consequence:	3	3				Consequence:	3	
	Risk Level:	9	9				Risk Level:	9	

Cause of risk:	• Capacity within existing BI team • Health inequality requirements via contract for 23/24	Impact:	• BI team making prioritised choices over aspects of reporting/analysis that it can cover in this financial year
Current methods of management (controls)	A. Routine information gathering as part of report collation B. Where significant transformation is taking place (e.g. cardiology, ophthalmology) members of the team have been trained or have experience in establishing meaningful engagement (in line with statutory/legal obligations)		

Assurance Framework – 3 Lines of Defence – linked to controls (A-B)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Through reporting documentation (basic stakeholder analysis) to show engagement approaches	• Teams engage relevant corporate support (health inequalities, communications) to advise and support where engagement is required	• EDs to support prioritisation of team resources to ensure appropriate support is given to most pressing risk areas (e.g. where corporate reputation may be at risk)

Gaps in control/assurance:
• There is no assurance currently that within existing resources, the BI team will be able to provide for this information being included within the standard reporting provided to operational teams

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	Audit to review the current levels of relevant information (e.g. ethnicity, protected characteristics) available within ESHT	Chief of Staff			
2.	Engagement with BI team and ICB data leads re: supporting resources that can be provided to support data analysis re: health inequalities	Chief of Staff			

Risk Summary							
BAF Reference and Summary Title:	BAF 12: Failure to meet the four-hour standard				Strategic Aims Impacted		
					X	X	X	X
Risk Description:	Due to ongoing challenges with patient flow, there is a risk that patients spend longer than they need to in the emergency department once they are clinically ready to proceed. This is due to a number of factors and also affects those patients who wait longer than they should to access the emergency department. There is evidence to suggest that patients who spend more than six hours in emergency departments are more likely to suffer harm.						
Lead Directors:	Chief Nurse and DIPC, Chief Medical Officer & Chief Operating Officer	Lead Committee:	Quality and Safety Committee		Date of last Committee review:	27/07/2023	

	BAF Risk Scoring								
Inherent Risk	Quarter	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Rationale for Risk Level	Anticipated Year End Risk		Target Date
(5x4) 20	Likelihood:	4				There is robust data/evidence on a daily basis that describes the length of time patients stay in the department and that the standard/ambition is not being met.	Likelihood:	4	Ongoing
	Consequence:	4					Consequence:	4	
	Risk Level:	16					Risk Level:	16	

Cause of risk:	• Bed occupancy in excess of 92% • Lengthy processes to assessment in ED, leading to high numbers of non-admitted breaches • High numbers of patients who do not meet CTR and are Discharge Ready • Insufficient bedded capacity (flow) immediately available • Insufficient community capacity (ESHT, care homes and discharge to assess) • Regular and ongoing Infection Control challenges (especially Covid19) affecting flow and operational response	Impact:	• Patients spending longer than they need to in the emergency department • Delays for patients being able to access the emergency department in a timely way • At times increased handover times for ambulance crews • Overcrowding of the emergency departments effecting the experience of patients and staff
Current methods of management (controls)	A. Live bed state provides accurate information regarding occupancy and available bedded capacity B. Urgent Care improvement plan		

Assurance Framework – 3 Lines of Defence – linked to controls (A-B)			
	1st line of Defence *(service delivery and day to day management of risk and control)*	**2nd Line of Defence** *(specialist support, policy and procedure setting, oversight responsibility)*	**3rd Line of Defence** *(Independent challenge on levels of assurance, risk and control)*
Assurance:	• Urgent Care improvement plan overseen by Urgent Care Oversight Group • Eliminate reliance on escalation and super surge areas • Focus on non-admitted breaches • Back to basics training for staff on discharge processes	• Discharge Front runner support across Sussex to reduce Discharge Ready numbers • Breach compliance assurance across divisions • Long length of stay review across divisions • High risk patient reviews by CNO and CMO	• Increase in D2A capacity across Sussex • Virtual ward increase in capacity • Discharge lounge usage • Weekend discharge improvement plan
Gaps in control/assurance:			
• Lack of Transfer of Care Hub in place in line with national requirement			

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Development of transfer of care hub	COO	March 2024	Links with Discharge front runner workstream	A
2.	Review of CHC process	COO	Oct 2023	Part of discharge front runner workplan	A
3.	Development of ward staff further	COO	Autumn 2023	Q1 Train the trainer programme delivered, Q3 training plan developed for delivery in Autumn	B

Appendix One – Links to Corporate Risk Register (only risks rated 15 and above appear on the Corporate Risk Register)

BAF 1 - Capacity constraints associated with supporting the collaborative infrastructure						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
			No current risks on the Corporate Risk Register that apply			
BAF 2 - Failure to attract, develop & retain a workforce that delivers the right care, right setting, right time						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	07/02/2013	965	Delays in reporting for Radiological Investigations	15	16	◀▶
	21/04/2015	1289	Consultant histopathology vacancies	12	20	◀▶
	23/06/2015	1324	A&E Handover Capacity	9	16	▼
	19/10/2016	1552	Cardiac Physiology staffing	12	16	◀▶
	14/11/2017	1680	Wait times for routine Child Development clinic referrals >36 months	12	16	◀▶
	17/05/2018	1721	Insufficient physiotherapy staffing for neurological outpatient service	15	15	◀▶
	03/12/2018	1765	Emergency Department nursing vacancies	12	16	◀▶
	21/12/2018	1772	Insufficient intensive care medical consultant staff to deliver 7 day consultant led service	20	16	◀▶
	06/09/2019	1830	Failure to meet turnaround times in cellular pathology	12	20	◀▶
	01/07/2020	1896	Unchaperoned ultrasound examinations	16	16	◀▶
	23/10/2020	1931	Health Visitor Vacancies	9	20	◀▶
	12/08/2021	2066	Inadequate staffing levels to provide consistent Lipid Clinic service	20	15	◀▶
	06/09/2021	2068	Cellular Pathology staffing	16	20	▲
	25/11/2021	2079	Construction project manager vacancies	25	16	◀▶
	25/11/2021	2080	Statutory compliance and quality assurance in construction activities	20	16	◀▶
	17/03/2022	2091	Reliance on non-qualified and temporary workforce in order to provide 24/7 Covid-19 lab testing service	16	16	◀▶
	28/06/2022	2114	Delays in out of hours patient assessment times	20	16	◀▶
	29/07/2022	2127	Vacancy rate of occupational therapists	20	20	◀▶
	01/08/2022	2128	Insufficient accommodation for international nurses	16	16	◀▶
	01/08/2022	2129	International nurses waiting more than 15 weeks for an OSCE place at national test centres	16	16	◀▶
	17/08/2022	2135	Vacancies in radiology and histopathology increasing diagnostic service waiting times	12	15	◀▶

	24/01/2023	2174	Cardiology consultant staffing	20	20	◀▶
	22/03/2023	2182	Integrated Support Worker staffing in Urgent Community Response team	20	16	◀▶
	01/06/2023	2192	Radiology Physics Service Staffing	20	15	◀▶
	28/06/2023	2200	Subject Access Requests / Redaction Software	15	15	◀▶
	18/08/2023	2213	Delays to Paediatric Dietetic Appointments	20	20	**NEW**
BAF 3 - Decline in staff welfare, morale and engagement impacts on activity levels and standards of care.						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Initial Risk Score**	**Current Risk Score**	**Change**
	14/12/2017	1686	Violence and Aggression in Emergency Departments	9	15	◀▶
	03/12/2018	1765	Emergency Department nursing vacancies	12	16	◀▶
	21/12/2018	1772	Insufficient intensive care medical consultant staff to deliver 7 day consultant led service	20	16	◀▶
	29/04/2020	1867	Violence and Aggression Trust wide	16	16	◀▶
	01/08/2022	2128	Insufficient accommodation for international nurses	16	16	◀▶
	01/08/2022	2129	International nurses waiting more than 15 weeks for an OSCE place at national test centres	16	16	◀▶
	01/06/2023	2192	Radiology Physics Service Staffing	20	15	◀▶
BAF 4 - Failure to deliver income levels/manage cost/expenditure impacts savings delivery						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Initial Risk Score**	**Current Risk Score**	**Change**
	13/04/2023	2183	Delivery of the 2023/24 financial plan	20	20	◀▶
BAF 5 - 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						
Links to Corporate Risk Register:	**Date:**	**Risk Register Number**	**Title**	**Initial Risk Score**	**Current Risk Score**	**Change**
	25/02/2002	19	Risk of Legionella	6	15	◀▶
	26/06/2003	79	Management and control of asbestos	6	15	◀▶
	07/02/2013	965	Delays in reporting for Radiological Investigations	15	16	◀▶
	10/12/2013	1118	Aging Building Management System (BMS)	15	15	◀▶
	23/06/2015	1324	A&E Handover Capacity	9	16	▼
	25/09/2015	1360	Cardiology Catheter Lab breakdowns	12	16	◀▶
	11/11/2015	1397	Clinical Environment Maintenance & Refurbishment	20	15	◀▶
	12/11/2015	1398	External Cladding/Façade at EDGH	20	15	◀▶
	12/11/2015	1410	Potential non-compliance with Fire Safety Legislation	16	16	◀▶
	12/11/2015	1425	Failure of lifts	16	16	◀▶
	09/05/2017	1621	Loss of Electrical Services to Critical Clinical Areas	16	16	◀▶
	09/05/2017	1622	Working at Height	15	15	◀▶
	03/08/2017	1655	Containment Level 3 Laboratory	15	20	◀▶
	01/03/2018	1703	Fire Detection System	16	16	◀▶

	27/06/2019	1806	Insufficient Ward decant accommodation	12	16	◀▶
	27/06/2019	1807	Insufficient isolation facilities to meet demand	12	16	◀▶
	28/11/2019	1854	Eastbourne Cath lab 1 equipment & Storage	16	16	◀▶
	21/04/2020	1866	Aseptic Unit	20	15	◀▶
	27/05/2020	1879	Capital - Sustainability	12	20	◀▶
	27/11/2020	1937	Eastbourne maternity environment	15	15	◀▶
	29/12/2020	1949	Insufficient air ventilation	16	16	◀▶
	02/07/2021	2053	Clinical Space on Frank Shaw Ward	20	15	◀▶
	03/08/2021	2065	Lack of availability of community obstetric venues/hubs	15	15	◀▶
	25/11/2021	2079	Construction project manager vacancies	25	16	◀▶
	25/11/2021	2080	Statutory compliance and quality assurance in construction activities	20	16	◀▶
	31/10/2022	2154	Conquest Radiology Imaging Equipment	20	16	◀▶
	30/05/2023	2190	Effect of Business Continuity & Critical or Major incidents	16	16	◀▶
	19/07/2023	2210	Obsolescence of software and equipment for Emergency Dental Services	25	15	**NEW**
	18/08/2023	2216	Scott Unit environment	20	16	**NEW**

BAF 6 - Vulnerability of IT network and infrastructure to prolonged outage and wider cyberattack

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	23/08/2017	1660	Cyber Security	20	16	◀▶
	01/02/2021	2026	The Disaster Recovery Solution for Critical Systems	15	15	◀▶
	21/03/2022	2092	Unmitigated Software Vulnerabilities	16	16	◀▶
	21/03/2022	2098	Asset management and shadow IT	20	16	◀▶
	21/03/2022	2099	ESHT data centre segregation	20	16	◀▶
	21/03/2022	2100	3rd party and supplier remote access controls	20	16	◀▶
	04/11/2022	2158	Multi Factor Authentication	16	16	◀▶
	30/05/2023	2190	Effect of Business Continuity & Critical or Major incidents	16	16	◀▶
	06/06/2023	2196	Network infrastructure devices	16	16	◀▶
	19/07/2023	2210	Obsolescence of software and equipment for Emergency Dental Services	25	15	**NEW**
	18/08/2023	2215	Digital booking management for paediatrics	16	16	**NEW**

BAF 7 - Failure to develop business intelligence weakens insightful and timely analysis to support decisions

Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
			No current risks on the Corporate Risk Register that apply			

BAF 8 - Failure to transform digitally and deliver associated improvements to patient care						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	07/02/2013	965	Delays in reporting for Radiological Investigations	15	16	◀▶
	25/09/2015	1360	Cardiology Catheter Lab breakdowns	12	16	◀▶
	01/02/2021	2026	The Disaster Recovery Solution for Critical Systems	15	15	◀▶
	31/10/2022	2154	Conquest Radiology Imaging Equipment	20	16	◀▶
	28/06/2023	2200	Subject Access Requests / Redaction Software	15	15	◀▶

BAF 9 - Failure to maintain focus on improvement						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
			No current risks on the Corporate Risk Register that apply	-	-	-

BAF 10 - Risk of not being able to maintain delivery of safe, high quality effective care due to significant numbers of patients that no longer meet the criteria to reside.						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	06/06/2016	1496	Demand exceeding capacity of District Nursing service	15	16	◀▶
	03/08/2017	1655	Containment Level 3 Laboratory	15	20	◀▶
	03/12/2018	1764	Inpatient flow impacting on delivery of care in the Emergency Department	12	20	◀▶
	18/04/2019	1792	Risk of delayed treatment due to overdue follow up appointments	16	16	◀▶
	27/06/2019	1806	Insufficient Ward decant accommodation	12	16	◀▶
	27/06/2019	1807	Insufficient isolation facilities to meet demand	12	16	◀▶
	06/09/2019	1830	Failure to meet turnaround times in cellular pathology	12	20	◀▶
	03/12/2020	1942	Risk of insufficient beds during winter	16	16	◀▶
	10/01/2022	2084	Inadequate psychological support for ESHT patients in the long term condition management and rehab services	20	16	◀▶
	29/07/2022	2127	Vacancy rate of occupational therapists	20	20	◀▶
	22/03/2023	2182	Integrated Support Worker staffing in Urgent Community Response team	20	16	◀▶
	16/05/2023	2186	Delays in surgical treatments	16	16	◀▶

BAF 11 - Failure to demonstrate fair and equal access to our services						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	10/01/2022	2084	Inadequate psychological support for ESHT patients in the long term condition management and rehab services	20	16	◀▶

BAF 12 – Failure to meet the four hour standard						
Links to Corporate Risk Register:	Date:	Risk Register Number	Title	Initial Risk Score	Current Risk Score	Change
	23/06/2015	1324	A&E Handover Capacity	9	16	▼
	06/06/2016	1496	Demand exceeding capacity of District Nursing service	15	16	◀▶
	03/12/2018	1764	Inpatient flow impacting on delivery of care in the Emergency Department	12	20	◀▶
	03/12/2018	1765	Emergency Department nursing vacancies	12	16	◀▶
	23/10/2020	1931	Health Visitor Vacancies	9	20	◀▶
	03/12/2020	1942	Risk of insufficient beds during winter	16	16	◀▶
	10/01/2022	2084	Inadequate psychological support for ESHT patients in the long term condition management and rehab services	20	16	◀▶
	28/06/2022	2114	Delays in out of hours patient assessment times	20	16	◀▶
	16/05/2023	2186	Delays in surgical treatments	16	16	◀▶

Appendix Two – BAF Summary 2022/23

BAF Ref	RISK SUMMARY	Monitoring Committee	Strategic Aims Impacted				Inherent Risk	Current position (Residual risk)				Change	Risk Appetite	Target Risk	Target date
								2022/23							
								Q1	Q2	Q3	Q4				
1	Minimal benefits from collaboration (e.g. better resource use & improved outcomes) for those in greatest need, due to System/Place focus on governance and architecture	Strat	X			X	12	9	6	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	15	12	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	16	◄►	Cautious / Open	12	Ongoing
4	Failure to deliver income levels/manage cost/expenditure impacts savings delivery	F&P			X	X	20	20	16	8	4	◄►	Cautious	8	31/01/23
5	Insufficient focus on recurrent delivery of income/cost/savings creates a viability issue post 22/23	F&P			X	X	15	10	10	16	16	◄►	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&P		X	X	X	20	16	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	16	◄►	Minimal	12	Ongoing
8	Failure to develop business intelligence weakens insightful and timely analysis to support decisions	F&P			X	X	20	16	16	16	16	◄►	Open	12	Ongoing
9	Failure to transform digitally and deliver associated improvements to patient care	F&P			X	X	20	16	16	16	12	▼	Significant	12	31/03/25
10	Failure to maintain focus on improving care	Strat				X	12	12	12	9	9	◄►	Cautious / Open	9	Review every two months
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	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	12	9	6	9	6	▼	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	12	9	◄►	Open	6	31/03/23

Appendix Three: Risk Matrix

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

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

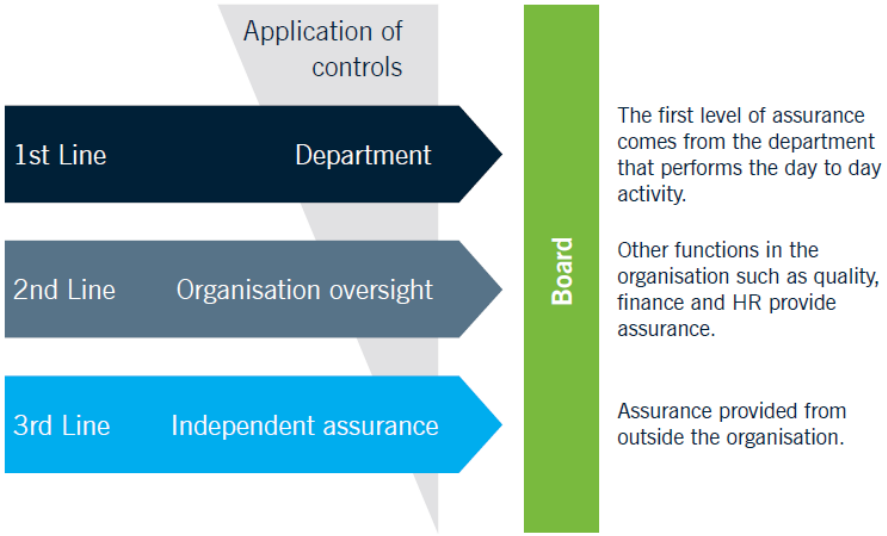
Table LIKELIHOOD X CONSEQUENCE/IMPACT = RISK RATING

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

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

Appendix Five – Three Lines of Defence Assurance Model

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



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

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

East Sussex Healthcare NHS Trust

Annual Equality Report

Purpose of the paper	The purpose of this report is to provide analysis on the Gender Pay Gap, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Equality Delivery System 2022 (EDS) indicators, highlight any disparities and provide recommendations on how to advance the agenda for equality. This annual report also covers other protected characteristics of age, religion and belief and sexual orientation and organisational inclusion. The data covers the period from the 1st April 2022 to 31st March 2023. Information within this report is taken directly from the staff survey results (2022), ESR and TRAC. The report provides assurance to the Board that our statutory duties are being met.						
	For Decision		For Assurance	x	For Information		
Sponsor/Author	Sponsor: Steve Aumayer Author: Sarah Feather						
Governance overview	This paper has been to staff network meetings, the Workforce Equality Meeting and POD Committee						

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 its associated actions.

Executive Summary

The annual report 2023 pulls together the gender pay gap, WRES and WDES reports and the EDS 2022, it also includes information relating to other protected characteristics of age, religion and belief and sexual orientation.

Key measures within the annual include a traffic light system of progress, illustrated by either a red (R), an amber (A) or a green (G) point. Green indicates any gaps between groups which are within accepted thresholds, and do not indicate concerns. Amber indicates work in progress and red indicates a decline beyond acceptable thresholds. This summary sets out the key measures in the gender pay gap, WRES and WDES.

WRES (page 7)
Indicator 2 – White people are more likely to be appointed than multicultural people. The Trust score of 2.21 falls outside the national median/benchmark value of 0.8 - 1.25. This is the non-adverse likelihood range set by the NHS WRES Strategy team. This is the first time that this indicator has declined since 2018 and has highlighted a data collection issue which we intend to resolve for next year.

The WRES action plan is monitored on a quarterly basis at the Workforce Equality Meeting. This ensures that actions are progressed throughout the year and any obstacles to delivery are identified.

Gender Pay Gap (page 11)

Our Gender Pay Gap for 2023 contains a number of elements:
Specific information is published on the government website for the snapshot date of 31st March 2023.

- 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

	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. In the NHS as a whole the Agenda for Change pay bands mean that pay is fixed at nationally set rates. Within each pay band, however, there is a link between the median pay gap and the proportion of men in each band, with higher pay bands (with a disproportionate proportion of men) showing a pay gap in favour of men. The Trust on average (median) women are paid £0.93 for every £1.00 that men are paid in our organisation. This does not include overtime or exceptional payments such as redundancy. ESHT will take the actions set out in report to reduce the Gender Pay Gap further. These actions are recommended in the Governments guidance on reducing the gender pay gap. **WDES (page 15)** 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 7 - Percentage of Disabled colleagues compared to non-disabled colleagues saying that they are satisfied with the extent to which their organisation values their work. The data indicates that colleagues without a long-term health condition or illness feel more valued for the work that they do compared to colleagues with long-term conditions or illness. This is a decreasing 5-year trend for colleagues who have long-term conditions or illness. Metric 9 - The score for the staff engagement theme is derived from the nine questions, grouped into three themes: motivation; involvement; and advocacy. It is mark out of 10 and colleagues with a disability score lower than colleagues without a disability. This score has declined over the 3 years. The WDES action plan is monitored on a quarterly basis at the Workforce Equality Meeting. This ensures that actions are progressed throughout the year and any obstacles to delivery are identified. **Bullying, harassment and discrimination** – each section references the negative experiences of colleagues within ESHT taken from the Staff Survey 2022. The actions within this workstream and delivered through the Bullying and Harassment Resolution Group, divisional meetings on the staff survey results and also monitored on a quarterly basis at the Workforce Equality Meeting. **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.

Next steps	This report will be published on our external website to meet our requirements under legislation for publishing WRES, WDES and Gender Pay Gap information annually.

East Sussex Healthcare NHS Trust

Annual Equality Report 2022/2023

If you would like this report in another format (e.g. large print) please contact s.feather@nhs.net

CONTENTS

FOREWORD

Welcome. This document reports progress against inclusion at East Sussex Healthcare NHS Trust (ESHT) across 2022-23.

1) PROTECTING OUR COLLEAGUES

Aim to have zero tolerance against abuse at ESHT to ensure that all our colleagues have a right to care for others without fear of being abused.

2) INCREASING REPRESENTATION

Increasing workforce representation at all levels and positive reports of colleague experience about equality of opportunity, as measured through the NHS staff survey.

Delivering our commitments in the national workforce race and disability equality standards, and the aspirational targets of multicultural and other diverse colleagues.

3) BUILDING AN INCLUSIVE CULTURE

Making sure that people feel comfortable to be themselves and feel that they belong. We are aiming for a psychologically safe environment with a just and learning culture.

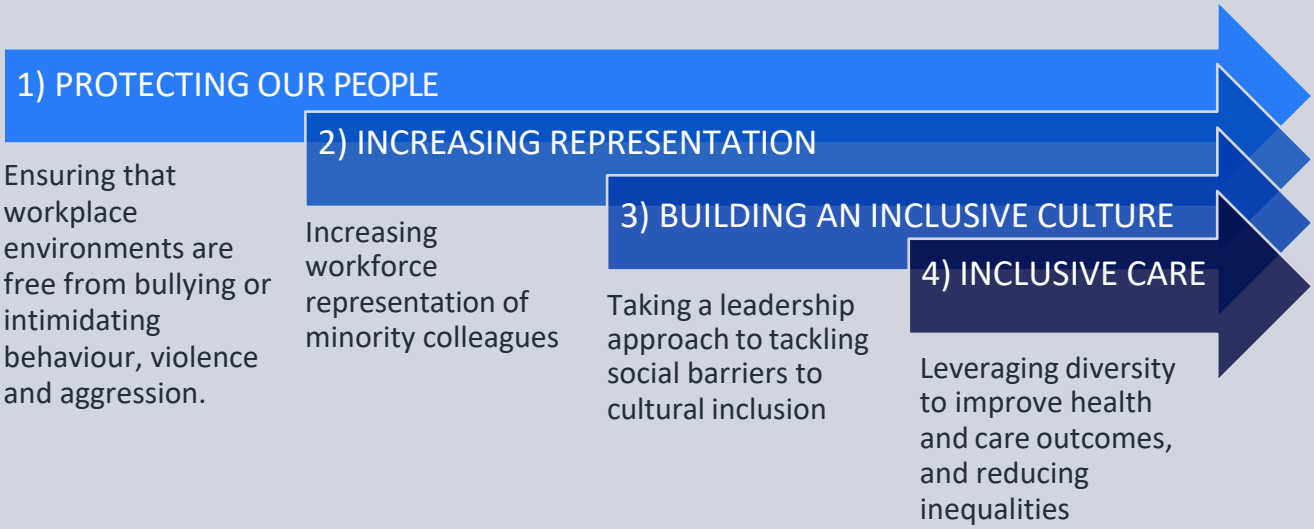
Continuing development of inclusive leaders and allies.

4) INCLUSIVE CARE

Supporting colleagues to recognise and tailor care towards people's cultural needs and attend to social and health inequalities.

We will continue to take every opportunity to advance equality, diversity and inclusion in the design, delivery and review of all our functions, policies and practices.

FIG. 1 ESHT Inclusion



SUMMARY

Below is a summary of the key findings against each area of the ESHT's equality, diversity and inclusion (EDI) programme:

RACE (page 7)

i. The proportion of our multicultural colleagues is 21.5% across ESHT, an increase of 4% over the last three years. Board representation remains at level of 6% since 2019.

ii. There has been an increase in the likelihood that a white person will be appointed compared to a multicultural person over the last year; this key national workforce race equality standard (WRES) measure is a priority in our action plan.

iii. Across three years there was a two-point increase in multicultural colleagues reporting the Trust provides equal opportunities, coinciding with the use of the Multicultural Network to disseminate training and development opportunities.

iv. There was a 0.5-point decrease in multicultural colleagues experiencing harassment, bullying or abuse from other colleagues in 2022.

RELIGION AND BELIEF (page 9)

v. The proportion of colleagues (75.5%) sharing their beliefs grew by 3.5% over the past year.

vi. The Chaplaincy Team continue to promote the Faith and Belief Network to encourage wider awareness and understanding of faith related issues.

vii. The Network's purpose is to benefit service users, patients and colleagues, offering a platform for identifying, promoting and addressing issues, as well as link in with the other Networks to promote intersectionality.

GENDER (page 11)

viii. 74.79% of the workforce is female with 25.21% male representation. We cannot evidence representation for Trans or non-binary people.

ix. Women were just as likely as men to experience bullying and harassment from other colleagues.

x. Men were less likely than women to experience discrimination from patients, relatives or members of the public.

xi. For every £1 earned by men, women earned £0.93; this remains unchanged for the last three years.

xii. Women occupied 70% of the highest paid jobs (Across Band 8 and 9).

SEXUAL ORIENTATION (page 13)

xiii. Just over 3.5% of the workforce shared with us that they identify as lesbian, gay or bisexual (LGB).

xiv. Bisexual people (49.8%) and those Preferring not to say (56.7%) scored lower than Heterosexual/straight (67.7%) and Gay people (69.1%) for their perceptions of the organisation respecting difference.

xv. Those identifying as Heterosexual/Straight or Other scored highest in the belief on the organisation taking action on health and wellbeing.

DISABILITY (page 15)

xvi. 5.19% of the workforce shared they identify as disabled on their electronic staff record, with 18.76% of the workforce choosing not to share their disability status.

xvii. People who were disabled were just as likely to be appointed from shortlisting than non-disabled people against this key national workplace disability equality standard (WDES) measure.

xviii. There was just over a four-point gap between disabled (51.4 %) and non-disabled (55.6%) colleagues who feel ESHT provides equal opportunities in career development.

xix. 76.7% of disabled colleagues felt ESHT made adequate adjustments to enable them to work; compared to 73.9% nationally.

AGE (page 17)

xx. A third of the workforce is aged 45-55 years old, which is comparable with the national data. This data shows that ESHT has an ageing workforce.

Equality Delivery System (EDS) (page 19)

xxi. Providing the position of ESHT in relation to demonstrating implementation of the EDS 2022.

ORGANISATIONAL INCLUSION (page 20)

xxii. In addition to the progress highlighted in each section, across 2022-23 ESHT continued certain trust-wide initiatives to advance equality of opportunity, eliminate discrimination and foster good relations.

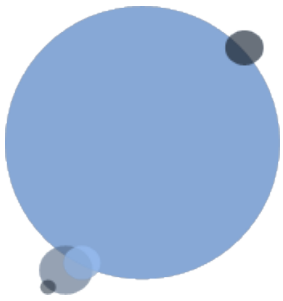
Conclusion

xxiii. The findings indicate areas of progress, particularly increasing representation, with some barriers to inclusion still requiring action. The findings also indicate pockets of negative experiences for some colleagues; a focus for the 12 months ahead.

xxiv. We will take time to align our work to the NHSE high impact actions (HIA) on equality, diversity and inclusion. This focus will help us draw together our EDI strategy.

xxv. Across 2023-24 we will increase support for colleagues to promote inclusive leadership to highlight and remove cultural barriers to inclusion.

xxvi. The end goal remains thriving and culturally competent staff providing inclusive care to promote positive health outcomes and tackle health inequalities.



INTRODUCTION

Welcome to our annual equality report 2022-23

This report demonstrates what we have achieved and where we need to continue progressing towards equality in our mission of providing safe, compassionate and high-quality community and hospital care.

Our equality, diversity and inclusion (EDI) programme delivers our people plan commitment for thriving colleagues to be inclusive, diverse and fair, and supports our other strategies, particularly on patient and carer experience and involvement.

The report is made up of eight sections that reflect our aspirations across: age, disability, gender, race, religion and belief, sex and sexual orientation, and organisational inclusion.

- Each section begins with our key achievements to advance equality, including fostering good relations
- There are then key findings including measures of workforce equality, in particular representation and recruitment rates
- There are measures of our work to eliminate discrimination, including harassment
- Each section then ends with next steps to address the findings that underpin the 2023/24 equality, diversity and inclusion action plans and links to the NHS England high impact actions for equality, diversity and inclusion.

Key measures include a traffic light system of progress, illustrated by either a red (**R**), an amber (**A**) or a green (**G**) point.

Green indicates any gaps between groups which are within accepted thresholds, and do not indicate concerns. Amber indicates work in progress and red indicates a decline beyond acceptable thresholds.

The data is taken from electronic staff records, employee relations case-trackers, staff surveys, gender pay gap and our WRES and WDES findings.

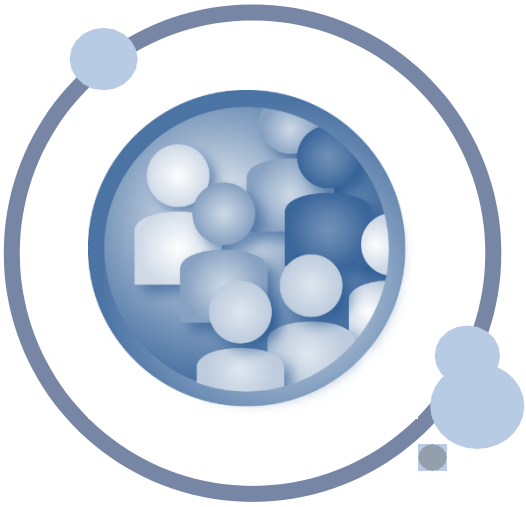
Patient data has not been included in this report; with progress over 2023-24 to update key systems capacity to record demographic details and accessible information.

This report evidences compliance with our specific equality duty (Equality Act 2010), our duty to publish gender pay gap information (on page 11) and our obligations to publish information relating to the workforce race equality standard (WRES; on page 7) and the workforce disability equality standard (WDES; on page 15).
It also provides the progress on our Equality, Diversity and Inclusion objectives 2022-2024.

RACE

The proportion of our multicultural colleagues grew by 4% over three years across ESHT. Representation at Board level remains at 6% since 2019.

Across three years there was a two-point increase in multicultural colleagues reporting the Trust provides equal opportunities, coinciding with the use of the Multicultural Network to disseminate training and development opportunities.



1.1. Across 2022-23 ESHT's Multicultural Network brought people together from different ethnic backgrounds committed to valuing individuality, supporting inclusion and promoting diversity. Key achievements include:

- A survey for ESHT's multicultural colleague experience.
- A month of events held to promote intercultural learning, culminating in the first cross system Black History Month celebrations
  ESHT adopted the system wide anti-racist statement.
- The multicultural network membership grew to 112 (approximately 1.5% of the total Trust workforce)

KEY FINDINGS: RACE

Workforce ethnicity representation (WRES 1)

1.2. The number of multicultural people in the workforce at 31 March 2023 was 1803, or 21.5% of the workforce overall. The Trust's multicultural workforce has grown by 4% over the past three years.

1.3. Medical and dental colleagues was 55.3% (n.392). Clinical staff was 24.5% (n. 1264). Agenda for Change (AfC) pay band 5 had the largest proportion of any AfC pay band at 40.9% (n.580), followed by band 6 at 18.46% (n.241), then band 2 at 16.25% (n.308).

1.4. By comparison the average multicultural workforce was 24.3% in the whole NHS South Region.

1.5. AfC 8d-9 and very senior managers (VSMs) is made up of 93.3 % White British and 6.3% multicultural people.

Fig. 2 Workforce by ethnic group

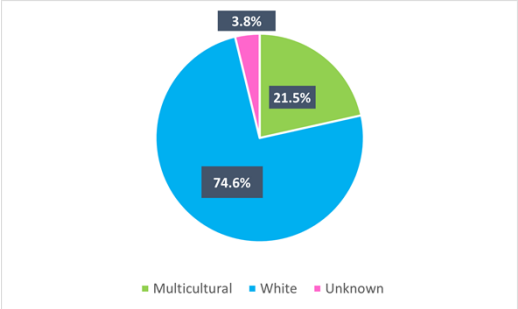
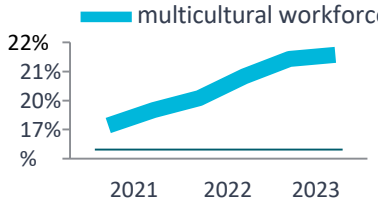


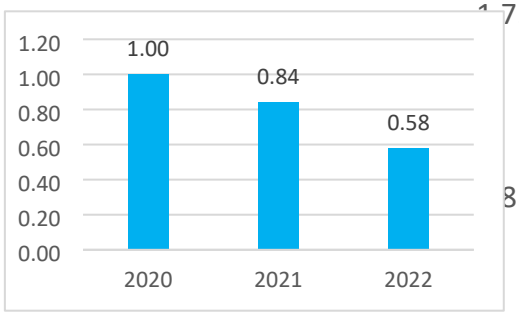
Fig. 3 Trust multicultural workforce % over time



Ethnicity shortlisting-to-appointment likelihood (WRES 2)

1.6. 574 people from a multicultural background and 1682 white people were appointed in 2022-23. White people were 2.21 times more likely to be appointed from shortlisting than people from a multicultural background, the same as the regional and the sector averages. This is a reduction from white people being 0.81 times more likely to be appointed in 2021-22.

Fig. 4 Likelihood BAME staff disciplinary



Formal disciplinary likelihood by ethnicity (WRES 3)

1.7. Multicultural people were less likely than white people to enter the formal disciplinary process. Only 0.34% (n.29) of the workforce went through the formal disciplinary process in 2022-23.

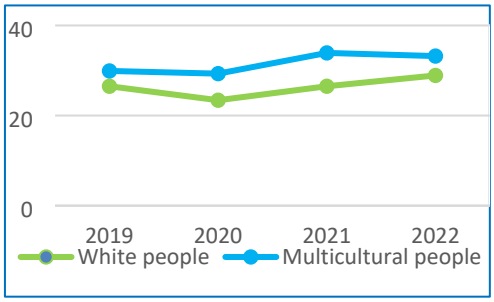
Non-mandatory training (WRES 4)

1.8. White people (n. 303) were 0.72 times as likely to access non-mandatory training and development as multicultural people (n. 121).

Harassment, bullying or abuse by ethnicity (WRES 5-6)

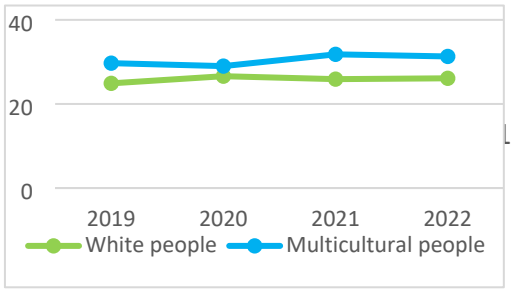
1.9. 33.2% of multicultural colleagues experienced harassment, bullying or abuse from patients, relatives or the public in the prior 12 months, although a decrease of 0.7 points than in 2022 it is 3.3 points greater than the 29.9% multicultural colleague response in 2019. This figure is just over 2.4% more than the 30.8% multicultural colleague provider benchmark. ESHT have committed to reducing this percentage to 26.5% over the next two years.

Fig. 5 Patient-on-staff harassment by ethnicity



1.10. 31.3% of multicultural colleagues experienced harassment, bullying or abuse from other colleagues in the prior 12 months, 3.1 points higher than the provider benchmark group and 1.6% points up from the 29.7 % multicultural colleagues in 2019. ESHT have committed to reducing this 25.9% over two years.

Fig. 6 Staff-on-staff harassment ethnic group



Racial equality of opportunity for promotions (WRES 7)

1.11. 48.3% of multicultural colleagues reported the Trust provided equal opportunities for promotion, with a positive trend over three years. The Trust is 2.2 points greater than the 46.1% multicultural colleague provider benchmark average but with the Trust's white staff reporting 58.6%, the rating is amber.

Staff work discrimination by ethnicity (WRES 8)

Fig.7 Staff experiencing discrimination from their manager/team leader

1.12. 15.1% of multicultural colleagues (n.81) experienced discrimination at work from their manager/team leader, an 8.7-point difference to the 6.4% of their white colleagues experiencing it but 2.2 points less from the 17.3% multicultural colleagues provider benchmark.

Board ethnicity membership (WRES 9)

1.13. The Board, including voting and executive, was 87.5% white and 6.3% multicultural and 6.3% unknown. Difference between multicultural representation in the workforce and on the board, overall is -15.2%

NEXT STEPS FOR RACE EQUALITY 2023-24

- Review of international recruitment induction and onboarding (HIA2)
- Incivility and poor behaviours campaign (HIA6)
- Examine ethnicity pay gap and diversity across pay bandings (HIA3)
- Examining issues related to data collection with the intention to resolve them for next year.

RELIGION AND BELIEF

The proportion of colleagues (75.5%) sharing their beliefs grew by 2.5% over the past 12 months.

Discrimination rates from patients or the public towards our colleagues are higher towards our Buddhist, and colleagues preferring not to state their religion.

2.1. Across 2022-23 ESHT's Faith and Belief Network was established and explored different faiths and what they mean to colleagues. Key achievements include:

- Supporting Muslim colleagues with wellbeing packs during Ramadan
- Involvement with the local multi-faith networks

KEY FINDINGS: RELIGION AND BELIEF

Workforce religion and belief representation 

2.2. The number of people sharing their religion or belief with the Trust at 31 March 2023 was 5,811, or 75.5% of the workforce. Colleagues in agenda for change (AfC) pay band 7 had the largest proportion identifying as religious at 78.8%. Over 12 months the proportion of colleagues sharing their belief information increased by 2.5%

2.3. Colleagues sharing, they were Christian was the largest belief group at 44.5% (n. 3,425), followed by the non-religious group at 24.5% (n. 1885) and then followed by the group sharing that they described themselves as Atheist at 16% (n.1231).

2.4. The proportion of all colleagues sharing that they identify as religious remained relatively static over five years.

2.5. The proportion sharing that they identify as non-religious decreased by 2.5% (n. 192) overall, over 12 months. The score is rated amber because 24.5% of colleagues do not wish to share their religion with us.

Fig. 8 Workforce by belief group

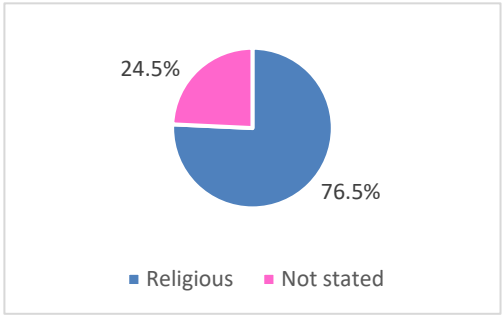
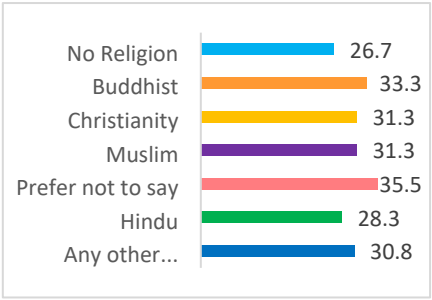


Fig. 9 Bullying & harassment score% (religion and belief group)



Religion and belief: We are safe and healthy by religion and belief.

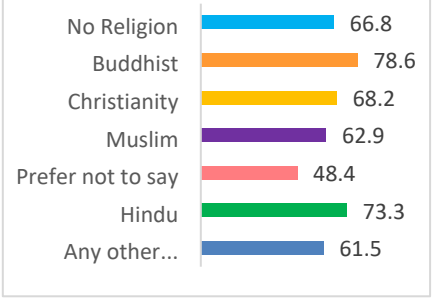
2.6. We are safe and healthy includes responses to a series of nine questions from the staff survey 2022 relating to personal experience of harassment, bullying or abuse from patients, relatives, members of the public, managers and / or colleagues.

Religion and belief: We are compassionate and inclusive.

2.7. We are compassionate and inclusive relates to a series of four questions taken from the staff survey 2022 relating to equal opportunities in career progression, discrimination at work and respecting individual differences.

Respecting individual difference identifies the group where the lowest score was those colleagues who prefer not to disclose their religion at 48.4% (n.213) followed by Any other religion at 61.5% (n.52) and Muslim colleagues at 62.9% (n.62). The highest score was Buddhist colleagues at 78.6% (n.28) followed by Hindu colleagues at 73.3% (n.45).

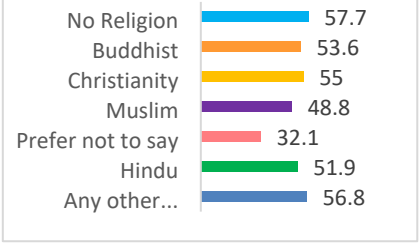
Fig.10 ESHT respects individual difference % (religion and belief)



Religion and belief equality of opportunity for career progression/promotions

2.8 On average, 54.6% of colleagues reported ESHT acts fairly with promotions. The group with the lowest proportion was Prefer not to say at 32.1% (n.212); nearly 25 points behind the highest score 56.8% Hindu colleagues (n.44) The next lowest in the Trust was Muslim colleagues at 48.8% (n.64) although this score is an increase of 6.4% from last year's results.

Fig.11 Equality of opportunity for promotions % (religion and belief)



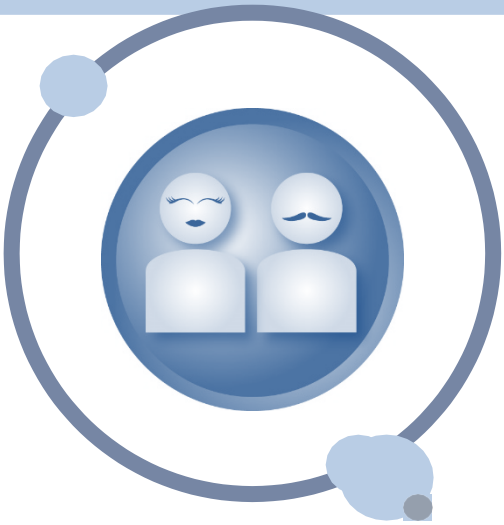
NEXT STEPS FOR RELIGION AND BELIEF EQUALITY 2023-24

- Increase membership of the faith and belief network (HIA5/6)
- Host a multifaith event.
- Find suitable space for the multifaith room on DGH site. (HIA 4)

GENDER (SEX)

The proportion of the male workforce has grown by 9% over five years, with an overall split currently of 76.5% female and 23.5% male. We cannot evidence representation for Trans or non-binary people. Women were just under one-and-a-half times as likely as men to experience bullying from patients. Men were just as likely as women to experience discrimination from other colleagues.

For every £1 earned by men, women earned £0.93; Women occupied 70.4% of the highest paid jobs (8a-9).



3.1. Across 2022-23 ESHT continued its work to promote gender equality between men, women and non-binary people, including trans people. Key achievements include:

- Women's consultant network created.
- Gender pay on part time and full time workers added to the diversity toolkit.
- Black history month menopause session held with a specific focus on multicultural women.
- Delivering trans awareness training to colleagues.

KEY FINDINGS: GENDER (SEX)

Workforce gender representation A

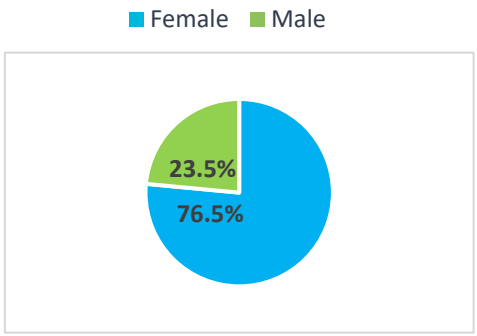
3.2. Out of 8,778 staff, 76.5% (n. 6,723) were recorded as female and 23.5% (n. 2,055) as male on their Electronic Staff Records (ESR). The proportion of the male workforce grew by 0.4%.

3.3. The female workforce in Agenda for Change pay bands was 78.2% (n. 5,445) compared to 41.8% (n. 298) of females with medical and dental contracts.

3.4. The voting board was comprised of 4 men and 7 women, inclusive of both executive directors and non-executive directors.

3.5. At present the national ESR system cannot record staff members who do not identify with a specific binary sex or who identify as Trans, hence this measure is rated amber.

Fig. 12 Workforce by sex



Harassment, bullying or abuse from staff by gender A

3.6. There was a 0.4-point difference between the proportion of females (20.9%) who reported experiencing harassment, bullying or abuse from colleagues and the proportion of males (20.5%) reporting this in the last twelve months.

Fig. 13 Colleague-on-colleague staff harassment (% gender)

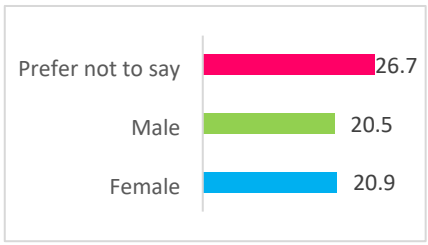


Fig. 14 Discrimination from patients towards colleagues by gender (%)

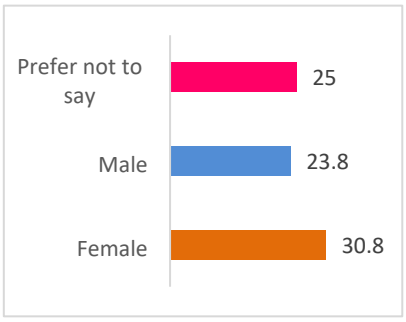
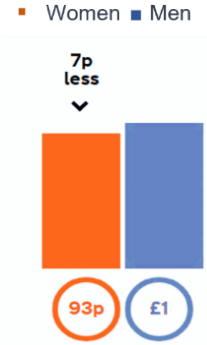


Fig. 15 Hourly wages pay gap by gender



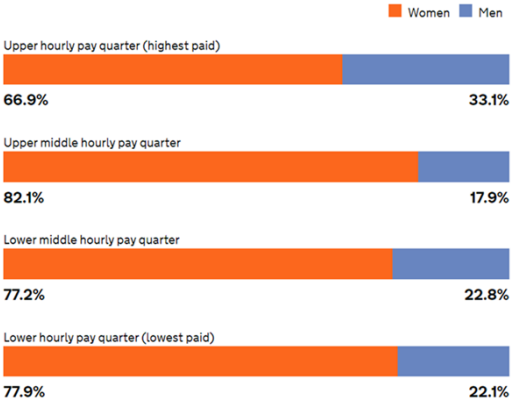


Fig.17 Gender bonus pay gap

Discrimination from patients, relatives, or membersof the public by gender

3.7. There was a seven point difference between the proportion of males (23.8%) who reported discrimination from patients, relatives or members of the public and the proportion of females (30.8%) reporting this in the last twelve months.

3.8. In ESHT, women earned £0.93 for every £1 than men earned when comparing median hourly wages (a change of £0.01 on the previous two years). Their median hourly pay is 6.9% lower than men's.

Proportion of women in each pay quarter

3.9. When comparing mean hourly wages, women's mean hourly pay is 19.9% lower than men's. In ESHT, women occupy 66.9% of the highest paid jobs and 77.9% of the lowest paid jobs.

3.10. 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 within ESHT.

Gender bonus gap

3.11. In ESHT, women earn £0.70 for every £1 that men earn when comparing median bonus pay. Their median bonus pay is 29.8% lower than men's. When comparing mean bonus pay women's mean bonus pay is 25.3% lower than men. 0.3 of women received bonus pay, 3% of men received bonus pay.

3.12. 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 31/3/23 was 69.2% male and 30.8%, so there is still a disparity.

NEXT STEPS FOR GENDER EQUALITY 2023-24

- Establish a women's network and support its development. (HIA4)
- Explore adding flexible working to all job adverts. (HIA2)
- Analysis of data by Divisions to help inform the underlying causes of their pay gaps. (HIA3)
- Supporting Trans colleagues in the workplace policy development. (HIA4)
- Work with wider system locally on action to reduce the pay gap (HIA3)

SEXUAL ORIENTATION

Nearly four percent of the workforce shared with us that they identify as lesbian, gay or bisexual (LGB). This is a relative de/increase of 0.5% over the past year. On average higher paid colleagues were more likely to share they were LGB.

Colleagues identifying as gay or lesbian scored 10 points higher than the ESHT average for their perceptions that the organisation acts fairly with regard to career progression, regardless of diversity. There are 63 registered members of the LGBTQ++ network.

4.1. Across 2022-23 ESHT continued its work to promote equality between people of all sexual orientations, including lesbian, gay, bisexual (LGB) and straight people. Key achievements include:

- Continued rollout Sexual Orientation and Gender Identity Training
- Hosting our first system wide event during LGBTQ+ History Month (Feb 2023)
- Delivering a session on Lived Experience to the Pharmacy Team

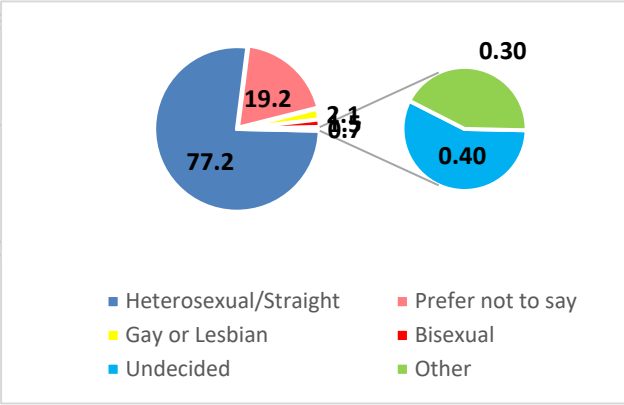
KEY FINDINGS: SEXUAL ORIENTATION

Workforce sexual orientation representation A

4.2. The number of people sharing their sexual orientation with the Trust at 31 March 2023 was 7,090 or 80% of the workforce.

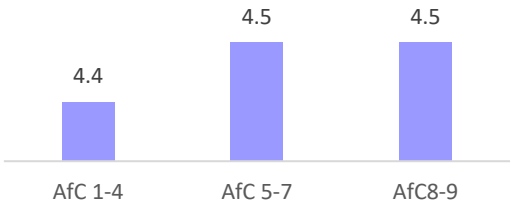
4.3. Colleagues sharing that they were heterosexual was the larges group at 77.2% (n. 5,544), followed by the group of colleagues sharing that preferred not to share their sexual orientation at 19.2% (n. 1688) then the colleagues sharing that they are gay o lesbian at 2.1% (n.149), then by colleagues who shared they identified as bisexual at 1.5% (n. 106) colleagues who shared they were undecided at 0.4% (n. 28) and lastly was 0.3% (n.21) of colleagues who selected their sexual orientation as "other".

Fig. 18 Workforce by sexual orientation %



4.4. Colleagues in Agenda for Change (AfC) pay group 5-7 and 8a-9 had the largest proportion identifying as LGB on their staff record at 4.5% each, compared to 4.3% in the workforce overall.

Fig. 19 LGB workforce by AfC pay group



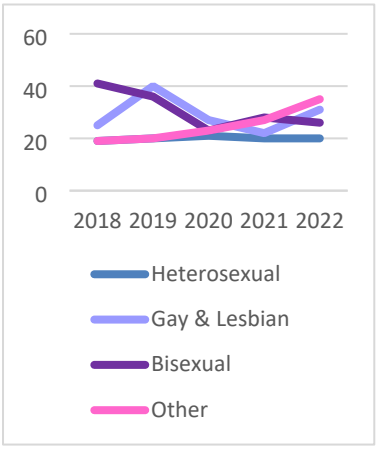
4.5. Correspondingly the lowest proportion of LGB on ESR was in Agenda for Change pay bands 1-4 at 4.4.% (n.5). With almost 20% of the workforce not wishing to share their sexual orientation an amber rating is given.

Safe environment (bullying and harassment)by sexual orientation

4.6. ESHT response to colleagues who have personally experienced discrimination from patients/services users, their relatives or other members of the public in the *preceding twelve months* was 8.3% from 3401 responding to the staff survey. The group with the lowest score was those colleagues sharing that they are heterosexual at 7.2%; 0.6 lower than the 7.8% average score in the provider benchmark. Colleagues sharing that they were bisexual were the highest at 16.2%, followed by lesbian and gay colleagues at 13.4%.

Colleagues experiencing harassment from colleagues by sexual orientation

Fig. 20 Bullying & harassment score from colleagues (sexual orientation)

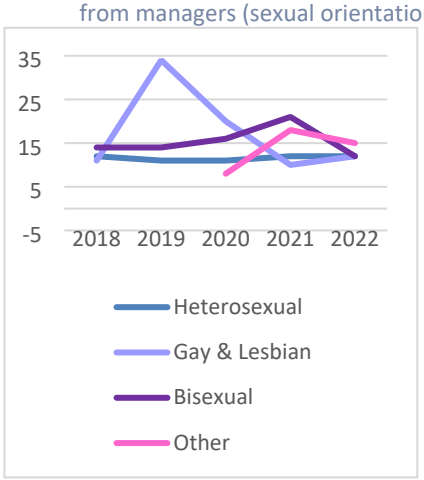


4.7. 35% (n.20) of those colleagues declaring as other experienced at least one incident of bullying, harassment or abuse from their colleagues. The next highest was colleagues preferring not to say at 33.6% (n. 226), followed by colleagues sharing their sexual orientation as gay or lesbian at 32.1% (n.81). There were decreases for colleagues who shared they were heterosexual and bisexual.

Colleagues experiencing harassment from managers by sexual orientation

4.8. All groups experienced harassment from managers with those identifying as other at the highest with 15% (n.20) and those identifying as heterosexual or straight and bisexual the lowest at 11.9%. Every group experiencing harassment from patients decreased except for an almost 2% increase for those identifying as gay or lesbian.

Fig. 22 Bullying & harassment score from managers (sexual orientation)



Equality of opportunity for career progression/promotions by sexual orientation

4.9. On average, 54.6% of colleagues reported ESHT acts fairly with promotions. The group with the lowest proportion were colleagues preferring not to share their sexual orientation at 35.9% (n.231); nearly 25 points behind the highest score 64.6% colleagues sharing that they were gay or lesbian (n.82).

LGBTQ+ Rainbow Scheme

4.10. In 2021 the NHS Rainbow Badge moved from a purely visual symbol, to also incorporating an assessment and accreditation model for NHS Trusts. ESHT will be seeking to achieve accreditation this year. In light of changes to the Pride flag in 2021 the network banner has also been updated.

NEXT STEPS FOR SEXUAL ORIENTATION EQUALITY 2023-24

- Accreditation of NHS Rainbow badge bronze and silver accreditation (HIA 4)
- Development and introduction of a Supporting trans colleagues in the workplace policy (HIA 4)
- Supporting talent management strategies targeting under-representation and diversity gaps (HIA 2)

DISABILITY

5.2% of the workforce shared that they identify as disabled on their electronic staff record, with 18.7% choosing not to share their disability status. People who were disabled were just as likely to be appointed from shortlisting than non-disabled people against this key national workplace disability equality standard (WDES) measure.

76.7% of disabled colleagues felt that ESHT made adequate adjustments to enable them towork; an increase of 0.1% on the previous twelve months. The disAbility staff network has 57 registered members.

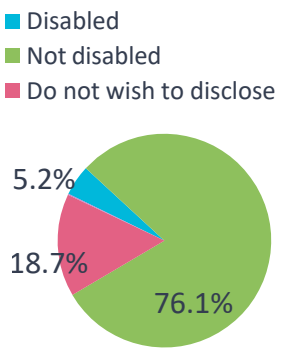
5.1. Across 2022-23 ESHT continued to advance disability equality and make reasonable adjustments for disabled people in our workplaces and to facilitate that their voices be heard (WDES 9):

- Continued support and guidance for the Disability and Health Passport, which was designed by the Trust's disAbility network.
- Developed a month of activities for wellness for disability history month that received over 1000 views on twitter.
- ESHT became a disability confident leader after an external assessment.

5.2. Disabled colleagues scored on average 6.3 out of 10 for how engaged they felt; 0.4% different from the 6.7 out of 10 score of non-disabled colleagues.

KEY FINDINGS: DISABILITY

Fig. 23 Workforce by disability status



Workforce disability representation (WDES 1) A

5.3. The number of people sharing their disability with the Trust at 31 March 2021 on their staff record was 387, or 5.2% of the workforce. The group not wishing to share their disability status is at 18.7%, hence the amber rating. There were 24.7% (n.841) of 3,407 who answered the staff survey 2020 and selected they were disabled.

5.4. Non-clinical colleagues in agenda for change (AfC) pay band 5-7 had the largest proportion of disabled colleagues at 7.3% (n. 84), with the lowest also being non-clinical colleagues with just 4% sharing they have a disability in the AfC 8c-9 and VSM cluster.

5.5. Over the last year the number of colleagues sharing their disability status grew by 0.81% overall.

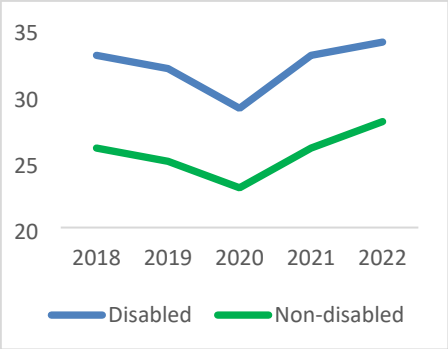
Shortlisting-to-appointment by disability (WDES 2) G

5.6. People with a disability were just as likely to be appointed from shortlisting as a person without a disability.

Formal capability likelihood by disability (WDES 3)

5.7. 1.5 (3 over two years) people who had shared they were disabled on their staff record entered a formal capability process in 2022-23. There were 32 (64 over two years) non-disabled people who entered a formal capability process.

Fig. 25 Patient-on-colleague harassment by Disability

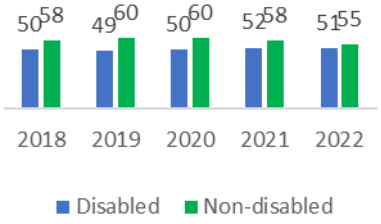


Harassment, bullying or abuse by disability (WDES 4)

5.8. 34.1% of disabled colleagues in the 2022 staff survey experienced harassment, bullying or abuse from patients, relatives, or the public in the prior 12 months, a 5.9% difference from the 28.2% of non-disabled colleagues, and a 1.1% difference from the disabled colleague provider benchmark (33%).

5.9. 16.9% of disabled colleagues experienced harassment, bullying or abuse from managers, nearly 6% higher than that of the 11.1% of non- disabled colleagues, and a decreasing five-year trend for non-disabled colleagues. 27.9% of disabled colleagues experienced harassment, bullying or abuse from other colleagues, an 8.5- point difference from the 19.4% of non-disabled colleagues.

Fig. 25 Equality of opportunity for career progression/promotions



Disability equal opportunities for promotion (WDES 5)

5.10. 51.4% of disabled colleagues felt ESHT provided equal opportunities for promotion, with a static trend over three years, a 4.2-point difference from the 55.6% of non-disabled staff, hence the amber rating. ESHT disabled colleague figure is the same as the disabled colleague provider benchmark.

Pressure to work when unwell by disability (WDES 6)

5.11. 22.9% of disabled colleagues felt management pressure to come to work when not feeling well enough, nearly a 6-point difference from the 17.7% of non-disabled colleagues. However, this is nearly a 7-point improvement on the previous twelve months and 8-points below the disabled colleague provider benchmark.

Trust values their work by disability (WDES 7)

5.12. 44.3% of disabled colleagues felt the Trust valued their work, a 11-point difference from the 55.3% of non-disabled staff but similar to that of the disabled provider benchmark of 44.6%.

Adequate adjustments for disabled people (WDES 8)

5.13. 76.7% of disabled colleagues felt ESHT made adequate adjustment(s) to enable them to carry out their work. A 2.3% increase on those disabled staff completing the staff survey in the previous twelve months.

Board disability membership (WDES 10)

5.14. The Board, including voting and executive, was 62.5% non-disabled and 37.5% undeclared.

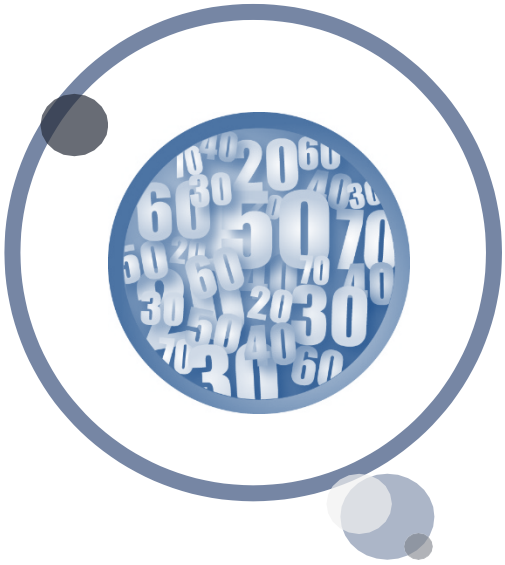
NEXT STEPS FOR DISABILITY EQUALITY 2023-24

- Centralise the reasonable adjustments process (HIA 6)
- Produce a handbook for managers in accessing the right information to support their neurodiverse colleagues (HIA 4)
- Examine disability pay gap and across pay bandings (HIA 3)
- Supporting talent management strategies targeting under-representation and diversity gaps (HIA 2)

AGE

Colleagues in the 16-50 years age group have higher perceptions of equality of opportunity than the average provider sector benchmark (55.6%).

Staff in the 51-66+ years age group report on average lower perceptions of equality of opportunity than all other age groups and the provider sector benchmark, with a decreasing trend over time.



6.1. Across 2022-23 the Trust continued its work to promote age equality between people of different ages. Key achievements include:

- Celebrating International Day of Older Persons 1st October.
- Work with the Princes Trust to assist young people back into work.
- Working with Project SEARCH - a supported employment initiative for young people with learning difficulties and disabilities

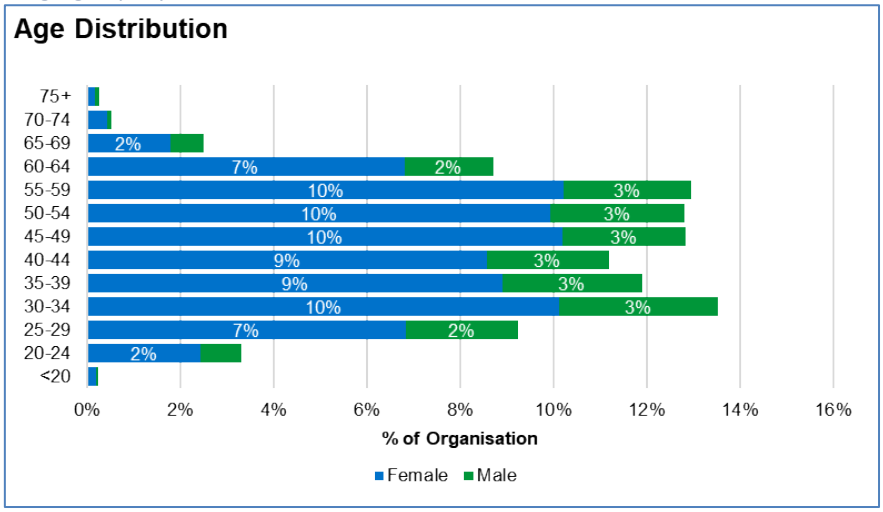
KEY FINDINGS: AGE

Workforce age representation

6.2. ESHT Colleagues in post grew by 5% over twelve months from 8359 in April 2022 to 8778 in April 2023.

6.3. The percentage of colleagues increase in any age group in the workforce over the last twelve months was similar across all years' group.

Fig. 27 Workforce age groups by %



We are safe and healthy (bullying and harassment) by age.

6.4. The 66+ years group gave the lowest negative response score 22% (n.59) to experiencing bullying and harassment from patients, service used, their relatives of other members of the public. The next lowest was the 16-20 years age group at 25% (n.13). The provider benchmark for all age groups was 47.4% and ESHT average was 50%.

6.5. The 21-30 years group gave the lowest score on ESHT, taking positive action on health and wellbeing at 49.9% (n.425) and had the biggest decrease(positive) (11.8%) in response on the previous twelve months. There were no other age groups with such a sharp decline.

6.6. The lowest response to having experienced discrimination from a manager or team leader was the 16–20-year group was under 1% (n.12). The highest response being from the 66+ year's group at 15.3% (n. 59) in comparison to the organisational score of 8.3% (n.281).

Age equality, we are compassionate and inclusive.

6.7. The 31-40- and 41-50-years' groups gave the highest positive response to ESHT acting fairly with regards to career progression at 57.1% (n. 687) and 57.4 % (n. 826). The lowest score was in the 51-56 years group at 51.9% (n. 1318).

6.8. The 16-20 years group had the biggest increase in positive response to the career progression question at 31% over the previous twelve months.

NEXT STEPS FOR AGE EQUALITY 2023-24

- Where possible support social mobility and improve employment opportunities across healthcare. (HIA 4)
- Increase the awareness of age discrimination across the ESHT.

EQUALITY DELIVERY SYSTEM (EDS)

The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

7.1 ESHT reviewed EDS 2022 in creating equality objectives in October 2022. However, the reporting template was not completed for two reasons:

- The standards are extremely broad (e.g., 'Individual patients (service users) health needs are met'), so at this stage every question would be scored 1 'Developing Activity'. As everything would score the same, there was little benefit in writing up the scoring exercise in addition to the equality objectives.

- The supporting technical guidance emphasises application of EDS 2022 at 'regional or ICS footprint'. And the Sussex ICS has said it wouldn't be in a position to lead implementation until later in the year.

7.2 In addition to this as the Trust will begin to implement the actions set out in the NHS EDI Implementation Plan. Work to implement these actions further supports ESHT in demonstrating compliance with the EDS.

NEXT STEPS FOR EDS 2022/NHSE HIA 2023-24

- We will continue to monitor demonstration of compliance with EDS 2022 and work with the ICS when they begin to lead on implementation.
- We will develop a programme of evidence-based action to meet the requirements of the NHS England high impact actions for EDI.

High Impact Actions (HIAs)

	High Impact Action (HIA)
HIA1	Chief executives, chairs and board members must have **specific and measurable EDI objectives** to which they will be individually and collectively accountable.
HIA2	**Embed fair and inclusive recruitment processes and talent management strategies** that target under-representation and lack of diversity.
HIA3	Develop an **improvement plan to eliminate pay gaps.**
HIA4	Develop an improvement plan to **address health inequalities** within their workforce.
HIA5	Develop a **comprehensive induction, onboarding and development programme for internationally recruited staff.**
HIA6	Create an environment which **eliminates the conditions in which bullying, discrimination, harassment and physical violence at work** occurs.

ORGANISATIONAL INCLUSION

ESHT joined a number of other NHS organisations on the NHS Employers Diversity in Health and Care Partnership Programme. Equality, Diversity and Inclusion policy and equality and health inequalities impact assessment process are both in review.

Networks will be strengthened with executive leadership sponsors and the Faith and Belief network was established introduction of a fifth women's network is in development. A new category for Inclusion and diversity was introduced for the Trust awards.

8.1 In addition to the progress highlighted in each section, across 2022-23 ESHT continued certain trust-wide initiatives to advance equality of opportunity eliminate discrimination and foster good relations. Key achievements include:

- Revision and update of diversity and inclusion webpages (both internal and external)
- Rolled out the accessibility information standard training for all staff on MyLearn
- A monthly diversity dialogue with a different topic for each month.
- A new category has been introduced on Inclusion and Diversity for the Trust Awards
- Reviews have begun of the Equality, Diversity and Inclusion policy and the Equality and Health Inequality Impact Assessment (EHIA)

KEY FINDINGS: INCLUSION

We are compassionate and inclusive: Diversity and equality

8.2 ESHT overall score for colleagues believing that ESHT respects individual differences was 66.2% (n. 2259). This was just below the average provider benchmark of 69.3%.

We are compassionate and inclusive: Inclusion

8.3 ESHT overall score for colleagues feeling a strong personal attachment to their team was 64% (n.2180), this is similar to the provider benchmark of 64.2%

NEXT STEPS FOR ORGANISATIONAL INCLUSION 2023-24

INCLUSIVE LEADERSHIP& CULTURE

- We will provide opportunities for allies and for role models to develop cultural competence by increasing support for leaders to identify bias, to reduce prejudice and to eliminate systemic barriers.
- We will align systems to strengthen the conditions for change; embedding inclusion within talent management.
- We will implement the NHS England high impact actions.

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 use of the Trust Seal since the last Board meeting.

Executive Summary	The Trust Seal was used to seal one document between 27th May 2023 and 3rd October 2023: **Sealing 97 – Reliance High-Tech Limited, 24th August 2023** Three year framework contract for the provision of CCTV and Access Control

Next steps	Not applicable

Maternity Transformation Update

Written by Speciality Lead: Sophie Moorsom

Month: July 2023

Current/Ongoing Improvement Project Overview
1. Midwifery Continuity of Carer (MCoC)
2. Perinatal equity
3. Personalised Care and Support Plans (PCSP)
4. MSW project
5. PREM 7
6. Perinatal Pelvic Health

1. Midwifery Continuity of Carer

The current ambition is to meet safe minimum staffing requirements by November 2023, allowing for further roll out of MCoC. We plan to allow a six-month period of preparation/induction and to work towards launching 2 teams in July 2024. In the interim, we continue to work on the building blocks for MCoC:

Building Block 3 Communication and Engagement

- surveys for midwives about MCoC designed – one for midwives who are currently or have previously worked in MCoC team at ESHT (launch July 2023) and another for midwives who have never worked in an MCoC at ESHT (launch August 2023)
- Café conversations with the support of the PMP team – planned for 17th and 18th July 2023
- Monthly MCoC newsletter – first edition June 2023, circulated.

Building Block 4 Training

Training needs analysis document designed – launch planned for August. Support from line managers and PMP team required. TNA can form part of appraisal discussion and/or restorative clinical supervision.

Building Block 5 Team building

As stated above, a six month period of orientation/induction for new team members built into projection of when to launch the new teams. This is to allow time for team building (as well as meeting any training needs). Communication and engagement events above designed to encourage discussion on team building activities.

Group Resilience Episode Protocol (GREP) sessions facilitated by Engagement and Wellbeing team tested by Ivy Team and found not to be helpful.

Building Block 6 Linked obstetrician

The need to define/clarify the role of the linked obstetrician was raised at the maternity board meeting in May 2023 and has been a topic of discussion at further meetings in relation to women/people who choose out of guidance care. The need for further discussion has been identified by senior leaders.

In the literature on MCoC, the linked obstetrician is defined as an individual who is an integral member of the team, who is available to the midwifery team by an agreed process and who attends team meetings on a regular basis (e.g. monthly) providing a clear, well-defined route for obstetric or other specialist referral. For information on the role of linked obstetricians, see Section 4.2 of B0961_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf

(england.nhs.uk) and Section 3.3 of ESHT Standard Operating Procedure (SOP) for Continuity of Carer teams 02237_P.pdf (esht.nhs.uk)

For reflections on the role of the linked obstetrician see The role of the consultant obstetrician in midwifery led care - Maternity & Midwifery Forum % (maternityandmidwifery.co.uk)

Building Block 8 Pay

In order to ensure that midwives are not financially disadvantaged as a result of working in MCoC teams, further consideration to be given to the different approaches to pay (e.g. recommendation for a 4.5 % uplift plus unsociable hours – the closest to the standard pay of a midwife working on delivery suite). Finance and payroll at ESHT contacted for advice and support.

Building Block 9 Estate and Equipment

Equipment for 2 new teams has been purchased and is currently in storage at EDGH. This does not include laptops and phones – these were not purchased back in July/August 2022 due to the delay in the implementation of MCoC and due to a lack of storage space and the money earmarked was spent elsewhere in the Trust with the understanding that it was owed to maternity for the purchase of laptops and phones when the time was right. Note that at the time there was a 25 week delay in the delivery of laptops and that if this remains the case, these would need to be ordered at the beginning of the 6 month orientation/induction period.

Estates – clarity required on status of estates in central Eastbourne, as it was noted that a clinic space previously available has been lost (as this is in an area identified as being high in deprivation, this represents a potential risk to perinatal equity and equality agenda). No significant change in estates is forecast. MCoC teams to occupy estates currently used by community midwives but plan to investigate if other solutions are warranted, given our demographic, and feasible e.g. in hotels, on premises of 3rd sector organisations, as happens in other Trusts e.g. SASH serving population high in numbers of migrant families in Crawley.

Building Block 11 Co-production

Ongoing project with MVP to design an evaluation tool of existing MCoC teams, to inform any changes/improvements of existing teams and the design of the teams to be rolled out.

The Ivy team prioritising pregnant women and people in the Hastings/Bexhill/Rye area, who, due to language barriers, their social circumstances, mental health history or previous bereavement, would benefit from MCoC, as well as women choosing to birth home - this is in line with referral criteria for the Ivy team outlined in SOP for Continuity of Carer teams 02237_P.pdf (esht.nhs.uk). Amendment to SOP to be discussed as: 1. obstetrically and neonatally low risk women/people and women/people with a previous traumatic birth (not previous C-sections) included in referral criteria, and 2. referral criteria currently include women with mild to moderate mental health problems rather than women with severe mental health problems. Reduced caseload (1:30) to reflect complexity of cases – to be reviewed.

The Lighthouse team (as an 'Enhanced' Midwifery Continuity of Carer team, providing care for young parents), has successfully recruited a band 3 team administrator (no start date agreed as yet). Duties will include allocation of caseloads; social media pages; managing data collection spreadsheets; managing the diary for A/N classes and 'Meet the Team' events and managing the inbox. This should free up midwifery time and enable the team leader, specialist midwife for young parents, to spend more dedicated time developing her speciality, participating in networking and educational events, to further develop and raise the profile of the Lighthouse team. Funding for this role, and for additional midwifery hours in the Lighthouse team is secured

to March 2023/24 with potential to extend beyond this date subject to successful evaluation and annual business planning.

2. **Perinatal Equity**

Please refer to Sussex LMNS Perinatal Equity Project plan 2022/23 - Perinatal Equity plan (East Sussex)

Specialist Practitioner for perinatal equity and equality successfully recruited to post – start date September 2023. Job purpose:

- To support national and regional project work for improving perinatal equity and equality, specifically actions 2, 3 and 5 of the Sussex LMNS Perinatal Equity Project Plan.
- To work with the Trust Equality, Diversity and Inclusion team, the Human Resources team, and maternity leaders to support the training, development, and experience of staff from multicultural and ethnically diverse backgrounds, in line with the NHS People Plan.
- To identify staff training needs and requirements to be culturally aware and culturally safe and lead on addressing these.
- To work with the maternity leadership team at ESHT, and other key stakeholders, to improve the care of service users from multicultural and ethnically diverse backgrounds and disadvantaged and marginalised groups in line with the ambitions of the NHS Long Term Plan and the Maternity Transformation Programme. To carry continuing responsibility for the holistic assessment of the health needs of these groups, together with the development, implementation, and evaluation of packages of care, to ensure that these needs are met.
- To work directly with service users from multicultural and ethnically diverse backgrounds, disadvantaged and marginalised groups on co-producing services to provide safe, effective and personalised care.

Job plan and orientation for this role being developed in time for the person starting in post.

Transformation midwives participate in monthly meetings of: 1. East Sussex Perinatal Equity and Equality steering group; 2. Contingency, Asylum seeker, Refugee and Migrant (CARM) Maternity and Child Health Task and Finish Group; 3. Perinatal Transformation catch up session with transformation colleagues at UH Sussex and East and West Sussex Senior Planned Care Managers.

3. **Personalised Care and Support Plans (PCSP)**

Personalised and equitable care cornerstone of 3 year delivery plan.

PCSP booklet ‘My pregnancy and birth choices’ has been reprinted for circulation to every pregnant woman/person at booking and to be revisited at every opportunity. QR code on the front of the booklet links to further information.

Badgernet PCSP continues to be developed. LMNS wide project (led by Digital Transformation Manager at the LMNS) with participation from our Badgernet lead midwife and maternity data analyst.

When we are satisfied that the Badgernet meets our specification we will still need to have hard copies available for those who prefer these and those who do not have digital access.

The booklet was co-produced in 2020 and is up for review. LMNS wide plan to:

- review the content with service users, proactively working with service users from multicultural and ethnically diverse backgrounds and disadvantaged and

marginalised groups, and organisations advocating for service users from these groups, to design the next iteration of the booklet.

- formally translate the document (LMNS website can translate documents but the engine is not sophisticated enough to get across the depth and complexity of this messaging for assurance on quality)
- make the document word light (easy read)
- make the document more representative
- ensure the document captures key perinatal equity messages
- ensure inclusive language is used
- include neonatal pathways to raise awareness of preterm birth and experiences of families when a baby requires specialist neonatal care

Personalised care training to be included on mandatory training as of August 2023, facilitated by deputy maternity transformation lead. All staff have been informed of e-learning in personalised care in maternity on Personalised Care Institute website.

See appendix 1 (at the end of this document) for East Sussex MVP Personalised Care and Support Plan – East Sussex SU feedback (Jan-June 2023).

4. **Maternity Support Worker Project**

Creating a new, professionalised, and standardised model for the role of the MSW. Supporting the education and career progression of all MSWs but with a particular focus on uplifting B2 MSWs to B3. Deputy clinical education midwife (in post since March 2023) and practice development MSW (starting in post August 2023) appointed with funding from HEE to support MSW project.

In order to be uplifted to B3, B2 MSWs who were employed by the Trust prior to December 2022, need to meet the following requirements: completed Care Certificate and functional skills in Maths and English, competence/sign-off in the clinical skills expected of an MSW.

Any MSW employed by the Trust after December 2022 as a band 2 is expected to complete a L3 Senior Healthcare Support Worker apprenticeship, as well as the educational requirements above, to be uplifted to B3.

The MSW recruitment plan is to employ people who already have a relevant L3 qualification into MSW roles but there will be exceptions to this and the apprenticeship pathway through the Trust supports career progression. To date, we have one MSW who has applied for the L3 Senior Healthcare Support Worker apprenticeship.

Since the MSW action plan was approved, two B2 MSWs have met the requirements to be uplifted to B3.

We currently have 12 B2 MSWs. All have expressed their commitment to meet the requirements to be uplifted to B3. 6 have completed their Care Certificates, 8 have started them but not yet completed them. 7 need to complete their functional skills. They are at different stages of competence with their clinical skills.

Stumbling blocks include:
1. lack of enthusiasm/confidence for functional skills (mirroring experience in other Trusts). Potential for creating a bespoke Maths and/or English competency for MSWs discussed with Julie Hales, HR business partner, and agreed the following: 1. that a bespoke program is unlikely to be recognised by an apprenticeship program and there would therefore be implications on an individual's further career progression; 2. for Julie to initiate discussions with the education team re. a) the design of a bespoke course, b) additional support for MSWs

undertaking functional skills to ensure success and c) the potential for courses to be run at different times of day to facilitate attendance.
2. lack of capacity in the ESHT vascular access team to facilitate a 'train the trainer' course for midwifery education team – frustrating efforts to teach and sign-off skills in cannulation and venepuncture.

5. **PREM 7**

7 steps towards optimisation and stabilisation of the preterm infant PREM 7 - Welcome (southeastclinicalnetworks.nhs.uk)**.** Aiming to improve outcomes for babies who are born prematurely in the South East region. Based on best practice the seven interventions can have a significant and positive impact on reducing brain injury and mortality rates amongst babies born prematurely. These interventions are based on the British Association of Perinatal Medicine best practice toolkits. Standing item on Labour Ward Forum. Elements 1-4 covered in SBLCB. Deputy maternity transformation lead and deputy fetal wellbeing midwife leading on QI project for Optimal Cord Management and Normothermia (elements 5 and 6). Infant feeding specialist midwife on element 7. Monthly PREM7 meetings scheduled starting July 23, to include all relevant stakeholders but open to anyone who wishes to participate. Mani Kandasamy confirmed as paediatric lead. Poster and QR codes up on LW and Neonatal unit. Planned launch of PREM 7 September 23. PREM 7 to be included in teaching schedule for new doctors, in October 23.

6. Perinatal Pelvic Health

June 23 Highlight Report by Speciality Lead: Anna Foord- PPHS Specialist Midwife

Current/Ongoing Improvement Project Overview	Lead	Completion Date	RAG
National Ambition to improve **Prevention**, **Identification** and **Treatment** of mild to moderate pelvic floor dysfunction following birth and reduce the no of women living with PFD postnatally and in later life.	LMNS PPHS project team	**March 24**	
Self- referral to Pelvic Health physio (SPOA)	PPHS project team	June 23	
AN Pelvic health education session	AF & WM	July 23	
PPHS dashboard	AF	June 23	
Perineal Clinic	AF	Sept 23	
Perineal Trauma & OASI guideline update	AF	??	
Bladder care guideline	AF	??	

Highlights/Successes:

SPOA
Self-referral for pelvic health physio is now live on the LMNS website, meaning that service users do not need to wait for a HCP to refer them. Need to link this with Badgernet so service users have easy access and communicate this to all HCP including GPs, HVs etc.

Mandatory Training.
The last training session under current format is 7/7/23 as the 3 yearly training will have been completed. 'Pelvic Health and perineal trauma-prevention of and OASI pathway and pelvic floor muscle training' has been added to the Core competency framework V2. This means that mandatory training for pelvic health needs to be given its own training allocation and will be taken off PROMPT allowing a fuller, more in-depth training package with to be delivered. Looking at October start, with formal lesson plans to meet CNST requirements.

The Education team have met and set out a plan for upcoming training as some of the ideas for education overlap between roles. Episiotomy and suturing training will start 8th Aug at Conquest and EMU. This will be offered on an 8 weekly basis and staff can book onto it. PETALS training will be offered quarterly.

PPHS Dashboard

Most of my work has focused on the PPHS dashboard which has been designed and is now live, with monthly submissions across the LMNS. We are collecting data on SVDs, instrumentals, epis rates (for assisted and SVDs, which is not broken down on BN), 3a,3b,3c & 4th tear numbers, 2nd stages> 2hrs (as this is a risk factor for PFD and OASI), postnatal readmissions, ward attenders for perineal infection/breakdown and referrals into PPHS.

I have also been tasked with looking at reviewing BAME data and 10% most deprived accessing PPHS. Which currently will need to be done using the Physio's referral system.

AN Pelvic health Education

The AN physio education presentation regarding pelvic health has been finalised. This will be delivered online initially by the Physio and Midwife. This will deliver one of the KPIs; to ensure that all service users receive routine antenatal education on pelvic floor exercises and pelvic health problems, are able to identify issues and seek treatment. However, I'm still awaiting a roll out plan.

Challenges/Barriers and support required:

Perineal Clinics

Work on this is ongoing. Following a meeting with the PPHS group regarding this, it was felt that the clinics may not be ready to pilot until Sept. Work is still ongoing regarding guidelines and SOPs etc as these need to be completed first. There also are no OASI clinics at ESHT for July, August and Sept, and the plan is for there to be a Perineal clinic running along-side the OASI clinic. However, I am pushing to set up the perineal clinic even with the absence of the OASI clinic if possible.

Hegenberger Retractor

I discussed this at the Labour ward Forum on 5/5. There was not much support offered, so I have decided to drop this as it was taking up too much time. Other Trusts are trialling it, so I felt it was best to wait till there was more evidence.

MVP

The MVP had reported to the HoM that some service users had reported issues/concerns in relation to pelvic health; delays with appointments etc. I asked the MVP for patient details so I could look into this, only one consented and it appears to have been a long-standing issue that coincided with when there was no Consultant running the OASI clinic. Since VA has taken over, the service user has been followed up and is awaiting further investigation. I have contacted the service user directly to discuss.

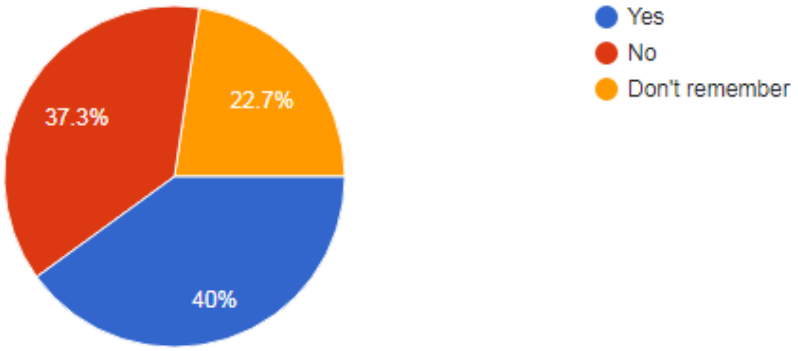
Perineal repair & OASI guidelines

These need updating, but until PPHS pathways and perineal clinics have been finalised I am reluctant to update them now as they will need to be updated again once pathways are up and running.

Personalised Care and Support Plan- East Sussex SU feedback (Jan-June 2023)

During pregnancy, were you/your partner given, or directed to, a copy of "My Choices for Pregnancy, Birth and Beyond" (a personalised care and support plan)?

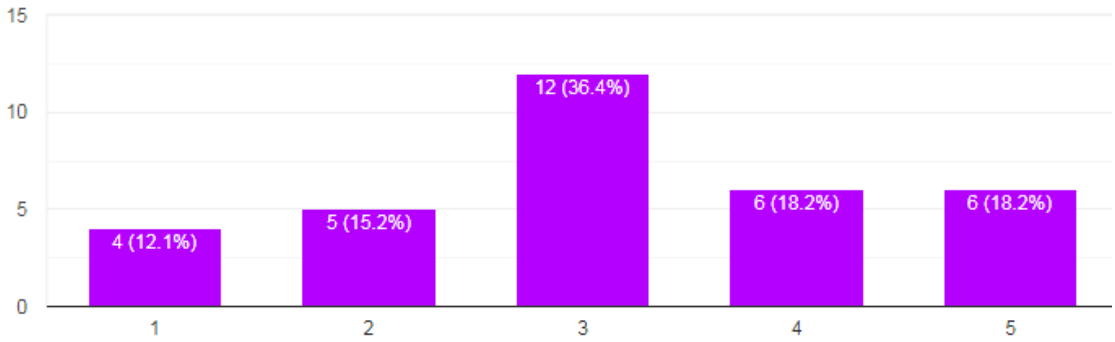
75 responses



If yes how useful did you find this resource? (Scale = 1 not at all useful, 3 somewhat useful, 5 very useful)

Copy

33 responses



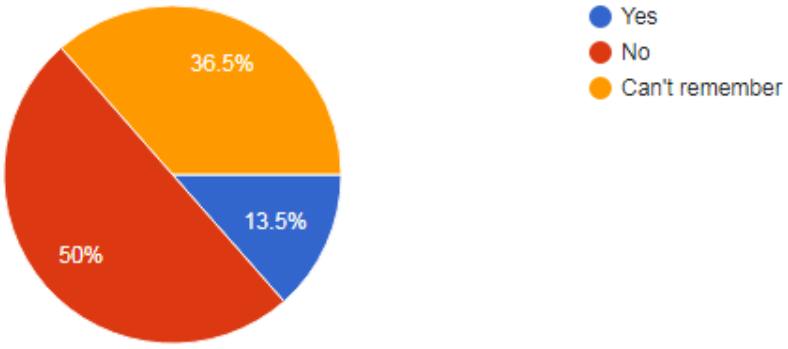
What could have made this resource more useful for you? (13 responses)

- If available electronically via an App. Found the care plan on Badgernet easier to complete but less informative then the booklet.
- Printed copy
- Printed copy given to me
- Cut out all the babble. Make it clear and easy to read. I gave up in the first few pages because of the sheer amount of infomation, its too overwhelming and in a textbook form.
- Don't know
- Was given it at the beginning and began to fill it out myself it was never brought up again or discussed

- Nothing that I can think of
- In person information gives much more sense of assurance and opportunity to ask questions
- Different formats for different communication needs. Eg Neurodivergent people
- Can't remember it
- Didn’t have a birth plan
- Receiving it
- Been told about it

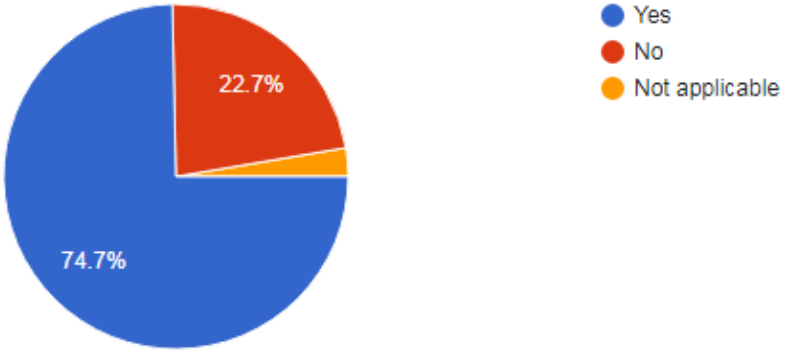
When you had contact with midwives/doctors did they refer to "My Choices for Pregnancy, Birth and Beyond"?

74 responses



Were you/your partner given enough information to make informed decisions about the antenatal care received?

75 responses



Saving Babies' Lives (SBL) Annual Report 2022/23

1. RISK ASSESSMENT AND SURVEILLANCE FOR FETAL GROWTH

There is strong evidence to suggest that Fetal growth restriction (FGR) is the biggest risk factor for stillbirth. Therefore, antenatal detection of growth restricted babies is vital and has been shown to reduce stillbirth risk significantly because it gives the option to consider timely delivery of the baby at risk.

Process and outcome indicators:

- Percentage of pregnancies where a risk status for FGR is identified and recorded at booking.
- Percentage of pregnancies where an SGA baby is antenatally detected.
- Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT).
- Percentage of babies 37+6 weeks (this is a measure of the effective detection and management of FGR).

Small for gestational age SGA refers to babies with a birthweight under the 10th centile and fetal growth restriction FGR to babies with a birthweight below the 3rd centile.

INTERVENTIONS

1.1 Assessing women at booking to determine if a prescription of aspirin is appropriate.

We have fully implemented prescription of aspirin for all people at risk of FGR and/or development of hypertensive disorders. The guidance from SBL Appendix C is incorporated in our clinical guidance and midwives are now able to supply aspirin for at risk pregnancies for timely commencement by 16 weeks. An audit of pregnancies at high risk in January bookings, demonstrated 100% compliance with aspirin recommendations.

1.2 Use a risk assessment pathway (for example, Appendix D) which triages women at increased risk of FGR into an appropriate clinical pathway to provide surveillance for FGR.

We introduced the SBL scanning algorithm from SBL Appendix D and adapted for local use, introduced in March 2020 it is now well established into practice. People are stratified into low, moderate and high risk pathways to increase surveillance. Multiple pregnancies follow surveillance as per NICE guidance. In 22/23 99% of pregnancies identified and recorded a FGR status at booking.

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
% pregnancies where FGR status is identified and recorded at booking	100%	99.20%	99.20%	98.80%	97.70%	99.20%	100%	97.40%	98.10%	98.40%	99.10%	98.40%

A local adaptation is that we offer serial ultrasound surveillance for people who smoke 10 or more cigarettes per day, SBL recommend surveillance for all smokers. We currently do not have the capacity for all smokers, but following findings from a recent SGA audit, smokers surveillance will be reviewed as it concluded that all smokers have an increased risk of growth restriction, regardless of number of cigarettes smoked.

1.3 In women not undergoing serial ultrasound scan surveillance of fetal growth, assessment is performed using antenatal symphysis fundal height (SFH) charts by clinicians trained in their use.

Training of fundal height measurement, both technique and referral is covered in our multidisciplinary MDT Fetal Wellbeing day, we are persistently over 90% for training midwifery and obstetric staff, 2023 training figures:

Jan 23	Feb 23	March 23	April 23
96%	96%	94%	94%

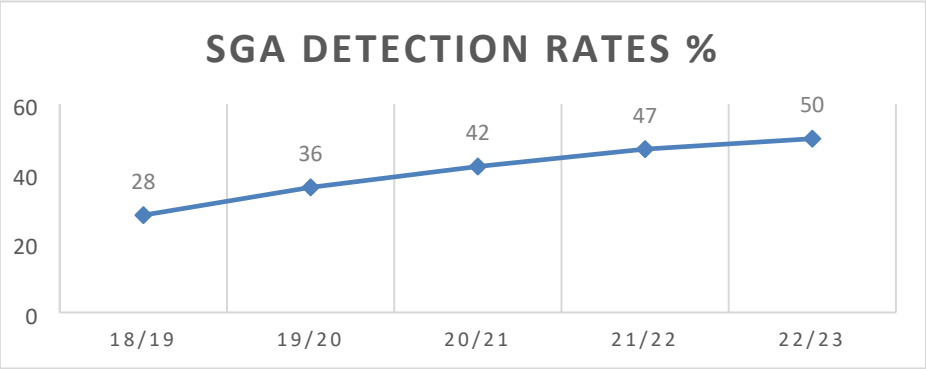
1.4 Management of the SGA and growth restricted fetus.

We have fully implemented and adopted SBL V2 management, early onset growth restriction detected prior to 34 weeks are referred for fetal medicine input. Babies between the 5th and 10th centile with no additional risk factors are offered induction of labour at 39 weeks and babies identified below the 5th centile offered IOL at 37 weeks with all management decisions involving the parents. Our centile thresholds differ slightly from SBL as our scanning software can only identify the 5th centile as the lower parameter. We have just introduced Viewpoint 6 which can now identify the 3rd centile so going forward this will be amended in our clinical guidance and practice to fully align.

For continuous learning we now audit all SGA cases both detected and undetected, this equates to around 9% of our birth rate. This allows us to ensure correct management is followed for detected cases and identify any learning and missed opportunity for any SGA cases not detected antenatally. In 2022 we audited 74 missed cases and actioned all learning points.

All required data is shared with the LMNS and compared to regional units within our LMNS for comparison purposes and sharing of learning within the LMNS safety and Quality meetings.

Increasing our local SGA detection rate has been a Trust Quality Improvement project since 2019. The average for Trusts using population based growth charts is 30% and for Trusts using customised growth charts based on individual characterises (such as parity, BMI, age etc) is 42%. Using QSIR methodology we have increased our SGA detection rate from 28% in 2018 to 50% in 22/23. Our QI aim was to increase to >40%, we have now exceeded our aim and increased detection by 78%.



There were 32 babies born below the 3rd centile >37+6 weeks gestation of which 50% were detected.

We have identified 1 stillbirth case in 22/23 in which identification and/or management of FGR has been a contributory factor in 22/23. Slowing growth was not identified at 35 weeks gestation. This is an ongoing HSIB – Healthcare Safety Investigation Branch investigation. The identified learning and recommendations points will be addressed in an action plan.

2. RAISING AWARENESS OF REDUCED FETAL MOVEMENT (RFM)

Enquiries into stillbirth have consistently described a relationship between episodes of RFM and stillbirth. In all reports unrecognised or poorly managed episodes of RFM have been highlighted as contributory factors to avoidable stillbirths. In addition, a growing number of studies have confirmed a correlation between episodes of RFM and stillbirth. This relationship increases in strength when women have multiple episodes of RFM in late pregnancy (after 28 weeks' gestation).

Process and outcome indicators:

- Percentage of people booked for antenatal care that receive the leaflet/information before 28 weeks gestation.
- Percentage of people who attend with RFM and have a computerised CTG.
- Percentage of stillbirths which had issues associated with RFM identified using PMRT.
- Rate of induction of labour when RFM is the only indication before 39 weeks gestation.

INTERVENTIONS

2.1 Information from practitioners, accompanied by an advice leaflet on RFM, based on current evidence, best practice and clinical guidelines, to be provided to all pregnant women by 28+0 weeks of pregnancy and RFM discussed at every subsequent contact.

The Tommy's evidence based 'baby movements leaflet' is incorporated into the badgernet library and a push notification sent at 24 weeks. Therefore, we are 100% compliant with providing the leaflet, and we are 100% compliant on evidencing that fetal movements are discussed at every contact during clinic appointments.

2.2. Use RFM checklist to manage care of pregnant women who report RFM, in line with national evidence-based guidance.

We have well established use of the recommended reduced fetal movements checklist that is incorporated in to the badgernet system in addition to computerised CTG analysis available on all sites. Audit demonstrated that 99% of all RFM attendances received a computerised CTG analysis which is considered the gold standard of antenatal fetal monitoring.

Our guidance follows national recommendation ensuring appropriate use of induction of labour when RFM is the only indication not to be performed before 39 weeks. There was 1 induction for RFM as the only risk factor in 22/23, the first case since November 2020. This was feedback to the individual staff member and reinforcement of the guidance is now within the mandatory fetal wellbeing day.

There have been no stillbirths that have had issues associated with RFM.

3. EFFECTIVE FETAL MONITORING IN LABOUR

The importance of good fetal monitoring during labour, in achieving delivery of a healthy baby is underlined in various national reports. Appropriate risk assessment and level of monitoring at the onset, during labour and level of monitoring for both intermittent auscultation and cardiotocograph CTG monitoring is paramount. CTG is a well-established method of confirming fetal wellbeing and identification of potential fetal hypoxia. Interpretation is a high-level skill and is susceptible to variation in judgement between clinicians and by the same clinician over time. These variations can lead to inappropriate care planning and subsequently impact on perinatal outcomes. Trusts must be able to demonstrate that all qualified staff who care for women in labour are competent to interpret CTG, always use the Buddy system and escalate accordingly when concerns arise, or risks develop.

Process and outcome indicators:

- Percentage of staff who have received training on CTG interpretation and auscultation, human factors, and situational awareness.
- Percentage of staff who have successfully completed mandatory annual competency assessment.
- The percentage of intrapartum stillbirths, early neonatal deaths, and severe brain injury where failures in intrapartum monitoring are identified as a contributory factor.

INTERVENTIONS

3.1 All staff who care for women in labour are required to undertake annual training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation. Training should be multidisciplinary and include training in situational awareness and human factors.

We now have a well-established full MDT fetal wellbeing day which covers all SBL and Ockenden requirements. The day is inclusive of a competency assessment and a fail pathway is followed to ensure staff do not work on labour ward unless they are in date with annual training and have met the minimum 85% pass mark set by the 2023 core competency framework. The competency assessment was produced in collaboration with the LMNS, and with the new SBL toolkit newly available, we will be able to submit all requirements to the ICB for verification. We have maintained >90% training for all staff throughout the year and in each quarterly report from Q3 were able to stratify all staff groups to ensure each discipline continued to be compliant. Annual training figures for 22/23:

	22/23
Midwives fetal monitoring training	93.5%
Midwives competency assessment	93.2%
Obstetricians fetal monitoring training	93%
Obstetricians' competency assessment	92.2%
All staff fetal monitoring training	93%
All staff competency assessment	92.7%

3.2 We have an intrapartum risk assessment based on national NICE guidance in place and use a 'buddy' system in the form of CTG 'peer reviews'. This is audited quarterly by the fetal wellbeing team and any learning point addressed if required.

3.3 We have 1 WTE Fetal wellbeing specialist midwife and 0.6 WTE deputy who encompass the 0.4 WTE equivalent requirement of Fetal monitoring lead into their roles. This includes all teaching, auditing, and reviews. To increase the benefits of this role further the deputy role is increasing to 1 WTE from September 2023, which will increase clinical presence in the acute site to provide support and in practice teaching. We have a designated Obstetric fetal monitoring lead who is job planned to receive 1 PA per week and is pivotal in the development and delivering of the fetal monitoring training to the MDT.

3.4 We have not identified any cases of intrapartum stillbirths, early neonatal deaths and severe brain injury where failures in intrapartum monitoring are identified as a contributory factor within 2022-23. Furthermore, we have had no cases of HIE 2&3 reported in last financial year.

4. REDUCING PRETERM BIRTHS

Preterm birth defined as delivery less than 37 weeks gestation, is a common complication of pregnancy, comprising of around 8% of births in England and Wales. It is the most important single determinant of adverse infant outcome with regards to survival and quality of life. The interventions of element 5 aim to reduce the number of preterm births and optimise care when preterm delivery cannot be prevented. The national ambition is to reduce the preterm birth rate from 8% to 6%.

Process and outcome indicators:

- Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.
- Percentage of singleton live births (less than 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids.
- Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth.
- Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).
- The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births:
  a. In the late second trimester (from 16+0 to 23+6 weeks).
  b. Preterm (from 24+0 to 36+6 weeks).

INTERVENTIONS

4.1 Assess all women at booking for the risk of preterm birth and stratify to low, intermediate and high risk pathways using the criteria in Appendix F SBLV2

We are now able to stratify all bookings into low, intermediate, and high risk of preterm birth. To ensure the correct surveillance pathway is followed, the fetal wellbeing team triage all bookings that are identified as intermediate and high risk for timely review and transvaginal cervical length scanning, which we can perform in house. Any cases which are identified to require a more advanced procedure for suture are referred to a tertiary unit for consultation. We continually evaluate the preterm pathway to review whether a designated preterm clinic would be beneficial. Our bookings also identify any people who would benefit from low dose aspirin, our placental histology pathway generates a letter to record any findings of placental dysfunction to report in any subsequent pregnancies.

4.2 Mid stream urinalysis is performed as routine for all bookings to screen for asymptomatic bacteriuria, recent audit demonstrated 100% compliance.

4.3 Optimise place of birth – women at imminent risk of preterm birth should be offered transfer to a unit with appropriate and available neonatal cot facilities when safe to do so and as agreed by the relevant neonatal Operational Delivery Network (ODN)

Our threshold for acceptance at ESHT is 31 weeks, in 2022-23 >99.5% of our babies were born in the appropriate care setting for gestation with 11 women giving birth less than 31 weeks gestation. Any birth below 31 weeks is reviewed at daily risk and an ODN exemption form is completed for MDT input regarding prevention, prediction and optimisation. Corticosteroid and magnesium sulphate compliance are also reviewed. All cases are also submitted via Saving babies lives quarterly report and any learning or missed opportunities for optimal care are actioned.

4.4 Antenatal corticosteroids to be offered to women between 24+0 and 33+6 weeks, optimally at 48 hours before a planned birth. A steroid-to-birth interval of greater than seven days should be avoided if possible. Magnesium sulphate to be offered to women between 24+0 and 29+6 weeks of pregnancy, and considered for women between 30+0 and 33+6 weeks of pregnancy, who are in established labour or are having a planned preterm birth within 24 hours.

Singleton livebirths <34 weeks	**32**
(A) that received a full course of corticosteroids within 7 days of birth	**15 (46%)**
(B) that received a full course of corticosteroids more than 7 days of birth	**4 (13%)**
Incomplete course of steroids – birthed prior due to clinical scenario	**9 (28%)**
Received no corticosteroids	**4 (13%)**
Singleton livebirths <30 weeks that received magnesium sulphate within 24hrs prior to birth	**3/5 singleton births (60%)**

Our singleton preterm birth rate for 2022/23 is 6.2% and our late second trimester losses 0.98% which is inline with the national average of 1-2% of pregnancies.

CONCLUSION

We have successful implemented Saving babies lives version 2 with high levels of compliance and sustainability. This has given us a good foundation to begin implementation of Saving babies' lives Version 3 with the aim for full implementation by March 2024.